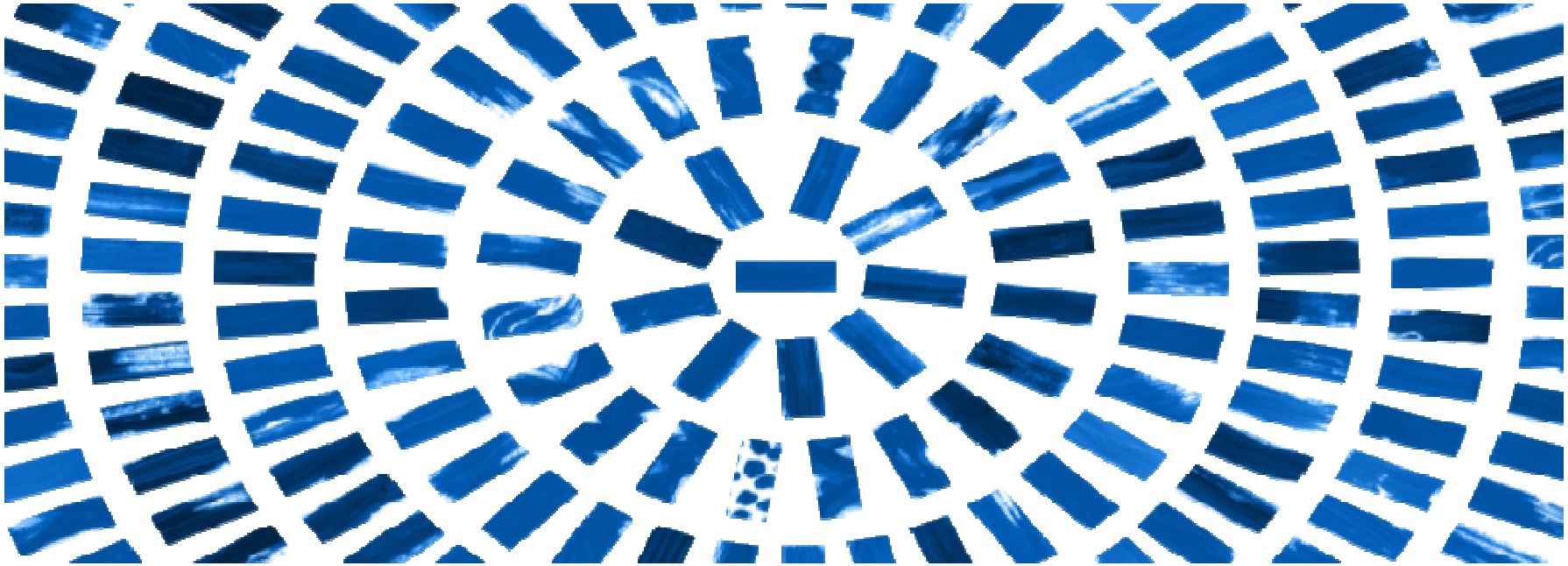
NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview



March 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 March 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, we anticipate this will be completed in time for the April 2025 report. In the interim, we will continue to report against the previous Trust four strategic objectives against which our performance metrics are designed to measure progress. These are:

- Improving health
- Improving care
- Improving resources
- Making SWYPFT a great place to work

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:

- Executive summary
- Strategic Objectives & Priorities
- Quality
- People
- National metrics
- Care groups including ward level detail
- Finance
- Systemwide monitoring

The national metrics section includes metrics contained within the NHS England oversight framework, operational planning guidance and NHS standard contract for 2024/25. The Trust is also keen to include performance data related to the West Yorkshire and South Yorkshire Integrated Care Systems (ICSs) – this is an iterative process as work is underway within the ICSs to determine how performance against their key objectives will be assessed and reported. On 1st October 2024 the Trust acquired Cheswold Park Hospital, which is a 112-bed low and medium secure mental health hospital based in Doncaster, providing services to male and female patients with a diagnosis of mental illness, personality disorder or neurodevelopmental disorders. Cheswold Park provides services to patients from South Yorkshire Adult Secure Provider Collaborative and placements for patients who may be from out of the area and need the specific treatment pathways the hospital provides. Data will be reported at the end of the Trust's Integrated Performance Report for Cheswold Park Hospital until all systems have migrated fully into the Trust and reporting systems have been amalgamated, expected to be 1st April 2025. Our Integrated Performance Strategic Overview Report is publicly available on the internet.

Headlines

This section of the report identifies metrics where there has been a change in performance or where expected levels are not being achieved. A hyperlink has been added to each section so the reader can look at the detail relating to the metrics in that section in the main body of the report as required.

Strategic Objectives & Priorities

Metric	Change from last month	Variation/ Assurance
Improving Resources		
Surplus/(deficit) against plan (monthly)	↑	
Capital spend against plan (Cumulative)	↑	

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

Metric	Change from last month	Variation/ Assurance
Making SWYPFT a great place to work		
Registered workforce growth	↑	
Appraisals - rolling 12 months	↑	
Mandatory training - Information governance (IG)	↓	
Sickness absence - YTD	↑	
Mandatory training - Cardiopulmonary resuscitation	↓	
Sickness Mandatory training - Reducing restrictive practice interventions (RRPI) - YTD	↓	

Metric	Change from last month	Variation/ Assurance
Quality		
Complaints - Number of responses provided within six months of the date a complaint	↑	
Friends and Family Test - Community	↓	

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

Metric	Change from last month	Variation/ Assurance
National metrics		
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4	↓	
Total number of Children and Younger People under 18 in adult inpatient wards	↓	
Total bed days of Children and Younger People under 18 in adult inpatient wards	↓	

Care Groups

Children and Families

Metric	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
Reducing restrictive physical interventions training compliance	↓	
Cardiopulmonary resuscitation (CPR) training compliance	↓	
Information Governance training compliance	↓	
% of feedback with staff values and behaviours as an issue	↓	

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
Information Governance training compliance	↓	
Cardiopulmonary resuscitation (CPR) training compliance	↓	
Reducing restrictive physical interventions training compliance	↓	
% of feedback with staff values and behaviours as an issue	↑	

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% of clients clinically ready for discharge	↓	
Sickness rate (monthly)	↑	
% Bed occupancy	↑	
Information Governance training compliance	↔	
% of feedback with staff values and behaviours as an issue	↓	

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% of clients clinically ready for discharge	↓	
Information Governance training compliance	↓	
Sickness rate (Monthly)	↑	
% of staff receiving supervision within policy guidance	↓	

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
Information Governance (IG) training compliance	↑	
Sickness rate (Monthly)	↑	
% of staff receiving supervision within policy guidance	↓	
% of feedback with staff values and behaviours as an issue	↓	

Forensic

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

Key

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

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

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

Strategic Objectives 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

• 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 52.0%, sexual orientation 57.0% and postcode at 99.5%. 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 51 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 March is provisional but is showing an improvement on the February position with 94.1% of inpatients having a risk assessment/staying safe plan in place within 24 hours of admission and 75.5% 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 24 violence and aggression incidents against staff on mental health wards involving race during March which is an increase on the previous month. We are very mindful of the personal impact this has on our colleagues. We provide support to those affected and we are 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 33% more people waiting for initial assessment at the end of March 2025 (2906) compared to March 2024 (2191). 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 March 94% against a target of 90% was achieved. This has shown a sustained 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 March has increased to 8.6%. This is still a lower level than we have seen in previous years. The increase in month relates to the end of contract for the Barnsley Liaison and Diversion service and a number of fixed term contracts coming to an end at the end of March.

• An overall low turnover rate for the Trust 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 March 2025, our workforce growth rate has continued to slow compared to earlier months and was at 2.3% (staff in post) year to date. This exceeds our annual budgeted growth rate of 0% and has resulted in financial pressures. The work taking place to review establishments may see an initial increase in growth but a reduction in agency and bank.

• Over the year, we have had 458 new starters and 432 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 have seen a downward trend in the number of new starters which could suggest the additional controls put in place are taking effect.

• Our year-to-date sickness decreased slightly to 5.2% with March sickness decreasing to 4.6%. There was a decrease in the number of cold and flu related absences during the month. The majority of absences are short term 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 positive increase 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 83.7% being achieved in March against a trajectory of 84.9%. Work is ongoing 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 March at 85.0%. 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. There are however issues in the following areas -

  • Reducing Restrictive Physical Interventions (RRPI) training stands at 79.6% which has dropped below 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 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.

  • Cardiopulmonary resuscitation (CPR) training has dropped below threshold at 79.7% in March. 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).

Local Quality Indicators

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

95% of incidents reported in March 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 184 to 177 reported in March. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remains within expected range – all incidents are reviewed, and learning is shared.

• The number of prone restraints decreased during the month to six. All instances 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 psychiatric intensive care units, Walton, relating to three service users that required seclusion and or administration of intramuscular medication and prone restraint was used. Reducing restrictive practice intervention training 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 11 information governance personal data breaches during March. The highest reported category continues to be 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 March 2025 decreased slightly to 44. 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 Trustwide 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 two complaints out of sixteen not receiving a response within six months (88%). 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:

• Work to maintain effective patient flow continues and use of out of area bed days remains lower than previous years, usage in March was 128 days (typically five people). The need for these beds mainly relates to the requirement for gender specific psychiatric intensive care (not commissioned locally). 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.

• 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 six weeks to a diagnostic appointment target, 117 out of 143 children (81.8%) received a diagnostic appointment within six weeks against a national threshold of 99% in March. 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 March, 75.9% 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 775 days in Kirklees and 349 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 March is 30 cases, the number of referrals received in March was 392. As demand is significant the care remains with the referrer until accepted by the service. This leads to lengthy waits.

• Mental health acute wards have continued to manage high levels of acuity, 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. Use of temporary staffing is being closely monitored by senior managers. Throughout March 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.

• Demand into the Single Point of Access (SPA) and capacity issues in Calderdale and Kirklees have continued and this continues to create pressures in the service, workforce challenges are continuing to compound these problems. During March, the Wakefield SPA have also been experiencing specific challenges including unprecedented absences and this has affected the overall achievement of the 75% target for referral to assessment within 2 weeks (external referrals),this is only the second month this year the Trust has not achieved the 75% standard. 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.

• 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, adult and older peoples wards and PICU. A review of clinically ready for discharge for Forensic services is also taking place. Further detail can be seen in the care group section of the report.

Finance

• The Trust financial target for 2024 / 25 is breakeven. This has been achieved with a small unaudited surplus of £245k.
• Agency expenditure run rate has continued to fluctuate but throughout the year has remained lower than the national target (3.2% of total pay expenditure). Spend in March 2025 is £422k which is £77k lower than February. Overall Quarter 4 expenditure is £200k less than Quarter 3. Sustained run rate reductions are required for 2025 / 26 in order to meet internal and external targets.
• The Trust financial sustainability programme for 2024 / 25 has a target of £22.0m to achieve the breakeven target. Overall £20.6m has been achieved which is £1.4m behind plan (6.4%). Throughout the year the main driver is within the workforce optimisation scheme with more worked whole time equivalents (WTE) than planned. This has been partially mitigated in the final position through non-recurrent mitigations.
• Cash has continued to reduce month on month throughout 2024 / 25. This has stabilised in Quarter 4 and despite the payment of Public Dividend Capital (PDC) of £2.2m in March has maintained at a similar level. It is expected to reduce further in April / May 2025 as outstanding invoices are paid although this will be partially offset by recovery of accrued income.
• The Trust has received a number of capital allocations within the year and a breakdown is provided within the capital detail page in the Finance appendix. Against the original core allocation (£8.1m) expenditure is £7.5m which is £0.6m less than planned (7%). This has been offset by additional expenditure within the IFRS 16 (leases) allocation. For 2025 / 26 this will be a singular allocation covering all capital expenditure.

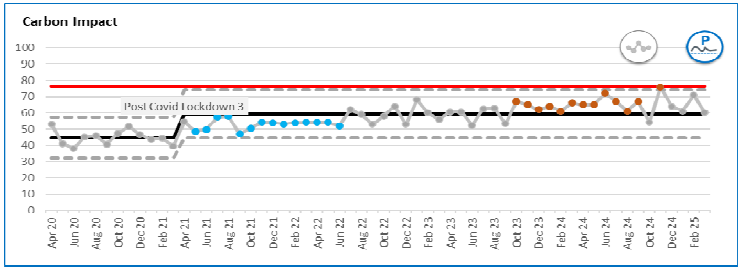
Cheswold Park Hospital

• 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 increased to 82% in March and is now above the 80% Trust threshold (80%).
• Mandatory training levels for cardiopulmonary resuscitation, reducing restrictive physical interventions, fire safety all remain well above the 80% threshold. Information governance training has dropped below the 95% threshold, reporting 94% in March – targeted action in place to ensure this is brought back up above threshold.
• There were 128 incidents reported during the month; two of those resulted in moderate harm. The common cause of these incidents related to medication, self-harm, safer staffing, security breaches, legislation and policy and violence and aggression.
Continued support for Cheswold Park is ongoing as part of the transition and improvement plan.

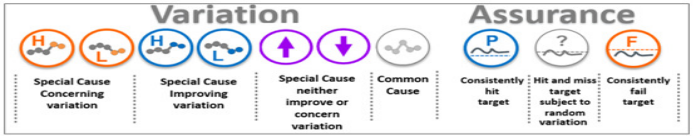
Improving health

Metrics	Threshold	Jan-25	Feb-25	Mar-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	226 - All staff (17.5%) 89 - excl medics (8.1%)	226 - All staff (17.4%) 91 - excl medics (8.3%)	228 - All staff (17.4%) 92 - excl medics (8.3%)		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%	96.6%	96.4%		
Percentage of service users who have had their equality data recorded - disability	50%	54.2%	53.3%	52.0%		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		59.0%	58.3%	57.0%		
Percentage of service users who have had their equality data recorded - deprivation (postcode)	90%	99.5%	99.5%	99.5%		
Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure)	Service timely completion - 75% Policy - 95%	93.1% Service 100% Policy	95.6% Service 99.5% Policy	94.9% Service 100% Policy		
Completion of equality mandatory training	>=80%	96.3%	96.3%	93.3%		
Number of job start/work retention outcomes during month by individual placement and support service	Trend monitor	12	15	13		A single client could have multiple job starts
Number of new people accessing Individual placement and support service during month	Trend monitor	66	46	51		First contact and work started on vocational profile. Average number of new people per month for the period Apr '24 - Mar '25 is 47, total number for the year is 567.
Carbon Impact (tonnes CO2e) - business miles	76	61	71	60		Data showing the carbon impact of staff travel / business miles. We have seen an overall increase in business miles across the Trust since October. On review of the data, this appears to be linked to staff supporting the introduction of services at Cheswold Park Hospital in Doncaster but also across community based services such as Barnsley Neighbourhood teams where we have seen a continued increase in demand for supporting people in their own home. 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 March 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.



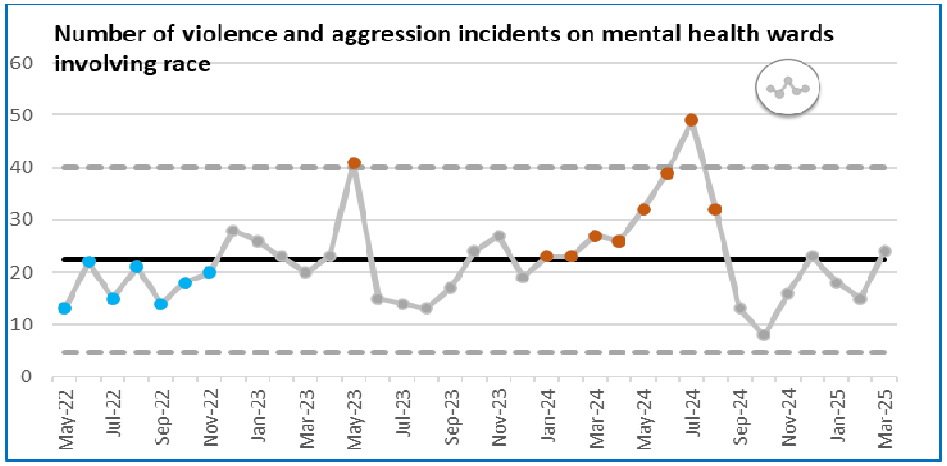
Improve Care

Metrics	Threshold	Jan-25	Feb-25	Mar-25	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% Improvement trajectory for Community - Jul/Aug 80% Sept 82.5% Oct 85% Nov 87.5% Dec 90% Jan 92.5% Feb 95%	87.3%	92.3%	*94.1%*		Within inpatient services, all service users have a risk assessment with 128 service users having had a risk assessment within 24 hours, a further 8 service users had a completed risk assessment - with 2 of those being between 10-15 hours over the 24-hour standard and 6 of those being 15 hours or more over the 24 hour standard). For community services 27 out of 143 people are showing to not have a risk assessment – all service users without a risk assessment are followed up individually in the care group to maintain patient safety.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		67.1%	76.3%	*75.5%*		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. Additional training support has been put in place for teams to assist with the transition. Data for March is provisional and will be refreshed in next months report.
% Service users on care programme approach with a plan of care developed collaboratively	85%	99.7%	99.7%	99.6%		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	1,134	1,138	1,143		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	164	165	166		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	18	15	24		Over the last three months, 57 incidents against staff on mental health wards involving race were reported, 14 of the 57 incidents were physical assaults with the remainder being verbal racial abuse. 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)	Jan - 155 Feb - 140 Mar - 155	106	92	128		National target is zero inappropriate out of area bed days. Local target as per operational plan (5 service users per month). Whilst we remain above the national threshold we have seen a notable improvement in the number of out of area bed days in the last 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%	5.2%	5.2%	6.0%		Performance in month has deteriorated. 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	Jan-25	Feb-25	Mar-25	Variation/ Assurance	Notes
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	328	312	349		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	737	888	775		
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	94% 51/54	94% 49/52		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%	92.4%	89.7%	83.8%		
Community health services two hour urgent response standard	70%	90.7%	90.2%	92.6%		
Referral to assessment within 2 weeks (external referrals)	75%	74.2%	85.1%	72.4%		Single Point of access (SPA) continue to prioritise risk screening of all referrals to ensure any urgent demand is met within 24 hours. The access standard for assessed within 14 days of referral has been met in Barnsley. There have been challenges with further admin vacancies in Calderdale & Kirklees SPA impacting on performance. Wakefield is also under threshold in March due to specific challenges including unprecedented absences in Wakefield primary care mental health provision impacting on referrals to SPA.

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 March 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	Jan-25	Feb-25	Mar-25	Variation/ Assurance	Notes
Surplus/(deficit) against plan (Cumulative)	Breakeven	(£1,898k)	(£567k)	£245k		The Trust financial target for 2024/25, of breakeven or better, has been achieved with an unaudited surplus of £245k.
Capital spend against plan (Cumulative)	£8.1m	£2,988k	£4,132k	£7,520k		The Trust capital allocation for 2024 / 25 is made up of a number of specific allocations. The target (£8.1m) was for the core Trust capital schemes. Against this £7.5m has been spent (93%). The underspend in this category has been utilised to support additional lease capital costs in year. For 2025 / 26 this will become a single allocation.
Agency spend managed within the overall workforce (Monthly)	3.5% £6.7m	£684k	£499k	£422k		There was sustained reduction in agency spend in 2023/24. Agency spend has continued to fluctuate during 2024/25 around an average run rate level. Spend is £77k less than the previous month.
Financial sustainability and efficiencies delivered over time (monthly)	£22m	£1,230k	£1,626k	£4,046k		The Trust financial sustainability programme for 2024/25 has a target of £22.0m. Additional mitigations have been realised in March 2025 as part of supporting the overall financial position. This was in line with previous Trust forecast scenario modelling.
Total pay costs	£24,022k (average pay Q4)	£24,310k	£23,894k	£23,700k		Pay expenditure, excluding notional pension contributions of £16.8m which are transacted but offset by an equal funding stream, are lower than the previous month.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	10				Six of the ten incidents related to violence and aggression on wards against staff. Four of those incidents related to Horizon and three of those related to the same service user with complex needs. In each of these cases, staff have been supported through their recuperation and follow ups made with occupational health and welcome back meetings with the department managers. There is ongoing work reviewing violence and aggression incidents which result in injuries to staff, to ensure we have as much assurance as possible that risk assessments and controls are up to date, communicated and implemented in departments.
Estates Urgent Response Times - Service level agreement (SLA)	95%	96.8%	95.8%	96.7%		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, Loler 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	Jan-25	Feb-25	Mar-25	Variation/ Assurance	Notes
Turnover external (rolling 12 months)	>12% - 13%<	7.8%	7.7%	8.6%		There has been an increase in month and this is attributed to a number of fixed term contracts which have come to an end and the contract ending for the Barnsley Liaison & Diversion service. Overall, turnover levels continue to remain at a lower level than previous years and 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	2.3%				This measures the difference between the number of full time equivalent staff at end of March 2024 compared to the number of full time equivalent staff at end of the reporting period. This growth includes funded investment priorities (i.e. Barnsley neighbourhood teams service).
Sickness absence - YTD	<=5%	5.3%	5.3%	5.2%		Further detail around sickness absence is provided in the relevant section of this report. In month sickness was 4.6%.
Appraisals - rolling 12 months	Projected Compliance: Jan - 78.3% Feb - 82.3% Mar - 84.9% Apr - 86.9% May - 88.7% Jun - 90.1%	82.5%	82.6%	83.7%		Due to technical issues with the external system supplier, the Trust was not able to access the appraisal system (WorkPal) from mid December 2024. 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%	84.7%	85.7%	85.0%		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%	80.9%	81.3%	79.7%		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%	81.5%	80.1%	79.6%		The learning and development team and RRPI team, are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training which has seen a positive impact over recent months. Rostering is used to ensure that wards have access to appropriately trained staff. Wards with high acuity and lower training levels are prioritised for training places.
Mandatory training - Fire	85%	90.6%	90.9%	88.9%		
Mandatory training - Information governance (IG)	95%	93.5%	93.1%	91.1%		Focussed monitoring is taking place for this area of training.

Quality Headlines

Section	KPI	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	TBC	83.4%	82.9%	78.2%	76.4%	76.4%	75.9%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	< 20%	16% (5/31)	24% (7/29)	19% (3/16)	14% (4/29)	19% (5/27)	20% (4/20)	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	93.8	
	Complaints - Number of responses provided within six months of the date a complaint received [16]	100%	71% (17/24)	100% (12/12)	88% (7/8)	92% (11/12)	84% (16/19)	88% (14/16)	
Service User Experience	Friends and Family Test - Mental Health	84%	94%	92%	92%	90%	92%	91%	1
	Friends and Family Test - Community	95%	96%	97%	96%	97%	97%	93%	1
Quality	Number of compliments received	N/A	66	27	27	65	30	46	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	8	7	5	10	8	11	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	1	0	1	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	0	0	0	0	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	96.2%	99.8%	99.7%	99.7%	99.7%	99.6%	1
	Number of Information Governance breaches [3]	<12	8	11	9	6	12	11	2
	% of inpatients clinically ready for discharge	3.5%	4.3%	4.4%	3.7%	5.2%	5.2%	6.0%	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%*	92.6%	93.8%	94.9%	87.3%	92.3%	*94.1%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		80.7%	77.6%	74.2%	67.1%	76.3%	*75.4%*	2
	Total number of reported incidents	Trend monitor	1260	1285	1300	1396	1155	1236	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	31	23	27	35	33	27	
	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	0	0	2	2	6	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	0	2	0	2	1	2	
	Safer staff fill rates	90%	131.2%	134.0%	128.8%	128.3%	132.8%	128.7%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	100.0%	104.0%	101.9%	100.5%	103.0%	101.1%	1
	Number of pressure ulcers which developed under SWYPFT care [1]	Trend monitor	31	20	47	49	36	31	
	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)	100% (9/9)	100% (10/10)	100% (5/5)	100% (13/13)	100% (6/6)	1
	Number of Falls (inpatients)	Trend monitor	50	32	37	43	49	44	
	Number of restraint incidents	Trend monitor	187	235	189	196	184	177	
	% of staff receiving supervision within policy guidance [15]	80%	84.4%	86.9%	84.4%	84.7%	85.7%	85.0%	2
	Potential under-reporting of patient safety incidents								
	% people dying in a place of their choosing [14]	80%	86.5%	97.3%	95.0%	86.2%	93.5%	96.2%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	1
	C Diff avoidable cases	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	0	0	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. This relates to complaints recieved during the month and until investigation process is complete, this may result in not all of those being upheld.
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 March.

• The overall number of restraint incidents in March was 177 which is a reduction on the previous month but remains within normal range. 36 of these incidents were attributed to Horizon centre and 17 to Elmdale 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 four in March. 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 six 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 16 complaints responded to during the month, 14 were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 93.8 days. Before the response is sent back to complainant, sign off is required which includes formulation of a written response and review by the customer services office manager, following a review by the Care Group trio (general manager, clinical lead and quality and governance lead), the director of service, an executive director and final sign off from the Chief Executive. Complaints vary in complexity and this is sometimes reflected in the amount of time taken to investigate and to move through the sign off process.

• Clinically ready for discharge (previously delayed transfers of care) - This has increased to 6.0% 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 44 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 date of the 1st December 2023 and an initial review is currently underway.

