NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

May 2024

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

Click on each section heading to navigate to that section

Introduction

Please find the Trust's Integrated Performance Report (IPR) for May 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 including ward level detail
- Finance
- Systemwide monitoring

The national metrics section has also been updated to reflect changes in the NHS England 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)	↓	
Financial sustainabiility and efficienceis delivered over time (monthly)	↓	
Premises Assurance Model (PAM)	↔	

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	↑	?

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	↑	
% of feedback with staff attitude as an issue	↓	
Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement	↓	

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)	↑	L
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	↓	?
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	↓	
Community waiting list	↓	

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	↑	H ?
Information Governance training compliance	↑	H ?
Reducing restrictive physical interventions training compliance	↓	?
Sickness rate (monthly)	↓	?
% Complaints with staff attitude as an issue	↓	

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	↓	F
Information Governance training compliance	↑	H ?
Reducing restrictive physical interventions training compliance	↓	F
Sickness rate (Monthly)	↓	?
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
Cardiopulmonary resuscitation (CPR) training compliance	↑	
FIRM Risk Assessments - Staying safe care plan in 24 hours	↑	H F
Information Governance training compliance	↑	H ?
Reducing restrictive physical interventions training compliance	↑	?

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 ?
Sickness rate (Monthly)	↓	?

Forensic

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	H F
Information Governance training compliance	↑	H ?
Reducing restrictive physical interventions training compliance	↑	?

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	● ● ●	● ?HL●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator Pass/Fail	Target Indicator Fail	Target Indicator Pass
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 96.9% against a target of 90%. For the Trust derived indicators, as of May 2024, disability is at 48%, sexual orientation 60.2% 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.

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 significant decrease during May with 34 days used. This is the lowest number of days used in a month since monitoring of this metric came into effect. 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. Workforce pressures also impact the successful management of acuity. 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 increased to 68.7% in May, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service only. The team continue delivering the improvements on the action plan.

Care planning and risk assessments

• For risk assessments, the May data shows a slight increase in performance from the previous month within inpatient services to 94.4%. This is the third month where an increase in performance has been recorded. For community services, performance for May has decreased to 68.1%. Service managers are undertaking a deep dive to understand why this has happened. Within inpatient services 134 service users had a risk assessment within 24 hours, 8 service users had a completed risk assessment but this was outside the 24 hours. For community services 45 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.

Quality continued

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.

• Improvement work on waiting list times in community learning disability services has led to an improvement in month, with 89.2% - (58 out of 65) 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. The LD team to continue also to focus on waits beyond 18 weeks.

• 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

96% of incidents reported in May 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 decreased to 226 (256 in April). Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain static, within expected range – all incidents are reviewed, and learning is shared. A small number of acutely unwell service users who display high levels of violence and aggression disproportionately impact the number of incidents.

• Prone incidents increased within psychiatric intensive care during the month. 95% of prone restraint incidents were for a duration of three minutes or less – this related to 21 incidents for the month of May. 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 eleven information governance personal data breaches during May which is an increase on the last 2 months (8 reported in April and 5 reported in March). Following the spike in February (20 incidents), an urgent communications campaign took place, with items issued via the intranet, the Headlines and the Brief. The appropriate Quality & Governance Leads have also been advised, and the Information Governance team working with them to ensure improvements are made. Information governance training compliance threshold was achieved.

• The number of inpatient falls in May was 39 which is slightly below the average reported over the last 6 months (45). All falls are reviewed to identify measures required to prevent reoccurrence. and more serious falls are investigated. There have been no red Datix incidents reported (falls with injury) during the month but there was one amber incident which related to a patient with complex needs. There was no significant injury reported.

• 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 over the last 12 months.

Our People

• Supervision data is included in the report at Trust level and by care group and inpatient ward. Improvement work has led to performance in May of 80% which is an improvement from the refreshed performance for April which is 77.4%. 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 32 violence and aggression incidents against staff on mental health wards involving race during May - 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 the year to date, we have had 92.6 new starters and 53.2 leavers.

• At the end of May 2024, our Trust growth rate has increased to 0.8% (staff in post). This exceeds our annual forecasted growth rate of 0%. Focus remains on keeping our workforce numbers static throughout 2024/25 to meet our planned workforce targets.

• Overall, our 12-month turnover rate in May has dropped slightly again this month to 9.9% which is a reflection of the continued low number of leavers and increase in new starters over the year. This means that more skills and experience have been retained.

• In May 2024 we have seen a slight increase in sickness overall to 4.7% and remains within threshold. Hotspots continue to be managed.

• 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 May remains at 5.0%. The proposed new threshold reflects this.

  • Our People Relations have been supporting line managers in all areas to actively manage long term sickness cases i.e. following process to review cases, have appropriate meetings etc. to either bring people back to work (or redeploy them) or end their employment on the grounds of medical capability.

  • Our People Business Partners have been working closely with Care Group leaders to highlight hotspots and provide more guidance for managers.

  • Forensic Teams sickness has dropped significantly during May as a result of focussed improvement work.

  • Our Mental Health care group has seen a decrease in long term sickness, however the short term sickness has increased. April to May saw an increase in coughs, colds and flu being reported with an increase in separate episodes across the care group.

  • Estates and Facilities sickness rate is currently 7.13%. Although this is still above target, the service have seen a month on month decrease since January 24 (10.88%).

• Our rolling appraisal compliance rate saw a slight drop in performance to 87.1% in May, as a number of appraisals went out of date at the same time. Actions remain in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.

• Our overall mandatory training compliance has increased slightly to 93%, we have also seen an improvement in areas of concern from previous months where we have been below threshold.

  • Reducing Restrictive Physical Interventions (RRPI) has increased to 74.0% but remains below Trust target. 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 which has seen some positive impact over recent months.

  • Information governance training has increased above threshold to 97.1% which contributed to the Trust exceeding the standards for the Data Security and Protection toolkit final submission.

  • Cardiopulmonary Resuscitation training compliance has increased to 80.7% and now above Trust target.

Targeted actions continue to be 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 sent to all staff. Wards use rostering to ensure the availability of appropriately trained staff at all times.

Care Groups

In addition to the care group information found within this report, a separate deep dive into the Mental health care care group can be found under item 9.2 on this board agenda.

The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of May, 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.

• Although recruitment has been positive, there is increased pressure on the wards from the number of learners that require support, for example student nurses, internationally recruited nurses and newly registered staff, creating additional pressures.

• Demand into the Single Point of Access (SPA) continues. SPA continues to prioritise risk screening of all referrals to ensure any urgent demand is met within 24 hours, performance for routine triage and assessment has been at risk of being delayed in all areas but has been achieved during May.

• 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 CAMHS inpatient provider collaborative executive trio.

• There were two patients under 18 years old in an adult bed during May. Whilst this is measured clearly, 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.

• Although there appears to be a reduction in the people who are clinically ready for discharge at 1.8%, this masks significant hotspots in Horizon assessment and treatment unit and inpatient wards for older people. Working is taking place with commissioners in each place.

Finance

• The Trust financial target for 2024 / 25 is breakeven with expenditure in line with the income we receive. For the year to date a position of £0.8m deficit has been reported. This is £0.6m worse than plan and will require corrective actions to ensure delivery of the target.

• There is sustained reduced levels of agency expenditure which is forecast to continue for the remainder of the financial year. Spend in May 2024 is £443k of which £49k relates to the provider collaborative and individual operational response. If the forecast of £5.2m is achieved this would be a £3.1m reduction from 2023 / 24.

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

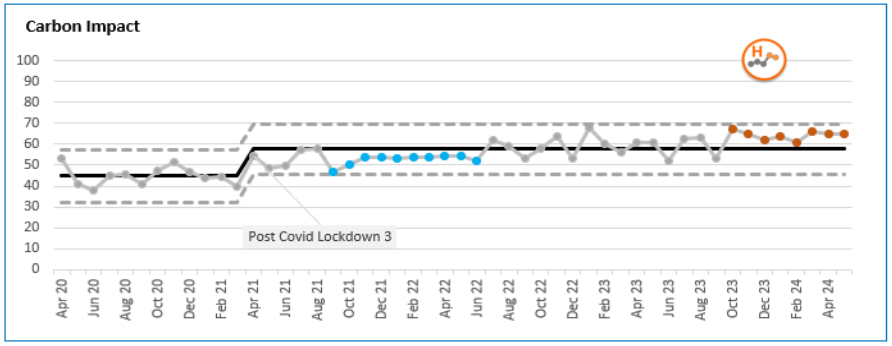
• The Trust cash position, whilst remaining strong, has reduced from the value held at the end of the last financial year. This is primarily due to payment of invoices received in late March and now paid. If the current deficit run rate continues this will have a negative impact on Trust cash balances.

• Performance against the Better Payment Practice Code is 99%.

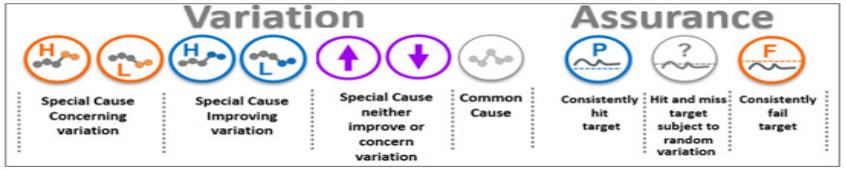
Improving health

Metrics	Threshold	Mar-24	Apr-24	May-24	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	94.9%	94.2%	96.9%		
Percentage of service users who have had their equality data recorded - disability	50%	47.5%	47.4%	48.0%		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		59.9%	59.6%	60.2%		
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	74.3% Service	75% 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%	96.1% Policy	96.7% Policy	97.3% 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	12	14	10		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	43	44	23		New metric added March 2024. First contact and work started on vocational profile
Carbon Impact (tonnes CO2e) - business miles	76	66	65	65	H	Data showing the carbon impact of staff travel / business miles. In May staff travel contributed 65 tonnes of carbon to the atmosphere. April and May 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%	69.9%	Due August 2024			Q1 - 64.9%, Q2 - 66.4%, Q3 - 67.7%, Q4 - 69.9%. 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	Mar-24	Apr-24	May-24	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	91.7%	92.7%	94.4%		May data shows a slight increase in performance from the previous month within inpatient services to 94.4%. This is the third month where an increase in performance has been recorded. For community services, performance for May has decreased to 68.1%. Within inpatient services 134 service users had a risk assessment within 24 hours, 8 service users had a completed risk assessment but this was outside the 24 hours. For community services 45 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		79.2%	78.5%	68.1%		
% Service users on CPA offered a copy of their care plan (collaborative)	80%	95.4%	95.3%	95.2%		The Care Plan and Risk Assessment Improvement Group continue to look at performance as well as quality of care planning and risk assessments. The figures shown have been updated to reflect the previously agreed reporting parameters and now reflects the collaborative approach to care planning.
Registered substantive staff in post mental health and learning disabilities services	Establishment	1109	1107	1115		
Registered substantive staff in neighbourhood teams	Establishment	176	171	172		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	27	26	32		Any increases will be monitored by the Patient Safety Team.
Inappropriate out of area bed placements (days)	0	138	119	34		The 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 92 days over the past 6 months from an average of 292 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%	2.5%	2.3%	1.8%		Performance in month has improved 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	683	672	578		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	611	647	647		
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	76.7% 35/46	82.0% 41/50	89.2% 58/65		This remains a key concern and actions are underway as part of the improving access priority programme. Where waits breached 18 weeks (7 in total in May) 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 continue to focus on those with the longest waits and this has had an impact on staffing capacity to meet the 18 week threshold.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	87.5%	94.6%	89.8%		
Community health services two hour urgent response standard	70%	88.2%	92.8%	89.7%		
Referral to assessment within 2 weeks (external referrals)	75%	89.3%	90.6%	83.8%		

Improve resources

Metrics	Threshold	Mar-24	Apr-24	May-24	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	(£53k)	(£192k)	(£613k)		A deficit of £804k has been recorded for May which is £613k worse than planned. Although pay / workforce remains overspent, with more worked WTE than planned, the main driver in May relates to non-pay expenditure. This includes timing and cost increase pressures; the latter relating to specific drug costs.
Capital spend against plan (monthly)	£8.1m	£2,766k	£334k	£346k		Capital expenditure in May 2024 is £553k. This is £346k more than plan. This is primarily due to the timing of spend for multi-year capital schemes and is forecast to remain within allocation in the current financial year.
Agency spend managed within the overall workforce (Monthly)	3.5% £6.7m	£438k	£442k	£396k		Agency expenditure has continued to reduced with £396k reported in month. This is the lowest individual month for a number of years. Performance here continues to be triangulated with other workforce costs such as bank.
Financial sustainability and efficiencies delivered over time (monthly)	£22m	£1,126k	£1,751k	£665k		Value for money performance is behind plan for the year to date. Live schemes, including new mitigations, continue to be progressed.
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%	100.0%	96.9%		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	8 Good 1 Requires Improvement	8 Good 1 Requires Improvement		PAM is a report measuring how well the Trust is run and includes Estates, Facilities, Governance, Patient Safety, and Efficiency & Effectiveness. In May, the PAM status remains 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	Mar-24	Apr-24	May-24	Variation/ Assurance	Notes
Turnover external (rolling 12 months)	>12% - 13%<	11.0%	10.0%	9.9%		
Registered workforce growth	3% (by March 24) 0% 2024/25	7.7%	0.8%			
Sickness absence - rolling 12 months	<=4.8%	5.0%	4.8%	5.0%		Further detail around sickness absence is provided in the relevant section of this report.
Workpal appraisals - rolling 12 months	Jun 24 89% Jul 24 91% Aug 24 93% Sep 24 onwards 95%	84.2%	87.4%	87.1%		For the month of May, the percentage rate 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%	74.9%	75.6%	80.2%		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%	77.8%	79.4%	80.7%		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%	73.0%	68.3%	74.0%		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%	89.2%	90.4%	91.1%		
Mandatory training - Information governance (IG)	95%	91.5%	92.8%	97.1%		

Quality Headlines

Section	KPI	Target	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	TBC	84.0%	84.0%	81.0%	80.0%	82.4%	85.8%	84.2%	80.9%	78.8%	79.9%	73.3%	75.6%	N/A
Complaints	% of feedback with staff attitude as an issue [12]	< 20%	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)	21% (5/24)	1
	Complaints - Number of responses provided within six months of the date a complaint received	100%	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)	77% (17/22)	
Service User Experience	Friends and Family Test - Mental Health	84%	91%	90%	90%	95%	89%	88%	94%	89%	92%	92%	92%	92%	1
	Friends and Family Test - Community	95%	96%	93%	97%	96%	95%	97%	98%	97%	97%	97%	97%	97%	1
Quality	Number of compliments received	N/A	33	35	22	17	18	35	16	2	8	6	12	26	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	25	24	35	24	30	19	15	17	15	18	12	14	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	3	3	5	4	6	3	1	0	0	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	0	1	0	0	0	0	1	3	0	0	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	96.8%	96.9%	96.8%	96.7%	96.6%	96.5%	96.1%	95.7%	95.9%	95.4%	95.3%	95.2%	1
	Number of Information Governance breaches [3]	<12	14	13	16	8	9	11	8	14	20	5	8	11	2
	% of inpatients clinically ready for discharge	3.5%	4.6%	4.8%	5.7%	5.7%	5.2%	5.8%	5.7%	4.3%	2.9%	2.5%	2.3%	1.8%	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%	86.7%	87.2%	88.0%	87.5%	89.9%	92.5%	94.1%	93.4%	90.1%	91.7%	92.7%	94.4%	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		66.1%	74.0%	72.2%	71.3%	71.1%	76.4%	70.0%	71.8%	74.7%	79.2%	78.5%	68.1%	2
	Total number of reported incidents	Trend monitor	1258	1159	1206	1150	1315	1322	1186	1287	1347	1446	1410	1412	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	19	21	28	23	25	20	17	23	21	35	25	34	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	5	1	4	1	4	1	1	5	4	1	0	1	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	1	2	3	1	3	2	2	2	0	1	0	1	
	Safer staff fill rates	90%	123.7%	123.9%	123.8%	124.1%	123.5%	128.8%	128.7%	129.6%	127.6%	128.5%	130.8%	130.0%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	93.1%	93.6%	92.1%	91.4%	91.3%	97.5%	96.2%	102.2%	100.8%	101.6%	107.1%	105.2%	1
	Number of pressure ulcers which developed under SWYPFT care ($_1$)	Trend monitor	40	36	43	43	28	33	27	45	58	42	22	36	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement ($_2$)	0	3	1	2	0	3	6	6	2	2	0	1	4	
	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%	89.5%	95.2%	90.0%	90.0%	91.7%	66.6%	100.0%	100.0%	100.0%	92.3%	100.0%	95.0%	1
	Number of Falls (inpatients)	Trend monitor	43	32	33	36	50	46	42	48	45	45	41	39	
	Number of restraint incidents	Trend monitor	201	145	146	92	198	153	193	121	165	188	256	226	
	% of staff receiving supervision within policy guidance [15]	80%	Reporting to start from Sept 23			65.8%	66.0%	70.1%	69.6%	70.8%	71.0%	76.3%	77.4%	80.0%	2
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing [14]	80%	87.8%	83.8%	81.8%	90.6%	91.3%	66.7%	95.1%	97.4%	88.9%	94.1%	100.0%	81.8%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	1	0	0	0	0	0	1
	C Diff avoidable cases	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	0	0	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	2	2	2	2	2	2	2	2	2	2	2	2	2	
	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 May.

• The % of feedback with staff attitude as an issue slightly exceeded the local threshold of less than 20% during the month with 5 out of 24 (21%) incidents relating to staff attitude. On review of such complaints, there does not appear to be any particular hotspot areas during the month.
• Although the number of reported incidents remains high in May, 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 May was 226 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 were four instances in May, each include learning points that are being taken on board.
• Clinically ready for discharge (previously delayed transfers of care) - This has decreased to 1.8% 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 May there were 39 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. The figures shown have been updated to reflect the previously agreed reporting parameters and now reflects the collaborative approach to care planning.
• The number of information governance breaches in relation to confidentiality breaches has increased to 11 during the month but remains below threshold.
• 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 Incident Response Framework (PSIRF)
As reported in the previous Integrated performance report, we have been working on our preparations for implementing the Patient Safety Incident Response Framework. The Trusts PSIRF plan and policy went live on the 1st December 2023.

Since launching PSIRF, we have:
- Reviewed linked policies and procedures
- Refined our guidance for learning responses using PDSA
- Reviewed incidents against our PSIRF Plan
- Supported services with considering if incidents meet the plan and if so what improvement work is already in place
- Developed the format of the Patient safety oversight group (PSOG) (formerly clinical risk panel) to align with PSIRF
- Updated Datix to reflect our processes for PSIRF

Learn from Patient Safety Events (LFPSE)
As reported in the previous IPR, Learn from Patient Safety Events will be a new national system that is being introduced to replace:
- National Reporting and Learning System (where we send our patient safety incidents)
- Strategic Executive Information System [StEIS] (where we report Serious Incidents)

Following a further upgrade of the Datix system in January 2024, incident form configuration, and thorough testing, the Trust went live with LFPSE on 14th February. This means that we no longer report to the National Reporting and Learning System from this date. Since launching LFPSE the team have been working on providing training to staff and developing monitoring processes.

Patient Safety Training
Training for all staff (level 1) and essential to job role (level 2) is available on the Electronic Staff Record. Level became mandatory from April 2024. This is currently progressing well at 96% completed.

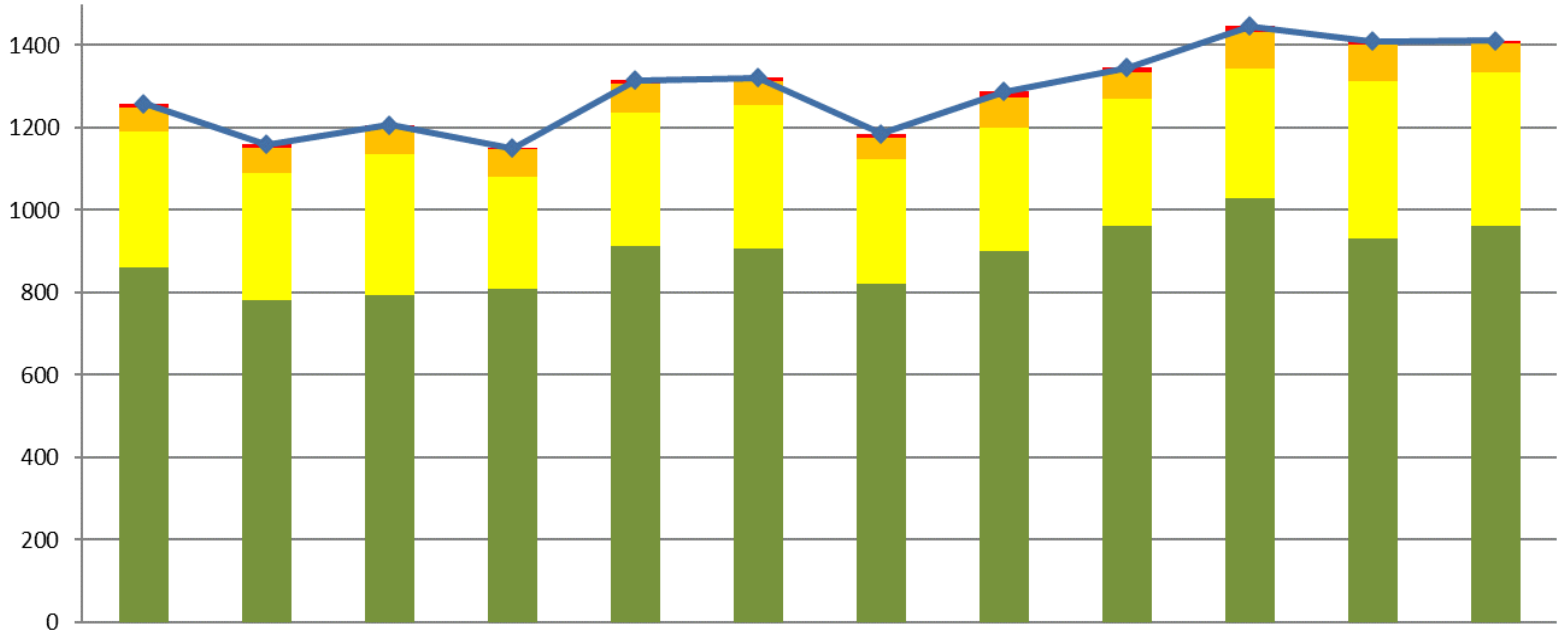
Patient Safety Partners (PSP)
The three patient safety partners (this is a volunteer role) have been inducted into the patient safety team. The PSPs have been invited to join the patient safety improvement group. The patient safety partners profiles are on the Trust website.

