NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

December 2024

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

Click on each section heading to navigate to that section

Introduction

Please find the Trust's Integrated Performance Report (IPR) for December 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 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
% 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 values and behaviours as an issue	↑	
C Diff avoidable cases	↓	
E. Coli bloodstream infection rate	↓	

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 ?
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	↓	?
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	↑	?
% of staff receiving supervision within policy guidance	↓	
Information Governance training compliance	↓	H ?

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	↑	H F
% of feedback with staff values and behaviours as an issue	↓	?

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	H F
% of clients clinically ready for discharge	↑	?
Sickness rate (Monthly)	↓	H ?
% bed occupancy	↓	↑
% of feedback with staff values and behaviours 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	↑	?
Sickness rate (Monthly)	↑	?

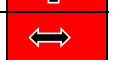
Barnsley Physical Health and Wellbeing

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

Forensic

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

Key

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

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

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

Strategic Objectives & Priorities

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. Work is currently taking place to identify how we will measure progress against these aims and the integrated performance report will be updated in readiness for 2025/26. In the interim, we will continue to report against the previous Trust four strategic objectives.

Improving health

• The Trust continues to work to improve the recording and collection of protected characteristics across all services in order to improve our service provision and experience of it. There is one national indicator which is for ethnicity, the Trust is performing at 96.1% against a target of 90%. Disability recording was at 52.6%, sexual orientation 58.1% and postcode at 99.6%. Work continues to ensure data capture will be extended to all services.

• 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.

• Key to improvement is the refresh of our Equality Diversity and Inclusion strategy, from this we will 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 December, the Trust had 79.9% of services with an up-to-date EIA in place and 100% of policies with an up-to-date EIA.

Improving care

• Risk assessments are integral to providing safe and effective care and making decisions on transition between services. October data shows an improvement in performance for both inpatient and community services which are at 94.9% and 74.7% respectively. All service users without a risk assessment are followed up individually in the care group to maintain patient safety.

• Communications and narrative about the importance of risk assessments and timeliness of this is being developed to share. Opportunities for improvement are regularly assessed and include making the data easier to review and adding pop up reminders to the system. Updated communications about the importance of risk assessments are being developed. A new mental health care plan has been launched during January. The new 'my health and wellbeing plan' aims to reflect the 5 key criteria for personalised care and support plans.

• The Trust had 23 violence and aggression incidents against staff on mental health wards involving race during December which is an increase on previous months. Over the last quarter 47 incidents were reported, 10 of these were physical assaults with the remainder being verbal aggression.

Incidents are reviewed by the Patient Safety Team, and Equity Guardians are alerted to all race related incidents against staff. Recognising the impact on colleagues, a robust process of personal and clinical support has been created to safeguard staff who experience racist abuse at work.

• Neurodevelopment waits remain a concern given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. There is an offer in place to support children and families whilst waiting. The neuro services across both Calderdale and Kirklees saw an increase in demand of over 130% between November 2023 and October 2024.

• Improvement work on waiting list times in community learning disability services has led to a sustained improvement against the 18 weeks standard and for the month of December 97% against a target of 90% was achieved.

Improving resources

Making SWYPFT a great place to work

• The number of RIDDOR incidents over quarter 3 was 11, this is an increase on quarter 2 (6) but lower than quarter 1 (17). Three incidents relate to staff slip, trips or falls (linked to inclement weather and incidents on wards) and eight relate to physical violence (contact made) against staff by patients. In each violence and aggression case, staff have been supported through their recuperation and follow ups made with occupational health and welcome back meetings with the department managers.
There were no enquiries from either the Health and Safety Executive or CQC following our reporting of RIDDOR reporting in quarter 3.
• Overall, our 12-month turnover rate in December decreased to 7.6% and is the lowest for several years. 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.
• At the end of December 2024, our workforce growth rate has slowed compared to earlier months and was at 2.3% (staff in post) year to date. This exceeds our annual budgeted growth rate of 0% and has resulted in financial pressures. Further actions and controls have been introduced to reduce this level of growth.
• For the year to date, we have had 353 new starters and 290 leavers. The Trust did see an increase in starters in earlier months which was as a result of positive recruitment activity last year and contributes to providing operational capacity to support patient care. December saw the lowest number of starters for the year which could suggest the additional controls put in place are taking effect.
• Our year-to-date sickness has increased this month to 5.3% with December sickness increasing to 5.7%. The Trust has seen an increase in the number of cold and flu and gastro related absences during the month with the majority being short term absence. All care groups, except Children, young people and families and ADHD, ASD and LD saw an increase in sickness absence during December. Hotspot areas continue to be managed with care groups. Staffing requirements have been reviewed as a result of sickness levels which will have led to use of bank and agency where needs required.
• Reporting on the appraisal rate shows a slight fall in performance to 85.9%. There have been significant technical issues and availability with the external system supplier meaning that the Trust have not been able to access the appraisal system since 16th December, this is having an impact on our reported compliance. Services are continuing to ensure appraisals are being undertaken locally and alternative approaches to recording are being assessed.
• Continued focus has led to supervision remaining above target in December at 82.3%. Supervision means that staff have had access to a supportive conversation about their practice.
• Our overall mandatory training compliance remains above threshold, with the majority of training areas sustaining performance.
• Reducing Restrictive Physical Interventions (RRPI) training has increased to 80.5% which is now above threshold. Training places available are being increased and a targeted approach is taken to booking staff onto refresher training. 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 will be promoted in the coming weeks to ensure the Trust can meet its 95% target in readiness for our annual data security and protection toolkit submission.

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

Patient Safety Indicators
95% of incidents reported in December 2024 resulted in no or low harm or were not under the care of the Trust, an overview of key indicators is below:
• The number of restraint incidents decreased to 189 from 236 reported in November. 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.
• All ten incidents of prone restraint that occurred during the month lasted under three minutes. Four of these incidents occurred on our Psychiatric Intensive Care Unit (PICU) wards where high levels of acuity have been reported. The use of prone has been reducing (further detail in the quality section of the report) and focus is being applied to situations where prone is used with the aim of reducing further.
• There were nine information governance personal data breaches during December. Learning from incidents is shared across care group.
• The number of inpatient falls reported during December 2024 is 37 (3.7 days per 1000 bed days), which is 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 has dipped slightly under the national threshold of 100%, this relates to one complaint and overall improved performance continues.

National Indicators
The Trust continues to perform well against the majority of national metrics. The following should be noted:
• The relatively low use of inappropriate out of area bed days, usage in December was 127 days (typically four people), remains under the local trajectory of 150 days. The need for these beds mainly relates to the requirement for gender specific psychiatric intensive care (not commissioned locally). The benefits of providing care locally are central to our aims. Further focus continues and we work with partners on our ability to discharge which could improve flow and pressure on wards.
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's mental health services.
• 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 92 out of 186 children (49.5%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in December. Agency cover was lost during the Christmas period, which alongside bank holidays led to a significant decrease in appointment capacity. Figures for January have subsequently improved. The service has set a trajectory for improvement and is preparing a business case for commissioners following a demand and capacity exercise.

Care Groups

• 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.
• Neuro development waits for children remain a concern and discussions continue with commissioners about how we can further strengthen the offer to reduce any impact on those who require assessment or support.
• 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.
• 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 support 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 December 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 progress on actions from the Trustwide SPA review are being implemented and are monitored through the care group governance processes.
• 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. Work continues across local systems to ensure that care is provided in the best place for children who are waiting for a bed. Concerns have been escalated by the executive trio to the CAMHS inpatient provider collaborative executive trio.
• There were no patients admitted to an adult bed under the age of 18 years old during the month.

Finance

• The Trust financial target for 2024/25 is breakeven. The current position is a deficit of £0.9m and actions continue to ensure delivery of the target.
• There was sustained reduction in agency spend in 2023/24. Agency spend has continued to fluctuate during 2024/25 around an average run rate level. Spend is £30k more than last month which includes increased costs for Cheswold Park Hospital.
• Although cash has slightly improved in month it did not increase as much as forecast. Outstanding cash receipts have been chased with commissioners.
• Total pay expenditure continues to be greater than the June 2024 benchmark value. This includes the impact of various pay awards in the intervening period, inclusion of Cheswold Park Hospital, and also utilising more workforce than plan.

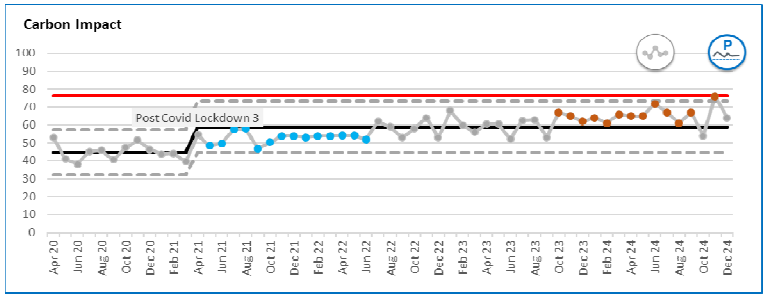
Cheswold Park Hospital

• Data for the newly acquired Cheswold Park Hospital services is included separately in the appendix of the report. It should be noted that the Trust threshold has been reported against to allow an assessment of performance against the wider Trust.
• The service has a good level of completeness of disability, sexual orientation, postcode and ethnicity recording and expect this position to be maintained.
• There were two RIDDOR incidents reported during December, both incidents relate to physical violence (contact made) against staff by patient and were reported to the Health and Safety Executive within the required timeframe.
• Staff supervision rate has seen further increase and is now above the 80% Trust threshold (83%).
• Mandatory training levels for cardiopulmonary resuscitation, reducing restrictive physical interventions, fire and information governance all remain well above the 80% threshold.
• There were 168 incidents reported during the month; two of those resulted in moderate harm. The common cause of these incidents related to self-injurious behaviours.

Improving health

Metrics	Threshold	Oct-24	Nov-24	Dec-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	247- All staff (17.5%) 109 - excl medics (9.0%)	248- All staff (17.6%) 111 - excl medics (9.2%)	248- All staff (17.4%) 113 - 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.
Percentage of service users who have had their equality data recorded - ethnicity	90%	96.5%	96.4%	96.1%		
Percentage of service users who have had their equality data recorded - disability	50%	54.5%	53.7%	52.6%		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		59.4%	58.7%	58.1%		
Percentage of service users who have had their equality data recorded - deprivation (postcode)	90%	99.5%	99.6%	99.6%		
Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure)	Service timely completion - 75%	79.9% Service	89.3% Service	79.9% Service		
	Policy - 95%	100% Policy	100% Policy	100% Policy		
Completion of equality mandatory training	>=80%	96.4%	96.4%	96.3%		
Number of job start/work retention outcomes during month by individual placement and support service	Trend monitor	14	11	11		A single client could have multiple job starts
Number of new people accessing Individual placement and support service during month	Trend monitor	32	36	24		First contact and work started on vocational profile. Average number of new people per month for the period Apr '24 - Nov '24 is 37, total number year to date is 337. December access number have been impacted by a number of issues linked to reduced capacity over the festive period; Increased rates of staff sickness during the month, limited throughout within Kirklees and Calderdale due to numbers waiting. The January position looks to be improved and will be reported in next months report.
Carbon Impact (tonnes CO2e) - business miles	76	54	76	64		Data showing the carbon impact of staff travel / business miles. We have seen an overall increase in business miles across the Trust since October. 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, this has reduced slightly during December but levels do remain slightly higher than previous months - this will continue to be monitored. There are a number of actions being put into place during 2024/25 to reduce our carbon impact. 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%	Q2 - 67.8%				Q1 - 68.5%, Q2 - 67.8% Q3 due in next months report. 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.

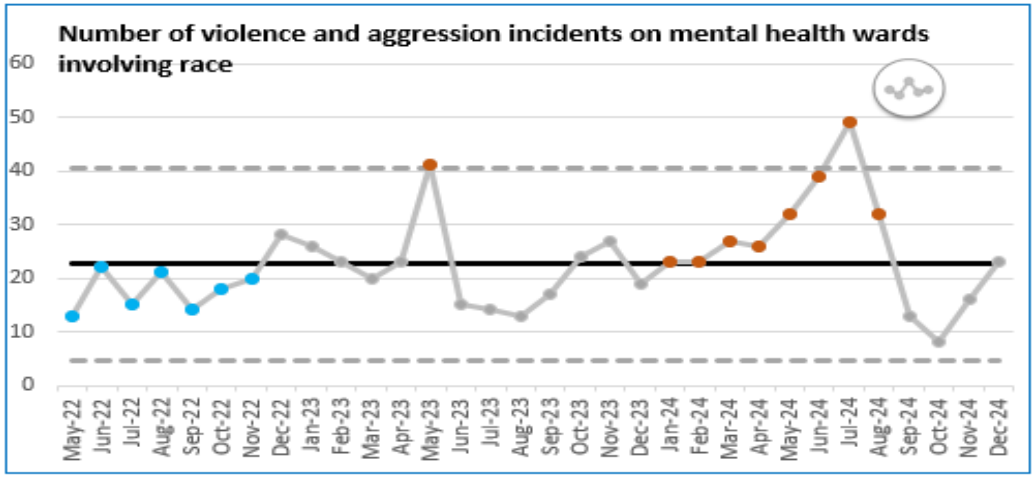
Improve Care

Metrics	Threshold	Oct-24	Nov-24	Dec-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%	92.6%	93.8%	*94.9%*		Within inpatient services, all service users have a risk assessment with 111 service users having had a risk assessment within 24 hours, a further 6 service users had a completed risk assessment - with 1 of those being between 3-4 hours over the 24-hour standard and 5 of those being 15 hours or more over the 24 hour standard). For community services 32 out of 150 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. For community services compliance is impacted by the specific order tasks are recorded on SystmOne. The Staying Safe Plan element of the FIRM has to be documented correctly within 7 working days of the first face to face contact that occurs after a patient is recorded as been 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. Breaches are investigated by clinical teams to understand the cause of the breach and ensure risk assessments are completed. 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. A new mental health care plan has been launched during January; this incorporates the staying safe plan from the risk assessment. Work is taking place to define new reporting measures for both care plans and risk assessments to align. Data for December is provisional and will be refreshed in next months report.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		80.7%	78.0%	*74.7%*		
% Service users on care programme approach with a plan of care developed collaboratively	85%	96.3%	96.2%	96.2%		The Care Plan and Risk Assessment Improvement Group continue to look at performance as well as quality of care planning and risk assessments. The 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	1,131	1,128	1,139		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	159	161	160		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	8	16	23		Over the last quarter 47 incidents were reported, 10 of the 47 incidents were physical assaults with the remainder being verbal violence and aggression , of the total incidents reported 37 related to verbal racial or sexualised abuse. In December 2024, the field "did this incident involve abuse or hate against an individual based on their protected characteristics?" has been made mandatory on Datix to strengthen data collection moving forwards. All incidents continue to be monitored the SWYPT governance structures and work regarding protected characteristics continue to be a priority through REACH and sexual safety workstreams. 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)	Oct - 155 Nov - 150 Dec - 155	96	131	127		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%	4.3%	4.4%	3.7%		Performance in month has improved. Work is taking place to review this data to ensure it is reflective of the number of people delayed. Data will be refreshed in the next report to reflect any changes. There are still a 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.

Improve Care Continued

Metrics	Threshold	Oct-24	Nov-24	Dec-24	Variation/ Assurance	Notes
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	277	273	291		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.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	701	748	785		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.
Learning Disability (LD) - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Improvement trajectory: Oct/Nov 88% Dec onwards 90%	89% 54/61	95% 58/61	97% 60/62		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%	89.8%	93.5%	90.0%		
Community health services two hour urgent response standard	70%	91.7%	88.1%	89.2%		
Referral to assessment within 2 weeks (external referrals)	75%	79.5%	80.2%	78.6%		

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 December 2024 due to the continued overall 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	Oct-24	Nov-24	Dec-24	Variation/ Assurance	Notes
Surplus/(deficit) against plan (Cumulative)	Breakeven	(£624k)	(£790k)	(£911k)		The Trust financial target for 2024/25 is breakeven. The current run rate remains a deficit and actions continue to ensure delivery of the target. The main finance report highlights performance of the various elements of the Trust.
Capital spend against plan (Cumulative)	£8.1m	£2,115k	£2,504k	£2,622k		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	£620k	£578k	£608k		There was sustained reduction in agency spend in 2023/24. Agency spend has continued to fluctuate during 2024/25 around an average run rate level. Spend is £30k more than last month which includes increased costs for Cheswold Park Hospital. The adult secure provider collaborative spend in month was £44k.
Financial sustainability and efficiencies delivered over time (monthly)	£22m	£2,145k	£1,440k	£1,209k		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)	£26,741k	£24,317k	£23,998k		Total pay expenditure continues to be greater than the June 2024 benchmark value. This includes the impact of various pay awards in the intervening period, inclusion of Cheswold Park Hospital, and also utilising more workforce than in June. However, there has been a reduction in December costs which can be linked to the reduction in substantive staff which can be seen in the people section of the report.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	11				Three incidents relate to staff slip, trips or falls (linked to inclement weather and incidents on wards) and eight relate to physical violence (contact made) against staff by patients. In each violence and aggression case, staff have been supported through their recuperation and follow ups made with occupational health and welcome back meetings with the department managers. There were no enquiries from either the Health and Safety Executive or CQC following our reporting of RIDDOR reporting in quarter 3.
Estates Urgent Response Times - Service level agreement (SLA)	95%	95.9%	95.6%	98.9%		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	Oct-24	Nov-24	Dec-24	Variation/ Assurance	Notes
Turnover external (rolling 12 months)	>12% - 13%<	7.6%	7.7%	7.6%		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	2.3%				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. 27% of this growth relates to funded investment priorities (Barnsley neighbourhood teams service).
Sickness absence - YTD	<=5%	5.2%	5.2%	5.3%		Further detail around sickness absence is provided in the relevant section of this report. In month sickness was 5.7%.
Work pal appraisals - rolling 12 months	95%	89.4%	87.9%	85.9%		There have been significant technical issues with the external system supplier meaning that the Trust have not been able to access the appraisal system since 16th December, this is having an impact on our reported compliance. Services are continuing to ensure appraisals are being undertaken locally and will be entered electronically when back online (Planned end of Jan). Further update will be provided in next months report.
% 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%	84.4%	86.3%	82.3%		As part of the review of the supervision of the workforce policy, an improvement programme is underway to use the learning from the Forensic care group to increase uptake and recording of supervision within the clinical workforce. This includes making further changes to the systems and reporting practice. (Band 4 and above, all supervision).
Mandatory training - Cardiopulmonary resuscitation	80%	81.3%	82.2%	82.0%		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%	76.7%	78.4%	80.5%		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%	90.5%	90.4%	90.0%		Threshold increased from >=80% in June 24.
Mandatory training - Information governance (IG)	95%	94.6%	94.5%	93.6%		

Quality Headlines

Section	KPI	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	TBC	84.6%	84.5%	83.3%	83.4%	82.9%	78.2%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	< 20%	0% (0/11)	32% (7/22)	33% (8/24)	16% (5/31)	24% (7/29)	19% (3/16)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)							91.8	
	Complaints - Number of responses provided within six months of the date a complaint received [16]	100%	81% (13/16)	66% (6/9)	85% (11/13)	71% (17/24)	100% (12/12)	88% (7/8)	
Service User Experience	Friends and Family Test - Mental Health	84%	92%	93%	90%	94%	92%	92%	1
	Friends and Family Test - Community	95%	98%	97%	97%	96%	97%	96%	1
Quality	Number of compliments received	N/A	65	92	54	66	27	27	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	9	8	7	4	6	2	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	0	1	0	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	0	0	0	0	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	96.2%	96.2%	96.4%	96.2%	96.2%	96.2%	1
	Number of Information Governance breaches [3]	<12	5	6	5	8	11	9	2
	% of inpatients clinically ready for discharge	3.5%	3.8%	4.9%	4.8%	4.3%	4.4%	3.7%	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%*	93.1%	91.9%	89.7%	92.6%	93.8%	*94.9%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		85.0%	76.2%	76.5%	80.7%	78.0%	*74.2%*	2
	Total number of reported incidents	Trend monitor	1481	1431	1257	1256	1280	1257	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	22	34	39	28	25	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	8	3	2	5	0	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	0	1	0	2	0	
	Safer staff fill rates	90%	132.4%	131.3%	129.4%	131.2%	134.0%	128.8%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	101.4%	98.6%	99.0%	100.0%	104.0%	101.9%	1
	Number of pressure ulcers which developed under SWYPFT care [1]	Trend monitor	41	42	55	33	21	48	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement [2]	0	1	0	0	1	0	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%	72.7% (8/11)	100% (14/14)	92.3% (12/13)	92.3% (12/13)	100% (9/9)	100% (10/10)	1
	Number of Falls (inpatients)	Trend monitor	50	53	47	50	32	37	
	Number of restraint incidents	Trend monitor	195	257	196	187	235	189	
	% of staff receiving supervision within policy guidance [15]	80%	85.6%	84.0%	84.1%	84.4%	86.3%	82.3%	2
	Potential under-reporting of patient safety incidents								
	% people dying in a place of their choosing [14]	80%	87.9%	87.5%	87.1%	86.5%	97.3%	95.0%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	1	0	0	1	1
	C Diff avoidable cases	0	0	0	1	0	0	1	1
	E. Coli bloodstream infection rate	0	0	0	1	0	0	1	
	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 December.

• The overall number of restraint incidents in December was 189 which is a decrease on the previous month and remains within acceptable range. 38 of these incidents were attributed to Melton ward and 27 to Horizon 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 values and behaviours as an issue - there were 3 in December. 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. Of the 8 complaints responded to during the month, 7 were undertaken within 6 months of the complaints being received, and the average number of working days these 8 complaints were open was 91.8 days. 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 decreased to 3.4% and is now below 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 37 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.

• There has been 1 E.coli bacteraemia case on the Stroke Rehabilitation Unit (SRU) and 1 Clostridioides difficile case on the Neurological Rehabilitation Unit (NRU) in December 2024; case note reviews undertaken and improvements if identified actioned.

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:

- Reviewing linked policies and procedures
- Care group will be conducting there first learning response.
- Reviewing incidents against our PSIRF Plan
- Supporting services with care group PSOGs
- Developing the format of the Patient safety oversight group (PSOG) to align with PSIRF
- Updated Datix to reflect our processes for PSIRF

Patient Safety Partners (PSP)

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

Cheswold Park

The patient safety team are working on the transition from the Ulysses system to Datix (the Trust's incident reporting system) for incident reporting in January 2025.

Safety Incident Response Accreditation Network (SIRAN)

The team have submitted evidence to support the SIRAN accreditation.

Safety First

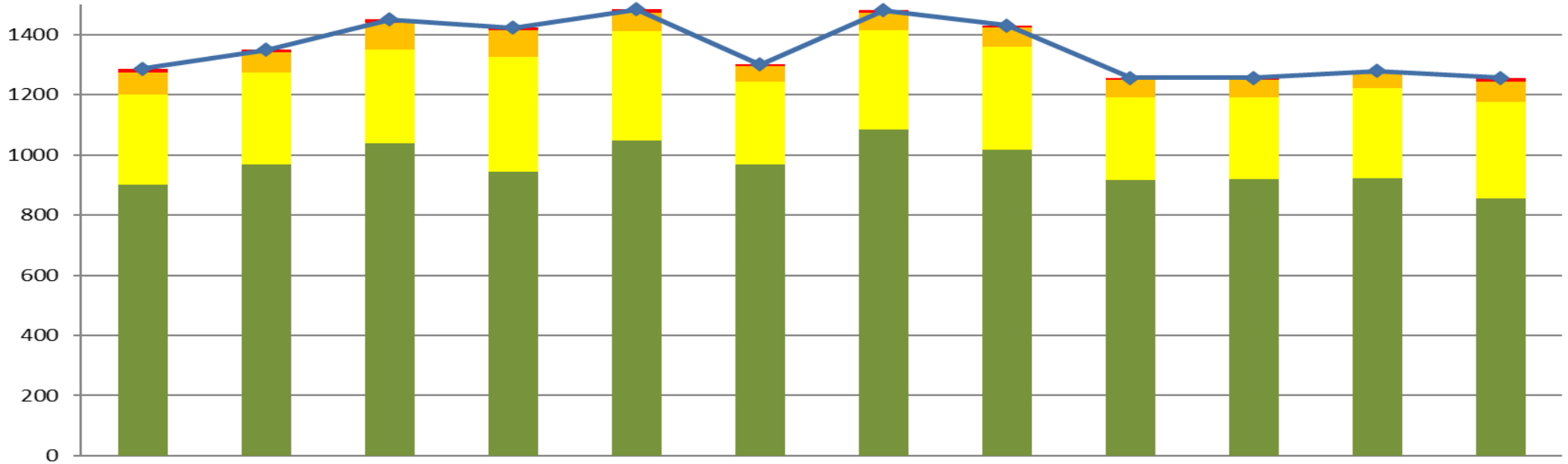
Summary of Incidents

Please note that incidents may be subject to regrading as more information becomes available

95% of incidents reported in December 2024 resulted in no harm or low harm or were not under the care of SWYPFT.

