South West Yorkshire Partnership Teaching
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

March 2026

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 March 2026.

The report format for 2025/26 aligns 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.

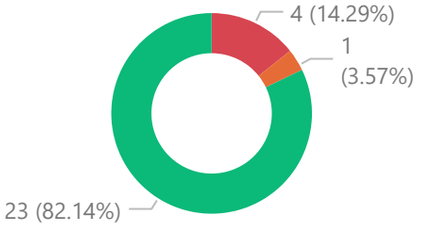
An exercise has been undertaken to review all metrics and thresholds to ensure they meet the requirements and priorities for 2025/26, the report has been updated to reflect this. In particular, the national metrics section includes those contained within the NHS oversight framework, operational planning guidance for 2025/26 and NHS standard contract items. This exercise will be undertaken for reporting from 2026/27.
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. Since this time, 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 March 2026 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 deployment of the Trusts Equality, diversity, and inclusion strategy.

Our Integrated Performance Report is publicly available on the internet.

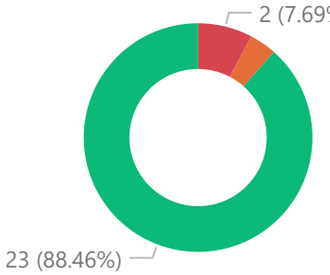
Headlines - Performance Rates Summary

This section of the IPR shows a very high-level overview of the performance rates for each area and Care Group based on the proportion of targeted metrics that have achieved threshold.

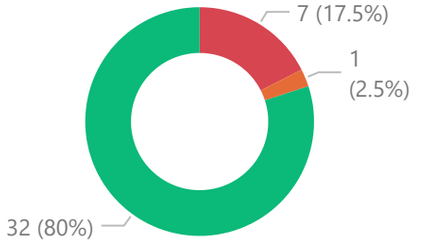
Quality & Safety Metrics Performance Rate



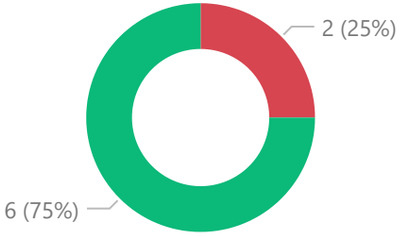
People Metrics Performance Rate



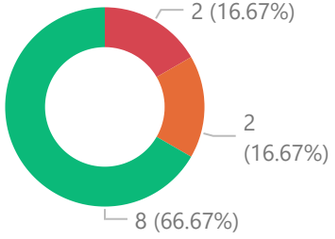
National Metrics Performance Rate



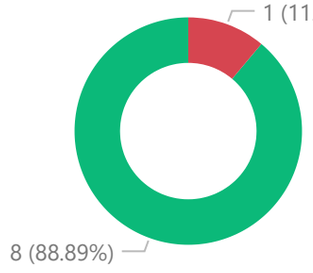
Finance Metrics Performance Rate



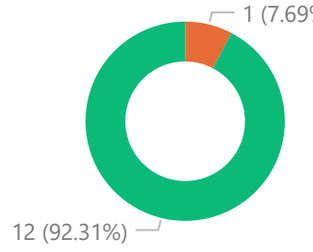
Barnsley Physical Health Metrics Performance Rate



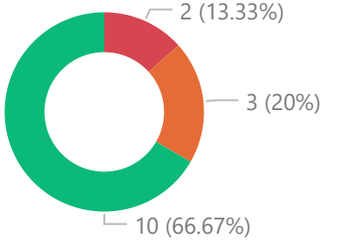
CAMHS Metrics Performance Rate



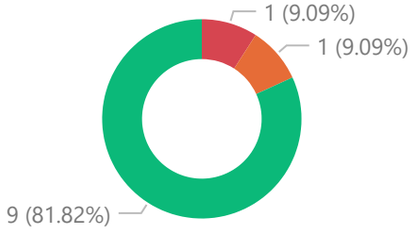
Mental Health Community Metrics Performance Rate



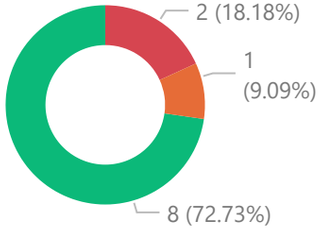
Mental Health Inpatient Metrics Performance Rate



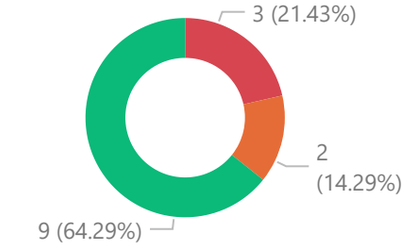
ASD/ADHD Metrics Performance Rate



Forensic SY Metrics Performance Rate



Forensic WY Metrics Performance Rate



Headlines

This section of the report identifies the metrics where there has been a change in performance or where expected levels are not being achieved. Metrics that are routinely meeting thresholds will not appear on this page. Whilst the metrics included may have seen a change since last month the assurance/variation icons where available, show if the data over time indicates that there is any action required.

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	↓	
% of inpatients clinically ready for discharge	↔	
% of feedback with staff values and behaviours as an issue	↑	
Number of Information Governance breaches	↔	
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	↑	
Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	↓	

People

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

National metrics

Metric	Change from last month	Variation/ Assurance
Children & Younger People with eating disorder - % Routine cases accessing treatment within 4 weeks	↓	
The number of incomplete Referral to Treatment (RTT) pathways	↓	
Virtual Ward Occupancy	↓	
Total bed days of Children and Younger People aged under 18 in adult inpatient wards	↓	
Total number of Children and Younger People aged under 18 in adult inpatient wards	↔	
Inappropriate out of area bed days	↑	

Finance

Metric	Change from last month	Variation/ Assurance
Bank spend	↑	
Capital Spend	↔	

Care Groups

Children and Young Peoples Mental Health Services (CAMHS)

Metric	Change from last month	Variation/ Assurance
Eating Disorder - Routine clock stops	↓	

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
Sickness rate (monthly)	↑	
% of feedback with staff values and behaviours as an issue	↑	

Mental Health Inpatient

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

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% of clients clinically ready for discharge	↓	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↓	

Forensic - West Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
Sickness rate (Monthly)	↑	
% Bed occupancy (incl leave)	↑	
Information Governance (IG) training compliance	↓	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↑	

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
Sickness rate (Monthly)	↑	
Maximum 6 week wait for diagnostic procedures	↓	
% Appraisal rate	↑	
% of feedback with staff values and behaviours as an issue	↑	
Information Governance (IG) training compliance	↓	

Forensic - South Yorkshire

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

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 number of responses provided within six months of the date a complaint received dropped to 83% for the month of March. This related to 4 complaints not achieving the standard. The average time to sign off for complaints closed during the month was 134.8 days and this had increased slightly from last month.

• The total number of reported incidents in March increased to 1,361, 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 slight increase, the numbers reported suggest data is in line with the number of incidents reported in previous months. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.

• The number of restraint incidents decreased slightly this month from 200 reported in January to 194. The highest number of incidents were at the Poplars unit (31) and Crofton ward (22) – both of these are older peoples mental health wards. There were also 21 incidents reported on Nostell, adult acute mental health ward. The majority of these incidents relate to service users with complex needs and reflect the levels of acuity being experienced across our wards. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain within expected range – all incidents are reviewed, and learning is shared.

• The Trust had 29 incidents against staff on mental health wards involving race during March. We are very aware of the personal impact this has on our colleagues. We are working closely with colleagues from the People Directorate to identify further wellbeing offers and strengthen support. An executive led focus group is also in the process of being established to review all issues relating to harm to others.

• There were five staff led prone restraints on our wards during March. 3 of those related to incidents on one of our psychiatric intensive care units during the month. Alternative seclusion exit training is embedded in both four-day initial and two-day annual refresher Reducing Restrictive Physical Interventions (RRPI) training. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan. There were a further two service user led incidents during the month. These incidents are also reviewed by the reducing restrictive practice intervention team.

• There were 12 information governance personal data breaches during March which is the same level as reported last month. This is just over the Trust threshold less than 12. 6 of these incidents relates to Children and Young people mental health services but across 6 different teams. Information disclosed in error continues to be the highest reported category. Work taking place to review the incidents and ensure learning is embedded to prevent future occurrences, alongside a quality improvement group to embed learning

• Sadly, 4 patient safety related deaths where the service user was known to the Trust's mental health services occurred during the month. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the family concerned in these tragic circumstances.

• There were 61 inpatient falls reported during March 2026, this is an increase from last month and the highest number reported since April 25 (63). 39 of the fall incidents relates to services users aged 65years and over; 38 of these service users have a history of falls. All patients with a history of falls had a multifactorial assessment completed and a good quality mobility plan in place. 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. The highest number of incidents during the month related to Beechdale (11), the Poplars (11), Ward 19 (14) all of which are our older peoples mental health wards.

• The number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations) reported during quarter 4 was 7. All of these incidents took place within our mental health services, with 5 relating to inpatient services and 2 relating to community services. A large proportion of these incidents related to violence and aggression and resulted in staff being injured. All staff are being supported appropriately and all of the reportable incidents were reported to the Health and Safety Executive within the required timeframe.

• 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 95.9% against a target of 90%. Disability recording was at 56.5%, sexual orientation 56.9% 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.

• For risk assessments and care plans, the Trust's aim is to work towards achievement of 95% against each of these standards. The metrics do show an overall increase in performance, however 95% has not been achieved across all 5 metrics in all areas – detail can be seen in the Quality dashboard and care group section of the report. care group and ward level detail can be seen in the detail of the report. All risk assessments and care plans that have not been completed within the timescale have oversight and scrutiny from the Care Groups.

• 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. This is alongside the required Historical, Clinical Risk Management 20 tool (HCR20) required for a patient in forensics.

• 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. 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. There is development work is occurring across all teams to ensure they update the risk assessment to ensure emerging risks are supported and mitigated.

People

• Our overall sickness absence rate has dropped again in March 26. Our long-term absences have reduced again this month, which is the third consecutive month there has been a reduction.
• Although we have increased compliance of Appraisals in March 26, Cheswold Park care group (66.6%) and Forensics care group (74.7%) remain areas of focus for improvement. The Trust continues to monitor compliance closely through data provided to our local leadership teams, Operational Management Groups and Executive Management Team.
• Our statutory and mandatory training compliance is consistently higher than our targets and has remained above our local threshold target since May 25 for all subjects. A comprehensive review of our local mandatory training requirements has concluded, and the recommendations have been endorsed by the Executive Management Team. This is in line with the national training review and will be fully implemented during 2026/27. This will ensure all colleagues are skilled and trained as per national guidance.

National Indicators

The Trust continues to perform well against most national metrics. The following should be noted:
• It is important that hearing loss is identified quickly to support a child's development including their language skills and cognitive pathways. Regarding the 6 weeks to a diagnostic appointment target, 107 out of 122 children (87.7%) received a diagnostic appointment within 6 weeks against a national threshold of 99% in March. The demand in referrals consistently outweighs commissioned activity levels – which is a national issue. We continue to work with commissioning colleagues to achieve a solution. There is a quality improvement plan to ensure we are using the resource effectively and to meet the needs of our community the best we can.
• Children & Younger People with an eating disorder – all urgent and routine referrals were seen within national expected time frames of one week. For routine referrals, there were four patients that were not seen within the four week standard, all of these cases were due to patient choice or service user illness.
• The Trust had one admission for a service user under 18 years of age to an adult acute ward. 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.
• Community services waiting list - This metric reports the total number of people waiting across a range of physical health and wellbeing services in Barnsley. There continues to be 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 mental health acute average length of stay (ALOS). The Trust has set itself a target to reduce adult acute lengths of stay by 10% by the end of March 2026 from March 2025 baseline. Overall, the average length of stay for people discharged in March (rolling 3 months) has increased compared to previous month (56.3 days) and remains below the planned trajectory 10% reduction. In terms of performance against the trajectory, we are meeting the trajectory for March in our South Yorkshire acute mental health and PICU wards and slightly above the 10% reduction in West Yorkshire. It is important to note that the performance will be affected by discharges of patients with particularly long lengths of stay and this may be impacted by the availability of external factors as identified when we highlight our performance against the clinically ready for discharge metric.
• Virtual Ward occupancy rate has decreased to 62.7% which is below the target of 80%. During the month, frailty virtual ward onboarding, for acute step downs, was paused for a period due to consultant geriatrician capacity to oversee the pathway. The Barnsley Physical Health and Wellbeing Care Group continue to work closely with Barnsley Hospitals NHS Foundation Trust to support step down from the acute hospital into our community teams and for hospital avoidance / admission avoidance.
• Expansion of mental health teams in schools – we are working with commissioners regarding the plans for Mental Health Support Teams in 2025/26 and into next year.
• 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.

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 treatment at the end of March, 86.2% of those waiting had been waiting for a period of 18 weeks or less which is a further improvement compared to previous months, however some young people are still waiting longer for treatment. All of these cases have had some form of screening, consultation or initial assessment before being placed on a treatment waiting list. The increased waiting time is linked to an increase in demand, focus on initial appointment and in particular a significant rise is Kirklees Keeping in Mind (KKiM) referrals. Commissioners have supported a new delivery model and this commenced in January 2026. There is a specific transformation programme for CAMHS to align services and make improvements across all places.
• Children's neurodevelopmental waits remain a major issue given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. Neuro-development waits are part of a specific pathway review across places in line with commissioned models. There is an offer in place to support children and families whilst waiting.
• Improvement work on waiting list times in community learning disability services has led to an overall improvement against the 18 weeks standard for patient having a completed assessment, care package and commenced service delivery within 18 weeks. March performance dropped slightly (87.1%) compared to the previous month (88.0%) against a 90% threshold with 8 patients out of 62 not been seen within the required standard. 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.
• The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. At the end of March, the Trust had 2 service users placed in an inappropriate out of area bed at the end of the month, with 73 bed days used over the month in total. This has been supported by significant improvements with patient flow and bed management and focus on this remains.
• Focus on patients clinically ready for discharge continues to take place across mental health and learning disabilities, with support from colleagues within place with improvements recognised. The main challenges continue to be specialist placements and housing. At the end of March, 32 people were clinically ready for discharge but remained in a bed.
• 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 29 cases across all three areas per month. The average number of referrals for ADHD received for these areas in the last three months was 301. Calderdale does not block commission assessments, but we do assess 7-8 people from that locality via the Patient Choice framework. The average number of referrals received per month for Calderdale is 25.
• 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 to offer face-to-face ADHD Triage is available to ensure that only clinically appropriate cases are offered an assessment. This is currently commissioned in Wakefield and Kirklees, and Calderdale has asked that we explore trialling this step for them, but Barnsley is still considering their preferred model.
• Whilst Mental health bed occupancy levels have seen an overall reduction from previous months, increased acuity remains a challenge. Particularly with risk to self and others, therefore requires enhanced observations to keep people safe.
• The temporary staffing group continues to have a focus on the use of temporary workforce, ensuring safe staffing whilst delivering a sustainable workforce to meet the patient needs. Bank and locum expenditure continues to fluctuate from month to month. Agency spend decreased in month compared to last month and overall has seen a reduction compared to previous years. Bank usage reduced compared to February. The temporary staffing weekly meeting scrutinises the use of additional staffing and any areas of improvement to reduce the reliance on bank staff. The standard operating procedure has been reviewed and added further scrutiny to agency use of band 2 and 3. whilst ensuring safety is priority.
• Single point of access (SPA) is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. In March the access standard for assessed within 14 days of referral has been met in all localities. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage and have achieved the access target in March.

Finance

• The Trust financial target for 2025 / 26 is breakeven. This has been achieved with a small unaudited surplus of £123k.
• Agency run rate has continued to reduce across the year. Total spend is £2.9m which is £1.4m less than plan and an overall reduction of £3.5m compared to the prior year.
• The Trust continues to utilise bank and locum staff as part of its overall workforce strategy. Target bank spend (£19.3m) has been exceeded by £6.1m with utilisation higher than plan throughout the year. Overall bank spend is £3.6m higher than the previous year.
• 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.
• The target is £28.2m as a result of the Trust Value For Money programme has been achieved. Of this £7.3m (26%) has been delivered non-recurrently. The implications of this are included in the Trust medium term financial plan.
• The Trust cash position remains positive and has increased in March 2026 with payment received for outstanding income from NHS England.
• As at 31st March 2026 a number of capital schemes remained in progress. The financial position includes the value of work completed to that date. Total spend of £14.8m is £3.0m less than the forecast at month 11.

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Best Quality	Responsive	TBC	63.8%	64.5%	67.5%	73.8%	76.1%	86.2%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	Best Quality	Caring	< 20%	8% (2/26)	15.7% (6/38)	8.8% (3/34)	14% (6/43)	22% (6/27)	9.1% (3/33)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	116.6	112.8	101.0	101.6	109.8	134.8	N/A
	Complaints - Number of responses provided within six months of the date a complaint received [16]	Best Quality	Well led	100%	92% (24/26)	95% (18/19)	100% (16/16)	94% (15/16)	94% (16/17)	83% (19/23)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	94%	93%	93%	91%	91%	92%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	96%	97%	96%	96%	99%	96%	1
	Number of compliments received	Best Quality	Caring	N/A	32	45	51	25	60	41	N/A
Quality	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Best Quality	Safe	Trend monitor	9	1	4	3	2	5	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Best Quality	Safe	Trend monitor	1	1	0	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	Best Quality	Safe	0	0	0	0	0	0	0	1
	Number of Information Governance breaches [3]	Best Quality	Well led	<12	8	6	8	10	12	12	2
	% of inpatients clinically ready for discharge *	Person first and in the centre	Responsive	3.5%	5.0%	5.7%	4.9%	5.3%	5.4%	5.4%	3
	Total number of reported incidents	Best Quality	Safe	Trend monitor	1541	1391	1457	1480	1318	1361	
	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	34	37	31	31	38	34	
	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	1	4	1	0	0	3	
	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	3	0	3	0	1	4	
	Safer staff fill rates *	Best Quality	Safe	90%	118.1%	120.1%	120.6%	116.3%	113.8%	112.3%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	97.6%	101.3%	100.3%	100.2%	100.6%	98.3%	1
	Number of pressure ulcers which developed under SWYPFT care [1]	Best Quality	Safe	Trend monitor	51	47	66	68	47	58	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement [2]	Best Quality	Safe	0	0	0	0	0	0	0	0
	Eliminating Mixed Sex Accommodation Breaches	Best Quality	Safe	0	0	0	0	0	0	0	1
	Number of Falls (inpatients) *	Best Quality	Safe	Trend monitor	60	54	58	59	45	61	
	Number of restraint incidents *	Best Quality	Safe	Trend monitor	244	168	220	175	200	194	
	% of staff receiving supervision within policy guidance [15]	Best place to work and learn	Well led	80%	88.4%	90.5%	88.7%	87.9%	90.3%	92.1%	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%	92.3%	90.5%	93.3%	97.4%	84.6%	87.10%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	16	20	11	14	7	9	N/A
	Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	Best Quality	Effective	55%		71.1%			Due May 2026		
	Number of incidents against staff on mental health wards involving race *	Best place to work and learn	Safe	Trend Monitor	39	32	39	24	28	29	N/A
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0		10			7		
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	100.0%	97.3%	100.0%	97.9%	95.6%	96.9%	
	Compliance with statutory requirements (Water, Gas, Electricity, Refrigeration, Pressure, Loler and Asbestos)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	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%	100.0%	100.0%	100.0%	
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	95.8%	95.8%	95.8%	95.4%	95.8%	95.9%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	57.8%	57.3%	56.9%	55.9%	56.5%	56.5%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	58.5%	57.8%	57.1%	56.5%	57.0%	56.9%	
	Percentage of service users who have had their equality data recorded - deprivation (postcode)	Best Quality	Responsive	90%	99.5%	99.5%	99.5%	99.5%	99.6%	99.6%	
	Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure) EIA policy reporting refers to policies signed off by the Executive Management Team (EMT) with an up to date EIA in place	Best Quality	Responsive	Service timely completion - 75% Policy - 95%	100% Service 99.3% Policy	99.4% Service 95.6% Policy	99.4% Service 100% Policy	100% Service 100% Policy	98.4% Service 100% Policy	99.4% Service 100% Policy	
	% on community active caseload at month end with a care plan which has been reviewed within the last year	Person first and in the centre	Caring		87.7%	89.4%	90.7%	91.1%	94.1%	92.6%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring	Interim trajectory 75-80% March 26: 95%	84.8%	85.0%	85.1%	94.5%	96.9%	96.5%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring		94.9%	90.9%	96.3%	97.8%	96.3%	96.8%	

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year End Forecast*
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe		92.8%	88.2%	94.1%	90.5%	89.7%	86.0%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe		92.6%	92.7%	93.5%	93.9%	92.5%	94.1%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	Aug and Sept – 8 October and November – 6 December and January – 4 February and March - 2	7	3	4	3	1	5	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor	49	134	122	187	97	98	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor	8,758	9,256	7,516	9,726	10,035	9,960	N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Person first and in the centre	Safe	6	0	0	1	0	0	0	1
	C Diff avoidable cases	Person first and in the centre	Safe	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	Person first and in the centre	Safe	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Person first and in the centre	Safe	0	0	0	0	0	0	0	
Improving Resource	NHS Oversight Framework segmentation	All	Well led	1/2	1			Due May 2026			
	Overall CQC rating	All	Well led		Good						
	CQC well - led rating	All	Well led		Good						

Quality & Safety Headlines

• Children and young people mental health services referral to treatment - March saw an increase in the number of young people waiting less than 18 weeks for their treatment appointment, this is still a much lower level that we would like to be experiencing. A number of issues are contributing to this position and this is explained in more detail in the care group section of the report.
• 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 23 complaints responded to during the month, 19 of these were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 134.8 days. Before the response is sent back to complainant, sign off is required which includes formulation of a written response and review by the customer services office manager, following a review by the Care Group trio (general manager, clinical lead and quality and governance lead), the director of service, an executive director and final sign off from the Chief Executive. Complaints vary in complexity and this is sometimes reflected in the amount of time taken to investigate and to move through the sign off process.
• 3 complaint incidents during the month related to staff values and behaviours. All incidents are currently under investigation following Trust policy to identify any learning
• There were 12 information governance personal data breaches during March which is the same level as reported last month. This is just over the Trust threshold less than 12. 6 of these incidents relates to Children and Young people mental health services but across 6 different teams. Information disclosed in error continues to be the highest reported category. Work taking place to review the incidents and ensure learning is embedded to prevent future occurrences.
• Focus on patients clinically ready for discharge continues to take place across mental health and learning disabilities, with support from colleagues within place with improvements recognised. The main challenges continue to be specialist placements and housing. At the end of March, 32 people were clinically ready for discharge but remained in a bed.
• The total number of reported incidents in March increased to 1,361, 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 slight increase, the numbers reported suggest data is in line with the number of incidents reported in previous months. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.
• Sadly, there were 4 patient safety related deaths occurred during the month where the service user was known to the Trust's mental health services. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the family concerned in these tragic circumstances.
• The Trust had 29 incidents against staff on mental health wards involving race during March. We are very aware of the personal impact this has on our colleagues. We are working with the People Directorate colleagues to identity further wellbeing offers to increase the support. Recognising that this has an impact on staff, a robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role.
• The number of restraint incidents decreased slightly this month from 200 reported in January to 194. The highest number of incidents were at the Poplars unit (31) and Crofton ward (22) – both of these are older peoples mental health wards. There were also 21 incidents reported on Nostell, adult acute mental health ward. The majority of these incidents relate service users with complex needs and reflect the levels of acuity being experienced across our wards. 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 61 inpatient falls reported during March 2026, this is an increase from last month and the highest number reported since April 25 (63). 39 of the fall incidents relates to services users aged 65years and over; 38 of these service users have a history of falls. All patients with a history of falls had a multifactorial assessment completed and a good quality mobility plan in place. 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. The highest number of incidents during the month related to Beechdale (11), the Poplars (11), Ward 19 (14) all of which are our older peoples mental health wards.
• The number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations) reported during quarter 4 was 7. All of these incidents took place within our mental health services, with 5 relating to inpatient services and 2 relating to community services. A large proportion of these incidents related to violence and aggression and resulted in staff being injured. All staff are being supported appropriately and all of the reportable incidents were reported to the Health and Safety Executive within the required timeframe.
• There were five staff led prone restraints on our wards during March. 3 of those related to incidents on one of our psychiatric intensive care units during the month. Alternative seclusion exit training is now embedded in both four-day initial and two-day annual refresher Reducing Restrictive Physical Interventions (RRPI) training. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan. There were a further two service user led incidents during the month. These incidents are also reviewed by the reducing restrictive practice intervention team.
• For risk assessments and care plans, the Trust's aim is to work towards achievement of 95% against each of these standards. The metrics do show an overall increase in performance, however 95% has not been achieved across all 5 metrics in all areas – detail can be seen in the care group section of the report. care group and ward level detail can be seen in the detail of the report. All risk assessments and care plans that have not been completed within the timescale have oversight and scrutiny from the Care Groups.
• 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. This is alongside the required Historical, Clinical Risk Management 20 tool (HCR20) required for a patient in forensics.
• 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. 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. There is development work occurring with community teams to ensure they update the risk assessment before admission to support inpatient staff to understand the change in risk and reason for admission.

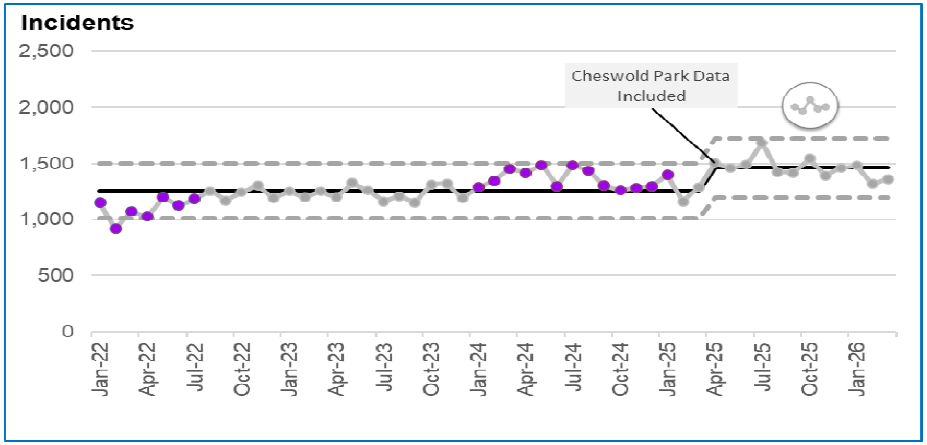
Quality & Safety Headlines Cont…

Patient Safety Incident Response Framework (PSIRF)
The review of the Trust's PSIRF plan and policy is currently underway. Several workstreams are underway to revise procedures, processes in response to reflects on the past 2 years of working under PSIRF. Stakeholder events were held in March 2026 to consult on revisions to the plan and the draft plan has been circulated for comments.

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.

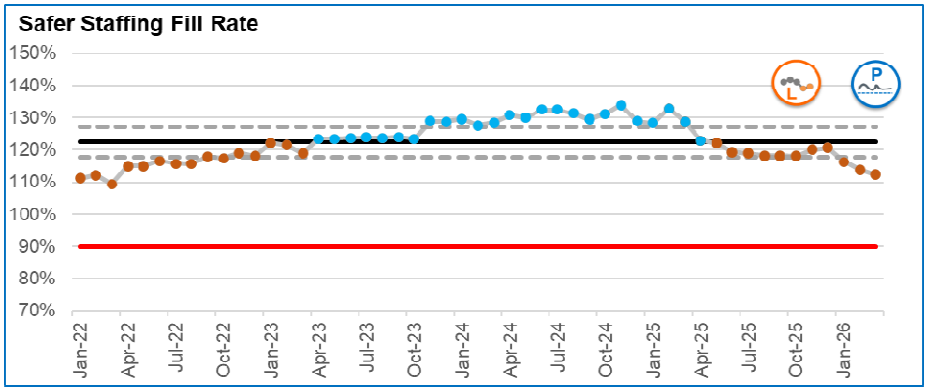
Statistical process control charts

Incidents

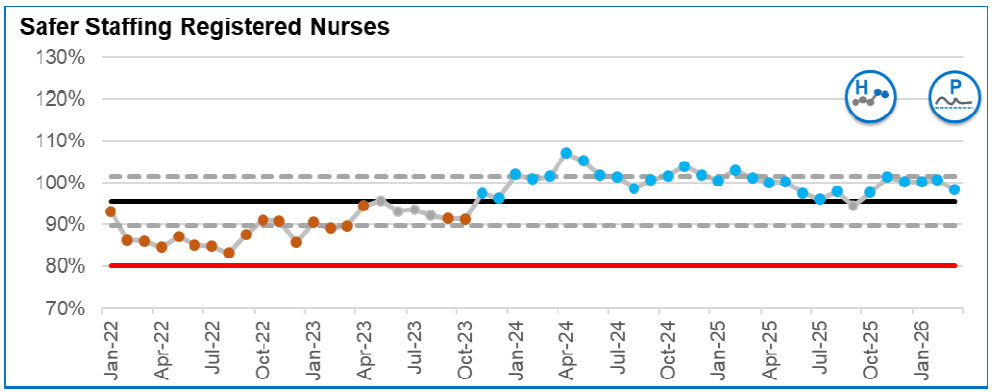


We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data. The chart shows that we are in a period of common cause variation (no concern).
It should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low harm incidents remains high as it does. 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).