Safety First

Summary of Incidents

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

96% of incidents reported in May 2024 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in May 2024



	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Red (should not be compared with SIs)	10	7	9	3	8	9	9	14	10	13	10	9
Amber	58	63	60	65	69	56	54	73	65	90	86	70
Yellow	330	307	342	272	324	349	301	300	309	313	383	372
Green	860	782	795	810	914	907	821	900	961	1030	931	961
Total	1258	1159	1206	1150	1315	1321	1185	1287	1345	1446	1410	1412

Safety First cont…

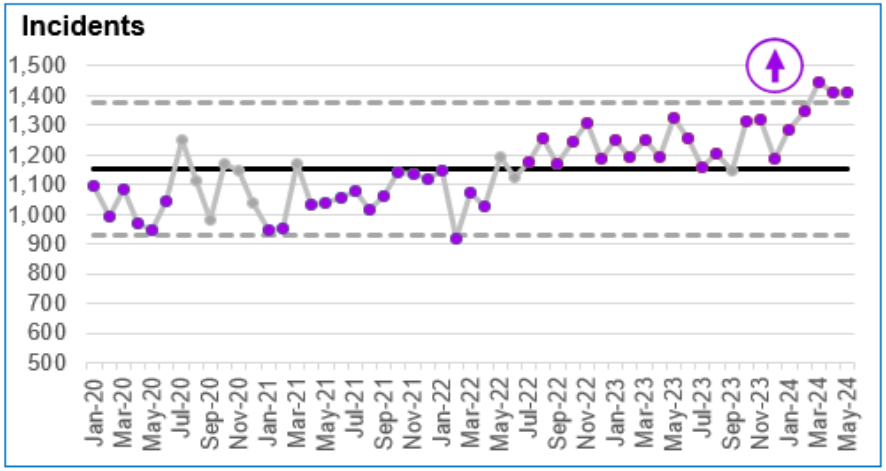
Summary of Patient Safety Incidents resulting in moderate or severe harm or death

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

1 severe harm incident relating to safeguarding concerns

Sadly there was also one patient safety related death in May. A learning response is under way in regards to this. Condolences have been offered to family.

Incidents



We remain in a period of special cause variation (something is happening and this should be investigated) in May 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.

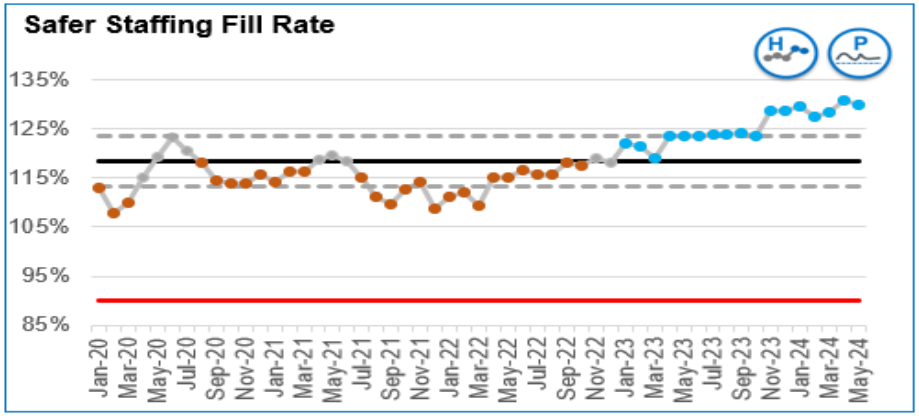
If you would like to attend or share your learning from experience with the learning network, please email learninglibrary@swyt.nhs.uk.

Patient Safety Alerts

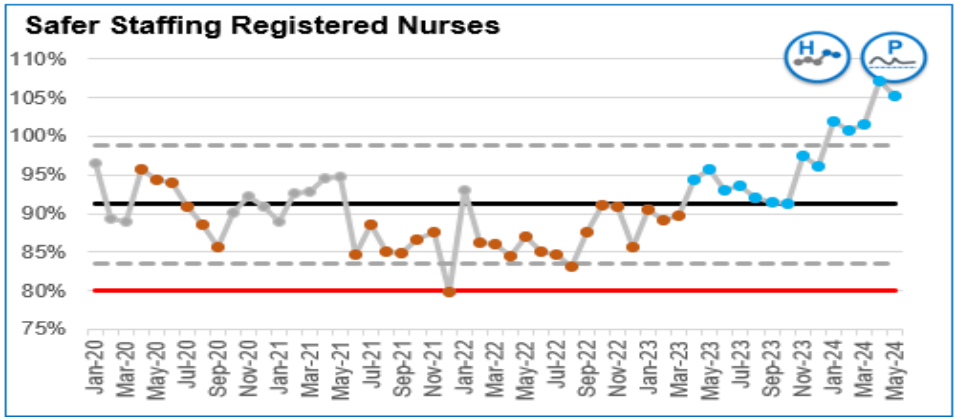
Patient Safety alerts not completed by deadline of May 2024 - zero.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2024/005/MVA	Shortage of Erelzi® (etanercept) 50mg solution for injection in pre-filled pen	03/05/2024	No - alert not applicable to Trust	10/05/2024	03/05/2024
NatPSA/2024/006/DHSC	Shortage of Orencia® ClickJectTM (abatacept) 125mg/1ml solution for injection pre-filled pens	23/05/2024	No - alert not applicable to Trust	06/06/2024	24/05/2024
NatPSA/2024/007/DHSC	Shortage Of Pancreatic Enzyme Replacement Therapy (Pert)	24/05/2024	Yes - circulated for information	10/06/2024	28/05/2024

Safer Staffing Inpatients



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

• Demand has increased due to increased annual leave being taken in May compared to April which is traditionally lower. Within the flexible staffing pool there were a total of 50 more shift requests, however the overall fill rate increased to 93.38%.
• All figures within the care groups indicate a very similar level in overall demand to deal with acuity given the small difference in number of requests. Flexible workforce fill rates at all levels (registered nurse, healthcare assistant, and overall) in May improved compared to April.
• Vacancy control groups are being established to ensure that targeted local recruitment replaces the centralised process.
• Work continues towards expanding the collaborative bank with a focus on training issues and compliance. To date, 80 individuals in the Trust have been cleared to work with Leeds and York Partnership Foundation Trust. Further progress has been made in clearing workers previously registered with agency.
• SafeCare continues to be utilised. While this remains inconsistent across the wards in which it has been implemented, the wider recognition of its importance is an important step in improving usage and will allow more areas to benefit from advantages seen in those areas where it has successfully been deployed. These areas can have meaningful data-supported discussions on staffing requirements and evidence-based deployments as well as indicating potential savings through effective utilisation of e-Rostering.
• The roll out of e-Rostering to all clinical workforce continues.
• The overall fill rate changed slightly with a decrease of 0.8% to 130%. There was continued improvement in the day fill rate for registered nurses with an increase of 0.5% to 99.5%. Seven wards fell below the 90% registered nurse day fill rate which was a decrease of one ward from April.
• In May no ward fell below the 90% overall fill rate threshold, which was consistent with the previous month.

Safer Staffing Inpatients cont…

Registered Nurses Days
There was an increase of 0.5% in overall registered Day fill rates to 99.5% in May compared with the previous month.

Registered Nurses Nights
There was an increase of 0.4% in overall registered Night fill rates to 115.6% in May compared with the previous month.

Overall Registered Rate: 105.2%, which was an increase of 0.4% on the previous month.
Overall Fill Rate: 130.0% (decrease of 0.8% on the previous month)

Overall Fill Rate	Mar-24	Apr-24	May-24
Adults and Older People	138%	139%	139%
Barnsley Integrated Services	114%	113%	113%
Forensic and LD	116%	119%	117%
Grand total	**129%**	**131%**	**130%**

Registered day rate	Mar-24	Apr-24	May-24
Adults and Older People	95%	98%	100%
Barnsley Integrated Services	99%	119%	116%
Forensic and LD	93%	97%	96%
Overall shift fill rate	**94%**	**99%**	**99%**

Registered night rate	Mar-24	Apr-24	May-24
Adults and Older People	106%	115%	117%
Barnsley Integrated Services	85%	84%	99%
Forensic and LD	116%	120%	117%
Overall shift fill rate	**109%**	**115%**	**116%**

• Bank staff filled 75.06% (an increase of 7.14% on the previous month) of registered nurse requests for flexible staffing and 86.74% (an increase of 2.09% on the previous month) of healthcare assistant requests.
• Agency staff filled 6.12% (a decrease of 1.7% on the previous month) of registered nurse requests for flexible staffing and 8.79% (a decrease of 1.65% on the previous month) of healthcare assistant requests.

Information Governance (IG)

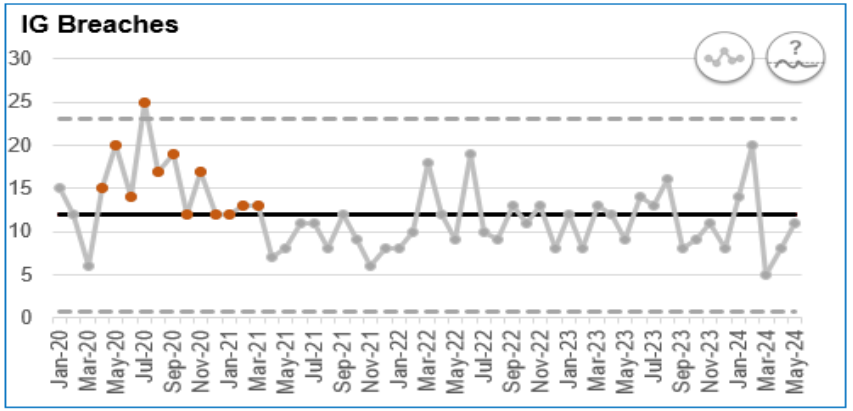
11 personal data breaches were reported during May, which is a slight increase on April.

The breaches were due to:
- Wrong addresses written on envelopes,
- Letters being put in the wrong envelope,
- Multiple letters put in one envelope,
- Failure to blind copy patient email addresses on a group email,
- Failure to update address information on system,
- Service users accessing unsecure paper records,
- Emails sent to the wrong address.

Two allegations of inappropriate access and sharing of information are currently being investigated and the People Directorate has been informed.

There are currently no open complaints with the Information Commissioner's Office.

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



Commissioning for Quality and Innovation (CQUIN)

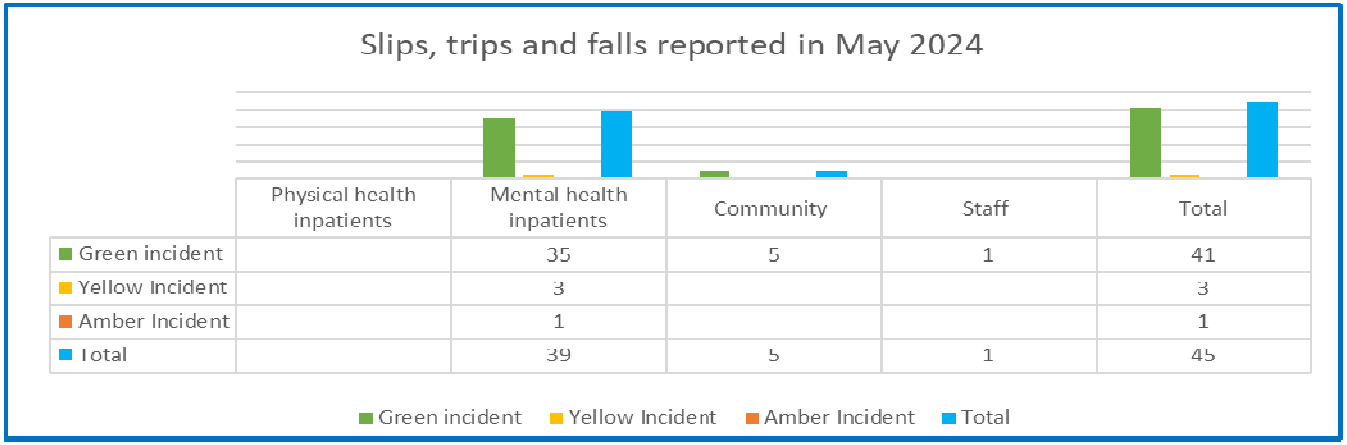
CQUIN schemes were in place for 2023/24 contracts. These mainly related to the Trust's contracts with our Place-based commissioners in each integrated care system (ICS). The overall financial value of CQUIN was 1.25% of total contract value.
The quarter 4 submission was undertaken at the end of May 2024. Underachievement was associated with 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

May 2024: A total of 45 slips, trips and falls were reported. 41 of these were in inpatient wards.

The current rate of inpatient falls in May 2024 is 2.99 per 1000 bed days. We continue to report within or just below the national average of 3-5 falls per 1000 bed days.



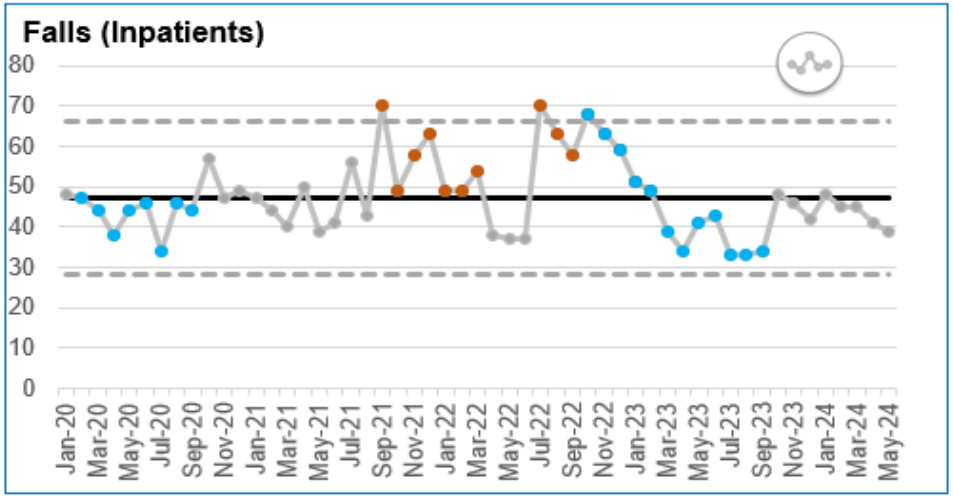
	Physical health inpatients	Mental health inpatients	Community	Staff	Total
Green incident		35	5	1	41
Yellow Incident		3			3
Amber Incident		1			1
Total		39	5	1	45

- There continues to be a very good response from staff reviewing physical and mental health needs. Organising multidisciplinary meetings, and seeking specialist advisor advice in a timely manner
- Physical health inpatient units recorded no falls in May
- Post Falls Protocol completion has averaged 94% this month, with a continued good response from staff
- 99% of patients had a good quality FRAT-18 completed within 24hrs of admission

Incident Grading
No red incidents.
Amber: 1 (2%) incident reported. Complex patient needs. There was no significant injury reported.
Yellow: 3 (7%) reported incidents had no significant injuries recorded and however intervention required. 1 of these falls occurred whilst the patient was on leave from the ward.
Green: 41 (91%) reported incidents had low or no harm recorded. 3 (7%) of these reported patient falls occurred when not on the ward, for example when on leave.

Falls (Inpatient)

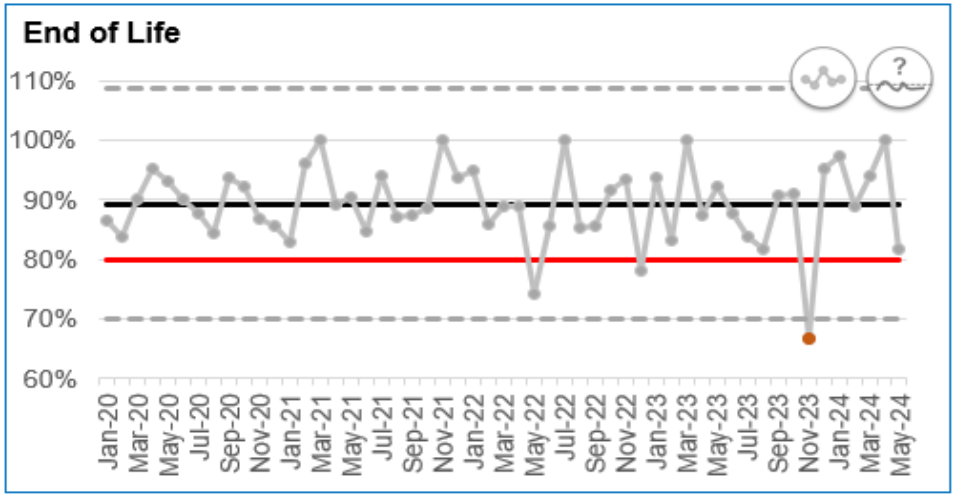
The total number of inpatient falls was 45 in May.



The SPC chart above shows that in May 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 82% in May. 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 May 2024 the performance against this metric remains in common cause 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	March	April	May
Mental health community	85%	92% (299)	95% (330)	92% (299)
Mental health inpatient	85%	83% (40)	86% (57)	83% (40)
Learning Disabilities	85%	100% (25)	88% (16)	100% (25)
ASD/ ADHD	85%	100% (1)	50% (2)	100% (1)
CAMHS	75%	93% (29)	77% (26)	93% (29)
Forensic	60%	100% (4)	33% (3)	100% (4)
Mental health overall	84%*	**92% (399)**	**92% (435)**	**92% (399)**
Barnsley Physical Health	95%	**97% (315)**	**97% (380)**	**97% (315)**
Trustwide	**85%**	**94% (715)**	**95% (817)**	**94% (715)**

** weighted for 2023/24*

	Top three positive themes	Top three negative themes
Trustwide	1. Staff	1. Staff
	2. Patient care	2. Communication
	3. Communication	3. Admission and discharge
Physical Health	1. Staff	1. Staff
	2. Patient care	2. Environment
	3. Communication	3. Communication
Mental Health	1. Staff	1. Staff
	2. Patient care	2. Communication
	3. Communication	3. Admission and discharge

This is a measure of the number of positive responses on the Friends and Family Test responses where 'Very Good' or 'Good' have been selected as ratings.

Satisfaction in learning disability services and forensic services has increased.

Satisfaction for community mental health services has declined but remains above target.

Satisfaction across mental health inpatient and ADHD services remains the same.

All services remain above target except for mental health inpatient where a smaller number of responses has impacted the percentage this month.

The number of Forensic returns remains low as Forensic survey is completed 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.

Safeguarding

Safeguarding Adults:
In May 2024, there were 37 Datix incidents categorised as safeguarding adults. 17 of these were graded as green, 17 were graded as yellow, three were graded as amber and there were no red Datix. The most common subcategories were physical abuse, neglect, financial abuse and emotional abuse.

In addition to the safeguarding adults Datix, there were 25 sexual safety Datix incidents, there were 16 green incidents, eight yellow incidents and there was one amber incident. 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 May 2024 there were 14 Datix incidents categorised as safeguarding children; six of these were graded as green, six were graded as yellow, two were graded as amber and there were no red Datix. The most common subcategories of these were physical abuse and child protection. In all of the Datix incidents submitted, Trust safeguarding advice was sought as appropriate.

Complaints

- Acknowledgement and receipt of the complaint within three working days –24/24 (100% of formal complaints)
- Number of responses provided within six months of the date a complaint received – 17/22 (77%)
- 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 24 new formal complaints in May 2024
- 26 compliments were received
- 22 formal complaints were closed in May 2024
- Number of concerns (informal issues) raised and closed in May 2024 – 47
- Number of enquiries responded to in May 2024 – 34
- Number of complaints re-opened during May 2024 - 0
- 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 - May 2024
- There was one Covid-19 outbreak on an older peoples inpatient ward.

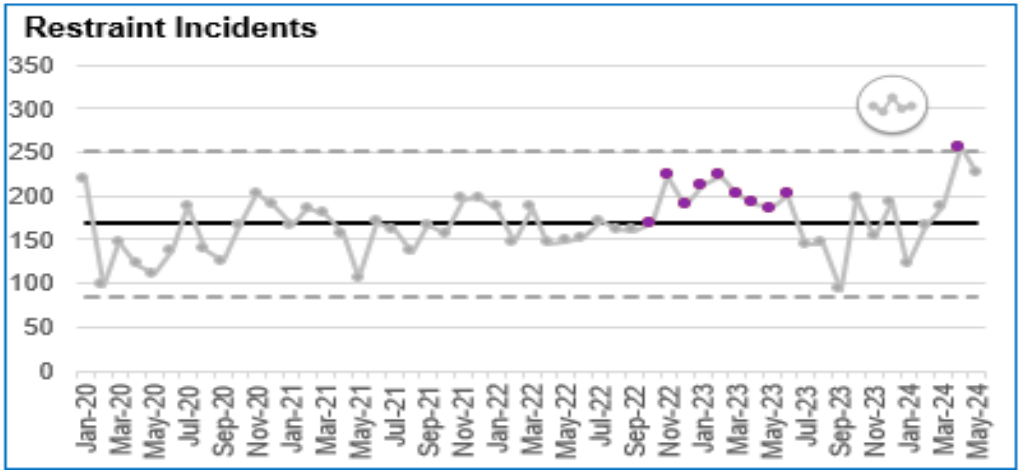
Reducing Restrictive Physical Intervention (RRPI)

- There were 226 reported incidents of RRPI used in May 2024 this was a reduction of 30 (11.7%) from April 2024 which stood at 256.
- 95% of prone (lying facedown) restraints in May 2024 lasted under three minutes.

