NHS
South West
Yorkshire Partnership
NHS Foundation Trust

# Integrated Performance Report
# Strategic Overview

## February 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 February 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.

# 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) | ⬆ | ? |
| Learning Disability (LD) - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks | ⬇ | H, ? |

### 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, F |

## Improving Resources

### 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 | ⟺ | L, ? |
| 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 | ↑ | |
| Information Governance training compliance | ↓ | H |

### 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 | ↑ | |

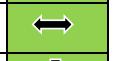
### Barnsley Physical Health and Wellbeing

| Metrics | Change from last month | Variation/ Assurance |
|---|---|---|
| % Appraisal rate | ↓ | F |
| Information Governance (IG) training compliance | ↓ | |
| Sickness rate (Monthly) | ↓ | |
| % of staff receiving supervision within policy guidance | ↓ | |

### 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<br>The icon which represents the last data point on an SPC chart is displayed. | | | | | | Assurance Icons<br>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 and 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. 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 Trust's previous four strategic objectives.

**Improving health**

• It is encouraging that solid progress has been made against the metrics identified to monitor progress against the improving health strategic objective. In particular there has been positive growth in the proportion of staff from an ethnic minority background in band 7 and above roles.
• 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 96.4% against a target of 90%. Disability recording was at 52.4%, sexual orientation 57.6% and postcode at 99.6%. Work continues to ensure data capture will be extended to all services.
• Key to improvement in addressing inequalities is the refresh of our Equality Diversity and Inclusion strategy, from this we will have very clear priorities on our areas of focus to tackle health inequalities.
• The benefits of employment are clearly recognised and 33 service users accessed support through our individual placement support teams during the month, a positive step into securing employment.

**Improving care**

• Risk assessments are integral to providing safe and effective care and making decisions on transition between services. In January 2025, the Trust implemented new mental health care plans for both inpatient and community settings. Data for February is provisional but is showing an improvement on the January position with 92.3% of inpatients having a risk assessment/staying safe plan in place within 24 hours of admission and 76.3% of community patients with a risk assessment/staying safe plan in place within 7 working days of first contact. All service users without a risk assessment are followed up individually in the care group to maintain patient safety.
• The Trust had 15 violence and aggression incidents against staff on mental health wards involving race during February which whilst a reduction on last month, this is still disappointing. We are very mindful of the personal impact this has on our colleagues. We provide support to those affected and working with other trusts to identify other opportunities to reduce the prevalence of these incidents.
• Neurodevelopment waits remain a major issue 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 continue to see an increase in demand and have 36% more people waiting for initial assessment at the end of February 2025 (2905) compared to February 2024 (2121). Close work with commissioners is underway across the place.
• Improvement work on waiting list times in community learning disability services has led to an overall improvement against the 18 weeks standard and for the month of February 94% against a target of 90% was achieved. This has shown a sustainable improvement over the last 6 months.
• The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. The benefits of providing care close to home are very evident. This can have an impact on our inpatient staffing costs given the high occupancy on many wards, and we are evaluating any unintended risks as a result of focus on maintaining local care.

**Improving resources**

**Making SWYPFT a great place to work**

• Our 12-month turnover rate in February has reduced slightly to 7.7% 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. Staffing establishments for mental health have been agreed therefore recruitment has commenced which will improve consistency of care and reduce the requirement for high use of temporary staffing in time. The establishment reviews for Forensics is taking place this month.

• At the end of February 2025, our workforce growth rate has continued to slow compared to earlier months and was at 2.5% (staff in post) year to date. This exceeds our annual budgeted growth rate of 0% and has resulted in financial pressures. The work taking place to review establishments may see an initial increase in growth but a reduction in agency and bank.

• For the year to date, we have had 432 new starters and 358 leavers. The Trust did see an increase in starters in earlier months which was largely a result of positive recruitment activity last year and contributes to providing operational capacity to support patient care. We continue to see a downward trend of number of starters which could suggest the additional controls put in place are taking effect.

• Our year-to-date sickness remains at 5.3% with February sickness decreasing to 5.1%. There was a decrease in the number of cold and flu related absences during the month. The majority of absences being short term absence but we are seeing an increase in stress and anxiety related absences.

Hotspot areas include mental health acute wards, older people inpatient, forensics wards including community, and these continue to be managed with care groups. Sickness absence on wards does lead to use of bank and agency staffing.

• Reporting on the appraisal rate shows a deterioration in performance during the month. As previously reported there have been significant technical issues with the external system supplier resulting in it being unavailable.  Appraisal data has now been successfully migrated from WorkPal to ESR. A trajectory of improvement has been established and this is being monitored, with 81.4% being achieved in February against a trajectory of 82.3%. Work continues to provide access for clinical lead and managers to be able to document the appraisal onto ESR. Focus remains in hotspot areas with Director oversight.

• Continued focus has led to supervision remaining above target in January at 85.3%. Regular 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 stands at 80.1% which remains above threshold. Training places available are being increased and a targeted approach is taken to booking staff onto refresher training. As from the 1st April 2025, line managers will be booking staff on the training which will allow planned trajectory and appropriate roster management. 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 compliance has slightly dropped this month, however a dedicated focus on non compliance is taking place 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:

96% of incidents reported in February 2025 resulted in no or low harm or were not under the care of the Trust, an overview of key indicators is below:

• The number of restraint incidents decreased from 196 to 178 reported in January. 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 increased during the month to 13. 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. The incidents reported this month were mostly attributed to one of our PICU wards, Walton, relating to three service users that required seclusion and or administration of intramuscular medication and prone restraint was used.

RRPI from the 1st April will teach all new starters and refresher training to exit seclusion and administer intramuscular medication without using prone restraint.

• There were 12 information governance personal data breaches during February. 7 of the incidents related to information being disclosed in error. These incidents were spread across care groups with no significant hotspots being identified. Learning from incidents is shared across care groups.

• The number of inpatient falls reported during February 2025 increased slightly to 49. We actively risk assess those service users who are at high risk of falling and implement care plans. All falls incidents are reviewed regularly by the Trust wide falls coordinator to ascertain any themes or actions required.

• The number of responses provided within six months of the date a complaint is under the national threshold of 100%, this relates to three complaints out of nineteen not receiving a response within six months (84%). Response times for complaints are more consistent and we are also monitoring the average number of days it takes for a complaint to be signed off.

**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 February was 92 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).

• 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 149 out of 165 children (90.3%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in February. This is being achieved via the use of agency staff which has an impact on our financial position and reported agency expenditure. Work is taking place to recruit to this post and review the service provision.

**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. For service users waiting for a first appointment at the end of February, 76.4% of those waiting had been waiting for a period of 18 weeks or less. This excludes waits for autistic spectrum disorder waits and neurodevelopmental teams which are reported separately and average wait for assessment is 312 days in Kirklees and 888 in Calderdale.
• 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. The commissioned level for Barnsley, Wakefield and Kirklees for February is 30 cases, the number of referrals received in February was 440.
• Mental health acute wards have continued to manage high levels of acuity, increased levels of risk to self and others, which requires an increase in observations. Further work is being carried out to understand how inefficiencies can be reduced to release time for nursing staff to care. Continued high occupancy levels contribute to increased acuity as more people with high levels of complex needs 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 February acute wards have continued to work above establishment.
• Demand into the Single Point of Access (SPA) and capacity issues in Calderdale and Kirklees have led to ongoing pressures in the service, workforce challenges are continuing to compound these problems. Business continuity plans are in place to ensure risk screening occurs routinely and management support and oversight is in place for the team. The progress on actions from the Trustwide SPA review are being implemented and are monitored through the care group governance processes.
• SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. The access standard for assessed within 14 days of referral has been met in Barnsley and Wakefield. There have been specific challenges with admin vacancies in Calderdale & Kirklees SPA impacting on performance.
• A focus on patients clinically ready for discharge is taking place across mental health and learning disabilities. Particular challenges are those associated to specialist placements. Hotspot areas include learning disabilities, older peoples and PICU. A review of clinically ready for discharge for Forensic services is also taking place.

**Finance**

• The Trust financial target for 2024 / 25 is breakeven. A surplus of £1.1m has been reported in month, through a combination of improved performance in all sectors and non-recurrent benefits which has reduced the year to date deficit to £0.6m. Further non-recurrent mitigations have been identified to support delivery of the year-end break-even target.
• Agency expenditure run rate has continued to fluctuate. Spend in January is £499k which is £185k less than last month. The provider collaborative spend in month was £50k which is £37k less than last month. Cheswold Park Hospital spend in month was £52k which is £127k less than last month; January was higher than the normal run rate due to medical staff arrears. Focus work on bank and agency is taking place with a plan to reduce as per planning guidance.
• Cash has continued to reduce month on month throughout 2024 / 25 and now stands at £55.9m. Although the financial position has improved in month the mitigations are non-cash. Steps to maximise our cash position by effectively managing our working capital continue.

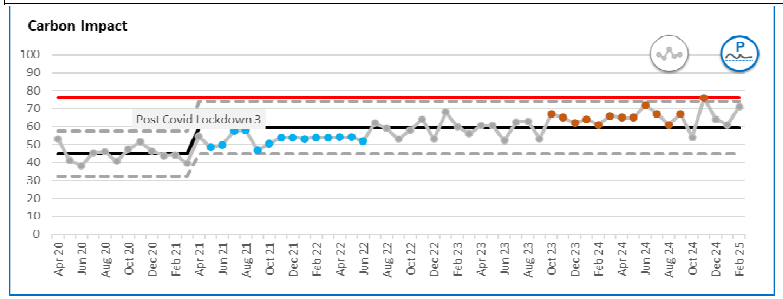
**Cheswold Park Hospital**

• Data for 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 has dropped just below the 80% Trust threshold (80%) reporting 79% in February.
• Mandatory training levels for cardiopulmonary resuscitation, reducing restrictive physical interventions, fire and information governance all remain well above the 80% threshold.
• There were 125 incidents reported during the month; one of those resulted in moderate harm. The common cause of these incidents related to medication, self-injurious behaviours and violence and aggression.
• Continued support for Cheswold Park is ongoing as part of the transition and improvement plan.

**Improving health**

| Metrics | Threshold | Dec-24 | Jan-25 | Feb-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 (17.4%) 113 - excl medics (9.2%) | 254- All staff (17.8%) 117 - excl medics (9.5%) | 256- All staff (17.8%) 121 - excl medics (9.8%) | | 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% | 96.6% | 96.5% | 96.4% | | |
| Percentage of service users who have had their equality data recorded - disability | 50% | 54.5% | 53.6% | 52.4% | | 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% | 58.5% | 57.6% | | |
| Percentage of service users who have had their equality data recorded - deprivation (postcode) | 90% | 99.5% | 99.5% | 99.6% | | |
| Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure) | Service timely completion - 75% Policy - 95% | 79.9% Service<br>100% Policy | 93.1% Service<br>100% Policy | 95.6% Service<br>99.5% Policy | | |
| Completion of equality mandatory training | >=80% | 96.3% | 96.3% | 96.3% | | |
| Number of job start/work retention outcomes during month by individual placement and support service | Trend monitor | 11 | 12 | 14 | | A single client could have multiple job starts |
| Number of new people accessing Individual placement and support service during month | Trend monitor | 25 | 51 | 33 | | 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 | 64 | 61 | 71 | | Data showing the carbon impact of staff travel / business miles.<br>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.<br>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% | Q3 - 71.6% | | | | Q1 - 68.5%, Q2 - 67.8% Q3 - 71.6%. 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 February 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.

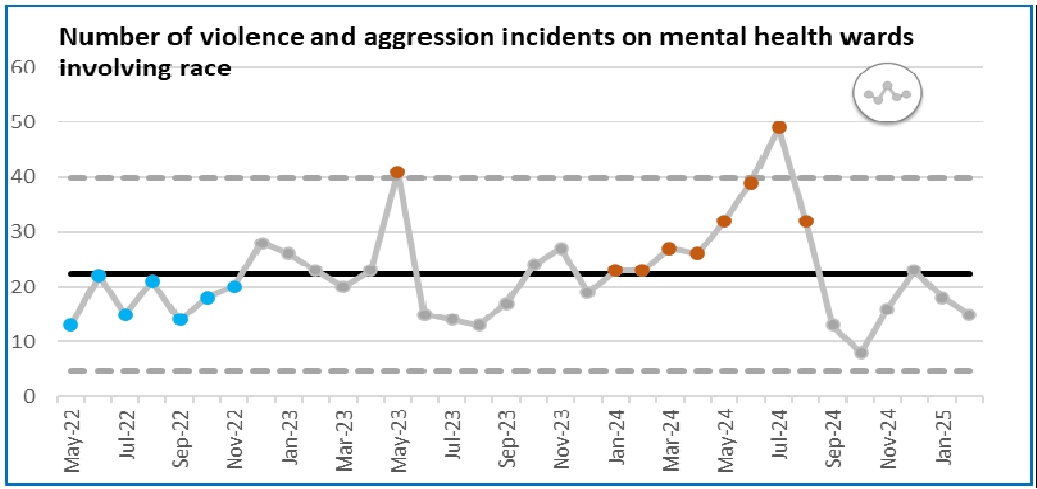
## Improve Care

| Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|
| The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient | 95%<br><br>Improvement trajectory for Community - Jul/Aug 80% Sept 82.5% Oct 85% Nov 87.5% Dec 90% Jan 92.5% | 94.9% | 87.3% | *92.3%* | | Within inpatient services, all service users have a risk assessment with 108 service users having had a risk assessment within 24 hours, a further 18 service users had a completed risk assessment - with 1 of those being between 4-5 hours over the 24-hour standard, 1 of those being between 10-15 hours over the 24-hour standard and 16 of those being 15 hours or more over the 24 hour standard). For community services 30 out of 156 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.<br><br>On 6th January 2025, the Trust implemented new mental health care plans for both inpatient and community settings. Whilst new practice is being embedded, we have seen a drop in performance for completion within the timescales. Data for February is provisional and will be refreshed in next months report. |
| The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community | | 74.2% | 67.1% | *76.3%* | | |
| % Service users on care programme approach with a plan of care developed collaboratively | 85% | 99.7% | 99.7% | 99.7% | | The Care Plan and Risk Assessment Improvement Group continue to review performance as well as quality of care planning and risk assessments. |
| Registered substantive staff in post mental health and learning disabilities services | Establishment - 1315 | 1,139 | 1,134 | 1,138 | | The establishment numbers reported are registered (band 5 and upwards) nursing staff only within each area. The monthly numbers exclude bank and agency staff which may have been utilised to support the operational impact of any gaps. |
| Registered substantive staff in neighbourhood teams | Establishment - 169 | 160 | 164 | 165 | | |
| Number of violence and aggression incidents against staff on mental health wards involving race | Trend monitor | 23 | 18 | 15 | | The 15 incidents reported during the month were spread across Forensic and mental health wards. 10 of those incidents involved 3 individuals and 5 incidents relating involved 1 individual.<br>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 and other abuse during their work in a clinical role. |
| Inappropriate out of area bed placements (days) | Dec - 155<br>Jan - 155<br>Feb - 140 | 127 | 106 | 92 | | National target is zero inappropriate out of area bed days.<br>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 in the lasy year. 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. |
| % service users clinically ready for discharge | <=3.5% | 3.7% | 5.2% | 5.2% | | Performance in month has remained static. 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. A significant issue tends to be the availability of specialist placements. |

**Improve Care Continued**

| Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|
| CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale | 126 | 291 | 328 | 312 | | Neurodevelopment waits remain an issue. This is in keeping with the national picture and forms part of system wide work. Children and young people are seen in order of need and not by how long they have waited. The number of referrals remains high. When referrals are screened and deemed clinically appropriate for assessment families are offered the choice of provider. |
| CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees | 126 | 785 | 737 | 888 | | |
| Learning Disability (LD) - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks | 90% | 97% 60/62 | 97% 60/62 | 94% 51/54 | | Improvement work on waiting list times in community learning disability services has led to an overall improvement. The learning disability team have robust oversight of all waits and are carrying out profession specific actions to address waits within individual disciplines. |
| The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care | 80% | 94.0% | 92.4% | 89.7% | | |
| Community health services two hour urgent response standard | 70% | 89.2% | 90.7% | 90.2% | | |
| Referral to assessment within 2 weeks (external referrals) | 75% | 78.6% | 74.2% | 85.1% | | |

**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 February 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 | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|
| Surplus/(deficit) against plan (Cumulative) | Breakeven | (£911k) | (£1,898k) | (£567k) | | The Trust financial target for 2024/25 is breakeven. A surplus, of £1.1m, has been reported in February. Of this approximately £0.7m related to non-recurrent mitigations which have been identified as part of the Trust mitigation plan to deliver the breakeven target. |
| Capital spend against plan (Cumulative) | £8.1m | £2,622k | £2,988k | £4,132k | | £4.1m has been spent to date due to delays with the major scheme that was planned some programmes have been brought forward from 2025/26 and whilst there is some risk the forecast remains to spend the full year budget. |
| Agency spend managed within the overall workforce (Monthly) | 3.5%<br>£6.7m | £608k | £684k | £499k | | 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 £185k less than the previous month. |
| Financial sustainability and efficiencies delivered over time (monthly) | £22m | £1,209k | £1,230k | £1,626k | | 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 | £24,022k<br>(average pay Q4) | £23,998k | £24,310k | £23,894k | | Threshold revised to take into account the pay award. Following this revision total pay is within expected threshold |
| 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.<br>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% | 98.9% | 96.8% | 95.8% |  | 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% |  | |

**Make SWYPFT a great place to work**

| Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|
| Turnover external (rolling 12 months) | >12% - 13%< | 7.6% | 7.8% | 7.7% | | Turnover continues to remain at a low level compared to previous years. There has been an ongoing reduction since October '23.<br>This can be linked to positive work on recruitment and retention as well as recognising the national financial picture an opportunities available. |
| Registered workforce growth | 0% 2024/25 | 2.5% | | | | 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.<br>This growth includes funded investment priorities (i.e. Barnsley neighbourhood teams service). |
| Sickness absence - YTD | <=5% | 5.3% | 5.3% | 5.3% | | Further detail around sickness absence is provided in the relevant section of this report. In month sickness was 5.1%. |
| Appraisals - rolling 12 months | Projected Compliance:<br>Jan - 78.3%<br>Feb - 82.3%<br>Mar - 84.9%<br>Apr - 86.9%<br>May - 88.7%<br>Jun - 90.1% | 85.9% | 81.8% | 81.4% | | 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 we are now monitoring against this. |
| % staff recommending the Trust as a place to work | 65% | 70.0% | | | | Results from national staff survey. |
| % staff recommending the Trust as a place to receive care and treatment | 65% | 72.0% | | | | |
| Staff supervision rate | 80% | 84.4% | 84.6% | 85.3% | | As part of the review of the supervision of the workforce policy, an improvement programme is underway to use the learning from the Forensic care group to increase uptake and recording of supervision within the clinical workforce. This includes making further changes to the systems and reporting practice. |
| Mandatory training - Cardiopulmonary resuscitation | 80% | 82.0% | 80.9% | 81.3% | | In order to maintain a safe environment, inpatient services ensure access to appropriately cardiopulmonary resuscitation trained staff on each shift. Targeted actions are in place and compliance is reported monthly to the Executive Management Team (EMT) with hot spot reports reviewed by the Operational Management Group (OMG). |
| Mandatory training - Reducing restrictive practice interventions (RRPI) | 80% | 80.5% | 81.5% | 80.1% | | 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.<br>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% | 90.0% | 90.6% | 90.9% | | |
| Mandatory training - Information governance (IG) | 95% | 93.6% | 93.5% | 93.1% | | |

## Quality Headlines

| Section | KPI | Target | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Year End Forecast* |
|---|---|---|---|---|---|---|---|---|---|
| Quality | CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5] | TBC | 83.3% | 83.4% | 82.9% | 78.2% | 76.4% | 76.4% | N/A |
| Complaints | % of feedback with staff values and behaviours as an issue [12] | < 20% | 33% (8/24) | 16% (5/31) | 24% (7/29) | 19% (3/16) | 14% (4/29) | 19% (5/27) | 1 |
| | Complaints - Average number of working days to sign off for closed complaints (in month) | Trend monitor | Reporting commenced Dec24 | | | 91.8 | 74.0 | 96.8 | |
| | Complaints - Number of responses provided within six months of the date a complaint received [16] | 100% | 85% (11/13) | 71% (17/24) | 100% (12/12) | 88% (7/8) | 92% (11/12) | 84% (16/19) | |
| Service User Experience | Friends and Family Test - Mental Health | 84% | 90% | 94% | 92% | 92% | 90% | 92% | 1 |
| | Friends and Family Test - Community | 95% | 97% | 96% | 97% | 96% | 97% | 97% | 1 |
| Quality | Number of compliments received | N/A | 54 | 66 | 27 | 27 | 65 | 30 | N/A |
| | Notifiable Safety Incidents (where Duty of Candour applies) [4] | Trend monitor | 10 | 7 | 9 | 8 | 9 | 5 | |
| | Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4] | Trend monitor | 0 | 1 | 0 | 1 | 0 | 0 | N/A |
| | Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4] | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| | % Service users on CPA offered a copy of their care plan | 80% | 96.4% | 96.2% | 99.8% | 99.7% | 99.7% | 99.7% | 1 |
| | Number of Information Governance breaches [3] | <12 | 5 | 8 | 11 | 9 | 6 | 12 | 2 |
| | % of inpatients clinically ready for discharge | 3.5% | 4.8% | 4.3% | 4.4% | 3.7% | 5.2% | 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%* | 89.7% | 92.6% | 93.8% | 94.9% | 87.3% | *92.3%* | 3 |
| | The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community | | 76.5% | 80.7% | 77.6% | 74.2% | 67.1% | *76.3%* | 2 |
| | Total number of reported incidents | Trend monitor | 1302 | 1258 | 1283 | 1297 | 1391 | 1122 | |
| | Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9] | Trend monitor | 39 | 28 | 25 | 25 | 35 | 30 | |
| | Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9] | Trend monitor | 2 | 5 | 0 | 0 | 2 | 3 | |
| | Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9] | Trend monitor | 1 | 0 | 2 | 0 | 2 | 1 | |
| | Safer staff fill rates | 90% | 129.4% | 131.2% | 134.0% | 128.8% | 128.3% | 132.8% | 1 |
| | Safer Staffing % Fill Rate Registered Nurses | 80% | 99.0% | 100.0% | 104.0% | 101.9% | 100.5% | 103.0% | 1 |
| | Number of pressure ulcers which developed under SWYPFT care [1] | Trend monitor | 56 | 33 | 21 | 50 | 52 | 38 | |
| | 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% | 92.3% (12/13) | 92.3% (12/13) | 100% (9/9) | 100% (10/10) | 100% (5/5) | 100% (13/13) | 1 |
| | Number of Falls (inpatients) | Trend monitor | 47 | 50 | 32 | 37 | 43 | 49 | |
| | Number of restraint incidents | Trend monitor | 196 | 187 | 235 | 189 | 196 | 178 | |
| | % of staff receiving supervision within policy guidance [15] | 80% | 84.1% | 84.4% | 86.9% | 84.4% | 84.6% | 85.3% | 2 |
| | Potential under-reporting of patient safety incidents | | | | | | | | |
| | % people dying in a place of their choosing [14] | 80% | 87.1% | 86.5% | 97.3% | 95.0% | 86.2% | 93.5% | 1 |
| Infection Prevention | Infection Prevention (MRSA & C.Diff) All Cases | 6 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| | C Diff avoidable cases | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| | E. Coli bloodstream infection rate | 0 | 1 | 0 | 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 February.

• The overall number of restraint incidents in February was 178 which is an increase on the previous month but remains within normal range. 24 of these incidents were attributed to Elmdale ward and 23 to Walton 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 5 in February. 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 19 complaints responded to during the month, 16 were undertaken within 6 months of the complaints being received, and the average number of working days these 8 complaints were open was 96.8days. 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 remained at 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 February there were 49 inpatient fall incidents. Actions have been put in place to further reduce the risk. Further detail is provided in the relevant section of this report.

## Patient Safety

**Patient Safety Incident Response Framework (PSIRF)**

As reported in the previous Integrated performance Report, we have been implementing the Patient Safety Incident Response Framework. The Trusts PSIRF plan and policy went live on the 1st December 2023.

**Patient Safety Partners (PSP)**

The three patient safety partners (this is a volunteer role) continue to support patient safety improvement work.

**Cheswold Park**

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

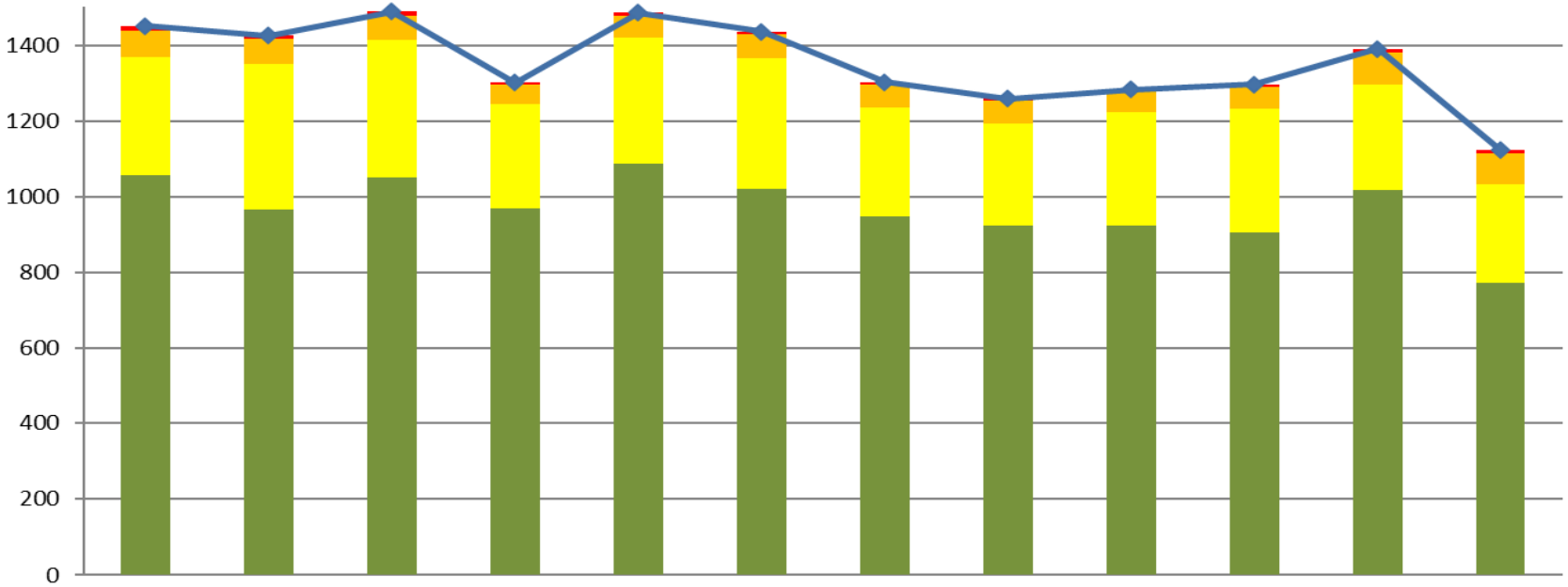
**Safety Incident Response Accreditation Network (SIRAN)**

The team have received the peer review and now awaiting review from the Safety Incident Response Accreditation Network team.