Safer Staffing Inpatients



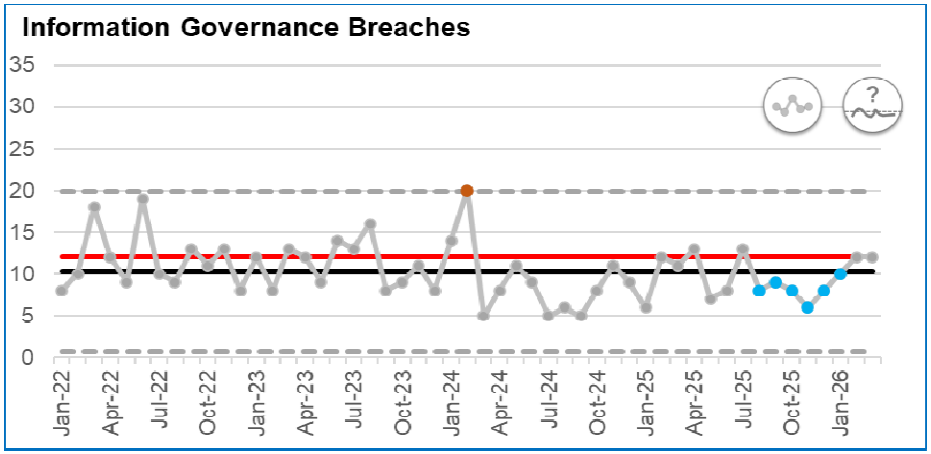
The chart above shows that in March 2026 we remain in a period of special cause concerning variation (something is happening and should be investigated). There has been an increase in demand which means more shifts are being requested, there has been a smaller increase in the number of shifts being filled however this is being outstripped by demand and that means that the number of unfilled shifts is actually increasing. Put into the mix the very deliberate reduction of agency this all leads us to where we are at the moment.



The chart above shows that in March 2026 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.

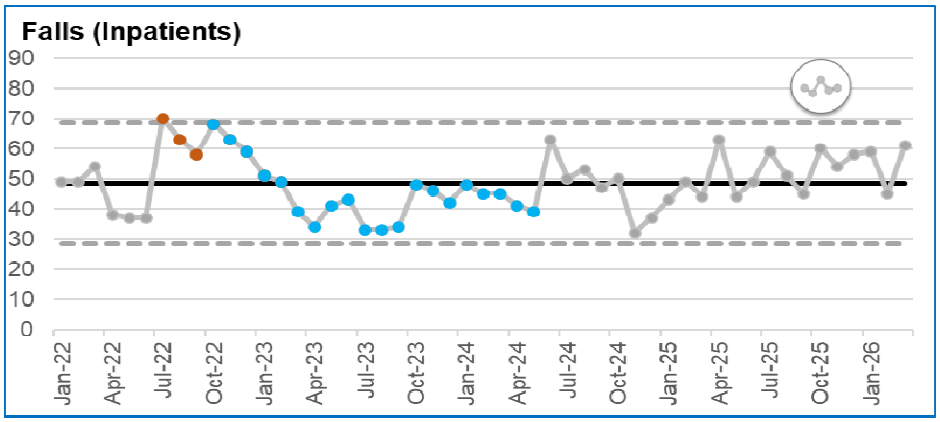
Statistical process control charts

Information Governance (IG)



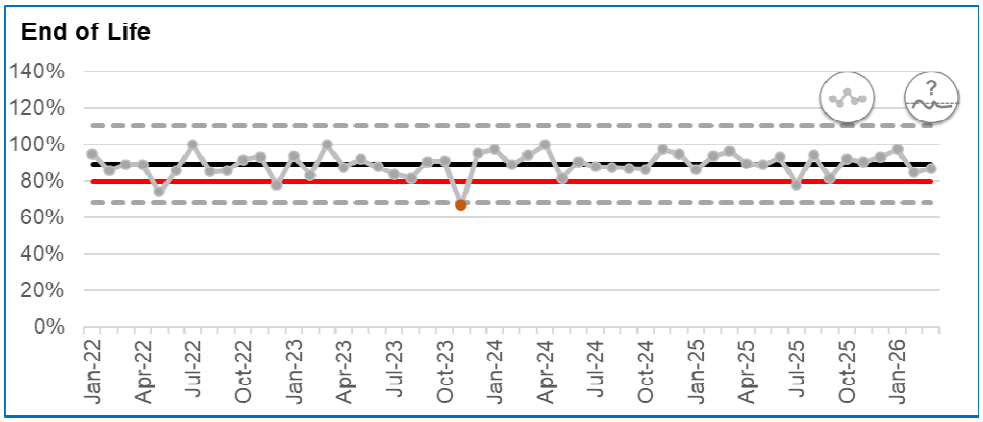
This SPC chart shows that as at March 2026 we have entered a period of common cause variation (no concern).

Falls (Inpatient)



The SPC chart above shows that in March 2026 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

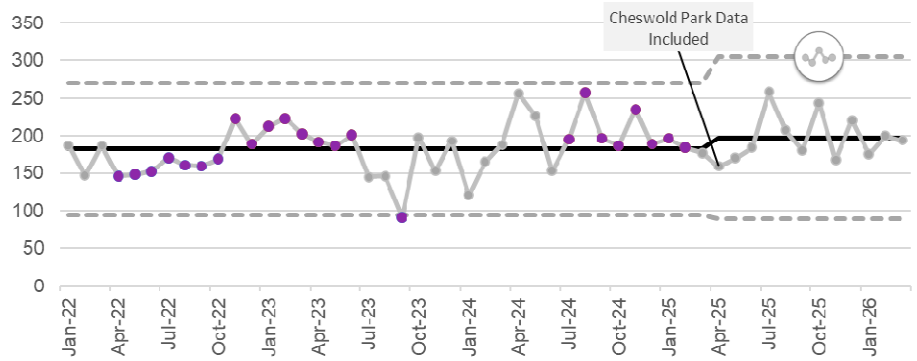


The chart above shows that in March 2026 the performance against this metric remains in common cause variation (no concern). The performance for the month remains above the target.

Statistical process control charts

Restraints

Total Restraint Incidents

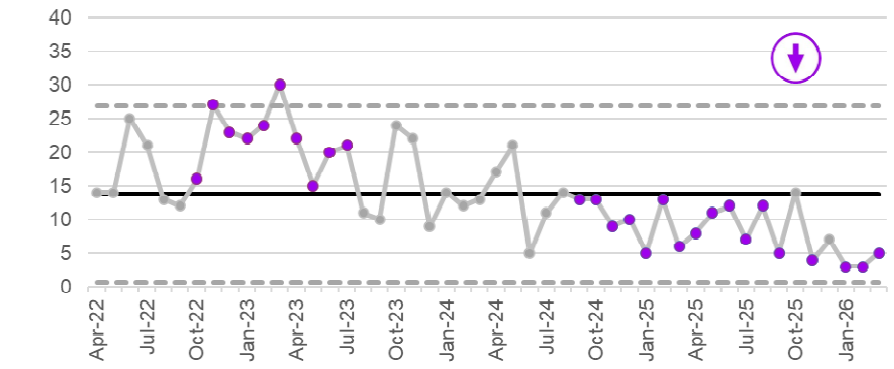


This SPC chart shows that in March 2026 we remain in a period of common cause variation (no concern).

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

We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data.

Prone Restraint (Total Number)



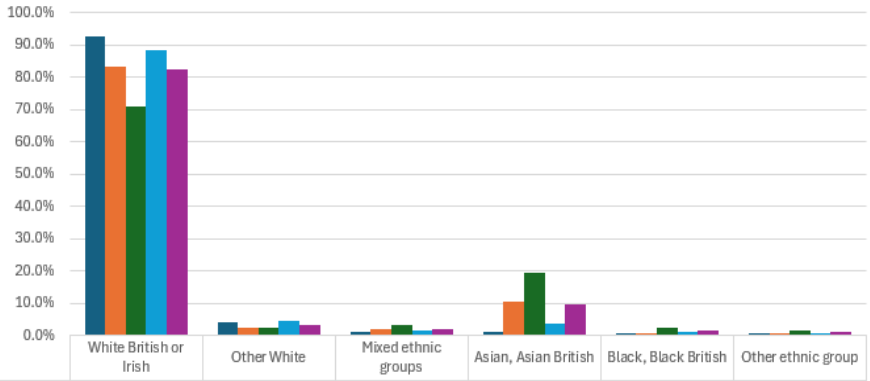
The total number of prone restraints continues to show a decreasing special cause variation in line with the continued work to reduce prone restraints. All of the five prone restraints in March 2026 were staff led.

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.

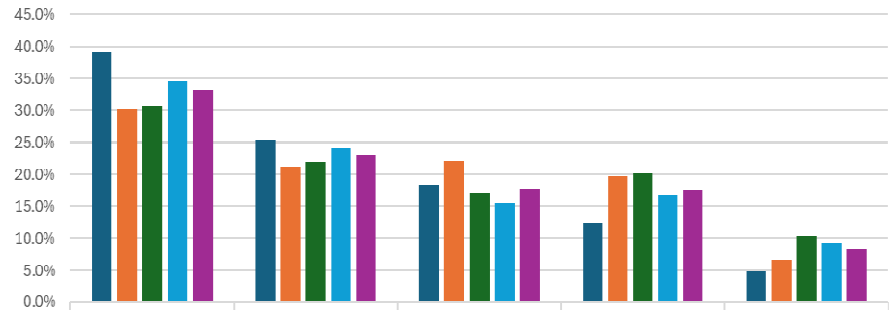
The population our Trust serves is varied in terms of ethnic make-up and also levels of deprivation. We can measure the relative deprivation of an area using 7 distinct domains of deprivation, which are: 1) Income 2) Employment 3) Health deprivation and disability 4) Education, skills & training 5) Crime, 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 (quintile or decile) 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	30.8%	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

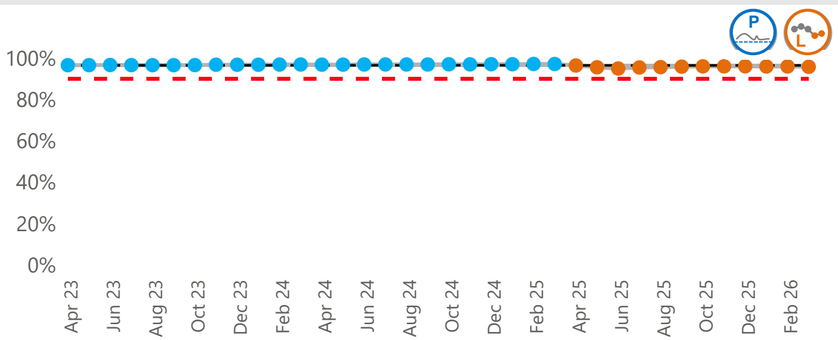
Data as of : 14/04/2026 13:27:33

NHS South West Yorkshire Partnership NHS Foundation Trust

In order to ensure equitable access to our services it is important to monitor the levels of our service users who have their equality data, such as ethnicity, disability status, sexual orientation, and postcode, completed. Data quality is vital to ensure we are able to offer services the meet the needs of the populations we serve. 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. This work involves the specific focus of improving the 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.

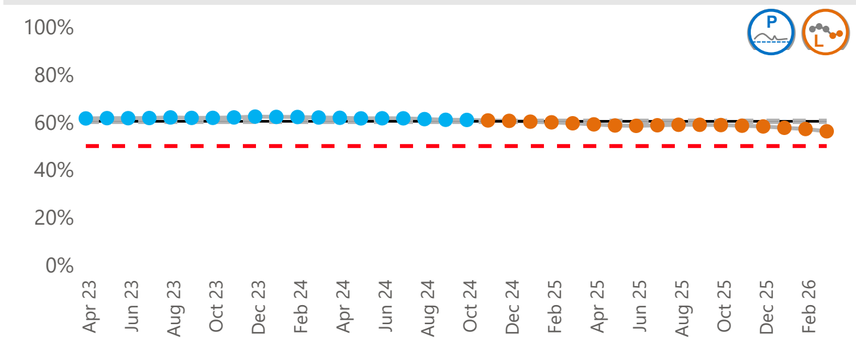
The SPC charts below show the completion rates for these measures.

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



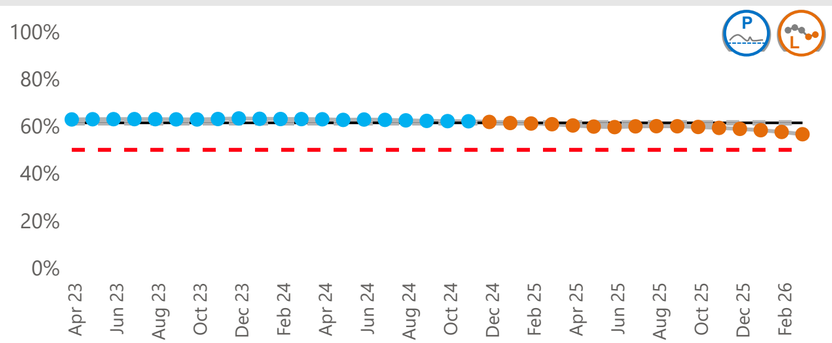
The Statistical Process Control (SPC) chart shows that in February 2026 due to the continued dip in performance we remain in a period of special cause deteriorating variation (something is happening and should be investigated). We are expected to meet the target against this metric. The data for service users in our secure CAMHS services shows the biggest change (reduction) over time with a 7% decline in recorded data since April 25. Conversations are ongoing to establish possible improvement activities.

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



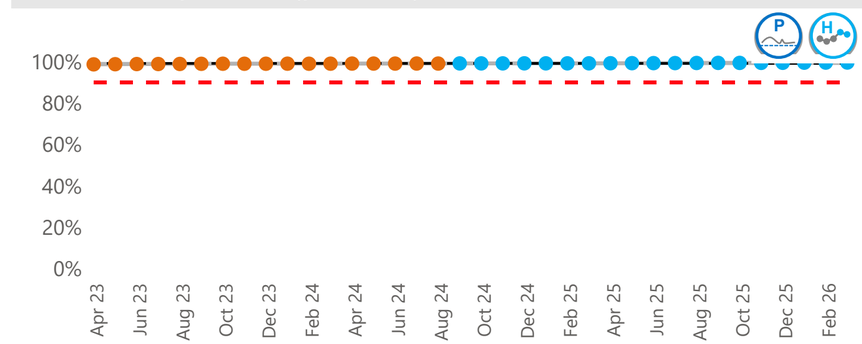
The SPC chart shows that in February 2026 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months. We are expected to meet the target against this metric. The data for service users in our OPS MH Community services shows the biggest change (reduction) over time with a 7% decline in recorded data since April 25. Conversations are ongoing to establish possible improvement activities.

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



The SPC chart shows that in February 2026 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. We are expected to meet the target against this metric. There are a number of service lines where data quality has reduced over the last 12 months and further work is being done to understand the reasons for this.

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



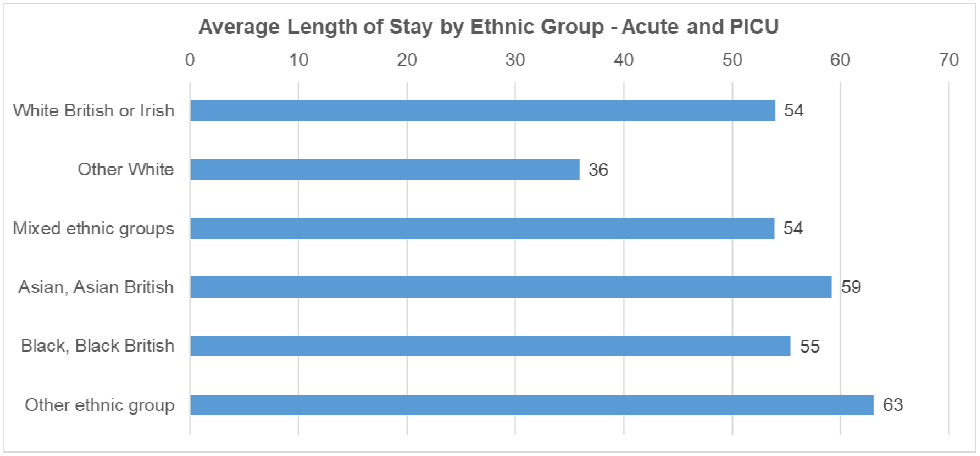
The SPC chart shows that in February 2026 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance. We are expected to meet the target against this metric.

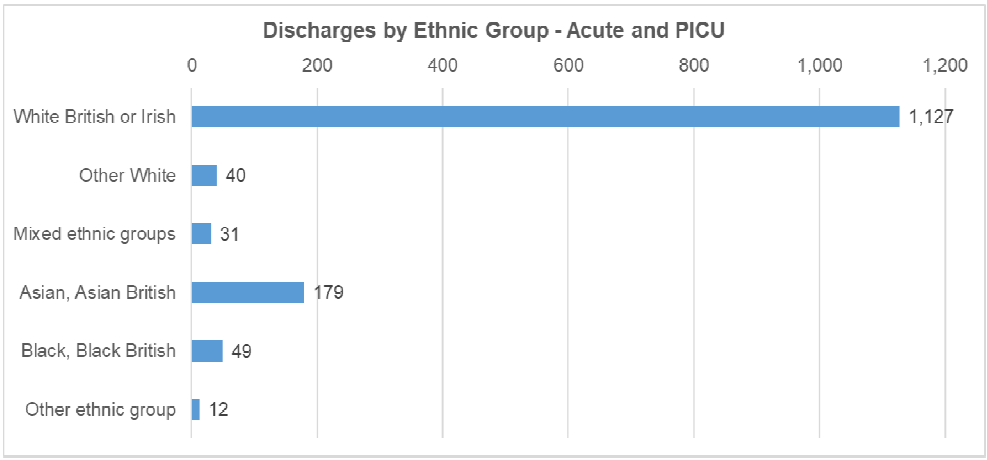
Reducing Inequalities

The charts show the average lengths of stay (ALOS) for our Acute and PICU, adult and older adults wards, for the financial year 2025/2026 (excluding 136 Suite and out of area stays).

Our review of inpatient length of stay (LoS) data highlights important patterns. Employing our quality improvement methodology and data driven approach we have been able to identify opportunities for further understanding. Examining variance of the median LoS (rather than the mean) has enabled us to have a better understanding of the average length of stay which accounts for the differences in cohort size. We have identified that LoS appears to vary significantly across clusters of conditions when reviewing the characteristics of individuals e.g. deprivation and ethnicity.

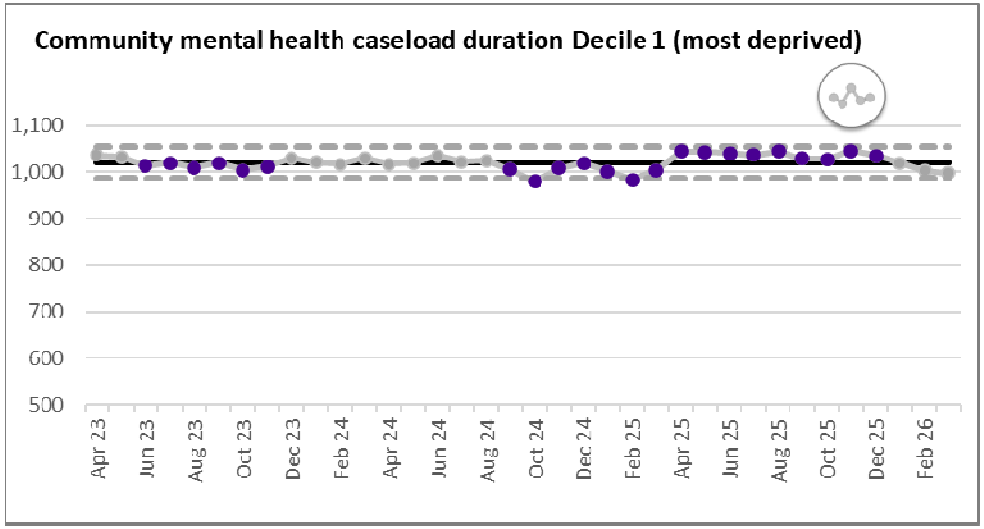
Differences in admission practices i.e. formal (compulsory) and informal (voluntary) also appear to influence LoS, with compulsory admissions tending to require more intensive interventions and longer discharge planning. Similarly, discharge approaches differ, with patients facing socioeconomic challenges or limited community support experiencing delays. Using the Trust's improvement methodology, insights are being derived and helping to identify systemic drivers and opportunities for change. Work is currently underway to engage with service users to understand their experiences. The first phase of this work is to engage with service users who have been admitted via A&E. The findings from this work will continue to be shared with the Acute Pathways and Inpatient Improvement Programme Steering Group and the Improving Access to Care Group to ensure informed decision making and opportunities for sharing good practice can be maximised. This will help us to plan and generate ideas that will inform targeted actions, ensuring that improvements in admission and discharge processes, culturally competent care, and partnership working are embedded across services.

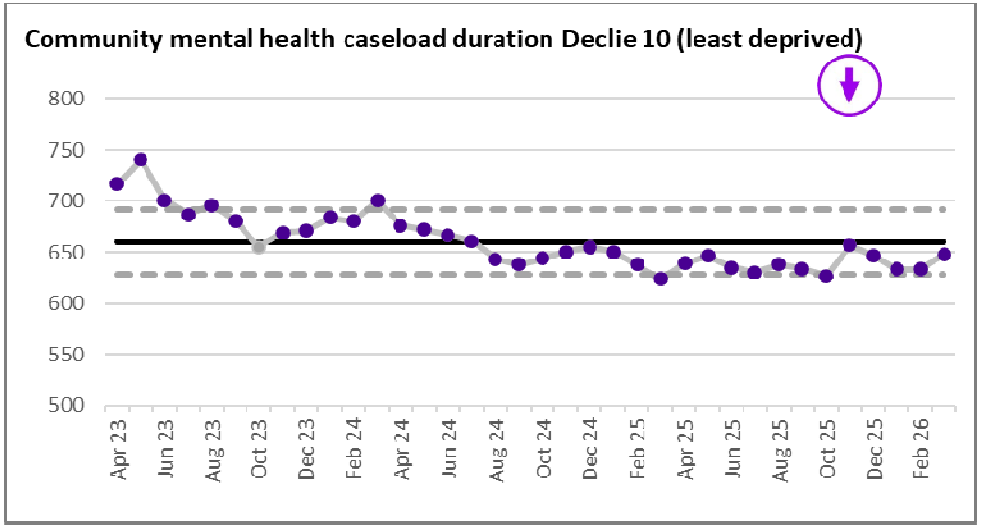




Reducing Inequalities

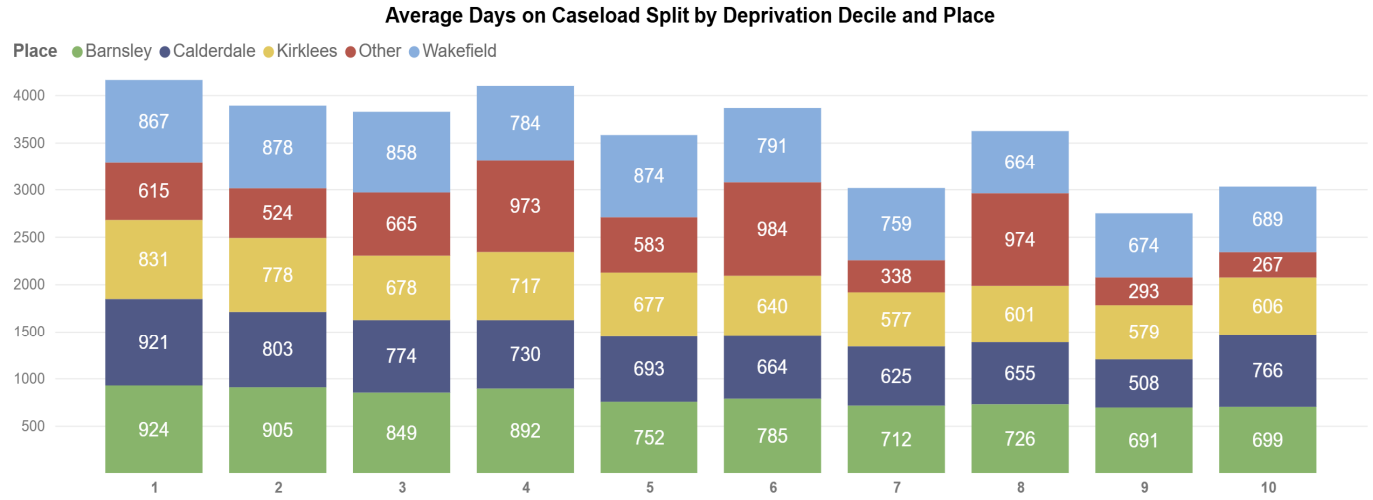
The charts below show the average caseload length for patients on the caseload of a community health team by those with a post code in the most deprived areas (Declie 1) and those with a post code in the least deprived areas (Decile 10). This data has remained consistent since 2023 and work is underway to understand the service areas for which there is the greatest variance. This work will also encompass and expand on our place data shown on the next page.

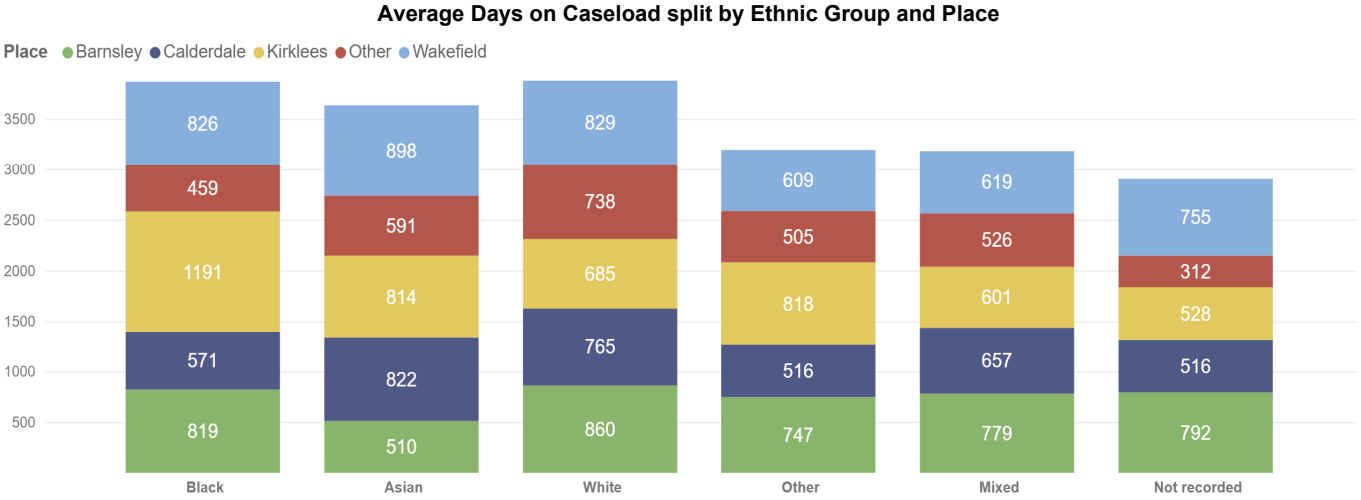




Reducing Inequalities

The charts below show the average caseload length of patients on a community mental health caseload split by ethnic group, and deprivation decile, and also split by Place.

