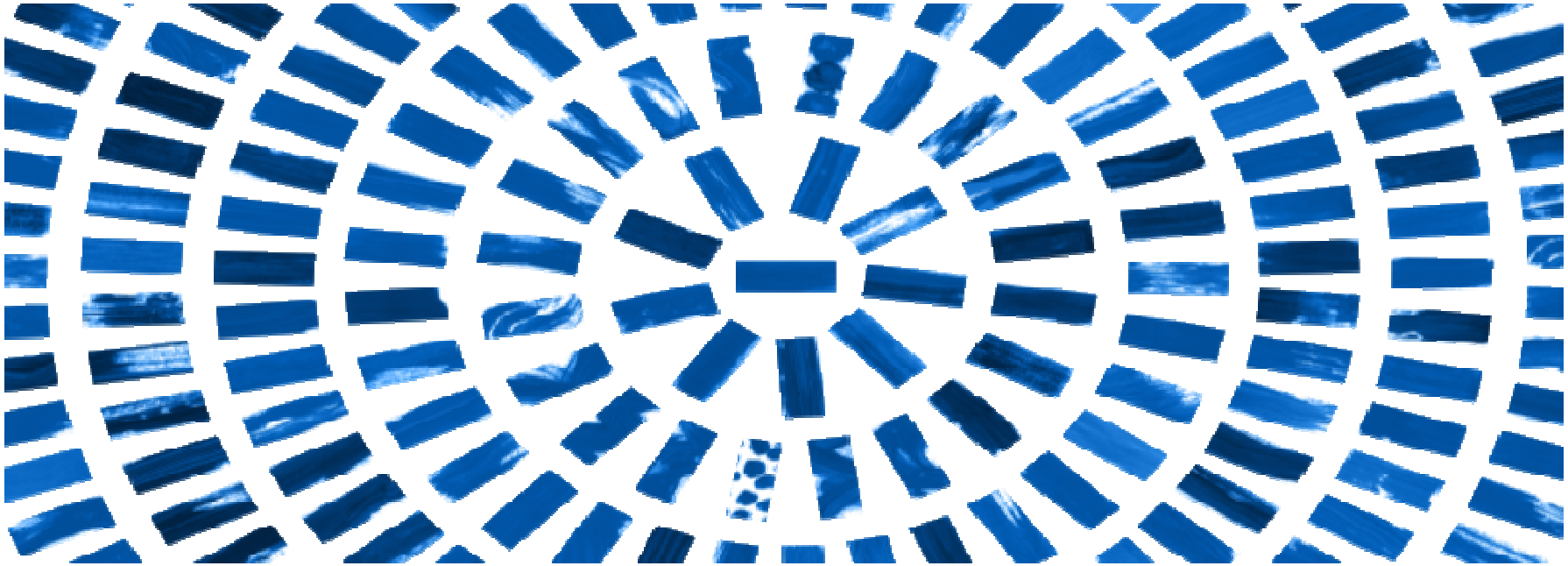
NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview



November 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 November 2024.

The Trust has recently undertaken a refresh of its Strategy and as a result has identified three new strategic aims: We will live our values, We will be the best we can be, We will be ambitious. A deployment plan has been developed to ensure that our strategy is fully embedded into the way we work moving forward. We will identify how and when the areas will be achieved along with the person responsible for the delivery. Work is currently taking place to identify how we will measure progress against these aims and the integrated performance report will be updated as this work progresses. In the interim, we will continue to report against the previous Trust 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 includes metrics contained within the NHS England oversight framework, operational planning guidance and NHS standard contract 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. On 1st October 2024 the Trust acquired Cheswold Park Hospital, which is a 112-bed low and medium-secure mental health hospital based in Doncaster, providing services to male and female patients with a diagnosis of mental illness, personality disorder or neurodevelopmental disorders. Cheswold Park provides services to patients from South Yorkshire Adult Secure Provider Collaborative and placements for patients who may be from out of the area and need the specific treatment pathways the hospital provides. Data will be reported at the end of the Trust's Integrated Performance Report for Cheswold Park Hospital until all systems have migrated fully into the Trust and reporting systems have been amalgamated, expected to be 1st April 2025. 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	↓	H ?
Improving Resources		
Surplus/(deficit) against plan (monthly)	↓	
Capital spend against plan (Cumulative)	↓	
Total pay costs	↑	

Metric	Change from last month	Variation/ Assurance
Improving Care		
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	↑	H F
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	↓	H F
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↑	?
% service users clinically ready for discharge	↓	

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	↑	
Mandatory training - Information governance (IG)	↓	
Sickness absence - YTD	↔	H ?

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

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

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

Care Groups

Children and Families

Metric	Change from last month	Variation/ Assurance
% Appraisal rate	↑	H F
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
Sickness rate (Monthly)	↑	?
Cardiopulmonary resuscitation (CPR) training compliance	↑	F
Reducing restrictive physical interventions training compliance	↑	F

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	H F
% of clients clinically ready for discharge	↔	?
Sickness rate (Monthly)	↑	?
% bed occupancy	↓	↑
% Complaints with staff attitude as an issue	↓	?

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	H F
% of clients clinically ready for discharge	↔	H F
Information Governance training compliance	↓	?
Reducing restrictive physical interventions training compliance	↑	H F
Sickness rate (Monthly)	↓	?

Barnsley Physical Health and Wellbeing

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

Forensic

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

Key

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

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

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

Strategic Objectives & Priorities

The Trust has recently undertaken a refresh of its strategy and as a result has identified three new strategic aims: We will live our values, We will be the best we can be, We will be ambitious. A deployment plan has been developed to ensure that our strategy is fully embedded into the way we work moving forward. We will identify how and when the areas will be achieved along with the person responsible for the delivery. Work is currently taking place to identify how we will measure progress against these aims and the integrated performance report will be updated as this work progresses. In the interim, we will continue to report against the previous Trust four strategic objectives against which our existing performance metrics are designed to measure progress.

• The Trust continues to work to improve the recording and collection of protected characteristics across all services. There is one national indicator which is for ethnicity, the Trust is performing at 96.1% against a target of 90%. For the Trust derived indicators, as of November 2024, disability was at 52.8%, sexual orientation 58.2% and postcode was at 99.6%. The low recording of disability data has two aspects to it, the first is a technical aspect which there have been delays in addressing. The second is related to consistent recording from colleagues when engaging with patients. There are two strands of work in place to address this. 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.

• Completeness of this data helps the Trust ensure that we are providing equal access to all members of our communities.

• 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 are available 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. Whilst we are making progress we are reviewing our Equality Diversity and Inclusion strategy, and as part of this we want to have very clear priorities on our areas of focus and programs of work to tackle health 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. In November, the Trust had 89.3% of services with an up-to-date EIA in place and 100% of policies with an up-to-date EIA. Equality impact assessments show that we are delivering on our public sector equality duty and giving due regard, advancing equality of opportunity and consideration to all those groups protected under the Equality Act 2010 along with carers, for whom the Trust recognise as an added group.

Quality

NHS England Indicators (national)

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

• Continued service improvement work supports the relatively low use of inappropriate out of area bed days, usage in November was 128 days, this remains under the local trajectory of 150 days used based on 5 people being placed out of area. The need for 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. 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. There were 5 people placed in out of area beds as at 30th November 24.

• Linked to bed capacity, the Trust continues to see a higher number of people who are clinically ready for discharge during November, reporting 4.4%. This has an impact on flow and bed capacity as well as individual's recovery. 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. Particular hotspot areas can be seen within learning disabilities and older people mental health services – further detail can be seen within the ward breakdown in the Care group section of the report.

• It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways. Ongoing development work is taking place to meet increases in demand. Regarding the 6 weeks to a diagnostic appointment target 130 out of 211 children (61.6%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in November. This is an improvement on the position reported at the end of October (60.7%). Two bank audiologists have joined the team. Other local services are requesting mutual aid for audiology services, however we have been unable to support this request. The service has set a trajectory for improvement and has prepared a business case for commissioners following a demand and capacity exercise.

Local Quality Indicators

The Trust continues to perform well against the majority of quality indicators; the following should be noted:

Care Planning and Risk Assessments

Risk assessments are integral to providing safe and effective care and making decisions on transition between services. November data shows an improvement in performance for inpatient services whilst performance for community services has deteriorated slightly. Within inpatient services, all service users have a risk assessment with 120 service users having had a risk assessment within 24 hours, a further 8 service users had a completed risk assessment - with 2 of those being between 10-15 hours over the 24-hour standard and 6 of those being 15 hours or more over the 24 hour standard). For community services 33 out of 206 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. Further detail regarding the issues affecting compliance can be seen in the care group section of the report.
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. In addition to this, work is taking place to develop new mental health care plans which will incorporate the staying safe plan from the risk assessment. This will result in new reporting measures for both care plans and risk assessments.

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.

• Neurodevelopment waits remain a concern particularly in Kirklees especially since the additional capacity stopped at the end of March 2024, this is further compounded by vacancies in the team. The service are seeking partners to support delivery of the contracted assessments there is an offer in place to support children and families should they need it whilst waiting. The number of referrals has increased significantly over recent years and months. The shift in demand between providers can be related to the Right to Choose pathways. Between August 2023 and February 2024 fewer families chose Trust child and adolescent mental health services (CAMHS) as other providers had shorter waiting lists. This led to increased waits for other providers and waits for the Trust reduced. Families are now predominantly choosing the shorter wait for CAMHS which has resulted in the large increase in referrals.

• Improvement work on waiting list times in community learning disability services has led to an overall improvement, although the service dipped below the 18 weeks standard for the month of November, reporting 95% against a target of 90%. 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. This leads to lengthy waits.

Patient Safety Indicators

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

• The number of restraint incidents increased to 235 from 187 reported in October. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain 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.

• There 9 incidents of prone restraint, all of these lasted 3 minutes or under. The majority of these incidents occurred on our Psychiatric Intensive Care Unit (PICU) wards and acute mental health wards where high levels of acuity have been reported. The circumstances where prone is used are influenced by the level of concern during the incident. All incidents are reviewed to ensure all opportunities for de-escalation are in please before prone was used. The use of prone has been reducing (further detail in the quality section of the report) but will fluctuate depending on the acuity of service users.

• There were 11 information governance personal data breaches during November. Following the higher number reported in February (20 incidents), messages on good information governance were strengthened. Information governance training compliance threshold has dropped slightly below threshold, the Trust is undertaking work to realign this indicator to the new Data Security and Protection Toolkit which suggests it is based on staff training needs analysis which is currently being undertaken. In the meantime, care groups and support services are monitoring their own performance and ensuring actions are in place where teams are noted to fall below compliance.

• There were 32 inpatient falls reported during the month, this is a reduction on last month (50) and remains well below the national average for inpatient falls of 6.3 per 1000 bed days. We remain vigilant and all falls incidents are reviewed regularly by the Trust wide falls coordinator to ascertain any themes or actions required.

• The number of responses provided within six months of the date a complaint is received has improved to 100% during the month, the improvement work continues.

Our People

• Supervision data is included in the report at Trust level and by care group and inpatient ward. Improvement work has led to supervision remaining above target in November at 85.1%. Supervision means that staff have had access to a supportive conversation about their practice.

• The Trust had 7 violence and aggression incidents against staff on mental health wards involving race during November, which represents a continued reduction from recent months (August – 32, September - 13, October - 8) the focus on further reduction remains. 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. Further detail can be seen in the Strategic Objectives section of the report.

• For the year to date, we have had 336.0 new starters and 260.4 leavers. This is as a result of positive recruitment activity last 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 November 2024, our Trust growth rate remains at 2.6% (staff in post) year to date. This exceeds our annual budgeted growth rate of 0%. Focus remains on keeping our workforce numbers static throughout 2024/25 to meet our planned workforce and financial targets.

• Overall, our 12-month turnover rate in November increased to 7.7% and although has increased sightly from last month, it remains the lowest in a number of years. This 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, staff are working in substantive teams and more service users will receive consistent care from staff that know them.

• Our year-to-date sickness remains at to 5.2% with November sickness reducing to 5.3%. Hotspot areas continue to be managed.

• The appraisal rate has decreased slightly from last month to 88%. 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.

• The number of staff eligible for appraisals has continued to rise as a higher number of staff have now been in the Trust over 12 months following new starters experienced in the last financial year.

• Our overall mandatory training compliance remains above threshold, with the majority of training areas sustaining performance.

• Reducing Restrictive Physical Interventions (RRPI) training remains below threshold though has increased to 78.4%. 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.

• Information governance training remains just below the threshold this month at 94.5% which is a slight reduction from last month (94.6%). This relates to a drop across all care groups except the mental health care group where performance remained the same as previous month. Targeted action is in place to ensure staff are up to date with training.

• 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. Continued high occupancy levels contribute to increased acuity as more people with high levels of distress are admitted. Capacity to meet demand for beds remains challenging.
• The need for additional staff to manage acuity has led to continued use of temporary staffing, primarily bank and use of temporary staffing is being closely monitored by senior managers. Throughout November acute wards have continued to work above establishment.
• 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. The Care Group has completed a trust wide review of the SPA as part of the Improving Access to Care (IATC) priority programme and an action plan is currently being developed. The workforce challenges in SPA have been further compounded in November by a continued number of admin vacancies. Business continuity plans have been implemented as a priority.
• Single point of access (SPA) is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. The access standard for assessed within 14 days of referral has been met in Barnsley and Wakefield. There have been specific challenges with admin vacancies in Calderdale & Kirklees SPA impacting on performance.
• 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 1 patient under the age of 18 years old admitted to an adult bed during the month. 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.

Finance

• The Trust financial target for 2024/25 is breakeven. The current run rate remains a deficit and, although this reduced in October, the Trust continues to spend more than the funding it receives to deliver those services each month. Actions continue to ensure delivery of the target both in the current year and for medium term financial sustainability.
• There was sustained reduction in agency spend in 2023/24. Spend in 2024/25 has fluctuated around a similar level. Spend is £42k less than last month despite the inclusion of agency costs related to Cheswold Park Hospital. The adult secure provider collaborative spend in month was £60k.
• The Trust cash balance has reduced in month. The priority remains timely receipt of income; the majority of this is expected to be received in December 2024.
• The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

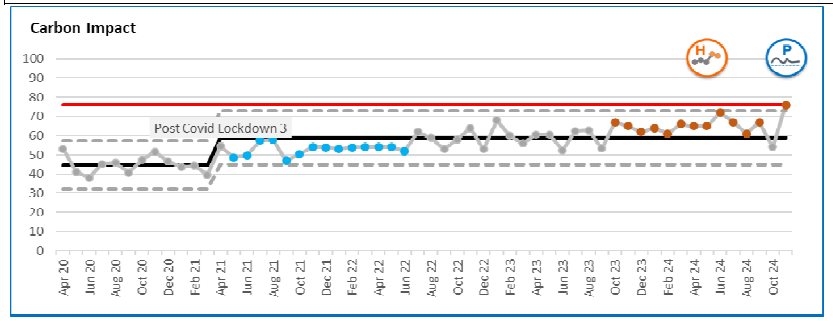
Cheswold Park Hospital

This is the second month the Trust has included Cheswold Park Hospital data, it should be noted that the Trust threshold has been reported against to allow an assessment of performance against the wider Trust. As the mobilisation continues, work will take place to review the data, systems and processes which may impact on reported performance.
• The service has a good level of completeness of disability, sexual orientation, postcode and ethnicity and expect this position to be maintained.
• There were 3 violence and aggression incidents against staff on mental health wards involving race – this is out of a total of 54 violence and aggression incidents during the month (5.5%)
• There were 201 incidents reported during the month, 4 of those resulted in moderate harm.
• There were 6 safeguarding adult incidents that occurred in Cheswold Park Hospital in November 2024, this is a reduction from the 24 reported in October 2024. All incidents resulted in no harm and the most common cause related to violence and aggression, bullying and harassment, patient compliance and drug and medication.
• There were 20 restraint incidents in November 2024, making up 10% (20/201) of total November incidents. There were no incidences of prone restraint during the month.

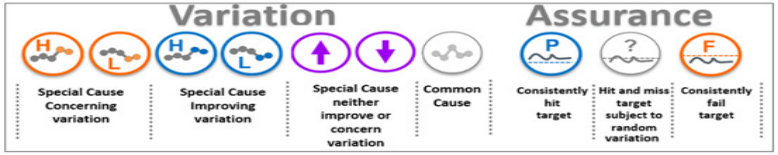
Improving health

Metrics	Threshold	Sep-24	Oct-24	Nov-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	241- All staff (17.1%) 103 - excl medics (8.5%)	247- All staff (17.5%) 109 - excl medics (9.0%)	248- All staff (17.6%) 111 - excl medics (9.2%)		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. 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%	96.4%	96.4%	96.1%		
Percentage of service users who have had their equality data recorded - disability	50%	54.8%	53.9%	52.8%		A statistical approach is being undertaken in order to work out a target that will be adjusted based on actual performance each month. The target continues to be reviewed and future plans for adjustment will continue to be monitored in line with our refreshed strategic aims. Please note that from January 2024 service users under 16 years of age have been excluded from the sexual orientation calculation. Data for disability has been refreshed to include some additional read codes and this has resulted in an increase in overall completeness of this data item and now reports above the 50% threshold.
Percentage of service users who have had their equality data recorded - sexual orientation		59.6%	58.8%	58.2%		
Percentage of service users who have had their equality data recorded - deprivation (postcode)	90%	99.6%	99.6%	99.6%		
Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure)	Service timely completion - 75%	76.7% Service	79.9% Service	89.3% Service		
	Policy - 95%	97.8% Policy	100% Policy	100% Policy		
Completion of equality mandatory training	>=80%	96.5%	96.4%	96.4%		
Number of job start/work retention outcomes during month by individual placement and support service	Trend monitor	16	14	11		A single client could have multiple job starts
Number of new people accessing Individual placement and support service during month	Trend monitor	45	32	36		First contact and work started on vocational profile. Average number of new people per month for the period Apr '24 - Nov '24 is 39, total number year to date is 313.
Carbon Impact (tonnes CO2e) - business miles	76	67	54	76		Data showing the carbon impact of staff travel / business miles. We have seen a further increase in business miles across the Trust during November. On review of the data, this appears to be linked to staff supporting the introduction of services at Cheswold Park Hospital in Doncaster but also across community based services such as Barnsley Neighbourhood teams where we have seen a continued increase in demand for supporting people in their own home. 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%	67.8%	Due March 2025			Q1 - 68.5%, Q2 - 67.8% 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. We remain under threshold, and in November 2024 have re-entered 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.



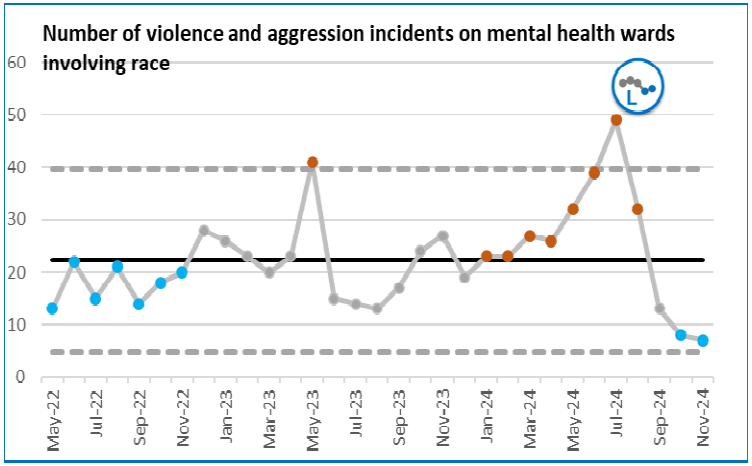
Improve Care

Metrics	Threshold	Sep-24	Oct-24	Nov-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 for Community - Jul/Aug 80% Sept 82.5% Oct 85% Nov 87.5% Dec 90% Jan 92.5% Feb 95%	89.7%	92.6%	*93.8%*	H F	Inpatients - all service users have a risk assessment with 120 service users having had a risk assessment within 24 hours, a further 8 service users had a completed risk assessment - with 2 of those being between 10-15 hours over the 24-hour standard and 6 of those being 15 hours or more over the 24 hour standard. Community services - 33 out of 206 people are showing to not have a risk assessment . Compliance is impacted by the specific order tasks are recorded on SystmOne. The Staying Safe Plan element of the FIRM has to be documented within 7 working days of the first face to face contact that occurs after a patient is placed on CPA. If any of these elements happen in a different order, or the risk assessment is documented differently in the care record, then this would be a breach. 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		76.5%	80.7%	*79.1%*	H F	The Care Plan and Risk Assessment Oversight Group meet monthly, within the group they review performance and quality continually seeking opportunities for improvement. In addition to this, work is taking place to develop new mental health care plans which will incorporate the staying safe plan from the risk assessment. This will result in new reporting measures for both care plans and risk assessments. The new care plans are due to go live Jan '25 and the new metrics planned to go live from Apr 25. Data for November is provisional and will be refreshed in next months report.
% Service users on care programme approach with a plan of care developed collaboratively	85%	96.4%	96.2%	96.2%	P	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 and now reflects the collaborative approach to care planning.
Registered substantive staff in post mental health and learning disabilities services	Establishment - 1315	1,109	1,131	1,128		The establishment numbers reported are registered (band 5 and upwards) nursing staff only within each area. This does not include other specialities or professions. The monthly numbers report the contracted whole time equivalent staff in post. As such this excludes bank and agency staff which may have been utilised to support the operational impact of any gaps (less contract staff than funded).
Registered substantive staff in neighbourhood teams	Establishment - 169	155	159	161		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	13	8	7		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)	Sept - 150 Oct - 155 Nov - 150	138	96	128		National target is zero inappropriate out of area bed days. 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. 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. Data includes all out of area placements regardless of commissioner.
% service users clinically ready for discharge	<=3.5%	4.8%	4.3%	4.4%		Performance in month remains above threshold. 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.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	236	277	273		Neurodevelopment waits remain a concern, especially given the additional capacity 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. The number of referrals remains high. This is due to the Right to Choose pathways. When referrals are screened and deemed clinically appropriate for assessment families are offered the choice of provider, between August 2023 and February 2024 very few families were choosing our Child and Adolescent mental health services (CAMHS) as the other providers had shorter waiting lists. However, these providers wait times increased whilst ours decreased leading to families have choosing our CAMHS resulting in increased referrals and a significant increase in wait times.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	685	701	748		

Improve Care Continued

Metrics	Threshold	Sep-24	Oct-24	Nov-24	Variation/ Assurance	Notes
Learning Disability (LD) - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Improvement trajectory: July/Aug/Sep 86% Oct/Nov 88% Dec onwards 90%	96% 48/50	89% 54/61	95% 58/61		Improvement work on waiting list times in community learning disability services has led to an overall improvement. The learning disability team have robust oversight of all waits and are carrying out profession specific actions to address waits within individual disciplines.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	94.1%	89.8%	93.5%		
Community health services two hour urgent response standard	70%	91.6%	91.7%	88.1%		
Referral to assessment within 2 weeks (external referrals)	75%	86.4%	79.5%	80.2%		

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

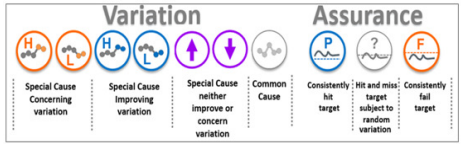


The chart shows that as at November 2024 due to the continued decrease in the number of violence and aggression incidents against staff on mental health wards involving race, we remain in a period of common cause variation.

The Trust Race Forward and race, equality and cultural heritage (REACH) networks have been working to highlight the need for more accurate recording of Datix hate (race) incidents so that a true picture of the impact of these incidents can be seen by the organisation.

The Race Forward Group within the Trust has identified a need to undertake a proactive review of race related hate incidents within the organisation in order to support front line practitioners and leaders to understand clearly their roles and duties when supporting those victim to hate incidents and to empower victims to know what to expect from the organisation in these situations.

Through recent work within the Trust, we have identified that there is under reporting therefore when we have undertaken the foundations for the improvement work around the response to race hate incidents, we are expecting spikes in reporting. The Trust should see these as a positive as previous surveys undertaken and soft intelligence tells us that many incidents have gone unreported.



