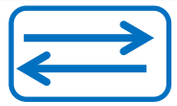
A note on the charts used in this data pack

Within this data pack there has been a concerted move to using Statistical Process Control (SPC) charts where this is the most appropriate way of visualising data. Where SPC charts are not deemed the most appropriate use of data, alternative charts and display mechanisms have been included. It is important to note that whilst the variation and assurance symbols are predominantly associated with SPC charts, we have taken the approach of standardising their use within this document across all data types to ensure consistency of language and approach. We have also included 'action status' symbols to highlight the current response to the data displayed in each chart.

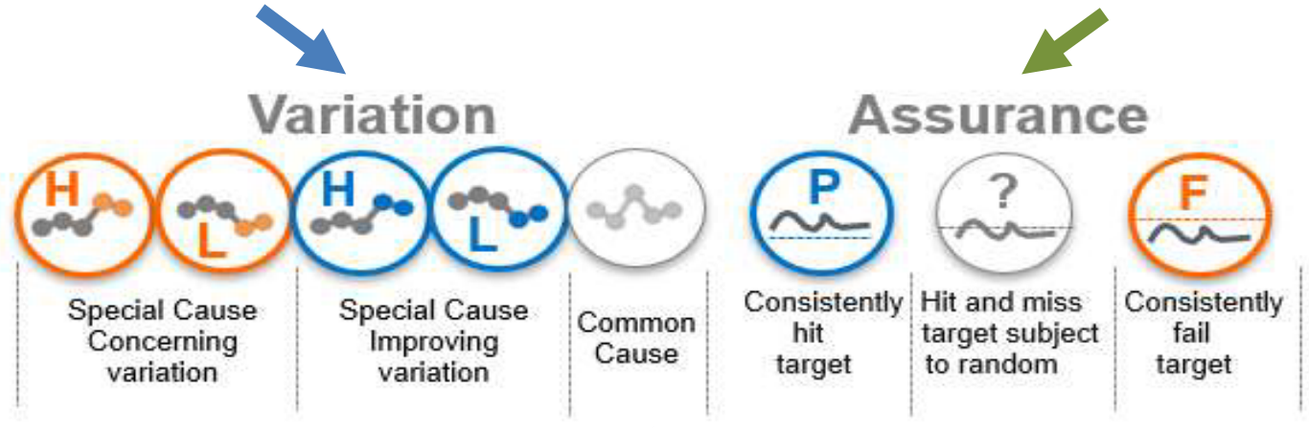
Following is a description of the meaning of the symbols used throughout this document.

Variation			Assurance			Action Status			
									
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target	Watching brief – continue to observe in order to better understand the current position	Improvement – continue actions to support improvement until steady state achieved	Deterioration or maintained under-performance – instigate or review actions to ensure drivers of current position are mitigated	Steady state – continue to monitor achievement of level of performance which is satisfactory, and which requires no intervention to maintain

A note on SPC charts – high level key

Are we improving, declining or staying the same?

Can we reliably hit the target?



ORANGE = significant concern or high pressure

BLUE = significant improvement or low pressure

GREY = no significant change

ORANGE = system change required to hit target

GREY = hit and miss, subject to random fluctuations

BLUE = will reliably hit the target

Quality and Safety Committee

Workforce Dashboard (May 2022)

Bradford District Care
NHS Foundation Trust

Metric	Goal & Assurance/ Action status	Current & Variation	Highlights/ Exceptions
Key Workforce Metrics – Recruitment Rate	10%	13.11%	Recruitment rate increasing from start of new financial year, now above target
Key Workforce Metrics – Sickness Rate	4%	6.00%	Sickness rate reduced by 0.8% from April 2022
Key Workforce Metrics – Labour Turnover (LTO) Rate	10%	15.41%	LTO continues to be above target and has been increasing since September 2021
Key Workforce Metrics – Vacancy Rate	10%	10.36%	Vacancy rate remained the same, and both below target and LTO rate
Mandatory Training Summary	80%	90.52%	Performance has been impacted by COVID-19- specifically for face to face training. Overall compliance remains above 80%
Appraisal Rates Summary	80%	87.19%	Performance has been consistently above 80% target from October 2020
Clinical Supervision Rates Summary	80%	83.81%	Compliance rate had been consistently above target
Safer Staffing – Compliance Levels/ Heat Map/ Working Time Directive Breaches / Bank and Agency - Fill Rates/ Booking reasons	-	-	Fill rates and bank and agency usage remain high due to Specialing, COVID impact. Working Time Directive breaches still difficult to manage

Lead Director	Bob Champion	Narrative agreed at	Quality Director call out	Action Status
Owner/Source	Michelle Holland	Accountable Committee	Finance, Business & Investment, Quality & Safety, Workforce & Equality	Overall – Watching Brief

