NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

January 2025

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for January 2025.

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.

NHS South West Yorkshire Partnership NHS Foundation Trust

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

Improving Resources

Metric	Change from last month	Variation/ Assurance
Surplus/(deficit) against plan (monthly)	↓	
Capital spend against plan (Cumulative)	↑	
Total pay costs	↓	

Improving Care

Metric	Change from last month	Variation/ Assurance
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	↓	H, F
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	↓	F
% service users clinically ready for discharge	↓	
Referral to assessment within 2 weeks (external referrals)	↓	?

Making SWYPFT a great place to work

Metric	Change from last month	Variation/ Assurance
Registered workforce growth	↓	
WorkPal appraisals - rolling 12 months	↓	
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	↑	
Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches	↓	

People

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

National metrics

Metric	Change from last month	Variation/ Assurance
Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	↓	H, ?
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	↑	?
Total number of Children and Younger People under 18 in adult inpatient wards	↓	L, ?
Total bed days 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	↓	
Reducing restrictive physical interventions training compliance	↑	H
Cardiopulmonary resuscitation (CPR) training compliance	↓	H
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	↓	H F
Reducing restrictive physical interventions training compliance	↑	H F
% of feedback with staff values and behaviours as an issue	↑	
Information Governance training compliance	↓	H

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 staff receiving supervision within policy guidance	↓	

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)	↓	
% of feedback with staff values and behaviours as an issue	↓	

Barnsley Physical Health and Wellbeing

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

Forensic

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	H F
Information Governance (IG) training compliance	↑	H
% Bed occupancy (incl leave)	↓	L 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 52.2%, sexual orientation 57.5% 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 January, the Trust had 93.1% 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. On 6th January 2025, the Trust implemented new mental health care plans for both inpatient and community settings. As part of this roll out, the Staying Safe Plan has been removed from the FIRM Risk Assessment and integrated into the new care plans. Whilst new practice is being embedded, we have seen a drop in performance for completion within the timescales. Data for January is provisional and will be refreshed in next months report. 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.

• The Trust had 18 violence and aggression incidents against staff on mental health wards involving race during January which is a reduction on last month.
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 January 97% against a target of 90% was achieved.

Improving resources

Making SWYPFT a great place to work

• Overall, our 12-month turnover rate in January has increased slightly to 7.8% and remains at the lowest overall level it has been 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 January 2025, our workforce growth rate has slowed compared to earlier months and was at 2.4% (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 401 new starters and 331 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 remains at 5.3% with January sickness decreasing to 5.5%. 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. Children, young people and families, mental health community ADHD, ASD and LD saw an increase in sickness absence during January. 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 further deterioration in performance during the month. 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. The drop in compliance reflects the length of time that WorkPal was unavailable, though this figure is expected to improve as appraisal data has now been successfully migrated from WorkPal to ESR. A local trajectory of improvement has been set and this will be monitored against from next month.
• Continued focus has led to supervision remaining above target in January at 83.4%. 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 81.5% which remains 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:

95% of incidents reported in January 2025 resulted in no or low harm or were not under the care of the Trust, an overview of key indicators is below:

• Sadly, there were three patient safety related deaths for service users know to the Trust's mental health services. All are subject to review and any learning will be identified.

• The number of restraint incidents increased from 189 to 196 reported in December. 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.

• The number of prone restraints reduced during the month to 5 incidents. All incidents of prone restraint that occurred during the month lasted under three minutes. 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 6 information governance personal data breaches during January. Learning from incidents is shared across care group.

• The number of inpatient falls reported during January 2025 was 43 which remains well below the national average for inpatient falls of 6.3 per 1000 bed days. We remain vigilant and all falls incidents are reviewed regularly by the Trust wide falls coordinator to ascertain any themes or actions required.

• The number of responses provided within six months of the date a complaint 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 January was 106 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 113 out of 149 children (75.8%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in January. 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.

• The Trust had one admission for one night under 18 years old to an adult acute mental health bed during January. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for

• staff on legal, safeguarding and care, and treatment reviews. Admissions are due to the national unavailability of a bed for young people to meet their specific needs. We routinely notify the Care Quality Commission (CQC) of these admissions and discuss the detail in our liaison meetings, actioning any points that the CQC request.

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 January 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. 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.

Finance

• The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £1.6m deficit has been reported which is a £0.6m increase from last month which is primarily due to the in month deficits reported by the Adult Secure Provider Collaboratives. Non recurrent mitigations have been identified to support delivery of the year end target.
• Agency expenditure run rate has continued to fluctuate. Spend in January is £684 which is £76k more than last month. The provider collaborative spend in month was £87k which is £32k less than last month. Cheswold Park Hospital spend in month was £179k which is £100k more than last month.
• 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.
• 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.

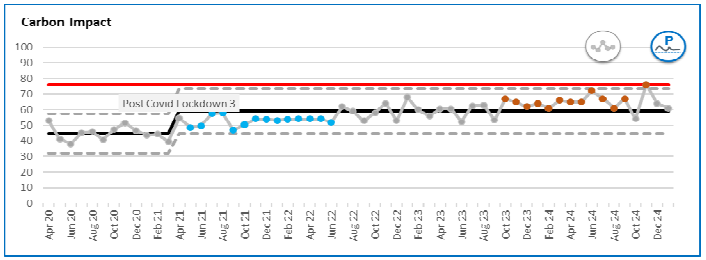
Cheswold Park Hospital

• 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.
• Staff supervision rate remains at the 80% Trust threshold (80%).
• Mandatory training levels for cardiopulmonary resuscitation, reducing restrictive physical interventions, fire and information governance all remain well above the 80% threshold.
• There were 147 incidents reported during the month; three of those resulted in moderate harm. The common cause of these incidents related to self-injurious behaviours and violence and aggression.

Improving health

Metrics	Threshold	Nov-24	Dec-24	Jan-25	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	248- All staff (17.6%) 111 - excl medics (9.2%)	248- All staff (17.4%) 113 - excl medics (9.2%)	254- All staff (17.8%) 117 - excl medics (9.5%)		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%	54.4%	53.7%	52.2%		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		59.5%	58.6%	57.5%		
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% Policy - 95%	89.3% Service 100% Policy	79.9% Service 100% Policy	93.1% Service 100% Policy		
Completion of equality mandatory training	>=80%	96.4%	96.3%	96.3%		
Number of job start/work retention outcomes during month by individual placement and support service	Trend monitor	12	11	12		A single client could have multiple job starts
Number of new people accessing Individual placement and support service during month	Trend monitor	36	24	52		First contact and work started on vocational profile. Average number of new people per month for the period Apr '24 - Jan '25 is 39, total number year to date is 389. December access number had 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 has improved.
Carbon Impact (tonnes CO2e) - business miles	76	76	64	61		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 January 2025 remain in a period of common cause variation. Levels are not expected to return to those seen pre-Covid-19 as a more blended approach to working is expected to continue.

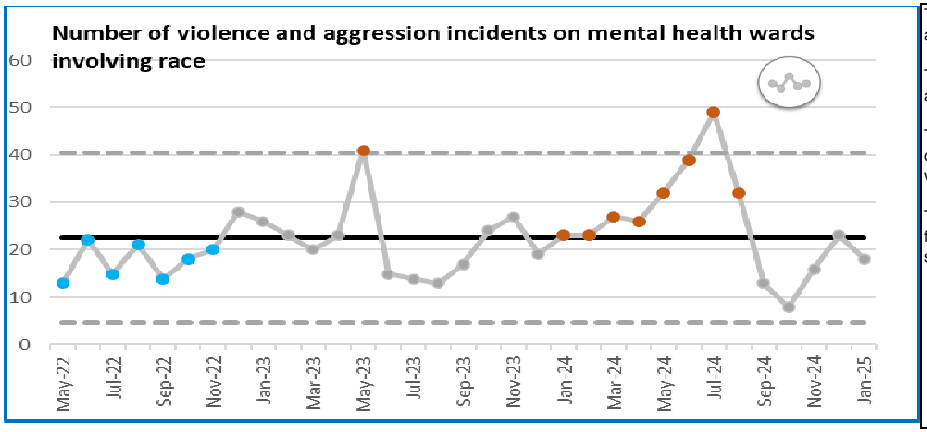
Improve Care

Metrics	Threshold	Nov-24	Dec-24	Jan-25	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%	93.8%	94.9%	*87.3%*		Within inpatient services, all service users have a risk assessment with 96 service users having had a risk assessment within 24 hours, a further 14 service users had a completed risk assessment - with 1 of those being between 5-10 hours over the 24-hour standard, 4 of those being between 10-15 hours over the 24-hour standard and 14 of those being 15 hours or more over the 24 hour standard). For community services 39 out of 153 people are showing to not have a risk assessment – all service users without a risk assessment are followed up individually in the care group to maintain patient safety.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		77.6%	73.7%	*66.7%*		On 6th January 2025, the Trust implemented new mental health care plans for both inpatient and community settings. As part of this roll out, the Staying Safe Plan has been removed from the FIRM Risk Assessment and integrated into the new care plans. Whilst new practice is being embedded, we have seen a drop in performance for completion within the timescales. Data for January is provisional and will be refreshed in next months report.
% Service users on care programme approach with a plan of care developed collaboratively	85%	99.8%	99.7%	99.7%		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	1,128	1,139	1,134		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	161	160	164		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	16	23	18		Over the last three months, 57 incidents against staff on mental health wards involving race were reported, 10 of the 57 incidents were physical assaults with the remainder being verbal violence and aggression , of the total incidents reported 47 related to verbal racial or sexualised abuse. In December 2024, the field " If this incident involved abuse or hate against an individual based on their protected characteristics, who was affected?" has been made mandatory on Datix to strengthen data collection moving forwards. All incidents continue to be monitored through SWYPT governance structures and work regarding protected characteristics continues 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	131	127	106		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%	4.4%	3.7%	5.2%		Performance in month has deteriorated. 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	Nov-24	Dec-24	Jan-25	Variation/ Assurance	Notes
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	273	291	328		Neurodevelopment waits remain a concern, especially given the additional capacity stopped at the end of March 2024. This is in keeping with the national picture and forms part of the system wide work. These metrics calculate length of wait in days for those discharged that month. Children and young people are seen in order of need and not by how long they have waited. The number of referrals remains high. This is due to the Right to Choose pathways. When referrals are screened and deemed clinically appropriate for assessment families are offered the choice of provider, between August 2023 and February 2024 very few families were choosing our Child and Adolescent mental health services (CAMHS) as the other providers had shorter waiting lists. However, these providers wait times increased whilst ours decreased leading to families choosing our CAMHS resulting in increased referrals and a significant increase in wait times.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	748	785	737		
Learning Disability (LD) - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Improvement trajectory: Nov 88% Dec onwards 90%	95% 58/61	97% 60/62	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%	93.5%	94.0%	92.4%		
Community health services two hour urgent response standard	70%	88.1%	89.2%	90.7%		
Referral to assessment within 2 weeks (external referrals)	75%	80.2%	78.6%	74.2%		

What the data is telling us. Statistical process control charts will be inserted here to alert the reader to charts which identify improvement or that require further work or investigation



The chart shows that as at January 2025 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	Nov-24	Dec-24	Jan-25	Variation/ Assurance	Notes
Surplus/(deficit) against plan (Cumulative)	Breakeven	(£790k)	(£911k)	(£1,898k)		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	£2,504k	£2,622k	£2,988k		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. Further will be added in month 11 for LED lighting. 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	£578k	£608k	£684k		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 £77k more than last month which includes increased costs for Cheswold Park Hospital. The adult secure provider collaborative spend in month was £87k.
Financial sustainability and efficiencies delivered over time (monthly)	£22m	£1,440k	£1,209k	£1,230k		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)	£24,317k	£23,998k	£24,310k		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.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	11		Due April 2025		Q3 - 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%	95.6%	98.9%	96.8%		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	Nov-24	Dec-24	Jan-25	Variation/ Assurance	Notes
Turnover external (rolling 12 months)	>12% - 13%<	7.7%	7.6%	7.8%		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	2.4%				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. This growth relates to funded investment priorities (Barnsley neighbourhood teams service).
Sickness absence - YTD	<=5%	5.2%	5.3%	5.3%		Further detail around sickness absence is provided in the relevant section of this report. In month sickness was 5.5%.
Appraisals - rolling 12 months	95%	87.9%	85.9%	80.1%		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. The drop in compliance reflects the length of time that WorkPal was unavailable, though this figure is expected to improve as appraisal data has now been successfully migrated from WorkPal to ESR. A local trajectory of improvement has been set and this will be monitored against from next month.
% 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%	86.9%	84.1%	83.8%		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%	82.2%	82.0%	80.9%		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%	78.4%	80.5%	81.5%		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%	90.4%	90.0%	90.6%		Threshold increased from >=80% in June 24.
Mandatory training - Information governance (IG)	95%	94.5%	93.6%	93.5%		

Quality Headlines

Section	KPI	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	TBC	84.5%	83.3%	83.4%	82.9%	78.2%	76.4%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	< 20%	32% (7/22)	33% (8/24)	16% (5/31)	24% (7/29)	19% (3/16)	14% (4/29)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)						91.8	74.0	
	Complaints - Number of responses provided within six months of the date a complaint received [16]	100%	66% (6/9)	85% (11/13)	71% (17/24)	100% (12/12)	88% (7/8)	92% (11/12)	
Service User Experience	Friends and Family Test - Mental Health	84%	93%	90%	94%	92%	92%	90%	1
	Friends and Family Test - Community	95%	97%	97%	96%	97%	96%	97%	1
Quality	Number of compliments received	N/A	92	54	66	27	27	65	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	12	10	6	8	7	9	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	1	0	1	0	1	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	0	0	0	0	0	0	1	1
	% Service users on CPA offered a copy of their care plan	80%	96.2%	96.4%	96.2%	99.8%	99.7%	99.7%	1
	Number of Information Governance breaches [3]	<12	6	5	8	11	9	6	2
	% of inpatients clinically ready for discharge	3.5%	4.9%	4.8%	4.3%	4.4%	3.7%	5.2%	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%*	91.9%	89.7%	92.6%	93.8%	94.9%	*86.5%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		76.2%	76.5%	80.7%	77.6%	73.7%	*66.9%*	2
	Total number of reported incidents	Trend monitor	1435	1302	1257	1282	1291	1355	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	34	39	28	25	25	36	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	3	2	5	0	0	4	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	0	1	0	2	0	3	
	Safer staff fill rates	90%	131.3%	129.4%	131.2%	134.0%	128.8%	128.3%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	98.6%	99.0%	100.0%	104.0%	101.9%	100.5%	1
	Number of pressure ulcers which developed under SWYPFT care [1]	Trend monitor	42	56	33	21	49	50	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement [2]	0	0	0	0	0	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%	100% (14/14)	92.3% (12/13)	92.3% (12/13)	100% (9/9)	100% (10/10)	100% (5/5)	1
	Number of Falls (inpatients)	Trend monitor	53	47	50	32	37	43	
	Number of restraint incidents	Trend monitor	257	196	187	235	189	196	
	% of staff receiving supervision within policy guidance [15]	80%	84.0%	84.1%	84.4%	86.9%	84.1%	83.8%	2
	Potential under-reporting of patient safety incidents								
	% people dying in a place of their choosing [14]	80%	87.5%	87.1%	86.5%	97.3%	95.0%	86.2%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	1	0	0	0	0	1
	C Diff avoidable cases	0	0	1	0	0	0	0	1
	E. Coli bloodstream infection rate	0	0	1	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	2	2	2	2	2	2	2	
	Overall CQC rating		Good						
	CQC well - led rating		Good						

Quality Headlines

Quality Headlines cont…

1 - Number of pressure ulcers which developed under SWYPFT care - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary
2 – Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage
3 - The Information Governance breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches
4 - Notifiable Safety Incidents are where Duty of Candour is applicable.
5 - CAMHS referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Excludes autistic spectrum disorder waits and neurodevelopmental teams.
8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available). All incident data is reviewed using SPC charts to identify any special cause variation, if this occurs this will be reported by exception. Otherwise reporting rates remain within normal variation.
11 - Number of records with up to date risk assessment - 'Older people and working age adult inpatients' - we are counting how many staying safe care plans were completed within 24 hours and for 'community services for service users on care programme approach' - we are counting from first contact then 7 working days from this point.
12 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return. Please note, the wording of this metric has changed from the November 24 report to align with wording used in the national reporting.
14 - This metric relates to the Macmillan service, end of life pathway.
15 - % of Band 4 and above clinical staff who have received supervision in the previous 90 days.
16 - Formal complaints should be responded to/closed within 6 months of the date received as is written into the NHS Complaints (England) Regulations 2009

Quality Headlines

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

• The overall number of restraint incidents in December was 196 which is an increase on the previous month but remains within acceptable range. 39 of these incidents were attributed to Horizon ward and 31 to Melton ward. Further detail is provided in the relevant section of this report. The Trust's ongoing ambition is for a reduction in all restraint incidents, and reducing restrictive physical interventions training has a clear focus on interventions to prevent escalation of a situation to the point where restraint is required.

• % of feedback with staff values and behaviours as an issue - there were 4 in January. 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 12 complaints responded to during the month, 11 were undertaken within 6 months of the complaints being received, and the average number of working days these 8 complaints were open was 74 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 increased to 5.2% and is above threshold. There are still a significant number of people who are delayed which may impact on performance in future months and further detail regarding hotspot areas can be seen in the care group and ward level sections of this report.

• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. In November there were 43 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.

• Duty of Candour - There has been one breach in January 2025. A verbal apology was given at the time of the incident. The patient was discharged from the inpatient ward and so a formal letter was posted as it could not be given in person.

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

Cheswold Park transitioned from Ulysses to Datix for incident reporting in January 2025.

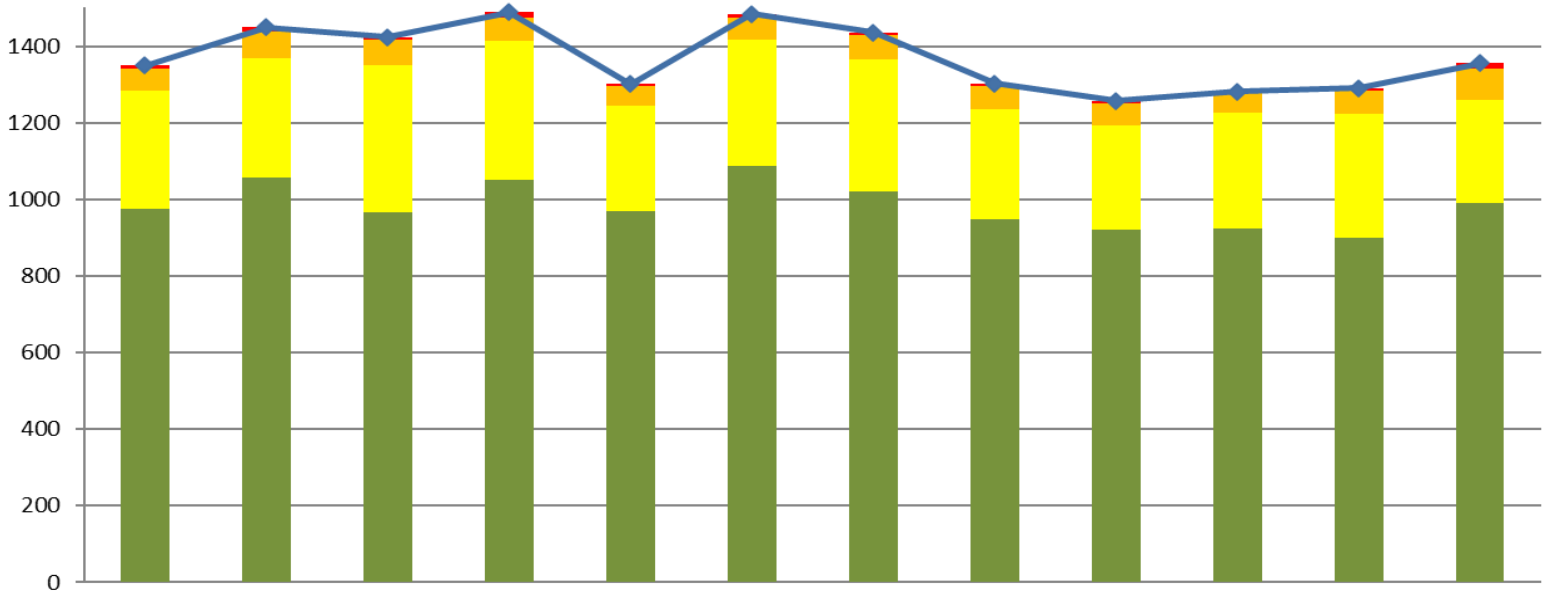
Safety Incident Response Accreditation Network (SIRAN)

The team have submitted evidence to support the SIRAN accreditation.

Safety First

Summary of Incidents

Although we have reported 15 red incidents in january, incidents may be subject to regrading as more information becomes available so this figure is subject to change.
95% of incidents reported in January 2025 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in January 2025



	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Red (should not be compared with SIs)	9	12	8	13	6	9	6	7	7	3	7	15
Amber	57	70	66	62	51	57	65	61	58	54	61	80
Yellow	308	311	383	362	275	331	344	285	271	300	323	271
Green	975	1057	967	1051	969	1087	1020	949	921	925	900	989
Total	1349	1450	1424	1488	1301	1484	1435	1302	1257	1282	1291	1355

Safety First cont…

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

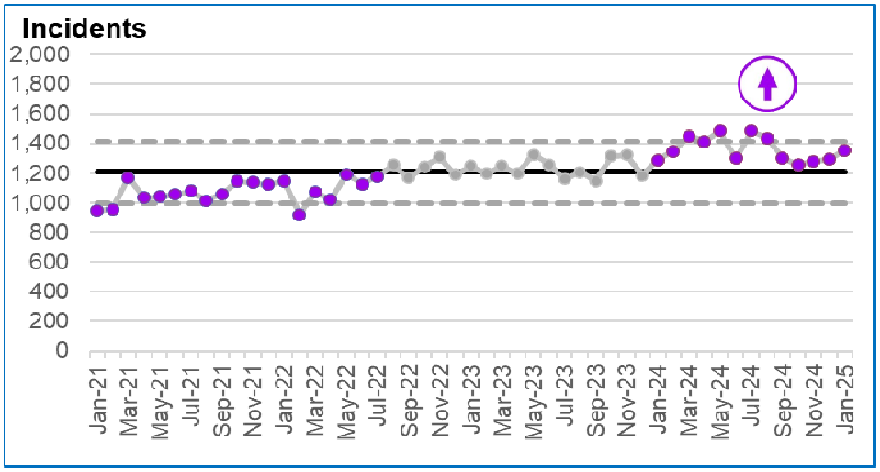
Breakdown of incidents in January 2025

36 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.

4 severe harm incidents:
All incidents were pressure ulcers.

Sadly, there were three patient safety related deaths for service users know to the Trust's mental health services. All are subject to review and any learning will be identified.

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.

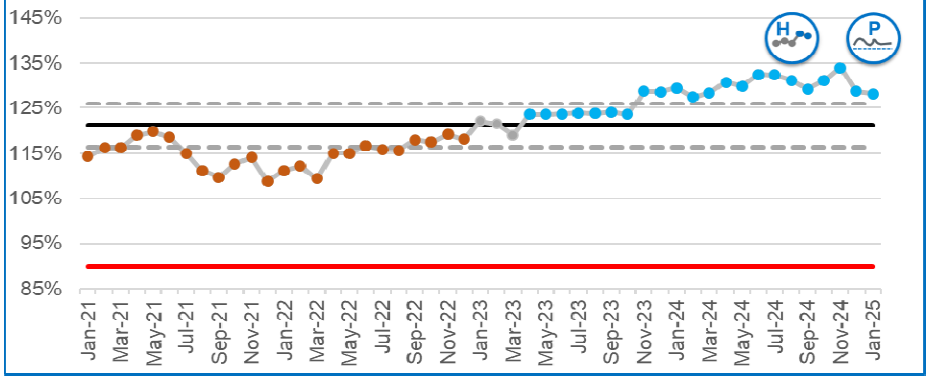
If you would like to attend or share your learning from experience with the learning network, please email learninglibrary@swyt.nhs.uk.

