NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

June 2024

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for June 2024.

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 any changes in the NHS England oversight framework, operational planning metrics and NHS standard contract metrics for 2024/25. 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	↑	
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	↓	
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	↑	
Inappropriate out of area bed placements (days)	↓	
% 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		
Registered workforce growth	↓	
Workpal appraisals - rolling 12 months	↓	
Mandatory training - Reducing restrictive practice interventions	↓	

Metric	Change from last month	Variation/ Assurance
Quality		
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	↑	

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

Metric	Change from last month	Variation/ Assurance
National metrics		
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	↓	
Total bed days of Children and Younger People under 18 in adult inpatient wards	↑	
Total number of Children and Younger People under 18 in adult inpatient wards	↑	
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	↑	

Care Groups

Children and Families

Metric	Change from last month	Variation/ Assurance
% Appraisal rate	↓	H F
% of staff receiving supervision within policy guidance	↓	
Reducing restrictive physical interventions training compliance	↓	?
% 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
Reducing restrictive physical interventions training compliance	↓	F
Sickness rate (Monthly)	↓	?
FIRM Risk Assessments - Staying safe care plan in 7 working days	↑	F

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	↓	?
Sickness rate (Monthly)	↓	

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	H F
% 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	↓	?

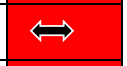
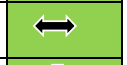
Barnsley Physical Health and Wellbeing

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

Forensic

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

This section has been developed to demonstrate progress being made against the Trust objectives using a range of key metrics. More detail is included in the relevant sections of the Integrated Performance Report.

Strategic Objectives & Priorities

• It is important that our workforce reflects the communities that we serve. As an employer we are committed to developing and supporting an inclusive workforce and have. Having a clear understanding of the equality data of our workforce is important which is why we carefully monitor this across our workforce.
• The Trust continues 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 97.3% against a target of 90%. For the Trust derived indicators, as of June 2024, disability is at 48.1%, sexual orientation 60.4% 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.
• The trust continues to prioritise addressing inequalities involvement and equality in each of our places and with our partners; having a workforce that reflects its local population will assist with ensuing we are delivering appropriate care to assist with reducing inequalities.
• 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)

• Continued service improvement work supports the overall use of inappropriate out of area bed days, there was a slight increase during June with 60 days used however, this remains under the local trajectory of 150 days used based on 5 people being placed out of area. 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 decreased to 66.7% in June, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service only. The small decline in the performance is due to leave and staff unavailability. Small changes in the team availability greatly impact the performance data. Conversations are underway with commissioners regarding resources available to the team. The team continue delivering the improvements on the action plan.

Care planning and risk assessments

For risk assessments, the June data shows a similar position in performance from the previous month within inpatient services at 94.2%. For community services, performance for June has increased to 75.8% from 68.1%. The teams review the detail of performance and all service users without a risk assessment are followed up individually in the care group to maintain patient safety. Improvement trajectories have been agreed towards full performance in July for inpatients and February 25 for community services.

Quality continued

Waiting Lists

• Child and adolescent mental health services (CAMHS) continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period.

• '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 at 526 days in Calderdale and 641 days in Kirklees, with a specific risk noted where additional capacity is no longer available in Kirklees. This means that children wait for an extended period to understand whether a neurodevelopmental condition is impacting their life. Children do not need to have a diagnosis to receive support from CAMHS 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 overall improvement. Although performance for June dropped to 86% from 89.2%, the learning disability team have robust oversight of all waits and are carrying out profession specific actions to address waits within individual disciplines.

• 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. For adult ADHD the detailed waiting list report presented to the Finance Investment and Performance Committee in June provided detail to demonstrate that in 3 Places, the commissioned monthly referrals for ADHD were 28 and the number of referrals received were 244. This leads to lengthy waits.

Patient Safety Indicators

96% of incidents reported in June 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 153 (226 in May). 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.

• 100% of prone restraint incidents that occurred during the month were for a duration of three minutes or less – this related to 5 incidents for the month of June which is a significant reduction from the spike of incidents (21) reported in May 24 – the majority of these incidents occurred on our Psychiatric Intensive Care Unit (PICU) wards which indicate a high level of acuity. 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. The improvement work continues and the SPC chart shows an overall reducing trend.

• There were 9 information governance personal data breaches during June which is a decrease compared to June (11 reported incidents). Following the spike in February (20 incidents), messages on good information governance were strengthened and 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 continues to be achieved.

• The number of inpatient falls in June was 63 compared to 39 incidents in May. All falls incidents are reviewed regularly by the Trust wide falls coordinator to ascertain any themes or actions required. There has been an increase in individual patients having repeated falls and particularly for patients who are experiencing agitation or who have dizziness or confusion related to infections. Actions have been put in place to further reduce the risk. Further detail is provided in the relevant section of this report.

• Although the number of responses provided within six months of the date a complaint remains under the Trust threshold of 100%, improvement work continues. This is reflected in the overall improvement of this metric over the last 12 months. Performance in June is impacted by smaller numbers (2/4).

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 June of 82.4% which is an improvement from the refreshed performance for May which is 81% and remains above the Trust threshold of 80%. 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 36 violence and aggression incidents against staff on mental health wards involving race during June, which is the highest number of such incidents reported over the last 12 month period - 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 127.4 new starters and 80.4 leavers. This is as a result of positive recruitment activity earlier in the year and contributes to providing operational stability and improved staff and service user experience, with improved staffing capacity. It is recognised that workforce growth places additional finance pressure.
• At the end of June 2024, our Trust growth rate has decreased slightly to 0.9% (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 June has decreased slightly again this month to 9.4% 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 June 2024 we have seen a slight increase in sickness to 4.8% and remains within the 5% threshold. Hotspots continue to be managed.
• The combination of reduced turnover, successful recruitment and an overall reduction in sickness (slight increase in month) should be considered to be related as working with regular staff in supportive teams contributes to a great place to work.
• Sickness absence rolling 12 month in June remains at 5.0%.
  o The people directorate have been supporting line managers in all areas to actively manage long term sickness.
  o Our people business partners have been working closely with Care Group leaders to highlight hotspots and provide more guidance for managers.
  o The Trust benchmarks well compared to peers in the region. In the NHS England workforce published data for the period April 23 – January 24, the Trust reports the lowest sickness absence rate. Other Trusts are experiencing a trend of rising sickness levels which is not currently evident within SWYPFT.
• The appraisal rate has dropped despite an increase in overall numbers of staff being complaint in month (up by 40 staff from last month). The impact of strong recruitment numbers last year means that more staff are now eligible for appraisal. This along with lower leaver numbers has now caused the overall response rate to fall slightly against target.
• Our overall mandatory training compliance remains above threshold, with the majority of training areas sustaining performance.
  o Reducing Restrictive Physical Interventions (RRPI) remains below threshold and has reduced to 72.8%. The 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 a positive impact over recent months.
  o Rostering is used to ensure that wards have access to appropriately trained staff. Wards with high acuity and lower training levels are prioritised for training places.
• 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

• 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.
• Workforce challenges have continued with continued use of temporary staffing, primarily bank.
• 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 June.
• 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 was one patient under 18 years old in an adult bed for one night during June. 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. The CAMHS team provide wrap around support and care planning advice when a child is admitted to an adult facility to minimise the impact on the child.
• Although there continues to be reduced position in the people who are clinically ready for discharge at 2.1%, 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.

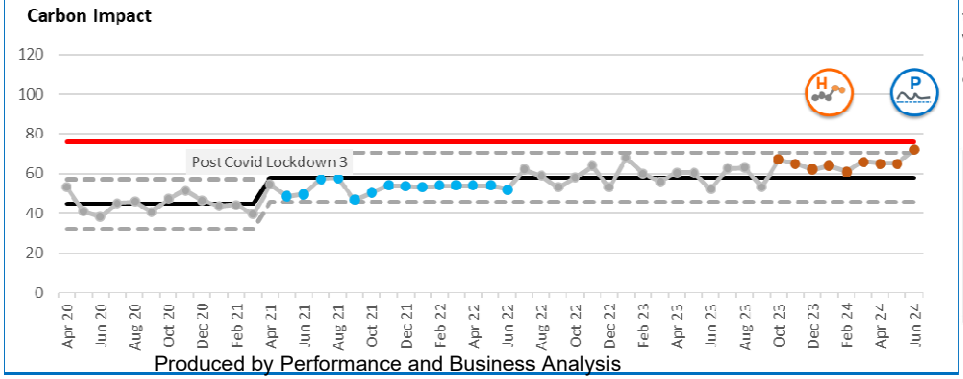
Finance

• The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £0.9m deficit has been reported. June's deficit of £0.1m was much improved compared to April & May but remains adverse to plan. A number of corrective actions are in place and we are continually assessing if further action is required.
• There has been a sustained reduction in agency expenditure over the past 9 months. Spend increased in June to £508k which is £37k more than the previous month. The main movement is an in-month increase in medical staff, 3 more WTE worked. The adult secure provider collaborative spend in month was £64k.
• Actions remain in place to address agency spend, which is being overseen by the Trust's agency group.
• The Trust cash position has increased in month and remains in excess of £60m. Actions to optimise cash are being taken, especially ensuring that all income has been invoiced for, are being progressed.
• Performance against the Better Payment Practice Code is 99%.

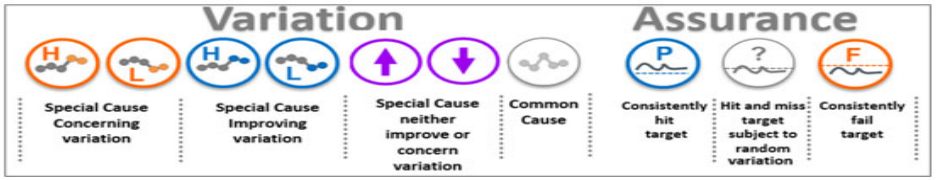
Improving health

Metrics	Threshold	Apr-24	May-24	Jun-24	Variation/ Assurance	Notes
Proportion of staff in senior leadership roles who are from ethnic minority background (relates to staff in posts band 7 and above, excludes bank staff)	Trend monitor	224 - All staff (16.2%) 95 - excl medics (8.0%)	230 - All staff (16.5%) 100 - excl medics (8.4%)	228 - All staff (16.5%) 99 - excl medics (8.3%)		It is important that our workforce reflects the communities that we serve. As an employer we are committed to developing and supporting an inclusive workforce and have. Having a clear understanding of the equality data of our workforce is important which is why we carefully monitor this across our workforce.
Percentage of service users who have had their equality data recorded - ethnicity	90%	94.2%	96.9%	97.3%		
Percentage of service users who have had their equality data recorded - disability	50%	47.4%	48.0%	48.1%		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%, this will be reviewed in September 24. 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		59.6%	60.2%	60.4%		
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%	74.3% Service	75% 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%	96.7% Policy	97.3% Policy	97.8% Policy		
Completion of equality mandatory training	>=80%	95.6%	95.6%	96.7%		
Number of job start/work retention outcomes during month by individual placement and support service	Trend monitor	16	12	14		A single client could have multiple job starts
Number of new people accessing Individual placement and support service during month	Trend monitor	44	43	31		First contact and work started on vocational profile
Carbon Impact (tonnes CO2e) - business miles	76	65	65	72	H P	Data showing the carbon impact of staff travel / business miles. In June staff travel contributed 72 tonnes of carbon to the atmosphere. There are a number of actions being put into place during 2024/25 to assist with further reduction of this. This includes a pilot to encourage car sharing, eBike pilot to encourage higher levels of active travel and we are also undertaking a communications campaign to continuously promote our message around minimising travel wherever possible.
Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	55%	Due August 2024				2023/24 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 remain in 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	Apr-24	May-24	Jun-24	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% *Improvement trajectory Inpatient - July 95% Community - Aug 80% Sept 82.5% Oct 85% Nov 87.5% Dec 90% Jan 92.5% Feb 95%*	92.7%	94.4%	94.2%		June data shows a smilar position in performance from the previous month within inpatient services. For community services, performance for June has increased to 75.8% from 68.1%. Within inpatient services 113 service users had a risk assessment within 24 hours,7 service users had a completed risk assessment but this was outside the 24 hours. For community services 29 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 number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		78.5%	68.1%	75.8%		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. An improvement trajectory has been set and will be monitored against from July.
% Service users on care programme approach with a plan of care developed collaboratively	85%	95.3%	95.2%	95.4%		The Care Plan and Risk Assessment Improvement Group continue to look at performance as well as quality of care planning and risk assessments. The wording of the metric has 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	1107	1115	1116		
Registered substantive staff in neighbourhood teams	Establishment	171	172	171		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	26	33	36		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.
Inappropriate out of area bed placements (days)	April - 150 May - 155 June - 150	119	34	60		National target zero. Local target as per operational plan (5 service users per month). Whilst we remain above the national threshold we have seen a notable improvement in the number of out of area bed days which is down to an average of 88 days over the past 6 months from an average of 233 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.
% service users clinically ready for discharge	<=3.5%	2.3%	1.8%	2.1%		Performance in month has deteriorated slightly but 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	672	578	526		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	647	647	641		
Learning Disability (LD) - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90% Imprvement trajectory: July 86% Oct 88% Dec 90%	82.0% 41/50	89.2% 58/65	86% 43/50		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 June) the service understand why and are taking appropriate action. 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%	94.6%	89.8%	89.0%		
Community health services two hour urgent response standard	70%	92.8%	89.7%	89.9%		
Referral to assessment within 2 weeks (external referrals)	75%	90.6%	83.8%	92.3%		

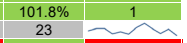
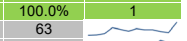
Improve resources

Metrics	Threshold	Apr-24	May-24	Jun-24	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	(£192k)	(£613k)	(£88k)		The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £0.9m deficit has been reported. June's deficit of £0.1m was much improved compared to April & May but remains adverse to plan. A number of corrective actions are in place and we are continually assessing if further action is required.
Capital spend against plan (monthly)	£8.1m	£334k	£346k	(£57k)		The Trust capital allocation for 2024 / 25 is £8.1m. Expenditure, for the year to date, is £1.2m and remains ahead of the plan profile. We are closely monitoring the timing of the Crofton Development Program.
Agency spend managed within the overall workforce (Monthly)	3.5% £6.7m	£442k	£396k	£508k		There has been a sustained reduction in agency expenditure over the past 9 months. Spend increased in June to £508k which is £37k more than the previous month. The main movement is an in-month increase in medical staff, 3 more WTE worked. The adult secure provider collaborative spend in month was £64k.
Financial sustainability and efficiencies delivered over time (monthly)	£22m	£1,751k	£665k	£1,368k		The Trust financial sustainability programme for 2024 / 25 has a target of £22.0m. Year to date performance is below plan and additional mitigation plans are being developed to cover this shortfall.
Total pay costs	£21,227 (June)	Reporting commenced June 24		£21,739		Trust only (excludes collabs and budgets held centrally). See finance appendix for further detail and breakdown.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	17				16 of the reported incidents related to violence and aggression against staff, in every case, staff have been supported through their recuperation. One incident relating to moving and handling has been referred to occupational health and adjustments put into place for safe working. Data relating to these incidents has been analysed and there have been above average incidents reported since March 24 with a spike in incidents occurring during May 24. Analysis of the previous 2 quarters indicates that this current quarters reporting is high. Looking at the longer term analysis there have been similar increases at certain points of the year with a return to lower numbers afterwards. Initial investigation attributes a number of the recent incidents to a particularly challenging service user. Operational Management Group (OMG) have asked for a piece of work to be undertaken analysing incidents in depth to be overseen by clinical governance with reports back to OMG in the first instance by the end of the calendar year.
Estates Urgent Response Times - Service level agreement (SLA)	95%	100.0%	96.9%	98.8%		Service level agreement 1 & 2 are the priorities given to emergency and urgent work which has a two day response time.
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	Apr-24	May-24	Jun-24	Variation/ Assurance	Notes
Turnover external (rolling 12 months)	>12% - 13%<	10.0%	9.9%	9.4%		
Registered workforce growth	0% 2024/25	0.9%				
Sickness absence - rolling 12 months	<=5%	4.8%	5.0%	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%	87.4%	87.1%	84.3%		The appraisal rate has dropped despite an increase in overall numbers of staff being complaint in month (up by 40 staff from last month). The impact of strong recruitment numbers last year means that more staff are now eligible for appraisal. This along with lower leaver numbers has now caused the overall response rate to fall slightly against target.
% staff recommending the Trust as a place to work	65%	N/A				Results from national staff survey.
% staff recommending the Trust as a place to receive care and treatment	65%	N/A				
Staff supervision rate	80%	78.0%	81.0%	82.4%		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%	79.4%	80.7%	80.3%		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 (RRPI)	80%	68.3%	74.0%	72.8%		The 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 a positive impact over recent months. Rostering is used to ensure that wards have access to appropriately trained staff. Wards with high acuity and lower training levels are prioritised for training places.
Mandatory training - Fire	85%	90.4%	91.1%	90.8%		Threshold increased from >=80% in June 24.
Mandatory training - Information governance (IG)	95%	92.8%	97.1%	95.5%		

Quality Headlines

Section	KPI	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	TBC	84.0%	81.0%	80.0%	82.4%	85.8%	84.2%	80.9%	78.8%	79.9%	73.3%	75.6%	86.0%	N/A
Complaints	% of feedback with staff attitude as an issue [12]	< 20%	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)	6% (1/18)	1
	Complaints - Number of responses provided within six months of the date a complaint received [16]	100%	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)	50% (2/4)	
Service User Experience	Friends and Family Test - Mental Health	84%	90%	90%	95%	89%	88%	94%	89%	92%	92%	92%	92%	91%	1
	Friends and Family Test - Community	95%	93%	97%	96%	95%	97%	98%	97%	97%	97%	97%	97%	96%	1
Quality	Number of compliments received	N/A	35	22	17	18	35	16	2	8	6	12	26	7	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	24	35	24	30	19	15	17	15	18	12	14	8	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	3	5	4	6	3	1	0	0	0	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	0	0	0	0	0	1	3	0	0	0	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	96.9%	96.8%	96.7%	96.6%	96.5%	96.1%	95.7%	95.9%	95.4%	95.3%	95.2%	95.4%	1
	Number of Information Governance breaches [3]	<12	13	16	8	9	11	8	14	20	5	8	11	9	2
	% of inpatients clinically ready for discharge	3.5%	4.8%	5.7%	5.7%	5.2%	5.8%	5.7%	4.3%	2.9%	2.5%	2.3%	1.8%	2.1%	3
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% Improvement trajectory: June 90%, July 92%, Aug 94%, Sept 95%	87.2%	88.0%	87.5%	89.9%	92.5%	94.1%	93.4%	90.1%	91.7%	92.7%	94.4%	94.2%	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		74.0%	72.2%	71.3%	71.1%	76.4%	70.0%	71.8%	74.7%	79.2%	78.5%	68.1%	75.8%	2
	Total number of reported incidents	Trend monitor	1159	1206	1150	1315	1322	1186	1288	1351	1450	1415	1472	1245	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	21	28	23	25	20	17	23	21	35	25	34	25	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	1	4	1	4	1	1	5	4	1	0	1	5	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	2	3	1	3	2	2	2	0	1	0	1	1	
	Safer staff fill rates	90%	123.9%	123.8%	124.1%	123.5%	128.8%	128.7%	129.6%	127.6%	128.5%	130.8%	130.0%	132.5%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	93.6%	92.1%	91.4%	91.3%	97.5%	96.2%	102.2%	100.8%	101.6%	107.1%	105.2%	101.8%	1
	Number of pressure ulcers which developed under SWYPFT care ($_1$)	Trend monitor	36	43	43	28	33	27	45	58	42	29	41	23	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement ($_2$)	0	1	2	0	3	6	6	2	2	1	2	1	0	
	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%	95.2%	90.0%	90.0%	91.7%	66.6%	100.0%	100.0%	100.0%	92.3%	100.0%	95.0%	100.0%	1
	Number of Falls (inpatients)	Trend monitor	32	33	36	50	46	42	48	45	45	41	39	63	
	Number of restraint incidents	Trend monitor	145	146	92	198	153	193	121	165	188	256	226	153	
	% of staff receiving supervision within policy guidance [15]	80%	Reporting from Sept 2		65.8%	66.0%	70.1%	69.6%	70.8%	71.0%	76.3%	78.0%	81.0%	82.4%	2
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing [14]	80%	83.8%	81.8%	90.6%	91.3%	66.7%	95.1%	97.4%	88.9%	94.1%	100.0%	81.8%	90.6%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	1	0	0	0	0	0	0	1
	C Diff avoidable cases	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	0	0	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	2	2	2	2	2	2	2	2	2	2	2	2	2	
	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.
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.
16 - Formal complaints should be responded to/closed within 6 months of the date received as is written into the NHS Complaints (England) Regulations 2009

Quality Headlines

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

• The overall number of restraint incidents in June was 153 which is within acceptable range and a reduction on the last four months. 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 reported in May, each of these have been reviewed and regraded reducing the number of incidents in May to 1. No incidents have been identified in June.
• Clinically ready for discharge (previously delayed transfers of care) - This has increased to 2.1% 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 June there were 63 inpatient fall incidents. There as been an increase in individual patients having repeated falls and particularly for patients who are experiencing agitation or who have dizziness or confusion related to infections. Actions have been put in place to further reduce the risk. Further detail is provided in the relevant section of this report.
• 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 date of the 1st December 2023.

Since launching PSIRF on 1 December 2023, we have:

• Reviewing linked policies and procedures
• Refining our guidance for learning responses using 'plan do study act' (PDSA)
• Reviewing incidents against our PSIRF Plan
• Supporting services with considering if incidents meet the plan and if so what improvement work is already in place
• Developing the format of the Patient safety oversight group (PSOG) to align with PSIRF
• Updated Datix to reflect our processes for PSIRF

Patient Safety Training
Training for all staff (level 1) and essential to job role (level 2) is available on the Electronic Staff Record. Level 1 became mandatory from April 2024. This is currently progressing well at 96% completed. We a recently worked with the learning and development team to create a crib sheet on how to find and complete level 2 training, this will be in Trust communications through July.

Patient Safety Partners
The three patient safety partners, PSP (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. The patient safety partners are attending the patient safety improvement group and quality monitoring visits.

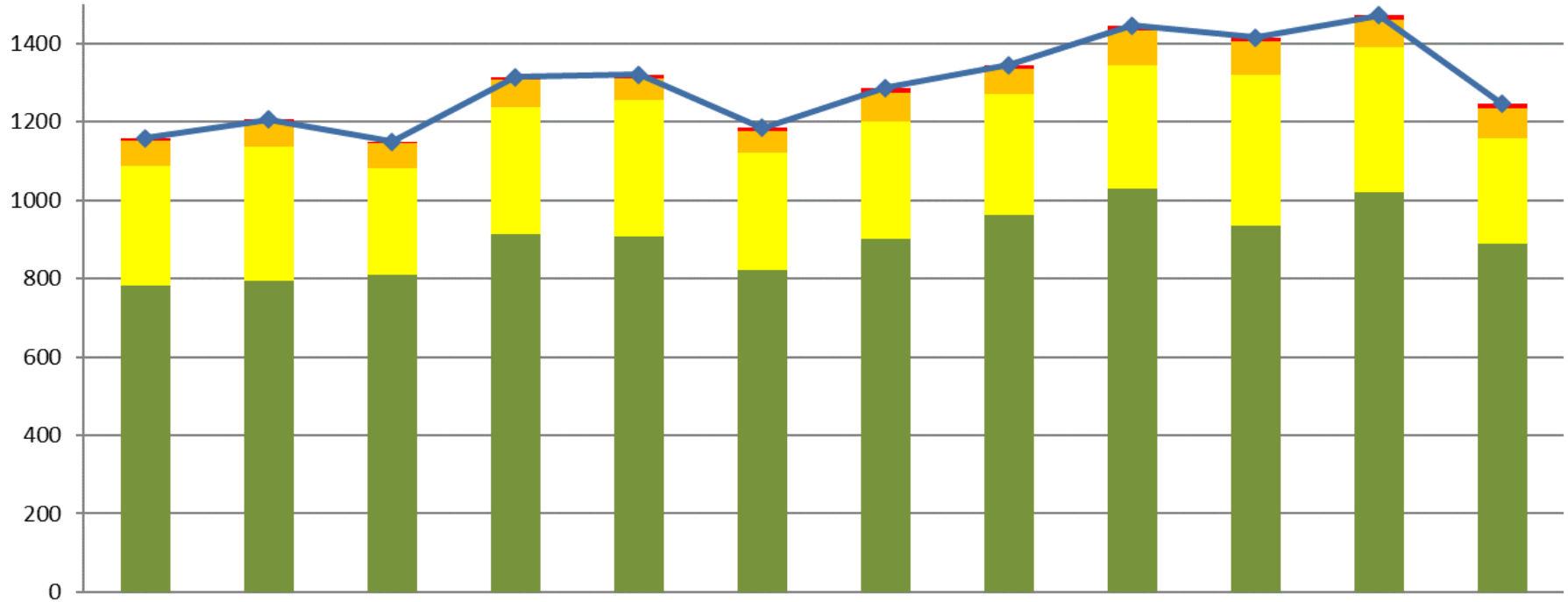
Annual Incident report
The annual incident report has received positive feedback from the quality and safety committee and Trust board. The team are currently working on reviewing the content for the quarterly reports to focus on learning and improvement to reflect PSIRF.

