South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 30 June 2026 at 9.30
Small Conference Room – Wellbeing and Development Centre
Fieldhead Hospital Wakefield

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.30**	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	**9.31**	**Declarations of interest**	Chair	**Paper**	2	To receive
3.	**9.33**	**Questions from the public** *(received in advance in writing by e:mail to membership@swyt.nhs.uk)*	Chair	**Verbal**	5	
4.	**9.38**	**Minutes from previous Trust Board meeting held 28 April 2026**	Chair	**Paper**	2	To approve
5.	**9.40**	**Matters arising from previous Trust Board meeting held 28 April 2026 and board action log**	Chair	**Paper**	5	To approve
6.	**09.45**	**Service user/ staff story**	Chief Operating Officer	**Verbal item**	10	To receive
7.	**09.55**	**Chair's remarks**	Chair	**Verbal item**	3	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
8.	**09:58**	**Chief Executive's report**	Chief Executive	**Paper**	7	To receive
9.	**10:05**	**Assurance from Trust Board Committees, Members' Council and Joint Partnership Board** - Joint Partnership Board 27 April 2026 - People and Remuneration Committee 5 May 2025 - Members' Council 6 May 2025 - Quality and Safety Committee 12 May 2026/9 June 2026 - Mental Health Act Committee 2 June 2026 - Commissioning Committee 16 June 2026 - Finance, Investment and Performance Committee 22 June 2026 - Audit Committee 23 June 2026	Committee Chairs	**Paper**	10	To receive
10.	**10.15**	**Performance**				
	10.15	10.1 Integrated performance report Month 2 2026/27	Executive Directors	**Paper**	30	To receive
	10.45	10.2 Care Group performance report	Chief Operating Officer	**Paper**	15	To receive
	11.00	*Break*			*10*	
11.	11.10	**Risk and Assurance**				
	11.10	11.1 Patient Safety Oversight Annual report	Chief Nurse/Director of Quality and Professions	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.15	11.2 Learning from Healthcare Deaths report	Chief Nurse/Director of Quality and Professions	**Paper**	5	To receive
	11.20	11.3 Patient experience annual report	Chief Nurse/Director of Quality and Professions	**Paper**	5	To receive
	11.25	11.4 Quality Account	Chief Nurse/Director of Quality and Professions	**Paper**	5	To approve
	11.30	11.5 Data security and protection toolkit	Director of Finance, Estates and Resources	**Paper**	5	To receive
	11.35	11.6 PESTLE and SWOT	Deputy Chief Executive & Director of Strategy, Inclusion and Change	**Paper**	5	To receive
	11.40	11.7 St Andrews Independent Review	Chief Nurse/Director of Quality and Professions	**Paper**	10	To receive
12.	**11.50**	**Integrated Care Systems and Partnerships**				
	11.50	12.1 South Yorkshire update including South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Deputy Chief Executive & Director of Strategy, Inclusion and Change	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.55	12.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Chief Executive	**Paper**	5	To receive
	12.00	12.3 Provider Collaboratives and Alliances	Director of Finance, Estates and Resources	**Paper**	5	To receive
13.	**12.05**	**Governance matters**				
	12.05	13.1 Compliance with NHS provider licence conditions and code of governance - self-certification	Deputy Chief Executive/ Director of Strategy, Inclusion and Change	**Paper**	5	To receive
	12.10	13.2 Trust Seal	Company Secretary	**Paper**	5	To receive
14.	**12.15**	**Strategies and Policies**				
	12.15	14.1 Digital strategy bi-annual update	Director of Finance, Estates and Resources	**Paper**	10	To receive
15.	**12.25**	**Trust Board work programme for 2026/27**	Chair	**Paper**	3	To approve
16.	**12.28**	**Any other business**	Chair	**Verbal**	4	To receive
17.	**12.32**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 28 July 2026	Chair	**Paper**	3	To receive
	12.35	*Close*				

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 2

Private/Public paper:	**Public**	
Title:	**Trust Board declaration of interests**	
Lead Director:	**Jayne Brown – Chair**	
Mission/values:	We are respectful, honest, open and transparent	
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the UK Corporate Governance Code, NHS England's Code of Governance for NHS Provider Trusts, the Trust's own Constitution and Fit and Proper Persons Test (FPPT) framework standards.	
Strategic aims:	Live Our Values	✓
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓
	Be ambitious	✓
BAF Risk(s):	N/A	
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust compliance with Fit and Proper Persons Test (FPPT) framework, standards, including declarations of interest, provides assurance to commissioners and partners that the Trust is well led.	
Any background papers / previously considered by:	Previous annual declaration of interest papers to the Trust Board.	
Executive summary:	**Declaration of interests** The Trust's Constitution, the UK Corporate Governance Code and NHS England's Code of Governance for NHS Provider Trusts, require Trust Board	

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	members to receive and consider details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a register of interests. During the year, if any declarations should change, the Chair and Directors are required to notify the Head of Corporate Governance (Company Secretary) so that the Register can be amended and reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. In the attached paper are declarations of interest for the Chair Jayne Brown and Chief People Officer Christine Brereton.
Recommendation:	**Trust Board members are asked to:** • **CONSIDER** the attached summary, particularly in terms of any risk presented to the Trust as a result of a director's declaration, and, subject to any comment, amendment or other action, formally record the details in the minutes of this meeting.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board 30 June 2026
Register of interests of the directors (Trust Board)
From 1 April 2026 to 31 March 2027

All members of Trust Board have signed a declaration against the fit and proper person requirement. All Non-Executive Directors have signed the declaration of independence as required by NHS England's Code of Governance for NHS Provider Trusts. This requires the Trust to identify in its annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement.

The following declarations of interest have been made by members of the Trust Board since the annual declarations report on 31 March 2026:

Name	Declaration
Chair	
BROWN, Jayne	No interests declared

Name	Declaration
Executive Directors	
BRERETON, Christine Interim Chief People Officer	Spouse is interim finance director at Nottinghamshire Health Care Mental Health Trust from 1 July 2026.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of the public Trust Board meeting held on 28 April 2026
Small Conference Room, Learning and Wellbeing Centre, Fieldhead Hospital

Present:	Marie Burnham (MBu)	Trust Chair
	Natalie McMillan (NMc)	Deputy Chair, Senior Independent Director
	Gary Ellis (GE)	Non-Executive Director
	Mike Ford (MF)	Non-Executive Director
	Martin Neeson (MN)	Non-Executive Director
	Rokaiya Khan (RK)	Non-Executive Director
	Margaret Kitching (MK)	Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	Dawn Lawson (DL)	Deputy Chief Executive / Director of Strategy, Inclusion and Change
	Adrian Snarr (AS)	Director of Finance, Estates and Resources
	Prof. Subha Thiyagesh (ST)	Chief Medical Officer
	Caroline Johnson (CJ)	Chief Nurse and Director of Quality and Professions
Apologies:	Mitch Waterman (MW)	Appointed University of Leeds Associate Non-Executive Director
	Christine Brereton (CB)	Chief People Officer
In attendance:	Ellie Valentine (EV)	Deputy Chief People Officer
	Adele Fox (AF)	Chief Operating Officer
	Izzy Worswick (IW)	Deputy Director of Partnerships, Planning and Governance
	Estelle Myers (EMy)	Freedom to speak up guardian (item 10.6 only)
	Danielle Benn (DB)	Ward manager Hepworth Ward, Forensic services (item 6 only)
	Angela (A)	Service User Carer (item 6 only)
	Andy Lister (AL)	Company Secretary
	Gemma Lockwood (GL)	Corporate Governance Manager
	Debbie Beynon-Fisher (DBF)	Corporate Governance Officer (author)

TB/26/34 Welcome, introductions and apologies (agenda item 1)

Marie Burnham (MBu), Chair, welcomed everyone to the meeting. Apologies were noted, and the meeting was deemed to be quorate and could proceed.

MBu outlined the Board meeting protocols and etiquette, and reported the meeting was being live streamed for the purpose of inclusivity, to allow members of the public access to the meeting.

MBu informed attendees that the meeting was being recorded for administration purposes, to support minute taking, and once the minutes had been completed the recording would not be retained. Attendees of the meeting were advised that they should not record the meeting unless they had been granted authority by the Trust prior to the meeting taking place.

TB/26/35 Declarations of interest (agenda item 2)

No declarations of interest were noted.

It was RESOLVED to NOTE the updated declarations of interest.

TB/26/36 Questions from the public (agenda item 3)

No questions were received from the public.

TB/26/37 Minutes from previous Trust Board meeting held 31 March 2026 (agenda item 4)

Mike Ford (MF) identified one correction in relation to the resolution for agenda item 11.5 Trust Planning 2026/27 which should read *"It was RESOLVED to RECEIVE the update on the Trust's operating plan and NOTE the final submission has been made in line with national timescales".*

Subject to the change noted above, the minutes of the meeting held on 31 March 2026 were accepted as an accurate record.

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 31 March 2026 as a true and accurate record.

TB/26/38 Matters arising from previous Trust Board meeting held 31 March 2026 and Board action log (agenda item 5)

It was RESOLVED to NOTE the updates to the action log and AGREE to close actions recorded within the action log as complete.

TB/26/39 Service User/Staff Member/Carer story (agenda item 6)

Adele Fox (AF) introduced Danielle Benn (DB), Ward Manager in Forensic Services, and Angela (A), a carer, who presented an overview on the work that has taken place to improve carer engagement and support within secure services at Newton Lodge.

DB advised that as a result of the Covid-19 pandemic, carer engagement had declined within forensic services. Recognising the importance of carers, DB described the work she has led to re-establish meaningful engagement, beginning with a Mother's Day event in 2024. Since then, carer engagement has grown substantially, with regular events now attended by an increasing number of carers and families at each event.

Initial feedback received from carers had reported feeling that the forensic environment was intimidating and anxiety-provoking, particularly due to the high level of security and unfamiliar processes. DB described how structured events, informal engagement, and staff support had helped to reduce these anxieties and improve carer understanding of services and the processes required to keep people safe. Further feedback from carers following the improvements made to carer engagement reported improved confidence, reassurance and a stronger sense of inclusion.

Angela provided a personal account of her experience as a carer, describing the emotional impact of her first visit to a secure unit, the fear and uncertainty she experienced, and the challenges of understanding the environment. She explained how involvement in carer events had helped her to better understand services, feel more supported and enabled her to positively support her son through his treatment journey. Angela described the events as welcoming, inclusive and impactful, noting the particular success of themed events including a combined Mother's Day and Eid celebration, which promoted inclusion, cultural awareness and helped strengthen relationships between carers, service users and staff.

DB and Angela were thanked for sharing an open and personal account which recognised the impact of the work for both carers and service users. It was noted that the initiative strongly reflected the Trust value that families and carers matter.

Subha Thiyagesh (ST) asked whether the initiative had made a difference to carers' experiences and what further improvements could be made. Angela confirmed that her personal experience had been positive, praising the care, communication and compassion shown by staff and highlighted the importance of clear information and reassurance for carers navigating secure services.

Nat McMillan (NMc) asked what the Trust could do going forward to help prepare carers for their first visit to secure care, acknowledging that anxiety was inevitable but could be mitigated. DB and Angela suggested proactive contact with carers prior to visits, clearer explanations of security measures, what to expect on arrival and to provide reassurance about why such measures were necessary.

Margaret Kitching (MK) suggested capturing the carer journey and experience in a short video or visual resource, to help prepare carers and families prior to visiting secure environments.

Caroline Johnson (CJ) asked how the Trust can continue to sustain the support provided for service users as they move through services and how the learning from this work could be extended to other wards and services across the Trust. DB stated that a wider group of staff were engaged in supporting the programme and that planning was underway to ensure continuity. She raised that encouraging wider carer involvement and staff ownership was key to sustaining and embedding the approach going forward.

Mark Brooks (MBr) thanked DB and Angela for their contribution, commending the work as making a real tangible difference to carers' and families' experiences. MBr emphasised the importance of ensuring consistency in carer engagement and support across the Trust and encouraged further consideration of how best practice could be shared and embedded more widely.

It was RESOLVED to RECEIVE the Staff Member Story, and the comments made.

TB/26/40 Chair's remarks (agenda item 7)

MBu noted that the private board meeting would include:

- Private risk register
- Commissioning Committee minutes due to being commercial in confidence
- Complex Clinical Matters report
- Finance and Value for Money update
- Investment Appraisal

It was RESOLVED to RECEIVE the Chair's remarks.

TB/26/41 Chief Executive's report (agenda item 8)

MBr presented the Chief Executive's report which was taken as read. MBr summarised the key points:

- The Trust is currently operating across two overlapping periods, with a continued focus on finalising 2025/26 year-end reporting while progressing planning and priorities for 2026/27. The significant volume of governance and year-end work underway was acknowledged and MBr thanked Izzy Worswick (IW) and Adrian Snarr (AS) and their teams for their work in leading this process.
- Recent NHS England (NHSE) regional engagement events have highlighted the need for continued improvement and transformation across the system. All organisations are required to implement workforce reduction plans, with recognition of the potential

impact on services, communities and staff. Within the North East Yorkshire and Humber region, significant financial challenges across some organisations were acknowledged.

- A period of industrial action has taken place over six days since the last Board meeting with higher levels of resident doctors participating. MBr thanked colleagues for effective planning and management during this time.
- South Yorkshire is one of two regions in the country where NHSE will appoint a new Integrated Care Board (ICB) Chair, who will also act as the Mayor's Health Commissioner, and the recruitment process is underway.
- The Trust has achieved its 2025/26 financial targets, which provide strong credibility within the region and a positive platform for future planning.
- Shadow Place Provider Partnership arrangements have commenced with initial meetings taking place and further meetings scheduled.
- An update was provided on the Integrated Care Board (ICB) reorganisation, with significant staff turnover reported across the system. MBr noted this continued period of uncertainty for partner organisations and recognised that this was contributing to wider system-level risk.
- Overall operational performance for the Trust has remained positive, despite a period of increased pressure during March due to higher inpatient bed demand. This was reflected in some areas of increased amber and red ratings within the Integrated Performance Report (IPR), particularly within mental health inpatient and forensic services, however overall performance remained stable.
- The impact of international conflicts on staff, service users and carers was highlighted, particularly in the Middle East, as well as the importance of awareness and sensitivity to the wider impact across the Trust's communities.
- The Covid-19 inquiry has begun publishing its first set of findings, with further reports expected. It was noted that the process would be iterative and that the Trust would reflect on the findings as further information became available.
- The Trust is currently operating within the pre-election period, which places some restrictions on communications and engagement.
- Initial findings from the Mental Health, Learning Disability and Autism Prevalence Review, confirmed increasing demand for services, with recommendations expected later in the year.
- The Trust Annual Excellence Awards will take place on 14 May 2026, alongside the long service and learner awards.
- Chris Edwards has been substantively appointed as Chief Executive of the South Yorkshire ICB.
- MBr confirmed the appointment of Christine Brereton (CB) as Substantive Chief People Officer, and acknowledged her contribution to the Trust over the preceding year.
- MBr also paid tribute to the Chair, MBu, recognising her significant contribution and leadership during her tenure, noting that this was her final public Trust Board meeting.
- Interviews for the new Chair will take place on 12 May 2026.

MBu thanked MBr for the update, noting the challenging national and system context within which the Trust continued to perform well.

It was RESOLVED to RECEIVE the Chief Executive's report.

TB/26/42 Assurance and approved minutes from Trust Board Committees (agenda item 9)

Commissioning Committee (CC)

Martin Neeson (MN) provided an update following the Commissioning Committee meeting held on 1 April 2026.

- Pressure continues within West Yorkshire male adult medium secure services, with sustained high occupancy levels and longer waits, necessitating the use of additional out-of-area placements during the reporting period.
- The Trust has received correspondence regarding the external report into St Andrew's Healthcare. Active work is underway to support the repatriation of two West Yorkshire service users back into the region, in line with commissioning and quality objectives.
- One provider returned to routine monitoring on the 13 March 2026 and are progressing a controlled programme of new admissions. Cheswold Park Hospital, previously subject to enhanced quality oversight, had also been returned to routine monitoring.
- Bed modelling work is underway across West Yorkshire in response to increasing demand for medium secure capacity. This work is supported by multi-system collaboration to explore opportunities for more integrated working across clinical pathways to maximise benefits for service users across the wider region.
- NHS collaborative contracts had been extended until 2027 and the implications of this extension were under active consideration by the Commissioning Committee, with further discussion scheduled to take place during the private session of the Board.

In relation to issues raised at St Andrew's Healthcare, MBr confirmed that the independent report will be presented to the June Board, to ensure that any learning was fully considered by the Trust.

MBr also noted the financial impact of exceptional packages of care. Currently there are three service users each receiving packages costing approximately £200k per month, equating to an annualised cost of approximately £7m. The Board noted the scale of this challenge and the importance of ongoing work at collaborative level to manage both cost pressures and quality of care.

It was noted that the minutes of the Commissioning Committee meeting held on 1 April 2026 would be reviewed in the private section of the Trust Board meeting

<u>Quality and Safety Committee (QSC)</u>
MK provided an update following the Quality and Safety Committee meeting held on 14 April 2026:

- Following the tragic deaths of two female inpatients, the chief executive asked that an external review of the women's pathway of care be commissioned. The findings will provide independent assurance and inform the ongoing redesign of the women's pathway. Pending the outcome of the review, an interim action plan has been put in place which includes increased psychological therapy resource on affected wards. Findings from the external review, together with associated action plans, will be brought back to a future Board meeting.
- Timeliness of medical reviews of seclusion continue to be identified in Care Quality Commission (CQC) Mental Health Act (MHA) inspections. A review of seclusion practice has been commissioned by the Chief Nurse/Director of Quality and Professions and the Chief Operating Officer, and a report will be presented to the Committee in July 2026 and subsequently escalated to the Board as appropriate.
- The Committee received a report from the Trust's Suicide Prevention Lead reviewing recent trends. The Trust is not a statistical outlier, however there are concerns regarding rising deaths among women under twenty five, often linked to self-harm and substance misuse. Four inpatient-associated deaths were noted and the Committee requested more detailed comparative data for better assurance and scrutiny.
- MBr noted the reduction in system-level investment in suicide prevention services across West Yorkshire. It was acknowledged that a significant proportion of people who die by suicide are not in contact with mental health services, highlighting the importance of wider system partnership working. MK noted that deaths occurring

while individuals were in the Trust's direct care remain a priority focus for governance and improvement.

The minutes of the Quality and Safety Committee meeting held on 10 March 2026 were accepted.

Audit Committee (AC)

The Board received an update from Mike Ford (MF) following the Audit Committee meeting held on 14 April 2026:

- An internal audit report on Safer Staffing had received a "moderate assurance" rating. The report will be reviewed in detail with progress against the agreed actions monitored and reported back to the Committee at a future meeting. It was noted that the Trust received several moderate assurance opinions during the year and this category was a new audit rating, adding to previous classifications.
- The Annual Health and Safety Survey has been completed, with positive results. However, MF reported that fifteen services had not returned a response and these services would therefore be subject to enhanced follow-up activity in the forthcoming year. The pressures faced by services were acknowledged, however the lack of full engagement was noted to be disappointing.
- An update was provided on Emergency Preparedness, Resilience and Response (EPRR) compliance. The Trust continues to be rated as "non-compliant" against national standards, with scores lower than expected. This is an issue not unique to the Trust. It was noted that some elements of the national framework were not considered proportionate to the Trust's operational context, although the Trust was required to continue reporting against these standards and work continues to improve the Trust's reported position.
- A positive cyber security report was received, benchmarking the Trust's cyber arrangements against national guidance. The Committee requested a more detailed dedicated session with relevant leads to strengthen Board assurance in this area.
- A paper recommending the appointment of external auditors was received and this would be taken forward to the Members' Council for final approval, with subsequent formal notification to the successful organisation.

MBr requested that EPRR arrangements, and fire safety and ward evacuation arrangements remain an area of active awareness and assurance within the Trust.

The minutes of the Audit Committee meetings held on 14 January 2026 were accepted.

Finance, Investment and Performance Committee (FIP)

Gary Ellis (GE) provided an update from the Finance, Investment and Performance Committee meeting held on 21 April 2026.

- The Trust has achieved a year-end surplus of £123k within the management accounts, confirming delivery against the 2025/26 financial plan target. This was recognised as a significant achievement given the wider financial pressures across the system.
- Bank expenditure remained above target during the year and addressing this would remain a priority for 2026/27.
- The Value for Money Programme delivered savings in excess of £20m. It was noted that £7.3m of these savings were non-recurrent, requiring careful consideration within the medium-term financial plan to ensure sustainability.
- Capital expenditure was below forecast and attributed to slippage in nationally funded schemes, particularly the solar panel programme and additional capital works at Cheswold Park Hospital. It was noted that some factors were outside the Trust's direct control. Capital delivery, particularly in relation to the Older People's Services scheme would remain a significant focus and risk area for the forthcoming year.

- Cash balances remain green at the year-end, and the Trust remains fully compliant with the Better Payment Practice Code, supporting timely payments to suppliers.
- A more detailed report in relation to the management of investment appraisal bids would take place within the private Board session.
- The Committee reviewed feedback on the Trust's Plan submission with confirmation that the Trust plan had been confirmed by NHSE as 'compliant with conditions'.
- It was noted that the NHS Oversight Framework quarter four position was expected to be confirmed towards the end of May 2026, and significant changes to performance metrics were anticipated in the new financial year. The Committee noted that the Trust currently had a good understanding of its performance against existing measures and would continue to adapt to the revised framework.

The minutes of the Finance, Investment and Performance Committee meeting held on 16 March 2026 were accepted.

Equality, Inclusion and Involvement Committee

MBu provided an update following the Equality, Inclusion and Involvement Committee meeting held on 11 March 2026.

- The Committee was formally concluded, as part of the transition to a revised Committee structure for the forthcoming governance year. In light of this, it was necessary for Trust Board to approve the final minutes of the Committee, as there was no longer a successor Committee with delegated authority to do so.
- The Board was therefore asked to consider and approve the minutes of the Equality, Inclusion and Involvement Committee meeting held on 11 March. It was raised that any outstanding actions or issues arising from the Committee's work would be picked up by the relevant Committee to ensure appropriate oversight and follow-through.
- The Board approved the minutes of the Equality, Inclusion and Involvement Committee meeting held on 11 March 2026.

It was RESOLVED to RECEIVE assurance and minutes from Trust Board Committees.

TB/26/43 Risk and assurance (agenda item 10)

TB/26/43a Board Assurance Framework (agenda item 10.1)

IW presented an update of the Board Assurance Framework (BAF) as part of the Quarter 4 review. In addition to the routine quarter four review, IW explained that a detailed review of the BAF took place at an EMT time-out on 12th March 2026, focusing on strengthening the alignment between the Trust's strategy, operational plans, BAF and Organisational Risk Register Risk Register. A mapping exercise had been undertaken to test this alignment, with supporting detail available via the Reading Room on Team Engine.

- At Quarter four, the Trust had sixteen strategic risks recorded within the BAF. These risks were reviewed at the Executive Management Team time out meeting on 12th March 2026 in detail and at EMT on 9 April 2026. The review considered the BAF in the context of the current operating environment, including our Trust staff survey results, operational pressures, changes to our ICBs, and potential changes arising from specialised commissioning arrangements. Particular focus during the review was given to:
  - Risk 3.1 – Workforce, relating to the Trust's ability to recruit, retain, support and maintain the wellbeing of staff
  - Risk 4.1 – Finance, reflecting ongoing and anticipated financial pressures
- In relation to workforce risk, it was noted that overall staff turnover remained static, although further work was required to better understand variation across staff groups.
- For financial risk, it was noted that changes to system finance reporting arrangements and likely impact would need to be considered in future reviews of this risk.

- Following the annual review, minor amendments have been made to the BAF schematic to improve clarity. Small wording changes were proposed for Risks 4.1 and 6.2, reflecting current understanding and context. These proposed changes were considered by the Audit Committee on 14 April 2026 which recommended them to the Board for approval.

MBr clarified that the review had deliberately focused on strategic, rather than operational, risks, and that each risk had been tested against changes quarter-on-quarter. While the Trust continued to operate in a challenging environment, there had been no material change sufficient to warrant altering the overall strategic risk ratings. Factors such as the Trust's oversight framework rating, progress at Cheswold Park Hospital, and planning developments for 2026/27 had all been considered as part of the review.

It was RESOLVED to RECEIVE the updates to strategic risks, APPROVE the updated BAF schematic for 2026/27 and APPROVE the proposed narrative changes for risks 4.1 and 6.2 for 2026/27.

TB/26/43b Corporate / Organisational Risk Register (agenda item 10.2)

IW presented the Organisational Risk Register (ORR). She confirmed the report was the Quarter 4 report on the Operational Risk Register, which had been reviewed in detail by EMT at its time out on 12th March and by EMT on 9 April 2026. The report is presented to Trust Board on a quarterly basis. IW outlined that:

- Individual risk review meetings took place with each Executive Director during February and March 2026 to ensure that risks were clearly articulated, appropriately scored, and supported by robust controls and mitigating actions.
- An emerging risk had been identified related to wider system change, specifically the development of Place Provider Partnerships and potential impacts on the Trust and its Places. This would be developed and presented back to Board in the next review of the ORR.
- A further emerging risk related to workforce planning was noted.
- At Quarter four, there were thirty one risks on the ORR, unchanged from Quarter three.
- The risk heat map shows that the majority of risks aligned to the strategic objective "Best we can be - Quality", reflecting the Trust's continued prioritisation of quality and safety. The lowest number of risks were aligned to the "Be Ambitious" objective.
- The average risk score remained amber, and the cumulative risk score remained unchanged at 302, indicating overall stability.
- The report outlined the proposed changes to the ORR risks and Trust Board was asked to review and approve the changes identified within the report.

MF noted that compared to the position at the same time last year, the strategic risk scores have increased, with some risks moving from "likely" to "possible," while the overall ORR scores have reduced, suggesting completion of actions leading to improved mitigation at the organisational level. AS explained that some financial risks have decreased because planned risks did not materialise, but significant strategic financial risks remain. Risk will continue to be monitored, with scores able to move dependent on level of risk at a given point of time, which is the purpose of the continuous review and oversight process. MBr added that system risks are more prominent now than a year ago, which may explain the difference between strategic and operational risk trends.

In relation to risk 1424, MF questioned the replacement of risk 1424 with individual risks, noting difficulty in mapping the four new risks to the five bullet points in the report under risk 1424.

MK noted the difficulty in determining risk likelihood and the difference between risks being likely or possible. She advised that due to timing of the report to Board, the risks have not yet been reviewed by the Quality and Safety Committee and the risk scores could change

following the Committee review. MBr confirmed that EMT had an in-depth conversation about the difference between "likely" and "possible" risk ratings and requested that this be discussed further at the Quality and Safety Committee.

Action – Caroline Johnson

Assurance was provided that that following the closure of risk 1956 related to Cheswold Park, any outstanding risks in relation to CPH would be reflected across other risks in the ORR, or new risks created as needed. The general risk in relation to integration however would be closed.

The Board discussed moving the Covid-19 risk from the ORR to the local register noting that meetings have finished and that should any future inquiry recommendations arise, the risk can be escalated again.

NMc noted that risks 1729, 1432, and 1840 are currently assigned to the Chief People Officer and had not yet been reviewed by the People and Remuneration Committee (PRC). It was agreed that these risks would be brought to the PRC for further review, and any feedback or changes from the Committee would be incorporated into future Board reports.

Gary Ellis (GE) highlighted that risk 1511 assurance score has been reduced from sixteen to twelve, which is a significant change and emphasised the importance of continued monitoring of this risk by the Board, especially in relation to exceptional packages of care, as these represent substantial financial pressures. AS clarified that while these exceptional packages are volatile and high-cost, the financial risk is shared in West Yorkshire through a risk share arrangement. The Board agreed to continue monitoring this risk, recognising the potential for significant financial impact.

It was RESOLVED to CONFIRM that Trust Board are ASSURED that current risk levels are appropriate, considering the Trust risk appetite, and given the current operating environment.

In addition, Trust Board RESOLVED to APPROVE the closure of risk 1424, to be replaced by four individual new risks, APPROVE the reduction in risk score for risk 1511, APPROVE the revised risk wording and reduction in risk score of risk 1957, APPROVE the revised risk wording of risk 275, 1614, 1689, 1729, 1820, 1839, 812 and 1432. APPROVE the move from "Best Place to Work and Learn" to "Live Our Values" for risk 1887, APPROVE the closure of risk 1840 and develop a new risk relating to the new appraisal system and appraisal window and APPROVE the stepping down of risks 1956 and 1545 to the local risk registers.

TB/26/43c Draft Annual Governance Statement (agenda item 10.3)

IW provided an update on the Draft Annual Governance Statement (AGS) for the year ended 31 March 2026:

- The draft Annual Governance Statement forms a statutory component of the Trust's annual reporting requirements and has been prepared in line with the Annual Reporting Manual.
- The draft version of the AGS will continue to be refined as year-end processes were completed.
- Certain sections of the AGS can only be finalised once additional year-end information becomes available, for example the head of internal audit opinion.
- This version will be shared with External Audit as part of the year-end audit process.
- The document will be finalised over the following weeks, as part of the finalisation of the Annual Report and Accounts.

IW confirmed that the AGS appropriately reflected governance arrangements up to 31 March 2026, with any material changes occurring after year-end to be addressed through appropriate narrative or addendum where required. IW added that a number of Non-Executive Directors (Mike Ford, Margaret Kitching and Rokaiya Khan) had reviewed the draft and provided feedback, which had been incorporated in the draft statement received by Board. In addition, detailed review had taken place by EMT.

It was RESOLVED to NOTE the draft annual governance statement.

TB/26/43d Quality account process for 2026 (agenda item 10.4)

Caroline Johnson (CJ) provided an update on the progress of the Quality Account for 2025/26 and confirmed that submission is required by 30 June 2026. Preparation was progressing well and in line with the agreed timetable and an early draft of the Quality Account had been developed and reviewed, with initial feedback already provided.

CJ outlined the next stages of the process, advising that:

- A draft of the Quality Account would be considered by EMT
- A further draft would be reviewed by the Quality and Safety Committee on 9th June before presentation to Trust Board prior to submission
- A final version will be brought back to Board on 30th June for approval, ahead of formal submission

CJ confirmed the Quality and Safety Committee meeting schedule had been adjusted and that governance arrangements would ensure appropriate scrutiny of the Quality Account prior to final Board approval. CJ added that, if required, additional arrangements could be made to ensure deadlines were met. It was also noted that the Quality Account was no longer subject to external audit but does still require robust internal governance and assurance.

It was RESOLVED to RECEIVE assurance through this report that the Quality Account for 2025/26 remains on track for delivery and publication by the statutory deadline of 30 June 2026.

Cheswold Park update (agenda item 10.5)

Adele Fox (AF) presented the Cheswold Park Closure Report, which marked the formal conclusion of the integration programme following the Trust's acquisition and stabilisation of Cheswold Park Hospital. It was noted that:

- The Trust completed the asset purchase of Cheswold Park Hospital on 1 October 2024.
- Implementation of transition and integration plans were overseen by a programme governance structure from October 2024 to March 2026.
- The original business case priorities were broken down into 20 specific areas of work. Of the original 20 priorities, 17 are fully completed. It was noted that the three remaining activities will continue to be delivered/managed as business as usual.
- Ongoing challenges relating to estates and workforce establishment reviews were acknowledged, with further work continuing to strengthen assurance in these areas.
- The Trust has developed a strong and positive reputation with system partners, including NHSE and commissioning hub colleagues, who had worked closely alongside the Trust throughout the improvement journey.
- AF highlighted the importance of recognising the contribution of key individuals and teams involved in achieving sustained improvement, including the forensic leadership team, clinical staff and operational leads.

CJ noted that she had attended a recent Quality Improvement Group meeting and had been impressed by the strengthened governance, leadership and quality improvement focus now in place. She emphasised the value of learning from the Cheswold Park improvement journey and consideration of how effective approaches might be applied more widely across other services.

AF confirmed that Cheswold Park services are now fully integrated within the Forensic Care Group, and that quality and performance oversight would continue through the Trust's established governance frameworks. MK added that enhanced oversight arrangements would continue on a quarterly basis until such time as Cheswold Park received a follow-up CQC inspection, and the Trust had external assurance of the improvements.

NMc acknowledged MK's leadership and scrutiny role in providing rigorous quality assurance throughout the improvement programme and highlighted the importance of Board-level recognition and thanked the Cheswold Park team for their work. It was agreed as an action that this recognition and thanks would be passed on to the Cheswold Park team.

Action – Adele Fox

MBr highlighted the scale of progress made since September 2024, including implementation of an electronic patient record system, introducing electronic prescribing, strengthened leadership and governance structures, harmonised policies and improved confidence from regulatory partners. MBu noted that while the formal closure of the improvement programme was appropriate, the Trust must remain vigilant to ensure that organisational values, behaviours and quality standards continue to be consistently upheld.

It was RESOLVED to NOTE the Cheswold Park Update report.

TB/26/43f Freedom to Speak Up bi-annual update (agenda item 10.6)

Estelle Myers (EM) joined the meeting

Estelle Myers (EMy), Freedom to Speak Up (FTSU) Guardian, presented the bi-annual update on FTSU:

- Sixty nine concerns were raised during 2025/26, of which twenty three were anonymous.
- Overall numbers of concerns have reduced from the previous year, with a reduction noted following the initial increase associated with the Trust's acquisition of Cheswold Park Hospital.
- There had been no reported cases of detriment during the year.
- There has been an increase in anonymous reporting. The importance of creating a culture where people feel safe to speak up was noted, and this will remain an area under review.
- Concerns have been raised across all Care Groups and staff groups, with the exception of healthcare scientists (audiologists) and themes remain consistent across all services areas.
- Equality data shows no significant variation between confidence in speaking up between white and Black and Minority Ethnic (BAME) staff. However, staff who identified as disabled, carers or LGBTQ+ reported lower confidence in speaking up, which was recognised as an area for further focus.

MK requested clarification regarding the number of employees suffering detriment after raising concerns through FTSU. EMy confirmed that in the previous year (2024-25), there was one case of detriment reported, but in 2025-26 there were none. EMy added that the Trust has an independent process to oversee cases of reported detriment.

Rokaiya Khan (RK) highlighted that 90% of FTSU reports were made by female staff, compared to the Trust workforce data showing 77.7% female staff and questioned whether

this proportion was unusually high or consistent with previous years. EMy advised that this could be due to an increased confidence in reporting amongst female staff. Improvements have been made to data collection, and ability to understand the demographics of staff raising concern, that will allow for better analysis and future comparison.

NMc requested assurance that concerns raised in relation to the 'worker safety and wellbeing' category is being triangulated with the staff survey results. EMy confirmed regular triangulation of data from with care group partnership meetings, the people directorate, nursing directorate, CQC data, complaints and family and friends test to identify areas needing attention. The importance of integrating FTSU feedback into action plans for worker safety and monitoring impact was noted.

MF explained that the National Guardian's Office sets definitions for worker safety and wellbeing in FTSU reporting. He but raised concerns about many non-safety issues being reported via FTSU, that could be potentially addressed via other routes letting the FTSU service focus on actual safety matters.

CJ highlighted that the Trust is seeing higher levels of anonymous FTSU concerns and suggested the need to better understand the reasons behind this trend, noting that many anonymous cases are not clinical concerns. EMy clarified that patient-related concerns are reported separately in the FTSU report and most concerns received are related to interpersonal issues between staff or dissatisfaction with managers, rather than patient safety. It is hoped that the Trust's supportive culture enables staff to raise patient safety issues directly with clinical leads, rather than through FTSU.

MBr noted the FTSU report has developed over time, providing greater assurance through feedback on concerns raised. He suggested a further review of all assurance mechanisms for speaking up. It was agreed that the Executive Team will review all assurance mechanisms for raising concerns to ensure they are capturing relevant issues and will report back on findings and any gaps identified.

Action – Izzy Worswick

It was RESOLVED to NOTE the Freedom to Speak Up update.
Estelle Myers (EM) left the meeting.

TB/26/43g LeDeR report (agenda item 10.7)

CJ presented an update on the national LeDeR (Learning from Lives and Deaths – people with a learning disability and autistic people) report noting that the data related to 2023 and had recently been re-issued after the initial publication was withdrawn due to data inaccuracies.

- People with learning disabilities die on average 19.5 years younger than the general population, with an average age of death at 63 years.
- The rate of avoidable deaths remained significantly higher than for those without a learning disability and main causes of avoidable death include influenza, pneumonia, cancers and circulatory diseases.
- The Trust's Learning Disabilities team is delivering significant work to improve health outcomes, with strong performance in annual health checks in each of the places we work. Uptake of health checks is:
  - Barnsley 87.1%
  - Calderdale 92%
  - Kirklees 76.5%
  - Wakefield 86.8%

For future reports, clearer measures of impact have been requested to support improved Board assurance regarding outcomes. There are plans to bring a strategic approach to improving physical health across the Trust, including assurance on diabetes and other checks

for all service users. Updates and action plans will be presented to the Quality and Safety Committee in due course.

MK emphasised that the LeDeR findings remain largely unchanged over the years, with persistent health inequalities and outcomes for people with learning disabilities, and highlighted the need to move beyond retrospective learning from deaths and focus on proactive physical health interventions when individuals access services. MK questioned whether the Trust is applying national toolkits in all settings and suggested auditing their use. CJ clarified that the scope should include both inpatient and community services, with a need for a strategic plan and audit to ensure toolkits are implemented and effective.

MBr confirmed that the Trust was already undertaking a range of initiatives, including work on STOMP (Stopping Over Medication of People with a learning disability and autistic people), introducing greenlight champions, physical health promotion and partnership working through place-based arrangements. The Board agreed that there would be benefit in drawing this work together into a clearer, more strategic view of physical health within mental health and learning disability services, with a focus on impact and assurance.

Subha Thiyagesh (ST) reiterated that the Trust has a clear action plan for LeDeR, with regular reports previously brought to the Quality and Safety Committee, and that the work has now moved into business as usual. Additional updates can be provided as part of the regular reporting structure. ST highlighted that current partnership work and actions from the LeDeR plan can be summarised through the executive trio report and brought back to the Board for assurance.

It was RESOLVED to NOTE the content of the report.

TB/26/44 Performance (agenda item 11)

TB/26/44a Integrated Performance Report (IPR) Month 12 2025/26 (agenda item 11.1)

AS provided a brief summary of the integrated performance report and the key points to note:

- At year end, the Trust was reporting against a large and complex performance framework, with a high proportion of indicators rated green, reflecting strong overall performance.
- Sickness absence had returned to within target range, acknowledging some seasonal impact but reflecting sustained improvement.
- There has been strong performance in relation to statutory and mandatory training and appraisals, with full compliance reported across Care Groups for a sustained period. This continues to be monitored at Care Group level through performance meetings.
- Agency usage had reduced significantly, with approximately half of agency staffing related to medical staffing. The Trust has achieved zero agency usage in non-clinical roles and reduced agency expenditure over recent years, representing a substantial improvement in workforce control.
- Bank usage remained above target but does not carry premium costs and provides necessary flexibility within services.
- There has been continued improvement in the reduction of out of area placements compared with previous years. While the position remained rated red given the national target of zero, the sustained downward trend and the considerable operational effort required to maintain current performance was acknowledged.
- Financial performance metrics within the IPR are aligned with the year-end position confirming delivery of key financial targets, achieved alongside ongoing operational pressures.

MF raised a question regarding the RAG rating in relation to the risk assessments and queried if this was a technicality that was being explored. He questioned whether the focus on improvements was the correct focus considering performance has fluctuated. AS advised

that the indicator is a key focus in monthly care group meetings, with plans in place to improve compliance. He acknowledged ongoing challenges and technicalities and advised that the target was not set during a period of process realignment, but would be reviewed once the risk assessment improvement work is completed in order to have a true understanding of our trajectory Once the target has been set, it would be monitored through the Finance, Investment and Performance (FIP) Committee and EMT.

DL provided an update on the Trust's work to address health inequalities, specifically referencing the analysis of average length of stay by ethnic group. She explained that recent data cleansing and a shift to using median rather than mean values have shown less disparity than previously reported. The next step is to explore qualitative aspects, focusing on patient experience across different groups, and this work will be brought back to the Strategic Board in May for further discussion.

DL also highlighted ongoing analysis of restraint data by ethnic group, noting that this is part of a broader effort to understand and address health inequalities within the Trust.

GE raised concern about the low virtual ward occupancy rate (62.7%), emphasising its significance for NHS core objectives and the urgency of resolving the issue, which is linked to delayed hospital discharges. MBr acknowledged the concern, noting that the issue is a priority in Place Provider Partnership discussions and is constrained by hospital capacity. He indicated that this challenge is recognised across the system and will be further addressed in the South Yorkshire update.

MBu raised staff turnover noting that while rates had stabilised, it would be important to ensure this did not mask underlying risks relating to organisational resilience, workforce refresh and improvement culture. This was flagged for continued monitoring through People and Workforce governance arrangements.

The Board reaffirmed its commitment to zero tolerance for prone restraint, noting significant reductions in its use. CJ confirmed work is underway to further reduce and prevent prone restraint, including independent reviews of training and practice, and ensuring accurate recording and description of incidents.

MBr reported positive progress in CAMHS (Child and Adolescent Mental Health Service) access within 18 weeks and highlighted an improvement in paediatric audiology, noting that performance on the 6 week access target has increased from 50–60% to around 90% for two consecutive months.

It was RESOLVED to NOTE the Integrated Performance Report and the associated comments.

TB/26/44b Care Group performance dashboards (agenda item 11.2)

AF presented a summary of the Forensic Care Group Performance Dashboard:

- Overall performance across the Care Group continued to fluctuate between wards, with some wards sustaining expected standards and other areas not consistently meeting required thresholds. A programme of work was in place to support improved and more consistent performance, particularly in areas where compliance was not yet sustainable.
- There is variation in appraisal performance across the care group. Cheswold Park appraisal performance appeared low, but this is believed to be due to data quality and recording issues within ESR. Work is underway to cleanse the data and ensure appraisal activity was accurately recorded.

- Sickness absence remained above threshold in some areas, with the People Directorate supporting a deeper dive to understand causes, target improvement activity and better understand turnover trends and variance.
- Supervision performance remained a sustained strength across the Care Group.
- The forensic care group consistently report zero prone restraint, and there may be learning to share regarding deescalation and alternative interventions within forensic settings, recognising the different context of secure services and a more stable patient cohort.
- In relation to Cardiopulmonary Resuscitation (CPR) compliance and ward-level variability, there was some under-performance noted which was linked to recording issues. AF confirmed that she had sought assurance that practice remained safe while data issues were resolved.
- The dashboard shows high staff turnover at Cheswold Park (reported at 17%). This figure is likely inflated due to the inclusion of redundancies in the calculation. Adjustments are being made to ensure turnover data accurately reflects actual staff movement, with support from the People Directorate to clarify figures and understand the underlying causes. Establishment reviews and ongoing recruitment efforts, especially for healthcare assistants, are in place to address turnover and maintain workforce stability within forensics.
- There has been no agency usage within the forensic care group. All staffing gaps have been covered using the staff bank, even during periods of increased acuity.
- Cheswold Park bed occupancy remained around the upper-70% range, with recent increases in patient numbers. AF and AS are working with clinical colleagues to consider pathway and capacity improvements across the wider forensic system to support regional requirements.

MK noted the prone restraint performance was reported as an absolute number rather than a percentage of overall restraint activity, which could be misleading and may not reflect relative performance appropriately. MK suggested that reporting by percentage may provide a fairer and more meaningful view. It was agreed that the approach to presenting this metric should be reviewed to ensure metrics support meaningful Board oversight and benchmarking.

Action – Adele Fox

It was RESOLVED to RECEIVE and NOTE the report.

TB/26/45 Integrated Care Systems and Partnerships (agenda item 12)

TB/26/45a South Yorkshire update including South Yorkshire Integrated Care System (SYICS) (agenda item 12.1)

MBr provided an update on the South Yorkshire integrated care system and partnerships and advised that the principal focus within South Yorkshire had been on preparing for organisational change following the conclusion of the ICB staff consultation and the move towards recruitment into the new target operating model. It was noted that the future structure of the ICB Board would be significantly smaller..

In relation to Place-based Provider Partnerships, MBr reported that work was underway with partners and a draft Memorandum of Understanding and Terms of Reference for Place Provider Partnership working were being developed and would be brought back to Board in due course.

MBr outlined three initial priority themes emerging from system discussions:

- Neighbourhood models of care
- Hospital at Home / care closer to home, including consideration of alternative cohorts who could be supported outside traditional hospital settings
- Discharge and flow, recognising the interdependencies between hospital, community and mental health services.

It was RESOLVED to RECEIVE the SYB ICS update.

TB/26/45b West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update (agenda item 12.2)

MBr provided an update on West Yorkshire:

- System partners have signed off the West Yorkshire plans, alongside agreement of the associated organisational change programme.
- Leadership changes within the system were noted, including the appointment of Jonathan Webb as Interim Chief Executive of the West Yorkshire ICB, and the intention of the incoming Chair to progress recruitment for the substantive role.
- Within the Mental Health, Learning Disability and Autism Collaborative, discussions focused on priorities for the forthcoming year, including crisis and patient care emergency pathways, with emphasis on ensuring services remained responsive and safe amid growing demand.
- Place Committees were being wound down, with no formal place committee reports brought to this meeting. Shadow Place Provider Partnership meetings had commenced in two places, representing the step towards new partnership arrangements.
- In Wakefield, there have been a number of leadership changes to the Mental Health Alliance With the departure of the joint Trust/ICB postholder, to ensure the valuable collaborative work is not lost, the Trust will offer to Chair the Alliance. Work is underway to agree future Chair arrangement to ensure continuity and build on existing good practice.

It was RESOLVED to RECEIVE and NOTE the update on the development of Integrated Care Systems and collaborations: West Yorkshire Health and Care Partnership, Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees and RECEIVE the minutes of relevant partnership boards/committees.

TB/26/45c Provider Collaboratives and Alliances (agenda item 12.3)

AS provided a summary of the provider collaboratives and alliances update:

- Provider Collaboratives for CAMHS, Perinatal Mental Health and Eating Disorders, which are not led by the Trust, continue to report largely positive performance, both operationally and financially. The CAMHS Collaborative has made notable improvements in managing out-of-area placements.
- Feedback from NHSE indicated ongoing interest in the financial and governance models underpinning Provider Collaboratives. The Trust's approach within West Yorkshire, based on risk-share arrangements, avoided inappropriate cross-subsidy between services and ensured that individual pathways remained accountable for their own performance.
- There has been increasing demand within West Yorkshire adult secure services, due to an increase in prison referrals. Demand from prisons is currently higher in West Yorkshire than in some neighbouring systems. The reasons for this are unclear however all referrals continue to be subject to appropriate clinical screening and assessment prior to admission.

In terms of the role of Cheswold Park capacity within the provider collaborative landscape, AS explained that while Cheswold Park offered opportunities to flex capacity, decision-making needed to balance current pressures with longer-term system trends, noting that demand across pathways could change over time. AS and AF are working closely with medical and clinical leadership to review pathways and consider where internal capacity could be utilised to reduce reliance on out-of-area placements.

It was RESOLVED to RECEIVE and NOTE the Specialised NHS-Led Provider Collaboratives Update.

TB/26/46 Governance (agenda item 13)

TB/26/46a Audit Committee annual report including committee annual reports and terms of reference (agenda item 13.1)

MF confirmed that the Audit Committee's Annual Effectiveness Review found risk management processes to be operating effectively, with integration across Committees and avoidance of duplication. All Committees completed self-assessments, reviewed terms of reference, and work programmes.

MF thanked Committee members, executives and support staff, highlighting the schematic showing consistent and effective Trust operations, with ongoing improvement to avoid complacency.

The Board was asked to approve updated Terms of Reference and work plans for all Committees, the closure of the Equality, Inclusion and Involvement Committee (EIIC), and the establishment of a new Transformation, Partnership and Innovation Committee.

IW confirmed that EIIC responsibilities had been mapped and allocated to relevant Committees, namely the Quality and Safety and People and Remuneration Committees.

DL provided clarification on how each Committee has a direct route to hear staff and service user voice through the "All of Us in Mind" group, rather than this being solely through the EIIC. It is hoped that this change would promote more tangible, issue-based input into Committee decision-making.

In relation to the People and Remuneration Committee Terms of Reference, MBr noted that the Board had previously agreed CB would be a non-voting member and requested this be reflected in the Terms of Reference.

Action – Andy Lister

The Board discussed whether certain non-committee governance groups such as the Joint Partnership Board and Ethics Committee might benefit from more formal annual recognition within the Trust's governance reporting. It was agreed that this could be considered outside the meeting and brought back in future governance reviews if appropriate.

Action – Andy Lister

The Board approved all recommendations and noted that future annual reports should specifically check that EIIC responsibilities remain appropriately managed. MBu thanked MF for his leadership as audit chair.

It was RESOLVED to RECEIVE the audit committee annual report, APPROVE the update to the Terms of reference for Trust committees, APPROVE the closure of the Equality, Inclusion and Involvement Committee and APPROVE the development of a new committee to cover transformation, partnerships and innovation.

TB/26/46b Trust Board Committee Membership (agenda item 13.2)

MBu confirmed that the proposed Trust Board Committee structure reflected the approved Governance Framework, including recent changes agreed earlier in the meeting, notably the closure of the EIIC and redistribution of its responsibilities.

A specific correction was noted in relation to the spelling of MK's surname, which was requested to be amended to ensure accuracy in the formal record.

Forthcoming changes in Board membership, including the future appointment of a new Audit Committee Chair and replacement of the Trust Chair would be considered separately and incorporated through normal governance processes.

The Board approved the Trust Board Committee structure and membership, subject to the agreed factual correction.

It was RESOLVED to APPROVE the proposed committee structure and membership.

TB/26/46c Going Concern Statement (agenda item 13.3)

AS provided an update on the Going Concern Statement as part of the year-end financial and governance process:

- The assessment of going concern is a standard requirement of the Trust's annual accounts and relates to the assumption that the Trust will continue to operate and provide services for the foreseeable future. This assessment considered the Trust's financial position, funding arrangements and ability to continue delivering statutory services.
- Based on the information available, AS advised that there was a reasonable expectation that the Trust would continue in operational existence and meet its obligations, and that it was therefore appropriate for the Trust's annual accounts for 2025/26 to be prepared on a going concern basis.

No concerns were raised by the Board who approved the preparation of the 2025/26 annual accounts on a going concern basis.

It was RESOLVED to APPROVE the preparation of the 2025 / 26 annual accounts and financial statements on a going concern basis.

TB/26/47 Trust Board work programme 2024/25 (agenda item 14)

The Board noted the importance of ensuring that emerging priorities continued to be clearly reflected within the programme. In particular, it was agreed that:

- Teaching Trust activity should be explicitly captured within the Work Programme, and within future AAA reports from the Teaching Trust Joint Partnership Board.
- Oversight of the Ethics Committee should be clearly referenced, recognising its importance within the Trust's governance and decision-making framework.

Subject to these additions, the Board approved the Trust Board Work Programme.

It was RESOLVED to NOTE the work programme.

TB/26/48 Any other business (agenda item 15)

No further business.

TB/26/49 Date of next meeting (agenda item 16)

The next meeting will be held on 30 June 2026 (June meeting).

Signature:

Date:

South West Yorkshire Partnership Teaching NHS Foundation Trust

TRUST BOARD 30 June 2026 – ACTION POINTS

= completed actions

Actions from 28 April 2026

Min reference	Action	Lead	Timescale	Progress
TB/26/43b	Discussion to take place at Quality and Safety Committee to confirm Committee members are aware of the difference between "likely" and "possible" risk ratings on the new risks on the ORR to replace risk 1424.	Caroline Johnson	June 2026	Scores discussed in QSC 9 June 2026 and agreed by Committee members.
TB/26/43e	Recognition and thanks to be sent to the Cheswold Park Team for their hard work through the integration process	Adele Fox	June 2026	The Chief Operating Officer has written all staff involved in the transition of Cheswold Park Hospital into the Trust.
TB/26/43f	Review all assurance mechanisms for raising concerns to ensure they are capturing relevant issues, with a focus on governance, improvement and patient safety and report back on findings and any gaps identified.	Izzy Worswick	July 2026	
TB/26/44b	Review the measuring of prone restraint performance to ensure metrics support meaningful Board oversight and benchmarking.	Adele Fox/Caroline Johnson	July 2026	
TB/26/46a(1)	PRC terms of reference to be updated to state the chief people officer as a non-voting member	Andy Lister	June 2026	Updated as requested.
TB/26/46a(2)	To consider whether certain non-committee governance groups might benefit from more formal annual recognition within the Trust's governance reporting	Andy Lister	July 2026	Joint Partnership Board and Clinical Ethics Committee to undertake annual reviews in line with Trust Board committee process for 26/27. This will be overseen by the head of corporate governance.

Actions from 31 March 2026

Min reference	Action	Lead	Timescale	Progress

With all of us in mind.

TB/26/25(1)	Include item on May strategy board re inequalities in relation to seclusions and detentions, particularly in relation to males from ethnic minorities	Dawn Lawson/Caroline Johnson	June 2026	Included in inpatient mental health care group report to Board in March 2026. To close.
TB/26/27 (1)	In relation to the CQC action report discussion took place regarding access to outdoor spaces. It was agreed that the Board should clearly document what is and is not possible regarding outdoor access, based on risk assessments and individualised care plans. It was agreed to provide a position statement for the Board, specifying resolved and unresolved areas, and ensure care plans demonstrate risk-based approaches to outdoor access, aiming to close this recurring issue in future CQC action reports.	Adele Fox/Caroline Johnson	July 2026	A paper on access outdoor spaces is to be presented to QSC in July and will follow on to Board.
TB/26/29b	Arrange meeting with MK about how care group governance is reflected in the Trusts internal governance framework	Izzy Worswick/Andy Lister	June 2026	Meeting held with MK.
TB/26/31	Trust Board work programme to reflect work of the Joint Partnership Board	Andy Lister	June 2026	Trust Board work programme updated to include triple A reporting from Join Partnership Board. E-mail discussion taken place with Mitch Waterman and Mitch will consider which items need Board scrutiny as the Joint Partnership evolves so these can be added to the Board work programme.

Actions from 27 January 2026

Min reference	Action	Lead	Timescale	Progress
TB/26/11.1(b)	Report on The Poplars to be presented to the Quality and Safety Committee, with input from the Chief Medical Officer.	Subha Thiyagesh	July 2026	Update report provided to May QSC (as part of the Trio report). The QSC asked for further assurance in relation to vacancies and temporary staffing. This will be presented to QSC in July.
TB/26/10.3	To provide further clarity in future safer staffing reports to ensure it is explicit when safer staffing refers solely to nursing	Caroline Johnson	July 2026 (date of next report)	This will be included in the report to Board in July 2026.

Actions from 2 December 2025

Min reference	Action	Lead	Timescale	Progress
TB/25/109c (CQC action plans)	To review the format and title of the CQC action plan for future meetings	Caroline Johnson	June 2026 (date of next report)	There is action outstanding which relates to medical reviews in seclusion and there is a task and finish in place to improve compliance (currently 73%) this is monitored closely by QSC and will be reported to Board via the triple A.
TB/25/113b	Board to review digital governance and capital planning alignment at a future development session	Adrian Snarr	August 2026	

Actions from 29 July 2025

Min reference	Action	Lead	Timescale	Progress
TB/25/ 60a (1)	Quality and Safety Committee to provide a report detailing risk assessment record keeping in both community services and inpatient wards in order to provide assurance to Trust Board.	Caroline Johnson	June 2026	January update - The care planning and risk assessment report went to QSC in September 2025. Work is in progress and a further update will go to EMT in April and then to QSC in May 2026. June 2026 – Following an internal audit on community risk assessments reaching a finding of limited assurance monthly updates are now provided to QSC by the Chief Nurse and Director of Quality and Professions. Updates will be provided to Board via triple until all audit actions are complete.

Board Story pre read

The Trusts Involvement approach – the importance of Community Connectors and Involving People approach

a. Background

Involvement is about people having a real say in their healthcare and in how NHS services are designed. It means:

- Being able to make informed choices about your own care, or the care of your loved ones.
- Sharing feedback, helping plan services, and working alongside the NHS to create better care together.

This involvement can range from individual decisions about the most appropriate treatment, to influencing the design and delivery of services for entire communities.

b. Drivers for this approach

There are multiple drivers for this approach namely:

- ✓ **The Equality Act 2010** – requires NHS bodies to work collaboratively and monitor the impact of their actions.
- ✓ **The NHS Constitution** – sets a statutory expectation for providers to involve people in planning and shaping system change.
- ✓ **NHSE guidance** (15 Step Challenge; Quality Transformation through Culture of Care) and CQC's Single Assessment Framework – strongly promote meaningful Service User involvement in all areas of service improvement.
- ✓ **Patient Care Race Equality Framework (PCREF) -** requires providers to work in partnership with racialised communities, embedding co-production (Pillar 2) and addressing racial inequalities in experience and outcomes.
- ✓ **Our own Trust Strategy and Values** emphasise the importance of Lived Experience, specifically through:
    - *Living our values* – collaboration and respect
    - *Being the best partner* – working **with** people, not **for** them
    - *Delivering best quality care* – co-designed, person-centred services

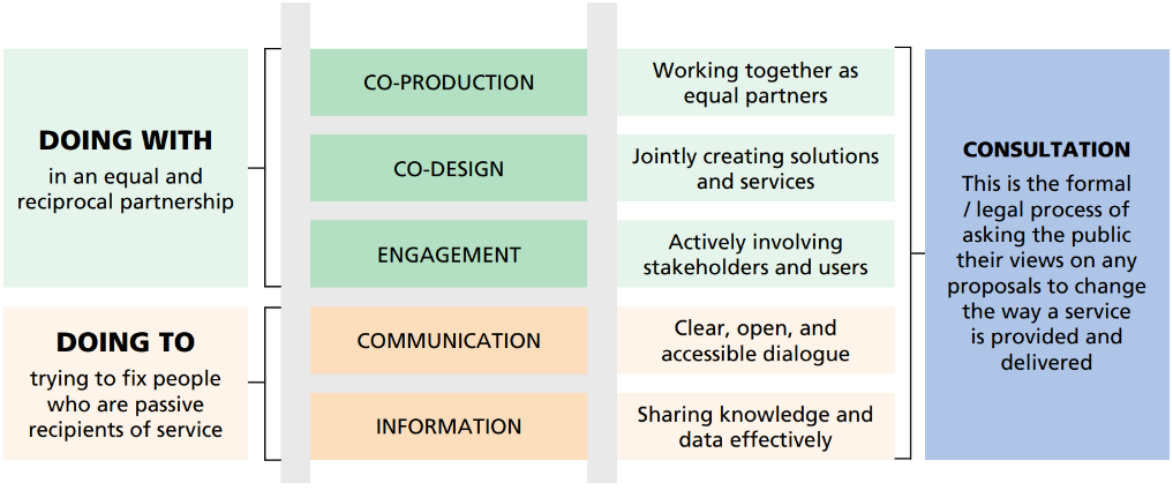
c. What is our Involvement approach

The Trust has developed an Involvement Guide and framework that outlines our approach and provides practical examples of meaningful engagement. We have also produced Valuing Involvement Guidance to support consistent reimbursement and payment processes.

The *Ladder of Involvement* is a key part of our Involvement approach and provides a visual and conceptual tool that illustrates the different ways people can participate in shaping the services they receive. It recognises that involvement is not a one-size-fits-all journey, nor is it necessarily linear.

The aim of our approach is to embed meaningful involvement at the heart of all Trust activity by providing a clear, consistent framework that supports flexible, inclusive, and proportionate

approaches to engagement, enabling people to influence the services they receive in ways that work best for them.



Each rung of the ladder represents a valuable and valid form of participation, from simply receiving information to full co-production.

d. Community Connector Programme

Our connecting people programme is a coordinated Trust wide approach with over 138 connectors trained. These are people from partner organisations, our workforce, and third sector organisations / communities who have undertaken training sessions with the Trust and are on a centralised database held by our EDI team for requests of involvement activity.

This approach has been used within the Trust in such projects as the Mental Health Detention Act Project, supported by NHS Confed, and the establishment of our PCREF external Advisory Group.

✓ **What is the Connecting People approach?**

Connecting People is based on the idea that strong social networks, community assets, and supportive relationships play a vital role in people's health and quality of life. The approach helps services and organisations:

- Work alongside people, not just deliver services
- Make better use of community strengths and local assets
- Support people to build and sustain social connections
- Improve outcomes related to wellbeing, independence, and community participation

✓ **Who is it for?**

The approach is relevant to a wide range of organisations, including:

- Voluntary, community and social enterprise (VCSE) organisations
- Local authorities and place-based partnerships
- Health and care providers
- Community groups and social initiatives
- Any organisation interested in working more closely with communities and embedding asset-based, person-centred ways of working can benefit.

✓ **How we support organisations**

Through the Connecting People programme, we offer:

- Training to become an active Connector

- ❖ Guidance on applying the Connecting People approach in practice
- ❖ Opportunities to link with others using similar approaches
- ❖ Access to tools and shared learning, including a Connecting People database
- ❖ Ongoing support from our Connecting People team

To align with the NHS Long-Term Plan's vision of integrated, person-centred care, the Trust must transition from some good examples of engagement but not consistency with approach to a consistent involvement offer.

By embedding our Involvement Approach into the local place based systems, we ensure that service transformation is driven by the actual needs of the communities they serve.

e. The Connecting People Model as the Trusts approach

The Connecting People (Community Connectors) model is the most viable key driver for this development for several reasons:

- ✓ With over **138** trained connectors across partner organisations, the workforce, and the third sector, the framework for cross-system collaboration is already in place.
- ✓ Unlike ward-based groups, Connectors are embedded within the "Trust geography," allowing them to bridge the gap between NHS providers and the diverse communities within a specific "Place".
- ✓ The model uses centralised equality monitoring to ensure we hear a reflective voice of the community, which is essential for PBPPs to address local health inequalities.
- ✓ This model has already demonstrated success in complex statutory areas, such as the Mental Health Detention Act Project.
- ✓ Its connection into VCFSE is so important.

f. Conclusion

While the Connector model is important for us to adopt as our preferred approach other elements of the Trusts Involvement approach have to be noted alongside this as they also provide essential support and align to the principles of the Involvement Ladder:

- ✓ External Stakeholder Service User Groups: Locality-specific panels, such as the Wakefield MH Panel, align closest to the Neighbourhood working model at place. These groups already utilise established formal processes and tools like "Citizen Coin" that can be adopted across the partnership to reward participation.
- ✓ Internal voice and service user involvement. If we only listen to the outside we won't be able to develop from within and support the Culture change at all levels, so the commitment to internal user groups and opportunities to engage within the ladder of Involvement is integral.
- ✓ Peer Educators: Utilising Peer Educators on bank contracts across all Care Groups ensures that the "lived experience" voice is professionalised and integrated into the daily delivery of care within the partnership. This also allows alignment into our Governance structures within the Trust.
- ✓ Volunteers: Continuing our volunteer commitment as we move toward PBPPs will provide deeper insight and connection into local communities.
- ✓ Complaints and Feedback mechanisms such as Friends and Family Test.

However by positioning Community Connectors as the primary link between the Trust and its Place-Based partners, we can move up the "Ladder of Involvement" toward true Co-

production, creating the opportunity for a live feedback loop and ensuring that the NHS Long-Term Plan is delivered through services that are worked on *with* people, not just *for* them.

At Board you will hear from our Connecting People Lead manager and hear about the experiences of a particular Connecting People Partner – **Spectrum People** CIC.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 8

Private/Public paper:	**Public**		
Title:	**Chief Executive's Report**		
Lead Director:	**Mark Brooks - Chief Executive**		
Mission/values:	As an all-encompassing report this reports aligns fully with the Trust mission and all of its values		
Purpose:	To provide the strategic context for the Trust Board conversation.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The report includes highlights of what is happening in both our systems and places. The Trust regularly reviews that its own objectives are aligned to those of our systems and places as well as taking account of national guidance and requirements.		
Any background papers / previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the Trust Board meeting and also external papers and links.		
Executive summary:	I am delighted to report that the Trust has retained its segmentation of 1 in the NHS Oversight Framework (NOF) for Quarter 4. Based on the metrics used in these calculations the Trust is ranked 3rd out of 61 trusts nationally which is a real credit to everyone in the Trust. The NOF metrics for 2026/27 are changing and increasing in number, so it is difficult to assess what our position will be during this coming year. Nevertheless, we should reflect positively on what has been achieved during this last year.		

With **all of us** in mind.

	Whilst positively the 2025/26 full year financial position was in line with plan, it will be even more challenging to deliver a break-even position this coming year. At the end of month 2 the Trust has recorded a deficit in excess of £1m, which whilst in line with plan highlights the scale of the challenge we have before us. This month's Trust Board papers include our plans for workforce reduction which are being submitted to NHS England. In addition, we have recently launched a Mutually Agreed Resignation Scheme (MARS) that will be open for applications until the end of July. The People and Remuneration Committee and Trust Board will be kept up to date with progress on this scheme which operates with tight parameters and oversight. The Trust is pro-active in promoting many awareness events. During May we promoted mental health awareness week. We used the week as an opportunity to promote the support offers in place, including support lines, access opportunities, creativity offers (recovery colleges, Creative Minds, Live Well etc.) and provided information on what people can do for self-care – through the Choose Well resources. June also saw the Trust and colleagues nationally actively participate in Learning Disability week. It is worth reflecting that in recent years more people are being identified on learning disability registers, more people are receiving annual health checks and health action plans, and there has been a significant reduction over recent years in the number of people with a learning disability in mental health inpatient settings. Keyworker support, stronger community services, reasonable adjustments and Oliver McGowan training are all playing a role in helping us better understand and respond to people's needs. Having said that many inequalities remain and as a Trust we must strive to make further improvements for those people who so very much need them. Thanks are given to colleagues who designed and organised some excellent events to promote their service offers and recognise the importance of continuing to focus on how we can improve people's lives. During June we have also celebrated Pride month which included the sharing of local events and celebrations, and marked Carers' Week 2026, which included hosting a celebration event on 10 June at Fieldhead in Wakefield. We took part in Volunteers' Week 2026, honouring the incredible contributions of volunteers who make our communities stronger every day and said thank you to our estates and facilities colleagues on 17 June on National Healthcare Estates and Facilities Day. The latest round of planned industrial action by resident doctors was suspended following an updated offer by the government. At the time of writing this report the proposed deal is being balloted on. If available a further update will be provided at the Trust Board meeting. Trust Board members have previously been made aware of the national work taking place regarding a fairer deal for nurses, which includes pay. The next steps in this process have now been communicated, and all organisations are required to submit a nursing Band 5 job evaluation delivery plan by 31 July 2026 to their region for review. These plans need to be realistic and deliverable and set out how all Agenda for Change Band 5 nursing roles will be reviewed by October 2028. The People and Remuneration Committee will have oversight of this process on behalf of the Trust Board.

	Lord Mann has recently published his review into tackling racism and antisemitism within the NHS along with several recommendations. We are all aware of the challenges in our own Trust and communities with appalling examples of racism against our colleagues occurring all too frequently. The measures outlined in the report aim to: a) strengthen leadership and accountability, b) improve understanding and capability through training and development, c) set clear expectations regarding political identifiers and inclusive practice, d) improve and standardise support and protection for staff who experience racism, and e) improve the consistency, quality and application of data relating to racism. Actions we have been asked to implement are: • To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles. • Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups (this will be monitored via the NHS Oversight Framework). • Prepare to implement the forthcoming NHS Staff Standards. • Adopt the new government definition of anti-Muslim hostility. • Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia. • Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months). • Ensure Board agreement to undertake new anti-racism training when it becomes available. • Ensure colleagues, staff representatives, patients and communities are aware of our actions through our internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally. • Ensure our Board and relevant committees fully understand our staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress. Our Trust has made considerable efforts to tackle racism, and we have already adopted a stance as an anti-racist organisation. We welcome these measures and will ensure Board oversight of implementation via our People and Remuneration Committee. A judgement handed down by the Supreme Court on Tuesday 2 June 20206 has resulted in immediate changes to the Deprivation of Liberty (DOLs) process. The original DOLs 'acid test' has been overturned and the considerations for determining consent to the deprivation of liberty have been broadened. The Department of Health & Social Care (DHSC) are developing guidance for the application of the new ruling. Experts in the Trust are working collaboratively with the local authorities for a consistent approach. In the 2026 King's Speech, the government outlined plans to introduce legislation to reform how the NHS is led and managed in the form of an NHS Modernisation Bill. Proposed reforms included: • The abolition of NHS England (NHSE), pulling functions directly into the Department of Health and Social Care (DHSC), including transferring of some powers directly to the Secretary of State

- The reconfiguration of certain duties of integrated care boards
- Establish the single patient record (SPR) which will bring together patient's health and social care records in one place, and empower patients to access their own records securely through the NHS App.
- Remove the requirement for foundation trusts (FTs) to have a council of governors, to enable more flexibility for FTs to design and deliver healthcare around local need.
- Transfer the functions of Healthwatch England and local Healthwatch into a new patient experience directorate at DHSC, and ICBs and local authorities respectively

Other changes included reducing the number of patient safety organisations, including bringing the Health Services Safety Investigations Body (HSSIB) into the Care Quality Commission (CQC), and changes to flexibility and governance of local NHS organisations. From a provider perspective to drive improvement there will be a reinvigorated and reinvented foundation trust model embodied by the introduction of advanced foundation trust status and the ability for NHS providers to hold integrated health organisation (IHO) contracts. It is currently expected the new legislation will take effect from April 2027 and we will review implications for us and ensure Trust Board members are fully communicated and engaged with.

The government has launched a Call for Evidence to inform a new cross-government Mental Health Strategy. This represents an excellent opportunity to shape the future of mental health, with a stronger focus on prevention, earlier intervention and joined-up support across health, education, employment and communities. As Board members are aware, demand for mental health services continues to rise significantly, particularly among children and young people. At the same time, we know too many people still only receive help when they reach crisis point. Whilst there has been investment in mental health services via the mental health investment standard coupled with workforce growth, there needs to be shift towards models of care that respond earlier and closer to home. The Trust will respond and is encouraging colleagues to personally respond to this Call for Evidence.

Nationally it is worth noting that close to six million children can now access mental health support in their school or college. Teams are operating in almost 11,800 schools and colleges across England and 90% of schools are reporting a positive effect. As a Trust we have continued to invest in mental health support teams in our places. Providing the right support at the right time will improve school attendance and enable children to perform better inside and beyond school, as well as supporting the early identification of mental health issues.

The Nursing & Midwifery Council (NMC) recently wrote to all trusts highlighting an historical issue they have identified with their processes in relation to managing disclosures from staff who have been convicted of offences. This has occurred over a 12-year period, meaning they have had to review 18,000 cases. They have now narrowed it down to 421 individuals who should have received a letter from the NMC on 27 May 2026 to inform them. We are not aware if any of our staff are affected at this point and have been instructed to let the NMC processes play out.

	We continue to work with partners on the introduction of place provider partnership (PPP) meetings in each of Barnsley, Calderdale, Kirklees and Wakefield. All PPPs are operating in shadow form with statutory decision-making and accountability remaining with ICB Place Committees under existing ICB delegations. The reorganisation of Integrated Care Boards (ICB) continues. Both South and West Yorkshire have launched phase 2 voluntary redundancy schemes and issued new structures and their operating models. Some staff will be slotted into roles in the new structure whilst there will be a competitive process where this is required. Recruitment into roles is taking place during June and July. This will include recruitment into integrator teams that will play a key role in the development of place provider partnerships. We are working closely with ICB colleagues during this period of change and uncertainty. This month's Trust Board meeting has a focus on performance and monitoring. Our performance metrics remain largely positive, with particular note given to levels of training compliance across the organisation. Demand for inpatient beds is relentless, and much credit goes to operational colleagues in supporting as many people as possible close to home and therefore avoiding out of area bed placements. We are currently focusing on the quality of our risk assessments and care plans to ensure improvements in patient experience continue to be a high area of focus. Following a challenge by the chief executive of NHS England, leaders of mental health providers have worked with national colleagues to identify three key priorities in which to make a real difference this year. Those priorities are to further reduce the use of out of area bed placements, access for children and young people, and reducing attendance in emergency departments of people known to mental health services. We are currently reviewing the proposed metrics to ensure we have an accurate understanding of our baseline against which we can report. I am sure all Trust Board members will reflect positively on what was an inspiring and uplifting evening at the Trust excellence awards in May. As well as the excellence awards, over 200 colleagues were awarded learning certificates or long service awards earlier in the day. Whilst we quite rightly regularly recognise the challenges on our services and the need to continually improve, it is also right that we recognise the many examples of excellence carried out by our colleagues every day, along with the commitment and dedication of those colleagues who have touched so many lives in a wide array of ways. Thanks are given to all those who planned and organised this day and our sponsors who supported the event financially to enable it to take place in the manner it did. Nationally there has been a change in the Secretary of State for Health and Care. Following the resignation of West Streeting, James Murray has been appointed into this role. Prior to this appointment Mr Murray was Chief Secretary to the Treasury. There have also been changes in political leadership locally following local elections in May. Reform now has a majority in Barnsley, Calderdale, and Wakefield, and whilst not having a majority in Kirklees they do have the highest number of seats.

	I am sure I speak on behalf of all Trust Board members and attendees in welcoming Jayne Brown OBE to the Trust as our new Chair. This is Jayne's first Trust Board meeting, and I look forward to working with her. In terms of non-executive director recruitment to replace Mike Ford, whose term with us ends in August has taken place. An appointment has been made and at the time of writing this report the standard background checks are being completed. In line with previous reports, I am providing a sample of positive achievements by our colleagues who continue to provide outstanding care in what can often be challenging circumstances. • Catering volunteer Jo-Anne achieved her Level 2 Food Hygiene certificate with the support of our catering team. • In June, our equipment, adaptations and sensory team hosted a partnership event in Barnsley. The event showcased the support available to improve independence, accessibility and quality of life for people with sensory differences and a disability. • Our maternal mental health service Paths launched a year-long project where they'll be reaching out to Black women to better understand what matters to help them get the mental health and support they need. To mark Maternal Mental Health Week 2026, our Paths maternal mental health service specialist midwives also shared their thoughts and reflections on why the week is so important. • On Sunday 17 May, more than 40 cyclists took part in a 38-mile bike ride which raised over £3,600 for our Trust charity, EyUp! • The Trust is preparing to introduce a new electronic prescription service which will make prescribing and dispensing medication more convenient for service users and staff. • On Thursday 4 June, colleagues from Wakefield Recovery and Wellbeing College were special guests at a district-wide event celebrating the power of creativity in health. • A new creative psychotherapy pathway has been introduced at HM YOI Wetherby, marking a step forward in trauma-informed mental health support for young people in custody. • Simeon Barclay, one of the artists working at Fieldhead as part of the hospital rooms project is on this year's four artist shortlist for the Turner Prize. I am also sharing some feedback recently received regarding colleagues on Clark Ward – 'I can't put into words how much you 3 have helped me. I will always be grateful. Thank you isn't a big enough word'.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the Chief Executive's report.

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NHS Foundation Trust

The Brief

30 April 2026

Monthly briefing for staff, including feedback from Trust Board and executive management team (EMT) meetings

With **all of us** in mind.

Our purpose and values

South West Yorkshire Partnership Teaching NHS Foundation Trust

It is important we focus on our values.

Our purpose is to help people reach their potential and live well in their community.

To achieve our purpose we have a strong set of values:

- We put people first and in the centre and know that families and carers matter
- We're respectful, honest, open and transparent
- We constantly improve and aim to be outstanding so that we're relevant today and ready for tomorrow



Our Kendray admin team dressed up for Easter this year to bring egg-stra special smiles to colleagues, service users and carers across the hospital.

With **all of us** in mind.

Our priorities for 2025-2026

We will be the best we can be and will focus on keeping our services safe.



Our improvement priorities	
BEST WE CAN BE	
Best Quality	**Improve our clinical pathways** so they are more effective and efficient and provide the best possible patient experience
Best value	**Make the most of our resources,** increasing efficiency and living within our means
Best place to work & learn	Ensure we continue to **support all our colleagues** so that they feel they belong, are proud to work here and want to stay
Best partner	Work with our partners, patients and service users to play a **leading role in integrated neighbourhood working**
LIVE OUR VALUES	
With **all of us** in mind.	Ensure we **live our values** in the decisions we make and the way we behave
	Reduce inequalities and better describe our impact on those we serve

Key achievements for 2025-26 include:

Strengthened our inpatient and community clinical pathways through continued use and enhancement of the flow dashboard, supporting improved triage, visibility of bed availability and timeseries based quality improvement monitoring.

Evidence indicating improved mental health emergency department waits, with ongoing work to triangulate data with acute partners.

Implemented and expanded the use of a Caseload Management Tool (160 staff, 761 uses during Jan–Mar), improving oversight and pathway progress, with bespoke adaptations underway for children and young people, forensic and psychology.

Children and young people waiting times significantly improving, with targeted rapid improvement work now achieving 75% of first interventions within 18 weeks. Supported by strengthened job planning, maximised clinical time, streamlined allocation processes, and improved service flow. Further work is now underway on neurodevelopmental pathways and 104 week waits.

Our priorities for 2026-2027

We will be the **best we can be** and will focus on keeping our **services safe.**

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Best quality

Improve our clinical pathways, reducing waiting times, and improving access and flow.

Best quality

Accelerate digitally enabled care, improving quality of care, patient outcomes and staff experience.

Best value

Make the most of our resources, increasing efficiency, and living within our means.

Best place to work and learn

Ensure our workforce is fit for the future, and supports all our colleagues so that they feel they belong, are proud to work here, and want to stay.

Best partner

Lead implementation of integrated neighbourhood care and development of Place Provider Partnerships and Provider Alliances.

Live our values

Reduce inequalities and better describe our impact on those we serve, being clear that we deliver on our purpose.



#allofusimprove
and be outstanding

With **all of us** in mind.

Underpinning all of our priorities is a continued focus on **quality and safety,** and **compassionate trauma- informed care.**

If you require a copy of this information in any other format or language please contact your line manager or your healthcare worker at the Trust.

JOB NO 5581 MAR26

Best partner

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We are continuing to work with our partners in each of our places to create a local and sustainable approach to health and care, building on the local progress we have already made.

Our **ICBs** (integrated care boards) are continuing with their restructuring and drive to provide greater efficiency through providing a different offer. Chris Edwards has recently been appointed as chief executive of the South Yorkshire Integrated Care Board. The interim chief executive of the West Yorkshire Integrated Care Board is Jonathan Webb. Place Provider Partnerships are being established to help manage local systems, and have now met for the first time in shadow form.

Our **research and development** team showcased how services can get involved in studies, and how they can support staff throughout the process at their annual conference in Fieldhead in April.



Join our next **Trauma-Informed Community of Practice** on 19 May, exploring how the Patient and Carer Race Equality Framework (PCREF) aligns with trauma-informed approaches. The session will highlight their shared focus on safe, equitable and accountable systems of care, address harm such as racial inequality and re-traumatisation, and show how PCREF supports the six principles of trauma-informed care and formulation-led practice.

The management and delivery of Care (Education) and Treatment Reviews (C(E)TR) and Dynamic Support Registers (DSR) for all age people with a learning disability and/or autism have been transferred from the ICB to adult **learning disability** services. Please note that this does not include Barnsley and processes remain with the ICB there. The service are currently updating the standard operating procedure and will be rolling out some awareness training on this across the Trust very soon.

One of the artists working at Fieldhead as part of the **Hospital Rooms** project is on this year's four artist shortlist for the Turner Prize. The artist Simeon has previously done artwork in the sports hall in the Bretton Centre.

We welcomed Dr Marcello Tanca from **ASL Gallura** in Italy for a second visit to Laura Mitchell Health and Wellbeing Centre. The session focused on the importance of nutrition for both general health and mental wellbeing, emphasising the vital role played by the connection within the 'mind–body' relationship.

Managing risk



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The Corporate Organisational Risk Register (ORR) records high level risks and the controls in place to manage and mitigate them. The organisational level risks are linked to our strategic objectives; and are aligned to one of our Trust Board Committees.

Key areas of risk identified in the risk register are:

- Increased demand, acuity and complexity
- Staffing, recruitment, and access to temporary staffing where it is needed
- Staff wellbeing
- Patient safety
- Out of area bed placements
- Young people waiting for treatment and access to inpatient beds
- Confidence in our services resulting from waiting times
- IT infrastructure and cyber crime
- Health inequalities
- Service provision and resource of local authorities
- Creating a positive culture for speaking up
- Sexual safety
- Finance
- Changes to the role of NHS England and ICBs
- Integration of Cheswold Park Hospital
- Medical Devices
- Fire

Risk assessments for patients. The purpose of risk assessments are to assess the likelihood or probability of a negative event, such as suicide, violence, self-harm, or severe self-neglect, occurring in relation to a person's mental illness. It should involve assessing both static (historical) and dynamic (changeable) factors to formulate a plan that balances safety with patient autonomy, often focusing on care rather than just prediction.

Areas of improvements that are required are:

1. Review of the risk assessment that teams have to complete
2. SOP to support completion
3. Carer and patient voice
4. Updating the risk assessment from interactions and any changes whilst in community before an admission and on admission

Please ensure you familiarise yourself with the **risk management governance framework**. It includes consequence and likelihood definitions for risk scoring.

We are introducing important updates to our **DBS** (Disclosure and Barring Service) policy to strengthen safeguarding and ensure a consistent approach across the Trust.

Best quality
Our performance in March

South West Yorkshire Partnership Teaching NHS Foundation Trust

- **55.7%** of people completing Talking Therapies treatment and moving into recovery
- **100%** of Talking Therapies referrals beginning treatment within 18 weeks. **98.6%** within 6 weeks.
- **87.3%** of MH service users followed up within 72 hours of discharge from inpatient care
- **88.8%** assessed within 14 days
- **89.7%** inpatient risk assessment completed within 24 hours before or after admission
- **92.5%** on community active caseload at month end with a risk assessment which has been reviewed within the last year
- **84.6%** of people died in a place of their choosing
- **76.1%** in CAMHS services waiting less than 18 weeks for treatment

Across our care groups we continue to strengthen our commitment to carers, embedding carer-inclusive practice across community and inpatient services. This includes improved communication with families, increased staff awareness through the carer awareness e-learning, and the development of our Young Carers Pathway. We are now preparing for the **Triangle of Care** Star 2 Panel Review on 22 July, where we will present evidence of progress since Star 1 and demonstrate how we are embedding the six Triangle of Care standards across the Trust.

Our **customer services** team dealt with 33 new formal complaints in March, a 22% increase from last month. The Trust received 182 enquiries in March which is a 20% increase from February.

Accessible Information Standard - This refreshed intranet page explains how staff must identify, record and meet the communication and information needs of service users and carers. Our new Trust guide to involvement can be found here.

The infection prevention and control (IPC) team will be celebrating Hand Hygiene Day by holding information stalls in Fieldhead, Kendray and Cheswold Park to share knowledge of why hand hygiene is so important. To help celebrate the day, send your photos of your team showing your “jazz hands” or “heart hands” to demonstrate our Trust’s commitment to good hand hygiene to ipc@swyt.nhs.uk. You could be in with a chance of winning a team hamper!



Best quality
Our performance in March

South West Yorkshire Partnership Teaching NHS Foundation Trust

- **73** inappropriate out of area bed days
- **1** child / young person under 18 in adult inpatient ward
- **5.4%** of service users clinically ready to discharge. There were 32 people still delayed at the end of the month.
- **96.5%** with care plan that includes service user input/views
- **95.9%** of our service users have their ethnicity equality data recorded, **56.5%** their disability status, **56.9%** their sexual orientation, and **99.6%** deprivation (postcode)
- We had **12** information governance breaches



We're rolling out the national **NHS healthcare uniform** later this year to improve clarity of roles and improve patient experience. If you have any surplus uniform that is clean and fit for reuse, please bring it to our drop off points at Kendray and Fieldhead Hospitals. Look out for messages over the next few weeks about our sizing portal.

Occupational health can check for immunity against Measles, Rubella, Chicken Pox, and Tuberculosis for all staff in a patient facing role, and Hepatitis B for those who may come into contact with blood. If you don't have any immunisation evidence the team can provide blood tests to verify your immunity and help ensure you are protected at work. Contact occupational Health on 01924 316031 or email occupational.health@swyt.nhs.uk for more information.

Lunch and learn in Dying Matters Week – join a session on Teams (all sessions 1pm-2pm).
- Dying to plan – 5 May
- Dying to know what dying is – 6 May
- Dying to talk – 7 May
- Dying to understanding the way we feel – 8 May

Email CommunitiesLearningTogether@swyt.nhs.uk with your name, job title, and organisation to book.

Mental health care plans have been added to **Patient Knows Best** (PKB) records. This is when patient consent has been provided. Clinicians are responsible for confirming consent at the point of care plan completion and supporting guidance is available for staff to help respond to any queries from service users.

Best quality Patient and Carer Race Equality Framework (PCREF)

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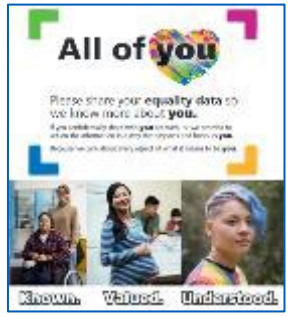
PCREF is about our aim to be a truly anti-racist organisation.

The Trust have been on a journey with PCREF for a while. Culture change and embedding sustainable and meaningful improvements into our ways of working doesn't happen overnight, but here's some of the work we've progressed so far, and some of our next priorities.



Progress:

- We have a 'health inequalities: PCREF working group' in place with experts by experience from across our communities to co-develop solutions and progress the agenda.
- PCREF has been added in EIA's to ensure services, policies, and strategies are considering potential impact for racialised, ethnically, and culturally diverse communities and staff.
- The 'All of You' campaign was developed to improve quality of data collection around protected characteristics, this is now a central hub for resources to support better conversations.



Priorities:

- Implementation of findings and recommendations from Empowering Partnerships in Communities (EPIC)
- Understand barriers to shortlisting and appointment for underrepresented groups through focus groups and survey interviews for those appointed, and those not successful at interview.
- Develop and run anti-bullying and discrimination training for leaders which embeds the "active bystander principles" to create a safe inclusive culture.



PCREF is everybody's business. If you'd like a conversation to explore the connectivity of PCREF in your role please contact the Involving people team.

All of you

Best quality

Medicines optimisation and pharmacy framework

NHS
South West Yorkshire Partnership Teaching NHS Foundation Trust

Our medicines optimisation and pharmacy framework sets out what we want to achieve across our clinical and pharmacy services and how we will achieve it.

Medicines play a central role in treating mental and physical health conditions, yet challenges remain nationally and locally. Our strategy is to respond to these issues by setting out a clear plan for improvement across five years.

This refreshed framework is aligned to the Trust's strategic aims. **Our objectives and principal aims are to:**

- Optimise the safe, evidence-based and cost-effective use of medicines as an integral part of person-centred care.
- Involve active engagement with and empowerment of service users and carers, improving their experience.
- Provide clear clinical leadership and accountability.



We've developed six clinical priorities using the feedback from our patients, service users, carers and clinicians.

- Equitable access and outcomes
- Consistently safe and responsive care
- Inclusive improvement
- Reducing inequalities
- Digital enablement
- Trauma-informed, recovery focused practice

My Meds, My Life – a recovery college course
The pharmacy have worked closely with the recovery college team to develop training material and resources for this course, which looks at the most commonly prescribed mental health medications, how they work, their benefits, and potential side effects. Find out more on the recovery college website.

"A really helpful course that empowers and enables participants to take control of their medication."
Course participant

By 2030, we want pharmaceutical care across the Trust to be safer, more equitable, digitally enabled, environmentally responsible and fully integrated across the health and care system. **Read the full framework on the intranet.**

With **all of us** in mind.

Best place to work and learn
Our performance in March

South West Yorkshire Partnership Teaching NHS Foundation Trust

- **4.9%** sickness rate for the month.
- The rolling 12 months sickness rate is **5.4%**
- **88.7%** of staff have a completed annual appraisal

Christine Brereton has been appointed as our substantive chief people officer. A new Trust Board and EMT poster is available on the intranet.



The **HealthHero** Assist Employee Assistance Programme (EAP) is a confidential and independent counselling and information service. The freephone support line gives access to telephone counselling, practical information and guidance for personal and work-related issues. Short-term brief therapy counselling can be arranged.

0800 358 4858

For online support join at: **https://www.my.healthhero.com**
Activation Code: **SUPPORT1**
Registration Code:

It is important that everyone is up to date with their **mandatory training,** including information governance.

Join our **Staff Network Day** #UnitedForEquity event on 15 May in the large conference room at Fieldhead. It's an opportunity to connect and learn about our vision and actions to support the growth of our staff networks. Find out more and book your ticket via Eventbrite

Do you enjoy writing poetry? The research and development team are working with the National Poetry Centre on a third anthology of poems based around four topics - silence, shadow, trace and longing. They're inviting people to submit their poems – find out how on the intranet.

Financial support is available for your educational and professional development. RCN Foundation education and career development grants support staff working within nursing to develop professionally, upskill themselves and enhance the care they give to patients. Apply by 13 May 2026.

New managed service provider for clinical agency staffing. This new arrangement is designed to streamline processes, improve compliance, and ensure consistent management of agency staffing.

Read our latest edition of the **Green Team newsletter** for all the recent sustainability updates. You can also loan one of four Trust eBikes! Email Kate Ledger to register your interest.



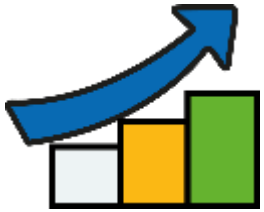
Our Excellence awards are on 14 May!

Best place to work and learn
Enhancing the appraisal process

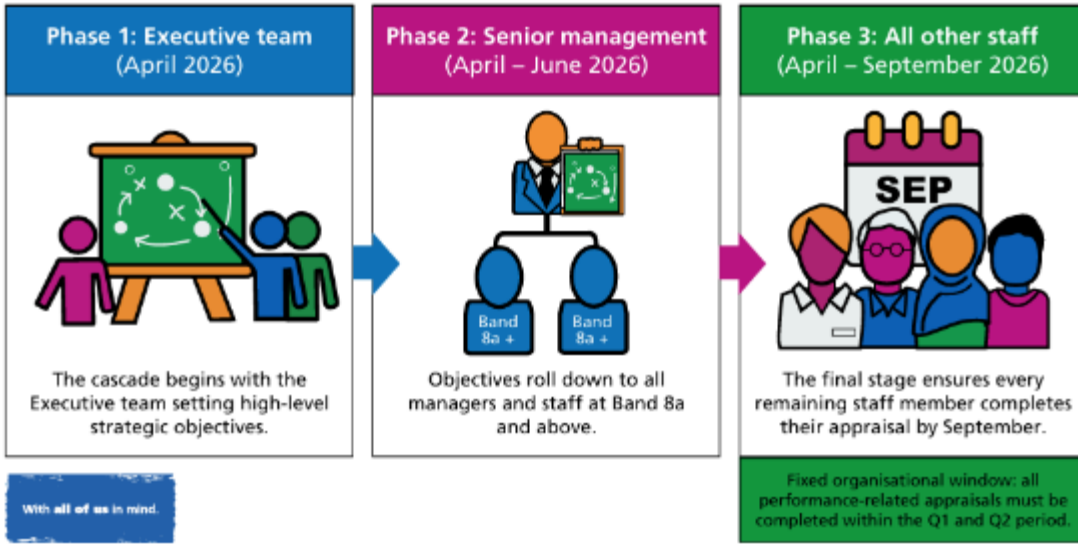
NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Following your feedback in the 2025 NHS Staff Survey, we're introducing a new Trust appraisal process to support a more engaging and effective workforce development planning. The **two key** changes include:

1. **A move from a rolling 12-month appraisal cycle to a fixed annual appraisal window**- running from April to September, aligned to the financial year and organisational planning cycle.
2. **The adoption of a revised, values-based appraisal template** - designed to support clearer objectives, meaningful development discussions, and improved engagement.



To ensure a consistent approach the new appraisal approach will be implemented through a cascade model:



The new changes to the process aim to:

- Strengthen performance management culture
- Improve the quality and consistency of appraisal conversations
- Ensure that appraisals contribute meaningfully to individual development and organisational objectives
- Support more effective workforce and development planning
- Establish a clear organisational rhythm for performance conversations and insight

For more information, guidance and to view the new appraisal form visit the appraisal intranet page.



Best value
Our finances in March



NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Performance Indicator	2025/26
Surplus / (Deficit)	£0.1m
Agency Spend	£2.9m
Bank Spend	£25.4m
Corporate Spend	£65.9m
Financial sustainability and efficiencies	£28.2m
Cash	£64.6m
Capital Spend	£14.8m
Better Payment Practice Code	98%

The Trust financial target for 2025/26 is breakeven. This has been achieved with a small unaudited surplus of £123k.

Our 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 last year.

Target bank spend 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. The target is £28.2m which has been achieved. Of this £7.3m has been delivered non-recurrently.

The Trust cash position remains positive and has increased in March.

As of 31 March 2026, a number of capital schemes remained in progress. The financial position includes the value of work completed to that date. The total spend of £14.8m is £3m less than the forecast.

95% of all valid invoices have been paid within 30 days of receipt.

Best value
Our value for money drive



NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Value for money continues to be a major focus across the whole NHS. We need to continue working hard to ensure we deliver value for money, improve our productivity, and live within our existing budgets. As a part of this drive we are focusing Trustwide on a number of initiatives to reduce costs. This includes pay, our largest expenditure, and our non-pay budgets.

Thank you to everyone who contributed to helping us achieve our target of break-even. It is a collective achievement. Over the next year we will need to continue to focus on our value of money work, reducing our costs and improving our efficiency and productivity. Please continue to do all you can to help.

Treat well for less - your actions can help to save money, our planet, and improve patient care.

- Consider switching trihexyphenidyl for hyoscine (which is 80% cheaper) – a total annual saving of around £30k
- Lots of long-acting injections/depots are available or can be given in different frequencies e.g. aripirazole can be given monthly or two-monthly. As well as an actual cost saving moving people to the longer gap between injections, we can also make savings on dispensing fees, nursing time and patient experience.



More tips are available on the intranet.

Please continue to send through your suggestions and ideas, which you can do on the intranet. We have already taken on board many of your suggestions, which have helped us to eliminate a lot of unnecessary and non-essential spend. Whatever your idea, send it in so we can look into it. You can find an online form on the value for money section on the intranet.



Take home messages

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Safety comes first. Do all you can to make our services and places as safe as possible.

Discuss our priorities for 2026-27 in your teams. What can you do to contribute.

Help us with our aim to be an anti-racist organisation supported by our PCREF work.

Take part in our hand hygiene day and dying matters week events.

Get involved in our staff networks and take part in our network day.

Learn more about our new approach to staff appraisals. Book yours in now!

Support our value for money work by following our ‘treat well for less’ tips.

Your wellbeing us important to us. Do all you can to look after yourself and those around you.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board 30 June 2026
Agenda item 9 – Assurance from Trust Board Committees

Joint Partnership Board

Date	27 April 2026
Presented by	Mitch Waterman, Non-Executive Director (Chair)
Key items to raise at Trust Board	**Alert** • This was the third meeting of the JPB, held at the University. • The JPB accepted the Minutes from 17 February 2026; actions identified in the log were either complete or updated accordingly. Brief consideration extended to the Terms of Reference (updated organogram, new members) and approved. • The action regarding the Partnership Framework between the Trust and University remains incomplete, pending a review by the University of existing Framework Agreements to reflect recent legal and operational changes, and the need to ensure such agreements remain deliverable and accurate. The Trust chief executive (CEO) will present the Partnership Agreement to the Trust Board in July. • The JPB chair noted the repeated reference, under various discussions, of workforce and workforce planning. • Organisational updates were provided by the Trust CEO, and University Faculty Executive Dean. Noting, for the Trust, inter alia changes in ICBs, the largely positive performance metrics, and the Trust's segmentation rating whilst acknowledging the wider system financial challenges. MB also advised the JPB that Marie Burnham as Trust Chair would be leaving the organisation. Prof. Kearney for the University advised inter alia that the Faculty was engaged in the annual year-end planning exercise, ongoing planning for the alignment with the Faculty of Biological Sciences, that discussion had started with Yorkshire Cancer Research regarding a potential University Academic Fellowship scheme, which may have some potential for the Partnership, positive performance metrics, the financial challenges faced by the wider HE sector whilst noting a potential shift towards investment, despite cost management. Positive discussions continue regarding a 'south campus' and there followed a short discussion about potential medical and nursing student number expansion, in the context of workforce planning, perceived to align with Trust recent discussions, with both parties acknowledging that innovative delivery models might be needed – directly relevant for the Education sub-group. • The JPB chair advised that the Board needed to be cognisant of the boundary conditions for the Partnership and prioritise initial objectives that could deliver for both organisations. • An initial set of priority objectives was agreed for the Partnership between the Trust and University (detailed under the 'Advise' section) following circulation of individual organisational priority list as per the JPB meeting of 17/02/26. • The process for establishment of two operational sub-groups (Education/Research) was determined, and first steps identified for working with those groups.

	Assure • JPB Terms of Reference (ToR) have been agreed. The Partnership Framework Agreement will be finalised, signed and presented to the Trust Board in July 2026. • As noted previously, Partnership business has no impact on either organisation's statutory responsibilities. • Jointly agreed objectives will be explicitly supportive of the Trust's workforce development and planning. • Sub-groups to concentrate on education and research priorities will be established, chaired by members of Trust staff, and will have the breadth of membership to identify risks, which, via chairs, will be escalated to the JPB and thereby to the Trust Board as necessary. • The breadth of sub-group membership will provide sufficient knowledge and experience across both domains to generate as a comprehensive a 'map' as possible for each domain. • Identification and escalation of risk will be incorporated explicitly in the draft ToR for each sub-group, as will workforce consideration, and as risks are escalated to the JPB, the JPB will reconcile any such risks with the organisational risk register (ORR) and if appropriate add to the ORR • The JPB will oversee a mutual accountability framework providing a single, consistent approach for assurance and accountability between partners. • The JPB will develop and deliver a joint communications strategy for the Partnership following a period of operation and reporting by the new operational sub-groups. The first stage in this strategy is likely to follow the development of the education and research 'maps' identified as tasks for the sub-groups. **Advise** • For the partnership, a 'Joint Priorities Matrix', was collated demonstrating that both organisations wished to pursue similar priorities. The priorities included all those identified in the JPB report of 17/02/2026 to the Board, recognising that some initial activity was necessary to provide the operational foundations. • Given similarities, the JPB chair recommended a set of concrete actions for the two subgroups to prioritise; the JPB supported this approach and agreed that the following actions should be the initial objectives for the two sub-groups, with each trio being considered single cohesive pieces of work: o *Education 1. List existing educational providers working with the Trust, to include the provider, nature of the provision (e.g. placement type), location and some assessment of impact.* o *Education 2. Based on above, examine options for new placement types/locations/specialties (focus to be determined, but for example, neighbourhood health, simulation, out of hours care). Promotion of diversity and inclusion in all existing and new provision.* o *Education 3. Based on above, examine opportunities for expansion, mindful of existing partnerships.* o *Research 1. List existing major (e.g. funded) research collaborators, to include collaborating organisations (e.g. other HEIs), funder & funding, identity of Principal Investigators, research 'theme' and fit with Trust research ambition. Bring relevant research leaders from both organisations together to review existing activity if not already members of the Research Sub-group.* o *Research 2. Examine current Trust research 'themes' and consider alignment with existing FMH research themes.*

	○ *Research 3. Identify methodological strengths and areas for development. Identify relevant FMH (or UoL) experts or training (e.g. M level modules) which might help with methods development.* • These will serve as foundations for subsequent JPB decision-making and operations by the sub-groups; across education and research, providing the most comprehensive picture yet of existing educational and research relationships with which the Trust is involved. In addition, the action will identify where such relationships are productive, experience challenges, and where opportunities for development, innovation or expansion might exist. The anticipated 'maps' are also likely to be valuable for the Trust Board, though with the caveat that they are necessarily a snapshot in time, and that further developments in both domains will follow. • The JPB agreed that two operational sub-groups should be established (E/R) with indicative memberships and terms of reference to be drawn up prior to the next JPB, for JPB approval at its next meeting. To enhance engagement and ownership, the chairs of each sub-group will be members of Trust staff, and will, once approved by the JPB, join the JPB as members who will thereafter report on sub-group activity and progress with JPB-agreed objectives. • Given the confirmed initial objectives, the JPB agreed that the JPB chair and Trust chief medical officer (CMO) should meet the two prospective sub-groups once formed, in order to outline how the interactions with the JPB will operate, the operational focus of each sub-group, and detail the intentions captured in the initial objectives. This 'pre-meeting' though recognised as occurring prior to formal JPB approval of ToR and membership, is intended to allow the sub-groups to act swiftly once JPB approval is granted. • Given references to workforce and planning, the JPB agreed that workforce considerations should be made explicit within each sub-group's ToR. • The Trust CMO confirmed that nominations from the Trust for membership of each sub-group had been received, and trust staff as prospective chairs identified. This is consistent with sub-group operation in other Teaching Trust partnerships with the University. • The University is currently reviewing the use of Honorary and Visiting academic titles, which will become increasingly relevant to the Partnership. The JPB confirmed that relevant University colleagues engaged in this work be invited to the next JPB in order to progress the appropriate recognition of Trust staff engaged in education and research.

People and Remuneration Committee

Date	5 May 2026
Presented by	Martin Neeson, Non-Executive Director (on behalf of the Chair of Committee)
Key items to raise at Trust Board	**Alert** • The BMA have advised further strike action being taken by resident doctors. Although to date the organisation has coped well with the efforts of our staff there is an ongoing risk around the impact on staff being asked to continue to step up and cover. There have been no adverse incidents as a result of the strike action to date. • The new appraisal process is being rolled out and the committee was alerted to the expectation that as the new approach is implemented and cascaded there will be a drop in the overall completion rates. This will be a temporary dip. (The Board has been made aware of and supported the change to an appraisal completion window between April and

	September to ensure the cascade of objectives, moving away from the 12 month rolling period previously in place. **Assure** • The committee received a deep dive into turnover and gained assurance that the overall figure being reported was not masking any hotpots or areas of concern other than one exception, which is Cheswold Park Hospital. The assurance was received based on the peer benchmarking through Model Hospital and regional comparators. Further assurance was provided on proactive steps to mitigate future immigration changes later this year and steps to mitigate. • The committee received assurance that sickness levels were back within tolerance levels as evidenced on the workforce IPR presented. • The committee received the quarterly Guardian of Safe Working report for both Quarter 2 and Quarter 3 and gained assurance through the reporting that there were no fines or concerns raised. • The committee received the Workforce Race Equality Scheme (WRES), the Workforce Disability Equality Scheme (WDES) and the Gender Pay Report. Assurance was taken through the existing EDI Action Plan, which this committee has previously received and continues to monitor for progress. **Advise** • The committee had the opportunity to hear first hand from colleagues working at Cheswold Park Hospital and their experience of transferring to the trust. It was particularly positive to hear their feedback about the prevalence of our values throughout their experience. • The committee received an update on the EDI action plan and the chair (NM) attended the recent staff network appreciation day to hear about the ongoing work to support these and ensure there are options for the board to hear about their role, impact and experience. The committee discussed the opportunity to ensure board sponsorship on this agenda alongside the other priority identified through the staff survey on keeping staff safe and healthy.
Approved Minutes of previous meeting for receiving	Minutes of 17 March 2026

Members' Council

Date	6 May 2026
Presented by	Gary Ellis, Non-Executive Director (on behalf of the Chair of Committee)
Key items to raise at Trust Board	• Governor's received feedback from Trust Board and the Chair's report. • Members' Council received an update from the Chief Executive on the operating context. • Members' Council received the Audit Committee Terms of Reference. • Members' Council received the Quality Assurance System Annual Report. • Members' Council received the Care Quality Commission action plan update. • Governor feedback and approved appointments to Members' Council groups were received. • Members' Council approved the annual reports and Terms of Reference for the Members' Council groups and the Nominations Committee. • The outcome of the Members' Council elections were received. • The Integrated Performance Report (IPR) was received.

	• Members' Council approved the re-appointment of the Lead Governor and the new Chair of Members' Council Quality Group. • The group received the Fit and Proper Person Test (FPPT) for board members). • Assurance from Members' Council groups and Nominations Committee was received. • Governors received a presentation around the structure of Members' Council including sub groups and committees. • The group took part in working groups discussing what the future looks like in terms of Members' Council. • Members' Council received an update of the Quality Account. • Members' Council approved the appointment of external auditors. • Members' Council received an update around the Chair's appraisal.
Approved Minutes of previous meeting for receiving	Minutes of 13 February 2026

Quality and Safety Committee

Date	19 May and 9 June 2026
Presented by	Margaret Kitching, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**<u>19 May 2026</u>** **<u>Alert:</u>** • Internal Audit - Care Planning and Risk Assessment -The audit identified variation in the quality and consistency of risk assessments and their translation into care plans and returned an opinion of limited assurance. A comprehensive action plan was in development planned to be shared at the June Quality and Safety Committee. It is proposed that monthly progress updates will be provided until the Committee are assured improvements are delivered and sustained. **<u>Advise:</u>** • The review of the women's pathway of care is progressing as planned and early feedback highlights a positive culture and strong staff commitment across services. However, the reviewers have noted a lack of clarity in the clinical model, which may be contributing to variation in service delivery and patient flow. • The Committee heard that an independent peer review of restrictive practices is underway to support further improvements to reducing restrictive practices. **<u>Assure:</u>** • The CAMHS team presented data-driven improvement work to reduce waits to the 18-week standard, reporting performance at about 94% compliance. • The Committee received the annual Infection Prevention and Control report, which summarised performance against national standards over the reporting period. The committee noted strong overall compliance, with most assurance criteria fully met. Infection rates remained low, with no MRSA or Clostridioides difficile cases and one case of Klebsiella bacteraemia. Improvements in outbreak management, including rapid response teams and enhanced governance, were also seen as strengthening the Trust's response capability. **<u>9 June 2026</u>** **<u>Alert:</u>** • Safer Staffing requires further triangulated analysis of workforce metrics, incidents, vacancies, sickness and appraisal data before sufficient assurance can be provided.

	• Risk assessment, care planning and documentation quality remain repeated findings from internal and external reviews. The Committee received an update on the actions being taken to address this and will continue to receive monthly updates on progress of improvement action and their impact. • Seclusion medical review compliance remains below expected standards, though improving, and requires continued monitoring. The improvement group remains in place to deliver the required improvements. **Advise:** • Community Mental Health Survey findings require a strengthened action plan focused on involvement in care, carer engagement, crisis access and continuity. • Health inequalities risk requires clearer scope, ownership and rationale for the reduced score to support effective oversight. • Restrictive practice, risk assessment, care planning and patient experience data triangulation remain areas of continued improvement and oversight. **Assure:** • Patient flow improvement work has demonstrated measurable progress in discharge rates, bed availability, length of stay and waits for admission. • Blanket restrictions governance has been further strengthened, with Horizon addressed as an isolated issue and oversight improved through Datix and dashboard reporting. • Falls, Patient Experience, Patient Safety and Learning from Deaths reports provided assurance on low harm, high satisfaction, no never events, stable mortality trends and robust review processes. • St Andrews assurance work confirmed strong safeguarding, governance and leadership visibility, with continued alignment to national learning.
Approved Minutes of previous meeting for receiving	Minutes of 14 April and 19 May 2026.