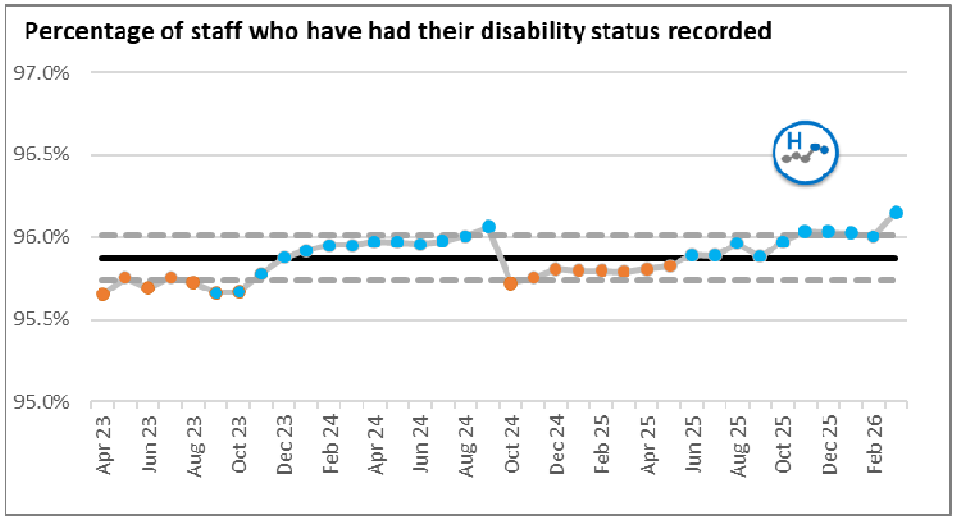


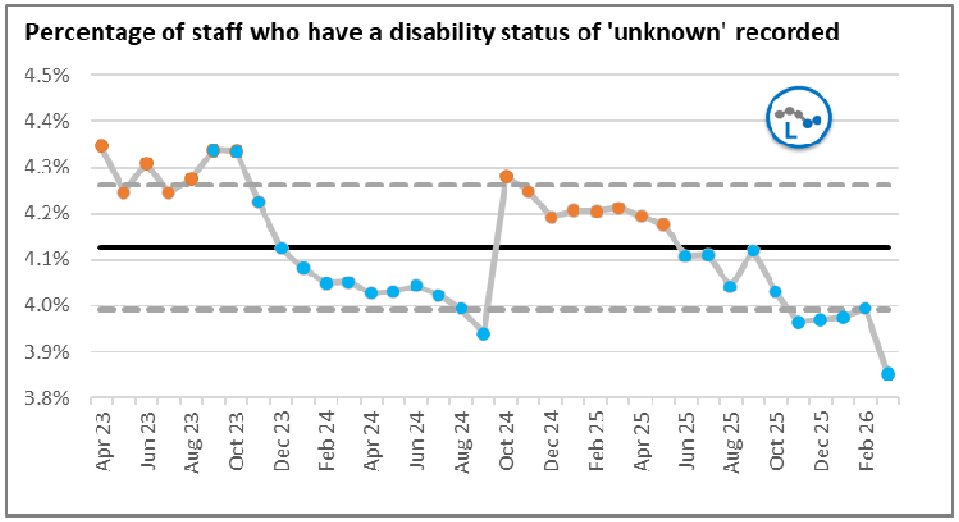


Reducing Inequalities

Disability Confidence and Data Transparency

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

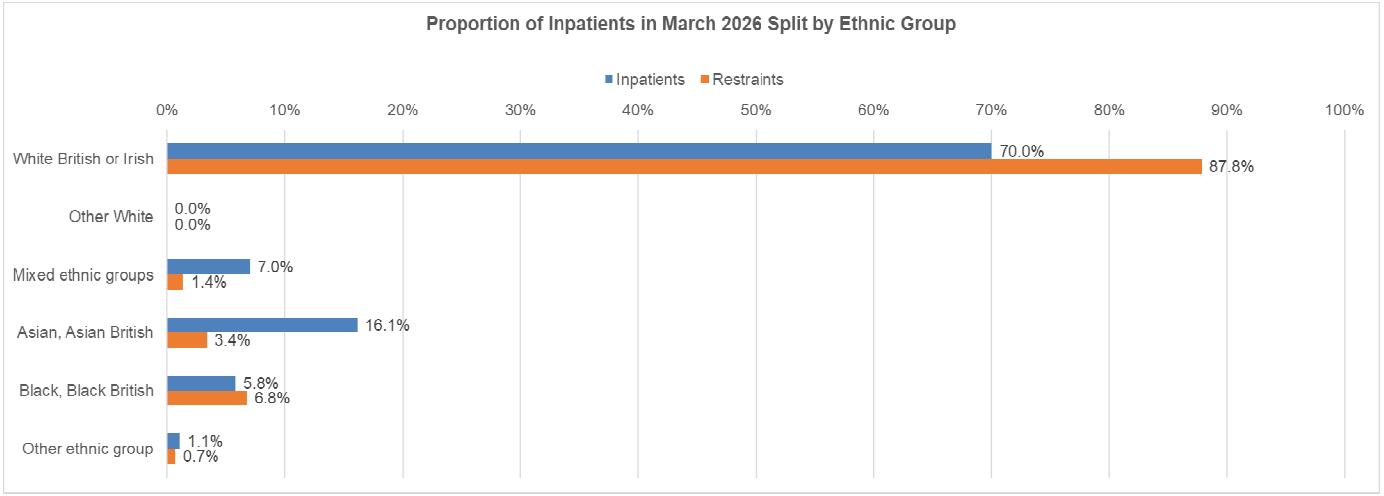


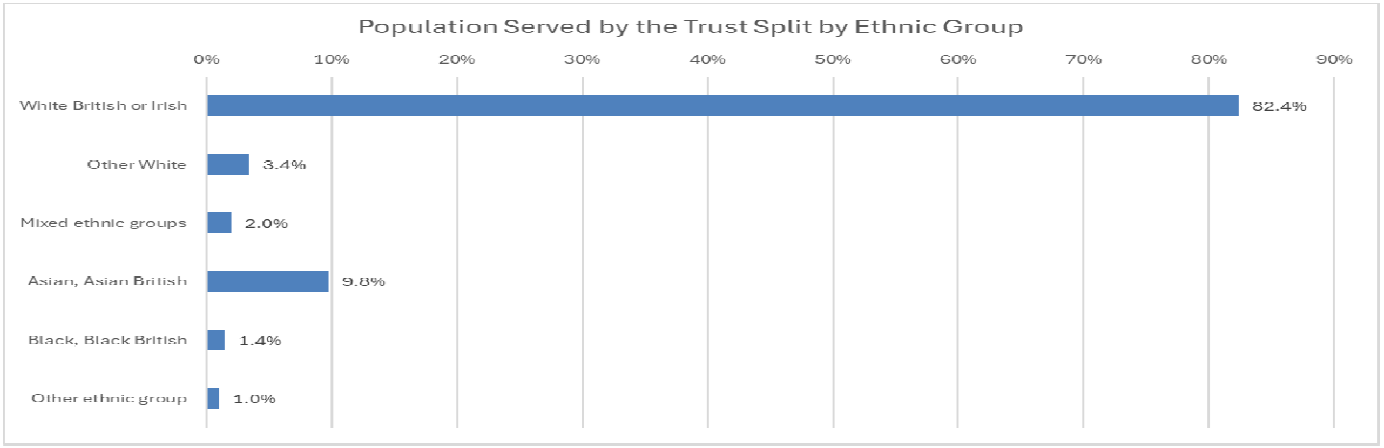


Further development of people related metrics will be undertaken over the coming months with focus being on the following areas: Increase Diversity in Senior Leadership, Fair and Trusted Processes, Wellbeing with Inclusion at the Core.

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. Early conversations are underway to aid the identification and understanding of some of the some of the context around protected characteristics as part of restraint, seclusion, and other restrictive practices.





People - Performance Wall

Trust Performance Wall

	Strategic Objective	CQC Domain	Threshold	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Establishment (Ledger excluding vacancy factor)	Best place to work and learn	Well led	-	5763.7	5756.4	5764.1	5789.5	5788.5	5790.8
Contracted Staff In Post (Ledger)	Best place to work and learn	Well led	-	5004.0	5033.0	5052.0	5068.0	5091.0	5115.0
Vacancies	Best place to work and learn	Well led	-	759.4	723.4	712.1	722.0	697.7	675.3
Turnover external (12 months rolling) *	Best place to work and learn	Well led	>12% - <13%	10.1%	9.6%	9.4%	9.1%	9.0%	8.2%
Starters	Best place to work and learn	Well led	-	45.3	36.6	21.3	51.4	47.5	39.0
Leavers	Best place to work and learn	Well led	-	26.3	21.3	28.8	29.0	35.6	36.2
% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	83.9%	84.9%	82.1%	84.8%	85.1%	85.0%
% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	83.5%	85.5%	87.4%	86.0%	91.1%	90.6%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	89.4%	90.1%	90.2%	87.2%	90.4%	90.1%
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	-	237 - all staff (18.1%) 117 - excl medics (10.4%)	240 - all staff (18.2%) 120 - excl medics (10.6%)	240 - all staff (18.1%) 121 - excl medics (10.6%)	246 - all staff (18.4%) 125 - excl medics (10.8%)	249 - all staff (18.4%) 125 - excl medics (10.8%)	257 - all staff (18.8%) 131 - excl medics (11.2%)
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	-	938 (71.5%)	946 (71.5%)	952 (71.7%)	962 (71.8%)	975 (72.1%)	986 (72.2%)
Sickness absence - Year-to-Date (YTD)	Best place to work and learn	Well led	<=5%	5.4%	5.4%	5.5%	5.5%	5.5%	5.4%
Sickness absence - Month	Best place to work and learn	Well led		5.9%	5.9%	6.0%	5.8%	5.2%	4.9%
Employees with long term sickness over 12 months	Best place to work and learn	Well led	-	0	0	1	1	1	1
Appraisals - rolling 12 months **	Best place to work and learn	Well led	90%	89.9%	86.5%	88.3%	89.2%	87.8%	88.7%
Employee Relations - Suspensions (over 90 days)	Best place to work and learn	Well led	-	1	1	1	1	3	3
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	66	75	60	69	66	60
Workforce growth (substantive staff)	Best place to work and learn	Well led	-2%	2.5%					
Registered substantive staff in post mental health and learning disabilities services	Best place to work and learn	Safe	Establishment - 1315	1,177	1,180	1,199	1,202	1,203	1209
Registered substantive staff in neighbourhood teams	Best place to work and learn	Safe	Establishment - 169	163	164	165	165	164	165
% staff recommending the Trust as a place to work	Best place to work and learn	Caring	65%	68.5%					
% staff recommending the Trust as a place to receive care and treatment	Best Quality	Caring	65%	72.4%					
Mandatory Training - TOTAL	Best place to work and learn	Well led		95.8%	95.6%	95.7%	95.4%	95.3%	95.3%
Mandatory Training - Reducing Restrictive Practice Interventions	Best place to work and learn	Well led		88.4%	88.4%	89.0%	88.4%	89.1%	90.1%
Mandatory Training - Cardiopulmonary Resuscitation	Best place to work and learn	Well led	>=80%	87.0%	86.8%	87.1%	86.1%	86.4%	86.6%
Mandatory Training - Clinical Risk	Best place to work and learn	Well led		97.0%	97.2%	97.7%	97.1%	96.8%	96.9%
Mandatory Training - Display Screen Equipment	Best place to work and learn	Well led		98.7%	98.6%	98.6%	98.7%	98.7%	98.8%
Mandatory Training - Equality & Diversity	Best place to work and learn	Well led		97.9%	97.7%	97.9%	98.0%	97.7%	97.5%
Mandatory Training - Fire Safety	Best place to work and learn	Well led	>=85%	94.4%	94.4%	94.5%	93.3%	92.5%	92.1%
Mandatory Training - Food Safety	Best place to work and learn	Well led		91.8%	92.3%	93.4%	93.1%	93.3%	93.8%
Mandatory Training - Freedom To Speak Up (FTSU)	Best place to work and learn	Well led	>=80%	98.0%	98.1%	98.0%	98.2%	98.1%	98.1%
Mandatory Training - Infection Control & Hand Hygiene	Best place to work and learn	Well led		96.6%	96.3%	96.4%	96.1%	95.7%	95.5%
Mandatory Training - Information Governance (Data Security)	Best place to work and learn	Well led	>=95%	97.8%	97.7%	97.4%	96.3%	95.8%	95.7%
Mandatory Training - Moving & Handling	Best place to work and learn	Well led		98.5%	98.5%	98.7%	98.6%	98.5%	98.6%
Mandatory Training - Nat Early Warning Score 2 (New S2)	Best place to work and learn	Well led	>=80%	98.5%	98.4%	98.4%	98.3%	98.1%	98.4%
Mandatory Training - Mental Capacity Act/Dols	Best place to work and learn	Well led		93.9%	94.1%	94.2%	94.3%	94.2%	93.9%
Mandatory Training - Mental Health Act	Best place to work and learn	Well led		93.9%	93.7%	93.9%	93.8%	93.8%	93.5%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism e-learning aspect of Level 1	Best place to work and learn	Well led		96.6%	96.7%	96.8%	97.0%	97.0%	97.0%
Mandatory Training - Prevent	Best place to work and learn	Well led		97.9%	97.6%	97.8%	97.5%	97.4%	97.2%
Mandatory Training - Safeguarding Adults	Best place to work and learn	Well led	>=80%	92.5%	92.4%	93.4%	92.9%	92.9%	92.7%
Mandatory Training - Safeguarding Children	Best place to work and learn	Well led		92.4%	93.4%	93.6%	93.2%	93.5%	93.9%

Notes:

• Establishment is the current budget, as set out in ledger, it's a wte conversion from a £ value. This is the total budget before any adjustments to reflect the vacancy factor. Budgeted staff(reported in Finance report) has been adjusted to account for the vacancy factor.

• Contracted Staff In Post (Ledger)- this represents the total number of people contracted to work for us throughout the total reporting period. It is calculated using the number of direct employees on ESR and those who have invoiced us for work done during the month using the ledger. Where individuals have worked part of the month, this is represented by a proportionate wte. It does not include overtime, additional hours worked or agency, which is reported separately n "actual worked" in the Finance report

** Appraisal figures for Cheswold reported separately to end Sept 25. See Forensic South Yorkshire Care Group dashboard for Cheswold performance.

Our current workforce
In March the overall Turnover percentage has dropped. This is mainly due to the Liaison and Diversion service (which was ceased in March 2025) no longer being included in the rolling 12 month figures.

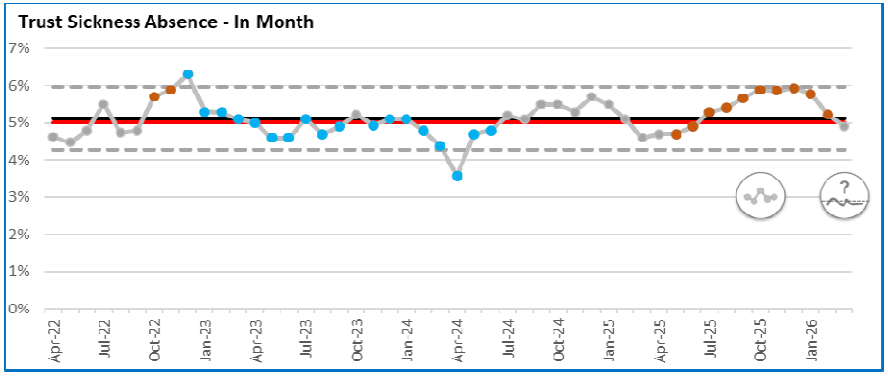
Despite the total leavers (in month) increasing in March 2026 (since January 2026) the Turnover percetnage has dropped. This is due to the successful recruitment and adjustment of contractual hours.

Sickness Absence
Our overall sickness absence rate has dropped again in March 2026. Our long term absences have reduced again this month, which is the third consecutive month there has been a reduction.

Appraisal Compliance
Although we have increased compliance of Appraisals in March 2026, Cheswold Park care group (66.6%) and Forensics care group (74.7%) remain areas of focus for improvement. The Trust continues to monitor compliance closely through data provided to our local leadership teams, Operational Management Groups and Executive Management Team.

Training Compliance
All our training is compliant and above our KPI

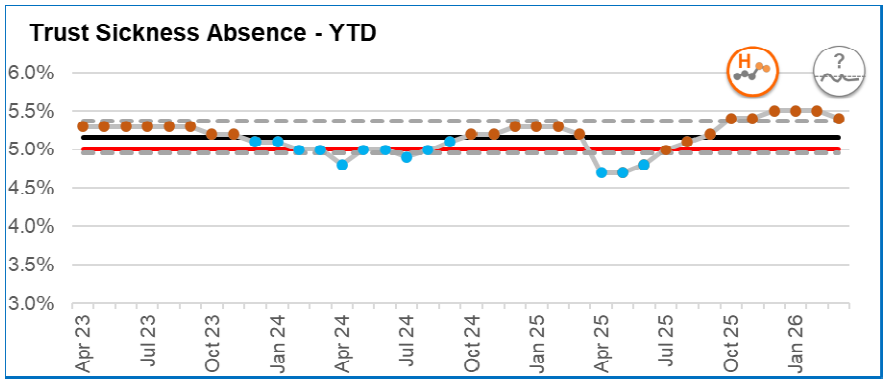
Statistical process control charts



The SPC chart shows that in March 2026 we have entered a period of common cause variation (no concern) following a decrease 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.

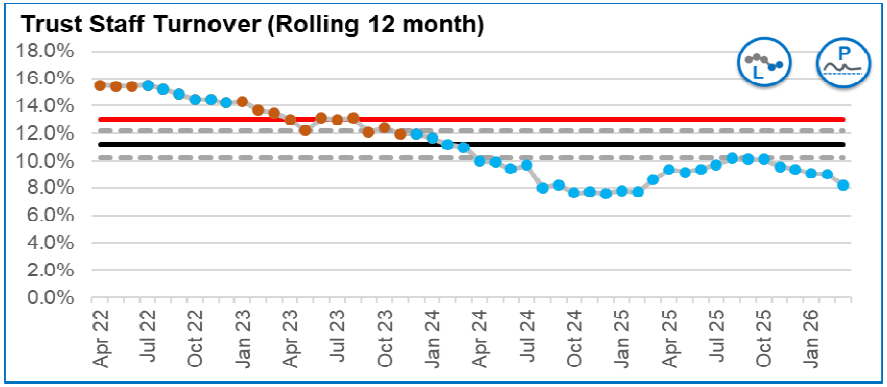


The SPC chart shows that in March 2026 we remain in a period of special cause concerning variation (something is happening and this should be investigated) following a sustained increase in the sickness rate.

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

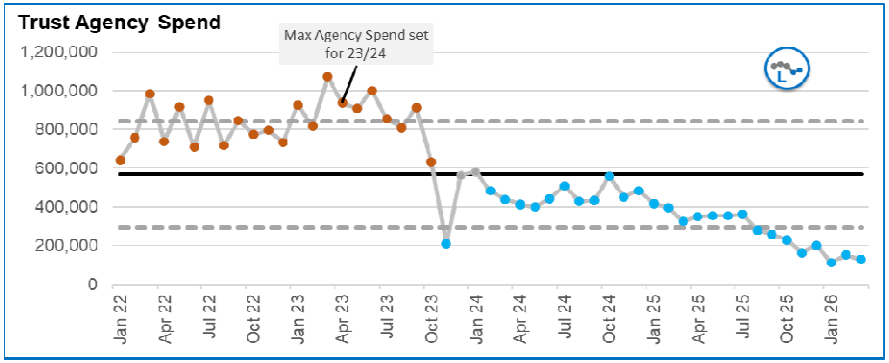
From April 2025 this data includes Cheswold Park Hospital.

Statistical process control charts



The SPC chart shows that in March 2026, 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 has continued to reduce in month. Spend in March 2026 is £127k which is a decrease compared to the previous month, but remains significantly lower than historical run rates. Total spend is £2.9m which is £1.4m less than plan and an overall reduction of £3.5m compared to the prior year.

The SPC chart shows that due to the sustained overall reduction in spend, in February 2026 we remain in a period of special cause improving variation.

From April 2025 this data includes Cheswold Park Hospital.

Please see the Finance Report for further information.

National Metrics

Data as of : 22/04/2026 14:59:18

NHS South West Yorkshire Partnership NHS Foundation Trust

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

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 overleaf 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.

National Metrics

Data as of : 22/04/2026 09:45:45

NHS South West Yorkshire Partnership NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more	Best Quality	Responsive		0			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%			97.1%	97.2%	97.8%	97.7%	97.5%	97.2%	97.1%	97.8%	97.5%	96%	95.6%	96.4%
M202	RTT waiting list, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive					31	53	58	50	47	56	75	61	54	52	48	59
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	0	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	4554	4641	4514	4287	3868	3946	4162
M205	RTT waiting list within 18 weeks, of which children aged 18 years and under (WLMDS)	Best Quality	Responsive					31	53	58	47	45	51	71	61	53	52	45	58
M206	Diagnostic test activity	Best Quality	Responsive		190			128	70	128	206	239	305	273	247	263	294	235	265
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%			97.8%	97.9%	100%	98.7%	96.3%	100%	98.9%	100%	100%	100%	100%	99.1%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0			144	148	159	196	203	234	155	97	76	52	28	73
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5			5	5	5	7	8	7	3	4	2	1	1	2
M7	72 hour follow-up from psychiatric in-patient care	Best Quality	Safe		80%			88.6%	95.7%	90.7%	91.1%	88.6%	88.2%	89.0%	87.8%	87.6%	91.1%	87.7%	87.3%
M208	Average Length of stay for Adult Acute Beds (rolling 3 months)	Best Quality	Responsive					58.9	58.7	56.7	58.0	60.2	59.1	60.2	56.0	54.1	55.1	54.7	56.3
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%			88.2%	88%	97.4%	95.5%	87.5%	93.3%	94.7%	96.4%	96.9%	89.7%	96.4%	96.2%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%			96.7%	97.4%	95.4%	96.1%	96.1%	96.4%	96.9%	96.7%	97.3%	96.8%	96.4%	96.0%
M34	% Clients in settled accommodation	Best Value	Effective	⚠	60%			83.2%	83.5%	83.0%	82.9%	76.0%	82.8%	82.9%	83.3%	83.0%	83.0%	83.2%	83.2%
M35	% Clients in employment	Best Value	Effective	⚠	10%			13.0%	13.2%	13.0%	13.3%	12.6%	13.3%	13.6%	14.0%	13.7%	14.0%	14.1%	14.2%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0			0	0	0	0	0	6	16	2	4	0	2	4
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0			0	0	0	0	0	1	1	1	1	0	1	1

National Metrics

Data as of : 22/04/2026 14:59:18

NHS South West Yorkshire Partnership NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%	?		100%	50%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%	?		75.6%	94.1%	91.3%	81.4%	88.2%	83.8%	94.4%	94.4%	92.9%	91.2%	100%	89.7%
M47	Virtual ward occupancy	Best Quality	Responsive		80%	?		101%	81.3%	90.7%	84%	89.3%	92%	74.7%	70.7%	72%	70.7%	85.3%	62.7%
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					111	109	105	87	99	102	102	83	105	98	101	115
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					24.3%	21.1%	25.7%	23.0%	25.3%	24.5%	20.6%	16.9%	17.1%	23.5%	14.9%	21.7%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%	P		99.7%	99.8%	99.8%	99.7%	99.4%	99.5%	99.3%	99.4%	98.9%	97.7%	98.9%	98.6%
M11	Talking Therapies - Treatment within 18 weeks of referral	Best Quality	Effective		95%	P	H	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
M23	Talking Therapies - Completion of outcome data for appropriate Service Users	Best Quality	Well Led		90%	P		99.5%	99.7%	99.2%	99.7%	99.6%	99.5%	99.5%	99.4%	98.1%	99.1%	99.3%	99.5%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%	?		48.6%	51.9%	47.3%	53.4%	47.2%	52.5%	52.9%	48.7%	50.2%	50.1%	50.5%	54.1%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%	?	H	68.3%	68.7%	65.4%	71.8%	65.8%	70.4%	70.5%	72.2%	68.5%	69.0%	69.7%	71.9%
M15	Data Quality Maturity Index	Best Quality	Well Led		95%	P	H	99.2%	99.6%	99.7%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.5%	99.5%	99.6%
M43	Community health services two hour urgent response standard	Best Quality			70%	F	H	90.9%	91.5%	91.3%	91.4%	92.0%	91.8%	87.4%	89.4%	88.5%	88.1%	88.8%	91.5%

National Metrics

Data as of : 22/04/2026 14:59:18

NHS South West Yorkshire Partnership NHS Foundation Trust

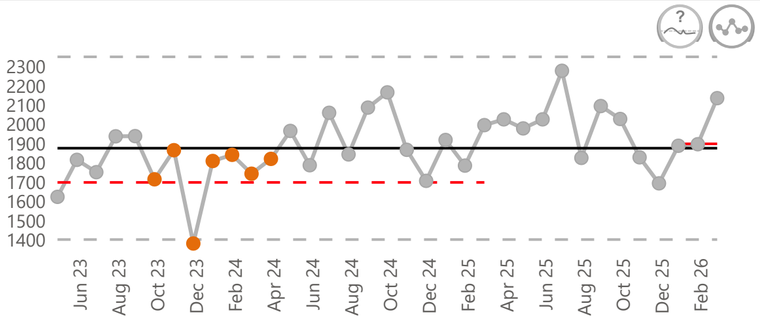
MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%	?		51.0%	53.5%	49.8%	56.1%	49.9%	54.2%	55.2%	50.5%	53.3%	53.1%	52.5%	55.7%
				Place	Barnsley	50%	?		51.3%	52.8%	48.1%	52.8%	52.6%	52.5%	50.9%	50.6%	51.1%	52.8%	49.3%	52.6%
					Kirklees	50%	?		50.7%	54.2%	51.6%	59.0%	47.8%	55.6%	58.0%	50.4%	54.6%	53.2%	54.6%	58.0%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				615	600	653	614	480	550	594	532	539	564	564	581
				Place	Barnsley				318	312	324	272	200	231	228	235	189	196	228	238
					Kirklees				297	288	329	342	280	319	366	297	350	368	336	343
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	14539	14596	14834	14914	14876	14977	14873	14902	14935	14955	15086	15063
				Place	Barnsley	2000	P	L	2831	2872	2934	2984	2991	3015	2940	2905	2866	2845	2831	2796
					Calderdale	1200	P	H	1448	1463	1482	1469	1452	1455	1465	1483	1483	1490	1512	1503
					Kirklees	3600	P	H	4680	4743	4818	4880	4842	4884	4868	4898	4985	5055	5153	5152
					Wakefield	3900	P	H	4332	4309	4403	4403	4427	4508	4533	4604	4629	4641	4716	4778
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust			H	1912	1982	2089	2168	2189	2200	2180	2170	2189	2203	2208	2143
				Place	Barnsley	283	F	H	298	314	332	342	341	349	346	347	346	363	369	352
					Calderdale	247	F	H	305	312	330	339	340	342	325	321	324	325	329	320
					Kirklees	541	?	H	660	694	735	765	780	778	778	777	786	789	795	776
					Wakefield	406	?	H	558	567	588	618	624	622	617	609	608	604	593	573
M194	Number of people accessing individual placement and support (IPS) services (rolling 12 months)	Best Quality	Responsive	Trust	Trust			H	702	710	717	720	718	728	734	728	739	747	755	776
				Place	Calderdale			H	138	138	139	128	122	123	127	126	122	124	121	127
					Kirklees			H	253	255	258	261	260	261	258	256	255	251	254	251
					Wakefield			H	307	313	316	327	334	341	346	343	359	369	376	395

National Metrics

Data as of : 22/04/2026 14:59:18

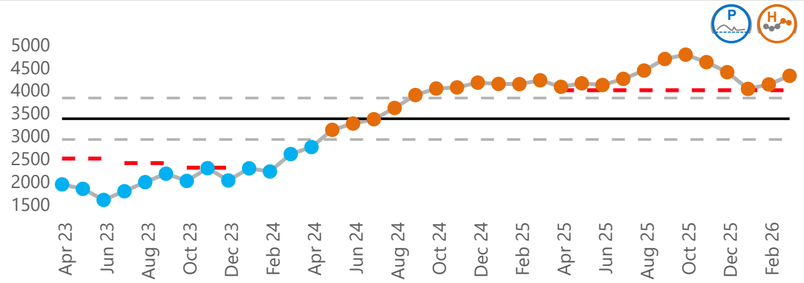
NHS South West Yorkshire Partnership NHS Foundation Trust

M184 - New RTT pathways (clock starts)



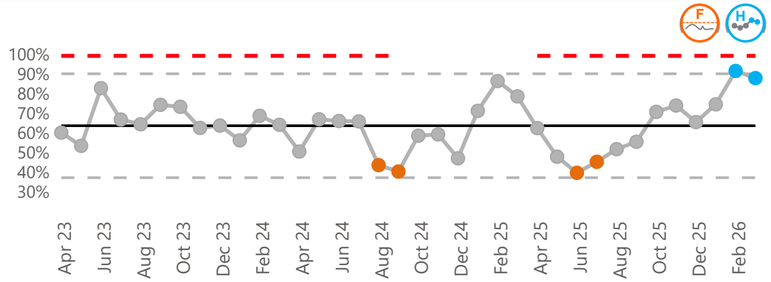
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers. A new target is in place for 2025/26.