Safety Incident Response Accreditation Network (SIRAN)

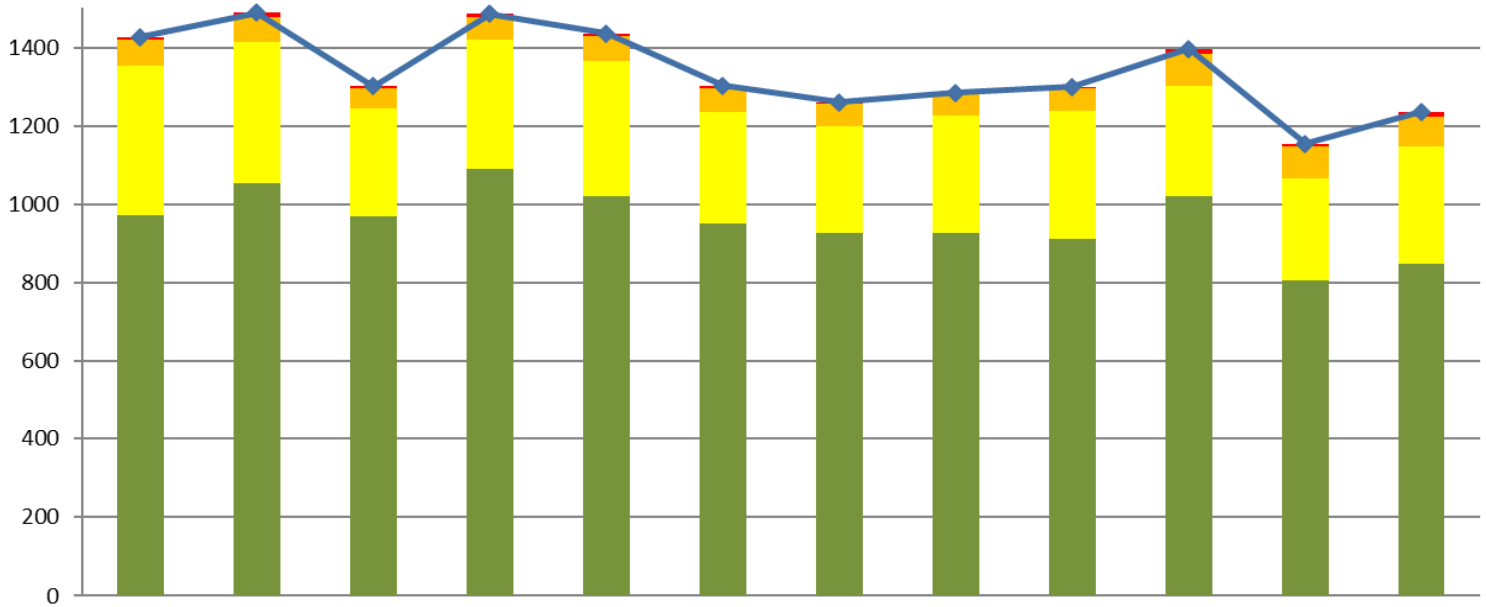
The team have received the draft report and are responding to comments.

Safety First

Summary of Incidents

Although we have reported 14 red incidents in March, incidents may be subject to regrading as more information becomes available so this figure is subject to change.

95% of incidents reported in March 2025 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in March 2025



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Red (should not be compared with SIs)	6	11	6	8	5	6	4	5	5	11	6	14
Amber	66	62	50	57	65	61	57	54	57	83	82	74
Yellow	383	362	275	331	344	285	271	300	326	280	260	299
Green	971	1053	970	1089	1021	951	928	926	912	1022	807	849
Total	1426	1488	1301	1485	1435	1303	1260	1285	1300	1396	1155	1236

Safety First cont…

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

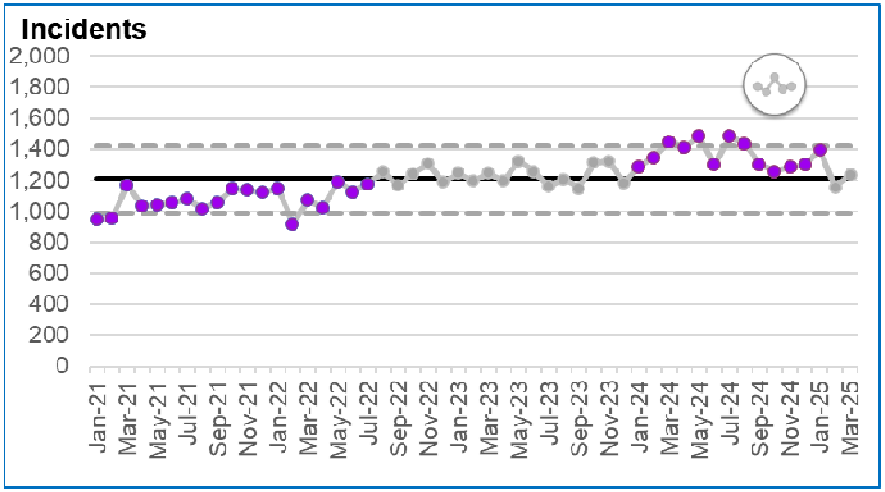
Breakdown of incidents in March 2025

37 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.

6 severe harm incidents:
The most common theme of these incidents related to self harm, with some also relating to pressure ulcers.

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

Incidents



We have entered a period of common cause variation in March 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 Trustwide 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.

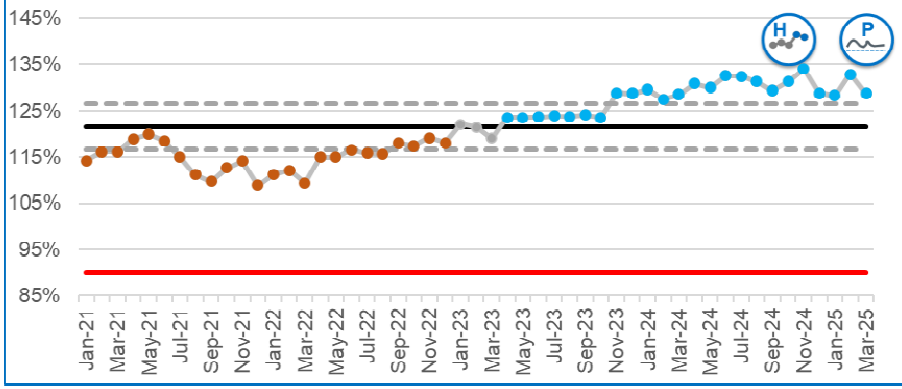
Patient Safety Alerts

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

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2025/001/DHSC	Discontinuation of Promixin® (colistimethate) 1-million unit powder for nebuliser solution unit dose vials	17/03/2025	No - alert not applicable to trust	30/04/2025	17/03/2025

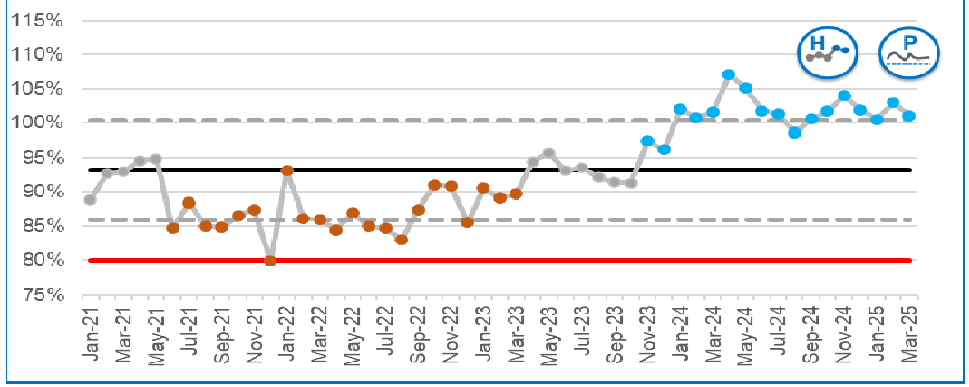
Safer Staffing Inpatients

Safer Staffing Fill Rate



The chart above shows that as at March 2025 due to the continued increasing staffing fill rate, we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are expected to meet the target.

Safer Staffing Registered Nurses



The chart above shows that in March 2025, due to the continued increase in the registered nurses fill rate, we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are expected to meet the target.

- There was a marked increase in March of 8.7% in overall demand.
- Within the flexible staffing pool there were a total of 512 more shift requests, however the overall fill rate decreased by 1.71% to 90.93%.
- Within overall fill rates there was a decrease in the fill rates of 3% for Forensic and Learning Disability care group to 123%, Adult and Older Peoples Care Group by 4% to 135% and Barnsley Integrated Services 6% to 105%.
- We continue to scrutinise flexible staffing usage in our temporary staffing scrutiny and e-rostering groups.
- We have stopped utilising agency workers except in authorised situations which is in line with our Grip and Control group.
- E-Rostering has launched into Cheswold Park Hospital to ensure they have a transparent system regarding working times, bank and agency usage.
- The overall fill rate had a decrease of 4.1% to 128.7%. The day fill rate for Registered Nurses (RNs) decreased by 1.6% to 100.6%. Three wards (consistent with February) Ward 19 (M) and Ward 19 (F) in the Adult and Older Peoples care group, Priestley within the Forensic and Learning Disability Care Group, fell below the 90% RN day fill rate. They were supported through local escalation plans.
- In March one ward, Ward 19 (F), an increase of one on the previous month, fell below the 90% overall fill rate threshold.

Safer Staffing Inpatients cont…

Registered Nurses Days
There was a decrease of 1.6% in overall registered Day fill rates to 100.6% in March compared with the previous month.

Registered Nurses Nights
There was a decrease of 3.7% in overall registered Night fill rates to 115.6% in March compared with the previous month.

Overall Registered Rate: In March the overall registered fill rate decreased by 1.9% to 101.1%.
Overall Fill Rate: 128.7% (a decrease of 4.1% 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	Jan-25	Feb-25	Mar-25
Adults and Older People	136%	139%	135%
Barnsley Integrated Services	109%	111%	105%
Forensic and LD	118%	126%	123%
Grand total	**128%**	**133%**	**129%**

Registered day rate	Jan-25	Feb-25	Mar-25
Adults and Older People	98%	101%	101%
Barnsley Integrated Services	134%	138%	112%
Forensic and LD	94%	98%	99%
Overall shift fill rate	**99%**	**102%**	**101%**

Registered night rate	Jan-25	Feb-25	Mar-25
Adults and Older People	114%	115%	110%
Barnsley Integrated Services	108%	100%	99%
Forensic and LD	125%	129%	127%
Overall shift fill rate	**118%**	**119%**	**116%**

Bank staff filled 85.72% (an increase of 2.45% on the previous month) of RN requests for flexible staffing and 82.56% (a decrease of 0.55% on the previous month) of HCA requests.
Agency staff filled 3.88% (a decrease of 1.62% on the previous month) of RN requests for flexible staffing and 8.61% (a decrease of 1.68% on the previous month) of HCA requests.

Information Governance (IG)

11 personal data breaches were reported during March 2025, which is one of the higher numbers reported during the current financial year. The monthly average number of breaches for the 2024/25 financial year is 9.4, which is lower than the past three financial years, which were all 11.4.

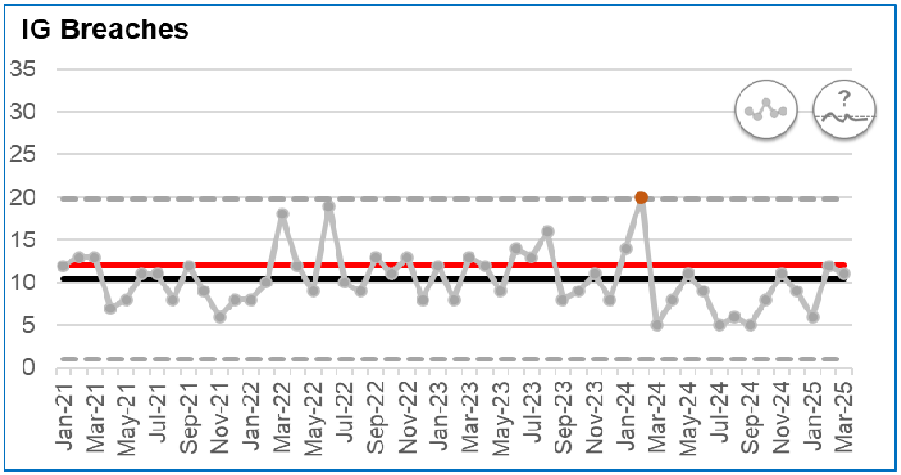
Information disclosed in error continues to be the highest reported category. Breaches during March were due to a number of issues regarding the sending of correspondence, both via mail and email, where information regarding service users was disclosed in error. A record keeping incident was also reported when it was confirmed that the next of kin recorded on a patient record was incorrect.

An amber incident was previously reported as a cabinet containing personal data was disposed of in error: this has since been downgraded as it has been confirmed that the cabinet and its contents have been permanently destroyed, therefore the risk of harm has been eliminated.

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.

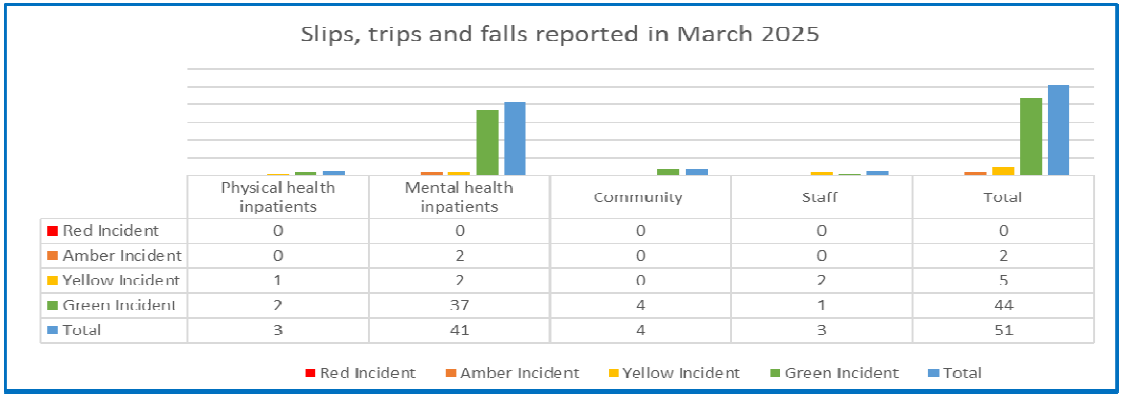
There are currently no open complaints with the Information Commissioner's Office.

This SPC chart shows that as at March 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 March 2025, a total of 51 slips, trips, and falls were reported. 44 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	2	0	0	2
Yellow Incident	1	2	0	2	5
Green Incident	2	37	4	1	44
Total	3	41	4	3	51

• There continues to be high level of physical health reviews, including bloods, urine, ECG, blood pressure, and referrals to specialist services such as SALT, dietetics, physiotherapy and occupational therapy

• Post Falls Protocol completion has averaged 93% this month, with a continued good response from staff

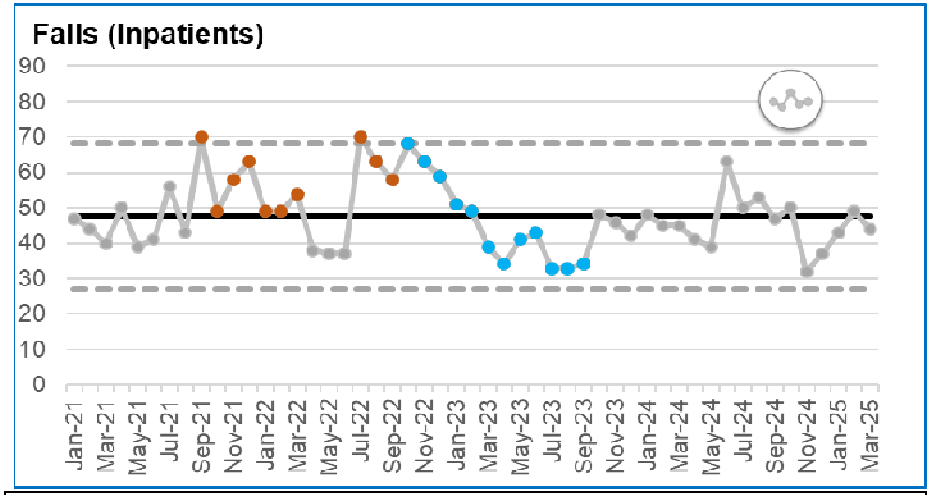
Incident Grading
There were no red incidents.
Amber: Two incidents (4%), one fall for a patient reaching to grab their cardigan causing them to overbalance and fall. They fractured their elbow, and conservative treatment was commenced. One patient had a fall with no fracture, the observation levels were not clear in the patient record, and this is being reviewed as part of the fact find.
Yellow: A total of five (9%) reported safety events needed higher intervention, such as attending A&E, or minor treatment
Green: A total of 44 (87%) reported safety events had low, or no harm recorded. Main themes were rolling/sliding from the bed, missing the chair when sitting down, agitation, dehydration affecting blood pressure, rehabilitation, and illness linked with infection. Three falls (7%) occurred whilst patients were on leave from the ward.

Inpatient falls had a high correlation with:
• 25 falls (57%) were by patients with a recognised history of falls
• 13 falls (30%) were younger people below 65yrs old, linked with agitation, feeling dizzy, history of neglect and drug use, going to attack another patient and fell over, and infection
• 24 falls (55%) were patients above 65 yrs old, of these 17 (71%) of the above older adults had a known diagnosis of dementia, and deconditioning/long-term physical health condition
• 63% of patients had a falls risk screen (FRAT-18) commenced within 24hrs of admission
• One ward appeared to have several FRAT-18 assessments commenced four to five days after admission, this is an anomaly. It has been highlighted to the ward manager and is being monitored.

National Audit of Inpatient Falls (NAIF): One fall (2%) was reviewed due to the change in reporting from 1st Jan 2025, where all fractures or head injuries are audited for risk assessment, intervention, and post falls reviews.
• No lapses in care found. There was some delay in the mobility assessment due to the patient not interacting with staff

Falls (Inpatient)

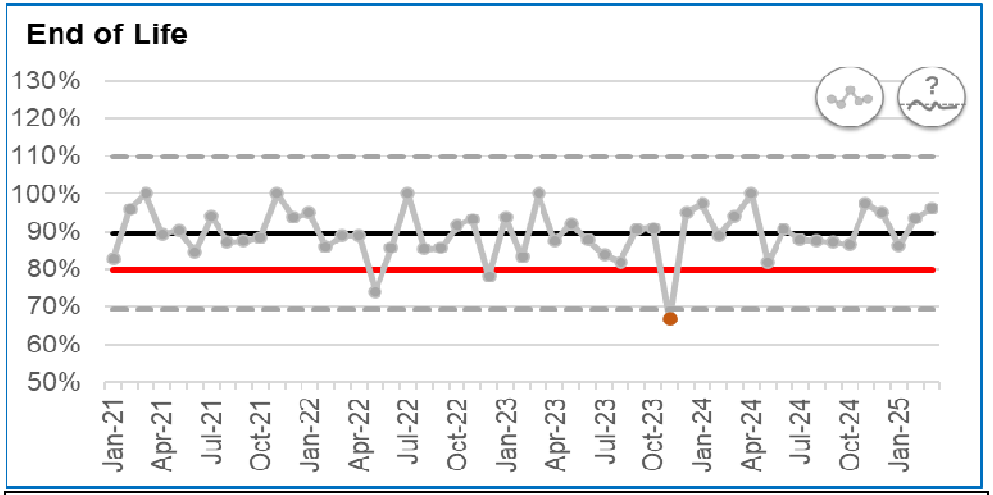
The total number of inpatient falls was 44 in March.



The SPC chart above shows that in March 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 96.2% in March. 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 March 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:

- 93% would recommend physical health services
- 91% would recommend mental health services

	Target	January	February	March
Mental health community	85%	93% (240)	95% (272)	95% (249)
Mental health inpatient	85%	93% (70)	89% (28)	90% (51)
Learning Disabilities	85%	100% (13)	95% (39)	100% (22)
ASD/ ADHD	85%	81% (21)	89% (28)	94% (32)
CAMHS	85%	76% (38)	82% (33)	83% (24)
Forensic	60%	58% (12)	85% (61)	63% (32)
Mental health overall	84%*	**90% (394)**	**92% (461)**	**91% (410)**
Barnsley Physical Health	95%	**97% (439)**	**97% (388)**	**93% (318)**
Trustwide	**85%**	**93% (833)**	**94% (849)**	**92% (728)**

** weighted for 2023/24*

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

Satisfaction increased in March across mental health inpatient, ADHD & ASD services, CAMHS, and Learning Disabilities.

Satisfaction in forensic, mental health overall and Barnsley physical health has declined but all service lines remain above target except for CAMHS and Barnsley physical health

There has been a significant decrease in the number of returns for Barnsley physical health since January falling slightly below target, this is due to text messaging being rolled out in majority of the physical health services. The Quality Governance Team continue to work with service to review response rates and develop actions for improving the number of responses.

ADHD & ASD services continue to see an increase in returns, 9% above target. Ongoing work with the team continues.

CAMHS has seen a decrease in the number of returns. Overall percentage has slightly increased and is just below target.

Safeguarding

Safeguarding Adults:
In March 2025 there were 49 Datix categorised as safeguarding adults. Of these, 16 were categorised as green, 25 were categorised as yellow and there were eight amber incidents. There were no red Datix. The most common subcategories of these were domestic abuse, emotional/psychological abuse and neglect.

In addition to the Safeguarding Adult Datix's, there were 11 sexual safety incidents reported in March 2025. Of these, none were red or amber, five were yellow and the remaining six were green.

Safeguarding Children:
In March 2025 there were 15 Datix categorised as Safeguarding Children. Of these, four were categorised as green incidents, eight categorised as yellow and two were amber. There were no red incidents reported. The most common subcategory of these was child protection (non specific).

Complaints

- In March 2025 there were 20 new formal complaints received Trustwide. This is consistent with previous months.
- Of these complaints, four have values and behaviours (of staff) identified as a primary reason for the complaint. This is a decrease from five in February 2025.
- 16 complaints were closed in February and 88% (14) of these were within the six-month statutory timeframe. Compliance with this six-month target remains high.
- Two complaints have been referred to the Parliamentary Health Service Ombudsman. This is consistent with previous months.
- 46 compliments were received in March 2025, an increase from 30 in February 2025.

Reducing Restrictive Physical Intervention (RRPI)

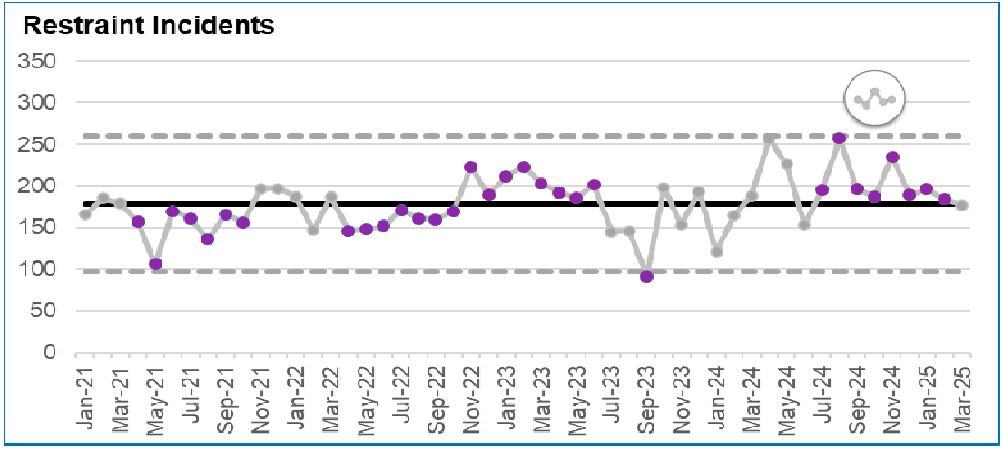
This report includes Cheswold Park data from this Month. In March 2025 there were:

- 177 reported incidents of restrictive physical interventions used, this was a reduction of 7 (3.8%%) from February 2025 which stood at 184.
- Prone restraint (those remaining in prone position and not rolled immediately) was reported 6 times, an increase of 1 (20%) from February 2025.
- 100% of prone restraints in March 2025 lasted under 3 minutes the same as February 2025.
- There were 58 incidents of seclusion used Trustwide, an increase of 7 (13.7%) from February 2025 which stood at 51.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	112	44.1%
Safety Pod	58	22.8%
Seated	38	15.0%
Supine - held on their back, regardless of surface	18	7.1%
Side	8	3.1%
Prone descent then remained in chest down position	6	2.4%
Restricted escort	6	2.4%
Kneeling	4	1.6%
Prone descent then immediately rolled to other position side/back	4	1.6%

Team Using Prone Restraint	Mar-25
Walton PICU	4
Elmdale Ward, The Dales, Calderdale	1
Newhaven Forensic Learning Disabilities Unit	1

Duration of Prone Restraint	Mar-25
0 - 1 minute	6

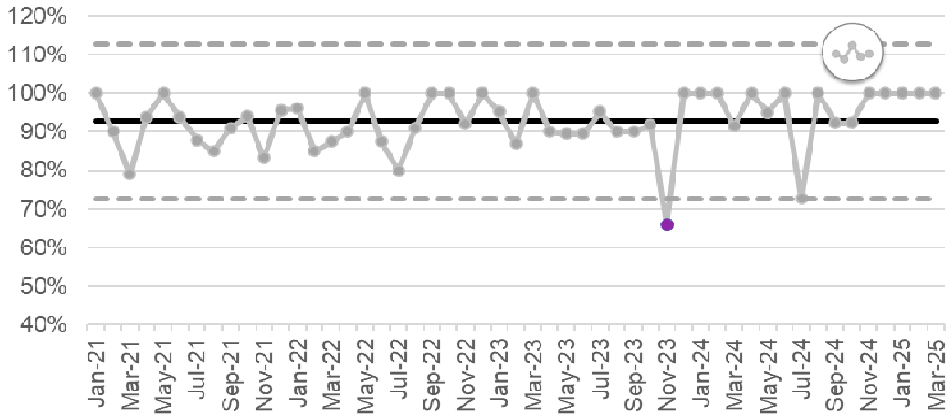


This SPC chart shows that in March 2025 we have entered a period of common cause improving variation.