Bradford District Care NHS Foundation Trust

KPI	Target	Mean	Lower Control Limit	Upper Control Limit

May 2022

Key workforce metrics

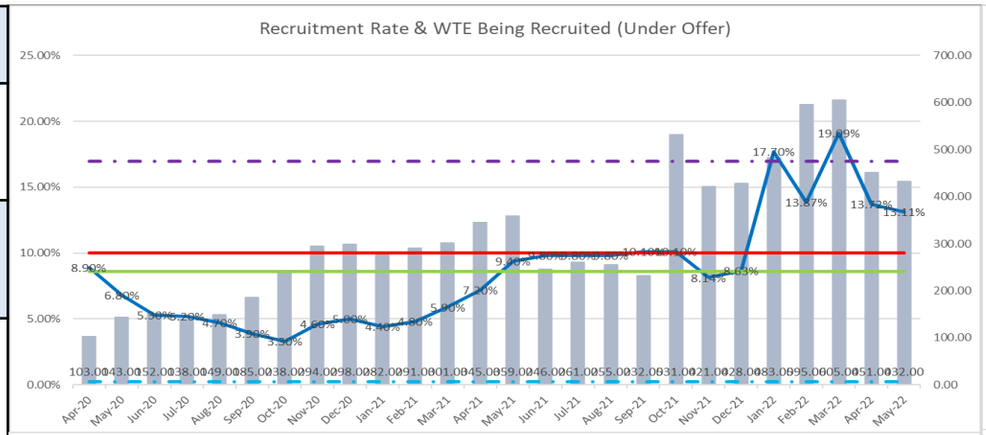
Data monitoring

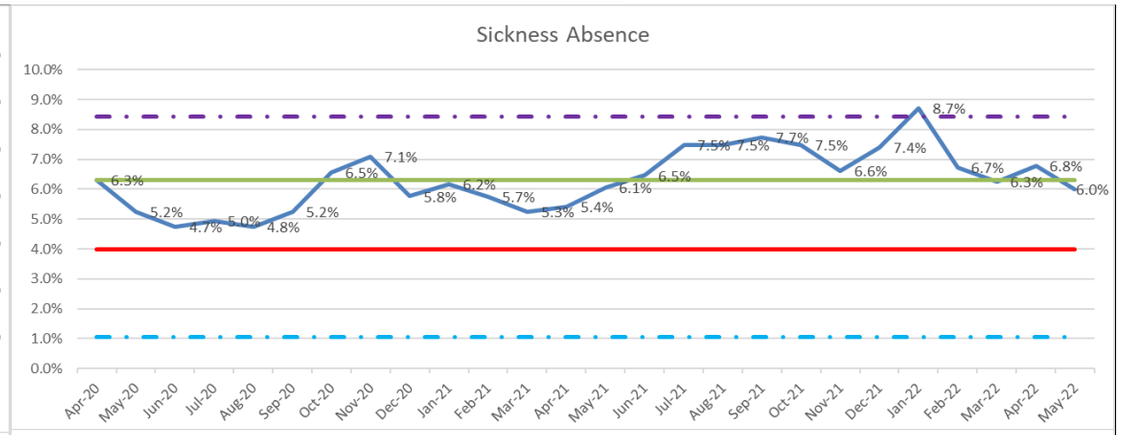
Sickness rate reducing over last quarter

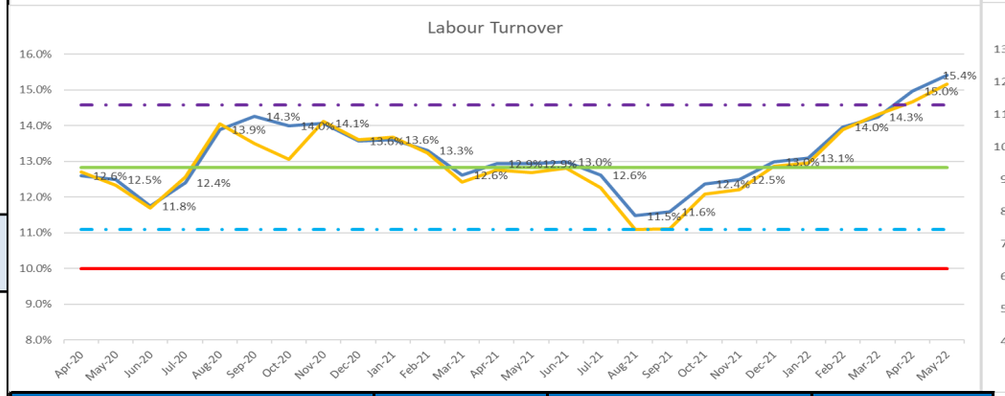
LTO rate continues to increase

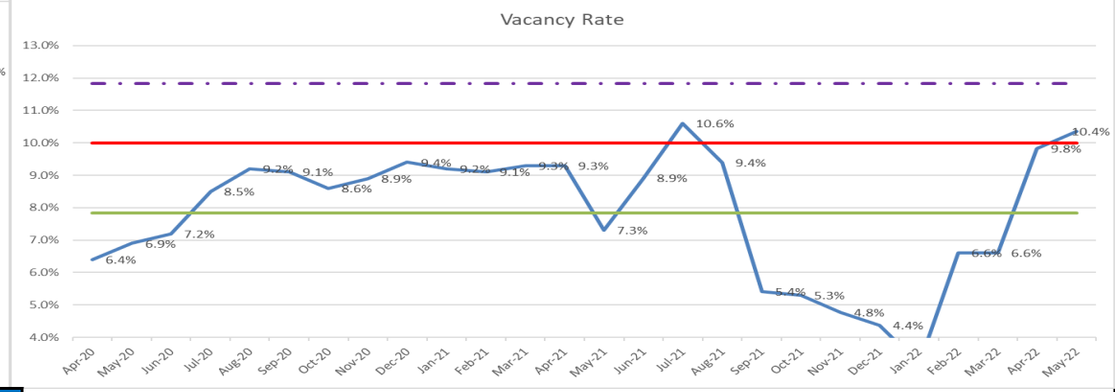
Goal/ target

10% target for labour turnover, recruitment and vacancy rates, and 4% target for sickness absence









	Apr-22	May-22	Change
Average Cost	£580,046.55	£ 512,485.63	-£ 67,560.91
Episodes	673	615	-58
LT Sick Days %	4.43%	4.03%	-0.40%
ST Sick Days %	2.36%	1.97%	-0.39%

Detail	What does the chart say?	Issues	Actions / Mitigation / Forward view
SPC charts to monitor the current trends around labour turnover (LTO), sickness, vacancy and recruitment rates.	Normal variation within the SPC ranges for all elements (with exception of Sickness), however all figures are towards the upper control limits. Sickness has been climbing yet has reduced slightly in May.	Sickness absence reduced from April, but remains higher than pre-COVID rates mainly due to the additional short term Covid cases, and a higher proportion of long term cases relating to Anxiety, Stress and Depression than before the pandemic. Labour turnover has increased this month, and remains above target. Remains concentrated across all operational services.	Sickness – COVID-19 monitoring continues via daily absence reporting submissions to NHS Improvement, with process in place for managing long COVID symptoms. Anxiety, stress and depression still at high levels for non-COVID absence - continue to promote the Trust Health and Wellbeing offer. A Health & Wellbeing lead is being appointed to support teams with team risk assessments and bespoke interventions to improve wellbeing. Labour Turnover – Exit questionnaire via Electronic Staff Record (ESR). Will monitor and review update of this new approach and analysis data at team /ward level to gain a better understanding of reasons for leaving.

Lead Director	Phillipa Hubbard	Narrative agreed at	Quality Director call out	Action Status
Owner/Source	Grainne Eloi/ Kelly Barker	Accountable Committee	Quality & Safety	X Under-performance