## Safety First

### Summary of Incidents

Although we have reported 7 red incidents in February, incidents may be subject to regrading as more information becomes available so this figure is subject to change.
96% of incidents reported in February 2025 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in February 2025




| | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Red (should not be compared with SIs) | 12 | 9 | 12 | 6 | 9 | 6 | 7 | 6 | 5 | 6 | 11 | 7 |
| Amber | 70 | 66 | 62 | 51 | 57 | 65 | 61 | 58 | 54 | 58 | 83 | 81 |
| Yellow | 312 | 383 | 362 | 275 | 331 | 344 | 285 | 270 | 300 | 326 | 280 | 262 |
| Green | 1057 | 967 | 1052 | 969 | 1088 | 1020 | 949 | 924 | 924 | 907 | 1017 | 772 |
| Total | 1451 | 1425 | 1488 | 1301 | 1485 | 1435 | 1302 | 1258 | 1283 | 1297 | 1391 | 1122 |

## Safety First cont…

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

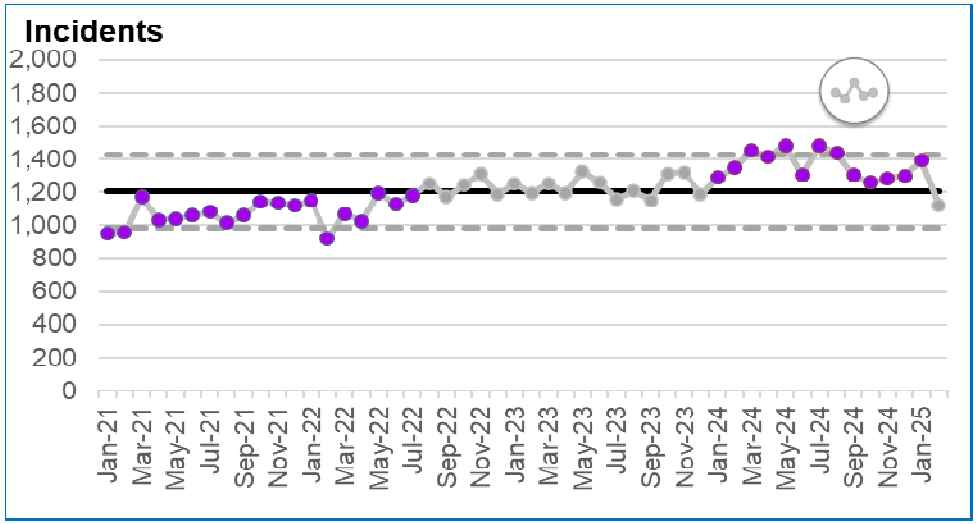
**Breakdown of incidents in February 2025**

**30 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.

**3 severe harm incidents:**
All incidents related to self harm.

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

**Incidents**




We have entered a period of common cause variation in February 2025 due a decrease 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

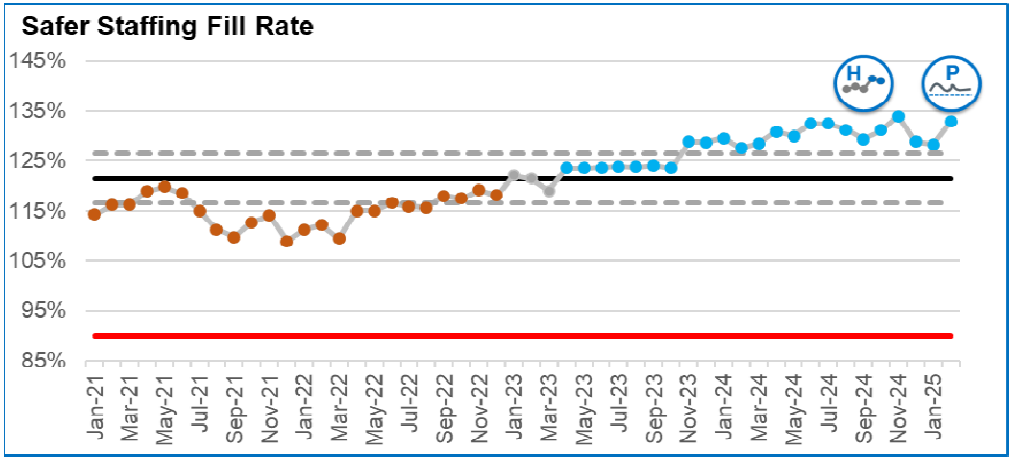
The learning library has been developed as a way to gather and share examples of learning from experience.
Further examples can be found on the SWYPFT intranet page.

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

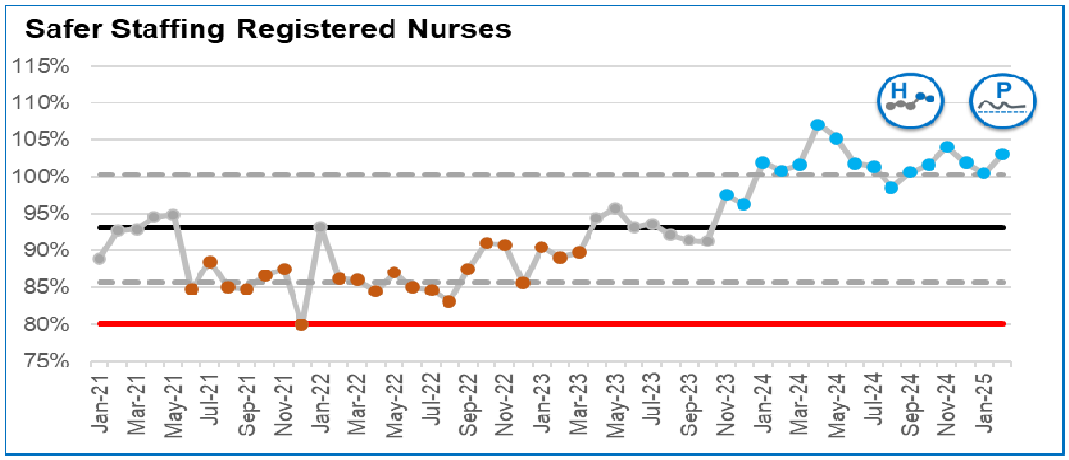
## Patient Safety Alerts

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

## Safer Staffing Inpatients




The chart above shows that as at February 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.




The chart above shows that in February 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 an increase in February in overall demand.
- Within the flexible staffing pool there were a total of 165 more shift requests, however the overall fill rate decreased by 1.1% to 92.6%.
- Within overall fill rates there was an increase in the fill rates of 8% for Forensic and Learning Disability care group to 126% with Adult and Older Peoples Care Group and Barnsley Integrated Services increasing by 3% and 2% respectively to 139% and 111%.
- 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 Associate (HCA) staff onto our systems which is in line with the reduction of agency spending.
- We will be supporting an agency band 2 – 3 HCA stop from mid-March.
- E-Rostering and SafeCare rollout resource has been refocused onto Cheswold Park Hospital to ensure they have a robust and transparent e-roster in place with a launch date of 17th March.
- The overall fill rate had a decrease of 4.5% to 132.8%. The day fill rate for registered nurses (RNs) increased by 3.3% to 102.2%. Three wards, consistent with January, Ward 19 (Male) in the Adult and Older Peoples Care Group, Johnson and Waterton within the Forensic and LD Care Group, fell below the 90% RN day fill rate. They were supported through local escalation plans.
- In February no ward, consistent with the previous month, fell below the 90% overall fill rate threshold.
- Safer staffing establishment reviews have been completed across all working age adult mental health and psychiatric intensive care wards. Reports are due to be finalised by the end of March 2025 and further reviews will take place across the remaining inpatient areas in the first quarter of 25/26.

## Safer Staffing Inpatients cont…

**Registered Nurses Days**
There was an increase of 3.3% in overall registered day fill rates to 102.2% in February compared with the previous month.

**Registered Nurses Nights**
There was an increase of 1.5% in overall registered night fill rates to 119.3% in February compared with the previous month.

**Overall Registered Rate:** In February the overall registered fill rate decreased by 2.5% to 103.0%.
**Overall Fill Rate:** 132.8% (a decrease of 4.5% on the previous month)
Despite the decrease in both the registered and overall fill rate, safer staffing levels were maintained at all times.

| Overall Fill Rate | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|
| Adults and Older People | 135% | 136% | 139% |
| Barnsley Integrated Services | 107% | 109% | 111% |
| Forensic and LD | 122% | 118% | 126% |
| **Grand total** | **129%** | **128%** | **133%** |

| Registered day rate | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|
| Adults and Older People | 96% | 98% | 101% |
| Barnsley Integrated Services | 130% | 134% | 138% |
| Forensic and LD | 96% | 94% | 98% |
| **Overall shift fill rate** | **98%** | **99%** | **102%** |

| Registered night rate | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|
| Adults and Older People | 114% | 114% | 115% |
| Barnsley Integrated Services | 104% | 108% | 100% |
| Forensic and LD | 124% | 125% | 129% |
| **Overall shift fill rate** | **117%** | **118%** | **119%** |

Bank staff filled 83.33% (a decrease of 0.39% on the previous month) of RN requests for flexible staffing and 83.11% (a decrease of 1.13% on the previous month) of HCA requests.
Agency staff filled 5.50% (a decrease of 0.07% on the previous month) of RN requests for flexible staffing and 10.29% (a decrease of 0.08% on the previous month) of HCA requests.

## Information Governance (IG)

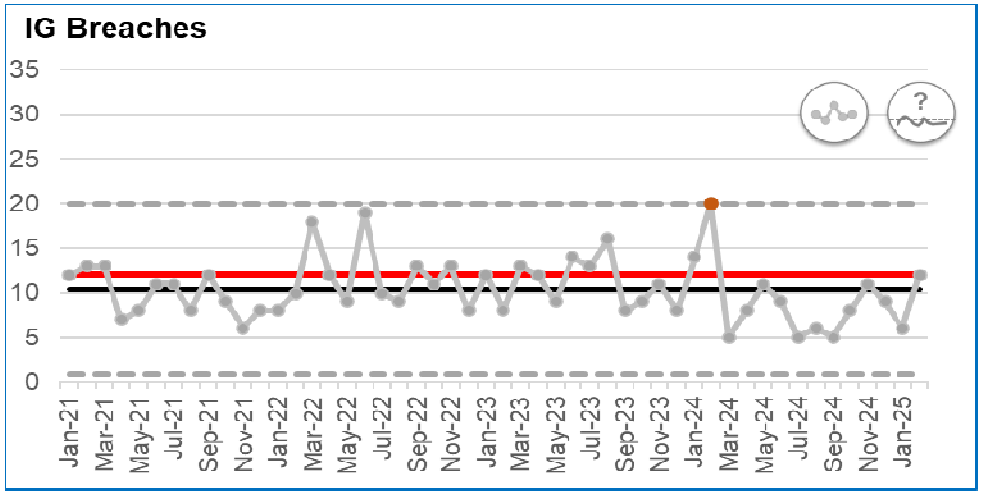
Twelve data breaches were reported during February 2025, which is typically higher than previous months this year. The average number of reported incidents for the year remains lower than the previous three years.

Information disclosed in error continues to be the highest reported category. Breaches during February were mainly due to correspondence errors including via email and post where the incorrect details or addresses were used or disclosed to incorrect parties.

A new comms campaign is in progress and personal responsibility for correctly identifying services users on the clinical systems is a key focus this month, to prevent further incidents.

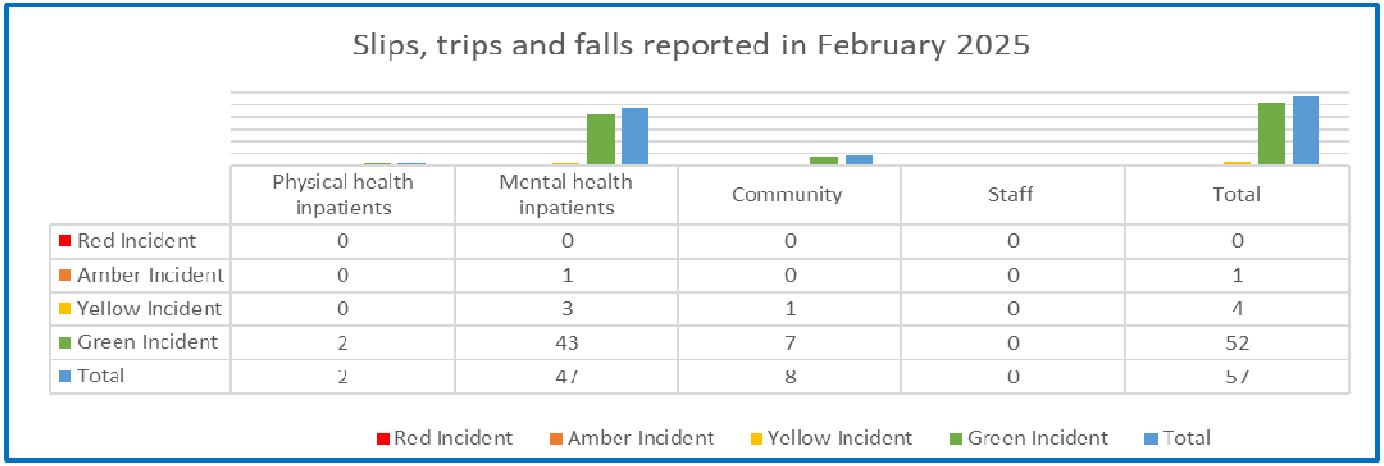
There are currently no open complaints with the Information Commissioner's Office.

This SPC chart shows that as at February 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 February 2025, a total of 57 slips, trips, and falls were reported. 49 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 | 1 | 0 | 0 | 1 |
| Yellow Incident | 0 | 3 | 1 | 0 | 4 |
| Green Incident | 2 | 43 | 7 | 0 | 52 |
| Total | 2 | 47 | 8 | 0 | 57 |

• There has been a high level of assessment and intervention completed to reduce falls risks including referrals to cardiology, neurology, and endocrinology. With increased reviews of physical health, medication and care planning

• Post Falls Protocol completion has averaged 86% this month, with a continued good response from staff

• 86% of patients had a falls risk screen (FRAT-18) commenced within 24hrs of admission

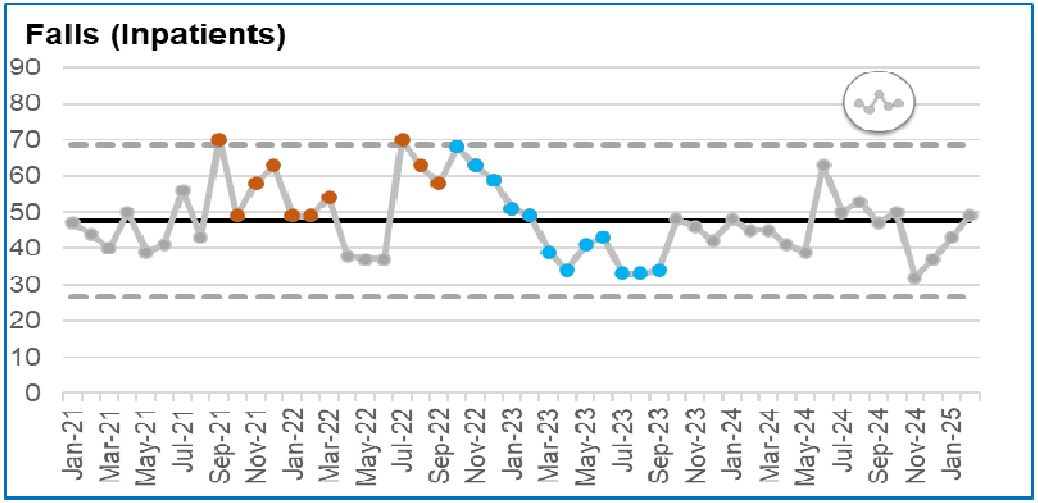
**Incident Grading**
There were no red incidents.
Amber: 1 (2%) fall for a patient who returned to the ward following an extended period on an acute ward. They fell after getting out of bed which caused a bone fracture. This fall was audited using the National Audit for Inpatient Falls (NAIF) and highlighted a good review of delirium and physical health needs prior to the patient fall, a review is taking place regarding the patient being moved from the floor prior to having an assessment.
Yellow: A total of 4 (7%) reported safety events needed higher intervention or were linked with patients having a repeated risk of falls.
Green: A total of 52 (91%) reported safety events had low, or no harm recorded. Main themes were rolling or sliding from the bed, hypotension, syncopal events, and illness linked with infection. 4 falls (8%) occurred whilst patients were on leave from the ward.

**Inpatient falls had a high correlation with:**
• 19 falls (39%) were by 5 patients having repeated falls. With an average age of 59yrs, these falls were linked with Postural Orthostatic Tachycardic Syndrome (PoTS), hypotension, carbamazepine toxicity, infection and associated delirium
• 25 falls (51%) occurred in patients <65yrs. These were linked with using the gym for rehabilitation, hypotension, PoTS, agitation, and slipping on stones in the garden
• 24 falls (49%) occurred in patients aged >64yrs, linked with getting up to use the toilet, pacing and unsettled behaviours
  • 11 (46%) of the above older adults had a known diagnosis of dementia
  • 14 (58%) of the above older adults had a long-term health condition/frailty

All of the falls described above have had individual scrutiny, and learning has been taken forward into the Trustwide Falls prevention workstream.

## Falls (Inpatient)

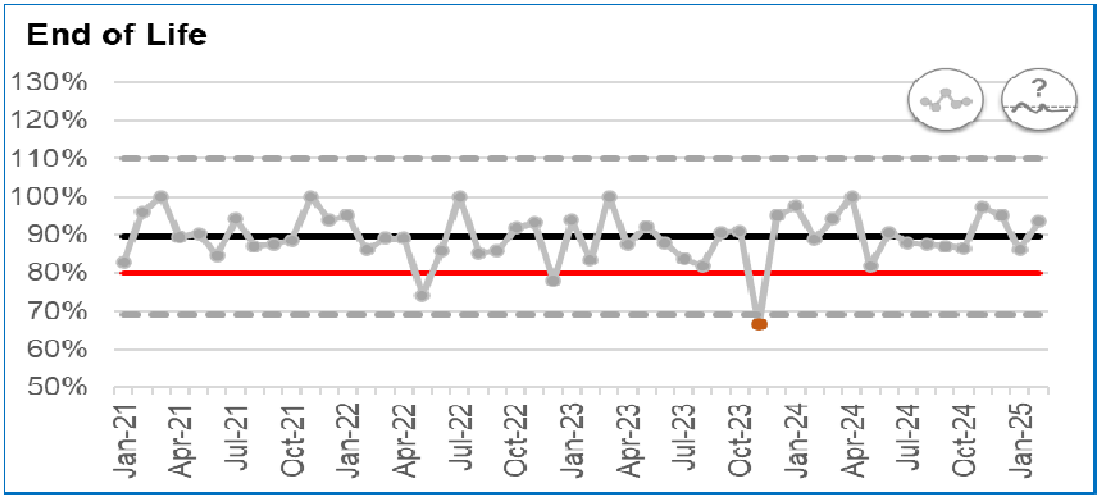
The total number of inpatient falls was 49 in February.




The SPC chart above shows that in February 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 93.5% in February. 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 February 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
- 92% would recommend mental health services

| | Target | December | January | February |
|---|---|---|---|---|
| Mental health community | 85% | 94% (244) | 93% (240) | 95% (272) |
| Mental health inpatient | 85% | 92% (26) | 93% (70) | 89% (28) |
| Learning Disabilities | 85% | 90% (10) | 100% (13) | 95% (39) |
| ASD/ ADHD | 85% | 90% (10) | 81% (21) | 89% (28) |
| CAMHS | 85% | 86% (35) | 76% (38) | 82% (33) |
| Forensic | 60% | 56% (9) | 58% (12) | 85% (61) |
| Mental health overall | 84%* | **92% (334)** | **90% (394)** | **92% (461)** |
| Barnsley Physical Health | 95% | **96% (213)** | **97% (439)** | **97% (388)** |
| **Trustwide** | **85%** | **93% (547)** | **93% (833)** | **94% (849)** |

** weighted for 2023/24*

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

Satisfaction across community mental health, ADHD & ASD services, CAMHS, and Forensics increased in February.

Satisfaction in mental health inpatient and learning disabilities has decreased but remains above target.

All service lines remain above target except for CAMHS though there has been an increase in month in the satisfaction rate in CAMHS.

## Safeguarding

**Safeguarding Adults:**
In February 2025 there were 32 Datix categorised as safeguarding adults. Of these, 12 were categorised as green, 18 were categorised as yellow and there were two amber incidents. There were no red Datix. The most common subcategories of these were domestic abuse, financial abuse and neglect.

In addition to the Safeguarding Adult Datix's, there were 24 sexual safety incidents reported in February 2025. Of these, none were red or amber, 18 were yellow and the remaining six were green.

**Safeguarding Children:**
In February 2025 there were 10 Datix submissions categorised as Safeguarding Children. Three were categorised as green incidents, five categorised as yellow and two were amber. There were no red incidents reported. The most common subcategory of these was neglect.

## Complaints

- In February there were 27 new formal complaints received. This is consistent with January.
- Of these complaints, 5 have values and behaviours (staff) identified as a primary reason for the complaint. This is a slight increase from 4 in January.
- 19 complaints were closed in February and 84% (16) of these were within the six-month statutory timeframe. Compliance with this six month target remains high.
- Four complaints have been referred to the Parliamentary Health Service Ombudsman. Two of these are from the same complainant. This is consistent with previous months.
- 30 compliments were received in February.

## Reducing Restrictive Physical Intervention (RRPI)

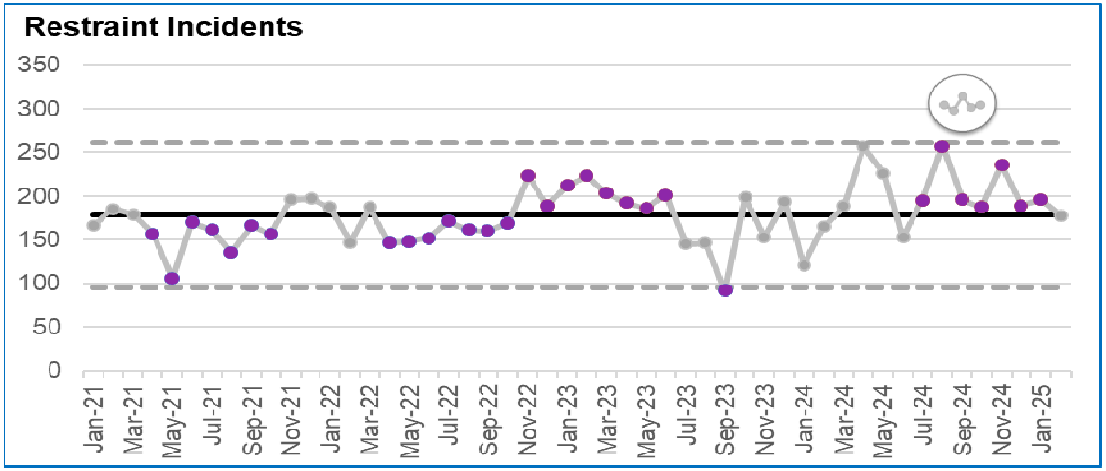
• There were 178 reported incidents of Reducing Restrictive Physical Interventions used in February 2025 this was a reduction of 18 (9.1%) from January 2024 that stood at 196.
• In February 2025 prone restraint (those remaining in prone position and not rolled immediately) was reported 13 times this in an increase on the January position however is more in line with previous months reported figures.

The increase in prone restraints is linked to a specific ward and a small cohort of patients within that ward. Bespoke training and advice is being facilitated by the RRPI team to the ward team. In addition to this, alternative exit seclusion training is becoming part of the RRPI four day initial, and two day refresher training from the 1st April 2025.

| Restraint Position | Total Restraint Positions Used | Percentage of Use |
|---|---|---|
| Standing | 98 | 35.6% |
| Safety Pod | 58 | 21.1% |
| Seated | 44 | 16.0% |
| Supine - held on their back, regardless of surface | 32 | 11.6% |
| Prone descent then remained in chest down position | 13 | 4.7% |
| Side | 13 | 4.7% |
| Restricted escort | 6 | 2.2% |
| Kneeling | 4 | 1.5% |
| Service User placed self in prone and staff immediately let go or rolled | 4 | 1.5% |
| Prone decent then immediately rolled to other position side/back | 3 | 1.1% |

| Team Using Prone Restraint | Feb-25 |
|---|---|
| Walton PICU | 7 |
| Nostell Ward | 2 |
| Beamshaw Ward - Barnsley | 1 |
| Elmdale Ward, The Dales, Calderdale | 1 |
| Melton PICU, Barnsley | 1 |
| Stanley Ward, Wakefield | 1 |

| Duration of Prone Restraint | Feb-25 |
|---|---|
| 0 - 1 minute | 9 |
| 1 - 2 minutes | 4 |

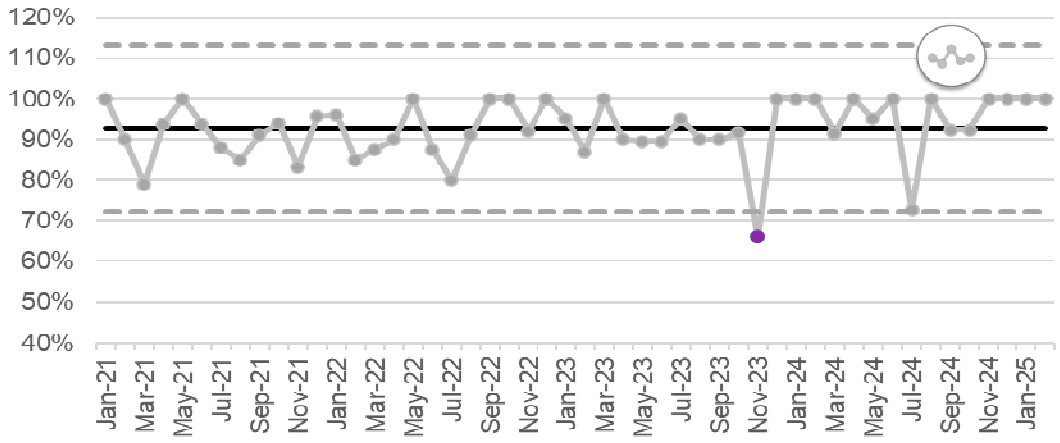



This SPC chart shows that in February 2025 we have entered a period of common cause improving variation.

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

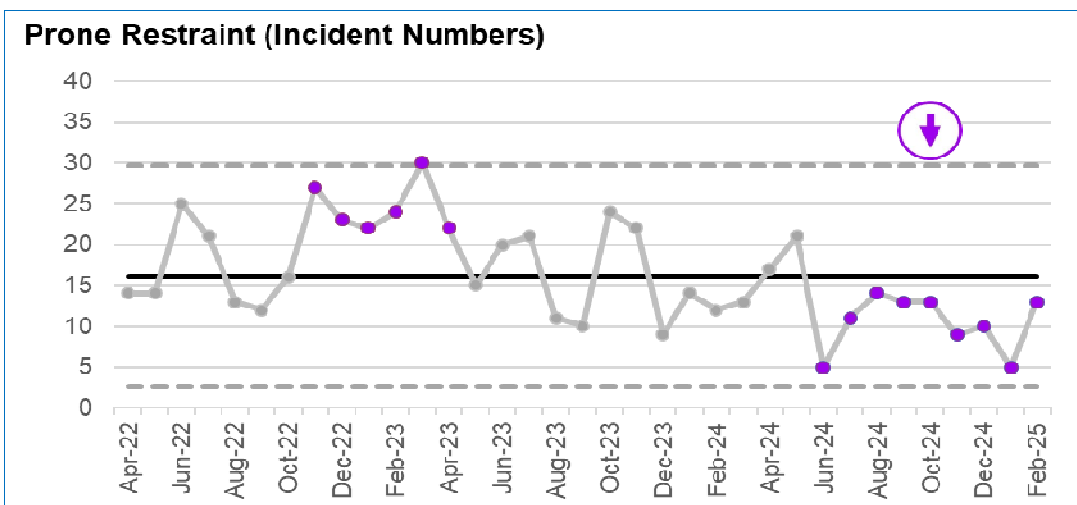
## Reducing Restrictive Physical Intervention (RRPI)

**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 increased in February though the SPC chart shows an overall reducing trend. All incidents of prone restraint are reviewed for learning in the Patient Safety Oversight Group. The improvement work continues.