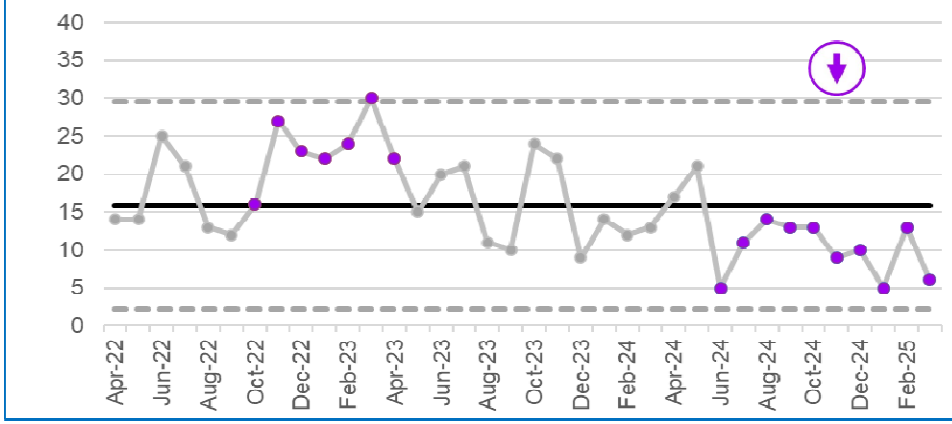
It should be noted that an increase in restraint incidents does not always indicate a deterioration in performance.

Reducing Restrictive Physical Intervention (RRPI)

Prone Restraint (% Under 3 Minutes)



Prone Restraint (Incident Numbers)



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

The number of prone restraints has decreased in March and 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	CQC Domain	Threshold	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Establishment	Improving Resources	Well Led	-	5512.2	5520.5	5524.3	5526.8	5523.1	5514.2
Contracted Staff In Post (Ledger)			-	4738.9	4756.6	4738.8	4746.5	4747.5	4749.9
Vacancies			-	773.3	763.9	785.5	780.4	775.7	764.3
Turnover external (12 months rolling)			>12% - <13%	7.6%	7.7%	7.6%	7.8%	7.7%	8.6%
Starters			-	40.0	35.7	17.4	48.3	30.6	25.2
Leavers			-	28.6	35.6	30.0	40.7	26.9	74.1
International Nurse Starters in Month			-	0	0	0	0	0	0
% Bank Fill Rates - Registered Nurses			-	82.4%	82.2%	79.2%	83.7%	83.3%	85.7%
% Bank Fill Rates - Health Care Assistants			-	80.9%	81.2%	82.6%	82.2%	83.1%	82.6%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)			-	92.6%	91.3%	91.7%	93.6%	92.6%	90.9%
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) *			-	227- All staff (17.7%) 90 - excl medics (8.3%)	226 - All staff (17.6%) 89 - excl medics (8.2%)	224 - All staff (17.4%) 89 - excl medics (8.1%)	226 - All staff (17.5%) 89 - excl medics (8.1%)	226 - All staff (17.4%) 91 - excl medics (8.3%)	228 - All staff (17.4%) 92 - excl medics (8.3%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)			-	909 (70.1%)	909 (70.9%)	915 (71.0%)	921 (71.2%)	927 (71.4%)	935 (71.4%)
Sickness absence - YTD			<=5% from June 24 was <=4.8%	5.2%	5.2%	5.3%	5.3%	5.3%	5.2%
Sickness absence - Month				5.5%	5.3%	5.7%	5.5%	5.1%	4.6%
Employees with long term sickness over 12 months			-	4	2	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%	89.4%	87.9%	85.9%	82.5%	82.6%	83.7%
Employee Relations - Suspensions (over 90 days)			-	1	1	0	0	2	2
Mandatory Training - TOTAL	Improving Care		>=80%	93.0%	93.2%	93.4%	93.6%	93.7%	93.3%
Mandatory Training - Reducing Restrictive Practice Interventions				76.7%	78.4%	80.5%	81.5%	80.1%	79.6%
Mandatory Training - Cardiopulmonary Resuscitation				81.3%	82.2%	82.0%	80.9%	81.3%	79.7%
Mandatory Training - Clinical Risk				94.9%	95.1%	95.1%	96.5%	96.6%	96.4%
Mandatory Training - Display Screen Equipment				97.7%	98.0%	97.9%	98.1%	98.0%	98.2%
Mandatory Training - Equality & Diversity				96.4%	96.5%	96.3%	96.4%	96.3%	95.9%
Mandatory Training - Fire Safety			>=85%	90.5%	90.4%	90.0%	90.6%	90.9%	88.9%
Mandatory Training - Food Safety			>=80%	92.2%	91.4%	91.3%	92.2%	92.4%	92.5%
Mandatory Training - Freedom To Speak Up (FTSU)				96.5%	96.9%	96.9%	97.0%	97.1%	97.2%
Mandatory Training - Infection Control & Hand Hygiene				94.4%	94.9%	94.9%	94.9%	95.3%	94.4%
Mandatory Training - Information Governance (Data Security)			>=95%	94.6%	94.5%	93.6%	93.5%	93.1%	91.1%
Mandatory Training - Moving & Handling			>=80%	97.5%	97.7%	97.7%	97.8%	97.9%	98.0%
Mandatory Training - Nat Early Warning Score 2 (New S2)				97.1%	97.6%	97.7%	98.1%	97.9%	97.9%
Mandatory Training - Mental Capacity Act/DoIs				90.5%	90.6%	91.0%	91.6%	91.6%	91.3%
Mandatory Training - Mental Health Act				87.9%	87.7%	88.5%	90.0%	90.5%	90.4%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				90.5%	91.4%	92.1%	92.9%	93.8%	94.0%
Mandatory Training - Prevent			>=80%	95.3%	95.5%	95.3%	95.7%	95.7%	95.4%
Mandatory Training - Safeguarding Adults				90.0%	89.9%	91.0%	91.1%	91.0%	91.1%
Mandatory Training - Safeguarding Children				92.4%	92.5%	93.3%	93.6%	92.9%	92.4%

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
• Our overall increase over the year for staff in post is 2.34%. The majority of the increase was at the start of the year and was due to recruitment activity carrying into the new financial year.

Vacancies
• Although vacancies have remained generally static overall. As the new financial year approaches it is expected there will be a significant drop as Finance are decreasing their establishment / budget for 2025/26.

Turnover
• Turnover has increased this month, however this is still very low and is expected to remain so, due to other Trusts making cost efficiencies

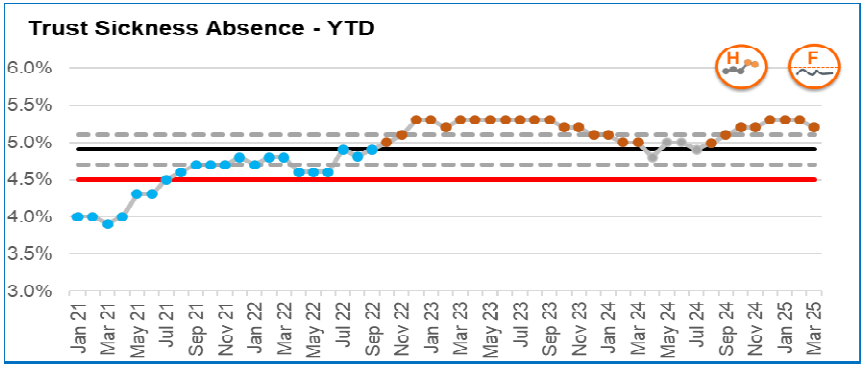
Stability
• Stability remains static, which indicates our employees are choosing to stay with us.

Sickness (Overall)
• Overall sickness has decreased slightly from 5.1% (Feb) to 4.6% (March)
• Although our Forensic care group were reducing sickness at the start of the year, we are now seeing an increase (up to 6.4%)
• Episodes of colds & flu have decreased significantly since Jan 25 (254), and are now better than the same time last year. This now demonstrates our seasonal absence period is over
• Episodes of Anxiety / Stress has 177 episodes in March 25. This is an increase on the same time last year.

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 and Support services

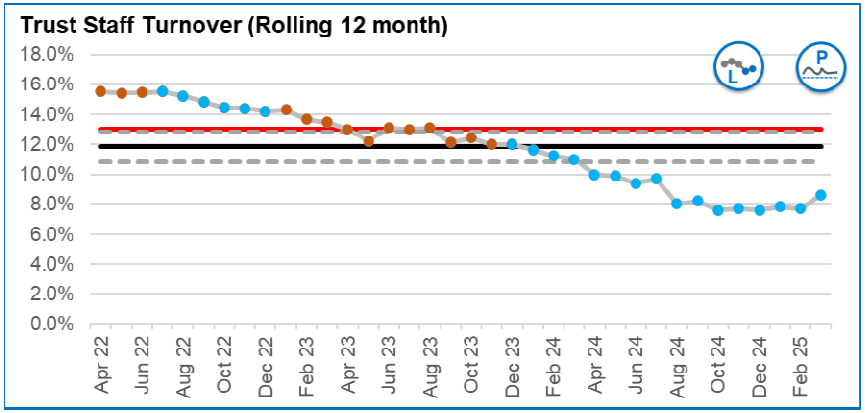
Training Compliance
• Training compliance continues to remain above target at 93.3%
• RRPI: RRPI Self Service and Manager self service is open and training planned until the end of September with availability on both 2 and 4 day programmes.
• Breakaway training is planned and additional training in Barnsley is being planned.
• CPR Training is planned until the end of July with dates available.

Statistical process control charts

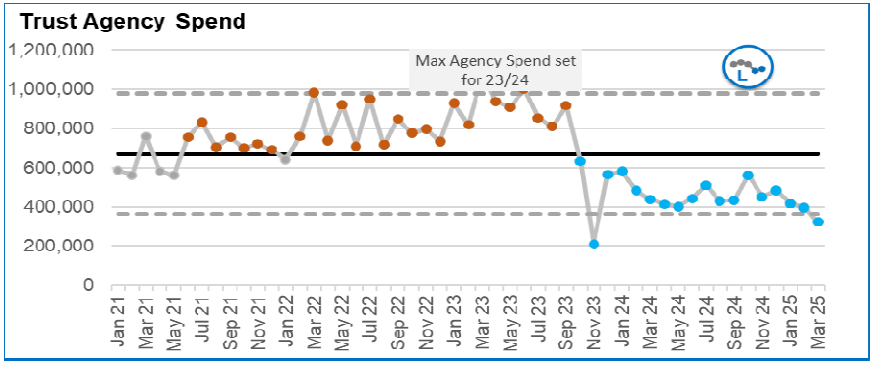


The SPC chart shows that in March 2025 we remain in a period of special cause concerning variation (something is happening and this should be investigated).

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



The SPC chart shows that in March 2025, we remain a period of special cause improving variation (something is happening and this should be investigated) following a sustained decrease in the turnover percentage.



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

The SPC chart shows the sustained reduction in spend and in March 2025 we remain in a period of special cause improving variation.

See the Finance Report for further information.

National Metrics

Data as of : 23/04/2025 14:00:35

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	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 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	119	62	114	111	124	138	96	131	127	106	92	128
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	P	H	87.5%	90.3%	92.7%	91.7%	86.2%	90.3%	97.6%	91.8%	96.7%	87.2%	94.1%	100%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?	L	52.3%	52.7%	51.1%	50.9%	50.9%	54%	54.0%	54.4%	52.4%	55.1%	53.0%	53.4%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P		100.0 %	100.0%	99.9%	99.7%	99.5%	99.5%	99.2%	99.0%	98.2%	97.2%	96.7%	97.0%
M7	72 hour follow-up from psychiatric in-patient care		80%	?		94.6%	89.8%	89%	91.2%	91.0%	94.9%	89.9%	93.5%	93.9%	92.4%	89.7%	83.8%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?	L	29	13	1	5	5	0	0	1	0	1	0	2
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?	L	1	2	1	3	1	0	0	1	0	1	0	1
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	99.3%	99.0%	98.7%	99.3%	99.4%	99.0%	98.7%	98.6%	97.8%	98.7%	99.8%	99.6%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.8%	100%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?	H		100%	100%	50%	100%	100%	100%	100%	100%	85.7%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?		97.5%	94.1%	96.6%	100%	87.5%	84.8%	88.9%	76%	59.3%	71.8%	73.3%	60.9%
M15	Data Quality Maturity Index		95%	P		99.3%	99.5%	99.5%	99.4%	99.5%	99.5%	99.6%	98.4%	98.4%	98.0%	99.6%	99.6%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P		99.0%	99.0%	99.8%	99.1%	99.3%	100%	99.0%	99.1%	99.2%	99.7%	99.8%	99.8%
M30	Number of detentions under the Mental Health Act (MHA)					92	101	99	106	105	97	94	118	96	91	100	92

National Metrics

Data as of : 23/04/2025 14:00:35

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					17.4%	23.8%	26.3%	26.4%	24.8%	10.3%	24.5%	20.3%	20.8%	23.1%	17%	19.6%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			97.2%	96.3%	95.9%	96.6%	96.7%	96.3%	96.3%	96.7%	97.9%	97.5%	97.0%	96.5%
M34	% Clients in settled accommodation	⚠	60%	P	L	83.4%	83.5%	83.2%	83.5%	83.6%	84.0%	83.3%	84.1%	84.4%	84.3%	83.1%	83.2%
M35	% Clients in employment	⚠	10%	P	H	13.0%	13.2%	13.0%	12.6%	12.7%	12.5%	13.1%	13.3%	12.8%	12.5%	13.2%	13.2%
M41	Completion of a valid NHS number		99%	P		99.9%	99.9%	99.9%	99.5%	100.0%	99.5%	100.0%	100.0%	100.0 %	100.0 %	100.0 %	100.0 %
M42	Completion of ethnicity coding for all service users		90%	P	H	99.5%	99.5%	99.4%	100.0%	99.4%	100.0%	99.5%	99.6%	99.5%	99.6%	99.6%	99.4%
M43	Community health services two hour urgent response standard		70%	P	H	92.8%	89.7%	89.9%	92.0%	91.6%	91.6%	90.9%	88.0%	89.2%	90.6%	90.2%	92.6%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500			1661	1589	1618	1963	1579	1804	2022	1851	1603	1948	1784	1893
M47	Virtual ward occupancy		80%		H	82.7%	94.3%	81.4%	91.4%	70%	82.9%	86.7%	112%	101%	100%	121%	119%
M49	Number of people who receive two or more contacts from community mental health services for adults and older adults with severe mental illnesses (MHSDS Definition) Rolling 12 months				L	14524	14518	14399	14349	14206	14092	14018	14004	13797	13867	13787	13728
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months				H	10444	10486	10466	10425	10365	10321	10246	10314	10331	10389	10435	10436
M171	% Admissions gate kept by crisis resolution teams		95%			98.8%	98.1%	95.6%	97.4%	97.9%	97.5%	100%	97.8%	100%	100%	98.9%	100%
M178	Talking Therapies - Reliable Recovery					50.4%	50.4%	48.5%	47.8%	49.7%	50.8%	52.1%	52.4%	50.7%	52.6%	49.4%	50.3%
M179	Talking Therapies - Reliable Improvement					69.7%	68.0%	69.3%	66.2%	68.9%	70.4%	71.1%	68.4%	68.6%	68.9%	67.9%	71.7%
M181	Women Accessing Specialist Community Perinatal Mental Health Services					1209	1221	1217	1233	1249	1305	1421	1519	1566	1642	1696	1833
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)					2	3	4	3	4	4	4	5	4	3	4	4
M183	Incomplete Referral to Treatment (RTT) pathways of 65 weeks or more		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M184	New RTT pathways (clock starts)		1700			1822	1967	1789	2061	1845	2088	2167	1869	1708	1920	1787	1997
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment					604	572	527	554	544	517	678	586	509	633	524	568
M188	Community services waiting list, over 52 weeks					4	2	5	2	0	0	0	1	1	1	1	0

National Metrics

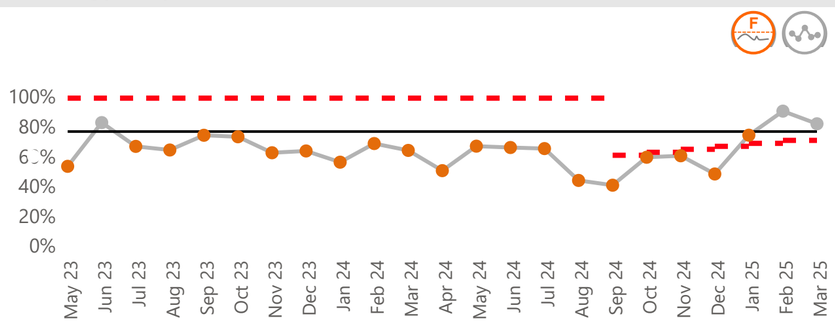
Data as of : 23/04/2025 14:00:35

NHS South West Yorkshire Partnership NHS Foundation Trust

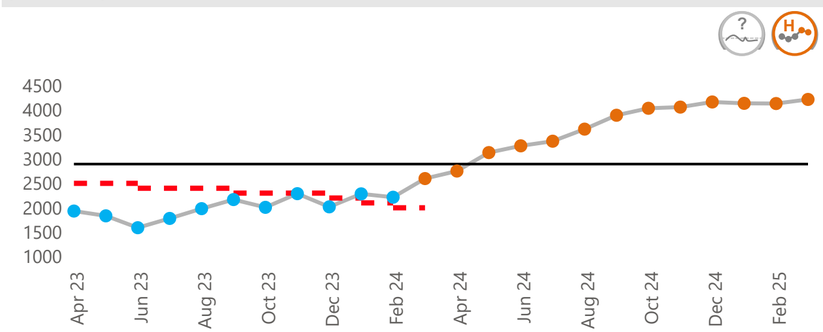
The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.

• There was one admission of an under 18 year old to an adult acute mental health bed during March.
• The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks is 60.9% in March - this relates to 28 service users who were not seen of which 14 are a result of the impact of the ARFID (Avoidant/Restrictive Food Intake Disorder) pathways and undefined reporting processes. These are being explored with NHS England. The urgent access to treatment measure is 100% in March, which is above the 95% threshold.
• The percentage of clients in employment and percentage of clients in settled accommodation - there are some data completeness issues that may be impacting on the reported position of these indicators however both are above their respective thresholds.
• Virtual Ward occupancy rate continues to increase and is now above target of 80% at 119% for March.
• Community services waiting list - This metric reports the total number of people waiting across a range of physical health and well-being services in Barnsley (aligned to the national community services SitRep). There has been a significant increase in demand for musculoskeletal services which is also reflected in the number of incomplete Referral to Treatment (RTT) pathways (M45). It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold.
• The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks in March is 81.8%, remaining below the national threshold of 99% but above the new locally set trajectory for improvement which is 70.8% in March. The service has been significantly impacted by staff sickness absence since late July. The service continues to explore options and introduce changes to increase hearing testing capacity and has appointed a trained audiologist to the service on a temporary basis via our Trust Bank.

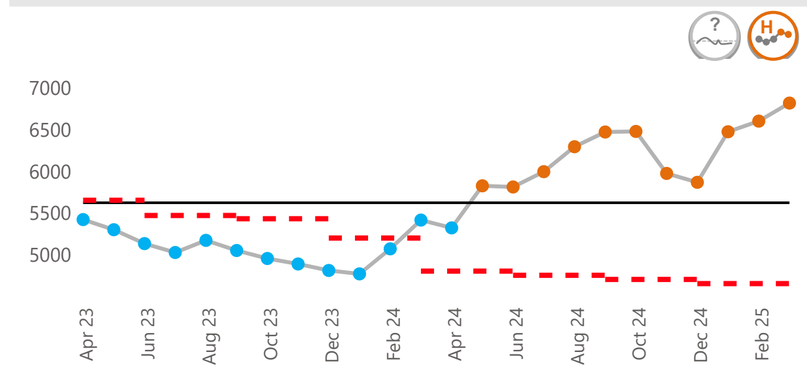
M6 - Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)

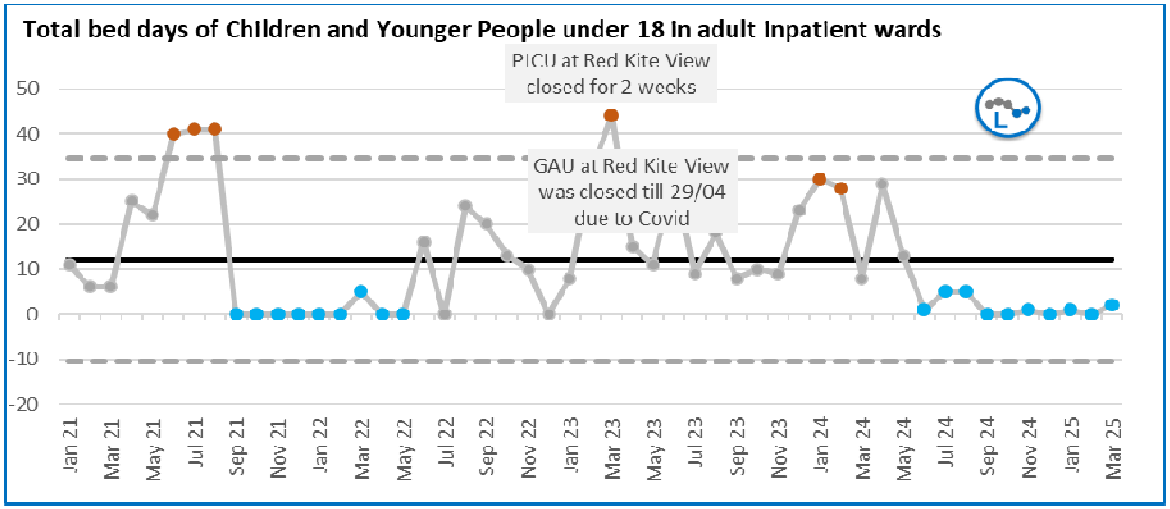


M45 - The number of incomplete Referral to Treatment (RTT) pathways

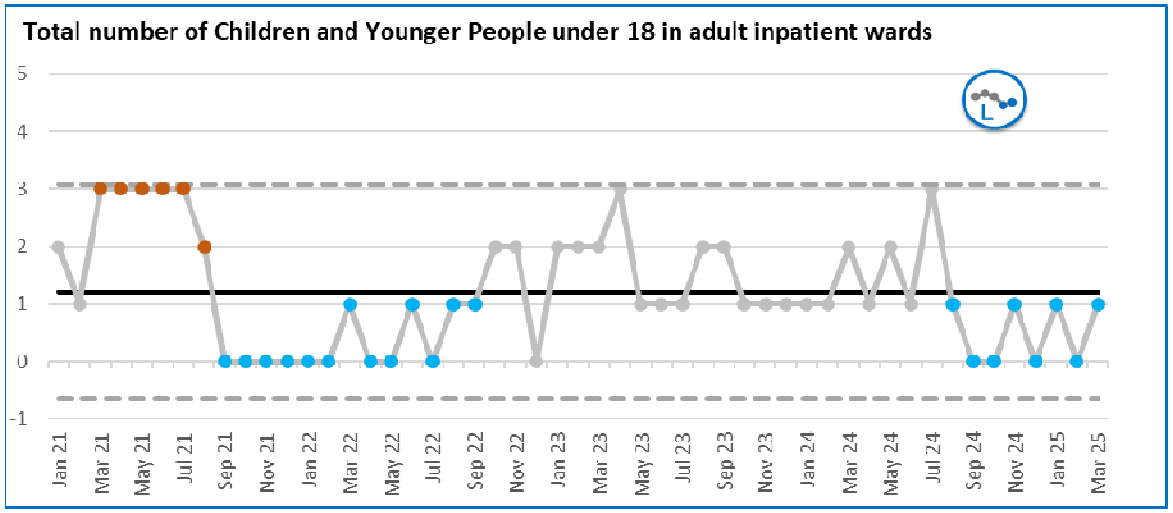


M48 - Community services waiting list





The statistical process control chart (SPC) shows that in March 2025 we remain in a period of special cause improvement, compared to previous performance, regarding the number of beds days for children and young people in adult wards.