May 2022

Safer Staffing – Compliance Levels

Data Monitoring

Improving fill rate of required shifts over last quarter

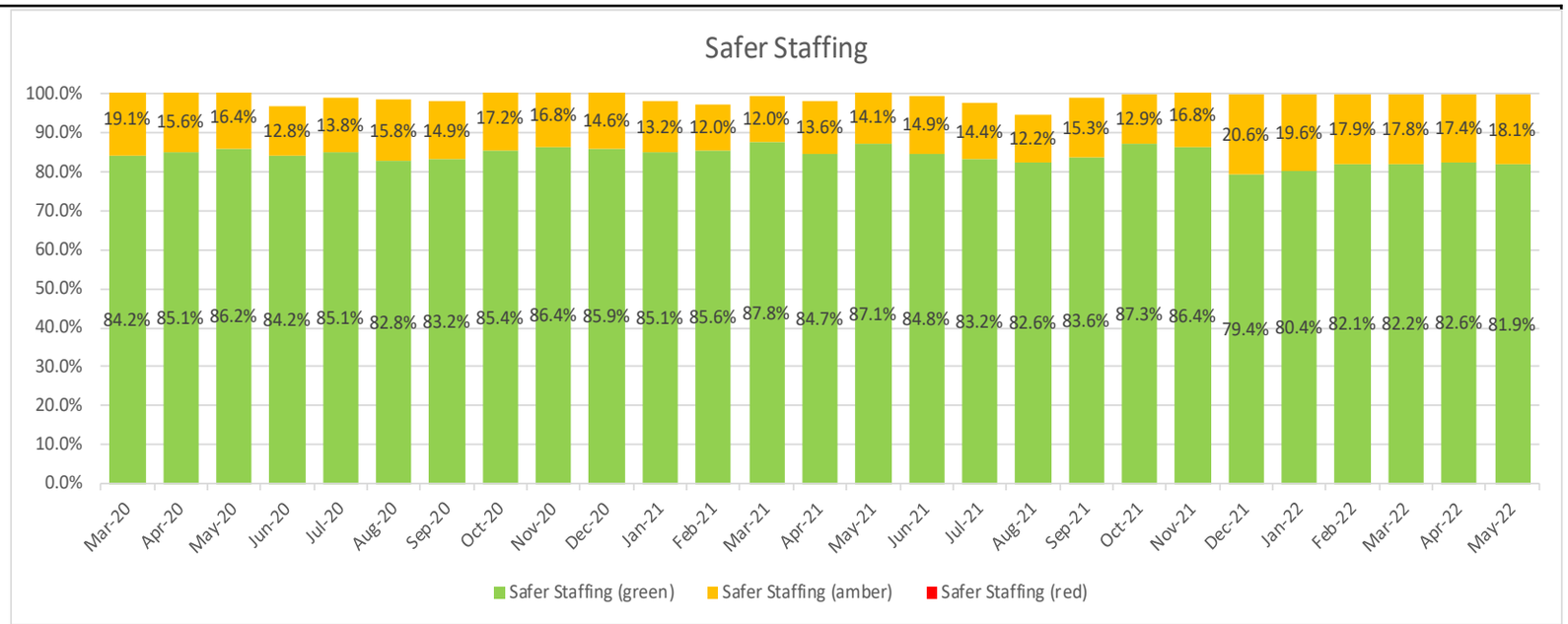
Goal/Target

100% filled at appropriate levels.

Amber - % of shifts filled below requested levels

Red - % of shifts unfilled with Registered Staff

Month	Safer Staffing (green)	Safer Staffing (amber)	Safer Staffing (red)
Mar-20	84.2%	19.1%	0.0%
Apr-20	85.1%	15.6%	0.0%
May-20	86.2%	16.4%	0.0%
Jun-20	84.2%	12.8%	0.0%
Jul-20	85.1%	13.8%	0.0%
Aug-20	82.8%	15.8%	0.0%
Sep-20	83.2%	14.9%	0.0%
Oct-20	85.4%	17.2%	0.0%
Nov-20	86.4%	16.8%	0.0%
Dec-20	85.9%	14.6%	0.0%
Jan-21	85.1%	13.2%	0.0%
Feb-21	85.6%	12.0%	0.0%
Mar-21	87.8%	12.0%	0.0%
Apr-21	84.7%	13.6%	0.0%
May-21	87.1%	14.1%	0.0%
Jun-21	84.8%	14.9%	0.0%
Jul-21	83.2%	14.4%	0.0%
Aug-21	82.6%	12.2%	0.0%
Sep-21	83.6%	15.3%	0.0%
Oct-21	87.3%	12.9%	0.0%
Nov-21	86.4%	16.8%	0.0%
Dec-21	79.4%	20.6%	0.0%
Jan-22	80.4%	19.6%	0.0%
Feb-22	82.1%	17.9%	0.0%
Mar-22	82.2%	17.8%	0.0%
Apr-22	82.6%	17.4%	0.0%
May-22	81.9%	18.1%	0.0%



Detail	What does the chart say?	Issues	Actions / Mitigation / Forward view
Proportion of required shifts filled to required levels of safety. Red shifts would indicate no registered staff assigned to work on a particular shift	Shows no shifts recorded as 'red' – i.e. no registered staff on shift. Amber shifts (i.e. no. of staff working is lower than required staffing level) show a fluctuating trend.	High patient acuity on some wards leading to reliance on temporary staff. COVID-19 has impacted on available pool of temporary staff to draw from. There are a number of shifts being covered by band 7 and above workers in order to meet safer staffing levels however these hours are not being captured on the roster.	Monitored through daily lean management. Safer staffing group reviews and escalate concerns to Quality and Safety Committee. Workforce Planning surgeries held with each ward to review and plan staffing levels. Work is underway to calculate the additional hours being worked by band 7 and over workers and a plan is being put in place to determine how this could be paid.

Lead Director	Phillipa Hubbard	**Narrative agreed at**	Quality Director call out	**Action Status**
Owner/Source	Kelly Barker / Grainne Eloi	**Accountable Committee**	Quality & Safety	X Under-performance

May 2022

Safer Staffing – Compliance Levels

Data Monitoring

Care Hours Per Patient per Day increasing over last quarter (which will have positive impact on quality of service delivery)