## People - Performance Wall

### Trust Performance Wall

| | Objective | Threshold | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|---|---|---|---|
| Establishment | Improving Resources | - | 5460.1 | 5512.2 | 5520.5 | 5524.3 | 5526.8 | 5523.1 |
| Contracted Staff In Post (Ledger) | | - | 4738.8 | 4738.9 | 4756.6 | 4738.8 | 4746.5 | 4747.5 |
| Vacancies | | - | 721.4 | 773.3 | 763.9 | 785.5 | 780.4 | 775.7 |
| Turnover external (12 months rolling) | | >12% - <13% | 8.2% | 7.6% | 7.7% | 7.6% | 7.8% | 7.7% |
| Starters | | - | 56.6 | 40.0 | 35.7 | 17.4 | 48.3 | 30.6 |
| Leavers | | - | 51.3 | 28.6 | 35.6 | 30.0 | 40.7 | 26.9 |
| International Nurse Starters in Month | | - | 0 | 0 | 0 | 0 | 0 | 0 |
| % Bank Fill Rates - Registered Nurses | | - | 80.6% | 82.4% | 82.2% | 79.2% | 83.7% | 83.3% |
| % Bank Fill Rates - Health Care Assistants | | - | 82.6% | 80.9% | 81.2% | 82.6% | 82.2% | 83.1% |
| Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive) | | - | 92.8% | 92.6% | 91.3% | 91.7% | 93.6% | 92.6% |
| 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) * | | - | 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%) | 256- All staff (17.8%) 121 - excl medics (9.8%) |
| Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff) | | - | 998 (70.7%) | 1003 (71.2%) | 1003 (71.2%) | 1013 (71.1%) | 1016 (71.1%) | 1029 (71.4%) |
| Sickness absence - YTD | | <=5% from June 24 was <=4.8% | 5.1% | 5.2% | 5.2% | 5.3% | 5.3% | 5.3% |
| Sickness absence - Month | | | 5.5% | 5.5% | 5.3% | 5.7% | 5.5% | 5.1% |
| Employees with long term sickness over 12 months | | - | 1 | 4 | 2 | 2 | 2 | 2 |
| Appraisals - rolling 12 months | | Projected Compliance: Jan - 78.3% Feb - 82.3% Mar - 84.9% Apr - 86.9% May - 88.7% Jun - 90.1% | 89.1% | 89.4% | 87.9% | 85.9% | 81.8% | 81.4% |
| Employee Relations - Suspensions (over 90 days) | | - | 1 | 1 | 1 | 0 | 0 | 2 |
| Mandatory Training - TOTAL | Improving Care | >=80% | 93.0% | 93.0% | 93.2% | 93.4% | 93.6% | 93.7% |
| Mandatory Training - Reducing Restrictive Practice Interventions | | | 76.1% | 76.7% | 78.4% | 80.5% | 81.5% | 80.1% |
| Mandatory Training - Cardiopulmonary Resuscitation | | | 82.0% | 81.3% | 82.2% | 82.0% | 80.9% | 81.3% |
| Mandatory Training - Clinical Risk | | | 95.3% | 94.9% | 95.1% | 95.1% | 96.5% | 96.6% |
| Mandatory Training - Display Screen Equipment | | | 97.9% | 97.7% | 98.0% | 97.9% | 98.1% | 98.0% |
| Mandatory Training - Equality & Diversity | | | 96.7% | 96.4% | 96.5% | 96.3% | 96.4% | 96.3% |
| Mandatory Training - Fire Safety | | >=85% | 90.4% | 90.5% | 90.4% | 90.0% | 90.6% | 90.9% |
| Mandatory Training - Food Safety | | >=80% | 92.0% | 92.2% | 91.4% | 91.3% | 92.2% | 92.4% |
| Mandatory Training - Freedom To Speak Up (FTSU) | | | 96.5% | 96.5% | 96.9% | 96.9% | 97.0% | 97.1% |
| Mandatory Training - Infection Control & Hand Hygiene | | | 94.5% | 94.4% | 94.9% | 94.9% | 94.9% | 95.3% |
| Mandatory Training - Information Governance (Data Security) | | >=95% | 94.7% | 94.6% | 94.5% | 93.6% | 93.5% | 93.1% |
| Mandatory Training - Moving & Handling | | >=80% | 97.7% | 97.5% | 97.7% | 97.7% | 97.8% | 97.9% |
| Mandatory Training - Nat Early Warning Score 2 (New S2) | | | 97.0% | 97.1% | 97.6% | 97.7% | 98.1% | 97.9% |
| Mandatory Training - Mental Capacity Act/DoIs | | | 90.6% | 90.5% | 90.6% | 91.0% | 91.6% | 91.6% |
| Mandatory Training - Mental Health Act | | | 88.1% | 87.9% | 87.7% | 88.5% | 90.0% | 90.5% |
| Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1 | | | 89.9% | 90.5% | 91.4% | 92.1% | 92.9% | 93.8% |
| Mandatory Training - Prevent | | >=80% | 95.4% | 95.3% | 95.5% | 95.3% | 95.7% | 95.7% |
| Mandatory Training - Safeguarding Adults | | | 90.4% | 90.0% | 89.9% | 91.0% | 91.1% | 91.0% |
| Mandatory Training - Safeguarding Children | | | 92.4% | 92.4% | 92.5% | 93.3% | 93.6% | 92.9% |

**Notes:**

- Contracted Staff In Post (Ledger) - this has replaced the previously reported Staff in Post (ESR Last Day of the month)
- The figures reported here differ to the figures included in the finance appendix 'WTE (whole time equivalent) worked' as this reflects contracted employment and therefore does not include overtime, additional hours worked or agency.
- Starters/Leavers vs Staff in Post – Whilst our starters and leavers figures give us a true account of turnover growth it will not exactly match the overall staff in post movement from month to month as this also includes any contracted hours changes of existing staff in that same month.
- Turnover - Quarterly reports from feedback of leavers are being appraised in the Trust's operational management group with reporting and actions from quarterly reports to care groups.
- Sickness absence - from April 23 - the reported figure is rolling over 12 months. For earlier months this was year to date
- .Bank fill rates - We are continuing to successfully recruit to band 2 and bank 5 posts for both substantive posts and bank. Our use of agency is under constant scrutiny, with bank being used as opposed to agency as much as possible, including for block bookings, and this is seeing a positive impact on agency spend.

**Staff In Post**
• The number of staff in post continues to gradually increase.

**Vacancies**
• Although the total vacancy numbers have remained static, there is a noticeable increase in vacancies for Learning Disability (LD) and Attention Deficit and Hyperactivity Disorder (ADHD) services of 2.3%.

**Turnover**
• Turnover remains static at 7.7%.

**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.

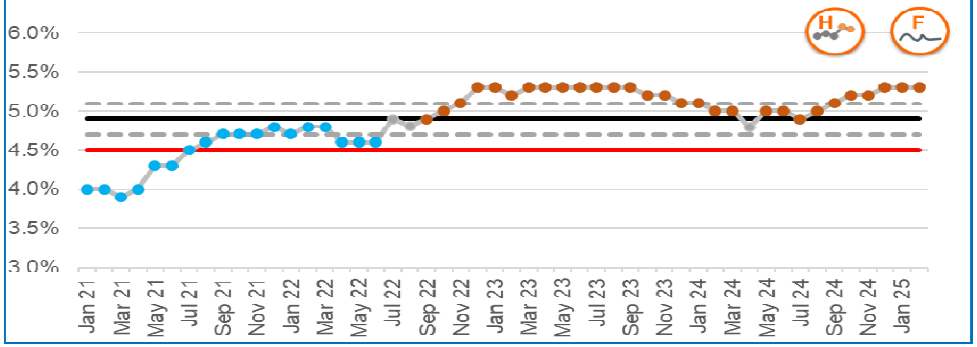
**Sickness (Overall)**
• Overall sickness has decreased slightly from 5.5% (Jan) to 5.1% (Feb)
• The only increases in sickness are in LD and ADHD long term sickness and within support services short term sickness
• Episodes of Colds & flu has decreased significantly since Jan '25 (254), and is better than the same time last year (Feb 25: 151 episodes, Feb 24: 175 episodes)
• Episodes of Anxiety / Stress continue to increase, currently 184 episodes in Feb 25 (Jan 25: 175, Feb 24: 160 episodes)

**Appraisal Compliance**
• As expected, now that appraisals have been migrated to ESR for a few weeks, there is an increase.
• Also reflected here is a significant increase by Forensic Services and Support Services

**Training Compliance**
• Training compliance continues to remain at 93.7%, above target

## Statistical process control charts

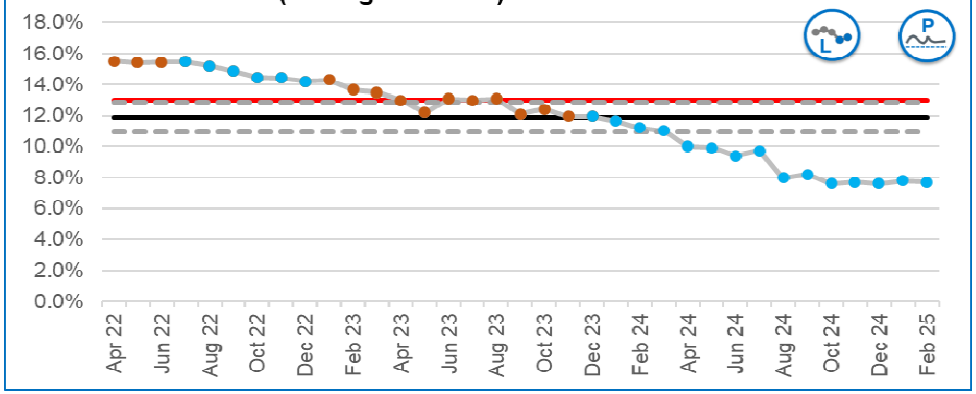
**Trust Sickness Absence - YTD**




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

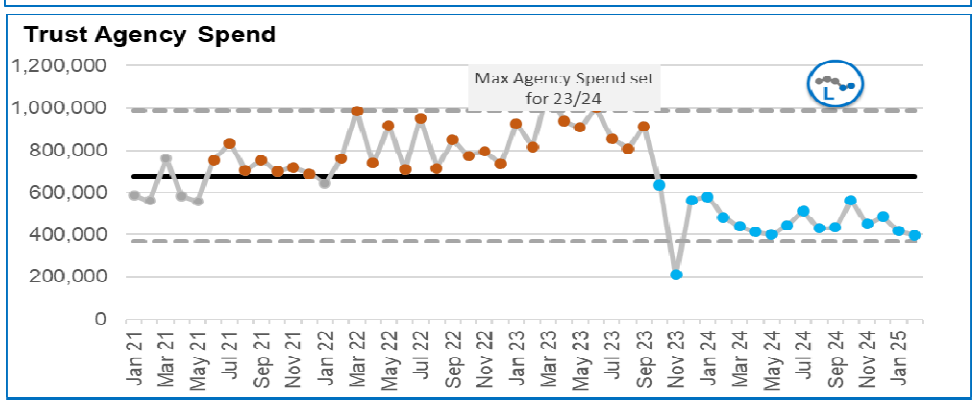
From July 2022 this data also includes absence due to Covid-19.

**Trust Staff Turnover (Rolling 12 month)**




The SPC chart shows that in February 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.

**Trust Agency Spend**




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 February 2025 we remain in a period of special cause improving variation.

See the Finance Report for further information.

# National Metrics

Data as of : 18/03/2025

NHS South West Yorkshire Partnership NHS Foundation Trust

This section of the report outlines the Trust's performance against a number of national metrics relating to operational performance.

The NHS Oversight Framework - From 1 July 2022 integrated care boards (ICBs) have been established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their integrated care system (ICS). NHS England will work with ICBs as they take on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities. 2022/23 will be a year of transition as Integrated Care Boards ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of proportionate and effective oversight of system-led care. The oversight framework has been updated for 22/23. It aligns to the priorities set out in the 2022/23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement (comprising Monitor and the NHS Trust Development Authority) into NHS England. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate.

This table only includes operational metrics, there are a number of other workforce, quality and finance metrics that are reported in the relevant section of the IPR.

| Metric | MetricName | Data Quality Rating | Target | Assurance | Variation | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 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 | 138 | 119 | 62 | 114 | 111 | 124 | 138 | 96 | 131 | 127 | 106 | 92 |
| M3 | Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops | | 60% | P | H | 94.1% | 87.5% | 90.3% | 92.7% | 91.7% | 86.2% | 90.3% | 97.6% | 91.8% | 96.7% | 87.2% | 94.1% |
| M4 | Talking Therapies - proportion of people completing treatment who move to recovery | | 50% | ? | | 52.9% | 52.3% | 52.7% | 51.1% | 50.9% | 50.9% | 54% | 54.0% | 54.4% | 52.4% | 55.1% | 52.8% |
| M5 | Max time of 18 weeks from point of referral to treatment - incomplete pathway | | 92% | P | | 99.9% | 100.0 % | 100.0% | 99.9% | 99.7% | 99.5% | 99.5% | 99.2% | 99.0% | 98.2% | 97.2% | 96.7% |
| M7 | 72 hour follow-up from psychiatric in-patient care | | 80% | ? | L | 87.5% | 94.6% | 89.8% | 89% | 91.2% | 91.0% | 94.9% | 89.9% | 93.5% | 93.9% | 92.4% | 89.7% |
| M8 | Total bed days of Children and Younger People under 18 in adult inpatient wards | | 0 | ? | L | 8 | 29 | 13 | 1 | 5 | 5 | 0 | 0 | 1 | 0 | 1 | 0 |
| M9 | Total number of Children and Younger People under 18 in adult inpatient wards | | 0 | ? | L | 2 | 1 | 2 | 1 | 3 | 1 | 0 | 0 | 1 | 0 | 1 | 0 |
| M10 | Talking Therapies - Treatment within 6 Weeks of referral | | 75% | P | | 99.0% | 99.3% | 99.0% | 98.7% | 99.3% | 99.4% | 99.0% | 98.7% | 98.6% | 97.8% | 98.7% | 99.8% |
| M11 | Talking Therapies - Treatment within 18 weeks of referral | | 95% | P | | 99.8% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 99.8% |
| M13 | Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week | | 95% | ? | H | 100% | n/a | 100% | 100% | 50% | 100% | 100% | 100% | 100% | 100% | 85.7% | 100% |
| M14 | Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks | | 95% | ? | L | 97.2% | 97.5% | 94.1% | 96.6% | 100% | 87.5% | 84.8% | 88.9% | 76% | 55.6% | 71.8% | 71.8% |
| M15 | Data Quality Maturity Index | | 95% | P | L | 99.4% | 99.3% | 99.5% | 99.5% | 99.4% | 99.5% | 99.5% | 99.6% | 98.4% | 98.4% | 98.0% | 98.3% |
| M23 | Talking Therapies - Completion of outcome data for appropriate Service Users | | 90% | P | | 98.6% | 99.0% | 99.0% | 99.8% | 99.1% | 99.3% | 100% | 99.0% | 99.1% | 99.2% | 99.7% | 99.8% |
| M30 | Number of detentions under the Mental Health Act (MHA) | | | | | 100 | 92 | 101 | 98 | 106 | 104 | 97 | 93 | 117 | 95 | 91 | 99 |

# National Metrics

Data as of : 18/03/2025

NHS South West Yorkshire Partnership NHS Foundation Trust

| Metric | MetricName | Data Quality Rating | Target | Assurance | Variation | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| M31 | Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin | | | | | 16% | 17.4% | 23.8% | 26.5% | 26.4% | 25% | 10.3% | 23.7% | 19.7% | 21.1% | 23.1% | 17.2% |
| M33 | % Service users on Care Programme Approach (CPA) having formal review within 12 months | | 95% | | | 96.2% | 97.2% | 96.3% | 95.9% | 96.6% | 96.8% | 96.4% | 96.3% | 96.7% | 97.9% | 97.4% | 96.5% |
| M34 | % Clients in settled accommodation | ⚠ | 60% | | | 83.5% | 83.4% | 83.5% | 83.2% | 83.5% | 83.6% | 84.0% | 83.3% | 84.1% | 84.4% | 84.3% | 83.1% |
| M35 | % Clients in employment | ⚠ | 10% | | | 13.5% | 13.0% | 13.2% | 13.0% | 12.6% | 12.7% | 12.5% | 13.1% | 13.3% | 12.8% | 12.5% | 13.2% |
| M41 | Completion of a valid NHS number | | 99% | | | 99.7% | 99.9% | 99.9% | 99.9% | 99.5% | 100.0% | 99.5% | 100.0% | 100.0% | 100.0 % | 100.0 % | 100.0% |
| M42 | Completion of ethnicity coding for all service users | | 90% | | | 100.0% | 99.5% | 99.5% | 99.4% | 100.0% | 99.4% | 100.0% | 99.5% | 99.6% | 99.5% | 99.6% | 99.6% |
| M43 | Community health services two hour urgent response standard | | 70% | | | 88.3% | 92.8% | 89.7% | 89.9% | 92.0% | 91.6% | 91.6% | 90.9% | 88.0% | 89.2% | 90.6% | 90.2% |
| M44 | The number of completed non-admitted RTT pathways in the reporting period | | 1500 | | | 1336 | 1661 | 1589 | 1618 | 1963 | 1579 | 1804 | 2022 | 1851 | 1603 | 1948 | 1784 |
| M47 | Virtual ward occupancy | | 80% | | | 101% | 82.7% | 94.3% | 81.4% | 91.4% | 70% | 82.9% | 86.7% | 112% | 103% | 101% | 123% |
| 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 | | | | | 14288 | 14129 | 14109 | 13997 | 13940 | 13775 | 13662 | 13592 | 13577 | 13372 | 13439 | 13365 |
| M50 | Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months | | | | | 10589 | 10444 | 10486 | 10466 | 10425 | 10365 | 10321 | 10246 | 10314 | 10330 | 10385 | 10433 |
| M171 | % Admissions gate kept by crisis resolution teams | | 95% | | | 95.7% | 98.8% | 98.1% | 95.6% | 97.4% | 97.9% | 97.5% | 100% | 97.8% | 100% | 100% | 98.9% |
| M178 | Talking Therapies - Reliable Recovery | | | | | 50.4% | 50.4% | 50.4% | 48.5% | 47.8% | 49.7% | 50.8% | 52.1% | 52.4% | 50.7% | 52.6% | 49.2% |
| M179 | Talking Therapies - Reliable Improvement | | | | | 64.6% | 69.7% | 68.0% | 69.3% | 66.2% | 68.9% | 70.4% | 71.1% | 68.4% | 68.6% | 68.9% | 67.9% |
| M181 | Women Accessing Specialist Community Perinatal Mental Health Services | | | | | 1188 | 1209 | 1221 | 1217 | 1233 | 1249 | 1305 | 1421 | 1519 | 1566 | 1642 | 1696 |
| M182 | Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) | | | | | 5 | 2 | 3 | 4 | 3 | 4 | 4 | 4 | 5 | 4 | 3 | 4 |
| M183 | Incomplete Referral to Treatment (RTT) pathways of 65 weeks or more | | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| M184 | New RTT pathways (clock starts) | | 1700 | | | 1745 | 1822 | 1967 | 1789 | 2061 | 1845 | 2088 | 2167 | 1869 | 1708 | 1920 | 1787 |
| M185 | NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment | | | | | 486 | 604 | 572 | 527 | 554 | 544 | 517 | 678 | 586 | 509 | 633 | 526 |
| M188 | Community services waiting list, over 52 weeks | | | | | 5 | 4 | 2 | 5 | 2 | 0 | 0 | 0 | 1 | 1 | 1 | 1 |

# National Metrics

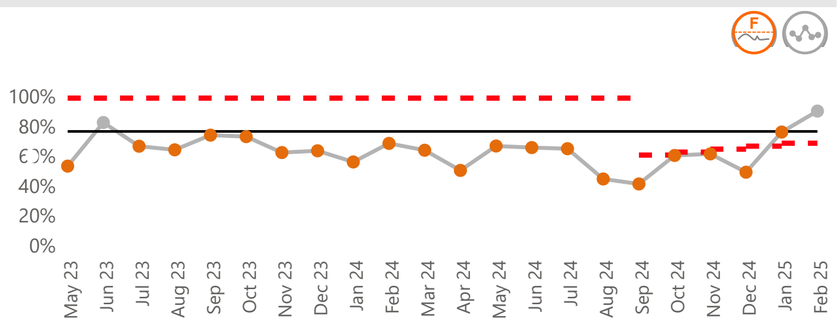
Data as of : 18/03/2025

NHS South West Yorkshire Partnership NHS Foundation Trust

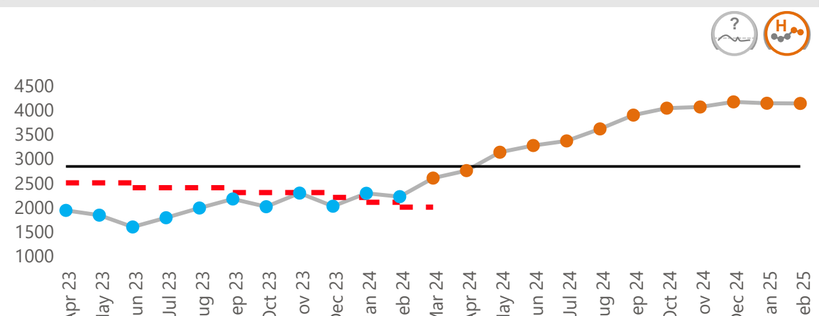
**The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.**

• There were no admissions for under year olds to an adult acute mental health bed during February.
• The percentage of children and young people with an eating disorder designated as routine cases who access concordant treatment within four weeks is . in February this relates to service users who were not seen of which are a result of the impact of the A F D (Avoidant estrictive Food ntake Disorder) pathways and undefined reporting processes. These are being e plored with H ngland. The urgent access to treatment measure is 00 in February, which is back above the 5 threshold.
• The percentage of clients in employment and percentage of clients in settled accommodation there are some data completeness issues that may be impacting on the reported position of these indicators however both are above their respective thresholds.
• irtual Ward occupancy rate continues to increase and is now above target of 0 at 3 for February.
• ommunity 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 it ep). There has been a significant increase in demand for musculoskeletal services which is also reflected in the number of incomplete eferral to Treatment ( TT) pathways ( 45). t is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold.
• The percentage of service users waiting for a diagnostic appointment ( aediatric Audiology service only) within weeks has increased in February to 0.3 , remaining below the national threshold of but above the new locally set tra ectory for improvement which is . in February. The service has been significantly impacted by staff sickness absence since late uly. The service continues to e plore 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.

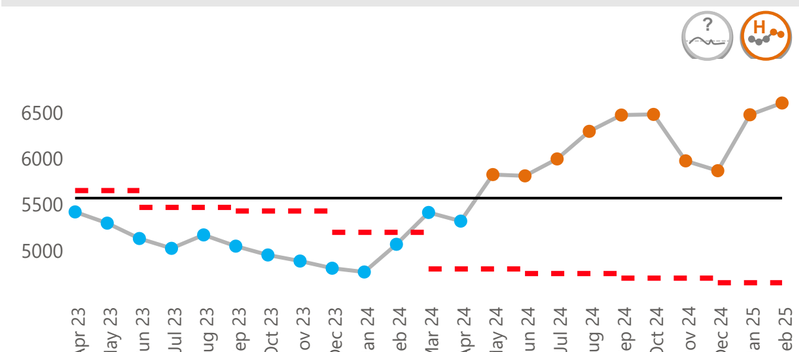
## M6 - Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)

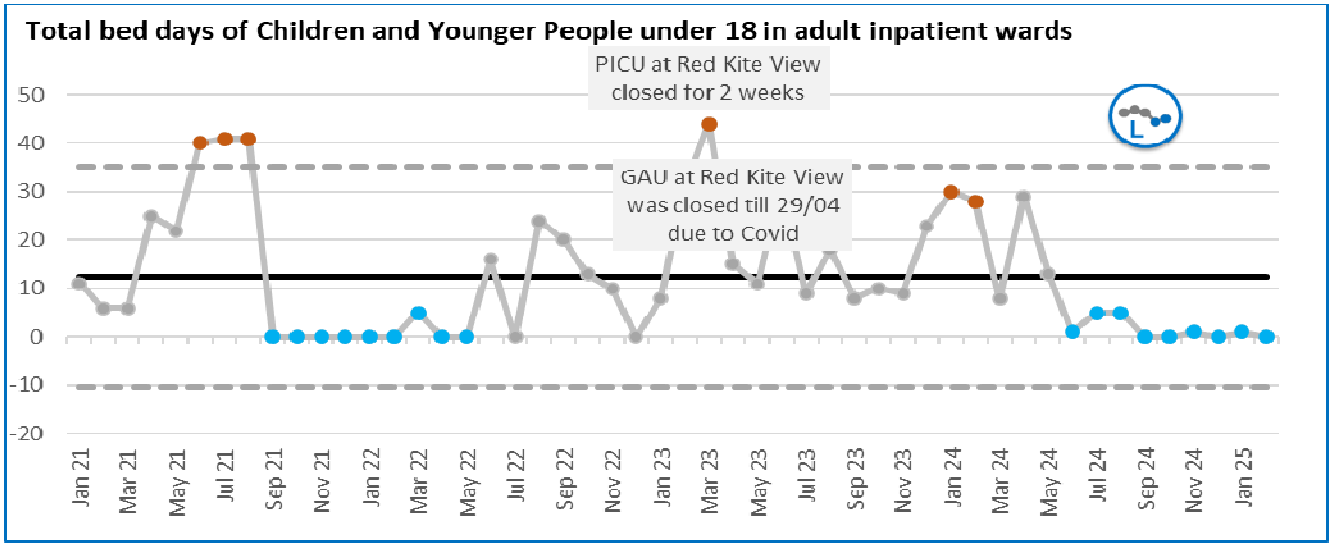



## M45 - The number of incomplete Referral to Treatment (RTT) pathways

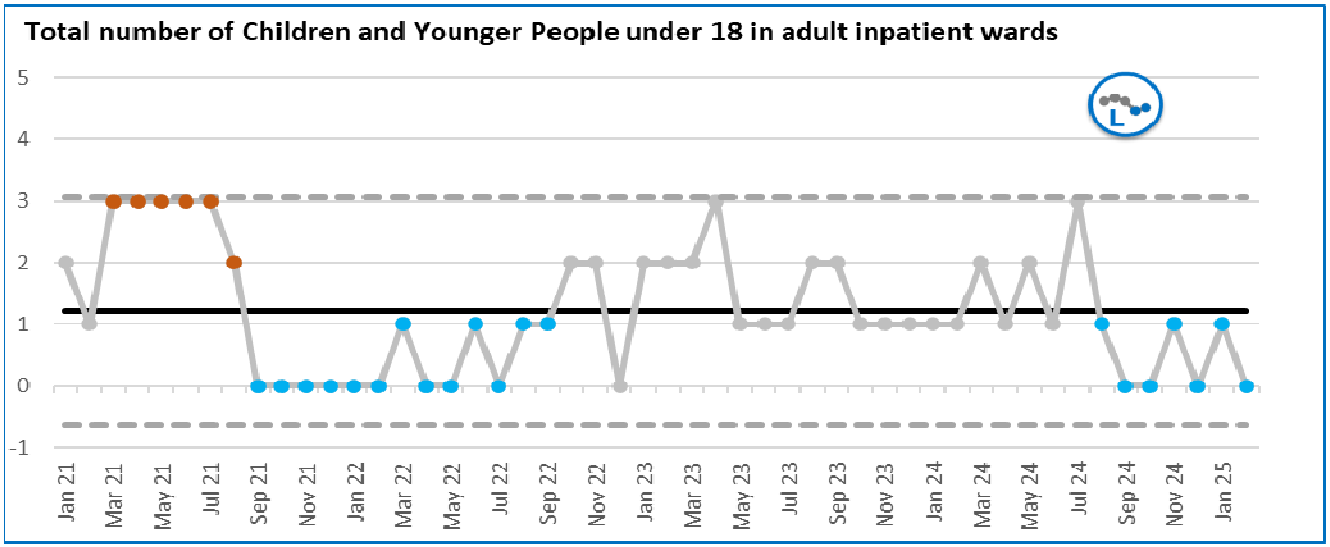



## M48 - Community services waiting list






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



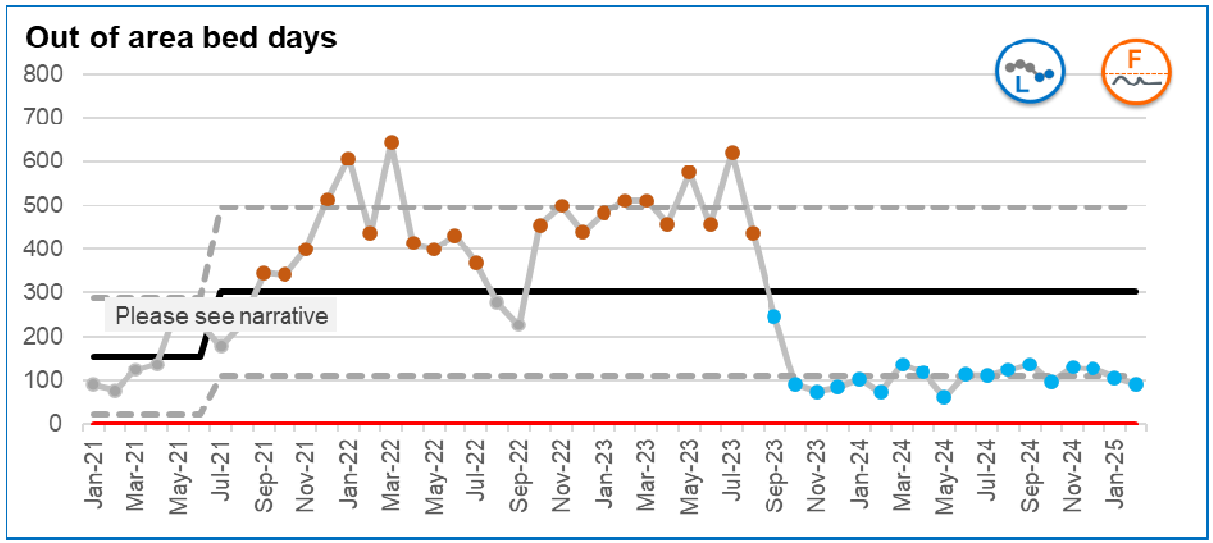

No people aged under 18 were admitted to adult inpatient wards in February 2025. Whilst the SPC chart shows us that this is an improving position when we compare it to the range of admissions we have had in the past, it is recognised that any admission of an individual under 18 is due to the national 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 February the following data quality issue has been identified in the reporting:

- The reporting for employment and accommodation shows 14.2% of records have missing employment and/or accommodation status with a further 1.8% that have an unknown employment status and 1.2% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

## Analysis




The SPC chart shows that we remain in a period of special cause improving variation (something is happening and this should be investigated). We are still not estimated to meet the national target of zero bed days though we are closer to this than we have been for over 2 years.