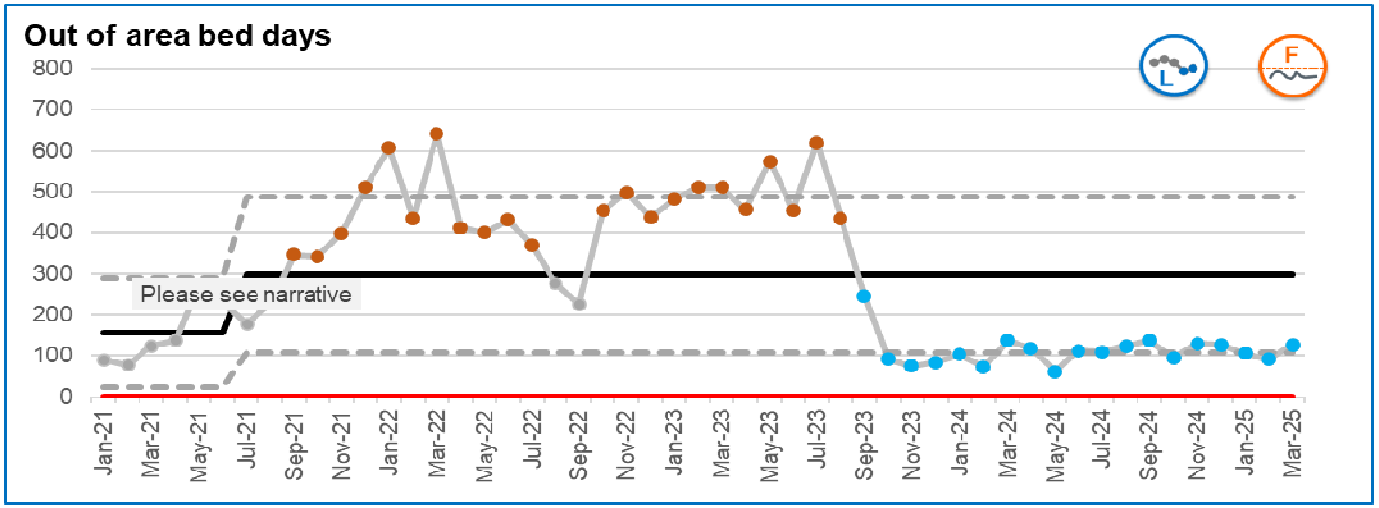
One person aged under 18 were admitted to adult inpatient wards in March 2025. Whilst the SPC chart shows us that this is an improving position when we compare it to the range of admissions we have had in the past, it is recognised that any admission of an individual under 18 is due to the national unavailability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

- The reporting for employment and accommodation shows 13.9% of records have missing employment and/or accommodation status with a further 1.7% that have an unknown employment status and 1.2% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

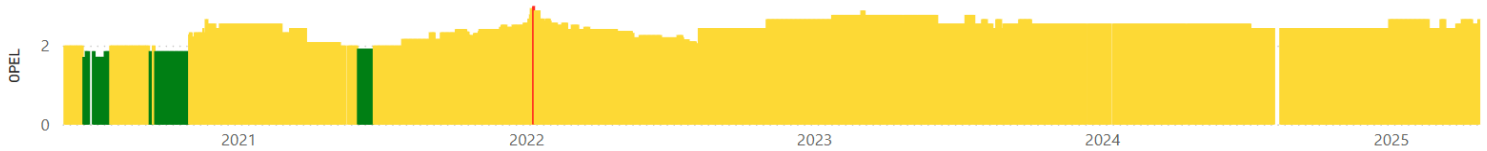
Analysis



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

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

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



Current average OPEL level

2.67

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

Children and Families Care Group

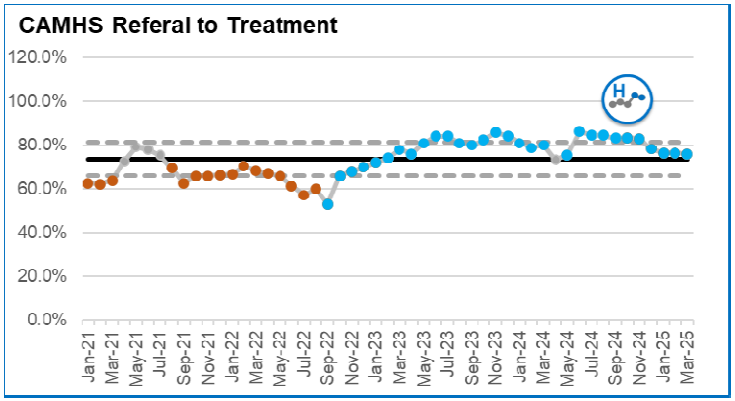
Headlines

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	Jan-25	Feb-25	Mar-25	Variation/ Assurance
% Appraisal rate	Projected Compliance: Jan - 78.3% Feb - 82.3% Mar - 84.9%	82.0%	81.8%	80.5%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/5)	0% (0/3)	33% (1/3)	
% of staff receiving supervision within policy guidance	80%	87.6%	84.3%	84.2%	
CAMHS - Crisis Response 4 hours	N/A	95.6%	100.0%	98.4%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.6%	81.5%	77.4%	
Eating Disorder - Routine clock stops	95%	71.8%	72.5%	51.2%	
Eating Disorder - Urgent/Emergency clock stops	95%	85.7%	100.0%	100.0%	
Maximum 6 week wait for diagnostic procedures	99%	76.2%	90.3%	81.8%	
Information Governance training compliance	>=95%	94.9%	93.8%	90.2%	
Reducing Restrictive Practice Interventions training compliance	>=80%	77.3%	79.1%	78.2%	
Sickness rate (Monthly)	5.0%	4.7%	4.2%	3.4%	

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



As you can see in March 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 waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees continue to 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) MHST continues to experience significant challenges around recruitment and retention especially with the band 5 roles. This appears to be a regional problem however is compounded by KKiM commissioner changes to service.
- Barnsley CAMHS eating disorders team- continue to work 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. Commissioners are aware of the issues and options available.
- CIC service specification- is being reviewed through work with commissioners and Head of Social Care on a wider piece of work with CIC and out of area placements in Barnsley. It has been agreed with a temporary hold with commissioners that out of area referrals for therapeutic support are paused in line with other localities.
- Wakefield CAHMS staffing – ReACH Team, Primary Intervention Team (PIT) which is the single point of access (SPA), eating disorder team and psychiatry pathway all in business continuity due to low staffing numbers. This is being covered by Bank and Agency with recruitment processes ongoing. Staffing model has been reviewed and three Band 7 Senior Clinician roles introduced. The team is Red on the risk register and remains at high risk due to significant staffing vacancies and complexity.
- The recovery pathway within ReACH has been closed with the focus now on Home Based Treatment to ensure high risk children and young people are covered in the community.
- Data quality across the care group - The recording of disability data (25.8%) and sexual orientation (aged 16 and above) (17.2%) remains a hot spot. These figures have remained static for months and focus work is a priority for the services to improve these numbers.

Advise

• Calderdale & Kirklees CAMHS Eating disorder performance is currently fluctuating especially in relation to 28-day referral to treatment KPI. Predominantly impacted by multiple staff vacancies (now out to advert) and increased number of Avoidant/Restrictive Food Intake Disorder (ARFID) referrals. Pathway review completed and new ARFID process being implemented. Time limited suspension of ARFID pathway to support evaluation and restructure. Commissioners agreed and sighted.
• 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 – The lack of clinical space means appointments cannot be offered in certain districts despite demand rising. This has been added to the risk register
• Paediatric Audiology - there was a slight decrease in waiting times performance in March (from 89.4% to 82.6%) due to staff taking annual leave. This a small team and therefore any staff absence impacts on service performance.
• Children's Therapy Service – There continues to be fewer children waiting to be seen for the OT and OT/PT joint pathways with the 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.
• Children's SALT – reassurance is be sought in relation to the funding of the Band 6-7 Autism Spectrum Disorder Assessment Team (ASDAT) post with commissioners however this has yet to be a fully resolved provision. General manager and service lead are in discussion with the Associate Director and Medical Clinical Lead from Barnsley Hospital Foundation Trust.
• Secure CAMHS - we continue to make good progress with the mobilisation of our new Secure CAMHS contract which starts on the 1st April 2025.
• Capacity and demand across Community CAMHS Crisis and Eating Disorder teams being monitored as some teams are invoking Business Continuity Plans (BCPs). This has been added to the Risk Register
• Wakefield CAMHS – Eating Disorders team continue to face staffing pressures. Recruitment is in process – there will likely be an overlap, meaning bank and agency will need to be used on a short term basis due to the risks of the children & young people cared for by the team.

Assure

• Sickness across the care group continues to be below the overall Trust sickness rate of 4.4% being 3.4% (as of 15.04.25) both long and short term sickness are being managed well
• Appraisal rates across the care group is at 81.4% (as of 15.04.24) with targeted action plans across the care group in place for those services indicating low appraisal rates
• Mandatory training across the care group is 93.8% (as of 15.04.24) with Data Security (Information Governance IG) standing at 92.1%. targeted action plans across the care group in place for those services indicating low compliance rates
• Clinical supervision recording stands at 84.2 % across the care group (as of 17.04.25)
• Calderdale Neuro team have exceeded the number of commissioned assessments for the past three months.
• The Health Integration Team in Urban House Wakefield are working with the ICB and Warrengate Practice to ensure that all residents in Urban House are registered with a GP. This collaborative approach aims to support and enhance the excellent service provided by our Health Integration Team within the setting.
• Children's audiology have been successful in recruiting to our audiology vacancy despite the challenges in recruitment that are being experienced within the region.
• A number of Services across the care group have been nominated for Excellence Awards

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. The sickness rate is above the Trust threshold on some wards, 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	Jan-25	Feb-25	Mar-25	Variation/ Assurance
% Appraisal rate	Projected Compliance: Jan - 78.3% Feb - 82.3% Mar - 84.9%	86.9%	86.4%	84.6%	
% Assessed within 14 days of referral (Routine)	75%	74.2%	85.1%	72.4%	
% Assessed within 4 hours (Crisis)	90%	97.7%	94.9%	96.7%	
% of feedback with staff values and behaviours as an issue	< 20%	30% 3/10	33% 4/12	14% 1/7	
% of staff receiving supervision within policy guidance	80%	86.8%	88.6%	87.4%	
% service users followed up within 72 hours of discharge from inpatient care	80%	92.4%	89.7%	83.8%	
% Service Users on CPA with a formal review within the previous 12 months	95%	97.3%	96.5%	95.8%	
% Treated within 6 weeks of assessment (routine)	70%	91.7%	93.3%	94.4%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.7%	80.3%	77.9%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	68.5%	76.5%	*75.7%*	
Information Governance training compliance	>=95%	94.2%	95.0%	91.1%	
Reducing Restrictive Practice Interventions training compliance	>=80%	78.9%	82.5%	79.1%	
Sickness rate (Monthly)	5.0%	5.6%	5.0%	4.2%	

Mental Health Inpatient

Metrics	Threshold	Jan-25	Feb-25	Mar-25	Variation/ Assurance
% Appraisal rate	Projected Compliance: Jan - 78.3% Feb - 82.3% Mar - 84.9%	82.4%	82.4%	91.3%	
% Bed occupancy (excl leave)	85%	91.4%	91.1%	89.7%	
% of feedback with staff values and behaviours as an issue	< 20%	0% 0/3	0% 0/12	50% 1/2	
% of staff receiving supervision within policy guidance	80%	80.3%	88.7%	87.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	86.9%	87.4%	86.8%	
% of clients clinically ready for discharge	3.5%	6.0%	6.7%	8.2%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	87.3%	92.2%	*94.1%*	
Inappropriate Out of Area Bed days	140 (Feb)	106	92	128	
Information Governance training compliance	>=95%	95.2%	93.8%	93.8%	
Physical Violence (Patient on Patient)	Trend Monitor	20	19	12	
Physical Violence (Patient on Staff)	Trend Monitor	53	50	51	
Reducing Restrictive Practice Interventions training compliance	>=80%	87.2%	87.7%	88.4%	
Restraint incidents	Trend Monitor	125	131	*92*	
Safer staffing (Overall)	90%	135.9%	139.1%	134.6%	
Safer staffing (Registered)	80%	103.4%	105.9%	103.8%	
Sickness rate (Monthly)	5.0%	6.4%	5.8%	5.2%	

Alert/Action

- Acute wards have continued to manage high levels of acuity.
- High occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
- 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 ICB's through the Multi Agency Discharge Event 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 March 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 March'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.
- 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. There have been challenges with further admin vacancies in Calderdale & Kirklees SPA impacting on performance. Wakefield is also under target in March due to specific challenges including unprecedented absences in Wakefield primary care MH provision impacting on referrals to SPA.

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.
• The Talking Therapies recovery rate for March is 54.12% for Kirklees and 52.65% for Barnsley, both achieving the national standard of 50%. In March both Barnsley and Kirklees Talking Therapies achieved the expected national standard of less than 10% for waits to second treatment within 90 days (Barnsley 7.32% and Kirklees 6.54%).
• 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 5 incidents of prone restraint in March, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration. The monthly restraint oversight meeting, led by NQP, involving RRPI, safeguarding and matrons, review all prone restraint incidents for any opportunities for learning.

Assure

• IHBT teams continue to perform well in gatekeeping admissions to our inpatient beds.
• The 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 March position remaining above threshold at 94.2%. 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	Jan-25	Feb-25	Mar-25	Variation/ Assurance
% Appraisal rate	Projected Compliance: Jan - 78.3% Feb - 82.3% Mar - 84.9%	82.4%	83.5%	85.9%	
% of feedback with staff values and behaviours as an issue	< 20%	25% (1/4)	0% (0/1)	0% (0/3)	
% of staff receiving supervision within policy guidance	80%	85.7%	82.9%	79.6%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	60.5%	68.8%	67.3%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.2%	89.2%	89.0%	
% of clients clinically ready for discharge	3.5%	80.0%	55.4%	55.7%	
Information Governance (IG) training compliance	>=95%	94.9%	94.0%	92.4%	
% 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%	94.4%	94.2%	

LD, ADHD & ASD

Metrics	Threshold	Jan-25	Feb-25	Mar-25	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	44	9	24	
Reducing Restrictive Practice Interventions training compliance	>=80%	88.2%	85.9%	85.8%	
Safer staffing (Overall)	90%	167.7%	198.4%	172.7%	
Safer staffing (Registered)	80%	163.9%	164.2%	170.3%	
Sickness rate (Monthly)	5.0%	5.5%	5.7%	4.5%	
Restraint incidents	Trend Monitor	39	15	*36*	

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

Alert/Action

ADHD
• The waiting lists in Adult ADHD continue to grow which is consistent with the national picture. 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.

• WY ICB Neurodevelopmental Assessment Service tender has been released in the last week the service is seeking to understand the implication of this. Despite this the service continues to collaborate with commissioners in each place to further improve the offer

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 2 GP practices have withdrawn all shared care agreements relating to ADHD medication (practices are in Barnsley and Kirklees. The service is working with ICB colleagues to identify longer term solutions.

Assure

- All KPI targets met.
- Excellent levels of supervision, appraisal and mandatory training.
- Low level of vacancies.
- FFT – 94% although below target showing a sustained improved position.
- All mandatory training meeting the threshold.
- ADHD Productivity for 2024/25 exceeded targets. We expected to assess or treat new cases in the year assuming we could operate at full capacity and keep staff absence levels within expected limits.

Learning disability services:

Alert/Action

Learning Disability (LD)
- Overall compliance with mandatory training is good with the only training not meeting the threshold being Information Governance at 90.3%
- Appraisals are 82.8% compliant.
- Supervision 78.3%

Community
- Recent data indicates a continued improvement in waiting list performance across all four localities. Improvement initiatives and process optimisation has underpinned this work. The Care Group continues to monitor this closely.
- Community Teams continue to report high levels of LD service users in crisis.

Assessment & Treatment Unit (ATU)
- Acuity remains high with all service users presenting with complex and challenging needs.
- Service users clinically ready for discharge remains a challenge with 55.7% of service users meeting the criteria.

Advise

Community
- Keeping my chest healthy pilot has been extended to early May and will be evaluated at that point to determine whether the service will benefit from wider rollout.
- The service extended the development post to include preceptorship for SaLT (Speech and Language Therapy) and this has proved successful with two more SaLTs being recruited into vacancies for band 5 to 6 development posts. The service is hopeful this will improve recruitment which has been a challenge in this discipline.
- 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.

Assessment & Treatment Unit (ATU)
- Previously cancelled ATU Workshop with system partners now rescheduled.
- Establishment review to be undertaken.
- Quality Improvement project on advanced choice documentation has been completed.
- LD ATU developed their own feedback process for service users and the last two discharges are now in the process of completing this.

Assure

- Medical recruitment progressing well.
- Annual health Checks in all 4 localities have exceeded the 75% threshold.
- Data Quality remains good.
- Friends and Family Test – 100%
- Preventing further breaches at 18 weeks has now met the target for 7 months and the waiting list project has now become business as usual.

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	Jan-25	Feb-25	Mar-25	Variation/ Assurance
% Appraisal rate	Projected Compliance: Jan - 78.3% Feb - 82.3% Mar - 84.9%	83.0%	82.1%	84.0%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/5)	20% (1/5)	25% (1/4)	
% people dying in a place of their choosing	80%	86.2%	93.5%	96.2%	
% of staff receiving supervision within policy guidance	80%	81.6%	79.4%	79.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.0%	83.1%	80.5%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	0.0%	

Barnsley Physical Health and Wellbeing

Metrics	Threshold	Jan-25	Feb-25	Mar-25	Variation/ Assurance
Information Governance (IG) training compliance	>=95%	93.7%	92.8%	93.3%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	97.2%	96.7%	97.0%	
Safer staffing (Overall)	90%	109.3%	110.7%	104.6%	
Safer staffing (Registered)	80%	125.5%	125.5%	107.8%	
Sickness rate (Monthly)	5.0%	4.8%	5.5%	4.8%	

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

Alert/Action

• MSK & Neuro Physio, Priory Day Centre – remains closed. Remedial works planned for April will no longer take place as there is no capital funding available to undertake the necessary work. Services affected continue to utilise Priory Campus as temporary alternative accommodation and this arrangement has been extended until end of July 2025. General Manager is working with both the MSK Service and our Strategic Planning Lead for SWYPFT Estates to explore long term options. This remains on the local risk register. 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.

Advise

• Information Governance training has seen a small increase but remains slightly below compliance for March at 93.3%; plans to target staff that are non-compliant continue to progress.
• Staff receiving supervision - continues to receive focus with a drive to improve recording. We have seen a small reduction to 79% for March which is slightly below compliance.
• Appraisals - for March the figure is showing an improvement at 84% against the revised target of 85%. We are aware of our hot spot areas and are supporting teams to get back on track. The April figure to date (17.4.25) is already showing a further improvement at 86.4%
• Friends and Family Test (FFT) 93% of people would recommend community services against a target of 95%. There has been a slight reduction in FFT returns in March. Out of the 300 responses receive 8 were poor or very poor (2.44%). The negative responses were across 3 services. We will monitor for any themes in future months.
• The Care Group is currently below compliance for Safeguarding Children Level 3; the list has been cleansed, and the Occupational Therapy and Physiotherapy rotational staff have been added. A training session for them has been arranged; this will take place in June, and we should see an increase in compliance after that.
• One instance of feedback with staff values and behaviours as an issue has been recorded during March. This relates to our Podiatry service and is being investigated.

Assure

• Sickness rates have improved during March and the care group is now meeting compliance at 4.8%.
• Urgent Community Response Service 2-hour target is 92.6% as at end of March 2025 which continues to be well above the 70% threshold.
• Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 97% as at March 2025.
• 96.2% of people dying in their place of choosing in March 2025; this remains consistently above the threshold of 80%.
• CPR training maintains compliance at 80.5% for March. We have reviewed the various training levels and are targeting hot spot areas.
• Virtual Ward occupancy rate has increased this month and continues to be above target of 80% at 119% for March. Virtual ward continues to support early supported discharge and hospital avoidance to support system pressures, reviewing capacity daily. We have seen some increase in hospital avoidance and admission prevention referrals during this last quarter (e.g. community step ups from primary care, Yorkshire Ambulance Service (YAS), SWYPFT services and admission avoidance from Emergency Department (ED) and Same Day Emergency Care (SDEC).
• Several staff and services in our Care Group have been shortlisted in the Trust's Excellence Awards:
    • Best Quality Excellence - 'Safe and Supported Hospital and Step Up Avoidance' – Urgent Community Response (UCR) Team
    • Unsung Hero – End of Life Care Facilitator
    • Leader of the Year – General Manager, Inpatients and Admin
    • Rising Star – Aspiring Advanced Nurse Practitioner, UCR
    • Outstanding Achievement – Senior Rehabilitation Officer, Equipment, Adaptations and Sensory Impairment (EASI) Team
• Our care group has been working with the Yorkshire Ambulance Service (YAS) to support trainee urgent care paramedics with placements. To date two trainees have completed placements in our community teams and two more are due to complete by April 2025. Reciprocal placements have been arranged for our care group staff.
• We celebrated Nutrition & Hydration Week focusing on the importance it plays in quality and safety in health and social care. Our Dietetics Service were actively promoting messages and tips to stay hydrated and encouraged teams across the Trust to make their pledge to show their support.
• Two of our Neuro Rehabilitation Unit therapists presented at Trust Board. They provided insights into the service and shared the story of a patient who had a life-changing brain injury, highlighting the care and commitment the unit provided to support them on their recovery journey.
• Dearne Area Council Team at the local authority recently expressed a huge thank you our care group representative from SWYPFT EyUp! NHS Charity for her recent successful bid with EyUp! which secured 50 first aid boxes which will be distributed to those who need them most. This has highlighted how collective efforts can make a real difference in supporting and caring for local populations.
• Decrease in hospital admissions - Over the past 3 years, (January 2022 – January 2025) there has been a 49% decrease in the number of hospital admissions per month for care home residents, based on data shared by our hospital colleagues. Our staff in Neighbourhood Teams contribute to this alongside other health care partners via: Virtual Ward; care home multi-disciplinary team meetings and ward rounds; training and education to care homes; expert advice and guidance support; excellent ongoing support to patients from services who form part of our Neighbourhood teams pathways; growing relationships with our colleagues in Yorkshire Ambulance Service. This is a great example of our staff assisting people to stay in their place of residence, whilst ensuring they have robust care plans in place that align with their own and their families' wishes.

Forensic Care Group

Headlines

The monthly sickness rate continues to be above threshold but has improved further in March (6.4%) 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	Jan-25	Feb-25	Mar-25	Variation/ Assurance
% Appraisal rate	Projected Compliance: Jan - 78.3% Feb - 82.3% Mar - 84.9%	75.3%	78.2%	82.0%	
% Bed occupancy (incl leave)	90%	82.9%	83.3%	85.6%	
% of feedback with staff values and behaviours as an issue	< 20%	0% (0/2)	0% (0/0)	0% (0/1)	
% of staff receiving supervision within policy guidance	80%	86.4%	90.0%	91.5%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	97.8%	99.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.8%	80.2%	82.3%	
% of clients clinically ready for discharge	3.5%	0.8%	0.1%	0.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	N/A	N/A	N/A	
Information Governance (IG) training compliance	>=95%	93.5%	91.2%	91.8%	
Physical Violence (Patient on Patient)	Trend Monitor	6	4	6	
Physical Violence (Patient on Staff)	Trend Monitor	9	12	12	
Reducing Restrictive Practice Interventions training compliance	>=80%	85.6%	83.4%	86.8%	
Restraint incidents	Trend Monitor	23	25	*8*	
Safer staffing (Overall)	90%	108.2%	114.1%	114.0%	
Safer staffing (Registered)	80%	100.4%	106.8%	105.3%	
Sickness rate (Monthly)	5.4%	7.0%	6.6%	6.4%	

Alert/Action

• Bed Occupancy – Newton Lodge 88.6%, Bretton 83,70%, Newhaven 72.5%. Under-occupancy 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 secure, referrals have been accepted but the service is waiting for process of transfer to be completed.
• Appraisal – The service continues to have appraisal as a key focus of activity across the service. Overall Appraisal is now on an improving trajectory at 83.6%.
• 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 who have advised the service on action to be taken for this to be escalated within Provider Collaborative processes.

Advise

• Mandatory training overall compliance: Newton Lodge – 92.5%, Bretton – 92.8%, Newhaven – 93.7%
Hotspots for Newton Lodge are: IG and Fire Safety (the service is undertaking some exploratory work to establish why this figure has dropped below the compliance threshold as face to face fire training takes place in annual security updates). Hotspot for Bretton is information governance. Newhaven is fully compliant.
• Supervision – levels remain high across the care group at over 90% compliance.
• 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 – turnover across the service is much lower than in previous years. Newton Lodge 10.1%, Bretton Centre 7.6% and Newhaven 4.5%.
• Newton Lodge – the service user awaiting transfer to high secure has now been transferred which should improve flow on the male pathway.
• Forensic Improvement Programme – is well underway with a number of workstreams focusing on improved service user experience and outcomes and improved efficiencies.

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 – 100%

Inpatients - Mental Health - Working Age Adults

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

Appraisal

• System issues continue to impact on accuracy of reporting, including exclusion data (e.g. sickness, contract changes) only being updated on ESR monthly.
• Proxy user access not being functional throughout March has also impacted and only ward managers could log appraisals, leading to recording delays in their absence.
• Nostell, Stanley, Ward 18, Beechdale. Ward 19 (male and female), Enfield Down and Lyndhurst have achieved the 95% target.
• Walton, Ashdale, and Poplar's appraisal compliance is below threshold in March but is above 90%. All other wards are above 80%.
• Matrons continue to work closely with ward managers to ensure outstanding appraisals are booked.

Sickness

• Sickness improved to below threshold in March on Poplars and Willow following the return of some staff from long term sickness.
• Sickness increased slightly above threshold on Beamshaw due to short-term sickness and 1 staff member who is long term sick because of a work-related assault.
• Sickness on Melton, Nostell, Stanley and Walton has reduced but remains above threshold and continues to be impacted by a combination of long and short-term sickness, no specific themes.
• Clark, although still slightly above threshold at 5.3%, have seen a reduction in sickness associated with fewer episodes of short-term sickness.
• Ward 18 sickness has increased at 11.3% due to a mixture of both long and short-term sickness, no specific themes.
• Beechdale (15.2%) has increased and remains significantly above threshold due to episodes of short-term sickness and ongoing staff long-term sickness (physical health related).
• 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 four weeks.

Supervision

• 12 wards above 80% compliance target.
• Beamshaw, Nostell and Poplars have dropped below compliance threshold in March. On Beamshaw this has been impacted by ward manager absence and both Nostell and Poplars have been impacted by ward acuity and the ward managers working in clinical numbers on frequent occasions.
• Ward 18 and Willow compliance remain under threshold in March, but Willow is currently 100% (as of 16/0/4/25). On Ward 18 the matron is overseeing focused work to prioritise supervision for the four staff who haven't received it in the last 90 days.

Mandatory Training

Information Governance
• Walton (94.6%). Ward 18 (81.5%), Elmdale (93.3%), and Beechdale (92.9%) compliance has dropped below threshold in March.
• Ward 18 training compliance has been impacted by ward manager absence due to sickness – the ward manager has returned and is working to address training compliance deficits with close oversight from the matron.
• Beamshaw (91.3%), Melton (81.5%), Stanley (88.9%), Ashdale (94.1%), and Willow (87.5%) compliance remains under threshold. Beamshaw, Ashdale, and Willow compliance has increased above threshold in April (as of 16/04/25) and action continues to be taken by the ward managers of the other wards to drive up improvement.
• The eight remaining wards are above the target of 95%
CPR
• 13 wards are above the CPR training compliance threshold.
• Melton (77.8%), Ward 18 (74.1%), and Crofton (75%) have dropped below compliance threshold and ward managers are reviewing and booking staff onto future training dates.
• Willow compliance remains under threshold at 58.3% and staff have either recently attended or are booked to attend future training dates and close oversight will be held by the ward manager with matron support.
RRPI
• 16 wards are above the RRPI training compliance threshold.
• Willow remains under compliance at 79.2%, an increase compared to previous month. 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
• Clark (81.8%), Beamshaw (81.5%), Stanley (81.5%), Walton (81.1%), Ward 18 (81.5%), Elmdale (83.3%), and Willow (83.3%) are under compliance.
• Booking of training is overseen by the ward managers as a priority and each of these wards has seen an increase in compliance in April. Clark, Beamshaw, Stanley, Elmdale, and Willow are above compliance threshold (as of 16/04/25).

