NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

May 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 May 2025.

The format of the report for 2025/26 has been changed slightly to align with the focus of Trust board. In months where the report is not included on the Trust board agenda (Strategy focus) or has a shorter time allocation (Risk focus) a more data focussed report with key headlines will be produced. For Performance focus months, this will be a full report including supporting narrative and we will continue to develop more in depth analysis over the year.

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:

- Headlines
- Executive summary
- Quality and Safety
- People
- National metrics
- Care groups including ward level detail
- Finance

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. Our Integrated Performance Report (IPR) provides a comprehensive view of Trust performance against our targets. We have mapped this performance information against the new strategic aims, values and best statements so that it is easy to see how the performance data links to the delivery of the strategy. Mapping of metrics included in the integrated performance report against the new strategic objectives has been undertaken and a new column added to dashboards to display this. A separate report will be provided to board with a specific focus on delivery of the Strategy. We have also mapped the metrics included in this report against the Care Quality Commission domains and this can also be seen in the addition of a column to each of the dashboards.

An exercise has been undertaken to review all metrics and thresholds to ensure they meet the requirements and priorities for 2025/26 and the report has been updated to reflect this. In particular, the national metrics section includes metrics contained within the NHS England oversight framework, operational planning guidance for 2025/26 and NHS standard contract items for 2024/25 - this will be updated once contracts for 2025/26 have been agreed. 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. Over the last eight months the Trust has been undertaking an integration programme to embed Cheswold Park Hospital Services into the Trust and reporting systems. We expect this project to be complete by the end of quarter two and as data becomes available within Trustwide systems, this will be included in the main report during this transition period, any metrics not yet available will be reported separately in the appendix for Cheswold Park Hospital. In this months report we have added a reducing inequalities section, this is linked to the Trust's equality, diversity and inclusion strategy and includes a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities and will guide us to being an inclusive employer where everyone can be themselves and feel valued for their contribution. We will continue to further develop this section of the report over the coming months in line with the depolyment of the Trusts Equality, diversity, and
inclusion strategy.

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.

Quality and Safety

Metric	Change from last month	Variation/ Assurance
Complaints - Number of responses provided within six months of the date a complaint received	⇔	
% service users clinically ready for discharge	⇩	
Number of Information Governance breaches	⇧	
% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	⇧	
% with care plan that includes service user input/views	⇧	New metric from April 25
% inpatient care plans commenced within 24hrs before or after admission	⇩	New metric from April 25
% inpatient risk assessment completed within 24hrs before or after admission	⇧	New metric from April 25
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	⇧	New metric from April 25
% on community active caseload at month end with a care plan which has % on community active caseload at month end with a care plan which has been reviewed within the last year reviewed within the last year	⇧	New metric from April 25

People

Metric	Change from last month	Variation/ Assurance
Registered workforce growth	⇧	
Mandatory training - Information governance (IG)	⇧	

Finance

Metric	Change from last month	Variation/ Assurance
Surplus/(deficit) against plan (monthly)	⇧	
Bank spend	⇧	New metric from April 25
Financial sustainability and efficiencies	⇧	New metric from April 25

National metrics

Metric	Change from last month	Variation/ Assurance
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	⇧	
Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	⇩	
Maximum 6 week wait for diagnostic procedures	⇩	
Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	⇩	New metric from April 25
Diagnostic test activity	⇩	New metric from April 25
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months - Kirklees	⇧	New metric from April 25
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months - Wakefield	⇩	New metric from April 25
Oinappropriate out of area bed days	⇩	
Community service waiting list over 52 weeks	⇧	
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months - Kirklees	⇧	
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months - Wakefield	⇩	

Care Groups

Children and Young Peoples Mental Health Services (CAMHS)

Metric	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
Reducing restrictive physical interventions 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
Referral to assessment within 14 days (external referrals)	↑	
Information Governance training compliance	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↑	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↓	New metric from April 25

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% inpatient risk assessment completed within 24hrs before or after admission	↑	New metric from April 25
% of clients clinically ready for discharge	↓	
Sickness rate (monthly)	↓	
% Bed occupancy	↓	
Information Governance training compliance	↑	
Average length of stay - Acute and Psychiatric Intensive Care Unit - West Yorkshire (3 Months Rolling)	↓	

LD, ADHD & ASD

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

Forensic - West Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
Information Governance (IG) training compliance	↑	
Sickness rate (Monthly)	↓	
% inpatient risk assessment completed within 24hrs before or after admission	↑	New metric from April 25
% Bed occupancy (incl leave)	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↑	

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Bed occupancy	↓	New metric from April 25
% of feedback with staff values and behaviours as an issue	↓	
% Appraisal rate	↑	
Information Governance training compliance	↑	

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
% of staff receiving supervision within policy guidance	↓	

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 give an overview of key headlines for each section of the report. More detail is included in the relevant sections of the Integrated Performance Report.

Quality & Safety

• The Trust had 35 violence and aggression incidents against staff on mental health wards involving race during May, which is a reduction on the previous month. This data now includes Cheswold Park hospital. We are very mindful of the personal impact this has on our colleagues. We provide support to those affected and are working with other trusts to identify other opportunities to reduce the prevalence of these incidents. Within the Trust, we are looking at developing bespoke training for services with a focus on equality and diversity to support this.

• The total number of incidents in month decreased to 1,402 in May 2025, this includes incidents relating to Cheswold Park Hospital which were reported separately prior to April 2025. Breakdown of this data can be seen in the Care Group dashboards, and the numbers reported suggest data is in line with the number of incidents reported in previous months. They continue to be subject to review by the patient safety team with relevant governance within the care groups.

• 96% of incidents reported in May 2025 resulted in no or low harm or were not under the care of the Trust. An overview of key indicators is below:

o 1 incident unfortunately related to a patient death which was sadly of a service user known to mental health community services. Condolences have been passed to the family and investigation and learning will be undertaken.

o the number of restraint incidents increased this month from 158 reported in April to 170. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain within expected range – all incidents are reviewed, and learning is shared.

o the number of prone restraints during the month was 11. This number, although reducing is disappointing. The medical director, chief operating officer and deputy director of nursing, quality and professions visited the psychiatric intensive care unit to understand barriers to using the new technique to exit seclusion and administer intramuscular medication. A review of the whole training package is taking place which will provide a trajectory of ensuring people are trained in the new technique. A deep dive into each case has been undertaken.

• There were 7 information governance personal data breaches during May, this is a reduction on last month (13). A security breach occurred when a laptop and papers were stolen during a break from a staff member's car. An amber incident was reported when a staff member reportedly shared sensitive personal information about a patient in a public place and resulted in a complaint which is being dealt with through the Trust complaints process.

A communications 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.

• The number of inpatient falls reported during May 2025 decreased to 44, which is a reduction from the spike we saw in April (63). 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 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 achieving 93.7% against a target of 90%. Disability recording was at 50.4%, sexual orientation 53.8% and postcode at 99.6%. Work continues to ensure data capture across all services and further detail of these metrics can be seen in the equalities section of this month's report.

• Risk assessments and care plans – as we aim to continually improve, we have further developed our metric regarding care plans. The new care plan metrics for community are now capturing the whole community caseload rather than only individuals on the care programme approach. From a safety and quality perspective, the Trust's aim is to work towards achievement of 95% against each of these standards. Clinical staff are adapting to the new requirements of where and how to record items and we have a phased trajectory progressively working towards 95%.

• All areas are focusing on continuing to improve performance for risk assessments. Staying Safe plans are now captured as part of the My Care and Safety Plan, rather than the FIRM risk assessment, following the changes to care plans that went live in January. The Staying Safe percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions and May'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. Clinical staff are adapting to the new requirements of where and how to record items measured in the metric, and some changes to care programme

Care Groups

• Children's 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 had 33% more people waiting for initial assessment at the end of March 2025 (2906) compared to March 2024 (2191). Close work with commissioners continues 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 May 100% was achieved. This has shown a sustained improvement and has been consistently achieved each month since November 2024.

• The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. Demand for beds continues to be a significant challenge and we have experienced increased use of out of are beds days in the last month. 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. We are working with commissioners to address the increase in clinically ready for discharge patients.

• 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 May, 74.9% 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. The average wait for neuro development assessment is 907 days in Kirklees and 332 days in Calderdale. Neurodevelopment 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 ADHD pathways in Barnsley, Wakefield and Kirklees for May is approx. 27 cases per month, the number of referrals for ADHD received for these areas in May was 376.

As demand in all areas is significantly more than capacity, this leads to lengthy waits, and the care remains with the referrer until accepted by the service. An innovative new step has been developed to offer face to face triage for ADHD to ensure only clinically appropriate cases are offered an assessment, this is commissioned in Wakefield and Kirklees. Barnsley and Calderdale have requested updated business cases for their consideration. The ADHD leadership team are working with commissioners to support the findings of the National ADHD taskforce report to align ourselves to the recommendations.

• 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 efficiency can be improved to release time for nursing staff to care. Continued high occupancy levels contribute to increased acuity. Capacity to meet demand for beds remains challenging and is placing significant pressure on patient flow, Intensive Home-Based Treatment Teams, community teams and wards. This pressure links to the urgent and emergency care planning guidance that escalates 12-hour breaches to the Integrated Care Board therefore, pressure to focus on those patients in the acute Trust Emergency departments.

• Temporary staffing has continued throughout May, however, a significant reduction in the use of agency staff on wards and a small reduction on bank staff has been achieved.

• 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.

• A focus on patients clinically ready for discharge is taking place across mental health and learning disabilities. Challenges are those associated to specialist placements. Hotspot areas include learning disabilities, adult and older peoples wards and psychiatric intensive care unit (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.

People

• Overall sickness absence remains low for May 2025 at 4.7%. Although sickness rates are similar to this period last year, we have seen a reduction in long-term sickness and a slight increase in short-term sickness. The introduction of a new sickness absence dashboard has been rolled out for managers to support them in managing absences and enabling more Trust wide information to be available.
• Appraisal compliance continues to improve at 89.8%. An improvement trajectory has been set with 90% and the data suggests this will be achieved by end June 2025.
• Our 12-month turnover rate in May has decreased slightly from last month to 9.2%. This is still a lower level than we have seen in previous years. A 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.
• In May, we had 19 new starters and 24 leavers. We continue to see a downward trend in number of starters which suggests the additional controls put in place are taking effect. May also saw a decrease in substantive staff, this is being monitored against a forecast 2% reduction expected to be achieved by end of March 2026.
• Our overall mandatory training compliance remains above threshold, with the majority of training areas sustaining performance. This is the first month of Trust level performance that has achieved compliance in all areas. Dedicated focus on non-compliance continues within all care groups.

National Indicators

The Trust continues to perform well against the majority of national metrics. The following should be noted:
• It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways. Ongoing development work is taking place to meet increases in demand. Regarding the 6 weeks to a diagnostic appointment target 118 out of 241 children (49%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in May, this is a deterioration in performance. A contributing factor to this is that the only current full-time member of staff took some annual leave during May. Additional staffing will be in post from the end of June and agency cover will continue until their induction period is completed. A trajectory for reduction of agency staff will coincide with start date.
• Children & Younger People with an eating disorder - % routine cases accessing treatment within 4 weeks remains below the national threshold of 95%, this however is an improved position. This relates to 2 service users out of a total of 32, both of which were on the ARFID (Avoidant/Restrictive Food Intake Disorder) pathway. The appropriateness of including these cases in this metric is being explored with NHS England. Performance against the urgent access to treatment measure is 50% in May, there were 2 patients not seen within 1 week of referral in May and this was due to one patient being offered an appointment within the time frame but this was declined by the family and the other was delayed due to the service having difficulties contacting the family to arrange an appointment.
• 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. Increase in demand can also be seen in the attended community care contacts metric which also shows a continued higher level than expected.
The following section provides an update on a number of key national operational priorities that the Trust will contribute to during 2025/26:
• Reduction in Acute length of stay (ALOS). The Trust has set itself a local target to reduce adult acute lengths of stay by 10% by the end of March 2025. Performance against this can be seen in the national metrics section above and individual care group and ward level compliance can be seen in the care group section of the report. Overall, the average length of stay for people discharged in May has increased – this can therefore be impacted by a long stay being discharged during the month. In terms of performance against the trajectory, we are meeting the trajectory for May for our West Yorkshire acute mental health and PICU wards (Calderdale, Kirklees, and Wakefield), but slightly above our trajectory for South Yorkshire wards (Barnsley).
• Productivity of services for children and young people – work is taking place across the Trust to improve productivity across all services whilst continuing to deliver (and improve) high quality and safe services. To support Trust financial viability. For services to work within the financial envelope defined within the establishment reviews, exploring and exploiting opportunities for working differently and effectively. Updates will be provided as this work progresses.
• Expansion of mental health teams in schools – we are working with commissioners regarding the plans for Mental Health Support Teams in 2025/26.
• Expansion of talking therapies service - The ongoing expansion of talking therapies services is progressing in alignment with national expansion targets and the corresponding funding provisions further plans for service development can be seen in the national metrics section of the report.

Finance

• The financial performance for May 2025 is a deficit of £0.6m which is £0.1m (14%) adverse to plan. This means that the year-to-date deficit is £1.4m (£0.2m - 17% adverse to plan). In order to secure the breakeven financial target improvements to the current run rate are required which are over and above the previously planned improvements. These are being led by the value for money programme.

• Agency worked WTE has continued to reduce in May.

• The Trust Bank expenditure has reduced by £293k (86 less worked WTE) when compared to April 2025. This reflects the actions implemented by the Trust. However, this does remain higher than plan and further actions will continue to be implemented.

• National guidance, and as part of the Trust Value for Money programme, identified corporate expenditure as a key performance indicator. In May spend is £0.3m less than planned.

• The value for money programme is £491k behind plan for the year to date. This is primarily due to workforce and temporary staffing (bank). The run rate has improved in month. Mitigations continue to be developed to ensure that the target is delivered in full as part of supporting delivery of the overall financial position.

• Cash continues to be monitored to ensure effective management of the Trust working capital position. In May 2025 this remains better than planned.

• Spend on capital is less than planned in May. This is expected to be rectified in June 2025. The remainder of the capital programme is profiled later in the year.

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Mar-25	Apr-25	May-25	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Best Quality	Responsive	TBC	75.9%	73.0%	74.9%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	Best Quality	Caring	< 20%	20% (4/20)	6% (2/32)	18% (5/28)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	93.8	85.6	116.1	N/A
	Complaints - Number of responses provided within six months of the date a complaint received [16]	Best Quality	Well led	100%	88% (14/16)	88% (14/16)	88% (15/17)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	91%	95%	94%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	93%	96%	96%	1
Quality	Number of compliments received	Best Quality	Caring	N/A	46	25	75	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Best Quality	Safe	Trend monitor	12	5	3	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Best Quality	Safe	Trend monitor	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	Best Quality	Safe	0	0	0	0	1
	Number of Information Governance breaches [3]	Best Quality	Well led	<12	11	13	7	2
	% of inpatients clinically ready for discharge *	Person first and in the centre	Responsive	3.5%	6.0%	5.9%	6.1%	3
	Total number of reported incidents [18] *	Best Quality	Safe	Trend monitor	1287	1497	1402	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	28	36	26	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	5	1	0	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	2	1	1	
	Safer staff fill rates *	Best Quality	Safe	90%	128.7%	123.0%	122.0%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	101.1%	100.3%	100.2%	1
	Number of pressure ulcers which developed under SWYPFT care [1]	Best Quality	Safe	Trend monitor	34	39	35	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement [2]	Best Quality	Safe	0	1	0	0	0
	Eliminating Mixed Sex Accommodation Breaches	Best Quality	Safe	0	0	0	0	1
	Number of Falls (inpatients) *	Best Quality	Safe	Trend monitor	44	63	44	
	Number of restraint incidents *	Best Quality	Safe	Trend monitor	177	158	170	
	% of staff receiving supervision within policy guidance [15]	Best place to work and learn	Well led	80%	86.4%	84.6%	83.7%	1
	Potential under-reporting of patient safety incidents	Best Quality	Safe					
	% people dying in a place of their choosing [14]	Person first and in the centre	Responsive	80%	96.2%	89.7%	88.9%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	13	16	9	N/A
	Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	Best Quality	Effective	55%	Q4 - 69.2%	Due August 2025		
	Number of violence and aggression incidents against staff on mental health wards involving race *	Best place to work and learn	Safe	Trend Monitor	25	38	35	N/A
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0	10	Due July 2025		
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	96.7%	95.4%	99.5%	
	Compliance with statutory requirements (Water, Gas, Electricity, Refrigeration, Pressure, Loler and Asbestos)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	
	% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	Best Quality	Well led	100%	100.0%	77.8%	100.0%	
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	96.7%	95.4%	93.7%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	53.3%	51.9%	50.4%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	57.6%	56.0%	53.8%	
	Percentage of service users who have had their equality data recorded - deprivation (postcode)	Best Quality	Responsive	90%	99.5%	99.5%	99.6%	

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Mar-25	Apr-25	May-25	Year End Forecast*
	Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure)	Best Quality	Responsive	Service timely completion - 75% Policy - 95%	94.9% Service 100% Policy	100% Service 100% Policy	88.2% Service 100% Policy	
	% on community active caseload at month end with a care plan which has been reviewed within the last year	Person first and in the centre	Caring	Interim trajectory 75-80%	Reporting commenced April 2025	58.7%	66.4%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring			66.2%	67.5%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring			86.2%	83.8%	
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe			75.7%	74.9%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe			82.6%	84.3%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	April and May – 12		8	11	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor		125	92	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor		4525	4814	N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Person first and in the centre	Safe	6	0	0	0	1
	C Diff avoidable cases	Person first and in the centre	Safe	0	0	0	0	1
	E. Coli bloodstream infection rate	Person first and in the centre	Safe	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Person first and in the centre	Safe	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	All	Well led	2	2	2	2	
	Overall CQC rating	All	Well led		Good			
	CQC well - led rating	All	Well led		Good			

Quality & Safety Headlines

• 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 17 complaints responded to during the month, 15 were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 116.1 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.

• The number of reported incidents - the total figure for May incudes 155 incidents that are attributed to Cheswold Park Hospital; 1247 incidents were attributed to the rest of the Trust and this is in line with figures previously reported.
  • there was no severe harm incidents reported during the month.
  • there was sadly, one patient that died. Condolences have been passed to the family and investigation and learning will be undertaken and disseminated as appropriate.

• The overall number of restraint incidents in May was 170 which is an increase compared to the April figure of 158 and now also includes data for Cheswold Park Hospital. 28 of these incidents were attributed to Walton Psychiatric Intensive Care Unit and 22 to Elmdale ward. 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.

• Clinically ready for discharge (previously delayed transfers of care) - Overall Trust position for May was 6.1%, this includes data for Cheswold Park Hospital. The performance excluding Cheswold Park Hospital is 7.1% which is a further increase on last month. 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 along with work taking place to reduce the number of delays, with partner agencies.

• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. In May there were 44 inpatient fall incidents which is a decrease on the 63 reported in April and is in line with previous months. Actions have been put in place to further reduce the risk. Further detail is provided in the relevant section of this report.

• % of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened) has increased to 100% in May.

• Following the implementation of the new care plan in January 25, a set of new metrics have been identified to monitor care plans and risk assessments and these have been in place since April 25. These now cover the whole community caseload rather than only individuals on the care programme approach (CPA) and this has impacted on the overall performance across all metrics. From a safety and quality perspective, the Trusts aim is to achieve 95% against each of these standards. Clinical staff are adapting to the new requirements of where and how to record items and this is adversely impacting on the overall compliance, as a result an interim trajectory of 75%-80% has been identified and work is taking place to set a trajectory of improvement to get services up to the 95% standard.

• All areas are focussing on continuing to improve performance for risk assessments. Staying Safe plans are now captured as part of the 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 April'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. 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. Oversight of these in each team is taking place.

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

Quality & Safety Headlines Cont…

Patient Safety Incident Response Framework (PSIRF)
A review of the Trust's PSIRF plan and policy is currently underway.

Safety Incident Response Accreditation Network (SIRAN)
Feedback has been received from the accreditation committee. There are two standards remaining outstanding relating to the implementation of feedback surveys. These are currently being finalised and will be submitted as evidence before September.

Quality & Safety Dashboard Footnotes:

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 received 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.

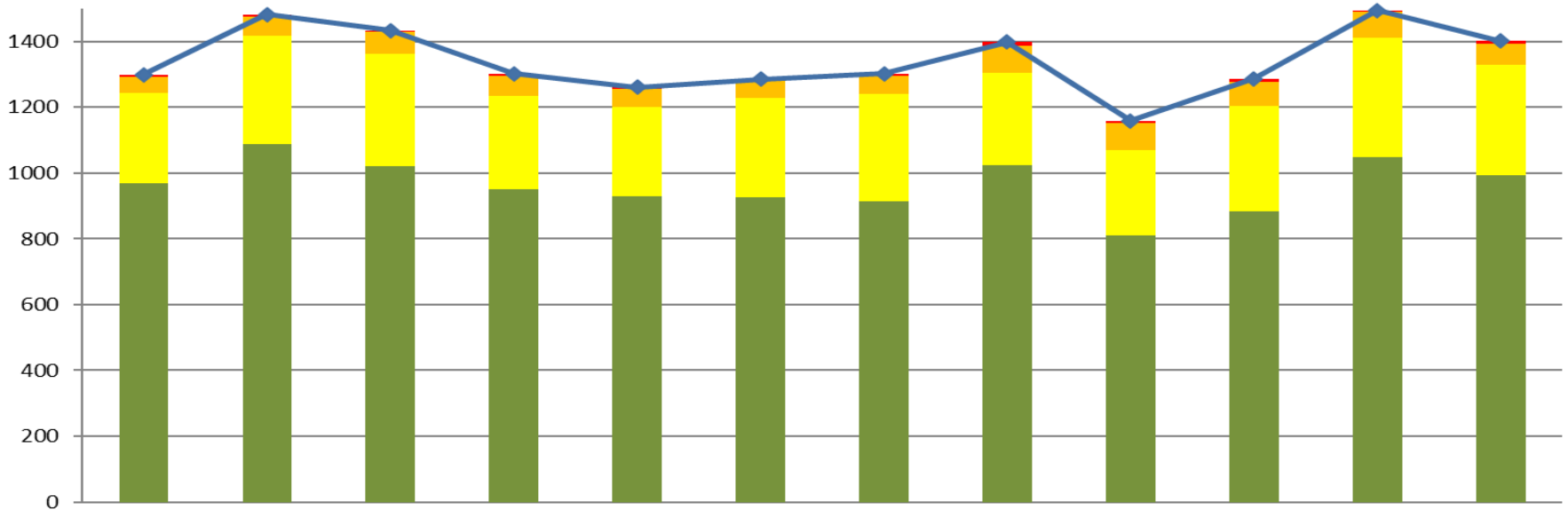
16 - Formal complaints should be responded to/closed within 6 months of the date received as is written into the NHS Complaints (England) Regulations 2009

* - includes data for Cheswold Park Hospital from April 2025.

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.
96% of incidents reported in May 2025 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in May 2025



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Red (should not be compared with SIs)	6	7	5	6	4	5	6	11	6	11	4	8
Amber	50	57	65	61	56	54	57	83	82	72	79	64
Yellow	275	331	344	285	272	300	326	280	261	319	362	337
Green	968	1088	1020	951	929	927	914	1024	810	885	1049	993
Total	1299	1483	1434	1303	1261	1286	1303	1398	1159	1287	1494	1402

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).

Safety First cont…

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

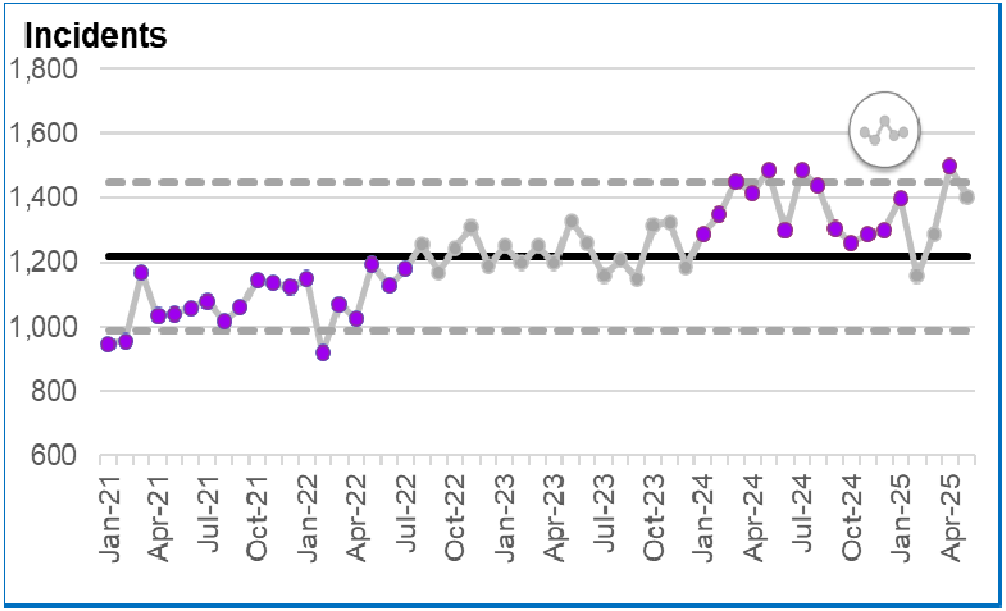
Breakdown of incidents in May 2025

26 moderate harm incidents:
The most common subcategories for incidents were pressure ulcers and self harm. 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.

There were no severe harm incidents

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

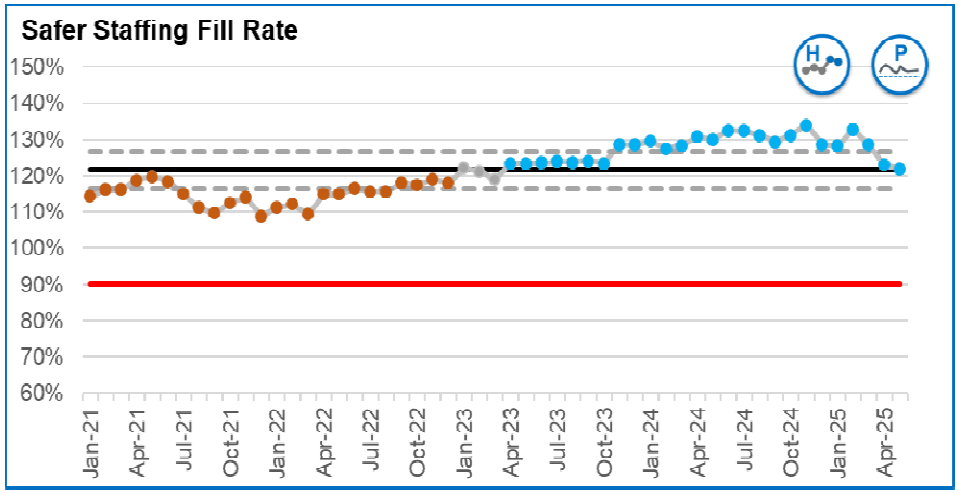
Incidents

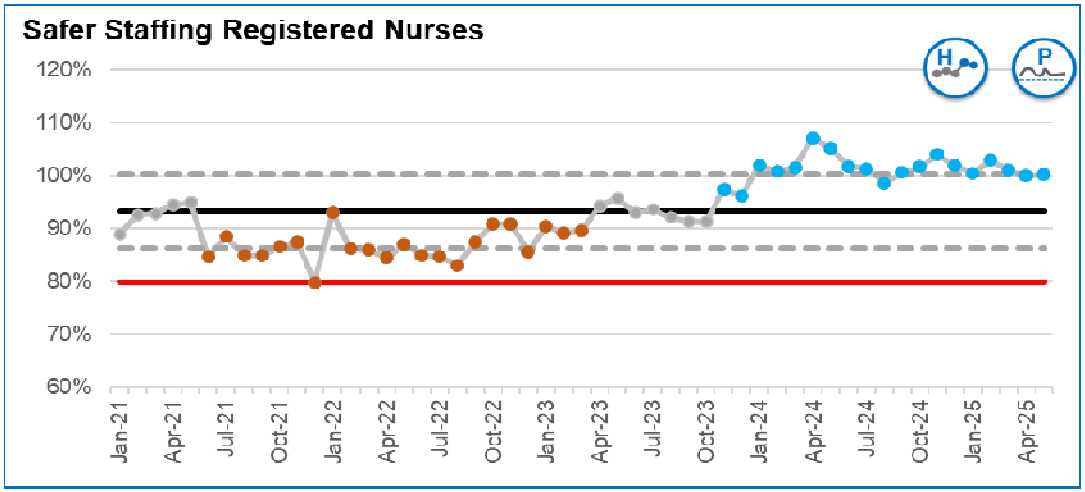


We have re-entered a period of common cause variation in May 2025 due a decrease in the number of incidents, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. Any outlier areas are explored with specialists and care groups, who are best placed to understand changes in light of other factors. They also ensure we are doing everything we can to support individuals to minimise patient safety incidents.

Discussion about patient safety incidents has been held through the year at the Patient Safety Improvement Group to aid understanding. During 2025/26, we will be adapting our Patient safety improvement group to focus discussion on the patient safety priorities in our PSIRF plan and this will include considering triangulating data, intelligence from incidents/feedback, local and national learning, and our related improvement work. We will also include looking at emerging patient safety areas not currently in our priorities. We hope to facilitate discussion to explore any hotspots and reasons why there may be changes, consider wider intelligence from other sources including input from care groups and specialist advisors, any national guidance/reports, and what our learning responses and improvement work are telling us.