Improve resources

Metrics	Threshold	Sep-24	Oct-24	Nov-24	Variation/ Assurance	Notes
Surplus/(deficit) against plan (Cumulative)	Breakeven	(£1,009k)	(£624k)	(£790k)		The Trust financial target for 2024/25 is breakeven. The current run rate remains a deficit and, although this reduced in October, the Trust continues to spend more than the funding it receives to deliver those services each month. Actions continue to ensure delivery of the target both in the current year and for medium term financial sustainability.
Capital spend against plan (Cumulative)	£8.1m	£1,894k	£2,115k	£2,504k		The Trust core capital allocation for 2024/25 is £8.1m and performance is monitored against this. There is additional allocations relating to IFRS 16 (leases) and the purchase, and ongoing capital works, for Cheswold Park Hospital. Expenditure for the year to date continues to be behind plan. Progress against all schemes have been reviewed with actions and mitigations being taken to ensure delivery.
Agency spend managed within the overall workforce (Monthly)	3.5% £6.7m	£492k	£620k	£578k		There was sustained reduction in agency spend in 2023/24. Spend in 2024/25 has fluctuated around a similar level. Spend is £42k less than last month despite the inclusion of agency costs related to Cheswold Park Hospital. The adult secure provider collaborative spend in month was £60k.
Financial sustainability and efficiencies delivered over time (monthly)	£22m	£2,066k	£2,145k	£1,440k		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. The mitigations will primarily be realised in March 2025.
Total pay costs	£21,227 (June)	£21,756k	£26,741k	£24,317k		Pay awards, including arrears to April 2024 were paid in October, with the final pay settlements made in November 2024. From October this pay value includes Cheswold Park Hospital.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	6	Due January 2025			
Estates Urgent Response Times - Service level agreement (SLA)	95%	96.8%	95.9%	95.6%		Service level agreements 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 2023 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	Sep-24	Oct-24		Variation/ Assurance	Notes
Turnover external (rolling 12 months)	>12% - 13%<	8.2%	7.6%	7.7%		Turnover continues to remain at a low level compared to previous months. There has been an overall reduction since October '23. This can be linked to work undertaken on cost efficiencies including internal vacancy recruitment panel establishment and recruitment freeze in other Trusts which are resulting in less opportunities being available.
Registered workforce growth	0% 2024/25	2.6%				This measures the difference between the number of full time equivalent staff at end of March 2024 compared to the number of full time equivalent staff at end of the reporting period.
Sickness absence - YTD	<=5%	5.1%	5.2%	5.2%		Further detail around sickness absence is provided in the relevant section of this report.
Workpal appraisals - rolling 12 months	95%	89.1%	89.4%	88.0%		The appraisal rate has deteriorated sightly this month and remains below trajectory. The impact of strong recruitment numbers last year means that more staff are now eligible for appraisal. Every Care Group (including Support Services) has improved it's uptake rates from last month. The number of staff eligible for appraisals has continued to rise as a higher number of staff have now been in the Trust over 12 months following new starters experienced in the last financial year.
% 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%	84.1%	84.0%	85.1%		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) August and September data has been refreshed.
Mandatory training - Cardiopulmonary resuscitation	80%	82.0%	81.3%	82.2%		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 practice interventions (RRPI)	80%	76.1%	76.7%	78.4%		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%	90.5%	90.4%		Threshold increased from >=80% in June 24.
Mandatory training - Information governance (IG)	95%	94.7%	94.6%	94.5%		

Quality Headlines

Section	KPI	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	TBC	86.0%	84.6%	84.5%	83.3%	83.4%	82.9%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	< 20%	6% (1/18)	0% (0/11)	32% (7/22)	33% (8/24)	16% (5/31)	24% (7/29)	1
	Complaints - Number of responses provided within six months of the date a complaint received [16]	100%	50% (2/4)	81% (13/16)	66% (6/9)	85% (11/13)	71% (17/24)	100% (12/12)	
Service User Experience	Friends and Family Test - Mental Health	84%	91%	92%	93%	90%	94%	92%	1
	Friends and Family Test - Community	95%	96%	98%	97%	97%	96%	97%	1
Quality	Number of compliments received	N/A	7	65	92	54	66	27	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	9	7	12	7	4	5	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	1	0	1	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	0	0	0	0	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	95.4%	96.2%	96.2%	96.4%	96.2%	96.2%	1
	Number of Information Governance breaches [3]	<12	9	5	6	5	8	11	2
	% of inpatients clinically ready for discharge	3.5%	2.7%	3.8%	4.9%	4.8%	4.3%	4.4%	3
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% *Improvement trajectory for Community - Jul/Aug 80%, Sept 82.5%, Oct 85%, Nov 87.5% Dec 90%, Jan 92.5% Feb 95%*	94.1%	93.1%	91.9%	89.7%	92.6%	*93.8%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		76.5%	85.0%	76.2%	76.5%	80.7%	*79.1%*	2
	Total number of reported incidents	Trend monitor	1301	1484	1434	1301	1253	1240	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	25	22	34	39	28	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	5	8	3	2	5	0	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	1	1	0	1	0	2	
	Safer staff fill rates	90%	132.5%	132.4%	131.3%	129.4%	131.2%	134.0%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	101.8%	101.4%	98.6%	99.0%	100.0%	104.0%	1
	Number of pressure ulcers which developed under SWYPFT care [1]	Trend monitor	25	43	42	56	32	19	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement [2]	0	1	1	0	0	1	0	
	Eliminating Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less [8]	90%	100% (5/5)	72.7% (8/11)	100% (14/14)	92.3% (12/13)	92.3% (12/13)	100% (9/9)	1
	Number of Falls (inpatients)	Trend monitor	63	50	53	47	50	32	
	Number of restraint incidents	Trend monitor	153	195	257	196	187	235	
	% of staff receiving supervision within policy guidance [15]	80%	83.9%	85.6%	84.0%	84.1%	84.0%	85.1%	2
	Potential under-reporting of patient safety incidents								
	% people dying in a place of their choosing [14]	80%	90.6%	87.9%	87.5%	87.1%	86.5%	97.3%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	1	0	0	1
	C Diff avoidable cases	0	0	0	0	1	0	0	1
	E. Coli bloodstream infection rate	0	0	0	0	1	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	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. Please note, the wording of this metric has changed from the November 24 report to align with wording used in the national reporting.
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 October.
• The overall number of restraint incidents in November was 235 which is within acceptable range although the Trust is seeing an overall increase in incidents. 56 of these incidents were attributed to Melton ward. 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.
• % of feedback with staff attitude as an issue - there were 7 in November. A piece of work is taking place to look at how these complaints are captured and categorised and to identify early learning from issues as they emerge.
• Complaints - Number of responses provided within six months of the date a complaint received – reporting against this metric aligns to the NHS Complaints (England) Regulations 2009 stating that complaints should be responded to/closed within 6 months of the date received. The Trust is undertaking work to review the time taken for complaints to be investigated and responded to, to help understand any areas for improvement and how this can be monitored locally. All 12 complaints responded to during the month, were undertaken within 6 months of complaint being received. Before the response is sent back to complainant, sign off is required which includes formulation of a written response and review by the customer services office manager, following a review by the Care Group trio (general manager, clinical lead and quality and governance lead), the director of service, an executive director and final sign off from the Chief Executive. Complaints vary in complexity and this is sometimes reflected in the amount of time taken to investigate and to move through the sign off process
• Clinically ready for discharge (previously delayed transfers of care) - This has increased slightly to 4.4% and remains above threshold. There are still a significant number of people who are delayed which may impact on performance in future months and further detail regarding hotspot areas can be seen in the care group and ward level sections of this report.
• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. In November there were 32 inpatient fall incidents. Actions have been put in place to further reduce the risk. Further detail is provided in the relevant section of this report.

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 Trust's PSIRF plan and policy went live on the 1st December 2023.

Since the launch of PSIRF on 1 December 2023, we have:
• Reviewed linked policies and procedures
• Assisted care groups in conducting their first learning response.
• Reviewed incidents against our PSIRF Plan
• Supported services with care group Patient Safety Oversight Group (PSOGs)
• Developed the format of the PSOG to align with PSIRF
• Updated Datix to reflect our processes for PSIRF

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

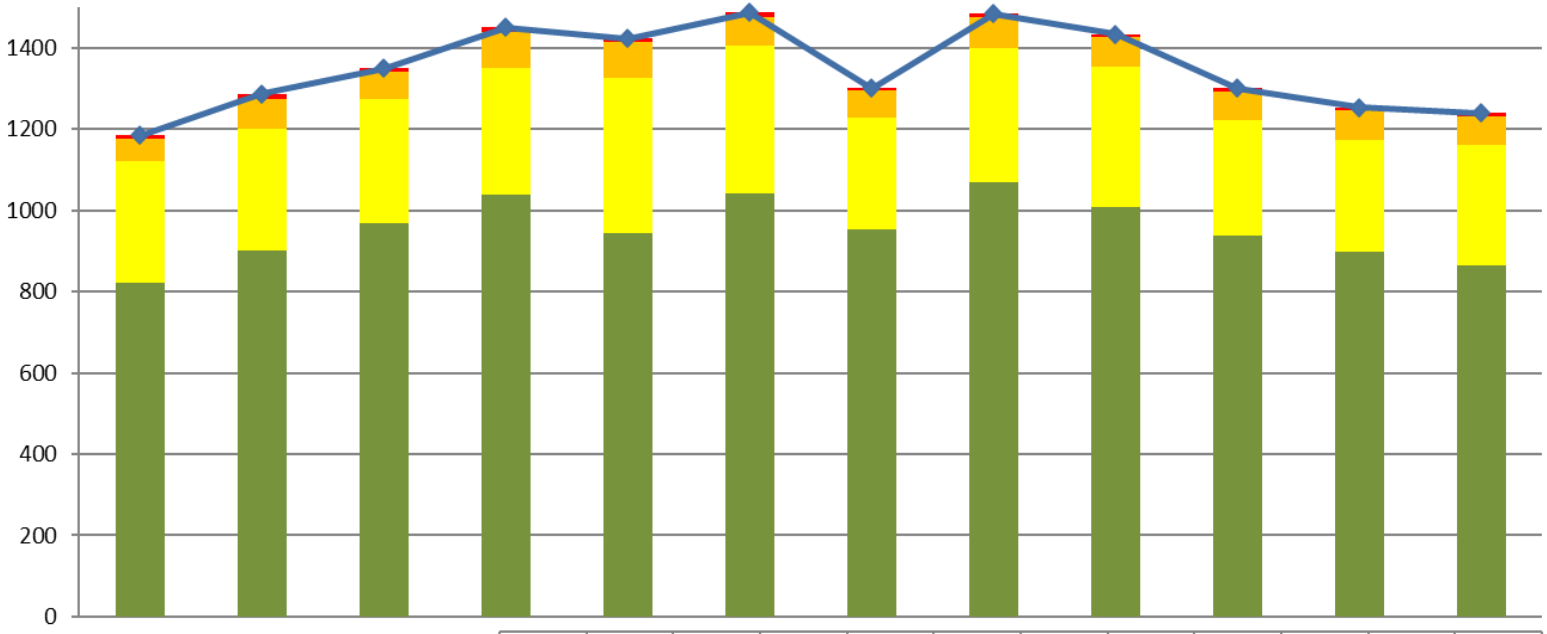
Safety Incident Response Accreditation Network (SIRAN)
The team are currently undertaking the SIRAN accreditation.

Safety First

Summary of Incidents

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

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



	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Red (should not be compared with SIs)	9	14	9	12	8	12	7	9	7	8	8	9
Amber	54	73	65	88	88	71	66	75	74	70	73	71
Yellow	301	300	308	312	383	363	275	331	344	284	274	296
Green	821	900	967	1038	944	1041	953	1069	1009	939	898	864
Total	1185	1287	1349	1450	1423	1487	1301	1484	1434	1301	1253	1240

Safety First cont…

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

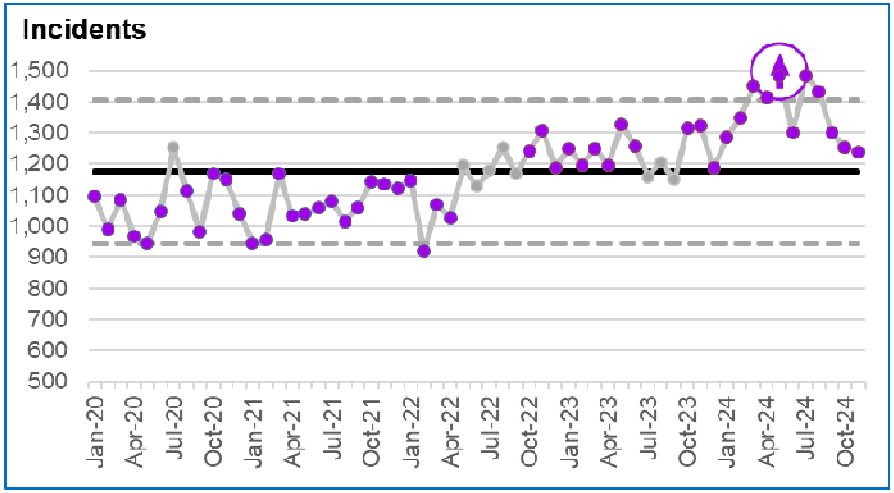
Breakdown of incidents in November 2024

25 moderate harm incidents:

The most common incidents were pressure ulcers. The moderate harm pressure ulcers have been reviewed, the service have seen an upward trend in all category 3 pressure ulcers since July 2024. The service are doing a deep dive into this to better understand contributing factors and to help to determine opportunities for prevention of escalation in category.

Sadly there have been two patient safety related deaths in November 2024.

Incidents



We remain in a period of special cause variation (something is happening and this should be investigated) in November due a continued increase in the number of incidents, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low harm incidents remains high as it does which is evidenced on the previous page. All incidents are reviewed by the care group management team and then by the Patient Safety Datix team to review the actual degree of harm to ensure consistency with national reporting. All amber and red incidents are monitored through the weekly Trust Clinical Risk Panel and all serious incidents are investigated using systems analysis techniques. Learning is shared via a number of routes; care group learning events following a Serious Incident, specialist advisor forums, quarterly trust wide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

Learning Library

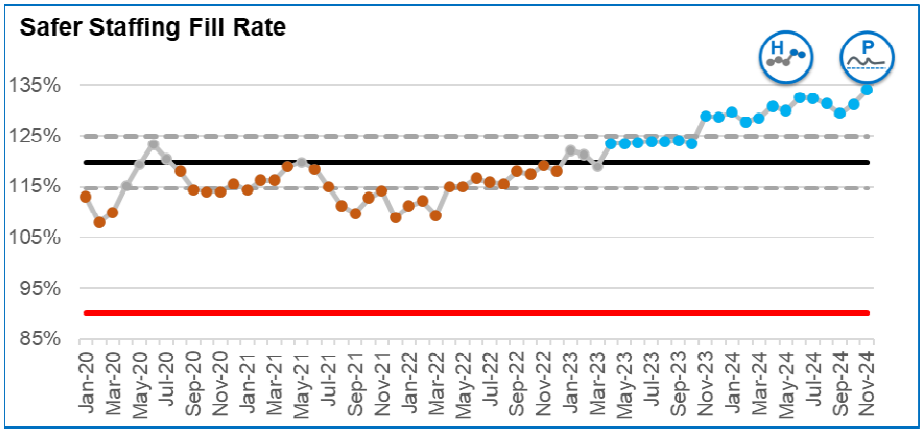
The learning library has been developed as a way to gather and share examples of learning from experience.
Further examples can be found on the SWYPFT intranet page.

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

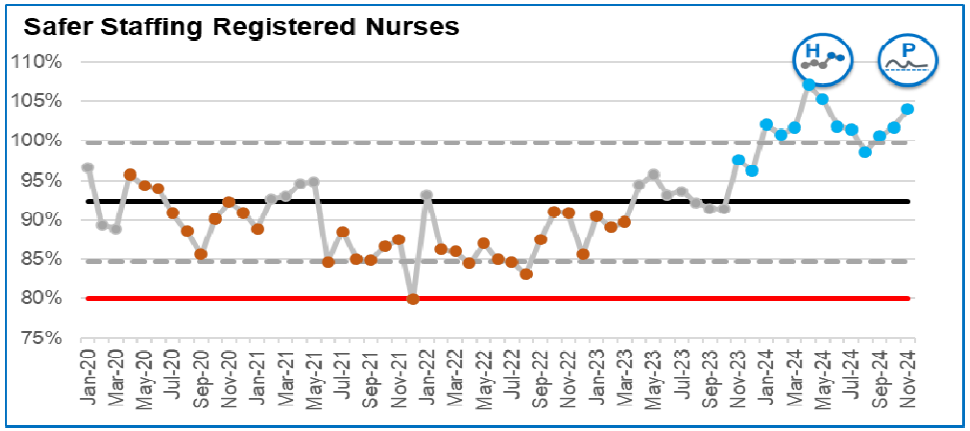
Patient Safety Alerts

There were no patient safety alerts that were not completed by deadline in November 2024.

Safer Staffing Inpatients



The chart above shows that as at November 2024 due to the continued increasing staffing fill rate, we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are expected to meet the target.



The chart above shows that in November 2024, due to the continued increase in the registered nurses fill rate, we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are expected to meet the target.

- There was a slight increase in November on demand which appears to be seasonal based on the demand this time last year.
- Within the flexible staffing pool there were a total of 31 more shift requests, however the overall fill rate decreased slightly to 91.33%.
- Following the successful recruitment campaigns for band 5s throughout '23/'24 we have received 244 less requests for Registered Nurses (RNs) this November in comparison with 2023.
- Within overall fill rates there was an increase in the fill rates of Adult and Older Peoples Care Group of 2% to 141%, Forensic and LD Care Group saw an increase of 6% to 126% whilst Barnsley Integrated Services decreased by 2% to 112%.
- We continue to scrutinise flexible staffing usage in our temporary staffing scrutiny and e-rostering groups.
- We have stopped registering any new agency Health Care Assistant (HCA) staff onto our systems which is in line with the reduction of agency spending.
- We will be proposing to introduce a zero tolerance approach to agency usage for band 2 in the new year.
- 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 2.8% to 134.0%. The day fill rate for RNs increased by 3.6% to 104.0%. Three wards, Lyndhurst in the Adult and Older Peoples care group, Hepworth and Priestley within the Forensic and LD Care Group, fell below the 90% RN day fill rate. They were supported through local escalation plans.
- In November no wards fell below the 90% overall fill rate threshold.

Safer Staffing Inpatients cont…

Registered Nurses Days
There was an increase of 3.6% in overall registered day fill rates to 104.0% in November compared with the previous month.

Registered Nurses Nights
There was an increase of 1.4% in overall registered night fill rates to 117.7% in November compared with the previous month.

Overall Registered Rate: In November the overall registered fill rate increased by 3.9% to 105.6%.
Overall Fill Rate: 134% (an increase of 3% on the previous month)

Registered day rate	Sep-24	Oct-24	Nov-24
Adults and Older People	99%	101%	104%
Barnsley Integrated Services	130%	136%	133%
Forensic and LD	94%	93%	99%
Overall shift fill rate	**99%**	**100%**	**104%**

Registered night rate	Sep-24	Oct-24	Nov-24
Adults and Older People	114%	113%	113%
Barnsley Integrated Services	101%	100%	105%
Forensic and LD	116%	124%	127%
Overall shift fill rate	**114%**	**116%**	**118%**

Overall Fill Rate	Sep-24	Oct-24	Nov-24
Adults and Older People	136%	139%	141%
Barnsley Integrated Services	108%	114%	112%
Forensic and LD	122%	120%	126%
Grand total	**129%**	**131%**	**134%**

• Bank staff filled 82.27% (a decrease of 0.13% on the previous month) of Registered Nurse requests for flexible staffing and 81.22% (an increase of 0.29% on the previous month) of Healthcare assistant requests.
• Agency staff filled 6.85% (a decrease of 0.73% on the previous month) of Registered Nurse requests for flexible staffing and 10.58% (a decrease of 1.68% on the previous month) of Healthcare assistant requests.

Information Governance (IG)

11 personal data breaches were reported during November 2024, which is slightly lower than the number reported during October but remains a concerning level.

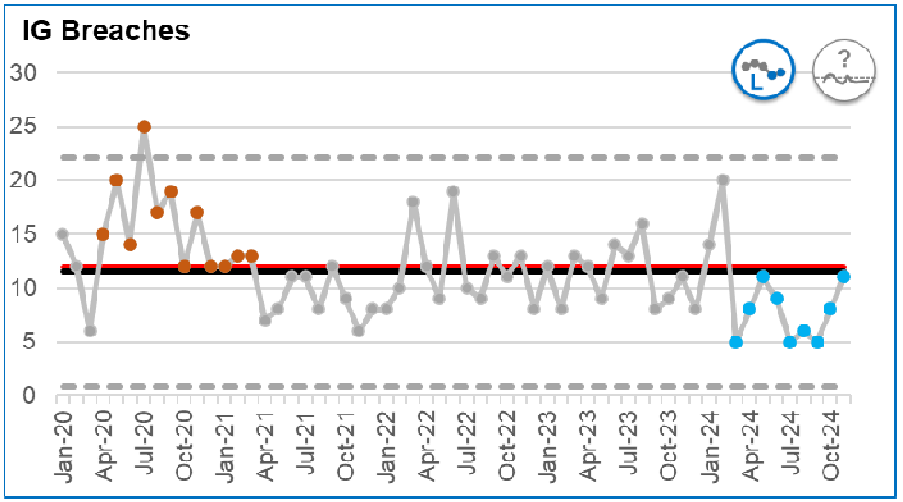
Information disclosed in error continues to be the highest reported category. Breaches during November were due to:

- Letters sent to the wrong recipient or wrong address
- Sharing with unauthorised third parties
- Emails sent to the wrong recipients
- Pre-completed questionnaires being sent out
- Paper personal data found in furniture received from surplus stock
- Service users overhearing confidential conversations
- Failure to correctly identify service user leading to sharing of personal data about another person with same name

An amber incident was reported when a sensitive report was sent to the wrong address and opened by the recipient, who later passed it on to the correct recipient. The affected party has reported harm and is now pursuing a legal claim against the Trust. The incident has been reported to the Information Commissioner's Office.

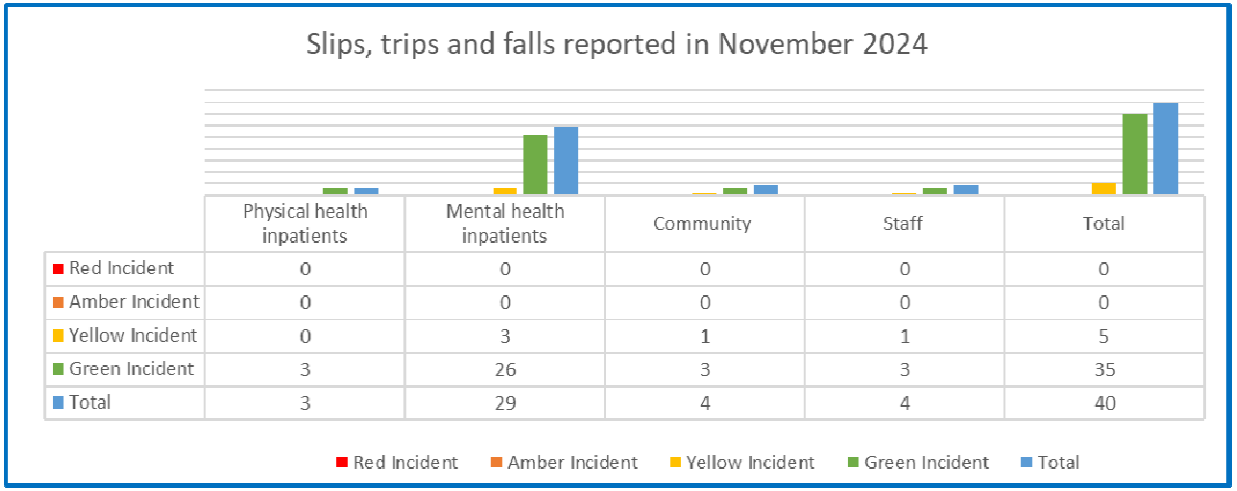
A communications campaign continues to remind staff of the need for accuracy and their personal responsibilities when sharing personal information.

This SPC chart shows that as at November 2024 we remain in a period of special cause improveing variation (something is happening and this should be investigated).



Trustwide Falls

In November 2024, a total of 40 slips, trips, and falls were reported. 32 of these were in inpatient wards.
November has reported 29% less falls than in September and October 2024. We continue to be below the national average for inpatient falls of 6.3 per 1000 bed days



	Physical health inpatients	Mental health inpatients	Community	Staff	Total
Red Incident	0	0	0	0	0
Amber Incident	0	0	0	0	0
Yellow Incident	0	3	1	1	5
Green Incident	3	26	3	3	35
Total	3	29	4	4	40

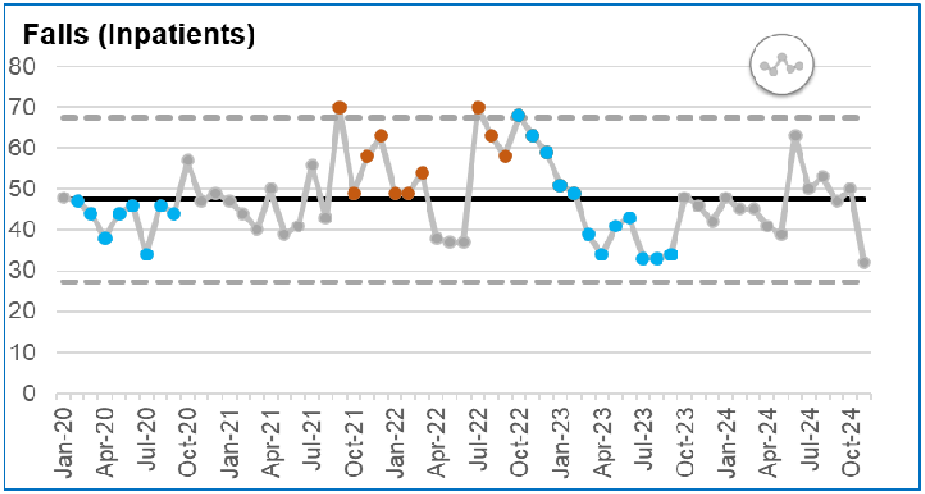
- Patients experiencing slips, trips, and falls are receiving a high level of multidisciplinary assessment and intervention.
- 100% of patients identified of having a history or risk of falling received a physiotherapy assessment
- Post-falls protocol completion has averaged 100% this month, with a continued good response from staff
- 87% of patients had a good quality falls risk screen (FRAT-18) completed within 24 hours of admission. 3 FRAT-18 were completed after 24 hours of admission. One person under 65 deemed high risk of falls had no FRAT-18, but a physiotherapist had reviewed and a care plan was in place

Incident Grading
No red or amber incidents.
Yellow: A total of 5 (12.5%) reported safety events needing higher levels of intervention. 1 of these reported falls occurred whilst the patient was on leave from the ward.
Green: A total 35 (87.5%) reported safety events had low, or no harm recorded. 4 of these reported falls occurred whilst the patient was on leave from the ward.

Inpatient falls had a high correlation with:
- 17 falls (59%) occurred in patients with no history of falls. There were slips related to icy weather when off the ward, smoking cigarettes that caused dizziness, falls with no predisposing factors found
- 17 falls (59%) occurred in patients below the age of 65 years. These falls were linked with self-harm behaviours, rolling out of bed, feeling drowsy, agitation, slipping on ice on leave from ward
  - 6 of those falls (35%) occurred in patients with a diagnosis of young onset dementia
- 15 falls (52%) occurred for patients with a diagnosis of dementia
  - 6 of those falls (40%) were due to 2 patients who had repeated falls. Both have received a full multidisciplinary review and interventions to reduce risk are in place
  - 9 of those falls (60%), the patient also had a recognised physical frailty

Falls (Inpatient)

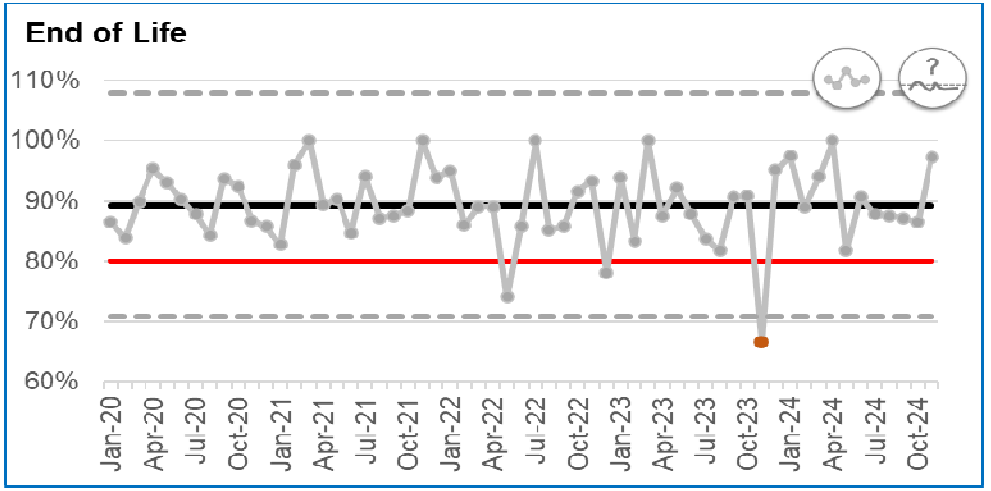
The total number of inpatient falls was 32 in November.



