NHS
South West Yorkshire
Partnership Teaching
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

August 2025

With **all of us** in mind.

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

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Introduction

Welcome to the Trust's Integrated Performance Report (IPR) for September 2025.

The report format for 2025/26 has been changed slightly this year to align with the Trust board's focus. 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, the report has been updated to reflect this. In particular, the national metrics section includes those contained within the NHS 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. We have added the reducing inequalities section to the report again this month, this is linked to the Trust's equality, diversity and inclusion strategy it includes a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities. The strategy will guide us to being a more 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.

Our Integrated Performance Report is publicly available on the internet.

Headlines

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

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	↓	
% people dying in a place of their choosing	↑	
Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	↓	
% 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 been reviewed within the last year	↑	New metric from April 25

People

Metric	Change from last month	Variation/ Assurance
Registered workforce growth	↔	
Sickness absence - Month	↓	
Appraisals - rolling 12 months	↓	

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	↑	
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
Inappropriate out of area bed days	↓	
Talking Therapies - Reliable Recovery	↓	
Talking Therapies - Reliable Improvement	↓	
Talking Therapies - proportion of people completing treatment who move to recovery - Trust	↓	
Talking Therapies - proportion of people completing treatment who move to recovery - Kirklees	↓	

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

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↔	New metric from April 25
Sickness rate (monthly)	↓	
% assessed within 14 days of refferal (routine)	↓	
% assessed within 4 hours (Crisis)	↑	

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	↑	
Average length of stay - Acute and Psychiatric Intensive Care Unit - South Yorkshire (3 Months Rolling)	↑	New metric from April 25
Out of area bed days	↓	

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% of clients clinically ready for discharge	↑	
% of feedback with staff values and behaviours as an issue	↑	

Forensic - West Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
% of feedback with staff values and behaviours as an issue	↑	
Sickness rate (Monthly)	↑	
% Bed occupancy (incl leave)	↔	
% 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

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
Cardiopulmonary resuscitation (CPR) training compliance	↓	
% Bed occupancy	↑	
Information Governance training compliance	↓	

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
% of feedback with staff values and behaviours as an issue	↓	
% of people dying in a place of their choosing	↑	

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 27 violence and aggression incidents against staff on mental health wards involving race during August. 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.

• The total number of reported incidents in August decreased to 1,374, 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. Although there has been a decrease, 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 August 2025 resulted in no or low harm or were not under the care of the Trust.

• The number of restraint incidents reduced this month from 258 reported in July to 208. 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.

• There were 9 prone restraints during the month where we have purposefully placed the person in the prone position. Five of these incidents took place on one of our psychiatric intensive care units for exiting seclusion. Alternative seclusion exit training is now embedded in both four-day initial and two-day annual refresher Reducing Restrictive Physical Interventions training. Additional bespoke sessions are being offered across inpatient units in collaboration with Ward Managers to ensure all inpatient nursing staff, both registered and unregistered staff are supported to undertake training in alternative seclusion exit techniques and feel confident to use. We expect this will support a move away from prone restraint being used as a method for exiting seclusion which as the data above shows is the primary reason for prone restraint use.

• There were 8 information governance personal data breaches during August which is an improvement based on last month and under the Trust threshold of 12 or less. Information disclosed in error continues to be the highest reported category, these were spread across various care groups. 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.

• There were 43 inpatient falls reported during August 2025. We actively risk assess those service users who are at high risk of falling and implement care plans. All fall incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. There has been a review by the falls lead across older adults' wards to establish any alternatives to enhanced observations to support service users. Recommendations have been progressed.

• The Trust continues to work to improve the recording and collection of protected characteristics across all services to improve our service provision and experience of it. For the ethnicity indicator, the Trust is achieving 94.2% against a target of 90%. Disability recording was at 50.2%, sexual orientation 55.7% 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.

• The reducing inequalities data has demonstrated a difference in the average length of stay, which is longer for Asian and Black service users. We are drilling down into this data so that we can pinpoint key actions to understand and address this.

• 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%. The Trust is meeting the planned trajectory to date for all metrics except for the metric % with care plan that includes service user input/views. The risk assessment and care planning workstream are focussing on all improvements and a trajectory to meet the 95% target by end March 2026. Performance against all metrics has seen an increase in August and all risk assessments and care plans that have not been completed within the timescale have oversight and scrutiny from the Care Groups. Detail can be seen in the Quality dashboard and care group section of the report.

Forensic risk assessments are completed prior to admission as part of the admission assessment and planning process. In line with good clinical practice these are then reviewed at the point of admission to ensure they are still clinically accurate, the admitting clinician will record this review within the risk assessment going forwards, which will enable capture of risk assessment.

• All services 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. 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 and communicated to the service user and ward staff. 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 approach recording.

• The Trust has seen a reduction in the safer staffing fill rate over the last six months; this is linked to the grip and control measures that have been put into place in relation to the use of

Care Groups

• Child and adolescent mental health services (CAMHS) continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period. For service users waiting for a first appointment at the end of August, 69.3% of those waiting had been waiting for a period of 18 weeks or less.

• 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 a deep dive being carried out and presented to Executive Management Team in October to understand this further and what improvements are required by place and what dedicated support can be offered. There is an offer in place to support children and families whilst waiting. Close work with commissioners continues across each 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 August 95.3% was achieved. This has shown a sustained improvement and been consistently achieved 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 psychiatric intensive care beds continues to be a significant challenge and we have experienced increased use of out of area beds days in the last month relating to 8 service users. 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.

• Focus on patients clinically ready for discharge continues to take place across mental health and learning disabilities, we have seen an overall increase in delays during August. Challenges remain associated to patients requiring specialist placements. Hotspot areas include learning disabilities, adult and older peoples wards and psychiatric intensive care unit (PICU). At the end of August 29 people were clinically ready for discharge but remained in a bed. Further detail can be seen in the care group section of the report.

• 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 is approximately 27 cases across all three areas per month. The number of referrals for ADHD received for these areas in August was 274. Calderdale does not block commission assessments, but we do assess 7-8 people from that locality via the Patient Choice framework. 23 referrals were received from Calderdale in August.

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 currently commissioned in Wakefield and Kirklees. Barnsley and Calderdale have received updated business cases for their consideration. A deep dive has been commissioned and will be presented to Executive Management Team in October to understand by place.

• Mental health acute wards have continued to manage high levels of acuity and increased levels of risk to self and others. 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.

• A significant reduction in the use of agency staff on wards has been sustained. However, use of bank staff increased during the month. The temporary staffing weekly meeting scrutinises the use of additional staffing and any areas of improvement to reduce the reliance on bank staff. There have been a significant number of bank staff transition to substantive staff and

People

• Year to date sickness absence has increase slightly above threshold for August 2025 at 5.1%. The in month sickness position for August increased to 5.4%. We have seen an overall rise in long term sickness as a % of total absence – these are being managed in Care Groups with support from the people directorate. The introduction of a new sickness absence dashboard has been rolled out for managers, to support them in managing absences and enabling more Trustwide information to be available.
• Appraisal compliance has dropped slightly this month and stands at 88.6%. Out of all Trust services, the Barnsley Physical Health and Wellbeing Care group are the only service area above the 90% threshold. Hotspot areas are being managed across the Trust to ensure all staff have access to a meaningful, timely appraisal.
• Our 12-month staff turnover rate in August has increased slightly from last month to 10.2%. This is still a lower level than we have seen in previous years and remains under our Trust threshold of between 12-13%.
• In August, we had 31 new starters and 77 leavers. August also saw a further 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. Dedicated focus on non-compliance continues within all care groups and the wider Trust.
• Information governance training compliance remains high.

National Indicators

The Trust continues to perform well against most national metrics. The following should be noted:
• NHS England published Trust Oversight Framework scores for quarter 1 at the end of August 2025.
• Due to the Trust submitting a deficit financial position adverse to plan for quarter 1, this resulted in the Trust overall score being 3. If the financial override had not taken effect, performance against the measures in the 5 domains is strong and our average Trust score puts the Trust as 3 out of 61 providers of non-acute hospitals (including Mental health and learning disability, community and care trusts). The detail of the performance against each metric in the framework can be seen in the national metrics section of the report.
• It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways. Regarding the 6 weeks to a diagnostic appointment target, 102 out of 213 children (47.9%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in August. The demand in referrals outweighs commissioned activity levels – this remains a national issue.
• Children & Younger People with an eating disorder - % routine cases accessing treatment within 4 weeks remains below the national threshold of 95%. This relates to 4 service users out of a total of 30, 2 of these cases relate to where an appointment was offered within the time frame, but this was cancelled or missed by the family. The other 2 breaches were seen but outside the timeframe.
• Community services waiting list - This metric reports the total number of people waiting across a range of physical health and wellbeing 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 It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold (18 weeks).
• 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 2026. Overall, the average length of stay for people discharged in August has remained at a similar level to last month (58.3 days) In terms of performance against the trajectory, we are meeting the trajectory for August for our West Yorkshire acute mental health and PICU wards but remain above our trajectory for Barnsley wards.
• 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. For services to work within the financial envelope opportunities for working differently and effectively need to be explored and introduced.
• 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.
• August 2025 saw a slight dip in performance for NHS Talking Therapies reliable recovery and reliable improvement indicators with both just dropping below threshold by 1%. Review of the data suggests this is linked to seasonal factors - the service saw a reduced number of clients accessing the service and pauses in treatment during the summer period. Both quarter and year to date, the service continues to exceed the recovery indicator.

Finance

• The financial performance for August 2025 is a surplus of £367k which is £0.8m better than plan. This is the first month in 2025 / 26 where a surplus has been achieved. This is through a combination of staffing numbers and the payment of the pay award being less than originally estimated. The year-to-date position is a deficit of £1.7m which is now £0.7m favourable to plan.
• Agency spend remains within planned levels primarily due to a reduction in medical agency spend in month. The forecast modelling, supported by individual exit plan, supports a continued reduction of the expenditure run rate.
• Trust bank expenditure has continued to increase in line with continued demand and acuity within inpatient wards. The forecast remains that the target will be breached. Usage, and the operational reasons, continue to be monitored weekly through the Trust temporary staffing management group.
• In August corporate services spend is £0.4m less than planned.
• The value for money programme is £0.6m behind plan for the year to date which is an improved position on last month. Additional non-recurrent mitigations have been identified which has reduced the value of red rated schemes. As valid schemes these continue to provide additional opportunities in future periods.
• Cash continues to be monitored to ensure effective management of the Trust working capital position. In August 2025 this remains better than planned at £60.1m.
• Capital spend is behind plan for the year to date and work continues on the major older people scheme. This has impacted on the overall spend profile and as such other schemes are being brought forward to ensure that the allocation is appropriately utilised.

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Jun-25	Jul-25	Aug-25	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Best Quality	Responsive	TBC	76.0%	73.0%	69.3%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	Best Quality	Caring	< 20%	8% (3/38)	17% (8/48)	9% (2/22)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	108.4	144.8	108.7	N/A
	Complaints - Number of responses provided within six months of the date a complaint received [16]	Best Quality	Well led	100%	95% (18/19)	84% (16/19)	95% (20/21)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	86%	91%	89%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	95%	97%	97%	1
	Number of compliments received	Best Quality	Caring	N/A	74	37	68	N/A
Quality	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Best Quality	Safe	Trend monitor	6	7	3	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Best Quality	Safe	Trend monitor	0	2	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	8	13	8	2
	% of inpatients clinically ready for discharge *	Person first and in the centre	Responsive	3.5%	5.4%	3.9%	5.2%	3
	Total number of reported incidents [18] *	Best Quality	Safe	Trend monitor	1488	1671	1374	
	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	32	37	29	
	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	2	4	2	
	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	0	0	0	
	Safer staff fill rates *	Best Quality	Safe	90%	119.4%	119.4%	118.3%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	97.5%	96.0%	97.9%	1
	Number of pressure ulcers which developed under SWYPFT care [1]	Best Quality	Safe	Trend monitor	38	50	45	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement [2]	Best Quality	Safe	0	0	1	0	0
	Eliminating Mixed Sex Accommodation Breaches	Best Quality	Safe	0	0	0	0	1
	Number of Falls (inpatients) *	Best Quality	Safe	Trend monitor	49	49	43	
	Number of restraint incidents *	Best Quality	Safe	Trend monitor	184	258	208	
	% of staff receiving supervision within policy guidance [15]	Best place to work and learn	Well led	80%	88.3%	88.9%	86.6%	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%	93.1%	78.1%	94.4%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	17	17	11	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%	69%	Due Nov 2025		
	Number of violence and aggression incidents against staff on mental health wards involving race *	Best place to work and learn	Safe	Trend Monitor	37	36	27	N/A
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0	9	Due October 2025		
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	98.9%	95.6%	92.4%	
	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%	100.0%	100.0%	
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	93.8%	94.3%	94.2%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	52.8%	52.4%	52.0%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	56.9%	56.3%	55.7%	
	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	Jun-25	Jul-25	Aug-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%	100% Service 100% Policy	100% Service 100% Policy	100% Service 97.3% 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%	65.4%	75.7%	84.6%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring		70.1%	70.0%	74.8%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring		92.5%	94.5%	96.9%	
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe		78.3%	81.1%	81.4%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe		88.8%	89.1%	91.5%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	June and July – 10 Aug and Sept - 8	7	5	9	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor	54	39	64	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor	5093	6639	6756	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 Oversight Framework segmentation	All	Well led	1/2	3	Due Nov 25		
	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 21 complaints responded to during the month, 20 were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 108.7 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.
• Compliments received during the month increased by 84% compared to July, reflecting a positive trend in service user and carer feedback.
• Clinically ready for discharge (previously delayed transfers of care) - Overall Trust position for August was 5.2%, this includes data for Cheswold Park Hospital. The performance excluding Cheswold Park Hospital is 5.46%. 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.
• The number of reported incidents - An reduction in incidents has been seen in August, the total figure for the month incudes 131 incidents that are attributed to Cheswold Park Hospital; 1243 incidents were attributed to the rest of the Trust. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.
• There were 2 severe harm incidents reported during the month one related to a pressure ulcer and one related to self harm. Both incidents were managed following Trust procedures.
• The overall number of restraint incidents in August was 208 though this figure now includes data for Cheswold Park Hospital. 31 of these incidents were attributed to Poplars ward, and 26 to Ward 18 at the Priestley Unit. 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.
• The number of prone restraint incidents where we had purposely put the person in the prone position was 9 for August. There were also 3 instances where the prone position was service user led. Alternative seclusion exit training is now embedded in both four day initial and two day annual refresher Reducing Restrictive Physical Interventions training. Additional bespoke sessions are being offered across inpatient units in collaboration with Ward Managers to ensure all inpatient nursing staff, both registered and unregistered staff are supported to undertake training in alternative seclusion exit techniques and feel confident to use. This should support a move away from prone restraint being used as a method for exiting seclusion which the data above shows is the primary reason for prone restraint use in August 2025.
• 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.

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. This has been finalised and submitted as evidence and will be reviewed by the Accreditation Committee by the end of September.

Learn from Patient Safety Events (LFPSE) Data Validation
The LFPSE is a standardised framework designed to categorise and report patient safety incidents in healthcare settings. Its purpose is to facilitate better data collection, reporting, and analysis, which ultimately aims to improve patient outcomes and care quality. LFPSE data validation has taken place in line with a national request. RLDatix have recently released LFPSE Taxonomy V6. An upgrade Datixweb will be carried out once scoping has taken place.

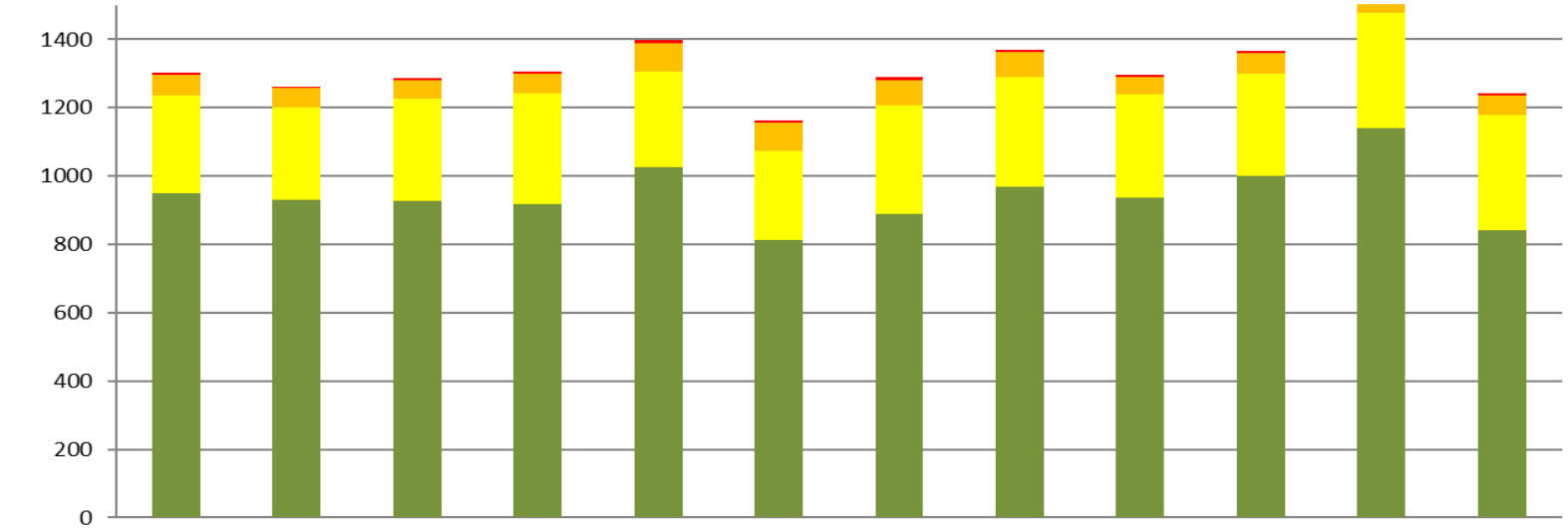
Quality & Safety Dashboard Footnotes:
1 - Number of pressure ulcers which developed under SWYPFT care - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions 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 2024 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 8 red incidents in August, incidents may be subject to regrading as more information becomes available, which means this figure is subject to change.

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



	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Red	6	4	6	5	10	6	10	4	7	8	7	8
Amber	61	56	54	57	83	82	72	73	51	61	78	57
Yellow	284	272	300	326	280	262	318	324	300	297	338	338
Green	951	929	927	917	1025	812	890	967	938	1001	1141	840

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).

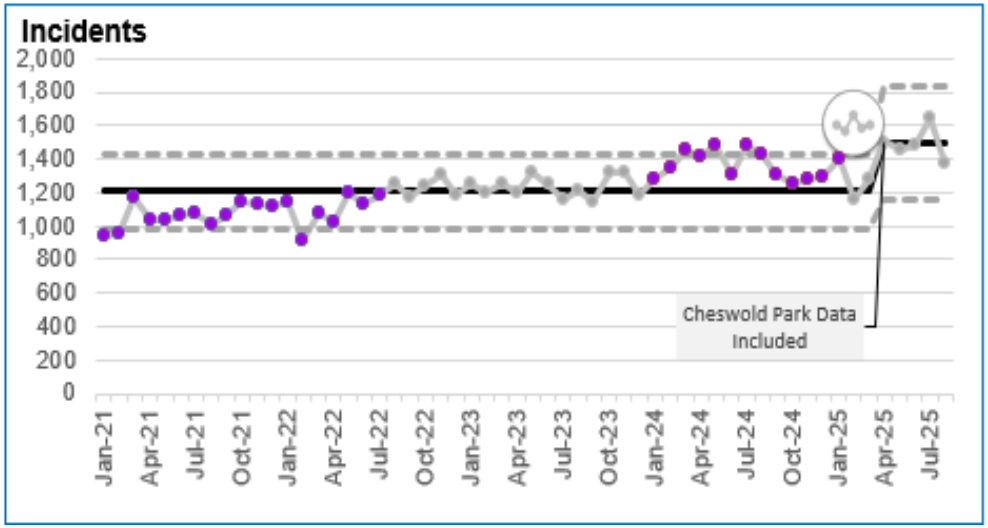
Safety First cont…

Summary of Patient Safety Incidents resulting in moderate or severe harm or death
Breakdown of incidents in August 2025

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

There were 2 severe harm incidents one in the Barnsley neighbourhood team and one in the Wakefield intensive home based treatment team.

Incidents



We have re-entered a period of common cause variation in August 2025 due to 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 (PSIRF) 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.

Learning Library

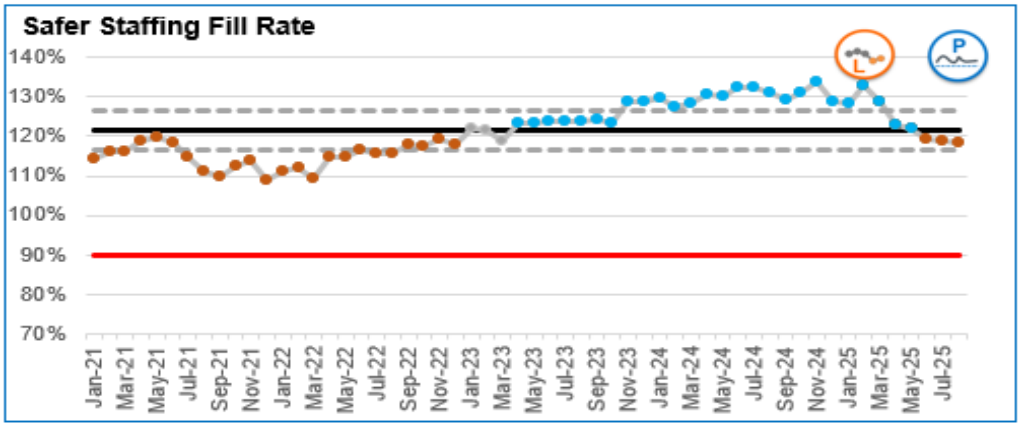
The learning library has been developed as a way to gather and share examples of learning from experience.
Further examples can be found on the SWYPFT intranet page.

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

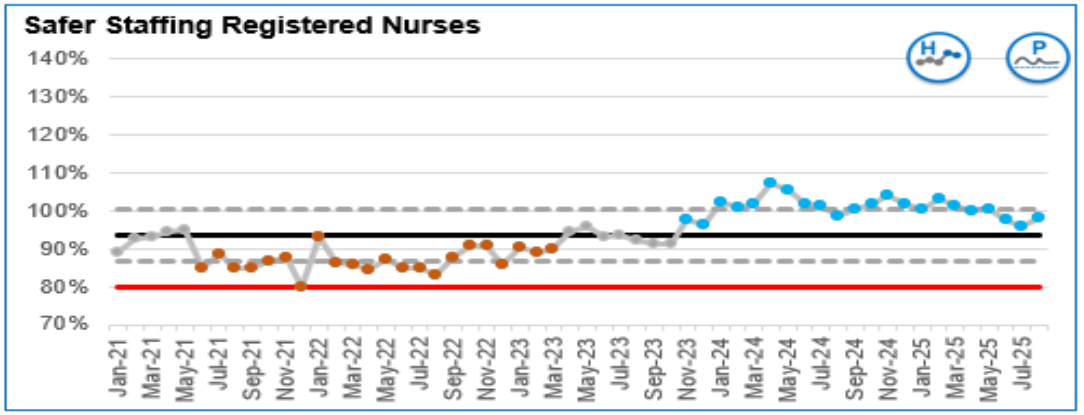
Patient Safety Alerts

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

Safer Staffing Inpatients



The chart above shows that as at August 2025, we remain in a period of special cause concerning variation (something is happening and this should be investigated) and we are expected to meet the target.



The chart above shows that in August 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 target.

- In August, excluding Cheswold Park Hospital (CPH), within the flexible staffing pool, there were a total of 53 (6,356) less shift requests, and the overall fill rate for flexible staffing decreased by 1.55% to 83.16%.
- Within overall fill rates there was an increase in the fill rates of 8.3% for Forensic and Learning Disability (LD) care group to 122.7%, Adult and Older Peoples Care Group reduced by 5.4% to 117.7%, Cheswold Park Hospital increased by 4.3% to 120.0% and Barnsley Integrated Services decreased 16.7% to 91.2% - although within Barnsley there was a low bed occupancy, annual leave and excess hours were being taken after a clinical risk assessment had been made regarding staffing requirement.
- We continue to scrutinise flexible staffing usage in our temporary staffing scrutiny and e-rostering groups.
- The utilisation of agency workers has increased in authorised situations which is in line with our Grip and Control group.
- The overall fill rate, with CPH, was similar to the previous month and was 118.3%. The day fill rate for Registered Nurses (RNs) decreased by 1.4% to 95.0%. Four wards, an increase of one on the previous month, Ward 19 in the Adult and Older Peoples care group, Calder Ward at Cheswold Park Hospital, Stroke Rehab within Barnsley Integrated Services and Waterton Ward within the Forensic and LD care group, fell below the 90% RN day fill rate. They were supported through local escalation plans.
- The night RN fill rate decreased (3.4%) to 102.5%. Night fill rate was not achieved by Calder Ward at Cheswold Park and Neuro Rehab in Barnsley Integrated Services. This was consistent with the previous month.
- In August two wards, Stroke Rehab (83.1%) within Barnsley Integrated Services and Aire Ward within Cheswold Park Hospital (88.8%), fell below the 90% overall fill rate threshold. This was consistent with the previous month. Please note, Stroke and Neuro rehab figures have been influenced by bed occupancy and resultant decisions are described above.
- There was a decrease of 11 registered unfilled shifts and a decrease of 39 unregistered additional shifts not being filled in comparison to the previous month. This does not include shifts that have been cancelled or taken off the system by the ward.
- We continue to develop the safer staffing power BI dashboard which will include Cheswold Park Hospital. All fill rate figures include CPH.

Safer Staffing Inpatients cont…

Registered Nurses Days

Registered day rate	Jun-25	Jul-25	Aug-25
Adults and Older People	95.6%	95.4%	94.8%
Barnsley Integrated Services	112.6%	112.3%	88.0%
Forensic and LD	96.1%	94.1%	93.3%
Cheswold Park Hospital	95.7%	99.3%	102.4%
Overall shift fill rate	**96.7%**	**96.4%**	**95.0%**

Registered Nurses Nights

Registered night rate	Jun-25	Jul-25	Aug-25
Adults and Older People	107.8%	109.3%	103.1%
Barnsley Integrated Services	99.3%	101.5%	101.6%
Forensic and LD	112.9%	112.9%	112.8%
Cheswold Park Hospital	88.6%	87.8%	85.2%
Overall shift fill rate	**105.3%**	**105.9%**	**102.5%**

Overall Registered Rate: 97.9%.

Overall Fill Rate:

Overall Fill Rate	Jun-25	Jul-25	Aug-25
Adults and Older People	124.4%	123.1%	117.7%
Barnsley Integrated Services	106.5%	107.9%	91.2%
Forensic and LD	112.4%	114.4%	122.7%
Cheswold Park Hospital	117.0%	115.7%	120.0%
Grand total	**118.9%**	**118.7%**	**118.3%**

Excluding Cheswold Park Hospital, Bank staff filled 71.0% (a decrease of 1.53% on the previous month) of RN requests for flexible staffing and 79.49% (a decrease of 1.81% on the previous month) of HCA requests.
Agency staff filled 2.42% (an increase of 0.91% on the previous month) of RN requests for flexible staffing and 5.77% (an increase of 0.32% on the previous month) of HCA requests.

Information Governance (IG)

Eight personal data breaches were reported during August 2025.

Information disclosed in error continues to be the highest reported category. Breaches during the month related to:

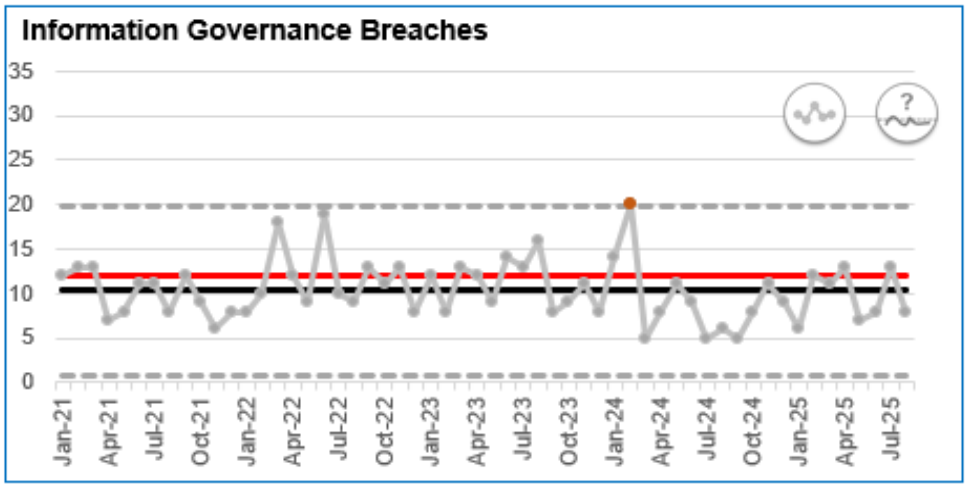
- Letter sent to wrong recipient due to being saved in the wrong patient folder.
- Letter sent to wrong address as record had not been updated.
- Two letters being placed into one envelope.
- Email sent to wrong recipient due to similar name as intended recipient.
- Information stored to wrong folder due to two individuals having the same name and subsequently shared in response to an access request.