The process limits were recalculated in June 2021 due to a conscious increase in out of area bed usage which in turn was due to staffing pressures across the wards, increased acuity, Covid-19 outbreaks and challenges to discharging people in a timely way.

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


Current average OPEL level

2.67

| Key |
|---|
| OPEL Level 1 |
| OPEL Level 2 |
| OPEL Level 3 |
| OPEL Level 4 |

## Children and Families Care Group

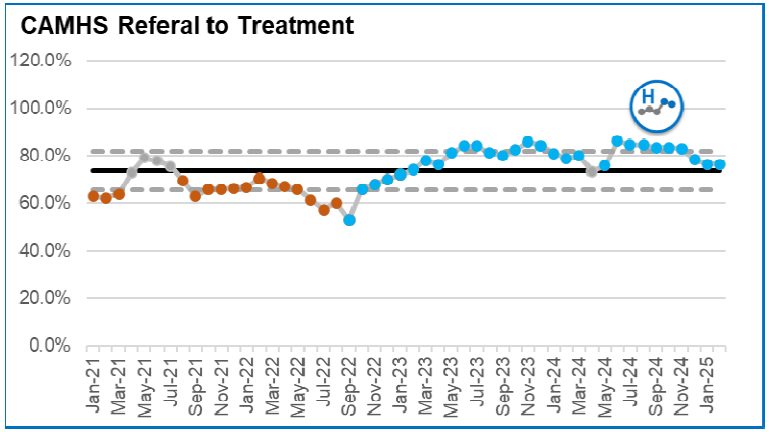
**Headlines**

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 | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance |
|---|---|---|---|---|---|
| % Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 90.2% | 81.2% | 80.4% | |
| % of feedback with staff values and behaviours as an issue | < 20% | 0% (0/0) | 0% (0/5) | 0% (0/3) | |
| % of staff receiving supervision within policy guidance | 80% | 83.6% | 87.2% | 84.1% | |
| CAMHS - Crisis Response 4 hours | N/A | 100.0% | 95.6% | 89.7% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 84.0% | 79.6% | 81.5% | |
| Eating Disorder - Routine clock stops | 95% | 55.6% | 71.8% | 71.8% | |
| Eating Disorder - Urgent/Emergency clock stops | 95% | 100.0% | 85.7% | 100.0% | |
| Maximum 6 week wait for diagnostic procedures | 99% | 49.5% | 76.2% | 90.3% | |
| Information Governance training compliance | >=95% | 94.6% | 94.9% | 93.8% | |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 76.4% | 77.3% | 79.1% | |
| Sickness rate (Monthly) | 5.0% | 4.3% | 4.7% | 4.2% | |

**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 February 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 continue to experience increasing waiting lists which are impacted by multiple challenges including staffing and referrals outstripping capacity.
- Calderdale & Kirklees CAMHS Teams are being challenged to review waiting times, consider their 'While You Wait' offers and develop new initiatives to support reduction e.g. Avoidant/restrictive food intake disorder (ARFID) pathway redesign.
- Calderdale & Kirklees CAMHS Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain challenging. This is further impacted by staff vacancies. This has been recorded on the risk register and actions are in progress to support. Commissioners are sighted on these challenges.
- Calderdale & Kirklees CAMHS Keeping Kirklees in Mind (KKiM) Mental health support team (MHST) experiencing significant challenges around recruitment and retention. In total approx. 40% vacancy rate across the team. Particular problems in the recruitment and retention of band 5 Education Mental Health Practitioners. This appears to be a regional problem however is compounded by KKiM not adhering to NHS England Mental health support team (MHST) model following variations imposed by commissioners which has led to service morphosis to meet variations which include adoption of 100% of Kirklees schools with minimal additional resource.
- Calderdale & Kirklees CAMHS - KKiM are also experiencing increasing waiting times for consultation, assessment and intervention which is outside of agreed NHS England model and key performance indicators. Commissioners sighted on challenges and meeting with children young people and families Interim and Associate Directors of service 24/3/25
- Barnsley CAMHS Eating Disorder team- working in business continuity due to vacancies, sickness and maternity. Some support is being provided by the crisis team; however, this does not meet the bespoke skill set to deliver treatment. Potentially may need to close to routine referrals which commissioners are aware of. Support from our People team and senior management with looking at options to maintain patient safety.
- Wakefield CAMHS - Locum due to start (awaiting date). Long term plan – shortlisted applicants are all from overseas, resulting in the recruitment process taking longer, places significant financial pressure on the service and increasing operational risks

**Advise**

• Calderdale & Kirklees CAMHS Eating disorder performance is currently fluctuating especially in relation to 28-day referral to treatment key performance indicator. Predominantly impacted by multiple staff vacancies (now out to advert) and increased number of ARFID referrals. Pathway review completed and new Avoidant/restrictive food intake disorder (ARFID) process implemented.
• Calderdale & Kirklees CAMHS Increased referrals and reduced resources are impacting waiting times for ADHD medication activity. NHS Right to Choose within Calderdale has generally reduced waiting times for assessment within place, however, increased diagnosis of ADHD has led to SWYFT receiving increased number of referrals for medication assessment from Right to Choose providers.
• Calderdale & Kirklees CAMHS Calderdale Service Manager is undertaking C&K wide ADHD service review to understand current need and plan for future provision. ADHD Non-Medical Lead post out to advert and will support future development and implementation.
• Wakefield CAMHS - Potential breach situation in Eating Disorders 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.
• Wakefield CAMHS - Reach (Crisis Team) referrals have increased in March – complexity remains the same but numbers are much higher.
• Paediatric Audiology - there has been a continued significant improvement in our waits for diagnostic appointments performance. This has increased from 75.8% as at end of January, to 90.3% for February.
• Children's Therapy Service - There are with fewer children waiting to be seen for the Occupational Therapy and Occupational Therapy/Physio therapy joint pathways with the Children's Therapy Service. Whilst we still have some long waits, it is anticipated that these will improve in line with the data for the reducing number of children on the waiting list.
• Secure CAHMS -We are making good progress with the mobilisation of our new Secure CAMHS contract which starts on the 01/04/25. There remain issues in relation to IM&T infrastructure and whilst an memorandum of understanding / Service Level Agreement with the current contract holder will cover a "day 1" solution" there is work to be done moving forwards.

**Assure**

• Sickness across CYP&F Care Group continues to be below the overall Trust sickness rate of 5.61% at 4.15% (as of 11.03.25) and both long and short term sickness are being managed well
• Appraisal rates across the CYP&F is at 89.7% (as of 11.03.25) with targeted action plans across the care group in place for those services indicating low appraisal rates
• Mandatory training across the care group is 96.5% (as of 11.03.25)
• Clinical supervision recording has improved in February to 85% across the care group
• Children's Therapy Service - We have been successful in recruiting to our physiotherapy vacancies within the children's therapy service. It is anticipated that this increased capacity will further positively impact upon our waiting times.
• Calderdale & Kirklees CAHMS - Kirklees primary care network 0-18 service now rolled out across all Kirklees PCNs with the exception of Multi-Agency Support Teams, which will be completed by end of this quarter. Positive feedback from children and young people and those that care for them along with external stakeholders.
• Wakefield CAMHS have seen a much-improved picture in the recording of clinical supervision with team recording between 88% -100% of supervision undertaken in the month.

## 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 | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance |
|---|---|---|---|---|---|
| % Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 92.5% | 89.9% | 88.7% | |
| % Assessed within 14 days of referral (Routine) | 75% | 78.6% | 74.2% | 85.1% | |
| % Assessed within 4 hours (Crisis) | 90% | 100.0% | 97.7% | 94.9% | |
| % of feedback with staff values and behaviours as an issue | < 20% | 66% 2/3 | 30% 3/10 | 33% 4/12 | |
| % of staff receiving supervision within policy guidance | 80% | 89.4% | 90.7% | 92.4% | |
| % service users followed up within 72 hours of discharge from inpatient care | 80% | 94.0% | 92.4% | 89.7% | |
| % Service Users on CPA with a formal review within the previous 12 months | 95% | 97.9% | 97.3% | 96.5% | |
| % Treated within 6 weeks of assessment (routine) | 70% | 95.2% | 91.7% | 93.3% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 77.8% | 76.7% | 80.3% | |
| FIRM Risk Assessments - Staying safe care plan in 7 working days | 95% | 80.9% | 69.0% | *78.1%* | |
| Information Governance training compliance | >=95% | 95.2% | 94.2% | 95.0% | |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 77.0% | 78.9% | 82.5% | |
| Sickness rate (Monthly) | 5.0% | 5.1% | 5.6% | 5.0% | |

### Mental Health Inpatient

| Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance |
|---|---|---|---|---|---|
| % Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 90.2% | 82.0% | 82.1% | |
| % Bed occupancy (excl leave) | 85% | 92.3% | 91.4% | 91.1% | |
| % of feedback with staff values and behaviours as an issue | < 20% | 14% 1/7 | 0% 0/3 | 0% 0/12 | |
| % of staff receiving supervision within policy guidance | 80% | 85.7% | 80.1% | 88.0% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 88.6% | 86.9% | 87.4% | |
| % of clients clinically ready for discharge | 3.5% | 3.4% | 6.0% | 6.7% | |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 94.9% | 87.3% | *92.3%* | |
| Inappropriate Out of Area Bed days | 140 (Feb) | 127 | 106 | 92 | |
| Information Governance training compliance | >=95% | 96.1% | 95.2% | 93.8% | |
| Physical Violence (Patient on Patient) | Trend Monitor | 14 | 20 | 19 | |
| Physical Violence (Patient on Staff) | Trend Monitor | 57 | 53 | 50 | |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 87.8% | 87.2% | 87.7% | |
| Restraint incidents | Trend Monitor | 133 | 125 | *126* | |
| Safer staffing (Overall) | 90% | 135.0% | 135.9% | 139.1% | |
| Safer staffing (Registered) | 80% | 102.6% | 103.4% | 105.9% | |
| Sickness rate (Monthly) | 5.0% | 7.2% | 6.4% | 5.8% | |

### Alert/Action

- Acute wards have continued to manage high levels of acuity.
- High occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
- There continues to be people who are clinically ready for discharge but are delayed. This is an area of focus as part of the priority programme work and is being addressed with the ICBs through the 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 February 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, 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.
- 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 February'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 CPA 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 fully functional has also impacted on recording completed appraisals.
- 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.
• In February both Barnsley and Kirklees Talking Therapies achieved the expected national standard of less than 10% for waits to second treatment within 90 days (Barnsley 8.9% and Kirklees 6.59%). Kirklees achieved the recovery rate national standard target of 50% in February 2025 (55.89%). Barnsley was slightly under target at 49.36%, the data suggests that this was due to three large Wellbeing Courses ending in the month of February. Some clients dropped out during the course, others were signposted to other services, either third sector organisations or secondary MH care services, whilst some clients will have remained within the service and are now waiting or receiving their one-to-one treatment.
• 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 trust wide quality improvement group to enhance how equality information is captured on System One. Completeness of equality data is on our data quality improvement action plan.
• There were 12 incidents of prone restraint in February, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration. The monthly restraint oversight meeting, led by NQP, involving RRPI, safeguarding and matrons, review all prone restraint incidents for any opportunities for learning.

**Assure**

• Intensive home based treatment teams continue to perform well in gatekeeping admissions to our inpatient beds.
• The care group is performing well in 72 hour follow up for people discharged into the community.
• 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 | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance |
|---|---|---|---|---|---|
| % Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 86.4% | 80.6% | 81.9% | |
| % of feedback with staff values and behaviours as an issue | < 20% | 0% (0/4) | 25% (1/4) | 0% (0/1) | |
| % of staff receiving supervision within policy guidance | 80% | 88.8% | 85.8% | 81.5% | |
| Bed occupancy (excluding leave) - Commissioned Beds | N/A | 55.6% | 60.5% | 68.8% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 84.8% | 88.2% | 89.2% | |
| % of clients clinically ready for discharge | 3.5% | 90.1% | 80.0% | 55.4% | |
| Information Governance (IG) training compliance | >=95% | 91.5% | 94.9% | 94.0% | |
| % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks | Improvement trajectory: Aug/Sep 86% Oct/Nov 88% Dec onwards 90% | 96.8% | 96.8% | 94.4% | |

**LD, ADHD & ASD**

| Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance |
|---|---|---|---|---|---|
| Physical Violence - Against Patient by Patient | Trend Monitor | 0 | 0 | 0 | |
| Physical Violence - Against Staff by Patient | Trend Monitor | 27 | 44 | 9 | |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 84.0% | 88.2% | 85.9% | |
| Safer staffing (Overall) | 90% | 162.4% | 167.7% | 198.4% | |
| Safer staffing (Registered) | 80% | 154.4% | 163.9% | 164.2% | |
| Sickness rate (Monthly) | 5.0% | 5.0% | 5.5% | 5.7% | |
| Restraint incidents | Trend Monitor | 27 | 39 | *15* | |

### 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 has no plans to close to referrals and are working with local commissioners to find local solutions, noting that some commissioners have other priorities currently.
• 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 launched 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.

**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.
ICB 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

**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. GP's report facing increased pressures related to ADHD medication. Recently two GP practices have withdrawn all shared care agreements relating to ADHD medication . The service is working with integrated care board colleagues to identify longer term solutions.

**Sickness** – Currently 5.85% and attributed to long term sickness.

## Assure

- All KPI 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 people from a legacy waiting list in Bradford has completed.
- Excellent levels of supervision and appraisal.
- Low level of vacancies.
- Friends and family test – 81% although below target showing a sustained improved position.
- All mandatory training meeting the threshold.

### Learning disability services:

## Alert/Action

**Learning Disability (LD)**
- Appraisal performance remains a focus and 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.
- Waiting lists across LD remain the focus of improvement activity and close monitoring.

**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)**
- Acuity remains high with all service users presenting with complex and challenging needs.
- Movement onwards from the service for those service users clinically ready for discharge remains a challenge.

## Advise

**Learning Disability (LD)**
- Improvement work around existing clinical pathways is progressing well. All four localities are now in the process of either implementing or having implemeted improved pathways for behaviour, transitions, dementia and physical health
- Speech and language therapy recruitment continues to be a challenge with vacancies impacting on the service. The service has recently extended the development posts to include preceptorship in the hope that this will attract more applicants.
- ADHD assessments for people with a learning disability continues to be a gap. Whilst commissioners have agreed a business case for additional resource to manage this in principle, there continues to be no additional funding available.
- Greenlight champion bi-monthly awareness raising sessions continue to be well attended and this has supported an increase of internal conversations regarding the greenlight approach and ensuring people with LD/autism access the right services.

## 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 | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance |
|---|---|---|---|---|---|
| % Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 87.9% | 81.3% | 79.8% | |
| % of feedback with staff values and behaviours as an issue | < 20% | 0% (0/1) | 0% (0/5) | 20% (1/5) | |
| % people dying in a place of their choosing | 80% | 95.0% | 86.2% | 93.5% | |
| % of staff receiving supervision within policy guidance | 80% | 86.4% | 81.6% | 79.1% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 83.7% | 83.0% | 83.1% | |
| Clinically Ready for Discharge (Previously Delayed Transfers of Care) | 3.5% | 0.0% | 0.0% | 0.0% | |

**Barnsley Physical Health and Wellbeing**

| Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance |
|---|---|---|---|---|---|
| Information Governance (IG) training compliance | >=95% | 94.2% | 93.7% | 92.8% | |
| Max time of 18 weeks from point of referral to treatment - incomplete pathway | 92% | 98.2% | 97.2% | 96.7% | |
| Safer staffing (Overall) | 90% | 107.1% | 109.3% | 110.7% | |
| Safer staffing (Registered) | 80% | 121.3% | 125.5% | 125.5% | |
| Sickness rate (Monthly) | 5.0% | 6.0% | 4.8% | 5.5% | |

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

### Alert/Action

### Advise

- MSK & Neuro Physio, Priory Day Centre – remains closed pending remedial works. Services affected continue to utilise Priory Campus as temporary alternative accommodation. This remains on the local risk register. Work scheduled on Priory Day Centre to commence in April 2025 with estates, with a target to return to venue estimated for June 2025. This has had an impact on the full-service offer in terms of group provision and could impact on the 18-week Referral to Treatment Target (RTT) although so far this target continues to be achieved.
- We have commenced the remarketing of the four additional out of area beds on our Neuro Rehabilitation Unit (NRU) however, Barnsley usage continues to be intermittently above the 8 commissioned beds.
- Information Governance training has seen a small dip remaining slightly below compliance for February at 92.8%; plans in place to target staff that are non-compliant.
- Sickness rates have increased slightly during February and the care group is now 5.5%.
- Staff receiving supervision - continues to receive focus with a drive to improve recording. We have seen a slight reduction to 79.1% for February which is slightly below compliance.
- Appraisals - for February the figure is showing as 79.8% but this has been impacted by gaps in data flow. We are aware of our hot spot areas and are supporting teams to get back on track.

### Assure

- Urgent Community Response Service 2-hour target is 89.5% as at end of February 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) – 96.7% as at February 2025.
- Friends and Family Test (FFT) 97% of people would recommend community services.
- 93.55% of people dying in their place of choosing in February 2025; this remains consistently above the threshold of 80%.
- CPR training maintains compliance at 83.1% for February.
- Virtual Ward occupancy rate has increased slightly this month and is still above target of 80% at 107% for February. Virtual ward continues to support early supported discharge and hospital avoidance to support system pressures, reviewing capacity daily.
- Intermediate Care new interim model – The remaining post has interviews which took place during March.
- A positive Quality Monitoring Visit to our Neuro Rehabilitation Unit (NRU) was conducted on 11 February 2025.
- Medical equipment servicing compliance in our community services has improved considerably and is now at 72%, with this set to increase throughout March; a further eight service days are also planned.

## Forensic Care Group

**Headlines**

The monthly sickness rate continues to be above threshold but has improved in February (6.6%) compared to January (7%) - 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 | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance |
|---|---|---|---|---|---|
| % Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 75.6% | 75.6% | 78.1% | |
| % Bed occupancy (incl leave) | 90% | 84.4% | 82.9% | 83.3% | |
| % of feedback with staff values and behaviours as an issue | < 20% | 0% (0/1) | 0% (0/2) | 0% (0/0) | |
| % of staff receiving supervision within policy guidance | 80% | 85.8% | 86.4% | 90.5% | |
| % Service Users on CPA with a formal review within the previous 12 months | 95% | 99.0% | 100.0% | 97.8% | |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 82.1% | 80.8% | 80.2% | |
| % of clients clinically ready for discharge | 3.5% | 0.8% | 0.8% | 0.1% | |
| FIRM Risk Assessments - Staying safe care plan in 7 working days | 95% | N/A | N/A | N/A | |
| Information Governance (IG) training compliance | >=95% | 92.6% | 93.5% | 91.2% | |
| Physical Violence (Patient on Patient) | Trend Monitor | 3 | 6 | 4 | |
| Physical Violence (Patient on Staff) | Trend Monitor | 5 | 9 | 12 | |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 86.1% | 85.6% | 83.4% | |
| Restraint incidents | Trend Monitor | 21 | 23 | *23* | |
| Safer staffing (Overall) | 90% | 115.7% | 108.2% | 114.1% | |
| Safer staffing (Registered) | 80% | 101.1% | 100.4% | 106.8% | |
| Sickness rate (Monthly) | 5.4% | 7.1% | 7.0% | 6.6% | |

**Alert/Action**

• **Bed Occupancy** – Newton Lodge 87.4%, Bretton 91%, Newhaven 78.7%. Underoccupancy in medium secure due to empty beds within LD and Women's services where there are no waiting lists. There have been empty beds on the male pathway in medium referrals have been accepted but the service is waiting for process of transfer to be completed.
• **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. Appraisal compliance is 81.8% medium secure, 81.3% low secure, 76.9% Newhaven but community services are 72.5% which is reducing overall compliance.
• **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%
• Sickness absence – remains a focus of attention across the service. There has been a spike in short term seasonal illnesses in Newton Lodge. The service is undertaking a dedicated piece of work to look at sickness absence across the care group. On closer scrutiny the majority of sickness in most teams is long term sickness.
• 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-months and is currently 8.67% across the care group.
• Newton Lodge has one service user currently awaiting a bed in high secure.
• Forensic Improvement Programme – is well underway with a number of workstreams focusing on improved service user experience and outcomes and improved efficiencies.
• Clinically Ready For Discharge- The service will be undertaking a detailed piece of work to understand the position and analyse the impact.

**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%.
• CPA has met the threshold.

## Inpatients - Mental Health - Working Age Adults

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

**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 has also impacted as 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 are recorded.
• Sickness levels and increased clinical acuity have impacted on appraisal performance with some scheduled appraisals needing to be rearranged.
• Beechdale and Ward 19 have achieved the 95% target.
• Beamshaw, Clark, Melton, Nostell, Walton, Poplars, Lyndhurst and Enfield Down appraisal compliance is below threshold in February but is above 80%. Elmdale, Stanley, Crofton and Willow are above 75%.
• 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.
• Ashdale performance has improved in February but is significantly under target at 60.6%. This is a recording issue that is being addressed as there is only one appraisal currently outstanding.
• Service managers continue to work closely with ward managers to ensure completed paper appraisals are recorded and outstanding appraisals are booked.

**Sickness**

• Sickness improved to below threshold in February on Crofton and Elmdale.
• Walton, Ward 18, Stanley and Poplars' sickness remains above threshold and continues to be impacted by a combination of long and short-term sickness, no specific themes.
• A number of ward sickness rates are significantly above threshold:
  • Nostell has seen sickness remain high at 13.7% due to long term sickness, three of which are registered staff and some of which is work related. Short-term sickness has also impacted.
  • Both Beechdale and Clark have seen increases in sickness to 12.3% and 11.4% respectively due to episodes of short-term sickness and ongoing staff long-term sickness. No specific themes on either ward.
  • Willow (11.5%) and Melton (9.3%) have had further reductions in sickness but remain high. Sickness rates continue to be impacted by both long and short-term sickness but no specific themes.
• 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**

• 14 wards above 80% compliance target.
• Melton, Willow and Ward 18 compliance is under threshold in February. On Ward 18 this has been impacted by ward manager absence and Melton has been affected by acuity on the ward. Focused work is being done to prioritise supervision for staff who haven't received it in the last 90 days.

**Mandatory Training**

Information Governance
• Enfield Down (93.8%) and Ashdale (91.2%) compliance has dropped below threshold in February.
• Crofton (92.9%), Melton (88%), Nostell (92%), Stanley (88.5%), Beamshaw (79.2%), Willow (87.5%) and Ward 19 M (92.6%) compliance remains under threshold.
• Action continues to be taken by the ward manager to address this and improvement is expected in March.
• The 8 remaining wards are above the target of 95%
CPR
• 16 wards are above the CPR training compliance threshold.
• Willow compliance is under threshold at 69.6% and booking of staff onto future training dates will be prioritised by the ward manager.
RRPI
• 15 wards are above the RRPI training compliance threshold.
• Poplars (78.6%) and Willow (78.3%) have fallen below threshold in February. Staff have either already completed or are booked on appropriate training to improve compliance.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.
Fire Safety
• Melton (84%), Beamshaw (80%), Willow (83.3%) and Beechdale (80%) are under compliance and booking of training will be overseen by the ward manager as a priority.

## Inpatients - Mental Health - Working Age Adults

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

**Bed Occupancy**

• Bed occupancy exceeding target is reflective of general increased demand for admissions, particularly across working age adults.
• Where the bed occupancy exceeds target, plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• Occupancy is lower on Clark and Nostell due to 'swing beds' on neighbouring wards (Beamshaw and Stanley) being used to meet male demand.
• Lower occupancy on Willow is due to a bedroom closure to allow estates improvement works to take place.
• 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 16.8% to 25.3% in February. This continues to be reflective of several service users awaiting placements.
• Beamshaw CRFD has improved in February from 31.2% to 17.8%. This relates to 3 service users awaiting either placement or supported accommodation.
• Walton has increased from 10.8% to 15.8% in February. This relates to 2 service users, one who is subject to Section 37/41 awaiting permissions from MOJ and one is waiting for supported living accommodation.
• 8 other wards are above the threshold for CRFD with Melton and Nostell, at more than 10%. Clark, Stanley, Ward 18, Willow, 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 Nostell, Melton, Elmdale, Enfield Down, Crofton and Poplars each had 1 Staying Safe breach in January.
• Willow's performance (75%) totals 2 breaches and a deep dive by the matron has identified staff recording the Staying Safe interventions incorrectly. Guidance to the staff team has been refreshed.
• 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)**

• 6 incidents of patient-on-patient physical violence and 7 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 RRPI and safeguarding is also sought as needed.
• Elmdale (10), Melton (5) and Nostell (6) had several incidents of patient-on-staff physical violence throughout January relating to a small number of service users with complex needs. Psychological formulation is developed on the wards as required to support management and care of individuals with complex needs.
• Risk specific care plans are in place to support managing incidences of violence with input from trust RRPI specialist advisors as needed.
• Staff involved in incidents are supported by ward leadership teams including both managerial and clinical supervision.

**Restraint incidents**

• Higher incidence on Walton and Beamshaw is reflective of current patient population and the presentation and risk profile of service users.
• Incidences on Nostell, Poplars and Elmdale correlate with incidents of physical violence as outlined above.

**Prone restraint incidents**

• 12 incidents of prone restraint in February, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration.
• All are reflective of individual service user presentation and high risks of violence and aggression, including the 7 prone restraints on Walton relating to 3 individual service users.
• The two reasons for prone restraint use were exiting seclusion and the administration of intra-muscular medication. The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administrating intra-muscular medication.