Safety First

Summary of Incidents

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

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



	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Red (should not be compared with SIs)	7	9	3	8	9	9	14	10	13	10	13	11
Amber	63	60	65	69	56	54	73	65	90	86	69	75
Yellow	307	342	272	324	349	301	300	309	313	383	371	269
Green	782	795	810	914	907	821	900	961	1030	936	1019	890
Total	1159	1206	1150	1315	1321	1185	1287	1345	1446	1415	1472	1245

Safety First cont…

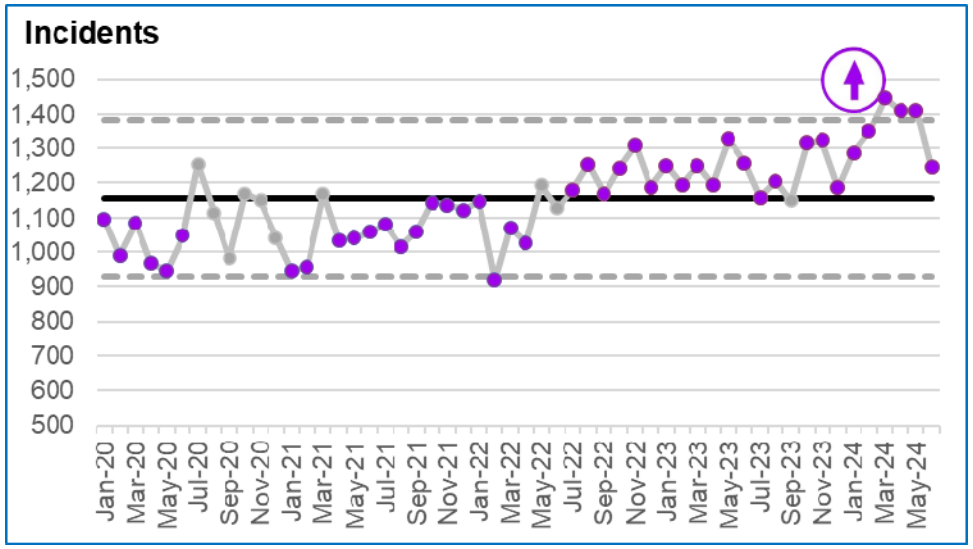
Summary of Patient Safety Incidents resulting in moderate or severe harm or death

Breakdown of incidents in June 2024
25 moderate harm incidents:
The most common incidents were pressure ulcers.

5 severe harm incidents
The most common incidents were pressure ulcers.

Sadly there was also one patient safety related death in June. 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 June 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

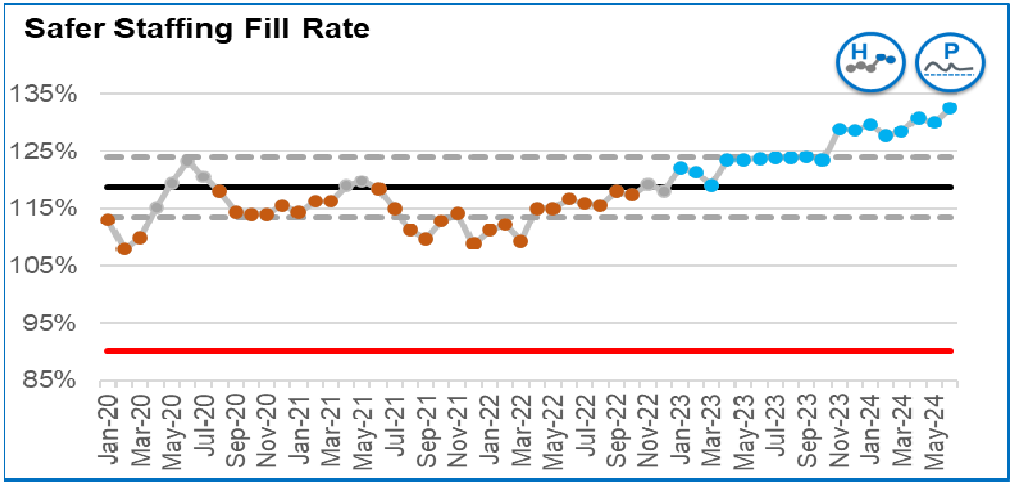
The learning library has been developed as a way to gather and share examples of learning from experience.
Further examples can be found on the SWYPFT intranet page.

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

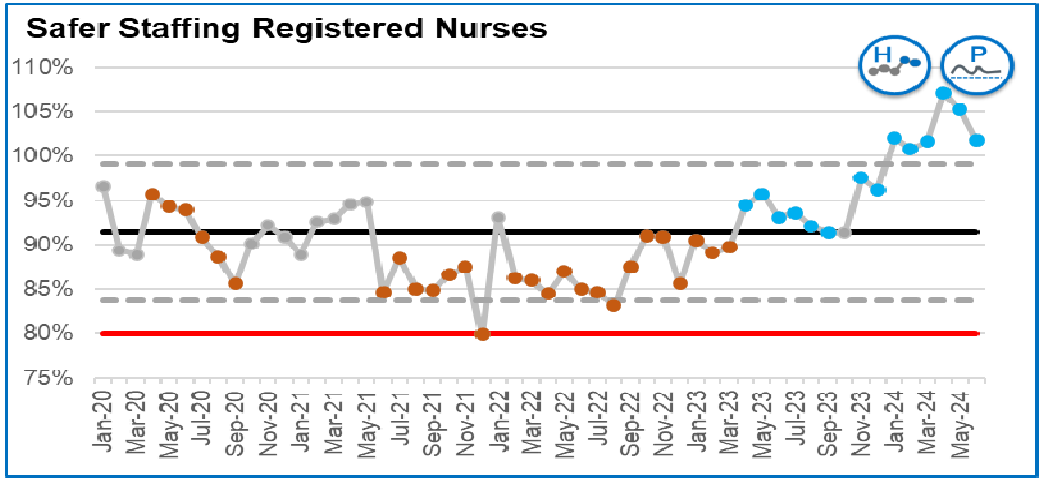
Patient Safety Alerts

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

Safer Staffing Inpatients



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

- There was an increase in June on demand, mainly due to the use of overtime being reduced from 373 overtime shifts in May to 71 in June which we should see the result in July's financial position.
- Within the flexible staffing pool there were a total of 409 more shift requests, however the overall fill rate increased to 94.15%.
- There were slight increases in the fill rates of Adult and Older Peoples and Barnsley Integrated Services of 5 and 2% whilst Forensic and Learning Disability remained unchanged.
- Vacancy control groups have been established to ensure a robust localised and inclusive recruitment process.
- Within the collaborative bank we continue to see an appetite to opt into it however, there are still some outstanding training issues which is preventing staff from being fully compliant to fill shifts in the various areas. This has resulted in 192 hours being filled within SWYPFT through this avenue.
- The e-rostering steering group is ensuring that SafeCare is being better utilised with more viable information being available to assist in decision making whilst the roll out of e-rostering to all clinical staff continues within community teams.
- The overall fill rate had an increase of 2.5% to 132.5%. There was continued improvement in the day fill rate for registered nurses with an increase of 0.8% to 100.3%. Four wards fell below the 90% registered nurse day fill rate which was a decrease of three ward from May.
- In June 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 0.8% in overall registered Day fill rates to 100.3% in June compared with the previous month.

Registered Nurses Nights
There was a decrease of 1.8% in overall registered Night fill rates to 113.8% in June compared with the previous month.

Overall Registered Rate: 101.8% (decrease of 3.4% on the previous month)
Overall Fill Rate: 132.5% (increase of 2.5% on the previous month)

Overall Fill Rate	Apr-24	May-24	Jun-24
Adults and Older People	139%	139%	144%
Barnsley Integrated Services	113%	113%	115%
Forensic and LD	119%	117%	117%
Grand total	**131%**	**130%**	**132%**

Registered day rate	Apr-24	May-24	Jun-24
Adults and Older People	98%	100%	100%
Barnsley Integrated Services	119%	116%	123%
Forensic and LD	97%	96%	97%
Overall shift fill rate	**99%**	**99%**	**100%**

Registered night rate	Apr-24	May-24	Jun-24
Adults and Older People	115%	117%	112%
Barnsley Integrated Services	84%	99%	108%
Forensic and LD	120%	117%	117%
Overall shift fill rate	**115%**	**116%**	**114%**

• Bank staff filled 79.26% (an increase of 4.2% on the previous month) of registered nurse requests for flexible staffing and 86.95% (an increase of 0.21% on the previous month) of health care assistant requests.
• Agency staff filled 5.59% (a decrease of 0.71% on the previous month) of registered nurse requests for flexible staffing and 8.81% (an increase of 0.02% on the previous month) of health care assistant requests.

Information Governance (IG)

9 personal data breaches were reported during June, which is slightly less than in May. The monthly average so far during the current financial year is 10.

Information disclosed in error continues to be the highest reported category. Breaches during June were due to:

- Letters sent to the wrong recipient
- Email addresses being inaccurately recorded
- Envelopes being incorrectly addressed
- Consent preferences inaccurately recorded
- Unauthorised third parties being copied on emails

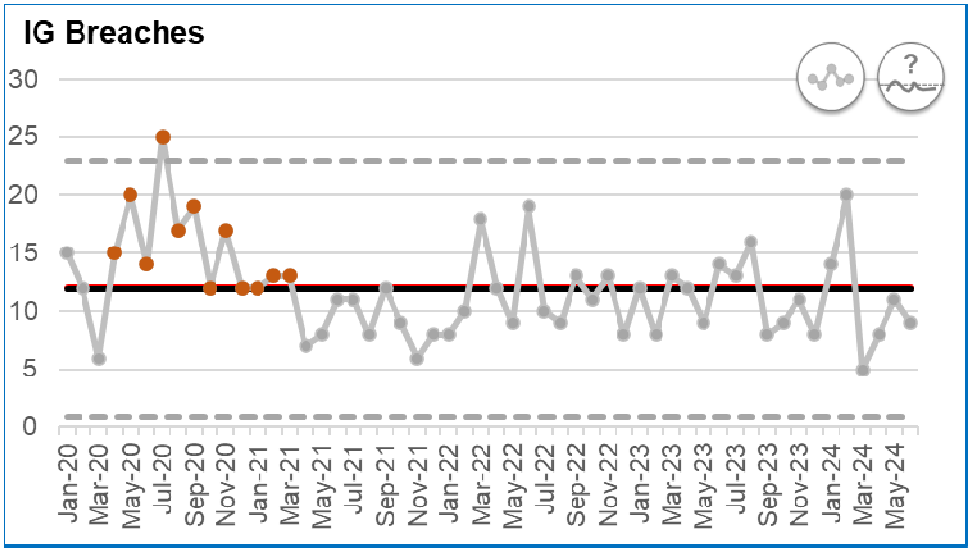
Two incidents of lost paperwork were reported when a printed email was found on a pavement on Trust premises and a notepad was left at a service user's house.

A communications campaign within the Trust continues to remind staff of the need for accuracy and their personal responsibilities when transporting personal information. The Adult & Older People's Mental Health Care Group has a improvement plan in place to reduce the number of breaches being reported.

In addition, a record keeping issue was reported when an on-call medic attended a ward to review a patient safety incident, which was reported separately, but did not add a note to SystmOne, raising concerns that a medic had not attended the incident. A retrospective note was added, and a communication was sent to on-call staff to remind them of their record keeping responsibilities.

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

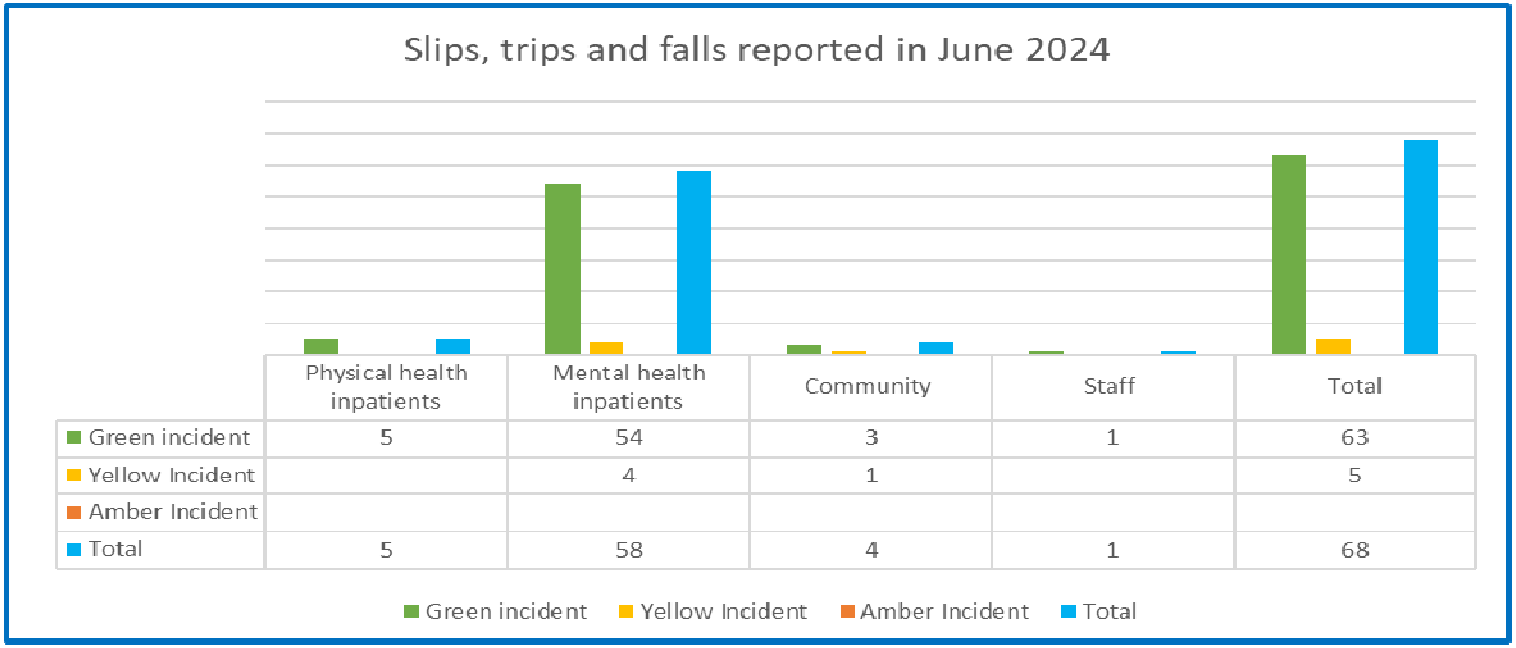
This SPC chart shows that as at June 2024 we remain in a period of common cause variation.



Trustwide Falls

June 2024: A total of 68 slips, trips and falls were reported. 63 of these were in inpatient wards.

The current rate of inpatient falls in June 2024 is 4.88 per 1000 bed days. We continue to report within or just below the national average for inpatient falls of 6.3 per 1000 bed days.



	Physical health inpatients	Mental health inpatients	Community	Staff	Total
Green incident	5	54	3	1	63
Yellow Incident		4	1		5
Amber Incident					
Total	5	58	4	1	68

- Staff review physical and mental health needs. Multidisciplinary meetings are arranged and timely specialist advice is sought.
- Patients having repeated falls all received high level assessment and intervention. This included a review of their physical and mental health, physiotherapy, reducing restrictive physical intervention (RRPI) interventions and moving and handling
- Post falls protocol completion has averaged 91% this month, with a continued good response from staff, and a staff/student educational resource has been developed to support best practice post-falls protocol
- 95% of patients had a good quality FRAT-18 (falls risk assessment tool) completed within 24hrs of admission

Incident Grading

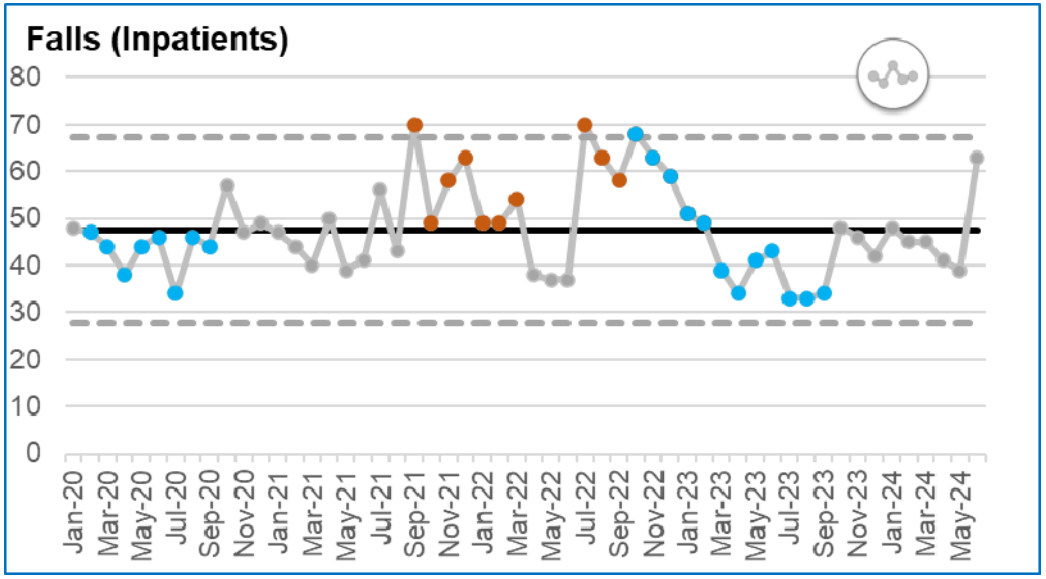
No red or amber incidents.

Yellow: 5 (7%) reported incidents had no significant injuries recorded, mostly graded yellow due to high intervention requirements. 1 of these falls occurred whilst the patient was on leave from the ward.

Green: 63 (93%) reported incidents had low or no harm recorded. 2 (3%) of these reported patient falls occurred when not on the ward, for example on leave.

Falls (Inpatient)

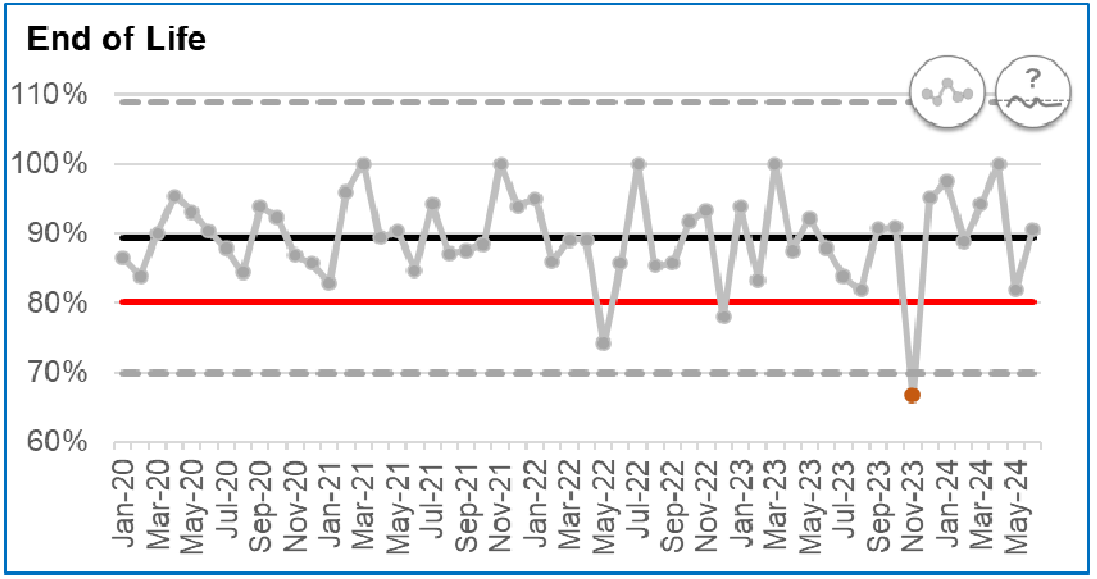
The total number of inpatient falls was 63 in June.



The SPC chart above shows that in June 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 90.6% in June. As is noted in the quality 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 June 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

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

	Target	April	May	June
Mental health community	85%	95% (330)	91% (330)	95% (232)
Mental health inpatient	85%	86% (57)	86% (63)	76% (55)
Learning Disabilities	85%	88% (16)	92% (12)	88% (17)
ASD/ ADHD	85%	50% (2)	50% (1)	100% (3)
CAMHS	75%	77% (26)	92% (36)	88% (32)
Forensic	60%	33% (3)	57% (7)	100% (3)
Mental health overall	84%*	**92% (435)**	**90% (446)**	**91% (344)**
Barnsley Physical Health	95%	**97% (380)**	**96% (342)**	**96% (297)**
Trustwide	**85%**	**95% (817)**	**92% (790)**	**93% (641)**

** weighted for 2023/24*

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

The satisfaction has increased in mental health services overall, remined the same for Barnsley physical health services and increased Trust wide overall.

Satisfaction community mental health, ADHD and Forensics has increased.

Satisfaction in mental health inpatient, learning disability and CAMHS has declined.

Satisfaction in physical health services has remained the same.

All services remain above target except for mental health inpatient.

There is a significant decline in the number of FFT returns for community mental health services, this is currently being reviewed.

Safeguarding

Safeguarding Adults:
In June 2024, there were 24 Datix incidents categorised as safeguarding adults. 18 of these were graded as green, six were graded as yellow and there were no amber or red Datix. The most common subcategories were physical abuse, neglect, financial abuse, domestic abuse and psychological/emotional abuse.

In addition to the safeguarding adults Datix, there were 26 sexual safety Datix; there were 20 were green incidents, four were yellow incidents and there were two amber incidents. One of the amber incidents was an incident in the community were a service user disclosed that they had been raped by an unknown male, police called appropriate actions and support provided. The second amber incident was in relation to two service users on an inpatient area where there were concerns that the two had sexual contact.

Safeguarding Children:
In June 2024 there were 14 Datix incidents categorised as safeguarding children; nine of these were graded as green, four were graded as yellow, one was graded as red and there were no amber Datix. The most common subcategories of these were physical abuse and neglect. 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 – 18/18 (100% of formal complaints)
- Number of responses provided within six months of the date a complaint received – 2/4 (50%)
- 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 18 new formal complaints in June 2024
- 7 compliments were received
- 4 formal complaints were closed in June 2024
- Number of concerns (informal issues) raised and closed in June 2024 – 32
- Number of enquiries responded to in June 2024 – 54
- Number of complaints re-opened during June 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 - June 2024

- Two Covid-19 outbreaks, on inpatient wards
- Four areas under monitoring for Covid-19, two inpatient wards and two community services affecting staff

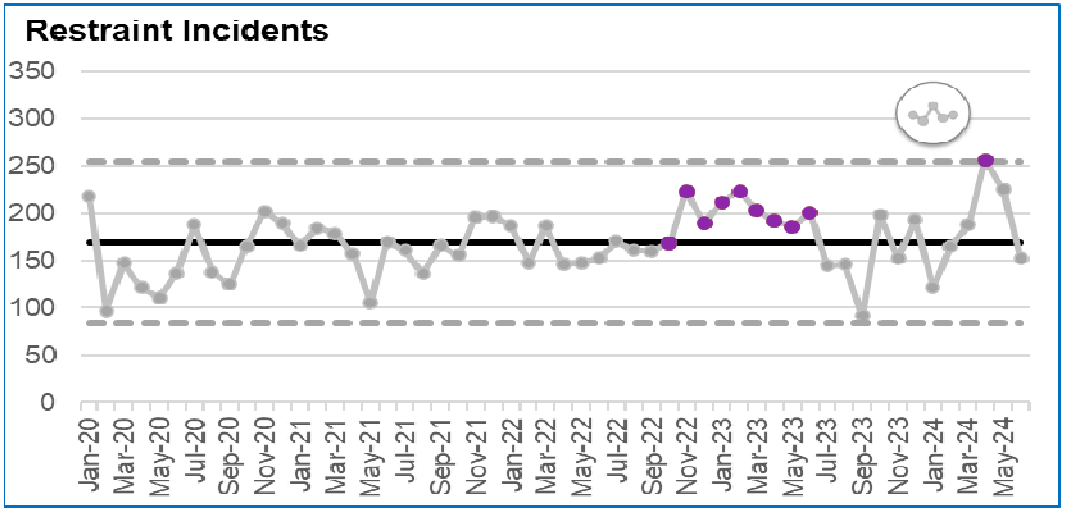
Reducing Restrictive Physical Intervention (RRPI)

• There were 153 reported incidents of Reducing Restrictive Physical Interventions used in June 2024 this was a reduction of 73 (32%) from May 2024 which stood at 226.
• 100% of prone (lying facedown) restraints in June 2024 lasted under three minutes.