Patient Safety Alerts

There were no patient safety alerts that were not completed by deadline in January 2025.

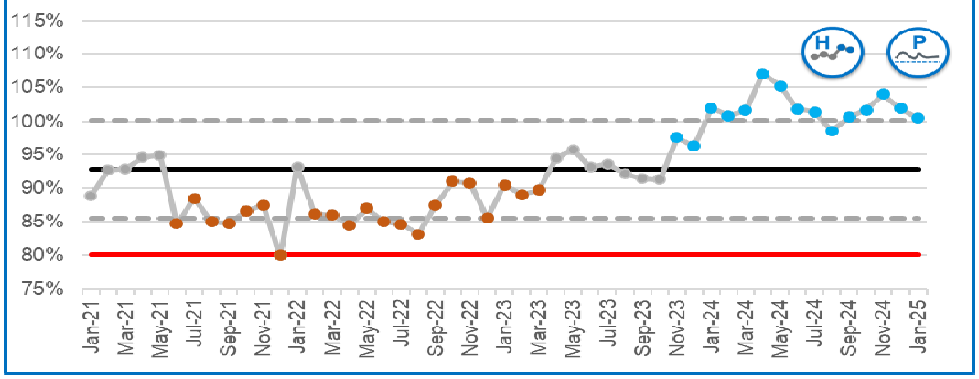
Safer Staffing Inpatients

Safer Staffing Fill Rate



The chart above shows that as at January 2025 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.

Safer Staffing Registered Nurses



The chart above shows that in January 2025, 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 January in overall demand.
- Within the flexible staffing pool there were a total of 56 less shift requests, however the overall fill rate increased by 1.96% to 93.64%.
- Within overall fill rates there was a decrease in the fill rates of 4% for Forensic and LD care group to 118%, with Adult and Older Peoples Care Group and Barnsley Integrated Services increasing by 1% and 2% respectively to 136% and 109%.
- 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 Assistants (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 the end of 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 saw a decrease of 0.5% to 128.3%. The day fill rate for Registered Nurses (RNs) increased by 0.6% to 98.9%. Three wards, consistent with December, Ward 18 in the Adult and Older Peoples care group, Johnson 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 January no ward, consistent with the previous month, fell below the 90% overall fill rate threshold.

Safer Staffing Inpatients cont…

Registered Nurses Days
There was an increase of 0.6% in overall registered Day fill rates to 98.9% in January compared with the previous month.

Registered Nurses Nights
There was an increase of 0.8% in overall registered Night fill rates to 117.8% in January compared with the previous month.

Overall Registered Rate: In January the overall registered fill rate decreased by 1.4% to 100.5%.
Overall Fill Rate: 128.3% (a decrease of 0.5% on the previous month)

Overall Fill Rate	Nov-24	Dec-24	Jan-25
Adults and Older People	141%	135%	136%
Barnsley Integrated Services	112%	107%	109%
Forensic and LD	126%	122%	118%
Grand total	**134%**	**129%**	**128%**

Registered day rate	Nov-24	Dec-24	Jan-25
Adults and Older People	104%	96%	98%
Barnsley Integrated Services	133%	130%	134%
Forensic and LD	99%	96%	94%
Overall shift fill rate	**104%**	**98%**	**99%**

Registered night rate	Nov-24	Dec-24	Jan-25
Adults and Older People	113%	114%	114%
Barnsley Integrated Services	105%	104%	108%
Forensic and LD	127%	124%	125%
Overall shift fill rate	**118%**	**117%**	**118%**

Bank staff filled 83.72% (an increase of 4.57% on the previous month) of RN requests for flexible staffing and 84.24% (an increase of 1.6% on the previous month) of HCA requests.
Agency staff filled 5.57% (a decrease of 1.34% on the previous month) of RN requests for flexible staffing and 10.37% (an increase of 0.32% on the previous month) of HCA requests.

Information Governance (IG)

Six personal data breaches were reported during January 2025. The current monthly average number of breaches is 9, which is lower than the past three financial years, which were all 11.4.

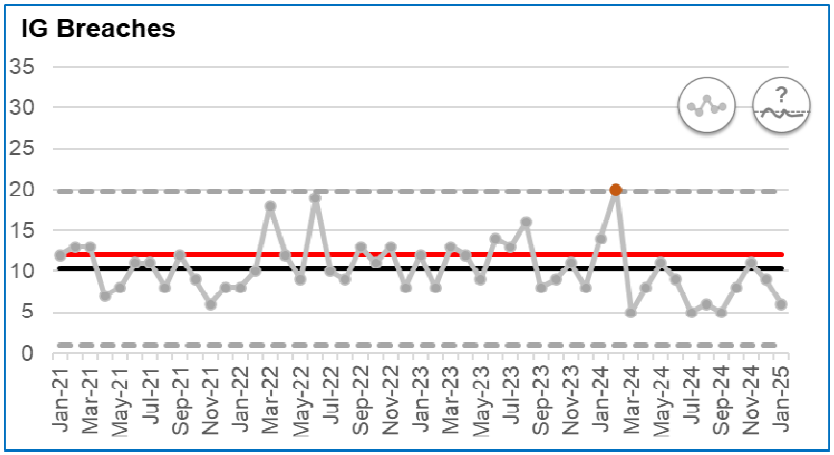
Information disclosed in error continues to be the highest reported category. Breaches during January were due to:

- Incorrect patient details on letters
- Emails sent to wrong recipient
- Incorrect patient details collected, leading to delay in care
- Confidential conversations being overheard

A new comms campaign has just been launched and personal responsibility for identifying the correct patient is a key feature of this.

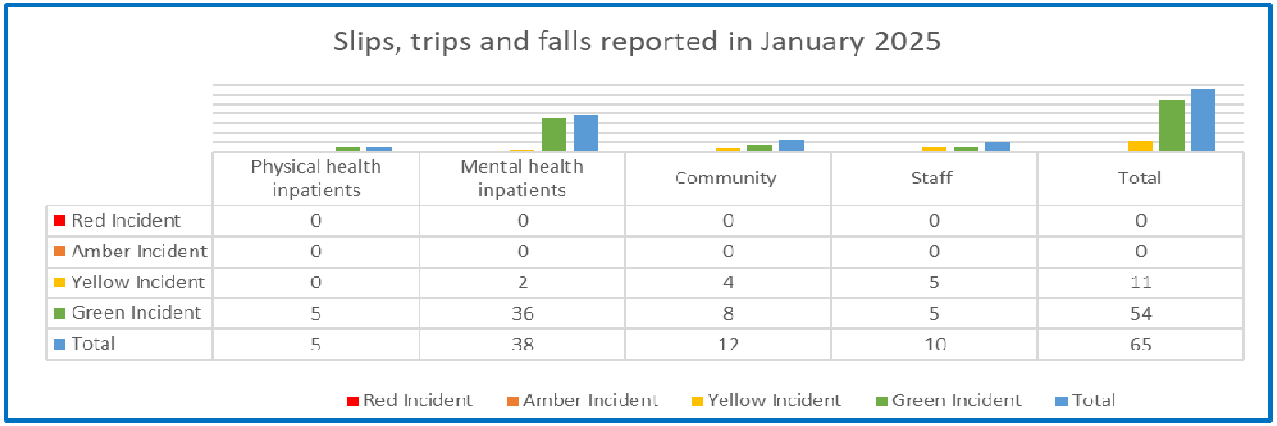
There are currently no open complaints with the Information Commissioner's Office.

This SPC chart shows that as at January 2025 we remain in a period of common cause variation. Overall there has been a decrease in the number of IG breaches.



Trustwide Falls

In January 2025, a total of 65 slips, trips, and falls were reported. 43 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	0	0	0
Yellow Incident	0	2	4	5	11
Green Incident	5	36	8	5	54
Total	5	38	12	10	65

• Post Falls Protocol completion has averaged 89% this month, with a continued good response from staff

• 88% of patients had a falls risk screen (FRAT-18) commenced within 24hrs of admission

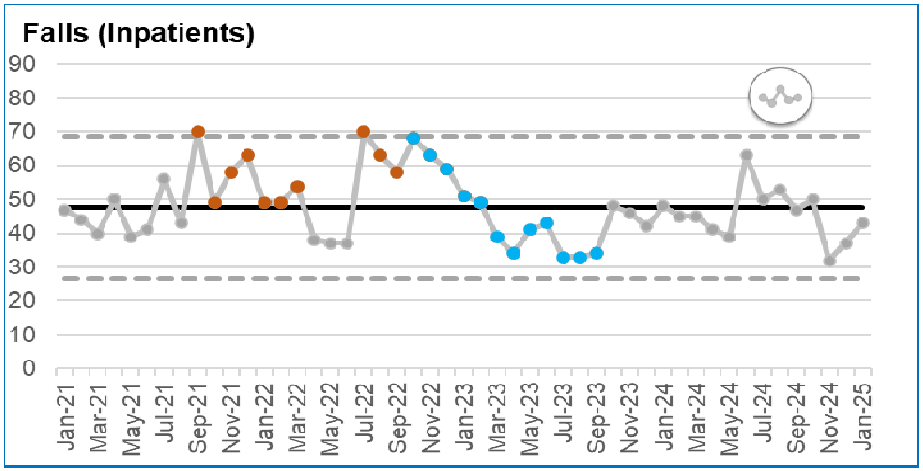
Incident Grading
There were no red or amber incidents.
Yellow: A total of 11 (17%) reported falls related safety events needed higher intervention. Two (18%) were reported on inpatient wards. One patient received a compound fragility fracture following a fall and returned to the ward with a conservative treatment plan, and another patient fell forward whilst sitting and attended A&E. Four falls (36%) were reported for patients falling at home who required a high-level of intervention. Four falls (36%) were staff who fell or slipped in icy conditions. One fall (9%) was a member of staff who fell whilst attending University.
Green: A total 54 (83%) reported safety events had low, or no harm recorded. One fall (2%) reported a patient fractured their nose following a fall. Four falls (7%) occurred whilst patients were on leave from the ward.

Inpatient falls had a high correlation with:
• 20 falls (47%) occurred for patients with a recognised level of deconditioning such as previous stroke, hyperactive delirium, polio with associated ankle weakness and older age
• 18 falls (42%) occurred in patients younger than 65. These were linked with play fighting, playing sports, ice and snow, agitation and general slips and trips
• 17 falls (40%) were patients with a known diagnosis of dementia
    • 12 of these (71%) had a level of deconditioning
    • 14 of these patients (82%) were 65 years old or older
    • Five of these falls (29%) were linked with associated behavioural and psychological symptoms of dementia

National Audit of Inpatient Falls (NAIF): Two falls (4%) were reviewed due to the change in reporting from 1st Jan 2025, where all fractures or head injuries are audited for risk assessment, intervention, and post falls reviews. No further learning was highlighted through this audit work.

Falls (Inpatient)

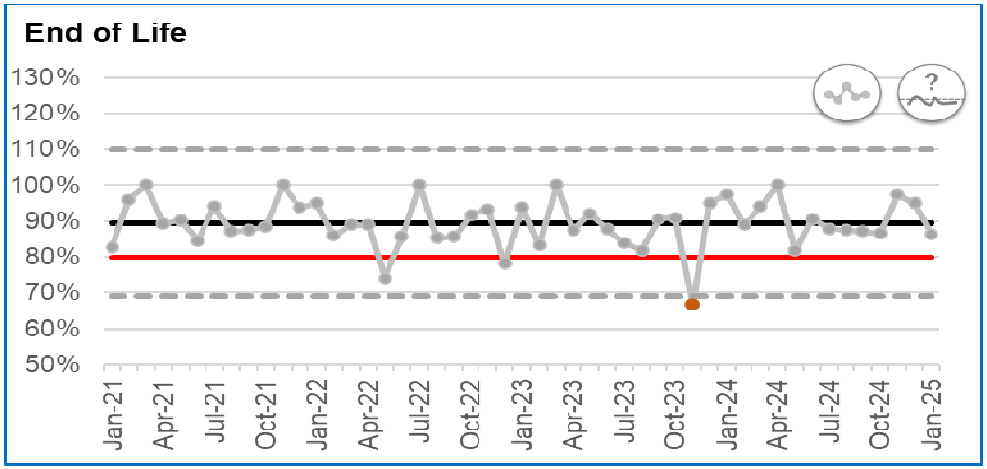
The total number of inpatient falls was 43 in January.



The SPC chart above shows that in January 2025 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 86.2% in January. 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 January 2025 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:

- 97% would recommend physical health services
- 90% would recommend mental health services

	Target	November	December	January
Mental health community	85%	90% (188)	94% (244)	93% (240)
Mental health inpatient	85%	98% (46)	92% (26)	93% (70)
Learning Disabilities	85%	94% (18)	90% (10)	100% (13)
ASD/ ADHD	85%	92% (12)	90% (10)	81% (21)
CAMHS	85%	94% (34)	86% (35)	76% (38)
Forensic	60%	N/A (0)	56% (9)	58% (12)
Mental health overall	84%*	**92% (298)**	**92% (334)**	**90% (394)**
Barnsley Physical Health	95%	**97% (259)**	**96% (213)**	**97% (439)**
Trustwide	**85%**	**94% (557)**	**93% (547)**	**93% (833)**

** weighted for 2023/24*

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

Overall, the satisfaction rate across the Trust has remained the same. The satisfaction in Barnsley Physical Health has increased slightly and the satisfaction in Mental Health services has declined slightly.

Satisfaction across mental health inpatients, Learning Disability, Forensics and Barnsley physical health services have increased in January.

Satisfaction in community mental health, ADHD & ASD service and CAMHS has declined.

ADHD/ASD, CAMHS and Forensics have dipped below the target in January.

There has been a significant increase in the number of responses returned for Barnsley physical health, this is due to text messaging being rolled out in majority of the physical health service.

Mental health responses continue to increase with the ongoing work with ADHD & ASD services and the local patient experience surveys being promoted.

Safeguarding

Safeguarding Adults:
In January 2025 there were 34 Datix categorised as safeguarding adults. Of these 19 were categorised as green, 14 were categorised as yellow and there was one amber incident. There were no red Datix. The most common subcategories of these were domestic abuse, financial abuse and self-neglect.

In addition to the safeguarding adults Datix, there were 30 sexual safety Datix. Of these 25 were green incidents, three were yellow and two were amber. There were no red incidents.

Safeguarding Children:
In January 2025 there were 17 Datix submissions categorised as Safeguarding Children. Eight were categorised as green incidents, Eight categorised as yellow and one was amber. There were no red incidents reported. The most common subcategories of these were child protection and physical abuse.

Complaints

- There were 29 new formal complaints received in January. Of these, four had values and behaviours (staff) identified as a primary reason for the complaint. This is a slight increase from three in December.
- 92% of responses were provided within the six month statutory timeframe, 11 out of 12 responses in January. This is a sustained level of improvement in the complaints responded to within six months.
- At the end of January there were no complaints waiting to be allocated to a complaint officer. This is a reduction from nine at the end of December.
- The Trust received 65 compliments in January.

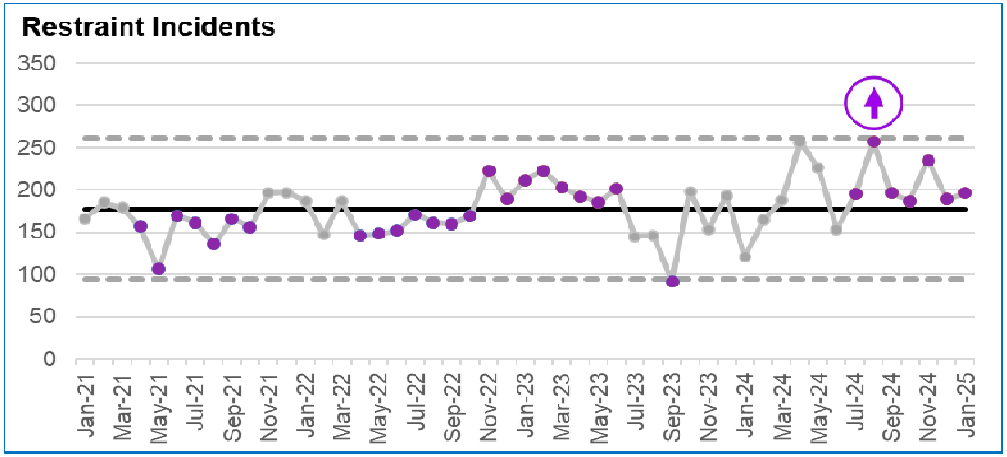
Reducing Restrictive Physical Intervention (RRPI)

• There were 196 reported incidents of Reducing Restrictive Physical Interventions used in January 2025, this was an increase of 7 (3.7%) from December 2024 which stood at 189.
• In January 2025 prone restraint (those remaining in prone position and not rolled immediately) was reported on 10 occasions, a reduction of five (50%) from December 2024.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	126	41.7%
Safety Pod	64	21.2%
Seated	52	17.2%
Supine	33	10.9%
Side	11	3.6%
Restricted escort	7	2.3%
Prone descent then remained in chest down position	5	1.7%
Kneeling	2	0.7%
Prone descent then immediately rolled to other position side/back	1	0.3%
Service User placed self in prone and staff immediately let go or rolled	1	0.3%

Team Using Prone Restraint	Jan-25
Walton PICU	2
Beamshaw Ward - Barnsley	1
Melton PICU, Barnsley	1
Nostell Ward, Wakefield	1

Duration of Prone Restraint	Jan-25
0 - 1 minute	3
1 - 2 minutes	2

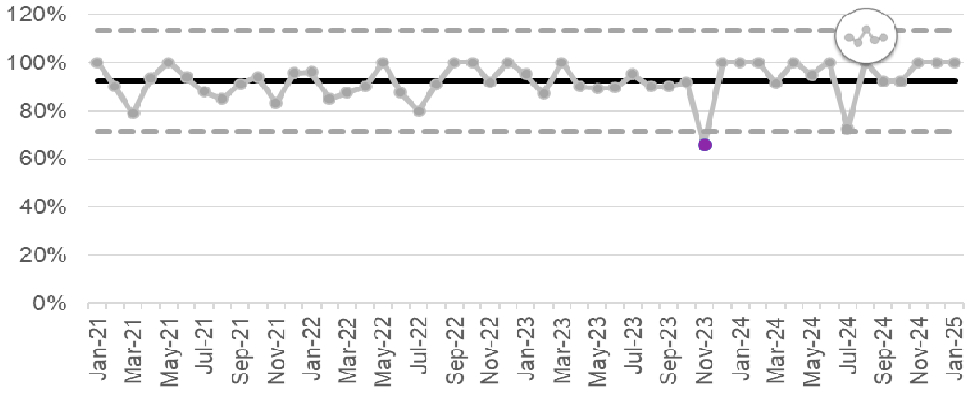


This SPC chart shows that in January 2025 we remain in a period of special cause improving variation (something is happening and this should be investigated).

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

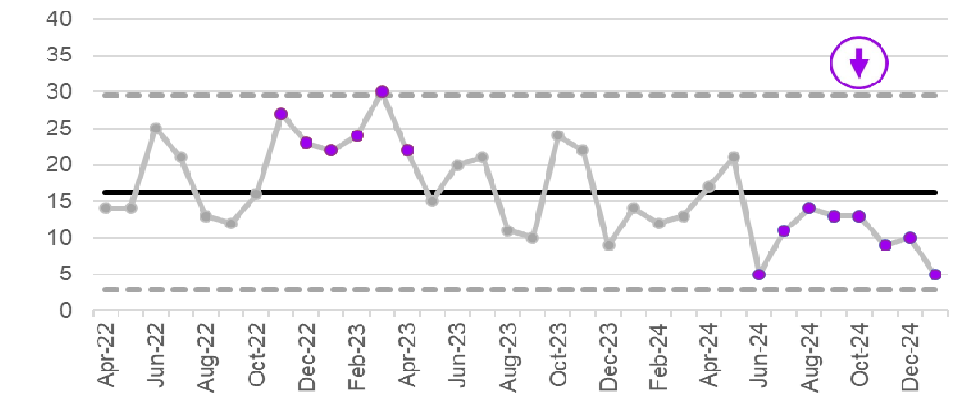
Reducing Restrictive Physical Intervention (RRPI)

Prone Restraint (% Under 3 Minutes)



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.

Prone Restraint (Incident Numbers)



The number of prone restraints has decreased in January. 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	Threshold	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Establishment	Improving Resources	-	5451.4	5460.1	5512.2	5520.5	5524.3	5526.8
Contracted Staff In Post (Ledger)		-	4720.5	4738.8	4738.9	4756.6	4738.8	4746.5
Vacancies		-	730.9	721.4	773.3	763.9	785.5	780.4
Turnover external (12 months rolling)		>12% - <13%	8.0%	8.2%	7.6%	7.7%	7.6%	7.8%
Starters		-	37.4	56.6	40.0	35.7	17.4	48.3
Leavers		-	41.4	51.3	28.6	35.6	30.0	40.7
International Nurse Starters in Month		-	0	0	0	0	0	0
% Bank Fill Rates - Registered Nurses		-	79.3%	80.6%	82.4%	82.2%	79.2%	83.7%
% Bank Fill Rates - Health Care Assistants		-	82.1%	82.6%	80.9%	81.2%	82.6%	82.2%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)		-	92.9%	92.8%	92.6%	91.3%	91.7%	93.6%
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) *		-	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%)	254- All staff (17.8%) 117 - excl medics (9.5%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)		-	996 (70.9%)	998 (70.7%)	1003 (71.2%)	1003 (71.2%)	1013 (71.1%)	1016 (71.1%)
Sickness absence - YTD		<=5% from June 24 was <=4.8%	5.0%	5.1%	5.2%	5.2%	5.3%	5.3%
Sickness absence - Month			5.1%	5.5%	5.5%	5.3%	5.7%	5.5%
Employees with long term sickness over 12 months		-	1	1	4	2	2	2
Appraisals - rolling 12 months		Jun 24 - 89% Jul 24 - 91%	86.7%	89.1%	89.4%	87.9%	85.9%	80.1%
Employee Relations - Suspensions (over 90 days)		-	1	1	1	1	0	0
Mandatory Training - TOTAL	Improving Care	>=80%	93.2%	93.0%	93.0%	93.2%	93.4%	93.6%
Mandatory Training - Reducing Restrictive Practice Interventions			75.8%	76.1%	76.7%	78.4%	80.5%	81.5%
Mandatory Training - Cardiopulmonary Resuscitation			80.7%	82.0%	81.3%	82.2%	82.0%	80.9%
Mandatory Training - Clinical Risk			95.2%	95.3%	94.9%	95.1%	95.1%	96.5%
Mandatory Training - Display Screen Equipment			97.6%	97.9%	97.7%	98.0%	97.9%	98.1%
Mandatory Training - Equality & Diversity			97.0%	96.7%	96.4%	96.5%	96.3%	96.4%
Mandatory Training - Fire Safety		>=85%	90.8%	90.4%	90.5%	90.4%	90.0%	90.6%
Mandatory Training - Food Safety		>=80%	91.0%	92.0%	92.2%	91.4%	91.3%	92.2%
Mandatory Training - Freedom To Speak Up (FTSU)			96.3%	96.5%	96.5%	96.9%	96.9%	97.0%
Mandatory Training - Infection Control & Hand Hygiene			94.6%	94.5%	94.4%	94.9%	94.9%	94.9%
Mandatory Training - Information Governance (Data Security)		>=95%	95.5%	94.7%	94.6%	94.5%	93.6%	93.5%
Mandatory Training - Moving & Handling		>=80%	97.9%	97.7%	97.5%	97.7%	97.7%	97.8%
Mandatory Training - Nat Early Warning Score 2 (New S2)			96.1%	97.0%	97.1%	97.6%	97.7%	98.1%
Mandatory Training - Mental Capacity Act/DoIs			90.7%	90.6%	90.5%	90.6%	91.0%	91.6%
Mandatory Training - Mental Health Act			88.4%	88.1%	87.9%	87.7%	88.5%	90.0%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1			89.0%	89.9%	90.5%	91.4%	92.1%	92.9%
Mandatory Training - Prevent		>=80%	95.0%	95.4%	95.3%	95.5%	95.3%	95.7%
Mandatory Training - Safeguarding Adults			89.2%	90.4%	90.0%	89.9%	91.0%	91.1%
Mandatory Training - Safeguarding Children			95.5%	92.4%	92.4%	92.5%	93.3%	93.6%

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

Staff In Post

• The number of staff in post has increased since last month by 7.2 full time equivalents (FTE). There is a similar increase by Barnsley physical health & wellbeing care group of 8.8 FTE. All other areas remain static.