Goal/Target

90% for fill rates,

10% for annual leave,

4% for sickness

Heat Map - Inpatient Wards

	Registered Safe Staffing						Unregistered Safe Staffing						Care Hour per Patient Day				
Inpatient Ward	Fill Rate % Days	% of Temp staff Days	Fill Rate % Nights	% of Temp Staff Nights	Sickness %	AL % Roster	Fill Rate % Days	% of Temp staff Days	Fill Rate % Nights	% of Temp Staff Nights	Sickness %	AL % Roster	Planned Registered CHPPD	Actual Registered CHPPD	Planned Unregistered CHPPD	Actual Unregistered CHPPD	Actual CHPPD Total
Fern	92.59%	25.33%	98.33%	55.93%	1.58%	3.60%	145.74%	70.21%	164.17%	87.31%	1.64%	2.30%	3.3	3.4	4.1	11.2	14.6
Heather	88.89%	8.75%	88.33%	90.57%	2.92%	2.20%	105.33%	55.70%	101.11%	74.18%	5.13%	3.07%	2.9	2.7	4.1	8.2	10.9
Bracken	86.52%	24.68%	86.67%	103.85%	4.87%	3.72%	147.18%	52.61%	147.33%	80.54%	5.72%	2.50%	3.1	2.6	5.5	6.0	8.6
Ashbrook	94.32%	16.87%	93.33%	103.57%	7.15%	9.90%	137.89%	62.21%	147.22%	84.53%	6.82%	4.96%	2.9	2.4	3.7	9.2	11.6
Maplebeck	82.76%	13.89%	103.33%	59.68%	4.03%	3.47%	227.88%	52.74%	280.00%	80.16%	8.64%	3.82%	2.6	1.9	3.4	7.8	9.7
Oakburn	100.00%	24.72%	100.00%	56.67%	3.71%	5.24%	127.88%	72.32%	147.62%	88.71%	3.41%	3.50%	3.1	3.0	3.9	7.6	10.5
Baildon	93.33%	0.00%	100.00%	3.33%	0.00%	3.76%	130.00%	58.97%	102.22%	48.91%	4.15%	6.21%	1.8	2.2	3.7	4.4	6.6
Ilkley	88.33%	1.89%	100.00%	0.00%	1.56%	5.59%	118.89%	52.34%	101.11%	37.36%	5.85%	4.44%	2.2	2.4	3.6	4.0	6.5
Thornton	73.56%	25.00%	93.33%	103.57%	6.00%	2.63%	163.80%	58.80%	132.00%	85.35%	1.15%	3.09%	4.2	4.6	8.8	13.0	17.6
Assessment & Treatment Unit (LD)	80.00%	8.75%	78.33%	51.06%	7.78%	4.87%	130.50%	32.95%	195.83%	91.06%	4.67%	6.07%	3.7	3.7	8.4	16.9	20.6
Clover (PICU)	81.25%	7.69%	65.06%	83.33%	1.89%	5.34%	110.53%	35.93%	120.08%	68.64%	2.11%	4.38%	7.7	7.8	11.6	20.9	28.7
Step Forward (Rehab)	86.67%	5.77%	100.00%	33.33%	2.58%	3.66%	108.89%	36.73%	101.11%	74.73%	4.32%	8.31%	5.8	4.8	7.7	5.5	10.3
Dementia Assessment Unit (DAU)	69.05%	15.52%	90.00%	88.89%	9.39%	4.40%	119.44%	34.42%	104.44%	63.83%	4.62%	4.28%	7.4	5.1	17.4	11.9	17.0
Total	**85.56%**	**14.41%**	**90.18%**	**69.98%**	**4.34%**	**4.53%**	**134.77%**	**52.59%**	**138.12%**	**77.92%**	**4.30%**	**4.19%**	**3.4**	**3.1**	**5.6**	**8.9**	**12.0**

This is based on the total number required in the month against the total number who worked

RAG Ratings

Fill rates
Over 100% - Blue
>90% - Green
80-90% - Amber
<80% - Red

Annual Leave
>14.1% - Red
10-14% - Amber
<10 - Green

Sickness
>5% - Red
4-5% - Amber
<4 - Green

Detail	What does the chart say?	Issues	Actions / Mitigation / Forward view
A heatmap to outline the fill rates, annual leave and sickness levels, against Care Hours Per Patient Day.	Overfill of Unregistered staff to compensate for areas where Registered staff requirements cannot be matched. Some areas of high sickness (mainly unregistered staff) leading to high % of temporary staff being used.	High volume of night shifts continue to be filled with temporary staff. Registered staff fill rates deteriorating with some wards still experiencing high number of vacancies – particularly registered nurses. High patient acuity continues to be experienced across acute wards. High sickness levels recorded across Assessment and Treatment Unit (ATU) and Clover for registered staff, with high sickness for unregistered staff across most acute wards, ATU, Dementia Assessment Unit and Bracken. Fatigue around the pandemic is also still present.	• Recruitment of bank and agency staff to Airedale Centre for Mental Health wards, helping to stabilise staffing levels. • Extra psychological support being provided for staff on Bracken ward due to high levels of sickness. • Acute wards at Lynfield Mount Hospital – Recruitment taking place for band 3 and 4 staff (including activity co-ordinators). • Focus on staff retention after student training. • A review of staff working across different shifts has been undertaken. • A patient safety lead has been recruited to engage with wards. • Workforce Planning surgeries held with each ward to review and plan staffing levels.

Safeguarding Dashboard (May 2022)

Metric	Goal & Assurance/ Action status	Current & Variation	Average
Safeguarding Adult Referrals	N/A	7 N/A	5.8
Safeguarding Children Referrals	N/A	20 (Bradford) 8 (Wakefield) N/A	22.1 (Bradford) 10.5 (Wakefield)
Duty Calls regarding adults	N/A	88 (Bradford) 0 (Wakefield) N/A	72.1 (Bradford) 0.0 (Wakefield)
Duty Calls regarding children	N/A	51 (Bradford) 21 (Wakefield) N/A	49.6 (Bradford) 22.8 (Wakefield)

Serious Incidents, Duty of Candour & Mortality Dashboard (May 2022)

Metric	Goal & Assurance/ Action status		Current & Variation		Average
Serious Incidents	N/A		2		2.7
Duty of Candour incidents	0		1		1.1
Suicides	N/A		1		1.4
Expected Deaths	N/A		9		13.2
Unexpected Deaths	N/A		11		6.7
COVID related deaths – community	N/A		1	N/A	3.3
COVID related deaths – inpatients	N/A		0	N/A	0.1
Structured Judgement Reviews	N/A		1	N/A	N/A

Incidents Dashboard (May 2022)

Metric	Goal & Assurance/ Action status	Current & Variation	Average
All incidents	N/A	683	938.7
Violence & Aggression	N/A	72	203.0
Medication Errors	0	39	46.8
Near Misses	N/A	7	20.2

Staff and Service User Feedback Dashboard (May 2022)

Metric	Goal & Assurance/ Action status	Current & Variation	Average
Formal Complaints	0	3	5.9
Concerns	0	46	53.2
Compliments	N/A	12	43.5
Freedom To Speak Up	N/A	15 N/A	N/A
Friends & Family Test	90%	92.8% -	-

Quality of Care Delivery Dashboard (May 2022)

Metric	Goal & Assurance/ Action status		Current & Variation		Average
Infection Prevention & Control	0		3	N/A	N/A
Pressure Ulcers	0		21	N/A	21
Insulin Errors	0		4	N/A	3.5
Facilities Summary (RIDDOR, Water Safety, Nutrition Standards)	N/A		0	N/A	N/A
Equipment maintenance	95%		91.4% High risk 78.2% All	N/A	N/A
Ligature assessments	100%		100%	N/A	100%
Clinical Audit	100%		100%	N/A	N/A

NHS Oversight Framework Metrics Dashboard (May 2022)