Restraint Position	Total Restraint Positions	Percentage of Use
Standing	91	41.6%
Seated	48	21.9%
Safety Pod	35	16.0%
Supine - held on their back, regardless of surface	15	6.8%
Side	12	5.5%
Restricted escort	6	2.7%
Prone descent then remained in chest down position	5	2.3%
Prone descent then immediately rolled to other position side/back	4	1.8%
Service User placed self in prone and staff immediately let go or rolled	2	0.9%
Kneeling	1	0.5%

Team Using Prone Restraint	Jun-24
Walton PICU	2
Bronte Ward, Newton Lodge, Forensic	1
Nostell Ward, Wakefield	1
Stanley Ward, Wakefield	1

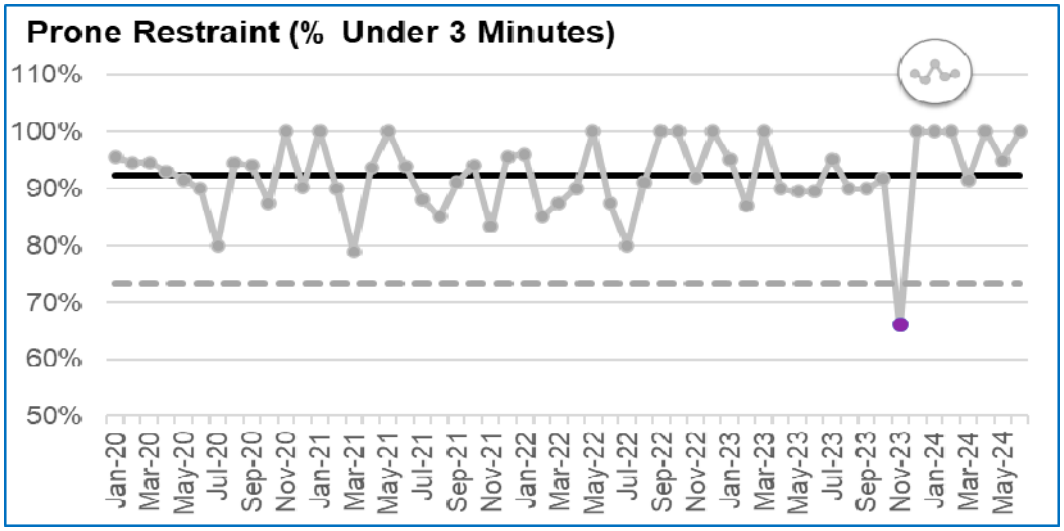
Duration of Prone Restraint	Jun-24
0 - 1 minute	4
2 - 3 minutes	1

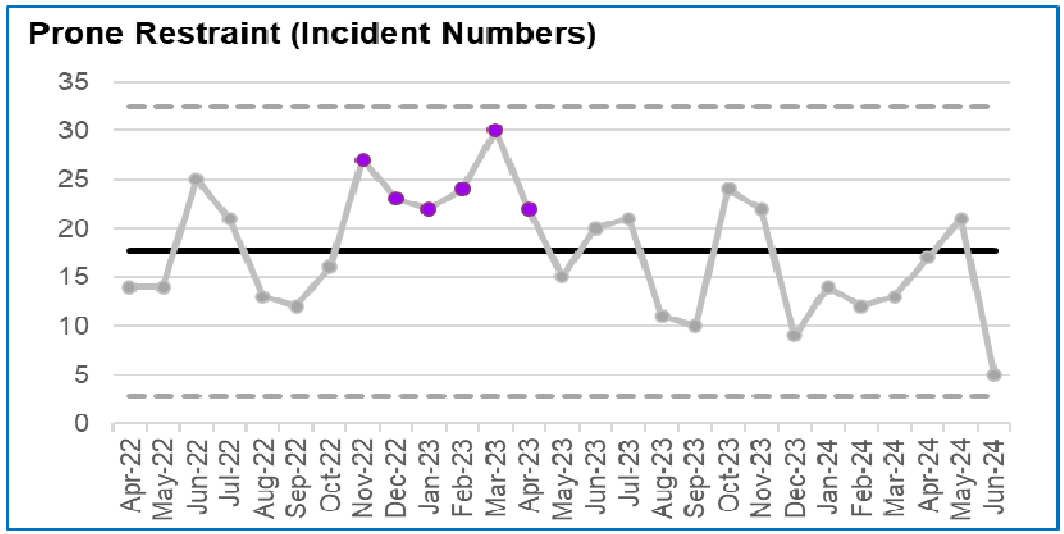


This SPC chart shows that in June 2024 we remain in a period of common cause variation (no concern). The increase in the number of restraint incidents in the past two months is linked directly to the acuity of particular service users.

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 decreased in June and all incidents of prone restraint are reviewed for learning in the Patient Safety Oversight Group. The improvement work continues and the SPC chart shows an overall reducing trend.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Establishment	Improving Resources	Well Led	-	5,196.6	5204.8	5321.0	5323.3	5329.5	5341.4	5412.1	5415.1	5422.1	5469.4	5451.0	5459.1
Contracted Staff In Post (Ledger)			-	4,400.5	4,432.7	4453.2	4425.9	4442.5	4471.3	4535.6	4574.5	4605.2	4655.9	4682.4	4673.6
Vacancies			-	796.1	772.1	867.8	897.4	887.0	870.1	876.6	840.6	817.0	813.5	768.8	785.5
Turnover external (12 months rolling)			>12% - <13%	13.0%	13.1%	12.1%	12.4%	12.0%	12.0%	11.6%	11.2%	11.0%	10.0%	9.9%	9.4%
Starters			-	53.9	64.0	63.3	69.4	61.6	42.8	91.4	49.8	38.3	56.4	36.2	34.8
Leavers			-	51.3	45.2	35.2	51.8	31.9	27.6	30.3	32.8	37.7	20.2	33.0	27.2
International Nurse Starters in Month			-	0	9	10	10	10	5	5	0	0	0	0	0
% Bank Fill Rates - Registered Nurses			-	Reporting commenced Aug 23	47.8%	49.6%	52.0%	59.1%	52.3%	60.3%	62.6%	68.3%	67.9%	75.1%	79.3%
% 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%	87.0%
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%	94.1%
Proportion of staff in senior leadership roles who are from ethnic minority 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%)	228 - All staff (16.5%) 99 - excl medics (8.3%)
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%)	958 (71.4%)
Sickness absence - Rolling 12 month			<=5% from June 24 was <=4.8%	5.3%	5.3%	5.3%	5.2%	5.2%	5.1%	5.1%	5.0%	5.0%	4.8%	5.0%	5.0%
Sickness absence - Month				5.1%	4.7%	4.9%	5.2%	4.9%	5.1%	5.1%	4.8%	4.4%	3.6%	4.7%	4.8%
Employees with long term sickness over 12 months			-	0	0	2	2	0	1	1	0	0	0	0	4
Appraisals - rolling 12 months			Jun 24 - 89% Jul 24 - 91% Aug 24 - 93% Sep 24 onwards 95%	76.5%	74.5%	72.5%	69.7%	73.1%	74.3%	79.6%	82.9%	84.2%	87.4%	87.1%	84.3%
Employee Relations - Suspensions (over 90 days)			-	3	3	3	4	2	2	2	2	3	1	2	1
Mandatory Training - TOTAL	Improving Care		>=80%	92.1%	92.5%	92.1%	92.5%	92.1%	91.9%	91.9%	91.8%	91.9%	92.5%	93.0%	92.6%
Mandatory Training - Reducing Restrictive Practice Interventions				76.2%	82.6%	82.8%	82.9%	85.0%	81.8%	77.0%	74.0%	73.0%	68.3%	74.0%	72.8%
Mandatory Training - Cardiopulmonary Resuscitation				81.0%	79.9%	80.0%	79.7%	78.5%	77.0%	77.5%	76.1%	77.8%	79.4%	80.7%	80.3%
Mandatory Training - Clinical Risk				95.2%	94.8%	94.0%	92.6%	91.3%	91.0%	90.6%	91.8%	92.5%	96.6%	93.8%	93.3%
Mandatory Training - Display Screen Equipment				97.1%	97.4%	97.4%	97.4%	97.1%	97.0%	95.2%	96.1%	96.4%	97.4%	97.1%	97.1%
Mandatory Training - Equality & Diversity				96.0%	95.9%	96.1%	95.4%	94.9%	94.9%	95.1%	95.3%	95.4%	95.8%	96.6%	96.7%
Mandatory Training - Fire Safety			>=85% (from June 24)	92.0%	91.4%	91.2%	91.0%	90.6%	90.8%	90.5%	89.6%	89.2%	90.4%	91.1%	90.8%
Mandatory Training - Food Safety			>=80%	87.8%	89.4%	89.3%	88.1%	89.0%	89.4%	90.0%	90.4%	90.2%	90.2%	90.8%	91.1%
Mandatory Training - Freedom To Speak Up (FTSU)				94.3%	94.7%	94.9%	95.0%	94.9%	95.0%	95.2%	95.2%	95.6%	95.8%	95.9%	95.9%
Mandatory Training - Infection Control & Hand Hygiene				94.3%	94.3%	95.6%	94.2%	93.6%	93.1%	93.7%	93.7%	92.8%	93.3%	94.5%	94.3%
Mandatory Training - Information Governance (Data Security)			>=95%	96.9%	95.3%	94.8%	94.5%	93.4%	94.0%	92.7%	91.8%	91.5%	92.8%	97.1%	95.5%
Mandatory Training - Moving & Handling			>=80%	95.1%	95.6%	94.8%	96.5%	96.9%	96.9%	97.3%	97.5%	97.6%	97.8%	97.9%	97.7%
Mandatory Training - Nat Early Warning Score 2 (New S2)				94.7%	95.2%	96.2%	96.0%	94.6%	94.1%	93.5%	93.6%	94.1%	95.7%	94.5%	94.8%
Mandatory Training - Mental Capacity Act/DoIs				93.4%	94.0%	96.7%	99.6%	99.2%	99.0%	99.1%	99.2%	99.4%	99.6%	91.2%	90.2%
Mandatory Training - Mental Health Act				91.1%	92.2%	99.8%	91.2%	90.5%	90.2%	90.7%	89.6%	89.1%	89.6%	88.6%	87.7%
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%	86.0%
Mandatory Training - Prevent			>=80%	94.1%	94.2%	91.7%	93.7%	92.1%	92.3%	92.9%	91.9%	92.6%	93.3%	94.5%	94.7%
Mandatory Training - Safeguarding Adults				89.5%	89.7%	93.9%	90.7%	89.6%	89.4%	88.4%	88.3%	88.2%	88.8%	89.6%	89.4%
Mandatory Training - Safeguarding Children				91.2%	91.7%	89.7%	95.1%	94.4%	94.0%	92.9%	93.6%	93.3%	94.1%	95.1%	95.2%

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. We have seen a slight reduction in our staff in post in June 24, which is reduced our net growth to 0.93% (previously 0.79%)
• In June the Trust had 7.6 full time equivalent more starters than leavers, however as our overall staff in post has reduced, this would indicate that some of our staff have reduced their hours
• Learning Disability (LD) & Attention Deficit Hyperactivity Disorder (ADHD) Care group has seen an increase of 4 full time equivalent over the previous month, which is proportionately high. ADHD/ASD increase is as a result of filling essential roles (non-recurrent) to work on a specific project to tackle waiting times.
• Learning Disabilities are clinical roles that have been filled in an area where we've historically had high vacancy levels.

Vacancies

• Our vacancies has increased very slightly. This aligns with our slight decrease in our staff in post
• The people directorate and finance are meeting to triangulate the information in recruitment and finance to help us make more informed decisions

Turnover

• Our turnover for June 24 continues to drop again this month. This has been a consistent monthly improvement since October 23.
• Our Forensic Care Group has also seen drop this month to 11.0% (May 11.4%).

Stability

• The stability rate has improved on a monthly basis year to date (from 90.7% - 90.0%).

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.
• Although our Forensics teams have increased in short term absence in June 24 further analysis has been completed regarding the recent improvements regarding absences. This is mainly attributed to our People Relations team having a more focussed approach on Forensics overall. Some of the People relation improvements made are as follows:
    • Improved resource within the team
    • New template designed for managers for stage 3 absence.
    • Other templates for managers streamlined
    • More training for managers in absence management
    • More support for managers
    • Regular check-in's within the People relations team
• Barnsley Physical Health and Wellbeing Care Group show a reduction in sickness from 5.6% in May to 4.9% in June. The spike in May was due to an increase in cardio and back problems. There was a slight increase in recording sickness as 'unknown' which has now been recorded correctly. The decrease was a result of short term sickness staff returning to work.
• Our Mental Health care group has seen a increase in long term sickness in June 24, however the short term sickness has decreased which indicates some of our short term absences have now converted to long term. The small increase in long term sickness between May and June seems to be spread across different areas of the care group and due to different long term sickness reasons rather than any hot spot areas. The biggest percentage increase between May and June is listed as due to 'Dental/oral', followed by 'Genitourinary and Gynaecological disorders' then 'Injury/fracture'.
• Estates and Facilities sickness rate continues to decrease month on month since January 24 10.88% to 6.9% in June, currently 2% above the Trust target of 5%. A small number of reasonable sickness absence dismissals have taken place, reasonable adjustments have been put in place to help staff return to work, such as light duties, part time work or another job. Absence management training is underway with regular check in with People relations and the people business partner.

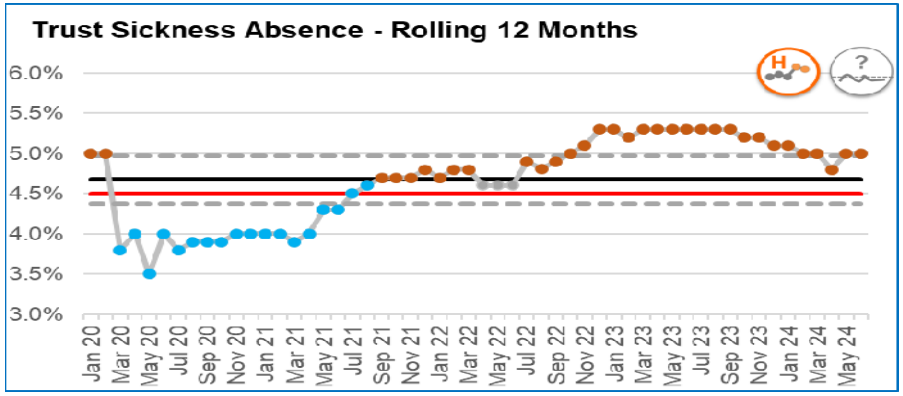
Appraisal Compliance

• The appraisal rate has dropped despite an increase in overall numbers of staff being complaint in month (up by 40 staff from last month). The impact of strong recruitment numbers last year (+12 months so now eligible for appraisal) vs lower leaver numbers now has caused the overall response rate to fall slightly against target as we are replacing compliant staff with non-compliant staff. Focus needs to be on staff approaching their 1st year of service with the Trust as recruitment in Q3 & Q4 of 2023-24 was even stronger.
• A trajectory for improvement has been set and monthly performance will be monitored against this and is set to reach 95% by September 24.
• Some actions being carried out on increasing Appraisal compliance include:
  • Additional Workpal and Appraisal skills training sessions booked in and advertised. Appraisal dashboard added to content
  • Offering 1-1 support for managers where relevant through ad hoc queries and meetings the learning partners attend
  • Working with comm's to increase appraisal focus (The View, Headlines etc)
  • Some of the slight drop in appraisal compliance can be explained by the higher numbers of appraisals in June (357) and July (314)2023 which mean more appraisals are needed to be completed than in previous months to impact the % figure

Training Compliance

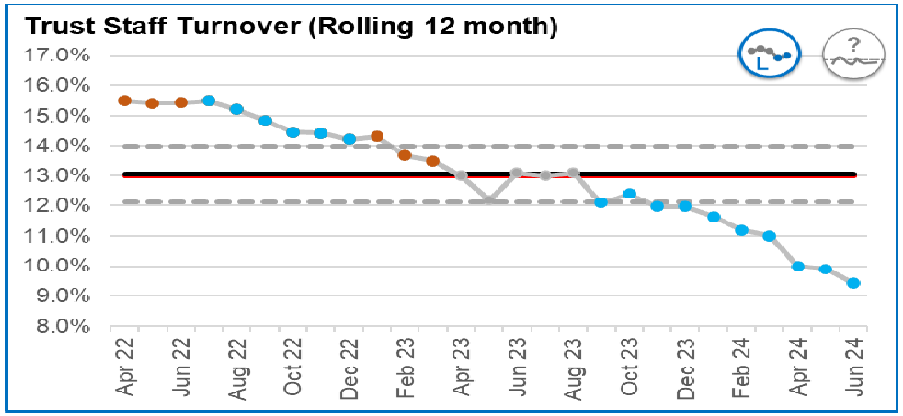
• A new dashboard has just been launched in the Trust. This will allow managers to see the compliance for their own staff and support managers in improving compliance.
• Reducing Restrictive Practice Interventions training has shown a deterioration in compliance to 72.8% The learning and development and Reducing Restrictive Practice Interventions Team have been working collaboratively to review the training needs of the organisation, and have introduced additional processes to identify staff and invite them to their refresher training as soon as possible. Reminders are also being sent to staff and managers to increase attendance.

Statistical process control charts

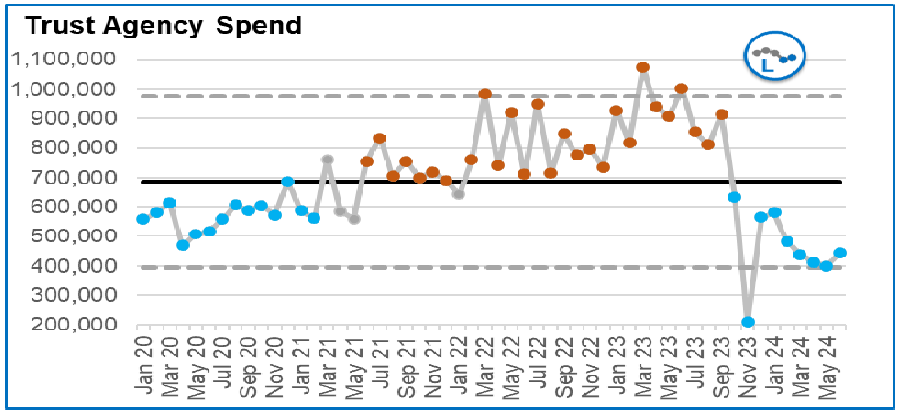


The SPC chart shows that in June 2024 we remain in a period of special cause concerning variation (something is happening and this should be investigated). See Finance Appendix for further information.

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



The SPC chart shows that in June 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 10 months.



The SPC chart shows that in June 2024 we have remain in 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.

MEDICAL APPRAISALS	Q1 2024-25	Q2 2024-25	Q3 2024-25	Q4 2024-25
Number of doctors due to have an appraisal meeting in the reporting period	38			
Number undertaken in period	34			
Number not undertaken for which the RO accepts postponement is reasonable	4			
Percentage of appraisals taken place and submitted on time	90%			

MEDICAL REVALIDATIONS	Q1 2024-25	Q2 2024-25	Q3 2024-25	Q4 2024-25
Number of revalidation recommendations due in period	13			
Number of positive recommendations	13			
Number of deferrals	0			
Number of non-engagements	0			
Percentage of revalidation recommendations made	100%			

RESPONDING TO CONCERNS	Q1 2024-25	Q2 2024-25	Q3 2024-25	Q4 2024-25
Number of active cases under Maintaining High Professional Standards procedures	0			

National Metrics

Data as of : 25/07/2024 12:53:55

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	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 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	589	400	187	66	75	85	104	74	138	119	34	60
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	P		93.3%	92.9%	86.4%	85.7%	86.1%	89.7%	81.6%	93.2%	94.1%	87.5%	90.3%	92.3%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?	L	50.4%	51.5%	51.6%	52.7%	51.6%	54.7%	50.2%	53.9%	53.0%	52.3%	52.6%	51.2%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	99.0%	99.5%	99.9%	100%	100%	99.7%	99.8%	99.9%	99.9%	100.0 %	100.0%	99.9%
M6	Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)		99%	?	L	67.1%	64.4%	74.9%	74.2%	63.0%	64.3%	55.9%	69.2%	66.1%	52.0%	68.8%	66.7%
M7	72 hour follow-up from psychiatric in-patient care		80%	?		87.7%	90.7%	88.6%	90.8%	89.0%	91.2%	88.7%	92%	87.5%	94.6%	89.8%	89%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?		9	18	8	2	9	23	30	28	8	29	13	1
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?		1	2	2	1	1	1	1	1	2	1	2	1
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	99.2%	98.3%	98.3%	99.0%	98.8%	98.6%	98.8%	98.7%	99.0%	99.3%	98.9%	98.7%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P		99.8%	99.8%	100%	99.9%	99.8%	99.8%	100%	100%	99.8%	100%	100%	100%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?		70%	66.7%	100%	100%	100%	75%	100%	66.7%	100%	N/A	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?	H	92%	91.3%	96.6%	91.7%	93.5%	88.6%	97.1%	97.3%	97.2%	97.5%	94.1%	96.4%
M15	Data Quality Maturity Index		95%	P	H	98.8%	99.3%	99.3%	99.5%	99.5%	99.5%	99.5%	99.4%	99.4%	99.3%	99.5%	99.5%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P		99.2%	99.7%	99.0%	99.1%	99.4%	99.2%	99.7%	99.4%	98.6%	99.0%	98.9%	99.8%
M30	Number of detentions under the Mental Health Act (MHA)					101	100	97	97	87	98	92	83	99	92	100	98
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					24.8%	19%	22.7%	21.6%	18.4%	19.4%	21.7%	19.3%	15.2%	17.4%	25%	27.6%

National Metrics

Data as of : 25/07/2024 12:53:55

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			98.5%	98.5%	97.2%	97.8%	98.2%	97.8%	97.8%	97.4%	96.7%	97.8%	96.7%	96.2%
M34	% Clients in settled accommodation	⚠	60%			83.8%	84.3%	84.3%	84.8%	85%	84.5%	84.6%	84.2%	83.5%	83.4%	83.5%	83.2%
M35	% Clients in employment	⚠	10%			12.0%	12.3%	12.6%	12.2%	12.3%	12.6%	13.2%	13.0%	13.5%	13.0%	13.2%	13.0%
M41	Completion of a valid NHS number		99%			99.8%	99.6%	99.6%	99.6%	99.7%	99.7%	99.8%	99.7%	99.7%	99.9%	99.9%	99.9%
M42	Completion of ethnicity coding for all service users		90%			99.4%	99.5%	99.4%	99.5%	99.4%	99.4%	99.4%	96.9%	100.0 %	99.5%	99.5%	99.4%
M43	Community health services two hour urgent response standard		70%			88.0%	89.5%	88.6%	88.1%	87.4%	85.3%	86.2%	87.8%	88.3%	92.8%	89.7%	89.9%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500			1509	1667	1656	1726	1844	1303	1700	1559	1336	1661	1589	1618
M47	Virtual ward occupancy		80%			51.4%	57.1%	60%	57.5%	78.8%	64.3%	81.4%	95.7%	101%	82.7%	94.3%	81.4%
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					14576	14576	14553	14587	14581	14397	14468	14385	14287	14123	14104	13988
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months					11153	10970	11072	11172	11238	11061	11142	11079	11056	10929	11005	10951
M171	% Admissions gate kept by crisis resolution teams		95%			96.6%	100%	99.1%	100%	97.9%	100%	98.1%	98.8%	95.7%	98.8%	98.1%	95.6%
M178	Talking Therapies - Reliable Recovery					48.4%	49.8%	48.4%	49.4%	48.6%	51.1%	47.5%	50.7%	50.6%	50.4%	50.3%	48.6%
M179	Talking Therapies - Reliable Improvement					66.0%	68.1%	64.6%	66.4%	66.6%	64.5%	66.8%	69.4%	64.7%	69.7%	67.8%	69.4%
M181	Women Accessing Specialist Community Perinatal Mental Health Services					1212	1218	1199	1221	1203	1177	1203	1214	1188	1209	1221	1197
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)					31	22	10	6	3	4	7	7	6	5	2	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	0
M184	New RTT pathways (clock starts)		1700			1753	1939	1940	1716	1867	1383	1811	1843	1745	1822	1967	1789
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment					621	574	599	667	650	484	597	631	487	604	571	526
M188	Community services waiting list, over 52 weeks					47	40	39	45	29	18	9	9	5	4	2	4

National Metrics

Data as of : 25/07/2024 12:53:55

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 66.7% in June, 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 June 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.