Vacancies

• Although the total vacancy numbers have remained static, there is a noticeable increase in vacancies for Learning Disability and Attention Deficit and Hyperactivity Disorder of 2.4%.

Turnover

• Turnover continues to increase slightly, now at 7.8%.

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)

• Overall sickness has decreased slightly from 5.7% (Dec) to 5.5% (Jan) with Barnsley having the largest decrease from 6.0% (Dec) down to 4.5% (Jan).
• The sickness absence position is higher than the same period last year where the absence rate was 5.1% but the Trust continues to benchmark well amongst peers.
• The three main reasons for episodes of sickness in January 25 are; 241 Episodes of Colds & flu (268 Jan 24), 171 Episodes Anxiety / Stress (161 Jan 24), 134 Episodes Gastro (125 Jan 24).
• Although Gastroenteritis maintains the same number of episodes since last month, Colds & Flu and Anxiety / Stress are decreasing since last month, with a marked improvement in Colds & Flu down from 288 episodes (Dec) down to 241 (Jan).
• Barnsley's long term sickness has improved from 4.0% (Dec) down to 2.8% (Jan). Though long term sickness within the urgent crisis response and community Continence and urology teams are both above 10% - this is being managed in line with the Trusts sickness absence policy.

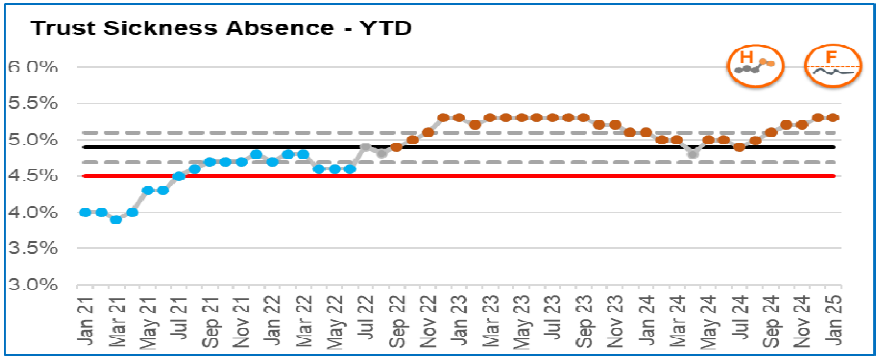
Appraisal Compliance

• Following the technical issues we reported last month, the Trust has moved to recording all appraisal data onto its electronic staff record (ESR) system. During the month, data has been successfully migrated from WorkPal to ESR and historic data transfer continues with this expected to be complete by end March 25.
• We did anticipate a drop in performance during this period and a local trajectory for performance has been set and this will be measured against from next month.
• Additionally, the Trust are exploring a daily refresh of the ESR data which will assist with compliance monitoring.

Training Compliance

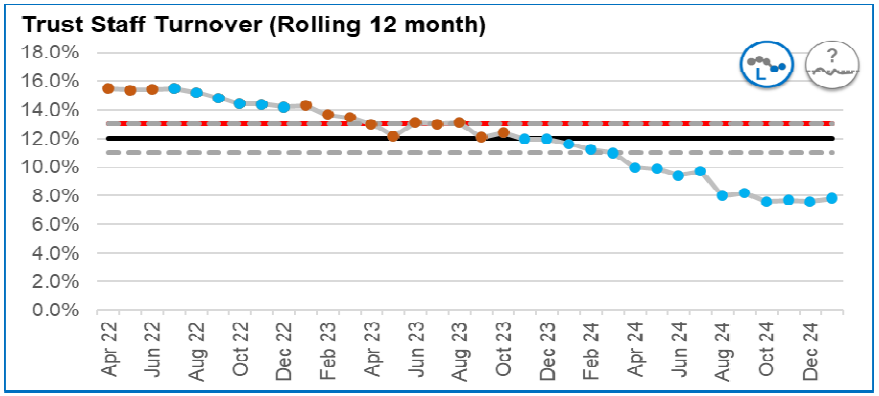
• Training compliance continues to increase steadily - now 93.6% with some hotspot areas which can be seen in the care group section of the report. Overall focus remains on the under performance for information governance training which is being managed within Care Groups.

Statistical process control charts

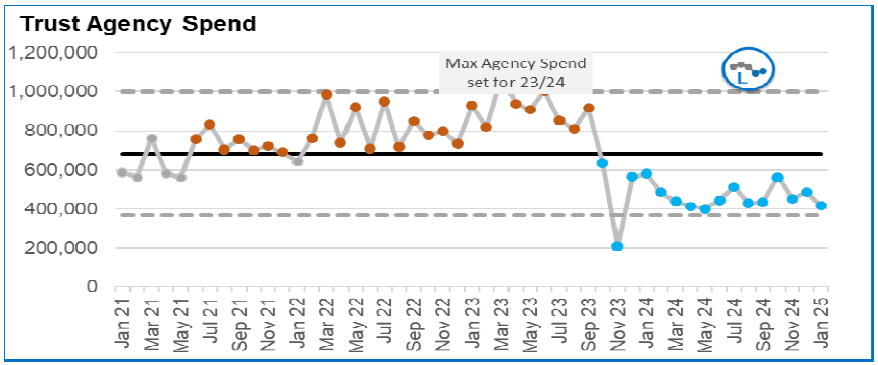


The SPC chart shows that in January 2025 we remain in a period of special cause concerning variation (something is happening and this should be investigated).

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



The SPC chart shows that in January 2025, 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 January 2025 we remain in a period of special cause improving variation.

See the Finance Report for further information.

National Metrics

Data as of : 20/02/2025 15:59:45

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	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
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	74	138	119	62	114	111	124	138	96	131	127	106
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	P	H	93.2%	94.1%	87.5%	90.3%	92.7%	91.7%	86.2%	90.3%	97.6%	91.8%	96.7%	87.2%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?	L	53.9%	52.9%	52.3%	52.7%	51.1%	50.9%	50.9%	54%	54.1%	54.5%	52.3%	55%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P		99.9%	99.9%	100.0 %	100.0%	99.9%	99.7%	99.5%	99.5%	99.2%	99.0%	98.2%	97.2%
M7	72 hour follow-up from psychiatric in-patient care		80%	?	L	92%	87.5%	94.6%	89.8%	89%	91.2%	91.0%	94.9%	89.9%	93.5%	93.9%	92.4%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?	L	28	8	29	13	1	5	5	0	0	1	0	1
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?	L	1	2	1	2	1	3	1	0	0	1	0	1
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	98.7%	99.0%	99.3%	99.0%	98.7%	99.3%	99.4%	99.0%	98.7%	98.6%	97.8%	98.7%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P	H	100%	99.8%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?	H	66.7%	100%	n/a	100%	100%	50%	100%	100%	100%	100%	100%	85.7%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?		97.3%	97.2%	97.5%	94.1%	96.6%	100%	87.5%	84.8%	88.9%	76%	55.6%	71.8%
M15	Data Quality Maturity Index		95%	P	L	99.4%	99.4%	99.3%	99.5%	99.5%	99.4%	99.5%	99.5%	99.6%	98.4%	98.4%	98.0%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P		99.4%	98.6%	99.0%	99.0%	99.8%	99.1%	99.3%	100%	99.0%	99.1%	99.2%	99.7%
M30	Number of detentions under the Mental Health Act (MHA)					83	100	92	101	98	106	104	97	93	118	95	90

National Metrics

Data as of : 20/02/2025 15:59:45

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					16.9%	16%	17.4%	23.8%	26.5%	24.5%	25%	10.3%	22.6%	20.3%	21.1%	22.2%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			97.1%	96.2%	97.3%	96.4%	96.1%	96.7%	96.9%	96.6%	96.5%	96.8%	98.0%	97.5%
M34	% Clients in settled accommodation	⚠	60%	P	L	84.2%	83.5%	83.4%	83.5%	83.2%	83.5%	83.6%	84.0%	83.3%	84.1%	84.4%	84.3%
M35	% Clients in employment	⚠	10%	P	H	13.0%	13.5%	13.0%	13.2%	13.0%	12.6%	12.7%	12.5%	13.1%	13.3%	12.8%	12.5%
M41	Completion of a valid NHS number		99%	P		99.7%	99.7%	99.9%	99.9%	99.9%	99.5%	100.0%	99.5%	100.0%	100.0%	100.0 %	100.0 %
M42	Completion of ethnicity coding for all service users		90%	P	H	96.9%	100.0%	99.5%	99.5%	99.4%	100.0%	99.4%	100.0%	99.5%	99.6%	99.5%	99.6%
M43	Community health services two hour urgent response standard		70%	P	H	87.8%	88.3%	92.8%	89.7%	89.9%	92.0%	91.6%	91.6%	90.9%	88.1%	89.2%	90.7%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500			1559	1336	1661	1589	1618	1963	1579	1804	2022	1851	1603	1948
M47	Virtual ward occupancy		80%			95.7%	101%	82.7%	94.3%	81.4%	91.4%	70%	82.9%	86.7%	112%	103%	101%
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	14385	14288	14129	14109	13997	13940	13774	13661	13589	13574	13362	13428
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months				L	10594	10589	10444	10486	10466	10425	10365	10321	10246	10313	10329	10384
M171	% Admissions gate kept by crisis resolution teams		95%			98.8%	95.7%	98.8%	98.1%	95.6%	97.4%	97.9%	97.5%	100%	97.8%	100%	100%
M178	Talking Therapies - Reliable Recovery					50.7%	50.4%	50.4%	50.4%	48.5%	47.8%	49.7%	50.8%	52.2%	52.5%	50.6%	52.5%
M179	Talking Therapies - Reliable Improvement					69.4%	64.6%	69.7%	68.0%	69.3%	66.2%	68.9%	70.4%	71.0%	68.5%	68.4%	68.9%
M181	Women Accessing Specialist Community Perinatal Mental Health Services					1214	1188	1209	1221	1217	1233	1249	1305	1421	1519	1566	1642
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)					4	5	2	3	4	3	4	4	4	5	4	3
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			1843	1745	1822	1967	1789	2061	1845	2088	2167	1869	1708	1920
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment					631	486	604	572	527	554	544	517	677	585	510	634
M188	Community services waiting list, over 52 weeks					9	5	4	2	5	2	0	0	0	1	1	1

National Metrics

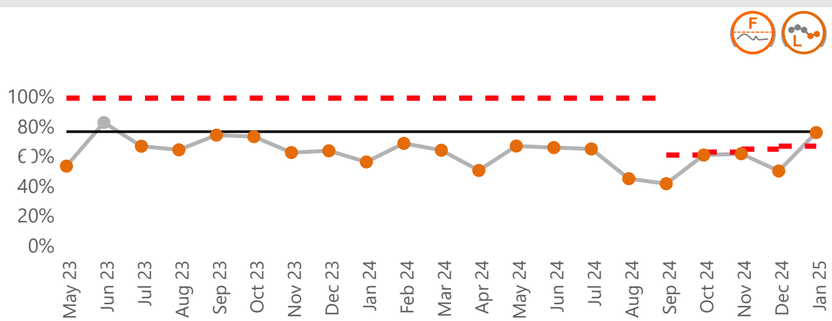
Data as of : 20/02/2025 15:59:45

NHS South West Yorkshire Partnership NHS Foundation Trust

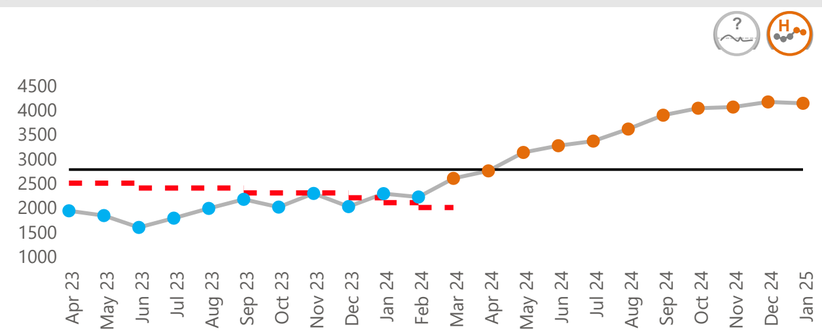
The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.

• The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks has increased in January to 75.8%, remaining below the national threshold of 99% but above the new locally set trajectory for improvement which is 66.7% in January. The service has been significantly impacted by staff sickness absence since late July. The service continues to explore options and introduce changes to increase hearing testing capacity and has appointed a trained audiologist to the service on a temporary basis via our Trust Bank.
• There was one admission for one night for an under 18 year old to an adult acute mental health bed during January.
• The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks is 71.8% in January - this relates to 11 service users who were not seen of which 10 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 has dipped to 85.7% in January, which is below the 95% threshold but only relates to one service user not seen in one week (service user was seen in 8 days).
• 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 101% for January.
• 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.

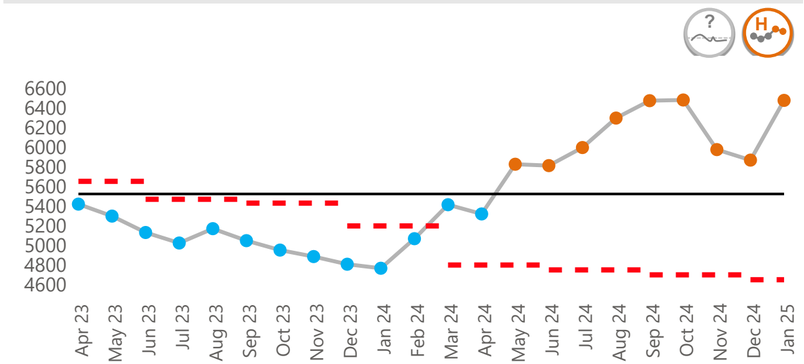
M6 - Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)

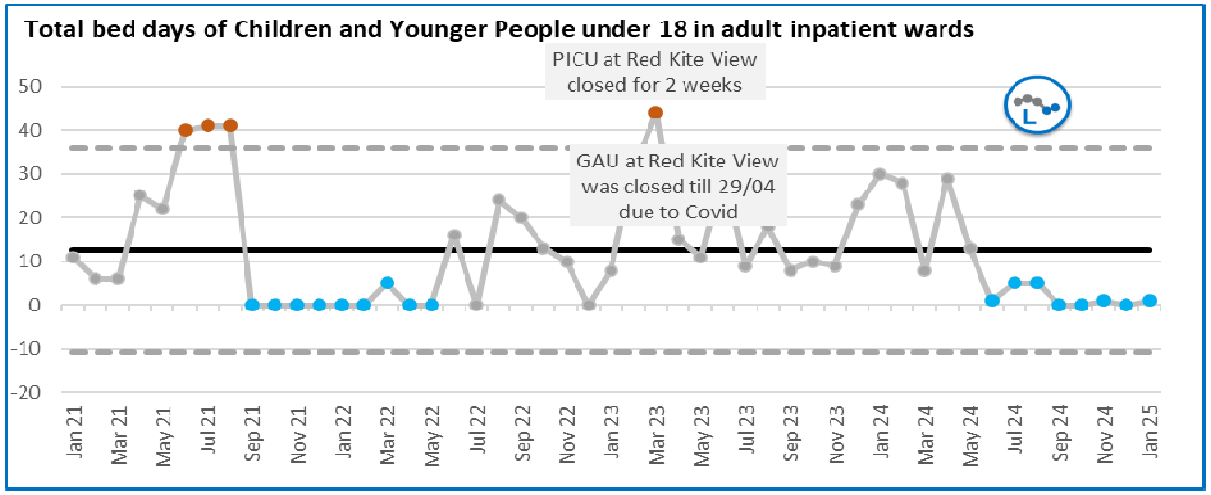


M45 - The number of incomplete Referral to Treatment (RTT) pathways

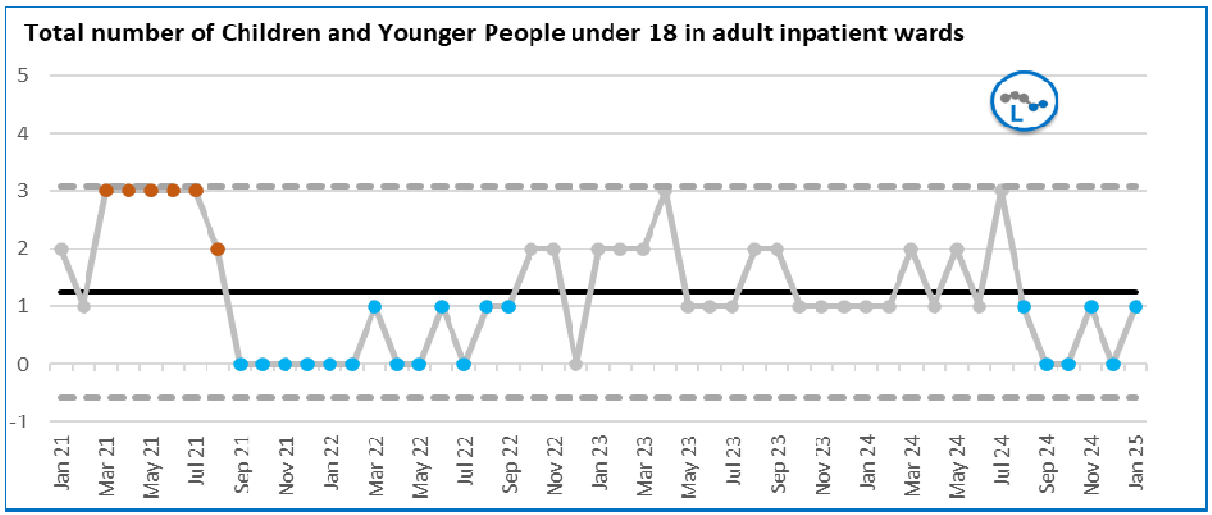


M48 - Community services waiting list





The statistical process control chart (SPC) shows that in January 2025 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.



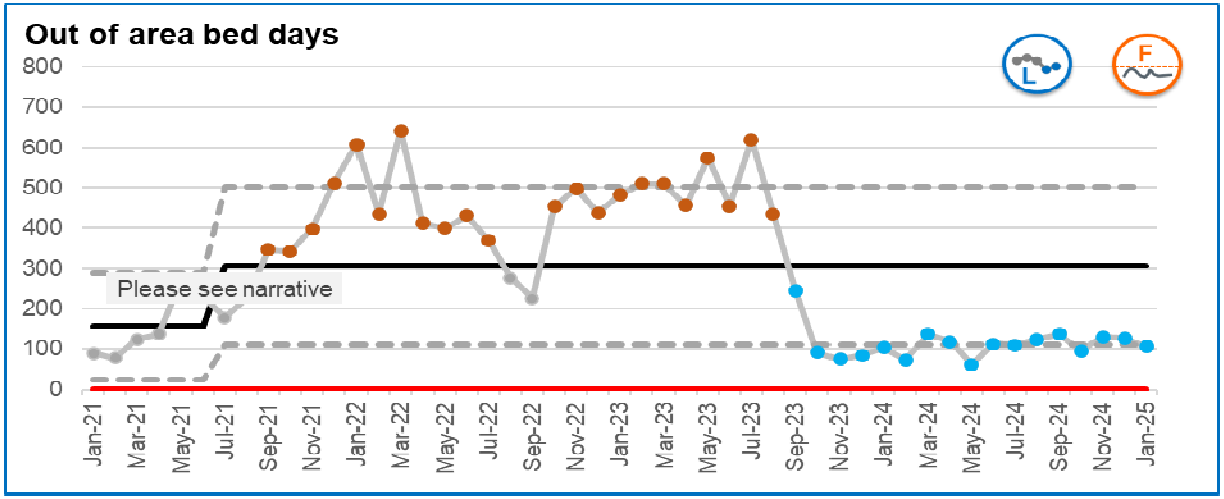
One person aged under 18 was admitted to an adult inpatient ward in January 2025. Whilst the SPC chart shows us that this is an improving position when we compare it to the range of admissions we have had in the past, it is recognised that any admission of an individual under 18 is due to the national 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 January the following data quality issue has been identified in the reporting:

- The reporting for employment and accommodation shows 15.5% 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

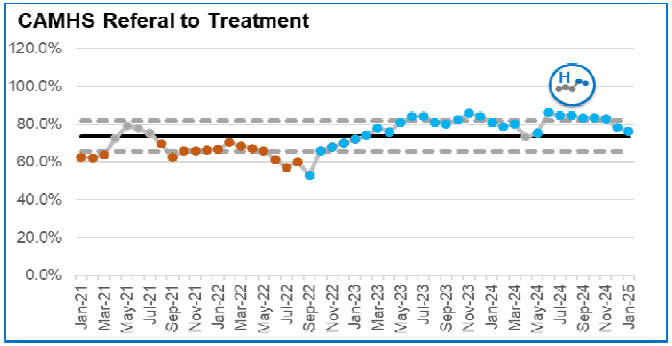
Headlines

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	Nov-24	Dec-24	Jan-25	Variation/ Assurance
% Appraisal rate	>=95%	90.8%	90.2%	81.2%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/4)	0% (0/0)	0% (0/5)	
% of staff receiving supervision within policy guidance	80%	85.8%	83.6%	86.7%	
CAMHS - Crisis Response 4 hours	N/A	100.0%	100.0%	91.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.2%	84.0%	79.6%	
Eating Disorder - Routine clock stops	95%	76.0%	55.6%	73.7%	
Eating Disorder - Urgent/Emergency clock stops	95%	100.0%	100.0%	85.7%	
Maximum 6 week wait for diagnostic procedures	99%	61.8%	49.5%	75.8%	
Information Governance training compliance	>=95%	96.2%	94.6%	94.9%	
Reducing Restrictive Practice Interventions training compliance	>=80%	72.4%	76.4%	77.3%	
Sickness rate (Monthly)	5.0%	4.4%	4.3%	4.7%	

**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 January 2025, 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

- Calderdale & Kirklees CAMHS - The performance of Kirklees and Calderdale CAMHS continues to require additional support. There are more patients waiting, for longer periods and some of the waiting time key performance indicators are consistently not being met. The team have been working hard to address these performance challenges and discussions are taking place with the Executive Team and the integrated care boards at place commissioners.
- Calderdale & Kirklees CAMHS - Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental (ND)I) diagnostic assessment in Calderdale/Kirklees remain problematic in that due to the model of commissioning, batched referrals coming through the single point of assessment (SPA) has created longer waits. This has been recorded on the risk register and remedial actions are in progress.
- Calderdale & Kirklees CAMHS - Calderdale ND assessment proposal has now been completed and will be submitted to the executive management team and then commissioners for consideration.
- Barnsley CAMHS - Staff turnover has increased due to the recent management of change work that has been undertaken in the CYP&F care group. However these staff have been retained within the Trust.
- Wakefield CAMHS - Locum doctor is required in ReACH team due to delayed overseas recruitment and service risk. This places significant financial pressure on the service
- Eating disorder performance continues to fluctuate, this is due to the impact of the Avoidant restrictive food intake disorder (ARFID) pathways and undefined reporting processes. These are being explored with NHS England. 6 out of 7 urgent cases were seen within the one week standard during the month. Once case was seen just outside the standard, at 8 days, multiple attempts to contact the family to arrange appointment were unsucessful and therefore impacted the wait to appointment.