Restraint Position	Total Restraint Positions	Percentage of Use
Standing	123	40.0%
Seated	56	18.1%
Safety Pod	47	15.2%
Supine - held on their back, regardless of surface	28	9.0%
Prone descent then remained in chest down position	21	6.8%
Side	20	6.4%
Prone descent then immediately rolled to other position side/back	4	1.2%
Restricted escort	4	1.2%
Kneeling	3	0.9%
Service User placed self in prone and staff immediately let go or rolled	2	0.6%
Total	**308**	

Team Using Prone Restraint	May-24
Walton PICU	9
Melton PICU, Barnsley	5
Beamshaw Ward, Barnsley	1
Clark Ward, Barnsley	1
Elmdale Ward, The Dales, Calderdale	1
Hepworth Ward, Newton Lodge, Forensic	1
Horizon Centre, Wakefield	1
Nostell Ward, Wakefield	1
Ward 18, Priestley Unit, Kirklees	1
Total	**21**

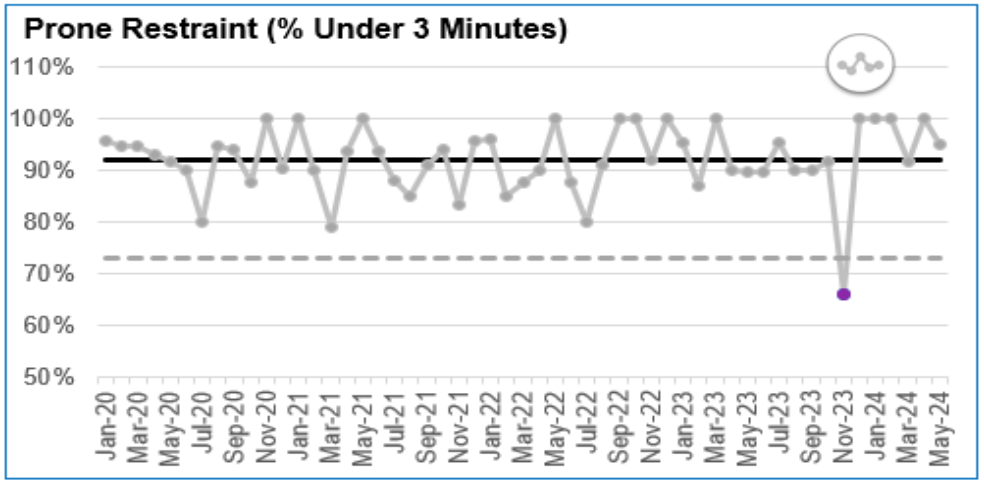
Duration of Prone Restraint	May-24
0 - 1 minute	15
1 - 2 minutes	3
2 - 3 minutes	2
6 - 7 minutes	1
Total	**21**

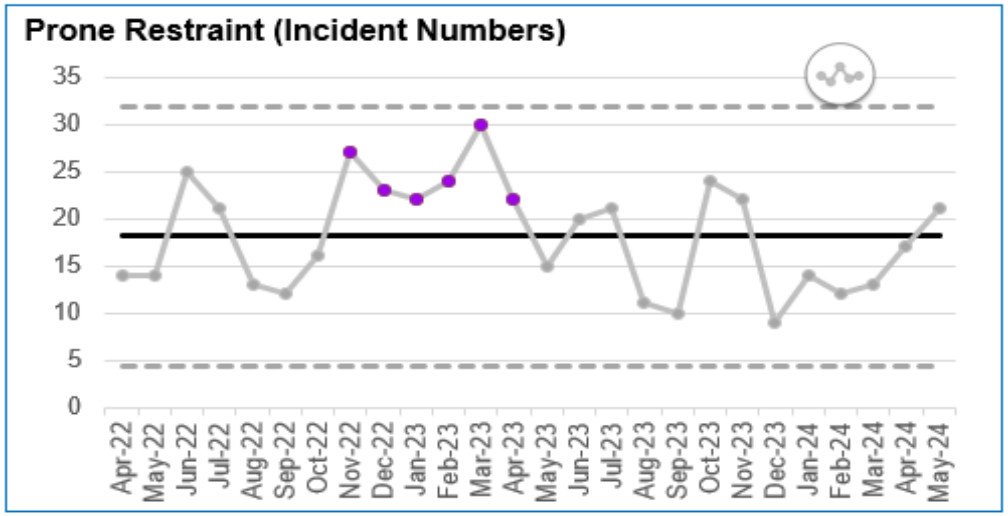


This SPC chart shows that in May 2024 we have re-entered a period of common cause variation (no concern). The increase in the number of restraint incidents in the past two months is linked directly to the acuity of particular service users.

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.

The number of prone restraints has increased in May however all incidents of prone restraint are reviewed for learning in the Patient Safety Oversight Group.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Establishment	Improving Resources	Well Led	-	5,193.8	5,196.6	5204.8	5321.0	5323.3	5329.5	5341.4	5412.1	5415.1	5422.1	5469.4	5451.0
Contracted Staff In Post (Ledger)			-	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	4682.4
Vacancies			-	818.4	796.1	772.1	867.8	897.4	887.0	870.1	876.6	840.6	817.0	813.5	768.8
Turnover external (12 months rolling)			>12% - <13%	13.1%	13.0%	13.1%	12.1%	12.4%	12.0%	12.0%	11.6%	11.2%	11.0%	10.0%	9.9%
Starters			-	57.5	53.9	64.0	63.3	69.4	61.6	42.8	91.4	49.8	38.3	56.4	36.2
Leavers			-	41.1	51.3	45.2	35.2	51.8	31.9	27.6	30.3	32.8	37.7	20.2	33.0
International Nurse Starters in Month			-	0	0	9	10	10	10	5	5	0	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%	75.1%
% Bank Fill Rates - Health Care Assistants			-			69.8%	70.2%	75.9%	80.3%	80.8%	82.2%	86.2%	85.2%	84.7%	86.7%
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%	93.4%
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%)	230 - All staff (16.5%) 100 - excl medics (8.4%)
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%)	984 (70.5%)
Sickness absence - Rolling 12 month			<=4.8%	5.3%	5.3%	5.3%	5.3%	5.2%	5.2%	5.1%	5.1%	5.0%	5.0%	4.8%	5.0%
Sickness absence - Month			<=4.8%	4.6%	5.1%	4.7%	4.9%	5.2%	4.9%	5.1%	5.1%	4.8%	4.4%	3.6%	4.7%
Employees with long term sickness over 12 months			-	0	0	0	2	2	0	1	1	0	0	0	0
Appraisals - rolling 12 months			Jun 24 89% Jul 24 91% Aug 24 93% Sep 24 onwards 95%	78.5%	76.5%	74.5%	72.5%	69.7%	73.1%	74.3%	79.6%	82.9%	84.2%	87.4%	87.1%
Employee Relations - Suspensions (over 90 days)			-	0	3	3	3	4	2	2	2	2	3	1	2
Mandatory Training - TOTAL	Improving Care		>=80%	92.0%	92.1%	92.5%	92.1%	92.5%	92.1%	91.9%	91.9%	91.8%	91.9%	92.5%	93.0%
Mandatory Training - Reducing Restrictive Practice Interventions				76.7%	76.2%	82.6%	82.8%	82.9%	85.0%	81.8%	77.0%	74.0%	73.0%	68.3%	74.0%
Mandatory Training - Cardiopulmonary Resuscitation				81.3%	81.0%	79.9%	80.0%	79.7%	78.5%	77.0%	77.5%	76.1%	77.8%	79.4%	80.7%
Mandatory Training - Clinical Risk				95.4%	95.2%	94.8%	94.0%	92.6%	91.3%	91.0%	90.6%	91.8%	92.5%	96.6%	93.8%
Mandatory Training - Display Screen Equipment				97.0%	97.1%	97.4%	97.4%	97.4%	97.1%	97.0%	95.2%	96.1%	96.4%	97.4%	97.1%
Mandatory Training - Equality & Diversity				96.2%	96.0%	95.9%	96.1%	95.4%	94.9%	94.9%	95.1%	95.3%	95.4%	95.8%	96.6%
Mandatory Training - Fire Safety				92.8%	92.0%	91.4%	91.2%	91.0%	90.6%	90.8%	90.5%	89.6%	89.2%	90.4%	91.1%
Mandatory Training - Food Safety				86.4%	87.8%	89.4%	89.3%	88.1%	89.0%	89.4%	90.0%	90.4%	90.2%	90.2%	90.8%
Mandatory Training - Freedom To Speak Up (FTSU)				94.0%	94.3%	94.7%	94.9%	95.0%	94.9%	95.0%	95.2%	95.2%	95.6%	95.8%	95.9%
Mandatory Training - Infection Control & Hand Hygiene				94.1%	94.3%	94.3%	95.6%	94.2%	93.6%	93.1%	93.7%	93.7%	92.8%	93.3%	94.5%
Mandatory Training - Information Governance (Data Security)			>=95%	96.8%	96.9%	95.3%	94.8%	94.5%	93.4%	94.0%	92.7%	91.8%	91.5%	92.8%	97.1%
Mandatory Training - Moving & Handling			>=80%	95.2%	95.1%	95.6%	94.8%	96.5%	96.9%	96.9%	97.3%	97.5%	97.6%	97.8%	97.9%
Mandatory Training - Nat Early Warning Score 2 (New S2)				93.8%	94.7%	95.2%	96.2%	96.0%	94.6%	94.1%	93.5%	93.6%	94.1%	95.7%	94.5%
Mandatory Training - Mental Capacity Act/Dols				93.7%	93.4%	94.0%	96.7%	99.6%	99.2%	99.0%	99.1%	99.2%	99.4%	99.6%	91.2%
Mandatory Training - Mental Health Act				91.2%	91.1%	92.2%	99.8%	91.2%	90.5%	90.2%	90.7%	89.6%	89.1%	89.6%	88.6%
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%	83.2%
Mandatory Training - Prevent			>=80%	92.1%	94.1%	94.2%	91.7%	93.7%	92.1%	92.3%	92.9%	91.9%	92.6%	93.3%	94.5%
Mandatory Training - Safeguarding Adults				89.3%	89.5%	89.7%	93.9%	90.7%	89.6%	89.4%	88.4%	88.3%	88.2%	88.8%	89.6%
Mandatory Training - Safeguarding Children				91.1%	91.2%	91.7%	89.7%	95.1%	94.4%	94.0%	92.9%	93.6%	93.3%	94.1%	95.1%

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.

Staff In Post
• It is the Trust's objective to see no net growth in staff throughout 2024/25. Although we have seen a slight growth up to May 24, this is minimal.
• There is some recruitment activity which was started during 23/24 which are now impacting on the SiP figures for 24/25 due to new starters in the new financial year. Further work is underway to easily identify real time recruitment activity which will provide useful information related to this. Further details on this will follow.

Vacancies
• Our vacancies have dropped this month, which aligns with our increase in Staff in Post
• A new 'real time' report is being developed to show how many vacancies are active. This will help us triangulate the recruitment activity

Turnover
• Our Turnover for May 24 continues to drop again this month. This has been a consistent monthly improvement Since October 23.
• Our Forensic Care Group has seen an increase this month to 11.4% (Apr 10.9).

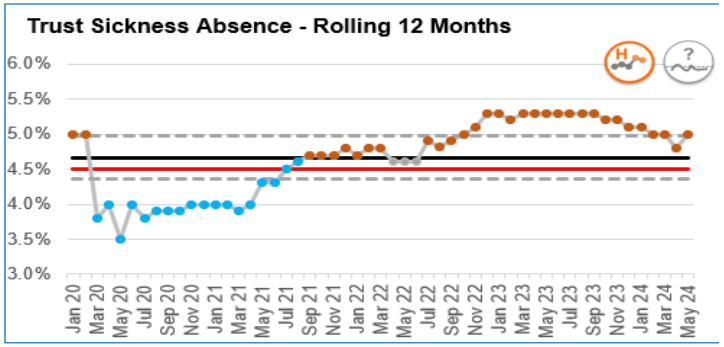
Stability
• The stability rate has improved on a monthly basis year to date (from 90.5% - 90.7%).

Sickness (Overall)
• Our People Relations 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.
• Our People Business Partners have been working closely with Care Group leaders to highlight hotspots and provide more guidance for managers.
• Forensic Teams have dropped significantly this month
• Our Mental Health care group has seen a decrease in long term sickness, however the short term sickness has increased. April to May saw an increase in coughs, colds and flu being reported with an increase in separate episodes across the care group, resulting in an overall increase in STS levels.
• Estates and Facilities sickness rate is currently 7.13%. Although this is still above target, the sickness rate has decreased on a monthly basis since January 24 (10.88%).

Appraisal Compliance
• Appraisal compliance has dropped slightly this month

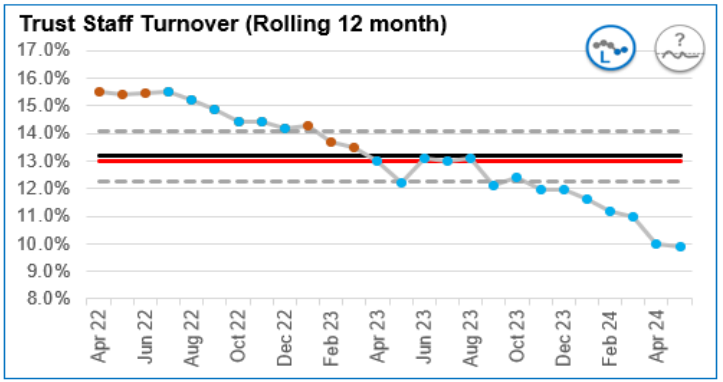
Training Compliance
• A new Power BI dashboard is in the final stages of development. This will allow managers to see the compliance for their own staff and support managers in improving compliance.

Statistical process control charts

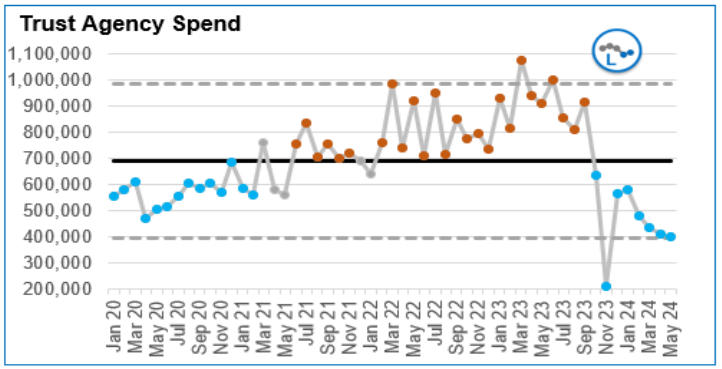


The SPC chart shows that in May 2024 we remain in a period of special cause concerning variation (something is happening and this should be investigated). See Finance Appendix for further information.

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



The SPC chart shows that in May 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 May 2024 we have entered a period of common cause improving variation (something is happening and this should be investigated) following a sustained decrease in agency spend over the last 6 months.

Please see finance section for further detail on agency spend.

National Metrics

Data as of : 27/06/2024 16:41:41

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.

This table only includes operational metrics, there are a number of other workforce, quality and finance metrics that are reported in the relevant section of the IPR.

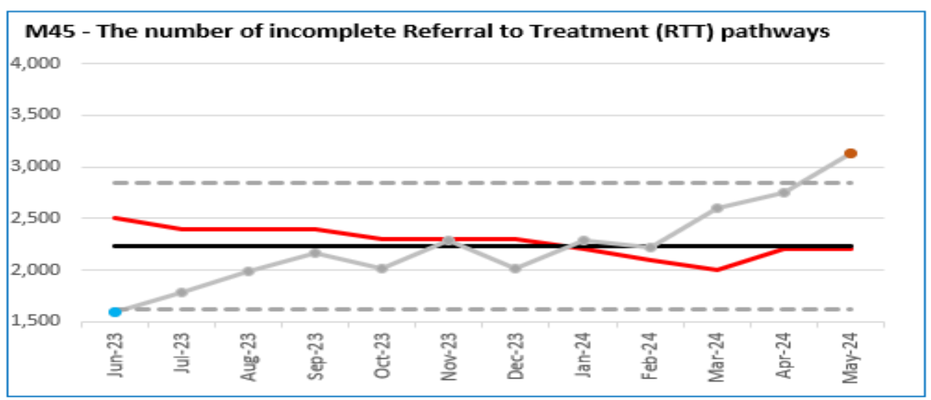
Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M2	Inappropriate out of area bed days		0	F	L	435	589	400	187	66	75	85	104	74	138	119	34
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	P		88.2%	93.3%	92.9%	86.4%	85.7%	86.1%	89.7%	81.6%	93.2%	94.1%	87.5%	90.3%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	99.6%	99.0%	99.5%	99.9%	100%	100%	99.7%	99.8%	99.9%	99.9%	100.0 %	100.0%
M6	Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)		99%	?	L	83.1%	67.1%	64.4%	74.9%	74.2%	63.0%	64.3%	55.9%	69.2%	66.1%	51.9%	68.7%
M7	72 hour follow-up from psychiatric in-patient care		80%	?		92.6%	87.7%	90.7%	88.6%	90.8%	89.0%	91.2%	88.7%	92%	87.5%	94.6%	89.8%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?		29	9	18	8	2	9	23	30	28	8	29	13
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?		1	1	2	2	1	1	1	1	1	2	1	2
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?		100%	70%	66.7%	100%	100%	100%	75%	100%	66.7%	100%	n/a	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?		100%	92%	91.3%	96.6%	91.7%	93.5%	88.6%	97.1%	97.2%	97.1%	97.5%	93.3%
M15	Data Quality Maturity Index		95%	P	H	99.5%	98.8%	99.3%	99.3%	99.5%	99.5%	99.5%	99.5%	99.4%	99.4%	99.3%	99.5%
M30	Number of detentions under the Mental Health Act (MHA)					93	101	100	97	97	87	98	92	83	99	92	100
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					12.9%	24.8%	19%	23.7%	22.7%	18.4%	18.4%	20.7%	18.1%	15.2%	16.3%	25%

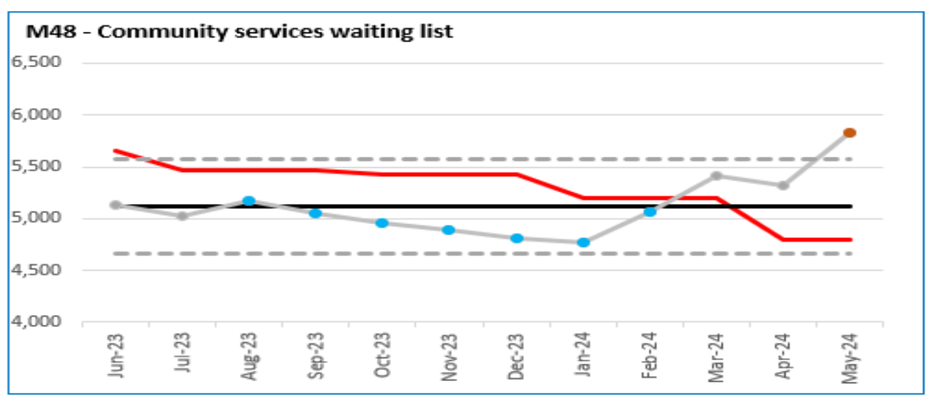
National Metrics

Data as of : 27/06/2024 16:41:41

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			98.0%	98.5%	98.5%	97.2%	97.8%	98.2%	97.8%	97.8%	97.5%	96.7%	97.8%	96.6%
M34	% Clients in settled accommodation	⚠	60%	P	L	84.3%	83.8%	84.3%	84.3%	84.8%	85%	84.5%	84.6%	84.2%	83.5%	83.4%	83.5%
M35	% Clients in employment	⚠	10%	P	H	11.7%	12.0%	12.3%	12.6%	12.2%	12.3%	12.6%	13.2%	13.0%	13.5%	13.0%	13.0%
M41	Completion of a valid NHS number		99%	P		99.7%	99.8%	99.6%	99.6%	99.6%	99.7%	99.7%	99.8%	99.7%	99.7%	100.0 %	99.6%
M42	Completion of ethnicity coding for all service users		90%	P	L	99.4%	99.4%	99.5%	99.4%	99.5%	99.4%	99.4%	99.4%	96.9%	100.0 %	93.2%	98.4%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500			2335	1509	1667	1656	1726	1844	1303	1700	1559	1336	1661	1589
M47	Virtual ward occupancy		80%			92.9%	51.4%	57.1%	60%	57.5%	78.8%	64.3%	81.4%	95.7%	101%	82.7%	94.3%
M49	Number of people who receive two or more contacts from community mental health services for adults and older adults with severe mental illnesses (MHSDS Definition) Rolling 12 months				L	14547	14576	14576	14553	14587	14581	14397	14469	14385	14287	14123	14101
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months					11134	11153	10970	11072	11172	11238	11061	11142	11078	11055	10928	10999
M171	% Admissions gate kept by crisis resolution teams		95%			100%	96.6%	100%	99.1%	100%	97.9%	100%	98.1%	98.8%	95.7%	98.8%	98.1%
M181	Women Accessing Specialist Community Perinatal Mental Health Services					1201	1212	1218	1199	1221	1203	1177	1203	1214	1188	1209	1221
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)					23	31	22	10	6	3	4	7	7	6	5	2
M183	Incomplete Referral to Treatment (RTT) pathways of 65 weeks or more					0	0	0	0	0	0	0	0	0	0	0	0
M184	New RTT pathways (clock starts)		1700			2410	2384	2509	2597	2269	2543	1790	2361	2432	2270	2410	2337





National Metrics

Data as of : 27/06/2024 16:41:41

NHS South West Yorkshire Partnership NHS Foundation Trust

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

• The percentage of service users waiting for a diagnostic appointment (paediatric audiology) within 6 weeks increased to 68.7% in May, this continues to remain below the national threshold of 99%. 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 May compared to previous months and this has impacted the performance 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.

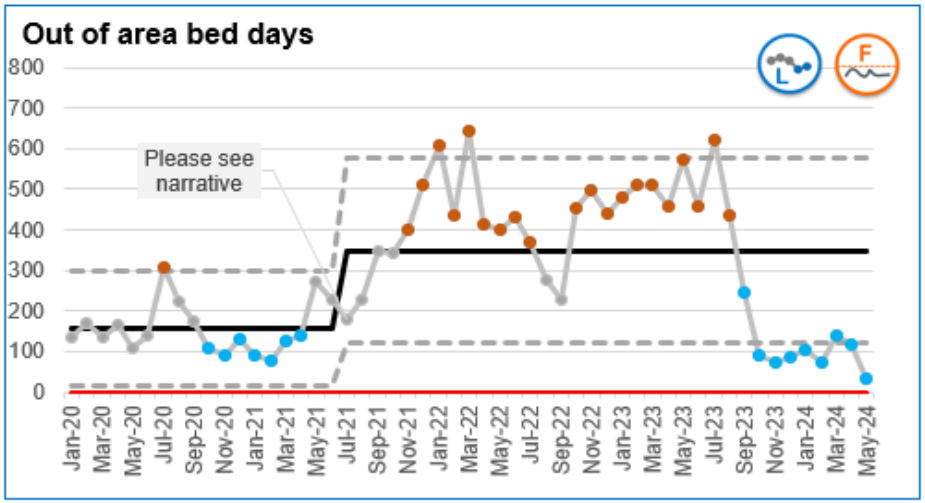
• The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week is 100% in May. The routine access to treatment measure has decreased slightly in May to 93.3%, which is just below the 95% threshold though this only relates to two clients not seen within the timeframe out of 30. Please see narrative in the Strategic Objectives & Priorities section of this report for further detail.

• During May, there were two service users aged under 18 years placed in adult inpatient wards with a total length of stay in the month of 13 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.

• Percentage of service users on the care programme approach (CPA) having formal review within 12 months has dipped below threshold at 92.3% during the month of May. This metric remains in a period of common cause variation. Fluctuations in the performance mean that achievement of the threshold cannot be estimated.

• M48 - Community services waiting list - This metric reports the total number of people waiting across a range of physical health and well-being services in Barnsley (aligned to the national community services SitRep). There has been a significant increase in demand for musculoskeletal services which is also reflected in the number of incomplete Referral to Treatment (RTT) pathways (M45) 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 above threshold.



The SPC chart shows that there has been a further decrease in the number of inappropriate out of area bed days in May 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.