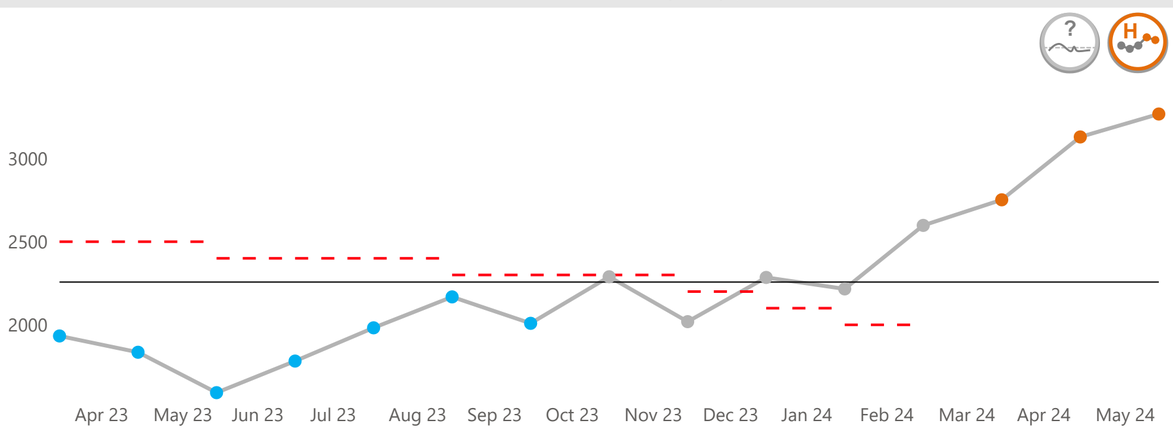
• The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week is 100% in June. The routine access to treatment measure has increased in June to 96.4%, which is now above the 95% threshold.

• During June, there was one service users aged under 18 years placed in adult inpatient ward for one night. 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.

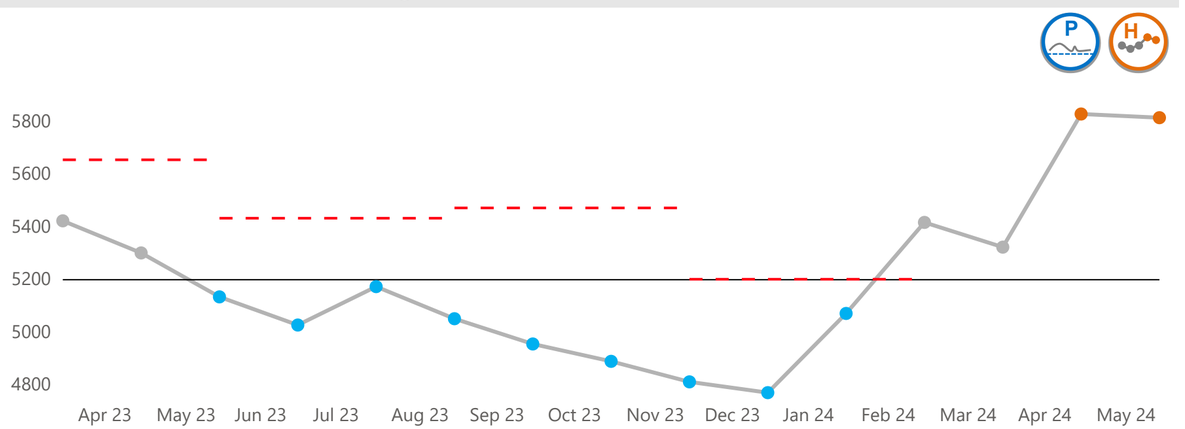
• The percentage of clients in employment and percentage of clients in settled accommodation - there are some data completeness issues that may be impacting on the reported position of these indicators however both are above their respective thresholds.

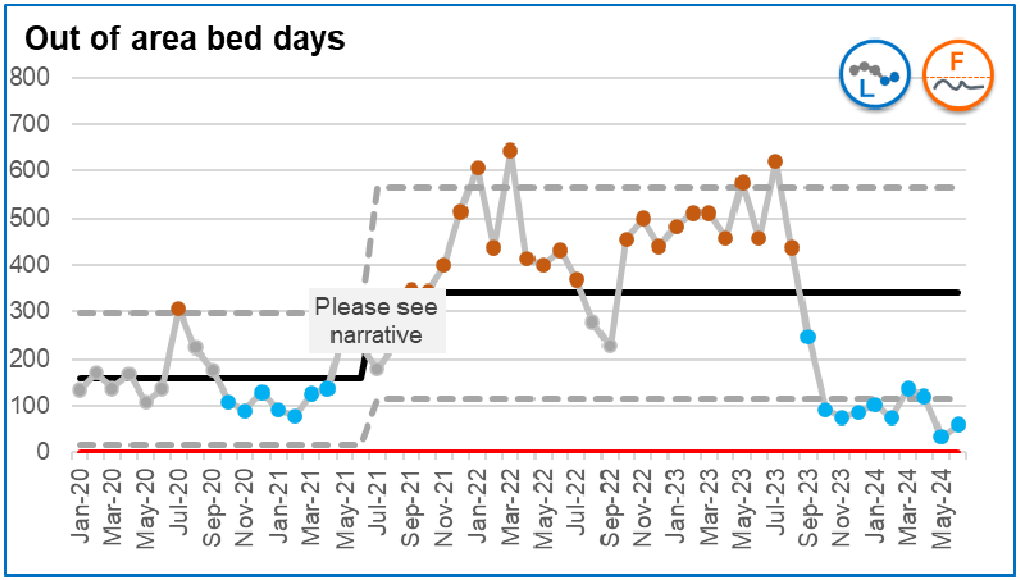
• Community services waiting list - This metric reports the total number of people waiting across a range of physical health and well-being services in Barnsley (aligned to the national community services SitRep). There has been a significant increase in demand for musculoskeletal services which is also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

M45 - The number of incomplete Referral to Treatment (RTT) pathways



M48 - Community services waiting list





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

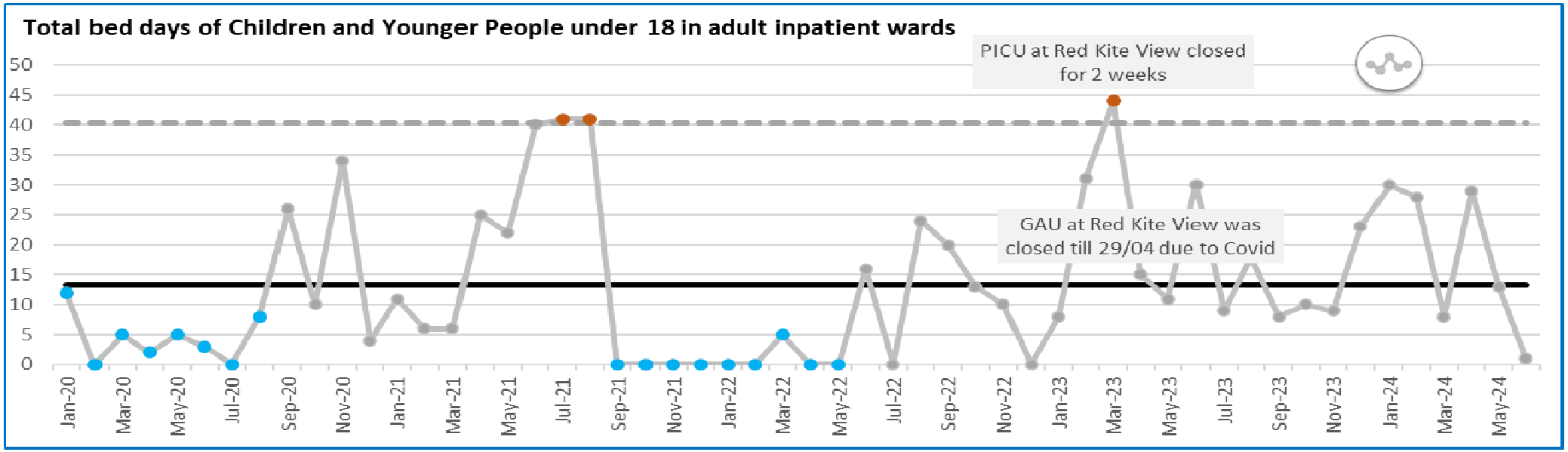
Summary	Actions	Assurance
The Trust remains in a period of special cause improving variation following a significant decrease in the number of bed days used.	The culmination of the work of the improvement programme which has focussed on: - Addressing barriers to discharge and reducing delays for people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

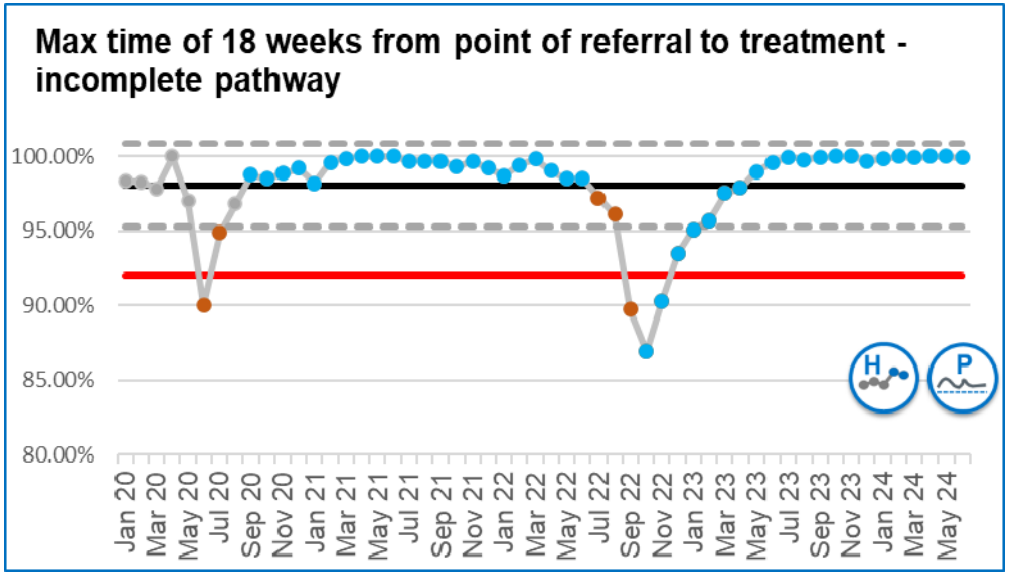
- The reporting for employment and accommodation shows 19.6% of records have missing employment and/or accommodation status with a further 1.2% that have an unknown employment status and 1.0% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

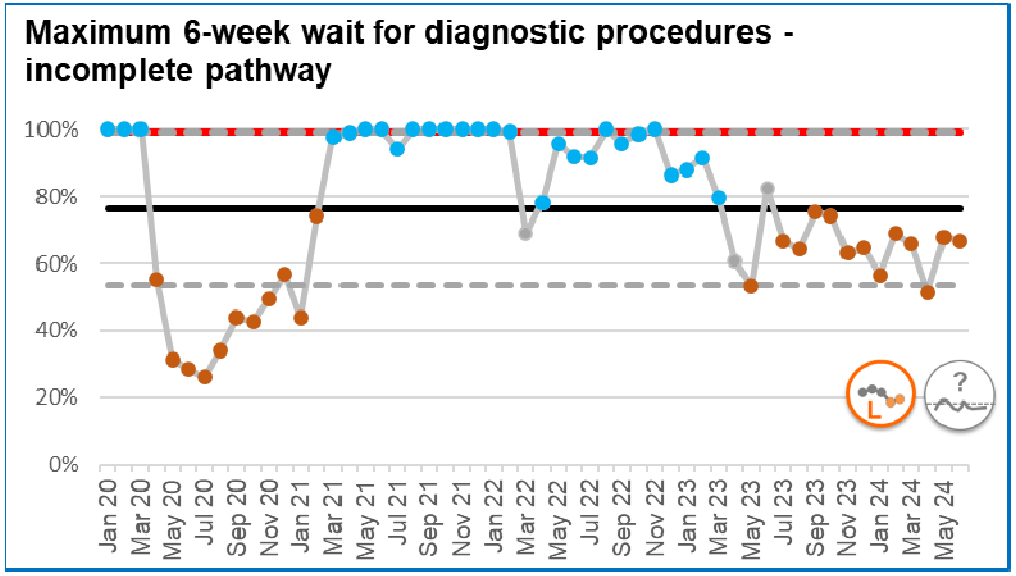
Analysis



The statistical process control chart (SPC) above shows that in June 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.

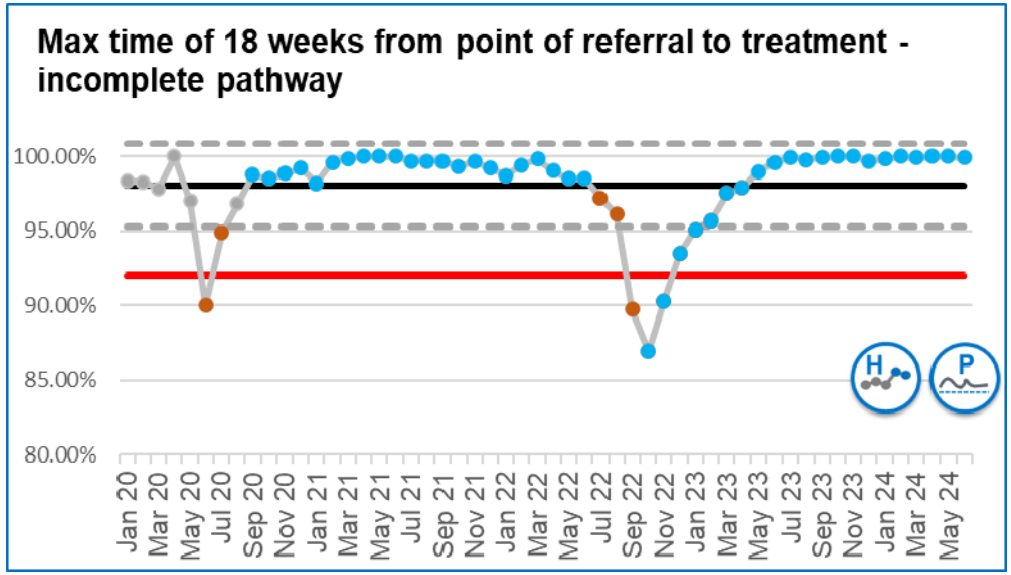
Analysis

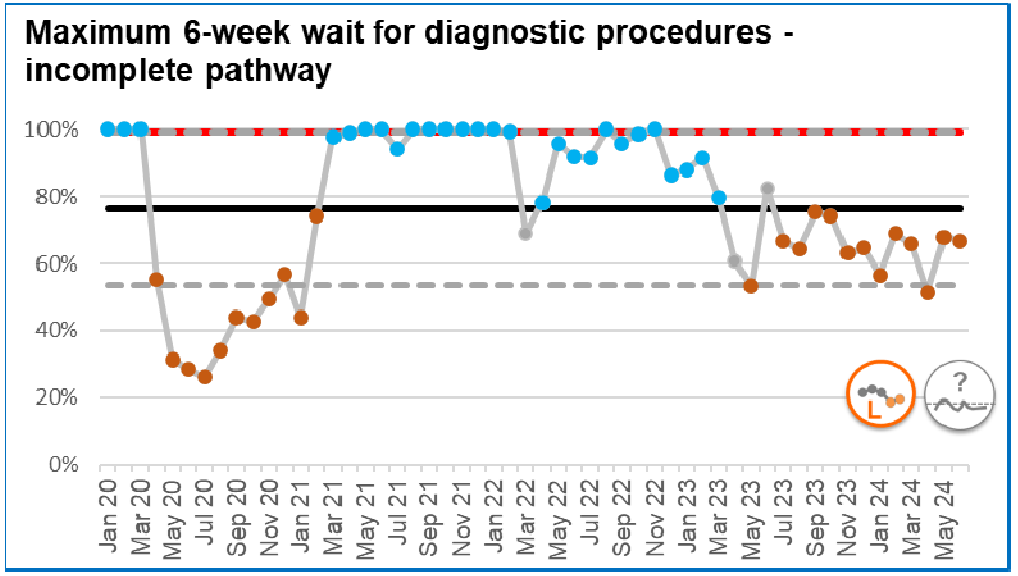




The SPC charts above show that in June 2024 we remain in a period of special cause improving variation (something is happening and this should be investigated) for clients waiting a maximum of 18 weeks from referral to treatment and we are estimated to achieve the target against this metric. As we have 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

Analysis





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The following section of the report has been created to give assurance regarding the quality and safety of the care we provide. A number of key metrics have been identified for each care group, and performance for the reporting month is stated along with variation/assurance for each metric where applicable. Figures in bold and italics are provisional and will be refreshed next month.

Current average OPEL level

2.44

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

Children and Families Care Group

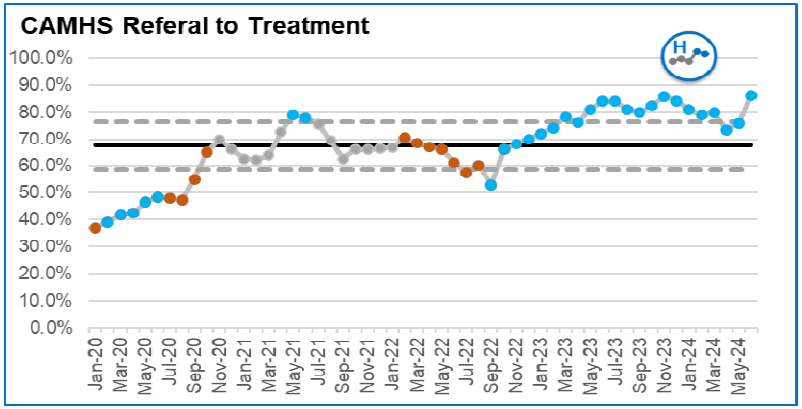
Headlines

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	Apr-24	May-24	Jun-24	Variation/ Assurance
% Appraisal rate	>=95%	91.9%*	88.8%	85.0%	
% Complaints with staff attitude as an issue	< 20%	33% 1/3	50% 1/2	0% (0/4)	
% of staff receiving supervision within policy guidance	80%	79.9%*	78.4%	78.2%	
CAMHS - Crisis Response 4 hours	N/A	100.0%	96.8%	85.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.6%*	81.8%	82.0%	
Eating Disorder - Routine clock stops	95%	95.0%	93.3%	96.4%	
Eating Disorder - Urgent/Emergency clock stops	95%	N/A	100.0%	100.0%	
Maximum 6 week wait for diagnostic procedures	99%	51.4%	68.7%	66.7%	
Information Governance training compliance	>=95%	92.1%*	98.7%	98.3%	
Reducing restrictive physical interventions training compliance	>=80%	72.9%*	69.9%	67.4%	
Sickness rate (Monthly)	4.5%	2.9%*	4.0%	3.8%	
% 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 June 2024, we remain in a period of special cause improving variation (something is happening and this should be investigated).

Alert/Action

- There has been a dip in performance for appraisals, Supervision, and Reducing restrictive physical interventions training, this is a cause for concern given that performance had declined for the last two months despite action plans being in place. Teams are working hard to address the performance issues however manager vacancies and changes are impacting on appraisals and supervision and access to training courses which align to staff availability are impacting on improvement.
- There has been a small decline in the Paediatric Audiology performance, this is due to leave and staff unavailability. Small changes in the team availability greatly impact the performance data. Conversations are underway with commissioners regarding resources available to the team. Data for June has shown there were 170 children and young people on the witing list, 70 of these had waited over 6 weeks. The longest waiter had waited 16 weeks and this is due to previous appointments not being accepted/attended. Appointments usually take place within 12 weeks and the median wait is 4 weeks. Performance is expected to improve again in July reporting.
- 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 remain in place.

Advise

- Crisis services 4 hour response times have shown a decline in performance- this needs to be reviewed as may be data recording issues and a learning need for the team.
- There are increasing numbers waiting increased lengths of time due to service pressures and service user complexity. Measures are being considered for how we define high levels of complexity to support further understanding of this.

Assure

- There have been no complaints with staff attitude this month, there is ongoing work to look at how complaints feedback is captured, used for learning.
- 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 reducing restrictive physical interventions training .
- Sickness rates are positive and remain below the Trust threshold, there is continued work on staff wellbeing to prevent/reduce sickness due to work related issues.
- 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.

The number of people who are clinically ready for discharge has increased slightly this month but remains at a relatively low level, however, 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 a further 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 and appraisal is being addressed through line management support and oversight and during June the care group has seen a positive increase in performance with the number of staff receiving supervision now being achieved across inpatient and community services.

Mental Health Community

Metrics	Threshold	Apr-24	May-24	Jun-24	Variation/ Assurance
% Appraisal rate	>=95%	85.9%	87.1%	84.2%	
% Assessed within 14 days of referral (Routine)	75%	90.6%	83.8%	92.3%	
% Assessed within 4 hours (Crisis)	90%	97.8%	93.9%	95.5%	
% Complaints with staff attitude as an issue	< 20%	27% (3/11	13% 2/15	0% 0/5	
% of staff receiving supervision within policy guidance	80%	74.4%	79.6%	80.3%	
% service users followed up within 72 hours of discharge from inpatient care	80%	90.8%	89.8%	89.0%	
% Service Users on CPA with a formal review within the previous 12 months	95%	97.1%	96.0%	95.9%	
% Treated within 6 weeks of assessment (routine)	70%	97.0%	92.4%	92.2%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.6%	75.5%	73.3%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	78.5%	68.1%	75.8%	
Information Governance training compliance	>=95%	92.3%	98.0%	96.5%	
Reducing restrictive physical interventions training compliance	>=80%	71.7%	70.2%	67.7%	
Sickness rate (Monthly)	4.5%	3.4%	4.8%	5.1%	
% rosters locked down in 6 weeks					

Mental Health Inpatient

Metrics	Threshold	Apr-24	May-24	Jun-24	Variation/ Assurance
% Appraisal rate	>=95%	93.1%	91.4%	86.9%	
% bed occupancy	85%	87.3%	86.5%	90.0%	
% Complaints with staff attitude as an issue	< 20%	0% 0/4	0% 0/2	25% 1/4	
% of staff receiving supervision within policy guidance	80%	82.2%	85.0%	92.1%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.6%	80.0%	76.8%	
% of clients clinically ready for discharge	3.5%	2.8%	2.1%	2.5%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	92.7%	94.4%	94.2%	
Inappropriate Out of Area Bed days	150 (June)	119	34	60	
Information Governance training compliance	>=95%	93.7%	98.9%	97.5%	
Physical Violence (Patient on Patient)	Trend Monitor	38	25	25	
Physical Violence (Patient on Staff)	Trend Monitor	102	71	56	
Reducing restrictive physical interventions training compliance	>=80%	70.9%	74.9%	74.1%	
Restraint incidents	Trend Monitor	192	151	*93*	
Safer staffing (Overall)	90%	139.5%	139.1%	143.7%	
Safer staffing (Registered)	80%	104.1%	105.9%	104.2%	
Sickness rate (Monthly)	4.5%	3.6%	4.2%	4.9%	
% 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 June acute wards have needed higher levels of staffing.
- 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 June 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 June is 50.37% for Kirklees and 52.14% 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.
• SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed in all areas.
• Work continues in collaboration with our places to implement community mental health transformation.
• Progress has been made in all areas on ensuring care plans are produced collaboratively and shared with service users. Achievement of the target is being maintained with continued support from Quality and Governance Leads.
• Care Programme Approach (CPA) review performance is above target in Calderdale, Kirklees and Wakefield. Barnsley is slightly under target at 93.91%. Action plans and support from Quality and Governance Leads remain in place.
• 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 50 people. Work is underway as part of the Improving Access priority program. Each locality has an action plan and there have been some demonstrable improvements to date and waiting lists will be monitored on a weekly basis.
A high proportion of inpatients within the Horizon centre remain clinically ready for discharge and awaiting a suitable placement - work continues with partners to encourage flow.