An availability breach occurred when observation records were not uploaded to the patient record so were missing when the shift changed over.

A security breach occurred when paper information provided by a family was shared with Trust staff and lost.

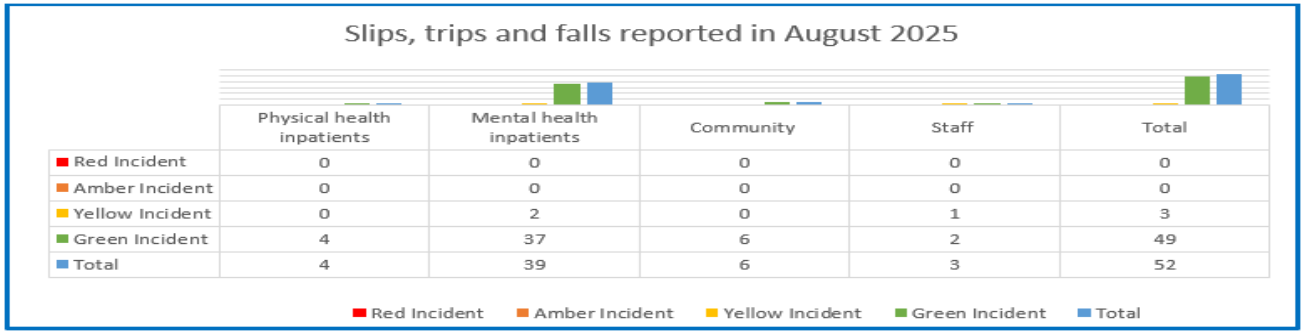
A communication campaign is in progress with a key focus being personal responsibility for ensuring emails are sent to the correct, intended recipients.

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



Trustwide Falls

August 2025, Datix reported a Trustwide total of 52 slips, trips and falls. This equates to 3.7% of all Datix safety events reported in August 2025. Below is a breakdown of falls and where they occurred in the community, inpatients or staff group/visitor.



	Physical health inpatients	Mental health inpatients	Community	Staff	Total
Red Incident	0	0	0	0	0
Amber Incident	0	0	0	0	0
Yellow Incident	0	2	0	1	3
Green Incident	4	37	6	2	49
Total	4	39	6	3	52

The Trust inpatient falls rate is 2.75 per 1,000 bed days. We continue to be below the National average for inpatient falls of 6.3 per 1,000 bed days

Incident Grading

Red: No red fall incidents reported.
Amber: No amber fall incidents reported.
Yellow: A total of 3 (6%) reported events needed higher intervention, such as attending A&E, or minor treatment.
Green: A total of 49 (94%) reported safety events had low, or no harm recorded. Main themes reported linked with developing infections and/or physical health needs such as shuffling gait/tremors, agitation and responding to unseen stimuli, and general slips and trips.

Inpatient falls had a high correlation with:

- there were 21 falls (49%) for older adults, aged >65yrs; of these falls:
- there were 19 (90%) patients who had a recognised falls risk and multifactorial assessment and mobility plan in place
- with 17 falls (81%) for patients with a diagnosed cognitive change such as dementia
- there were six falls (14%) directly linked with agitation
- and seven falls (18%) linked with physical health need such as developing infection, tremor, pneumonia
- and three falls (7%) occurring on leave and not on the inpatient unit

National Institute of Clinical Excellence (NICE) quality standard reviews in August 2025, across older adult, and the stroke/neuro wards they had approximately 80 patients, 65 years and above, recognised as being at a high risk of falls, of those:

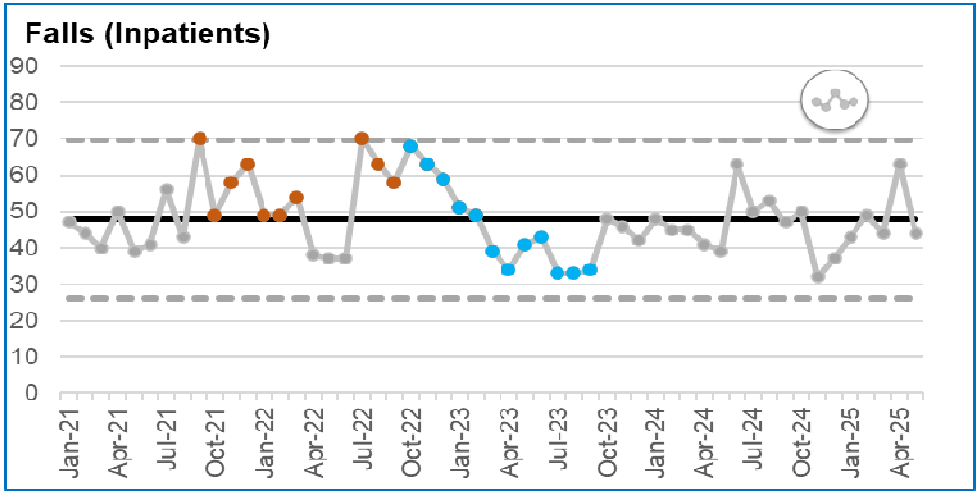
- all patients (100%) were referred to a physiotherapist for assessment
- on review, 79 patients (99%) had a good quality multifactorial risk assessment documented in the progress notes
- with 46 patients (58%) receiving education to reduce falls risk. There has been an approximate 25% increase in falls education evident in mobility plans and progress notes since April 2025

Things to celebrate

- Post Falls Protocol completion has averaged 89% this month, with a continued good response from staff. Where the Post Falls Protocol or checklist was not completed, staff had documented clear progress notes.
- Physical health checks were completed in 100% of all patients who had a fall.

Falls (Inpatient)

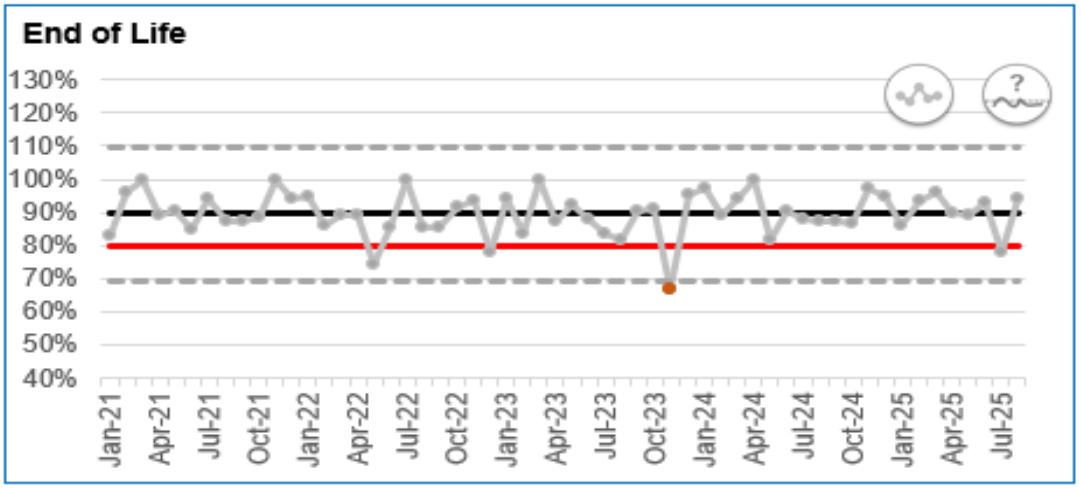
The total number of inpatient falls was 43 in August.



The SPC chart above shows that in August 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 94.4% in August. 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 August 2025 the performance against this metric remains in common cause variation (no concern). As the mean performance for this measure is high (90%), the upper control limit (based on the average of the moving range) shows as above 100%.

Patient Experience

Friends and family test results (FFT) show:

- 97% would recommend physical health services
- 89% would recommend mental health services

	Target	June	July	August
Mental health community	85%	94% (268)	95% (377)	88% (145)
Mental health inpatient	85%	92%(64)	79% (66)	83% (29)
Learning Disabilities	85%	97% (36)	97% (38)	98% (46)
ASD/ ADHD	85%	88% (43)	90% (69)	90% (29)
CAMHS	85%	77% (26)	79%(28)	81% (16)
Forensic	60%	N/A	75% (52)	75% (4)
Mental health overall	84%*	86% (480)	91% (630)	89% (273)
Barnsley Physical Health	95%	95% (371)	97% (355)	97% (319)
Trustwide	**85%**	90% (854)	93%(985)	93% (592)

** weighted for 2023/24*

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

- All services met their performance targets in August, with the exception of Mental Health Inpatients and CAMHS. However, both services performance improved in August.
- Satisfaction levels remained the same across ADHD & ASD services, Forensic Inpatients, and Barnsley General Operations.
- Mental Health Community Services experienced a decline in satisfaction, which is currently under review by the Quality Governance Team. This trend is likely influenced by seasonal factors, as response rates typically dip during August and September due to holiday periods.
- A reduction in survey returns was noted across all services, except for Learning Disabilities, which saw an increase.
- Forensic Inpatients also reported a decrease in returns, attributed to the biannual schedule of the patient experience survey. Despite this, satisfaction levels remained consistent.

Safeguarding

Safeguarding Adults:
In August 2025, there were 27 safeguarding adult incidents recorded on Datix. Of these, there were zero incidents graded red, 4 graded amber, 11 graded yellow and the remaining 12 were graded green. The most common subcategories of these were self-neglect and neglect, physical, domestic and emotional/psychological abuse.

In addition to the Safeguarding Adult Datix's, there were 19 sexual safety incidents recorded on Datix. Of these, there were zero Datix graded red or amber, 5 were graded yellow and 12 were graded green. The most common subcategory related to inappropriate sexual behaviour.

Safeguarding Children:
In August 2025 there were 20 Datix categorised as Safeguarding Children. The most common subcategories of these were requests for service, sexual abuse and child protection (non specific).

Complaints

• In August there were 22 new formal complaints received into the Trust. This includes Cheswold Park. This represents a significant 54% decrease compared to the previous record high of 48 complaints.
• 18 (82%) were acknowledged within the required three working days. An improvement plan is in place with the customer service administrative team to further strengthen timely acknowledgements.
• Closure of complaints: In August, 21 complaints were closed. Of these, 20 (95%) were resolved within the statutory six-month timeframe. The one case that exceeded the target involved complex circumstances, including the need for Caldicott Guardian approval (as the service user lacked capacity) and extended discussions to agree the scope of the complaint with the complainant.

Infection Prevention Control (IPC)

Outbreaks - August 2025
• There was an outbreak of Covid-19 on Willow Ward. This was managed by the ward and the infection prevention control team.

Reducing Restrictive Physical Intervention (RRPI)

This report includes Cheswold Park data from April 2025.

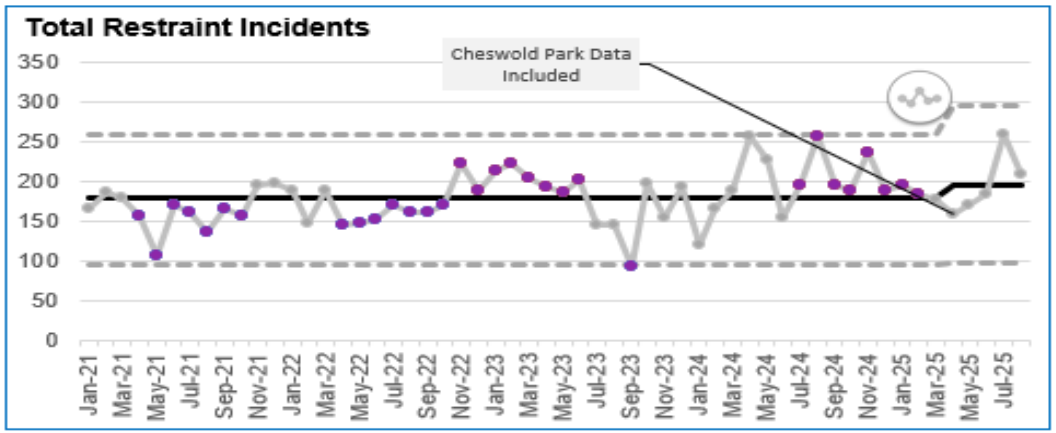
• There were 208 incidences of restrictive interventions in August 2025, a decrease of 50 from July 2025.

• There were nine prone restraints across the organisation in August 2025 where we have purposefully placed the person in the prone position. There were also three prone restraints that were service user led. 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 8 restraints during August has not been achieved. 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 restraint table shows the type of restraint positions used Trustwide August 2025 (in 208 restraints)

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	115	37.7%
Safety Pod	34	11.1%
Side	21	6.9%
Seated	69	22.6%
Supine - held on their back regardless of surface	23	7.5%
Prone descent then remained in chest down position	10	3.3%
Restricted escort	12	3.9%
Kneeling	9	3.0%
Prone descent then immediately rolled to other position side/back	7	2.3%
Service User placed self in prone and staff immediately let go or rol	3	1.0%
Safety Pod Technique (Immediate Exit)	1	0.3%
Safety Pod Technique (IM administration then exit)	1	0.3%
Total	305	100.0%

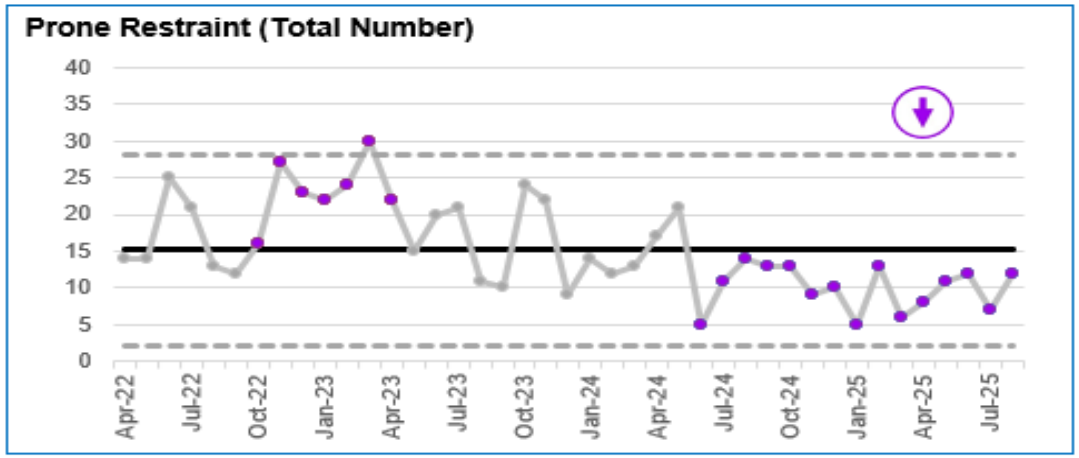
Please note there are more positions used than incidents due to multiple positions used during one incident.

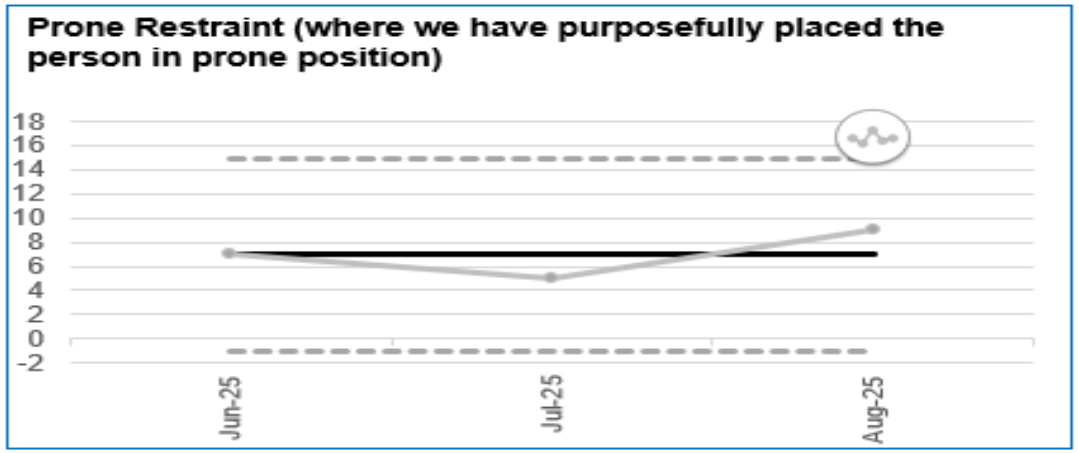


This SPC chart shows that in August 2025 we remain in a period of common cause improving variation.

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

Reducing Restrictive Physical Intervention (RRPI)





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.

From June 2025 we have separated out the number of prone restraints where we have purposefully placed the service user in the prone position from those that were service user led.

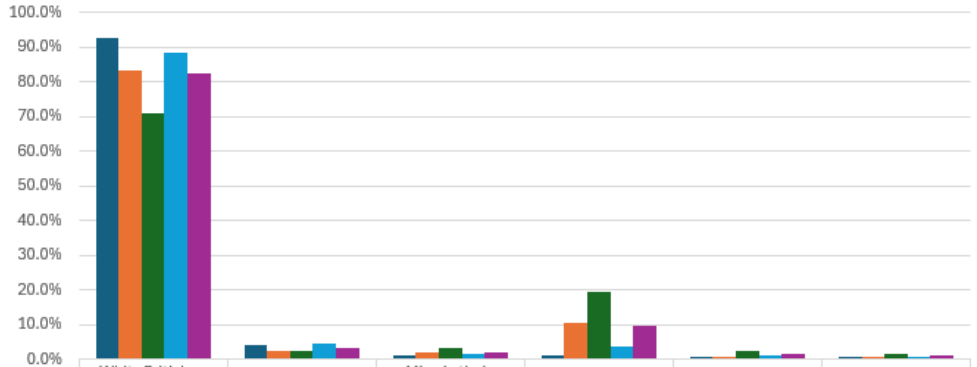
In August 2025 there were three instances of prone restraint that were service user led.

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.

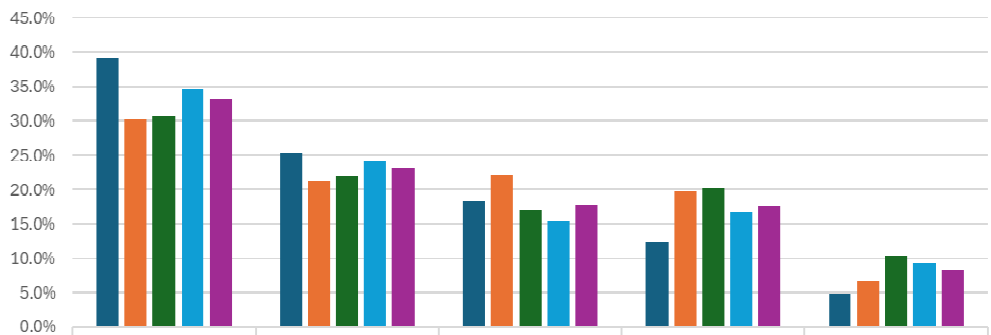
The population our Trust serves is varied in terms of ethnic make-up and also levels of deprivation. We can measure the relative deprivation of an area using 7 distinct domains of deprivation, which are: 1) Income 2) Employment 3) Health deprivation and disability 4) Education, skills & training 5) Crime, 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

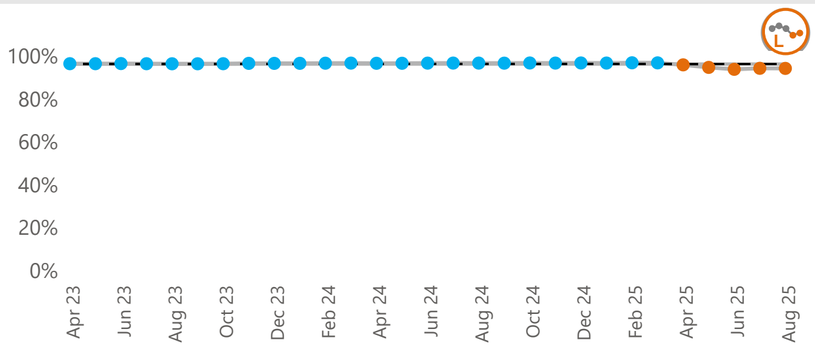
Data as of : 24/09/2025 17:16:26

NHS South West Yorkshire Partnership Teaching 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. A priority area of equality diversity and inclusion has been agreed at EMT to align to strategic priority programmes to Improve our Clinical Pathways, apply the Patient Carer Race Equality Framework core actions to reduce the gap in inequalities and improve access, experience and outcomes for communities faring worse across all of our mental health, learning disability and community health services with specific focus on improving systematic collection and analysis of data (both numbers and voice) according to protected characteristics and continue to promote 'All of You' campaign. This will provide insights that can be used to develop understanding and as the basis for our decisions leading to improved performance and positive impact for people.

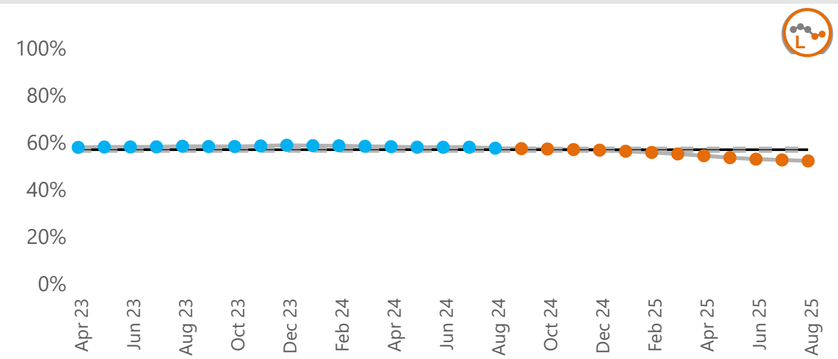
The SPC charts below show the completion rates for these measures.

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



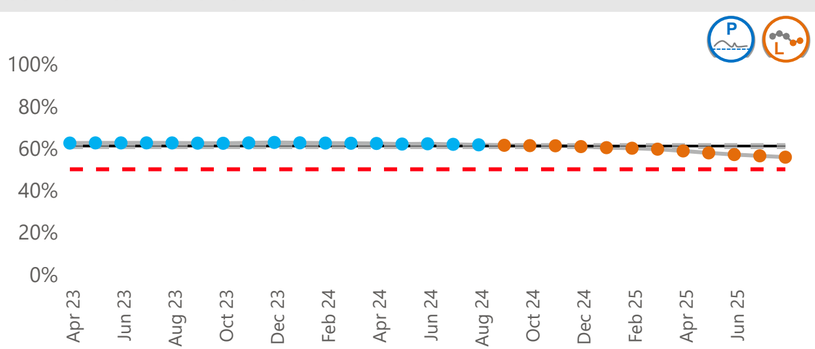
The Statistical Process Control (SPC) chart shows that in August 2025 due to the continued dip in performance we have entered a period of special cause deteriorating variation (something is happening and should be investigated). We are expected to meet the target against this metric.

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



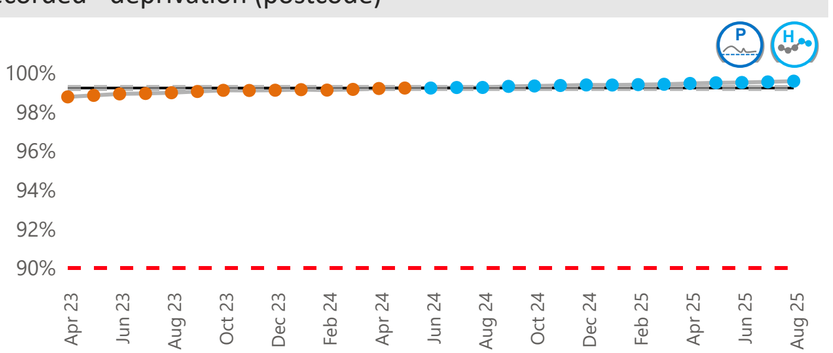
The SPC chart shows that in August 2025 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months.

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



The SPC chart shows that in August 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)



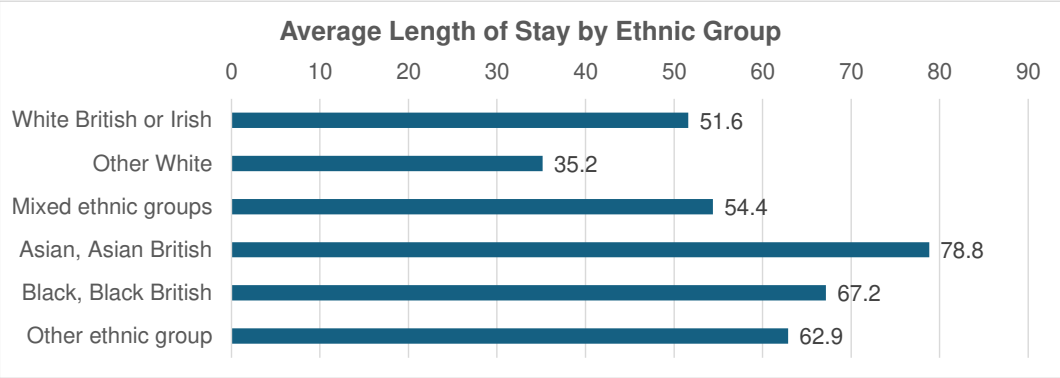
The SPC chart shows that in August 2025 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance.

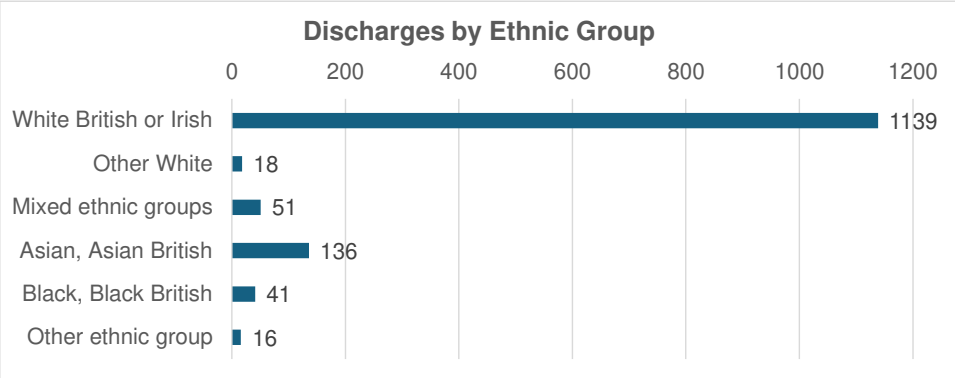
Reducing Inequalities

Please note the charts have been revised due to an error in the previous data reported. The charts 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). A review of the data relating to admissions for an inpatient stay is currently underway (anticipated completion October 2025). This work will look at:

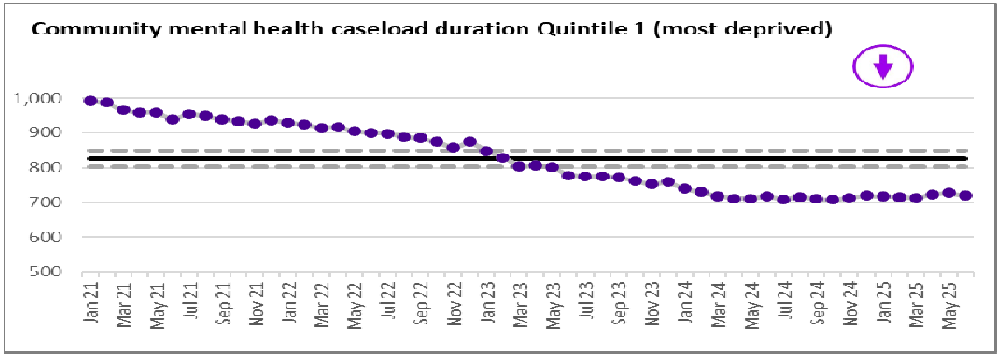
- Sex
- Age
- Ethnicity
- Deprivation
- Admission type / reason i.e. formal, informal
- Admission route
- LoS (review as a median to provide greater understanding of the distribution of the data)

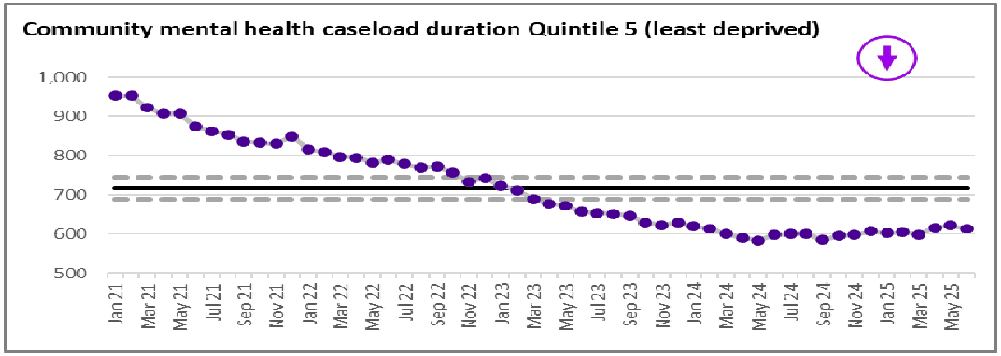
The findings will be presented at the Acute Pathways & Inpatient Improvement Programme Steering Group for follow up and review of any themes identified.