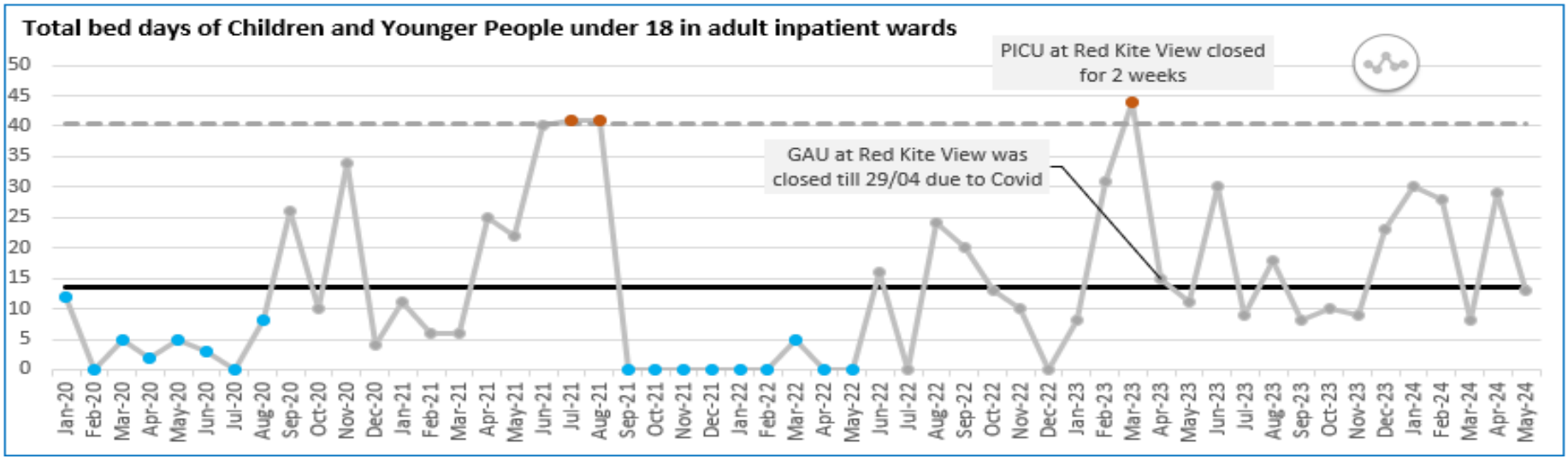
Summary	Actions	Assurance
The Trust remains in a period of special cause improving variation following a significant decrease in the number of bed days used.	The culmination of the work of the improvement programme which has focussed on: - Addressing barriers to discharge and reducing delays for people 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 May the following data quality issue has been identified in the reporting:

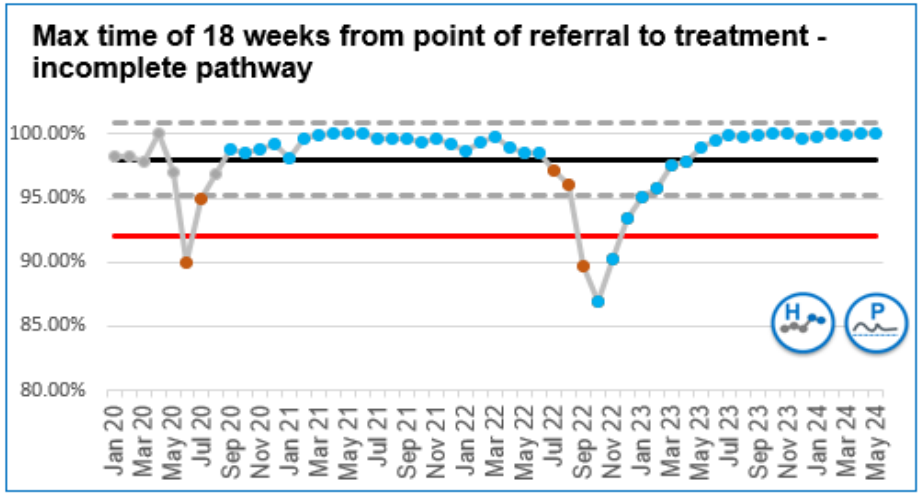
- The reporting for employment and accommodation shows 18.3% of records have missing employment and/or accommodation status with a further 1.6% that have an unknown employment status and 1.1% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

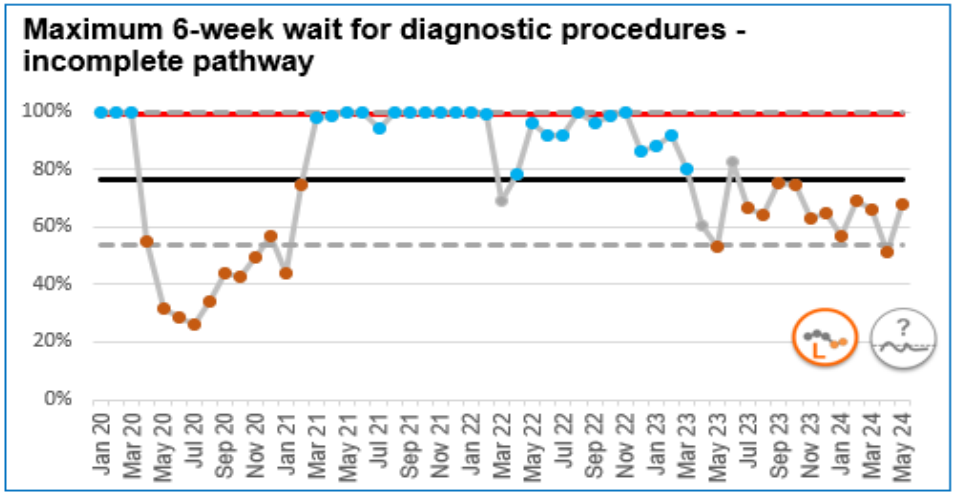
Analysis



The statistical process control chart (SPC) above shows that in May 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 May 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.
Paediatric Audiology waits have seen an improvement, however these can change quite quickly with small changes to service delivery. Work is ongoing to understand demand and capacity, the impact of improvement work and ongoing support for the team.

Current average OPEL level

2.56

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

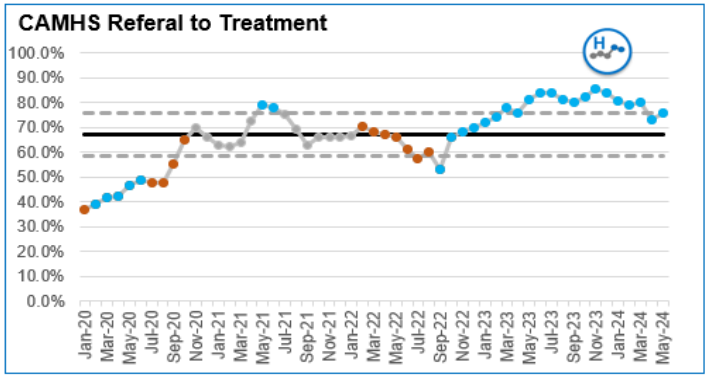
Children and Families Care Group

Headlines
The data now includes children's therapy services in Barnsley as per the new care group structure, therefore there are variances in performance from previous months data.
Neurodevelopment waits remain a concern particularly in Kirklees especially since the additional capacity stopped at the end of March 2024, this is likely to be further compounded by vacancies in the team.

Children and Families

Metrics	Threshold	Mar-24	Apr-24	May-24	Variation/ Assurance
% Appraisal rate	>=95%	88.4%	90.0%*	88.8%	
% Complaints with staff attitude as an issue	< 20%	0% 0/2	33% 1/3	50% 1/2	
% of staff receiving supervision within policy guidance	80%	75.7%	78.4%*	76.9%	
CAMHS - Crisis Response 4 hours	N/A	100.0%	100.0%	96.8%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.7%	78.6%*	81.8%	
Eating Disorder - Routine clock stops	95%	97.1%	95.0%	93.3%	
Eating Disorder - Urgent/Emergency clock stops	95%	100.0%	N/A	100.0%	
Maximum 6 week wait for diagnostic procedures	99%	65.7%	51.4%	68.7%	
Information Governance training compliance	>=95%	90.4%	92.1%*	98.7%	
Reducing restrictive physical interventions training compliance	>=80%	75.3%	72.9%*	69.9%	
Sickness rate (Monthly)	4.5%	4.9%	2.9%*	4.0%	
% 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 May 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 reducing restrictive physical interventions training compliance. All teams have been reminded about the importance of this training and team managers are supporting staff to access courses.
- Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. This is likely to be further impacted by staff vacancies. 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.
- There has been an increase in the number of days waited from referral to first contact for CAMHS services. This is due to some pressure at the entry point to services with staffing vacancies and sickness, business continuity measures have been put in place.
- Complaints with staff attitude as an issue are showing as an area for concern for the second month in a row, this is due to very small numbers of complaints being received by the service. Concerns highlighted through the complaints process are managed locally by the service and learning is shared across the care group. Further work is due to take place with the complaints department in how we report the reason for a complaint.
- Paediatric Audiology waits have seen an improvement, however these can change quite quickly with small changes to service delivery. Work is ongoing to understand demand and capacity, the impact of improvement work and ongoing support for the team.

Advise

- Mental Health Support Teams (MHST) referrals have increased in Kirklees, this is expected based upon the changes to school coverage, this is seen as a positive indictor at this time but needs to monitored.
- Appraisal and supervision performance has dropped a little. Supervision is showing reduced performance in all teams apart from Barnsley children's services. Appraisals are showing reduced performance across all teams. This is impacted on by managerial vacancies and changes.
- We have seen a slight rise in sickness across the care group, however there are no themes emerging at this time.
- There has been a slight reduction in the crisis response within 4 hours, and the emergency clock stops within eating disorders this is normal to see small fluctuations based upon service demand and service users needs. This will be monitored as we had seen positive performance for several consecutive months.

Assure

- There has been a marked improvement in mandatory training compliance for the care group with all courses now meeting the desired compliance rates except for RRPI training.
- The role out of the new Kirklees Interim entry pathway is progressing well and partnerships remain strong.
- The partnership with Wakefield council in delivering services to children in care were shortlisted and highly commended at the recent LGC awards.
- Medical recruitment to all services with vacancies has been positive and new starters are expected to join the service soon.

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.
Although there appears to be a reduction in the people who are clinically ready for discharge at 1.8%, this masks significant hotspots in Horizon assessment and treatment unit and inpatient wards for older people. Working is taking place with commissioners in each place.
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.
Both community and inpatient have seen an increase 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 and during May the Care group has seen a positive increase in performance with information governance being achieved across inpatient and community services and other areas seeing increased compliance.

Mental Health Community

Metrics	Threshold	Mar-24	Apr-24	May-24	Variation/ Assurance
% Appraisal rate	>=95%	82.8%	85.5%	87.1%	
% Assessed within 14 days of referral (Routine)	75%	89.3%	90.6%	83.8%	
% Assessed within 4 hours (Crisis)	90%	98.1%	97.8%	93.9%	
% Complaints with staff attitude as an issue	< 20%	22% (2/9)	27% (3/11	13% 2/15	
% of staff receiving supervision within policy guidance	80%	68.0%	70.6%	79.1%	
% service users followed up within 72 hours of discharge from inpatient care	80%	87.5%	90.8%	89.8%	
% Service Users on CPA with a formal review within the previous 12 months	95%	96.4%	97.1%	96.0%	
% Treated within 6 weeks of assessment (routine)	70%	97.8%	97.0%	92.4%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.0%	77.6%	75.5%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	73.7%	78.5%	68.1%	
Information Governance training compliance	>=95%	92.0%	92.3%	98.0%	
Reducing restrictive physical interventions training compliance	>=80%	74.2%	71.7%	70.2%	
Sickness rate (Monthly)	4.5%	3.8%	3.4%	4.8%	
% rosters locked down in 6 weeks					

Mental Health Inpatient

Metrics	Threshold	Mar-24	Apr-24	May-24	Variation/ Assurance
% Appraisal rate	>=95%	91.3%	92.8%	91.4%	
% bed occupancy	85%	90.6%	87.3%	86.5%	
% Complaints with staff attitude as an issue	< 20%	25% (1/4)	0% 0/4	0% 0/2	
% of staff receiving supervision within policy guidance	80%	89.6%	82.0%	85.6%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.7%	75.6%	80.0%	
% of clients clinically ready for discharge	3.5%	3.1%	2.8%	2.1%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	91.7%	92.7%	94.4%	
Inappropriate Out of Area Bed days	92	138	119	34	
Information Governance training compliance	>=95%	92.2%	93.7%	98.9%	
Physical Violence (Patient on Patient)	Trend Monitor	21	38	25	
Physical Violence (Patient on Staff)	Trend Monitor	107	102	71	
Reducing restrictive physical interventions training compliance	>=80%	75.8%	70.9%	74.9%	
Restraint incidents	Trend Monitor	113	192	*138*	
Safer staffing (Overall)	90%	137.6%	139.5%	139.1%	
Safer staffing (Registered)	80%	98.9%	104.1%	105.9%	
Sickness rate (Monthly)	4.5%	5.2%	3.6%	4.2%	
% 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 May 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.
- 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. There has been a reduction in appraisal compliance in May due to a combination of factors including changes in line management and a number of staff requiring appraisals in Month.

Advise

• Improvement work is underway to consider how quality and safety is maintained on inpatient wards which are monitored via the Inpatient Priority Programme 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 May is 54.28% for Kirklees and 50.41% 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.
• Single point of access 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
• 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 7 breaches out of 65 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	Mar-24	Apr-24	May-24	Variation/ Assurance
% Appraisal rate	>=95%	78.5%	86.3%	86.0%	
% Complaints with staff attitude as an issue	< 20%	17% (1/6)	0% (0/5)	0% (0/1)	
% of staff receiving supervision within policy guidance	80%	84.7%	84.2%	87.7%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	50.0%	47.9%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.5%	78.3%	85.1%	
% of clients clinically ready for discharge	3.5%	50.0%	50.0%	50.0%	
Information Governance (IG) training compliance	>=95%	94.9%	94.3%	95.0%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	76.7%	82.0%	89.2%	

LD, ADHD & ASD

Metrics	Threshold	Mar-24	Apr-24	May-24	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	19	17	24	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	76.8%	71.8%	77.8%	
Safer staffing (Overall)	90%	162.1%	152.5%	158.4%	
Safer staffing (Registered)	80%	116.7%	118.5%	119.7%	
Sickness rate (Monthly)	4.5%	2.7%	1.6%	2.1%	
Restraint incidents	Trend Monitor	34	18	*31*	
% rosters locked down in 6 weeks					

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

Alert/Action

- Friend & Family Test – 100%, efforts continue to increase the number of responses. Service is looking to use chat pads to aim to improve engagement with service users.
- Integrated Care Board West Yorkshire Neurodiversity Project – Work ongoing across West Yorkshire with no significant developments to report.
- Appraisal 96.4%.
- ADHD – national shortage of medication is having a direct impact on the service as primary care often refer people back into the service for an alternative prescription.
- Community Pharmacy – during the pandemic a community pharmacy offered to distribute prescriptions across the Trust footprint (to assist service users who could not access Manygates) this has now been withdrawn with some impact on the team resources and capacity.
- Service Review - relating to recommendations of the service review are ongoing and many are completed. The Service has met with members of the Executive Trio to discuss progress and a second meeting is planned in August.

Advise

ADHD Pathway
- Referral rates remain high and waiting lists continue to grow. The Service typically receives 270 referrals per month and has capacity to assess a maximum 560 people per year. There are currently 5443 people waiting for an ADHD assessment. This remains a national challenge.
- The service is working very closely with individual commissioners to develop bespoke packages that meet the needs of the local population in all areas except Calderdale who moved to the 'Any Qualified Provider' model (AQP)

Autism Pathway
- Referral rates remain high but there are minimal waits for assessment across Barnsley, Kirklees and Wakefield. There are 33 adults currently waiting from these areas and the longest wait for assessment is currently 11 weeks from referral. The wait for an Autism assessment is relatively short because of the screening and triage step in place in those areas (which is a recommendation of the NHSE Guidance for ICB's published in April 2023)
- Barnsley commissioners have invested to provide a 17+ Pathway for 20 young people. Community Paediatrics in Barnsley have already referred 16 young people who will now be seen sooner than if they had remained with children's services. The service is not anticipating any issues delivering the service as planned but has no resources spare to expand the current offer.
- Collaborative efforts are underway to expand this 17+ pathway across the Trust in alignment with Trust CAMHS Teams, a proposal has been shared and we await a response.
- The legacy waiting list inherited from Bradford District Care Trust continues to reduce as planned. At point of transfer this list had 507 people on it, 92% have been discharged leaving just 40 people on the list.

Assure

- All KPI targets met.
- Mandatory training compliance is good with National Early Warning Score2 being the only amber training.
- Relationship with Bradford working very well.
- Excellent levels of supervision and appraisal.
- Excellent staff survey results.

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 84.1%↓ The reduction coincides with a number of appraisals becoming out of date at the same time. Actions are underway to address this.
• Supervision 87.9%↑
• Plans in place to address mandatory training hotspots in progress with an increase in performance in all hotspot areas (see table above) CPR 82.1↑%, IG 93.8%↑ and RRPI 76.6%↑.

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. All areas now showing an improved trajectory with Barnsley and Calderdale now achieving the target.
• STOMP (Stopping the over medication for people with a learning disability, autism or both) 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)
• The service has 3 service users clinically ready for discharge (75%) patients on ATU and ward are continuing to work through discharge plans.

Advise

LD (Learning Disability)
• The service intend to launch an Easy Read library soon with resources to improve communication with people with a learning disability where relevant.
• Lack of appropriate bespoke community placements impacts on Horizon and community service offer.
• Trustwide LD event was very successful.

Community
• Challenges continue with the recruitment of specialists in Speech and Language, Psychology and Occupational Therapy.
• Commissioners have confirmed there is no available funding for the ADHD business case.
• Conversations with ICBs ongoing 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.
• Assessment and Treatment Service Review now underway.

Assure

• Friends and Family Test 92%
• Staff survey results demonstrate improvements.
• All localities have exceeded 75% target for annual health checks.
• Service Learning/LeDeR (learning from lives and deaths) group developing well and sharing learning across the LD service and with the wider Trust. Next newsletter will be focussed on keeping people with a learning disability well during hot weather.

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 further this month 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	Mar-24	Apr-24	May-24	Variation/ Assurance
% Appraisal rate	>=95%	86.9%	89.3%*	90.5%	
% Complaints with staff attitude as an issue	< 20%	0% (0/1)	0% (0/0)	0% (0/2)	
% people dying in a place of their choosing	80%	94.1%	100.0%	81.8%	
% of staff receiving supervision within policy guidance	80%	62.6%	70.1%	74.4%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.1%	81.8%	83.8%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	>=95%	95.7%	94.6%	96.6%	

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Mar-24	Apr-24	May-24	Variation/ Assurance
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.9%	100.0%	100.0%	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	80.0%	80.0%	100.0%	
Safer staffing (Overall)	90%	113.6%	113.5%	113.0%	
Safer staffing (Registered)	80%	94.0%	107.8%	110.1%	
Sickness rate (Monthly)	4.5%	4.1%	4.0%	5.6%	
% 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 to achieve compliancy. Ongoing challenge to fill trained staff shifts; we continue to supplement with untrained staff. Significant work has taken place with Finance and Contracting colleagues followed by a meeting with Director of Finance. Paper re safe staffing requirements in process by Contracting colleagues. This issue remains on the local risk register.
- Priory Day Centre – currently closed due to confirmed Legionella spores in water. Will remain closed until early July due to additional testing and works completion. Impact on MSK and Parkinsons group clinics. This remains on local risk register and Estates are working to identify alternative clinic space.

Advise

- Clinical supervision continues to receive a special focus with a drive to improve recording and a further 4.3% increase has been seen from April to May.
- Appraisals - many of our 42 service lines are at 100%. As a care group we have seen a further increase as at end of May to 90.5%.

To note: Appraisal data refreshes on a weekly basis therefore the data is not live.
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.

- 4 x Areas for Improvement to report for May 2024, for pressure sores. Although classed as areas for improvement they are actually minor learning points. Despite being an increase on last month this figure is around average for the year.
- Lone Worker Devices – focussed piece of work underway and usage is already increasing. Work continues regarding monitoring and ensuring importance of using devices is promoted to relevant staff.

Assure

- Urgent Community Response Service 2-hour target is 89.7% as at end of May 2024 which continues to be 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) – 99.97% as at May 2024.
- Friends and Family Test (FFT) 96% of people would recommend community services.
- 82.82% of people dying in their place of choosing as at May 2024. This is a reduction but still consistently above the threshold of 80%
- Cardio Pulmonary Resusitation (CPR) training 83.8% compliant as a care group; this is a further slight increase. In addition NRU has now achieved compliance at 81.8%

To note: Resus Lead has advised that the process for CPR training recording is that they send the signature sheets to the Learning and development team. These are inputted by 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 now 96.6% as a care group; this has now achieved compliance.
- At the Trust Excellence awards on 2 May, our retiring Biomechanics Lead Podiatrist won the Outstanding Achievement award. In addition, Our Live Well Wakefield service won the award for Partnership Working Excellence for their Waiting Well initiative.
- Our Yorkshire Smokefree Doncaster Manager achieved Level 5 Leadership and Management qualification which was presented at the Trust Learner Recognition Event along with a Quality Improvement certification for our Acting Health and Wellbeing Community Manager.
- The Trust has been successful in its bid to retain our Yorkshire Smoke Free (YSF) Wakefield contract.
- Calderdale Yorkshire Smoke Free contract has moved on to the next stage following Executive Management Team and is now awaiting sign off from SWYPFT and Commissioners.
- Intermediate Care bed base - Acorn Unit (formerly at Highstone Mews) has now relocated to Ward 12 at Barnsley Hospitals NHS Foundation Trust.

Forensic Care Group

Headlines

Sickness has improved in May. 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	Mar-24	Apr-24	May-24	Variation/ Assurance
% Appraisal rate	>=95%	79.8%	79.9%	77.7%	
% Bed occupancy	90%	81.9%	86.2%	88.2%	
% 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%	91.9%	89.3%	90.8%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	100.0%	97.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.4%	81.5%	87.0%	
% 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%	93.4%	94.1%	96.9%	
Physical Violence (Patient on Patient)	Trend Monitor	6	5	3	
Physical Violence (Patient on Staff)	Trend Monitor	8	15	11	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	75.0%	72.7%	77.4%	
Restraint incidents	Trend Monitor	22	35	*20*	
Safer staffing (Overall)	90%	105.5%	115.7%	110.7%	
Safer staffing (Registered)	80%	96.1%	102.6%	101.2%	
Sickness rate (Monthly)	5.4%	6.3%	4.2%	4.1%	
% rosters locked down in 6 weeks					

Alert/Action

- Bed Occupancy – Newton Lodge 87.78%↑, Bretton 92.87%↑, Newhaven 79.84%↑. Underoccupancy in medium secure largely due to empty beds within learning disability and Womens services where there are no waiting lists.
- Sickness absence – continues to be a concern across the service with year to date data indicating Newton Lodge 4.4%, Bretton Centre 7.8% and Newhaven 2.2%.
- Bed Modelling Event late June – this is the planned second session to explore current need and capacity across the provider collaborative.

Advise

- The West Yorkshire Provider Collaborative continue to develop future intentions for the Women's pathways.
- Mandatory training overall compliance:
  - Newton Lodge – 93.2%↑
  - Bretton – 92%↑
  - Newhaven –92.2%↓

The above figures represent the overall position for each service. There are some hotspots in Reducing restrictive physical interventions and Information Governance which are being managed and monitored closely. All services displaying an improving trajectory.

- Appraisal (93% using local data). Work is being undertaken with the People Performance Team to reconcile this data with Trust data.
- Newton Lodge has 2 service users currently awaiting beds in high secure both service users require seclusion. The current trajectory would indicate this situation is likely to last several months. This impacts upon capacity and acuity in Newton Lodge

Assure

- High levels of Data Quality across the Care Group.
- 100% compliance for HCR20 being completed within 3 months of admission.
- 25 Hours of meaningful activity 100%.
- CPA 97.96%
- 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 once the workforce data is provided to the service.