Metric	Goal & Assurance/ Action status	Current & Variation	Average
Improving Access to Psychological Therapies (IAPT) Access Rate	962	582	
IAPT Recovery Rate	50%	53.9%	53.2%
Waiting times IAPT i) 6 weeks	75%	92.4%	95.7%
Waiting times IAPT ii) 18 weeks	95%	99.1%	99.5%
IAPT waiting >90 days between 1st & 2nd Treatment	<10%	40.4%	
Children & young people's eating disorder waiting times – urgent	95%	75.0%	
Children & young people's eating disorder waiting times - routine	95%	14.2%	
Inappropriate out of area bed days	2063 (Q1)	990 (May)	
Data Quality – Mental Health Services Dataset (MHSDS) Score	80% (2021/22)	93.9%	
Consultant led waiting times (Referral to Treatment)	92%	89.7%	73.5%
Waiting times – first episode of psychosis	60%	77.9%	79.4%

Lead Director	Tafadzwa Mugwagwa	Narrative agreed at	Senior Leadership Team	Action Status
Owner/Source	Business Intelligence	Accountable Committee	Quality & Safety Committee	X Underperformance

May 2022

May - 582 (provisional)
Year to date - 1085 (April - May

Data monitoring

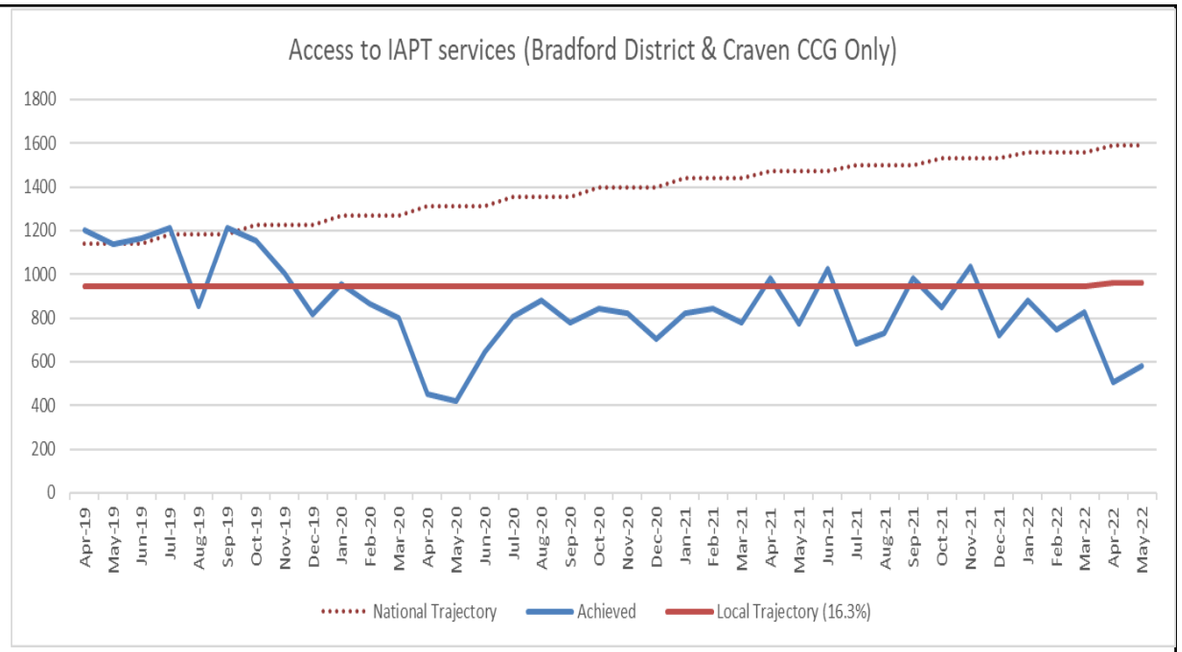
Variation indicates falling short of the local contractual target

Goal/ target

National trajectory
= 1589 (Month - May)
= 3178 (Year to date – April - May)

Local contractual target
= 962 (Month - May)
= 1924 (Year to date – April - May)

Period	Target		Actual
	National	Contractual	
Apr-22	1589	962	503
May-22	1589	962	582
YTD	**3178**	**1924**	**1085**
Jun-22	1589	962	
Jul-22	1619	982	
Aug-22	1619	982	
Sep-22	1619	982	
Oct-22	1649	1000	
Nov-22	1649	1000	
Dec-22	1649	1000	
Jan-23	1679	1020	
Feb-23	1679	1020	
Mar-23	1679	1020	