No never events reported in December 2024

As at the time of report writing the number of red incidents has been revised to 8. This will be updated in next month's report.



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Red (should not be compared with SIs)	14	9	12	8	12	6	9	6	7	7	3	13
Amber	73	65	88	88	62	51	57	65	60	58	54	67
Yellow	300	308	312	383	361	275	331	344	274	271	299	321
Green	900	967	1038	944	1049	968	1084	1016	916	920	924	856
Total	1287	1349	1450	1423	1484	1300	1481	1431	1257	1256	1280	1257

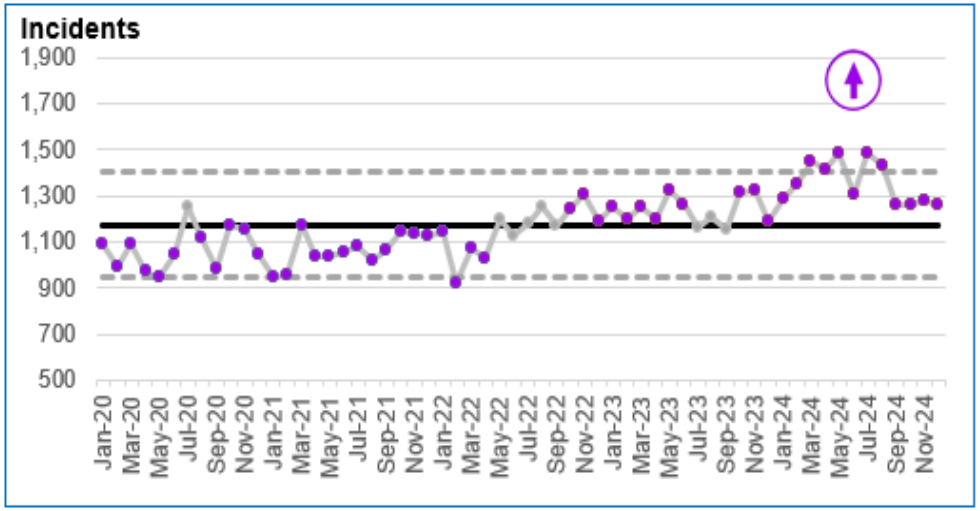
Safety First cont…

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

Breakdown of incidents in December 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.

Incidents



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

Learning Library

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

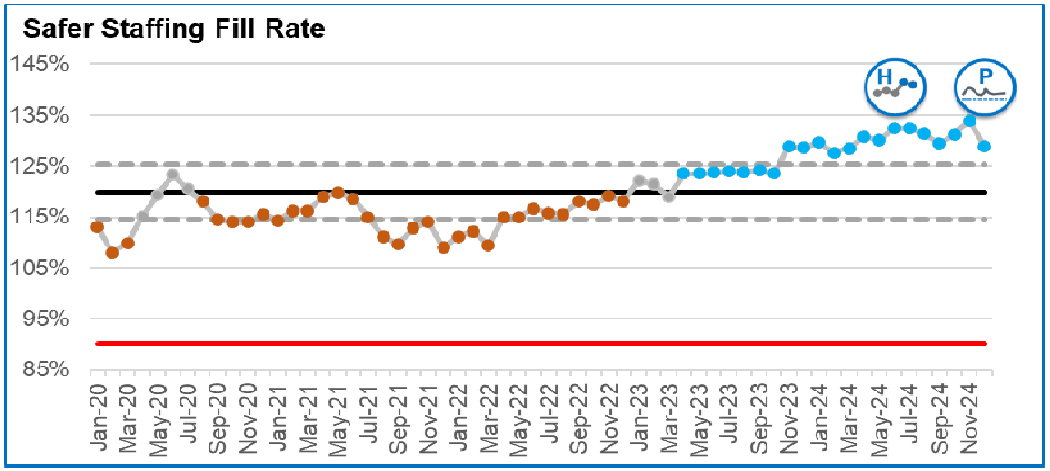
If you would like to attend or share your learning from experience with the learning network, please email learninglibrary@swyt.nhs.uk.

Patient Safety Alerts

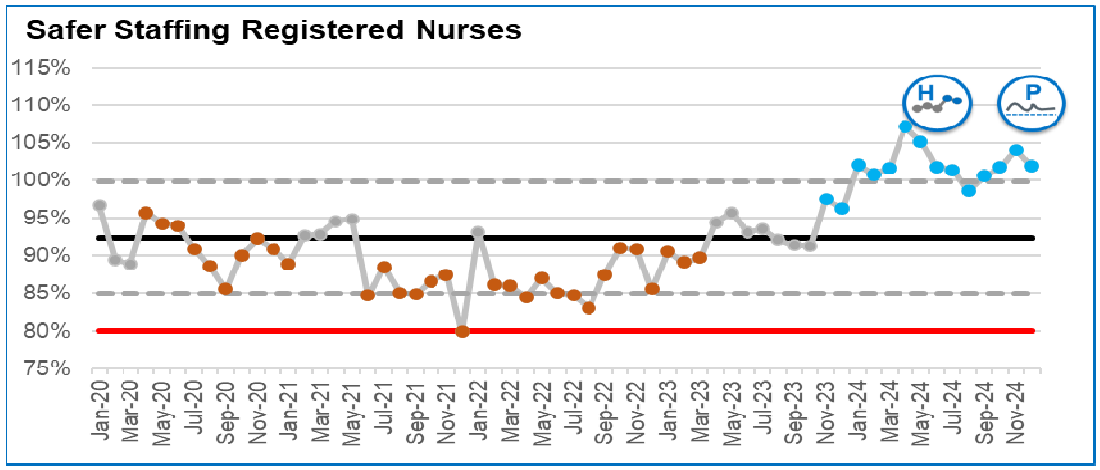
There were no patient safety alerts that were not completed by deadline in December 2024.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2024/013/DHSC	Shortage of Pancreatic enzyme replacement therapy (PERT) – Additional actions	11/12/2024	Yes - circulated for information	24/12/2024	24/12/2024

Safer Staffing Inpatients



The chart above shows that as at December 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 December 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 decrease in December in overall demand.
- There was a reduction of 447 shifts on requests in 2023.
- Within the flexible staffing pool there were a total of 174 less shift requests, however the overall fill rate increased slightly by 0.35% to 91.68%.
- Following the successful recruitment campaigns for band 5s throughout 23/24 we have received 242 less requests for registered nurses (RNs) this December in comparison with 2023.
- Within overall fill rates there was a decrease in the fill rates of all care groups with Adult and Older Peoples Care Group reducing by 6% to 135%, Forensic and LD Care Group saw a decrease of 4% to 122% whilst Barnsley Integrated Services decreased by 5% to 107%.
- 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 informing an agency band 2 – 3 HCA disengagement plan by February.
- 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 a decrease of 5.2% to 128.8%. The day fill rate for RNs decreased by 5.7% to 98.3%. Three wards, consistent with November, Lyndhurst and Ward 18 in the Adult and Older Peoples care group, 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 December no ward, consistent with the previous month, fell below the 90% overall fill rate threshold.

Safer Staffing Inpatients cont…

Registered Nurses Days
There was a decrease of 5.7% in overall registered day fill rates to 98.3% in December compared with the previous month.

Registered Nurses Nights
There was a decrease of 0.7% in overall registered night fill rates to 117.0% in December compared with the previous month.

Overall Registered Rate: In December the overall registered fill rate decreased by 3.7% to 101.9%.
Overall Fill Rate: 128.8% (a decrease of 5.2% on the previous month)

Registered day rate	Oct-24	Nov-24	Dec-24
Adults and Older People	101%	104%	96%
Barnsley Integrated Services	136%	133%	130%
Forensic and LD	93%	99%	96%
Overall shift fill rate	**100%**	**104%**	**98%**

Registered night rate	Oct-24	Nov-24	Dec-24
Adults and Older People	113%	113%	114%
Barnsley Integrated Services	100%	105%	104%
Forensic and LD	124%	127%	124%
Overall shift fill rate	**116%**	**118%**	**117%**

Overall Fill Rate	Oct-24	Nov-24	Dec-24
Adults and Older People	139%	141%	135%
Barnsley Integrated Services	114%	112%	107%
Forensic and LD	120%	126%	122%
Grand total	**131%**	**134%**	**129%**

- Bank staff filled 79.15% (a decrease of 3.12% on the previous month) of RN requests for flexible staffing and 82.64% (an increase of 1.42% on the previous month) of HCA requests.
- Agency staff filled 6.91% (an increase of 0.06% on the previous month) of RN requests for flexible staffing and 10.05% (a decrease of 0.53% on the previous month) of HCA requests.

Information Governance (IG)

Nine personal data breaches were reported during December 2024, which is slightly lower than the numbers reported during October and November.

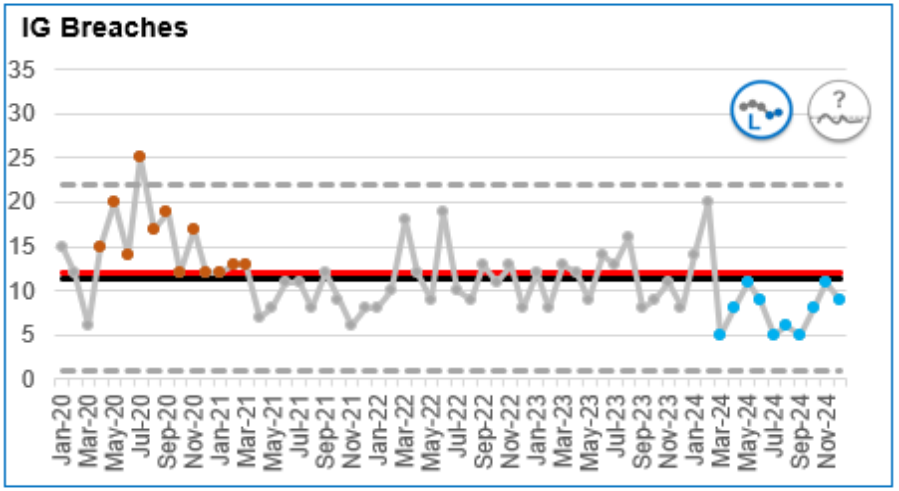
Information disclosed in error continues to be the highest reported category. Breaches during December were due to:

- Letters sent to the wrong recipient or wrong address
- Incorrect details record on system
- Incorrect email attachments
- Unauthorised parties copied on emails in error
- Failure to blind copy emails to groups of services users and/or relatives/carers

The Information Commissioner's Office have closed an incident that was reported to them but advised recommendations for improvement. The incident involved sensitive documentation being posted to the wrong house due to the address being handwritten wrongly. The Information Governance Manager and General Manager are working to ensure improvements are made to ensure this does not happen again.

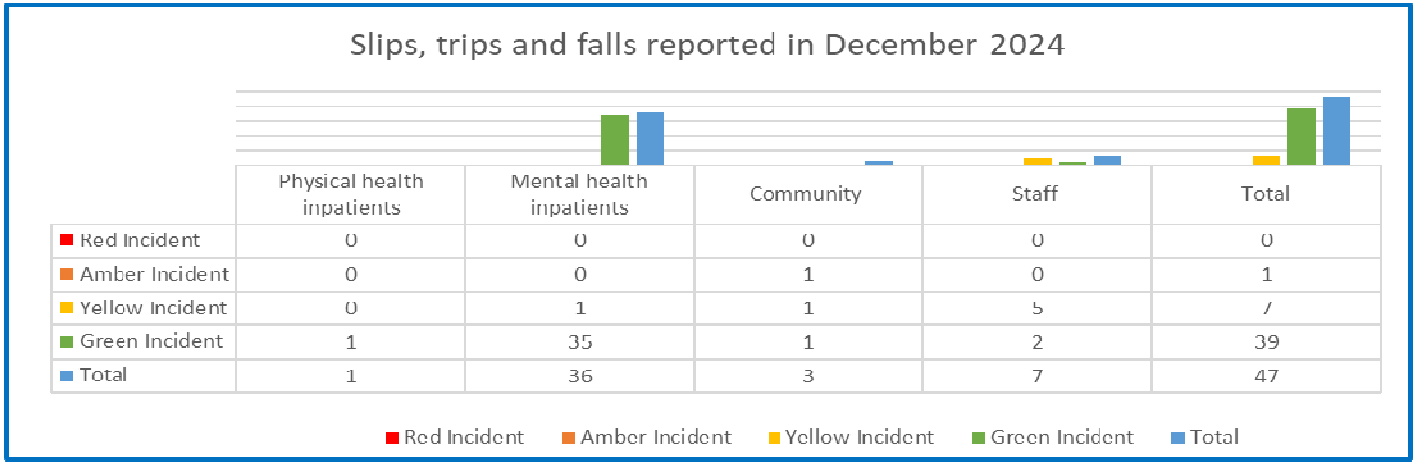
A revised communications campaign is being planned to remind staff of personal responsibility when preparing documents for external posting, as well as the need for accuracy and requirements for sharing personal information.

This SPC chart shows that as at December 2024 we remain in a period of special cause improving variation (something is happening and this should be investigated). Overall there has been a decrease in the number of IG breaches.



Trustwide Falls

In December 2024, a total of 47 slips, trips, and falls were reported. 37 of these were in inpatient wards.
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	1	0	1
Yellow Incident	0	1	1	5	7
Green Incident	1	35	1	2	39
Total	1	36	3	7	47

- 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 89% this month, with a continued good response from staff
- 100% of patients had a good quality falls risk screen (FRAT-18) completed within 24 hours of admission

Incident Grading

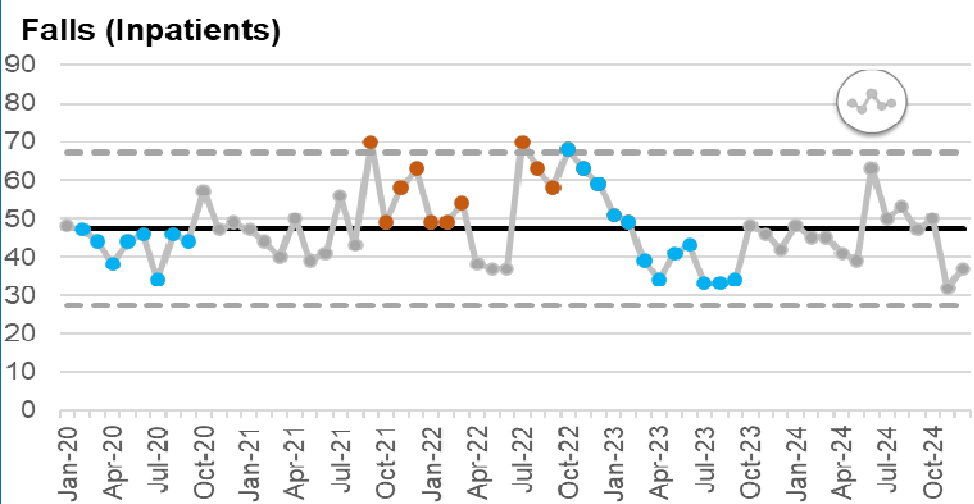
There were no red incidents.
Amber: A total of one (2%) reported safety event was for a younger patient living in 24-hour care who was deemed at high risk of falls and injury due to a change in their physical health. They were quickly supported to another 24-hour care environment that can meet their needs.
Yellow: A total of seven (13%) reported safety events needed higher intervention. Five (83%) of these falls, were staff who reported general slips, falling off a curb, falling down some outdoor steps on a visit due to poor lighting and weather conditions, and a member of staff who fell whilst running to support a patient. One (14%) patient returned from leave reporting a fall at home. Ward staff arranged a review, and the patient was diagnosed with a minimally displaced fracture of the proximal fibular shaft.
Green: A total 39 (85%) reported safety events had low, or no harm recorded. Four (10%) of these reported falls occurred whilst the patient was on leave from the ward.

Inpatient falls had a high correlation with:

- 17 falls (49%) occurred in patients with a recognised level of deconditioning with reports of generalised weakness in legs giving way, slipping on a wet area in the toilet, losing balance, and rolling/slipping from bed
- 16 falls (46%) occurred in patients aged under 65. These were linked with sports activity, agitation, dehydration, chest infection, and two younger adults with a diagnosis of dementia
- Four falls (10%) were by one patient, there has been a reduction in patients having repeated falls (3 or more falls per month)
- 22 falls (56%) were unwitnessed, 10 of these falls (45%) were by patients aged under 65.
- The top three risk areas for inpatient falls were; 16 falls (44%) occurred within patient bedrooms, seven (19%) of falls occurred in lounge areas, five (14%) of falls occurred in corridors

Falls (Inpatient)

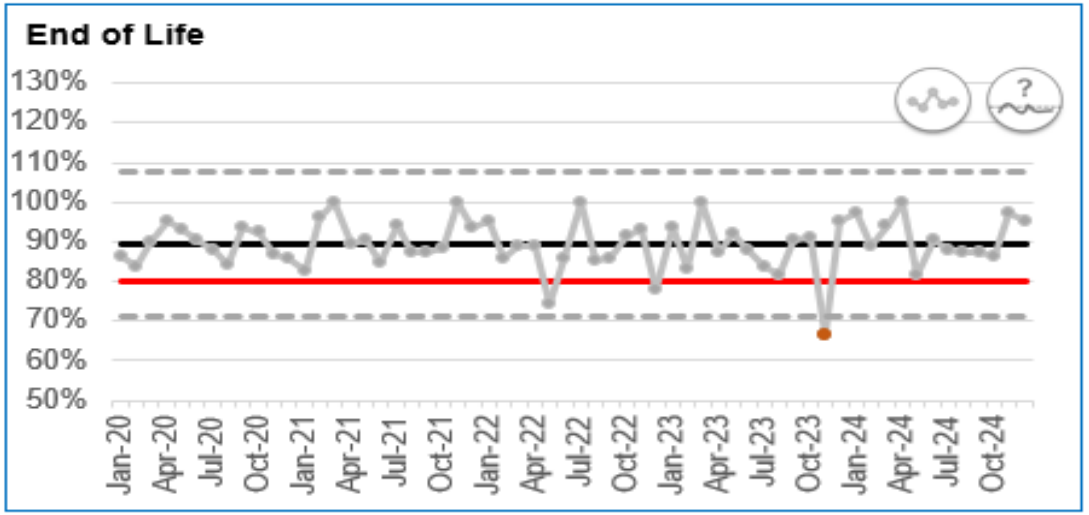
The total number of inpatient falls was 37 in December.



The SPC chart above shows that in December 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 95.0% in December. 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 December 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 results (FFT) show:

- 96% would recommend physical health services
- 92% would recommend mental health services

	Target	October	November	December
Mental health community	85%	95% (333)	90% (188)	94% (244)
Mental health inpatient	85%	86% (63)	98% (46)	92% (26)
Learning Disabilities	85%	100% (23)	94% (18)	90% (10)
ASD/ ADHD	85%	100% (19)	92% (12)	90% (10)
CAMHS	75%	93% (28)	94% (34)	86% (35)
Forensic	60%	100% (2)	N/A (0)	56% (9)
Mental health overall	84%*	**94% (468)**	**92% (298)**	**92% (334)**
Barnsley Physical Health	95%	**96% (311)**	**97% (259)**	**96% (213)**
Trustwide	**85%**	**95%(779)**	**94% (557)**	**93% (547)**

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

The satisfaction rate Trustwide remains consistent with previous months, showing a slight decline (94-93%). Satisfaction in CAMHS and learning disability services has declined slightly but remain above target.

Satisfaction across mental health community services and increased. Satisfaction across all other services has declined.

All service lines remain above target.

Learning disabilities, ADHD and ASD Services Trustwide satisfaction has decreased across the past three months. The Quality Governance Team continue to work with service to review response rates and any themes from feedback to support patient experience.

Safeguarding

Safeguarding Adults:
In December 2024 there were 44 Datix categorised as safeguarding adults. Of these 20 were categorised as green, 19 were categorised as yellow and there were 5 amber incidents. There were no red Datix. The most common subcategories of these were domestic abuse, neglect, financial abuse and physical abuse.

In addition to the safeguarding adults Datix, there were seven sexual safety Datix. Of these four were green incidents and three were yellow. There were no amber or red incidents.

Safeguarding Children:
In December 2024 there were seven Datix submissions categorised as Safeguarding Children. Four were classified as yellow incidents and three were classified as green incidents. This is a significant decrease in incident reporting from November however there were no red or amber incidents reported.

Complaints

- There were 16 new formal complaints received during December. This is a decrease from 29 in November.
- Of these complaints three have values and behaviours (staff) identified as a primary reason for the complaint. This is a decrease from seven in November.
- 88% (7 out of 8) responses were provided within the six month statutory timeframe. This is a slight decrease from 100% in November. Though the average number of working days that these complaints were open was only 91.8 days.
- There were nine complaints waiting for allocation to a complaint officer at the end of December. This is an increase on recent months (seven in November) and is due to team capacity during the month. This is being closely monitored and is expected to resolve during January.
- The Trust received 27 compliments during December.

Infection Prevention Control (IPC)

There has been 1 E.coli bacteraemia case and 1 Clostridioides difficile case in December 2024, case note review undertaken and improvements if identified actioned.

Ward 19 sadly had a Covid-19 death in November 2024 within 28 days of a positive result, a post infection review will be undertaken using PSIRF and any improvement will be actioned and shared as appropriate.

Crofton Ward sadly had an influenza death, part two on the death certificate in November 2024. IPC PSIRF matrix was used, and a case review has been undertaken. Learning and improvements will be shared with the service and shared for wider learning.

Outbreaks - December 2024
- Two inpatient areas had outbreaks of Influenza A. Five inpatient areas monitored for Influenza A and one inpatient area monitored for diarrhoea and vomiting (no causative organism).