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



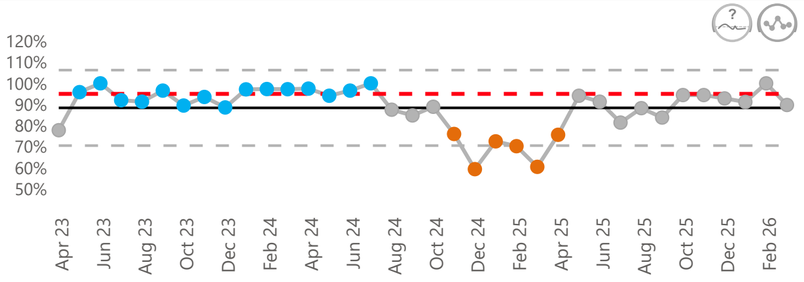
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months.

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



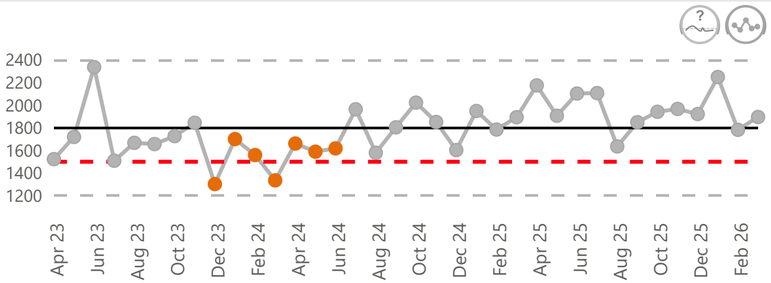
The SPC chart shows that we have entered a period of special cause improving variation (something is happening and should be investigated).

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



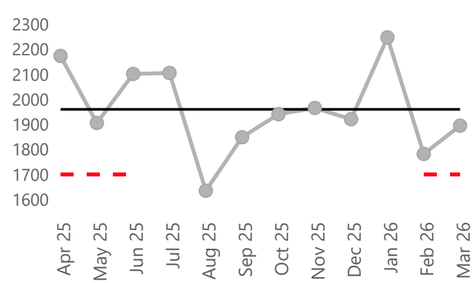
The SPC chart shows that we have re-entered a period of common cause variation (no concern) following an increase in performance in the last month which is back in line with usual performance.

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



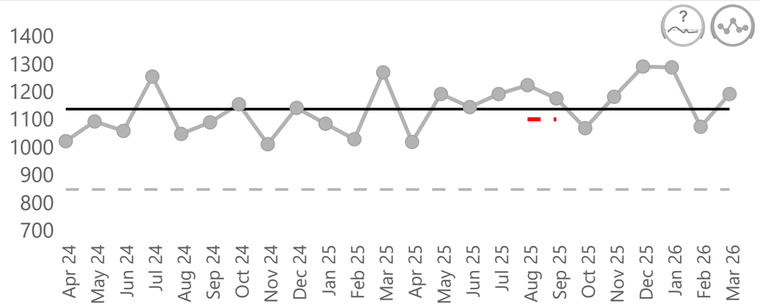
The run chart shows the continued performance above the target for this measure. As this is a new metric from April 2025 we cannot yet determine any patterns in variation.

National Metrics

Data as of : 22/04/2026 14:59:18

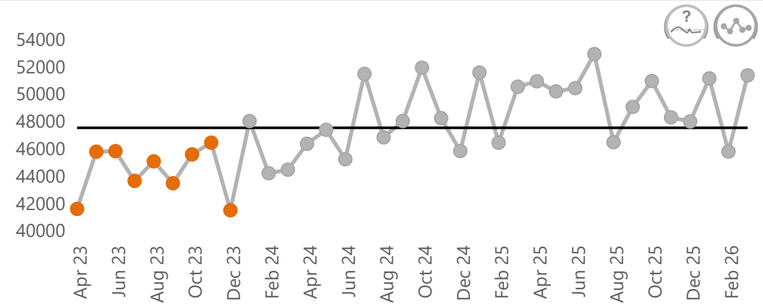
NHS South West Yorkshire Partnership NHS Foundation Trust

M187 - Urgent Community Response (UCR) referrals



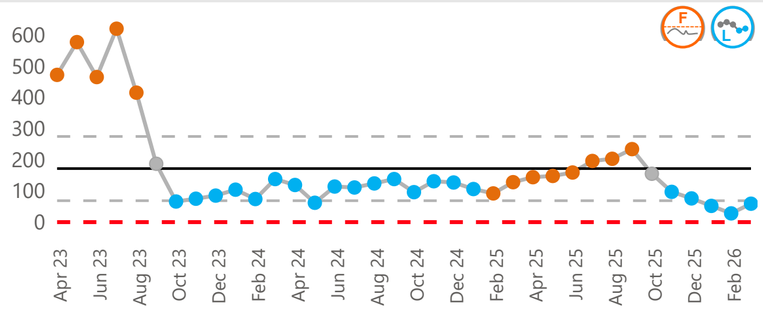
The SPC chart shows that we remain in a period of common cause variation (no concern).

M207 - Attended Community Care Contacts



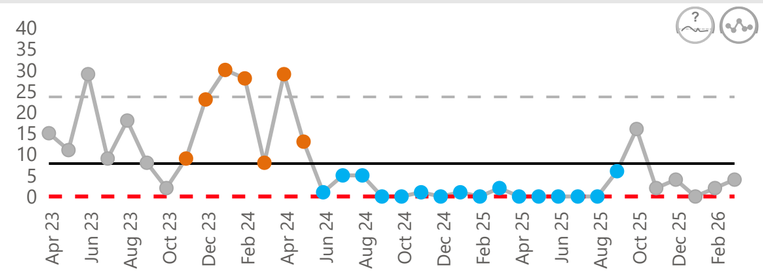
The SPC chart shows that we remain in a period of common cause variation (no concern).

M2 - Inappropriate out of area bed days



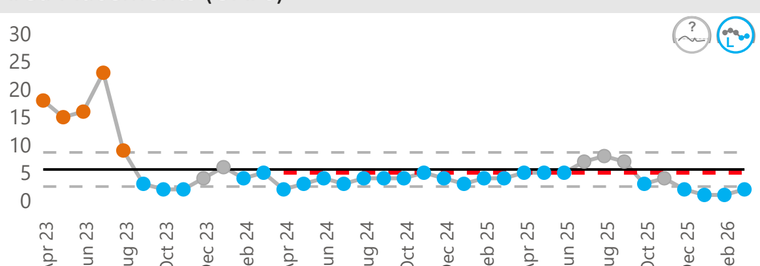
The SPC chart shows that due to the continued improvement in the number of out of area bed days we remain in a period of special cause improving variation (something is happening and should be investigated). Though we are still not anticipated to achieve the target of zero.

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



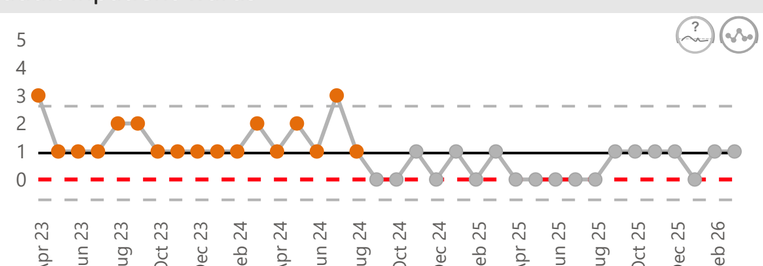
The SPC chart shows that we have entered a period of common cause variation (no concern).

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



The SPC chart shows that due to the continued improvement in the number of out of area placements we have entered a period of special cause improving variation (something is happening and should be investigated).

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



There was one admission of an under 18 year old to an adult ward in March 2026. They were an inpatient for four days

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 : 22/04/2026 09:45:45

NHS South West Yorkshire Partnership NHS Foundation Trust

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

• There was one admission to an adult mental health ward where the person was under 18 years old. The person was an inpatient for four days.
• There was a slight increase in out of area bed usage up to 73 days with three 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 89.5% in March, which relates to 4 cases not seen in 4 weeks. The urgent access to treatment measure has achieved 100% in March.
• Average Length of Stay (ALOS). We continue to see an overall reduction in lengths of stay.
• 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 has decreased to 62.7% in March which is below the target of 80%. Virtual ward onboarding has continued to be affected by consultant capacity to support the pathway during parts of the month. Onboarding has been paused, during the month to ensure that the multi-disciplinary team can safely manage current patients and to process discharges in a timely manner.
• Community services waiting list - This metric reports the total number of people waiting across a range of physical health and well-being services in Barnsley (aligned to the national community services SitRep). There has been a significant increase in demand for musculoskeletal services which is also reflected in the number of incomplete Referral to Treatment (RTT) pathways (M45). It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold.
• The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks in has decreased slightly to 87.7% in Marcg, remaining below the national threshold of 99%. We are continuing to see a decrease in the actual number of patients waiting.

Benchmarking Metrics

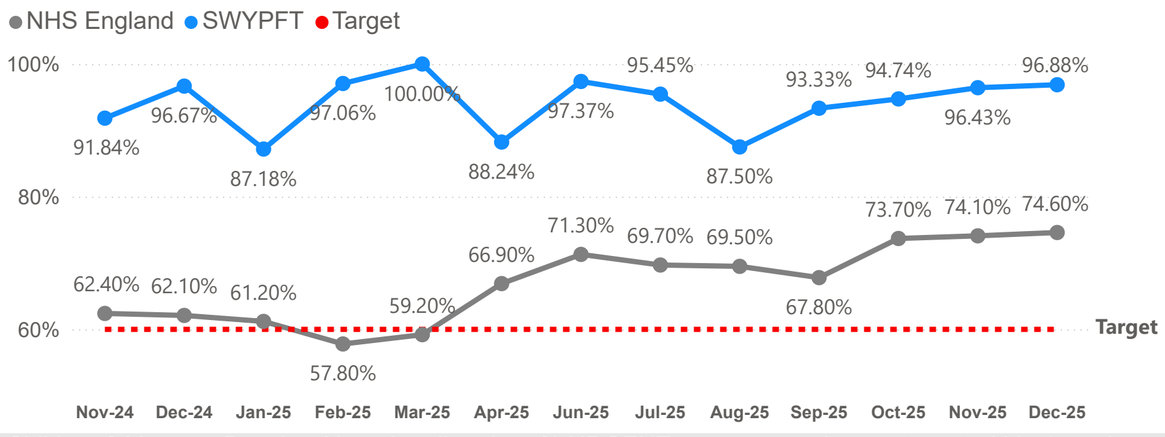
Data as of : 22/04/2026 14:59:18

NHS South West Yorkshire Partnership NHS Foundation Trust

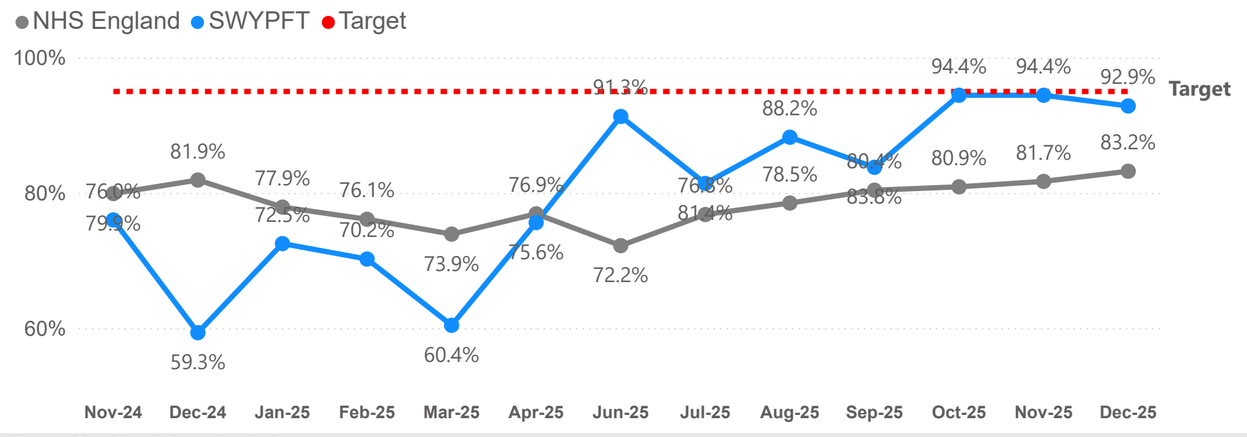
Benchmarking Headlines

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.

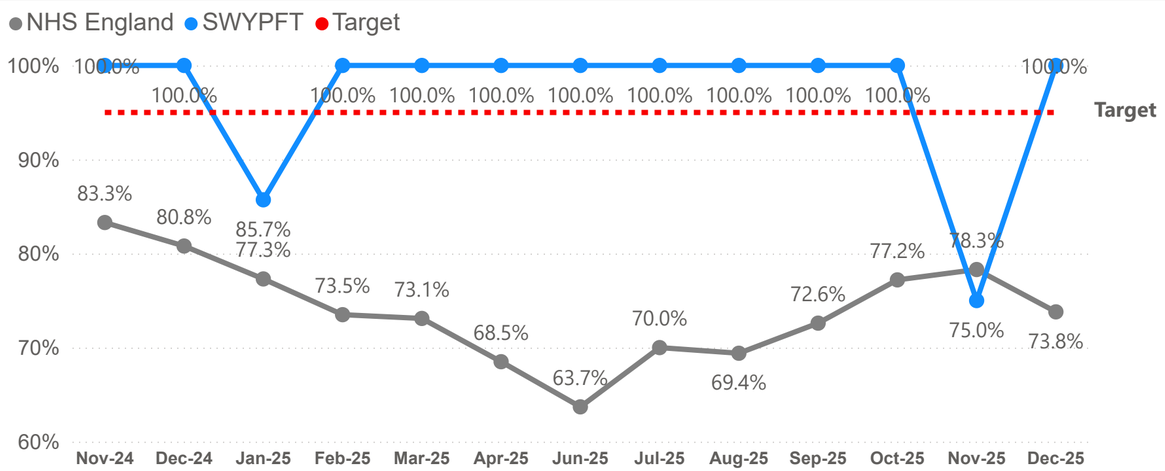
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops



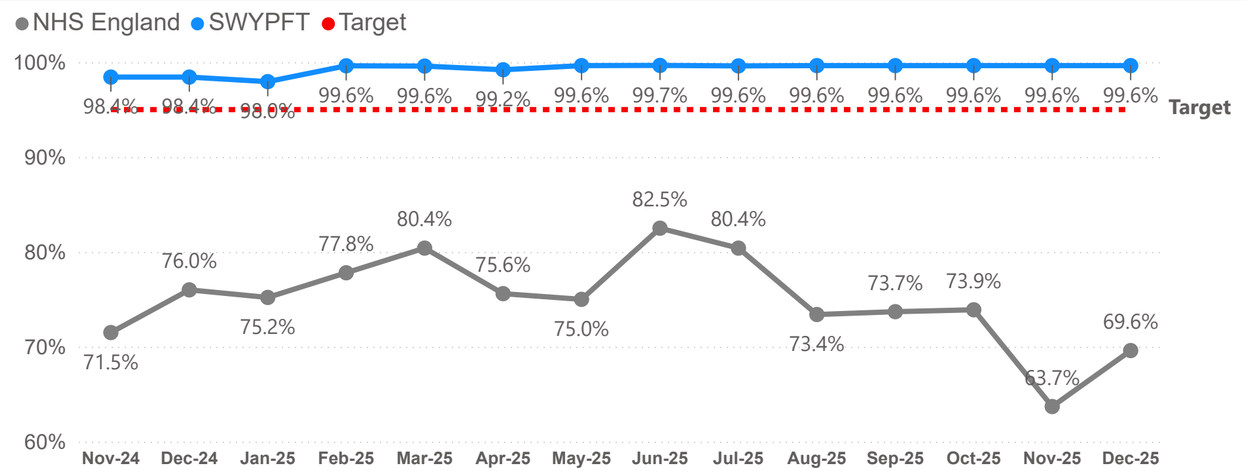
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks



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



Data Quality Maturity Index



NHS Oversight Framework 2025/26

The framework introduced for 2025/26 outlines a consistent and transparent approach to assessing Integrated Care Boards (ICBs), 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 are 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 and 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 quarters 1 and 2 can be seen in the table below and are also publicly available via NHS.co.uk.
The majority of these metrics are already included in the IPR and performance is monitored monthly, where available.

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST (RXG)									
	Quarter 1			Quarter 2			Quarter 3		
	Q1 performance	Q1 score	Q1 rank	Q2 performance	Q2 score	Q2 rank	Q3 performance	Q3 score	Q3 rank
Percentage of community services waiting list waiting over 52 weeks	0.00%	1.00	1/41	0.00%	1.00	1/41	0.00%	1.00	1/41
% 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	34/46	3.12%	2.78	30/49	3.67%	2.90	33/49
DOMAIN SCORE - Access to Services		**2.14**			**1.89**			**1.95**	
National CQC community mental health survey overall experience rating	As expected	2.00		As expected	2.00		As expected	2.00	
Urgent Community Response % achieving 2hr standard	97.68%	1.00	1/37	97.91%	1.07	2/38	64.19%	4.00	38/38
Percentage of adult discharges with a length of stay above 60 days	22.09%	1.83	14/47	25.88%	2.85	30/47	19.84%	1.83	14/47
DOMAIN SCORE - Effectiveness and Experience		**1.61**						**2.61**	
NHS Staff Survey raising concerns sub-score (MHPRV)	6.92	2.00	21/61	6.92	2.00	21/61	6.92	2.00	21/61
Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours	72.24%	1.67	11/45	80.85%	1.37	6/48	80.74%	1.19	4/48
DOMAIN SCORE - Patient Safety		**1.83**						**1.60**	
Sickness absence rate	5.14%	2.19	18/61	4.83%	2.41	21/61	5.44%	2.78	25/61
NHS Staff Survey engagement sub-score (MHPRV)	7.19	2.10	23/61	7.19	2.10	23/61	7.19	2.10	23/61
DOMAIN SCORE - People and Workforce		**2.15**						**2.44**	
Planned surplus / deficit as a proportion of turnover	0.0%		15/61	0.0%	1.00	16/61	0.0%		16/61
YTD surplus / deficit	-0.1%		52/61	0.83%	1.00	3/61	0.63%		6/61
Aggregated finance score		1.00			1.00			1.00	
Relative cost difference	88.55	1.40	10/60	88.96%	1.39	9/61	88.96%	1.39	9/61
DOMAIN SCORE - Productivity and Value for Money		**1.20**						**1.20**	
Total score		28.40			19.97			22.19	
OVERALL AVERAGE SCORE		**2.58**	3/61		1.82			2.02	
FINAL SEGMENTATION	**3 * financial override applied**		26/61	**1**		4/61	**1**		12/61

The Trust's overall score for quarter 3 remains at segment 1 from segment 3. Performance against the measures in the 5 domains is strong and our average Trust score puts the Trust as ranked 4 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.

Underpinning all the operational metrics is data quality. Data used for the metrics is taken from existing data flows, it is therefore 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.

Quarter 4 performance is expected to be published in May or June 2026.

Data quality:
An additional column has been added to the national metrics dashboards to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.

For the month of March the following data quality issue has been identified in the reporting:
- The reporting for employment and accommodation shows 14.4% of records have missing employment and/or accommodation status with a further 2.0% that have an unknown employment status and 1.5% 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.

<u>Operational Planning 2026/27 +</u>
The Trust received feedback from NHS England on our plan on 9th April 2026 confirming the plan as 'Compliant with conditions.

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 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

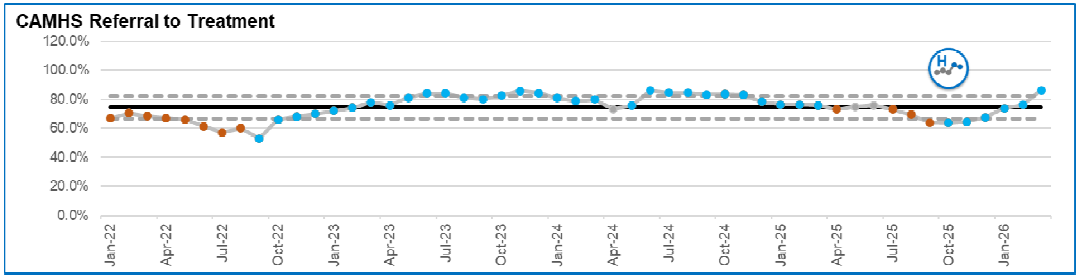
Children and Young Peoples Mental Health Services

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.
Decrease in sickness in February now below threshold. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.

Children and Young Peoples Mental Health Services (CAMHS)

Metrics	Strategic Objective	CQC Domain	Threshold	Jan-26	Feb-26	Mar-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	88.8%	91.1%	92.8%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (2/6)	0% (0/2)	0% (0/6)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	90.5%	91.8%	93.5%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	100.0%	100.0%	98.5%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.8%	86.7%	85.5%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	90.9%	100.0%	89.5%	
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%	95.7%	96.0%	95.4%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.3%	90.5%	89.8%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.2%	4.4%	4.0%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	535	565	595	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	1083	1081	1137	
Total number of reported incidents	Best Quality	Safe	Trend monitor	59	51	55	



In March 2026, the SPC chart indicates that we remain in a period of special cause improving variation (something is happening and this should be investigated). See narrative below for further information.

Alert/Action

• Kirklees Keeping in Mind (KKiM) MHST (mental health support into schools) continues to experience significant challenges around referral numbers and recruitment and retention. The service is developing its offer to align with its provision with the national model, working collaboratively with schools, local Authority and ICB. Further funding will be available over the next 3 years to provide sufficient resource to provide MHST service to 100% of schools in Kirklees.
• Wakefield CAMHS ReACH Team and Primary Intervention Team (PIT), which is the single point of access (SPA), have experienced challenges recruiting to posts. Recent recruitment to the Team has improved allocation. The team remains red on the risk register due to long term sickness and position and vacancies awaiting recruitment. Paediatric Liaison has been streamlined and formalised to ensure this resource complements ReACH. Core team long term sickness and maternity leave is impacting on waits for psychotherapy interventions. There is an action plan in place, monitored in the waits improvement group.
• Secure CAMHS –The installation of SWYFT IT system access within the three settings has been approved, and the majority of the work has been completed. Adel Beck and Aldine House Secure Children's Homes now have the SWYFT network; however, installation in Wetherby YOI remains outstanding.
• Secure CAMHS –Work continues to determine the responsibilities and associated finance for the prescribing of mental health medications in the secure children's homes in accordance with contractual arrangements.
• The 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
• Barnsley CAMHS- are experiencing challenges with transitions to adult services for children and young people with ADHD and on prescribed medication. This is impacted by the current position regarding shared care agreements being taken by primary care. Discussions at place and with partners are ongoing.
• A weekly rapid improvement group has been established to reduce CAMHS treatment waits and each locality has an action plan. Actions include streamlining meeting attendance, job planning reviews to increase clinical appointment capacity, streamlining clinical pathways including allocation and data quality improvement work.

Advise

• Barnsley CAMHS- The business proposal approved by commissioners for two posts for learning disability nursing will positively impact health inequalities and service user experience. Mobilisation plans are in place, and the service have successfully recruited into post. Funding has been approved for phase 2 of the model, which is a more comprehensive team for CAMHS LD, recruitment is underway. Funding will flow in April.
• 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 are 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. The 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.
• Calderdale C&YP have been part of the area SEND inspection the outcome of which we will learn after to May elections.

Assure

• The appraisal rate in C&YP in March was 92.5% above the 90% target.
• Overall mandatory training compliance for C&YP in March was 95% above the target of 80%
• Sickness levels were 3.75% in March.

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. Usage of out of area beds continues to be closely monitored and managed and has seen a sustained reduction over the past months.

Bed occupancy has stayed around the same but high acuity remains. 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 though there has been reduction in February. 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 sickness has also increased and remains above Trust threshold.

Appraisal rate within inpatient services is improving and now just below the threshold.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Jan-26	Feb-26	Mar-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	90.9%	91.0%	93.0%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	85.0%	88.8%	88.8%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	100.0%	99.1%	98.4%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	10% (2/20)	31% (5/16)	13% (2/16)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	92.9%	93.8%	94.3%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	91.1%	87.7%	87.3%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	96.2%	95.3%	95.4%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	96.9%	96.5%	96.3%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.4%	84.9%	86.5%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	96.2%	96.5%	97.1%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.0%	95.9%	96.8%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	88.6%	88.6%	90.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.4%	5.3%	5.1%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,131	13,212	13,221	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	151	128	104	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Jan-26	Feb-26	Mar-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	86.3%	84.7%	89.1%	
% Bed occupancy (excl leave)	Best Quality	Safe	85%	88.8%	88.8%	86.8%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/3)	0% (0/5)	0% (0/4)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	89.0%	91.3%	93.9%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.6%	88.2%	89.6%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.7%	8.7%	10.1%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	91.0%	90.9%	86.4%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	155 (March)	52	28	73	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.6%	97.3%	97.3%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	18	25	16	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	55	53	43	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	89.9%	89.9%	89.0%	
Restraint incidents	Best Quality	Safe	Trend Monitor	111	154	*127*	
Safer staffing (Overall)	Best Quality	Safe	90%	117.6%	119.1%	117.3%	
Safer staffing (Registered)	Best Quality	Safe	80%	99.8%	99.9%	100.1%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	7.1%	5.3%	5.2%	
Average length of stay - Acute and Psychiatric Intensive Care Unit - West Yorkshire (3 Months Rolling)	Best Quality	Safe	Jan 58.3, Feb 57.8, Mar 57.2	47.2	52.7	57.5	
Average length of stay - Acute and Psychiatric Intensive Care Unit - South Yorkshire (3 Months Rolling)	Best Quality	Safe	Jan 59.0, Feb 58.5, Mar 58.0	52.9	45.0	47.3	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	549	589	548	

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 safety 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.
• 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 March some acute wards have worked above establishment. This is closely monitored by senior managers.
• Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The situation remains challenging in March 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. FIRM percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions. There is a high level of scrutiny when a FIRM risk assessment is not completed or reviewed and updated within 24 hours pre or post admission. 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.
• Care plan metrics for community capture the whole community caseload rather than only individuals on CPA. The care group are working with P&BI to ensure the metric reflects practice. Continued improvement in March in all areas.
• Care Programme Approach (CPA) review performance is above target in Barnsley, Calderdale and Wakefield. Kirklees is slightly under the 95% target this month at 94.18%. Action plans and support from Quality and Governance Leads remain in place and all areas are expected to be above threshold in April.
• 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. In March the access standard for assessed within 14 days of referral has been met in all localities. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage and have achieved the access target in March.

Advise

• Improvement work is underway to understand the capacity and demand pressures on inpatient services and is monitored via the Inpatient Priority Programme. In addition, there is a focus on implementing the culture of care standards to improve the therapeutic nature of inpatient care for both service users and staff.
• Work continues in front line community services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home including provision of robust gatekeeping and crisis alternatives, trauma informed care and effective intensive home treatment.
• The Talking Therapies recovery rate for March is 52.56% for Barnsley and 58.41% for Kirklees, both achieving the national standard of 50%. In March Barnsley achieved the expected national standard of less than 10% for waits to second treatment within 90 days at 9.09%. Kirklees Talking Therapies were above the expected national standard at 14.5%. 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.
• The care group holds monthly meetings to track and review progress of Equality Impact Assessments (EIAs). Performance remains strong. Delay in completion of EIAs in some areas have been due to manager changes/sickness and the service line Trios are supporting the teams in their completion.
• Equality data – we are working with a Trustwide quality improvement group to enhance how equality information is captured on SystmOne. Completeness of equality data is on our data quality improvement action plan.
• There were four incidents of prone restraint within the care group in March, all were under 3 minutes duration. The prone restraints were staff led for clinical reasons specific to the individuals and related to exiting seclusion. All prone restraints are reviewed by RRPI specialist advisors and any identified learning shared to the clinical team. The care group continue to work collaboratively with colleagues in Nursing, Quality, and Professions to support the Trusts ambition for zero staff led prone restraint.

Assure

• IHBT teams continue to perform well in gatekeeping admissions to our inpatient beds.
• Supervision continues to be above the 80% threshold in March at 94.3%
• The care group appraisal rate was also above the 90% threshold at 92%
• The care group is above target in all areas of mandatory training.

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. 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.
Clinically ready for discharge rate has reached 100%.

LD, ADHD & ASD

Metrics	Strategic Objective	CQC Domain	Threshold	Jan-26	Feb-26	Mar-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	91.6%	91.7%	92.1%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	25% (2/8)	0% (0/2)	0% (0/2)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	90.4%	93.8%	96.6%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	50.0%	50.0%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.1%	90.5%	89.9%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	75.0%	75.0%	100.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	95.3%	96.8%	98.2%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	88.2%	88.0%	87.1%	
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	9	4	9	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.2%	92.7%	91.6%	
Safer staffing (Overall)	Best Quality	Safe	90%	123.4%	122.1%	121.5%	
Safer staffing (Registered)	Best Quality	Safe	80%	178.0%	188.0%	171.8%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.8%	4.2%	4.4%	
Restraint incidents	Best Quality	Safe	Trend Monitor	7	8	*5*	
Average length of stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	40	42	37	

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

Alert/Action

West Yorkshire ICB Neurodiversity Project – Update
Other NHS providers across West Yorkshire are working with the ICB commissioned independent sector to support the management of ADHD and Autism assessment waiting lists for both children, young people and adults. This service has not yet commenced transfers via this route. In collaboration with CAMHS colleagues, the position has been appropriately escalated, and constructive discussions with commissioners are scheduled to consider the most appropriate and equitable approach for this population.