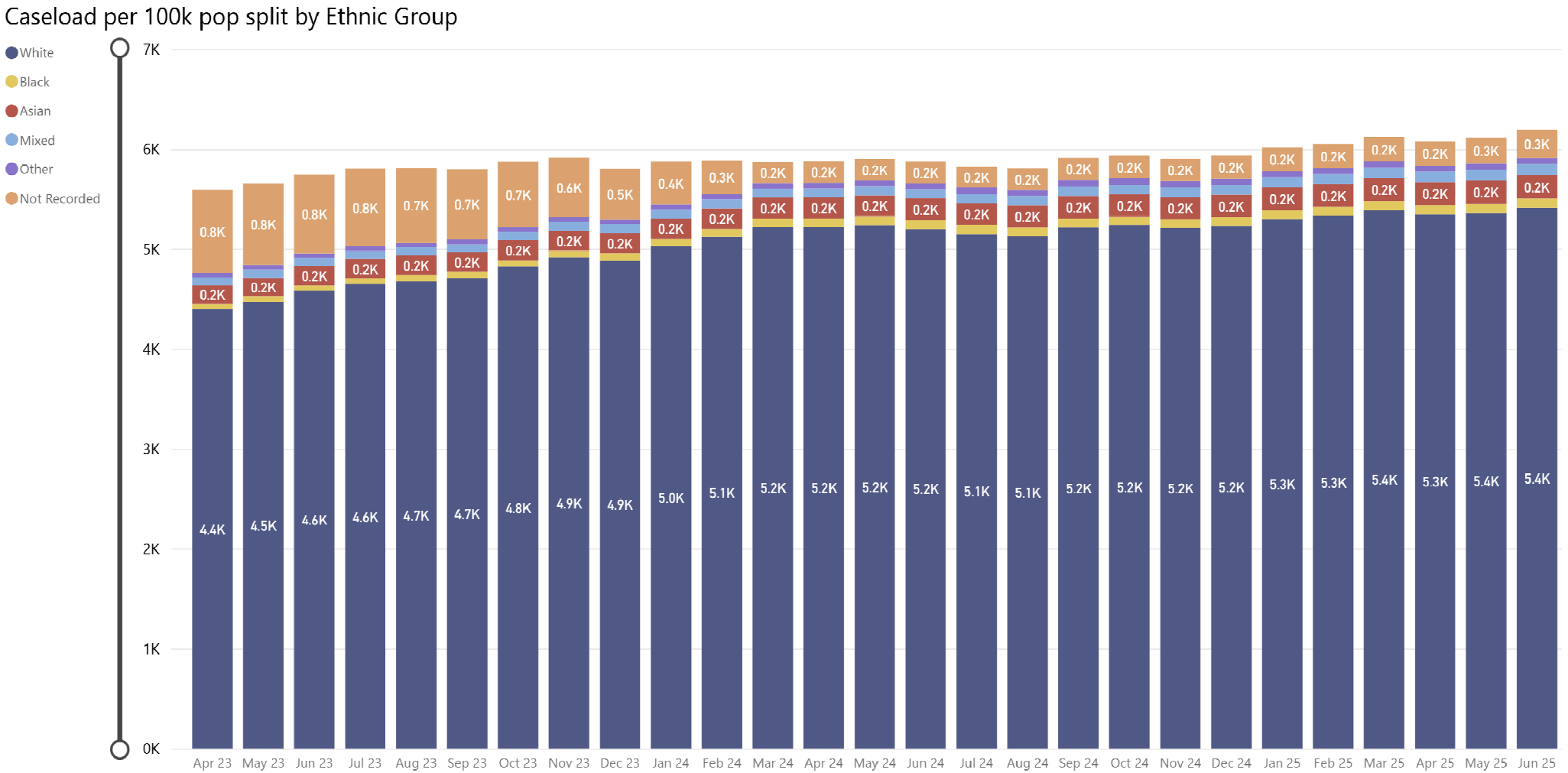
The charts below show the average caseload length for patients on the caseload of a community health team by those with a post code in the most deprived areas (Quintile 1) and those with a post code in the least deprived areas (Quintile 5).





Reducing Inequalities

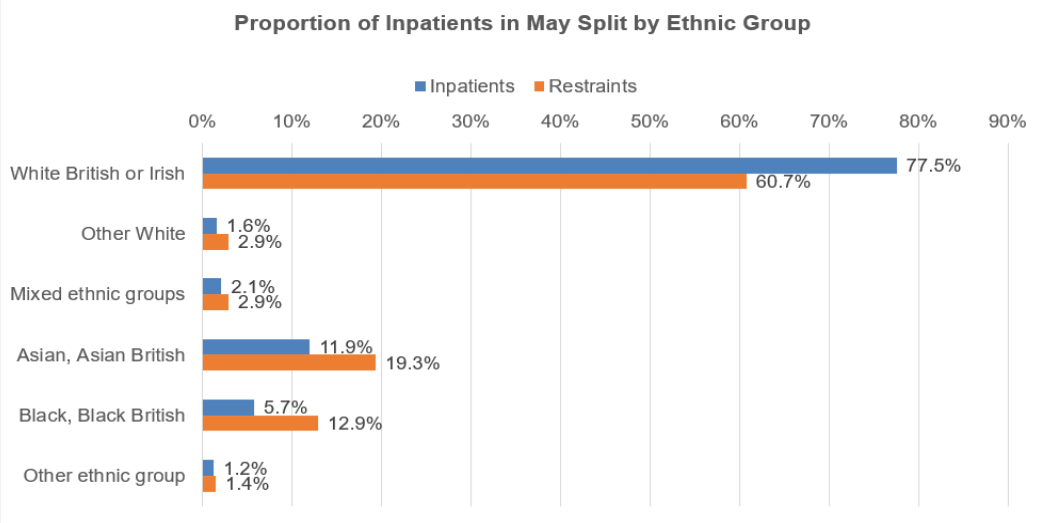
The chart below shows the split by the ethnic group of the clients on the caseload of a community health team, shown per 100,000 population.

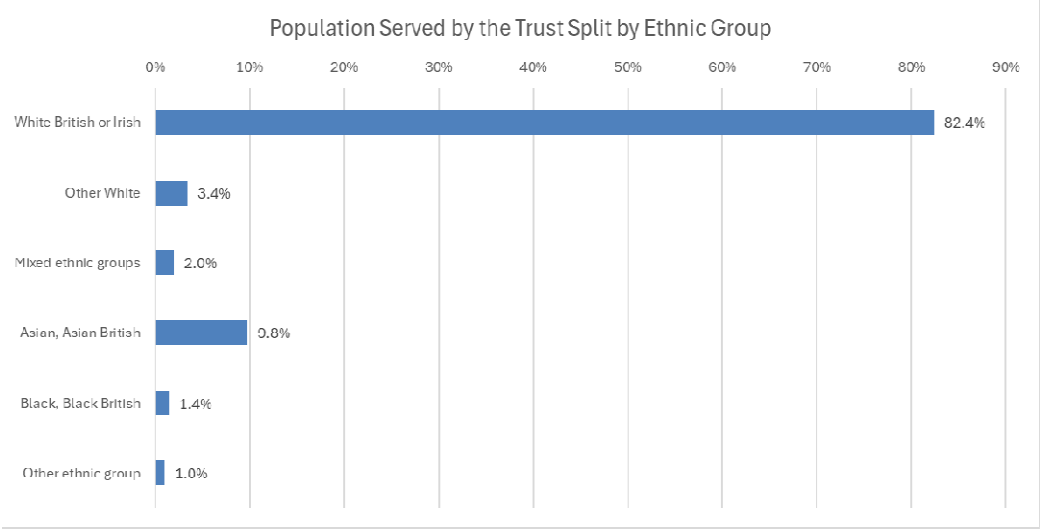


NB: 'White Other' is incorporated in the 'white' category in this chart.

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.

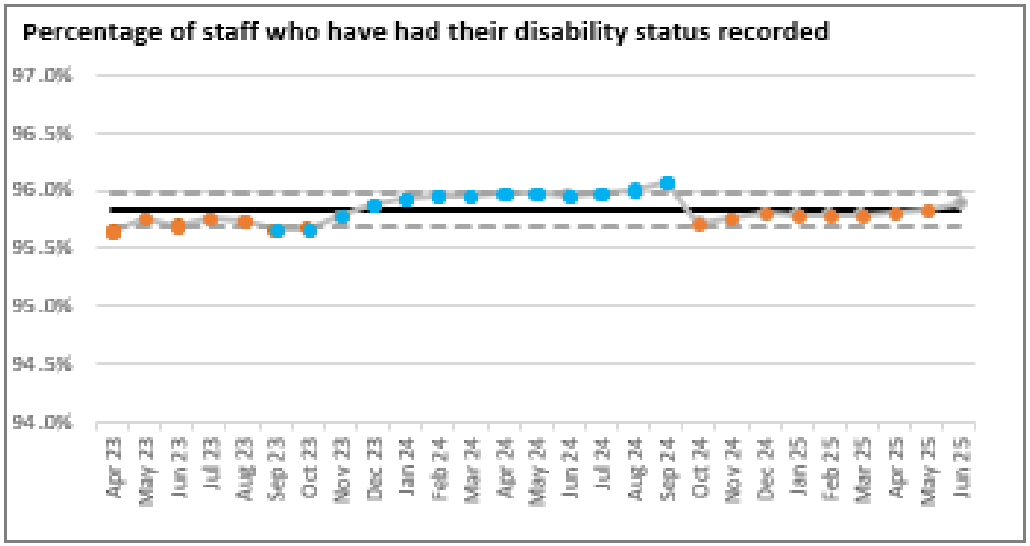


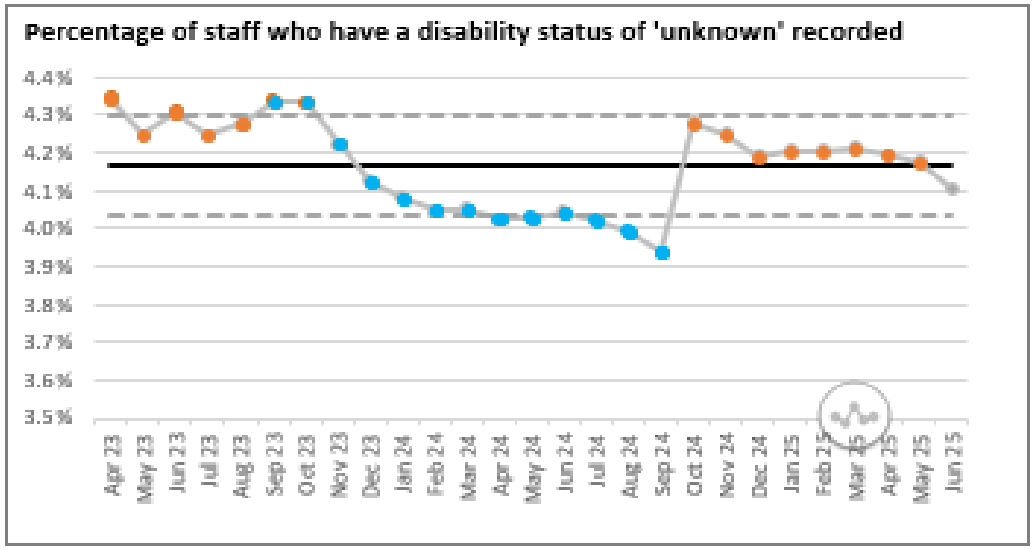


Reducing Inequalities

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	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Establishment	Best place to work and learn	Well led	-	5514.2	5733.3	5733.3	5728.1	5724.5	5757.0
Contracted Staff In Post (Ledger)	Best place to work and learn	Well led	-	4749.9	4988.0	4971.6	4980.1	4959.0	4981.0
Vacancies	Best place to work and learn	Well led	-	764.3	745.3	761.7	748.0	765.5	776.0
Turnover external (12 months rolling) *	Best place to work and learn	Well led	>12% - <13%	8.6%	9.4%	9.2%	9.4%	9.7%	10.2%
Starters	Best place to work and learn	Well led	-	25.2	21.2	19.4	30.0	17.8	31.2
Leavers	Best place to work and learn	Well led	-	74.1	41.8	24.0	38.1	41.7	77.7
% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	85.7%	84.6%	80.8%	77.0%	72.5%	71.0%
% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	82.6%	85.2%	87.3%	82.4%	81.3%	79.5%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	90.9%	89.7%	89.5%	86.6%	84.7%	83.1%
Proportion of staff in senior leadership roles who are from ethnic minority background (relates to staff in post band 7 and above, excludes bank staff) *	Best place to work and learn	Well led	-	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%)	232 - All staff (17.7%) 95 - excl medics (8.6%)	232 - All staff (17.7%) 94 - excl medics (8.6%)	237 - All Staff (18.1%) 94 - excl medics (8.5%)
Proportion of staff in senior leadership roles who were women (relates to staff in posts band 7 and above, excludes bank staff)	Best place to work and learn	Well led	-	935 (71.4%)	936 (71.4%)	937 (71.3%)	933 (71.2%)	930 (71.1%)	71.2%
Sickness absence - Year-to-Date (YTD)	Best place to work and learn	Well led	<=5%	5.2%	4.7%	4.7%	4.8%	5.0%	5.1%
Sickness absence - Month	Best place to work and learn	Well led		4.6%	4.7%	4.7%	4.9%	5.3%	5.4%
Employees with long term sickness over 12 months	Best place to work and learn	Well led	-	2	1	1	1	0	0
Appraisals - rolling 12 months	Best place to work and learn	Well led	Feb 82.3% Mar 84.9% April 87% May 88% June 89% July onwards 90%	86.3%	88.9%	90.8%	89.9%	90.2%	88.6%
Employee Relations - Suspensions (over 90 days)	Best place to work and learn	Well led	-	2	2	6	4	2	4
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	60	66	72	74	65	62
Workforce growth (substantive staff)	Best place to work and learn	Well led	-2%	2.3%	-0.9%				
Registered substantive staff in post mental health and learning disabilities services	Best place to work and learn	Safe	Establishment - 1315	1,143	1,174	1,174	1,180	1,176	1,174
Registered substantive staff in neighbourhood teams	Best place to work and learn	Safe	Establishment - 169	166	162	160	161	160	159
% 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		93.3%	94.0%	94.7%	95.1%	95.3%	95.7%
Mandatory Training - Reducing Restrictive Practice Interventions	Best place to work and learn	Well led		79.6%	82.1%	84.3%	83.4%	84.0%	86.4%
Mandatory Training - Cardiopulmonary Resuscitation	Best place to work and learn	Well led	>=80%	79.7%	80.9%	82.7%	84.9%	85.7%	87.0%
Mandatory Training - Clinical Risk	Best place to work and learn	Well led		96.4%	96.7%	97.0%	97.6%	97.7%	97.4%
Mandatory Training - Display Screen Equipment	Best place to work and learn	Well led		98.2%	98.3%	98.5%	98.5%	98.6%	98.7%
Mandatory Training - Equality & Diversity	Best place to work and learn	Well led		95.9%	96.6%	97.3%	97.5%	97.5%	97.8%
Mandatory Training - Fire Safety	Best place to work and learn	Well led	>=85%	88.9%	90.7%	91.9%	93.2%	94.3%	94.4%
Mandatory Training - Food Safety	Best place to work and learn	Well led		92.5%	94.0%	94.6%	95.1%	95.1%	92.0%
Mandatory Training - Freedom To Speak Up (FTSU)	Best place to work and learn	Well led	>=80%	97.2%	97.4%	97.7%	97.8%	97.9%	98.0%
Mandatory Training - Infection Control & Hand Hygiene	Best place to work and learn	Well led		94.4%	95.6%	96.3%	96.0%	95.8%	96.1%
Mandatory Training - Information Governance (Data Security)	Best place to work and learn	Well led	>=95%	91.1%	92.4%	95.8%	97.8%	98.2%	98.3%
Mandatory Training - Moving & Handling	Best place to work and learn	Well led		98.0%	98.3%	98.7%	98.3%	98.3%	98.4%
Mandatory Training - Nat Early Warning Score 2 (New S2)	Best place to work and learn	Well led	>=80%	97.9%	98.0%	98.3%	98.2%	98.4%	98.4%
Mandatory Training - Mental Capacity Act/DoIs	Best place to work and learn	Well led		91.3%	91.8%	92.2%	92.8%	93.2%	93.5%
Mandatory Training - Mental Health Act	Best place to work and learn	Well led		90.4%	91.7%	92.4%	93.7%	93.5%	93.2%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism e-learning aspect of Level 1	Best place to work and learn	Well led		94.0%	94.8%	95.3%	95.7%	95.8%	96.1%
Mandatory Training - Prevent	Best place to work and learn	Well led		95.4%	96.4%	96.9%	97.3%	97.7%	97.7%
Mandatory Training - Safeguarding Adults	Best place to work and learn	Well led	>=80%	91.1%	91.6%	91.4%	92.0%	92.0%	92.9%
Mandatory Training - Safeguarding Children	Best place to work and learn	Well led		92.4%	91.7%	91.7%	92.1%	91.6%	92.7%

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

• We continue to see and overall reduction in staff. A large proportion of this is due to ending of diversion liaison services. It has also, to lesser extent, been down to terminations of fixed term contracts as part of the Trust Value for Money programme. 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
• Ongoing recruitment of Clinical Support Workers (Health Care Support Worker) roles into our ward areas continues. This has come from both bank to substantive conversion and values based assessment centre recruitment. A number of starters have either start dates agreed or to be confirmed. A second wave of recruitment over the coming weeks has been planned to meet the remaining identified vacancies from the establishment review.

Turnover & Stability

• The increase in turnover from 9.7% to 10.2% is as a result of seeing sustained higher turnover rate within Cheswold Park (20.3%) since October 24

Our Leavers

We have seen 77.7FTE of leavers, within August 25. This is a78% increase since July 25, which is as a result of a significant number of Fixed Term contracts ending in August. As part of our VFM, KLOE we are now seeing the impact of fixed term contracts, of which there were 23 (20.4 FTE) employees, this compared with previous months, which were considerably lower (July – 4 FTE / June – 2 FTE).

Sickness

• Overall sickness absence (year to date rolling) has risen in August to 5.1% which is now just outside overall target.
• We are seeing higher absence rates in Forensics (7.35%) and Estates (6.95%) and Mental Health (6.11%) with majority relating to higher levels of long term sickness cases which are being pro-actively managed between People Directorate Business Partners and Operational leads.
• 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.

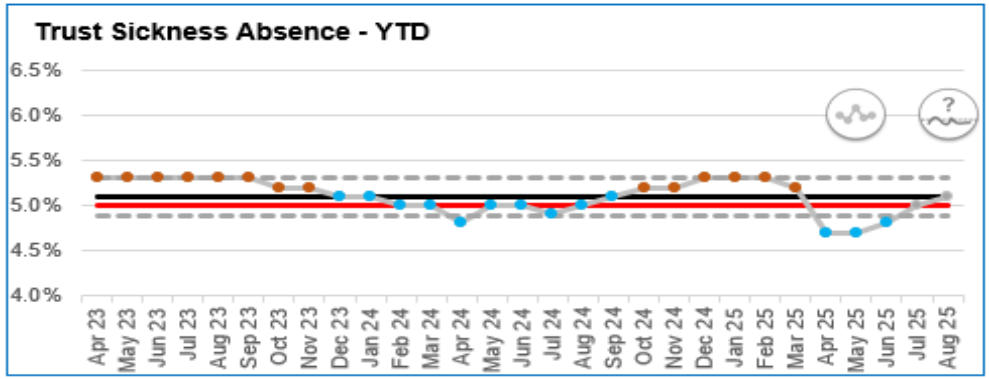
Appraisal Compliance

• The overall year to date figure in August 2025 is 88.6%. This has now slightly reduced from July (90.2%). Uptake by care group continues to be an Operational Management Group focus.
• Work to integrate the Cheswold Park Hospital appraisal rates into Trust reporting is ongoing.

Training Compliance

• Our overall mandatory training compliance remains above target at 95.7% and has risen month on month since February.
• All mandatory training at Trust level in August remains above our targets (Green).
• Information Governance training is now green at 98.2%nd is the highest compliance level the Trust has ever achieved.
• Reducing Restrictive Practice Interventions Self Service and Manager self-service is open, and training planned until the end of September with availability on both 2 and 4-day

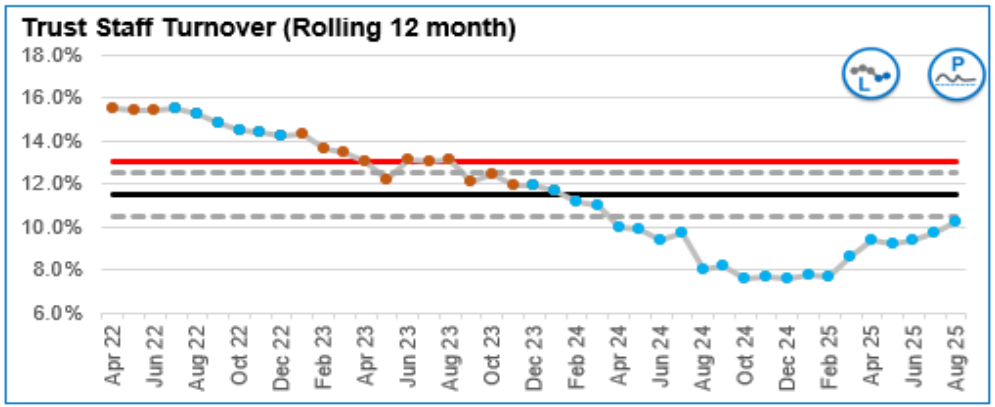
Statistical process control charts



The SPC chart shows that in August 2025 we have entered a period of common cause variation (no concern) following a sustained improvement in the sickness rate.

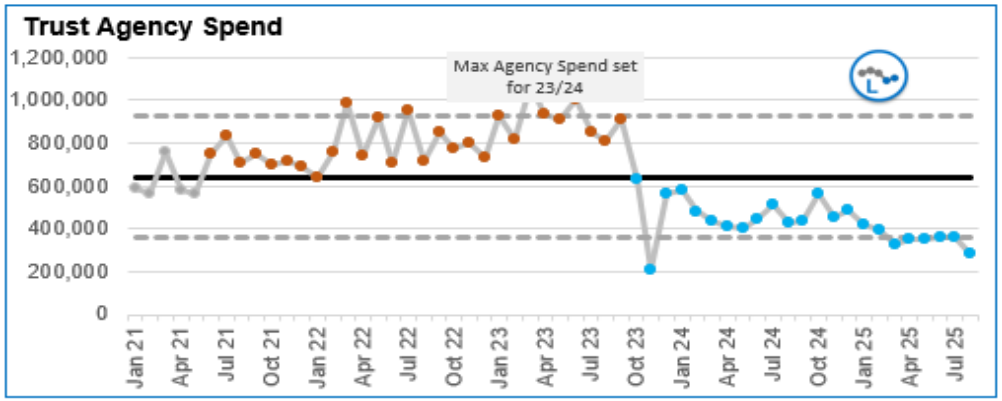
From July 2022 this data also includes absence due to Covid-19.

From April 2025 this data includes Cheswold Park Hospital.



The SPC chart shows that in August 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.



Agency spend in August is £281k. This remains within planned levels primarily due to a reduction in medical agency spend in month. The forecast modelling, supported by individual exit plan, supports a continued reduction of the expenditure run rate.

The SPC chart shows that due to the sustained reduction in spend in August 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.

NHS Oversight Framework 2025/26

On 26th June NHS England published the NHS Oversight Framework (NOF) for 2025/26. The framework outlines a consistent and transparent approach to assessing Integrated Care Boards (ICBs) and NHS Trusts and Foundation Trusts.

It ensures public accountability for performance and is a foundation for how NHS England will work with systems and providers to support improvement.

It is a 1-year framework and will be reviewed at the end of 2025/26. A range of agreed metrics will be used to assess performance. These reflect the 2025/26 NHS priorities and operational planning guidance. Not all metrics will be used to formulate the segmentation; some metrics are contextual metrics which will be used for consideration in NHS England's oversight response. All metrics are split into domains: access to services, effectiveness and experience of care, patient safety, people and workforce, finance and productivity, improving health and reducing inequality. Assessment of the scoring metrics will determine a segmentation score.

Segmentation scores will range from 1 (high performing) to 4 (low performing). An additional segment (5) will be used if the organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve, or an organisation is a challenged provider where NHS England has identified significant concerns. All organisations in deficit, or in receipt of deficit support, will be limited to an organisational delivery score of no greater than 3. Promotion of improvement and identification of support needs. Segmentation data will be reviewed at least quarterly as part of a review meeting and segments may be updated at any time based on emerging information. Data on Trust performance for quarter 1 can be seen in the table below and is also publicly available NHS.co.uk

The majority of these metrics are already included in the IPR and performance is monitored monthly, where available. Work will take place to report actual performance and associated NOF score for the Trust as soon as the data is publicly available, we are also working to have a more timely local forecast of our position.

NHS Oversight Framework			
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST (RXG)	Quarter 1		
	Performance	Score derived	Average score
Percentage of community services waiting list waiting over 52 weeks	0.00%	1.00	
% change in number of under 18s supported through NHS funded mental health with at least one contact in a rolling 12 month period	0.63%	3.28	
DOMAIN SCORE - Access to Services			**2.14**
National CQC community mental health survey overall experience rating	As expected	2.00	
Urgent Community Response % achieving 2hr standard	97.68%	1.00	
Percentage of adult discharges with a length of stay above 60 days	22.09%	1.83	
DOMAIN SCORE - Effectiveness and Experience			**1.61**
NHS Staff Survey raising concerns sub-score (MHPRV)	6.92	2.00	
Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours	72.24%	1.67	
DOMAIN SCORE - Patient Safety			**1.83**
Sickness absence rate	5.14%	2.19	
NHS Staff Survey engagement sub-score (MHPRV)	7.19	2.10	
DOMAIN SCORE - People and Workforce			**2.15**
Planned surplus / deficit as a proportion of turnover	0.0%		
YTD surplus / deficit	-0.1%		
Aggregated finance score		1.00	
Relative cost difference	88.55	1.40	
DOMAIN SCORE - Productivity and Value for Money			**1.20**
Total Score	19.47		
OVERALL AVERAGE SCORE			**1.77**
FINAL SEGMENTATION		**3**	

Due to the Trust submitting a deficit financial position, this has resulted in the Trust overall score being 3. If the financial override had not taken effect, performance against the measures in the 5 domains is strong and our average Trust score puts the Trust as 3 out of 61 providers of non-acute hospitals (including Mental health and learning disability, community and care trusts). Performance against each of the applicable metrics can be seen above.

Drilling down into the individual metrics - areas of risk for us relate to:

* % change in number of under 18s supported through NHS funded mental health with at least one contact in a rolling 12 month period. The Trust has a score of 3.28 for quarter 1 reporting a 0.63% increase over the last 12 months (June 24 - June 25), this places us as 34 out of 46 (Trusts where this metric is applicable). The metric is looking for an increase in people under 18 years old accessing the services so a higher value is better. The average value across Trusts where this metric is applicable is 4.57%. The data for this metric feeds from the Trusts Mental Health Services Data Set (MHSDS) submission which is a monthly submission of data extracted from our clinical information system, SystmOne.

Underpinning all the operational metrics is data quality. Data used for the metrics is taken from existing data flows, it is there essential that the Trust is submitting data of a high quality and this message is being re-enforced across care groups and some detailed guidance relating to the metrics is being shared with operational services to increase their knowledge and understanding of this.

A local dashboard is being developed which will allow users to drill down to patient level is being established to be able to monitor performance on this.