The SPC chart above shows that in November 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 97.3% in November. 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 November 2024 the performance against this metric remains in common cause variation (no concern). As the mean performance for this measure is high (90%), the upper control limit (based on the average of the moving range) shows as above 100%.

Patient Experience

Friends and family test (FFT) shows

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

	Target	September	October	November
Mental health community	85%	92% (140)	95% (333)	90% (188)
Mental health inpatient	85%	95% (43)	86% (63)	98% (46)
Learning Disabilities	85%	100% (5)	100% (23)	94% (18)
ASD/ ADHD	85%	71% (17)	100% (19)	92% (12)
CAMHS	75%	90% (30)	93% (28)	94% (34)
Forensic	60%	72% (14)	100% (2)	N/A (0)
Mental health overall	84%*	**90% (249)**	**94% (468)**	**92% (298)**
Barnsley Physical Health	95%	**97% (319)**	**96% (311)**	**97% (259)**
Trustwide	**85%**	**94% (568)**	**95%(779)**	**94% (557)**

** weighted for 2023/24*

	Top three positive themes	Top three negative themes
Trustwide	1. Staff	1. Staff
	2. Communication	2. Admission & discharge
	3. Patient Care	3. Communication
Physical Health	1. Staff	1. Staff
	2. Communication	2. Admission & discharge
	3. Access & waiting times	3. Clinical treatment
Mental Health	1. Staff	1. Staff
	2. Communication	2. Communication
	3. Patient Care	3. Admission & discharge

The satisfaction Trustwide and in community mental health services has declined slightly, although remains within target.

Satisfaction has increased in Barnsley physical health services, mental health inpatients and CAMHS.

Satisfaction in mental health community, learning disabilities has declined, although remains within target.

The satisfaction across CAMHS has continued to increase for the past three months.

All service lines remain above target.

Forensic services received no friends and family test feedback for November.

Safeguarding

Safeguarding Adults:
In November 2024 there were 44 Datix categorised as safeguarding adults, 17 were categorised as green, 24 were categorised as yellow, three amber incidents and no red Datix. The most common subcategories of these were domestic abuse, psychological/emotional abuse and physical abuse.

In addition to the safeguarding adults Datix, there were 25 sexual safety Datix; These were 19 green incidents, six yellow and one amber.

Safeguarding Children:
In November 2024 there were 19 Datix submissions categorised as Safeguarding Children. One was classified as Amber, eight were classified as yellow incidents and 10 were classified as green incidents. This is an increase in incident reporting from October however there were no red incidents reported. The most common subcategories of these were child protection and neglect.

Complaints

- There were 29 new formal complaints received during November. This is a decrease from October but remains within normal volumes.
- Of these complaints 7 have values and behaviours (staff) identified as a primary reason for the complaint. This is an increase from 5 in October.
- 100% of responses provided in November were within the six month statutory timeframe. This is the first time 100% has been achieved for a number of years.
- There were 12 complaint responses sent during November.
- At the end of November there were seven complaints waiting allocation to a customer services officer. The customer services team are working to ensure that these are allocated as quickly as possible
- The Trust received 27 compliments during November.

Infection Prevention Control (IPC)

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

Outbreaks - November 2024
- Two outbreaks in inpatient wards; one Covid-19 and one Influenza A

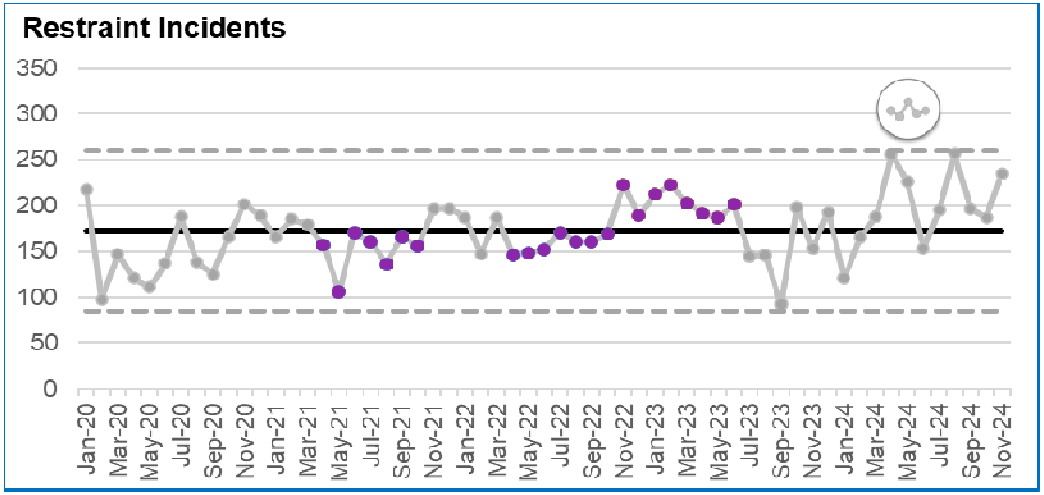
Reducing Restrictive Physical Intervention (RRPI)

• There were 235 reported RRPI incidents in November 2024 this was an increase of 48 (25.6%) from October 2024 which stood at 187.
• In 2024 prone restraint (those remaining in prone position and not rolled immediately) was reported nine times a reduction of four (30.7%) from October 2024 which stood at 13.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	99	29.5%
Safety Pod	72	21.4%
Side	56	16.7%
Seated	42	12.5%
Supine - held on their back, regardless of surface	33	9.8%
Restricted escort	10	3.0%
Prone descent then remained in chest down position	8	2.4%
Prone descent then immediately rolled to other position side/back	6	1.8%
Kneeling	5	1.5%
Service User placed self in prone and staff immediately let go or rolled	4	1.2%
PILOT AREAS ONLY v3 Safety Pod Technique (IM administration then exit)	1	0.3%

Team Using Prone Restraint	Nov-24
Melton PICU, Barnsley	2
Stanley Ward, Wakefield	2
Nostell Ward, Wakefield	2
Bronte Ward, Newton Lodge, Forensic	1
Clark Ward - Barnsley	1
Walton PICU	1

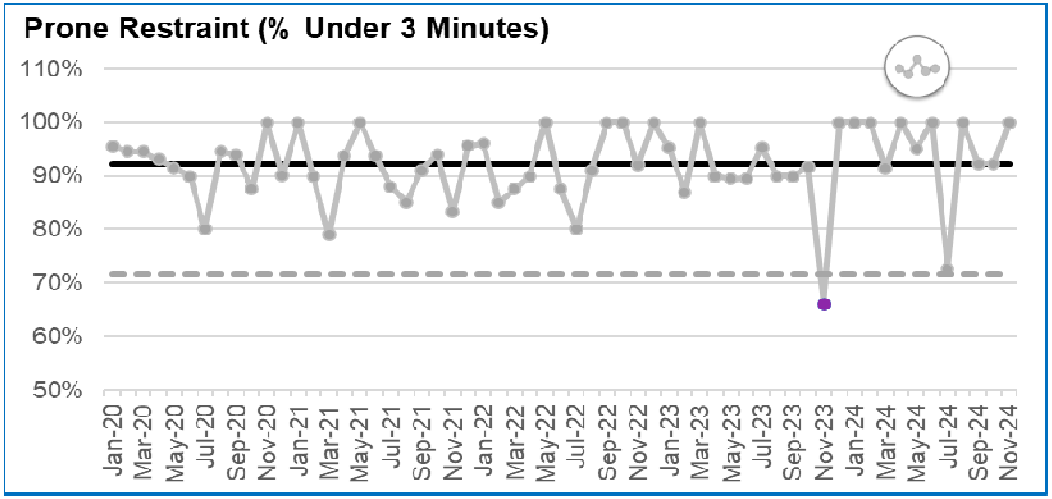
Duration of Prone Restraint	Nov-24
0 - 1 minute	7
1 - 2 minutes	1
2 - 3 minutes	1



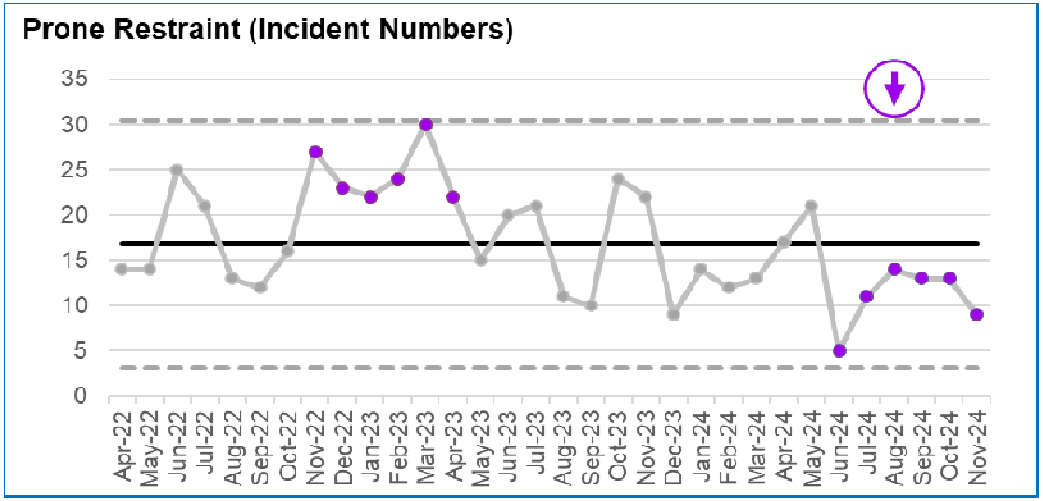
This SPC chart shows that in November 2024 we remain in a period of common cause variation (no concern).

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

Reducing Restrictive Physical Intervention (RRPI)



The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication.



The number of prone restraints has decreased slightly in November 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	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Establishment	Improving Resources	Well Led	-	5459.1	5461.6	5451.4	5460.1	5512.2	5520.5
Contracted Staff In Post (Ledger)			-	4673.6	4688.2	4720.5	4738.8	4738.9	4756.6
Vacancies			-	785.5	773.3	730.9	721.4	773.3	763.9
Turnover external (12 months rolling)			>12% - <13%	9.4%	9.7%	8.0%	8.2%	7.6%	7.7%
Starters			-	34.8	39.0	37.4	56.6	40.0	35.7
Leavers			-	27.2	23.1	41.4	51.3	28.6	35.6
International Nurse Starters in Month			-	0	0	0	0	0	0
% Bank Fill Rates - Registered Nurses			-	79.3%	79.3%	79.3%	80.6%	82.4%	82.2%
% Bank Fill Rates - Health Care Assistants			-	87.0%	83.1%	82.1%	82.6%	80.9%	81.2%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)			-	94.1%	93.6%	92.9%	92.8%	92.6%	91.3%
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) *			-	228 - All staff (16.5%) 99 - excl medics (8.3%)	232 - All staff (16.8%) 101 - excl medics (8.5%)	240 - All staff (17.1%) 105 - excl medics (8.7%)	241- All staff (17.1%) 103 - excl medics (8.5%)	247- All staff (17.5%) 109 - excl medics (9.0%)	248- All staff (17.6%) 111 - excl medics (9.2%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)			-	958 (71.4%)	984 (71.1%)	996 (70.9%)	998 (70.7%)	1003 (71.2%)	1003 (71.2%)
Sickness absence - YTD			<=5% from June 24 was <=4.8%	5.0%	4.9%	5.0%	5.1%	5.2%	5.2%
Sickness absence - Month				4.8%	5.2%	5.1%	5.5%	5.5%	5.3%
Employees with long term sickness over 12 months			-	4	0	1	1	4	2
Appraisals - rolling 12 months			Jun 24 - 89% Jul 24 - 91% Aug 24 - 93% Sep 24 onwards 95%	84.4%	85.0%	86.7%	89.1%	89.4%	88.0%
Employee Relations - Suspensions (over 90 days)			-	1	1	1	1	1	1
Mandatory Training - TOTAL	Improving Care		>=80%	92.6%	93.0%	93.2%	93.0%	93.0%	93.2%
Mandatory Training - Reducing Restrictive Practice Interventions				72.8%	74.9%	75.8%	76.1%	76.7%	78.4%
Mandatory Training - Cardiopulmonary Resuscitation				80.3%	80.2%	80.7%	82.0%	81.3%	82.2%
Mandatory Training - Clinical Risk				93.3%	94.2%	95.2%	95.3%	94.9%	95.1%
Mandatory Training - Display Screen Equipment				97.1%	97.3%	97.6%	97.9%	97.7%	98.0%
Mandatory Training - Equality & Diversity				96.7%	97.2%	97.0%	96.7%	96.4%	96.5%
Mandatory Training - Fire Safety			>=85% (from June 24)	90.8%	91.1%	90.8%	90.4%	90.5%	90.4%
Mandatory Training - Food Safety			>=80%	91.1%	90.9%	91.0%	92.0%	92.2%	91.4%
Mandatory Training - Freedom To Speak Up (FTSU)				95.9%	96.1%	96.3%	96.5%	96.5%	96.9%
Mandatory Training - Infection Control & Hand Hygiene				94.3%	94.9%	94.6%	94.5%	94.4%	94.9%
Mandatory Training - Information Governance (Data Security)			>=95%	95.5%	95.7%	95.5%	94.7%	94.6%	94.5%
Mandatory Training - Moving & Handling			>=80%	97.7%	97.6%	97.9%	97.7%	97.5%	97.7%
Mandatory Training - Nat Early Warning Score 2 (New S2)				94.8%	95.2%	96.1%	97.0%	97.1%	97.6%
Mandatory Training - Mental Capacity Act/Dols				90.2%	90.6%	90.7%	90.6%	90.5%	90.6%
Mandatory Training - Mental Health Act				87.7%	88.0%	88.4%	88.1%	87.9%	87.7%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				86.0%	87.6%	89.0%	89.9%	90.5%	91.4%
Mandatory Training - Prevent			>=80%	94.7%	95.1%	95.0%	95.4%	95.3%	95.5%
Mandatory Training - Safeguarding Adults				89.4%	88.8%	89.2%	90.4%	90.0%	89.9%
Mandatory Training - Safeguarding Children				95.2%	95.4%	95.5%	92.4%	92.4%	92.5%

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
• We have seen a slight increase in our overall staff in post in November.

Vacancies
• Our recruitment team have recruited 34 staff in November, 11 of these were additional clinical services (Health Care Assistants)

Turnover
• Turnover has increased to 7.7% and although slightly higher than last month, this is the lowest position the Trust has seen in several years. It can be assumed this is as a result of less positions being recruited to across the NHS due to limitations on funding.

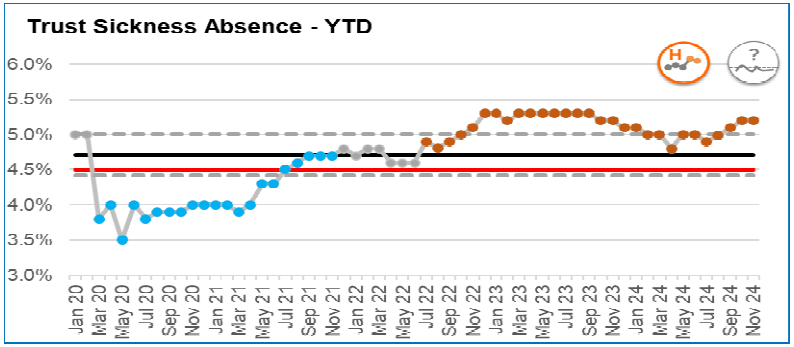
Stability
• Although stability has dropped slightly this month, it still remains above the 90% threshold, which indicates our employees are staying with us.

Sickness (Overall)
• The sickness absence rate (5.3%) has dropped this month compared to last month and is higher than this time last year (4.9%).
• Learning Disability & Attention Deficit Hyperactivity Disorder is the only care group which has increased in absence which appears to be due to short term absence.
• Sickness absence reasons of cold and flu remain at 1% which is the same as last month. This is the same absence rate as November 2023.
• Although there are less episodes of gastro related absences since October, the overall absence rate has increased in November. This suggests individuals with gastro related absences in November are absent for a longer period of time.

Appraisal Compliance
• The learning and development team and People Business Partners continue to work closely with managers in care groups and support services on ensuring that out of date appraisals are prioritised.
• Appraisal “power hours" have been run across a number of care groups and support services now and will continue to allow managers and staff to resolve issues with appraisals
• Appraisal compliance has dropped from 89.5% to 87.7%. Large number of appraisals due from November 2023 (resulting in them being due again in November 2024) and also unplanned system downtime for a week during the month. the months performance has also been impacted by the reduced capacity of the human resource people business partners due to sickness absence and a focus on Cheswold activity - capacity will increase in the New Year and focus will be targeted on those areas where the rates have reduced.

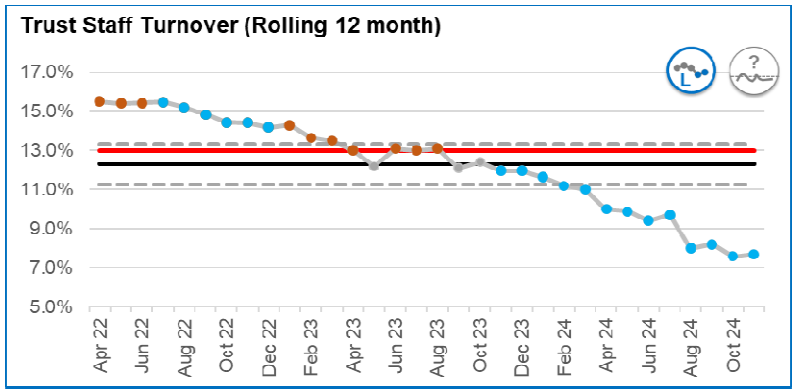
Training Compliance
• Slight increase in training compliance to 93.3%
• Continued focus on Reducing Restrictive Practice Interventions training with training needs analysis for 2025 under way and compliance at 86%. The learning and development team continue to work closely with Reducing Restrictive Physical Interventions team to flag issues and increase attendance at courses. The number of do not attends do remain an issue and the communications team have been circulated on this.

Statistical process control charts

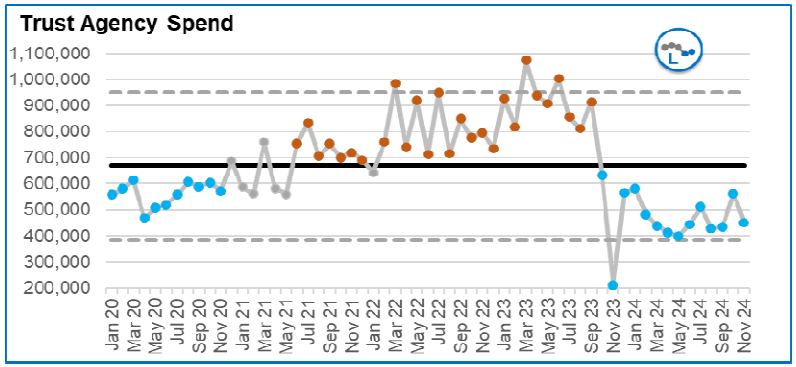


The SPC chart shows that in November 2024 we remain in a period of special cause concerning variation (something is happening and this should be investigated).

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



The SPC chart shows that in November 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.



The SPC chart shows that in November 2024 we remain in a period of common cause improving variation (something is happening and this should be investigated) following a sustained decrease in agency spend.

Please see finance section for further detail on agency spend.

National Metrics

Data as of : 20/12/2024 15:42:36

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	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more		0			0	0	0	0	0	0	0	0	0	0	0	0
M2	Inappropriate out of area bed days		0			85	104	74	138	119	62	114	111	124	138	96	131
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%			89.7%	81.6%	93.2%	94.1%	87.5%	90.3%	92.7%	91.7%	86.2%	90.3%	97.6%	91.8%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%			54.5%	50.2%	53.9%	52.9%	52.3%	52.7%	51.1%	50.9%	50.9%	54%	54.1%	54.6%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%			99.7%	99.8%	99.9%	99.9%	100.0 %	100.0%	99.9%	99.7%	99.5%	99.5%	99.1%	98.3%
M7	72 hour follow-up from psychiatric in-patient care		80%			91.2%	88.7%	92%	87.5%	94.6%	89.8%	89%	91.2%	91.0%	94.1%	89.9%	93.5%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0			23	30	28	8	29	13	1	5	5	0	0	1
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0			1	1	1	2	1	2	1	3	1	0	0	1
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%			98.6%	98.8%	98.7%	99.0%	99.3%	99.0%	98.7%	99.3%	99.4%	99.0%	98.7%	98.6%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%			99.8%	100%	100%	99.8%	100%	100%	100%	100%	100%	100%	100%	100%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%			75%	100%	66.7%	100%	n/a	100%	100%	50%	100%	100%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%			88.6%	97.1%	97.3%	97.2%	97.5%	94.1%	96.6%	100%	87.5%	84.8%	88.6%	77.1%
M15	Data Quality Maturity Index		95%			99.5%	99.5%	99.4%	99.4%	99.3%	99.5%	99.5%	99.4%	99.5%	99.5%	99.6%	98.4%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%			99.2%	99.7%	99.4%	98.6%	99.0%	99.0%	99.8%	99.1%	99.3%	100%	99.0%	99.1%

National Metrics

Data as of : 20/12/2024 15:42:36

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					19.2%	19.6%	18.1%	16%	17.4%	23.8%	26.5%	25.5%	26.0%	11.3%	20.7%	19.8%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			97.7%	97.7%	97.2%	96.4%	97.5%	96.6%	96.3%	96.9%	97.1%	96.8%	96.4%	96.5%
M34	% Clients in settled accommodation	⚠	60%			84.5%	84.6%	84.2%	83.5%	83.4%	83.5%	83.2%	83.5%	83.6%	84.0%	83.3%	84.1%
M35	% Clients in employment	⚠	10%			12.6%	13.2%	13.0%	13.5%	13.0%	13.2%	13.0%	12.6%	12.7%	12.5%	13.1%	13.3%
M41	Completion of a valid NHS number		99%			99.7%	99.8%	99.7%	99.7%	99.9%	99.9%	99.9%	99.5%	100.0%	99.5%	100.0 %	100.0%
M42	Completion of ethnicity coding for all service users		90%			99.4%	99.4%	96.9%	100.0 %	99.5%	99.5%	99.4%	100.0 %	99.4%	100.0 %	99.5%	99.6%
M43	Community health services two hour urgent response standard		70%			85.3%	86.2%	87.8%	88.3%	92.8%	89.7%	89.9%	92.0%	91.6%	91.6%	90.9%	88.1%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500			1303	1700	1559	1336	1661	1589	1618	1963	1579	1804	2022	1851
M47	Virtual ward occupancy		80%			64.3%	81.4%	95.7%	101%	82.7%	94.3%	81.4%	91.4%	70%	82.9%	86.7%	113%
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					14398	14469	14386	14288	14129	14109	13997	13940	13774	13661	13589	13570
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months					11062	11143	11080	11059	10933	11009	10958	10938	10712	10735	10879	10875
M171	% Admissions gate kept by crisis resolution teams		95%			100%	98.1%	98.8%	95.7%	98.8%	98.1%	95.6%	97.4%	97.9%	97.5%	100%	97.8%
M178	Talking Therapies - Reliable Recovery					51.0%	47.5%	50.7%	50.4%	50.4%	50.4%	48.5%	47.8%	49.7%	50.8%	52.2%	52.6%
M179	Talking Therapies - Reliable Improvement					64.3%	66.8%	69.4%	64.6%	69.7%	68.0%	69.3%	66.2%	68.9%	70.4%	71.0%	68.6%
M181	Women Accessing Specialist Community Perinatal Mental Health Services					1177	1203	1214	1188	1209	1221	1217	1233	1249	1305	1421	1519
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)					4	6	4	5	2	3	4	3	4	4	4	5
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			1383	1811	1843	1745	1822	1967	1789	2061	1845	2088	2167	1869
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment					485	597	631	486	604	572	527	554	544	517	677	586
M188	Community services waiting list, over 52 weeks					18	9	9	5	4	2	5	2	0	0	0	0

National Metrics

Data as of : 20/12/2024 15:42:36

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 service only) within 6 weeks has increased in November to 61.6%, however this continues to remain well below the national threshold of 99%. The service have agreed a new locally set trajectory for improvement to the end of March 2025 which is ambitious in its expected improvement of 2% each month, from the September 2024 baseline figure. The service has been significantly impacted by staff sickness absence since late July. The service continues to explore options and introduce changes to increase hearing testing capacity and has appointed a trained audiologist to the service on a temporary basis via our Trust Bank.

• There was one admission for one night for an under 18 year old to an adult acute mental health bed during November. 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. Admissions are due to the national unavailability of a bed for young people to meet their specific needs. We routinely notify the Care Quality Commission (CQC) of these admissions and discuss the detail in our liaison meetings, actioning any points that the CQC request.

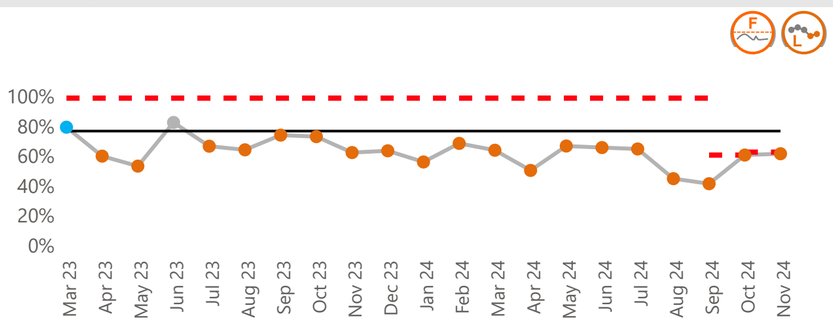
• The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks is 77.1% in November - this relates to 11 service users who were not seen all cases are a result of the impact of the ARFID (Avoidant/Restrictive Food Intake Disorder) pathways and undefined reporting processes. These are being explored with NHS England. The urgent access to treatment measure remains at 100% in November, which is above the 95% threshold.

• 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.