South Yorkshire ICB Neurodiversity Project – Update
The service has been advised that decisions on the business cases submitted for this financial year will be delayed. Further clarification on next steps is awaited, and confirmation of future meeting arrangements is expected in due course.

Advise

Kirklees ADHD & Autism
Kirklees has fully invested in a Neurodiversity Single Point of Access (SPA). All referrals from this area are routed to the Trust for a decision regarding clinical appropriateness before individuals are able to exercise choice of provider for assessment under the Right to Choose framework. Referrals assessed as not clinically appropriate are not progressed to assessment, in line with Kirklees commissioning arrangements.
There remains a backlog within ADHD triage; however, additional investment from April 2026 is expected to support backlog reduction over the next 12 months, subject to referral rates remaining consistent.

Calderdale ADHD & Autism
Calderdale commissioners have advised Business Development colleagues of their intention to formally agree a capped block contract for both ADHD and Autism, aligned to current activity levels. The proposed contract would not include ADHD or Autism triage; however, commissioners are also considering offering non recurrent funding to reinstate Autism triage (paused in May 2023) and to introduce ADHD triage.
The service is currently scoping this proposal to ensure it is operationally deliverable and sustainable within the proposed funding envelope. Unlike the Kirklees pathway, referrers within Calderdale are not currently required to obtain a clinical appropriateness decision prior to referral.

Wakefield ADHD
Wakefield has confirmed recurrent funding for ADHD triage and has discussed commissioning preferences with the service. Recent reductions in demand mean that current funding is sufficient to deliver triage at present activity levels, though it would not accommodate an increase in demand or address the existing backlog.
The service is developing options for consideration via EMT, including potential referral capping arrangements, to ensure activity remains financially sustainable. As with Calderdale, Wakefield referral pathways do not currently require a clinical appropriateness decision prior to referral, differing from the Kirklees model.

Assure

- All KPI targets met.
- Excellent levels of supervision, appraisal and mandatory training.
- Low level of vacancies.
- All mandatory training meeting the threshold.

Learning disability services:

Alert/Action

Responsibility for the delivery and oversight of Care (Education) and Treatment Reviews (C(E)TRs) and the Dynamic Support Register (DSR) for Calderdale, Kirklees and Wakefield has now transferred to Learning Disability Services.

Community
• The service has enrolled in the Quality Network for Learning Disabilities (QNLD) Development Programme to strengthen the quality and consistency of community provision in line with QNLD standards, supporting progression towards accreditation.

Horizon – Assessment and Treatment Unit (ATU)
• A comprehensive review of Assessment and Treatment Unit (ATU) provision across West Yorkshire is progressing in partnership with system partners, supported by dedicated collaborative workstreams. The review is nearing completion, with an options appraisal being finalised to define a sustainable, system aligned model that reflects demand, quality expectations, and financial sustainability.

Advise

Appraisal, Supervision & Training
Supervision and Appraisal – The service continues to focus on meeting supervision and appraisal standards. Appraisal compliance has improved and is now above the required threshold at 90.8%. Compliance with mandatory training continues to improve and is meeting required thresholds.

Community
• Following a successful six month proof of concept, recurrent funding has now been confirmed for the Learning Disability ADHD diagnostic service.
• Waiting lists continue to be effectively managed, supported by a clear and detailed understanding of current pressures and challenges. The service maintains strong oversight of cases where treatment times have exceeded expected standards. Any performance gaps are attributable to vacancy or absence within single post holder roles, rather than systemic service issues.
• Routine audits of risk assessments and care plans are now embedded across all service areas, with ongoing action planning in place. These processes have already delivered measurable improvements, with further progress continuing.
• Revised service specifications for Calderdale, Kirklees and Wakefield have been implemented, with constructive discussions underway with Barnsley commissioners to agree the revised specification.

Horizon – Assessment and Treatment Unit (ATU)
• There have been four admissions, with four individuals currently identified as ready for discharge. Of these, one individual is in transition and expected to be discharged by the end of May; two have confirmed placements but are not expected to be ready until September; and one has potential placements identified and is progressing through the best interests decision making process.
• Three clinicians have completed training on the revised HoNOS outcome measure, and this is now being embedded into routine ward based practice.

Assure

Annual health checks in all four localities have exceeded the 75% threshold.
Appraisal – now meeting the threshold.
Mandatory training compliance is meeting required thresholds across all teams.

Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue though there has been a slight decrease - 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	Jan-26	Feb-26	Mar-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	80.0%	76.3%	74.4%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	87.2%	86.4%	87.8%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/0)	0% (0/0)	0% (0/0)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	87.0%	89.0%	87.6%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	100.0%	100.0%	99.1%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.0%	83.7%	82.0%	
% 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%	100.0%	100.0%	100.0%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95.0%	80.2%	81.7%	83.9%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	94.7%	93.8%	94.0%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	3	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	8	4	9	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.1%	89.4%	91.0%	
Restraint incidents	Best Quality	Safe	Trend Monitor	22	13	*17*	
Safer staffing (Overall)	Best Quality	Safe	90%	115.0%	104.4%	105.4%	
Safer staffing (Registered)	Best Quality	Safe	80%	100.7%	102.4%	99.9%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	7.0%	6.1%	6.0%	
Average length of stay	Best Quality	Safe	Trend Monitor	1320	540	660	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	193	149	181	

Forensic - West Yorkshire:

Alert/Action

Future Capacity & Demand

Work is progressing within the West Yorkshire Provider Collaborative and across the wider region to model future demand, inform system planning, and align capacity to support sustainable service delivery.

Bed Occupancy

Occupancy across medium secure services remains broadly unchanged this month, with the most significant variance continuing within the learning disabilities (LD) pathway. Four of the eight LD beds remain unoccupied, and a proportion of occupied capacity continues to reflect out of area placements. Discharges have progressed within the male pathway, alongside admissions within the women's pathway, which is now operating at full occupancy.

Pathway specific pressures continue to impact operational efficiency and resource utilisation. To support forward planning, the service has commenced a detailed bed modelling exercise in partnership with the commissioning hub, to ensure future configuration and capacity across all pathways are aligned with current activity patterns and projected demand.

- Newton Lodge: 88.96%
- Bretton Centre: 90.41%
- Newhaven: 75%

Vacancies

HCA vacancies remain high this month continuing to place pressure on rota coverage and operational resilience, which also impacts on the services use of temporary staffing. Recruitment activity is ongoing but high turnover in the cohort of staff means the service is making limited impact on the overall number of vacancies.

Advise

Sickness Absence – Sickness absence continues to be a key area of focus across the service. A targeted programme of work is now underway, supported by the People Directorate, to support teams in understanding and addressing the underlying drivers of absence and to strengthen overall attendance.
The year to date position is as follows: Newton Lodge 6.3%, Bretton Centre 8.6%, and Newhaven 10.2%. The increase at Bretton Centre in March reflects a rise in short term sickness absence, primarily related to seasonal physical illness. In contrast, the in month position for Newhaven demonstrates a significant reduction.
The targeted actions in place are subject to regular review through established workforce and performance governance arrangements. Progress will continue to be monitored at locality and service level, with a focus on reducing short term absence, sustaining recent improvements, and ensuring appropriate early support and management interventions are in place. This approach is expected to deliver a gradual and sustainable improvement in attendance over the coming months.

Mandatory training overall compliance: Compliance remains strong overall, with identified hotspots including CPR at Newton Lodge (79.2%), Information Governance (IG) at Newton Lodge (92.6%), and IG at Newhaven (88.2%). Targeted actions are in place to address these areas, including focused follow up with staff, planned training sessions, and local management oversight. Compliance is monitored through established governance arrangements, and the service is confident that these actions will bring performance back within required thresholds over the coming reporting period, with appropriate assurance maintained in the interim.

Forensic Improvement Programme – The programme continues to make steady progress, with several workstreams focused on improving service user experience and outcomes, as well as driving operational efficiencies. These workstreams form part of a coordinated improvement programme and are being actively monitored through the Care Group Governance structure and the Operational Management Group (OMG), ensuring appropriate oversight, risk management, and delivery against agreed milestones.

FIRM Risk Assessment and Care Planning – Targeted quality improvement work has been implemented to strengthen compliance with FIRM risk assessment and care planning standards. Compliance has now reached the required threshold, with ongoing audit and governance arrangements in place to sustain improvement and provide continued assurance.

Appraisal – Appraisal performance has dipped, with compliance currently at 72.8%. This reduction reflects the volume of staff becoming due for appraisal at this point in the annual cycle. Planning is underway to support recovery of compliance alongside preparation for the introduction of the new appraisal system. This includes phased implementation planning, management briefings, and alignment of appraisal schedules to ensure a smooth transition. These arrangements are expected to support improved visibility, timeliness, and sustainability of appraisal completion over the coming months, providing assurance as the new system is embedded.

Assure

- High levels of Data Quality across the Care Group.
- 100% compliance for HCR20 completed within 3 months of admission.
- CPA – 100%
- Turnover rates within normal variation, Newton Lodge 10.1%, Bretton Centre 3.1% & Newhaven 10.2%

Forensic - South Yorkshire							
Metrics	**Strategic Objective**	**CQC Domain**	**Threshold**	**Jan-26**	**Feb-26**	**Mar-26**	**Variation/ Assurance**
% Appraisal rate	Best place to work and learn	Well led	90%	76.5%	71.1%	63.3%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	84.4%	82.4%	84.8%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	0% (0/0)	0% (0/1)	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	98.3%	97.3%	94.7%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.5%	87.6%	82.4%	
% 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%	95.8%	95.3%	94.8%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	0	3	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	3	9	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.4%	82.6%	89.5%	
Restraint incidents	Best Quality	Safe	Trend Monitor	16	9	*8*	
Safer staffing (Overall)	Best Quality	Safe	90%	125.5%	114.9%	112.2%	
Safer staffing (Registered)	Best Quality	Safe	80%	96.0%	98.9%	89.9%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.4%	3.9%	3.3%	3.3%	
Average length of stay	Best Quality	Safe	Trend Monitor	967	700	1273	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	178	101	157	

Forensic - South Yorkshire:

Alert/Action

• **Water Quality –** Ongoing water quality issues are being actively managed. Remedial estates works have been completed, with daily flushing regimes and continued water quality testing in place. Esk Ward bedrooms have now reopened following the completion of maintenance works, providing assurance on environmental safety.
• **Patient Property –** A review of patient property arrangements is underway. Revised property limits for both low and medium secure services have now been approved, supporting consistency and safety across settings.
• Relational Security Training – A training need in relation to relational security has been identified. Immediate actions have been agreed, with staff scheduled to attend Boundary Violation Training in April 2026, delivered with support from West Yorkshire Forensic Services.
• Policy Reviews and Transfers – The following policies are scheduled for transfer during Q1 and Q2 2026/27, aligned to Trust wide review cycles and training needs identified outside of the mandatory training programme:
    • Observation and Engagement Policy
    • Section 17 (S17) Policy
    • Supervision Policy
• **Capacity and Demand Modelling –** A system wide capacity and demand modelling exercise is underway across South Yorkshire, West Yorkshire, and the Humber, supporting strategic planning and alignment of future service configuration with projected demand. Current bed occupancy is 79.
• **Appraisal –** Appraisal performance has dipped, with compliance currently at 65.5%. This reduction largely reflects the volume of staff becoming due for appraisal at this point in the annual cycle. Planning is underway to support recovery of compliance alongside preparation for the introduction of the new appraisal system. This includes phased implementation planning, management briefings, and alignment of appraisal schedules to ensure a smooth transition. These arrangements are expected to support improved visibility, timeliness, and sustainability of appraisal completion over the coming months, providing assurance as the new system is embedded.
• **Turnover –** The recent workforce deep dive identified turnover at 17.1%. The service is undertaking further analysis to develop a more detailed understanding of the underlying drivers, including role specific and local factors, to inform targeted retention actions and strengthen workforce stability.

Advise

Wentbridge Ward Update (ASD Service)
Wentbridge Ward remains closed; however, roof repair works have now commenced. Progress has been slower than anticipated due to the recent period of wet weather, but work continues and will be monitored closely.
Mobile Phone Access Policy – A review of the mobile phone access policy is planned for April 2026 to ensure continued alignment with security, therapeutic engagement, and patient safety requirements.
Restrictive Practice Reduction (RRP) – RRP training for Cheswold Park Hospital (CPH) staff has commenced and is being positively received. Delivery of the RRP integration plan remains on track, with approximately 80% of staff projected to have completed training by the end of March 2026. RRP training will transition into business as usual from 1 April 2026.
Electronic Prescribing and Medicines Administration (EPMA) has now been successfully implemented across all wards.
FIRM Risk Assessment – FIRM risk assessment training has been completed, with plans in place to transition from START to FIRM by 20 March 2026.
Benchmarking and Learning – A benchmarking exercise has been undertaken against the findings from the St Andrew's CQC initial inspection report, with comparative review across South and West Yorkshire forensic inpatient services to support shared learning and service improvement.
Annual Quality Review – a commissioner led review will take place in April.
Cheswold Park – The service continues to integrate into the Forensic Care Group, embedding Trust governance and operational frameworks to ensure consistent standards and strong oversight. Quality and safety remain key priorities and are monitored through the internal Quality Improvement Group, which now meets quarterly. External assurance from NHSE and the South Yorkshire Provider Collaborative continues at routine levels, reflecting confidence in the progress made to date.

As outlined previously, strategic priorities remain focused on stabilisation, service development, and future planning. Work is underway to establish a clear clinical and operational model to guide future service delivery and inform workforce planning.

Assure

- Relationships with the South Yorkshire Provider Collaborative are much improved with joint working regarding future bed modelling continuing to be a priority.
- SWYPFT policy integration continues.

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). This continues to be a national issue and the Care Group continue to discuss with commissioners.

The sickness rate remains above threshold but is reducing.

Barnsley Physical Health and Wellbeing

Metrics	Strategic Objective	CQC Domain	Threshold	Jan-26	Feb-26	Mar-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	89.8%	88.0%	89.4%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/3)	50% (1/2)	0% (0/2)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	97.37%	84.62%	87.10%	
% of staff receiving supervision within policy guidance	Best place to work and learn	Well led	80%	78.8%	83.5%	86.3%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.2%	87.7%	86.2%	
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%	95.6%	94.6%	94.0%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	96.0%	95.6%	96.4%	
Safer staffing (Overall)	Best Quality	Safe	90%	93.6%	94.6%	93.8%	
Safer staffing (Registered)	Best Quality	Safe	80%	91.7%	98.3%	93.4%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	6.0%	6.0%	5.4%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	99%	75.2%	91.3%	87.7%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	6,578	6,659	7,038	
Total number of reported incidents	Best Quality	Safe	Trend monitor	298	250	271	

Barnsley Physical Health and Wellbeing Care Group

Alert/Action

• Virtual Ward occupancy rate has seen an expected decrease below compliance to 62.7% against the target of 80%. Frailty Virtual Ward onboarding, for acute step-downs, was paused from 12th March 2026 – 7th April 2026 due to consultant geriatrician capacity to oversee the pathway. We continued to support step-up onboardings for hospital avoidance / admission avoidance patients.

Advise

• Paediatric Audiology 6-week target for diagnostic procedures has seen a slight reduction during March from 90.63% to 87.7% against the target of 99%. The total number waiting continues to reduce and as at 12.4.26 this figure was down to 106 patients. To note: The target of 99% is not achieved nationally.
• Overall sickness rates remain outside compliance for the month of March but are showing a further improvement at 5.4%. We continue to have some instances of long-term sicknesses relating to serious illnesses. The care group 12-month rolling figure is 5.04%. Our year-to-date figure achieves compliancy at 5%.
• Appraisals - for March, the overall care group figure is 89.4% which is marginally below the target of 90%. To note: the care group was a pilot site for the new appraisal system during January and February and therefore this impacted compliance during the short term as staff had to attend training before they could undertake appraisals due during that period. For the services that are not currently meeting compliance, General Managers have been focussing on these teams and have plans in place with appraisals scheduled where necessary. For some teams there has been an issue regarding inputting which should be rectified soon. In addition, our Specialist Nursing teams are small in terms of whole time equivalent and headcount therefore when impacted by short term sickness, this generates a significant change in percentage compliancy.
• Information Governance training is marginally below compliance at 94%. Senior Management are aware and focussing on this with teams.

Assure

• Staff receiving supervision - the March figure has continued to improve and increased to 86.3%. Professional Leads and Quality, Governance and Performance Manager are continuing to undertake work to improve supervision levels as we enter the new separate targets from April 2026.
• Urgent Community Response Service 2-hour target has achieved 91.4% for March which continues to be well above the 70% threshold.
• Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 96.43% for March 2026.
• People dying in their place of choosing continues to maintain compliancy at 87.1% for March against the threshold of 80%.
• Friends and Family Test (FFT) – 96% of people would recommend community services.
• CPR training maintains compliance at 86.2% for March.
• Penistone Neighbourhood Nursing Team recognised and celebrated an incredible 50 years of service to the NHS one of their district nurses.
• Our Neighbourhood Rehabilitation Service (NRS), supporting patients in the Cedars Intermediate Care (IMC) unit at Buckingham Care Home in Penistone, recently received outstanding feedback from the South Yorkshire Integrated Care Board Contracts Manager. Colleagues received significant praise from care home staff for their shared learning and support to deliver high quality care. The seamless approach highlights the importance of collaborative working to provide a better experience for residents and patients on the unit.
• One of our Stroke Physiotherapists has been awarded an NIHR-funded internship (National Institute for Health and Care Research) as part of the inaugural cohort for the Yorkshire and Humber Community of Research Practice.
• Our Stroke Association Support Worker has completed a qualification as a Mental Health First Aider which will benefit both stroke survivors and carers.

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
• 12 wards out of 17 are above the 90% compliance threshold in March.
• Nostell (82.4%) and Ward 19 Female (88.2%), are both above compliance as of 16/04/26 following targeted work by the ward managers.
• Ashdale (80%) compliance has improved to 87.5% (as of 16/04/26) with outstanding appraisals scheduled.
• The compliance drop on Ward 18 (38.1%) is due to a large number of staff appraisals expiring at the same time. Some appraisals have been completed but not recorded and those outstanding have been scheduled throughout April.
• Crofton (38.9%) compliance remains below threshold and continues to be impacted by ongoing ward manager absence. The matron has scheduled appraisals however they have needed to be cancelled due to either staff absence or clinical demands. These have been rebooked and strong efforts are being made by the matron to action appraisals as soon as possible.

Sickness
• 6 wards have sickness rates below 5% compliance threshold.
• Sickness improved to below threshold in March on Nostell and Ashdale following the return of staff from long term sick.
• Sickness increased to above threshold on Melton (7.9%), Ward 18 (5.5%), Beechdale (5.6%) and Enfield Down (5.1%) due to both long and short-term sickness, no themes.
• Sickness remains above threshold and has increased on Willow (14%) and Lyndhurst (6.5%) due to both short term and long-term sickness, no themes.
• Although still above threshold, sickness on Beamshaw (5.2%), Elmdale (8.3%), Crofton (6.6%), Poplars (6.7%), and Ward 19 Female (11.9%) has reduced following the return of staff from long term sickness and a reduction in 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
• 16 wards are above 80% compliance target for March, 9 of those wards are at 100% supervision compliance.
• Nostell (57.1%) remain below compliance impacted by a combination of vacancies and high clinical acuity, with the ward manager supporting in clinical numbers on numerous occasions. The matron is supporting oversight with staff outside of compliance being prioritised.
• The senior leadership team maintain close oversight of supervision compliance via the weekly inpatient quality and performance meeting.

Mandatory Training
Information Governance (IG)
• 11 wards are above 95% compliance target for March.
• Beamshaw (91.7%), Melton (93.8%), Nostell (88.5%) and Ashdale (93.9%) are under threshold and action is being taken by the ward managers to ensure the staff outstanding complete the e-learning.
• Willow (88.9%) and Ward 19 Female (84.2%) are under threshold due to staff outside of compliance being absent from work due to long-term sickness.
• The senior leadership team maintain close oversight of information governance training compliance via the weekly inpatient quality and performance meeting.

Cardiopulmonary resuscitation (CPR)
• 15 wards are at or above the CPR training compliance threshold in March.
• Crofton (79.2%) dropped just below compliance and staff are booked to attend training dates in April.
• Ward 19 Male (77.3%) also dropped below compliance impacted by 1 staff member on long term sick and 1 staff member on maternity leave.

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

Mandatory Training Continued

Reducing Restrictive Practice Interventions (RRPI)

• 16 wards are above the RRPI training compliance threshold.
• Although still under threshold, Beamshaw (75%) compliance has increased with outstanding staff booked to attend training dates in April and May.
• Ashdale (78.8%) dropped just below compliance and staff are booked to attend training throughout April and May.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.

Fire Safety

• 12 wards are above fire safety training compliance threshold.
• Ashdale (81.8%), Poplars (81.8%), Beechdale (72.7%), Ward 19 Male (81.8%) and Ward 19 Female (68.4%) are under compliance impacted by cancellations to locality training sessions due to trainer absence. Action is being taken by the ward managers to ensure staff out of compliance are booked onto future fire training sessions.

Bed Occupancy

• Ongoing environmental repairs mean Beamshaw and Elmdale operated on reduced bed base of 2 throughout March.
• Bed occupancy exceeding target is reflective of general increased demand for admissions, particularly across working age adults.
• Where the bed occupancy exceeds target, plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.

Average Length of Stay (ALOS)

• Length of stay (LOS) is measured at the point of discharge. The discharge of service users with a significantly long length of stay in any given month will impact to increase the overall average length of stay for the ward.
• Rehab and Recovery length of stays also include any acute/PICU ward stays.

Clinically Ready for Discharge (CRFD)

• CRFD rates are significantly above threshold on two wards:
    • Poplars CRFD is 21% in March and is reflective of several service users awaiting placements.
    • Ward 19 Female CRFD is 26% and is reflective of 5 service users awaiting placements, 3 of whom have been recently discharged.
• 11 other wards are above the threshold for CRFD with Clark, Stanley, Walton, Ashdale, Willow, Beechdale and Ward 19 Male above 10%. This is due to the number of service users with complex needs who are awaiting placement or suitable accommodation and also a small number of service users awaiting MoJ permissions.
• 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.

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

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 March was 86.4% (20 breaches) for 24hr target and 92.3% (11 breaches) completed within 48hrs.
• During March, Beamshaw had 1 FIRM breach which was over the 24hr target by only 2hrs. Clark had 2 breaches. Nostell, Ward 18, Elmdale, and Ashdale had 4 breaches each.
• 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. These will be reviewed at the weekly inpatient quality and performance meeting and shared with Quality and Governance Leads in community to ensure a collaborative approach to improvement.
• Several March breaches related to service users who had to wait MHA assessment or bed allocation. The FIRM risk assessment was completed at point of referral and remained valid and current at time of admission, albeit outside of the 24hr target.
• 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 (Patient on Patient)

• 16 incidents of patient-on-patient physical violence throughout March across multiple wards.
• 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.

Physical violence (Patient on Staff)

• 43 incidents of patient on staff physical violence throughout March.
• Highest number of incidents on Nostell (8), Poplars (8), and Ward 19 Male (8). These incidents relate to a small number of service users with a risk profile of violence and aggression.
• Where service users are a known risk of violence and aggression, risk specific care plans are in place with input from trust RRPI specialist advisors as needed.
• Staff involved in incidents are supported by ward leadership teams including both managerial and clinical supervision.

Restraint incidents

• High incidences on Nostell (19), Poplars (30), and Ward 19 Male (13) correlate with incidents of physical violence outlined above as well as being reflective of current patient population and the presentation and risk profile of service users.
• High incidence on Walton (19) is reflective of current patient population and the presentation and risk profile of service users.
• Ward teams seek advice and support from RRPI specialist advisors as needed to inform individualised and person-centred care planning for those service users with a known risk of violence and aggression.

Prone restraint incidents

• 4 incidents of prone restraint in March:
  • Walton (3) – All staff led and relate to different service users. In each instance the service user drove forward into a prone position but were held in prone for a brief period by staff due to their presentation and risk. All incidents have been reviewed by RRP Team specialist advisors and feedback provided.
  • Stanley (1) – Staff led to exit seclusion. RRP specialist advisor comments note that alternative seclusion exit techniques should be attempted initially and this feedback has been shared with the team.
• Prone restraint as an emergency intervention is still taught within RRPI training.
• The care group continue to work collaboratively with colleagues in Nursing, Quality, and Professions to support the Trusts ambition for zero staff led prone restraint.