National Metrics

Data as of : 24/09/2025 16:50:03

NHS South West Yorkshire Partnership Teaching NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 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
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive		92%	P		99.5%	99.2%	99.0%	98.2%	97.2%	96.7%	97.0%	97.1%	97.2%	97.8%	97.7%	97.5%
M202	RTT waiting list, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive												31	53	58	50	47
M203	Number of 52+ week RTT waits, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive		0										0	0	0	0	0
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680										3957	4035	4025	4151	4319
M205	RTT waiting list within 18 weeks, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive												31	53	58	47	45
M206	Diagnostic test activity	Best Quality	Responsive		190										128	70	128	206	239
M209	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Best Quality	Responsive		5%										35.7%	51.3%	60.4%	53.5%	47.9%
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%			97.5%	100%	97.8%	100%	100%	98.9%	100%	97.8%	97.9%	100%	98.7%	96.3%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0	F	L	138	96	131	127	106	92	128	144	148	159	196	203
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5		L	4	4	5	4	3	4	4	5	5	5	7	8
M208	Average Length of stay for Adult Acute Beds (rolling 3 months)	Best Quality	Responsive				H	59.9	61.7	64.1	59.2	61.6	62.7	65.3	58.9	58.7	56.8	58.0	58.3
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%	P	H	90.3%	97.6%	91.8%	96.7%	87.2%	94.3%	100%	88.2%	88%	97.4%	95.5%	86.7%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%			96.4%	96.4%	96.9%	98.0%	97.8%	97.5%	97.0%	97.0%	97.6%	95.6%	96.0%	95.9%
M34	% Clients in settled accommodation	Best Value	Effective	⚠	60%	P	L	84.0%	83.3%	84.1%	84.4%	84.3%	83.1%	83.2%	83.2%	83.5%	83.0%	82.9%	75.9%
M35	% Clients in employment	Best Value	Effective	⚠	10%	P	H	12.5%	13.1%	13.3%	12.8%	12.5%	13.2%	13.2%	13.0%	13.2%	13.0%	13.3%	12.5%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0		L	0	0	1	0	1	0	2	0	0	0	0	0
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0		L	0	0	1	0	1	0	1	0	0	0	0	0

National Metrics

Data as of : 24/09/2025 16:50:03

NHS South West Yorkshire Partnership Teaching NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%			100%	100%	100%	100%	85.7%	100%	100%	100%	50%	100%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%			84.8%	88.9%	76%	59.3%	72.5%	70.2%	60.4%	75.6%	93.9%	93.3%	79.5%	86.7%
M47	Virtual ward occupancy	Best Quality	Responsive		80%			82.9%	86.7%	112%	101%	98.7%	121%	119%	101%	81.3%	90.7%	84%	90.7%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0	F	L	0	0	0	0	0	0	0	0	0	0	0	0
M30	Number of detentions under the Mental Health Act (MHA)	Best Quality	Safe					97	95	117	99	91	102	93	111	109	103	87	98
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					10.3%	24.2%	17.9%	18.2%	25.3%	15.7%	19.4%	24.3%	22.0%	26.2%	23.0%	24.5%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%	P	H	99.0%	98.7%	98.6%	97.8%	98.7%	99.8%	99.6%	99.7%	99.8%	99.8%	99.7%	99.4%
M11	Talking Therapies - Treatment within 18 weeks of referral	Best Quality	Effective		95%	P	H	100%	100%	100%	100%	100%	99.8%	100%	100%	100%	100%	100%	100%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users	Best Quality	Well Led		90%	P	H	100%	99.0%	99.1%	99.2%	99.7%	99.8%	99.8%	99.5%	99.7%	99.2%	99.7%	99.6%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%			50.7%	52.0%	52.6%	50.7%	52.6%	49.4%	50.1%	48.5%	51.9%	47.3%	53.5%	47.6%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%			70.3%	71.0%	68.4%	68.6%	68.9%	67.9%	71.6%	68.1%	68.5%	66.0%	72.1%	66.0%
M15	Data Quality Maturity Index	Best Quality	Well Led		95%	P		99.5%	99.6%	98.4%	98.4%	98.0%	99.6%	99.6%	99.2%	99.6%	99.7%	99.6%	99.6%
M41	Completion of a valid NHS number	Best Value	Well Led		99%	P	H	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100.0%	100%	100.0%	100.0%
M42	Completion of ethnicity coding for all service users	Best Value	Well Led		90%	P		100.0%	99.5%	99.6%	99.5%	99.6%	99.6%	99.4%	99.4%	99.5%	99.0%	99.6%	99.6%
M43	Community health services two hour urgent response standard	Best Quality			70%		H	91.6%	90.9%	88.0%	89.2%	90.6%	90.2%	92.6%	90.3%	91.0%	91.3%	90.9%	91.9%

National Metrics

Data as of : 24/09/2025 16:50:03

NHS South West Yorkshire Partnership Teaching NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%	?		54.1%	53.9%	54.6%	52.4%	55.1%	53.0%	53.2%	51.0%	53.5%	49.8%	56.2%	50.3%
				Place	Barnsley	50%	?		51.2%	51.0%	50.8%	50.9%	50.8%	49.4%	52.7%	51.3%	52.8%	48.1%	52.8%	52.6%
					Kirklees	50%	?		56.8%	57.0%	59.1%	53.8%	59.2%	56.3%	53.8%	50.7%	54.2%	51.6%	59.2%	48.6%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				518	679	586	509	633	524	566	615	600	653	613	476
				Place	Barnsley				253	355	317	241	311	244	270	318	312	324	272	200
					Kirklees				265	324	269	268	322	280	296	297	288	329	341	276
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			H	15145	15125	15096	15087	15044	14961	15248	15215	15284	15490	15560	15511
				Place	Barnsley	2000	P	H	2793	2796	2765	2750	2756	2711	2777	2862	2902	2967	3021	3026
					Calderdale	1200	P	H	1391	1400	1415	1433	1457	1480	1531	1532	1547	1559	1549	1544
					Kirklees	3600	P		4967	4879	4897	4875	4767	4699	4780	4749	4810	4887	4950	4917
					Wakefield	3900	P		4585	4620	4587	4583	4613	4632	4741	4715	4699	4779	4771	4771
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust			H	1305	1421	1519	1566	1642	1696	1833	1912	1982	2089	2168	2189
				Place	Barnsley	283	F	H	203	226	244	250	252	255	278	298	314	332	342	341
					Calderdale	247	F	H	242	261	264	269	279	281	302	305	312	330	339	340
					Kirklees	541	F	H	486	521	546	553	570	576	626	660	694	735	765	780
					Wakefield	406	?	H	347	375	418	440	477	508	543	558	567	588	618	624
M194	Number of people accessing individual placement and support (IPS) services (rolling 12 months)	Best Quality	Responsive	Trust	Trust			H	485	482	480	480	483	466	463	448	437	447	446	436
				Place	Calderdale			H	115	113	108	102	109	106	110	104	99	105	99	95
					Kirklees			H	162	162	127	125	141	142	157	153	149	155	157	167
					Wakefield			H	188	186	186	182	173	158	151	150	154	153	158	156

National Metrics

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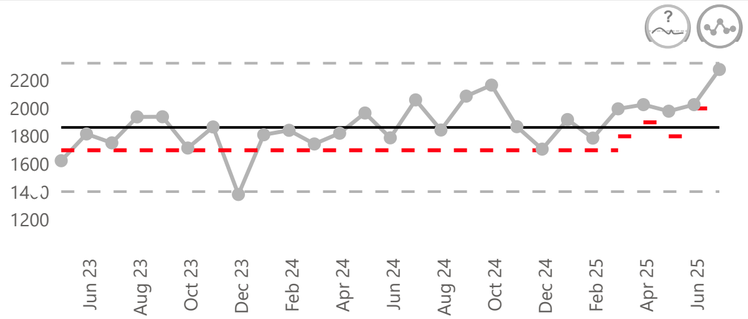
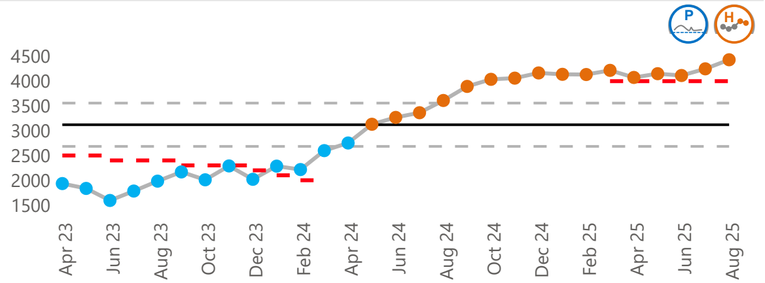
NHS South West Yorkshire Partnership Teaching NHS Foundation Trust

M184 - New RTT pathways (clock starts)



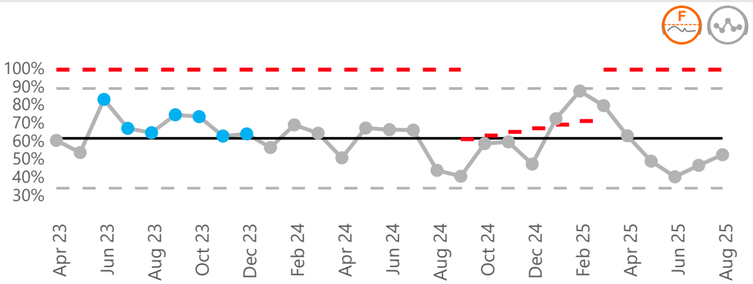
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers. A new target is in place for 2025/26.

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



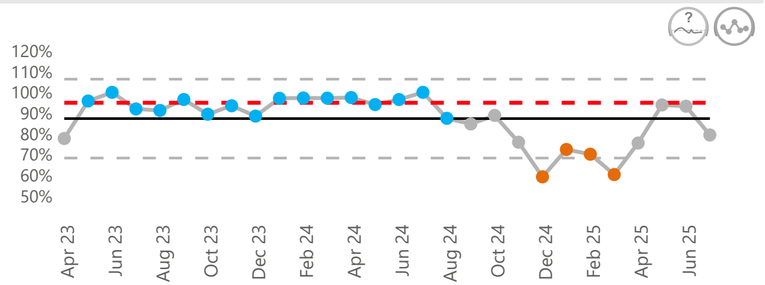
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months.

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



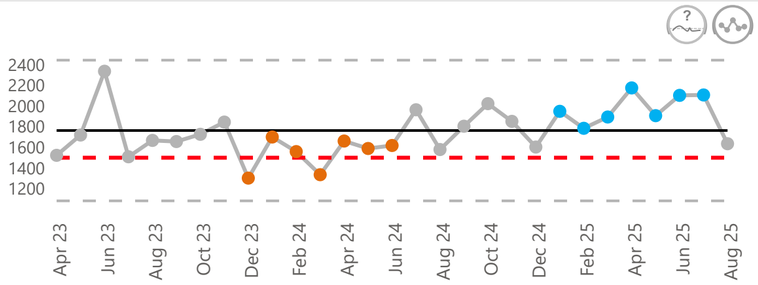
The SPC chart shows that we remain in a period of common cause variation (no concern.

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.

M210 - The number of completed non-admitted RTT pathways in the reporting period

The run chart shows the continued performance above the target for this measure. As this is a new metric from April 2025 we cannot yet determine any patterns in variation.

National Metrics

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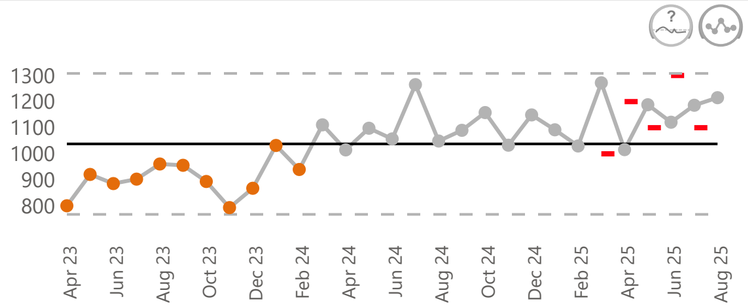
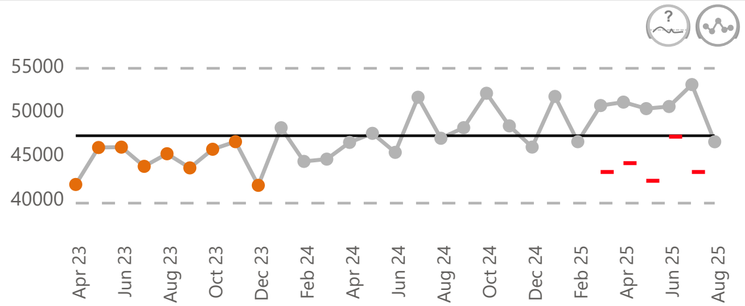
NHS South West Yorkshire Partnership Teaching NHS Foundation Trust

M187 - Urgent Community Response (UCR) referrals



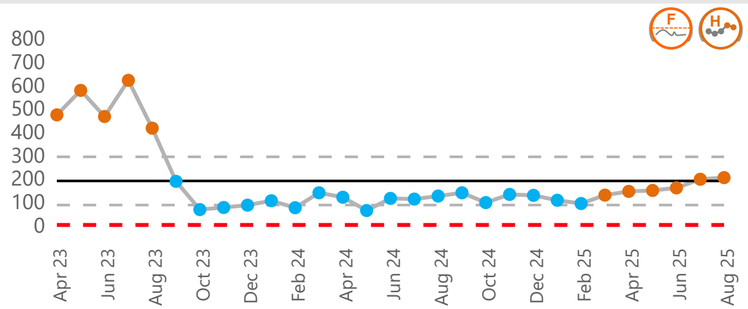
The SPC chart shows that we remain in a period of common cause variation (no concern).

M207 - Attended Community Care Contacts



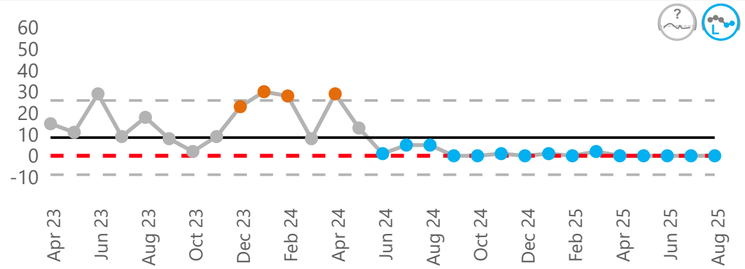
The SPC chart shows that we remain in a period of common cause variation (no concern).

M2 - Inappropriate out of area bed days



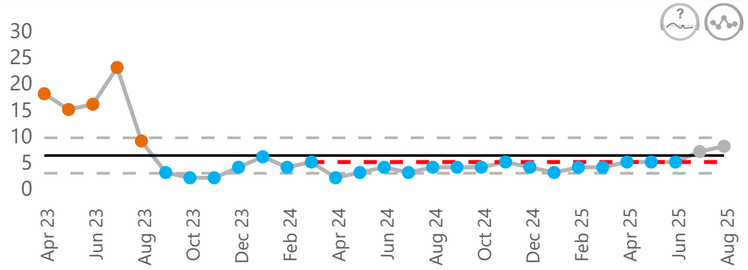
The SPC chart shows that we remain in a period of special cause improving variation (something is happening and should be investigated) following a continued overall reduction in the performance in August. We are still not anticipated to achieve the target of zero.

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



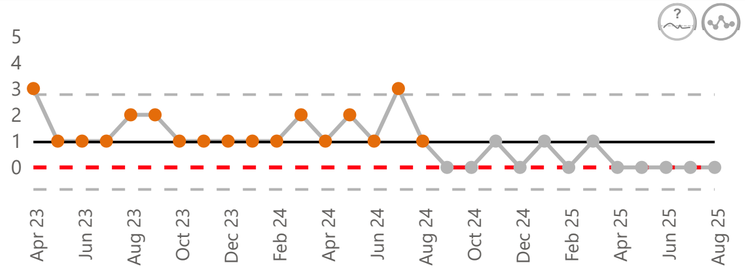
The SPC chart shows that we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained reduction in the number of bed days for under 18 year-olds.

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 August 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 : 24/09/2025 16:50:03

NHS South West Yorkshire Partnership Teaching 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 August.
• There was a further increase in out of area bed usage, up to 203 days used in August and 8 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 86.7% in August - this relates to eight service users who was not seen, three of which relate to the ARFID (avoidant restrictive food intake disorder) pathway. The urgent access to treatment measure has achieved 100% in August.
• 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 90.7% for August.
• 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.
• Talking Therapies - Proportion of people who complete treatment who move to recovery - has decreased below threshold to 48.6% in August for Kirklees, though the Trust position remains just above the 50% threshold. The reliable recovery and reliable improvement figures for August have also dropped just below their respective targets.
• The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks in has increased in August to 52.1%, remaining below the national threshold of 99%.

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 fourth month performance against these metrics has been reported in the integrated performance report. In August none of these metrics are below expected levels.

Benchmarking Metrics

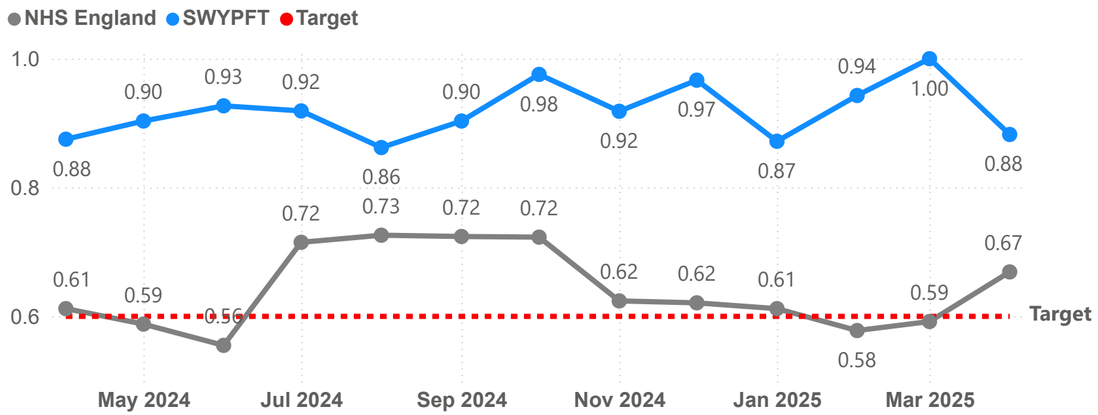
Data as of : 24/09/2025 16:50:03

NHS South West Yorkshire Partnership Teaching NHS Foundation Trust

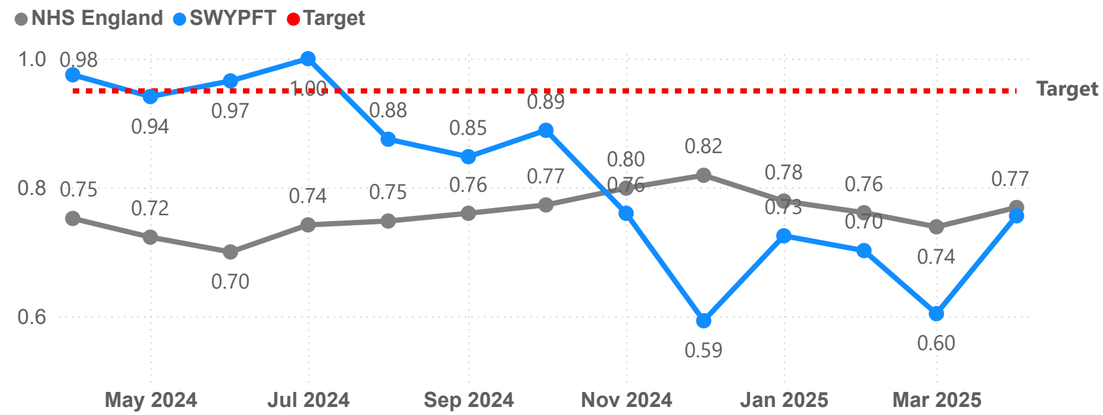
Benchmarking Headlines

This section of the report shows how the Trust benchmarks against the national England position for a number of metrics where data is readily available via NHS Futures Mental Health Core data pack. As you can see from the charts below, for all metrics except children and young people with an eating disorder % of routine cases accessing treatment within 4 weeks the Trust performs consistently above the England average. As noted above, this is due to the metric including Avoidant/Restrictive Food Intake Disorder pathway data – work continues to explore with NHS England whether these cases should be included within this metric.

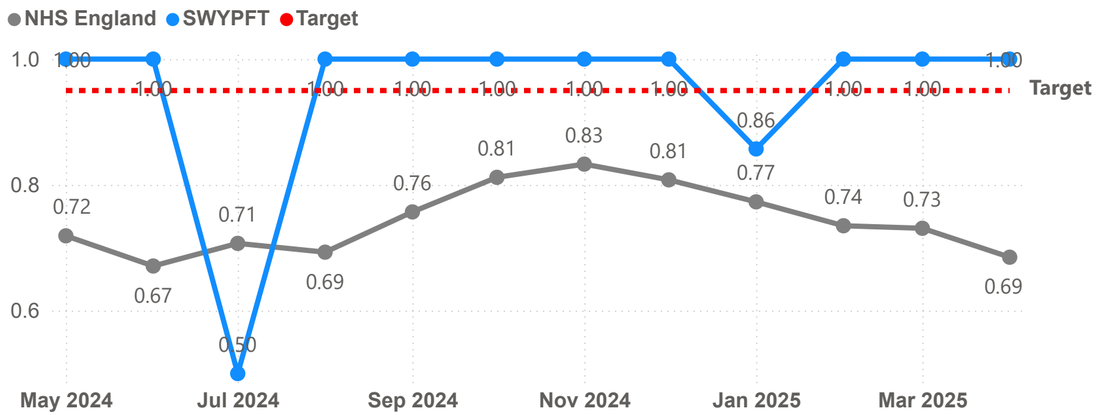
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops



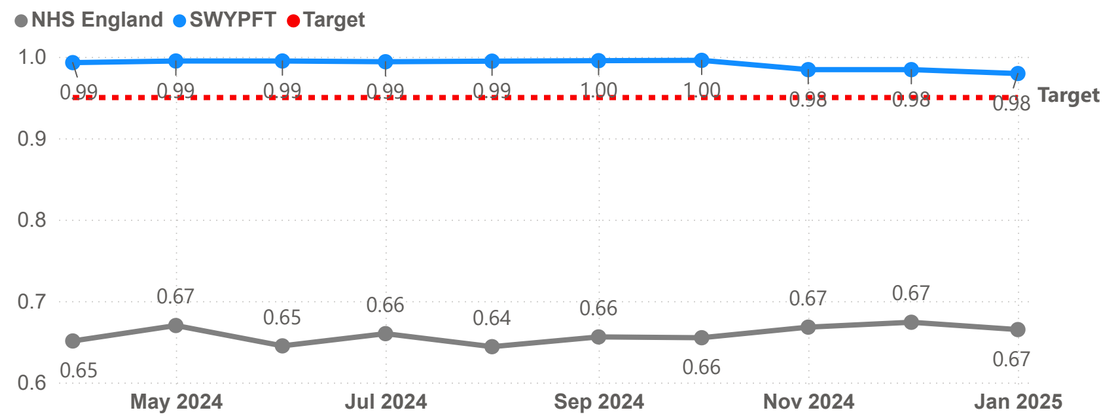
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks



Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week



Data Quality Maturity Index



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

- The reporting for employment and accommodation shows 12.8% of records have missing employment and/or accommodation status with a further 2.1% 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.

Work will be taking place over the coming weeks to prepare for planning for 2026 onwards, it is anticipated that this will include 5 year rolling plans, national guidance awaited.

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

Current average OPEL level

2.67

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

Children and Young Peoples Mental Health Services

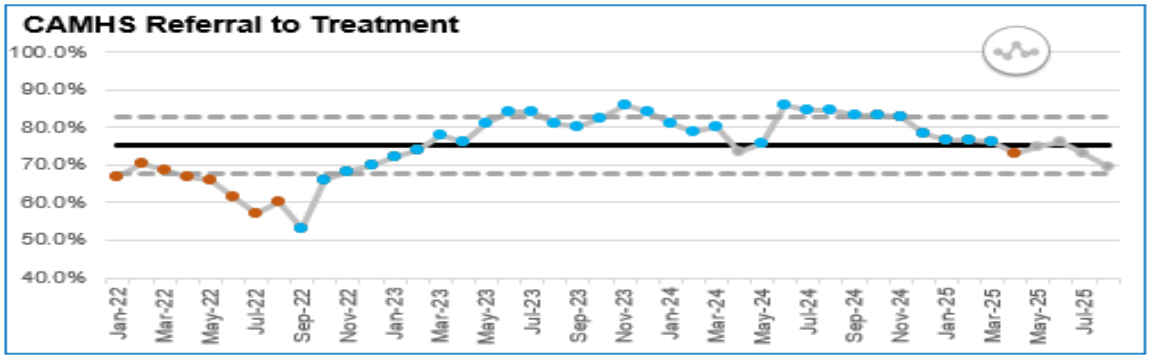
Headlines

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	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	84.0%	88.2%	88.7%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/5)	0% (0/5)	33% (1/3)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	87.1%	90.9%	89.6%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	98.4%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.0%	82.8%	81.7%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	93.3%	79.5%	86.7%	
Eating Disorder - Urgent/Emergency clock stops	Best Quality	Effective	95%	100.0%	100.0%	100.0%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	98.7%	99.0%	97.8%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	78.5%	78.7%	80.6%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.6%	4.0%	4.1%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	370	356	408	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	921	959	905	
Total number of reported incidents	Best Quality	Safe	Trend monitor	46	49	29	

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



In August 2025, the SPC chart indicates that we remain in a period of common cause variation (no concern), 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. Services are implementing While You Wait offers.
• Calderdale & Kirklees CAMHS Keeping Kirklees in Mind (KKiM) MHST (Mental Health Support into Schools) continues to experience significant challenges around referral numbers and recruitment and retention. These directly correlate to increased waiting numbers across all KKiM waiting lists. The Service have worked with Commissioners and now have a funded recovery plan in place, which will commence in September 2025.
• 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.
• Wakefield CAMHS staffing – ReACH Team, Primary Intervention Team (PIT) which is the single point of access (SPA) and ED Teams implementing business continuity plans due to low staffing numbers and challenges recruiting to posts although this is now an improving situation. A range of options is being considered activated led by the General Manager. The Paediatric Liaison offer is being streamlined and formalised to ensure this resource is accessible to ReACH.
• Wakefield CAMHS PIT/SPA Team is experiencing increased waits. The team is the front door to the service and handles all referrals and assessments. The KPI wait is 12 weeks for assessments and the wait now is 31 weeks. Recruitment is a real challenge. Focused work is underway around triage and developing a new assessment model.
• Secure CAMHS –The installation of SWYFT IT system access within the three settings has been approved, the timescales of the work being commenced is to be agreed. The lack of SWYFT IM&T infrastructure within the three secure settings continues to provide challenges and risks. This issue remains on the risk register due to concerns of the impact that this will have upon service delivery but has been downgraded to amber.
• Secure CAMHS –Work continues to determine the responsibilities and associated finance for the prescribing of mental health medications in the secure children's homes
• The new care plan metrics for community are now capturing the whole community caseload including CYP&F. The care group are working with P&BI 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.

Advise

• Calderdale & Kirklees CAMHS experiencing increased referrals and reduced resources which are impacting waiting times for ADHD medication activity. Increased prevalence of ADHD has led to SWYFT receiving an increased number of referrals for medication assessment and titration from Right to Choose (RtC) providers specifically within Calderdale. Kirklees numbers are directly related to the number of diagnosed assessments undertaken by the Neuro Developmental assessment team in Kirklees. Calderdale commissioners considering business proposal for increasing capacity with Calderdale ADHD.
• Calderdale & Kirklees CAMHS Crisis team continues to receive in the region of 100 referrals per month for CYP requiring emergency or urgent support. In addition, the C&K CAMHS Crisis line receives in the region of 100 calls per month and also a further 25 calls per month from NHS 111. Service is working with IM&T to maximise telephony provision to streamline calls more productively.
• 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. Kirklees ND are predicting 95% establishment by end of October. Once inducted this will increase the number of assessments completed, however, demand will still outstrip capacity.
• Wakefield CAMHS – Eating Disorders team will face staffing pressures due to vacancies. Recruitment is in process. The team is using resource from across CAMHS teams to deliver the core assessment offer which adds to pressures across the service and a bank member of staff is also offering support to this process.
• Some GP practices in Barnsley are no longer accepting shared care agreements for ADHD prescriptions. This means that there is an increase in prescribing workload. Adult ADHD service will not accept CYP who do not have shared care arrangements in place, this means a delay in transition and CHYP staying on the CAMHS caseload post 18 years on and so delaying other CYP in starting medication treatment.
• Appraisal rates across the Care Group continue to improve at 89.5% in August. Targeted action plans across the care group continue for those services indicating low appraisal rates.