Advise

- Mandatory training i.e. information governance, cardiopulmonary resuscitation and reducing restrictive practice Interventions are slightly below thresholds as at January 25 with remedial actions in place.
- Calderdale & Kirklees CAMHS - ADHD medication requests continue 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 across all CAMHS services 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 CAMHS - waiting numbers have increased on the brief intervention pathway. An initial review of causation suggests that we have accepted more patients onto this pathway on a gradual increase year on year. This pathway has been impacted by sickness and increased demand.
- Wakefield CAMHS - Potential breach situation in eating disorder team. This has been managed and is under close review.
- Wakefield CAMHS - Referrals into SPA remain high. This month activity has spiked – mirroring picture for last year in early February.
- Wakefield CAMHS - CORE wait is now at 17 weeks. Factors relating to this include vacancies, supporting PIT in Business Continuity. Recovery plan in place and fully recruited. Expected to fall below 12 weeks once again within next month or so.
- Calderdale & Kirklees CAMHS – Kirklees Single Point of Access and Entry Pathway discussions and mapping continuing. Contracting are supporting this process. There is a potential need to divert resources from elsewhere in Kirklees CAMHS provision to provide clinical oversight into Entry Pathway. This will impact capacity/ activity within areas where resources may move and will be fully risk assessed.
- Paediatric Audiology - there has been a significant improvement in our performance against the 6 week wait for diagnostic procedures metric. This is an improving position having moved from 49.5% last month to 75.8% as at end of January.
- Appraisal performance has fallen. However, this is likely to be a recording issue linked to the technical issues experienced with WorkPal and the transition onto a new system (ESR). Teams are working hard to meet the 95% target and are manually recording via ESR.

Assure

- Sickness across the Care Group is currently at 4.67% which is below the overall Trust sickness rate of 5.61%. These are largely short-term winter related illnesses e.g. coughs, colds and gastro systems.
- Mandatory training performance for the care group is on target against Trustwide performance.
- Barnsley CAMHS - Deeper Dive of Brief Intervention Pathway and Branching Minds underway to look at efficiency of the pathway and any immediate improvements that can be made.

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, although this has reduced from 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	Nov-24	Dec-24	Jan-25	Variation/ Assurance
% Appraisal rate	>=95%	91.3%	90.1%	85.6%	
% Assessed within 14 days of referral (Routine)	75%	80.2%	78.6%	74.2%	
% Assessed within 4 hours (Crisis)	90%	95.3%	100.0%	97.7%	
% of feedback with staff values and behaviours as an issue	< 20%	20% 2/10	66% 2/3	30% 3/10	
% of staff receiving supervision within policy guidance	80%	85.3%	83.0%	85.0%	
% service users followed up within 72 hours of discharge from inpatient care	80%	93.5%	94.0%	92.4%	
% Service Users on CPA with a formal review within the previous 12 months	95%	96.0%	97.9%	97.3%	
% Treated within 6 weeks of assessment (routine)	70%	94.5%	95.2%	91.7%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.1%	77.8%	76.7%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	77.2%	78.0%	*68.5%*	
Information Governance training compliance	>=95%	95.4%	95.2%	94.2%	
Reducing Restrictive Practice Interventions training compliance	>=80%	74.6%	77.0%	78.9%	
Sickness rate (Monthly)	5.0%	5.0%	5.1%	5.6%	

Mental Health Inpatient

Metrics	Threshold	Nov-24	Dec-24	Jan-25	Variation/ Assurance
% Appraisal rate	>=95%	90.1%	88.0%	73.2%	
% Bed occupancy (excl leave)	85%	90.4%	92.3%	91.4%	
% of feedback with staff values and behaviours as an issue	< 20%	56% 10/18	14% 1/7	0% 0/3	
% of staff receiving supervision within policy guidance	80%	93.0%	84.9%	79.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.0%	88.6%	86.9%	
% of clients clinically ready for discharge	3.5%	4.8%	3.4%	6.0%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	93.8%	94.9%	*86.5%*	
Inappropriate Out of Area Bed days	155 (Dec)	131	127	106	
Information Governance training compliance	>=95%	96.2%	96.1%	95.2%	
Physical Violence (Patient on Patient)	Trend Monitor	13	14	20	
Physical Violence (Patient on Staff)	Trend Monitor	40	57	53	
Reducing Restrictive Practice Interventions training compliance	>=80%	86.6%	87.8%	87.2%	
Restraint incidents	Trend Monitor	171	133	*119*	
Safer staffing (Overall)	90%	141.1%	135.0%	135.9%	
Safer staffing (Registered)	80%	107.1%	102.6%	103.4%	
Sickness rate (Monthly)	5.0%	6.5%	7.2%	6.4%	

Alert/Action

• Acute wards have continued to manage high levels of acuity. An admission of a child to our adult ward areas, has presented additional challenges in terms of safeguarding and necessary support and intervention.
• High occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• There continues to be people who are clinically ready for discharge but are delayed, particularly on some of our Older People's wards. This is an area of focus as part of the priority programme work and is being addressed with the ICB's through the Multi-Agency Discharge Event (MADE) meetings as well as a weekly Director of Services led challenge meeting with general managers.
• Workforce challenges have led to continued use of temporary staffing, primarily bank. Throughout January acute wards have worked above establishment. This is closely monitored by senior managers on a daily basis with action plans to address.
• 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 (IHBTT), and community teams is triangulated and monitored.
• Intensive Home-Based Treatment teams in Calderdale and Kirklees are experiencing ongoing workforce challenges, recent recruitment has indicated some improvement, however challenges remain.
• Gatekeeping assessments from our IHBTTs prior to an acute inpatient admission continue to be above 90%, following a manual check for exception reporting where the gatekeeping has come via a mental act health assessment.
• All areas are focussing on continuing to improve performance for FIRM risk assessments. Staying safe plans are now captured as part of the Inpatient My Care and Safety Plan, rather than the FIRM risk assessment, following the changes to care plans that went live on 6th January.
• The staying safe percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions and January's compliance is impacted further by ward teams adjusting to the new layout and format of care plans. 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 go live of the new mental health care plan has negatively impacted on this metric reporting, in part due to clinical staff adapting to the new requirements of where and how to record items measured in the metric, and some changes to care programme approach recording.
• 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. System issues are impacting on accuracy of reporting, including exclusion data (e.g. sickness, contract changes) only being updated on ESR monthly. Proxy user access not being functional throughout January also impacted and only ward/team managers could log appraisals, leading to recording delays in their absence.
• Ward/team managers are also working to ensure the backlog of completed paper appraisals from December into January are recorded on ESR and we are now continuing to proactively flagging appraisals that are due to go out of date in the next 30 days to aid planning.
• Inpatient appraisal and supervision completion is lower in January due to sickness levels and clinical pressures, specific actions are in place. January data is also affected by the downtime from WorkPal, the migration to ESR and managers getting to grips with the new way of recording.
• 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 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) 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.

Advise

• Improvement work is underway to understand the capacity and demand pressures on inpatient services and is monitored via the Inpatient Priority Programme. In addition, there is a focus on implementing the culture of care standards to improve the therapeutic nature of inpatient care for both service users and staff.
• 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 and crisis alternatives, trauma informed care and effective intensive home treatment.
• Both Barnsley and Kirklees Talking Therapies achieved the recovery rate national standard in January 2025 (Barnsley 50.68% and Kirklees 59.41%) against the national agreed target of 50%. Both services were over the expected national standard of less than 10% for waits to second treatment within 90 days (Barnsley 11.68% and Kirklees 11.08%), but as this is a year-end expectation the services will meet target by end of Q4. The national position for December 2024 was 21.7%.
• 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 Trustwide 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 EIAs in some areas have been due to manager changes/sickness and the service line trios are supporting the teams in their completion.
• Equality data – we are working with a Trustwide 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 5 incidents of prone restraint in January, 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 Interventions, safeguarding teams and matrons, review all prone restraint incidents for any opportunities for learning.

Assure

• IHBT teams continue to perform well in gatekeeping admissions to our inpatient beds. We are working to understand where issues maybe for specific teams.
• The care group is performing well in 72 hour follow up for people discharged into the community at 92.1% for January.
• 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 January position remaining 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	Nov-24	Dec-24	Jan-25	Variation/ Assurance
% Appraisal rate	>=95%	81.1%	85.4%	78.7%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/5)	0% (0/4)	25% (1/4)	
% of staff receiving supervision within policy guidance	80%	86.3%	88.8%	85.8%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	60.8%	55.6%	60.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.5%	84.8%	88.2%	
% of clients clinically ready for discharge	3.5%	80.0%	90.1%	80.0%	
Information Governance (IG) training compliance	>=95%	91.1%	91.5%	94.9%	
% 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%	95.1%	96.8%	96.8%	

LD, ADHD & ASD

Metrics	Threshold	Nov-24	Dec-24	Jan-25	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	12	27	44	
Reducing Restrictive Practice Interventions training compliance	>=80%	83.5%	84.0%	88.2%	
Safer staffing (Overall)	90%	164.7%	162.4%	167.7%	
Safer staffing (Registered)	80%	135.9%	154.4%	163.9%	
Sickness rate (Monthly)	5.0%	5.8%	5.0%	5.5%	
Restraint incidents	Trend Monitor	29	27	*39*	

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

Alert/Action

ADHD
Pathway innovations - SWYPFT Service has over 6400 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 can 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 is also considering a similar approach to Kirklees.
• The number of people currently waiting and the longest waiting time varies by Place. There are a number of factors that affect these including the referral rate for each Place, the number of transitions from children's services, engagement rates of those we invite for assessment (some people decide they no longer want to be assessed or have sought a diagnosis from another provider since referral), recurrent investment in the Adult ADHD service and historic investment to reduce or clear waiting lists.
• We are beginning to see and increase in referrals following the closure to new referrals of the Leeds adult ADHD service.

Autism
The Adult Autism pathway already includes screening and/or triage in four of the five Places. Calderdale Place did include this step until the launch of their Any Qualified Provider (AQP) framework on 1st May 2023. The Service was required to deliver services in a similar way to other providers but there has been an increase in waiting times.
Integrated care board investment for the Calderdale Autism Screening and Triage pathway has since been reallocated to the Autism Assessment pathway increasing capacity for assessment from 30 to approx. 55 cases per year, but as demand is more than 3 times service capacity, there is a building waiting list. When the service was determining clinical appropriateness, waiting times for assessment were less than 12 weeks as it currently is for Barnsley, Kirklees and Wakefield.

Advise

NHSE - has set up a group to better understand the Regional Challenges in relation to ADHD assessments both in Children & Young People and adults. It is creating a list of priorities, and our Trust is actively engaged offering solutions.

West Yorkshire Integrated Care Board Neurodiversity Project
The plan to have an agreed model for Patient Choice in place for April 2025 is looking likely to be postponed for now. The intgrated care board continues to work on contractual frameworks and service specifications.

ADHD Medication
National shortage of medication is having a direct impact on the service as primary care often refer into the service for an alternative prescription.

Shared Care Arrangements
The Adult ADHD Service has previously entered Shared Care with all GP referrers when appropriate. GPs report facing increased pressures related to ADHD medication. The service are working with integrated care board colleagues to identify long term solutions for ADHD medication where cases have shared care arrangements with primary care..

Assure

- All key performance indicator targets met.
- Relationship with Bradford working very well. Bradford now has similar waits to Barnsley, Kirklees and Wakefield. This is because the project to clear patients from a Bradford District Care Trust legacy waiting list has been completed.
- Excellent levels of supervision and appraisal.
- Low level of vacancies.
- Results from our Friends and Family test survey reported that 81% of service services users would reccomend the Trusts services.
- 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. Focused interventions are now in place to support the service to reach the threshold.
- Supervision performance has also improved overall reaching the required threshold.
- '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. Work on waiting well and fairly continues to progress.
- Community Teams – reporting an increase in LD service users in crisis creating some operational pressures.
- 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)
- Three service users are clinically ready for discharge. Best interest meeting for one service user has been held and preferred placement has now gone to social care panel for approval.
- Three new service users admitted taking up to 6 beds occupied - staffing levels are at their highest for a while - 16 on days and 14 on nights

Advise

Learning Disability (LD)
- 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.
- Friends and Family Test – 100%
- Sustained efforts to increase improvement in waiting times continues to progress.

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 March 2025 to accommodate forward booking of outpatient activity. This remains on the local risk register. This is having an impact on the full-service offer and may lead to an impact on the 18-week Referral to Treatment target (RTT).

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Nov-24	Dec-24	Jan-25	Variation/ Assurance
% Appraisal rate	>=95%	90.4%	87.9%	78.9%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/1)	0% (0/1)	0% (0/5)	
% people dying in a place of their choosing	80%	97.3%	95.0%	86.2%	
% of staff receiving supervision within policy guidance	80%	86.2%	86.4%	81.1%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.2%	83.7%	83.0%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	0.0%	

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Nov-24	Dec-24	Jan-25	Variation/ Assurance
Information Governance (IG) training compliance	>=95%	95.1%	94.2%	93.7%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.0%	98.2%	97.2%	
Safer staffing (Overall)	90%	112.4%	107.1%	109.3%	
Safer staffing (Registered)	80%	123.7%	121.3%	125.5%	
Sickness rate (Monthly)	5.0%	5.4%	6.0%	4.8%	

**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 March 2025 to accommodate forward booking of outpatient activity. This remains on the local risk register. Work scheduled on Priory Day centre in June 2025 with estates, further negotiation under way with Priory Campus owners to extend this temporary fix further 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).

Advise

• Information Governance training has seen a small dip remaining slightly below compliance for January at 93.7%; plans in place to target staff that are non-compliant.
• Appraisals - for January the figure is showing as 78.9% but this has been impacted by gaps in data flow.

Assure

• Staff receiving supervision - continues to receive focus with a drive to improve recording. We continue to achieve compliance for January at 81.1%.
• Sickness rates have improved during January and the care group is now achieving compliance target at 4%.
• Urgent Community Response Service 2-hour target is 90.7% as at end of January 2025 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) – 97.2% as at January 2025.
• Friends and Family Test (FFT) 97% of people would recommend community services.
• 86.21% of people dying in their place of choosing in January 2025; this remains consistently above the threshold of 80%.
• Cardiopulmonary resuscitation training maintains compliance at 83% for January.
• Virtual Ward occupancy rate has reduced slightly this month but is still above target of 80% at 101% for January. Virtual ward continues to support early supported discharge and hospital avoidance to support system pressures, reviewing capacity daily.
• Intermediate Care new interim model – 94% of posts have now been recruited to with the majority of staff already in post. There are only three posts left to recruit to; two are currently out to advert and the remaining post has interviews taking place week commencing 10 February 2025.
• Positive feedback noted in The View 10.1.25 in reference to staff efforts during adverse weather on 5.1.25 and subsequent days; ensuring priority patients received the care they needed.
• Friends and Family Test – text messaging went live for our care group on 6 January 2025; patients will now have the option to complete the survey via a text link.
• PurposeT – a trial of the new Pressure Ulcer Risk Assessment tool went live for a number of our services on 13 January 2025. The plan is for further services to follow. This will be evaluated after a 3 to 4 months trial to determine whether Purpose T is appropriate to replace the existing Waterlow assessment.
• Experience of the Workplace event held 14 January at Kendray – 30 Year 9 students from Barnsley Academy spent the day learning about different AHP (Allied Health Professional) careers in the NHS; the event received excellent feedback from both pupils and teachers.

Forensic Care Group

Headlines

The monthly sickness rate continues to be ablove threshold but has improved slightly in January (7%) compared to December (7.1%) - 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	Nov-24	Dec-24	Jan-25	Variation/ Assurance
% Appraisal rate	>=95%	81.5%	74.7%	74.0%	
% Bed occupancy (incl leave)	90%	84.7%	84.4%	82.9%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/0)	0% (0/1)	0% (0/2)	
% of staff receiving supervision within policy guidance	80%	91.3%	85.8%	86.1%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	99.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.1%	82.1%	80.8%	
% 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%	94.4%	92.6%	93.5%	
Physical Violence (Patient on Patient)	Trend Monitor	2	3	6	
Physical Violence (Patient on Staff)	Trend Monitor	6	5	9	
Reducing Restrictive Practice Interventions training compliance	>=80%	82.7%	86.1%	85.6%	
Restraint incidents	Trend Monitor	18	21	*16*	
Safer staffing (Overall)	90%	122.5%	115.7%	108.2%	
Safer staffing (Registered)	80%	109.9%	101.1%	100.4%	
Sickness rate (Monthly)	5.4%	6.2%	7.1%	7.0%	

Alert/Action

• **Bed Occupancy** – Newton Lodge 86.42%, Bretton 83.28%, Newhaven 62.5%. Underoccupancy in medium secure due to empty beds within LD and Women's services where there are no waiting lists. There has also been some turnover in the male pathway. Underoccupancy in Bretton Centre is due to recent discharge activity and beds are identified for admissions awaiting transfer paperwork.
• **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. Ward summary data indicates an improvement in 6 out of 7 medium secure wards and 2 out of 4 low secure wards.
• **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 – 92.5%, Bretton – 92.4%, Newhaven –94.6%
Each service line is compliant with all mandatory training except for one are as follows: Newton Lodge- Fully compliant for all mandatory training. Fire training is face to face. Bretton Centre- Fully compliant for all mandatory training. Fire training is face to face. Newhaven - Information Governance is at 94.4% all other training reaching compliance thresholds.
• 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.
• Sickness – Overall increase but more profound in low secure, activity underway to explore.

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%.
• Care Programme Approach 100%

Inpatients - Mental Health - Working Age Adults

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

Appraisal

• Ward managers continue to complete appraisals on paper forms and are now recording them on ESR.
• System issues are impacting on accuracy of reporting, including exclusion data (e.g. sickness, contract changes) only being updated on ESR monthly. Proxy user access not being functional throughout January also impacted and only ward managers could log appraisals, leading to recording delays in their absence.
• Ward managers are also working to ensure the backlog of completed paper appraisals from December into January are recorded.
• Sickness levels and increased clinical acuity have impacted on appraisal performance with some scheduled appraisals needing to be rearranged.
• Beechdale achieved the 95% target.
• Beamshaw, Clark, Melton, Nostell, Walton, Elmdale, Crofton, Poplars, Willow and Enfield Down appraisal compliance is below threshold in January but is above 70%. Service managers continue to work closely with ward managers to ensure completed paper appraisals are recorded and outstanding appraisals are booked.
• Ward 18 appraisal compliance is impacted by ward manager absence – appraisals have been completed on paper forms but have not been able to be recorded on ESR due to functionality issues with proxy user access.
• Ward 19 (male) and Ward 19 (female) reduction in reported appraisal compliance in January is a consequence of the change from WorkPal to ESR recording and compliance in February is at 95.7% and 100% respectively.
• Similarly, Lyndhurst reduction in appraisal compliance (23.3%) is also because of the change from WorkPal to ESR recording. A high number of appraisals were due after WorkPal ceased being operational and the ward manager completed these on paper forms but was unable to record them. Compliance in February is at 80% and the ward manager is prioritising outstanding appraisals with close oversight from the service manager.
• Stanley (47.8%) and Ashdale (54.5%) performance has dropped in January. Performance of both wards has improved in February although is still below compliance threshold and the ward managers are prioritising outstanding appraisals with close oversight from the service manager.

Sickness

• Sickness improved to below threshold in January on Ward 19 (female) following the return to work of two staff from long term sickness.
• Elmdale have seen an increase to slightly above threshold (5.2%) due to short term sickness.
• Walton and Crofton sickness remains above threshold and continues to be impacted by a combination of long and short-term sickness, no specific themes.
• A number of wards sickness rates are significantly above threshold:
    • Nostell has seen sickness increase to 14.1% due to long term sickness, 3 of which are registered staff and some of which is work related. Short-term sickness has also impacted.
    • Both Melton and Poplars have seen increases in sickness to 11.8% due to episodes of short-term sickness and ongoing staff long-term sickness. No specific themes on either ward.
    • Ward 18 sickness has slightly reduced to 13.9% but continues to be impacted by long-term sickness which has continued into February as well as some short-term absences.
    • Willow has had a further reduction in sickness but remains high at 13.5% and continues to be impacted by both long and short-term sickness but no specific themes.
    • Similarly, Beechdale sickness has reduced slightly but remains high at 10.7% with the long-term sickness of three staff continuing.
• Ward managers are supported by People Directorate colleagues to actively manage long term sickness. Timely referrals to occupational health are made but the current time from referral being made to staff having their occupational health appointment is approximately 4 weeks.

Supervision

• 10 wards above 80% compliance target.
• Melton, Elmdale, and Stanley 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.
• Ashdale compliance remained static in January (52.6%) but focused work has been undertaken and February's dashboard compliance is currently at 80% (17/02/25).
• Throughout January there has been a notable decline in supervision compliance on Clark (57%), Walton (57.9%) and Ward 18 (66.7%) and service managers and matrons are supporting ward leadership teams to address this. February's dashboard compliance for Clark and Walton is above 80% (17/02/25) and Ward 18 is expected to be above 80% by month end.

Mandatory Training

Information Governance
• Beamshaw (90.5%), Melton (90.9%), Nostell (91.7%). Beechdale (87.8%), and Ward 19 (male & female; both 87.8%) compliance has dropped below threshold in January and ward managers are taking focused intervention to address this.
• Crofton (88.9%) compliance remains under threshold. Action continues to be taken by the ward manager to address this and improvement is noted in February's dashboard data (17/02/25).
• Willow compliance (94.4%) also remains just under threshold and is impacted by long-term sickness.
CPR
• 13 wards are above the CPR training compliance threshold.
• Beechdale (75.4%), Ward 19 (male; 75.3%), and Ward 19 (female; 75.4%) compliance has increased and is above threshold in February's dashboard data (17/02/25).
• Willow compliance is under threshold at 72.2% and booking of staff onto future training dates will be prioritised by the ward manager.
RRPI
• 12 wards are above the RRPI training compliance threshold.
• Walton (78.8%), Beechdale (74.6%), Ward 19 (male; 74.5%), Ward 19 (female; 74.6%), and Enfield Down (79.5%) compliance has increased and is above threshold in February's dashboard data (17/02/25).
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.

Inpatients - Mental Health - Working Age Adults

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

Mandatory Training Continued...
Fire Safety
• Melton (81.8%) and Walton (84.8%) are under compliance and booking of training will be overseen by the ward manager.
• Ward 19 (M; 84.9%); Ward 19 (F; 85%) staff attended fire training sessions in January and are above threshold in February's dashboard data (17/02/25).

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 increased from 17.3% to 22.8% in January. This continues to be reflective of several service users awaiting placements.
• Beamshaw has increased in January to 31.2%. This relates to 4 service users awaiting either placement or supported accommodation. One of these service users has been discharged in February.
• Walton has increased from 0% to 10.8% in January. This relates to 2 service users, who are subject to Section 37/41 and permissions from Ministry of Justice are being awaited.
• 10 other wards are above the threshold for CRFD with Clark, Melton, Nostell, at more than 10%. Stanley, Ward 18, Elmdale, Willow, 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.
• 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
• Staying Safe plans are now captured as part of the Inpatient My Care and Safety Plan, rather than the FIRM risk assessment following the changes to care plans that went live on 6th January.
• Compliance has been impacted whilst ward teams adjust to the care plan changes and Stanley, Walton, Ward 18, Elmdale, and Beechdale each had one Staying Safe breach in January.
• Crofton's performance (62.5%) totals 3 breaches and a deep dive by the matron has identified staff recording the Staying Safe interventions in the wrong place. Guidance to the staff team has been refreshed.
• Nostell's performance (53.8%) totals 6 breaches and is impacted by registered nurse sickness as well as staff recording the Staying Safe interventions in the wrong place. Guidance to the staff team, including the temporary workforce, has been refreshed and the matron is facilitating staff drop-in sessions to support familiarisation with the new care plan.
• 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)
• Five incidents of patient-on-patient physical violence and 13 incidents of patient on staff physical violence at Poplars. Incidents relate to specific service users with behavioural and psychological symptoms of dementia. Risk management care plans are in place and the ward psychologist is supporting with psychological formulation. Trust specialist advice from the Reducing Restrictive Practice Interventions team and safeguarding is also sought as needed.
• Crofton and Beechdale had several incidents of patient-on-staff physical violence throughout January relating to a small number of service users with cognitive impairments and a risk profile of violence and aggression.
• Risk specific care plans are in place to support managing this with input from trust Reducing Restrictive Practice Interventions specialist advisors as needed.
• Staff involved in incidents are supported by ward leadership teams including both managerial and clinical supervision.