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Suite Jan-26	Beamshaw Suite Feb-26	Beamshaw Suite Mar-26	Clark Suite Jan-26	Clark Suite Feb-26	Clark Suite Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	88.9%	100.0%	85.0%	95.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.7%	7.1%	5.2%	4.2%	0.6%	1.9%
Supervision	Best place to work and learn	Well led	80%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.0%	96.0%	91.7%	95.7%	88.0%	96.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.0%	68.0%	75.0%	91.3%	92.0%	88.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.0%	96.0%	91.7%	95.7%	92.0%	92.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	92.0%	87.5%	95.7%	92.0%	96.0%
Bed occupancy**	Best Quality	Safe	85%	94.8%	94.3%	92.3%	94.8%	94.3%	92.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	38	30	110	48	50	17
Safer staffing (Overall)	Best Quality	Safe	90%	112.0%	112.9%	108.1%	98.0%	106.4%	103.7%
Safer staffing (Registered)	Best Quality	Safe	80%	94.3%	99.2%	96.8%	101.6%	100.8%	97.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	9.1%	6.5%	0.9%	8.1%	11.0%	10.6%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	50.0%	87.5%	100.0%	75.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	2	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	0	1	4	0
Restraint incidents	Best Quality	Safe	Trend Monitor	6	5	*0*	6	7	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	11	6	3	5	7	1

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

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

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Melton Suite Jan-26	Melton Suite Feb-26	Melton Suite Mar-26	Nostell Jan-26	Nostell Feb-26	Nostell Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	96.4%	100.0%	96.4%	77.8%	83.3%	82.4%
Sickness	Best place to work and learn	Well led	5.0%	5.0%	3.6%	7.9%	6.6%	5.3%	1.7%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	93.8%	83.3%	66.7%	57.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	96.9%	93.8%	100.0%	100.0%	88.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.6%	93.8%	93.8%	95.7%	96.2%	96.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	93.1%	93.8%	93.8%	100.0%	84.6%	88.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.1%	93.8%	90.6%	100.0%	96.2%	92.3%
Bed occupancy	Best Quality	Safe	85%	98.9%	104.2%	93.0%	97.1%	98.6%	96.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	225	237	33	57	50	27
Safer staffing (Overall)	Best Quality	Safe	90%	116.1%	111.4%	108.2%	94.5%	111.2%	113.1%
Safer staffing (Registered)	Best Quality	Safe	80%	97.9%	95.8%	94.8%	105.8%	107.6%	116.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	21.3%	12.2%	0.0%	4.5%	0.6%	6.1%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	73.3%	93.8%	70.6%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	1	5	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	0	6	2	8
Restraint incidents	Best Quality	Safe	Trend Monitor	6	6	*0*	8	19	*19*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	1	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	25	9	4	2	14	12

*** 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 Jan-26	Stanley Feb-26	Stanley Mar-26	Walton Jan-26	Walton Feb-26	Walton Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	69.6%	84.0%	91.7%	84.8%	100.0%	93.8%
Sickness	Best place to work and learn	Well led	5.0%	5.4%	2.3%	3.0%	5.4%	4.4%	3.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	84.6%	91.7%	82.4%	82.4%	88.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	97.6%	100.0%	95.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.7%	96.7%	96.8%	95.1%	97.4%	92.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	96.7%	96.8%	70.7%	71.1%	80.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.7%	93.3%	90.3%	87.8%	97.4%	95.0%
Bed occupancy**	Best Quality	Safe	85%	97.1%	98.6%	96.8%	97.2%	95.4%	96.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	33	64	34	123	N/A	49
Safer staffing (Overall)	Best Quality	Safe	90%	126.8%	115.6%	105.5%	136.1%	118.1%	113.2%
Safer staffing (Registered)	Best Quality	Safe	80%	93.3%	90.2%	91.9%	92.8%	91.0%	93.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	11.4%	21.9%	19.9%	18.3%	14.7%	14.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	80.0%	88.9%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	0	0	0	1	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	2	4	6	1	2
Restraint incidents	Best Quality	Safe	Trend Monitor	9	4	*6*	10	7	*19*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	*1*	1	1	*3*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	12	8	10	5	6

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

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Ashdale Jan-26	Ashdale Feb-26	Ashdale Mar-26	Ward 18 Jan-26	Ward 18 Feb-26	Ward 18 Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	95.7%	73.9%	80.0%	85.0%	85.7%	38.1%
Sickness	Best place to work and learn	Well led	5.0%	9.8%	8.4%	4.5%	6.8%	1.3%	5.5%
Supervision	Best place to work and learn	Well led	80%	87.5%	87.5%	93.8%	93.3%	93.3%	93.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.3%	93.3%	93.9%	96.7%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.9%	86.7%	78.8%	93.3%	93.5%	83.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	67.7%	80.0%	87.5%	86.7%	87.1%	83.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.1%	80.0%	81.8%	100.0%	100.0%	96.8%
Bed occupancy	Best Quality	Safe	85%	99.1%	99.4%	95.7%	96.5%	98.1%	99.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	40	58	41	30	30	38
Safer staffing (Overall)	Best Quality	Safe	90%	99.4%	98.9%	101.8%	101.4%	101.2%	101.4%
Safer staffing (Registered)	Best Quality	Safe	80%	95.5%	104.6%	102.3%	110.0%	104.4%	104.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	4.2%	8.7%	12.4%	5.8%	4.6%	3.6%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	81.8%	54.5%	80.0%	92.0%	88.9%	85.2%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	4	1	2	3	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	3	2	1	3	0
Restraint incidents	Best Quality	Safe	Trend Monitor	5	10	*8*	1	13	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	4	2	4	1	5

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale Jan-26	Elmdale Feb-26	Elmdale Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	90.0%	90.5%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	10.7%	10.6%	8.3%
Supervision	Best place to work and learn	Well led	80%	78.6%	93.3%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.8%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	95.8%	100.0%	95.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.7%	95.7%	95.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	95.8%	95.8%
Bed occupancy	Best Quality	Safe	85%	91.1%	92.6%	88.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	71	29	100
Safer staffing (Overall)	Best Quality	Safe	90%	114.1%	112.6%	110.2%
Safer staffing (Registered)	Best Quality	Safe	80%	98.8%	97.4%	97.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	6.5%	6.2%	8.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	92.9%	76.5%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	3	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	10	6
Restraint incidents	Best Quality	Safe	Trend Monitor	20	14	*5*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	19	4	9

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton Jan-26	Crofton Feb-26	Crofton Mar-26	Poplars CUE Jan-26	Poplars CUE Feb-26	Poplars CUE Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	56.3%	43.8%	38.9%	89.7%	86.2%	96.6%
Sickness	Best place to work and learn	Well led	5.0%	21.4%	9.2%	6.6%	8.6%	8.4%	6.7%
Supervision	Best place to work and learn	Well led	80%	60.0%	77.8%	100.0%	84.6%	84.6%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.0%	95.5%	87.5%	71.9%	84.8%	84.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.0%	81.8%	79.2%	78.1%	84.8%	90.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.2%	95.7%	92.3%	81.8%	82.4%	81.8%
Bed occupancy	Best Quality	Safe	85%	92.9%	93.8%	92.1%	78.9%	75.7%	77.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	63	70	145	90	116	88
Safer staffing (Overall)	Best Quality	Safe	90%	161.7%	174.0%	178.7%	195.7%	205.8%	200.5%
Safer staffing (Registered)	Best Quality	Safe	80%	127.2%	130.2%	140.1%	103.6%	99.0%	102.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	6.2%	34.6%	12.9%	21.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	100.0%	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	2	4	3	7	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	6	3	12	10	8
Restraint incidents	Best Quality	Safe	Trend Monitor	1	25	*18*	16	27	*30*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	25	15	15	29	18	23

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow Jan-26	Willow Feb-26	Willow Mar-26	Beechdale Jan-26	Beechdale Feb-26	Beechdale Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	88.9%	84.2%	94.1%	83.3%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	21.2%	8.8%	14.0%	2.4%	1.9%	5.6%
Supervision	Best place to work and learn	Well led	80%	100.0%	88.9%	87.5%	90.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.1%	100.0%	88.9%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.2%	94.4%	94.4%	90.5%	91.3%	95.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.1%	94.4%	94.4%	90.0%	81.8%	90.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.1%	100.0%	88.9%	90.5%	73.9%	72.7%
Bed occupancy	Best Quality	Safe	85%	90.3%	98.6%	91.0%	97.0%	99.1%	92.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	54	70	57	157	109	117
Safer staffing (Overall)	Best Quality	Safe	90%	115.5%	127.8%	112.7%	152.2%	151.1%	134.5%
Safer staffing (Registered)	Best Quality	Safe	80%	104.7%	103.2%	85.7%	101.0%	102.8%	100.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.7%	6.0%	11.5%	14.3%	10.3%	12.1%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	100.0%	100.0%	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	1	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*2*	0	1	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	13	9	8	11	0	4

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male Jan-26	Ward 19 - Male Feb-26	Ward 19 - Male Mar-26	Ward 19 - Female Jan-26	Ward 19 - Female Feb-26	Ward 19 - Female Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	93.8%	100.0%	75.0%	94.4%	88.2%
Sickness	Best place to work and learn	Well led	5.0%	3.6%	3.9%	1.5%	3.7%	13.7%	11.9%
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%	95.2%	95.5%	95.2%	85.7%	84.2%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.0%	100.0%	90.9%	85.7%	85.7%	89.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.0%	81.0%	77.3%	85.7%	76.2%	84.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	85.0%	85.7%	81.8%	81.0%	76.2%	68.4%
Bed occupancy	Best Quality	Safe	85%	98.5%	99.8%	92.7%	97.2%	96.2%	98.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	85	97	95	54	38	87
Safer staffing (Overall)	Best Quality	Safe	90%	101.4%	119.0%	145.4%	120.2%	127.1%	133.5%
Safer staffing (Registered)	Best Quality	Safe	80%	89.7%	97.5%	87.1%	101.9%	90.0%	101.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	16.9%	9.4%	12.0%	0.7%	25.3%	26.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	2	1	2	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	12	3	8	12	4	2
Restraint incidents	Best Quality	Safe	Trend Monitor	23	4	*13*	23	11	*6*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	5	9	12	19	12

Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down Jan-26	Enfield Down Feb-26	Enfield Down Mar-26	Lyndhurst Jan-26	Lyndhurst Feb-26	Lyndhurst Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	86.0%	83.3%	100.0%	82.8%	82.1%	92.6%
Sickness	Best place to work and learn	Well led	5.0%	5.7%	3.8%	5.1%	8.2%	5.6%	6.5%
Supervision	Best place to work and learn	Well led	80%	92.3%	100.0%	96.3%	73.3%	87.5%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.2%	100.0%	98.1%	100.0%	96.3%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	86.3%	84.0%	86.3%	89.3%	81.5%	82.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.3%	91.1%	93.5%	82.1%	96.3%	89.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.4%	94.1%	90.4%	100.0%	96.3%	89.3%
Bed occupancy	Best Quality	Safe	Trend Monitor	46.8%	47.1%	49.2%	72.4%	55.6%	50.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	223	766	120	N/A	961	315
Safer staffing (Overall)	Best Quality	Safe	90%	98.2%	97.1%	97.5%	95.2%	102.2%	97.9%
Safer staffing (Registered)	Best Quality	Safe	80%	99.0%	96.8%	97.1%	90.6%	99.5%	97.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	100.0%	N/A	0.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	2	1	1

Inpatients - Forensic West Yorkshire - Medium Secure

Medium Secure

• Supervision compliance remains excellent, with consistently high completion rates across the service. Managers and clinicians continue to prioritise regular, high-quality supervision, ensuring strong oversight, reflective practice, and adherence to professional standards. One hotspot is evident on Hepworth (75%), and this unusual variation is under review by the Ward Manager.

• Sickness absence performance has improved significantly across all areas. While one area (Appleton) remains slightly above target at 5.5%, it continues to show a positive and improving trend. Ongoing targeted support and interventions will be maintained to support maintaining continued improvement.

• A continued focus on high-quality appraisals remains a priority for the service, with the current rise in outstanding appraisals reflects a cyclical peak in the appraisal schedule. Four wards, Bronte (94.7%), Hepworth (100%), Chippendale (100%) and Waterton (100%) currently are at above target. Three medium secure wards are currently below the required threshold: Johnson (85.2%), Priestley (70.6%), and Appleton (85.7%). Remedial actions are in place, and a strengthened monitoring system is being used within the Care Group to support improvement.

• Challenges in mandatory training compliance have been identified and are under active review. Mitigating actions are being developed to improve compliance and provide appropriate assurance. Fire Safety training is delivered through the annual security update and has typically maintained good levels of compliance. Current compliance across all wards is below target, suggesting a system issue, which is now under review by the Clinical Lead for Security. IG Training on Waterton (83.3%), Priestley (94.6%) and Bronte (90.0%) is a further hotspot that is recognised annual pressure point, reflecting the time of year when a large number of staff are due for their update. Challenges with CPR training have been evident with compliance on Johnson (75.0%), Hepworth (78.9%) and Bronte (65.0%). The service has had challenges in the release of staff from shift for this ½ day, mid-day training and have requested staff to not book this whilst on shift to support attendance. The Care Group is reviewing these areas and determining the support required to enable the ward to reach the expected standards.

Bed occupancy on Appleton remains low at 56.0%, reflecting a continued reduction in learning disability referrals to secure care. Occupancy in the women's service has seen a period of unusual variation, with Johnson Ward (medium secure) at 97.4%. On the make pathway, although overall occupancy appears reduced within the data, our capacity is within our admission wards and rehabilitation wards are at full capacity (Waterton 100% and Priestley 100%). This demonstrates a positive position for patient flow. Where there is reduced occupancy this is often to support process for new admissions.

• There was one prone restraint on Johnson which relates to an individual service user and has been reviewed by PSOG, and Incidents of restraint show broad consistency.

•The service continues to experience high levels of acuity, with some wards frequently operating above establishment to meet clinical need. Staffing levels are reviewed daily through the morning meeting, supported by team leaders to ensure proactive deployment of resources and the reallocation of staff from the wider multi-disciplinary team where required. A focused piece of work, supported by the E-Rostering team, has helped to further embed SafeCare within the morning meeting and routine practice, contributing to improvements in the quality and accuracy of SafeCare data.

The metric relating to completion of inpatient risk assessments within 24 hours has been reviewed by the service. Within forensic services, forensic risk assessments are completed prior to admission as part of the gatekeeping process, supporting safe and effective planning. A communication has been issued to ensure these assessments are reviewed and formally signed off again on admission. The service is currently compliant (100%) and will continue to monitor this closely to maintain high standards.

Low Secure

• Sickness levels continue to be monitored closely, with ward managers working alongside the People Directorate and Occupational Health with continued fluctuations noted. Newhaven (5.4%) is now within expected compliance range. Sandal (7.5%), Thornhill (8.2%) and Ryburn (19.9%) continue to be impacted by both long-term and short-term absence. The Ward Managers with support of the People Directorate continue to review the position, and planned return-to-work arrangements are expected to support further improvement in long-term sickness levels.

• Mandatory training compliance remains positive across the service. Hotspots for this month are Newhaven IG training which is 88.2% and Sandal CPR which is 69.5%. The service has had challenges in the release of staff from shift for this ½ day training and have requested staff to not book this whilst on shift to support attendance. Targeted actions are in place to improve compliance.

• A continued focus on high-quality appraisals remains a priority for the service, with the current rise in outstanding appraisals reflects a cyclical peak in the appraisal schedule. Current compliance stands at 75.9% on Thornhill, 75.0% on Sandal and 69.7% on Newhaven, with improving trajectories on Ryburn (90.9%). Work has taken place to address data quality issues, and the service remains committed to ensuring that all staff receive a timely and high-quality appraisal.

• Supervision is above compliance at 100% on Newhaven and 85.7% on Ryburn and 80% on Sandal. There is an unusual variation in supervision compliance across Thornhill (78.6%). Further review has been undertaken and plans in place to address operational challenges.

• The metric relating to completion of inpatient risk assessments within 24 hours has been reviewed by the service. Within forensic services, forensic risk assessments are completed prior to admission as part of the gatekeeping process, supporting safe and effective planning. A communication has been issued to ensure these assessments are reviewed and formally signed off again on admission. The service is currently compliant with 100% (Sandal) for risk assessments completed within 24 hours.

• The service continues to work closely with the provider collaborative to support effective use of bed occupancy across West Yorkshire. The Bretton Centre currently has good occupancy with Sandal (89.7%), Thornhill (100%) with processes in place to support admissions. Ryburn (71.4%) currently has service users working towards transition. Newhaven (75.0%) continues to experience lower level of referrals and has no waiting list. It has one service user within the referral / admission process.

• There were no prone restraint incidents, and Incidents of restraint show broad consistency, albeit at a lower baseline, reflecting the positive impact of improved flow.

• Safer staffing levels are within the expected compliance range. Increased acuity on Newhaven (120.4%) and Sandal (107%) has resulted in additional staffing to ensure safe service delivery.

Metrics	Strategic Objective	CQC Domain	Threshold	Appleton Jan-26	Appleton Feb-26	Appleton Mar-26	Bronte Jan-26	Bronte Feb-26	Bronte Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	92.9%	78.6%	85.7%	100.0%	100.0%	94.7%
Sickness	Best place to work and learn	Well led	5.4%	8.9%	7.7%	5.5%	6.6%	9.7%	4.6%
Supervision	Best place to work and learn	Well led	80%	90.0%	88.9%	100.0%	92.3%	84.6%	84.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	83.3%	83.3%	95.0%	95.0%	90.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%	100.0%	95.0%	90.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	77.8%	77.8%	60.0%	60.0%	65.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.5%	66.7%	72.2%	85.0%	90.0%	80.0%
Bed occupancy	Best Quality	Safe	90%	62.5%	62.5%	56.0%	99.1%	74.5%	84.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	355	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	137.2%	146.3%	143.7%	126.4%	106.0%	103.6%
Safer staffing (Registered)	Best Quality	Safe	80%	92.8%	105.8%	103.4%	109.7%	96.5%	96.4%
% 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	2	1	3	2	0	3
Restraint incidents	Best Quality	Safe	Trend Monitor	4	5	*6*	8	3	*7*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	1	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	17	12	5	9	1	2

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale			Hepworth		
				Jan-26	Feb-26	Mar-26	Jan-26	Feb-26	Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	94.7%	100.0%	100.0%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	4.6%	2.6%	5.3%	1.6%	2.0%	1.6%
Supervision	Best place to work and learn	Well led	80%	100.0%	92.3%	100.0%	91.7%	91.7%	75.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.2%	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%	95.2%	95.2%	90.5%	89.5%	89.5%	89.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	76.2%	76.2%	90.5%	89.5%	84.2%	78.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.2%	95.2%	90.5%	89.5%	89.5%	84.2%
Bed occupancy	Best Quality	Safe	90%	83.3%	88.4%	88.7%	92.9%	89.0%	76.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	1041	140	813
Safer staffing (Overall)	Best Quality	Safe	90%	95.9%	94.0%	96.0%	92.1%	96.8%	97.4%
Safer staffing (Registered)	Best Quality	Safe	80%	120.7%	104.4%	114.9%	84.3%	89.2%	85.5%
% 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	100.0%	100.0%	N/A	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	0	0	0	1	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	2	1	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	0	0	0	1	0

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson Jan-26	Johnson Feb-26	Johnson Mar-26	Priestley Jan-26	Priestley Feb-26	Priestley Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	78.6%	78.6%	85.2%	89.5%	73.7%	70.6%
Sickness	Best place to work and learn	Well led	5.4%	3.4%	2.5%	1.3%	7.6%	7.5%	5.2%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	81.8%	100.0%	83.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.6%	90.6%	96.9%	100.0%	95.0%	94.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	78.1%	84.4%	84.4%	94.7%	89.5%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	71.9%	75.0%	75.0%	100.0%	94.7%	88.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.8%	87.5%	84.4%	75.0%	85.0%	84.2%
Bed occupancy	Best Quality	Safe	90%	80.0%	90.2%	97.4%	97.3%	97.3%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	939	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	121.4%	132.5%	124.6%	91.2%	93.7%	95.1%
Safer staffing (Registered)	Best Quality	Safe	80%	110.0%	102.8%	95.5%	105.8%	104.5%	103.8%
% 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	100.0%	100.0%	N/A	N/A	N/A
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	0	0	1	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	*2*	0	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*1*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	7	13	6	0	1	0

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton Jan-26	Waterton Feb-26	Waterton Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	89.5%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.4%	12.4%	12.0%	6.2%
Supervision	Best place to work and learn	Well led	80%	81.8%	90.9%	90.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.3%	87.0%	83.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.0%	87.0%	91.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	82.6%	83.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.0%	87.0%	83.3%
Bed occupancy	Best Quality	Safe	90%	99.6%	100.0%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	1315	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	118.8%	105.2%	106.2%
Safer staffing (Registered)	Best Quality	Safe	80%	98.3%	99.5%	92.3%
% 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	0	1	1
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	21	5	5

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill Jan-26	Thornhill Feb-26	Thornhill Mar-26	Sandal Jan-26	Sandal Feb-26	Sandal Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	89.3%	82.8%	75.9%	95.7%	81.3%	75.0%
Sickness	Best place to work and learn	Well led	5.4%	9.1%	7.8%	8.2%	4.0%	3.1%	7.5%
Supervision	Best place to work and learn	Well led	80%	86.7%	73.3%	78.6%	71.4%	78.6%	80.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.8%	100.0%	96.9%	100.0%	96.4%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.5%	93.9%	96.9%	85.7%	92.9%	89.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.3%	84.8%	81.3%	71.4%	71.4%	69.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.8%	100.0%	100.0%	100.0%	96.4%	93.1%
Bed occupancy	Best Quality	Safe	85%	99.6%	99.8%	100.0%	83.7%	81.3%	89.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	330	N/A	N/A	167	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	106.1%	99.0%	98.2%	127.0%	98.9%	107.0%
Safer staffing (Registered)	Best Quality	Safe	80%	97.2%	101.7%	98.6%	105.9%	104.0%	103.1%
% 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	100.0%	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	1	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	7	6	29	7	6

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn Jan-26	Ryburn Feb-26	Ryburn Mar-26	Newhaven Jan-26	Newhaven Feb-26	Newhaven Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	90.0%	90.9%	90.9%	81.3%	70.6%	69.7%
Sickness	Best place to work and learn	Well led	5.4%	7.7%	4.5%	19.9%	9.9%	7.6%	5.4%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	85.7%	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%	94.1%	94.3%	88.2%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%	100.0%	96.8%	96.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%	86.7%	93.5%	86.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	97.1%	94.3%	91.2%
Bed occupancy	Best Quality	Safe	85%	83.4%	71.9%	71.4%	68.8%	69.9%	75.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	2535	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	97.5%	99.1%	100.3%	131.1%	125.6%	120.4%
Safer staffing (Registered)	Best Quality	Safe	80%	99.3%	101.8%	101.4%	98.3%	102.5%	100.7%
% 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	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	3	3	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	6	3	*2*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	2	0	31	11	6

Inpatients - Non-Mental Health

• **Appraisal rate:**
NRU rate has improved significantly and is now achieving compliance at 97.1%.
SRU rate continues to maintain compliance at 97.1% for March.

• **Sickness:**
NRU – sickness for March has increased and is outside compliance at 5.3%. The current position includes some instances of long term sickness.
SRU – Sickness for March has increased significantly and is outside compliance at 5.5%. The current position includes several instances of long term sickness.
Sickness on both units is being monitored and managed via Supporting Wellbeing (Sickness and Attendance Procedure)

• **Supervision:**
NRU has shown a slight decrease in March to 78.3% which is just below compliance. However, figures in April are already improving; as at 17.4.26 the unit is compliant at 82.6%
SRU have seen an improvement this month and are only marginally below compliance at 79.1% for March. Unit Manager continues to focus on ensuring staff have access to supervision.

• **Information Governance Training:**
NRU continues to maintain compliancy for March at 95.1%.
SRU continues to maintain compliancy for March at 97.1%.

• **Cardiopulmonary resuscitation (CPR) Training:**
NRU is has seen a good increase towards compliancy during March at 74.4%.
SRU compliancy has fallen below threshold this month and is at 71.2% for March.
All staff who are out of date are booked to attend future dates of ILS and BLS. Operational Manager has chased with Resus Lead regarding recording of training recently completed which is not yet showing.
In addition, it has been confirmed by Learning & Development, that managers are unable to exclude maternity leave staff from these statistics. As at 20.4.26, this involves two staff on NRU and one on SRU.
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.

• **Safer Staffing** - overall (Threshold 90%):
NRU – within compliance
SRU – below compliance; this is due to two patients requiring 1:1 observations and consistently high occupancy rates.
Safer staffing (registered 80%) is within compliance for both units. To note: the establishment figures for both wards were reviewed in November 2025 and work continues to realign this on e-roster following a further meetings in February and March 2026.

Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit (NRU) Jan-26	Neuro Rehabilitation Unit (NRU) Feb-26	Neuro Rehabilitation Unit (NRU) Mar-26	Stroke Rehabilitation Unit (SRU) Jan-26	Stroke Rehabilitation Unit (SRU) Feb-26	Stroke Rehabilitation Unit (SRU) Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	97.1%	80.6%	97.1%	98.6%	98.6%	97.1%
Sickness	Best place to work and learn	Well led	5.0%	5.3%	4.6%	5.3%	4.5%	2.0%	5.5%
Supervision	Best place to work and learn	Well led	80%	79.2%	83.3%	78.3%	88.4%	72.7%	79.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.4%	95.1%	95.1%	95.9%	95.8%	97.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	69.4%	68.4%	74.4%	84.3%	80.9%	71.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	89.7%	85.4%	85.4%	89.2%	93.1%	92.9%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	85.8%	88.7%	97.0%	98.7%	90.2%	96.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	71	39	90	37	30	23
Safer staffing (Overall)	Best Quality	Safe	90%	103.4%	106.1%	102.6%	85.6%	85.6%	86.7%
Safer staffing (Registered)	Best Quality	Safe	80%	87.5%	103.3%	97.9%	95.9%	93.7%	89.0%
% 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	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	2	5	12	38	24	19

Inpatients - Mental Health - Learning Disability

Headlines

- Positive appraisal performance across the team at 100%. The unusual variation in supervision has now been rectified, with compliance restored to 88.9%.
- Sickness has now returned to 3.5%, reflecting a positive downward trend.
- Low occupancy is understood and aligned with wider Assessment Treatment Unit (ATU) workstream.
- Continued CRFD at 75% and understood and in relation to pathway challenges. The service continued to support system wider working to identify appropriate packages of care. In real terms this represents 3 of the 4 services users on Horizon. All 3 have placements identified the challenge remains the bespoke nature of the packages.
- On staffing levels, we have undertaken the establishment review and are just working on finalisation and ensuring template reflects new agreed staffing.
- Due to current acuity and needs of individual service users, the service has required additional staffing in the overall staffing (122.1%) and registered staffing (188%).
- There are no prone restraints and restraint incidents remain broadly consistent.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon Jan-26	Horizon Feb-26	Horizon Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	97.3%	100.0%	94.1%
Sickness	Best place to work and learn	Well led	5.0%	5.3%	3.5%	7.3%
Supervision	Best place to work and learn	Well led	80%	50.0%	88.9%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.0%	95.3%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.2%	92.7%	87.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.2%	95.1%	97.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	88.4%	95.3%	92.7%
Bed occupancy	Best Quality	Safe	N/A	50.0%	50.0%	50.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	123.4%	122.1%	121.5%
Safer staffing (Registered)	Best Quality	Safe	80%	178.0%	188.0%	171.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	75.0%	75.0%	100.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	0.0%	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	9	4	9
Restraint incidents	Best Quality	Safe	Trend Monitor	7	8	*5*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor	25	18	21

Inpatients - Forensic South Yorkshire

Medium Secure

- Supervision compliance is above threshold across both wards (100%)
- Sickness absence has risen on Foss in the last month but reduced on Skipton.
- Safer staffing is within compliance and is reviewed by service management on a daily basis.
- Mandatory training compliance is a mixed picture and there remains issues with training being recorded consistently.Foss areas requiring improvement are IG and CPR (plans in place to mitigate low compliance). Skipton areas to address are IG, RRPI and CPR (plans are in place to mitigate the risks).
- Bed occupancy on Skipton (80.9%) and Foss (78.6%) whilst below usual compliance this is in relation to the mobilisation of Cheswold Park Hospital and plans are in place. Skipton continues to have a bespoke package of care taking up 2 beds. Skipton has also received more referrals so occupancy should rise.
- Prone restraints - none across the service
- Risk assessment data is not currently captured as Cheswold Park Hospital (CPH) do not currently complete FIRM risk assessments; this is within the improvement plan.

Low Secure

- Supervision: Above threshold across all wards with the exeption of Esk (63.6%).
- Sickness: Within compliance on all wards following a reduction on Esk.
- Mandatory training: Generally strong, though some local vs Trust reporting mismatches persist due to system alignment issues post-Cheswold transfer. Compliance against IG training has dropped on Aire this month (88.9%). Training plans are in place to target individuals who require training
- Bed occupancy: generally an improving position. Referrals are strong and once Esk is able to open the 4 beds which are currently closed this should increase.
- No prone restraints across all low secure wards.
- Risk assessment reporting still unavailable for CPH - linked areas pending FIRM implementation.