Safer Staffing Inpatients





The chart above shows that as at May 2025 despite the recent decrease in staffing fill rate, we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are

The chart above shows that in May 2025, due to the sustained 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 Trust has seen a reduction in the safer staffing fill rate over the last 4 months, this is linked to the grip and control measures that have been put into place in relation to the use of temporary staffing.
• May's figures are reported with Cheswold Park Hospital (CPH) being separated out due to integration issues with all the other data sets, this is being investigated and addressed as a matter of urgency.
• In May the overall demand varied by just one shift on the previous month.
• Within the flexible staffing pool there were a total of one more shift request, and the overall fill rate decreased by 0.2% to 89.47%.
• Within overall fill rates there was a decrease in the fill rates of 4% for Forensic and Learning Disability care group to 116%, Adult and Older Peoples Care Group reduced by 4% to 128% and Barnsley Integrated Services decreased 3% to 103%. Cheswold Park Hospital increased by 7% to 118%
• 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.
• The overall fill rate reduced by 3.9% to 122.4% (and had a decrease of 1% with CPH to 122%) The day fill rate for registered nurses decreased by 2.4% to 99.0%. Two wards, a decrease on April of two, Ward 19 (Male) and Willow in the Adult and Older Peoples care group, fell below the 90% registered nurse day fill rate. They were supported through local escalation plans.
• The night registered nurse fill rate increased by 2% to 108%. Night fill rate was not achieved by Calder and Skipton Wards at Cheswold Park and Neuro Rehab in Barnsley Integrated Services. This was an increase of two wards on April.
• In May no ward fell below the 90% overall fill rate threshold.

Safer Staffing Inpatients cont…

Registered Nurses Days

The day fill rate for registered nurses decreased by 2.4% to 99.0%. There is a particular decrease in Barnsley Integrated services which is linked to vacancies within the neuro and stroke rehabilitation units.

Registered day rate	Mar-25	Apr-25	May-25
Adults and Older People	101%	102%	99%
Barnsley Integrated Services	112%	118%	101%
Forensic and LD	99%	97%	97%
Cheswold Park Hospital		99%	102%
Overall shift fill rate	**101%**	**101%**	**99%**

Registered Nurses Nights

The night registered nurse fill rate increased by 2% to 108%

Registered night rate	Mar-25	Apr-25	May-25
Adults and Older People	110%	109%	107%
Barnsley Integrated Services	99%	104%	105%
Forensic and LD	127%	120%	121%
Cheswold Park Hospital		79%	90%
Overall shift fill rate	**116%**	**106%**	**108%**

Overall Registered Rate: In May the overall registered fill rate decreased by 0.1% to 100.2%.
Overall Fill Rate: reduced by 3.9% to 122.4% (and had a decrease of 1% with CPH to 122%)

Overall Fill Rate	Mar-25	Apr-25	May-25
Adults and Older People	135%	132%	128%
Barnsley Integrated Services	105%	106%	103%
Forensic and LD	123%	120%	116%
Cheswold Park Hospital		111%	118%
Grand total	**129%**	**123%**	**122%**

Bank staff filled 80.78% (a decrease of 3.87% on the previous month) of registered nurse requests for flexible staffing and 87.28% (an increase of 2.07% on the previous month) of Healthcare assistant requests.
Agency staff filled 0.55% (an increase of 0.04% on the previous month) of registered nurse requests for flexible staffing and 3.83% (a decrease of 1.41% on the previous month) of Healthcare assistant requests.

Information Governance (IG)

Seven personal data breaches were reported during May 2025.

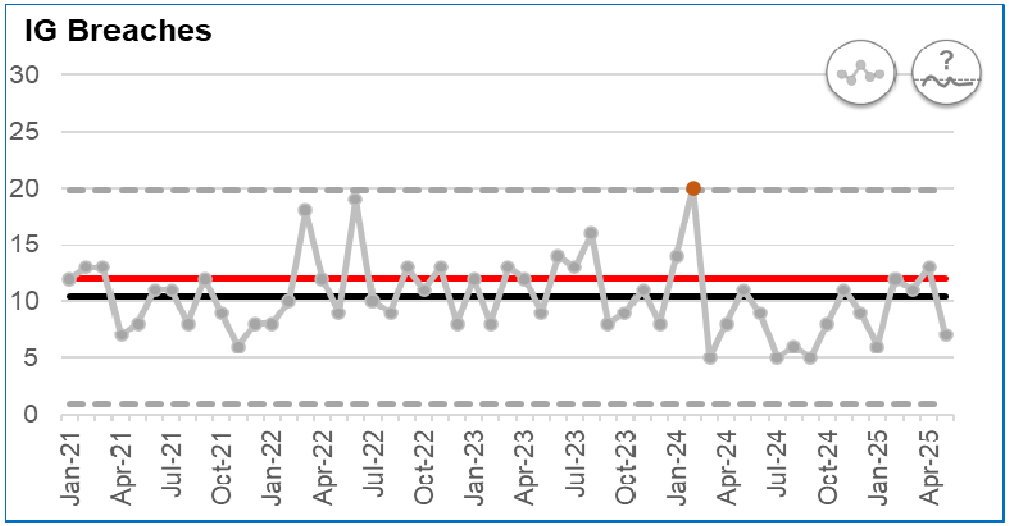
Information disclosed in error continues to be the highest reported category. Breaches during May were due to:
- Multiple patients' letters being put in one envelope
- Wrong patient identified on system and contacted

A security breach occurred when a laptop and papers were stolen during a break in to a staff member's car.

An amber incident was reported when a staff member reportedly shared sensitive personal information about a patient in a public place. The patient made a formal complaint, which is being managed by the ward manager.

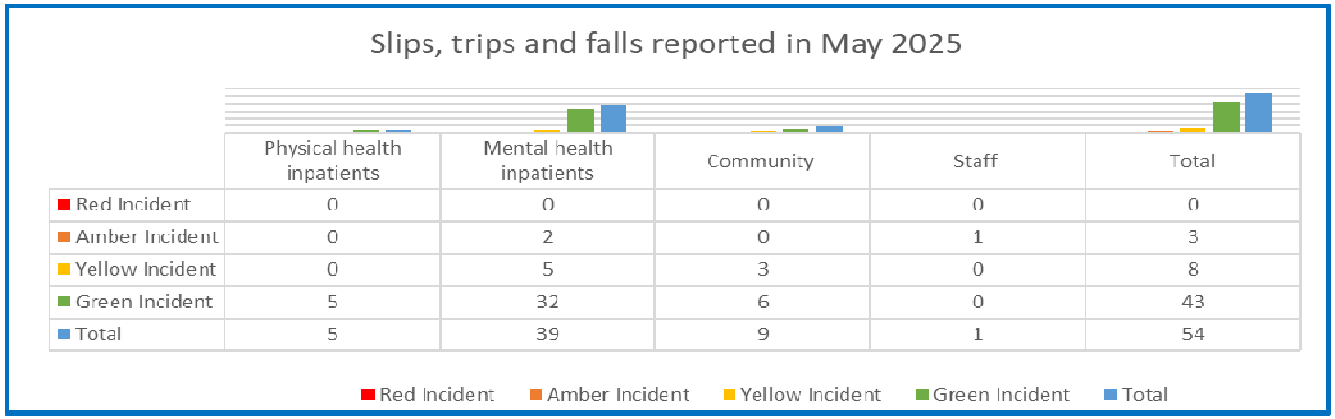
A communications campaign is in progress and personal responsibility for correctly identifying services users on the clinical systems is a key focus this month, to prevent further incidents.

This SPC chart shows that as at May 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 May 2025, a total of 54 slips, trips, and falls were reported. 44 of these were in inpatient wards.



	Physical health inpatients	Mental health inpatients	Community	Staff	Total
Red Incident	0	0	0	0	0
Amber Incident	0	2	0	1	3
Yellow Incident	0	5	3	0	8
Green Incident	5	32	6	0	43
Total	5	39	9	1	54

The Trust inpatient falls rate is 2.72 per 1000 bed days. The falls rate has seen a reduction; partly due to a lower number of falls in May, and a further reduction linked to the additional bed days from Cheswold Park Hospital. We continue to be below the National average for inpatient falls of 6.3 per 1000 bed days.

Post Falls Protocol completion has averaged 98% this month, with a continued good response from staff.

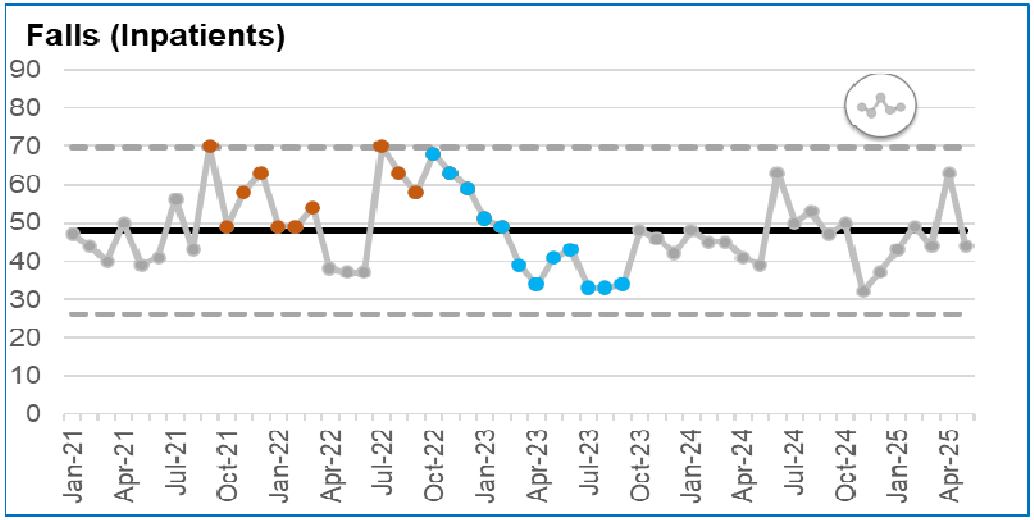
Incident Grading
There were no red incidents.
Amber: A total of three falls (6%), two falls for inpatients who were diagnosed with a hip fracture. One amber fall for a member of staff who did not harm themselves; highlighted as needing further review as appeared to have several previous incidents with the same service user potentially targeting the member of staff.
Yellow: A total of seven (13%) reported events needed higher intervention, such as attending A&E, or minor treatment.
Green: A total of 43 (81%) reported safety events had low, or no harm recorded. Main themes reported linked with over reaching for items; agitation; low blood pressure and dizziness; and early signs of infection.

Inpatient falls had a high correlation with:
• there were 18 falls (41%) were for older adults
• some reported falls (9%) did not occur on the wards. Three falls were patients on leave; one fall for a visitor who fell when they went out with their relative
• there were 27 falls (61%) involving patients with a recognised history of falls, and of these falls:
  - there were 16 falls (59%) for patients with a diagnosis of dementia
  - all 27 patients (100%) had multiple long-term health conditions

NICE quality standard reviews in May 2025 across the older adult, stroke/neuro wards showed approximately 81 patients, 65 years and above; recognised as being at a high risk of falls, of those:
• there were 18 falls (22%) for people aged above 65yrs old
• long-term health conditions were reported in 78 (96%) of all older patients at risk of falls
• there were 56 (69%) patients needing support with daily living skills
• physiotherapy reviews took place for 81 (100%) patients recognised as a higher risk of falls
• individualised mobility plans were in place for 77 patients (95%) and included education, and therapy groups to reduce deconditioning

Falls (Inpatient)

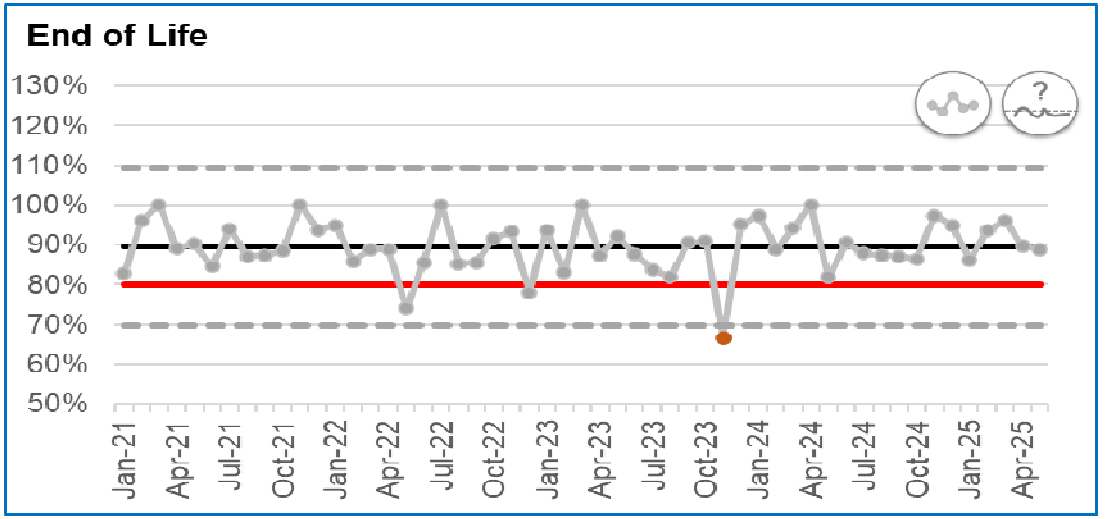
The total number of inpatient falls was 44 in May.



The SPC chart above shows that in May 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 88.9% in May. 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 May 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:

- 96% would recommend physical health services
- 94% would recommend mental health services

	Target	March	April	May
Mental health community	85%	95% (249)	95% (208)	95% (314)
Mental health inpatient	85%	90% (51)	91% (23)	91% (32)
Learning Disabilities	85%	100% (22)	100% (21)	94% (49)
ASD/ ADHD	85%	94% (32)	100% (17)	92% (12)
CAMHS	85%	83% (24)	86% (21)	88% (33)
Forensic	60%	63% (32)	N/A	N/A
Mental health overall	84%*	**91% (410)**	95% (308)	94% (450)
Barnsley Physical Health	95%	**93% (318)**	96% (394)	96% (421)
Trustwide	**85%**	**92% (728)**	96% (702)	95% (871)

** weighted for 2023/24*

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

Overall satisfaction across the Trust has slightly decreased in May, however, remains above target.

Trustwide returns have increased for the first time in the past 3 months the overall satisfaction has seen a decreased but remains above target.

Satisfaction across Child and adolescent mental health services (CAMHS) increased in May and is the highest for many months, with an increased number of returns.

All service lines remain above target.

Attention Deficit Hyperactivity Disorder & Autistic Spectrum Disorder services have seen a decrease in returns, but the overall satisfaction remains above target. There is ongoing work with the team to increase the number of returns.

Learning disabilities have seen an increase in returns, the overall satisfaction has decreased but remains above target.

Safeguarding

Safeguarding Adults:
In May 2025, there were 62 safeguarding adult incidents recorded on Datix. Of these, there were Zero incidents graded red, three graded amber, 27 graded yellow and the remaining 32 were graded green. The most common subcategories of these were financial abuse, self-neglect and neglect.

In addition to the Safeguarding Adult Datix's, there were 24 sexual safety incidents recorded on Datix. Of these, 11 were graded yellow and 13 were graded green with the most common subcategory relating to inappropriate sexual behaviour.

Safeguarding Children:
In May 2025 there were 10 Datix categorised as Safeguarding Children. There were no red incidents reported, one was classified as amber, seven were classified as yellow incidents and three were classified as green incidents. The most common subcategories of these were sexual abuse and child protection (non specific).

Complaints

• In May there were 28 new formal complaints received into the Trust. This includes Cheswold Park. This is a slight decrease from April, however is higher than the same time last year.
• Of these, 5 had the initial theme of values and behaviours (staff) as the primary reason for the complaint. It is important to note these are complaints which have not yet been investigated.
• 17 complaints were closed in May and 88% (15) were closed within the six month statutory timeframe. Of the two that were outside of the six month one was delayed due to complex consent issues and the other due to consent and difficulty agreeing the scope of the complaint.
• No complaints were re-opened in May.
• There were 75 compliments received, which is a notable increase from 25 in April.

Reducing Restrictive Physical Intervention (RRPI)

This report includes Cheswold Park data from April 2025. In May 2025 there were

• 170 reported incidents of restrictive physical interventions used in May 2025, this was an increase of 12 (7.5%) from April which stood at 158

• Prone restraint (those remaining in prone position and not rolled immediately) was reported 11 times an increase of 3 (22.22%) from April 2025 which stood at 8. The use of prone has been reducing compared to previous years and focus is being applied to situations where prone is used with the aim of reducing to zero incidents by April 2026. The trajectory of no more than 12 restraints during April and May has been achieved, however, there was an increase in incidents in May. Incidents were mostly attributed to our psychiatric intensive care units. A deep dive into each case is undertaken and learning shared across teams. Reducing restrictive practice intervention training from the 1st April teaches all new starters and refresher training to exit seclusion and administer intramuscular medication without using prone restraint. The trajectory for June and July is no more than 10.

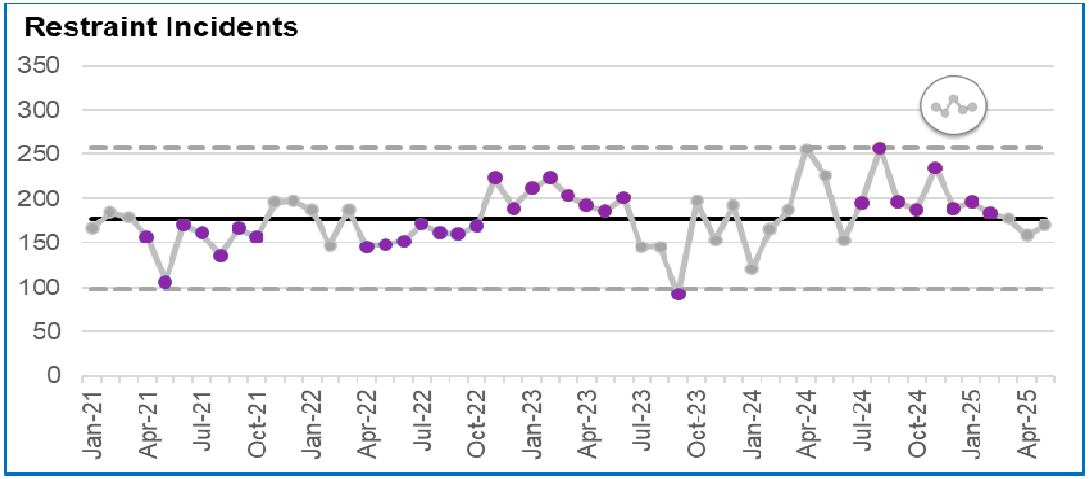
• 100% of Prone Restraints in May 2025 lasted under 3 minutes.

• In May 2025 there were 48 incidents of Seclusion use Trustwide, a decrease of 7 (12.7%) from April 2025 which stood at 55.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	83	35.2%
Safety Pod	46	19.5%
Side	34	14.4%
Seated	31	13.1%
Supine - held on their back regardless of surface	20	8.5%
Prone descent then remained in chest down position	9	3.8%
Restricted escort	6	2.5%
Kneeling	5	2.1%
Prone descent then immediately rolled to other position side/back	2	0.8%

Team Using Prone Restraint	May-25
Walton PICU	3
Melton PICU, Barnsley	2
Stanley Ward, Wakefield	2
Ashdale Ward, The Dales, Calderdale	1
Clark Ward	1
Horizon	1
Nostell	1

Duration of Prone Restraint	May-25
0 - 1 minute	9
1 - 2 minutes	2

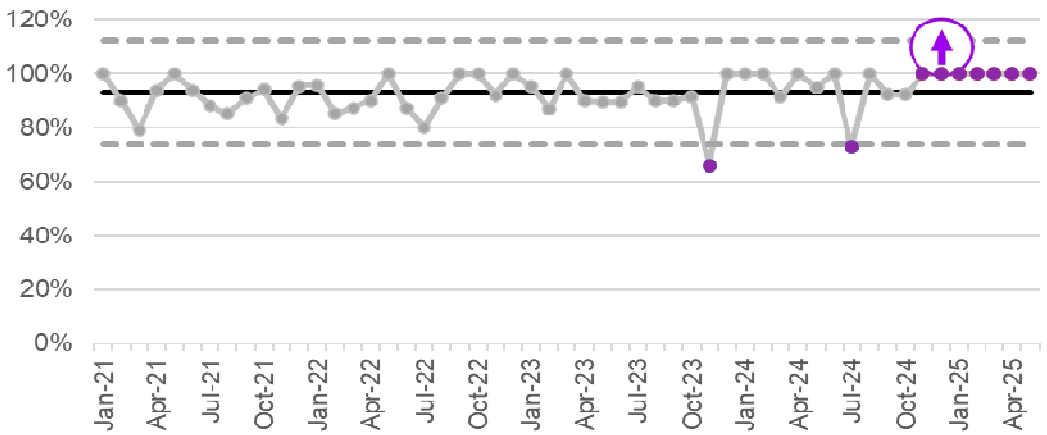


This SPC chart shows that in May 2025 we remain in a period of common cause improving variation.

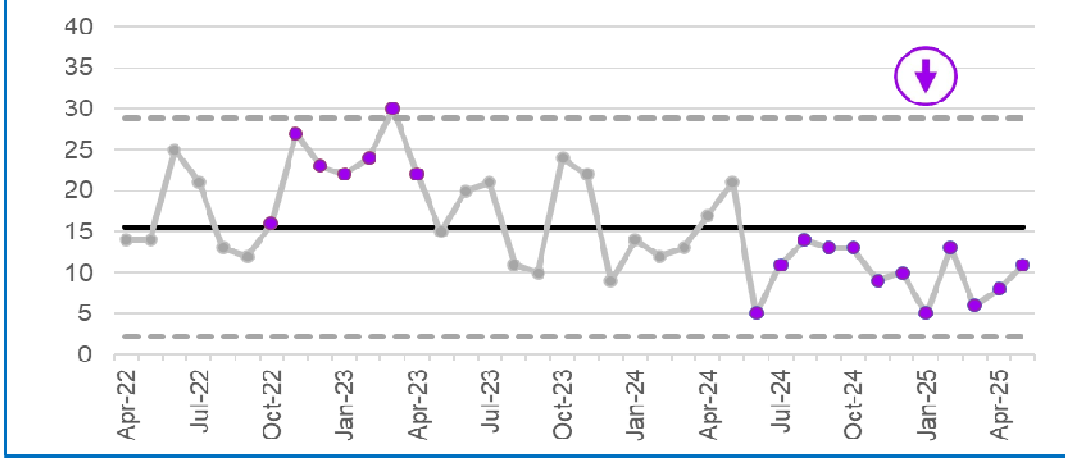
It should be noted that an increase in restraint incidents does not always indicate a deterioration in performance.

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.

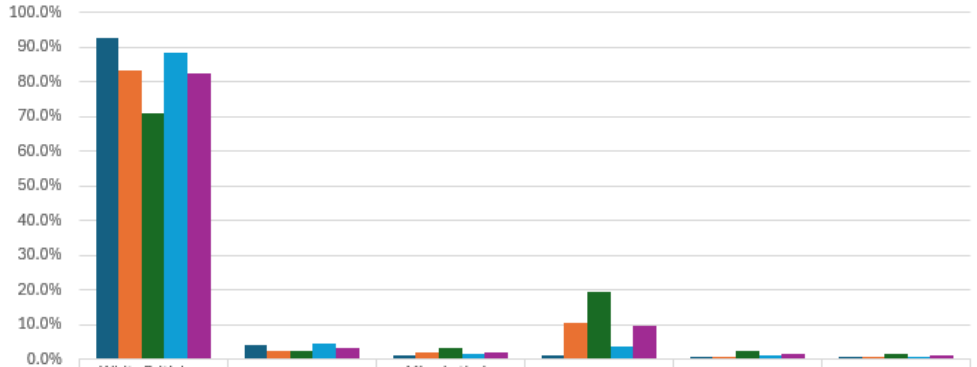
The number of prone restraints has increased in May, however the SPC chart shows an overall reducing trend. All incidents of prone restraint are reviewed for learning in the Patient Safety Oversight Group. The improvement work continues.

Reducing Inequalities

This section of the report has been added to give focus to a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities and will guide us to being an inclusive employer where everyone can be themselves and feel valued for their contribution. We will continue to further develop this section of the report over the coming months in line with the deployment of our Equality, diversity and inclusion (EDI) strategy.

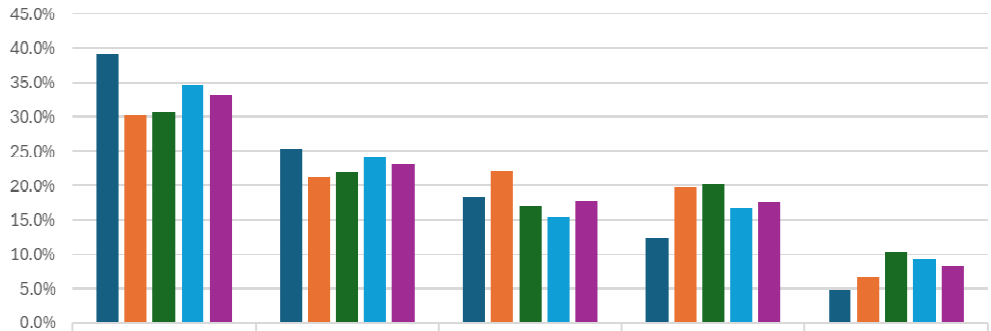
The population our Trust serves is varied in terms of ethnic make-up and also levels of deprivation. We can measure the relative deprivation of an area using 7 distinct domains of deprivation, which are: 1) Income 2) Employment 3) Health deprivation and disability 4) Education, skills & training 5) Crime, 6) Barriers to housing and services, 7) Living environment. These can be examined individually or collectively and as a collective these are known as Indices of Multiple Deprivation (IMD). IMD can be shown grouped as quintiles or deciles (5 levels or 10 levels respectively), with IMD 1 or quintile being the most deprived. From the Trust data it is possible to see that a significant proportion of all our populations experience higher levels of deprivation. The charts below show the populations of the main areas we serve as well as a Trust total split by Ethnicity and deprivation level.

Population Served by the Trust and each of its Main Localities Split by Ethnicity



	White British or Irish	Other White	Mixed ethnic groups	Asian, Asian British	Black, Black British	Other ethnic group
Barnsley	92.8%	4.1%	0.9%	0.9%	0.7%	0.5%
Calderdale	83.5%	2.6%	1.9%	10.5%	0.7%	0.8%
Kirklees	71.1%	2.6%	3.1%	19.4%	2.3%	1.5%
Wakefield	88.5%	4.6%	1.4%	3.6%	1.3%	0.7%
Trust	82.4%	3.4%	2.0%	9.8%	1.4%	1.0%

Population Served by the Trust and each of its Main Localities Split by Deprivation Level



	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Barnsley	39.1%	25.3%	18.3%	12.4%	4.9%
Calderdale	30.2%	21.3%	22.2%	19.7%	6.6%
Kirklees	30.6%	22.0%	16.9%	20.2%	10.3%
Wakefield	34.5%	24.2%	15.4%	16.7%	9.2%
Trust	33.3%	23.1%	17.7%	17.6%	8.3%

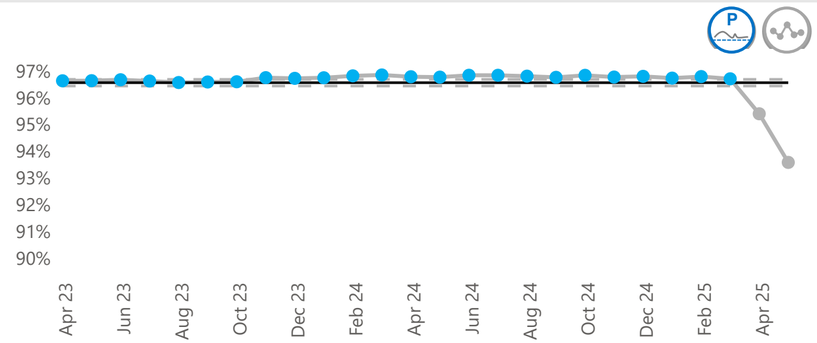
Reducing Inequalities

Data as of : 10/06/2025 12:53:23

NHS South West Yorkshire Partnership NHS Foundation Trust

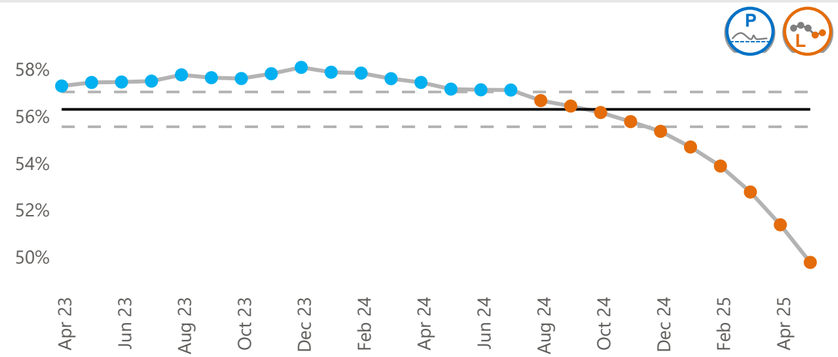
In order to ensure equitable access to our services it is important to monitor the levels of our service users who have their equality data, such as ethnicity, disability status, sexual orientation, and postcode, completed. Data quality is vital to ensure we are able to offer services the meet the needs of the populations we serve. The SPC charts below show the completion rates for these measures.
Please note the scales in the below charts are different due to the small variation between data points, using a larger scale would lose the fluctuation between data points.