LD, ADHD & ASD

Metrics	Threshold	Apr-24	May-24	Jun-24	Variation/ Assurance
% Appraisal rate	>=95%	83.1%	86.0%	87.5%	
% Complaints with staff attitude as an issue	< 20%	0% (0/5)	0% (0/1)	0% (0/2)	
% of staff receiving supervision within policy guidance	80%	86.7%	89.4%	87.3%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	47.9%	50.0%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.3%	85.1%	84.0%	
% of clients clinically ready for discharge	3.5%	50.0%	50.0%	50.0%	
Information Governance (IG) training compliance	>=95%	94.3%	95.0%	92.3%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	82.0%	89.2%	86.0%	

LD, ADHD & ASD

Metrics	Threshold	Apr-24	May-24	Jun-24	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	17	24	12	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	71.8%	77.8%	76.1%	
Safer staffing (Overall)	90%	152.5%	158.4%	154.7%	
Safer staffing (Registered)	80%	118.5%	119.7%	126.7%	
Sickness rate (Monthly)	4.5%	1.6%	2.1%	2.4%	
Restraint incidents	Trend Monitor	18	32	*24*	
% rosters locked down in 6 weeks					

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

Alert/Action

- Friend & Family Test – 100%↑
- Integrated care board West Yorkshire Neurodiversity project - Work ongoing across West Yorkshire.
- Appraisal 100%.
- Mandatory training hotspots in Reducing restrictive physical interventions and National Early Warning Score 2 (NEWS2) – plans in place to address.
- ADHD – national shortage of medication is having a direct impact on the service as primary care often refer 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 been withdrawn immediately with some impact on the team resources and capacity.
- Service Review - recommendations of the service review are ongoing and many are completed. The service met with the executive trio to discuss progress and a second meeting is planned in August.

Advise

ADHD
- 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.
- 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'

Autism
- Referral rates remain high but there are minimal waits for assessment across Barnsley, Kirklees and Wakefield. 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 NHS England guidance for integrated care boards published in April 2023)
- Barnsley commissioners have invested this service to provide a 17+ Pathway for 20 young people. Community Paediatrics in Barnsley have already referred 16 children 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 SWYPFT child and adolescent mental health teams, a proposal has been shared and we await a response.
- The legacy waiting list 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 key performance indicator targets met.
- Mandatory training compliance is good with NEWS2 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
• Appraisal performance remains a focus plans are in place to ensure compliance across the care group. Current compliance is 85%↑.
• Supervision above target.
• Plans in place to address mandatory training hotspots in progress with an increase in performance in all hotspot areas Information governance 90.3%↓, Reducing restrictive physical interventions 75.5%↓.
• Improvement work on FIRM Risk Assessments will be undertaken.

Community Services
• Waiting Lists – Improvement work continues with action plans in place for each locality.
There has been significant improvement with Barnsley and Calderdale meeting the target and an improving trajectory noted in Wakefield and Kirklees.
• STOMP (stopping over medication of people with a learning disability and autistic people) RAG (red, amber, green) rating tool has been standardised and utilised in all localities.
• Discussions with commissioners commenced to determine local accommodation issues/ pressures across all areas.

ATU (Assessment & Treatment Unit)
• 100% of service users are clinically ready for discharge and plans are being worked through to find the most appropriate solution.

Advise

LD (Learning disability)
• No funding is available from commissioners to provide a solution to the ADHD demand for people with a learning disability.
• Lack of appropriate bespoke community placements impacts on Horizon and the community service offer.

Community
• Challenges continue with the recruitment of specialist speech and language therapist posts and waiting lists for communication assessments are a pressure.
• Conversations with ICBs on-going to develop increased suitable provider accommodation across the patch with robust environments and skilled staff to prevent admission. Further meeting with commissioners scheduled for June.

ATU
• Improvement work continues to be embedded into the service.
• Assessment and Treatment Service Review now underway. Bradford and the integrated care board leading this work.

Assure

• Friends and Family Test 88%
• Staff survey results demonstrate improvements.
• All localities have exceeded 75% target for annual health checks.
• Host commissioners review report received with good feedback and 14 out of 15 confidence rating.

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 and is now just below the Trust threshold and continues to be addressed through line management support and oversight.

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Apr-24	May-24	Jun-24	Variation/ Assurance
% Appraisal rate	>=95%	90.0%*	90.5%	90.7%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/2)	0% (0/2)	
% people dying in a place of their choosing	80%	100.0%	81.8%	90.6%	
% of staff receiving supervision within policy guidance	80%	84.6%	76.8%	79.8%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	81.8%	83.8%	79.7%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	>=95%	94.6%	96.6%	97.2%	

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Apr-24	May-24	Jun-24	Variation/ Assurance
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	100.0%	100.0%	99.9%	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	80.0%	100.0%	75.4%	
Safer staffing (Overall)	90%	113.5%	113.0%	115.1%	
Safer staffing (Registered)	80%	107.8%	110.1%	118.3%	
Sickness rate (Monthly)	4.5%	4.0%	5.6%	4.9%	
% 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; a paper re safe staffing requirements has been taken to Executive Management Team (EMT) meeting and has been agreed. Recruitment plans have been developed.
• Priory Day Centre – remained closed during June due to confirmed Legionella spores in water. Plan to reopen early July was postponed pending test results. Update received early July confirming Legionella is no longer the issue, but further work is needed on piping. Closure to be extended with no planned date to reopen. Services continue to work with Estates and alternative clinic space has been sourced. This remains on the local risk register due to the impact on MSK (Musculo Skeletal) and Parkinson's clinic group sessions.

Advise

• Appraisals - many of our 42 service lines are at 100%. As a care group we have seen a further slight increase as at end of June to 90.7%.
To note: Appraisal data refreshes on a weekly basis therefore the data is not live.
• Yorkshire Smoke Free - Grant funding monies are starting to become available to increase quit dates set across the UK. The money is to go to commissioners in Local Authorities to work with services on innovative ways to increase the numbers. All services are having discussions with commissioners looking at various opportunities that commissioners may wish to invest in.

Assure

• Staff receiving supervision - continues to receive focus with a drive to improve recording. A further 3% increase has been seen from May to June reaching 79.8% which is very slightly below compliance, however the June figure showing on the supervision dashboard as at 22.7.24 is 80.1% which now achieves compliance.
• Urgent Community Response Service 2-hour target is 89.9% as at end of June 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) – 99.91% as at June 2024.
• Friends and Family Test (FFT) 96% of people would recommend community services.
• 90.6% of people dying in their place of choosing as at end of June 2024. This is an increase and remains consistently above the threshold of 80%.
• Information Governance training compliance maintained - 95.1% for June.
• CPR training - maintains compliance at 81.2% for June.
To note: Resus Lead has advised that the process for CPR training recording is that they send the signature sheets to L&D. These are inputted by L&D but at irregular intervals once per month. Therefore there is a potential for up to a 6-week lag before the updated training statistics are showing.
• Both our inpatient wards are compliant with Fire Safety Training.
• Our Stroke and Neuro Rehabilitation Units (SRU and NRU) went live on the EPMA system (Electronic Prescribing and Medication Administration) on 19 June; this completes the rollout of all inpatient units across the Trust.
• Our Pulmonary Rehabilitation team in Barnsley were also recently recognised nationally for their exemplary care. They were chosen as a good practice case study by the Royal College of Physicians' National Respiratory Audit Programme after 100% of patients were able to start pulmonary rehabilitation within 90 days of their referral in both 2022 and 2023.

Forensic Care Group

Headlines

Sickness has deteriorated in June. 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	Apr-24	May-24	Jun-24	Variation/ Assurance
% Appraisal rate	>=95%	80.4%	77.8%	75.5%	
% Bed occupancy	90%	86.2%	88.2%	88.5%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/0)	0% (0/1)	
% of staff receiving supervision within policy guidance	80%	91.0%	92.1%	93.5%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	97.9%	97.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	81.5%	87.0%	84.0%	
% 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%	94.1%	96.9%	95.0%	
Physical Violence (Patient on Patient)	Trend Monitor	5	3	6	
Physical Violence (Patient on Staff)	Trend Monitor	15	11	11	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	72.7%	77.4%	74.3%	
Restraint incidents	Trend Monitor	35	25	*20*	
Safer staffing (Overall)	90%	115.7%	110.7%	108.7%	
Safer staffing (Registered)	80%	102.6%	101.2%	102.7%	
Sickness rate (Monthly)	5.4%	4.2%	4.1%	5.1%	
% rosters locked down in 6 weeks					

Alert/Action

• Bed Occupancy – Newton Lodge 88.04%↑, Bretton 92.72%↓, Newhaven 81.25%↑. Underoccupancy in medium secure largely due to empty beds within learning disability and women's services where there are no waiting lists. Further work being undertaken with the commissioning team regarding out of area use.
• Sickness absence – continues to be a concern with particular hotspots. Year to date data indicating Newton Lodge 4.4%, Bretton Centre 7.8% and Newhaven 2.7%. Work ongoing.
• Seclusion – work is currently concluding on a new seclusion suite at Newton Lodge.

Advise

• The West Yorkshire Provider Collaborative continue to develop future intentions for the women's pathways.
• Mandatory training overall compliance: Newton Lodge – 92%↓; Bretton – 91%↓; Newhaven –93%↑ These figures represent the overall position for each service. Hotspots in Reducing restrictive physical interventions and Information Governance training compliance are being managed and monitored closely.
• Appraisal – there is still a difference in local data and the Trust data. The service will seek to reconcile this by the end of July 2024.
• Newton Lodge has service users currently waiting for beds in high secure. Their risks indicate that they need seclusion. The current trajectory suggests this situation is likely to last several months this is causing some pressure within the secure estate across west Yorkshire and impacts on the care that can be provided.

Assure

• High levels of data quality across the care group.
• 100% compliance for HCR20 (historical clinical and risk management tool) being completed within 3 months of admission.
• 25 Hours of meaningful activity 100%
.• % Service Users on Care programme approach with a formal review within the previous 12 months remains to be above threshold.
• Clinical supervision exceeding the target.

Inpatients - Mental Health - Working Age Adults

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

Appraisal

• Six wards are achieving the 95% target.
• Significant reduction in compliance on Beamshaw in June due to staff absence and new manager leading to system alignment issues on WorkPal. The position has improved with current performance for July at 80%.
• Crofton has improved appraisal performance with current performance at 95.9% Enfield Down has similarly improved very recently with performance in July at 95.5%
• Compliance on Melton has been impacted by long term sickness and both Ward 18 and Elmdale are having issues with appraiser/appraisee alignment on WorkPal.
• Currently no facility to exclude people from the data manually, for example when they are on long term sick leave, so this impacts the data.

Sickness

• Slight reduction on Beamshaw but still above threshold mainly due to long term sickness.
• Melton and Poplars have sickness rates above 9% due to long term sickness. Poplars have also had some short-term sickness.
• Willow are significantly above threshold at 13.3% due to 4 staff with long term sickness and additional short term sickness in June. Plans are in place for 1 member of staff to return in August.

Supervision

• Above target on 15 wards with 12 of these at 100%.
• Beamshaw and Melton were under target relating to inaccuracies in recording which have been improved (July compliance is 94.1%)

Mandatory Training

• Ward managers have been directly booking staff on cardiopulmonary resuscitation (CPR) courses around rosters. Staff from Enfield Down, Ward 18, Melton and Beamshaw are booked on courses. Specific plans in place where compliance is low particularly Poplars and Ashdale.
• RRPI (Reducing Restrictive Practice Interventions) compliance continues to be 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, Ward 18, Poplars, 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 October.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.

Bed Occupancy

• Where the bed occupancy exceeds target, plans are in place to mitigate any impact on quality, such as increased staffing levels.
• Occupancy levels in rehabilitation units are related to the model of care and pathway incorporating flexibility between inpatient and community interventions.

Clinically Ready For Discharge (CRFD)

• There has been a reduction in CRFD on a number of wards with some reporting 0%. This is due to focussed work on early identification of barriers to discharge enabling resolution prior to the individual being CRFD.

FIRM Risk assessments

• Percentage compliance is significantly impacted by small number of admissions. Melton, Elmdale and Stanley each had 1 breach in June. 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

Physical violence incidents

• Increase on Walton due to the presentation and risk profiles of specific service users on the ward. Appropriate care plans are in place and the individuals are showing improvement in their mental state following treatment plan.

Inpatients - Mental Health - Working Age Adults

Beamshaw Suite

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	100.0%	88.0%	65.4%
Sickness	4.5%	2.7%	8.2%	7.7%
Supervision	80%	100.0%	81.3%	75.0%
Information Governance training compliance	>=95%	93.5%	96.7%	96.7%
Reducing restrictive physical interventions training compliance	>=80%	74.2%	83.3%	80.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.0%	76.7%	70.0%
Fire Safety training compliance	>=80%	90.3%	86.7%	93.3%
Bed occupancy	85%	115.5%	106.7%	109.0%
Safer staffing (Overall)	90%	133.4%	136.8%	127.6%
Safer staffing (Registered)	80%	141.7%	131.3%	124.4%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	1.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	92.3%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	4	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	2	1
Restraint incidents	Trend Monitor	5	6	*2*
Prone Restraint incidents	Trend Monitor	1	1	*0*
Unfilled Shifts	Trend Monitor	9	21	2

Clark Suite

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	94.4%	95.0%	90.0%
Sickness	4.5%	4.5%	8.1%	4.9%
Supervision	80%	55.6%	87.5%	100.0%
Information Governance training compliance	>=95%	95.8%	100.0%	95.7%
Reducing restrictive physical interventions training compliance	>=80%	70.8%	79.2%	87.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.0%	100.0%	95.7%
Fire Safety training compliance	>=80%	91.7%	100.0%	100.0%
Bed occupancy	85%	88.8%	89.9%	88.8%
Safer staffing (Overall)	90%	139.5%	137.6%	128.6%
Safer staffing (Registered)	80%	99.5%	98.2%	97.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	83.3%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	3	0	2
Restraint incidents	Trend Monitor	10	3	*3*
Prone Restraint incidents	Trend Monitor	1	1	*0*
Unfilled Shifts	Trend Monitor	6	24	9

Melton Suite

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	87.0%	87.0%	83.3%
Sickness	4.5%	0.0%	4.5%	9.1%
Supervision	80%	83.3%	100.0%	76.9%
Information Governance training compliance	>=95%	100.0%	100.0%	96.0%
Reducing restrictive physical interventions training compliance	>=80%	96.2%	92.3%	88.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.6%	88.5%	76.0%
Fire Safety training compliance	>=80%	100.0%	96.2%	100.0%
Bed occupancy	85%	104.4%	103.8%	102.8%
Safer staffing (Overall)	90%	160.2%	176.5%	198.2%
Safer staffing (Registered)	80%	97.8%	104.9%	95.3%
% 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%	66.7%	75.0%
Physical Violence (Patient on Patient)	Trend Monitor	3	0	1
Physical Violence (Patient on Staff)	Trend Monitor	6	10	6
Restraint incidents	Trend Monitor	13	16	*6*
Prone Restraint incidents	Trend Monitor	1	5	*0*
Unfilled Shifts	Trend Monitor	19	30	5

Nostell

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	100.0%	96.2%	92.6%
Sickness	4.5%	0.0%	2.2%	4.1%
Supervision	80%	70.6%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	78.6%	83.3%	76.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	92.9%	100.0%	96.7%
Fire Safety training compliance	>=80%	93.1%	100.0%	100.0%
Bed occupancy	85%	92.6%	89.1%	95.5%
Safer staffing (Overall)	90%	136.4%	135.2%	174.2%
Safer staffing (Registered)	80%	98.2%	103.1%	97.2%
% of clients clinically ready for discharge	3.5%	5.8%	4.7%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	1
Physical Violence (Patient on Staff)	Trend Monitor	7	9	3
Restraint incidents	Trend Monitor	6	15	*9*
Prone Restraint incidents	Trend Monitor	0	1	*1*
Unfilled Shifts	Trend Monitor	13	8	9

Inpatients - Mental Health - Working Age Adults

Stanley

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	100.0%	95.8%	91.3%
Sickness	4.5%	3.5%	2.9%	2.5%
Supervision	80%	83.3%	85.7%	100.0%
Information Governance training compliance	>=95%	85.2%	96.2%	96.2%
Reducing restrictive physical interventions training compliance	>=80%	85.2%	88.5%	96.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	63.0%	69.2%	73.1%
Fire Safety training compliance	>=80%	92.6%	92.3%	92.3%
Bed occupancy	85%	99.7%	105.9%	101.2%
Safer staffing (Overall)	90%	144.8%	130.6%	135.6%
Safer staffing (Registered)	80%	119.3%	118.8%	111.5%
% of clients clinically ready for discharge	3.5%	4.1%	4.1%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	95.2%	100.0%	92.9%
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	0	0
Restraint incidents	Trend Monitor	4	5	2
Prone Restraint incidents	Trend Monitor	0	0	1
Unfilled Shifts	Trend Monitor	19	16	16

Walton

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	96.9%	100.0%	90.6%
Sickness	4.5%	2.9%	3.5%	6.5%
Supervision	80%	78.6%	87.5%	100.0%
Information Governance training compliance	>=95%	95.1%	100.0%	97.4%
Reducing restrictive physical interventions training compliance	>=80%	65.0%	67.6%	70.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.5%	78.4%	81.1%
Fire Safety training compliance	>=80%	85.4%	94.7%	86.8%
Bed occupancy	85%	86.0%	92.4%	102.1%
Safer staffing (Overall)	90%	154.3%	145.6%	145.9%
Safer staffing (Registered)	80%	101.9%	98.2%	101.1%
% of clients clinically ready for discharge	3.5%	14.1%	7.5%	1.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	66.7%	71.4%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	13	3	10
Restraint incidents	Trend Monitor	58	22	15
Prone Restraint incidents	Trend Monitor	7	9	2
Unfilled Shifts	Trend Monitor	16	22	15

Ashdale

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	92.9%	96.6%	100.0%
Sickness	4.5%	0.0%	5.2%	4.8%
Supervision	80%	75.0%	75.0%	100.0%
Information Governance training compliance	>=95%	96.9%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	56.3%	65.6%	71.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.0%	71.9%	64.5%
Fire Safety training compliance	>=80%	93.8%	87.5%	96.8%
Bed occupancy	85%	98.5%	98.3%	98.3%
Safer staffing (Overall)	90%	118.9%	120.7%	116.4%
Safer staffing (Registered)	80%	100.1%	98.9%	102.6%
% of clients clinically ready for discharge	3.5%	0.0%	2.2%	2.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	88.9%	100.0%	93.8%
Physical Violence (Patient on Patient)	Trend Monitor	1	6	11
Physical Violence (Patient on Staff)	Trend Monitor	1	5	3
Restraint incidents	Trend Monitor	1	6	7
Prone Restraint incidents	Trend Monitor	0	0	0
Unfilled Shifts	Trend Monitor	0	17	1

Ward 18

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	92.6%	78.6%	75.0%
Sickness	4.5%	2.0%	1.6%	5.2%
Supervision	80%	100.0%	80.0%	90.0%
Information Governance training compliance	>=95%	84.4%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	78.1%	75.7%	78.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.1%	78.8%	78.1%
Fire Safety training compliance	>=80%	87.5%	90.9%	90.6%
Bed occupancy	85%	98.4%	93.1%	99.9%
Safer staffing (Overall)	90%	105.9%	109.2%	110.6%
Safer staffing (Registered)	80%	78.1%	81.3%	84.0%
% of clients clinically ready for discharge	3.5%	6.2%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	94.1%	95.2%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	9	1
Physical Violence (Patient on Staff)	Trend Monitor	8	7	3
Restraint incidents	Trend Monitor	14	10	14
Prone Restraint incidents	Trend Monitor	2	1	0
Unfilled Shifts	Trend Monitor	3	11	8

Inpatients - Mental Health - Working Age Adults

Elmdale				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	86.4%	81.8%	76.2%
Sickness	4.5%	7.8%	6.7%	7.7%
Supervision	80%	80.0%	100.0%	100.0%
Information Governance training compliance	>=95%	92.0%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	68.0%	66.7%	74.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	62.5%	69.2%	76.9%
Fire Safety training compliance	>=80%	84.0%	92.6%	100.0%
Bed occupancy	85%	96.0%	98.1%	99.3%
Safer staffing (Overall)	90%	125.6%	121.8%	124.7%
Safer staffing (Registered)	80%	76.3%	88.1%	89.9%
% of clients clinically ready for discharge	3.5%	0.0%	1.5%	5.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	92.9%	100.0%	80.0%
Physical Violence (Patient on Patient)	Trend Monitor	7	0	2
Physical Violence (Patient on Staff)	Trend Monitor	7	3	5
Restraint incidents	Trend Monitor	10	6	*3*
Prone Restraint incidents	Trend Monitor	0	1	*0*
Unfilled Shifts	Trend Monitor	0	6	2

Inpatients - Mental Health - Older People Services

Crofton				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	95.8%	95.7%	87.0%
Sickness	4.5%	3.6%	4.3%	7.8%
Supervision	80%	90.9%	100.0%	100.0%
Information Governance training compliance	>=95%	96.3%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	61.5%	73.1%	70.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.2%	88.5%	85.2%
Fire Safety training compliance	>=80%	96.3%	85.2%	96.4%
Bed occupancy	85%	68.1%	81.5%	87.1%
Safer staffing (Overall)	90%	224.6%	209.8%	184.1%
Safer staffing (Registered)	80%	170.1%	161.3%	150.8%
% 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%	80.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	4	0	0
Physical Violence (Patient on Staff)	Trend Monitor	9	7	2
Restraint incidents	Trend Monitor	33	28	*3*
Prone Restraint incidents	Trend Monitor	1	0	*0*
Unfilled Shifts	Trend Monitor	58	33	44

Poplars CUE				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	87.5%	96.0%	100.0%
Sickness	4.5%	3.2%	5.9%	9.2%
Supervision	80%	45.5%	88.9%	100.0%
Information Governance training compliance	>=95%	100.0%	96.7%	96.7%
Reducing restrictive physical interventions training compliance	>=80%	76.9%	75.0%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	70.4%	66.7%
Fire Safety training compliance	>=80%	89.3%	86.7%	86.7%
Bed occupancy	85%	78.4%	79.4%	71.1%
Safer staffing (Overall)	90%	250.4%	235.4%	221.9%
Safer staffing (Registered)	80%	115.5%	120.1%	119.3%
% of clients clinically ready for discharge	3.5%	12.0%	6.7%	9.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	13	6	8
Physical Violence (Patient on Staff)	Trend Monitor	35	13	10
Restraint incidents	Trend Monitor	32	22	*15*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	94	49	62

Inpatients - Mental Health - Older People Services

Willow

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	100.0%	100.0%	100.0%
Sickness	4.5%	4.0%	12.4%	13.3%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	96.2%	100.0%	95.5%
Reducing restrictive physical interventions training compliance	>=80%	69.2%	69.6%	72.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.9%	73.9%	90.9%
Fire Safety training compliance	>=80%	96.2%	95.7%	90.9%
Bed occupancy	85%	85.7%	92.3%	103.0%
Safer staffing (Overall)	90%	194.0%	229.3%	284.0%
Safer staffing (Registered)	80%	119.5%	123.0%	115.1%
% of clients clinically ready for discharge	3.5%	10.3%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	85.7%	33.3%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	1	4	*4*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	20	18	42