Assure

• Supervision continues to be above the 80% threshold in August at 86.6%
• In August overall mandatory training compliance for CYP&F in August is 94.2% above the target of 80%.
• The C&YP Management Team has realigned some of its portfolio responsibilities, and from 01.09.25 each both Calderdale and Kirklees will have a dedicated GM in each area. This will increase operational and strategic focus and provide additional support for both teams.
• Barnsley CAMHS- Our business proposal has been approved by Commissioners for the LD CAMHS pathway and wider provision which will positively impact health inequalities and service user experience. Mobilisation plans are being developed, and recruitment has commenced.

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 and we did see an increase in use of out of area beds during July and August.

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. Community services also saw an increase in sickness during August.

Under-performance in appraisals is being addressed through line management support and oversight.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	90.5%	90.2%	86.6%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	76.0%	72.7%	62.6%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	96.2%	88.0%	95.3%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	13% (1/8)	14% (3/22)	0% (0/6)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	91.5%	91.9%	87.6%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	90.7%	90.1%	88.6%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	94.6%	95.4%	95.3%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	95.8%	95.4%	95.7%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.3%	82.8%	85.5%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	91.7%	92.4%	92.4%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.8%	98.4%	98.4%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	83.9%	84.9%	87.3%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.8%	5.5%	5.9%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,207	13,182	13,176	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	129	137	107	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	94.0%	93.1%	94.9%	
% Bed occupancy (excl leave)	Best Quality	Safe	85%	91.2%	91.2%	89.6%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	10% (2/20)	14% (1/7)	0% (0/3)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	94.3%	92.2%	92.3%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.7%	89.9%	90.2%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.7%	6.3%	8.4%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	82.1%	83.8%	85.0%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	155 (July)	158	196	203	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	99.0%	99.2%	98.8%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	22	28	22	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	46	61	59	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	87.6%	89.8%	90.3%	
Restraint incidents	Best Quality	Safe	Trend Monitor	111	160	119	
Safer staffing (Overall)	Best Quality	Safe	90%	124.4%	123.1%	117.7%	
Safer staffing (Registered)	Best Quality	Safe	80%	99.9%	100.2%	97.8%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	6.4%	6.6%	7.6%	
Average length of stay - Acute and Psychiatric Intensive Care Unit - West Yorkshire (3 Months Rolling)	Best Quality	Safe	Jun 62.0, Jul 61.5, Aug 60.9	54.6	53.3	56.9	
Average length of stay - Acute and Psychiatric Intensive Care Unit - South Yorkshire (3 Months Rolling)	Best Quality	Safe	Jun 62.4, Jul 62.2, Aug 61.7	67.1	74.3	66.8	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	669	753	618	

Alert/Action

• Acute wards have continued to manage high levels of acuity.
• High occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• There continues to be people who are clinically ready for discharge but are delayed. This is an area of focus as part of the priority programme work and is being addressed with the ICB's through the 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 August 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 remains challenging in August 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.
• 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. The Staying Safe percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions and August'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.
• 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 P&BI 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.
• Care Programme Approach (CPA) review performance is above target in Calderdale and Wakefield. Barnsley and Kirklees are slightly under target this month at 94.04% and 94.69% respectively. Action plans and support from Quality and Governance Leads remain in place and all areas are expected to be above threshold in August.
• The sickness rate is above the Trust threshold on some wards. Wards and teams with high sickness are where there are a number of people with long term sickness in addition to short term sickness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
• The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administrating intra-muscular medication. Matrons attend the monthly restraint oversight meeting chaired by RRPI specialist advisors and includes an in-depth review of all prone restraint incidents for learning.
• SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. The access standard for assessed within 14 days of referral has been met in Barnsley 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 August is 52.63% for Barnsley achieving the national standard of 50%. Kirklees was under target at 48.8% in August. Barnsley and Kirklees Talking Therapies were above the expected national standard of less than 10% for waits to second treatment within 90 days at 25.97% and 22.78% respectively. 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 System One. Completeness of equality data is on our data quality improvement action plan.
• There were 10 incidents of prone restraint in August all of which were on working age adult (WAA) inpatient wards and were under 3 minutes duration. The monthly restraint oversight meeting, led by NQP, involving RRPI, safeguarding and matrons, review all prone restraint incidents for any opportunities for learning.

Assure

• Intensive Home Based Treatment teams continue to perform well in gatekeeping admissions to our inpatient beds.
• The use of out of area beds remains low due to continued intensive work as part of the care closer to home workstream
• Supervision continues to be above the 80% threshold at 89.2%
• The appraisal target of 90% was met in August (90.4%)

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 - 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 number of discharges have taken place which have positively impacted those identified as clinically ready for discharge work continues with partners to encourage flow.

LD, ADHD & ASD

Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	88.4%	85.9%	87.3%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/7)	20% (1/5)	0% (0/4)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	85.8%	93.8%	88.3%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	32.1%	40.7%	43.1%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.3%	86.0%	88.4%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	81.8%	44.6%	56.1%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	95.8%	97.2%	96.7%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	93.1%	91.5%	95.3%	
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	7	8	1	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	86.0%	85.9%	89.5%	
Safer staffing (Overall)	Best Quality	Safe	90%	104.5%	115.4%	118.9%	
Safer staffing (Registered)	Best Quality	Safe	80%	172.9%	170.5%	171.1%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.9%	4.4%	4.8%	
Restraint incidents	Best Quality	Safe	Trend Monitor	11	5	4	
Average length of stay	Best Quality	Safe	Trend Monitor	114	333	27	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	52	41	24	

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

Alert/Action

Integrated Care Board (ICB) West Yorkshire Neurodiversity Project – Emerging Developments
• West Yorkshire Integrated Care Board (ICB) are consulting on the development of an all-age Neurodiversity (ND) hub. The hub would act as a first point of contact; offering triage, early intervention, and potential diversion from formal assessment pathways.

Adult ADHD Service
• Referral Prioritisation: Patients are not seen strictly in referral order; prioritisation is based on clinical need and multi disciplinary team decisions, including referrer requests.
• Screening & Triage - 835 individuals are awaiting ADHD triage.
• Introduced in Kirklees and Wakefield (Summer 2024) to improve referral quality.
• Early data shows reduced waiting list growth in Wakefield (from 3.7% to 1.2%).
• Barnsley and Calderdale have not yet commissioned triage but have requested updated business cases.
• Assessment Waiting List - over 6,500 people are waiting, with some waiting up to three years.
• The service is on track to meet its annual target of 430 assessments; 126 (29%) have started since April 2025.

2025/26 Capacity & Commissioning:
• Capacity remains at 430 assessments.
• Only 330 places commissioned by Barnsley, Kirklees, and Wakefield.
• Remaining capacity offered to Calderdale, with reimbursement expected via Patient Choice.

Adult Autism Pathways
• Referral Growth & Triage:
• Referrals in Barnsley, Kirklees, and Wakefield have more than doubled since 2019/20, with projected volumes exceeding 1,300 in 2025/26.
• All three areas have commissioned a triage model, where autism specialists review referral information and health records to determine clinical appropriateness.
• While feedback from some patient groups has been mixed, the model aligns with NHS England's April 2023 guidance for all-age autism pathways.
• Despite increased referrals, there has not been a corresponding rise in clinically appropriate cases, helping to keep waiting times relatively low.
• Calderdale Pathway - Waiting times have increased significantly. ICB funding originally allocated for triage was redirected to expand assessment capacity (from 30 to 55 cases/year), however, demand continues to exceed capacity by over threefold, resulting in a growing

Advise

Shared Care for ADHD Medication
The service has been delivering shared care for ADHD medication in Barnsley, Kirklees, and Wakefield for several years, and has recently expanded to include Calderdale following agreement with the ICB. National medication shortages and increased demand for ADHD assessments have placed added pressure on primary care.

Barnsley 17+ Autism Pathway
• The service have been invited to submit a business case to deliver approximately 20 autism assessments for 17-year-olds in Barnsley. This proposal mirrors a successful project delivered last year and aims to reduce waiting times for young people currently on the paediatric caseload at Barnsley Hospital NHS Foundation Trust. The business case has been developed and shared with the relevant stakeholders and outcome is awaited.
• Innovations - the service are actively reviewing and developing processes to enhance efficiency and improve outcomes for both staff and service users. Innovations include the ADHD Triage model, now commissioned in Wakefield and Kirklees, and the upcoming launch of digitised self-questionnaire tools within six months. These initiatives aim to improve patient experience, optimise clinical time, and reduce non-pay costs, offering potential financial benefits to the Trust and the wider ICB.

Assure

• All key performance targets are met
• Excellent levels of supervision, appraisal and mandatory training.
• Low level of vacancies.
• All mandatory training meeting the threshold.

Learning disability services:

Alert/Action

Waiting List – Quality Improvement Programme:
- Significant progress since March 2024 in reducing longest waits.
- Targeted resource deployment (e.g., Wakefield nursing staff supporting Barnsley).
- Short-term locum cover for Speech and Language Therapy, prioritising dysphagia assessments.
- 22 additional staff trained to deliver ADOS assessments, improving autism waiting list management.
- Strong clinician engagement and embedded culture of waiting list management.
- Implementation of 'Waiting Well' and 'Waiting Fairly' approaches to accelerate progress on lower-priority cases.
- Non-urgent work paused to focus on reducing waits; enhanced caseload planning and allocation.

Calderdale Physiotherapy:
- Service transitioned to the Trust on 1 April 2025.
- Contract limits caseload to 12 open cases, contributing to a growing waiting list.
- Three service users have exceeded the 18-week wait, with one waiting over 50 weeks.

Clinical Acuity
- Community Teams continue to report high levels of learning disability service users in crisis.
- Contract specifications for Calderdale, Kirklees and Wakefield are currently being updated by commissioners, these are expected back during the month for review.

Assessment and Treatment Unit (ATU) (Horizon)
- Following a recent workshop, several focused workstreams will commence in September to improve operational effectiveness and patient flow:
  - Bed Utilisation and Optimisation: Reviewing occupancy and throughput to ensure efficient use of beds aligned with clinical need.
  - Contract & Finance: Strengthening engagement with commissioning partners to clarify expectations, funding, and service delivery.
  - Clinically Ready for Discharge: Enhancing processes for identifying and progressing patients ready for discharge, reducing delays, and supporting recovery pathways.
  - Governance - These workstreams will be supported by cross-functional teams and progress will be monitored through existing governance structures.
- The service has successfully discharged five service users over the summer period.

Advise

Community
- Following the successful pilot of the 'Keeping My Chest Healthy' initiative, the service is now committed to rolling out the programme across all localities.
- Recruitment to Speech and Language Therapy (SaLT) posts continues to be a challenge.
- ADHD Assessments – Commissioners have requested a proof of concept for the ADHD assessment pathway. This will demonstrate the proposed model's effectiveness, feasibility, and potential impact on waiting times and service quality.

Assessment and Treatment Unit
- A review of the current establishment is planned to ensure staffing structures and resource allocation remain aligned with service delivery needs and strategic priorities. Further details will be shared as the review progresses.
- While the service has successfully discharged a number of service users recently, challenges persist in securing suitable accommodation to meet the needs of this service user group.
- Mandatory Training – the service is reaching the threshold for all mandatory training. Appraisal compliance has increased from last month to 86%, Supervision levels are at 87.6%
- Quality improvement - work continues, with ongoing focus on care planning and FIRM Risk Assessment. Notable improvements in compliance have already been observed.

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 performance was 98% for the month.

Barnsley Physical Health and Wellbeing Care Group

Headlines

The Care Group continue to perform well against most metrics, however, there remains an issue with performance against the national 6 week wait for diagnostics (Paediatric audiology) which is a national issue and the Care Group continue to discuss with commissioners.

Barnsley Physical Health and Wellbeing

Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	93.9%	94.4%	93.5%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (1/3)	33% (1/3)	100% (1/1)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	93.1%	78.1%	94.4%	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	81.3%	80.7%	80.4%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.5%	88.8%	89.5%	
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%	98.0%	98.5%	98.5%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	97.8%	97.7%	97.5%	
Safer staffing (Overall)	Best Quality	Safe	90%	106.5%	107.9%	91.2%	
Safer staffing (Registered)	Best Quality	Safe	80%	108.2%	108.8%	92.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.0%	4.1%	3.6%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	99%	40.2%	46.5%	52.1%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	6,887	6,989	7,116	
Total number of reported incidents	Best Quality	Safe	Trend monitor	225	326	235	

Barnsley Physical Health and Wellbeing Care Group

Alert/Action

• Paediatric Audiology 6-week target for diagnostic procedures has seen a further slight improvement in August from 46.5% to 52.1% against the target of 99%. We are also continuing to see a decrease in the actual number of patients waiting. The Director of Services has highlighted to the Executive Management Team that this target of 99% is not achievable and this is reflected nationally.
• Average wait time continues to be monitored closely by the service and Service Manager is looking at maximising the use of current appointment slots. The team have also volunteered to join the SystmOne pilot to help address DNA (Did Not Attend) rates.
• Agency cover continues until end of September to maintain service delivery, whilst new staff member completes their induction period.
• We are still awaiting the outcome of the business case approved at EMT and submitted to the Barnsley Integrated Care Board (ICB) Deputy Chief Nurse to request investment into the service aligned to Quality National Standards.

Advise

• One instance of feedback with staff values and behaviours as an issue has been recorded during August. This relates to our Urgent Community Response Team (UCR) and we are currently awaiting consent from the family via the Trust's Customer Service Team. In the meantime, a timeline and fact find has commenced internally to investigate the concerns in order to proceed with further investigation once the scope is agreed; this will enable us to ascertain if the complaint is upheld.
• Medical Equipment Service compliance is a focus for our Board due to the number of devices used in our care group. Whilst compliance remains at 69%, slight improvements have been made on all years based on July data which was received mid-August.

Assure

• Appraisals - for August, the overall care group figure is 93.5% which exceeds the target of 90%.
• Staff receiving supervision - ongoing focus with a drive to improve recording and increased numbers of trained supervisors. August figure is achieving compliance at 80.4% with improvement continuing into September data. To note: 2 sessions of Clinical Supervisor Training have been cancelled recently which has an impact on our ability to achieve compliance in some teams.
• Overall sickness rates continue to improve and in August the care group is achieving compliance at 3.6%.
• Urgent Community Response Service 2-hour target is 91.9% at end of August 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) – 97.45% for August 2025.
• People dying in their place of choosing has increased in August and is achieving 94.44% compliancy against the threshold of 80%.
• Information Governance training maintains compliance at 98.5%.
• Friends and Family Test (FFT) 97% of people would recommend community services.
• CPR training maintains compliance at 89.5% for August.
• Virtual ward occupancy rate maintains compliancy at 90.7% which continues to be above the target of 80%.
• The Trust's first T Level student (business and management) secured a substantive role within our Community Administration Team at Kendray.
• Our Care Group registered interest with NHS England to be part of the national evaluation of Virtual wards, and we have been selected to take part.
• The waiting list for Long Term Conditions (LTC) Occupational Therapy is now reduced to 8 weeks (19 patients waiting), which is the lowest it has been for some time and demonstrates the team's commitment to patient care.
• Notes from The Nest (RSPB Nature Prescriptions e-newsletter) references our Integrated Community Stroke Team in the August edition. Both the ward and community elements of the service have been trialling Nature Prescription for several years with positive outcomes. The theme of nature connection has been brought into the Stroke Support Cafes. In our ward setting, all rooms have access to the ward garden encouraging time outside and engagement with nature for our patients supported by our staff.

Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue - hotspot areas can be seen in the ward level breakdown of the report. The People Directorate Business Partner continues to work closely with the care group regarding sickness and actions are underway in line with the policy. Individual ward sickness performance is also impacted by the allocation of staff with long term conditions into less acute areas.

Work on pathways with the collaborative is underway to address the underoccupancy in medium secure services.

Focus remains on ensuring staff have a timely and comprehensive appraisal, although external issues with access to the appraisal system are impacting on reported performance.

Liaison with the collaborative is underway to find appropriate solutions for the patients waiting for high secure placements.

Forensic - West Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	84.3%	85.8%	79.4%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	81.9%	85.3%	85.3%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	66% (2/3)	0% (0/1)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	91.4%	88.1%	87.3%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	100.0%	98.9%	97.9%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.1%	86.3%	86.5%	
% 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%	50.0%	0.0%	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%	96.8%	92.3%	90.5%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	96.2%	96.5%	97.6%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	5	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	20	16	9	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.5%	88.0%	86.8%	
Restraint incidents	Best Quality	Safe	Trend Monitor	34	38	*15*	
Safer staffing (Overall)	Best Quality	Safe	90%	118.1%	120.7%	129.7%	
Safer staffing (Registered)	Best Quality	Safe	80%	100.6%	102.5%	98.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	7.5%	8.8%	7.4%	
Average length of stay	Best Quality	Safe	Trend Monitor	670	1309	1899	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	232	246	224	

Forensic - West Yorkshire:

Alert/Action

Forensic Community Transition Team
The Forensic Community Transition Team currently operates without designated funding from the West Yorkshire Provider Collaborative and has not received investment for community service development. Despite escalation, the issue was reviewed at the Adult Secure Services Board in July, where it was confirmed that funding for the service will not be supported going forward. In response, the service will complete a Decision Tree analysis to inform discussion at the upcoming Value for Money meeting on 20th October 2025.

Bed Occupancy
Occupancy levels across medium secure services remain below commissioned capacity, with the most notable underutilisation seen in the Learning Disabilities (LD) and Women's pathways, where there are currently no active waiting lists. This continues to present challenges around service efficiency and the optimal use of resources.
Conversely, referrals for male medium secure beds have increased significantly, resulting in a growing waiting list and contributing positively to overall utilisation. This shift in referral patterns may reflect emerging trends in demand and warrants close attention in future service planning and pathway development.
In response to these dynamics, the service has commenced more detailed discussions around bed modelling to better align provision with current and projected needs across pathways.
• Newton Lodge: 86.38% – Increased referrals in the male pathway; occupancy spans learning disability and women's services.
• Bretton Centre: 87.27% – Admissions are pending due to legal processes.
• Newhaven: 74.19% – Reflects ongoing underoccupancy.

Appraisals
Appraisal completion remains a key workforce priority, reflecting the service's commitment to staff development, engagement, and accountability. Significant progress has been made, with current completion rates at 80.9% for inpatient services and 71.4% for community services. The recent dip in performance is attributed to an increased number of staff requiring appraisal in September.
To support improvement and ensure thresholds are met, the Care Group is working closely with the People Business Partner, who is providing targeted support to managers across services.

Advise

Sickness Absence

Service Overview

Sickness absence rates remain above the expected threshold across several service areas, with current year-to-date figures as follows:

- Newton Lodge: 6.9%
- Bretton Centre: 8.2%
- Newhaven: 13.4%

Workforce stability and resilience remain areas of focus, with ongoing challenges particularly evident at Newhaven, where absence levels have been significantly elevated. The service continues to work closely with the People Relations team to explore underlying causes and identify targeted interventions. This includes reviewing absence patterns, enhancing wellbeing and support mechanisms, and ensuring managers are equipped to respond proactively.

Encouragingly, in-month absence rates have reduced across all three inpatient services, with current figures at:

- Newton Lodge: 6.6%
- Bretton Centre: 8.8%
- Newhaven: 9.5%

Further updates will be provided as improvement plans are developed and implemented

Mandatory training overall compliance:

- Newton Lodge – 94.2%
- Bretton – 94.9%
- Newhaven –95%

To note all mandatory training is above the threshold across the three inpatient services.

Forensic Improvement Programme – is well underway with several workstreams focusing on improved service user experience and outcomes and improved efficiencies.

FIRM Risk Assessment – a quality improvement initiative is underway to strengthen compliance with the FIRM Risk Assessment process. Early indications show that compliance is already improving, supporting safer and more consistent clinical decision-making.

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%.
- The percentage of 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**	**Jun-25**	**Jul-25**	**Aug-25**	**Variation/ Assurance**
% Appraisal rate	Best place to work and learn	Well led	May 88% June 89% July 90%	84.4%	94.3%	95.3%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	78.3%	81.2%	84.8%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/3)	0% (0/1)	0% (0/1)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	81.0%	94.6%	96.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	79.4%	76.9%	75.5%	
% of clients clinically ready for discharge	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%	96.2%	94.0%	89.8%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	2	1	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	10	8	3	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	86.3%	85.3%	85.6%	
Restraint incidents	Best Quality	Safe	Trend Monitor	15	16	11	
Safer staffing (Overall)	Best Quality	Safe	90%	123.0%	122.1%	131.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	94.6%	96.3%	101.5%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	5.1%	4.7%	3.8%	
Average length of stay	Best Quality	Safe	Trend Monitor	2637	1077	851	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	121	107	131	

Forensic - South Yorkshire:

Alert/Action

• Wentbridge (ASD ward) - Following heavy rainfall, a roof leak on Wentbridge Ward necessitated the evacuation of the ward. Initially, service users were temporarily accommodated across the service while Estates and Facilities colleagues carried out remedial work on Hamilton Ward, where service users will now remain until repairs to Wentbridge are completed.
The roof works are estimated to take approximately six months.
• Water Quality - Water quality remains an ongoing risk, and all admissions are subject to a water hygiene risk assessment as part of standard procedures. This risk is actively monitored and reviewed on both the Estates and Facilities Risk Register and the Cheswold Park Hospital Programme Group Risk Register, ensuring visibility and oversight at multiple governance levels.
• Bed Occupancy - Following its reopening under SWYPFT in October 2024, Cheswold Park has steadily resumed operations, including both admissions and discharges. The service has continued to support new admissions throughout the reopening phase, gradually rebuilding capacity and stabilising core functions.
Current Bed Occupancy is 76. Including patients requiring a warrant, there are an additional 11 admissions planned by 31 October 2025. Informed by lessons from previous admissions, regular updates on warrant progress are being requested to support timely and coordinated transfers.
There are currently three planned discharges with identified onward pathways, also scheduled to take place by 31 October 2025.
If all planned admissions and discharges proceed as expected, occupancy will reach 84 by the end of October. It is important to note that all planned admissions are subject to successful medical staff recruitment. The Chief Medical Officer is working closely with the medical clinical lead to support this process.
• Cardio pulmonary resuscitation (CPR) training compliance - 75.5% with a recovery plan to be above threshold and mitigating actions to ensure CPR trained staff are on duty at all times.
• Information Governance training compliance is 89.8%

Advise

Cheswold Park – Integration and Service Development Update
• Cheswold Park continues to make steady progress in its integration into the Forensic Care Group, aligning with Trust-wide governance structures and operational frameworks. This integration is supporting greater consistency in standards, oversight, and strategic direction.
• A corporate services establishment review has now been completed, providing clarity on resource requirements and supporting future planning.
• Quality and safety oversight is maintained through the internal Quality Improvement Group, which now meets quarterly to provide structured assurance and a forum for continuous improvement. External oversight from NHS England and the South Yorkshire Provider Collaborative remains at a routine monitoring level, reflecting confidence in the service's progress.
• Strategic priorities have been defined for the next six months across both the Programme Group and Clinical/Operational services, with a clear focus on stabilisation, development, and future planning.
• Work is underway to develop a clear clinical and operational model to guide future service delivery and inform workforce planning. A medical workforce business case has been submitted to the extended management team and approved, supporting future admissions in line with the overarching business case. Additional business cases for Psychology, Allied Health Professionals, and Pharmacy are in development to strengthen multidisciplinary provision.
• The service is also progressing with policy and procedure alignment to meet Trust, CQC, and secure service standards. A ward manager development programme is underway to enhance leadership capability and align roles with Trust-wide expectations.
• Support is being provided to improve internal and external reporting mechanisms, enhancing performance monitoring. Additionally, access to the Trust bank has now been established, improving the sustainability and flexibility of ward staffing.

Assure

• Turnover remains at a low level reporting 1.1%.
• 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

• 15 wards have achieved the 90% threshold target in August.
• Beamshaw (80%) remained below compliance threshold, impacted by clinical acuity and ward manager absence (maternity leave). The matron is maintaining oversight to ensure completion of outstanding appraisals and current compliance is above threshold (95.2% as of 18/09/25).
• Melton (73.9%) also remained below compliance threshold, impacted by clinical acuity, and the ward manager working in clinical numbers, meaning that planned appraisals needed to be rescheduled. Targeted work is ongoing, and current compliance is 87% (as of 18/09/25).
• Matrons continue to work closely with ward managers to ensure outstanding appraisals are booked.

Sickness

• 5 wards have sickness rates below 5% compliance threshold.
• Sickness improved to below threshold in August on Ward 19 (Female) following the return of staff from long term sickness.
• Sickness increased to above threshold on Ward 18 (7.0%) and Beechdale (7.5%) due to both short term and long-term sickness, no themes.
• Although still above threshold, sickness on Poplars (6%) and Lyndhurst (6.8%) has reduced following the return of staff from long term sickness.
• Nostell (9.7%), Elmdale (10.8%), Crofton (6.7%) Enfield Down (8.8%), sickness has increased due to a mixture of both long and short-term sickness, no themes.
• Sickness on Melton (13.3%) and Walton (13.3%) has increased due a mixture of both long and short-term sickness. A short-term sickness theme is cold and flu symptoms.
• Sickness on Ashdale has increased (18.5%) and continues to be impacted by long-term sickness with themes of personal and work-related stress, work related injury, and long-term physical health conditions.
• Sickness on Willow has also reduced but remains above threshold at 12.9%. This is impacted by both short and long-term sickness, with cold and flu symptoms being a theme for short-term sickness.
• Ward managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made.

Supervision

• 14 wards are above 80% compliance target for August, 9 of those wards are at 100% supervision compliance.
• Ward 18 (70.0%) and Lyndhurst (78.6%) are below compliance however focused work has been undertaken by the ward leadership teams and both wards are above the 80% threshold in September (as of 18/09/25).
• Melton (63.6%) are below compliance and as described above, this is impacted by clinical acuity, the ward manager working in clinical numbers, and scheduled supervision needing to be rearranged. Targeted work is being undertaken, overseen by the matron, to prioritise supervision for staff outside of compliance.
• The senior leadership team maintain close oversight of supervision compliance via the weekly inpatient quality and performance meeting.

Mandatory Training

Information Governance

• 16 wards are above 95% compliance target for August, 12 of those wards are at 100% information governance training compliance
• Walton is just below target at 92.5%. Staff out of compliance are being supported to complete their e-learning training and current compliance is above threshold (95.1% as of 18/09/2025).
• Ward managers, with oversight from matrons, continue to ensure outstanding staff complete information governance training.

Cardio Pulmonary Resuscitation

• 15 wards are above the CPR training compliance threshold.
• Elmdale (78.6%) dropped below compliance in August. Staff have attended recent training, and current compliance is 81.5% (as of 18/09/2025).
• Walton (77.5%) remains below compliance threshold in August. Staff with outstanding training are booked to attend courses in September and October.

Reducing restrictive practice interventions

• 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

• 16 wards are above fire safety training compliance threshold.
• Walton (82.5%) dropped below compliance in August. Staff have either attended recent fire training sessions or are booked to attend upcoming dates and current compliance is above threshold at 85.4% (as of 18/09/2025).

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

Bed Occupancy

• Bed occupancy exceeding target is reflective of general increased demand for admissions, particularly across working age adults.
• Melton high bed occupancy (111.8%) reflects one service user with complex needs and high risk being nursed in the extra care area.
• Where the bed occupancy exceeds target, plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.

Clinically Ready for Discharge (CRFD)

• CRFD rates are significantly above threshold on several wards:
  o Melton CRFD is 28.97% in August. This is 2 service users awaiting placements.
  o Poplars CRFD has increased to 25.7% and is reflective of 7 service users awaiting placements, 5 of whom have now been discharged.
  o Clark CRFD is 21.14% reflecting 3 service users awaiting placements, 1 of whom has been recently discharged.
• 9 other wards are above the threshold for CRFD with Beamshaw, Walton, Ward 19 (Male), Willow and Enfield Down above 10%. Beechdale, Nostell, Stanley, and Ward 18 and 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.
• Overall compliance in August was 85% for 24hr target and 91.7% completed within 48hrs.
  During August, Stanley, Crofton, and Ward 19 Male had 1 FIRM breach each. Clark (2), Nostell (2), Elmdale (2), Ward 19 Male, Ward 18 (3), and Ashdale (5), and had multiple.
• In line with the Risk Assessment and Risk Management policy, the team who assessed the service user as requiring admission have a responsibility to update the FIRM risk assessment to reflect the change in risk necessitating inpatient admission.
• Compliance monitoring dashboards support oversight and a deep dive will be conducted by the inpatient matron for each breach to identify learning and inform improvement. This will be shared with Quality and Governance Leads in community to ensure a collaborative approach to 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. A Staying Safe risk management care plan is also implemented within 24hrs of admission.