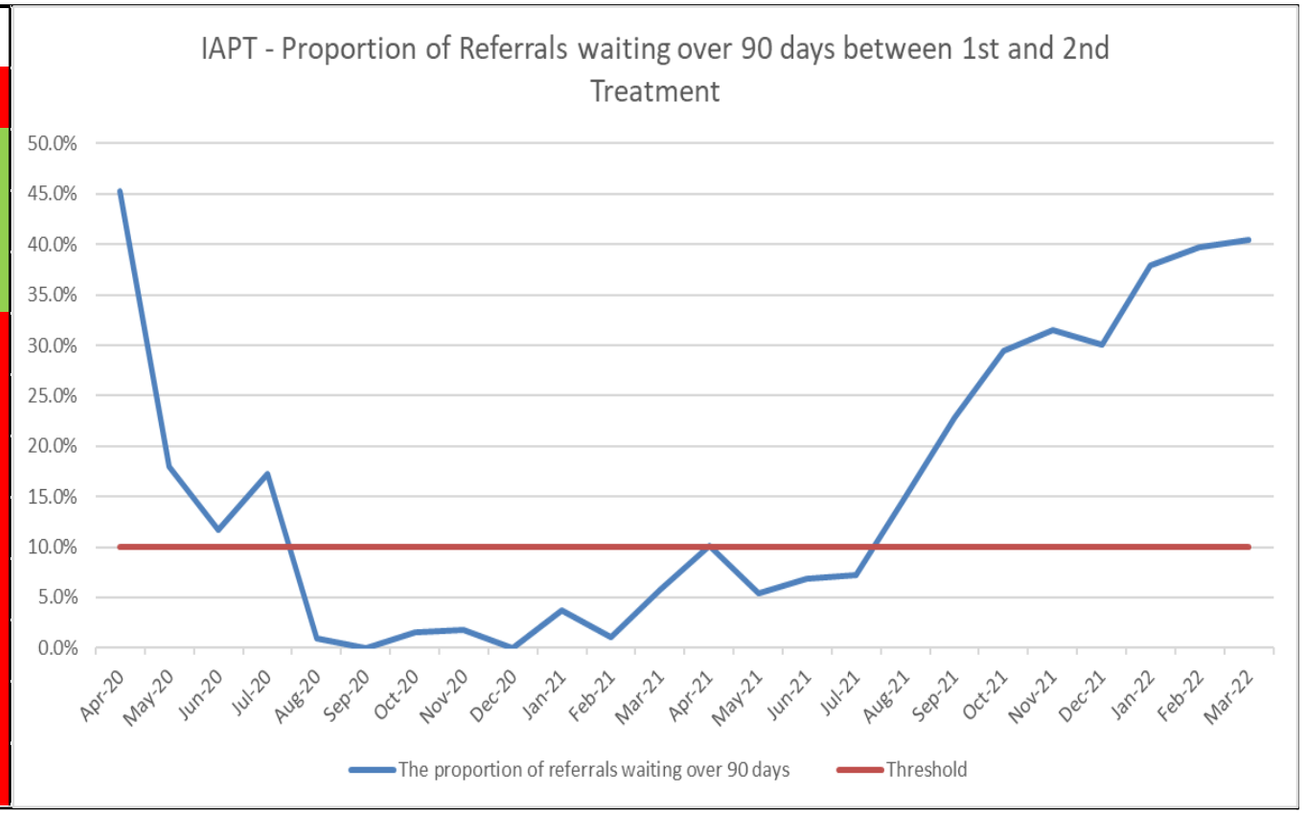


Detail	What does the chart say?	Issues	Actions	Mitigation	Forward view
Number of people who first receive Improving Access to Psychological Therapies (IAPT) recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period.	• COVID-19 resulted in 65% reduction in referrals. Referrals now returned to pre-COVID levels. • Commissioned activity is below the Clinical Commissioning Group (CCG) national access target.	• Increasing intensity in steps 2 and 3 and reduced need for group therapy. • High levels of sickness and maternity leave. Assessments cancelled in April and May due to staff long term sickness. • Several vacancies, with national shortage of qualified staff. Loss of qualified practitioners to independent sector providers, particularly to roles that are 'remote only'.	• Targeted recruitment of current vacancies and backfill of staff on maternity leave. • Focus on IAPT workforce issues at West Yorkshire level, including consideration of a West Yorkshire 'virtual' IAPT offer on behalf of all places to increase service resilience and allow places to focus on face to face provision in their locality.	Monthly waiting list meeting in place, with review of outliers.	As part of the 2022/23 operational plan, funding agreed to increase people accessing treatment from 11,316 in 2021/22 to 13,164 by 2023/24. Whilst the local access rate will still be below the national Long Term Plan ambition, this reflects the workforce challenges faced in recruiting qualified practitioners, together with increased complexity that impacts session length.

Lead Director	Tafadzwa Mugwagwa	Narrative agreed at	Senior Leadership Team	Action Status
Owner/Source	Business Intelligence	Accountable Committee	Quality & Safety Committee	X Underperformance

March 2022
40.4%
Note: March 2022 is the latest published data
Data monitoring
Goal/ target
<10%

Period	Target	Actual
Apr-21	10%	10.1%
May-21	10%	5.6%
Jun-21	10%	6.9%
Jul-21	10%	7.2%
Aug-21	10%	14.9%
Sep-21	10%	22.8%
Oct-21	10%	29.4%
Nov-21	10%	31.5%
Dec-21	10%	30.0%
Jan-22	10%	37.9%
Feb-22	10%	39.7%
Mar-22	10%	40.4%

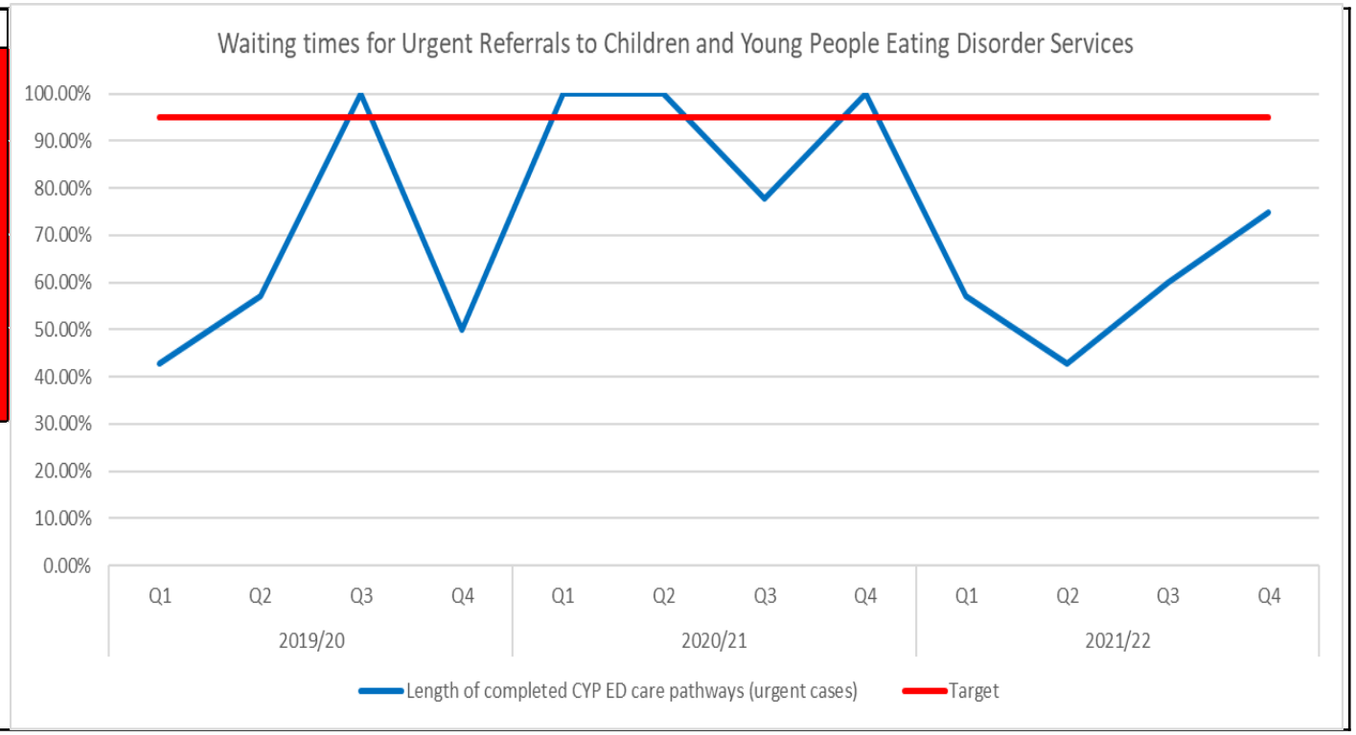


Detail	What does the chart say?	Issues	Actions	Mitigation	Forward view
Improving access to psychological therapies (IAPT) - Proportion of referrals waiting over 90 days between 1st and 2nd treatment.	There is some variation. The proportion of referrals waiting over 90 days has increased since July 2021.	• Increasing intensity and waits in steps 2 and 3 (4 months) and reduced need for group therapy. 30% of step 3 are PTSD. • High levels of sickness and maternity leave. • Several vacancies, with national shortage of qualified staff.	• Targeted recruitment of current vacancies and backfill of staff on maternity leave • Focus on IAPT workforce issues at West Yorkshire level, including consideration of a West Yorkshire 'virtual' IAPT offer on behalf of all places to increase service resilience and allow places to focus on face to face provision in their locality.	Monthly waiting list meeting in place, with review of outliers.	Investment agreed as part of the 2022/23 operational plan to increase access, with a trajectory that reflects the workforce challenges faced in recruiting qualified practitioners, together with increased complexity that impacts session length.