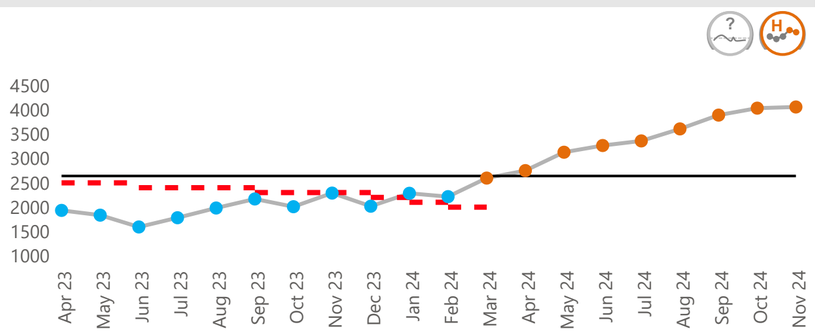
• Virtual Ward occupancy rate continues to increase and is now above target of 80% at 113% for November. Virtual Ward activity for November has exceeded our reported capacity levels of 75 beds, seeing a couple of peaks throughout the month, mostly towards the latter end of November. Demand levels and system pressures, OPEL 3-4 reporting in the acute trust have impacted on virtual ward referrals supporting patient flow and diverting patients from Emergency Department (ED) / Same Day Emergency Care (SDEC). This has been under constant review across partners to ensure that we can safely support this number of patients reviewing levels of acuity, planned discharges, case load reviews etc.

• 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.

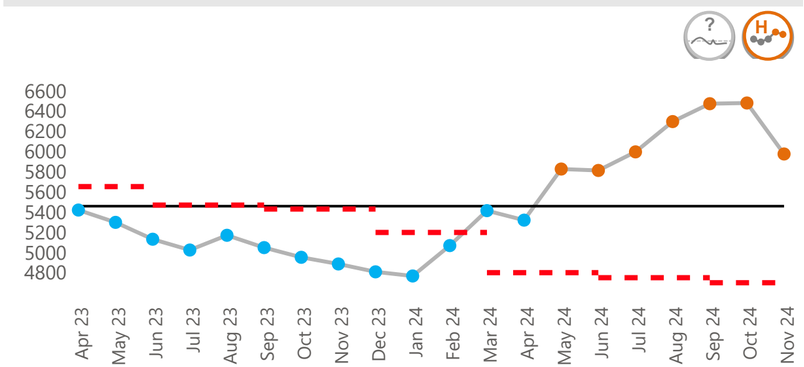
M6 - Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)

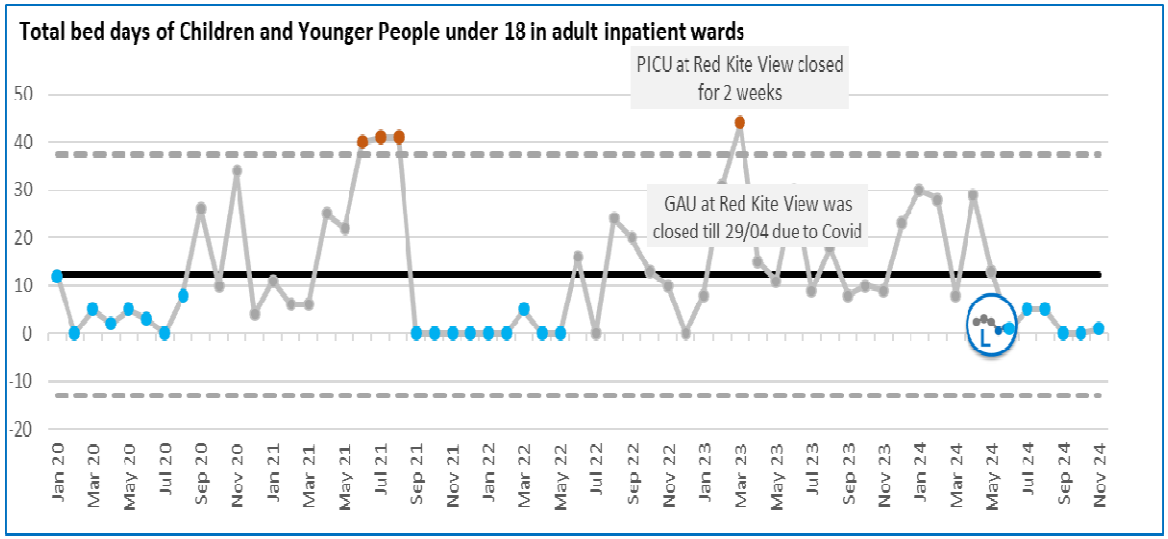


M45 - The number of incomplete Referral to Treatment (RTT) pathways

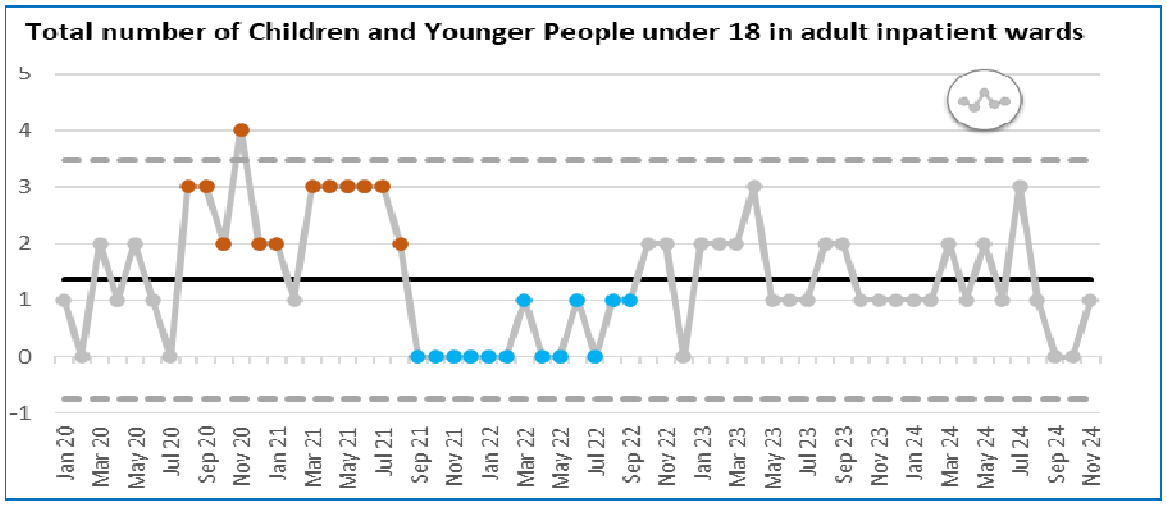


M48 - Community services waiting list





The statistical process control chart (SPC) shows that in November 2024 we remain in a period of special cause improvement, compared to previous performance, regarding the number of beds days for children and young people in adult wards.



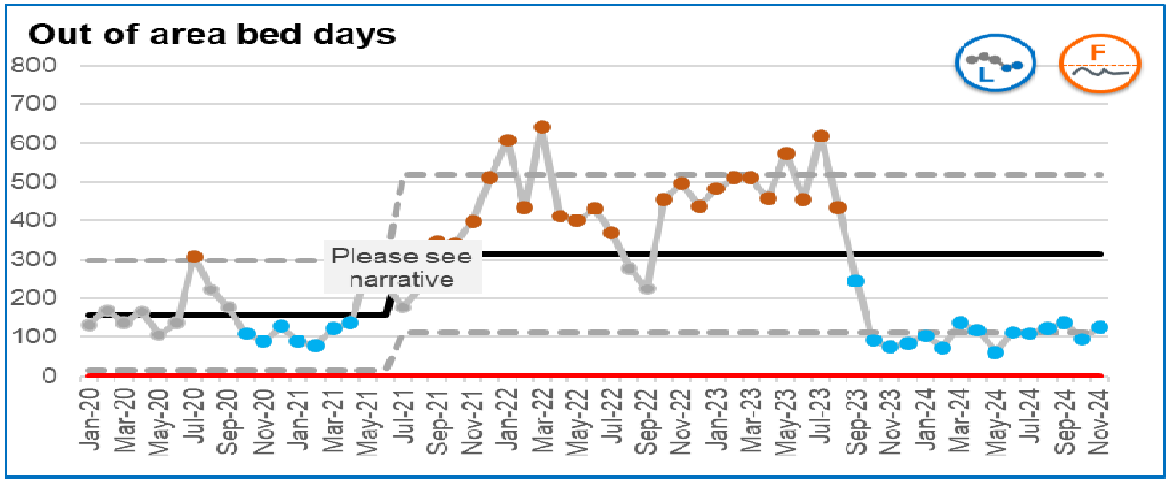
There has been an increase in the number of people aged under 18 admitted to an inpatient ward in November 2024, with one admission. Whilst the SPC chart shows us that this is still within common cause variation when we compare it to the range of admissions we have had in the past, it is recognised that any admission of an individual under 18 is due to the national unavailability of a bed for young people to meet their specific needs. 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.

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 November the following data quality issue has been identified in the reporting:

- The reporting for employment and accommodation shows 16.2% of records have missing employment and/or accommodation status with a further 1.7% that have an unknown employment status and 1.2% 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 SPC chart shows that 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 national 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.

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

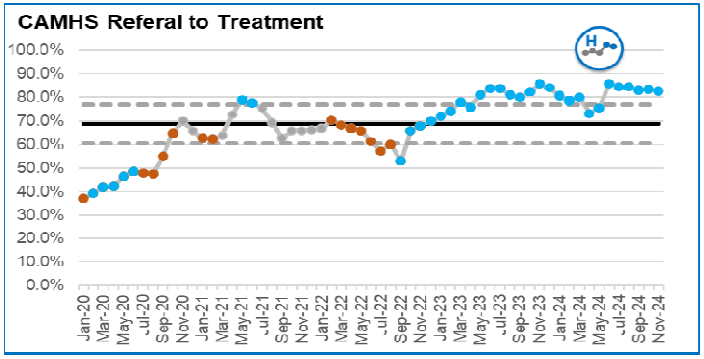
Headlines

Neurodevelopment waits remain a concern and discussions are underway with commissioners about how we can further strengthen the offer to reduce any impact on those who require assessment or support.

Children and Families

Metrics	Threshold	Sep-24	Oct-24	Nov-24	Variation/ Assurance
% Appraisal rate	>=95%	88.9%	89.2%	90.9%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/1)	33% (1/3)	0% (0/4)	
% of staff receiving supervision within policy guidance	80%	84.8%	85.0%	83.2%	
CAMHS - Crisis Response 4 hours	N/A	94.4%	98.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.1%	83.8%	84.2%	
Eating Disorder - Routine clock stops	95%	84.8%	88.6%	77.1%	
Eating Disorder - Urgent/Emergency clock stops	95%	100.0%	100.0%	100.0%	
Maximum 6 week wait for diagnostic procedures	99%	41.9%	60.7%	61.6%	
Information Governance training compliance	>=95%	97.5%	96.7%	96.2%	
Reducing Restrictive Practice Interventions training compliance	>=80%	74.0%	73.0%	72.4%	
Sickness rate (Monthly)	5.0%	3.6%	4.8%	4.4%	

**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 November 2024, we remain in a period of special cause improving variation (something is happening and this should be investigated), following a sustained increase in the percentage.

Alert/Action

- The performance of Kirklees and Calderdale CAMHS continues to require additional support, there are more patients waiting, for longer times, some of the waiting time KPI's are not being met consistently and there are challenges in some areas of training. The team have been working hard to address performance challenges, which have been impacted by changes in management, sickness, increased demand and changes to process pathways at place. The TRIO are working together to support the improvements.
- Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. This is further impacted by staff vacancies. This has been recorded on the risk register and actions are in progress to support.
- Disability and sexual orientation recording continues to be a challenge despite targeted efforts and action plans in each area. This will be picked up through the local equalities and engagement group going forward.
- Eating disorder performance is currently fluctuating and has shown a reduction for the last 4 months, this is due to the impact of the ARFID pathways and undefined reporting processes. These are being explored with NHS England to ensure we have accurate reporting processes for these cases which should not sit within the eating disorder waiting time standards. Local audits confirm all eating disorder cases were seen within expected timeframes. All urgent cases have been seen in expected timeframes.

Advise

- Requests for ADHD medications is increasing – these service users have been started on medications within private services then requesting the CAMHS team to continue prescribing. Options for ongoing prescribing being considered with commissioners.
- Referrals have reduced slightly in November but still remain high. However emergency referrals have reduced slightly from last month and remain within expected parameters based on overall referral numbers.
- Changes to the national gender identity services are requiring a response from CAMHS services. The services are working with regional and national stakeholders to understand the impact of this and to ensure a consistent and equitable approach to service offers.

Assure

- There has been an improvement in Paediatric Audiology performance, which now sits at 60.7% the service has returned to the performance they were delivering in July before being impacted by staff non availability. This demonstrates a resilience and confidence in our ability to progress towards the 6-week referral to treatment target with investment. The two bank audiologists who joined the team and are backfilling the lost capacity and are welcome additional day of audiology time has been confirmed for January. A business case will be finalised in December 2024 for additional resources. We have set an ambitious target to improve by 2% per month to ensure we continue to focus on optimising service capacity whilst maintaining quality and experience. The additional resource due in January will help with this increase. It is unlikely the team can achieve above 70% without the full business case. Longest waits continue to range between 11-13 weeks.
- Appraisal performance has improved and has hit over 90% with some teams reaching above the 95% target. Where teams are below 90% it is linked to absence and/or new management and there are clear plans in place to improve this performance.
- The number of staff receiving supervision continues to meet performance expectations.
- The overall sickness rates for the care group remains within the expected targets and lower than the trust average, however we are seeing a lot of short term sickness linked to coughs colds and flu symptoms.
- Mandatory training performance for the care group has been sustained with all courses sustaining the desired compliance rates except for RRPI training, there are numbers of our staff booked onto the December course.
- Friends and Family Test results remain positive and have provided some positive feedback for individuals and teams which have been locally celebrated.

Mental Health Care Group

Headlines

The improvement work continues to contribute to an overall 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 remains above threshold but has reduced slightly in month. Significant hotspots remain in Horizon assessment and treatment unit and inpatient wards for older people. Work 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.
Inpatient services continue to have a high level of sickness but this has reduced compared to last 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 appraisals is being addressed through line management support and oversight.

Mental Health Community

Metrics	Threshold	Sep-24	Oct-24	Nov-24	Variation/ Assurance
% Appraisal rate	>=95%	88.0%	90.6%	91.3%	
% Assessed within 14 days of referral (Routine)	75%	86.4%	79.5%	80.2%	
% Assessed within 4 hours (Crisis)	90%	97.5%	99.0%	95.3%	
% of feedback with staff values and behaviours as an issue	< 20%	46% 5/11	18% 3/17	20% 2/10	
% of staff receiving supervision within policy guidance	80%	81.8%	80.3%	83.2%	
% service users followed up within 72 hours of discharge from inpatient care	80%	94.1%	89.8%	93.5%	
% Service Users on CPA with a formal review within the previous 12 months	95%	96.2%	96.1%	96.0%	
% Treated within 6 weeks of assessment (routine)	70%	96.1%	95.3%	94.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.4%	76.6%	77.1%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	77.0%	82.1%	*79.8%*	
Information Governance training compliance	>=95%	95.6%	95.6%	95.4%	
Reducing Restrictive Practice Interventions training compliance	>=80%	73.2%	72.8%	74.6%	
Sickness rate (Monthly)	5.0%	4.6%	5.9%	5.0%	

Mental Health Inpatient

Metrics	Threshold	Sep-24	Oct-24	Nov-24	Variation/ Assurance
% Appraisal rate	>=95%	93.2%	90.4%	90.1%	
% Bed occupancy (excl leave)	85%	92.0%	89.9%	90.4%	
% of feedback with staff values and behaviours as an issue	< 20%	20% 2/10	25% (1/4)	56% 10/18	
% of staff receiving supervision within policy guidance	80%	88.0%	93.0%	92.6%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.0%	89.3%	88.0%	
% of clients clinically ready for discharge	3.5%	5.5%	4.8%	4.8%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	89.7%	92.6%	*93.8%*	
Inappropriate Out of Area Bed days	155 (Oct)	138	96	128	
Information Governance training compliance	>=95%	95.5%	94.5%	96.2%	
Physical Violence (Patient on Patient)	Trend Monitor	24	14	13	
Physical Violence (Patient on Staff)	Trend Monitor	53	52	40	
Reducing Restrictive Practice Interventions training compliance	>=80%	82.4%	84.9%	86.6%	
Restraint incidents	Trend Monitor	96	106	*160*	
Safer staffing (Overall)	90%	136.1%	139.4%	141.1%	
Safer staffing (Registered)	80%	104.4%	105.0%	107.1%	
Sickness rate (Monthly)	5.0%	7.6%	8.0%	6.5%	

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.
- There has been an increase in people who are clinically ready for discharge but are delayed, particularly on some of our Older People's wards. This is an area of focus as part of the priority programme work.
- Workforce challenges have led to continued use of temporary staffing, primarily bank. Throughout November acute wards have worked above establishment. There has been a review and subsequent action plan to address. Temporary staffing is being closely monitored by senior managers.
- Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The situation has become more challenging and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is monitored.
- Intensive Home Based Treatment teams in Calderdale and Kirklees are experiencing ongoing 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. For community services compliance is impacted by the specific order tasks are recorded on SystmOne. Service users may have a staying well plan completed within the timeframe but if recordkeeping is not completed in the correct order (i.e. person's CPA start date added after a contact) this does not count as compliant according to the criteria of the report.
- 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 all teams to achieve the target of all staff having an appraisal. We are now proactively flagging appraisals that are due to go out of date in the next 30 days to aid planning. Inpatient appraisal completion is lower in November due to sickness levels and clinical pressures, specific actions are in place. November data is also impacted by the WorkPal downtime for over 2 weeks. Overall care group appraisal performance is at 90.9%.
- The sickness rate is above the Trust threshold on some wards. Wards and teams with high sickness are where there are a number of people with long term sickness in addition to short term sickness due to seasonal illness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
- The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administrating intra-muscular medication. Matrons attend the recently established monthly restraint oversight meeting chaired by Reducing restrictive physical interventions specialist advisors and includes an in-depth review of all prone restraint incidents for learning.
- Single point of access (SPA) is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. The access standard for assessed within 14 days of referral has been met in Barnsley and Wakefield. There have been specific challenges with administration vacancies in Calderdale and Kirklees SPA impacting on performance.

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 November is 58.96% for Kirklees and 50.66% for Barnsley, both achieving the national standard of 50%. Kirklees is achieving the national standard of less than 10% waiting for a second appointment more than 90 days. Barnsley are on track to achieve by March 25 but is currently not meeting the standard as the data is collected on discharge and therefore measures practice from some months ago.
• 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. The Care Group has completed a trust wide review of the SPA as part of the Improving Access to Care (IATC) priority programme and an action plan is currently being developed.
• Care Programme Approach (CPA) review performance is above target in Barnsley, Kirklees and Wakefield. Kirklees is slightly under target this month at 92.83. Action plans and support from Quality and Governance Leads remain in place and all areas are expected to be above threshold in November.
• 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). Service managers are leading on improvement plans. The new mandatory training dashboard is a positive development, and work continues with training leads to address priority areas and utilise all training capacity. Although RRPI training compliance remains below threshold, it has improved in November with further improvement expected.
• The care group holds monthly meetings to track and review progress of Equality Impact Assessments (EIAs). Performance remains strong. Delay in completion of EIAs in some areas have been due to manager changes/sickness and the service line Trios are supporting the teams in their completion.
• Equality data – we are working with a trust wide quality improvement group to enhance how equality information is captured on System One. Completeness of equality data is on our data quality improvement action plan.
• There were 8 incidents of prone restraint in November, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration. The monthly restraint oversight meeting, led by NQP, involving RRPI, safeguarding and matrons, review all prone restraint incidents for any opportunities for learning.

Assure

• IHBT teams continue to perform well in gatekeeping admissions to our inpatient beds.
• The care group is performing well in 72 hour follow up for people discharged into the community at 91.7% for November.
• The use of out of area beds remains low due to continued intensive work as part of the care closer to home workstream

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:
Improvement work on waiting list times in community learning disability services has led to an overall improvement in the number of Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks with the November position reporting above threshold at 95.1%. The learning disability team continue to have robust oversight of all waits and are carrying out profession specific actions to address waits within individual disciplines
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	Sep-24	Oct-24	Nov-24	Variation/ Assurance
% Appraisal rate	>=95%	81.1%	84.2%	81.6%	
% of feedback with staff values and behaviours as an issue	< 20%	50% (1/2)	0% (0/1)	0% (0/5)	
% of staff receiving supervision within policy guidance	80%	84.8%	87.4%	84.1%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	62.5%	62.5%	60.8%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.8%	82.1%	85.5%	
% of clients clinically ready for discharge	3.5%	80.0%	80.0%	80.0%	
Information Governance (IG) training compliance	>=95%	93.4%	93.4%	91.1%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Improvement trajectory: Aug/Sep 86% Oct/Nov 88% Dec onwards 90%	96.0%	88.5%	95.1%	

LD, ADHD & ASD

Metrics	Threshold	Sep-24	Oct-24	Nov-24	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	29	24	12	
Reducing Restrictive Practice Interventions training compliance	>=80%	78.6%	79.6%	83.5%	
Safer staffing (Overall)	90%	178.4%	171.4%	164.7%	
Safer staffing (Registered)	80%	113.7%	152.5%	135.9%	
Sickness rate (Monthly)	5.0%	4.3%	5.1%	5.8%	
Restraint incidents	Trend Monitor	40	33	*28*	

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

Alert/Action

West Yorkshire Integrated Care Board Neurodiversity Project
No significant updates from the WY Project Group at this point, the plan remains to have an agreed model for Patient Choice in place for April 2025. The focus for this work remains on establishing a consistent service delivery offer across West Yorkshire

Leeds ADHD Service
The Adult ADHD service in Leeds is temporarily closed to non-urgent new referrals from 11/10/24. They intend to review the existing waiting list of 4500 and where possible direct people to other providers. At present, the service within SWYPFT has not been affected by that decision. If this changes the situation will be escalated.

ADHD
Referral rates to ADHD services are approximately seven times higher than commissioned capacity in Barnsley and Kirklees, and eleven times higher in Wakefield. This means an increased number of people are on the waiting list for the service and work continues with local commissioners to develop solutions to reduce the list as much as possible.

Autism
It is noted that there is now a significant difference between the Calderdale waiting times compared to Wakefield, Kirklees and Barnsley. Calderdale launched an Any Qualified Provider model on 1st May 2023. In line with the changes the service was required to adopt a short all-age referral form with minimal clinical information and to accept all complete referrals as clinical appropriateness for assessment was to be determined by Primary Care. This meant that the screening & triage step that we were delivering to determine clinical appropriateness was removed so that all providers operating in Calderdale were operating a similar pathway. The service has provided feedback to Calderdale and the wider West Yorkshire Neurodiversity Project.

Advise

• ADHD Medication – 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.
Shared Care Arrangements
• The Adult ADHD service has previously entered Shared Care with all GP referrers when appropriate. GPs report facing increased pressures related to ADHD medication. Recently two GP practices have withdrawn all shared care agreements relating to ADHD medication (practices are in Barnsley and Kirklees). The service is working with ICB colleagues to identify longer term solutions.

Waiting Lists – Adult ADHD
Our service has a large number of people waiting for an ADHD assessment. The service has no plans to close to referrals and are in discussions with our local commissioners to discuss local plans for managing the waiting lists in their areas.
• Kirklees Place has already recurrently invested in ADHD screening & triage. This is an innovative new step that includes a shorter referral form and a face-to-face appointment with the individual to determine if it is clinically appropriate for an ADHD assessment to take place. These will commence January 2025.
• Barnsley typically has a greater proportion of young people transitioning from CAMHS. This leaves capacity to assess approximately 60 people per year from the standard waiting list (this list has increased by approx. 420 people in the last 12 months).
• Calderdale has never recurrently invested in Adult ADHD but opted for a case by base funding review with typically 20-30 cases each year. This has increased to approx. 100 people per year since the launch of the Any Qualified Provider (AQP) framework in May 2023 but demand still outstrips capacity.
• Wakefield have recurrently invested and historically funded some clearing of waiting lists, however Wakefield also has the highest number of monthly referrals. Wakefield Paediatric Services have also referred a higher number of young people over the past 18 months due to a pause in transitioning their young people during the pandemic. This has reduced annual capacity for people on the standard waiting list from 100 to 50. Approx 700 people have been added to this standard waiting list in the past 12 months.

Assure

• All key performance targets met.
• Relationship with Bradford working very well.
• Excellent levels of supervision and appraisal.
• Low level of vacancies.
• Friends and family test showing a positive result at 92% for the month.
• All mandatory training meeting the threshold.

Learning disability services:

Alert/Action

Learning Disability
• Appraisal performance remains a focus plans are in place to ensure compliance across the Care Group. Current compliance is 78.5%↓. Focused interventions are now in place to support the service to reach the threshold.
• Supervision performance has also improved to 84.1%%↑.

Community
• Waiting Lists – Performance on waiting lists continues to be monitored closely by the management team within LD services. Performance has been exacerbated by community services experiencing an increase of crisis interventions to keep people safe.
• Speech and Language therapy recruitment continues to be a challenge with vacancies impacting on service delivery as a whole and waiting lists.

Assessment & Treatment Unit (ATU)
• The number of service users Clinically Ready for Discharge remains at 80% on the per-performance dashboard this will reduce due to a discharge in the last few days of November.
• Horizon is compliant with appraisal and supervision thresholds. Some remedial work re-quired on IG (91.9%) and Cardiopulmonary Resuscitation (79.4%).

Advise

• Business case for ADHD has been re submitted to commissioners and the service feed-back indicates approval in principle but funds will need to be identified.
• Out of area service user has been brought back into the ATU system but pressures on availability of beds across the system continues to be a challenge
• The service made an application to become an early adopter of the "Keeping my chest healthy" project and have been successful. Some selected multi disciplinary team clinicians will participate in the pilot which will mean access to tools and training to proactively support respiratory needs for people with a learning disability.

Assure

• Medical recruitment progressing well.
• Data quality remains good.
• Horizon action plan now complete waiting for Trust final sign off.
• Friends and Family Test – 94%

Barnsley Physical Health and Wellbeing Care Group

Headlines

Musculoskeletal (MSK) and neurological physiotherapy estate issues continue to utilise Priory Campus as temporary alternative accommodation until the end of March 2025 to accommodate forward booking of outpatient activity. This remains on the local risk register. This is having an impact on the full-service offer and may lead to an impact on the 18-week Referral to Treatment target (RTT).