Beechdale

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	96.0%	96.2%	96.2%
Sickness	4.5%	0.2%	0.3%	1.4%
Supervision	80%	100.0%	100.0%	91.7%
Information Governance training compliance	>=95%	96.3%	96.3%	96.4%
Reducing restrictive physical interventions training compliance	>=80%	74.1%	77.8%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.3%	88.9%	92.6%
Fire Safety training compliance	>=80%	88.9%	88.9%	96.4%
Bed occupancy	85%	95.2%	87.3%	86.3%
Safer staffing (Overall)	90%	122.5%	125.6%	139.4%
Safer staffing (Registered)	80%	93.3%	105.5%	100.3%
% of clients clinically ready for discharge	3.5%	5.9%	10.4%	6.4%
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	1
Physical Violence (Patient on Staff)	Trend Monitor	0	0	1
Restraint incidents	Trend Monitor	0	2	*2*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	5	9	8

Ward 19 - Male

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	100.0%	93.8%	93.8%
Sickness	4.5%	0.0%	6.0%	6.9%
Supervision	80%	88.9%	100.0%	100.0%
Information Governance training compliance	>=95%	88.9%	100.0%	95.8%
Reducing restrictive physical interventions training compliance	>=80%	55.6%	54.2%	58.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.3%	91.7%	83.3%
Fire Safety training compliance	>=80%	88.9%	87.5%	91.7%
Bed occupancy	85%	91.6%	80.2%	99.1%
Safer staffing (Overall)	90%	129.2%	127.6%	141.7%
Safer staffing (Registered)	80%	98.5%	97.3%	102.3%
% of clients clinically ready for discharge	3.5%	0.0%	7.7%	1.3%
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	4	0
Physical Violence (Patient on Staff)	Trend Monitor	10	3	5
Restraint incidents	Trend Monitor	5	6	*8*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	3	0	4

Ward 19 - Female

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	100.0%	100.0%	100.0%
Sickness	4.5%	10.8%	5.9%	1.6%
Supervision	80%	90.0%	100.0%	100.0%
Information Governance training compliance	>=95%	86.4%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	66.7%	61.9%	60.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	61.9%	90.0%	86.4%
Fire Safety training compliance	>=80%	90.9%	85.7%	82.6%
Bed occupancy	85%	93.3%	72.9%	87.8%
Safer staffing (Overall)	90%	93.0%	96.3%	91.6%
Safer staffing (Registered)	80%	103.8%	113.2%	118.4%
% of clients clinically ready for discharge	3.5%	5.0%	6.6%	5.6%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	4	0
Physical Violence (Patient on Staff)	Trend Monitor	10	3	5
Restraint incidents	Trend Monitor	5	6	*8*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	4	1	10

Inpatients - Mental Health - Rehab

Enfield Down				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	81.4%	86.7%	86.7%
Sickness	4.5%	7.7%	4.5%	2.5%
Supervision	80%	90.5%	86.4%	100.0%
Information Governance training compliance	>=95%	96.1%	100.0%	98.1%
Reducing restrictive physical interventions training compliance	>=80%	60.0%	76.0%	70.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.3%	78.3%	74.5%
Fire Safety training compliance	>=80%	96.1%	96.1%	88.5%
Bed occupancy	85%	49.4%	52.5%	56.1%
Safer staffing (Overall)	90%	96.7%	96.7%	96.3%
Safer staffing (Registered)	80%	88.8%	92.4%	94.6%
% of clients clinically ready for discharge	3.5%	0.0%	5.5%	5.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	2
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	2	0

Lyndhurst				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	95.7%	95.8%	95.7%
Sickness	4.5%	10.5%	6.4%	7.3%
Supervision	80%	86.7%	66.7%	93.8%
Information Governance training compliance	>=95%	100.0%	100.0%	96.4%
Reducing restrictive physical interventions training compliance	>=80%	57.1%	62.1%	57.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.4%	82.8%	82.1%
Fire Safety training compliance	>=80%	92.9%	93.1%	92.9%
Bed occupancy	85%	66.2%	66.1%	67.4%
Safer staffing (Overall)	90%	95.4%	97.2%	93.8%
Safer staffing (Registered)	80%	103.2%	96.9%	91.4%
% 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	1	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	1	1	0

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. Appraisals remain the key focus for the service with local data indicating the service is closer to compliance rather than the Trust data. However the service is aware a number of staff now require an appraisal.

Medium Secure

• Supervision remains a focus for the service. All wards now achieving the target.
• Sickness variable across medium secure with Appleton, Waterton, Priestley and Bronte being hotspots. The spike on Bronte, Appleton and Waterton is attributable to a pike in 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 who have undertaken an audit which is being used to inform future actions.
• Compliance for reducing restrictive physical interventions (RRPI) remains challenging for the service with particular challenges accessing courses. Bronte is 100% compliant and there is an improving trajectory in Johnson and Waterton Wards. Other wards appear to have dipped and further analysis is needed to understand this.
• 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 Newhaven this month with Thornhill experiencing a small spike in short term sickness. Sandals sickness has reduced but remains higher than target. Sickness levels on Sandal 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 and Newhaven with Ryburn and Sandal yet to achieve compliance.
• Bed occupancy in low secure has improved across Thornhill and Sandal and Ryburn. 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**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	90.5%	90.5%	81.0%
Sickness	5.4%	4.5%	4.5%	6.1%
Supervision	80%	85.7%	100.0%	100.0%
Information Governance training compliance	>=95%	91.7%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	87.5%	95.5%	81.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	82.6%	82.6%
Fire Safety training compliance	>=80%	100.0%	100.0%	95.5%
Bed occupancy	90%	65.4%	62.5%	49.6%
Safer staffing (Overall)	90%	97.9%	97.0%	99.4%
Safer staffing (Registered)	80%	120.2%	102.7%	103.9%
% 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	0	1	1
Physical Violence (Patient on Staff)	Trend Monitor	0	4	3
Restraint incidents	Trend Monitor	5	9	6
Prone Restraint incidents	Trend Monitor	0	0	0
Unfilled Shifts	Trend Monitor	0	0	1

Bronte				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	100.0%	73.3%	62.5%
Sickness	5.4%	4.4%	10.4%	10.6%
Supervision	80%	100.0%	91.7%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	69.6%	73.9%	72.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.3%	81.3%	95.5%
Fire Safety training compliance	>=80%	100.0%	100.0%	100.0%
Bed occupancy	90%	97.1%	86.2%	100.0%
Safer staffing (Overall)	90%	103.8%	99.1%	104.1%
Safer staffing (Registered)	80%	103.0%	108.8%	108.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	1
Restraint incidents	Trend Monitor	1	0	3
Prone Restraint incidents	Trend Monitor	1	0	1
Unfilled Shifts	Trend Monitor	0	2	1

Chippendale				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	87.0%	87.0%	83.3%
Sickness	5.4%	2.4%	1.2%	1.7%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	96.4%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	82.1%	86.7%	76.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.4%	86.7%	86.7%
Fire Safety training compliance	>=80%	92.9%	93.3%	90.0%
Bed occupancy	90%	94.4%	92.7%	98.9%
Safer staffing (Overall)	90%	144.1%	147.1%	146.6%
Safer staffing (Registered)	80%	131.1%	136.0%	139.3%
% 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	2	0	1
Restraint incidents	Trend Monitor	5	5	*4*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	1	3

Hepworth				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	96.2%	95.8%	88.5%
Sickness	5.4%	0.0%	1.6%	1.8%
Supervision	80%	87.5%	100.0%	93.3%
Information Governance training compliance	>=95%	96.7%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	76.7%	81.5%	82.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	93.1%	96.2%	88.9%
Fire Safety training compliance	>=80%	96.7%	100.0%	100.0%
Bed occupancy	90%	87.1%	98.9%	86.0%
Safer staffing (Overall)	90%	95.4%	95.3%	96.2%
Safer staffing (Registered)	80%	78.6%	69.3%	74.0%
% 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	1
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	2	3	*1*
Prone Restraint incidents	Trend Monitor	1	1	*0*
Unfilled Shifts	Trend Monitor	0	6	1

Inpatients - Forensic - Medium Secure

Johnson				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	89.7%	90.0%	87.5%
Sickness	5.4%	1.8%	2.4%	1.1%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	97.1%	97.1%	94.3%
Reducing restrictive physical interventions training compliance	>=80%	65.7%	76.5%	85.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	91.4%	97.1%	88.6%
Fire Safety training compliance	>=80%	91.4%	97.1%	91.4%
Bed occupancy	90%	73.3%	73.3%	73.3%
Safer staffing (Overall)	90%	123.5%	123.9%	122.9%
Safer staffing (Registered)	80%	109.5%	109.7%	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	1
Physical Violence (Patient on Staff)	Trend Monitor	1	1	0
Restraint incidents	Trend Monitor	0	0	*2*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	5	3	3

Priestley				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	77.8%	70.0%	66.7%
Sickness	5.4%	10.6%	7.9%	8.3%
Supervision	80%	81.8%	92.3%	91.7%
Information Governance training compliance	>=95%	90.9%	100.0%	87.0%
Reducing restrictive physical interventions training compliance	>=80%	52.4%	66.7%	59.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.4%	81.0%	77.3%
Fire Safety training compliance	>=80%	90.9%	90.9%	91.3%
Bed occupancy	90%	91.2%	88.2%	92.2%
Safer staffing (Overall)	90%	93.7%	92.3%	94.0%
Safer staffing (Registered)	80%	99.2%	98.8%	96.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	1	0

Waterton				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	40.0%	42.9%	42.1%
Sickness	5.4%	4.2%	2.2%	7.6%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	63.6%	68.0%	72.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	68.2%	88.0%	81.8%
Fire Safety training compliance	>=80%	95.5%	96.0%	100.0%
Bed occupancy	90%	100.0%	100.0%	97.3%
Safer staffing (Overall)	90%	127.7%	127.6%	120.5%
Safer staffing (Registered)	80%	114.6%	109.7%	102.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	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	4	3	2

Inpatients - Forensic - Low Secure

Thornhill				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	91.3%	91.3%	90.9%
Sickness	5.4%	0.9%	2.2%	5.1%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	96.3%	96.3%	84.6%
Reducing restrictive physical interventions training compliance	>=80%	70.4%	77.8%	76.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	81.5%	96.3%	96.2%
Fire Safety training compliance	>=80%	100.0%	100.0%	100.0%
Bed occupancy	85%	82.0%	91.4%	96.7%
Safer staffing (Overall)	90%	98.4%	99.7%	100.2%
Safer staffing (Registered)	80%	96.3%	93.1%	92.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	3	7	7

Sandal				
Metrics	**Threshold**	**Apr-24**	**May-24**	**Jun-24**
Appraisal rate	>=95%	69.6%	77.3%	77.3%
Sickness	5.4%	7.7%	7.7%	6.3%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	92.9%	93.3%	96.6%
Reducing restrictive physical interventions training compliance	>=80%	60.7%	73.3%	65.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	67.9%	76.7%	72.4%
Fire Safety training compliance	>=80%	92.9%	93.3%	96.6%
Bed occupancy	85%	92.5%	96.0%	89.4%
Safer staffing (Overall)	90%	133.8%	110.6%	105.8%
Safer staffing (Registered)	80%	98.1%	101.8%	114.8%
% 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	1	1	0
Restraint incidents	Trend Monitor	8	1	*1*
Prone Restraint incidents	Trend Monitor	1	0	*0*
Unfilled Shifts	Trend Monitor	3	5	2

Inpatients - Forensic - Low Secure

Ryburn				
Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	100.0%	77.8%	66.7%
Sickness	5.4%	25.5%	16.2%	15.3%
Supervision	80%	75.0%	80.0%	80.0%
Information Governance training compliance	>=95%	100.0%	88.9%	90.0%
Reducing restrictive physical interventions training compliance	>=80%	75.0%	77.8%	80.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	88.9%	60.0%
Fire Safety training compliance	>=80%	87.5%	88.9%	80.0%
Bed occupancy	85%	87.1%	88.9%	91.9%
Safer staffing (Overall)	90%	98.1%	99.2%	100.3%
Safer staffing (Registered)	80%	97.4%	98.4%	100.0%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	1	0

Newhaven				
Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	90.9%	100.0%	96.0%
Sickness	5.4%	3.5%	8.0%	3.5%
Supervision	80%	100.0%	85.7%	100.0%
Information Governance training compliance	>=95%	93.1%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	62.1%	58.6%	65.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.8%	89.7%	89.7%
Fire Safety training compliance	>=80%	96.6%	100.0%	100.0%
Bed occupancy	85%	75.0%	79.8%	81.3%
Safer staffing (Overall)	90%	125.7%	126.5%	124.9%
Safer staffing (Registered)	80%	107.8%	105.0%	108.3%
% 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	4	2	3
Physical Violence (Patient on Staff)	Trend Monitor	9	5	6
Restraint incidents	Trend Monitor	14	7	*3*
Prone Restraint incidents	Trend Monitor	3	0	*0*
Unfilled Shifts	Trend Monitor	2	5	5

Inpatients - Non-Mental Health

Headlines
Recovery Plan for Wards continues to be monitored / updated monthly.

• Appraisal rate:
Critical staffing levels mean that it has been difficult to release staff from clinical duties (see care group tab for further detail regarding staffing levels on Neuro Rehabilitation Unit (NRU)).
Stroke Rehabilitation Unit (SRU) rate has maintained a level of 89.7%. This ward has been impacted by long term sickness in terms of management/senior staff.

• Sickness:
NRU – sickness has improved this month from 8.4% in May to 5.9% in June. This is being managed via people directorate processes and sickness reviews. Four short term sicknesses have contributed to this figure.
SRU – sickness has increased for June and is now at 7.3%. The unit continues to have some ong term sickness which management are aware is likely to continue for an extended period due to nature of illness. Three short term sicknesses have also impacted this figure.

• Supervision:
Critical staffing levels mean that it has been difficult to release staff from clinical duties (see care group tab for further detail regarding staffing levels on NRU).SRU figures have increased from 66.7 to 71.4%%.
Towards the end of July, the senior team are delivering some a focussed group supervision session on both units.

• Information Governance:
SRU – slight decrease this month to 87.7% due to sickness and annual leave.

• Cardiopulmonary resuscitation (CPR):
SRU – a slight increase to 77% in June which remains slightly below 80% compliance. Further sessions are planned.
To note: Resus Lead has advised that the process for CPR training recording is that they send the signature sheets to learning and development team (L&D). These are inputted by L&D but at irregular intervals once per month. Therefore there is a potential for up to a 6-week lag before the updated training statistics are showing.

• Bed occupancy:
NRU 52.8% against target of 80% - this is a reduction during June but remains within variance on activity report for rolling occupancy rates.
SRU 99.2% against target of 80%.

These patient cohorts do not have a predictable or seasonal trend due to the nature of the conditions and bed occupancy is determined by patient flow from the regional trauma centres and regional Hyper Acute Stroke Units (HASUs) respectively.
In view of this, for future months, narrative will only be included if there is an exception due to service delivery e.g. ward / bed closures.

Neuro Rehabilitation Unit (NRU)

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	68.0%	80.0%	81.5%
Sickness	4.5%	3.9%	8.4%	5.9%
Supervision	80%	62.5%	58.8%	58.3%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.1%	81.8%	82.9%
Fire Safety training compliance	>=80%	93.9%	97.1%	100.0%
Bed occupancy (Barnsley Commissioned beds only)	80%	43.3%	62.4%	52.8%
Safer staffing (Overall)	90%	119.6%	120.6%	126.9%
Safer staffing (Registered)	80%	93.5%	100.6%	117.5%
% 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	1	0
Unfilled Shifts	Trend Monitor	0	0	0

Stroke Rehabilitation Unit (SRU)

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	94.6%	89.7%	89.7%
Sickness	4.5%	2.7%	5.4%	7.3%
Supervision	80%	59.4%	66.7%	71.4%
Information Governance training compliance	>=95%	95.5%	90.6%	87.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.4%	76.7%	77.0%
Fire Safety training compliance	>=80%	83.6%	82.8%	86.2%
Bed occupancy	80%	87.5%	87.9%	99.2%
Safer staffing (Overall)	90%	108.8%	107.2%	106.2%
Safer staffing (Registered)	80%	120.5%	118.5%	119.0%
% 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	1	0
Unfilled Shifts	Trend Monitor	0	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 June). Appraisal is at 94.1%
• Cardiopulmonary resuscitation & reducing restrictve physical intervention training are both compliant
• 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.

Horizon

Metrics	Threshold	Apr-24	May-24	Jun-24
Appraisal rate	>=95%	90.3%	97.1%	94.4%
Sickness	4.5%	0.0%	4.6%	3.0%
Supervision	80%	92.9%	100.0%	100.0%
Information Governance training compliance	>=95%	94.9%	94.9%	84.6%
Reducing restrictive physical interventions training compliance	>=80%	70.3%	81.1%	81.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	59.5%	83.8%	81.1%
Fire Safety training compliance	>=80%	92.3%	92.3%	84.6%
Bed occupancy	N/A	47.9%	50.0%	50.0%
Safer staffing (Overall)	90%	152.5%	158.4%	154.7%
Safer staffing (Registered)	80%	118.5%	119.7%	126.7%
% 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	17	24	12
Restraint incidents	Trend Monitor	18	32	*24*
Prone Restraint incidents	Trend Monitor	2	1	*0*
Unfilled Shifts	Trend Monitor	0	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 within 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 using system data and intelligence in Calderdale. In Barnsley we have worked with others to develop a proposal for a community development approach to addressing health inequalities which uses approximately 600k of funding to work with communities on this important agenda	
Improving care	Transform our Older People inpatient services	The independently produced report of findings from the public consultation – to be published post-election in July. Joint health overview and scrutiny committee Scheduled for mid-August. Stakeholder Workshop to consider findings of consultation to be held in late August. Recommendations will then be reach and taken into governance in late September / early October.	
	Improve our mental health services so they are more responsive, inclusive, and timely	**Improving Access to Care (IATC) Programme: Waiting well waiting fairly** The first steps of this Quality Improvement programme, to identify and understand, have commenced using evidence base from sources such as Kings Fund, internal data sources and community insight, linking to key drivers such as reducing health inequalities reducing waiting times, and current place-based initiatives. quality improvement approach, Plan on a page, and terms of reference have been revised to reflect this refocus and drafts have been circulated with improving access to care steering group members for consideration. **Care Closer to Home (CC2H) Programme** • Work continuing to sustain the reduction in out of area admissions. This to include engagement with integrated care boards regarding areas of pressure/safe spaces • Ongoing review/stocktake of 23/24 outcomes and next steps for 24/25. • Bed drill down report produced for Quality & Safety committee. • Ongoing work to progress actions/outputs from the staff engagement events. • Planning for service user and carer experience • Sign off Quality improvement end of year report in July **Inpatient Priority Programme** • Actions from therapeutic inpatient improvement plan progressing • Discharge priorities reviewed and updated • Evaluation of mental health inpatient preceptorship training to be produced in August • Outcomes dashboard – continuing to monitor usage and further training planned • Sign off quality improvement end of year report in July • Commencement of quality improvement coaching sessions for culture of care programme **Community MH Transformation (CMHT) Priority Programme** • A stocktake report is being produced to capture the progress made so far and recommends continuation of work at Care group level • The Care Pathway Review Sub Group has continued its work focused on Primary Care Pathway • Interoperability Operational (SMI/PHC) Steering group continues reviewing templates and coding within SWYPFT including a review of the new waiting tmes standards. • Pathway working groups have met under the guidance of the General Manager's leading on their review and draft standard operating procedures have been developed and are currently being reviewed across key stakeholders within the Trust including Team Managers. • The 2nd West Yorkshire evaluation report written by NICHE reads very favourably of SWYPFT's involvement in West Yorkshire community mental health teams.	

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 to continue developing the care planning good practice guide, training programme and performance and quality metrics. • A final iteration of the new care plan has been developed and further staff engagement is underway with drop-in sessions being arranged for late July and early August. Check and challenge sessions are being scheduled with care groups leads and service users to test the new care plan during August. • A set of proposed new measures have been developed alongside care groups and Performance and business intelligence colleagues and initial engagement commenced during July. • Arrangements to bring the priority programme to a close and return to business as usual are being developed with presentations to Operational Management Group, Executive Management Team and Quality and Safety Committee scheduled for September and October 2024. **Personalised care (moving on from Care Programme Approach)** • A stock take report has been completed for review by the Steering Group • SWYPFT have showcased the Portia (IMX Digital Solutions) Tool for PROMS collation and review at the Regional and Local Networks gaining favourable responses from across various Trusts. • Re-design of Intranet page is taking place in line with the first Draft of a Policy design. • Use of PROMS guidance is in draft. Engagement on 'what a Care Plan may look like' has commenced. • Engagement with staff groups on developing Principles of Named Keyworker continues, with next focus on how Keyworkers will be assigned and the processes for allocation. • We have met with Kirklees Local Authority to initiate discussions in regards how this programme will align with Local Authority Colleagues and presented to Wakefield Mental Health Panel, a subgroup of the Alliance in Wakefield.	
Improving use of resources	Spend money wisely and increase value	**Value for money (VfM)** • Built in savings (£22m) are behind plan at the end of Quarter1 with pay costs being the biggest driver of this variance. Identification of new schemes is required to cover this shortfall and help secure the overall financial position. • Weekly value for money meetings continue to be chaired by Chief Operating Officer, attended by Director of Services. • With regards pay schemes, pay premiums (overtime and bank enhancements) have now ceased with little initial impact on services. • Financial impact expected from month 4 reports onwards. • Smaller schemes additional to plan continue to progress, and indicative provisional savings are being identified. • Staff are engaging with the iHub conversation and putting forward ideas, these are reviewed and followed up as appropriate.	
	Make digital improvements	**Digital Dictation** • Four onsite demonstrations and two virtual demonstrations completed during June and July. • Application testing is now underway and due to be completed early July 2024. • On track for deployment and training to start to service one (Barnsley Memory Service) from July 24, service two (Adult ADHD and Autism) during August 24 and service three (Wakefield BDU) from September 2024. • The deployment plan for services from October onwards was signed off by the Project Board in July 2024.	
Great place to work	People Directorate 90-day plan	As agreed at People Renumeration Committee, the 90 day plan has come to an end with a number of workstreams being taken into business as usual. Work is now being scoped based on the People Promise headings for some of the strategic areas that need continued focus	

Overall Financial Performance 2024/25

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast 2024/25	Narrative
1	Surplus / (Deficit)	(£0.9m)	£0m	The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £0.9m deficit has been reported. June's deficit of £0.1m was much improved compared to April & May but remains adverse to plan. A number of corrective actions are in place and we are continually assessing if further action is required.
2	Agency Spend	£1.4m	£5.3m	There has been a sustained reduction in agency expenditure over the past 9 months. Spend increased in June to £508k which is £37k more than the previous month. The main movement is an in-month increase in medical staff, 3 more whole time equivalent worked. The adult secure provider collaborative spend in month was £64k.
3	Financial sustainability and efficiencies	£4m	£20.3m	The Trust financial sustainability programme for 2024 / 25 has a target of £22.0m. Year to date performance is below plan and additional mitigation plans are being developed to cover this shortfall.
4	Cash	£63.5m	£59.9m	The Trust cash position has increased in month and remains in excess of £60m. Actions to optimise cash are being taken, especially ensuring that all income has been invoiced for, are being progressed.
5	Capital	£1.2m	£8.1m	The Trust capital allocation for 2024 / 25 is £8.1m. Expenditure, for the year to date, is £1.2m and remains ahead of the plan profile. We are closely monitoring the timing of the Crofton Development Program.
6	Better Payment Practice Code	99%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

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

System-wide monitoring

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

West Yorkshire Health and Care Partnership -

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

South Yorkshire ICS -

ICB Board meeting and minutes :: South Yorkshire ICB

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

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 3 (2024 / 25)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

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1.0 Executive Summary / Key Performance Indicators

Key Performance Indicator		Year to date	Forecast 2024 / 25	Narrative
1	Surplus / (Deficit)	(£0.9m)	£0m	The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £0.9m deficit has been reported. June's deficit of £0.1m was much improved compared to April & May but remains adverse to plan. A number of corrective actions are in place and we are continually assessing if further action is required.
2	Agency Spend	£1.4m	£5.3m	There has been a sustained reduction in agency expenditure over the past 9 months. Spend increased in June to £508k which is £37k more than the previous month. The main movement is an in-month increase in medical staff, 3 more WTE worked. The adult secure provider collaborative spend in month was £64k.
3	Financial sustainability and efficiencies	£4m	£20.3m	The Trust financial sustainability programme for 2024 / 25 has a target of £22.0m. Year to date performance is below plan and additional mitigation plans are being developed to cover this shortfall.
4	Cash	£63.5m	£59.9m	The Trust cash position has increased in month and remains in excess of £60m. Actions to optimise cash are being taken, especially ensuring that all income has been invoiced for, are being progressed.
5	Capital	£1.2m	£8.1m	The Trust capital allocation for 2024 / 25 is £8.1m. Expenditure, for the year to date, is £1.2m and remains ahead of the plan profile. We are closely monitoring the timing of the Crofton Development Program.
6	Better Payment Practice Code	99%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