Mental Health Act Committee

Date	2 June 2026
Presented by	Rokaiya Khan, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • **Mental Health Act 2025 Implementation:** The Committee received an update on preparations for implementation of the Mental Health Act 2025. While implementation will be phased over a number of years, the legislation will introduce significant changes affecting detention criteria, patient rights, tribunal activity, care planning processes and workforce capability. • The Committee reviewed the associated risk register and received assurance that governance arrangements are in place to oversee implementation. However, given the scale of the reforms and the evolving national guidance, the Committee will continue to monitor progress closely and provide further updates to the Board as implementation plans develop. • **Embedding Learning from CQC Monitoring Activity:** The Committee reviewed the latest Care Quality Commission Mental Health Act monitoring activity. Overall assurance remains positive, with a significant number of actions closed during the reporting period and no significant concerns identified.

	• However, the Committee noted that recurring themes continue to emerge across a number of services, particularly in relation to collaborative care planning, risk assessments, documentation, recording practices and seclusion reviews. While these issues do not indicate systemic non-compliance, the Committee requested ongoing oversight to ensure improvements are consistently embedded and sustained across the organisation. **Assure** • **Care Quality Commission Monitoring and Compliance:** The Committee received assurance that Mental Health Act monitoring arrangements remain robust. Five Care Quality Commission visits were completed during Quarter 4. Thirty seven actions were closed during the reporting period compared to eighteen new actions raised, with only a small number of overdue actions remaining. Forensic Services reported particularly strong performance, with all actions closed and no overdue actions outstanding. • **Mental Health Act and Mental Capacity Act Governance:** The Committee reviewed performance, audit and compliance reporting and received assurance that Mental Health Act and Mental Capacity Act processes continue to operate effectively across the organisation. Monitoring of patient rights, advocacy access, statutory compliance and governance arrangements demonstrated continued adherence to legislative requirements. • **Risk Management:** The Committee reviewed both organisational risks and the Committee risk register. Members received assurance that key risks remain stable and that mitigation measures remain effective. Whilst recognising ongoing system pressures, including local authority workforce challenges and bed capacity pressures, the Committee was assured that there is currently no evidence of patient harm arising from these issues. **Advise** • **The Act in Practice: Older People's Services and Partnership Working:** The Committee received a presentation exploring the practical application of the Mental Health Act and Mental Capacity Act within Older People's Services and the importance of effective partnership working with acute hospital providers. • Members noted the increasing complexity of patient presentations, particularly where physical health needs, mental health needs and capacity considerations intersect. The Committee recognised the importance of strong partnership working across organisational boundaries to support timely decision making, minimise delays and ensure patients receive care in the most appropriate setting. • **Partnership Working and Advocacy:** The Committee received updates regarding partnership working with advocacy services, local authorities, acute trusts and other key stakeholders. Members noted positive progress in collaborative working arrangements and recognised the value of regular engagement forums in supporting communication, shared learning and improved patient experience. • The Committee also received an update regarding the continued integration of Independent Hospital Managers. Progress remains positive, with governance arrangements, training and hearing provision continuing to operate effectively.
Approved Minutes of previous meeting for receiving	Minutes of 4 March 2026

Commissioning Committee

Date	16 June 2026
Presented by	Martin Neeson, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • **Capacity pressures**: High occupancy and reduced discharge rates across the male pathway impacting patient flow. South Yorkshire (SYB) and West Yorkshire both reporting their highest occupancy rates since the collaboratives were established in 2021 (158 in SYB, 275 in WY). • **Rising demand across the system**: Increasing forensic referrals and limited bed availability leading to longer waits and out-of-area (OOA) placements. SYB report 14 (OOA) and WY report 57 cases OOA during the period. • **St Andrew's pathway risk**: repatriation and loss of specialist provision creating risks to system capacity nationally with reduced options for placements. Of the two WY service users being hosted by this provider, through the weekly transition meetings being held with the national team, one is being discharged to ICB funded level 2 rehab and the other has been accepted to a location in Berkshire when a bed becomes available, likely at the end of 2026. • **Financial pressure**: Whereas SYB report a positive financial position for the first reporting month, this has turned to an adverse position in month 2. WY report forecast an adverse £246k for the year. **Assure** • **Quality oversight**: strong quality governance, monitoring and oversight arrangement in place across both South and West Yorkshire, with no significant safety concerns. • **Improved reporting and data insight**: enhanced granularity (including SPC analysis and patient-level tracking) supporting decision-making in support of improving patient flow management, length of stay and repatriation work. • **Progress on patient flow**: evidence of repatriation activity and strengthened discharge planning processes. • **Focus on inequalities and patient-centred care**: ongoing work addressing length of stay, ethnicity, and patient experience. • **Collaborative working**: positive cross-system engagement and development of shared workstreams to address system challenges. **Advise** • **Operational planning**: The footprint of the Trust combining with the footprint of the SYB & WY collaboratives is enabling option appraisals of bed configurations to address demand & capacity to alleviate some of the pressures within the male pathway. • **Regional collaboration**: regional workshops (WY, SYB and York & Humber) have identified four workstreams (Single Point of Access-SPA, OOA, patient demographics and LDA low- & medium- secure pathways) with opportunities to improve access, flow, and capacity across the system. This is being progressed through structured work-packages with clear leadership being provided by both the WY and the SYB collaboratives. There is no formal update from NHSE in respect to what will follow the collaborative contracts that have been extended until April 2027. • **Community forensic team**: SYB have opted to expand their community forensic teams where the business case supports this key intervention to improve flow and reduce long-term pressures. • **Reducing length of stay:** The WY core ambition to reduce the amount of time patients stay in hospital is progressing to a good level where the average length of stay has reduced by 190 days during the period October 2023-April 2026.

Approved Minutes of previous meeting for receiving	Minutes of 1 April 2026 presented to private board due to being commercial in confidence.

Finance, Investment and Performance Committee

Date	22 June 2026
Presented by	Gary Ellis, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	Verbal update to be provided during the meeting

Audit Committee

Date	23 June 2026
Presented by	Mike Ford, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	Verbal update to be provided during the meeting

Note: assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of People and Remuneration Committee Meeting held on 17 March 2026 Microsoft Teams Meeting

Present:	Nat McMillan (NM) (Chair) Marie Burnham (MBu) Martin Neeson (MN) Christine Brereton (CB) Mark Brooks (MB)	Non-Executive Director Chair of the Trust Non-Executive Director Interim Chief People Officer Chief Executive Officer
In attendance:	Damien Macdonald-Bloomfield DMB) Subha Thiyagesh (ST) Ellie Valentine (EV) Paul Harrison (PH) for item 6	Associate Director of Education, Learning and OD (ELOD) Chief Medical Officer (CMO) Deputy Chief People Officer IPS Specialist

PRC/26/285 Welcome, introduction and apologies (agenda item 1)

No apologies to note.

PRC/26/286 Declarations of interest (agenda item 2)

No declarations of interest to note.

It was RESOLVED to NOTE there were no further declarations of interest.

PRC/26/287 Minutes from previous meetings of People and Remuneration (agenda item 3)

It was RESOLVED to APPROVE the minutes of the People and Remuneration Committee meeting held on the 26 January 2026 as a true and accurate record.

PRC/26/288 Matters arising from previous People and Remuneration Committee meeting held on 26 January 2026 and action log (agenda item 4)

Employment Rights Act – Probationary Periods (Verbal Update)

CB provided a verbal update in response to the committee's previous request for clarification regarding probationary clauses in employment contracts. She confirmed that all executive director contracts *do* include a probationary clause. This was included in a recent appointment, providing assurance that senior-level recruitment is already following this practice. Agenda for Change (AfC) contracts currently do not include probationary clauses. Following the committee's query, CB undertook a national survey of HR Directors, receiving over 100 responses. Results showed approximately 50% of organisations do include probationary clauses, 50% do not. This even split indicates no national standard or expectation. There is no legal requirement to include a probationary clause in contracts.

CB noted that the Employment Rights Act introduces a reduction in the qualifying period for employees to gain protection against ordinary unfair dismissal from two years to six months, creating a timely opportunity for the Trust to consider whether probationary clauses should be introduced for AfC staff. CB also emphasised that no decision has yet been taken and the issue has not yet been discussed at EMT. A full analysis of the advantages and disadvantages will be undertaken before a paper is brought back to the committee.

NM thanked CB for the update and noted the committee's assurance regarding senior appointments. NM requested that the item be added to the work plan to ensure it is not lost and that the timing of the next update is clear.

CB proposed bringing a full update to the July committee, allowing the item to progress through EMT beforehand. Committee members agreed this was reasonable.

It was RESOLVED to RECEIVE the UPDATE and NOTE the changes to the action log.

PRC/26/289 Actions from the Trust Board (agenda item 5)
No actions received.

It was RESOLVED to NOTE the actions from the Trust Board.

PRC/26/290 Staff Story – Recruitment Experience – (agenda item 6)

CB introduced the item, noting that the people directorate is currently reviewing recruitment processes and that it would be beneficial to hear directly from a recently appointed staff member. Paul was therefore invited to attend to give an honest overview of his recruitment and onboarding experience.

PH provided a detailed account of his journey from application through induction, highlighting what worked well, where delays occurred, and what improvements had already been made based on feedback from him and two colleagues who joined at the same time. PH explained that he applied for the IPS Specialist role following funding uncertainty in the charity sector. The interview process, was described as well-organised, professional, supportive and challenging but fair.

PH felt valued throughout and received prompt communication regarding his success. PH praised the administrative support from Zoe within the recruitment team, highlighting regular, proactive updates, clear instructions, efficient handling of documentation, rapid DBS turnaround (acknowledging this varies). He emphasised the shared responsibility between the new starter and the organisation in completing checks promptly. His line managers met with him on his first day and they provided clear explanations of NHS and Trust values, expectations and processes and a welcoming and reassuring introduction to the role.

PH described the culture as calm, transparent, values-driven, and "not daunting". While his internal induction was smooth, service deployment was delayed due to agreements needing sign-off between PCNs, Clinical Directors, and the Trust, the complexity of establishing a new primary care service, he emphasised that this delay was not due to internal failings but external dependencies. PH and two fellow new starters supported one another through the early stages, they met with managers to offer feedback on improving the process for future starters. A buddy/mentor system was introduced as a direct result. Non-managerial practical day-to-day support helps reduce anxiety for new employees Already making onboarding smoother for new cohorts. PH repeatedly emphasised strong Trust values, welcoming staff interactions across sites and the power of simple gestures such as smiles, greetings, and approachability. He contrasted this positively with other workplaces where new staff can feel isolated.

NM praised PH emphasis on Trust values and noted their importance to the organisation. PH agreed, sharing how visible the values felt to him across all levels—from Board to frontline staff.

MB thanked PH, noting his feedback reflects positively on the People Directorate's improvement work.

PH expressed gratitude for being invited and confirmed his positive comments were sincere and not influenced by senior presence. CB thanked PH for his honesty and for highlighting Zoe's contribution.

EV asked what aspects of PH positive experience should be "bottled" and embedded for all candidates. PH highlighted personal contact throughout onboarding, clear communication, mentorship/buddy system, a consistently warm culture and the impact of simple, everyday kindness (smiles, greetings, approachability).

The committee expressed strong appreciation for Paul's frank and detailed account. His feedback provided assurance on improvements made to recruitment and onboarding, staff experience of Trust values, the positive impact of People Team interventions (e.g., admin support, induction design). The committee noted the delay issues related to PCNs and Primary Care Networks and recognised these as external process challenges, not internal failures. The committee welcomed the buddy system, recognising it as a practical improvement driven by staff voice.

It was RESOLVED to NOTE the update on the staff story (agenda item 6)

PRC/26/291 Chief People Officer Remarks/Update (agenda item 7)

The committee were asked to take the paper as read.

A report was submitted by the CPO which outlined updates on internal and external matters. CB drew the committee's attention to key areas given the volume of national and local workforce activity. She indicated she wished to highlight major updates for assurance.

CB noted ongoing work within the People Directorate, referencing a recently improved morale and engagement picture from the staff survey, with green shoots evident. Well-received engagement sessions had been held across the directorate, with further sessions scheduled later in March. Positive feedback is emerging from staff attending these sessions.

CB confirmed that all verbal local agreements with trade unions for Cheswold Park had now been secured and formal sign-off was expected at Trust Partnership Forum next week.

CB highlighted several important national developments, the 26/27 AfC pay award will be implemented in April pay, earlier than previous years which was welcomed. Pay decisions for Senior Managers / Very Senior Managers and Doctors & Dentists are still pending. Government announcements linked to RCN discussions mean that nursing job profiles will be *accelerated* for JE review. This will trigger a large-scale piece of work for the Trust, already anticipated locally.

Leadership & Management and Mandatory Training Frameworks are expected to be released nationally in May. New National Staff Standards will be embedded into the NOF (National Oversight Framework). In 2026/27, metrics will be drawn from specific staff survey questions (exact questions not yet confirmed). CB noted recent staff survey performance should provide a strong starting position, subject to final question selection.

MN asked for more detail regarding the Trust having been selected as one of the organisations for the NHS Workforce Solution initiative. He requested clarification on scope and the lead within the People Directorate. CB responded that EV will be the lead officer for this programme. It is at an early scoping stage, but CB confirmed discussions are underway.

She proposed that EV and MN connect outside the meeting to explore the scope and expectations in more detail.

NM thanked CB for a comprehensive report and noted the volume of national workforce change is significant and consequential, the committee must remain attentive to the capacity of the People Directorate to absorb and operationalise these multiple changes, the committee will continue monitoring potential resourcing pressures throughout the year.

It was RESOLVED to NOTE the update on the Chief People Officers Remarks / Update and comments made.

PRC/26/292 Consideration of items from the Organisational Risk Register allocated to the People and Remuneration Committee (Previously Strategic Workforce Risks) (agenda item 8.1)

The committee were asked to take the paper as read.

CB introduced the organisational risk register update, confirming that the Q4 organisational risk register had been reviewed by senior colleagues (CPO, CN and CMO). Several risks had been reworded for greater clarity, responding directly to feedback previously given by the committee. EMT had held a time-out session the previous week to strengthen alignment between risks, controls, and future workforce priorities for 2026–27. Further proposals will follow once this work is finalised.

MN referenced the risk relating to staff not feeling safe from sexual harm. He noted the CPO report highlighted some increased reporting in the national staff survey. He queried whether the Trust understands the underlying issues behind responses indicating staff feel unsafe. Whether further work is planned to probe more deeply, given this was not detailed in the main staff survey summary paper later in the agenda. MN was asking how the Trust intends to respond to the sensitivity of this risk area.

CB provided assurance that the Trust undertook a self-assessment in November against the new national framework on sexual misconduct and harm, which was reported to PRC. The Trust scored positively overall on that assessment. The staff survey results may refer to a rise in reporting, which may be due to the Trust's active messaging through the new framework, and increased staff confidence to speak up. Increased reporting is therefore viewed as positive, as it enables early action and support. The organisation is strengthening visibility by adding a new indicator to the Integrated Performance Report (IPR) on sexual safety numbers. Employment-relations cases already capture sexual misconduct issues, and these are reported separately by EV as part of workforce casework updates.

DMB emphasised that the Trust is awaiting the full narrative of comments from the staff survey. These will be received by the Trust within the next 10 days. Once received, colleagues will analyse themes and link these to specific risks, localised hotspots and departmental trends. This will provide a richer and more actionable insight into why staff responded the way they did.

MN confirmed he was satisfied that the issue was recognised, monitored, and that appropriate analysis was planned. He emphasised the importance of continuing to surface risks and thanked both CB and DMB. The committee welcomed the increased transparency around these issues. The decision to embed sexual misconduct indicators into formal reporting strengthens the Trust's assurance position. The committee would like follow-up reporting on this once narrative comments from the staff survey are analysed. CB also highlighted a second point relating to the risk register wording: Risk 1614 – Clinical Staff Supply.

NM noted the planned review of Risk 1614, which covers clinical staffing shortages and welcomed the proposal for EMT to review the narrative wording, particularly to ensure it accurately captures distinct challenges for healthcare assistants and distinct challenges for

medical staff. This refinement will support clearer risk identification and escalation. CB acknowledged this and confirmed the work is underway.

The committee expressed assurance on the review process already undertaken improved clarity of risk wording, planned EMT-led enhancement of the 2026–27 risk framework, strengthened oversight of sexual harm reporting and analysis and requested follow-up reporting once staff survey narrative data becomes available.

It was RESOLVED to RECEIVE the consideration of items from the Organisational Risk Register allocated to the People and Remuneration Committee (Previously Strategic Workforce Risks)

PRC/26/293 Integrated Workforce Performance Report (agenda item 9.1)
The committee were asked to take the paper as read.

EV highlighted key areas for the committee's attention, covering workforce supply, absence trends, appraisal performance, and mandatory training compliance. Substantive workforce growth continues positively across the Trust. Improvement is particularly strong in clinical support worker recruitment, which aligns with priorities highlighted in the risk register. Turnover remains within target across most areas. Turnover at Cheswold Park remains higher than target, this is affected by rolling reporting periods. High turnover immediately after acquisition continues to influence current figures but the measure should stabilise around May 2026. Ongoing immigration rule changes present an additional risk to support worker retention.

EV referenced the pipeline also included in the Temporary Staffing Report (Item 9.2), noting that there is a steady inflow of new support workers into the system and this will support a planned reduction in temporary staffing reliance.

Sickness Absence remains above target, but the overall trend is improving. Short-term sickness remains high due to seasonal viral illness and longer recovery times. Long-term sickness is reducing, with notable improvements in Forensics and Estates & Facilities. Improvements followed targeted, localised interventions. EV emphasised that increased days lost to short-term sickness is a regional and national trend, not specific to SWYPFT. The Trust will focus on "We Are Safe and Healthy" as part of the annual priorities for 2026/27.

Appraisal figures continue with a positive upward trajectory. Forensics reported a notable increase in compliance. Oversight continues through both OMG and EMT. Mandatory training remains above target Trust-wide. A small number of local hotspots exist but each has a local action plan, clear ownership and monitoring via business partners.

NM sought assurance on sickness absence. While encouraged by improving trends, she could not yet say she was assured about sickness absence and needed clearer analysis, more explicit actions, connection to specific hotspots, she described past deep dives (Estates, Forensics) and requested a more unified, systematic approach moving forward.

MB noted the need for comparative benchmarking in Forensics. Acknowledged wider national patterns for example forensic units often have higher sickness levels, have less positive staff survey outcomes.

CB confirmed sickness absence is a Trust-wide annual priority as described so this will start to take shape in feedback to the committee as part of the People Strategy updates and the safe and healthy focus from staff survey. She further explained that national frameworks (IPR, NOF, annual planning) require downward sickness trajectories so this will have continued oversight. CB also made connection to the upcoming Forensics cultural diagnostics paper on the agenda was also highlighted, which directly stemmed from the sickness-absence concerns as part of the deep dive.

NM welcomed the insights but emphasised the need for future papers to be more explicit on hotspot trends on sickness absence and to clarify actions the Trust is taking now and to translate staff survey insights directly into targeted action to be assured. She confirmed assurance on Mandatory training and appraisal compliance.

EV confirmed that the previous deep dives, which she confirmed were presented to the committee in November 25 are still delivering improvements. Workflows for the May IPR refresh will include triangulated analysis. Reinforced that structured action planning is underway following the EMT engagement day.

NM summarised that the committee welcomes improvements, particularly in appraisals and mandatory training. However, sickness absence requires deeper, clearer, and more systematic assurance. The planned alignment of staff survey insight, the new national standards and the IPR refresh will be vital. The committee was assured on appraisals, mandatory training, workforce supply progress but was not yet assured on sickness absence (pending further analysis). The committee recognised continuing improvements while requesting further depth in future reports.

It was RESOLVED to RECEIVE the Integrated Workforce Performance Report.

PRC/26/294 Temporary Staffing Update (Agenda item 9.2)

The committee were asked to take the paper as read.

EV highlighted she would focus on the essential points of assurance, drawing attention to utilisation trends, agency spend, governance controls and areas of continued risk.

Workforce utilisation continues to show a positive trend, with reduced reliance on agency staffing and improved internal fulfilment. The Trust remains within NHS England agency caps, and the report details the controls being applied to ensure compliance. Agency usage has materially reduced, reflecting better recruitment pipelines, stronger local controls, improved governance through OMG and temporary staffing groups. EV noted that remaining breaches mostly relate to medical staffing, which aligns with the medical recruitment update also provided during the meeting.

EV emphasised that the recent positive recruitment of clinical support workers is beginning to impact temporary staffing demand. The medical recruitment pipeline included several starters between February and early March, expected to reduce medical agency reliance. EV confirmed governance remains strong, with weekly oversight tight controls on off-framework usage and continued adherence to agency rules. Temporary staffing reporting has been built into OMG discussions, which improves alignment between operational and workforce oversight. Unregistered nursing and Band 2–3 agency use remains a residual pressure, although reducing. Work continues with the recruitment and workforce teams to minimise usage within these bands, especially in inpatient settings.

MN stated he was very encouraged by the continued positive direction of travel. He particularly welcomed improvements in agency control and governance. He recorded thanks to the People Directorate for sustaining reductions over several reporting cycles. EV thanked MN and agreed that the progress reflects a collective effort across People, Operations, and Recruitment teams. She reiterated that governance reforms, especially embedding temporary staffing oversight into OMG, were helping to maintain standards. NM highlighted that the medical recruitment pipeline presented earlier was very helpful. She welcomed seeing, start dates, impact on workforce stability, expected reductions in agency medical usage. EV confirmed the recruitment updates were intentionally aligned across agenda items. She noted that early evidence is showing positive effects, though “still a journey”. MB supported EV’s report and noted recruitment alone will not resolve all pressures. Turnover for support worker roles in some wards remains high. He cautioned that some staff join the NHS without fully appreciating the complexity and challenge of inpatient services. Therefore, turnover may remain structurally higher in some wards.

MB emphasised the need to maintain a steady, ongoing recruitment pipeline, as full establishment is unlikely to be sustained for long periods. MB felt that a deeper dive on turnover hotspots would be useful. Agreed to bring this back to the next meeting.

NM summarised that the committee is assured about progress on agency reduction strong governance and effective integration with recruitment plans. The committee also recognises the ongoing challenges with certain support worker roles, the importance of workforce pipeline sustainability and the need for continued rigorous oversight. NM thanked EV and the team for the sustained improvement.

It was RESOLVED to RECEIVE the update on Temporary Staffing Update and the comments made.

PRC/26/295 Update on Employee Relation Cases (Agenda item 9.3)

The committee were asked to take the paper as read.

EV highlighted that the report provides a summary of current formal employee relations cases, including grievances, disciplinaries and complex HR matters, an update on high-risk cases, including those with external processes involved (e.g. police investigation), a summary of the Trust's Employment Tribunal (ET) position and a note on improvements being sought under the avoidable harm workstream to reduce avoidable delays in ER proceedings. EV noted she would highlight specific areas of interest to the committee.

EV explained that some case progress is delayed because staff involved are absent, external bodies must complete prior investigations or additional information has been requested from claimants. No new ET claims have been received in the reporting period.

EV referred to the avoidable harm work being undertaken, emphasising a key risk in ER processes is avoidable delay, often linked to staff absence during proceedings. The workstream is exploring more proactive support mechanisms to reduce stress-related absence, earlier interventions and stronger case management strategies. This work aims to reduce delays and provide faster resolution for staff and managers.

NM thanked EV for the report and noted that the committee is assured that employee relations cases are being actively managed, particularly higher-risk matters and recognises the complexities introduced b external investigations, staff absence and tribunal information requirements. The red-rated ET case requires continued monitoring once the tribunal provides the requested material.

The committee took assurance that there is robust oversight of complex ER cases, no new ET claims have been received in the period and that processes are being tightened through the avoidable harm workstream

The committee requested continued visibility of the red-rated ET case as it progresses.

It was RESOLVED to RECEIVE the update on Employee Relation Cases and the comments made.

PRC/26/296 Workforce Internal Audit Updates (agenda item 9.4)

The committee were asked to take the paper as read.

CB noted that this month's update was brief, as several audit actions have recently been completed or are approaching closure, CB confirmed the report's purpose was to provide assurance on progress against previously raised internal audit findings, confirm closure of completed actions, update the committee on any ongoing or outstanding items and highlight any live audit activity relevant to workforce or People Directorate functions.

CB confirmed all outstanding actions arising from the Temporary Staffing internal audit have now been fully completed. The audit is now closed from a management-action perspective. Improvements from this work are now embedded within OMG oversight, Temporary staffing governance and agency control processes. This aligns with positive trends discussed under Items 9.1 and 9.2.

CB reported that recruitment (vacancy control) internal audit has a small number of remaining actions, but all actions are on track to be completed by 31 March. CB expressed confidence that the deadline will be met. CB confirmed that an internal audit on Equality, Diversity and Inclusion compliance is currently underway. The Directorate is supporting internal auditors to complete fieldwork and testing. The committee will receive the audit's formal outcome, the RAG-rated assurance rating, and associated actions at a future PRC meeting once completed. No concerns were raised at this stage.

There were no questions raised by committee members for this item. NM welcomed the closure of the temporary staffing audit actions, noted the assurance provided that recruitment actions remain on track, acknowledged the EDI audit underway and awaited future reporting and confirmed the committee had no concerns requiring further discussion

It was RESOLVED to RECEIVE the update on Workforce Internal Audit Updates and the comments made.

PRC/26/297 10 Point Plan Update – Improving Resident Doctors Working Lives (agenda item 9.5)

The committee were asked to take the paper as read.

Subha Thiyagesh (ST) introduced the 10-Point Plan update, noting it provides assurance on progress to improve resident doctors' working lives in line with NHS England expectations. A comprehensive written report with RAG ratings was supplied to the committee.

ST highlighted that the task and finish groups continue to meet regularly and are now well established. One resident doctor lead has left the trust due to rotation, recruitment for a replacement has attracted strong interest requiring formal interviews with support from CB's team.

Some timescales have been adjusted, not due to lack of progress, but because of dependencies on acute trust partners (e.g. estates), ongoing national guidance from NHS England, and broader quality improvement work requested by resident doctors.

Subgroups are addressing estates and facilities (including rest areas and parking), quality improvement related to handover and annual leave and clinical education and supervisor guidance. Assurance given that resident doctors feel supported and that the Trust is addressing issues, such as e-rostering performance.

A recommendation was made to incorporate elements of the 10-point plan into Board Assurance Framework risk 3.1 ("inability to effectively recruit, train, support the well-being of workforce"). The plan will continue to be reported to the committee every other meeting as part of the 2026–27 work schedule.

CB informed the committee that NHS England now requires a NED sponsor for the 10-point plan proposing that the NED sponsor should come from PRC given its oversight role.

MB acknowledged overall good progress but raised concern about how shifting close dates may appear if externally reviewed. Are revised deadlines well-justified? CB explained some original dates were early estimates, set before the Trust fully understood the scope of the actions. Resident doctors themselves requested a more comprehensive QI approach, leading to extended deadlines for thoroughness.

Additional delays come from NHS England updating or delaying national guidance, requiring the Trust to adjust timings. CB confirmed revised dates are now accompanied by clear rationale in the cover report to ensure an audit trail.

MBu raised capacity of NED's to take on additional sponsor roles given recent changes to board committee structures, so may need to understand the ask further before we can clarify who may take up this role. CB acknowledged the need to clarify the expected commitment for the NED sponsor role. MBu noted she is already developing a paper consolidating all board committee memberships. The Trust must review mandatory vs. optional NED champion roles. A discussion with all NED's is planned for mid-April to rebalance workloads. The committee agreed the 10-point plan NED sponsorship should form part of that wider review.

NM highlighted issues relating to parking and facilities, particularly at the Dales site (owned by CHT), and asked whether external estate ownership complicates progress. ST confirmed that working across multiple organisations (CHFT, Mid Yorkshire, internal SWYPFT sites) introduces complexity. Estates teams are collaborating across partners, but some issues are constrained by capacity and ownership. MB added parking capacity at some acute sites is reduced due to ongoing building programmes. Trust-owned sites (e.g., Laura Mitchell, Drury Lane) also have limited parking, creating similar pressures. ST explained that this is why a full QI approach has been chosen, to identify practical, realistic improvements rather than idealistic solutions.

The committee expressed overall assurance at this time regarding progress, engagement with resident doctors, and transparency around revised deadlines. The committee supported incorporating the plan into the BAF as a control and action area. Identification of a NED sponsor was recognised as a required action (linked to wider NED role review). Reporting on the plan will continue bi-monthly.

It was RESOLVED to RECEIVE the 10 Point Plan Update – Improving Resident Doctors Working Lives and the comments made.

PRC/26/298 Medical staffing compliance updates (agenda item 9.6)

The committee were asked to take the paper as read

ST introduced the Medical Staffing Compliance Update, reminding the committee that elements were previously presented in November 2025 and verbally in January 2026.

This report also responded to Action PRC 25/26, requesting assurance on consultants working over 12 Programmed Activities (PA's), legal compliance, including working time regulations (WTR), private practice overlap and governance arrangements. A comprehensive appendix with detailed consultant data accompanied the report.

ST detailed consultant PA's and contractual position. Consultants can legally work more than 10 PA's if this is mutually agreed and documented via job planning. The Trust does not advertise posts above 10 PA's but may mutually agree additional PA's where appropriate on an individual basis. All senior staff agree PA's through formal job planning with ST for consultants, clinical leads and general managers for specialty doctors. ST emphasised that all consultants undertaking >10 PA's have explicitly agreed to this.

All private practice and additional work contribute toward Working Time Regulations totals. Doctors may, legally, opt out of WTR if they choose. A new declaration form was sent to all medical staff to capture private practice, Mental Health Act additional work, Category 2 work and any activities that may impact NHS duties. This adds an extra layer of governance beyond: annual appraisal, job planning and revalidation requirements. ST confirmed that non-declaration would breach GMC probity standards.

NHS England changed national job-planning timelines, requiring Trusts to complete and submit data by end of March 2026, significantly earlier than previous years.

The Trust had to implement a new L2P platform, retrain all doctors (completed January 2026) and re-do job plans agreed in September/October 2025. Updated job-planning progress (as of last week) 42% complete, 20% in sign-off, 22% ongoing and no escalations or appeals raised. Annual leave before March was a constraint as both medical staff and general managers required sign-off time.

ST confirmed existing job plans remain valid until updated, twice-weekly monitoring is in place and full completion is expected in the next fortnight.

Medical appraisal compliance last year was 99%. Although figures may fluctuate due to maternity leave, sickness, or appraiser availability, all doctors ultimately receive a valid appraisal. Revalidation remains 100% compliant; deferrals are used appropriately and only after GMC liaison. Many additional PA's (highlighted in yellow in the appendix) relate to temporary ward-cover pressures due to vacancies, sickness and maintaining safe inpatient care. Using existing consultants providing short-term PA's is safer (continuity) and more cost-effective than agency locums. Benchmarking shows neighbouring inpatient units often require 1.5 WTE consultants for a 22–24 bed ward. SWYPFT covers these wards with 1.0 WTE consultant + 2 additional PA's, hence occasional uplift.

CB advised that a deep dive into medical staffing compliance and financial value-for-money has been commissioned via the VFM programme for 2026–27, which will analyse overall costs.

NM asked whether the committee could be assured on the legalities of opting out and the work time regulations based on today's report. Members confirmed they were assured on the legal compliance position and strengthened governance around appraisals and revalidation.

They agreed the next stage of assurance must focus on triangulating WTR opt-out data with incident data financial analysis and value for money ensuring no detriment to patient safety or staff wellbeing.

It was RESOLVED to RECEIVE the Medical staffing compliance updates and the comments made.

PRC/26/299 Staff Survey Results 2025 (agenda item 9.7)

The committee were asked to take the paper as read.

DMB introduced the Staff Survey 2025 results and noted that the Trust's overall position remains strong, with clear strategic actions identified.

The Trust ranked 11th out of 49 Mental Health & Learning Disability Trusts nationally. This places the organisation on the verge of the Top 10, demonstrating sustained strong performance over multiple years. Compared with previous years, the Trust has held its position rather than declining, which DMB described as positive given the national environment.

DMB emphasised two strategic priority areas chosen for organisational focus: We are safe and healthy and we are compassionate and inclusive. He explained that the choice of these two people promise indicators was driven by staff survey data showing increases in discrimination reports, particularly race, disability and religion or belief. DMB clarified an important point that 315 people responded "Yes" to experiencing discrimination (Q16). Sub-percentages (e.g. 50% related to race) are proportions of this 315, not the whole workforce. Nonetheless, this remains a priority for cultural improvement.

We Are Safe & Healthy was chosen due to national priority areas for reducing sickness absence and looking after staff and local staff survey.

Strategic planning workshops have begun with EMT and senior leaders to define Trust-wide interventions. The cascade of results to divisions and care groups has begun. DMB will meet with Executive Directors their direct reports and Care Group leadership teams.

Each area must identify a local people promise theme based on their own data, aligned to national guidance requiring three organisational priorities.

CB emphasised specific highlights for the People Directorate staff were 3 out of 7 People Promise elements had improved, 2 remained the same and 2 decreased (but these were still in line with or above trust benchmark). Importantly overall engagement and morale had improved, indicating strong internal progress since the start of the directorate reform programme. The Directorate has already begun targeted improvement work based on these findings.

MN noted significant negative sentiment among bank staff in the results and expressed concern that their experience may become "corrosive" if not addressed. The Trust still relies on bank workers, even as it transitions more staff to substantive roles. The organisation must consider how bank staff feel and experience the Trust culture.

DMB acknowledged the importance of MN's point. Noted that the bank staff survey response rate was very low. Only 110 out of 625 responded. Low engagement may mean the responses reflect those with stronger negative views and may not represent the overall bank workforce.

The priority will be to improve engagement and participation among bank workers. Analyse themes once a more representative response pool exists. DMB emphasised the Trust must understand bank staff views, as many continue to play a vital role.

CB noted the Trust will review bank-only comments once staff survey narrative data is received. Bank staff may have different issues from substantive staff. Future actions may need to be targeted accordingly.

MB added historical context that the previous national AfC pay uplift did not include bank staff, causing national dissatisfaction. Many bank workers are also substantive staff working extra shifts, and the survey may reflect complex emotions around this. NM noted that the "We Are Always Learning" theme had not been chosen as a strategic priority and asked for clarification as this seemed one of the lowest scoring people promise themes.

CB confirmed that priority themes were chosen not solely from staff survey scores but also from WRES / WDES, employee relations data, complaints and concerns, strategic workforce risks and annual priorities and NOF alignment. The two priorities selected were those likely to have biggest organisational impact. However, CB advised "We Are Always Learning" will still be explored through narrative comments, considered within divisions' own action planning and incorporated into the final plan if themes warrant it. CB also stated that a number of questions in this theme related to appraisal, and a separate piece of work was underway to reform the appraisal process, which may address some of the issues highlighted. NM confirmed this explanation provided assurance.

NM summarised that the committee is assured by the strong organisational ranking and overall stability of results. The committee supports the two chosen strategic priorities, the cascade process and the People Directorate's positive internal results. The committee recognises the need for deeper exploration of discrimination concerns, further engagement of bank staff and careful consideration of narrative comments once available. The results will also be presented at Trust Board on 31 March.

It was RESOLVED to RECEIVE the update on Staff Survey Results 2025 and the comments made.

PRC/26/300 EDI Action plan update (agenda item 10.1)

The committee were asked to take the paper as read.

DMB confirmed the paper and its detailed appendices had been circulated and emphasised that the Trust continues to make solid, demonstrable progress across all five themes of the EDI action plan.

The purpose of today's update was to provide assurance on progress against each action, highlight areas where actions are ahead, on track, or supported by ongoing work and describe how EDI activity integrates with wider workforce programmes, including leadership, talent, wellbeing, and culture.

He explained that the deep dive into inclusive recruitment is well underway. Phase 1 of the analysis is complete. Phase 2 examining patterns in shortlisting, assessment and appointment outcomes is in progress. DMB described upcoming candidate experience listening events scheduled for 7 April, designed to highlight barriers and opportunities for improvement. CB and DMB emphasised that this work forms the foundations for wider talent and succession planning interventions scheduled for 2026/27. EDI components are now built into the new People Management training essentials programme. This programme will begin piloting in April with a full roll out by June. It includes training on handling concerns, reducing bias, managing conflict earlier and creating psychologically safe teams. While the broader Trust-wide talent pipeline is scheduled for 2027–28, supporting work has already begun, including "In Conversation With…" diverse leaders, a reciprocal mentoring programme planned for September and strengthening SPA job planning processes for leadership activity. DMB confirmed these activities support improved access to development and visibility for underrepresented staff groups.

DMB highlighted that the second Staff Network Appreciation Day is scheduled for 14 May. Work is underway to strengthen network governance, ensure clear terms of reference and recruit to lead roles. Networks remain a key pillar of staff voice in the EDI ecosystem.

NM thanked DMB and CB, noting the action plan demonstrates clear progress and interventions show strong integration across leadership, staffing, and wellbeing. The committee would support the planned reciprocal mentoring scheme, the recruitment deep dive and the linkages with wider organisational culture initiatives. NM reinforced the need to ensure fairness and transparency remain central to all EDI activity.

It was RESOLVED to RECEIVE the update on the EDI Action plan update and the comments made.

PRC/26/301 Forensics Cultural Review (agenda item 10.2)

The committee were asked to take the paper as read.

DMB introduced the Forensics Cultural Review update, noting that since the review had been commissioned, significant progress has been made. The review is focused concerns raised earlier in the year regarding sickness absence, staff experience, and culture. The update presented today is an interim progress position, not the final report, as more qualitative data is still being collected. DMB stated the purpose of the review is to understand the reasons behind staff experience concerns, triangulate cultural, behavioural and workforce data, undertake an evidence-based approach before making any recommendations to EMT and to provide a final report to the committee at a future meeting, emphasising that the review is due to be completed by the end of May.

DMB outlined the substantial work undertaken so far. A programme of focus groups has been completed with frontline staff. One-to-one listening conversations have been held where staff requested confidential discussions. An anonymous cultural survey ran across Forensics, enabling staff to share concerns without fear of identification. The review is drawing upon, staff survey data, workforce trends including sickness, turnover and ER cases, themes raised through Speak Up and insight from operational and clinical leaders. Although not yet finalised, it was noted that clear themes are beginning to surface and further triangulation is underway to strengthen the evidence.

CB confirmed that Adele Fox is progressing external benchmarking with other secure-estate providers. This is necessary to ensure Forensic culture and workforce metrics are not interpreted in isolation, but in the context of higher levels of patient acuity and nationally recognised secure-service challenges.

NM concluded that the committee is satisfied with progress and welcomes the careful approach being taken. The interim update appropriately reflects the complexity of the issues, the need to fully understand staff experience and the importance of triangulating safety, cultural, and operational data. NM thanked DMB and CB for the update and noted the committee looks forward to receiving the full report when it is concluded and findings are known.

It was RESOLVED to RECEIVE the update on the Forensics Cultural Review and the comments made.

PRC/26/302 Committee Effectiveness – annual review (agenda item 11.1)

The committee were asked to take the paper as read.

CB noted that the annual survey responses had been collated and shared with the committee. She confirmed that the results demonstrate a strong positive trajectory for the committee over the past year. Improvements reflect the significant work undertaken within the People Directorate, including strengthened reporting, improved action-tracking, and better alignment of workforce intelligence. A small number of areas were identified for continued strengthening, which will inform committee development over the next 12 months.

CB summarised the themes emerging from the effectiveness survey responses: These included high confidence in quality of workforce performance reporting, robustness of discussions held at the committee, improvements in People Directorate leadership and responsiveness and clarity of papers and actions provided. Members expressed strong satisfaction with the structure and focus of meetings, the committee's ability to scrutinise effectively and stronger strategic alignment with Trust priorities. A small number of responses suggested a desire for even greater visibility of emerging workforce risks, continued refinement of deep-dive presentations and ensuring comprehensive forward planning for workforce-related national changes. CB confirmed that these areas are already being incorporated into the committee's future work plan and reporting schedule.

MN had no concerns or amendments. His previous contribution to item 7 and item 8.1 already acknowledged improvements in reporting quality and assurance, which align with survey findings. CB acknowledged the committee's positive feedback and thanked members for their continued challenge, which has supported improvements.

NM explicitly acknowledged the improvements evident in the results and praised CB's leadership, the contribution of EV, DMB and the wider People Directorate and the increased robustness and quality of committee papers and discussions. NM reiterated that the committee is "in a much better place than it was before," and expressed her appreciation for the level of progress. CB thanked NM, noting that improvement has been a collective effort and that the Directorate continues to act on feedback to strengthen reporting and assurance.

NM summarised that the committee welcomed the results and endorsed the direction of travel. Recognition was given to the People Directorate for the significant improvement in quality, pace, and clarity of reporting. The committee was assured that the review accurately reflects performance, the areas identified for development are valid and manageable and the annual report will be finalised following today's meeting.

It was RESOLVED to RECEIVE the update on the Committee Effectiveness – annual review and the comments made.

PRC/26/303 Committee Annual Report (agenda item 11.2)

The committee were asked to take the paper as read.

CB noted that the report is scheduled for submission to the Audit Committee on 14 April and therefore was looking for approval today, with a small number of final updates to be incorporated following the meeting. These final updates relate specifically to the Terms of Reference review, and the confirmation of actions and assurances provided during today's proceedings. CB confirmed that, once these elements are added, the report will be complete and ready for onward submission.

CB outlined that the annual report provides assurance on how the committee has discharged its duties during the year demonstrating how it has operated in line with its Terms of Reference. It summarises the key areas of scrutiny, decisions made, risks overseen, progress against the People Strategy, internal audit outcomes and workforce performance governance. It will accompany the reviewed Terms of Reference to Audit Committee and subsequently to Trust Board.

CB confirmed the report accurately reflects the breadth and depth of committee oversight throughout the year. MN referred to the final section of the annual report dealing with Executive Director appraisal and objective processes. He queried whether the narrative describing the CEO's submission of assurance on Executive Directors' performance represents the normal process, and whether the wording accurately reflects how assurance is provided. CB confirmed that ordinarily the CEO provides an annual report on Executive Director performance and appraisal outcomes, and this goes through the People & Remuneration Committee as required. Last year, her understanding was this had been done via a discussion with the chair due to the timing of the committee, which is what was recorded in the annual report. CB confirmed that performance appraisals for 26 would be submitted to the committee in May 2026 as part of work schedule. MBu confirmed this is what had happened in 25/26. MN confirmed he was satisfied with the explanation.

NM summarised that the committee supports the annual report and is assured that it reflects the year's activity. The contributions from CB, EV and DMB over the year have strengthened the overall quality of workforce governance, the reliability of reporting and the committee's ability to provide meaningful assurance to the Board. NM accepted the minor updates still required and confirmed approval subject to their inclusion.

It was RESOLVED to RECEIVE the update on the Committee Annual Report and the comments made.

PRC/26/304 Terms of Reference (agenda item 11.3)

The committee were asked to take the paper as read.

CB presented the updated Terms of Reference (ToR) for the People & Remuneration Committee (PRC) and explained that the ToR have been reviewed and updated following committee feedback.

Amendments already incorporated include clarifications to improve readability, strengthened descriptions of the committees duties and incorporation of responsibilities previously belonging to the Equality, Inclusion & Involvement Committee (EIIC), in which it is being proposed to disband it. The updated ToR are presented today for Committee approval. CB confirmed that the ToR will accompany the Committee Annual Report to the Audit Committee on 14 April, and subsequently to the Trust Board. CB noted that many responsibilities of the EIIC have now been lifted and shifted into the PRC ToR to ensure continuity and avoid duplication. The updates ensure that PRC now fully covers Equality, Diversity & Inclusion strategic oversight

for workforce, workforce performance, organisational development, cultural indicators and leadership, talent, and workforce planning.

The ToR are aligned with the Trust's governance framework, NHS England requirements and the current workforce priorities. CB confirmed she had worked with DL (Corporate Governance) to ensure accuracy and completeness.

MBu asked whether the work plan accompanying the ToR also reflects the widened EDI responsibilities being transferred from the EIIC and queried whether the Committee was reviewing the updated ToR or an older version of the work plan that does not yet include EDI oversight items. CB confirmed that as explained today's ToR do include EDI responsibilities transferred from EIIC. Acknowledged that the workplan presented may still reflect the previous structure. It was expressed that EDI-related items have been built into the revised ToR, but further refinement of the work plan will be required. Additional updates will follow once the new committee structure is fully agreed. MBu accepted this clarification.

MB noted that the Trust is currently restructuring board committees. EIIC is being proposed to be disbanded and a new committee is being created. Final governance arrangements will require further ToR amendments. MB proposed that today's ToR be approved but recognise they will likely require another round of minor revision by the end of April, after EMT finalises the governance model. CB agreed with MB's assessment and confirmed that additional changes can be incorporated once the new committee structure is finalised. EDI oversight responsibilities are fully embedded. NM confirmed this was a pragmatic and appropriate approach.

NM summarised that the revised Terms of Reference reflect current committee functions and the expanded remit following EIIC closure. The committee supports the revised ToR and recognises that one further update cycle may be required following governance changes at the end of April. The committee is also satisfied that the ToR are suitable to be submitted to the Audit Committee, subject to any final amendments. NM thanked CB for her work in preparing the revised documents.

It was RESOLVED to RECEIVE the update on the Terms of Reference and the comments made.

PRC/26/305 Work Schedule – 26/27 (agenda item 11.4)

The committee were asked to take the paper as read.

CB presented the draft Work Schedule for 2026/27, noting that the schedule had been shared previously at the January committee and members had been given an opportunity to review it. The schedule reflects the committee's standing duties, regular workforce performance and assurance items, annual cycles (staff survey, medical appraisal updates, gender pay gap etc.) and key strategic workforce programmes. The work schedule also aims to incorporate items previously escalated through effectiveness surveys and earlier action logs. CB requested committee approval of the schedule.

MBu queried whether the work schedule fully reflected the widened scope of the Committee following the disbanding of the Equality, Inclusion & Involvement Committee (EIIC) and the transfer of relevant EDI responsibilities into the PRC Terms of Reference (Item 11.3)

She noted that some items were included (RES, DES, EDI Annual Report), but she was not confident that all EDI elements previously overseen by the EIIC were represented.

CB confirmed the work schedule is new and was developed to reflect the *revised Terms of Reference*. Most EIIC responsibilities referring to workforce had been incorporated. However, she agreed it would be prudent to review the schedule again to ensure that relevant EIIC responsibility has been correctly transferred.

CB committed to cross-referencing the schedule with the EIIC work plan, updating the schedule ahead of finalisation, ensuring there are no gaps ahead of submission to Audit Committee. MBu welcomed this assurance.

MB (in an earlier item) had highlighted that Trust governance arrangements are changing, and committee structures will shift in April.

NM thanked CB for preparing the work schedule, noting that it is a substantial improvement on previous years, it shows clear sight of recurring responsibilities, it reflects the expanded role of the committee and it remains important to ensure EDI oversight is embedded thoroughly.
No further comments were raised by Committee members.

NM concluded that the committee is broadly satisfied with the draft Work Schedule for 2026/27. A small caveat remains, CB will cross-check EDI responsibilities, given the transition from the EIIC and subject to that check, the committee approves the schedule. The committee recognises that further amendments may be required following Trust governance restructuring at the end of April.

It was RESOLVED to RECEIVE the update on the Work Schedule – 26/27 and the comments made.

PRC/26/306 Items to bring to the attention of the Trust Board

Alert:

- Risk 1888: The committee has previously had reports on sexual safety and has asked for triangulation with the staff survey results.
- Risk 1614: The committee supported the review to take place by EMT to amend the narrative of this risk which currently references clinical shortages and a need to focus this risk on HCAs and medical staff.
- Sickness absence is above target although the committee received benchmarking data that showed the trust's performs better in comparison. Hotspot areas remain including Forensics, Estates and Facilities and Barnsley Physical Health. The committee noted the triangulation with the staff survey priority areas including safety and wellbeing and will receive ongoing reports on the impact of this focus in improving staff wellbeing.

Advise:

- The committee noted the decision to prioritise two People Promise themes in response to the staff survey findings; Compassionate and Inclusive and Safe and Healthy.
- The committee received the regular Employee Relations report
- The committee received an update on the EDI plan with good progress to date noted.
- The committee were supportive of the CPO's decision to give some focus to partnership working with trade union colleagues.

Assure:

- The committee gained assurance on a previous matter arising regarding probationary periods for executive director positions which are confirmed as being in place. This provides mitigation for risks of appointment at this level. The CPO and EMT are undertaking a wider review of probationary periods to decide if they should be included in all contracts of employment terms. This will be reported back to PRC.
- Performance across the workforce metrics remain positive overall. Mandatory training rates are above target. Sickness absence rates continue to exceed target with focussed work ongoing. Appraisals are marginally below the target of 90% at 89.2% which is a positive position given board had previously been advised of the transition in approach and the impact was expected to be more significant.
- The committee received the report on compliance with the 10 Point Plan for Resident Doctors.
- The committee were assured on the progress on temporary staffing this year.

- The committee had previously requested oversight of medical staffing compliance and received a comprehensive report on job planning and evidence that the trust is not breaching any legal requirements. However, the committee will receive further reports to triangulate those job plans exceeding 12PAs in terms of safety, quality and wellbeing value for money.
- The committee received an update report on the culture review being undertaken across forensic services and noted the progress to date. The review is due to conclude in May 2026 and PRC will receive a report detailing outcomes following, recommendations and actions discussed at EMT.
- The committee received the annual effectiveness survey and noted the positive progress in the last year and recognised and thanked the interim CPO for her leadership and impact and the contributions of their wider team. There are some areas which continue to need focus including the insight and analysis of reports coming to committees but overall the effectiveness has improved considerably.
- The committee approved the workplan for 2026-27 with the caveat of assuring all elements of the EIIC had been included with the proposed changes in committee structure.

It was RESOLVED to NOTE the update on Items to bring to the attention of the Trust Board and the comments made.

PRC/26/307 Agree redactions for minutes going to public board (agenda item 11.5)

It was RESOLVED to NOTE the redactions for minutes going to public board and the comments made.

PRC/26/308 Date and Time of Next Meeting (agenda item 13)

5th May 2026

It was RESOLVED to NOTE the date and time of the next meeting.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of the Joint Trust Board and Members' Council meeting
13 February 2026, 10.10 – 13.00
MS Teams meeting

Present:	Marie Burnham (MBu)	Chair
	John Laville (JLa)	Public – Kirklees (Lead Governor)
	Keith Stuart-Clarke	Public – Barnsley
	Phil Shire (PS)	Public – Calderdale
	Bob Morse (BM)	Public – Kirklees
	Emma Hall (EH)	Appointed - Mid Yorks Teaching NHS Trust
	Valentina McParland	Public – Kirklees
	Farida Ali (FA)	Public – Kirklees
	Donna Kemp (DK)	Appointed – University of Huddersfield
	Ian Grace (IG)	Staff – Medicine and Pharmacy
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
In attendance:	Natalie McMillan (NMc)	Deputy Chair/Senior Independent Director
	Gary Ellis (GE)	Non-executive director
	Mike Ford (MF)	Non-executive director
	Martin Neeson (MN)	Non-executive director
	Rokaiya Khan (RK)	Non-executive Director
	Christine Brereton (CB)	Interim Chief People Officer
	Margaret Kitching (MK)	Non-executive director
	Mark Brooks (MBr)	Chief Executive
	Dawn Lawson (DL)	Executive director of strategy and change/Deputy Chief Executive
	Adrian Snarr (AS)	Executive Director of Finance, Estates and Resources
	Darryl Thompson (DT)	Chief Nurse and Director of Quality and Professions
	Adele Fox (AF)	Chief Operating Officer
	Izzy Worswick (IW)	Assistant Director of Corporate Governance
	Andy Lister (AL)	Head of Corporate Governance / Company Secretary
	Gemma Lockwood (GL)	Corporate governance manager (author)
	Debbie Beynon-Fisher (DBF)	Corporate Governance Officer (author)
Apologies:	Sarah Leason – Hurley (SLH)	Staff – Social workers
	Elaine Lane (EL)	Staff – Allied Health Professionals
	Claire Den Burger-Green (CDBG)	Public – Kirklees
	Leonie Gleadall (LG)	Staff – Non-clinical support
	Fatima Shahzad (FS)	Public – Rest of Yorkshire
	Amaina Elzoubir (AE)	Public – Wakefield
	Sara Javid (SJ)	Public – Kirklees
	Rosie King (RS)	Public – Wakefield
	Nesar Rafiq (NR)	Public – Wakefield
	Daniel Goff (DG)	Public – Barnsley
	Daz Dooler (DD)	Public - Wakefield
	Anne Magee (AM)	Appointed – Staff side
	Jacob Agoro (JA)	Staff – Nursing
	Nik Vlissides (NV)	Staff – Psychological Services
	Cllr Dorothy Coates (DC)	Appointed – Barnsley Council
	Cllr Duncan Smith (DS)	Appointed – Wakefield Council

Cllr Adam Zaman (AZ)	Appointed – Kirklees Council
Professor Subha Thiyagesh (ST)	Chief Medical Officer

MC/26/01 Welcome, introductions and apologies (agenda item 1)
Marie Burnham (MBu) formally welcomed everyone to the meeting, apologies were noted as above. Mbu reported the meeting was being held virtually due to forecast severe weather conditions, and expressed thanks to attendees for adapting to Teams at short notice.

MBu offered condolences following the recent passing of Geraldine Carter, a valued Governor from Calderdale Council, and acknowledged her positive contribution to the Members' Council and the Trust.

MBu acknowledged Phil Shire's (PS) final Members' Council meeting after three terms and thanked him for his commitment and impact on the Members' Council Quality Group.

MBu expressed thanks to the governors who are retiring by rotation for their valued input. MBu encouraged eligible Governors to reapply and wished success to all in the upcoming elections, emphasising the importance of maintaining a full governing body.

Donna Kemp (DK) was welcomed as the new appointed Governor from Huddersfield University, replacing Warren Gillibrand. MBu thanked Warren for his long-standing service.

MBu acknowledged Darryl Thompson's (DT) retirement as Chief Nurse and Director of Nursing, Quality and Professions. MBu thanked DT for his service, leadership and contribution to the Members' Council Quality Group.

Caroline Johnson was welcomed as the Chief Nurse and Director of Nursing, Quality and Professions designate, who will formally assume the role after DT's retirement at the end of March 2026.

It was RESOLVED to RECEIVE the welcome, introductions and apologies as described above.

MC/26/02 Declarations of interest (agenda item 2)
There were no new declarations of interest.

It was RESOLVED to RECEIVE the individual declarations from governors.

MC/26/03 Minutes of the previous Members' Council meeting held on 14 November 2025 (agenda item 3)
The minutes of the Members Council meeting held on 14 November 2025 were reviewed.

Mike Ford (MF) requested a correction on page 15 to change "management training compliance" to "mandatory training compliance."

John Laville (JLa) noted that Helen Dale was incorrectly listed as present, as she had previously stood down.

Subject to the amendments noted above, the minutes of the previous Members' Council meeting held on 14 November 2025 were accepted as an accurate record of the meeting.

It was RESOLVED to APPROVE minutes of the Members' Council meeting on 14 November 2025 as a true and accurate record.

MC/26/04 Matters arising from the previous meeting held on 14 November 2025 (agenda item 4)

The matters arising and action log were reviewed, with completed actions marked in blue.

MC/25/38g (1) Andy Lister (AL) reported that Daniel Goff has received information about membership and is being connected with the Equalities Team to further engage young members; this work is ongoing.

No other matters arising or issues were raised.

It was RESOLVED to RECEIVE the action log of the Members' Council.

MC/26/05 Chair's report and feedback from Trust Board (agenda item 5)

AL presented the Chair's report and asked for it to be taken as read. AL advised that the report provides a summary of the activities of the Chair and all Non-Executive Directors since the previous meeting, noting their high level of engagement and busy schedules.

MBu highlighted the importance of the report for accountability and its use in Non-Executive Director one-to-ones and appraisals, noting that Non-executive Directors are actively involved in the Trust and committed to their roles.

No questions or concerns were raised by Governors regarding the report.

It was RESOLVED to RECEIVE the Chairs' report.

MC/26/06 Chief Executive's comments on the operating context (agenda item 6)

Mark Brooks (MBr) introduced the Chief Executive's report, confirming it had been circulated in advance and invited questions from the group.

Phil Shire (PS) asked for clarification on the Trust's segmentation status, specifically what segmentation means and its implications.

MBr explained that segmentation is a national NHS performance rating system, with league tables, and SWYPTFT has achieved the highest rating (segmentation one). This high rating will position the Trust well for future freedoms under the new Advanced Foundation Trusts framework and means the Trust is not subject to NHS England intervention.

MBr clarified that while segmentation one does not immediately grant additional freedoms, it is a prerequisite for applying for Advanced Foundation Trust status, which could provide more operational flexibility in the future.

JLa asked about the Trust's involvement in developing neighbourhood care and provider partnerships, questioning whether SWYPTFT is part of a pilot?

MBr responded that the Trust is operating in "shadow" form for a year, developing place-based provider partnerships as part of NHS structural changes, with SWYPTFT is acting as host for Kirklees. This work is in line with national policy and is designed to reduce demand on hospitals.

JLa raised concerns about delays in capital projects, specifically the older people's transformation and works at the Priestley unit.

AS explained that the delays were due to new fire safety legislation following the Grenfell disaster, which had resulted in a six-month delay in the capital programme, with the bulk of delivery now expected in the 2026/27 financial year.

It was RESOLVED to RECEIVE the Chief Executive's comments on the operating context.

MC/26/07 Members' Council business items (agenda item 7)

MC/26/07a Appointment to Members' Council groups (agenda item 7.1)

AL presented the paper detailing current vacancies on Members Council groups:

- Members' Council Coordination Group - one appointed Governor and two public Governors for Barnsley and Calderdale).
- No vacancies were reported for the Members' Council Quality Group, Nomination Committee or Equality Involvement and Inclusion Committee.

AL emphasised that the paper reflects the position as at today and will be reviewed after the upcoming election process in May, as group composition may change.

The Corporate Governance Team will continue to circulate vacancies and seek volunteers over the coming months.

MBu encouraged Governors to consider volunteering for the vacant positions, highlighting the importance of filling these roles.

It was RESOLVED to RECEIVE the Appointment to Members' Council Groups.

MC/26/07b Assurance from Members' Council groups and Nominations Committee (agenda item 7.2)

MBu introduced the assurance report and summarised activities and minutes from the Coordination Group, Quality Group and Nominations Committee, with all relevant papers and meeting minutes provided.

It was RESOLVED to RECEIVE the Assurance from Members' Council and Nominations Committee.

MC/26/07c Review of Chair and Non-Executive director remuneration (agenda item 7.3)

Christine Brereton (CB) provided an update on the remuneration of Chair and Non-Executive Director roles, confirming the Trust remains aligned to the NHSE framework and at this time there is no change.

It was RESOLVED to RECEIVE the review of Chair and Non-Executive director remuneration.

MC/26/07d Care Quality Commission (CQC) Action Plan Update (agenda item 7.4)

Darryl Thompson (DT) presented the update on progress against the CQC action plans, including actions inherited from the previous provider at Cheswold Park Hospital. The report

had been reviewed by the Executive Management Team, Quality and Safety Committee and Trust Board prior to this meeting.

DT noted that while some actions remain open for an extended period, this reflects the complexity of the issues and the need to ensure changes are fully embedded before closure. He emphasised the importance of not closing actions prematurely and confirmed that the Trust maintains ongoing informal and quarterly meetings with the CQC, who are satisfied with current progress.

JLa queried the pace of closing actions and asked whether the Trust and CQC was content with progress. DT reiterated the Trust's approach of thoroughness over speed and described a positive, collaborative relationship with the CQC, including regular updates and shared understanding on challenging actions such as access to outside areas.

MK provided additional assurance from the Quality and Safety Committee, confirming that Non-executive Directors regularly scrutinise the timeliness and effectiveness of action closure, with a focus on ensuring changes are sustainable and evidenced in practice. MK highlighted the ongoing quality improvement work at Cheswold Park has received positive feedback from the CQC.

It was RESOLVED to RECEIVE the Care Quality Commission (CQC) Action Plan update.

MC/26/07e Chairs' appraisal – process (agenda item 7.5)

AL outlined the appraisal process for the Trust Chair for 2025/26, confirming it will follow the NHS England appraisal framework for Provider Chairs.

The process includes four strands: a pre-appraisal meeting between the Chair and Senior Independent Director (Nat McMillan), consultation with external stakeholders, governor consultation via a meeting and survey and consideration of specific areas such as meeting chairing, leadership style, corporate understanding, strategic awareness, personal style, independence, self-development, and impact.

MBu's objectives for the year were agreed in consultation with the Members Council and are highlighted in the paper. Executive and non-executive directors will complete questionnaires, and MBu will undertake a self-assessment. The governor feedback will be discussed at the May meeting, the appraisal submitted to NHS England in June, and the final report presented to the Members Council in August.

It was RESOLVED to AGREE the Chairs' appraisal process.

MC/26/07f Lead Governor and Quality Group Chair Appointment process (agenda item 7.6)

AL reported that John Laville's (JLa) second term as Lead Governor concludes on 30 April 2026, and JLa is eligible to reapply.

The Nominations Committee is responsible for appointments to Lead Governor, Deputy Lead Governor, Chair, Non-Executive Directors, Deputy Chair and Senior Independent Director.

The process for Lead Governor and Deputy Lead Governor is to invite self-nominations from publicly elected Governors, supported by a brief written statement.

The Nominations Committee will review nominations, invite presentations and make a recommendation to the Members Council. An extraordinary Members Council meeting may be arranged if required to complete the process before the term ends.

In terms of the Quality Group Chair, AL confirmed that Phil Shire's (PS) term ends on 30 April 2026. It is proposed to the Member's Council that the appointment process mirrors that of the Lead Governor, with public governors invited to self-nominate. PS offered to speak with any public governors interested in the Quality Group Chair role.

JLa expressed thanks to PS for his significant contribution and leadership of the Members' Council Quality Group, noting the positive transformation of the group's function and the value of site-based quality meetings.

The Members Council approved the proposed appointment process for both roles.

It was RESOLVED to APPROVE the process for the nomination and appointment of the Lead Governor and Chair of the Members' Council Quality Group.

MC/26/07g Members' Council elections – update (agenda item 7.7)

AL provided an update on the Members Council election process, confirming that nominations opened on 11 February 2026 and the process is managed by Civica.

Public seats available:

- Barnsley – two
- Calderdale - three
- Kirklees - two
- Wakefield – two
- Rest of Yorkshire – one

Staff seats available:

- Non-clinical support
- Medicine
- Pharmacy
- Nursing
- Nursing support

AL outlined the election timetable and advised that nominations close on 11 March 2026. Withdrawals are permitted until 16 March 2026 and voting (if required) opens 1 April and closes 29 April with results announced on 30 April 2026. New terms of office will begin on 1 May. Uncontested seats will not require an election.

AL noted there has been a publicity campaign in Calderdale to support recruitment and reported an increase in membership numbers.

AL invited Governors to contact him with any election-related queries.

It was RESOLVED to RECEIVE the Members' Council elections update.

MC/26/07h Governor feedback from virtual meetings (agenda item 7.8)

JLa provided feedback from Governors, highlighting ongoing concerns about discharge processes.

JLa reported cases where service users were unaware of their discharge and received medication changes without proper follow-up.

Adele Fox (AF) explained that discharge audits are part of the improvement programme and requested more specific information, such as dates and times, in order to enable the Trust to investigate further.

Dawn Lawson (DL) suggested working with the Involvement Team to collect feedback confidentially. JLa agreed to try to obtain more details.

JLa described an incident at Folly Hall in Huddersfield where two sons were denied access to a consultation, despite parental consent. AF requested a date and time so that the Trust can investigate. DL proposed a process for gathering such information without exposing identities.

Issues were raised following a recent quality group visit to Ward 19, including staff requests for more ensuite bathrooms as part of the older people's transformation programme.

JLa has been informed there are no ensuite bathrooms due to draining issues and/or reducing the number of beds.

AF and AS confirmed there have been delays in the capital programme due to fire safety regulations and agreed to review staff suggestions and communicate updates to JLa**.**

Action – Adele Fox/Adrian Snarr

Phil Shire (PS) questioned the clarity and imminence of the transformation programme, noting staff uncertainty about retraining and timelines.

AS confirmed a six-to-nine-month delay..
AF assured Members' Council that staff have been informed about delays and would revisit communicating clinical modelling and needs.

JLa relayed staff governor concerns about tight staffing levels and difficulties justifying bank staff usage.

Ian Grace (IG) described challenges in maintaining safe staffing and the need to balance financial constraints with service safety.

MBu emphasised that safety would not be compromised for financial reasons and encouraged ongoing communication about staffing issues.

JLa asked about rumours of relocating the well-being suite from the Priestley Unit to Beckside Court, causing some disquiet, and asked if staff were aware or involved.

AS stated he was not aware of such plans but would investigate further, confirming Beckside Court is primarily an administrative base which will become the North Kirklees Hub.

Action – Adrian Snarr

Farida Ali's (FA) upcoming participation in a roundtable on drug and alcohol abuse in the Muslim community was noted and her intention to report back to the Members' Council.

Concerns were raised regarding digital connectivity, specifically the NHS app not reflecting recent hospital stays etc.

IG reported encouraging progress with new system links to acute hospitals and AS confirmed ongoing phased rollout of diagnostic connectivity.

It was RESOLVED to RECEIVE the Governor feedback from virtual meetings

MC/26/07i Integrated Performance Report (to be taken as read and submit questions in advance) (agenda item 7.9)

Martin Neeson (MN) provided an overview of the Trust's Integrated Performance Report, asking for it to be taken as read and noted the following:

- There is continued improvement in reducing prone restraints, with numbers decreasing with the Trust aiming for zero incidents.
- There has been significant progress in patient flow and bed management. The number of patients clinically ready for discharge remains above target, equating to 21 people at the end of December 2025. Efforts are ongoing to create bed space and facilitate community or safe housing placements.
- Out-of-area placements were reported as two for December 2025, totalling 76 bed days.
- Patient experience metrics showed strong performance, with 93% recommending mental health services and 96% recommending community health services.
- Incident reporting levels were within expected boundaries, and transparency in reporting was encouraged.
- Sickness absence rates increased to 5.96%, reflecting national and regional trends, with active management of long-term absence.
- Substantive staff numbers increased by 1.2%, attributed to transferring staff from bank and reducing agency spend.
- Statutory and mandatory training compliance remained above local thresholds.
- Appraisal rates were at 88.1%, close to the 90% target.
- Staff turnover rates are positive and continue to be monitored.
- The Trust achieved a surplus run rate, with agency spend reducing and bank/locum spend higher than planned, reflecting conscious decisions to maintain service safety.
- The Value for Money programme focused on corporate expenditure, with delivery back in line with plan.
- Delays in capital expenditure for older people's services have been noted as per earlier discussion, with the forecast cash position expected to reduce as capital spending increases.

In discussion, IG commented that sickness rates were encouraging given the early flu season. NMc added that benchmarking showed SWYPTFT's rates were lower than other NHS organisations, with targeted support for specific services.

JLa requested clarification of the metric "percentage admissions gate kept by crisis response teams".

AF explained it refers to response times for seeing people, typically within four hours, and confirmed the Trust was meeting the target.

It was RESOLVED to RECEIVE the Integrated Performance Report.

MC/26/08 Focus on item: Biennial Evaluation (agenda item 8)

AL advised that a survey was sent to all governors via Microsoft Forms

AL presented the results of the biennial evaluation survey and highlighted the following:

- Out of 27 governors, responses were received from 16 Governors, eight public, five staff, three appointed, with most responses being from new Governors with 0–3 years' experience.
- High levels of understanding were reported for the Trust's missions and values, with good awareness of the services the Trust provides, however, engagement was noted to be lower in the Trust Strategy and Equality, Diversity and Inclusion (EDI) membership strategy, but this was possibly due to the timing of the survey and governor turnover.
- Governors showed strong knowledge of their own and non-executive director roles, with areas for development identified in understanding the lead governor and company secretary roles.
-
- Training and meeting access were rated positively, though access to GovernWell events and Place visits was lower.
- Hybrid meetings were viewed as effective and inclusive, with requests for shorter paper summaries, however papers are noted to be clear.
- 13% of Governors who responded expressed a need for further training. The governor handbook access was flagged, with paper copies to be made available at in-person meetings to avoid rising postage costs.
- The evaluation also raised the idea of changing the name "Governor" in light of upcoming constitutional changes.AL and MBu confirmed this will be considered as part of future planning with involvement from Members Council.

DL expressed disappointment at perceived low engagement in strategy and EDI following extensive involvement at Members' Council and across the Trust, seeking feedback on improving involvement. Farida Ali and AL agreed this could be related to the timing and induction for new governors who joined after these sessions were held. AL advised that refreshing strategy information should be included in future induction processes.

Action: Corporate Governance

JLa praised DL for how governor involvement has been driven and suggested better "closing the loop" on governor input to strategy, so feedback is visibly reflected in outcomes. AL agreed to look at this for future joint Trust Board Members Council meetings about strategy.

Action – Andy Lister

AL advised that an action plan will be put together and presented through Members Council Co-ordination group.

AL reiterated that the corporate governance team are always available to speak with and share any ideas or suggestions.

It was RESOLVED to RECEIVE the Biennial Evaluation.

MC/26/09 Members' Council Objectives (agenda item 9)

Izzy Worswick (IW) provided an update on the Trust's planning process, emphasising a coordinated approach involving staff, communities and Governors to ensure plans are informed by broad engagement and support ownership across the organisation.

IW confirmed that the final plan was submitted on 12 February 2026, forecasting a balanced financial position for the coming year, though achieving this will require continued efficiency and value for money initiatives.

Workforce planning focuses on reducing temporary staffing, particularly bank usage and activity plans are compliant with national provider metrics except for children and young people's neurodevelopmental waits, which remain a national challenge.

Six key priorities for the Trust were identified:
- Improving clinical pathways (including waiting times, access, and flow)
- Maximizing resources
- Reducing inequalities
- Leading integrated neighbourhood care and place provider partnerships
- Enabling digitally supported care
- Ensuring a future-fit workforce.

Quality, safe care and trauma-informed care remain areas of focus and each priority is supported by specific actions, timelines and measurable outcomes, with ongoing work to cascade the plan throughout the organisation and align individual objectives with overall Trust priorities.

JLa presented the Members' Council Objectives for 2026/27 and commended the Trust's bottom-up planning process, highlighting broad engagement and alignment with organisational priorities. Continuity in Members' Council objectives was noted, with some repetition from previous years reflecting their ongoing relevance and effectiveness.

JLa provided a summary of the objectives:
- The first objective addresses the future transition, focusing on co-producing with the Trust a new structure that maintains and improves current Members' Council functions in light of the anticipated NHS constitutional changes. The 10-year plan still refers to three cohorts as public, staff and partners and how to be equipped for the future.
- The second objective centres on involvement and ensures members and communities understand the Trust's work, promoting Governor roles, encouraging young people's participation, identifying inequalities and supporting the Triangle of Care and carer engagement.
- The third objective is quality and supporting the Trust's aspiration to be outstanding, maintaining transparency through the Members Council Quality Group, continuing quality walkarounds and PLACE visits, and reinvigorating feedback mechanisms for Governors to raise community concerns.
- The fourth objective is effectiveness and holding Non-executive Directors to account, maximising opportunities for Governors to gain insight into Trust operations and ensure robust induction and training for new Governors, especially given upcoming vacancies. Staff Governors were encouraged to develop mechanisms to represent their constituencies fully.

JLa confirmed these objectives are set for 2026–27 but may be adapted as NHS legislation evolves.

It was RESOLVED TO APPROVE the Members' Council Objectives.

MC/26/10 Closing remarks and annual work programme 2025/26 (agenda item 10)

The annual work programme for 2025–2026 was presented to Members' Council and outlines the planned activities and areas of focus for the upcoming year. MBu confirmed it continues to support the Board and Members' Council in meeting statutory and governance requirements, ensuring all necessary business is scheduled and tracked.

No comments or concerns were raised by attendees regarding the current work programme. The programme was received and noted as fit for purpose.

It was RESOLVED to RECEIVE the work programme for 2025/26.

MC/26/11 Any Other Business (agenda item 11)

JLa thanked Darryl Thompson on behalf of the Members' Council for his contribution over the years, especially with Members' Council Quality Group.

Keith Stuart-Clarke (KSC) raised a query regarding the qualifications of the Trust's fire safety trainer, seeking assurance that the trainer holds an appropriate rank and experience.

AL and AS confirmed that the fire safety trainer is a retired fire officer with substantial experience and has been employed by the Trust for several years as a trainer.

No further items of other business were raised.

It was RESOLVED to NOTE any other business.

MC/26/12 Next Members' Council meeting (agenda item 12)

Wednesday 6 May 2026 hybrid/Large Conference Room, Fieldhead Hospital, Wakefield.

It was RESOLVED to RECEIVE the dates of the next Members' Council meeting.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of Quality & Safety Committee
14 April 2026
9-11.30
MS Teams

Present:	Margaret Kitching (MK) Nat McMillan (NM) Mike Ford (MF) Caroline Johnson (CJ Prof Subha Thiyagesh (SThi) Adele Fox (AF)	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director Chief Nurse / Director of Quality and Professions (Lead Director) Chief Medical Officer Chief Operating Officer
Apologies:	none	
In attendance:	Sarah Harrison (SLH) Amy Hartley (AH) Naomi Sutcliffe (NS) Yvonne French (YF)	PA to Chief Nurse / Director of Quality & Professions Deputy Director of Nursing, Quality & Professions Suicide Prevention Lead (item 6) Associate Director of Legal Services
Observing	Elaine Lane (EL)	Staff Governor

QSC/26/1 Welcome, introduction and apologies (agenda item 1)
Margaret Kitching (MK) welcomed all to the meeting and apologies were noted as above. MK confirmed Elaine Lane, Staff Governor was in attendance as an observer and with quoracy, the meeting could proceed.

QSC/26/2 Declarations of interest (agenda item 2)
The Committee noted that there were no further declarations over and above those previously made.

The Quality & Safety Committee NOTED the declaration.

QSC/26/3 Minutes from previous Quality and Safety Committee meeting held 10 March 2026 (agenda item 3)
The minutes from the previous meeting on 10 March 2026 were approved as an accurate record

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 10 March 2026 as a true and accurate record.

QSC/26/4 Matters arising from previous Quality & Safety Committee meetings and action log (agenda item 4)
The action log was reviewed, and the following was noted:

QSC/25/225 Staff Team Story
Audit Committee presentation
The Committee discussed the action to share the presentation with the Audit Committee. Mike Ford (MF) advised the Audit Committee's April agenda is a year-end meeting and June is limited to accounts sign-off; the next full meeting is July. The Chair proposed closing the QSC action as the recommendation had been made and as chair of the Audit Committee MF would ensure that it was added to the Adut committee workplan.. Committee agreed.

QSC/25/234 Internal Audit Report
Safer staffing audit – sexual safety / mixed sex accommodation (Beechdale)
Caroline Johnson (CJ) summarised that the safer staffing internal audit referenced sexual safety concerns on Beechdale and that a Datix review identified six occasions involving patients of the opposite-sex pod being accommodated in the pod. Adele Fox (AF) described mitigations used (individualised plans, enhanced observations, dedicated bathroom arrangements) and emphasised the "last resort" context where bed availability is constrained. The Chair clarified the formal definition of a mixed-sex accommodation breach and requested further assurance to avoid incorrect national breach reporting. Subha Thiyagesh (SThi) reinforced that under NHS guidance, where bedroom/bathroom separation and safe access are maintained, this may not technically constitute a breach; the Committee noted the importance of consistent classification and assurance.

It was noted that weekly monitoring occurs via the Patient Safety Oversight Group (PSOG) and the practice is rare/exceptional.

CJ agreed to confirm current national definitions and ensure classification/approach remains compliant and consistent, including CQC expectations.

Action: Caroline Johnson

QSC 25/205 – Quality Regulatory Oversight Report
Johnson Ward post-repair checks
Members asked for clarity on this action and whether it was related to the fob readers/access for Johnson Ward and noted the subsequent update required.

The Chair requested the original minutes be checked to confirm scope before closure.

Action: Caroline Johnson

QSC/25/214 ICB Colleagues attendance at QSC
The Committee reaffirmed that any ICB attendance arrangement is subject to a six-month review rather than blanket attendance.

QSC/25/177 Review of Committee Related Risks
Risk 1424
CJ confirmed that EMT have reviewed the proposal to disaggregate the elements of this risk into component parts. EMT challenged some of the proposed scoring of the risks and the amendments will be made. The risk will be presented to Board in June. Natalie McMillan (NM) requested an interim verbal update in May to maintain momentum; Committee agreed.

It was RESOLVED to NOTE the changes to the action log and AGREE to close those where this had been agreed. Others would be returned to later in the agenda.

QSC/26/5 Review of Committee related risks – update following Board discussion (agenda item 5)

CJ introduced the item, the report was taken as read.
The Committee received an update in relation to Committee-owned risks

CJ presented the operational risk register, highlighting key risks resources constraints impacting quality, service availability, waiting lists, neurodevelopmental assessments, CAMHS bed risk, medical devices, bed availability, FTSU, sexual safety. AF advised the CAMHS safety bed risk may be reduced based on improved regional access and will review.
Medical devices risk (1757) and monitoring approach; risk 1424 disaggregation; bed availability risk; and Freedom to Speak Up risk (1887) including plan to sample cases for embedded improvements.
NM queried who would conduct FTSU sample review and where the findings will be reported. CJ to confirm with the Guardian and will clarify once known. NM suggested independence (not the same person reviewing their own work).

Action: Caroline Johnson

MF requested that, after a settling-in period, the executive trio provides a comparative assessment on whether the risk register reflects an appropriate risk set, informed by experience and frontline insight in around three months..

Action: Executive Trio

It was RESOLVED to RECEIVE the update.

QSC/26/6 Staff/Team Story (agenda item 6)

Naomi Sutcliffe (NS) Suicide Prevention Lead joined the meeting today to present to the group the Suicide Prevention Strategy and give a presentation in relation to the Apparent Suicide Report.

Naomi outlined planned improvements including increased year-on-year comparison and clearer narrative linking to actions; she also intends to produce more regular “AAA-style” updates rather than solely annual reporting.
MF raised concerns about report data and rolling average calculation consistency; Naomi acknowledged further robust quality checking may be required. CJ requested evidence-based comparative context including “not an outlier” claims be brought back.

Action: Caroline Johnson / Naomi Sutcliffe

Naomi highlighted increase in deaths in under 25’s (especially females under 25), higher prevalence of self-harm history and substance misuse, and noted four inpatient-associated deaths

AF asked about diagnostic background; Naomi stated a diagnostic questionnaire was temporarily lost during Datix changes when the Trust was aligning with the national LPFSE system but this ahs now been reinstated and the next report will capture better; deep dive information.

SThi asked about neurodiversity and deprivation/inequalities; Naomi advised the neurodiversity field had been added to Datix ~18 months prior however noted some complexities and links to culture of care and risk work and emphasised reviewing out-of-scope deaths to ensure they are not excluded due to access barriers.

AF asked about Navigo learning; Naomi confirmed that this was on a list of things to be discussed with Caroline in a forthcoming 1:1.

MK asked whether inpatient suicides make the Trust an outlier; Naomi advised that the Trust was not an outlier but did note some benchmarking limitations and agreed to explore regional comparisons.

The Committee discussed governance of the suicide prevention strategy and advised that it had been presented previously but not formally approved. CJ recommended it return for formal approval after the amendments have been made. MF offered detailed feedback stating that the strategy too detailed at the front and that the logic map at end should be earlier in the report. CJ proposed circulating a word version to the group and then track changes could be made before re-submission for sign-off.

Action: Caroline Johnson

Strategy to return to QSC for formal approval.

Item QSC/26/7 Executive Trio Update inc update of topical & legal risks, escalations, quality impact assessment (QIA) (agenda item 7)
CJ and AF presented the key headlines to the Committee.

Patient flow/escalation:
AF reported that the Trust entered OPAL 4 for one and half weeks in March; OPAL action cards and governance escalation process worked effectively; the wider system supported the Trust; and there were no undue waits for beds.

Women's services pathway:
External review commencing 17–18th April reviewers to visit teams across four places and review pathway/notes. In parallel, EMT approved for a proposal for the mental health care group to recruit an 8B Psychologist to work across four female wards supported by an assistant psychologist on each female ward.

Industrial action
SThi noted that the strike action was managed well. The Trust strike rates were lower than regional peers and that coverage was achieved largely via internal/bank staff with no locum use.

AF and CJ advised that they have been accepted as executive reviewers for CQC well-led inspections.

It was RESOLVED to RECEIVE the Executive Trio Update.

QSC/26/8 CASE Database (agenda item 8)
Clinical Audit & Service Evaluation Database
CJ noted that the database had been improved and that updates are now routinely included within quality/regulatory reporting and advised that audit priorities will also be included when Committee identified any areas of concern. CJ will also be meeting the team to link audit to embeddedness of actions from patient safety incidents.

MF suggested a clearer "overview status" and raised concerns about closure assurance where outcomes are not received due to staff leaving.

It was RESOLVED to RECEIVE the Update

Action: Caroline Johnson

QSC/26/9 Quality & Regulatory Oversight Paper (agenda item 9)
Quality & Regulatory Oversight Update (CQC / MHA)
CJ reported progress against the CQC action plans and confirmed that formal closure had been agreed for both the acute mental health and Cheswold action plans. Ongoing monitoring arrangements remain in place to ensure sustained compliance and to mitigate the risk of regression. A Trust-wide position statement on the closure of blanket restrictions, including access to outdoor spaces, will be presented to the Executive Management Team (EMT) and subsequently to the Committee, with submission anticipated in May.

Action: Caroline Johnson

In relation to whistleblowing, six cases were received during January–February, of which four have been closed and two remain open pending assurance. Updates were provided on Mental Health Act inspections at Beamshaw, Stanley and Newton Lodge, where action plans have been submitted. Recurring themes include the quality of seclusion reviews and the recording of therapeutic activity. Emphasis was placed on the CQC position that effective care must be demonstrable through documentation, and work is underway to strengthen recording practices.

Members discussed benchmarking the volume of concerns raised; Caroline advised that current levels appear broadly consistent with prior organisational experience. It was also noted that the family of an inpatient who died is currently in contact with the CQC. Mike Ford queried why whistleblowing concerns relating to Walton Ward had not been raised via Freedom to Speak Up (FTSU) routes and suggested that local promotion and visibility of FTSU should be reinforced. MF also asked whether the Committee would receive sight of the Trust's draft response to the CQC assessment framework consultation; Caroline agreed that a Committee update would be appropriate, noting that the consultation response is due by 12 June.

Action: Caroline Johnson

The Chair requested that seclusion review work be formally added to the Committee work programme for scrutiny. It was agreed that an integrated report would be brought to the July meeting, incorporating seclusion practice, review processes, training and induction arrangements, documentation standards, and equality and diversity analysis, with contributions from the relevant leads and a target delivery in July is feasible.

Action: Caroline Johnson

It was RESOLVED to RECEIVE and NOTE the Quality & Regulatory Oversight Report.

QSC/26/10 Quality Assurance System Update Report (agenda item 10)
Quality Assurance Update
Caroline reported that the quality assurance system is maturing and strengthening the Trust's ability to identify emerging risks. Eleven quality walk rounds have been completed. Elmdale is entering enhanced monitoring, and peer-to-peer walk rounds are being rolled out in community services. Work is also underway to ensure early warning signals from frontline audits and learning are effectively linked into governance reporting.

The Committee noted the update.

It was RESOLVED to RECEIVE and NOTE the QAS System Update Report.

QSC/26/11 Patient Experience Update Report (agenda item 11)

The Committee considered the Patient Experience Update.

Patient experience results remained high across domains (feeling safe, involvement, and being listened to), at approximately 99% for respondents. CJ reported that, while patient experience metrics remain strong, there has been a 77% increase in formal complaints; despite this increase, complaint-handling timeliness remains strong. She advised that she is exploring the drivers for the increase, with early indications suggesting a link to ADHD/ASD access.

Caroline agreed to bring a deeper analysis of the growth in complaints, including drivers (e.g., ADHD/ASD access), classification and benchmarking comparability, Cheswold contribution, SPC interpretation, and comparator definitions.

Action Caroline Johnson

A new patient experience system is in development (Microsoft solution with automated text messaging), and procurement is underway.

MF highlighted special cause variation within the SPC chart and requested a deeper review to understand and manage the emerging trend. Amy Hartley (AH) shared sector intelligence that the increased use of AI to draft complaints and Subject Access Requests (SARs) may be contributing to higher volumes and accessibility. Members agreed that AI may enable more legitimate complaints to be raised, and that consistency of measurement against peer organisations should be reviewed (e.g., definitions and classification of informal resolution versus formal complaints).

Action Caroline Johnson

The Committee noted the report.

It was RESOLVED to RECEIVE the Patient Experience Update.

QSC/26/12 Internal Audit Reports (agenda item 12)
There were no reports to be received at this meeting.

QSC/26/13 Completion of Actions from Internal Audits (agenda item 13)
Internal Audit – Completion of Actions / Embeddedness
CJ presented the proposal that internal audit follow-up becomes a standing item at the Clinical Governance Group, supported by monthly AAA updates to QSC and a quarterly assurance report. Mike Ford queried whether actions arising from the restraint internal audit were included; Caroline Johnson committed to confirm.

Action; Caroline Johnson

The approach was noted and the strengthening of governance arrangements was supported.

The Committee RECEIVED and NOTED the Update.

QSC/26/14 Pressure Ulcer Update Report (agenda item 14)
The Committee considered the revised Pressure Ulcer Update Report.

The report presented Trust-wide data for the period 1 April 2025 to 31 March 2026, including total incidents and prevalence/incidence breakdowns. Barnsley Physical Health & Wellbeing reported the highest incidence rates, as expected given the clinical model and contact patterns. Improvement work includes specialist review of category 3/4 pressure ulcers (via

Barnsley tissue viability services) and strengthening the quality of photographs and incident reports to support accurate categorisation.

SThi queried whether the category 3/4 review process applies across the Trust or only within Barnsley. The Chair clarified that other places use external tissue viability services and requested that the report wording be amended for clarity.

Action: Caroline Johnson

NM asked about the development of improvement trajectories and targets. Caroline advised that there is an ambition to develop a trajectory; however, achieving 100% reduction may be unrealistic for some categories. A trajectory will be developed through the ongoing improvement programme.

It was RESOLVED to RECEIVE the Pressure Ulcer Update Report.

QSC/26/15 Sexual Safety Report (deferred from March (agenda item 15)

AH summarised staff and service user sexual safety work, noting completion of the national audit and an action plan. She reported that staff reporting has not risen as expected and a more coordinated Trust-wide approach is needed (visibility of posters, communications and staff survey follow-up routes).

The Chair noted concern that incident numbers appear to be rising year-on-year and requested ongoing scrutiny, particularly for patient-on-patient incidents. AF highlighted the need to clarify “red line” thresholds and alignment with restorative/just culture approaches. Mike Ford asked how the Trust compares with other organisations; Caroline Johnson advised trends appear similar elsewhere and causality (reporting vs incidence) remains difficult to interpret.

The Committee noted the report and continued monitoring required.

It was resolved to RECEIVE and NOTE the Sexual Safety Report.

QSC/26/16 Deprivation of Access Report (agenda item 16)

SThi highlighted to the Committee that the action related to the discussion in Mental Health Act Committee (MHAC) where it was noted that people from the most deprived areas nationally were more likely to have a hospital admission to access treatment that could have been avoided if suitable alternatives were available in the community.

Further data analyses focusing on other aspects of quality of admission including length of stay were being reviewed via the performance report data presented to the MHAC.

It was agreed for MK, ST,hi YF and possibly Rokaiya Khan, NED to meet to review the impact of the above discussion and statement.

Action: Subha Thiyagesh

It was resolved to RECEIVE and NOTE the Deprivation of Access Report

QSC/26/17 LeDer Learning Disabilities Mortality Review (agenda item 17)

Learning Disability Mortality Review (LeDeR) – national report

CJ summarised the republished national LeDeR data (2023). Key findings include significant levels of premature mortality and avoidable deaths, with stark inequalities for people from ethnic minority groups and for autistic adults without a learning disability, where the most common causes of death remain suicide, misadventure, and accidental death. The report includes a local action plan.

The Committee asked that future reports provide a comparison between the findings of the National LeDeR report and the Trust's local practice and learning. It also requested inclusion of the Trust's own data, along with evidence of actions taken in response, including monitoring and analysis of avoidable and premature deaths.

Action: Caroline Johnson

AF made reference to annual health check data and SThi highlighted the growth of Green Light Champions (50 across the Trust) and STOMP activity (reducing over-prescribing) as contributing to improved impact.

It was resolved to RECEIVE and APPROVE the report for Trust Board.

QSC/26/18 Medicines Optimisation and Pharmacy Framework and Plan (agenda item 18)

Medicines Optimisation & Pharmacy Framework

SThi presented the revised framework (renamed from "strategy") and confirmed that it includes a clear executive summary. She also confirmed that the year-one plan has been approved by the Drugs & Therapeutics Sub-Committee. MF emphasised the importance of measurable outcomes and metrics to evidence delivery; Subha confirmed that the year-one plan includes actions, owners, target dates and intended outcomes, and will be tracked through governance, with progress updates provided via AAA reporting.

The Chair confirmed the Committee's approval.

It was resolved to RECEIVE and APPROVE the report.

QSC/26/19 Reports from Formal sub-committees (agenda item 19)

The Committee received and noted the Sub-Committee updates.

- RRP training duration: MF queried the Trust's ability to release staff for the four-day course. CJ and AF confirmed that four days reflects national expectations and is essential, particularly for new starters. AF also noted the IPR indicates attendance is occurring

- ICIG: MF raised concern that FOI timeliness is slipping, with potential reputational and financial risks, and requested that this is reported in future updates.

- Safer Staffing: MF requested explicit inclusion of "care hours per patient day" in reporting, not solely safer staffing metrics. Caroline Johnson will pick this up with Tim Mellard.

Action: Caroline Johnson

The Committee RECEIVED and NOTED the Reports from Formal sub-committees Update.

QSC/26/20 Issues and items to be brought to the attention of Trust Board/Committees (agenda item 20)

MK and CJ reviewed the AAA (Assure, Advise, Alert) items to be reported to the Trust Board, covering key topics discussed in the meeting.

Alert

- In light of two female inpatient deaths, an external review of the women's pathway of care has been commissioned. The findings will provide independent assurance and inform the ongoing redesign of the women's pathway. Pending the outcome of the review an action plan has been put in place overseen by EMT. As part of the immediate plan EMT has approved investment in psychological therapy resource across the female wards.
- Timeliness of medical reviews of seclusion continue to be identified in CQC MHA inspections. The committee were advised that review of seclusion practice has been commissioned by the Chief Nurse/director of quality and professions and the Chief operating Officer. A report will be provided to the Committee in July.

Advise

- The Committee received a presentation from the Trust's suicide prevention lead on the apparent suicide report. Key emerging themes included an increase in deaths among those under 25, particularly females, a higher prevalence of self-harm history and substance misuse, and four inpatient-associated deaths in-year (including deaths occurring on leave, AWOL, or within two weeks of discharge). The Committee requested additional benchmarking and comparative data to provide assurance on how the Trust's position compares with peer organisations.
- The Committee requested a review of the governance processes in place for the delivery of actions arising from clinical audits, particularly in relation to handover when the action owners leave the organisation.
- The Committee received the LeDER report based on the republished national LeDER report (2023). The report provided positive updates in relation to improvement activity within the Trust. The committee requested that future reports include Trust level comparative data and impact measures.

Assure

- The Committee received sexual safety report, which provided assurance in relation to the processes in place for oversight. However, the committee noted an increase in year-on-year incidents and requested further analysis of the data and themes.
- The Committee approved the Medicines Optimisation & Pharmacy Framework
- The Committee were advised that the outstanding CQC actions were agreed for closure except for the access to outdoor space action which is awaiting a closure report in May for review by EMT

QSC/26/21 Risk Register Review (agenda item 21)

CJ asked if any discussion during the meeting would change decisions about public risks on the risk register; the Committee confirmed there were no changes needed based on the items reviewed.

QSC/26/22 Work Programme (agenda item 22)

Mike Ford requested that the work programme be tidied to remove legacy items that have been transferred elsewhere. CJ advised that these items would be removed after the start of the new financial year, and that a broader Committee review is commencing. AF suggested reconsidering the frequency of the Executive Trio report, citing workload pressures and limited time to evidence progress. The Committee agreed that this would be included within the committee review.

QSC/26/23 Date and time of next meeting (agenda item 23)

19 May 2026- MS Teams

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of Quality & Safety Committee
19 May 2026
12.30 -15.00
MS Teams

Present:	Margaret Kitching (MK) Nat McMillan (NM) Mike Ford (MF) Caroline Johnson (CJ Prof Subha Thiyagesh (SThi) Adele Fox (AF)	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director Chief Nurse / Director of Quality and Professions (Lead Director) Chief Medical Officer Chief Operating Officer
Apologies:	Sarah Harrison	PA to Chief Nurse / Director of Quality & Professions
In attendance:	Jane Barratt (JB) Amy Hartley (AH) Dr Kiran Rele (KR) Laura McClure (LMc) Dr Sam Willerton (SW)	PA to Chief Executive (Copilot) Deputy Director of Nursing, Quality & Professions Consultant Psychiatrist General Manager, Barnsley CAMHS (Item 6) Principal Clinical Psychologist (item 6)
Observing	Debi Gibson (DG)	West Yorkshire ICB

QSC/26/28 Welcome, introduction and apologies (agenda item 1)
Margaret Kitching (MK) welcomed attendees, noted apologies as above, and confirmed that Debi Gibson of West Yorkshire ICB was observing as part of a trial of ICB attendance to widen oversight and transparency. The meeting was quorate and proceeded.

QSC/26/29 Declarations of interest (agenda item 2)
No additional declarations were made beyond those previously recorded.

The Quality & Safety Committee NOTED the declaration.

QSC/26/30 Minutes from previous Quality and Safety Committee meeting held 14 April 2026 (agenda item 3)
The minutes of 14 April 2026 were approved as an accurate record, subject to NM's amendment that the *Learning from Deaths* section should better reflect the expectation that learning be translated into immediate practice improvements.

MF noted that Julie Hall should be removed from the attendance list following a role change.
Action: Sarah Harrison

MF also noted that some expected actions, particularly on the clinical audit database and patient experience variation, had not been recorded, and raised a governance concern that private section minutes must be removed before papers progress to Board.

It was agreed that Caroline Johnson (CJ) would amend the *Learning from Deaths* wording to reflect immediate application of learning and review where actions may have been implied but not formally recorded.

Action: Caroline Johnson

MK highlighted a recurring theme of assurance around patient safety data is stronger than for patient experience.
She noted that complaints, surveys and qualitative feedback are not yet triangulated as robustly as incident data, limiting organisational insight. MK framed this as a wider NHS challenge and an opportunity for the Trust to strengthen its approach and show leadership.
Members agreed that better triangulation would strengthen assurance to the Board by identifying themes earlier, testing assumptions, and integrating patient experience more deliberately into governance.

Executive team to explore and bring forward a structured approach to triangulating patient experience data alongside safety and performance metrics

Action: Caroline Johnson

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 14 April 2026 as a true and accurate record.

QSC/26/31 Matters arising from previous Quality & Safety Committee meetings and action log (agenda item 4)
The action log was reviewed, and the following was noted:

QSC 26.5 Review of Committee Related Risks
Freedom to Speak Up (FTSU)

- Further detail to be provided on how learning from FTSU cases is embedded across the organisation.
- Outcome of the rescheduled review meeting to be reported back to Committee.
- **Action:** Bring full update to Quality & Safety Committee.
- **Timescale:** July meeting.

QSC 26.5 – Review of Committee Related Risks
Risk Register Review Timing

- Clarification that the review cycle relates to July and September
- **Action:** Amend wording in the action log to reflect correct timescales.

QSC 26.6 –Staff / Team Story
Data Quality / Rolling Average

- Data has been updated; however, Committee members require formal assurance and clarity as it has not been clearly sighted.
- **Action:** Revised data and explanation to be brought back to Committee for review prior to closure.
- **Timescale:** Next meeting (June).

QSC 26.16 – Deprivation of Access Report

- Update pending following newly arranged meeting with stakeholders.
- **Action:** Progress work and bring report back to Committee.
- **Timescale:** June meeting.

QSC 26.19 – Reports from Formal Sub Committees
Safer Staffing AAA

- Required data now included within agenda papers.
- **Action:** None – item agreed complete.

QSC 25.229 – Executive Trio Update
Blanket Restrictions / Locked Doors

- Work delayed due to staff absence; Committee agreed to receive a complete report rather than partial update.
- **Action:** Final report to be completed and presented.
- **Timescale:** June meeting (then closed following assurance).

QSC/25/234 Internal Audit Report
Mixed Sex Arrangements – Beechdale

- Review confirmed no breach of mixed-sex accommodation standards.
- **Action:** None – item closed following assurance.

QSC/25/237 – Sexual Safety Report

- Reporting to be integrated into routine reporting cycle to provide ongoing assurance.
- **Action:** Implement revised reporting approach. Item closed

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QSC/25/205 – Quality & Regulatory Oversight Report
Post-Repair / Water Quality Checks

- No contamination identified; ongoing monitoring in place.
- **Action:** None – item closed, with continued vigilance noted.

QSC/25/206 – Quality Strategy Update

- Refresh deferred pending publication of national Quality Strategy.
- **Action:** Hold until national guidance available.

QSC/25/177 – Review of Committee Related Risks
Risk Disaggregation

- Update provided through ORR report.
- **Action:** None – item closed.

QSC/25/180 Patient Experience Update
Further work required to improve capture and triangulation of patient experience data.

- **Action:** Develop approach and bring update to Committee.
- **Timescale:** June meeting.

QSC/25/181 Safer Staffing – Establishment Review

- Full review completed but still undergoing EMT scrutiny.
- **Action:** Present full establishment review to Committee.
- **Timescale:** June meeting.

QSC/25/163 – R&D Strategy

- Further development required following EMT feedback and completion of Equality Impact Assessment.
- **Action:** Re-submit strategy via EMT and bring to Committee in final form.
- **Timescale:** July meeting (ahead of Board).

QSC/26/32 Review of Committee related risks, update following Board discussion (agenda item 5)
The revised risk register, including the disaggregation of a previously broad risk, was welcomed as giving clearer visibility of specific risks and how they are managed.
Members said the revised format would improve scrutiny by enabling clearer tracking of trends and movement over time. Future reports will present consistent scoring for all risks to support comparison.

MK noted that the improved visibility supports stronger governance and assurance.

It was RESOLVED to RECEIVE the update.

QSC/26/33 Staff/Team Story (agenda item 6)

Laura McClure, General Manager for Barnsley CAMHS, and Dr Sam Willerton, Principal Clinical Psychologist, joined the meeting to present quality improvement work that has significantly improved waiting times for children and young people.

The CAMHS team presented data-driven improvement work to reduce waits to the 18-week standard, reporting performance at about 94% compliance.

Discussion focused on both success factors and the risks to sustaining performance, including workforce instability, high demand and wider system pressures. The team said improvements had come from better data quality, stronger oversight, multidisciplinary working and more flexible whole-service approaches.
CJ asked about sustainability, noting that early gains from QI can be hard to maintain. AF asked how additional workforce support, particularly in learning disability pathways, could help, and MF sought assurance that learning from Barnsley had been shared across the Trust.

In response, the team outlined how changes had been embedded into routine practice through job plan reviews, stronger caseload management and regular oversight meetings. Members were reassured by the collaborative approach, continuous monitoring and visible clinical engagement.

Members strongly supported the work, describing it as a strong example of improvement methodology in practice and emphasising the need to continue monitoring to sustain gains.

IQSC/26/33 Executive Trio Update inc. update of topical & legal risks, escalations, quality impact assessment (QIA) (agenda item 7)

The Trio report prompted discussion of both strong performance and ongoing risks. Members noted progress in the emergency department improvement programme, including reduced waiting times for mental health patients, but identified uncertainty around future national policy, particularly 24-hour mental health hubs, as a developing strategic risk.

Discussion also covered early findings from the women's services review. While feedback pointed to a positive culture and committed staff, members noted a lack of clarity around the clinical model, with possible implications for service delivery and patient flow.

The most detailed discussion focused on staffing pressures at The Poplars. Members recognised the operational effort to maintain safe staffing despite high vacancies and reliance on bank staff but questioned the sustainability of this model given fluctuating acuity and wider workforce pressures.

MK summarised that current arrangements were maintaining safety but did not offer a stable long-term solution.

The Trio were asked to undertake a detailed deep dive on Poplars staffing and sustainability to be presented to the Committee.

Action: Trio

It was RESOLVED to RECEIVE the Executive Trio Update.

QSC/26/34 Approval of Quality Account (agenda item 8)
CJ introduced the Trust's Quality Account, inviting the Committee to consider how the organisation's quality narrative is presented externally.

Members agreed the document had improved significantly and now presented the Trust's strategy, performance and priorities in a coherent, accessible way, reflecting both the breadth of activity and a positive trajectory.

Discussion then turned to tone and risk. NM questioned whether the statement that "quality and safety will never be compromised" fully reflected the realities of financial constraint and competing pressures, stressing the need for public statements to remain credible and defensible.

Members discussed the meaning of "quality", recognising that while patient safety must remain non-negotiable, other dimensions such as experience or responsiveness may be affected by available resources. MK emphasised balancing ambition with honesty in public-facing documents to maintain trust and avoid reputational risk.

The Committee agreed that a small but important wording refinement would strengthen the document and better reflect both organisational commitment and context.

It was RESOLVED to RECEIVE the Update

QSC/26/35 Internal Audit Report (agenda item 9)
Internal Audit Report – Care Planning and Risk Assessment.
CJ presented an update on the internal audit of risk assessment and care planning, which had received a limited assurance rating and prompted detailed discussion.

Members focused on underlying causes and implications. They noted that concerns about the quality and consistency of risk assessments, and how these translate into care plans, were longstanding rather than unexpected, as MF observed.

Discussion moved beyond documentation to culture and practice. Members noted that processes can become overly focused on completion and compliance rather than clinical purpose, with risk assessments at times treated as administrative tasks instead of dynamic tools to guide care.

AF added that some findings also reflected policy clarity rather than clinical practice alone. For example, expectations for "fully completed" risk assessments did not always fit the stage of a patient's journey, such as initial triage, so some services may have been assessed against requirements that were not practically applicable.

The Committee agreed that both structural and practice issues needed to be addressed through a combination of policy review, workforce training and stronger clinical ownership.

Members emphasised that the response must be robust and sustained, with the audit treated as part of a continuous improvement programme supported by quality improvement methodology.

It was agreed that a comprehensive action plan would be brought back to the Committee, with monthly updates and embedded quality improvement support to maintain oversight and deliver sustainable change.

Action: Caroline Johnson

It was RESOLVED to RECEIVE and NOTE the update.

QSC/26/36 Clinical Strategy Update (agenda item 10)

The Committee received a progress update on the Clinical Strategy, presented as a thematic overview across the six priority domains.

Although the report covered a wide range of initiatives, including digital innovation, workforce development, research and care improvement, discussion focused on how strategic progress is evidenced and tracked.

MF questioned whether the examples represented the full scope of delivery or only selected highlights, noting that without the full implementation plan the Committee could not easily assess overall progress and trajectory.
It was clarified that a full implementation plan exists and that the report highlighted key areas rather than the full detail. Members agreed, however, that greater visibility would strengthen oversight by showing how individual actions contribute to delivery of the wider strategy.

STHi noted that much of the work is delivered in an integrated way across multiple programmes, including digital and research, which can reduce visibility but also reflects a more joined-up approach.

It was agreed to provide fuller visibility of the implementation plan, either in the report or as an appendix, and to present progress in a way that shows overall delivery as well as individual highlights.

Action: Caroline Johnson

NM requested the opportunity to attend a clinical strategy group meeting and it was agreed that this could be arranged.

Action: Caroline Johnson

It was RESOLVED to RECEIVE and NOTE the Clinical Strategy Update.

QSC/26/37 Pressure Ulcer Update Report (agenda item 11)

The Committee reviewed the pressure ulcer report, noting incident numbers and the split between prevalence and incidence cases.
Members said the lack of contextual data limited meaningful interpretation. AF noted that, without an SPC chart, it was not possible to judge whether performance was improving, deteriorating or stable.

MF added that, as this was the first report of the new year, comparative data from previous periods would be especially important.

MK added that changes to national definitions and categorisation could also affect reporting and interpretation, and stressed the need to align with national standards so data remains accurate and comparable.

Members agreed that, although the underlying data may be sound, the current format does not provide sufficient assurance.

The following actions were agreed: Caroline Johnson

- Include SPC chart in future reports to demonstrate trends
- Provide comparative data (e.g. previous year or rolling periods)

- Ensure alignment with national reporting standards to support interpretation

It was RESOLVED to RECEIVE the Pressure Ulcer Update Report.

QSC/26/38 Infection Prevention & Control Annual Report (agenda item 12)
The Committee received the annual Infection Prevention and Control report, which summarised performance against national standards over the reporting period.

Members noted strong overall compliance, with most assurance criteria fully met. Infection rates remained low, with no MRSA or Clostridioides difficile cases and one case of Klebsiella bacteraemia. Improvements in outbreak management, including rapid response teams and enhanced governance, were also seen as strengthening the Trust's response capability.

Members also considered areas needing attention, particularly partial compliance on FFP3 fit testing. MK noted that universal compliance across all staff would not be proportionate for mental health and community services, given that many staff do not undertake procedures requiring such equipment.

The Committee emphasised that staff undertaking higher-risk interventions must be fully trained and compliant. Members were reassured on this point but asked future reports to distinguish between whole-workforce compliance and compliance within relevant staff groups.

The report also highlighted priorities for the coming year, including improving vaccination uptake and hand hygiene compliance. Members agreed that continued focus in these areas would be needed to maintain standards and reduce risk.

It was RESOLVED to RECEIVE and NOTE the IPC Annual Report.

QSC/26/39 R&D Strategy (deferred from March 2026) (agenda item 13)
The Committee was advised that the R&D Strategy had been deferred following discussion at EMT.

STHi explained that, although EMT had considered a draft, further refinement was needed in response to executive feedback, completion of the Equality Impact Assessment, and alignment with other organisational priorities.

It was agreed that the strategy would return to EMT after further development and then come back to the Committee in a near-final form. Members preferred a more complete and scrutinised version rather than an early draft, to support effective review.

The discussion reflected the Committee's preference for quality and completeness over speed, given the strategy's importance to longer-term development and innovation.

The R&D Strategy will return to the Committee once further refinement is complete, provisionally in July.

The update was NOTED.

QSC/26/40 Patient Safety Learning Audit (agenda item 14)
The Committee received a report on developing a more structured link between patient safety learning and audit activity, following an earlier request for stronger assurance that incident learning is embedded in practice.

CJ said this was a relatively new development, bringing together patient safety and effectiveness teams to align audit activity with the Trust's safety priorities so that high-risk areas and key learning receive targeted review.

Members welcomed the shift from traditional audit towards testing whether changes from incident learning are implemented and sustained.

Members recognised that this represents a more mature approach to assurance, linking data, learning, and practice in a continuous improvement cycle.

The Committee recognised this as a more mature assurance approach. Although still at an early stage, members welcomed the direction of travel and agreed that future reports should show how the model is being operationalised and what impact it is having on patient safety outcomes.

It was RESOLVED to RECEIVE the Patient Safety Learning Audit.

QSC/26/41 EMT Approved Position Statement on Blanket Restrictions (agenda item 15)

The Committee revisited an action on blanket restrictions, particularly locked doors and patient rights. A full report was still outstanding, partly because of staffing challenges and the absence of a key policy lead.

CJ explained that concerns first arose when doors remained locked after estates work, prompting a broader review of blanket restrictions and the application of relevant policies.

Review indicated that the main issue lay not with the policy itself but with consistent implementation in practice. Further assurance work had increased confidence that processes were broadly robust, though some variation in adherence remained.