Inpatients - Mental Health - Working Age Adults

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

Appraisal
• There has been a reduction on some wards in May.
• A number of factors have impacted on compliance including new manager on Beamshaw and new staff on ward 18 not correctly aligned on WorkPal. Also there are a number of staff requiring an appraisal in month on Elmdale, Melton, Crofton and Walton.
• Targeted work underway ensure appraisals are booked on Clarke and Enfield Down.

Sickness
• Some improvement on Elmdale although remains above threshold relating to long term sickness.
• Increases on Clarke, Ashdale and Willow are due to a combination of long and short term absence including planned surgery.
• Lyndhurst and Poplars remain above threshold despite improvement due to the reasons outlined above.

Supervision
• Above target on the majority of wards.
• Ashdale and Lyndhurst will be above target in June following an improvement in recording.

Mandatory Training
• Ward managers have been directly booking staff on Cardiopulmonary resuscitation (CPR) courses around rosters. Staff from Enfield Down, Walton, Ashdale Poplars and Willow are booked on courses. Specific plans in place where compliance is low particularly Elmdale and Stanley.
• 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 Wd19, Walton, Ashdale, Elmdale, Willow, Crofton, Enfield Down and Lyndhurst. Compliance has also been impacted by new starters requiring the 4-day course. Staff with outstanding training are booked on which should positively impact compliance by the end of August.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.

Bed Occupancy
• Ward 19 is underoccupied in May due to several days of ward closure due to Covid-19.
• 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.

Clinically Ready For Discharge (CRFD)
• High percentage affect on Beechdale due to small numbers of patients on the ward (16 beds). Beechdale have experienced some challenges in May sourcing placements and alternative housing options for service users.
• 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. Melton, Walton, Willow are under target for admissions in May. A deep dive is conducted for each breach to identify learning and inform improvement.
• 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 Nostell, Melton and Ashdale 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 Melton, Nostell, Ashdale and Ward 18 due to the presentation and risk profiles of particular service users on the ward. Specific management plans are in place.

Inpatients - Mental Health - Working Age Adults

Beamshaw Suite

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	100.0%	95.7%	76.0%
Sickness	4.5%	4.0%	2.7%	8.2%
Supervision	80%	100.0%	100.0%	81.3%
Information Governance training compliance	>=95%	90.6%	93.5%	96.7%
Reducing restrictive physical interventions training compliance	>=80%	71.9%	74.2%	83.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	53.1%	71.0%	76.7%
Fire Safety training compliance	>=80%	87.5%	90.3%	86.7%
Bed occupancy	85%	111.1%	115.5%	106.7%
Safer staffing (Overall)	90%	132.8%	133.4%	136.8%
Safer staffing (Registered)	80%	139.8%	141.7%	131.3%
% 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%	87.5%	100.0%	92.3%
Physical Violence (Patient on Patient)	Trend Monitor	1	4	0
Physical Violence (Patient on Staff)	Trend Monitor	2	1	2
Restraint incidents	Trend Monitor	4	5	*6*
Prone Restraint incidents	Trend Monitor	1	1	*1*
Unfilled Shifts	Trend Monitor	8	9	21

Clark Suite

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	100.0%	100.0%	90.0%
Sickness	4.5%	5.1%	4.5%	8.1%
Supervision	80%	55.6%	55.6%	87.5%
Information Governance training compliance	>=95%	95.2%	95.8%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	90.5%	70.8%	79.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.4%	75.0%	100.0%
Fire Safety training compliance	>=80%	95.2%	91.7%	100.0%
Bed occupancy	85%	89.6%	88.8%	89.9%
Safer staffing (Overall)	90%	149.1%	139.5%	137.6%
Safer staffing (Registered)	80%	98.7%	99.5%	98.2%
% of clients clinically ready for discharge	3.5%	2.5%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	75.0%	83.3%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	3	1	0
Physical Violence (Patient on Staff)	Trend Monitor	11	3	0
Restraint incidents	Trend Monitor	21	10	*3*
Prone Restraint incidents	Trend Monitor	1	1	*1*
Unfilled Shifts	Trend Monitor	20	6	24

Melton Suite

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	87.0%	87.0%	91.3%
Sickness	4.5%	0.1%	0.0%	4.5%
Supervision	80%	100.0%	83.3%	100.0%
Information Governance training compliance	>=95%	96.2%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	96.2%	96.2%	92.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.9%	84.6%	88.5%
Fire Safety training compliance	>=80%	100.0%	100.0%	96.2%
Bed occupancy	85%	98.4%	104.4%	103.8%
Safer staffing (Overall)	90%	160.2%	160.2%	176.5%
Safer staffing (Registered)	80%	97.1%	97.8%	104.9%
% 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%	85.7%	100.0%	66.7%
Physical Violence (Patient on Patient)	Trend Monitor	0	3	0
Physical Violence (Patient on Staff)	Trend Monitor	1	6	10
Restraint incidents	Trend Monitor	8	13	*16*
Prone Restraint incidents	Trend Monitor	0	1	*5*
Unfilled Shifts	Trend Monitor	23	19	30

Nostell

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	100.0%	100.0%	92.6%
Sickness	4.5%	1.8%	0.0%	2.2%
Supervision	80%	94.4%	64.7%	100.0%
Information Governance training compliance	>=95%	96.8%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	76.7%	78.6%	83.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	93.3%	92.9%	100.0%
Fire Safety training compliance	>=80%	93.5%	93.1%	100.0%
Bed occupancy	85%	88.7%	92.6%	89.1%
Safer staffing (Overall)	90%	151.6%	136.4%	135.2%
Safer staffing (Registered)	80%	100.6%	98.2%	103.1%
% of clients clinically ready for discharge	3.5%	5.5%	5.8%	4.7%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	5	7	9
Restraint incidents	Trend Monitor	9	6	*14*
Prone Restraint incidents	Trend Monitor	4	0	*1*
Unfilled Shifts	Trend Monitor	17	13	8

Inpatients - Mental Health - Working Age Adults

Stanley

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	92.0%	100.0%	95.7%
Sickness	4.5%	5.4%	3.5%	2.9%
Supervision	80%	85.7%	83.3%	85.7%
Information Governance training compliance	>=95%	89.7%	85.2%	96.2%
Reducing restrictive physical interventions training compliance	>=80%	82.8%	85.2%	88.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.0%	63.0%	69.2%
Fire Safety training compliance	>=80%	93.1%	92.6%	92.3%
Bed occupancy	85%	106.0%	99.7%	105.9%
Safer staffing (Overall)	90%	131.7%	144.8%	130.6%
Safer staffing (Registered)	80%	115.7%	119.3%	118.8%
% of clients clinically ready for discharge	3.5%	4.6%	4.1%	4.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	95.2%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	1	0
Physical Violence (Patient on Staff)	Trend Monitor	2	2	0
Restraint incidents	Trend Monitor	1	4	*5*
Prone Restraint incidents	Trend Monitor	1	0	*0*
Unfilled Shifts	Trend Monitor	12	19	16

Walton

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	100.0%	93.9%	90.9%
Sickness	4.5%	3.5%	2.9%	3.5%
Supervision	80%	100.0%	78.6%	87.5%
Information Governance training compliance	>=95%	94.4%	95.1%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	71.4%	65.0%	67.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.7%	77.5%	78.4%
Fire Safety training compliance	>=80%	94.4%	85.4%	94.7%
Bed occupancy	85%	97.2%	86.0%	92.4%
Safer staffing (Overall)	90%	128.9%	154.3%	145.6%
Safer staffing (Registered)	80%	107.2%	101.9%	98.2%
% of clients clinically ready for discharge	3.5%	6.8%	14.1%	7.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	80.0%	66.7%	71.4%
Physical Violence (Patient on Patient)	Trend Monitor	2	0	0
Physical Violence (Patient on Staff)	Trend Monitor	5	13	3
Restraint incidents	Trend Monitor	7	58	*21*
Prone Restraint incidents	Trend Monitor	1	7	*9*
Unfilled Shifts	Trend Monitor	6	16	22

Ashdale

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	92.6%	92.9%	96.4%
Sickness	4.5%	4.4%	0.0%	5.2%
Supervision	80%	73.3%	75.0%	75.0%
Information Governance training compliance	>=95%	97.0%	96.9%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	66.7%	56.3%	65.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.8%	75.0%	71.9%
Fire Safety training compliance	>=80%	87.9%	93.8%	87.5%
Bed occupancy	85%	98.9%	98.5%	98.3%
Safer staffing (Overall)	90%	121.4%	118.9%	120.7%
Safer staffing (Registered)	80%	87.9%	100.1%	98.9%
% of clients clinically ready for discharge	3.5%	2.5%	0.0%	2.2%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	91.7%	88.9%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	1	6
Physical Violence (Patient on Staff)	Trend Monitor	3	1	5
Restraint incidents	Trend Monitor	1	1	*6*
Prone Restraint incidents	Trend Monitor	1	0	*0*
Unfilled Shifts	Trend Monitor	0	0	17

Ward 18

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	100.0%	92.3%	78.6%
Sickness	4.5%	1.8%	2.0%	1.6%
Supervision	80%	87.5%	100.0%	88.9%
Information Governance training compliance	>=95%	90.6%	84.4%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	81.3%	78.1%	75.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	68.8%	78.1%	78.8%
Fire Safety training compliance	>=80%	84.4%	87.5%	90.9%
Bed occupancy	85%	99.3%	98.4%	93.1%
Safer staffing (Overall)	90%	130.1%	105.9%	109.2%
Safer staffing (Registered)	80%	82.4%	78.1%	81.3%
% of clients clinically ready for discharge	3.5%	8.3%	6.2%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	83.3%	94.1%	95.2%
Physical Violence (Patient on Patient)	Trend Monitor	1	1	9
Physical Violence (Patient on Staff)	Trend Monitor	11	8	7
Restraint incidents	Trend Monitor	15	14	*6*
Prone Restraint incidents	Trend Monitor	1	2	*0*
Unfilled Shifts	Trend Monitor	3	3	11

Inpatients - Mental Health - Working Age Adults

Elmdale

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	85.0%	86.4%	63.6%
Sickness	4.5%	14.6%	7.8%	6.7%
Supervision	80%	81.8%	80.0%	100.0%
Information Governance training compliance	>=95%	85.7%	92.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	76.2%	68.0%	66.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	70.0%	62.5%	69.2%
Fire Safety training compliance	>=80%	90.5%	84.0%	92.6%
Bed occupancy	85%	96.8%	96.0%	98.1%
Safer staffing (Overall)	90%	128.5%	125.6%	121.8%
Safer staffing (Registered)	80%	69.3%	76.3%	88.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	1.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	92.9%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	6	7	0
Physical Violence (Patient on Staff)	Trend Monitor	6	7	3
Restraint incidents	Trend Monitor	7	10	*6*
Prone Restraint incidents	Trend Monitor	0	0	*1*
Unfilled Shifts	Trend Monitor	2	0	6

Inpatients - Mental Health - Older People Services

Crofton

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	91.7%	95.7%	91.3%
Sickness	4.5%	0.2%	3.6%	4.3%
Supervision	80%	90.9%	91.7%	100.0%
Information Governance training compliance	>=95%	100.0%	96.3%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	66.7%	61.5%	73.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.3%	96.2%	88.5%
Fire Safety training compliance	>=80%	96.4%	96.3%	85.2%
Bed occupancy	85%	94.6%	68.1%	81.5%
Safer staffing (Overall)	90%	175.1%	224.6%	209.8%
Safer staffing (Registered)	80%	150.5%	170.1%	161.3%
% 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%	100.0%	80.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	4	0
Physical Violence (Patient on Staff)	Trend Monitor	0	9	7
Restraint incidents	Trend Monitor	1	33	*27*
Prone Restraint incidents	Trend Monitor	0	1	*0*
Unfilled Shifts	Trend Monitor	22	58	33

Poplars CUE

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	84.0%	83.3%	100.0%
Sickness	4.5%	0.7%	3.2%	5.9%
Supervision	80%	100.0%	45.5%	90.0%
Information Governance training compliance	>=95%	89.7%	100.0%	96.7%
Reducing restrictive physical interventions training compliance	>=80%	81.5%	76.9%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.8%	80.0%	70.4%
Fire Safety training compliance	>=80%	96.6%	89.3%	86.7%
Bed occupancy	85%	78.9%	78.4%	79.4%
Safer staffing (Overall)	90%	231.7%	250.4%	235.4%
Safer staffing (Registered)	80%	111.2%	115.5%	120.1%
% of clients clinically ready for discharge	3.5%	20.4%	12.0%	6.7%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	2	13	6
Physical Violence (Patient on Staff)	Trend Monitor	35	35	13
Restraint incidents	Trend Monitor	28	32	*20*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	52	94	49

Inpatients - Mental Health - Older People Services

Willow

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	100.0%	100.0%	100.0%
Sickness	4.5%	2.9%	4.0%	12.4%
Supervision	80%	90.0%	100.0%	100.0%
Information Governance training compliance	>=95%	96.0%	96.2%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	76.0%	69.2%	69.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.0%	76.9%	73.9%
Fire Safety training compliance	>=80%	96.0%	96.2%	95.7%
Bed occupancy	85%	84.2%	85.7%	92.3%
Safer staffing (Overall)	90%	188.0%	194.0%	229.3%
Safer staffing (Registered)	80%	96.9%	119.5%	123.0%
% of clients clinically ready for discharge	3.5%	11.0%	10.3%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	75.0%	85.7%	33.3%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	1
Restraint incidents	Trend Monitor	4	1	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	11	20	18

Beechdale

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	91.7%	96.0%	96.2%
Sickness	4.5%	4.0%	0.2%	0.3%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	92.0%	96.3%	96.3%
Reducing restrictive physical interventions training compliance	>=80%	84.0%	74.1%	77.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.0%	96.3%	88.9%
Fire Safety training compliance	>=80%	92.0%	88.9%	88.9%
Bed occupancy	85%	94.2%	95.2%	87.3%
Safer staffing (Overall)	90%	124.8%	122.5%	125.6%
Safer staffing (Registered)	80%	91.6%	93.3%	105.5%
% of clients clinically ready for discharge	3.5%	0.0%	5.9%	10.4%
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	0	0	0
Restraint incidents	Trend Monitor	1	0	*2*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	9	5	9

Ward 19 - Male

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	100.0%	100.0%	100.0%
Sickness	4.5%	6.1%	0.0%	6.0%
Supervision	80%	100.0%	80.0%	100.0%
Information Governance training compliance	>=95%	91.7%	88.9%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	65.2%	55.6%	54.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.6%	96.3%	91.7%
Fire Safety training compliance	>=80%	91.7%	88.9%	87.5%
Bed occupancy	85%	97.6%	91.6%	80.2%
Safer staffing (Overall)	90%	135.7%	129.2%	127.6%
Safer staffing (Registered)	80%	94.7%	98.5%	97.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	7.7%
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	1	4
Physical Violence (Patient on Staff)	Trend Monitor	16	10	3
Restraint incidents	Trend Monitor	5	5	*6*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	4	3	0

Ward 19 - Female

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	94.4%	100.0%	100.0%
Sickness	4.5%	5.6%	10.8%	5.9%
Supervision	80%	90.0%	81.8%	100.0%
Information Governance training compliance	>=95%	90.5%	86.4%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	75.0%	66.7%	61.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	50.0%	61.9%	90.0%
Fire Safety training compliance	>=80%	76.2%	90.9%	85.7%
Bed occupancy	85%	95.1%	93.3%	72.9%
Safer staffing (Overall)	90%	110.8%	93.0%	96.3%
Safer staffing (Registered)	80%	86.9%	103.8%	113.2%
% of clients clinically ready for discharge	3.5%	0.0%	5.0%	6.6%
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	1	4
Physical Violence (Patient on Staff)	Trend Monitor	16	10	3
Restraint incidents	Trend Monitor	5	5	*6*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	4	1

Inpatients - Mental Health - Rehab

Enfield Down

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	72.7%	83.3%	88.6%
Sickness	4.5%	7.6%	7.7%	4.5%
Supervision	80%	94.1%	90.9%	87.0%
Information Governance training compliance	>=95%	92.2%	96.1%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	72.0%	60.0%	76.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.9%	73.3%	78.3%
Fire Safety training compliance	>=80%	92.2%	96.1%	96.1%
Bed occupancy	85%	54.1%	49.4%	52.5%
Safer staffing (Overall)	90%	92.0%	96.7%	96.7%
Safer staffing (Registered)	80%	78.9%	88.8%	92.4%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	5.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	100.0%	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	1	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	2	2	2

Lyndhurst

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	95.0%	100.0%	95.7%
Sickness	4.5%	14.7%	10.5%	6.4%
Supervision	80%	85.7%	87.5%	66.7%
Information Governance training compliance	>=95%	92.0%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	64.0%	57.1%	62.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	68.0%	71.4%	82.8%
Fire Safety training compliance	>=80%	88.0%	92.9%	93.1%
Bed occupancy	85%	73.0%	66.2%	66.1%
Safer staffing (Overall)	90%	95.1%	95.4%	97.2%
Safer staffing (Registered)	80%	93.9%	103.2%	96.9%
% 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	0	0	1
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	1	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. All wards now achieving the target.
• Sickness variable across medium secure with Priestley and Bronte being hotspots. The spike on Bronte is short term sickness whilst Priestley has some staff with longer term ill health. 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.
• Compliance for reducing restrictive physical interventions (RRPI) remains challenging for the service with particular challenges accessing courses. However the extra resources available for training are yielding an improving trajectory across all wards.
• Bed occupancy on Appleton is an issue and is due to a reduction in overall learning disability referrals to secure care. Bed occupancy in the women's service (Johnson medium secure) is also low. Whilst there are some empty beds on the male pathway within Newton Lodge the ability to admit is being affected by the 2 service users requiring seclusion and awaiting beds in high secure but the underoccupancy is being largely impacted by Appleton and Johnson and both services have no waiting list.
• Cardio pulmonary rehabilitation compliance is the focus of targeted improvement work. All wards are now compliant with the target.
• Compliance with Appraisal has reduced and the service is currently undertaking further exploration into this metric.

Low Secure
• Sickness across all wards monitored closely significant improvement in Thornhill's position. Sandals sickness has reduced but remains higher than target. Sickness levels Sandal, Newhaven and Ryburn remain high and are the focus of attention. 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 has been achieved on Thornhill, Ryburn and Newhaven with only Sandal not yet achieving but demonstration an improving trajectory.
• Bed occupancy in low secure has improved across Thornhill and Sandal and Ryburn remains at 100%. Overall performance remains below the target. Newhaven continues to experience lower level of referrals and has no waiting list.
• Supervision is excellent across all 4 wards with all wards attaining compliance.
• 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	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	90.5%	90.9%	81.0%
Sickness	5.4%	3.0%	4.5%	4.5%
Supervision	80%	91.7%	80.0%	86.7%
Information Governance training compliance	>=95%	100.0%	91.7%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	95.5%	87.5%	95.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.6%	80.0%	82.6%
Fire Safety training compliance	>=80%	100.0%	100.0%	100.0%
Bed occupancy	90%	60.5%	65.4%	62.5%
Safer staffing (Overall)	90%	96.1%	97.9%	97.0%
Safer staffing (Registered)	80%	113.0%	120.2%	102.7%
% 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	1
Physical Violence (Patient on Staff)	Trend Monitor	1	0	4
Restraint incidents	Trend Monitor	3	5	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	1	0	0

Bronte

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	100.0%	100.0%	62.5%
Sickness	5.4%	4.4%	4.4%	10.4%
Supervision	80%	100.0%	100.0%	92.3%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	70.8%	69.6%	73.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.0%	78.3%	81.3%
Fire Safety training compliance	>=80%	95.8%	100.0%	100.0%
Bed occupancy	90%	91.2%	97.1%	86.2%
Safer staffing (Overall)	90%	100.8%	103.8%	99.1%
Safer staffing (Registered)	80%	98.8%	103.0%	108.8%
% 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	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	0	1	*0*
Prone Restraint incidents	Trend Monitor	0	1	*0*
Unfilled Shifts	Trend Monitor	1	0	2

Chippendale

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	95.2%	90.9%	83.3%
Sickness	5.4%	2.3%	2.4%	1.2%
Supervision	80%	100.0%	100.0%	92.9%
Information Governance training compliance	>=95%	100.0%	96.4%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	79.2%	82.1%	86.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	95.8%	96.4%	86.7%
Fire Safety training compliance	>=80%	95.8%	92.9%	93.3%
Bed occupancy	90%	90.1%	94.4%	92.7%
Safer staffing (Overall)	90%	151.4%	144.1%	147.1%
Safer staffing (Registered)	80%	132.4%	131.1%	136.0%
% 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	1	2	0
Restraint incidents	Trend Monitor	5	5	*5*
Prone Restraint incidents	Trend Monitor	1	0	*0*
Unfilled Shifts	Trend Monitor	5	2	1

Hepworth

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	91.7%	96.0%	84.0%
Sickness	5.4%	4.7%	0.0%	1.6%
Supervision	80%	94.1%	83.3%	100.0%
Information Governance training compliance	>=95%	96.6%	96.7%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	79.3%	76.7%	81.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	89.3%	93.1%	96.2%
Fire Safety training compliance	>=80%	89.7%	96.7%	100.0%
Bed occupancy	90%	85.8%	87.1%	98.9%
Safer staffing (Overall)	90%	95.7%	95.4%	95.3%
Safer staffing (Registered)	80%	82.3%	78.6%	69.3%
% 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	0	0	0
Restraint incidents	Trend Monitor	1	2	*3*
Prone Restraint incidents	Trend Monitor	0	1	*1*
Unfilled Shifts	Trend Monitor	4	0	6

Inpatients - Forensic - Medium Secure

Johnson

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	92.9%	89.7%	87.1%
Sickness	5.4%	1.0%	1.8%	2.4%
Supervision	80%	100.0%	94.7%	100.0%
Information Governance training compliance	>=95%	90.3%	97.1%	97.1%
Reducing restrictive physical interventions training compliance	>=80%	67.7%	65.7%	76.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.3%	91.4%	97.1%
Fire Safety training compliance	>=80%	93.5%	91.4%	97.1%
Bed occupancy	90%	71.6%	73.3%	73.3%
Safer staffing (Overall)	90%	122.5%	123.5%	123.9%
Safer staffing (Registered)	80%	109.0%	109.5%	109.7%
% 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	1	1
Restraint incidents	Trend Monitor	1	0	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	6	5	3

Priestley

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	77.8%	76.5%	68.4%
Sickness	5.4%	10.2%	10.6%	7.9%
Supervision	80%	75.0%	75.0%	92.3%
Information Governance training compliance	>=95%	95.0%	90.9%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	52.6%	52.4%	66.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.9%	71.4%	81.0%
Fire Safety training compliance	>=80%	95.0%	90.9%	90.9%
Bed occupancy	90%	92.2%	91.2%	88.2%
Safer staffing (Overall)	90%	97.3%	93.7%	92.3%
Safer staffing (Registered)	80%	90.6%	99.2%	98.8%
% 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	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	0	0
Restraint incidents	Trend Monitor	2	0	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	0	1