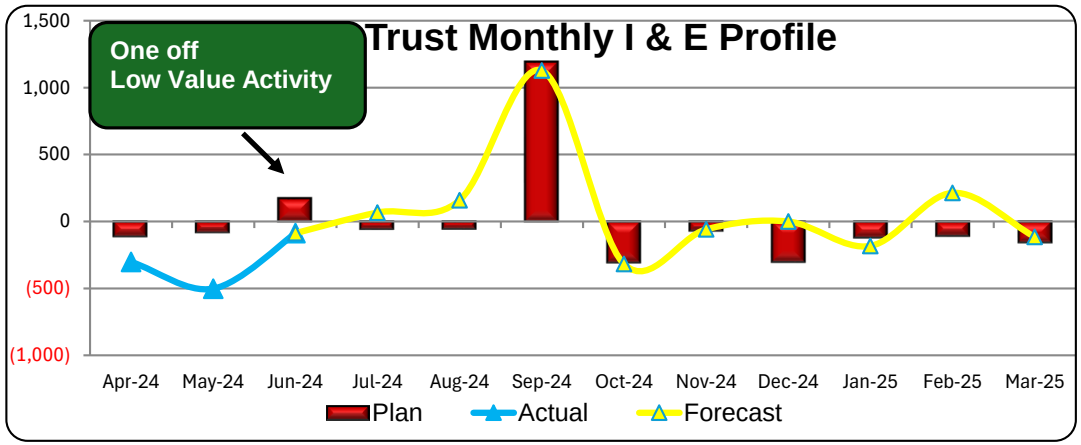
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

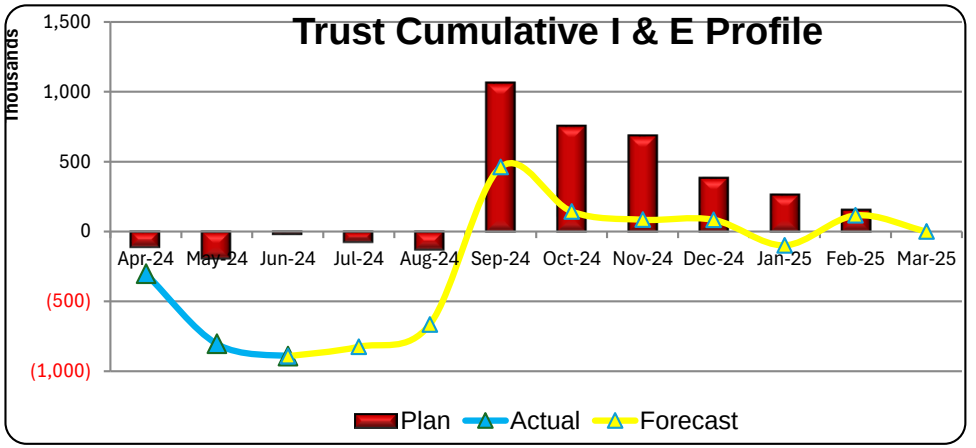
2.0 Income & Expenditure Position 2024 / 25

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, are 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					35,189	34,439	(750)	102,643	102,464	(179)	407,198	406,476	(722)
Other Operating Revenue					1,358	1,271	(87)	3,521	3,616	95	15,151	15,040	(111)
Total Revenue					**36,546**	**35,709**	**(837)**	**106,164**	**106,080**	**(84)**	**422,349**	**421,516**	**(833)**
Pay Costs	5,025	5,098	73	1.5%	(21,460)	(22,017)	(557)	(64,361)	(65,335)	(974)	(257,543)	(259,641)	(2,097)
Non Pay Costs					(14,502)	(13,404)	1,098	(40,596)	(40,584)	11	(159,924)	(157,878)	2,046
Gain / (loss) on disposal					0	0	0	0	22	22	0	22	22
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,025**	**5,098**	**73**	**1.5%**	**(35,962)**	**(35,421)**	**541**	**(104,957)**	**(105,898)**	**(941)**	**(417,467)**	**(417,497)**	**(30)**
EBITDA	**5,025**	**5,098**	**73**	**1.5%**	**584**	**288**	**(296)**	**1,207**	**183**	**(1,024)**	**4,882**	**4,019**	**(863)**
Depreciation					(526)	(536)	(10)	(1,577)	(1,577)	0	(6,304)	(6,060)	244
PDC Paid					(179)	(179)	0	(537)	(537)	0	(2,148)	(2,148)	0
Interest Received					294	339	45	889	1,040	151	3,570	4,190	620
Surplus / (Deficit) - ICB performance measure	**5,025**	**5,098**	**73**	**1.5%**	**173**	**(88)**	**(261)**	**(18)**	**(892)**	**(874)**	**(0)**	**(0)**	**(0)**
Depn Peppercorn Leases (IFRS16)					(9)	(9)	(0)	(26)	(26)	0	(94)	(94)	0
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,025**	**5,098**	**73**	**1.5%**	**164**	**(96)**	**(261)**	**(45)**	**(918)**	**(874)**	**(94)**	**(94)**	**(0)**





Income & Expenditure Position 2024 / 25

The consolidated financial position is a year to date deficit of £0.9m. This is £0.9m behind plan.
In June 2024 this is a deficit of £0.1m which is £0.3m behind plan.

In line with national guidance the Trust submitted a breakeven financial plan for 2024 / 25 in May 2024. An updated plan submission was made in June 2024 to take account of the consultant pay award and tariff uplift. The Trust plan remained at breakeven. As this tariff uplift will not fully fund the cost increase this creates an additional financial pressure which will require mitigation. Further updates will be required as other pay awards are agreed in year.

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 to the West Yorkshire Integrated Care Board (ICB). The corresponding declaration is made within the return itself.

The submission is for the total consolidated financial position which operates as a single segment for the purpose of providing healthcare services. Within this report the financial information is split into core Trust, Provider Collaboratives and budgets held centrally. This is to highlight the specific financial positions of each element that make the whole. This is summarised in the table below.

	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
Description	**WTE**	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Trust (core)	4,989	5,064	75	1.5%	254	(117)	(371)	233	(830)	(1,063)	(87)	(5,391)	(5,304)
Provider Collaboratives	23	34	12	50.6%	3	103	100	8	67	58	33	13	(21)
Budgets held centrally	13	0	(13)	100.0%	(84)	(74)	9	(260)	(129)	131	54	5,378	5,324
Total - Consolidated position (ICB performance measure)	**5,025**	**5,098**	**73**	**1.5%**	**173**	**(88)**	**(261)**	**(18)**	**(892)**	**(874)**	**(0)**	**(0)**	**(0)**

Each of these elements will be reported within the remainder of this report with additional information provided on key focus areas.

Overall a deficit of £88k has been reported which is £261k behind plan, albeit much improved compared to April and May. The main driver is the main Trust position which is behind plan in month and for the year to date. This is being partially offset by the financial performance of the provider collaboratives and budgets held centrally.

The consolidated forecast position continues to be reported as breakeven. The presentation above highlights that the current pressures included in the Trust position which require actions to mitigate. Internally these actions are presented to Finance, Investment and Performance Committee as part of the monthly forecast scenario modelling.

2.0 Income & Expenditure Position 2024/ 25

This section focusses on the financial performance of South West Yorkshire Partnership NHS Foundation Trust. This excludes the financial impact of Provider Collaboratives and budgets held centrally which are presented separately within this report. The movement between the total consolidated financial position and the table below is reconciled on the previous page for ease.

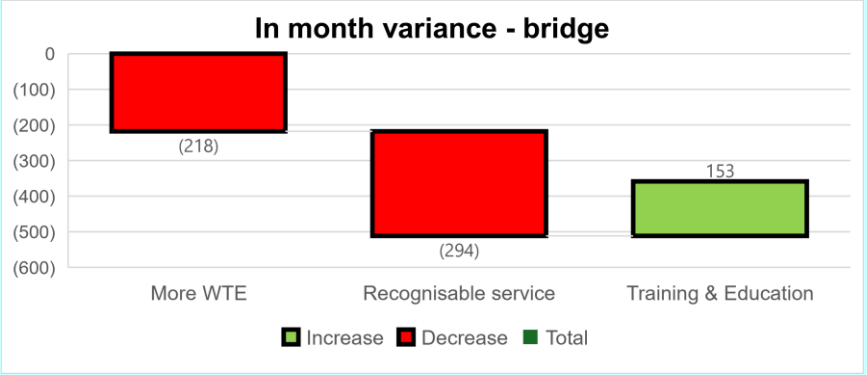
To confirm that the individual analysis within the report highlights the Trust only values.

Total Financial Position - Core Trust only

	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
Description / Heading	**WTE**	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Healthcare contracts					25,514	25,289	(225)	75,343	75,035	(309)	299,614	298,362	(1,252)
Other Operating Revenue					1,297	1,205	(92)	3,319	3,414	96	13,359	13,300	(58)
Total Revenue					**26,811**	**26,493**	**(317)**	**78,662**	**78,449**	**(213)**	**312,972**	**311,662**	**(1,310)**
Pay Costs	4,989	5,064	75	1.5%	(21,227)	(21,739)	(512)	(63,661)	(64,565)	(904)	(254,744)	(258,346)	(3,603)
Non Pay Costs					(4,918)	(4,495)	424	(13,543)	(13,661)	(118)	(53,434)	(54,710)	(1,276)
Gain / (loss) on disposal					0	0	0	0	22	22	0	22	22
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,989**	**5,064**	**75**	**1.5%**	**(26,145)**	**(26,234)**	**(88)**	**(77,204)**	**(78,204)**	**(1,001)**	**(308,178)**	**(313,034)**	**(4,857)**
EBITDA	**4,989**	**5,064**	**75**	**1.5%**	**665**	**260**	**(406)**	**1,458**	**245**	**(1,214)**	**4,795**	**(1,372)**	**(6,167)**
Depreciation					(526)	(536)	(10)	(1,577)	(1,577)	0	(6,304)	(6,060)	244
PDC Paid					(179)	(179)	0	(537)	(537)	0	(2,148)	(2,148)	0
Interest Received					294	339	45	889	1,040	151	3,570	4,190	620
Surplus / (Deficit) - ICB performance measure	**4,989**	**5,064**	**75**	**1.5%**	**254**	**(117)**	**(371)**	**233**	**(830)**	**(1,063)**	**(87)**	**(5,391)**	**(5,304)**
Depn Peppercorn Leases (IFRS16)					(9)	(9)	(0)	(26)	(26)	0	(94)	(94)	0
Losses Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,989**	**5,064**	**75**	**1.5%**	**246**	**(125)**	**(371)**	**207**	**(856)**	**(1,063)**	**(181)**	**(5,485)**	**(5,304)**

There are numerous drivers and factors impacting on the Trust financial position, for in month and year to date. Without trying to over simplify, where possible, these are consolidated and summarised below as key themes. This is not intended to give a full reconciliation of the variance to plan.

Key headlines include:	£k
Net overspend on pay primarily driven by total WTE worked being higher than planned	(218)
Payment to staff for recognisable service. This includes £257k relating to prior years which hadn't been previously accounted for.	(294)
Non Pay - reduced run rate. Training & education	153

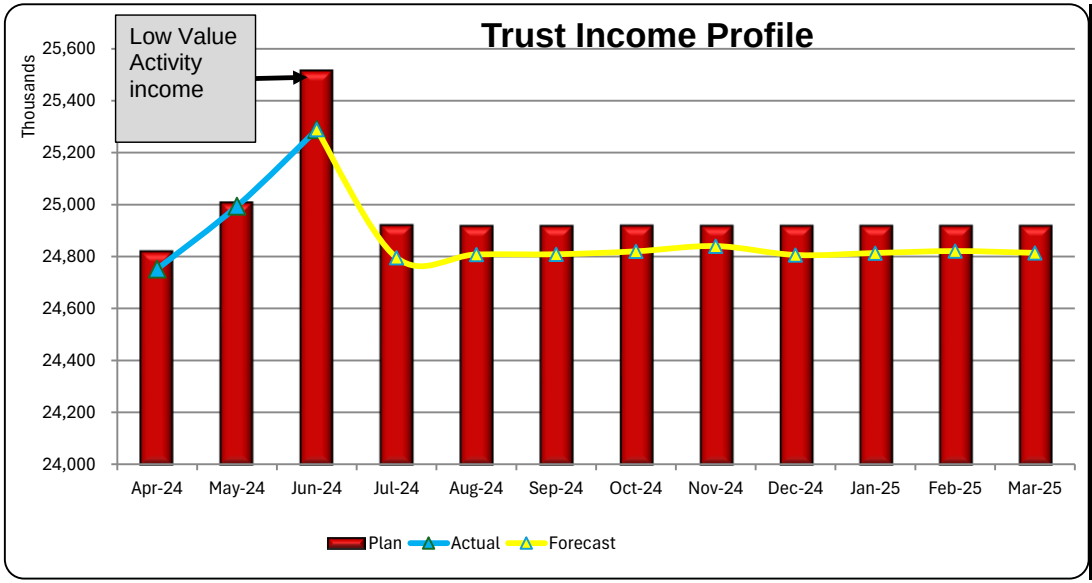


2.1 Income Information

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 (fixed / block contract value). 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). The Specialist Commissioner includes the SWYPFT contractual element of the Adult Secure Provider Collaborative.

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	21,716	21,144	21,144	21,144	21,144	21,144	21,144	21,144	21,144	21,153	**254,304**	254,298	6
Specialist Commissioner	**34,541**	2,943	2,962	2,974	2,955	2,955	2,955	2,955	2,955	2,955	2,955	2,955	2,955	**35,469**	35,469	0
Local Authority	**5,799**	378	400	371	367	379	380	391	412	377	385	393	385	**4,620**	5,007	(387)
Partnerships	**6,748**	205	219	191	205	205	205	205	205	205	205	205	205	**2,464**	2,971	(507)
Other Contract Income	**1,454**	131	220	37	125	125	125	125	125	125	125	125	117	**1,505**	1,869	(364)
Total	**293,862**	**24,752**	**24,994**	**25,289**	**24,796**	**24,808**	**24,809**	**24,820**	**24,840**	**24,806**	**24,814**	**24,821**	**24,814**	**298,362**	**299,614**	**(1,252)**
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	9,150	9,160	9,179	9,211	8,860	8,854	8,860	8,860	8,841	8,859	**108,114**		
Total	**293,862**	**33,870**	**34,155**	**34,439**	**33,956**	**33,987**	**34,020**	**33,680**	**33,694**	**33,666**	**33,674**	**33,663**	**33,673**	**406,476**		



Income, and budgets, increase in June 2024 for the receipt of low value activity income. This is received as a block amount from numerous Integrated Care Boards to reflect activity undertaken on their behalf. Historically this would have been invoiced on a cost per case basis but is now a nationally calculated value (based on Trust data submissions) and received in full in June.

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

* Partnership - Youth Offenders Contract £507k
Reimbursement based on actual costs incurred
* Yorkshire Smokefree - Payment by results £307k
This is partially offset by reduced non pay costs
* Additional Roles Reimbursement Posts £285k
Offset by reduced pay costs. Recharged on staff in post

2.2 Pay Information

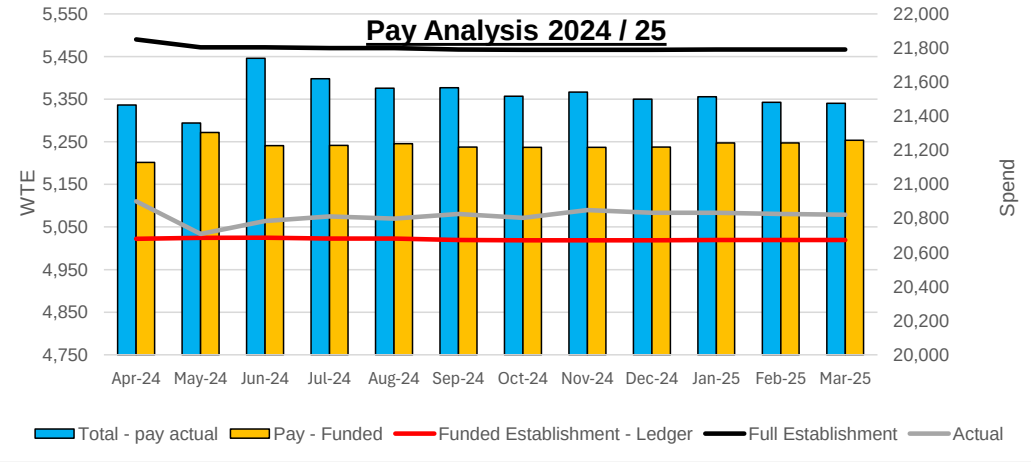
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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	19,622	19,479	19,532	19,625	19,556	19,623	19,645	19,664	19,668	19,679	**234,569**
Bank & Locum	1,955	1,581	1,673	1,667	1,631	1,563	1,577	1,561	1,535	1,513	1,493	1,493	**19,240**
Agency	413	400	444	475	402	379	385	358	320	338	320	304	**4,537**
Total	**21,466**	**21,360**	**21,739**	**21,620**	**21,564**	**21,566**	**21,517**	**21,542**	**21,500**	**21,514**	**21,481**	**21,476**	**258,346**
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%	7.7%	7.7%	7.6%	7.2%	7.3%	7.2%	7.1%	7.0%	7.0%	7.0%	7.4%
Agency as % (in month)	1.9%	1.9%	2.0%	2.2%	1.9%	1.8%	1.8%	1.7%	1.5%	1.6%	1.5%	1.4%	1.8%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,574	4,574	4,591	4,606	4,614	4,641	4,634	4,657	4,660	4,665	4,668	4,667	**4,629**
Bank & Locum	474	401	411	409	400	385	387	384	376	371	366	366	**394**
Agency	62	59	62	59	56	54	50	50	47	47	47	46	**53**
Total	**5,110**	**5,034**	**5,064**	**5,075**	**5,070**	**5,080**	**5,071**	**5,090**	**5,083**	**5,084**	**5,080**	**5,079**	**5,077**
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 Trust plan assumes no workforce growth in 2024 / 25 unless it is supported by new funding from commissioners. As such the plan is predicated on a period of consolidating and stabilising the current workforce, reducing premium costs and any inefficiencies in processes.

In June there has been an increase in all WTE worked categories when compared to the previous month and overall remains higher than planned. The increase is 17 WTE in substantive, 10 in bank and 3 in agency making a total increase of 30 WTE worked in month.

This is reflected in the increased expenditure in month in all 3 categories.

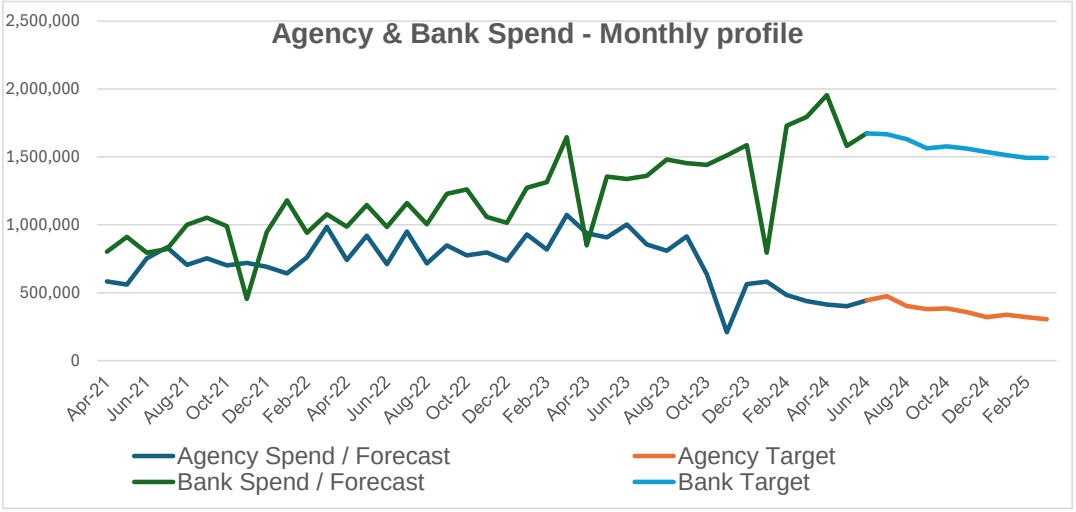
The impact of actions already taken should begin to be visible within the financial reports from July but further actions and mitigations will be required in order to achieve the financial target.

2.2 Temporary Staffing Focus

Trust spend in June 2024:
Agency £444k
Bank £1,673k

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	448	130	**578**
Other Medical	313	190	**504**
Reg Nursing	110	1,203	**1,312**
UnReg Nursing	251	3,159	**3,410**
Other Clinical	104	213	**316**
A & C	31	314	**345**
Other	1	0	**1**
Total	**1,257**	**5,209**	**6,466**
Lead Provider Collaborative	164	0	**164**
Budgets held centrally	(1)	0	**(1)**
Total	**1,420**	**5,209**	**6,629**

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 £8.2 which is 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 been reducing for agency although there was an increase in June 2024. Bank has been increasing over the same period with spend in June higher than in May but lower than the peak in April 2024.

Agency expenditure continues to be driven by the objective to provide safe staffing levels to support our service users. For June there has been a number of additional medical vacancies which are being covered by agency staff (adult inpatient wards across all places) and increased nursing staff on inpatient wards when compared to May. In addition there are a number of new agency placements within provider development (specific time limited project) and pharmacy whilst recruitment continues.

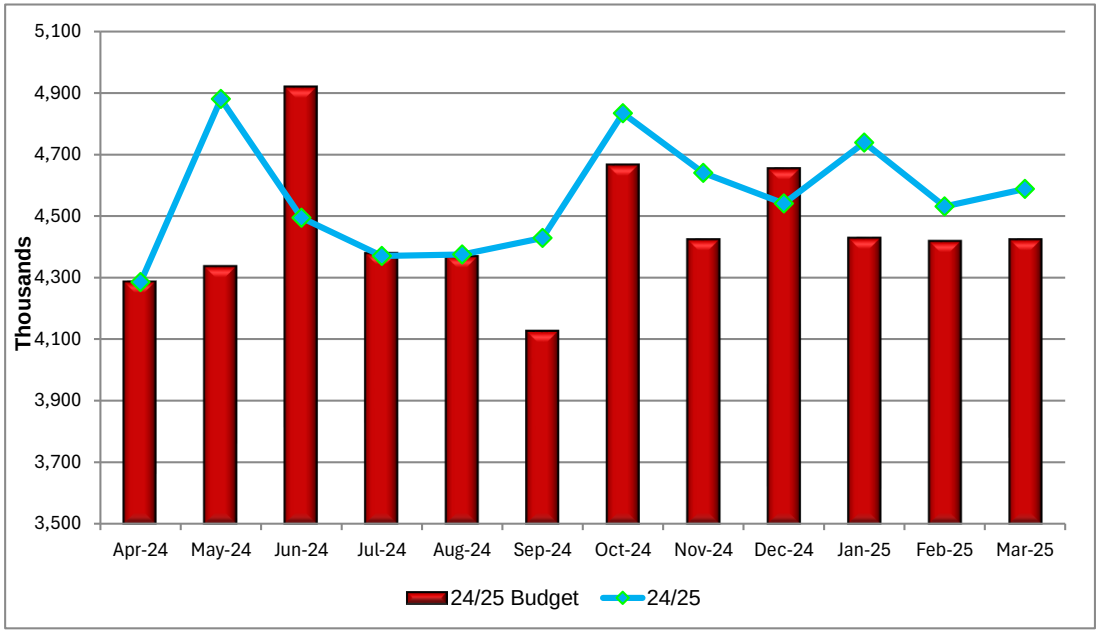
Bank usage has also increased in the same areas with a focus on inpatient wards (adult, older people and Forensics). Usage elsewhere remains minimal however all care groups, including corporate services, have been developing action plans to minimise as far as possible.

2.3 Non Pay Expenditure

Whilst pay expenditure accounts for the majority of Trust costs, 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. To confirm that this also excludes expenditure relating to the provider collaboratives and budgets held centrally.