Discussion also touched on the wider governance framework, including EMT's role in approving position statements that clarify organisational expectations and standards.

Members agreed that, although progress had been made, a full and considered report would provide a stronger basis for assurance. Full consideration was therefore deferred until a comprehensive report is available.

The Committee agreed that it was preferable to defer full consideration until a comprehensive report could be presented once available, ensuring that any conclusions or decisions were based on robust evidence.

It was resolved to RECEIVE and NOTE the Approved Position Statement on Blanket Restrictions.

QSC/26/42 Reports from Formal sub-committees (agenda item 16)

The Committee formally received a range of subcommittee AAA reports.

- Infection Prevention & Control
- Safeguarding
- Safer Staffing
- Nutrition
- Medical Devices
- Sexual Safety

Although the reports were largely taken as read, discussion highlighted a governance issue about how “alerts” in AAA reports are interpreted and handled.

MF questioned how alerts are escalated and tracked, and whether all alerts are intended for the Quality & Safety Committee or some are for other governance routes.

This led to a wider discussion about consistency and clarity in AAA reporting, with MK noting that some items labelled as alerts did not appear to meet the threshold, while others may not have been emphasised enough.

It was agreed that feedback will be given on the reports:-

- Clarify within AAA reports:
  - Which alerts require Committee attention
  - Which are delegated elsewhere
- Introduce a mechanism to track previous alerts and their resolution, ensuring governance closure
- Review training/expectations for subcommittee leads completing AAA reports

Action; Caroline Johnson

The Committee RECEIVED and NOTED the Reports from Formal sub-committees Update.

QSC/26/43 Issues and items to be brought to the attention of Trust Board/Committees (agenda item 17)
MK and CJ reviewed the AAA items to be reported to the Trust Board, covering the key issues discussed at the meeting.

Alert
- Internal Audit, Care Planning and Risk Assessment
- Workforce Pressures (Poplars)

Advise
- .Women’s services pathway
- Work on restrictive practices

Assure
- CAMHS presentation on reducing waiting times to 18 weeks
- IPC Annual Report

QSC/26/44 Risk Register Review (agenda item 18)
CJ asked whether any discussion during the meeting changed the position on public risks; the Committee confirmed that no changes were required.

QSC/26/45 Work Programme (agenda item 19)
The Committee reviewed the forward work programme in light of the short interval before the next meeting.

MK proposed a pragmatic approach to agenda setting, prioritising key items and avoiding unnecessary pressure that could weaken report quality or scrutiny.

Members supported this approach, recognising that overloaded agendas can dilute focus and reduce meaningful scrutiny of complex issues.

It was agreed that the next agenda should therefore be streamlined, with priority given to:

- Items requiring escalation or follow-up
- Key statutory or assurance reports
- Areas where further scrutiny has already been identified

The executive team confirmed that alignment between EMT processes and Committee reporting should support timely preparation of core papers.

QSC/26/46 Date and time of next meeting (agenda item 20)

9 June 2026- MS Teams

South West Yorkshire Partnership Teaching NHS Foundation Trust

Minutes of Mental Health Act Committee Meeting
Wednesday 4th March 2026
Virtual Via MS Teams

Present:	Rokaiya Khan (RK) Margaret Kitching (MK) Gary Ellis (GE) Caroline Johnson (CJ) Subha Thiyagesh (ST) Darryl Thompson (DT)	Non-Executive Director (Chair of Committee) Non-Executive Director Non-Executive Director Chief Nurse / Director of Quality and Professions Chief Medical Officer (CMO/Lead Director) Chief Nurse / Director of Quality and Professions
Apologies:	Chris Lennox (CL)	Director of Services, Adults and Older People Mental Health
In Attendance:	Julie Carr (JC) David Longstaff (DL) Yvonne French (YF) Carly Thimm (CT) Claire Wilkinson (CW) Sarah Burns (SB)	Clinical Legislation Manager Chair of Independent Associate Hospital Managers Associate Director of Legal Services Mental Health Act/MCA Senior Manager (Trust Wide) Quality, Governance and Performance Lead PA to Chief Medical Officer
Presenting	Esther Loganathan (EL)	Higher Trainee in Forensic Psychiatry
Observing	Mike Ford (MK)	Non-Executive Director

MHAC/26/01 Welcome, Introduction and Apologies (Agenda item 1)
The Chair, Rokaiya Khan (RK) welcomed everyone to the meeting.

The meeting was deemed to be quorate, and the apologies were noted.

MHAC/26/02 Declarations of Interest (Agenda item 2)
The Committee noted that there were no new declarations of interest.

MHAC/26/02a The Act in Practice – Medical Recommendations Audit (Agenda item 2a)

ST provided an overview of the work undertaken. EL and colleagues completed a significant and valuable piece of work, and discussions took place about how best to share the findings, recommendations, and learn from this. This includes dissemination both across the Trust and more widely, given the relevance of the work to quality improvement and the importance of medical recommendations when service users are detained under the Mental Health Act.

It was thought that the Mental Health Committee would particularly benefit from hearing this work, to support understanding of current gaps, the proposed actions to address these, and the ways in which the Mental Health Act team is contributing to this programme of improvement.

EL is based at Newton Lodge, medium secure unit, Fieldhead. The clinical audit was completed under the supervision of Dr Mike Ventress during her low secure placement.

EL explained that the audit is titled 'The Quality of Medical Recommendations'. EL outlined that the choice of topic stemmed from recognising that the decision to detain an individual under mental health legislation is one of the most significant and consequential decisions made within psychiatry. EL emphasised that such decisions must be grounded, meticulous, and clearly documented, with robust clinical justifications for why a person should be deprived of their liberty.

Medical recommendations for a Section 2 or Section 3, explicitly states that "reasons should be given to explain how the symptoms and behaviour lead you to an opinion."

When recommendations are submitted as part of the statutory legal process, they are sent to a Consultant Psychiatrist within the Trust to approve them as being medically sound.

The aim of the audit was to compare clinical practice within the Trust against the statutory guidance set out in the Mental Health Act Code of Practice, as well as the requirements specified within the statutory forms themselves.

EL explained that doctors are introduced to the MHA assessment during undergraduate training as part of their university curriculum. When students come to the Trust on placement, they also receive further learning and exposure to the process.

EL explained that in postgraduate training, doctors learn about completing these forms during their psychiatry rotations, through induction programmes, Section 12 training, and within supervision sessions with their clinical and educational supervisors. When attending Mental Health Act assessments in the community, they are then able to put this learning into practice. Completing the forms in real situations and receiving feedback on them further develops their skills and confidence.

EL met with the Head of Research from the Trust's Clinical Research Team to seek advice and discuss the scope of the project.

A sample of 50 historical medical recommendations was provided by the Mental Health Act Office, covering the period from January to June 2025. The intention had been to review Section 2 and Section 3 recommendations, including both single and joint recommendations, and to initially focus on the Wakefield area.

However, EL noted that the sample provided consisted only of Section 3 single recommendations from across the Trust, and this was identified partway through the data-collection process. Given that the work was already halfway completed, the decision was made to continue to the end.

The data for the audit was collected through a review process conducted by two reviewers over a three-month period, between August and October 2025. It is noted that only one of the reviewers was Section 12 approved. Where there was any disagreement about whether specific criteria had been met, the form was referred to a third reviewer, who was also Section 12 approved. A final decision was then made as to whether the criteria were considered to have been met.

The audit reviewed eight elements: whether the doctor stated the mental disorder, described symptoms, addressed nature or degree, and gave adequate reasons relating to the patient's health, safety, or protection of others. It also assessed whether doctors explained why treatment in the community was not appropriate and why informal admission was not suitable.

The team did not rely solely on their own judgement of what was sufficient. Instead, they referred directly to the Mental Health Act Code of Practice to determine what is considered acceptable and used this guidance to inform their assessments.
The audit showed full compliance in documenting the mental disorder, describing symptoms, addressing nature or degree, providing reasons related to the patient's health, and explaining why informal admission was not suitable.

Areas requiring improvement included only partial compliance in giving reasons related to the protection of others and explaining why community-based treatment was not appropriate, All the medical recommendations reviewed had passed consultant scrutiny and were lawful. The findings therefore related to opportunities to improve the quality of documentation, rather than any concerns about legality

The audit findings were shared with medical colleagues across the Trust to gather their views on potential improvements. Initial feedback was presented to the Forensic Services Teaching Programme, followed by a Trust-wide presentation at Joint Academic Psychiatric Seminar (JAPS). Two suggestions were put forward: the first was to develop a guidance template for all doctors, not as a prescriptive format but to outline the minimum information that should be included, while still allowing clinicians to add further detail as appropriate.

Further work is planned with the Mental Health Act Office to explore developing a documentation template.

A second area under discussion is how individual feedback from consultant scrutiny could be shared directly with doctors in a supportive way.

If these proposed changes are implemented, the team intends to allow time for them to embed and then repeat the audit in approximately three to six months to assess whether the quality of medical recommendations has improved.

RK advised that it would be beneficial for the Mental Health Act Committee to receive the findings and feedback arising from the three- to six-month review once completed.

MK observed that questions four and five appeared very similar and could easily be mistaken as duplicates, which may potentially contribute to lower compliance. MK suggested if possible, separating or distinguishing these more clearly on the form.

EL agreed this was a helpful point and noted it may explain some of the issues seen in the audit. Although the two criteria sit within the same section of the Code of Practice, they are separated on the statutory form and refer to different considerations. This distinction may not always be clear to doctors completing the forms.

ST stated that the layout of the statutory form is consistent with the Code of Practice, .ST agreed with MK's point regarding the wording around health and safety, though explained that the two criteria can represent different situations, for example, where a person's health may be deteriorating but their safety is not yet at risk. Because of this, each risk can be struck out separately on the form.

GE questioned whether, in the areas that did not achieve full compliance, were there any trends or themes which had emerged that might help explain the lower levels of compliance.

ST enquired whether, during the JAPS presentation, there had been any feedback that might explain why the 'patient's own safety' criterion scored lower than others. ST noted that the template may help address this though was interested in whether doctors had identified any barriers or reasons for the lower compliance in that specific domain. ST added that it was reassuring that all detentions were lawful, but that qualitatively it would be helpful to understand the variation. ST acknowledged that, as MK had pointed out, some doctors may view 'health' and 'safety' together and not distinguish them clearly on the form.

EL noted that there had been no specific feedback from doctors at the JAPS session. The presentation had already outlined examples of what was and was not acceptable for the health and safety criteria, which may be why no additional comments were offered.

DT thanked EL for beginning the presentation by emphasising the gravity of decisions that involve depriving a person of their liberty. DT noted that, although these decisions are made frequently in clinical practice, it is important not to lose sight of their significant human impact and appreciated the grounding tone this had set.

It was RESOLVED to RECEIVE the presentation from the Medical Recommendations Audit

MHAC/26/03 Minutes from previous Mental Health Act Committee Meeting held on 10th December 2025 (Agenda item 3)
There were no further amendments or corrections to the minutes from 10th December 2025.

It was RESOLVED to APPROVE the minutes from previous Mental Health Act Committee meeting held on 10th December 2025

MHAC/26/04 Matters arising from previous Mental Health Act Committee meeting held on 10th December 2025. (Agenda item 4)
Committee agreed that there were no matters arising from the previous meeting, other than those on the Matters Arising action log.

- MHAC/25/52 Performance Report - CT explained that the item remains open and pending for Quarter 1. She noted that she and Mike Garnham have a meeting on 26 March, so the work is in progress and will be reported from Quarter 1. Action remains open.

MHAC/26/05 Care Quality Commission Visits (Agenda item 5)
MHAC/26/05a Care Quality Commission: MHA 1983 Visit, Summary Action and Updates Report Quarter 3 2025/26 (Agenda item 5.1)
MHAC/26/05b Mental Health Care Group Action Progress (Mental Health) (Agenda item 5.2)
The Committee agreed to take the paper as read.

CT explained that over the last 12 months the CQC has adapted its approach to Trust visits, moving to a multi-ward, service-line-led model. This has resulted in more complex action plans covering multiple areas, unlike previous single-ward plans which were simpler and quicker to process. CT noted that this shift has contributed to delays in recent action plans. CT and CW have recently reviewed the situation and are working to adapt the governance structure around CQC action plans to respond to these changes.

For example, the Trust-wide CTO visit in October had highlighted these challenges. As it was a Trust-wide visit, the actions span services across the whole Trust.

Future multi-ward CQC visits will require Matrons and Ward Managers to complete actions specific to their areas. CW will then provide governance oversight by collating these into a single Trust-wide response, enabling clearer identification of variation across service lines and any additional governance or assurance required. This approach should help ensure that reports presented to Directors are more robust and support quicker turnaround times.

CJ stated that many of the repeat themes, including those highlighted by the CQC, will also begin to appear through the Trust's own quality visits. CJ noted the importance of bringing all the governance processes together so the Trust can clearly demonstrate learning and improvement. It would be of use to look at governance processes within directorates and how these link together, which may also help make some of the work easier to manage.

CW explained that although an overarching theme such as care planning may appear on more than one occasion, it is not always the same care-planning issue. The Trust may improve in one area, such as strengthening the patient voice within care plans, though still needs to continue improving to reach a gold-standard level overall. This reflects the ongoing, continual quality improvement process the Trust is engaged in.

MK commented that, when looking at the 16 outstanding actions, it seemed that the actions themselves had largely been completed, though the Trust had not yet gained full assurance that they were embedded. MK suggested that it may be clearer in future to reflect this distinction, as some areas will naturally take longer to evidence assurance. MK felt that continuing to label these as 'outstanding actions' might give the wrong impression and offered this as a point for future consideration.

CJ questioned whether the Trust has the right audits in place, so the audit framework is not constantly shifting, so key issues are consistently picked up rather than the Trust reacting to themes as they emerge. CJ noted the importance of being clear from the outset about what assurance is needed to close actions, as some actions become difficult to sign off.

RK queried the working adults' services, noting that they appeared to account for the majority of new and overdue actions this quarter, and asked whether anything specific was contributing to this.

CW clarified that some of the actions relating to working age adults sit outside the care group's direct control. Five of these actions relate to environmental issues, such as courtyard areas, where the service is waiting for Estates work to be completed. Other actions relate to care planning and risk assessment, where the focus is now on how the Trust gains assurance that actions taken are having the desired impact. CW acknowledged the points made by MK and CJ and would discuss further with CT.

It was RESOLVED to RECEIVE the Care Quality Commission Visits, Care Quality Commission: MHA 1983 Visit, Summary Action and Updates Report Quarter 2 2025/26 and Mental Health Care Group Action Progress (Mental Health)

MHAC/26/06 Feedback from Local Partners (Agenda item 6)
MHAC/26/06a Partner Engagement Report (Agenda item 6.1)
The Committee agreed to take the paper as read.

CT reported that the service-level agreements with all acute partners are progressing well and are due to be signed off shortly, providing a further 12 months of collaboration with acute trusts. CT confirmed that finance arrangements have now been resolved, enabling the Trust to recharge for work delivered under the SLAs, which is a positive development and has been fully set up with Finance.

CT noted that meetings with CAMHS and PLT colleagues are sometimes postponed or delayed due to the nature of both services' workloads. The team is considering rebranding the group to encourage improved engagement and attendance and may also explore separating it into CAMHS and PLT if this would better meet clinicians' needs and provide more effective support.

CT reported that there has been a change in the Chair of the Hospital Managers, as mentioned earlier by DL, with Clive Barratt appointed as the new Vice-Chair.

Overall, CT noted that partnership working continues to be strong, with no negatives identified and good levels of support across all parties involved.

GE emphasised that when meetings are repeatedly postponed, it creates a sense of a gap in communication. While acknowledging the routine contacts in place, GE questioned whether the meeting is still necessary and, if it is, stressed that it needs to take place consistently.

CT agreed with GE's point and explained that there is frequent contact with CAMHS colleagues, often several times a week about specific cases, so the operational links remain strong. The level of day-to-day engagement may mean the formal meeting is no longer required in its current format, as professionals are naturally checking in and supporting one another.

For context, ST explained that the departmental engagement work has developed over the last few years, crediting both CT and YF teams for leading this. ST noted that advocacy had previously been a recurring issue highlighted during CQC visits, with concerns that referrals were not routine and service users were not consistently involved. This was taken forward as a quality improvement project by CT and others, with proactive engagement of advocacy providers. For example, when Cheswold Park was incorporated, relationships were already established to support continuity of advocacy services. Some engagement work has been driven by past issues, while other elements have been pre-emptive, and provided this context to outline how the current approach has evolved.

RK welcomed the focus on strengthening the patient voice within hearings, particularly ensuring it is captured effectively when patients do not attend in person.

It was RESOLVED to RECEIVE the Feedback from Local Partners and the Partner Engagement Report

MHAC/26/06b Independent Hospital Managers Feedback (Agenda item 6.2)

DL stated that, following the merger with Cheswold Park colleagues, there had initially been some differences in processes, though the teams are now working together effectively.

DL noted that managers are chairing and liaising across both sites, with mixed panels involving existing Hospital Managers and the new colleagues from Cheswold Park, which is working well.

DL acknowledged the challenges posed by distance though confirmed that all hearings are being covered. Some Cheswold Park managers also hold roles in Nottingham and Lincolnshire, bringing different perspectives that can be helpful in challenging existing thinking. DL concluded that while full integration may take up to 12 months, progress is positive and, in time, distinctions between teams will become minimal.

It was RESOLVED to RECEIVE the Independent Hospital Managers Feedback.

MHAC/26/07 MHAC Annual Review (Agenda item 7)
MHAC/26/07a Annual Report (Agenda item 7.1)
RK explained that this section relates to bringing together all annual review materials, including the annual report, committee activities, terms of reference, the forward work programme, and the committee's self-assessment.

RK noted that the Committee is being asked to review these documents and confirm that the current structure, remit, and work programme remain appropriate and fit for purpose.

RK introduced the annual review and hoped that members had an opportunity to read the paper. RK explained that it provides an overview of the Committee's activity over the year, bringing together the various sources of information relating to Mental Health Act activity across the Trust. Overall, the report confirms that the Committee has provided appropriate assurance during the year, while recognising the increasing complexity of both the legislative and operational environment. RK highlighted that the team is mindful of this and is already considering forward planning, particularly in light of the forthcoming Mental Health Act Reform and the Liberty Protection Safeguards discussed at the previous committee meeting.

RK noted that the report reflects a stable compliance position overall, while also highlighting the increasing systems and legislative complexity the Trust is operating within. RK acknowledged this and, with no further questions from committee members, confirmed that the Committee was happy to approve the annual review.

MHAC/26/07b Terms of Reference (Agenda item 7.2)
RK referred to the Terms of Reference noting that a small number of queries and suggestions had been submitted and confirmed that one of the recommendations had been accepted and incorporated.

Regarding the Terms of Reference, RK drew attention to point 18 under the duties of the group, which states that the Committee should consider the experiences and views of service users, carers and families, with a particular focus on vulnerable groups, Black, Asian and minority ethnic communities, and those with protected characteristics. RK noted the wider discussions taking place at Trust Board level about ensuring Equality, Diversity and Inclusion (EDI) is fully embedded across all groups and highlighted the importance of reflecting this focus within the Committee's work.

In relation to point 18 in the Terms of Reference. RK queried whether the wording could be strengthened by changing "to consider" to "to ensure," in line with the Trust-wide focus on embedding EDI across all groups. RK acknowledged that some felt this responsibility may sit more appropriately within the wider EDI remit and invited views on whether the committee group should adopt the strengthened wording.

ST noted that this was an important point in the context of the Trust Board's priorities around EDI. ST explained that if the wording in the Terms of Reference were changed from "to consider" to "to ensure," the Committee would need to be clear about what this entails in practice. ST observed that, to some extent, the Committee already fulfils this expectation, for example, through reviewing performance data such as length of stay by protected characteristics, and through the annual report on protected characteristics, now in its third year. These could be viewed as evidence of assurance. ST added that if the Committee thought this was not sufficient, additional work might be required, which may include drawing on information from the Mental Health Act and Mental Capacity Act teams and working closely with operational colleagues to demonstrate delivery. Consideration would also be needed regarding how this would interface with the EDI team and whether further capacity would be required.

RK was happy to hear views from the committee and fully acknowledged that an EDI lens is already evident in the Committee's work. RK noted that the suggestion was simply about strengthening the wording, recognising the difference between "ensure" and "consider," even if the distinction is partly semantic. RK felt assured that the Committee already maintains a strong focus on EDI.

YF explained that the key concern was ensuring the team can deliver what the Committee requires and noted that the comment was made simply to highlight this responsibility and confirmed that, where delivery is possible, the team will deliver it.

RK expressed full confidence and thanked YF for the clarification. RK was happy to keep the wording as it stands, noting that the EDI lens is clearly evident in the Committee's work. RK also thanked the team for incorporating the other small amendments suggested by ST to the Terms of Reference.

MF commented that, as part of the wider governance process, Committee Chairs will attend future Audit Committee meetings to present their approved annual reports.

With no further questions from committee members, RK confirmed that the Committee was happy to approve the Terms of Reference.

MHAC/26/07c Work Programme (Agenda item 7.3)

RK noted that the Committee was asked to review the programme and confirm that it provides an appropriate balance and assurance in terms of the oversight of the work.

MK queried, in reference to the CQC Mental Health Act visits and the action planning, where this appeared within the quality improvement or key risk sections of the work plan and asked for clarification.

JC confirmed that this sits under the Compliance and Assurance section of the work plan, Care Quality Commission Mental Health Act Visit Reports and Outstanding Actions and Progress Reports, which are reported at each Committee meeting.

YF explained that the Mental Health Act 2025 Implementation Plan has been added to the work plan under the Quality Improvement section and will be reported quarterly as agreed.

ST noted that while the work could sit under Quality Improvement, this would involve checking, refining, and going through several stages, it could also, when viewed more simply, fall under Compliance and Assurance, as it relates to the Mental Health Act, the Code of Practice, and statutory requirements.

ST added that it may be taking it too far to treat it as a key clinical risk, as it is already captured on the relevant risk registers. ST confirmed being happy for it to sit wherever the Committee feels it best fits, and that the important thing is for it to remain within the Committee's oversight so the Board can be assured it is being properly scrutinised.

RK commented that it seemed the item could sit under either Quality Improvement or Compliance and Assurance, and suggested the Committee monitor this as reporting develops. RK proposed that if, over time, it becomes clear that one area does not provide sufficient assurance, whether on quality or compliance, the Committee could then consider moving it.

YF added that, under the annual items section of the work plan, the Ministry of Justice restricted patients annual report is currently scheduled for May 2026, though the Mental Health Act team would like to move it to August 2026. This is because the external paper arrives later than the current timetable allows, leaving very limited time to review it and prepare the report. Moving it one quarter later will give sufficient time to complete the work properly. The Committee agreed that this item should be moved to August 2026.

RK noted that the work plan is comprehensive and provides a clear structure for the Committee's activity. RK added that it will be important for the plan to remain flexible so it can respond to emerging needs, and that the Committee may need to continue reviewing milestones, rather than focusing solely on the reporting standards.

MHAC/26/07d Self-Assessment (Agenda item 7.4)

RK noted that the Committee was asked to review the findings of the self-assessment and consider whether there are any development actions that are required.

RK commented that the report provides an overview of performance against several governance standards. In the context of forthcoming legislative reforms and increasing complexities, RK added that the self-assessment also offers an opportunity to consider whether the Committee's current approach to oversight remains sufficient.

MK raised that completing the same self-assessment survey as other members can be challenging for Committee Chairs, as many questions require judging their own performance. MK suggested that Chairs may benefit from a separate survey, both to ensure anonymity in relation to other NEDs and directors and to avoid situations where the Chair feels unable to answer certain questions. MK proposed this as a consideration for all committees. MF to contact Andy Lister and Izzy Worswick.

ACTION: Mike Ford

RK noted that the aim of the self-assessment is to gain a true reflection, as the process is about learning and identifying areas for improvement. RK added that, if a different approach would help members provide more constructive feedback on what could be improved, it may be worth considering.

MHAC/26/08 Risk Registers (Agenda item 8)

MHAC/26/08a Consideration of the items from the Organisational Risk Register (Agenda item 8.1)

RK noted that the Committee was asked to consider whether the current risk rating and mitigation arrangements remain appropriate.

The Committee agreed to take the paper as read.

JC reported that there have been no changes to any of the risks identified since the Quarter 2 report that would affect the work of the Mental Health Act Committee. The key risks continue to relate to the availability of resources, service provision with local authorities and other partners, access to CAMHS and admission beds, transfer activity, and the integration of Cheswold Park.

The report provides assurance against each activity and associated risk, confirming that the impacts continue to be monitored and that the Committee remains assured the related risks are being appropriately managed.

MK queried, in relation to risk 275 concerning local authority resourcing and external partners, whether there have been any incidents indicating actual harm to individuals as a result, or whether this remains a potential rather than an active risk.

JC confirmed that there is no evidence of any harm to individuals as a result of this risk. JC noted that some months ago, there were occasions where changes within local authorities caused gaps in the AMHP rota. However, as set out in the mitigation, CT maintains regular contact with AMHP leads, enabling forward planning and early communication with wards. As a result, there have been no unavoidable delays and no situations where anyone has been placed at risk due to these issues.

MHAC/26/08b MHA Committee Risk Register (Agenda item 8.2)

RK noted that the Committee was asked to review the risks and confirm that the kind of mitigation arrangements and monitoring remain appropriate.

ST explained that this item was first brought to the Committee in December to consider whether the Mental Health Act Reform should sit on the Mental Health Act Committee risk register. Training had been delivered last year to the Trust Board and colleagues on the Mental Health Act Bill and its potential implications for clinicians, the Trust as an employer, and the Board. One of the recommendations from that session was to consider adding a risk relating to implementation.

ST noted that the risk was initially added to the Mental Health Act Committee register, though following discussion at EMT, it was agreed it would be better placed on Datix for regular review by the Operational Management Group, with escalation to Mental Health Act Committee as needed, given that most implementation aspects, training, e-learning, workforce and skill mix, are operational. ST advised that today's update is to outline what has happened since, including new national updates, and to confirm whether the Committee is content to keep the risk where it currently sits.

YF explained that since the Committee last met in December, the Bill received Royal Assent on 18 December 2025. As a result, several changes to the Mental Health Act came into force on 18 February 2026. The risk register has been updated to reflect

Royal Assent and the two pieces of legislation already enacted on that date, and these updates have also been made on Datix. YF noted that the reporting arrangements remain unchanged, as outlined by ST. Going forward, the risk register will be updated ahead of each Mental Health Act Committee, with any progress on implementation reported as part of the agreed work plan under the updated Terms of Reference.

It was RESOLVED to RECEIVE the Consideration of the items from the Organisational Risk Register and the Mental Health Act Committee Risk Register.

MHAC/26/09 Statistical information use of the MHA 1983 and MCA 2005 (Agenda item 9)

MHAC/26/09a Performance Report – Monitoring Information, Quarter 3, October - December 2025 (Agenda item 9.1)

Committee agreed to take the report as read.

CW noted that, from a Care Group perspective, there is interest in the data showing the under-representation of some ethnic groups accessing services, alongside the over-representation of Black and Black British groups in admissions and detentions. CW added that the Empowering Partnerships in Communities research report has recently been finalised and shared, and the Care Group is considering its findings and how these should inform operational and clinical practice. Oversight of this work will continue through the Transforming Clinical Pathways programme and the Operational Management Group.

CW reported that internal transfer activity reduced in Quarter 3 compared with Quarter 2. The primary reason for internal transfers continues to be moving people closer to their home areas, which is clinically driven and supports person-centred care, maintaining family and community links, and promoting recovery and discharge pathways. CW confirmed that the Care Group continues to monitor closely the impact of the ‘local beds for local people’ approach.

CW also noted an increase in assessments undertaken in Section 136 suites this quarter. A working hypothesis is that current improvement work on capacity and demand has led to fewer detentions to suites and reduced length of stay, thereby improving suite availability. This is being monitored through the Care Closer to Home workstreams.

For assurance, CW highlighted that training compliance for the Mental Health Act and Mental Capacity Act remains positive and above Trust-agreed standards. CW also drew attention to strong performance in relation to Section 17 leave, with only 0.5% of Mental Health Care Group escorted leave having been cancelled in Quarter 3. Care Groups continue to closely monitor any cancellations linked specifically to staffing.

RK commented the consistency between this report and the themes discussed at the December 2025 meeting, particularly regarding ongoing pressures. The reduction in internal transfers this quarter and referred back to the previous discussion about cancellations of Section 17 leave. RK questioned whether further data is available on the reasons behind those cancellations and whether this is being monitored elsewhere.

CT confirmed that all wards use a standardised cancellation-of-leave report, where every cancelled period of escorted Section 17 leave is coded (A to H) to indicate the reason. CT noted that, in forensics in particular, a large proportion of cancellations fall under the “other” category. As working age adults, older people and rehab services have very low cancellation rates, the focus will be on understanding what sits within that “other” category for forensics. CT confirmed that this will be explored further in Quarter 1, as the detailed information is not currently available.

MK highlighted the significant progress in reducing length of stay and noted the importance of understanding the quality impact. MK queried whether data, particularly on readmissions, is available to indicate whether the improvement is being achieved appropriately. MK also queried whether SPC analysis or comparator data with similar organisations was available, suggesting this may sit within the IQPR.

RK noted that comparative information may already exist and emphasised the value of reviewing such data to understand the Trust’s position. RK commented that the report reflects broadly stable compliance and highlighted encouraging trends, particularly reductions in key areas and improvements in safety management despite challenging circumstances.

ST noted that 53% of applications to the tribunal service had been cancelled and sought clarification on the primary reason for this. The understanding was that cancellations were mainly due to reduced length of stay, meaning that by the time a tribunal was arranged, service users had improved and were discharged under Section 23. ST sought assurance that cancellations were not occurring due to avoidable issues such as staff sickness or panels not being convened, but rather because the tribunal was no longer required.

CT explained that, for detained patients under sections other than Section 2, the average timeframe from initiating a tribunal hearing to its conclusion is around 12–15 weeks. Due to shorter lengths of stay, many patients are discharged before their hearing takes place. CT noted that appeal rates remain appropriate, though a significant number of hearings are not reached because patients leave hospital before the date, combined with the tribunal service’s challenges in convening panels.

CT highlighted that 83% of tribunals are now held face to face due to the tribunal service experiencing difficulties with the number of platforms used for virtual hearings and the limited availability of panel members able to participate online. CT added that, prior to Christmas, the courts encouraged a move back towards face-to-face hearings. Cancellations were largely occurring because of the time it takes the tribunal service to arrange hearings, during which time many patients are discharged. CT also highlighted the additional pressure this shift places on clinical services and professionals, given the high proportion of hearings now held in person.

CJ highlighted that the ethnicity data shows longer average lengths of detention for Asian and Black groups, noting the importance of understanding the reasons behind this. CJ also observed that Kirklees has a high number of Asian and Asian British individuals on CTOs and expressed interest in seeing this information in percentage terms against the population served in those areas. CJ noted that this aligns with the national picture, where people from global majority backgrounds are more likely to be subject to restrictions than their white counterparts, and suggested further exploration of the underlying factors.

RK explained that this issue has been consistently raised and discussed by the committee, and that the Mental Health Act team are well aware of it. RK referred to the presentation at the previous committee meeting, which included deep-dive work comparing population data with access and experiences of global majority communities in both community and inpatient mental health services. RK acknowledged the ongoing work to further understand these disparities and emphasised the need for continued focus and scrutiny in this area.

CT explained that the annual CTO report includes this data and offered to share the most recent version with CJ to provide assurance regarding how population and ethnicity information is reviewed.

ACTION: Carly Thim

ST explained that the Trust commissioned the NHS Confederation to undertake a detailed deep dive into the experiences of Black and Asian men, where evidence shows they are 6–8 times more likely to be detained than white men. This work involved partners in the community, clinical engagement groups, and outreach through Dawn Lawson's team. Aboo Bhana, Equality and Involvement Manager, previously presented the findings to the committee. JC has been leading the work alongside clinical colleagues. ST suggested that JC share this information with CJ.

ACTION: Julie Carr

ST explained that the next step is to use the findings from the deep dive to understand the implications for services, for example, whether a Black man coming into EIP may experience care differently from a white counterpart. ST added that clinical colleagues within the group are exploring potential visits to other organisations to identify different approaches that could be adopted and also noted that a further piece of work is underway through a national QI programme.

RK reflected that the key issue is how the Trust uses the information and data it receives to drive change, particularly in how services are delivered and how visible and accessible they are to communities. RK commented that it was encouraging to hear that the work is moving beyond data collection and analysis towards understanding what it means in practice and what actions need to follow.

RK emphasised the importance of maintaining oversight of this area, noting that such efforts are what will ultimately improve experiences for people from these communities. RK thanked colleagues for their insight and for keeping this a continued focus for the committee.

No further comments were raised by the committee.

It was RESOLVED to RECEIVE the Performance report – monitoring information October to December 2025.

MHAC/26/10 Audit and Compliance (Agenda item 10)
MHAC/26/10a Annual s.17 Leave Compliance Report (Agenda item 10.1)
Committee agreed to take the report as read.

CT outlined the highlights of the report.

In Quarter 3, forensics maintained a consistent position, with 87% of approved unescorted leave being taken, a slight decrease from 90% in the same quarter last year. Although the 3% difference is small, it will be reviewed further in the next reporting cycle. Working Age Adult, Older People's, and Rehab services sustained a 99% rate. In Quarter 3, clinicians approved 6,411 escorted leaves, and 99% of the leave requested was taken, which was highlighted as a particularly strong performance. For forensic services, 1,590 leaves were approved, with 87% being taken. While this is lower than the 99% achieved in working age services, the different nature and restrictions in forensic settings were acknowledged, and performance was viewed positively given the context.

CT provided assurance to the committee that, although the CQC has highlighted that 75% of the action plans developed in response to a ward visit relate to issues around access to Section 17 leave, the figures presented offer confidence that escorted leave is being facilitated when patients request it with greater frequency than the CQC activity would indicate.

CT explained that, for the first time, the report includes the Key Performance Indicator of completion of page two, outlining the Mental Health Act Office's compliance checks. 5,982 forms were reviewed in Quarter 3 to ensure completion and accuracy compliance. Any form found to be incomplete is returned to the relevant ward nursing team for correction to ensure that families, friends, carers, and service users receive the required information to support leave being taken. This provides an additional layer of assurance to the committee that the correct processes and safeguards are in place.

CT added that compliance with the Code of Practice requirements remains strong. Overall, CT emphasised that both the low cancellation rate of escorted Section 17 leave and the continued high compliance with page-two checks reflect positively on Clinical Services and the Mental Health Act Office.

MK raised a number of points, querying why the CQC had identified that 75% of action plans relate to Section 17 leave. MK also queried whether the data shows if cancellations relate to the same individuals, for example, whether repeated cancellations for one person are contributing to the overall figures, or whether the 13% of cancellations in forensics reflect different service users. MK further asked whether it is possible to separate cancellations made by the service user themselves from those cancelled by services.

CT explained that, at present, the data collection tools do not show whether cancellations relate to the same individual or multiple service users and noted that this is an area that could potentially be explored further. CT also highlighted the value of distinguishing between cancellations and suggested that next year's report should consider incorporating this level of detail.

CJ reflected on a recent visit to forensics as part of their induction, noting that several patients reported experiencing issues with their Section 17 leave and explained that, although concerns are often raised at face value, the underlying issues are usually more complex once explored in detail, which may influence how the CQC interprets initial feedback.

CJ highlighted two themes from the visit. First, how the MDT defines and supports therapeutic Section 17 leave, some patients described wanting brief opportunities, such as a quick walk or fresh air, and queried whether more could be done to enable more people to go out at the same time. CJ noted that patients had mentioned the walking group had stopped and suggested that reinstating or adapting such activities could be beneficial.

Secondly, CJ emphasised the importance of evidencing triangulation of data, noting that while the data itself is essential, demonstrating through community meetings that the team has explored patient-reported issues and developed co-produced solutions provides strong assurance to the CQC. CJ stressed that showing collaborative work with service users and evidence of unpicking concerns together is valuable and positive evidence of good practice.

CJ added that staff described the challenges involved when several patients request multiple short walks, noting that this places significant demand on staffing resources. Staff reported that a considerable amount of their time is spent facilitating these quick Section 17 walks, which creates an ongoing and difficult balance to manage.

ST reflected on how cancelled leave is currently captured and highlighted the challenges involved, noting that, while considering possible improvements, was conscious of not placing additional burden on the Mental Health Act Office, given the already significant volume of forms being processed (between 7,000 and 8,000 per quarter trustwide). ST suggested that, in the longer term, it may be worth exploring whether more meaningful data collection could be supported through digital solutions.

ST emphasised the importance of this work in the context of a potential forthcoming CQC well-led visit, noting that similar issues recur in inspections, for example, assessments recorded as incomplete when, in practice, they may have been completed later the same day. The need to consider how best to evidence assurance to the CQC, and that having accurate data will help demonstrate the distinction between issues identified by inspectors and what is shown in internal records.

CJ also supported the suggestion of separating cancellations due to patient choice from those relating to staffing or service-level factors, recognising the value of clarifying what is within staff responsibility and what is not.

No further comments were raised by the committee.

MHAC/26/10b Consent to Treatment Review Report (Agenda item 10.2)

RK noted that the committee was asked to note the assurance provided regarding compliance.

Committee agreed to take the report as read.

CT highlighted that the Quality Improvement programme led by the Mental Health Act Office over the past few years is now fully embedding and delivering steady, strong compliance. The Trust is now at 100% compliance for all patients requiring an assessment of capacity to support certificates of authorisation for treatment being recorded in the clinical notes. Although this reflects only a 1% increase from 99% last year, CT emphasised that the key message is the sustained stability and consistency of this practice across clinical teams, doctors, and the Mental Health Act Office.

CT noted that statements of capacity are now rarely used, which is appropriate as the code of practice requires a full record of the assessment of capacity to support the decision-specific nature of consent to treatment. This shift was described as a positive development.

Improvement in SOAD outcome recording began later and is still developing. Compliance has risen to 96%, a 4% increase from last year, and CT anticipated that this is likely to reach 100% next year as the process continues to embed.

CT reiterated that the increasing consistency between clinical staff and the Mental Health Act Office reflects well-established practice across the Trust, and that overall progress is very positive.

CJ observed that a couple of wards appear to be struggling and asked what support is being provided to them, what learning could be shared from areas where practice has been more successful.

CT explained that when a specific ward or consultant appears to be struggling, the Mental Health Act Office links them with peers who demonstrate strong practice, for example, clinicians who complete high-quality assessments or consistently record SOAD outcomes well. That examples are shared, and one-to-one support is offered where needed. CT added that this proactive approach has contributed to the reduction in issues, as any early signs of gaps are quickly identified and addressed through these steps.

RK queried whether any implications are anticipated from the forthcoming Mental Health Act reforms, particularly in relation to consent to treatment and associated processes.

JC explained that significant changes to consent-to-treatment processes are expected under the forthcoming Mental Health Act reforms. The Mental Health Act team is still working through the detail, which is why embedding current practice fully is so important; doing so will support a smoother transition when the new requirements come into effect.

JC highlighted that, for example, the three-month rule will move to a two-month rule, meaning assessments will need to be completed more quickly. JC also advised that there will be an increase in referrals to SOADs, as more decisions will require SOAD authorisation before treatment can proceed. In addition, advanced choice documents will need to be taken into account, which may also trigger the need for SOAD involvement before prescribing.

JC confirmed that although there is considerable detail still being worked through, the Trust is in a strong position, and JC felt assured that preparations underway will support implementation while ensuring that patient rights remain central throughout.

No further comments were raised by the committee.

MHAC/26/11 Legal Briefings (Agenda Item 11)
MHAC/26/11a MHA 2025 Update (Agenda Item 11.1)
Committee agreed to take the report as read.

JC explained that one of the key changes is the introduction of what has become known as the supervised discharge provision. This is intended to address the MM matter from Manchester and the Manchester judgements, which ruled that a conditional discharge cannot be used for someone who has capacity and is consenting to a care plan that still amounts to a deprivation of liberty. The government introduced a temporary interim fix, though this has had limited workability, which is why this provision is one of the first elements to come through in the reforms.

JC added that this change is particularly important for individuals in the forensic estate who are ready for discharge but cannot be discharged under current rules. The new provision will allow the Secretary of State and the Tribunal to grant a conditional discharge with conditions that amount to deprivation of liberty, which is different from a DoLS authorisation. These individuals will remain under Ministry of Justice oversight and will have more frequent tribunals to ensure their Article 5(4) rights are upheld.

JC also noted that the provision will give consultants an additional route to apply for discharge, helping to support patients and their progression through the system.

JC explained that CT has systematically gone through all of the changes highlighted in the Tribunal reports and that guidance is now available on the intranet. A briefing has been circulated to all doctors and will be discussed with the Code of Practice Group on 9th March and the Clinical Governance Group, to ensure wider dissemination. JC added that the Trust also has patients subject to Section 37/41 who are being recalled to the Mental Health Care Group rather than forensics, which presents a challenge in terms of how to progress these individuals towards discharge.

CT explained that there is currently a patient within Working Age services who is being considered for transfer to a more suitable setting. The Mental Health Act Office has liaised with the ward, shared the relevant guidance, and taken staff through how they might adapt their reports to better reflect a recommendation to the Tribunal in line with the new legislation introduced on 18 February 2026. The ward has updated their report accordingly and is now well prepared to attend the hearing, with a clearer understanding of the options available and how to discuss these in detail.

CT added that this demonstrates how, as the organisation learns, the Mental Health Act Office is actively linking in with clinical staff, offering practical advice to support patients, other service users, and ward teams. CT emphasised that this approach ensures the new processes are meaningfully embedded within clinical services as and when required.

RK noted that the briefings, training and updates are underway and thanked the team for their continuous work. RK emphasised not to underestimate the amount of effort involved and highlighted that this represents a significant period of change for mental health services. While some changes will be gradual, RK acknowledged the importance of the early preparation already taking place.

It was RESOLVED to RECEIVE the legal briefings

MHAC/26/12 MHA/MCA Code of Practice Oversight Group (Agenda item 12)

MHAC/26/12a COPG AAA Report (Agenda item 12.1)

Committee agreed to take the report as read.

JC advised that the group continues to meet monthly and now includes two medical representatives, which is a positive development given the crucial role the group will play as implementation progresses.

JC confirmed that information relating to the Mental Health Act 2025 provisions will be taken through this group. The group has agreed to provide support as new elements, such as the updated Code of Practice are released, using members' specialist knowledge to review specific chapters, enhance understanding, and contribute to any required consultations.

JC added that there is scope to extend the meeting duration and widen membership as needed to ensure that all clinical and operational areas affected by the forthcoming legislative changes are fully considered and addressed.

MHAC/26/12b Annual Blanket Restrictions Report (Agenda item 12.2)

Committee agreed to take the report as read.

JC noted that this is a new report and only the second of its kind to be produced. JC explained that learning from the past year has informed further development, including the creation of a dashboard that will provide regular reporting to the Code of Practice Group as a standing agenda item. This will allow any early learning or emerging issues to be identified promptly and shared as Trust-wide learning. The dashboard will be led by the Nursing Directorate, who will take responsibility for leading on this going forward.

JC added that there was nothing further to highlight at this stage, as much of the report is self-explanatory and that the content will continue to build and strengthen as the year progresses.

DT noted that, as MK Chairs the Quality and Safety Committee, there is often a significant overlap in agenda and focus between the two committees. That occasionally both meetings fall on the same day, this can be interesting because it highlights the linkage between them. DT commented that the same topics often arise, sometimes just from a slightly different angle, for the Mental Health Act Committee the focus may be on legal duties, while for the Quality and Safety Committee it is about the quality and experience of the person in our care, that there are substantial overlaps between the two.

MK commented that listing the number of restrictions for the quarter alone is not helpful in understanding the issues. As DT highlighted, this is also an issue frequently raised during quality assurance visits. While not complaints in the formal sense, these concerns are regularly raised by individuals, and MK felt it would be helpful to have more detailed information reflected in the report. This remains an area of focus both through quality assurance visits and within the Quality Committee. Vaping was highlighted as an example, with MK noting that there are significant concerns raised within forensics about vaping being applied as a blanket restriction.

RK noted that aggression, violence and infection control were among the most common reasons for blanket restrictions and emphasised the need to remain mindful of their impact and how these are being monitored.

ST questioned from a CQC perspective, how blanket restrictions are being monitored and whether the dashboard would be able to identify issues that may arise during CQC mental health or well-led visits. ST emphasised the importance of triangulating the data so that it reflects not just the numbers but their meaning, specifically whether there are wards where concerns are emerging or potential hotspots. That while the numbers are helpful, understanding the context and impact is essential.

ST was cautious about suggesting anything that would significantly increase workload or capacity pressures, though emphasised that if additional work is required, the committee needs to understand this so appropriate support can be considered.

ST noted they were not expecting an immediate answer though felt it was important to explore whether this is feasible in order to provide assurance.

JC confirmed that Sam Johnson, Assistant Director, is leading and developing this work and will convey the feedback provided by the committee.

ACTION: Julie Carr

CJ raised the issue of accidental blanket restrictions. CJ provided an example from Horizon, where a door had been locked due to an estates-related safety issue. Although the work had been completed and the issue fixed, the door remained locked for several weeks, resulting in an unintended blanket restriction. CJ queried how frequently blanket restrictions are reviewed, how the Trust ensures that new or accidental restrictions are not introduced and whether such checks form part of regular audit processes.

No further comments from the committee.

It was RESOLVED to RECEIVE the update for the feedback report in relation to the MHA / MCA Code of Practice Oversight group.

MHAC/26/13 Key Messages to Trust Board and other Committees (Agenda item 13)
MHAC/26/13a MHAC AAA Report (Agenda item 13.1)

Messages for Trust Board agreed as:

- System pressures affecting patient pathways, particularly the impact on discharge and flow through services
- Internal transfer activity within inpatient services, with a focus on understanding drivers and impact on patient experience
- Implementation of Mental Health Act legislative reform, including the scale of change and ongoing work to support delivery

Alerts from the AAA report:
The Committee did not identify any immediate areas requiring escalation to the Board. However, the Committee agreed that the following areas require continued oversight:

- The implementation of the Mental Health Act 2025 and the scale of associated legislative change, including implications for workforce, pathways and compliance
- Internal transfer activity across inpatient services, particularly the potential impact on patient experience and continuity of care

Advise from the AAA report:
The Committee highlighted the following areas of ongoing development and improvement:

- Continued progress of the Mental Health Act detentions and ethnicity quality improvement work, including deeper understanding of disparities and focus on translating learning into changes in practice
- Ongoing integration of Cheswold Park Hospital, with continued alignment of processes, policies and patient experience
- Strengthened partnership working with external partners, including advocacy services and acute providers, supporting improved coordination and service delivery
- Learning from audit and quality improvement activity, including the Medical Recommendations Audit, with a focus on improving documentation quality and clinical practice

Assurance from the AAA report:
The Committee received assurance in the following areas:

- No breaches of the Mental Health Act identified through Care Quality Commission monitoring, with action plans in place and progress being tracked
- Stable performance across key Mental Health Act and Mental Capacity Act activity, with no significant concerns identified
- Strong training compliance across services, exceeding Trust standards
- Effective operation of Hospital Managers' hearings and governance processes

- Continued high levels of compliance in key areas such as consent to treatment and Section 17 leave processes, with improvements embedding across the Trust

MHAC/26/14 Work Programme (Agenda item 14)

No further comments from the committee.

It was RESOLVED to RECEIVE the work programme.

Date and Time of Next Meeting:
The next meeting will be held on Wednesday 27th May 2026 at 14:00 to 16:30 via MS Teams

RK closed the meeting.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 10.1

Private/Public paper:	Public		
Title:	**Integrated Performance Report (IPR)**		
Lead Director:	**Adrian Snarr – Executive director of finance, estates, and resources**		
Mission/values:	The paper supports achievement of all Trust values: Person first and in the centre; Families and carers matter; respectful, honest, open and transparent; Improve and am to be outstanding, Relevant today and ready for tomorrow.		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for May 2026.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All BAF risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust performance management framework and reporting provides the Integrated Care Boards (ICB) with assurance that the Trust has an effective performance management system to contribute to the delivery of the ICB's strategic priorities and delivery plans.		
Any background papers / previously considered by:	The IPR is reviewed at Trust Board meetings held in public eight times a year. On months when meetings in public are not held, it is circulated to Board members and published on the Trust website. The IPR is reviewed monthly by the Executive Management Team (EMT). The IPR is reviewed monthly at the Operational Management Group (OMG) meeting.		

With **all of us** in mind.

Executive summary:	Performance against the Trust's new strategy will be reported separately to the IPR for 2026/27, however, all metrics reported in the IPR have been mapped to the new strategic objectives as well as to the Care Quality Commission domains. **Quality and Safety** • Performance for this section of the report shows 76% of the metrics are being fully achieved. This summary highlights some areas of improvement required and provides assurance regarding actions in place to ensure we maintain safety across our services for staff, patients and carers. • The proportion of responses provided within six months of the date a complaint received was 91%. This related to 1 complaint out of 11, with the remainder all achieving the standard. Our responsiveness to complaints remains consistently good. • The total number of reported incidents in May was 1,323 which is a little lower than the average number over the past 6 months but in line with normal range. All incidents continue to be subject to review by the patient safety team with relevant governance and learning within the care groups. • The number of restraint incidents in May was 152. The highest number of incidents were on one of our psychiatric intensive care units (27) where 11 related to 1 service user and Nostell adult mental health ward (20), where 7 of the reported incidents related to 1 service user. 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 reducing restrictive practice (RRPI) team are involved in the review of care plans and exit strategies and support both the staff and services involved in such incidents. • The Trust had 27 incidents involving race against staff on mental health wards during May. Thirteen of these incidents occurred at Cheswold Park Hospital across 5 wards/teams. We are very aware of the personal impact this has on our colleagues and are working with 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. • Our focus on reducing the use of prone restraint continues to show significant improvement with 2 staff led prone restraints on our mental health wards during May. Both related to the administration of intramuscular (IM) medication and were clinically led decisions made to manage risk safely and during the incidents. The service user's physical health was monitored throughout, no concerns were identified, and all positions were maintained for the shortest duration necessary to ensure safety and dignity. • Alternative seclusion exit training is embedded in both four-day initial and two-day annual refresher 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 five information governance personal data breaches during May which is the lowest number reported since September 2024. The five incidents were generally spread across care groups and no hotspot areas identified.

	• Sadly, there was one patient death during the month where the service user was known to the Trust's mental health services. This incident is 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 65 inpatient falls reported during May 2026. 28 of the fall incidents relates to services users aged 65 years and over; 4 patients had repeated falls and accounted for 19 of the total incidents. There were no red graded fall incidents reported this month. A total of 16 (21%) reported events needed higher intervention or were recognised as a higher risk of repeat 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 Trust's falls coordinator to ascertain any themes or actions required. Falls on inpatient wards per 1,000 bed days are notably lower than national averages. • 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 95.7%% against a target of 90%. Disability recording was at 56.8%, sexual orientation 56.7% and postcode at 99.6%. Work continues to ensure data capture across all services and further detail of these metrics can be seen in the equalities section of this month's report. • 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 compared to last year, however 95% has not yet been achieved across all five metrics in all areas – detail can be seen in the main body of the IPR. 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. Development work is occurring across all teams to ensure they update the risk assessment to ensure emerging risks are supported and mitigated. • There were eight sexual safety incidents against staff (by patients) in May. The most common theme for these incidents was inappropriate sexual behaviour. We are very aware of the personal impact this has on our colleagues. In the event of an incident, a sexual safety panel is convened which includes individuals who have undertaken specialist training. • There were five sexual safety incidents by patients against patients reported during the month. The sexual safety working group focused on patient

related sexual safety incidents is well established and includes support and guidance to staff on managing and supporting patient related sexual safety.
- The Trust has recently reviewed its supervision policy and as a result has moved to a new method of reporting splitting out management and clinical supervision and reporting against a 60-day standard and also widening the scope to include all clinical staff not just registered staff as previous. This approach has been well received and targeted work is taking place to ensure the trajectory remains positive.

People

- Our sickness absence rate for May is 4.8% and this is under our target of 5%. Our long Term and short-term sickness are both lower than the same period last year.
- In May 2026 we are achieving our Trust target for staff appraisals, with a current compliance rate of 93.5%. We are currently transitioning into the new appraisal reporting arrangements.
- Our statutory and mandatory training compliance remains above Trust target at 95.4% (target greater than or equal to 80%). Information Governance (IG) training remains consistently strong at 94%, in May. This reflects the importance we place on keeping confidential information safe.

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, 113 out of 114 children (99.1%) received a diagnostic appointment within 6 weeks, this is now significantly above the revised national threshold. The demand in referrals consistently outweighs commissioned activity levels – which is a national issue. The quality improvement plan has clearly achieved a sustained improvement; this is fragile due to the small resource (2 whole time equivalent staff) within the team.
- Children & Younger People with an eating disorder – all urgent and routine referrals were seen within national expected time frames of one and four weeks.
- The Trust had 2 admissions for service users under 18 years of age to an adult ward which were due to lack of nationally available beds. The Trust has robust governance arrangements in place to safeguard young people when these situations arise.
- Reduction in our mental health length of stay is now split between adult acute and psychiatric intensive care unit (PICU) and older people. The Trust has set itself a target to reduce adult acute lengths of stay by 10% by the end of March 2027. We continue to achieve our forecast position for May for adult and PICU lengths of stay (45.6 days against a forecast of 49.1 days) but have exceeded our forecast for older people lengths of stay (92.9 days against a forecast of 81.7 days). Reported performance is affected by discharges of patients with particularly long lengths of stay and this may be impacted by the availability of appropriate external placements. There are robust escalation processes in place to expedite those clinically ready for discharge.

	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 May, 87.9% had been waiting for a period of 18 weeks or less which represents a sustained improvement compared. All of these cases have had some form of screening, consultation, or initial assessment before being placed on a treatment waiting list. This service is experiencing an increase in demand, particularly in Kirklees. Commissioners have supported a new delivery model, which 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 significant 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. Performance in May improved to 96.2%. • The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. At the end of May, the Trust had three service users placed in an inappropriate out of area bed with 82 bed days used over the month. This has been supported by significant ongoing focus and improvements on patient flow and bed management. • Focus on patients clinically ready for discharge continues to take place across all services. At the end of May, 23 people were clinically ready for discharge but remained in bed, accounting for a total of 759 bed days over the month. The main challenges to discharge continue to be specialist placements and housing and we are continually in dialogue with partners to identify solutions. • 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 295. • 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 have asked that we explore trialling this step for them, Barnsley is still considering their preferred model. • Mental health bed occupancy (excluding leave) remains within acceptable range at 89.6%. There are individual wards which have a much higher occupancy and increasing acuity of patients places further challenge on colleagues.

	• 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 has continued to be maintained at an overall low level. Spend in May 2026 was £143k and within plan. The use of agency staff largely relates to very limited number of medical staff although some pressures are expected in the coming weeks due to pending staff retirements. Bank usage remains above plan. Use of bank staff continues to be scrutinised, and we are planning to recruit an increasing number of substantive health support workers over the course of the year. • Single point of access (SPA) prioritises risk screening of all referrals to ensure any urgent demand is met within 24 hours. In May, the access standard for assessed within 14 days of referral has been met in all localities. Routine triage and assessment remain at risk of being delayed in all areas. 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. **Finance** • Our year-to-date deficit is £1.2m. This remains marginally ahead of plan, but action is required to change the run rate direction and ensure that the breakeven target can be delivered. • Although Trust actions are forecast to achieve a £5.0m reduction in bank staff the current run rate is to exceed that. For the year to date spend is £0.4m (14.1%) higher than plan. • The Trust value for money programme is in line with plan for the year to date. This is primarily due to the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025/26. The trajectory includes the identification, and delivery, of new schemes later in the year. • The current cash position remains positive. • Capital spend remains ahead of plan in May 2026 due to the timing of updated lease contracts in the previous month. This was originally planned for June 2026. The forecast remains in line with allocation, including a new allocation for community hubs, and schemes are progressing. Any revisions to timescales or forecasts will be agreed through Trust Board.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the Integrated Performance Report and **COMMENT** accordingly.

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Integrated Performance Report
Strategic Overview



May 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 May 2026.

The report format for 2026/27 aligns with the Trust board's focus and national priorities. 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. Please note, data is correct at the time of reporting and will be refreshed each month. This can mean that historical months performance will change as records are updated.
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

Our Integrated Performance Report (IPR) provides a comprehensive view of Trust performance against our targets. We have mapped this performance information against our strategic aims, values and best statements so that it is easy to see how the performance data links to the delivery of the strategy. 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.

An exercise has been undertaken to review all metrics and thresholds to ensure they meet the requirements and priorities for 2026/27; 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.

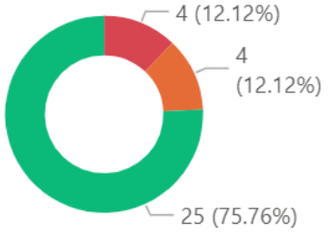
On 1st October 2024, the Trust acquired Cheswold Park Hospital, which is a 112-bed low and medium secure mental health hospital based in Doncaster, providing services to male and female patients with a diagnosis of mental illness, personality disorder or neurodevelopmental disorders. Cheswold Park provides 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. This project was completed by the end of March 2026 and as a result, reporting for this service is now integrated in the main body of the report and in the Forensic Care group section. A review of the reducing inequalities section is to be undertaken over the next few months, 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. This reporting will align to the deployment of the Trusts Equality, diversity, and inclusion strategy.

Our Integrated Performance Report is publicly available on the internet.

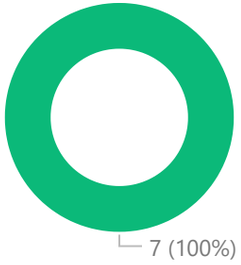
Headlines - Performance Rates Summary

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.

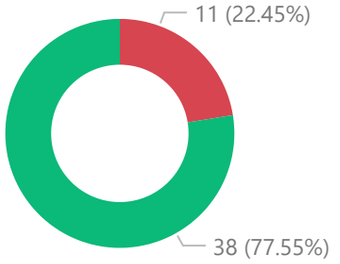
Quality & Safety Metrics Performance Rate



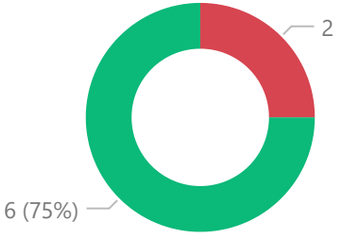
People Metrics Performance Rate



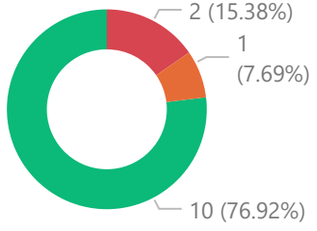
National Metrics Performance Rate



Finance Metrics Performance Rate



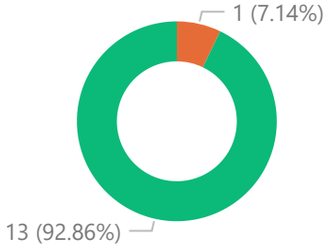
Barnsley Physical Health Metrics Performance Rate



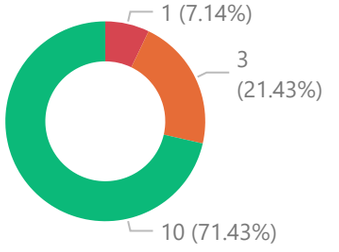
CAMHS Metrics Performance Rate



Mental Health Community Metrics Performance Rate



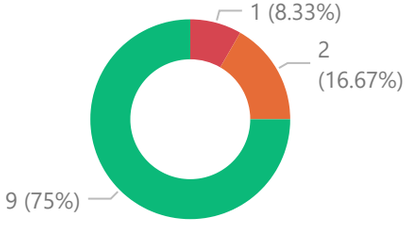
Mental Health Inpatient Metrics Performance Rate



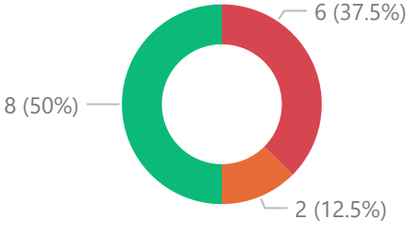
ASD/ADHD Metrics Performance Rate



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 from non achievement to achievement 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	↑	
Number of Information Governance breaches	↑	
Friends and Family Test - community	↑	
% of staff receiving supervision within policy guidance - Clinical	↑	
% of staff receiving supervision within policy guidance - Management	↑	
% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	↓	
% on community active caseload at month end with a care plan which has been reviewed within the last year	↑	
% inpatient risk assessment completed within 24hrs before or after admission	↑	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↓	

People

Metric	Change from last month	Variation/ Assurance
No changes to report in May. Performance sustained and achieveing expected thresholds.		

Finance

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

National metrics

Metric	Change from last month	Variation/ Assurance
The number of completed non-admitted Referral to Treatment (RTT) pathways	↓	
The number of incomplete Referral to Treatment (RTT) pathways	↑	
Community bed occupancy/availability	↓	
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	↑	

Care Groups

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	↑	
% of staff receiving supervision within policy guidance - Clinical	↓	New Metric
% of staff receiving supervision within policy guidance - Management	↓	New Metric
% of feedback with staff values and behaviours as an issue	↑	
% Appraisal rate	↑	

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
Sickness rate (monthly)	↑	
% Service Users on CPA with a formal review within the previous 12 months	↑	
% of staff receiving supervision within policy guidance - Management	↑	New Metric
Information Governance training compliance	↓	

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% of feedback with staff values and behaviours as an issue	↑	
% inpatient risk assessment completed within 24hrs before or after admission	↑	
% of clients clinically ready for discharge	↑	
Sickness rate (monthly)	↓	
% of staff receiving supervision within policy guidance - Management	↓	

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	↑	
% of staff receiving supervision within policy guidance - Clinical	↑	New Metric
% of staff receiving supervision within policy guidance - Management	↓	New Metric
% with care plan that includes service user input/views	↓	New Metric
% inpatient risk assessment completed within 24hrs before or after admission	↓	

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% Bed occupancy	↑	
% of staff receiving supervision within policy guidance - Clinical	↑	New Metric
% of staff receiving supervision within policy guidance - Management	↑	New Metric

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
Sickness rate (Monthly)	↑	
% of staff receiving supervision within policy guidance - Clinical	↑	New Metric
% of staff receiving supervision within policy guidance - Management	↑	New Metric

Children and Young Peoples Mental Health Services (CAMHS)

Metric	Change from last month	Variation/ Assurance
% of staff receiving supervision within policy guidance - Clinical	↑	New Metric
% of staff receiving supervision within policy guidance - Management	↑	New Metric
Children & Younger People with eating disorder - % Routine cases accessing treatment within 4 weeks	↑	
Information Governance training compliance	↓	
Sickness rate (Monthly)	↓	

KEY

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

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

This section has been developed to 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

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• The total number of reported incidents in May was 1,323 which is a little lower than the average number over the past 6 months but in line with normal range. All incidents continue to be subject to review by the patient safety team with relevant governance and learning within the care groups.

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• Sadly, there was one patient death during the month where the service user was known to the Trust's mental health services. This incident is 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 65 inpatient falls reported during May 2026. 28 of the fall incidents relates to services users aged 65 years and over; 4 patients had repeated falls and accounted for 19 of the total incidents. There were no red graded fall incidents reported this month. A total of 16 (21%) reported events needed higher intervention or were recognised as a higher risk of repeat 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 Trust's falls coordinator to ascertain any themes or actions required. Falls on inpatient wards per 1,000 bed days are notably lower than national averages.

• 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 95.7%% against a target of 90%. Disability recording was at 56.8%, sexual orientation 56.7% and postcode at 99.6%. Work continues to ensure data capture across all services and further detail of these metrics can be seen in the equalities section of this month's report.

• 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 compared to last year, however 95% has not yet been achieved across all five metrics in all areas – detail can be seen in the main body of the IPR. 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. Development work is occurring across all teams to ensure they update the risk assessment to ensure emerging risks are supported and mitigated.

• There were eight sexual safety incidents against staff (by patients) in May. The most common theme for these incidents was inappropriate sexual behaviour. We are very aware of the personal impact this has on our colleagues. In the event of an incident, a sexual safety panel is convened which includes individuals who have undertaken specialist training.

• There were five sexual safety incidents by patients against patients reported during the month. The sexual safety working group focused on patient related sexual safety incidents is well established and includes support and guidance to staff on managing and supporting patient related sexual safety.

• The Trust has recently reviewed its supervision policy and as a result has moved to a new method of reporting splitting out management and clinical supervision and reporting against a 60-day standard and also widening the scope to include all clinical staff not just registered staff as previous. This approach has been well received and targeted work is taking place to ensure the trajectory remains positive.

People

• Our sickness absence rate for May is 4.8% and this is under our target of 5%. Our long Term and short-term sickness are both lower than the same period last year.
• In May 2026 we are achieving our Trust target for staff appraisals, with a current compliance rate of 93.5%. We are currently transitioning into the new appraisal reporting arrangements.
• Our statutory and mandatory training compliance remains above Trust target[CB1.1] at 95.4% (target greater than or equal to 80%). Information Governance (IG) training remains consistently strong at 94%, in May. This reflects the importance we place on keeping confidential information safe.

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, 113 out of 114 children (99.1%) received a diagnostic appointment within 6 weeks, this is now significantly above the revised national threshold. The demand in referrals consistently outweighs commissioned activity levels – which is a national issue. The quality improvement plan has clearly achieved a sustained improvement; this is fragile due to the small resource (2 whole time equivalent staff) within the team.
• Children & Younger People with an eating disorder – all urgent and routine referrals were seen within national expected time frames of one and four weeks.
• The Trust had 2 admissions for service users under 18 years of age to an adult ward which were due to lack of nationally available beds. The Trust has robust governance arrangements in place to safeguard young people when these situations arise.
• Reduction in our mental health length of stay is now split between adult acute and psychiatric intensive care unit (PICU) and older people. The Trust has set itself a target to reduce adult acute lengths of stay by 10% by the end of March 2027. We continue to achieve our forecast position for May for adult and PICU lengths of stay (45.6 days against a forecast of 49.1 days) but have exceeded our forecast for older people lengths of stay (92.9 days against a forecast of 81.7 days). Reported performance is affected by discharges of patients with particularly long lengths of stay and this may be impacted by the availability of appropriate external placements. There are robust escalation processes in place to expedite those clinically ready for discharge.

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 May, 87.9% of those waiting had been waiting for a period of 18 weeks or less which is a sustained improvement compared to previous months and an increase on last month, 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. May performance increased to 96.2% and is exceeding the local threshold of 90% with 2 patients out of 52 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 May, the Trust had 2 service users placed in an inappropriate out of area bed at the end of the month, with 51 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. At the end of May, although the overall numbers delayed had reduced compared to April, 23 people were clinically ready for discharge but remained in a bed with a total of 759 bed days being occupied by patients that had been identified as clinically ready for discharge over the month. The main challenges to discharge continue to be specialist placements and housing.
• 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 295. 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 years, there has been an increase in month to 89.6%. The acuity of patients 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 has continued to be maintained at an overall low level. Spend in May 2026 is £143k and within plan. The main area is very limited number of medical staff although some pressures are expecting moving forwards due to pending staff retirements. Bank usage remains above plan. 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 May 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.

Finance

• Our year-to-date deficit is £1.2m. This remains marginally ahead of plan, but action is required to change the run rate direction and ensure that the breakeven target can be delivered.
• Although Trust actions are forecast to achieve a £5.0m reduction in bank staff the current run rate is to exceed that. For the year to date spend is £0.4m (14.1%) higher than plan.
• The Trust value for money programme is in line with plan for the year to date. This is primarily due to the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025/26. The trajectory includes the identification, and delivery, of new schemes later in the year.
• The current cash position remains positive.
• Capital spend remains ahead of plan in May 2026 due to the timing of updated lease contracts in the previous month. This was originally planned for June 2026. The forecast remains in line with allocation, including a new allocation for community hubs, and schemes are progressing. Any revisions to timescales or forecasts will be agreed through Trust Board.

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Best Quality	Responsive	TBC	64.5%	67.5%	73.8%	76.1%	86.2%	85.7%	87.9%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	Best Quality	Caring	< 20%	15.7% (6/38)	8.8% (3/34)	14% (6/43)	22% (6/27)	9.1% (3/33)	10% (3/30)	0% (0/33)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	112.8	101.0	101.6	109.8	134.8	101.3	119.7	N/A
	Complaints - Number of responses provided within six months of the date a complaint received [16]	Best Quality	Well led	100%	95% (18/19)	100% (16/16)	94% (15/16)	94% (16/17)	83% (19/23)	100% (14/14)	91% (10/11)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	93%	93%	91%	91%	92%	86%	93%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	97%	96%	96%	99%	96%	91%	96%	1
Quality	Number of compliments received	Best Quality	Caring	N/A	45	51	25	60	41	40	33	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Best Quality	Safe	Trend monitor	1	4	3	2	6	2	2	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Best Quality	Safe	Trend monitor	1	0	0	0	1	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	0	1
	Number of Information Governance breaches [3]	Best Quality	Well led	<12	6	8	10	12	12	12	5	2
	% of inpatients clinically ready for discharge *	Person first and in the centre	Responsive	3.5%	5.7%	4.9%	5.3%	5.4%	5.4%	6.1%	4.8%	3
	Total number of reported incidents	Best Quality	Safe	Trend monitor	1391	1459	1487	1332	1413	1447	1323	
	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	37	31	34	39	41	35	27	
	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	4	1	0	0	1	0	0	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	0	3	0	2	4	2	1	
	Safer staff fill rates *	Best Quality	Safe	90%	120.1%	120.6%	116.3%	113.8%	112.3%	114.0%	115.1%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	101.3%	100.3%	100.2%	100.6%	98.3%	99.7%	98.6%	1
	% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	84.9%	82.1%	84.8%	85.1%	85.0%	90.5%	86.7%	
	% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	85.5%	87.4%	86.0%	91.1%	90.6%	95.3%	93.0%	
	Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	90.1%	90.2%	87.2%	90.4%	90.1%	94.3%	91.7%	
	Number of pressure ulcers which developed under SWYPFT care [1]	Best Quality	Safe	Trend monitor	47	66	68	47	62	55	45	
	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	0
	Eliminating Mixed Sex Accommodation Breaches	Best Quality	Safe	0	0	0	0	0	0	0	0	1
	Number of Falls (inpatients) *	Best Quality	Safe	Trend monitor	54	58	59	45	61	53	65	
	Number of restraint incidents *	Best Quality	Safe	Trend monitor	168	220	175	200	194	185	152	
	% of staff receiving supervision within policy guidance [15]	Best place to work and learn	Well led	80%	90.5%	88.7%	87.9%	90.3%	92.1%	N/A	N/A	1
	% of staff receiving supervision within policy guidance [15] - Clinical			80%	Reporting commenced April 26					74.7%	78.4%	
	% of staff receiving supervision within policy guidance [15] - Management			80%	Reporting commenced April 26					64.6%	69.2%	
	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%	90.5%	93.3%	97.4%	84.6%	87.1%	93.5%	100%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	20	11	14	7	9	8	7	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 June 2026			Due Aug 26		
	Number of incidents against staff on mental health wards involving race *	Best place to work and learn	Safe	Trend Monitor	32	39	24	28	29	34	27	N/A
	Number of sexual safety incidents against patients	Best Quality	Safe	Trend Monitor	Reporting commenced April 26					6	5	
	Number of sexual safety incidents against staff (patient on staff)	Best place to work and learn	Safe	Trend Monitor						16	8	
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0	10		7			Due July 26		
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	97.3%	100.0%	97.9%	95.6%	96.9%	99.0%	95.9%	
	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%	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%	87.1%	
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	95.8%	95.8%	95.4%	95.8%	95.9%	96.0%	95.7%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	57.3%	56.9%	55.9%	56.5%	56.5%	56.9%	56.8%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	57.8%	57.1%	56.5%	57.0%	56.9%	57.4%	56.7%	
	Percentage of service users who have had their equality data recorded - deprivation (postcode)	Best Quality	Responsive	90%	99.5%	99.5%	99.5%	99.6%	99.6%	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%	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	95.2% Service 100% Policy	92.7% Service 100% Policy	

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Year End Forecast*
	% 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	25/26 Interim trajectory: 75-80% April 26: 95%	89.4%	90.7%	91.1%	94.1%	92.6%	93.9%	94.3%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring		85.0%	85.1%	94.5%	96.9%	96.5%	97.1%	96.7%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring		90.9%	96.3%	97.8%	96.3%	96.8%	97.4%	96.7%	
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe		88.2%	94.1%	90.5%	89.7%	86.0%	91.4%	92.0%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe		92.7%	93.5%	93.9%	92.5%	94.1%	93.9%	93.8%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	Dec & Jan – 4, Feb & Mar – 2, 26/27 stretch target to reduce to zero	3	4	3	1	5	3	2	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor	134	122	187	97	98	73	144	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor	9,256	7,516	9,726	10,035	9,960	12,000	11,968	N/A
	Medical Devices compliance rate	Best Quality	Safe	Trend Monitor	Reporting commenced April 26					75%	75%	
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Person first and in the centre	Safe	6	0	1	0	0	0	0	0	1
	C Diff avoidable cases	Person first and in the centre	Safe	0	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	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Person first and in the centre	Safe	0	0	0	0	0	0	0	0	
Improving Resource	NHS Oversight Framework segmentation	All	Well led	1/2	1		Due June 2026				1	
	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 - May saw an increase in the number of young people waiting less than 18 weeks for their treatment appointment. Following a period of focussed work on this metric since December 2025, performance has improved and has been above 80% for the last two months. Data for the metric will continue to be monitored to ensure we see a sustained improvement trend in the coming months.
• 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 11 complaints responded to during the month, 10 these were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 119.7 days. Before the response is sent back to complainant, sign off is required which includes formulation of a written response and review by the customer services office manager, following a review by the Care Group trio (general manager, clinical lead and quality and governance lead), the director of service, an executive director and final sign off from the Chief Executive. Complaints vary in complexity and this is sometimes reflected in the amount of time taken to investigate and to move through the sign off process.
• There were five information governance personal data breaches during May which is significantly less than reported last month. 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 May, 23 people were clinically ready for discharge but remained in a bed. Delays are spread across all our places and services.
• The trust has recently reviewed its supervision policy and as a result from 1st April, has moved to a new method of reporting splitting out management and clinical supervision and reporting against a 60 day standard and also widened the scope to include all staff not just registered staff as previous. This now shows some under performance against the 80% standard and targeted work is taking place in care groups to address and ensure staff are fully supported. A trajectory for improvement will be identified and update provided next month.
• The total number of reported incidents in May decreased compared to the previous month. A breakdown of this data can be seen in the care group dashboards. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.
• Sadly, there was one patient safety related death 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 27 incidents against staff on mental health wards involving race during May. 2 incidents in Forensics Care Group across 2 wards/teams; 12 incidents in MH inpatients across 9 wards/teams - ward 19 had the highest number (3); 13 incidents in Cheswold Park Hospital across 5 wards/teams - Hamilton ward had the highest number (7) .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.
• There were five incidents of sexual safety incidents against patients in May. The most common theme for these incidents was inappropriate sexual behaviour. The sexual safety working group focused on patient related sexual safety incidents is well established and represented from across the Trust. This meeting reviews incidents related to patients and has developed support and guidance to staff on managing and supporting patient related sexual safety. Individual incidents are reviewed at this meeting and themes and trends used to the support the development of ways to reduce sexual safety incidents in inpatient settings. This includes a trauma informed approach to current and historical sexual safety incidents. This group reports into the sexual safety oversight group.
• There were eight incidents of sexual safety incidents against staff (by patients) in May. The most common themes for these incidents was inappropriate sexual behaviour and sexual harassment. 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.
• The percentage of ligature jobs completed within timeframe has dropped under threshold this month, this related to 6 jobs, 4 have been found to be duplicate orders and this will be picked up in the clinical environment safety group. One job was not completed due to an issue with access and this has now been re-issued. Where an access issue occurs, these will be escalated to prevent delay and reduce any associated risk. The final outstanding job has been issued but on review is determined to not be a ligature risk.
• The number of restraint incidents decreased again this month from 185 reported in April to 152. The highest number of incidents were on Walton PICU (27), with 11 of these incidents relating to one complex service users. 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 65 inpatient falls reported during May 2026, this is an increase from last month. Further detail can be seen in the falls section of the report.
• Our focus on reducing the use of prone restraint continues to show significant improvement with 2 staff led prone restraints on our mental health wards during May. Both related to the administration of intramuscular (IM) medication and were clinically led decisions made to manage risk safely and during the incidents. The service user's physical health was monitored throughout, no concerns were identified, and all positions were maintained for the shortest duration necessary to ensure safety and dignity.
Alternative seclusion exit training is embedded in both four-day initial and two-day annual refresher RRPI training. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan.

Quality & Safety Headlines Cont…

• 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.

Patient Safety Incident Response Framework (PSIRF)
The review of the Trust's PSIRF plan and policy is currently underway. Several workstreams have been underway to revise procedures, processes in response to reflects on the past 2 years of working under PSIRF. The draft PSIRF plan is currently being finalised for approval.

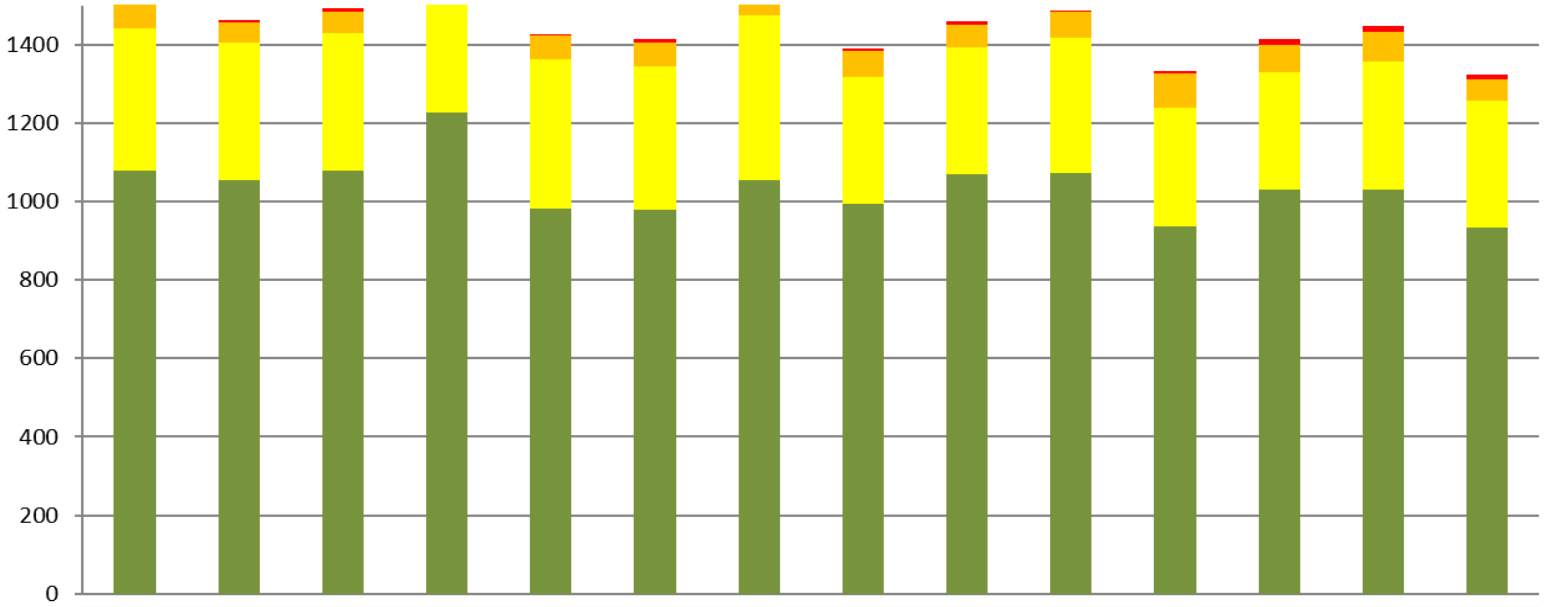
Quality & Safety Dashboard Footnotes:
1 - Number of pressure ulcers which developed under SWYPFT care - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary
2 – Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage
3 - The Information Governance breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches
4 - Notifiable Safety Incidents are where Duty of Candour is applicable.
5 - CAMHS referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Excludes autistic spectrum disorder waits and neurodevelopmental teams.
8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available). All incident data is reviewed using SPC charts to identify any special cause variation, if this occurs this will be reported by exception. Otherwise reporting rates remain within normal variation.
11 - Number of records with up to date risk assessment - 'Older people and working age adult inpatients' - we are counting how many staying safe care plans were completed within 24 hours and for 'community services for service users on care programme approach' - we are counting from first contact then 7 working days from this point.
12 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return. Please note, the wording of this metric has changed from the November 2024 report to align with wording used in the national reporting. This relates to complaints received during the month and until investigation process is complete, this may result in not all of those being upheld.
14 - This metric relates to the Macmillan service, end of life pathway.
15 - % of Band 4 and above clinical staff who have received supervision in the previous 90 days.
16 - Formal complaints should be responded to/closed within 6 months of the date received as is written into the NHS Complaints (England) Regulations 2009
* - includes data for Cheswold Park Hospital from April 2025.

Safety First

Summary of Incidents

Although we have reported 11 red incidents in May, incidents may be subject to regrading as more information becomes available, which means this figure is subject to change.

97% of incidents reported in May 2026 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in May 2026



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Red	2	6	7	2	2	8	9	7	8	2	6	15	13	11
Amber	70	52	55	77	60	61	59	67	57	68	88	68	76	56
Yellow	364	350	350	379	380	366	418	322	324	344	302	301	328	323
Green	1078	1056	1080	1226	983	978	1056	995	1070	1073	936	1029	1030	933

We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low harm incidents remains high as it does which is evidenced on the previous page. All incidents are reviewed by the care group management team and then by the Patient Safety Datix team to review the actual degree of harm to ensure consistency with national reporting. All amber and red incidents are monitored through the weekly Trust Clinical Risk Panel and all serious incidents are investigated using systems analysis techniques. Learning is shared via a number of routes; care group learning events following a Serious Incident, specialist advisor forums, quarterly Trustwide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

Safety First cont…

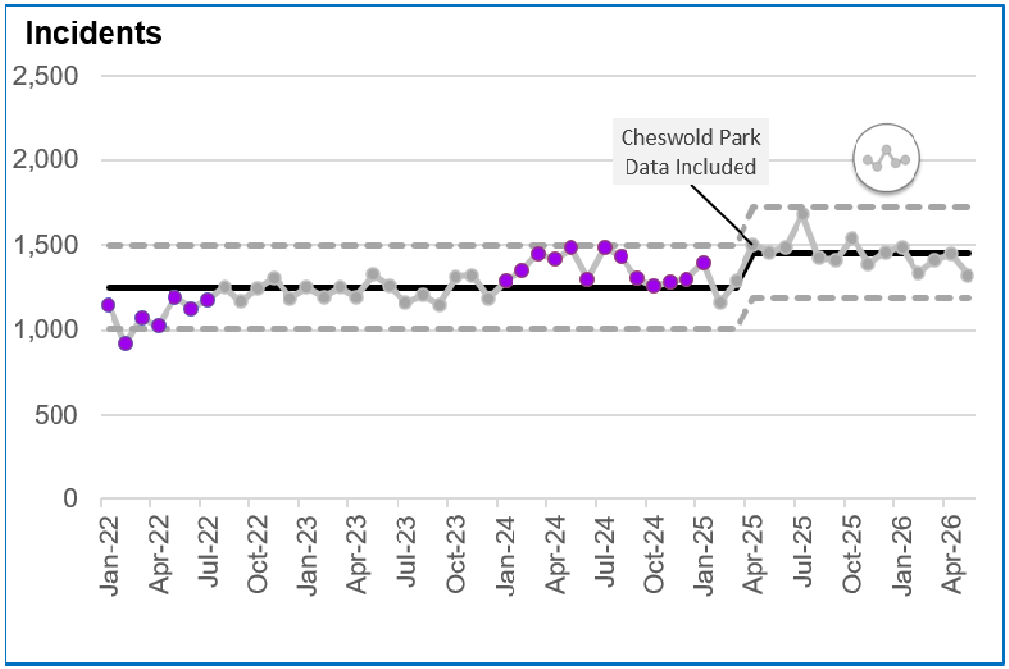
Summary of Patient Safety Incidents resulting in moderate or severe harm or death

Breakdown of incidents in May 2026

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

Sadly, there was one patient safety related death in May where the service user was known to the Trust's mental health services. This incident is subject to review and any learning will be identified. Condolences and support have been offered to the family concerned in these tragic circumstances.

Incidents

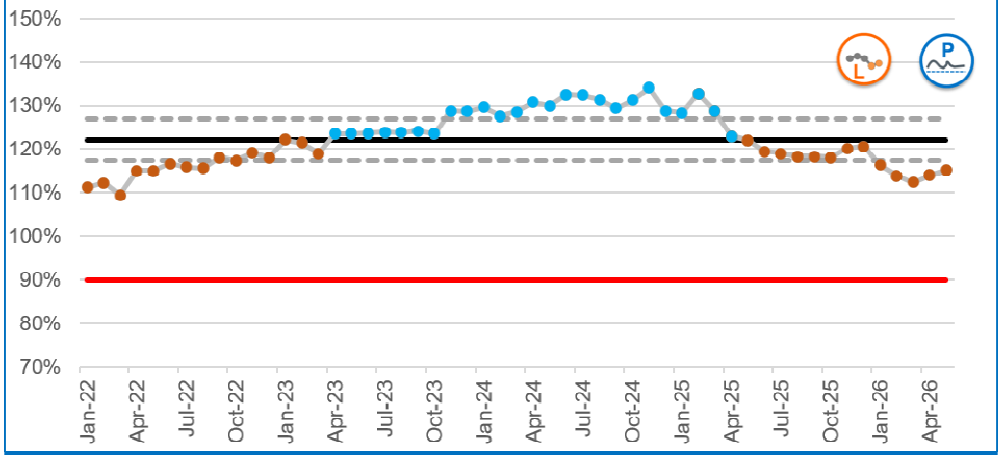


We have remained in a period of common cause variation in May 2026 due to an overall decrease in the number of incidents, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. Any outlier areas are explored with specialists and care groups, who are best placed to understand changes in light of other factors. They also ensure we are doing everything we can to support individuals to minimise patient safety incidents.

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

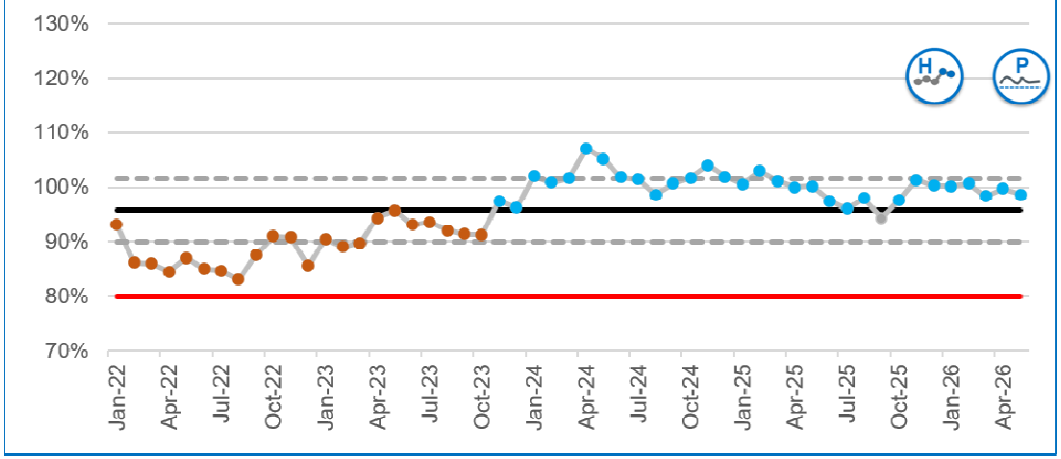
Safer Staffing Inpatients

Safer Staffing Fill Rate



The chart above shows that as at May 2026, due to the sustained decrease we remain in a period of special cause concerning variation (something is happening and this should be investigated) but we are expected to meet the target (see narrative below).

Safer Staffing Registered Nurses



The chart above shows that in May 2026, due to the sustained increase in the registered nurses fill rate, we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are expected to meet the target.

- In May within the flexible staffing pool, there was a total of 523 (5,724) less shift requests, and the overall fill rate for flexible staffing decreased by 2.6% to 91.7%
- Within overall fill rates there was a decrease in the fill rates of 1.0% for Forensic and LD care groups to 114.2%, Adult and Older Peoples Care Group increased by 2.3% to 121.3%, Cheswold Park Hospital increased by 0.4% to 105.8% and Barnsley Integrated Services decreased 0.7% to 95.7%
- We continue to scrutinise flexible staffing usage in our temporary staffing scrutiny group
- The utilisation of agency workers has decreased in authorised situations which is in line with our SOP for agency usage with no shifts being worked in inpatient areas in May
- The overall fill rate has increased compared to the previous month by 0.9% and was 115.1%
- The day fill rate for RNs decreased by 1.4% to 96.2%. With a decrease of two on the previous month, eight wards fell below the 90% RN Day fill rate, Walton Ward within Working Aged Adults, Stroke Rehab within Barnsley Physical Health Services and Appleton, Hepworth and Priestley Wards within the Forensic and LD care group, Willow within Older Aged Adults and Calder and Skipton within Cheswold Park Hospital. They were supported through local escalation plans
- The night Registered Nurse (RN) fill rate decreased by 0.6% to 102.3%. Night fill rate threshold of 90% was not achieved by five wards, which was consistent with the previous month. They were Wentbridge, Skipton, Don and Calder Ward at Cheswold Park and Neuro Rehab Unit within Barnsley Physical Health care group.
- In May one ward fell below the 90% overall fill rate threshold which was Stroke Rehab within Barnsley Physical Health. This was an increase of one on the previous month

Safer Staffing Inpatients cont…

Registered Nurse Day Rate:

Registered day rate	Mar-26	Apr-26	May-26
Adults and Older People	98.3%	100.4%	98.7%
Barnsley Integrated Services	88.1%	86.3%	88.7%
Forensic and LD	97.5%	97.5%	95.5%
Cheswold Park Hospital	96.2%	92.2%	91.5%
Overall shift fill rate	**97.2%**	**97.6%**	**96.2%**

Registered Nurse Night Rate:

Registered night rate	Mar-26	Apr-26	May-26
Adults and Older People	102.1%	106.0%	104.6%
Barnsley Integrated Services	101.9%	96.3%	97.2%
Forensic and LD	112.9%	114.3%	112.8%
Cheswold Park Hospital	74.9%	84.3%	85.8%
Overall shift fill rate	**99.5%**	**102.9%**	**102.3%**

Overall Registered Rate: 98.6%.

Overall Fill Rate:

Overall Fill Rate	Mar-26	Apr-26	May-26
Adults and Older People	116.9%	119.0%	121.3%
Barnsley Integrated Services	93.8%	96.4%	95.7%
Forensic and LD	110.5%	115.2%	114.2%
Cheswold Park Hospital	106.8%	105.4%	105.8%
Grand total	**112.2%**	**114.2%**	**115.1%**

Bank staff filled 86.7% (a decrease of 3.9% on the previous month) of RN requests for flexible staffing and 93.0% (a decrease of 2.2% on the previous month) of Health Care Assistant (HCA) requests.
Agency staff filled 0.0% (consistent the previous month) of RN requests for flexible staffing and 0.0% (a decrease of 0.03% on the previous month) of HCA requests.

Hours Worked	Substantive	Bank	Agency
Mar-26	63.7%	35.8%	0.5%
Apr-26	68.4%	31.6%	0.0%
May-26	67.8%	32.2%	0.0%
Grand Total	**66.6%**	**33.2%**	**0.2%**

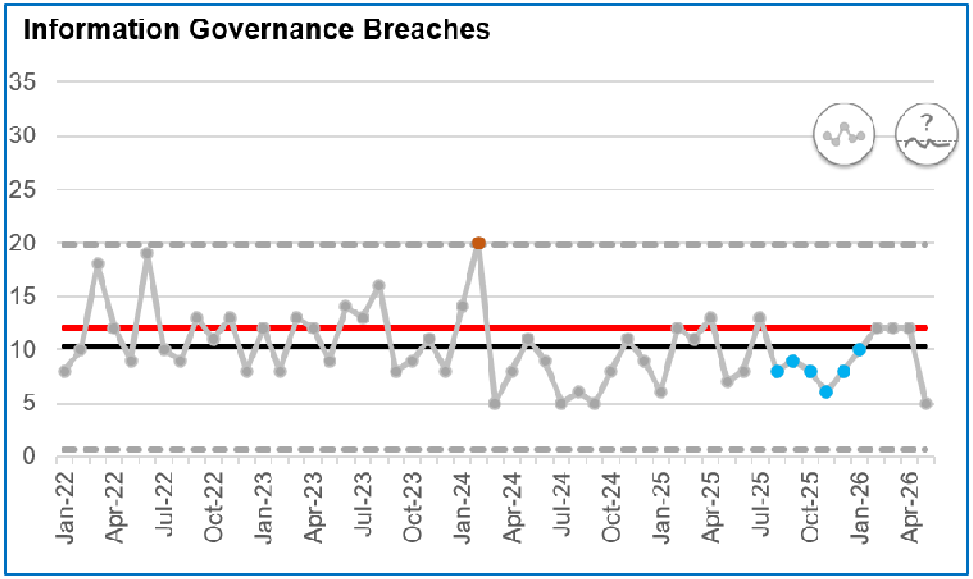
Information Governance (IG)

Five personal data breaches were reported during May 2026, which is the lowest in month reported number for over 12 months.

Information disclosed in error continues to be the highest reported category with breaches also reported due to a disclosure including another patient's data, an email sent to the wrong recipient and a letter sent to the wrong address.

The Information Governance Manager is working with the management teams for the areas that reported the highest numbers of incidents during March and April 2026. A comms campaign continues and personal responsibility for ensuring outgoing post and email correspondence is sent to the correct recipient is a key message.

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



Learning Library

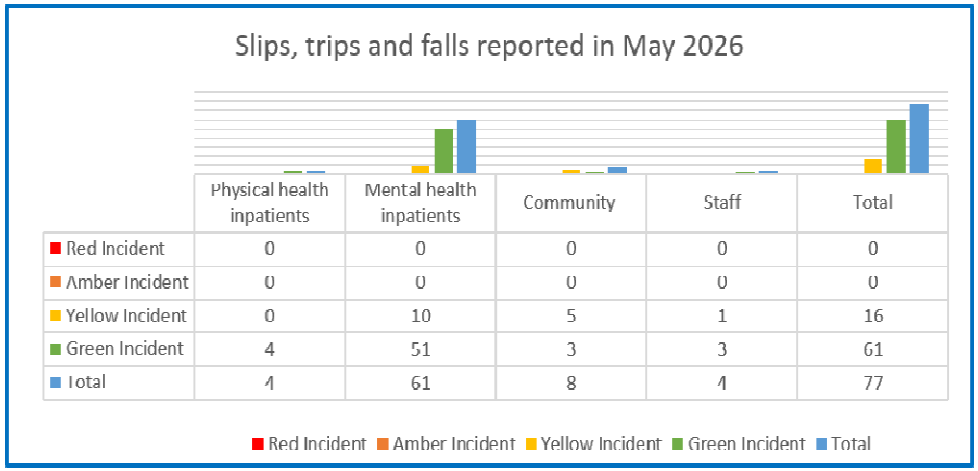
The learning library has been developed as a way to gather and share examples of learning from experience.
Further examples can be found on the SWYPFT intranet page.

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

Patient Safety Alerts

There were no patient safety alerts that were not completed by deadline in May 2026.

Trustwide Falls



	Physical health inpatients	Mental health inpatients	Community	Staff	Total
Red Incident	0	0	0	0	0
Amber Incident	0	0	0	0	0
Yellow Incident	0	10	5	1	16
Green Incident	4	51	3	3	61
Total	4	61	8	4	77

May 2026, Datix reported a Trustwide total of 77 slips, trips and falls. This equates to 5.5% of all Datix safety events reported in May 2026. Below is a breakdown of falls and where they occurred in the community, inpatients, or staff group/visitor.

The Trust inpatient falls rate is approximately 3.95 per 1000 bed days. We continue to be below the National average for inpatient falls of 6.63 per 1000 bed days.

Things to celebrate
• Across OPS wards, SRU/NRU there were a total of 93 patients (62% of patients) assessed as a high risk of falls. Of those patients, 24 (26%) experienced one or more falls. With 69 (74%) higher risk patients having no falls.
• There was 100% of physical health checks completed post falls.
• There was 97% of patients with a good quality mobility plan and associated education/groupwork documented.

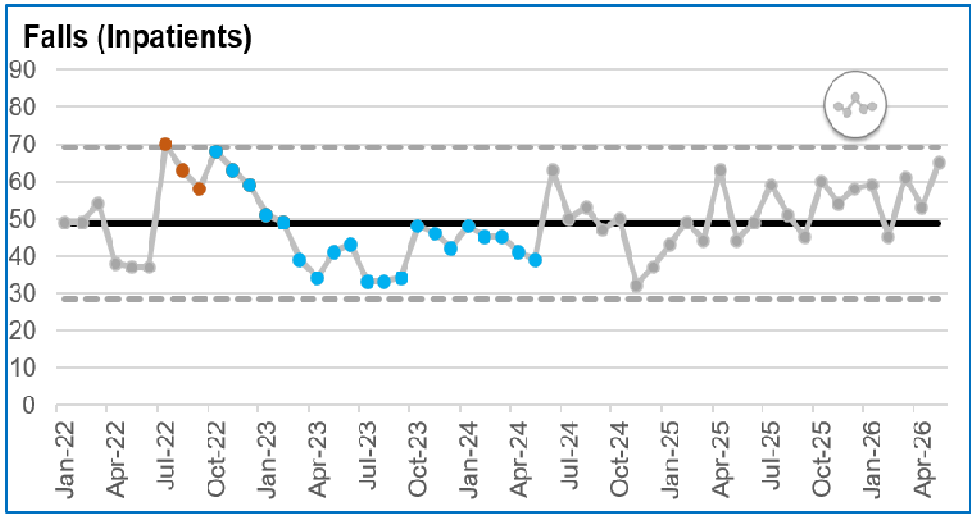
Incident Grading
Red: No red fall incidents reported.
Amber: No amber fall incidents reported.
Yellow: A total of 16 (21%) reported events needed higher intervention or were recognised as a higher risk of repeat falls.
Green: A total of 61 (79%) reported safety events had low, or no harm recorded.

Inpatient falls accounted for 65 falls and had a high correlation with:
• three falls (5%) for patients out on leave or off the ward when the fall occurred
• seven falls (11%) directly linked to deteriorating physical illness such as urinary tract infection, vomiting, developing physical illness
• there were 17 falls (26%) linked to agitation, pacing, and aggressive behaviours
• four patients had repeated falls (2+ falls); and accounted for 19 (29%) inpatient falls
    • one patient had 12 falls linked with significant agitation, and behaviours associated to dementia and to trauma. Reviews, including discussions with family continue to support care and discharge planning

When reviewing age related information:
• there were 28 falls (43%) by patients aged below 65 years old, of these:
    • there were 17 falls (61%) where the patient had no history of falls, chaotic behaviours, falling asleep at a dining table, physical illness, and possible placing self to floor to support a transfer to A&E
    • and 11 falls (49%) for younger patients with known falls risk, one person with Parkinson's disease attempting to strike staff, and three falls for younger people not using their walking aids as shown
• there were 37 falls (57%) for patients aged 65 years and above, of these:
    • 36 patients (97%) had a known history of falls
    • 30 falls (80%) for patients with a diagnosed dementia or neurological condition, of those falls
    • 14 falls (50%) were linked with an attempted AWOL, agitation and behavioural aspects of dementia

Falls (Inpatient)

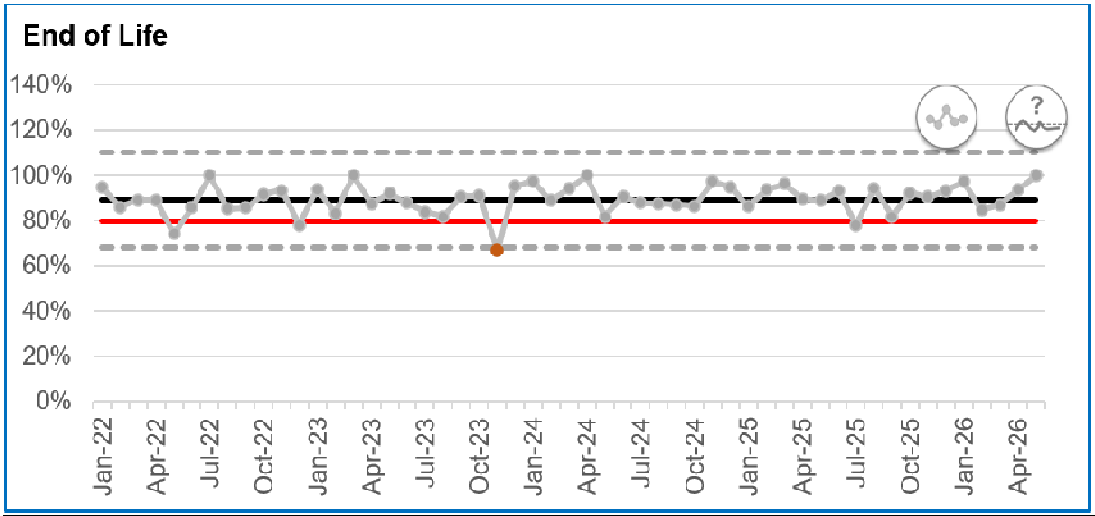
The total number of inpatient falls was 65 in May.



The SPC chart above shows that in May 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 total percentage of people dying in a place of their choosing was 100% in May. As is noted in the quality dashboard, performance against this metric remains above threshold this month. This metric relates to the Macmillan service, end of life pathway.



The chart above shows that in May 2026 the performance against this metric remains in common cause variation (no concern). As the mean performance for this measure is high (90%), the upper control limit (based on the average of the moving range) shows as above 100%.

Patient Experience

Friends and family test results (FFT) show:

- 96% would recommend physical health services
- 93% would recommend mental health services

	Target	Mar-26	Apr-26	May-26
Mental health community	85%	92% (158)	87% (373)	95% (312)
Mental health inpatient	85%	85% (34)	70% (23)	95% (65)
Learning Disabilities	85%	94% (17)	100% (1)	97% (38)
ASD/ ADHD	85%	100% (29)	95% (21)	76% (17)
CAMHS	85%	75% (16)	82% (28)	81% (31)
Forensic	60%	No Responses	100% (2)	50% (2)
Mental health overall	84%*	92% (280)	86% (448)	93% (466)
Barnsley Physical Health	95%	96% (335)	91% (160)	96% (171)
Trustwide	**85%**	94% (541)	88% (608)	94% (637)

** weighted for 2026/27*

	Top three positive themes	Top three negative themes
Trustwide	1. Staff	1. Communication
	2. Patient Care	2. Access & Waiting Times
	3. Communication	3. Values & Behaviours
Physical Health	1. Staff	1. Communication
	2. Patient care	2. Staff
	3. Clinical treatment	3. Clinical Treatment
Mental Health	1. Staff	1. Access & Waiting Times
	2. Patient Care	2. Communication
	3. Communication	3. Clinical Treatment

The satisfaction rate across the Trust has increased from the previous month and remain above target.

- Mental Health Community, Mental Health Inpatient, Learning Disability, and Barnsley Physical Health all performed above target in May.
- ADHD & ASD, CAMHS, and Forensics were below target for the same period.
- Mental Health Community, Mental Health Inpatient and Barnsley Physical Health services experienced an improvement in satisfaction levels compared to April.
- Physical Health services responses have increased compared to April but are still low compared to March. This is due to patient experience surveys being unavailable during April. These surveys are currently being transitioned to Microsoft Forms, with completion expected by the end of May.
- Barnsley general ops response rate has increased in May and are above target this month an improvement compared to April.
- FFT figures are currently being monitored closely following the implementation of Patient Knows Best and the QR code poster.

Safeguarding

Safeguarding Adults:
In May 2026, there were 47 safeguarding adult incidents recorded on Datix. Of these, there were zero incidents graded red or amber, 23 graded yellow and the remaining 24 incidents were graded green. The most common subcategories of these were neglect, self neglect and physical abuse.

In addition to the Safeguarding Adult Datix's, there were 15 sexual safety incidents recorded on Datix. Of these, there was one Datix incident graded red or amber, three were graded yellow and 12 were graded green. The most common subcategory related to inappropriate sexual behaviour.

Safeguarding Children:
In May 2026 there were 35 Datix categorised as Safeguarding Children. The most common subcategories of these were requests for service and child protection (non-specific).

Complaints

- There have been 33 new formal complaints received in May 2026 which is a 10% increase from the previous month.
- There were 11 complaints closed in May which is a 24% decrease from 14 in April, and 91% were closed within the six-month statutory timeframe.
- There were 0 formal complaints which had values and behaviours (staff) as a primary reason for the complaint.
- The Trust received a small increase in the number of informal concerns in May.

Infection Prevention Control (IPC)

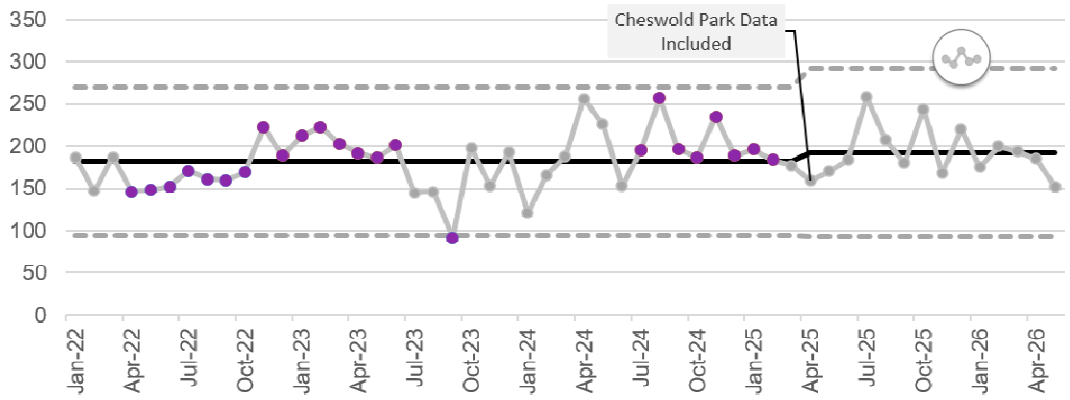
Outbreaks / Clusters
In May there was one outbreak on Beamshaw ward (Para Influenza)

Reducing Restrictive Physical Intervention (RRPI)

• During May 2026, there were 152 incidents of physical restraint throughout the Trust, a decrease of 36 from April 2026.
• There were two incidents of prone restraint in May 2026 this is a slight reduction from three incidents in April 2026. The two incidents of prone restraint were both staff led.
• The restraint table shows the type of restraint positions used Trustwide May 2026 (in 152 restraints). Please note there are more positions used than incidents due to multiple positions being used during one incident.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	70	24.5%
Seated	48	16.8%
Safety Pod	46	16.1%
Escorted under restraint	21	7.3%
Supine - held on their back, regardless of surface	11	3.8%
Side	9	3.1%
Prone descent then immediately rolled to other position side/back	6	2.1%
Safety Pod Technique (IM administration then exit)	4	1.4%
Kneeling	1	0.3%
Immediate disengagement from prone	1	0.3%
Reverse arms seclusion exit (knees position)	1	0.3%
Safety Pod Technique (Immediate Exit)	1	0.3%
Prone descent then remained in chest down position	0	0.0%
Total	286	100.0%

Total Restraint Incidents

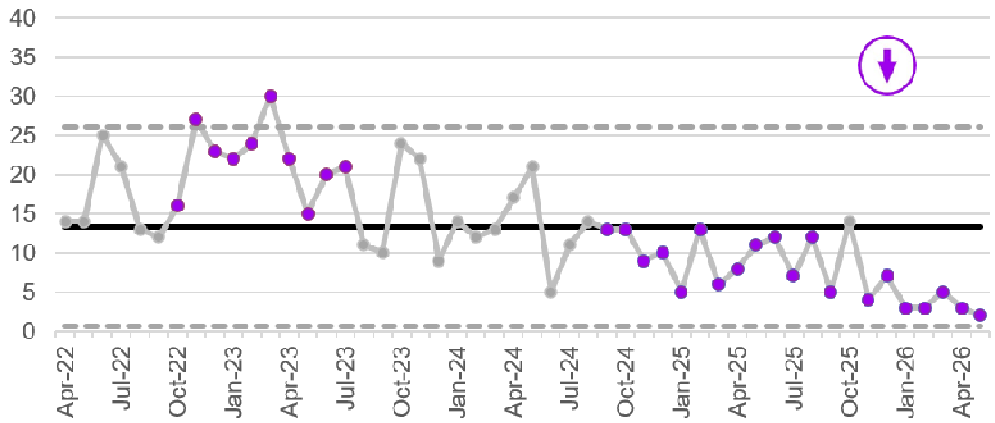


This SPC chart shows that in May 2026 we remain in a period of common cause improving variation.