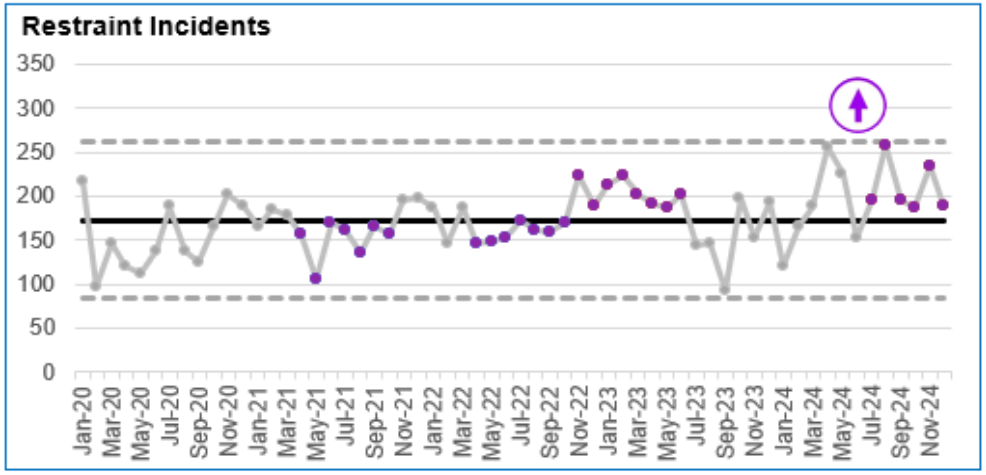
Reducing Restrictive Physical Intervention (RRPI)

• There were 189 reported incidents of Reducing Restrictive Physical Interventions used in December 2024 this was a reduction of 46 (19.5%) from November 2024 which stood at 235.
• In December 2024 Prone restraint (those remaining in Prone position and not rolled immediately) was reported 10 times an increase of 1 (11.1%) from last month.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	99	37.6%
Safety Pod	60	22.8%
Seated	43	16.3%
Supine - held on their back, regardless of surface	23	8.7%
Side	19	7.2%
Prone descent then remained in chest down position	10	3.8%
Restricted escort	5	1.9%
Kneeling	2	0.8%
Prone descent then immediately rolled to other position side/back	1	0.4%
PILOT AREAS ONLY v3 Safety Pod Technique (IM administration then exit)	1	0.4%

Team Using Prone Restraint	Dec-24
Melton PICU, Barnsley	2
Walton PICU	2
Bretton Centre - Building Related	1
Clark Ward - Barnsley	1
Hepworth Ward, Newton Lodge, Forensic	1
Nostell Ward, Wakefield	1
Sandal Ward (Bretton Centre)	1
Stanley Ward, Wakefield	1

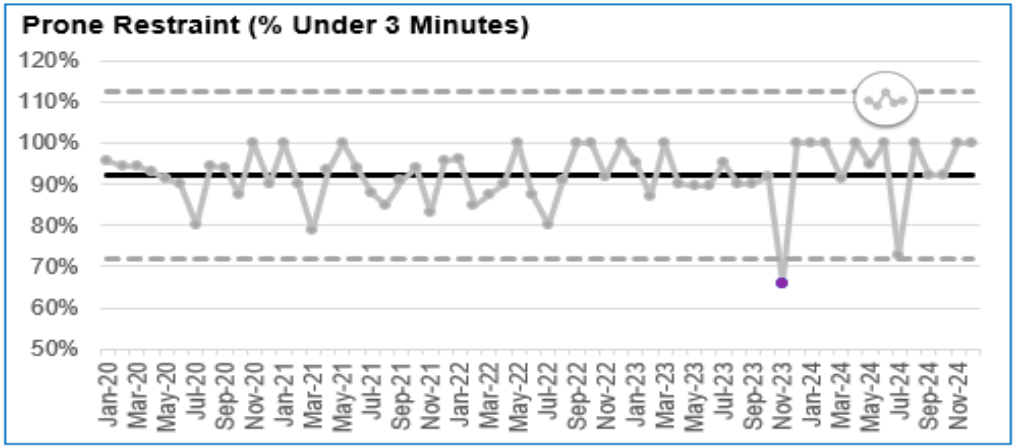
Duration of Prone Restraint	Dec-24
0 - 15 seconds	5
1 - 2 minutes	5

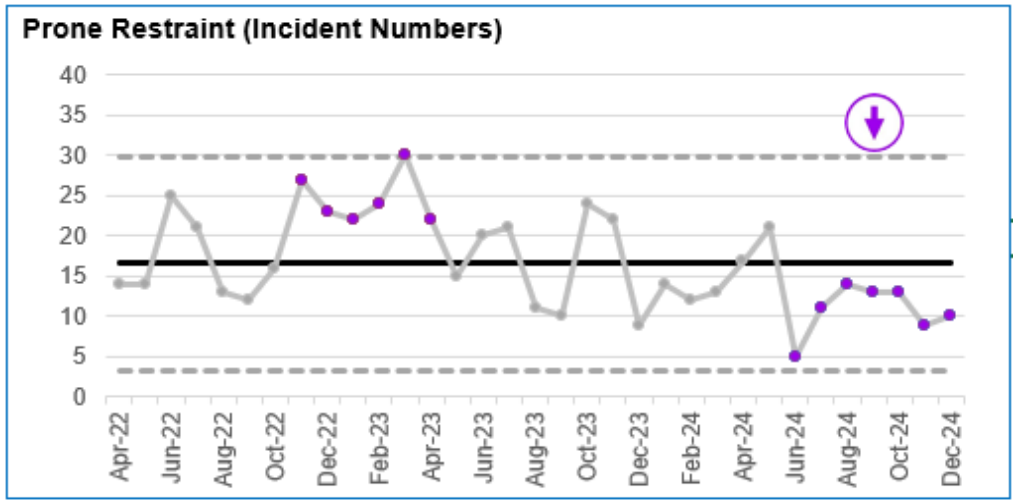


This SPC chart shows that in December 2024 we have entered a period of special cause improving variation (something is happening and this should be investigated).

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

Reducing Restrictive Physical Intervention (RRPI)





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

The number of prone restraints has increased slightly in December. All incidents of prone restraint are reviewed for learning in the Patient Safety Oversight Group. The improvement work continues and the SPC chart shows an overall reducing trend.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Establishment	Improving Resources	Well Led	-	5461.6	5451.4	5460.1	5512.2	5520.5	5524.3
Contracted Staff In Post (Ledger)			-	4688.2	4720.5	4738.8	4738.9	4756.6	4738.8
Vacancies			-	773.3	730.9	721.4	773.3	763.9	785.5
Turnover external (12 months rolling)			>12% - <13%	9.7%	8.0%	8.2%	7.6%	7.7%	7.6%
Starters			-	39.0	37.4	56.6	40.0	35.7	17.4
Leavers			-	23.1	41.4	51.3	28.6	35.6	30.0
International Nurse Starters in Month			-	0	0	0	0	0	0
% Bank Fill Rates - Registered Nurses			-	79.3%	79.3%	80.6%	82.4%	82.2%	79.2%
% Bank Fill Rates - Health Care Assistants			-	83.1%	82.1%	82.6%	80.9%	81.2%	82.6%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)			-	93.6%	92.9%	92.8%	92.6%	91.3%	91.7%
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) *			-	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%)	248- All staff (17.4%) 113 - 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)			-	984 (71.1%)	996 (70.9%)	998 (70.7%)	1003 (71.2%)	1003 (71.2%)	1013 (71.1%)
Sickness absence - YTD			<=5% from June 24 was <=4.8%	4.9%	5.0%	5.1%	5.2%	5.2%	5.3%
Sickness absence - Month				5.2%	5.1%	5.5%	5.5%	5.3%	5.7%
Employees with long term sickness over 12 months			-	0	1	1	4	2	2
Appraisals - rolling 12 months			Jun 24 - 89% Jul 24 - 91%	85.0%	86.7%	89.1%	89.4%	87.9%	85.9%
Employee Relations - Suspensions (over 90 days)			-	1	1	1	1	1	0
Mandatory Training - TOTAL	Improving Care		>=80%	93.0%	93.2%	93.0%	93.0%	93.2%	93.4%
Mandatory Training - Reducing Restrictive Practice Interventions				74.9%	75.8%	76.1%	76.7%	78.4%	80.5%
Mandatory Training - Cardiopulmonary Resuscitation				80.2%	80.7%	82.0%	81.3%	82.2%	82.0%
Mandatory Training - Clinical Risk				94.2%	95.2%	95.3%	94.9%	95.1%	95.1%
Mandatory Training - Display Screen Equipment				97.3%	97.6%	97.9%	97.7%	98.0%	97.9%
Mandatory Training - Equality & Diversity				97.2%	97.0%	96.7%	96.4%	96.5%	96.3%
Mandatory Training - Fire Safety			>=85% (from June 24)	91.1%	90.8%	90.4%	90.5%	90.4%	90.0%
Mandatory Training - Food Safety			>=80%	90.9%	91.0%	92.0%	92.2%	91.4%	91.3%
Mandatory Training - Freedom To Speak Up (FTSU)				96.1%	96.3%	96.5%	96.5%	96.9%	96.9%
Mandatory Training - Infection Control & Hand Hygiene				94.9%	94.6%	94.5%	94.4%	94.9%	94.9%
Mandatory Training - Information Governance (Data Security)			>=95%	95.7%	95.5%	94.7%	94.6%	94.5%	93.6%
Mandatory Training - Moving & Handling			>=80%	97.6%	97.9%	97.7%	97.5%	97.7%	97.7%
Mandatory Training - Nat Early Warning Score 2 (New S2)				95.2%	96.1%	97.0%	97.1%	97.6%	97.7%
Mandatory Training - Mental Capacity Act/Dols				90.6%	90.7%	90.6%	90.5%	90.6%	91.0%
Mandatory Training - Mental Health Act				88.0%	88.4%	88.1%	87.9%	87.7%	88.5%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				87.6%	89.0%	89.9%	90.5%	91.4%	92.1%
Mandatory Training - Prevent			>=80%	95.1%	95.0%	95.4%	95.3%	95.5%	95.3%
Mandatory Training - Safeguarding Adults				88.8%	89.2%	90.4%	90.0%	89.9%	91.0%
Mandatory Training - Safeguarding Children				95.4%	95.5%	92.4%	92.4%	92.5%	93.3%

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

• The number of staff in post has reduced since last month by 13.3 full time equivalents (FTE). Although there has been an increase in Barnsley physical health & well being FTE, there has been a noticeable drop in FTE within the Mental Health Care Group. All other areas remain static.

Vacancies

• Our recruitment team have recruited 17.4 staff in December which is the lowest level we have seen in a number of years. The vacancies have increased slightly this month. This is mainly as a result of the leavers within mental health.

Turnover

• Turnover has decreased to 7.6% which is the second time this year it has been at the lowest position the Trust has seen in several years. It can be reasonably assumed that this reduction is linked to the fact that there are 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 choosing to stay with us.

Sickness (Overall)

• The majority of episodes of sickness for December are due to colds and influenza. This is an increase of 47 episodes of sickness in December for 'Cold and Flu' as a sickness reason.
• Employees absent due to gastro related absences have also increased year on year for December (2023 = 97; 2024 = 132)
• Although 'Anxiety and Stress' absences have increased during 2024 there has been a significant drop for November and December. An assumption can be made that the significant increase in seasonal related absences has resulted in less employees being absent due to 'Anxiety and Stress'.

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%. There are a 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 month's 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 Park Hospital activity - capacity will increase in the New Year and focus will be targeted on those areas where the rates have reduced.

• Issues with the external supplier of the Trusts appraisal system has meant that the Trust has been without access to the WorkPal system since 16th December. Work is ongoing to remedy this and is a priority. A number of actions are currently being undertaken which include:

  • The Trust currently has access to an appraisal recording product within ESR and this is being scoped for replacement use, both in the short term and the long term.

  • A new Microsoft Forms version of the Appraisal Document is being made available on the Trusts intranet. This is a short-term solution. All Trust areas are using this in the short term and will continue to undertake appraisals with individuals with a view to later upload.

  • Communications on the position is being conducted regularly and continues to be a standing agenda item in OMG (weekly) and EMT (fortnightly).

  • Briefing and options paper to go to EMT (January)

  • Procurement, Communications, IT and Reporting engaged regarding contract/next steps/reputational damage/recompense.

  • Download of data a priority including the objectives data etc.

  • To maintain current appraisal compliance rates there are 1063 appraisals due in quarter 4 (Jan 480 / Feb 344 / Mar 239).

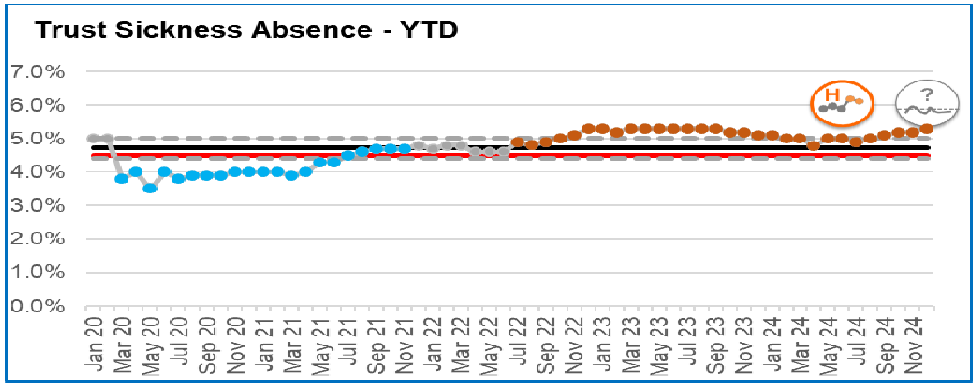
  • We estimate that we will see a 15% drop off in rates between now and any system access being restored (end of Jan).

Training Compliance

• Slight increase in training compliance to 93.4%

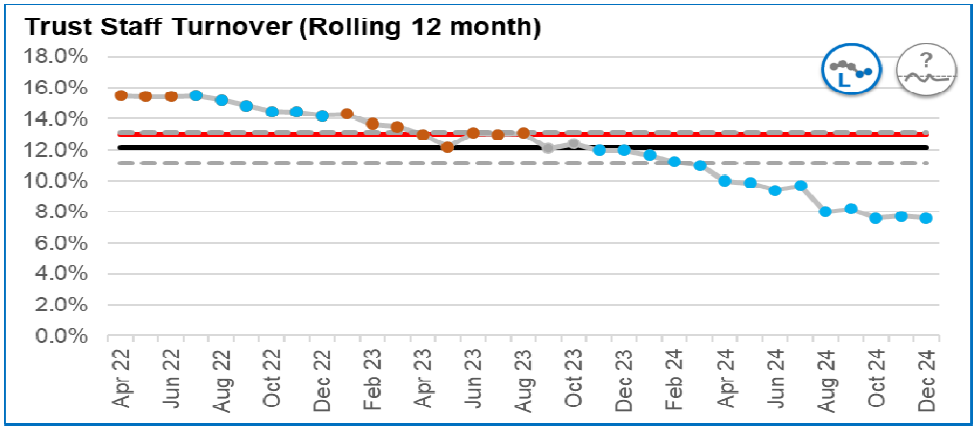
• Continued focus on Reducing Restrictive Practice Interventions training with training needs analysis for 2025 under way and compliance at 80.5% which is now just above the Trust threshold of 80%. The learning and development team continue to work closely with Reducing Restrictive Physical Interventions 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

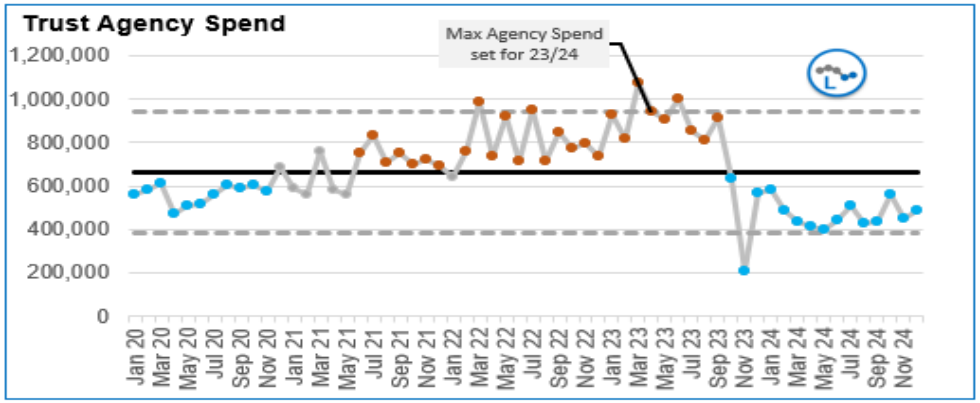


The SPC chart shows that in December 2024 we remain in a period of special cause concerning variation (something is happening and this should be investigated).

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



The SPC chart shows that in December 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.



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

The SPC chart shows the sustained reduction in spend and in December 2024 we remain in a period of common cause improving variation.

See the Finance Report for further information.

MEDICAL APPRAISALS	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
Number of doctors due to have an appraisal meeting in the reporting period	38	38	44	
Number undertaken in period	34	34	40	
Number not undertaken for which the RO accepts postponement is reasonable	4	3	4	
Percentage of appraisals taken place and submitted on time	90%	90%	91%	

MEDICAL REVALIDATIONS	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
Number of revalidation recommendations due in period	13	9	5	
Number of positive recommendations	13	9	4	
Number of deferrals	0	0	1	
Number of non-engagements	0	0	0	
Percentage of revalidation recommendations made	100%	100%	100%*	

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

*Please note that a deferral is still a recommendation so none outstanding

National Metrics

Data as of : 22/01/2025

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	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M2	Inappropriate out of area bed days		0	F	L	104	74	138	119	62	114	111	124	138	96	131	127
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	P	H	81.6%	93.2%	94.1%	87.5%	90.3%	92.7%	91.7%	86.2%	90.3%	97.6%	91.8%	96.6%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	99.8%	99.9%	99.9%	100.0 %	100.0%	99.9%	99.7%	99.5%	99.5%	99.2%	99.0%	98.2%
M7	72 hour follow-up from psychiatric in-patient care		80%	?	L	88.7%	92%	87.5%	94.6%	89.8%	89%	91.2%	91.0%	94.1%	89.9%	93.5%	94%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?	L	30	28	8	29	13	1	5	5	0	0	1	0
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?	L	1	1	2	1	2	1	3	1	0	0	1	0
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?		100%	66.7%	100%	n/a	100%	100%	50%	100%	100%	100%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?		97.1%	97.3%	97.2%	97.5%	94.1%	96.6%	100%	87.5%	84.8%	88.9%	76%	54.7%
M15	Data Quality Maturity Index		95%	P	L	99.5%	99.4%	99.4%	99.3%	99.5%	99.5%	99.4%	99.5%	99.5%	99.6%	98.4%	98.4%

National Metrics

Data as of : 22/01/2025

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					18.5%	18.1%	16%	17.4%	22.8%	26.5%	25.5%	26.0%	11.3%	19.6%	19.8%	22.1%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			97.6%	97.1%	96.3%	97.4%	96.5%	96.2%	96.8%	97.0%	96.7%	96.6%	96.9%	98.0%
M34	% Clients in settled accommodation	⚠	60%	P	L	84.6%	84.2%	83.5%	83.4%	83.5%	83.2%	83.5%	83.6%	84.0%	83.3%	84.1%	84.4%
M35	% Clients in employment	⚠	10%	P	H	13.2%	13.0%	13.5%	13.0%	13.2%	13.0%	12.6%	12.7%	12.5%	13.1%	13.3%	12.8%
M41	Completion of a valid NHS number		99%	P		99.8%	99.7%	99.7%	99.9%	99.9%	99.9%	99.5%	100.0%	99.5%	100.0%	100.0%	100.0%
M42	Completion of ethnicity coding for all service users		90%	P	H	99.4%	96.9%	100.0%	99.5%	99.5%	99.4%	100.0%	99.4%	100.0%	99.5%	99.6%	99.5%
M43	Community health services two hour urgent response standard		70%	P	H	86.2%	87.8%	88.3%	92.8%	89.7%	89.9%	92.0%	91.6%	91.6%	90.9%	88.1%	89.2%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500			1700	1559	1336	1661	1589	1618	1963	1579	1804	2022	1851	1603
M47	Virtual ward occupancy		80%			81.4%	95.7%	101%	82.7%	94.3%	81.4%	91.4%	70%	82.9%	86.7%	112%	103%
M49	Number of people who receive two or more contacts from community mental health services for adults and older adults with severe mental illnesses (MHSDS Definition) Rolling 12 months				L	14468	14385	14287	14128	14108	13996	13939	13773	13661	13588	13571	13361
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months				L	11143	11080	11059	10933	11009	10958	10939	10713	10737	10882	10878	10856
M171	% Admissions gate kept by crisis resolution teams		95%			98.1%	98.8%	95.7%	98.8%	98.1%	95.6%	97.4%	97.9%	97.5%	100%	97.8%	100%
M181	Women Accessing Specialist Community Perinatal Mental Health Services					1203	1214	1188	1209	1221	1217	1233	1249	1305	1421	1519	1538
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)					6	4	5	2	3	4	3	4	4	4	5	4
M183	Incomplete Referral to Treatment (RTT) pathways of 65 weeks or more		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M184	New RTT pathways (clock starts)		1700			1811	1843	1745	1822	1967	1789	2061	1845	2088	2167	1869	1708
M188	Community services waiting list, over 52 weeks					9	9	5	4	2	5	2	0	0	0	0	0

National Metrics

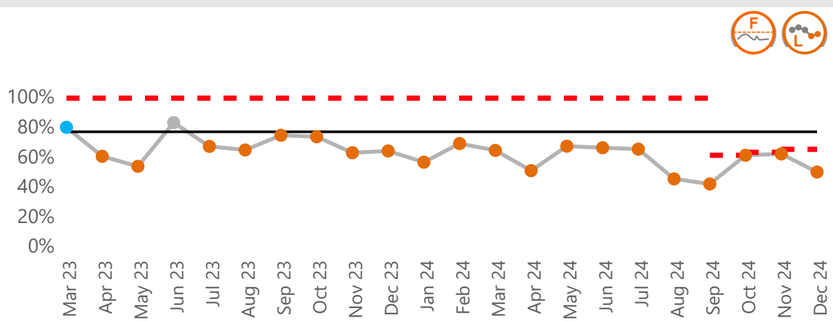
Data as of : 22/01/2025

NHS South West Yorkshire Partnership NHS Foundation Trust

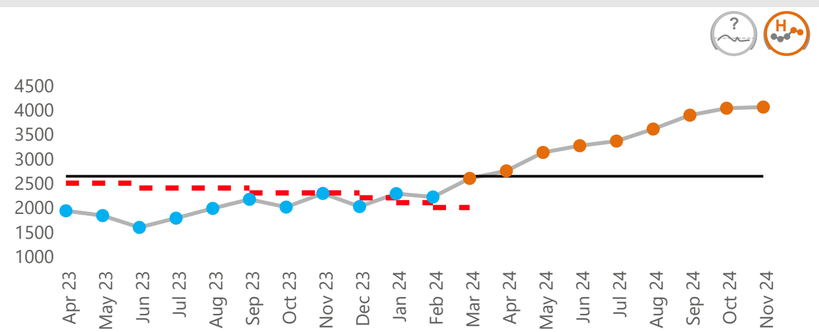
The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.

• The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks has decreased in December to 49.5%, remaining well below the national threshold of 99% and also below the new locally set trajectory for improvement which is 64.7% in December. 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 were no admissions for under 18 year olds to an adult acute mental health bed during December.
• The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks is 54.7% in December - this relates to 24 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 December, 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 103% for December.
• 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). It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold.