## Inpatients - Mental Health - Working Age Adults

| Beamshaw Suite<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 84.6% | 79.2% | 83.3% |
| Sickness | 5.0% | 1.5% | 4.3% | 2.3% |
| Supervision | 80% | 62.5% | 80.0% | 80.0% |
| Information Governance training compliance | >=95% | 95.7% | 90.5% | 79.2% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 95.7% | 81.0% | 87.5% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 78.3% | 85.7% | 91.7% |
| Fire Safety training compliance | >=85% | 87.0% | 90.5% | 83.3% |
| Bed occupancy** | 85% | 101.8% | 99.4% | 96.3% |
| Safer staffing (Overall) | 90% | 138.7% | 141.8% | 171.8% |
| Safer staffing (Registered) | 80% | 117.1% | 116.9% | 123.9% |
| % of clients clinically ready for discharge | 3.5% | 13.6% | 31.2% | 17.8% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | 100.0% | *100.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 2 | 3 | 3 |
| Restraint incidents | Trend Monitor | 2 | 4 | *17* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 1 (100%) | *1 (100%)* |
| Unfilled Shifts | Trend Monitor | 28 | 18 | 18 |

*** Bed occupancy is combined with Clark Suite due to use of swing beds*

| Clark Suite<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 91.3% | 75.0% | 88.9% |
| Sickness | 5.0% | 1.7% | 3.6% | 11.4% |
| Supervision | 80% | 85.7% | 57.0% | 84.6% |
| Information Governance training compliance | >=95% | 92.0% | 100.0% | 100.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 96.0% | 100.0% | 100.0% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 100.0% | 96.0% | 90.9% |
| Fire Safety training compliance | >=85% | 96.0% | 100.0% | 95.5% |
| Bed occupancy** | 85% | 101.8% | 99.4% | 96.3% |
| Safer staffing (Overall) | 90% | 159.0% | 156.9% | 130.8% |
| Safer staffing (Registered) | 80% | 107.2% | 109.2% | 106.9% |
| % of clients clinically ready for discharge | 3.5% | 6.1% | 10.4% | 7.7% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 66.7% | 100.0% | *100.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 1 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 5 | 3 | 1 |
| Restraint incidents | Trend Monitor | 15 | 4 | *2* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 1 (100%) | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 32 | 24 | 18 |

*** Bed occupancy is combined with Beamshaw Suite due to use of swing beds*

| Melton Suite<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 88.9% | 84.6% | 80.8% |
| Sickness | 5.0% | 8.6% | 11.8% | 9.3% |
| Supervision | 80% | 64.3% | 71.4% | 69.2% |
| Information Governance training compliance | >=95% | 95.8% | 90.9% | 88.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 100.0% | 100.0% | 100.0% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 91.7% | 86.4% | 84.0% |
| Fire Safety training compliance | >=85% | 87.5% | 81.8% | 84.0% |
| Bed occupancy | 85% | 100.5% | 100.0% | 101.2% |
| Safer staffing (Overall) | 90% | 177.2% | 195.8% | 174.4% |
| Safer staffing (Registered) | 80% | 98.2% | 96.1% | 95.6% |
| % of clients clinically ready for discharge | 3.5% | 16.4% | 16.7% | 16.4% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | N/A | *0.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 9 | 3 | 5 |
| Restraint incidents | Trend Monitor | 38 | 30 | *7* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 2 (100%) | 1 (100%) | *1 (100%)* |
| Unfilled Shifts | Trend Monitor | 39 | 27 | 30 |

| Nostell<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 100.0% | 87.0% | 87.0% |
| Sickness | 5.0% | 9.8% | 14.1% | 13.7% |
| Supervision | 80% | 81.3% | 87.5% | 93.3% |
| Information Governance training compliance | >=95% | 96.2% | 91.7% | 92.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 92.0% | 87.5% | 88.0% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 92.0% | 87.5% | 92.0% |
| Fire Safety training compliance | >=85% | 92.3% | 91.7% | 96.0% |
| Bed occupancy** | 85% | 99.0% | 96.3% | 98.1% |
| Safer staffing (Overall) | 90% | 170.0% | 156.9% | 120.8% |
| Safer staffing (Registered) | 80% | 106.0% | 108.1% | 111.3% |
| % of clients clinically ready for discharge | 3.5% | 4.4% | 14.1% | 13.7% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | 53.8% | *90.9%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 1 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 7 | 1 | 6 |
| Restraint incidents | Trend Monitor | 18 | 11 | *11* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 1 (100%) | 1 (100%) | *2 (100%)* |
| Unfilled Shifts | Trend Monitor | 34 | 14 | 9 |

*** Bed occupancy is combined with Stanley due to use of swing beds*

## Inpatients - Mental Health - Working Age Adults

| Stanley<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 95.8% | 47.8% | 79.2% |
| Sickness | 5.0% | 5.7% | 3.4% | 7.5% |
| Supervision | 80% | 100.0% | 75.0% | 80.0% |
| Information Governance training compliance | >=95% | 96.0% | 96.0% | 88.5% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 96.0% | 88.0% | 96.2% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 100.0% | 96.0% | 88.5% |
| Fire Safety training compliance | >=85% | 88.0% | 92.0% | 88.5% |
| Bed occupancy** | 85% | 99.0% | 96.3% | 98.1% |
| Safer staffing (Overall) | 90% | 125.5% | 131.0% | 164.8% |
| Safer staffing (Registered) | 80% | 97.1% | 107.1% | 109.6% |
| % of clients clinically ready for discharge | 3.5% | 4.0% | 8.5% | 7.4% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | 92.3% | *100.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 1 | 3 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 2 | 2 |
| Restraint incidents | Trend Monitor | 4 | 8 | *6* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 1 (100%) | 0 | *1 (100%)* |
| Unfilled Shifts | Trend Monitor | 14 | 6 | 27 |

*** Bed occupancy is combined with Nostell due to use of swing beds*

| Walton<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 94.3% | 85.3% | 88.6% |
| Sickness | 5.0% | 7.7% | 8.4% | 7.3% |
| Supervision | 80% | 90.0% | 57.9% | 89.5% |
| Information Governance training compliance | >=95% | 94.1% | 97.0% | 97.3% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 72.7% | 78.8% | 89.2% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 78.8% | 81.8% | 83.8% |
| Fire Safety training compliance | >=85% | 88.2% | 84.8% | 89.2% |
| Bed occupancy | 85% | 101.4% | 100.7% | 106.9% |
| Safer staffing (Overall) | 90% | 136.7% | 126.5% | 139.7% |
| Safer staffing (Registered) | 80% | 92.8% | 93.6% | 94.9% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 10.8% | 15.8% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 83.3% | 87.5% | *100.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 4 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 2 | 4 |
| Restraint incidents | Trend Monitor | 5 | 4 | *23* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 2 (100%) | 2 (100%) | *7 (100%)* |
| Unfilled Shifts | Trend Monitor | 17 | 5 | 6 |

| Ashdale<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 87.5% | 54.5% | 60.6% |
| Sickness | 5.0% | 3.5% | 0.4% | 1.2% |
| Supervision | 80% | 52.6% | 52.6% | 85.0% |
| Information Governance training compliance | >=95% | 93.9% | 97.0% | 91.2% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 87.9% | 90.9% | 91.2% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 90.9% | 87.9% | 88.2% |
| Fire Safety training compliance | >=85% | 100.0% | 100.0% | 94.1% |
| Bed occupancy | 85% | 101.9% | 98.0% | 98.7% |
| Safer staffing (Overall) | 90% | 130.0% | 129.7% | 142.1% |
| Safer staffing (Registered) | 80% | 113.4% | 116.7% | 117.9% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 0.0% | 2.7% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 85.7% | 100.0% | *90.9%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 3 | 1 | 2 |
| Physical Violence (Patient on Staff) | Trend Monitor | 5 | 3 | 1 |
| Restraint incidents | Trend Monitor | 9 | 8 | *7* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 5 | 9 | 10 |

| Ward 18<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 72.0% | 56.0% | 46.2% |
| Sickness | 5.0% | 15.8% | 13.9% | 7.6% |
| Supervision | 80% | 87.5% | 66.7% | 75.0% |
| Information Governance training compliance | >=95% | 100.0% | 95.5% | 100.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 87.5% | 86.4% | 84.6% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 87.5% | 86.4% | 80.8% |
| Fire Safety training compliance | >=85% | 95.8% | 90.9% | 92.3% |
| Bed occupancy | 85% | 97.3% | 97.8% | 97.7% |
| Safer staffing (Overall) | 90% | 112.8% | 114.0% | 108.0% |
| Safer staffing (Registered) | 80% | 81.4% | 87.4% | 94.3% |
| % of clients clinically ready for discharge | 3.5% | 11.0% | 6.1% | 6.5% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | 92.3% | *100.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 2 | 1 | 5 |
| Physical Violence (Patient on Staff) | Trend Monitor | 8 | 4 | 3 |
| Restraint incidents | Trend Monitor | 12 | 13 | *5* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 16 | 5 | 7 |

## Inpatients - Mental Health - Working Age Adults

| Elmdale<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 90.5% | 75.0% | 78.3% |
| Sickness | 5.0% | 4.4% | 5.2% | 4.0% |
| Supervision | 80% | 75.0% | 75.0% | 91.7% |
| Information Governance training compliance | >=95% | 96.6% | 92.9% | 96.6% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 93.1% | 92.9% | 93.1% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 100.0% | 92.6% | 96.4% |
| Fire Safety training compliance | >=85% | 100.0% | 92.9% | 93.1% |
| Bed occupancy | 85% | 97.0% | 98.4% | 95.5% |
| Safer staffing (Overall) | 90% | 122.6% | 119.5% | 117.4% |
| Safer staffing (Registered) | 80% | 97.6% | 101.9% | 99.5% |
| % of clients clinically ready for discharge | 3.5% | 4.1% | 1.4% | 2.7% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | 92.3% | *94.7%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 1 | 4 | 3 |
| Physical Violence (Patient on Staff) | Trend Monitor | 1 | 3 | 10 |
| Restraint incidents | Trend Monitor | 10 | 2 | *24* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 5 | 1 | 3 |

## Inpatients - Mental Health - Older People Services

| Crofton<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 65.5% | 89.3% | 77.8% |
| Sickness | 5.0% | 5.6% | 6.9% | 3.6% |
| Supervision | 80% | 80.0% | 93.3% | 92.9% |
| Information Governance training compliance | >=95% | 92.6% | 88.9% | 92.9% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 84.0% | 88.0% | 88.5% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 84.0% | 84.0% | 84.6% |
| Fire Safety training compliance | >=85% | 88.9% | 88.9% | 92.9% |
| Bed occupancy | 85% | 104.6% | 103.6% | 99.8% |
| Safer staffing (Overall) | 90% | 160.3% | 178.3% | 177.5% |
| Safer staffing (Registered) | 80% | 143.0% | 138.5% | 153.5% |
| % 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% | 62.5% | *75.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 1 | 5 | 2 |
| Restraint incidents | Trend Monitor | 2 | 10 | *0* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 28 | 24 | 20 |

| Poplars CUE<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 88.9% | 84.6% | 85.7% |
| Sickness | 5.0% | 10.2% | 11.8% | 6.9% |
| Supervision | 80% | 92.9% | 92.3% | 92.3% |
| Information Governance training compliance | >=95% | 100.0% | 96.0% | 100.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 91.3% | 87.0% | 78.6% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 95.7% | 95.7% | 92.9% |
| Fire Safety training compliance | >=85% | 92.0% | 96.0% | 96.7% |
| Bed occupancy | 85% | 80.9% | 84.1% | 83.8% |
| Safer staffing (Overall) | 90% | 228.1% | 220.8% | 242.3% |
| Safer staffing (Registered) | 80% | 105.8% | 106.0% | 103.0% |
| % of clients clinically ready for discharge | 3.5% | 17.3% | 16.8% | 25.3% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | N/A | *0.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 5 | 6 |
| Physical Violence (Patient on Staff) | Trend Monitor | 10 | 13 | 7 |
| Restraint incidents | Trend Monitor | 12 | 13 | *12* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 47 | 37 | 58 |

## Inpatients - Mental Health - Older People Services

| Willow<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 94.7% | 73.9% | 75.0% |
| Sickness | 5.0% | 17.3% | 13.5% | 11.5% |
| Supervision | 80% | 100.0% | 91.7% | 66.7% |
| Information Governance training compliance | >=95% | 94.7% | 94.4% | 87.5% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 94.7% | 94.4% | 78.3% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 94.7% | 72.2% | 69.6% |
| Fire Safety training compliance | >=85% | 84.2% | 88.9% | 83.3% |
| Bed occupancy | 85% | 96.8% | 91.3% | 88.6% |
| Safer staffing (Overall) | 90% | 141.9% | 155.0% | 171.6% |
| Safer staffing (Registered) | 80% | 98.8% | 101.4% | 98.4% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 8.0% | 3.7% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | 100.0% | *0.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 2 | 0 | 0 |
| Restraint incidents | Trend Monitor | 2 | 0 | *2* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 16 | 12 | 34 |

| Beechdale<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 100.0% | 100.0% | 100.0% |
| Sickness | 5.0% | 12.3% | 10.7% | 12.3% |
| Supervision | 80% | 100.0% | 91.7% | 100.0% |
| Information Governance training compliance | >=95% | 100.0% | 87.8% | 100.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 91.7% | 74.6% | 92.0% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 91.7% | 75.4% | 95.8% |
| Fire Safety training compliance | >=85% | 91.7% | 85.0% | 80.0% |
| Bed occupancy | 85% | 93.3% | 91.9% | 93.5% |
| Safer staffing (Overall) | 90% | 117.3% | 126.7% | 154.1% |
| Safer staffing (Registered) | 80% | 101.2% | 101.0% | 114.9% |
| % of clients clinically ready for discharge | 3.5% | 7.3% | 3.7% | 0.0% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | 85.7% | *100.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 2 | 1 | 3 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 6 | 4 |
| Restraint incidents | Trend Monitor | 1 | 9 | *8* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 2 | 4 | 13 |

| Ward 19 - Male<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 78.3% | 75.0% | 95.7% |
| Sickness | 5.0% | 4.2% | 4.2% | 3.2% |
| Supervision | 80% | 100.0% | 92.3% | 100.0% |
| Information Governance training compliance | >=95% | 100.0% | 87.8% | 92.6% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 87.5% | 74.5% | 88.9% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 79.2% | 75.3% | 88.9% |
| Fire Safety training compliance | >=85% | 100.0% | 84.9% | 100.0% |
| Bed occupancy | 85% | 96.6% | 101.9% | 101.9% |
| Safer staffing (Overall) | 90% | 106.1% | 107.2% | 110.2% |
| Safer staffing (Registered) | 80% | 103.7% | 91.6% | 82.8% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 0.0% | 0.0% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | 100.0% | *N/A* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 2 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 1 | 4 | 1 |
| Restraint incidents | Trend Monitor | 2 | 8 | *2* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 6 | 3 | 4 |

| Ward 19 - Female<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 77.8% | 72.2% | 100.0% |
| Sickness | 5.0% | 11.2% | 1.6% | 0.6% |
| Supervision | 80% | 100.0% | 91.7% | 100.0% |
| Information Governance training compliance | >=95% | 100.0% | 87.8% | 100.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 70.6% | 74.6% | 90.5% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 94.1% | 75.4% | 90.5% |
| Fire Safety training compliance | >=85% | 88.2% | 85.0% | 95.2% |
| Bed occupancy | 85% | 95.3% | 94.8% | 92.9% |
| Safer staffing (Overall) | 90% | 93.5% | 97.6% | 93.2% |
| Safer staffing (Registered) | 80% | 113.5% | 103.5% | 106.6% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 0.0% | 3.2% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 100.0% | 100.0% | *100.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 2 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 1 | 4 | 1 |
| Restraint incidents | Trend Monitor | 2 | 8 | *2* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 12 | 3 | 1 |

## Inpatients - Mental Health - Rehab

| Enfield Down<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 87.8% | 78.7% | 87.2% |
| Sickness | 5.0% | 5.8% | 2.2% | 2.8% |
| Supervision | 80% | 100.0% | 91.7% | 96.2% |
| Information Governance training compliance | >=95% | 97.8% | 97.8% | 93.8% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 82.2% | 79.5% | 80.9% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 85.7% | 90.2% | 86.0% |
| Fire Safety training compliance | >=85% | 91.3% | 91.1% | 91.7% |
| Bed occupancy | Trend Monitor | 55.4% | 55.3% | 52.8% |
| Safer staffing (Overall) | 90% | 95.3% | 93.6% | 94.1% |
| Safer staffing (Registered) | 80% | 96.3% | 99.9% | 105.2% |
| % of clients clinically ready for discharge | 3.5% | 5.6% | 5.6% | 5.9% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | N/A | 0.0% | *0.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 1 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 0 | 0 |
| Restraint incidents | Trend Monitor | 0 | 1 | *0* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 0 | 0 | 0 |

| Lyndhurst<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 86.7% | 23.3% | 93.3% |
| Sickness | 5.0% | 3.8% | 1.5% | 0.6% |
| Supervision | 80% | 93.3% | 87.5% | 93.8% |
| Information Governance training compliance | >=95% | 100.0% | 100.0% | 96.7% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 88.9% | 88.9% | 86.7% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 92.6% | 85.2% | 90.0% |
| Fire Safety training compliance | >=85% | 96.3% | 92.6% | 90.0% |
| Bed occupancy | Trend Monitor | 69.1% | 69.4% | 68.1% |
| Safer staffing (Overall) | 90% | 92.8% | 91.1% | 93.9% |
| Safer staffing (Registered) | 80% | 84.1% | 86.6% | 86.7% |
| % of clients clinically ready for discharge | 3.5% | 9.1% | 9.3% | 9.1% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | N/A | N/A | *N/A* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 0 | 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 Waterton (95.5%), Ryburn (100%), Bronte (100%), Chippendale (100%), Johnson (100%) are all now within compliance. An improving trajectory is noted on Newhaven (82.1%), Thornhill (90.9%), both with projected improvements planned in March due to appraisal meetings being booked with staff. Sandal (64%) saw an increase in staff requiring an appraisal and plans have been in place to address with noted improvements (70.4%) in mid-March. Hepworth (89.3%) have noted some data quality issues and are working through these. Priestley (38.1%) currently have a robust plan and weekly reporting in place in relation to performance and appraisal. The reduction in performance is understood to be a number of staff who require and an appraisal and have one booked but also a number of staff away from work (maternity leave / long term sickness) where data quality issues are impacting on ability to exclude.

**Medium Secure**

• Six wards are above supervision compliance (Appleton, Bronte, Chippendale, Hepworth, Priestley and Johnson). This includes noted improvements on Johnson (93.8%). Waterton, albeit below compliance at 64.3% has continued to demonstrate an improving trajectory, evidencing the embedding of plans in implementation by the Ward Manager.
• Attendance is within compliance Appleton (1.5%), Hepworth (2.7%), Bronte (3.1%), and Johnson (2.3%). Sickness also remains above compliance on Chippendale (11.0%) Priestley (12.4%) and Waterton (10.0%) which is a combination of long-term sickness absence and short-term absence.
• The plans in place to improve cardiopulmonary resuscitation compliance have seen improvements with the exception of Priestley (75.0%) and Johnson (66.7%). This will be an area of focus for the service, with the Ward Managers on these areas supporting a close review of skill mix on wards to support safety whilst this improves.
•Information Governance compliance remains a focus of targeted improvement work, compliance has now been achieved on Chippendale (100%), Appleton (100%) and Waterton (95.7%), with hotspots identified on Hepworth (93.5%), Johnson (92.6%), Priestley (92.0%) and Bronte (91.7%). The service has a clear plan for addressing with individuals and an improving trajectory is expected on all areas.
•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 have been in place to address. All wards except for Priestley (80%) are now within expected targets. Those who require training are now being supported to book on Trust training.
• Compliance for reducing restrictive physical interventions (RRPI) has notable improvements in compliance across the service with six wards now above compliance. Priestley (79.2%) 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 (68.1%), however all these beds have individuals who are waiting for appropriate approvals to support admission.
There were no prone restraints in medium secure and incidents of violence and restraint incidents remains broadly consistent.
• 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. Improvement has been noted in all areas with Ryburn (0%), Newhaven (3.9%) and Sandal (5.7%). Thornhill (16.5%) remains a hot spot, in part impacted by the long term and short-term sickness absence. All staff on long-term sick returned in February.
• Mandatory training compliance has noted a continued improvement in low secure. Hotspots remain in Fire Safety on Newhaven (83.3%). This was due to some training that was cancelled. Staff are now being supported to book onto Trust training. A further hotspot in IG training has been noted on Sandal (93.8%) and Thornhill (87.5%). This is four staff on Sandal and two staff on Thornhill. The ward managers have plans remaining in place to address shortfalls and maintain performance.
• Bed occupancy in low secure is within compliance for Sandal. Thornhill is currently below expected occupancy at 73.1%; however, this is expected to be short term with current access assessments underway. Newhaven has had one admission, however continues to experience lower level of referrals and has no waiting list.
• An increase in service acuity is evidence through and increase in patient on staff incidents and patient on patients incidents. The service have accessed the support of wider Trust services, RRPI / safeguarding to ensure robust support plans in place to manage risks. There was one prone restraint on Newhaven, lasting under 3 minutes.

| Appleton<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 86.4% | 89.5% | 89.5% |
| Sickness | 5.4% | 5.9% | 1.6% | 1.5% |
| Supervision | 80% | 80.0% | 81.3% | 93.3% |
| Information Governance training compliance | >=95% | 100.0% | 95.7% | 100.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 91.7% | 91.3% | 95.7% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 83.3% | 78.3% | 82.6% |
| Fire Safety training compliance | >=85% | 83.3% | 82.6% | 91.3% |
| Bed occupancy | 90% | 62.5% | 62.5% | 62.5% |
| Safer staffing (Overall) | 90% | 92.0% | 92.9% | 92.1% |
| Safer staffing (Registered) | 80% | 102.1% | 103.9% | 101.1% |
| % 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 | 1 |
| Restraint incidents | Trend Monitor | 5 | 5 | *6* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 0 | 0 | 2 |

| Bronte<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 95.2% | 100.0% | 100.0% |
| Sickness | 5.4% | 2.6% | 0.6% | 3.1% |
| Supervision | 80% | 100.0% | 100.0% | 100.0% |
| Information Governance training compliance | >=95% | 94.4% | 94.7% | 91.7% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 94.4% | 94.7% | 91.7% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 77.8% | 89.5% | 87.5% |
| Fire Safety training compliance | >=85% | 88.9% | 89.5% | 91.7% |
| Bed occupancy | 90% | 100.0% | 92.6% | 100.0% |
| Safer staffing (Overall) | 90% | 124.3% | 99.9% | 96.6% |
| Safer staffing (Registered) | 80% | 119.9% | 108.1% | 100.3% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 0.0% | 0.0% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | N/A | N/A | N/A |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 0 | 0 |
| Restraint incidents | Trend Monitor | 2 | 1 | *1* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 8 | 4 | 0 |

| Chippendale Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 83.3% | 79.2% | 100.0% |
| Sickness | 5.4% | 3.6% | 8.0% | 11.0% |
| Supervision | 80% | 93.3% | 88.9% | 89.5% |
| Information Governance training compliance | >=95% | 96.2% | 100.0% | 100.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 88.5% | 87.0% | 90.5% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 80.8% | 69.6% | 85.7% |
| Fire Safety training compliance | >=85% | 84.6% | 91.3% | 90.5% |
| Bed occupancy | 90% | 97.8% | 94.1% | 96.7% |
| Safer staffing (Overall) | 90% | 126.3% | 130.4% | 130.5% |
| Safer staffing (Registered) | 80% | 129.7% | 136.3% | 133.8% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 0.0% | 0.0% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | N/A | N/A | N/A |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 1 | 0 | 0 |
| Restraint incidents | Trend Monitor | 0 | 0 | *0* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 7 | 7 | 2 |

| Hepworth Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 83.9% | 92.9% | 89.3% |
| Sickness | 5.4% | 5.1% | 3.2% | 2.7% |
| Supervision | 80% | 100.0% | 85.0% | 84.2% |
| Information Governance training compliance | >=95% | 96.6% | 93.3% | 93.5% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 82.8% | 90.0% | 83.9% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 86.2% | 73.3% | 83.9% |
| Fire Safety training compliance | >=85% | 82.8% | 80.0% | 87.1% |
| Bed occupancy | 90% | 93.5% | 88.0% | 68.1% |
| Safer staffing (Overall) | 90% | 102.7% | 111.8% | 115.4% |
| Safer staffing (Registered) | 80% | 90.5% | 93.0% | 96.0% |
| % of clients clinically ready for discharge | 3.5% | 7.1% | 7.6% | 1.7% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | N/A | N/A | N/A |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 2 | 2 | 1 |
| Restraint incidents | Trend Monitor | 7 | 4 | *4* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 1 (100%) | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 6 | 4 | 5 |

## Inpatients - Forensic - Medium Secure

| Johnson Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 46.4% | 88.5% | 100.0% |
| Sickness | 5.4% | 4.7% | 7.4% | 2.3% |
| Supervision | 80% | 100.0% | 76.5% | 93.8% |
| Information Governance training compliance | >=95% | 80.0% | 84.6% | 92.6% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 96.7% | 100.0% | 96.3% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 93.3% | 76.9% | 66.7% |
| Fire Safety training compliance | >=85% | 73.3% | 88.5% | 92.6% |
| Bed occupancy | 90% | 80.0% | 80.0% | 80.0% |
| Safer staffing (Overall) | 90% | 133.2% | 133.9% | 140.4% |
| Safer staffing (Registered) | 80% | 90.6% | 86.6% | 99.9% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 0.0% | 0.0% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | N/A | N/A | N/A |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 2 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 1 | 2 | 1 |
| Restraint incidents | Trend Monitor | 1 | 6 | *0* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 5 | 2 | 8 |

| Priestley Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 36.4% | 52.4% | 38.1% |
| Sickness | 5.4% | 10.4% | 10.1% | 12.4% |
| Supervision | 80% | 85.7% | 85.7% | 87.5% |
| Information Governance training compliance | >=95% | 87.0% | 92.0% | 92.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 77.3% | 75.0% | 79.2% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 90.9% | 87.5% | 75.0% |
| Fire Safety training compliance | >=85% | 82.6% | 80.0% | 80.0% |
| Bed occupancy | 90% | 80.3% | 85.6% | 94.7% |
| Safer staffing (Overall) | 90% | 90.5% | 92.2% | 93.2% |
| Safer staffing (Registered) | 80% | 76.4% | 86.0% | 91.4% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 0.0% | 0.0% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | N/A | N/A | N/A |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 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 | 1 | 0 |

| Waterton<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 81.8% | 90.9% | 95.5% |
| Sickness | 5.4% | 9.4% | 7.5% | 10.0% |
| Supervision | 80% | 38.5% | 42.9% | 64.3% |
| Information Governance training compliance | >=95% | 91.3% | 100.0% | 95.7% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 87.0% | 82.6% | 82.6% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 87.0% | 87.0% | 73.9% |
| Fire Safety training compliance | >=85% | 91.3% | 95.7% | 100.0% |
| Bed occupancy | 90% | 93.8% | 95.4% | 98.7% |
| Safer staffing (Overall) | 90% | 117.9% | 118.9% | 125.1% |
| Safer staffing (Registered) | 80% | 104.1% | 96.6% | 97.3% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 0.0% | 0.0% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | N/A | N/A | N/A |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 0 | 0 |
| Restraint incidents | Trend Monitor | 0 | 0 | *0* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 1 | 4 | 1 |

## Inpatients - Forensic - Low Secure

| Thornhill<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 79.2% | 80.0% | 90.9% |
| Sickness | 5.4% | 4.1% | 9.7% | 16.5% |
| Supervision | 80% | 71.4% | 80.0% | 92.9% |
| Information Governance training compliance | >=95% | 96.2% | 96.0% | 87.5% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 96.2% | 96.0% | 91.7% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 100.0% | 92.0% | 91.7% |
| Fire Safety training compliance | >=85% | 100.0% | 100.0% | 95.8% |
| Bed occupancy | 85% | 83.4% | 79.8% | 73.1% |
| Safer staffing (Overall) | 90% | 98.7% | 102.4% | 121.6% |
| Safer staffing (Registered) | 80% | 104.1% | 100.1% | 119.1% |
| % 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 | 1 |
| Restraint incidents | Trend Monitor | 0 | 0 | *0* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 0 | 5 | 5 |

| Sandal<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 73.1% | 68.0% | 64.0% |
| Sickness | 5.4% | 10.9% | 9.4% | 5.7% |
| Supervision | 80% | 88.2% | 94.4% | 94.4% |
| Information Governance training compliance | >=95% | 96.7% | 96.4% | 93.8% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 93.3% | 92.9% | 90.6% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 76.7% | 85.7% | 81.3% |
| Fire Safety training compliance | >=85% | 96.7% | 96.4% | 96.9% |
| Bed occupancy | 85% | 81.5% | 86.1% | 87.7% |
| Safer staffing (Overall) | 90% | 148.9% | 130.2% | 124.7% |
| Safer staffing (Registered) | 80% | 112.9% | 116.8% | 122.6% |
| % 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 | 3 | 1 | 1 |
| Physical Violence (Patient on Staff) | Trend Monitor | 1 | 0 | 1 |
| Restraint incidents | Trend Monitor | *5* | 0 | *2* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | *1(100%)* | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 11 | 17 | 10 |

## Inpatients - Forensic - Low Secure

| Ryburn<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 85.7% | 100.0% | 100.0% |
| Sickness | 5.4% | 22.8% | 14.7% | 0.0% |
| Supervision | 80% | 100.0% | 100.0% | 100.0% |
| Information Governance training compliance | >=95% | 100.0% | 100.0% | 100.0% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 100.0% | 100.0% | 90.0% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 100.0% | 100.0% | 90.0% |
| Fire Safety training compliance | >=85% | 100.0% | 100.0% | 100.0% |
| Bed occupancy | 85% | 96.3% | 84.3% | 93.4% |
| Safer staffing (Overall) | 90% | 99.9% | 99.3% | 99.1% |
| Safer staffing (Registered) | 80% | 100.0% | 100.1% | 100.0% |
| % of clients clinically ready for discharge | 3.5% | 0.0% | 0.0% | 0.0% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | N/A | N/A | N/A |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 0 | 0 |
| Restraint incidents | Trend Monitor | 0 | 0 | *0* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *0* |
| Unfilled Shifts | Trend Monitor | 0 | 0 | 0 |

| Newhaven<br>Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 79.5% | 66.7% | 82.1% |
| Sickness | 5.4% | 4.6% | 6.0% | 3.9% |
| Supervision | 80% | 85.7% | 95.0% | 86.4% |
| Information Governance training compliance | >=95% | 94.9% | 92.3% | 95.2% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 88.9% | 88.9% | 84.2% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 72.2% | 86.1% | 84.2% |
| Fire Safety training compliance | >=85% | 89.7% | 84.6% | 83.3% |
| Bed occupancy | 85% | 68.8% | 62.5% | 66.5% |
| Safer staffing (Overall) | 90% | 117.6% | 96.7% | 108.7% |
| Safer staffing (Registered) | 80% | 106.6% | 101.5% | 104.3% |
| % 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 | 3 | 3 |
| Physical Violence (Patient on Staff) | Trend Monitor | 0 | 5 | 7 |
| Restraint incidents | Trend Monitor | 0 | 7 | *10* |
| Prone Restraint incidents (under 3 minutes) | Trend Monitor | 0 | 0 | *1 (100%)* |
| Unfilled Shifts | Trend Monitor | 12 | 6 | 5 |

## Inpatients - Non-Mental Health

**• Appraisal rate:**
Neuro Rehabilitation Unit (NRU) rate is showing 78.6% for February with an increase during March to 82.9% as at 13th March.
Stroke Rehabilitation Unit (SRU) rate is 76.9% for February.
New interim Stroke Team Manager started in post in February so we should see an improvement over the next period of time.