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Sep-24	Oct-24	Nov-24	Variation/ Assurance
% Appraisal rate	>=95%	94.9%	94.0%	90.7%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/3)	0% (0/6)	0% (0/1)	
% people dying in a place of their choosing	80%	80.8%	86.5%	97.3%	
% of staff receiving supervision within policy guidance	80%	81.6%	83.2%	85.4%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.9%	82.1%	84.2%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	0.0%	

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Sep-24	Oct-24	Nov-24	Variation/ Assurance
Information Governance (IG) training compliance	>=95%	95.1%	93.4%	95.1%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.5%	99.1%	98.3%	
Safer staffing (Overall)	90%	108.3%	114.1%	112.4%	
Safer staffing (Registered)	80%	120.4%	124.4%	123.7%	
Sickness rate (Monthly)	5.0%	6.1%	5.7%	5.4%	

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

Alert/Action

• MSK & Neurological Physiotherapy, Priory Day Centre – closed until further notice. Services affected continue to utilise Priory Campus as temporary alternative accommodation until the end of March 2025 to accommodate forward booking of outpatient activity. This remains on the local risk register. Work scheduled on Priory Day centre in June 2025 with estates, further negotiation under way with Priory Campus owners to extend this temporary fix further. This is having an impact on the full-service offer and may lead to an impact on the 18-week Referral to Treatment target (RTT).

Advise

• Appraisals - As a care group our compliance is seeing more consistent levels; for November, the figure is 90.7%.

Assure

• Sickness rates have improved again during November, achieving compliance at 5.0%. Triangulation of vacancies alongside the implementation of restrictions in overtime/bank/agency had shown a slight spike in sickness across our care group. Work on our top two reasons for sickness (Musculo-skeletal and stress/anxiety) is now in development using a health & wellbeing and prevention approach.
• Staff receiving supervision - continues to receive focus with a drive to improve recording. We continue to achieve compliance for November at 85.4%.
• Urgent Community Response Service 2-hour target is 88.3% as at end of November 2024 which, this is a slight decrease linked to increased activity on the late shift but 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) – 99.02% as at November 2024.
• Friends and Family Test (FFT) 97% of people would recommend community services.
• 97.3% of people dying in their place of choosing in November 2024; this is an increase and remains consistently above the threshold of 80%.
• Information Governance training has seen an increase to 95.1% for November to achieve compliance.
• CPR training maintains compliance with a further increase to 84.2% for November.
• Virtual Ward occupancy rate continues to increase and is now above target of 80% at 113% for November. Virtual Ward activity for November has exceeded our reported capacity levels of 75 beds, seeing a couple of peaks throughout the month, mostly towards the latter end of November. Demand levels and system pressures, OPEL 3-4 reporting in the acute trust have impacted on virtual ward referrals supporting patient flow and diverting patients from Emergency Department (ED) / Same Day Emergency Care (SDEC). This has been under constant review across partners to ensure that we can safely support this number of patients reviewing levels of acuity, planned discharges, case load reviews etc.
• No areas for improvement to report for pressure ulcers for November. The number of pressure ulcers reported to have developed under of care of Neighbourhood Nursing is less than 1% of the activity of the service during November.
• Intermediate care new interim model, recruitment drive continues with further interviews taking place during December. The service will then review the position in January in relation to any remaining vacancies.
• Urgent Community Response (UCR) Night service pilot commenced in November. This is in partnership with Barnsley Metropolitan Borough Council (BMBC).
• Multi-Disciplinary Team (MDT) Frailty clinic pilot went live at Goldthorpe Centre in November. This will take place weekly on a Tuesday for 4-6 months with patients from Dearne GP practices.
• Safeguarding Awareness Week – on 21st November our Neighbourhood Rehabilitation Services (NRS) were at the Glassworks in Barnsley to promote falls safety, environmental safety and safe moving and handling practices.
• We Care into The Future – careers event for schools held at Barnsley Metrodome in November. Significant numbers of SWYPFT staff contributed to running and attending this event including role play scenarios representing patient journeys, along with career pathway information for school pupils who might be interested in a career in healthcare. Attendance from multiple clinical and non-clinical areas, including corporate colleagues. This event was in partnership with Barnsley Hospital NHS Foundation Trust, BMBC and Barnsley Integrated Care Board.
• NRU (Neurological Rehabilitation Unit) Safer staffing – the two additional Band 5 trained nurses that were agreed by Executive Management Team (EMT) are now recruited and in post.

Forensic Care Group

Headlines

The monthly sickness rate has deteriorated further in November - hotspot areas can be seen in the ward level breakdown of the report. The People Directorate Business Partner continues to work closely with the care group regarding 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.
Focus remains on ensuring staff have a timely and comprehensive appraisal.
Liaison with the collaborative is underway to find appropriate solutions for the patients waiting for high secure placements.

Forensic

Metrics	Threshold	Sep-24	Oct-24	Nov-24	Variation/ Assurance
% Appraisal rate	>=95%	86.4%	85.8%	80.0%	
% Bed occupancy (incl leave)	90%	86.5%	85.3%	84.7%	
% of feedback with staff values and behaviours as an issue	< 20%	100% (1/1)	0% (0/0)	0% (0/0)	
% of staff receiving supervision within policy guidance	80%	92.8%	86.9%	88.1%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.0%	83.8%	85.1%	
% of clients clinically ready for discharge	3.5%	0.8%	0.8%	0.8%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	N/A	N/A	N/A	
Information Governance (IG) training compliance	>=95%	93.6%	94.3%	94.4%	
Physical Violence (Patient on Patient)	Trend Monitor	5	4	2	
Physical Violence (Patient on Staff)	Trend Monitor	5	5	6	
Reducing Restrictive Practice Interventions training compliance	>=80%	75.6%	79.8%	82.7%	
Restraint incidents	Trend Monitor	48	26	*15*	
Safer staffing (Overall)	90%	114.7%	114.8%	122.5%	
Safer staffing (Registered)	80%	100.7%	102.4%	109.9%	
Sickness rate (Monthly)	5.4%	5.5%	6.0%	6.2%	

Alert/Action

- Bed occupancy – Newton Lodge 84.81%, Bretton 88.42%, Newhaven 75%. Under-occupancy in medium secure due to empty beds within learning disability and women's services where there are no waiting lists.
- Newton Lodge - are providing an enhanced package of care for an individual who otherwise would have required an out of area placement.
- Appraisal – remains a significant challenge across the service. The current position has been impacted by larger numbers of people requiring appraisal at this time of year, a slight increase in sickness and a surge of acuity across several of the wards. In medium secure performance has dropped across all wards except Bronte which has now reached threshold. In low secure Ryburn and Thornhill have reached the threshold, Newhaven has a deterioration in performance and Sandal has improved. The service will be working with individual ward managers to develop a trajectory to reach compliance.

Advise

- Mandatory training overall compliance: Newton Lodge – 92.9%, Bretton – 91.8%, Newhaven –94.6%
- Each service line is compliant with all mandatory training except for following: Newton Lodge - Fire Training 83.9% (the service is looking into this as fire training is built into the annual security training), Bretton Centre - IG 93.5%, Newhaven - IG 89.5%
- Sickness absence – remains a focus of attention across the service. There has been a spike in short term seasonal illnesses in Newton Lodge.
- West Yorkshire Provider Collaborative - The West Yorkshire Provider Collaborative continue to develop future intentions for the women's pathways and community services. The service has met with the commissioning hub following two earlier bed modelling workshops to discuss potential areas for exploration in terms of future capacity and demand.
- Turnover – significantly reduced over the last 12-month period.
- Newton Lodge has two service users currently awaiting beds in high secure facilities, both service users require seclusion. A tentative date has been identified for one service user.

Assure

- High levels of data quality across the care group.
- 100% compliance for HCR20 completed within 3 months of admission.
- 25 Hours of meaningful activity 100%.
- % Service Users on CPA with a formal review within the previous 12 months continues to achieve 100% in November.

Inpatients - Mental Health - Working Age Adults

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

Appraisal
• Four wards achieving the 95% target and another three wards above 90% compliance with outstanding appraisals scheduled.
• Ashdale, Beamshaw, Melton, Elmdale, Ward 19 (Female), and Walton appraisal compliance is below threshold in November but is above 80%. Service managers are working closely with ward managers to ensure outstanding appraisals are booked.
• Ward 18 appraisal performance improved in November but remains under target at 78.6%. Targeted work has been undertaken to continue improvement.
• Crofton and Poplars are under target at 79.3% and 77.8% respectively, WorkPal has now been correctly aligned and outstanding appraisals are scheduled.
• System issues continue to impact on accuracy of reporting, including WorkPal downtime for over 2 weeks in November, appraiser/appraisee alignment issues on WorkPal and inability to manually exclude for long term absence (e.g. sickness, maternity leave), leading to a delay in exclusions.

Sickness
• Sickness improved in November on Beamshaw and Melton due to the return to work of staff from long term sickness.
• A number of wards have reduced sickness although significantly above threshold:
  - Poplars and Ward 19 have had some staff return to work but sickness remains high, impacted by long-term sickness as well as some short-term sickness.
  - Elmdale at 11.6% is impacted by both long-term sickness and short-term sickness.
  - Willow sickness has decreased in November but still remains very high at 17.9%. 4 staff are on long term sick, but no trends.
• Elmdale, Walton and ward 18 remain above threshold due to a combination of long and short term sickness.
• Beechdale sickness has increased in November to 12.2% impacted by long-term sickness.
• Ward managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made.

Supervision
• All wards above 80% compliance target with 9 of these at 100%.

Mandatory Training
Information Governance (IG)
• Ashdale, Elmdale, Willow, Clark and Walton are under compliance in November but are showing on the live dashboard as having achieved the target (17/12/24).
• Beamshaw compliance has dropped below 95% in November. Focused intervention is being taken by ward managers to address this.

Cardio Pulmonary Resuscitation (CPR)
• 15 wards are above the CPR training compliance threshold.
• Poplars and Ward 19 remain below target impacted by course cancellations by the Resus team.

Reducing Restrictive Physical Intervention (RRPI)
• 16 wards are above the RRPI training compliance threshold.
• Ward 19 (female) and Enfield Down remain below RRPI training target.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.
• Recent review of Datix violence and aggression incidents showed no links to ward RRPI training compliance.

Fire Safety
• Stanley remains under the 85% compliance threshold at 84.6%. Staff have attended fire safety training sessions throughout November and compliance is expected to be above threshold by end of December.
• Ward 19 (female) remains under the 85% compliance threshold. Two staff with outstanding training have attended in November which is not yet showing in the data and compliance is currently 94%.

Inpatients - Mental Health - Working Age Adults

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

Bed Occupancy

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

Clinically Ready For Discharge (CRFD)

• Poplars CRFD has reduced from 52.5% but remains high in November at 28.7%. This is reflective of several service users awaiting placements.
• Nine wards are above the threshold for CRFD with Beamshaw, Beechdale and Melton at more than 12%. Clark, Nostell, Ward 18 and Lyndhurst are also above target. This is due to the number of service users with complex needs who are awaiting placement or suitable accommodation.
• Across all wards the multi-disciplinary team continue to collaborate to progress pathways as timely as possible.
• An additional check and challenge weekly meeting has been established led by the Director of Service to ensure senior oversight and focus and timely external escalations.

FIRM Risk assessments

• Percentage compliance is significantly impacted by the small number of admissions. Ashdale and Ward 18 each had 1 breach in November. A deep dive is conducted for each breach to identify learning and inform improvement.
• Crofton had 4 breaches impacted by additional demands relating to the influenza outbreak on the ward.
• 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 – (Patient on Patient)

• 15 incidents of patient-on-staff physical violence on Ward 18 throughout November relating to a specific service user with complex needs.
• Risk specific care plans are in place to support managing this with input from trust RRPI specialist advisors as needed.
• Staff involved are supported by ward leadership teams including both managerial and clinical supervision.

Restraint incidents

• Higher incidence on Melton, Nostell, Walton and Ward 18 is reflective of current patient population and the presentation and risk profile of service users.

Prone restraint incidents

• 8 incidents of prone restraint in November, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration.
• Reflective of individual service user presentation and high risks of violence and aggression.
• The main reason for prone restraint use was exiting seclusion and the secondary reason was administration of intra-muscular medication. The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administrating intra-muscular medication.

Inpatients - Mental Health - Working Age Adults

Beamshaw Suite Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	91.7%	88.0%	88.0%
Sickness	5.0%	11.4%	7.2%	4.2%
Supervision	80%	100.0%	81.3%	81.3%
Information Governance training compliance	>=95%	96.0%	87.5%	91.7%
Reducing Restrictive Practice Interventions training compliance	>=80%	84.0%	87.5%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.0%	100.0%	87.5%
Fire Safety training compliance	>=85%	96.0%	95.8%	95.8%
Bed occupancy	85%	111.7%	98.2%	94.3%
Safer staffing (Overall)	90%	139.5%	143.8%	136.0%
Safer staffing (Registered)	80%	115.6%	116.3%	112.4%
% of clients clinically ready for discharge	3.5%	11.9%	13.6%	14.2%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	80.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	3	1	1
Physical Violence (Patient on Staff)	Trend Monitor	2	2	0
Restraint incidents	Trend Monitor	6	6	*3*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	21	23	24

Clark Suite Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	95.5%	100.0%	90.5%
Sickness	5.0%	8.1%	4.1%	1.7%
Supervision	80%	91.7%	100.0%	91.7%
Information Governance training compliance	>=95%	95.8%	95.7%	91.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	95.8%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	95.8%	100.0%	100.0%
Fire Safety training compliance	>=85%	95.8%	100.0%	95.7%
Bed occupancy	85%	88.8%	100.9%	103.8%
Safer staffing (Overall)	90%	136.9%	181.2%	193.5%
Safer staffing (Registered)	80%	106.4%	114.1%	113.0%
% of clients clinically ready for discharge	3.5%	3.6%	3.6%	6.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	60.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	1
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	1	3	*9*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*1 (100%)*
Unfilled Shifts	Trend Monitor	24	30	36

Melton Suite Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	96.3%	96.3%	88.9%
Sickness	5.0%	4.1%	5.6%	4.7%
Supervision	80%	92.9%	92.9%	92.9%
Information Governance training compliance	>=95%	88.0%	96.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	96.0%	96.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.0%	88.0%	92.0%
Fire Safety training compliance	>=85%	100.0%	92.0%	88.0%
Bed occupancy	85%	100.0%	104.3%	100.6%
Safer staffing (Overall)	90%	115.5%	145.5%	184.6%
Safer staffing (Registered)	80%	96.8%	104.9%	99.1%
% of clients clinically ready for discharge	3.5%	0.0%	9.3%	14.2%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	7	0	0
Physical Violence (Patient on Staff)	Trend Monitor	4	9	1
Restraint incidents	Trend Monitor	8	9	*53*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	2 (100%)	0	2 (100%)
Unfilled Shifts	Trend Monitor	14	17	34

Nostell Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	100.0%	100.0%	100.0%
Sickness	5.0%	0.8%	0.5%	2.7%
Supervision	80%	100.0%	94.1%	87.5%
Information Governance training compliance	>=95%	100.0%	89.7%	96.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	78.6%	78.6%	84.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	100.0%	96.2%
Fire Safety training compliance	>=85%	79.3%	96.6%	92.6%
Bed occupancy	85%	93.3%	86.4%	89.2%
Safer staffing (Overall)	90%	166.0%	186.5%	166.3%
Safer staffing (Registered)	80%	106.8%	106.8%	118.3%
% of clients clinically ready for discharge	3.5%	6.3%	5.5%	9.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	91.7%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	1
Physical Violence (Patient on Staff)	Trend Monitor	0	1	3
Restraint incidents	Trend Monitor	7	12	*27*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	2 (100%)
Unfilled Shifts	Trend Monitor	8	35	31

Inpatients - Mental Health - Working Age Adults

Stanley Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	95.5%	95.0%	95.2%
Sickness	5.0%	5.7%	1.0%	3.7%
Supervision	80%	50.0%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	96.2%	96.2%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	100.0%	96.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.0%	96.2%	100.0%
Fire Safety training compliance	>=85%	84.0%	69.2%	84.6%
Bed occupancy	85%	105.8%	108.7%	108.9%
Safer staffing (Overall)	90%	133.6%	134.2%	140.8%
Safer staffing (Registered)	80%	98.4%	103.8%	103.0%
% of clients clinically ready for discharge	3.5%	1.1%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	1	0
Physical Violence (Patient on Staff)	Trend Monitor	1	1	0
Restraint incidents	Trend Monitor	3	6	*6*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	3 (100%)	3 (100%)	2 (100%)
Unfilled Shifts	Trend Monitor	22	12	24

Walton Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	88.2%	84.4%	93.5%
Sickness	5.0%	5.7%	7.7%	8.8%
Supervision	80%	88.9%	100.0%	100.0%
Information Governance training compliance	>=95%	97.4%	97.2%	93.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	78.4%	77.1%	84.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.8%	80.0%	87.5%
Fire Safety training compliance	>=85%	76.3%	80.6%	87.9%
Bed occupancy	85%	101.9%	105.8%	98.1%
Safer staffing (Overall)	90%	134.3%	125.2%	121.9%
Safer staffing (Registered)	80%	95.3%	100.0%	97.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.6%	9.6%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	2	0	0
Physical Violence (Patient on Staff)	Trend Monitor	3	2	1
Restraint incidents	Trend Monitor	8	8	*17*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	2 (100%)	2 (100%)	1 (100%)
Unfilled Shifts	Trend Monitor	5	13	15

Ashdale Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	100.0%	87.5%	87.5%
Sickness	5.0%	2.6%	0.7%	2.5%
Supervision	80%	83.3%	94.4%	94.4%
Information Governance training compliance	>=95%	91.2%	90.9%	90.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	76.5%	78.8%	84.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	91.2%	93.9%	93.9%
Fire Safety training compliance	>=85%	97.1%	97.0%	100.0%
Bed occupancy	85%	98.9%	99.2%	97.9%
Safer staffing (Overall)	90%	117.9%	113.8%	129.5%
Safer staffing (Registered)	80%	105.6%	112.7%	116.3%
% 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%	92.9%	*90.0%*
Physical Violence (Patient on Patient)	Trend Monitor	2	2	6
Physical Violence (Patient on Staff)	Trend Monitor	15	4	3
Restraint incidents	Trend Monitor	12	4	*6*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	7	6	14

Ward 18 Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	89.7%	65.5%	78.6%
Sickness	5.0%	10.6%	7.8%	7.9%
Supervision	80%	100.0%	72.7%	88.9%
Information Governance training compliance	>=95%	93.1%	93.1%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	86.2%	86.2%	80.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.8%	75.9%	80.8%
Fire Safety training compliance	>=85%	93.1%	93.1%	92.3%
Bed occupancy	85%	100.9%	99.9%	101.3%
Safer staffing (Overall)	90%	119.0%	104.1%	116.2%
Safer staffing (Registered)	80%	88.7%	88.4%	86.8%
% of clients clinically ready for discharge	3.5%	4.2%	8.1%	7.6%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	93.3%	87.5%	*94.7%*
Physical Violence (Patient on Patient)	Trend Monitor	2	2	0
Physical Violence (Patient on Staff)	Trend Monitor	2	5	15
Restraint incidents	Trend Monitor	4	12	*13*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	1	0	12

Inpatients - Mental Health - Working Age Adults

Elmdale Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	81.8%	82.6%	82.6%
Sickness	5.0%	8.0%	11.6%	8.3%
Supervision	80%	69.2%	92.3%	100.0%
Information Governance training compliance	>=95%	93.3%	93.3%	93.1%
Reducing Restrictive Practice Interventions training compliance	>=80%	86.7%	90.0%	93.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	100.0%	96.4%
Fire Safety training compliance	>=85%	100.0%	100.0%	100.0%
Bed occupancy	85%	99.0%	98.9%	99.3%
Safer staffing (Overall)	90%	114.3%	138.2%	149.5%
Safer staffing (Registered)	80%	95.8%	98.4%	106.0%
% of clients clinically ready for discharge	3.5%	8.2%	3.5%	4.9%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	93.8%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	4	2
Physical Violence (Patient on Staff)	Trend Monitor	0	4	6
Restraint incidents	Trend Monitor	5	15	*5*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	2 (100%)	*0*
Unfilled Shifts	Trend Monitor	1	4	4

Inpatients - Mental Health - Older People Services

Crofton Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	88.5%	85.2%	79.3%
Sickness	5.0%	5.4%	7.9%	3.6%
Supervision	80%	100.0%	87.5%	86.7%
Information Governance training compliance	>=95%	96.7%	96.6%	96.6%
Reducing Restrictive Practice Interventions training compliance	>=80%	78.6%	77.8%	81.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.6%	85.2%	85.2%
Fire Safety training compliance	>=85%	93.3%	96.6%	89.7%
Bed occupancy	85%	95.8%	91.9%	90.0%
Safer staffing (Overall)	90%	193.0%	190.6%	174.4%
Safer staffing (Registered)	80%	153.6%	159.1%	143.4%
% 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%	90.9%	100.0%	*63.6%*
Physical Violence (Patient on Patient)	Trend Monitor	0	1	0
Physical Violence (Patient on Staff)	Trend Monitor	4	2	1
Restraint incidents	Trend Monitor	5	5	*7*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	0	*0*
Unfilled Shifts	Trend Monitor	36	38	26

Poplars CUE Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	95.7%	84.6%	77.8%
Sickness	5.0%	9.6%	11.4%	5.8%
Supervision	80%	100.0%	100.0%	85.7%
Information Governance training compliance	>=95%	94.7%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	76.1%	88.0%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.0%	96.3%	79.2%
Fire Safety training compliance	>=85%	90.4%	96.2%	96.2%
Bed occupancy	85%	80.2%	81.3%	79.3%
Safer staffing (Overall)	90%	253.3%	239.4%	220.1%
Safer staffing (Registered)	80%	123.4%	118.4%	120.4%
% of clients clinically ready for discharge	3.5%	48.8%	52.5%	28.7%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	3	1	1
Physical Violence (Patient on Staff)	Trend Monitor	6	9	4
Restraint incidents	Trend Monitor	12	9	*10*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	49	48	42

Inpatients - Mental Health - Older People Services

Willow Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	84.2%	94.4%	89.5%
Sickness	5.0%	26.8%	24.7%	17.9%
Supervision	80%	83.3%	100.0%	80.0%
Information Governance training compliance	>=95%	100.0%	100.0%	89.5%
Reducing Restrictive Practice Interventions training compliance	>=80%	86.4%	94.7%	89.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.9%	94.7%	94.7%
Fire Safety training compliance	>=85%	90.9%	84.2%	84.2%
Bed occupancy	85%	97.3%	88.4%	96.0%
Safer staffing (Overall)	90%	179.8%	183.8%	168.2%
Safer staffing (Registered)	80%	119.7%	110.2%	95.9%
% of clients clinically ready for discharge	3.5%	1.3%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	50.0%	80.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	2	0
Restraint incidents	Trend Monitor	3	7	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	18	30	30

Beechdale Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	100.0%	100.0%	100.0%
Sickness	5.0%	7.5%	10.3%	12.2%
Supervision	80%	92.3%	100.0%	100.0%
Information Governance training compliance	>=95%	92.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	84.0%	88.0%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	88.0%	87.5%
Fire Safety training compliance	>=85%	96.0%	96.0%	95.8%
Bed occupancy	85%	96.9%	97.4%	95.6%
Safer staffing (Overall)	90%	149.1%	136.4%	128.9%
Safer staffing (Registered)	80%	119.1%	103.4%	110.7%
% of clients clinically ready for discharge	3.5%	13.5%	8.2%	12.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	1
Physical Violence (Patient on Staff)	Trend Monitor	2	0	0
Restraint incidents	Trend Monitor	2	1	*2*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	12	5	1

Ward 19 - Male Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	90.0%	95.0%	95.0%
Sickness	5.0%	10.0%	14.4%	8.5%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	95.8%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	83.3%	87.5%	83.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.5%	91.7%	75.0%
Fire Safety training compliance	>=85%	87.5%	83.3%	95.8%
Bed occupancy	85%	96.9%	90.5%	82.0%
Safer staffing (Overall)	90%	106.3%	108.6%	106.1%
Safer staffing (Registered)	80%	95.0%	85.3%	98.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	2	1	0
Physical Violence (Patient on Staff)	Trend Monitor	8	8	2
Restraint incidents	Trend Monitor	20	9	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	9	0	1

Ward 19 - Female Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	87.5%	87.5%	82.4%
Sickness	5.0%	10.1%	15.6%	13.2%
Supervision	80%	91.7%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	88.9%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	70.0%	77.8%	72.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.0%	77.8%	77.8%
Fire Safety training compliance	>=85%	75.0%	77.8%	83.3%
Bed occupancy	85%	95.1%	97.0%	94.0%
Safer staffing (Overall)	90%	115.1%	99.0%	100.6%
Safer staffing (Registered)	80%	97.0%	107.6%	115.9%
% of clients clinically ready for discharge	3.5%	4.8%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	66.7%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	2	1	0
Physical Violence (Patient on Staff)	Trend Monitor	8	8	2
Restraint incidents	Trend Monitor	20	9	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	4	9	3

Inpatients - Mental Health - Rehab

Enfield Down Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	95.7%	93.8%	91.7%
Sickness	5.0%	4.2%	6.0%	5.8%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	92.0%	100.0%	98.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	75.5%	81.6%	77.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.6%	80.0%	86.4%
Fire Safety training compliance	>=85%	76.0%	78.0%	87.8%
Bed occupancy	Trend Monitor	53.0%	51.9%	51.4%
Safer staffing (Overall)	90%	96.4%	93.7%	97.8%
Safer staffing (Registered)	80%	94.0%	90.2%	104.1%
% of clients clinically ready for discharge	3.5%	5.8%	6.1%	6.2%
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	2	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	2	2

Lyndhurst Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	96.4%	96.4%	96.7%
Sickness	5.0%	1.2%	4.1%	4.5%
Supervision	80%	78.6%	93.3%	100.0%
Information Governance training compliance	>=95%	96.4%	96.4%	96.4%
Reducing Restrictive Practice Interventions training compliance	>=80%	82.1%	85.7%	89.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	89.3%	85.7%	89.3%
Fire Safety training compliance	>=85%	92.9%	92.9%	92.9%
Bed occupancy	Trend Monitor	71.2%	61.5%	73.1%
Safer staffing (Overall)	90%	93.3%	90.8%	91.7%
Safer staffing (Registered)	80%	88.3%	85.2%	85.3%
% of clients clinically ready for discharge	3.5%	9.1%	9.5%	9.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	0.0%	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 (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	0	0

Inpatients - Forensic - Medium Secure

Ward Level Headlines - Forensics

Performance for all wards is being addressed through regular performance clinics with ward managers and the general manager. Appraisals remains a key focus for the service with support from the people business partner. November has seen a number of appraisals require review which has impacted on performance across the service. There are interventions planned which will support the service achieve compliance. Interventions are targeted at individual wards with weekly reviews in place to track progress. The service continues close oversight of mandatory training and has identified areas for targeted improvement.