				Medium Secure Services Foss			Skipton		
Metrics	Strategic Objective	CQC Domain	Threshold	Jan-26	Feb-26	Mar-26	Jan-26	Feb-26	Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	83.3%	63.6%	61.9%	73.9%	58.1%	43.3%
Sickness	Best place to work and learn	Well led	5.4%	7.6%	6.4%	8.2%	4.8%	5.7%	4.7%
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%	93.1%	92.0%	89.7%	100.0%	96.6%	93.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.1%	92.0%	93.1%	62.5%	51.7%	79.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	62.1%	68.0%	58.6%	69.6%	69.0%	69.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.1%	92.0%	93.1%	95.7%	89.7%	93.1%
Bed occupancy	Best Quality	Safe	90%	78.6%	78.6%	78.6%	67.7%	69.9%	80.9%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	1631	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	92.6%	92.9%	112.1%	201.9%	179.4%	123.6%
Safer staffing (Registered)	Best Quality	Safe	80%	103.5%	97.0%	97.7%	108.7%	118.6%	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%
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	2	1	2	1	1	3
Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	*0*	12	6	*6*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor		6	25		72	60

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Esk			Wentbridge		
				Jan-26	Feb-26	Mar-26	Jan-26	Feb-26	Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	86.4%	85.3%	81.3%	50.0%
Sickness	Best place to work and learn	Well led	5.4%	9.5%	6.3%	4.3%	2.2%	1.0%	1.0%
Supervision	Best place to work and learn	Well led	80%	100.0%	78.6%	63.6%	97.1%	100.0%	91.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	96.2%	97.2%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%	86.1%	85.3%	94.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.5%	95.7%	91.7%	88.9%	94.1%	88.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	81.8%	86.4%	92.3%	94.4%	97.1%	97.1%
Bed occupancy	Best Quality	Safe	90%	68.8%	68.8%	74.4%	87.5%	75.0%	80.2%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.6%	102.6%	105.4%	131.3%	96.4%	107.4%
Safer staffing (Registered)	Best Quality	Safe	80%	92.5%	88.4%	85.7%	98.0%	90.4%	88.4%
% 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	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	0	0	1	2
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	*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		2	10		25	30

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire Jan-26	Aire Feb-26	Aire Mar-26	Don Jan-26	Don Feb-26	Don Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	60.0%	54.8%	48.4%	73.9%	65.2%	54.5%
Sickness	Best place to work and learn	Well led	5.4%	1.5%	0.9%	2.3%	3.0%	2.0%	2.1%
Supervision	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	89.5%	95.2%	95.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.9%	92.6%	88.9%	95.2%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	81.8%	77.8%	89.3%	85.0%	90.0%	90.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.8%	82.8%	82.8%	90.5%	90.0%	85.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	96.3%	96.3%	95.2%	100.0%	95.0%
Bed occupancy	Best Quality	Safe	90%	90.3%	81.3%	87.1%	100.0%	100.0%	100.0%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	303	700	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	109.9%	92.7%	92.4%	101.1%	112.0%	107.9%
Safer staffing (Registered)	Best Quality	Safe	80%	95.1%	87.5%	86.3%	77.0%	100.5%	87.5%
% 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
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	*0*	1	0	*0*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor		9	9		6	14

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Calder Jan-26	Feb-26	Mar-26
Appraisal rate	Best place to work and learn	Well led	90%	87.0%	86.4%	81.8%
Sickness	Best place to work and learn	Well led	5.4%	1.2%	0.3%	0.6%
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%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	90.5%
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%	100.0%	100.0%	92.7%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	1273
Safer staffing (Overall)	Best Quality	Safe	90%	91.3%	92.8%	91.0%
Safer staffing (Registered)	Best Quality	Safe	80%	74.7%	74.5%	64.9%
% 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	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*1*
Prone Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Unfilled Shifts	Best Quality	Safe	Trend Monitor		7	21

Overall Financial Performance 2025/26

Executive Summary / Key Performance Indicators

	Performance Indicator	Strategic Objective	CQC Domain	2025/26	Narrative
1	Surplus / (Deficit)	Best Value	Well Led	£0.1m	The Trust financial target for 2025 / 26 is breakeven. This has been achieved with a small unaudited surplus of £123k.
2	Agency Spend	Best Value	Well Led	£2.9m	Agency run rate has continued to reduce across the year. Total spend is £2.9m which is £1.4m less than plan and an overall reduction of £3.5m compared to the prior year.
3	Bank Spend	Best Value	Well Led	£25.4m	Target bank spend (£19.3m) has been exceeded by £6.1m with utilisation higher than plan throughout the year. Overall bank spend is £3.6m higher than the prior year.
4	Corporate Spend	Best Value	Well Led	£65.9m	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.
5	Financial sustainability and efficiencies	Best Value	Well Led	£28.2m	The target is £28.2m as a result of the Trust Value For Money programme has been achieved. Of this £7.3m (26%) has been delivered non-recurrently. The implications of this are included in the Trust medium term financial plan.
6	Cash	Best Value	Well Led	£64.6m	The Trust cash position remains positive and has increased in March 2026 with payment received for outstanding income from NHS England.
7	Capital Spend	Best Value	Well Led	£14.8m	As at 31st March 2026 a number of capital schemes remained in progress. The financial position includes the value of work completed to that date. Total spend of £14.8m is £3.0m less than the forecast at month 11.
8	Better Payment Practice Code	Best Value	Well Led	98%	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	Jan-26	Feb-26	Mar-26
Mandatory Training - TOTAL	Improving Care		>=80%	95.0%	95.0%	96.0%
Mandatory Training - Reducing Restrictive Practice Interventions				84.4%	82.6%	89.5%
Mandatory Training - Cardiopulmonary Resuscitation				85.5%	87.6%	82.4%
Mandatory Training - Clinical Risk				N/A	N/A	N/A
Mandatory Training - Display Screen Equipment				N/A	N/A	N/A
Mandatory Training - Equality & Diversity				98.1%	97.3%	97.8%
Mandatory Training - Fire Safety			>=85%	91.3%	91.1%	92.1%
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				95.4%	95.5%	96.1%
Mandatory Training - Information Governance (Data Security)			>=95%	95.8%	95.3%	94.8%
Mandatory Training - Moving & Handling			>=80%	91.3%	91.1%	92.1%
Mandatory Training - Mental Capacity Act/Dols				79.2%	81.3%	84.3%
Mandatory Training - Mental Health Act				79.2%	81.3%	84.3%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism - e-learning aspect of Level 1				99.6%	99.6%	99.6%
Mandatory Training - Prevent			>=80%	N/A	N/A	N/A
Mandatory Training - Safeguarding Adults				95.0%	95.7%	95.1%
Mandatory Training - Safeguarding Children				89.7%	95.0%	95.1%

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Finance Report

Month 12 (2025 / 26)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0	Executive Summary / Key Performance Indicators		
Key Performance Indicator		**2025 / 26**	**Narrative**
1	**Surplus / (Deficit)**	£0.1m	The Trust financial target for 2025 / 26 is breakeven. This has been achieved with a small unaudited surplus of £123k.
2	**Agency Spend**	£2.9m	Agency run rate has continued to reduce across the year. Total spend is £2.9m which is £1.4m less than plan and an overall reduction of £3.5m compared to the prior year.
3	**Bank Spend**	£25.4m	Target bank spend (£19.3m) has been exceeded by £6.1m with utilisation higher than plan throughout the year. Overall bank spend is £3.6m higher than the prior year.
4	**Corporate Spend**	£65.9m	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.
5	**Financial sustainability and efficiencies**	£28.2m	The target is £28.2m as a result of the Trust Value For Money programme has been achieved. Of this £7.3m (26%) has been delivered non-recurrently. The implications of this are included in the Trust medium term financial plan.
6	**Cash**	£64.6m	The Trust cash position remains positive and has increased in March 2026 with payment received for outstanding income from NHS England.
7	**Capital**	£14.8m	As at 31st March 2026 a number of capital schemes remained in progress. The financial position includes the value of work completed to that date. Total spend of £14.8m is £3.0m less than the forecast at month 11.
8	**Better Payment Practice Code**	98%	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.

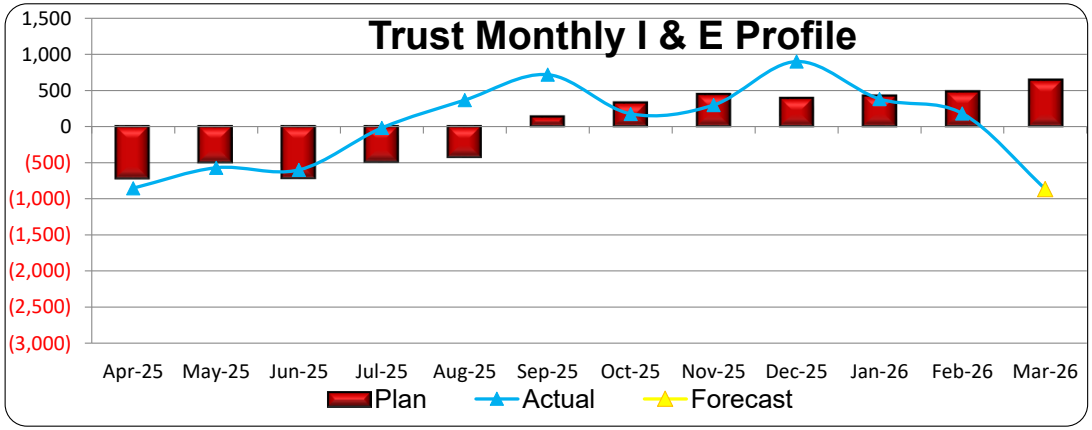
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

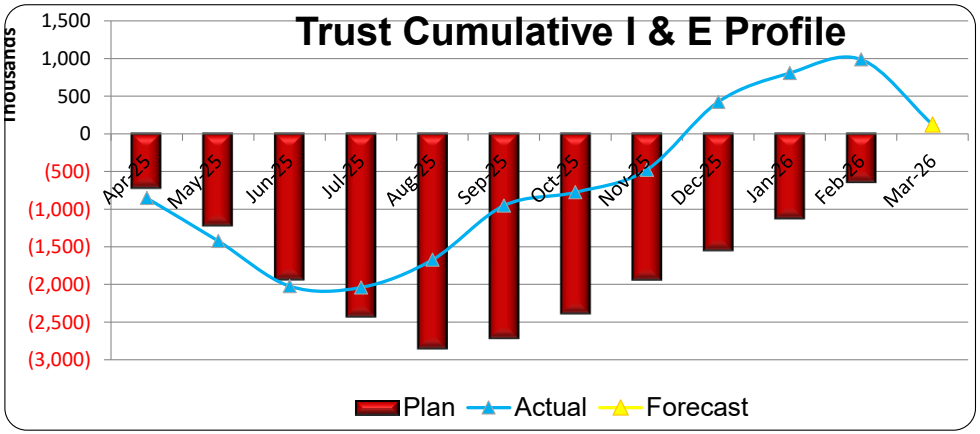
2.0 Income & Expenditure Position 2025 / 26

The table below presents the total consolidated financial position for South West Yorkshire Partnership Teaching 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					41,397	41,615	217	461,140	463,785	2,645	461,140	463,785	2,645
Other Operating Revenue					1,484	19,669	18,185	16,236	35,015	18,779	16,236	35,015	18,779
Total Revenue					**42,881**	**61,284**	**18,402**	**477,376**	**498,800**	**21,424**	**477,376**	**498,800**	**21,424**
Pay Costs	5,435	5,422	(13)	0.2%	(25,324)	(44,190)	(18,865)	(301,771)	(317,791)	(16,020)	(301,771)	(317,791)	(16,020)
Non Pay Costs					(16,085)	(17,558)	(1,473)	(165,701)	(172,882)	(7,181)	(165,701)	(172,882)	(7,181)
Gain / (loss) on disposal					0	0	0	0	446	446	0	446	446
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,435**	**5,422**	**(13)**	**-0.2%**	**(41,410)**	**(61,748)**	**(20,338)**	**(467,472)**	**(490,226)**	**(22,754)**	**(467,472)**	**(490,226)**	**(22,754)**
EBITDA	**5,435**	**5,422**	**(13)**	**-0.2%**	**1,472**	**(464)**	**(1,936)**	**9,904**	**8,574**	**(1,330)**	**9,904**	**8,574**	**(1,330)**
Depreciation					(622)	(614)	8	(7,447)	(7,774)	(327)	(7,447)	(7,774)	(327)
PDC Paid					(378)	10	388	(4,534)	(3,519)	1,015	(4,534)	(3,519)	1,015
Interest Received					170	204	34	2,077	2,842	765	2,077	2,842	765
Surplus / (Deficit) - ICB performance measure	**5,435**	**5,422**	**(13)**	**-0.2%**	**641**	**(864)**	**(1,505)**	**(0)**	**123**	**123**	**(0)**	**123**	**123**
Depn Peppercorn Leases (IFRS16)					(5)	(41)	(36)	(94)	(97)	(3)	(94)	(97)	(3)
Depn Peppercorn Leases (IFRS16)					0	182	182	0	182	182	0	182	182
Revaluation of Assets					0	0	0	0	(2,173)	(2,173)	0	(2,173)	(2,173)
Surplus / (Deficit) - Total	**5,435**	**5,422**	**(13)**	**-0.2%**	**636**	**(724)**	**(1,360)**	**(94)**	**(1,965)**	**(1,871)**	**(94)**	**(1,965)**	**(1,871)**





Income & Expenditure Position 2025 / 26

The unaudited financial outturn for 2025 / 26 is a surplus of £123k.
As such this achieves the Trust financial target.

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

NHS England - monthly submission

The actual financial performance reported here is consistent with the monthly return made to NHS England and also to that reported to the West Yorkshire Integrated Care Board (ICB). The corresponding declaration is made within the return itself.

The submission is for the total consolidated financial position which operates as a single segment for the purpose of providing healthcare services. Within this report the financial information is split into core Trust, Provider Collaboratives and budgets held centrally. Cheswold Park Hospital, which was purchased in October 2024 and was reported separately during 2024 / 25, has now been consolidated into the Core Trust as business as usual. Previous year comparators have been updated to include this. 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)	5,412	5,400	(12)	0.2%	2,017	2,190	173	(4,465)	2,937	7,403	(4,465)	2,937	7,403
Provider Collaboratives	23	23	(0)	1.4%	2	(413)	(416)	28	(370)	(398)	28	(370)	(398)
Budgets held centrally	0	0	0	0.0%	(1,379)	(2,641)	(1,263)	4,437	(2,445)	(6,881)	4,437	(2,445)	(6,881)
Total - Consolidated position (ICB performance measure)	**5,435**	**5,422**	**(13)**	**-0.2%**	**641**	**(864)**	**(1,505)**	**(0)**	**123**	**123**	**(0)**	**123**	**123**

The core Trust has continued to report a surplus in month and is better than plan.

The financial performance of provider collaboratives remains volatile and has moved from a surplus up to February 2026 to a deficit of £370k in March 2026. This incldues the risk share impact of other collaboratives not hosted by the Trust.

Budgets held centrally is primarily targets for value for money / efficiency schemes which have not yet been allocated against individual budgets. The budget for elements linked to additional national funding have been transacted in month 12 to reflect the receipt.

2.0 Income & Expenditure Position 2025 / 26

This section focusses on the financial performance of South West Yorkshire Partnership Teaching 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.

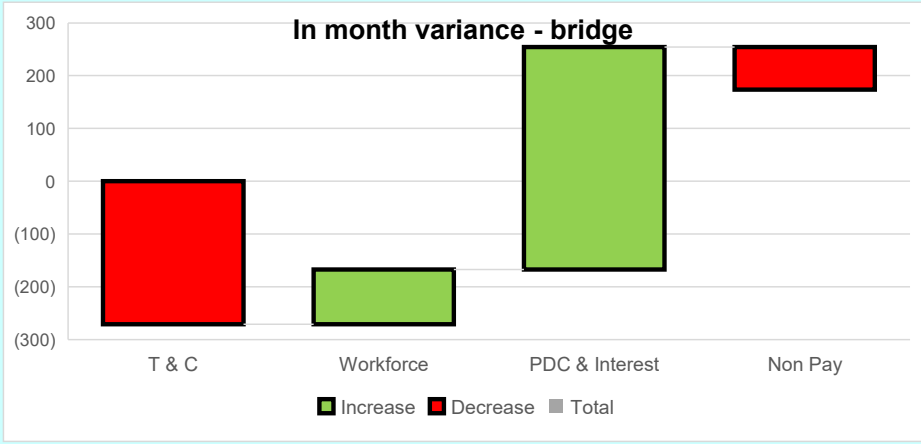
Total Financial Position - Core Trust only

	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					32,015	31,902	(112)	348,831	349,958	1,127	348,831	349,958	1,127
Other Operating Revenue					1,406	1,650	245	15,281	16,028	747	15,281	16,028	747
Total Revenue					**33,420**	**33,553**	**132**	**364,112**	**365,986**	**1,874**	**364,112**	**365,986**	**1,874**
Pay Costs	5,412	5,400	(12)	0.2%	(25,098)	(25,129)	(31)	(299,052)	(297,239)	1,813	(299,052)	(297,239)	1,813
Non Pay Costs					(5,475)	(5,833)	(359)	(59,621)	(57,805)	1,816	(59,621)	(57,805)	1,816
Gain / (loss) on disposal					0	0	0	0	446	446	0	446	446
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,412**	**5,400**	**(12)**	**-0.2%**	**(30,573)**	**(30,962)**	**(390)**	**(358,673)**	**(354,598)**	**4,075**	**(358,673)**	**(354,598)**	**4,075**
EBITDA	**5,412**	**5,400**	**(12)**	**-0.2%**	**2,848**	**2,590**	**(258)**	**5,439**	**11,388**	**5,949**	**5,439**	**11,388**	**5,949**
Depreciation					(622)	(614)	8	(7,447)	(7,774)	(327)	(7,447)	(7,774)	(327)
PDC Paid					(378)	10	388	(4,534)	(3,519)	1,015	(4,534)	(3,519)	1,015
Interest Received					170	204	34	2,077	2,842	765	2,077	2,842	765
Surplus / (Deficit) - ICB performance measure	**5,412**	**5,400**	**(12)**	**-0.2%**	**2,017**	**2,190**	**173**	**(4,465)**	**2,937**	**7,403**	**(4,465)**	**2,937**	**7,403**
Depn Peppercorn Leases (IFRS16)					(5)	(41)	(36)	(94)	(97)	(3)	(94)	(97)	(3)
Losses Peppercorn Leases (IFRS16)					0	0	0	0	(2,173)	(2,173)	0	(2,173)	(2,173)
Surplus / (Deficit) - Total	**5,412**	**5,400**	**(12)**	**-0.2%**	**2,012**	**2,149**	**137**	**(4,559)**	**667**	**5,226**	**(4,559)**	**667**	**5,226**

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 requirement for these schemes are held centrally until schemes are identified. At this stage the Trust (core) budget remains in a deficit position.

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

	£k
Accounting estimates for ongoing workforce terms and conditions programme	(271)
Workforce - Reduction in pay run rate in historically overspent care groups including Adult and Older People inpatients and CAMHS	104
PDC & Interest - Impact of timing of capital programme and Trust cash balances.	422
Non pay - additional spend in month as previously highlighted.	(81)

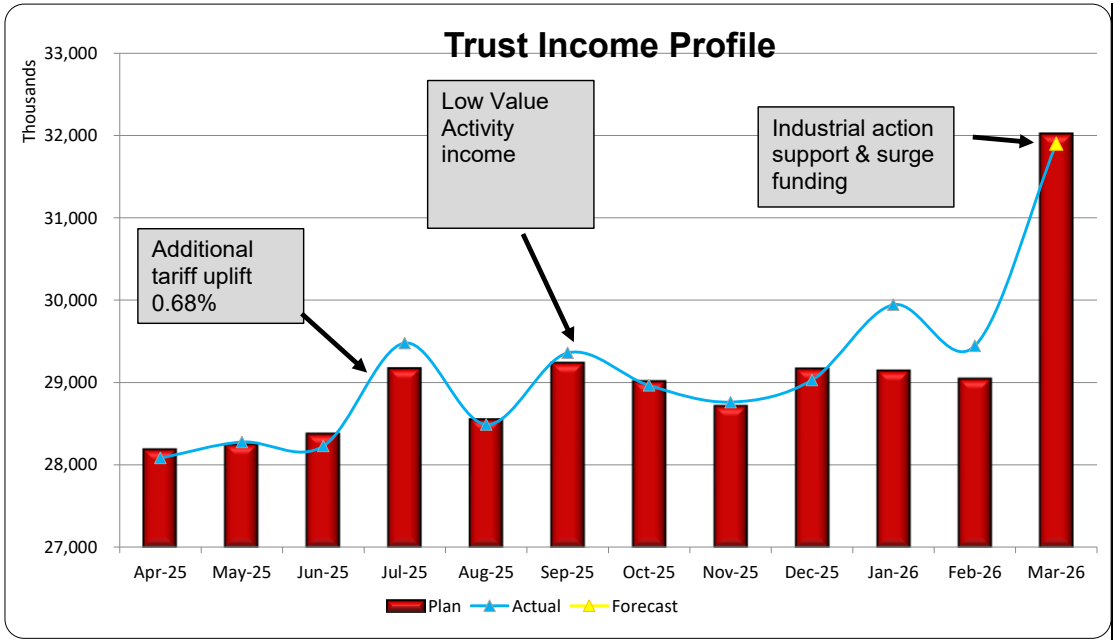


2.1 Income Information

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	23,549	23,130	23,009	23,325	23,720	23,336	26,045	**280,716**	280,505	211
Specialist Commissioner	36,788	4,697	4,723	4,666	4,861	4,956	5,036	4,919	4,922	5,006	5,317	5,522	5,147	**59,771**	57,593	2,178
Local Authority	5,141	318	465	314	680	303	422	486	483	427	441	294	396	**5,030**	5,503	(473)
Partnerships	2,940	248	251	243	251	233	197	238	212	76	345	182	129	**2,605**	3,099	(494)
Other Contract Income	1,583	127	168	155	141	149	155	191	136	197	121	111	184	**1,836**	2,131	(295)
Total	**312,292**	**28,082**	**28,276**	**28,227**	**29,479**	**28,488**	**29,359**	**28,964**	**28,761**	**29,030**	**29,944**	**29,445**	**31,902**	**349,958**	**348,831**	**1,127**
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	10,021	9,356	9,535	9,647	9,417	9,474	9,713	**113,827**		
Total	**312,292**	**37,286**	**37,484**	**37,424**	**38,930**	**38,092**	**39,381**	**38,320**	**38,297**	**38,677**	**39,361**	**38,919**	**41,615**	**463,785**		



Additional national funding has been received in March 2026 and the plan has been increased accordingly.

Final values for 2025 / 26 have been agreed with the main Trust commissioners through the Agreement of Balances exercise and there are no mismatches.

Although the majority of income remains within Aligned Incentive Contracts (AIC), and essential block contracts in value, there are a limited number of variances to plan:

	Forecast
* Additional roles reimbursement	£290k

Recharge of salary based on staff in post. Revised due to current staffing level and maternity arrangements

* Local Authority - Yorkshire Smokefree	£466k

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

2.2 Pay Information

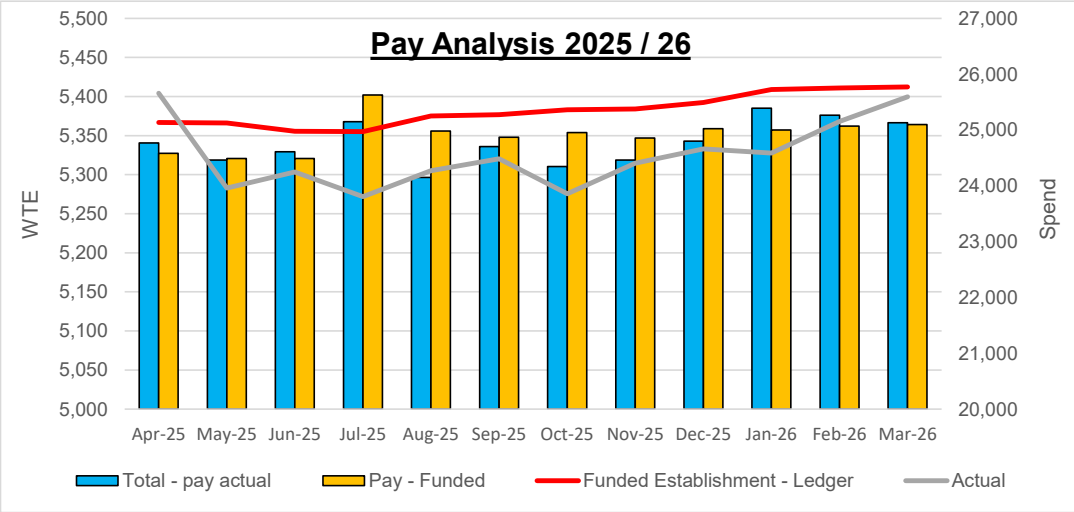
Our workforce is our greatest asset; ensuring that we have the right staff, with the right skills available at the right place and time in order to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). 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	22,338	22,357	22,455	22,716	23,371	23,211	23,195	**271,004**
Bank & Locum	2,216	1,926	1,964	2,057	1,913	2,106	1,761	1,844	1,884	1,908	1,900	1,806	**23,286**
Agency	352	355	356	361	281	260	228	163	200	112	152	127	**2,949**
Total	**24,768**	**24,463**	**24,610**	**25,151**	**24,150**	**24,704**	**24,346**	**24,461**	**24,800**	**25,392**	**25,264**	**25,129**	**297,239**
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%	8.5%	7.2%	7.5%	7.6%	7.5%	7.5%	7.2%	7.8%
Agency as % (in month)	1.4%	1.5%	1.4%	1.4%	1.2%	1.1%	0.9%	0.7%	0.8%	0.4%	0.6%	0.5%	1.0%

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	4,809	4,838	4,863	4,887	4,888	4,916	4,970	**4,850**
Bank & Locum	528	443	452	452	487	481	408	428	424	427	440	421	**449**
Agency	39	31	42	35	35	31	30	23	22	13	12	9	**27**
Total	**5,404**	**5,283**	**5,303**	**5,272**	**5,305**	**5,320**	**5,276**	**5,315**	**5,333**	**5,328**	**5,368**	**5,400**	**5,326**
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**



The trend of increased worked WTE has continued in March 2026 with an overall increase of 32 WTE. This consists of 54 additional substantive with reductions of 19 in bank and 3 in agency.

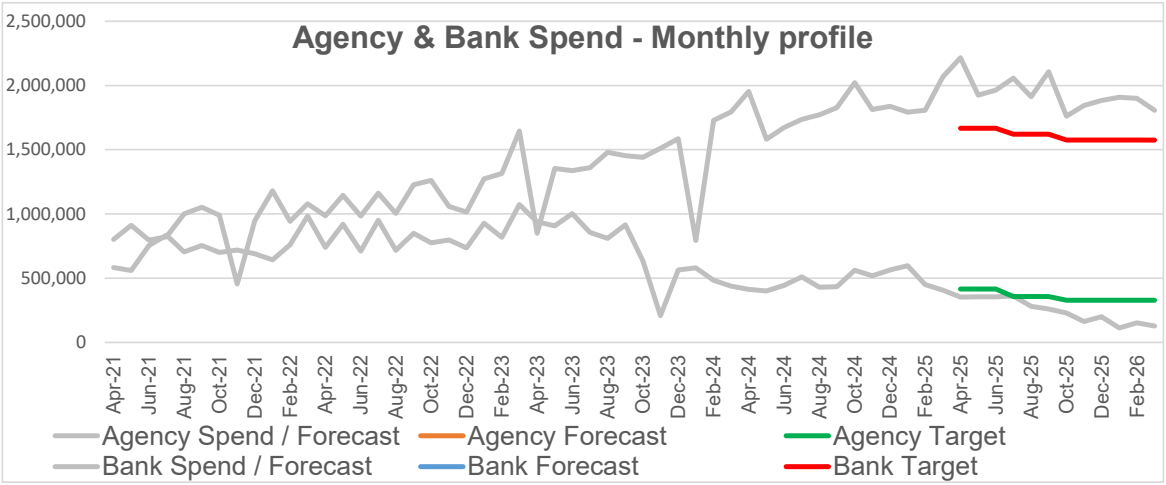
With the exception of April 2026, worked WTE has remained less than plan for each individual month and this has contributed to the overall delivery of the Trust financial target.

2.2 Temporary Staffing Focus

Trust spend in March 2026:
Agency £127k
Bank £1,806k

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	1,645	557	**2,202**
Other Medical	603	549	**1,153**
Reg Nursing	48	6,119	**6,167**
UnReg Nursing	556	14,675	**15,231**
Other Clinical	94	657	**752**
A & C	2	729	**731**
Other	0	0	**0**
Total	**2,949**	**23,286**	**26,235**
Lead Provider Collaborative	25	11	**36**
Budgets held centrally	(63)	2,125	**2,062**
Total	**2,912**	**25,422**	**28,334**

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. Further percentage reductions have been outlined within the planning guidance for 2026 / 27. 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 has continued to reduce month on month. Although the number of indiviudals utilised is small (4.65 WTE) the largest spend remains on medical staff. This is £70k in March 2026. Unregistered nursing spend is £6k in month and whilst this is slightly more than the national target of zero usage this remains a significant reduction from previous run rates. Any usage continues to be approved in line with the Trust Standard Operating Procedure.

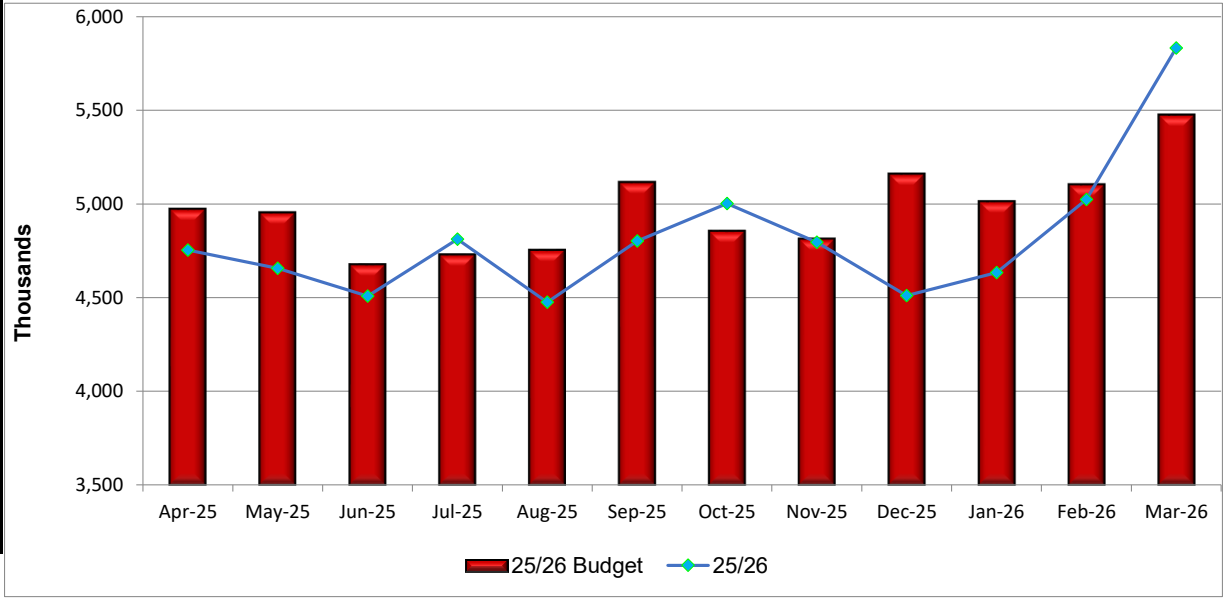
Bank and locum expenditure has continued to fluctuate from month to month as shown by the graph above. There is a reduction from February to March 2026 of £94k but this remains higher than planned.