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' 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 rate has increased from 25.3% to 31.2% in March. This continues to be reflective of several service users awaiting placements.
• Clark has increased from 7.7% to 25.8% in March. This relates to 3 service users, all of whom are awaiting placement or supported living accommodation.
• Ward 19 (Male) has increased above the threshold for CRFD in March to 5.3%. This is one service user who is awaiting placement.
• 10 other wards are above the threshold rate for CRFD with Beamshaw, Melton, and Walton, above 10%. Nostell, Stanley, Ashdale, Ward 18, Willow, Ward 19 (female) and Lyndhurst are also above target. This is due to the number of service users with complex needs who are awaiting placement or suitable accommodation.
• Across all wards the multi-disciplinary team continue to collaborate to progress pathways as timely as possible.
• An additional check and challenge weekly meeting has been established led by the Director of Service to ensure senior oversight and focus and timely external escalations.

FIRM Risk assessments
• Staying Safe plans are now captured as part of the 'Inpatient - My Care and Safety Plan', rather than the FIRM risk assessment following the changes to care plans that went live on 6th January.
• Compliance has been impacted whilst ward teams adjust to the care plan changes and Stanley, Walton, Crofton, and Ward 19 (Male), each had one staying safe breach in March. Nostell's performance (87.5%) totals two breaches and has been impacted by high clinical acuity
• A deep dive is conducted by the matron for each breach to identify learning and inform improvement.
• At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed.

Physical violence
• 13 incidents of patient on staff physical violence at Poplars. Incidents relate to specific service users with behavioural and psychological symptoms of dementia. Risk management care plans are in place and the ward psychologist is supporting with psychological formulation. Trust specialist advice from RRPI and safeguarding is also sought as needed.
• Ward 18 (5), Elmdale (5) and Nostell (7) had several incidents of patient-on-staff physical violence throughout March 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 numbers of incidents on Walton and Elmdale are reflective of the current patient population and the presentation and risk profile of service users.
• The incidents on Ward 18 and Nostell correlate with instances of physical violence as outlined above.

Prone restraint incidents
• Five incidents of prone restraint in March, all of which were on working age adult (WAA) inpatient wards and were under three minutes duration.
• All are reflective of individual service user presentation and high risks of violence and aggression, including the four prone restraints on Walton relating to three 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

Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	79.2%	79.2%	82.6%
Sickness	5.0%	4.3%	2.3%	6.3%
Supervision	80%	80.0%	80.0%	64.3%
Information Governance training compliance	>=95%	90.5%	79.2%	91.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	81.0%	87.5%	91.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.7%	91.7%	87.0%
Fire Safety training compliance	>=85%	90.5%	83.3%	91.3%
Bed occupancy**	85%	99.4%	96.3%	99.1%
Safer staffing (Overall)	90%	141.8%	171.8%	163.5%
Safer staffing (Registered)	80%	116.9%	123.9%	116.0%
% of clients clinically ready for discharge	3.5%	31.2%	17.8%	16.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	1
Physical Violence (Patient on Staff)	Trend Monitor	3	3	1
Restraint incidents	Trend Monitor	4	17	*4*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	18	18	33

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

Clark Suite

Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	73.7%	88.9%	88.2%
Sickness	5.0%	3.6%	11.4%	5.3%
Supervision	80%	57.1%	92.3%	91.7%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	100.0%	95.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.0%	90.9%	100.0%
Fire Safety training compliance	>=85%	100.0%	95.5%	81.8%
Bed occupancy**	85%	99.4%	96.3%	99.1%
Safer staffing (Overall)	90%	156.9%	130.8%	105.8%
Safer staffing (Registered)	80%	109.2%	106.9%	108.1%
% of clients clinically ready for discharge	3.5%	10.4%	7.7%	25.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	1
Physical Violence (Patient on Staff)	Trend Monitor	3	1	4
Restraint incidents	Trend Monitor	4	2	*4*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	24	18	12

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

Melton Suite

Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	84.6%	80.8%	81.5%
Sickness	5.0%	11.8%	9.3%	8.4%
Supervision	80%	69.2%	69.2%	92.3%
Information Governance training compliance	>=95%	90.9%	88.0%	81.5%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	100.0%	96.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	86.4%	84.0%	77.8%
Fire Safety training compliance	>=85%	81.8%	84.0%	81.5%
Bed occupancy	85%	100.0%	101.2%	100.0%
Safer staffing (Overall)	90%	195.8%	174.4%	170.8%
Safer staffing (Registered)	80%	96.1%	95.6%	101.6%
% of clients clinically ready for discharge	3.5%	16.7%	16.4%	16.2%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	0.0%	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	3	5	3
Restraint incidents	Trend Monitor	30	9	*6*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	27	30	28

Nostell

Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	91.3%	87.0%	95.7%
Sickness	5.0%	14.1%	13.7%	7.0%
Supervision	80%	85.7%	93.3%	68.8%
Information Governance training compliance	>=95%	91.7%	92.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	87.5%	88.0%	92.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.5%	92.0%	92.6%
Fire Safety training compliance	>=85%	91.7%	96.0%	85.2%
Bed occupancy**	85%	96.3%	98.1%	93.7%
Safer staffing (Overall)	90%	156.9%	120.8%	132.5%
Safer staffing (Registered)	80%	108.1%	111.3%	110.8%
% of clients clinically ready for discharge	3.5%	14.1%	13.7%	10.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	53.8%	90.9%	*87.5%*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	1
Physical Violence (Patient on Staff)	Trend Monitor	1	6	7
Restraint incidents	Trend Monitor	11	11	*9*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	1 (100%)	2 (100%)	*0*
Unfilled Shifts	Trend Monitor	14	9	14

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

Inpatients - Mental Health - Working Age Adults

Stanley Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	65.2%	79.2%	95.8%
Sickness	5.0%	3.4%	7.5%	5.7%
Supervision	80%	73.3%	86.7%	86.7%
Information Governance training compliance	>=95%	96.0%	88.5%	88.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	88.0%	96.2%	92.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	96.0%	88.5%	92.6%
Fire Safety training compliance	>=85%	92.0%	88.5%	81.5%
Bed occupancy**	85%	96.3%	98.1%	93.7%
Safer staffing (Overall)	90%	131.0%	164.8%	180.7%
Safer staffing (Registered)	80%	107.1%	109.6%	111.9%
% of clients clinically ready for discharge	3.5%	8.5%	7.4%	9.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	92.3%	100.0%	*93.3%*
Physical Violence (Patient on Patient)	Trend Monitor	3	0	1
Physical Violence (Patient on Staff)	Trend Monitor	2	2	4
Restraint incidents	Trend Monitor	8	6	*8*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	6	27	37

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

Walton Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	94.1%	88.6%	91.2%
Sickness	5.0%	8.4%	7.3%	6.7%
Supervision	80%	57.9%	89.5%	82.4%
Information Governance training compliance	>=95%	97.0%	97.3%	94.6%
Reducing Restrictive Practice Interventions training compliance	>=80%	78.8%	89.2%	86.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	81.8%	83.8%	91.9%
Fire Safety training compliance	>=85%	84.8%	89.2%	81.1%
Bed occupancy	85%	100.7%	106.9%	92.6%
Safer staffing (Overall)	90%	126.5%	139.7%	150.4%
Safer staffing (Registered)	80%	93.6%	94.9%	96.4%
% of clients clinically ready for discharge	3.5%	10.8%	15.8%	18.9%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	87.5%	100.0%	*83.3%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	4	3
Restraint incidents	Trend Monitor	4	23	*12*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	2 (100%)	7 (100%)	*4 (100%)*
Unfilled Shifts	Trend Monitor	5	6	9

Ashdale Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	54.5%	60.6%	93.8%
Sickness	5.0%	0.4%	1.2%	1.4%
Supervision	80%	52.6%	85.0%	100.0%
Information Governance training compliance	>=95%	97.0%	91.2%	94.1%
Reducing Restrictive Practice Interventions training compliance	>=80%	90.9%	91.2%	88.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.9%	88.2%	91.2%
Fire Safety training compliance	>=85%	100.0%	94.1%	94.1%
Bed occupancy	85%	98.0%	98.7%	100.3%
Safer staffing (Overall)	90%	129.7%	142.1%	132.4%
Safer staffing (Registered)	80%	116.7%	117.9%	114.6%
% of clients clinically ready for discharge	3.5%	0.0%	2.7%	3.9%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	90.9%	*90.9%*
Physical Violence (Patient on Patient)	Trend Monitor	1	2	2
Physical Violence (Patient on Staff)	Trend Monitor	3	1	1
Restraint incidents	Trend Monitor	8	7	*4*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	9	10	22

Ward 18 Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	64.0%	53.8%	96.2%
Sickness	5.0%	13.9%	7.6%	11.3%
Supervision	80%	75.0%	75.0%	75.0%
Information Governance training compliance	>=95%	95.5%	100.0%	81.5%
Reducing Restrictive Practice Interventions training compliance	>=80%	86.4%	84.6%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	86.4%	80.8%	74.1%
Fire Safety training compliance	>=85%	90.9%	92.3%	81.5%
Bed occupancy	85%	97.8%	97.7%	97.9%
Safer staffing (Overall)	90%	114.0%	108.0%	99.8%
Safer staffing (Registered)	80%	87.4%	94.3%	94.8%
% of clients clinically ready for discharge	3.5%	6.1%	6.5%	9.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	92.3%	100.0%	*95.5%*
Physical Violence (Patient on Patient)	Trend Monitor	1	5	2
Physical Violence (Patient on Staff)	Trend Monitor	4	3	5
Restraint incidents	Trend Monitor	13	8	*8*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	5	7	7

Inpatients - Mental Health - Working Age Adults

Elmdale Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	90.0%	78.3%	88.0%
Sickness	5.0%	5.2%	4.0%	3.8%
Supervision	80%	75.0%	91.7%	83.3%
Information Governance training compliance	>=95%	92.9%	96.6%	93.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	92.9%	93.1%	93.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	92.6%	96.4%	96.6%
Fire Safety training compliance	>=85%	92.9%	93.1%	83.3%
Bed occupancy	85%	98.4%	95.5%	92.1%
Safer staffing (Overall)	90%	119.5%	117.4%	121.8%
Safer staffing (Registered)	80%	101.9%	99.5%	102.4%
% of clients clinically ready for discharge	3.5%	1.4%	2.7%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	92.3%	94.7%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	4	3	1
Physical Violence (Patient on Staff)	Trend Monitor	3	10	5
Restraint incidents	Trend Monitor	2	24	*16*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*1 (100%)*
Unfilled Shifts	Trend Monitor	1	3	5

Inpatients - Mental Health - Older People Services

Crofton Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	85.7%	77.8%	87.5%
Sickness	5.0%	6.9%	3.6%	1.3%
Supervision	80%	100.0%	92.9%	100.0%
Information Governance training compliance	>=95%	88.9%	92.9%	96.2%
Reducing Restrictive Practice Interventions training compliance	>=80%	88.0%	88.5%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	84.0%	84.6%	75.0%
Fire Safety training compliance	>=85%	88.9%	92.9%	88.5%
Bed occupancy	85%	103.6%	99.8%	102.2%
Safer staffing (Overall)	90%	178.3%	177.5%	185.7%
Safer staffing (Registered)	80%	138.5%	153.5%	147.5%
% 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%	62.5%	75.0%	*90.9%*
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	5	2	2
Restraint incidents	Trend Monitor	10	0	*2*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	24	20	36

Poplars CUE Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	84.6%	89.3%	90.3%
Sickness	5.0%	11.8%	6.9%	3.8%
Supervision	80%	92.3%	92.3%	76.9%
Information Governance training compliance	>=95%	96.0%	100.0%	96.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	87.0%	78.6%	80.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	95.7%	92.9%	93.3%
Fire Safety training compliance	>=85%	96.0%	96.7%	96.9%
Bed occupancy	85%	84.1%	83.8%	81.9%
Safer staffing (Overall)	90%	220.8%	242.3%	220.5%
Safer staffing (Registered)	80%	106.0%	103.0%	99.5%
% of clients clinically ready for discharge	3.5%	16.8%	25.3%	31.2%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	0.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	5	6	0
Physical Violence (Patient on Staff)	Trend Monitor	13	7	13
Restraint incidents	Trend Monitor	13	12	*11*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	37	58	48

Inpatients - Mental Health - Older People Services

Willow Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	87.0%	75.0%	81.0%
Sickness	5.0%	13.5%	11.5%	1.3%
Supervision	80%	91.7%	66.7%	63.6%
Information Governance training compliance	>=95%	94.4%	87.5%	87.5%
Reducing Restrictive Practice Interventions training compliance	>=80%	94.4%	78.3%	79.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.2%	69.6%	58.3%
Fire Safety training compliance	>=85%	88.9%	83.3%	83.3%
Bed occupancy	85%	91.3%	88.6%	83.9%
Safer staffing (Overall)	90%	155.0%	171.6%	129.8%
Safer staffing (Registered)	80%	101.4%	98.4%	98.2%
% of clients clinically ready for discharge	3.5%	8.0%	3.7%	7.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	0.0%	*100.0%*
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	2	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	12	34	18

Beechdale Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	100.0%	100.0%	100.0%
Sickness	5.0%	10.7%	12.3%	15.2%
Supervision	80%	91.7%	100.0%	100.0%
Information Governance training compliance	>=95%	87.8%	100.0%	92.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	74.6%	92.0%	82.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.4%	95.8%	92.6%
Fire Safety training compliance	>=85%	85.0%	80.0%	85.7%
Bed occupancy	85%	91.9%	93.5%	101.4%
Safer staffing (Overall)	90%	126.7%	154.1%	130.6%
Safer staffing (Registered)	80%	101.0%	114.9%	105.8%
% of clients clinically ready for discharge	3.5%	3.7%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	85.7%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	1	3	2
Physical Violence (Patient on Staff)	Trend Monitor	6	4	0
Restraint incidents	Trend Monitor	9	8	*5*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	4	13	10

Ward 19 - Male Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	87.5%	95.7%	95.8%
Sickness	5.0%	4.2%	3.2%	0.4%
Supervision	80%	92.3%	100.0%	100.0%
Information Governance training compliance	>=95%	87.8%	92.6%	96.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	74.5%	88.9%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.3%	88.9%	92.6%
Fire Safety training compliance	>=85%	84.9%	100.0%	100.0%
Bed occupancy	85%	101.9%	101.9%	96.6%
Safer staffing (Overall)	90%	107.2%	110.2%	100.5%
Safer staffing (Registered)	80%	91.6%	82.8%	78.7%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	5.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	N/A	*83.3%*
Physical Violence (Patient on Patient)	Trend Monitor	2	0	1
Physical Violence (Patient on Staff)	Trend Monitor	4	1	1
Restraint incidents	Trend Monitor	8	2	*2*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	3	4	2

Ward 19 - Female Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	88.9%	100.0%	100.0%
Sickness	5.0%	1.6%	0.6%	0.9%
Supervision	80%	91.7%	100.0%	100.0%
Information Governance training compliance	>=95%	87.8%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	74.6%	90.5%	95.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.4%	90.5%	85.7%
Fire Safety training compliance	>=85%	85.0%	95.2%	100.0%
Bed occupancy	85%	94.8%	92.9%	93.1%
Safer staffing (Overall)	90%	97.6%	93.2%	88.2%
Safer staffing (Registered)	80%	103.5%	106.6%	93.2%
% of clients clinically ready for discharge	3.5%	0.0%	3.2%	4.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	*100.0%*
Physical Violence (Patient on Patient)	Trend Monitor	2	0	1
Physical Violence (Patient on Staff)	Trend Monitor	4	1	1
Restraint incidents	Trend Monitor	8	2	*2*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	3	1	1

Inpatients - Mental Health - Rehab

Enfield Down Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	91.5%	85.4%	95.8%
Sickness	5.0%	2.2%	2.8%	2.4%
Supervision	80%	96.2%	96.2%	96.2%
Information Governance training compliance	>=95%	97.8%	93.8%	95.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	79.5%	80.9%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.2%	86.0%	88.6%
Fire Safety training compliance	>=85%	91.1%	91.7%	89.8%
Bed occupancy	Trend Monitor	55.3%	52.8%	53.4%
Safer staffing (Overall)	90%	93.6%	94.1%	93.1%
Safer staffing (Registered)	80%	99.9%	105.2%	98.8%
% of clients clinically ready for discharge	3.5%	5.6%	5.9%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	0.0%	N/A	*N/A*
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	1	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	0	0

Lyndhurst Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	76.7%	93.3%	96.7%
Sickness	5.0%	1.5%	0.6%	0.7%
Supervision	80%	87.5%	93.8%	93.3%
Information Governance training compliance	>=95%	100.0%	96.7%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	88.9%	86.7%	86.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.2%	90.0%	96.7%
Fire Safety training compliance	>=85%	92.6%	90.0%	90.0%
Bed occupancy	Trend Monitor	69.4%	68.1%	63.6%
Safer staffing (Overall)	90%	91.1%	93.9%	94.6%
Safer staffing (Registered)	80%	86.6%	86.7%	89.8%
% of clients clinically ready for discharge	3.5%	9.3%	9.1%	9.5%
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 remain 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. All wards except for Priestley are now within compliance. An improving trajectory is noted on Priestley (63.6%) from 40% in February 2025. A number of the staff that are not compliant are due to long term sickness and maternity leave. The ward manager and general manager continue to closely review the improvement plan on a regular basis.

Medium Secure

• Six wards are above supervision compliance (Appleton, Bronte, Chippendale, Hepworth, Priestley and Johnson). Waterton, albeit below compliance at 76.9% has continued to demonstrate an improving trajectory, evidencing the embedding of plans in implementation by the Ward Manager.
• Improvements in the overall attendance compliance are noted within the medium secure service. Attendance is within compliance Appleton (1.7%), Hepworth (4.9%), Bronte (2.0%), Johnson (0.7%) and Priestley (3.1%). Significant improvements are noted on Priestley due to improvements in LTS. Sickness also remains below compliance on Chippendale (7.1%) and Waterton (11.5%) 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 Appleton (87%), Bronte (80%), Chippendale (87%), Hepworth (93.8%) and Waterton (87%) all above compliance. Improvements are noted on Johnson to 75% and Priestley has maintained compliance (74.1.%) 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, further challenges have been evident in March with a number of staff going out of date. Compliance has now been achieved on Appleton (100%), Bronte (96%) and Hepworth (100%) with hotspots identified on Chippendale (91.3%), Johnson (92.9%), Priestley (89.3%) and Waterton (87%). 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 (78.6%) are now within expected targets. Additional dates continue to be available within the forensic care group and staff are also 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 (77.8%) 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 (64.9%) 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. Bed occupancy within all other areas is within compliance.
There were no prone restraints in medium secure and incidents of violence and restraint incidents remains broadly consistent.
• Continued work and increased oversight of Priestley 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.

Low Secure

• Sickness across all wards monitored closely, and ward managers are working closely with people directorate colleagues. Improvement has been noted on Sandal (3.4%). Recent improvements in sickness absence on Ryburn and Newhaven have not been sustained, and the service are working to understand the increases in short term absence on both these wards. In part the size of the workforce on Ryburn should be considered. The size of the staff group on Ryburn does impact on the data. Thornhill (15.8%) remains a hot spot, in part impacted by long term sickness absence. A number of staff do now have support plans to return to work so improvements are expected.
• Mandatory training compliance has noted a continued improvement across all areas. A hotspot remains in Information Governance on Thornhill (92.9%). This is an improving trajectory, and plans continue to be monitored
• Bed occupancy in low secure is within compliance for Sandal and Ryburn. Thornhill is currently below expected occupancy at 79.1%; however, this is expected to be short term with current access assessments underway. Newhaven (72.6%) has had one admission in February, however, continues to experience lower level of referrals and has no waiting list.
• There have been no prone restraint incidents. An increase in acuity remains evident on Sandal and Newhaven with incidents of physical violence. A reduction in restraint incidents on Newhaven is also noted and the service have continued to access the support of wider Trust services, RRPI / safeguarding to ensure robust support plans in place to manage risks.
• Supervision is above compliance in all wards within low secure.

Appleton Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	89.5%	94.7%	94.7%
Sickness	5.4%	1.6%	1.5%	1.7%
Supervision	80%	86.7%	93.3%	93.3%
Information Governance training compliance	>=95%	95.7%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	91.3%	95.7%	95.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.3%	82.6%	87.0%
Fire Safety training compliance	>=85%	82.6%	91.3%	91.3%
Bed occupancy	90%	62.5%	62.5%	64.9%
Safer staffing (Overall)	90%	92.9%	92.1%	99.1%
Safer staffing (Registered)	80%	103.9%	101.1%	109.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	2
Restraint incidents	Trend Monitor	5	6	*7*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	2	3

Bronte Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	100.0%	100.0%	100.0%
Sickness	5.4%	0.6%	3.1%	2.0%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	94.7%	91.7%	96.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	94.7%	91.7%	88.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	89.5%	87.5%	80.0%
Fire Safety training compliance	>=85%	89.5%	91.7%	88.0%
Bed occupancy	90%	92.6%	100.0%	94.9%
Safer staffing (Overall)	90%	99.9%	96.6%	98.0%
Safer staffing (Registered)	80%	108.1%	100.3%	99.7%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	3
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	1	1	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	4	0	1

Chippendale Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	83.3%	95.2%	100.0%
Sickness	5.4%	8.0%	11.0%	7.1%
Supervision	80%	88.9%	89.5%	88.2%
Information Governance training compliance	>=95%	100.0%	100.0%	91.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	87.0%	90.5%	82.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.6%	85.7%	87.0%
Fire Safety training compliance	>=85%	91.3%	90.5%	87.0%
Bed occupancy	90%	94.1%	96.7%	91.7%
Safer staffing (Overall)	90%	130.4%	130.5%	127.6%
Safer staffing (Registered)	80%	136.3%	133.8%	127.4%
% 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	7	2	4

Hepworth Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	92.9%	92.9%	92.6%
Sickness	5.4%	3.2%	2.7%	4.9%
Supervision	80%	85.0%	84.2%	100.0%
Information Governance training compliance	>=95%	93.3%	93.5%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	90.0%	83.9%	90.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.3%	83.9%	93.8%
Fire Safety training compliance	>=85%	80.0%	87.1%	87.5%
Bed occupancy	90%	88.0%	68.1%	86.2%
Safer staffing (Overall)	90%	111.8%	115.4%	108.7%
Safer staffing (Registered)	80%	93.0%	96.0%	94.5%
% of clients clinically ready for discharge	3.5%	7.6%	1.7%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	1	0
Restraint incidents	Trend Monitor	4	4	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	4	5	3

Inpatients - Forensic - Medium Secure

Johnson Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	95.8%	96.4%	92.9%
Sickness	5.4%	7.4%	2.3%	0.7%
Supervision	80%	75.0%	93.8%	93.8%
Information Governance training compliance	>=95%	84.6%	92.6%	92.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	96.3%	96.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.9%	66.7%	75.0%
Fire Safety training compliance	>=85%	88.5%	92.6%	92.9%
Bed occupancy	90%	80.0%	80.0%	80.0%
Safer staffing (Overall)	90%	133.9%	140.4%	143.1%
Safer staffing (Registered)	80%	86.6%	99.9%	101.0%
% 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	2	0	1
Physical Violence (Patient on Staff)	Trend Monitor	2	1	1
Restraint incidents	Trend Monitor	6	0	*1*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	2	8	33

Priestley Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	52.4%	40.0%	63.6%
Sickness	5.4%	10.1%	12.4%	3.1%
Supervision	80%	85.7%	87.5%	81.3%
Information Governance training compliance	>=95%	92.0%	92.0%	89.3%
Reducing Restrictive Practice Interventions training compliance	>=80%	75.0%	79.2%	77.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.5%	75.0%	74.1%
Fire Safety training compliance	>=85%	80.0%	80.0%	78.6%
Bed occupancy	90%	85.6%	94.7%	94.1%
Safer staffing (Overall)	90%	92.2%	93.2%	90.0%
Safer staffing (Registered)	80%	86.0%	91.4%	91.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	1	0	4

Waterton Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	95.5%	95.5%	95.2%
Sickness	5.4%	7.5%	10.0%	11.5%
Supervision	80%	42.9%	64.3%	76.9%
Information Governance training compliance	>=95%	100.0%	95.7%	87.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	82.6%	82.6%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.0%	73.9%	87.0%
Fire Safety training compliance	>=85%	95.7%	100.0%	91.3%
Bed occupancy	90%	95.4%	98.7%	100.0%
Safer staffing (Overall)	90%	118.9%	125.1%	145.1%
Safer staffing (Registered)	80%	96.6%	97.3%	102.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	2
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	4	1	16

Inpatients - Forensic - Low Secure

Thornhill Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	76.9%	86.4%	91.7%
Sickness	5.4%	9.7%	16.5%	15.8%
Supervision	80%	78.6%	92.9%	85.7%
Information Governance training compliance	>=95%	96.0%	87.5%	92.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	96.0%	91.7%	92.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	92.0%	91.7%	89.3%
Fire Safety training compliance	>=85%	100.0%	95.8%	89.3%
Bed occupancy	85%	79.8%	73.1%	79.1%
Safer staffing (Overall)	90%	102.4%	121.6%	119.8%
Safer staffing (Registered)	80%	100.1%	119.1%	110.7%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	5	5	5

Sandal Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	70.8%	66.7%	96.0%
Sickness	5.4%	9.4%	5.7%	3.4%
Supervision	80%	94.4%	94.4%	94.4%
Information Governance training compliance	>=95%	96.4%	93.8%	96.9%
Reducing Restrictive Practice Interventions training compliance	>=80%	92.9%	90.6%	96.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.7%	81.3%	84.4%
Fire Safety training compliance	>=85%	96.4%	96.9%	93.8%
Bed occupancy	85%	86.1%	87.7%	89.5%
Safer staffing (Overall)	90%	130.2%	124.7%	113.0%
Safer staffing (Registered)	80%	116.8%	122.6%	117.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	1	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	3
Restraint incidents	Trend Monitor	0	2	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	17	10	20

Inpatients - Forensic - Low Secure

Ryburn Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	100.0%	100.0%	100.0%
Sickness	5.4%	14.7%	0.0%	6.2%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	>=80%	100.0%	90.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	100.0%	90.0%	80.0%
Fire Safety training compliance	>=85%	100.0%	100.0%	100.0%
Bed occupancy	85%	84.3%	93.4%	80.2%
Safer staffing (Overall)	90%	99.3%	99.1%	98.9%
Safer staffing (Registered)	80%	100.1%	100.0%	99.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	0	0

Newhaven Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	66.7%	83.8%	86.1%
Sickness	5.4%	6.0%	3.9%	7.2%
Supervision	80%	95.0%	86.4%	90.5%
Information Governance training compliance	>=95%	92.3%	95.2%	97.6%
Reducing Restrictive Practice Interventions training compliance	>=80%	88.9%	84.2%	86.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	86.1%	84.2%	81.6%
Fire Safety training compliance	>=85%	84.6%	83.3%	85.7%
Bed occupancy	85%	62.5%	66.5%	72.6%
Safer staffing (Overall)	90%	96.7%	108.7%	110.9%
Safer staffing (Registered)	80%	101.5%	104.3%	105.6%
% 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	3	0
Physical Violence (Patient on Staff)	Trend Monitor	5	7	6
Restraint incidents	Trend Monitor	7	12	*0*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	1 (100%)	*0*
Unfilled Shifts	Trend Monitor	6	5	4

Inpatients - Non-Mental Health

• Appraisal rate:
Neurological Rehabilitation Unit (NRU) is showing as 87.2% for March which achieves the new compliance figure of 85%.
Stroke Rehabilitation Unit (SRU) has increased to 83.9% for March which is much closer to compliance and is continuing to increase into April – as at 17.4.25 the figure has improved further to 87.5%.
For SRU, there have been some technical issues regarding appraisals being input onto ESR but not showing on the dashboard. New interim Stroke Team Manager has liaised with People Planning and Performance Lead who has investigated this and logged the data on our behalf whilst the issue is corrected.