Medium Secure

• Supervision compliance is within target across the service, except for Priestley (62.5%). The service continues focused work to improve both the uptake, quality and reporting of supervision.
• Sickness variable across medium secure with Priestley (8.8%), Waterton (6.2%) and Chippendale (7.4%) being hotspots with this largely being due to long term sickness on Priestley and Waterton. All other wards are below Trust thresholds reflecting the efforts of managers across the service improving practice following the previous audit.
• Cardiopulmonary rehabilitation compliance plan have demonstrated improvements, with Bronte just below target. at 77.8% IG compliance is the focus of targeted improvement work, with hotspots identified on Priestley (91.3%), Johnson (93.3%) and Bronte (94.4%). The service have worked with the fire service to support staff attending training and plans are in place to improve Hepworth (82.8%) and Johnson (73.3%)
• Compliance for reducing restrictive physical interventions (RRPI) remains challenging for the service but has notable improvements in compliance across the service with Appleton, Johnson, Bronte and Chippendale now compliance and improvements noted for Waterton, Priestley and Hepworth. Continued engagement with occupational health and the RRPI team is in place for staff who have been deferred for advice to support completion of the course. Cross ward working and effective rostering are used to ensure access to staff trained in RRPI.
• Bed occupancy on Appleton (62.5%) 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 72%) is also low but has noted a slight improvement. Neither of these services have a waiting list. Whilst compliant, there are some empty beds on the male pathway within Newton Lodge, these are however within the rehabilitation pathways, Waterton (88.3%) and Priestley (82.2%). The ability to admit and patient flow is being impacted by the wait for high secure care for 2 service users.
• There has been one prone restraint in medium secure (Bronte), under 3 minutes. This does demonstrate a reduction. The service is working with the RRPI team on exit of seclusion training to support reducing the use of prone restraint.
In October a high level of acuity on Bronte impacted on performance, additional focus and support in place has enabled gradual improvements in performance.
Continued work and increased oversight of Priestly is in place to understand the challenges in performance and enable focused intervention and support is in place. We are expecting an improving trajectory.

Low Secure

• Sickness across all wards monitored closely. Sickness levels on Newhaven and Thornhill have remained within target, with Sandal continuing to experience challenges at 6.8%. Ryburn has seen gradual sustained improvement from 24% in September to 15.9% in November. The service is currently being supported by the People Directorate to improve performance.
• Mandatory training compliance has noted a continued improvement in low secure. Hot spots remain on Newhaven in IG (89.7%) and CPR (79.3%), with plans remaining in place to address shortfalls and maintain performance.
• Bed occupancy in low secure is within compliance for Ryburn and Thornhill. Sandal is currently below expected occupancy, however, has experienced a number of recent admissions and clinical acuity. This continued to be monitored. Newhaven continues to experience lower level of referrals and has no waiting list.
• Supervision compliance is within target across the service, except for Thornhill. The service continues focused work to improve both the uptake, quality and reporting of supervision. A plan is in place in relation to Thornhill and this evidenced improvements from 69.2% in October to 76.9% in November.
A continued focus on appraisals has seen improvements on Ryburn (100%), Thornhill remains in target (95.5%). A small increase has also been noted on Sandal at 92%. Newhaven has seen compliance reduce to 89.7%, which is reflective of the number of staff requiring update in November and current service acuity. Plans are in place to ensure all staff have a quality appraisal.
• There were no prone restrains in the service.

Appleton Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	87.5%	87.5%	83.3%
Sickness	5.4%	1.7%	2.4%	1.4%
Supervision	80%	86.7%	85.7%	81.3%
Information Governance training compliance	>=95%	96.0%	92.0%	95.8%
Reducing Restrictive Practice Interventions training compliance	>=80%	92.0%	92.0%	83.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.0%	84.0%	83.3%
Fire Safety training compliance	>=85%	96.0%	96.0%	87.5%
Bed occupancy	90%	62.5%	62.5%	62.5%
Safer staffing (Overall)	90%	111.6%	111.9%	96.3%
Safer staffing (Registered)	80%	100.5%	109.6%	100.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	2	0
Physical Violence (Patient on Staff)	Trend Monitor	2	2	2
Restraint incidents	Trend Monitor	24	19	*9*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	0	*0*
Unfilled Shifts	Trend Monitor	3	3	0

Bronte Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	95.2%	90.9%	95.5%
Sickness	5.4%	4.5%	4.0%	1.5%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	88.9%	83.3%	94.4%
Reducing Restrictive Practice Interventions training compliance	>=80%	77.8%	88.9%	94.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.3%	66.7%	77.8%
Fire Safety training compliance	>=85%	77.8%	77.8%	88.9%
Bed occupancy	90%	85.7%	85.7%	93.8%
Safer staffing (Overall)	90%	99.7%	102.7%	135.7%
Safer staffing (Registered)	80%	96.7%	100.1%	129.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	1	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	3
Restraint incidents	Trend Monitor	0	0	*5*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*1 (100%)*
Unfilled Shifts	Trend Monitor	0	2	4

Chippendale Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	86.4%	81.8%	77.3%
Sickness	5.4%	6.0%	6.6%	7.4%
Supervision	80%	100.0%	86.7%	81.3%
Information Governance training compliance	>=95%	96.3%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	77.8%	77.8%	84.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.9%	81.5%	88.5%
Fire Safety training compliance	>=85%	92.6%	92.6%	88.5%
Bed occupancy	90%	100.0%	100.0%	100.0%
Safer staffing (Overall)	90%	139.4%	130.2%	129.8%
Safer staffing (Registered)	80%	138.6%	131.5%	122.8%
% 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	0	0
Restraint incidents	Trend Monitor	11	4	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	7	7	5

Hepworth Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	100.0%	96.4%	86.2%
Sickness	5.4%	3.8%	5.8%	4.1%
Supervision	80%	93.3%	94.4%	100.0%
Information Governance training compliance	>=95%	96.4%	96.6%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	75.0%	72.4%	75.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.9%	89.3%	89.3%
Fire Safety training compliance	>=85%	96.4%	89.7%	82.8%
Bed occupancy	90%	92.4%	92.0%	92.4%
Safer staffing (Overall)	90%	96.8%	94.5%	93.4%
Safer staffing (Registered)	80%	81.4%	74.0%	80.4%
% of clients clinically ready for discharge	3.5%	7.2%	7.2%	7.2%
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	3	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	0	*0*
Unfilled Shifts	Trend Monitor	1	0	0

Inpatients - Forensic - Medium Secure

Johnson Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	96.3%	88.9%	77.8%
Sickness	5.4%	2.6%	3.4%	4.4%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	86.7%	93.3%	93.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	86.7%	96.7%	96.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	93.3%	93.3%	96.7%
Fire Safety training compliance	>=85%	93.3%	83.3%	73.3%
Bed occupancy	90%	73.3%	68.6%	72.0%
Safer staffing (Overall)	90%	113.5%	116.3%	128.0%
Safer staffing (Registered)	80%	101.8%	99.1%	99.8%
% 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	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	4	2	5

Priestley Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	71.4%	63.6%	50.0%
Sickness	5.4%	9.3%	10.6%	8.8%
Supervision	80%	92.9%	71.4%	62.5%
Information Governance training compliance	>=95%	87.0%	100.0%	91.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	54.5%	71.4%	77.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	95.5%	90.5%	90.9%
Fire Safety training compliance	>=85%	82.6%	90.9%	87.0%
Bed occupancy	90%	89.8%	88.2%	82.2%
Safer staffing (Overall)	90%	91.6%	89.3%	91.7%
Safer staffing (Registered)	80%	86.9%	84.6%	89.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	1	0	0

Waterton Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	68.2%	85.7%	80.0%
Sickness	5.4%	8.4%	7.6%	6.2%
Supervision	80%	92.3%	83.3%	81.8%
Information Governance training compliance	>=95%	96.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	68.0%	73.9%	77.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.0%	78.3%	86.4%
Fire Safety training compliance	>=85%	96.0%	100.0%	95.5%
Bed occupancy	90%	89.6%	91.7%	88.3%
Safer staffing (Overall)	90%	120.1%	119.1%	123.8%
Safer staffing (Registered)	80%	112.5%	107.1%	117.7%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	2	2

Inpatients - Forensic - Low Secure

Thornhill Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	100.0%	100.0%	95.5%
Sickness	5.4%	1.2%	1.8%	1.2%
Supervision	80%	92.3%	69.2%	76.9%
Information Governance training compliance	>=95%	100.0%	100.0%	96.2%
Reducing Restrictive Practice Interventions training compliance	>=80%	92.3%	96.2%	96.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.2%	96.2%	96.2%
Fire Safety training compliance	>=85%	100.0%	100.0%	100.0%
Bed occupancy	85%	86.4%	90.5%	90.7%
Safer staffing (Overall)	90%	107.4%	97.2%	98.3%
Safer staffing (Registered)	80%	95.9%	97.5%	103.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	3	0	0

Sandal Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	91.7%	91.7%	92.0%
Sickness	5.4%	5.7%	6.8%	6.8%
Supervision	80%	93.3%	93.3%	93.8%
Information Governance training compliance	>=95%	96.9%	96.8%	96.7%
Reducing Restrictive Practice Interventions training compliance	>=80%	68.8%	83.9%	80.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	81.3%	74.2%	80.0%
Fire Safety training compliance	>=85%	96.9%	93.5%	96.7%
Bed occupancy	85%	92.9%	88.9%	82.1%
Safer staffing (Overall)	90%	133.2%	148.2%	176.5%
Safer staffing (Registered)	80%	102.9%	111.6%	128.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	2	0	2
Physical Violence (Patient on Staff)	Trend Monitor	0	1	1
Restraint incidents	Trend Monitor	8	3	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	4	8	6

Inpatients - Forensic - Low Secure

Ryburn Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	100.0%	87.5%	100.0%
Sickness	5.4%	24.0%	23.1%	15.9%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	85.7%	85.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	100.0%	100.0%
Fire Safety training compliance	>=85%	100.0%	100.0%	100.0%
Bed occupancy	85%	94.8%	89.9%	98.1%
Safer staffing (Overall)	90%	99.0%	99.9%	100.0%
Safer staffing (Registered)	80%	98.4%	99.9%	100.7%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	0	0

Newhaven Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	92.0%	92.6%	89.7%
Sickness	5.4%	5.0%	4.9%	4.9%
Supervision	80%	81.3%	82.4%	94.1%
Information Governance training compliance	>=95%	96.6%	100.0%	89.7%
Reducing Restrictive Practice Interventions training compliance	>=80%	79.3%	86.2%	89.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	89.7%	86.2%	79.3%
Fire Safety training compliance	>=85%	96.6%	96.6%	93.1%
Bed occupancy	85%	75.8%	75.0%	75.0%
Safer staffing (Overall)	90%	120.1%	115.5%	115.0%
Safer staffing (Registered)	80%	106.0%	111.6%	115.4%
% 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	2	1	0
Physical Violence (Patient on Staff)	Trend Monitor	1	1	0
Restraint incidents	Trend Monitor	2	0	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	17	2	0

Inpatients - Non-Mental Health

• **Appraisal rate:**
NRU rate is showing a consistent figure for November of 89.7%.
SRU rate has seen a further increase to 95.0% for November which achieves full compliance.

• **Sickness:**
NRU – sickness has dipped for November at 8.7%. Significant LTS due to 2 x bereavement and 2 x planned surgery (hip replacements). This is being managed via HR processes and sickness reviews.
SRU – sickness has significantly improved during November to achieve compliance at 1.3% - 3 staff on LTS have returned to work.

• **Supervision:**
NRU remains at similar level this month - below compliance at 73.1% for November. Acuity and dependency of patient cohort have impacted capacity to undertake supervision sessions. In addition, the 4 out of area beds have now opened also.
SRU figures for November have maintained compliancy at 94.7%.

• **Information Governance:**
NRU – continues to maintain compliance achieving 100%.
SRU – has seen a further dip this month to 89.1%. Targeted approach to individual members of staff with outstanding IG training.

• **Cardiopulmonary resuscitation (CPR):**
NRU – an increase during November to 79.5% almost achieving compliance.
SRU – remains at 73.3% for November.
Further training took place on 19 and 20 November which should show in December figures.
To note: Resus Lead has advised that the process for CPR training recording is that they send the signature sheets to L&D. These are inputted by L&D but at irregular intervals once per month. Therefore, there is a potential for up to a 6-week lag before the updated training statistics are showing.

Neuro Rehabilitation Unit (NRU) Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	88.6%	89.7%	89.7%
Sickness	5.0%	8.6%	5.9%	8.7%
Supervision	80%	90.9%	74.1%	73.1%
Information Governance training compliance	>=95%	97.5%	97.6%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	72.5%	79.5%
Fire Safety training compliance	>=85%	90.0%	82.9%	85.4%
Bed occupancy (Barnsley Commissioned beds only)	80%	54.2%	72.8%	72.8%
Safer staffing (Overall)	90%	113.5%	121.5%	118.5%
Safer staffing (Registered)	80%	113.9%	114.5%	117.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Unfilled Shifts	Trend Monitor	0	0	0

Stroke Rehabilitation Unit (SRU) Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	94.7%	94.9%	95.0%
Sickness	5.0%	6.8%	8.1%	1.3%
Supervision	80%	91.4%	94.7%	94.7%
Information Governance training compliance	>=95%	95.3%	92.2%	89.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.3%	73.3%	73.3%
Fire Safety training compliance	>=85%	92.2%	87.5%	89.1%
Bed occupancy	80%	94.4%	94.6%	80.0%
Safer staffing (Overall)	90%	104.3%	108.4%	107.8%
Safer staffing (Registered)	80%	126.1%	133.2%	129.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Unfilled Shifts	Trend Monitor	0	0	0

Inpatients - Mental Health - Learning Disability

Headlines

• Strong progress on appraisals (97.2%), reflected in improved performance.
• Good supervision compliance (88.2%) and remains within target.
• Maintained progress in RRPI training (94.1%) and fire training compliance (89.2%), some hotspots in IG (91.1%) and CPR (79.4%) compliance that the Ward Manager has plans has identified as an area of focus and continued plans in place to address. Continued engagement with occupational health and the RRPI team is in place for staff who have been deferred for advice to support completion of the course.
• 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. There has been some potential progress, and the service are planning for a discharge in January. A continued reduction in incidents involving restraint is evident, with 28 incidents in November (from 40 in September and 33 in October). No prone restraint.

Horizon

Metrics	Threshold	Sep-24	Oct-24	Nov-24
Appraisal rate	95%	94.7%	89.2%	97.2%
Sickness	5.0%	2.3%	6.0%	6.9%
Supervision	80%	80.0%	100.0%	88.2%
Information Governance training compliance	>=95%	94.4%	94.6%	91.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	84.8%	95.3%	94.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.8%	79.4%	79.4%
Fire Safety training compliance	>=85%	83.3%	89.2%	89.2%
Bed occupancy	N/A	62.5%	62.5%	60.8%
Safer staffing (Overall)	90%	178.4%	171.4%	164.7%
Safer staffing (Registered)	80%	113.7%	152.5%	135.9%
% of clients clinically ready for discharge	3.5%	80.0%	80.0%	80.0%
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	29	24	12
Restraint incidents	Trend Monitor	40	33	*28*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*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 with/in agreed timescales
A	Needs additional action to stay on track and/or on schedule
R	Not on track and/or at risk of not delivering within agreed timescales. Requires review
B	Completed

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving health	Address inequalities involvement and equality in each of our places with our partners	Work continues with partners in each of our four places to address inequalities. We are clear what the differential impacts are for key groups of the people we serve. Reducing inequalities is one of our leadership priorities to improve quality going forward. A governance structure has been developed to coordinate and connect the different strands of work . In West Yorkshire, attended Patient Carer Race Equality Framework (PCREF) workshop and shared our Trusts approach to implementation, shared learning and insight, explored opportunities to work as a system to overcome challenges and collaboration on development of West Yorkshire Equality, Diversity, Inclusion (EDI) strategy. In South Yorkshire, attended anti racism workshops exploring collective approach to developing an assessment framework, based on North West Alliance anti racism framework. This is the approach the Trust has already agreed to follow on our journey to becoming a truly anti racist organisation as part of our refreshed EDI strategy.	
Improving care	Transform our Older People inpatient services	In November 2024 the Joint Integrated Care Board committee of Calderdale, Kirklees and Wakefield approved the decision-making business case and option 1A for implementation and a range of communications has taken place. The staff consultation (with staff based at the Poplars) is taking place through December 2024 and into January 2025. Work to procure a preferred supplier for estates work in Wakefield is continuing. Planning of implementation phase is now taking place. New governance and working groups for implementation phase will be established through January and February 2025.	
	Improve our mental health services so they are more responsive, inclusive, and timely	**Improving Access to Care Programme** Data gathering is underway to support understanding (Quality Improvement step 2 improvement) for both Core Psychology and Memory Services waits. In-depth proforma returned gathering processes, views and team differences/ similarities as well as meetings with psychology leads. Further exploration of data quality working with the Trusts Performance & Business Intelligence team. Workshops for Calderdale and Kirklees memory services have taken place and Barnsley and Wakefield organised to process map and understand variations in pathways across the places. This work continues to be underpinned by the fundamental key drivers such as reducing health inequalities through application of literature and policy (CORE20Plus5 and Kings Fund). **Care Closer to Home (CC2H) Programme** • Discharge Oversight Group: Discharge Initiatives plan has been reviewed and is awaiting approval by the group to commence January 2025. • Work continues on maintaining a low out of area presence and quality monitoring the impact on both inpatient services and community teams. • Meetings being held with commissioners in each locality regarding accessing alternatives to admission. • Work to improve communications, response and escalation processes with the acute trusts almost completed • Working with local services to manage people within locality where possible • Set up weekly clinically ready for discharge meetings to tackle blockages • Setting up review panels to explore alternative to admissions with teams **Inpatient Mental Health Improvement Programme** New governance structure in place to align inpatient programme with CC2H and forensic programme. Therapeutic inpatient care activity continues with the Reducing Restrictive Physical Interventions (RRPI) service and a focus on self-harm. Sensory Rainbow lighting has been installed in Horizon ward. Creative installations are planned in Ashdale ward and Ward 19 (December 2024, January 2025). Culture of care quality improvement activity now continuing, all wards have completed NHS England benchmarking framework and are implementing triangle of care. Wards are developing lived experience roles and approaches and trauma informed approaches.	

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** Following agreement to re-plan the implementation of the new care plan for January 2025 to incorporate the further enhancements, a final iteration of the new care plan is now being developed. Further workshops were held with staff during November 24. A showcase of all products created during the programme including the care plan, good practice guide and training programme was held in October. A set of proposed new measures has been developed alongside care groups and Performance and Business Intelligence colleagues and will launch alongside the care plan in January 25.	
Improving use of resources	Spend money wisely and increase value	**Value for money (VfM)** • Built in savings (£22m) continue to be behind plan. • Whilst there are some positive schemes the main driver, as linked to the overall financial position, relates to workforce growth which has been higher than planned. • Additional non-recurrent mitigations to ensure delivery of the financial position are being developed with an estimate included in the forecast. • VfM Programme Board chaired by director of finance and resources relaunched 22nd November, whilst initial focus is remaining schemes for 24/25; key lines of enquiry are being reviewed for 25/26, senior responsible officers have been assigned and development of documentation for each scheme is in progress. • Annual planning workshops are complete for care groups, with value for money initiatives forming part of these discussions across all directorates and services.	
	Make digital improvements	**Digital Dictation** Project remains in amber status due to the escalation triggered in November from issues, defects and application errors which hindered operational activity. A task and finish group including supplier continues to meets three times weekly with weekly reporting of progress to escalation management group. A fix is expected from a new version of Lexacom (v1.0.10) which is currently being tested. Testing is going well and it is anticipated that further deployments will be resumed from January 25 if this continues.	
Great place to work	People Directorate – Delivery of People Promise	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)	(£0.8m)	£0m	The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £0.8m deficit has been reported which is a £0.2m increase from last month. The main financial driver remains workforce related expenditure.
2	Agency Spend	£4.2m	£6.1m	Agency expenditure run rate has continued to fluctuate. Spend in November is £578k which is £42k less than last month. The average run rate for the year to date is £521k per month. The provider collaborative spend in month was £60k.
3	Financial sustainability and efficiencies	£12.6m	£21.7m	The Trust financial sustainability programme for 2024 / 25 has a target of £22.0m to achieve the breakeven target. Whilst there are some positive schemes the main driver, as linked to the overall financial position, relates to workforce growth which has been higher than planned. Additional non-recurrent mitigations to ensure delivery of the financial position are being developed with an estimate included in the forecast.
4	Cash	£55.7m	£51.1m	The Trust cash balance has reduced in month. The priority remains timely receipt of income; the majority of this is expected to be received in December 2024.
5	Capital	£2.5m	£8.1m	The Trust capital allocation for 2024 / 25 is £8.1m. Expenditure is currently behind the expected profile with variances against IM & T schemes (orders in process) and the older people transformation scheme for which expenditure profiles have been revised. The forecast remains that the allocation will be fully utilised. From October 2024 capital expenditure relating to Cheswold Park has been added. This is presented separately as this has specific capital allocation backing.
6	Better Payment Practice Code	98%		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.

Appendix 1 - Cheswold Park Hospital

Improving health

Metrics	Trust Threshold	Oct-24	Nov-24	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	98.5%	98.5%	Based on all current inpatients (65 as at 30/11/2024)
Percentage of service users who have had their equality data recorded - disability	50%	100.0%	100.0%	Based on all current inpatients (65 as at 30/11/2024)
Percentage of service users who have had their equality data recorded - sexual orientation		93.8%	93.8%	
Completion of equality mandatory training	>=80%	99.0%	99.0%	100% of ward and central support services staff; 92% of clinical staff

Improving Care

Metrics	Trust Threshold	Oct-24	Nov-24	Notes
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	2	3	Out of a total number (54) of violence and aggression incidents occurred in November 2024

Make SWYPFT a great place to work

Metrics	Trust Threshold	Oct-24	Nov-24	Notes
Turnover external (in month)	>12% - 13%<	2.1%		
Sickness absence - In month	<=5.4%	6.3%		
Staff supervision rate	80%	61.0%	72.5%	
Mandatory training - Cardiopulmonary resuscitation	80%	96.0%	93.0%	includes training for Immediate Life Support, Basic Life Support
Mandatory training - Reducing restrictive physical interventions (RRPI)	80%	96.0%	93.0%	includes training for Prevention and Management of Violence and Aggression and Breakaway
Mandatory training - Fire	85%	97.0%	98.0%	
Mandatory training - Information governance (IG)	95%	97.0%	97.0%	

Appendix 1 - Cheswold Park Hospital

Quality Headlines

Section	KPI	Trust Threshold	Oct-24	Nov-24
Complaints	% of feedback with staff attitude as an issue	< 20%	18% (2/11)	50% (7/14)
	Complaints - Number of responses provided within six months of the date a complaint received	100.0%	100.0%	N/A
Quality	Notifiable Safety Incidents (where Duty of Candour applies)	Trend monitor	0	0
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions	Trend monitor	0	0
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches	0	0	0
	% Service users on CPA offered a copy of their care plan	80%	100.0%	
	Number of Information Governance breaches	<12	2	2
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95.0%	No admissions	No admissions
	Total number of reported incidents	Trend monitor	215	201
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available)	Trend monitor	2	4
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available)	Trend monitor	0	0
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available)	Trend monitor	0	0
	Safer staff fill rates (% Overall)	90%	94.4%	97.8%
	Safer Staffing % Fill Rate - Registered Nurses Overall	80%	142.9%	105.9%
	Safer Staffing % Fill Rate - Registered Nurses Days	80%	157.8%	100.7%
	Safer Staffing % Fill Rate - Registered Nurses Nights	80%	126.5%	113.2%
	% of prone restraint with duration of 3 minutes or less	90%	No prone restraints	No prone restraints
	Number of Falls (inpatients)	Trend monitor	2	1
	Number of restraint incidents	Trend monitor	14	20
	% of staff receiving supervision within policy guidance	80.0%	61.0%	75.5%
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	0	0	0

Quality Headlines

Number of Information Governance breaches - 2 incidents reported during the month related to an email being sent to the incorrect recipient. Email was not delivered and has bounced back; the second incidents related to ward handover document was left in the activity room.

Appendix 1 - Cheswold Park Hospital

Safety First

Summary of Incidents

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

90% of incidents occurred in November 2024 resulted in no harm or near miss.
No never events, or incident resulted in major, permanent, catastrophic harm or death occurred in November 2024.

	Oct	Nov
2 AMBER	3	4
1 YELLOW	20	16
0 GREEN	192	181

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

Breakdown of incidents in November 2024 - 4 moderate harm incidents:
The most common cause(s) for these incidents were due to self injurious behaviours and violence and aggression.
No severe harm incidents

Appendix 1 - Cheswold Park Hospital

Safeguarding

Safeguarding Adults:
There were six safeguarding adult incidents at Cheswold Park Hospital in November 2024 all of which resulted in no harm. The most common reasons for these incidents were 'Violence and Aggression' and 'Bullying and Harrassment'.

Safeguarding Children:
There were no safeguarding children incidents in November 2024.

Complaints

- There were 14 new complaints in November of which nine were formal and five informal. All of the complaints received were regarding inpatients.
- Of the 14 new complaints received, three are noted as 'awaiting investigator appointment', four are 'under investigation', one is 'extension', and six 'response sent & closed'.
- Seven of the new complaints related to 'Attitude Of Staff', and seven related to 'All Aspects Of Clinical Treatment'.
- Eight responses were sent in November.
- Seven compliments were received in November 2024 including five that related to 'Attitude Of Staff' and two relating to 'All Aspects Of Clinical Treatment'.

Reducing Restrictive Physical Intervention (RRPI)

- There were 20 restraint related incidents occurred in November 2024, making up 10% (20/201) of the total November incidents.
- As in October, there was no incidents implemented in prone position in November.