Lead Director Owner/Source	Tafadzwa Mugwagwa Business Intelligence	Narrative agreed at Accountable Committee	Senior Leadership Team Quality & Safety Committee	Action Status	☒ Underperformance

Quarter 4 2021/22
75.0%
Data monitoring
Goal/ target
95%

Period	Target	Actual
Q1	95%	57.1%
Q2	95%	42.8%
Q3	95%	60.0%
Q4	95%	75.0%

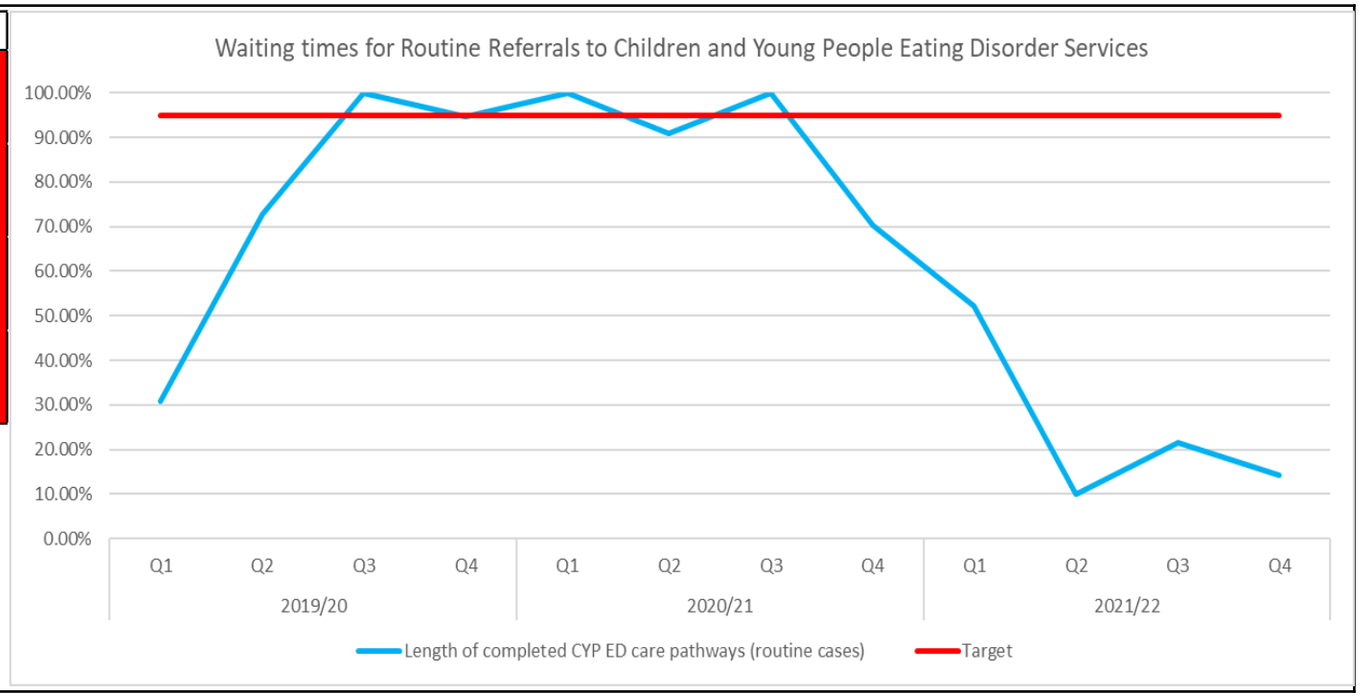


Detail	What does the chart say?	Issues	Actions	Mitigation	Forward view
The proportion of children and young people with eating disorders (urgent cases) that wait one week or less from referral to start of NICE-approved treatment	The target has not been achieved since quarter 4 of 2020/21. Relatively small numbers results in variation. In quarter 4 of 2021/22, 3 out of 4 children and young people waited less than one week to start treatment.	• Significant increase in referrals as a result of the COVID-19 pandemic. Commissioned resource is for 50 cases per year but demand increased to 100 cases per year. • Changing profile of children and young people with higher complexity and acuity of presentations • Inpatient capacity challenges - increase in the number of acutely unwell patients being cared for in the community	Service Development funding approved in 2021/22 and additional staff commenced in post during quarters 3 and 4 of 2021/22.	Core CAMHS support and respond to eating disorder cases with consultation from the eating disorder team if referrals are in excess of eating disorder capacity.	Forward trajectory agreed as part of 2022/23 operational plan. Forecast to meet 95% target from quarter 3 of 2022/23.

Lead Director	Tafadzwa Mugwagwa	Narrative agreed at	Senior Leadership Team	Action Status
Owner/Source	Business Intelligence	Accountable Committee	Quality & Safety Committee	☒ Underperformance