**• Sickness:**
NRU – sickness has improved again for February with a reduction from 8.3% to 7.5%. Significant long-term sickness (LTS) due to 2 x planned surgery (hip replacements) continued throughout February. Staff who have had surgery are due back in March. This is being managed via HR processes and sickness reviews.
SRU – sickness has increased this month to 5.6% for February. This is across both ward and ESD staff with varying reasons – a mixture of short and long term sickness (surgery, flu, anxiety and MSK issues). This is being managed via HR processes and sickness reviews.

**• Supervision:**
NRU has seen an improvement to achieve compliance at 85.2% for February following a focus on supervision during the last month and a further increase to 88% as at 13 March.
SRU figures for February have dropped to 79.5% - very slightly below compliance. The new team manager has now completed supervision training.

**• Information Governance:**
NRU – continues to maintain compliance achieving 97.7%.
SRU – has seen an increase to achieve compliance this month at 95.7%.

**• Cardiopulmonary resuscitation (CPR):**
NRU – a slight reduction in February, just below compliance at 78%. Five staff are due, and they are all booked onto upcoming dates – this may show in March or April figures depending on the recording lag as noted below.
SRU – an increase in February to 83.1% to achieve compliance
*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 | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 84.6% | 85.4% | 78.6% |
| Sickness | 5.0% | 9.8% | 8.3% | 7.1% |
| Supervision | 80% | 73.1% | 70.4% | 85.2% |
| Information Governance training compliance | >=95% | 100.0% | 97.4% | 97.7% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 75.7% | 83.3% | 78.0% |
| Fire Safety training compliance | >=85% | 87.2% | 92.1% | 86.0% |
| Bed occupancy (Barnsley Commissioned beds only) | 80% | 59.7% | 67.7% | 55.7% |
| Safer staffing (Overall) | 90% | 113.6% | 112.2% | 113.6% |
| Safer staffing (Registered) | 80% | 114.9% | 114.0% | 104.3% |
| % 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 | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 92.2% | 77.6% | 76.9% |
| Sickness | 5.0% | 5.5% | 3.9% | 3.4% |
| Supervision | 80% | 92.1% | 92.5% | 79.5% |
| Information Governance training compliance | >=95% | 93.7% | 93.8% | 95.7% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 70.0% | 72.1% | 83.1% |
| Fire Safety training compliance | >=85% | 92.1% | 95.3% | 95.7% |
| Bed occupancy | 80% | 101.9% | 98.1% | 99.1% |
| Safer staffing (Overall) | 90% | 102.1% | 107.0% | 108.5% |
| Safer staffing (Registered) | 80% | 126.9% | 135.4% | 144.0% |
| % 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 |

## 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 service in addition has a number of staff who now require appraisal and plans are in place to improve compliance.
• Some reduction in supervision during February to 68.4% 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.
Improvements noted in sickness and absence although remains over target at 5.5%
• A reduction in clinically ready for discharge is noted following the discharge of a service users (55.4%). 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. A reduction in patient on staff incidents is evident.

| Horizon Metrics | Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|
| Appraisal rate | Projected Compliance: Jan - 78.3% Feb - 82.3% | 97.1% | 90.9% | 87.9% |
| Sickness | 5.0% | 7.9% | 9.4% | 5.5% |
| Supervision | 80% | 83.3% | 78.9% | 68.4% |
| Information Governance training compliance | >=95% | 97.2% | 100.0% | 97.4% |
| Reducing Restrictive Practice Interventions training compliance | >=80% | 97.1% | 93.5% | 89.5% |
| Cardiopulmonary resuscitation (CPR) training compliance | >=80% | 88.2% | 90.3% | 84.2% |
| Fire Safety training compliance | >=85% | 91.7% | 90.6% | 94.9% |
| Bed occupancy | N/A | 55.6% | 60.5% | 68.8% |
| Safer staffing (Overall) | 90% | 162.4% | 167.7% | 198.4% |
| Safer staffing (Registered) | 80% | 154.4% | 163.9% | 164.2% |
| % of clients clinically ready for discharge | 3.5% | 90.1% | 80.0% | 55.4% |
| FIRM Risk Assessments - Staying safe care plan in 24 hours | 95% | 0.0% | N/A | *100.0%* |
| Physical Violence (Patient on Patient) | Trend Monitor | 0 | 0 | 0 |
| Physical Violence (Patient on Staff) | Trend Monitor | 27 | 43 | 9 |
| Restraint incidents | Trend Monitor | 27 | 39 | *15* |
| 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 | The Equality Diversity and Inclusion (EDI) strategy has been agreed by the Equality, Involvement and Inclusion Committee and is scheduled to be approved at Trust Board in March. The strategy has six strategic aims , one of which is about reducing inequalities. The lead person for this work has been confirmed and will commence in post on the 1st April<br>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. The implementation plan has been developed and a soft launch is planned for early April<br>A range of activities were delivered in race equality week (3rd to 7th February) which included the sharing of our anti racism approach<br>Our Equality Delivery System (EDS) 2022 assessment has been finalised and we have received a grading of 'achieving' | |
| **Improving care** | Transform our Older People inpatient services | Activity is now progress on the operational plan. Programme Board meeting held February 2025. Estates procurement is progressing (Crofton); the first Principal Supply Chain Partnerships took place in February; progress was made on the preparation and confirmation of contract options and tools established to evaluate suppliers – start and target completion dates to be confirmed in the next period. Operational Work-strand: Meetings with ward managers taking place to review current and future establishments, safer staffing inpatient exercise is taking place and output will be used to review against staffing establishment. | |
| | Improve our mental health services so they are more responsive, inclusive, and timely | **Care Closer to Home (CC2H):**<br>• Work continues on maintaining a low out of area presence and quality monitoring the impact on both inpatient services and community teams.<br>• The process to support systematic daily review of informal admission requests is continuing to be developed<br>• Optimising Community Solutions and enhancing Patient Flow work has commenced and a Process mapping session is planned for April with Intensive Home Based Treatment managers - follow ups are planned with medics and staff in April/ May. Terms of Reference have been agreed for the steering group leading this work.<br>• There is a review taking place around the General Manager monthly clinics which will be undertaken with staff and team managers<br><br>**Improving Access to Care**<br>• Data gathering is continuing to support understanding of issues for both Core Psychology and Memory Services waits and work is progressing towards generating ideas for improvement.<br>• Core Psychology: Following team day in January to share early findings of similarities and differences in pathway and ways of working, outcomes are being written up into a summary report and including recommendations for further work (Apr). Further understanding is required for place specific challenges and dates have been arranged / continue to be arranged for these meetings (Mar-Apr).<br>• Memory services: Shared outcomes from workshops for teams to review. Refined process maps with Kirklees and Wakefield to accurately reflect pathways and identify specific areas for further understanding. Follow-up workshop arranged for 3rd April on MS Teams and teams invited to develop shared understanding of service and generate ideas for improvement.<br><br>**Inpatient Improvement:**<br>**- The inpatient staffing establishment** has been approved by EMT. Work is progressing to review job roles and to map workforce vacancies to inform our recruitment needs. New roster templates are being introduced onto the system from 1st April 2025.<br>**- Therapeutic offer** – reviewing our approach to improving our therapeutic offer across inpatient areas. Core workstreams identified (which also link closely with culture of care standards) are:<br>• Purpose of admission<br>• Trauma informed care<br>• Care & treatment for people who have autism<br>• Care & treatment for people who have emotionally complex needs<br>• Embedding evidence-based practice, such as NICE Quality standards for inpatient care and Patient Experience standards, and Safe Wards standards.<br>• Therapeutic environments<br>**- Creative Practitioners:** Work is progressing with the 'Working on Arts Council funding application. The Baring Foundation – Everyone Arts has reviewed allocation of funds and will fund four local Creative Minds Partners. This project will continue to raise awareness of the offer and explore how to increase community visits by linking up with staff, service users, and Creative Minds community provision. Working with Equality and Involvement team to explore ways of accurately capturing service user participation in sessions. Ongoing development of handbook for Social Prescribing activity and wellbeing activities. Creative Practitioners now have access to group supervision, counselling and peer support/shadowing opportunities. Ward 19 murals and acoustic panels installed. Ambient Music Boards now in place at The Poplars, The Dales and Priestley Units (further information can be found on the intranet Resource Page. )<br>**- Culture of care programme:** All wards continue active quality improvement work with National Collaborating Centre for Mental Health (NCCMH). Key ward project team members have joined the Patient Carer Race Equality (PCREF) Internal Advisory Group to align quality improvement work into the Trusts developing approach. Culture of Care has been presented across the established Mental Health Alliances in place and to the External PCREF advisory group. The Developing an Autistic Approach in SWYPFT away day took place on the 27th of February - report will be compiled through March and highlights distributed across the SWYPFT communication platforms throughout March. The Internet resource has been created Culture of Care - South West Yorkshire Partnership NHS Foundation Trust and will be agreed at the Oversight group in April 2025.<br>**- Forensic Data workstream:** The Forensic In-patient Dashboard is now in place and data quality issues are continuing to be addressed. Training for Ward Managers has been undertaken and further feedback considered.<br>**- Forensic Therapeutic / Intervention Workstream:** An initial meeting has developed a report about the challenges and issues faced within the Intervention Pathway. Work continues reviewing pathways and developing a future vision, this includes service user and staff groups.<br>**- Forensic Social Work Workstream:** The project plan has been put on hold as discussions take place between SWYPFT and Wakefield Local Authority about the interface between the two organisations for these services. The first development session is being planned for April 2025 | |

| Strategic Objective | Priority Programme | Highlights (progress against milestones and other updates by exception) | Progress |
|---|---|---|---|
| **Improving care** | Improve safety and quality | **Care Planning & Risk Assessment**<br>The new care plan went live on SystmOne on 6th January '25. Care Planning and Risk Assessment Oversight group now established and meets monthly. Task and finish groups set up to complete the training requirements for each care group and work is progressing. The new metrics associated with the care plan will be reported from April '25 and a task and finish group is also in place to manage the transition. 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 we are forecasting a breakeven position, the Value for money initiatives have under delivered this year and has required a number of additional non-recurrent technical adjustments to achieve this value.<br>• The main driver throughout has continued to be workforce growth and it being higher than planned.<br>• Initial draft high level plan values have been submitted to WY ICB on 27th February, with a final submission being worked up for 27th March.<br>• 25/26 key lines of enquiry continue to be scoped, with detailed delivery plans to be developed over the coming weeks. | |
| | Make digital improvements | Digital Dictation<br>The project is now reporting green and is back on track following a period of escalation. Barnsley Memory Service and Drury Lane resumed use of Lexacom in February and deployment to Barnsley Physical Health Service commenced in February as per plan and is on track to complete in March. Deployment to North and South Kirklees and Calderdale services is planned for March. Benefit realisation/productivity work is in progress and meetings with Finance in March are scheduled. The first SystmOne integration test has been completed and further tests will take place in March. The trial looking with meeting minute efficiencies was agreed by the Project Board and will commence in April. | |
| **Great place to work** | People Directorate – Delivery of People Promise | As agreed at People Renumeration Committee, the 90 day plan has come to an end with a number of workstreams being taken into business as usual. Work is now being scoped based on the People Promise headings for some of the strategic areas that need continued focus. | |

# Overall Financial Performance 2024/25

## Executive Summary / Key Performance Indicators

| Performance Indicator | | Year to Date | Forecast 2024/25 | Narrative |
|---|---|---|---|---|
| 1 | Surplus / (Deficit) | (£0.6m) | £0m | The Trust financial target for 2024/25 is breakeven. A surplus of £1.1m has been reported in month, through a combination of improved performance in all sectors and non recurrent benefits which has reduced the year to date deficit to £0.6m. Further non recurrent mitigations have been identified to support delivery of the year end target. |
| 2 | Agency Spend | £6m | £6.5m | Agency expenditure run rate has continued to fluctuate. Spend in January is £499k which is £185k less than last month. The provider collaborative spend in month was £50k which is £37k less than last month. Cheswold Park Hospital spend in month was £52k which is £127k less than last month; January was higher than the normal run rate due to medical staff arrears. |
| 3 | Financial sustainability and efficiencies | £16.6m | £20.8m | 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 £20.8m, being £1.2m 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 | £55.9m | £50.1m | Cash has continued to reduce month on month throughout 2024/25. Although the financial position has improved in month the mitigations are non cash. Steps to ensure that outstanding invoices / awaiting cash payment continue to be actioned. |
| 5 | Capital | £4.1m | £7.6m | 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 has been added in month 11 for LED lighting following a successful grant bid. |
| 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 | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|
| Percentage of service users who have had their equality data recorded - ethnicity | 90% | 98.4% | 98.4% | 95.5% | | Based on all current inpatients (66 as at 28/02/2025) |
| Percentage of service users who have had their equality data recorded - disability | 50% | 100.0% | 100.0% | 100.0% | | Based on all current inpatients (66 as at 28/02/2025) |
| Percentage of service users who have had their equality data recorded - sexual orientation | | 93.7% | 93.7% | 87.9% | | |
| Completion of equality mandatory training | >=80% | 100.0% | 100.0% | 99.0% | | 100% of ward; 98% central support services staff; 92% of clinical staff |

**Improving Care**

| Metrics | Trust Threshold | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|
| Number of violence and aggression incidents against staff on mental health wards involving race | Trend monitor | 0 | 1 | 1 | | Out of a total number (27) of violence and aggression incidents occurred in February 2025 |

**Make SWYPFT a great place to work**

| Metrics | Trust Threshold | Dec-24 | Jan-25 | Feb-25 | Variation/ Assurance | Notes |
|---|---|---|---|---|---|---|
| Turnover external (in month) | >12% - 13%< | 2.1% | 0.9% | 1.6% | | |
| Sickness absence - In month | <=5.4% | 7.1% | 6.9% | 4.2% | | |
| Staff supervision rate | 80% | 83.0% | 80.0% | 79.0% | | |
| Mandatory training - Cardiopulmonary resuscitation | 80% | 96.0% | 94.0% | 94.0% | | includes training for Immediate Life Support, Basic Life Support |
| Mandatory training - Reducing restrictive physical interventions (RRPI) | 80% | 92.0% | 93.0% | 91.0% | | includes training for Prevention and Management of Violence and Aggression and Breakaway |
| Mandatory training - Fire | 85% | 99.0% | 98.0% | 97.0% | | |
| Mandatory training - Information governance (IG) | 95% | 98.0% | 98.0% | 98.0% | | |

# Appendix 1 - Cheswold Park Hospital

NHS South West Yorkshire Partnership NHS Foundation Trust



## Quality Headlines

| Section | KPI | Trust Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|---|
| Complaints | % of feedback with staff attitude as an issue | < 20% | 9.09% (1/11) | 0% (0/6) | 0% (0/5) |
| | Complaints - Number of responses provided within six months of the date a complaint received | 100.0% | 18.18% (2/11) | 50.00% (3/6) | 80.00%(4/5) |
| 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% | 100% (64/64) | 100% (64/64) | 93.75% (60/64) |
| | 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 | 100% (2/2) | 100% (3/3) |
| | Total number of reported incidents | Trend monitor | 165 | 199 | 125 |
| | Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) | Trend monitor | 2 | 3 | 1 |
| | Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) | Trend monitor | 0 | 0 | 0 |
| | Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) | Trend monitor | 0 | 0 | 0 |
| | Safer staff fill rates (% Overall) | 90% | 90.1% | 95.0% | 96.2% |
| | Safer Staffing % Fill Rate - Registered Nurses Overall | 80% | 86.2% | 102.2% | 107.0% |
| | Safer Staffing % Fill Rate - Registered Nurses Days | 80% | 80.2% | 95.9% | 107.8% |
| | Safer Staffing % Fill Rate - Registered Nurses Nights | 80% | 94.6% | 111.0% | 106.4% |
| | % 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 | 0 | 2 | 0 |
| | Number of restraint incidents | Trend monitor | 6 | 6 | 7 |
| | % of staff receiving supervision within policy guidance | 80.0% | 83.0% | 80.0% | 79.0% |
| Infection Prevention | Infection Prevention (MRSA & C.Diff) All Cases | 0 | 0 | 0 | 0 |

## Quality Headlines

Number of Information Governance breaches - 2 incidents reported in February 2025. One incidnet ralated to, patients blood results sent to wrong GP; Second incident related to former employee had access to CPH Rota.

# Appendix 1 - Cheswold Park Hospital

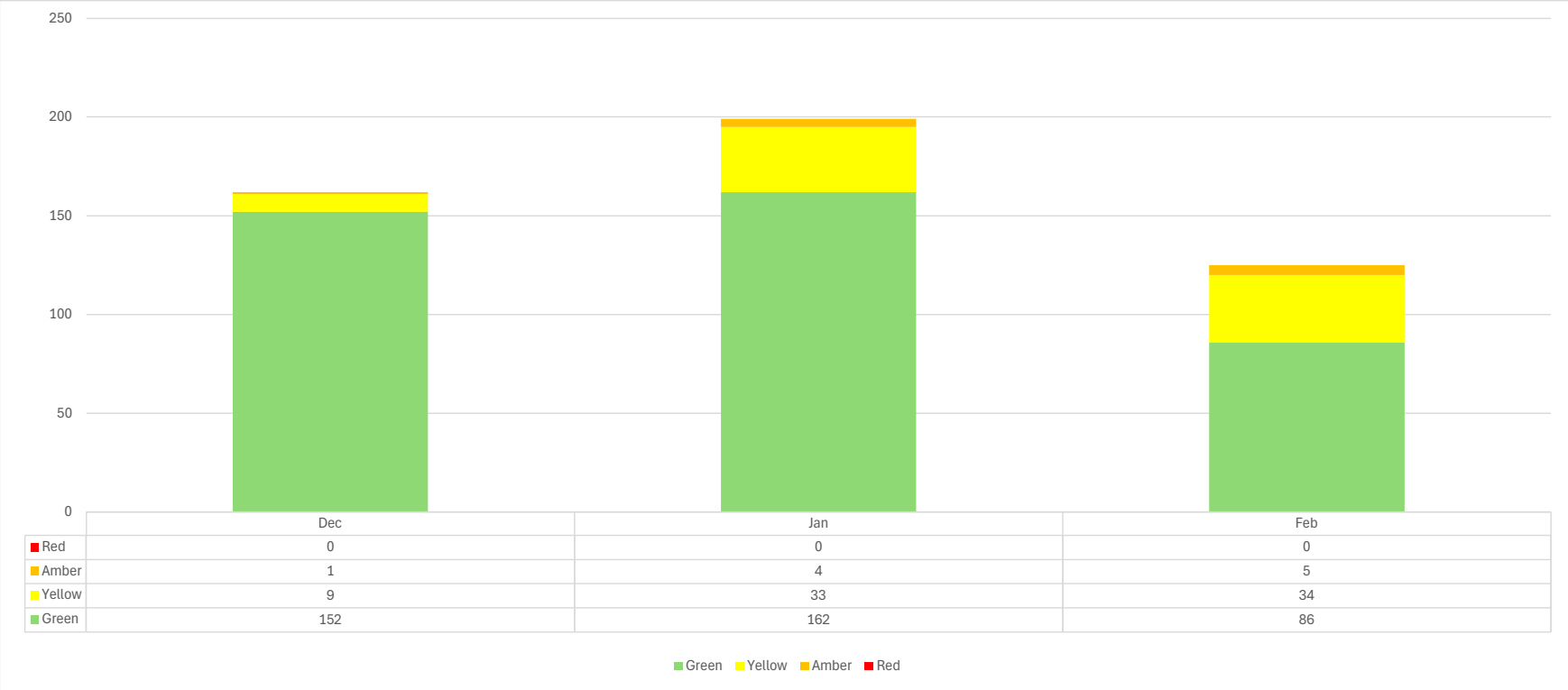


## Safety First

**Summary of Incidents**

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

82.40% of incidents occurred in February 2025 resulted in No harm or injury occurred.
No incident related to Severe - permanent and significant/long term harm occurred in February 2025.
No never events, or incident resulted in major, catastrophic harm or death occurred in February 2025.




| | Dec | Jan | Feb |
|---|---|---|---|
| Red | 0 | 0 | 0 |
| Amber | 1 | 4 | 5 |
| Yellow | 9 | 33 | 34 |
| Green | 152 | 162 | 86 |

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

Breakdown of incidents in February 2025 - 1 moderate harm incident:
The most common cause(s) for these incidents were due to Medication, Self injurious behaviours and Violence and aggression.
No severe harm incidents

# Appendix 1 - Cheswold Park Hospital



## Safeguarding

**Safeguarding Adults:**
There were 1 safeguarding adult incidents in February 2025.

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

## Complaints

- There were 5 new complaints in February of which are all were formal. All of the complaints received were regarding inpatients.
- Of the 5 new complaints received, 1 are noted as 'Remains open', 4 are 'closed'.
- One of the new complaints related to 'Issues with peer on the ward', one related to 'Damaged property by staff', one related to 'Washington Red Skin Hat stolen', one related to 'Food taken from the fridge' and one related to 'Discharge and accommodation after this'.
- 4 Complaints were closed in February 2025.
- No compliments were received in February 2025.

## Reducing Restrictive Physical Intervention (RRPI)

- There were 7 restraint related incidents occurred in February 2025, making up 5.60% (7/125) of the total February 2025 incidents.
- As in February 2025 there was no incidents implemented in prone position.

# Appendix 1 - Cheswold Park Hospital



## People - Performance Wall

### Trust Performance Wall

| | Objective | CQC Domain | Trust Threshold | Dec-24 | Jan-25 | Feb-25 |
|---|---|---|---|---|---|---|
| Establishment | Improving Resources | Well Led | - | 324.1 | 324.1 | Data not available at the time of producing the report |
| Contracted Staff In Post (Ledger) | | | - | 317.3 | 322.0 | |
| Vacancies | | | - | -6.8 | -2.0 | |
| Turnover external (in month) | | | >12% - <13% | 2.1% | 0.9% | 1.6% |
| Starters | | | - | 0.0 | 0.0 | Data not available at the time of producing the report |
| Leavers | | | - | 6.0 | 3.0 | |
| International Nurse Starters in Month | | | - | 0 | 0 | 0 |
| % Bank Fill Rates - Registered Nurses | | | - | 4.44% (34/765) | 7.10%(54/760) | 8.47%(61/720) |
| % Bank Fill Rates - Health Care Assistants | | | - | 7.8% (153/1957) | 16.23%(314/1934) | 19.44%(366/1882) |
| Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive) | | | - | 6.87% (187/2722) | 13.65%(368/2694) | 16.41%(427/2602) |
| Sickness absence - Month | | | <=5% | 7.1% | 6.9% | 4.2% |
| Employees with long term sickness over 12 months | | | - | 1 | 1 | Data not available |
| Appraisals - rolling 12 months | | | 95% | 81.0% | 79.0% | 73.0% |
| Employee Relations - Suspensions (over 90 days) | | | - | 0 | 0 | Data not available |
| Mandatory Training - TOTAL | Improving Care | | >=80% | 99.0% | 98.0% | 98.0% |
| Mandatory Training - Reducing Restrictive Practice Interventions | | | | 92.0% | 93.0% | 91.0% |
| Mandatory Training - Cardiopulmonary Resuscitation | | | | 96.0% | 94.0% | 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 | | | | 100.0% | 100.0% | 99.0% |
| Mandatory Training - Fire Safety | | | >=85% | 99.0% | 98.0% | 97.0% |
| Mandatory Training - Food Safety | | | >=80% | 100.0% | 99.0% | 100.0% |
| Mandatory Training - Freedom To Speak Up (FTSU) | | | | 100.0% | 99.0% | 100.0% |
| Mandatory Training - Infection Control & Hand Hygiene | | | | 99.0% | 100.0% | 98.0% |
| Mandatory Training - Information Governance (Data Security) | | | >=95% | 98.0% | 98.0% | 98.0% |
| Mandatory Training - Moving & Handling | | | >=80% | 99.0% | 98.0% | 97.0% |
| Mandatory Training - Mental Capacity Act/Dols | | | | 97.0% | 97.0% | 97.0% |
| Mandatory Training - Mental Health Act | | | | 97.0% | 97.0% | 97.0% |
| Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1 | | | | 98.0% | 97.0% | 98.0% |
| Mandatory Training - Prevent | | | >=80% | N/A | N/A | N/A |
| Mandatory Training - Safeguarding Adults | | | | 99.0% | 98.0% | 97.0% |
| Mandatory Training - Safeguarding Children | | | | 99.0% | 98.0% | 97.0% |

South West Yorkshire Partnership NHS Foundation Trust

# Finance Report

## Month 11 (2024 / 25)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

## 1.0 Executive Summary / Key Performance Indicators

| Key Performance Indicator | | Year to date | Forecast 2024 / 25 | Narrative |
|---|---|---|---|---|
| 1 | Surplus / (Deficit) | (£0.6m) | £0m | The Trust financial target for 2024 / 25 is breakeven. A surplus of £1.1m has been reported in month, through a combination of improved performance in all sectors and non recurrent benefits which has reduced the year to date deficit to £0.6m. Further non recurrent mitigations have been identified to support delivery of the year end target. |
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| 4 | Cash | £55.9m | £50.1m | Cash has continued to reduce month on month throughout 2024 / 25. Although the financial position has improved in month the mitigations are non cash. Steps to ensure that outstanding invoices / awaiting cash payment continue to be actioned. |
| 5 | Capital | £4.1m | £7.6m | 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 has been added in month 11 for LED lighting following a successful grant bid. |
| 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. |