Appendix 1 - Cheswold Park Hospital

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Trust Threshold	Oct-24	Nov-24
Establishment	Improving Resources	Well Led	-	335.9	331.5
Contracted Staff In Post (Ledger)			-		
Vacancies			-	-11.8	-7.4
Turnover external (October only)			>12% - <13%	1.5%	
Starters			-	0.0	0.0
Leavers			-	7.0	7.0
International Nurse Starters in Month			-	0	0
% Bank Fill Rates - Registered Nurses			-	N/A	N/A
% Bank Fill Rates - Health Care Assistants			-	N/A	N/A
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)			-	N/A	N/A
Sickness absence - Month			<=5%	6.3%	
Employees with long term sickness over 12 months			-	1	1
Appraisals - rolling 12 months			95%	64.0%	62.0%
Employee Relations - Suspensions (over 90 days)			-	0	0
Mandatory Training - TOTAL	Improving Care		>=80%	98.0%	98.0%
Mandatory Training - Reducing Restrictive Practice Interventions				96.0%	93.0%
Mandatory Training - Cardiopulmonary Resuscitation				96.0%	93.0%
Mandatory Training - Clinical Risk				N/A	N/A
Mandatory Training - Display Screen Equipment				N/A	N/A
Mandatory Training - Equality & Diversity				99.0%	99.0%
Mandatory Training - Fire Safety			>=85%	97.0%	98.0%
Mandatory Training - Food Safety			>=80%	99.0%	99.0%
Mandatory Training - Freedom To Speak Up (FTSU)				99.0%	99.0%
Mandatory Training - Infection Control & Hand Hygiene				98.0%	98.0%
Mandatory Training - Information Governance (Data Security)			>=95%	97.0%	97.0%
Mandatory Training - Moving & Handling			>=80%	97.0%	98.0%
Mandatory Training - Mental Capacity Act/Dols				96.0%	95.0%
Mandatory Training - Mental Health Act				96.0%	95.0%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				97.0%	98.0%
Mandatory Training - Prevent			>=80%	N/A	N/A
Mandatory Training - Safeguarding Adults				93.0%	99.0%
Mandatory Training - Safeguarding Children				93.0%	99.0%

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 8 (2024 / 25)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

Key Performance Indicator		Year to date	Forecast 2024 / 25	Narrative
1	Surplus / (Deficit)	(£0.8m)	£0m	The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £0.8m deficit has been reported which is a £0.2m increase from last month. The main financial driver remains workforce related expenditure.
2	Agency Spend	£4.2m	£6.1m	Agency expenditure run rate has continued to fluctuate. Spend in November is £578k which is £42k less than last month. The average run rate for the year to date is £521k per month. The provider collaborative spend in month was £60k.
3	Financial sustainability and efficiencies	£12.6m	£21.7m	The Trust financial sustainability programme for 2024 / 25 has a target of £22.0m to achieve the breakeven target. Whilst there are some positive schemes the main driver, as linked to the overall financial position, relates to workforce growth which has been higher than planned. Additional non-recurrent mitigations to ensure delivery of the financial position are being developed with an estimate included in the forecast.
4	Cash	£55.7m	£51.1m	The Trust cash balance has reduced in month. The priority remains timely receipt of income; the majority of this is expected to be received in December 2024.
5	Capital	£2.5m	£8.1m	The Trust capital allocation for 2024 / 25 is £8.1m. Expenditure is currently behind the expected profile with variances against IM & T schemes (orders in process) and the older people transformation scheme for which expenditure profiles have been revised. The forecast remains that the allocation will be fully utilised. From October 2024 capital expenditure relating to Cheswold Park has been added. This is presented separately as this has specific capital allocation backing.
6	Better Payment Practice Code	98%		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.

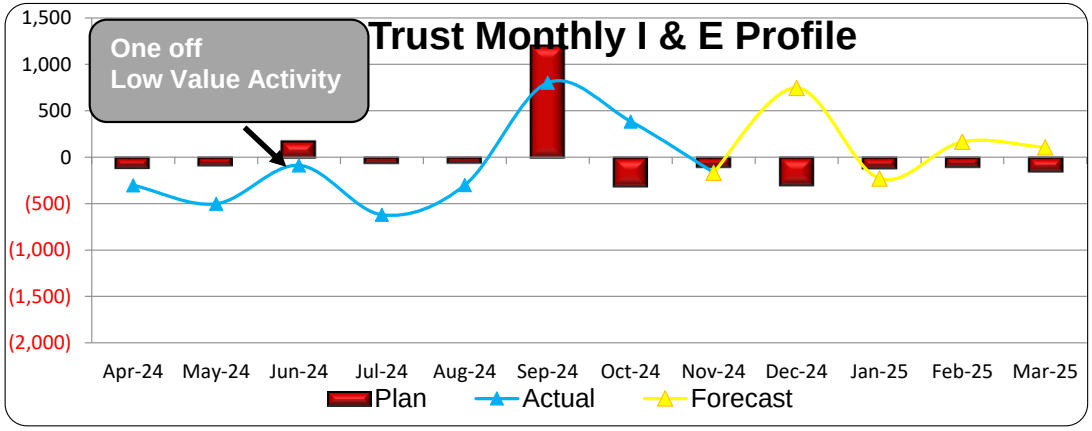
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

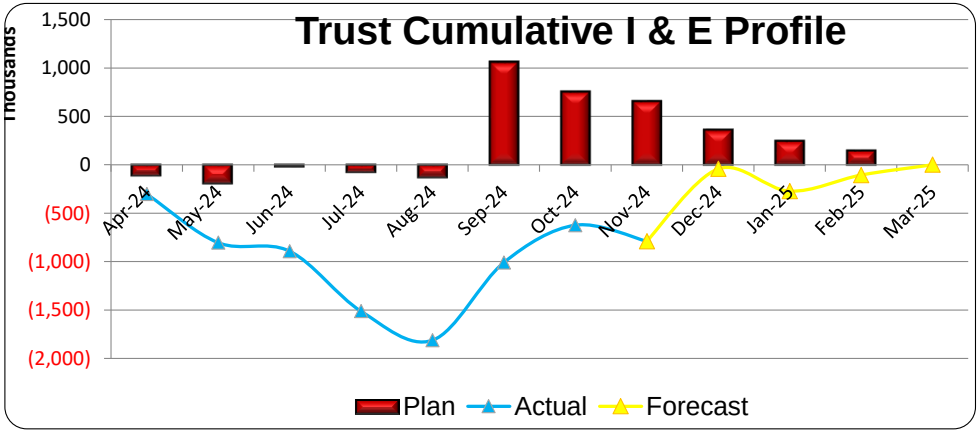
2.0 Income & Expenditure Position 2024 / 25

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					36,904	37,871	967	284,199	285,118	918	431,032	432,111	1,079
Other Operating Revenue					1,366	1,433	68	11,281	11,877	596	16,429	17,179	750
Total Revenue					**38,270**	**39,304**	**1,035**	**295,480**	**296,994**	**1,514**	**447,461**	**449,290**	**1,830**
Pay Costs	5,419	5,468	49	0.9%	(24,137)	(24,317)	(180)	(182,013)	(183,427)	(1,414)	(277,265)	(278,205)	(940)
Non Pay Costs					(13,663)	(14,581)	(918)	(109,229)	(110,757)	(1,528)	(164,306)	(165,012)	(706)
Gain / (loss) on disposal					0	0	0	0	24	24	0	24	24
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,419**	**5,468**	**49**	**0.9%**	**(37,800)**	**(38,899)**	**(1,099)**	**(291,242)**	**(294,160)**	**(2,918)**	**(441,571)**	**(443,193)**	**(1,623)**
EBITDA	**5,419**	**5,468**	**49**	**0.9%**	**470**	**406**	**(64)**	**4,238**	**2,835**	**(1,404)**	**5,890**	**6,097**	**207**
Depreciation					(598)	(582)	16	(4,351)	(4,347)	3	(6,742)	(6,760)	(18)
PDC Paid					(274)	(295)	(21)	(1,622)	(1,930)	(308)	(2,718)	(3,190)	(472)
Interest Received					303	305	3	2,390	2,653	263	3,570	3,853	283
Surplus / (Deficit) - ICB performance measure	**5,419**	**5,468**	**49**	**0.9%**	**(99)**	**(166)**	**(66)**	**656**	**(790)**	**(1,446)**	**0**	**(0)**	**(0)**
Depn Peppercorn Leases (IFRS16)					(9)	(9)	0	(70)	(70)	0	(94)	(94)	0
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,419**	**5,468**	**49**	**0.9%**	**(108)**	**(175)**	**(66)**	**586**	**(860)**	**(1,446)**	**(94)**	**(94)**	**0**





Income & Expenditure Position 2024 / 25

The consolidated financial position is a year to date deficit of £0.8m. This is £1.5m behind plan. Financial performance in November is a deficit of £0.2m which is £0.1m worse than planned.

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 with a reiterated commitment to achieve breakeven. This commitment was again made following the impact of additional pay awards paid in October and November. Whilst income uplifts were also received this has also created a further financial pressure which will require mitigation.

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. In October 2024 Cheswold Park Hospital has also been included as a separate section. This is primarily to help with comparability of the core Trust financial values due to the part year stepped change. 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)	5,050	5,110	60	1.2%	(341)	(261)	81	(1,131)	(2,192)	(1,061)	(2,014)	(4,459)	(2,446)
Cheswold Park Hospital	334	324	(10)	3.0%	111	154	43	222	165	(56)	665	178	(487)
Provider Collaboratives	23	34	11	49.7%	2	37	35	20	539	520	29	(85)	(114)
Budgets held centrally	12	0	(12)	100.0%	129	(97)	(225)	1,546	698	(848)	1,319	4,366	3,047
Total - Consolidated position (ICB performance measure)	**5,419**	**5,468**	**49**	**0.9%**	**(99)**	**(166)**	**(66)**	**656**	**(790)**	**(1,446)**	**0**	**(0)**	**(0)**

Three, out of the 4, components of the consolidated Trust financial position have reported better than plan in month. For the main Trust services this is an in month deficit of £261k and is the main driver of the overall total deficit. Expenditure against budgets held centrally relates to provision for ongoing national workforce issues.

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

2.0 Income & Expenditure Position 2023 / 24

This section focusses on the financial performance of South West Yorkshire Partnership NHS Foundation Trust. This excludes the financial impact of Provider Collaboratives, Cheswold Park Hospital and budgets held centrally which are presented separately. 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.

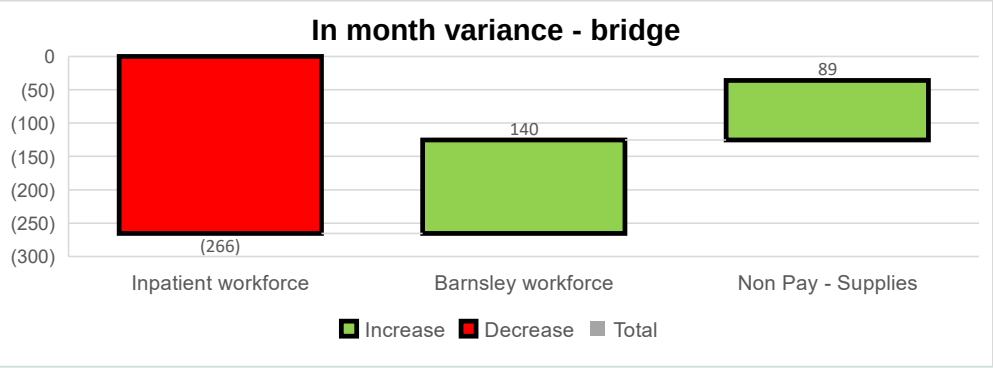
Total Financial Position - Core Trust only

	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					26,157	26,305	148	206,412	205,790	(622)	310,303	309,149	(1,154)
Other Operating Revenue					1,309	1,357	47	9,760	9,964	204	14,636	14,923	287
Total Revenue					**27,466**	**27,661**	**195**	**216,172**	**215,754**	**(417)**	**324,939**	**324,073**	**(866)**
Pay Costs	5,050	5,110	60	1.2%	(22,724)	(22,870)	(146)	(177,793)	(178,958)	(1,164)	(267,393)	(268,867)	(1,474)
Non Pay Costs					(4,682)	(4,607)	75	(36,263)	(35,677)	586	(54,678)	(54,552)	125
Gain / (loss) on disposal					0	0	0	0	24	24	0	24	24
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,050**	**5,110**	**60**	**1.2%**	**(27,406)**	**(27,477)**	**(71)**	**(214,057)**	**(214,611)**	**(554)**	**(322,071)**	**(323,395)**	**(1,325)**
EBITDA	**5,050**	**5,110**	**60**	**1.2%**	**60**	**184**	**124**	**2,115**	**1,144**	**(971)**	**2,868**	**677**	**(2,191)**
Depreciation					(525)	(530)	(5)	(4,205)	(4,229)	(24)	(6,304)	(6,350)	(46)
PDC Paid					(179)	(220)	(41)	(1,432)	(1,760)	(328)	(2,148)	(2,640)	(492)
Interest Received					303	305	3	2,390	2,653	263	3,570	3,853	283
Surplus / (Deficit) - ICB performance measure	**5,050**	**5,110**	**60**	**1.2%**	**(341)**	**(261)**	**81**	**(1,131)**	**(2,192)**	**(1,061)**	**(2,014)**	**(4,459)**	**(2,446)**
Depn Peppercorn Leases (IFRS16)					(9)	(9)	0	(70)	(70)	0	(94)	(94)	0
Losses Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,050**	**5,110**	**60**	**1.2%**	**(350)**	**(269)**	**81**	**(1,201)**	**(2,262)**	**(1,061)**	**(2,108)**	**(4,553)**	**(2,446)**

As previously noted the core Trust position is an in month deficit although this is a lower deficit than planned. Workforce, with worked WTE greater than plan, is the largest driver of the pay overspend with is offset by better than plan positions on income and non pay.

Key headlines are included below and illustrated within the bridge:

	£k
Workforce pressures - Inpatient (Adult, Older People for Wakefield & Barnsley)	(266)
Workforce pressures - continued recruitment into new service model	140
Non pay - Supplies & Services sub category less than planned	89

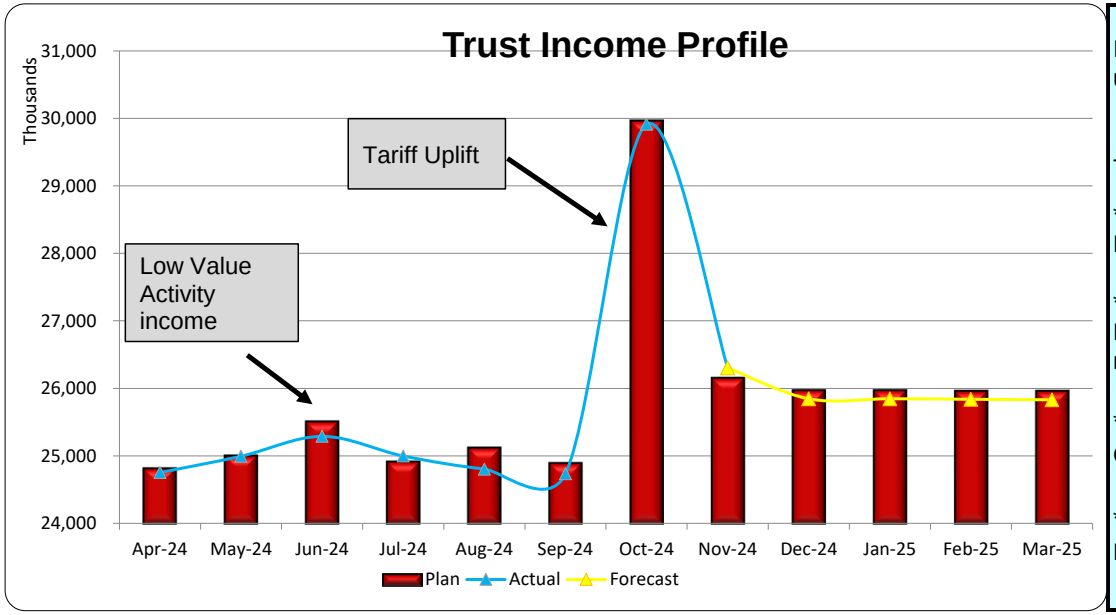


2.1 Income Information

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	21,299	21,144	21,210	25,592	22,037	22,067	22,067	22,067	22,059	**263,545**	263,556	(11)
Specialist Commissioner	**34,541**	2,943	2,962	2,974	2,947	2,956	2,827	5,239	1,495	3,039	3,039	3,039	3,038	**36,495**	36,681	(186)
Local Authority	**5,799**	378	400	371	398	377	360	381	684	397	398	386	386	**4,916**	5,196	(279)
Partnerships	**6,748**	205	219	191	218	207	207	222	293	209	210	214	215	**2,611**	3,008	(398)
Other Contract Income	**1,454**	131	220	37	135	121	131	136	140	133	133	133	133	**1,582**	1,861	(279)
Total	**293,862**	**24,752**	**24,994**	**25,289**	**24,997**	**24,805**	**24,735**	**31,570**	**24,649**	**25,845**	**25,846**	**25,838**	**25,830**	**309,149**	**310,303**	**(1,154)**
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	9,186	9,176	9,627	10,686	9,938	9,308	9,289	9,224	9,308	**113,171**		
Total	**293,862**	**33,870**	**34,155**	**34,439**	**34,183**	**33,981**	**34,362**	**42,256**	**34,586**	**35,153**	**35,135**	**35,062**	**35,138**	**422,321**		



Income, actuals and budgets, have been updated for the tariff uplift actioned in October and backdated to April.

The key variances are shown below:

* Partnership - Youth Offenders Contract £398k
Reimbursement based on actual costs incurred

* Yorkshire Smokefree - Payment by results £162k & £76k
Less income than plan due to activity levels. Offset by a similar reduction in expenditure.

* Additional Roles Reimbursement Posts £266k
Offset by reduced pay costs. Recharged on staff in post

* NHS England Liaision & Diversion £134k
Reduced income from slippage in recruitment

2.2 Pay Information

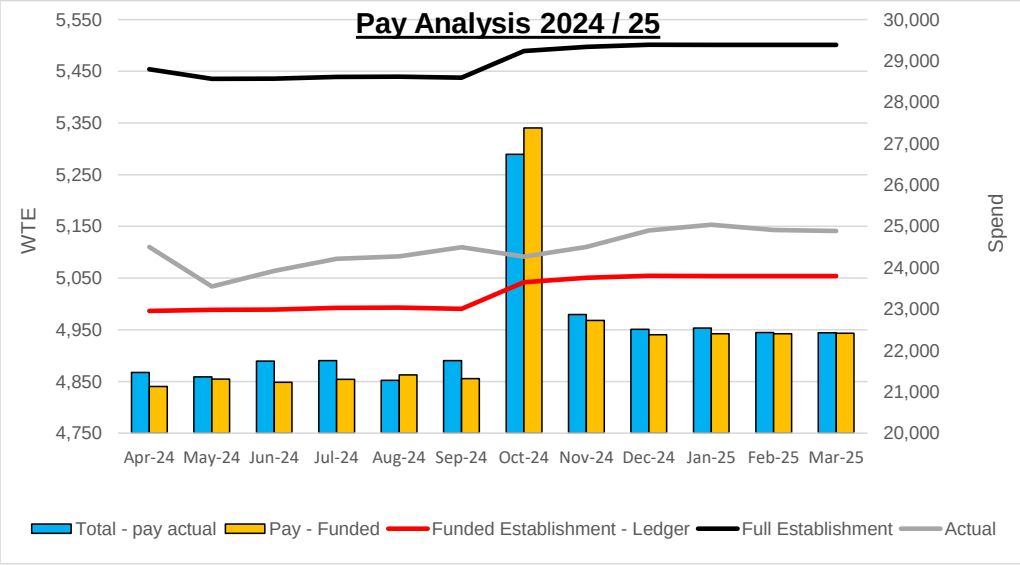
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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	19,503	19,075	19,495	24,199	20,625	20,343	20,390	20,380	20,380	**242,489**
Bank & Locum	1,955	1,581	1,673	1,738	1,771	1,827	1,980	1,793	1,751	1,757	1,709	1,704	**21,239**
Agency	413	400	444	510	429	434	561	452	416	396	342	343	**5,140**
Total	**21,466**	**21,360**	**21,739**	**21,751**	**21,275**	**21,756**	**26,741**	**22,870**	**22,509**	**22,543**	**22,431**	**22,427**	**268,867**
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%	8.0%	8.3%	8.4%	7.4%	7.8%	7.8%	7.8%	7.6%	7.6%	7.9%
Agency as % (in month)	1.9%	1.9%	2.0%	2.3%	2.0%	2.0%	2.1%	2.0%	1.8%	1.8%	1.5%	1.5%	1.9%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,574	4,574	4,591	4,579	4,565	4,588	4,590	4,603	4,645	4,659	4,662	4,662	**4,608**
Bank & Locum	474	401	411	435	456	460	431	445	434	433	423	421	**435**
Agency	62	59	62	74	71	62	70	62	63	60	58	58	**64**
Total	**5,110**	**5,034**	**5,064**	**5,087**	**5,092**	**5,110**	**5,092**	**5,110**	**5,142**	**5,153**	**5,143**	**5,141**	**5,107**
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**



In November 2024 the remaining pay awards for 2024 / 25, back dated to April 2024, have now been paid. No further rate adjustments are expected in year and these rates have been incorporated into the forecast run rate.

The total worked WTE in November is a 18 WTE increase from October. The variation in workforce follows a similar patttern to the movement from August to September.

This consists of a 13 worked WTE increase in substantive, an additional 14 increase in bank offset by a 8 reduction in agency.

The main increases are in Barnsley Physical Health and Wellbeing care group and Childrens, Young People and Families care group. For Barnsley this includes new investment in Intermediate Care services.

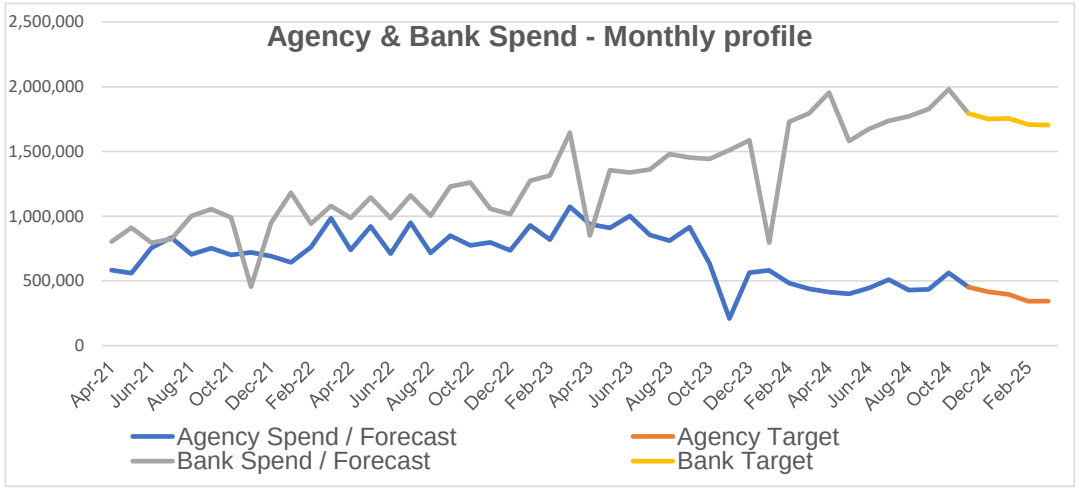
The forecast model shows an increase in substantive staff in the coming months. Some of this is offset by reductions in bank and agency but are not necessarily in the same care or staff group.

2.2 Temporary Staffing Focus

Trust spend in November 2024:
Agency £452k
Bank £1,793k

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	1,186	372	**1,557**
Other Medical	831	425	**1,256**
Reg Nursing	236	3,365	**3,601**
UnReg Nursing	826	8,854	**9,680**
Other Clinical	231	492	**724**
A & C	120	811	**932**
Other	(6)	0	**(6)**
Total	**3,424**	**14,319**	**17,744**
Lead Provider Collaborative	465	5	**470**
Budgets held centrally	(8)	0	**(8)**
Cheswold Park Hospital	67	60	**127**
Total	**3,948**	**14,385**	**18,333**

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

Detailed analysis continues to be presented to the monthly Trust temporary staffing scrutiny and management group. The report highlights that agency spend has continued to fluctuate month on month with November being a reduction of £110k compared to last month. This is reduction is primarily in adult inpatient wards. As shown in the graph above the financial modelling identifies reducing run rates as a result of actions being taken.

In terms of NHS England agency controls the Trust continues to have a number of areas outside of the control parameters. This includes the use of off framework agency (relating to specific care of an individual within the provider collaboratives) and also has once instance of non-clinical agency staff. This relates to catering assistants, to ensure service provision, whilst recruitment continues. Breaches of NHS capped rates continue to be reported to NHS England.

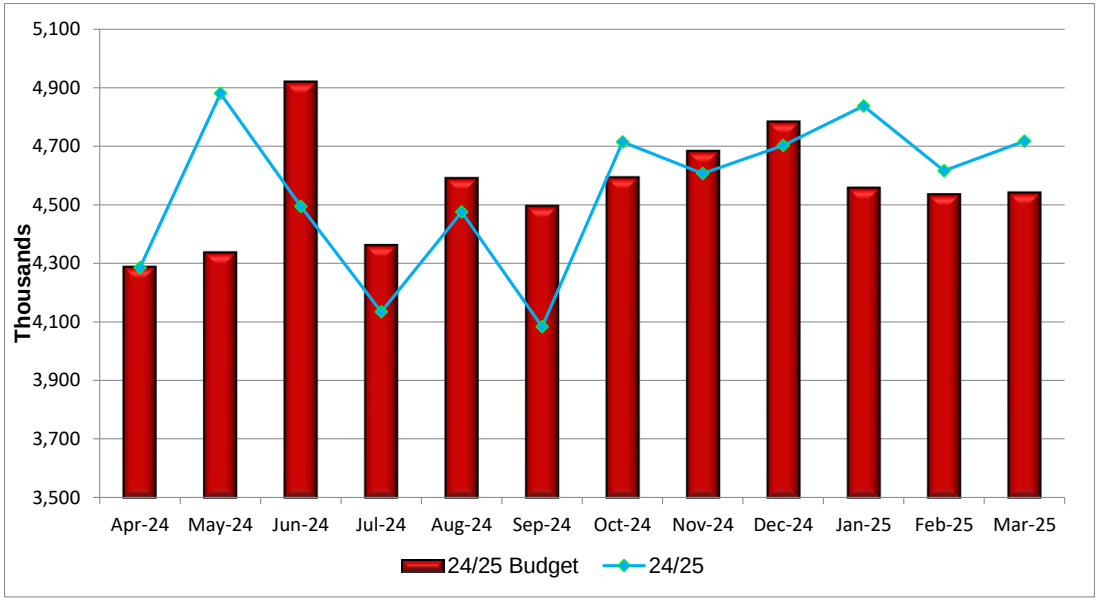
Utilisation of bank, as part of the overall workforce solution, has continued to grow. Expenditure has reduced from October although this did include pay award and arrears. In comparison worked WTE has increased since last month and this correlates with the same areas that have seen a reduction in agency.