• Sickness:
NRU – sickness has improved again for March with a reduction from 7.1% to 6.8%. To members of staff remain on long term sickness which is impacting this figure. This is being managed via HR processes and sickness reviews.
SRU – Sickness for March has increased to 7.7%; this continues to be a mixture of ward and ESD (Early Supported Discharge). Some of this was short term and staff have now returned to work. However, there were also some significant illnesses / infections (no trends / patterns) with some sickness absence that has continued into April. This is being managed via HR processes and sickness reviews.

• Supervision:
NRU has seen a further increase to maintain compliance, showing 87.5% for March.
SRU figures for March have seen a good improvement to achieve compliance at 86.1%, following completion of supervision training by new team manager.

• Information Governance:
NRU – a slight drop below compliance to 91.3% for March. Some staff have now completed this training in early April and remaining staff have had targeted reminder.
SRU – has seen a further increase to above compliance this month at 98.6%.

• Cardiopulmonary resuscitation (CPR):
NRU – a good increase in March to achieve compliance at 84.1% - this reflects the training that was upcoming at the time of the last report.
SRU – a decrease in March below compliance at 71.2%. 2 staff have now completed their training and 5 more are booked on during April.
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.

• Fire Training:
NRU – a small reduction during March to 84.8% which is very slightly below compliance. Bespoke fire training has been booked for early May which is the earliest that training colleagues could facilitate.

Neuro Rehabilitation Unit (NRU) Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	87.5%	80.5%	87.2%
Sickness	5.0%	8.3%	7.1%	6.8%
Supervision	80%	77.8%	85.2%	87.5%
Information Governance training compliance	>=95%	97.4%	97.7%	91.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.3%	78.0%	84.1%
Fire Safety training compliance	>=85%	92.1%	86.0%	84.8%
Bed occupancy (Barnsley Commissioned beds only)	80%	67.7%	55.7%	71.8%
Safer staffing (Overall)	90%	112.2%	113.6%	116.5%
Safer staffing (Registered)	80%	114.0%	104.3%	94.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Unfilled Shifts	Trend Monitor	0	0	0

Stroke Rehabilitation Unit (SRU) Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	79.4%	80.3%	83.9%
Sickness	5.0%	3.9%	3.4%	7.7%
Supervision	80%	92.5%	79.5%	86.1%
Information Governance training compliance	>=95%	93.8%	95.7%	98.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.1%	83.1%	71.2%
Fire Safety training compliance	>=85%	95.3%	95.7%	88.6%
Bed occupancy	80%	98.1%	99.1%	99.5%
Safer staffing (Overall)	90%	107.0%	108.5%	95.5%
Safer staffing (Registered)	80%	135.4%	144.0%	119.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Unfilled Shifts	Trend Monitor	0	0	0

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 continues to monitor closely and is within compliance at 91.2%
• Plans in place by the ward manager to improve supervision compliance are demonstrating effectiveness and this now within compliance at 84.2%.
• Mandatory training compliance remains positive, with a hotspot in Information Governance (92.5%) due to staff requiring updates. Plans are in place to address.
Improvements noted in sickness and absence, and this is now within compliance at 3.6%.

Horizon Metrics	Threshold	Jan-25	Feb-25	Mar-25
Appraisal rate	Jan - 78.3% Feb - 82.3% Mar - 84.9%	90.9%	87.9%	91.2%
Sickness	5.0%	9.4%	5.5%	3.6%
Supervision	80%	78.9%	73.7%	84.2%
Information Governance training compliance	>=95%	100.0%	97.4%	92.5%
Reducing Restrictive Practice Interventions training compliance	>=80%	93.5%	89.5%	92.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	90.3%	84.2%	82.1%
Fire Safety training compliance	>=85%	90.6%	94.9%	95.0%
Bed occupancy	N/A	60.5%	68.8%	67.3%
Safer staffing (Overall)	90%	167.7%	198.4%	172.7%
Safer staffing (Registered)	80%	163.9%	164.2%	170.3%
% of clients clinically ready for discharge	3.5%	80.0%	55.4%	55.7%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	100.0%	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	43	9	24
Restraint incidents	Trend Monitor	39	15	*36*
Prone Restraint incidents (under 3 minutes)	Trend Monitor	0	0	*0*
Unfilled Shifts	Trend Monitor	0	0	0

The following section highlights the performance against the Trust's strategic objectives and priority change and ongoing improvement programmes.
The Trust has in place a robust system for the development, agreement and governance of these priority areas of work: Framework for governance and assurance.
Programme plans are in place with key agreed milestones identified and reporting against these will be provided at the identified date or by exception.
Progress against milestones and other updates by exception are reported in this section.

Progress key	
G	On track against plan and/or on schedule with/in agreed timescales
A	Needs additional action to stay on track and/or on schedule
R	Not on track and/or at risk of not delivering within agreed timescales. Requires review
B	Completed

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving health	Address inequalities involvement and equality in each of our places with our partners	The Equality Diversity and Inclusion (EDI) strategy has been agreed by the Equality, Involvement and Inclusion Committee and has been 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 commenced in post on the 1st April. Work to deliver the Patient and Carer Race Equality Framework (PCREF) is being coproduced with over 150 community connectors and representatives from across the Trustwide footprint. The implementation plan has been developed and a soft launch is planned for early April Our Equality Delivery System (EDS) 2022 assessment has been finalised and we have received a grading of 'achieving'. In 2025/26 there is a Trust priority to reduce inequalities and better describe our impact on those we serve. A co-ordination group will be developed from a review of current governance structure underneath the Board committee.	
Improving care	Transform our Older People inpatient services	Activity continues to progress on the operational plan to deliver the new model of care, which was approved in 2024/25. Estates procurement is progressing (Crofton) with tender review being held in April 2025 – start and target completion dates not yet confirmed, now due in the next period. Operational Work strand: Meetings with ward managers held place to review current and future establishments, safer staffing inpatient exercise has taken place and outputs will be used to review against staffing establishment. The work strands that the SWYPFT implementation group oversees are as follows: Estates; Workforce and Operational Delivery; In reach / Partnership; Clinical pathways and staff development; Travel and Transport This programme of work will continue through 2025/26 with the aim of the new model going live early in the 2026/27 financial year.	
	Improve our mental health services so they are more responsive, inclusive and timely	**Care Closer to Home (CC2H):** • Work continues on maintaining a low out of area presence and quality monitoring the impact on both inpatient services and community teams. • In 2024/25 we have standardised the structure, leadership and outputs of barriers to discharge and MADE meetings. Clinically Ready for Discharge initiative has been implemented across service lines and staff have been trained on the criteria led discharge tool. Pathways have been developed for supporting people who are homeless. • In 25/26 discharge activity will focus on enhancing community offer to improve timely discharge in 2025/26. Work with IHBT and other teams on admission avoidance and there will be continued activity on patient flow. **Improving Access to Care** • Memory services initiative: comprehensive process maps have been developed and similarities/differences and themes across the places have been identified, as well as shared learning. • Activity has taken place with psychology leads including workshops which explored challenges and opportunities and an initial paper has been established to capture these. • In 2025/26, a follow-up memory services workshop has been arranged for April 2025 for shared learning and generating change ideas. A follow up workshop on Psychology waits has been scheduled for May 2025. • For both, work will take place to prioritise, define improvement initiatives and develop an action plan for implementation, following by commencement of the improvement work. • Access and waiting has been identified as a focus area across a number of the Care Groups annual plans for 2025/26. **Inpatient Improvement:** • Four wards are actively engaged in the NHSE culture of care programme – benchmarked against NHSE standards. A trauma informed approach has been implemented and embedded on Clark ward and aligned to the culture of care programme. All inpatient wards have benchmarked themselves against standards as part of the triangle of care initiative, developed improvement plans which are being implemented. The RRPI team now working directly into the inpatient improvement programme. • Creative approaches have been implemented across the year, the Hospital Rooms project has delivered improvements in the environment of many wards in 24/25. Creative practitioners have been introduced with positive staff and patient feedback with improvements in gym training, music in care & therapy, dog visits. • An inpatient outcomes dashboard has been developed and quality & performance oversight meeting is now embedded within the service. Examples of improvement in performance are appraisal rates (prior to WorkPal closure), recording of section 17 leave, targeted prone restraint improvements. • A preceptorship package has been developed and implemented to support newly registered and internationally educated nurses in our bid to develop a confident and competent workforce and actions from the health & wellbeing plan have been implemented. • A robust governance has been developed to support roster planning and a deep dive has taken place into the use of temporary staff across adult and older adult inpatient services, resulting in improvement actions. • A roll out of trauma informed pathways is planned for Elmdale & Nostell wards. • The culture of care programme is to continue across 4 wards in 25/26 with the intention to roll out across all wards in 26/27. In 2024/25, the culture of care programme has been supported by 2 staff in integrated change team. It has a £54K budget for the programme for 25/26 with some resource committed and £22K yet to allocate. • **Forensic pathways**: Work has started with the Forensic Care Group on the plan to review interventions and improve systems and pathways. This includes a programme of improvement linked to dashboard and data use improvements and a social work interventions review has taken place with Wakefield Local Authority. • Continued development and implementation for Forensic programme is to take place in 2025/26.	

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving care	Improve safety and quality	**Care Planning & Risk Assessment** The new care plan went live on SystmOne on 6th January 2025. 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 2025 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	VfM initiatives have supported Trust achievement of break even in 2024/25. The VFM programme board has been established in 2024/25 to ensure effective governance is in place and now oversees numerous initiatives that aim to deliver financial sustainability to the Trust, with governance supported and coordinate with the Integrated Change Team. The non-pay delivery group has overseen a range of activities, for example, the patient transport programme has established a new SOP (Safe Patient Transport Procedure) and working to the principles of it, has saved approximately £100K to end of December 2025, compared with spending in the previous year. The transport programme is set to conclude and be passed to business as usual in June 2025. The non-pay programme has overseen a reduction in assessment centres and recruitment fairs and different procurement activity around purchase of laptops etc that have created “cost avoidance”. A range of other activity has taken place across the VfM programme. For example, a CAMHS on call review of opportunities took place through 2024 and identified potential options to progress, though this programme currently paused and may restart if prioritised as part of 25/26 activity. Additional activity has taken place in 2024/25 to identify key lines of enquiries and establish project initiation documentation for activity that will by priorities for the 2025/26 programme. In 2025/26, Making the most of our resources, increasing efficiency and living within our means has been identified as a key priority for the Trust which requires support to move at pace.	
	Make digital improvements	**Digital Dictation** The project continues to report green following a period of escalation. Deployment for north and south Kirklees and Calderdale groups has taken place. Preparing Calderdale and Kirklees CAMHS and Barnsley CAMHS from April 2025 and Wakefield CAMHS postponed to May whilst the list of users is completed. A trial of Lexacom Echo Scribe is to 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		2024/25 Outturn	Narrative
1	Surplus / (Deficit)	£0.2m	The Trust financial target for 2024 / 25 is breakeven. This has been achieved with a small unaudited surplus of £245k.
2	Agency Spend	£6.4m	Agency expenditure run rate has continued to fluctuate but throughout the year has remained lower than the national target (3.2% of total pay expenditure). Spend in March 2025 is £422k which is £77k lower than February. Overall Quarter 4 expenditure is £200k less than Quarter 3. Sustained run rate reductions are required for 2025 / 26 in order to meet internal and external targets.
3	Financial sustainability and efficiencies	£20.6m	The Trust financial sustainability programme for 2024 / 25 has a target of £22.0m to achieve the breakeven target. Overall £20.6m has been achieved which is £1.4m behind plan (6.4%). Throughout the year the main driver is within the workforce optimisation scheme with more worked whole time equivalents (WTE) than planned. This has been partially mitigated in the final position through non-recurrent mitigations.
4	Cash	£55.7m	Cash has continued to reduce month on month throughout 2024 / 25. This has stabilised in Quarter 4 and despite the payment of Public Dividend Capital (PDC) of £2.2m in March has maintained at a similar level. It is expected to reduce further in April / May 2025 as outstanding invoices are paid although this will be partially offset by recovery of accrued income.
5	Capital	£7.5m	The Trust has received a number of capital allocations within the year and a breakdown is provided within the capital detail page in the Finance appendix. Against the original core allocation (£8.1m) expenditure is £7.5m which is £0.6m less than planned (7%). This has been offset by additional expenditure within the IFRS 16 (leases) allocation. For 2025 / 26 this will be a singular allocation covering all capital expenditure.
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	Jan-25	Feb-25	Mar-25	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	98.4%	95.5%	100.0%	Based on all current inpatients (71 as at 31/03/2025)
Percentage of service users who have had their equality data recorded - disability	50%	100.0%	100.0%	100.0%	Based on all current inpatients (71 as at 31/03/2025)
Percentage of service users who have had their equality data recorded - sexual orientation		93.7%	87.9%	91.5%	
Completion of equality mandatory training	>=80%	100.0%	99.0%	99.0%	99% of ward; 98% central support services staff; 96% of clinical staff

Improving Care

Metrics	Trust Threshold	Jan-25	Feb-25	Mar-25	Notes
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	1	1	1	Out of a total number (23) of violence and aggression incidents occurred in March 2025

Make SWYPFT a great place to work

Metrics	Trust Threshold	Jan-25	Feb-25	Mar-25	Notes
Turnover external (in month)	>12% - 13%<	0.9%	1.6%	1.9%	Data not Provided/Received
Sickness absence - In month	<=5.4%	6.9%	4.2%	3.7%	Data not Provided/Received
Staff supervision rate	80%	80.0%	79.0%	82.0%	
Mandatory training - Cardiopulmonary resuscitation	80%	94.0%	94.0%	92.0%	includes training for Immediate Life Support, Basic Life Support
Mandatory training - Reducing restrictive physical interventions (RRPI)	80%	93.0%	91.0%	89.0%	includes training for Prevention and Management of Violence and Aggression and Breakaway
Mandatory training - Fire	85%	98.0%	97.0%	94.0%	
Mandatory training - Information governance (IG)	95%	98.0%	98.0%	94.0%	

Appendix 1 - Cheswold Park Hospital

NHS South West Yorkshire Partnership NHS Foundation Trust

Quality Headlines

Section	KPI	Trust Threshold	Jan-25	Feb-25	Mar-25
Complaints	% of feedback with staff attitude as an issue	< 20%	0% (0/6)	0% (0/5)	0% (0/14)
	Complaints - Number of responses provided within six months of the date a complaint received	100.0%	50.00% (3/6)	80.00%(4/5)	71.42% (10/14)
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)	93.75% (60/64)	93.93% (62/66)
	Number of Information Governance breaches	<12	2	1	0
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95.0%	100% (2/2)	100% (3/3)	No admissions
	Total number of reported incidents	Trend monitor	200	131	128
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available)	Trend monitor	3	2	2
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available)	Trend monitor	0	0	0
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available)	Trend monitor	0	0	0
	Safer staff fill rates (% Overall)	90%	95.0%	96.2%	91.6%
	Safer Staffing % Fill Rate - Registered Nurses Overall	80%	102.2%	107.0%	95.7%
	Safer Staffing % Fill Rate - Registered Nurses Days	80%	95.9%	107.8%	91.4%
	Safer Staffing % Fill Rate - Registered Nurses Nights	80%	111.0%	106.4%	101.7%
	% of prone restraint with duration of 3 minutes or less	90%	No prone restraints	No prone restraints	No prone restraints
	Number of Falls (inpatients)	Trend monitor	2	0	0
	Number of restraint incidents	Trend monitor	6	7	8
	% of staff receiving supervision within policy guidance	80.0%	80.0%	79.0%	82.0%
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	0	0	0	1

Quality Headlines

Number of Information Governance breaches - No incidents reported in March 2025.

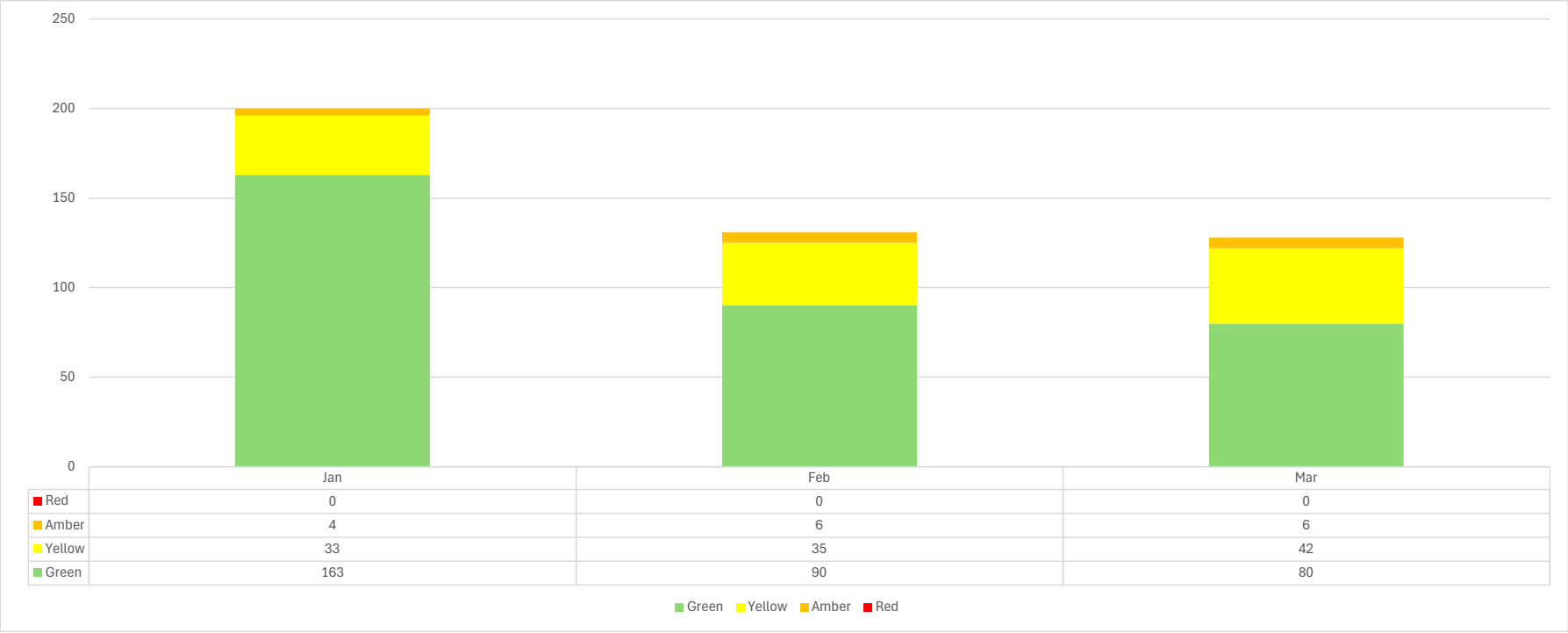
Appendix 1 - Cheswold Park Hospital

Safety First

Summary of Incidents

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

81.25% of incidents occurred in March 2025 resulted in No harm or injury occurred.
No incident related to Severe - permanent and significant/long term harm occurred in March 2025.
No never events, or incident resulted in major, catastrophic harm or death occurred in March 2025.



	Jan	Feb	Mar
Red	0	0	0
Amber	4	6	6
Yellow	33	35	42
Green	163	90	80

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

Breakdown of incidents in March 2025 - 2 moderate harm incident:

The most common cause(s) for these incidents were due to Medication, Self Harm, Safer Staffing, Security Breaches, Legislation and Policy and Violence and aggression.

No severe harm incidents

Appendix 1 - Cheswold Park Hospital

Safeguarding

Safeguarding Adults:
There were 4 safeguarding adult incidents in March 2025.

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

Complaints

- There were 12 new complaints in March. 10 were Local Resolutions and 2 were formal. All of the complaints received were regarding inpatients.
- Of the 12 new complaints received, 10 are noted as 'closed', 2 are 'Remains open'.
- 10 Complaints were closed in March 2025.
- 9 compliments were received in March 2025.

Reducing Restrictive Physical Intervention (RRPI)

- There were 8 restraint related incidents occurred in March 2025, making up 6.25% (8/128) of the total March 2025 incidents.
- As in March 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	Jan-25	Feb-25	Mar-25
Establishment	Improving Resources	Well Led	-	324.1	335.7	335.7
Contracted Staff In Post (Ledger)			-	322.0	321.5	316.4
Vacancies			-	-2.0	14.2	19.3
Turnover external			>12% - <13%	0.9%	1.6%	1.9%
Starters			-	0.0	0.5	1.0
Leavers			-	3.0	4.0	6.7
International Nurse Starters in Month			-	0	0.0	0.0
% Bank Fill Rates - Registered Nurses			-	7.10%(54/760)	8.47%(61/720)	13.06%(90/689)
% Bank Fill Rates - Health Care Assistants			-	16.23%(314/1934)	19.44%(366/1882)	25.57%(476/1861)
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)			-	13.65%(368/2694)	16.41%(427/2602)	22.19%(566/2550)
Sickness absence - Month			<=5%	6.9%	4.2%	3.7%
Employees with long term sickness over 12 months			-	1	0	0
Appraisals - rolling 12 months			95%	79.0%	73.0%	78.4%
Employee Relations - Suspensions (over 90 days)			-	0	0	0
Mandatory Training - TOTAL	Improving Care		>=80%	98.0%	98.0%	98.0%
Mandatory Training - Reducing Restrictive Practice Interventions				93.0%	91.0%	89.0%
Mandatory Training - Cardiopulmonary Resuscitation				94.0%	94.0%	92.0%
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%	99.0%	99.0%
Mandatory Training - Fire Safety			>=85%	98.0%	97.0%	94.0%
Mandatory Training - Food Safety			>=80%	99.0%	100.0%	100.0%
Mandatory Training - Freedom To Speak Up (FTSU)				99.0%	100.0%	100.0%
Mandatory Training - Infection Control & Hand Hygiene				100.0%	98.0%	96.0%
Mandatory Training - Information Governance (Data Security)			>=95%	98.0%	98.0%	94.0%
Mandatory Training - Moving & Handling			>=80%	98.0%	97.0%	94.0%
Mandatory Training - Mental Capacity Act/Dols				97.0%	97.0%	95.0%
Mandatory Training - Mental Health Act				97.0%	97.0%	95.0%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				97.0%	98.0%	99.0%
Mandatory Training - Prevent			>=80%	N/A	N/A	N/A
Mandatory Training - Safeguarding Adults				98.0%	97.0%	96.0%
Mandatory Training - Safeguarding Children				98.0%	97.0%	96.0%

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 12 (2024 / 25)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

Key Performance Indicator		2024 / 25 Outturn	Narrative
1	Surplus / (Deficit)	£0.2m	The Trust financial target for 2024 / 25 is breakeven. This has been achieved with a small unaudited surplus of £245k.
2	Agency Spend	£6.4m	Agency expenditure run rate has continued to fluctuate but throughout the year has remained lower than the national target (3.2% of total pay expenditure). Spend in March 2025 is £422k which is £77k lower than February. Overall Quarter 4 expenditure is £200k less than Quarter 3. Sustained run rate reductions are required for 2025 / 26 in order to meet internal and external targets.
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5	Capital	£7.5m	The Trust has received a number of capital allocations within the year and a breakdown is provided within the capital detail page. Against the original core allocation (£8.1m) expenditure is £7.5m which is £0.6m less than planned (7%). This has been offset by additional expenditure within the IFRS 16 (leases) allocation. For 2025 / 26 this will be a singular allocation covering all capital expenditure.
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.