M92 - Percentage of service users who have had their equality data recorded - ethnicity



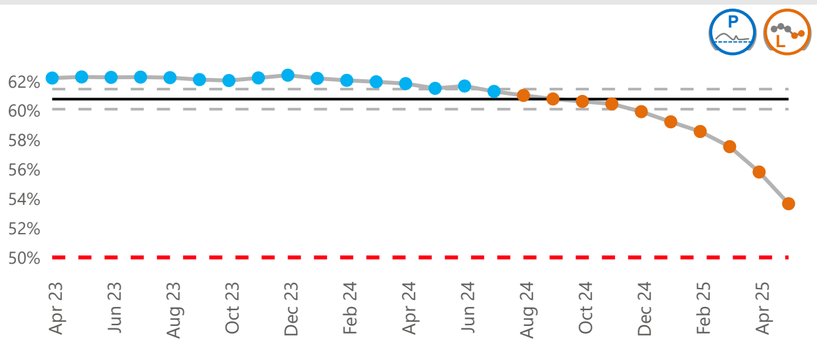
The Statistical Process Control (SPC) chart shows that in April 2025 we remain in a period of common cause variation (no concern). We are expected to meet the target against this metric.

M93 - Percentage of service users who have had their equality data recorded - disability



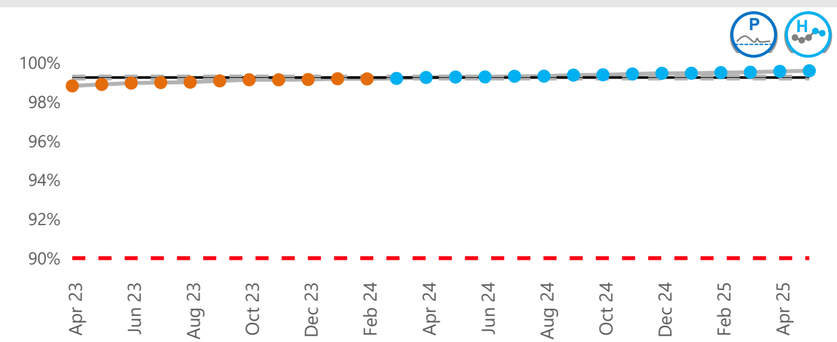
The SPC chart shows that in April 2025 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months.

M94 - Percentage of service users who have had their equality data recorded - sexual orientation



The SPC chart shows that in April 2025 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months.

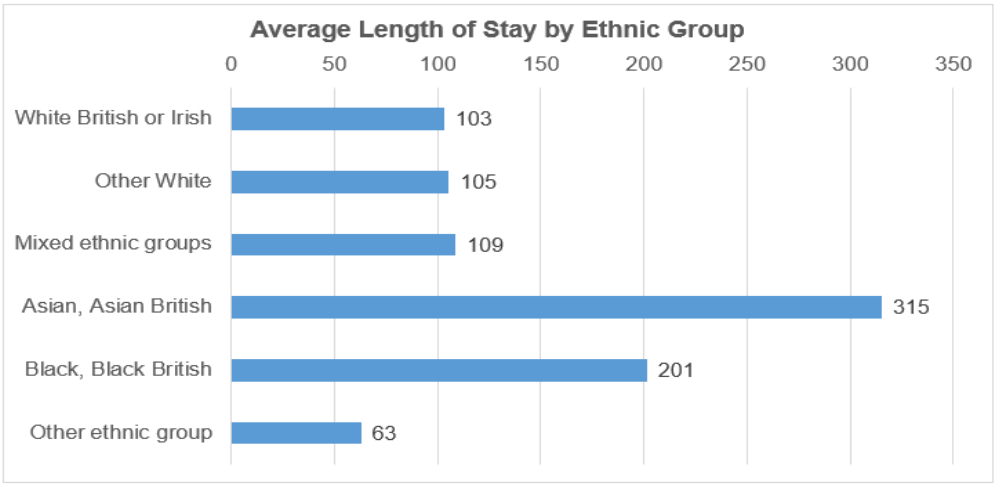
M95 - Percentage of service users who have had their equality data recorded - deprivation (postcode)

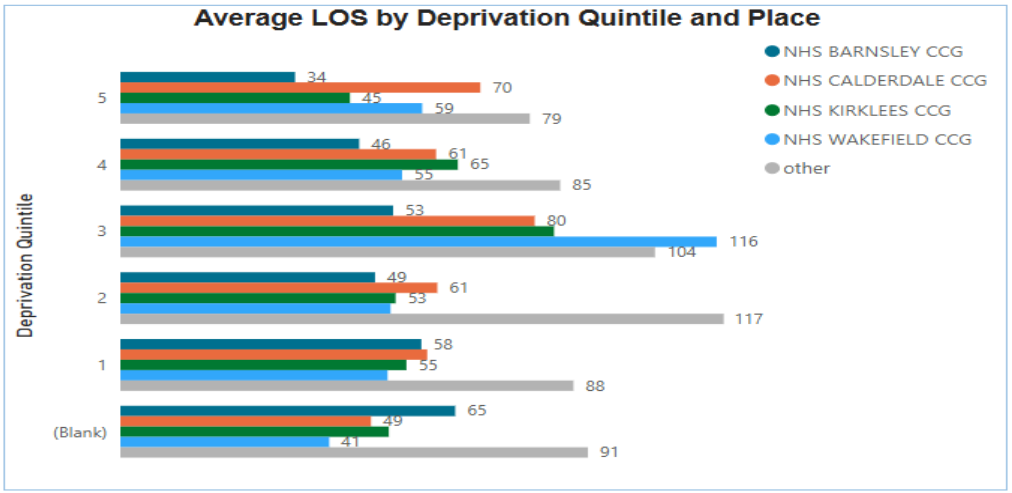


The SPC chart shows that in April 2025 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance.

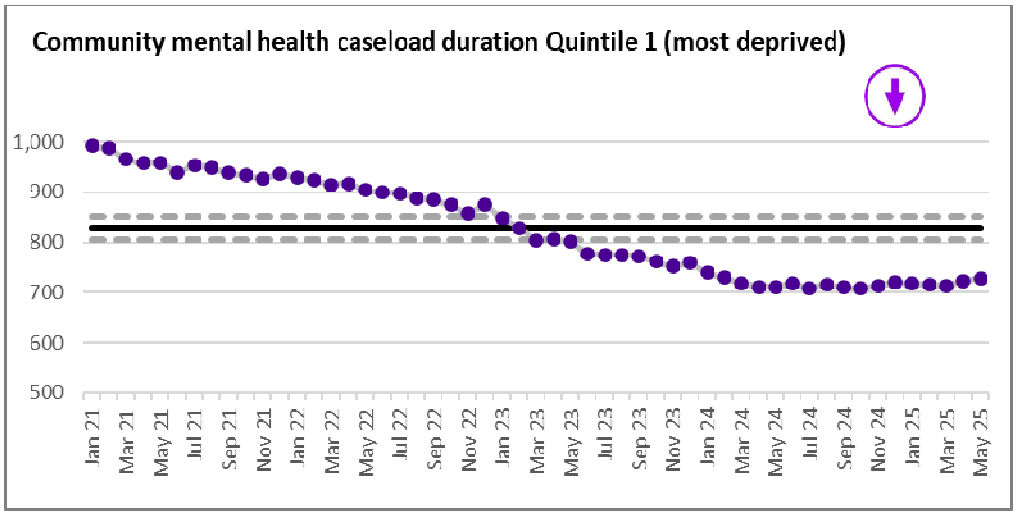
Reducing Inequalities

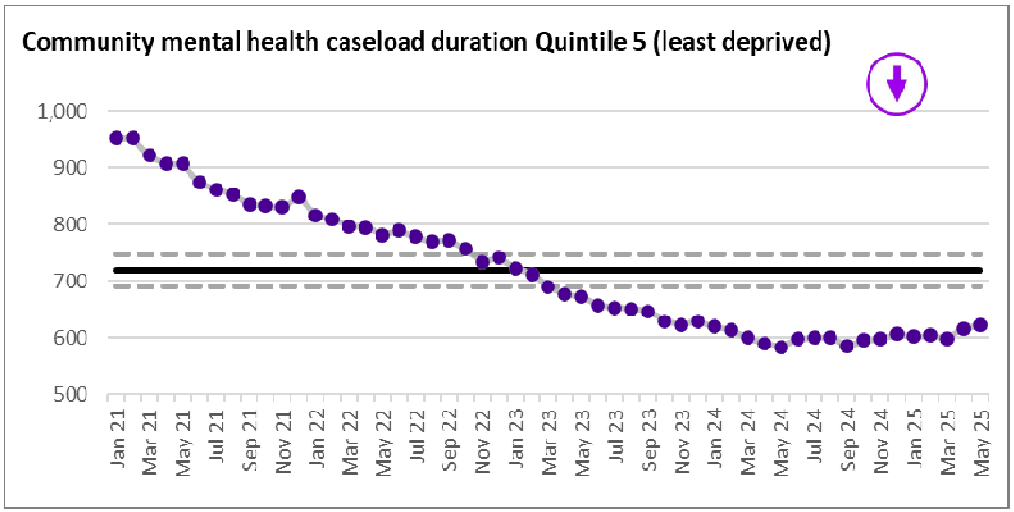
The charts below show the average lengths of stay (ALOS) for our Acute and PICU, adult and older adults wards, for the financial year 2024/2025 (excluding 136 Suite and out of area stays). The data suggests that deprivation may be an independent factor that affects caseload duration. Services are working hard to understand if and how this may factor in their own data.





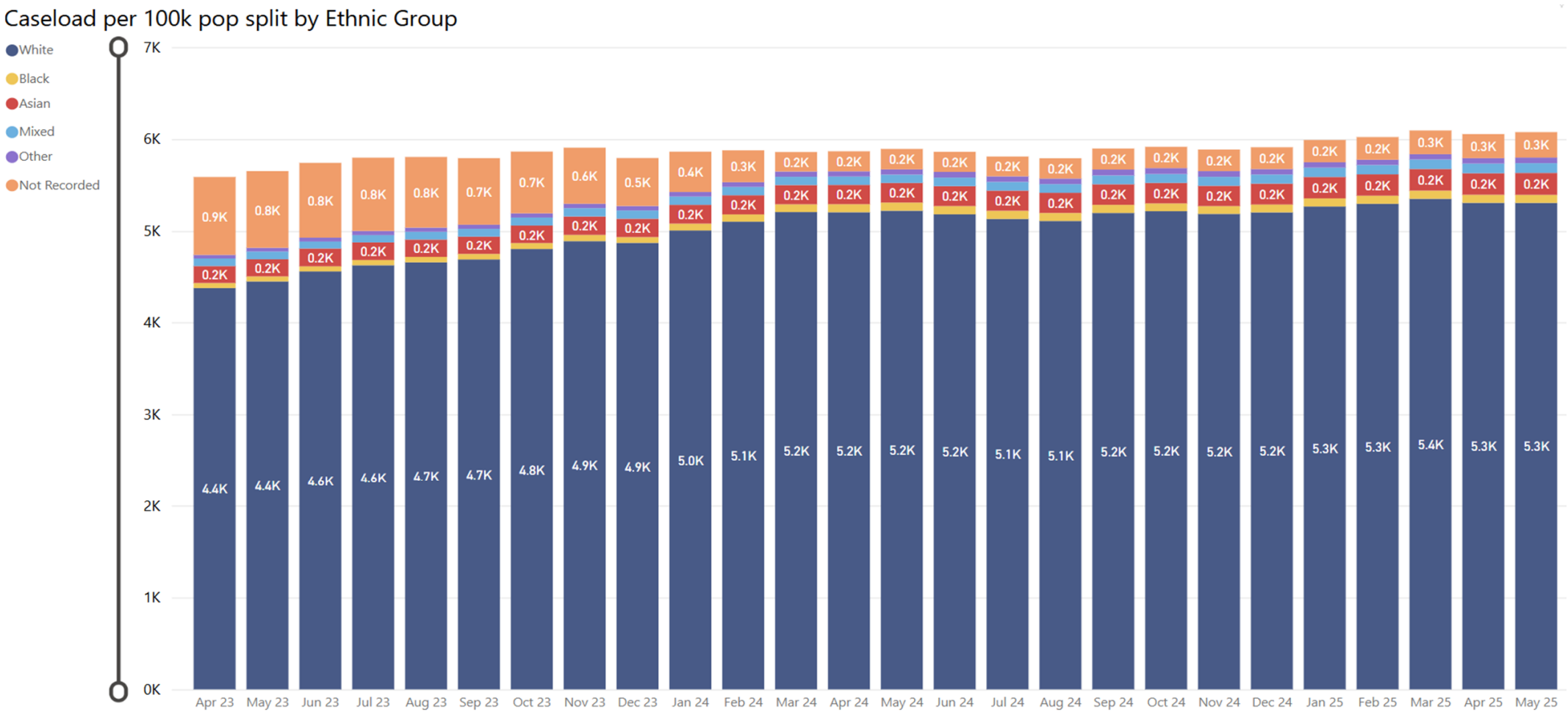
The charts below show the average caseload length for patients on the caseload of a community health team by those with a post code in the most deprived areas (Quintile 1) and those with a post code in the least deprived areas (Quintile 5).





Reducing Inequalities

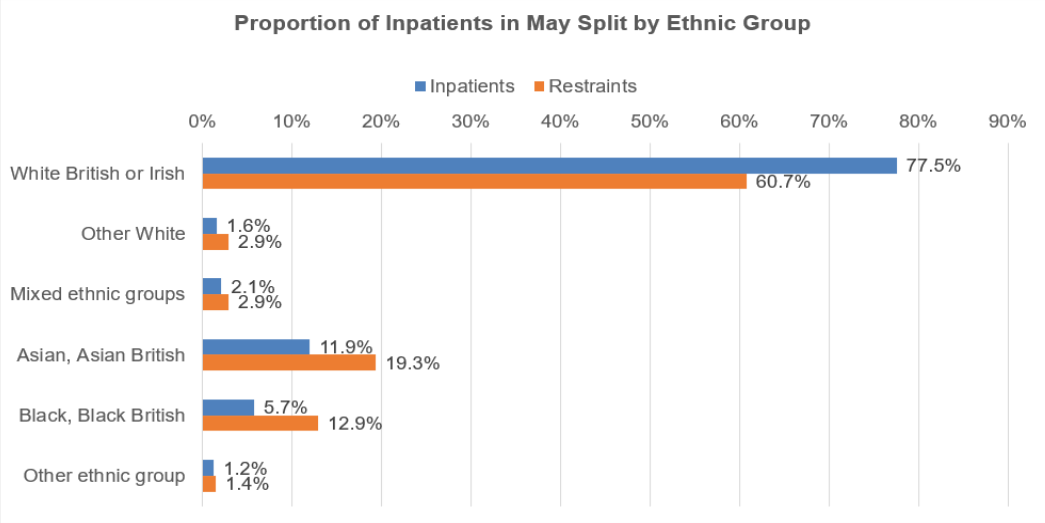
The chart below shows the split by the ethnic group of the clients on the caseload of a community health team, shown per 100,000 population.

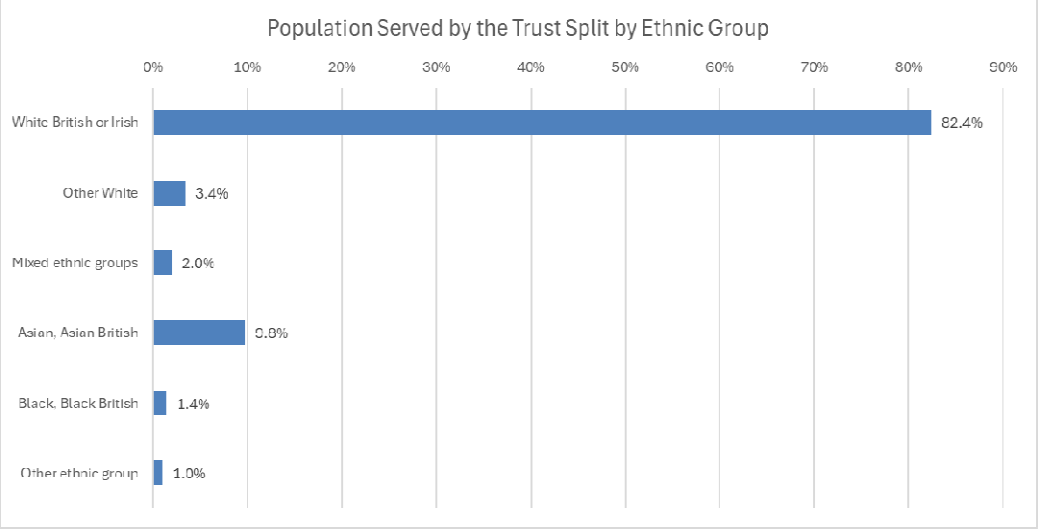


NB: 'White Other' is incorporated in the 'white' category in this chart.

Reducing Inequalities

The chart below shows the proportion of inpatients and proportion of restraints split by ethnic group. The population of the Trust split by ethnic group is shown alongside for ease of comparison.

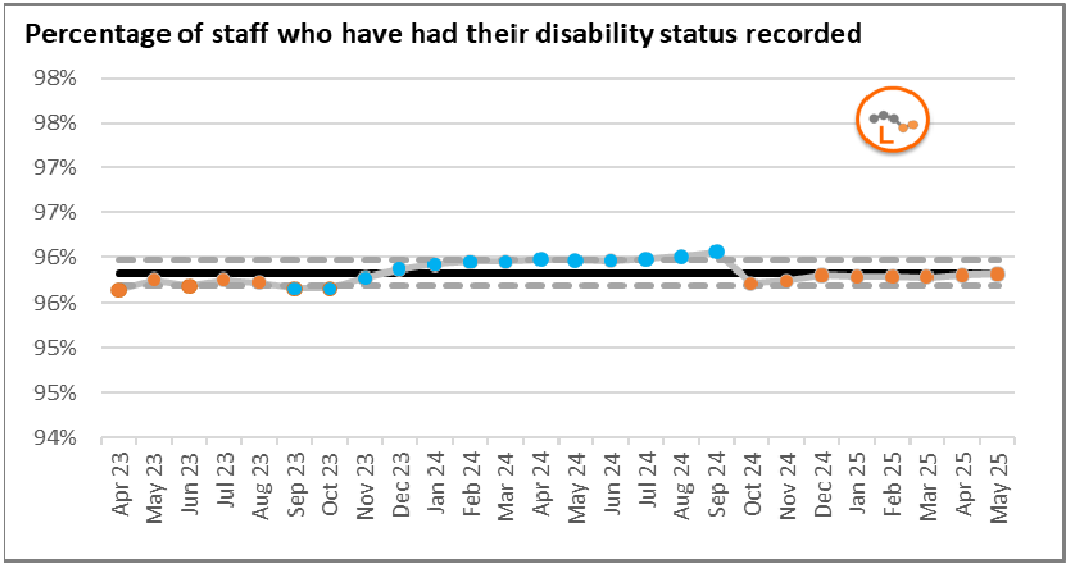


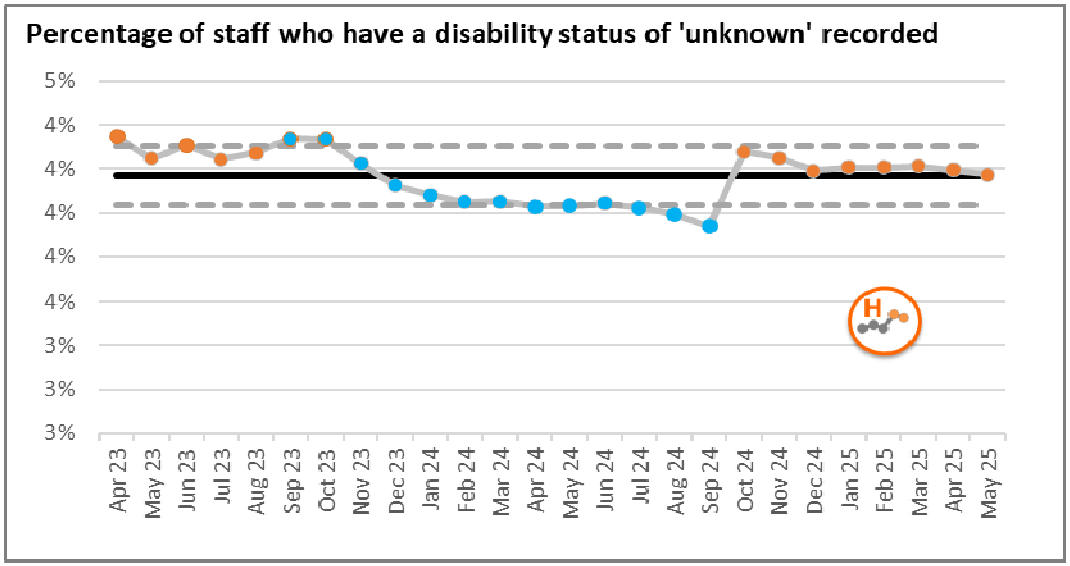


Reducing Inequalities

Disability Confidence and Data Transparency

Objective: Foster a culture where more colleagues feel safe and supported in disclosing their disability status.





Further development of people related metrics will be undertaken over the coming months with focus being on the following areas: Increase Diversity in Senior Leadership, Fair and Trusted Processes, Wellbeing with Inclusion at the Core.

People - Performance Wall

Trust Performance Wall

	Strategic Objective	CQC Domain	Threshold	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Establishment	Best place to work and learn	Well led	-	5524.3	5526.8	5523.1	5514.2	5733.3	5733.3
Contracted Staff In Post (Ledger)	Best place to work and learn	Well led	-	4738.8	4746.5	4747.5	4749.9	4988.0	4971.6
Vacancies	Best place to work and learn	Well led	-	785.5	780.4	775.7	764.3	745.3	761.7
Turnover external (12 months rolling) *	Best place to work and learn	Well led	>12% - <13%	7.6%	7.8%	7.7%	8.6%	9.4%	9.2%
Starters	Best place to work and learn	Well led	-	17.4	48.3	30.6	25.2	21.2	19.4
Leavers	Best place to work and learn	Well led	-	30.0	40.7	26.9	74.1	41.8	24.0
% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	79.2%	83.7%	83.3%	85.7%	84.6%	80.8%
% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	82.6%	82.2%	83.1%	82.6%	85.2%	87.3%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	91.7%	93.6%	92.6%	90.9%	89.7%	89.5%
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) *	Best place to work and learn	Well led	-	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%)	229 - All staff (17.4%) 93 - excl medics (8.4%)	232 - All staff (17.7%) 94 - excl medics (8.5%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)	Best place to work and learn	Well led	-	915 (71.0%)	921 (71.2%)	927 (71.4%)	935 (71.4%)	936 (71.4%)	937 (71.3%)
Sickness absence - YTD	Best place to work and learn	Well led	<=5%	5.3%	5.3%	5.3%	5.2%	4.7%	4.7%
Sickness absence - Month	Best place to work and learn	Well led		5.7%	5.5%	5.1%	4.6%	4.7%	4.7%
Employees with long term sickness over 12 months	Best place to work and learn	Well led	-	2	2	2	2	1	1
Appraisals - rolling 12 months	Best place to work and learn	Well led	Feb 82.3% Mar 84.9% April 87% May 88%	88.6%	84.2%	84.3%	86.3%	88.4%	89.8%
Employee Relations - Suspensions (over 90 days)	Best place to work and learn	Well led	-	0	0	2	2	2	6
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	64	61	71	60	66	72
Workforce growth (substantive staff)	Best place to work and learn	Well led	-2%	2.3%				-0.3%	
Registered substantive staff in post mental health and learning disabilities services	Best place to work and learn	Safe	Establishment - 1315	1,139	1,134	1,138	1,143	1,174	1,174
Registered substantive staff in neighbourhood teams	Best place to work and learn	Safe	Establishment - 169	160	164	165	166	162	160
% staff recommending the Trust as a place to work	Best place to work and learn	Caring	65%	70%				Annual metrics - due Jan 26	
% staff recommending the Trust as a place to receive care and treatment	Best Quality	Caring	65%	72%					
Mandatory Training - TOTAL	Best place to work and learn	Well led	>=80%	93.4%	93.6%	93.7%	93.3%	94.0%	94.7%
Mandatory Training - Reducing Restrictive Practice Interventions	Best place to work and learn	Well led		80.5%	81.5%	80.1%	79.6%	82.1%	84.3%
Mandatory Training - Cardiopulmonary Resuscitation	Best place to work and learn	Well led		82.0%	80.9%	81.3%	79.7%	80.9%	82.7%
Mandatory Training - Clinical Risk	Best place to work and learn	Well led		95.1%	96.5%	96.6%	96.4%	96.7%	97.0%
Mandatory Training - Display Screen Equipment	Best place to work and learn	Well led		97.9%	98.1%	98.0%	98.2%	98.3%	98.5%
Mandatory Training - Equality & Diversity	Best place to work and learn	Well led		96.3%	96.4%	96.3%	95.9%	96.6%	97.3%
Mandatory Training - Fire Safety	Best place to work and learn	Well led	>=85%	90.0%	90.6%	90.9%	88.9%	90.7%	91.9%
Mandatory Training - Food Safety	Best place to work and learn	Well led	>=80%	91.3%	92.2%	92.4%	92.5%	94.0%	94.6%
Mandatory Training - Freedom To Speak Up (FTSU)	Best place to work and learn	Well led		96.9%	97.0%	97.1%	97.2%	97.4%	97.7%
Mandatory Training - Infection Control & Hand Hygiene	Best place to work and learn	Well led		94.9%	94.9%	95.3%	94.4%	95.6%	96.3%
Mandatory Training - Information Governance (Data Security)	Best place to work and learn	Well led	>=95%	93.6%	93.5%	93.1%	91.1%	92.4%	95.8%
Mandatory Training - Moving & Handling	Best place to work and learn	Well led	>=80%	97.7%	97.8%	97.9%	98.0%	98.3%	98.7%
Mandatory Training - Nat Early Warning Score 2 (New S2)	Best place to work and learn	Well led		97.7%	98.1%	97.9%	97.9%	98.0%	98.3%
Mandatory Training - Mental Capacity Act/Dols	Best place to work and learn	Well led		91.0%	91.6%	91.6%	91.3%	91.8%	92.2%
Mandatory Training - Mental Health Act	Best place to work and learn	Well led		88.5%	90.0%	90.5%	90.4%	91.7%	92.4%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1	Best place to work and learn	Well led		92.1%	92.9%	93.8%	94.0%	94.8%	95.3%
Mandatory Training - Prevent	Best place to work and learn	Well led	>=80%	95.3%	95.7%	95.7%	95.4%	96.4%	96.9%
Mandatory Training - Safeguarding Adults	Best place to work and learn	Well led		91.0%	91.1%	91.0%	91.1%	91.6%	91.4%
Mandatory Training - Safeguarding Children	Best place to work and learn	Well led		93.3%	93.6%	92.9%	92.4%	91.7%	91.7%

Notes:

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

Staff in post

• The reduction in staff between April and May has been largely down to the ending of Liaison & Diversion services roles (around 33 whole time equivalents) at the end of the contract. There have also been some terminations of fixed term contracts ending in May which have not been renewed (3). Further fixed term contracts will be coming to an end throughout the year.

Vacancies

• Due to the reduction of staff in post we have seen a rise in vacancies (+16.4) against a static establishment figure (no change).
• The Trust has concluded it's first level establishment review and identified 116 Community Support Workers (Health Care Support Workers) vacancies across all ward areas. A full recruitment plan between now and March 2026 is in place. The first cohort (15) was identified on 21st June.

Turnover & Stability

• External turnover has reduced by 0.2% in month. This is still under our target of between 12-13%. We are seeing higher turnover in clinical support roles (12%), but sustained low turnover in nursing (7%) and medics (6%).
• As a result of higher leavers in the first 2 months, our overall stability has dropped, but still remains around 90% which is within expected range.
• As previously mentioned the end of contract for the Liaison and Diversion service resulted in the ending of around 33 whole time equivalent staff. There have also been some terminations of fixed term contracts ending in May which have not been renewed (3). Further fixed term contracts will be coming to an end throughout the year.

Sickness

• Overall sickness absence remains low in May at 4.7%.
• We are seeing higher absence rates in Forensics (7.8%) and Estates (7.0%) with both relating to higher levels of long term sickness cases which are being pro-actively managed between People business partners and Operational leads.
• The higher levels of long term sickness in these two areas are contributing factors to an overall rise in long term sickness as a % of total absence.
• The introduction of a new 'Live' sickness absence dashboard has been rolled out Trustwide, enabling faster, more dynamic intervention and management of hotspot areas for sickness in teams and individuals.