Physical violence

• There were 22 incidents of patient-on-patient physical violence throughout August. 8 of these incidents were on Ward 18 and related to a small number of service users with a risk profile of violence and aggression.
• Service users are supported on an individual basis by staff teams and risks are managed through individual care planning. Appropriate safeguarding actions taken by ward teams, including liaison with trust safeguarding specialist advisors and reporting to the police.
• 14 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.
• 13 incidents of patient on staff physical violence at Ward 18. 10 of those incidents relate to one specific service user with complex needs. Psychological formulation is developed on the wards as required to support management and care of individuals with complex needs.
• Risk specific care plans are in place to support managing incidences of violence with input from trust RRPI specialist advisors as needed.
• Staff involved in incidents are supported by ward leadership teams including both managerial and clinical supervision.

Restraint incidents

• Higher incidence on Nostell (14) is reflective of current patient population and the presentation and risk profile of service users.
• Higher incidence on Poplars (29) is linked to a small number of service users with cognitive impairment who present with risks of violence and aggression during personal care interventions.

Prone restraint incidents

• 10 incidents of prone restraint in August across Beamshaw (4), Nostell (1), and Walton (5) all of which were under 3 minutes duration.
• The main reason for prone restraint use was exiting seclusion. 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.
• The one incident of prone restraint on Nostell was patient preference.

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Jun-25	Beamshaw Jul-25	Beamshaw Aug-25	Clark Suite Jun-25	Clark Suite Jul-25	Clark Suite Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	90.5%	75.0%	80.0%	94.4%	89.5%	95.0%
Sickness	Best place to work and learn	Well led	5.0%	6.9%	0.5%	3.0%	2.7%	4.2%	2.5%
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%	100.0%	100.0%	96.4%	100.0%	100.0%	95.8%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.3%	87.0%	85.7%	95.2%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.3%	91.3%	82.1%	95.2%	95.0%	91.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.0%	87.0%	85.7%	100.0%	100.0%	87.5%
Bed occupancy**	Best Quality	Safe	85%	106.0%	107.1%	106.2%	106.0%	107.1%	106.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	77	73	58	64	83	42
Safer staffing (Overall)	Best Quality	Safe	90%	139.1%	122.4%	136.2%	135.5%	119.8%	103.5%
Safer staffing (Registered)	Best Quality	Safe	80%	100.4%	99.1%	92.6%	108.7%	106.1%	101.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	10.7%	13.0%	19.2%	18.3%	15.2%	21.1%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	80.0%	100.0%	75.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	0	3	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	2	5	7	7	2
Restraint incidents	Best Quality	Safe	Trend Monitor	7	2	*10*	16	11	*8*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	2	0	*4*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	12	19	37	11	11	17

*** 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 Jun-25	Melton Suite Jul-25	Melton Suite Aug-25	Nostell Jun-25	Nostell Jul-25	Nostell Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	87.5%	75.0%	73.9%	95.0%	100.0%	95.0%
Sickness	Best place to work and learn	Well led	5.0%	4.8%	5.9%	13.3%	10.4%	7.9%	9.7%
Supervision	Best place to work and learn	Well led	80%	92.3%	80.0%	63.6%	85.7%	64.3%	92.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.8%	100.0%	100.0%	100.0%	100.0%	96.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	96.4%	78.3%	87.5%	85.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	95.8%	96.4%	82.6%	95.8%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.5%	87.5%	89.3%	95.7%	95.8%	100.0%
Bed occupancy	Best Quality	Safe	85%	106.7%	120.3%	111.8%	98.9%	99.0%	99.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	104	N/A	221	59	56	67
Safer staffing (Overall)	Best Quality	Safe	90%	138.5%	176.0%	153.8%	134.7%	120.4%	97.4%
Safer staffing (Registered)	Best Quality	Safe	80%	92.1%	93.9%	86.9%	102.8%	106.5%	98.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	15.6%	27.2%	29.0%	7.9%	10.6%	4.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	N/A	100.0%	100.0%	85.7%	71.4%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	1	2	1	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	5	2	2	8	3	3
Restraint incidents	Best Quality	Safe	Trend Monitor	12	22	*4*	34	14	*14*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	3	0	*1*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	23	34	41	21	17	10

*** 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 Jun-25	Stanley Jul-25	Stanley Aug-25	Walton Jun-25	Walton Jul-25	Walton Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	90.5%	95.8%	100.0%	87.9%	93.8%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.9%	4.5%	2.2%	8.9%	9.4%	13.3%
Supervision	Best place to work and learn	Well led	80%	92.9%	92.3%	100.0%	88.2%	64.7%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	97.1%	97.1%	92.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.3%	96.2%	93.8%	91.4%	94.3%	92.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.5%	88.5%	96.9%	74.3%	74.3%	77.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.3%	96.2%	100.0%	85.7%	88.6%	82.5%
Bed occupancy**	Best Quality	Safe	85%	98.9%	99.0%	99.9%	103.3%	99.3%	101.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	53	38	46	80	70	69
Safer staffing (Overall)	Best Quality	Safe	90%	117.5%	113.6%	107.5%	127.5%	126.2%	125.5%
Safer staffing (Registered)	Best Quality	Safe	80%	97.1%	93.6%	99.4%	94.7%	89.7%	94.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	14.1%	3.9%	5.6%	31.1%	16.5%	18.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	66.7%	90.0%	90.9%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	1	1	2	2	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	0	2	1	4	3
Restraint incidents	Best Quality	Safe	Trend Monitor	2	5	*8*	6	7	*11*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	*0*	3	1	*5*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	17	12	11	11	15	21

*** 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 Jun-25	Ashdale Jul-25	Ashdale Aug-25	Ward 18 Jun-25	Ward 18 Jul-25	Ward 18 Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	92.0%	92.3%	91.7%	95.8%	96.0%	96.0%
Sickness	Best place to work and learn	Well led	5.0%	21.8%	14.5%	18.5%	2.2%	2.1%	7.0%
Supervision	Best place to work and learn	Well led	80%	86.7%	86.7%	80.0%	90.9%	90.0%	70.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	80.0%	74.1%	82.1%	82.1%	86.2%	93.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	92.6%	82.1%	71.4%	86.2%	90.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.0%	100.0%	100.0%	96.4%	96.6%	100.0%
Bed occupancy	Best Quality	Safe	85%	99.7%	98.7%	99.6%	103.9%	100.8%	99.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	60	46	56	40	29	65
Safer staffing (Overall)	Best Quality	Safe	90%	115.7%	107.0%	100.0%	105.3%	104.9%	102.0%
Safer staffing (Registered)	Best Quality	Safe	80%	101.3%	99.6%	95.5%	97.5%	104.7%	96.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	3.1%	2.8%	0.0%	3.5%	4.2%	3.6%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	57.1%	69.2%	37.5%	70.0%	77.3%	77.8%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	4	7	4	0	3	8
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	1	2	2	10	13
Restraint incidents	Best Quality	Safe	Trend Monitor	3	12	*5*	3	31	*11*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	1	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	8	6	2	4	3	2

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	90.5%	95.8%	96.0%
Sickness	Best place to work and learn	Well led	5.0%	8.6%	10.0%	10.8%
Supervision	Best place to work and learn	Well led	80%	85.7%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.9%	96.0%	89.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.6%	80.0%	78.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	74.1%	96.0%	100.0%
Bed occupancy	Best Quality	Safe	85%	103.3%	98.5%	96.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	35	60	29
Safer staffing (Overall)	Best Quality	Safe	90%	102.6%	105.3%	99.0%
Safer staffing (Registered)	Best Quality	Safe	80%	93.6%	97.9%	93.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	1.2%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	69.2%	84.6%	86.7%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	4	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	7	6
Restraint incidents	Best Quality	Safe	Trend Monitor	16	24	*11*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	14	5

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton Jun-25	Crofton Jul-25	Crofton Aug-25	Poplars CUE Jun-25	Poplars CUE Jul-25	Poplars CUE Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	95.5%	90.9%	90.9%	100.0%	96.4%	96.6%
Sickness	Best place to work and learn	Well led	5.0%	4.7%	6.6%	6.7%	4.6%	9.7%	6.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	83.3%	100.0%	90.9%	90.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.0%	90.0%	95.5%	80.0%	89.3%	89.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.0%	100.0%	100.0%	96.7%	92.9%	89.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	100.0%	100.0%	100.0%	93.1%	96.6%
Bed occupancy	Best Quality	Safe	85%	105.8%	96.6%	89.5%	74.2%	68.0%	69.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	35	68	65	100	123	91
Safer staffing (Overall)	Best Quality	Safe	90%	168.7%	169.0%	175.8%	225.6%	191.6%	178.5%
Safer staffing (Registered)	Best Quality	Safe	80%	138.4%	143.1%	140.5%	104.4%	102.3%	100.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	27.5%	17.0%	25.7%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	83.3%	87.5%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	1	2	4	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	11	1	9	11	14
Restraint incidents	Best Quality	Safe	Trend Monitor	0	11	*2*	8	12	*29*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	29	35	27	23	26	11

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow Jun-25	Willow Jul-25	Willow Aug-25	Beechdale Jun-25	Beechdale Jul-25	Beechdale Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	95.0%	95.2%	95.5%	100.0%	95.5%	95.2%
Sickness	Best place to work and learn	Well led	5.0%	17.8%	13.2%	12.9%	7.1%	4.5%	7.5%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	91.7%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	92.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.3%	86.4%	87.0%	91.3%	84.0%	92.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.4%	95.5%	91.3%	100.0%	91.7%	95.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	95.5%	95.7%	82.6%	88.0%	92.0%
Bed occupancy	Best Quality	Safe	85%	105.0%	94.5%	89.4%	106.0%	97.4%	94.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	99	44	56	70	124	105
Safer staffing (Overall)	Best Quality	Safe	90%	119.9%	113.6%	125.9%	113.1%	136.0%	134.4%
Safer staffing (Registered)	Best Quality	Safe	80%	81.3%	85.5%	93.5%	94.2%	107.8%	103.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.9%	0.3%	10.3%	4.3%	5.7%	5.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	85.7%	66.7%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	3	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	2	0	2	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	2	*0*	3	3	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	11	22	2	8	10

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male			Ward 19 - Female		
				Jun-25	Jul-25	Aug-25	Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	2.9%	4.7%	5.0%	4.8%	5.7%	4.0%
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%	95.8%	95.8%	100.0%	100.0%	100.0%	95.8%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.5%	83.3%	84.0%	91.3%	91.3%	83.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	95.8%	92.0%	91.3%	95.7%	91.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.8%	95.8%	96.0%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	85%	105.1%	99.8%	96.1%	98.4%	93.1%	84.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	64	80	138	105	39	91
Safer staffing (Overall)	Best Quality	Safe	90%	111.3%	123.3%	115.1%	96.2%	107.9%	112.9%
Safer staffing (Registered)	Best Quality	Safe	80%	82.5%	85.6%	81.9%	113.3%	103.9%	98.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	16.1%	12.0%	15.2%	0.2%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	66.7%	71.4%	100.0%	60.0%	100.0%
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	2	1	3	2	1	3
Restraint incidents	Best Quality	Safe	Trend Monitor	1	3	*4*	1	3	*4*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	3		2	13	

Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down Jun-25	Enfield Down Jul-25	Enfield Down Aug-25	Lyndhurst Jun-25	Lyndhurst Jul-25	Lyndhurst Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	93.3%	87.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.6%	7.9%	8.8%	5.1%	7.5%	6.8%
Supervision	Best place to work and learn	Well led	80%	96.3%	100.0%	100.0%	87.5%	100.0%	78.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.7%	89.4%	87.5%	79.3%	85.7%	81.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.5%	95.3%	86.4%	100.0%	96.4%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.0%	95.8%	91.8%	96.6%	100.0%	92.6%
Bed occupancy	Best Quality	Safe	Trend Monitor	59.6%	51.6%	50.8%	66.2%	59.4%	56.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	265	1058	N/A	821	N/A	305
Safer staffing (Overall)	Best Quality	Safe	90%	96.0%	104.3%	97.0%	102.9%	97.1%	97.3%
Safer staffing (Registered)	Best Quality	Safe	80%	101.2%	96.7%	95.7%	102.7%	101.0%	100.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	5.4%	11.9%	11.8%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	N/A	N/A	N/A	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	3	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	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	0	11	1	4	2	0

Inpatients - Forensic West Yorkshire - Medium Secure

Medium Secure

• Six of the seven wards are above supervision compliance (Bronte, Appleton, Chippendale, Waterton, Johnson and Priestley). Hepworth (64.3%) is under compliance and understood to be a recording issue that is currently under review by the Ward Manager.

• Some noted improvements in sickness absence noted Priestley (0.7%), Johnson (1.1%), Hepworth (2.6%). Appleton (5.4%) also remains within compliance. Some improvements also noted on Bronte (7.9%) with an expectation for an improving trajectory. Chippendale (9.7%) and Waterton (18.7%) have both noted an increase in sickness absence. 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.

• An ongoing focus on quality appraisals is a service priority. Four wards currently remain above compliance (Bronte, Chippendale, Hepworth and Johnson). Hotspots have been identified on Waterton (85.7%), Priestley (68.2%) and Appleton (66.7%). Review has highlighted some recording and systems challenges alongside a spike in appraisal acuity. A session has been arranged with the People Planning and Performance Lead on Dashboards, Data and Workforce to support understanding and rectification of any system challenges.

• Good compliance is noted for mandatory training across the medium secure service. Hotspots are evident for RRPI on Johnson (79.3%) and CPR on Waterton (75%) with plans in place on both areas to address compliance.

• Bed occupancy on Appleton (66.7%) is below compliance and due to a reduction in overall learning disability referrals to secure care. Occupancy in the women's service (Johnson medium secure 73.3%) is also low but has noted a slight improvement. Neither of these services have a waiting list. Bed occupancy on the male pathway has increased significantly due to a spike in medium secure referrals.

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. An improving trajectory has evidenced improved performance that will be monitored to support embedding.

Low Secure

• Sickness across all wards monitored closely, and ward managers are working closely with people directorate colleagues and the clinical service manager. Improvement has been noted on Thornhill (3.2%). Newhaven (9.5%) is related to three long term sickness and absence. A plan is in place with the People Directorate and additional Occupational Health Support using the CRISSP approach which has seen two staff return from LTS. Increases in sickness absence noted on Sandal (14.9%) which is related to a long-term sickness absence. Plans are in place to support a number of these staff return to work. Ryburn (16.2%) is impacted by the size of the team and has two staff on long term sickness absence with support plans in place with the People Directorate.

• Mandatory training compliance remains positive across the service. Some hotspots are identified on Sandal for IG (91.7%) with a plan in place and improving trajectory and CPR (79.2%). On review of the CPR this includes three staff who require CPR and three staff BLS with a plan in place with the Ward Manager to ensure all are prioritised to attend.

• An ongoing focus on quality appraisals is a service priority. Sandal remains within compliance at 90.9%. There has been a reduction in compliance for Ryburn (77.8%), Newhaven (84.4%) and Thornhill (85.2%). Review has highlighted some recording and systems challenges alongside a spike in appraisal acuity. A session has been arranged with the People Planning and Performance Lead on Dashboards, Data and Workforce to support understanding and rectification of any system challenges.

• The Inpatient risk assessment completed within 24 hours has been reviewed by the service. Within forensic services, forensic risk assessments are completed prior to admission as part of the gate keeping process to support planning. Communication has been shared to ensure that this is reviewed, and all parts are being signed off again as part of the admission process. This should support

• Bed occupancy has increased across all 4 wards in low secure, with Ryburn (100%) and Sandal (86.5%). The service is currently working to support transitions to Thornhill (82.5%) to support capacity for admissions. Newhaven (74. 2%) continues to experience lower level of referrals and has no waiting list.

• There has been one prone incident on Sandal and was under 3 minutes in duration. The reason for prone restraint use was exiting seclusion. 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.

• Supervision is above compliance on Ryburn (100%), Sandal (100%) and Newhaven (86.7%). Thornhill (50%) have experienced a drop in performance, which has been reviewed by the service and understood. and the service is taking action to identify the causes and take action.

Metrics	Strategic Objective	CQC Domain	Threshold	Appleton Jun-25	Appleton Jul-25	Appleton Aug-25	Bronte Jun-25	Bronte Jul-25	Bronte Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	86.7%	80.0%	66.7%	94.4%	95.0%	90.5%
Sickness	Best place to work and learn	Well led	5.4%	4.4%	3.3%	5.4%	4.7%	8.0%	7.9%
Supervision	Best place to work and learn	Well led	80%	90.9%	83.3%	90.0%	100.0%	92.9%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	95.2%	100.0%	95.7%	95.5%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.9%	81.0%	85.0%	84.0%	81.8%	82.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	95.2%	90.0%	95.7%	95.5%	91.3%
Bed occupancy	Best Quality	Safe	90%	62.5%	58.9%	52.0%	83.3%	96.3%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1511	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	125.7%	126.0%	136.2%	97.7%	94.1%	94.5%
Safer staffing (Registered)	Best Quality	Safe	80%	92.5%	93.4%	89.6%	102.0%	87.0%	87.2%
% 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%	N/A	N/A	100.0%	100.0%	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	1	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	7	2	3	3	3	1
Restraint incidents	Best Quality	Safe	Trend Monitor	18	10	*4*	1	6	4
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	22	26	19	2	1	0

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale Jun-25	Chippendale Jul-25	Chippendale Aug-25	Hepworth Jun-25	Hepworth Jul-25	Hepworth Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	89.5%	95.0%	95.0%	95.8%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	6.4%	4.8%	9.7%	4.8%	3.4%	2.6%
Supervision	Best place to work and learn	Well led	80%	93.3%	100.0%	100.0%	88.9%	81.3%	64.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.5%	100.0%	100.0%	100.0%	100.0%	95.8%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.9%	91.3%	91.3%	88.5%	88.5%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.9%	87.0%	91.3%	92.3%	92.3%	91.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	91.3%	95.7%	96.2%	96.2%	91.7%
Bed occupancy	Best Quality	Safe	90%	96.7%	100.0%	100.0%	88.9%	81.7%	79.1%
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%	118.8%	103.6%	141.4%	89.8%	91.5%	94.9%
Safer staffing (Registered)	Best Quality	Safe	80%	114.1%	97.3%	116.8%	85.9%	90.2%	89.7%
% 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%	N/A	N/A	N/A	0.0%	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	2	*0*	1	0	*3*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	23	7	30	0	0	3

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson Jun-25	Johnson Jul-25	Johnson Aug-25	Priestley Jun-25	Priestley Jul-25	Priestley Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	92.3%	76.2%	69.6%	68.2%
Sickness	Best place to work and learn	Well led	5.4%	10.1%	8.4%	1.1%	5.3%	2.2%	0.7%
Supervision	Best place to work and learn	Well led	80%	94.1%	93.3%	93.8%	87.5%	81.3%	93.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	96.4%	96.6%	88.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	85.2%	78.6%	79.3%	82.6%	87.5%	90.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.8%	82.1%	86.2%	82.6%	83.3%	86.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.6%	96.4%	93.1%	80.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	73.1%	73.3%	73.3%	96.7%	94.1%	96.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	722	790	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	113.0%	119.6%	118.8%	93.0%	86.5%	92.9%
Safer staffing (Registered)	Best Quality	Safe	80%	88.3%	89.6%	91.4%	99.4%	101.7%	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%
% 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
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	1	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*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	16	17	4	1	2	4

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	85.0%	90.0%	85.7%
Sickness	Best place to work and learn	Well led	5.4%	12.6%	16.1%	18.7%
Supervision	Best place to work and learn	Well led	80%	84.6%	84.6%	84.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.7%	90.9%	90.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.7%	81.8%	75.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	78.9%	86.4%	90.0%
Bed occupancy	Best Quality	Safe	90%	89.2%	100.0%	96.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	679	N/A	1431
Safer staffing (Overall)	Best Quality	Safe	90%	163.1%	156.3%	151.9%
Safer staffing (Registered)	Best Quality	Safe	80%	98.2%	99.4%	89.4%
% 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%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	10	25	21

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill Jun-25	Thornhill Jul-25	Thornhill Aug-25	Sandal Jun-25	Sandal Jul-25	Sandal Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	94.7%	100.0%	85.2%	95.7%	91.3%	90.9%
Sickness	Best place to work and learn	Well led	5.4%	5.7%	4.7%	3.2%	8.0%	11.5%	14.1%
Supervision	Best place to work and learn	Well led	80%	75.0%	50.0%	50.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	92.0%	91.7%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	93.3%	90.6%	96.2%	92.0%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.4%	90.0%	93.8%	92.3%	84.0%	79.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	96.2%	92.0%	95.8%
Bed occupancy	Best Quality	Safe	85%	75.8%	83.0%	82.2%	76.9%	85.3%	86.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	45	N/A	2366	1235	594	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	113.7%	110.7%	115.3%	110.9%	125.9%	154.0%
Safer staffing (Registered)	Best Quality	Safe	80%	100.0%	104.7%	104.1%	104.3%	104.7%	99.5%
% 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%	N/A	N/A	N/A	50.0%	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	2	2	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	5	8	*4*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	2	1	*1*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	13	8	6	25	27	26

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn Jun-25	Ryburn Jul-25	Ryburn Aug-25	Newhaven Jun-25	Newhaven Jul-25	Newhaven Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	77.8%	90.3%	96.3%	84.4%
Sickness	Best place to work and learn	Well led	5.4%	20.3%	12.8%	16.2%	13.4%	15.2%	9.5%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	89.5%	93.3%	86.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	97.0%	96.8%	96.9%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	80.0%	88.9%	88.9%	93.1%	88.9%	96.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.0%	100.0%	100.0%	79.3%	92.6%	85.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	88.9%	90.9%	90.3%	90.6%
Bed occupancy	Best Quality	Safe	85%	85.7%	87.1%	100.0%	68.1%	74.2%	74.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	2342	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	97.7%	97.6%	99.2%	124.0%	132.2%	138.2%
Safer staffing (Registered)	Best Quality	Safe	80%	96.5%	96.8%	98.4%	102.9%	104.1%	92.0%
% 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%	N/A	N/A	N/A	N/A	N/A	100.0%
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	6	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	8	11	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	1	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	0	0	26	23	24

Inpatients - Non-Mental Health

• **Appraisal rate:**
NRU rate is showing a slight decrease at 82.9% for August figures. When reviewing details at individual level, it appears some completed appraisals have not pulled through despite showing as completed on ESR; senior team to investigate further and escalate.

SRU rate has maintained compliance this month at 95.2% for August.

• **Sickness:**
NRU – sickness has continued to improve considerably from 6.8% in July to achieve compliance at 2% for August.

SRU – Sickness for August has continued to improve and has decreased from 5.2% to 4.3% to achieve compliance. The current position still includes two instances of LTS:
•1 due to anxiety - until end of October
•1 due to planned surgery - until September
Sickness absence for both units continues to be managed via HR processes and sickness reviews.

• **Supervision:**
NRU has seen further improvement in August to reach 89.5% compliance with continuing improvement into September.

SRU figures have seen a decrease in August to 71.4%. However, as of 22.9.25, the unit has increased to 82.9% for September.

• **Information Governance:**
Both wards continue to maintain compliancy for August.

• **Cardiopulmonary resuscitation (CPR):**
NRU is showing a small decrease at 76.3%. Some staff have completed the training during week commencing 8.9.25 and further staff are booked within the next 4 weeks.
To note: maternity leave cannot be excluded from training statistics and NRU currently has 3 staff on mat leave.

SRU continues to exceed the compliancy level.

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 are achieving compliance in August.

Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit Jun-25	Neuro Rehabilitation Unit Jul-25	Neuro Rehabilitation Unit Aug-25	Stroke Rehabilitation Unit Jun-25	Stroke Rehabilitation Unit Jul-25	Stroke Rehabilitation Unit Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	79.4%	78.9%	82.9%	93.5%	93.8%	95.2%
Sickness	Best place to work and learn	Well led	5.0%	10.4%	6.8%	2.0%	7.0%	5.2%	4.3%
Supervision	Best place to work and learn	Well led	80%	70.0%	81.0%	89.5%	80.5%	82.9%	71.4%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	97.6%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.7%	88.9%	76.3%	91.0%	92.5%	94.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.1%	84.2%	90.2%	92.9%	92.9%	97.1%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	66.9%	65.1%	47.3%	83.6%	90.6%	80.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	45	55	38	26	25	24
Safer staffing (Overall)	Best Quality	Safe	90%	119.2%	117.8%	102.0%	96.8%	100.3%	83.1%
Safer staffing (Registered)	Best Quality	Safe	80%	94.5%	98.6%	90.2%	120.2%	117.4%	94.7%
% 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	1	66	57	30

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, and compliance remains good.
- Mandatory training compliance remains positive, with CPR now being achieved. Training delivery continues, and mitigating actions are in place to ensure that a CPR-trained staff member is on duty at all times, maintaining safety and clinical standards
- Sickness absence has increased in month.
- In terms of patient flow, the number of service users clinically ready for discharge remains high and 3 individuals were clinically ready for discharge during the month but delayed. Identifying suitable community placements continues to be a challenge, which may impact future discharge planning and throughput.
- Risk assessment compliance has dropped during the month, this related to one admission where a risk assessment was completed but outside the 24 hour target.
- Due to the current acuity and individual needs of service users, the service has required additional staffing, reflected in the overall safer staffing and registered safer staffing figures.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	2.8%	3.0%	6.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	95.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.4%	100.0%	97.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.6%	92.1%	97.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	64.9%	76.3%	84.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	97.4%	97.5%	95.0%
Bed occupancy	Best Quality	Safe	N/A	32.1%	40.7%	43.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	114	333	27
Safer staffing (Overall)	Best Quality	Safe	90%	104.5%	115.4%	118.9%
Safer staffing (Registered)	Best Quality	Safe	80%	172.9%	170.5%	171.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	81.8%	44.6%	56.1%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	0% (0/1)
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	7	8	1
Restraint incidents	Best Quality	Safe	Trend Monitor	11	5	*4*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	21	21	10

Inpatients - Forensic South Yorkshire

Medium Secure

- Supervision is above compliance Skipton and Foss (100%).
- The transition to Trust systems for recording appraisals is ongoing as part of integration and will bring the services in line with Trustwide appraisal reporting standards.
- Sickness absence is above target for Foss (14.7%) and Skipton (6.3%). This is now being closely monitored by ward managers with support from the People Directorate.
- Safer staffing is within compliance and is reviewed by service management on a daily basis.
- Good compliance against mandatory training however CPR (66.7%) and IG (83.3%) on Foss below target. Plans in place to support completion of this training.
- Bed occupancy on Skipton (71.5%) demonstrates significant improvement comparative to 58.3% last month. Foss bed occupancy at 74.7% and in line with overall hospital admissions plan.
- There were no prone restraints.
- Risk assessment data is not currently captured as Cheswold Park Hospital do not currently complete FIRM risk assessments; this is within the improvement plan.

Low Secure

- Supervision compliance is above threshold for all low secure wards expect Don which is slightly below at 79.2%.
- The transition to Trust systems for recording appraisals is ongoing as part of integration and will bring the services in line with Trustwide appraisal reporting standards.
- Sickness absence has improved across all low secure wards, all now within current threshold. Notable improvements on Aire and Don.
- Good compliance against mandatory training is noted across all areas. Information governance compliance has remains below compliance on Aire (83.3%) and Don (76%) with plans in place to improve. Some challenges with CPR compliance are noted and have been reviewed by the service. Whilst Immediate Life Support (ILS) training is noted to be positive (100%), the challenges are noted to be with Basic Life Support (BLS). A new approach has been introduced to support BLS training and will be reviewed.
- Bed occupancy has improved across all low secure wards and only Esk (80.2%) drops slightly below the threshold. This is in line with the overall hospital admissions plan.
- There were no prone restraints.
- Risk assessment data is not currently captured as Cheswold Park Hospital do not currently complete FIRM risk assessments, this is within the improvement plan.