Restraint incidents
• Higher number of incidents on Ward 18 is reflective of current patient population and the presentation and risk profile of service users.
• Incidences on Crofton, Poplars, and Beechdale correlate with incidents of physical violence as outlined above.
• Reduction in incidence on Melton is reflective of reduced incidents of self-harming behaviour from a specific service user who is making positive progress in terms of recovery.

Prone restraint incidents
• Five incidents of prone restraint in January, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration.
• This is 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 Trustwide 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	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	88.0%	84.6%	79.2%
Sickness	5.0%	4.2%	1.5%	4.3%
Supervision	80%	81.3%	62.5%	80.0%
Information Governance training compliance	>=95%	91.7%	95.7%	90.5%
Reducing Restrictive Practice Interventions training compliance	>=80%	87.5%	95.7%	81.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.5%	78.3%	85.7%
Fire Safety training compliance	>=85%	95.8%	87.0%	90.5%
Bed occupancy	85%	94.3%	94.9%	94.9%
Safer staffing (Overall)	90%	136.0%	138.7%	141.8%
Safer staffing (Registered)	80%	112.4%	117.1%	116.9%
% of clients clinically ready for discharge	3.5%	14.2%	13.6%	31.2%
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	0	2	3
Restraint incidents	Trend Monitor	2	2	*4*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*1 (100%)*
Unfilled Shifts	Trend Monitor	24	28	18

Clark Suite

Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	90.9%	91.3%	75.0%
Sickness	5.0%	1.7%	1.7%	3.6%
Supervision	80%	91.7%	85.7%	57.0%
Information Governance training compliance	>=95%	91.3%	92.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	96.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	100.0%	96.0%
Fire Safety training compliance	>=85%	95.7%	96.0%	100.0%
Bed occupancy	85%	103.8%	108.8%	103.9%
Safer staffing (Overall)	90%	193.5%	159.0%	156.9%
Safer staffing (Registered)	80%	113.0%	107.2%	109.2%
% of clients clinically ready for discharge	3.5%	6.3%	6.1%	10.4%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	66.7%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	1
Physical Violence (Patient on Staff)	Trend Monitor	0	5	3
Restraint incidents	Trend Monitor	12	15	*3*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	36	32	24

Melton Suite

Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	88.9%	88.9%	84.6%
Sickness	5.0%	4.7%	8.6%	11.8%
Supervision	80%	92.9%	64.3%	71.4%
Information Governance training compliance	>=95%	100.0%	95.8%	90.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	92.0%	91.7%	86.4%
Fire Safety training compliance	>=85%	88.0%	87.5%	81.8%
Bed occupancy	85%	100.6%	100.5%	100.0%
Safer staffing (Overall)	90%	184.6%	177.2%	195.8%
Safer staffing (Registered)	80%	99.1%	98.2%	96.1%
% of clients clinically ready for discharge	3.5%	30.0%	16.4%	16.7%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*N/A*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	9	3
Restraint incidents	Trend Monitor	54	38	*11*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	2 (100%)	2 (100%)	*1 (100%)*
Unfilled Shifts	Trend Monitor	34	39	27

Nostell

Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	100.0%	100.0%	87.0%
Sickness	5.0%	2.7%	9.8%	14.1%
Supervision	80%	87.5%	81.3%	87.5%
Information Governance training compliance	>=95%	96.3%	96.2%	91.7%
Reducing Restrictive Practice Interventions training compliance	>=80%	84.6%	92.0%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.2%	92.0%	87.5%
Fire Safety training compliance	>=85%	92.6%	92.3%	91.7%
Bed occupancy	85%	89.2%	99.0%	90.9%
Safer staffing (Overall)	90%	166.3%	170.0%	156.9%
Safer staffing (Registered)	80%	118.3%	106.0%	108.1%
% of clients clinically ready for discharge	3.5%	9.1%	4.4%	14.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*53.8%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	1
Physical Violence (Patient on Staff)	Trend Monitor	3	7	1
Restraint incidents	Trend Monitor	25	18	*11*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	2 (100%)	1 (100%)	*1 (100%)*
Unfilled Shifts	Trend Monitor	31	34	14

Inpatients - Mental Health - Working Age Adults

Stanley

Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	95.8%	95.8%	47.8%
Sickness	5.0%	3.7%	5.7%	3.4%
Supervision	80%	100.0%	100.0%	75.0%
Information Governance training compliance	>=95%	96.2%	96.0%	96.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	96.2%	96.0%	88.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	100.0%	96.0%
Fire Safety training compliance	>=85%	84.6%	88.0%	92.0%
Bed occupancy	85%	108.9%	99.1%	101.8%
Safer staffing (Overall)	90%	140.8%	125.5%	131.0%
Safer staffing (Registered)	80%	103.0%	97.1%	107.1%
% of clients clinically ready for discharge	3.5%	0.0%	4.0%	8.4%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*92.3%*
Physical Violence (Patient on Patient)	Trend Monitor	0	1	3
Physical Violence (Patient on Staff)	Trend Monitor	0	0	2
Restraint incidents	Trend Monitor	6	4	*8*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	2 (100%)	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	24	14	6

Walton

Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	94.1%	94.3%	85.3%
Sickness	5.0%	8.8%	7.7%	8.4%
Supervision	80%	100.0%	90.0%	57.9%
Information Governance training compliance	>=95%	93.9%	94.1%	97.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	84.4%	72.7%	78.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.5%	78.8%	81.8%
Fire Safety training compliance	>=85%	87.9%	88.2%	84.8%
Bed occupancy	85%	98.1%	101.4%	100.7%
Safer staffing (Overall)	90%	121.9%	136.7%	126.5%
Safer staffing (Registered)	80%	97.8%	92.8%	93.6%
% of clients clinically ready for discharge	3.5%	9.6%	0.0%	10.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	83.3%	*87.5%*
Physical Violence (Patient on Patient)	Trend Monitor	0	4	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	2
Restraint incidents	Trend Monitor	17	5	*4*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	2 (100%)	*2 (100%)*
Unfilled Shifts	Trend Monitor	15	17	5

Ashdale

Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	87.5%	87.5%	54.5%
Sickness	5.0%	2.5%	3.5%	0.4%
Supervision	80%	94.7%	52.6%	52.6%
Information Governance training compliance	>=95%	90.9%	93.9%	97.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	84.8%	87.9%	90.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	93.9%	90.9%	87.9%
Fire Safety training compliance	>=85%	100.0%	100.0%	100.0%
Bed occupancy	85%	97.9%	101.9%	98.0%
Safer staffing (Overall)	90%	129.5%	130.0%	129.7%
Safer staffing (Registered)	80%	116.3%	113.4%	116.7%
% 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%	90.0%	85.7%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	6	3	1
Physical Violence (Patient on Staff)	Trend Monitor	3	5	3
Restraint incidents	Trend Monitor	6	9	*8*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	14	5	9

Ward 18

Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	78.6%	72.0%	56.0%
Sickness	5.0%	7.9%	15.8%	13.9%
Supervision	80%	88.9%	87.5%	66.7%
Information Governance training compliance	>=95%	100.0%	100.0%	95.5%
Reducing Restrictive Practice Interventions training compliance	>=80%	80.8%	87.5%	86.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.8%	87.5%	86.4%
Fire Safety training compliance	>=85%	92.3%	95.8%	90.9%
Bed occupancy	85%	101.3%	97.3%	97.8%
Safer staffing (Overall)	90%	116.2%	112.8%	114.0%
Safer staffing (Registered)	80%	86.8%	81.4%	87.4%
% of clients clinically ready for discharge	3.5%	7.6%	11.0%	8.4%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	94.7%	100.0%	*92.3%*
Physical Violence (Patient on Patient)	Trend Monitor	0	2	1
Physical Violence (Patient on Staff)	Trend Monitor	15	8	4
Restraint incidents	Trend Monitor	18	12	*11*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	12	16	5

Inpatients - Mental Health - Working Age Adults

Elmdale Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	86.4%	90.5%	75.0%
Sickness	5.0%	8.3%	4.4%	5.2%
Supervision	80%	100.0%	75.0%	75.0%
Information Governance training compliance	>=95%	93.1%	96.6%	92.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	93.1%	93.1%	92.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.4%	100.0%	92.6%
Fire Safety training compliance	>=85%	100.0%	100.0%	92.9%
Bed occupancy	85%	99.3%	97.0%	98.4%
Safer staffing (Overall)	90%	149.5%	122.6%	119.5%
Safer staffing (Registered)	80%	106.0%	97.6%	101.9%
% of clients clinically ready for discharge	3.5%	4.9%	4.1%	4.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*92.3%*
Physical Violence (Patient on Patient)	Trend Monitor	2	1	4
Physical Violence (Patient on Staff)	Trend Monitor	6	1	3
Restraint incidents	Trend Monitor	8	10	*2*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	4	5	1

Inpatients - Mental Health - Older People Services

Crofton Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	79.3%	65.5%	89.3%
Sickness	5.0%	3.6%	5.6%	6.9%
Supervision	80%	85.7%	80.0%	93.3%
Information Governance training compliance	>=95%	96.6%	92.6%	88.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	81.5%	84.0%	88.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.2%	84.0%	84.0%
Fire Safety training compliance	>=85%	89.7%	88.9%	88.9%
Bed occupancy	85%	90.0%	104.6%	103.6%
Safer staffing (Overall)	90%	174.4%	160.3%	178.3%
Safer staffing (Registered)	80%	143.4%	143.0%	138.5%
% 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%	63.6%	100.0%	*62.5%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	1	5
Restraint incidents	Trend Monitor	7	2	*9*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	26	28	24

Poplars CUE Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	77.8%	88.9%	84.6%
Sickness	5.0%	5.8%	10.2%	11.8%
Supervision	80%	85.7%	92.9%	92.3%
Information Governance training compliance	>=95%	100.0%	100.0%	96.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	91.7%	91.3%	87.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.2%	95.7%	95.7%
Fire Safety training compliance	>=85%	96.2%	92.0%	96.0%
Bed occupancy	85%	79.3%	80.9%	84.1%
Safer staffing (Overall)	90%	220.1%	228.1%	220.8%
Safer staffing (Registered)	80%	120.4%	105.8%	106.0%
% of clients clinically ready for discharge	3.5%	28.7%	17.3%	22.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*N/A*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	5
Physical Violence (Patient on Staff)	Trend Monitor	4	10	13
Restraint incidents	Trend Monitor	13	12	*12*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	42	47	37

Inpatients - Mental Health - Older People Services

Willow Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	90.0%	94.7%	73.9%
Sickness	5.0%	17.9%	17.3%	13.5%
Supervision	80%	88.9%	100.0%	91.7%
Information Governance training compliance	>=95%	89.5%	94.7%	94.4%
Reducing Restrictive Practice Interventions training compliance	>=80%	89.5%	94.7%	94.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	94.7%	94.7%	72.2%
Fire Safety training compliance	>=85%	84.2%	84.2%	88.9%
Bed occupancy	85%	96.0%	96.8%	91.3%
Safer staffing (Overall)	90%	168.2%	141.9%	155.0%
Safer staffing (Registered)	80%	95.9%	98.8%	101.4%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	8.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	2	0
Restraint incidents	Trend Monitor	1	2	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	30	16	12

Beechdale Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	100.0%	100.0%	100.0%
Sickness	5.0%	12.2%	12.3%	10,7%
Supervision	80%	100.0%	100.0%	91.7%
Information Governance training compliance	>=95%	100.0%	100.0%	87.8%
Reducing Restrictive Practice Interventions training compliance	>=80%	87.5%	91.7%	74.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.5%	91.7%	75.4%
Fire Safety training compliance	>=85%	95.8%	91.7%	85.0%
Bed occupancy	85%	95.6%	93.3%	91.9%
Safer staffing (Overall)	90%	128.9%	117.3%	126.7%
Safer staffing (Registered)	80%	110.7%	101.2%	101.0%
% of clients clinically ready for discharge	3.5%	12.8%	7.3%	6.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*85.7%*
Physical Violence (Patient on Patient)	Trend Monitor	1	2	1
Physical Violence (Patient on Staff)	Trend Monitor	0	0	6
Restraint incidents	Trend Monitor	1	1	*9*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	1	2	4

Ward 19 - Male Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	90.5%	78.3%	75.0%
Sickness	5.0%	8.5%	4.2%	4.2%
Supervision	80%	100.0%	100.0%	92.3%
Information Governance training compliance	>=95%	100.0%	100.0%	87.8%
Reducing Restrictive Practice Interventions training compliance	>=80%	83.3%	87.5%	74.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.0%	79.2%	75.3%
Fire Safety training compliance	>=85%	95.8%	100.0%	84.9%
Bed occupancy	85%	82.0%	96.6%	101.9%
Safer staffing (Overall)	90%	106.1%	106.1%	107.2%
Safer staffing (Registered)	80%	98.8%	103.7%	91.6%
% 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%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	2
Physical Violence (Patient on Staff)	Trend Monitor	2	1	4
Restraint incidents	Trend Monitor	1	2	*8*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	1	6	3

Ward 19 - Female Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	77.8%	77.8%	72.2%
Sickness	5.0%	13.2%	11.2%	1.6%
Supervision	80%	100.0%	100.0%	91.7%
Information Governance training compliance	>=95%	100.0%	100.0%	87.8%
Reducing Restrictive Practice Interventions training compliance	>=80%	72.2%	70.6%	74.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.8%	94.1%	75.4%
Fire Safety training compliance	>=85%	83.3%	88.2%	85.0%
Bed occupancy	85%	94.0%	95.3%	94.8%
Safer staffing (Overall)	90%	100.6%	93.5%	97.6%
Safer staffing (Registered)	80%	115.9%	113.5%	103.5%
% 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%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	2
Physical Violence (Patient on Staff)	Trend Monitor	2	1	4
Restraint incidents	Trend Monitor	1	2	*8*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	3	12	3

Inpatients - Mental Health - Rehab

Enfield Down Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	91.7%	87.8%	78.7%
Sickness	5.0%	5.8%	5.8%	2.2%
Supervision	80%	100.0%	100.0%	91.7%
Information Governance training compliance	>=95%	98.0%	97.8%	97.8%
Reducing Restrictive Practice Interventions training compliance	>=80%	77.1%	82.2%	79.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	86.4%	85.7%	90.2%
Fire Safety training compliance	>=85%	87.8%	91.3%	91.1%
Bed occupancy	Trend Monitor	51.4%	55.4%	55.3%
Safer staffing (Overall)	90%	97.8%	95.3%	93.6%
Safer staffing (Registered)	80%	104.1%	96.3%	99.9%
% of clients clinically ready for discharge	3.5%	6.2%	5.6%	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	1
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	0	0

Lyndhurst Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	96.7%	86.7%	23.3%
Sickness	5.0%	4.5%	3.8%	1.5%
Supervision	80%	100.0%	93.3%	87.5%
Information Governance training compliance	>=95%	96.4%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	89.3%	88.9%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	89.3%	92.6%	85.2%
Fire Safety training compliance	>=85%	92.9%	96.3%	92.6%
Bed occupancy	Trend Monitor	73.1%	69.1%	69.4%
Safer staffing (Overall)	90%	91.7%	92.8%	91.1%
Safer staffing (Registered)	80%	85.3%	84.1%	86.6%
% of clients clinically ready for discharge	3.5%	9.1%	9.1%	9.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	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. The downtime of WorkPal resulted in completion of appraisals using paper forms. Following the move to ESR, a programme to upload these has commenced, consequently data does not currently reflect appraisals completed to date. The teams continue to work through these plans and an improving trajectory is noted on Appleton (89.5%), Bronte (100%), Hepworth (92.9%, Johnson (88.5%), Priestley (52.4%), Waterton (90.9%). Chippendale compliance has reduced to 79.2%.

Medium Secure

• Five wards are above supervision compliance (Appleton, Bronte, Chippendale, Hepworth and Priestley). Johnson ward has reduced to 76.5% which is reported to a recording issue. Waterton is at 42.9% which is due capacity in supervisors and plans are in place by the Ward Manager to improve supervision uptake.
• Improvements in attendance noted for Appleton (1.6%), Bronte (0.6%), Hepworth (3.2%). Sickness and absence have increased on Johnson (7.4%) attributed to an increase in long term sickness. Sickness also remains above compliance on Chippendale (8.0%), Priestley (10.1%) and Waterton (7.5%) which is a combination of long-term sickness absence and short term absence.
• Following recent improvements in cardiopulmonary resuscitation compliance has reduced in all areas in January with the exception of Bronte and Waterton. This will be an area of focus for the service.
•Information Governance compliance remains a focus of targeted improvement work, with hotspots identified on Chippendale (69.6%), Hepworth (93.3%), Johnson (84.6%), Priestley (92.0%) and Bronte (94.7%).
•The service includes fire training within the annual security updates. Following some challenges in trainer availability the service has worked with the fire service to support additional training sessions and plans are in place to improve Hepworth (80%), Priestley (80%) and Appleton (82.6%).
• Compliance for reducing restrictive physical interventions (RRPI) has notable improvements in compliance across the service with six wards now above compliance. Priestley (75%) is the only ward 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 Reducing Restrictive Practice Interventions.
• 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. There has been some reduction in occupancy on Hepworth (88%), however all these beds have individuals who are waiting for appropriate approvals to support admission.
• There has been no prone restraints. A noted increase on patient-to-patient violence on Johnson. This is due to complex presentation of the service user group and plans are in place to manage risk.
• Continued work and increased oversight of Priestly has been in place to understand the challenges in performance and enable focused intervention and support is in place. A gradual improving trajectory is noted. Also of note is that Johnson has had a brief gap in leadership which appears to have impacted on performance, with improvements now being noted and monitored.

Low Secure

• Sickness across all wards monitored closely, and Ward Managers are working closely with people directorate colleagues. Sickness levels have increased on Thornhill (9.7%) and Newhaven (6.0%). Whilst remaining above compliance sickness has reduced on Ryburn (14.7%) and Sandal (9.4%). This is a combination of both long term and short-term sickness absence.
• Mandatory training compliance has noted a continued improvement in low secure. Hotspots remain on Newhaven in IG (92.3%) and Fire Safety (84.6%) with plans remaining in place to address shortfalls and maintain performance.
• Bed occupancy in low secure is within compliance for Ryburn and Sandal. Thornhill is currently below expected occupancy; however, this is expected to be short term. Newhaven continues to experience lower level of referrals and has no waiting list.
• Supervision is above compliance in all wards within low secure.
• There were no prone restrains in the service. Both Sandal and Newhaven have seen an increase in patient-on-patient violence relating to a small number of service users with complex needs. Risk assessments have been undertaken and plans in place with support from safeguarding and Reducing Restrictive Practice Interventions are in place.

Appleton Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	82.6%	86.4%	89.5%
Sickness	5.4%	1.4%	5.9%	1.6%
Supervision	80%	81.3%	80.0%	81.3%
Information Governance training compliance	>=95%	95.8%	100.0%	95.7%
Reducing Restrictive Practice Interventions training compliance	>=80%	83.3%	91.7%	91.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.3%	83.3%	78.3%
Fire Safety training compliance	>=85%	87.5%	83.3%	82.6%
Bed occupancy	90%	62.5%	62.5%	62.5%
Safer staffing (Overall)	90%	96.3%	92.0%	92.9%
Safer staffing (Registered)	80%	100.2%	102.1%	103.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	0	0
Restraint incidents	Trend Monitor	8	5	*5*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	0	0

Bronte Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	95.5%	95.2%	100.0%
Sickness	5.4%	1.5%	2.6%	0.6%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	94.4%	94.4%	94.7%
Reducing Restrictive Practice Interventions training compliance	>=80%	94.4%	94.4%	94.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.8%	77.8%	89.5%
Fire Safety training compliance	>=85%	88.9%	88.9%	89.5%
Bed occupancy	90%	93.8%	100.0%	92.6%
Safer staffing (Overall)	90%	135.7%	124.3%	99.9%
Safer staffing (Registered)	80%	129.2%	119.9%	108.1%
% 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	3	0	0
Restraint incidents	Trend Monitor	5	2	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	0	*0*
Unfilled Shifts	Trend Monitor	4	8	4

Chippendale Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	78.3%	83.3%	79.2%
Sickness	5.4%	7.4%	3.6%	8.0%
Supervision	80%	93.3%	93.3%	88.9%
Information Governance training compliance	>=95%	100.0%	96.2%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	84.6%	88.5%	87.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.5%	80.8%	69.6%
Fire Safety training compliance	>=85%	88.5%	84.6%	91.3%
Bed occupancy	90%	100.0%	97.8%	94.1%
Safer staffing (Overall)	90%	129.8%	126.3%	130.4%
Safer staffing (Registered)	80%	122.8%	129.7%	136.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	5	7	7

Hepworth Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	87.1%	83.9%	92.9%
Sickness	5.4%	4.1%	5.1%	3.2%
Supervision	80%	100.0%	100.0%	85.0%
Information Governance training compliance	>=95%	100.0%	96.6%	93.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	75.9%	82.8%	90.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	89.3%	86.2%	73.3%
Fire Safety training compliance	>=85%	82.8%	82.8%	80.0%
Bed occupancy	90%	92.4%	93.5%	88.0%
Safer staffing (Overall)	90%	93.4%	102.7%	111.8%
Safer staffing (Registered)	80%	80.4%	90.5%	93.0%
% of clients clinically ready for discharge	3.5%	7.2%	7.1%	7.6%
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	0	2	2
Restraint incidents	Trend Monitor	0	7	*4*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	0	6	4

Inpatients - Forensic - Medium Secure

Johnson Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	77.8%	46.4%	88.5%
Sickness	5.4%	4.4%	4.7%	7.4%
Supervision	80%	100.0%	100.0%	76.5%
Information Governance training compliance	>=95%	93.3%	80.0%	84.6%
Reducing Restrictive Practice Interventions training compliance	>=80%	96.7%	96.7%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.7%	93.3%	76.9%
Fire Safety training compliance	>=85%	73.3%	73.3%	88.5%
Bed occupancy	90%	72.0%	80.0%	80.0%
Safer staffing (Overall)	90%	128.0%	133.2%	133.9%
Safer staffing (Registered)	80%	99.8%	90.6%	86.6%
% 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	2
Physical Violence (Patient on Staff)	Trend Monitor	0	1	2
Restraint incidents	Trend Monitor	3	1	*6*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	5	5	2

Priestley Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	50.0%	36.4%	52.4%
Sickness	5.4%	8.8%	10.4%	10.1%
Supervision	80%	78.6%	85.7%	85.7%
Information Governance training compliance	>=95%	91.3%	87.0%	92.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	77.3%	77.3%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.9%	90.9%	87.5%
Fire Safety training compliance	>=85%	87.0%	82.6%	80.0%
Bed occupancy	90%	82.2%	80.3%	85.6%
Safer staffing (Overall)	90%	91.7%	90.5%	92.2%
Safer staffing (Registered)	80%	89.2%	76.4%	86.0%
% 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	1

Waterton Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	77.3%	81.8%	90.9%
Sickness	5.4%	6.2%	9.4%	7.5%
Supervision	80%	81.8%	38.5%	42.9%
Information Governance training compliance	>=95%	100.0%	91.3%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	77.3%	87.0%	82.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	86.4%	87.0%	87.0%
Fire Safety training compliance	>=85%	95.5%	91.3%	95.7%
Bed occupancy	90%	88.3%	93.8%	95.4%
Safer staffing (Overall)	90%	123.8%	117.9%	118.9%
Safer staffing (Registered)	80%	117.7%	104.1%	96.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	1	4

Inpatients - Forensic - Low Secure

Thornhill Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	95.7%	79.2%	80.0%
Sickness	5.4%	1.2%	4.1%	9.7%
Supervision	80%	76.9%	71.4%	80.0%
Information Governance training compliance	>=95%	96.2%	96.2%	96.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	96.2%	96.2%	96.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.2%	100.0%	92.0%
Fire Safety training compliance	>=85%	100.0%	100.0%	100.0%
Bed occupancy	85%	90.7%	83.4%	79.8%
Safer staffing (Overall)	90%	98.3%	98.7%	102.4%
Safer staffing (Registered)	80%	103.3%	104.1%	100.1%
% 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	5

Sandal Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	92.3%	73.1%	68.0%
Sickness	5.4%	6.8%	10.9%	9.4%
Supervision	80%	93.8%	88.2%	94.4%
Information Governance training compliance	>=95%	96.7%	96.7%	96.4%
Reducing Restrictive Practice Interventions training compliance	>=80%	80.0%	93.3%	92.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	76.7%	85.7%
Fire Safety training compliance	>=85%	96.7%	96.7%	96.4%
Bed occupancy	85%	82.1%	81.5%	86.1%
Safer staffing (Overall)	90%	176.5%	148.9%	130.2%
Safer staffing (Registered)	80%	128.1%	112.9%	116.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	2	3	1
Physical Violence (Patient on Staff)	Trend Monitor	1	1	0
Restraint incidents	Trend Monitor	1	*5*	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	*1(100%)*	*0*
Unfilled Shifts	Trend Monitor	6	11	17

Inpatients - Forensic - Low Secure

Ryburn Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	100.0%	85.7%	100.0%
Sickness	5.4%	15.9%	22.8%	14.7%
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%	100.0%	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%	98.1%	96.3%	84.3%
Safer staffing (Overall)	90%	100.0%	99.9%	99.3%
Safer staffing (Registered)	80%	100.7%	100.0%	100.1%
% 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

Newhaven Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	78.9%	79.5%	66.7%
Sickness	5.4%	4.9%	4.6%	6.0%
Supervision	80%	95.2%	85.7%	95.0%
Information Governance training compliance	>=95%	89.7%	94.9%	92.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	89.7%	88.9%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.3%	72.2%	86.1%
Fire Safety training compliance	>=85%	93.1%	89.7%	84.6%
Bed occupancy	85%	75.0%	68.8%	62.5%
Safer staffing (Overall)	90%	115.0%	117.6%	96.7%
Safer staffing (Registered)	80%	115.4%	106.6%	101.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	3
Physical Violence (Patient on Staff)	Trend Monitor	0	0	5
Restraint incidents	Trend Monitor	1	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	12	6

Inpatients - Non-Mental Health

• **Appraisal rate:**
Neuro Rehab Unit (NRU) rate is showing 85.4% for January.
Stroke Rehab Unit (SRU) rate is 77.6% for January.
Stroke Team Manager post has been vacant since 14 January which has impacted on the delivery of appraisals. An interim replacement has been appointed and will start in post on 24 February.