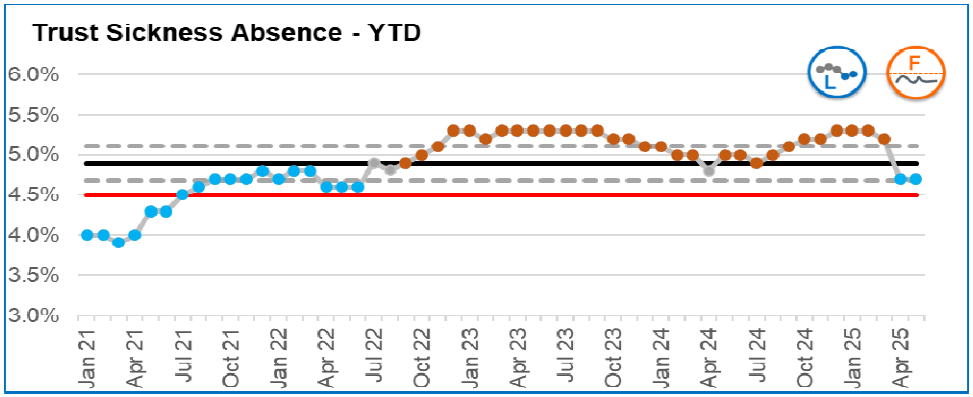
Appraisal Compliance

• The overall year to date figure in May 25 is 89.7%: an increase of 6.7% since March 25.
• We are projecting the rate will improve to 90.1% by the end of June. This will mean we have met the target set by executive management team by the end of June (90% KPI)
• All areas of the Trust have improved their appraisal position month on month since April 25.
• The roll out of online Electronic Staff Record Oracle Learning Management (ESR OLM) continues with development of agreed templates with operational/human resource collaboration for suitability

Training Compliance

• Our overall mandatory training compliance remains above target at 94.7%.
• All mandatory training in May is above our target (Green). This is the first time the Trust has achieved this.
• Information Governance training is now green at 95.8%
• Reducing Restrictive Practice Interventions training 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 and as a result has seen an increase in compliance to 84.3%.
• The Trust Learning & Development team are part of the work led by Skills for Health to reform national mandatory training delivery into the national Core Skills Training Framework. We are also reviewing our 'Essential To Job Training' matrixes.

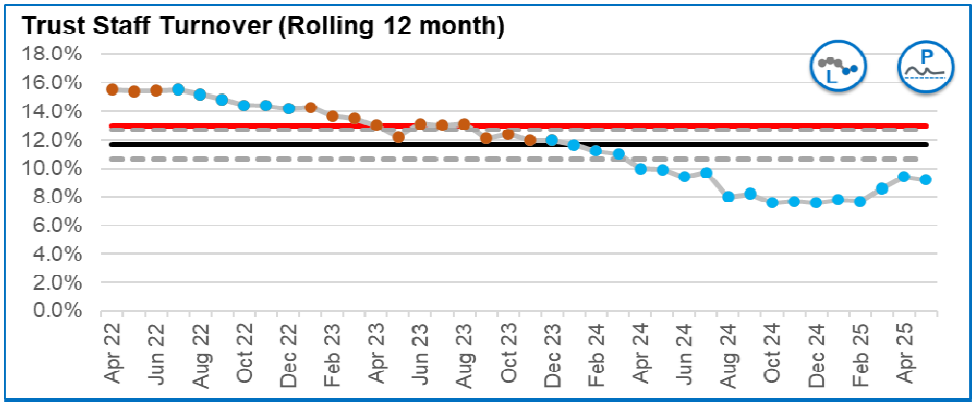
Statistical process control charts



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

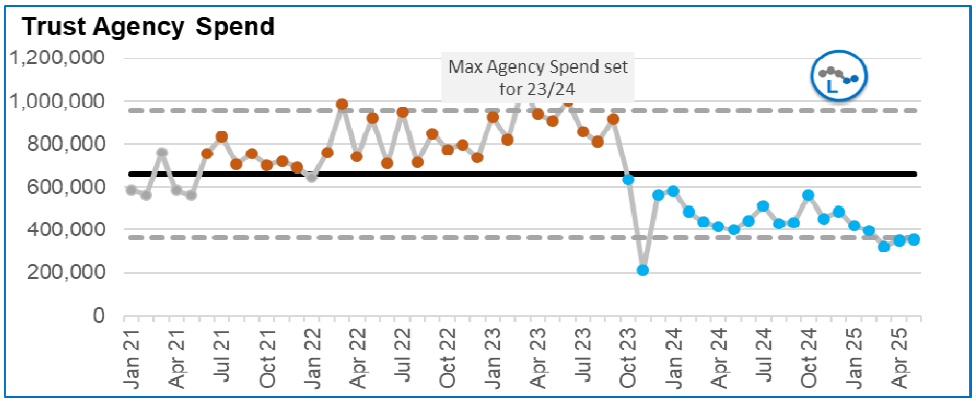
From July 2022 this data also includes absence due to Covid-19.

From April 2025 this data includes Cheswold Park Hospital.



The SPC chart shows that in May 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.

From April 2025 this data includes Cheswold Park Hospital.



The Trust agency expenditure plan included a reduction in line with planning guidance. In April expenditure (£0.4m) is less than plan and this is forecast to continue.

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

From April 2025 this data includes Cheswold Park Hospital.

Please see the Finance Report for further information.

National Metrics

Data as of : 19/06/2025 16:39:52

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.

On the 27th March 2025, as part of its Board meeting papers, NHS England (NHSE) published an updated NHS Performance Assessment Framework for 2025/26. NHSE's Board approved the updated framework for consultation (to take place 2nd to 23rd May) and engagement during the first quarter of 2025/26. The intention is to publish the final framework at the end of quarter 1, with the first formal segmentation of all Trusts and Integrated Care Boards (ICBs) being undertaken and published in July. As part of the framework, a number of delivery metrics have been identified that, subject to approval following the consultation, would be applicable to the Trust and would underpin the segmentation scores for each organisation. The Trust awaits publication of the technical guidance and once available, we will undertake an assessment of its performance against these metrics which have been grouped into the following categories: operating priorities, financial and productivity metrics, public health and patient outcome metrics and, quality and inequalities metrics. Once the metrics and definitions have been confirmed, these will also be reported in the IPR. In the meantime, the Trust will continue to report on national metrics from the current version of the NHS Oversight Framework 2022/23, and updates have been undertaken to align with operational planning priorities for 2025/26. In addition, further updates will be made to align to any key contractual reporting requirements that are not already included as the contracts are finalised.

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

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more	Best Quality	Responsive		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M210	The number of completed non-admitted RTT pathways in the reporting period	Best Quality	Responsive		1700													2174	1906
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive		92%	P		99.9%	99.7%	99.5%	99.5%	99.2%	99.0%	98.2%	97.2%	96.7%	97.0%	97.1%	97.2%
M202	RTT waiting list, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive															31	53
M203	Number of 52+ week RTT waits, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive		0													0	0
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680													3957	4035
M205	RTT waiting list within 18 weeks, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive															1	1
M206	Diagnostic test activity	Best Quality	Responsive		190													128	70
M209	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Best Quality	Responsive		5%													35.7%	51.3%
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%			95.6%	97.4%	97.9%	97.5%	100%	97.8%	100%	100%	98.9%	100%	97.8%	97.9%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0	F	L	114	111	124	138	96	131	127	106	92	128	144	150
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5		L	4	3	4	4	4	5	4	3	4	4	5	5
M208	Average Length of stay for Adult Acute Beds (rolling 3 months)	Best Quality	Responsive					52.2	59.2	56.7	68.9	64.1	58.2	52.9	70.2	61.9	62.3	54.1	57.1
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%	P	H	92.7%	91.7%	86.2%	90.3%	97.6%	91.8%	96.7%	87.2%	94.3%	100%	87.9%	87.5%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%			96.0%	96.6%	96.8%	96.5%	96.5%	96.9%	98.1%	97.8%	97.4%	96.9%	96.8%	97.2%

National Metrics

Data as of : 19/06/2025 16:39:52

NHS South West Yorkshire Partnership NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
M34	% Clients in settled accommodation	Best Value	Effective	⚠	60%	P	L	83.2%	83.5%	83.6%	84.0%	83.3%	84.1%	84.4%	84.3%	83.1%	83.2%	83.2%	83.5%
M35	% Clients in employment	Best Value	Effective	⚠	10%	P	H	13.0%	12.6%	12.7%	12.5%	13.1%	13.3%	12.8%	12.5%	13.2%	13.2%	13.0%	13.2%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		1	5	5	0	0	1	0	1	0	2	0	0
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?	L	1	3	1	0	0	1	0	1	0	1	0	0
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%	?		100%	50%	100%	100%	100%	100%	100%	85.7%	100%	100%	100%	50%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%	?		96.6%	100%	87.5%	84.8%	88.9%	76%	59.3%	71.8%	71.7%	59.6%	73.7%	93.8%
M47	Virtual ward occupancy	Best Quality	Responsive		80%	?		81.4%	91.4%	70%	82.9%	86.7%	112%	101%	100%	121%	119%	103%	82.7%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0	F	L	6	3	1	1	1	2	2	2	3	2	3	0
M30	Number of detentions under the Mental Health Act (MHA)	Best Quality	Safe					99	106	105	97	94	118	96	90	102	92	109	106
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					27.3%	24.5%	25.7%	11.3%	25.5%	20.3%	19.8%	23.3%	15.7%	20.7%	22.0%	23.6%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%	P	H	98.7%	99.3%	99.4%	99.0%	98.7%	98.6%	97.8%	98.7%	99.8%	99.6%	99.7%	99.8%
M11	Talking Therapies - Treatment within 18 weeks of referral	Best Quality	Effective		95%	P		100%	100%	100%	100%	100%	100%	100%	100%	99.8%	100%	100%	100%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users	Best Quality	Well Led		90%	P	H	99.8%	99.1%	99.3%	100%	99.0%	99.1%	99.2%	99.7%	99.8%	99.8%	99.5%	99.7%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%	?	L	48.5%	47.8%	49.8%	50.7%	52.0%	52.6%	50.7%	52.6%	49.4%	50.1%	48.5%	51.9%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%	?		69.2%	66.2%	69.0%	70.3%	71.0%	68.4%	68.6%	68.9%	67.9%	71.6%	68.1%	68.5%
M15	Data Quality Maturity Index	Best Quality	Well Led		95%	P		99.5%	99.4%	99.5%	99.5%	99.6%	98.4%	98.4%	98.0%	99.6%	99.6%	99.2%	99.6%
M41	Completion of a valid NHS number	Best Value	Well Led		99%	P	H	99.9%	99.5%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100.0%
M42	Completion of ethnicity coding for all service users	Best Value	Well Led		90%	P	H	99.4%	100.0%	99.4%	100.0%	99.5%	99.6%	99.5%	99.6%	99.6%	99.4%	99.4%	99.5%
M43	Community health services two hour urgent response standard	Best Quality			70%	?	H	89.9%	92.0%	91.6%	91.6%	90.9%	88.0%	89.2%	90.6%	90.2%	92.6%	90.3%	91.0%

National Metrics

Data as of : 19/06/2025 16:39:52

NHS South West Yorkshire Partnership NHS Foundation Trust

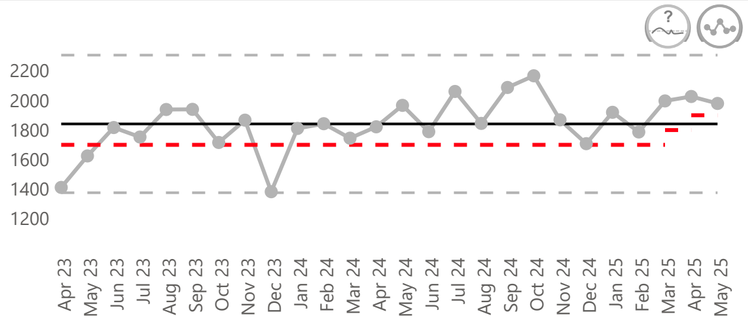
MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%	?	L	51.3%	50.9%	51.0%	54.1%	53.9%	54.6%	52.4%	55.1%	53.0%	53.2%	51.0%	53.5%
				Place	Barnsley	50%	?		52.1%	50.9%	50.4%	51.2%	51.0%	50.8%	50.9%	50.8%	49.4%	52.7%	51.3%	52.8%
					Kirklees	50%	?		50.6%	50.8%	51.5%	56.8%	57.0%	59.1%	53.8%	59.2%	56.3%	53.8%	50.7%	54.2%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				529	554	545	518	679	586	509	633	524	566	615	600
				Place	Barnsley			H	241	237	278	253	355	317	241	311	244	270	318	312
					Kirklees				288	317	267	265	324	269	268	322	280	296	297	288
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months	Best Quality	Responsive	Trust	Trust				10466	10425	10366	10322	10247	10315	10332	10390	10444	10452	10608	10591
				Place	Barnsley	2000	P	H	2148	2146	2174	2164	2182	2218	2206	2209	2202	2183	2202	2205
					Calderdale	1200	F	H	1168	1166	1171	1177	1175	1157	1171	1178	1179	1199	1232	1247
					Kirklees	3600	F	H	3113	3105	3099	3086	3034	3017	3092	3167	3246	3272	3319	3349
					Wakefield	3900	P	L	4037	4008	3922	3895	3856	3923	3863	3836	3817	3798	3855	3790
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust			H	1217	1233	1249	1305	1421	1519	1566	1642	1696	1833	1913	1982
				Place	Barnsley	283	F	H	191	190	197	203	226	244	250	252	255	278	299	314
					Calderdale	247	F	H	225	225	230	242	261	264	269	279	281	302	305	312
					Kirklees	541	F	H	464	468	464	486	521	546	553	570	576	626	660	694
					Wakefield	406	F	H	322	330	335	347	375	418	440	477	508	543	558	567
M194	Number of people accessing individual placement and support (IPS) services (rolling 12 months)	Best Quality	Responsive	Trust	Trust			H	467	470	474	485	482	480	480	483	466	463	448	437
				Place	Calderdale			H	115	115	113	115	113	108	102	109	106	110	104	99
					Kirklees			H	164	168	170	179	167	167	163	161	157	158	153	149
					Wakefield			H	185	184	188	188	186	186	182	173	158	151	150	154

National Metrics

Data as of : 19/06/2025 16:39:52

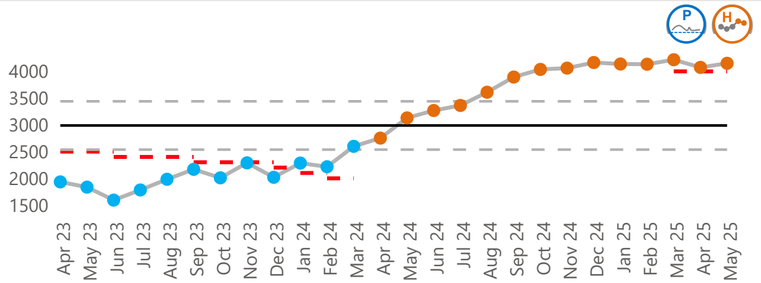
NHS South West Yorkshire Partnership NHS Foundation Trust

M184 - New RTT pathways (clock starts)



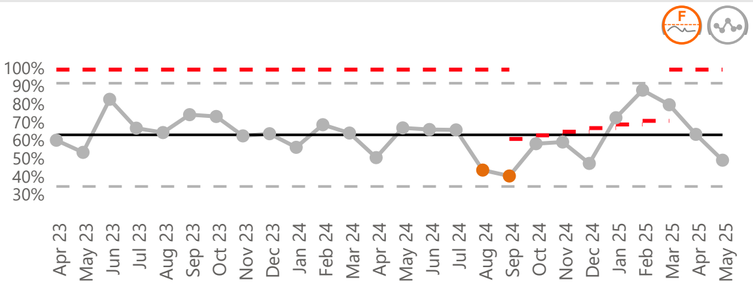
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). We are expected to meet the target against this metric. Though a new target is in place for 2025/26.

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



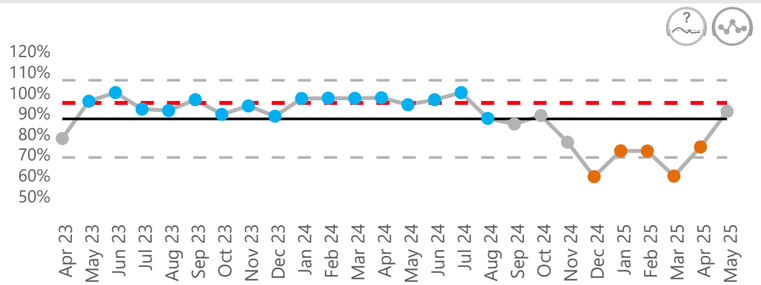
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months.

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



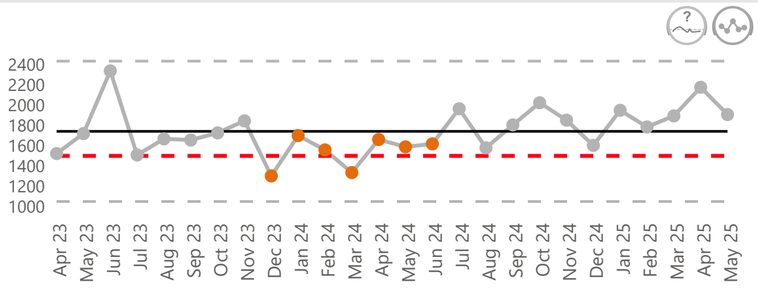
The SPC chart shows that we remain in a period of common cause variation (no concern.

M14 - Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks



The SPC chart shows that we have re-entered a period of common cause variation (no concern) following an increase in performance in the last month which is back in line with usual performance.

M44 - The number of completed non-admitted RTT pathways in the reporting period



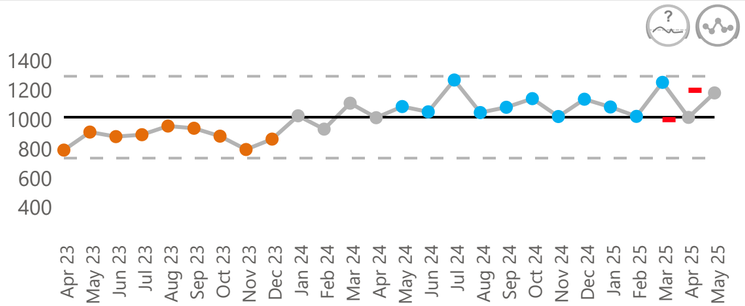
The SPC chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers this time last year.

National Metrics

Data as of : 19/06/2025 16:39:52

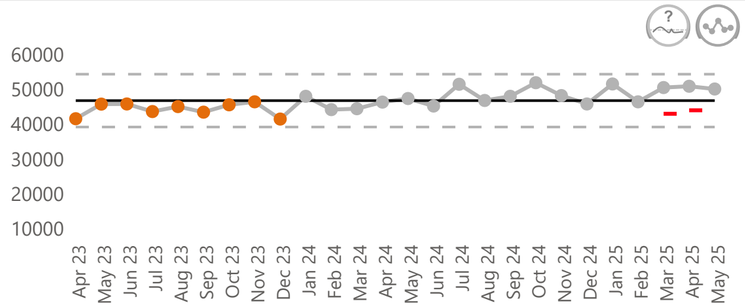
NHS South West Yorkshire Partnership NHS Foundation Trust

M187 - Urgent Community Response (UCR) referrals



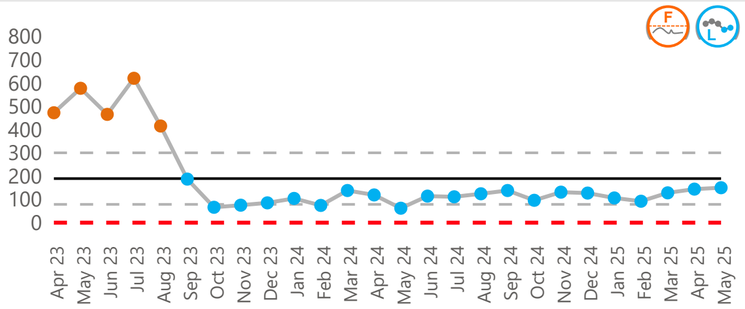
The SPC chart shows that we remain in a period of common cause variation (no concern).

M207 - Attended Community Care Contacts



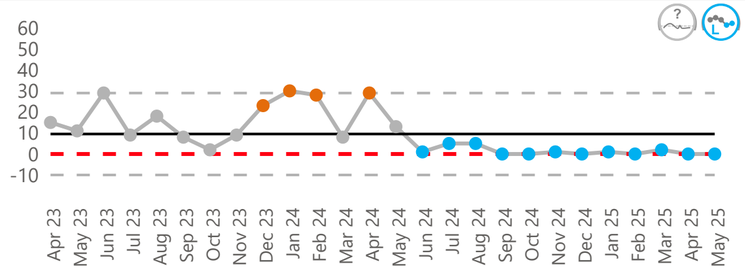
The SPC chart shows that we remain in a period of common cause variation (no concern).

M2 - Inappropriate out of area bed days



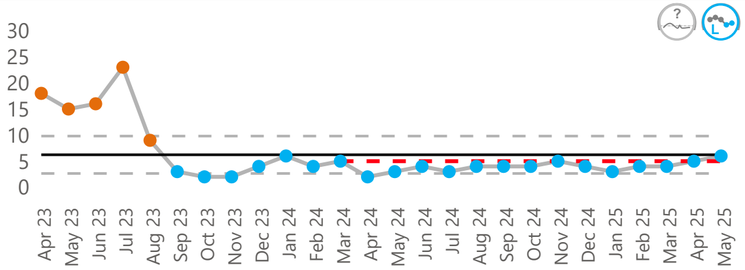
The SPC chart shows that we remain in a period of special cause improving variation (something is happening and should be investigated) following a continued overall reduction in the performance in May. We are still not anticipated to achieve the target of zero.

M8 - Total bed days of Children and Younger People under 18 in adult inpatient wards



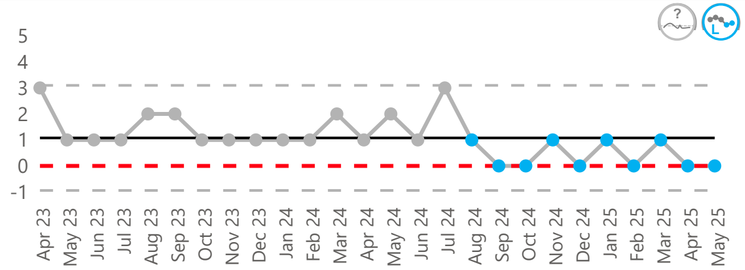
The SPC chart shows that we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained reduction in the number of bed days for under 18 year-olds.

M182 - Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)



The SPC chart shows that we remain in a period of special cause improving variation (something is happening and should be investigated) due a sustained reduction in the number of clients placed out of area.

M9 - Total number of Children and Younger People under 18 in adult inpatient wards



There were no admissions aged under 18 to an adult ward in May 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.

National Metrics

Data as of : 19/06/2025 16:39:52

NHS South West Yorkshire Partnership NHS Foundation Trust

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

- There were no admissions of under 18 year olds to adult acute mental health beds during May.
- There was a slight increase in out of area bed usage up to 150 days used in May and 6 people remaining placed out of area at the end of the month.
- The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks is 93.8% in May - this relates to 2 service users who were not seen, both were a result of the impact of the ARFID (Avoidant/Restrictive Food Intake Disorder) pathways and undefined reporting processes. These are being explored with NHS England. The urgent access to treatment measure has dropped to 50% in May. Of the two breaches, one was offered an appointment within the time frame but this was declined by the family and the other was delayed due to the service having difficulties contacting the family to arrange an appointment.
- 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 remains above the target of 80% at 82.7% for May.
- 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 has decreased in May to 63.9%, remaining below the national threshold of 99%. A contributing factor to this is that the only current full-time member of staff took some annual leave during May. Additional staffing will be in post from the end of June and agency cover will continue until their induction period is completed. A trajectory for reduction of agency staff will coincide with start date.

A number of new national metrics were applicable to the Trust from April 2025, these are part of the operational planning framework. Forecasts for 2025/26 were agreed with place commissioners at the start of the financial year aligning to national, local and regional priorities. This is the second month performance against these metrics has been reported in the integrated performance report and a number of these are showing as being outside expected levels:

- The number of non admitted RTT pathways in the reporting period – this relates to the Musculoskeletal service and the higher number than forecast continues to relate to an overall increase in demand for the service.
- Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months – Kirklees - slight under performance against the forecast for May although achieving 93% of forecast target, we will continue to monitor performance against this line.
- Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months – Wakefield – slight under performance against the forecast for May although achieving 97% of forecast target, we will continue to monitor performance against this line.

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 May the following data quality issue has been identified in the reporting:

- The reporting for employment and accommodation shows 11.7% 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.

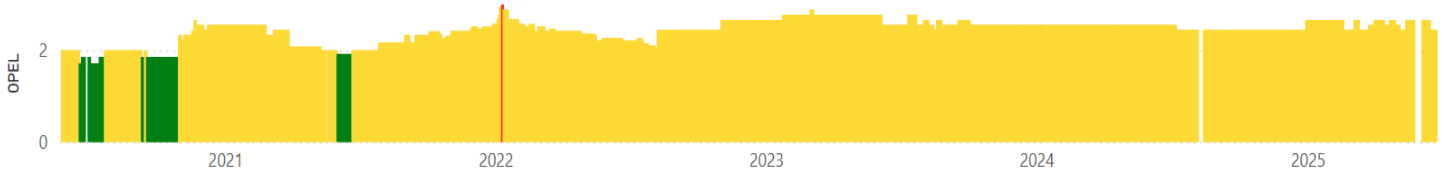
Operational planning priorities

On 30th January 2025, NHS England (NHSE) released its 2025/26 priorities and operational planning guidance.
The guidance outlines the ambition for the NHS to transform and to address the challenges highlighted by Lord Darzi's "Independent investigation of the NHS in England", 12 September 2024, such as long wait times and declining public health. Key priorities include improving productivity, shifting care to community settings, focusing on prevention, and embracing digital transformation. Local systems will have more control over funding, and integrated care is being developed. Leadership and management will be strengthened, and a new framework will assess performance. Financial responsibility is crucial to ensure resources are used wisely within the allocated financial envelope. Additionally, a new 10-Year Health Plan aims to create a modern, sustainable health service. These changes aim to make the NHS more efficient, and patient focused.
The guidance also sets the expectation for integrated care boards (ICBs), Trusts, and primary care providers to collaborate with other integrated care system (ICS) partners to achieve a balanced financial position. Further detail in relation to the Trusts response to this can be seen in the Trusts Operational Plan for 2025/26.

The following section provides an update on a number of key national operational priorities that the Trust will contribute to during 2025/26:

- Reduction in 12-hour breaches of people presenting at acute A&E with mental illness – to be good partners we are working with our acute Trusts in West Yorkshire on a national project to reduce the Emergency Department waits. To understand the impact of this on the whole pathway for those waiting for beds in mental health services, the project will look at how we share data to align the 12-hour breach waits to our internal waits. Once this is established, we will try to report on the 12-hour breaches.
- Reduction in acute length of stay. The Trust has set itself a local target to reduce adult acute lengths of stay by 10% by the end of March 2025. Performance against this can be seen in the national metrics section above and individual care group and ward level compliance can be seen in the care group section of the report.
- Increased access for children and young people – our performance against this metric can be seen in the national metrics section above.
- Productivity of services for children and young people – work is taking place across the Trust to improve productivity across all services whilst continuing to deliver (and improve) high quality and safe services. To support Trust financial viability. For services to work within the financial envelope defined within the establishment reviews, exploring and exploiting opportunities for working differently and effectively. Updates will be provided as this work progresses.
- The Trust does not anticipate further expansion of Mental Health Support Team (MHST) services in 2025/26, aside from continuing to embed the Wave 12 teams following the investment made at the end of 2024/25 and realisation of the full-year effect (FYE) in 2025/26. Efforts will focus on maximising the impact of existing funding to reduce waiting times and improve access to services. This will involve close collaboration with local communities, schools, and healthcare providers to tailor support to local needs. The Trust will also implement digital innovations to enhance service delivery, map workforce requirements to ensure appropriate staffing, and collect and analyse feedback to drive continuous improvement. Ongoing staff training and development will be prioritised, alongside the creation of integrated care pathways to ensure seamless support across services. Additionally, staff wellbeing will remain a key focus to maintain a resilient and effective workforce.
- Expansion of talking therapies service - The ongoing expansion of talking therapies services is progressing in alignment with national expansion targets and the corresponding funding provisions further plans for service development include:
    - Aim to increase performance against reliable recovery and reliable improvement metrics in line with funding and locally agreed targets.
    - Use benchmarking to compare your performance against peers, identify areas of variation, and set measurable goals for improvement.
    - Identify initiatives that aim to reduce missed appointment rates (also known as Did Not Attends (DNAs) reducing overall waiting times and increasing reliable recovery/improvement.
    - Additional focus on improving recovery waits for all communities with a focus on black, Asian and minority ethnic communities and on older people.
    - Ensure our service strategy is aligned with the Long-Term Plan and the Advancing mental health equalities strategy with a focus on improving access, outcomes and experiences for specific populations and under-represented groups.
    - Identifying gaps and opportunities for skill mixing to enhance capacity and efficiency in community services.