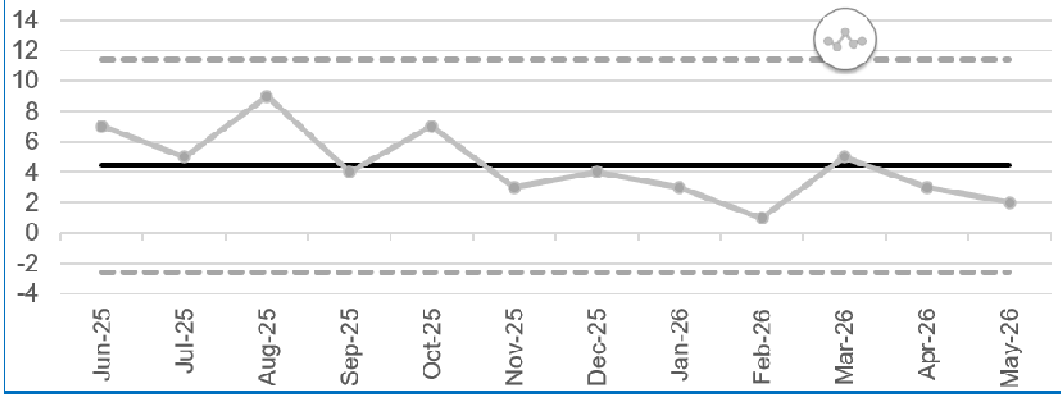
It should be noted that an increase in restraint incidents does not always indicate a deterioration in performance.

Reducing Restrictive Physical Intervention (RRPI)

Prone Restraint (Total Number)



Prone Restraint (where we have purposefully placed the person in prone position)



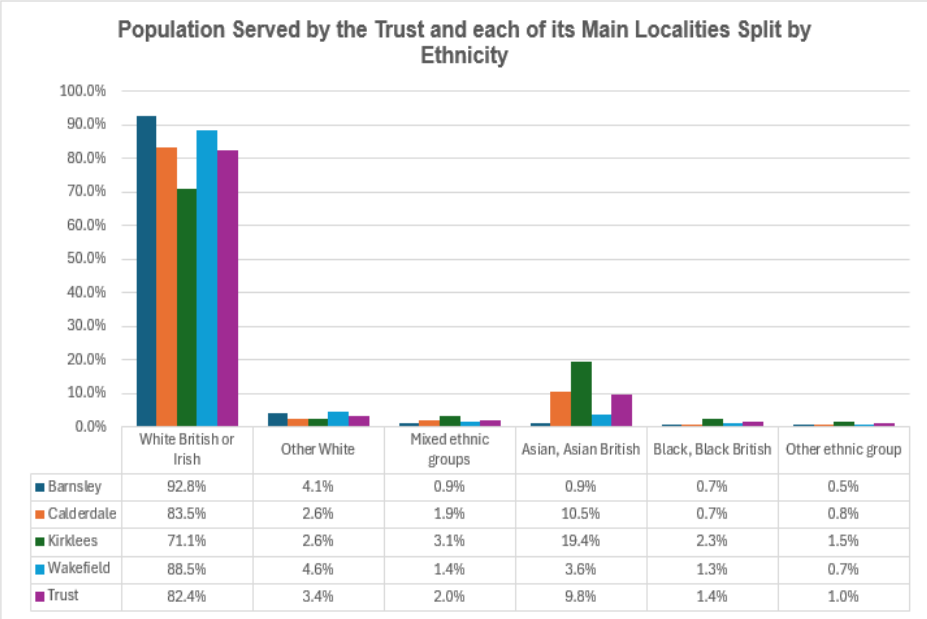
The circumstances where prone is used will be influenced by the level of concern during the incident. Alternative seclusion exit training is now embedded in both four-day initial and two-day annual refresher Reducing Restrictive Physical Interventions training. Additional bespoke sessions are being offered across inpatient units in collaboration with Ward Managers to ensure all inpatient nursing staff, both registered and unregistered staff are supported to undertake training in alternative seclusion exit techniques and feel confident to use. We expect this will further support a move away from prone restraint being used as a method for exiting seclusion

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

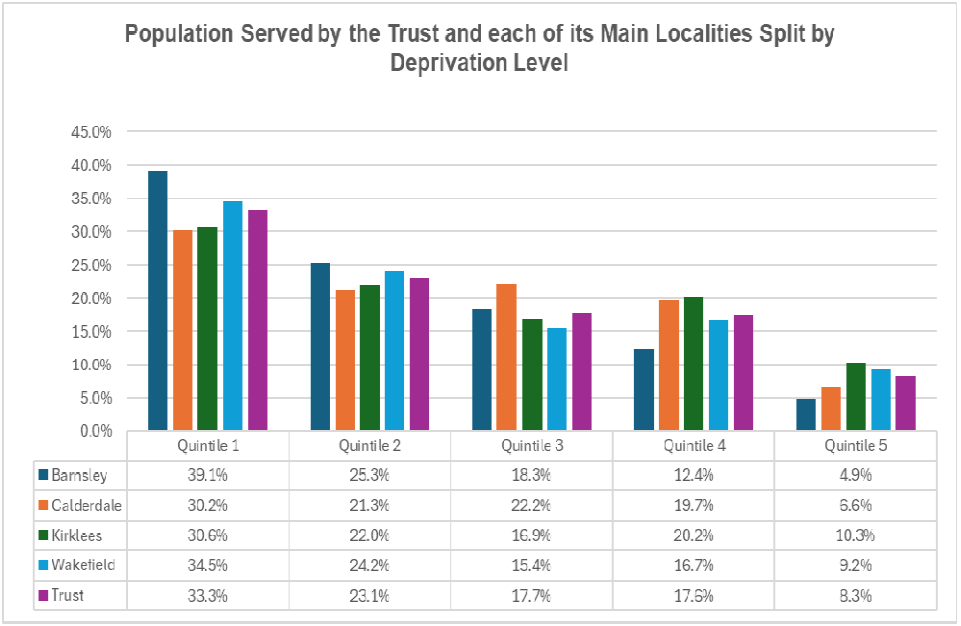
In May 2026 there were two instances of prone restraint where the service user was purposefully placed in the prone position.

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.



	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%

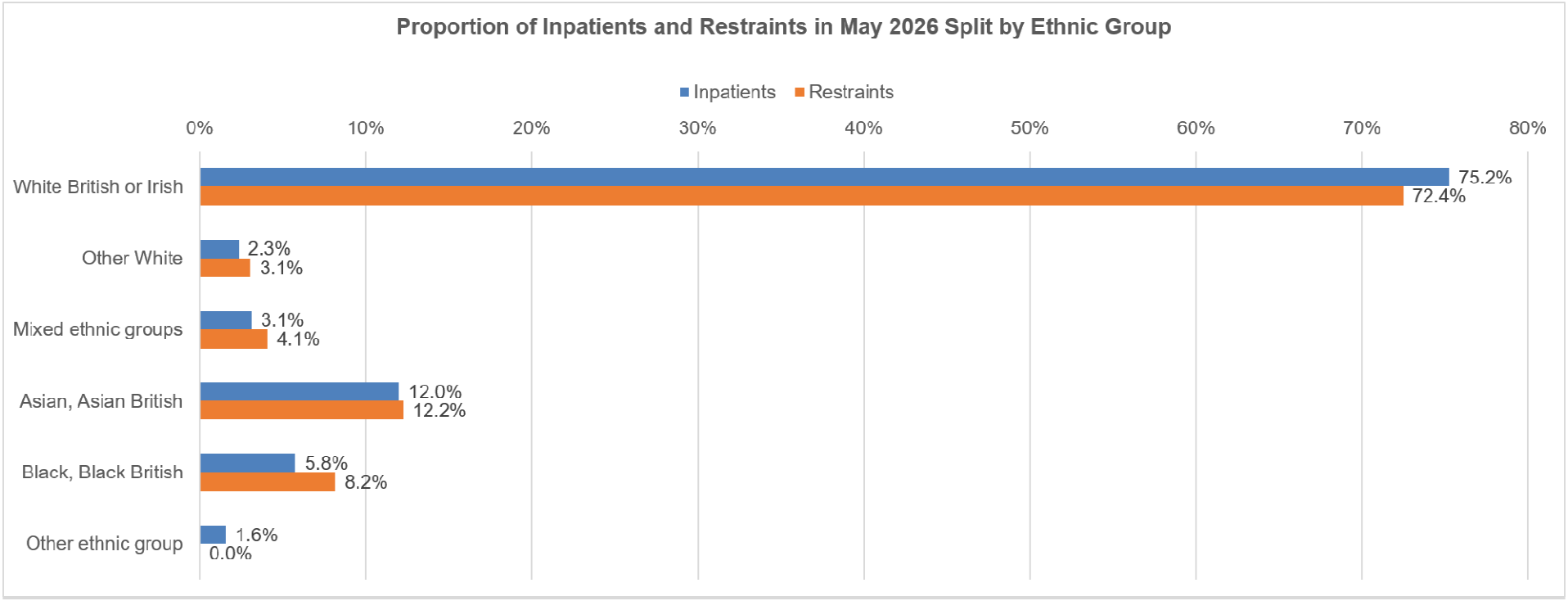


	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Barnsley	39.1%	25.3%	18.3%	12.4%	4.9%
Calderdale	30.2%	21.3%	22.2%	19.7%	6.6%
Kirklees	30.6%	22.0%	16.9%	20.2%	10.3%
Wakefield	34.5%	24.2%	15.4%	16.7%	9.2%
Trust	33.3%	23.1%	17.7%	17.6%	8.3%

The data on this page will not be refreshed except when population estimate data is published. However this page helps to provide important context about the varied population our Trust serves in terms of ethnic make-up and 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.

Reducing Inequalities

The data on this page continues to be developed and in this edition only data for May 2026 is included. We are working to refresh this and looking to adopt a 12m rolling data review to provide more meaningful actions. The purpose of this data is to understand whether there is any disproportion in the proportional levels of restraint experienced by inpatients of different ethnic groups. 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. Specific actions relating to this data will be formulated and held in governance via the EDI Operational Group.



Reducing Inequalities

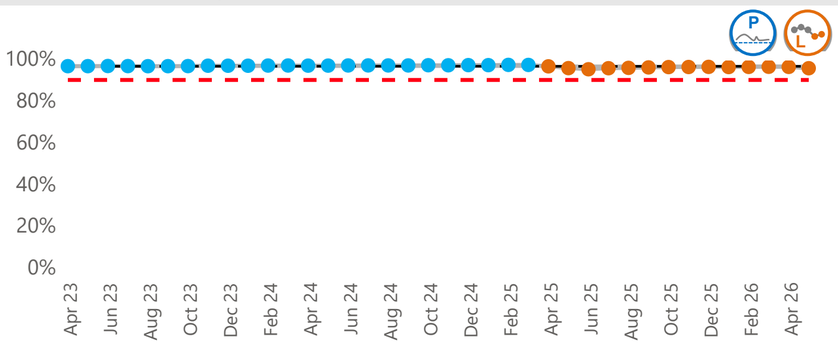
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NHS South West Yorkshire Partnership NHS Foundation Trust

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. All services continue to work hard to maintain their data quality and future monitoring will form a standing agenda item in Care Group Data Quality meetings with specific actions held in governance via the EDI Operational Group.

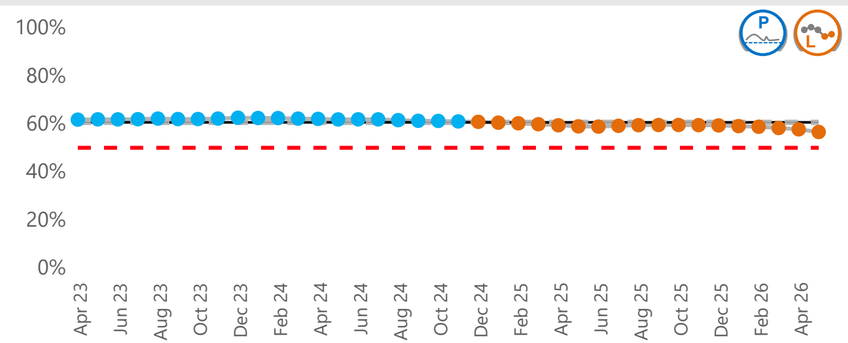
The SPC charts below show the completion rates for these measures.

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



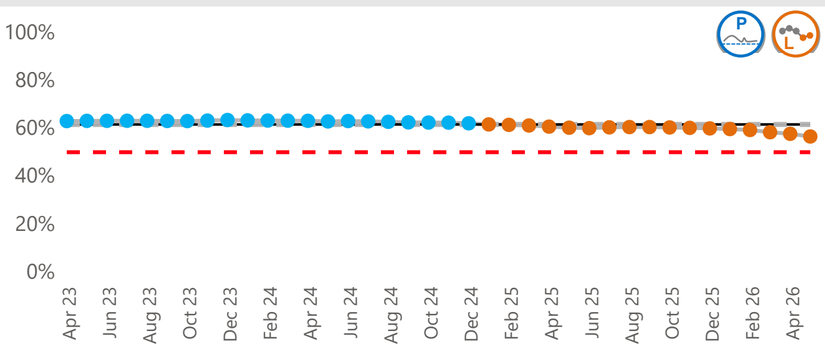
The Statistical Process Control (SPC) chart shows that in April 2026 due to the continued dip in performance we remain in a period of special cause deteriorating variation (something is happening and should be investigated). We are expected to meet the target against this metric.

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



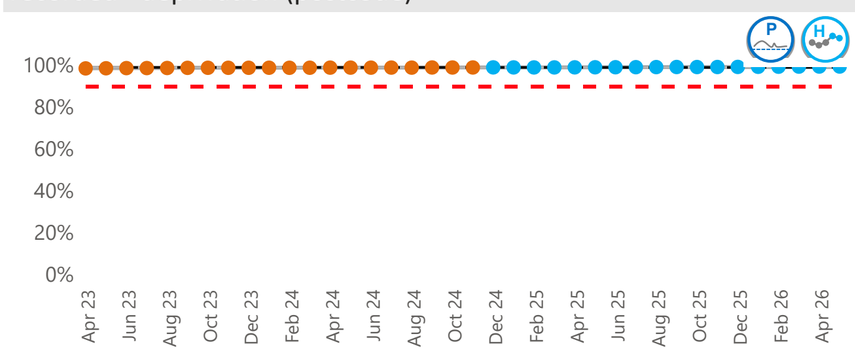
The SPC chart shows that in April 2026 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months. We are expected to meet the target against this metric. There are a number of service lines where data quality has reduced over the last 12 months and further work is being done to understand the contributing factors and direct improvement.

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



The SPC chart shows that in April 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)



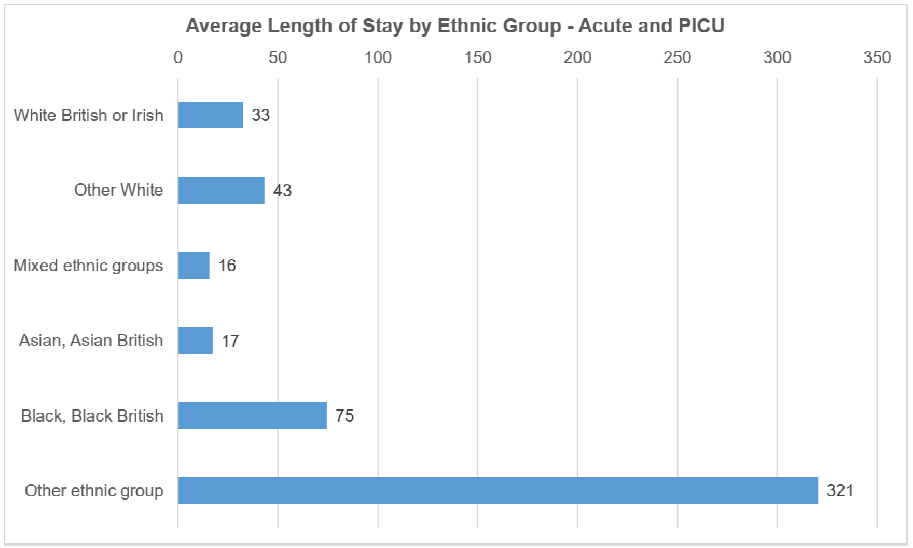
The SPC chart shows that in April 2026 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance. We are expected to meet the target against this metric.

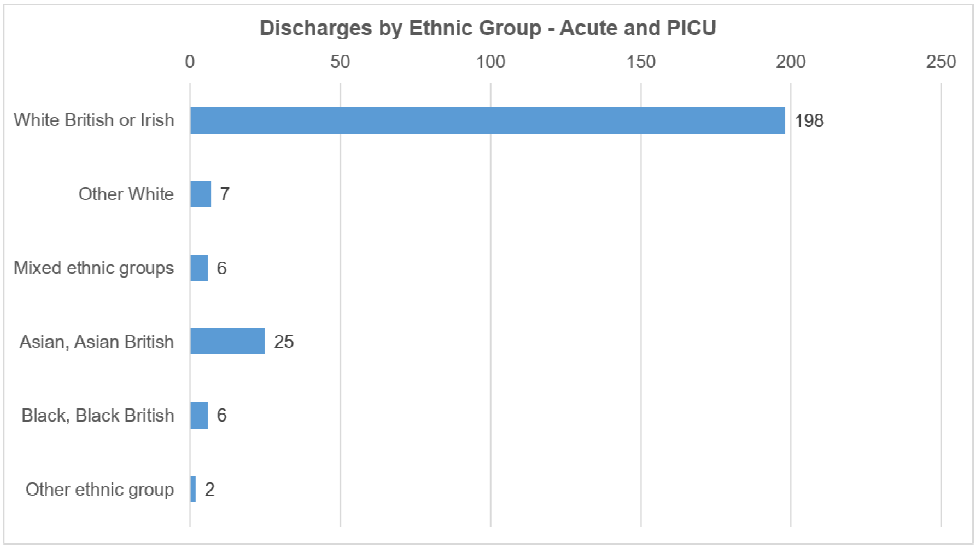
Reducing Inequalities

The charts show the average lengths of stay (ALOS) for our Acute and PICU, adult and older adults wards, for the financial year 2026/2027 (excluding 136 Suite and out of area stays). This data is calculated at the point of discharge and is therefore affected by skew where a patient is discharged following an extended LoS. It is noted that the data below only inlcudes data from April 26. We are working to refresh this and looking to adopt a 12m rolling average review.

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 (alongside the traditional measure of 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.

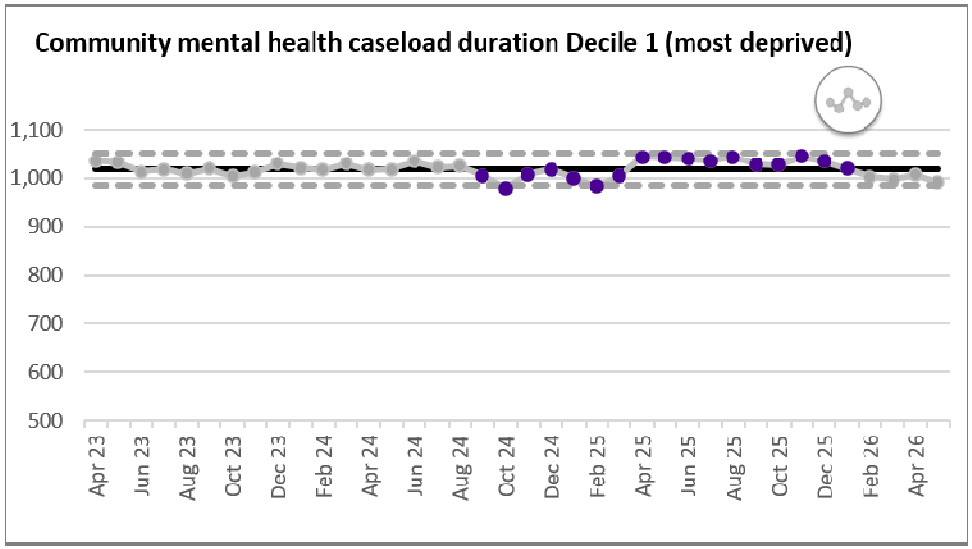
Differences in admission practices i.e. formal (compulsory) and informal (voluntary) also appear to influence LoS, with compulsory admissions tending to require more intensive interventions and longer discharge planning. Similarly, discharge approaches differ, with patients facing socioeconomic challenges 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.

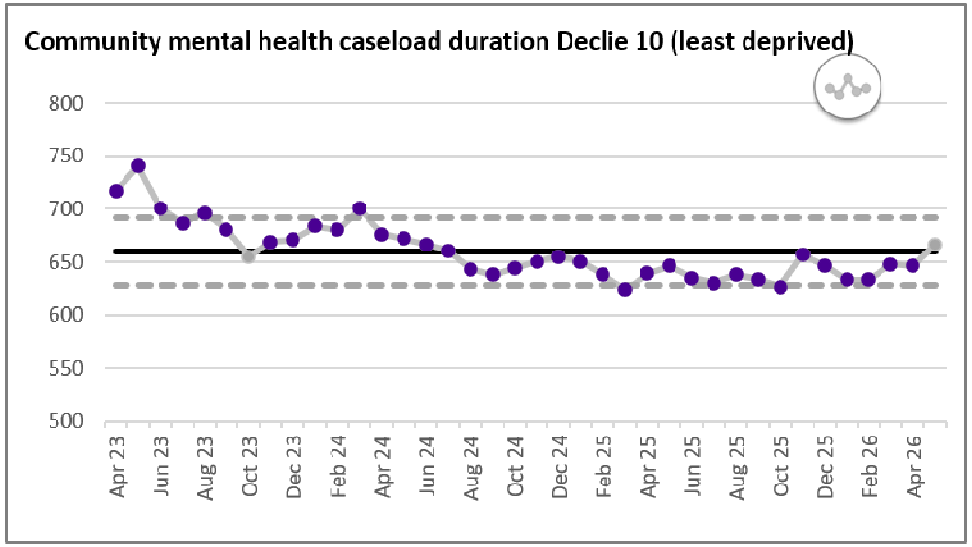




Reducing Inequalities

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. Work is underway to understand the May increase in caseload duration for those in IMD10, however early indications are that this may be part of a subtle annual variation linked to service user choice, rather than servcie change.

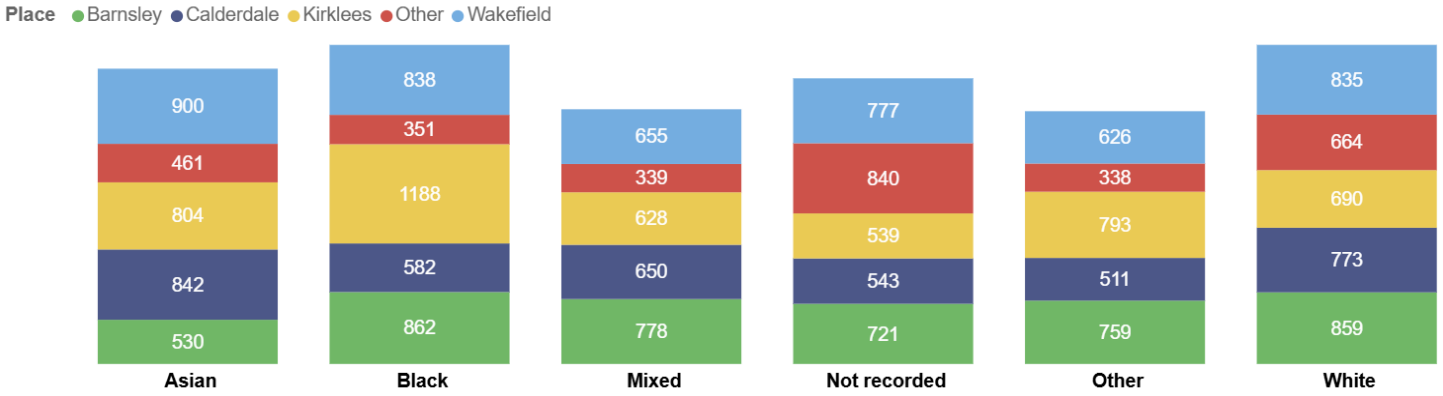




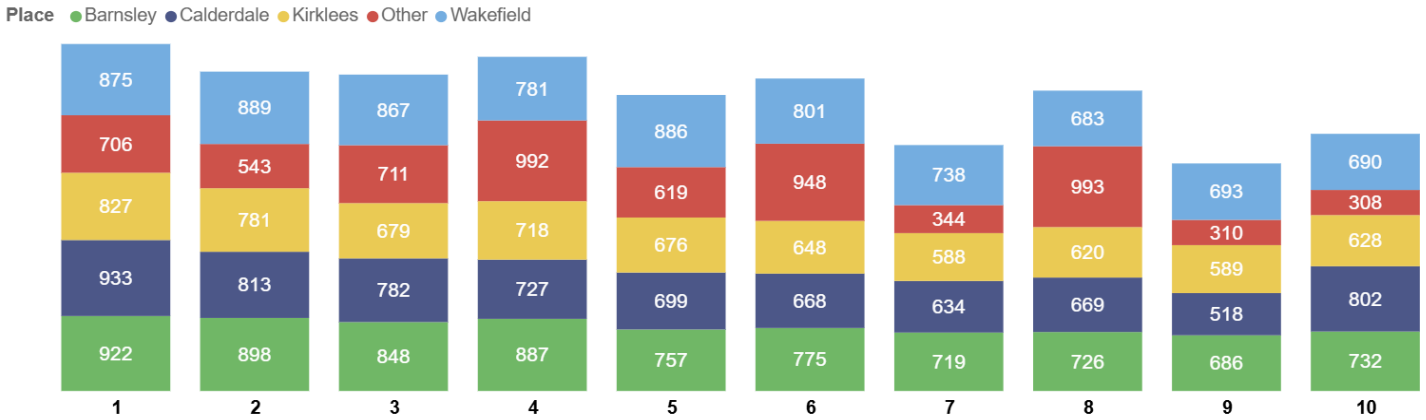
Reducing Inequalities

The charts below show the average caseload length (days) for the group of patients on a community mental health caseload split by ethnic group, and deprivation decile, and also split by Place. We can see that the pattern of lower duration on caseload in IMD10 is mirrored accross all our places. Further work is underway to direct future work but it is important to remember that for the data on this page, the dfferent number of service users in each group (IMD or ethnicity) is different in each place and comparisons are therefore representative, rather than a direct comparison.

Average Days on Caseload Split by Ethnic Group and Place - Mental Health Rolling 12 Months



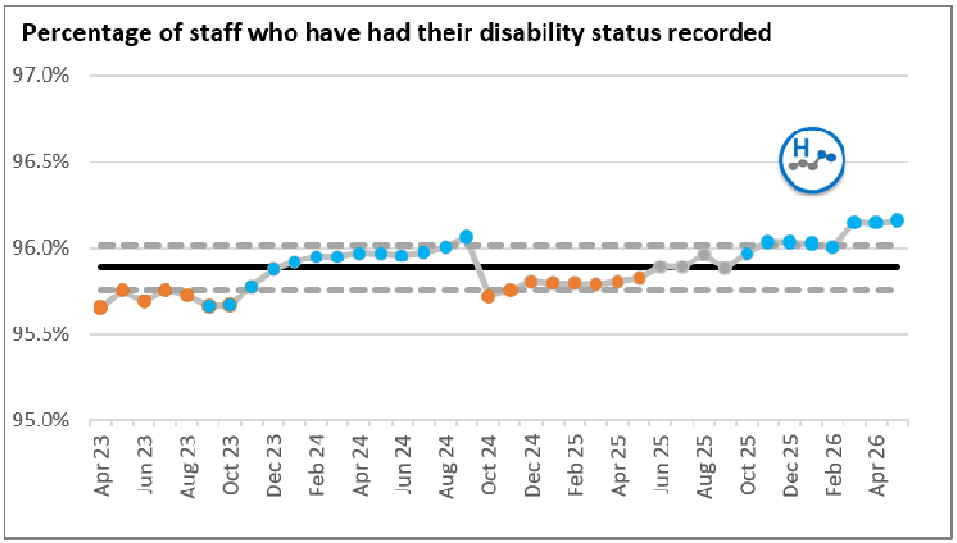
Average Days on Caseload Split by Deprivation Decile and Place - Mental Health Rolling 12 Months

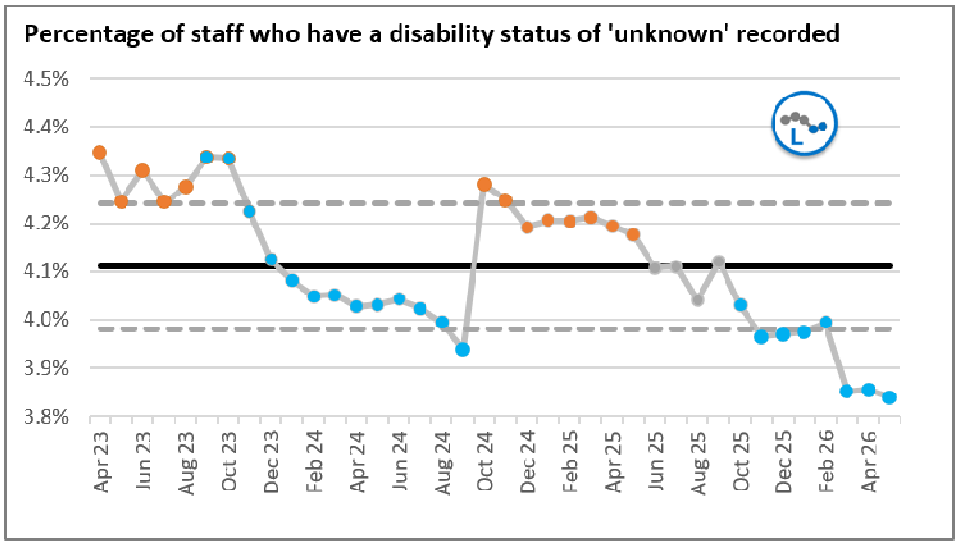


Reducing Inequalities

Disability Confidence and Data Transparency

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





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

People - Performance Wall

Trust Performance Wall

	Strategic Objective	CQC Domain	Threshold	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Vacancy Rate	Best place to work and learn	Well led	8%			Reporting Commenced April 2026		6.4%	6.6%
Turnover external (12 months rolling)	Best place to work and learn	Well led	25/26 - 13% 26/27 - 10%	9.4%	9.1%	9.0%	8.2%	8.4%	9.3%
Starters	Best place to work and learn	Well led	-	21.3	51.4	47.5	39.0	37.3	14.8
Leavers	Best place to work and learn	Well led	-	28.8	29.0	35.6	36.2	28.9	39.3
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 and medics) *	Best place to work and learn	Well led	-	121 (10.6%)	125 (10.8%)	125 (10.8%)	131 (11.2%)	132 (11.2%)	134 (11.4%)
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	-	952 (71.7%)	962 (71.8%)	975 (72.1%)	986 (72.2%)	985 (72.3%)	985 (72.4%)
Sickness absence - Year-to-Date (YTD)	Best place to work and learn	Well led	<=5%	5.5%	5.5%	5.5%	5.4%	4.9%	4.9%
Sickness absence - Month	Best place to work and learn	Well led		6.0%	5.8%	5.2%	4.9%	4.9%	4.8%
Appraisals - rolling 12 months	Best place to work and learn	Well led	90%	88.3%	89.2%	87.8%	88.7%	92.2%	93.5%
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	60	69	66	60	64	65
Sexual Safety Incidents - Staff	Best place to work and learn	Safe	Trend Monitor			Reporting Commenced April 2026		0	0
Mandatory Training - TOTAL	Best place to work and learn	Well led	>=80%	95.7%	95.4%	95.3%	95.3%	95.2%	95.4%

Our workforce supply

Turnover

In May 2026 our turnover rate was 9.32%, which is below our KPI target. Turnover within the Support Services (10.4%) and Forensics Care Groups (12.7%) for May 26 is above our KPI target. As Cheswold Park Hospital (CPH) has now been integrated into the Forensics Care Group, the turnover within this care group includes the planned workforce Cheswold Park changes following the acquisition of the site and the impact of changes in right to work. The impact of this on the turnover data will continue until July 2026.

Vacancy Rate

Our vacancy rate has also increased slightly in May 26 due to there being more leavers than new starters. Our CPH teams within our Forensic care group are seeing a high number of vacancies, in particular within our CSW workforce. A recruitment campaign is underway to reduce these vacancies.

We are safe and healthy

Sickness Absence

Our overall sickness absence rate remains under our KPI target for May 26. Our Long Term and Short term sickness are both lower than this period last year. Latest national benchmark data is February 2025. The Trust rate was 5.19% in month, compared to 5.43% nationally; 5.96% in North East and Yorkshire; and 5.96% within Mental Health and Learning Disability Trusts.

We are compassionate and inclusive

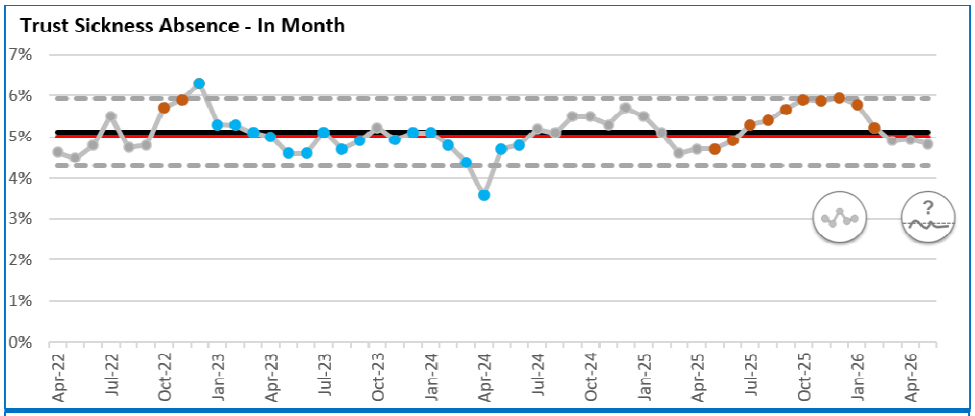
Appraisal Compliance

In May 26 we are achieving our KPI target with a current compliance rate of 93.3%. This does include some employees who are due their appraisal, however they are transitioning into the new appraisal window. A new dashboard has been rolled out to support this and We are expecting all appraisals to be completed by the end of September 2026.

Training Compliance

Our overall statutory and mandatory training compliance remains above Trust target. There are currently some employees who have expired in their Information Governance (IG) training, with Trust compliance against Information Governance training has dropped to 94.0% in May. This needs a focussed review within care groups to improve the compliance.

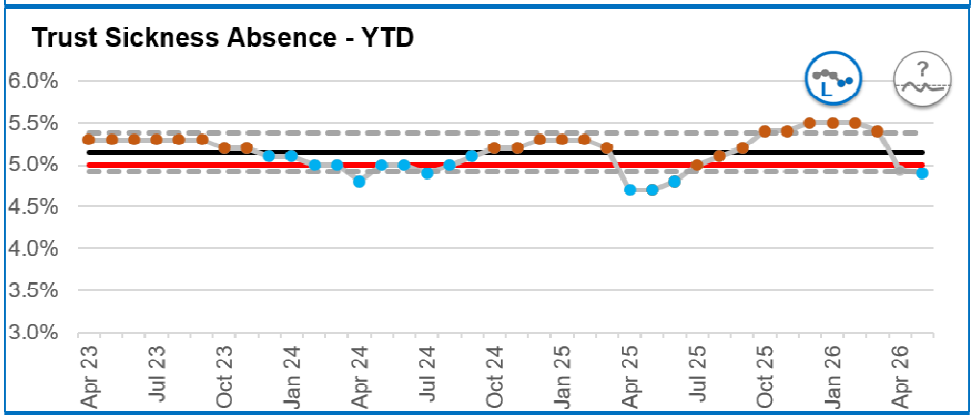
Statistical process control charts



The SPC chart shows that in May 2026 we remain in 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 May 2026 we have entered a period of special cause variation (something is happening and this should be investigated) 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.

National Metrics

Data as of : 23/06/2026 17:28:25

NHS South West Yorkshire Partnership NHS Foundation Trust

This section of the report includes the Trust performance against a range of 2026/27 national operational metrics including national priorities, operational planning and NHS Oversight Framework performance. NHS Oversight Framework 2025/26 - Quarter 4 results are included in this section of the report. Where metrics have been carried forward from 2025/26, there may be a change in threshold, this is reflected in this section.

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more	Best Quality	Responsive		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive		92%	P		97.8%	97.7%	97.5%	97.2%	97.1%	97.8%	97.5%	96%	95.6%	96.4%	97.5%	97.5%
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680			4025	4151	4319	4554	4641	4514	4287	3868	3946	4162		
					4043													4273	4354
M206	Diagnostic test activity	Best Quality	Responsive		190			128	206	239	305	273	247	263	294	235	265		
					193													249	205
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%	P	H	100%	98.7%	96.3%	100%	98.9%	100%	100%	100%	100%	99.1%	100%	100%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0	F	L	159	196	203	234	155	97	76	52	28	73	90	82
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5	?	L	5	7	8	7	3	4	2	1	1	3	3	3
M7	72 hour follow-up from psychiatric in-patient care	Best Quality	Safe		80%	?	H	90.7%	91.1%	88.6%	88.2%	89.0%	87.8%	87.6%	91.1%	87.7%	87.3%	86.5%	87.2%
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%	P		97.4%	95.5%	87.5%	93.3%	94.7%	96.4%	96.9%	89.7%	96.4%	96.2%	85.3%	86.8%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%	?	H	95.3%	96.0%	96.1%	96.4%	96.9%	96.7%	97.4%	96.9%	96.4%	96.4%	95.8%	96.3%
M34	% Clients in settled accommodation	Best Value	Effective	⚠	60%	P	L	83.0%	82.9%	76.0%	82.8%	82.9%	83.3%	83.0%	83.0%	83.2%	83.2%	82.9%	83.4%
M35	% Clients in employment	Best Value	Effective	⚠	10%	P	H	13.0%	13.3%	12.6%	13.3%	13.6%	14.0%	13.7%	14.0%	14.1%	14.2%	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	6	16	2	4	0	2	4	12	25
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		0	0	0	1	1	1	1	0	1	1	1	2

National Metrics

Data as of : 23/06/2026 17:28:25

NHS South West Yorkshire Partnership NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%	?		100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%	?	H	91.3%	81.4%	88.2%	83.8%	94.4%	94.4%	92.9%	91.2%	100%	89.7%	95%	100%
M47	Virtual ward occupancy	Best Quality	Responsive		80%	?		90.7%	84%	89.3%	92%	74.7%	70.7%	72%	70.7%	85.3%	62.7%	108%	80%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0	F	L	8	6	11	10	13	12	8	5	5	1	0	0
M30	Number of detentions under the Mental Health Act (MHA)	Best Quality	Safe					106	87	99	102	102	83	106	98	101	116	113	122
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					26.4%	23.0%	24.2%	25.5%	21.6%	16.9%	17.0%	22.4%	13.9%	21.6%	24.8%	23.8%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%	P		99.8%	99.7%	99.4%	99.5%	99.3%	99.4%	98.9%	97.7%	98.9%	98.6%	99.8%	99.6%
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		99.2%	99.7%	99.6%	99.5%	99.5%	99.4%	98.1%	99.1%	99.3%	99.5%	99.3%	99.0%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%	?		47.3%	53.4%	47.2%	52.5%	52.9%	48.7%	50.2%	50.1%	50.5%	53.9%	56.8%	54.4%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%	?		65.4%	71.8%	65.8%	70.4%	70.5%	72.2%	68.5%	69.0%	69.7%	71.8%	73.2%	72.8%
M15	Data Quality Maturity Index	Best Quality	Well Led		95%	P	H	99.7%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.5%	99.5%	99.6%	99.7%	99.7%
M43	Community health services two hour urgent response standard	Best Quality			70%	P		91.4%	91.4%	92.1%	92.0%	87.3%	89.5%	88.3%	88.2%	88.6%	91.3%	90.1%	90.5%

National Metrics

Data as of : 23/06/2026 17:28:25

NHS South West Yorkshire Partnership NHS Foundation Trust

The following metrics have Place based targets which have been updated for the 2026/2027 financial year. Data for the previous financial year therefore is no longer shown.

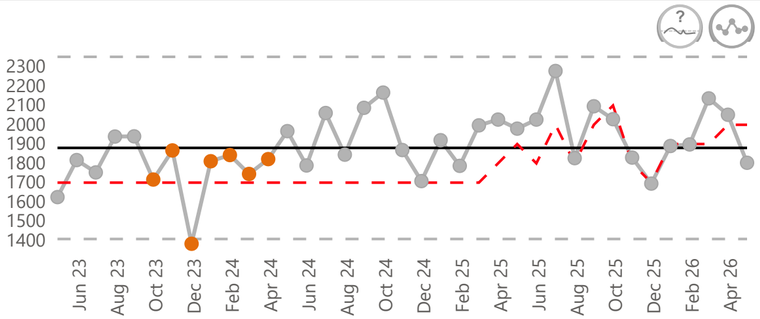
MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Apr 26	May 26
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%	?		59.9%	55.6%
				Place	Barnsley	50%	?		59.4%	50.5%
					Kirklees	50%	?		60.1%	59.2%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				571	511
				Place	Barnsley				219	206
					Kirklees				352	305
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	13400	P	H	15099	15082
				Place	Barnsley	2900	?	L	2747	2689
					Calderdale	1400	?	H	1501	1469
					Kirklees	4800	?	H	5249	5300
					Wakefield	4300	P	H	4774	4798
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust			H	2098	2030
				Place	Barnsley	283	F	H	344	333
					Calderdale	247	?	H	311	287
					Kirklees	541	?	H	760	738
					Wakefield	406	?	H	573	560
M194	Number of people accessing individual placement and support (IPS) services (rolling 12 months)	Best Quality	Responsive	Trust	Trust			H	788	782
				Place	Calderdale			H	128	131
					Kirklees			H	256	253
					Wakefield			H	401	395

National Metrics

Data as of : 23/06/2026 17:28:25

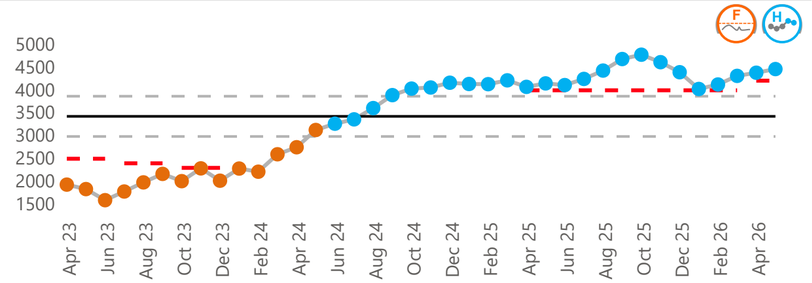
NHS South West Yorkshire Partnership NHS Foundation Trust

M184 - New RTT pathways (clock starts)



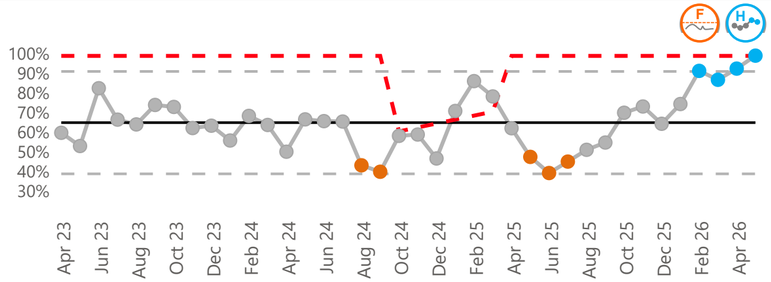
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers. A new moving target is in place for 2025/26.

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



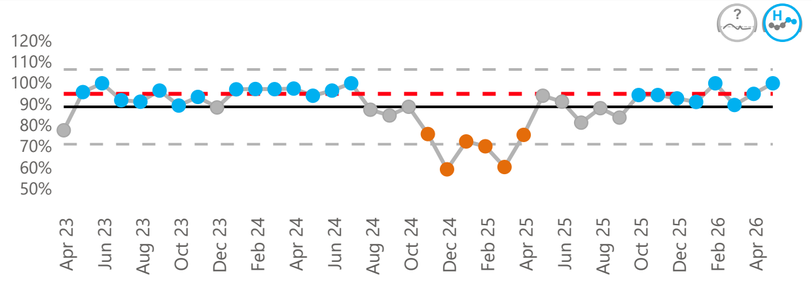
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months. We are not currently forecast to meet the target though current performance is above the target.

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



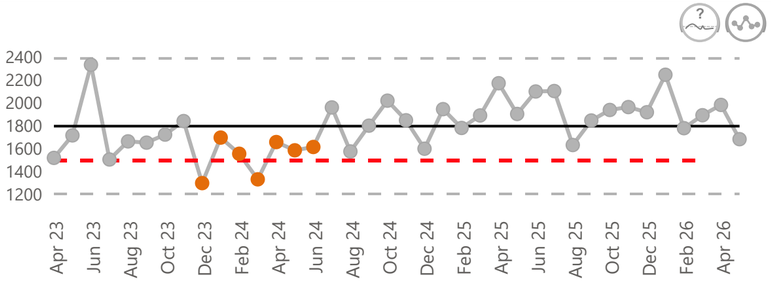
The SPC chart shows that we have entered a period of special cause improving variation (something is happening and should be investigated). Though we are not expected the meet the target.

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



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

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



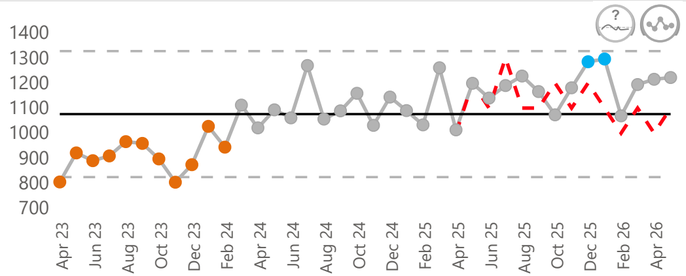
The SPC chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers this time last year.

National Metrics

Data as of : 23/06/2026 17:28:25

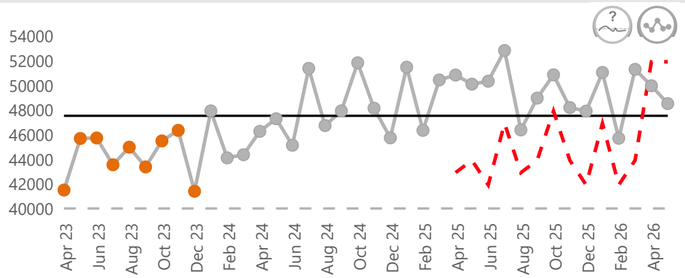
NHS South West Yorkshire Partnership NHS Foundation Trust

M187 - Urgent Community Response (UCR) referrals



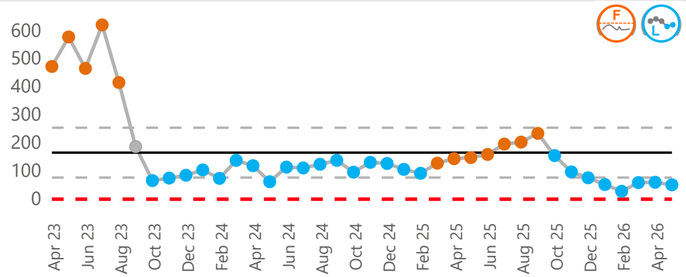
The SPC chart shows that we remain in a period of common cause variation (no concern).

M207 - Attended Community Care Contacts



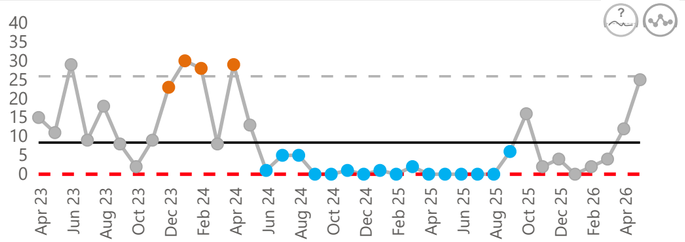
The SPC chart shows that we remain in a period of common cause variation (no concern).

M2 - Inappropriate out of area bed days



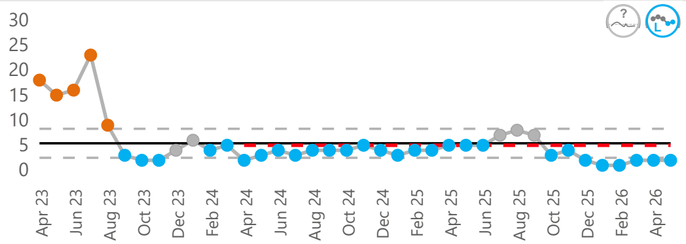
The SPC chart shows that due to the continued improvement in the number of out of area bed days we remain in a period of special cause improving variation (something is happening and should be investigated). Though we are still not anticipated to achieve the target of zero.

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



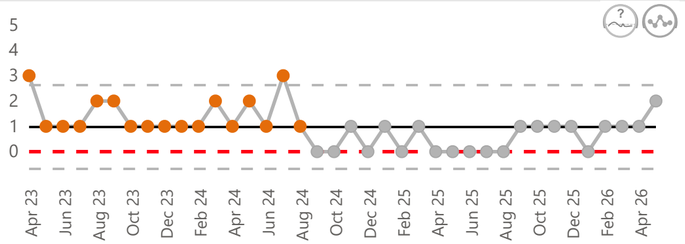
The SPC chart shows that although there has been an increase in this month in the number of under 18s admitted we remain in common cause variation (no concern).

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 were two admissions of an under 18 year old to an adult ward in May 2026. Their combined length of stay was 25 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.

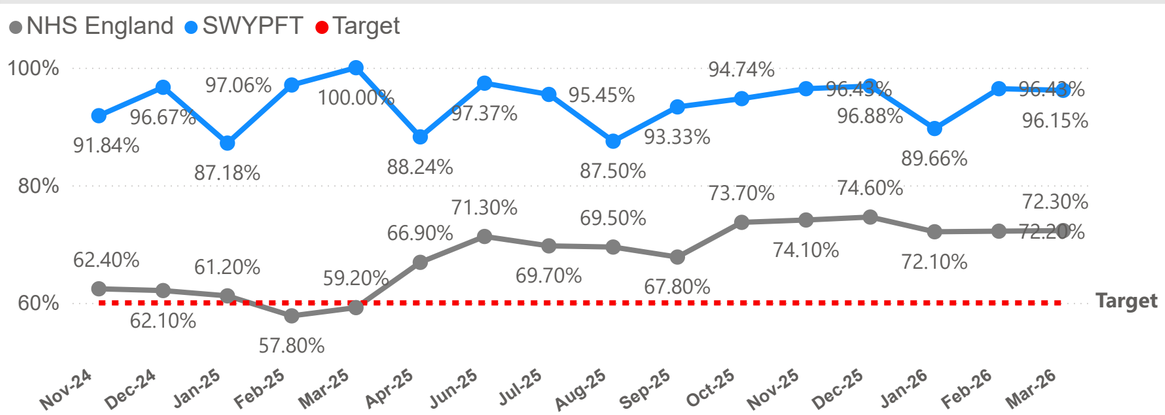
Benchmarking Metrics

Data as of : 26/06/2026 10:56:25

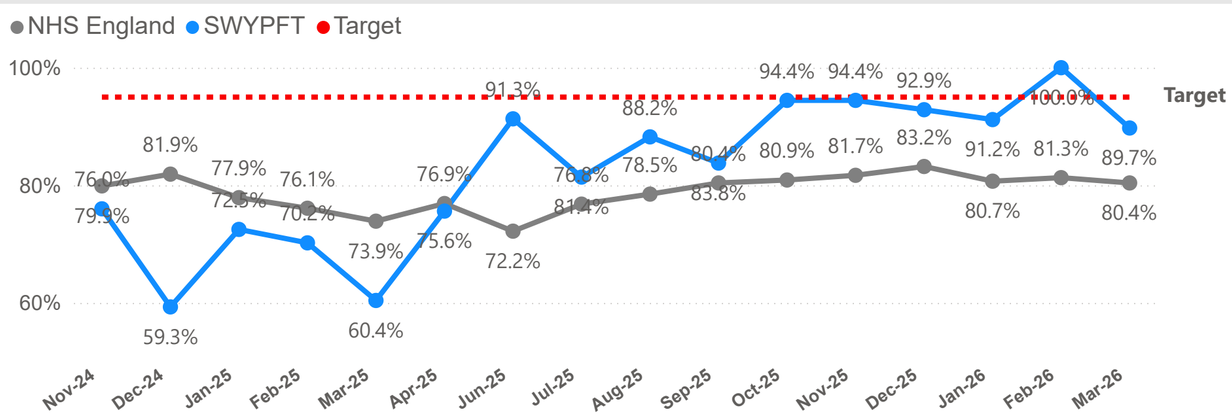
NHS South West Yorkshire Partnership NHS Foundation Trust

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.

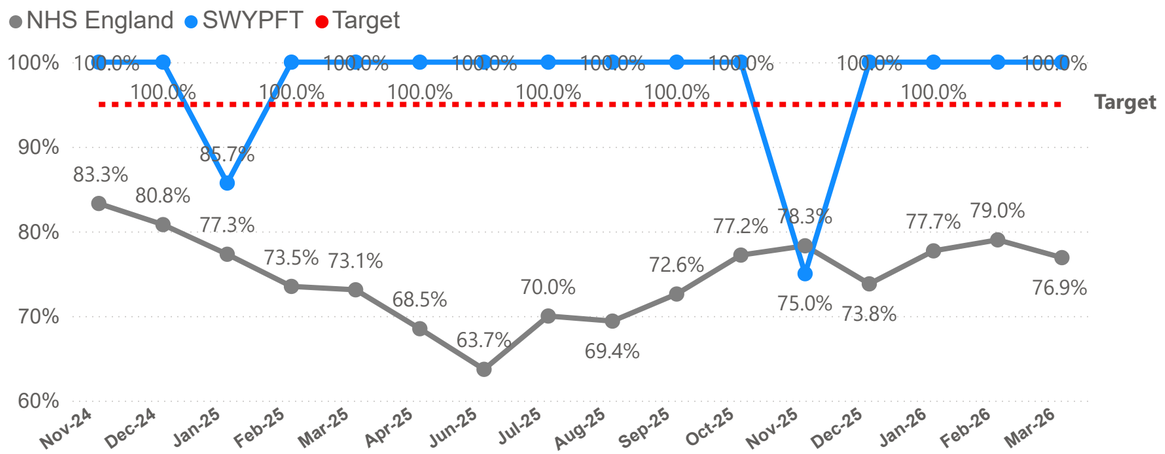
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops



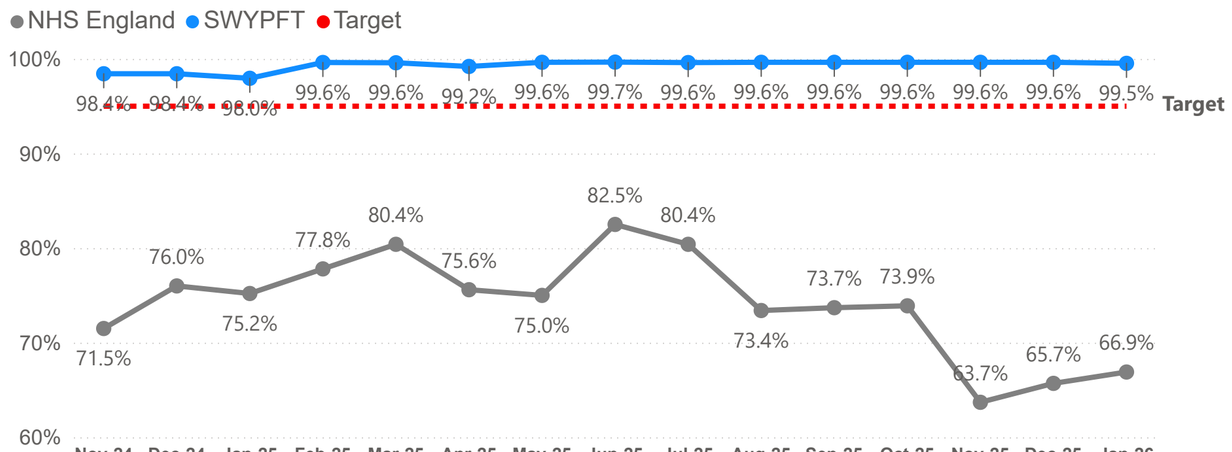
Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks



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



Data Quality Maturity Index



KPI	Strategic Objective	CQC Domain	Target	Apr-26	May-26
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Trust	Best Quality	Responsive	Apr - 455 May - 451	Due June 26	
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Barnsley	Best Quality	Responsive	Apr - 83 May - 82		
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Calderdale	Best Quality	Responsive	44		
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Kirklees	Best Quality	Responsive	Apr - 258 May - 256		
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Wakefield	Best Quality	Responsive	35		
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - Trust	Best Quality	Responsive	Apr - 48.0 May - 49.1	47.7	45.6
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - South Yorkshire	Best Quality	Responsive	Apr - 58.1 May - 60.0	44.6	48.7
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - West Yorkshire	Best Quality	Responsive	Apr - 44.7 May - 45.7	46.4	42.9
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - Trust	Best Quality	Responsive	Apr - 82.2 May - 81.7	89.1	92.9
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - South Yorkshire	Best Quality	Responsive	Apr - 76.8 May - 79.3	72.4	73.3
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - West Yorkshire	Best Quality	Responsive	Apr - 77.4 May - 78.7	96.0	100.0
Access to Mental Health Support Teams Mental Teams in schools and colleges - Kirklees	Best Quality	Responsive	Apr - 800 May - 830	848	965
Access to Mental Health Support Teams Mental Teams in schools and colleges - Wakefield	Best Quality	Responsive	1300	1561	1680
Number of patients accessing Individual Placement Support services - rolling 12-month - Calderdale	Best Quality	Responsive	Apr - 158 May - 160	128	131
Number of patients accessing Individual Placement Support services - rolling 12-month - Kirklees	Best Quality	Responsive	Apr - 296 May - 304	256	253
Number of patients accessing Individual Placement Support services - rolling 12-month - Wakefield	Best Quality	Responsive	Apr - 279 May - 281	401	395
Percentage of people on entire waiting lists who are waiting 18 weeks or less	Best Quality	Responsive	78% by March 27	87.5%	89.0%
Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	Best Quality	Responsive	78% by March 27	97.5%	97.8%
Percentage of people on waiting lists for CYP Community Services per system who are waiting 18 weeks or less as proportion of entire CYP waiting list	Best Quality	Responsive	78% by March 27	58.0%	61.0%

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			Quarter 4		
	Q1 performance	Q1 score	Q1 rank	Q2 performance	Q2 score	Q2 rank	Q3 performance	Q3 score	Q3 rank	Q4 performance	Q4 score	Q4 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	0.00%	1.00	1/42
% 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	33/50	4.04%	2.78	32/50
DOMAIN SCORE - Access to Services		**2.14**			**1.89**			**1.95**			**1.89**	
National CQC community mental health survey overall experience rating	As expected	2.00		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	95.40%	1.24	4/38
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	22.07%	2.09	18/47
DOMAIN SCORE - Effectiveness and Experience		**1.61**						**2.61**			**1.78**	
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	6.86	1.75	16/61
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	78.23%	1.72	12/45
DOMAIN SCORE - Patient Safety		**1.83**						**1.60**			**1.74**	
Sickness absence rate	5.14%	2.19	18/61	4.83%	2.41	21/61	5.44%	2.78	25/61	5.87%	2.44	21/61
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	7.17	1.65	14/61
Crude rate of restrictive interventions per 1,000 occupied bed days				N/A								
DOMAIN SCORE - People and Workforce		**2.15**						**2.44**			**2.05**	
Planned surplus / deficit as a proportion of turnover	0.0%		15/61	0.0%	1.00	16/61	0.0%		16/61	0.02%		16/61
YTD surplus / deficit	-0.1%		52/61	0.83%	1.00	3/61	0.63%		6/61	0.03%		47/61
Aggregated finance score		1.00			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	88.96%	1.39	9/61
Productivity	N/A			N/A								
DOMAIN SCORE - Productivity and Value for Money		**1.20**						**1.20**			**1.20**	
Total score		28.40			19.97			22.19			19.06	
OVERALL AVERAGE SCORE		**2.58**	3/61		1.82			2.02			1.73	
FINAL SEGMENTATION	**3 * financial override**		26/61	**1**		4/61	**1**		12/61	**1**		3/61

The Trust's overall score for quarter 4 remains at segment 1. Performance against the measures in the 5 domains is strong and our average Trust score puts the Trust as ranked 3 out of 61 providers of non-acute hospitals (including Mental Health and Learning Disability, Community and Care Trusts). Performance against each of the applicable metrics can be seen above.

The 2026/27 framework was published by NHS England on 11th June 2026. A greater number of metrics will be applicable to the Trust for this year and work is underway to review the metrics and interpret the new national guidance. A further update will be provided as more information becomes available.

National Metrics

Data as of : 23/06/2026 17:28:25

NHS South West Yorkshire Partnership NHS Foundation Trust

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

• There were two admissions to an adult mental health ward where the person was under 18 years old. The combined length of stay for these two people was 25 days. It is recognised that any admission of an individual under 18 is due to the national unavailability of an appropriate 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.

• There was an decrease in out of area bed usage to 82 days in May and three people remained out of area at the end of the month. The overall decrease in the number of out of area bed days, means that we remain in a period of special cause improving variation (something is happening and should be investigated).

• The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks is 100% in May. The urgent access to treatment measure also achieved 100% in May.

• 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. The reporting for employment and accommodation shows 14.9% of records have missing employment and/or accommodation status with a further 2.0% that have an unknown employment status and 1.3% 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.

• 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 increased again in May to 99.1% and is above the revised threshold of 52.6% for 2026/27. The continued increased in performance has meant that we have now entered a period of special cause improving variation (something is happening and should be investigated).

• Reduction in our mental health length of stay is now split between adult acute and psychiatric intensive care unit (PICU) and Older people. The Trust has set itself a target to reduce adult acute lengths of stay by 10% by the end of March 2027 from August 2025 baseline. At Trust level, we are achieving our forecast position for April for adult and PICU lengths of stay (45.6 days against a forecast of 49.1 days) but have exceeded our forecast for older people lengths of stay (92.9 days against a forecast of 81.7 days). 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.

• Performance against number of patients accessing Individual Placement Support services is monitored at place level and is an operational planning activity metric. IPS services help people with severe mental illness gain and maintain paid employment. This metric counts the number of people who have accessed the service over a rolling 12 month period. There is currently some under performance against target in both Calderdale and Kirklees and this in part relates to our performance only including SWYPFT activity and not activity for primary care workers – work is to take place to review this issue to ensure data is flowing correctly. Wakefield performance is currently operating above target however focused work is on-going in terms of developing secondary care referral rates specifically for the unemployed cohort which may further improve the access numbers.

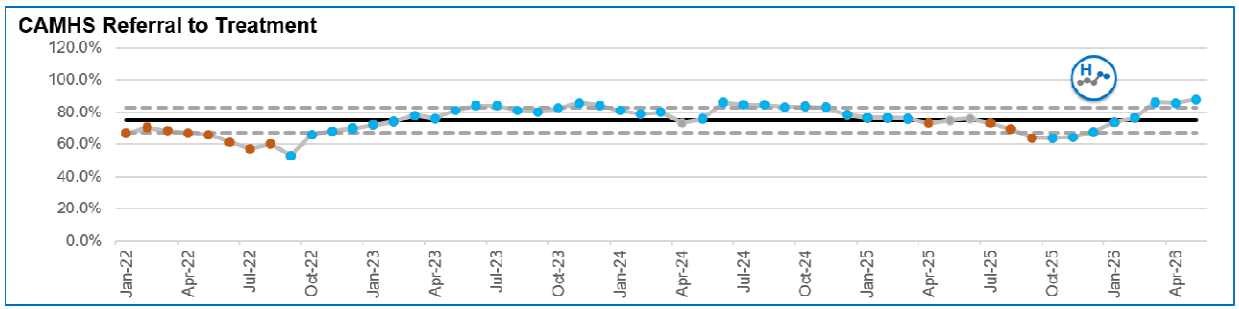
The following section of the report has been created to give assurance regarding the quality and safety of the care we provide. A number of key metrics have been identified for each care group, and performance for the reporting month is stated along with variation/assurance for each metric where applicable.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

Child and Adolescent Mental Health Services (CAMHS)

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.
All urgent and routine referrals for children and young people with an eating disorder were seen within national expected time frames of one and four weeks during the month.

Child and Adolescent Mental Health Services (CAMHS)							
Metrics	**Strategic Objective**	**CQC Domain**	**Threshold**	**Mar-26**	**Apr-26**	**May-26**	**Variation/ Assurance**
% Appraisal rate	Best place to work and learn	Well led	90%	92.8%	94.2%	93.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/6)	0% (0/7)	0% (0/3)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reported From April 26	73.5%	76.2%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%		75.1%	75.7%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	98.5%	100.0%	94.3%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.5%	84.9%	82.2%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	89.7%	94.9%	100.0%	
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%	95.4%	96.4%	90.9%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.8%	91.4%	91.8%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.0%	4.2%	5.2%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	595	590	648	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	1137	1065	1156	
Total number of reported incidents	Best Quality	Safe	Trend monitor	66	70	36	



In May 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 & Calderdale medical workforce is currently 57% of establishment due to leavers and long-term sickness leading to. There is a focus on recruitment of both substantive vacancies and temporary staffing. Actions are in place to mitigate reduced capacity for routine & emergency appointment and to cover medical on call
• Kirklees CAMHS ADHD waiting list continues to rise due to increased referrals, Kirklees ICB RtC decision making, medical staffing vacancies and limited NMP support (0.6wte). Current longest wait (non-allocated appointment) is 75 weeks. Escalated to DoS and contracting colleagues.
• Kirklees Keeping in Mind (KKiM) MHST (mental health support into schools) is still experiencing significant challenges around referral numbers and recruitment and retention. The service continues develop its offer to align with its provision with the national model, working collaboratively with schools, local Authority and ICB. Wave 16 funding has been agreed in principle, and a decision tree is being prepared for EMT.
• Wakefield CAHMS ReACH Team and Primary Intervention Team (SPA), continues to experience challenges recruiting to posts. The Service 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. The action plan remains in place and is monitored in the wait's improvement group.
• Secure CAMHS – discussions have been undertaken with NHSE 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. A business case submitted in relation to this was rejected. Further discussions are to take place internally with our contracting and finance colleagues.
• 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- continue to experience 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. ADHD referrals for assessments are rising above capacity to deliver expectations; this compounds the challenge with patient flow through the pathway.
• The work of the weekly rapid improvement group established to reduce CAMHS treatment waits continues and is beginning to have a positive impact.

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. Staff members have been recruited and funding has flowed since the beginning of the finance year.
• 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. Kirklees ICB commissioners have instructed GPs wishing to pursue Right to Choose pathway for ASD/ADHD assessments that these will need to be first screened by Kirklees CAMHS Neuro Assessment Service. This has led to an increase in referrals to the service and changes in practice for allocation to SWYFT ND assessment waiting list. Additionally, the increasing use of RtC by GPs will have a direct impact on Kirklees CAMHS ADHD medication waiting list.
• 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 20calls per month from NHS 111. The Service continues to work 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.
• Some of the Services have experienced an increase in IG breeches this month. These are being reviewed and an improvement action plan is being developed.
• Supervision reporting changed as of 1st April with separate 60-day targets for clinical and management supervision. There is an action plan is in place and there is an improvement in May to 79.2 % for clinical supervision and 76.7% for management across C&YP.

Assure

• The Sickness level across Children young people (CYP) in May was 4.5%.
• Medical Devices EBME servicing compliance data was 87% in May

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 compared to usage in previous years.

Bed occupancy has slightly reduced from levels reported in the previous year 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.

General managers have a firm grip on sickness absence with staff being supported and managed in line with Trust policies. Community services sickness has now reduced to under local threshold and is the first time since June 2025 it has been under Trust threshold.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-26	Apr-26	May-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	93.0%	94.9%	96.4%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	88.8%	87.9%	85.8%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	98.4%	100.0%	99.1%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	13% (2/16)	7% (1/15)	0% (0/15)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reported From April 26	83.1%	88.1%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%		73.4%	83.0%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	87.3%	86.5%	87.2%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	95.4%	94.6%	95.8%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	96.3%	97.4%	96.7%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.5%	85.8%	86.2%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	97.4%	97.7%	97.5%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.8%	96.7%	94.1%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	90.7%	90.6%	92.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.1%	5.3%	4.8%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,227	13,221	13,206	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	119	119	106	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-26	Apr-26	May-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	89.1%	96.9%	96.8%	
% Bed occupancy (excl leave)	Best Quality	Safe	85%	86.8%	85.2%	89.6%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/4)	33% (1/3)	0% (0/7)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reported From April 26	83.5%	83.1%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%		81.8%	75.7%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.6%	87.8%	86.7%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	10.1%	9.9%	7.3%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	86.4%	92.5%	93.0%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	155 (May)	73	90	82	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.3%	97.8%	95.2%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	16	11	14	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	43	60	52	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	89.0%	90.3%	90.1%	
Restraint incidents	Best Quality	Safe	Trend Monitor	148	128	*90*	
Safer staffing (Overall)	Best Quality	Safe	90%	117.3%	119.0%	121.3%	
Safer staffing (Registered)	Best Quality	Safe	80%	100.1%	102.4%	100.8%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	5.2%	4.8%	5.4%	
Readmissions within 28 days				Reporting	11	13	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	549	581	567	

Alert/Action

• Acute wards have continued to manage high levels of acuity. During May the service operated at OPEL level 3 for three weeks, with the pressure being sustained and triggering OPEL level 4 for several days.
• 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 May 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 May and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is triangulated and monitored.
• Intensive Home-Based Treatment (IHBT) teams in Calderdale and Kirklees are experiencing ongoing workforce challenges, recruitment is underway.
• Calderdale IHBT are amber for 4hr assessment in May due to requiring assistance to access a property, the assessment took place 30minutes beyond the timeframe.
• 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. The care group are reviewing the locally agreed standards for documenting the review of FIRM risk assessments on admission, and this work will be shared into the trust wide risk assessment quality improvement work.
• 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 May in all areas.
• Care Programme Approach (CPA) review performance is above target in Calderdale and Wakefield. Barnsley and Kirklees are slightly under the 95% target this month at 94.18% and 92.17% respectively. Action plans and support from Quality and Governance Leads remain in place and all areas are expected to be above threshold in May.
• 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 May 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.

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.
• Supervision reporting changed as of 1st April with separate 60-day targets for clinical and management supervision. Inpatient services have achieved the 60 day target overall for both clinical and management supervision. Community services have also achieved both targets with the exception of management supervision in Barnsley which has been identified as a data quality issue. There is an action plan is in place and there is an improvement from 66.4% in April to 76.2% in May.
• The Talking Therapies recovery rate for May is 50.49% for Barnsley and 59.17% for Kirklees, both achieving the national standard of 50%.
• The care group holds monthly meetings to track and review progress of Equality Impact Assessments (EIAs). Performance remains strong. Delay in completion of EIAs in some areas have been due to manager changes/sickness and the service line Trios are supporting the teams in their completion.
• Equality data – we are working with a trust wide quality improvement group to enhance how equality information is captured on System One. Completeness of equality data is on our data quality improvement action plan.
• There were two incidents of prone restraint in May, both were under 3 minutes duration. Both prone restraints were related to administration of medication and were staff led for clinical reasons specific to the individuals. 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.
• Mandatory training compliance for the care group is 94.8%.
• The care group achieved 96.3% of appraisals completed within 12 months.

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:
There has been an improved position in waiting list times for community learning disability services 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 remains at 100% and the service are working with partners to facilitate safe discharge to appropriate settings.

LD, ADHD & ASD

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-26	Apr-26	May-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	92.1%	88.5%	91.0%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/2)	33% (1/3)	0% (0/2)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reported From April 26	69.2%	69.0%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%		64.1%	62.4%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	50.0%	50.0%	42.3%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.9%	89.5%	88.4%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	100.0%	100.0%	100.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	98.2%	95.1%	95.2%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	87.3%	81.7%	96.2%	
Physical Violence - Against Patient by Patient	Best Quality	Safe	Trend Monitor	0	0	1	
Physical Violence - Against Staff by Patient	Best Quality	Safe	Trend Monitor	9	11	12	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.6%	92.7%	91.4%	
Safer staffing (Overall)	Best Quality	Safe	90%	121.5%	133.7%	120.2%	
Safer staffing (Registered)	Best Quality	Safe	80%	171.8%	167.9%	162.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.4%	3.0%	3.1%	
Restraint incidents	Best Quality	Safe	Trend Monitor	6	8	*8*	
Average length of stay	Best Quality	Safe	Trend Monitor	N/A	N/A	524	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	40	49	49	

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

Alert/Action

ICB West Yorkshire Neurodiversity Project
Other NHS providers across West Yorkshire are currently utilising ICB-commissioned independent sector provision to support the reduction of ADHD and Autism assessment waiting lists across children, young people and adult pathways. Commissioners have now requested that this service commences transfers via this route. In partnership with CAMHS colleagues, this position has been appropriately escalated. Constructive discussions with commissioners are scheduled to confirm the operational approach, ensuring this is implemented in a clinically safe, equitable and system-aligned way for the populations served.

SY ICB Neurodiversity Project
The service has been advised that decisions regarding the business cases submitted for this financial year will be delayed. Further clarity on next steps is awaited, including confirmation of future meeting arrangements.

Waiting Times
ADHD waiting lists continue to increase, with over 7,500 individuals currently awaiting assessment or intervention. Waiting times are now approaching four years, reflecting sustained demand and ongoing capacity challenges within the service. In contrast, autism assessment waiting times remain within 18 weeks, except in cases where delays are attributable to individual service user choice.

Barnsley ADHD
Commissioners have requested a meeting with the service to scope the potential development of a pathway aligned to the Kirklees model.

Advise

Kirklees ADHD & Autism
Kirklees has fully implemented a Neurodiversity Single Point of Access (SPA), through which all referrals are received by the Trust and subject to an initial assessment of clinical appropriateness. Individuals assessed as meeting criteria are subsequently supported to exercise choice of provider for assessment under the Right to Choose framework.
In line with commissioner direction, individuals who do not meet the clinical threshold for assessment are not progressed to a diagnostic pathway.
There is currently a backlog within ADHD triage; however, additional investment from April 2026 is expected to support recovery. Subject to referral rates remaining stable, the backlog is anticipated to reduce over the next 12 months.
Calderdale ADHD & Autism
Kirklees operates a fully established Neurodiversity Single Point of Access (SPA), with all referrals received by the Trust and subject to an initial assessment of clinical appropriateness. Individuals who meet the required criteria are then supported to exercise choice of provider for assessment under the Right to Choose framework.
In accordance with commissioner expectations, individuals who do not meet the clinical threshold for assessment are not progressed to a diagnostic pathway.
A backlog currently exists within ADHD triage; however, additional investment from April 2026 is anticipated to support recovery. Provided referral rates remain stable, the backlog is expected to reduce over the next 12 months.
Wakefield ADHD
Wakefield commissioners have recurrently funded ADHD triage and have engaged constructively with the service on their preferred approach. While current demand has reduced and is broadly manageable within the available funding, the resource remains limited and would require review should activity increase, and it does not address the existing backlog. In response, the service is developing a range of options for consideration through EMT, including the potential to cap referral numbers to ensure financial sustainability. Unlike the Kirklees pathway, there is currently no consistent requirement within Wakefield for referrals to undergo an initial clinical appropriateness decision prior to entry into the pathway, which continues to influence demand. A proposed model has been shared with commissioners, and the service is awaiting advice from Business Development colleagues regarding next steps.

Assure

- All key performance indicator targets met.
- Excellent levels of supervision, appraisal and mandatory training.
- Low level of vacancies within the service.
- All mandatory training meeting the required threshold.

Learning disability services:

Alert/Action

Community

• Learning Disability Services continue to operate within constrained psychiatry capacity, which is affecting the timeliness of specialist clinical input, including assessment, formulation and review, and is contributing to ongoing pressure across community pathways.
Mitigating actions are in place through workforce planning and service prioritisation; however, these constraints remain a key factor influencing overall service delivery and responsiveness.
• Variability in access to psychiatric liaison provision with learning disability expertise within acute hospitals is resulting in increased demand across the wider system, with community LD medical teams providing additional support where required.

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 through established collaborative workstreams. The review is nearing completion, with the options appraisal in its final stages to support the development of a sustainable, system aligned model that reflects demand, quality expectations and financial considerations.

Advise

Learning Disability

• Appraisal compliance is strong at 91.1%.
• There is an improving trajectory for risk assessment and care planning documentation.
• Sickness levels remain below the agreed threshold, indicating a stable workforce position.
• Mandatory training compliance is good overall, with the only area in amber being Information Governance at 94.6%, which is being actively monitored to ensure it returns to full compliance.
• Supervision remains an area of focus, particularly following the separation of management and clinical roles. While the change has strengthened clinical leadership and clarified accountability, it has also led to some inconsistency in the recording and frequency of supervision. Actions are underway to improve compliance, including reinforcing expectations, increasing managerial oversight, and implementing more robust monitoring arrangements. This is expected to support a more consistent and high-quality approach to supervision across the service.

Community

• Learning Disability (LD) Week was highly successful, bringing together service users, carers and colleagues across all areas to participate in a range of inclusive events. An LD Away Day was also held, providing teams with an opportunity to showcase areas of pride, share good practice and celebrate achievements through team awards.
• In partnership with service users, the service has developed a series of cancer screening awareness videos designed specifically for peer audiences. These are in the final stages of refinement and will shortly be shared across the Trust and more widely to support improved awareness and access.

Horizon – Assessment and Treatment Unit (ATU)

• In total, three service users are at 100% CRFD, all of whom have clear discharge plans in place.
• One service user is planned for discharge in mid-July, which will utilise two bed spaces.
• Two further service users currently in High Intensity Support Areas have identified long-term placements, with transitions planned for November. In the interim, the ward is actively exploring alternative placement options in partnership with system colleagues to support timely step-down.

Assure

• Annual health checks in all four localities have exceeded the 75% threshold.
• Appraisal – now meeting the threshold.
• FFT – 97%

Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue for our West Yorkshire services, however, there has been a slight improvement in May - hotspot areas can be seen in the ward level breakdown of the report.
The people directorate business partner continues to work closely with the care group regarding sickness and actions are underway in line with the policy. Individual ward sickness performance is also impacted by the allocation of staff with long term conditions into less acute areas.
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	Mar-26	Apr-26	May-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	74.4%	78.5%	79.9%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	87.8%	89.0%	90.8%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/0)	0% (0/0)	0% (0/1)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reported From April 26	64.2%	66.5%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%		46.2%	45.7%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	99.1%	97.3%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.0%	81.1%	81.1%	
% 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%	80.0%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95.0%	83.9%	86.6%	89.5%	
% with care plan that includes service user input/views	Best Quality	Safe	95.0%	91.5%	90.6%	90.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	94.0%	96.1%	94.6%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	7	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	9	3	2	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.0%	90.1%	89.8%	
Restraint incidents	Best Quality	Safe	Trend Monitor	20	24	*7*	
Safer staffing (Overall)	Best Quality	Safe	90%	105.4%	111.8%	119.5%	
Safer staffing (Registered)	Best Quality	Safe	80%	99.9%	101.3%	100.8%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	6.0%	6.4%	5.6%	
Average length of stay	Best Quality	Safe	Trend Monitor	660	1,049	1,389	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	181	176	155	

Forensic - West Yorkshire:

Alert/Action

Future Capacity & Demand
Work is advancing through the West Yorkshire Provider Collaborative, in partnership with regional colleagues, to model future demand and strengthen system-wide planning for specialised services. This includes comprehensive analysis of activity, length of stay, patient flow, and projected demand trends, supporting a more proactive, data-led approach to service configuration and capacity planning.

The Best Place to Work and Learn
Programme is progressing, with a focused piece of work underway to explore culture across West Yorkshire Forensic Services. Engagement with staff has been positive and productive, providing valuable insight into the current culture. This has also highlighted a number of areas requiring improvement, with targeted action plans now in development under Executive oversight.

Bed Occupancy
Occupancy across Newhaven, Newton Lodge and the Bretton Centre show minor variation this month, with a slight increase at Newhaven and Newton Lodge, and a marginal reduction at the Bretton Centre. Overall levels remain broadly stable, with the most notable variance continuing within the learning disability (LD) pathway. Four of the eight LD beds remain unoccupied.
• Newton Lodge: 90.22%
• Bretton Centre: 92.28%
• Newhaven: 77.22%

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.

Risk Assessment - Compliance with completion of risk assessments within 24 hours has reduced from 100% to 80% this month. The reasons for this drop is that one patients risk assessment was not confirmed on admission, however, the HCR20 risk assessment was valid. A review is underway to understand the cause and improvements required to ensure all risk assessments are validated on admission.

Supervision
Performance is currently variable across sites and below the 80% target in a number of areas. This is not reflective of the usual position, as West Yorkshire Forensic Services has a well-established track record of strong supervision compliance.
At Newton Lodge, both management and clinical supervision have shown slight improvement (43.7% and 69.0% respectively) but remain below target. The Bretton Centre continues to report the lowest compliance, with only marginal improvement (management 35.9%, clinical 45.7%) although this does reflect
At Newhaven, performance is mixed. Clinical supervision has improved significantly to 90.3%, exceeding the target, while management supervision has reduced to 71.0% and is now below the required standard.
Targeted actions are in place across all sites, with oversight focused on restoring compliance to expected levels.

Advise

Sickness Absence – Sickness absence continues to be a key area of focus across the service. A targeted programme of work remains underway, supported by the People Directorate, to enable teams to better understand and address the underlying drivers of absence and to strengthen overall attendance.
Sickness absence has increased slightly at Newton Lodge (5.1%), while Newhaven continues to report low levels at 0.8%. Absence at the Bretton Centre has reduced to 10.1%, though this area remains a relative hotspot. The management team is continuing to review contributory factors and implement targeted actions to support improvement

Forensic Improvement Programme – The programme continues to progress, with workstreams focused on improving service user experience, outcomes, and operational efficiency. Activity is delivered through a coordinated approach and monitored via Care Group governance and the Operational Management Group, ensuring oversight, risk management and delivery against agreed milestones.

Mandatory Training Compliance – Overall compliance remains strong. Areas below the required threshold include CPR at Newton Lodge (78.4%) and Information Governance training (93.8%), with Newhaven also slightly below target for IG at 94.1%.
Targeted actions are in place, including focused follow-up with staff, planned training sessions, and oversight from local management. Compliance continues to be monitored through established governance processes, with improvement expected over the next reporting period.

Appraisal – Planning is underway to recover appraisal compliance alongside introduction of the new system, supported by targeted training and additional support. This includes phased implementation, management briefings, and alignment of appraisal schedules, with improved oversight and timeliness expected as the system embeds.

Turnover – Below 10% across all service lines.

Assure

- High levels of Data Quality across the Care Group.
- 100% compliance for HCR20 completed within 3 months of admission.
- CPA – 100%
- 25 hrs meaningful activity 100%
- Positive relationships with West Yorkshire Provider Collaborative partners

Forensic - South Yorkshire							
Metrics	**Strategic Objective**	**CQC Domain**	**Threshold**	**Mar-26**	**Apr-26**	**May-26**	**Variation/ Assurance**
% Appraisal rate	Best place to work and learn	Well led	90%	68.2%	75.4%	80.5%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	84.8%	85.3%	86.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	0% (0/1)	0% (0/2)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reported from April 26	69.8%	86.0%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%		54.2%	79.6%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.4%	84.6%	89.7%	
% 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%	94.8%	97.3%	95.7%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	0	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	9	5	1	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.5%	83.3%	87.5%	
Restraint incidents	Best Quality	Safe	Trend Monitor	10	7	*8*	
Safer staffing (Overall)	Best Quality	Safe	90%	112.2%	107.9%	109.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	89.9%	87.9%	87.3%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	3.3%	2.8%	2.3%	
Average length of stay	Best Quality	Safe	Trend Monitor	1,273	1,075	2,449	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	158	164	149	

Forensic - South Yorkshire:

Alert/Action

Capacity and Demand Modelling – A system-wide capacity and demand modelling exercise is currently underway across South Yorkshire, West Yorkshire and the Humber to inform future service configuration and support longer-term strategic planning across forensic pathways. This work is bringing together activity, flow, acuity and population-level demand data to develop a shared understanding of current and future need, including the impact of national policy drivers such as the Provider Collaborative agenda and the continued shift towards community-based care. Current bed capacity is 79.

Appraisal – Appraisal compliance is currently 80.5%, which is below the expected organisational threshold and reflects the position within the annual appraisal cycle. This shortfall is recognised and is being actively addressed through a structured recovery plan.
Targeted actions are in place to support improvement, including strengthened managerial oversight, clearer accountability for completion, and the introduction of enhanced tracking and reporting mechanisms to improve timeliness. In parallel, the implementation of the new appraisal system is expected to drive improvements in both the quality and consistency of appraisals, as well as provide better real-time visibility of compliance at team and service level.

Turnover – Turnover is 17% following a recent workforce deep dive. Further analysis is underway to understand the drivers and inform targeted retention actions.

Advise

FIRM Risk Assessment & Care Planning – Implementation is progressing well following completion of training. Current compliance is 50% but is expected to reach the compliance threshold within the next two months.

Annual Quality Review – Annual Quality Review – The South Yorkshire Hub visit was positive and provided assurance on progress across the service. Areas of good practice were recognised, alongside a clear understanding of where further improvement is needed.
An action plan is now being developed to take this forward, focusing on strengthening key areas and embedding improvements through existing governance arrangements. Progress will be monitored to ensure actions are delivered and sustained.

Cheswold Park – Integration into the Forensic Care Group continues, with Trust governance and operational frameworks embedding. Quality and safety remain key priorities, supported through the internal Quality Improvement Group and ongoing external assurance. Strategic focus remains on stabilisation, service development, and future planning, including development of a clear clinical and operational model.

Supervision - The move to a split model of managerial and clinical supervision has led to a dip in overall compliance. Current performance stands at 79% for managerial supervision and 86% for clinical supervision.
Despite this, there remains a strong commitment across the service to improve compliance and restore performance. Actions are in place to support recovery, including clearer expectations, improved tracking, and greater oversight at team level. The intention is to ensure supervision is both consistent and meaningful, supporting staff wellbeing, development, and safe practice.

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.
- Key performance metrics showing an improving trajectory.

Barnsley Physical Health and Wellbeing Care Group

Headlines

The care group continue to perform well against most metrics, and performance has increased against the national 6 week wait for diagnostics (Paediatric audiology) during the month. There does continue to be a national issue and the care group continue to discuss with commissioners.

The sickness rate remains above threshold and has improved in month.

Barnsley Physical Health and Wellbeing

Metrics	Strategic Objective	CQC Domain	Threshold	Mar-26	Apr-26	May-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	89.4%	95.9%	97.7%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/2)	0% (0/1)	0% (0/3)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	87.1%	93.5%	100.0%	
% of staff receiving supervision within policy guidance - Clinical	Best Quality	Safe	80%	Reported From April 26	65.2%	67.4%	
% of staff receiving supervision within policy guidance - Management	Best Quality	Safe	80%		42.2%	44.5%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.2%	88.2%	86.8%	
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%	94.0%	97.5%	96.4%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	96.4%	97.5%	97.5%	
Safer staffing (Overall)	Best Quality	Safe	90%	93.8%	96.4%	95.7%	
Safer staffing (Registered)	Best Quality	Safe	80%	93.4%	90.2%	91.9%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.4%	5.9%	5.3%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	25/26 - 99% 26/27 - 52.6%	87.7%	93.5%	99.1%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	7,038	7,070	7,029	
Total number of reported incidents	Best Quality	Safe	Trend monitor	288	265	252	

Barnsley Physical Health and Wellbeing Care Group

Alert/Action

• Staff receiving supervision – following the introduction of the new separate 60-day targets for clinical and management supervision, the care group is undergoing a period of monitoring and reviewing the revised statistics and their impact on the achievement of compliance for this measure. Figures for May against the target of 80% are remaining largely consistent with a steady increase:
Clinical supervision – 67.4%
Management supervision – 44.5%
The care group has been working to improve both clinical and managerial supervision uptake and recording. This has included communicating clear expectations, and targeted work with teams to review the supervision dashboard and strengthen monitoring and oversight.
Posters and key information sheets have been developed, alongside clearer, relevant recording documentation for the care group, including direct links to the database to support recording. Engagement with team leads has also helped identify and address local barriers. These actions are expected to support a steady improvement in uptake and help embed a strong supervision culture.

Advise

• Overall sickness rates have improved into amber but remain slightly outside compliance for the month of May at 5.3%. We continue to have some instances of long-term sicknesses relating to serious illnesses. The care group 12-month rolling figure is 5.28%. People directorate colleagues are supporting the care group in reviewing long term sickness absence and triangulating with other data which may impact e.g. number of additional shifts, vacancies whilst excluding some reasons e.g. elective surgery
• 18-week waiters - Overall, our community services are achieving the national expectation of 78% by March 27 being seen within 18 weeks, at 88.95% for May. We do, however, have some long waiters in our Children's SALT (Speech and Language Therapy) service and as a result this is impacting the percentage of people on waiting lists for Children and Young People (CYP) Community Services who are waiting 18 weeks or less as proportion of entire children and young people waiting list. This is linked to an increase in complex patients requiring a longer stay on the caseload. A remedial action plan is in place, and a full review of the Children's speech and language therapy service has begun as part of the Trust's Value for Money workstream which has identified and escalated a financial shortfall across Children's Therapy services. In addition, the review will look to improve service efficiencies alongside a reduction in waiting times. To Note: in terms of the children and young people measure, we have seen an improvement towards compliance of almost 3% from April to May.
• Medical devices – one of the challenges in achieving compliance that the care group is experiencing recently is that staff have been taking their kit for servicing and the provider has been running out of time to complete these during the advertised session. These instances have been reported via Datix.

Assure

• Appraisal compliance using the previous system shows an increase to 97.7% for May.
• Paediatric Audiology 6-week target for diagnostic procedures has seen a further increased during May into compliance at 99.12%. The total number on the waiting list as at 31.5.26 this figure was 113 patients, with only 1 waiting over 6 weeks.
NB: The 2026/27 Diagnostic Waiting Times and Activity Measure (DM01) threshold has been realigned with national expectation and Operational Planning / NHS interim trajectories – this is currently set at 52.6% within 6 weeks.
• Virtual Ward occupancy levels for May are at the target of 80%; this is a decrease in occupancy levels compared to April 2026 but still within our target parameters. This will be kept under review as we move into June 2026 as we have seen a decrease in onboardings specifically related to respiratory. This could potentially be a seasonal impact.
• Friends and Family Test (FFT) – 96% of people would recommend community services which is back within compliance for the month of May, following the implementation of the Trust wide in-house system being from the 1st April. The total number of responses is still lower than previous years but has increased slightly during May.
• Information Governance training has achieved 96.4%.for May, maintaining compliancy with a continued focussed effort on monitoring by managers.
• Urgent Community Response Service 2-hour target has achieved 81.6% for May which continues to be well above the 70% threshold.
• Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 97.5% for May.
• People dying in their place of choosing remains compliant and has further risen to 100% in May, exceeding the 80% threshold.
• Cardiopulmonary resuscitation training maintains compliance at 86.8% for May.
• Clinically Ready for Discharge – the care group is fully compliant at 0%. Sustained compliance on our 2 wards is due to most admissions/discharges being planned. Anticipated discharge dates are set on admission and discussed at the weekly multi disciplinary team meting, adjusting when clinically appropriate.
• 52-week waiters – the care group continues to achieve compliance at 0% and are one of the top performers in the country for this metric in the NHS Oversight Framework.

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
• 16 wards are above the 90% compliance threshold in April.
• Although Crofton (77.8%) compliance remains below threshold it has significantly improved comparative to March following focused work by the matron in the absence of the ward manager. Outstanding appraisals are booked and strong efforts are being made by the ward leadership team to action them as soon as possible.

Sickness
• 10 wards have sickness rates below 5% compliance threshold.
• Sickness improved to below threshold in April on Beamshaw, Ward 18, Elmdale, Poplars, and Enfield Down following the return of staff from long term sick and a reduction in short term sickness.
• Sickness increased to above threshold on Stanley (9.3%) due to long-term sickness (no themes).
• Although still above threshold, sickness on Willow (7.0%) and Ward 19 Female (7.8%) has reduced following the return of staff from long term sickness.
• Sickness remains above threshold and has increased on Melton (11.8%), Crofton (9.4%), Beechdale (6.8%), and Lyndhurst (8.1%) due to long-term sickness, no themes.
• Ward managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made.

Supervision
• Supervision reporting changed as of 1st April with separate 60-day targets for clinical and management supervision.
• Matrons are working with ward leadership teams to review systems and processes relating to supervision oversight to support compliance with the new changes.
• The senior leadership team maintain close oversight of supervision compliance via the weekly inpatient quality and performance meeting.
Clinical:
• 12 wards are above the 80% compliance target for April
• Nostell (60%), Ashdale (78.8%), Ward 18 (62.2%), Crofton (76.9%), are all below compliance impacted by a combination of vacancies and high clinical acuity.
• Lyndhurst (74.1) is below compliance impacted by ward manager absence. The service manager is providing oversight and a plan to action clinical supervision with staff outside of compliance has been agreed with the Band 6 team.
• Matrons are supporting oversight with staff outside of compliance being prioritised.
Management:
• 12 wards are above the 80% compliance target for April
• Nostell (73.3%) performance has improved following concerted effort by the ward manager and current compliance is 93.1% (as of 15/05/26)
• Ashdale (75.8%), Ward 18 (62.2%), Crofton (73.1%), and Lyndhurst (74.1%) are below compliance with both Crofton and Lyndhurst being impacted by ward manager sickness absence. Matrons are supporting oversight with staff outside of compliance being prioritised.

Mandatory Training
Information Governance (IG)
• 14 wards are above 95% compliance target for April.
• Ward 18 (94.3%), Willow (87.5%), and Ward 19 Male (92.3%) are under threshold, and action is being taken by the ward managers to ensure the staff outstanding complete the e-learning.
• The senior leadership team maintain close oversight of information governance training compliance via the weekly inpatient quality and performance meeting.

Cardiopulmonary resuscitation (CPR)
• 14 wards are at or above the CPR training compliance threshold in April.
• Crofton (79.2%) remain just below compliance and staff have either recently attended training or are booked to attend training throughout May and June.
• Ward 19 Male (69.2%) and Ward 19 Female (65%) are below compliance impacted by staff absence from work (long-term sick, maternity leave). Staff out of compliance are booked to attend future training dates.

Reducing Restrictive Practice Interventions (RRPI)
• All 17 wards are above the RRPI training compliance threshold.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.

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

Mandatory Training Continued

Fire Safety

• 14 wards are above fire safety training compliance threshold.
• Poplars (84.8%) compliance increased compared to March following the delivery of locality training sessions.
• Ward 19 Male (76.9%) and Ward 19 Female (70%) are under compliance impacted by cancellations to locality training sessions due to trainer absence. Sessions have been rearranged for May and June and staff out of compliance are booked to attend.

Bed Occupancy

• During April several beds were out of action across wards relating to scheduled works, unplanned repairs, and infestations (ants and scabies).
• 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.
• In April, Walton ALOS increased from 49 days to 159 days. Walton had a total of 6 discharges in April – LOS for these service users ranged from 14 days to 427 days.
• 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:
    • Walton CRFD is 29.3% in April and is reflective of 5 service users, 3 of whom have been recently discharged, and 1 of whom is restricted and discharge plans are subject to MoJ approval.
    • Poplars CRFD is 43.5% and is reflective of 10 service users awaiting placements, 8 of whom have been discharged.
• 9 other wards are above the threshold for CRFD with Beamshaw, Clark, Stanley, Ashdale, Beechdale and Ward 19 Female 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.

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 April was 92.5% (11 breaches) for 24hr target and 96.5% (5 breaches) completed within 48hrs.
• During April, Elmdale, Ward 19 Female, and Willow had 1 FIRM breach each. Nostell had 2 breaches. Ashdale had 6 breaches.
• 5 of the Ashdale 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. There were no recurrent patterns identified across these 5 incidences; it was coincidental that all patients were allocated a bed on Ashdale.
• 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.
• 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.
• The inpatient SLT are in the process of reviewing the locally agreed standards for documenting the review of FIRM risk assessments on admission, and this work will be shared into the trust wide risk assessment quality improvement work.

Physical violence (Patient on Patient)

• 11 incidents of patient-on-patient physical violence throughout April across multiple wards.
• 6 incidents on Ashdale, all relate to different service users and reflect the risk profiles of individual service users.
• 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.

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

Physical violence (Patient on Staff)

• 8 incidents of patient on staff physical violence throughout April.
• Highest number of incidents on Poplars (13) and Ward 18 (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 incidence on Poplars (18) correlates 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 Nostell (24) and Walton (15) is reflective of current patient population and the presentation and risk profile of service users, including restraint to prevent self-harm.
• 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

• 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.
• 3 incidents of staff led prone restraint in April:
    • Stanley (2). One incident of service user falling forward during restraint onto the safety pod and ending in a semi-standing posture with chest leaning on safety pod. Unsafe for staff to disengage. For transparency incident recorded as prone and graded Amber. Review of incident and support provided to team by RRP Team specialist advisors. One incident of service user driving forward into a prone position but held in prone for a brief period by staff due to their presentation and risk. Incident reviewed by RRP Team specialist advisors and feedback provided.
    • Walton (1). Service user laying in prone position and assessed by staff as safest option to administer intramuscular medication.

Cancelled S17 Leave

• There was 1 episode of cancelled agreed Section 17 leave in April on Poplars. The leave was cancelled due to service user physical health concerns.
• Melton and Willow are recorded as N/A due to Section 17 leave data collections not being submitted. Matrons will link with the ward teams to review and ensure robust processes are in place.

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Suite Mar-26	Beamshaw Suite Apr-26	Beamshaw Suite May-26	Clark Suite Mar-26	Clark Suite Apr-26	Clark Suite May-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	5.2%	3.5%	4.8%	1.9%	0.7%	4.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	89.3%	100.0%	Reported From April 2026	89.3%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%		89.3%	100.0%		78.6%	89.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	91.7%	100.0%	100.0%	96.0%	96.6%	96.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	75.0%	88.9%	92.9%	88.0%	89.7%	93.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.7%	96.3%	92.9%	92.0%	96.6%	96.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.5%	92.6%	89.3%	96.0%	100.0%	100.0%
Bed occupancy**	Best Quality	Safe	85%	92.3%	93.7%	103.2%	92.3%	93.7%	103.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	110	79	35	17	37	51
Safer staffing (Overall)	Best Quality	Safe	90%	108.1%	108.3%	117.2%	103.7%	110.9%	114.2%
Safer staffing (Registered)	Best Quality	Safe	80%	96.8%	98.3%	97.3%	97.9%	100.8%	102.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.9%	16.3%	5.4%	10.6%	11.8%	13.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	50.0%	100.0%	100.0%	75.0%	100.0%	90.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	0	2	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	3	0	7	4
Restraint incidents	Best Quality	Safe	Trend Monitor	0	3	*2*	2	9	*10*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/17)	0% (0/38)	From April 2026	0% (0/18)	10% (3/30)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	3		1	4	

*** 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 Mar-26	Melton Suite Apr-26	Melton Suite May-26	Nostell Mar-26	Nostell Apr-26	Nostell May-26
Appraisal rate	Best place to work and learn	Well led	90%	96.4%	96.2%	100.0%	82.4%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.9%	11.8%	3.3%	1.7%	1.0%	1.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	97.0%	96.9%	Reported From April 2026	60.0%	79.3%
Supervision - Management	Best place to work and learn	Well led	80%		97.0%	96.9%		73.3%	93.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	96.9%	93.8%	88.5%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.8%	90.6%	84.4%	96.2%	96.4%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	93.8%	87.5%	84.4%	88.5%	89.3%	96.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.6%	96.9%	100.0%	92.3%	89.3%	86.2%
Bed occupancy	Best Quality	Safe	85%	93.0%	97.2%	104.3%	96.8%	99.6%	98.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	33	15	37	27	29	50
Safer staffing (Overall)	Best Quality	Safe	90%	108.2%	111.2%	114.4%	113.1%	104.8%	117.1%
Safer staffing (Registered)	Best Quality	Safe	80%	94.8%	91.6%	95.0%	116.7%	122.2%	123.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	15.1%	6.1%	0.0%	4.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	70.6%	84.6%	70.0%
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	8	4	6
Restraint incidents	Best Quality	Safe	Trend Monitor	0	5	*2*	21	27	*20*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	N/A	0% (0/38)	From April 2026	0% (0/110)	0% (0/110)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	3		12	7	

*** 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 Mar-26	Stanley Apr-26	Stanley May-26	Walton Mar-26	Walton Apr-26	Walton May-26
Appraisal rate	Best place to work and learn	Well led	90%	91.7%	100.0%	100.0%	93.8%	96.7%	96.8%
Sickness	Best place to work and learn	Well led	5.0%	3.0%	9.3%	8.7%	3.0%	4.6%	5.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	87.5%	87.5%	Reported From April 2026	87.8%	95.0%
Supervision - Management	Best place to work and learn	Well led	80%		90.6%	81.3%		87.8%	87.5%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	97.0%	93.9%	95.0%	100.0%	97.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.8%	97.0%	93.9%	92.5%	97.5%	97.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.8%	93.9%	90.9%	80.0%	82.5%	85.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.3%	90.9%	84.8%	95.0%	95.0%	95.0%
Bed occupancy**	Best Quality	Safe	85%	96.8%	99.6%	98.8%	96.3%	94.3%	94.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	34	58	42	49	159	22
Safer staffing (Overall)	Best Quality	Safe	90%	105.5%	100.0%	108.2%	113.2%	124.0%	115.9%
Safer staffing (Registered)	Best Quality	Safe	80%	91.9%	96.5%	95.1%	93.5%	95.2%	88.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	19.9%	15.4%	14.7%	14.9%	29.3%	13.4%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	1	2	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	3	4	2	4	5
Restraint incidents	Best Quality	Safe	Trend Monitor	8	6	*7*	21	15	*27*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	1	2	0	3	1	1
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/165)	0% (0/131)	From April 2026	0% (0/165)	0% (0/99)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	8	1		6	6	

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

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Ashdale Mar-26	Ashdale Apr-26	Ashdale May-26	Ward 18 Mar-26	Ward 18 Apr-26	Ward 18 May-26
Appraisal rate	Best place to work and learn	Well led	90%	80.0%	91.7%	100.0%	38.1%	95.2%	87.0%
Sickness	Best place to work and learn	Well led	5.0%	4.5%	4.6%	4.0%	5.5%	3.4%	1.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	78.8%	74.3%	Reported From April 2026	62.2%	60.6%
Supervision - Management	Best place to work and learn	Well led	80%		75.8%	74.3%		62.2%	66.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.9%	100.0%	97.1%	100.0%	94.3%	86.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	78.8%	88.2%	88.6%	83.9%	91.4%	89.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	84.8%	82.4%	83.9%	80.0%	73.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	81.8%	94.1%	94.3%	96.8%	94.3%	81.1%
Bed occupancy	Best Quality	Safe	85%	95.7%	94.0%	98.1%	99.9%	98.3%	99.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	41	53	52	38	20	24
Safer staffing (Overall)	Best Quality	Safe	90%	101.8%	123.1%	117.2%	101.4%	114.4%	119.3%
Safer staffing (Registered)	Best Quality	Safe	80%	102.3%	103.1%	101.0%	104.1%	114.9%	110.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	12.4%	13.8%	11.1%	3.6%	0.3%	1.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	80.0%	57.1%	72.7%	85.2%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	6	3	0	2	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	3	1	0	8	3
Restraint incidents	Best Quality	Safe	Trend Monitor	10	6	*4*	3	7	*5*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/663)	0% (0/630)	From April 2026	0% (0/562)	0% (0/604)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	3		5	8	

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale Mar-26	Elmdale Apr-26	Elmdale May-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	8.3%	4.6%	3.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	94.1%	94.1%
Supervision - Management	Best place to work and learn	Well led	80%		94.1%	94.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	97.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	95.8%	93.5%	97.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.7%	96.7%	90.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.8%	90.3%	91.2%
Bed occupancy	Best Quality	Safe	85%	88.8%	89.7%	92.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	100	37	51
Safer staffing (Overall)	Best Quality	Safe	90%	110.2%	99.3%	108.9%
Safer staffing (Registered)	Best Quality	Safe	80%	97.5%	101.9%	101.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.0%	6.3%	7.6%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	76.5%	95.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	1	4
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	6	4	7
Restraint incidents	Best Quality	Safe	Trend Monitor	5	3	*14*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/275)	0% (0/239)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	5	

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton			Poplars CUE		
				Mar-26	Apr-26	May-26	Mar-26	Apr-26	May-26
Appraisal rate	Best place to work and learn	Well led	90%	38.9%	77.8%	78.9%	96.6%	93.3%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	6.6%	9.4%	15.0%	6.7%	3.2%	8.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	76.9%	50.0%	Reported From April 2026	93.9%	88.2%
Supervision - Management	Best place to work and learn	Well led	80%		73.1%	41.7%		93.9%	85.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	96.2%	100.0%	97.0%	97.0%	96.9%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.5%	83.3%	100.0%	84.4%	84.4%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	79.2%	79.2%	81.8%	90.6%	90.6%	93.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.3%	96.2%	95.8%	81.8%	84.8%	87.5%
Bed occupancy	Best Quality	Safe	85%	92.1%	76.5%	89.9%	77.2%	69.3%	64.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	145	105	29	88	114	109
Safer staffing (Overall)	Best Quality	Safe	90%	178.7%	169.8%	158.5%	200.5%	207.7%	210.6%
Safer staffing (Registered)	Best Quality	Safe	80%	140.1%	123.7%	110.4%	102.4%	108.6%	112.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	6.2%	6.4%	0.0%	21.0%	43.5%	27.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	N/A	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	4	0	0	1	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	1	0	8	13	16
Restraint incidents	Best Quality	Safe	Trend Monitor	20	7	*2*	32	27	*16*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/5)	0% (0/23)	From April 2026	7% (1/14)	33% (2/6)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	15	10		23	31	

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow Mar-26	Willow Apr-26	Willow May-26	Beechdale Mar-26	Beechdale Apr-26	Beechdale May-26
Appraisal rate	Best place to work and learn	Well led	90%	94.1%	93.8%	94.1%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	14.0%	7.0%	5.2%	5.6%	6.8%	3.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	83.3%	68.8%	Reported From April 2026	100.0%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%		83.3%	68.8%		100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	88.9%	87.5%	93.8%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.4%	81.3%	81.0%	95.5%	95.7%	95.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.4%	87.5%	93.8%	90.5%	95.5%	95.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	88.9%	93.8%	100.0%	72.7%	95.7%	100.0%
Bed occupancy	Best Quality	Safe	85%	91.0%	77.7%	95.8%	92.3%	90.6%	98.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	57	57	61	117	139	120
Safer staffing (Overall)	Best Quality	Safe	90%	112.7%	112.9%	114.2%	134.5%	144.3%	136.1%
Safer staffing (Registered)	Best Quality	Safe	80%	85.7%	93.3%	80.3%	100.9%	101.7%	102.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	11.5%	8.4%	2.1%	12.1%	14.3%	10.7%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	3	*1*	0	0	*1*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	N/A	0% (0/23)	From April 2026	0% (0/17)	0% (0/32)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	8	4		4	3	

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male			Ward 19 - Female		
				Mar-26	Apr-26	May-26	Mar-26	Apr-26	May-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	93.8%	88.2%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	1.5%	4.2%	8.5%	11.9%	7.8%	6.4%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	95.7%	95.5%	Reported From April 2026	94.4%	94.7%
Supervision - Management	Best place to work and learn	Well led	80%		95.7%	100.0%		100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.5%	92.3%	88.0%	84.2%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.9%	88.5%	88.0%	89.5%	85.0%	85.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.3%	69.2%	72.0%	84.2%	65.0%	76.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	81.8%	76.9%	80.0%	68.4%	70.0%	71.4%
Bed occupancy	Best Quality	Safe	85%	92.7%	88.2%	101.3%	98.5%	85.3%	95.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	95	76	96	87	96	73
Safer staffing (Overall)	Best Quality	Safe	90%	145.4%	129.0%	132.1%	133.5%	119.6%	130.8%
Safer staffing (Registered)	Best Quality	Safe	80%	87.1%	88.3%	93.7%	101.3%	106.0%	106.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	12.0%	1.3%	2.7%	26.0%	11.6%	2.4%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	2	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	8	4	2	2	6	1
Restraint incidents	Best Quality	Safe	Trend Monitor	15	5	*2*	9	5	*3*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/50)	0% (0/54)	From April 2026	0% (0/10)	0% (0/14)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	3		12	17	

Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down Mar-26	Enfield Down Apr-26	Enfield Down May-26	Lyndhurst Mar-26	Lyndhurst Apr-26	Lyndhurst May-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	97.9%	100.0%	92.6%	92.3%	92.3%
Sickness	Best place to work and learn	Well led	5.0%	5.1%	4.2%	6.1%	6.5%	8.1%	7.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	89.1%	95.7%	Reported From April 2026	74.1%	69.2%
Supervision - Management	Best place to work and learn	Well led	80%		87.0%	30.4%		74.1%	57.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	98.1%	100.0%	90.4%	100.0%	96.3%	92.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	86.3%	84.3%	84.6%	82.1%	88.9%	92.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	93.5%	95.7%	89.1%	89.3%	81.5%	84.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.4%	96.2%	96.2%	89.3%	92.6%	96.2%
Bed occupancy	Best Quality	Safe	Trend Monitor	49.2%	53.8%	56.4%	50.9%	56.0%	52.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	120	18	307	315	69	1161
Safer staffing (Overall)	Best Quality	Safe	90%	97.5%	99.1%	98.0%	97.9%	101.6%	102.7%
Safer staffing (Registered)	Best Quality	Safe	80%	97.1%	97.6%	97.5%	97.0%	103.5%	101.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	N/A	50.0%	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	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/102)	0% (0/104)	From April 2026	0% (0/22)	4% (1/25)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0		1	0	

Inpatients - Forensic West Yorkshire - Medium Secure

Medium Secure

• A continued focus on high-quality appraisals remains a priority for the service, with focused intervention to ensure all staff have a quality appraisal. All wards are currently above compliance.