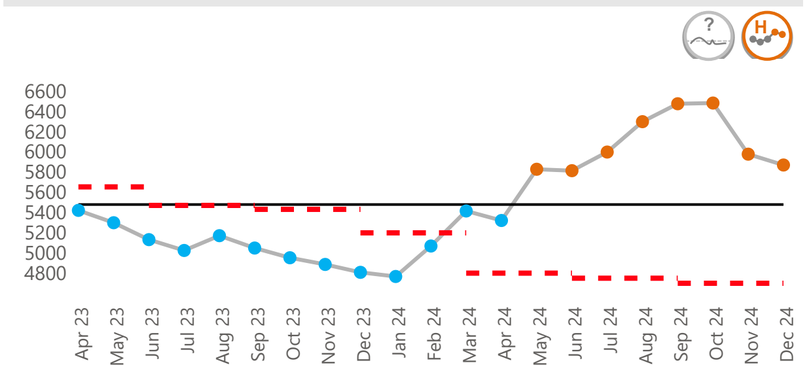
M6 - Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)

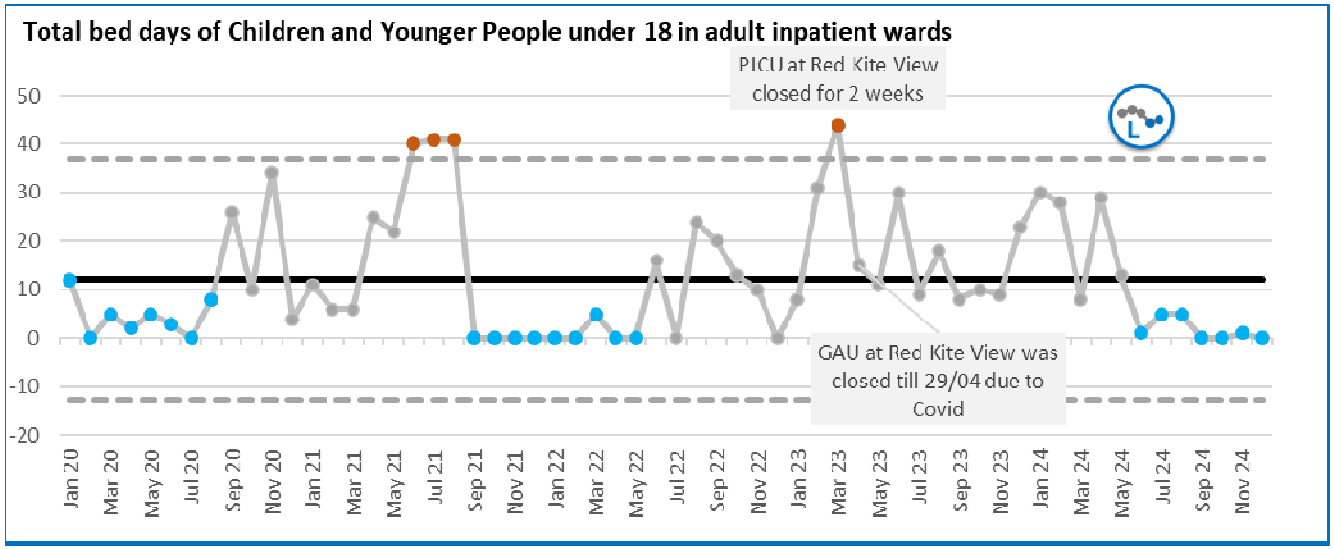


M45 - The number of incomplete Referral to Treatment (RTT) pathways

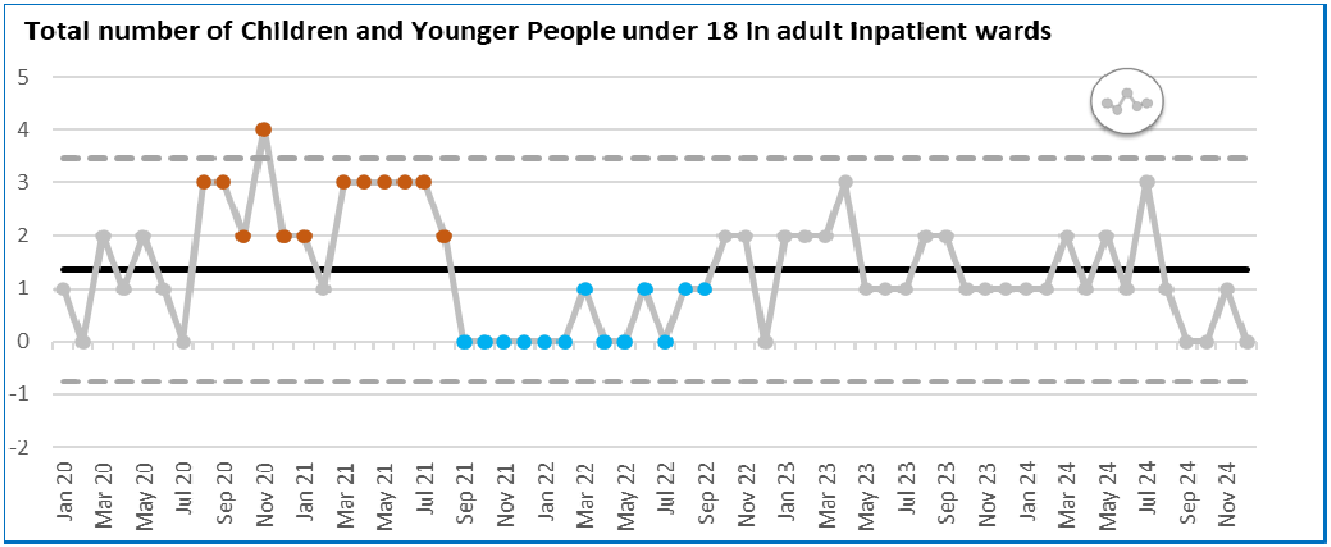


M48 - Community services waiting list





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



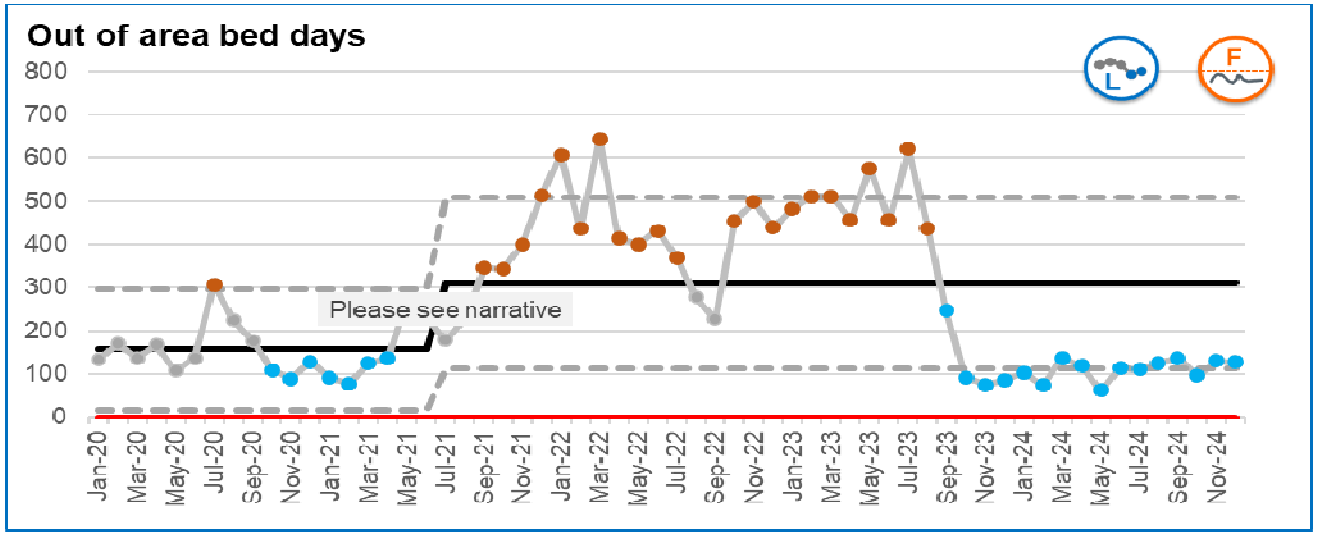
There has been a decrease in the number of people aged under 18 admitted to an inpatient ward in December 2024, with no admissions. Whilst the SPC chart shows us that this is still within common cause variation when we compare it to the range of admissions we have had in the past, it is recognised that 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 December the following data quality issue has been identified in the reporting:

- The reporting for employment and accommodation shows 14.6% of records have missing employment and/or accommodation status with a further 1.6% that have an unknown employment status and 1.0% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

Analysis



The 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

2.67

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

Children and Families Care Group

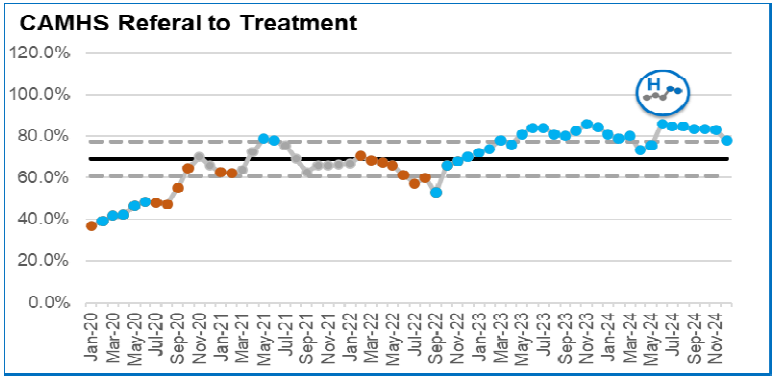
Headlines

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	Oct-24	Nov-24	Dec-24	Variation/ Assurance
% Appraisal rate	>=95%	89.2%	90.8%	90.2%	
% of feedback with staff values and behaviours as an issue	< 20%	33% (1/3)	0% (0/4)	0% (0/0)	
% of staff receiving supervision within policy guidance	80%	85.3%	84.4%	79.1%	
CAMHS - Crisis Response 4 hours	N/A	98.0%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.8%	84.2%	84.0%	
Eating Disorder - Routine clock stops	95%	88.9%	76.0%	54.7%	
Eating Disorder - Urgent/Emergency clock stops	95%	100.0%	100.0%	100.0%	
Maximum 6 week wait for diagnostic procedures	99%	60.9%	61.8%	49.5%	
Information Governance training compliance	>=95%	96.7%	96.2%	94.6%	
Reducing Restrictive Practice Interventions training compliance	>=80%	73.0%	72.4%	76.4%	
Sickness rate (Monthly)	5.0%	4.8%	4.4%	4.3%	

**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 December 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. Discussions are taking pace with the executive team and the integrated care board at Place commissioners.
- Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. This has been recorded on the risk register and actions are in progress to support. This work is also linked the model of commissioning under any qualified provider (AQP) and the number of batched referrals coming through the Spa managing the AQP referrals on behalf of the system.
- Staff turnover has increased in Barnsley CAMHS due to the recent management of change work that has been undertaken in the children, young people and families care group, staff have moved and been retained within the Trust.
- There has been a reduction in Paediatric Audiology performance, which now sits at 49.73%. Agency cover was lost during the Christmas period, which alongside bank holidays led to a significant decrease in appointment capacity. Clinician provision post-Christmas has resumed and figures for January have subsequently improved.

Advise

- Eating disorder performance continues to fluctuate, this is due to the impact of the ARFID (Avoidant/restrictive food intake disorder) pathways and undefined reporting processes. These are being explored with NHS England. All urgent cases have been seen in expected timeframes.
- Information governance training has dipped just below 95%this is due to a few staff being off sick that were due in December.
- Requests for ADHD medications continues to increase, these service users have been started on medications within private services then requesting the CAMHS team to continue prescribing.
- Overall referrals continue to increase and are at the highest they have been for 12 months. However, emergency referrals have reduced slightly from last month and remain within expected parameters.
- Barnsley has seen a rise in the numbers of patients on waiting lists and is the highest it has been in 12 months. The areas impacted the most are initial assessment and ADHD medication pathways.
- We are reviewing the level of turnover in our CAMHS Barnsley service to assess impact on continuity of care and waiting times for our service users.
- The care group currently have interim leadership arrangements in place and is due to recruit in the coming months.

Assure

- Appraisal performance has remained relatively stable. Teams are working hard to meet the 95% target with two teams achieving. Noted that the December figure is not accurate due to the issues with WorkPal.
- The overall sickness rates for the care group remain 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 reducing restrictive practice interventions training.

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.
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 and this has increased 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	Oct-24	Nov-24	Dec-24	Variation/ Assurance
% Appraisal rate	>=95%	90.6%	91.3%	90.1%	
% Assessed within 14 days of referral (Routine)	75%	79.5%	80.2%	78.6%	
% Assessed within 4 hours (Crisis)	90%	99.0%	95.3%	100.0%	
% of feedback with staff values and behaviours as an issue	< 20%	18% 3/17	20% 2/10	66% 2/3	
% of staff receiving supervision within policy guidance	80%	80.6%	84.7%	81.5%	
% service users followed up within 72 hours of discharge from inpatient care	80%	89.8%	93.5%	90.0%	
% Service Users on CPA with a formal review within the previous 12 months	95%	96.1%	96.0%	97.9%	
% Treated within 6 weeks of assessment (routine)	70%	95.3%	94.5%	95.2%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.6%	77.1%	77.8%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	81.0%	77.7%	*80.1%*	
Information Governance training compliance	>=95%	95.6%	95.4%	95.2%	
Reducing Restrictive Practice Interventions training compliance	>=80%	72.8%	74.6%	77.0%	
Sickness rate (Monthly)	5.0%	5.9%	5.0%	5.1%	

Mental Health Inpatient

Metrics	Threshold	Oct-24	Nov-24	Dec-24	Variation/ Assurance
% Appraisal rate	>=95%	90.7%	90.1%	87.9%	
% Bed occupancy (excl leave)	85%	89.9%	90.4%	92.3%	
% of feedback with staff values and behaviours as an issue	< 20%	25% (1/4)	56% 10/18	14% 1/7	
% of staff receiving supervision within policy guidance	80%	93.0%	92.9%	83.8%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	89.3%	88.0%	88.6%	
% of clients clinically ready for discharge	3.5%	4.8%	4.8%	3.4%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	92.6%	93.8%	*95.7%*	
Inappropriate Out of Area Bed days	155 (Dec)	96	131	127	
Information Governance training compliance	>=95%	94.5%	96.2%	96.1%	
Physical Violence (Patient on Patient)	Trend Monitor	14	13	14	
Physical Violence (Patient on Staff)	Trend Monitor	52	40	57	
Reducing Restrictive Practice Interventions training compliance	>=80%	84.9%	86.6%	87.8%	
Restraint incidents	Trend Monitor	106	171	*127*	
Safer staffing (Overall)	90%	139.4%	141.1%	135.0%	
Safer staffing (Registered)	80%	105.0%	107.1%	102.6%	
Sickness rate (Monthly)	5.0%	8.0%	6.5%	7.2%	

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.
- Although the overall Trust position for clinically ready for discharge is showing a reduction for the month, there are hotspot areas across the care group particularly on some of our Older People's wards. This is an area of focus as part of the priority programme work and is being addressed with the integrated care groups through the Multi Agency Discharge Event (MADE) meetings.
- Workforce challenges have led to continued use of temporary staffing, primarily bank. Throughout December 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 admin is not completed in the correct order this does not 'count' as compliant.
- 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 December due to sickness levels and clinical pressures, specific actions are in place. December data is also impacted by the WorkPal downtime for over 2 weeks.
- 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 RRPI specialist advisors and includes an in-depth review of all prone restraint incidents for learning.
- Single Point of Access (SPA) are prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessments remain 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.

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 December is 54% for Kirklees and 50.87% 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.
- 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.
- The care group holds monthly meetings to track and review progress of Equality Impact Assessments (EIAs). Performance remains strong. Delay in completion of equality impact assessment 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 seven incidents of prone restraint in December, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration. The monthly restraint oversight meeting, led by the nursing, quality and professions directorate, involving the Reducing Restrictive Practice Intervention and safeguarding teams and matrons, review all prone restraint incidents for any opportunities for learning.

Assure

- The intensive home based treatment 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 91.9% for December.
- 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 December position remain above threshold at 96.8%. 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	Oct-24	Nov-24	Dec-24	Variation/ Assurance
% Appraisal rate	>=95%	84.2%	80.7%	84.5%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/1)	0% (0/5)	0% (0/4)	
% of staff receiving supervision within policy guidance	80%	88.1%	85.6%	86.7%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	62.5%	60.8%	55.6%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.1%	85.5%	84.8%	
% of clients clinically ready for discharge	3.5%	80.0%	80.0%	90.1%	
Information Governance (IG) training compliance	>=95%	93.4%	91.1%	91.5%	
% 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%	88.5%	95.1%	96.8%	

LD, ADHD & ASD

Metrics	Threshold	Oct-24	Nov-24	Dec-24	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	24	12	27	
Reducing Restrictive Practice Interventions training compliance	>=80%	79.6%	83.5%	84.0%	
Safer staffing (Overall)	90%	171.4%	164.7%	162.4%	
Safer staffing (Registered)	80%	152.5%	135.9%	154.4%	
Sickness rate (Monthly)	5.0%	5.1%	5.8%	5.0%	
Restraint incidents	Trend Monitor	33	29	*25*	

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

Alert/Action

ADHD Service Leeds
Leeds Adult ADHD Service have been temporarily closed to non-urgent new referrals since October 2024. 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
Waiting lists – adult ADHD
Our Service has over 6200 people currently waiting for an ADHD assessment. The service are working with commissioners to find local solutions to assist with reducing the length of wait.
• 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. This new step launches on 20th January 2025 and will occur before a person is offered Patient Choice and has an opportunity to select a provider. It is expected it will offer financial savings by reducing the number of people added to waiting lists in future and will bring added benefits such as directing people to appropriate support and reducing pressures in Primary Care.
• Wakefield Place is also considering this as an option and have asked for an options paper to understand the impact on the assessment pathway if there is no increase in investment.

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

West Yorkshire Integrated Care Board Neurodiversity Project
No significant updates from the West Yorkshire 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

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. GP's 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 integrated care board colleagues to identify longer term solutions.

Assure

- All key performance targets met.
- Relationship with Bradford working very well.
- Low level of vacancies.
- Friends and family test results – 90%
- All mandatory training meeting the threshold.

Learning disability services:

Alert/Action

Learning Disability (LD)
- Appraisal performance remains a focus plans are in place to ensure compliance across the Care Group. Current compliance is 82.6%. Focused interventions are now in place to support the service to reach the threshold.
- Supervision performance has also improved to 85.7%.
- 'Keeping my chest healthy' pilot commenced in Kirklees and Wakefield community teams.

Community
- Waiting Lists – Performance on waiting lists continues to be monitored closely by the management team within LD services. All localities have reached the required threshold. This reflects a reduction of service users breaching at 18 weeks as well as a reduction of the longest waits. Work on waiting well and fairly continues to progress.
- 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 has increased to 90%. This has been escalated within the Trust and commissioners.
- Horizon is compliant with appraisal and supervision thresholds. Some remedial work required on information governance.

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

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 and now are using alternative accommodation until the end of June 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	Oct-24	Nov-24	Dec-24	Variation/ Assurance
% Appraisal rate	>=95%	94.0%	90.4%	87.9%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/6)	0% (0/1)	0% (0/1)	
% people dying in a place of their choosing	80%	86.5%	97.3%	95.0%	
% of staff receiving supervision within policy guidance	80%	83.8%	86.0%	85.7%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.1%	84.2%	83.7%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	0.0%	

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Oct-24	Nov-24	Dec-24	Variation/ Assurance
Information Governance (IG) training compliance	>=95%	93.4%	95.1%	94.2%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.2%	99.0%	98.2%	
Safer staffing (Overall)	90%	114.1%	112.4%	107.1%	
Safer staffing (Registered)	80%	124.4%	123.7%	121.3%	
Sickness rate (Monthly)	5.0%	5.7%	5.4%	6.0%	

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

Alert/Action

• Musculoskeletal & Neuro Physio, Priory Day Centre – remains closed until further notice. Services affected continue to utilise Priory Campus as temporary alternative accommodation until the end of June 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 as initial indications are that remedial works should be completed by end of July. This is having an impact on the full-service offer and may lead to impact on the 18-week Referral to Treatment Target (RTT). We continue to see an increase in referrals into the service.

Advise

• One avoidable case of C Difficile – this relates to a patient on Neuro Rehabilitation Unit (NRU) who had previously had C. Diff this during their inpatient stay at the acute Trust. On admission to NRU the patient was asymptomatic. During their inpatient stay on NRU, a sample was sent off to test for suspected Norovirus, but laboratory results were positive for C.Diff. Attributable Meeting deemed that this was a joint event for SWYPFT and BHNFT. Learning has been disseminated regarding blood samples.
One E. Coli Bacteria case on Stroke Rehab Unit (SRU) – no identified learning.
• Information Governance training has seen a very slight dip just below compliance for December at 94.2%.
• Sickness rates have increased during December to 6.0%. This is reflective of the local area in terms of seasonal viruses, but we also have a number of long-term sicknesses in our care group related to planned surgeries and bereavements. Previous 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.
• Appraisals - As a care group our compliance is seeing more consistent levels; for December (figures only available as at 16.12.24 due to system issues), the figure is 87.9%%.

Assure

• Staff receiving supervision - continues to receive focus with a drive to improve recording. We continue to achieve compliance for December at 85.7%.
• Urgent Community Response Service 2-hour target is 89.2% as at end of December 2024 which continues to be well above the 70% threshold.
• Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 98.22% as at December 2024.
• Friends and Family Test (FFT) 96% of people would recommend community services.
• 95% of people dying in their place of choosing in December 2024; this remains consistently above the threshold of 80%.
• Cardiopulmonary resuscitation training maintains compliance at 83.7% for December.
• Virtual Ward occupancy rate has reduced this month but is still above target of 80% at 103% for December. As outlined in the November report, virtual ward continues to support early supported discharge and hospital avoidance to support system pressures, reviewing capacity daily.
• Intermediate Care new interim model – increase to caseload of 170; this encompasses patients in their own homes (including spot purchase beds) who require therapy input.
• Intermediate Care new interim model – 89% of the total new posts have been filled; recruitment continues during January. 63% of the vacancies filled have already started in post; 17% have start dates planned. The remaining 20% are current undergoing recruitment checks.
• E-Prescribing for Neighbourhood Teams went live on 10 December 2024.
• Yorkshire Smokefree Wakefield in partnership with Wakefield Council have launched a new quit bus that will provide specialist stop smoking support across the Wakefield District.
• The latest SSNAP (Sentinel Stroke National Audit Programme) report has shown the best results since the inception of our Integrated Community Stroke Rehabilitation Team in April 2020. These will be the last results in the current format as the dataset changed in October 2024.
• District Nurse / Clinical Practice Teacher 8am-8pm working Organisational Change and Consultation process has been finalised and will be implemented from mid-February.

Forensic Care Group

Headlines

The monthly sickness rate has deteriorated further in December - 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, although external issues with access to the appraisal system are impacting on reported performance.
Liaison with the collaborative is underway to find appropriate solutions for the patients waiting for high secure placements.

Forensic

Metrics	Threshold	Oct-24	Nov-24	Dec-24	Variation/ Assurance
% Appraisal rate	>=95%	85.9%	79.7%	70.8%	
% Bed occupancy (incl leave)	90%	85.3%	84.7%	84.4%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/0)	0% (0/0)	0% (0/1)	
% of staff receiving supervision within policy guidance	80%	88.2%	91.3%	83.4%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	100.0%	99.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.8%	85.1%	82.1%	
% 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%	94.3%	94.4%	92.6%	
Physical Violence (Patient on Patient)	Trend Monitor	4	2	3	
Physical Violence (Patient on Staff)	Trend Monitor	5	6	5	
Reducing Restrictive Practice Interventions training compliance	>=80%	79.8%	82.7%	86.1%	
Restraint incidents	Trend Monitor	26	18	*20*	
Safer staffing (Overall)	90%	114.8%	122.5%	115.7%	
Safer staffing (Registered)	80%	102.4%	109.9%	101.1%	
Sickness rate (Monthly)	5.4%	6.0%	6.2%	7.1%	

Alert/Action

• Bed Occupancy – Newton Lodge 87.13%, Bretton 84.9%, Newhaven 68.75%. Underoccupancy in medium secure due to empty beds within learning disability and women's services where there are no waiting lists. Underoccupancy in Bretton Centre is due to recent discharge activity.
• 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. The service is now monitoring performance on a weekly basis with each of the ward/team managers.
• Forensic Community Transition Team – this team is currently not funded by the West Yorkshire Provider Collaborative and is not identified as a priority service for funding in the community work undertaken. This has been escalated to the Provider Collaborative and within the Trust.

Advise

• Mandatory training overall compliance: Newton Lodge – 92.9%, Bretton – 92.9% both have increased on last month↑, Newhaven –94.5% performance remains the same as last month.
Each service line is compliant with all mandatory training except for one are as follows:
Newton Lodge - Fire Training 82.6% (the service is looking into this as fire training is built into the annual security training).
Bretton Centre - Fully compliant for all mandatory training.
Newhaven - Information governance performance is 94.9%
• 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 one service user currently awaiting a bed in high secure, one service user has been transferred to Rampton after a very long wait.

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 care programme approach with a formal review within the previous 12 months remains above threshold at 98.28%

Inpatients - Mental Health - Working Age Adults

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

Appraisal

- The ongoing downtime of WorkPal is impacting on reporting accuracy; dashboard data hasn't been updated since 16/12/24, consequently data won't reflect appraisals completed since this date. Ward managers are completing appraisals on paper forms with a plan to record them once WorkPal is back operational.
- Three wards are achieving the 95% target and another four wards are above 90% compliance with any outstanding appraisals scheduled.
- Beamshaw, Melton, Ashdale, Poplars, Enfield Down and Lyndhurst appraisal compliance is below threshold in December but is above 80%. Service managers continue to work closely with ward managers to ensure outstanding appraisals are booked.
- Ward 18 appraisal performance reduced in December. Targeted work has been undertaken by the ward manager and all outstanding appraisals have been completed throughout January.
- Ward 19 (male) and Ward 19 (female) reduction in appraisal performance in December is a consequence of WorkPal downtime and the ward manager being unable to record completed appraisals on the system.
- Crofton performance has dropped in December to 65.5% and in part has been impacted by staff sickness. The ward manager is prioritising outstanding appraisals with close oversight from the service manager.
- Other system issues continue to impact on accuracy of reporting, including 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 December on Elmdale and Ward 19 (male) following the return to work of staff from long term sickness.
- Melton and Nostell have seen an increase in sickness above threshold due to staff long-term sickness, some of which is work related.
- Stanley and Crofton have also seen an increase above threshold but due to short term sickness and no specific themes.
- Whilst both Walton and Ward 19 (female) sickness remain above threshold, both have reduced slightly and continue to be impacted by a combination of long and short-term sickness.
- A number of wards sickness rates are significantly above threshold:
  - Willow has had a very small reduction in sickness to 17.3% and continue to be impacted by both long and short-term sickness but no specific themes. Two staff on long-term sick have recently returned to work.
  - Ward 18 at 15.8% is impacted by both long and short-term sickness. Some long-term sickness is work related and RIDDOR reported. All three staff are expected to have returned by end of January.
  - Beechdale remains high at 12.3% with the long-term sickness of three staff continuing.
  - Poplars sickness has increased to 10.2% and is mix of both long and short-term sickness with no specific themes.
- Ward managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made.