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	4,802	5,002	4,795	4,511	4,633	5,023	5,833	**57,805**
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	4,620	4,445	(175)
Establishment	9,806	9,919	112
Lease & Property Rental	8,934	8,593	(341)
Premises (inc. rates)	5,444	5,824	379
Utilities	3,006	3,009	3
Purchase of Healthcare	7,324	6,995	(329)
Travel & vehicles	6,569	6,046	(523)
Supplies & Services	9,211	8,911	(300)
Training & Education	1,290	869	(421)
Clinical Negligence & Insurance	1,755	1,447	(308)
Other non pay	1,662	1,747	85
Total	**59,621**	**57,805**	**(1,816)**
Total Excl OOA and Drugs	**47,678**	**46,366**	**(1,312)**



Key Messages

As forecast previously there has been additional spend in March 2026. The largest increases in the run rate is in Supplies & Services which includes IM & T purchases.

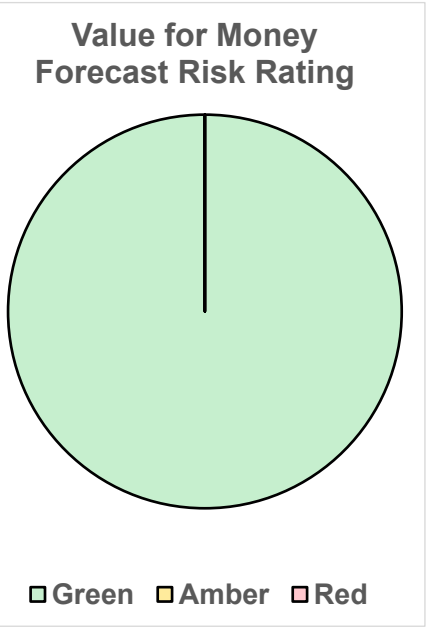
Overall, whilst less than planned, non pay expenditure is £2,047k more than spend last year. Nonb pay budgets have been reset for 2026 / 27 based on the Trust budget setting principles.

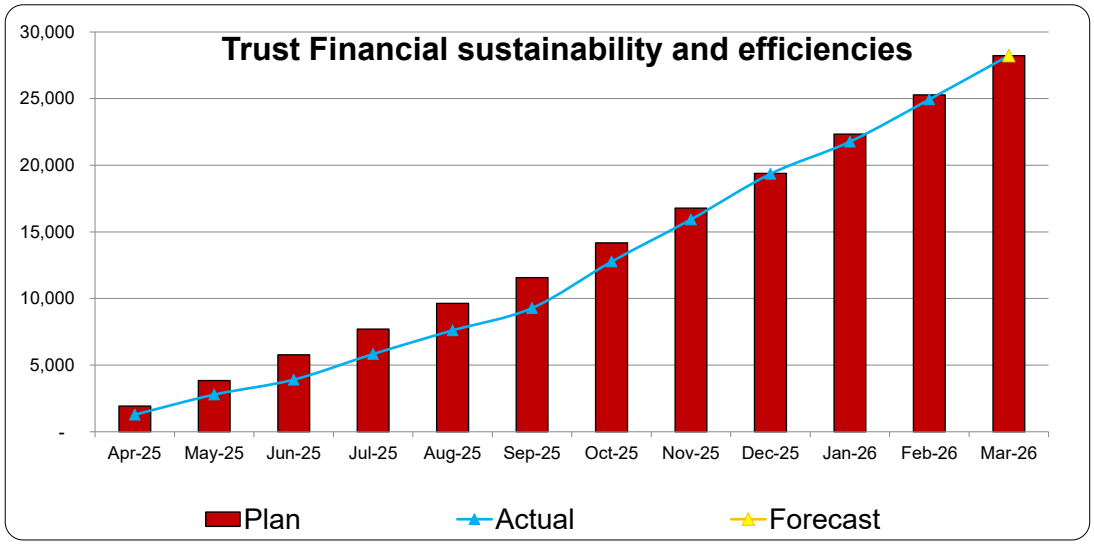
3.0 Value for Money & Financial sustainability

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	10,500	8,778		(1,722)	10,500	0	10,500	8,778	0		(1,722)
	Unallocated	0	0		(0)	3,400	(3,400)	0			0	(0)
	Fixed Term Contracts	500	362		(138)	500	0	500	362			(138)
	Corp / non clinical	3,000	2,004	1,604	608	2,000	1,000	3,000	3,608			608
	Productivity	1,100	0		(1,100)	1,100	0	1,100	0		0	(1,100)
	Temporary Staffing	3,900	3,211		(689)	3,900	0	3,900	3,211	0		(689)
	Difficult Decisions	1,000	0		(1,000)	1,000	0	1,000	0			(1,000)
Non Pay	Non Pay	1,130	1,732		602	1,130	0	1,130	823			(307)
	Difficult Decisions	0	236		236	0	0	0	236			236
Other	Corporate Services	1,700	1,745		45	1,700	0	1,700	1,745			45
	Provider Collaboratives	1,500	2,121		621	1,500	0	1,500	2,121			621
	Bed Sales	500	0		(500)	500	0	500	0			(500)
	Income	705	705		0	0	705	705	705			0
	Misc income - overage	520		448	(72)	0	520	520	448	0		(72)
	Technical	2,175		5,285	3,110	1,000	1,175	2,175	6,194			4,019
Total		**28,230**	**20,894**	**7,336**	**(0)**	**28,230**	**0**	**28,230**	**28,230**	**0**	**0**	**(0)**
Recurrent		14,735	20,894		6,159	16,430	(2,695)	14,735	19,685	0	0	4,950
Non Recurrent		13,495		7,336	(6,159)	11,800	2,695	13,495	8,545	0	0	(4,950)





The Trust value for money plan, as submitted in April 2025, included £3.4m high risk / unallocated. Actions have continued throughout the year and, as schemes have progressed, the high risk value has been allocated against new mitigations. An adjustment column has been added to the table above to show these reallocations.

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

Although there are variances at indiviudal scheme level £28.2m has been delivered in line with the overall total.

However of this £7.3m (26%) has been delivered non recurrently. The consequences of this for 2026 / 27 are considered as part of the Trust medium term financial plan.

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	192,811	
Current Assets			
Inventories & Work in Progress	248	209	
NHS Trade Receivables (Debtors)	2,453	618	
Non NHS Trade Receivables (Debtors)	989	1,145	
Prepayments	2,863	3,491	1
Accrued Income	6,235	1,266	2
Cash and Cash Equivalents	55,748	64,559	Pg 15
Total Current Assets	**68,537**	**71,289**	
Current Liabilities			
Trade Payables (Creditors)	(10,899)	(8,786)	3
Capital Payables (Creditors)	(1,551)	(2,386)	
Tax, NI, Pension Payables, PDC	(9,478)	(10,482)	
Accruals	(14,054)	(16,998)	4
Deferred Income	(644)	(1,966)	5
Other Liabilities (IFRS 16 / leases)	(48,793)	(43,717)	
Total Current Liabilities	**(85,419)**	**(84,334)**	
Net Current Assets/Liabilities	**(16,882)**	**(13,045)**	
Total Assets less Current Liabilities	**180,552**	**179,765**	
Provisions for Liabilities	(3,357)	(3,329)	
Total Net Assets/(Liabilities)	**177,195**	**176,436**	
Taxpayers' Equity			
Public Dividend Capital	76,344	79,119	
Revaluation Reserve	21,306	12,067	6
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	74,325	80,029	
Total Taxpayers' Equity	**177,195**	**176,436**	

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 are higher than previous years and current procurement practices are being reviewed to ensure that they are in line with Trust Standing Financial Instructions and present best value for money.

2. Accrued income has been minimised with invoices raised where possible. The largest value (£800k) remains relating to income from NHS England for Cheswold Park Hospital. C. £3.6m was paid in March 2026.

3. Creditors are normally high at year end but we have continued to pay suppliers promptly and, as a result, this is lower than previous year ends. Elements of this is reflected in the higher accruals value where invoices have not yet been received.

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 has increased compared to the prior year. The largest value (£632k) relates to funding from commissioners for work which has not yet commenced. A further £618k relates to the research centre project and other live research schemes.

6. Revaluation reserve reduced in year as a result of the annual exercise. The accounting judgement was presented to the Trust Audit Committee.

4.1 Capital Programme 2025 / 26

Capital schemes	Annual Budget £k	2025 / 26 Outturn £k	Variance £k
Major Capital Schemes			
Older People Transformation	7,425	1,046	(6,379)
Estates safety	675	675	0
Seclusion rooms	0	1,092	1,092
Backlog Maintenance	0	2,612	2,612
Equipment	0	75	75
Vehicles	0	310	310
IM & T	0	2,377	2,377
Other	0	720	720
Leases (IFRS 16)	6,148	4,172	(1,976)
TOTALS	**14,248**	**13,081**	**(1,167)**
Additional allocations			
Net Zero (solar funding)	1,952	518	(1,434)
Cheswold - seclusion room	0	0	0
Cheswold - Minor Capital	2,082	1,206	(876)
Cheswold - IM & T			0
TOTALS	**18,282**	**14,804**	**(3,478)**

Capital Expenditure 2025 / 26

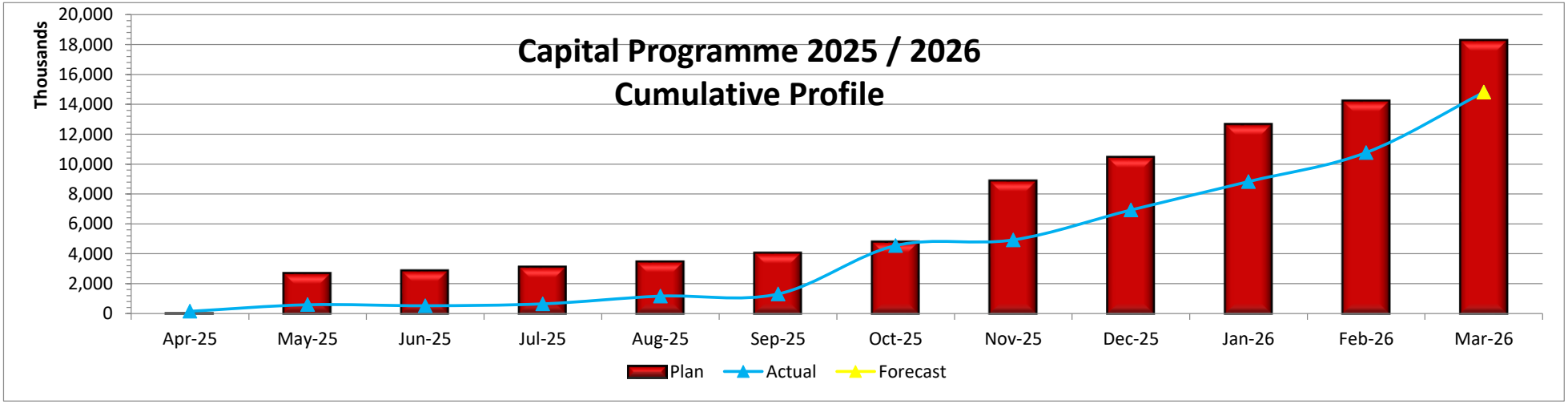
The table on the left summarises the capital programme for 2025 / 26. The first section is activity as reported against the standard West Yorkshire Integrated Care Board capital allocation. For 2025 / 26 the Trust programme was prioritised against the main older people transformation scheme and the impact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

For the main allocation spend of £13,081k has been reported. Due to technical issues the older people transformation scheme has not progreessed at the pace assumed witihn the plan and this has allowed other mitigation schemes to be delivered in year.

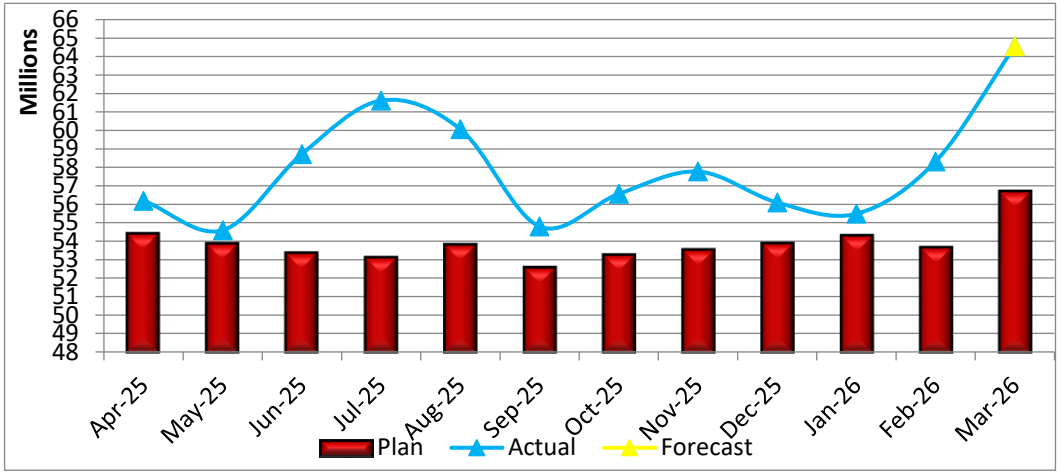
This is £481k less than previously forecast.

Additional allocations, secured in year, are reported seperately. The net zero (solar) scheme and works at Cheswold Park Hospital have spent less than planned at month 11.

The expenditure commitment, due to schemes being started but not complete, will have a financial impact into the 2026 / 27 programme.



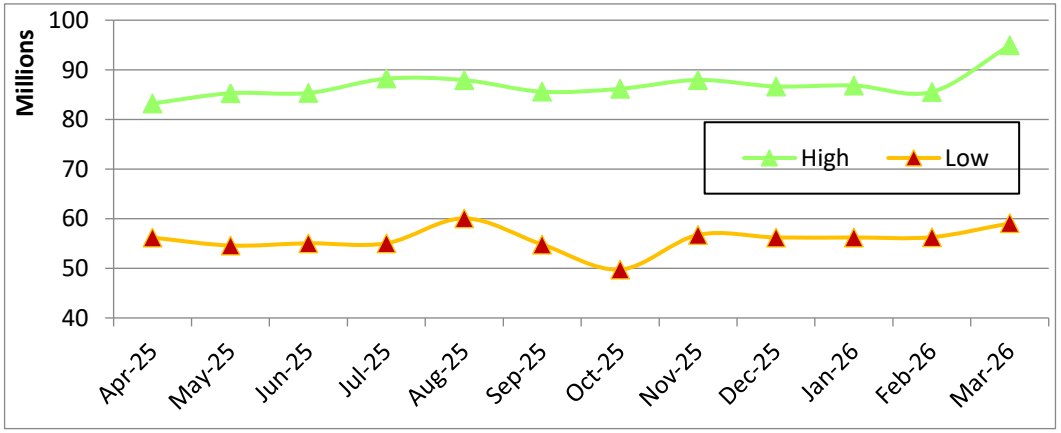
4.2 Cash Flow & Cash Flow Forecast 2025 / 2026



Cash remains above plan

Cash has continued to increase in March 2026. The main factor is receipt of cash payment from NHS England for the majority of the agreed value. A small value does remain in accrued income.

	Plan £k	Actual £k	Variance £k
Opening Balance	55,839	55,839	
Closing Balance	56,676	64,559	7,883



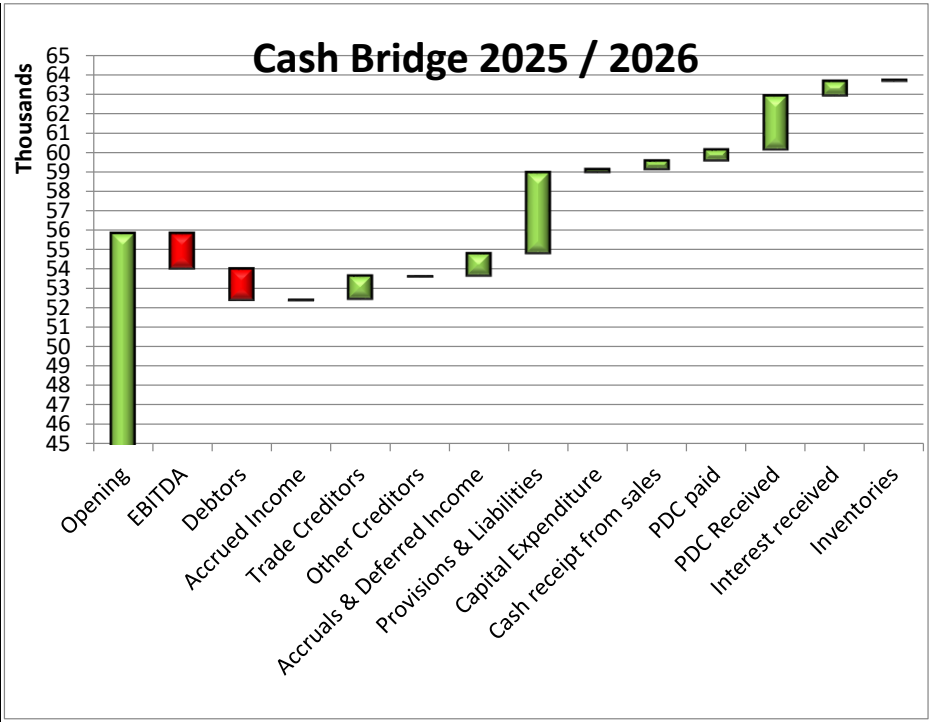
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £94.9m
The lowest balance is: £59.1m

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)	19,031	17,223	(1,808)	
Movement in working capital:				
Inventories & Work in Progress	0	39	39	
Receivables (Debtors)	5,800	4,213	(1,587)	
Trade Payables (Creditors)	450	1,650	1,200	
Accruals & Deferred income	0	1,146	1,146	
Provisions & Liabilities	(2,889)	1,287	4,176	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(9,952)	(9,797)	155	
Cash receipts from asset sales	0	448	448	
Leases	(9,145)	(9,134)	11	
PDC Dividends paid	(4,534)	(3,972)	562	
PDC Dividends received	0	2,775	2,775	
Interest (paid)/ received	2,077	2,842	765	
Closing Balances	**56,676**	**64,558**	**7,882**	



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.

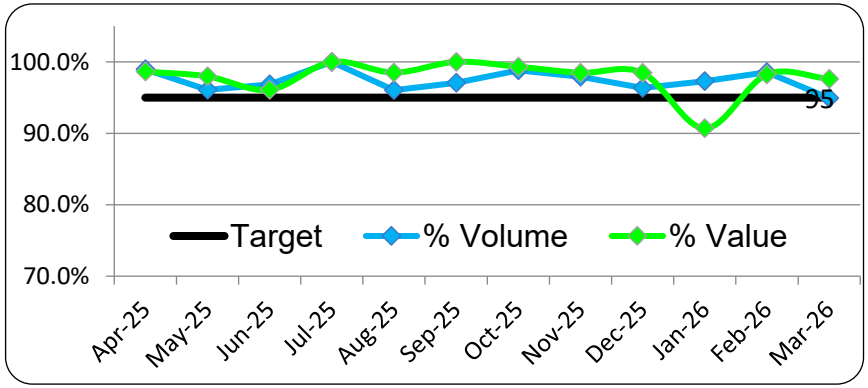
5.0 Better Payment Practice Code

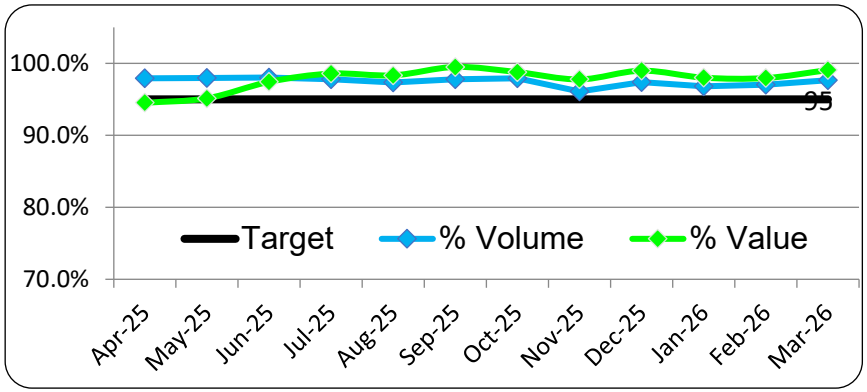
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	95%	98%
Cumulative Year to Date	97%	98%

Non NHS	Number %	Value %
In Month	98%	99%
Cumulative Year to Date	98%	98%





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5.1 Transparency Disclosure

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

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

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

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

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
06-Mar-26	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	2000032943	739,248
20-Mar-26	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	2000033105	739,248
11-Mar-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1006672	717,325
06-Mar-26	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	206586	663,103
23-Mar-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS68	400,000
02-Mar-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010981	370,371
24-Mar-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002271	343,531
23-Mar-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS45	240,000
18-Mar-26	Purchase of Healthcare	AS Collaborative	Northpoint Wellbeing Ltd	INV15974	234,678
06-Mar-26	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 313	232,724
09-Mar-26	Audit Fees	Trustwide	Deloitte LLP	8007112129	216,300
17-Mar-26	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600039465	169,230
13-Mar-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS066SN	138,536
19-Mar-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004214	136,176
05-Mar-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004154	122,997
19-Mar-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34064476	121,439
21-Mar-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34064967	120,000
06-Mar-26	IT Services	Trustwide	Wavenet Ltd	1498124	108,300
09-Mar-26	Purchase of Healthcare	Trustwide	Leeds & York Partnership NHS Foundation Trust	1006635	91,431
16-Mar-26	Rewards	Wakefield	Edenred Uk Group Ltd	ES000014	89,050
02-Mar-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510010977	86,545
10-Mar-26	NHS recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710182927	81,705
18-Mar-26	Staff Recharge	Wakefield	Wakefield Metropolitan District Council	91317996982	73,460
06-Mar-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34062958	69,512
31-Mar-26	Staff Recharge	Wakefield	Wakefield Metropolitan District Council	91318108009	69,495
13-Mar-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS066INV	65,846
27-Mar-26	Drugs	Trustwide	Rowlands Pharmacy	1800005656	64,728
12-Mar-26	NHS recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6029482	63,887
11-Mar-26	Lease Cars	Trustwide	Athlon Mobility Services Uk Ltd	202680006583	63,671
17-Mar-26	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	332269	58,946
18-Mar-26	Rates	Calderdale	Calderdale Metropolitan Borough Council	25202690998909	58,310

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
26-Mar-26	Furniture	Trustwide	Pineapple Contracts	SI107253	52,973
24-Mar-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002270	50,072
23-Mar-26	Staff Recharge	Forensics	Leeds & York Partnership NHS Foundation Trust	1006731	49,784
08-Mar-26	IT Equipment	Trustwide	Dell Corporation Ltd	7403161436	47,700
05-Mar-26	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	332170	46,553
03-Mar-26	Purchase of Healthcare	Forensics	Sheffield Childrens NHS Foundation Trust	2400010797	45,840
12-Mar-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC046INV	44,878
10-Mar-26	Drugs	Trustwide	NHS Business Services Authority	1000087273	44,231
11-Mar-26	Utilities	Trustwide	Edf Energy Customers Ltd	000027110809	43,600
13-Mar-26	Lease Cars	Trustwide	Arval Uk Ltd	RI0014696081	42,968
25-Mar-26	Rates	Wakefield	Wakefield Council	8885112606032026	41,167
25-Mar-26	Rates	Kirklees	Kirklees Council	96921639X2026	39,445
18-Mar-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34059817	39,091
03-Mar-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001515EPC	36,987
10-Mar-26	Purchase of Healthcare	Forensics	Humber Teaching NHS Foundation Trust	59898198	36,769
02-Mar-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898136	36,701
06-Mar-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1006522	34,831
23-Mar-26	Staff Recharge	Forensics	Leeds & York Partnership NHS Foundation Trust	1006731	34,198
27-Mar-26	NHS recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710182941	34,033
20-Mar-26	NHS recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600039470	33,723
02-Mar-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34011303	30,915
25-Mar-26	Rates	Kirklees	Kirklees Council	9689426262026	30,380
23-Mar-26	Equipment	Doncaster	Technogym Uk Ltd	2670004075	29,406
25-Mar-26	Rates	Barnsley	Barnsley Metropolitan Borough Council	5602654242026	28,979
10-Mar-26	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	WKE0456915	28,420
09-Mar-26	Purchase of Healthcare	Forensics	Change Grow Live	IN16464	28,406
06-Mar-26	NHS recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710182867	27,891
25-Mar-26	Rates	Kirklees	Kirklees Council	9692164152026	27,685
30-Mar-26	Staff Recharge	Trustwide	Sheffield Health & Social Care NHS Foundation Trust	0000002173	27,441
25-Mar-26	Rates	Kirklees	Kirklees Council	9689128942026	27,440
02-Mar-26	Service Charge	Kirklees	Bradbury Investments Ltd	19981	27,158
30-Mar-26	Utilities	Trustwide	Totalenergies Gas & Power Ltd	40895249426	26,785
31-Mar-26	Hardware	Trustwide	Vodafone Ltd	SP99033	26,676
25-Mar-26	Rates	Kirklees	Kirklees Council	96951667X2026	26,459
05-Mar-26	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72491812	26,345
05-Mar-26	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	IN1001996	25,727
27-Mar-26	Rates	Kirklees	Kirklees Council	9692163802026	25,412
02-Mar-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898133	25,283
02-Mar-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898134	25,283
02-Mar-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898135	25,283
27-Mar-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898325	25,283
27-Mar-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898326	25,283
02-Mar-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898137	25,283
27-Mar-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898329	25,283
02-Mar-26	Purchase of Healthcare	Forensics	Tees Esk & Wear Valleys NHS Foundation Trust	4810028972	25,249

5.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

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

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

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

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

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

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

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

Appendix 3 - Statistical Process Control (SPC) Charts Explained

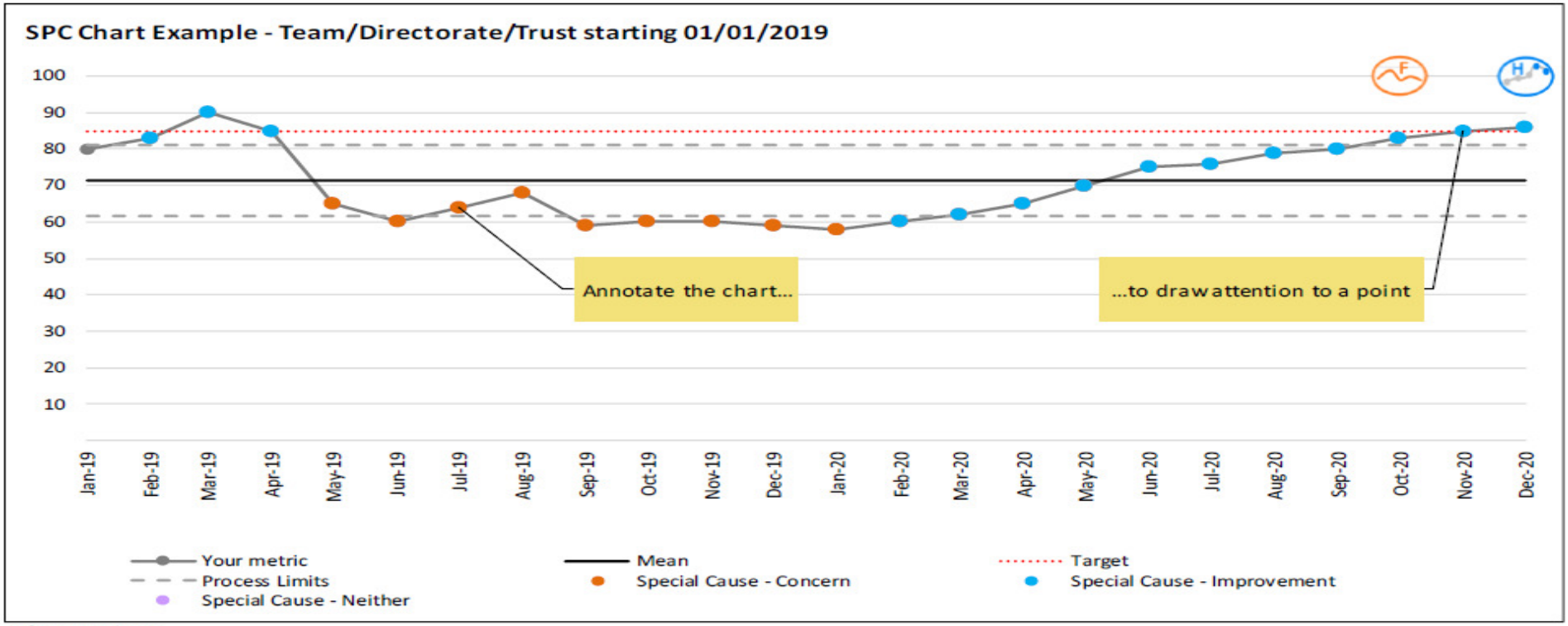
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

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

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

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

Appendix 3 - Statistical Process Control (SPC) Charts Explained



Observations

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

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