Waterton

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	40.0%	40.0%	45.0%
Sickness	5.4%	7.5%	4.2%	2.2%
Supervision	80%	60.0%	100.0%	100.0%
Information Governance training compliance	>=95%	89.3%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	64.3%	63.6%	68.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.4%	68.2%	88.0%
Fire Safety training compliance	>=80%	95.7%	95.5%	96.0%
Bed occupancy	90%	91.1%	100.0%	100.0%
Safer staffing (Overall)	90%	128.7%	127.7%	127.6%
Safer staffing (Registered)	80%	100.8%	114.6%	109.7%
% 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	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	8	4	3

Inpatients - Forensic - Low Secure

Thornhill

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	82.6%	91.3%	91.3%
Sickness	5.4%	5.2%	0.9%	2.2%
Supervision	80%	92.9%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	96.3%	96.3%
Reducing restrictive physical interventions training compliance	>=80%	69.2%	70.4%	77.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.1%	81.5%	96.3%
Fire Safety training compliance	>=80%	100.0%	100.0%	100.0%
Bed occupancy	85%	64.7%	82.0%	91.4%
Safer staffing (Overall)	90%	96.5%	98.4%	99.7%
Safer staffing (Registered)	80%	96.4%	96.3%	93.1%
% 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	0	1	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	3	7

Sandal

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	69.6%	71.4%	77.3%
Sickness	5.4%	6.8%	7.7%	7.7%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	89.3%	92.9%	93.3%
Reducing restrictive physical interventions training compliance	>=80%	64.3%	60.7%	73.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.4%	67.9%	76.7%
Fire Safety training compliance	>=80%	85.7%	92.9%	93.3%
Bed occupancy	85%	76.8%	92.5%	96.0%
Safer staffing (Overall)	90%	101.6%	133.8%	110.6%
Safer staffing (Registered)	80%	103.8%	98.1%	101.8%
% 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	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	1	1
Restraint incidents	Trend Monitor	1	8	*1*
Prone Restraint incidents	Trend Monitor	0	1	*0*
Unfilled Shifts	Trend Monitor	0	3	5

Inpatients - Forensic - Low Secure

Ryburn

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	87.5%	100.0%	77.8%
Sickness	5.4%	24.8%	25.5%	16.2%
Supervision	80%	100.0%	80.0%	80.0%
Information Governance training compliance	>=95%	100.0%	100.0%	88.9%
Reducing restrictive physical interventions training compliance	>=80%	77.8%	75.0%	77.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	100.0%	88.9%
Fire Safety training compliance	>=80%	88.9%	87.5%	88.9%
Bed occupancy	85%	95.9%	87.1%	88.9%
Safer staffing (Overall)	90%	99.1%	98.1%	99.2%
Safer staffing (Registered)	80%	99.8%	97.4%	98.4%
% 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	0	0	1

Newhaven

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	81.0%	85.7%	95.8%
Sickness	5.4%	9.5%	3.5%	8.0%
Supervision	80%	94.4%	100.0%	85.7%
Information Governance training compliance	>=95%	88.5%	93.1%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	69.2%	62.1%	58.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.9%	82.8%	89.7%
Fire Safety training compliance	>=80%	84.6%	96.6%	100.0%
Bed occupancy	85%	65.9%	75.0%	79.8%
Safer staffing (Overall)	90%	109.3%	125.7%	126.5%
Safer staffing (Registered)	80%	87.9%	107.8%	105.0%
% 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	4	4	2
Physical Violence (Patient on Staff)	Trend Monitor	7	9	5
Restraint incidents	Trend Monitor	8	14	*6*
Prone Restraint incidents	Trend Monitor	1	3	*0*
Unfilled Shifts	Trend Monitor	4	2	5

Inpatients - Non-Mental Health

Headlines

Appraisal rate:
• NRU rate is showing as 82.8% this is a further increase since April.
• Critical staffing levels mean that it has been difficult to release staff from clinical duties (see AAA re NRU staffing levels).
• SRU rate has seen a slight decrease from 91.1% to 89.7%. This ward has been impacted by long term sickness in terms of management/senior staff.

Supervision:
• NRU figures have seen a slight increase from 58.8% to 60%. This has been impacted by staffing as noted earlier.
• SRU figures have increased from 56.3% to 66.7%. This ward has been impacted by long term sickness in terms of management /senior staff. The figure as at 24.6.24 is showing a further improvement at 71.4%.

Cardiopulmonary resuscitation CPR:
• NRU – A further increase during May to 81.8 % to achieve compliance.
• SRU – a slight decrease from 79.4% to 76.7% in May which is slightly below 80% compliance. Further training has taken place in early June which should improve figures next month.
To note: Resus Lead has advised that the process for CPR training recording has a potential for up to a 6-week lag due to delays in the data input process.

Information Governance (IG):
• NRU – 100% during May 2024 to maintain maximum compliancy.
• SRU – slight decrease this month to 90.6% Amber due to sickness and annual leave.

Sickness:
• NRU – sickness has increased this month and is now at 8.4%. This is being managed via HR processes and sickness reviews. Two staff have gone off long term sick during May which has impacted this figure.
• SRU – sickness has increased for May and is now at 5.4%. The unit continues to have some long term sickness which management are aware is likely to continue for an extended period due to nature of illness.

Bed Occupancy:
• NRU 62.4% against target of 80% - this is an increase during May and is now within variance on activity report for rolling occupancy rates.
• SRU 87.9% against target of 80% - this is consistent with last month.

Neuro Rehabilitation Unit (NRU)

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	29.2%	65.4%	81.5%
Sickness	4.5%	6.8%	3.9%	8.4%
Supervision	80%	78.6%	58.8%	60.0%
Information Governance training compliance	>=95%	97.1%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.7%	78.1%	81.8%
Fire Safety training compliance	>=80%	94.1%	93.9%	97.1%
Bed occupancy (Barnsley Commissioned beds only)	80%	71.2%	43.3%	62.4%
Safer staffing (Overall)	90%	120.4%	119.6%	120.6%
Safer staffing (Registered)	80%	79.8%	93.5%	100.6%
% 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	2	0	1
Unfilled Shifts	Trend Monitor	1	0	0

Stroke Rehabilitation Unit (SRU)

Metrics	Threshold	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	87.7%	91.1%	89.7%
Sickness	4.5%	3.2%	2.7%	5.4%
Supervision	80%	76.9%	56.3%	66.7%
Information Governance training compliance	>=95%	90.8%	95.5%	90.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	70.5%	79.4%	76.7%
Fire Safety training compliance	>=80%	80.0%	83.6%	82.8%
Bed occupancy	80%	96.2%	87.5%	87.9%
Safer staffing (Overall)	90%	108.6%	108.8%	107.2%
Safer staffing (Registered)	80%	106.1%	120.5%	118.5%
% 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	1
Unfilled Shifts	Trend Monitor	14	0	0

Inpatients - Mental Health - Learning Disability

Headlines

• Improvements to supervision levels have been made with supervision now being rostered in for all staff (100% in May). Appraisal is at 97.1%
• Cardiopulmonary resuscitation training is now compliant and RRPI training is demonstrating an improving trajectory.
• Focused attention on information governance training to achieve compliance is underway.
• 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	Mar-24	Apr-24	May-24
Appraisal rate	>=95%	73.3%	100.0%	97.1%
Sickness	4.5%	3.2%	0.0%	4.6%
Supervision	80%	100.0%	92.9%	100.0%
Information Governance training compliance	>=95%	97.3%	94.9%	94.9%
Reducing restrictive physical interventions training compliance	>=80%	77.1%	70.3%	81.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	62.9%	59.5%	83.8%
Fire Safety training compliance	>=80%	91.9%	92.3%	92.3%
Bed occupancy	N/A	50.0%	47.9%	50.0%
Safer staffing (Overall)	90%	162.1%	152.5%	158.4%
Safer staffing (Registered)	80%	116.7%	118.5%	119.7%
% 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	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	18	17	24
Restraint incidents	Trend Monitor	34	18	*31*
Prone Restraint incidents	Trend Monitor	0	2	*1*
Unfilled Shifts	Trend Monitor	19	0	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. E.g. work to improve understanding of the people who are waiting for services in Barnsley and work using system data and intelligence in Calderdale	
Improving care	Transform our Older People inpatient services	The programme team will publish the independently produced report of findings from the public consultation post-election. The programme will then enter a phase of deliberation of the findings throughout July and August. Some re-planning and rescheduling of activity has been required as a result of entering a pre-election period.	
	Improve our mental health services so they are more responsive, inclusive, and timely	**Improving Access to Care (IATC) Programme** **1. Improving Access to Core Psychological Therapies:** Project aims have been achieved and delivered on schedule. Recommendations report produced which includes a summary of progress of the project and recommended improvement actions for the service to take. Project closure agreed by IATC steering group. **2. Mental Health Single Point of Access Review:** Project aims have been achieved and delivered on schedule. Recommendations report produced which includes a summary of progress of the project and recommended improvement actions for the service to take. Project closure agreed by IATC steering group. **3. Waiting Well Waiting Fairly:** EMT have agreed for IATC steering group to commence oversight of improvement activity taking place in identified service areas aiming to reduce waiting times for those who are on waiting lists and provide individuals with necessary support and preparation for their intervention/therapy/assessment while they wait. Terms of reference will be refreshed and work programme commenced by the end of June 2024. **Care Closer to Home (CC2H) Programme** • Work continuing to sustain the reduction in out of area admissions • Patient flow website launched • Ongoing work to progress actions/outputs from the staff engagement events • Planning for service user and carer experience • Planning further Calderdale engagement event • Sign off quality improvement end of year report in July **Inpatient Priority Programme** • Ongoing development of therapeutic inpatient care improvement plan with leads/timescales, work aligned to culture of care improvement programme • Draft staff engagement strategy proposal developed, and implementation planned. • Mental health inpatient preceptorship training evaluating exceptionally well. Evaluation August 2024. • Outcomes dashboard – usage of dashboard being monitored and further training to be rolled out. • Quality & Performance oversight meeting now embedded within inpatient services. **Community Mental Health Transformation Priority Programme** A stocktake report of the impact of improvement activity undertaken to date has been drafted and was taken to the Community Mental Health Transformation Priority steering group for agreement, prior to being presented to the Improving Mental Health Oversight Group for sign off in July. There is a recommendation to support the removal of this project as a priority programme and move into operational management which was agreed to be progressed. There are a number of activities outlined within the report for the group to continue focus on.	

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving care	Improve safety and quality	**Care Planning and Risk Assessment** Work is progressing in line with the improvement plan to continue to develop the care planning good practice guide, training programme and performance and quality metrics. A second iteration of the new care plan is being developed and further staff engagement will take place during July 24. A further workshop is scheduled for August '24 with members of the Improvement Group. **Personalised Care (moving on from Care Programme Approach)** A stocktake report of the impact of improvement activity has been drafted and will be taken to the Personalised Care & Support Steering group for agreement in July. This will be presented at Improving Mental Health Oversight Group in July for sign off. There is a recommendation to support a bi-monthly steering group meeting, from monthly as the main activity is undertaken within the already established task and finish groups focused. These groups are: • Keyworker and Multidisciplinary Team Principles • Patient Reported Outcome Measures • Care plan policy, training and good practice. There are a number of activities outlined within the report for the group to continue focus on including continued discussion with Local Authority and voluntary sector partners, and the development of pulling together all the work from the Task and finish groups into a draft policy.	
Improving use of resources	Spend money wisely and increase value	**Value for Money** Built in savings are currently reporting behind plan, and additional schemes continue to be required to close the gap. Trustwide messaging formally launched the programme, with a value for money focussed edition of The View, messaging through the Brief, and the launch of a new iHub challenge. Weekly value for money meetings continue to provide scrutiny and support to both pay and non pay value for money schemes. Majority of care group schemes have now been approved through the impact assessment process as appropriate. Good progress has been made with the transport initiative and some of the smaller local schemes, some identified schemes are still in the very early planning stages. Links have been made with neighbouring Trusts around their value for money reporting and monitoring mechanisms. Preliminary work has commenced gathering documentation in support of the internal audit.	
	Make digital improvements	**Digital Dictation** Four onsite virtual demonstrations completed with two virtual demonstrations planned for June. Application testing underway and due to be completed early July '24. Deployment data collection completed and initial services for deployment chosen and signed off by Project Board. Deployment to start to in service one (Barnsley Memory Service) from July '24.	
Great place to work	People Directorate 90-day plan	As agreed at the 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)	(£0.8m)	£0m	The Trust financial target for 2024/25 is breakeven with expenditure in line with the income we receive. For the year to date a position of £0.8m deficit has been reported. This is £0.6m worse than plan and will require corrective actions to ensure delivery of the target.
2	Agency Spend	£0.9m	£5.2m	There is sustained reduced levels of agency expenditure which is forecast to continue for the remainder of the financial year. Spend in May 2024 is £443k of which £49k relates to the provider collaborative and individual operational response. If the forecast of £5.2m is achieved this would be a £3.1m reduction from 2023/24.
3	Financial sustainability and efficiencies	£2.4m	£20.1m	The Trust financial sustainability programme for 2024/25 has a target of £22.0m. Year to date, and forecast, performance are behind plans and additional mitigation plans are being developed to cover this shortfall and help secure the overall financial position.
4	Cash	£62.7m	£58.6m	The Trust cash position, whilst remaining strong, has reduced from the value held at the end of the last financial year. This is primarily due to payment of invoices received in late March and now paid. If the current deficit run rate continues this will have a negative impact on Trust cash balances.
5	Capital	£1m	£8.1m	The Trust capital allocation for 2024/25 is £8.1m. Expenditure, for the year to date, is £948k which is ahead of plan. The main driver is the timing / profile of two multi-year schemes and is forecast to be delivered within plan in year.
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.

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 2 (2024 / 25)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

	Key Performance Indicator	Year to date	Forecast 2024 / 25	Narrative
1	Surplus / (Deficit)	(£0.8m)	£0m	The Trust financial target for 2024 / 25 is breakeven with expenditure in line with the income we receive. For the year to date a position of £0.8m deficit has been reported. This is £0.6m worse than plan and will require corrective actions to ensure delivery of the target.
2	Agency Spend	£0.9m	£5.2m	There is sustained reduced levels of agency expenditure which is forecast to continue for the remainder of the financial year. Spend in May 2024 is £443k of which £49k relates to the provider collaborative and individual operational response. If the forecast of £5.2m is achieved this would be a £3.1m reduction from 2023 / 24.
3	Financial sustainability and efficiencies	£2.4m	£20.1m	The Trust financial sustainability programme for 2024 /25 has a target of £22.0m. Year to date, and forecast, performance are behind plans and additional mitigation plans are being developed to cover this shortfall and help secure the overall financial position.
4	Cash	£62.7m	£58.6m	The Trust cash position, whilst remaining strong, has reduced from the value held at the end of the last financial year. This is primarily due to payment of invoices received in late March and now paid. If the current deficit run rate continues this will have a negative impact on Trust cash balances.
5	Capital	£1m	£8.1m	The Trust capital allocation for 2024 / 25 is £8.1m. Expenditure, for the year to date, is £948k which is ahead of plan. The main driver is the timing / profile of two multi year schemes and is forecast to be delivered within plan in year.
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.

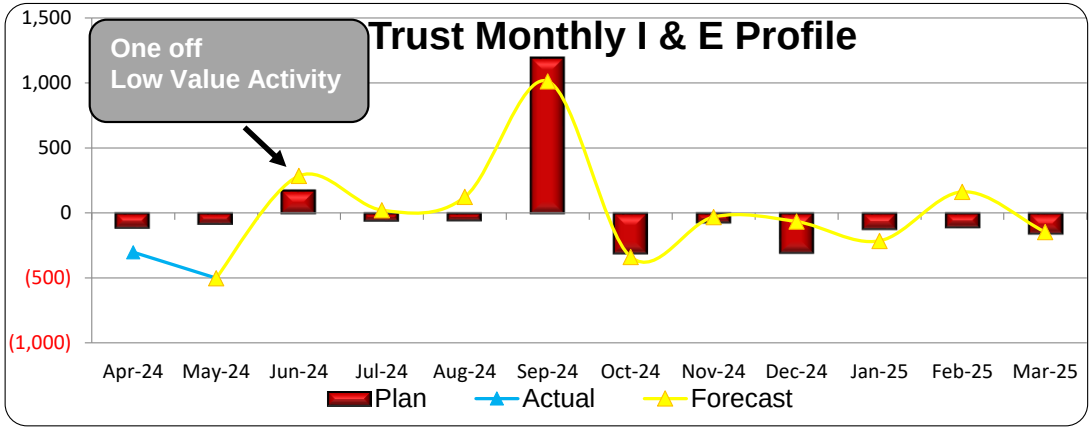
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

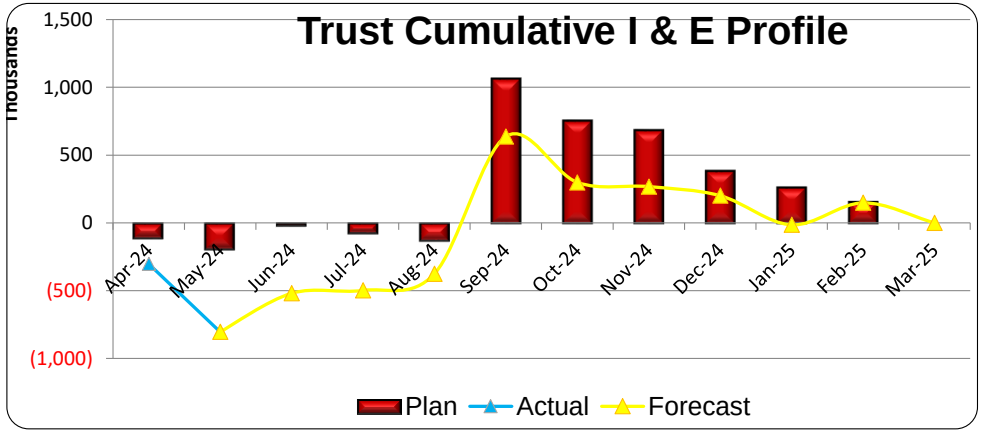
2.0 Income & Expenditure Position 2024 / 25

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

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					33,796	34,155	359	67,454	68,025	571	405,250	406,593	1,343
Other Operating Revenue					1,079	1,155	76	2,164	2,346	182	13,809	14,356	547
Total Revenue					**34,875**	**35,310**	**435**	**69,618**	**70,371**	**753**	**419,059**	**420,950**	**1,891**
Pay Costs	5,024	5,069	44	0.9%	(21,492)	(21,608)	(116)	(42,901)	(43,318)	(417)	(257,509)	(260,439)	(2,930)
Non Pay Costs					(13,059)	(13,865)	(805)	(26,094)	(27,180)	(1,086)	(156,668)	(156,544)	125
Gain / (loss) on disposal					0	22	22	0	22	22	0	22	22
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,024**	**5,069**	**44**	**0.9%**	**(34,551)**	**(35,451)**	**(900)**	**(68,995)**	**(70,477)**	**(1,482)**	**(414,177)**	**(416,961)**	**(2,784)**
EBITDA	**5,024**	**5,069**	**44**	**0.9%**	**324**	**(141)**	**(465)**	**623**	**(106)**	**(728)**	**4,882**	**3,989**	**(893)**
Depreciation					(526)	(521)	5	(1,051)	(1,041)	10	(6,304)	(6,041)	262
PDC Paid					(179)	(179)	0	(358)	(358)	0	(2,148)	(2,148)	0
Interest Received					300	339	39	595	701	105	3,570	4,201	631
Surplus / (Deficit) - ICB performance measure	**5,024**	**5,069**	**44**	**0.9%**	**(81)**	**(502)**	**(421)**	**(192)**	**(804)**	**(613)**	**(0)**	**0**	**0**
Depn Peppercorn Leases (IFRS16)					2	(9)	(11)	(17)	(17)	0	(94)	(94)	0
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,024**	**5,069**	**44**	**0.9%**	**(79)**	**(511)**	**(432)**	**(209)**	**(822)**	**(613)**	**(94)**	**(94)**	**0**





Income & Expenditure Position 2024 / 25

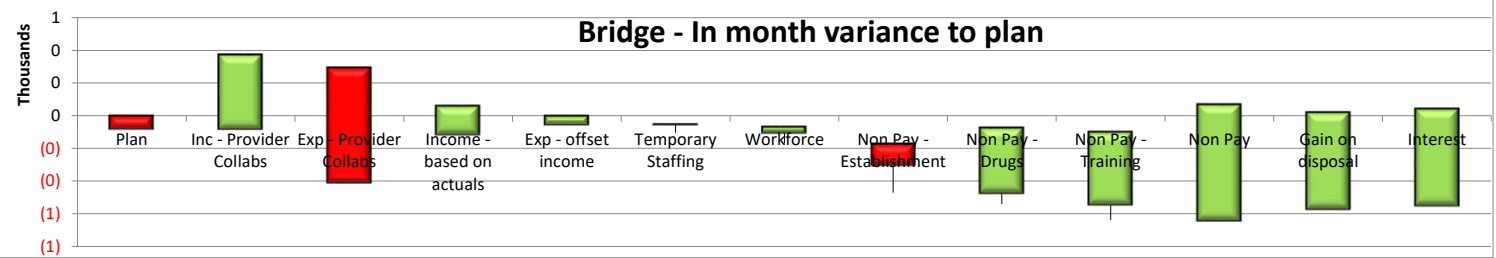
The consolidated financial position is a year to date deficit of £0.8m. This is £0.6m behind plan.
In May 2024 this is a deficit of £0.4m which is £0.4m behind plan.

In line with national guidance the Trust submitted a breakeven financial plan for 2024 / 25 in May 2024. An updated plan submission is required in June 2024 to take account of the consultant pay award and tariff uplift. The tariff uplift will not fully fund the cost increase; whilst this causes a financial pressure for the Trust it is not expected that the resubmission will change the breakeven plan. A seperate update on this submission will be provided to Trust Board.

NHS England - monthly submission

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

The key drivers of the financial position, with variance to plan, are highlighted below. The forecast remains delivery of the financial target and the risk, and scenario modelling, in relation to this are presented to the Trust Finance, Investment and Performance Committee.



The graph above highlights the key headline variances to plan for the current month (May 2024). Where this is a continuation of previous month trends the cumulative impact is highlighted below.

Provider Collaboratives

Although there are variances, compared to plan, within the provider collaboratives the net impact is £34k worse than planned. This is due to costs associated with exceptional packages of care.

Income

As identified on the income focus page, whilst the majority of income is fixed in nature, there are a number of specific contracts which are based on actual costs incurred. These are therefore shown as a variance in both income and expenditure. The net impact is shown above.

Pay

Although there has been significant reductions in temporary staffing costs, when compared to April 2024, in month these remain £48k more than planned. The main driver is more bank staff than planned. Overall there is 44 more worked WTE than planned which is leading to the pay overspend.

Non Pay

Non pay expenditure, excluding the lead provider collaborative is £544k overspent in month. The main headings are drugs (although this is now back in line with plan for the year to date) where the change in volume and value is being investigated, training expenses which is due to the timing of courses (this is forecast to come back in line with plan later in the year) and establishment. This includes the timing of VPN purchases for the year.