Supervision

- 11 wards above 80% compliance target with 6 of these at 100%.
- Nostell, Elmdale, and Crofton compliance is under threshold but above 70% and focused work is being done to prioritise supervision for staff who haven't received it in the last 90 days.
- There has been a notable decline in supervision compliance on Beamshaw (62.5%), Melton (64.3%) and Ashdale (52.6%) and service managers and matrons are supporting ward leadership teams to address this.
- Supervision on some WAA wards has been impacted by clinical acuity and ward managers supporting in clinical numbers.

Mandatory Training

Information Governance

- Crofton compliance has dropped below threshold in December to 92.6% and the ward manager is taking focused intervention to address this.
- Clark (92%), Walton (94.1%), Ashdale (93.9%), and Willow (94.7%) compliance has increased in December but remains under threshold. Action continues to be taken by ward managers to address this and all four wards have seen an improvement in January's dashboard data (20/01/25).

CPR

- 14 wards are above the CPR training compliance threshold.
- Beamshaw (78.3%) and Walton (78.8%) compliance has increased and is above threshold in January's dashboard data (20/01/25).
- Ward 19 male (79.2%) have had staff attended recent training sessions in January with other staff booked onto upcoming future sessions.

RRPI

- 15 wards are above the RRPI training compliance threshold.
- Walton has dropped out of compliance (72.7%) due to a number of staffs competency expiring. These staff have either recently attended training or are booked onto an upcoming date.
- Ward 19 male remains below compliance threshold (79.2%) due to two staff being previously deferred on the training pending occupational health advice. They are now awaiting future training date allocation.
- Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.

Fire Safety

- Willow is under compliance threshold at 84.2% with two staff requiring training. Booking of training will be overseen by the ward manager.

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 further reduced from 28.7% to 17.3% in December. This continues to be reflective of several service users awaiting placements.
- 9 other wards are above the threshold for CRFD with Beamshaw and Ward 18 at more than 10%. Clark, Nostell, Stanley, Elmdale, Beechdale, Enfield Down 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.
- Melton 0% CRFD is inaccurate with one service user with complex needs awaiting placement. The service will discuss with colleagues in PB&I. Ward 19 male, and Ward 19 female 0% CRFD is a recording issue and is being addressed by the General Manager.
- 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. Clark, Walton, and Ashdale each had 1 breach in December. A deep dive is conducted for each breach to identify learning and inform improvement.
- At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed.

Physical violence – (Patient on Staff)

- Melton (9) and Ward 18 (8) had several incidents of patient-on-staff physical violence throughout December relating to a small number of service users with complex needs.
- Also 10 incidents of patient-on-staff physical violence on Poplars related to a specific service users with cognitive impairments and a risk profile of violence and aggression during interventions.
- 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, and Ward 18 is reflective of current patient population and the presentation and risk profile of service users.

Prone restraint incidents

- Seven incidents of prone restraint in December, 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 two reasons for prone restraint use were exiting seclusion and the 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	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	88.0%	88.0%	84.6%
Sickness	5.0%	7.2%	4.2%	1.5%
Supervision	80%	81.3%	81.3%	62.5%
Information Governance training compliance	>=95%	87.5%	91.7%	95.7%
Reducing Restrictive Practice Interventions training compliance	>=80%	87.5%	87.5%	95.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	87.5%	78.3%
Fire Safety training compliance	>=85%	95.8%	95.8%	87.0%
Bed occupancy	85%	98.2%	94.3%	94.9%
Safer staffing (Overall)	90%	143.8%	136.0%	138.7%
Safer staffing (Registered)	80%	116.3%	112.4%	117.1%
% of clients clinically ready for discharge	3.5%	13.6%	14.2%	13.6%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	1	0
Physical Violence (Patient on Staff)	Trend Monitor	2	0	2
Restraint incidents	Trend Monitor	6	2	*2*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	23	24	28

Clark Suite Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	100.0%	90.9%	91.3%
Sickness	5.0%	4.1%	1.7%	1.7%
Supervision	80%	100.0%	91.7%	85.7%
Information Governance training compliance	>=95%	95.7%	91.3%	92.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	100.0%	96.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	100.0%	100.0%
Fire Safety training compliance	>=85%	100.0%	95.7%	96.0%
Bed occupancy	85%	100.9%	103.8%	108.8%
Safer staffing (Overall)	90%	181.2%	193.5%	159.0%
Safer staffing (Registered)	80%	114.1%	113.0%	107.2%
% of clients clinically ready for discharge	3.5%	3.6%	6.3%	6.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*66.7%*
Physical Violence (Patient on Patient)	Trend Monitor	0	1	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	5
Restraint incidents	Trend Monitor	3	12	*13*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	1 (100%)	*1 (100%)*
Unfilled Shifts	Trend Monitor	30	36	32

Melton Suite Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	96.3%	88.9%	88.9%
Sickness	5.0%	5.6%	4.7%	8.6%
Supervision	80%	92.9%	92.9%	64.3%
Information Governance training compliance	>=95%	96.0%	100.0%	95.8%
Reducing Restrictive Practice Interventions training compliance	>=80%	96.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.0%	92.0%	91.7%
Fire Safety training compliance	>=85%	92.0%	88.0%	87.5%
Bed occupancy	85%	104.3%	100.6%	100.5%
Safer staffing (Overall)	90%	145.5%	184.6%	177.2%
Safer staffing (Registered)	80%	104.9%	99.1%	98.2%
% of clients clinically ready for discharge	3.5%	25.3%	30.0%	16.4%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	9	1	9
Restraint incidents	Trend Monitor	9	54	*36*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	2 (100%)	2 (100%)
Unfilled Shifts	Trend Monitor	17	34	39

Nostell Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	100.0%	100.0%	100.0%
Sickness	5.0%	0.5%	2.7%	9.8%
Supervision	80%	94.1%	87.5%	75.0%
Information Governance training compliance	>=95%	89.7%	96.3%	96.2%
Reducing Restrictive Practice Interventions training compliance	>=80%	78.6%	84.6%	92.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	96.2%	92.0%
Fire Safety training compliance	>=85%	96.6%	92.6%	92.3%
Bed occupancy	85%	86.4%	89.2%	99.0%
Safer staffing (Overall)	90%	186.5%	166.3%	170.0%
Safer staffing (Registered)	80%	106.8%	118.3%	106.0%
% of clients clinically ready for discharge	3.5%	5.5%	9.1%	4.4%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	91.7%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	1	0
Physical Violence (Patient on Staff)	Trend Monitor	1	3	7
Restraint incidents	Trend Monitor	12	25	*18*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	2 (100%)	1 (100%)
Unfilled Shifts	Trend Monitor	35	31	34

Inpatients - Mental Health - Working Age Adults

Stanley Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	95.7%	95.8%	95.8%
Sickness	5.0%	1.0%	3.7%	5.7%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	96.2%	96.2%	96.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	96.2%	96.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.2%	100.0%	100.0%
Fire Safety training compliance	>=85%	69.2%	84.6%	88.0%
Bed occupancy	85%	108.7%	108.9%	99.1%
Safer staffing (Overall)	90%	134.2%	140.8%	125.5%
Safer staffing (Registered)	80%	103.8%	103.0%	97.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	4.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	1
Physical Violence (Patient on Staff)	Trend Monitor	1	0	0
Restraint incidents	Trend Monitor	6	6	*4*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	3 (100%)	2 (100%)	1 (100%)
Unfilled Shifts	Trend Monitor	12	24	14

Walton Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	84.8%	94.1%	94.3%
Sickness	5.0%	7.7%	8.8%	7.7%
Supervision	80%	100.0%	100.0%	90.0%
Information Governance training compliance	>=95%	97.2%	93.9%	94.1%
Reducing Restrictive Practice Interventions training compliance	>=80%	77.1%	84.4%	72.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	87.5%	78.8%
Fire Safety training compliance	>=85%	80.6%	87.9%	88.2%
Bed occupancy	85%	105.8%	98.1%	101.4%
Safer staffing (Overall)	90%	125.2%	121.9%	136.7%
Safer staffing (Registered)	80%	100.0%	97.8%	92.8%
% of clients clinically ready for discharge	3.5%	0.6%	9.6%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*83.3%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	4
Physical Violence (Patient on Staff)	Trend Monitor	2	1	0
Restraint incidents	Trend Monitor	8	17	*5*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	2 (100%)	1 (100%)	2 (100%)
Unfilled Shifts	Trend Monitor	13	15	17

Ashdale Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	87.5%	87.5%	87.5%
Sickness	5.0%	0.7%	2.5%	3.5%
Supervision	80%	94.4%	94.7%	52.6%
Information Governance training compliance	>=95%	90.9%	90.9%	93.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	78.8%	84.8%	87.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	93.9%	93.9%	90.9%
Fire Safety training compliance	>=85%	97.0%	100.0%	100.0%
Bed occupancy	85%	99.2%	97.9%	101.9%
Safer staffing (Overall)	90%	113.8%	129.5%	130.0%
Safer staffing (Registered)	80%	112.7%	116.3%	113.4%
% 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%	92.9%	90.0%	*85.7%*
Physical Violence (Patient on Patient)	Trend Monitor	2	6	3
Physical Violence (Patient on Staff)	Trend Monitor	4	3	5
Restraint incidents	Trend Monitor	4	6	*7*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	6	14	5

Ward 18 Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	65.5%	78.6%	72.0%
Sickness	5.0%	7.8%	7.9%	15.8%
Supervision	80%	72.7%	88.9%	87.5%
Information Governance training compliance	>=95%	93.1%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	86.2%	80.8%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.9%	80.8%	87.5%
Fire Safety training compliance	>=85%	93.1%	92.3%	95.8%
Bed occupancy	85%	99.9%	101.3%	97.3%
Safer staffing (Overall)	90%	104.1%	116.2%	112.8%
Safer staffing (Registered)	80%	88.4%	86.8%	81.4%
% of clients clinically ready for discharge	3.5%	8.1%	7.6%	11.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	87.5%	94.7%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	2	0	2
Physical Violence (Patient on Staff)	Trend Monitor	5	15	8
Restraint incidents	Trend Monitor	12	18	*12*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	0	*0*
Unfilled Shifts	Trend Monitor	0	12	16

Inpatients - Mental Health - Working Age Adults

Elmdale Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	86.4%	86.4%	90.5%
Sickness	5.0%	11.6%	8.3%	4.4%
Supervision	80%	92.3%	100.0%	75.0%
Information Governance training compliance	>=95%	93.3%	93.1%	96.6%
Reducing Restrictive Practice Interventions training compliance	>=80%	90.0%	93.1%	93.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	96.4%	100.0%
Fire Safety training compliance	>=85%	100.0%	100.0%	100.0%
Bed occupancy	85%	98.9%	99.3%	97.0%
Safer staffing (Overall)	90%	138.2%	149.5%	122.6%
Safer staffing (Registered)	80%	98.4%	106.0%	97.6%
% of clients clinically ready for discharge	3.5%	3.5%	4.9%	4.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	4	2	1
Physical Violence (Patient on Staff)	Trend Monitor	4	6	1
Restraint incidents	Trend Monitor	15	8	*10*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	2 (100%)	0	*0*
Unfilled Shifts	Trend Monitor	4	4	5

Inpatients - Mental Health - Older People Services

Crofton Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	85.2%	79.3%	65.5%
Sickness	5.0%	7.9%	3.6%	5.6%
Supervision	80%	87.5%	85.7%	73.3%
Information Governance training compliance	>=95%	96.6%	96.6%	92.6%
Reducing Restrictive Practice Interventions training compliance	>=80%	77.8%	81.5%	84.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.2%	85.2%	84.0%
Fire Safety training compliance	>=85%	96.6%	89.7%	88.9%
Bed occupancy	85%	91.9%	90.0%	104.6%
Safer staffing (Overall)	90%	190.6%	174.4%	160.3%
Safer staffing (Registered)	80%	159.1%	143.4%	143.0%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	63.6%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	1	1
Restraint incidents	Trend Monitor	5	7	*2*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	38	26	28

Poplars CUE Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	84.6%	77.8%	88.9%
Sickness	5.0%	11.4%	5.8%	10.2%
Supervision	80%	100.0%	85.7%	92.9%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	88.0%	91.7%	91.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.3%	79.2%	95.7%
Fire Safety training compliance	>=85%	96.2%	96.2%	92.0%
Bed occupancy	85%	81.3%	79.3%	80.9%
Safer staffing (Overall)	90%	239.4%	220.1%	228.1%
Safer staffing (Registered)	80%	118.4%	120.4%	105.8%
% of clients clinically ready for discharge	3.5%	52.5%	28.7%	17.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	1	0
Physical Violence (Patient on Staff)	Trend Monitor	9	4	10
Restraint incidents	Trend Monitor	9	13	*12*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	48	42	47

Inpatients - Mental Health - Older People Services

Willow Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	94.4%	90.0%	94.7%
Sickness	5.0%	24.7%	17.9%	17.3%
Supervision	80%	100.0%	88.9%	100.0%
Information Governance training compliance	>=95%	100.0%	89.5%	94.7%
Reducing Restrictive Practice Interventions training compliance	>=80%	94.7%	89.5%	94.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	94.7%	94.7%	94.7%
Fire Safety training compliance	>=85%	84.2%	84.2%	84.2%
Bed occupancy	85%	88.4%	96.0%	96.8%
Safer staffing (Overall)	90%	183.8%	168.2%	141.9%
Safer staffing (Registered)	80%	110.2%	95.9%	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%	80.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	0	2
Restraint incidents	Trend Monitor	7	1	*2*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	30	30	16

Beechdale Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	100.0%	100.0%	100.0%
Sickness	5.0%	10.3%	12.2%	12.3%
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%	88.0%	87.5%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.0%	87.5%	91.7%
Fire Safety training compliance	>=85%	96.0%	95.8%	91.7%
Bed occupancy	85%	97.4%	95.6%	93.3%
Safer staffing (Overall)	90%	136.4%	128.9%	117.3%
Safer staffing (Registered)	80%	103.4%	110.7%	101.2%
% of clients clinically ready for discharge	3.5%	8.2%	12.8%	7.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	1	2
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	1	1	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	5	1	2

Ward 19 - Male Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	95.0%	90.5%	78.3%
Sickness	5.0%	14.4%	8.5%	4.2%
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%	87.5%	83.3%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	91.7%	75.0%	79.2%
Fire Safety training compliance	>=85%	83.3%	95.8%	100.0%
Bed occupancy	85%	90.5%	82.0%	96.6%
Safer staffing (Overall)	90%	108.6%	106.1%	106.1%
Safer staffing (Registered)	80%	85.3%	98.8%	103.7%
% 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%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	8	2	1
Restraint incidents	Trend Monitor	9	1	*3*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	1	6

Ward 19 - Female Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	87.5%	77.8%	77.8%
Sickness	5.0%	15.6%	13.2%	11.2%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	88.9%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	77.8%	72.2%	70.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.8%	77.8%	94.1%
Fire Safety training compliance	>=85%	77.8%	83.3%	88.2%
Bed occupancy	85%	97.0%	94.0%	95.3%
Safer staffing (Overall)	90%	99.0%	100.6%	93.5%
Safer staffing (Registered)	80%	107.6%	115.9%	113.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	66.7%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	8	2	1
Restraint incidents	Trend Monitor	9	1	*3*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	9	3	12

Inpatients - Mental Health - Rehab

Enfield Down Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	93.8%	91.7%	87.8%
Sickness	5.0%	6.0%	5.8%	5.8%
Supervision	80%	100.0%	100.0%	96.0%
Information Governance training compliance	>=95%	100.0%	98.0%	97.8%
Reducing Restrictive Practice Interventions training compliance	>=80%	81.6%	77.1%	82.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	86.4%	85.7%
Fire Safety training compliance	>=85%	78.0%	87.8%	91.3%
Bed occupancy	Trend Monitor	51.9%	51.4%	55.4%
Safer staffing (Overall)	90%	93.7%	97.8%	95.3%
Safer staffing (Registered)	80%	90.2%	104.1%	96.3%
% of clients clinically ready for discharge	3.5%	6.1%	6.2%	5.6%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	2	0

Lyndhurst Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	96.4%	96.7%	86.7%
Sickness	5.0%	4.1%	4.5%	3.8%
Supervision	80%	93.3%	100.0%	93.3%
Information Governance training compliance	>=95%	96.4%	96.4%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	85.7%	89.3%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.7%	89.3%	92.6%
Fire Safety training compliance	>=85%	92.9%	92.9%	96.3%
Bed occupancy	Trend Monitor	61.5%	73.1%	69.1%
Safer staffing (Overall)	90%	90.8%	91.7%	92.8%
Safer staffing (Registered)	80%	85.2%	85.3%	84.1%
% of clients clinically ready for discharge	3.5%	9.5%	9.1%	9.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	0.0%	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

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. December has seen a number of appraisals compliance increase with the exception of Johnson and Priestley. 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 Waterton 15.4%. The service is currently undertaking action to understand this figure and undertake remedial action. It does appear there are some recording shortfalls on Waterton.
• Sickness variable across medium secure with Priestley (104%) & Waterton (9.4%) are current hotspots but all wards with the exception of Chippendale have seen an increase in sickness /absence which is seasonal illness and predicted to be short term.
• 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. Johnson and Priestley are the two wards not meeting the threshold with 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. There has been a slight drop in performance for Fire Safety training which is unusual and predicted to be short term due to trainer unavailability.
• 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 80%) 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 pathway with Priestley dropping to 80.3%. The ability to admit and patient flow is being impacted by the wait for high secure care and the high use of seclusion.
• There has been one prone restraint in medium secure (Hepworth), 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. 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. Also of note is that Johnson has had a brief gap in leadership which appears to have impacted on performance.

Low Secure

• Sickness across all wards monitored closely. Sickness levels have risen on all 4 areas due to short term seasonal illness.
• Mandatory training compliance has noted a continued improvement in low secure. Hotspots remain on Newhaven in IG (94.9%) and CPR (72.2%), with plans remaining in place to address shortfalls and maintain performance.
• Bed occupancy in low secure is within compliance for Ryburn. Sandal is currently below expected occupancy, however, has experienced a number of recent admissions and clinical acuity and Thornhill has had some discharges. This continues to be monitored closely and the service has received referrals and are awaiting admissions. Newhaven continues to experience lower level of referrals and has no waiting list.
• Supervision has generally dropped in performance and this is due to higher levels of short term sickness and very high levels of acuity across the ward areas.
• Continued focus on appraisals which are currently being recorded locally.
• There were 2 prone restrains on Sandal both lasting less than 3 minutes.

Appleton Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	87.0%	82.6%	86.4%
Sickness	5.4%	2.4%	1.4%	5.9%
Supervision	80%	87.5%	81.3%	80.0%
Information Governance training compliance	>=95%	92.0%	95.8%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	92.0%	83.3%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.0%	83.3%	83.3%
Fire Safety training compliance	>=85%	96.0%	87.5%	83.3%
Bed occupancy	90%	62.5%	62.5%	62.5%
Safer staffing (Overall)	90%	111.9%	96.3%	92.0%
Safer staffing (Registered)	80%	109.6%	100.2%	102.1%
% 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	0
Physical Violence (Patient on Staff)	Trend Monitor	2	2	0
Restraint incidents	Trend Monitor	19	8	*5*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	3	0	0

Bronte Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	90.9%	95.5%	95.2%
Sickness	5.4%	4.0%	1.5%	2.6%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	83.3%	94.4%	94.4%
Reducing Restrictive Practice Interventions training compliance	>=80%	88.9%	94.4%	94.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	66.7%	77.8%	77.8%
Fire Safety training compliance	>=85%	77.8%	88.9%	88.9%
Bed occupancy	90%	85.7%	93.8%	100.0%
Safer staffing (Overall)	90%	102.7%	135.7%	124.3%
Safer staffing (Registered)	80%	100.1%	129.2%	119.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	3	0
Restraint incidents	Trend Monitor	0	5	*2*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	2	4	8

Chippendale Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	81.8%	78.3%	83.3%
Sickness	5.4%	6.6%	7.4%	3.6%
Supervision	80%	86.7%	93.3%	93.3%
Information Governance training compliance	>=95%	100.0%	100.0%	96.2%
Reducing Restrictive Practice Interventions training compliance	>=80%	77.8%	84.6%	88.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	81.5%	88.5%	80.8%
Fire Safety training compliance	>=85%	92.6%	88.5%	84.6%
Bed occupancy	90%	100.0%	100.0%	97.8%
Safer staffing (Overall)	90%	130.2%	129.8%	126.3%
Safer staffing (Registered)	80%	131.5%	122.8%	129.7%
% 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	1
Restraint incidents	Trend Monitor	4	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	0	*0*
Unfilled Shifts	Trend Monitor	7	5	7

Hepworth Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	96.6%	87.1%	83.9%
Sickness	5.4%	5.8%	4.1%	5.1%
Supervision	80%	94.4%	100.0%	100.0%
Information Governance training compliance	>=95%	96.6%	100.0%	96.6%
Reducing Restrictive Practice Interventions training compliance	>=80%	72.4%	75.9%	82.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	89.3%	89.3%	86.2%
Fire Safety training compliance	>=85%	89.7%	82.8%	82.8%
Bed occupancy	90%	92.0%	92.4%	93.5%
Safer staffing (Overall)	90%	94.5%	93.4%	102.7%
Safer staffing (Registered)	80%	74.0%	80.4%	90.5%
% of clients clinically ready for discharge	3.5%	7.2%	7.2%	7.1%
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	2
Restraint incidents	Trend Monitor	0	0	*7*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*1 (100%)*
Unfilled Shifts	Trend Monitor	0	0	6

Inpatients - Forensic - Medium Secure

Johnson Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	88.9%	77.8%	46.4%
Sickness	5.4%	3.4%	4.4%	4.7%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	93.3%	93.3%	80.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	96.7%	96.7%	96.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	93.3%	96.7%	93.3%
Fire Safety training compliance	>=85%	83.3%	73.3%	73.3%
Bed occupancy	90%	68.6%	72.0%	80.0%
Safer staffing (Overall)	90%	116.3%	128.0%	133.2%
Safer staffing (Registered)	80%	99.1%	99.8%	90.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	1
Restraint incidents	Trend Monitor	0	3	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	5	5

Priestley Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	63.6%	50.0%	36.4%
Sickness	5.4%	10.6%	8.8%	10.4%
Supervision	80%	76.9%	78.6%	85.7%
Information Governance training compliance	>=95%	100.0%	91.3%	87.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	71.4%	77.3%	77.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.5%	90.9%	90.9%
Fire Safety training compliance	>=85%	90.9%	87.0%	82.6%
Bed occupancy	90%	88.2%	82.2%	80.3%
Safer staffing (Overall)	90%	89.3%	91.7%	90.5%
Safer staffing (Registered)	80%	84.6%	89.2%	76.4%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	0	0

Waterton Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	82.6%	77.3%	81.8%
Sickness	5.4%	7.6%	6.2%	9.4%
Supervision	80%	83.3%	81.8%	15.4%
Information Governance training compliance	>=95%	100.0%	100.0%	91.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	73.9%	77.3%	87.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.3%	86.4%	87.0%
Fire Safety training compliance	>=85%	100.0%	95.5%	91.3%
Bed occupancy	90%	91.7%	88.3%	93.8%
Safer staffing (Overall)	90%	119.1%	123.8%	117.9%
Safer staffing (Registered)	80%	107.1%	117.7%	104.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	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	1

Inpatients - Forensic - Low Secure

Thornhill Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	100.0%	95.7%	79.2%
Sickness	5.4%	1.8%	1.2%	4.1%
Supervision	80%	69.2%	76.9%	71.4%
Information Governance training compliance	>=95%	100.0%	96.2%	96.2%
Reducing Restrictive Practice Interventions training compliance	>=80%	96.2%	96.2%	96.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.2%	96.2%	100.0%
Fire Safety training compliance	>=85%	100.0%	100.0%	100.0%
Bed occupancy	85%	90.5%	90.7%	83.4%
Safer staffing (Overall)	90%	97.2%	98.3%	98.7%
Safer staffing (Registered)	80%	97.5%	103.3%	104.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	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

Sandal Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	92.0%	92.3%	73.1%
Sickness	5.4%	6.8%	6.8%	10.9%
Supervision	80%	93.3%	93.8%	88.2%
Information Governance training compliance	>=95%	96.8%	96.7%	96.7%
Reducing Restrictive Practice Interventions training compliance	>=80%	83.9%	80.0%	93.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.2%	80.0%	76.7%
Fire Safety training compliance	>=85%	93.5%	96.7%	96.7%
Bed occupancy	85%	88.9%	82.1%	81.5%
Safer staffing (Overall)	90%	148.2%	176.5%	148.9%
Safer staffing (Registered)	80%	111.6%	128.1%	112.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	2	3
Physical Violence (Patient on Staff)	Trend Monitor	1	1	1
Restraint incidents	Trend Monitor	3	1	*5*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	0	*2 (100%)*
Unfilled Shifts	Trend Monitor	8	6	11

Inpatients - Forensic - Low Secure

Ryburn Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	87.5%	100.0%	85.7%
Sickness	5.4%	23.1%	15.9%	22.8%
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%	85.7%	85.7%	100.0%
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%	89.9%	98.1%	96.3%
Safer staffing (Overall)	90%	99.9%	100.0%	99.9%
Safer staffing (Registered)	80%	99.9%	100.7%	100.0%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	0	0

Newhaven Metrics	Threshold	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	83.8%	78.9%	79.5%
Sickness	5.4%	4.9%	4.9%	4.6%
Supervision	80%	86.4%	95.2%	76.2%
Information Governance training compliance	>=95%	100.0%	89.7%	94.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	86.2%	89.7%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	86.2%	79.3%	72.2%
Fire Safety training compliance	>=85%	96.6%	93.1%	89.7%
Bed occupancy	85%	75.0%	75.0%	68.8%
Safer staffing (Overall)	90%	115.5%	115.0%	117.6%
Safer staffing (Registered)	80%	111.6%	115.4%	106.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	0
Restraint incidents	Trend Monitor	0	1	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	0	12

Inpatients - Non-Mental Health

• **Appraisal rate:**
NRU rate is showing 84.6% as at 16 December (noting report is incomplete due to WorkPal system being unavailable from 20.12.24).
SRU rate is 92.2% as at 16.12.24.