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

2.44

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

Children and Young Peoples Mental Health Services

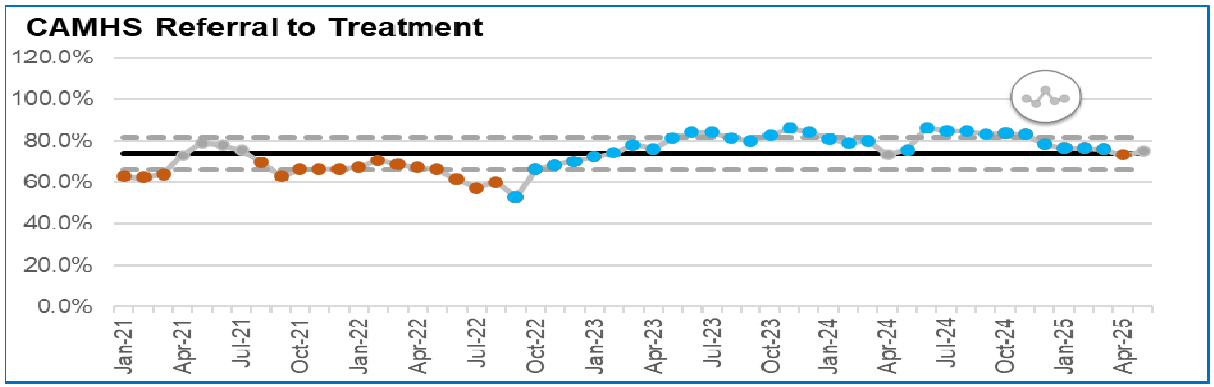
Headlines

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 Young Peoples Mental Health Services (CAMHS)

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	81.9%	85.0%	86.1%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (1/3)	33% (1/3)	0% (0/3)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	86.6%	83.5%	84.0%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	98.4%	94.1%	97.6%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.4%	80.1%	82.0%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	59.6%	73.7%	90.9%	
Eating Disorder - Urgent/Emergency clock stops	Best Quality	Effective	95%	100.0%	100.0%	25.0%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.2%	90.9%	96.5%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	78.2%	80.8%	79.3%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.4%	2.8%	2.1%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	349	341	332	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	775	806	907	
Total number of reported incidents	Best Quality	Safe	Trend monitor	55	33	31	

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



In May 2025, the SPC chart indicates that we have entered a period of common cause variation (no action required), following a recent downward trend in the percentage. See narrative below for further information.

Alert/Action

• Calderdale & Kirklees CAMHS continue to experience increasing waiting lists which are impacted by multiple challenges including staffing levels and referrals into services outstripping capacity, resulting in some teams operating in business continuity.
• 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. Commissioners are sighted on these challenges.
• Calderdale & Kirklees CAMHS Keeping Kirklees in Mind (KKiM) mental health support team (MHST) continues to experience significant challenges around recruitment and retention especially with band 5 roles. This appears to be a regional problem. Discussions are ongoing with Kirklees commissioners regarding variations in the service model.
• Capacity and Demand across Community CAMHS Crisis and Eating Disorder teams are being monitored, some teams utilising business continuity measures and rated as red on Risk Register. In Wakefield as temporary staffing cannot be supported via agency, and there are no bank staff with the specialist skills, the team cannot deliver anything beyond the basic core offer.
• Wakefield CAHMS staffing – ReACH Team, Primary Intervention Team (PIT) which is the single point of access (SPA) (including the Eating Disorder Team) all utilising business continuity measures due to low staffing numbers and challenges recruiting to posts. A range of options is being considered and activated, lead by the General Manager.
• Secure CAHMS – Information Technology access of clinical systems and people files needs to be transferred from partner server as part of the Wetherby Youth Offenders Institute mobilisation with access to Trust drives essential. The lack of Trust IM&T infrastructure within the three secure settings continues to provide challenges and risks. This issue has now been added to the risk register due to concerns of the impact that this will have upon service delivery and is rated as red.

Advise

• Calderdale & Kirklees CAMHS- Eating Disorder Service have reopened the Avoidant/Restrictive Food Intake Disorder (ARFID) pathway to referrals following an internal review supported by commissioners. Referral criteria have been updated to support the reduction of inappropriate referrals and workshops for stakeholders on the revised service have been provided. Senior management continue to monitor the situation.
• Calderdale & Kirklees CAMHS- Increased referrals and reduced resources are impacting waiting times for ADHD medication activity. Increased diagnosis of ADHD has led to the Trust receiving an increased number of referrals for medication assessment from Right to Choose (RtC) providers specifically within Calderdale. Kirklees numbers are directly related to number of diagnosed assessments undertaken by the ND assessment team in Kirklees, which currently does not utilise RtC.
• Calderdale & Kirklees CAMHS Crisis team continues to receive in the region of 100 referrals per month for children and young people requiring emergency or urgent support. In addition, the Calderdale & Kirklees CAMHS Crisis line receives in the region of 100 calls per month and also a further 25 calls per month from NHS 111.

Assure

• Sickness across the Children and Adolescent mental health care group is consistently below the overall Trust sickness rate of 4.77% at 2.6%. Both long and short term are being managed well
• Appraisal rates across the CAMHS for May is 86% (as of 11.06.25) This is an improvement on April's figure which was 81.25%. There are targeted action plans across the care group in place for those services indicating low appraisal rates
• Mandatory training across the care group is 95% (as of 11.06 25) which is an improvement on Aprils figure of 83.8 % with Data Security (Information Governance IG) standing at 96.2 %. (as of 27.05.25) Again an improvement on the April figure which was 92 1%
• Clinical supervision recording stands at 85.5 % across the care group (as of 16.06.25) and is an improvement from April's performance which was 84.2%
• The Secure Children's Home Aldine House in Sheffield achieved a rating of Good from the Care Quality Commission visit (2 weeks into contract)

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. 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 and has seen some improvement during the month.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	87.5%	88.4%	90.0%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	72.4%	68.1%	81.8%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	96.7%	97.1%	96.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	14% 1/7	6% 1/16	18% 2/11	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	89.3%	87.6%	89.8%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	83.8%	88.7%	95.7%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	95.8%	96.0%	96.1%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	94.4%	96.0%	96.5%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.9%	76.6%	78.7%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	From April 2025	92.5%	91.8%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.1%	92.1%	95.6%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	79.1%	81.5%	84.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.2%	3.9%	4.6%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,728	13,722	13,668	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	127	150	129	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	91.6%	96.0%	97.2%	
% Bed occupancy (excl leave)	Best Quality	Safe	85%	89.7%	90.1%	96.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	50% 1/2	0% 0/6	0% 0/4	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	88.1%	91.5%	87.7%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.8%	86.3%	87.1%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.2%	8.8%	9.5%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	From April	83.2%	85.3%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	155 (May)	128	144	148	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	94.6%	96.9%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	12	15	14	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	49	45	41	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	88.4%	88.4%	92.9%	
Restraint incidents	Best Quality	Safe	Trend Monitor	101	95	*96*	
Safer staffing (Overall)	Best Quality	Safe	90%	134.6%	132.1%	128.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	103.8%	104.3%	101.8%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	5.2%	5.3%	5.6%	
Average length of stay - Acute and Psychiatric Intensive Care Unit - West Yorkshire (3 Months Rolling)	Best Quality	Safe	From April 25 Apr - 63.1 May 62.5	60.5	55.6	55.0	
Average length of stay - Acute and Psychiatric Intensive Care Unit - South Yorkshire (3 Months Rolling)	Best Quality	Safe	From April 25 Apr - 63.9 May - 63.3	72.0	61.2	70.8	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	638	672	607	

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 Integrated Care Boards through the MADE meetings as well as a weekly Director of Services led challenge meeting with general managers.
• Workforce challenges have led to continued use of temporary staffing, primarily bank. Throughout May, 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 in May 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, recruitment is underway. Kirklees had 1 breach for assessment within 4 hours due to staffing pressures (assessed 30mins outside of target timeframe) and did not meet the 90% target in May.
• All areas are focussing on continuing to improve performance for FIRM risk assessments. Staying Safe plans are now captured as part of the 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 May'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. The go live of the new mental health care plan has negatively impacted on this metric reporting, in part due to clinical staff adapting to the new requirements of where and how to record items measured in the metric, and some changes to care programme approach (CPA) recording.
• The new care plan metrics for community are now capturing the whole community caseload rather than only individuals on CPA. The care group are working with the performance and business intelligence team to ensure the metric reflects practice. Clinical staff are adapting to the new requirements of where and how to record items adversely impacting on the overall compliance.
• 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 electronic staff record (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 levels are experiencing a number of long term sickness issues in addition to short term sickness. 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.
• The Single point of access (SPA) teams are prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. The access standard for assessed within 14 days of referral has been met in Barnsley and Wakefield. There have been challenges with admin vacancies in Calderdale & Kirklees SPA and there has been work focussing on assessing individuals waiting longer than 14days which have both impacted on performance.

Advise

• Improvement work is underway to understand the capacity and demand pressures on inpatient services and is monitored via the Inpatient Priority Programme. In addition, there is a focus on implementing the culture of care standards to improve the therapeutic nature of inpatient care for both service users and staff.
• Work continues in front line community services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home including provision of robust gatekeeping and crisis alternatives, trauma informed care and effective intensive home treatment.
• The Talking Therapies recovery rate for May is 54.24% for Kirklees and 52.81% for Barnsley, both achieving the national standard of 50%. In May, Barnsley Talking Therapies achieved the expected national standard of less than 10% for waits to second treatment within 90 days (5.47%). Kirklees is above target at 12.9%. This is measured on completion of treatment and is therefore measuring access some months ago. Data shows that current waits for second treatment are lower.
• 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). Care Group compliance has improved, particularly in inpatients where the target has been achieved. 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 SystmOne. Completeness of equality data is on our data quality improvement action plan.
• There were 8 incidents of prone restraint in May, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration. The monthly restraint oversight meeting, led by nursing quality and professions team, involving RRPI, safeguarding and matrons, review all prone restraint incidents for any opportunities for learning.
• The average length of stay metric for South Yorkshire (Barnsley wards) increased in May. This metric counts the average length of stay for people discharged during a rolling three month period. During March, April and May, there were 3 discharges that had had a particularly long length of stay with one of those being clinically ready for discharge since October 2024 but unable to discharge due to availability of suitable placement. The figure reported in April (February, March and April discharges) had discharges that were lower than average lengths of stay and this was due to a number of shorter stays being discharged during the period.

Assure

• Intensive home based treatment 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 May position achieving 100% and achievement of this standard has consistently been met since November 2024. 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	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	88.6%	87.3%	88.7%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/3)	0% (0/5)	40% (2/5)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	79.6%	75.0%	76.3%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	67.3%	55.4%	49.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.0%	85.1%	81.8%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	55.7%	90.1%	78.3%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	92.4%	94.8%	94.3%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	94.2%	91.2%	100.0%	
Physical Violence - Against Patient by Patient	Best Quality	Safe	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Best Quality	Safe	Trend Monitor	24	22	19	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	85.8%	87.2%	84.9%	
Safer staffing (Overall)	Best Quality	Safe	90%	172.7%	144.1%	138.5%	
Safer staffing (Registered)	Best Quality	Safe	80%	170.3%	157.4%	179.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.5%	5.1%	4.4%	
Restraint incidents	Best Quality	Safe	Trend Monitor	36	23	*22*	
Average length of stay	Best Quality	Safe	Trend Monitor	35	1015	270	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	71	55	60	

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

Alert/Action

• West Yorkshire Integrated Care Board (WY ICB) Neurodiversity project - The West Yorkshire tender process to increase the number of providers operating in West Yorkshire is underway. The new providers will offer ADHD and Autism assessments across all age groups and must be able to or have plans to offer ADHD medication under shared care too. The launch date has been delayed by 4 weeks to 1st August 2025. At present, this does not affect existing NHS contracts.
• Shared Care agreements for adults with ADHD in Calderdale - have reached an agreement with Calderdale Cares Partnership to be able to offer Shared Care agreements for adults with ADHD in Calderdale. This agreement enables our Service to retain patients on its caseload for automatic reviews, in accordance with national institute of clinical excellence (NICE) Guidelines, following the completion of their titration stage, rather than discharging them to primary care. Progress is already being made with this initiative.

Advise

Consultation
There is a consultation process taking place over the summer to establish how an all-age Neurodiversity hub might work as a first point of contact to offer support to people and potentially divert people from assessments, and to offer triage to the people that do.

Waiting Lists - Screening & Triage
• ADHD Our Service has over 725 people currently waiting for an ADHD triage appointment. This is an innovative new step available to people in Kirklees and Wakefield and is helping to ensure only clinically appropriate cases are added to the waiting lists. Analysis of Wakefield waiting lists shows that monthly waiting list growth has reduced from typically 3.7% to 1.2% per month since this step launched in the summer of 2024.
• Barnsley and Calderdale have not commissioned this, but both have expressed an interest and asked for updated business cases. The Calderdale paper has been shared with the business development team, the Barnsley one is almost complete.
• There are currently over 6400 people waiting for an ADHD assessment and the longest wait is typically around 3 years.
• It is important to note that despite these long waiting lists, the Service is continuing to deliver contracted activity. The service has capacity to assess up to 430 new cases each year and is on track to reach that target. 99 people (23%) have started the assessment process since April 2025.

Autism
• The Adult Autism pathway already includes screening and/or triage in 4 of the 5 Places (the Bradford service is included in this). Where this is in place in Bradford, Wakefield and Kirklees waiting lists are less than 12 weeks.
• Barnsley and Calderdale have expressed a desire to replicate the model.

Assure

• Excellent levels of supervision, appraisal and mandatory training.
• Low level of vacancies.
• Friends and family test results continue to show a sustained improved position but di remain under Trust threshold.
• All mandatory training meeting the threshold.

Learning disability services:

Alert/Action

Learning Disability (LD)
• Overall compliance with mandatory training is good with the only information governance training requiring additional focus.
• Appraisals, supervision remain a workforce priority. Slight dip in performance for supervision but appraisal compliance continues to improve.
• Progress being made on the NHS Survey Action Plan.
• 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

Community
• Recent data indicates a continued improvement in waiting list performance across 3 localities, but the service notes a drop in performance in Barnsley which will be addressed once understood..
• Community Teams continue to report high levels of LD service users in crisis.

Assessment & Treatment Unit (ATU)
• The service attended a strategic workshop involving West Yorkshire Providers and commissioners to discuss the current provision of the Assessment and Treatment services across West Yorkshire. Bradford have confirmed experiencing similar pressures re delivery of the service within the financial envelope. All who attended committed to a workstream to explore better use of available beds.
• Acuity remains high with all service users presenting with complex and challenging needs.
• 2 of the service users clinically ready for discharge have placements identified and plans are in place to discharge in June 2025.

Advise

Community
• The recruitment to speech and language therapy posts continues to be a challenge.
• Raising awareness of the Greenlight toolkit across the Trust has noticeably improved communication about individual service users when agreeing service provision or signposting.

Assessment & Treatment Unit (ATU)
• 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 – 94%.

Barnsley Physical Health and Wellbeing Care Group

Headlines

Musculoskeletal (MSK) and neurological physiotherapy estate issues continue and now are using alternative accommodation until the end of September 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	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	86.1%	92.9%	95.0%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	25% (1/4)	0% (0/2)	0% (0/1)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	96.2%	89.7%	88.9%	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	80.6%	78.6%	72.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.5%	84.2%	86.4%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	93.3%	95.3%	97.3%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	97.0%	97.1%	97.2%	
Safer staffing (Overall)	Best Quality	Safe	90%	104.6%	106.2%	102.9%	
Safer staffing (Registered)	Best Quality	Safe	80%	107.8%	113.1%	102.3%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.8%	4.6%	4.1%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	99%	79.6%	63.2%	49.0%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	6,821	6,741	7,036	
Total number of reported incidents	Best Quality	Safe	Trend monitor	203	261	223	

Barnsley Physical Health and Wellbeing Care Group

Alert/Action

• Musculo Skeletal (MSK) Service & Neuro Physio - Priory Day Centre remains closed. Remedial works planned will no longer take place as there is no capital funding available. Services affected continue to utilise Priory Campus as temporary alternative accommodation and this arrangement has been extended further until end of September 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.
• Paediatric Audiology 6-week target for diagnostic procedures has seen a further dip in May from 63.9% to 49% against the target of 99%. A contributing factor to this is that the only current full-time member of staff took some annual leave during May. Additional staffing will be in post from the end of June and agency cover will continue until their induction period is completed.

Advise

• Staff receiving supervision - continues to receive focus with a drive to improve recording and increased numbers of trained supervisors. We have seen a small reduction to 72.2% for May which is below compliance. We are seeing an increase into June already at 76.5%.

Assure

• Appraisals - for May the figure has increased again and is exceeding compliance at 95%
• Overall Care Group sickness rates have improved further during May, and the care group continues to meet compliance at 4.1%, with a year-to-date figure of 4.4%.
• Urgent Community Response Service 2-hour target is 91% as at end of May 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) – 97.21% as at May 2025.
• 88.89% of people dying in their place of choosing in May 2025; this remains consistently above the threshold of 80%.
• Information Governance training has increased, and we have maintained compliance at 97.3%.
• Friends and Family Test (FFT) 96% of people would recommend community services which exceeds the target of 95%.
• CPR training maintains compliance at 86.4% for May.
• Virtual Ward occupancy rate has reduced this month to 82.7% but continues to be above the target of 80%. Numbers have reduced over the last month as the team have been undertaking focused work to address the length of stay on the pathway as Barnsley is currently an outlier.
• Smoking Quit Rates continue to exceed the target of 55% - data is reported retrospectively and for the most recent data available (Quarter 3) this was 71.6%.
• On 14 May our Wound Care drop-in clinic launched. This is targeted at individuals experiencing homelessness / rough sleeping in the central neighbourhood. The clinic is running in conjunction with Waythrough's (Recovery Steps) rough sleeper breakfast club on Wednesdays between 10am and 12 noon at McLintock's Building. Our Advanced Clinical Practitioners (ACPs) and Community Matrons will facilitate the clinic with future support from our Neighbourhood Nursing Service (NNS).
• BBC Radio Sheffield joined the Trust on 22nd May to talk about the 'capturing the seasons' project. This was developed by Creative Minds in collaboration with the Barnsley Integrated Community Stroke Rehabilitation Team and the Stroke Association. Meeting over the course of a year, a group of eight stroke survivors photographed the changing seasons in Locke Park in Barnsley. The artwork is on display at the Cooper Gallery in Barnsley during June and will then be permanently moved to the Stroke Recovery Unit at Kendray.

Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue in May - 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.

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 - West Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-25	Apr-25	May-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	85.6%	83.8%	83.2%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	85.6%	85.1%	84.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	0% (0/0)	0% (0/3)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	91.8%	86.2%	83.6%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	99.0%	99.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.3%	79.6%	82.8%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	Reporting commenced April 2025	33.3%	75.0%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95.0%		100.0%	100.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	91.8%	92.2%	94.2%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	6	6	3	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	12	13	11	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	86.8%	85.5%	89.6%	
Restraint incidents	Best Quality	Safe	Trend Monitor	14	21	*18*	
Safer staffing (Overall)	Best Quality	Safe	90%	114.0%	116.5%	117.8%	
Safer staffing (Registered)	Best Quality	Safe	80%	105.3%	101.5%	102.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	6.4%	7.2%	7.7%	
Average length of stay	Best Quality	Safe	Trend Monitor	526	985	353	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	181	178	188	

Forensic - West Yorkshire:

Alert/Action

• Bed Occupancy
  • Newton Lodge: 87.71% - Referrals have increased in the male pathway, occupancy is across learning disability (LD) and women's pathways.
  • Bretton Centre: 79.71% - awaiting legal processes to facilitate admissions.
  • Newhaven: 75%
  • Medium secure services are currently experiencing underoccupancy, particularly within LD and women's services, where there are no active waiting lists. However, there has been a recent increase in referrals for male medium secure beds.
• Appraisals remain a key area of focus across the service. The overall appraisal completion rate has shown improvement and currently stands at 84.1%, indicating a positive upward trend.
• Forensic Community Transition Team is not currently funded by the West Yorkshire Provider Collaborative and has not been prioritized for community service funding. The issue has been escalated to the Provider Collaborative, which has advised on the necessary steps for further escalation within their internal processes.
• West Yorkshire Provider Collaborative – have signalled their intention to discuss the male and female pathways within Medium Security.

Advise

• Mandatory training overall compliance: Newton Lodge – 93.7%, Bretton – 94.3%, Newhaven – 94.7%.
Hotspots for Newton Lodge are: information governance with the Bretton Centre being compliant across all mandatory training and Newhaven with hotspots in CPR and IG, plans are in place to address.
• Supervision – levels remain high across the care group with the exception of the Bretton Centre which has reduced due the acuity within the service.
• 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 at 10% or less.
• 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%.
• % Service Users on care programme approach with a formal review within the previous 12 months –100%

Forensic - South Yorkshire							
Metrics	**Strategic Objective**	**CQC Domain**	**Threshold**	**Mar-25**	**Apr-25**	**May-25**	**Variation/ Assurance**
% Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	78.4%	83.5%	91.5%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	From April	77.3%	73.5%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/14)	40% (2/5)	50% (1/2)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	82.0%	89.0%	91.0%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%				
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.0%	88.7%	86.8%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	From April 2025	0.0%	0.0%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%		N/A	N/A	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	94.0%	94.7%	98.0%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	8	4	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.0%	92.5%	91.5%	
Restraint incidents	Best Quality	Safe	Trend Monitor	8	8	*5*	
Safer staffing (Overall)	Best Quality	Safe	90%	91.6%	115.5%	123.3%	
Safer staffing (Registered)	Best Quality	Safe	80%	95.7%	96.1%	100.4%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	3.7%	4.5%	4.0%	
Average length of stay	Best Quality	Safe	Trend Monitor	From April	1015	N/A	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	130	138	155	

Forensic - South Yorkshire:

Alert/Action

- Cheswold Park continues to integrate into the Forensic Care Group.
- Admissions remain a priority with 14 service users being admitted since January 2025.
- Establishment review for corporate services continues.
- Quality and safety continues to be monitored internally through a Quality Improvement Group.

Advise

- Priorities have been set for the next 6 months both for the Programme Group and for Clinical and Operational services.
- The service will develop a clear future clinical/operational model.
- Build on relationships with commissioners to determine long term needs of forensic population.
- Future medical workforce business case to be submitted to EMT to support future admissions in accordance with the overall business case.
- Business case regarding pharmacy also in development.
- Future medical workforce business case submitted
- The service is currently reviewing and developing business cases for AHP/Psychology workforce.
- The service continues system policy and procedure alignment in line with Trust, CQC and medium secure standards.
- Ward Manager development programme is underway which will support the role to align to a ward manager role in the wider Trust.
- The service is being supported to develop both internal and external reporting.
- Access to Trust Bank is now in place making staffing of the wards more sustainable.

Assure

- NHS England and the South Yorkshire Provider Collaborative have stepped down the enhanced monitoring.
- Turnover 1.9%.
- Relationships with the South Yorkshire Provider Collaborative are much improved with joint working regarding future bed modelling continuing to be a priority.

The following section of the report has been created to give assurance regarding the quality and safety of the care we provide on our inpatient wards. A number of key metrics have been identified the wards and performance against these for the past three months is stated. The wards in Cheswold Park Hospital are now incorporated into this report and the monthly data will be added over the financial year so that a three month rolling position is also shown. Figures in bold and italics are provisional and will be refreshed next month.

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

Appraisal
• All 17 wards have achieved the May 88% threshold target, 11 of those wards are at 100% appraisal compliance.
• Matrons continue to work closely with ward managers to ensure outstanding appraisals are booked.

Sickness
• 8 wards have sickness rates below 5% compliance threshold.
• Sickness improved to below threshold in May on Melton and Elmdale following the return of staff from long term sickness. Sickness also reduced to below threshold on Poplars following a reduction in the number of short-term sickness episodes.
• Sickness increased to just above threshold on Clark (5.6%) and Ward 19 Female (6.2%). On both wards this is due to short term sickness and one episode of long-term sickness.
• Sickness on Ashdale has increased significantly above threshold to 13.5% in May. This is impacted by long-term sickness with themes of personal and work-related stress.
• Sickness on Stanley, Walton, and Beechdale and has reduced but remains above threshold and continues to be impacted by a combination of long and short-term sickness, no specific themes.
• Nostell (7.9%) and Ward 18 (8.1%) sickness has increased due to a mixture of both long and short-term sickness, no specific themes.
• Sickness on Willow has further increased and is significantly above threshold at 20%. This is impacted by both short and long-term sickness. Themes include pregnancy related absence and work-related absence (including work-related assault).
• 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 3-4 weeks.

Supervision
• 14 wards above 80% compliance target, 8 of those wards are at 100% supervision compliance.
• Stanley dropped below compliance threshold in May, but this has improved in June and compliance is currently 86.7% (as of 17/06/25).
• Elmdale dropped just below compliance in May (77.8%). The ward manager is prioritising the staff who haven't received supervision in the last 90 days.
• Beamshaw compliance remains under threshold in May and has been impacted by high clinical acuity with scheduled supervision sessions having to be rearranged. Focused work to prioritise supervision for those staff who haven't received it in the last 90 days has been undertaken and June compliance is 85.7% (as of 17/06/25).

Mandatory Training
Information Governance
• Melton (87.5%) compliance has dropped below threshold in May. June compliance is 92% (as of 19/06/2025) with two staff outstanding, one of whom is long term sick and will be supported to complete on their return to work.
• Walton (88.6%) compliance remains under threshold in May and action continues to be taken by the ward manager, with matron oversight, to drive up improvement. June compliance is 97.1% (as of 19/06/25)
• The 15 remaining wards are above the target of 95%
CPR
• 15 wards are above the CPR training compliance threshold.
• Melton (79.2%) dropped slightly below compliance threshold in May and staff are booked onto future training dates throughout June and July. June compliance is 88% (as of 19/06/25).
• Ward 18 (60.7%) remains below compliance threshold. The majority of Ward 18 staff out of compliance are booked onto future training dates throughout June and July, with remaining staff booked onto August dates.
RRPI
• All 17 wards are above the RRPI training compliance threshold.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.
Fire Safety
• 14 wards are above fire safety training compliance threshold.
• Stanley has dropped under compliance (84%) and staff who are non-compliant are booked onto training in June and July. June compliance is at 88.5% (as of 19/06/25).
• Melton (75%) and Walton (82.9%) are also under compliance. Booking of training is being overseen by the ward managers as a priority.

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

Bed Occupancy

• Bed occupancy exceeding the target is reflective of general increased demand for admissions, particularly across working age adults.
• Where the bed occupancy exceeds the target plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.

Clinically Ready for Discharge (CRFD)

• CRFD rates are significantly above threshold on several wards:
  • Poplars CRFD is 39.3% in May and is reflective of several service users awaiting placements, five of whom have now been discharged.
  • Clark CRFD (32.2%) and Walton (22.8%) relates to several service users awaiting either placement or suitable accommodation. A service user on Walton is awaiting Ministry of Justice permissions.
  • Willow CRFD is 30.7% in May. This relates to four service users, all of whom were awaiting placement but have recently been discharged.
  • Melton CRFD has increased to 28.3% in May, reflective of two service users who are awaiting funding agreement for placements.
• Nostell CRFD has seen a considerable increase from 6.9% to 17.5% in May. This reflects five service users awaiting care package or suitable accommodation, four of whom have been recently discharged.
• Five other wards are above the threshold for CRFD with Beamshaw, and Ward 19 (male) above 10%. Stanley, Ward 19 (female) and Enfield Down 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.
• There is a weekly check and challenge meeting led by the Director of Service to ensure senior oversight and focus and timely external escalations.

FIRM Risk assessments

• The reporting metric changed as of 1st April to percentage of inpatient risk assessment completed within 24hrs before or after admission.
• Compliance monitoring dashboards have only recently gone live (8th May) and matrons are engaging with ward teams to ensure processes are in place for daily oversight.
• During May Ward 19 (male) had 1 FIRM breach. Ashdale (5), Nostell (5), Ward 18 (3), Stanley (2) had multiple impacted by high number of admissions.
• A deep dive will be conducted by the matron for each breach to identify learning and inform improvement.
• The inpatient team receive a handover of risk prior to admission and 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

• 12 incidents of patient on staff physical violence at Poplars. Incidents relate to specific service users with behavioural and psychological symptoms of dementia. Risk management care plans are in place and the ward psychologist is supporting with psychological formulation. Trust specialist advice from RRPI and safeguarding is also sought as needed.
• Elmdale had 10 incidents of patient-on-staff physical violence throughout May relating to two specific 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

• High incident numbers (27) on Walton relates to four individual service users and reflects their presentation, risks of violence and aggression, and need for restraint to safely administer intra-muscular medication to reduce agitation.
• Higher incident number on Elmdale and Nostell is reflective of current patient population and the presentation and risk profile of service users.
• Incident numbers on Poplars correlate with incidents of physical violence as outlined above.