Other

In May a one off gain on disposal (£22k) has been recorded. This relates to an overage receipt for Ossett health Centre that was sold a number of years ago. There is also a positive variance on interest received.

2.0 Income & Expenditure Position 2023 / 24

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

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					25,009	24,994	(14)	49,830	49,746	(84)	299,505	298,402	(1,103)
Other Operating Revenue					1,016	1,169	152	2,021	2,209	188	12,017	12,613	596
Total Revenue					**26,025**	**26,163**	**138**	**51,851**	**51,955**	**104**	**311,522**	**311,015**	**(507)**
Pay Costs	4,988	5,034	45	0.9%	(21,305)	(21,360)	(55)	(42,434)	(42,826)	(392)	(254,709)	(258,713)	(4,004)
Non Pay Costs					(4,337)	(4,881)	(544)	(8,624)	(9,166)	(542)	(52,108)	(53,871)	(1,763)
Gain / (loss) on disposal					0	22	22	0	22	22	0	22	22
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,988**	**5,034**	**45**	**0.9%**	**(25,642)**	**(26,219)**	**(577)**	**(51,058)**	**(51,970)**	**(912)**	**(306,818)**	**(312,563)**	**(5,745)**
EBITDA	**4,988**	**5,034**	**45**	**0.9%**	**383**	**(56)**	**(439)**	**793**	**(15)**	**(808)**	**4,704**	**(1,548)**	**(6,252)**
Depreciation					(526)	(521)	5	(1,051)	(1,041)	10	(6,304)	(6,041)	262
PDC Paid					(179)	(179)	0	(358)	(358)	0	(2,148)	(2,148)	0
Interest Received					300	339	39	595	701	105	3,570	4,201	631
Surplus / (Deficit) - ICB performance measure	**4,988**	**5,034**	**45**	**0.9%**	**(22)**	**(417)**	**(395)**	**(21)**	**(714)**	**(692)**	**(178)**	**(5,536)**	**(5,358)**
Depn Peppercorn Leases (IFRS16)					2	(9)	(11)	(17)	(17)	0	(94)	(94)	0
Losses Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,988**	**5,034**	**45**	**0.9%**	**(20)**	**(425)**	**(405)**	**(39)**	**(731)**	**(692)**	**(272)**	**(5,630)**	**(5,358)**

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

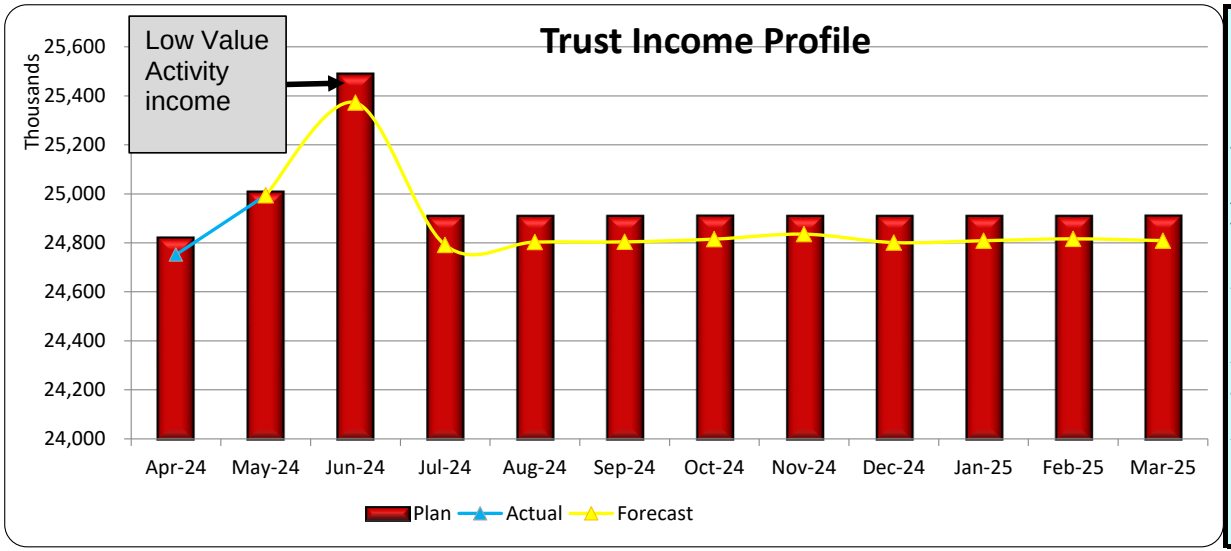
Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Total Consolidated Position	5,024	5,069	44	0.9%	(79)	(511)	(432)	(209)	(822)	(613)	(94)	(94)	0
Provider Collaboratives	23	35	12	54.4%	3	(31)	(34)	6	(37)	(42)	33	(144)	(177)
Budgets held centrally	13	0	(13)	100.0%	(62)	(54)	7	(176)	(54)	121	145	5,680	5,536
Total excluding Collaboratives (as shown above)	**4,988**	**5,034**	**45**	**0.9%**	**(20)**	**(425)**	**(405)**	**(39)**	**(731)**	**(692)**	**(272)**	**(5,630)**	**(5,358)**

2.1 Income Information

The Trust receives income from it's commissioners in order to deliver healthcare services to meet the defined needs of the local population. The majority of this is in the form of an Aligned Incentive Contract (AIC) with a set value agreed. As such this provides income stability, and financial certainty, to enable the Trust to plan effectively. This is amended to take account of any tariff changes (set nationally) and for agreed changes in service provision (investment and / or disinvestment).

The main table below is the core Trust income and excludes income received for the commissioning role for mental health collaboratives, although this value is noted. The table highlights where income is received from, by organisation type. This confirms that the vast majority is received from local Integrated Care Boards (ICB's - both West Yorkshire and South Yorkshire).

Income source	Total 23/24 £k	Apr-24 £k	May-24 £k	Jun-24 £k	Jul-24 £k	Aug-24 £k	Sep-24 £k	Oct-24 £k	Nov-24 £k	Dec-24 £k	Jan-25 £k	Feb-25 £k	Mar-25 £k	Total £k	Budget £k	Variance £k
NHS Commissioners	**245,319**	21,094	21,193	21,720	21,144	21,144	21,144	21,144	21,144	21,144	21,144	21,144	21,150	**254,305**	254,298	7
Specialist Commissioner	**34,541**	2,943	2,962	2,947	2,947	2,947	2,947	2,947	2,947	2,947	2,947	2,947	2,947	**35,371**	35,363	8
Local Authority	**5,799**	378	400	373	368	381	381	392	413	379	386	394	386	**4,631**	5,004	(373)
Partnerships	**6,748**	205	219	205	205	205	205	205	205	205	205	205	205	**2,478**	2,971	(493)
Other Contract Income	**1,454**	131	220	127	127	127	127	127	127	127	127	127	122	**1,617**	1,869	(253)
Total	**293,862**	**24,752**	**24,994**	**25,372**	**24,791**	**24,803**	**24,804**	**24,815**	**24,835**	**24,801**	**24,809**	**24,816**	**24,809**	**298,402**	**299,505**	**(1,103)**
2023 / 24		23,486	23,590	25,476	23,783	24,304	23,945	23,797	23,815	24,298	25,157	25,583	26,628	**293,862**		
Provider Collab		9,118	9,161	9,153	9,210	9,210	9,204	8,860	8,854	8,860	8,860	8,841	8,860	**108,191**		
Total	**293,862**	**33,870**	**34,155**	**34,525**	**34,001**	**34,013**	**34,008**	**33,675**	**33,689**	**33,661**	**33,669**	**33,658**	**33,669**	**406,593**		



Income, and budgets, from NHS commissioners have been increased in May 2024 to reflect the additional 0.3% national tariff uplift. This is in relation to the revised Consultant contract; pay budgets and spend have also been increased to take account of this change.

As noted the majority of income is fixed in nature but the key variances to plan are noted below:

* Partnership - Youth Offenders Contract £493k
Reimbursement based on actual costs incurred

* Yorkshire Smokefree - Payment by results £352k
This is partially offset by reduced non pay costs

* Additional Roles Reimbursement Posts £265k
Offset by reduced pay costs. Recharged on staff in post

2.2 Pay Information

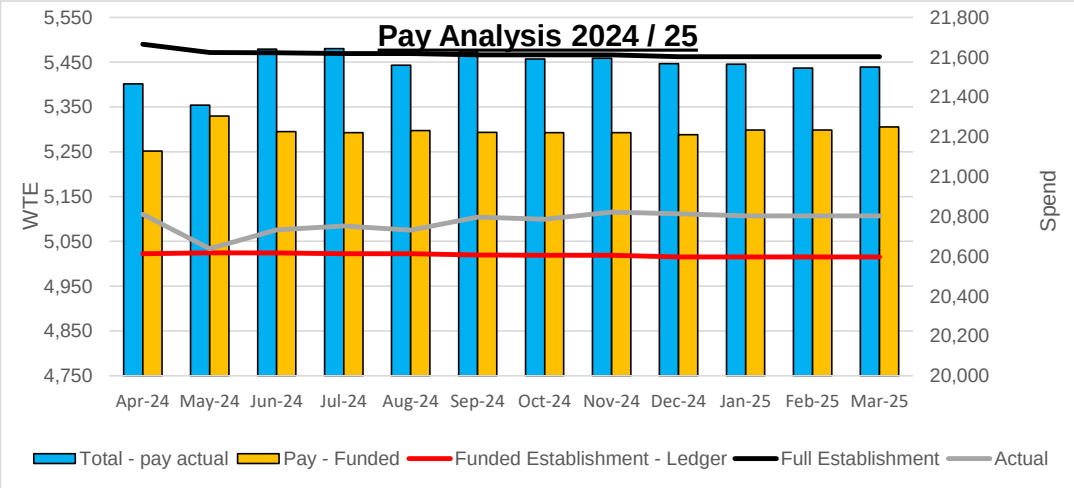
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives).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

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

Staff type	Apr-24 £k	May-24 £k	Jun-24 £k	Jul-24 £k	Aug-24 £k	Sep-24 £k	Oct-24 £k	Nov-24 £k	Dec-24 £k	Jan-25 £k	Feb-25 £k	Mar-25 £k	Total £k
Substantive	19,099	19,378	19,550	19,558	19,591	19,691	19,652	19,705	19,750	19,758	19,765	19,764	**235,259**
Bank & Locum	1,955	1,581	1,645	1,615	1,575	1,544	1,549	1,533	1,501	1,476	1,463	1,463	**18,902**
Agency	413	400	445	471	394	392	391	357	317	331	317	324	**4,552**
Total	**21,466**	**21,360**	**21,640**	**21,644**	**21,560**	**21,627**	**21,592**	**21,595**	**21,568**	**21,565**	**21,545**	**21,551**	**258,713**
23/24	18,936	20,296	20,278	19,819	20,540	20,195	20,200	19,722	20,475	17,837	21,734	21,262	**241,295**

Bank as % (in month)	9.1%	7.4%	7.6%	7.5%	7.3%	7.1%	7.2%	7.1%	7.0%	6.8%	6.8%	6.8%	7.3%
Agency as % (in month)	1.9%	1.9%	2.1%	2.2%	1.8%	1.8%	1.8%	1.7%	1.5%	1.5%	1.5%	1.5%	1.8%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,574	4,574	4,610	4,627	4,633	4,665	4,667	4,687	4,695	4,693	4,696	4,696	**4,651**
Bank & Locum	474	401	404	396	385	382	379	377	368	364	361	362	**388**
Agency	62	59	61	61	58	58	54	52	49	49	49	49	**55**
Total	**5,110**	**5,034**	**5,076**	**5,085**	**5,075**	**5,104**	**5,100**	**5,115**	**5,112**	**5,107**	**5,107**	**5,107**	**5,094**
23/24	4,689	4,770	4,767	4,775	4,830	4,846	4,854	4,882	4,935	4,972	5,044	5,075	**4,870**



The core Trust pay run rate is shown above including a breakdown of bank / locum and agency staff expenditure. The Trust breakeven financial plan is predicated on consolidating and stabilising the current workforce and reducing premium costs and systematic inefficiencies.

In May substantive workforce (worked WTE) has remained the same but expenditure has increased. Bank and locum costs, and WTE, have reduced significantly from the peak in April 2024. The impact of actions taken continue to be assessed.

Agency usage has continued to reduce as reported on the temporary staff focus page.

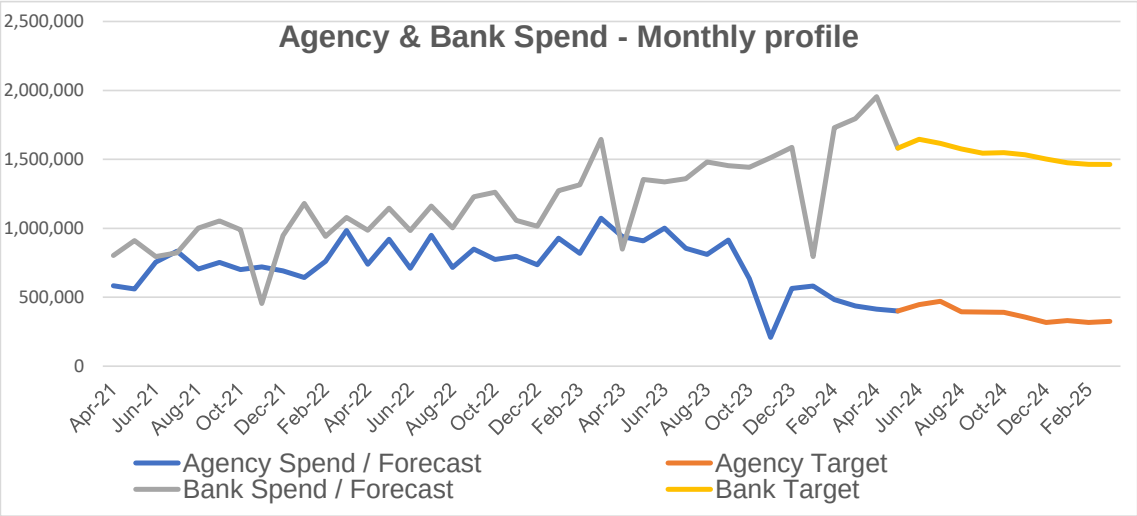
Overall the 5,033 total worked WTE is a reduction of 77 WTE since last month. This is, however, 45 more WTE than the funded establishment. The key areas of reduction are adult and older people inpatient wards and are linked to the bank reduction described above.

2.2 Temporary Staffing Focus

Spend in May 2024:
Agency £396k
Bank £1,579k

We continue to acknowledge that temporary staffing solutions continue to play an important role in the overall workforce strategy of the Trust. However this must fit within the overall context of ensuring the best possible use of resources and value for money whilst ensuring that operational pressures are effectively managed.

The focus has expanded from purely agency staff to total temporary staffing costs especially those which are paid a premium rate to those paid under normal terms and conditions. This includes agency staff, Trust bank staff and also enhanced payments made to substantive Trust staff for additional hours.



Temporary Staff costs to date - by category			
Category	**Agency**	**Bank**	**Total**
	£k	**£k**	**£k**
Consultant	280	96	**377**
Other Medical	203	126	**328**
Reg Nursing	88	824	**912**
UnReg Nursing	164	2,121	**2,286**
Other Clinical	59	153	**212**
A & C	18	216	**234**
Other	1	0	**1**
Total	**813**	**3,536**	**4,349**
Lead Provider Collaborative	100	0	**100**
Budgets held centrally	(1)	0	**(1)**
Total	**912**	**3,536**	**4,448**

As defined within NHS planning guidance the Trust has an agency target of 3.2% of total pay expenditure. Based upon the Trust plan this equated to £8.2m which would be in line with total agency expenditure in 2023 / 24. However due to the sustained reductions reported in quarter 3 and 4 2023 / 24 the Trust set a plan for 2024 / 25 of £6.7m.

The Trust scrutiny and management group has been expanded to review agency, bank and other temporary staffing. Run rates, as shown in the graph above, have reduced for agency and increasing bank.

Agency expenditure has continued to reduce in May 2024 with a reduction of £17k compared to the previous month. In headline terms this is within registered nursing and inpatient wards. Bank expenditure has also reduced in May 2024, £374k from the exceptionally high cost experienced in April 2024. Whilst this is also in inpatient wards the reduction comes from both registered and unregistered nursing staff.

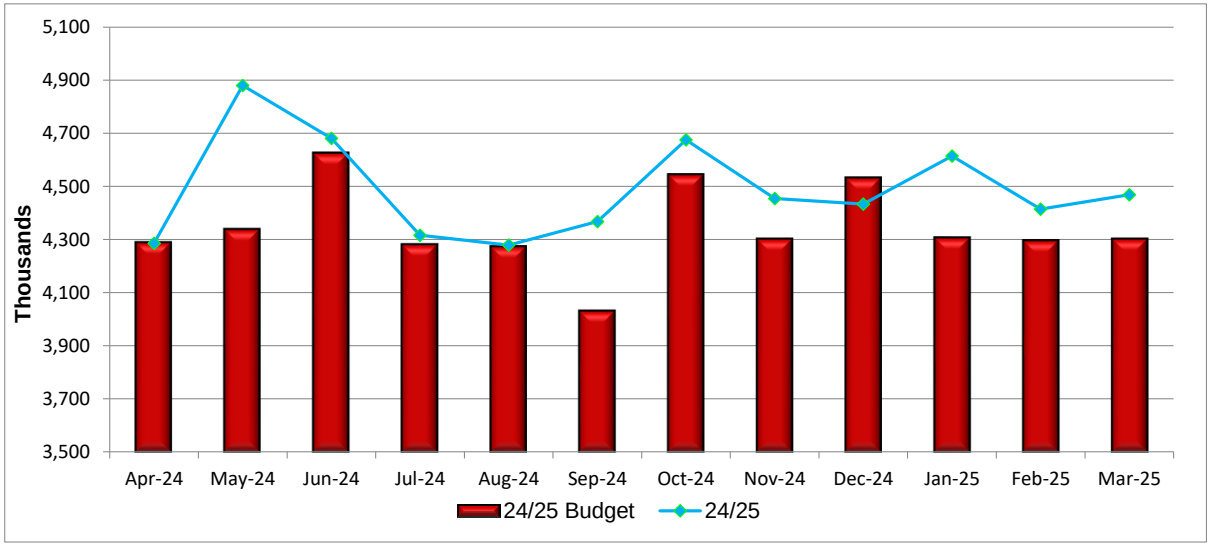
The Trust annual plan and financial sustainability programme is focussed on the reduction of all temporary staff costs especially those which have been paid a premium rate. Decisions and actions taken in May 2024 are expected to improve this position over the coming months. This will continue to be monitored through this report and internal groups.

2.3 Non Pay Expenditure

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

Non pay spend	Apr-24 £k	May-24 £k	Jun-24 £k	Jul-24 £k	Aug-24 £k	Sep-24 £k	Oct-24 £k	Nov-24 £k	Dec-24 £k	Jan-25 £k	Feb-25 £k	Mar-25 £k	Total £k
2024 / 25	4,286	4,881	4,681	4,316	4,279	4,367	4,676	4,455	4,434	4,615	4,415	4,469	**53,871**
2023 / 24	5,035	4,097	5,015	4,621	4,719	4,851	4,793	5,489	4,749	9,659	4,382	6,177	**63,586**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	688	676	(12)
Establishment	1,429	1,793	364
Lease & Property Rental	1,488	1,473	(14)
Premises (inc. rates)	927	946	18
Utilities	455	458	3
Purchase of Healthcare	1,017	945	(72)
Travel & vehicles	827	886	59
Supplies & Services	1,293	1,327	34
Training & Education	120	223	103
Clinical Negligence & Insurance	194	199	5
Other non pay	187	241	54
Total	**8,624**	**9,166**	**542**
Total Excl OOA and Drugs	**6,919**	**7,545**	**626**



Key Messages

Non pay budgets were reviewed as part of the annual planning process for 2024 / 25. Where appropriate they were reset to take account of changes in cost (i.e. inflationary increases) and volume (i.e. additional demand and usage).

Key variances for the year to date are in the establishment category and training and education. Both of these relate to the timing of expenditure and is expected to come back in line with plan in future months. These costs, alongside increased drugs charges, have been incurred in May 2024 and explain the increase in non pay expenditure run rate shown in the graph above.

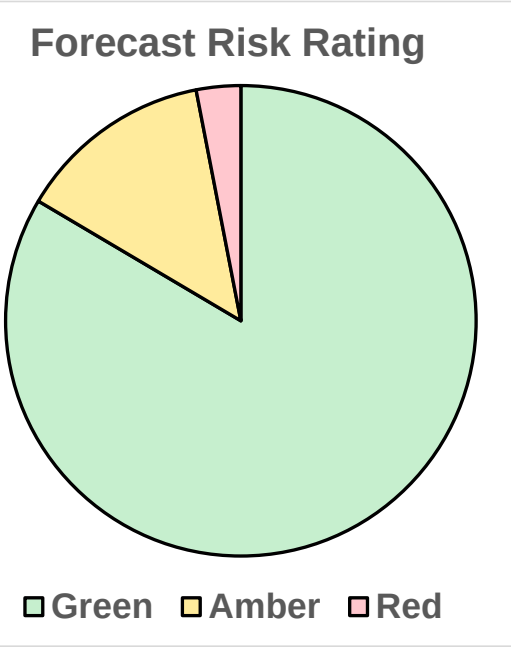
3.0 Value for Money, Financial sustainability and efficiency

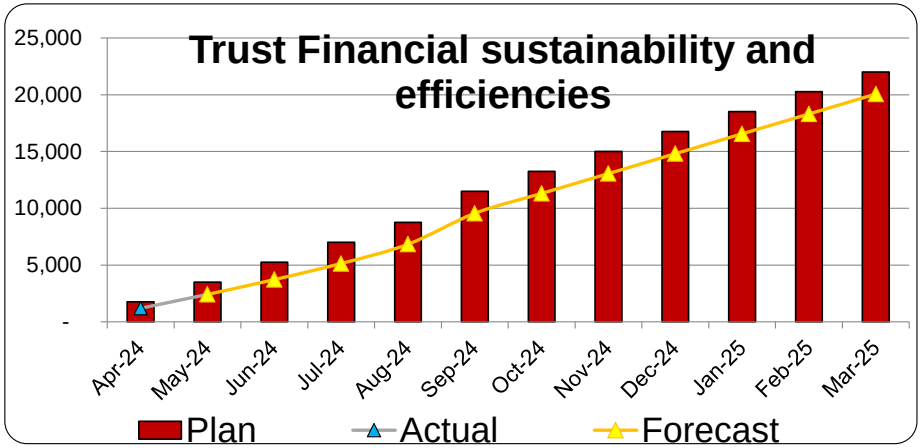
The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial sustainability. For 2024 / 25 a target of £22.0m has been identified and included within the plan. Additional mitigations will be required if the Trust run rate varies from plan.