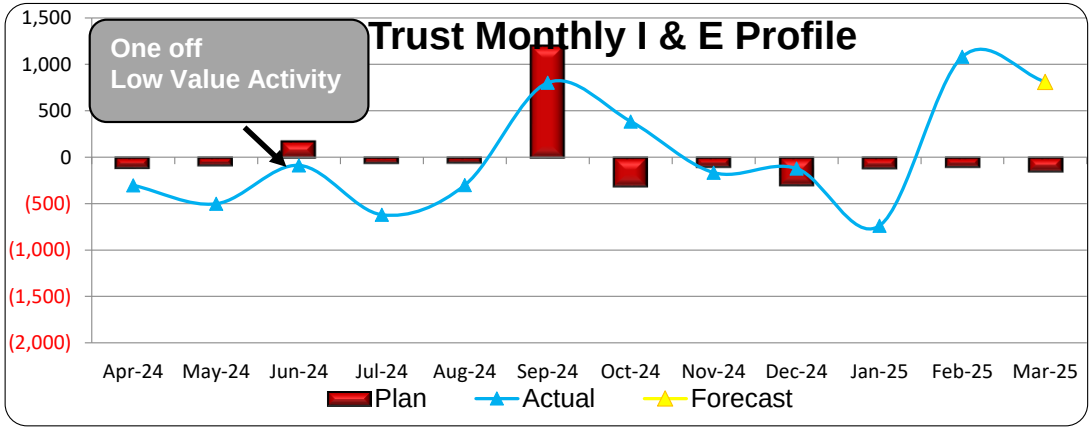
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

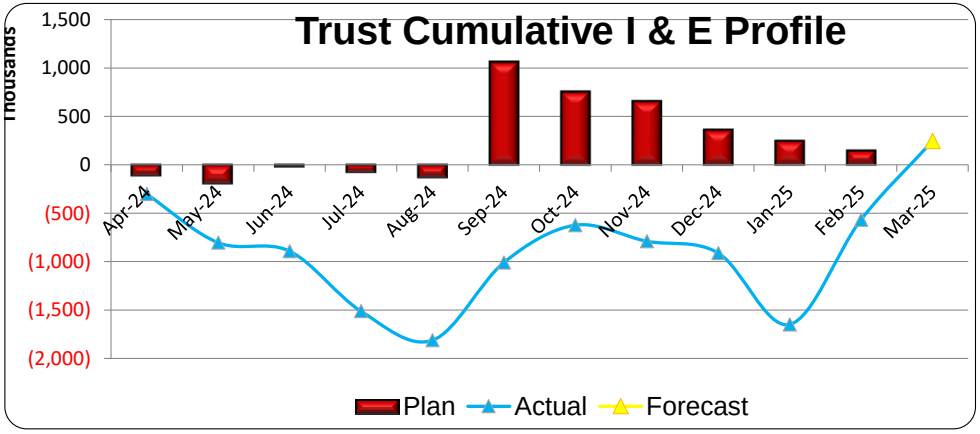
2.0 Income & Expenditure Position 2024 / 25

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					38,697	40,242	1,545	433,643	437,385	3,742	433,643	437,385	3,742
Other Operating Revenue					18,120	18,496	376	33,429	34,751	1,322	33,429	34,751	1,322
Total Revenue					**56,816**	**58,738**	**1,921**	**467,072**	**472,136**	**5,064**	**467,072**	**472,136**	**5,064**
Pay Costs	5,434	5,451	17	0.3%	(40,873)	(40,476)	398	(294,650)	(296,105)	(1,455)	(294,650)	(296,105)	(1,455)
Non Pay Costs					(15,518)	(16,582)	(1,063)	(166,533)	(169,373)	(2,841)	(166,533)	(169,373)	(2,841)
Gain / (loss) on disposal					0	(25)	(25)	0	(0)	(0)	0	(0)	(0)
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,434**	**5,451**	**17**	**0.3%**	**(56,392)**	**(57,082)**	**(690)**	**(461,182)**	**(465,478)**	**(4,296)**	**(461,182)**	**(465,478)**	**(4,296)**
EBITDA	**5,434**	**5,451**	**17**	**0.3%**	**425**	**1,656**	**1,231**	**5,890**	**6,658**	**768**	**5,890**	**6,658**	**768**
Depreciation					(598)	(631)	(33)	(6,742)	(6,774)	(32)	(6,742)	(6,774)	(32)
PDC Paid					(274)	(456)	(182)	(2,718)	(3,351)	(633)	(2,718)	(3,351)	(633)
Interest Received					299	242	(56)	3,570	3,712	142	3,570	3,712	142
Surplus / (Deficit) - ICB performance measure	**5,434**	**5,451**	**17**	**0.3%**	**(148)**	**812**	**960**	**(0)**	**245**	**245**	**(0)**	**245**	**245**
Depn Peppercorn Leases (IFRS16)					(5)	(16)	(11)	(94)	(105)	(11)	(94)	(105)	(11)
Revaluation of Assets					0	(76)	(76)	0	(12,031)	(12,031)	0	(12,031)	(12,031)
Surplus / (Deficit) - Total	**5,434**	**5,451**	**17**	**0.3%**	**(153)**	**720**	**873**	**(94)**	**(11,891)**	**(11,797)**	**(94)**	**(11,891)**	**(11,797)**





Income & Expenditure Position 2024 / 25

The unaudited financial outturn for 2024 / 2025 is a surplus of £245k.
As such this acheives the financial target of breakeven.

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)	5,063	5,077	13	0.3%	1,344	720	(624)	(340)	(1,070)	(730)	(340)	(1,070)	(730)
Cheswold Park Hospital	336	341	5	1.4%	111	23	(88)	665	127	(538)	665	127	(538)
Provider Collaboratives	23	34	11	47.8%	2	(966)	(968)	29	(1,136)	(1,165)	29	(1,136)	(1,165)
Budgets held centrally	12	0	(12)	100.0%	(1,606)	1,036	2,641	(354)	2,324	2,678	(354)	2,324	2,678
Total - Consolidated position (ICB performance measure)	**5,434**	**5,451**	**17**	**0.3%**	**(148)**	**812**	**960**	**(0)**	**245**	**245**	**(0)**	**245**	**245**

As this is the final position for 2024 / 25 a number of items / issues previously included within the Trust forecast modelling, and reported against the budgets held centrally line, have been realised. Where appropriate, and as far as possible, these have been included within the Trust (core) year end position. Overall the Trust (core) is a deficit of £1,070k with the overall £245k surplus made possible through non-recurrent mitigations (and reported against the budgets held centrally line).

Cheswold Park Hospital has reported a small surplus in month, and for the year, with a small positive contribution to Trust overheads costs. This has been lower than plan and work continues to ensure that income is maximised (with a focus on occupancy which helps the provider collaborative to repartiate and reduce their cost pressures) and costs incurred represent value for money. Both of these workstreams will be validated against the original business case assumptions.

All provider collaboratives, both those lead by the Trust and those for which it is a partner, have reported financial deficits in 2024 / 25. The only exception is Forensic CAMHS for which the Trust has been the lead for a longer time period. There has been movement in month with an increased deficit reported and the detail of this is provided to the Trust Finance, Investment and Performance (FIP) committee.

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.

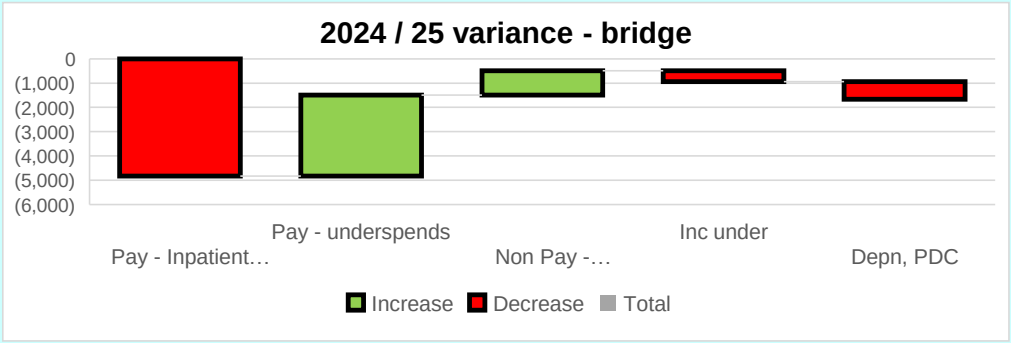
To confirm that the individual analysis within this report highlights the Trust only values.

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					27,933	27,884	(50)	312,747	312,292	(455)	312,747	312,292	(455)
Other Operating Revenue					1,333	1,500	167	14,900	15,446	546	14,900	15,446	546
Total Revenue					**29,267**	**29,384**	**117**	**327,647**	**327,738**	**91**	**327,647**	**327,738**	**91**
Pay Costs	5,063	5,077	13	0.3%	(22,706)	(22,672)	33	(267,935)	(269,036)	(1,101)	(267,935)	(269,036)	(1,101)
Non Pay Costs					(4,812)	(5,153)	(341)	(55,170)	(54,161)	1,009	(55,170)	(54,161)	1,009
Gain / (loss) on disposal					0	(25)	(25)	0	(0)	(0)	0	(0)	(0)
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,063**	**5,077**	**13**	**0.3%**	**(27,518)**	**(27,850)**	**(333)**	**(323,105)**	**(323,197)**	**(92)**	**(323,105)**	**(323,197)**	**(92)**
EBITDA	**5,063**	**5,077**	**13**	**0.3%**	**1,749**	**1,533**	**(216)**	**4,542**	**4,541**	**(1)**	**4,542**	**4,541**	**(1)**
Depreciation					(525)	(695)	(170)	(6,304)	(6,542)	(238)	(6,304)	(6,542)	(238)
PDC Paid					(179)	(361)	(182)	(2,148)	(2,781)	(633)	(2,148)	(2,781)	(633)
Interest Received					299	242	(56)	3,570	3,712	142	3,570	3,712	142
Surplus / (Deficit) - ICB performance measure	**5,063**	**5,077**	**13**	**0.3%**	**1,344**	**720**	**(624)**	**(340)**	**(1,070)**	**(730)**	**(340)**	**(1,070)**	**(730)**
Depn Peppercorn Leases (IFRS16)					(5)	(16)	(11)	(94)	(105)	(11)	(94)	(105)	(11)
Losses Peppercorn Leases (IFRS16)					0	(76)	(76)	0	(12,031)	(12,031)	0	(12,031)	(12,031)
Surplus / (Deficit) - Total	**5,063**	**5,077**	**13**	**0.3%**	**1,339**	**628**	**(711)**	**(434)**	**(13,206)**	**(12,773)**	**(434)**	**(13,206)**	**(12,773)**

As highlighted on the previous page a surplus, although less than the plan in month, has been reported for March 2025. This includes items which have been moved from budgets held centrally (and included in the Trust forecast modelling) into the core Trust financial position.

Key headlines are included below and illustrated within the bridge:	£k
Workforce utilised more than plan - Adult inpatient, Forensics, Older People wards	(4,830)
Workforce utilised less than plan - Barnsley physical health, Children's Young People & Families, corporate services	3,334
Non Pay underspends - most categories. Primarily mental health care group and Barnsley physical health.	1,009
Income under recovery based on actuals offset by underspends in pay and non pay - salary recharges, Smokefree drugs	(455)
Movements in depreciation and public dividend capital	(729)

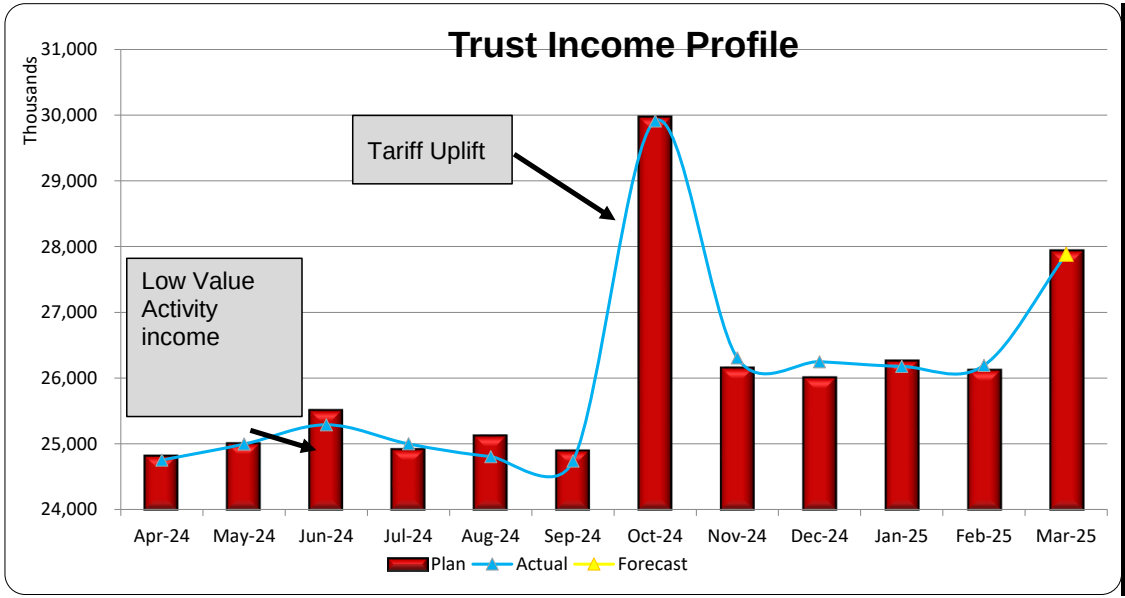


2.1 Income Information

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	23,720	**265,839**	265,733	106
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	3,050	**36,788**	36,681	107
Local Authority	**5,799**	378	400	371	398	377	360	381	684	314	410	589	479	**5,141**	5,490	(348)
Partnerships	**6,748**	205	219	191	218	207	207	222	293	222	228	226	501	**2,940**	3,022	(82)
Other Contract Income	**1,454**	131	220	37	135	121	131	136	140	129	138	131	134	**1,583**	1,837	(253)
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**	**27,884**	**312,292**	**312,763**	**(471)**
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	10,646	**115,014**		
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**	**38,530**	**427,306**		



In March 2025 additional income has been received which has supported the achievement of the Trust financial target. Key values were factored into the Trust forecast modelling, but now has an agreed valuation; some of which were more than expected.

Overall, due to the block nature, the majority of income has been received in line with agreed contracts. This has been received as cash payments and therefore present no financial risk in the year end position.

Where there has been under recovery of income, against plan, in year this is offset by underspend on costs including reimbursement for Additional Roles Reimbursement Scheme (ARRS), Smokefree services and Youth Offenders Institute sub contract.

Baseline line contract values, incorporating current assumptions on tariff uplifts, have been agreed with commissioners for 2025 / 26.

2.2 Pay Information

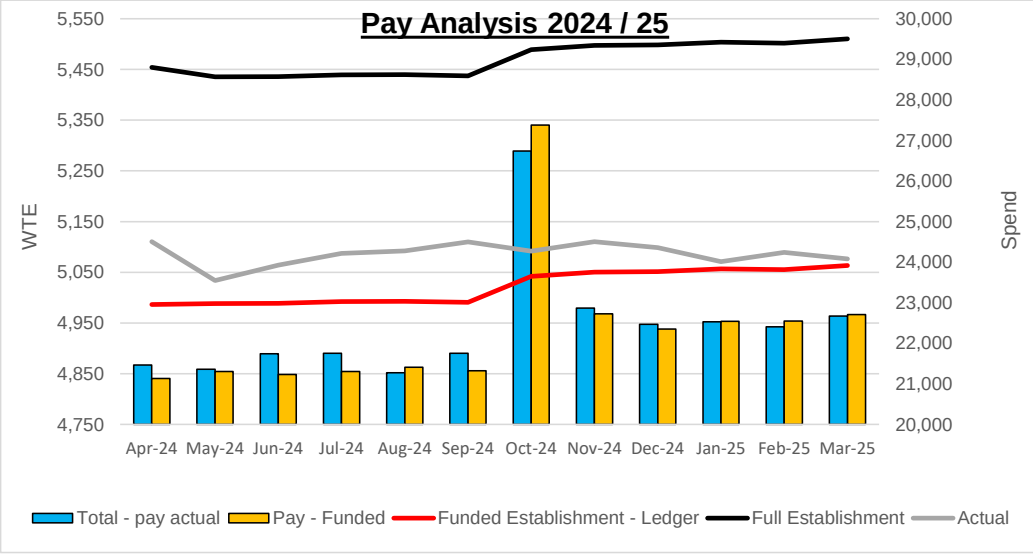
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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	20,490	**242,366**
Bank & Locum	1,955	1,581	1,673	1,738	1,771	1,827	1,980	1,793	1,770	1,732	1,724	1,859	**21,405**
Agency	413	400	444	510	429	434	561	452	484	418	397	323	**5,265**
Total	**21,466**	**21,360**	**21,739**	**21,751**	**21,275**	**21,756**	**26,741**	**22,870**	**22,469**	**22,529**	**22,408**	**22,672**	**269,036**
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%	8.2%	8.0%
Agency as % (in month)	1.9%	1.9%	2.0%	2.3%	2.0%	2.0%	2.1%	2.0%	2.2%	1.9%	1.8%	1.4%	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	4,588	**4,588**
Bank & Locum	474	401	411	435	456	460	431	445	437	418	429	436	**436**
Agency	62	59	62	74	71	62	70	62	60	57	59	53	**63**
Total	**5,110**	**5,034**	**5,064**	**5,087**	**5,092**	**5,110**	**5,092**	**5,110**	**5,098**	**5,071**	**5,089**	**5,077**	**5,086**
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**



This position remains for the cost Trust position. As such this excludes the notional expenditure (which is offset by notional income) for NHS pension contributions which have been paid directly. For 2025 / 26 this equated to £16.7m and by excluding from this presentation helps with comparability.

Expenditure has increased by £264k (1%) in March 2025 with the largest increase in bank and locum costs. This is reflected in the increase of bank and locum WTE worked in month. This is typical at year end which normally sees an increase in temporary staffing.

For March 2025 this has been bank and locum increases with a reduction of 6 WTE in agency. Further details are provided on page 9.

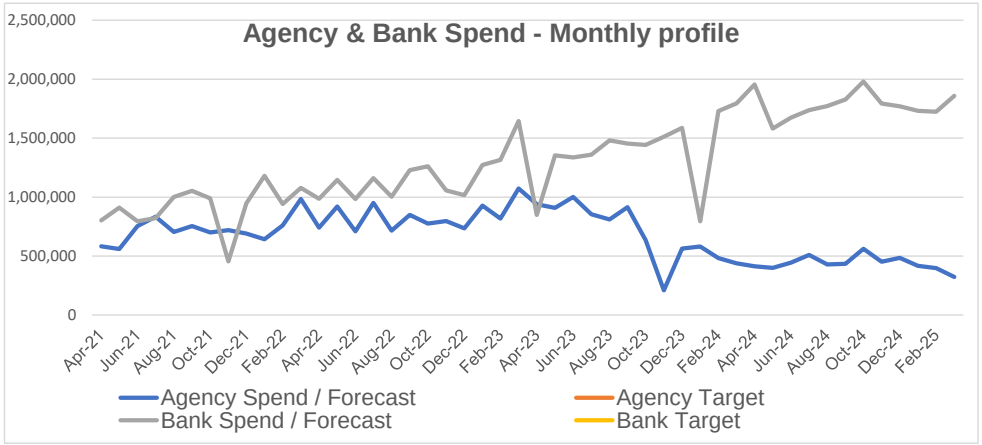
Following development of the 2025 / 26 plan the baseline workforce trajectory is predicated on maintaining operational workforce at the same level as December 2024. At March 2025 this is 22 WTE worked less than this baseline. Further montioring will continue throughout the year.

2.2 Temporary Staffing Focus

Trust spend in March 2025:
Agency £323k
Bank £1,859k

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 £k	Bank £k	Total £k
Consultant	1,989	601	**2,590**
Other Medical	1,207	625	**1,832**
Reg Nursing	283	5,150	**5,434**
UnReg Nursing	1,243	13,139	**14,382**
Other Clinical	409	712	**1,121**
A & C	133	1,176	**1,310**
Other	1	0	**1**
Total	**5,265**	**21,405**	**26,670**
Lead Provider Collaborative	698	7	**705**
Budgets held centrally	(44)	(38)	**(83)**
Cheswold Park Hospital	460	479	**939**
Total	**6,380**	**21,852**	**28,232**

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. This has been achieved with spend of £6.4m (£0.3m less).

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. These reductions have been included witihn the Trust plans for 2025 / 26 and actions to ensure 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 March being a further £77k reduction compared to last month. This is offset partially within the overall consolidated position with increases in both the provider collaboratives and Cheswold Park Hospital. The Trust areas with less expenditure is primarily in the mental health care group and adult inpatient wards which have seen month on month reductions within Quarter 4. We do, however, continue to see monthly fluctations.

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.

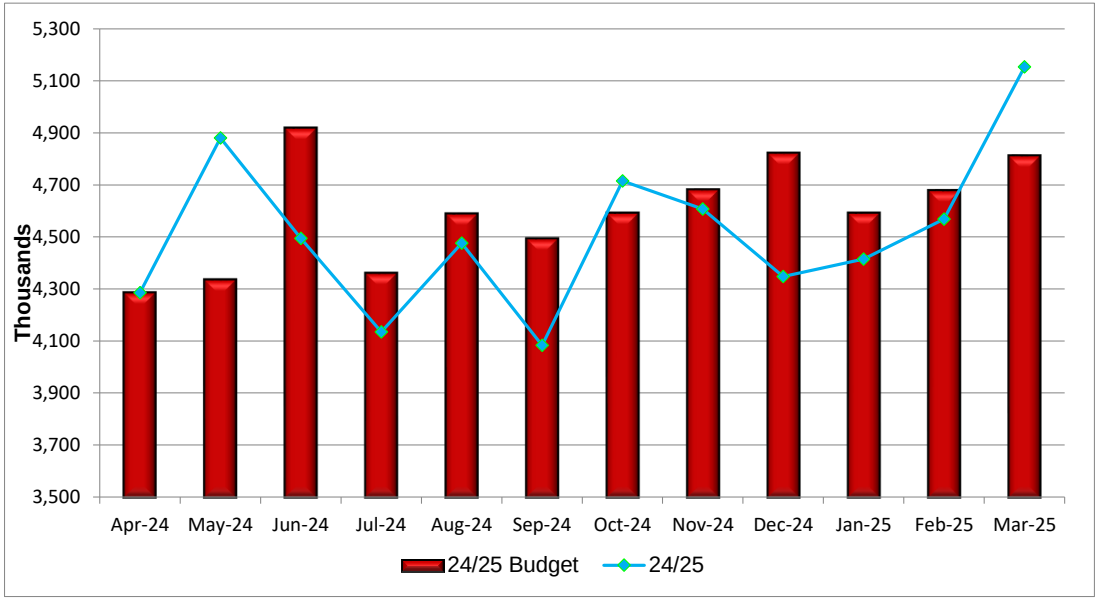
Utilisation of bank, as part of the overall workforce solution, has continued to grow over the past couple of years. As expected from 2025 / 26 this will be subject to NHS England target reductions. There has continued to be small monthly reductions in the run rate but further actions, as identified 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	5,153	**54,161**
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	4,408	4,061	(347)	
Establishment	9,798	9,474	(324)	
Lease & Property Rental	8,809	8,884	76	
Premises (inc. rates)	5,074	5,010	(64)	
Utilities	2,812	2,874	61	
Purchase of Healthcare	6,155	5,982	(173)	
Travel & vehicles	5,830	5,795	(35)	
Supplies & Services	8,398	8,271	(127)	
Training & Education	1,332	982	(350)	
Clinical Negligence & Insurance	1,164	1,166	2	
Other non pay	1,390	1,820	429	
Total	**55,170**	**54,319**	**(851)**	
Total Excl OOA and Drugs	**44,608**	**44,276**	**(331)**	



Key Messages

Although not seen in 2023 / 24 it is typical that there is an increase in non pay expenditure in month 12 each year. Overall expenditure is approximately £600k more than February 2025 and is £146k more than previously forecast. This movement is across a number of non pay categories.

Overall, despite the increase in March 2025, most categories have remained lower than plan in year. The main exception is other non pay which is a wide ranging category and picks up costs not mapped into any of the other categories.

Other small overspends are within the lease and utilities categories.

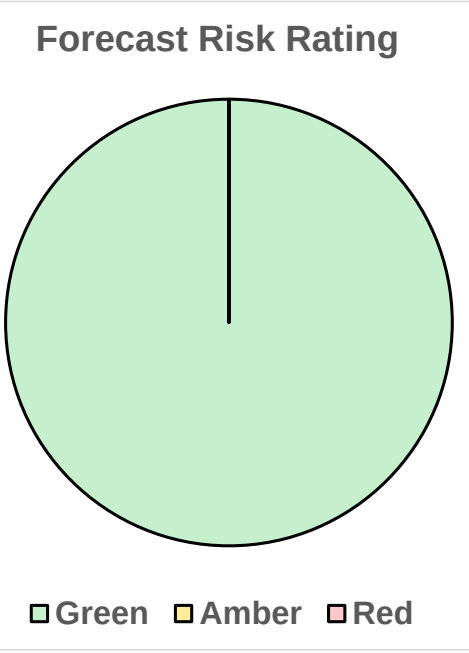
Non pay expenditure budgets have been reset for 2025 / 26 based on the Trust budget setting principles.