• **Sickness:**
NRU – sickness has dipped further for December at 9.8%. Significant long-term sickness (LTS) due to 3 x bereavement and 2 x planned surgery (hip replacements) continued throughout December. As of 14 January, 2 bereavements have returned to work with the third planning to return on 2 Feb. Staff who have had surgery are due back in March. One further MSK LTS continues to be off sick. This is being managed via HR processes and sickness reviews.
SRU – sickness has increased on this unit during December to 5.5%. This is comprised of 5 short term sicknesses; these have all now returned to work as of 14.1.25 so figures will continue to impact into January's reporting period.

• **Supervision:**
NRU has seen a further dip this month - below compliance at 73.1% for December. Level of long-term sickness has impacted capacity to undertake supervision sessions.
SRU figures for December have maintained compliancy at 92.1%.

• **Information Governance:**
NRU – continues to maintain compliance achieving 100%.
SRU – has seen an increase towards compliance this month at 93.7%. Targeted approach to individual members of staff with outstanding IG training continues.

• **Cardiopulmonary resuscitation (CPR):**
NRU – a decrease during December to 75.7%
SRU – a decrease during December to 70%
Further training which took place on 19 and 20 November may not yet be showing in December figures due to recording lag plus Christmas period.
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	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	89.7%	89.7%	84.6%
Sickness	5.0%	5.9%	8.7%	9.8%
Supervision	80%	81.5%	80.8%	73.1%
Information Governance training compliance	>=95%	97.6%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.5%	79.5%	75.7%
Fire Safety training compliance	>=85%	82.9%	85.4%	87.2%
Bed occupancy (Barnsley Commissioned beds only)	80%	72.8%	72.8%	59.7%
Safer staffing (Overall)	90%	121.5%	118.5%	113.6%
Safer staffing (Registered)	80%	114.5%	117.1%	114.9%
% 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	Oct-24	Nov-24	Dec-24
Appraisal rate	95%	93.3%	95.2%	92.2%
Sickness	5.0%	8.1%	1.3%	5.5%
Supervision	80%	94.7%	94.7%	92.1%
Information Governance training compliance	>=95%	92.2%	89.1%	93.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.3%	73.3%	70.0%
Fire Safety training compliance	>=85%	87.5%	89.1%	92.1%
Bed occupancy	80%	94.6%	80.0%	101.9%
Safer staffing (Overall)	90%	108.4%	107.8%	102.1%
Safer staffing (Registered)	80%	133.2%	129.5%	126.9%
% 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 (97.1%), reflected in improved performance.
• Good supervision compliance (83.3%) and remains within target.
• Maintained progress in RRPI training (97.1%) and fire training compliance (91.7%), IG (97.2%) and CPR (88.2%). There has been an increase in sickness which is a mixture of short and longer term. Seasonal illnesses have resulted in December's rise.
• 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. An increase in incidents and restraint are as a result of increased acuity due to a new admission. No prone restraint.

Horizon				
Metrics	**Threshold**	**Oct-24**	**Nov-24**	**Dec-24**
Appraisal rate	95%	89.2%	97.3%	97.1%
Sickness	5.0%	6.0%	6.9%	7.9%
Supervision	80%	100.0%	88.9%	83.3%
Information Governance training compliance	>=95%	94.6%	91.9%	97.2%
Reducing Restrictive Practice Interventions training compliance	>=80%	95.3%	94.1%	97.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.4%	79.4%	88.2%
Fire Safety training compliance	>=85%	89.2%	89.2%	91.7%
Bed occupancy	N/A	62.5%	60.8%	55.6%
Safer staffing (Overall)	90%	171.4%	164.7%	162.4%
Safer staffing (Registered)	80%	152.5%	135.9%	154.4%
% of clients clinically ready for discharge	3.5%	80.0%	88.0%	90.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	*0.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	24	12	27
Restraint incidents	Trend Monitor	33	29	*25*
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 within agreed timescales
A	Needs additional action to stay on track and/or on schedule
R	Not on track and/or at risk of not delivering within agreed timescales. Requires review
B	Completed

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving health	Address inequalities involvement and equality in each of our places with our partners	Involvement and inclusion - the sharing of community connector approach at Barnsley Place as part of discussion for adoption by partner organisations Anti racism and Patient and Carer Race Equality Framework (PCREF) - activity in both South Yorkshire (SY) and West Yorkshire (WY) Integrated Care Board (ICB) regional networks, updating shared learning and approach at WY Mental Health alliance, development of community advisory group and first meeting held with over 30 community connectors and representatives in attendance from across the trust-wide footprint. Equality Diversity and Inclusion (EDI) strategy refresh – internal and external conversations taking place which are shaping the refresh of the strategy into one that reflects equality inclusion and diversity for the next 5 years. NHS plan – contributions to big discussions internally and at place to feed into shaping the future direction of NHS. Equality – Equality Delivery System (EDS) 2022 assessment taking place across the services identified by South Yorkshire and West Yorkshire ICBs with stakeholder panel scheduled for 20th January 2025.	
Improving care	Transform our Older People inpatient services	The staff consultation (with staff based at the Poplars) is taking place through December 2024 and into January 2025. New Governance being established to focus on how the model will be operationalised. Initial meetings on Estates, Workforce and clinical pathways / staff development scheduled for January 2025.	
	Improve our mental health services so they are more responsive, inclusive, and timely	**Care Closer to Home:** - Discharge Initiatives plan has been reviewed and is awaiting approval by the group - to commence January 2025. - Partnership activity: ongoing dialogue with ICBs. Currently exploring the merits of a decisions unit approach which involves short term informal admissions before a decision is taken whether to admit. - A new initiative is being explored on whether/how to establish systematic daily review of informal admission requests and if it can be aligned to Clinically Ready for Discharge meetings. Activity to agreeing membership and planning the meeting set up is now taking place, timing of initial meeting TBC. - GM monthly clinics, which are a forum for front line staff to share experiences and suggestions, and started in October, have seen an increase in staff attendance recently (7 people in total). - Escalation and communications work with Acute Trusts (CC2H) to be completed. **Improve access to care programme** Data gathering is continuing to support understanding of issues for both Core Psychology and Memory Services waits and work is progressing toward generating ideas for improvement. Core psychology: Continued work with Performance and Business Intelligence on dashboard development to enable comparison of waiting lists - to be completed in January. Psychology and service leads to review early findings and consider improvement ideas in late January. Memory services: Workshops in all 4 places held throughout November and December to understand differences/ similarities in processes and pathways. The process maps are being finalised throughout January to enable identification of themes for areas of improvement. **Inpatient Improvement:** - **Reducing restrictive practice intervention (RRPI) and Trauma informed** - planning to take place in January-February 2025. - **Creative activity:** Mural installations in Ashdale and Ward 19 taking place through December and January and Sensory Rainbow lighting has been installed in Horizon ward. Hospital Rooms Charity coproduction workshops to start gathering ideas for art installations in Melton, Walton, Ryburn, Thornhill and Sandal – January 2025. - **Culture of care programme:** Pilot wards have commenced active Quality Improvement work with National Collaborating Centre for Mental Health (NCCMH), November Sandall, December Melton and Beamshaw, Enfield Down to be rescheduled to commence – aiming for January 2025. The Internet resource for Culture of Care has been drafted and will be reviewed by the oversight in January 2025 (aiming to launch in February). - Forensic inpatient improvement now forms part of the inpatient governance: key activity includes: - **Forensic service dashboard** development work commenced in November and is now in final stages of review; Dashboard Training is set for Managers in February; Data requirements to be captured in March after implementation - **Forensic therapeutic Workstream**: A needs analysis has commenced to support understanding our service user intervention needs, engagement sessions with service users are planned for January 2025 with support of the Yorkshire and Humber Involvement team and an intervention pathway mapping session is being planned. - **Forensic Social Work Workstream**: work is commencing in January to undertake a Social Work review, to ensure we are using the resource appropriately and supports us in delivering the intervention led approach above. The Terms of Reference have been developed and meetings commence in January 2025.	

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving care	Improve safety and quality	**Care Planning & Risk Assessment** The new care plan went live on SystmOne on 6th January 25. The first meeting of the Care Planning and Risk Assessment Oversight group was held in January 25 with a task and finish group set up to complete the training requirements for each care group. The new metrics associated with the care plan will be reported from April 25. A suite of products including the good practice guide and the quality audits are available on the Trust intranet site.	
Improving use of resources	Spend money wisely and increase value	• Built in savings (£22m) continue to be behind plan. • The main driver of this variance remains related to workforce growth and it being higher than planned. We continue to flag the reliance on non-recurrent mitigations. • Annual planning workstreams, including the value for money group, are focussed on ensuring there is longer term financial sustainability. • Value for Money Programme Board reviewed Plan on a Page documentation for each Key Line of enquiry, these were for discussion at the Executive Management Team timeout 16th January. • Annual planning documentation has been issued for completion by corporate services, with value for money initiatives forming part of these plans.	
	Make digital improvements	**Digital Dictation:** The project remains in amber status due to the escalation triggered in November from issues, defects and application errors which hindered operational activity and will remain in escalation until all users are upgraded to V1.0.10 which is anticipated to be completed by end January 25. The task and finish group including supplier continues to meet but the frequency reduced to once per week with reporting of progress to escalation management group as required. Deployment recommenced in January 25 and Forensics completed in January 25. Preparations are underway to deploy to Barnsley Physical Health in February 25. A further plan to complete all deployments by September 25 is in development and will be submitted to the Project Board in February 25.	
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)	(£0.9m)	£0m	The Trust financial target for 2024/25 is breakeven. For the year to date a position of £0.9m deficit has been reported which is a £0.1m increase from last month. The main financial driver remains workforce related expenditure. Non recurrent mitigations have been identified to support delivery of the year end target.
2	Agency Spend	£4.8m	£6.3m	Agency expenditure run rate has continued to fluctuate. Spend in December is £608k which is £30k more than last month. The average run rate for the year to date is £531k per month so spend in December is higher. The provider collaborative spend in month was £44k which is £16k less than last month.
3	Financial sustainability and efficiencies	£13.8m	£21m	The Trust financial sustainability programme for 2024/25 has a target of £22.0m to achieve the breakeven target. Overall the programme is behind plan for the year to date with the main driver being the continued level of workforce utilised being above plan. The forecast of £21m, being £1m less than planned, relies upon a number of non-recurrent mitigations to deliver. These schemes have been identified as measures to ensure delivery of the financial target.
4	Cash	£56.5m	£51.5m	Although cash has slightly improved in month it did not increase as much as forecast. Outstanding cash receipts have been chased with commissioners. Overall income remains lower than planned.
5	Capital	£2.6m	£8.1m	The Trust now has a number of separate capital allocations for 2024/25. The original allocation was £8.1m and performance is shown on the left. Additional allocations relating to IFRS 16 (leases) and Cheswold Park Hospital are shown on the detailed capital page. Although expenditure is less than plan for the year to date it is still forecast that the full allocation will be utilised.
6	Better Payment Practice Code	99%		This performance is based upon a combined NHS/Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

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

System-wide monitoring

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

West Yorkshire Health and Care Partnership -

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

South Yorkshire ICS -

ICB Board meeting and minutes :: South Yorkshire ICB

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

Appendix 1 - Cheswold Park Hospital

Improving health

Metrics	Trust Threshold	Oct-24	Nov-24	Dec-24	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	98.5%	98.5%	98.4%		Based on all current inpatients (64 as at 31/12/2024)
Percentage of service users who have had their equality data recorded - disability	50%	100.0%	100.0%	100.0%		Based on all current inpatients (64 as at 31/12/2024)
Percentage of service users who have had their equality data recorded - sexual orientation		93.8%	93.8%	93.7%		
Completion of equality mandatory training	>=80%	99.0%	99.0%	100.0%		100% of ward and central support services staff; 92% of clinical staff

Improving Care

Metrics	Trust Threshold	Oct-24	Nov-24	Dec-24	Variation/ Assurance	Notes
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	2	3	0		Out of a total number (55) of violence and aggression incidents occurred in December 2024

Improve Resources

Metrics	Trust Threshold	Oct-24	Nov-24	Nov-24	Variation/ Assurance	Notes
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	2				Both RIDDOR incidents relate to physical violence (contact made) against staff by patient and were reported to the HSE within the required timeframe.

Make SWYPFT a great place to work

Metrics	Trust Threshold	Oct-24	Nov-24	Dec-24	Variation/ Assurance	Notes
Turnover external (in month)	>12% - 13%<	2.1%				Data not Provided for November and December
Sickness absence - In month	<=5.4%	6.3%				Data not Provided for November and December
Staff supervision rate	80%	61.0%	72.5%	83.0%		
Mandatory training - Cardiopulmonary resuscitation	80%	96.0%	93.0%	96.0%		includes training for Immediate Life Support, Basic Life Support
Mandatory training - Reducing restrictive physical interventions (RRPI)	80%	96.0%	93.0%	92.0%		includes training for Prevention and Management of Violence and Aggression and Breakaway
Mandatory training - Fire	85%	97.0%	98.0%	99.0%		
Mandatory training - Information governance (IG)	95%	97.0%	97.0%	98.0%		

Appendix 1 - Cheswold Park Hospital

NHS South West Yorkshire Partnership NHS Foundation Trust

Quality Headlines

Section	KPI	Trust Threshold	Oct-24	Nov-24	Dec-24
Complaints	% of feedback with staff attitude as an issue	< 20%	18% (2/11)	50% (7/14)	9.09% (1/11)
	Complaints - Number of responses provided within six months of the date a complaint received	100.0%	100% (11/11)	85.71% (12/14)	18.18% (2/11)
Quality	Notifiable Safety Incidents (where Duty of Candour applies)	Trend monitor	0	0	0
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions	Trend monitor	0	0	0
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches	0	0	0	0
	% Service users on CPA offered a copy of their care plan	80%	96.92% (63/65)	92.31% (60/65)	100% (64/64)
	Number of Information Governance breaches	<12	2	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	No admissions
	Total number of reported incidents	Trend monitor	215	201	168
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available)	Trend monitor	3	4	2
	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	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	0
	Safer staff fill rates (% Overall)	90%	88.3%	97.8%	90.1%
	Safer Staffing % Fill Rate - Registered Nurses Overall	80%	142.9%	105.9%	86.2%
	Safer Staffing % Fill Rate - Registered Nurses Days	80%	157.8%	100.7%	80.2%
	Safer Staffing % Fill Rate - Registered Nurses Nights	80%	126.5%	113.2%	94.6%
	% of prone restraint with duration of 3 minutes or less	90%	No prone restraints	No prone restraints	No prone restraints
	Number of Falls (inpatients)	Trend monitor	2	1	0
	Number of restraint incidents	Trend monitor	15	20	6
	% of staff receiving supervision within policy guidance	80.0%	74.0%	80.0%	83.0%
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	0	2	0	0

Quality Headlines

Number of Information Governance breaches - 2 incidents reported in December 2024. One incident related to, confidential waste from an inpatient ward being found in another ward area. The second incident related to a letter regarding a member of staff being sent to the wrong address.

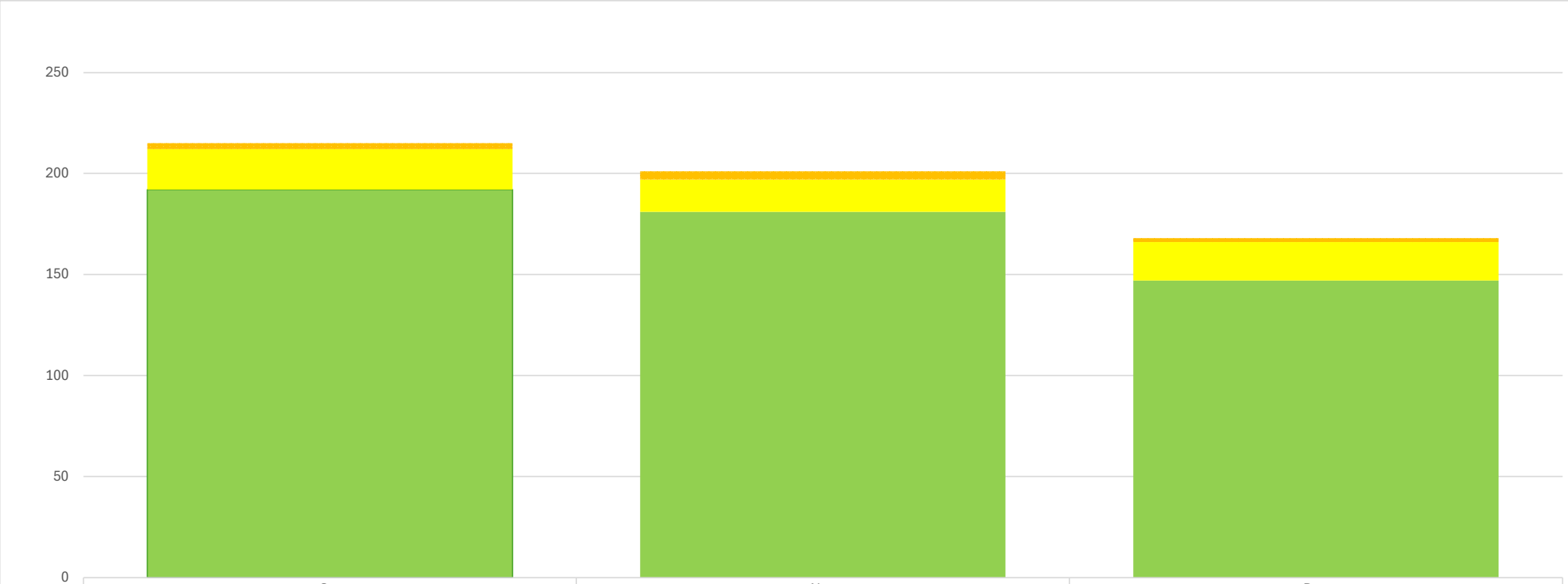
Appendix 1 - Cheswold Park Hospital

Safety First

Summary of Incidents

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

87.5% of incidents occurred in December 2024 resulted in no harm or near miss.
No never events, or incidents resulting in major, permanent, catastrophic harm or death occurred in December 2024.



	Oct	Nov	Dec
Red	0	0	0
Amber	3	4	2
Yellow	20	16	19
Green	192	181	147

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

Breakdown of incidents in December 2024 - 2 moderate harm incidents:
The most common causes 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 11 safeguarding incidents relating to adults in December 2024.

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

Complaints

• There were 11 new complaints in December of which are all were formal. All of the complaints received were regarding inpatients.
• Of the 11 new complaints received, two are noted as 'awaiting investigator appointment', six are 'under investigation', one is ‘extension’, and two 'response sent & closed'.
• One of the new complaints related to 'Attitude Of Staff', seven related to 'All Aspects Of Clinical Treatment', one related to 'Patient Property/expenses', one related to 'Failure To Follow Agreed Procedures' and one related to 'Other'.
• Thirteen responses were sent in December 2024.
• No compliments were received in December 2024.

Reducing Restrictive Physical Intervention (RRPI)

• There were 8 restraint related incidents in December 2024, making up 4.76% (8/168) of the total December incidents.
• As in December there was no incidents implemented in prone position.