• Separation of supervision recording has highlighted inconsistencies in distinguishing management and clinical supervision. A targeted QI programme, led by Ward Managers, is underway to strengthen supervision structures, quality and recording. This includes clarifying supervision trees to ensure all staff receive appropriate management, clinical, and primary nursing support. Current focus is on embedding clear, consistent recording systems and improving capture of group supervision (e.g. reflective practice) to strengthen oversight. Overall, general improvement has been observed. A key area of concern remains on Waterton. The Ward Manager has undertaken a review and confirmed that recording practices have been identified as the primary challenge, with improvement plans now in place.

• Sickness absence continues to improve overall. Chippendale (5.2%), Appleton (5.3%) and Priestley (5.1%) remain consistent despite a revised target, the overall trend is positive. Targeted interventions remain in place, addressing both short- and long-term absence to sustain improvement. While one area (Waterton) remains above target at 22.9%, and an increase has been observed, primarily attributed to long-term sickness absence, with a notable proportion of staff requiring surgery. Due to the extended nature of these absences, this continues to present a challenge; however, improvement has been seen in short-term sickness absence, and work remains ongoing.

• There have been improvements in mandatory training, with previous hotspots in fire, CPR and RRPI showing notable progress. However, hotspots remain in Information Governance (IG), on Johnson (90.6%), Priestley (94.7%), Chippendale (94.7%) and Appleton (88.9%). This is considered to be a seasonal issue, reflecting the number of staff requiring updates during this period and all Ward Managers have a plan in place to improve compliance. Two additional individual hotspots remain on individual wards. These are RRPI on Hepworth (75%) with staff booked onto courses and CPR on Bronte (68.2%). Challenges have been identified in releasing staff from shifts to attend CPR training. Staff have therefore been advised not to book onto sessions during shifts, which has led to improved attendance, with further improvements expected on Bronte.

• Bed occupancy on Appleton remains low at 50.0%, 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 100%. On the male pathway, although overall occupancy appears reduced within the data, our capacity is within our admission wards and rehabilitation wards are at full capacity. This demonstrates a positive position for patient flow. Of note, there is one bedroom closed on Hepworth waiting for repair work however generally where there is reduced occupancy on Bronte (88.5%) and Hepworth (75%), this is to support process for new admissions.

• There were no prone restraints 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. One hotspot is noted on Hepworth (66.7%), the position is largely driven by increased admissions and some workforce instability in registered team. Plans are in place to consider workforce across the service to support stability.

• The service reviews staffing levels daily using professional judgement alongside SafeCare data. Where challenges arise in providing Section 17 (S17) escorts, these are actively reviewed and prioritised to ensure urgent health and legal appointments are maintained. An increase in inpatient acuity, combined with a higher demand for staff escorts, has placed additional pressure on staffing capacity across the service. This will continue to be closely monitored.

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 (0.5%) and Sandal (3.1%) are now within expected compliance range. Thornhill (7.5%) and Ryburn (17.6%) 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 recognised as an annual pressure point, and remains at 94.1%. Sandal CPR which is 67.9% is an additional hotspot. 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. Thornhill (96.7%), Sandal (91.3%) and Ryburn (90.9%) are within agreed performance standards. Current compliance stands at 74.2% for Newhaven with a clear plan for an improving trajectory in place and lead by the Ward Manager. 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.

• Separation of supervision recording has highlighted inconsistencies in distinguishing management and clinical supervision. A targeted quality improvement programme, led by Ward Managers, is underway to strengthen supervision structures, quality and recording. This includes clarifying supervision trees to ensure all staff receive appropriate management, clinical, and primary nursing support. Current focus is on embedding clear, consistent recording systems and improving capture of group supervision (e.g. reflective practice) to strengthen oversight.

• 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 Sandal and Newhaven at 100% 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 processes in place to support admissions. Newhaven (77.2%) continues to experience lower level of referrals and has no waiting list.

• There were no prone restraint incidents, and Incidents of restraint show broad consistency in line with patient flow and new admissions.

• Safer staffing levels are within the expected compliance range. Increased acuity on Sandal (151.3%) has resulted in additional staffing to ensure safe service delivery.

The service reviews staffing levels daily using professional judgement alongside SafeCare data. Where challenges arise in providing Section 17 (S17) escorts, these are actively reviewed and prioritised to ensure urgent health and legal appointments are maintained. An increase in inpatient acuity, combined with a higher demand for staff escorts, has placed additional pressure on staffing capacity across the service. This will continue to be closely monitored.

Metrics	Strategic Objective	CQC Domain	Threshold	Appleton Mar-26	Appleton Apr-26	Appleton May-26	Bronte Mar-26	Bronte Apr-26	Bronte May-26
Appraisal rate	Best place to work and learn	Well led	90%	85.7%	93.3%	93.3%	94.7%	95.0%	95.0%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	5.5%	3.0%	5.3%	4.6%	0.9%	0.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	66.7%	70.6%	Reported From April 2026	65.2%	95.7%
Supervision - Management	Best place to work and learn	Well led	80%		53.5%	58.8%		4.3%	13.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	83.3%	94.4%	88.9%	90.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	94.4%	90.0%	100.0%	95.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.8%	88.9%	83.3%	65.0%	66.7%	68.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	72.2%	77.8%	88.9%	80.0%	90.5%	90.9%
Bed occupancy	Best Quality	Safe	90%	56.0%	50.0%	50.0%	84.3%	88.1%	88.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	355	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	143.7%	134.8%	125.0%	103.6%	98.2%	98.6%
Safer staffing (Registered)	Best Quality	Safe	80%	103.4%	96.1%	89.7%	96.4%	99.1%	98.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	100.0%	100.0%	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	3	1	0	3	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	7	6	*2*	7	2	*1*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/4)	N/A	From April 2026	0% (0/6)	0% (0/8)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	2		2	0	

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale			Hepworth		
				Mar-26	Apr-26	May-26	Mar-26	Apr-26	May-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	94.4%	89.5%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	5.3%	5.3%	5.2%	1.6%	1.3%	1.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	90.0%	84.2%	Reported From April 2026	50.0%	75.0%
Supervision - Management	Best place to work and learn	Well led	80%		90.0%	68.4%		35.0%	40.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	94.7%	100.0%	100.0%	95.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.5%	100.0%	84.2%	89.5%	89.5%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.5%	85.0%	94.7%	78.9%	78.9%	85.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.5%	95.0%	94.7%	84.2%	84.2%	80.0%
Bed occupancy	Best Quality	Safe	90%	88.7%	91.7%	98.4%	76.1%	80.9%	83.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	813	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.0%	99.0%	97.6%	97.4%	99.2%	95.3%
Safer staffing (Registered)	Best Quality	Safe	80%	114.9%	111.8%	107.5%	85.5%	86.1%	87.1%
% 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%	100.0%	N/A	N/A	100.0%	N/A	66.7%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*1*	0	0	*2*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	8% (2/26)	13% (4/31)	From April 2026	40% (2/5)	0% (0/4)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0		0	1	

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson Mar-26	Johnson Apr-26	Johnson May-26	Priestley Mar-26	Priestley Apr-26	Priestley May-26
Appraisal rate	Best place to work and learn	Well led	90%	85.2%	100.0%	96.2%	70.6%	76.5%	88.2%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	1.3%	2.6%	3.7%	5.2%	5.2%	5.1%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	96.7%	66.7%	Reported From April 2026	61.1%	66.7%
Supervision - Management	Best place to work and learn	Well led	80%		50.0%	51.5%		55.6%	55.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.9%	90.9%	90.6%	94.6%	100.0%	94.7%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.4%	78.8%	90.6%	88.9%	94.4%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.0%	75.8%	87.5%	88.9%	88.9%	83.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	84.4%	90.9%	90.6%	84.2%	89.5%	89.5%
Bed occupancy	Best Quality	Safe	90%	97.4%	100.0%	100.0%	100.0%	98.0%	94.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	775	1389
Safer staffing (Overall)	Best Quality	Safe	90%	124.6%	131.0%	112.8%	95.1%	107.8%	134.7%
Safer staffing (Registered)	Best Quality	Safe	80%	95.5%	100.6%	96.8%	103.8%	101.5%	92.3%
% 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%	100.0%	N/A	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	1	*1*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	1	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	6% (2/34)	12% (3/26)	From April 2026	21% (6/28)	0% (0/14)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	6		0	4	

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton Mar-26	Waterton Apr-26	Waterton May-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	93.3%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	6.2%	7.6%	22.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	44.0%	40.0%
Supervision - Management	Best place to work and learn	Well led	80%		24.0%	32.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	83.3%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.7%	91.3%	90.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.3%	73.9%	85.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	83.3%	91.3%	90.0%
Bed occupancy	Best Quality	Safe	90%	100.0%	99.6%	97.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1359	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	106.2%	107.9%	109.2%
Safer staffing (Registered)	Best Quality	Safe	80%	92.3%	96.3%	103.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/72)	1% (1/80)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	1	

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill Mar-26	Thornhill Apr-26	Thornhill May-26	Sandal Mar-26	Sandal Apr-26	Sandal May-26
Appraisal rate	Best place to work and learn	Well led	90%	75.9%	81.5%	96.7%	75.0%	88.0%	91.3%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	8.2%	15.2%	7.5%	7.5%	7.0%	3.1%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	45.5%	47.1%	Reported From April 2026	36.4%	46.9%
Supervision - Management	Best place to work and learn	Well led	80%		33.3%	38.2%		21.2%	34.4%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.9%	93.8%	96.9%	100.0%	96.6%	96.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.9%	90.6%	96.9%	89.7%	89.7%	92.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.3%	84.4%	87.5%	69.0%	65.5%	67.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	93.8%	100.0%	93.1%	89.7%	85.7%
Bed occupancy	Best Quality	Safe	85%	100.0%	94.7%	96.3%	89.7%	95.4%	91.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1900	N/A	N/A	162	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	98.2%	95.7%	97.5%	107.0%	138.1%	151.3%
Safer staffing (Registered)	Best Quality	Safe	80%	98.6%	102.1%	101.4%	103.1%	105.4%	105.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	0	1	4	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	1	0	2	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	2	*0*	0	7	*2*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	7% (10/135)	20% (34/168)	From April 2026	8% (6/74)	5% (1/20)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	0		6	20	

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn Mar-26	Ryburn Apr-26	Ryburn May-26	Newhaven Mar-26	Newhaven Apr-26	Newhaven May-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	90.9%	69.7%	74.2%	74.2%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	19.9%	19.4%	17.6%	5.4%	1.0%	0.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	58.3%	23.1%	Reported From April 2026	67.7%	90.3%
Supervision - Management	Best place to work and learn	Well led	80%		58.3%	30.8%		83.9%	71.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	88.2%	94.1%	94.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	90.9%	81.8%	96.7%	93.5%	91.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	81.8%	90.9%	86.7%	87.1%	90.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	90.9%	100.0%	91.2%	94.1%	94.1%
Bed occupancy	Best Quality	Safe	85%	71.4%	81.9%	85.7%	75.0%	75.0%	77.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	100.3%	96.3%	99.0%	120.4%	113.0%	114.8%
Safer staffing (Registered)	Best Quality	Safe	80%	101.4%	96.7%	99.5%	100.7%	102.7%	102.1%
% 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	N/A	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	2	2	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	2	6	*2*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	100% (1/1)	100% (2/2)	From April 2026	3% (1/39)	8% (3/37)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0		6	3	

Inpatients - Non-Mental Health

• **Appraisal rate (90%):**
Appraisal compliance shows an increase for both units to achieve compliance during May:
NRU 100%
SRU 97.1%

• **Supervision (80%):**
Work continues to improve clinical and managerial supervision; both uptake and recording. On both units there has been higher than normal sickness levels alongside high bed occupancy which correlates with a slight dip in compliance. This can also be seen in some of the mandatory training compliance (see below)
See also narrative on page 1 for wider Care Group; this also applies to both wards

• **Sickness (5%):**
NRU – sickness for May has continued to increase and is outside compliance at 8.9%. The current position includes some instances of long term sickness.
SRU – Sickness for May shown an improvement but remained outside compliance at 6.0%. 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). As noted last month, some staff were not due to return to work until mid-May, therefore this has impacted this month's figures. This will also be the case into June.

• **Information Governance (95%):**
NRU compliancy has remained below threshold this month and is at 92.5% for May.
SRU compliancy has increased and is achieving the target at 95.6% for May.
The reduction on NRU is related to the high levels of sickness.

• **CPR (80%):**
NRU has seen a slight reduction during May at 76.3%.
SRU remains below compliance but has seen a good increase to 74.6% for May.
Sickness on both units has impacted attendance this month as a number of staff who were booked on future sessions were unable to attend due to sickness absence. All staff who are out of date are re-booked to attend future dates of ILS and BLS and we expect to see an improvement in compliance.
In addition, Learning and Development colleagues are exploring the use of local venues to enable Barnsley staff to attend this training more easily and reduce the amount of travel time.

• **Fire Safety Training (85%):**
NRU – remains below compliance at 80.0% for May.
Sickness has impacted attendance at face-to-face training both in terms of staff off sick and other colleagues who have been unable to leave ward due to ensuring sufficient cover, particularly alongside increased occupancy. All staff out of date have been booked onto future sessions at the earliest opportunity.

• **Safer Staffing - overall (90%):**
NRU – within compliance – at 106.2%
SRU – slightly below compliance – at 87%
During May we have been utilising an additional trained nurse on SRU and therefore reduced the untrained staff ratio. This is demonstrated in the overall figure. The reason for this was to support consistently high occupancy rates.
Safer staffing (registered 80%) is within compliance for both units.
In terms of the care group, safer staffing is compliant for both registered and overall staffing.
To note: the establishment figures for both wards were reviewed in November 2025 and work continues to realign this on e-roster following further meetings in February and March 2026. An additional establishment review planned for 11.5.26 was cancelled. General Manager and Operational Manager met with Safer Staffing colleagues on 18.5.26 to discuss additional work required on SRU establishment. A further establishment review meeting is to be arranged.

Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit (NRU) Mar-26	Neuro Rehabilitation Unit (NRU) Apr-26	Neuro Rehabilitation Unit (NRU) May-26	Stroke Rehabilitation Unit (SRU) Mar-26	Stroke Rehabilitation Unit (SRU) Apr-26	Stroke Rehabilitation Unit (SRU) May-26
Appraisal rate	Best place to work and learn	Well led	90%	97.1%	85.7%	100.0%	97.1%	94.0%	97.1%
Sickness	Best place to work and learn	Well led	5.0%	5.3%	7.7%	8.9%	5.5%	6.5%	6.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	61.5%	55.3%	Reported From April 2026	55.7%	40.8%
Supervision - Management	Best place to work and learn	Well led	80%		53.8%	50.0%		48.6%	43.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.1%	92.7%	92.5%	97.1%	94.2%	95.6%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	74.4%	79.5%	76.3%	71.2%	69.2%	74.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	85.4%	80.5%	80.0%	92.9%	94.2%	89.7%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	97.0%	95.3%	96.0%	96.2%	97.2%	91.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	90	69	67	23	23	28
Safer staffing (Overall)	Best Quality	Safe	90%	102.6%	100.4%	106.2%	86.7%	93.1%	87.0%
Safer staffing (Registered)	Best Quality	Safe	80%	97.9%	86.7%	86.3%	89.0%	93.7%	97.5%
% 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
Unfilled Shifts	Best Quality	Safe	Trend Monitor	12	5		19	30	

Inpatients - Mental Health - Learning Disability

Headlines

• Appraisal compliance has significantly improved to 97.1% this month, returning to expected levels and in line with normal variation. This reflects the strength of established management processes and continued proactive oversight across the service. All outstanding appraisals relate to a very small number of staff, with reviews now scheduled, including for those recently returning from sick leave. Clear processes remain in place to support transition to the new appraisal framework, with robust governance ensuring timely completion and sustained quality.
• Sickness has continued to reduce to 4.2% this month, demonstrating sustained improvement and remaining within compliance. This reflects effective management oversight and ongoing focus on attendance across the service.
• Supervision continues to meet expected compliance levels, with clinical supervision at 97.3% and management supervision at 94.6%. This reflects a strong culture of support, accountability, and effective clinical oversight across the service.
• Mandatory training remains within target, reflecting strong compliance and a continued focus on maintaining required standards across the service.
• Low occupancy is understood and aligned with wider Assessment Treatment Unit (ATU) workstream.
• Clinically ready for discharge (CRFD), currently at 100% and understood and in relation to pathway challenges. The service continued to support system wider working to identify appropriate packages of care. At the point of report two service user had active plans in place for imminent discharge. Two service users are waiting for community placements, that require building work. . In May, 1 service user was discharged successfully to her placement and 3 remained on the ward CRFD - all 3 of them now have agreed placements identified.
• 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 (120.2%) and registered staffing (160.0%). Following template changes this would more accurately reflect proposed staffing.
• There have been no prone restraints this period. While there has been a slight increase in restraint incidents, levels remain broadly consistent with usual service parameters and reflect the acuity of a small number of service users
• Cancelled leave is routinely monitored across the service.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon Mar-26	Horizon Apr-26	Horizon May-26
Appraisal rate	Best place to work and learn	Well led	90%	94.1%	77.8%	97.1%
Sickness	Best place to work and learn	Well led	5.0%	7.3%	4.7%	4.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	88.4%	97.3%
Supervision - Management	Best place to work and learn	Well led	80%		79.1%	94.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	97.6%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.2%	92.3%	95.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	97.4%	94.9%	92.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.7%	92.7%	95.1%
Bed occupancy	Best Quality	Safe	N/A	50.0%	50.0%	42.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	524
Safer staffing (Overall)	Best Quality	Safe	90%	121.5%	133.7%	120.2%
Safer staffing (Registered)	Best Quality	Safe	80%	171.8%	167.9%	162.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	100.0%	100.0%	100.0%
% 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	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	9	11	12
Restraint incidents	Best Quality	Safe	Trend Monitor	6	8	*7*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	From April 2026	0% (0/196)	0% (0/166)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	21	30	

Inpatients - Forensic South Yorkshire

Medium Secure

• Appraisal rates improved across both wards, with Skipton exceeding the 90% target in May (96.7%) and Foss increasing to 87.0%, although still below target.
• Sickness absence remains a concern in Foss, at 7.2% in May, compared with 2.1% in Skipton, which is well within the ≤5% target.
• Mandatory training compliance improved significantly, with both wards achieving target compliance for CPR training by May (Foss 87.5%, Skipton 80.0%) and Fire Safety training (Foss 100%, Skipton 94.1%).
• Bed occupancy remains below the 90% target, particularly in Foss where occupancy was static at 78.6% across all three months; Skipton improved to 88.6% in May.
• Safer staffing levels were maintained above target, with overall staffing exceeding the 90% threshold throughout the reporting period in both wards; however, registered staffing in Skipton fell to 68.8% in May, below the 80% target.
• Safety indicators were generally positive, with patient-on-staff violence reducing to zero incidents by May in both wards and no prone restraint incidents reported; however, restraint incidents increased in Skipton from 3 in March to 5 in May..
• Prone restraints - none across the service

Low Secure

• Appraisal compliance remains the principal area for improvement, with Calder achieving target, whilst Aire, Don and Wentbridge demonstrated improvement but remain below the 90% standard. Esk experienced a slight decline during the reporting period.
• Supervision compliance improved across most wards, although performance remains inconsistent and below target in several areas, particularly within Aire and Don.
• Mandatory training compliance remains strong, with most wards achieving or exceeding targets for Information Governance, CPR, Fire Safety and Reducing Restrictive Practice training by May.
• Sickness absence remained below the organisational threshold across all wards, demonstrating good workforce wellbeing and attendance management.
• Overall staffing levels remained above target throughout the service, although registered staffing shortages persist within some wards, most notably Wentbridge.
• Bed occupancy remained high across the service from the available beds), with Don and Esk operating at or near full capacity, reflecting sustained demand and ongoing pressures on patient flow.
• Safety performance remained positive, with patient-on-patient violence reducing to zero by May and patient-on-staff incidents remaining low across all wards.
• Restrictive practice indicators remained favourable, with very low restraint activity and no prone restraint incidents reported during the reporting period.

				Medium Secure Services					
				Foss			Skipton		
Metrics	Strategic Objective	CQC Domain	Threshold	Mar-26	Apr-26	May-26	Mar-26	Apr-26	May-26
Appraisal rate	Best place to work and learn	Well led	90%	61.9%	86.4%	87.0%	43.3%	90.0%	96.7%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	8.2%	6.7%	7.2%	4.7%	3.6%	2.1%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	70.4%	96.3%	Reported From April 2026	77.1%	97.1%
Supervision - Management	Best place to work and learn	Well led	80%		63.0%	88.9%		74.3%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	89.7%	95.8%	95.8%	93.1%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.1%	87.5%	87.5%	79.3%	82.9%	85.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	58.6%	62.5%	87.5%	69.0%	71.4%	80.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.1%	75.0%	100.0%	93.1%	82.9%	94.1%
Bed occupancy	Best Quality	Safe	90%	78.6%	78.6%	78.6%	80.9%	83.3%	86.8%
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%	112.1%	125.3%	119.3%	123.6%	99.7%	100.8%
Safer staffing (Registered)	Best Quality	Safe	80%	97.7%	104.1%	97.9%	89.7%	70.2%	68.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	0	0	3	2	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*2*	*8*	4	*5*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	Reported From April 2026	14% (6/44)	11% (4/35)	Reported From April 2026	18% (7/38)	14% (4/29)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	25	16		60	31	

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Esk Mar-26	Low Secure Services Esk Apr-26	Low Secure Services Esk May-26	Wentbridge Mar-26	Wentbridge Apr-26	Wentbridge May-26
Appraisal rate	Best place to work and learn	Well led	90%	86.4%	90.9%	90.9%	50.0%	53.1%	78.1%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	4.3%	5.4%	2.0%	1.0%	1.5%	1.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	83.3%	91.3%	Reported From April 2026	73.5%	97.1%
Supervision - Management	Best place to work and learn	Well led	80%		41.7%	73.9%		58.8%	94.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.2%	95.7%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	82.6%	81.8%	94.1%	97.1%	97.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.7%	87.0%	85.7%	88.2%	91.2%	97.1%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.3%	73.9%	100.0%	97.1%	97.1%	100.0%
Bed occupancy	Best Quality	Safe	90%	74.4%	85.0%	79.0%	80.2%	87.5%	87.5%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	1075	3080	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	105.4%	99.0%	99.9%	107.4%	112.9%	119.3%
Safer staffing (Registered)	Best Quality	Safe	80%	85.7%	90.5%	96.7%	88.4%	95.9%	91.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	2	3	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	2	0	2	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*1*	1	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	Reported From April 2026	15% (4/26)	19% (6/32)	Reported From April 2026	0% (0/28)	8% (3/40)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	10	2		30	15	

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire Mar-26	Aire Apr-26	Aire May-26	Don Mar-26	Don Apr-26	Don May-26
Appraisal rate	Best place to work and learn	Well led	90%	48.4%	48.3%	59.3%	54.5%	56.5%	68.2%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	2.3%	2.2%	3.4%	2.1%	0.6%	1.1%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	77.4%	75.9%	Reported From April 2026	30.4%	69.6%
Supervision - Management	Best place to work and learn	Well led	80%		29.0%	62.1%		26.1%	69.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	88.9%	100.0%	100.0%	100.0%	95.7%	95.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.3%	83.3%	89.3%	90.9%	78.3%	77.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.8%	83.3%	89.3%	85.0%	91.3%	86.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.3%	93.3%	100.0%	95.0%	91.3%	100.0%
Bed occupancy	Best Quality	Safe	90%	87.1%	75.6%	84.7%	100.0%	100.0%	99.7%
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%	92.4%	99.4%	96.7%	107.9%	102.0%	104.3%
Safer staffing (Registered)	Best Quality	Safe	80%	86.3%	91.3%	92.7%	87.5%	87.8%	90.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*1*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	Reported From April 2026	9% (2/22)	14% (5/36)	Reported From April 2026	11% (5/45)	12% (6/52)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	7		14	10	

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Calder Mar-26	Apr-26	May-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	90.9%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	0.6%	0.0%	1.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reported From April 2026	100.0%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%		86.4%	90.9%
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%	90.5%	100.0%	95.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	95.5%	100.0%
Bed occupancy	Best Quality	Safe	90%	92.7%	88.3%	89.7%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	1273	N/A	1818
Safer staffing (Overall)	Best Quality	Safe	90%	91.0%	96.1%	95.7%
Safer staffing (Registered)	Best Quality	Safe	80%	64.9%	86.7%	91.8%
% 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	2	1	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	Reported From April 2026	4% (1/23)	16% (8/51)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	21	6	

Overall Financial Performance 2026/27

Executive Summary / Key Performance Indicators

	Performance Indicator	Strategic Objective	CQC Domain	Year to Date	2026/27 Forecast	Narrative
	NHS Oversight Framework	Best Value	Well Led	1	1	The score of 1 means that the financial override is not applied against the Trust National Oversight Framework score. This will be reviewed in line with any changes to the National Oversight Framework and the calculation of financial metrics.
1	Surplus / (Deficit)	Best Value	Well Led	(£1.2m)	£0m	The deficit run rate has increased in May 2026 with £791k overspend. This brings the year to date deficit to £1,246k. This remains marginally ahead of plan but action is required to change the run rate direction and ensure that the breakeven target can be delivered.
2	Agency Spend	Best Value	Well Led	£0.3m	£2m	Agency spend is currently being maintained at a historically low level. Spend in May 2026 is £143k, within plan and is constricted to a limited number of medical posts. This is forecast to increase over the coming months due to pending staff retirements.
3	Bank Spend	Best Value	Well Led	£3.8m	£20.4m	Although Trust actions are forecast to achieve a £5.0m reduction in bank staff the current run rate, and forecast, is that the nationally set maximum spend limit will be exceeded. For the year to date this is £0.4m (14.1%).
4	Financial sustainability and efficiencies	Best Value	Well Led	£2m	£17.7m	The Trust value for money programme is in line with plan for the year to date. This is primarily due to the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025 / 26. The trajectory includes the identification, and delivery, of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of breakeven is maintained.
5	Cash	Best Value	Well Led	£59.1m	£67.2m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position.
6	Capital Spend	Best Value	Well Led	£1.3m	£14.7m	Capital spend remains ahead of plan in May 2026 due to the timing of updated lease contracts in the previous month. This was originally planned for June 2026. The forecast remains in line with allocation, including a new allocation for community hubs, and schemes are progressing. Any revisions to timescales or forecasts will be agreed through Trust Board.
7	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

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Finance Report

Month 2 (2026 / 27)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0	Executive Summary / Key Performance Indicators

Key Performance Indicator		Year to Date	Forecast 2026 / 27	Narrative
NOF 1	National Oversight Framework	1	1	The score of 1 means that the financial override is not applied against the Trust National Oversight Framework score. This will be reviewed in line with any changes to the National Oversight Framework and the calculation of financial metrics.
1	Surplus / (Deficit)	(£1.2m)	£0m	The deficit run rate has increased in May 2026 with £791k overspend. This brings the year to date deficit to £1,246k. This remains marginally ahead of plan but action is required to change the run rate direction and ensure that the breakeven target can be delivered.
2	Agency Spend	£0.3m	£2m	Agency spend is currently being maintained at a historically low level. Spend in May 2026 is £143k, within plan and is constricted to a limited number of medical posts. This is forecast to increase over the coming months due to pending staff retirements.
3	Bank Spend	£3.8m	£20.4m	Although Trust actions are forecast to achieve a £5.0m reduction in bank staff the current run rate, and forecast, is that the nationally set maximum spend limit will be exceeded. For the year to date this is £0.4m (14.1%).
4	Financial sustainability and efficiencies	£2m	£17.7m	The Trust value for money programme is in line with plan for the year to date. This is primarily due to the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025 / 26. The trajectory includes the indentification, and delivery, of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of breakeven is maintained.
5	Cash	£59.1m	£67.2m	The current cash position continues to be positive but, in line with national focus in this area, best practice continues to be reviewed to ensure that we have effective management of the Trust working capital position.
6	Capital	£1.3m	£14.7m	Capital spend remains ahead of plan in May 2026 due to the timing of updated lease contracts in the previous month. This was originally planned for June 2026. The forecast remains in line with allocation, including a new allocation for community hubs, and schemes are progressing. Any revisions to timescales or forecasts will be agreed through Trust Board.
7	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.

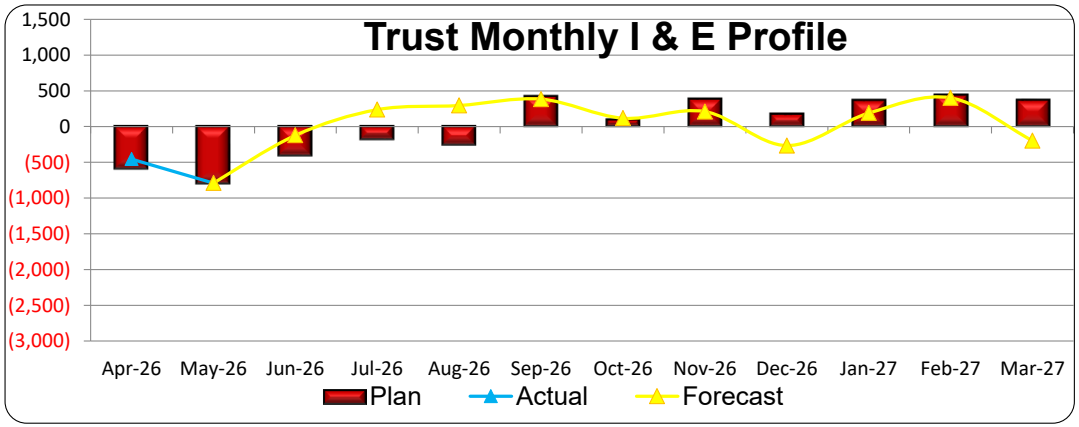
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

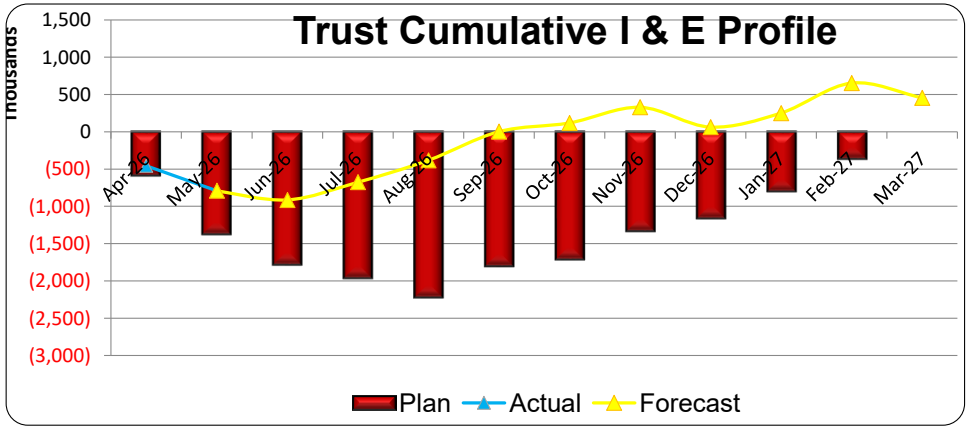
2.0 Income & Expenditure Position 2026 / 27

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					34,566	34,625	59	69,313	69,349	36	415,718	415,085	(633)
Other Operating Revenue					1,275	1,351	76	2,578	2,670	91	15,502	15,814	311
Total Revenue					**35,841**	**35,975**	**134**	**71,891**	**72,019**	**128**	**431,220**	**430,899**	**(321)**
Employee expenses	5,387	5,375	(12)	0.2%	(25,669)	(26,007)	(338)	(51,291)	(52,136)	(845)	(304,534)	(316,062)	(11,528)
Operating expenses exc. Employee expenses					(10,710)	(10,582)	128	(21,471)	(20,784)	687	(123,461)	(112,646)	10,816
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,387**	**5,375**	**(12)**	**-0.2%**	**(36,379)**	**(36,589)**	**(210)**	**(72,762)**	**(72,921)**	**(158)**	**(427,995)**	**(428,707)**	**(712)**
Operating Surplus / (Deficit)	**5,387**	**5,375**	**(12)**	**-0.2%**	**(538)**	**(614)**	**(76)**	**(871)**	**(901)**	**(30)**	**3,225**	**2,192**	**(1,034)**
Finance expense					(55)	(60)	(5)	(111)	(119)	(8)	(665)	(664)	1
PDC Paid					(362)	(362)	0	(724)	(724)	0	(4,343)	(4,343)	(0)
Finance income					156	237	81	308	481	174	1,645	2,731	1,086
Surplus / (Deficit) - Total	**5,387**	**5,375**	**(12)**	**-0.2%**	**(799)**	**(799)**	**0**	**(1,398)**	**(1,263)**	**135**	**(138)**	**(84)**	**54**
Adjusted Financial Performance													
Depn Peppercorn Leases (IFRS16)					11	8	(3)	23	16	(7)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB performance measure	**5,387**	**5,375**	**(12)**	**-0.2%**	**(788)**	**(791)**	**(3)**	**(1,375)**	**(1,246)**	**129**	**0**	**0**	**0**





Income & Expenditure Position 2026 / 27

The consolidated Trust deficit in May 2026 is £791k.
This is £3k worse than plan.

In line with national guidance the Trust submitted a risk assessed breakeven financial plan for 2026 / 27. Within this position there were identified risks and opportunities and these will be continually assessed as the year progresses. These are discussed monthly at the Trust Finance, Investment and Performance Committee.

NHS England - monthly submission

The actual financial performance reported here is consistent with the monthly return made to NHS England. 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. 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)	5,363	5,353	(10)	0.2%	(1,140)	(591)	549	(2,014)	(1,174)	839	(4,923)	(14,737)	(9,814)
Provider Collaboratives	23	21	(2)	8.3%	(55)	(206)	(151)	(13)	(87)	(74)	20	(1,041)	(1,061)
Budgets held centrally	0	0	0	0.0%	407	6	(401)	651	15	(637)	4,902	15,777	10,875
Total - Consolidated position (ICB performance measure)	**5,387**	**5,375**	**(12)**	**-0.2%**	**(788)**	**(791)**	**(3)**	**(1,375)**	**(1,246)**	**129**	**0**	**0**	**0**

The previously positive run rate in 2025 / 26 has continued to deteriorate with the monthly deficit increasing from £456k to £791k. May 2026 is £3k worse than planned but we remain ahead of plan for the year to date. Whilst the Trust profile recognised a potential financial challenge in months 1 and 2 this is modelled to improve in future months. The profile set within the Trust financial plan recognised that there would be a change from the positive run rate in 2025 / 26 as we started the financial year.

The Trust (core) deficit is broadly the same as month 1 and remains a deficit; albiet it better than plan. The baseline forecast, constructed from detailed discussions with budget holders, currently incorporates an increase in expenditure run rate (primarily pay). This is being reviewed and triangulated with Trust actions and the impact of this is included in the Trust forecast scenario modelling.

As flagged in previous reporting the financial performance of the provider collaboratives remains volatile for both out of area placements and additional costs relating to exceptional pakcages of care. This is shown in month with a deficit reported compared to the surplus last month. In turn this has an impact on the forecast position.

Budgets held centrally remains for items that are not able to be coded through care groups. Actual expenditure remains limited but the budget requires additional value for money schemes to be allocated against it. The forecast is significant improvement in order to achieve the breakeven target. The action plan, and forecast scenarios, is presented to the Trust Finance, Investment and Performance Committee.

2.0 Income & Expenditure Position 2026 / 27

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.

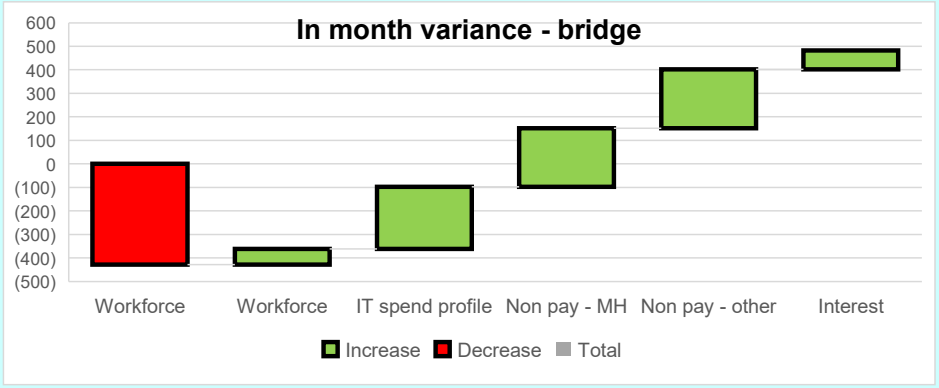
To confirm that the individual analysis within this report highlights the Trust only values unless explicitly stated otherwise.

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					24,902	24,868	(34)	49,986	49,895	(91)	299,755	298,395	(1,360)
Other Operating Revenue					1,229	1,270	41	2,453	2,516	63	14,547	14,964	417
Total Revenue					**26,131**	**26,138**	**7**	**52,439**	**52,411**	**(28)**	**314,302**	**313,359**	**(943)**
Employee expenses	5,363	5,353	(10)	0.2%	(25,493)	(25,876)	(383)	(50,941)	(51,874)	(933)	(302,433)	(314,444)	(12,011)
Operating expenses exc. Employee expenses					(1,528)	(676)	852	(3,007)	(1,366)	1,642	(13,566)	(11,460)	2,106
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,363**	**5,353**	**(10)**	**-0.2%**	**(27,021)**	**(26,552)**	**469**	**(53,948)**	**(53,240)**	**708**	**(315,999)**	**(325,904)**	**(9,905)**
Operating Surplus / (Deficit)	**5,363**	**5,353**	**(10)**	**-0.2%**	**(890)**	**(414)**	**476**	**(1,509)**	**(829)**	**681**	**(1,697)**	**(12,545)**	**(10,848)**
Finance expense					(55)	(60)	(5)	(111)	(119)	(8)	(665)	(664)	1
PDC Paid					(362)	(362)	0	(724)	(724)	0	(4,343)	(4,343)	(0)
Finance income					156	237	81	308	481	174	1,645	2,731	1,086
Surplus / (Deficit) - Total	**5,363**	**5,353**	**(10)**	**-0.2%**	**(1,151)**	**(599)**	**552**	**(2,036)**	**(1,190)**	**846**	**(5,060)**	**(14,821)**	**(9,760)**
Depn Peppercorn Leases (IFRS16)					11	8	(3)	23	16	(7)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB	**5,363**	**5,353**	**(10)**	**-0.2%**	**(1,140)**	**(591)**	**549**	**(2,014)**	**(1,174)**	**839**	**(4,923)**	**(14,737)**	**(9,814)**

The Trust plan for 2026 / 27 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) remains in a deficit position.

The key headlines, against these budget assumptions, are included below and illustrated within the bridge:	£k
Workforce - Expenditure cost pressures exceed planned assumptions. Primarily mental health care group and Forensics.	(428)
Workforce - continuation of utilisation of less staffing than plan. Support care groups	67
Non pay - IM & T equipment expenditure forecast later in the year	264
Non pay - contract reductions. Mental health care group but general reductions across the Trust	249
Finance income - due to cash position, and maintained interest rates, inter	81

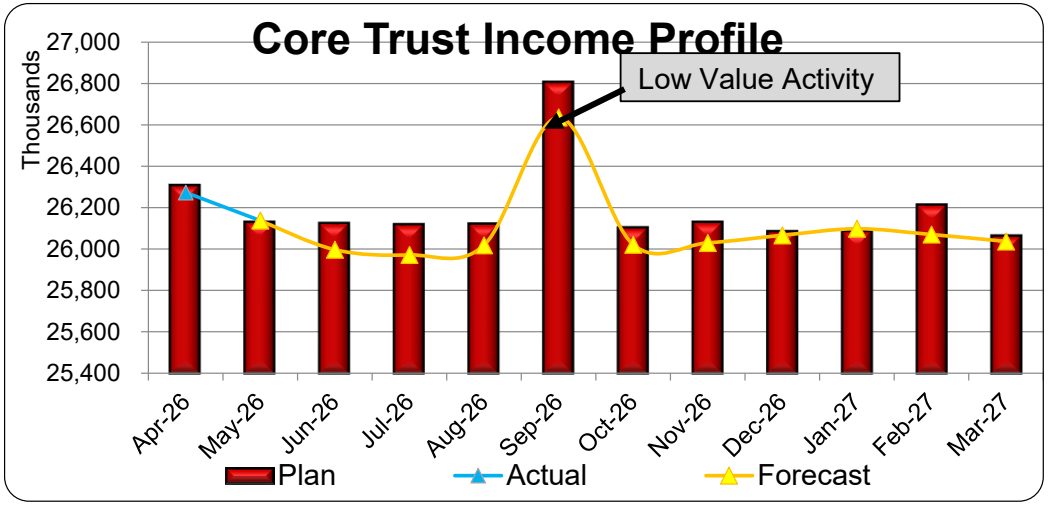


2.1 Income Information

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 funding 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 table below categorises total income received by commissioner type.

	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	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Trust (core)									
NHS Commissioners	23,454	23,453	(1)	46,996	46,977	(18)	281,999	281,889	(110)
Specialised Commissioning (NHS E)	604	643	38	1,332	1,369	37	7,112	6,170	(942)
Local Authorities	432	435	3	861	862	1	5,157	5,135	(22)
Partnerships	244	224	(19)	462	442	(20)	3,476	3,644	169
Other Healthcare income	115	84	(31)	230	163	(68)	1,382	982	(400)
Other non clinical income	1,276	1,293	17	2,548	2,588	40	15,116	15,479	362
Total - Trust core income	**26,126**	**26,133**	**7**	**52,429**	**52,401**	**(28)**	**314,243**	**313,299**	**(944)**
Provider Collaboratives	9,664	9,756	93	19,327	19,454	127	115,963	116,690	727
Budgets held centrally	46	81	35	125	154	28	955	850	(106)
Total - Consolidated income	**35,836**	**35,970**	**134**	**71,882**	**72,009**	**128**	**431,162**	**430,839**	**(322)**



Risks and opportunities

Although the majority of income is fixed in nature, and aligned with contracts and budgets, there are a limited number of variances.

These forecast variances are offset by corresponding reductions in pay and non pay.

* Additional roles reimbursement	£368k
* Yorkshire Smokefree - prescribing & activity	£47k
* Any qualified provider activity	£110k

Other income variances include:

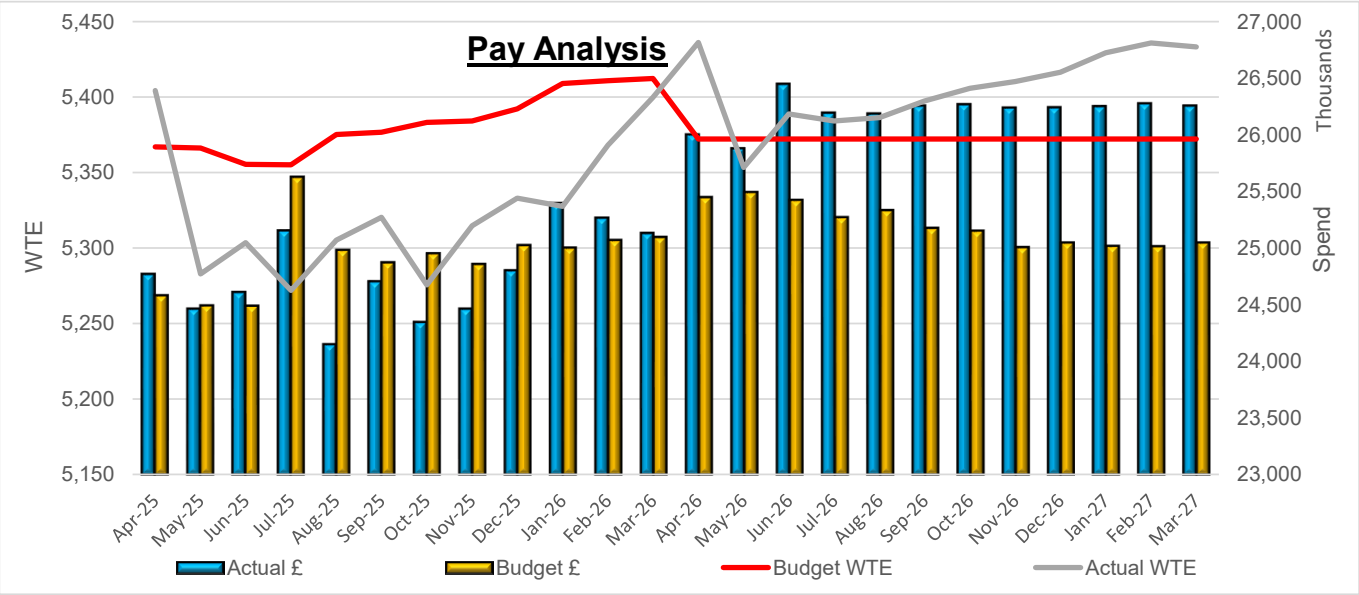
* Income received for bed sales inc. Provider Collabs	£215k

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 Provider 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.

	In month		Year to Date	Forecast		Movement since last month	
Description	**Worked WTE**	**£k**	**£k**	**Worked WTE**	**£k**	**Worked WTE**	**£k**
Substantive	4,946	23,925	47,785	5,061	292,033	(6)	65
Bank & locum	402	1,808	3,821	362	20,403	(77)	(205)
Agency	5	143	269	9	2,008	0	18
Total	**5,353**	**25,876**	**51,874**	**5,433**	**314,444**	**(83)**	**(122)**
Budget	**5,363**	**25,493**	**50,941**	**5,372**	**302,433**	**0**	**46**
Over / (Under)	**(10)**	**383**	**933**	**61**	**12,011**	**(83)**	**(168)**



The table to the left, and graph below, show the breakdown of Trust pay expenditure.

The spike in April 2026, primarily due to increased bank staff, has reverted in May 2026 with worked WTE less than planned in month. The current baseline forecast, of increasing workforce, continues to be discussed and triangulated with Trust actions.

The impact of this is considered within the Trust forecast scenario.

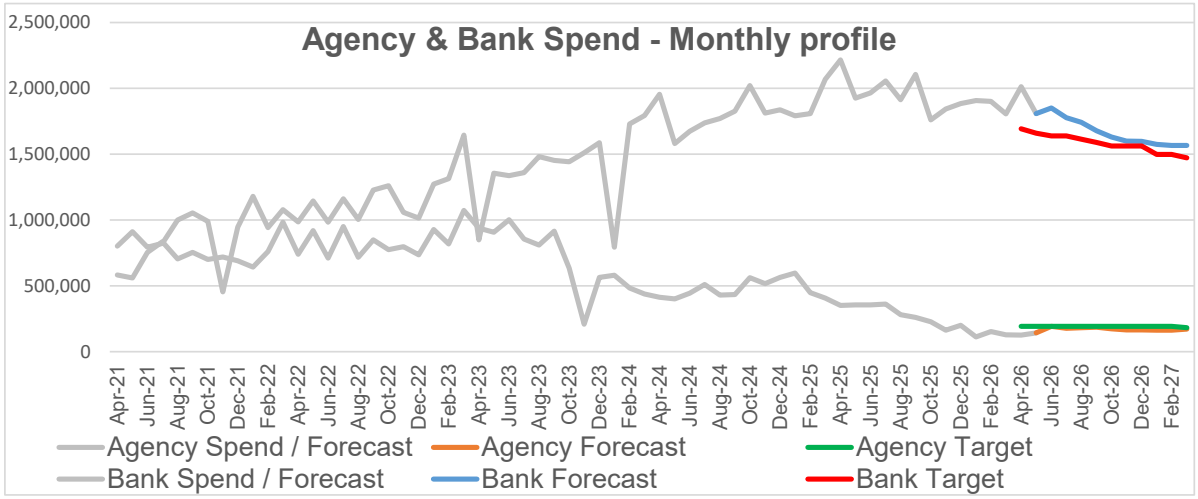
Although the worked WTE is under plan, actual £ spend is more than plan. Work continues to ensure this is understood and aligned with the Trust Value For Money position.

2.2 Temporary Staffing Focus

Trust spend in May 2026:
Agency £143k
Bank £1,808k

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	191	61	**253**
Other Medical	77	105	**182**
Reg Nursing	(0)	1,151	**1,151**
UnReg Nursing	0	2,310	**2,311**
Other Clinical	0	94	**94**
A & C	0	99	**99**
Other	0	0	**0**
Total	**269**	**3,821**	**4,090**
Lead Provider Collaborative		3	**3**
Budgets held centrally		0	**0**
Total	**269**	**3,823**	**4,092**

In line with national guidance the Trust financial plan for 2026 / 27 included spend reduction targets; c. 30% reduction in agency and 15% reduction in bank. Further reductions are required for future financial years. 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.

As shown above agency spend has been maintained at a low level and, in May 2026, the Trust only used medical staffing agency. Future pressures have been identified in this area especially relating to staffing retirements. The current forecast remains that the target can be acheived.

Bank spend has continued to fluctuate and has reported stepped increase in April 2026 followed by a stepped reduction in May 2026. The currrent forecast trajectory has usage reducing but remaining above the target requirement.

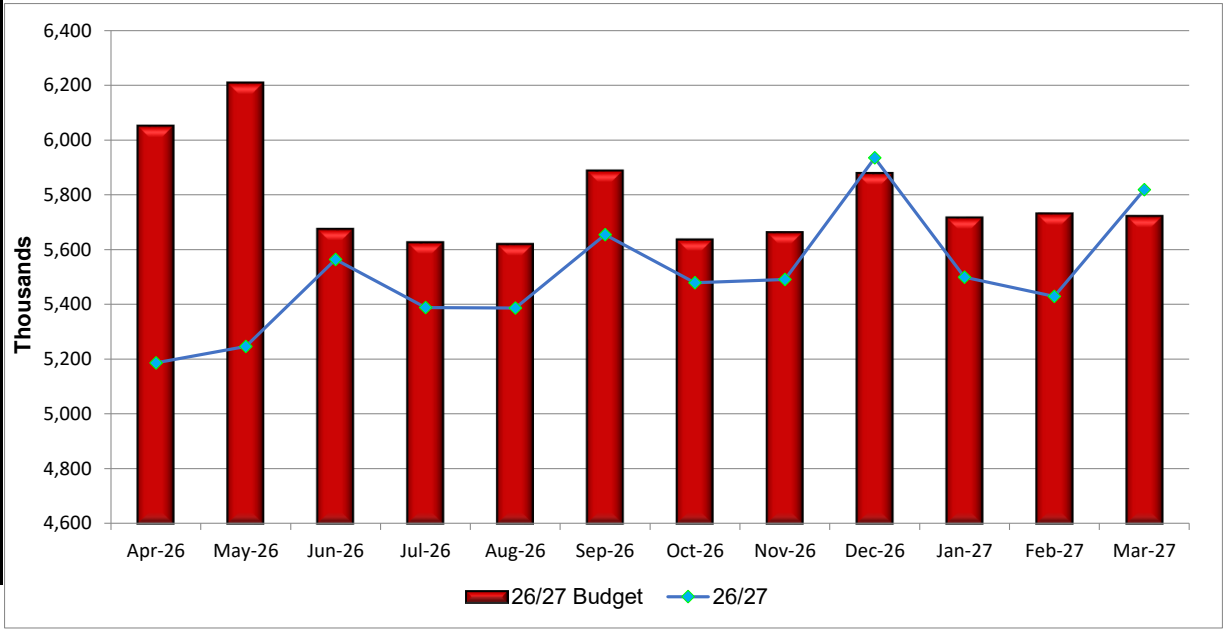
Action plans continue to be developed through the Trust temporary staffing group.

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, To re-confirm that this presentation excludes non pay expenditure relating to the provider collaboratives and budgets held centrally.

Non pay spend	Apr-26 £k	May-26 £k	Jun-26 £k	Jul-26 £k	Aug-26 £k	Sep-26 £k	Oct-26 £k	Nov-26 £k	Dec-26 £k	Jan-27 £k	Feb-27 £k	Mar-27 £k	Total £k
2026 / 27	5,186	5,246	5,564	5,388	5,387	5,654	5,479	5,490	5,935	5,499	5,429	5,818	**66,075**
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**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	769	701	(68)
Establishment	2,225	1,553	(672)
Lease & Property Rental	1,456	1,445	(11)
Premises (inc. rates)	1,009	891	(118)
Utilities	547	482	(65)
Purchase of Healthcare	1,313	942	(371)
Travel & vehicles	1,017	910	(107)
Supplies & Services	1,486	1,383	(104)
Training & Education	222	109	(113)
Clinical Negligence & Insurance	242	238	(4)
Capital Charges Depn, PDC,	1,714	1,498	(216)
Other non pay	258	279	21
Total	**12,259**	**10,432**	**(1,826)**
Total Excl OOA and Drugs	**10,176**	**8,789**	**(1,388)**



Key Messages

Non pay expenditure, being significantly less than plan, continues to support the overall Trust financial position although it should be noted that the profile did have more budget in April and May 2026. The largest of these is the timing of planned IM & T expenditure including the Trust laptop replacement programme.

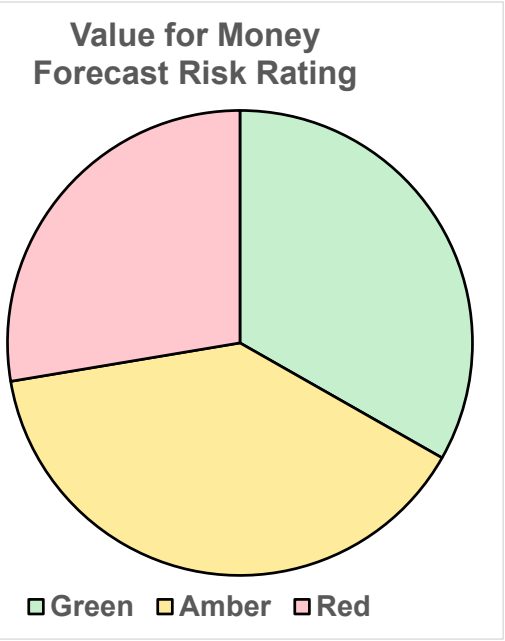
Although non pay expenditure is forecast to increase in the remaining 10 months of the year this remains within planned levels. For month 3 a focus on triangulation of actions, cost reduction and reporting as part of value for money will be undertaken.

3.0 Value for Money & Financial sustainability

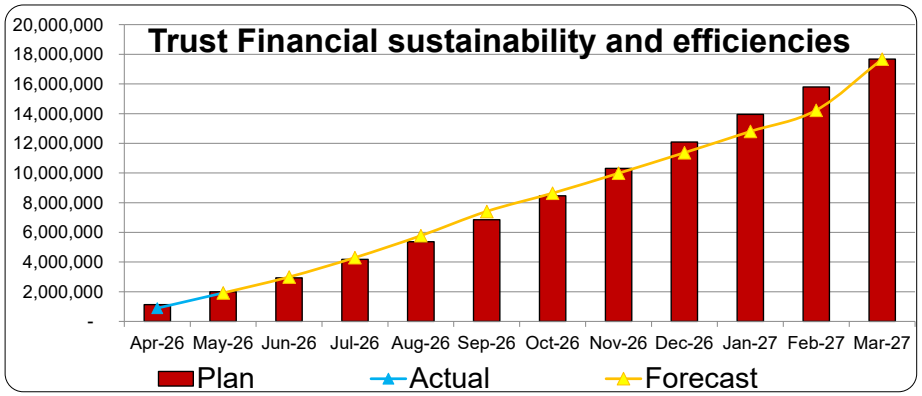
The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial sustainability. For 2025 / 26 the value included in the plan was £17.7m. 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	Revised Target £k	Green £k	Amber £k	Red £k	Variance £k
Pay	Workforce	0	131	0	131	3,689	131	1,001	4,886	2,328
	Temporary Staffing	929	785	0	(143)	4,412	785	5,123		1,497
	Corporate Pay	332	332	0	(0)	1,991	1,991			0
	Productivity	0	0	0	0	1,400				(1,400)
	Difficult Decisions	100	45	0	(55)	2,138	155			(1,983)
Non Pay	Non Pay	16	22	0	6	248	100			(148)
	Drugs optimisation	36	2	0	(34)	220	2	6		(211)
	Digitial optimisation	6	36	0	30	35	236			201
	Out of Area placements	60	159	0	99	357	159	623		424
	Difficult Decisions	0	38	0	38	0	103			103
	Non pay - establishment	34	19	0	(15)	265	24	27		(213)
Other	Provider Collaboratives	360	360	0	0	2,160	2,160			0
	Bed Sales	0	0	0	0	0				0
	Income	128	27	0	(101)	760	27	136		(597)
	Misc income - overage	0	0	0	0	0				0
Total		**2,001**	**1,957**	**0**	**(44)**	**17,675**	**5,874**	**6,916**	**4,886**	**(0)**
Recurrent		1,875	1,957		82	16,925	5,874	6,916	0	(4,136)
Non Recurrent		126		0	(126)	750	0	0	4,886	4,136



GREEN	On track for delivery: The scheme is on track, savings are being realised according to the plan, and there are no significant risks to the budget.
AMBER	There are risks or minor delays in achieving savings. The scheme requires management attention but is generally considered resolvable. Cost overruns or timing of delivery risks.
RED	The scheme is failing to meet its financial targets. It is likely to be significantly over budget or fail to deliver the required savings within the timescale agreed. Or the scheme is not yet scoped.



The phasing of the Trust Value for Money schemes is set roughly as £1m per month for the first half of the financial year, and £1.8m in the second half as schemes progress.

For April and May 2026, £1,957k has been achevied. The largest, such as temporary staffing and out of area placements, relfects the maintenance of reduced run rates from 2025 / 26. As such the run rate against these schemes will slow down in the latter part of the year.

At that point, current schemes and / or further additional schemes, will be required to deliver new cost reductions. As at May 2026, £4,886k (28%) has been RAG rated as red and the Trust Value For Money group is leading on reduction of

The impact of this, including the current recurrent / non recurrent position, is factored into the Trust underlying financial position and analysis and the baseline for the Trust medium term financial plan.

4.0 Statement of Financial Position (SOFP) 2026 / 27

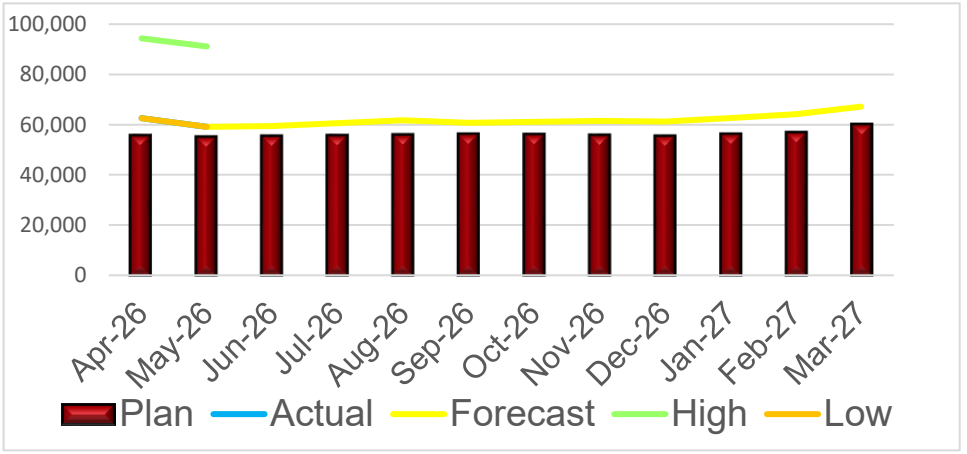
Whilst the focus is traditionally on the Trust income and expenditure position, the Statement of Financial Position (SOFP - balance sheet) presents a key snapshot of the Trusts overall financial health, stability and can provide important early warning flags of potential financial issues.

The balance sheet shows that the Trust owns (assets) and what it owes (liaiblities).

Balance Sheet / Statement of Financial Position (SOFP)	Current £k	Note
Assets		
Non-Current (Fixed) Assets	191,319	Pg 13
Inventories & Work in Progress	209	
Trade receivables (Debtors)	890	
Accrued Income	3,919	Pg 14
Prepayments	4,558	
Cash and Cash Equivalents	59,108	
Total Assets	**260,002**	
Liabilities		
Payables (Creditors)	(13,992)	
Accruals	(18,957)	
Deferred Income	(2,493)	Pg 14
Provisions	(3,309)	
IFRS 16 / leases liabilities	(46,078)	
Total Liabilities	**(84,829)**	
Total Net Assets/(Liabilities)	**175,173**	
Taxpayers' Equity		
Public Dividend Capital	(79,119)	
Revaluation Reserve	(12,067)	
Other Reserves	(5,220)	
Income & Expenditure Reserve	(78,767)	
Total Taxpayers' Equity	**(175,173)**	

Non Current (Fixed assets): The value of Trust assets is impacted by additional capital purchases and disposals (page 13), reduced by the impact of depreciation and amortisation and annual revaluation exercises.

Cash: The Trust cash position is shown below. The graph shows the position at the end of each month and also the highest / lowest cash point during that month. This is monitored to highlight any risk or opportunity. Actual cash is £59.1m.

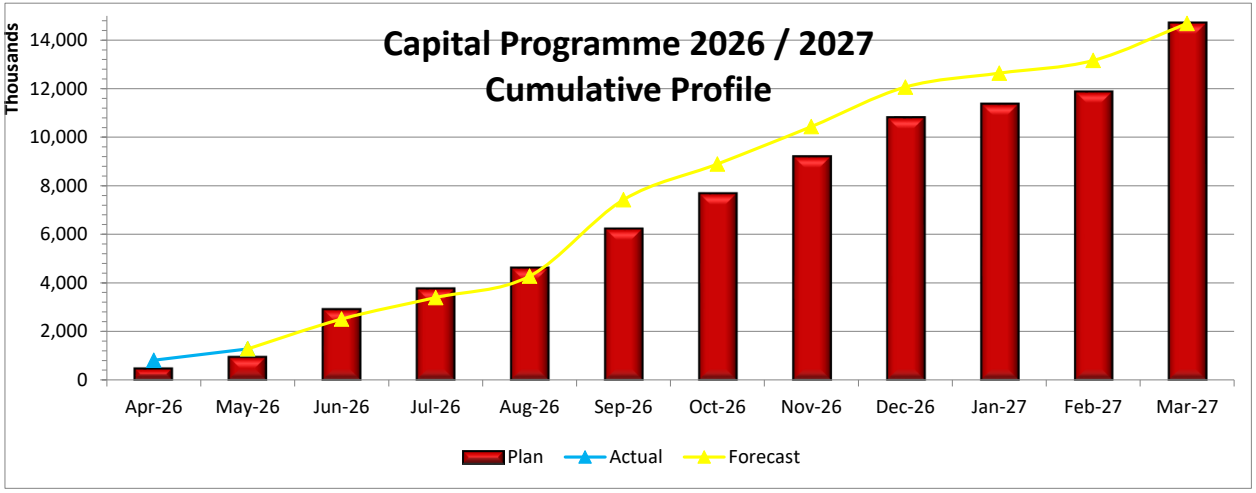


Overall the Trust balance sheet remains strong with assets greater than liabilities.

The taxpayers equity section, similar to shareholders equity, illustrates that Trust funding is entirely from public taxation.

4.1 Capital Programme 2026 / 27

Capital schemes	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Annual Budget £k	2026 / 27 Outturn £k	Variance £k
Major Capital Schemes						
Older People Transformation	870	102	(768)	5,428	5,428	0
IM & T - Digital Infrastructure	0	0	0	1,650	1,650	0
IM & T - Cyber Security	0	0	0	250	250	0
IM & T - Digital Care Records	32	0	(32)	200	200	0
IM & T - Digital Information Sharing	0	0	0	100	100	0
IM & T - Digital Insights	0	0	0	200	200	0
IM & T - Digitally Empowered Workforce	0	0	0	100	100	0
Net Zero Carbon	0	380	380	0	1,903	1,903
Other	0	(272)	(272)	0	(1,920)	(1,920)
Leases (IFRS 16)	0	1,067	1,067	3,011	3,029	18
TOTALS	**902**	**1,277**	**375**	**10,939**	**10,939**	**0**
Additional allocations						
Cheswold	40	0	(40)	3,000	3,000	0
Community hub	0	0	0	750	750	0
			0			0
TOTALS	**942**	**1,277**	**335**	**14,689**	**14,689**	**0**



Capital Expenditure 2026 / 27

The table,left, summarises the Trust capital programme for 2026 / 27. This is split between the Trust core capital allocation and additional allocations which have been secured. The core allocation includes leases (IFRS 16). The main scheme is the continuation of the Older People Inpatient Transformation project.

An additional allocation has been secured for both 2026 / 27 and 2027 / 28 in relation to improvements for Cheswold Park Hospital. In May 2026 the Trust also received confirmation of additional £750k funding to develop a community hub.

Total spend, for April and May 2026, remains ahead of plan due to the timing of leases which were originally expected in June 2026. This is partially offset by the credit, recorded against other, which relates to VAT rebates for previous schemes.

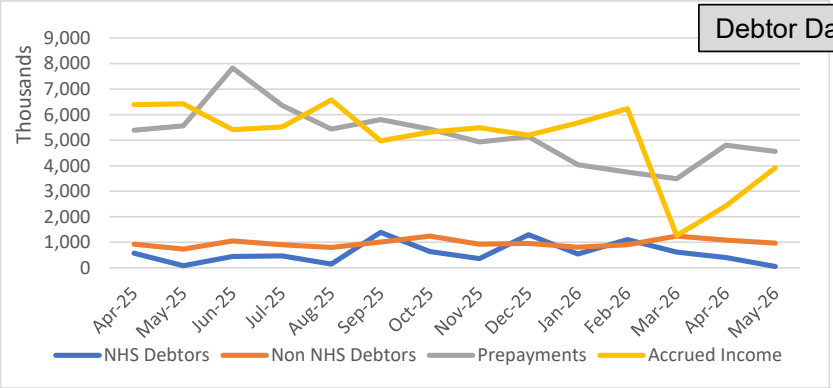
The plan and forecast continues to align with the February 2026 plan submission. This continues to be reviewed, as schemes are progressing, to ensure that current positions are incorporated within the forecast position.

This will need to include programme changes to mitigate the current over subscription of the Trust capital allocation in year.

4.2 Balance sheet analysis

The presentation of this data, and supporting narrative, has been revised in order to enhance the awareness of potential future risk areas and the actions being taken to manage them.

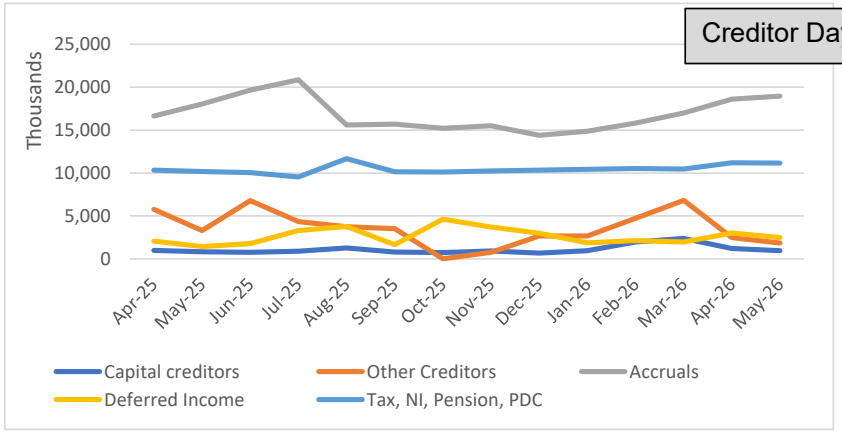
Debtors: A debtor is an indiviudal or company who owes money to the Trust for services provided. This directly impacts on cashflow. The action is to minimise these balances as far as possible and ensure that debts are recovered in a timely manner. Both the value and age is shown below.



	Not Due £k	1 - 30 days £k	31 - 60 days £k	61 + days £k	Total £k
NHS	254	25	2	(30)	251
Non NHS	114	91	60	138	403
Total	**368**	**117**	**61**	**108**	**654**

Overall debtors remain very low and aged debts are being appropriately managed. As expected accrued income has increased from April to May; invoices traditionally raised at quarter end.

Creditors: The risk flag is when creditors are increasing, both value and timing, meaning that we are not paying Trust suppliers in a timely manner. This will temporarily increase the cash position. This can be triangulated with Better Payment Practice Code (BPPC) performance which shows the percentage of suppliers paid within 30 days.



	Not Due £k	1 - 30 days £k	31 - 60 days £k	61 + days £k	Total £k
NHS	898	(7)	20	0	912
Non NHS	1,754	129	142	233	2,258
Total	**2,652**	**123**	**162**	**233**	**3,170**

Overall the Trust continues to pay suppliers in a timely fashion and does not have significant outstanding creditors. Action continues for all greater than 30 days.
The largest creditors remain accruals and Tax / Pension payments (monthly in arrears).

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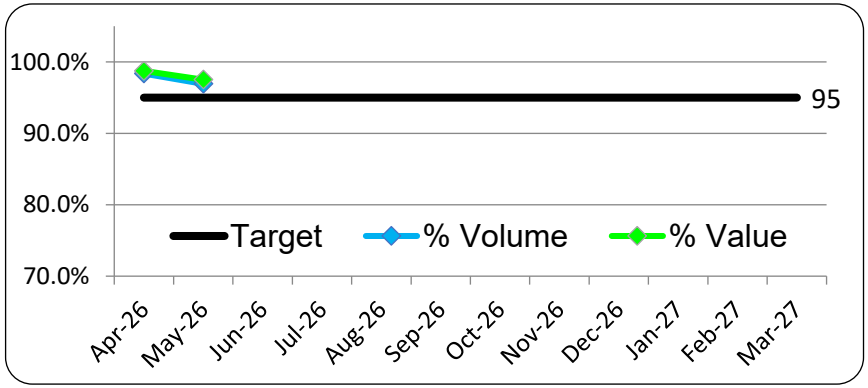
5.0 Better Payment Practice Code

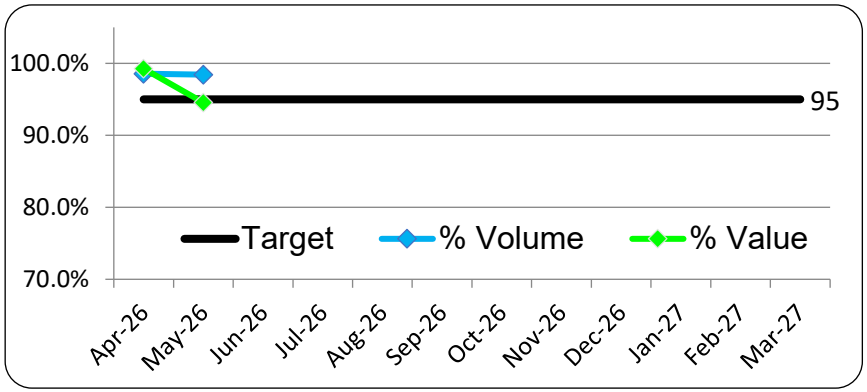
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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

Non NHS	Number %	Value %
In Month	98%	95%
Cumulative Year to Date	98%	97%





"

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 (£)
18-May-26	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	2000033477	766,326
14-May-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1007213	744,584
29-May-26	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	206894	667,943
05-May-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011166	434,573
20-May-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS70	400,000
21-May-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002346	344,069
21-May-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002363	344,069
12-May-26	Data costs	Trustwide	Virgin Media Business Ltd	927686168	258,127
20-May-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS47	240,000
07-May-26	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HONHSLS315	232,724
09-May-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004386	131,823
14-May-26	Purchase of Healthcare	Trustwide	Diabetes Digital Media Ltd	INV8040	131,488
19-May-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34069816	127,682
19-May-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34069804	120,000
13-May-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS068INV	115,589
15-May-26	Purchase of Healthcare	Trustwide	Bradford District Care NHS Foundation Trust	206260	110,415
26-May-26	IT Services	Trustwide	Wavenet Ltd	1531529	106,816
05-May-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011162	103,403
14-May-26	IT Services	Trustwide	Wavenet Ltd	N019667	88,761
13-May-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC048INV	82,938
13-May-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS068SN	77,255
14-May-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1007212	72,524
14-May-26	Drugs	Barnsley	Rowlands Pharmacy	1800006087	71,323
09-May-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004413	64,727
09-May-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004414	64,727
06-May-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34068968	59,856
08-May-26	Lease Cars	Trustwide	Arval Uk Ltd	RI0014990533	57,061
28-May-26	Purchase of Healthcare	Forensics	Spectrum Community Health Cic	SINV10092	53,992
21-May-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002345	50,150
21-May-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002364	50,150
08-May-26	Drugs	Trustwide	NHS Business Services Authority	1000087916	48,459

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
01-May-26	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400011406	45,786
15-May-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898508	45,672
08-May-26	Lease Cars	Trustwide	Athlon Mobility Services Uk Ltd	202680013984	44,469
28-May-26	Utilities	Trustwide	Edf Energy Customers Ltd	000027985623	44,450
01-May-26	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400011406	42,830
12-May-26	Drugs	Trustwide	NHS Business Services Authority	1000088244	41,239
06-May-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001555EPC	40,464
22-May-26	Advocacy Services	Forensics	Cloverleaf Advocacy 2000 Ltd	16506	35,537
01-May-26	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400011406	31,733
18-May-26	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	WKE0463990	31,059
01-May-26	Purchase of Healthcare	AS Collaborative	Sheffield Childrens NHS Foundation Trust	2400011406	30,201
15-May-26	Purchase of Healthcare	Forensics	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004297	30,150
18-May-26	Purchase of Healthcare	Trustwide	Nouvita Ltd	14225	29,100
08-May-26	Drugs	Doncaster	Speeds Healthcare Ltd	INV172231	28,796
27-May-26	Software Licence	Calderdale	Boxxe Ltd	INV0105499	27,415
28-May-26	NHS recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710183286	27,015
22-May-26	Mobile Phones	Trustwide	Cura Technology Ltd	INV3691	26,508
06-May-26	Purchase of Healthcare	AS Collaborative	St Andrews Healthcare	IN1003359	25,727
22-May-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898568	25,299
22-May-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898569	25,299
22-May-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898570	25,299
22-May-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898571	25,299

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 2 - Statistical Process Control (SPC) Charts Explained

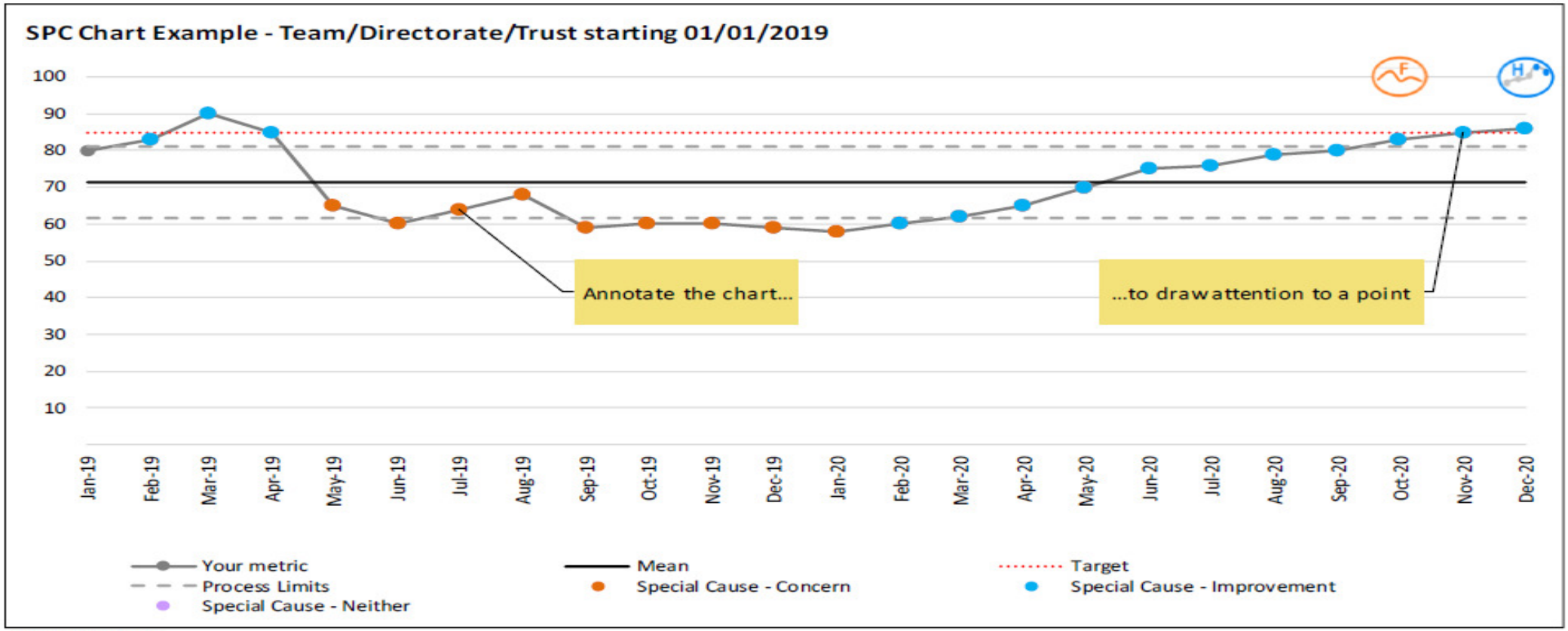
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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 2 - 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.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Public Board
30 June 2026
Agenda item 10.2

Private/Public paper:	**Public Board**		
Title:	**Care Group Deep Dive – Attention Deficit Disorder (ADHD), Autism Spectrum Disorder (ASD) and Leaning Disability (LD) Services**		
Lead Director:	**Adele Fox – Chief Operating Officer**		
Mission/values:	The report focuses on service delivery and as such aligns with the mission and values for the organisation. Improving performance in all front-line services contributes towards the Trust's vision to provide outstanding physical, mental and social care in a modern health and care system. The key performance indicators link to all the Trust's values which are: • We put the person first and, in the centre, • We know that families and carers matter • We are respectful, honest, open and transparent • We improve and aim to be outstanding • We are relevant today and ready for tomorrow		
Purpose:	To provide Board with a summary of the performance in Attention Deficit Disorder(ADHD), Autism Spectrum Disorder(ASD) and Leaning Disability(LD) Services and the action being taken to deliver high quality care. The report provides assurance to board member members on compliance with key performance indicators. It identifies emerging issues and actions being taken to address risks to operational delivery and therefore achievement of strategic intent.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	Monitoring and managing performance in attention deficit disorder (ADHD), Autism Spectrum Disorder (ASD) and Leaning Disability (LD) Services		

	contributes to managing all the risks on the Board Assurance Framework and makes a specific contribution to actions to address the following risks: 1.1 - Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. 2.3 - Failure to create a learning environment leading to lack of innovation and to repeat incidents. 2.4 - Increased demand of services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes. 3.1 - Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience. 4.3 - Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve. 5.1 - Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Attention Deficit Disorder (ADHD), Autism Spectrum Disorder (ASD) and Leaning Disability (LD) Services are a key component of care across both South and West Yorkshire. Providing services that are accessible, safe and to a high quality is fundamental to achieving the aims of both of our integrated care systems.
Any background papers / previously considered by:	Care group performance is provided in an aggregated format within the integrated performance report provided to the board held in public. To provide more opportunity for understanding of specific groups a format has been developed which will result in each care group providing reporting with greater depth on a rolling basis. This report has been reviewed by the Executive Management Team. Reporting is one month retrospective to allow sufficient time for the report preparation.
Executive summary:	Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD) and Leaning Disability (LD) services continually focus on performance and sustainability of performance to improve the experience for both staff and service users. Senior leadership across the care group have oversight on quality of care, operational performance and improvements that may be required to enhance service user experience and support staff with training and development where required to meet the needs of our service users. **Areas of note:** • ADHD/ASD services continue to deliver strong performance across their workforce, quality, and finance metrics.

	• Learning Disability (LD) services show improvement whilst simultaneously facing specialist workforce and discharge challenges. • Demand remains very high across ADHD/ASD pathways with significant waiting lists; this is variable across each place. There is workstream in Calderdale, Kirklees and Wakefield (CKW) to support reductions in the waiting list and we continue to work with commissioners to establish a safe process to support services users to choose alternative providers for assessments. All commissioned activities are met. Demand significantly exceeds commissioned capacity in each place. **Workforce** • ADHD/ASD: Sustained performance in this service area with 100% appraisal compliance, low sickness (1.5%), and sustained supervision of 96%. • LD: There has been a recent reduction in appraisal compliance to 85%, although the recent trend has been positive. Higher sickness absence over winter due to seasonal illness was noted and there has recently been a subsequent reduction in sickness absence in this service. Support has been provided by the People Directorate to support people to be well at work. Supervision has recently been split to have a separate focus on clinical (63%) and management (59%) supervision. As the new process becomes embedded an improving trajectory is projected. **Operational Performance** • ADHD services across our places receive 4,000 referrals/year and have 7,000 people waiting. 12% of these are seen within 12 weeks. All commissioned activity is achieved. There are significantly more referrals than the Trust is commissioned or has capacity to deliver. Innovative approaches are taken internally to delivery to enable improvement and there is collaborative work to improve access across all places. • Autism: Variable waiting times arise due to pathway differences. Good progress has been seen in Kirklees and Wakefield where screening and triage have been introduced and face to face early reviews. • LD: Sustained performance for LD screening remains strong in the margin of 95-100%. The 18-week performance has improved but remains fragile due to specialist vacancy and sickness. There is continuous focus on this area and redeployment in teams to support across place. **Quality & Safety** • Overall, the number of incidents has reduced. Falls have increased which is related to three service users in the assessment and treatment unit (ATU) that had specific physical health related concerns that have required support. All risk assessments have been updated • Friends and Family Test (FFT): ADHD/ASD have improved and is within the range of 90-100%, this continues to require focus. LD FFT consistently above 90%. • There are several discharges due to waiting for specialist placement including one premise to be built. These have been escalated with commissioners requesting interim placements. **Finance** • ADHD/ASD: No agency or bank spend.

	• LD: Agency spend variable and is on specialist nurses. There is a focus on reducing this spending although minimal. Bank spending has been reduced **Inequalities** Work across services continues to ensure we provide and meet all service users' needs from all communities. Key points to note are: • ADHD/ASD: Under-representation of minority and deprived groups. • LD: Referrals broadly representative of communities and work continues to understand and support this further
Recommendation:	**Trust Board members are asked to:** **RECEIVE** and **NOTE** the report.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

ADHD-ASD-LD Care Group



April 2026

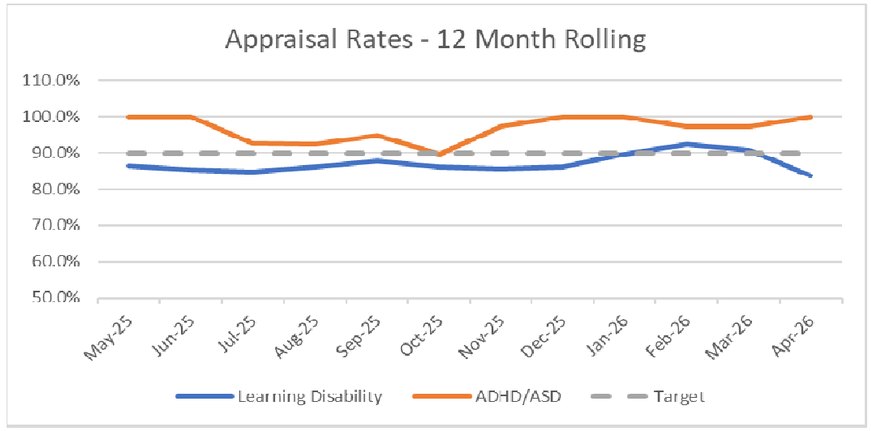
With **all of us** in mind.

Adult Attention Deficit Hyperactivity Disorder (ADHD) Autism Spectrum Disorder (ASD) and Learning Disability (LD) Services

LD- Comprises of four locality teams Wakefield, Barnsley, Calderdale and Kirklees. Each Team includes psychiatry, psychology, specialist learning disability nursing, therapists and an intensive support team with many different skills. The teams provide specialised support to people with learning disabilities who are unable to access mainstream health services and aims to improve their overall health and wellbeing. The team works with adults of all ages and many other agencies. The teams are also supported by a strategic health facilitator in each area and a newly developed Out of Hours service. In addition to this the Trust works with Bradford District Care Trust as the coordinating provider to provide inpatient assessment and treatment to people with a learning disability across West Yorkshire. The Trust's assessment & treatment service is provided at the Horizon Unit .
ADHD/ASD- The service provides a person-centred service that enables an individual with Adult ADHD and/or Autism to reach their full potential and live well in their community. The service provides a comprehensive assessment and interventions service for adults aged 18+ with ADHD or autism, operating as part of a range of integrated services with the local authority, including access to appropriate psychological interventions, information covering diagnosis, assessment, and support provided to patients, and carers.

Workforce

Appraisals

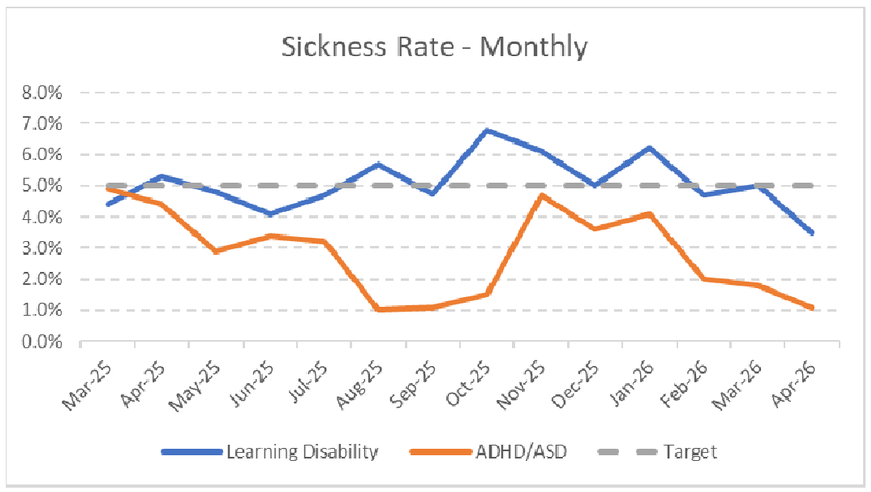


Insights

LD - Learning disability appraisal compliance has consistently operated above 85% and often at the threshold of 90% over the past year. There was a drop in compliance to 85% in April, which whilst still relatively positive is below our target. The reasons for this are being reviewed and actions will be identified to bring back into line. Our new appraisal process went live in April 2026 which requires all staff appraisals to be completed by September. Managers are developing appraisal schedules for all staff and achievement will be closely monitored through existing governance arrangements to ensure all appraisals are completed within the required timeframe.
. Compliance will be monitored closely through existing Governance arrangements to identify and address any barriers to completion to ensure all appraisals are completed within the required timeframe.

ADHD/ASD - has a strong track record of compliance, consistently maintaining performance above 90%. Robust monitoring arrangements are in place, with current compliance at 100%, demonstrating effective oversight and operational grip.

Sickness



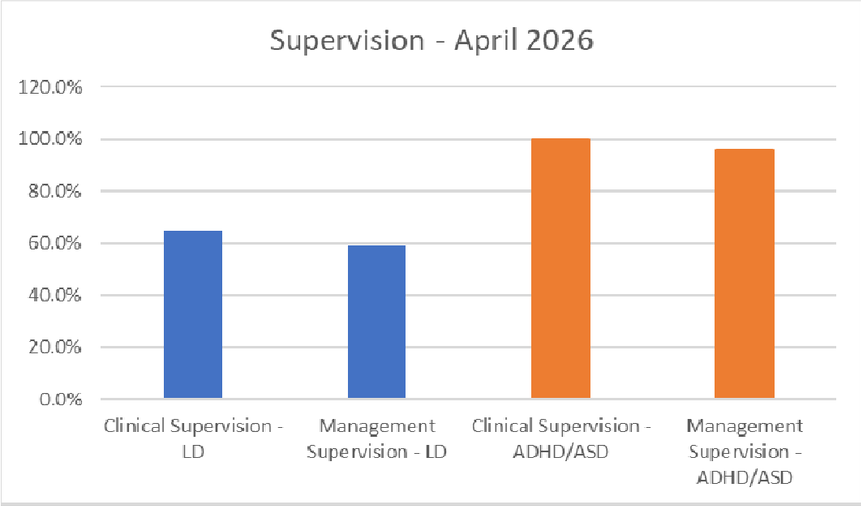
Insights

LD - Performance Summary
Sickness levels have fluctuated within the whole service throughout the year. Significant peaks occurred in: Aug-25 (~5.8%), Oct-25 (~6.9%),Nov-25 (~6.2%) ,Jan-26 (~6.4%). There are no related themes although can assume winter month spike was associated with seasonal illness.
Support for people to return to work is led by managers with advice form occupational health resilience.

ADHD/ASD - **Performance Summary**
sickness rates have remained consistently below target throughout the reporting period and demonstrate a strong overall performance. Following a brief increase during winter months, absence levels reduced significantly and finished the year at approximately 1.5%. The service will continue to focus on maintaining effective wellbeing and attendance management practices whilst sharing learning across other service areas.

Workforce

Supervision



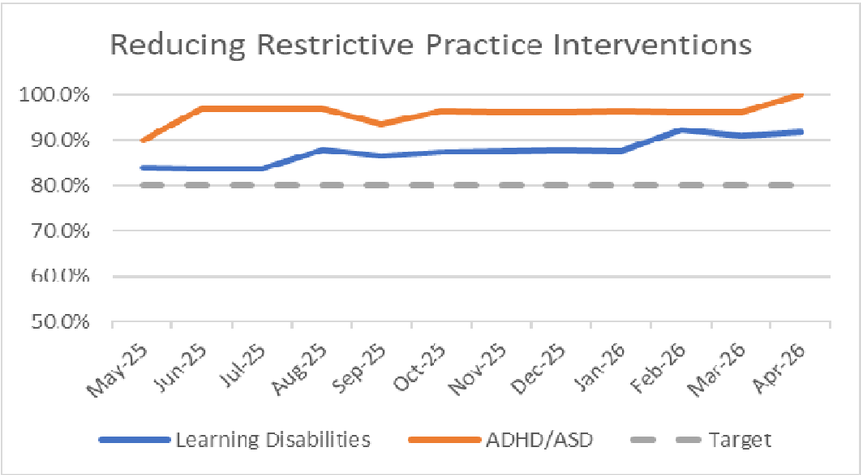
Insights

Clinical supervision is a structured form of reflective practice designed to support the delivery of safe and effective care. It provides a framework for professional support and learning, enabling individuals to develop both their clinical practice and personal effectiveness. The Trust standard for supervision compliance is set at 80%.
There has been a change to supervision to support a focus on clinical supervision, which means staff have two dedicated supervision sessions, clinical and managerial. The service has been working towards achieving this by instigating protected time and having dedicated support from mangers. This will take time to embed therefore some areas have be able to reach the target better than other.

LD - clinical supervision reached 63% and management supervision reached 59%. A focused improvement plan is in place. Inpatients services rely on support to cover to allow supervision to take place there for individual service line have identified plans.

ADHD/ASD - The service demonstrates a well-established and embedded culture that prioritises high-quality clinical supervision. Performance data for April shows supervision compliance exceeding 96%, with consistently strong performance maintained over the preceding 12 months.
This sustained focus on supervision is having a demonstrably positive impact on staff. In particular, there is a notable correlation between high supervision compliance and the team's low levels of sickness absence, suggesting that regular, supportive supervision is contributing to staff wellbeing, resilience, and retention.

Mandatory Training

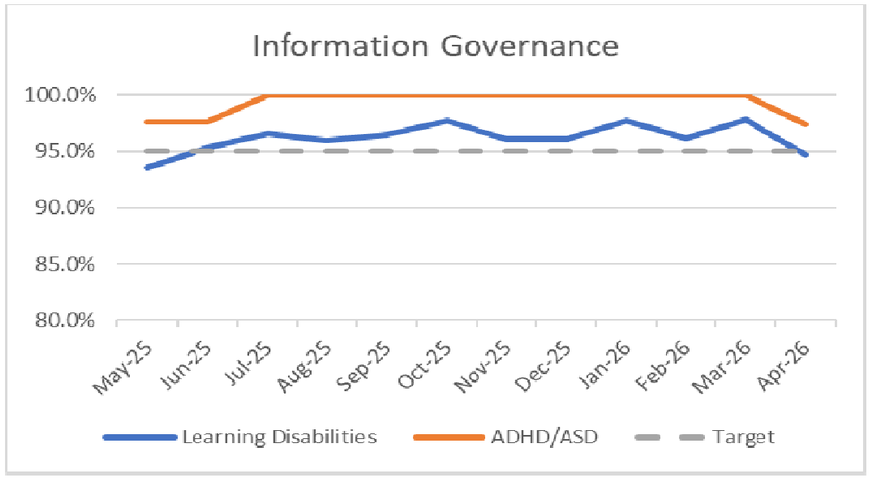


Insights

Learning Disabilities (LD)
Reducing restrictive practice is important as this improves patient safety, dignity and recovery. Ensuring staff are trained in the promotes safe practice to minimise restrictive interventions through prevention, de-escalation and person centred approach. The Learning Disabilities service maintained compliance above the target throughout the year, demonstrating a positive and sustained performance trend and this has resulted in lower incidents on the ward.

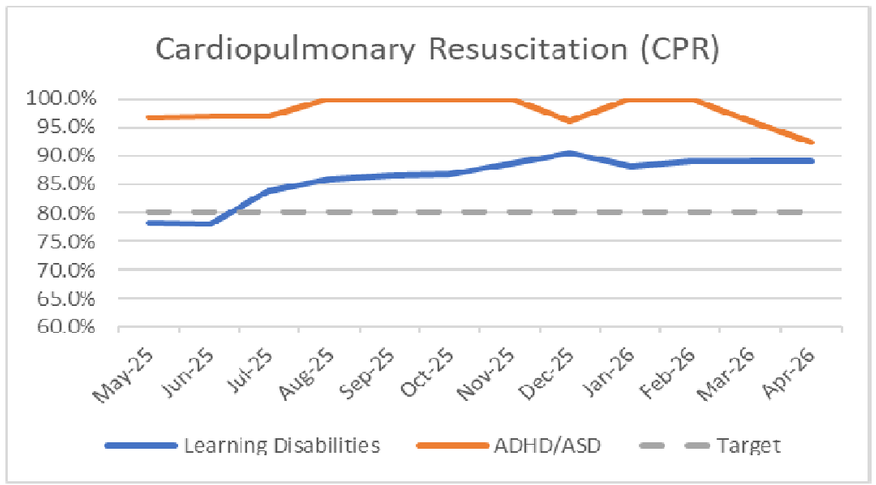
ADHD/ASD
The ADHD/ASD service demonstrated consistently strong performance throughout the reporting period and remained the highest-performing service line.

Workforce



Learning Disabilities (LD)
The Learning Disabilities service maintained compliance above the target throughout the year, demonstrating a positive and sustained performance trend. The slight drop in March is related to year end and will be monitored to ensure a sustained performance.

ADHD/ASD Service
The ADHD/ASD service demonstrated consistently strong performance throughout the reporting period and remained the highest-performing service line.

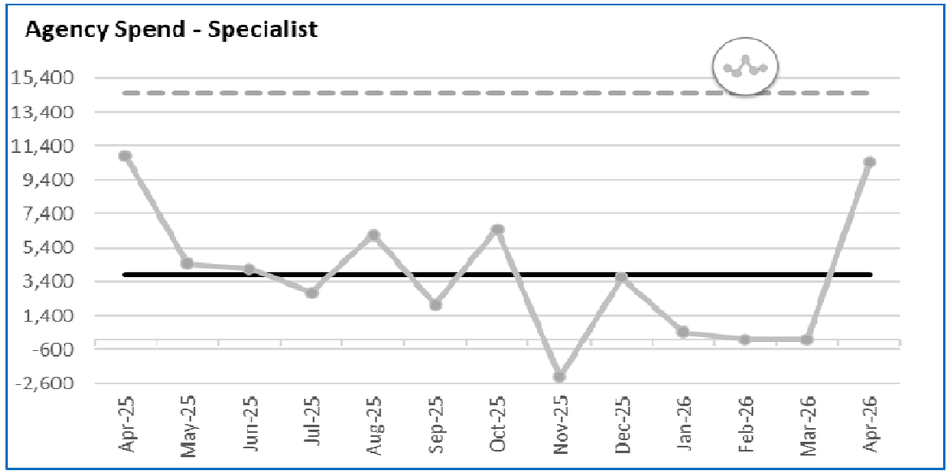


Learning Disabilities
CPR is important to ensure patient and staff safety and trained staff are important to be able to respond to emergency situations. Although LD service has fluctuated they have a focus on ensuring everyone is trained. The ward ensure the shift is covered by appropriately trained staff to maintain safety.

ADHD/ASD
The ADHD/ASD service maintained high levels of CPR compliance throughout the year, consistently exceeding the 80% target. Although there was a small decline towards the end of the period, performance remained above 90%. Continued monitoring should ensure standards are maintained.

Finance

Agency Spend

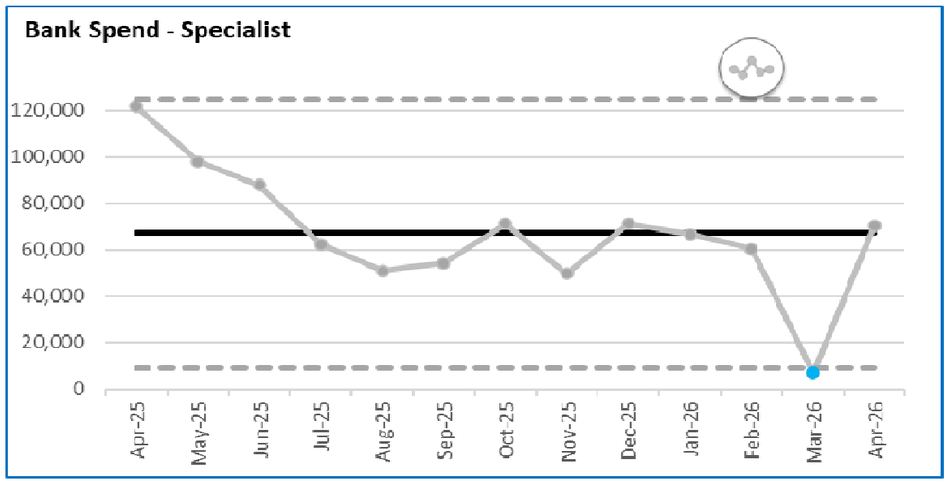


Insights

Learning Disabilities (LD)
Agency spend within the Learning Disabilities Specialist Service remains variable throughout the reporting period, reflecting the highly complex nature of the client group and the requirement to maintain safe staffing levels. Agency usage is predominantly associated with covering short-term sickness absence and supporting bespoke packages of care for individuals requiring enhanced levels of observation and intervention, including 1:1, 2:1 and 3:1 staffing arrangements within Assessment and Treatment pathways. Agency shifts are for specialist nurses that are not always available on the trust bank.
The service forms part of a West Yorkshire-wide provision delivered collaboratively by South West Yorkshire Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Leeds and York Partnership NHS Foundation Trust. Whilst Leeds currently provides no inpatient beds, demand across the wider system continues to place pressure on staffing resources.
Although agency expenditure fluctuates month to month, this is largely driven by the changing acuity and dependency needs of service users rather than workforce instability. Since the service was established, staffing requirements have consistently exceeded the original funded establishment, reflecting the complexity of individuals accessing the service and the need to provide safe, person-centred care.
Agency expenditure should be viewed within the context of a highly specialised service supporting individuals with complex needs requiring enhanced staffing levels. Expenditure is driven primarily by clinical acuity, patient safety requirements and short-term absence cover, rather than routine workforce shortages. A West Yorkshire-wide review is underway to explore sustainable workforce and service models that will reduce reliance on temporary staffing while maintaining safe and effective care.

ADHD/ASD - No agency spend.

Bank Spend



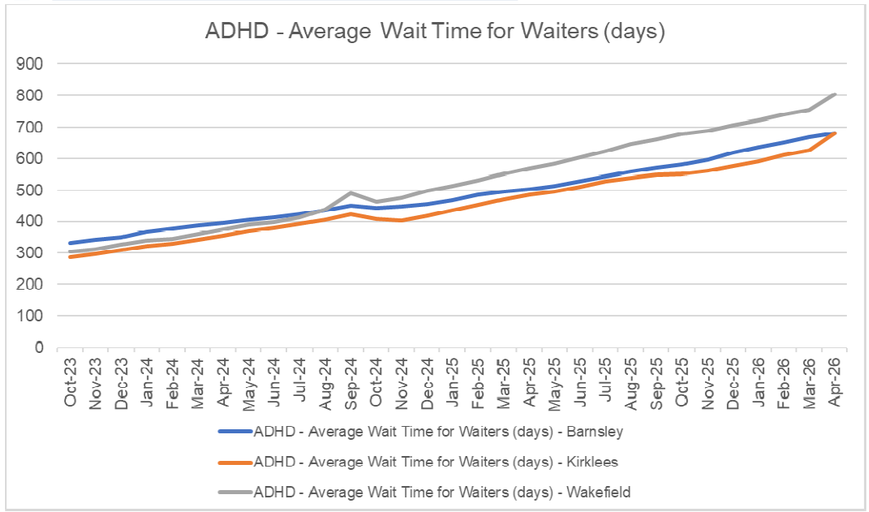
Insights

Learning Disabilities (LD)
Bank spend within the LD service has reduced significantly over the reporting period, falling from approximately £120k per month at the start of 2025 to a more stable level averaging around £66k per month. This improvement reflects successful recruitment to vacant posts, a reduction in service acuity, and increased patient discharge activity, which together have reduced reliance on temporary staffing.
While monthly variation remains, expenditure has been consistently lower than at the beginning of the period, demonstrating progress in strengthening substantive staffing and improving workforce sustainability. The low spend recorded in March 2026 reflects the combined impact of vacancy reductions, lower demand pressures and effective workforce management. Continued focus on recruitment and patient flow will be important to sustain these gains and minimise future reliance on bank staffing.

ADHD/ASD
No bank spend.

Access

ADHD - Average waiting time (days)



Insights

ADHD Waiting Times

Referrals are not managed on a purely chronological basis; instead, individuals are prioritised according to clinical need associated with ADHD. The multidisciplinary team (MDT) may also agree to expedite assessments where clinically indicated or at the request of the referrer.

In the 12 months to 31 March 2026, 52 individuals (12%) were offered an appointment within 12 weeks of referral, reflecting this targeted prioritisation approach.

The service is commissioned to complete 345 new ADHD assessments annually, with additional capacity to undertake a further 100 assessments for Calderdale residents under the Right to Choose framework.

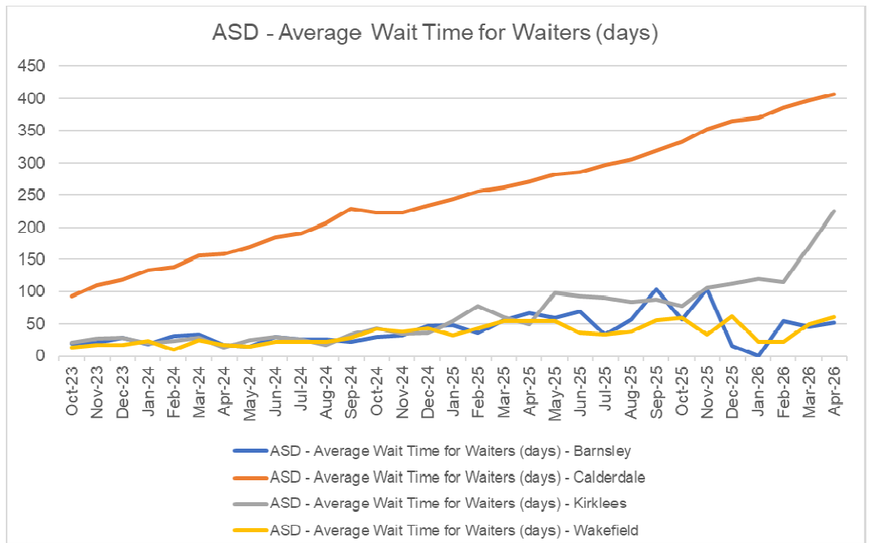
Referral volumes remain high, with approximately 4,000 referrals received in the past year and around 7,000 individuals currently awaiting assessment. This reflects sustained demand for ADHD assessment services.