Prone restraint incidents

• There were eight incidents of prone restraint in May, all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration.
• All are reflective of individual service user presentation and high risks of violence and aggression.
• 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

Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Suite Mar-25	Beamshaw Suite Apr-25	Beamshaw Suite May-25	Clark Suite Mar-25	Clark Suite Apr-25	Clark Suite May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	82.6%	91.3%	100.0%	88.2%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	6.3%	3.8%	2.9%	5.3%	2.2%	5.6%
Supervision	Best place to work and learn	Well led	80%	64.3%	64.3%	64.3%	91.7%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.3%	100.0%	100.0%	100.0%	95.2%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.3%	95.5%	91.3%	95.5%	90.5%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	86.4%	83.3%	100.0%	100.0%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	91.3%	90.9%	91.7%	81.8%	95.2%	100.0%
Bed occupancy**	Best Quality	Safe	85%	99.1%	105.4%	104.6%	99.1%	105.4%	104.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	137	45	90	40	6	97
Safer staffing (Overall)	Best Quality	Safe	90%	163.5%	130.7%	125.3%	105.8%	99.8%	109.9%
Safer staffing (Registered)	Best Quality	Safe	80%	116.0%	115.7%	106.8%	108.1%	115.6%	111.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	16.1%	10.3%	13.1%	25.8%	28.2%	32.2%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	100.0%	100.0%	Reporting Commenced	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	1	2	1	2	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	1	4	2	3
Restraint incidents	Best Quality	Safe	Trend Monitor	4	3	*3*	5	2	*5*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*1*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	33	11	17	12	6	8

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

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Melton Suite Mar-25	Melton Suite Apr-25	Melton Suite May-25	Nostell Mar-25	Nostell Apr-25	Nostell May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	88.9%	92.3%	100.0%	91.3%	87.0%	90.5%
Sickness	Best place to work and learn	Well led	5.0%	8.4%	6.6%	2.6%	7.0%	6.8%	7.9%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	84.6%	68.8%	93.3%	81.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	81.5%	96.2%	87.5%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.3%	100.0%	100.0%	92.6%	88.0%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.8%	80.8%	79.2%	92.6%	88.0%	87.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	81.5%	73.1%	75.0%	85.2%	92.0%	95.8%
Bed occupancy	Best Quality	Safe	85%	100.0%	100.6%	106.5%	93.7%	96.9%	98.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	51	N/A	102	48	33	26
Safer staffing (Overall)	Best Quality	Safe	90%	170.8%	130.5%	123.3%	132.5%	168.4%	133.7%
Safer staffing (Registered)	Best Quality	Safe	80%	101.6%	99.8%	98.5%	110.8%	109.8%	100.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	16.2%	15.9%	28.3%	10.0%	6.9%	17.5%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	100.0%	100.0%	Reporting Commenced	92.9%	58.3%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	1	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	0	1	7	4	1
Restraint incidents	Best Quality	Safe	Trend Monitor	8	6	*2*	14	3	*9*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*0*	0	0	*1*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	28	19	14	14	9	4

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

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Stanley			Walton		
				Mar-25	Apr-25	May-25	Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	95.7%	96.0%	100.0%	90.3%	96.8%	93.8%
Sickness	Best place to work and learn	Well led	5.0%	5.7%	9.2%	5.4%	6.7%	10.0%	9.1%
Supervision	Best place to work and learn	Well led	80%	86.7%	86.7%	73.3%	82.4%	94.4%	83.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	88.9%	100.0%	96.0%	94.6%	88.6%	88.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.6%	88.0%	92.0%	86.5%	88.6%	94.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.6%	84.0%	84.0%	91.9%	85.7%	82.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	81.5%	92.0%	84.0%	81.1%	82.9%	82.9%
Bed occupancy**	Best Quality	Safe	85%	93.7%	96.9%	98.4%	92.6%	96.4%	97.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	47	43	56	73	141	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	180.7%	125.4%	136.7%	150.4%	157.4%	155.7%
Safer staffing (Registered)	Best Quality	Safe	80%	111.9%	112.1%	105.7%	96.4%	90.7%	90.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	9.3%	8.5%	6.2%	18.9%	19.5%	22.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	57.1%	85.7%	Reporting Commenced	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	1	1	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	0	0	3	2	3
Restraint incidents	Best Quality	Safe	Trend Monitor	8	9	*4*	12	16	*27*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*2*	4	5	*3*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	37	15	11	9	6	6

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

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Ashdale Mar-25	Ashdale Apr-25	Ashdale May-25	Ward 18 Mar-25	Ward 18 Apr-25	Ward 18 May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	93.8%	96.9%	93.3%	96.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	1.4%	4.7%	13.5%	11.3%	6.3%	8.1%
Supervision	Best place to work and learn	Well led	80%	100.0%	93.3%	80.0%	75.0%	77.8%	88.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.1%	93.9%	96.8%	81.5%	74.1%	96.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.2%	90.9%	90.3%	88.9%	88.9%	89.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.2%	100.0%	100.0%	74.1%	63.0%	60.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.1%	93.9%	96.8%	81.5%	85.2%	92.9%
Bed occupancy	Best Quality	Safe	85%	100.3%	100.4%	98.4%	97.9%	97.8%	101.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	89	59	51	46	24	34
Safer staffing (Overall)	Best Quality	Safe	90%	132.4%	137.9%	127.9%	99.8%	105.8%	97.4%
Safer staffing (Registered)	Best Quality	Safe	80%	114.6%	114.8%	103.9%	94.8%	92.6%	96.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	3.9%	2.9%	0.0%	9.8%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	50.0%	68.8%	Reporting Commenced	86.2%	87.5%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	3	2	2	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	3	5	2	1
Restraint incidents	Best Quality	Safe	Trend Monitor	4	6	*7*	8	7	*5*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	2	*1*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	22	12	8	7	1	2

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	92.0%	96.0%	88.5%
Sickness	Best place to work and learn	Well led	5.0%	3.8%	7.0%	4.4%
Supervision	Best place to work and learn	Well led	80%	83.3%	88.9%	77.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.3%	96.3%	96.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.3%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.6%	96.2%	92.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	83.3%	96.3%	100.0%
Bed occupancy	Best Quality	Safe	85%	92.1%	97.6%	94.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	36	54	56
Safer staffing (Overall)	Best Quality	Safe	90%	121.8%	109.9%	114.0%
Safer staffing (Registered)	Best Quality	Safe	80%	102.4%	96.1%	95.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	7.0%	3.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	91.7%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	2	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	5	3	10
Restraint incidents	Best Quality	Safe	Trend Monitor	16	3	*14*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	8	10

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton Mar-25	Crofton Apr-25	Crofton May-25	Poplars CUE Mar-25	Poplars CUE Apr-25	Poplars CUE May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	87.5%	92.0%	100.0%	90.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	1.3%	1.9%	1.4%	3.8%	8.1%	4.1%
Supervision	Best place to work and learn	Well led	80%	100.0%	78.6%	100.0%	84.6%	92.3%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.2%	96.2%	100.0%	96.9%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.7%	91.7%	95.2%	80.0%	86.2%	86.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.0%	70.8%	81.0%	93.3%	89.7%	93.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	88.5%	88.5%	91.3%	96.9%	93.3%	93.5%
Bed occupancy	Best Quality	Safe	85%	102.2%	94.8%	98.6%	81.9%	79.8%	71.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	57	77	79	115	108	103
Safer staffing (Overall)	Best Quality	Safe	90%	185.7%	201.3%	186.1%	220.5%	230.4%	223.5%
Safer staffing (Registered)	Best Quality	Safe	80%	147.5%	155.5%	154.3%	99.5%	103.0%	110.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	31.2%	31.5%	39.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	90.0%	100.0%	Reporting Commenced	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	2	0	0	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	6	1	13	15	12
Restraint incidents	Best Quality	Safe	Trend Monitor	2	11	*3*	12	11	*10*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	36	33	18	48	31	36

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow Mar-25	Willow Apr-25	Willow May-25	Beechdale Mar-25	Beechdale Apr-25	Beechdale May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	81.0%	95.2%	95.0%	100.0%	100.0%	95.5%
Sickness	Best place to work and learn	Well led	5.0%	1.3%	12.5%	20.0%	15.2%	13.2%	9.2%
Supervision	Best place to work and learn	Well led	80%	63.6%	100.0%	100.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	87.5%	100.0%	100.0%	92.9%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	79.2%	72.7%	85.7%	82.1%	86.4%	90.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	58.3%	100.0%	81.0%	92.6%	100.0%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	83.3%	100.0%	100.0%	85.7%	100.0%	95.2%
Bed occupancy	Best Quality	Safe	85%	83.9%	85.7%	91.0%	101.4%	94.6%	96.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	210	101	132	52	87	85
Safer staffing (Overall)	Best Quality	Safe	90%	129.8%	132.9%	127.7%	130.6%	127.4%	122.7%
Safer staffing (Registered)	Best Quality	Safe	80%	98.2%	100.8%	77.4%	105.8%	95.9%	98.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	7.0%	26.6%	30.7%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	100.0%	100.0%	Reporting Commenced	66.7%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	1	0	1	2
Restraint incidents	Best Quality	Safe	Trend Monitor	1	3	*3*	5	5	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	18	18	13	10	9	5

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male Mar-25	Ward 19 - Male Apr-25	Ward 19 - Male May-25	Ward 19 - Female Mar-25	Ward 19 - Female Apr-25	Ward 19 - Female May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	0.4%	3.2%	1.5%	0.9%	5.0%	6.2%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.3%	100.0%	95.8%	100.0%	100.0%	95.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.9%	91.7%	91.7%	95.2%	87.5%	95.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.6%	100.0%	100.0%	85.7%	91.7%	86.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	91.7%	95.8%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	85%	96.6%	94.9%	97.0%	93.1%	94.4%	91.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	115	84	121	58	91	89
Safer staffing (Overall)	Best Quality	Safe	90%	100.5%	113.7%	99.6%	88.2%	91.8%	94.7%
Safer staffing (Registered)	Best Quality	Safe	80%	78.7%	86.0%	79.9%	93.2%	90.5%	101.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	5.3%	18.4%	13.5%	4.5%	6.5%	6.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	80.0%	50.0%	Reporting Commenced	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	3	2	1	3	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	0	1	3	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	10	*3*	2	10	*3*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	2	6	1	1	1

Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down Mar-25	Enfield Down Apr-25	Enfield Down May-25	Lyndhurst Mar-25	Lyndhurst Apr-25	Lyndhurst May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	97.8%	100.0%	96.6%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	2.4%	2.6%	3.7%	0.7%	0.4%	0.9%
Supervision	Best place to work and learn	Well led	80%	96.2%	92.3%	81.5%	93.3%	93.8%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.9%	94.0%	100.0%	100.0%	93.1%	96.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.5%	79.6%	85.7%	86.7%	86.2%	86.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.6%	90.9%	95.5%	96.7%	79.3%	96.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	89.8%	90.0%	88.0%	90.0%	93.1%	96.6%
Bed occupancy	Best Quality	Safe	Trend Monitor	53.4%	54.3%	57.1%	63.6%	52.1%	50.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	910	520	N/A	252	688	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	93.1%	96.2%	100.6%	94.6%	100.5%	113.4%
Safer staffing (Registered)	Best Quality	Safe	80%	98.8%	106.9%	107.9%	89.8%	98.2%	99.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	5.3%	5.2%	9.5%	7.5%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	50.0%	100.0%	Reporting Commenced	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	2	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	2	0	2	1

Inpatients - Forensic West Yorkshire - 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. Improvements in compliance have been noted with Appleton, Bronte, Chippendale, Hepworth and Ryburn achieving 100%. Johnson (95.2%), Waterton (94.7%), Thornhill (96.3%) and Sandal (95.7%) are also now above compliance. Newhaven (78.6%) are below compliance and have two outstanding appraisals that have time booked in to complete. Priestley (65.2%) is also below compliance which is attributed to several staff returning from long term sickness absence with appraisal discussions booked following return to work plans and also some recording issues. Robust plans are in place that are under regular review with the service manager. Staffer staffing reports remain within compliance.

Medium Secure

• Five wards are above supervision compliance (Bronte, Chippendale, Hepworth, Waterton and Johnson). Waterton, has now met compliance following an improving trajectory, evidencing the embedding of plans in implementation by the Ward Manager. Appleton (50%) is under compliance and understood to be a recording issue due to team high acuity. This is an unusual variation for Appleton and plans are in place. Priestley (75%) has reduced compliance and continue to embed new recording systems. There is now an identified lead on the ward who is closely monitoring.
• An increase in sickness absence is noted across the service with Appleton (5.7%), Bronte (8.7%), Chippendale (7.0%), Hepworth (6.2%), Johnson (10.8%) and Waterton (12.1%). This is a combination of both increases in long-term sickness absence and short-term. Individual support plans are in place by Ward Managers with support from our People Directorate.
• The plans in place to improve cardiopulmonary resuscitation compliance have seen improvements with Appleton (81.8%), Bronte (90.9%), Chippendale (81.8%), Hepworth (96.4%), Waterton (86.4%) and Priestley (80%) all above compliance. Improvements are noted on Johnson to 73.3% with close oversight from the Ward Manager. Staff are booked onto this training, and the service will continue to closely monitor, and monitor skill mix across the service.
• Information Governance compliance remains a focus of targeted improvement work, further challenges have been evident in May with a number of staff going out of date. Johnson (96.7), Waterton (95.2%) and Hepworth (96.4%) are within compliance with hotspots identified on Chippendale (90.9%), Priestley (84.6%), Waterton (90.9%) and Appleton (90.9%). 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 (76.9%) and Waterton (81.8%) are now within expected targets and continued improvement has been noted. 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 all wards now above compliance.
• Bed occupancy on Appleton (62.5%) is below compliance and due to a reduction in overall learning disability referrals to secure care. Of note the service has seen referrals that are now in process. Bed occupancy in the women's service (Johnson medium secure 73.3%) is also low but has noted a slight improvement and referrals have been received into the service. Neither of these services have a waiting list. Bed occupancy on Bronte (70.5%), although reduced the service users has service users waiting for admission processes to complete. Whilst Priestley and Waterton are red at 100%, this
would be viewed as positive within the forensic pathway as support use of admission beds and
demonstrates appropriate flow through the service.
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, albeit 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 (2.1%) and Ryburn (3.0%). Newhaven (13.0%) has several staff (4) on long term sickness and some short-term sickness absence. A plan is in place with the People Directorate and additional Occupational Health Support using the CRISSP approach. Thornhill (10.2%) remains a hot spot, albeit some continued gradual improvement noted. Several staff do now have support plans to return to work so improvements are expected.
• Mandatory training compliance remains positive across all areas. A hotspot has been identified in CPR training on Ryburn (66.7%) and Newhaven (73.3%). Positive improvements are noted following review and actions from Ward Manager. There are now 2 staff on Ryburn who both are booked on training. There are 9 staff outstanding on Newhaven, 3 of these are on long term sickness, the others are booked onto training. 2 Newhaven staff on LTS also require data security awareness training, and this will be undertaken on return to work.
•The Inpatient risk assessment completed within 24 hours on Thornhill is a data quality issue, the service user was not admitted but transferred and a risk assessment was in place.
• Bed occupancy is low within low secure services with Thornhill (6£%) and Sandal (91.3%). The service is currently working to support transitions to Thornhill to support capacity on Sandal (admission ward). Ryburn currently has no empty beds. Newhaven (75%) continues to experience lower level of referrals and has no waiting list.
• There have been no prone restraint incidents. 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

Metrics	Strategic Objective	CQC Domain	Threshold	Appleton Mar-25	Appleton Apr-25	Appleton May-25	Bronte Mar-25	Bronte Apr-25	Bronte May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	1.7%	3.4%	5.7%	2.0%	5.7%	8.7%
Supervision	Best place to work and learn	Well led	80%	93.3%	68.8%	50.0%	100.0%	86.7%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	95.7%	90.9%	96.0%	88.0%	95.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	95.7%	91.3%	100.0%	88.0%	80.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	82.6%	81.8%	80.0%	88.0%	90.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	91.3%	91.3%	86.4%	88.0%	92.0%	95.5%
Bed occupancy	Best Quality	Safe	90%	64.9%	68.3%	62.5%	94.9%	78.1%	70.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1856	N/A	N/A	383	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.1%	111.7%	128.6%	98.0%	96.5%	95.9%
Safer staffing (Registered)	Best Quality	Safe	80%	109.3%	104.8%	104.7%	99.7%	101.2%	106.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	N/A	Reporting Commenced	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	0	3	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	0	5	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	11	7	*11*	0	0	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	15	11	1	6	0

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale Mar-25	Chippendale Apr-25	Chippendale May-25	Hepworth Mar-25	Hepworth Apr-25	Hepworth May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	100.0%	100.0%	96.2%	95.8%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	7.1%	6.9%	7.0%	4.9%	8.0%	6.2%
Supervision	Best place to work and learn	Well led	80%	88.2%	93.8%	81.3%	100.0%	100.0%	94.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.3%	90.0%	90.9%	100.0%	100.0%	96.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	82.6%	90.0%	86.4%	90.6%	88.9%	92.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	80.0%	81.8%	93.8%	88.9%	96.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.0%	95.0%	95.5%	87.5%	100.0%	92.9%
Bed occupancy	Best Quality	Safe	90%	91.7%	89.2%	87.4%	86.2%	93.1%	96.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1329	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	127.6%	113.2%	102.7%	108.7%	91.7%	92.8%
Safer staffing (Registered)	Best Quality	Safe	80%	127.4%	115.6%	120.1%	94.5%	89.9%	91.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	N/A	Reporting Commenced	0.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	1	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	13	1	3	0	1

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson Mar-25	Johnson Apr-25	Johnson May-25	Priestley Mar-25	Priestley Apr-25	Priestley May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	96.3%	96.7%	96.3%	66.7%	66.7%	65.2%
Sickness	Best place to work and learn	Well led	5.4%	0.7%	2.9%	10.8%	3.1%	1.1%	3.1%
Supervision	Best place to work and learn	Well led	80%	93.8%	94.7%	93.3%	80.0%	75.0%	75.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.9%	96.9%	96.7%	89.3%	88.5%	84.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.4%	87.5%	90.0%	77.8%	76.0%	84.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.0%	71.9%	73.3%	74.1%	64.0%	80.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.9%	96.9%	93.3%	78.6%	84.6%	76.9%
Bed occupancy	Best Quality	Safe	90%	80.0%	80.9%	73.3%	94.1%	97.6%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	943	N/A	N/A	898	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	143.1%	156.8%	118.0%	90.0%	89.3%	92.0%
Safer staffing (Registered)	Best Quality	Safe	80%	101.0%	107.6%	87.9%	91.2%	92.0%	105.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	0.0%	N/A	Reporting Commenced	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	2	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	3	2	*0*	0	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	33	36	13	4	0	0

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	95.2%	94.7%	94.7%
Sickness	Best place to work and learn	Well led	5.4%	11.5%	8.1%	12.1%
Supervision	Best place to work and learn	Well led	80%	76.9%	90.9%	90.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	87.0%	95.2%	90.9%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	90.5%	86.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	85.7%	86.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	91.3%	90.5%	81.8%
Bed occupancy	Best Quality	Safe	90%	100.0%	95.4%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1253	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	145.1%	118.4%	124.2%
Safer staffing (Registered)	Best Quality	Safe	80%	102.9%	93.3%	98.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced April 2025	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	16	7	12

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill Mar-25	Thornhill Apr-25	Thornhill May-25	Sandal Mar-25	Sandal Apr-25	Sandal May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	96.2%	96.3%	95.8%	95.7%	95.7%
Sickness	Best place to work and learn	Well led	5.4%	15.8%	12.2%	10.2%	3.4%	2.2%	2.1%
Supervision	Best place to work and learn	Well led	80%	84.6%	84.6%	78.6%	94.1%	93.3%	80.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.9%	100.0%	100.0%	96.9%	96.4%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.9%	96.6%	100.0%	96.9%	92.9%	96.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.3%	89.7%	82.8%	84.4%	92.9%	92.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	89.3%	93.1%	89.7%	93.8%	92.9%	92.6%
Bed occupancy	Best Quality	Safe	85%	79.1%	66.2%	63.0%	89.5%	93.8%	91.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	273	387	98	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	119.8%	115.9%	122.6%	113.0%	144.4%	126.9%
Safer staffing (Registered)	Best Quality	Safe	80%	110.7%	105.2%	105.0%	117.2%	114.7%	104.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	0.0%	Reporting Commenced	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	3	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	16	18	20	26	30

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn Mar-25	Ryburn Apr-25	Ryburn May-25	Newhaven Mar-25	Newhaven Apr-25	Newhaven May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	100.0%	100.0%	100.0%	86.1%	81.5%	78.6%
Sickness	Best place to work and learn	Well led	5.4%	6.2%	1.7%	3.0%	7.2%	10.3%	13.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	85.7%	100.0%	90.5%	75.0%	88.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	97.6%	97.0%	94.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	88.9%	86.8%	86.2%	96.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.0%	60.0%	66.7%	81.6%	69.0%	73.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	85.7%	90.9%	94.1%
Bed occupancy	Best Quality	Safe	85%	80.2%	86.7%	88.9%	72.6%	75.0%	75.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	740	N/A	31800.0%	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	98.9%	100.0%	98.4%	110.9%	111.1%	124.9%
Safer staffing (Registered)	Best Quality	Safe	80%	99.5%	100.0%	100.0%	105.6%	101.6%	97.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	N/A	Reporting Commenced	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	6	10	5
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	10	*4*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	4	12	2

Inpatients - Non-Mental Health

• **Appraisal rate:**
Neuro Rehabilitation Unit (NRU) rate is showing as 86.5% for May which maintains the rate slightly below compliance. Some of this can be attributed to annual leave of Unit Manager.
Stroke Rehabilitation Unit (SRU) rate has increased again to maintain compliance this month at 95.2% for May.

• **Sickness:**
NRU – sickness has slightly increased in May from 7% to 7.2%. One LTS (long term sickness) re hip surgery replacement continues to be off sick due to post operative complications; this will continue until early July. We still have one LTS staff member (anxiety) with their latest sick note running into July (planned return to work on 7.7.25), plus a further LTS where a staff member continues to be on sick leave into June (anxiety) due to a critically ill spouse. An additional sickness absence during May relates to planned surgery; this also continues into June. These are all being managed via HR processes and sickness reviews.
SRU – Sickness for May has significantly decreased from 14.1% to 8.4%. As noted last month, we anticipated an improving picture based on the staff returning to work in early June. This continues to improve, and we expect a further reduction in sickness by the end of June. This is being managed via HR processes and sickness reviews.

• **Supervision:**
NRU has seen a further decrease during May to 39.1%.
Due to the ongoing requirement to ensure safe staffing levels, along with LTS impacting our qualified nursing cohort in particular, patient care has had to be prioritised which has impacted the ability to make progress towards the target again this month. Senior management are aware of significant staffing issues due to sickness and maternity leave which will continue to impact. A new member of staff commenced in post mid-June and further recruitment is ongoing.
SRU figures for May have seen an increase to 70%. We continue to see the figures increase into June to achieve compliance – as at 20.6.25 the figures are showing as 82.9%

• **Information Governance:**
NRU – maintained compliance during May at 97.6%.
SRU – maintained compliance during May at 98.5%.

• **Cardiopulmonary resuscitation (CPR):**
NRU – further improved compliance at 92.3% for May.
SRU – a significant increase during May to achieve compliance at 90.6%.
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:**
Both units achieving compliance above 90% following bespoke fire training which took place in early May.

Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit (NRU) Mar-25	Apr-25	May-25	Stroke Rehabilitation Unit (SRU) Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	88.9%	86.5%	86.5%	85.0%	91.5%	95.2%
Sickness	Best place to work and learn	Well led	5.0%	6.8%	7.0%	7.2%	7.7%	14.1%	8.4%
Supervision	Best place to work and learn	Well led	80%	87.0%	69.6%	39.1%	86.1%	65.8%	70.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.3%	97.6%	97.6%	98.6%	98.5%	98.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.1%	85.0%	92.3%	71.2%	77.8%	90.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	84.8%	90.5%	92.7%	88.6%	89.6%	91.2%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	71.8%	70.3%	63.2%	99.5%	98.3%	90.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	38	46	155	38	39	28
Safer staffing (Overall)	Best Quality	Safe	90%	116.5%	120.4%	116.9%	95.5%	95.3%	92.2%
Safer staffing (Registered)	Best Quality	Safe	80%	94.9%	104.2%	95.0%	119.1%	121.1%	108.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	10	0	0	86

Inpatients - Mental Health - Learning Disability

Headlines

- The service continues to support the provision of appraisal. The service continues to monitor closely and is compliant at 100%.
- The Ward Manager has been undertaking some quality improvement work on supervision, which reflects the improving compliance currently at 100%.
- Mandatory training compliance remains positive, with a hotspot in CPR (68.4%) due to staff requiring updates. Plans are in place to address, and staff are booked onto training.
- Sickness absence has now returned to with compliance levels.
- There are a high number of service users that are clinically ready for discharge. These relate to the ongoing complex packages of care.
- The service has reviewed the risk assessment and has plans in place to support compliance.
- Due to the current acuity and individual needs of service users, the service has required additional staffing, reflected in the overall safer staffing (138.5%) and registered safer staffing (179.7%).
- There was one prone restraint that was a seclusion exit. Training is in place with the RRPI team to support alternative seclusion exit approaches.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon Mar-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	Mar 84.9% April 87% May 88%	94.1%	94.1%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.6%	5.8%	3.1%
Supervision	Best place to work and learn	Well led	80%	84.2%	90.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.5%	100.0%	97.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.3%	91.9%	89.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.1%	78.4%	68.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.0%	97.4%	94.1%
Bed occupancy	Best Quality	Safe	N/A	67.3%	55.4%	49.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	35	1015	270
Safer staffing (Overall)	Best Quality	Safe	90%	172.7%	144.1%	138.5%
Safer staffing (Registered)	Best Quality	Safe	80%	170.3%	157.4%	179.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	55.7%	90.1%	78.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	Reporting Commenced	N/A	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	24	19	19
Restraint incidents	Best Quality	Safe	Trend Monitor	36	23	*22*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*1*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	16

Inpatients - Forensic South Yorkshire

Medium Secure

- Supervision compliance is above compliance for Foss and Skipton (100%).
- Appraisal compliance has seen an improvement on both Foss (92.3%) and Skipton (100%).
- Sickness absence is above target for Foss (5.6%) and Skipton (7.6%). This will be closely monitored by the managers.
- Safer staffing on Skipton (Registered 77.1%) is slightly below expected threshold, this has been reviewed by the service manager and has been resolved. Staffing remains to be reviewed daily by the service manager.
- Good compliance against mandatory training is noted across all areas.
- Bed occupancy on Skipton (50%), whilst below usual compliance this is in relation to the mobilisation of CPH and plans are in place.
- There were no prone restraints.
- Risk assessment data is not currently captured as CPH do not currently complete FIRM risk assessments, this is within the improvement plan.

Low Secure

- Supervision compliance is above compliance for Aire (100%), Don (96.2%) and Calder (96.3%). For Esk (66.2%) and Wentbridge (77.3%) this is identified as a recording issue.
- Appraisal compliance across three low secure wards (Esk 75%, Wentbridge 83.8% and Don (72%) remain below expected compliance. A review is underway to understand the challenges within the service.
- Sickness absence is above target for Wentbridge (10.1%). This will be closely monitored by the managers and wellbeing checks have been carried out appropriately.
- Good compliance against mandatory training is noted across all areas with exception of Cardiopulmonary resuscitation (CPR) on Wentbridge (72.7%).
- Bed occupancy on Calder (62.3%), whilst below usual compliance both are in relation to the mobilisation of CPH and plans are in place.
- There were no prone restraints.
- Risk assessment data is not currently captured as CPH do not currently complete FIRM risk assessments, this is within the improvement plan.