Appendix 1 - Cheswold Park Hospital

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Trust Threshold	Oct-24	Nov-24	Dec-24
Establishment	Improving Resources	Well Led	-	324.1	324.1	324.1
Contracted Staff In Post (Ledger)			-	335.9	331.5	317.3
Vacancies			-	-11.8	-7.4	-6.8
Turnover external			>12% - <13%	1.5%		
Starters			-	0.0	0.0	0.0
Leavers			-	8.0	8.0	6.0
International Nurse Starters in Month			-	0	0	0
% Bank Fill Rates - Registered Nurses			-	2.27% (16/703)	2.81% (37/941)	4.44% (34/765)
% Bank Fill Rates - Health Care Assistants			-	5.96% (111/1860)	12.56% (309/2459)	7.8% (153/1957)
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)			-	4.95% (127/2563)	10.17% (346/3400)	6.87% (187/2722)
Sickness absence - Month			<=5%	6.3%		
Employees with long term sickness over 12 months			-	1	1	1
Appraisals - rolling 12 months			95%	75.0%	76.0%	81.0%
Employee Relations - Suspensions (over 90 days)			-	0	0	0
Mandatory Training - TOTAL	Improving Care		>=80%	98.0%	98.0%	99.0%
Mandatory Training - Reducing Restrictive Practice Interventions				96.0%	93.0%	92.0%
Mandatory Training - Cardiopulmonary Resuscitation				96.0%	93.0%	96.0%
Mandatory Training - Clinical Risk				N/A	N/A	N/A
Mandatory Training - Display Screen Equipment				N/A	N/A	N/A
Mandatory Training - Equality & Diversity				99.0%	99.0%	100.0%
Mandatory Training - Fire Safety			>=85%	97.0%	98.0%	99.0%
Mandatory Training - Food Safety			>=80%	99.0%	99.0%	100.0%
Mandatory Training - Freedom To Speak Up (FTSU)				99.0%	99.0%	100.0%
Mandatory Training - Infection Control & Hand Hygiene				98.0%	98.0%	99.0%
Mandatory Training - Information Governance (Data Security)			>=95%	97.0%	97.0%	98.0%
Mandatory Training - Moving & Handling			>=80%	97.0%	98.0%	99.0%
Mandatory Training - Mental Capacity Act/Dols				96.0%	95.0%	97.0%
Mandatory Training - Mental Health Act				96.0%	95.0%	97.0%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				97.0%	98.0%	98.0%
Mandatory Training - Prevent			>=80%	N/A	N/A	N/A
Mandatory Training - Safeguarding Adults				93.0%	99.0%	99.0%
Mandatory Training - Safeguarding Children				93.0%	99.0%	99.0%

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 9 (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)	(£0.9m)	£0m	The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £0.9m deficit has been reported which is a £0.1m increase from last month. The main financial driver remains workforce related expenditure. Non recurrent mitigations have been identified to support delivery of the year end target.
2	Agency Spend	£4.8m	£6.3m	Agency expenditure run rate has continued to fluctuate. Spend in December is £608k which is £30k more than last month. The average run rate for the year to date is £531k per month so spend in December is higher. The provider collaborative spend in month was £44k which is £16k less than last month.
3	Financial sustainability and efficiencies	£13.8m	£21m	The Trust financial sustainability programme for 2024 / 25 has a target of £22.0m to achieve the breakeven target. Overall the programme is behind plan for the year to date with the main driver being the continued level of workforce utilised being above plan. The forecast of £21m, being £1m less than planned, relies upon a number of non-recurrent mitigations to deliver. These schemes have been identified as measures to ensure delivery of the financial target.
4	Cash	£56.5m	£51.5m	Although cash has slightly improved in month it did not increase as much as forecast. Outstanding cash receipts have been chased with commissioners. Overall income remains lower than planned.
5	Capital	£2.6m	£8.1m	The Trust now has a number of separate capital allocations for 2024 / 25. The original allocation was £8.1m and performance is shown on the left. Additional allocations relating to IFRS 16 (leases) and Cheswold Park Hospital are shown on the detailed capital page. Although expenditure is less than plan for the year to date it is still forecast that the full allocation will be utilised.
6	Better Payment Practice Code	99%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

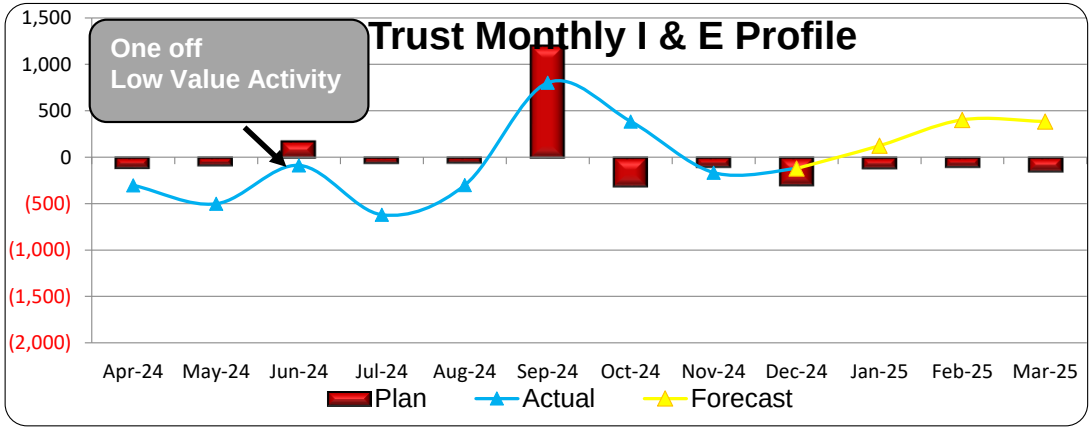
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

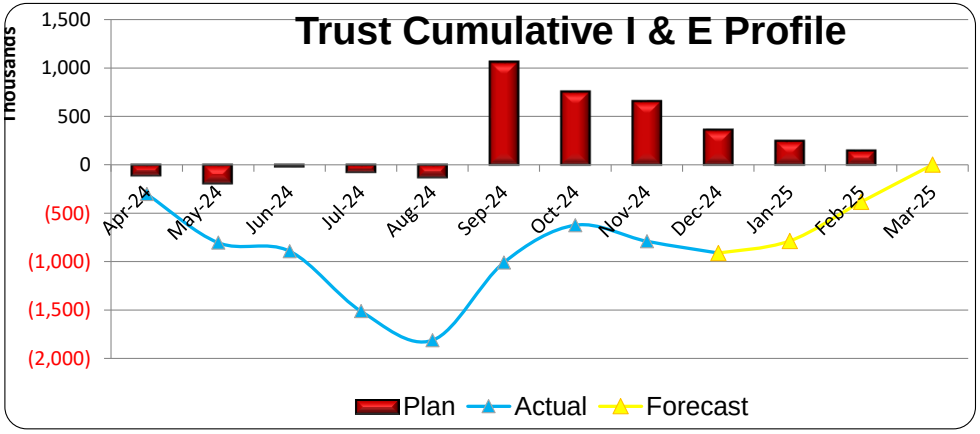
2.0 Income & Expenditure Position 2024 / 25

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

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					36,744	37,358	614	320,943	322,475	1,533	431,062	433,283	2,222
Other Operating Revenue					1,316	1,307	(8)	12,597	13,184	587	16,396	17,191	795
Total Revenue					**38,060**	**38,665**	**606**	**333,540**	**335,660**	**2,120**	**447,458**	**450,475**	**3,017**
Pay Costs	5,420	5,451	32	0.6%	(23,764)	(23,998)	(234)	(205,777)	(207,425)	(1,648)	(277,226)	(278,769)	(1,543)
Non Pay Costs					(14,016)	(14,142)	(127)	(123,245)	(124,899)	(1,655)	(164,342)	(165,488)	(1,146)
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	**5,420**	**5,451**	**32**	**0.6%**	**(37,780)**	**(38,140)**	**(361)**	**(329,022)**	**(332,300)**	**(3,278)**	**(441,568)**	**(444,233)**	**(2,665)**
EBITDA	**5,420**	**5,451**	**32**	**0.6%**	**280**	**525**	**245**	**4,518**	**3,360**	**(1,158)**	**5,890**	**6,241**	**352**
Depreciation					(598)	(590)	8	(4,949)	(4,937)	12	(6,742)	(6,788)	(46)
PDC Paid					(274)	(335)	(61)	(1,896)	(2,265)	(369)	(2,718)	(3,210)	(492)
Interest Received					298	278	(20)	2,688	2,931	243	3,570	3,756	186
Surplus / (Deficit) - ICB performance measure	**5,420**	**5,451**	**32**	**0.6%**	**(294)**	**(121)**	**173**	**362**	**(911)**	**(1,273)**	**(0)**	**(0)**	**(0)**
Depn Peppercorn Leases (IFRS16)					(9)	(9)	(0)	(79)	(79)	0	(94)	(94)	0
Revaluation of Assets					0	680	680	0	680	680	0	680	680
Surplus / (Deficit) - Total	**5,420**	**5,451**	**32**	**0.6%**	**(303)**	**550**	**853**	**283**	**(310)**	**(593)**	**(94)**	**586**	**680**





Income & Expenditure Position 2024 / 25

The consolidated financial position is a year to date deficit of £0.9m. This is £1.3m behind plan. Financial performance in December is a deficit of £0.1m which is £0.2m better 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)	5,051	5,098	47	0.9%	(385)	148	533	(1,516)	(2,044)	(528)	(2,029)	(4,058)	(2,028)
Cheswold Park Hospital	334	319	(15)	4.4%	111	48	(63)	332	213	(120)	665	80	(585)
Provider Collaboratives	23	34	11	49.5%	2	(247)	(249)	22	292	270	29	(510)	(539)
Budgets held centrally	12	0	(12)	100.0%	(23)	(70)	(47)	1,523	627	(895)	1,335	4,488	3,153
Total - Consolidated position (ICB performance measure)	**5,420**	**5,451**	**32**	**0.6%**	**(294)**	**(121)**	**173**	**362**	**(911)**	**(1,273)**	**(0)**	**(0)**	**(0)**

As shown within the Trust (core) financial position this is a surplus, and better than plan, for December. This is primarily due to one off / non-recurrent income adjustments which have helped to support the position. Financial pressures, mainly from more workforce utilised than planned, remain.

The costs for Cheswold park continue to be reviewed now that we are operationally running the hospital and validated against the business case.

In relation to the Provider Collaboratives financial position the main driver is South Yorkshire Adult Secure with additional out of area placements in month.

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.

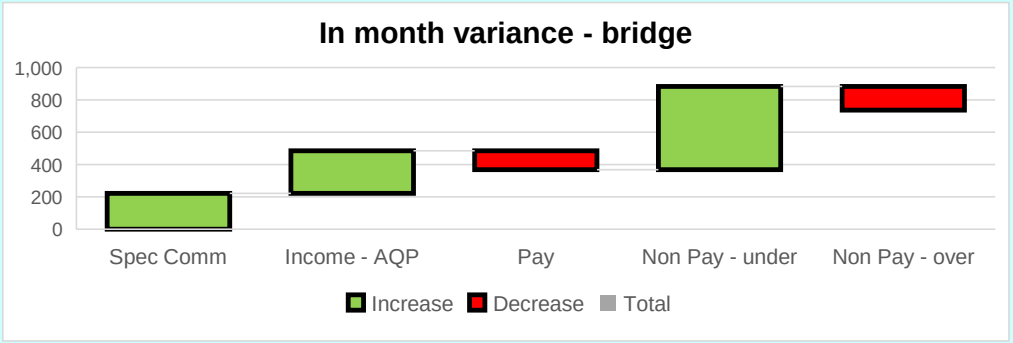
Total Financial Position - Core Trust only

	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					26,008	26,249	240	232,420	232,039	(381)	310,333	309,632	(701)
Other Operating Revenue					1,187	1,188	2	10,947	11,153	206	14,604	14,918	314
Total Revenue					**27,195**	**27,437**	**242**	**243,367**	**243,191**	**(175)**	**324,936**	**324,550**	**(386)**
Pay Costs	5,051	5,098	47	0.9%	(22,351)	(22,469)	(118)	(200,144)	(201,426)	(1,282)	(267,354)	(269,090)	(1,737)
Non Pay Costs					(4,822)	(4,348)	474	(41,085)	(40,025)	1,061	(54,730)	(54,308)	422
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	**5,051**	**5,098**	**47**	**0.9%**	**(27,173)**	**(26,816)**	**357**	**(241,230)**	**(241,427)**	**(197)**	**(322,084)**	**(323,374)**	**(1,290)**
EBITDA	**5,051**	**5,098**	**47**	**0.9%**	**22**	**621**	**599**	**2,137**	**1,764**	**(372)**	**2,852**	**1,176**	**(1,677)**
Depreciation					(525)	(530)	(5)	(4,730)	(4,759)	(30)	(6,304)	(6,350)	(46)
PDC Paid					(179)	(220)	(41)	(1,611)	(1,980)	(369)	(2,148)	(2,640)	(492)
Interest Received					298	278	(20)	2,688	2,931	243	3,570	3,756	186
Surplus / (Deficit) - ICB performance measure	**5,051**	**5,098**	**47**	**0.9%**	**(385)**	**148**	**533**	**(1,516)**	**(2,044)**	**(528)**	**(2,029)**	**(4,058)**	**(2,028)**
Depn Peppercorn Leases (IFRS16)					(9)	(9)	(0)	(79)	(79)	0	(94)	(94)	0
Losses Peppercorn Leases (IFRS16)					0	680	680	0	680	680	0	680	680
Surplus / (Deficit) - Total	**5,051**	**5,098**	**47**	**0.9%**	**(393)**	**820**	**1,213**	**(1,594)**	**(1,443)**	**152**	**(2,123)**	**(3,472)**	**(1,348)**

The core Trust position is a small in month surplus. This is better than planned and helps to reduce the year to date overspend against plan. As for each month of the year the largest financial driver is workforce with worked WTE greater than plan. In December this is offset by better than plan positions on healthcare income and non pay costs.

Key headlines are included below and illustrated within the bridge:

	£k
One off income - Specialist Commissioning	221
Any Qualified Provider Income - invoices raised. Now included in baseline	264
Pay Pressures - consolidated variance to plan in month	(118)
Non Pay underspends - training, establishment, premises	516
Non pay pressure - purchase of healthcare	(147)

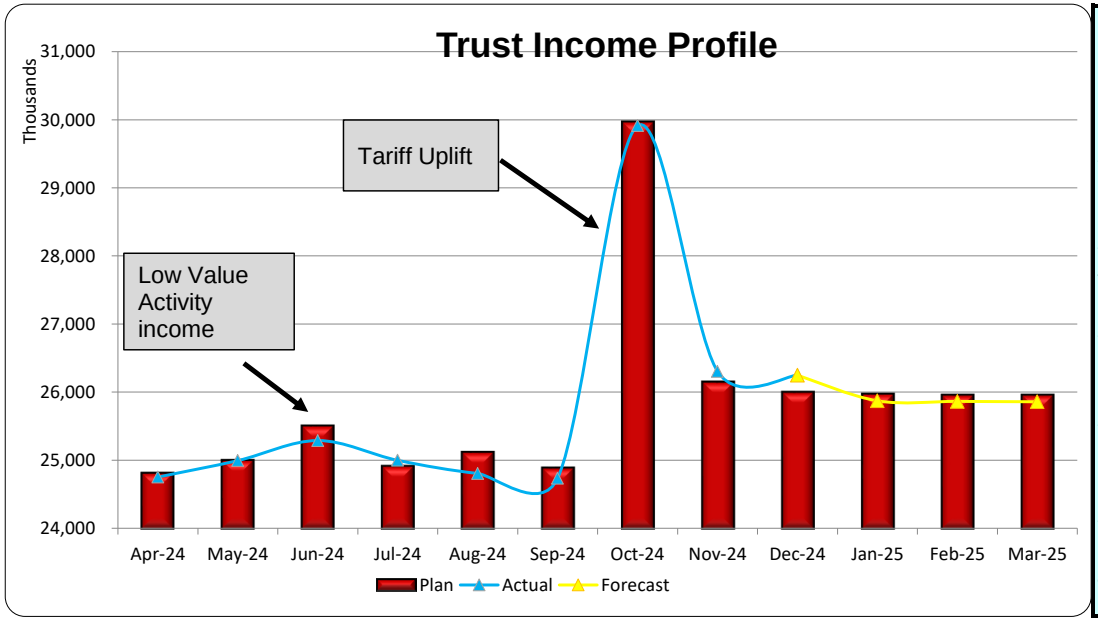


2.1 Income Information

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	22,288	22,092	22,092	22,086	**263,843**	263,558	285
Specialist Commissioner	**34,541**	2,943	2,962	2,974	2,947	2,956	2,827	5,239	1,495	3,295	3,039	3,039	3,038	**36,752**	36,681	71
Local Authority	**5,799**	378	400	371	398	377	360	381	684	314	396	384	384	**4,829**	5,240	(411)
Partnerships	**6,748**	205	219	191	218	207	207	222	293	222	212	216	217	**2,631**	3,008	(378)
Other Contract Income	**1,454**	131	220	37	135	121	131	136	140	129	133	133	133	**1,578**	1,861	(283)
Total	**293,862**	**24,752**	**24,994**	**25,289**	**24,997**	**24,805**	**24,735**	**31,570**	**24,649**	**26,249**	**25,872**	**25,863**	**25,858**	**309,632**	**310,349**	**(717)**
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	9,426	9,468	9,416	9,487	**113,840**		
Total	**293,862**	**33,870**	**34,155**	**34,439**	**34,183**	**33,981**	**34,362**	**42,256**	**34,586**	**35,674**	**35,340**	**35,279**	**35,345**	**423,472**		



Significant variances, showing in month and forecast positions, are highlighted below. In most cases, where reimbursement is based on actual costs incurred, these variances are offset within pay and non pay.

	In month	YTD
* Partnership - Youth Offenders Service Reimbursement based on actual costs incurred	£28k	£378k
* Yorkshire Smokefree Various commissioners. Actual costs and payment by results	£24k	£243k
* Additional Roles Reimbursement Posts Offset by reduced pay costs. Recharged on staff in post	£19k	£265k
* NHS England Liaison & Diversion Reduced income from slippage in recruitment	£34k	(£96k)
* Any Qualified Provider income Invoices raised. Now included in baseline position. This is a positive with income higher than plan.	(£226k)	(£299k)

2.2 Pay Information

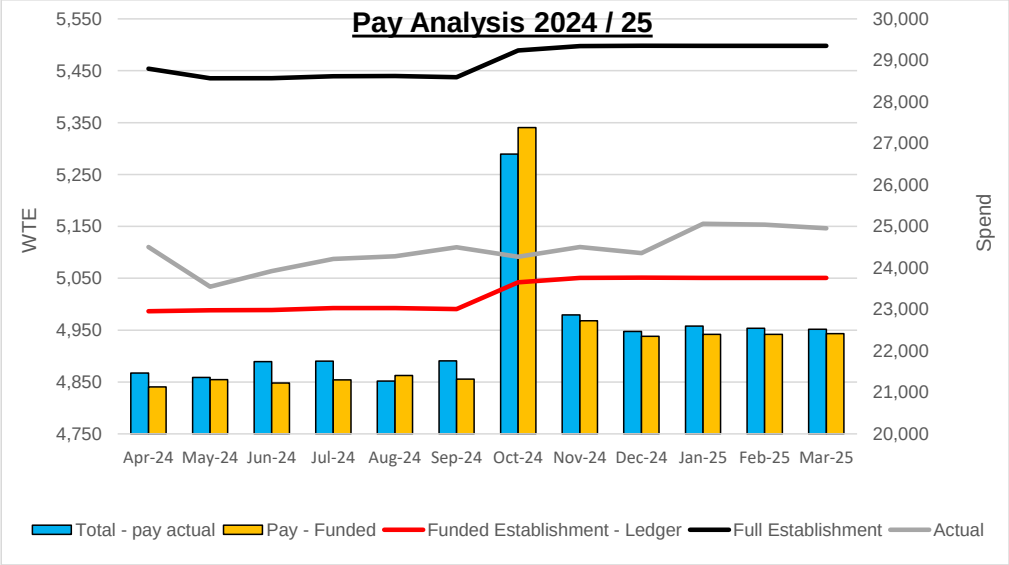
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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	20,215	20,387	20,375	20,357	**242,330**
Bank & Locum	1,955	1,581	1,673	1,738	1,771	1,827	1,980	1,793	1,770	1,782	1,766	1,757	**21,393**
Agency	413	400	444	510	429	434	561	452	484	426	405	409	**5,368**
Total	**21,466**	**21,360**	**21,739**	**21,751**	**21,275**	**21,756**	**26,741**	**22,870**	**22,469**	**22,596**	**22,546**	**22,522**	**269,090**
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%	7.9%	7.9%	7.8%	7.8%	8.0%
Agency as % (in month)	1.9%	1.9%	2.0%	2.3%	2.0%	2.0%	2.1%	2.0%	2.2%	1.9%	1.8%	1.8%	2.0%

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	4,602	4,657	4,659	4,654	**4,603**
Bank & Locum	474	401	411	435	456	460	431	445	437	438	435	433	**438**
Agency	62	59	62	74	71	62	70	62	60	60	59	59	**63**
Total	**5,110**	**5,034**	**5,064**	**5,087**	**5,092**	**5,110**	**5,092**	**5,110**	**5,098**	**5,155**	**5,153**	**5,146**	**5,104**
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**



Expenditure in December is lower than November. In part this is due to Resident Doctors pay awards, back dated to April, which were paid in November. In total worked WTE has reduced by 12 in month with reductions in all areas but primarily bank staff.

Although a relatively small movement overall there has been increases in substantive staffing for Barnsley physical health & wellbeing and Children's, Families and Young People care groups (12 and 6 worked WTE respectively).

This is offset by a reduction of substantive WTE worked in the Mental health (11 WTE) and Adult Inpatient (8 WTE) care groups. The impact of this is considered within the Trust temporary staffing scrutiny and management group.

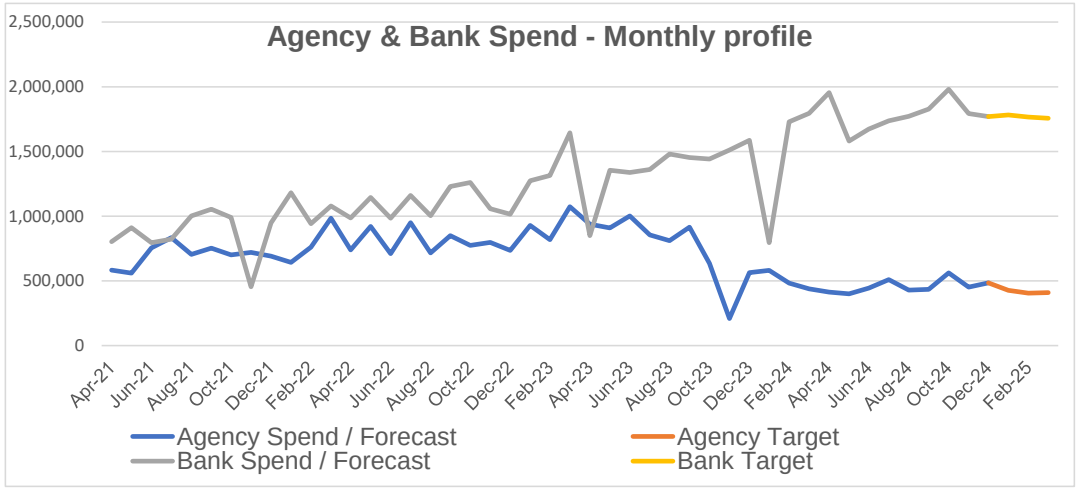
The forecast scenario modelling continues to assume additional workforce growth for the remainder of the year. This continues to be validated.

2.2 Temporary Staffing Focus

Trust spend in December 2024:
Agency £484k
Bank £1,770k

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	1,449	419	**1,868**
Other Medical	936	470	**1,407**
Reg Nursing	254	3,779	**4,033**
UnReg Nursing	946	9,965	**10,911**
Other Clinical	278	553	**831**
A & C	124	903	**1,027**
Other	(6)	0	**(6)**
Total	**3,981**	**16,089**	**20,069**
Lead Provider Collaborative	509	6	**516**
Budgets held centrally	(8)	0	**(8)**
Cheswold Park Hospital	145	128	**274**
Total	**4,628**	**16,223**	**20,851**

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 December being a £32k increase compared to last month. This increase 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 and primarily relate to medical staff.

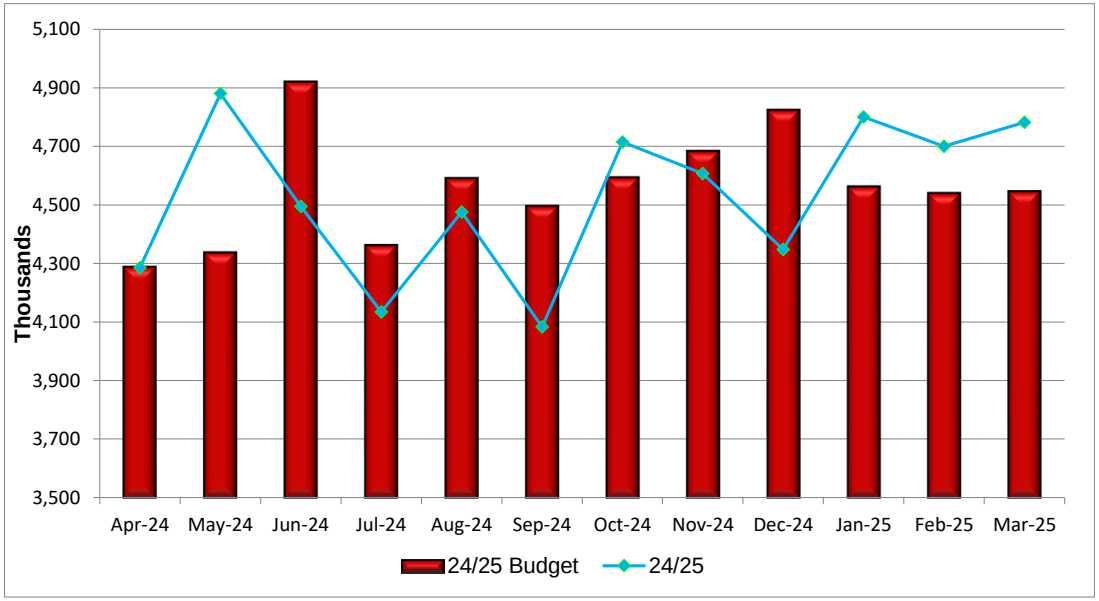
Utilisation of bank, as part of the overall workforce solution, has continued to grow over the past couple of years. Expenditure is roughly the same in November and December 2024 and is forecast to continue at a similar rate for the rest of the financial year.

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	4,348	4,800	4,700	4,782	**54,308**
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	3,299	3,031	(268)	
Establishment	7,196	7,245	49	
Lease & Property Rental	6,611	6,668	57	
Premises (inc. rates)	3,856	3,609	(248)	
Utilities	1,982	1,961	(21)	
Purchase of Healthcare	4,674	4,551	(123)	
Travel & vehicles	4,298	4,120	(179)	
Supplies & Services	6,297	5,978	(319)	
Training & Education	880	729	(152)	
Clinical Negligence & Insurance	873	876	3	
Other non pay	1,119	1,259	139	
Total	**41,085**	**40,025**	**(1,061)**	
Total Excl OOA and Drugs	**33,112**	**32,442**	**(670)**	



Key Messages

Overall non pay expenditure is £474k less than planned in month. For the year to date this is £1,061k underspent. This remains lower than expenditure in 2023 / 24.