There are indications that waiting list growth is beginning to stabilise. This is associated with a combination of factors, including changes in referral patterns as a result of increased availability of independent providers across West Yorkshire, and the introduction of the Screening and Triage model in Wakefield and Kirklees.

Under this model, all new referrals are offered an initial face-to-face appointment with an ADHD specialist to confirm clinical appropriateness for full assessment. This supports consistent clinical decision-making, improved referral quality, and more effective use of available assessment capacity. Calderdale and Barnsley are considering investment in this approach as part of wider pathway development across the system.

Access

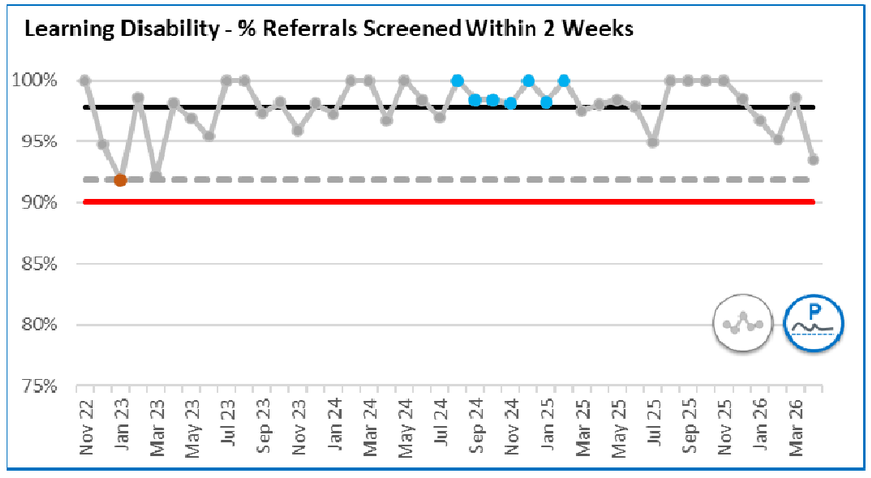
ASD - Average waiting time (days)



Insights

Autism Waiting Times
Waiting times across autism pathways vary by locality, reflecting differences in pathway design and demand.
In areas where a structured clinical review of referrals is embedded early in the pathway, waiting times for those progressing to diagnostic assessment have remained relatively low and stable. This approach supports consistent decision-making and ensures that assessments are offered where there is a clear clinical indication, in line with national guidance.
In some areas, additional pathway steps have been introduced to strengthen the quality and consistency of information available at the point of assessment. These typically involve direct clinical contact at an early stage and are intended to improve patient experience and support effective use of assessment capacity. The inclusion of these steps can be reflected in overall pathway times.
Across the system, referral volumes have increased over recent years, resulting in growth in the number of people awaiting assessment in some areas. Work is ongoing to further develop pathways to ensure they continue to respond effectively to demand, support equitable access, and make best use of available clinical resource.

LD - Referrals screened within 2 weeks

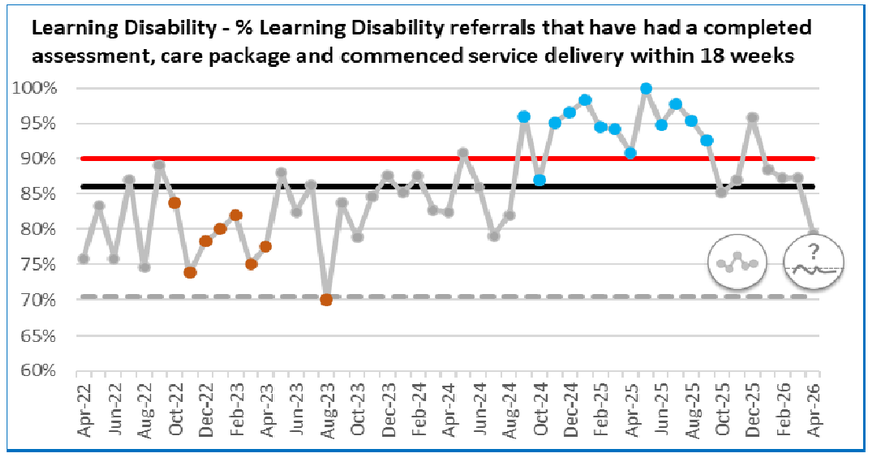


Insights

Learning Disabilities (LD)
Performance against the Learning Disability referral screening standard remains strong, with the percentage of referrals screened within two weeks consistently exceeding the 90% target throughout the reporting period. Performance has generally ranged between 95% and 100%, demonstrating a reliable and responsive screening process. While there has been some normal variation over time, no sustained deterioration is evident.

Access

LD - Face to Face Contact within 18 Weeks

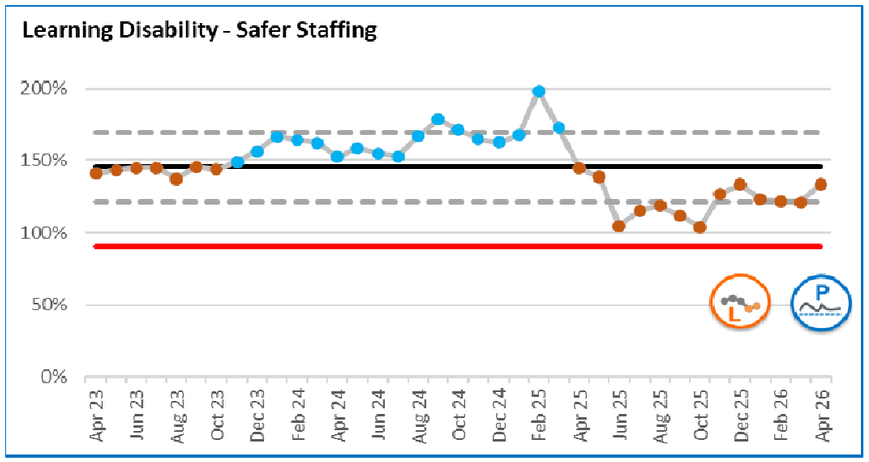


Insights

Learning Disabilities (LD)
Performance against the 18-week standard has shown significant improvement since late 2024, with a sustained run of data points above the historical mean and frequently above the 90% target. This indicates that improvement work undertaken across the service has had a positive impact on reducing delays and ensuring service delivery commences within expected timeframes.
Despite this improvement, performance remains vulnerable due to workforce capacity within some specialist disciplines. Several professional groups are staffed by only a single practitioner, meaning that periods of sickness, annual leave, maternity leave, or vacancies can have a disproportionate impact on performance. In these circumstances, even a small number of delayed cases can result in breaches of the 18-week standard and cause noticeable variation in monthly performance.
The chart demonstrates that whilst the overall process is more stable than in previous years, there continues to be occasional variation that is likely linked to these capacity pressures rather than deterioration in service quality. Given the limited resilience within some disciplines, maintaining performance requires ongoing oversight of waiting lists, proactive vacancy management, cross-cover arrangements where possible, and regular review of referral demand against available workforce capacity.

Quality and Safety

Safer Staffing



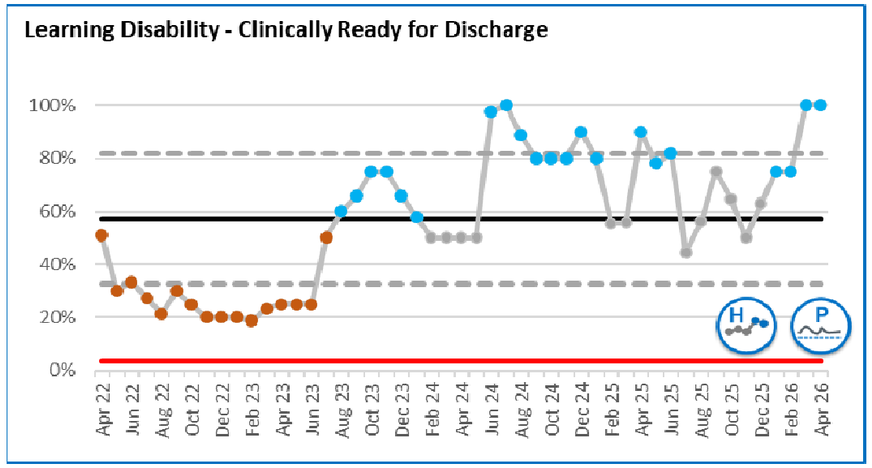
Insights

Learning Disabilities (LD)
The Learning Disability safer staffing measure demonstrates a sustained period of elevated staffing requirements between 2023 and early 2025, reflecting the complexity and dependency of the ATU client group. From April 2025 there is clear special cause variation, with a significant and sustained reduction in staffing requirements.

This coincides with changes in the ATU population, including reduced admissions, successful discharges and fewer enhanced observation requirements. In addition there has been more robust management of the use of temporary staffing and some innovative ways that other disciplines support the ward which has Performance has subsequently stabilised at a lower level, indicating a new baseline of demand rather than deterioration in staffing provision. Continued monitoring will ensure staffing remains responsive to changes in patient acuity and service demand.

Quality and Safety

Clinically Ready for Discharge

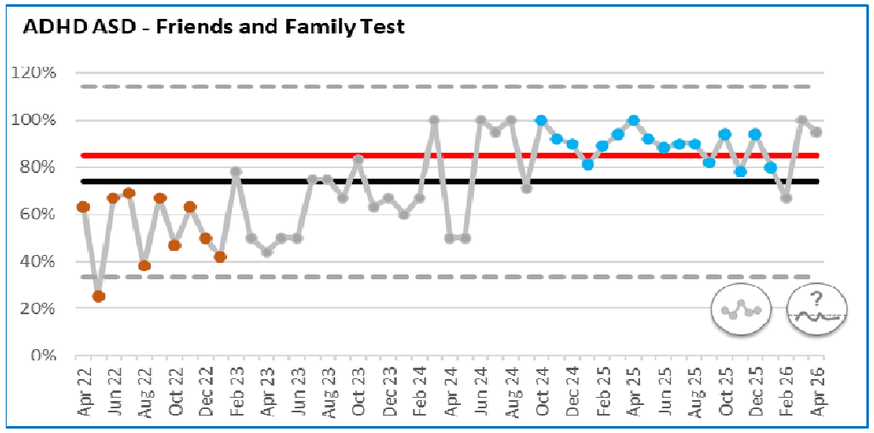


Insights

The Population that are admitted to the ATU often stay longer than clinically indicated due to system wide challenges with the provision of suitable community placements, that are often bespoke to the individual. This leads to delays on discharge.
Conversations regarding this continue with commissioners and partners.
It should be noted that although people may be clinically ready for discharge from Horizon, this does not necessarily relate to a reduction in their need for support and reduced staffing levels. For example, a person requiring observation and engagement from 2 staff may continue to need this in their community placement. Staying on Horizon once they are clinically ready for discharge will not impact this and potentially increase their support needs if they are someone who has been assessed as needing their own private space or support to access leave.

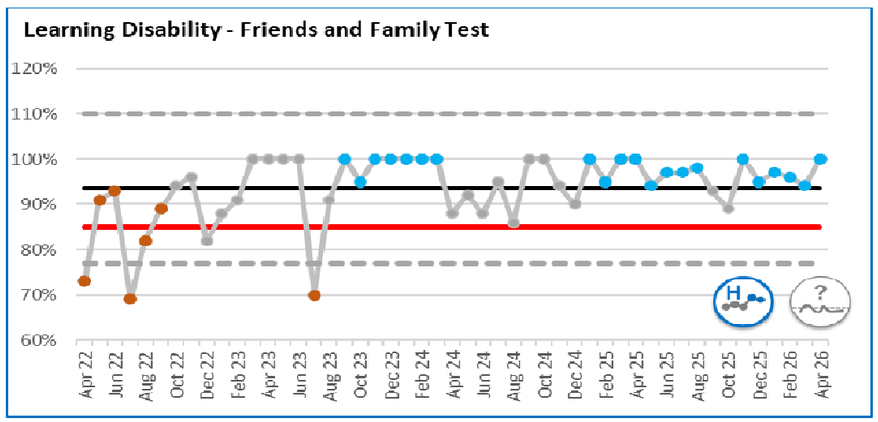
There are currently 5 service users at Horizon and 4 of which are ready for discharge. Of the four clinically ready for discharge one has a discharge date at the end of November, one is awaiting a bespoke placement being built and 2 service users have yet to have an appropriate bespoke placement identified. The long waits have been escalated through the partnership arrangements with Bradford and with the respective ICB's.

Friends and Family Test



Insights

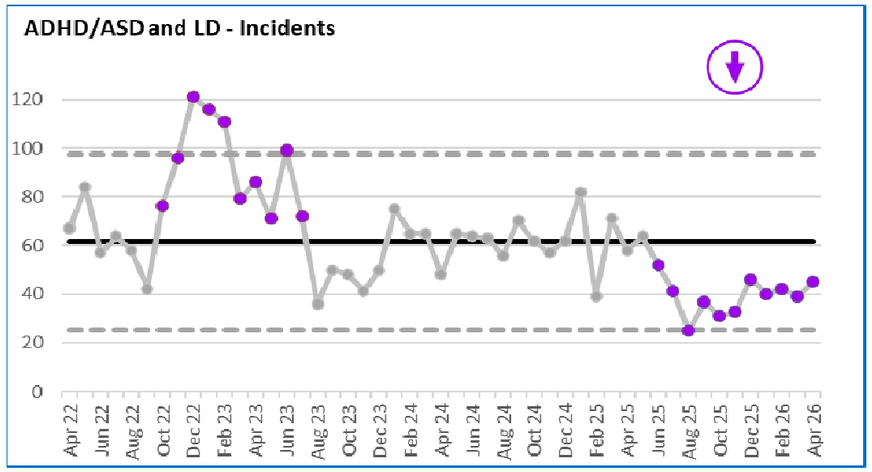
ADHD/ASD
The ADHD/ASD Friends and Family Test shows a generally positive upward trend over the reporting period. Early results in 2022 were variable, with scores frequently below the desired benchmark and engagement levels fluctuating considerably. This reflects the difficulties experienced in encouraging family and carers to participate and provide feedback.
Throughout 2023 and into 2024, the service responded proactively by trialling different methods of engagement, including adapting communication approaches, offering greater flexibility in how feedback could be provided, and continuing to promote the importance of family involvement. These efforts appear to have contributed to a gradual improvement in outcomes.
From late 2024 onwards, scores consistently exceeded the internal benchmark and frequently remained above 80%, with several periods approaching or exceeding 90%. This suggests that the alternative engagement strategies implemented by the service have had a positive impact and have helped strengthen relationships with families and carers.
While some fluctuations remain, which is expected given the ongoing challenges in engaging this group, the overall trend demonstrates sustained improvement and resilience. The most recent results continue to compare favourably against the benchmark, indicating that the service is successfully maintaining high levels of satisfaction among those family members



Learning Disabilities (LD)
The Learning Disability Friends and Family Test demonstrates consistently positive patient and family experience, with performance remaining predominantly above 90% throughout the reporting period. Following some variation in 2022–2023, the process has stabilised, and recent results indicate sustained positive feedback.

Quality and Safety

Incidents

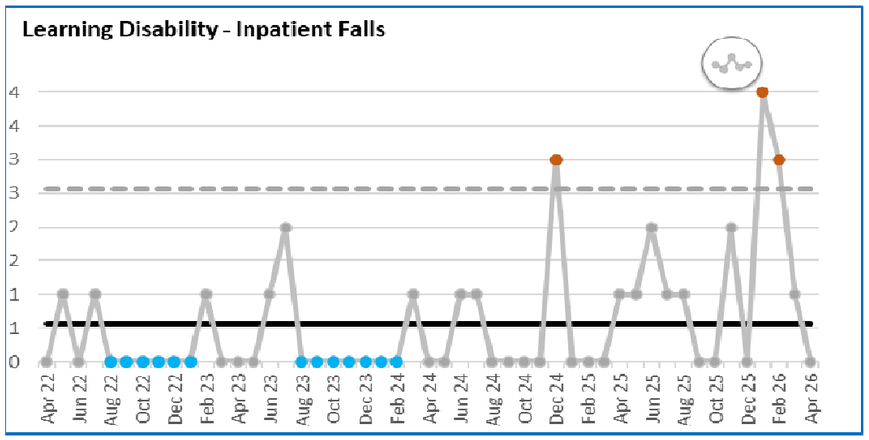


Insights

LD & ADHD/ASD
Significant support has been dedicated to the inpatient ward (ATU) where majority if the incidents are reported to train staff in least restrictive practices, positive behavioural support plans and reducing restrictive practice and this has resulted in a reduction in incidents. There will be a proportion of the results indicated to the service user population however this approach has sustained reduced incidents

Reported incidents across ADHD, ASD and Learning Disability services have demonstrated a statistically significant and sustained reduction since mid-2025. Following a historical baseline of approximately 60 incidents per month, a clear special cause variation has been observed, with incident levels reducing by around 40% and remaining consistently below the previous mean over successive months.
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Falls

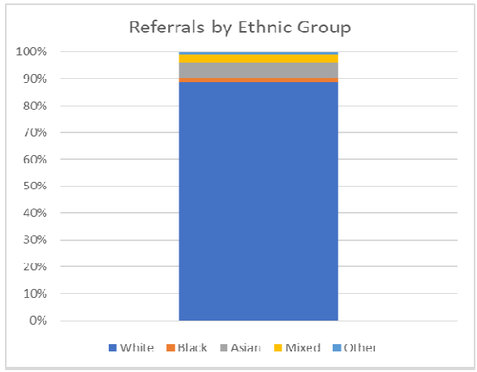


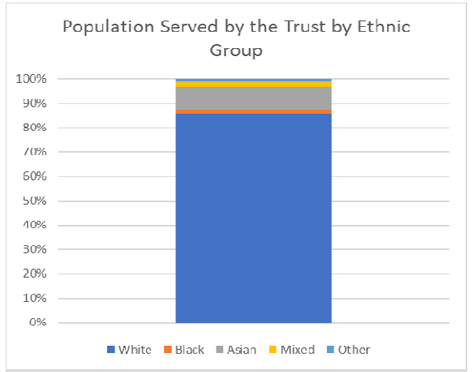
Insights

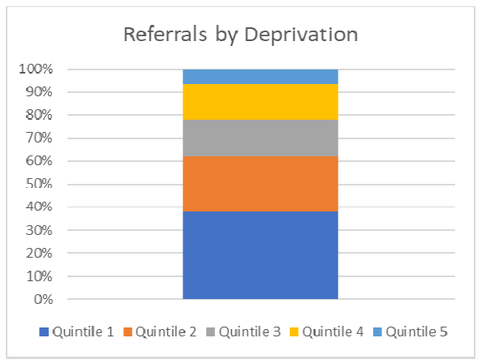
Learning Disabilities (LD)
Inpatient falls remained low and stable from 2022 through most of 2024, with several extended periods recording zero falls. However, from December 2024 onwards there has been a sustained increase in falls, including three special-cause signals above the upper control limit. The highest value occurred in February 2026 (4 falls). The falls are attributed to 3 services users, all have physical health related conditions and are under assessment with physical health care. All have been reviewed and have an updated risk assessment.

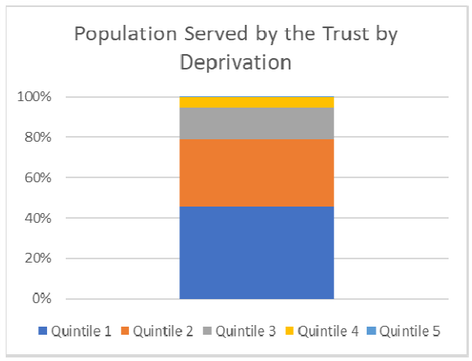
Inequalities

ADHD and ASD Referrals









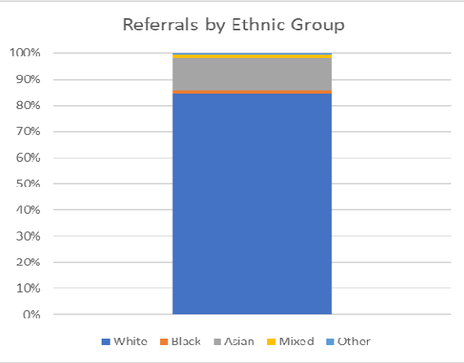
Insights

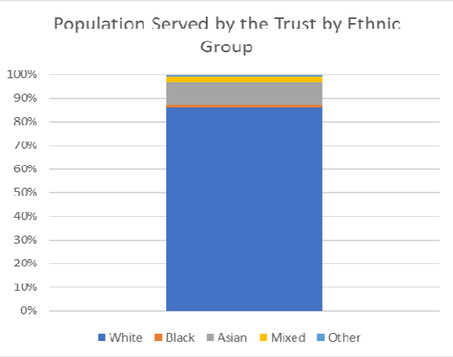
ADHD/ASD
Understand the inequalities in our communities is important as this enable us to identity and address disparities in access, experience and outcomes, ensuring care is equitable and responsive to individual needs.
Based on 12 months of referrals (May 2025 - April 2026)
Comparison of referral ethnicity with the ethnicity profile of the population served by the Trust shows that White patients account for the largest proportion of referrals and appear slightly over-represented when compared with the local population. Asian, Black, Mixed and Other ethnic groups comprise a smaller proportion of referrals and appear slightly under-represented relative to the population served.
Overall, the referral profile broadly reflects the ethnic composition of the Trust population; however, there is evidence that referrals are proportionally higher for White patients and lower for some minority ethnic groups.

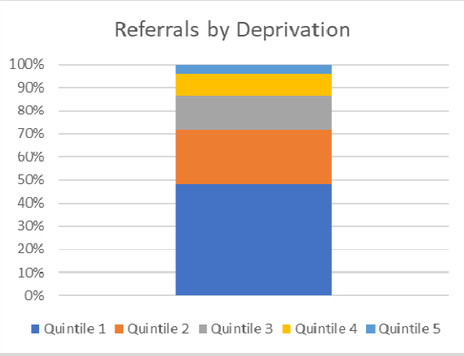
Understanding deprivation within our communities helps us identify where social and economic factors impact health, enabling us to target support and reduce inequalities in outcomes.
Based on 12 months of referrals (May 2025 - April 2026)
Comparison of referrals by deprivation quintile with the deprivation profile of the population served by the Trust indicates that referrals are received from all levels of deprivation. The highest proportion of referrals originates from Quintile 1 (most deprived areas), reflecting the demographic profile of the Trust population. However, when compared with the population served, individuals from the most deprived quintiles appear to be proportionally under-represented within referrals, while those from less deprived quintiles appear over-represented. In particular, residents from Quintiles 4 and 5 account for a larger share of referrals than would be expected based on their representation within the Trust population.
These findings may suggest potential inequalities in access to referral pathways for people living in more deprived communities and warrant further exploration to understand whether barriers to referral, awareness of services, or differences in help-seeking behaviour are contributing factors.

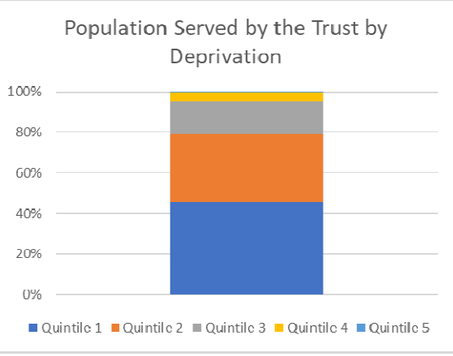
Inequalities

LD Referrals









Insights

Learning Disabilities (LD)
Based on 12 months of referrals (May 2025 - April 2026)
The ethnic profile of referrals is broadly consistent with the ethnic profile of the population served by the Trust. White service users comprise the majority of both referrals and the resident population, with only small differences between the two. Black, Asian, Mixed and Other ethnic groups also appear to be represented in referrals at levels broadly proportionate to their representation within the population served.

Based on 12 months of referrals (May 2025 - April 2026)
Referrals are concentrated amongst individuals living in the most deprived areas. Quintile 1 (most deprived) represents the largest proportion of referrals and appears slightly over-represented when compared with the population served. Conversely, the least deprived quintiles (Quintiles 4 and 5) appear slightly under-represented.

Community Learning Disability Teams and Strategic Health Facilitators continue to work closely with General Practitioners to improve uptake of Annual Health Checks for people with a learning disability. All localities exceeded the 75% national target in 2023/24 and are on track to achieve this again in the current year. Further work is underway to strengthen accessible communication, supporting service users to better understand the importance of health screening, including cancer prevention.
The STOMP (Stopping Over-Medication of People with a learning disability) programme continues to progress across all four localities. This has supported safe reductions in medication for a number of individuals, enabling some to transition back to primary care under GP oversight.
The service maintains an established Reducing Health Inequalities Group, which leads the sharing of tools, learning and best practice to address preventable causes of early death. In addition to reviewing published LeDeR reports, which are reported retrospectively, the group maintains a focus on more recent deaths to ensure learning is timely and informs current practice. Relevant insights are shared across the Trust.
The service has also contributed to the introduction of Green Light Champions across the wider Trust, strengthening the support available to individuals with a learning disability and/or autism who access non-

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Statistical Process Control (SPC) Charts Explained

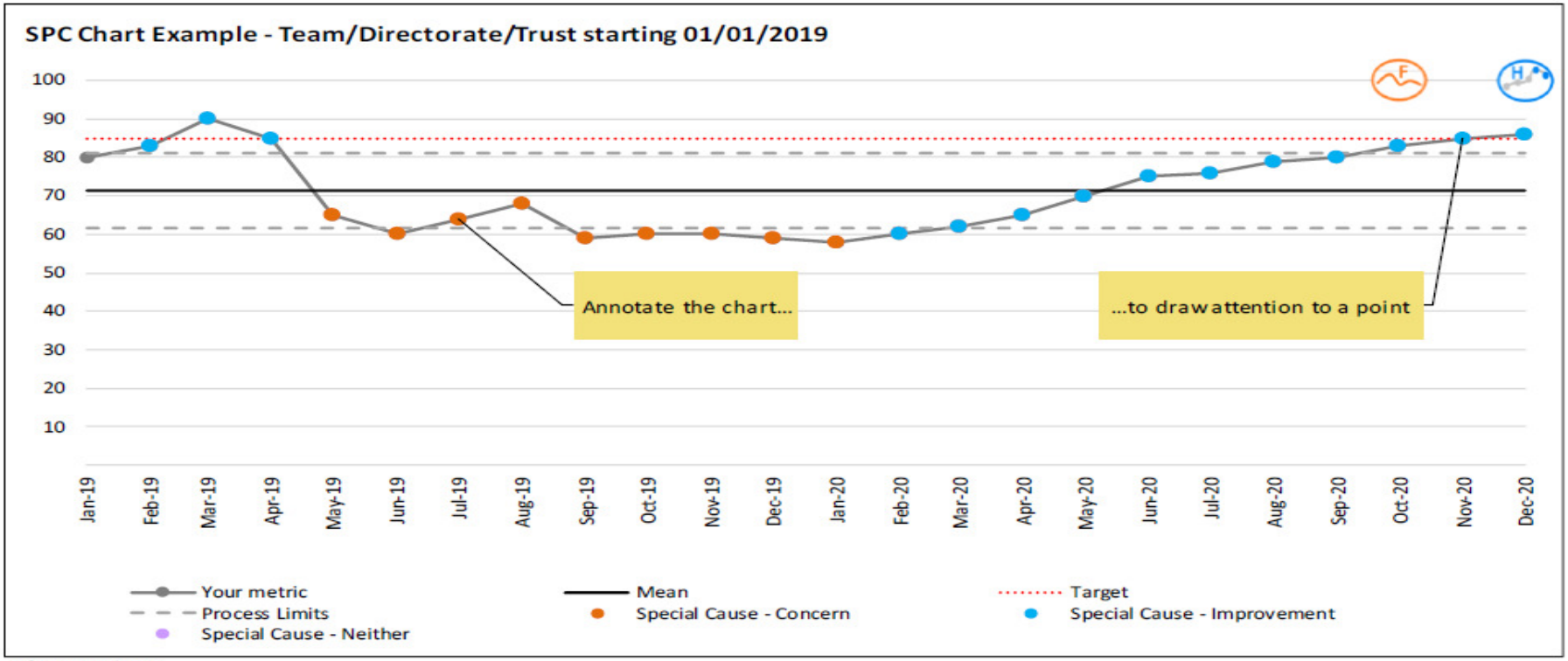
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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

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.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 11.1

Private/Public paper:	**Public**		
Title:	**Patient Safety Oversight Report Quarter 4/Annual Report 2025/26**		
Lead Director:	**Caroline Johnson, Chief Nurse / Director of Quality and Professions**		
Mission/values:	• We are respectful, honest, open and transparent • We put the person first and, in the centre • We are always improving		
Purpose:	The purpose of this report is to provide assurance and oversight of patient safety activity in South West Yorkshire Partnership NHS Foundation Trust in line with the Patient Safety Incident Response Framework (PSIRF). The report also provides assurance regarding safety incidents overview, emerging themes/trends and learning and improvement and updates on wider patient safety activity. It also provides assurance that learning from healthcare deaths arrangements are in place..		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Delivering safe and effective services is a priority of all health and social care providers. This is a shared priority across the Integrated Care System, Integrated Care Board, Place based partnerships and is a regular feature of our shared objectives and actions. Ensuring there is understanding of the incidents which take place within our services, the impact of these and the learning to ensure future risk or harm can be avoided or reduced is essential. Sharing learning and best practice, themes, trends and analysis can help to identify opportunities to work together to address concerns or celebrate good practice. Learning from incidents is vital to improve patient safety, staff and service user/carer experience and to provide assurance of good governance and risk management processes.		

With all of us in mind.

Any background papers / previously considered by:	Quality and Safety Committee and Trust Board have previously received quarterly and annual patient safety oversight reports, learning from healthcare deaths reports and patient safety updates. NHS England PSIRF oversight guidance asks that trusts move towards a focus on learning and improvement and the content of this report reflects this. This report has been reviewed by the Executive Management Team and Quality and Safety Committee prior to Trust Board.
Executive summary:	The Trust has strong patient safety systems in place, with no Never Events reported, most incidents resulting in no or low harm, and a small number of in-depth investigations (including 8 PSIIs) and deaths reviewed through robust governance processes. PSIRF is well embedded, with a shift to proportionate, system-based learning, evidenced by a high volume of assessment reviews alongside targeted, in-depth investigations where required. Learning is being generated consistently, with clear themes across services, particularly relating to: Risk assessment and safety planning • Access to means and suicide prevention • Medicines safety and administration practice • Physical health monitoring within mental health care • Violence, aggression, and therapeutic engagement Targeted improvement work is in place across all patient safety priorities, with early positive impact seen in: • Improved patient involvement in care and safety planning • Greater consistency in risk assessment and documentation • Strengthened falls prevention and physical health monitoring Some areas showed specific variation or emerging risk (e.g. self-harm clusters, pressure ulcers), but these have been identified, analysed, and are subject to focused improvement actions. Investment in training (including SWARM and AAR) is supporting the embedding of PSIRF methodologies and strengthening learning capability across teams. Learning from deaths continues to highlight health inequalities, particularly for people with severe mental illness and learning disabilities, reinforcing the need for continued focus on physical health and equitable care. The Terms of Reference for the Patient Safety and Learning and Improvement Group are being strengthened to enhance organisational oversight, coordination, and delivery of improvement. Data quality and triangulation remain areas for development, particularly in relation to ethnicity and understanding variation in outcomes; targeted actions are underway to address this. Overall, the Trust is progressing well in embedding a learning culture, with a clear focus in 2026/27 on demonstrating measurable impact and sustained improvement

Recommendation:	Trust Board members are asked to: • **RECEIVE** the Patient Safety Oversight Annual Report 2025/26.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Patient Safety Oversight Report

Annual report 2025/26 (1 April 2025 to 31 March 2026)

Prepared by Patient Safety Support Team

Trust Board – 30 June 2026

With all of us in mind.

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1. Purpose and Introduction

This report provides assurance and oversight of patient safety activity within South West Yorkshire Partnership Teaching NHS Foundation Trust (SWYPTFT), in line with the Patient Safety Incident Response Framework (PSIRF). It presents an overview of patient safety incidents, key themes and trends, learning and improvement activity, wider patient safety developments, and learning from deaths

Where content has been previously reported and remains unchanged, it has not been repeated in this report.

- **17,604** incidents reported
- **2.4%** increase in reporting on 2024/25
- **96%** of incidents resulted in no/low harm
- No Never Events
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

The Trust has established robust systems to oversee, monitor, and learn from patient safety events; however, these continue to be strengthened to fully realise the intended benefits of PSIRF, particularly in ensuring that learning is consistently translated into measurable improvement. Learning is disseminated through established mechanisms, including structured processes for sharing urgent safety information and medication-related learning. Overall, these arrangements provide assurance that patient safety is being actively managed.

During the reporting period, there were no 'Never Events' meeting the current national definition. NHS England is reviewing this framework to further strengthen patient safety improvement across the NHS; an updated position is expected in Spring 2026 and was awaited at the time of writing.

Healthcare inequalities can contribute to, or increase, the risk of patient harm. When viewed through a patient safety lens, these inequalities highlight a critical area for action, where healthcare systems and professionals have a clear responsibility. Ethnicity data is presented within each patient safety priority. Further work is underway to strengthen triangulation across incidents, complaints, and other sources of patient safety intelligence, to better understand potential inequalities and ensure this informs improvement activity

The Trust's PSIRF Plan will be finalised and published by the end of July 2026. A further review will be undertaken following publication of updated NHS England guidance, now expected towards the end of 2026 (revised from the original April 2026 timeline).

The Trust's PSIRF review aims to capture learning from implementation to date and to inform ongoing improvement. During Quarter 4, the following actions were completed:

- Incorporation of learning from the practical application of PSIRF compared to original expectations
- Refinement of Learning Response methodologies including processes and templates
- Strengthening governance arrangements for learning responses and learning assessments
- Review of patient safety priorities
- Review of trust-wide and local improvement workstreams

- Reassessment of capacity to support effective incident response, learning, and improvement
- Development of a decision-making flowchart to support PSIRF response selection

PSIRF is a contractual requirement for providers of NHS-funded care. It replaces the Serious Incident Framework (SIF) and aims to promote a culture of learning and improvement within and across organisations. It is less prescriptive about which incidents require investigation and removes the distinction between patient safety incidents and serious incidents.

The framework has four key aims:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of system-based approaches to learning
- considered and proportionate responses to patient safety incidents
- supportive oversight focused on strengthening system functioning and improvement

In line with PSIRF the Trust identified nine patient safety priorities for 2025/26 which were:

- Self harm
- Inpatient falls
- Medication errors
- Violence and aggression against patients
- Pressure ulcers
- Apparent suicides
- Risk assessment
- Physical health/mental health
- Patient absent without leave (AWOL)

Following the PSIRF review, it was agreed that the focus would remain on strengthening oversight and operational engagement to better integrate learning across these priorities and further develop organisational learning and triangulation.

In January 2025, prior to the start of the reporting period the Patient Safety Team undertook an internal review to assess the implementation and robustness of the Trust's approach to PSIRF. The findings informed the actions taken during 2025/26 and provide assurance in the effectiveness of current oversight arrangements.

This report demonstrates continued progress in embedding PSIRF across the Trust, while recognising areas for further development to strengthen the translation of learning into measurable improvement.

2. PSIRF Implementation and Review

The NHS Patient Safety Incident Response Framework (PSIRF) guidance recognises that implementing the new framework requires Trusts to design and establish a comprehensive set of systems and processes. These changes take time to implement effectively, embed within organisational practice, and evaluate for impact. Over the past year (2025/26), as part of our 15-month review, the Patient Safety Team has undertaken the following key activities:

PSIRF review workstream	Work Completed
Incident reporting and management procedure	• Refreshed the procedure to ensure it remains fit for purpose and aligned with current PSIRF principles • Strengthened the procedure to promote open and transparent reporting of patient safety concerns and all other incidents • Removed PSIRF learning response types from the procedure, with the intention for these to be incorporated within the overarching PSIRF Policy • Developed a clear flowchart to support staff in understanding the incident reporting and management process, including governance and oversight arrangements • Implemented revisions to Datix to better align with and support PSIRF ways of working
PSIRF plan and policy	• Incorporated learning from the practical application of PSIRF, reflecting on how implementation has compared with initial expectations • Reviewed and refreshed our Patient Safety Priorities to ensure continued alignment with organisational risks and learning • Reviewed both Trust-wide and local improvement workstreams to assess effectiveness and alignment with PSIRF principles • Revisited organisational capacity to respond to patient safety incidents, ensuring a focus on learning and continuous improvement • Developed a flowchart to support consistent and informed decision-making for PSIRF responses • Reflected on the evolution of the Patient Safety Oversight Group processes over the past two years to strengthen governance and assurance • Refined Learning Response methods, including the development of supporting processes and templates to improve consistency and quality • Incorporated feedback and learning from the SIRAN accreditation process into our PSIRF approach

PSIRF review workstream	Work Completed
Compassionate engagement and involvement of those affected	• Developed a series of flowcharts to support the Being Open approach, strengthening engagement and involvement with patients and families following patient safety incidents • Aligned the available Trust support mechanisms for staff involved in patient safety incidents, ensuring a more coordinated, compassionate, and accessible offer
PSIRF training	• Commissioned external training (accredited by NHS England) in After Action Review (AAR) and SWARM methodologies, delivered on 27 March 2026 for Quality and Governance Leads and Matrons • Developed a condensed, internally deliverable version of this training to support wider organisational rollout and sustainability

3. Learning Responses

The Patient Safety Team undertook a review of learning responses undertaken between 1 December 2023 and 31 December 2025. This analysis demonstrated that in many cases the Manager's 48-hour review was sufficient to identify key learning, align findings with existing improvement workstreams, and confirm where learning had already been embedded into routine practice or where appropriate risk-mitigating actions had been implemented. In these instances, no additional learning response was required.

While this approach had previously been classified as a formal learning response, the Manager's 48-hour review is, in essence, an established management tool designed to support timely incident assessment. This tool has since been enhanced to incorporate a stronger systems-based perspective, further strengthening its contribution to organisational learning and improvement. In February 2026, this approach was relaunched as the *Service-Learning Review*.

Where more structured learning responses had been undertaken, the review identified that alternative methods could often have achieved the same outcomes more efficiently, or that limited additional learning had been generated. As a result, decision-making processes have been refined to ensure that responses are proportionate, targeted towards generating new insight, and avoid unnecessary duplication where learning is already well established

3.1 Overview of Learning Responses

Table 1 summarises the range and volume of PSIRF assessment and learning responses undertaken since the Trust's transition to PSIRF. It demonstrates a high volume of proportionate assessment activity, alongside a smaller number of more resource-intensive learning responses, reflecting a targeted approach to gaining insight and supporting improvement.

Table 1. Total PSIRF Responses since Transition

PSIRF response type	Response	Number
Assessment responses	Managers 48 hour rapid review (replaced by Service-Learning Review February 2026)	2579 (all incident types)
Learning responses	Debrief	870 (all incident types)
	After Action Review	18
	Specialist Learning Review	8
	Patient Safety Incident Investigation (individual case)	6
	Patient Safety Incident Investigation (thematic projects)	2
	Involvement in external Patient Safety Incident Investigations	4
	Case note review (Infection Prevention and Control)	5
	Case note review	19
	Structured Judgement Review	29

This profile reflects a deliberate shift towards proportionate, system-focused learning, with more intensive investigation reserved for incidents where deeper insight is required.

To support the continued development of systems-based approaches to learning, the Trust hosted externally delivered After Action Review (AAR) and SWARM training on 27 March 2026, provided by an NHS England accredited organisation. This training was targeted at Quality and Governance Leads and Matrons.

Building on this, the Patient Safety Team is developing internal capability to deliver SWARM training more widely, with further external training planned later in the year. This next phase will focus on ward managers and clinical team leaders, ensuring that learning is timely, meaningful, and translated rapidly into practice.

SWARM debrief is a newly adopted learning response methodology within the Trust. From May 2026, this approach will be implemented across services. SWARM debriefs bring multidisciplinary teams together at an early stage following an incident to reflect on what has occurred, identify contributory factors, address any immediate patient safety concerns, and ensure that staff wellbeing needs are recognised and supported.

As this approach becomes embedded, teams will be encouraged to use SWARM methodology flexibly to support learning wherever structured reflection would add value. This applies across all incident types, not solely those included within formal PSIRF response plans, helping to integrate continuous learning into everyday practice.

4. Learning themes and actions

Consistent with the principles of PSIRF, immediate actions are taken in response to patient safety incidents to ensure services remain safe. The Trust Patient Safety Oversight Group (PSOG) meets weekly, with representation from all Care Groups, specialist advisors, and Executive colleagues. The group reviews patient safety incidents to identify new or significant learning, regardless of the level of harm.

Over the coming year, the scope of PSOG will continue to evolve. The focus will increasingly shift towards reviewing incidents aligned to the Trust's patient safety priorities, irrespective of harm level, and identifying emerging themes. This will enable earlier recognition of potential risks, support proactive intervention, and provide oversight of existing improvement work to determine whether further action is required.

From June 2026, a newly established Learning and Improvement Group will support this approach. This group will be responsible for commissioning improvement activity, monitoring the outputs and

impact of learning, and ensuring that changes are embedded across the Trust. It will also strengthen triangulation of intelligence from patient safety incidents, supporting a more comprehensive organisational understanding of risk.

In addition, patient safety incidents are escalated to the Patient Safety Executive Group where more in-depth discussion is required, including decisions on commissioning learning responses or escalating system-level challenges. Weekly patient safety meetings also take place at Care Group level, attended by specialist advisors, ensuring local oversight and timely action.

Immediate learning is shared Trust-wide through established mechanisms, including safety alerts, Blue Lights, and the Learning Network. The introduction of SWARM debriefs will further enhance the quality and timeliness of learning, supporting teams to generate richer insight from incidents. This will be complemented by the introduction of Patient Safety Huddles from June 2026. These huddles will bring together Quality Governance Leads, Matrons, and specialist advisors to support rapid understanding of incidents and enable timely learning, support, and action.

In Quarter 4, the Trust completed three Patient Safety Incident Investigations (PSIIs) and a thematic review of inpatient suicide and self-harm. Learning from these, alongside wider PSIRF learning responses, has identified several key areas of ongoing focus and improvement across services:

I. **Access to means:** Review and strengthening of access to means guidance across inpatient and community settings, aligned with enhanced professional curiosity and risk assessment practices. This is supported by the development of the women's pathway.
II. **Violence and aggression:** Exploration of pathways for service users presenting via Section 136, including consideration of alternative pathways. This is a multi-agency workstream aligned with the RCRP programme.
III. **Physical Health Monitoring:** Improving and strengthening the monitoring processes for individuals with long-term conditions, to more effectively address their physical health requirements in conjunction with their mental health care and support.
IV. **Multi agency support plans:** Strengthening processes for monitoring individuals with long-term conditions, ensuring physical health needs are effectively addressed alongside mental health care.
V. **Care planning and formulation of risk:** Continued development through the Care Planning and Risk Formulation Oversight Group, supporting the transition from risk stratification to individualised, collaboratively developed care.
VI. **Failed discharge/ discharged not medically fit:** Align with the work that has commenced around transfer of care.
VII. **Apparent suicides:** Implementation of new NHS England guidance on suicide prevention, supported by staff e-learning and a Trust-wide briefing.
VIII. **Absconsion/ AWOL**: Further development of the Missing Persons (MISPER) policy to strengthen expectations around the documentation of pre leave risk assessment, management of AWOL incidents, and processes for reinstating leave.
IX. **Observations**: Development and implementation of the Enhanced Therapeutic Observations of Care (ETOC) policy, promoting therapeutic engagement to reduce risk, including violence and aggression.

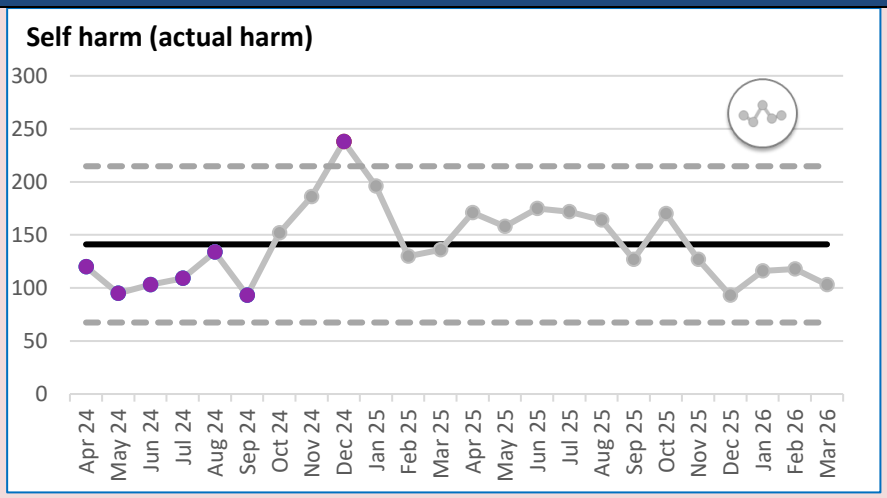
5. PSIRF Priorities Review

As part of the PSIRF approach, the Patient Safety Team and Care Groups have progressed a comprehensive programme of work to address key patient safety risks, including self-harm, inpatient falls, medication errors, violence and aggression, pressure ulcers, apparent suicides, risk assessment, physical health, and AWOL incidents. This work has been a core focus during 2025/2026; however, it does not preclude the ongoing identification, learning from, and response to emerging incidents and safety themes as they arise.

The Patient Safety Team has undertaken a review of the PSIRF priorities for 2026–2027. This was informed through two stakeholder engagement events, ensuring a broad range of perspectives were considered and that all relevant areas were appropriately reflected within the updated plan. Further detail is provided within the PSIRF Plan.

The section below outlines the current patient safety priorities, including associated incident data, improvement work undertaken to date, and areas of newly emerging focus.

5.1 Self-harm

Patient safety priority	Statistical Process Control chart (where available)
Self-harm **PSIRF plan focus:** • Inpatient – self harm associated with ligatures or swallowing objects Community – overdose of prescribed medication	

Data analysis

In 2025/26 the Trust identified a period of special cause variation in self-harm incidents between November 2024 and January 2025. Analysis of the data from September 2024 to February 2025 indicates that this variation was largely attributable to a small number of service users across Mental Health inpatient wards. Of these incidents 96% resulted in no harm or low harm or were unrelated to SWYPFT care, with 4% resulting in moderate harm.

Mental Health inpatient – 2025/26

89% of self-harm incidents occurred within mental health inpatient settings. Of these, 97% resulted in no or low harm or were unrelated to SWYPFT care, while 3% resulted in moderate harm requiring acute hospital treatment.

White - English/Welsh/Scottish/Northern Irish/British	90.4%
Asian/Asian British - Pakistani	3.4%
Mixed/multiple ethnic groups – white and black Caribbean	1.1%
Asian/Asian British – Indian	0.4%
Black/African/Caribbean/Black British – African	0.3%
Mixed/multiple ethnic groups – white and Asian	0.3%
White – any other white background	0.2%
Asian/Asian British – Any other Asian background	0.1%
Other ethnic group – Arab	0.1%
Unknown/not stated	3.7%

Mental Health community – 2025/26

11% of self-harm incidents were reported by mental health community teams. Of these, 69% resulted in no or low harm or were unrelated to SWYPFT care, while 27% resulted in moderate harm and 4% in severe harm.

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Ethnicity data MH community (25/26):

White – English/Welsh/Scottish/Northern Irish/British	77.2%
Asian/Asian British – Pakistani	3.6%
Black/African/Caribbean/Black British – African	1.8%
White – any other white background	1.2%
Mixed/multiple ethnic groups – white and black Caribbean	0.6%
Mixed/multiple ethnic groups – white and Asian	0.6%
Asian/Asian British – Indian	0.6%
Mixed/multiple ethnic groups – other mixed or multiple ethnic groups	0.6%
Unknown/not stated	13.8%

Learning identified

- Safety plans are more effective when co-produced with service users and reviewed daily
- Variability in staff confidence in risk assessment has been identified, highlighting the need to implement the 'staying safe from suicide' guidance.
- A training need has been identified to support consistent application of risk assessment and safety planning.
- There is a need to further support positive therapeutic risk-taking within care planning.

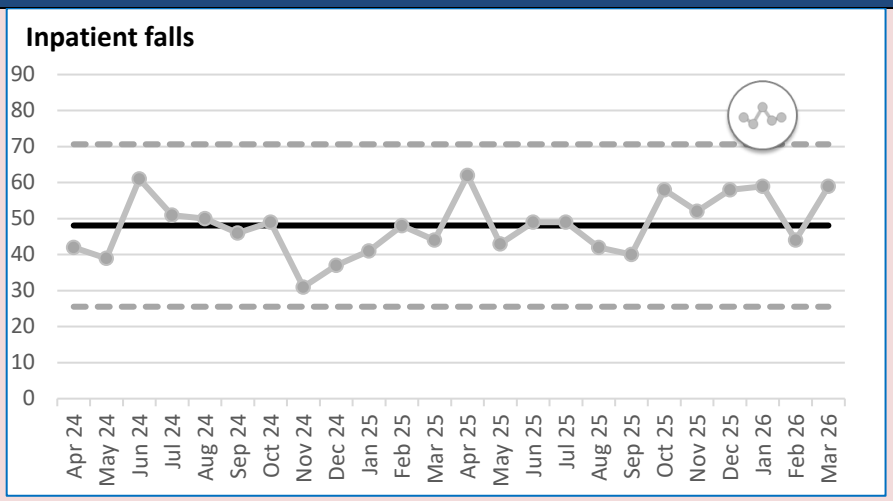
Local improvement work

- Delivery of trauma-informed training to support staff in responding to patient risk and distress.
- Strengthening multi-agency collaboration through the development of Multi-Service Support Plans (MSSPs), with a Task and Finish Group reviewing:
- Processes for establishing MSSPs
- Roles and responsibilities across agencies
- Patient involvement and engagement
- Implementation of the Therapeutic Inpatient Environments priority programme.
- Development of the Women's Pathway which will be informed by an external peer review commissioned by the Chief Operating Officer.

Impact

- Reduction in repeat self-harm incidents for patients with co-produced safety plans
- Improved staff confidence and consistency in risk formulation following training and strengthened environmental risk mitigation through audit processes.
- Positive patient feedback on feeling "more involved" in their care and safety planning

5.2 Inpatient falls

Patient safety priority	Statistical Process Control chart (where available)
Inpatient falls PSIRF Plan: • Learning from well managed incidents and/or near misses • Priority area covered by Improvement plan • Learning response by exception only	

Data analysis

The Trust continues to observe 'normal' variation in the number of inpatient falls incidents reported.

The Falls Coordinator actively promotes the reporting of all falls, including those resulting in no harm, and has raised awareness of the importance of reporting 'no harm' events. This has contributed to an increase in reported low-harm ('green') falls incidents, from which valuable learning can be identified.

In 2025/26:

Ethnicity data 2025/26:

White - English/Welsh/Scottish/Northern Irish/British	87.3%
Asian/Asian British - Indian	1.8%
Asian/Asian British - Pakistani	1.8%
White - any other white background	0.5%
Mixed/multiple ethnic group - white and black African	0.5%
Asian/Asian British - Any other Asian background	0.5%
White - Irish	0.3%
Black/African/Caribbean/Black British - Caribbean	0.3%
Any other ethnic group	0.3%
Mixed/multiple ethnic groups - other mixed or multiple ethnic groups	0.2%
Black/African/Caribbean/Black British - Any other Black background	0.2%
Unknown/not stated	6.2%

• 92% of falls incidents occurred in mental health inpatient wards, of which 61% were reported within older people's services. • 8% occurred in general community inpatient ward .	Most falls incidents involved patients from a White British background (87.3%), broadly reflecting the Trust's population profile. A proportion of incidents (6.2%) had ethnicity recorded as unknown or not stated, indicating an opportunity to improve data completeness. Of all reported falls incidents, 62% resulted in no harm, 36% in low harm, and 2% in moderate harm requiring acute hospital treatment (typically fractures). .

Learning identified

- Through the falls governance pathway cohorts of patients experiencing frequent low level (graded green) falls have been identified.
- An increase in falls associated with agitation and aggression has been observed.
- Younger adults experiencing frequent falls linked to mental state and trauma have been identified as an emerging group.
- Post-falls checks are consistently completed and documented, with 100% compliance for inpatient falls.

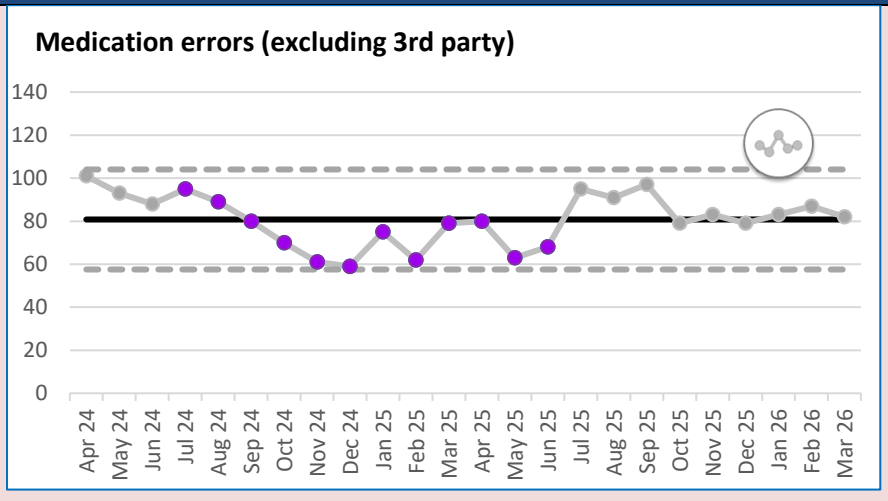
Local improvement work

- Implementation of NICE Quality Standard (QS86) has supported improved documentation of multifactorial falls assessments and mobility plans, including patient education and therapy.
- Targeted patient reviews and ward-level support have facilitated:
  - Optimisation and reduction of medication where appropriate
  - Improved discharge planning
  - Identification and dissemination of good practice

Impact

- A 60% improvement in the documentation of patient education and therapy/exercise.
- Introduction of a physiotherapy screening tool, supporting consistent assessment and documentation.
- Improvement in the quality of multifactorial falls assessments, with over 90% achieving a good-quality assessment and associated mobility plan.
- Further work is planned for 2026/27 to address frequent fallers, including a thematic review to identify good practice and areas for improvement.

5.3 Medication Errors

Patient safety priority	Statistical Process Control chart (where available)
Medication errors **PSIRF plan:** • Administration of insulin Medication storage (fridges/clinic rooms)	
Data analysis	**Ethnicity data (community settings) 2025/26:**

The Trust continues to observe 'normal' variation in the number of medication errors.
In 2025/26:
71% occurred in mental health inpatient wards
18% occurred in mental health community settings
9% occurred in general community services
1% occurred in general community inpatient wards
<1% were reported by Trust wide pharmacy services

Ethnicity data (inpatient settings) 2025/26:

White – English/Welsh/Scottish/Northern Irish/British	71.3%
Asian/Asian British – Pakistani	5.9%
Black/African/Caribbean/Black British – African	2.5%
Black/African/Caribbean/Black British – Caribbean	1.9%
Black/African/Caribbean/Black British – Any other Black background	1.1%
White – any other white background	1%
Mixed/multiple ethnic groups – white and black Caribbean	0.5%
Mixed/multiple ethnic groups – white and Asian	0.5%
Asian/Asian British – Indian	0.5%
Other ethnic group – Arab	0.5%
White – Irish	0.3%
Mixed/multiple ethnic group – white and black African	0.3%
Mixed/multiple ethnic groups – other mixed or multiple ethnic groups	0.3%
Asian/Asian British – Any other Asian background	0.2%
Unknown/Not stated	13.2%

Ethnicity data (community settings) 2025/26:

White – English/Welsh/Scottish/Northern Irish/British	79.8%
Asian/Asian British – Pakistani	2.4%
White – any other white background	1.2%
Mixed/multiple ethnic group – white and black African	0.8%
Asian/Asian British – Indian	0.8%
Mixed/multiple ethnic groups – white and black Caribbean	0.4%
Mixed/multiple ethnic groups – white and Asian	0.4%
Mixed/multiple ethnic groups – other mixed or multiple ethnic groups	0.4%
Asian/Asian British – Any other Asian background	0.4%
Black/African/Caribbean/Black British – African	0.4%
Any other ethnic group	0.4%
Unknown/not stated	12.5%

Across both inpatient and community settings, the majority of incidents involved patients from a White British background, broadly reflecting the Trust's population profile. A proportion of incidents (13.2% inpatient; 12.5% community) were recorded as unknown or not stated, highlighting an opportunity to improve data completeness.

In all settings, 92% of medication incidents resulted in no harm, 7% in low harm, and less than 1% in moderate harm, providing assurance that the majority of incidents do not result in significant patient harm.

Detailed oversight and analysis are provided through the Safe Medicines Practice Group.

Learning identified

- Feedback from matrons indicates a need to strengthen adherence to the fundamentals of medicines administration practice.
- The rollout of Electronic Prescribing and Medicines Administration (EPMA) has reduced certain types of medication-related incidents, although variation remains.

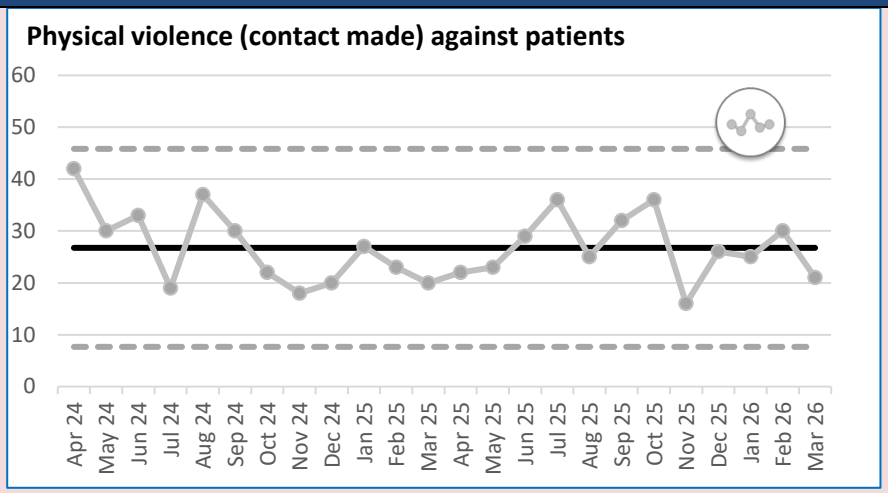
Local improvement work

- Full rollout of EPMA across all inpatient areas.
- Updating the medicines code (inpatient administration section) to align with EPMA processes.
- Enhancements to mandatory training and monitoring arrangements to support safe medicines administration.

Impact

- The implementation of EPMA has changed the profile of medication administration errors, with a reduction in some error types; however, this has not yet resulted in an overall reduction in incident volume.
- This indicates a need for continued focus on embedding practice, staff competency, and safe administration behaviours.

5.4 Violence and aggression against patients

Patient safety priority	Statistical Process Control chart (where available)
Violence and aggression against patients • Violence resulting in moderate harm or above • Incidents involving use of force resulting in moderate harm or above • Incidents where system issue identified	

Data analysis

The Trust continues to observe 'normal' variation in the number of violence and aggression incidents against patients.

In 2025/26:

- 98% of incidents occurred within mental health inpatient settings
- 2% occurred within mental health community settings

Of these incidents, 60% resulted in no harm, 38% in low harm, and 2% in moderate harm.

This profile reflects the higher acuity and concentration of risk within inpatient settings.

Detailed oversight and analysis are provided through the **Reducing Restrictive Physical Intervention Group**.

Ethnicity data 25/26:

White – English/Welsh/Scottish/Northern Irish/British	63%
Asian/Asian British – Pakistani	13.8%
Black/African/Caribbean/Black British – African	4.2%
Asian/Asian British – Indian	2.0%
Asian/Asian British – Any other Asian background	1.7%
Any other ethnic group	1.1%
White – any other white background	0.8%
Mixed/multiple ethnic groups – white and black Caribbean	0.8%
Black/African/Caribbean/Black British – Caribbean	0.8%
Mixed/multiple ethnic group – white and black African	0.6%
Mixed/multiple ethnic groups – other mixed or multiple ethnic groups	0.6%
Black/African/Caribbean/Black British – Any other Black background	0.3%
Other ethnic group – Arab	0.3%
Unknown/not stated	9.9%

Most incidents involved patients from a White British background (63%), broadly reflecting the Trust's inpatient population. A higher proportion were recorded for patients from Asian (particularly Pakistani, 13.8%) and Black ethnic groups (including African, 4.2%), highlighting the need for continued monitoring to understand any potential variation in risk or experience.

A proportion of incidents (9.9%) were recorded as unknown or not stated, indicating an opportunity to improve data completeness. Further work is required to triangulate ethnicity data across multiple sources to inform targeted improvement.

Local improvement work

- Embedding person-centred, trauma-informed practice to ensure care is responsive to individual needs and clinical complexity.
- Ongoing implementation of the Safewards model to strengthen relational security and reduce restrictive practices.
- Use of safety pods and continued work to reduce the use of prone restraint, aligned with least restrictive practice principles.
- Delivery of the Long-Term Segregation (LTS) and seclusion improvement plan, to improve quality, governance, and patient outcomes.
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Impact

- Effective use of safety pods in high-pressure situations has been identified in specific areas,

with plans to disseminate learning and support wider adoption.

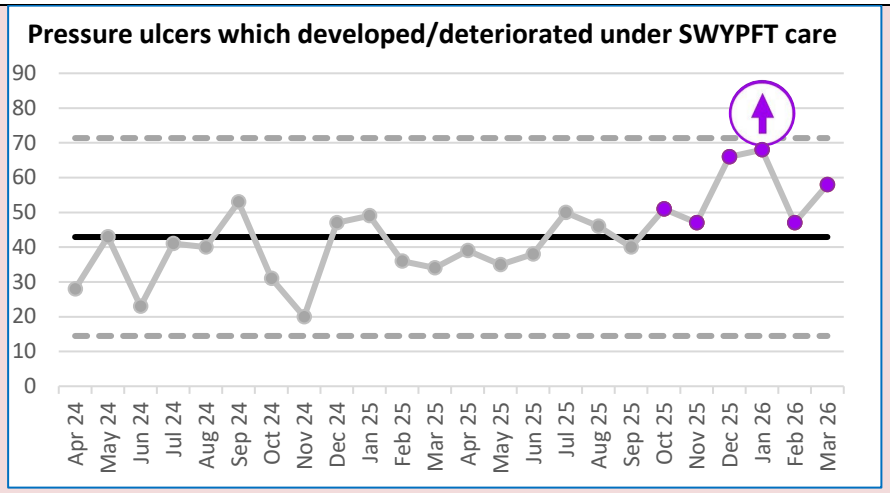
- Implementation of the Safewards model has demonstrated positive impact in some areas, including positive service user feedback at Newhaven.
  Wards such as Hepworth have avoided the use of prone restraint, through the adoption of alternative trauma-informed strategies aligned with least restrictive practice principles.

5.5 Pressure ulcers

Pressure ulcers

- Category 2 resulting in learning not covered in existing improvement work.
- Category 2 or 3 deteriorating to category 3 or 4 (unrelated to end of life)

Clinical documentation including Waterlow risk assessment



Data analysis
In 2025/26, the Trust identified a period of special cause variation, reflecting an increase in the number of Category 2, 3 and 4 pressure ulcers that developed or deteriorated under SWYPFT care.

Most incidents (98%) were reported within Barnsley physical health services. Smaller numbers were reported within Mental Health inpatient services (8 incidents) and general community inpatient wards (6 incidents).

Ethnicity data:
94% of incidents involved patients from a White British background, broadly reflecting the patient population. A small proportion were recorded across other ethnic groups (<1% each), with 4% recorded as unknown or not stated, indicating an opportunity to improve data completeness.

In terms of severity, 53% of pressure ulcers were classified as low harm (typically Category 2), 46% as moderate harm (typically Category 3), and 1% as severe harm (typically Category 4). This classification reflects the severity of the wound rather than confirmed problems in care.
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Learning identified

- Variability in the quality of documentation and risk assessment (including Waterlow assessment and scheduling) was identified as a key contributory factor in pressure ulcer incidents.

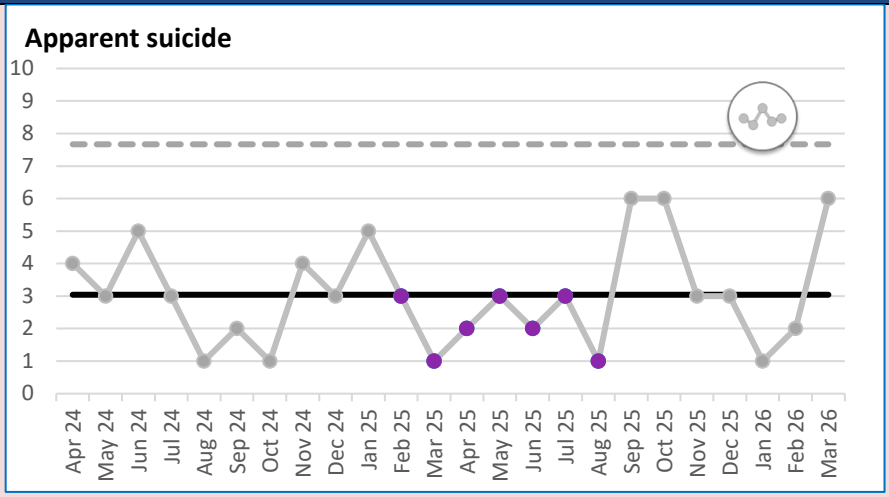
Local improvement work

- Implementation of Purpose T across neighbourhood teams, supported by completed audit activity.
- Development of a standardised wound care template to improve consistency of documentation.
- Review of care plans and planned implementation of the Auto Planner (automated scheduling tool within SystmOne) to improve timeliness of interventions.
- Planned implementation of a combined safeguarding and pressure ulcer tool to strengthen oversight and risk management.

Impact

- Improved identification and screening of patients at risk of pressure ulcers through the multiprofessional implementation of Purpose T.
- Improved consistency in documentation and risk assessment processes within neighbourhood teams.
- Purpose T is not yet fully implemented within inpatient services, representing an ongoing area for improvement.

5.6 Apparent suicides

Patient safety priority	Statistical Process Control chart (where available)
Apparent suicides PSIRF plan: Focus on suicide prevention at team level	

Data analysis

This graph includes all deaths recorded on Datix as apparent suicides, in line with the Trust's Learning from Deaths policy. These relate to service users who have died while under recent Trust care, where the death is considered likely to be suicide.

The classification of 'apparent suicide' does not represent a confirmed coroner's conclusion. Records are updated as further information becomes available, including coroner outcomes (e.g. where deaths are subsequently classified as natural causes). As such, data may change over time. This analysis is based on the incident date.

n 2025/26, 89% of apparent suicides occurred within community mental health settings.

A further 11% (n=4) were recorded by inpatient mental health services. Of these:
- Two deaths occurred in the community or in non-mental health inpatient settings (e.g. while on leave from the ward)
- Two deaths occurred within inpatient settings

In terms of ethnicity, 88% of individuals were recorded as White British, 2% as White (other background), and 10% as unknown or not stated, indicating an opportunity to improve data completeness.

Statistical Process Control (SPC) data is monitored monthly through the Operational Management Group.

Learning identified

- Safety plans are more effective when co-produced with service users and reviewed daily
- Variability in staff confidence in risk assessment has been identified, highlighting the need to implement the 'staying safe from suicide' guidance.
- A training need has been identified to support consistent and effective risk assessment and safety planning.
- There is a need to further support positive therapeutic risk-taking within care planning

Local improvement work

- Delivery of trauma-informed training (now non-mandatory but widely accessible) to support staff in responding to patient risk and distress.
- Strengthening multi-agency collaboration through the development of Multi-Service Support Plans (MSSPs), involving key partners such as housing, police, and social care to support holistic risk assessment.
- Review and enhancement of staff support following a patient death, including evaluation of current processes.

Impact

- Reduction in repeat self-harm incidents for patients with co-produced safety plans.
- Improved staff confidence and consistency in risk formulation, supported by training and strengthened environmental risk mitigation through audit cycles.
- Positive patient feedback, with individuals reporting feeling more involved in their care and safety planning

5.7 Physical health/mental health

The key themes, learning and improvement actions relating to the monitoring and management of patients' physical health within mental health services remain a priority focus, with particular emphasis on the use of NEWS2. The Trust is currently implementing electronic observations; once in place, this will enable improved tracking and measurement of progress through data, consistent with other patient safety priorities.

Themes and trends

- Wards are adhering to the standard of completing physical health observations at least once weekly, with frequency increased where clinically indicated.
- Some services, particularly Older People's wards, undertake daily observations due to increased patient complexity, including comorbidities and higher risk of deterioration.

Learning identified

- Increased and more consistent use of the National Early Warning Score (NEWS2) to support the early identification of deterioration.
- The need to strengthen the use of clear escalation plans linked to NEWS2 scores.

Local improvement work

- Ongoing monitoring of NEWS2 use across all inpatient areas.
- Ensuring each patient has an individual NEWS2 chart.
- Ensuring physical health observations are completed and documented in line with Trust policy (minimum weekly for all patients).
- Monitoring the accuracy and completeness of individual observation recordings.
- Monitoring compliance with NEWS2 use and completion in line with national guidance
- Implementation of e-observations

Impact

- Improved quality and consistency of record-keeping for physical health observations, particularly within forensic services.
- Increased staff awareness and compliance in documenting patient refusal of observations, supporting more complete and defensible records.
- Enhanced clinical decision-making and personalised care, through use of 'what is normal' guidance to support appropriate escalation.
- Strengthened recognition and response to patient deterioration, with greater emphasis on early escalation in response to high NEWS2 scores

6. Learning, Triangulation and Insight

Learning is systematically triangulated from complaints, incidents, learning response outputs, and wider patient safety data to identify emerging themes and trends. This includes routine thematic review alongside engagement with specialist advisors, ensuring that issues identified through learning responses are validated against frontline clinical insight and expert advisory feedback. This approach is being further strengthened through the refreshed Learning and Improvement Group (formerly PSIG), which provides a formal governance structure for the oversight of learning and its translation into improvement. This forum will enhance how evidence is captured, synthesised, and clearly articulated within organisational reporting.

Our 'learning journey' currently brings together themes and trends identified through learning responses. This will be further developed to incorporate a broader range of patient safety intelligence, including incidents, complaints, coronial outcomes, and other relevant data sources. This will support a more cohesive and comprehensive understanding of patient safety risks and opportunities for improvement.

At present, ethnicity data is reported at priority level; however, further work is required to triangulate this across multiple datasets and assess disproportionality, in line with the Trust's commitment to addressing health inequalities.

In addition, the development of a centralised SharePoint platform to provide live oversight of improvement activity across multiple sources will enhance transparency, enable effective tracking, and support alignment of actions. This will further strengthen the clarity, consistency, and coherence of reporting over time, while supporting the work of the Learning and Improvement Oversight Group.

Engagement with stakeholders through the PSIRF review has directly informed this approach, supporting a collaborative, organisation-wide commitment to continuous patient safety improvement.

7. Learning from deaths

The Trust's Learning from Deaths report has been completed and is presented separately alongside this report for review.

All reported deaths, irrespective of cause or perceived severity, continue to be reviewed by patient safety specialists. These primarily relate to service users who have died whilst receiving care in the community, or within six months prior to their death. Each case is assessed to determine whether it meets the criteria for a formal mortality review, in line with the established framework described earlier in this report.

National evidence continues to highlight significant health inequalities in mortality. People living with severe mental illness (SMI) experience a life expectancy gap of 15–20 years compared to the general population, with a substantial proportion of deaths attributable to preventable physical health conditions (Royal College of Psychiatrists, 2024; King's College London, 2026).
Recent analysis indicates that over 130,000 adults with SMI in England died prematurely between 2020 and 2022, with approximately two-thirds of these deaths linked to preventable physical conditions (Royal College of Psychiatrists, 2024)

Similarly, the Learning from Lives and Deaths (LeDeR) programme demonstrates that people with a learning disability die on average around 19–20 years earlier than the general population. In 2023, 39% of deaths in this group were considered avoidable, compared with around 21–22% in the wider population, highlighting a persistent and significant inequality (NHS England/LeDeR, 2025).

More broadly, there were 568,613 deaths registered in England and Wales in 2024, with ongoing variation in mortality rates and significant regional inequalities, reinforcing the importance of robust mortality review processes (ONS, 2025).
In response to this national context, the Trust adopts a broad and inclusive approach to reviewing deaths, recognising the importance of maximising learning opportunities to address avoidable harm and health inequalities.

The Trust has worked collaboratively with other providers across the North of England to strengthen and standardise its approach to learning from deaths. All reportable deaths are reviewed in line with Trust policy. Engagement with families and carers remains a key priority, recognising the invaluable insight they provide in identifying learning and driving improvements in care.

A representative from the Patient Safety Support Team attends quarterly regional mortality meetings to support the sharing of learning and best practice across organisations.

- A review of the Structured Judgement Review (SJR) process is currently underway, including reviewer allocation, training provision, thematic analysis, and reporting outputs.
- The ongoing review of the PSIRF plan, policy, and procedures includes the introduction of decision-making flowcharts to support the selection of the most appropriate PSIRF response. These tools also strengthen alignment with Learning from Deaths requirements by supporting the identification of whether a death may have resulted from a problem in care

8. Impacts and challenges during Year 1 of PSIRF Implementation

During the first year of PSIRF implementation several positive impacts and key challenges and have been identified. These insights are informing the next phase of development and improvement: of the PSIRF Plan.

Positive impact of PSIRF	• Increased focus on improvement activity aligned to patient safety priorities • Improved oversight of data and work in progress supporting better visibility of PSIRF priorities. • Enhanced levels of discussion and shared learning, supporting greater understanding and application of patient safety insights across teams. • Delivery of SWARM and AAR training (March 2026) building capability within care groups to lead and effectively implement these learning response methodologies • Strengthened engagement within PSII processes including frontline staff and families, supporting meaningful involvement and improved quality of learning. • The Family Liaison Officer (FLO) has developed stronger links with the trauma-informed pathway, enhancing the Trust's ability to provide compassionate, trauma-informed engagement with those affected by patient safety incidents across both the FLO role and the wider patient safety team • Establishment of the PSIRF response decision-making meeting, providing a structured forum to review patient safety events, align improvement activity, and ensure proportionate responses • Strengthened executive oversight through the Patient Safety Executive Group, supporting enhanced scrutiny and organisational assurance. • Improved system-wide collaboration, including work with local acute trusts to develop aligned approaches and shared

	learning through revised Memoranda of Understanding.
Reflection on challenges in Year 1	• The transition from Serious Incident (SI) investigations to an increased volume of PSIRF learning responses has not yet released the anticipated capacity for improvement activity. As a result, the intended benefit of creating time for learning and continuous improvement has not been fully realised. • Further work is required to ensure that learning is consistently translated into improvement, with a stronger focus on implementing and evidencing change rather than generating recommendations alone. • Patient Safety Partner capacity remains limited, with only one partner currently in post. Additional recruitment is required to strengthen co-production and provide robust challenge across key safety meetings and workstreams. • Improvement activity is often undertaken in silos, with a lack of a clearly defined, cross-Trust improvement framework aligned to patient safety priorities. • limited audit activity to provide assurance that improvements are embedded and delivering intended outcomes. • A need to strengthen cross-care group learning and collaboration, ensuring consistent application and spread of learning across services • The standing down of the Patient Safety Improvement Group resulted in a delay in collective reflection, coordination, and organisational oversight of improvement activity

8.1 Addressing Challenges and Strengthening Impact

In response to the challenges identified, several actions are underway to strengthen the Trust's approach to learning, improvement, and oversight in line with PSIRF principles.

These actions include:

- Refresh of the terms of reference for the Patient safety Executive Group, strengthening oversight of learning response activity.
- Relaunch of the Patient Safety Improvement Group providing clearer organisational oversight of improvement activity and delivery of patient safety priorities.
- Improved alignment of audits to provide assurance on the impact and sustainability of improvement actions.
- Further embedding of the bi-monthly Learning Network supporting cross care group and team learning; and dissemination of improvement activity.
- Development of a centralised SharePoint platform to support real-time oversight of improvement workstreams enabling improved visibility, coordination and alignment of actions across the organisation.

9. Next Steps

In the coming year, the Patient Safety Support Team will continue to:

- Work with the Trust's Procurement Team to review options for a future risk management system, including consideration of systems to replace or enhance current functionality (incidents, complaints, risks, safety alerts, legal processes, and actions). This will include ensuring improved capability for capturing equality data, triangulating learning, and reporting improvement activity.
- Strengthen the quality and relevance of data captured within DatixWeb by reviewing data fields with

specialist advisors, ensuring that information collected supports meaningful analysis and prepares the Trust for any future system transition.
- Continue embedding the relaunched PSIRF Plan, including supporting processes, governance structures, and workforce capability.
- Review and strengthen the Patient Safety Partner model, ensuring alignment with the revised PSIRF Plan and supporting co-production, challenge, and meaningful involvement.
- Relaunch mortality meetings, strengthening oversight of learning from deaths and improving dissemination of learning, including from LeDeR reports.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 11.2

Private/Public paper:	**Public**		
Title:	**Learning from Healthcare Deaths Annual report**		
Lead Director:	**Caroline Johnson, Chief Nurse / Director of Quality and Professions**		
Mission/values:	• We are respectful, honest, open and transparent • We put the person first and, in the centre • We are always improving		
Purpose:	The purpose of this report is to provide the Trust Board with assurance that the Learning from Healthcare Deaths framework is being effectively implemented in line with national guidance. It sets out how deaths are identified, reviewed, and analysed across the Trust, and how learning is captured and translated into improvements in patient safety and quality of care. The report also highlights key themes, areas of learning, and ongoing improvement activity, including actions to address health inequalities and reduce preventable deaths.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Delivering safe and effective services is a priority of all health and social care providers. This is a shared priority across the Integrated Care System, Integrated Care Board, Place based partnerships and is a regular feature of our shared objectives and actions. Ensuring there is understanding of the incidents which take place within our services, the impact of these and the learning to ensure future risk or harm can be avoided or reduced is essential. Sharing learning and best practice, themes, trends and analysis can help to identify opportunities to work together to address concerns or celebrate good practice. Learning from incidents is vital to improve patient safety, staff and service user/carer experience and to provide assurance of good governance and risk management processes.		

Any background papers / previously considered by:	Quality and Safety Committee and Trust Board have previously received quarterly and annual patient safety oversight reports, learning from healthcare deaths reports and patient safety updates. NHS England PSIRF oversight guidance asks that trusts move towards a focus on learning and improvement and the content of this report reflects this. The Executive Management Team and Quality and Safety Committee have reviewed and provided comments on this report prior to submission to Trust Board.
Executive summary:	This report provides the Trust Board with a comprehensive overview of the implementation and effectiveness of the Learning from Healthcare Deaths framework for the period 1 April 2025 to 31 March 2026. It demonstrates how the Trust continues to meet national requirements set out by the National Quality Board, ensuring deaths are systematically identified, reviewed, and used to support organisational learning and improvements in patient safety and quality of care. During 2025/26, a total of 2,125 deaths were recorded on the Trust's clinical systems where there had been contact within the preceding 180 days, consistent with the previous year (2,150). Of these, 390 deaths were reported and reviewed via Datix, with 277 meeting the Trust's criteria for in-scope review. This stability provides assurance that identification and reporting processes are embedded and consistently applied. All in-scope deaths have undergone proportionate review in line with the Trust's three-tier mortality framework, including certification, service-learning reviews, Structured Judgement Reviews (SJRs), and, where appropriate, formal learning responses under the Patient Safety Incident Response Framework (PSIRF). Robust governance arrangements, including oversight by the Patient Safety Oversight Group and Quality and Safety Committee, ensure consistency and scrutiny. Analysis demonstrates no evidence of special cause variation with expected levels of variation observed over time. Most deaths relate to patients receiving community mental health services, reflecting the Trust's service profile. Twenty-four inpatient deaths were recorded. A death is deemed to be an inpatient death both on a ward and up to 30 days following discharge. Of these deaths, four deaths were identified as apparent suicides, one death was attributed to choking, and the remaining nineteen deaths were associated with physical health deterioration. These individuals were either receiving end-of-life care under SWYPFT at the time of death or died in other organisations due to terminal conditions. There were no in-patient learning disability deaths. An independent review of an inpatient apparent suicide has been commssioned and an independent review of the women's pathway has been commissioned and is due to conclude in July 2026. This will further inform improvements to the model of care and safety. The report highlights continued focus on learning disability and autism mortality, with 40 deaths identified and appropriately reported through the LeDeR programme. Regional findings continue to highlight inequalities, particularly for autistic individuals, including increased risks of premature mortality and inconsistent access to autism-informed care. These insights are informing ongoing Trust improvement work.

	There is clear evidence of organisational learning and improvement, including strengthened approaches to: • Physical health monitoring and deterioration • End-of-life care planning, including DNAR/ReSPECT • Inter-organisational care coordination • Risk management, including choking The Trust continues to enhance its patient safety systems, including refreshing the PSIRF Plan review (due for approval at Quality and Safety Committee in July), strengthened mortality governance, and improved mechanisms for thematic learning. Work is also underway to enhance the quality and consistency of SJRs and improve data capture to support real-time intelligence. Overall, the report provides strong assurance that the Learning from Deaths framework is embedded, effective, and continuing to mature, with evidence that learning is translated into improvements in care. It also highlights key areas of ongoing focus, particularly addressing health inequalities, improving care for vulnerable groups, addressing the specific needs of women and strengthening system-wide collaboration to reduce preventable deaths.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the report and be assured that the Learning from Deaths framework is being effectively implemented, embedded, and monitored across the Trust.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Learning from Healthcare Deaths Report

Cumulative data covering the period 1/4/2025 – 31/3/2026

Prepared by Patient safety support team

Trust Board – 30 June 2026

1. Introduction

Scrutiny of healthcare deaths remains a national priority. The Trust has had a Learning from Healthcare Deaths policy in place since 2017, aligned to National Quality Board guidance, which sets out how deaths are identified, reported, reviewed, and how learning is derived to improve care. The Trust has published its Learning from Deaths data since October 2017 in line with national requirements.

While many people receive high-quality care from the NHS in the weeks, months, and years leading up to their death, there remain important opportunities to learn where care may not have met expected standards, including where system factors contribute to outcomes. National evidence continues to highlight significant health inequalities in mortality. People living with severe mental illness experience a life expectancy gap of 15–20 years compared to the general population, with a substantial proportion of deaths linked to preventable physical health conditions (Royal College of Psychiatrists, 2024; King's College London, 2026). Similarly, people with a learning disability die, on average, around 19–20 years earlier than the general population, with a significantly higher proportion of deaths considered avoidable (NHS England/LeDeR, 2025).

More broadly, national mortality data continues to demonstrate significant variation and inequality in outcomes, reinforcing the importance of robust review processes and system learning (ONS, 2025).

In response, the Trust adopts a broad and inclusive approach to reviewing deaths, ensuring that opportunities for learning are maximised, particularly in relation to health inequalities, physical health, and the quality of care provided across systems.

The Trust continues to work collaboratively with partners across the North of England to develop and strengthen its approach. All reportable deaths are reviewed in line with Trust policy, with a strong emphasis on engagement with families and carers, recognising the valuable insights they provide in understanding care and identifying learning. A representative from the Patient Safety Support Team attends quarterly regional mortality meetings to support the sharing of learning and best practice across organisations.

This Learning from Deaths report is presented alongside the Patient Safety Oversight Report and forms part of the Trust's wider arrangements for patient safety oversight and assurance to the Quality and Safety Committee and Trust Board.

2. Scope

The Trust has systems in place to identify and capture the known deaths of its service users on its electronic clinical information system. The Learning from Deaths policy sets out how deaths are responded to, which deaths are reportable, how they are reviewed, and how the Trust engages with bereaved families and carers.

For core reporting purposes, the Trust is deemed the main provider of care if, at the time of death, the patient met one or more of the following criteria:

1. An episode of inpatient care within our service.

2. Patient discharged from SWYPFT inpatient bed in the 30 days prior to death.
3. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
4. A Community Treatment Order.
5. A conditional discharge.
6. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
7. Guardianship
8. Deprivation of Liberties legislation (DOLS)

It should be noted that there will be some overlap in reporting with other providers due to complexities in healthcare provision.

Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny adopted by the Trust, consistent with National Quality Board guidance.

All in-scope deaths are considered using one of the following levels of review:

Death Certification

- Review of the cause of death as certified by the attending doctor.
- In some cases, the Trust may only be notified that the death was certified or referred to the Coroner, without detailed information regarding the cause.

Case Record Review

Proportionate review of the clinical record to identify learning, including:

- Manager's Service-Learning Review (formerly 48-hour review)
- Structured Judgement Review (SJR) where a more in-depth assessment of care is required

Learning Response

Where further understanding is required, a PSIRF learning response may be commissioned. These approaches aim to identify system factors and opportunities for improvement and may include:

- After Action Review (AAR)
- Patient Safety Incident Investigation (PSII)
- Learning from Lives and Deaths Reviews (LeDeR) (for people with learning disabilities and/or autism)
- Other external reviews, such as safeguarding reviews

Reported deaths predominantly relate to service users who have died whilst receiving care in the community, or within six months prior to their death. All reported deaths are reviewed to determine whether they meet the criteria for inclusion within a mortality review, in line with the scope and criteria outlined earlier in this report. The Trust has strong record for triggering appropriate learning responses to address any patient safety concerns such as commissioning of thematic review, external reviews and reviews of care pathway.

3. Annual Cumulative Dashboard[1] Report 2025/26 covering the period 01/04/2025 – 31/03/2026

A summary of deaths reported during 2025/26 is presented in table 1. A total of 2,125 deaths were identified on the Trust's clinical systems where there had been contact within 180 days prior to death, which is broadly consistent with the previous year (2,150).

Of these, 390 deaths were reported on Datix and reviewed, of which 277 met the Trust's criteria for being in scope for further review. The remaining 113 deaths were not within scope, in line with the defined reporting criteria.

Table 1 Summary of 2025/26 Annual Death reporting by financial quarter to 31/03/2026

Reporting criteria		2024/ 2025 total	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	2025/ 2026 Total
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death[2]	2150	517	546	567	495	2125
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	427	102	89	112	87	390
3	Total Number of deaths which were in scope	282	74	67	77	59	277
4	Total Number of deaths reported on Datix that were not in the Trust's scope	145	28	22	35	28	113

Figure 1 presents two Statistical Process Control (SPC) charts for the period 1 January 2024 to 31 March 2026, showing:

- All deaths reported (by reported date)
- Deaths identified as being in scope for further review

The chart of all reported deaths demonstrates normal (expected) variation over time. Although there was an increase in reported deaths in January 2025, this did not meet the threshold for special cause variation and therefore did not require further investigation. A proportion of these deaths were not in scope for mortality review, in line with the criteria outlined earlier.

The chart of deaths in scope for review also shows stable variation within expected limits, providing assurance that there are no emerging trends or signals of concern requiring escalation.

[1] Dashboard format and content as agreed by Northern Alliance group.
[2] Data extracted from Business Intelligence Dashboards. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems

Figure 1 Statistical Process Control charts for all deaths reported in the 24 month period up to the end of the financial quarter by date reported and all deaths which were in scope for further review

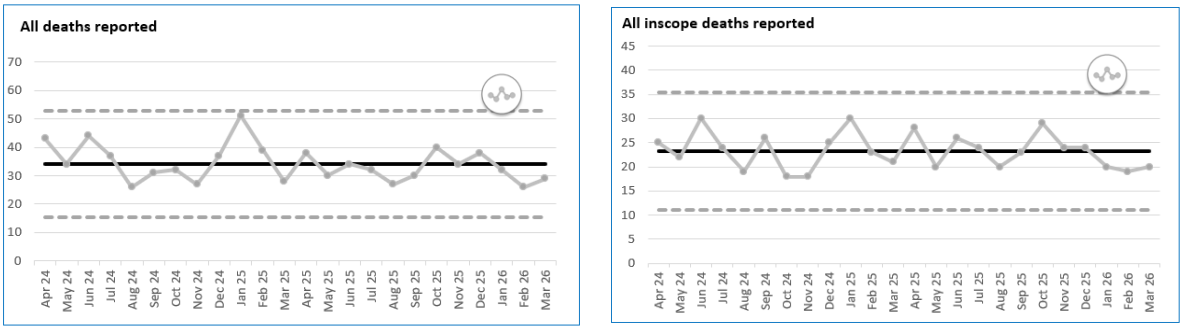


Table 2 shows the distribution of 277 deaths in scope for review during 2025/26 across Care Groups. The majority of in-scope deaths (217; 78%) relate to Mental Health Community services, reflecting the nature of the Trust's service provision, where most patients receive care in community settings. Smaller numbers are seen across Mental Health Inpatient services (20), Learning Disability services (31), and other Care Groups, with very low numbers reported in Forensic Services, Children and Young People's Services, and Cheswold Park Hospital.

The data demonstrates consistent reporting across quarters, with no significant variation between Care Groups, providing assurance that deaths are being identified and reported in line with Trust policy.

Table 2 Breakdown of the total number of deaths in scope for review in 2025/26 by Care Group by financial quarter

Financial quarter - date reported	Barnsley Physical Health & Wellbeing Care Group	Mental Health Care Group (Inpatient)	Mental Health Care Group (Community)	Forensic Services Care Group	Cheswold Park Hospital	Learning Disability and ASD/ADHD Care Group	Children Young People and Families Care Group	Total
2025/26 Q1	1	5	57	0	1	10	0	74
2025/26 Q2	2	4	50	0	0	9	2	67
2025/26 Q3	2	7	61	1	0	6	0	77
2025/26 Q4	0	4	49	0	0	6	0	59
Total	**5**	**20**	**217**	**1**	**1**	**31**	**2**	**277**

Table 3 outlines how these deaths were reviewed. All 277 deaths should have received a first-stage case note review (Service-Learning Review), which provides the information required to support decision-making on whether further review or investigation is needed. Where a death is certified and no further concerns or indicators for additional review are identified, it is recorded as

'certification'. Where a death requires further learning, it is recorded under the relevant review or learning response type.
The data has been refreshed for the full year 2025/26 to reflect the most up-to-date position, including any changes following confirmation of cause of death or progression of review processes.

Table 3 Summary of total number of all in scope deaths in 2025/26 by the respective level of mortality review process

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review		Level 3: Learning Response				
	Certification of death	service learning review (1st stage case note review)	Structured Judgment Review (SJR)	After Action Review	Patent Safety Incident Investigation (PSII)	Learning Disability Death process (LeDeR)	Other reviews	Total
2025/26 Q1	37	16	6	1	0	13	1	74
2025/26 Q2	32	22	3	1	0	9	0	67
2025/26 Q3	31	27	6	0	2	8	3	77
2025/26 Q4	24	27	0	0	0	8	0	59
Total	**124**	**92**	**15**	**2**	**2**	**38**	**4**	**277**

3.1 Learning Disability deaths

The death of any patient with a diagnosis of Learning Disability and/or Autism is reported to the Learning from Life and Death Reviews LeDeR[3] process. This programme was previously known as the Learning Disabilities Mortality Review. The LeDeR work originated from the Confidential Inquiry into the Premature deaths of people with Learning Disabilities (CIPOLD). Information available here. In line with the national reporting of deaths, we are asked to separate our reporting of in scope deaths into learning disability deaths and all other deaths. Tables 4 and 5 below provide this breakdown.

It should be noted that the figures in the sections below may not tally with the numbers by care group (in table 2 above). This is because we identify Learning Disability and Autism diagnosis by a field on Datix to determine if any patient who died had a learning disability and/or autism diagnosis, irrespective of where they were cared for.

Table 4 shows there were 40 deaths of people with a diagnosis of learning disabilty and/or autism. These breakdown as below:

- 31 patients were under the care of learning disability teams (or within the previous 6 months) (learning disabilty and/or autism)
- Seven patients were under the care of other Trust mental health services:

[3] Learning Disability deaths reportable to Learning from Life and Death Reviews (LeDeR)

  - Five patients under Core Team care (learning disability or autism diagnosis)
  - One patients under Enhanced Team care (learning disability diagnosis)
  - One early intervention
- Two patients were under the care of Trust physical health services:
  - One patients under Neighbourhood nursing team care (learning disability diagnosis)
  - One patient under Paediatric therapy team care (learning disability diagnosis)

Figure 5 below shows the number of deaths of people with a learning disability and/or autism diagnosis who had contact with the Trust, either current or within the previous six months prior to death. These deaths are reported to the Learning from Life and Death Review Programme (LeDeR). We check to ensure a death meets the LeDeR criteria, and if a death is already known to LeDeR by another provider.

Table 4 Summary of total number of in scope deaths in 2025/26 by the Review process (including people with Learning Disability and/or Autism diagnoses)

	Reported to Learning Disability Death process (LeDeR)	Reported on LEDER by another organisation	Not reportable to LEDER as under 18 years of age	Total
2025/26 Q1	12	1	0	13
2025/26 Q2	9	0	0	9
2025/26 Q3	8	0	2	10
2025/26 Q4	8	0	0	7
Total	**37**	**1**	**2**	**40**

As shown in figure 6, two deaths were not reported to LeDeR, as this applies only to those aged 18 and over.

LeDeR reviews are led by colleagues outside of the Trust services, such as by an Integrated Care Board. This gives them objectivity and the ability to review the whole care provision of the person who has died. As these reviews can take some time to conclude, we ask managers to complete the service learning review to ensure any internal learning and reflection can take place at a much earlier stage.

Across the region of West and South Yorkshire a process is established for the reviewing of all deaths under the LeDeR framework. SY ICB routinely share to Patient Safety Support Team the outcomes of all reviews completed, this has also included the outcome of a thematic analysis completed over the period of time September 2024 up to March 2026.

Learning shared following the thematic analysis identified that out of 32 individual reviews completed the reports highlighted persistent inequities for autistic adults when compared with the wider LeDeR population, in relation to premature mortality, suicide risk, mental health need, and inconsistent autism-informed practice.

The reports cites that the findings reinforce the need for a coordinated, system-wide response focused on autism-informed suicide prevention, improved mental and physical healthcare, consistent implementation of reasonable adjustments, and proactive identification and support for socially isolated autistic adults.

A sustained shift from reactive models of care to anticipatory, personalised and prevention-focused approaches, with clear ownership and accountability across health, social care, and partner organisations

SWYPFT are aware of a difference in the approach across the West ICB where reports completed are not being shared back to the Trust. This has been noted as an action to take forward in to the relaunched SWYPFT internal Mortality meeting, where LeDeR learnings are an identified standing agenda item to help inform and shape actions internally. This will support the ongoing improvement workstreams across physical health, culture of care and suicide prevention strategic aims and objectives.

3.2 Other deaths

Table 5 below shows all deaths where the patient is recorded as not having a learning disability or autism diagnosis along with the level of review which was completed. All deaths reported have a service learning review completed to ensure the care and treatment leading up to a death was considered, although if there is another review process followed or the death was certified, this will be what is included in this report. For example, if a death is reported in the table below as Certified, or has a Structured Judgement Review, it will also have had a service learning review completed as standard process.

Table 5. Summary of total number of in scope deaths in 2025/26 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Learning Response			
	Certification of death	service learning review (1st stage case note review)	Case note review	Structured Judgment Review (SJR)	After Action Review	Patent Safety Incident Investigation (PSII)	Specialist learning review	Total
2025/26 Q1	37	16	1	6	1	0	0	61
2025/26 Q2	32	22	0	3	1	0	0	58
2025/26 Q3	29	27	0	6	0	2	3	67
2025/26 Q4	24	27	0	0	0	0	0	61
Total	**122**	**92**	**1**	**15**	**2**	**2**	**3**	**237**

3.3 Inpatient deaths

Table 6 below shows that over the year 2025/26 to date there have been 24 inpatient deaths across Forensic, Cheswold park, Mental Health Acute inpatient units and Neuro-rehabilitation.

As with all deaths, every inpatient death is reviewed to determine the most appropriate level of learning response. Across all four quarters, each death underwent a manager-led service learning review, and the 'Death of a Service User' questionnaires were completed appropriately. All initial learning responses were subsequently reviewed by the Trust's Patient Safety Oversight Group to determine the need for, and level of, any further review.

A detailed review of each of the 24 deaths classified as inpatient deaths under the Learning from Deaths framework has been completed or is ongoing. Of these, four deaths were identified as apparent suicides, one death was attributed to choking, and the remaining nineteen deaths were associated with physical health deterioration. These individuals were either receiving end-of-life care under SWYPFT at the time of death or died in other organisations due to terminal conditions. There were no in-patient learning disability deaths.

One inpatient death occurred as a result of choking. This case was subject to detailed review at care group level, alongside completion of a Structured Judgement Review (SJR). The Trust has previously undertaken a comprehensive programme of improvement work arising from the Learning from Deaths framework, specifically focused on the identification and management of choking risks.The SJR provided assurance that learning from previous incidents had been effectively implemented and embedded across the organisation, with clear evidence of sustained improvements in clinical practice. No gaps in care or service delivery were identified. At the time of the incident, a partner organisation raised concerns regarding Trust equipment and staff competence in its use. However, the review confirmed that staff acted appropriately, in line with Trust policies, procedures, and training, and utilised the equipment available to them effectively. Compliance with Basic Life Support (BLS) and Intermediate Life Support (ILS) training was also confirmed to be at a good standard, further supporting the position that prior organisational learning has been translated into safe and consistent frontline practice.

At each stage of the reporting process, opportunities for learning are identified and acted upon. Care group leaders are actively encouraged to implement immediate improvements where this can be achieved at a local level, ensuring teams are empowered to lead on safety and quality. This approach supports timely intervention and reduces reliance on the completion of formal reporting processes before action is taken. It also mitigates the risk of recurrence by avoiding unnecessary delays in implementing changes while reviews are ongoing.

With the exception of apparent suicides, which remain subject to ongoing review, no inpatient deaths due to physical health causes were identified as having been contributed to by the care or treatment provided by the Trust.
A number of areas for learning have been identified to support continuous improvement. These include strengthening processes for inter-organisational transfers of care for patients who are physically unwell; ensuring walking (mobility) assessments are routinely updated; enhancing

staff understanding of individual needs when patients are approaching end of life; and improving consistency in end-of-life pathways and care planning.
Further learning relates to increasing awareness and application of the ReSPECT process, as well as ensuring clarity and completeness of Do Not Attempt Resuscitation (DNAR) documentation.

Table 6 Trust wide Inpatient deaths in 2025/26 by date reported

Care Group	Service	Ward	Financial quarter - date reported				Total
			2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4	
Mental Health Care Group (Inpatient)	Older People Inpatient	Beechdale	2	0	1	1	4
		Crofton	1	0	0	1	2
		Poplars	1	1	2	1	5
		Ward 19	1	0	1	0	2
		Willow	0	0	1	0	1
	Adult Acute Inpatient	Beamshaw	0	1	0	0	1
		Elmdale	0	1	1	1	3
		Nostell	0	1	1	0	2
Forensic Care Group including Cheswold Park Hospital	Low Secure Inpatient	Thornhill Ward	0	0	1	0	1
		Esk Ward	1	0	0	0	1
Barnsley Physical Health and Wellbeing	General Community Inpatient	Neuro Rehab Unit	0	2	0	0	2
Total			**6**	**6**	**8**	**4**	**24**

The inpatient deaths reported in Table 6 include those occurring in the community where death took place within 30 days of discharge from inpatient care. The dataset has been refreshed to include activity from 1 April 2025 to ensure completeness and accuracy of reporting.

3.3.1 Inpatient apparent suicides

During 2025/26, there have been four inpatient apparent suicides: two occurring on the ward, one whilst on agreed leave, and one in the days following discharge. All investigations remain ongoing, including one independently commissioned Patient Safety Incident Investigation (PSII). In addition, the Trust has commissioned an independent review of the women's care pathway, due to conclude in July 2026. The findings from this review, alongside the ongoing investigations, will further inform targeted improvement activity.

The Suicide Prevention Lead is also undertaking a retrospective review of inpatient apparent suicides between April 2023 and March 2025. The aim of this review is to undertake detailed analysis of themes and patterns across these deaths, including for patients who were on the ward, on agreed leave, absent without leave, or within 30 days of discharge. This analysis is intended to strengthen organisational learning, inform service improvement, and support actions to prevent future loss of life.

4. Wider Patient Safety and Learning System Updates

The following section provides an overview of broader patient safety developments and system improvements.

- The review of the Patient Safety Incident Response Framework (PSIRF) plan, policy and procedures is nearing completion. The final version of the PSIRF Plan is scheduled for review by the Quality and Safety Committee in July 2026. Updated procedures and flowcharts will be published on the Trust's patient safety webpages, alongside clarified governance and sign-off arrangements, to ensure that learning is consistently captured, reviewed and shared. The review has also introduced practical flowcharts to support the selection of the most appropriate PSIRF response. These include alignment with Learning from Deaths requirements, supporting decision-making where there is a need to determine whether a death may have resulted from problems in care.
- All reported deaths, irrespective of cause or severity, continue to undergo review by Patient Safety Specialists. Findings are systematically escalated through the Trust's Patient Safety Oversight Group (PSOG) and mortality governance meetings, ensuring robust oversight and organisational learning.
- Separate reports on the Suicide Prevention Strategy and the thematic review of apparent suicides have been presented to the Quality and Safety Committee, providing focused assurance and oversight in these priority areas.

5. Next Steps

The following section outlines the key actions and developments planned to further strengthen the Trust's approach to mortality review, learning, and patient safety.

- A review of the Structured Judgement Review (SJR) template is underway to ensure full alignment with the updated national template requirements.
- The Datix 'Death of a Service User' questionnaire has been enhanced to align with regional reporting requirements, supporting near real-time suicide surveillance and improved system-wide intelligence.
- Work is in progress to strengthen the organisation's understanding of the needs and care pathways for individuals with co-existing drug and alcohol use disorders who have died, to inform targeted improvement actions.
- The SJR process is being further developed, including a review of training provision, the allocation process for SJRs, and opportunities for medical investigators to undertake or support reviews to enhance clinical input and consistency.
- Mortality governance arrangements have been strengthened, with the re-establishment of monthly mortality review meetings and a quarterly forum focused on thematic learning. These forums include Care Group representation and provide oversight of both local and national learning.
- Mechanisms for sharing learning are being reinforced through the Improvement and Learning Group, supporting thematic analysis of deaths and enabling the organisation to better use mortality data to identify trends and inform improvement priorities.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 11.3

Private/Public paper:	**Public**
Title:	**Patient Experience (including complaints) Annual Report 2025/26.**
Lead Director:	**Dr Caroline Johnson, Chief Nurse and Director of Quality and Professions**
Mission/values:	The report demonstrates commitment to all the Trust's values, which are fundamental to delivering safe and high-quality health care: • We put the person first and in the centre • We know that families and carers matter • We are respectful, honest, open and transparent • We improve and aim to be outstanding • We are relevant today and ready for tomorrow
Purpose:	The purpose of the paper is to present the Patient Experience (including complaints) Annual Report for 2025/26. This annual report includes customer services (complaints, compliments, concerns and comments), friends and family test and service line patient experience survey information.
Strategic aims:	Live Our Values ✓ Be the best we can be: • Best quality ✓ • Best partner ✓ • Best value ✓ • Best place to work and learn ✓ Be ambitious ✓
BAF Risk(s):	The patient experience annual report 2025/26 supports a number of BAF risks, including:

1.1	Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience.
1.2	Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.
2.2	The increasing demand for actionable analysis based on robust information systems and staff/patient voice means there is insufficient high-quality management and clinical information to meet all of our strategic objectives.
2.3	Failure to create a learning environment leads to lack of innovation and to repeat incidents.

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Each provider Trust within the ICS is governed by regulatory bodies. It is important that regulatory activity is monitored, learning is taken from feedback, and action is taken to remedy any findings. Understanding the quality of care and the feedback from the people who use our services, their families and carers is integral to enabling our services to grow and develop. It supports collaborative working across our partnerships and our contribution to system wide discussions and developments in a meaningful way.
Any background papers / previously considered by:	Patient Experience highlight reports are shared with Quality and Safety Committee and Executive Management Team on a quarterly basis. This annual report was presented to Quality and Safety Committee on 9 June 2026.
Executive summary:	The Patient Experience annual report brings together information, data intelligence and learning from customer services (complaints, compliments, concerns and comments), friends and family test and patient experience surveys. Good patient experience is associated with improved clinical outcomes and contributes to patients having control over their own health. The patient experience headlines for 2025/26 are as follows: • The Trust received 11,880 pieces of feedback (customer services, friends and family test and patient experience surveys). • There has been an increase in formal complaints, increasing from 144 in 2024/25 to 212 in 2025/26. • 92% of complaints were resolved within the six-month timeframe. This is an improvement from 82% in the previous year. Of these 50% were closed within three months. • There has been a decrease in the number of reopened complaints. • There were 9109 friends and family test responses sent during the year. This is a 6% increase on the previous year. • Trust wide satisfaction rates have increased to 97%, from 94% in 2024/25. • There has been a small decrease in satisfaction for community services (96%-94%) and mental health services (92%-91%). • 652 patients and carers provided feedback using the service line patient experience surveys. • Satisfaction rates increase in areas including feeling safe and being treated with dignity and respect. • Satisfaction rates declined in areas including feeling involved in care, carer involvement and feeling listened to. Themes, both positive and negative, across patient experience, are largely consistent with previous years, and it is the specifics from these themes that supports improvement of quality, safety and culture within individual services and teams. However, there has been a notable decline in complaints related to values and behaviours (staff) during 2025/26.

	The main positive themes from the feedback related to staff, communication, admission and discharge and access and waiting times. The main negative themes from the feedback relate to access and waiting times, staff, communication and clinical treatment. Feedback was received from 2,015 service users, 406 carers and 103 parents. The majority of feedback is received from working age adults (65%), with 35% being from people over 60. This is an improvement on the previous year in terms of older adults providing feedback. 65% of feedback received is people who are female, and 35% from males. 74% of feedback is from people of a white English/Welsh/Scottish/northern Irish background, with 18% white and Asian and 2.3% from Asian/Asian British people. Volunteers continue to work within both customer services and patient experience teams, and these roles are supporting the collection of feedback. The report also sets out action and development plans for the next 12 months including: • Strengthening triangulation and embedding of learning from feedback. • Enhancing the quality of complaint investigations. • Expanding the use of data and dashboards, in line with making data count. • Embedding the Experience of Care Framework across all services. • Embedding NICE Quality Standards for support patient feedback. In addition, the patient experience agenda will continue to support the implementation of the patient and carer race equality framework (PCREF) and the triangle of care workstreams, enable feedback into priority programmes of work and support the quality assurance system in providing quality oversight and quality improvement.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the Patient Experience Annual report 2025/26.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Patient Experience Annual Report 2025/26

With **all of us** in mind.