				Medium Secure Services					
				Foss			Skipton		
Metrics	Strategic Objective	CQC Domain	Threshold	Jun-25	Jul-25	Aug-25	Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	89.7%	93.6%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	6.4%	8.7%	14.7%	12.2%	7.3%	6.3%
Supervision	Best place to work and learn	Well led	80%	51.3%	100.0%	100.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	93.5%	83.3%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.7%	86.7%	86.7%	86.2%	86.2%	86.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.9%	67.7%	66.7%	86.2%	82.1%	71.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.1%	87.1%	83.3%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	81.0%	78.6%	74.7%	53.1%	58.3%	71.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	749	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	102.2%	113.5%	101.8%	108.2%	105.1%	163.5%
Safer staffing (Registered)	Best Quality	Safe	80%	98.3%	107.6%	109.1%	87.1%	84.1%	107.8%
% 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	1	0	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	3	0	3	2	0
Restraint incidents	Best Quality	Safe	Trend Monitor	3	7	*0*	5	8	*9*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor						

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Esk Jun-25	Jul-25	Aug-25	Wentbridge Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	73.7%	100.0%	0.0%	78.0%	95.0%	97.5%
Sickness	Best place to work and learn	Well led	5.4%	2.6%	4.6%	2.9%	7.5%	3.1%	2.0%
Supervision	Best place to work and learn	Well led	80%	86.4%	95.0%	100.0%	95.5%	92.5%	97.5%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	87.0%	95.2%	87.0%	100.0%	100.0%	97.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.0%	90.5%	91.3%	90.5%	90.5%	87.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.6%	76.2%	81.8%	61.9%	72.5%	65.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	91.3%	88.1%	85.7%	78.0%
Bed occupancy	Best Quality	Safe	90%	69.8%	76.6%	80.2%	80.0%	87.5%	91.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	4525	N/A	50	N/A	N/A	1662
Safer staffing (Overall)	Best Quality	Safe	90%	116.8%	108.5%	99.6%	150.7%	149.9%	151.1%
Safer staffing (Registered)	Best Quality	Safe	80%	92.5%	94.6%	98.8%	94.9%	100.0%	91.2%
% 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	1	0	0	0	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	3	2	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*1*	2	0	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor						

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire			Don		
				Jun-25	Jul-25	Aug-25	Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	80.6%	100.0%	N/A	68.0%	76.9%	75.0%
Sickness	Best place to work and learn	Well led	5.4%	2.2%	8.3%	2.1%	7.1%	6.1%	1.2%
Supervision	Best place to work and learn	Well led	80%	62.9%	95.0%	100.0%	48.0%	80.8%	79.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	93.9%	83.3%	88.5%	80.0%	76.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	81.3%	75.8%	70.0%	92.3%	96.0%	92.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.8%	81.8%	67.7%	76.9%	76.0%	64.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.6%	84.8%	76.7%	92.3%	92.0%	88.0%
Bed occupancy	Best Quality	Safe	90%	77.8%	76.3%	90.1%	95.3%	97.0%	91.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	1077	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.2%	91.9%	88.8%	132.6%	122.8%	132.0%
Safer staffing (Registered)	Best Quality	Safe	80%	90.7%	89.8%	85.4%	102.3%	94.3%	100.0%
% 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	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	1		0	0	
Restraint incidents	Best Quality	Safe	Trend Monitor	3	1	*0*	2	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor						

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Calder Jun-25	Jul-25	Aug-25
Appraisal rate	Best place to work and learn	Well led	June 89% July onwards 90%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	4.4%	3.8%	3.4%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	95.7%	95.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	95.8%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	79.4%	93.8%	95.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	840
Safer staffing (Overall)	Best Quality	Safe	90%	107.1%	106.4%	92.2%
Safer staffing (Registered)	Best Quality	Safe	80%	81.3%	84.7%	68.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor			

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	(£1.7m)	£0m	The financial performance for August 2025 is a surplus of £367k which is £0.8m better than plan. This is the first month in 2025 / 26 where a surplus has been achieved. This is through a combination of staffing numbers and the payment of the pay award being less than originally estimated. The year-to-date position is a deficit of £1.7m which is now £0.7m favourable to plan.
2	Agency Spend	Best Value	Well Led	£1.7m	£3.3m	Agency spend remains within planned levels primarily due to a reduction in medical agency spend in month. The forecast modelling, supported by individual exit plan, supports a continued reduction of the expenditure run rate.
3	Bank Spend	Best Value	Well Led	£10.1m	£21.2m	Trust bank expenditure has continued to increase . The forecast remains that the target will be breached. Usage, and the operational reasons, continue to be monitored weekly through the Trust temporary staffing management group.
4	Corporate Spend	Best Value	Well Led	£27.2m	£67.6m	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, as per the Trust reporting hierarchy, with the RAG rating as a comparison against plan following agreed budgetary reductions. In a continuation of the run rate August spend is £0.4m less than planned.
5	Financial sustainability and efficiencies	Best Value	Well Led	£7.6m	£28.2m	Value for money schemes have performed better than plan in August which has helped to reduce the year to date shortfall from £0.7m to £0.6m. Additional non-recurrent mitigations have been identified which has reduced the value of red rated schemes. As valid schemes these continue to provide additional opportunities in future periods.
6	Cash	Best Value	Well Led	£60.1m	£52.7m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position. The position is forecast to reduce in future months due to the timing of capital expenditure.
7	Capital Spend	Best Value	Well Led	£1.2m	£19.3m	Capital spend is behind plan for the year to date and work continues on the major older people scheme. This has impacted on the overall spend profile and as such other schemes are being brought forward to ensure that the allocation is appropriately utilised.
8	Better Payment Practice Code	Best Value	Well Led	97%		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

	Objective	CQC Domain	Trust Threshold	Jun-25	Jul-25	Aug-25
Mandatory Training - TOTAL	Improving Care		>=80%	96.0%	96.0%	94.0%
Mandatory Training - Reducing Restrictive Practice Interventions				86.3%	85.3%	85.6%
Mandatory Training - Cardiopulmonary Resuscitation				79.4%	76.9%	75.5%
Mandatory Training - Clinical Risk				N/A	N/A	N/A
Mandatory Training - Display Screen Equipment				N/A	N/A	N/A
Mandatory Training - Equality & Diversity				99.3%	98.6%	97.9%
Mandatory Training - Fire Safety			>=85%	95.2%	92.6%	86.9%
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				95.0%	94.5%	90.6%
Mandatory Training - Information Governance (Data Security)			>=95%	96.2%	94.0%	89.8%
Mandatory Training - Moving & Handling			>=80%	95.2%	92.6%	86.9%
Mandatory Training - Mental Capacity Act/Dols				93.7%	94.7%	90.7%
Mandatory Training - Mental Health Act				93.7%	94.7%	90.7%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				99.0%	98.9%	98.9%
Mandatory Training - Prevent			>=80%	N/A	N/A	N/A
Mandatory Training - Safeguarding Adults				93.8%	92.5%	86.4%
Mandatory Training - Safeguarding Children				93.8%	92.5%	86.4%

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 5 (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)**	(£1.7m)	£0m	The financial performance for August 2025 is a surplus of £367k which is £791k better than plan. This is the first month in 2025 / 26 where a surplus has been achieved. This is through a combination of staff worked less than planned and the payment of the pay award being less than estimated.
2	**Agency Spend**	£1.7m	£3.3m	Agency spend in August is £281k. This remains within planned levels primarily due to a reduction in medical agency spend in month. The forecast modelling, supported by individual exit plan, supports a continued reduction of the expenditure run rate.
3	**Bank Spend**	£10.1m	£21.2m	Bank usage, primarily for unregistered nurses, has continued to increase and the forecast remains that the target will be breached. Usage, and the operational reasons, continue to be monitored weekly through the Trust temporary staffing management group.
4	**Corporate Spend**	£27.2m	£67.6m	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, as per the Trust reporting hierarchy, with the RAG rating as a comparison against plan following agreed budgetary reductions. In a continuation of the run rate August spend is £0.4m less than planned.
5	**Financial sustainability and efficiencies**	£7.6m	£28.2m	Value for money schemes have performed better than plan in August which has helped to reduce the year to date shortfall from £0.7m to £0.6m. Additional non-recurrent mitigations have been identified which has reduced the value of red rated schemes. As valid schemes these continue to provide additional opportunities in future periods.
6	**Cash**	£60.1m	£52.7m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position. The position is forecast to reduce in future months due to the timing of capital expenditure.
7	**Capital**	£1.2m	£19.3m	Spend on capital and leases is less than planned for the year to date. Leases annual revaluations have been actioned, but are less than planned, whilst work continues on the Older People Scheme. The forecast position, still assuming full utilisation of the various allocations. As such some schemes have been brought forward from future years.
8	**Better Payment Practice Code**	97%		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.

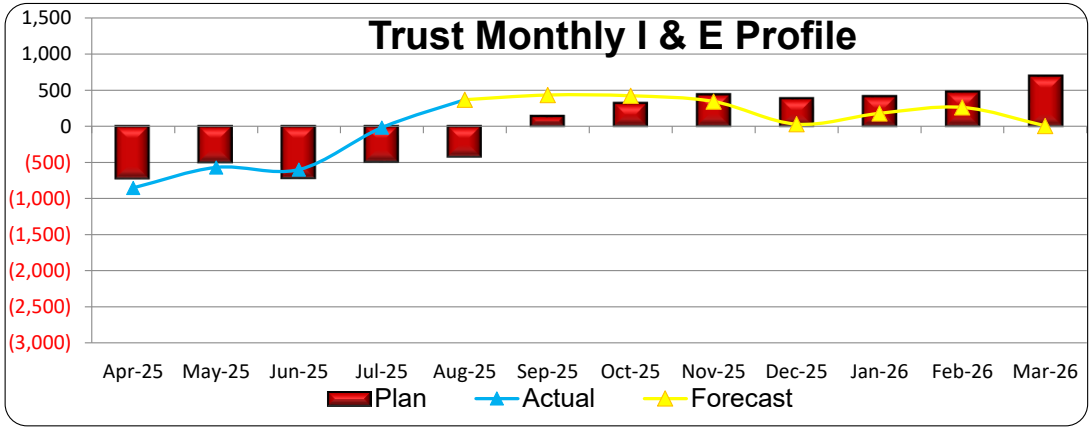
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

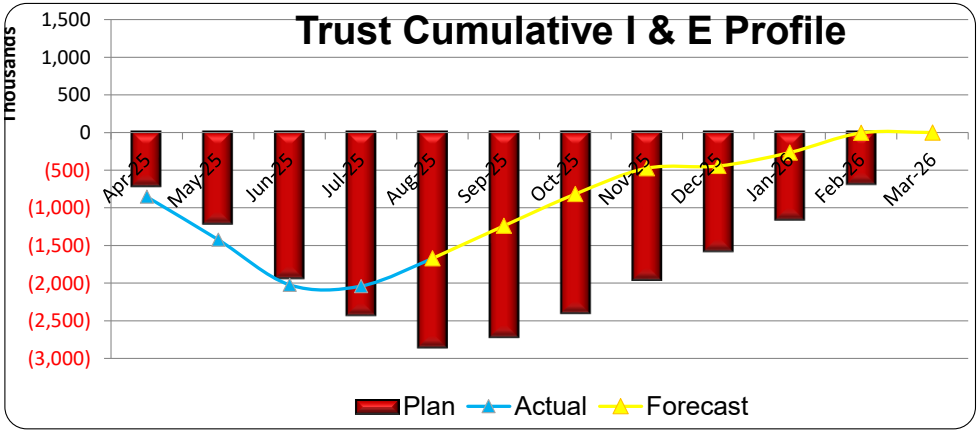
2.0 Income & Expenditure Position 2025 / 26

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					37,888	38,092	204	188,934	189,216	282	455,890	456,629	739
Other Operating Revenue					1,326	1,369	43	6,381	6,638	257	15,498	15,878	380
Total Revenue					**39,214**	**39,461**	**247**	**195,315**	**195,854**	**539**	**471,388**	**472,507**	**1,119**
Pay Costs	5,398	5,330	(68)	1.3%	(25,211)	(24,302)	909	(125,316)	(123,872)	1,444	(300,822)	(297,088)	3,734
Non Pay Costs					(13,615)	(14,008)	(393)	(68,805)	(69,712)	(906)	(160,662)	(165,236)	(4,574)
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	**5,398**	**5,330**	**(68)**	**-1.3%**	**(38,826)**	**(38,310)**	**516**	**(194,122)**	**(193,583)**	**538**	**(461,484)**	**(462,324)**	**(840)**
EBITDA	**5,398**	**5,330**	**(68)**	**-1.3%**	**388**	**1,151**	**763**	**1,194**	**2,271**	**1,077**	**9,904**	**10,183**	**279**
Depreciation					(615)	(659)	(45)	(3,067)	(3,302)	(235)	(7,447)	(8,368)	(921)
PDC Paid					(378)	(382)	(4)	(1,889)	(1,910)	(21)	(4,534)	(4,584)	(50)
Interest Received					181	258	77	917	1,269	351	2,077	2,769	692
Surplus / (Deficit) - ICB performance measure	**5,398**	**5,330**	**(68)**	**-1.3%**	**(423)**	**367**	**791**	**(2,845)**	**(1,672)**	**1,173**	**0**	**0**	**0**
Depn Peppercorn Leases (IFRS16)					(9)	(5)	4	(44)	(25)	18	(94)	(61)	33
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,398**	**5,330**	**(68)**	**-1.3%**	**(432)**	**362**	**794**	**(2,889)**	**(1,698)**	**1,191**	**(94)**	**(61)**	**33**





Income & Expenditure Position 2025 / 26

The Trust surplus in August 2025 is £367k.
This is £791k better than plan.

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. Financial performance 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)	5,375	5,305	(70)	1.3%	(754)	349	1,103	(3,798)	(1,525)	2,273	(7,232)	(4,448)	2,784
Provider Collaboratives	23	25	2	7.6%	2	(1)	(3)	11	(255)	(266)	26	(96)	(122)
Budgets held centrally	0	0	0	0.0%	329	19	(310)	942	107	(835)	7,206	4,544	(2,662)
Total - Consolidated position (ICB performance measure)	**5,398**	**5,330**	**(68)**	**-1.3%**	**(423)**	**367**	**791**	**(2,845)**	**(1,672)**	**1,173**	**0**	**0**	**0**

August 2025 is the second consecutive month where the core Trust has reported a surplus. This was £14k in July increasing to £349k in August and is a continuation of an improving run rate in previous months. In turn this reduces the year to date deficit position. The improvements seen, as described later in this report, have supported an improvement in the baseline forecast deficit; reducing from £5,603k to £4,448k (a £1,155k improvement).

This does remain a deficit and therefore needs to be considered in conjunction with budgets held centrally. These are primarily the targets for value for money which need to be realised and, where possible, allocated into the core Trust. Due to the nature of actions included within the Trust forecast scenario modelling this will not be possible for all especially those which are non-recurrent in nature. The implications of this are considered within the Trust underlying financial position.

Provider collaboratives are in line with plan in month and are forecast to maintain for the remainder of the financial year. As confirmed in other reporting these areas remain volatile; small changes in activity can result in significant financial changes and will continue to be monitored.

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.

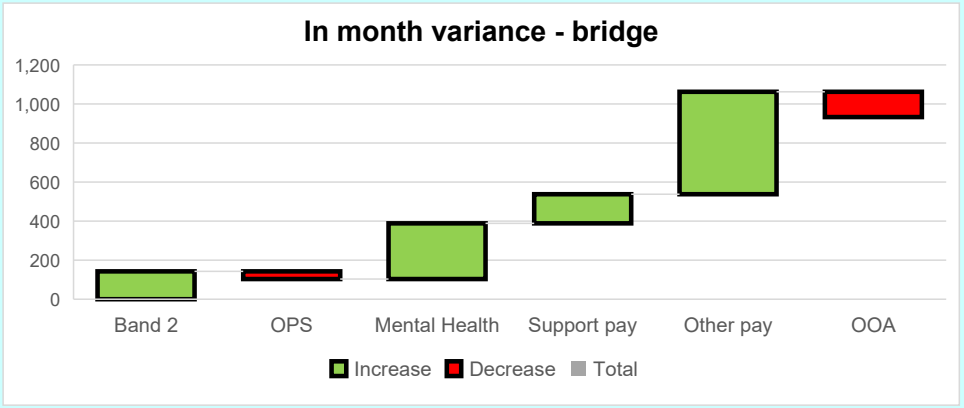
Total Financial Position - Core Trust only

	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					28,548	28,488	(60)	142,520	142,552	32	344,097	343,839	(258)
Other Operating Revenue					1,246	1,269	23	5,983	6,213	230	14,543	14,915	372
Total Revenue					**29,794**	**29,758**	**(37)**	**148,503**	**148,765**	**262**	**358,640**	**358,753**	**114**
Pay Costs	5,375	5,305	(70)	1.3%	(24,983)	(24,150)	833	(124,175)	(123,142)	1,033	(298,084)	(295,373)	2,712
Non Pay Costs					(4,754)	(4,475)	279	(24,087)	(23,205)	882	(57,883)	(57,646)	237
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	**5,375**	**5,305**	**(70)**	**-1.3%**	**(29,737)**	**(28,625)**	**1,113**	**(148,262)**	**(146,347)**	**1,915**	**(355,967)**	**(353,019)**	**2,949**
EBITDA	**5,375**	**5,305**	**(70)**	**-1.3%**	**57**	**1,133**	**1,076**	**241**	**2,418**	**2,177**	**2,672**	**5,735**	**3,063**
Depreciation					(615)	(659)	(45)	(3,067)	(3,302)	(235)	(7,447)	(8,368)	(921)
PDC Paid					(378)	(382)	(4)	(1,889)	(1,910)	(21)	(4,534)	(4,584)	(50)
Interest Received					181	258	77	917	1,269	351	2,077	2,769	692
Surplus / (Deficit) - ICB performance measure	**5,375**	**5,305**	**(70)**	**-1.3%**	**(754)**	**349**	**1,103**	**(3,798)**	**(1,525)**	**2,273**	**(7,232)**	**(4,448)**	**2,784**
Depn Peppercorn Leases (IFRS16)					(9)	(5)	4	(44)	(25)	18	(94)	(61)	33
Losses Peppercorn Leases (IFRS16)					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**5,375**	**5,305**	**(70)**	**-1.3%**	**(763)**	**344**	**1,107**	**(3,841)**	**(1,550)**	**2,291**	**(7,326)**	**(4,509)**	**2,817**

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
Agenda for Change pay award accrual - Band 2	142
Staffing - greater than plan. Older People Inpatient (Barn & Wake)	(40)
Staffing - Mental health care group. Largest underspend	285
Staffing - Support. Majority of service lines spending less than plan	149
Staffing - most care groups underspend against pay in month.	525
Out of area placements higher than planned	(129)

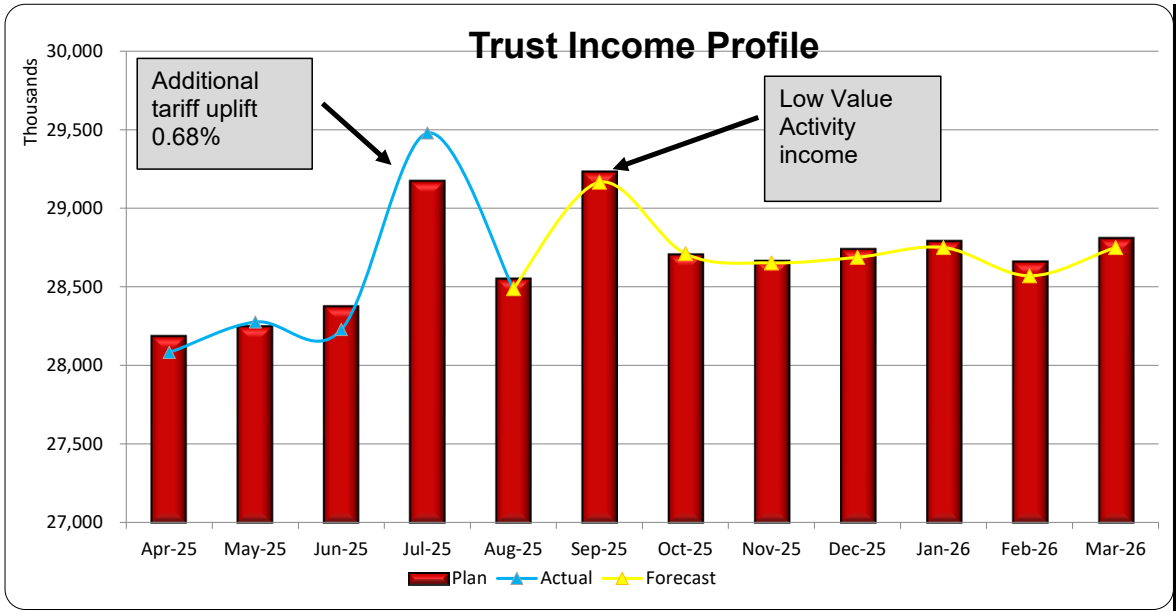


2.1 Income Information

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	22,849	23,546	22,847	23,580	22,979	22,979	22,979	22,979	22,979	22,980	**276,060**	276,094	(33)
Specialist Commissioner	36,788	4,697	4,723	4,666	4,861	4,956	4,790	4,928	4,877	4,928	4,990	4,833	4,990	**58,240**	57,587	653
Local Authority	5,141	318	465	314	680	303	417	417	417	395	395	395	395	**4,912**	5,250	(339)
Partnerships	2,940	248	251	243	251	233	226	233	226	233	233	211	233	**2,821**	3,099	(278)
Other Contract Income	1,583	127	168	155	141	149	152	152	152	152	152	152	152	**1,806**	2,066	(261)
Total	**312,292**	**28,082**	**28,276**	**28,227**	**29,479**	**28,488**	**29,166**	**28,710**	**28,652**	**28,688**	**28,750**	**28,570**	**28,750**	**343,839**	**344,097**	**(258)**
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	9,196	9,452	9,604	9,761	9,396	9,393	9,396	9,396	9,387	9,396	**112,790**		
Total	**312,292**	**37,286**	**37,484**	**37,424**	**38,930**	**38,092**	**38,927**	**38,107**	**38,046**	**38,084**	**38,147**	**37,957**	**38,147**	**456,629**		



As highlighted last month income, and expenditure, have been updated to reflect the impact of the additional tariff uplift. This has been included in signed contracts with commissioners for 2025 / 26.

Income is forecast to increase next month with the receipt of low value activity income for the year. This is a key movement towards delivering the breakeven target.

The forecast variance is primarily due to :

	Forecast
* Additional roles reimbursement	£247k

Recharge of salary based on staff in post

* Local Authority - Yorkshire Smokefree	£339k

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

2.2 Pay Information

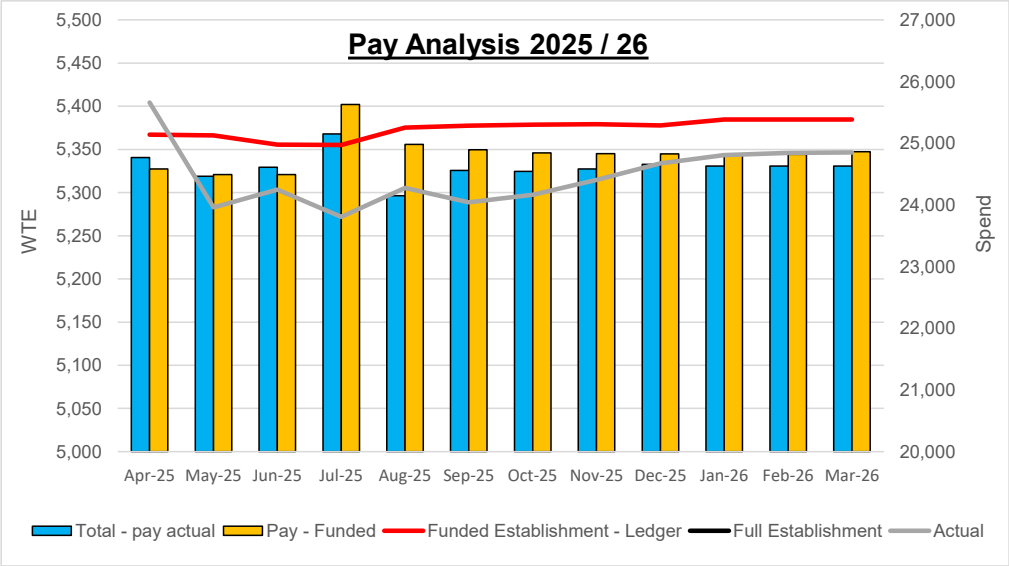
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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	22,290	22,734	21,955	22,558	22,704	22,795	22,863	22,842	22,861	22,867	**270,851**
Bank & Locum	2,216	1,926	1,964	2,057	1,913	1,719	1,605	1,575	1,575	1,571	1,558	1,540	**21,218**
Agency	352	355	356	361	281	281	233	212	219	217	213	221	**3,303**
Total	**24,768**	**24,463**	**24,610**	**25,151**	**24,150**	**24,558**	**24,542**	**24,583**	**24,657**	**24,630**	**24,632**	**24,629**	**295,373**
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%	8.0%	8.2%	7.9%	7.0%	6.5%	6.4%	6.4%	6.4%	6.3%	6.3%	7.2%
Agency as % (in month)	1.4%	1.5%	1.4%	1.4%	1.2%	1.1%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	1.1%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,837	4,809	4,810	4,785	4,783	4,869	4,907	4,931	4,949	4,959	4,964	4,968	**4,881**
Bank & Locum	528	443	452	452	487	388	365	361	361	360	358	355	**409**
Agency	39	31	42	35	35	32	26	23	24	24	24	24	**30**
Total	**5,404**	**5,283**	**5,303**	**5,272**	**5,305**	**5,289**	**5,297**	**5,315**	**5,334**	**5,343**	**5,346**	**5,346**	**5,320**
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**



Pay awards, with arrears to April 2025, have been paid in August. This was lower than previously estimated. The largest variance was on band 2 staff where uplifts were actually paid from April to ensure that all staff were above the higher national minimum wage rates. As such the uplift percentage in August was lower with no arrears. This has been updated into forecast position.

Although only a reduction of 2 worked WTE substantive staff has continued to follow the reducing trend of previous months. This is forecast to increase, and support the forecast reduction in bank staff, as conversion of posts are realised.

In month bank staff has increased by 35. This is highest month in year with the exception of April (which is traditionally high due to year end actions).

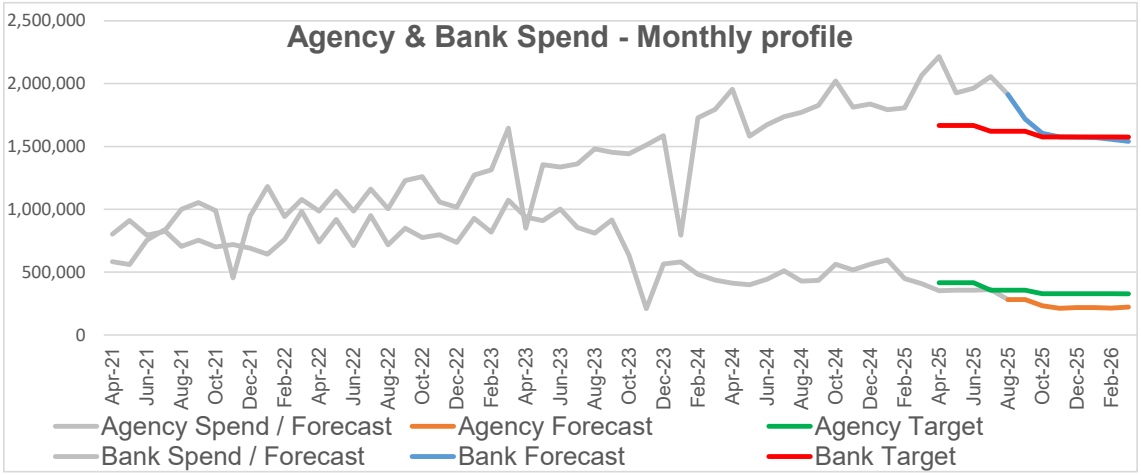
The operational impact of this continues to be understood within the Trust including weekly insight through the Trust Temporary Staffing Scrutiny and Management group.

2.2 Temporary Staffing Focus

Trust spend in August 2025:
Agency £281k
Bank £1,913k

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 solely agency staff to total temporary staffing costs especially those which are paid a premium rate when compared 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	805	283	**1,088**
Other Medical	480	190	**670**
Reg Nursing	34	2,467	**2,501**
UnReg Nursing	287	6,436	**6,723**
Other Clinical	98	298	**396**
A & C	2	401	**404**
Other	0	0	**0**
Total	**1,706**	**10,076**	**11,782**
Lead Provider Collaborative	25	2	**28**
Budgets held centrally		11	**11**
Total	**1,732**	**10,089**	**11,821**

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 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 and as overall key financial performance indicators (KPI). These are considered as absolute values and not in the context of other pay expenditure movements.

Agency spend continues to be under plan for the year to date with spend in August reducing to £281k. This is primarily due to reductions medical agency spend. Individual exit plans have been updated and this supports the continued forecast reductions in future months. Decisions and actions previously taken continue to be in place and relevant. As such there is compliance with national guidance and spend is limited to medical and nursing staff in August.