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	4,495	4,370	4,375	4,429	4,835	4,641	4,541	4,739	4,532	4,588	**54,710**
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	Trend Actual £k
Drugs	1,098	1,060	(37)	
Establishment	2,547	2,762	215	
Lease & Property Rental	2,218	2,202	(16)	
Premises (inc. rates)	1,321	1,272	(49)	
Utilities	677	731	54	
Purchase of Healthcare	1,550	1,466	(85)	
Travel & vehicles	1,343	1,338	(5)	
Supplies & Services	1,965	2,013	48	
Training & Education	221	170	(51)	
Clinical Negligence & Insurance	291	296	5	
Other non pay	311	350	39	
Total	**13,543**	**13,661**	**118**	
Total Excl OOA and Drugs	**10,894**	**11,135**	**240**	



Key Messages

As noted, and shown by the graph above, non pay expenditure in May 2024 was higher than the normal run rate. Of these a number of headlines have reverted in month with drugs expenditure (less than budget in month) and training & education now also spending less than plan.

Establishment remains the largest overspend area against budget although this has also reduced from £364k overspent as at May 2024.

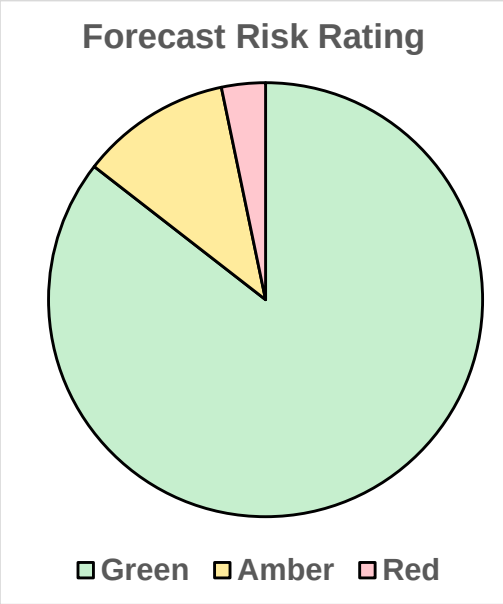
Purchase of healthcare expenditure remains lower than plan with out of area placements less than plan (4 PICU placements as at the end of June compared to a plan of 5 placements in total). Detailed weekly internal reporting continues but, currently, no additional financial focus is provided within this report.

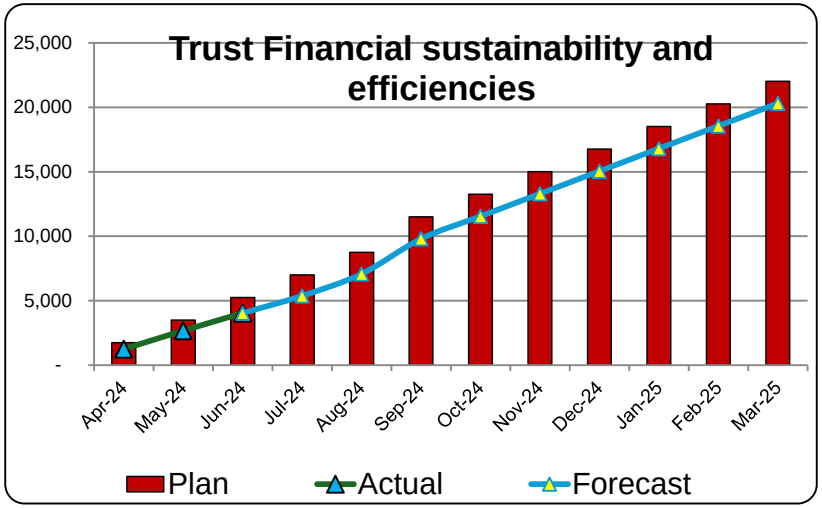
3.0 Value for Money, Financial sustainability and efficiency

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		3,117	255	1,689	12,468	10,976		
Non pay - Impact of workforce optimisation		105	95		420	410		
Out of area placements		718	968		2,871	968	2,153	
Non pay - digital		62	49		246	234		
Non pay - Estates		125	42		500			374
Non pay - medicines optimisation		120	0		480			290
Procurement		63	0		250		125	
Provider Collaboratives		285	285		1,140	1,140		
Income - contribution, FYE		660	660		3,638	3,638		
Total		**5,253**	**2,353**	**1,689**	**22,013**	**17,366**	**2,278**	**664**
Recurrent		2,586	2,353		10,345	6,964	2,278	664
Non Recurrent		2,667		1,689	11,668	10,401		





The Trust value for money programme target for 2024 / 25 is £22m. This is a combination of recurrent and non-recurrent schemes with the focus on 2 specific areas.

Pay schemes are focussed on stabilisation of current workforce and reduction of any cost or volume inefficiencies. This is behind for the year to date and forecast. The run rate will increase from July 2024 as the impact of actions taken are realised.

The volume of staff utilised by the Trust, as identified within the main financial position, remains higher than planned and therefore this scheme remains behind target.

Non pay schemes are generally targeted at ensuring that value for money is secured.

There is positive performance on elements of these, such as out of area placements, where the volume of placements remains lower than planned. However some schemes remain behind plan, including medicines optimisation (schemes defined but actions need to be enforced and benefits realised) and procurement (although positive work on cost mitigation continues).

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	169,074	1
Current Assets			
Inventories & Work in Progress	179	179	
NHS Trade Receivables (Debtors)	1,072	537	
Non NHS Trade Receivables (Debtors)	344	1,537	
Prepayments	3,491	6,307	
Accrued Income	1,062	3,503	2
Cash and Cash Equivalents	69,199	63,493	Pg 15
Total Current Assets	**75,347**	**75,557**	
Current Liabilities			
Trade Payables (Creditors)	(12,728)	(7,725)	3
Capital Payables (Creditors)	(1,392)	(722)	
Tax, NI, Pension Payables, PDC	(8,469)	(8,742)	
Accruals	(13,966)	(19,456)	4
Deferred Income	(409)	(790)	
Other Liabilities (IFRS 16 / leases)	(51,040)	(52,978)	1
Total Current Liabilities	**(88,004)**	**(90,413)**	
Net Current Assets/Liabilities	**(12,657)**	**(14,856)**	
Total Assets less Current Liabilities	**155,161**	**154,218**	
Provisions for Liabilities	(3,510)	(3,485)	
Total Net Assets/(Liabilities)	**151,651**	**150,733**	
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	84,462	
Total Taxpayers' Equity	**151,651**	**150,733**	

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.

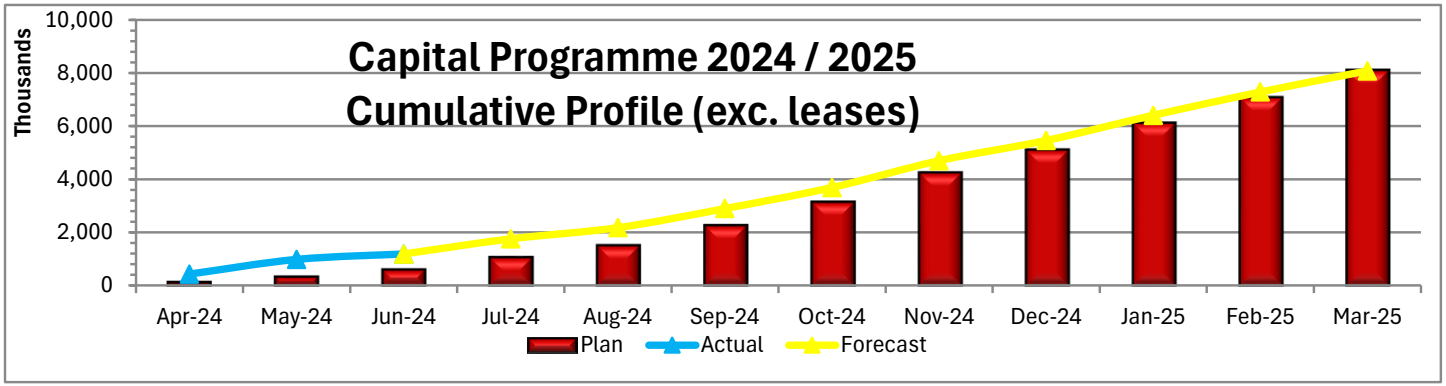
2. Accrued income is traditionally low at year end and then increases during quarter 1. These will be invoiced as soon as possible.

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. Accruals have increased since year-end, some of this relates to receiving invoices from other NHS bodies as these values are agreed, this is expected to decrease over the next couple of months.

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	280	724	444	1,000	0
Anti-ligature Doors	1,000	190	246	56	1,000	0
Maintenance (Minor) Capital						
Clinical Improvement	311	0	2	2	341	31
Safety	302	18	5	(13)	335	33
Sustainability / Carbon Neutral	510	0	0	0	510	0
Backlog	360	14	8	(5)	404	44
Equipment	41	0	19	19	79	38
Other	171	9	47	38	257	86
IM & T	1,470	36	83	47	1,470	0
Contingency	219	0	0	0	(13)	(232)
Staff Costs	200	50	46	(4)	200	0
TOTALS	**8,082**	**596**	**1,182**	**585**	**8,082**	**(0)**
Lease Impact (IFRS 16) New lease	5,910	3,657	3,826	169	5,910	0
TOTALS	**13,992**	**4,254**	**5,008**	**754**	**13,992**	**0**



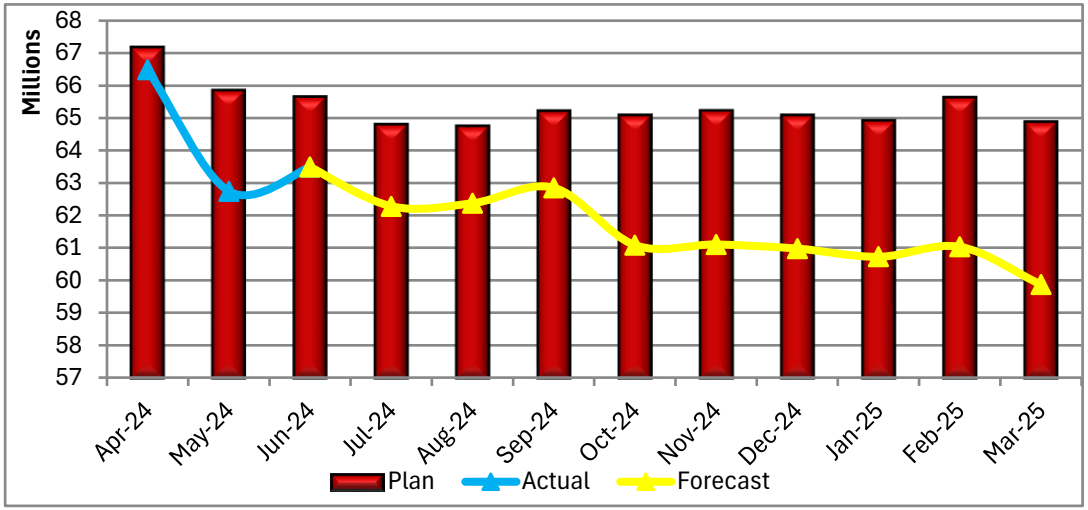
Capital Expenditure 2024 / 25

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

Capital is currently ahead of plan due to the ongoing works on both seclusion rooms and the door scheme.

Other schemes are currently being planned to commence in line with plan.

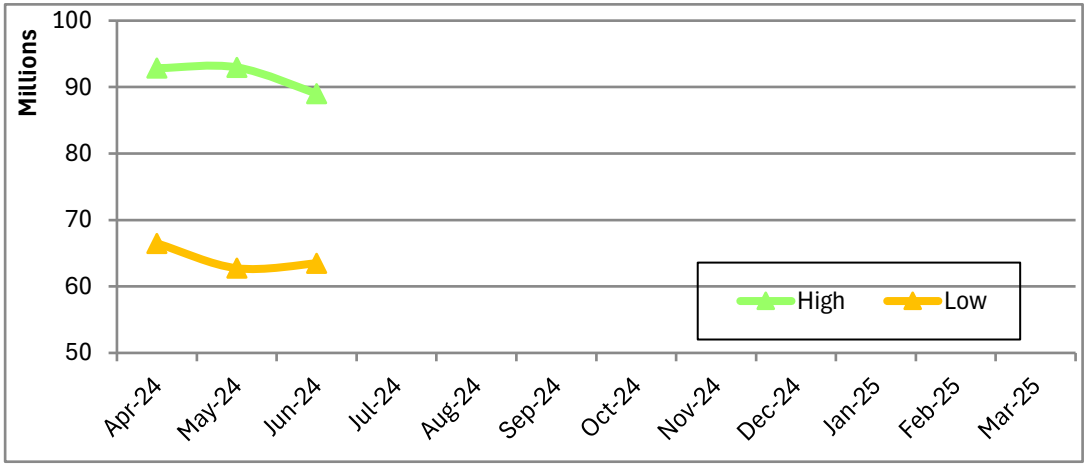
4.2 Cash Flow & Cash Flow Forecast 2024 / 2025



Cash remains lower than plan

Cash is lower than plan. At Month 3 both prepayments and accrued income are high which reduces cash. Work is ongoing to reduce the level of accrued income.

	Plan £k	Actual £k	Variance £k
Opening Balance	71,353	69,199	
Closing Balance	65,651	63,493	(2,158)



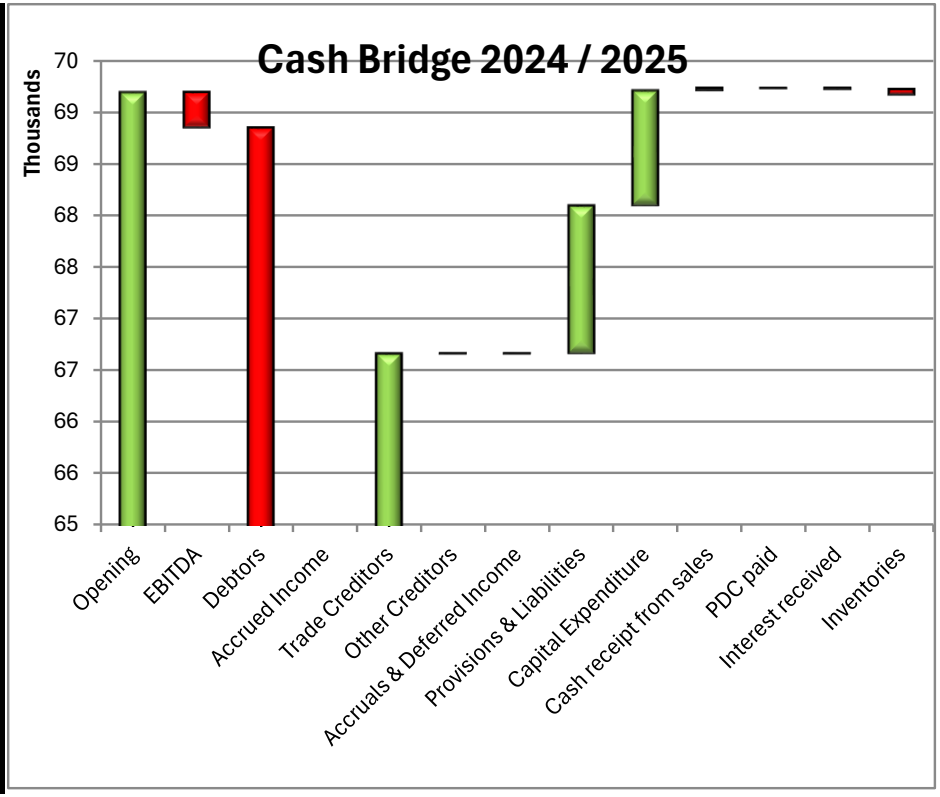
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £89m
The lowest balance is: £63.5m

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)	2,781	2,436	(345)	
Movement in working capital:				
Inventories & Work in Progress	52	0	(52)	
Receivables (Debtors)	(120)	(5,915)	(5,795)	
Trade Payables (Creditors)	(3,000)	603	3,603	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	(1,080)	357	1,437	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(2,968)	(1,851)	1,117	
Cash receipts from asset sales	0	22	22	
Leases	(2,418)	(2,396)	22	
PDC Dividends paid	0	0	0	
PDC Dividends received	0		0	
Interest (paid)/ received	1,051	1,040	(11)	
Closing Balances	**65,651**	**63,493**	**(2,158)**	



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

There is significant movements when compared to plan and this will help to inform the 2024 / 25 planning submission. Overall the main driver for the reduction is that one off agreements have been physical cash payments but these have been offset by one off non cash adjustments such as release of provisions or reduction in accruals.

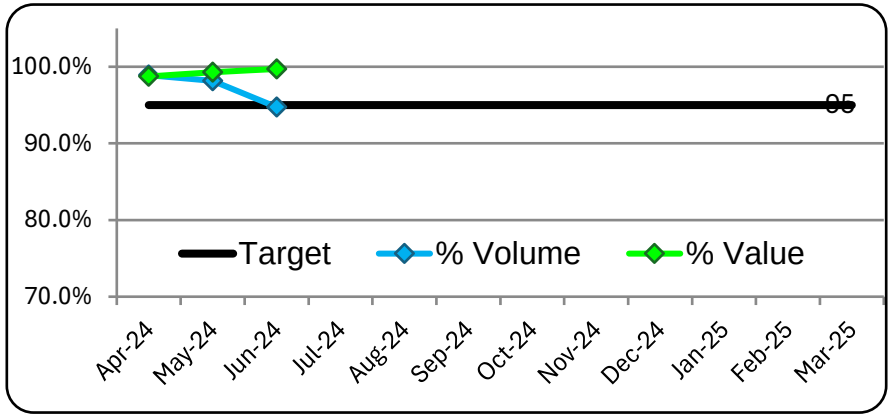
5.0 Better Payment Practice Code

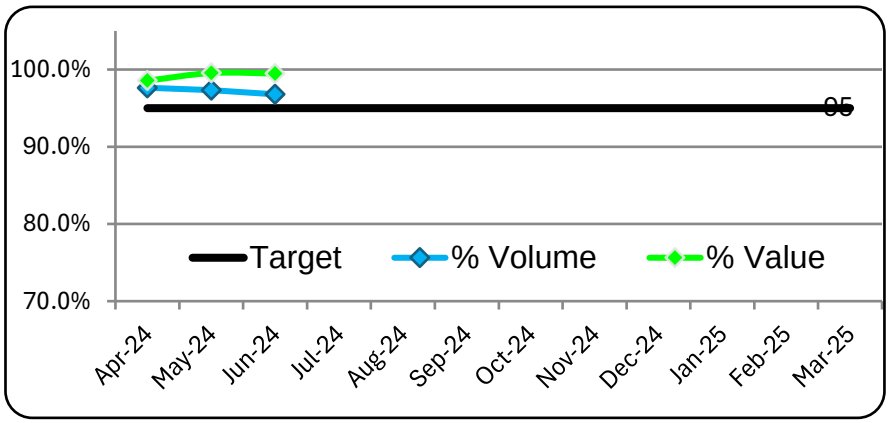
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	95%	100%
Cumulative Year to Date	98%	99%

Non NHS	Number %	Value %
In Month	97%	99%
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 (£)
04-Jun-24	Computer Licences	Trustwide	Trustmarque Solutions Ltd	2384936	1,405,332
06-Jun-24	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000058191	744,624
21-Jun-24	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	204508	629,964
19-Jun-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS47	450,000
03-Jun-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510009063	351,047
07-Jun-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5516	299,000
19-Jun-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS24	270,000
28-Jun-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5537	240,000
07-Jun-24	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Found	4400001556	233,646
11-Jun-24	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 285	210,865
28-Jun-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5538	200,000
04-Jun-24	Computer Licences	Trustwide	Trustmarque Solutions Ltd	2384934	147,384
03-Jun-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510009060	122,442
07-Jun-24	IT Services	Trustwide	Daisy Corporate Services	3I528319	90,250
14-Jun-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5519	86,845
19-Jun-24	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710179791	86,650
15-Jun-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5522	83,755
12-Jun-24	Utilities	Trustwide	Edf Energy Customers Ltd	000019364825	62,439
06-Jun-24	Purchase of Healthcare	Kirklees	Northorpe Hall Child & Family Trust	INV0649	57,568
10-Jun-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS045INV	56,341
21-Jun-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	NCO2000008394	56,000
27-Jun-24	Drugs	Trustwide	NHS Business Services Authority	1000080995	51,370
11-Jun-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC025INV	45,371
05-Jun-24	Purchase of Healthcare	Kirklees	St Andrews Healthcare	90137431	39,431
05-Jun-24	Purchase of Healthcare	Kirklees	Partnerships In Care Ltd	D190001189EPC	37,587
01-Jun-24	Staff Recharge	Barnsley	Stroke Association (The)	MSSI5131	37,530
07-Jun-24	Insurance	Trustwide	Willis Ltd	10958GP24000001PRM	36,388
24-Jun-24	Computer Licences	Trustwide	Trustmarque Solutions Ltd	2386036	36,350
12-Jun-24	Utilities	Trustwide	Edf Energy Customers Ltd	000019341490	35,937
06-Jun-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	NCO2000008288	35,467
12-Jun-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	ARB06037	33,810

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

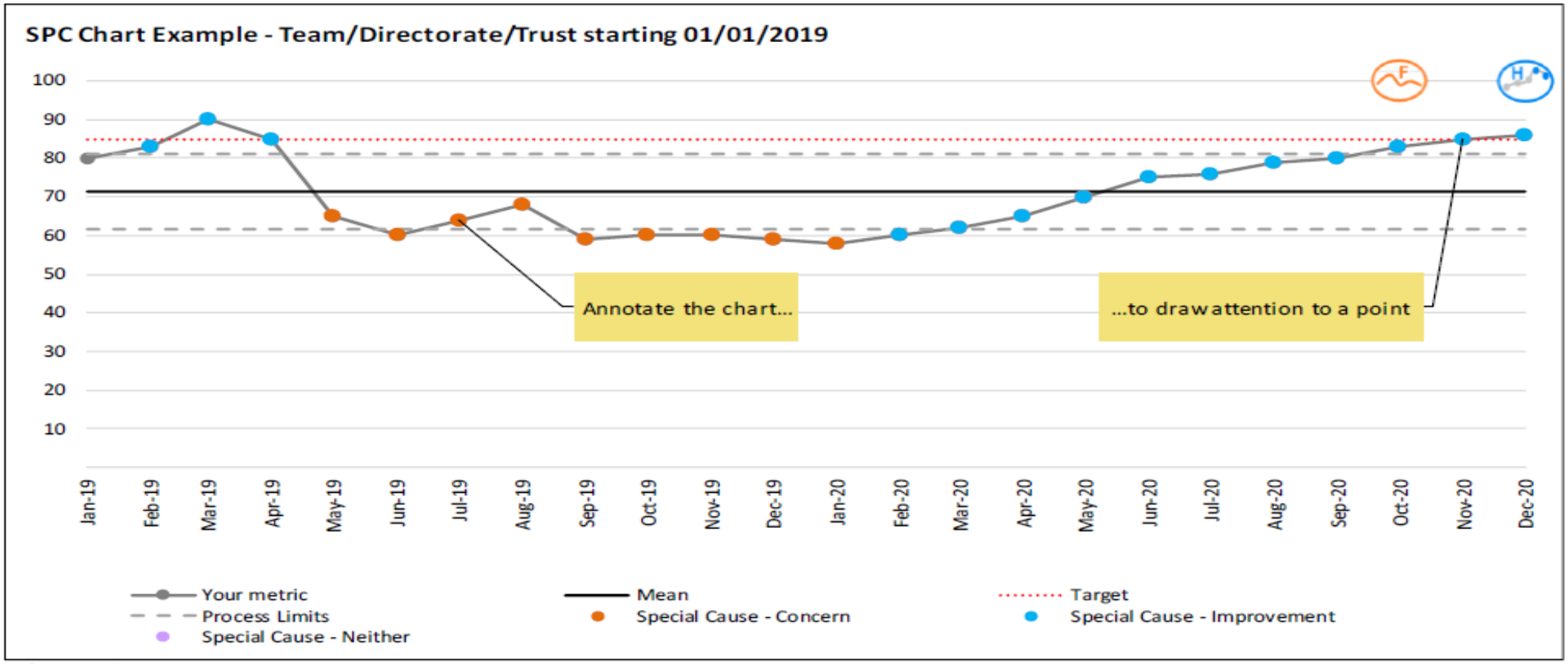
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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