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1. Introduction

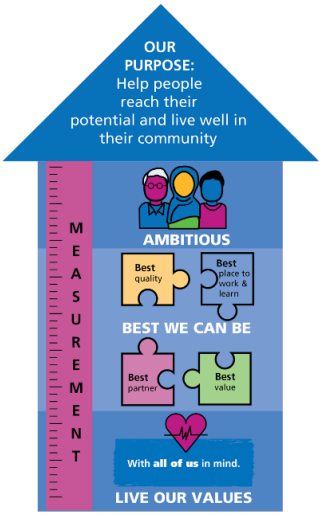
1.1. What is patient experience?

Patient experience is recognised as a key indicator of quality in healthcare provision and is closely aligned with the other two core components of quality: clinical effectiveness and patient safety. A positive patient experience is associated with improved clinical outcomes and supports individuals to have greater control over their own health and care. It is also recognised that positive staff experience is fundamental to delivering consistently high-quality patient experience.

The measurement of patient experience feedback is used to identify strengths and weaknesses in healthcare delivery, inform commissioning decisions, drive quality improvement, and promote patient choice. For the purposes of this report, the term *patient* is used to encompass *service user*, which is more commonly adopted in other Trust documentation.



Across the Trust live our values and are working towards achieving our priorities which are visualised in the image below.



Patient experience is a central element of all the work undertaken across the Trust, ensuring that care is person-centred and that the voices of families and carers are heard. Understanding the experiences of patients, their families, and carers enables the Trust to identify opportunities for improvement as it continues to progress towards being an outstanding organisation and delivering outstanding care and outcomes.

1.2. Gathering patient experience

Patient experience is captured across the Trust through a range of methods, and this report presents the information, themes, and outputs generated from these approaches. The data gathered is triangulated to provide an overarching view of the experiences of patients, their families, and carers, and to demonstrate how this intelligence has been used to drive improvements in the quality of care.

This report will cover the following:

- Customer services contact, including complaints, concerns and compliments.
- Friends and family test results.
- Patient experience surveys.

2. Patient experience as a pillar of quality

The National Quality Board's (NQB) single view of quality and the delivery of high-quality, personalised, and equitable care for all is defined in the infographic below:



Experience can be understood in the following ways:

- What the person experiences when they receive care or treatment
    - The interactions between the person receiving care and the person providing the care, e.g. how the person providing care communicates with the person receiving care
    - The process the person is involved in, such as booking an appointment
- How the person's interaction with a staff member, care provision, or services made them feel

There are three key areas an organisation should consider when planning for improvement:

1. Co-production
2. Using insight and feedback
3. Improving experience of care at the core of priority programmes of work

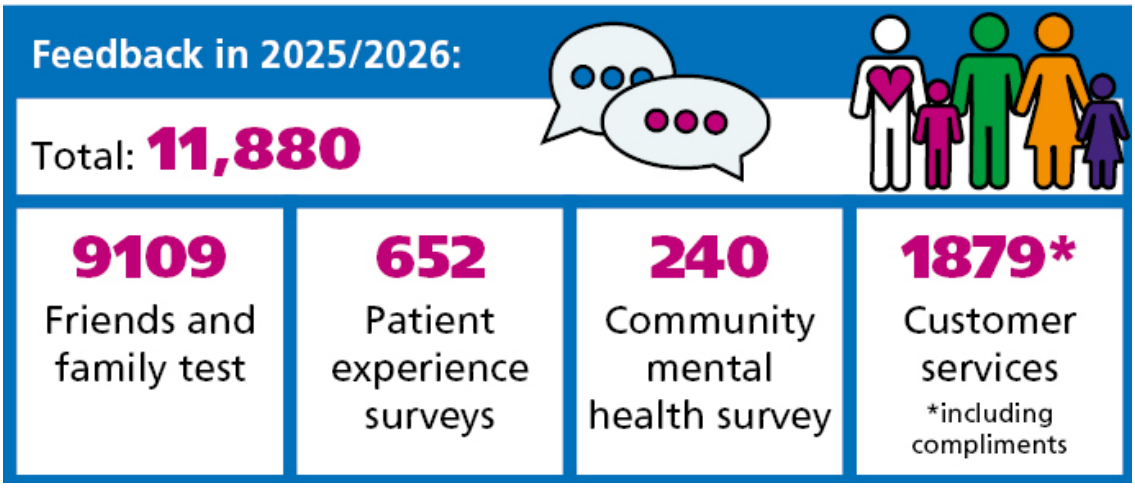
In line with strategic aim two, in our Trust Strategy 2024-2030, patient experience feedback is vital to supporting progress in being the best we can be.

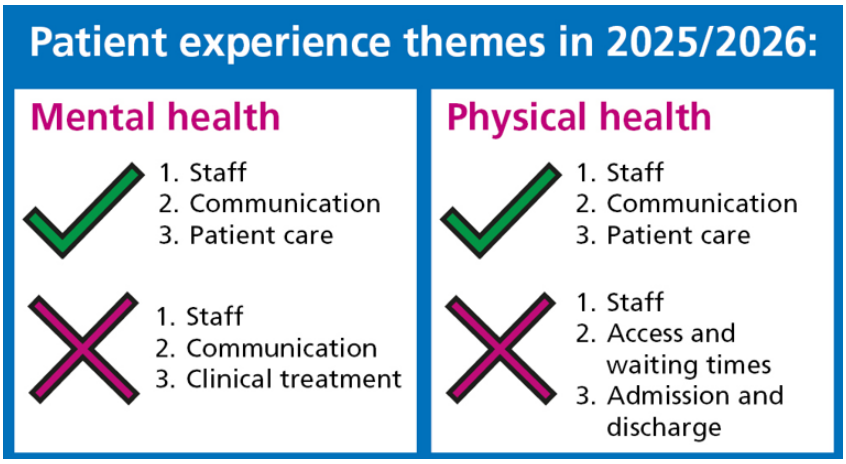
Strategic aim two: We will be the best we can be



3. Key facts and findings

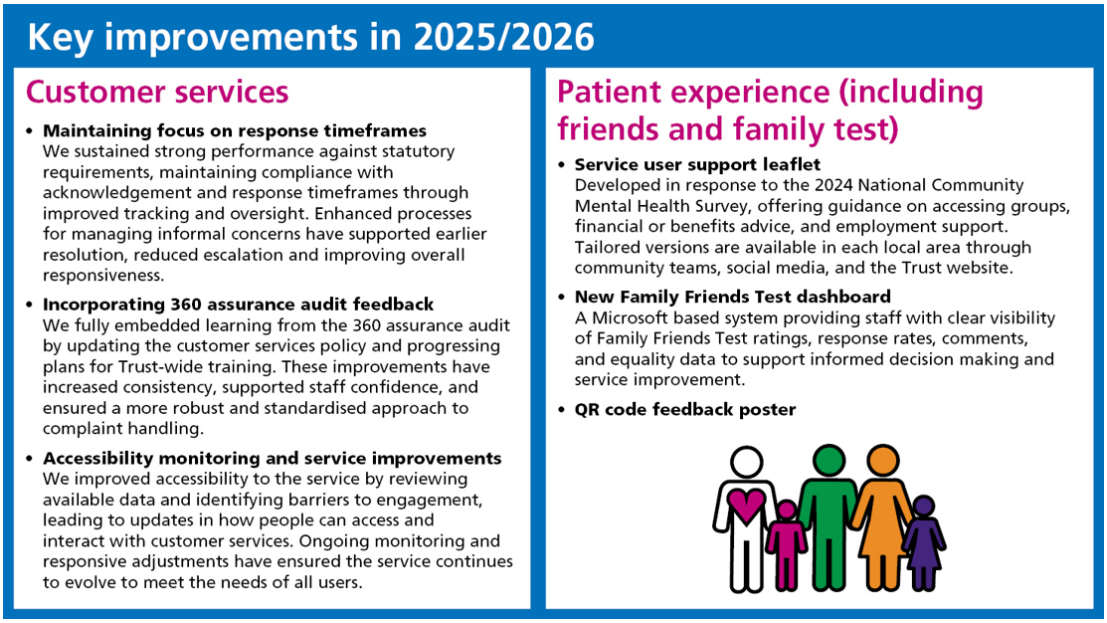
3.1. Overview of feedback received





The patient experience themes above combine customer services, friends and family test and patient experience survey information. The themes are predominantly the same regardless of how feedback is collected.

3.2. Key improvements made in 2025/26



3.3. Who gave us feedback in 2025/26

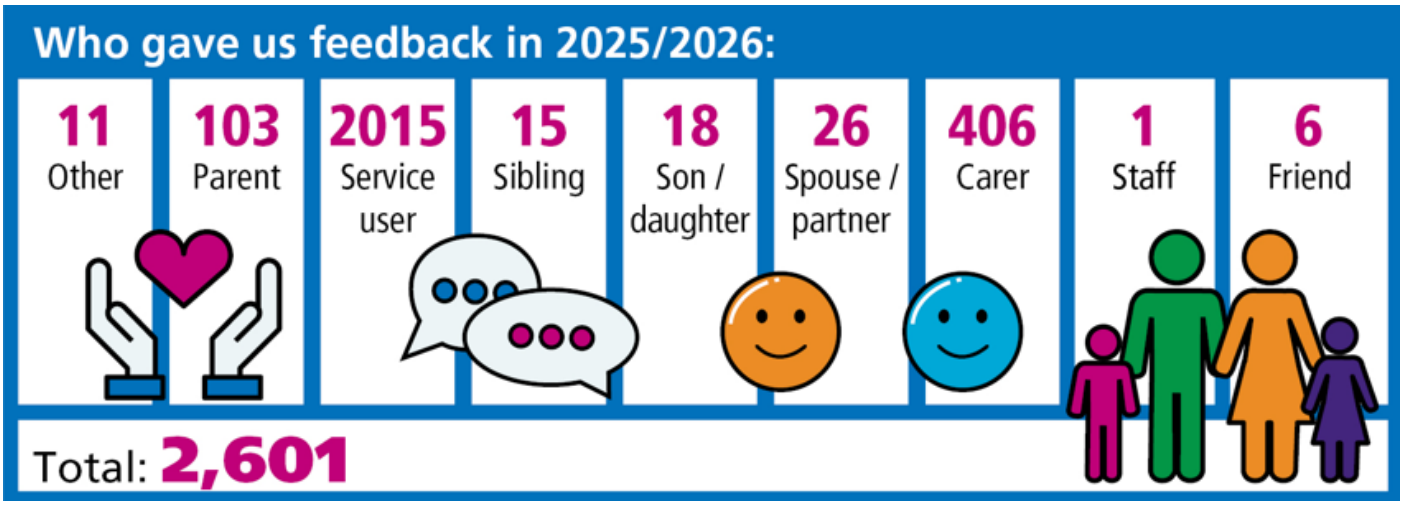
The information below is related to customer services, patient experience surveys and friends and family test and is detailed within the relevant sections. Not all respondents during 2025/26 provided equality data, therefore the figures below are lower than the overall number of returns for patient experience.

During 2025/26 (of those who provided the information) 71% of the feedback received came directly from patients (service users) themselves, with 17% from a carer/relative or friend and 9% from a parent.

The equality data for ALL feedback is contained within Appendix 2.

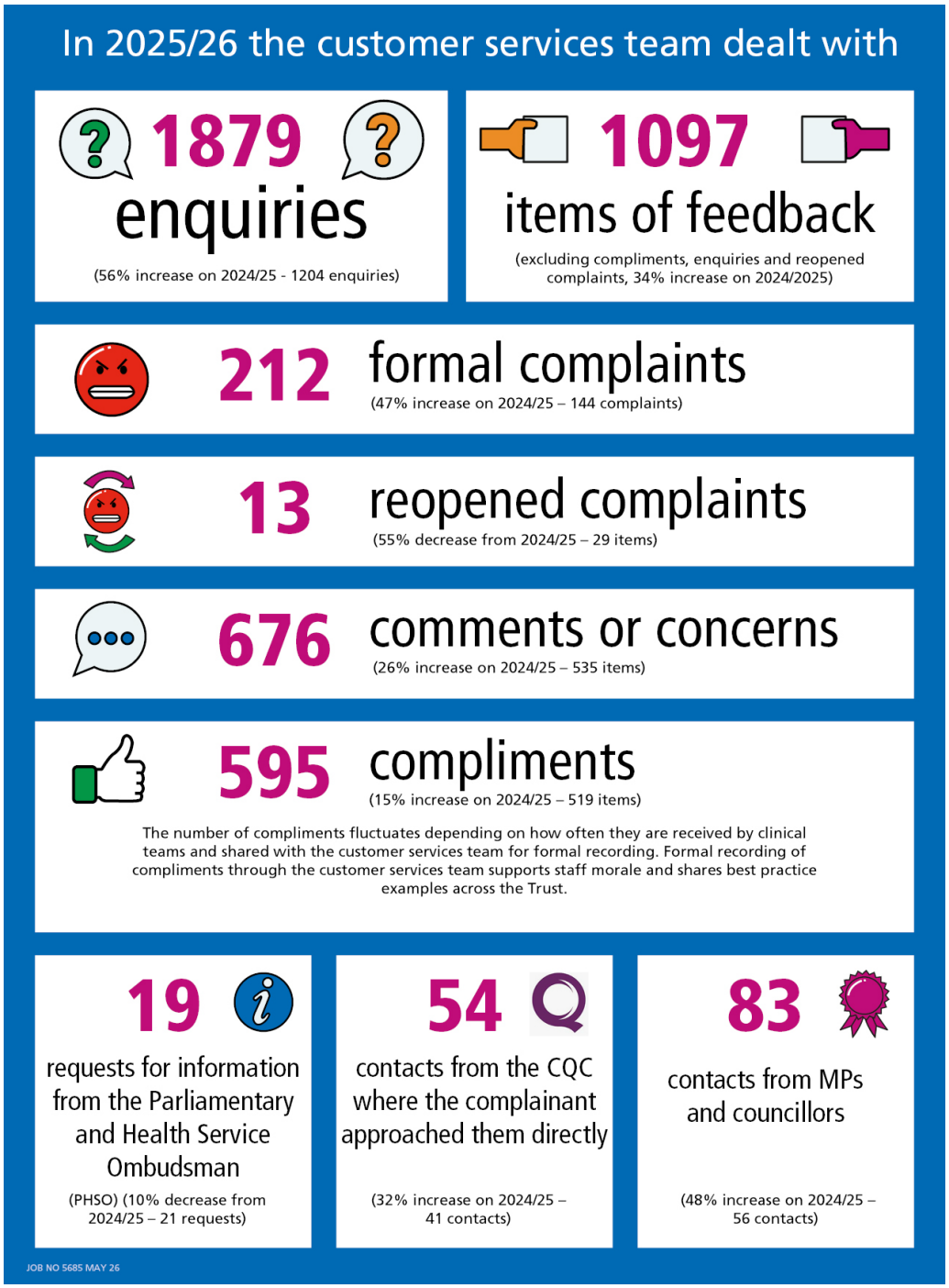
The data suggests that feedback is received from a wide range of people who access Trust services. The majority of feedback is received from working age adults (65%), with 35% being from people over 60. This is an improvement on the previous year in terms of older adults providing feedback.

65% of feedback received is people who are female, and 35% from males. 74% of feedback is from people of a white English/Welsh/Scottish/northern Irish background, with 18% white and Asian and 2.3% from Asian/Asian British people.



Development in enhancing data collection and using it to help drive improvements will form part of the Patient and Carer Race Equality Framework (PCREF).

4. Customer Services



4.1. Overview

Trust Board monitors complaints via the integrated performance report (IPR). The quality and safety committee (QSC) and executive management team (EMT) also receive assurance reports regarding customer service key performance indicators and quarterly reports are shared with the West Yorkshire Integrated Care Board (ICB) as part of the Trust contract.

This report includes the annual data related to complaints, in line with the Trust's aim to learn from concerns/complaints raised, improve patient experience, and ensure Trust Board oversight of the compliance against our registration with the Care Quality Commission (CQC) in relation to complaints management. This includes:

- The monitoring arrangements for complaints handing in the Trust.
- Trends in complaints themes; and
- The Parliamentary and Health Service Ombudsman (PHSO) status

Themes from feedback are used to support quality improvement across our services and enable patient, carer, and staff experience to be captured within the work we do and the care we provide every day.

The customer services team deals with the following types of feedback:

Enquiries	When an individual is seeking information and does not wish to raise a concern about their treatment. This can also include signposting to other organisations.
Comments	A comment is a matter that is not about an individual's care and treatment. It is something that is a cause for concern to the person, e.g., they may be unhappy with parking arrangements at the service, or someone leaving lights on when a building is empty.
Compliments	Positive feedback received regarding care, generally from service users, their relatives and/or carers. Compliments are also sometimes received from other health care professionals, services or external partners.
Informal concerns	A concern is a matter which an individual wishes to be considered on an informal basis. This can be done by the complainant directly with the service and should be resolved to the individual's satisfaction within two working days (in line with NHS complaint regulations). All staff are expected, on a routine and daily basis, to deal with patient concerns as presented to them. Wherever possible, staff are encouraged to achieve speedy resolution of the concern by either resolving it personally or establishing a dialogue between the complainant and the relevant personnel within operational/clinical areas, allowing for timely and informal resolution of the concern.
Formal complaints	An expression of dissatisfaction with care, services or facilities provided by the Trust, where any of the following apply: • Action or activity by the Trust or someone working for the Trust has detrimentally affected the experience of the service user or carer. • The complainant believes that a mistake or error occurred and that this has detrimentally affected them. • The complainant brings to the attention of the Trust an issue about a Trust service which could detrimentally affect them or someone else which

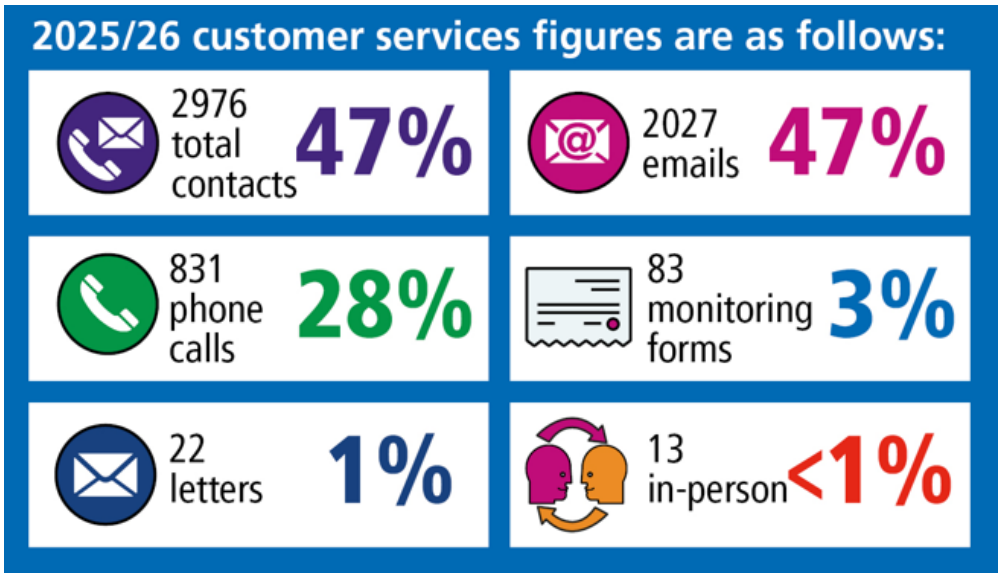
they expect the Trust to put right.

During 2025/26 the customer services team:

- Dealt with 1,879 enquiries regarding information about the services we provide, the complaints process and signposting to other organisations.
- Received 1,097 items of feedback, which consisted of formal complaints, informal concerns, and comments, and breaks down as follows:
    - 421 were formal complaints, which is a 48% increase from the previous year (285 in 2024/25). Of these:
        - 212 (of the 421) (50%) are proceeding as formal complaints (these are complaints where consent has been received from the complainant and the scope of the investigation agreed to enable an investigation to begin i.e. timescales start). This compares with 144 (47% increase) from the previous year.
        - 21 (of the 421) (5%) are awaiting consent to be returned at the time of writing.
        - 15 (of the 421) (4%) are waiting for their complaint be allocated to a complaint handler, at the time of writing. This figure fluctuates week on week depending on demand on the Customer Services team at the time. It is uncommon for this number to be greater than 10.
        - 15 (of the 421) (4%) are agreeing the scope of investigation with their complaint handler.
        - 158 (of the 421) (38%) formal complaints raised during the year, did not proceed to investigation, either through the complainant not returning valid consent, inability to agree a scope for the complaint or no further contact being received from the individual.

4.2. Recording feedback – a summary

Feedback is received into the customer services team by email, letter, by a staff member, online form from the website, monitoring form (from the customer services leaflet), or by a phone call.



Effective signposting and the provision of timely, appropriate responses to both the public and staff are fundamental components of the customer services function. In undertaking this role, the team manages a diverse range of enquiries from multiple sources. These enquiries vary from straightforward service-related queries to more complex matters that require detailed review and careful consideration prior to response. In some instances, initial contacts do not clearly articulate

the issue, or relate to services outside of the Trust's remit, necessitating further clarification and liaison to ensure appropriate direction and support.

A substantial proportion of enquiries are inherently complex and may involve sensitive subject matter, multiple organisations, or historical concerns. Such cases require a measured and considered approach, underpinned by clear and effective communication.

The administrative team plays a critical role in this process, consistently demonstrating professionalism, empathy, and diligence in information gathering and signposting. Their contribution is integral to ensuring that individuals feel acknowledged and supported throughout their engagement with the service. This supports the Trust's commitment to delivering a responsive, accessible, and compassionate service. By maintaining transparency and openness, the service demonstrates its commitment to listening and to ensuring that all individuals can access appropriate support. This approach reinforces that all concerns and enquiries are taken seriously and managed with due consideration.

Information relating to the number of comments and compliments received is also included later within this report.

Where appropriate, concerns are initially managed through an informal resolution process. This typically involves the relevant service or team reviewing the matter and, where suitable, making direct contact with the individual to discuss their concerns. As a result, a proportion of concerns are resolved at this stage and do not progress to the formal complaints process.

In circumstances where an individual requests formal handling from the outset, or where informal resolution has not been achieved, the matter is progressed in accordance with the Trust's formal complaints procedure. This report therefore includes data relating to both informally resolved feedback and complaints managed through the formal process. Complaint themes are analysed at a Trust-wide level and are also reported at individual service level.

All complaints received by the customer services team are subject to a risk assessment using the Trust's established risk matrix. This assessment is undertaken by the customer services manager and shared with relevant clinical services to ensure that any immediate risks are identified and appropriately managed. Complaints identified as complex or high risk are reviewed either through the monthly Complex Complaints Panel and/or escalated to the weekly Patient Safety Oversight Group (PSOG).

The PSOG is attended by the Executive Trio, comprising the Chief Operating Officer, Chief Nurse, Director of Quality and Professions, and the Chief Medical Officer. All complaints assessed as high risk (red) are presented at PSOG, providing assurance that actions relating to the most serious complaints are appropriately implemented and embedded within clinical services.

In addition, customer services convene a monthly Complex Complaints Panel to review cases that are particularly complex, involve multiple agencies, or include involvement from external bodies such as the Care Quality Commission (CQC) or the Parliamentary and Health Service Ombudsman (PHSO). Representatives from a range of professional disciplines are invited to contribute their expertise and provide guidance to support effective case management.

4.3. The customer services team

The customer services team comprises highly trained staff with specialist expertise in the management of NHS complaints. In addition to their technical knowledge, the team demonstrates strong interpersonal and communication skills, enabling them to effectively support individuals who

may be experiencing a wide range of emotional presentations linked to dissatisfaction with services. This includes engaging sensitively and professionally with people who are recently bereaved, those identified as high-risk service users, and individuals expressing distress or suicidal ideation. The team is experienced in managing complex and emotionally charged situations, ensuring that all concerns are handled with empathy, professionalism, and appropriate escalation where required.

Throughout 2025/26, the team has maintained a consistent and efficient flow of complaints and concerns through established processes, contributing to continued improvements in response times and overall service delivery. Further information and supporting data are provided later in this report.

4.4. Volunteer contribution and future role in service improvement

Over the past year, the customer services team has been supported by a dedicated volunteer whose primary focus has been to improve the accessibility and accuracy of customer service materials. The volunteer has undertaken a comprehensive review and update of customer service leaflets to reflect local changes to advocacy services, and has ensured their distribution, alongside supporting posters, across all service areas within the Trust. This work has contributed to improving the availability and relevance of information for service users and stakeholders. The volunteer has since successfully secured a Healthcare Assistant (HCA) role within the Trust.

Looking ahead, the team is welcoming two new volunteers who will undertake a key role in supporting the collection of feedback from a wide range of stakeholders. Their responsibilities will include the distribution of satisfaction surveys to complainants, staff involved in managing and responding to feedback, staff named within feedback, partner NHS organisations, local authorities, and advocacy services. This structured approach will support the collection of meaningful insights into how the customer services team engages with and supports stakeholders throughout the feedback process.

Analysis of the feedback received will enable the identification of areas for improvement, as well as the recognition of effective practice, thereby informing ongoing service development. The contribution of volunteers in this area will strengthen feedback mechanisms and support the Trust's commitment to continuous improvement and organisational learning.

In addition, volunteers will play a role in enhancing engagement with complainants and carers who express an interest in volunteering opportunities. This includes supporting involvement in care groups, Trust focus groups, and wider service improvement initiatives across the organisation. Volunteers make a valued contribution to the delivery and development of the customer services function.

Our volunteers play a valuable role in supporting our commitment to enhancing the quality of our service and we are grateful for their time, dedication and commitment.

4.5. Managing complex complaints

Complaints are often complex and longstanding in nature. Complainants' expectations of what can be achieved through the complaints process may be unachievable and individuals often require support to understand the potential outcomes available through the complaint's procedure.

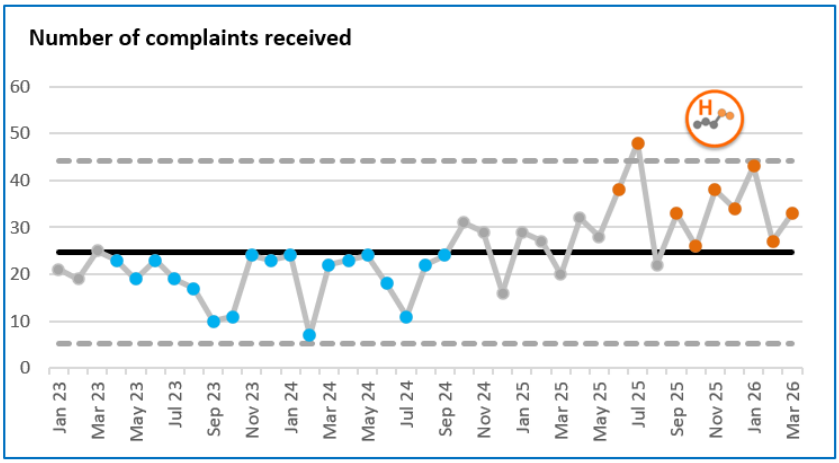
Alongside a noticeable rise in complaints which have been generated using artificial intelligence (AI), there are a higher proportion of complex cases and more frequent contact from individuals who remain dissatisfied. This dissatisfaction may relate to our processes, disagreement with how

their complaint has been defined, the outcome provided, or the limits of what further resolution we are able to offer. In addition, there has been a growing demand from Trust services for our support in managing particularly challenging interactions with members of the public and service users. This combination is contributing to increased pressure on the team and highlights the need for continued focus on how we respond effectively, consistently, and with appropriate support for both staff and complainants.

In addition, there are a small number of people where the frequency of their contact with the customer services team, or their individual behaviour, hinders consideration of their own and/or other people's complaints. This is defined as persistent or unreasonable behaviour. A section in the: *Customer services policy: supporting the management of complaints, concerns, comments and compliments (September 2023)* supports the customer services team and the Trust in supporting individuals who are defined in this way. This includes letters which have been developed to explain the process to the person. These letters have been reviewed through a trauma informed lens and by a person with lived experience.

4.6. Formal complaints

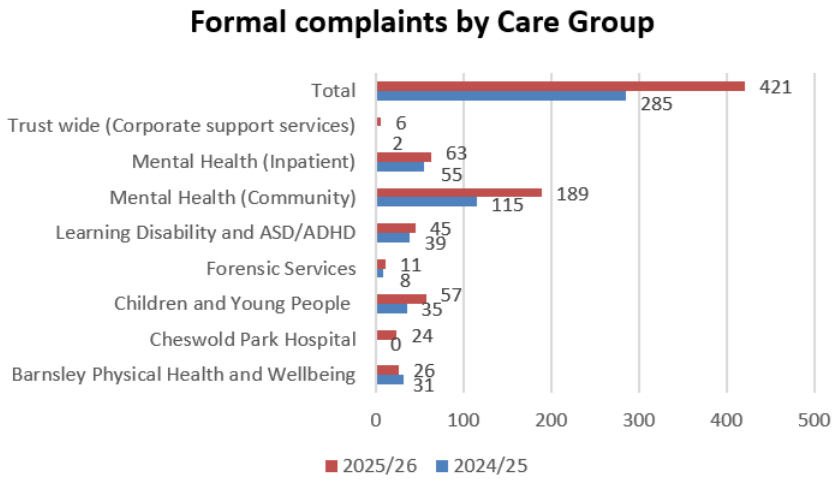
Trends in the number of complaints received each month



Statistical Process Control (SPC) charts are time-series graphs used to monitor process performance, identify trends, and distinguish between normal variation (common cause) and unusual variation (special cause).

The above SPC chart shows the monthly number of complaints received from January 2023 to March 2026. The number of complaints received each month is also reported in the Trust's publicly available integrated performance report (IPR).

The SPC chart demonstrates that between June 2025 and March 2026 the Trust received a statistically significant increase in the number of complaints, with a record high of 48 in July 2025. These complaints are broken down further below.



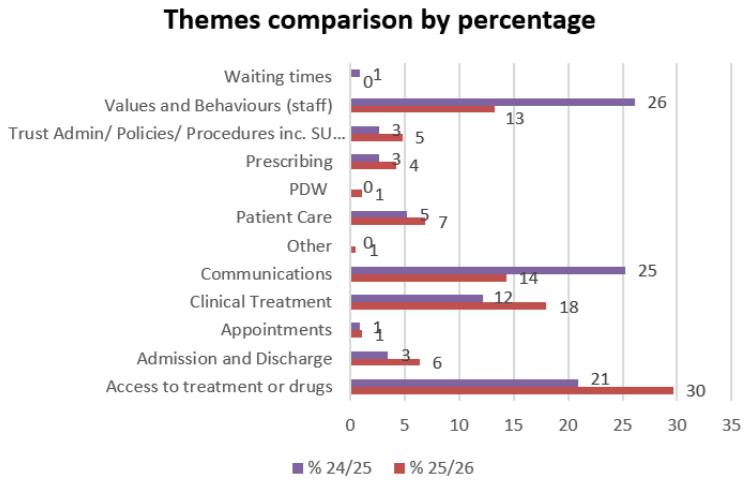
The bar chart above shows a comparison for the total number of formal complaints received by each Care Group across the Trust in 2024/25 and 2025/26. The graph demonstrates that there has been a 48% increase in complaints received in 2025/26 compared to 2024/25. This includes 24 complaints for Cheswold Park Hospital, which have been managed for the first time by the Trust Customer Services team during 2025/26.

In 2025/26 the following has been noted:

- adults and older peoples' services (OPS) mental health (community) service line received the highest number of complaints (n=189) which is consistent with the previous year, and this service have experienced an increase of 74 complaints from the previous year. This is explored further below.
- adults and OPS inpatient services (n=63) received the second highest number of complaints, which is also consistent with previous years.
- There has been a rise of 63% for complaints for children and young people services when compared with the previous year (35 in 2024/25, increasing to 57 in 2025/26). Further detail is shared below.

In October 2025, a report from Healthwatch noted that written complaints reached a record high in 2025. Over the last decade, the number of written complaints the NHS receives has increased by 24%, from 207,407 complaints recorded in 2014-15. The majority of NHS recorded complaints are for General Practice and dental services.

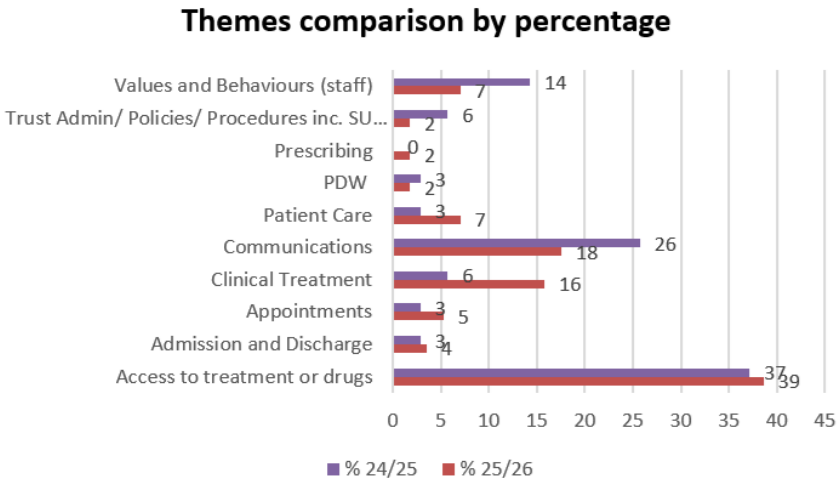
Mental health care group adults and OPS (community)



Analysis of the percentage increase in complaints by theme for mental health care group adults and OPS (community) demonstrates the following:

- A 9% increase between 2024/25 and 2025/26 for access to treatment or drugs with 95% of these being about access to secondary mental health services.
- A 6% increase in complaints about clinical treatment in 2025/26. 44% of these were related to inappropriate treatment and 15% were about dispute over diagnosis and incorrect diagnosis respectively.
- A significant decrease in complaints about values and behaviours (staff) (13%) and communications (11%).

Children and young people services



Analysis of the increase in complaints by theme for children and young people's services demonstrates the following:

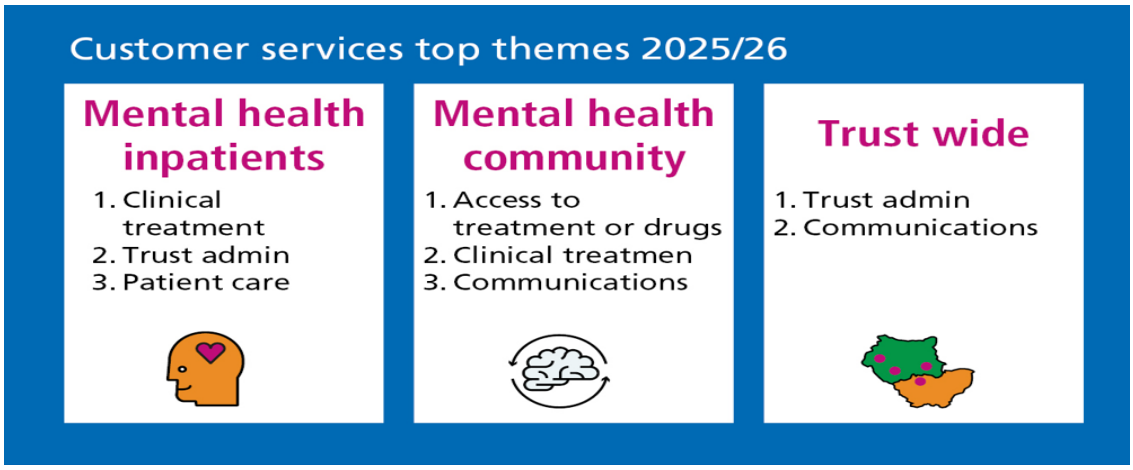
- a 10% increase in complaints about clinical treatment in 2025/26. However, the number (n=9) is low and there is not a meaningful pattern with a number of sub-categories relating to clinical treatment.
- an 8% decrease in complaints about communications
- a 7% decrease in complaints about values and behaviours (staff).
- Complaints about access to treatment or drugs is relatively stable in terms of percentage and remains the most common theme, although there has been an increase in number from 13 in 2024/25 to 22 in 2025/26. Access to treatment or drugs includes access to services and 91% of complaints are about access with a common issue being around children and young people not meeting the criteria for support from specialist tier three services.

Most of the complaints received (98%) for the Learning Disability and ASD/ADHD services related to autistic spectrum disorder and attention deficit hyperactivity disorder (ASD/ADHD) services (n=44), which is a 33% increase from 2024/25. There was a 14% increase in complaints about clinical treatment. This incorporates disagreements over how the assessment was carried out and the outcome. There has been a 6% increase in complaints about Trust administration, which includes alleged inaccuracies and information contained in health records.

As a result of this feedback, the customer services team continue to support ASD/ADHD services by providing further information to complainants to understand the outcomes that the complaint process can provide. For example, service users have the right to request a second opinion which follows Trust policy to determine if this is clinically appropriate.

Whilst the graph demonstrates the spread of complaints across different Care Groups and service lines, it is important to note that these areas are not comparable, due to differing service user groups and the numbers of people who are supported by each service. The opportunity for learning and improvement does not always equate to the Care Groups with the most complaints.

4.9. Themes from complaints



Complaints typically contain multiple themes/issues and in 2025/26, the primary subject of each complaint was themed into 17 categories. The themes are the primary reason the person is complaining and do not reflect the findings from our investigation. Therefore, the themes do not demonstrate an actual failing or proven issue, although they do reflect the complainant's perception.

The themes for complaints are based on NHS Digital's categorisation, and many different sub-categories sit within each overarching theme. Further information can be found here.

- Access to treatment or drugs (n=94, 22%) is the top primary subject for complaints in 2025/26. This includes sub-categories such as funding of medication, length of waiting list, service not available and service provision. In 2024/25 the most common subject was communications.
- Clinical treatment was the second most common theme for complaints in 2025/26 (n=83, 20%) This includes sub-categories such as delay or failure in treatment for infection, delay or failure to monitor wound, dispute over diagnosis and failure to follow up on observations/recognise deteriorating patient. In 2024/25 the second most common theme was values and behaviours (staff).
- Communications was the third most common theme (n=59, 14%) for complaints. This theme includes communication failure between departments, communication with patient, communication with relatives/carers, inadequate record keeping, method/style of communications. In 2024/25 the third most common theme was access to treatment or drugs.

Breakdown of complaints by theme:

Primary subject	Number	%
Access to treatment or drugs	94	22%
Admission and Discharge	21	5%
Appointments	9	2%
Clinical Treatment	83	20%

Commissioning	1	0
Communications	59	14%
Consent	1	0
Facilities	4	1%
Other	10	2%
Patient Care	39	9%
Privacy, dignity, wishes (PDW)	4	1%
Prescribing	12	3%
Restraint	1	0
Staff Numbers	1	0
Trust Admin/ Policies/ Procedures inc. SU records	32	8%
Values and Behaviours (staff)	48	11%
Waiting Times	2	0
Total	421	100%

Throughout 2025/26, the Customer Services team has continued to play a central role in supporting Care Groups to monitor, review, and embed learning from complaints and feedback. Our approach is focused on ensuring that concerns raised by service users and their representatives are not only addressed individually but are used to inform continuous improvement at every level of care delivery.

Themes and learning identified through complaints are routinely shared with Care Group clinical governance meetings, where they inform local improvement plans and contribute to wider Trust priorities. This includes alignment with Trust-wide initiatives such as the Care planning and risk assessment improvement group and the accessible information standards programme. Feedback from complaints has also been instrumental in shaping the review of the Trust's discharge and transfer of care policy, highlighting the importance of joined-up learning across multiple service areas.

During this period, we strengthened our support for Care Groups by focusing on how learning is cascaded and implemented at the team, service, and directorate level. This work is designed to help ensure that identified learning is not only acknowledged but acted upon, improving the experience of future and existing service users; their families and carers and supporting safer, more responsive care.

To achieve this, each Care Group has been assigned a named member of the customer services team. These complaint handlers provide tailored, ongoing support, including monthly feedback reports outlining trends, themes, and the status of all open and recently closed complaints. This closer collaboration enables Care Groups to have timely oversight and to take ownership of actions required.

4.7. Responding in a timely manner

In line with the NHS Complaints (England) Regulations (2009) and the Trust's customer service standard, all complaints are expected to be acknowledged within three working days and a formal written response provided, and the complaint closed within six months of receipt.

4.7.1. Acknowledgement within three working days

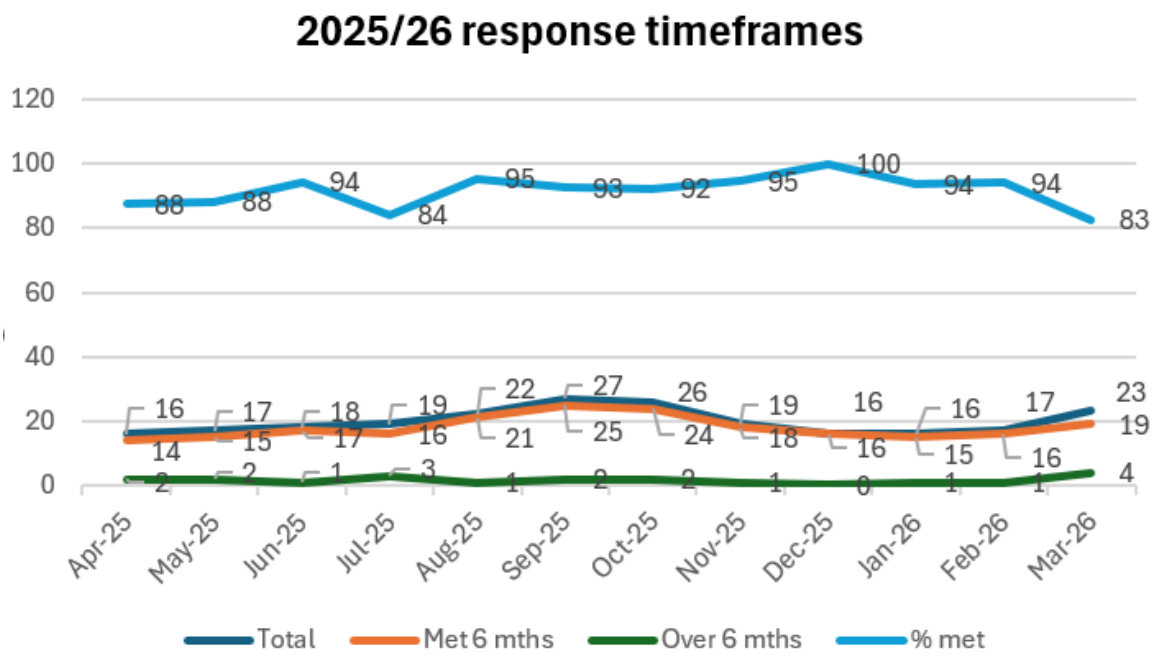
- During 2025/26, 96% (n=405) of the 421 formal complaints received met this target which is a reduction from 99% in the previous year.

- Of the 16 complaints (4%) that missed the target, all were due to human factors and human error. Human errors are always addressed with the individual and where appropriate, the wider team to ensure learning and improvement occurs.

Timescales for responding to a complaint are negotiated on an individual basis (but remain within regulatory requirements), with each complainant offered regular updates on the progress of their complaint until the issues are resolved to their satisfaction or a full explanation has been provided. A complaint investigation should be proportionate to the concerns raised. The target for when a complainant can expect to receive a formal response is agreed between the customer services officer and the complainant.

All complaints are dealt with as quickly as possible. Directors of services and general managers across services are kept updated on the progress of complaint investigations. The customer services team works with individual services to support the identification of lead investigators who have capacity and dedicated time for conducting the investigations. A partnership model has been implemented where each investigator is supported by a dedicated customer services officer, improving oversight and timeliness.

4.7.2. Responding and closing complaints within six months



During 2025/26:

- 236 formal complaints were closed. This is an increase from 168 in the previous year.

Of these:

- 118 (50%) of complaints were closed within three months
- 98 (42%) were closed between four and six months
- 20 (8%) exceeded the six-month target
- This reflects that 92% of formal complaints were closed within six-months, which is an increase from 82% across the previous year.

These improvements reflect the continued prioritisation of timely allocation and investigation of complaints following the elimination of the waiting list in October 2023. However, sustaining this performance remains challenging due to an increase in both the volume and complexity of complaints received. It is not uncommon for complaints to include an agreed scope of more than

30 individual questions or concerns requiring investigation and response. Complaints comprising more than 10 questions are classified as complex.

Enhanced performance is also attributable to effective collaboration between the customer services team, Care Groups, and Directors responsible for oversight and complaint sign-off.

Despite this progress, there are occasions where delays in responding to complaints occur. These delays are often due to a range of factors, including:

- Delays in obtaining valid consent to enable the investigation to proceed
- Time required to agree the scope of the investigation with the complainant
- Availability of an appropriate lead investigator within the relevant Care Group
- Timely completion of the complaint investigation toolkit
- The progression of complaints through the various stages of the quality assurance process

Further detail about complaint responses timeframes by Care Group can be found in Appendix 1.

4.8. Reopened complaints

During 2025/26, a total of 13 formal complaints were reopened (reactivated) following the completion of the initial investigation and the issuing of an outcome letter to the complainant. This represents 6% (13 out of 236) of all formal complaints closed during the year, which is a notable decrease compared to the previous year, where 17% (29 out of 168) of complaints were reopened.

The Trust continues to receive correspondence from complainants who remain dissatisfied following receipt of a final response. Not all such cases are reopened; a further review of the outstanding concerns is undertaken by both clinical services and the customer services team. Where this review concludes that all aspects of the complaint have been appropriately investigated and addressed, and that no additional meaningful information can be provided, a closure letter is issued. This letter confirms that local resolution has been exhausted and signposts the complainant to the Parliamentary and Health Service Ombudsman (PHSO) as the next stage.

These cases are not recorded as reopened complaints, as no further investigation is undertaken. Closure letters are issued following careful review by clinical and customer services to establish if there is anything further the Trust can meaningfully add to our original complaint response.

There is a notable increase in the complexity of outstanding issues which are raised by complainants, and these often involve multiple services, clinical decision making, or historical concerns. For example, following a detailed 27-page coordinated response to address an episode of care between 2024 and 2025, one complainant has responded with 26 outstanding concerns that they feel were not fully addressed. In addition, complainants' expectations continue to evolve, with some seeking more detailed explanations or assurances about actions taken in response to their concerns.

4.10. Learning from complaints

Themes emerging from patient, carer, and staff feedback are systematically reviewed and shared with Care Groups to support reflection, oversight, and continuous improvement. Where appropriate, targeted actions are implemented to address identified issues, ensuring that learning is effectively embedded across the organisation. This structured approach enables us to translate feedback into meaningful service enhancements and ensures that the lived experiences of patients, carers, and staff continue to shape both our strategic priorities and the delivery of day-to-day care.

During the reporting period, there has been a strengthened emphasis on collaborative working across teams and services throughout the Trust. We are increasingly aligning our approach to learning by working in partnership with colleagues across multiple functions, including information governance (IG), Quality Governance, Patient Safety, and Legal services. This collaborative model supports the sharing, monitoring, and implementation of learning from a wide range of sources, enabling a more joined-up and consistent approach to quality improvement.

A significant proportion of complainants seek a clear, transparent, and comprehensive explanation as the primary outcome of raising concerns. In response, all complainants receive a detailed and personalised reply that fully addresses the issues raised, alongside a sincere and formal apology acknowledging their experience and any identified shortcomings.

Key themes identified through complaints are triangulated with insights from other governance and assurance processes, further strengthening our ability to identify trends, reduce variation, and drive improvement. Many of these themes align closely with existing quality improvement initiatives, reinforcing a culture of continuous learning, openness, and service development across the organisation.

Several themes identified through complaints align with ongoing quality improvement initiatives, supporting a culture of continuous learning and service development.

We know that families and carers matter**:**

- Carers' needs should be actively explored, including offering formal carers' assessments where appropriate.
- Families should be appropriately involved in care planning, with clear boundaries where this supports recovery.
- Communication with relatives must be timely, documented, and sensitive to differing perspectives.
- Decisions impacting family relationships (e.g. visiting, placements) should be clearly explained and justified.
- Feedback from families should inform service learning and improvements in care planning.
- Staff should recognise the emotional impact on families and respond with empathy and clarity.

We are respectful, open, honest and transparent:

- Language used in records and communication should be respectful, clear, and not perceived as dismissive.
- When things go wrong, timely apologies and honest explanations should always be provided.
- Clinical decisions and their rationale must be clearly explained to service users and families.
- Documentation should accurately reflect discussions, decisions, and outcomes.
- Transparency in processes (e.g. safeguarding, medication, detention) helps build trust.
- Services should acknowledge uncertainty or gaps in records where these occur.

We improve and aim to be outstanding:

- Strengthening record-keeping through audits and training is a consistent priority.
- Learning from complaints should lead to measurable changes in practice (e.g. escalation, documentation).
- Staff reflection and supervision are key to improving communication and decision-making.
- Service reviews (e.g. referral pathways, waiting lists) should be used to identify system improvements.

- Training should continue to evolve, including areas such as trauma-informed care and neurodiversity.
- Continuous monitoring of processes ensures sustained improvement and accountability.

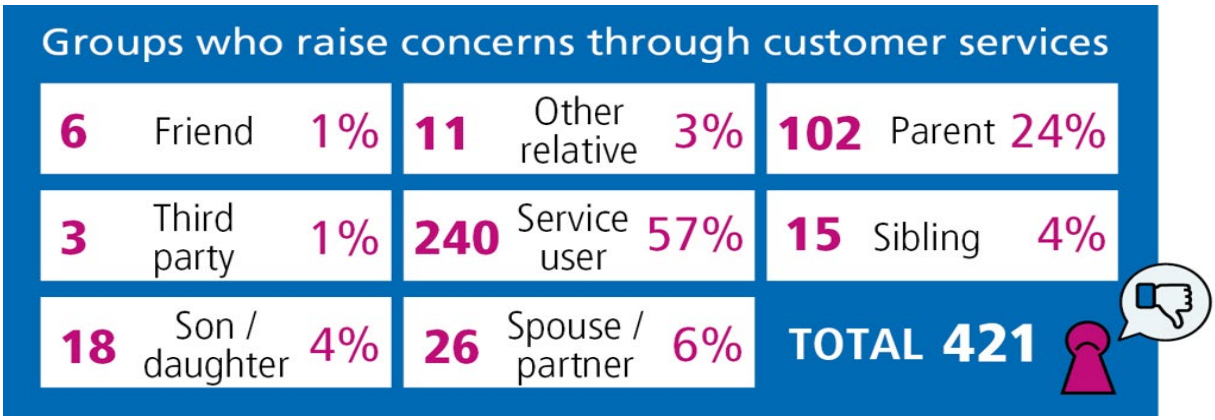
We put the person first and in the centre:

- Service users should be fully involved in decisions about their care, including discharge and treatment.
- Care should be tailored to individual readiness, circumstances, and risks.
- Cultural, spiritual, and personal needs must be considered in care planning.
- Communication should ensure service users understand their care pathways and options.
- Therapeutic approaches and materials should be appropriate to the individual's history and needs.
- Consistency in care decisions is important to avoid confusion and distress.

We are relevant today and ready for tomorrow:

- Services must adapt to increasing demand (e.g. ADHD assessments) while maintaining quality.
- Systems and processes (e.g. triage, waiting list management) should be regularly reviewed and updated.
- Improvements in communication methods and record systems are essential for modern care delivery.
- Learning reviews should inform future service design and patient pathways.
- Workforce development should reflect emerging needs, including specialist knowledge gaps.
- Forward planning should ensure services remain responsive, accessible, and sustainable.

4.11. Equality and protected characteristics – who's making complaints?



Equality data is crucial for understanding who accesses the formal complaints process and who might be using the process less. Equality data can also help the Trust to understand if people with protected characteristics feel unfairly treated within services or if there are themes from complaints which support improvements across the Trust and within specific services.

Equality data related to the complainant, when consent was provided and when the service user is not the complainant can be found in Appendix 2.

Analysis of the equality data does not indicate a disproportionate number of complaints from people with protected characteristics or for a reason related to a protected characteristic.

4.11.1. Develop a deeper understanding of equality data during 2026/27

Building on the foundations established in 2025/26, we will further strengthen our approach to understanding and addressing inequalities within the complaints process through more advanced analysis and targeted action. Our focus will be on using data more effectively to identify gaps in access, experience, and outcomes, and to implement measurable improvements.
In 2026/27, we will:

- Increase awareness of the value of equality and diversity data by embedding clear messaging within all feedback channels and communications.
- Enhance consent and data collection processes by simplifying forms and providing clearer, more accessible explanations to support informed participation.
- Further develop staff confidence and capability through targeted guidance and training on how to request and record sensitive information appropriately and compassionately.
- Review and refine all customer services communications to ensure they are inclusive, accessible, and actively encourage engagement from underrepresented and seldom-heard communities.
- Strengthen triangulation of equality data across complaints, incidents, and wider patient feedback to develop a more comprehensive understanding of the experiences of people from ethnic minority groups, those with protected characteristics, and marginalised communities.

Through continued collection, analysis, and use of this data, we will move beyond identification of themes to implementing targeted interventions, enabling us to reduce inequalities and ensure our services are responsive, inclusive, and equitable for all.

4.11.2. Complaints related to a protected characteristic

The following table outlines a small number of complaints received within the year which relate to a protected characteristic. This highlights how these complaints have been managed and the outcome for the complainant.

Protected characteristic	Issue	Resolution
Disability	Mother of service user unhappy with the assessment process used with her son, believing the process to be discriminatory against her son's disability.	We explained that we understood how distressing it can feel when a service cannot meet a child's needs, and that we are mindful of the importance of equitable access to care. We explained that we did not seek to deny any support based on disability but that at the current time the trust does not have a commissioned service for learning disability or an intellectual disability pathway. It was explained that there is current development of Barnsley's own leaning disability pathway and this will enable us to have a wider offer to meet the needs to children and young people with more complex neurodevelopmental presentations.
Race and religion	Service user is unhappy that they have been discharged from services and claims this is because of discrimination based on religion.	We apologised for the experience the service user had with the interpreter that the Trust had engaged to support them. The investigation did not identify any evidence that there was any bias or prejudice and explained to the service user that interpreters do not have a clinical role and are

		only engaged to support effective communication between doctor and patient. The decision to discharge from the service was based on clinical decision and judgement.

4.12. Regulation: Parliamentary and Health Service Ombudsman (PHSO)

The PHSO are currently dealing with a high volume of complaints. Over the last year, they have seen a 25% increase in complaints raised to them which need further investigation and have communicated that they have a current waiting time of up to six months.

During 2025/25, 19 cases were escalated to the PHSO, out of the 236 formal complaints closed by the Trust. This equates to 8% of all formal complaints closed. This is a small decrease compared to 2024/25 where 13% (21 cases) of complaints were escalated to the PHSO. It is worth noting that the Trust will always provide the information requested in a timely manner and may also provide further responses following the initial request which could take place over several months.

For example, the initial request for a complex complaint involving suicide was received 24 June 2025 and the requested records provided 30 June 2025. The PHSO issued their provisional recommendations to the Trust on 5 December 2025, and we provided our response to these on 5 January 2026. The PHSO confirmed on 19 March 2026 that they would not be taking any further action as overall; they considered the Trust has already taken proportionate action in line with the NHS Complaint Standards to resolve the complaint.

Detail about cases involving the PHSO:

- The Trust has not yet received an outcome from the PHSO for 14 of the cases (74%) and we have been asked to provide further information for a number of these. There is one case where we have recently been asked to respond to the provisional views and recommendations report having initially responded 24 July 2025 to confirm that the Trust had not been approached by the complainant to respond through stage one of the complaint process.
- The PHSO has returned an outcome for 5 cases (26%) and none of these involved recommendations/actions for the Trust to take.
- Mental Health Care Group (Community) received the majority (63%) of PHSO requests in 2025/26 followed by 16% for the Adult ADHD and Autism Service. This corresponds with the PHSO advising that they will be focusing on cases relating to ADHD/ASD services in 2025/26.
- The Trust received 11 outcomes from the PHSO in 2025/26 and 55% of the original enquiries were first received prior to the current reporting period. For example, one enquiry was first received 19 December 2022. None of these cases generated any recommendations or actions for the Trust.

There are no identified themes for the complaints which have been escalated to the PHSO.

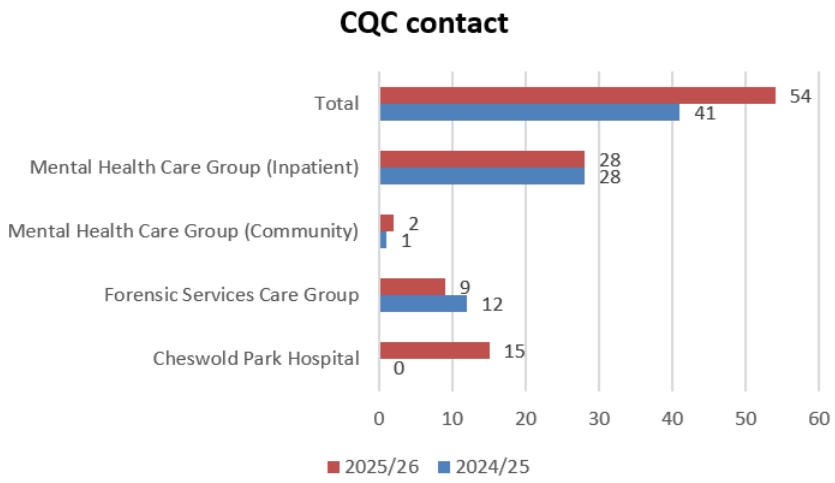
4.13. Care Quality Commission (CQC) complaints

During 2025/26 the customer services team received 54 contacts from the CQC whereby the complainant had approached them directly which is a 32% increase from the previous year (41).

In 2025/26, the CQC contacts related to four Care Groups: adults and OPS mental health (inpatients), adults and OPS mental health (community), Cheswold Park Hospital and forensic

services. There are common themes across Care Groups such as dissatisfaction with Section 17 (Mental Health Act) leave arrangements, disputes about diagnosis and concerns about care and treatment.

The graph below demonstrates that the increase in CQC contacts is accounted for by the acquisition of Cheswold Park Hospital.



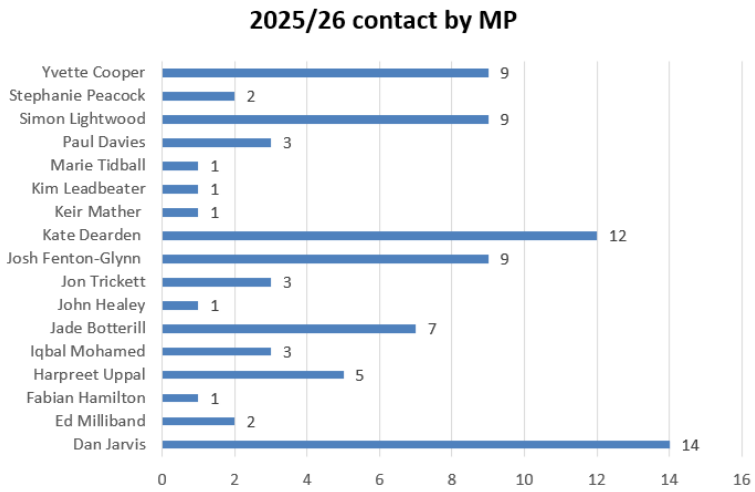
When a complaint is received via the CQC, the customer services team triangulate information with the quality governance team and the safeguarding team to identify if other contact has been received from the service user/complainant. This ensures that investigations and responses are consistent.

Customer services provide regular progress reports to the CQC's Mental Health Act complaints department on complaints they have shared or raised with us. The updates contain information including if the complaint has been concluded and if a response has been sent to the complainant. If a complaint is still under investigation, customer services will provide an update and an estimated timeframe of when a response will be provided. A copy of the response letter sent to the complainant is also shared with the CQC for their information. There has been a change in process since January 2026 following advice from the Trust's Data Protection Officer. The Trust will not proceed with a complaint investigation unless explicit consent is obtained from the service user to demonstrate that their SystmOne records can be accessed for non-care purposes.

4.14. Member of Parliament (MP) contacts

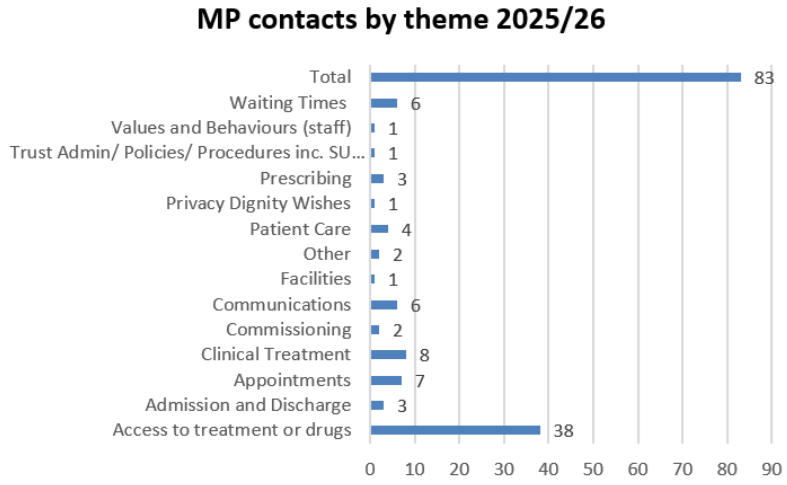
The Trust also receives contact from Members of Parliament, raising concerns on behalf of constituents. During 2025/26, 83 MP contacts were received, which is an increase from 56 during 2024/25.

The graph below demonstrates where the contacts were received from:



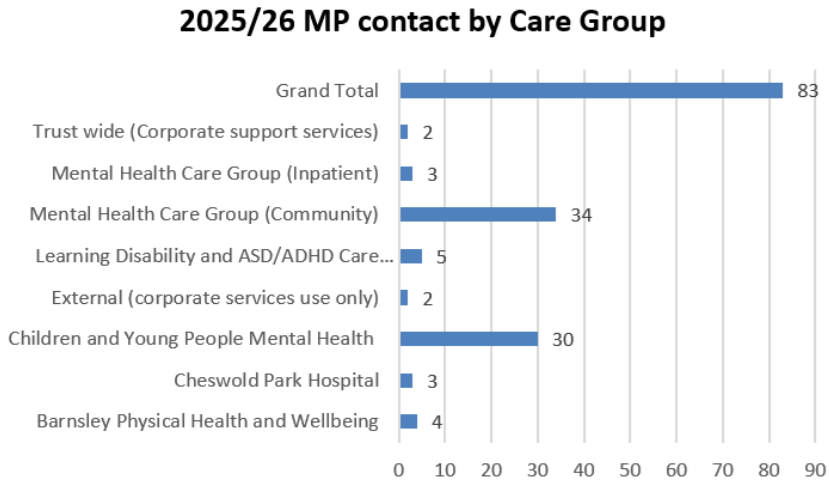
Contact by Care Group remained consistent in 2025/26 when compared to 2024/25 with Adults and OPS Mental Health Care Group (Community) still receiving the most MP contact at 41%. These often involve complex issues regarding multiple services, for example challenges with benefits, housing and immigration and the associated impact on mental health.

The graph below demonstrates that the 83 MP contacts in 2025/26 encompassed 14 themes with the majority (46%) about access to treatment or drugs (n=38). Considering that clinical treatment ranked second at 10% (n=8) and appointment at 8% (n=7) this demonstrates that access to treatment is an emotive subject.



Family members often contact their MP when they are concerned about the support being provided to their loved one which involves additional complexities around consent and the information the Trust can share.

Children, young people and families Care Group received the second highest MP contact at 36% Most of the feedback related to access to treatment for children and young people and waiting times.



4.15. Joint working 2025/26

National guidance around complaint management emphasises the importance of organisations working jointly where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single coordinated response.

Joint working protocols are in place with each working partnership. The purpose of these is to simplify the complaint process when this involves more than one organisation and improve accessibility for users of health and social care service.

There has been a 65% increase in complaints requiring joint working in 2025/26 compared to 2024/25 (n=125). Over the last 10 years complaints involving multiple organisations has increased, with complaints becoming more complex and complainants expecting more from their complaint response. The following table outlines where we have worked jointly with another organisation to resolve concerns and complaints.

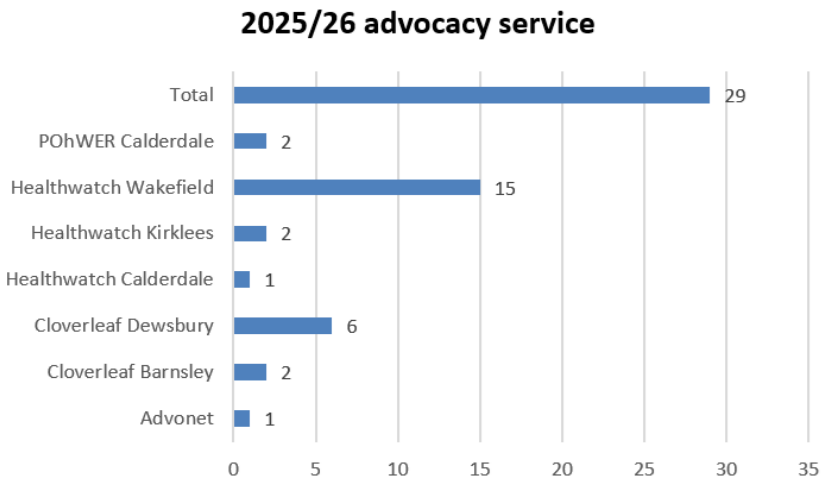
Organisation	Complaint	Reopened complaint	Informal concern	Service issue	Total
Barnsley Hospital NHS Foundation Trust	7	0	0	1	**8**
Barnsley Metropolitan Borough Council	2	0	2	0	**4**
Calderdale & Huddersfield NHS Trust	3	0	1	0	**4**
Calderdale Metropolitan Borough Council	1	0	0	0	**1**
Care Quality Commission	49	0	7	0	**56**
Healthwatch	4	1	0	0	**5**
Kirklees Council	2	0	0	0	**2**
Leeds & York Partnership NHS Trust	1	0	0	0	**1**
Member of Parliament	19	1	58	5	**83**
Mid Yorkshire Hospital NHS Trust	8	2	0	0	**10**
NHS Barnsley ICB	1	0	0	1	**2**
NHS Calderdale ICB	1	0	0	0	**1**
NHS Kirklees ICB	0	0	2	0	**2**
NHS Sheffield ICB	2	0	0	0	**2**
NHS Wakefield ICB	1	0	0	0	**1**
Other	6	0	3	0	**9**

Sheffield Teaching Hospital	1	0	0	0	**1**
Wakefield Metropolitan District Council	1	0	1	0	**2**
Yorkshire Ambulance Service NHS Trust	0	0	3	9	**12**
Total	**109**	**4**	**77**	**16**	**206**

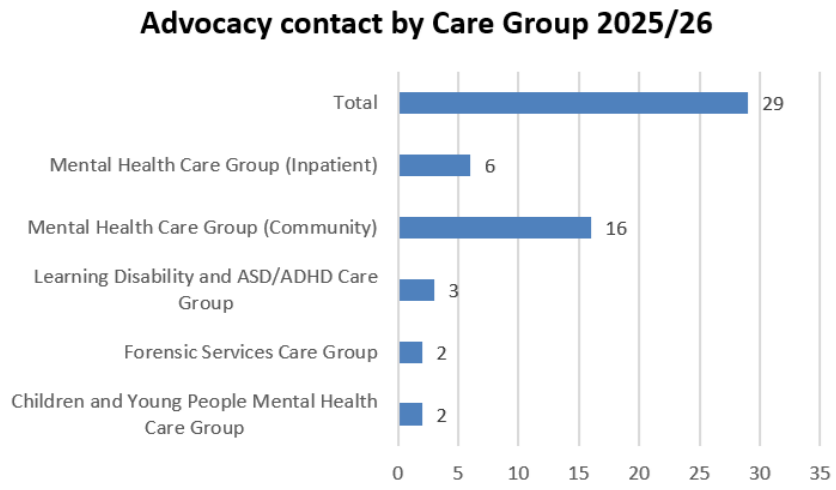
4.16. Independent Complaints Advocacy Services (ICAS)

The NHS complaints advocacy services provide practical support and information for those wishing to make a complaint about care and treatment within the NHS which they, or someone they know, has received. Advocates are independent from the Trust. The customer services team provides all complainants with details of local advocacy services when the formal acknowledgement information pack is issued.

Advocates covering all areas of the Trust have attended customer services team meetings (virtually) in recent years to foster positive working relationships and enable them to provide feedback to support service improvements. During 2025/26 there were 29 complaints raised with/by an advocate which is a slight increase from 28 in 2024/25. However, advocacy services have advised that they are experiencing long waiting lists which could explain the small decrease in the percentage of complaints raised by an advocate from 10% in 2024/25 to 7% in 2025/26. Advocacy support was provided by the following advocacy services with the highest number of contacts from Healthwatch Wakefield (n=15, 52%) which is consistent with 2024/25 followed by Cloverleaf Dewsbury (n=6, 21%).



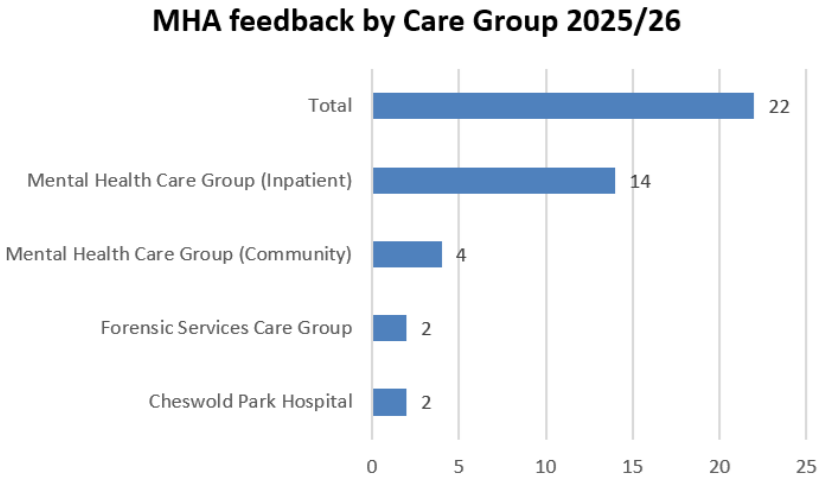
Mental health (community) received the highest number of complaints with advocacy support (n=16, 55%) followed by mental health (inpatient) (n=6, 21%) which is consistent with 2024/25.



4.17. Mental Health Act complaints

Information on the numbers of complaints/concerns regarding application of the Mental Health Act (MHA) is routinely reported to the Mental Health Act sub-committee of the Trust Board. In 2025/26 there were 22 pieces of feedback which included the MHA as one of the subjects/themes, which is a slight reduction from 24 in 2024/25.

Most of the feedback related to the MHA is for the mental health inpatient setting as this is the service where the MHA is commonly applied. Feedback regarding the MHA for community mental health services is often from relatives who would like their relative to be assessed under the MHA or from service users who have previously been assessed or detained under the MHA.

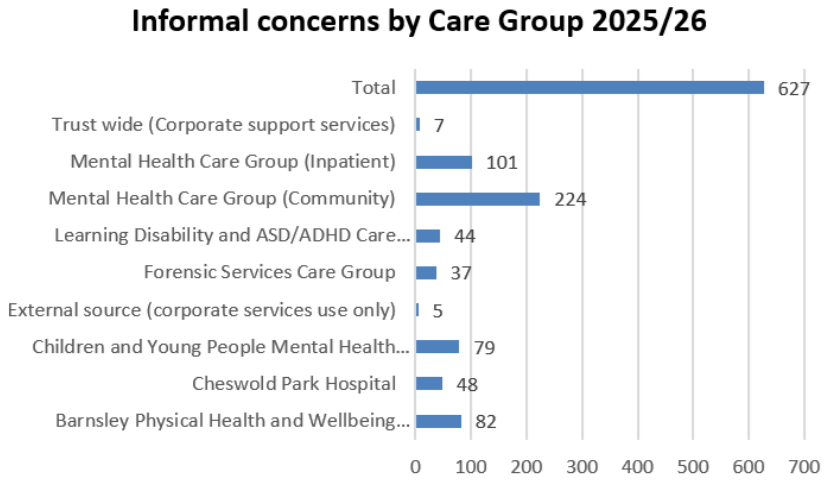


4.18. Number of informal concerns made into customer services

The Trust received 627 informal concerns in 2025/26, compared to 492 in 2024/25, which is a 27% increase. Adults and older peoples' mental health Care Group (community) received the most (n=224, 36%) informal concerns with 50% for Calderdale and Kirklees, 29% for Wakefield and 21% for Barnsley. These are concerns which are referred directly to the service concerned to attempt informal resolution without the need for a complaint to be investigated formally and a written response provided.

Across the Trust, access to treatment or drugs is the most common reason for raising informal concerns accounting for 22% (n=135).

For example, someone may have been assessed by Single Point of Access (SPA) and be unhappy that their identified needs do not meet the threshold for access to Trust services. This would be appropriate for informal resolution as the complaint process is unable to influence or overturn a clinical decision whereas a conversation with a clinician may better explain it. Communications was the second most common reason for raising informal concerns at 18% (n=113). A timely apology and explanation with a clinician delivers a quicker and more effective resolution than a formal complaint.

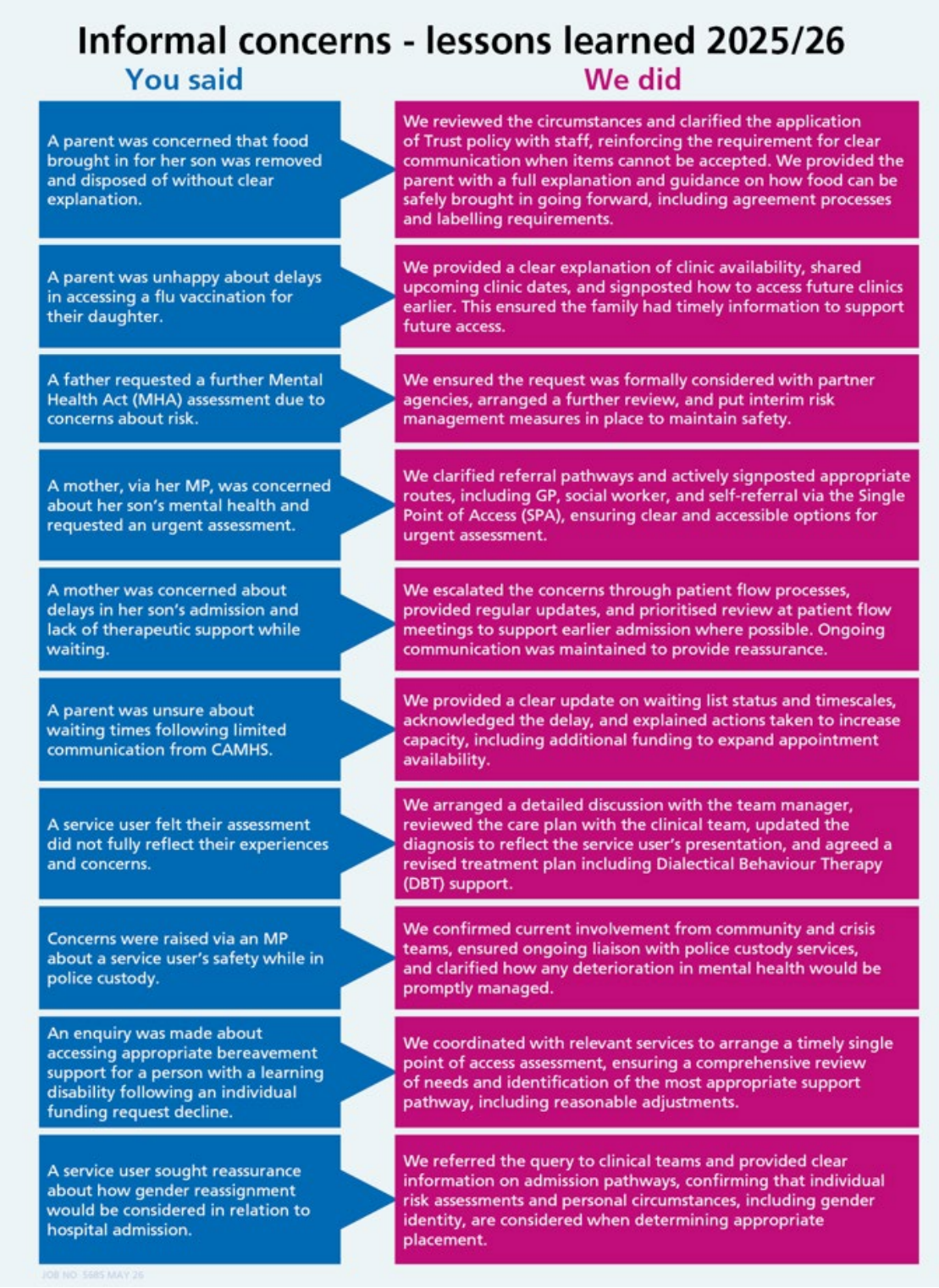


4.18.1. Response times for informal concerns

The Trust's complaints process supports local resolution in the first instance and contact with the service provider to resolve concerns directly at source. The customer services team works closely with clinical services to ensure that informal concerns are responded to by services within 2 working days. However, with agreement from the complainant, this statutory timeframe can be extended.

Of the 627 informal concerns dealt with in 2025/26, 46% (n=286) were closed within 2 working days. Of the 627 informal concerns, 179 (29%) exceeded the 2 working days target although a resolution was provided by services. 162 informal concerns (26%) did not have a resolution communicated to customer services. Collaborative work between the customer services team and clinical services is underway to ensure the process for sharing feedback is robust. The ongoing work involves gathering feedback from our services, analysing themes and trends, and sharing best practice and resolution plans across the entire organisation.

Some examples of informal concerns received by customer services, and responded to by services:



4.19. Compliments

During 2025/26, 595 compliments were recorded in total which is an increase of 15% compared to 519 in 2024/25. Details of compliments, broken down by Care Group are contained within Appendix 3. This includes some specific examples.

Children and young people mental health care group

"My daughter really struggles with anxiety, ritualistic behaviour, and panic attacks; this has huge implications for her life. We have recently concluded parent led therapy and my daughter has engaged in several intervention sessions. We have found the service offered to us, flexible to our needs, responded to us on an individual basis, free from judgement, with warmth and compassion and effective."

Forensic services care group

''Thank you so much for all the help and support you all have given me in the 8 weeks I have been here. It has been a wonderful experience working with all of you. Thank you for all the kindness with me as it was a new environment for me.''

Learning disability services

''Service user managed his first blood test at home despite really struggling with needle phobia. He did amazingly well using the desensitisation pathway over the last two months and putting his knowledge and relaxation techniques into practice. He managed to have his bloods done which avoided him having to be admitted to hospital overnight and a general anaesthetic to obtain them (which has been the process every 3-6 months for 10 years). He is very proud of himself and wearing his gauze and tape as a medal of honour!"

Adult ADHD and autism service

"I would like to say a massive thank you to all of the staff at the clinic!! I actually looked forward to attending my appointments because I knew the staff would always be friendly, there to reassure me about any issues I was facing, advocate for my health and wellbeing, and genuinely listen to me. They do an amazing job under the extreme pressure the services are under right now, and should feel proud of the work they do! No question was ever too much for them and I never felt rushed during appointments, if anything it was the opposite and the clinicians ensured to be very thorough. Though I can't remember their names, I hope this message can somehow be passed on to those who treated me during my time at the service."

Mental health care group (community)

''I have been receiving crisis care and when I began to feel unwell, colleagues received a referral from my fiancée. The team recognised my name and approached this very sensitively. They advised her that although they would be more than willing to support me, it may be more appropriate for another team to see me given that I worked in the same building as them. This was an excellent example of patient centred care because they recognised the challenges of confidentiality and dignity and made an appropriate plan. This was a real concern of mine at the time and one that was navigated in a way which enabled me to access help without feelings of prejudice. I received excellent support through a very challenging time from the team. Regrettably, many of the faces I have seen I cannot remember the names of. Despite this I wanted to extend my sincere thanks to the entire team. The Trust is lucky to have such an expert, compassionate and professional team providing crisis care, and I am truly grateful for the support afforded to me.''

Mental health care group (Inpatient)

''To all the staff, especially those who saved my life and have been helping me recover. Thank you even though thank you will never be enough to express my gratitude to you all. I grew up thinking my heroes were famous, singing on stage or winning big races. I have known for a while not that's not the case that heroes wear scrubs not masks and capes. That real heroes are human like you and I. They walk alongside us, look us straight in the eye. They say we will help you and mean what they say. If you're careless, you'll miss it - the difference they make as it may not be you who needs them most that day. But the day that you do, their hands are safe. It was a quiet Wednesday when they saved me. A life about to end before it was time. They said not today, today you won't die and something out there listened. The universe, my spirit or some god in the sky but it was the work of my heroes that let me survive. And I won't just survive; I swear I'll live. I will love and hope and liberally give. I will laugh and dance and cry openly. I will face my demons and set myself free. I promise, I guarantee I will honour this life that my heroes returned to me.''

Trust wide (Corporate support services)

''I just wanted to update you that I've now received a formal appointment confirmation. Given this progress, I am happy for my complaint to be closed, and I'm grateful that the matter was resolved without the need for a full complaint process. Your personal involvement and support made all the difference — thank you again.''

4.20. Number of comments made into customer services

Comments are unrelated to care and treatment provision, and customer services received 49 comments in 2025/26, compared to 43 in 2024/25 which is a 14% increase.

Examples of comments which were made into the customer services team included:

- Local councillor raising concerns on behalf of residents about the closure of a Trust car park to members of the public as this is very close to a nursery and there are concerns about increasing the risk of an accident as parents struggle to find somewhere to park. This was responded to jointly with estates and facilities colleagues.
- Service user raised concerns about proposed changes to the use of and access to mobile phones on wards. This was addressed by the ward manager and the service leads.
- Service user unhappy about the wording used on an online form placing biological males and transitioned males into the same category and then asking as a secondary question their gender. This was raised with the Equality, Diversity and Inclusion team and Trust Communications team.

4.21. Key improvements during 2025/26

During 2025/26, the Trust continued to strengthen its approach to managing and learning from complaints, concerns, comments, and compliments. Several key developments and improvements were successfully implemented, aimed at enhancing the quality, transparency, and accessibility of the feedback process.

1. Learning from care groups and promoting feedback
We strengthened our partnership with Care Groups to ensure feedback is consistently captured, reviewed, and translated into meaningful action, with clear oversight of learning and outcomes. This was further enhanced by aligning feedback themes with wider Trust improvement programmes and increasing transparency through the development of a dedicated “learning from feedback” intranet and website presence.

2. Maintaining focus on response timeframes
We sustained strong performance against statutory requirements, maintaining compliance with acknowledgement and response timeframes through improved tracking and oversight. Enhanced processes for managing informal concerns have supported earlier resolution, reduced escalation and improving overall responsiveness.

3. Incorporating 360 assurance audit feedback
We fully embedded learning from the 360 Assurance Audit by updating the customer services Policy, and progressing plans for Trust-wide training. These improvements have increased consistency, supported staff confidence, and ensured a more robust and standardised approach to complaint handling.

4. Accessibility monitoring and service improvements
We improved accessibility to the service by reviewing available data and identifying barriers to engagement, leading to updates in how people can access and interact with customer services. Ongoing monitoring and responsive adjustments have ensured the service continues to evolve to meet the needs of all users.

5. Involvement and volunteer support

Strengthened volunteer contribution through the Experience administrator role, supporting the review and distribution of accessible patient information.

Recruited additional volunteers to support the co-ordination and evaluation of feedback from complainants, third parties, and staff, helping to identify opportunities for continuous improvement in the complaints process.

4.22. Customer service team priorities for 2026/27



The customer services function remains committed to continuously improving how feedback is received, handled, and acted upon. In the year ahead, we will continue to embed improvements, particularly focusing on increasing satisfaction, ensuring accessibility for all service users, and improving how learning is shared and evidenced across the organisation.

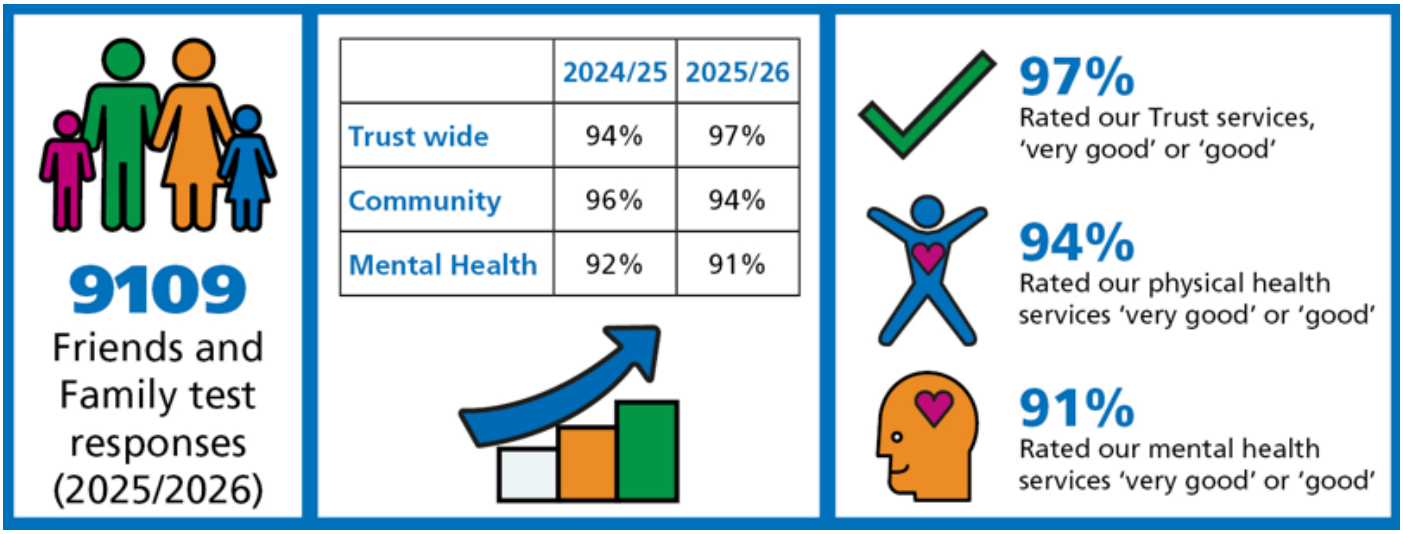
5. Friends and Family Test (FFT)

5.1. How patient experience feedback is gathered

A range of methods are used across the Trust to collect Friends and Family Test (FFT) and patient experience survey feedback. Electronic methods remain the most commonly used approach, including text messaging with embedded online links and the use of QR codes available within services and via the Trust website. Paper-based surveys and FFT cards are also available in both standard and easy-read formats. Posters and leaflets are displayed across Trust settings, and staff are encouraged to proactively offer opportunities for feedback throughout a service user's care and treatment. In addition, the Trust is launching Patient Knows Best (PKB) in 2026/27 to enable the collection of FFT feedback through the PKB platform and the NHS App.

5.2. Friends and Family Test (FFT)

The FFT was launched by NHS England in April 2013 and is a key feedback mechanism that enables service users and carers to share their experiences of care. The FFT asks respondents to rate the service they received, from *'very good'* to *'very poor'*, and includes a free-text question to capture the reasons for their rating.

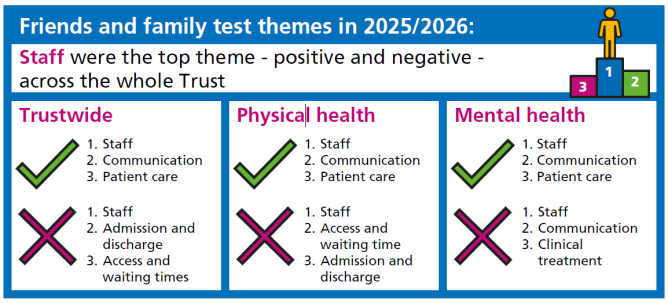


In 2025/26, the overall proportion of respondents rating Trust services as *'very good'* or *'good'* remained consistent with 2024/25. Satisfaction within physical health services increased by 1% to 97%, while satisfaction within mental health services decreased by 1% to 91%.

In 2025/26, the Trust received 9,109 Friends and Family Test (FFT) responses, representing a 6% increase compared with 2024/25 (8,573 responses). The results demonstrate consistently high levels of satisfaction across services:

- 94% of respondents rated Trust services as *'very good'* or *'good'*.
- 97% of respondents rated physical health services as *'very good'* or *'good'*.
- 91% of respondents rated mental health services as *'very good'* or *'good'*.

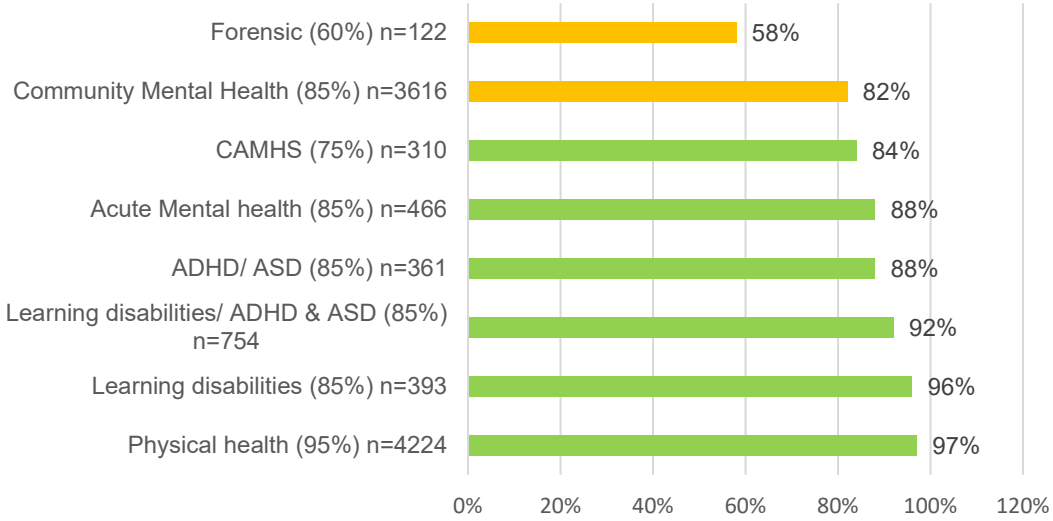
5.3. Themes from FFT feedback



Themes from FFT feedback have remained consistent over the reporting period. Staff, communication, and patient care being the most consistent themes for both positive and negative feedback.

5.4. Care Group FFT results

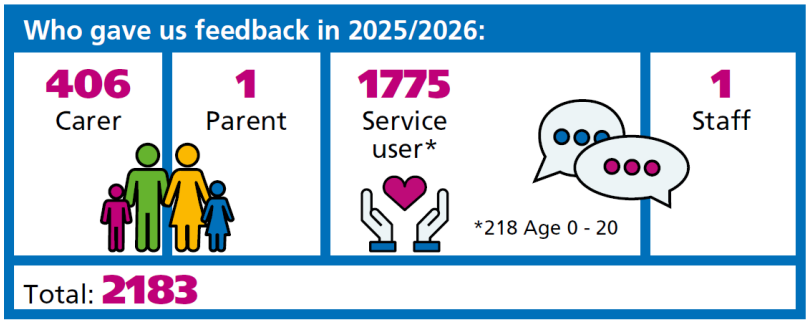
Each Care Group has a target satisfaction rate. The graph below highlights that most service lines consistently achieve the target satisfaction rate, except for Forensics and community mental services.



A detailed breakdown of ratings can be found in Appendix 6.

5.5. Who's providing FFT feedback across the Trust?

Not all respondents who provided equality data completed every characteristic, which limits the Trust's ability to undertake comprehensive analysis. The available dataset supports improved identification of groups who may require additional support to provide feedback and helps to highlight any variations in experience across different population groups.



Analysis of the FFT equality data for 2025/26 shows that feedback is predominantly provided by service users, with particularly strong engagement from people reporting a mental health condition and from working-age adults between 31 and 60.

Women continue to be more likely than men to share their experiences, and while the age profile is broad, older adults are proportionally less represented.

The ethnic profile of respondents is heavily weighted toward White British patients, with comparatively low response rates from minority ethnic communities. Sexual orientation data remains extremely limited, suggesting low confidence or relevance in this question for many respondents. These patterns indicate that while the FFT captures a substantial volume of feedback, it does not fully reflect the diversity of the population served, and targeted efforts are needed to strengthen representation across under-represented groups.

The Trust continues to focus on strengthening the collection of equality data. The data reflects diversity among those providing feedback through the FFT, although it is not directly comparable to the overall Trust population, a review of the data suggests that the focus for 2026/27 should include:

- Increase engagement with underrepresented ethnic groups by working with community partners, using translated materials, and promoting FFT through culturally relevant channels.
- Improve accessibility for older adults by offering supported completion options.
- Strengthen carer involvement by promoting FFT through carer support groups and ensuring carers understand they can provide feedback on behalf of those they support.

Equality data from feedback is routinely shared through the Trust's FFT reports to inform equality impact assessments and to support the identification of gaps in feedback from under-represented groups.

A full breakdown of equality data for the FFT can be found in Appendix 5. A review of the feedback from ethnic minority groups does not demonstrate a poorer or different experience from other groups. As feedback from these groups expands over the coming year a further review will be conducted to identify any areas which suggest discrimination.

6. Patient Experience Surveys

6.1. Local Surveys

The Trust started to introduce patient experience surveys across service lines in 2021/22 to enhance opportunities for service users and their families to share feedback. This approach enables the Trust to identify areas of good practice as well as areas requiring improvement.

Patient experience surveys are now embedded across forensic inpatient services, mental health inpatient services, learning disability services, ADHD and ASD services, and physical health services. Surveys for children and young people are scheduled for deployment in Quarter 1 of 2026/27. The CAMHS survey was initially delayed allowing for the identification of an appropriate pilot site; Barnsley CAMHS successfully piloted the survey during Quarter 4 of 2025/26. Although response numbers were relatively low, the pilot generated positive feedback from both staff and service users, further strengthening the Trust's ability to listen to and act on the experiences of children, young people, and families. Work is now underway with CAMHS to explore additional feedback collection methods to better support and encourage participation from young people.

Development of a local community mental health patient experience survey will commence in Quarter 2.

This initiative aims to generate more detailed and locally relevant insight than the national survey alone, enabling the Trust to better understand the specific needs of its local population. The findings will support more targeted quality improvement and help ensure that services are shaped by the experiences and voices of the communities they serve.

All surveys contain a core set of questions that score the Trust on key themes around service user experience of Trust services, including feeling safe, feeling involved, feeling listened to, being treated with dignity and respect, and knowing how to raise concerns. These also align to the Care Quality Commission (CQC) five lines of enquiry.

The Trust received feedback from 652 patients and carers through patient experience surveys in 2025/26. Service users and carers across the Trust reported the following:

Trust wide (n=1403)	24/25 %	25/26%
feeling safe	96%	98%
service user feeling involved	95%	91%
carer being involved	91%	82%
feeling listened to	98%	97%
being treated with dignity & respect	97%	98%
knowing how to raise concerns	89%	92%

Patients continue to report very high levels of feeling safe when using Trust services, with positive responses increasing from 96% in 2024/25 to 98% in 2025/26. This reflects sustained confidence in the safety of care and the environments in which services are delivered. Similarly, the proportion of respondents who felt they were treated with dignity and respect increased slightly from 97% to 98%, reinforcing compassionate and respectful care as a clear Trust strength.

There has also been improvement in awareness of how to raise concerns, increasing from 89% to 92%. This suggests progress in ensuring patients and carers are better informed about how to share feedback, raise concerns and seek support when needed.

While overall experience remains strong, some areas have seen a reduction compared with the previous year. The proportion of service users who felt involved in their care decreased from 95% to 91%, and those who felt listened to reduced marginally from 98% to 97%. Although these scores remain high, they indicate the need for continued focus on involvement, shared decision-making and communication.

The most notable change relates to carer involvement, which fell from 91% in 2024/25 to 82% in 2025/26. This feedback suggests that carers do not always feel as involved in care and treatment as they would wish. This aligns with themes identified through other patient experience feedback and reinforces the importance of ongoing work linked to the Triangle of Care (ToC) to strengthen carer engagement and support.

During 2025/26, there was a 53% reduction in the number of patient experience survey responses compared with the previous year. A number of factors are likely to have contributed to this decline. The unavailability of CHATpads during the year has limited opportunities for digital completion within services, and many service users reported a preference not to complete paper-based surveys as an alternative. In addition, ongoing operational pressures across services meant that staff did not always have sufficient capacity to support and promote survey completion during care delivery.

Staff also reported a perceived reduction in service users' willingness to participate in patient experience surveys, potentially reflecting survey fatigue or competing demands on individuals during periods of high service pressure.

In response, the Trust will take the following actions during 2026/27:

- Explore the re-establishment of digital feedback options, including the rollout of improved digital platforms and devices to support real-time feedback.
- Launch the Patient Knows Best (PKB) platform and NHS App integration to enable easier and more flexible completion of FFT feedback.
- Increase use of real-time dashboards to support services in monitoring response rates and acting promptly on feedback.
- Strengthen staff awareness and confidence in offering feedback opportunities, supported through local guidance and quality improvement support.
- Review feedback formats and approaches to ensure they are accessible, proportionate and engaging, with particular focus on groups who may be less likely to provide feedback.
- Continue to triangulate patient experience survey results with other feedback sources to ensure robust understanding of patient and carer experience.

These actions aim to increase participation, reduce barriers to feedback, and ensure that patient experience continues to inform learning and improvement across the Trust.

Overall, Trust-wide patient experience remains very positive, with strong performance in safety, dignity and respect. The results highlight clear areas of strength alongside opportunities to further improve how patients and carers are involved in care decisions and feel listened to. These findings will inform patient experience priorities and targeted improvement work during 2026/27.

Staff behaviour and patient care were consistently identified as key themes within patient experience survey feedback, featuring prominently in both positive and negative comments. Positive feedback frequently highlighted staff kindness, professionalism and the quality of care provided, while negative comments most often related to communication, perceived attitudes, or inconsistencies in care delivery. This reinforces the central role that staff interactions play in shaping overall patient experience and highlights the importance of continued focus on communication, compassion and person-centred care.

Reporting on patient experience surveys is provided automatically monthly and a quarterly review is undertaken and shared with services and support services to review and update the action plan as appropriate. A detailed breakdown is provided on questions and response, including a comparison of the previous reporting periods results. Free text information is provided including thematic analysis. Actions plans are completed by services and returned to the quality governance team for reviewing monitoring.

6.1.1 Actions as a result of feedback

Actions from patient experience survey have included the following for 2025/26.

Location	Issue	Action
Mental Health Inpatient Survey	Several wards are reporting low return rates for the patient experience survey, resulting in limited insight into service users' experiences. Contributing factors include patient	To minimise survey fatigue and reduce the impact on ward staff, the inpatient survey is scheduled four times per year throughout 2026/27: June, September, November and February. This approach avoids December and January, when winter pressures are typically at their peak. As a result, the survey is conducted once per quarter.

	acuity, clinical pressures, and reduced staff capacity to promote the survey or support individuals in completing it. In addition, some service users have shown low interest in participating due to long lengths of stay and reluctance to repeat the survey.	
Forensics Inpatient Survey	Activities on the ward are poor.	Activities have been added to all community meetings, giving service users the opportunity to suggest activities they would enjoy on the ward.
	Food quality and choice are poor.	Regular catering meetings have been established, and feedback forms are provided during mealtime to capture real-time feedback which is reviewed by the catering team and the appropriate action taken.
	Ward décor is poor.	The ward décor is kept natural colour to meet a wide range of needs and allow for easier maintain if areas become damaged. There is an annual plan is in place to keep paintwork fresh.
ADHD & ASD Patient Experience Survey	My GP will not prescribe ADHD medication through shared care.	The service is aware that some GP practices have declined to enter shared care to continue prescribing ADHD medication. To ensure that service users under our care can continue with their medication, the service has worked in partnership with the Trust's pharmacy service to put in place a process so that medication can continue.
	The appointments I am sent through the post are not always convenient for me.	Data has been reviewed and it can be seen that a large proportion of medication appointments were not attended or cancelled at short notice. The process has been revised that the appointments are booked in collaboration with the individual at the end of each medication appointment.
	I had long waits between appointments.	Data was reviewed and this found that the longest waits were between initial autism appointments and further assessment appointments. An audit found the delay was largely due to cancellation of appointments offered. As a result, the process has been revised and a pilot run where the allocated clinician contacts the person directly to arrange a mutually convenient appointment in a location of their choice. In addition, the data showed that some further assessment appointments in the ADHD pathway were delayed longer than we would expect in some areas. We now track this closely and adjust the operational capacity plan to remove any back logs as needed.

	Feedback given that service users and carers can find diagnostic feedback appointments difficult.	The service is aware that sensitive and compassionate communication is key when delivering feedback following a diagnostic assessment. Bespoke communications training was delivered to all clinicians. The service has also developed a framework to use when discussing the outcome of an assessment. Positive feedback has been collected to demonstrate the impact for service user and clinicians.

6.2. Community Mental Health Survey 2025

The Community Mental Health Survey is an annual, mandated assessment carried out by an external provider on behalf of the Care Quality Commission (CQC). The survey captures the experiences of individuals receiving care within community mental health services.

Questionnaires were distributed to a sample of 1,250 people aged 16 and over who were receiving care or treatment for a mental health condition and had been seen between 1 April and 31 May 2024. Fieldwork was conducted between August and November 2025.

The Trust received 240 completed questionnaires, representing a 20% response rate (n=240/1,219). This reflects a 1.5 percentage point decrease compared with the 2024 response rate of 21.5%. Respondents were predominantly White British (88%), aged between 36 and 65 (51%), and female (52%).

6.2.1. National results

The results show improvement in some areas, including support while waiting for care and interactions with staff. However, overall performance of NHS community mental health services nationally remains poor, especially for certain groups. Many people are still reporting poor experiences of contacting crisis services and the care they receive. Wider areas of a person's life are not being supported where people would have liked this support including support with physical health, joining a group or finding work or benefits. Overall, younger people, autistic people and disabled people reported worse than average experiences of care.

Overall, patient experience results show steady improvements across several areas of mental health care. More people are receiving support while waiting for treatment, rising from 58% in 2023 to 62%, with 92% finding this support appropriate. Interactions with mental health teams have also strengthened, with increases in patients feeling listened to (55%) and given enough time to discuss their needs (53%). Forty-one per cent 'definitely' received the help they needed, and 67% felt they were 'always' treated with care and compassion. Medication discussions remain strong, with most patients receiving clear explanations about purpose (91%) and benefits (87%), alongside small but positive increases in understanding side-effects and what happens if medication is stopped (both 43%). More people reported needing support to access care (35%), and among those who did, two-thirds felt this support met their needs.

Key areas for improvement highlight ongoing challenges in crisis care, access, and involvement in treatment planning. While most people know who to contact in a crisis, many still face delays or difficulty getting through, and a third do not receive the help they need, with limited support offered to families or carers. Longer waits continue to be linked with worsening mental health, and nearly a quarter of respondents were not involved in a care plan or did not feel supported to make decisions. Access to psychological therapies remains an issue, with 39% wanting therapy they did not receive and 40% feeling waits were too long. Support with wider life needs is also lacking, with

many receiving no help around groups, activities, money, benefits, or physical health, and one in five wanting greater involvement of family or friends. Experiences among children and young people using CAMHS were notably poorer, with long waits, limited support while waiting, and low involvement in care planning. In contrast, older people's mental health services showed more positive interactions, though gaps remain in care planning and support with social or financial needs.

National comparison shows that the 5 of our Trusts scores are in the top 20% range, 27 intermediate range and 2 are in the bottom range.

6.2.2. Compared to other Trusts

Compared to the other Trusts involved in the survey, the Trust has performed:

- 'Worse than most' Trusts in one question:
  - Q12 Did you have to repeat your mental health history to your NHS mental health team?
- 'Somewhat better' than expected for one question:
  - Q21.5 Have any of the following been discussed with you about your medication? What will happen if I stop taking my medication
- 'About the same' for 32 questions

6.2.3. Local Results

Each year, the Trust reviews the survey results against the previous three years to understand whether actions taken have led to measurable improvements and to identify where further work is needed. This longitudinal comparison helps the Trust spot emerging trends, assess the impact of quality-improvement initiatives, and ensure that any recurring issues are addressed in a timely and targeted way. By analysing performance over multiple years rather than in isolation, the Trust can make more informed decisions, prioritise resources effectively, and maintain a continuous focus on enhancing the experience of people using community mental health services.

Key areas for review this year include:

- Q31 In the last 12 months, has your NHS mental health team supported you with your physical health needs?
- Q32b In the last 12 months, did your NHS mental health team give you any help or advice with finding support for… Finding or keeping work
- Q32c In the last 12 months, did your NHS mental health team give you any help or advice with finding support for… Help with money or benefits
- Q40 Aside from this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?
- Q12 Did you have to repeat your mental health history to your NHS mental health team?

The following themes are from comments received from the survey:

Positive

1. **Improved Support and Communication**
   - More people are receiving support while waiting, and most feel it is appropriate.
   - Clear explanations around medication remain consistently strong.
2. **Better Experiences with Mental Health Teams**
   - Increases in feeling listened to, treated with compassion, and given enough time.
   - More people report 'definitely' receiving the help they need.

3. **Improved Access and Experience for Older Adults**
    - Shorter waiting times and more support while waiting in OPMHS.
    - High levels of compassion and feeling heard.

Negative

1. **Crisis Care Difficulties**
    - Long waits, difficulty getting through, and many not receiving the help they need.
    - Limited support for families and carers during crises.
2. **Long Waits and Limited Access to Treatment**
    - Longer waits linked to worsening mental health.
    - Many wanting therapy they did not receive or waiting too long for it.
3. **Lack of Involvement and Support in Care Planning**
    - Significant numbers not involved in care plans or decision-making.
    - Limited support with wider life needs (money, benefits, physical health, social activities).

National and local results are reviewed with Care Group quality governance leads and an action plan developed which is monitored within the Care Groups and triangulated with other improvement work. This work will continue throughout 2026/27.

6.3. Using feedback for learning and improvements

Throughout 2025/26, patient experience feedback was shared with services on a monthly basis to enable review at local level, discussion with teams and service users, identification of good practice, and implementation of appropriate actions where required. In 2026/27, the Trust will launch a dashboard, utilising Power BI software, enabling services to access data in real time and take timely, informed action in response to feedback received. This has been shared with services, receiving very positive feedback.

FFT results are displayed within services (where appropriate) alongside 'You Said, We Did' posters, enabling learning to be shared with service users and their carers, and demonstrating how feedback has informed improvements.

Feedback is also used to support a range of wider projects and improvement programmes across the Trust, including consultations, quality walkarounds and CQC inspections, ensuring that the experiences of people accessing Trust services are consistently included. Patient experience feedback also informs key workstreams such as the Triangle of Care (ToC) and the Patient and Carer Race Equality Framework (PCREF). In addition, patient experience survey findings are shared with support services to help identify any wider, cross-organisational actions required.

Specific examples of where feedback has led to improvements can be found in Appendix 7.

6.4. Achievements and improvements for patient experience during 2024/25

Throughout 2025/26 there have been a number of improvements made relating to the patient experience agenda. The high-level themes of these improvements include:

1. As a result of the 2024 National Community Mental Health Survey findings, a leaflet has been developed to support service users with accessing groups or activities, obtaining financial or benefits advice, and finding or maintaining employment. The leaflet has been tailored to each local area and is available to service users through support staff within community teams. It has also been shared on social media and published on the Trust's website to ensure wider accessibility.

2. A new FFT system has been developed using Microsoft tools, featuring an enhanced dashboard that will be accessible to staff.
   The dashboard will provide teams with clear visibility of FFT ratings, response rates, service-user comments, and equality data, supporting more informed decision-making and service improvement.
3. A new QR code poster has been launched across the Trust to promote the range of ways service users, carers, and families can provide feedback. The poster also highlights opportunities for involvement and volunteering, helping to strengthen engagement and participation across services.
4. Three volunteers have been deployed across the Trust to support services in collecting FFT feedback and capturing service user experience, helping to strengthen engagement and improve the quality of insight gathered.