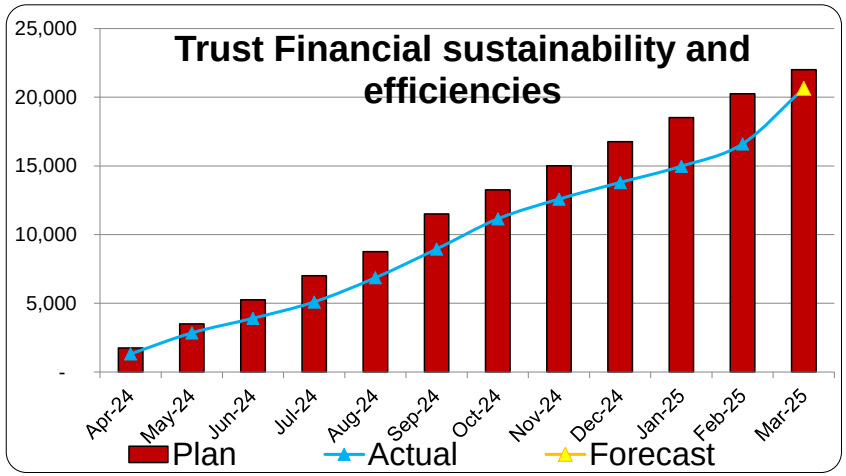
3.0 Value for Money, Financial sustainability and efficiency

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		12,468	572	8,429	12,468	9,001			(3,467)
Non pay - Impact of workforce optimisation		420	423		420	423			3
Out of area placements		2,871	2,881		2,871	2,881	0		10
Non pay - digital		246	179		246	179			(67)
Non pay - Estates		500	406	22	500	428			(72)
Non pay - medicines optimisation		480	0		480			0	(480)
Non Pay - other		0	218		0	218			218
Procurement		250	0		250		0		(250)
Provider Collaboratives		1,140	1,140		1,140	1,140			0
Non Recurrent mitigations		0	2,550		0	2,550			2,550
Income - contribution, Full Year Effect		3,638	3,780		3,638	3,780			142
Total		**22,013**	**12,150**	**8,451**	**22,013**	**20,600**	**0**	**0**	**(1,413)**
Recurrent		10,345	12,150		10,345	8,621	0	0	(1,724)
Non Recurrent		11,668		8,451	11,668	11,979			311





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 year end position is acheviement of £20,600k against this target (£1,413k less than plan). The main variance is witihn the workforce optimisation category which is £3,467k less than plan and has led to the requirement of additional mitigations. For 2024 / 25 these have been non-recurrent and often of a technical financial nature (review of balance sheet etc).

Value for money schemes have been developed for 2025 / 26 and progress will be monitored in year. Oversight of progress now resides under the Value For Money Programme Board which is chaired by the Director of Finance.

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	197,434	
Current Assets			
Inventories & Work in Progress	179	248	
NHS Trade Receivables (Debtors)	1,072	2,453	
Non NHS Trade Receivables (Debtors)	344	989	
Prepayments	3,491	2,863	
Accrued Income	1,062	6,235	1
Cash and Cash Equivalents	69,199	55,748	Pg 15
Total Current Assets	**75,347**	**68,537**	
Current Liabilities			
Trade Payables (Creditors)	(12,728)	(10,899)	2
Capital Payables (Creditors)	(1,392)	(1,551)	
Tax, NI, Pension Payables, PDC	(8,469)	(9,478)	
Accruals	(13,966)	(14,054)	3
Deferred Income	(409)	(644)	4
Other Liabilities (IFRS 16 / leases)	(51,040)	(48,793)	
Total Current Liabilities	**(88,004)**	**(85,419)**	
Net Current Assets/Liabilities	**(12,657)**	**(16,882)**	
Total Assets less Current Liabilities	**155,161**	**180,552**	
Provisions for Liabilities	(3,510)	(3,357)	
Total Net Assets/(Liabilities)	**151,651**	**177,195**	
Taxpayers' Equity			
Public Dividend Capital	45,696	76,344	
Revaluation Reserve	15,355	21,306	5
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	85,380	74,325	
Total Taxpayers' Equity	**151,651**	**177,195**	

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 has remained 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. As per previous year the Trade creditors has increased during Quarter 4 and reaches a peak at year end. As demonstrated by the continued positive better payment practice code performance, we continue to pay suppliers promptly.

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. As per previous years the value of deferred income is minimal at year end. Any income deferred is specific and supported by appropriate auditable documentation.

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

4.1 Capital Programme 2024 / 2025

Capital schemes	Annual Budget £k	2024 / 25 Outturn £k	Variance £k
Major Capital Schemes			
Older People Transformation	2,500	56	(2,444)
Seclusion Rooms	1,000	1,087	87
Anti-ligature Doors	1,000	387	(613)
Maintenance (Minor) Capital			
Clinical Improvement	311	360	50
Safety	302	942	640
Sustainability / Carbon Neutral	510	328	(182)
Backlog	360	1,133	773
Equipment	41	378	338
Other	193	923	730
IM & T	1,470	1,735	265
Contingency	219	0	(219)
Staff Costs	200	191	(9)
TOTALS	**8,104**	**7,520**	**(584)**
Lease Impact (IFRS 16)	5,910	9,048	3,138
Asset Purchase	0	34,893	34,893
Cheswold - Minor Capital		563	563
Cheswold - IM & T		632	632
LED Lighting	648	648	0
TOTALS	**14,662**	**53,305**	**38,643**

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 was added in February 2025 following a successful grant bid to support LED lighting.

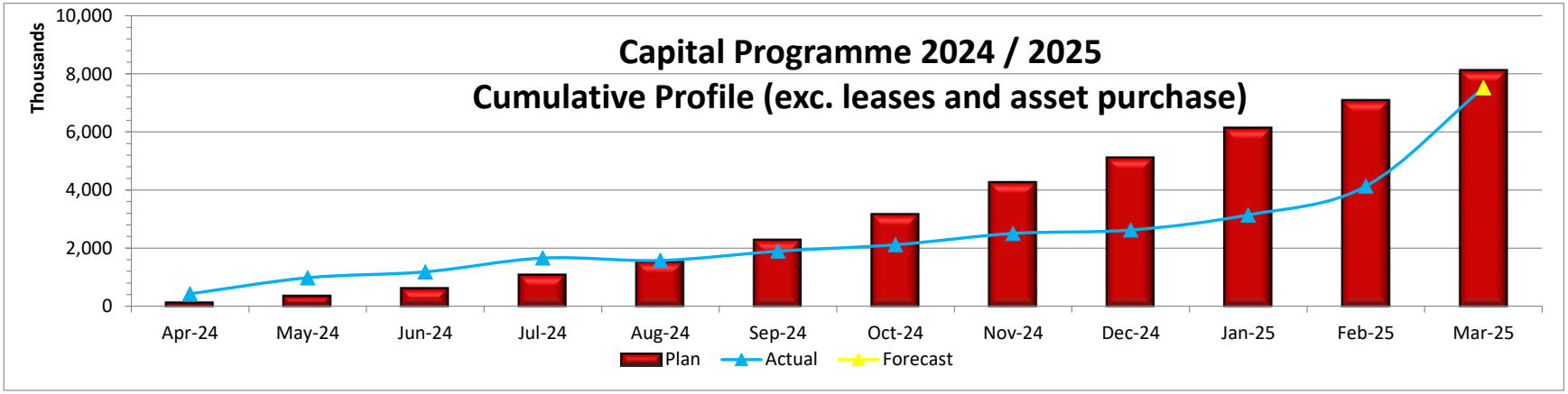
Overall expenditure is £8,168k, against the allocation of £8,752k so is £584k less. However this is offset by IFRS 16 expenditure which has been higher than plan.

For 2025 / 26 this is a single allocation and will need to be managed within the total. This does provide timing issues as lease expenditure will vary across years depending on lease renewal dates.

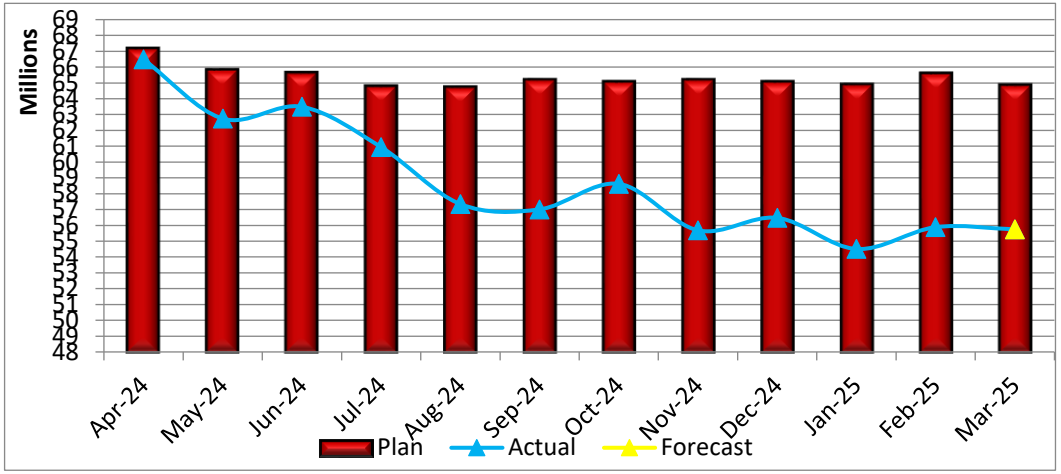
The major success in year is the purchase of Cheswold Park Hospital in October 2024 and the commencement of capital improvement schemes.

Other successes include:

* Successful substitution for underspend on the Older People scheme to invest in safety and backlog schemes. These have helped to reduce our backlog scores substantially.
* Digital infrastructure workplan delivered in line with continuous modernisation programme



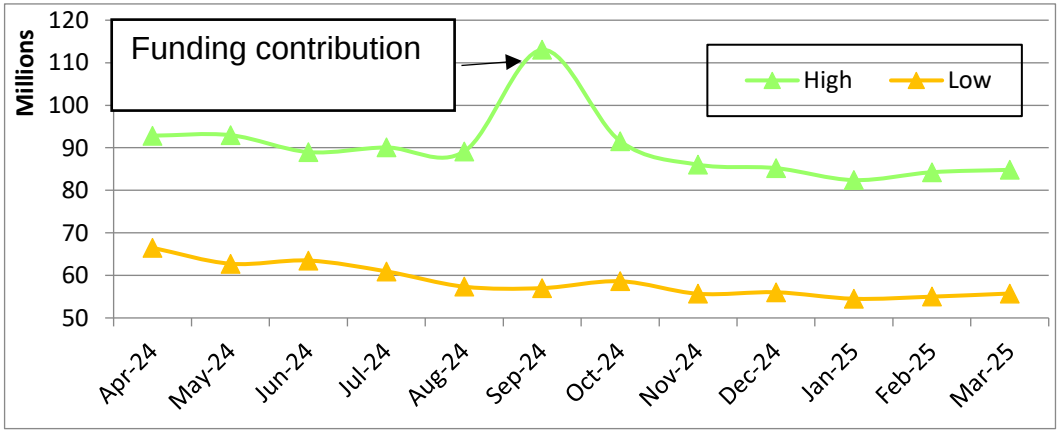
4.2 Cash Flow & Cash Flow Forecast 2024 / 2025



Trust cash balances have reduced in 2024 / 25

	Plan £k	Actual £k	Variance £k
Opening Balance	71,353	69,199	
Closing Balance	64,878	55,748	(9,130)

Despite the inclusion of payment of PDC (Public Dividend Capital) in March the overall position has been maintained. Due to the value of creditors in March this is expected to reduce further in April / May as these invoices are paid. This will, however, be offset by receipt of accrued income.



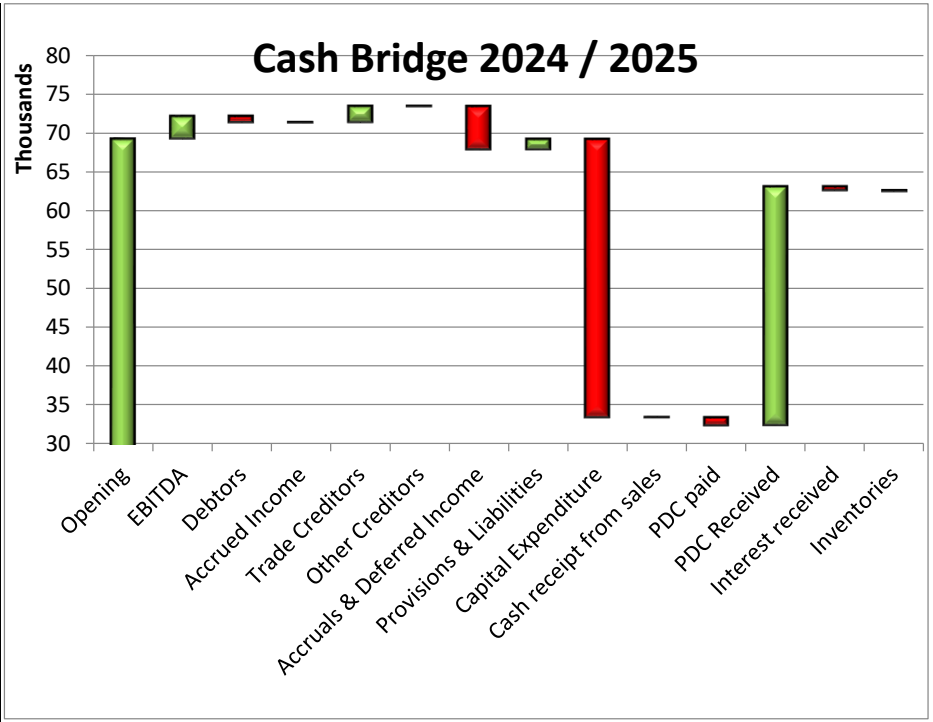
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £84.8m
The lowest balance is: £55.7m

This reflects cash balances built up from historical surpluses.

4.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**71,353**	**69,199**	(2,154)	
Surplus / Deficit (Exc. non-cash items & revaluation)	12,995	15,935	2,940	
Movement in working capital:				
Inventories & Work in Progress	52	(69)	(121)	
Receivables (Debtors)	530	(289)	(819)	
Trade Payables (Creditors)	(2,750)	(662)	2,088	
Accruals & Deferred income	0	(5,591)	(5,591)	
Provisions & Liabilities	(1,429)	(82)	1,348	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(8,328)	(44,098)	(35,770)	
Cash receipts from asset sales	0	24	24	
Leases	(9,598)	(9,822)	(224)	
PDC Dividends paid	(2,148)	(3,186)	(1,038)	
PDC Dividends received	0	30,678	30,678	
Interest (paid)/ received	4,201	3,712	(489)	
Closing Balances	**64,878**	**55,748**	**(9,129)**	



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.

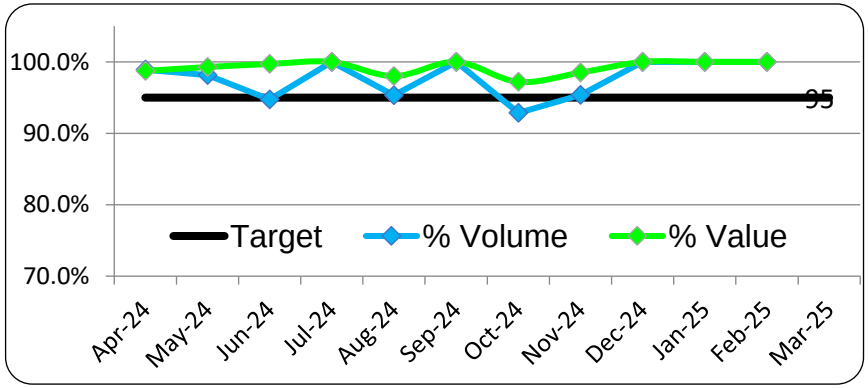
5.0 Better Payment Practice Code

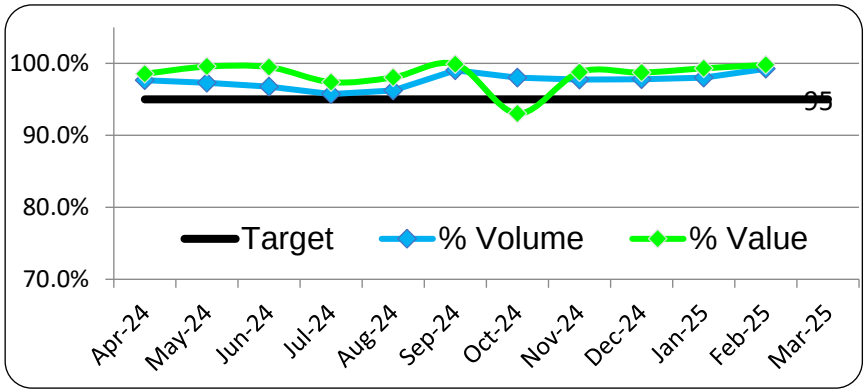
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	98%	99%
Cumulative Year to Date	98%	99%

Non NHS	Number %	Value %
In Month	99%	99%
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 (£)
11-Mar-25	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare Nhs Trust	1000058914	769,054
07-Mar-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003775	697,584
14-Mar-25	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	205444	644,853
20-Mar-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care Nhs Foundation Tru	0000001466	451,500
28-Mar-25	Rates	Wakefield	Wakefield Metropolitan District Council	8885115809532025	430,125
20-Mar-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS56	400,000
06-Mar-25	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber Nhs Found	4400002715	241,311
20-Mar-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS33	240,000
21-Mar-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS33BINV	240,000
28-Mar-25	Rates	Barnsley	Barnsley Metropolitan Borough Council	5602653012025	220,613
06-Mar-25	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 295	219,196
21-Mar-25	NHS Recharge	Trustwide	Mid Yorkshire Hospitals Nhs Trust	1600034892	218,052
28-Mar-25	Data Lines	Trustwide	Virgin Media Business Ltd	927686141	210,310
04-Mar-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	CHA04542	206,489
03-Mar-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510009884	182,241
01-Mar-25	Purchase of Healthcare	AS Collaborative	Oxford Health Nhs Foundation Trust	A0132294A	168,834
14-Mar-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003770	163,010
11-Mar-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS054SN	141,340
27-Mar-25	Purchase of Healthcare	AS Collaborative	Humber Teaching Nhs Foundation Trust	59896635	129,990
28-Mar-25	Rates	Doncaster	City Of Doncaster Council	94005800652025	122,655
12-Mar-25	NHS Recharge	Barnsley	Barnsley Hospital Nhs Foundation Trust	6028484	101,469
28-Mar-25	Rates	Kirklees	Kirklees Council	9691650732025	100,455
14-Mar-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34025266	95,769
27-Mar-25	IT Services	Trustwide	Daisy Corporate Services Trading Ltd	3I541203	90,250
27-Mar-25	IT Services	Sheffield	Daisy Corporate Services Trading Ltd	3I541204	90,250
18-Mar-25	NHS Recharge	Calderdale	Calderdale & Huddersfield Nhs Foundation Trust	4710181161	86,650
17-Mar-25	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 296	84,651
03-Mar-25	Staff Recharge	Forensics	Wakefield Metropolitan District Council	91316621184	75,184
04-Mar-25	Drugs	Trustwide	Lp Hcs Ltd	SIH001420	74,893
26-Mar-25	Staff Recharge	Forensics	Wakefield Metropolitan District Council	91316883568	71,720

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
07-Mar-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1003799	67,949
20-Mar-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care Nhs Foundation Tru	0000001467	65,809
25-Mar-25	Drugs	Trustwide	Bradford Teaching Hospitals Nhs Foundation Trus	329138	62,554
18-Mar-25	Rates	Calderdale	Calderdale Metropolitan Borough Council	252025909989012025	61,605
19-Mar-25	Drugs	Trustwide	Nhs Business Services Authority	1000083516	54,655
11-Mar-25	Utilities	Trustwide	Edf Energy Customers Ltd	000022570618	52,662
26-Mar-25	Drugs	Trustwide	Nhs Business Services Authority	1000083834	52,177
20-Mar-25	Healthcare Promotion	Doncaster	Edenred Uk Group Ltd	PR2449796	50,000
24-Mar-25	Purchase of Healthcare	Forensics	Sheffield Childrens Nhs Foundation Trust	2400007664	48,473
21-Mar-25	Training	Trustwide	University Of Wolverhampton	45116210	48,000
12-Mar-25	NHS Recharge	Barnsley	Barnsley Hospital Nhs Foundation Trust	6028488	44,170
28-Mar-25	Purchase of Healthcare	Kirklees	Northpoint Wellbeing Ltd	RGA15610	44,119
18-Mar-25	Rates	Kirklees	Kirklees Council	96921639X2025	40,793
19-Mar-25	Utilities	Trustwide	Totalenergies Gas & Power Ltd	37151590825	40,330
17-Mar-25	Lease Cars	Trustwide	Arval Uk Ltd	RI0013139305	40,299
11-Mar-25	Purchase of Healthcare	Trustwide	Cygnet Nw Ltd	BUR0396404	39,380
01-Mar-25	IT Hardware	Trustwide	Dell Corporation Ltd	7403077613	38,300
28-Mar-25	NHS Recharge	Barnsley	Barnsley Hospital Nhs Foundation Trust	6028363	36,034
04-Mar-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001321EPC	35,979
26-Mar-25	Rates	Wakefield	Wakefield Metropolitan District Council	8885112606032025	35,798
28-Mar-25	Purchase of Healthcare	Barnsley	Touchstone-Leeds	SINV20240194	35,382
10-Mar-25	Purchase of Healthcare	Forensics	Humber Teaching Nhs Foundation Trust	59896365	34,947
13-Mar-25	Purchase of Healthcare	Trustwide	Nouvita Ltd	12956	34,655
31-Mar-25	Staff Benefits	Trustwide	Reward Gateway Uk Ltd	PR2455171	31,750
21-Mar-25	Continence Products	Barnsley	Supply Chain Coordination Limited	248425	31,335
14-Mar-25	Rates	Barnsley	Barnsley Metropolitan Borough Council	5602654242025	30,248
19-Mar-25	Utilities	Trustwide	Totalenergies Gas & Power Ltd	37151584225	29,783

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
24-Mar-25	MFDs	Trustwide	Annodata Ltd	1389475	29,778
07-Mar-25	Building Contract	Trustwide	Pinpoint Ltd	74998	29,612
18-Mar-25	Rates	Kirklees	Kirklees Council	9689128942025	29,415
11-Mar-25	Utilities	Trustwide	Edf Energy Customers Ltd	000022579679	28,995
11-Mar-25	Purchase of Healthcare	Trustwide	Cygnet (Dh) Ltd	HEX0395425	28,980
18-Mar-25	Rates	Kirklees	Kirklees Council	9692164152025	28,583
11-Mar-25	Purchase of Healthcare	Forensics	Tees Esk & Wear Valleys Nhs Foundation Trust	4810026277	27,815
11-Mar-25	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	COV0396328	27,748
11-Mar-25	Purchase of Healthcare	Trustwide	Cygnet Nw Ltd	BUR0396451	27,748
31-Mar-25	Computer Software	Trustwide	Boxxe Ltd	INV0067092	27,006
17-Mar-25	Healthcare Promotion	Wakefield	Edenred Uk Group Ltd	PR2449947	26,959
26-Mar-25	Drugs	Doncaster	Speeds Healthcare Ltd	INV152312	26,824
10-Mar-25	Rent	Kirklees	Bradbury Investments Ltd	1928	26,168
01-Mar-25	IT Hardware	Trustwide	Dell Corporation Ltd	7403077614	26,044
07-Mar-25	Purchase of Healthcare	AS Collaborative	Mersey Care Nhs Foundation Trust	72489164	25,627
28-Mar-25	Purchase of Healthcare	AS Collaborative	Humber Teaching Nhs Foundation Trust	59896633	25,058
07-Mar-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90148795	25,019
07-Mar-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90148797	25,019

5.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

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

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

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

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

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

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

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

Appendix 3 - Statistical Process Control (SPC) Charts Explained

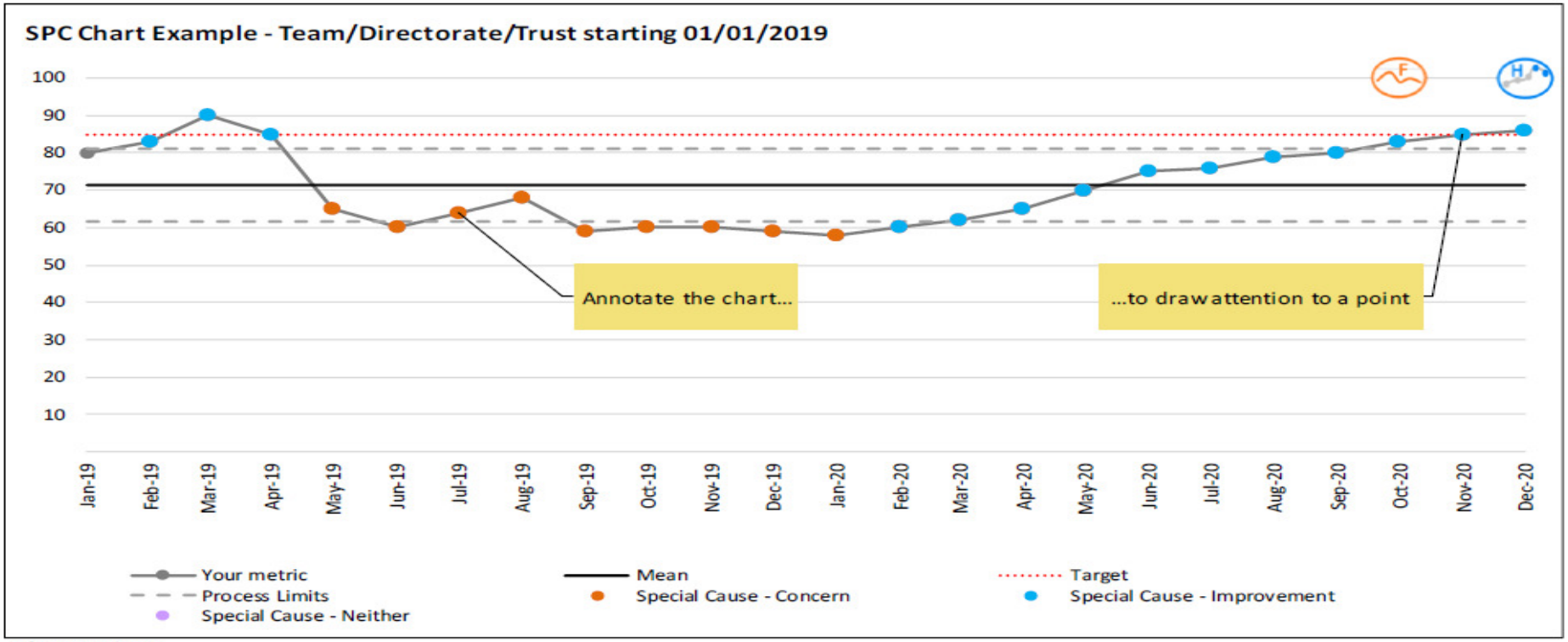
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

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

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

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

Appendix 3 - Statistical Process Control (SPC) Charts Explained



Observations

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

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