2.3 Non Pay Expenditure

Whilst pay expenditure is 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 re-confirm that this also excludes expenditure relating to the provider collaboratives, Cheswold Park Hospital 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	4,134	4,476	4,083	4,715	4,607	4,703	4,838	4,616	4,718	**54,552**
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	2,933	2,694	(239)	
Establishment	6,238	6,579	340	
Lease & Property Rental	5,883	5,932	49	
Premises (inc. rates)	3,429	3,295	(133)	
Utilities	1,701	1,679	(21)	
Purchase of Healthcare	4,204	3,934	(270)	
Travel & vehicles	3,790	3,640	(150)	
Supplies & Services	5,552	5,313	(239)	
Training & Education	731	689	(42)	
Clinical Negligence & Insurance	776	779	3	
Other non pay	1,026	1,142	116	
Total	**36,263**	**35,677**	**(586)**	
Total Excl OOA and Drugs	**29,127**	**29,049**	**(78)**	



Key Messages

Overall non pay expenditure is £75k less than planned in month. For the year to date this is £586k underspent and is less than expenditure in 2023 / 24.

Non pay expenditure has continued to fluctuate and has reduced by £108k from October to November 2024. The largest reduction is in the Establishment category (£227k less than last month) which had seen the biggest increase in the previous month due to a number of one off purchases.

Other headline reductions are reported against the drugs and premises categories.

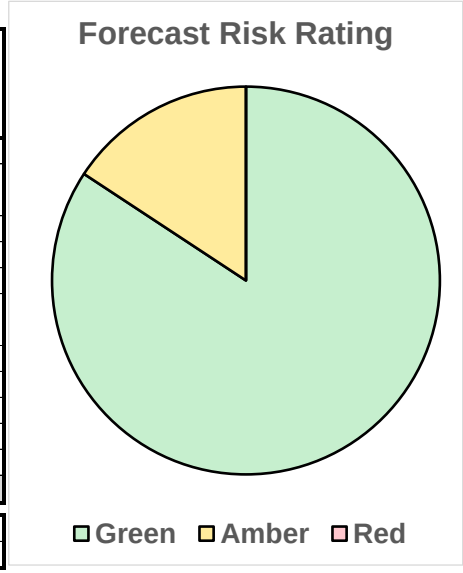
Increased expenditure is reported against the utilities and purchase of healthcare categories with both incurring higher expenditure than planned in month.

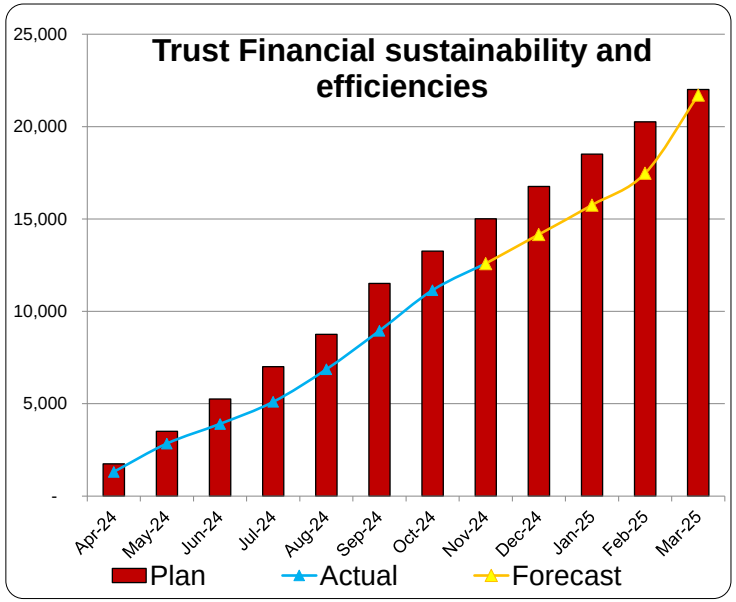
3.0 Value for Money, Financial sustainability and efficiency

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	**Variance** £k
Workforce optimisation		8,312	298	5,399	12,468	9,782			(2,686)
Non pay - Impact of workforce optimisation		280	282		420	407			(13)
Out of area placements		1,914	2,217		2,871	2,217	845		192
Non pay - digital		164	122		246	179			(67)
Non pay - Estates		333	267	22	500	428			(72)
Non pay - medicines optimisation		320	0		480			0	(480)
Non Pay - other		0	165		0	218			218
Procurement		167	0		250		0		(250)
Provider Collaboratives		760	760		1,140	1,140			0
Non Recurrent mitigations		0	0		0		2,570		2,570
Income - contribution, Full Year Effect		2,759	3,021		3,638	3,921			283
Total		**15,009**	**7,132**	**5,421**	**22,013**	**18,292**	**3,415**	**0**	**(305)**
Recurrent		6,897	7,132		10,345	8,146	845	0	(1,353)
Non Recurrent		8,112		5,421	11,668	10,146	2,570		1,048





The Trust value for money programme target for 2024 / 25 is £22,013k. This is a combination of recurrent and non-recurrent schemes with the focus on 2 specific areas.

Pay schemes are focussed on stabilisation of current workforce and reduction of any cost or volume inefficiencies. This is behind plan for the year to date and forecast although there has been positive delivery on a number of premium rate schemes including overtime and bank payments.

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.

Schemes, in this category, including medicines optimisation and procurement best practice are behind plan. Work does continue in this area, procurement in particular working on cost avoidance.

Delivery of the value for money is target is supported by an additional £2.6m of non recurrent schemes. This is items identified within the Trust forecast scenario and have been rated as amber as specific values will be confirmed later in the financial year.

The imperative remains on identifying, and delivering, recurrent schemes and the Trust Value for Money Group has been refocussed in this regard.

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	199,367	
Current Assets			
Inventories & Work in Progress	179	179	
NHS Trade Receivables (Debtors)	1,072	1,616	
Non NHS Trade Receivables (Debtors)	344	1,126	
Prepayments	3,491	4,370	
Accrued Income	1,062	5,892	1
Cash and Cash Equivalents	69,199	55,682	Pg 15
Total Current Assets	**75,347**	**68,866**	
Current Liabilities			
Trade Payables (Creditors)	(12,728)	(3,743)	2
Capital Payables (Creditors)	(1,392)	(252)	
Tax, NI, Pension Payables, PDC	(8,469)	(9,571)	
Accruals	(13,966)	(16,769)	3
Deferred Income	(409)	(2,203)	4
Other Liabilities (IFRS 16 / leases)	(51,040)	(51,395)	
Total Current Liabilities	**(88,004)**	**(83,933)**	
Net Current Assets/Liabilities	**(12,657)**	**(15,067)**	
Total Assets less Current Liabilities	**155,161**	**184,300**	
Provisions for Liabilities	(3,510)	(3,508)	
Total Net Assets/(Liabilities)	**151,651**	**180,792**	
Taxpayers' Equity			
Public Dividend Capital	45,696	75,696	
Revaluation Reserve	15,355	15,355	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	85,380	84,521	
Total Taxpayers' Equity	**151,651**	**180,792**	

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

A bridge of cash movements is shown on page 15.

1. Accrued income is higher than year end and higher than planned. Tariff uplifts from commissioners, as highlighted last month, have now been received. £3.5m of the total relates to Adult Secure Provider Collaboratives including funds expected from NHS England and for out of area bed placements. Work continues to ensure cash is recevied in December 2024.

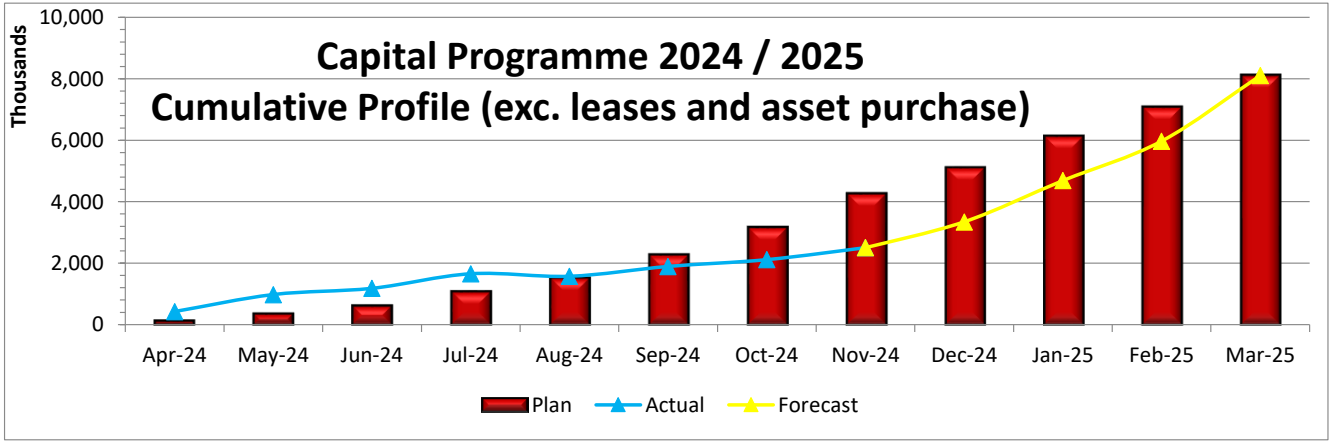
2. Trade creditors have reduced from the year end, and as demostrated by the continued positive better payment practice code performance, we continue to pay suppliers promptly. Aged creditors are reviewed and actively targeted for resolution. £0.1m of creditors are over 60 days.

3. Accruals continue to be monitored and any NHS related will be subject to agreement through the month 9 Agreement of Balances exercise.

4. Deferred income is higher than year end. This is expected with reducing balances to year end and all lines continue to be reviewed on a monthly basis.

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	600	0	(600)	1,000	(1,500)
Seclusion Rooms	1,000	730	1,025	295	1,034	34
Anti-ligature Doors	1,000	640	363	(277)	1,000	0
Maintenance (Minor) Capital						
Clinical Improvement	311	282	200	(82)	343	32
Safety	302	296	75	(220)	867	566
Sustainability / Carbon Neutral	510	50	126	76	510	0
Backlog	360	153	52	(101)	491	131
Equipment	41	30	81	51	113	73
Other	193	130	16	(114)	671	478
IM & T	1,470	1,221	439	(782)	1,470	0
Contingency	219	0	0	0	413	195
Staff Costs	200	133	128	(6)	191	(9)
TOTALS	**8,104**	**4,265**	**2,504**	**(1,761)**	**8,104**	**(0)**
Lease Impact (IFRS 16)	5,910	5,860	4,252	(1,608)	5,438	(472)
Asset Purchase	0	0	35,000	35,000	35,000	35,000
Cheswold - Minor Capital		0	0	0	1,265	1,265
Cheswold - IM & T		0	9	9	750	750
TOTALS	**14,014**	**10,125**	**41,764**	**31,639**	**50,557**	**36,543**



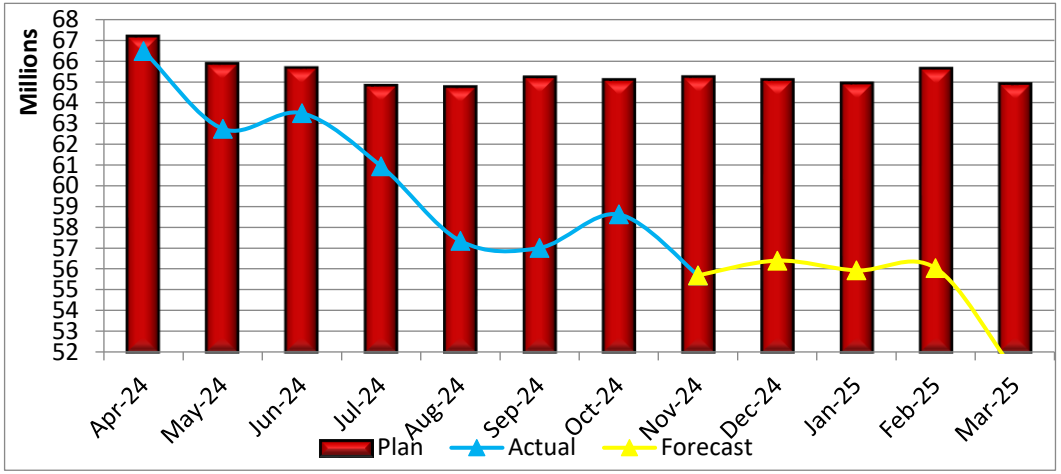
Capital Expenditure 2024 / 25

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. A further £22k has been added following additional income from a previous capital disposal (overage).

There are a number of additional expenditure areas outside of this allocation. This includes IFRS 16 (leases) and in year includes the acquisition of Cheswold Park Hospital and associated capital works. This is funded from a combination of national funding and South Yorkshire ICB capital allocation.

In terms of performance against the main allocation, expenditure for the year to date is less than planned. This is mainly due to delays in IM & T schemes (orders now placed) and older people transformation which has been reprofiled.

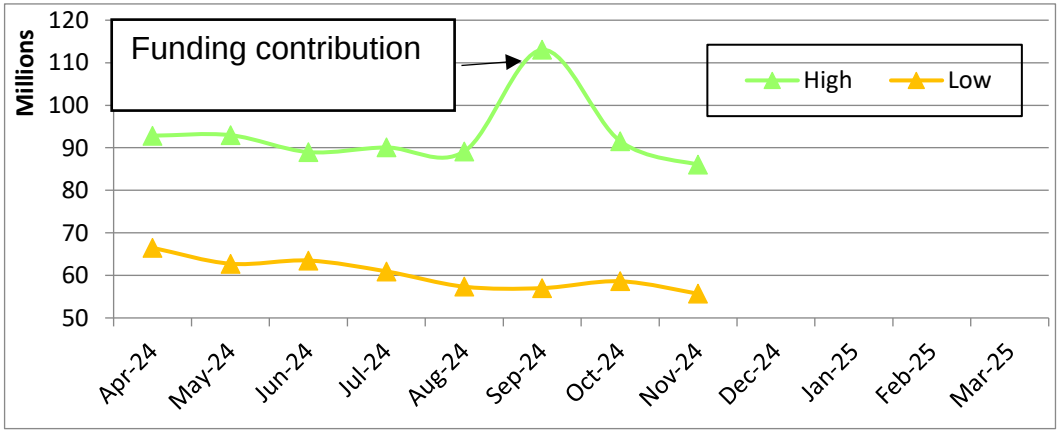
4.2 Cash Flow & Cash Flow Forecast 2024 / 2025



Cash has reduced again in month. The focus is on receipt of monies owed.

	Plan £k	Actual £k	Variance £k
Opening Balance	71,353	69,199	
Closing Balance	65,224	55,682	(9,542)

The Trust cash position has reduced in month. As shown on the balance sheet this is mainly due to increased debtors / accrued income. Work continues to ensure timely receipt of income especially with NHS England relating to Cheswold Park Hospital payments. The majority of these are expected in December.



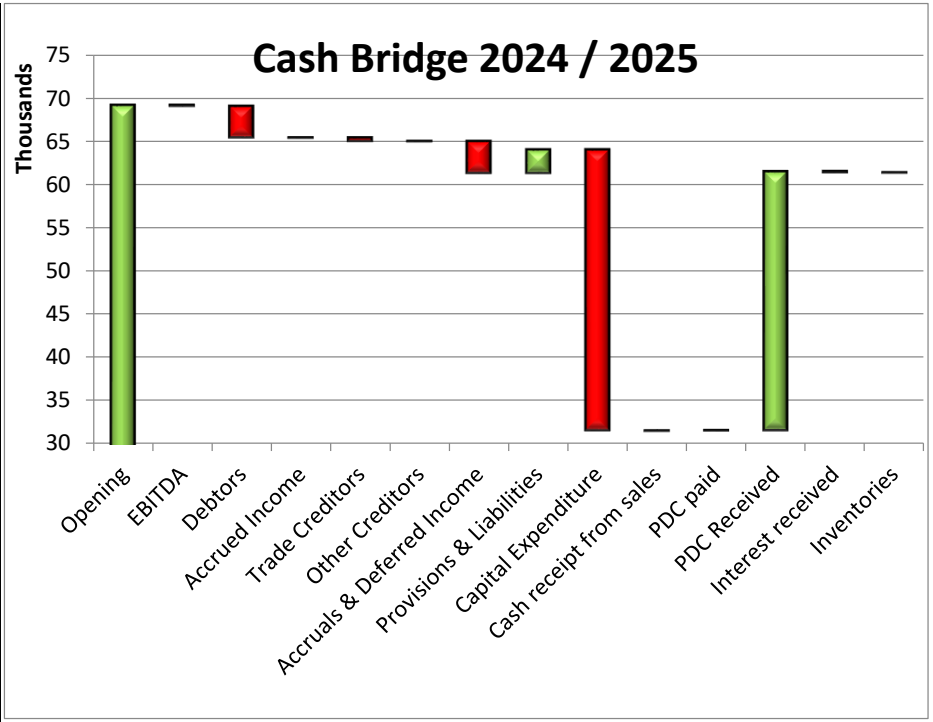
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £86m
The lowest balance is: £55.7m

This reflects cash balances built up from historical surpluses.

4.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**71,353**	**69,199**	(2,154)	
Surplus / Deficit (Exc. non-cash items & revaluation)	9,039	8,944	(94)	
Movement in working capital:				
Inventories & Work in Progress	52	0	(52)	
Receivables (Debtors)	330	(3,346)	(3,676)	
Trade Payables (Creditors)	(3,750)	(4,166)	(416)	
Accruals & Deferred income	0	(3,690)	(3,690)	
Provisions & Liabilities	(930)	1,793	2,723	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(6,101)	(38,653)	(32,552)	
Cash receipts from asset sales	0	24	24	
Leases	(6,496)	(6,027)	469	
PDC Dividends paid	(1,074)	(1,050)	24	
PDC Dividends received	0	30,000	30,000	
Interest (paid)/ received	2,801	2,653	(148)	
Closing Balances	**65,224**	**55,682**	**(9,542)**	



The table above summarises the reasons for the movement in the Trust cash position during 2024 / 2025. This is also presented graphically within the cash bridge. This highlights the main movements relate to the funding received, and purchase of, Cheswold Park Hospital.

The main headlines are picked out on the previous page.

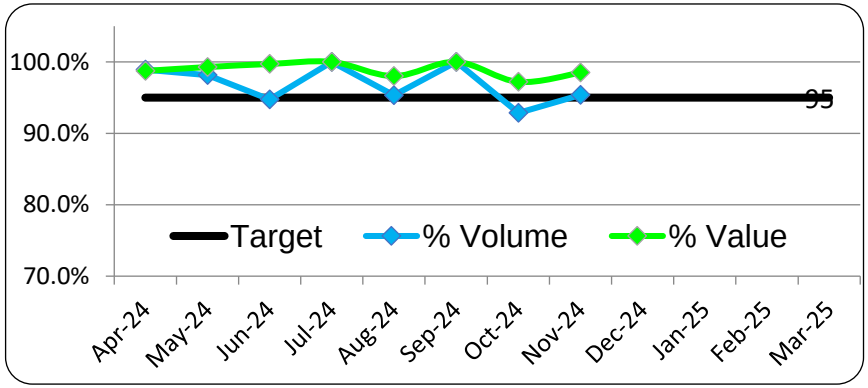
5.0 Better Payment Practice Code

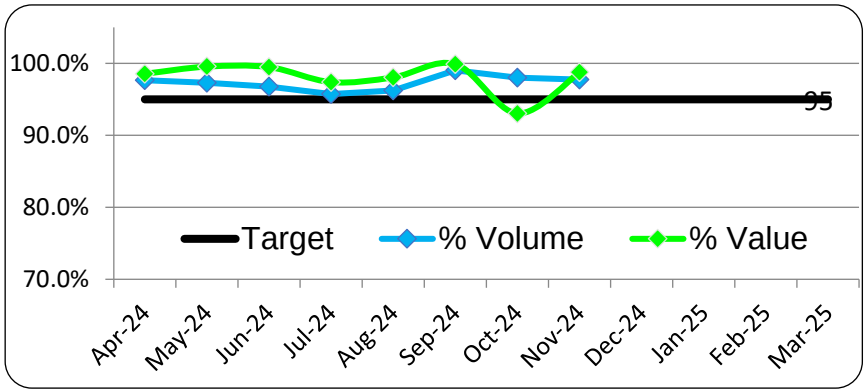
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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%	99%
Cumulative Year to Date	97%	99%

Non NHS	Number %	Value %
In Month	98%	99%
Cumulative Year to Date	97%	98%





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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 (£)
07-Nov-24	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000058570	746,845
19-Nov-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS52	450,000
01-Nov-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510009528	387,617
19-Nov-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS29	270,000
05-Nov-24	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Four	4400002190	241,311
05-Nov-24	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 291	212,125
21-Nov-24	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000058589	177,678
08-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34010845	162,301
01-Nov-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510009524	148,480
14-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34011087	122,872
08-Nov-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS050SN	112,246
22-Nov-24	Purchase of Healthcare	AS Collaborative	Oxford Health NHS Foundation Trust	A0131562	107,773
06-Nov-24	IT Services	Trustwide	Daisy Corporate Services	3I535961	90,250
01-Nov-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D5100094371	87,888
13-Nov-24	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710180447	86,650
11-Nov-24	Computer Licence	Barnsley	Pcmis Health Technologies Ltd	140772	81,583
13-Nov-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYSCYGUP050INV	76,490
19-Nov-24	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	328053	75,080
14-Nov-24	Drugs	Trustwide	Lp Hcs Ltd	SIH001134	70,858
28-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34012118	56,000
18-Nov-24	Purchase of Healthcare	Trustwide	Elysium Healthcare Ltd	34010699	54,739
19-Nov-24	Drugs	Trustwide	NHS Business Services Authority	1000082570	54,041
12-Nov-24	Utilities	Trustwide	Edf Energy Customers Ltd	000021109564	53,032
15-Nov-24	Computer Licence	Barnsley	American Well Corporation Ireland Ltd	INV69463	49,929
23-Nov-24	Purchase of Healthcare	Forensics	Spectrum Community Health Cic	SINV8031	48,868
24-Nov-24	Computer Licence	Trustwide	Trustmarque Solutions Ltd	2395062	46,248
18-Nov-24	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6028170	44,008
08-Nov-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS050INV	42,005
01-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34007383	40,575
21-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34011304	40,575

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
05-Nov-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001260EPC	39,834
04-Nov-24	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90143930	39,431
01-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	THO05457	38,104
20-Nov-24	Mobile Phones	Trustwide	Vodafone Ltd	107014074	36,570
01-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	ARB06338	33,389
27-Nov-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS015INV	32,676
14-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34007773	32,605
01-Nov-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D5100094331	31,333
12-Nov-24	Purchase of Healthcare	Trustwide	Cygnet Behavioural Health Ltd	WOL0376994	30,721
12-Nov-24	Purchase of Healthcare	Trustwide	Cygnet Nw Ltd	BUR0376387	30,721
12-Nov-24	Utilities	Trustwide	Edf Energy Customers Ltd	000021044680	30,476
19-Nov-24	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90144257	27,896
05-Nov-24	NHS Recharge	Trustwide	Sheffield Health & Social Care NHS Foundation Tr	0000001018	27,522
28-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	THO05485	27,467
12-Nov-24	Purchase of Healthcare	Trustwide	St Andrews Healthcare	90143339	26,430
06-Nov-24	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72488296	25,627
01-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	THO05456	25,613
08-Nov-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34010604	25,360
19-Nov-24	Utilities	Trustwide	Totalenergies Gas & Power Ltd	35972391924	25,209

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.

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Appendix 3 - Statistical Process Control (SPC) Charts Explained

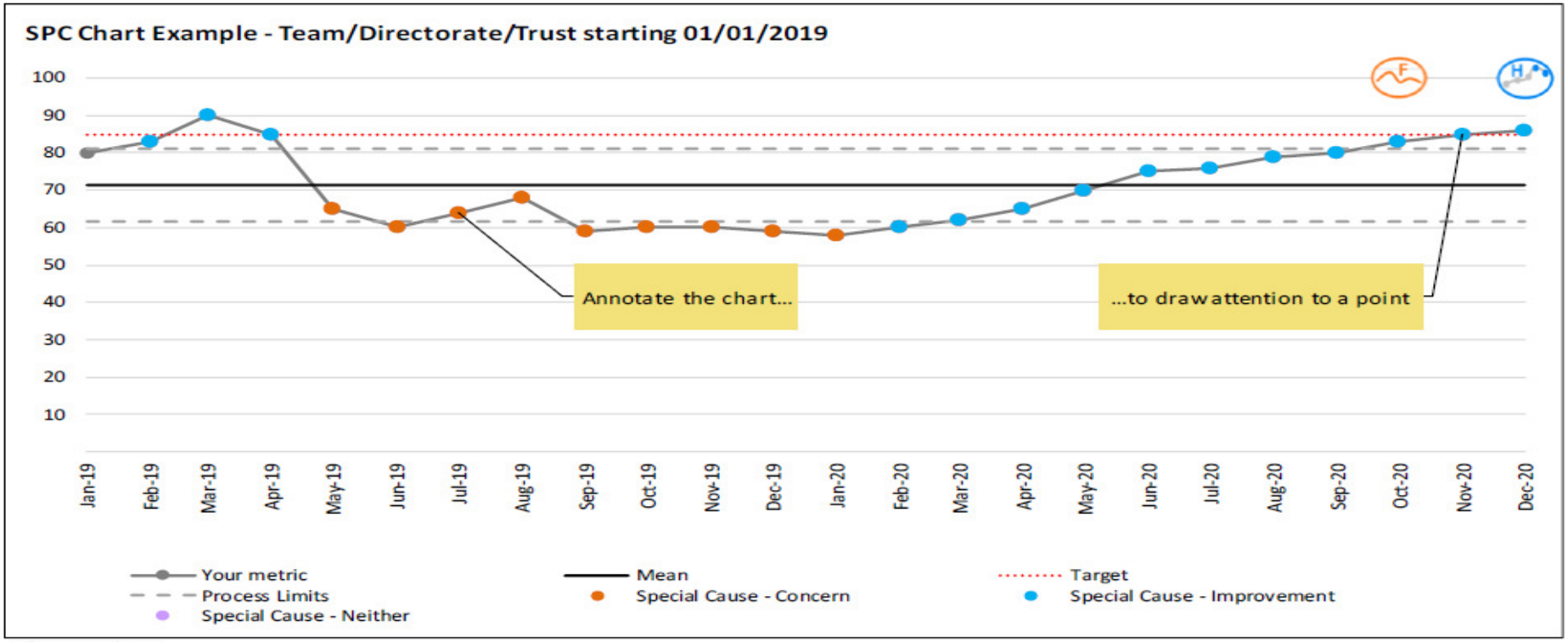
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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 3 - 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.