				Medium Secure Services Foss		Skipton		Low Secure Services Esk		Wentbridge	
Metrics	Strategic Objective	CQC Domain	Threshold	Apr-25	May-25	Apr-25	May-25	Apr-25	May-25	Apr-25	May-25
Appraisal rate	Best place to work and learn	Well led	April 87% May 88%	55.6%	92.3%	77.8%	100.0%	85.0%	75.0%	83.3%	93.2%
Sickness	Best place to work and learn	Well led	5.4%	7.3%	5.6%	6.6%	7.6%	6.3%	5.1%	8.4%	10.1%
Supervision	Best place to work and learn	Well led	80%	87.9%	100.0%	70.4%	100.0%	83.3%	65.2%	91.3%	88.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	90.9%	100.0%	100.0%	95.5%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.6%	93.1%	94.1%	93.5%	100.0%	95.5%	93.2%	93.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.0%	93.1%	93.9%	93.1%	100.0%	95.2%	77.3%	72.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.0%	89.7%	93.9%	100.0%	95.5%	95.5%	88.6%	88.9%
Bed occupancy	Best Quality	Safe	90%	81.7%	85.7%	50.0%	50.0%	85.2%	87.5%	87.5%	87.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	1015	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	91.0%	105.2%	108.9%	102.9%	101.7%	114.5%	149.2%	155.7%
Safer staffing (Registered)	Best Quality	Safe	80%	99.5%	112.9%	83.8%	77.1%	111.0%	105.5%	106.6%	106.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	2	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0	6	3
Restraint incidents	Best Quality	Safe	Trend Monitor	1	*0*	3	*3*	0	*0*	2	*2*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	*0*	0	*0*	0	*0*	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0	0	0

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire Apr-25	Low Secure Services Aire May-25	Don Apr-25	Don May-25	Calder Apr-25	Calder May-25
Appraisal rate	Best place to work and learn	Well led	April 87% May 88%	100.0%	100.0%	95.8%	72.0%	88.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	4.5%	0.9%	0.5%	2.5%	4.6%	3.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	96.2%	88.5%	96.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.9%	97.0%	96.2%	96.4%	95.8%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.9%	84.8%	92.3%	94.6%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.3%	84.8%	84.6%	84.6%	95.8%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	87.9%	100.0%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	90.8%	91.4%	98.3%	91.9%	54.8%	62.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	102.3%	110.8%	119.0%	128.9%	94.8%	99.2%
Safer staffing (Registered)	Best Quality	Safe	80%	87.4%	99.7%	82.7%	101.0%	62.5%	75.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	*0*	0	*0*	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	*0*	0	*0*	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0

Overall Financial Performance 2025/26

Executive Summary / Key Performance Indicators

	Performance Indicator	Strategic Objective	CQC Domain	Year to Date	Forecast 2025/26	Narrative
1	Surplus / (Deficit)	Best Value	Well Led	(£1.4m)	£0m	The financial performance for May 2025 is a deficit of £0.6m which is £0.1m (14%) worse than plan. This means that the year to date deficit is £1.4m (£0.2m - 17% worse than plan). In order to secure the breakeven financial target improvements to the current run rate are required which are over and above the previously planned improvements.
2	Agency Spend	Best Value	Well Led	£0.7m	£2.9m	Agency worked WTE has continued to reduce in May. However expenditure has increased, £19k more than last month, due to additional charges received relating to previous accounting periods.
3	Bank Spend	Best Value	Well Led	£4.1m	£23.3m	Bank expenditure has reduced by £293k (86 less worked WTE) when compared to April 2025. This reflects the actions implemented by the Trust. However this does remain higher than plan and further actions will continue to be implemented.
4	Corporate Spend	Best Value	Well Led	£11m	£67.3m	National guidance, and as part of the Trust Value for Money programme, identified corporate expenditure as a key performance indicator. This value is total corporate expenditure with the RAG rating as a comparison against plan following agreed budgetary reductions. In May spend is £0.3m less than planned.
5	Financial sustainability and efficiencies	Best Value	Well Led	£2.8m	£28.2m	The value for money programme is £491k behind plan for the year to date. This is primarily due to workforce and temporary staffing (bank). The run rate has improved in month as April 2025 was £465k behind plan. Mitigations continue to be developed to ensure that the target is delivered in full as part of supporting delivery of the overall financial position.
6	Cash	Best Value	Well Led	£54.6m	£53.3m	Cash continues to be monitored to ensure effective management of the Trust working capital position. At May 2025 this remains better than planned.
7	Capital Spend	Best Value	Well Led	£0.6m	£14.2m	Spend on capital is less than planned in May. This is due to issues with invoices for leased properties which has meant that the annual revaluation has not been possible to calculate. This is expected to be rectified in June 2025. The remainder of the capital programme is profiled later in the year.
8	Better Payment Practice Code	Best Value	Well Led	96%		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

Appendix 1 - Cheswold Park Hospital

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Trust Threshold	Mar-25	Apr-25	May-25
% of staff receiving supervision within policy guidance	Improving Resources	Well Led	80.0%	82.0%	89.0%	91.0%
Appraisals - rolling 12 months			95%	78.4%	83.5%	91.5%
Mandatory Training - TOTAL	Improving Care		>=80%	98.0%	97.0%	97.0%
Mandatory Training - Reducing Restrictive Practice Interventions				93.5%	92.5%	91.5%
Mandatory Training - Cardiopulmonary Resuscitation				90.5%	88.7%	86.8%
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				98.7%	99.0%	98.3%
Mandatory Training - Fire Safety			>=85%	94.4%	94.7%	94.6%
Mandatory Training - Food Safety			>=80%	100.0%	100.0%	100.0%
Mandatory Training - Freedom To Speak Up (FTSU)				100.0%	100.0%	100.0%
Mandatory Training - Infection Control & Hand Hygiene				95.7%	95.5%	95.6%
Mandatory Training - Information Governance (Data Security)			>=95%	94.5%	94.7%	98.0%
Mandatory Training - Moving & Handling			>=80%	94.4%	94.7%	94.6%
Mandatory Training - Mental Capacity Act/Dols				94.8%	93.4%	93.2%
Mandatory Training - Mental Health Act				94.8%	93.4%	93.2%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				98.7%	98.7%	99.0%
Mandatory Training - Prevent			>=80%	N/A	N/A	N/A
Mandatory Training - Safeguarding Adults				96.1%	94.4%	95.3%
Mandatory Training - Safeguarding Children				96.1%	94.4%	95.3%

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 2 (2025 / 26)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

	Key Performance Indicator	Year to Date	Forecast 2025 / 26	Narrative
1	Surplus / (Deficit)	(£1.4m)	£0m	The financial performance for May 2025 is a deficit of £0.6m which is £0.1m (14%) worse than plan. This means that the year to date deficit is £1.4m (£0.2m - 17% worse than plan). In order to secure the breakeven financial target improvements to the current run rate are required which are over and above the previously planned improvements.
2	Agency Spend	£0.7m	£2.9m	Agency worked WTE has continued to reduce in May. However expenditure has increased, £19k more than last month, due to additional charges received relating to previous accounting periods.
3	Bank Spend	£4.1m	£23.3m	Bank expenditure has reduced by £293k (86 less worked WTE) when compared to April 2025. This reflects the actions implemented by the Trust. However this does remain higher than plan and further actions will continue to be implemented.
4	Corporate Spend	£11m	£67.3m	National guidance, and as part of the Trust Value for Money programme, identified corporate expenditure as a key performance indicator. This value is total corporate expenditure with the RAG rating as a comparison against plan following agreed budgetary reductions. In May spend is £0.3m less than planned.
5	Financial sustainability and efficiencies	£2.8m	£28.2m	The value for money programme is £491k behind plan for the year to date. This is primarily due to workforce and temporary staffing (bank). The run rate has improved in month as April 2025 was £465k behind plan. Mitigations continue to be developed to ensure that the target is delivered in full as part of supporting delivery of the overall financial position.
6	Cash	£54.6m	£53.3m	Cash continues to be monitored to ensure effective management of the Trust working capital position. At May 2025 this remains better than planned.
7	Capital	£0.6m	£14.2m	Spend on capital is less than planned in May. This is due to issues with invoices for leased properties which has meant that the annual revaluation has not been possible to calculate. This is expected to be rectified in June 2025. The remainder of the capital programme is profiled later in the year.
8	Better Payment Practice Code	96%		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.

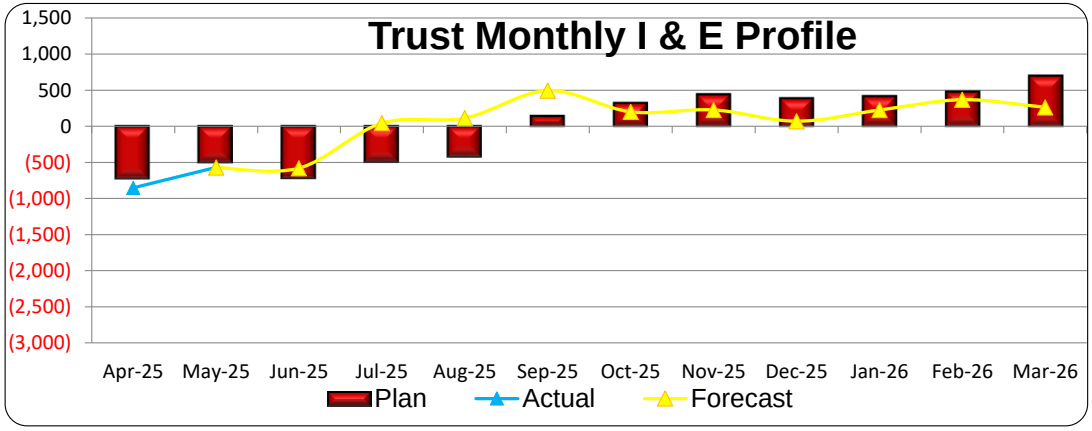
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

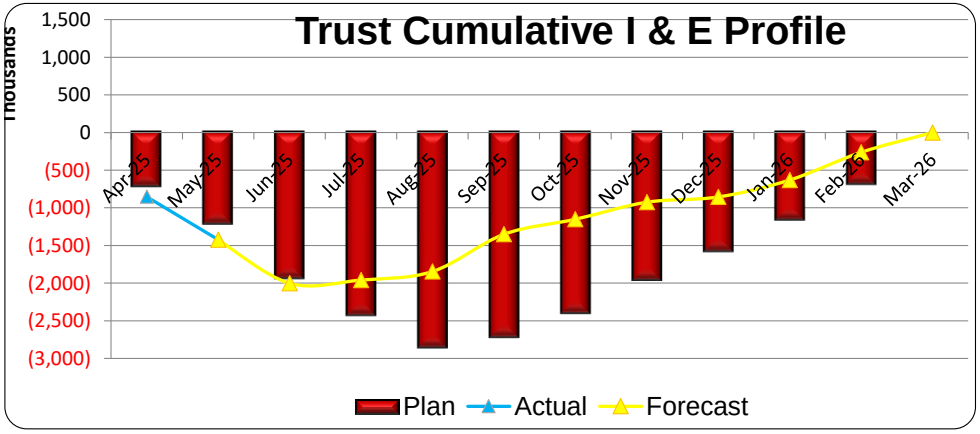
2.0 Income & Expenditure Position 2025 / 26

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

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					37,452	37,484	31	74,843	74,770	(73)	450,376	449,822	(554)
Other Operating Revenue					1,294	1,248	(46)	2,527	2,616	90	15,697	15,499	(197)
Total Revenue					**38,746**	**38,732**	**(15)**	**77,370**	**77,386**	**17**	**466,073**	**465,322**	**(751)**
Pay Costs	5,389	5,307	(82)	1.5%	(24,717)	(24,619)	99	(49,527)	(49,521)	5	(296,307)	(294,459)	1,849
Non Pay Costs					(13,730)	(13,891)	(161)	(27,458)	(27,716)	(258)	(159,862)	(161,282)	(1,420)
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,389**	**5,307**	**(82)**	**-1.5%**	**(38,447)**	**(38,510)**	**(63)**	**(76,984)**	**(77,237)**	**(253)**	**(456,169)**	**(455,740)**	**429**
EBITDA	**5,389**	**5,307**	**(82)**	**-1.5%**	**299**	**222**	**(78)**	**385**	**149**	**(236)**	**9,904**	**9,582**	**(323)**
Depreciation					(613)	(661)	(48)	(1,225)	(1,322)	(97)	(7,447)	(7,762)	(315)
PDC Paid					(378)	(382)	(4)	(756)	(764)	(8)	(4,534)	(4,584)	(50)
Interest Received					193	251	58	379	514	135	2,077	2,764	687
Surplus / (Deficit) - ICB performance measure	**5,389**	**5,307**	**(82)**	**-1.5%**	**(498)**	**(570)**	**(72)**	**(1,216)**	**(1,423)**	**(206)**	**0**	**0**	**0**
Depn Peppercorn Leases (IFRS16)					(9)	(5)	4	(17)	(10)	7	(94)	(61)	33
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,389**	**5,307**	**(82)**	**-1.5%**	**(507)**	**(575)**	**(68)**	**(1,234)**	**(1,433)**	**(199)**	**(94)**	**(61)**	**33**





Income & Expenditure Position 2025 / 26

The Trust deficit in May 2025 is £570k.
Actions are required to ensure delivery of the breakeven target.

In line with national guidance the Trust submitted a risk assessed breakeven financial plan for 2025 / 26. This consciously included an element of unidentified efficiency requirement and will require corrective action in order to achieve this position.

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. Cheswold Park Hospital, which was purchased in October 2024 and was reported separately during 2024 / 25, has now been consolidated into the Core Trust as business as usual. Previous year comparators have been updated to include this. 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)	5,366	5,283	(83)	1.6%	(783)	(459)	324	(1,805)	(1,388)	417	(6,632)	(6,006)	625
Provider Collaboratives	23	24	1	4.5%	3	(112)	(115)	4	(56)	(61)	27	90	63
Budgets held centrally	0	0	0	0.0%	283	2	(281)	584	22	(562)	6,605	5,917	(688)
Total - Consolidated position (ICB performance measure)	**5,389**	**5,307**	**(82)**	**-1.5%**	**(498)**	**(570)**	**(72)**	**(1,216)**	**(1,423)**	**(206)**	**0**	**0**	**0**

At month 2 there has been improvement in the Trust (core) financial position. Whilst this remains in a monthly deficit run rate this is £469k less than April 2025. Overall the year to date position is a deficit of £1,388k. The drivers behind the Trust financial performance are considered in detail in the remainder of the report.

Both Adult Secure Provider Collaboratives have reported deficits in month as a result of activity pressures. This will continue to be monitored and mitigation plans developed as required. The financial position for 2025 / 26 for the provider collaboratives which SWYPFT is a partner will be incorporated once known. These are currently assumed to be breakeven.

Budgets held centrally are primarily the targets for value for money and will be allocated as plans progress. As reflected within the value for money analysis schemes are currently behind plan and, hence, the negative impact on the financial position.

2.0 Income & Expenditure Position 2025 / 26

This section focusses on the financial performance of South West Yorkshire Partnership NHS Foundation Trust. This excludes the financial impact of Provider Collaboratives 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 unless explicitly stated otherwise.

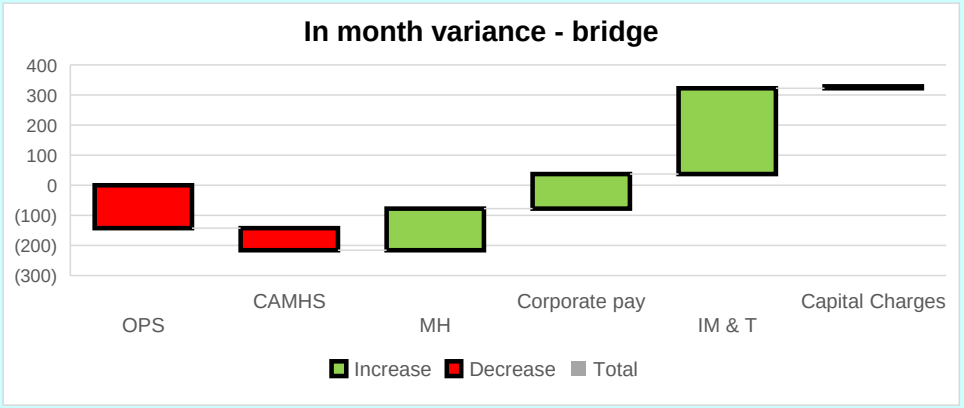
Total Financial Position - Core Trust only

	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					28,246	28,276	30	56,430	56,358	(73)	339,901	339,353	(548)
Other Operating Revenue					1,214	1,175	(39)	2,367	2,468	101	14,741	14,641	(101)
Total Revenue					**29,460**	**29,452**	**(9)**	**58,798**	**58,826**	**28**	**354,642**	**353,994**	**(648)**
Pay Costs	5,366	5,283	(83)	1.6%	(24,492)	(24,463)	29	(49,075)	(49,231)	(157)	(293,599)	(292,786)	814
Non Pay Costs					(4,954)	(4,656)	298	(9,926)	(9,411)	516	(57,771)	(57,633)	137
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,366**	**5,283**	**(83)**	**-1.6%**	**(29,446)**	**(29,119)**	**327**	**(59,001)**	**(58,642)**	**359**	**(351,370)**	**(350,419)**	**951**
EBITDA	**5,366**	**5,283**	**(83)**	**-1.6%**	**14**	**332**	**318**	**(203)**	**184**	**387**	**3,272**	**3,575**	**303**
Depreciation					(613)	(661)	(48)	(1,225)	(1,322)	(97)	(7,447)	(7,762)	(315)
PDC Paid					(378)	(382)	(4)	(756)	(764)	(8)	(4,534)	(4,584)	(50)
Interest Received					193	251	58	379	514	135	2,077	2,764	687
Surplus / (Deficit) - ICB performance measure	**5,366**	**5,283**	**(83)**	**-1.6%**	**(783)**	**(459)**	**324**	**(1,805)**	**(1,388)**	**417**	**(6,632)**	**(6,006)**	**625**
Depn Peppercorn Leases (IFRS16)					(9)	(5)	4	(17)	(10)	7	(94)	(61)	33
Losses Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,366**	**5,283**	**(83)**	**-1.6%**	**(792)**	**(464)**	**328**	**(1,822)**	**(1,398)**	**424**	**(6,726)**	**(6,067)**	**658**

The Trust plan for 2025 / 26 is profiled with a deficit in the early part of the year and reducing as value for money schemes have an impact. The budget deficit arises, following a period of small surpluses in the monthly run rate in late 2024 / 25, due to inflationary cost pressures such as pay award assumptions and national insurance changes set by government.

The key headlines, against these budget assumptions, are included below and illustrated within the bridge:

	£k
Staffing - Older People (Barnsley and Wakefield). More staff utilised than planned. Primarily bank staffing	(142)
Staffing - CAMHS. Staffing higher than plan. Medical staffing cost pressures	(74)
Staffing - Mental Health care group. Reduction in worked WTE in month	138
Staffing - Corporate pay less than planned. Over and above value for money schemes. Reflected in VFM additional delivery.	116
Support - timing of IM & T purchases	285
Capital charges - interest received higher than planned. Offsetting depreciation charges	6

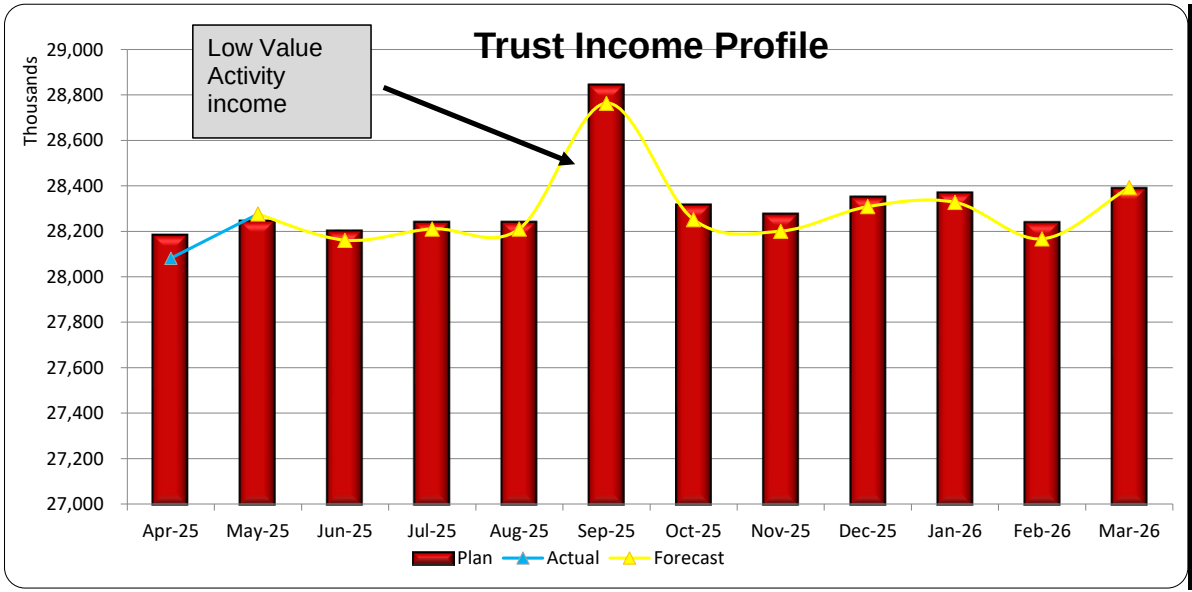


2.1 Income Information

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 24/25 £k	Apr-25 £k	May-25 £k	Jun-25 £k	Jul-25 £k	Aug-25 £k	Sep-25 £k	Oct-25 £k	Nov-25 £k	Dec-25 £k	Jan-26 £k	Feb-26 £k	Mar-26 £k	Total £k	Budget £k	Variance £k
NHS Commissioners	265,839	22,693	22,668	22,676	22,676	22,676	23,279	22,676	22,676	22,676	22,676	22,676	22,722	**272,767**	272,767	0
Specialist Commissioner	36,788	4,697	4,723	4,684	4,726	4,726	4,684	4,726	4,684	4,726	4,726	4,600	4,726	**56,426**	56,881	(455)
Local Authority	5,141	318	465	411	411	411	411	411	411	411	411	411	411	**4,896**	5,232	(337)
Partnerships	2,940	248	251	243	251	251	243	292	282	349	367	332	386	**3,494**	2,958	536
Other Contract Income	1,583	127	168	148	148	148	148	148	148	148	148	148	148	**1,771**	2,063	(291)
Total	**312,292**	**28,082**	**28,276**	**28,161**	**28,211**	**28,211**	**28,764**	**28,252**	**28,201**	**28,309**	**28,328**	**28,167**	**28,393**	**339,353**	**339,901**	**(548)**
2024 / 25		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**		
Provider Collab		9,204	9,207	9,205	9,207	9,207	9,205	9,207	9,205	9,207	9,207	9,199	9,209	**110,469**		
Total	**312,292**	**37,286**	**37,484**	**37,366**	**37,418**	**37,418**	**37,969**	**37,459**	**37,405**	**37,516**	**37,535**	**37,366**	**37,602**	**449,822**		



As identified the majority of income is block / fixed in value. Key variances are noted below. Unless stated the variance in income is offset by an equal variance in pay / non pay with reimbursement based on actual costs incurred.

	Forecast
* Additional roles reimbursement	£268k

Recharge of salary based on staff in post

* Local Authority - Yorkshire Smokefree	£337k

Payment by results on some Smokefree contracts and recharge of actual prescribing costs

* NHS England - patient monies	£22k

Recharge of actual payments made

2.2 Pay Information

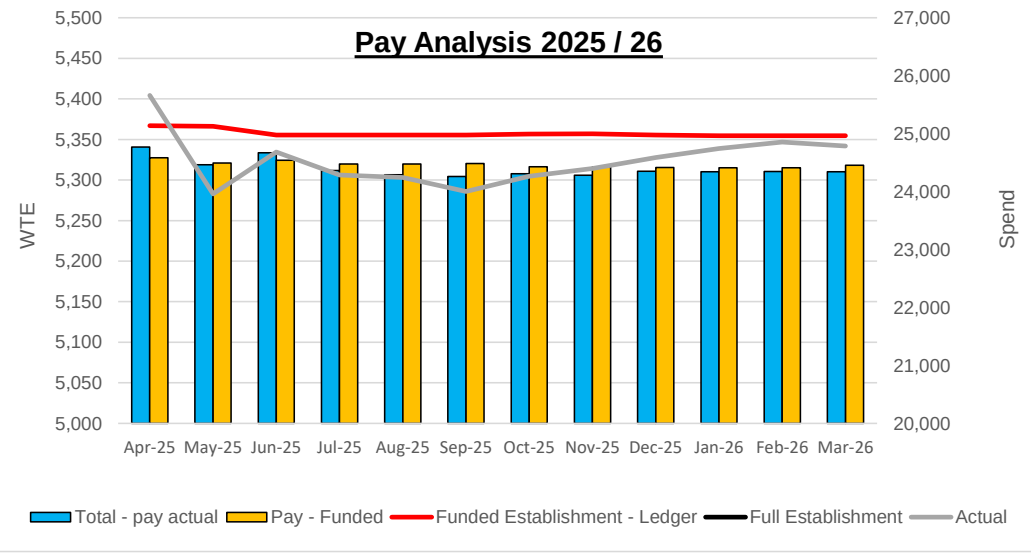
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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-25 £k	May-25 £k	Jun-25 £k	Jul-25 £k	Aug-25 £k	Sep-25 £k	Oct-25 £k	Nov-25 £k	Dec-25 £k	Jan-26 £k	Feb-26 £k	Mar-26 £k	Total £k
Substantive	22,200	22,182	22,339	22,147	22,118	22,140	22,208	22,225	22,261	22,267	22,293	22,295	**266,674**
Bank & Locum	2,216	1,926	2,018	1,947	1,933	1,913	1,904	1,884	1,909	1,893	1,878	1,860	**23,282**
Agency	352	355	311	268	242	206	196	175	182	181	177	186	**2,830**
Total	**24,768**	**24,463**	**24,669**	**24,362**	**24,293**	**24,259**	**24,308**	**24,284**	**24,352**	**24,341**	**24,348**	**24,341**	**292,786**
24 / 25	21,466	21,360	21,739	21,751	21,275	21,756	27,051	23,069	22,694	22,843	22,707	22,922	**270,633**

Bank as % (in month)	8.9%	7.9%	8.2%	8.0%	8.0%	7.9%	7.8%	7.8%	7.8%	7.8%	7.7%	7.6%	8.0%
Agency as % (in month)	1.4%	1.5%	1.3%	1.1%	1.0%	0.8%	0.8%	0.7%	0.7%	0.7%	0.7%	0.8%	1.0%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,837	4,809	4,831	4,830	4,830	4,827	4,843	4,858	4,865	4,877	4,889	4,889	**4,849**
Bank & Locum	528	443	484	461	459	447	452	447	454	451	448	443	**460**
Agency	39	31	20	15	14	12	10	9	9	10	9	9	**16**
Total	**5,404**	**5,283**	**5,335**	**5,306**	**5,303**	**5,286**	**5,305**	**5,314**	**5,328**	**5,339**	**5,347**	**5,342**	**5,324**
24 / 25	5,110	5,034	5,064	5,087	5,092	5,110	5,421	5,434	5,418	5,399	5,425	5,417	**5,251**



In line with national guidance we continue to assume the standard 2.8% pay award within the Trust financial position. We are aware of proposed pay award values for 2025 / 26, differing between medical staff and agenda for change, and these will be included when confirmed. At the same time income will be uplifted.

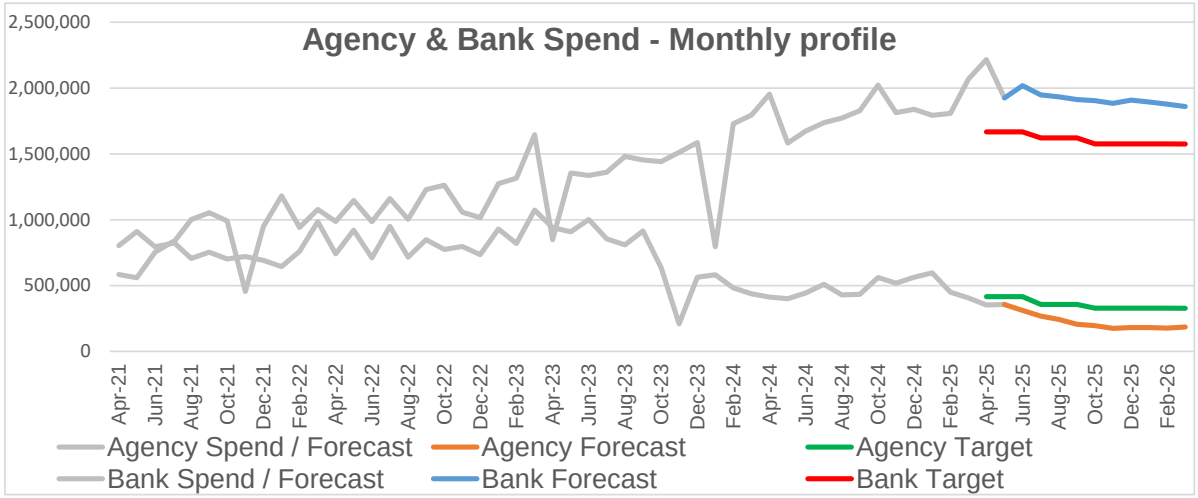
There has been a reduction in all categories in May 2025. The reduction is 28 substantive, 86 bank and 8 agency giving a total reduction of 121 when compared to April 2025. This also means that worked WTE is less than plan in month. Based on detailed forecast information this is expected to be maintained throughout the year.

2.2 Temporary Staffing Focus

Trust spend in May 2025:
Agency £355k
Bank £1,926k

We continue to acknowledge that temporary staffing solutions continue to play an important role in the overall workforce strategy of the Trust. However this must fit within the overall context of ensuring the best possible use of resources and value for money whilst ensuring that operational pressures are effectively managed.

The focus has expanded from purely agency staff to total temporary staffing costs especially those which are paid a premium rate to those paid under normal terms and conditions. This includes agency staff, Trust bank staff and also enhanced payments made to substantive Trust staff for additional hours.



Temporary Staff costs to date - by category			
Category	**Agency**	**Bank**	**Total**
	£k	**£k**	**£k**
Consultant	333	119	**452**
Other Medical	201	78	**280**
Reg Nursing	14	1,017	**1,031**
UnReg Nursing	90	2,617	**2,708**
Other Clinical	66	122	**188**
A & C	3	188	**191**
Other	0	0	**0**
Total	**708**	**4,142**	**4,850**
Lead Provider Collaborative	25	2	**28**
Budgets held centrally			**0**
Total	**733**	**4,144**	**4,877**

In line with national guidance the Trust financial plan for 2025 / 26 included spend reduction targets; 30% reduction in agency and 10% reduction in bank. The target levels of expenditure per month are now shown in the graph above.

Performance measurement of these targets is based upon total consolidated agency and bank expenditure and are reported as part of the Trust value for money programme.

Agency spend continues to be reported as green with expenditure less than plan in both April and May. This is forecast to continue to reduce. The table highlights that the majority of spend relates to medical staff (£534k out of £708k - 75%). Next steps continue to be developed and are reported weekly through the Trust temporary staffing scrutiny and management group.

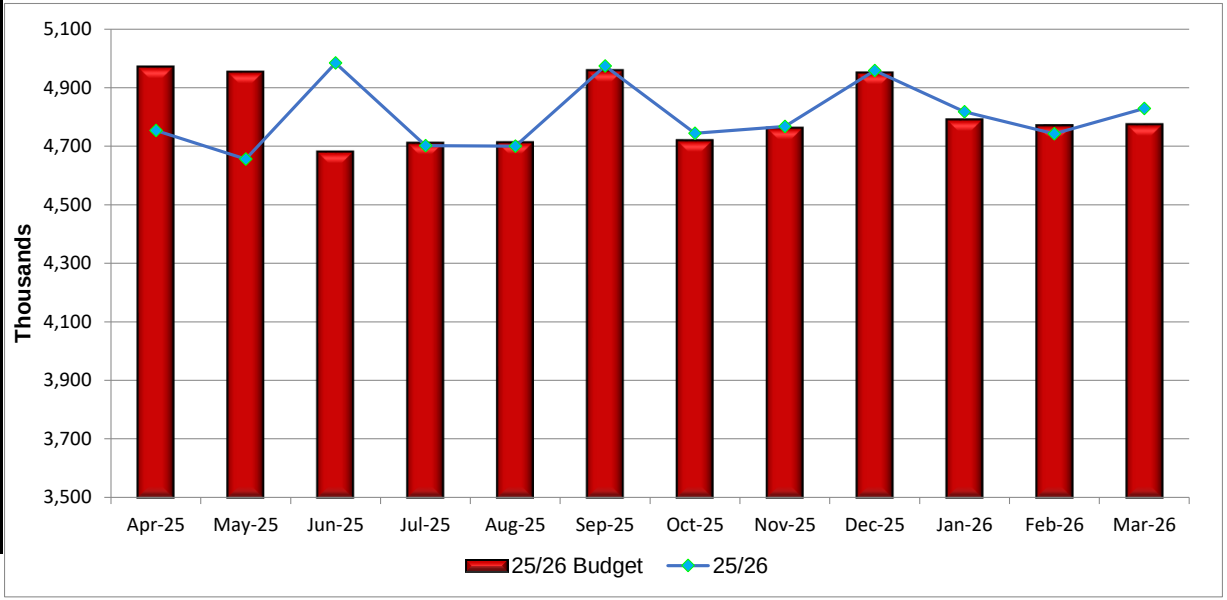
Bank expenditure, however, although reduced in May remains significantly higher than planned level. The reduction of spend in month is £122k with the largest reduction in adult inpatient wards (£101k). Forensics had seen a small increases in month which, in part, is due to additional staffing requirements in response to a specific incident. In all cases a process for break glass is established to ensure that safety is maintained.