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

		Year to Date			Forecast			
Workstream Categorisation	**Breakdown**	**Target £k**	**Achieved Recurrent £k**	**Achieved Non Recurrent £k**	**Target £k**	**Green £k**	**Amber £k**	**Red £k**
Workforce optimisation		2,078	170	865	12,468	10,667		
Non pay - Impact of workforce optimisation		70	50		420	400		
Out of area placements		479	660		2,871	660	2,574	
Non pay - digital		41	41		246	246		
Non pay - Estates		83	0		500			322
Non pay - medicines optimisation		80	0		480			290
Procurement		42	0		250		125	
Provider Collaboratives		190	190		1,140	1,140		
Income - contribution, FYE		440	440		3,638	3,638		
Total		**3,502**	**1,551**	**865**	**22,013**	**16,751**	**2,699**	**612**

Recurrent								
Non Recurrent								





The Trust value for money programme target for 2024 / 25 is £22,013k. This is a combination of recurrent and non-recurrent schemes with the focus on 2 specific areas. Pay schemes are focused on stabilisation of current workforce and reduction of any cost or volume inefficiencies. Non pay schemes are generally targeted at ensuring that value for money is secured.

As at month 2 there is a gap in both year to date and forecast delivery which has a corresponding impact on the overall financial forecast. Where schemes are in place this need to maximise the saving that they realise and where slippage has occurred alternative mitigations need to be identified.

4.0 Statement of Financial Position (SOFP) 2024 / 25

Balance Sheet / Statement of Financial Position (SOFP)	2023 / 2024 £k	Current £k	Note
Non-Current (Fixed) Assets	167,819	169,985	1
Current Assets			
Inventories & Work in Progress	179	179	
NHS Trade Receivables (Debtors)	1,072	589	
Non NHS Trade Receivables (Debtors)	1,058	892	
Prepayments	3,491	5,038	
Accrued Income	1,062	2,498	2
Cash and Cash Equivalents	69,199	62,745	Pg 15
Total Current Assets	**76,061**	**71,942**	
Current Liabilities			
Trade Payables (Creditors)	(13,442)	(6,194)	3
Capital Payables (Creditors)	(1,392)	(778)	
Tax, NI, Pension Payables, PDC	(8,469)	(8,749)	
Accruals	(13,966)	(16,583)	4
Deferred Income	(409)	(1,145)	
Other Liabilities (IFRS 16 / leases)	(51,040)	(54,158)	1
Total Current Liabilities	**(88,718)**	**(87,607)**	
Net Current Assets/Liabilities	**(12,657)**	**(15,665)**	
Total Assets less Current Liabilities	**155,161**	**154,319**	
Provisions for Liabilities	(3,510)	(3,490)	
Total Net Assets/(Liabilities)	**151,651**	**150,829**	
Taxpayers' Equity			
Public Dividend Capital	45,696	45,696	
Revaluation Reserve	15,355	15,355	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	85,380	84,558	
Total Taxpayers' Equity	**151,651**	**150,829**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2024.

1. In addition to the capital programme expenditure there is an increase in fixed asset values due to increases in lease / rental costs at the start of the year. This results in increases in both assets and liabilities.

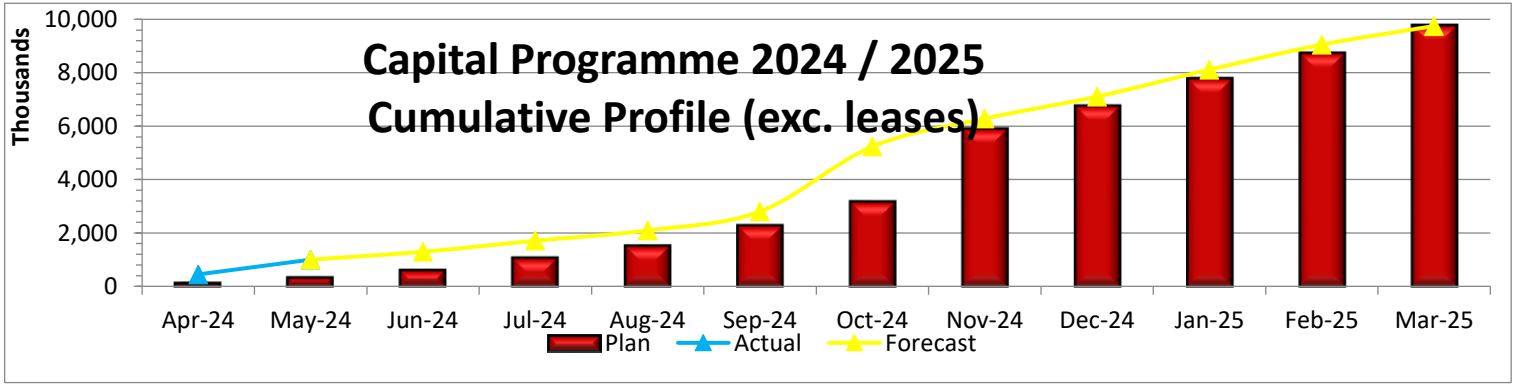
2. Accrued income is traditionally low at year end and then increases during quarter 1. These will be invoiced as soon as possible.

3. Creditors were exceptionally high at year end with a large number of invoices received in March which have now been paid. We continue to monitor the timing of invoices to ensure that any issues are resolved in a timely manner. This is supported the strong performance against the Better Payment Practice Code.

4. The value of accruals has reduced from previous years. These are reviewed monthly to ensure that any actions are taken as required.

4.1 Capital Programme 2024 / 2025

Capital schemes	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k
Major Capital Schemes						
Older People Transformation	2,500	0	0	0	2,500	0
Seclusion Rooms	1,000	190	416	226	1,000	0
Anti-ligature Doors	1,000	100	136	36	1,000	0
Maintenance (Minor) Capital						
Clinical Improvement	311	0	0	0	311	0
Safety	302	0	0	0	302	0
Sustainability / Carbon Neutral	510	0	0	0	510	0
Backlog	360	14	0	(14)	351	(9)
Equipment	41	0	11	11	64	24
Other	171	0	321	321	513	342
IM & T	1,470	0	65	65	1,470	0
Contingency	219	0	0	0	(138)	(357)
Staff Costs	200	33	31	(3)	200	0
TOTALS	**8,082**	**337**	**979**	**642**	**8,082**	**0**
Lease Impact (IFRS 16) New lease	1,857	0	3,678	3,678	5,962	4,105
TOTALS	**9,939**	**337**	**4,657**	**4,320**	**14,044**	**4,105**



Capital Expenditure 2024 / 25

As part of the West Yorkshire Integrated Care Board (WY ICB) capital prioritisation process the Trust capital programme for 2024 / 25 is £8,082k.

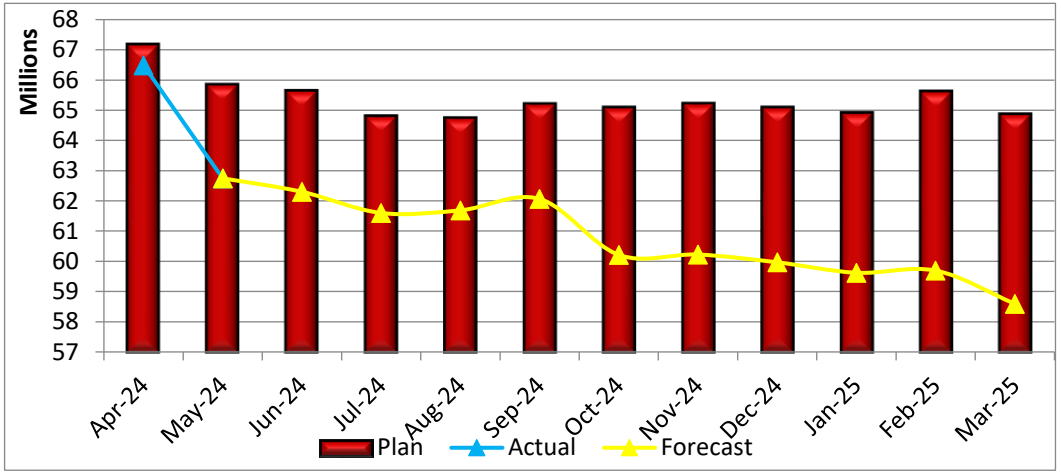
Expenditure, for the year to date, is ahead of plan. This is mainly due to the timing of costs on the contination of long term schemes (seclusion rooms, anti ligature doors).

Spend in the other category primarily relates to finalisation of schemes from the 2023 / 24 programme.

The deliverability of all schemes, and ensuring that this remains within the financial allocation, continue to be assessed. Althought risks exist, at this stage of the year, it is belived that these will be mitigated and the programme will be delivered in full.

4,657 14,044

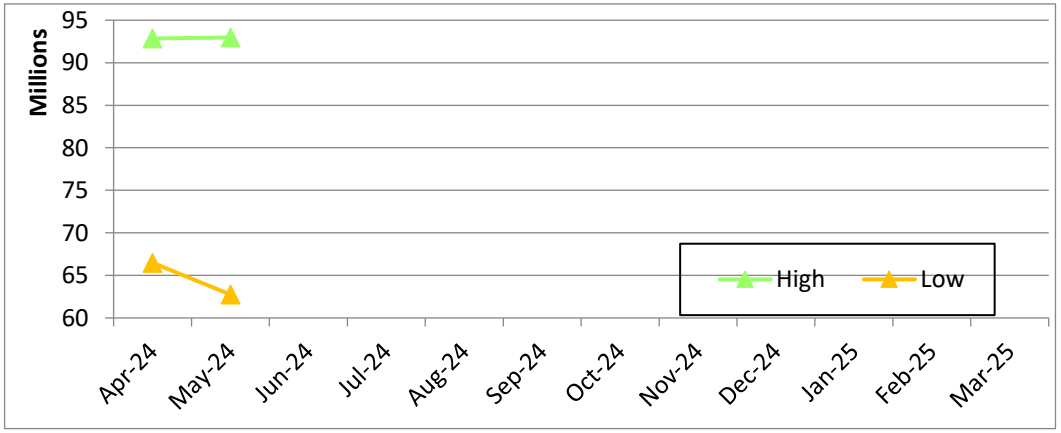
4.2 Cash Flow & Cash Flow Forecast 2024 / 2025



Cash has reduced in month as invoices have been paid

There was a signficant reduction in the Trust cash position in May 2024 as invoices received have been paid. This is shown in the reduced level of creditors within the balance sheet. These were paid within payment terms as also shown within the positive Better Payment Practice Code position.

	Plan £k	Actual £k	Variance £k
Opening Balance	71,353	69,199	
Closing Balance	65,851	62,745	(3,106)



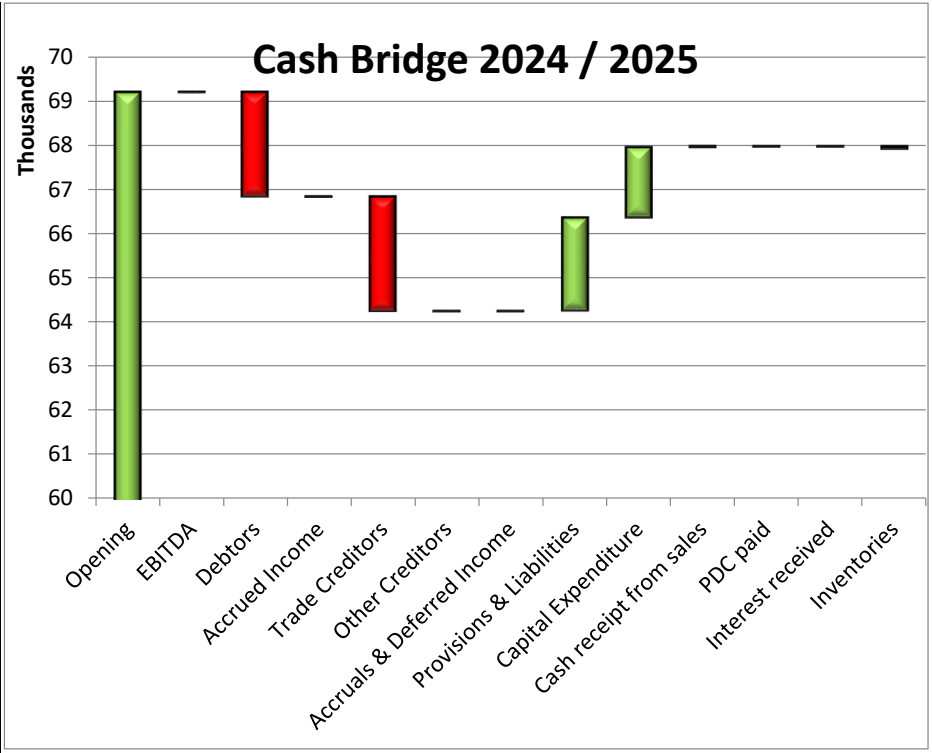
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £93m
The lowest balance is: £62.7m

This reflects cash balances built up from historical surpluses.

4.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**71,353**	**69,199**	(2,154)	
Surplus / Deficit (Exc. non-cash items & revaluation)	1,389	1,390	1	
Movement in working capital:				
Inventories & Work in Progress	52	0	(52)	
Receivables (Debtors)	30	(2,334)	(2,364)	
Trade Payables (Creditors)	(2,000)	(4,587)	(2,587)	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	(1,390)	717	2,107	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(2,572)	(979)	1,593	
Cash receipts from asset sales	0	22	22	
Leases	(1,712)	(1,382)	330	
PDC Dividends paid	0	0	0	
PDC Dividends received	0		0	
Interest (paid)/ received	701	701	(0)	
Closing Balances	**65,851**	**62,745**	**(3,106)**	



The table above summarises the reasons for the movement in the Trust cash position during 2024 / 2025. This is also presented graphically within the cash bridge.

The variance between plan and actual in the opening balances is due to the timing of the plan submission. This was prepared prior to the actual end of the financial year and final values being known. This has a subsequent impact on the other movements as well.

The cash position continues to be driven by the overall financial surplus / deficit of the Trust. Other variances in debtors (higher than plan) and creditors (also lower than plan) also have a negative impact on cash. The forecast, and actions to be taken to maximise the Trust cash balances are being reviewed.

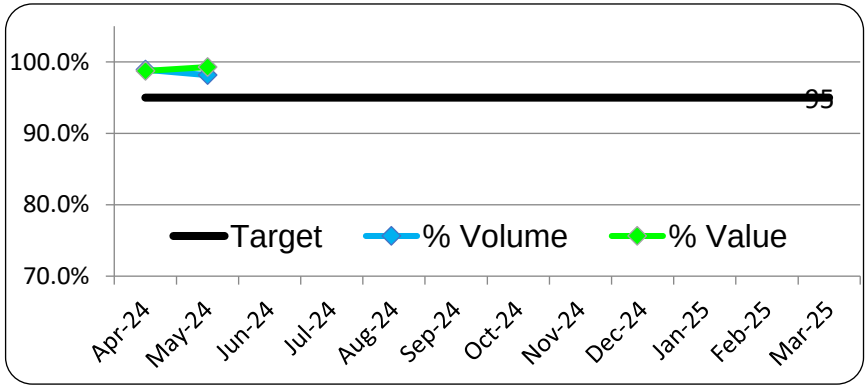
5.0 Better Payment Practice Code

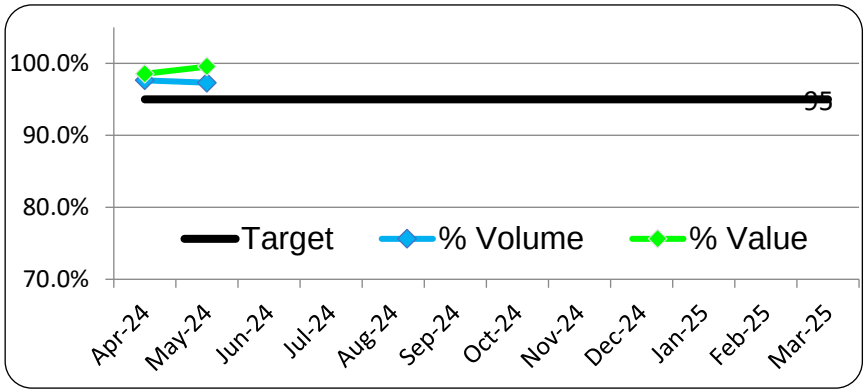
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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

NHS	Number %	Value %
In Month	98%	99%
Cumulative Year to Date	98%	99%

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





"

5.1 Transparency Disclosure

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

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

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

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

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
21-May-24	Computer Maintenance	Trustwide	Phoenix Partnership (Leeds) Ltd	15372	840,823
31-May-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5492	800,000
08-May-24	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000058058	744,624
15-May-24	Insurance	Trustwide	Willis Ltd	11738GP24000001PRM	627,368
02-May-24	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	204388	624,374
17-May-24	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	204428	624,374
13-May-24	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Four	4400001422	467,292
21-May-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS46	450,000
01-May-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008978	382,153
15-May-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5487	274,000
08-May-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS22	270,000
21-May-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS23	270,000
14-May-24	Regulator Fee	Trustwide	Care Quality Commission	43525518	226,521
08-May-24	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 284	217,894
24-May-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5490	133,992
01-May-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008976	126,523
15-May-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	NCO2000008123	112,152
17-May-24	IT Services	Trustwide	Daisy Corporate Services	3I527286	90,250
23-May-24	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710179628	86,650
28-May-24	Drugs	Trustwide	NHS Business Services Authority	1000080678	60,245
21-May-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	NCO2000008158	56,000
10-May-24	Rent	Barnsley	Dr A D Mellor And Partners	300030	55,868
23-May-24	Utilities	Trustwide	Edf Energy Customers Ltd	000019010044	48,968
01-May-24	Purchase of Healthcare	Kirklees	Spectrum Community Health Cic	SINV6715	48,868
30-May-24	Purchase of Healthcare	Kirklees	Spectrum Community Health Cic	SINV7396	48,868
09-May-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS044INV	44,265
21-May-24	Consultancy	Kirklees	Kirklees Council	8608797225	43,750
01-May-24	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400004264	41,372
14-May-24	Purchase of Healthcare	AS Collaborative	Everybody Arts Cic	23260	40,879
29-May-24	Agency Staff	Kirklees	Socrates Clinical Psychology Ltd	SPS09834RMD9834	40,800
03-May-24	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90136311	40,746
17-May-24	Purchase of Healthcare	Barnsley	Family Lives	2585	39,709

01-May-24	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400004264	39,281
01-May-24	Mobile Phones	Trustwide	Vodafone Ltd	105772311	37,871
09-May-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC024INV	37,663
28-May-24	Data Lines	Trustwide	Vodafone Ltd	105978833	36,456
01-May-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001178EPC	36,374
14-May-24	Purchase of Healthcare	Trustwide	Touchstone-Leeds	SINV20240011	35,382
01-May-24	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400004264	34,183
30-May-24	Agency Staff	Kirklees	Socrates Clinical Psychology Ltd	SPS09869RMD9869	31,200
31-May-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	ARB05986	30,159
30-May-24	Continence Products	Barnsley	Supply Chain Coordination Limited	1125045704	29,071
01-May-24	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400004264	28,162
24-May-24	Professional Fees	Trustwide	Medical Premises Consultants Ltd	INV0121	27,950
30-May-24	Insurance	Trustwide	Aon Uk Ltd	532844768	26,706
01-May-24	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400004264	25,576
30-May-24	Rent	Wakefield	Bradbury Investments Ltd	1871	25,530
22-May-24	Taxis	Wakefield	Wakefield Cars Ltd	9251	25,086
16-May-24	NHS Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	1001665	25,000

5.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

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

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

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

* Value for Money / Cost Savings - The Trust priority of Value For Money is intrinsically linked to the ability to maintain financial sustainability. In addition to value for money this are also called savings, effeciencies, and Cost Improvement Programmes (CIP). In each case this is the identification of schemes to increase effeciency, reduce expenditure or increase income.

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

* ICS - Integrated Care System. ICB - Integrated Care Board.

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

Appendix 2 - Statistical Process Control (SPC) Charts Explained

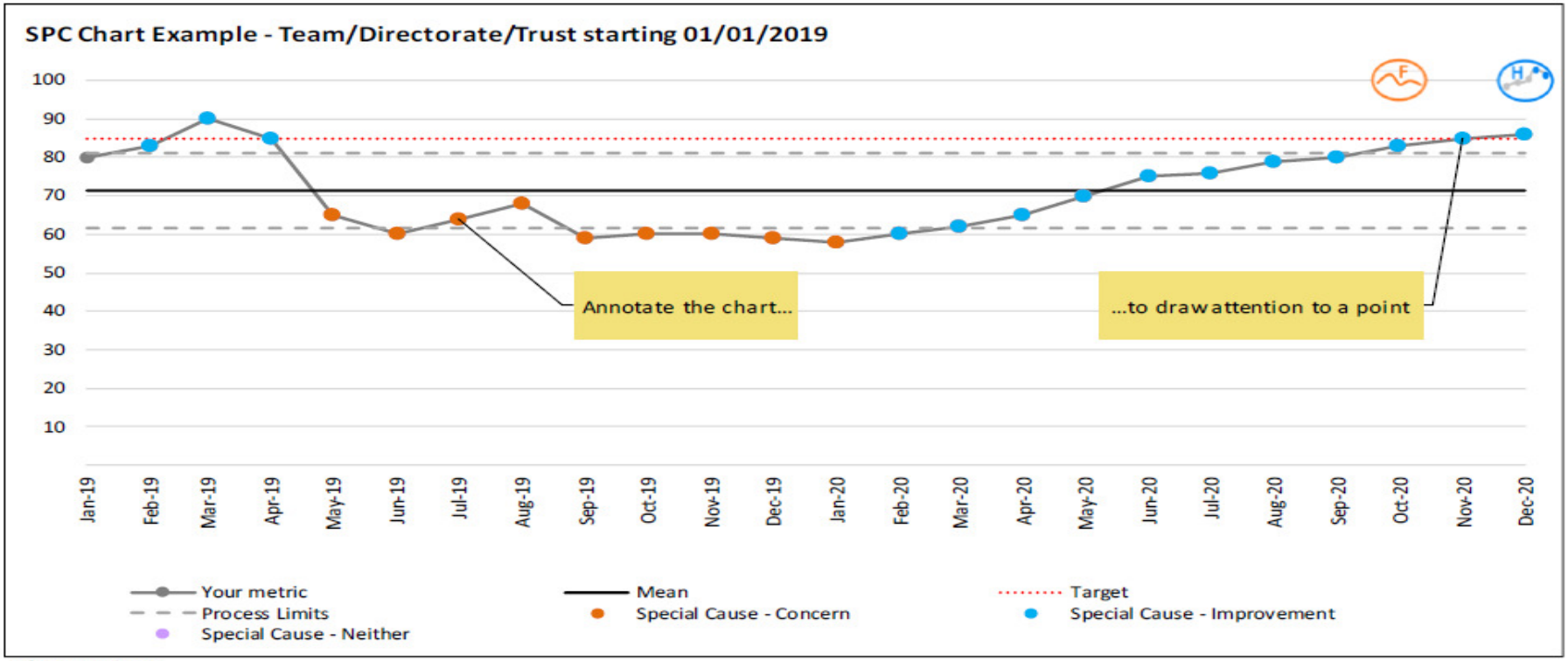
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

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

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

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

Appendix 2 - Statistical Process Control (SPC) Charts Explained



Observations

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

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