• **Sickness:**
NRU – sickness has improved slightly for January with a reduction from 9.8% to 8.3%. Significant long-term sickness (LTS) continued throughout January. All are due to return in the next 2 months though one instance has a planned return date in April 2025. This is being managed via human resource processes and sickness reviews.
SRU – sickness has significantly improved to achieve compliance at 3.9% for January
• **Supervision:**
NRU has seen a slight dip this month - below compliance at 70.4% for January. As of 17 February this has increased to 77.8%. The level of long-term sickness has impacted capacity to undertake supervision sessions, but leadership team are focussing on this during February.
SRU figures for January have maintained compliancy at 92.5%.

• **Information Governance:**
NRU – continues to maintain compliance achieving 97.4%.
SRU – has seen a slight increase towards compliance this month at 93.8%.
Targeted approach to individual members of staff with outstanding IG training continues and will regain additional focus when interim manager commences in post in February '25.

• **Cardiopulmonary resuscitation (CPR):**
NRU – an increase during January to achieve compliance at 83.3%.
SRU – a slight increase towards compliance during January to 72.1%. Further training is booked w/com 17.2.25 including 3 staff on ILS 18.2.25 and further staff on BLS later the same week.
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	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	89.7%	84.6%	85.4%
Sickness	5.0%	8.7%	9.8%	8.3%
Supervision	80%	80.8%	73.1%	70.4%
Information Governance training compliance	>=95%	100.0%	100.0%	97.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.5%	75.7%	83.3%
Fire Safety training compliance	>=85%	85.4%	87.2%	92.1%
Bed occupancy (Barnsley Commissioned beds only)	80%	72.8%	59.7%	67.7%
Safer staffing (Overall)	90%	118.5%	113.6%	112.2%
Safer staffing (Registered)	80%	117.1%	114.9%	114.0%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Unfilled Shifts	Trend Monitor	0	0	0

Stroke Rehabilitation Unit (SRU) Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	95.2%	92.2%	77.6%
Sickness	5.0%	1.3%	5.5%	3.9%
Supervision	80%	94.7%	92.1%	92.5%
Information Governance training compliance	>=95%	89.1%	93.7%	93.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.3%	70.0%	72.1%
Fire Safety training compliance	>=85%	89.1%	92.1%	95.3%
Bed occupancy	80%	80.0%	101.9%	98.1%
Safer staffing (Overall)	90%	107.8%	102.1%	107.0%
Safer staffing (Registered)	80%	129.5%	126.9%	135.4%
% 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

• The service continues to support the provision of appraisal. During the WorkPal downtime, these have been completed on paper and are now being uploaded onto ESR. The current data therefore does not accurately reflect the service uptake.
• Some reduction in supervision during January to 78.9% due to service acuity but plans in place via Ward Manager to re-establish in line with usual practice.
• All mandatory training is with compliance.
• A small reduction in clinically ready for discharge is noted following the discharge of a service users (80%). 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. No prone restraint. A high number of patients on staff incidents is evident due to the complex needs of the service users within the service.

Horizon Metrics	Threshold	Nov-24	Dec-24	Jan-25
Appraisal rate	95%	97.3%	97.1%	90.9%
Sickness	5.0%	6.9%	7.9%	9.4%
Supervision	80%	88.9%	83.3%	78.9%
Information Governance training compliance	>=95%	91.9%	97.2%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	94.1%	97.1%	93.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.4%	88.2%	90.3%
Fire Safety training compliance	>=85%	89.2%	91.7%	90.6%
Bed occupancy	N/A	60.8%	55.6%	60.5%
Safer staffing (Overall)	90%	164.7%	162.4%	167.7%
Safer staffing (Registered)	80%	135.9%	154.4%	163.9%
% of clients clinically ready for discharge	3.5%	88.0%	90.1%	80.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	0.0%	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	12	27	43
Restraint incidents	Trend Monitor	29	27	*39*
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	Work continues on the Equality Diversity and Inclusion (EDI) strategy refresh using the extensive engagement and analysis . Proposed strategic aims are being tested both internally and externally with the strategy document under development for presenting into March Trust Board for agreement Work to deliver the Patient and Carer Race Equality Framework (PCREF) is being coproduced with over 30 community connectors and representatives from across the trust-wide footprint. A development plan for delivering anti racism is in place with race equality week (3rd to 7th February) as a key focus to share this work Equality – Equality Delivery System (EDS) 2022 assessment is being finalised	
Improving care	Transform our Older People inpatient services	The staff consultation (with staff based at the Poplars) is now complete. New Governance has been established to focus on how the model will be operationalised. Initial meetings on Estates, Workforce and clinical pathways / staff development were held in January 2025. High level implementation timelines now established. Programme Board meeting February 2025.	
	Improve our mental health services so they are more responsive, inclusive, and timely	**Care Closer to Home (CC2H):** • Low out of area usage continues to be supported by quality monitoring systems to measure unintended impacts on both inpatient services and community teams • Optimising Community Solutions and enhancing Patient Flow work has commenced. Oversight group has been established first meeting planned in Feb 25. • 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 will commence March 25. • There is continued engagement with front line clinicians in the CC2H programme led by the GM. • Escalation and communication work with Acute Trusts (CC2H completed). **Improving 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: Psychology leads team day concluded in January sharing early findings of current similarities/ differences in the pathway as well as ways of working and developing potential new ways of working. Pull together outcomes from team day in February and gather any further information required for understanding. • Memory services: Workshop outcomes written up and shared with services to review. Further understanding work to be identified and carried out such as demand and capacity modelling. Identifying date for follow up workshop for encouraging shared learning and generating ideas for improvement in April. **Inpatient Improvement:** • **Therapeutic Inpatient Care:** Nursing staff establishment review is ongoing across the adults and older adult inpatient services to ensure we have sufficient staffing levels and the right staff to provide safe care (March 25). • **Creative activity:** Currently working with Allied Health Professionals, Occupational Therapists and Culture of care representatives to develop a plan to support smooth transitions into creative sessions for men who wish to continue creative health sessions on discharge (Feb 25). Hospital Rooms - initial consultations are underway in Melton, Walton and Bretton Wards. (Feb 25) Completed installation of the Landscape Mural of 'Wicklow Gap' in Ashdale Ward. The Murals featuring Service User artwork and acoustic panel were also installed in Ward 19. (Jan 25) Creative practitioners now have access to a funded group of supervision and counselling sessions to support their wellbeing and delivery. • **Culture of Care programme:** All wards have commenced active Quality Improvement (QI) work with National Collaborating Centre for Mental Health (NCCMH). An away day focused on Developing an Autistic Approach in SWYPFT arranged for February 2025, in collaboration with service User Representatives from Wakefield Community Mental Health Panel. • The Internet resource for Culture of Care has been delayed but will be drafted for review in February 2025. • **Forensic Data Workstreams.** The Forensic In-patient Dashboard is completed, training for Ward Managers has been undertaken and further feedback considered. • **Forensic therapeutic workstream:** In January, service user engagement sessions have been undertaken with support from the Y&H Involvement network in the Bretton Centre and Newton Lodge. Sessions have also been facilitated in January with the intervention strategy group and ANPs to consider current multi disciplinary team intervention pathways. • **Forensic Social work workstream:** Work commenced in January 2025 to undertake a Social Work review a project plan is being developed with Wakefield LA (Feb 25).	

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	• Whilst built in savings (£22m) continue to be behind plan, we are forecasting a breakeven position. • The main driver of this variance throughout has remained related to workforce growth and it being higher than planned. • Key lines of enquiry presented to extended management team on 16th January are being financially quantified for including in 25/26 planning and further discussed at extended management team timeout on 13th February. • Additional key lines of enquiry (KLOE) including Cheswold park hospital integration, Provider Collaborative and corporate efficiencies and management are being scoped. • Planning guidance has been reviewed, and we are in the process of submitting various ICB templates in preparation for our first NHSE submission on 27th February.	
	Make digital improvements	**Digital Dictation:** The project was taken out of escalation, the task and finish group stood down and deployment re-commenced in January to Forensics, Live Well Wakefield and Adult Epilepsy Service. Preparations are underway and on track to deploy to Barnsley Physical Health in February 25. The Lexacom smart phone app is now available on Trust issued devices from January 25. A further plan to accelerate and complete all deployments by September 25 has been completed and approved by 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)	(£1.6m)	£0m	The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £1.6m deficit has been reported which is a £0.6m increase from last month which is primarily due to the in month deficits reported by the Adult Secure Provider Collaboratives. Non recurrent mitigations have been identified to support delivery of the year end target.
2	Agency Spend	£5.5m	£6.7m	Agency expenditure run rate has continued to fluctuate. Spend in January is £684 which is £76k more than last month. The provider collaborative spend in month was £87k which is £32k less than last month. Cheswold Park Hospital spend in month was £179k which is £100k more than last month.
3	Financial sustainability and efficiencies	£14.9m	£20.5m	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 £20.5m, being £1.5m 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	£54.5m	£50.8m	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	£3.1m	£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. A further £648k will be added in month 11 for LED lighting.Work continues to ensure 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	Nov-24	Dec-24	Jan-25	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	98.5%	98.4%	98.4%		Based on all current inpatients (64 as at 31/01/2025)
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 31/01/2025)
Percentage of service users who have had their equality data recorded - sexual orientation		93.8%	93.7%	93.7%		
Completion of equality mandatory training	>=80%	99.0%	100.0%	100.0%		100% of ward and central support services staff; 96% of clinical staff

Improving Care

Metrics	Trust Threshold	Nov-24	Dec-24	Jan-25	Variation/ Assurance	Notes
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	3	0	1		Out of a total number (30) of violence and aggression incidents occurred in January 2025

Make SWYPFT a great place to work

Metrics	Trust Threshold	Nov-24	Dec-24	Jan-25	Variation/ Assurance	Notes
Turnover external (in month)	>12% - 13%<	Data not available				
Sickness absence - In month	<=5.4%	Data not available				
Staff supervision rate	80%	72.5%	83.0%	80.0%		
Mandatory training - Cardiopulmonary resuscitation	80%	93.0%	96.0%	94.0%		includes training for Immediate Life Support, Basic Life Support
Mandatory training - Reducing restrictive physical interventions (RRPI)	80%	93.0%	92.0%	93.0%		includes training for Prevention and Management of Violence and Aggression and Breakaway
Mandatory training - Fire	85%	98.0%	99.0%	98.0%		
Mandatory training - Information governance (IG)	95%	97.0%	98.0%	98.0%		

Appendix 1 - Cheswold Park Hospital

Quality Headlines

Section	KPI	Trust Threshold	Nov-24	Dec-24	Jan-25
Complaints	% of feedback with staff attitude as an issue	< 20%	50% (7/14)	9.09% (1/11)	0% (0/6)
	Complaints - Number of responses provided within six months of the date a complaint received	100.0%	85.71% (12/14)	18.18% (2/11)	50.00% (3/6)
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%	92.31% (60/65)	100% (64/64)	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	100% (2/2)
	Total number of reported incidents	Trend monitor	201	168	147
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available)	Trend monitor	4	2	3
	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	1
	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%	97.8%	90.1%	95.0%
	Safer Staffing % Fill Rate - Registered Nurses Overall	80%	105.9%	86.2%	102.2%
	Safer Staffing % Fill Rate - Registered Nurses Days	80%	100.7%	80.2%	95.9%
	Safer Staffing % Fill Rate - Registered Nurses Nights	80%	113.2%	94.6%	111.0%
	% 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	1	0	2
	Number of restraint incidents	Trend monitor	20	6	5
	% of staff receiving supervision within policy guidance	80.0%	80.0%	83.0%	80.0%
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	0	0	0	0

Quality Headlines

Number of Information Governance breaches - 2 incidents reported in January 2025. One incident ralated to, housekeeping team found MDT Care Plan Review Minutes in the Conference Rook; the second incidents related to, potential data security breach concerning CCTV footage that was sent to the Social Work England.

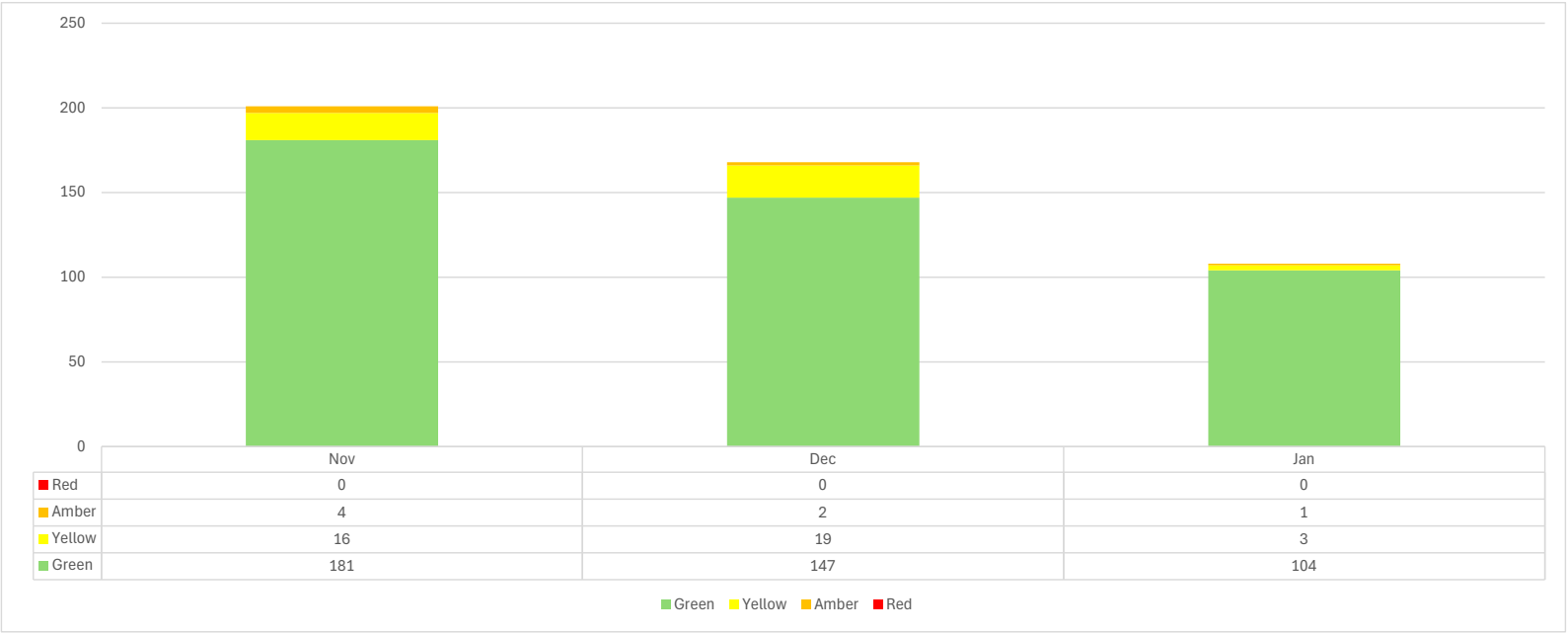
Appendix 1 - Cheswold Park Hospital

Safety First

Summary of Incidents

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

97.27% of incidents occurred in January 2025 resulted in No harm or injury occurred.
One incident related to Severe - permanent and significant/long term harm occurred in January 2025.
No never events, or incident resulted in major, catastrophic harm or death occurred in January 2025.



	Nov	Dec	Jan
Red	0	0	0
Amber	4	2	1
Yellow	16	19	3
Green	181	147	104

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

Breakdown of incidents in January 2025 - 3 moderate harm incidents:
The most common cause(s) for these incidents were due to self injurious behaviours and violence and aggression.
No severe harm incidents

Appendix 1 - Cheswold Park Hospital

Safeguarding

Safeguarding Adults:
There were 2 safeguarding adult incidents in January 2025.

Safeguarding Children:
There were no safeguarding children incidents in January 2025.

Complaints

- There were 6 new complaints in January of which are all were formal. All of the complaints received were regarding inpatients.
- Of the 6 new complaints received, 3 are noted as 'Remains under investigating', 3 are 'closed'.
- One of the new complaints related to 'Issues with peer on the ward', one related to 'Cancelled section 17 leave which resulted in her not seeing her brother', one related to 'Physical Health', one related to 'Staff – Refusal of takeaway' and two related to 'Staff Confidentiality'.
- 11 Complaints were closed in January 2025.
- No compliments were received in January 2025.

Reducing Restrictive Physical Intervention (RRPI)

- There were 6 restraint related incidents occurred in January 2025, making up 4.08% (6/147) of the total January 2025 incidents.
- As in January 2025 there was no incidents implemented in prone position.

Appendix 1 - Cheswold Park Hospital

NHS South West Yorkshire Partnership NHS Foundation Trust

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Trust Threshold	Nov-24	Dec-24	Jan-25
Establishment	Improving Resources	Well Led	-	324.1	324.1	324.1
Contracted Staff In Post (Ledger)			-	331.5	317.3	322.0
Vacancies			-	-7.4	-6.8	-2.0
Turnover external			>12% - <13%	Data not available		
Starters			-	0.0	0.0	0.0
Leavers			-	8.0	6.0	3.0
International Nurse Starters in Month			-	0	0	0
% Bank Fill Rates - Registered Nurses			-	2.81% (37/941)	4.44% (34/765)	7.10%(54/760)
% Bank Fill Rates - Health Care Assistants			-	12.56% (309/2459)	7.8% (153/1957)	8.32%(161/1934)
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)			-	10.17% (346/3400)	6.87% (187/2722)	7.98% (215/2694)
Sickness absence - Month			<=5%	Data not available		
Employees with long term sickness over 12 months			-	1	1	1
Appraisals - rolling 12 months			95%	76.0%	81.0%	80.6%
Employee Relations - Suspensions (over 90 days)			-	0	0	0
Mandatory Training - TOTAL	Improving Care		>=80%	98.0%	99.0%	98.0%
Mandatory Training - Reducing Restrictive Practice Interventions				93.0%	92.0%	93.0%
Mandatory Training - Cardiopulmonary Resuscitation				93.0%	96.0%	94.0%
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%	100.0%	100.0%
Mandatory Training - Fire Safety			>=85%	98.0%	99.0%	98.0%
Mandatory Training - Food Safety			>=80%	99.0%	100.0%	99.0%
Mandatory Training - Freedom To Speak Up (FTSU)				99.0%	100.0%	99.0%
Mandatory Training - Infection Control & Hand Hygiene				98.0%	99.0%	100.0%
Mandatory Training - Information Governance (Data Security)			>=95%	97.0%	98.0%	98.0%
Mandatory Training - Moving & Handling			>=80%	98.0%	99.0%	98.0%
Mandatory Training - Mental Capacity Act/Dols				95.0%	97.0%	97.0%
Mandatory Training - Mental Health Act				95.0%	97.0%	97.0%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				98.0%	98.0%	97.0%
Mandatory Training - Prevent			>=80%	N/A	N/A	N/A
Mandatory Training - Safeguarding Adults				99.0%	99.0%	98.0%
Mandatory Training - Safeguarding Children				99.0%	99.0%	98.0%

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 10 (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)	(£1.6m)	£0m	The Trust financial target for 2024 / 25 is breakeven. For the year to date a position of £1.6m deficit has been reported which is a £0.6m increase from last month which is primarily due to the in month deficits reported by the Adult Secure Provider Collaboratives. Non recurrent mitigations have been identified to support delivery of the year end target.
2	Agency Spend	£5.5m	£6.7m	Agency expenditure run rate has continued to fluctuate. Spend in January is £684 which is £76k more than last month. The provider collaborative spend in month was £87k which is £32k less than last month. Cheswold Park Hospital spend in month was £179k which is £100k more than last month.
3	Financial sustainability and efficiencies	£14.9m	£20.5m	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 £20.5m, being £1.5m 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	£54.5m	£50.8m	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	£3.1m	£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. A further £648k will be added in month 11 for LED lighting. Work continues to ensure 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.