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 and budgets held centrally.

Non pay spend	Apr-25 £k	May-25 £k	Jun-25 £k	Jul-25 £k	Aug-25 £k	Sep-25 £k	Oct-25 £k	Nov-25 £k	Dec-25 £k	Jan-26 £k	Feb-26 £k	Mar-26 £k	Total £k
2025 / 26	4,754	4,656	4,984	4,702	4,701	4,974	4,744	4,768	4,959	4,818	4,743	4,829	**57,633**
2024 / 25	4,286	4,881	4,495	4,134	4,476	4,083	5,026	4,807	4,573	4,729	4,866	5,403	**55,758**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	750	733	(17)
Establishment	1,970	1,566	(404)
Lease & Property Rental	1,496	1,485	(11)
Premises (inc. rates)	918	934	16
Utilities	481	600	120
Purchase of Healthcare	1,099	1,052	(47)
Travel & vehicles	1,076	1,069	(7)
Supplies & Services	1,495	1,396	(99)
Training & Education	96	133	37
Clinical Negligence & Insurance	293	246	(47)
Other non pay	252	196	(56)
Total	**9,926**	**9,411**	**(516)**
Total Excl OOA and Drugs	**8,077**	**7,625**	**(452)**



Key Messages

Within non pay, excluding provider collaboratives and budgets held centrally, most areas are reporting expenditure less than the plan. The largest is establishment which includes a timing delay in purchase of computer equipment. This equates to £286k behind plan for the year to date.

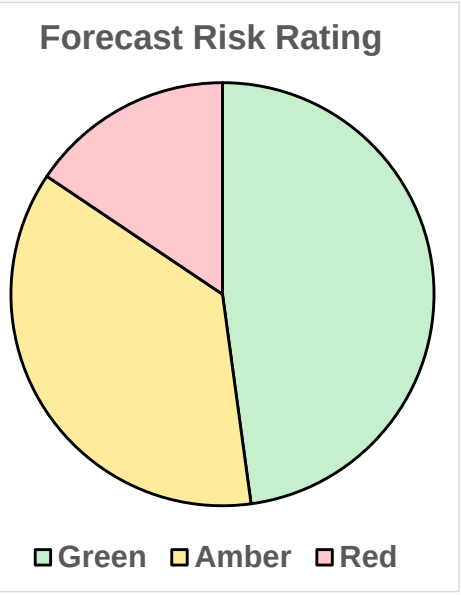
The largest overspend is utilities. The financial position reflects invoices received to date although a number are in query. As such this should be a prudent assessment of the financial risk.

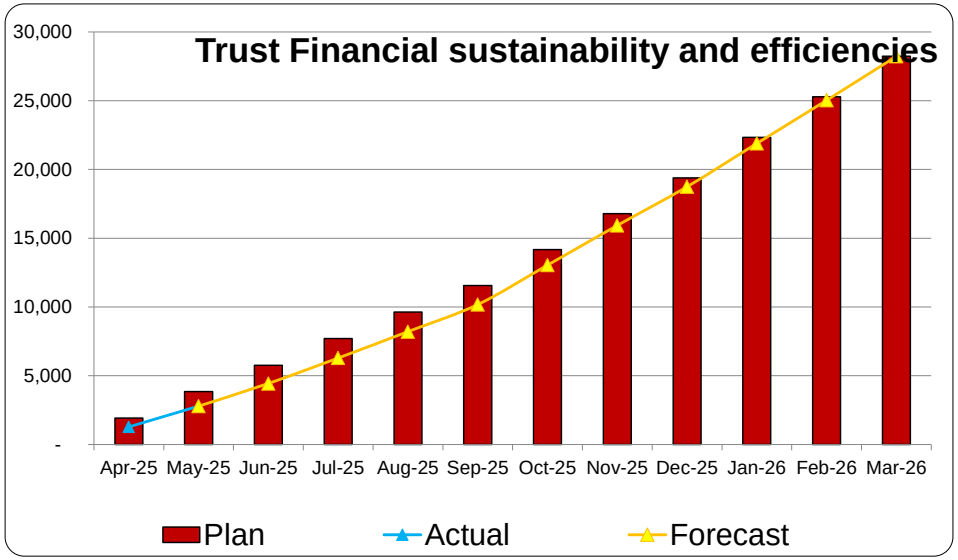
3.0 Value for Money & Financial sustainability

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 2025 / 26 a target of £28.2m 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				
Group	Key lines of enquiry	Target £k	Achieved Recurrent £k	Achieved Non Recurrent £k	Variance £k	Target £k	Green £k	Amber £k	Red £k	Variance £k
Pay	Workforce	1,750	0	1,439	(311)	10,500	1,439	7,928		(1,133)
	Unallocated	0	0		0	3,400	0		3,400	0
	Fixed Term Contracts	84	0		(84)	500	0	500		0
	Corp / non clinical	100	311	219	430	2,000	3,056			1,056
	Productivity	0	0		0	1,100	0	1,100		0
	Temporary Staffing	650	98		(552)	3,900	1,430	0		(2,470)
	Difficult Decisions	0	0		0	1,000	0		1,000	0
Non Pay	Non Pay	162	79		(83)	1,130	354	796		20
Other	Corporate Services	284	290		6	1,700	1,745			45
	Provider Collaboratives	250	354		104	1,500	2,121			621
	Bed Sales	0	0		0	500	500			0
	Technical	0	0		0	1,000	2,862			1,862
Total		**3,280**	**1,132**	**1,657**	**(491)**	**28,230**	**13,506**	**10,324**	**4,400**	**0**
Recurrent		1,480	1,132		(348)	16,430	7,854	2,396	4,400	(1,780)
Non Recurrent		1,800		1,657	(143)	11,800	5,652	7,928	0	1,780





At this early stage of the financial year progress is being made on developing and realising schemes. The year to date position is £491k behind plan.

Positive run rate reductions in corporate pay expenditure, and in the provider collaboratives scheme, help to offset those schemes which are currently behind plan. The largest of these is temporary staffing, and as reported elsewhere, is linked to bank usage higher than plan. Bank spend has reduced in month but will require further reductions to realise this scheme. There has been significant reductions on sub sections of this scheme including the reduction of corporate bank spend.

This is reflected in the full year forecast with temporary staffing a key scheme which is forecast to be behind plan and requiring additional mitigations. The actions will be considered by the Value for Money board but are currently rated as green and achievable within this financial year.

The expectation is that as the year progresses we will see a movement of schemes from red to amber and to green reflecting the reduction in financial risk as schemes are realised.

4.0 Statement of Financial Position (SOFP) 2025 / 26

Balance Sheet / Statement of Financial Position (SOFP)	2024 / 2025 £k	Current £k	Note
Non-Current (Fixed) Assets	197,434	195,270	
Current Assets			
Inventories & Work in Progress	248	248	
NHS Trade Receivables (Debtors)	2,453	88	
Non NHS Trade Receivables (Debtors)	989	696	
Prepayments	2,863	5,561	1
Accrued Income	6,235	6,428	2
Cash and Cash Equivalents	55,748	54,593	Pg 15
Total Current Assets	**68,537**	**67,615**	
Current Liabilities			
Trade Payables (Creditors)	(10,899)	(3,292)	3
Capital Payables (Creditors)	(1,551)	(847)	
Tax, NI, Pension Payables, PDC	(9,478)	(10,186)	
Accruals	(14,054)	(18,052)	4
Deferred Income	(644)	(1,444)	5
Other Liabilities (IFRS 16 / leases)	(48,793)	(49,954)	
Total Current Liabilities	**(85,419)**	**(83,776)**	
Net Current Assets/Liabilities	**(16,882)**	**(16,160)**	
Total Assets less Current Liabilities	**180,552**	**179,110**	
Provisions for Liabilities	(3,357)	(3,348)	
Total Net Assets/(Liabilities)	**177,195**	**175,762**	
Taxpayers' Equity			
Public Dividend Capital	76,344	76,344	
Revaluation Reserve	21,306	21,306	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	74,325	72,892	
Total Taxpayers' Equity	**177,195**	**175,762**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2025.

A bridge of cash movements is shown on page 15.

1. Prepayments continue to be higher than year end as charges covering 2025 / 26 have been received and paid. This includes annual charges such as insurance. This value traditionally reduces over the course of a financial year.

2. Accrued income remains high, as it was at year end, and primarily relates to income from NHS England in relation to provider collaboratives. These values have been agreed with commissioners and physical cash payment has been chased. This will be received as a direct cash payment and therefore an invoice has not been raised.

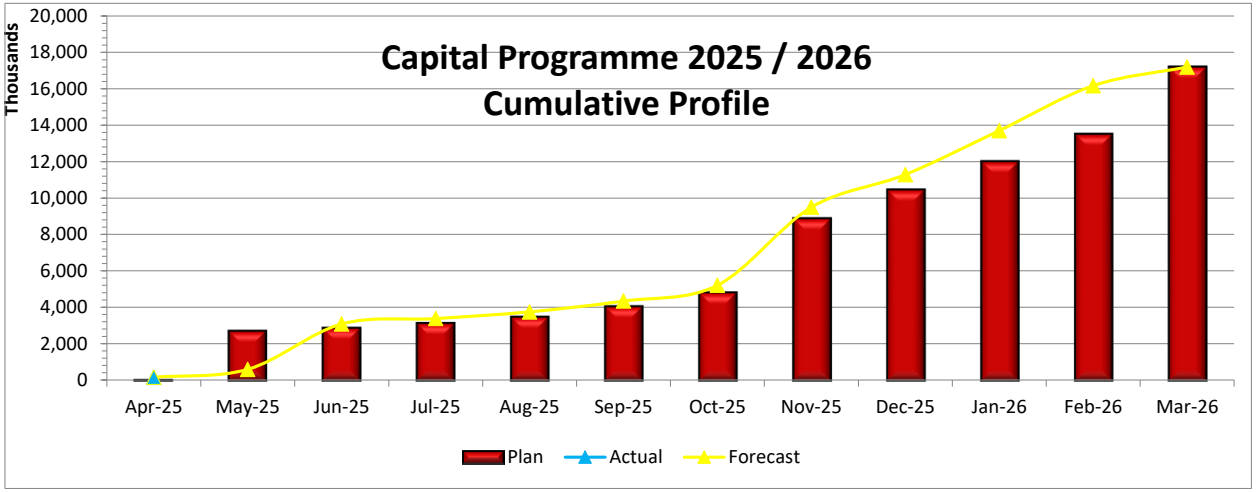
3. As is normal Trade creditors were exceptionally high at year end and have now reduced in April and May 2025. As demonstrated by the continued positive better payment practice code performance, we continue to pay suppliers promptly. Aged creditors are reviewed and actively targeted for resolution. In May creditors older than 30 days are only £17k

4. Accruals continue to be monitored to ensure that they are in line with accounting standards and that issues, or areas of uncertainty, are allowed to build up.

5. Deferred income remains at a relatively low level. The largest element remains the timing of education training funding from NHS England with June 2025 deferred (£684k).

4.1 Capital Programme 2025 / 26

Capital schemes	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Annual Budget £k	2024 / 25 Outturn £k	Variance £k
Major Capital Schemes						
Older People Transformation	100	0	(100)	7,425	8,100	675
Estates safety	0	0	0	675	0	(675)
Backlog Maintenance	0	8	8	0	13	13
Other	0	136	136	0	(74)	(74)
Leases (IFRS 16)	2,631	443	(2,188)	6,148	6,210	62
TOTALS	**2,731**	**587**	**(2,144)**	**14,248**	**14,248**	**0**
Additional allocations						
Net Zero (solar funding)	0	0	0	1,952	1,952	0
Cheswold - seclusion room	0	1	1	1,000	1,000	0
Cheswold - Minor Capital	0	0	0	2,082	2,082	0
Cheswold - IM & T	0	0	0			0
TOTALS	**2,731**	**588**	**(2,143)**	**19,282**	**19,282**	**0**



Capital Expenditure 2025 / 26

The table on the left summarises the capital programme for 2025 / 26. The first section is activity as reported against the standard West Yorkshire Integrated Care Board capital allocation. For 2025 / 26 the Trust programme was prioritised against the main older people transformation scheme and the impact of leases.

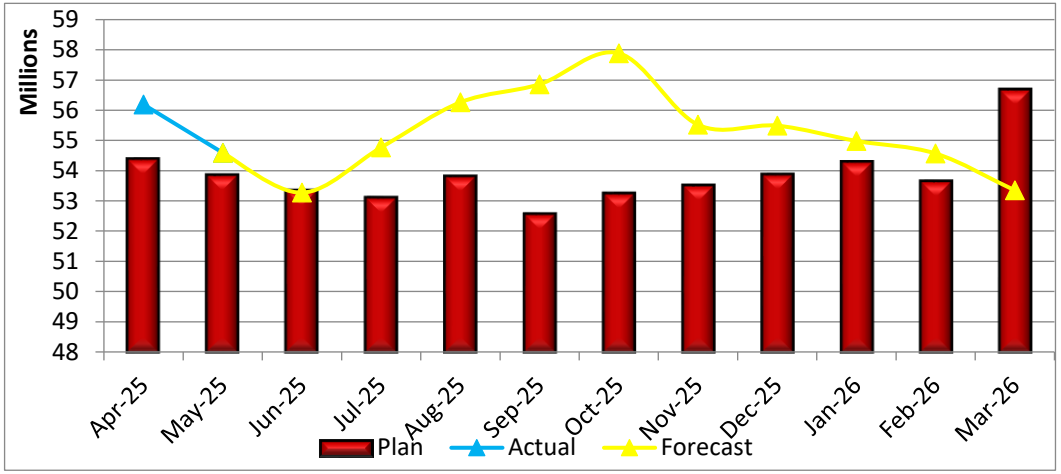
Unlike previous years leases is included within the single allocation value and will need to be managed as such.

Additional funding has been secured either as a result of previous business cases, for example Cheswold investment from South Yorkshire allocations, or external bids in the case of net carbon zero and Cheswold seclusion rooms.

Through national frameworks the Trust has a construction partner and progressing schemes accordingly. As per the profile graph the majority of expenditure is planned for the second half of the financial year.

Whilst the year to date shows a significant variance to plan this is due to invoicing issues in relation to lease renewals. These are expected to be resolved in June 2025.

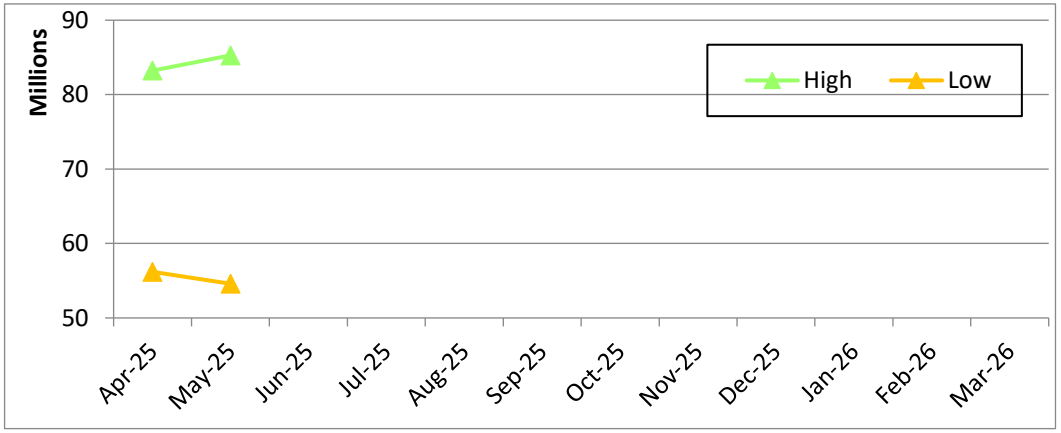
4.2 Cash Flow & Cash Flow Forecast 2025 / 2026



The Trust cashflow forecast remains under review

Whilst current cash balances are higher than plan this is forecast to flucatate over the course of the year based on I & E position and the Trust capital programme.

	Plan £k	Actual £k	Variance £k
Opening Balance	55,839	55,839	
Closing Balance	53,858	54,593	734



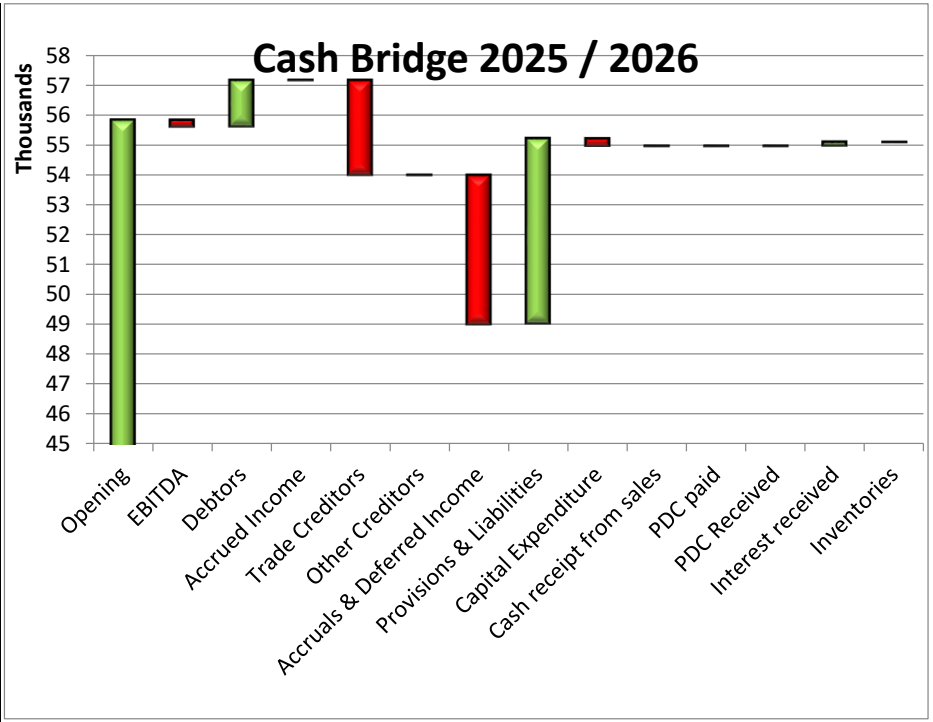
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £85.3m
The lowest balance is: £54.6m

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	**55,839**	**55,839**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	1,906	1,668	(238)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	3,100	4,660	1,560	
Trade Payables (Creditors)	300	(2,859)	(3,159)	
Accruals & Deferred income	0	(4,984)	(4,984)	
Provisions & Liabilities	(5,412)	784	6,196	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(600)	(848)	(248)	
Cash receipts from asset sales	0	0	0	
Leases	(1,654)	(180)	1,474	
PDC Dividends paid	0	0	0	
PDC Dividends received	0	0	0	
Interest (paid)/ received	379	514	135	
Closing Balances	**53,858**	**54,593**	**734**	



The table above summarises the reasons for the movement in the Trust cash position during 2025 / 2026. This is also presented graphically within the cash bridge.

The main headlines are picked out on the previous page.

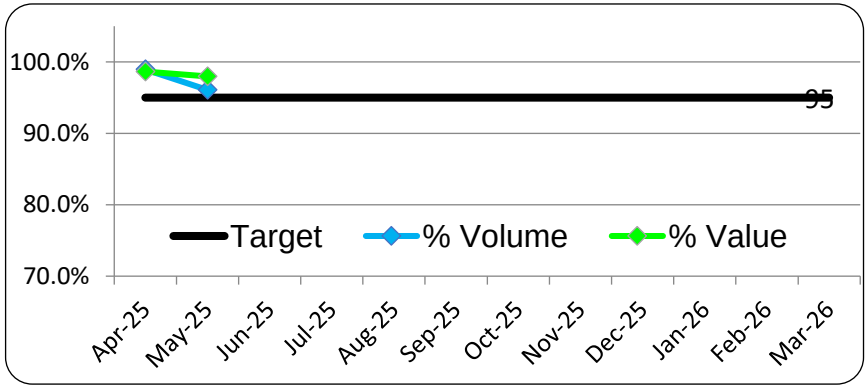
5.0 Better Payment Practice Code

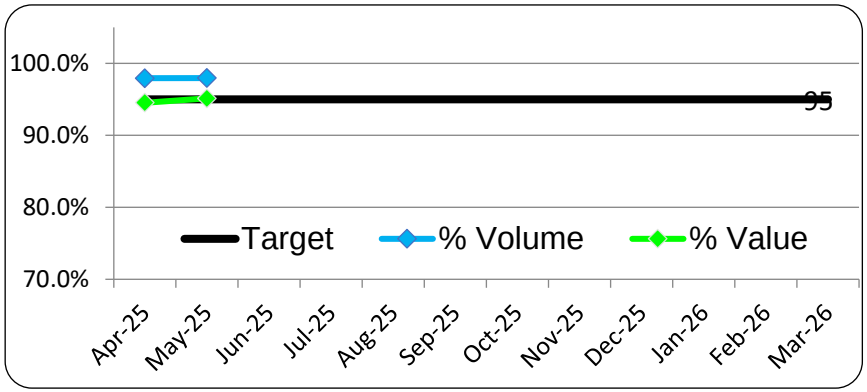
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	96%	98%
Cumulative Year to Date	98%	98%

Non NHS	Number %	Value %
In Month	98%	95%
Cumulative Year to Date	98%	95%





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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 (£)
13-May-25	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000059072	734,353
07-May-25	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	205616	658,717
21-May-25	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	205649	658,717
02-May-25	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400002954	492,999
20-May-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS58	400,000
01-May-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010069	398,935
23-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000001620	334,600
21-May-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS35	240,000
09-May-25	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 299	226,385
09-May-25	Data Lines	Trustwide	Virgin Media Business Ltd	927686155	224,631
01-May-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010066	151,827
13-May-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS056SN	133,309
07-May-25	IT Services	Trustwide	Wavenet Ltd	1306822	108,300
12-May-25	IT Services	Trustwide	Wavenet Ltd	1331521	108,300
16-May-25	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6028577	87,045
27-May-25	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	329711	82,416
20-May-25	Purchase of Healthcare	Trustwide	Diabetes Digital Media Ltd	INV8031	79,156
28-May-25	Computer Software	Trustwide	Patients Know Best Ltd	INV1184	76,893
28-May-25	Drugs	Trustwide	Bradford District Care NHS Foundation Trust	205642	69,444
27-May-25	Drugs	Trustwide	Rowlands Pharmacy	1800002621	64,358
27-May-25	Drugs	Trustwide	Rowlands Pharmacy	1800002947	64,358
27-May-25	Drugs	Trustwide	Rowlands Pharmacy	1800003124	64,358
09-May-25	Purchase of Healthcare	AS Collaborative	Cumbria Northumberland Tyne And Wear NHS Foundation Trust	9810036028	61,832
09-May-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34029364	56,000
10-May-25	Insurance	Trustwide	Willis Ltd	10958GP25000001PRM	52,601
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	51,572
22-May-25	Computer Software	Barnsley	Pcmis Health Technologies Ltd	144592	50,874
19-May-25	Drugs	Trustwide	NHS Business Services Authority	1000084151	49,715
23-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000001621	48,770
07-May-25	Lease Cars	Trustwide	Athlon Mobility Services Uk Ltd	202580012668	47,949

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
16-May-25	Lease Cars	Trustwide	Arval Uk Ltd	RI0013380288	47,374
13-May-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS056INV	44,835
27-May-25	Drugs	Trustwide	NHS Business Services Authority	1000084466	44,107
08-May-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34031350	42,770
21-May-25	Utilities	Trustwide	Edf Energy Customers Ltd	000023460710	42,570
28-May-25	Purchase of Healthcare	Kirklees	Invictus Wellbeing Services Cic	435	42,433
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	42,354
01-May-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34030705	40,575
20-May-25	Purchase of Healthcare	Calderdale	Invictus Wellbeing Services Cic	434	39,500
01-May-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001349EPC	38,549
08-May-25	Utilities	Trustwide	Totalenergies Gas & Power Ltd	37443612225	38,487
08-May-25	Insurance	Trustwide	Willis Ltd	11738GP24000002ADP	37,884
20-May-25	Computer Software	Barnsley	Cinnamon Digital Applications Ltd	INV213	36,713
01-May-25	Purchase of Healthcare	Trustwide	Cygnet (Dh) Ltd	HEX0399988	32,085
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	30,157
30-May-25	MFDs	Trustwide	Annodata Ltd	1398002	29,778
14-May-25	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6028656	29,490
07-May-25	Drugs	Doncaster	Speeds Healthcare Ltd	INV158453	29,182
19-May-25	Lease Cars	Trustwide	Athlon Mobility Services Uk Ltd	202580009801	28,103
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	28,027
21-May-25	Utilities	Trustwide	Totalenergies Gas & Power Ltd	37443648525	27,908
09-May-25	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400008062	26,998
13-May-25	Insurance	Trustwide	Aon Uk Ltd	544205062	26,413
19-May-25	Purchase of Healthcare	Trustwide	Nouvita Ltd	13136	26,367
21-May-25	Utilities	Trustwide	Edf Energy Customers Ltd	000023266362	26,118
20-May-25	Rates	Kirklees	Kirklees Council	96951667X2025	25,200
07-May-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90150924	25,019
07-May-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90150926	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

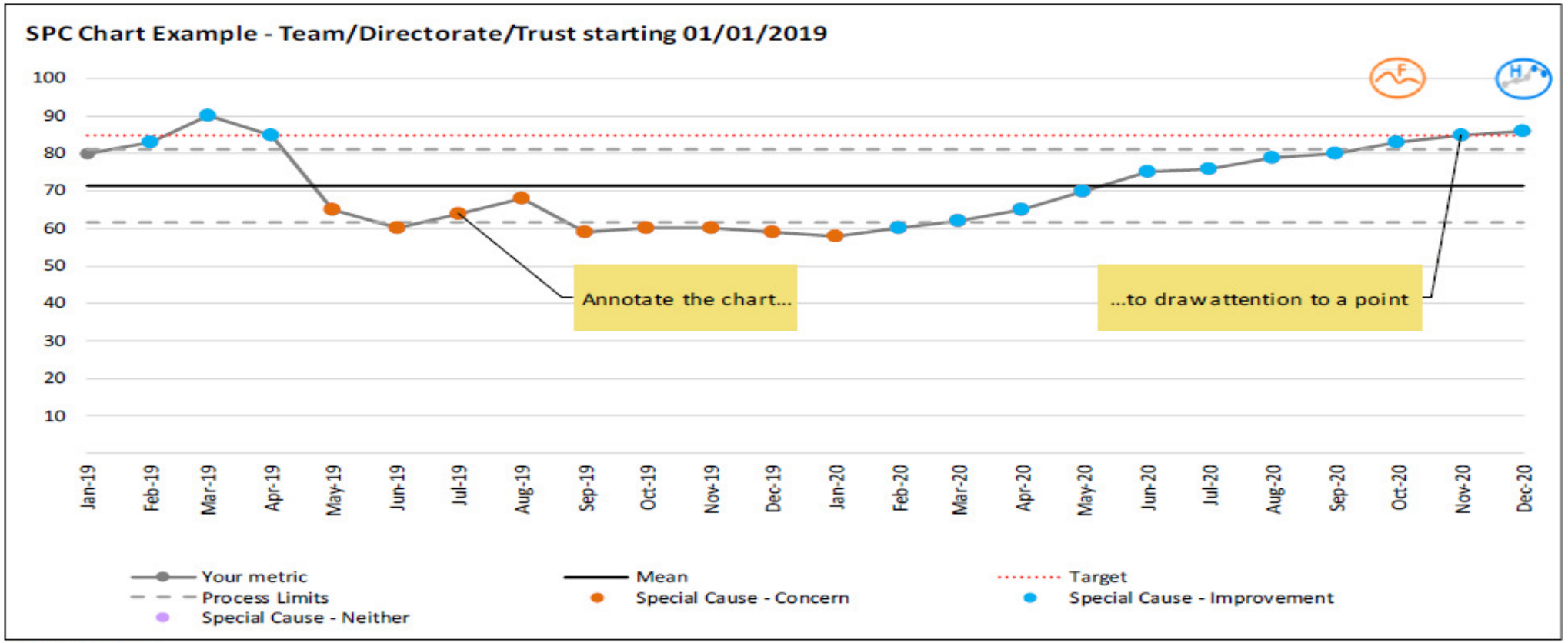
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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