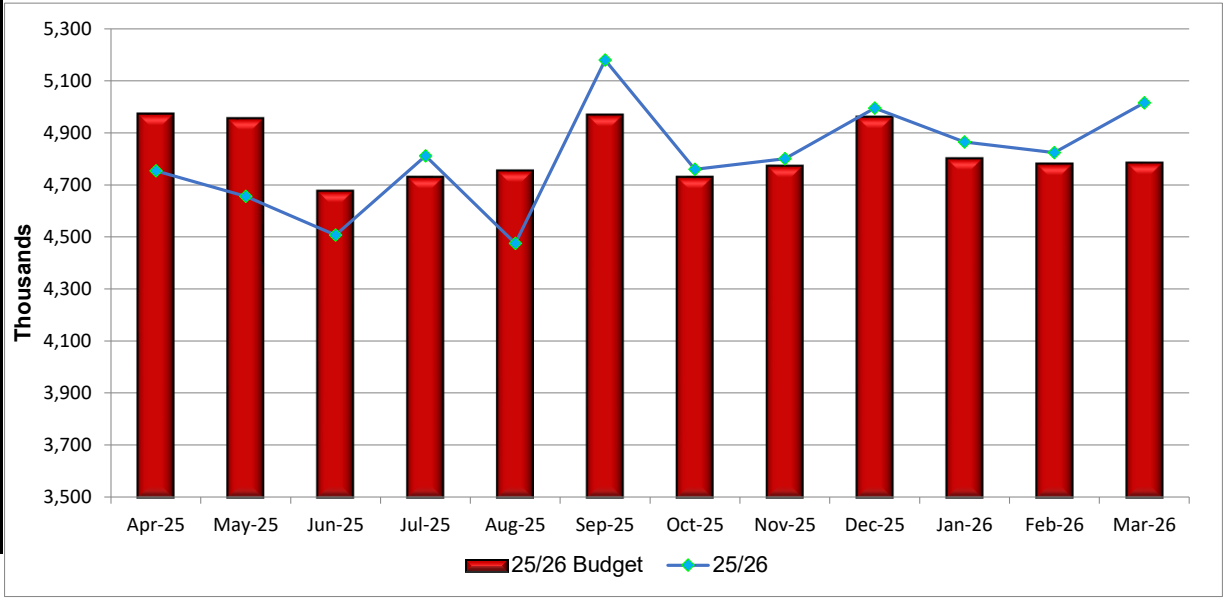
As per the standard operating procedure bank usage is the first option to meet operational requirements. Although spend has reduced (see previous comments on the impact of actual agenda for change pay award) usage has increased from 452 worked WTE to 487 WTE. The operational requirements are scrutinised in detail with an improved, clear understanding at a detailed level through the Trust Temporary Staffing Group. This is forecast to reduce, to a level broadly in line with the plan run rate, for the remainder of the year.

2.3 Non Pay Expenditure

Whilst pay expenditure is the majority of Trust costs, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the care groups and corporate services, and excludes capital charges (depreciation and PDC) which are shown separately in the Trust Income and Expenditure position. To re-confirm that this also excludes expenditure relating to the provider collaboratives 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	4,507	4,812	4,475	5,180	4,760	4,801	4,995	4,865	4,824	5,016	**57,646**
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	1,877	1,850	(27)
Establishment	4,087	3,812	(274)
Lease & Property Rental	3,741	3,567	(174)
Premises (inc. rates)	2,274	2,301	27
Utilities	1,143	1,178	36
Purchase of Healthcare	2,739	2,937	198
Travel & vehicles	2,760	2,602	(158)
Supplies & Services	3,758	3,616	(142)
Training & Education	381	254	(127)
Clinical Negligence & Insurance	731	604	(127)
Other non pay	597	483	(114)
Total	**24,087**	**23,205**	**(882)**
Total Excl OOA and Drugs	**19,471**	**18,418**	**(1,053)**



Key Messages

Non pay expenditure, excluding provider collaboratives and budgets held centrally, has returned to a run rate in line with the rest of the year. As reported in July 2025 the increased expenditure primarily related to the timing of computer equipment replacement programme purchases (was planned but later than originally intended). As such expenditure is less than planned in month.

The largest overspend relates to the purchase of healthcare which has increased to £198k, from £106k, overspent for the year to date. Out of area placements (both acute and PICU) have remained higher than plan and are reflective of the operational pressures being experienced in order to meet the demand for our inpatient services. Whilst this is a relatively low variance to plan, especially when considering historical levels of spend, this does remain a financial pressure which requires mitigation. Potential changes in activity are included within the Trust forecast scenario modelling.

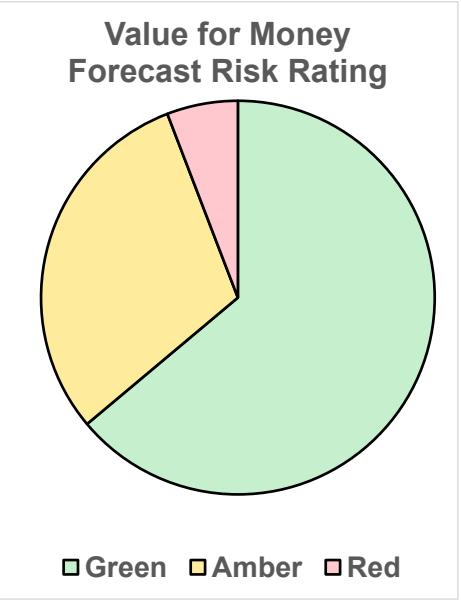
Other non pay costs are currently being managed within budgets and this will continue to be monitored.

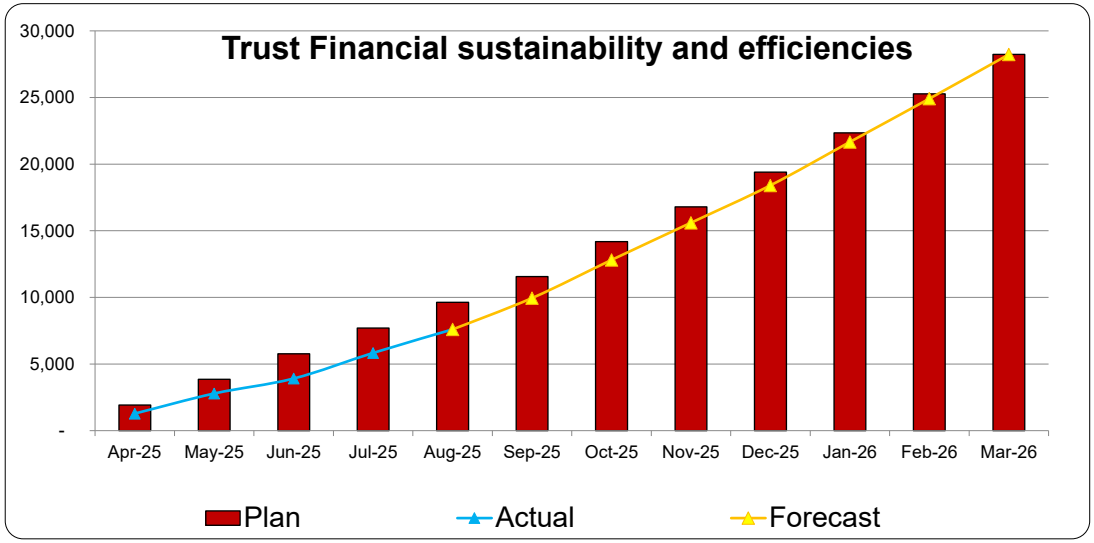
3.0 Value for Money & Financial sustainability

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	Original Target £k	Adjust £k	Revised Target £k	Green £k	Amber £k	Red £k	Variance £k
Pay	Workforce	3,146	0	3,148	2	10,500	0	10,500	3,148	7,230		(122)
	Unallocated	0	0		(0)	3,400	(3,400)	0			0	(0)
	Fixed Term Contracts	210	41		(169)	500	0	500	362			(138)
	Corp / non clinical	665	819	657	811	2,000	1,000	3,000	2,703			(297)
	Productivity	0	0		0	1,100	0	1,100	0		646	(454)
	Temporary Staffing	1,625	745		(880)	3,900	0	3,900	2,795	0		(1,105)
	Difficult Decisions	0	0		0	1,000	0	1,000	0		1,000	0
Non Pay	Non Pay	425	286		(139)	1,130	0	1,130	267	796		(67)
Other	Corporate Services	710	725		15	1,700	0	1,700	1,745			45
	Provider Collaboratives	625	885		260	1,500	0	1,500	2,121			621
	Bed Sales	0	0		0	500	0	500	500			0
	Income	294	294		0	0	705	705	705			0
	Misc income - overage	520		0	(520)	0	520	520		520		0
	Technical	0		0	0	1,000	1,175	2,175	3,692			1,517
Total		**8,220**	**3,795**	**3,805**	**(621)**	**28,230**	**0**	**28,230**	**18,038**	**8,546**	**1,646**	**0**
Recurrent		4,429	3,795		(634)	16,430	(2,695)	14,735	13,347	8,026	1,646	8,284
Non Recurrent		3,791		3,805	14	11,800	2,695	13,495	4,691	520	0	(8,284)





The Trust value for money plan, as submitted in April 2025, included £3.4m high risk / unallocated. By month 3 (June 2025) schemes have progressed, and this value has been allocated, meaning that there is no unallocated value within the Trust programme. An adjustment column has been added to the table above to show these reallocations.

The original plan profile has been retained for consistency of reporting with external returns.

At August 2025 there are 2 schemes which are RAG rated as red. These relate to productivity and loss making services. Progress continues on both but it is unlikely they will deliver their full planned savings in year. In August this value has reduced as other mitigations, albeit non-recurrent, have been identified.

The implications of this, and potential timing changes into 2025 / 26, are considered as part of the Trust annual planning and underlying financial position work.

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	191,828	
Current Assets			
Inventories & Work in Progress	248	248	
NHS Trade Receivables (Debtors)	2,453	147	
Non NHS Trade Receivables (Debtors)	989	753	
Prepayments	2,863	5,431	1
Accrued Income	6,235	6,579	2
Cash and Cash Equivalents	55,748	60,064	Pg 15
Total Current Assets	**68,537**	**73,223**	
Current Liabilities			
Trade Payables (Creditors)	(10,899)	(3,754)	3
Capital Payables (Creditors)	(1,551)	(1,275)	
Tax, NI, Pension Payables, PDC	(9,478)	(11,675)	
Accruals	(14,054)	(15,591)	4
Deferred Income	(644)	(3,764)	5
Other Liabilities (IFRS 16 / leases)	(48,793)	(50,238)	
Total Current Liabilities	**(85,419)**	**(86,297)**	
Net Current Assets/Liabilities	**(16,882)**	**(13,075)**	
Total Assets less Current Liabilities	**180,552**	**178,753**	
Provisions for Liabilities	(3,357)	(3,281)	
Total Net Assets/(Liabilities)	**177,195**	**175,472**	
Taxpayers' Equity			
Public Dividend Capital	76,344	76,344	
Revaluation Reserve	21,306	14,152	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	74,325	79,755	
Total Taxpayers' Equity	**177,195**	**175,472**	

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 has increased by £1m since last month, £3m of the balance relates to monies agreed with NHS England in relation to Cheswold. Discussions continues to realise payment of these values.

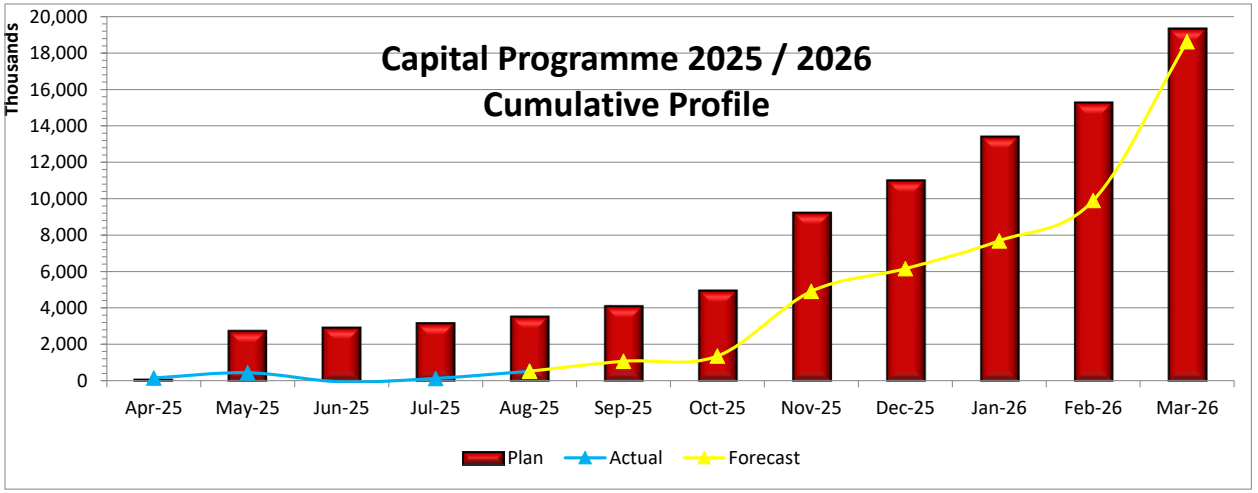
3. As is normal Trade creditors were exceptionally high at year end and have now reduced. As demonstrated by the continued positive better payment practice code performance, we continue to pay suppliers promptly. Aged creditors are reviewed and actively targeted for resolution.

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, the largest element is the timing of education training funding from NHS England (£1.0m) and £0.6m in relation to the Research and Development capital scheme and £0.5m in relation to low value activity income.

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	800	209	(591)	7,425	3,825	(3,600)
Estates safety	0	0	0	675	675	0
Backlog Maintenance	0	22	22	0	1,523	1,523
Equipment	0	0	0	0	45	45
Vehicles	0	0	0	0	36	36
IM & T	0	396	396	0	1,139	1,139
Other	0	217	217	0	1,347	1,347
Leases (IFRS 16)	2,706	317	(2,389)	6,148	4,158	(1,990)
TOTALS	**3,506**	**1,161**	**(2,345)**	**14,248**	**12,748**	**(1,500)**
Additional allocations						
Net Zero (solar funding)	0	0	0	1,952	1,952	0
Cheswold - seclusion room	0	4	4	1,000	2,000	1,000
Cheswold - Minor Capital	0	0	0	2,082	2,582	500
Cheswold - IM & T	0	0	0			0
TOTALS	**3,506**	**1,165**	**(2,341)**	**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 are included within the single allocation value and are being managed as such.

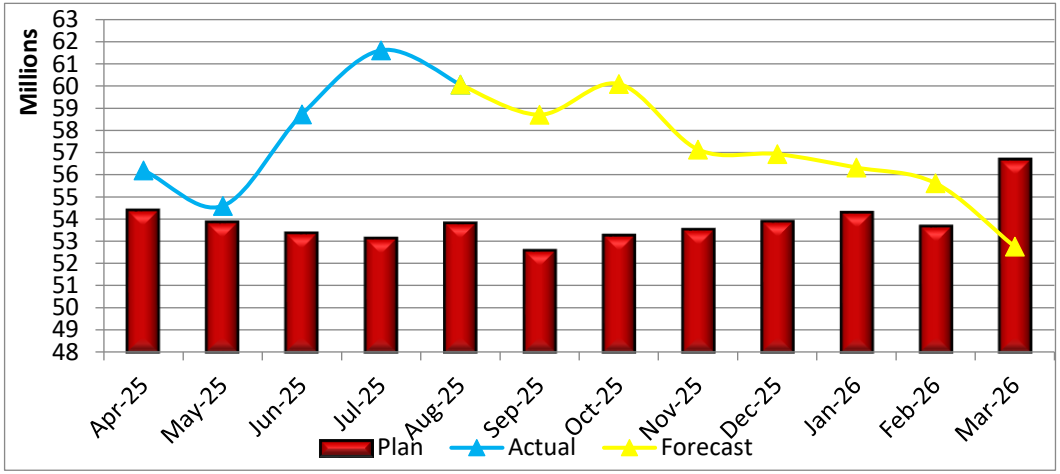
There has been minimal spend to date. For leases the annual revaluations have been completed but were less than planned.

Development, with the Trust construction partner, continues for the Older People Transformation programme. The expenditure profile was updated in July and this continues to be validated.

This change facilitates other schemes within the Trust Estates Strategy to be brought forward and this will be reviewed to ensure that the allocation is fully utilised in year.

The impact of these changes are included into the longer term capital plan.

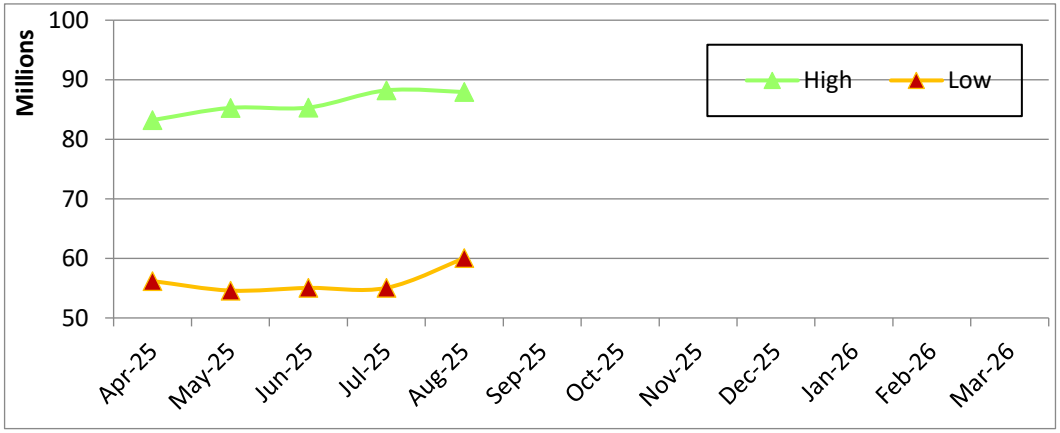
4.2 Cash Flow & Cash Flow Forecast 2025 / 2026



Cash remains above plan

There is a focus on cash nationally and within the Integrated care system. To support this guidance and instructions on working capital management, and the reporting on cash, are being re-reviewed.

	Plan £k	Actual £k	Variance £k
Opening Balance	55,839	55,839	
Closing Balance	53,814	60,064	6,249



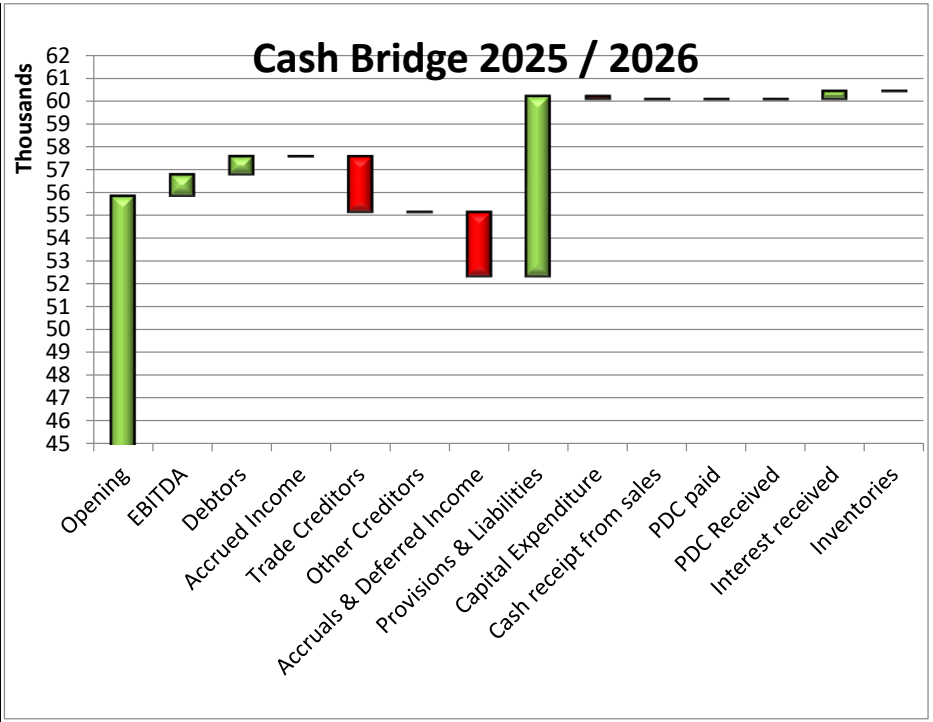
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £87.9m
The lowest balance is: £60.1m

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)	5,015	5,951	936	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	1,550	2,355	805	
Trade Payables (Creditors)	250	(2,194)	(2,444)	
Accruals & Deferred income	0	(2,816)	(2,816)	
Provisions & Liabilities	(4,850)	3,037	7,887	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(1,000)	(1,124)	(124)	
Cash receipts from asset sales	0	0	0	
Leases	(3,906)	(2,253)	1,653	
PDC Dividends paid	0	0	0	
PDC Dividends received	0	0	0	
Interest (paid)/ received	917	1,269	351	
Closing Balances	**53,814**	**60,064**	**6,249**	



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.

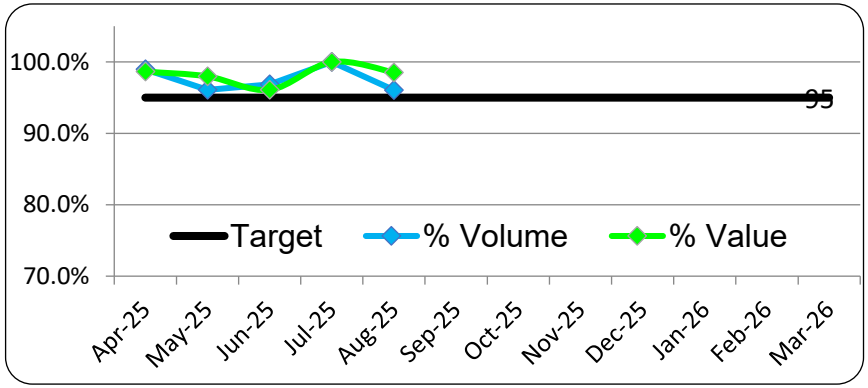
5.0 Better Payment Practice Code

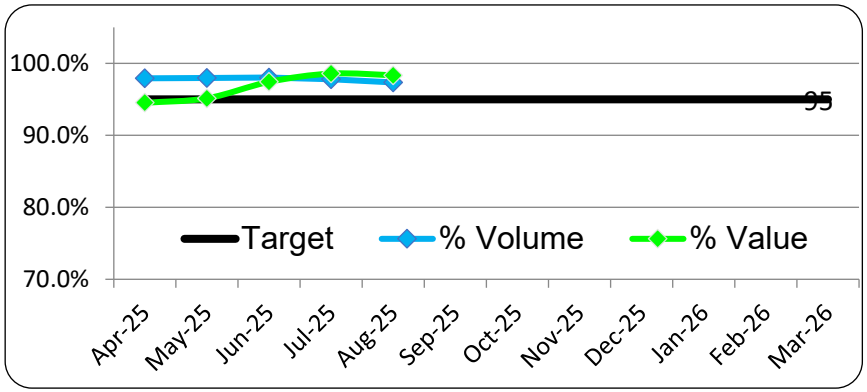
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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%	99%
Cumulative Year to Date	98%	98%

Non NHS	Number %	Value %
In Month	97%	98%
Cumulative Year to Date	98%	96%





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5.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000 (including VAT where applicable).

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
12-Aug-25	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000059249	734,353
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004939	717,325
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004940	717,325
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004941	717,325
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004942	717,325
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004962	717,325
21-Aug-25	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710181964	408,526
21-Aug-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS61	400,000
04-Aug-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010341	377,540
28-Aug-25	Purchase of Healthcare	AS Collaborative	Oxford Health NHS Foundation Trust	A0133839	362,659
21-Aug-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000001804	341,793
06-Aug-25	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400003335	246,499
21-Aug-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS38	240,000
05-Aug-25	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 302	226,385
21-Aug-25	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600037562	168,614
27-Aug-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34042980	120,000
20-Aug-25	NHS Recharge	Barnsley	Mid Yorkshire Hospitals NHS Trust	1600037617	119,921
01-Aug-25	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010338	110,541
20-Aug-25	IT Services	Trustwide	Wavenet Ltd	1378852	108,300
11-Aug-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS059SN	100,552
19-Aug-25	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	330393	76,226
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004934	69,872
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004935	69,872
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004936	69,872
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004937	69,872
06-Aug-25	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1004938	69,872
29-Aug-25	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710181965	69,669
08-Aug-25	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34042399	62,491
29-Aug-25	Purchase of Healthcare	Trustwide	Cygnet Behavioural Health Ltd	KHS0420255	58,404
20-Aug-25	Drugs	Trustwide	NHS Business Services Authority	1000085407	55,494

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
11-Aug-25	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS059INV	55,150
21-Aug-25	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600037562	50,169
21-Aug-25	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000001806	49,819
15-Aug-25	Utilities	Trustwide	Edf Energy Customers Ltd	000024500785	41,124
21-Aug-25	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600037562	36,774
08-Aug-25	Purchase of Healthcare	Trustwide	Cygnet Behavioural Health Ltd	APL0419771	35,961
20-Aug-25	Purchase of Healthcare	Trustwide	Caireach Ltd	WDH0418871	33,185
08-Aug-25	Purchase of Healthcare	Trustwide	Cygnet Behavioural Health Ltd	KHS0420274	32,860
20-Aug-25	Purchase of Healthcare	Trustwide	Cygnet Behavioural Health Ltd	APL0419758	32,860
21-Aug-25	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600037562	31,536
06-Aug-25	Drugs	Doncaster	Speeds Healthcare Ltd	INV162046	27,895
08-Aug-25	Purchase of Healthcare	AS Collaborative	Oxford Health NHS Foundation Trust	A0133699	27,172
07-Aug-25	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72490335	26,170
27-Aug-25	Interpretation	Trustwide	Word360 Ltd	130489	25,679
06-Aug-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90154059	25,019
06-Aug-25	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	90154061	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

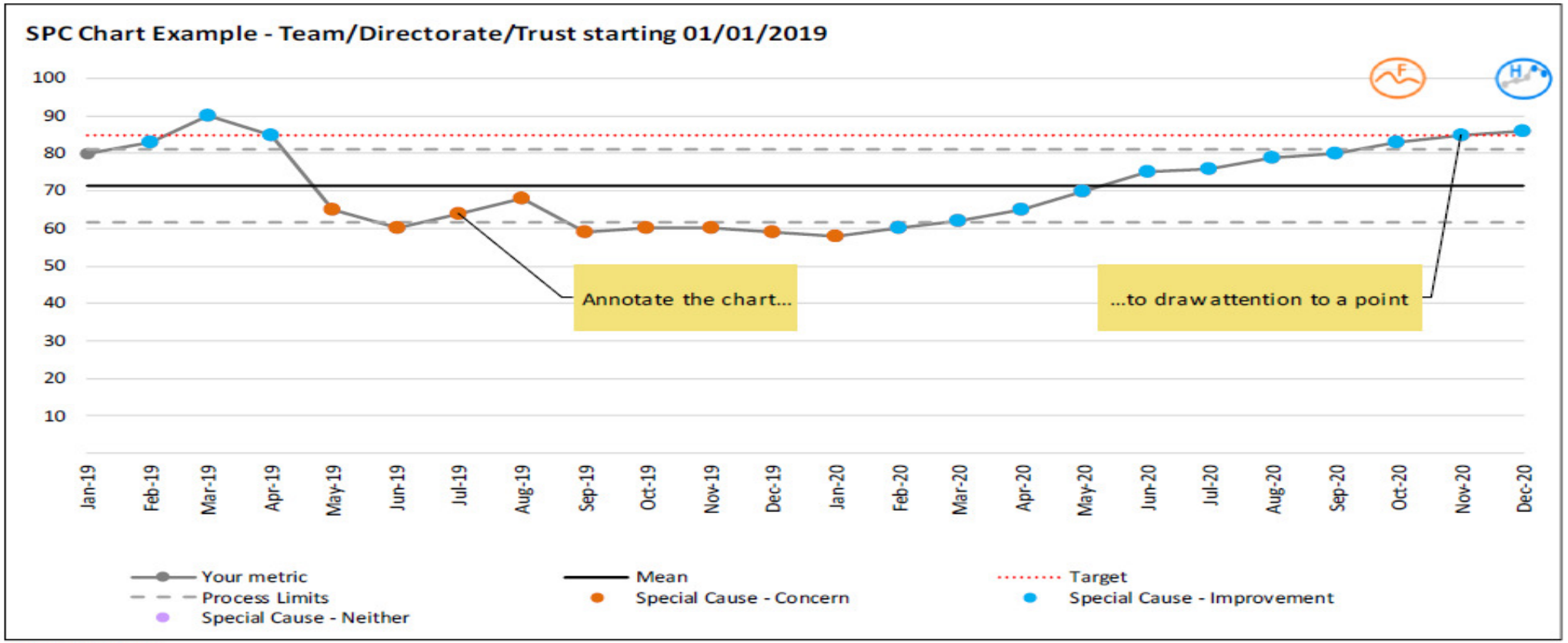
natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data which are unlikely to have occurred due to chance and require investigation. They can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting 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 base 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 thi is by design (I) and consider whether the target is still appropriate should be stretched, or whether resource can b directed elsewhere without risking the ongoing achievement o 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.