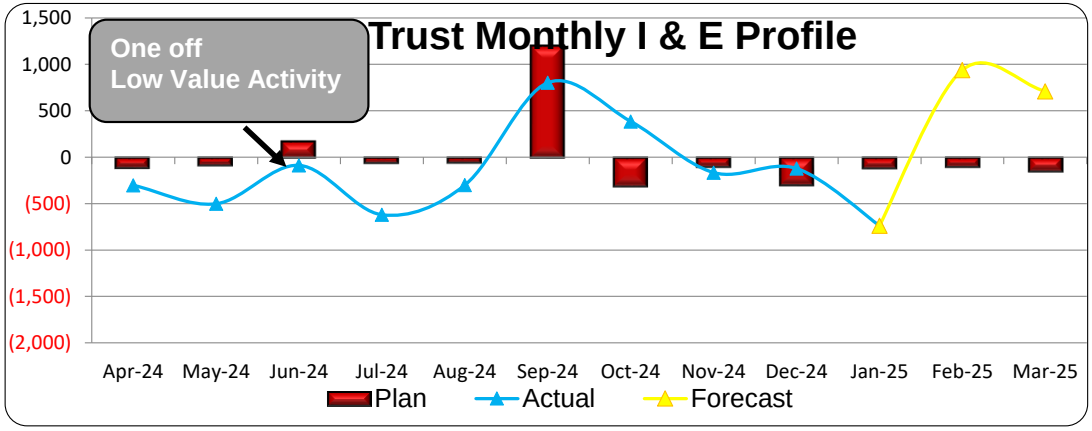
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

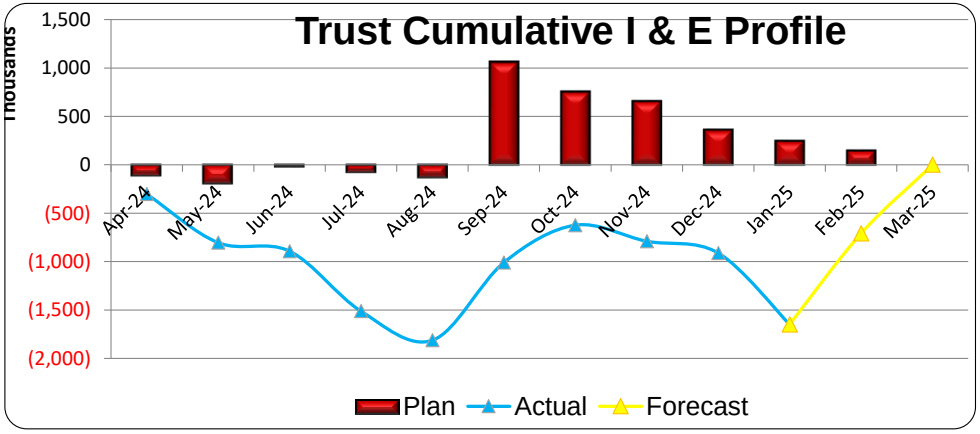
2.0 Income & Expenditure Position 2024 / 25

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					37,003	37,114	111	357,945	359,589	1,644	431,449	433,424	1,975
Other Operating Revenue					1,265	1,407	142	13,862	14,592	730	16,396	17,285	889
Total Revenue					**38,268**	**38,521**	**253**	**371,807**	**374,181**	**2,373**	**447,845**	**450,709**	**2,864**
Pay Costs	5,426	5,433	7	0.1%	(23,952)	(24,310)	(358)	(229,729)	(231,735)	(2,006)	(277,432)	(279,462)	(2,030)
Non Pay Costs					(13,848)	(14,300)	(452)	(137,092)	(139,199)	(2,106)	(164,523)	(165,065)	(542)
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	**5,426**	**5,433**	**7**	**0.1%**	**(37,800)**	**(38,610)**	**(810)**	**(366,821)**	**(370,910)**	**(4,089)**	**(441,955)**	**(444,503)**	**(2,548)**
EBITDA	**5,426**	**5,433**	**7**	**0.1%**	**468**	**(89)**	**(557)**	**4,986**	**3,271**	**(1,715)**	**5,890**	**6,207**	**317**
Depreciation					(598)	(603)	(5)	(5,546)	(5,540)	6	(6,742)	(6,746)	(4)
PDC Paid					(274)	(315)	(41)	(2,170)	(2,580)	(410)	(2,718)	(3,210)	(492)
Interest Received					291	268	(22)	2,979	3,200	221	3,570	3,750	180
Surplus / (Deficit) - ICB performance measure	**5,426**	**5,433**	**7**	**0.1%**	**(113)**	**(738)**	**(625)**	**249**	**(1,649)**	**(1,898)**	**0**	**0**	**0**
Depn Peppercorn Leases (IFRS16)					(5)	(5)	(0)	(84)	(84)	0	(94)	(94)	0
Revaluation of Assets					0	38	38	0	718	718	0	718	718
Surplus / (Deficit) - Total	**5,426**	**5,433**	**7**	**0.1%**	**(118)**	**(705)**	**(587)**	**165**	**(1,015)**	**(1,180)**	**(94)**	**624**	**718**





Income & Expenditure Position 2024 / 25

The consolidated financial position is a year to date deficit of £1.6m. This is £1.9m behind plan. Financial performance in January is a deficit of £0.7m which is £0.6m 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)	5,057	5,071	14	0.3%	(58)	24	82	(1,574)	(2,020)	(446)	(1,881)	(3,679)	(1,797)
Cheswold Park Hospital	334	328	(5)	1.6%	111	(202)	(313)	443	11	(432)	665	(83)	(748)
Provider Collaboratives	23	34	11	48.6%	2	(588)	(590)	25	(295)	(320)	29	(634)	(663)
Budgets held centrally	12	0	(12)	100.0%	(168)	28	195	1,355	655	(700)	1,187	4,396	3,209
Total - Consolidated position (ICB performance measure)	**5,426**	**5,433**	**7**	**0.1%**	**(113)**	**(738)**	**(625)**	**249**	**(1,649)**	**(1,898)**	**0**	**0**	**0**

As shown within the Trust (core) financial position this is a surplus and better than plan. Although this remains small in value this is the second consecutive month where a surplus has been reported and contributes to a reduction in the year to date deficit. The forecast includes a significant increase in expenditure in the remaining months of the year. This is in both pay and non pay expenditure areas and is being challenged as part of financial planning and sustainability discussions.

Cheswold Park Hospital has reported a deficit in month but is broadly making the planned contribution for the year to date. We continue to review costs now that we are operationally running the hospital and these costs are validated against the business case.

The largest in month movements relate to the Adult Secure Provider Collaboratives and specifically the South Yorkshire Collaborative including additional out of area placements and exceptional packages of care costs.

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.

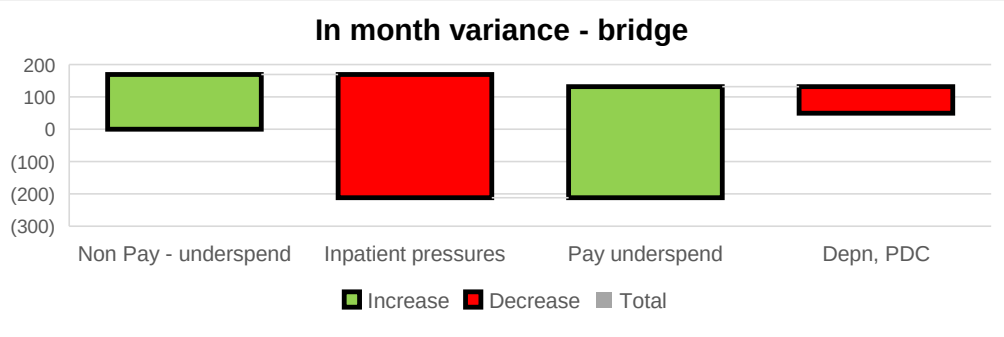
To confirm that the individual analysis within the report highlights the Trust only values.

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					26,267	26,177	(90)	258,687	258,216	(471)	310,720	310,043	(677)
Other Operating Revenue					1,219	1,285	66	12,165	12,438	272	14,604	14,972	369
Total Revenue					**27,486**	**27,462**	**(23)**	**270,853**	**270,654**	**(199)**	**325,323**	**325,015**	**(308)**
Pay Costs	5,057	5,071	14	0.3%	(22,539)	(22,529)	10	(222,683)	(223,955)	(1,272)	(267,560)	(269,093)	(1,533)
Non Pay Costs					(4,593)	(4,415)	178	(45,678)	(44,439)	1,239	(54,762)	(54,343)	419
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	**5,057**	**5,071**	**14**	**0.3%**	**(27,131)**	**(26,943)**	**188**	**(268,361)**	**(268,370)**	**(9)**	**(322,323)**	**(323,412)**	**(1,090)**
EBITDA	**5,057**	**5,071**	**14**	**0.3%**	**355**	**519**	**165**	**2,491**	**2,284**	**(208)**	**3,001**	**1,603**	**(1,398)**
Depreciation					(525)	(544)	(19)	(5,254)	(5,303)	(49)	(6,304)	(6,391)	(87)
PDC Paid					(179)	(220)	(41)	(1,790)	(2,200)	(410)	(2,148)	(2,640)	(492)
Interest Received					291	268	(22)	2,979	3,200	221	3,570	3,750	180
Surplus / (Deficit) - ICB performance measure	**5,057**	**5,071**	**14**	**0.3%**	**(58)**	**24**	**82**	**(1,574)**	**(2,020)**	**(446)**	**(1,881)**	**(3,679)**	**(1,797)**
Depn Peppercorn Leases (IFRS16)					(5)	(5)	(0)	(84)	(84)	0	(94)	(94)	0
Losses Peppercorn Leases (IFRS16)					0	38	38	0	718	718	0	718	718
Surplus / (Deficit) - Total	**5,057**	**5,071**	**14**	**0.3%**	**(64)**	**57**	**120**	**(1,658)**	**(1,386)**	**272**	**(1,975)**	**(3,054)**	**(1,079)**

The core Trust position is a small in month surplus which is the second consequtive month. 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 although overall pay expenditure is slightly less than plan. The main mitigation continues to be underspends on non pay.

Key headlines are included below and illustrated within the bridge:	£k
Non Pay underspends - drugs, training & education	169
Pay overspends - inpatient (adult, older people, Forensics)	(381)
Pay underspends - Children & Young People, Mental Health	344
Movements in depreciation and public dividend capital	(82)

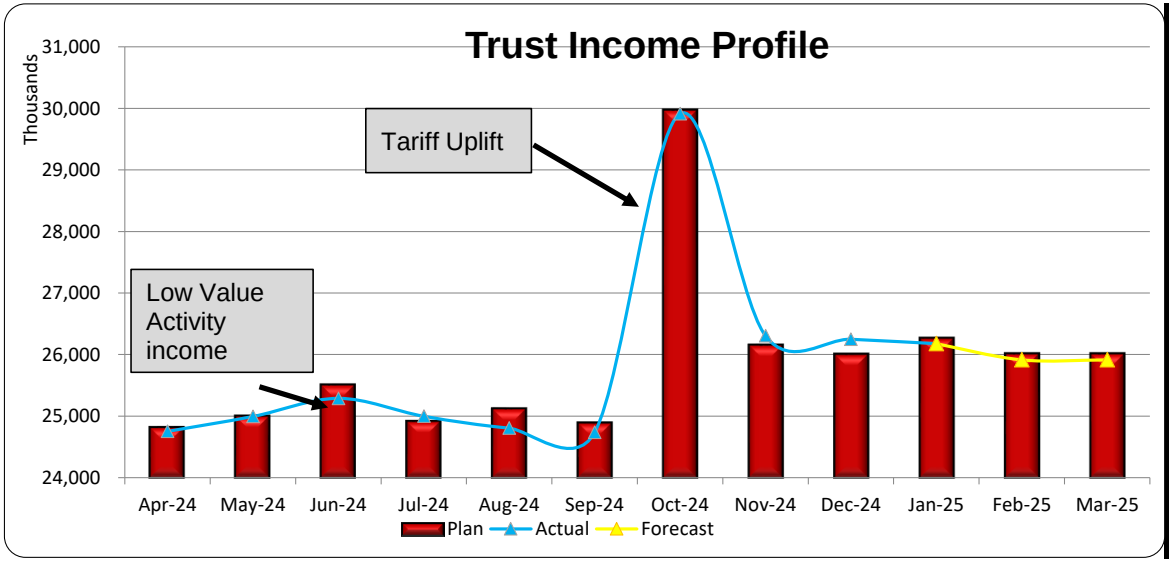


2.1 Income Information

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	22,354	22,134	22,134	**264,195**	263,912	283
Specialist Commissioner	**34,541**	2,943	2,962	2,974	2,947	2,956	2,827	5,239	1,495	3,295	3,047	3,039	3,038	**36,761**	36,681	79
Local Authority	**5,799**	378	400	371	398	377	360	381	684	314	410	389	389	**4,853**	5,272	(420)
Partnerships	**6,748**	205	219	191	218	207	207	222	293	222	228	219	220	**2,653**	3,008	(355)
Other Contract Income	**1,454**	131	220	37	135	121	131	136	140	129	138	132	132	**1,581**	1,861	(280)
Total	**293,862**	**24,752**	**24,994**	**25,289**	**24,997**	**24,805**	**24,735**	**31,570**	**24,649**	**26,249**	**26,177**	**25,913**	**25,913**	**310,043**	**310,736**	**(693)**
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	9,299	9,384	9,444	**113,595**		
Total	**293,862**	**33,870**	**34,155**	**34,439**	**34,183**	**33,981**	**34,362**	**42,256**	**34,586**	**35,674**	**35,476**	**35,297**	**35,357**	**423,638**		



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	£23k	£355k
Reimbursement based on actual costs incurred		
* Yorkshire Smokefree	£24k	£245k
Various commissioners. Actual costs and payment by results		
* Additional Roles Reimbursement Posts	£24k	£271k
Offset by reduced pay costs. Recharged on staff in post		
* Any Qualified Provider income	(£25k)	(£299k)
Invoices raised. Now included in baseline position.		

2.2 Pay Information

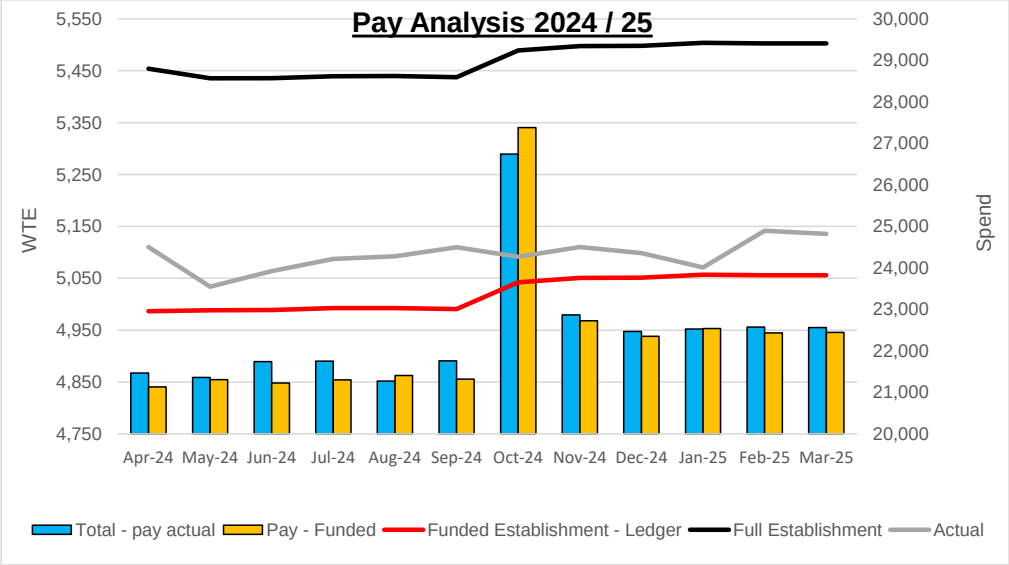
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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	20,379	20,346	20,348	**242,283**
Bank & Locum	1,955	1,581	1,673	1,738	1,771	1,827	1,980	1,793	1,770	1,732	1,780	1,771	**21,371**
Agency	413	400	444	510	429	434	561	452	484	418	449	445	**5,439**
Total	**21,466**	**21,360**	**21,739**	**21,751**	**21,275**	**21,756**	**26,741**	**22,870**	**22,469**	**22,529**	**22,575**	**22,563**	**269,093**
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%	7.7%	7.9%	7.8%	7.9%
Agency as % (in month)	1.9%	1.9%	2.0%	2.3%	2.0%	2.0%	2.1%	2.0%	2.2%	1.9%	2.0%	2.0%	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	4,595	4,646	4,642	**4,596**
Bank & Locum	474	401	411	435	456	460	431	445	437	418	433	431	**436**
Agency	62	59	62	74	71	62	70	62	60	57	63	62	**64**
Total	**5,110**	**5,034**	**5,064**	**5,087**	**5,092**	**5,110**	**5,092**	**5,110**	**5,098**	**5,071**	**5,141**	**5,135**	**5,095**
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 January is £60k higher than December however WTE have reduced in all of substantive, bank and agency. Overall this is 27 WTE less than previously and in month was only 14 WTE worked more than planned.

As previously Barnsley health and wellbeing care group have increased the size of their workforce following investment. Most other care groups have seen reductions with the largest in Specialist care group and corporate services.

The current increase forecast for February and March, as developed in conjunction with budget holders, is being reviewed as part of the Trust annual planning and financial sustainability discussions.

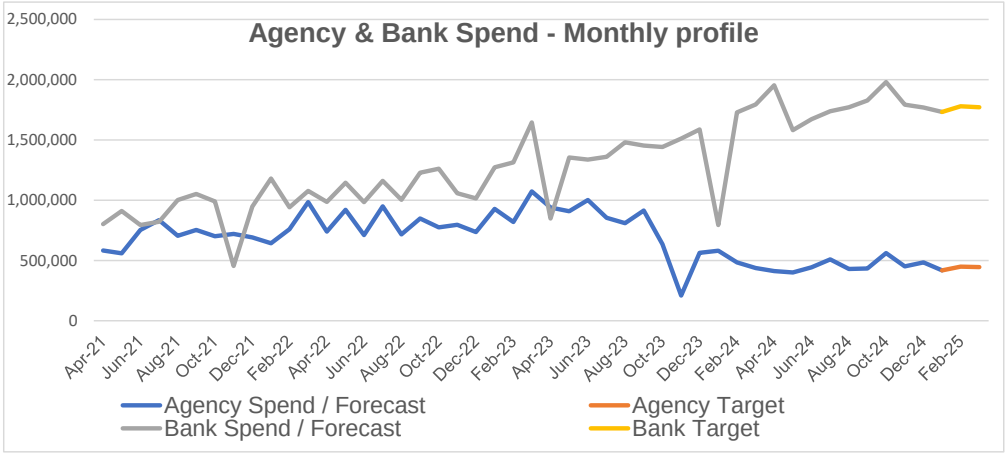
The stepped increase provides an opportunity to the overall financial forecast.

2.2 Temporary Staffing Focus

Trust spend in January 2025:
Agency £418k
Bank £1,732k

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	1,535	454	**1,988**
Other Medical	1,038	523	**1,561**
Reg Nursing	272	4,190	**4,462**
UnReg Nursing	1,037	11,066	**12,103**
Other Clinical	332	603	**934**
A & C	129	986	**1,115**
Other	(6)	0	**(6)**
Total	**4,337**	**17,821**	**22,158**
Lead Provider Collaborative	597	6	**603**
Budgets held centrally	(8)	0	**(8)**
Cheswold Park Hospital	324	187	**512**
Total	**5,250**	**18,015**	**23,265**

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.

Planning guidance for 2025 / 26 includes a target minimum reduction, based on month 8 forecast positions, of 30% against agency. This equates to a £1.8m reduction. Guidance also includes a minimum target 10% reduction on bank spend which equates to £2.1m. Action plans for delivery of these targets are underway.

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 January being a £67k reduction compared to last month. The overall consolidated position is reported as an increase due to further agency costs within the provider collaboratives and Cheswold Park Hospital. The Trust reduction is primarily in adult inpatient wards which is typically the most subject to monthly fluctuations. As shown in the graph above the financial modelling identifies reducing run rates but further actions will be required to deliver the 2025 / 26 targets.

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.

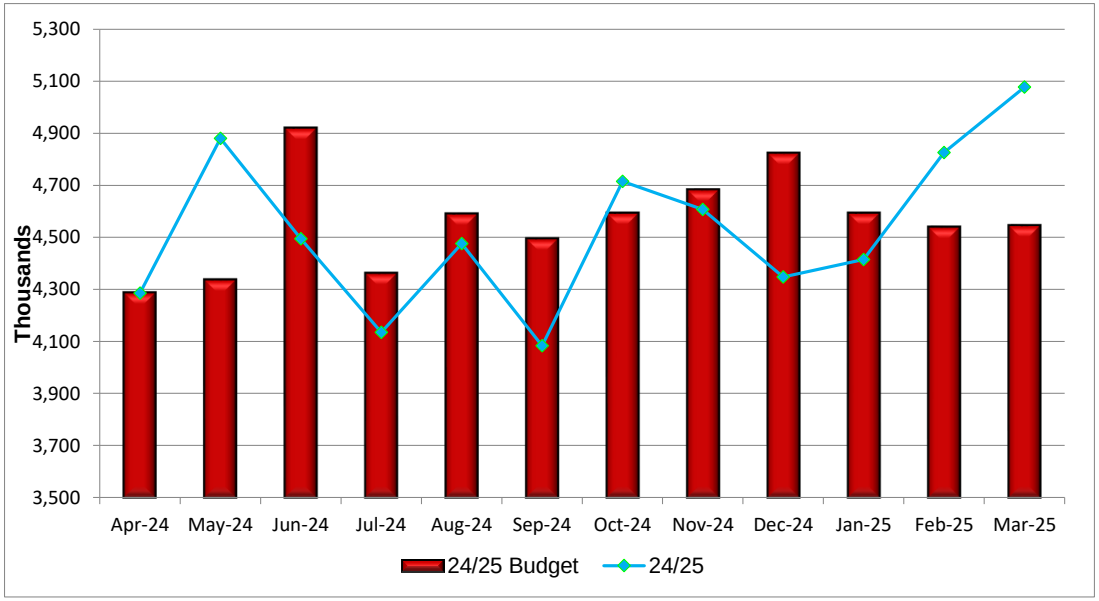
Utilisation of bank, as part of the overall workforce solution, has continued to grow over the past couple of years. As expected from 2025 / 26 this will be subject to NHS England target reductions. There has continued to be small monthly reductions in the run rate but further actions, as identified within the Trust scrunity group are expected to support continuation of this trend.

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	4,415	4,826	5,078	**54,343**
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	3,666	3,358	(308)	
Establishment	7,912	7,962	50	
Lease & Property Rental	7,357	7,406	49	
Premises (inc. rates)	4,248	3,929	(319)	
Utilities	2,260	2,324	64	
Purchase of Healthcare	5,175	5,096	(79)	
Travel & vehicles	4,803	4,695	(108)	
Supplies & Services	7,047	6,635	(412)	
Training & Education	1,032	751	(280)	
Clinical Negligence & Insurance	970	973	3	
Other non pay	1,208	1,311	102	
Total	**45,678**	**44,439**	**(1,239)**	
Total Excl OOA and Drugs	**36,837**	**35,986**	**(852)**	



Key Messages

Overall non pay expenditure is £178k less than planned in month. For the year to date this is £1,239k underspent. This remains lower than expenditure in 2023 / 24 although it should be noted that the prior year did include a number of exceptional expenditure items.

The main variances in month are:

* Drugs - £40k less than budget. Main reductions within Calderdale and Kirklees community teams with the roll out of e-prescribing being suggested as a positive contributor.

* Training & Education - this continues to be an area of focus with expenditure £129k less than planned. The Trust continues to fund significant professional development.

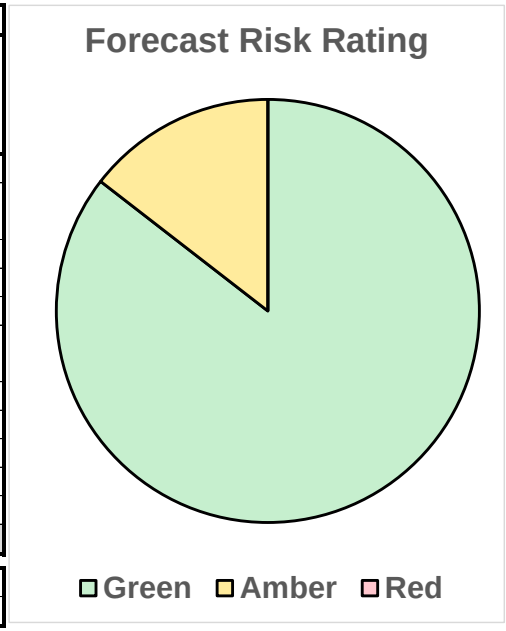
* Utilities costs, although seasonality is included within the Trust plan, have been £85k more than planned in January.