The total value of non pay expenditure has reduced by £260k from November to December 2024. The larger reductions, which are also underspent against budget in month, have been reported in:

* Training & Education - reduced expenditure profile as agreed by Trust Executive Management Team.

* Establishment - reductions in a number of areas including stationary purchases, employment requirements including DBS checks and visas. There were also some one off costs in November, such as removal expenses reimbursement, which have not been incurred in December.

* Premises - non recurrent benefit in month for reconciliation of historical charges for Trust use of estate in Barnsley managed by Community Healthcare Partnerships.

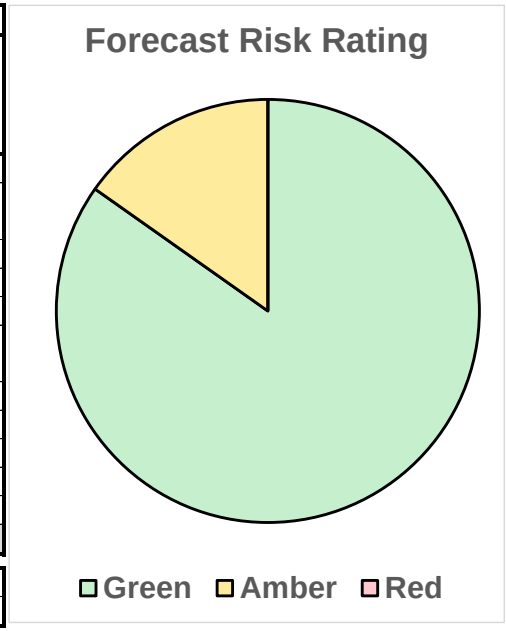
The main increase, and with spend above budget, is within the purchase of healthcare heading. This includes increased costs for PICU out of area placements and locked rehab placements.

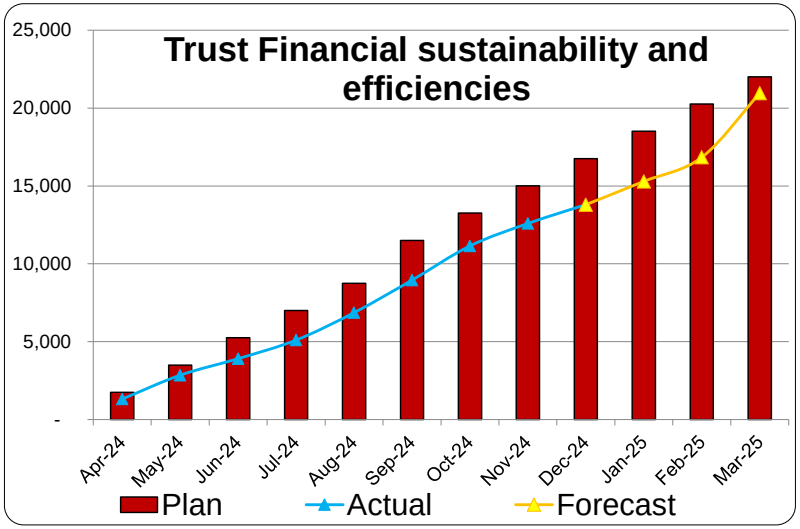
3.0 Value for Money, Financial sustainability and efficiency

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		9,351	363	5,990	12,468	9,179			(3,289)
Non pay - Impact of workforce optimisation		315	318		420	423			3
Out of area placements		2,153	2,374		2,871	2,374	638		141
Non pay - digital		185	136		246	179			(67)
Non pay - Estates		375	302	22	500	428			(72)
Non pay - medicines optimisation		360	0		480			0	(480)
Non Pay - other		0	178		0	218			218
Procurement		188	0		250		0		(250)
Provider Collaboratives		855	855		1,140	1,140			0
Non Recurrent mitigations		0	0		0		2,550		2,550
Income - contribution, Full Year Effect		2,979	3,222		3,638	3,824			186
Total		**16,760**	**7,746**	**6,012**	**22,013**	**17,765**	**3,188**	**0**	**(1,060)**
Recurrent		7,759	7,746		10,345	8,218	638	0	(1,489)
Non Recurrent		9,001		6,012	11,668	9,547	2,550		429





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.

The current forecast is that £20,953k of schemes will be delivered in 2024 / 25. This is £1,060k less than planned and will require mitigation within the overall financial position. The unachieved gap has increased from last month (was £305k) and this is in relation to the workforce optimisation scheme as we continue to utilise more staff than planned.

Other schemes remain in line with previous months including the reliance on additional non-recurrent mitigations to support delivery of the breakeven financial target.

The Value For Money steering group is co-ordinating a number of key lines of enquiry, with project initiation documents being developed, to accelerate identification and delivery of new schemes. Whilst this is intrinsically linked to development of the 2025 / 26 financial plan any early achievements will supporting year delivery as well.

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	198,839	
Current Assets			
Inventories & Work in Progress	179	179	
NHS Trade Receivables (Debtors)	1,072	1,855	
Non NHS Trade Receivables (Debtors)	344	1,295	
Prepayments	3,491	4,447	
Accrued Income	1,062	5,227	1
Cash and Cash Equivalents	69,199	56,473	Pg 15
Total Current Assets	**75,347**	**69,477**	
Current Liabilities			
Trade Payables (Creditors)	(12,728)	(5,538)	2
Capital Payables (Creditors)	(1,392)	(314)	
Tax, NI, Pension Payables, PDC	(8,469)	(9,527)	
Accruals	(13,966)	(15,572)	3
Deferred Income	(409)	(2,113)	4
Other Liabilities (IFRS 16 / leases)	(51,040)	(50,649)	
Total Current Liabilities	**(88,004)**	**(83,713)**	
Net Current Assets/Liabilities	**(12,657)**	**(14,236)**	
Total Assets less Current Liabilities	**155,161**	**184,602**	
Provisions for Liabilities	(3,510)	(3,516)	
Total Net Assets/(Liabilities)	**151,651**	**181,087**	
Taxpayers' Equity			
Public Dividend Capital	45,696	75,696	
Revaluation Reserve	15,355	15,100	5
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	85,380	85,070	
Total Taxpayers' Equity	**151,651**	**181,087**	

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 continues to be higher than as at 31st March 2024 and also higher than planned. The main factor relates to funding for Adult Secure provider collaboratives for which direct payment has been agreed but has not yet been received (in arrangements post covid a direct payment is received rather than raising an invoice).

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.

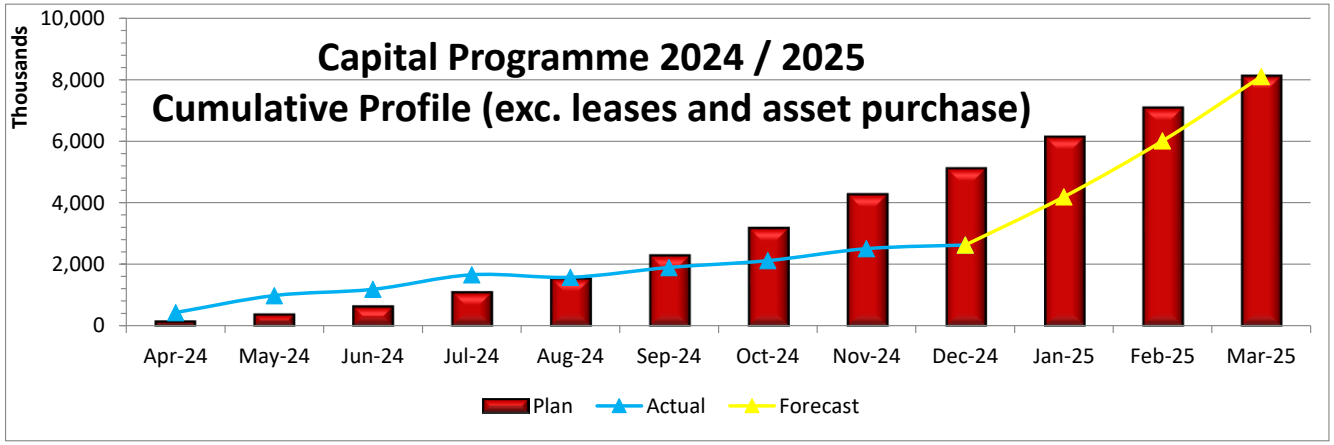
3. Accruals continue to be monitored and any NHS related will be subject to agreement through the month 9 Agreement of Balances exercise. A detailed line by line review has been conducted and actions identified. This is as per a West Yorkshire Integrated Care System request linked to financial grip and control.

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. Minimal value is expected to be deferred at year end.

5. The value of the revaluation reserve has been updated following the annual estates valuation exercise completed in December 2024.

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	1,000	0	(1,000)	1,000	(1,500)
Seclusion Rooms	1,000	820	1,024	204	1,075	75
Anti-ligature Doors	1,000	730	359	(371)	1,000	0
Maintenance (Minor) Capital						
Clinical Improvement	311	311	197	(113)	428	118
Safety	302	296	96	(199)	867	566
Sustainability / Carbon Neutral	510	200	132	(68)	510	0
Backlog	360	162	61	(101)	588	228
Equipment	41	30	91	61	164	124
Other	193	130	25	(105)	668	475
IM & T	1,470	1,282	494	(788)	1,470	0
Contingency	219	0	0	0	142	(76)
Staff Costs	200	150	143	(7)	191	(9)
TOTALS	**8,104**	**5,110**	**2,622**	**(2,488)**	**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	256	256	750	750
TOTALS	**14,014**	**10,970**	**42,130**	**31,160**	**50,557**	**36,543**



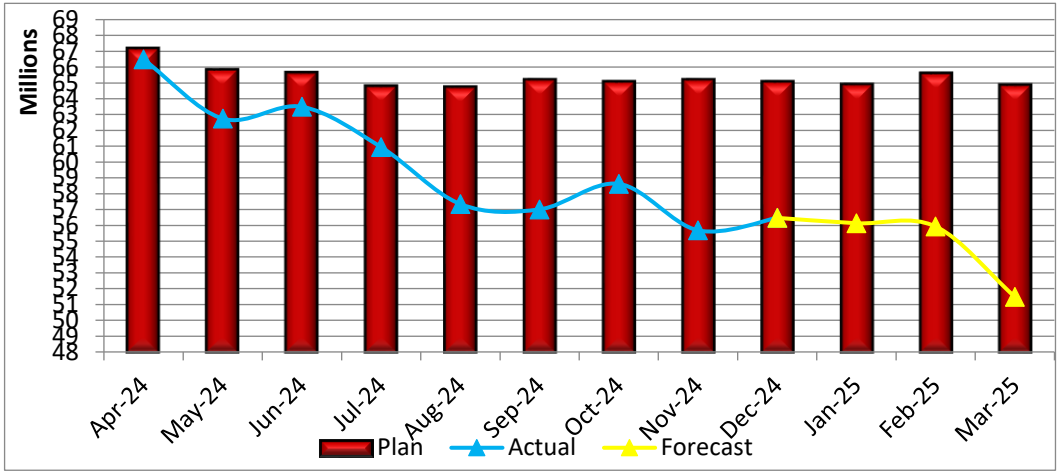
Capital Expenditure 2024 / 25

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).

Each indiviudal scheme continues to be reviewed to ensure that they will be delivered in year. This includes a review of orders placed and progress against these.

Although we recognise there is significant expenditure forecast for Q4 the team are confident this will be complete.

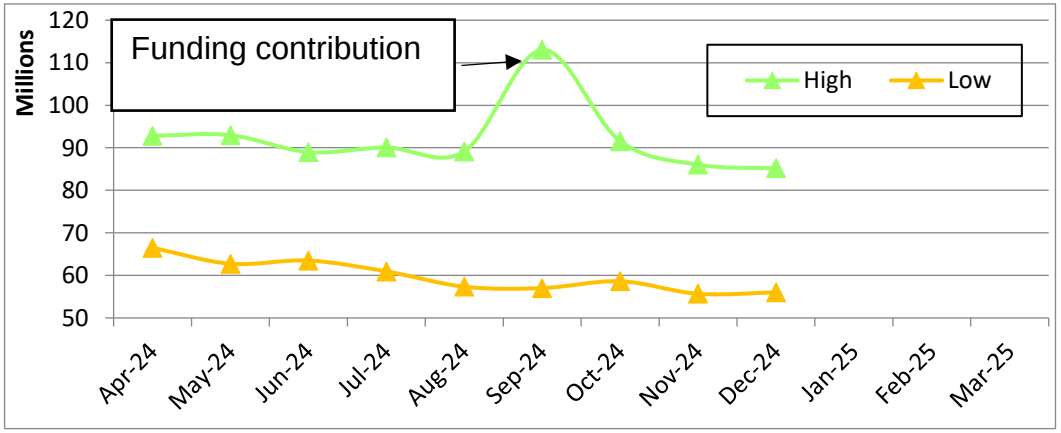
4.2 Cash Flow & Cash Flow Forecast 2024 / 2025



Cash levels have been maintained in month

The Trust cash position has been maintained in month. The focus remains on receipt of income for services delivered.

	Plan £k	Actual £k	Variance £k
Opening Balance	71,353	69,199	
Closing Balance	65,091	56,473	(8,618)



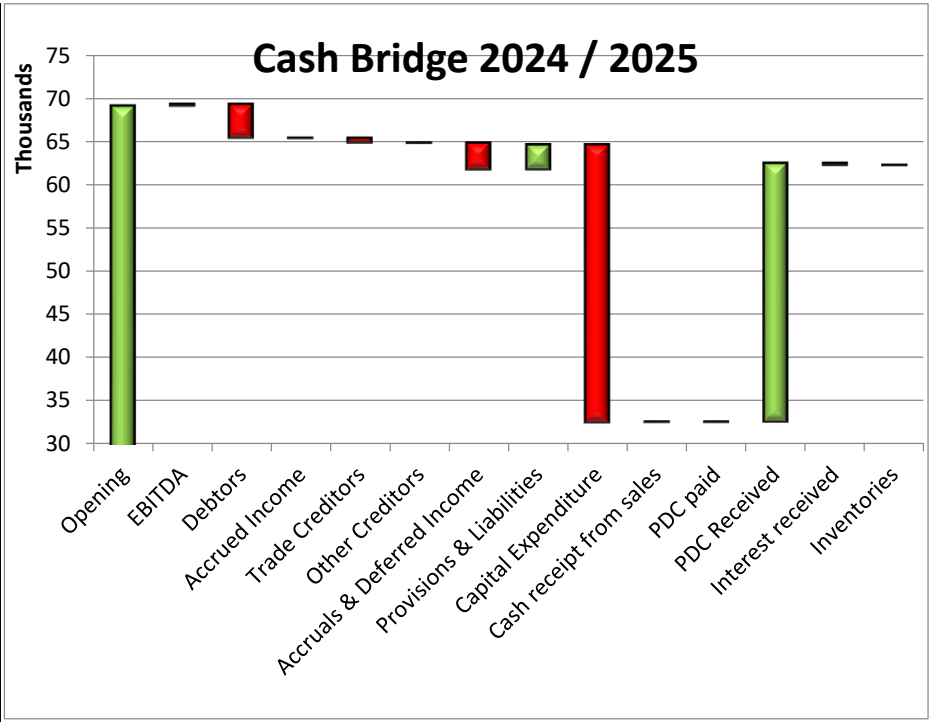
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £85.2m
The lowest balance is: £56m

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)	10,043	10,232	189	
Movement in working capital:				
Inventories & Work in Progress	52	0	(52)	
Receivables (Debtors)	180	(3,741)	(3,921)	
Trade Payables (Creditors)	(3,500)	(4,037)	(537)	
Accruals & Deferred income	0	(3,114)	(3,114)	
Provisions & Liabilities	(1,180)	1,710	2,890	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(6,760)	(38,956)	(32,196)	
Cash receipts from asset sales	0	24	24	
Leases	(7,174)	(6,724)	450	
PDC Dividends paid	(1,074)	(1,050)	24	
PDC Dividends received	0	30,000	30,000	
Interest (paid)/ received	3,151	2,931	(220)	
Closing Balances	**65,091**	**56,474**	**(8,618)**	



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.

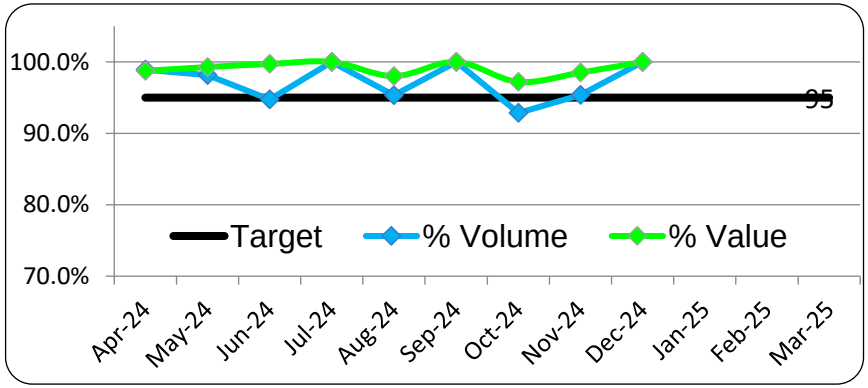
5.0 Better Payment Practice Code

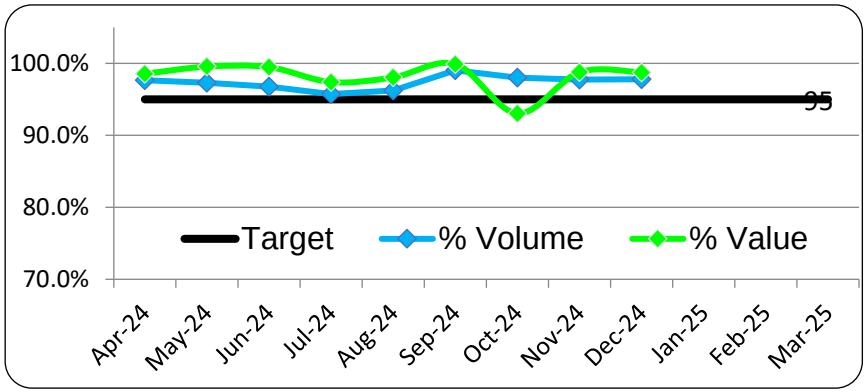
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	100%	100%
Cumulative Year to Date	98%	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 (£)
12-Dec-24	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000058642	769,054
06-Dec-24	Purchase of Healthcare	AS Collaborative	Oxford Health NHS Foundation Trust	A0131680	651,839
17-Dec-24	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	205158	644,853
17-Dec-24	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	205159	644,853
12-Dec-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS53	450,000
02-Dec-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510009620	400,537
01-Dec-24	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000001208	323,972
24-Dec-24	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000001239	323,972
12-Dec-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS30	270,000
04-Dec-24	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foun	4400002310	241,311
12-Dec-24	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 292	219,196
03-Dec-24	IT Services	Trustwide	Insight Direct (Uk) Ltd	2101048926	160,313
02-Dec-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510009616	153,429
17-Dec-24	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	205160	130,309
09-Dec-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS051SN	108,563
19-Dec-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34015409	97,322
04-Dec-24	IT Services	Trustwide	Daisy Corporate Services	3I537374	90,250
24-Dec-24	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710180667	86,650
31-Dec-24	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	328376	73,529
11-Dec-24	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6028122	67,789
19-Dec-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34015436	56,000
09-Dec-24	Utilities	Trustwide	Edf Energy Customers Ltd	000021465829	54,264
04-Dec-24	Purchase of Healthcare	Kirklees	Northpoint Wellbeing Ltd	RGA15342	47,351
01-Dec-24	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000001209	47,221
24-Dec-24	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000001240	47,221
03-Dec-24	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90145306	43,169
19-Dec-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34014794	40,575
17-Dec-24	Computer Hardware	Trustwide	Dell Corporation Ltd	7403059748	40,534
04-Dec-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001277EPC	38,549
30-Dec-24	Utilities	Trustwide	Vodafone Ltd	107187981	36,652

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
16-Dec-24	Levy Payment	Trustwide	Financial Conduct Authority	PFK240237018	36,000
12-Dec-24	Purchase of Healthcare	Forensics	Humber Teaching NHS Foundation Trust	59895878	34,947
17-Dec-24	Purchase of Healthcare	Calderdale	Invictus Wellbeing Services Cic	329	34,750
18-Dec-24	Utilities	Trustwide	Total Energies Gas & Power Ltd	36269545924	34,243
12-Dec-24	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59895858	33,372
18-Dec-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	CHA04658	32,833
09-Dec-24	Utilities	Trustwide	Edf Energy Customers Ltd	000021366230	30,501
24-Dec-24	NHS Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	1003303	30,473
11-Dec-24	Purchase of Healthcare	Trustwide	Cygnet Nw Ltd	BUR0381126	29,730
24-Dec-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	THO05516	28,383
02-Dec-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	THO05486	27,961
18-Dec-24	Utilities	Trustwide	Total Energies Gas & Power Ltd	36269507424	27,726
10-Dec-24	Continence Products	Barnsley	Supply Chain Coordination Limited	231793	26,032
06-Dec-24	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72488543	25,627
03-Dec-24	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90145305	25,019
03-Dec-24	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90145307	25,019

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, efficiencies, and Cost Improvement Programmes (CIP). In each case this is the identification of schemes to increase efficiency, reduce expenditure or increase income.

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

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

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

Appendix 3 - Statistical Process Control (SPC) Charts Explained

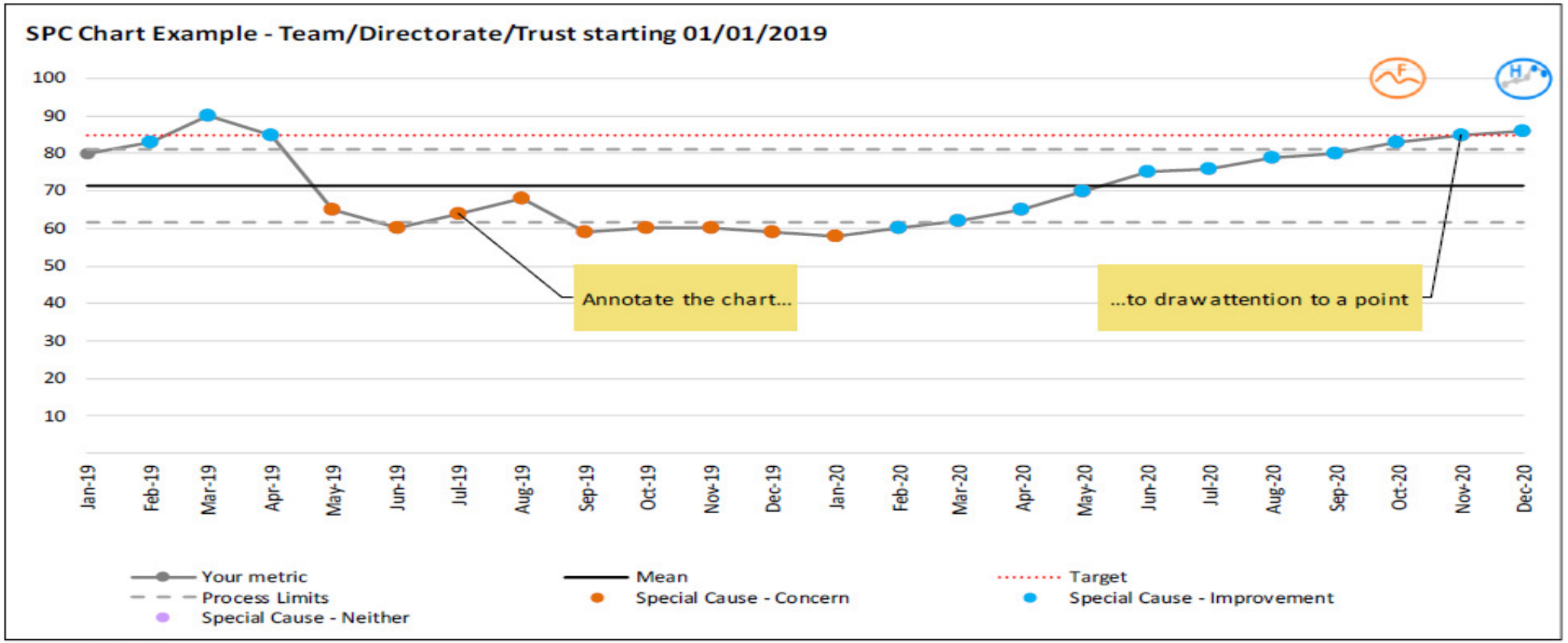
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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