Quarter 4 2021/22
14.2%
Data monitoring
Goal/ target
95%

Period	Target	Actual
Q1	95%	52.3%
Q2	95%	10.0%
Q3	95%	21.4%
Q4	95%	14.2%

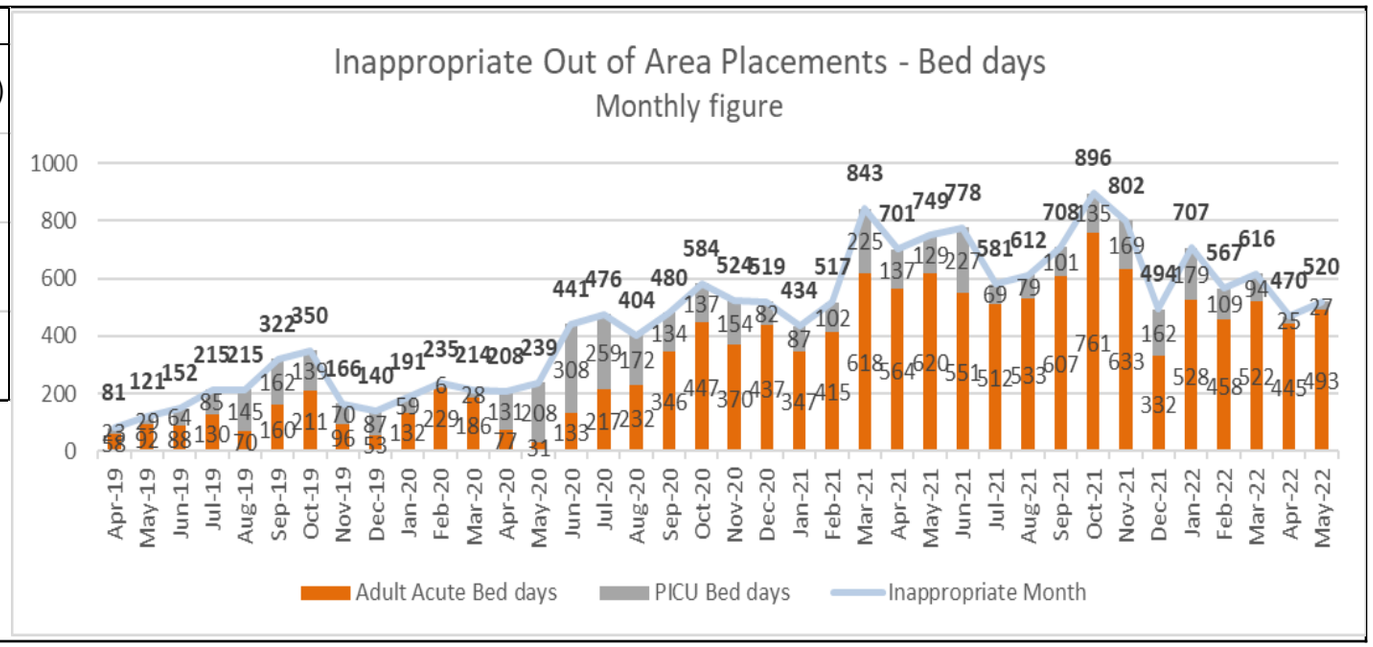


Detail	What does the chart say?	Issues	Actions	Mitigation	Forward view
The proportion of children and young people with eating disorders (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment	The target has not been achieved since quarter 3 of 2020/21. Relatively small numbers results in variation. In quarter 4 of 2021/22, 3 out of 21 children and young people waited less than one week to start treatment.	• Significant increase in referrals as a result of the COVID-19 pandemic. Commissioned resource is for 50 cases per year but demand increased to 100 cases per year. • Changing profile of children and young people with higher complexity and acuity of presentations • Inpatient capacity challenges - increase in the number of acutely unwell patients being cared for in the community	Service Development funding approved in 2021/22 and additional staff commenced in post during quarters 3 and 4 of 2021/22.	Core CAMHS support and respond to eating disorder cases with consultation from the eating disorder team if referrals are in excess of eating disorder capacity.	Forward trajectory agreed as part of 2022/23 operational plan. Forecast to meet 95% target from quarter 3 of 2022/23.

Lead Director	Tafadzwa Mugwagwa	Narrative agreed at	Senior Leadership Team	Action Status
Owner/Source	Business Intelligence	Accountable Committee	Quality & Safety Committee	X Underperformance

2022/23 Quarter 1 (Apr – May)
990 bed days
Data monitoring
Meeting 2022/23 trajectory
Goal/ target
2063 Q1 1406 Q2 0 Q3 0 Q4

Period	Trajectory	Actual
Q1	2063	990 (May)
Q2	1406	
Q3	0	
Q4	0	



Detail	What does the chart say?	Issues	Actions	Mitigation	Forward view
Inappropriate out of area placements for adult mental health services – number of bed days patients have spent out of area	**Adult acute**: 35 patients out of area in May (493 bed days). **Psychiatric Intensive Care Unit (PICU)**: 2 patients out of area in May (27 bed days).	• High levels of acuity on adult acute wards. • Actions to maintain COVID safe ward environments – capacity reduced by 10 beds to support isolation and cohorting of patients. • In April and May 2022, meeting the trajectory agreed as part of the 2022/23 operational plan. However, in 2022/23 quarters 1 and 2, the trajectory does not meet the national expectation of the elimination of out of area placements.	• Quality improvement work on purposeful admission and safe discharge, supported by the Kaizen Promotion Office. • Independent sector contract initiated January 2021, extended for 2022/23, with assurance framework in place to oversee quality and maximise capacity available.	• Daily communication cells, chaired at general manager and head of nursing level, across inpatient services, focussing on staffing and deployment and on expediting discharges to free up capacity. • West Yorkshire system wide work on adult acute mental health pathway and PICU pathway.	2022/23 trajectory assumes: • continuation of COVID cohorting arrangements • anticipated reductions in length of stay • expected impact of six crisis respite beds being mobilised by Bradford and Craven Clinical Commissioning Group and Bradford Council • application of continuity principles from September 2022 under which independent sector block contract beds would not be considered as inappropriate out of area placements.

Metrics Dashboard (April 2022)

Metric	Goal & Assurance/ Action status	Current & Variation	Average
Use of Mental Health Act (MHA) – Sections free from fundamental errors	98% 	100.0% 	99.5%
Use of MHA – Sections Reviewed on time	98% 	98.8% 	99.2%

Incidents Dashboard (April 2022)

Metric	Goal & Assurance/ Action status	Current & Variation	Average per month
Full Interventions	0	22	51
Full Interventions Males only	0	8	34
Full Interventions Females only	0	14	28
Full interventions Male & Female tracked	0	NA	NA
Prone Restraint	0	0	0.3
Rapid Tranquillisation	0	10	24
Seclusion	0	0	5
Restrictions and Segregation totals	0	21 (down from 39)	N/A	61
Blanket Restrictions	0	21 (down from 38)	N/A	59
Individual Restrictions	0	0 (down from 1)	N/A	1
Long-Term Segregation	0	0 (0 for 2 months)	N/A	0.6

Training Dashboard (April 2022)

Metric Training	Goal & Assurance/ Action status	Current & Variation	Average
Teams where Training Compliance is below 80%	80%	69 staff (up from 57)	
Care Programme Approach (CPA) Roles & Responsibilities	80%	94.50%	80.70%
CPA Care Planning	80%	96.90%	84.50%
CPA Clinical Risk	80%	91.50%	83.20%
Mental Capacity Act	80%	95.30%	95.60%
Mental Health Act Qualified Staff	80%	95.40%	87.70%
Mental Health Act for Health Care Support Workers	80%	98.60%	86.30%

Workforce & Equality Committee

Committee Dashboard (May 2022)

Metric	Goal & Action status	Current Performance	Comment
Theme 1 – Looking After Our People	-	-	Indicators include: Staff Survey overall scores, labour turnover, sickness rate
Theme 2 – Belonging in the Organisation	-	-	Indicators include: Equality Diversity & Inclusion, Workforce Race Equality Standard, Workforce Disability Equality Standard, appraisal and clinical supervision compliance
Theme 3 – New ways of working and delivering care	-	-	Indicators currently include: bank and agency data
Theme 4 – Growing for the future	-	-	Indicators include: recruitment, vacancies, new roles/skill mix, mandatory training, Leadership & Management Development Passport programme