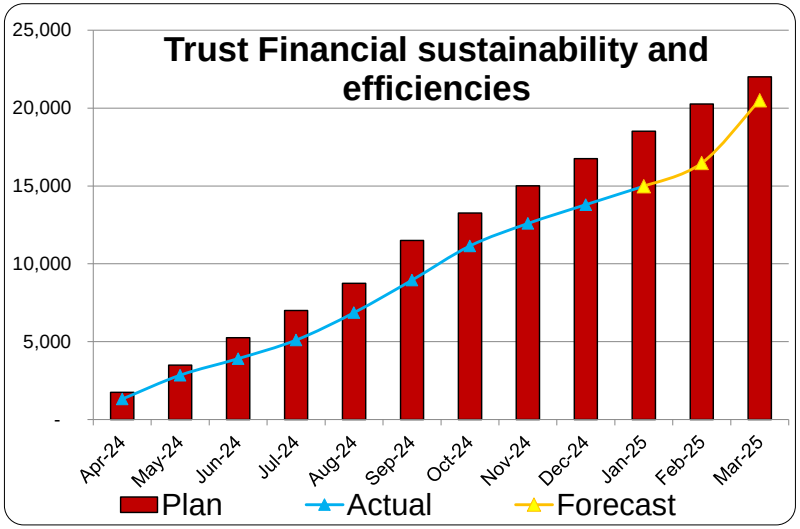
3.0 Value for Money, Financial sustainability and efficiency

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		10,390	423	6,461	12,468	8,693			(3,775)
Non pay - Impact of workforce optimisation		350	353		420	423			3
Out of area placements		2,393	2,632		2,871	2,632	425		187
Non pay - digital		205	150		246	179			(67)
Non pay - Estates		417	337	22	500	428			(72)
Non pay - medicines optimisation		400	0		480			0	(480)
Non Pay - other		0	191		0	218			218
Procurement		208	0		250		0		(250)
Provider Collaboratives		950	950		1,140	1,140			0
Non Recurrent mitigations		0	0		0		2,550		2,550
Income - contribution, Full Year Effect		3,198	3,419		3,638	3,818			180
Total		**18,511**	**8,455**	**6,482**	**22,013**	**17,530**	**2,975**	**0**	**(1,508)**
Recurrent		8,621	8,455		10,345	8,468	425	0	(1,452)
Non Recurrent		9,890		6,482	11,668	9,062	2,550		(56)





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 £20,505k of schemes will be delivered in 2024 / 25. This is £1,508k less than planned and will require mitigation within the overall financial position. The unachieved gap has increased by £448k since last month 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 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	199,625	
Current Assets			
Inventories & Work in Progress	179	179	
NHS Trade Receivables (Debtors)	1,072	2,119	
Non NHS Trade Receivables (Debtors)	344	802	
Prepayments	3,491	3,770	
Accrued Income	1,062	4,723	1
Cash and Cash Equivalents	69,199	54,506	Pg 15
Total Current Assets	**75,347**	**66,100**	
Current Liabilities			
Trade Payables (Creditors)	(12,728)	(4,908)	2
Capital Payables (Creditors)	(1,392)	(567)	
Tax, NI, Pension Payables, PDC	(8,469)	(9,651)	
Accruals	(13,966)	(14,782)	3
Deferred Income	(409)	(1,466)	4
Other Liabilities (IFRS 16 / leases)	(51,040)	(50,674)	
Total Current Liabilities	**(88,004)**	**(82,047)**	
Net Current Assets/Liabilities	**(12,657)**	**(15,947)**	
Total Assets less Current Liabilities	**155,161**	**183,677**	
Provisions for Liabilities	(3,510)	(3,467)	
Total Net Assets/(Liabilities)	**151,651**	**180,210**	
Taxpayers' Equity			
Public Dividend Capital	45,696	75,696	
Revaluation Reserve	15,355	14,928	5
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	85,380	84,365	
Total Taxpayers' Equity	**151,651**	**180,210**	

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.

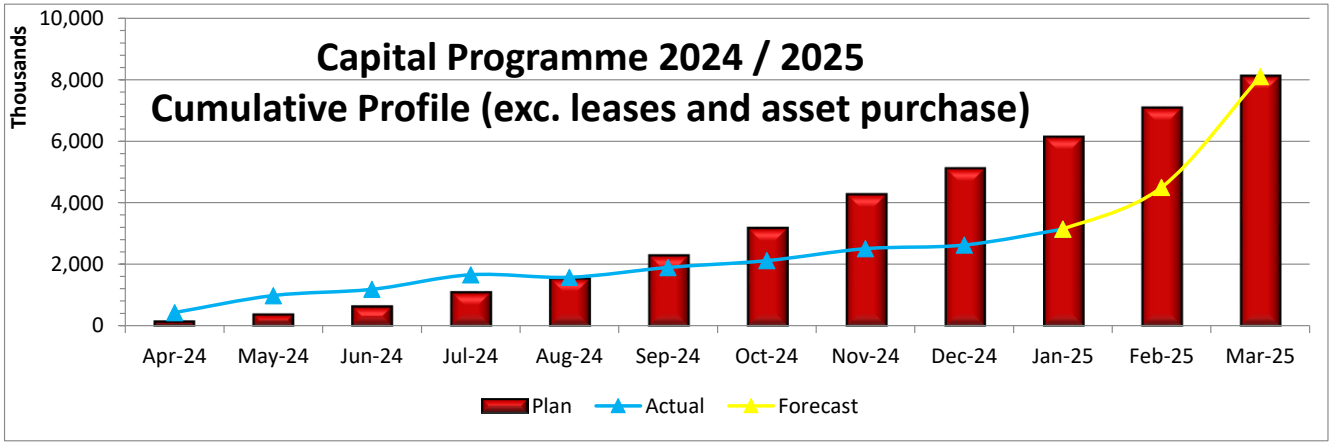
3. Accruals continue to be monitored. A detailed line by line review has been conducted and actions identified. This is as per a West Yorkshire Integrated Care System request linked to financial grip and control. Following the Month 9 agreement of balances exercise NHS accruals are been validated with other NHS bodies.

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	1,500	0	(1,500)	700	(1,800)
Seclusion Rooms	1,000	910	1,026	116	1,087	87
Anti-ligature Doors	1,000	820	364	(456)	865	(135)
Maintenance (Minor) Capital						
Clinical Improvement	311	311	280	(30)	335	25
Safety	302	302	243	(58)	958	657
Sustainability / Carbon Neutral	510	350	157	(193)	396	(114)
Backlog	360	212	140	(72)	1,166	806
Equipment	41	41	108	68	364	323
Other	193	130	16	(114)	714	521
IM & T	1,470	1,388	648	(740)	1,470	0
Contingency	219	0	0	0	(142)	(361)
Staff Costs	200	167	159	(7)	191	(9)
TOTALS	**8,104**	**6,129**	**3,142**	**(2,988)**	**8,104**	**(0)**
Lease Impact (IFRS 16)	5,910	5,860	8,015	2,155	8,023	2,113
Asset Purchase	0	0	35,000	35,000	35,000	35,000
Cheswold - Minor Capital		0	9	9	1,265	1,265
Cheswold - IM & T		0	344	344	750	750
TOTALS	**14,014**	**11,989**	**46,510**	**34,521**	**53,142**	**39,128**

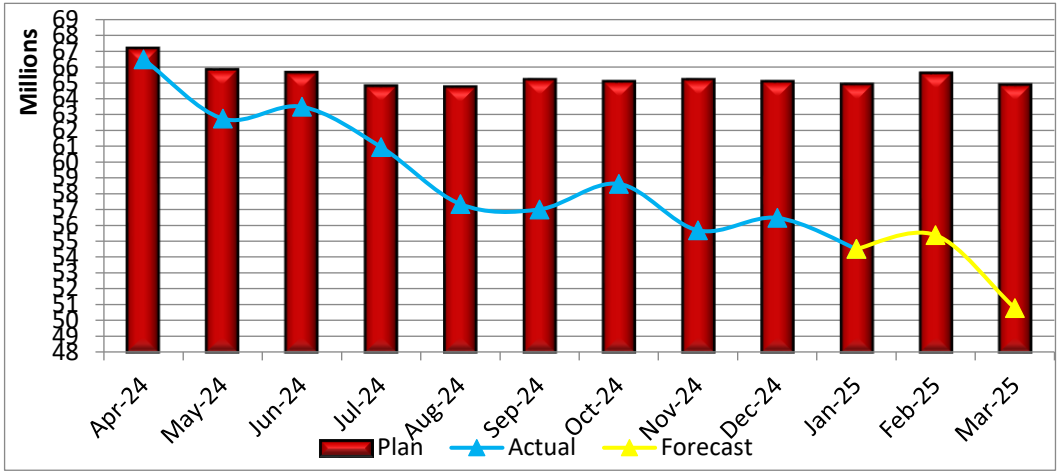


Capital Expenditure 2024 / 25

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).

A further £648k will be added in February 2025 (both allocation and forecast expenditure) following a successful grant bid to support LED lighting.

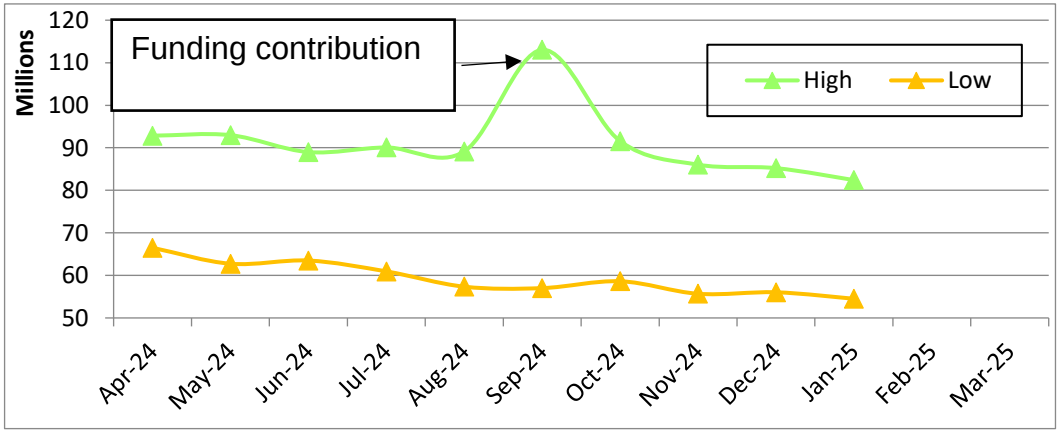
4.2 Cash Flow & Cash Flow Forecast 2024 / 2025



Cash levels have reduced in month

With the continued deficit run rate the trend of reducing cash balances has continued in January. To recover this the focus remains on receipt of income for services delivered.

	Plan £k	Actual £k	Variance £k
Opening Balance	71,353	69,199	
Closing Balance	64,920	54,506	(10,414)



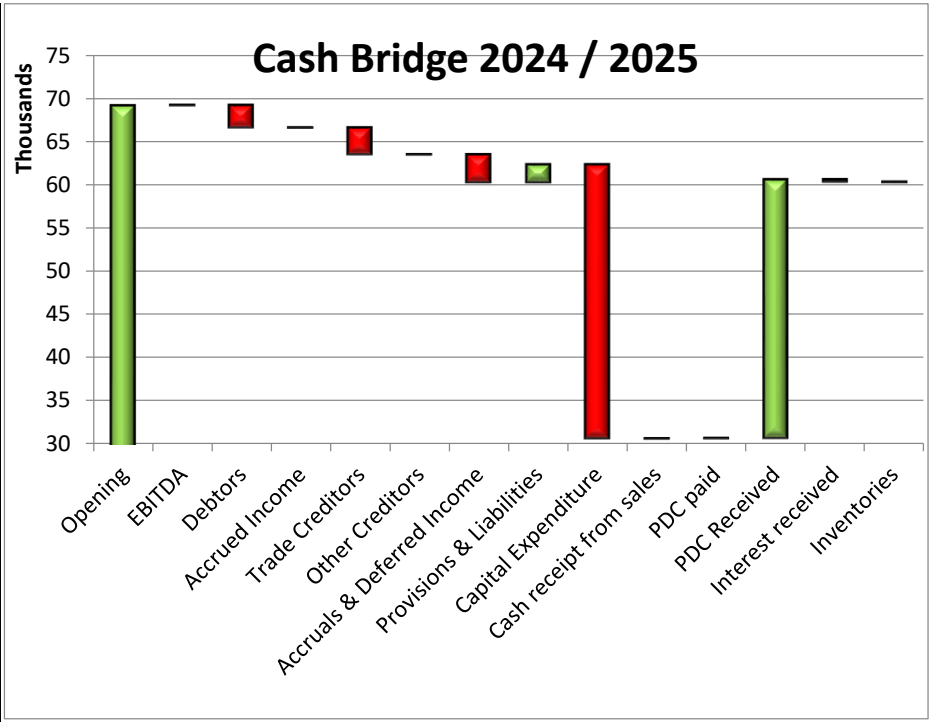
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £82.4m
The lowest balance is: £54.5m

This reflects cash balances built up from historical surpluses.

4.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**71,353**	**69,199**	(2,154)	
Surplus / Deficit (Exc. non-cash items & revaluation)	10,890	10,936	46	
Movement in working capital:				
Inventories & Work in Progress	52	0	(52)	
Receivables (Debtors)	430	(2,189)	(2,619)	
Trade Payables (Creditors)	(3,250)	(6,335)	(3,085)	
Accruals & Deferred income	0	(3,257)	(3,257)	
Provisions & Liabilities	(1,230)	851	2,081	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(7,553)	(39,320)	(31,767)	
Cash receipts from asset sales	0	24	24	
Leases	(8,199)	(7,553)	646	
PDC Dividends paid	(1,074)	(1,050)	24	
PDC Dividends received	0	30,000	30,000	
Interest (paid)/ received	3,501	3,200	(301)	
Closing Balances	**64,920**	**54,506**	**(10,414)**	



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.

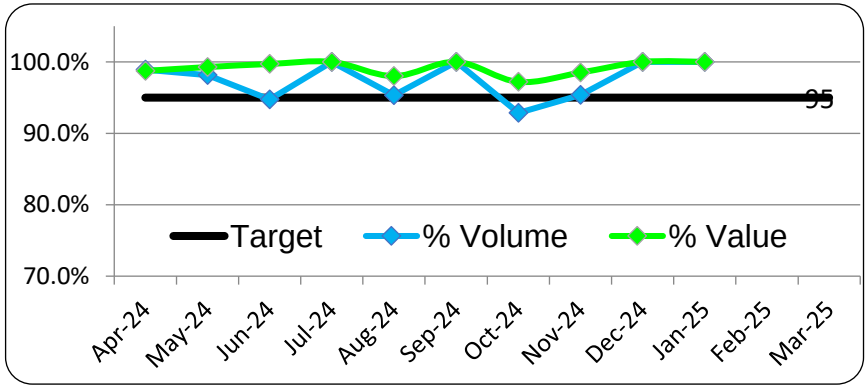
5.0 Better Payment Practice Code

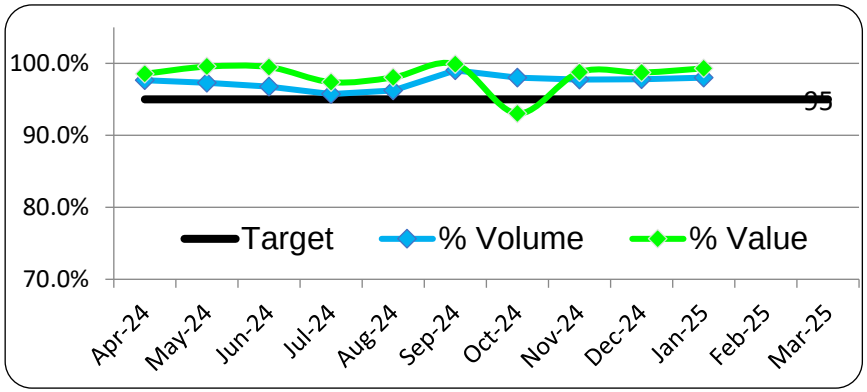
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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 (£)
09-Jan-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003378	838,568
14-Jan-25	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare Nhs Trust	1000058744	769,054
09-Jan-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003379	697,584
09-Jan-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003380	697,584
16-Jan-25	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	205236	644,853
20-Jan-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS54	450,000
02-Jan-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510009708	400,537
24-Jan-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care Nhs Foundation Tru	0000001302	323,972
21-Jan-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS31	270,000
06-Jan-25	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber Nhs Found	4400002428	241,311
09-Jan-25	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 293	219,196
02-Jan-25	NHS Recharge	Wakefield	Mid Yorkshire Hospitals Nhs Trust	1600033980	201,760
07-Jan-25	NHS Recharge	Wakefield	Mid Yorkshire Hospitals Nhs Trust	1600033723	201,760
28-Jan-25	NHS Recharge	Wakefield	Mid Yorkshire Hospitals Nhs Trust	1600034252	201,760
02-Jan-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510009704	186,688
09-Jan-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS052SN	112,182
02-Jan-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care Nhs Foundation Tru	0000000792	94,442
16-Jan-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34017765	92,178
06-Jan-25	IT Services	Trustwide	Daisy Corporate Services	3I538523	90,250
28-Jan-25	NHS Recharge	Calderdale	Calderdale & Huddersfield Nhs Foundation Trust	4710180855	86,650
08-Jan-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003362	81,683
23-Jan-25	Drugs	Trustwide	Bradford Teaching Hospitals Nhs Foundation Trus	328591	75,833
13-Jan-25	Drugs	Trustwide	Lp Hcs Ltd	SIH001348	74,033
08-Jan-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003363	67,949
08-Jan-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003364	67,949
08-Jan-25	Purchase of Healthcare	Barnsley	Barnsley Healthcare Federation Cic	INV2669	67,916
24-Jan-25	Rates	Doncaster	Doncaster Metropolitan Borough Council	94005800651501202560167 70	60,168
09-Jan-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D5100097041	56,769
21-Jan-25	Utilities	Trustwide	Edf Energy Customers Ltd	000021853384	56,316
22-Jan-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34018296	56,000

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
30-Jan-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens Nhs Foundation Trust	2400006955	53,405
20-Jan-25	IT Services	Trustwide	Daisy Corporate Services	3I538100A	49,986
06-Jan-25	Purchase of Healthcare	Forensics	Spectrum Community Health Cic	SINV8365	48,868
07-Jan-25	Purchase of Healthcare	Kirklees	Northpoint Wellbeing Ltd	RGA15499	47,351
24-Jan-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care Nhs Foundation Tru	0000001303	47,221
30-Jan-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens Nhs Foundation Trust	2400006955	45,560
07-Jan-25	NHS Recharge	Wakefield	Mid Yorkshire Hospitals Nhs Trust	1600033729	43,438
07-Jan-25	Purchase of Healthcare	Forensics	Sheffield Childrens Nhs Foundation Trust	2400006810	43,280
10-Jan-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90146501	43,169
07-Jan-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001292EPC	42,472
11-Jan-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34017672	40,575
25-Jan-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34018719	40,575
21-Jan-25	Utilities	Trustwide	Totalenergies Gas & Power Ltd	36603401425	39,072
15-Jan-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003361	38,122
28-Jan-25	Mobile Phones	Trustwide	Vodafone Ltd	107354593	36,887
30-Jan-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens Nhs Foundation Trust	2400006955	35,827
15-Jan-25	Continence Products	Barnsley	Supply Chain Coordination Limited	239749	34,701
30-Jan-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens Nhs Foundation Trust	2400006955	33,966
07-Jan-25	NHS Recharge	Barnsley	Barnsley Hospital Nhs Foundation Trust	6028305	31,204
10-Jan-25	Purchase of Healthcare	Trustwide	Cygnet Nw Ltd	BUR0385796	30,721
16-Jan-25	MFD	Trustwide	Annodata Ltd	1387399	30,591
21-Jan-25	Utilities	Trustwide	Totalenergies Gas & Power Ltd	36603457525	30,097
09-Jan-25	Computer Software	Trustwide	Civica Uk Ltd	COH319034	30,000
30-Jan-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens Nhs Foundation Trust	2400006955	28,797
26-Jan-25	Rent	Kirklees	Bradbury Investments Ltd	1918	28,491
30-Jan-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	THO05550	28,383
27-Jan-25	NHS Recharge	Barnsley	Sheffield Teaching Hospitals Nhs Foundation Trus	1400036825	27,655
14-Jan-25	Lease Car	Trustwide	Athlon Mobility Services Uk Ltd	202480028558	27,303
07-Jan-25	Drugs	Trustwide	Speeds Healthcare Ltd	INV153356	25,926
10-Jan-25	Purchase of Healthcare	Trustwide	Cygnet Behavioural Health Ltd	APL0386011	25,875
09-Jan-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS052INV	25,731
06-Jan-25	Purchase of Healthcare	AS Collaborative	Mersey Care Nhs Foundation Trust	72488714	25,627
10-Jan-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90146500	25,019
10-Jan-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90146502	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.

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Appendix 3 - Statistical Process Control (SPC) Charts Explained

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

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

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

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

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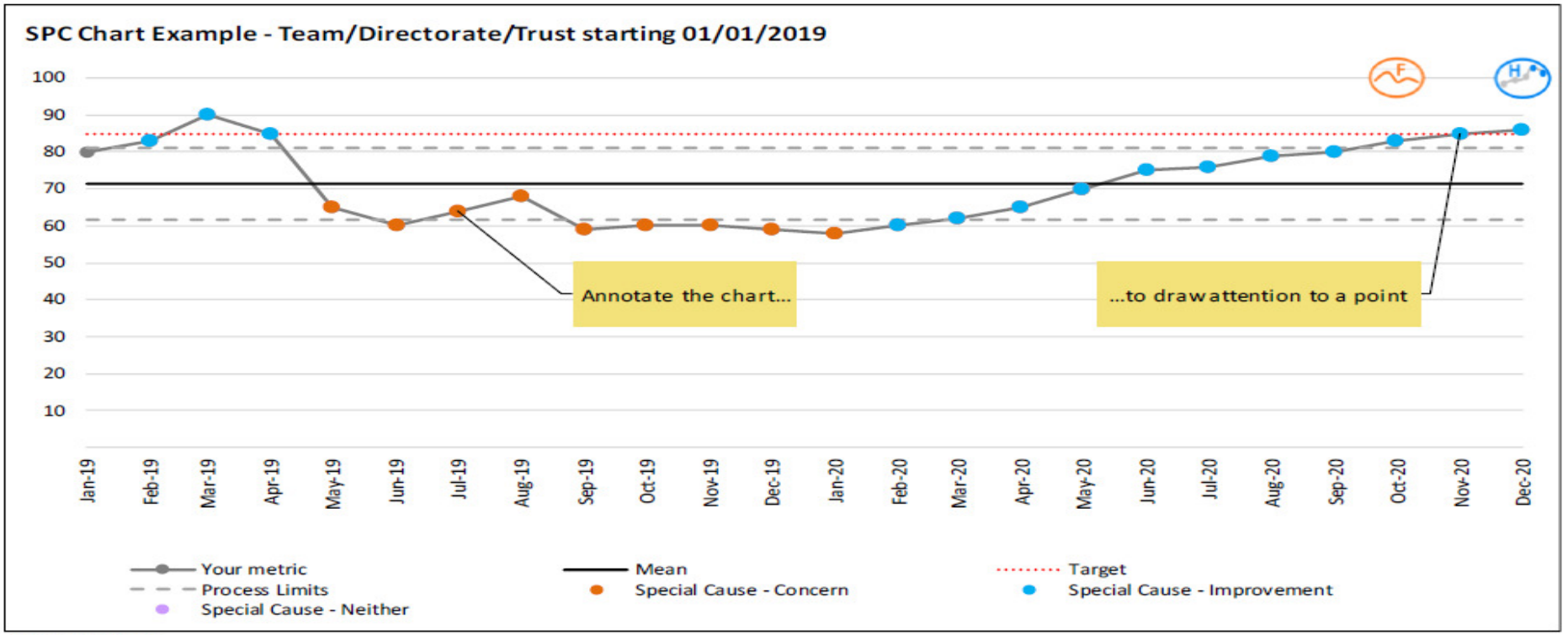
Appendix 3 - Statistical Process Control (SPC) Charts Explained



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.