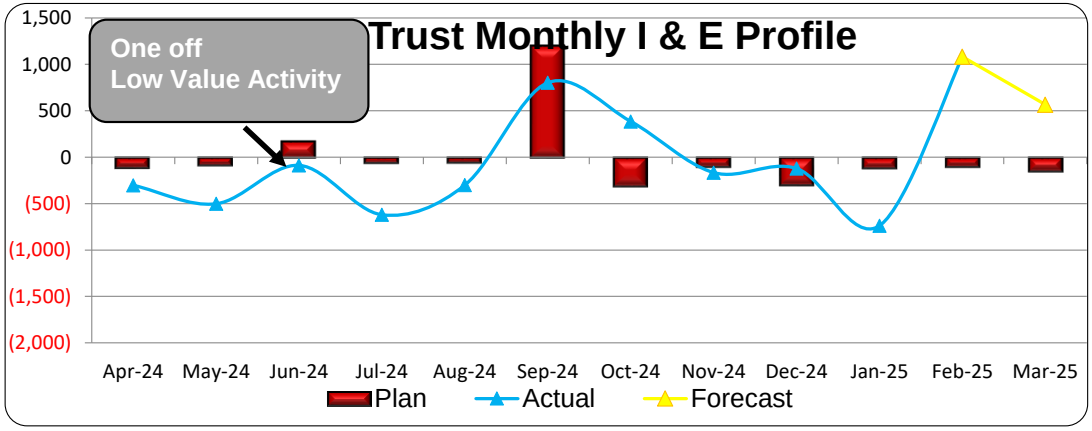
| | |
|---|---|
| Red | Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels |
| Amber | Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels |
| Green | In line, or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

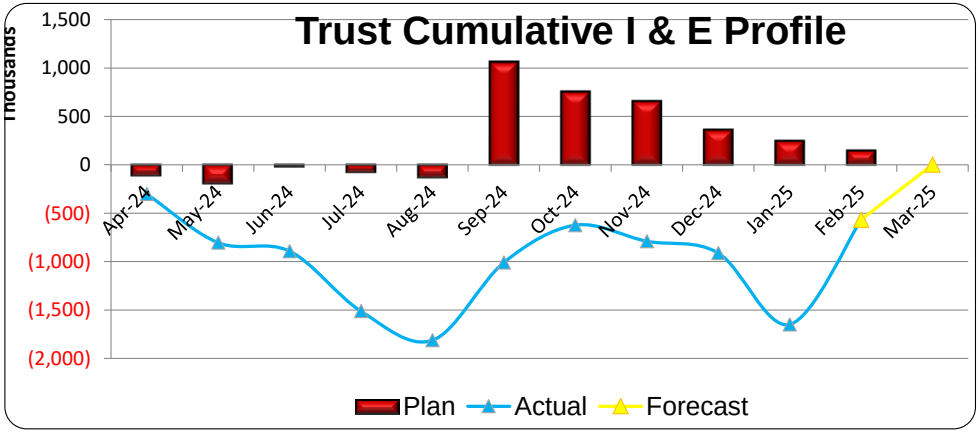
# 2.0 Income & Expenditure Position 2024 / 25

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 | | | | | 37,001 | 37,554 | 553 | 394,946 | 397,143 | 2,196 | 431,795 | 434,225 | 2,430 |
| Other Operating Revenue | | | | | 1,447 | 1,664 | 217 | 15,309 | 16,256 | 946 | 16,594 | 17,626 | 1,031 |
| **Total Revenue** | | | | | **38,448** | **39,217** | **769** | **410,256** | **413,398** | **3,143** | **448,389** | **451,850** | **3,461** |
| Pay Costs | 5,426 | 5,459 | 33 | 0.6% | (24,048) | (23,894) | 154 | (253,776) | (255,629) | (1,853) | (277,725) | (279,437) | (1,713) |
| Non Pay Costs | | | | | (13,922) | (13,593) | 329 | (151,014) | (152,792) | (1,777) | (164,775) | (166,225) | (1,451) |
| 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** | **5,459** | **33** | **0.6%** | **(37,970)** | **(37,487)** | **483** | **(404,791)** | **(408,397)** | **(3,606)** | **(442,499)** | **(445,639)** | **(3,139)** |
| **EBITDA** | **5,426** | **5,459** | **33** | **0.6%** | **479** | **1,731** | **1,252** | **5,465** | **5,002** | **(463)** | **5,890** | **6,212** | **322** |
| Depreciation | | | | | (598) | (603) | (5) | (6,144) | (6,143) | 1 | (6,742) | (6,746) | (4) |
| PDC Paid | | | | | (274) | (315) | (41) | (2,444) | (2,895) | (451) | (2,718) | (3,210) | (492) |
| Interest Received | | | | | 293 | 270 | (23) | 3,271 | 3,470 | 198 | 3,570 | 3,745 | 175 |
| **Surplus / (Deficit) - ICB performance measure** | **5,426** | **5,459** | **33** | **0.6%** | **(100)** | **1,083** | **1,183** | **148** | **(567)** | **(715)** | **(0)** | **0** | **0** |
| Depn Peppercorn Leases (IFRS16) | | | | | (5) | (5) | 0 | (89) | (89) | 0 | (94) | (94) | 0 |
| Revaluation of Assets | | | | | 0 | (12,673) | (12,673) | 0 | (11,955) | (11,955) | 0 | (11,955) | (11,955) |
| **Surplus / (Deficit) - Total** | **5,426** | **5,459** | **33** | **0.6%** | **(105)** | **(11,596)** | **(11,491)** | **59** | **(12,611)** | **(12,670)** | **(94)** | **(12,049)** | **(11,955)** |



# Income & Expenditure Position 2024 / 25

**The consolidated financial position is a year to date deficit of £0.6m. This is £0.7m behind plan. Financial performance in February is a surplus of £1.1m which is £1.2m better than planned.**

In line with national guidance the Trust submitted a breakeven financial plan for 2024 / 25 in May 2024. An updated plan submission was made in June 2024 to take account of the consultant pay award and tariff uplift with a reiterated commitment to achieve breakeven. This commitment was again made following the impact of additional pay awards paid in October and November 2024. Whilst income uplifts were also received this has also created a further financial pressure which has required 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) | 5,055 | 5,089 | 34 | 0.7% | (110) | 230 | 340 | (1,684) | (1,790) | (106) | (1,874) | (2,556) | (682) |
| Cheswold Park Hospital | 336 | 336 | 0 | 0.1% | 111 | 94 | (17) | 554 | 105 | (449) | 665 | 107 | (558) |
| Provider Collaboratives | 23 | 33 | 11 | 47.0% | 2 | 126 | 123 | 27 | (170) | (197) | 29 | (539) | (569) |
| Budgets held centrally | 12 | 0 | (12) | 100.0% | (104) | 633 | 737 | 1,251 | 1,288 | 37 | 1,180 | 2,988 | 1,809 |
| **Total - Consolidated position (ICB performance measure)** | **5,426** | **5,459** | **33** | **0.6%** | **(100)** | **1,083** | **1,183** | **148** | **(567)** | **(715)** | **(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 third consecutive month where a surplus has been reported and contributes to a reduction in the year to date deficit.

Cheswold Park Hospital has reported a small surplus in month partly due to confirmation of income, both bed pricing and mobilisation funding, being finalised. As previously highlighted we continue to review costs now that we are operationally running the hospital and these costs are validated against the business case.

The provider collaboratives, collectively, have also reported a surplus in month which helps to reduce the year to date deficit. This is primarily within South Yorkshire Adult Secure collaborative where contractual assumptions with other providers have been finalised.

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.

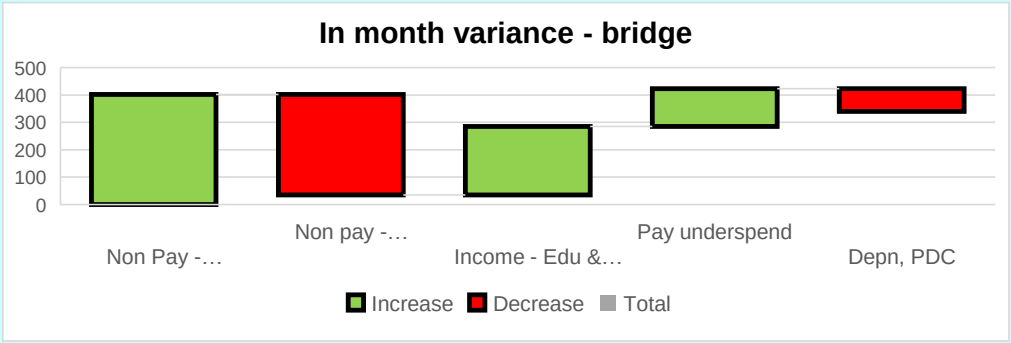
To confirm that the individual analysis within the report highlights the Trust only values.

## 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 | | | | | 26,127 | 26,192 | 66 | 284,814 | 284,409 | (405) | 310,899 | 310,377 | (522) |
| Other Operating Revenue | | | | | 1,401 | 1,508 | 107 | 13,566 | 13,946 | 380 | 14,802 | 15,229 | 427 |
| **Total Revenue** | | | | | **27,527** | **27,700** | **173** | **298,380** | **298,354** | **(26)** | **325,701** | **325,605** | **(95)** |
| Pay Costs | 5,055 | 5,089 | 34 | 0.7% | (22,546) | (22,408) | 138 | (245,229) | (246,364) | (1,134) | (267,747) | (268,874) | (1,127) |
| Non Pay Costs | | | | | (4,680) | (4,568) | 111 | (50,358) | (49,008) | 1,350 | (54,946) | (54,026) | 921 |
| 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** | **5,055** | **5,089** | **34** | **0.7%** | **(27,226)** | **(26,977)** | **249** | **(295,587)** | **(295,347)** | **240** | **(322,693)** | **(322,876)** | **(183)** |
| **EBITDA** | **5,055** | **5,089** | **34** | **0.7%** | **301** | **724** | **423** | **2,793** | **3,007** | **215** | **3,008** | **2,730** | **(278)** |
| Depreciation | | | | | (525) | (544) | (19) | (5,779) | (5,847) | (68) | (6,304) | (6,391) | (87) |
| PDC Paid | | | | | (179) | (220) | (41) | (1,969) | (2,420) | (451) | (2,148) | (2,640) | (492) |
| Interest Received | | | | | 293 | 270 | (23) | 3,271 | 3,470 | 198 | 3,570 | 3,745 | 175 |
| **Surplus / (Deficit) - ICB performance measure** | **5,055** | **5,089** | **34** | **0.7%** | **(110)** | **230** | **340** | **(1,684)** | **(1,790)** | **(106)** | **(1,874)** | **(2,556)** | **(682)** |
| Depn Peppercorn Leases (IFRS16) | | | | | (5) | (5) | 0 | (89) | (89) | 0 | (94) | (94) | 0 |
| Losses Peppercorn Leases (IFRS16) | | | | | 0 | (12,673) | (12,673) | 0 | (11,955) | (11,955) | 0 | (11,955) | (11,955) |
| **Surplus / (Deficit) - Total** | **5,055** | **5,089** | **34** | **0.7%** | **(115)** | **(12,448)** | **(12,334)** | **(1,773)** | **(13,834)** | **(12,061)** | **(1,968)** | **(14,605)** | **(12,637)** |

The core Trust position is a small in month surplus which is the third consecutive month. This is better than planned and helps to reduce the year to date overspend against plan. All compenents of the Trust operating position are showing as better than planned in month. Overall the main mitigation of the financial postion, including overspend on pay, is through non pay.

| Key headlines are included below and illustrated within the bridge: | £k |
|---|---|
| Non Pay underspends - establishment including timing delays | 402 |
| Non Pay overspends - supplies & services, purchase of healthcare, premises | (367) |
| Additional income - Education & Training | 250 |
| Pay underspends - | 138 |
| Movements in depreciation and public dividend capital | (83) |

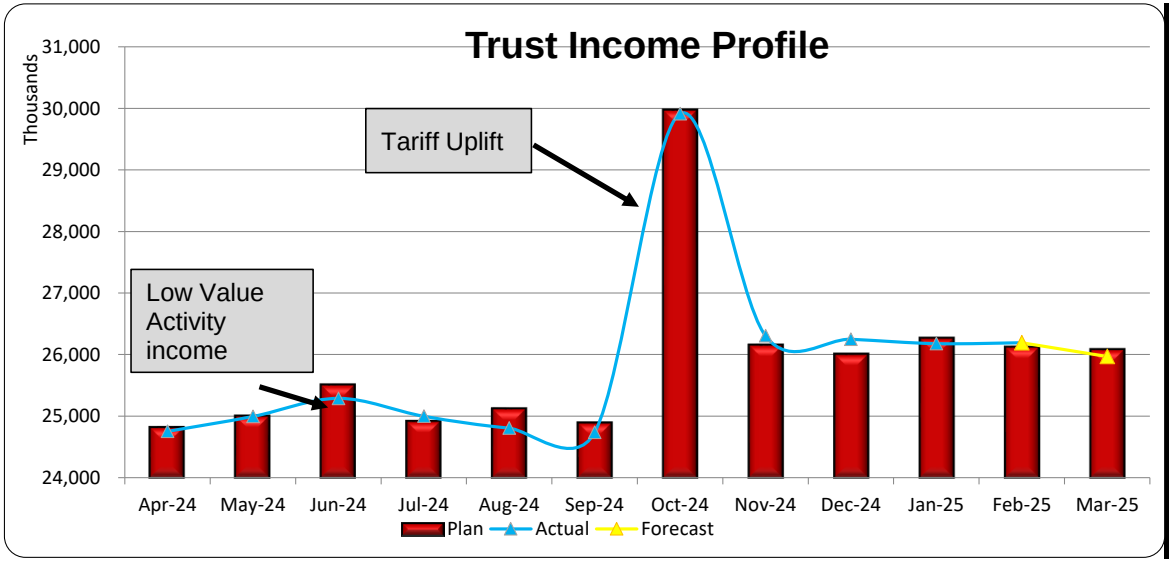


## 2.1 Income Information

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 | 22,193 | 22,189 | **264,309** | 264,051 | 257 |
| **Specialist Commissioner** | **34,541** | 2,943 | 2,962 | 2,974 | 2,947 | 2,956 | 2,827 | 5,239 | 1,495 | 3,295 | 3,047 | 3,054 | 3,038 | **36,776** | 36,681 | 95 |
| **Local Authority** | **5,799** | 378 | 400 | 371 | 398 | 377 | 360 | 381 | 684 | 314 | 410 | 589 | 389 | **5,052** | 5,337 | (286) |
| **Partnerships** | **6,748** | 205 | 219 | 191 | 218 | 207 | 207 | 222 | 293 | 222 | 228 | 226 | 220 | **2,660** | 3,008 | (349) |
| **Other Contract Income** | **1,454** | 131 | 220 | 37 | 135 | 121 | 131 | 136 | 140 | 129 | 138 | 131 | 131 | **1,581** | 1,837 | (256) |
| **Total** | **293,862** | **24,752** | **24,994** | **25,289** | **24,997** | **24,805** | **24,735** | **31,570** | **24,649** | **26,249** | **26,177** | **26,192** | **25,968** | **310,377** | **310,915** | **(538)** |
| 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 | 9,601 | 9,451 | **113,819** | | |
| **Total** | **293,862** | **33,870** | **34,155** | **34,439** | **34,183** | **33,981** | **34,362** | **42,256** | **34,586** | **35,674** | **35,476** | **35,793** | **35,419** | **424,196** | | |




There is a minimal variance to plan in month. Financial values for 2024 / 25 have been agreed with West Yorkshire commissioners ahead of the financial year end.

| | YTD |
|---|---|
| * Partnership - Youth Offenders Service<br>Reimbursement based on actual costs incurred | £349k |
| * Yorkshire Smokefree<br>Various commissioners. Actual costs and payment by results | £265k |
| * Additional Roles Reimbursement Posts<br>Offset by reduced pay costs. Recharged on staff in post | £247k |
| * Any Qualified Provider income<br>Invoices raised. Now included in baseline position. | (£281k) |

# 2.2 Pay Information

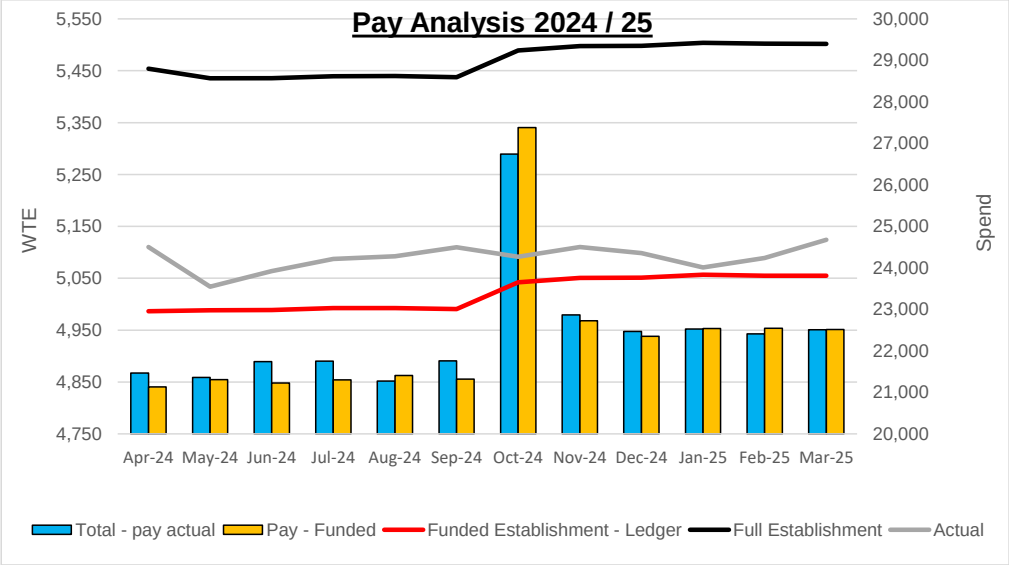
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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 | 20,287 | 20,375 | **242,252** |
| **Bank & Locum** | 1,955 | 1,581 | 1,673 | 1,738 | 1,771 | 1,827 | 1,980 | 1,793 | 1,770 | 1,732 | 1,724 | 1,734 | **21,279** |
| **Agency** | 413 | 400 | 444 | 510 | 429 | 434 | 561 | 452 | 484 | 418 | 397 | 401 | **5,343** |
| **Total** | **21,466** | **21,360** | **21,739** | **21,751** | **21,275** | **21,756** | **26,741** | **22,870** | **22,469** | **22,529** | **22,408** | **22,511** | **268,874** |
| 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% | 7.7% | 7.7% | 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% | 1.8% | 1.8% | 2.0% |

| WTE Worked | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | WTE | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Substantive** | 4,574 | 4,574 | 4,591 | 4,579 | 4,565 | 4,588 | 4,590 | 4,603 | 4,602 | 4,595 | 4,602 | 4,644 | **4,592** |
| **Bank & Locum** | 474 | 401 | 411 | 435 | 456 | 460 | 431 | 445 | 437 | 418 | 429 | 426 | **435** |
| **Agency** | 62 | 59 | 62 | 74 | 71 | 62 | 70 | 62 | 60 | 57 | 59 | 54 | **63** |
| **Total** | **5,110** | **5,034** | **5,064** | **5,087** | **5,092** | **5,110** | **5,092** | **5,110** | **5,098** | **5,071** | **5,089** | **5,124** | **5,090** |
| 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** |




Exepnditure has reduced in February when compared to January which will partly, especially for temporary staffing, be due to the number of days in the month. This doesn't neccesarily translate into the WTE calculation (as 1.00 would still be a full month).

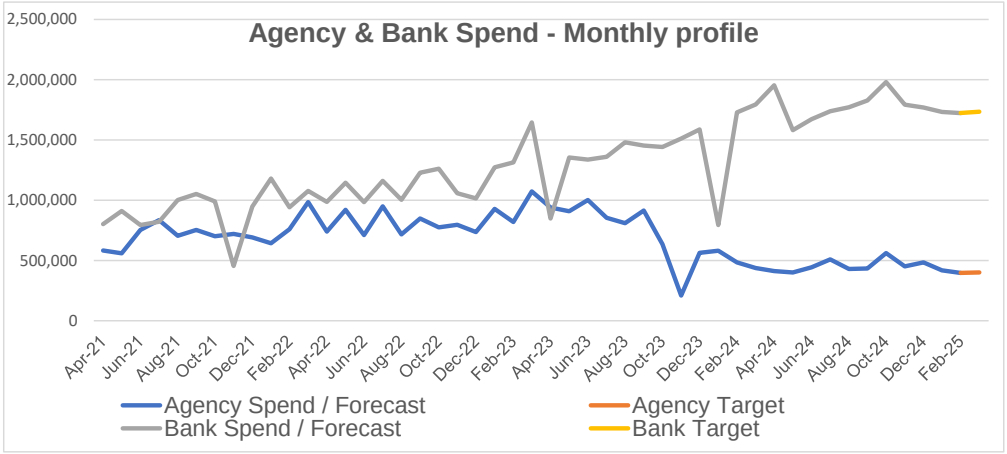
Overall the WTE has increased by 18 in month when compared to January. It is, however, 9 WTE less than December 2024 which is one of the key planning principles for 2025 / 26 although this is within bank and may relate to the shorter month.

# 2.2 Temporary Staffing Focus

**Trust spend in February 2025:**
**Agency £397k**
**Bank £1,724k**

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 | 1,893 | 483 | **2,377** |
| Other Medical | 1,138 | 572 | **1,710** |
| Reg Nursing | 270 | 4,638 | **4,907** |
| UnReg Nursing | 1,143 | 12,119 | **13,262** |
| Other Clinical | 366 | 651 | **1,017** |
| A & C | 132 | 1,081 | **1,213** |
| Other | 1 | 0 | **1** |
| **Total** | **4,942** | **19,545** | **24,487** |
| Lead Provider Collaborative | 647 | 6 | **653** |
| Budgets held centrally | (8) | 0 | **(8)** |
| Cheswold Park Hospital | 376 | 271 | **647** |
| **Total** | **5,958** | **19,822** | **25,780** |

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, within the main Trust, with February being a further £21k reduction compared to last month. The overall consolidated position reports a larger reduction with less spend in month in both the provider collaboratives and Cheswold Park Hospital. The Trust reduction is primarily in the mental health care group and adult inpatient wards although we do continue to see monthly fluctatuons in these areas. Althought there is a slight reduction in the trend information further action will be required to secure 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 one 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.

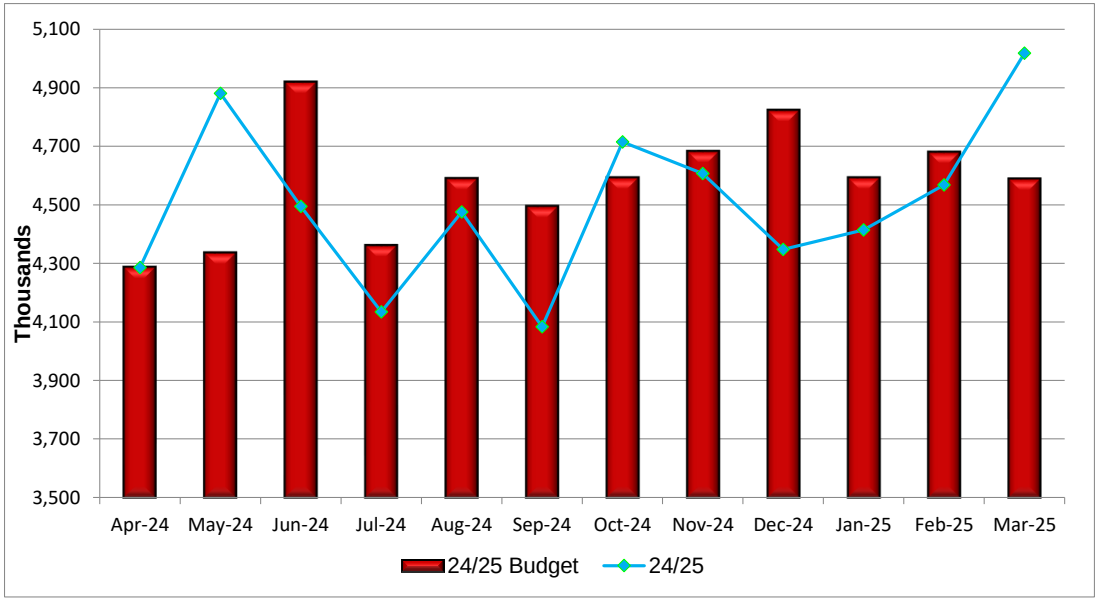
Utilisation of bank, as part of the overall workforce solution, has continued to grow over the past couple of years. As expected from 2025 / 26 this will be subject to NHS England target reductions. There has continued to be small monthly reductions in the run rate but further actions, as identified 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 | 4,568 | 5,018 | **54,026** |
| **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 | 4,033 | 3,745 | (288) | |
| Establishment | 8,976 | 8,624 | (351) | |
| Lease & Property Rental | 8,084 | 8,105 | 21 | |
| Premises (inc. rates) | 4,663 | 4,450 | (213) | |
| Utilities | 2,536 | 2,525 | (11) | |
| Purchase of Healthcare | 5,666 | 5,692 | 27 | |
| Travel & vehicles | 5,315 | 5,263 | (52) | |
| Supplies & Services | 7,550 | 7,292 | (257) | |
| Training & Education | 1,167 | 834 | (333) | |
| Clinical Negligence & Insurance | 1,067 | 1,070 | 3 | |
| Other non pay | 1,301 | 1,406 | 105 | |
| **Total** | **50,358** | **49,008** | **(1,350)** | |
| **Total Excl OOA and Drugs** | **40,659** | **39,570** | **(1,088)** | |




**Key Messages**

The value of non pay expenditure, continuing to be less than spent in 2023 / 24, and less than planned in month for 2024 / 25 continues to support the overall Trust financial position. In total the underspend is £111k in February and increases the year to date to £1,350k. Additional expenditure has been forecast in March 2025 and this continues to be validated.

The main variances in month are:

* Establishment £402k under plan - in part this includes purchase of additional laptops which is now included in the March forecast. This is due to timing of deliveries.

* Utilities are £75k less than budget in month. This includes some non-recurrent adjustments as aged invoices have been resolved.

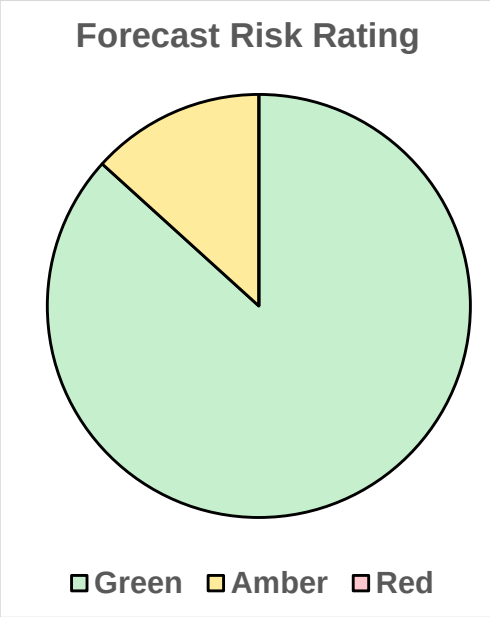
* There are overspends in month in the Supplies & Services, purchase of healthcare and premises categories. No specific issues have been identified.

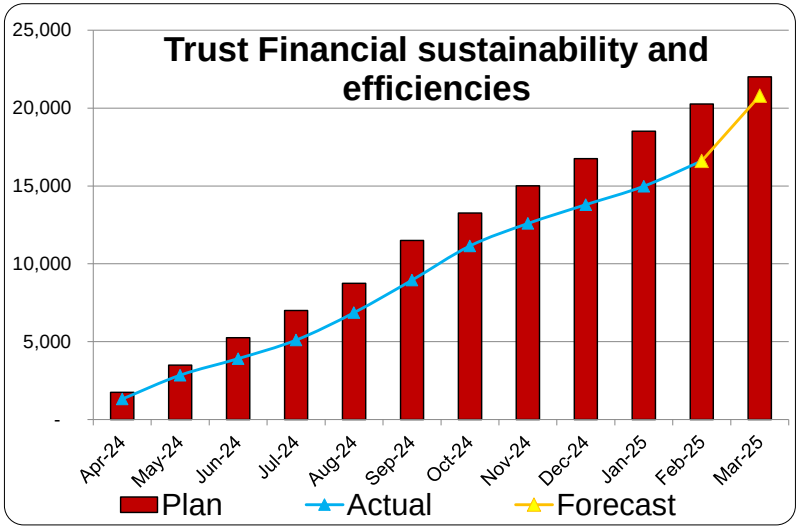
# 3.0 Value for Money, Financial sustainability and efficiency

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 | | 11,429 | 497 | 7,429 | 12,468 | 9,010 | | | (3,458) |
| Non pay - Impact of workforce optimisation | | 385 | 388 | | 420 | 423 | | | 3 |
| Out of area placements | | 2,632 | 2,822 | | 2,871 | 2,822 | 210 | | 161 |
| Non pay - digital | | 226 | 165 | | 246 | 179 | | | (67) |
| Non pay - Estates | | 458 | 372 | 22 | 500 | 428 | | | (72) |
| Non pay - medicines optimisation | | 440 | 0 | | 480 | | | 0 | (480) |
| Non Pay - other | | 0 | 205 | | 0 | 218 | | | 218 |
| Procurement | | 229 | 0 | | 250 | | 0 | | (250) |
| Provider Collaboratives | | 1,045 | 1,045 | | 1,140 | 1,140 | | | 0 |
| Non Recurrent mitigations | | 0 | 0 | | 0 | | 2,550 | | 2,550 |
| Income - contribution, Full Year Effect | | 3,418 | 3,617 | | 3,638 | 3,813 | | | 175 |
| **Total** | | **20,262** | **9,109** | **7,451** | **22,013** | **18,032** | **2,760** | **0** | **(1,221)** |
| Recurrent | | 9,483 | 9,109 | | 10,345 | 8,650 | 210 | 0 | (1,484) |
| Non Recurrent | | 10,779 | | 7,451 | 11,668 | 9,382 | 2,550 | | 264 |




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 £20,792k £20,505k of schemes will be delivered in 2024 / 25. This is £1,221k less than planned and will require mitigation within the overall financial position. The unachieved gap has reduced by £287k due to movement in the workforce optimisation scheme.

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 | 193,995 | |
| **Current Assets** | | | |
| Inventories & Work in Progress | 179 | 201 | |
| NHS Trade Receivables (Debtors) | 1,072 | 2,061 | |
| Non NHS Trade Receivables (Debtors) | 344 | 781 | |
| Prepayments | 3,491 | 3,086 | |
| Accrued Income | 1,062 | 5,388 | 1 |
| Cash and Cash Equivalents | 69,199 | 55,887 | Pg 15 |
| **Total Current Assets** | **75,347** | **67,404** | |
| **Current Liabilities** | | | |
| Trade Payables (Creditors) | (12,728) | (4,338) | 2 |
| Capital Payables (Creditors) | (1,392) | (878) | |
| Tax, NI, Pension Payables, PDC | (8,469) | (9,482) | |
| Accruals | (13,966) | (14,935) | 3 |
| Deferred Income | (409) | (1,774) | 4 |
| Other Liabilities (IFRS 16 / leases) | (51,040) | (50,662) | |
| **Total Current Liabilities** | **(88,004)** | **(82,070)** | |
| **Net Current Assets/Liabilities** | **(12,657)** | **(14,665)** | |
| **Total Assets less Current Liabilities** | **155,161** | **179,330** | |
| Provisions for Liabilities | (3,510) | (3,450) | |
| **Total Net Assets/(Liabilities)** | **151,651** | **175,880** | |
| **Taxpayers' Equity** | | | |
| Public Dividend Capital | 45,696 | 75,696 | |
| Revaluation Reserve | 15,355 | 22,194 | 5 |
| Other Reserves | 5,220 | 5,220 | |
| Income & Expenditure Reserve | 85,380 | 72,769 | |
| **Total Taxpayers' Equity** | **151,651** | **175,880** | |

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 demonstrated by the continued positive better payment practice code performance, we continue to pay suppliers promptly. Aged creditors are reviewed and actively targeted for resolution.

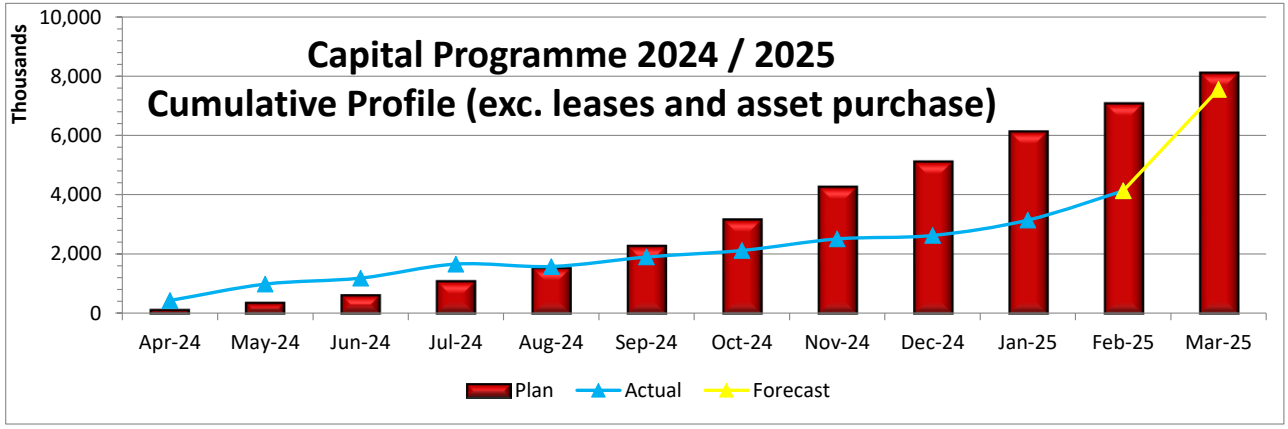
3. Accruals continue to be monitored. These continue to be reviewed on a detailed line by line basis and audit working papers refreshed in advance of year end.

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. Further movement in month relates to the Cheswold Park Hospital transaction which has been actioned fully.

# 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 | 2,000 | 0 | (2,000) | 100 | (2,400) |
| Seclusion Rooms | 1,000 | 1,000 | 1,039 | 39 | 1,090 | 90 |
| Anti-ligature Doors | 1,000 | 910 | 377 | (533) | 400 | (600) |
| **Maintenance (Minor) Capital** | | | | | | |
| Clinical Improvement | 311 | 311 | 306 | (5) | 337 | 27 |
| Safety | 302 | 302 | 301 | (0) | 964 | 662 |
| Sustainability / Carbon Neutral | 510 | 460 | 170 | (290) | 300 | (210) |
| Backlog | 360 | 316 | 513 | 197 | 1,216 | 856 |
| Equipment | 41 | 41 | 173 | 133 | 411 | 371 |
| Other | 193 | 150 | 384 | 234 | 911 | 718 |
| IM & T | 1,470 | 1,404 | 692 | (712) | 1,829 | 359 |
| Contingency | 219 | 0 | 0 | 0 | (191) | (410) |
| Staff Costs | 200 | 183 | 175 | (8) | 191 | (9) |
| **TOTALS** | **8,104** | **7,076** | **4,132** | **(2,944)** | **7,557** | **(547)** |
| Lease Impact (IFRS 16) | 5,910 | 5,860 | 8,015 | 2,155 | 8,875 | 2,965 |
| Asset Purchase | 0 | 0 | 34,893 | 34,893 | 34,893 | 34,893 |
| Cheswold - Minor Capital | | 0 | 179 | 179 | 1,265 | 1,265 |
| Cheswold - IM & T | | 0 | 359 | 359 | 552 | 552 |
| LED Lighting | 648 | 0 | 0 | 0 | 648 | 0 |
| **TOTALS** | **14,662** | **12,936** | **47,578** | **34,642** | **53,790** | **39,128** |



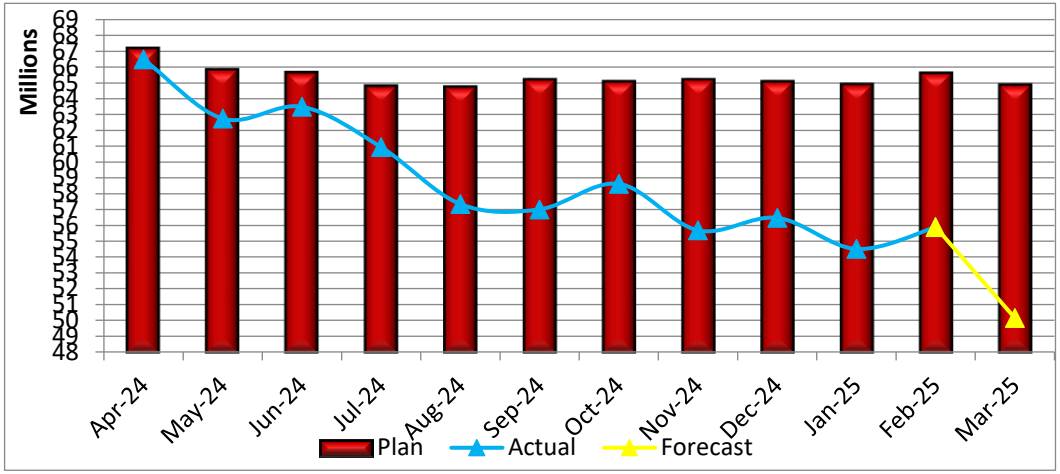

**Capital Expenditure 2024 / 25**

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 has been added in February 2025 (both allocation and forecast expenditure) following a successful grant bid to support LED lighting.

In February a switch has been made between operational capital and IFRS 16 leases to support the expansion of an existing lease. This is possible with all capital now treated as the same total allocation.

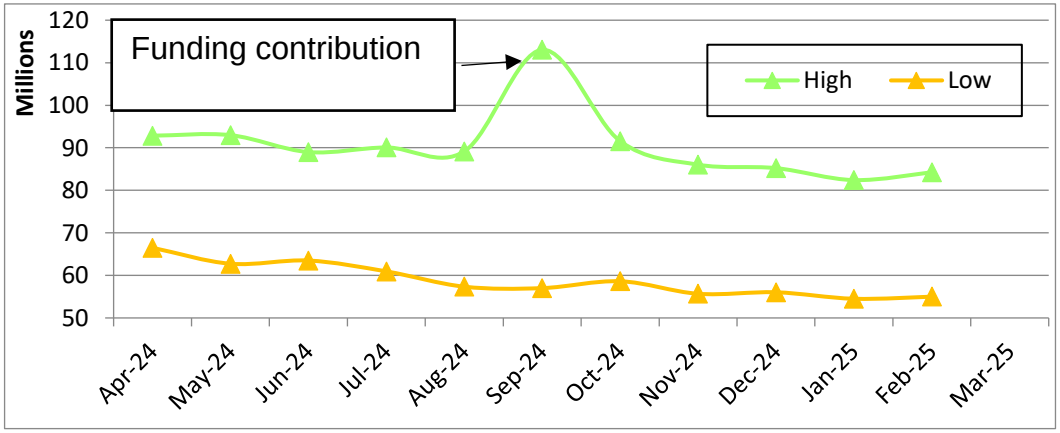
# 4.2 Cash Flow & Cash Flow Forecast 2024 / 2025




**Cash levels have increased in month**

Cash balances have increased slightly in month but are expected to fall again in March as capital is spent and PDC is paid.

| | Plan £k | Actual £k | Variance £k |
|---|---|---|---|
| Opening Balance | 71,353 | 69,199 | |
| Closing Balance | 65,629 | 55,887 | (9,742) |



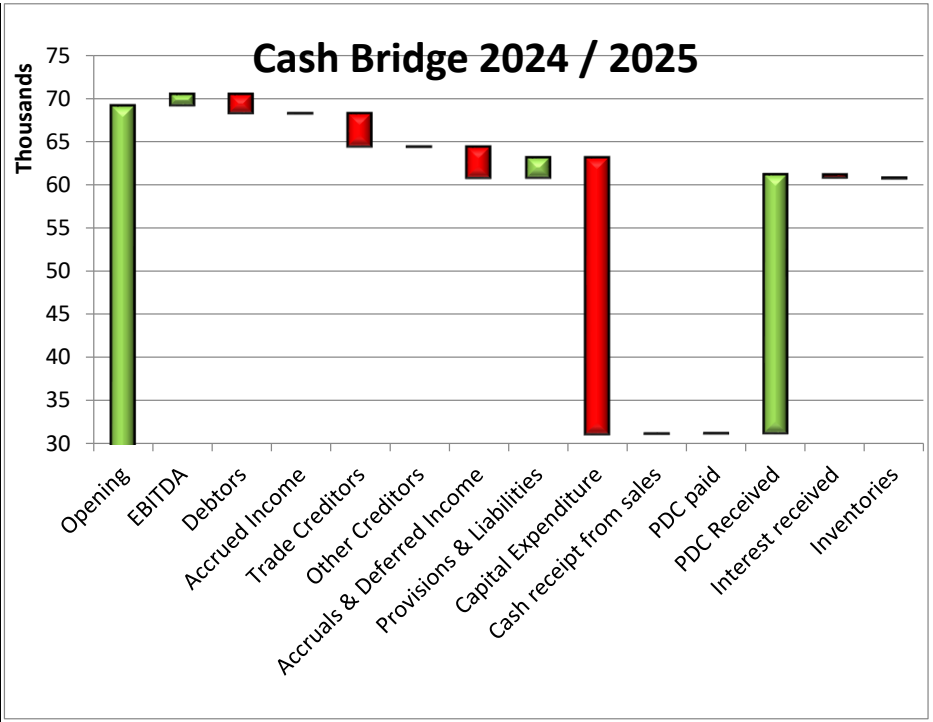

The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £84.3m
The lowest balance is: £55m

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) | 12,114 | 13,438 | 1,324 | |
| ***Movement in working capital:*** | | | | |
| Inventories & Work in Progress | 52 | (22) | (74) | |
| Receivables (Debtors) | 480 | (1,733) | (2,213) | |
| Trade Payables (Creditors) | (3,000) | (6,888) | (3,888) | |
| Accruals & Deferred income | 0 | (3,615) | (3,615) | |
| Provisions & Liabilities | (1,230) | 1,141 | 2,371 | |
| ***Movement in LT Receivables:*** | | | | |
| Capital expenditure & capital creditors | (8,052) | (40,077) | (32,025) | |
| Cash receipts from asset sales | 0 | 24 | 24 | |
| Leases | (8,865) | (8,001) | 864 | |
| PDC Dividends paid | (1,074) | (1,050) | 24 | |
| PDC Dividends received | 0 | 30,000 | 30,000 | |
| Interest (paid)/ received | 3,851 | 3,470 | (381) | |
| **Closing Balances** | **65,629** | **55,886** | **(9,743)** | |




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.

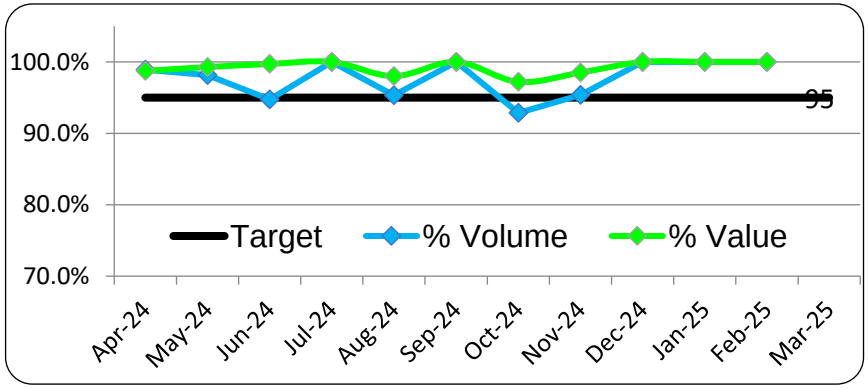
# 5.0 Better Payment Practice Code

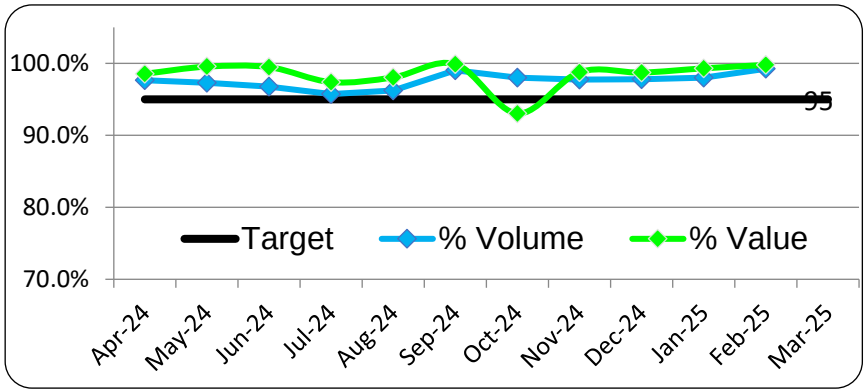
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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 | 99% | 100% |
| Cumulative Year to Date | 98% | 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 (£) |
|---|---|---|---|---|---|
| 17-Feb-25 | Purchase of Healthcare | AS Collaborative | Nottinghamshire Healthcare Nhs Trust | 1000058823 | 769,054 |
| 24-Feb-25 | Purchase of Healthcare | AS Collaborative | Leeds & York Partnership Nhs Foundation Trust | 1003732 | 697,584 |
| 11-Feb-25 | Purchase of Healthcare | AS Collaborative | Bradford District Care Nhs Foundation Trust | 205364 | 644,853 |
| 24-Feb-25 | Purchase of Healthcare | AS Collaborative | Cygnet Health Care Ltd | CYGWYS55 | 450,000 |
| 03-Feb-25 | Purchase of Healthcare | AS Collaborative | Partnerships In Care Ltd | D510009800 | 382,992 |
| 20-Feb-25 | Purchase of Healthcare | AS Collaborative | Sheffield Health & Social Care Nhs Foundation Tru | 0000001371 | 323,972 |
| 17-Feb-25 | Purchase of Healthcare | Kirklees | Kirklees Council | 8609332087 | 262,500 |
| 05-Feb-25 | Purchase of Healthcare | AS Collaborative | Rotherham Doncaster & South Humber Nhs Found | 4400002575 | 241,311 |
| 20-Feb-25 | Purchase of Healthcare | AS Collaborative | Cygnet Health Care Ltd | CYGSYS32 | 240,000 |
| 07-Feb-25 | Purchase of Healthcare | AS Collaborative | Waterloo Manor Ltd | HO NHS LS 294 | 197,983 |
| 26-Feb-25 | NHS Recharge | Wakefield | Mid Yorkshire Hospitals Nhs Trust | 1600034629 | 192,575 |
| 03-Feb-25 | Purchase of Healthcare | AS Collaborative | Partnerships In Care Ltd | D510009796 | 186,749 |
| 26-Feb-25 | Building Contract | Trustwide | Kingsway Group | 115673 | 125,995 |
| 12-Feb-25 | Utilities | Trustwide | Edf Energy Customers Ltd | 000022216629 | 125,038 |
| 10-Feb-25 | Purchase of Healthcare | AS Collaborative | Cygnet Health Care Ltd | WYS053SN | 112,182 |
| 15-Feb-25 | NHS Recharge | Calderdale | Calderdale & Huddersfield Nhs Foundation Trust | 4710180958 | 86,650 |
| 25-Feb-25 | Purchase of Healthcare | AS Collaborative | Elysium Healthcare Ltd | 34020983 | 84,773 |
| 26-Feb-25 | Purchase of Healthcare | AS Collaborative | Elysium Healthcare Ltd | 34020983 | 84,773 |
| 26-Feb-25 | Mobile Phones | Trustwide | Vodafone Ltd | 107537271 | 74,011 |
| 21-Feb-25 | Utilities | Trustwide | Totalenergies Gas & Power Ltd | 36875634925 | 72,779 |
| 25-Feb-25 | Drugs | Trustwide | Bradford Teaching Hospitals Nhs Foundation Trus | 328891 | 67,925 |
| 12-Feb-25 | Utilities | Trustwide | Edf Energy Customers Ltd | 000022155452 | 66,324 |
| 10-Feb-25 | Utilities | Trustwide | Edf Energy Customers Ltd | 000021791697 | 64,627 |
| 21-Feb-25 | Utilities | Trustwide | Totalenergies Gas & Power Ltd | 36875750425 | 58,646 |
| 20-Feb-25 | Healthcare Promotion | Sheffield | Edenred Uk Group Ltd | PR2432159 | 58,146 |
| 25-Feb-25 | Utilities | Trustwide | Totalenergies Gas & Power Ltd | 32384046723 | 57,956 |
| 25-Feb-25 | Purchase of Healthcare | AS Collaborative | Elysium Healthcare Ltd | 34023485 | 56,000 |
| 05-Feb-25 | Computer Software | Trustwide | Mri Software Emea Ltd | MRIUK1035350 | 55,498 |
| 13-Feb-25 | NHS Recharge | Trustwide | Sheffield Health & Social Care Nhs Foundation Tru | 0000001344 | 54,315 |
| 05-Feb-25 | NHS Recharge | Trustwide | Sheffield Health & Social Care Nhs Foundation Tru | 0000001274 | 53,971 |

| Invoice Date | Expense Type | Expense Area | Supplier | Transaction Number | Amount (£) |
|---|---|---|---|---|---|
| 05-Feb-25 | Drugs | Trustwide | NHS Business Services Authority | 1000082884 | 52,495 |
| 20-Feb-25 | Purchase of Healthcare | AS Collaborative | Sheffield Health & Social Care NHS Foundation Tr | 0000001372 | 47,221 |
| 19-Feb-25 | Continence Products | Barnsley | Supply Chain Coordination Limited | 245748 | 46,973 |
| 10-Feb-25 | Continence Products | Barnsley | Supply Chain Coordination Limited | 241748 | 45,524 |
| 19-Feb-25 | Continence Products | Barnsley | Supply Chain Coordination Limited | 244748 | 43,835 |
| 03-Feb-25 | Data Lines | Trustwide | Virgin Media Business Ltd | 927686152 | 42,929 |
| 14-Feb-25 | Drugs | Trustwide | Speeds Healthcare Ltd | INV154552 | 42,106 |
| 05-Feb-25 | Purchase of Healthcare | AS Collaborative | Partnerships In Care Ltd | D190001306EPC | 38,763 |
| 28-Feb-25 | MFDs | Trustwide | Annodata Ltd | 1392408 | 36,823 |
| 06-Feb-25 | Purchase of Healthcare | AS Collaborative | Elysium Healthcare Ltd | CHA04658 | 32,833 |
| 11-Feb-25 | Purchase of Healthcare | Trustwide | Cygnet Health Care Ltd | COV0390028 | 30,721 |
| 11-Feb-25 | Purchase of Healthcare | Trustwide | Cygnet Nw Ltd | BUR0390455 | 30,721 |
| 19-Feb-25 | Purchase of Healthcare | AS Collaborative | Unique Nursing Services Ltd | 026082 | 28,988 |
| 11-Feb-25 | Purchase of Healthcare | Trustwide | Cygnet Health Care Ltd | COV0391311 | 28,739 |
| 05-Feb-25 | NHS Recharge | Trustwide | Sheffield Health & Social Care NHS Foundation Tr | 0000001274 | 27,928 |
| 11-Feb-25 | Staff Recharge | Calderdale | Calderdale Metropolitan Borough Council | IN24188175 | 27,854 |
| 13-Feb-25 | NHS Recharge | Trustwide | Sheffield Health & Social Care NHS Foundation Tr | 0000001344 | 27,568 |
| 25-Feb-25 | Drugs | Trustwide | Bradford Teaching Hospitals NHS Foundation Trus | 328891 | 27,170 |
| 03-Feb-25 | Purchase of Healthcare | AS Collaborative | Unique Nursing Services Ltd | 025916 | 26,846 |
| 13-Feb-25 | Purchase of Healthcare | AS Collaborative | Unique Nursing Services Ltd | 026036 | 26,846 |
| 23-Feb-25 | Purchase of Healthcare | AS Collaborative | Unique Nursing Services Ltd | 026119 | 26,687 |
| 10-Feb-25 | Continence Products | Trustwide | Supply Chain Coordination Limited | 243748 | 26,678 |
| 06-Feb-25 | Computer Software | Trustwide | Daisy Corporate Services Trading Ltd | 13621326 | 26,079 |
| 27-Feb-25 | Purchase of Healthcare | AS Collaborative | Elysium Healthcare Ltd | THO05575 | 25,636 |
| 07-Feb-25 | Purchase of Healthcare | AS Collaborative | Mersey Care NHS Foundation Trust | 72488944 | 25,627 |
| 24-Feb-25 | Lease Car | Trustwide | Athlon Mobility Services Uk Ltd | 202580000134 | 25,426 |
| 26-Feb-25 | Building Contract | Trustwide | Kingsway Group | 115673 | 25,199 |

## 5.2 Glossary

* Recurrent - an action or decision that has a continuing financial effect.

* Non-Recurrent - an action or decision that has a one off or time limited effect.

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year.

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a post / new investment were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year.

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year.

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions). This is set in advance of the year and before all variables are known.

* Value for Money / Cost Savings - The Trust priority of Value For Money is intrinsically linked to the ability to maintain financial sustainability. In addition to value for money this are also called savings, efficiencies, and Cost Improvement Programmes (CIP). In each case this is the identification of schemes to increase efficiency, reduce expenditure or increase income.

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

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

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

# Appendix 3 - Statistical Process Control (SPC) Charts Explained

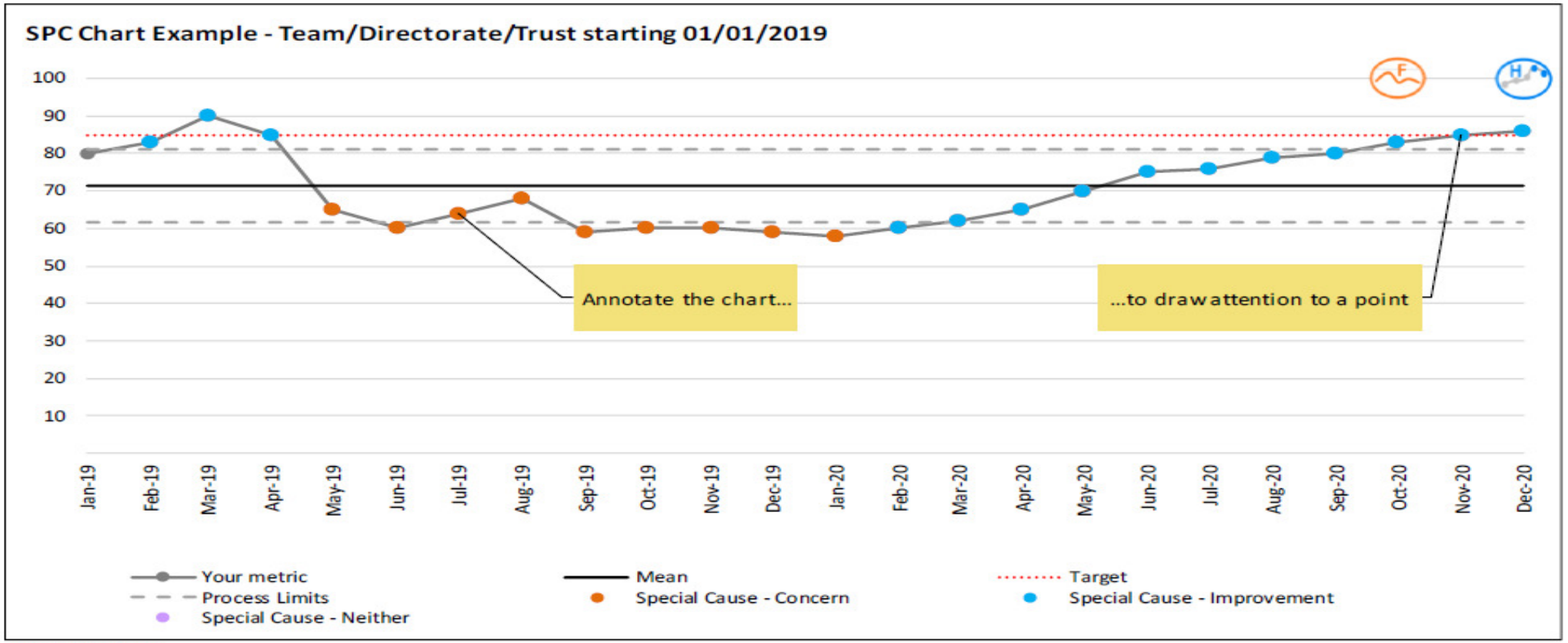
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

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

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

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

# Appendix 3 - Statistical Process Control (SPC) Charts Explained




**Observations**

Based on the data from latest calculation date (data point 1 - 01/01/19).

| | |
|---|---|
| Single Point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There are 6 points above the UCL and 7 points below the LCL. |
| Trend | When there is a run of 6 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control. |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. |