6.5. Priorities and developments for 2026/27

The following will be priorities for 2026/27:

1. Embed the Experience of Care Framework Across All Services
The Trust will adopt and embed the national Experience of Care Framework to strengthen understanding of patient, carer and staff experience, using its domains to guide service improvement and ensure experience is considered in planning, delivery and evaluation.

2. Embed NICE Quality StandardQS14 - Service user experience in adult mental health services, across Adult Mental Health Services
The Trust will strengthen person centered mental health care by embedding the principles of NICE QS14 across all adult mental health pathways, improving shared decision-making, communication, dignity, respect, carer involvement, and care planning.

3. Strengthening Trust Patient Feedback Systems
The Trust will enhance the way feedback is collected by re-establishing digital feedback options, rolling out improved devices and platforms, launching PKB and NHS App integration for FFT, and introducing real-time dashboards to support timely action.

4. Improve Accessibility, Inclusion and Representation
Feedback processes will be redesigned to be more accessible and inclusive, with targeted engagement for underrepresented groups, enhanced equality data collection, and stronger involvement of carers, older adults, and minority ethnic communities. These improvements will enable the Trust to better understand and act on feedback from people with protected characteristics.

5. Enhance Staff Capability and Confidence
Staff will receive improved guidance, training and support to increase confidence in offering feedback opportunities, ensuring consistent and proactive engagement with service users and carers across all services.

6. Deepen Insight Through Better Data and Triangulation
The Trust will strengthen how patient experience data is analysed by triangulating FFT, surveys, complaints, compliments and incident data, and by developing more robust physical health reporting to support evidence-based improvement.

7. Expand and Improve Local Patient Experience Surveys

Local surveys will be further developed and embedded, including the new community mental health survey and continued CAMHS rollout, to generate richer, more meaningful insight that reflects local needs and drives targeted quality improvement.

7. Next steps

There are a number of areas of focus for 2025/26 which are outlined within this report. In addition to these, the main areas for gathering patient experience feedback (customer services, friends and family test and service line patient experience surveys) will work together and alongside the equality and involvement team, to continue to understand and support improvements in patient experience. This will include:

- Strengthening triangulation and embedding of learning from feedback.
- Enhancing the quality of complaint investigations.
- Expanding the use of data and dashboards, in line with making data count.
- Embedding the Experience of Care Framework across all services.
- Embedding NICE Quality Standard for support patient feedback.

8. Conclusion

Patient experience is a key indicator of quality in healthcare and good patient experience is associated with improved clinical outcomes.

Throughout this report, feedback on the experience of patients, their families/carers and other people in our communities have been used to provide us with a picture of satisfaction and areas for improvement. The data provided demonstrates that the Trust receives feedback from a wide range of patients and service users, from across the communities we serve.

During 2025/26 we have seen an increase in formal complaints (47%) which have been received and investigated by the Trust, and 92% of complaints closed in the year were resolved within the six-month target. There has been a slight decrease in the number of reopened complaints as the review by clinical and customer services often demonstrates that there is nothing further the Trust can meaningfully add to the original response. We have also seen an increase in compliments, and these are spread across services.

The FFT feedback shows an increase in satisfaction across the Trust, however there is a slight decrease in satisfaction with community services and across mental health services. Most care Groups continue to meet target satisfaction levels, except for Children and Families and Forensic Services. Improvement work throughout the year has seen an increase in returns for these areas. Focused work with young people to support gathering feedback is underway.

Themes, both positive and negative are largely consistent with previous years, and it is the specifics from these themes that support improvement of quality, safety and culture within individual services and teams. There has been a notable decline in complaints with values and behaviours (staff) as a key theme.

This report demonstrates that feedback into the Trust is robust and provides us with rich information which the Trust as a whole, and Care Groups and services can take forward into improvement work and sharing good practice.

It is through the triangulation of patient experience feedback with other measures of quality, such as freedom to speak up, performance dashboards/measures, CQC cases and patient safety incident response framework (PSIRF) incidents that a robust picture of patient satisfaction will be formed, and this work will develop further during 2026/27.

Appendix 1 – Complaint response time by Care Group

The following chart breaks down complaint responses within six months by Care Group. It is worth noting that whilst the performance below is by Care Group, the reason there is a delay in responding is not solely within the gift of the Care Group. The Care Group is responsible for timely allocation of an investigator; timely return of the completed investigation toolkit and Care Group sign off of the complaint response as part of the governance process. Therefore, it is not always reflective of Care Group performance when there is a delay in a complaint response being sent.

Care Group	Total	< 6 months	> 6 months
Adults and OPS (Community)	95	80	15
Adults and OPS (Inpatient)	35	25	0
Barnsley Physical Health and Wellbeing	29	28	1
Children, Young People and Families	26	24	2
Cheswold Park Hospital	6	6	0
Forensic Services	11	10	1
Learning Disability and ASD/ADHD	32	31	1
Trust wide (Corporate support services)	2	2	0
Total	**236**	**216**	**20**

In 2025/26, Cheswold Park Hospital, Trust-wide (Corporate support services) and Mental Health (Inpatient) Care Groups achieved 100% compliance with the six-month target for complaint resolution. However, except for Mental Health (Inpatient) these areas also received the lowest volume of complaints, which may have supported timely responses.

Barnsley Physical Health and Wellbeing and Learning Disability and ASD/ADHD Care Groups also performed strongly with both achieving 97% compliance based on a similar number of closed complaints.

Adults and Older People's Services (Community) Care Group had the lowest rate of compliance at 85% although they continue to manage the highest number of complaints, and several cases were impacted by factors such as delays in obtaining consent or agreeing the scope of the investigation. In a few instances, internal delays, such as returning toolkits or sign-off processes, also contributed.

To support improvement, we are working with these Care Groups to identify and address barriers to timely resolution where delays are within their control. Actions include providing additional guidance around consent processes, streamlining internal steps such as toolkit reviews, and strengthening oversight during the sign-off stage. The aim is to build consistency across all services while recognising the unique pressures faced by different teams.

Appendix 2 - Customer services equality data



		Service users	
Ethnicity	**Complaints**	**Number**	**Percentage**
White – British & Irish	68%	80,055	81.9%
White – other	3%	2,420	2.5%
Mixed group	3%	954	1.0%
Asian & Asian British	2%	4,186	4.3%
Black & Black British	2%	1,567	1.6%
Other	1%	1,517	1.6%
Not recorded	20%	7,003	7.2%
Total	**99**	**242**	**100%**



		Service users	
Age	**Complaints**	**Number**	**Percentage**
0-6 years old	0%	3,402	3.5%
6-17 years old	1%	14,871	15.2%
18-25 years old	5%	7,791	8.0%
26-55 years old	68%	32,650	33.4%
56-64 years old	12%	10,704	11.0%
65-74 years old	9%	10,122	10.4%
75 years and over	1%	18,162	18.6%
Unknown	4%	0	0%
Total	**100%**	**97,702**	**100%**



		Service users	
Sexuality	**Complaints**	**Number**	**Percentage**
Bisexual	4%	647	1%
Heterosexual	59%	43,069	44%
Homosexual	3%	1,061	1%
Other sexual orientation	1%	124	0%
Person declined to respond	11%	1,354	1%
Person unsure	0%	173	0%
Unknown	22%	51,274	52%
Total	**100%**	**97,702**	**99%**



		Service users	
Gender	Complaints	Number	Percentage
Female	62%	53,478	54.7%
Male	34%	44,190	45.2%
Indeterminate	0%	11	0.0%
Transgender	1%	0	0.0%
Unknown	3%	23	0.0%
Total	**100%**	**97,702**	**100%**



		Service users	
Disability	Complaints	Number	Percentage
Not disabled	11%	39,000	40%
Registered disabled	42%	7,137	7%
Disability NOS	3%	3,283	3%
Not recorded	44%	48,282	49%
Total	**100%**	**97,702**	**99%**

Analysis of equality data for Customer Services

Equality data related to the complainant

The customer services team capture equality data from the complainant - the person raising the complaint. Whenever possible, basic equality data is collected when the complaint is made or more detailed data when the equality form is returned. Complainants are informed about the importance of this data for ensuring equal access to the complaints process.

The equality form includes nine protected characteristics: age, disability, gender reassignment, ethnicity, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. Additionally, we ask if the complainant is a carer and if they are registered with their General Practitioner (GP) as one. This aligns with the services we offer, and the Trust considers this additional characteristic as important as the nine protected characteristics. This enables the customer services team to ensure that complainants are fully supported based on their needs.

The team continues to explore best practices for capturing equality data, both internally and externally, incorporating any learnings into routine processes.

The Trust's equality and diversity managers review all complaints and feedback where concerns are raised about possible less favourable treatment due to a protected characteristic. This ensures that any trends or patterns of harassment are identified and addressed appropriately.

Comparing the data suggests that those raising concerns and complaints are representative of our service user population. Although this data is not directly comparable as complaint equality data is

for all complainants, rather than just service users, a large proportion in 2025/26 (n=240, 5%) are from the service user.

A review of the age profile of complainants in 2025/26 shows that 58% of formal complaints (n=246) were submitted by individuals aged between 26 and 55. In contrast, only 7% (n=31) were received from people aged over 65.

This disparity suggests there may be barriers, perceived or actual, that make it more difficult for older individuals to access or engage with the complaints process. While it is likely that some older service users rely on family members or carers to raise concerns on their behalf, we recognise the importance of ensuring that the complaints process is inclusive, accessible, and user-friendly for all age groups

As part of our commitment to ensuring equity and accessibility within our complaints process, we conducted a focused review in 2024/25 and again in 2025/26 to better understand the lower representation of older adults, particularly those aged 65 and over, among complainants.

Analysis of complaints submitted by third parties, predominantly family members and carers on behalf of individuals accessing older people's services, continues to highlight a consistent theme. Concerns are frequently raised not directly by the older person, but by those supporting them, often reflecting feelings of frustration, uncertainty, and exclusion. Key issues identified include limited involvement in care planning, lack of clarity around discharge processes, and insufficient or inconsistent communication regarding treatment decisions. This indicates that families and carers can feel disconnected from the care being delivered and are often using the complaints process to advocate on behalf of their loved ones.

In response, we have undertaken a review of our complaints and feedback materials to assess their accessibility and suitability for older adults.
This included consideration of language, tone, format, and ease of access across both printed and digital platforms. While areas of good practice were identified, the review highlighted the need to further improve accessibility, particularly for individuals with visual impairments, cognitive difficulties, or limited access to digital resources.

As this remains an ongoing theme, we will continue to prioritise monitoring and improvement in this area throughout 2026/27. Actions include the development of clearer, more accessible information using a range of formats (including large print, easy read, and alternative languages), and strengthening how this information is shared across settings more frequently accessed by older people, such as GP practices, community services, and care homes. We will also increase awareness and uptake of advocacy services to better support both patients and carers in raising concerns.

In addition, we are introducing new approaches to further understand and address this issue. This includes more proactive engagement with families and carers during the complaints process, targeted feedback collection directly from older people where possible, and closer triangulation of complaints data with patient experience, patient safety, and discharge pathway reviews. We will also work with clinical teams to reinforce the importance of inclusive communication and carer involvement in care planning and decision-making.

Through these actions, we aim not only to improve the accessibility of the complaints process but also to strengthen communication, involvement, and trust between services, patients, and those who support them, ensuring a more inclusive and person-centred approach to care.

Equality data when consent was provided

The equality form, described above, captures where the complaint is coming from, and this enables identification of when the complainant is the service user. Customer services can only collate more detailed equality data when the consent form is returned, and the following breakdown relates only to those cases (n=242) where consent was provided.

The data shows that most complaints come from people who are of a working age, between 26-55 (68%) and 67% class themselves as white British. 58% of complaints were raised by the service user. The majority of complainants are female (62%) and 34% are male. Three complainants described themselves as transgender and a small number either did not or declined to provide an answer (n=6). There is a spread across other ethnic groups which falls broadly in line with our service user population. Data suggests that people from ethnic minority groups appear to be proportionate to those accessing our services. Notably, 68% of complainants identify as white British/Irish, which is significantly less than the Trust's service user population of 84%. However, it should also be noted that 20% (n=49) either did not provide ethnicity details or stated that they preferred not to say.

Complaints are received from people with a wide range of disabilities although it is striking that for those who returned the equality form (n=242) in 2025/26, only 11% stated that they do not have a disability. 34% of complainants (n=83) either did not answer or declined to provide disability information. 14% of complainants (n=33) declared a mental health condition and 18% (n=7) declared a mental health condition plus another type of impairment. Most people who provided information about their sexual orientation (n=142) are heterosexual (59%), with a small proportion (7%) who are representatives of the LGBTQ community. Notably, 33% of complainants (n=79) declined to provide information about their sexual orientation.

It was previously only possible to identify the equality data for service users who are the complainant, rather than for all people the complaints relate to.
The consent form was amended on 9 September 2024 and where possible, we also collect equality data from the service user when a complaint has been raised on their behalf by a third party.

Equality data when the service user is not the complainant

During 2025/26, 101 of the 242 complaints received (42%) with returned consent were raised by a third party on behalf of a service user. This reflects the important role that families, carers, and advocates continue to play in supporting individuals to raise concerns.

From September 2024, an update to the Datix system enabled us to begin collecting equality and diversity information for service users in cases where they are not the complainant. This dataset provides useful insight into the demographics of the service users for whom complaints were raised.

Demographic highlights from the third-party complaints:

Age of service users:

- 33% were aged 26–55 years, 32% were aged 6–17 years, 8% were aged 75 years and over.
- 14% were aged 18–25, 7% were aged 56–64 years and 6% were aged 65–74 years.

This spread highlights that third-party complaints are most commonly raised for adults of working age and children or young people, with a notable number relating to older adults.

Gender identity:

- 62% of service users were male, 38% were female.

Ethnicity and language:

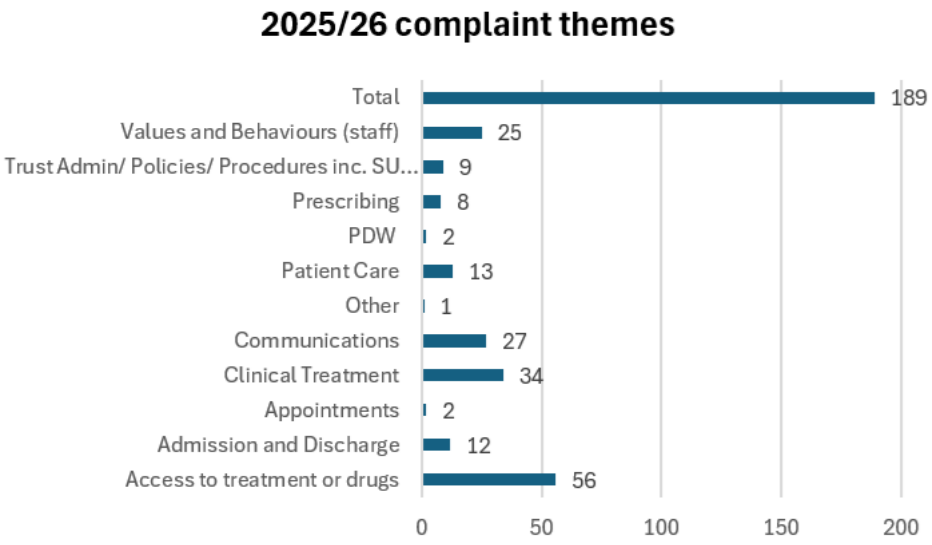
- 60% identified of service users described themselves as White British and 30% did not provide ethnicity data.
- 71% reported English as their main language, 3% advised that English was not their main language which included Punjabi, Polish and Ukrainian and 26% did not disclose their main language.

Additionally, 14% of these third-party complaints (n=14) were raised in relation to deceased individuals. In these cases, only limited demographic data such as age and gender are collected, out of respect and to minimise intrusion.

This analysis highlights the potential value of collecting and analysing demographic data in third-party complaints.

Appendix 3 - Customer services feedback by Care Group

Adults and Older People Mental Health Care Group (Community)



Top three complaint themes

1. Access to treatment or drugs
2. Clinical treatment
3. Communications

During 2025/26 Adults and OPS Mental Health Care Group (Community) received 189 complaints and 112 compliments

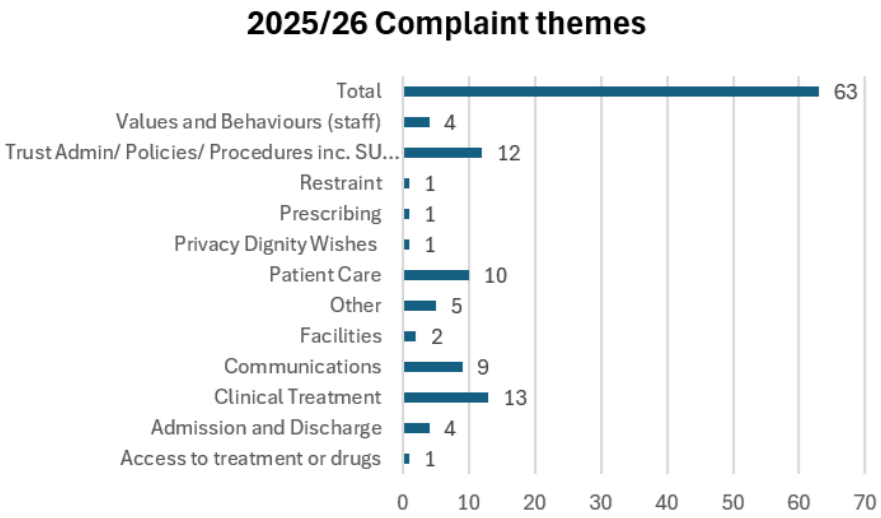
Complaint examples

1. Service user concerned about the attitude of a practitioner during a crisis episode.
2. Service user concerned that because they complained about a staff member that the support they receive from the wider service has been withdrawn.
3. Service user unhappy with the way their care has been managed and communicated; they have not felt involved despite their diagnosis of schizophrenia. Concerned that they are displaying early warning signs and despite previous hospital admissions, they are being discharged.

Compliment examples

1. My husband has vascular dementia and can be prone to anger outbursts. Staff member dealt with him well and has a very good manner. We both got on with him very well.
2. Thank you for everything, I mean it, you have made a very difficult journey easier to navigate and process, and I am so grateful you were part of my journey. You are fab at what you do. It really helped that we got on and formed a solid therapeutic bond as it enabled me to open up. It also helped that you're a Yorkshire lass and similar in age that made a massive difference for me personally. Going to miss our appointments.
3. I just wanted to say a huge thank you to the staff for being so helpful recently. I haven't been feeling very well but my nurse and support worker have been so much help and given me so much support. I can't fault them at all. I'm grateful, it's much appreciated. Thank you.

Adults and Older People Mental Health Care Group (Inpatient)



Top three complaint themes

1. Clinical treatment
2. Trust Admin/ Policies/ Procedures inc. SU records
3. Patient Care

During 2025/26 Adults and OPS Mental Health Care Group (Inpatient) received 63 complaints and 58 compliments

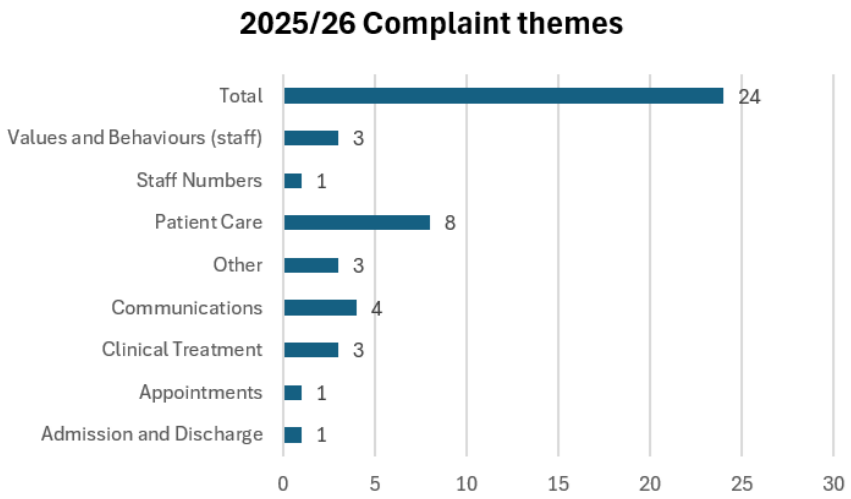
Complaint examples

1. Sister of service user unhappy with the quality of care and support provided on ward.
2. Mother of service user unhappy about all the possessions her daughter alleges were stolen by staff and service users and when they have approached the ward manager, they have refused to process any claims.
3. Carer of service user very concerned regarding incident where friend who is detained under MHA went missing whilst an inpatient and how this was managed by staff including communications to carer.

Compliment examples

1. Thank you so much to all of you for the care you have given to myself and my family. We will forever appreciate you all. Over the last 7 months you have become our family and for that we will be forever grateful. Thank you for all you do.
2. Staff on the ward have done an amazing job supporting my loved one and I am really impressed with the care and treatment she has received. Also, communication with the ward has been excellent and I think staff have really gone above and beyond
3. I just wanted to say a heartfelt thank you for the kindness, patience, and support you showed while looking after mum during her time in your care. It gave our family real comfort knowing she was in such capable and compassionate hands. We are truly grateful for the respect and dignity you showed her every day. Your work makes an enormous difference to families like ours, and we will always remember it with appreciation.

Cheswold Park Hospital



Top three complaint themes

1. Patient Care
2. Communications
3. Clinical Treatment/Values and Behaviours (staff), Other

During 2025/26 Cheswold Park Hospital received 24 complaints and 50 compliments

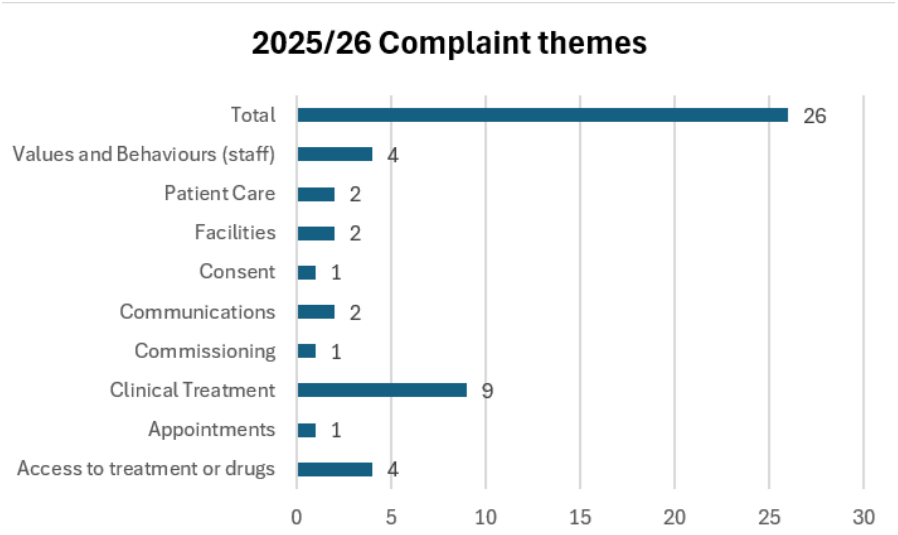
Complaint examples

1. Grandmother of service user unhappy that home visits have been suspended.
2. Service user has contacted the CQC because she feels that services are ignoring her physical health issues relating to catheter and not allowing her access to support when she tries to discuss these.
3. Service user unhappy with response of staff following an incident of self-harm.

Compliment examples

1. The food has been very good these last few weeks. Thank you very much for your care and thoughtfulness and association with your food arrangements!
2. Thank you for all doing an amazing job and working well as a team when the new admission came.
3. A nurse supported a service user to make contact with their sister, as they had no phone for a while. They were really grateful for this as they had gone nearly 2 days without speaking to their family.

Barnsley Physical Health and Wellbeing Care Group



Top three complaint themes

1. Clinical treatment
2. Access to treatment or drugs
3. Values and behaviours (staff)

During 2025/26 Barnsley Physical Health and Wellbeing Care Group received 26 complaints and 165 compliments

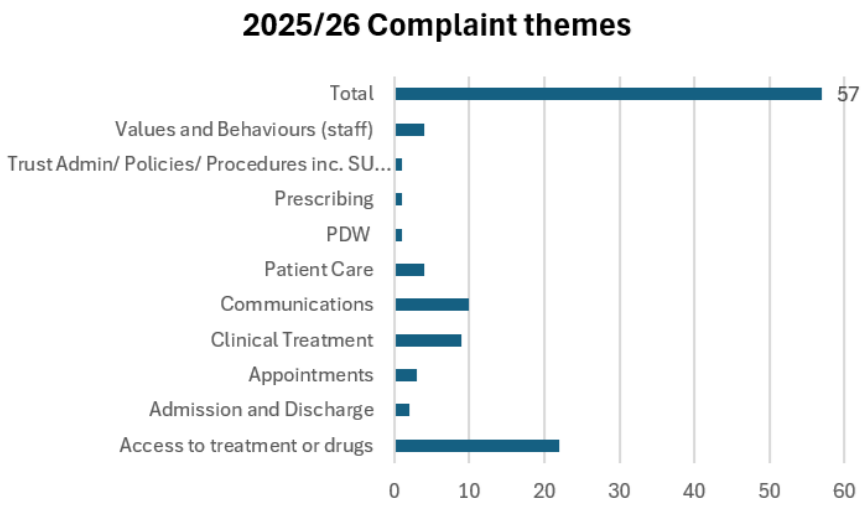
Complaint examples

1. Wife raising concerns about her late husband's care and treatment from the service and their belief that early warning signs of sepsis were missed.
2. Daughter of service user has concerned that care plan that was shared with services in August 2025 hasn't been implemented. This has resulted in an ulcer remaining infected and the service user being in considerable pain and discomfort. There is also a constant pungent smell from the wound.
3. Granddaughter of service user wanting to raise concerns that equipment wasn't fit for purpose causing a fall which resulted in a fracture. Service user was hospitalised. Has now returned home and the equipment is still there.

Compliment examples

1. To all staff, thank you for making my journey easier, you truly are amazing and to the patients who have shared their journeys with me, I hope your journey is positive.
2. Just to say a massive thank you to you all for the care, love, support and dedication you gave to our mum during the 5 weeks of her illness. We cannot thank you enough.
3. I am writing this letter to sincerely thank you for the exceptional care, kindness and professionalism you have shown me during my TB treatment. Your dedication, patience, and compassion made a difficult time much easier to bear, and I am truly grateful for the support you provided. Your gentle approach, encouraging words, and constant attention went far beyond what I could have expected. You not only cared for my health but also brought comfort and reassurance, which meant so much to me and my family.

Children, Young People and Families Care Group



Children, Young People and Families Care Group received 57 complaints in 2025/26 and 99 compliments

Top three complaint themes

1. Access to treatment or drugs
2. Communications
3. Clinical treatment

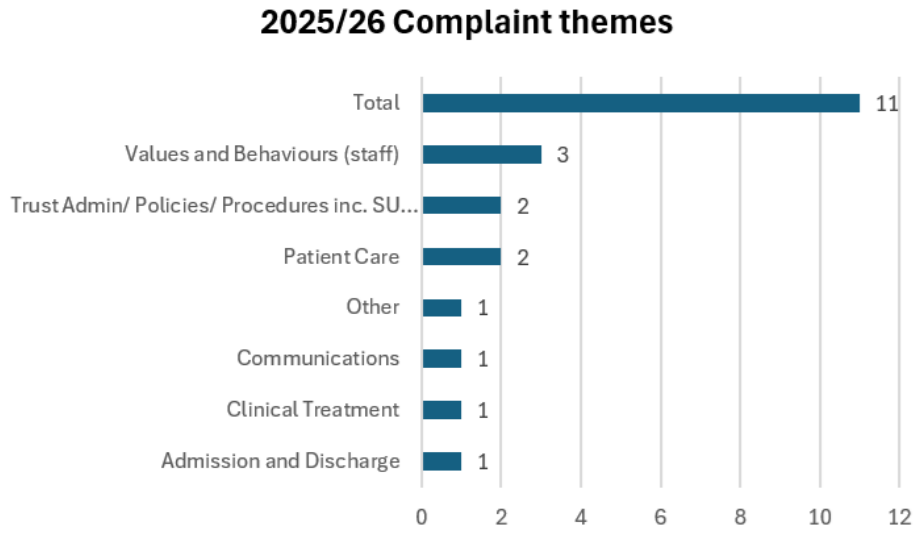
Complaint examples

1. Mother of young person concerned about the care that is being provided to her daughter who has anorexia and that her concerns are being minimised. This has now resulted in a deterioration in her condition and hospital admission with possible detention being considered.
2. Mother of service user unhappy that her son is being declined access to support that she feels he needs.
3. Mother of service user unhappy that they have received information about another service user not in their family and potential breach of their son's information.

Compliment examples

1. Mother of a young person on waiting list wanted staff to know that they appreciate the pressures, and that they have always found our service to be helpful, friendly, kind and considerate, and thanked staff for what we do within the constraints we have.
2. Just a quick email to say a big thank you so far for all the help and support the team are giving my daughter. Nearly 7 years ago we started on this journey to get her help to process what had happened to our family unit. Finally, today I am happy she's getting the help she needs. To be able to go through this process with the team to get her to this point I am ever so grateful to you all. The work you all do as a team is invaluable; you're helping my little girl and I will be forever thankful.
3. I wanted to get in touch to acknowledge the excellent service that my daughter, and we as parents, recently received. My daughter really struggles with anxiety, ritualistic behaviour, and panic attacks; this has huge implications of her life. We have recently concluded parent led therapy and my daughter has engaged in several intervention sessions. We have found the service offered to us, flexible to our needs, responded to us on an individual basis, free from judgement, with warmth and compassion and effective. The staff really have gone over and above to engage with my daughter, demonstrated by bringing visual tools tailored to their interests (such as horse riding). I am grateful for the staff's time, commitment, and passion to engage and support my daughter. We can see definite improvements in her behaviour, which means most importantly that her anxiety and rituals have reduced, and she can have more life opportunities and experiences.

Forensic Services Care Group



Forensic Services Care Group received 11 complaints and 38 compliments in 2025/26

Top three complaint themes

1. Values and behaviours (staff)
2. Patient care
3. Trust Admin/ Policies/ Procedures inc. SU records

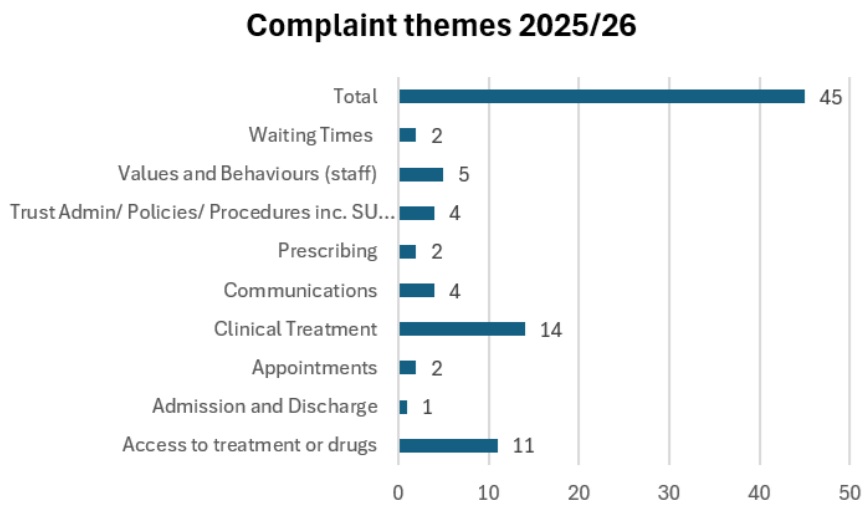
Complaint examples

1. Complainant raising concerns about his son's consultant psychiatrist.
2. Mother of service user unhappy about the transition process for her son which placed him at high risk in the community because it was an inappropriate location. Services have since had to readmit the service user because of the risk, so his transition has gone back to square one.
3. Service user is unhappy with how the leave process is managed as he feels he has been discriminated against.

Compliment examples

1. I think they're very good, always there to help. I feel I can trust them a lot. They have definitely helped me with my mental health and if I went into crisis, I would seek help from them.
2. Thank you all for being an important part of my learning journey and for the support I am truly grateful for the kindness, guidance and encouragement I received from everyone.
3. First of all, I would like to tell you that the staff member does excellent work. She always comes to work with a smile on her face. She never talks depressed. She's a good listener. She never brings her problems with her to work and she's very kind.

Learning Disability and ASD/ADHD Care Group



Learning Disability and ASD/ADHD Care Group received 45 complaints (n=1 LD) and 36 compliments (n=29 LD) in 2025/26

Top three complaint themes

1. Clinical treatment
2. Access to treatment or drugs
3. Values and behaviours (staff)

Complaint examples

1. Sister raising concerns about her brother who hasn't been on the correct medication since his discharge from LD service in April 2025 meaning his mental health has now deteriorated.
2. Service user unhappy with their ADHD assessment and treatment from service. After a three-year wait, their assessment concluded difficulties were anxiety and depression and they had to seek a private diagnosis from Care ADHD, which confirmed severe combined ADHD.
3. Service user unhappy that services have declined to do medication titration as this is not within commissioned remit.

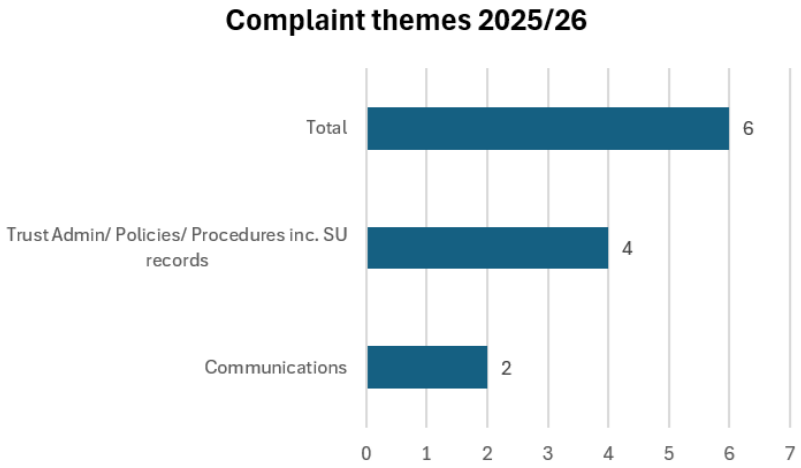
Compliment examples

1. Another success story around the newly developed blood tolerance pathway. Service user is non-verbal and has a diagnosis of significant LD, Autism and complex need. He has required some urgent bloods which primary care have struggled to obtain. They have been awaiting these bloods for 3 years! Today I supported him to his local GP for his first attempt - I had gone with the expectation this would be a trial run to just climatise him to the nurse and room. We had booked one hour time slot, to allow him to orientate and settle. Well, this morning they proved me wrong, they were in out and all blood samples obtained within 5 minutes. He was very pleased with himself and even gave himself a high five!
2. Service user's father gave positive feedback during ADHD medication titration appointment. He was particularly appreciative of the time and care that the staff member dedicated to reviewing his son's clinical history and current presentation, undertaken to establish the most appropriate and individualised care plan, especially considering that he has not met his son in person. He praised the thoroughness and clarity of the documented clinical review. He specifically stated that the details provided in the letter were the most accurate account of his son's care that they have received throughout their entire time under professional services. Both parents shared that they are very grateful for the support provided by the team, and that the detailed

approach and dedication to care have made them feel understood and well supported.

3. The service has proved to be invaluable, not only for my adult daughter, but me also, her carer. Most importantly we were both listened to. The staff members were approachable, knowledgeable with sensible and practical advice. They were easily contactable, and replies were quick. We both felt that they were on our side and gave appropriate and helpful advice when we needed it. It's fantastic when a service really delivers. Thank you.

Trust wide (Corporate support services)



It is not possible to meaningfully analyse complaint themes for Trust wide (Corporate support services) due to the low number received

Trust wide (Corporate support services) received 6 complaints and 37 compliments in 2025/26

Complaint examples

1. Complainant is unhappy about her contact with Trust services in the process of trying to resolve an issue with their GP practice about service provided to their elderly mother with severe mental illness and the annual health check.
2. Concerns that correct procedures were not followed regarding Subject Access Request (SAR).
3. Complainant unhappy with response received from information governance regarding SAR and unhappy with customer services and complaint handling process.

Compliment examples

1. Thank you so much you have been very helpful. I was going round in circles trying to find out who to contact. Thank you again.
2. I just wanted to update you that I've now received a formal appointment confirmation. Given this progress, I am happy for my complaint to be closed, and I'm grateful that the matter was resolved without the need for a full complaint process. Your personal involvement and support made all the difference - thank you again.
3. Two staff from finance went above and beyond for a patient who was struggling financially and aided the ward staff to support him, which really aided with maintaining the patient's safety.

Appendix 7 - Compliments – customer services successes 'Heard, supported delivered'

This appendix highlights the positive feedback received by the customer services team from stakeholders, including complainants, staff, and members of the public. It reflects the consistent recognition of the team's approach to listening carefully, providing meaningful support, and ensuring clear, timely communication throughout each interaction.

Stakeholders have particularly valued the team's ability to keep people informed and involved, helping them feel heard, reassured, and empowered during what can often be complex or sensitive situations. The feedback demonstrates not only the quality of individual interactions but also the team's commitment to delivering fair, responsive, and outcome-focused service.

These compliments reinforce the importance of a customer-centred approach and provide assurance that the team's efforts are building trust, improving experiences, and contributing positively to the organisation's reputation.

Here are some examples of what we have received:

Compliments – customer services successes

'Heard, supported delivered'

This appendix highlights the positive feedback received by the customer services team from stakeholders, including complainants, staff, and members of the public. It reflects the consistent recognition of the team's approach to listening carefully, providing meaningful support, and ensuring clear, timely communication throughout each interaction.

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These compliments reinforce the importance of a customer-centred approach and provide assurance that the team's efforts are building trust, improving experiences, and contributing positively to the organisation's reputation.

Here are some examples of what we have received:

''You are the only person who has made me feel properly listened to''
From a patient

''Thank you so much for taking the time to understand my case (where others haven't!)''
From a patient's family member

''Amazing support''
From a member of staff

''A massive thank you for your coaching and support''
From a member of staff

''You know something, thank you. Since losing my hearing all the way back in 2020 you are the first person to ever acknowledge that above. Fantastic, thank you so much honestly. It makes all the difference in the world of just feeling heard and feeling human. I appreciate it more than you know'.
A patient

''Thank you very much for this letter, it is excellent. I appreciate this has been really hard to do but grateful for all your work on it.''
A member of staff

''Thank you for the kindness you have shown to me I can't tell you how much I appreciate it''.
A patient's family member

''Thank you for your help. It's such a hard and stressful time for us all, I appreciate your help.''
A patient's family member

''Thank you, I knew I had to up my game to reach your high standards. I am happy with the response and have no amendments or comments to add. Hope to work with you again soon.''
A member of staff

''I would also like to commend X for her involvement and support throughout this protracted process. She is efficient, responsive and above all, empathetic. I really appreciated having her direct the whole process and for communicating with me so readily.''
A patient

''Please let me know if I can support you in any way; you have done a marvellous job, and I am sorry that you have had to do this all yourself. I must commend you for your diligence, perseverance and patience, I could not have asked for more...you have gone above and beyond and in my opinion are an absolute credit to your team and the wider Trust.''
A member of staff

''Thank you for your message and for taking the time to explore a possible resolution without the need for a new formal complaint. I also want to sincerely thank you for your support and for helping move this forward so quickly — without the need to go through another formal complaint process. I truly appreciate your time and efforts on our behalf.''
A patient's family member

''Thank you so much you have been very helpful. I was going round in circles trying to find out who to contact. Thank you again.''
A patient

''Thank you I just didn't know who to turn to in trying to find out how to make a complaint. Thank you so much for the information.''
A patient's mother

"Thank you for taking the time to listen – You are a star."
A patient's family member

"Thank you for explaining the process. I was confused at first, but you have cleared up everything for me."
A patient's family member

"I wish the service could listen like you have. I wouldn't have needed to make this call if they had."
A patient

"It's an excellent letter thank you"
Director of services

''I am writing to express my appreciation for the positive outcome of the informal concern I raised a few weeks ago.

Although it is still early days, I'm hopeful that this decision will allow me to build and maintain a strong therapeutic alliance with my clinical team, and to continue working hard toward my mental wellbeing. I am especially pleased that my capacity was recognised in this process, and I'm looking forward to fostering meaningful connections in the community as I prepare for my future.''
A patient

"Thank you for providing this comprehensive and compassionate response."
Healthwatch

"The client is pleased with the earlier response you sent through, and he said it was the best response he's ever received from mental health services.''
Cloverleaf Advocacy

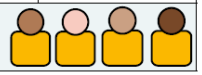
Appendix 4 - Learning & actions taken following complaints

You said	We did
You did not understand how your EUPD diagnosis was reached and why therapy was not offered.	We explained how your diagnosis was made and that it can be reconsidered through reassessment if re-referred. At the time, due to distress and physical health issues, trauma-focused therapy was not appropriate, and you were signposted to more suitable support.
You raised concerns about your catheter care.	A fact-finding review was completed and discussed in a multi-disciplinary team meeting. Appropriate escalation took place and a plan was made to trial removal of the catheter.
Your experience highlighted issues with communication and care.	We have strengthened audit processes, reinforced record-keeping training, and supported staff reflection on escalation and communication to improve practice.
Your records were incomplete.	We are improving record-keeping through audits, refresher guidance, and ongoing discussion at Nursing Council meetings.
Your physical health concerns were not escalated appropriately.	We have addressed this through staff reflection and training. We apologised and acknowledged that escalation should have happened sooner.
Your spiritual needs were not fully considered.	We confirmed your leave supports daily mosque visits and that your spiritual needs are considered in care planning and risk assessments.
You were distressed by how medication was administered.	We explained the legal basis for treatment under restraint and apologised for the impact this has had on your trust.
You were concerned about a safeguarding referral.	We explained that staff are legally required to report safeguarding concerns to the Local Authority for investigation.
You were unclear about your contact with the service.	We clarified that involvement was limited, particularly regarding your leg length concerns.
You disagreed with reimbursement decisions.	We explained that only certain items (such as vapes) can be reimbursed and that other items remained your responsibility.
You questioned decisions about capacity.	We explained how capacity is assessed and clarified that decisions about possessions can differ from treatment decisions.
Communication could have been better.	The practitioner has reflected in supervision to improve communication in future situations.
You had concerns about family involvement and care decisions.	We explained actions taken, including communication with family, safeguarding considerations, and documentation improvements.
Your contact was not followed up.	Staff have been reminded to document and respond to all service user contact promptly.
You questioned the assessment outcome.	We confirmed the assessment followed correct guidance and that you were referred to the most appropriate service.
Language used by staff felt insensitive.	We acknowledged this and will use your feedback to improve training in communication and awareness, including ARFID.
You were unhappy with leave and visiting decisions.	We explained these were based on clinical judgement and safety, and confirmed support was later provided for you to visit your mother.
A resource used in therapy caused distress.	We apologised and are reviewing how materials are selected to ensure they are trauma-informed.
Therapy materials were not appropriate.	We will review all materials, stop routine use of the documentary, and ensure risk assessments and content warnings are used.
Your son's placement caused distress.	We acknowledged this and confirmed the placement was carefully considered with all agencies and your son's involvement
Your A&E experience was upsetting.	We apologised for delays and language used and acknowledged gaps in documentation and communication.
You did not understand clinical decisions.	We provided clear explanations of the decision-making process.
You had concerns about medication and documentation.	We explained prescribing decisions and acknowledged documentation could have been clearer.
You were unhappy with referral triage processes.	We attempted resolution and acknowledged concerns about reliance on self-reporting.

You said	We did
Your belongings were not stored appropriately.	We have changed practice, so items are now stored securely in ward offices.
You did not understand why an assessment and discharge occurred.	We explained the need for assessment and why discharge and signposting were appropriate.
Your care changes were not communicated well.	We apologised and confirmed your transfer to a new team with ongoing support and referrals in place.
Important life events were not recorded.	Staff have been reminded to accurately document significant information and reflect on this.
You experienced long waits and felt dismissed.	We explained national pressures, apologised for your experience, and clarified how assessments are conducted.
You had concerns about medication and side effects.	We explained treatment decisions, medication changes, and the rationale for depot medication.
The referral process caused delays.	We have improved triage systems, introduced “While You Wait” packs, and are undertaking a service review.
You were concerned about medication management.	We confirmed all procedures were followed safely once your physical health improved.
You wanted your complaint reopened.	We provided a full response and confirmed your current care and support arrangements.
You were unhappy with how an incident was handled.	We provided a detailed explanation based on records and confirmed actions taken to ensure safety.
There were delays in your care being reallocated.	We acknowledged this was unacceptable and confirmed learning while outlining interim support provided.
You had concerns about care following an overdose.	We confirmed no errors changed the outcome but have improved documentation and procedures.
You felt your needs were not recognised.	We explained assessment decisions and signposted you to appropriate primary care support.
Staff comments about personal items felt insensitive.	We have reminded staff to be respectful and sensitive in their approach.
Communication about appointments was unclear.	Staff have been reminded to check preferences and ensure records are accurate and consistent.
There were concerns about equipment safety.	We confirmed maintenance processes and that all equipment will be updated through routine servicing.
Staff manner during assessments was not appropriate.	Staff have been reminded to maintain a supportive and attentive approach.
You wanted a review of your care.	A new outpatient appointment has been arranged with a different consultant.
You disagreed with not accepting a private ADHD diagnosis.	We explained why an NHS assessment is required before treatment can be prescribed.
Carer needs were not considered.	We will ensure carers’ health needs are explored and assessments offered where appropriate.
You were not involved in decisions about your care.	We acknowledged this and reinforced that patients must be fully involved in decisions.
Your discharge was unclear.	We acknowledged this and will ensure discharge processes are clearly communicated.
The response to your request felt dismissive.	We acknowledged this and reinforced the need for sensitive communication.
Your care felt inconsistent.	We acknowledged this and will work to ensure clearer, more consistent decision-making.
You were concerned about the interpreter.	We found no evidence of bias and clarified the interpreter’s role is to support communication only.
Care pathways were not clearly explained.	Staff have been reminded to clearly explain options and check understanding of next steps.

Appendix 5 - FFT equality data

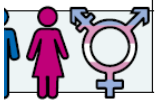
Ethnicity	Number	%
Any other Asian background	14	0
Any other Black background	2	0
Any other ethnic group	71	2
Any other mixed background	5	0
Asian/Asian British	89	2
Bangladeshi	1	0
Black/African/Caribbean/Black British	38	1
Indian	14	0
Mixed/multiple ethnics groups	53	1
Pakistani	16	0
White - Any other	167	4
White and Asia	4	0
White and Black African	1	0
White and Black Caribbean	5	0
White English/Welsh/Scottish/Northern Irish/British	3239	87
Total	**3719**	



Age	Number	%
0-16	92	2
17-20	126	3
21-30	450	12
31-40	642	16

Disability	Number	%
Mental health condition	823	39
I do not have a disability	343	16
Long standing illness	309	14
Physical impairment	179	8
Cognitive impairment	149	7
Learning disability	127	6
I prefer not to say	104	5
Other	73	3
Speech impairment	25	1
Total	**2132**	





I am a...	Number	%
Caerer	406	19
Parent	1	0
Service user	1775	81
Staff	1	0
Total	**2183**	



Sexual orentation	Number	%
Bisexual	1	3
Heterosexual	25	86
I prefer not to say	2	7
Lesbian	1	3
Total	**29**	



Appendix 6 - FFT breakdown by Care Group/ service line/ area

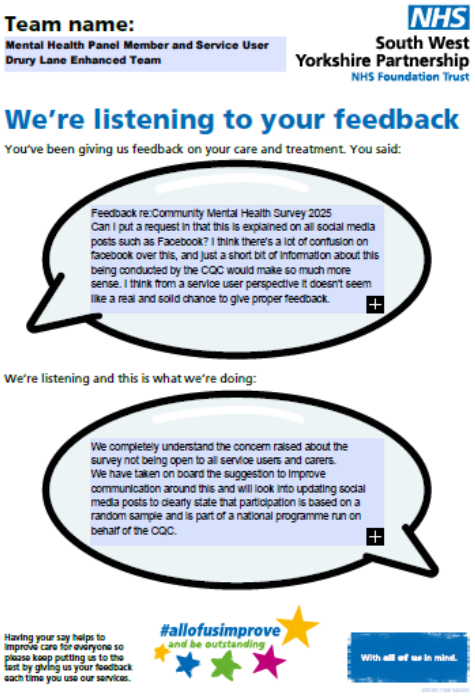
Care Group	Number	Percentage
Acute Mental Health (85%)	**475**	**88%**
Barnsley	66	86%
Calderdale	53	79%
Kirklees	233	96%
Wakefield	123	95%
Mental Health (85%)	**3199**	**82%**
Barnsley	1613	84%
Calderdale & Kirklees	1059	89%
Wakefield	527	74%
Forensic (60%)	**121**	**58%**
All age community	22	81%
Low	52	46%
Medium	47	64%
CAMHS & Children	**668**	
Children (95%)	346	97%
CAMHS (75%)	322	84%
Physical Health (95%)	**3865**	**94%**
Inpatient	74	95%
Nursing	217	96%
Long term conditions	687	98%
Health & wellbeing	1568	97%
Therapy	1319	95%
Learning Disability/ ASD/ ADHD (85%)	**702**	**92%**
Learning disabilities	358	96%
ASD/ ADHD	344	88%

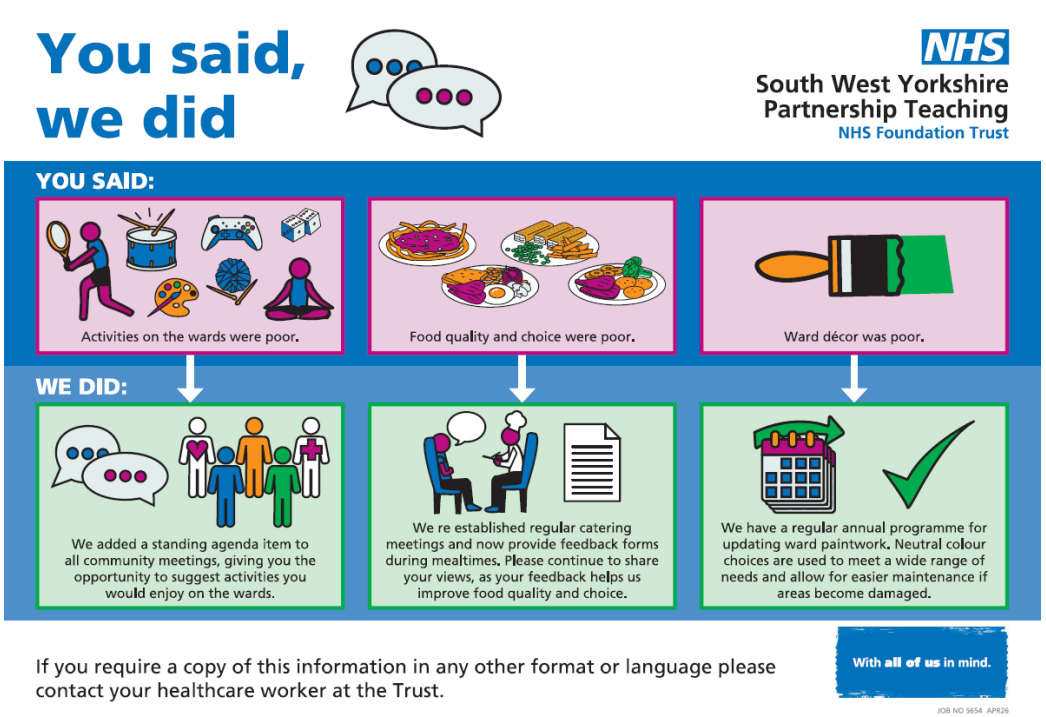
Appendix 7 - Learning & actions taken from FFT Feedback

Location	You Said	We Did
Neuro Rehabilitation Unit (NRU)	Lack of activities on ward in the evening.	The ward introduced movie night and quiz night.
	Mattresses on the ward were uncomfortable.	New mattresses ordered.
	Patient rooms are cold.	Staff to check to check with patients to see if they need blankets.
	More information regarding NRU to be provided.	Details on the internet and information is provided through the therapy team.
Barnsley Recovery College	The duration of the courses is too long, and we would like courses to be more frequent.	We changed some of our workshops into courses, extending and introducing new course content.
Calderdale CAMHS	You'd like to know who you might be seeing when you come for your appointments	We created a presentation providing info about who CAMHS are and who you might see at your appointment, and displayed this on the TVs in the waiting room
	You'd like to see the waiting room brightened up	We installed TV's and created bright and engaging content to be displayed
Kirklees CAMHS	You'd like to know who you might be seeing when you come for your appointments	We created a presentation providing info about who CAMHS are and who you might see at your appointment, and displayed this on the TVs in the waiting room
	You'd like to see the waiting room brightened up	We installed TV's and created bright and engaging content to be displayed
Nostell	" I would like it if we could choose our meals the day before"	Thank you for your feedback. Catering is rolling out new ordering system which will ensure every service user gets a choice of what they want to eat for every meal.
Stanley	"There should be more salad and sandwich options in this weather"	Catering are rolling out individual ordering to Stanley ward by the end of June. This will allow service users to choose what you want daily.
	'The food is rubbish, it seems to be the same thing each week'	Catering are working on a new menu to be launched soon & looking into more options to improve the quality and variety of food across the trust.
Calderdale Neurodevelopmental Assessment Service	Our initial letters did not provide enough information about the assessment and who would be completing it.	More information has been added to the first appointment letter, along with staff team pictures.

	You felt that being invited to a 'feedback appointment' did not reflect the importance of the meeting. You wanted something to take away from the final appointment to support your understanding of the diagnosis.	If the report is ready in time for your outcome appointment, you will receive a physical copy of this to take away that day. We have changed the wording we use for this final appointment to 'outcome appointment
Kirklees CAMHS IST Team	You'd like the option to come to a different base to meet your needs	We now offer appointments at our other bases to meet your needs
	You'd like more options for where/how assessments take place to make them more accessible	We introduced telephone and home visit appointments
	The Behaviour in Bitesize course was too long	We reduced the number of sessions to 8 weeks







South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 11.4

Private/Public paper:	**Public**		
Title:	**Quality Account 2025/26**		
Lead Director:	**Caroline Johnson, Chief Nurse / Director of Quality and Professions**		
Mission/values:	The report demonstrates commitment to all the Trust's values, which are fundamental to delivering safe and high-quality health care: • We put the person first and in the centre • We know that families and carers matter • We are respectful, honest, open and transparent • We improve and aim to be outstanding • We are relevant today and ready for tomorrow		
Purpose:	The purpose of the paper is to provide Trust Board with the final version of the Quality Account for 2025/26. The quality account contains the statutory required data updates alongside the Trust's journey of improvement across services, for staff and for service users.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	The Quality Account contributes to all BAF risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Each provider trust within an Integrated Care System is governed by regulatory bodies, and production of a Quality Account is a formal requirement of each trust. It is important that regulatory activity is monitored, learning is taken from feedback, and action is taken to remedy any findings. Quality of care is a key priority for our Integrated Care Boards and the information provided in the Quality Account supports and describes the delivery of quality care.		
Any background papers / previously considered by:	The Quality Account has been shared with executive management team and Quality and Safety Committee in May 2026 and has been reviewed by the Chief Nurse and Trust communications team.		

With **all of us** in mind.

	The Quality Account for 2024/25 was shared and approved at Quality and Safety Committee in June 2025.
Executive summary:	The Quality Account for 2025/26 has been completed within the nursing, quality and professions directorate. The report contains the requirements set out in the detailed requirements for quality reports 2019/20 along with any updates/changes from NHS England in more recent years. This includes: • A statement on quality from the Chief Executive and Chair • Priorities for improvement and statements of assurance from the Board • Other information The Quality Account is produced annually and in line with the guidance from NHS England, focuses on the quality of services by looking at: • Patient safety • Effectiveness of patient treatments • Patient feedback about care provided Feedback from the previous year indicated that the Quality Account for 2024/25 was too detailed and not easy to read or follow. As a result, a review of several other NHS Trusts' Quality Accounts has been completed, and this will be reflected in changes and additions to the Trust Quality Account for 2025/26. In the Quality Account for 2024/25, it was stated that the 2025/26 Quality Account would reflect the 'Best Quality' statement. The Quality Account for 2025/26 is separated into three parts: Part One: A welcome from our Chief Executive, Mark Brooks and then provides an overview of South West Yorkshire Partnership Teaching NHS Foundation Trust, our Trust strategy and the foundations that underpin quality across our services. This section also contains a patient story and a showcase of our successes throughout 2025/26. Part Two: An outline of the progress we have made during 2025/26, in relation to our quality priorities (the 'Best Quality' statement). This includes some showcase items where improvements in quality and care have been made. It also discusses our achievements and sets out objectives for 2026/27 and beyond. Part Three: A report on key national indicators, set out by NHS England and shares our performance, in relation to other indicators which are monitored by the Trust Board. • The report is also being shared with the clinical governance group and operational management group. • External stakeholders require 28 days for consultation and review and as such the draft Quality Account has been shared following agreement at EMT. External stakeholders include Members Council Quality Group and ICB colleagues. • This updated version contains feedback received to date.

	• Following receipt of feedback, the report will be updated and the final version shared with the Chair and the Chief Executive, and Trust Board on 30 June. • The report will then be published on our external website by the 30 June, in line with requirements.
Recommendation:	**Trust Board members are asked to:** • **APPROVE** the Quality Account for 2025/26 for publication on the Trust external website.

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Quality account 2025 – 26



With **all of us** in mind.

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Part one: Welcome to the quality account

1.1. Welcome to the South West Yorkshire Partnership Teaching NHS Foundation Trust quality account for 2025/26

All providers of NHS care are required to produce an annual quality account, showcasing the work undertaken during the year to continuously improve the quality of our services and the care we provide. We are proud to be able to share the excellent work that our staff, patients and carers have achieved throughout the year and our priorities for the coming 12 months.

This document is divided into three sections:

Part one: Includes a welcome from our chief executive, Mark Brooks, and then provides an overview of South West Yorkshire Partnership Teaching NHS Foundation Trust, our Trust strategy and the foundations which underpin quality across our services.

This section also contains a patient story and a showcase of our successes throughout 2025/26.

Part two: Outlines the progress we have made during 2025/26, in relation to our quality priorities. This includes some showcase items where improvements in quality and care have been made. We discuss our achievements and set out our objectives for 2026/27 and beyond.

Part three: Includes a report on key national indicator set out by NHS England and shares our performance in relation to other indicators which are monitored by the Trust Board.

We also share comments from our key stakeholders in relation to the quality account. These can be found within the appendices.

1.2. Chief executive and chair's welcome

Welcome to our 2025/26 quality account. We are pleased to introduce this reflection of our services outlining our performance and priorities for improvement.

Our patients and service users need us to provide the very best services that we can, when they need them, and in a way that makes them feel included. For us to achieve this, it's essential that we have a clear, coherent strategic direction, and that we have a thorough understanding of our external environment and internal capabilities.

Last year the government introduced a new way to rate NHS trusts using a performance dashboard. Based on a range of performance metrics, each trust is placed into one of four core segments. Segment 1 represents the organisations with the least challenges, while segment 4 contains those with the most. This means that being given a rating of one is the best a trust can achieve.

At the end of the first quarter of 2025, we were in segmentation three. This was because of our financial position at the time. At the end of quarter two our segmentation improved to one, and we remain in segmentation one at the end of quarter four. We are now ranked third in the country, out of a total of 61 comparable organisations. This reflects the amazing work we do every day to deliver exceptional services and help the people and communities we serve. It also recognises all we have done to help manage our budgets effectively and provide value for money.

Achieving our rating took drive and determination from everyone, and to retain this rating has taken a continuing effort. This is thanks to our colleagues' unwavering commitment to our improvement journey.

Over the past two years we have been working more closely to formalise our partnership with the University of Leeds with regards to student education and research and development. Building on our existing Associated Teaching Trust agreement, in 2025 the University of Leeds approved our application to become a Teaching Trust.

We are excited to continue our journey together to further create innovative opportunities in teaching, learning, and research, and to embed evidence-based practice. The partnership is one of the very few nationally where Teaching Trust status has been achieved by a trust that provides not only community services but also mental health, learning disability, and autism services. This demonstrates our collective commitment to parity of esteem for physical and mental health.

We formally launched our new name, South West Yorkshire Partnership Teaching NHS Foundation Trust, at our 2025 annual members' meeting held on 17 September 2025.

On 1 October 2024, services at Cheswold Park Hospital (CPH) transferred to the Trust. This transition was enabled through external funding provided by NHS England.

In the months leading up to the transfer, the Trust established a dedicated programme team to develop and implement a structured plan to align the hospital with NHS ways of working, including the adoption of NHS systems, governance arrangements, and organisational policies.

In June 2025, NHS England removed Cheswold Park Hospital from enhanced monitoring. This decision reflects NHS England's assurance that the Trust has the appropriate leadership, workforce, systems, and policies in place to deliver high-quality, safe care for patients.

The NHS is built on a founding principle of equality and social justice. We all share a commitment to fostering an inclusive, respectful and professional environment for colleagues, service users, carers and visitors. Through our equality, diversity and inclusion work, we continue to strengthen our efforts to prevent, challenge and address racism and abuse, ensuring everyone feels heard, valued and supported. Creating

a safe and inclusive workplace is essential for the wellbeing of our teams and the quality of care we provide.

As part of our continued commitment to being trauma-informed and responsive, we have an ambition to become a staff-led zero prone restraint organisation. This initiative reflects our shared dedication to enhancing both service user and staff experiences, fostering a culture of safety, dignity, and compassion across all care settings.

In 2025, the Trust was recognised as one of the top five mental health trusts in the country for supporting privacy, dignity and wellbeing in care. The results were published as part of NHS England's Patient-Led Assessments of the Care Environment (PLACE) programme.

PLACE (Patient-Led Assessments of the Care Environment) assesses a range of non-clinical aspects of healthcare premises that are identified by patients and the public as being important to their experience of care. As part of this assessment, patients and staff score trusts on the extent to which privacy and dignity are supported within care environments.

Our Trust achieved a score of 99%, representing an improvement from 97% in 2023, and demonstrating our continued commitment to providing environments that respect and promote patient privacy and dignity.

The financial position across the NHS remains challenging, and our Trust is not immune to these pressures. However, through the hard work, commitment, and professionalism of our staff, we have successfully delivered our financial plan while continuing to maintain and improve the quality of care we provide.

We are unequivocal that safety will never be compromised. Our values underpin everything we do, and during times of financial challenge they become even more important. Our leadership approach and the decisions we take are firmly grounded in these values.

We remain true to our purpose: to help people reach their potential and live well within their communities. This commitment continues to guide our priorities and actions, even in the most demanding circumstances.

1.3. Statement of assurance

This quality report has been prepared in line with the requirements of the NHS Act 2009, regulations of the Health and Social Care Bill 2012 and NHS Improvement, the independent regulator of foundation trusts. The Board of Directors has reviewed the quality report and to the best of our knowledge, we confirm that the information contained in this report is an accurate account of our performance and represents a balanced view of the quality of services provided by the Trust.



Chief executive: Mark Brooks



Chair: Jayne Brown M.J. Brown.

1.4. Patient story

I have spent most of my life living with constant physical discomfort, exhaustion, sleep deprivation, malnutrition, pain, suicidal thoughts and anxiety. For many years, these symptoms were put down to depression, or I was investigated for physical conditions such as Cushing's disease or thyroid problems. I knew that I did not have depression but as the physical tests were always clear, doctors insisted that I was depressed and prescribed anxiety medication that I refused to take. Due to a change of jobs I incidentally learnt about autism and my profile seemed to fit. I completed several self assessments; after 2 years of consideration and a period of intense exhaustion, I spoke with my GP, and he referred me to the adult autism service. I was reassured that it formed part of a wider service, which I felt would help reduce the chance of a misdiagnosis.

The diagnostic process was intense and tiring. I worried about the unknown: the chair I would have to sit on (some fabric, for example on buses, is painful to sit on), whether the paperwork (that forced me to engage on a personal level with family) might get lost, the strong smell in the Manygates car park and whether it would follow me into the clinic room. I did not want an autism diagnosis as there is no 'cure' and I worried that if I was autistic, how could I possibly manage another forty years living with this level of discomfort and exhaustion. I hoped it would be something else with a cure.

Although the process was challenging for me the professionalism of the team made it accessible, the receptionist was kind and answered my questions with patience, she was empathic without being patronising; this gave me the confidence to attend the first appointment. The service was clear, logical, and structured, which helped me engage. The first clinician I spoke to actively listened with an open mind in a way I had never experienced before. That alone meant more than I can say and was therapeutic in its own right; normally, sharing that type of personal experience results in being dismissed.

The Manygates building comes with physical challenges which were visual, auditory, and scent related. The formal task-based assessment requiring imaginative, storytelling and communication skills was so draining that I felt so tired when driving home. To this day I have no idea how a number of children's games can be so overwhelming. The wait between the final session and receiving the diagnosis felt very long but enabled processing time.

When I received my diagnosis in a face-to-face meeting, it was unsettling but opened the door to support I desperately needed. The clinician took time to explain what help was available, which reassured me. The diagnosis process was detailed and comprehensive, which I needed to enable confidence in the findings; it took a number of months to really believe that I was autistic.

Afterwards, I received communication sessions and home-based support from an occupational therapist. She supported me with practical strategies at home, helped me understand myself more clearly, and encouraged me to be kinder to myself. These interventions have been truly life-changing. My sensory assessment was particularly important; I have learned that sensory needs aren't always obvious and I do not have the ability to identify my needs or emotions independently. Having a formal sensory profile with the sensory diet I follow has genuinely saved my life. I no longer have suicidal thoughts as I am comfortable; over 40 years of constant pain has gone.

The communication course was eye opening helped me understand other people better. The diagnosis gave me confidence to be openly autistic in the workplace and seek formal reasonable adjustments.

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My experience of the autism service has transformed my life. From a continuous improvement perspective there are some small changes that could make things even better.

Differences in clinician training can lead to very different experiences, so I strongly encourage wider use of Oliver McGowan training - it is very clear when staff have not completed it.

- Routine sensory profiling with sensory diets designed for autistic adults
- Simple post-assessment support to help people recover from the exhaustion of appointments
- Specific interventions addressing interoception
- Linking training and service outcomes to national quality assurance processes, so care is consistent everywhere in the country

My life has been difficult at times, but thanks to the support I received, I can ensure that my needs are met, I stay safe and can manage wider family relationships better. I have had less physical accidents, trips and falls, have significantly more energy, an improved diet and rarely feel physical discomfort and pain.

Finally, I wanted to say a massive thank you to the team of professionals that I have met and the staff in the background that have ensured a comprehensive quality service.

1.5. About our Trust

We are a specialist Teaching NHS Foundation Trust that provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. We also provide some medium secure (forensic) services to the whole of Yorkshire and the Humber.

We exist to help people reach their potential and live well in their community. Our organisation provides services that promote healthier communities and prevention through supported self-care, recovery focused approaches, peer support and community involvement, as well as volunteering and supported engagement. We are proud of our Recovery Colleges, three linked charities of Creative Minds, Spirit in Mind, and the Mental Health Museum, our volunteering services, and Altogether Better (a national organisation that is hosted by the Trust) further contribute to this.

We have almost 5,000 colleagues, in both clinical and non-clinical support services, working hard every day to make a difference to the lives of service users, their families and carers.

According to the latest census data 2021, the Trust serve 1.237 million people living across South and West Yorkshire. The Trust also has services and colleagues in North Leeds, Sheffield, Doncaster, and Rotherham. Most of the care we provide is delivered in local communities. This means we work in all the villages, towns, and cities, from Todmorden and Hebden Bridge in the west, to Castleford and Pontefract in the east, Hoyland and the Dearne Valley to the south of Barnsley.

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Our Trust provides a wide range of services across several communities. These services are commissioned by two separate ICBs and we work across five place-based partnerships:

- West Yorkshire Health and Care Partnership
  - Kirklees place
  - Calderdale place
  - Wakefield place
- South Yorkshire Integrated Care Partnership
  - Barnsley place
  - Doncaster place

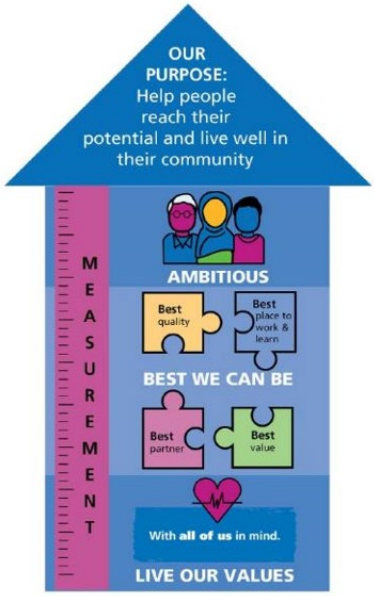
Some of the Trust's specialist services such as the forensic mental health services are commissioned under specialist commissioning which comes directly from NHS England.

1.6. Trust strategy 2024-2030

Our Trust strategy for 2024–2030 was approved by the Trust Board in October 2024. The strategy sets out our clear ambitions and priorities for the period to 2030 and describes how we will deliver our purpose as an organisation.

A summary of the strategy is illustrated in the infographic below.

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Our strategic aims:

1. We will live our values
2. We will be the best we can be
3. We will be ambitious

Our purpose was developed through extensive co-creation with stakeholders and is to **help people reach their potential and live well in their community**.

Our strategy describes our role within neighbourhoods, communities, and places, setting out how we will work together and what we aim to achieve. As our overarching Trust strategy, it informs all other strategies and plans, providing clear direction and alignment. It brings clarity to our focus, priorities, and the actions we will take to deliver our purpose.

Our three strategic aims allow us to focus on specific areas where we can collectively make the greatest difference. These are:

- **Strategic aim one: We will live our values**
- **Strategic aim two: We will be the best we can be**
- **Strategic aim three: We will be ambitious**

For each strategic aim, and informed by evidence from our engagement and analysis, we have:

- Set out clear strategic objectives detailing what we will do
- Defined what success will look like and what we will see if we are getting it right
- Identified measurable indicators to track progress

This approach ensures a clear line of sight from our strategy through to delivery, supported by robust measures that enable us to assess progress and determine whether we are achieving what we set out to do.

Strategic aim two is particularly pertinent to this quality account, as it focuses on our commitment to delivering the highest standards of quality, safety, equity, and continuous improvement across all our services. The priorities and achievements set out in this quality account align directly with this strategic aim and demonstrate how we are delivering on our ambition to be the best we can be for the people we serve.

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Strategic aim two: We will be the best we can be

Our second strategic aim is to be the best we can possibly be. We aim to do this every day and for every contact we have with those we serve and those colleagues we work with. For this strategic aim we have identified **four best statements** which we have used to theme our strategic objectives.



Best quality

To provide the best quality we can we have identified four strategic objectives. These are set out below. Within the strategy there are statements about how we will know if we are getting it right and examples of the measures and metrics we will use:

- We will ensure equitable access, experience and outcomes for all
- We will ensure our services are consistently safe, responsive, personalised and effective
- We will ensure continuous inclusive improvement is integral to developing and delivering creative and innovative services
- We will consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation

Priorities for 2026/27

We have developed our priorities for 2026/27 through our annual planning processes, aligning them closely to the Trust strategy. Our comprehensive bottom-up and top-down planning process has developed an ‘all of us’ annual plan that sets out what we will do, in line with our strategy. Our priorities for 2026/27 have been developed through our annual planning processes and are closely aligned with the Trust strategy. A comprehensive, integrated planning approach—bringing together both bottom-up and top-down input—has enabled us to develop an ‘all of us’ annual plan.

This plan clearly sets out what we will deliver during 2026/27 and how this will support the achievement of our strategic ambitions.

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There are specific areas of quality improvement work that sit beneath these strategic improvement priorities. These focus on particular areas of concern identified through our analysis of available data, feedback, and intelligence.

Under the **best quality** priority, this will include examples such as:

- Responding to clinical demand, capacity, resources, patient flow
- Reducing length of stay in inpatient areas
- Productivity
- Undertaking evidence-based establishment reviews
- Continuing the focus on reducing restrictive practice
- Improving clinical record keeping
- Ensuring we continue to do all we can to provide mental health inpatient care close to a person's home

1.7. Clinical strategy

The Trust's inaugural clinical strategy was published in 2025 and sets out our ambitions for clinical services, including what we aim to achieve and how we will deliver this.

Since publication, we have worked collaboratively with key stakeholders to co-develop a comprehensive clinical strategy implementation plan. We continue to meet on a quarterly basis to oversee delivery and monitor progress against the agreed clinical priorities.

Strong facilitation with clinical leads has been a key enabler, and we are now building further momentum by strengthening alignment and support from our operational lead colleagues. All priorities remain on track for delivery within the timeframes identified.

Recent updates include, but are not limited to:

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Co-production:

- Pharmacy-led pilot delivering seven-day discharge follow-ups in primary care
- Programme underway to strengthen the role and impact of allied health professionals (AHPs) within mental health inpatient units

Equality:

- Psychological professions are engaged in North East and Yorkshire (NEY) reciprocal mentoring scheme for aspiring leaders of the global majority. Continuing professional development (CPD) events aimed at health care support workers (HCSW) who have a psychology degree to ensure equity of access to experience and career progression
- Implementation of the deaf inclusivity project, including clinical tools and a business case for in-house British Sign Language (BSL) interpretation services
- First internationally educated professional nurse advocates (PNA) recruited and trained, with further in training

Learn:

- The research and development team organised a funding and networking seminar on 2nd June 2026
- Student-led placement piloted with higher education institute (HEI) partners to shape future research and leadership placement opportunities
- Bitesize learning sessions embedded into preceptorship forums, with plans for expanded study-day provision

Grow:

- Work has started on new pre-registration placement pathways with advanced practice colleagues
- Our chief allied health professional (AHP) is contributing to national-evidence gathering on safer AHP staffing in mental health wards
- Phase two of the community nursing safer staffing tool implemented in Barnsley neighbourhood rehabilitation service (NRS), with staff training planned

Lead:

- Development of enhanced trauma-informed clinical supervision training is underway
- PNA workforce has expanded to 42, with 21 more in training and plans to secure funding for additional training

Holistic:

- Development of a governed psychological therapies system and complex emotional needs pathway
- Psychological therapists added to older adult crisis teams to embed formulation and trauma-informed practice
- Leadership established for neuropsychological expertise development
- Preceptorship offer now fully multiprofessional, with forums open to assessed and supported year in employment (AYSE) social workers and trainee clinical psychologists

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1.8. Equality, diversity and inclusion (EDI) strategy

In April 2025, our Trust Board agreed a new equality, diversity and inclusion (EDI) strategy. This new strategy was developed through extensive engagement, comprehensive analysis and clear alignment to our overall Trust strategy.

Our EDI strategy ensures that **EVERYONE** is supported to live well in their community. It describes how we will work to actively understand our communities and colleagues so that all of us reach our potential, identity does not predict outcome, and this is the best place to work and learn for everyone. Explicitly, the strategy sets out our EDI approach and plans for both our community of colleagues (our colleagues) and also the communities we serve (our public). An important part of the communities we serve are our service users, patients and carers.

The strategy contains six strategic aims.

1. Strengthen our approach to equality, inclusion and involvement

We will strengthen our approach and weave equality, inclusion and involvement through everything that we do, so it is easier to do the right thing.

2. Embrace equality

We will consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation and the wider determinants of health.

3. Recognise diversity

We will ensure we recognise and value diversity through the systematic collection and analysis of data (both numbers and voice) according to protected characteristics. We will use this to develop understanding and inform decision-making.

4. Deliver inclusivity

We will ensure inclusive practices with #allofusinmind so that our colleagues feel they belong, are proud to work here and want to stay.

5. Involvement

We will truly listen to all our communities and demonstrate the difference we make to those we serve.

6. Data and insight

We already have a range of metrics and measurement in place around the EDI agenda. Further work had been undertaken to clarify the measures to assess how well we are delivering against our aims and to identify where additional or different effort is required.

Examples of our progress and achievements

- **Equality impact assessments (review)**

A task and finish group has adopted a quality improvement-led approach to review and streamline the current tools and processes.

Drawing on recognised best practice from across the public sector, the group is identifying and testing solutions designed to strengthen assurance, improve compliance, and enhance equity across services, supporting the organisation to give due regard to its statutory equality duties under the Equality Act 2010.

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Implementation activity remains on track, with current efforts focused on gathering and responding to feedback on the proposed tools.

1.9. Quality foundations

Alongside the Trust strategy and the supportive and enabling clinical strategy and EDI strategy, the Trust has a number of key areas that provide the foundations for the delivery of high-quality care.

1.9.1 Patient-Led Assessment of the Care Environment (PLACE)

Each year the Trust participates in the Patient-Led Assessment of the Care Environment (PLACE) assessments, which enables NHS patients to be involved reviewing the care environment. These assessments consider how the environment supports the provision of clinical care in areas such as privacy and dignity, food, cleanliness, general building maintenance and the extent to which the environment supports the care of people living with dementia or a disability. The assessments take place annually and help to drive improvements in the care environment.

All Trust wide inpatient wards (with the exception of Lyndhurst unit) are included in the PLACE audit and in 2025, Cheswold Park Hospital was assessed for the first time. In summary, the results for 2025 evidence the commitment and dedication of staff across the Trust and our estates and facilities colleagues working together to continue to achieve and maintain high standards of quality. In most areas the scores remain positive and well-maintained, providing assurance that the Trust represents good practice and is meeting the needs of patients in non-clinical aspects of healthcare. The full PLACE report for 2025 is available separately.

The Trust was revealed as one of the top five mental health trusts in the country for supporting privacy, dignity and wellbeing in care in the PLACE programme.

1.9.2 Infection prevention and control

Infection prevention and control (IPC) is essential to delivering safe, high-quality care. It protects patients, staff, and visitors from avoidable harm by reducing the risk of healthcare-associated infections. As required under the Health and Social Care Act, organisations must have robust IPC systems, policies, and procedures, making IPC a legal responsibility, not an optional activity.

Evidence-based IPC practices support therapeutic, recovery-focused mental health environments, where patients often share communal spaces and may have challenges engaging with their physical health needs. IPC is also a core element of the PLACE assessments, enabling service users to shape safer and cleaner care environments.

By embedding clear routines such as effective environmental cleaning, hand hygiene arrangements, and tailored risk assessment, IPC safeguards vulnerable individuals whose mental or physical health conditions may increase their susceptibility to infection.

IPC also contributes positively to organisational learning through incident review, advice on best practice and support to the physical health agenda, all of which can reduce patient safety incidents. It supports continuity of care by preventing ward closures, minimising service disruption and reducing staff sickness through surveillance of infection and outbreak management all of which directly impact safe delivery of services.

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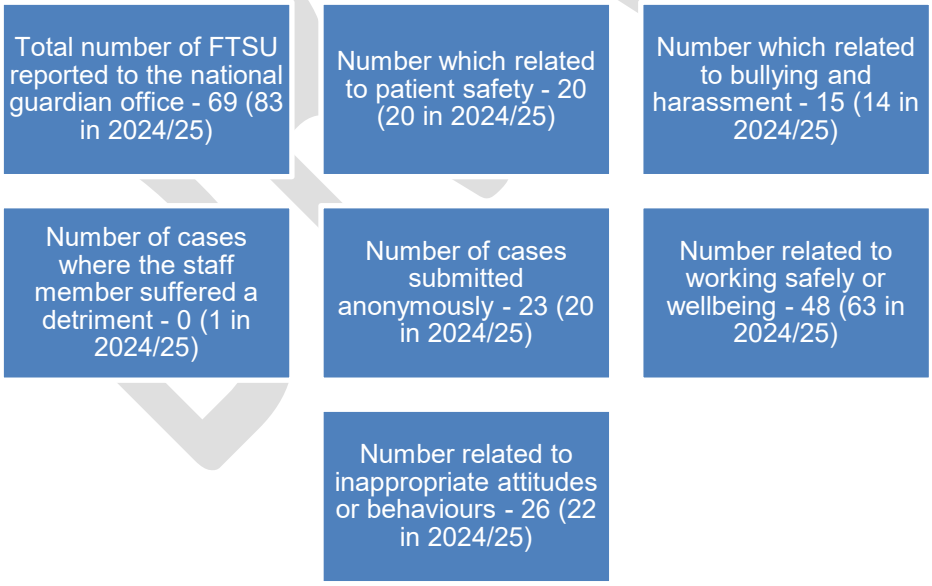
Strong IPC practice fosters trust, dignity, and confidence amongst patients and staff, reinforcing a culture of safety and compassion. In mental health settings, where holistic, person-centred care is essential, IPC is integral to protecting recovery, stability, and the overall high quality care experience.

1.9.3 Freedom to Speak Up (FTSU)

The Trust recognises the importance of creating an organisational culture where staff feel able and safe to raise concerns at work including issues relating to malpractice, patient and staff safety issues, harassment and bullying, and fraud. To support this, the Trust has a full-time Freedom to Speak Up Guardian (FTSUG), who is supported by two part-time guardians.

The FTSUG continues to proactively develop and promote a more open and transparent culture, supporting the organisational priority for staff to feel safe and encouraged to raise concerns appropriately. Freedom to Speak Up is a key element of organisational induction for all new starters and the FTSUG attends the Trust welcome event. FTSU training is available to all staff and line manager training incorporates freedom to speak up principles to support managers in embedding an open culture. A network of civility and respect champions also continues to provide signposting and support to staff.

In 2025/26 the Trust reviewed the NHS England Board-level FTSU reflection and planning tool, which was approved by Trust Board in November 2025. A new Freedom to Speak up action plan was subsequently established and is monitored through the Trust's audit committee. The FTSU policy was also reviewed in 2025/26 in line with organisational requirements. A FTSU oversight group meets every six weeks to oversee the strategic delivery of FTSU across the Trust, and themes and learning from FTSU cases are shared at care group partnership meetings.



1.9.4 Patient and Carer Race Equality Framework (PCREF)

In our equality, diversity and inclusion (EDI) strategy, PCREF is identified as a key tool for delivery and for measuring a meaningful and sustainable progress towards greater participation and collaboration. This national framework sets the foundations for improvement in our work to actively involve our patients and carers in decision making, and to improve their access, experiences and outcomes. It acts as an anti-

racism, race equity and accountability framework, supporting mental health trusts to demonstrate how they are meeting their core legislative requirements and how they can improve organisational cultural competence.

The aim of the PCREF programme is to improve access, experience and outcomes for our racialised and marginalised communities, including our workforce, by:

- Fostering closer working relationships with our racialised and marginalised communities to implement real-time and transparent feedback loops
- Ensuring ethnically and culturally diverse patients and carers are treated as equal partners in decision making on their care and treatment, and are actively involved in the design, development and review of care pathways

We have established this programme of work in the Trust. This includes the development of an external PCREF advisory group made up of members of our communities with lived experience, or those advocating on behalf of others through the voluntary, community and social enterprises (VCSE) sector. The group has rated the NHS England identified competencies from highest to lowest based on their perspectives and lived experience. This has enabled the co-production of our PCREF action plan.

The Trust has an agreed Anti-Racism Statement and aligns this within the aims of the PCREF programme to improve access, experience and outcomes for our racialised and marginalised communities, including our workforce by:

- On a day-to-day basis, we deliver our PCREF commitments through embedded approaches that shape care and culture across the organisation. This includes but isn't exhaustively having a nominated Executive lead, and operational person with responsibility for driving the commitments within the Organisation
- A Quality Improvement methodology with inbuilt dashboards so that data in the form of both numbers and voice provide insight around focus and impact.
- Working towards person-centred care planning that reflects identity, culture and lived experience
- Learning from staff networks to inform policy and practice
- Adopting a proportionate approach to Equality Impact Assessments (EIA) that routinely consider the impact of decisions on racialised communities; and clear reporting, response and learning processes for racialised incidents, ensuring concerns are addressed and drive improvement.

We have also ensured that the work is aligned with other existing programmes, including Culture of Care, Mental Health Act, the Triangle of Care, and our anti-racism work.

1.9.5 Trauma-informed care

"Being trauma-informed is a duty of care for the whole organisation and requires a whole cultural change in how we operate. A trauma informed approach must be embraced in all aspects; as well as in direct therapeutic interventions, it should be integrated into leadership, estates services, human resources, research and strategic priorities." (www.candi.nhs.uk, 2023)

Becoming a trauma-informed (TI) organisation is included in the Trust strategy and clinical strategy and we have ensured it is considered as part of annual planning processes. Employment policy reviews continue to be undertaken through a trauma-informed lens, alongside a focus on staff support and wellbeing, and alignment with the newly developed people plan.

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The work continues in collaboration with partners across the system. For example, trauma-informed principles underpin the Wakefield district plan and the Trust's clinical lead has contributed to the complex lives workstream.

Other examples of improving quality though engaging TI principles include:

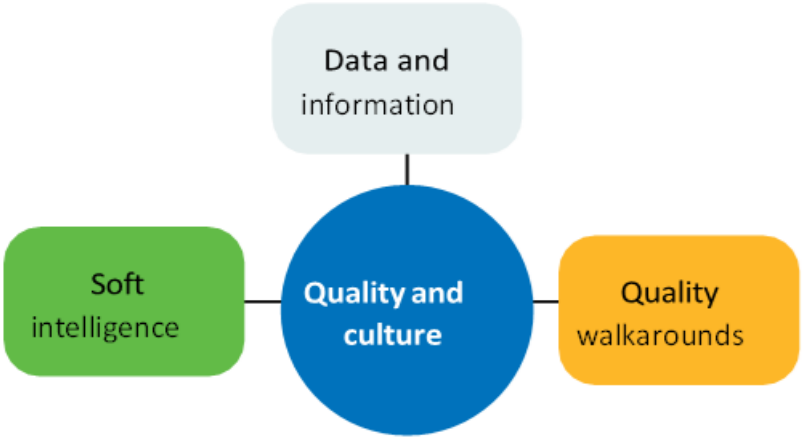
- Colleagues in physical health have adapted ROOTS (a tool for assessing trauma informed maturity) to better meet service needs following feedback from colleagues in the neurological rehabilitation unit (NRU). This adapted version is about to be piloted by podiatry colleagues in Barnsley
- Ongoing delivery of trauma-informed training in response to service-specific requests, including child and adolescent mental health services (CAMHS) and older people's services (OPS)
- Following review, trauma-informed training will continue to be introduced through staff induction and service-specific learning days using case-based examples, rather than as a standalone mandatory training module. This approach will be implemented as part of the wider mandatory training and learning reviews
- The principles have been thoughtfully considered as part of recent work on sexual safety across the Trust and will underpin evolving development around work focused on a women's pathway



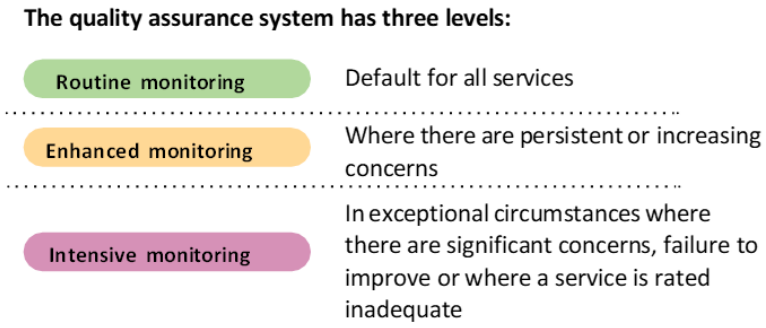
The drive to embed and connect TI practice with different agendas continues, with good progress to improve quality of service delivery for service users, carers and staff.

1.9.6 Quality assurance system (QAS) and quality walkarounds

The Trust quality assurance system (QAS) was launched formally in early 2025. This framework triangulates data, information and feedback to provide oversight of quality and culture across Trust services. It has been designed to provide the Trust with a robust system for monitoring and assuring the quality of services, and to identify risks early so that actions can be put in place.



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A key element of the QAS is a quality walkaround. This is a quality intervention that focuses on open and transparent communication. It enables service users, staff and others to work together to identify areas of excellent practice, where improvements are needed and overcome any barriers to these.

In 2025/26 there have been:



1.10 Achieving recognition and celebrating excellence

1.10.1 Teaching Trust status

In May 2025 the University of Leeds approved the Trust's application to become a Teaching Trust.

The Trust and the University of Leeds already had a strong history of partnership working in relation to student education and research and development, and over the last two years have worked together to formalise the partnership.

This partnership is one of very few nationally in which Teaching Trust status has been achieved by a trust that provides not only community services but also mental health, learning disability and autism services.

Teaching Trust status enables the Trust to create innovative opportunities for teaching, learning, and research, and to embed evidence-based practice. The partnership with the University of Leeds will further enhance education, training, and learning opportunities for all staff and students.

1.10.2 Older people mental health team in Barnsley

The team has been re-accredited for a second consecutive cycle by the Royal College of Psychiatrists through the Accreditation for Community Mental Health Services (ACOMHS) programme, with accredited status confirmed until July 2028.

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This re-accreditation provides independent assurance that the service continues to meet nationally recognised standards for quality, safety, multidisciplinary working, and patient-centred care.

1.10.3 Safety Incident Response Accreditation Network (SIRAN)

The Trust was awarded **SIRAN accreditation** by the Royal College of Psychiatrists. This accreditation demonstrates that robust processes and governance arrangements are in place to review safety incidents, identify learning, and implement improvements that reduce risk and enhance outcomes for patients and staff.

This is important because it provides independent assurance that patient safety is actively prioritised, learning from incidents is embedded into practice, and continuous improvement is central to how we deliver care.

1.10.4 British Journal of Learning Disabilities

As part of the national review of mental health legislation, the government commissioned NHS England to deliver a national quality improvement programme focused on improving equity of experience for people from ethnically diverse backgrounds, and for people with learning disabilities and autism.

With the support of our chief medical officer, Professor Subha Thiyagesh, alongside the senior leadership team at the Horizon assessment and treatment unit and colleagues from legal services, the Trust undertook a significant piece of work exploring the use of advance choice documents (ACDs) for people with learning disabilities admitted to Horizon under the Mental Health Act.

This work examined how ACDs can support greater involvement, autonomy, and person-centred decision-making for this population. The findings have been peer-reviewed and published in the *British Journal of Learning Disabilities*, demonstrating the Trust's contribution to national learning and evidence-based improvement in mental health care.

1.10.5 Care and commitment to staff

On Thursday 1 May 2025, the Trust celebrated the care, dedication, and commitment of its staff through a special day of recognition. This included our learner and long service presentations, as well as our annual Excellence awards, recognising the outstanding contributions of colleagues across the organisation.

1.10.6 Research fellowship

Dr Estelle Verdi, principal counselling psychologist and service lead of the West Yorkshire Maternal Mental Health Service – Paths, was awarded a Medical Humanities in Practice Research Fellowship with the Institute for Medical Humanities (IMH) at Durham University.

1.11 Our quality achievement headlines for 2025/26

April	• Launch of the Patient and Carer Race Equality Framework • SystmOne (patient record system) went live at Cheswold Park Hospital • Quality assurance system (QAS) was launched across the Trust
May	• Trauma-informed celebration and learning event held, attended by 130 people • Application to become a Teaching Trust was approved • The Trust was revealed as one of the top five mental health providers in the country for supporting privacy, dignity and wellbeing in care

	• Our first clinical audit showcase event was held, with a range of presentations and guest speakers
June	• Our third annual research, discovery and innovation conference was held • Marked Clinical Audit Awareness Week (2-6 June), celebrating the benefits and impact of clinical audit and quality improvement work in healthcare • Trust simulation suite opened in Barnsley, designed to enhance the skills of community-based NHS staff • Celebrated Learning Disability Week with the theme 'do you see me?', which focused on challenging the barriers people with a learning disability face and celebrating the things they bring to society
July	• Celebrated 25 years of delivering smoking cessation services • The all-age forensic community services hosted a stakeholder event which promoted the innovative forensic community offer • Two catering managers represented the Trust in the NHS Chef of the Year regional heats • Patients Know Best (PKB), a secure personal health record system, went live in the integrated neighbourhood teams SystmOne unit in early July
August	• A new wound care drop-in clinic opened in Barnsley • The Trust engaged with the final two stages of the Culture of Care programme • The caring garden at Fieldhead Hospital was shortlisted for an NHS Forest award
September	• Team members from Paths, our West Yorkshire maternal mental health service, attended an event at the Houses of Parliament to mark Black Maternal Mental Health week • Our South Kirklees early intervention in psychosis team successfully delivered clozapine treatment in a community setting for the first time • A caseload management tool for community mental health services was established to support services to deliver effective caseload management • Barnsley musculoskeletal (MSK) community service successfully held their first community appointment day on 4 September, offering patients on the MSK waiting list faster access to personalised and holistic care • We hosted our 2025 annual members meeting on 17 September, reflecting on our achievements from the year and looking ahead at our plans for the future
October	• Held our annual safeguarding conference, with a theme of sexual abuse and intrafamilial harm • Opened a new Kirklees sensory integration assessment and therapy room at the learning disability resource centre in Fox View in Dewsbury • Our Trustwide volunteer service created a co-production group for the lived experience community • To mark Diwali, the Trust held a celebration in the wellbeing and learning centre at Fieldhead on Thursday 23 October. The event gave the opportunity for colleagues from all backgrounds to connect with each other and learn more about the festival of light
November	• On Carers Rights Day (20 November) we launched our new commitment to family, friends and carers • Electronic prescribing and medication administration (EPMA) was successfully rolled out across all our intensive home-based treatment teams (IHBTT) • We marked Occupational Therapy Week, celebrating colleagues and sharing stories, highlighting the impact and difference they make

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	• From 10-14 November, we recognised Psychological Professions Week by celebrating more than 400 psychological professions staff across our services and holding a continuing professional development event • We launched the re-designed Trustwide clinical record keeping audit
December	• Held our annual connecting people celebration event, highlighting the importance of the diverse and reflective voice from our communities • Launched our sexual safety programme for staff • On 5 December, we held an event to celebrate the dedication and hard work of our staff taking part in a registered nurse degree apprenticeship in partnership with The Open University
January	• Reviewed our inpatient falls management flowchart to reflect recently updated NICE guidelines • Our recovery colleges welcomed a delegation of guests from Hong Kong to support co-production, lived experience and peer support • Colleagues from early intervention in psychosis services completed Maastricht interviewing to enable them to explore and understand service users' voice-hearing experiences
February	• Supported Race Equality Week (2-8 February), with the theme #ChangeNeedsAllofUs emphasising that progress requires participation from everyone • Marked National Apprenticeship Week and reflected that 434 colleagues have successfully completed programmes across 28 different apprenticeship standards since we began offering apprenticeships • We became the lead NHS partner of a new mental health research centre with the University of Huddersfield to improve mental health research capacity
March	• Trust dietitians supported Nutrition and Hydration Week by attending the Glassworks in Barnsley to share tips and advice on good nutrition and hydration and resources for older adults on nourishing meal and drink ideas • Child and adolescent services and early intervention in psychosis teams in Calderdale were recognised for their involvement in a recent special educational needs and disabilities (SEND) inspection, in which they showcased partnership working and clinical expertise • Work continues to strengthen our deaf inclusivity, including rolling our deaf champions training • Held our third annual suicide prevention conference joined by guest speakers and colleagues from across the region

Part Two: Priorities for improvement

2.1 Quality improvement

To deliver the quality improvements set out in our priorities, the Trust uses an evidence-based quality improvement (QI) approach. This consistent and systematic method for improvement across the organisation is known as **#allofusimprove**.

Quality improvement is embedded throughout the Trust's new strategy, aligned to our shared vision and purpose of being the best we can be. This ensures that improvement activity is systematic, sustained, and focused on achieving meaningful benefits for the people who use our services.

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A strong and consistent narrative across the Trust is that quality improvement is everyone's business. Regardless of role, profession, or work setting, every colleague has a part to play and a responsibility to contribute to continual improvement.

The Trust is supported by a dedicated quality improvement team, made up of colleagues with specialist QI skills and expertise. The team provides support, advice, and guidance to individuals, teams, and care groups, enabling them to develop, deliver, and sustain improvements within their local areas.

All individuals and teams across the Trust have access to a wide range of quality improvement tools to support improvement in their areas of practice. This includes the **model for improvement toolkit**, which is used to design, test, and implement small-scale or incremental improvements, as well as the **six-step quality improvement project toolkit**, which is used to support larger-scale and more complex improvement work.

The six-step quality improvement project toolkit guides teams through our bespoke improvement methodology, covering each stage of the process. This includes identifying the challenge, using quality improvement tools to understand the underlying issues, generating and testing ideas for change, implementing improvements, and evaluating and sharing learning and improvement stories to support spread and sustainability.



Our quality improvement model aligns to the five pillars of NHS Impact and our offer to all colleagues across the organisation spans the four quadrants of:

- People
- Training, skills and knowledge
- Support
- Connecting and sharing

Our people are at the heart of the model, and it is important to us that we have **effective leadership for improvement.**

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This year we have continued to ensure we have an **organisational focus on data and measurement** to ensure the work we do is making a difference.

Creating a workplace culture that supports quality improvement is vital to ensuring our systematic approach to improvement is embedded across the Trust.

The team work alongside colleagues within the Trust's learning and development team to ensure that quality improvement is built into the fabric of colleagues one to one discussions, supervision sessions and appraisals.

The Trust offers a variety of mechanisms to **build improvement skills from senior leaders through to frontline staff** as our training offer is open to anyone who has an interest in quality improvement.

Quality improvement example – inpatient food waste, quality and cost improvement

During 2025/26, the catering and facilities team, alongside ward staff, undertook a project which focused on monitoring, managing and actively reducing food waste. This looked at production waste, plate waste and unserved meals. Reducing food waste is an effective strategy for lowering environmental impact and is in line with the Trust's food and drink strategy and social responsibility and sustainability strategy.

The Trust facilities team started by auditing the number of food portions served, portions remaining unserved, and associated weight of food waste (in tonnes) across a 10-month period at Fieldhead Hospital. This work built on learning from the impact of individual food ordering at Kendray Hospital on food wastage.

The findings from this audit informed the catering team's work plan for individual meal and food ordering as a means to reduce food waste. This involved patient engagement in ward catering orders and a move away from historical bulk ordering towards tailored, individual meals. Horizon unit and Walton ward commenced individual ordering in April 2025, with all other wards at Fieldhead following in July 2025.

Results and improvements

Food waste in hospitals remains a significant sustainability challenge. Since 2022, all food waste has been segregated and repurposed as a valuable resource for the generation of green energy.

The results of the changes over a 10-month period for Newton Lodge and Fieldhead Hospital wards demonstrate an overall reduction in food waste of 47%, decreasing from 2.515 tonnes in May 2024 to 1.325 tonnes in August 2025.

In addition, the initial audit results informed several quality and cost saving improvements including:

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Product	Action	Cost savings per portion
Creamed potato	Changed the product to a better quality and tastier product	£0.59 per portion ↓ to £0.34; ↓ recently £0.28
Parmentier potato		£0.49 per portion ↓ £0.27; ↓ recently to £0.22
Halal meals	x2 naan breads served were noted going to waste –now served optional request of x1 naan bread	£0.54 per portion (150g = 444kcal,16g protein) ↓ to £0.27
Rice	Change of product	£0.52 per portion ↓ £0.24 per portion
Milk	↓ amount of milk daily due to excessive amounts noted by the inpatient wards – a cost saving of ~ £6570 per week (Each ward 1 pint / patient & 4 additional)	
Water	Sourced a larger bottle at a cheaper cost	
Seclusion pack	Reviewed with a cost saving of £0.24p per pack	

The next steps are to replace traditional paper-based ordering with digital technology, in line with National Standards for Healthcare Food and Drink. Digital solutions reduce paper and printing costs, enable real-time adjustments to meet individual patient needs, and improve efficiency and sustainability. This supports the delivery of more personalised mealtimes and helps optimise nutrition and recovery for patients.

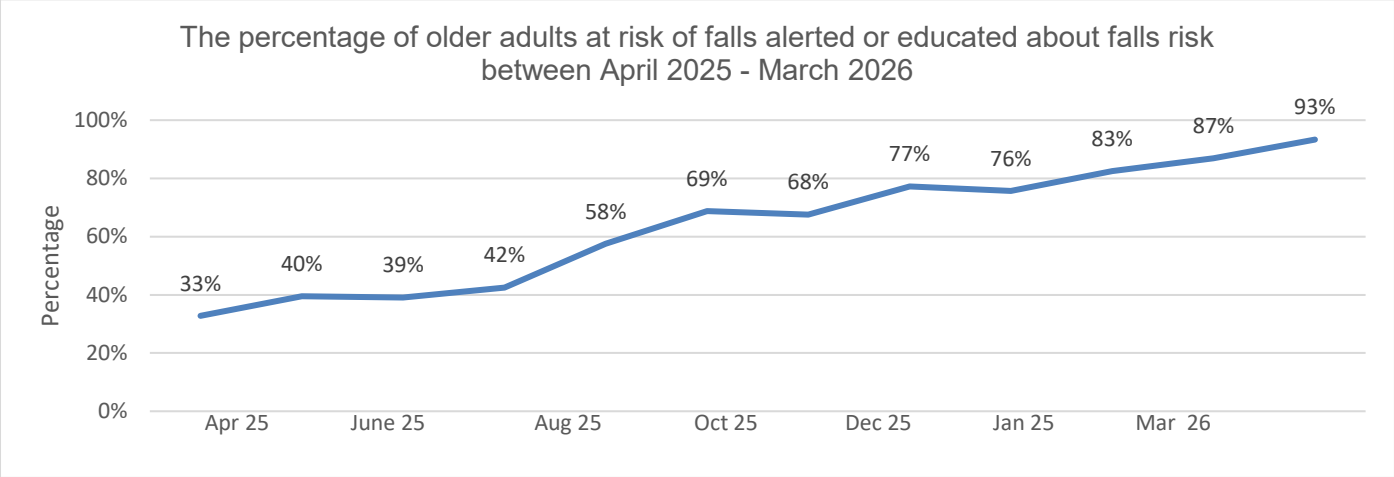
Quality improvement example – falls improvement

Throughout **2025/26**, the Trust has maintained a strong focus on patient safety and reducing harm related to falls. This work has been focused not only on preventing falls, but on minimising associated harm and protecting patients' health, wellbeing, and independence. Improving understanding of falls risk among patients, families, and staff has been a key driver of these improvements and has supported more proactive and preventative care.

A range of quality improvement initiatives have been delivered during the year, which have strengthened consistency, reliability, and effectiveness in falls prevention and management, including:

- Using the NICE quality standard for falls to improve the quality and completeness of multi-factorial risk assessments, resulting in more individualised care planning, targeted therapeutic interventions, and clearer mobility plans
- Embedding safety huddles within inpatient wards to improve communication and shared situational awareness of risk, contributing to earlier identification of deterioration and improved management of patients at higher risk of falling
- Updating the Trust's falls and bone health policy and the inpatient falls management pathway to strengthen clinical decision making, escalation processes and governance oversight
- Ongoing collaboration with the research and development team on electronic falls (eFalls) monitoring, which has identified higher rates of falls among younger adults and links with gender, polypharmacy and diagnosis; a draft clinical validation study has been submitted for publication
- Measurable improvements in patient education relating to falls risk, as demonstrated in the graph below, supporting safer behaviours and contributing to a reduction in avoidable falls through increased awareness and engagement

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Looking ahead to 2026/27, the Trust will continue to build on this progress to further reduce the frequency and impact of falls across services. This will include strengthened review of patient safety events to ensure learning is consistently identified and translated into practice; thematic reviews of patients experiencing frequent falls to identify best practice and address potential missed opportunities; continued alignment with NICE quality standards; and the systematic sharing of learning and outcomes across services to support sustained improvement and harm reduction.

Quality improvement example – reducing the use of prone restraint

Across our services, we have a clear and sustained ambition to become a **zero prone restraint organisation**. Prone restraint refers to the use of physical restraint where a person is held or placed face down. This position is associated with a significantly increased risk of physical harm, including respiratory compromise, positional asphyxia, and increased psychological distress. For these reasons, prone restraint is widely recognised as a restrictive practice that should be avoided wherever possible and used only as a last resort.

Throughout 2025/26, work has continued to support staff to use safer, alternative approaches when supporting patients. Improvement activity has been informed by enhanced use of data, with a particular focus on reducing staff-led prone restraint, including during seclusion exits and for the administration of intramuscular medication. This has strengthened our understanding of risk and enabled targeted action in areas where prone restraint has been most frequently used.

Every incident of staff-led prone restraint is subject to structured review involving specialist advisors and relevant clinical teams and is considered through the Trust's reducing restrictive practice (RRP) action group. This process enables learning to be identified, supports staff to reflect on decision-making, and promotes safer, less restrictive approaches, contributing to a sustained reduction in the use of prone restraint.

Communication and reporting processes have been further strengthened to improve the accuracy, consistency, and reliability of prone restraint data. This has enhanced organisational oversight and reinforced our focus on reducing harm and improving patient safety.

More recently, a dedicated dashboard has been developed to clearly distinguish between staff-led prone restraint and service user-initiated prone positioning. This improved clarity supports more meaningful

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analysis of practice, enables identification of both good practice and areas requiring improvement, and ensures trauma-informed principles remain central to learning and service development.

In addition, a clinical decision making flowchart is being developed to support clinicians in consistently distinguishing between staff-led prone restraint and service user-led positioning. This will further strengthen shared understanding, improve reporting accuracy, and support safer clinical practice across inpatient services.

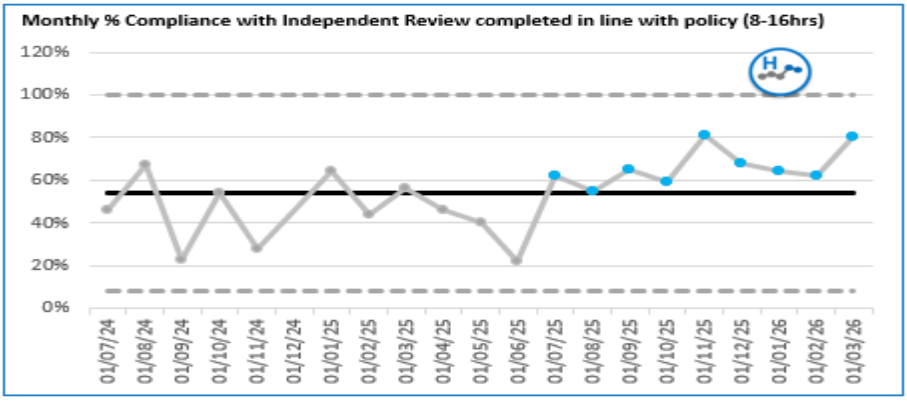
The table below illustrates the number of occasions on which staff-led prone restraint has been used within inpatient services. Any increase in usage is subject to detailed review through the Trust patient safety oversight group. It is also reported to the quality and safety committee and Trust Board, ensuring robust governance, transparency, and accountability.

Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
6	9	11	12	7	13	5	14	4	7	3	3	5

Quality improvement example – reducing the use of seclusion in inpatient settings

In line with our commitment to promoting and embedding a least-restrictive approach, a focused programme of quality improvement is underway to reduce the use of seclusion across inpatient services. Seclusion is only used when absolutely necessary, and practice is underpinned by continuous assessment to support termination at the earliest safe opportunity, in accordance with the Mental Health Act Code of Practice. Preventative strategies are further strengthened through Restraint Reduction Network (RRN) accredited training.

Following an internal audit, additional quality improvement work has been undertaken to review and refine electronic seclusion documentation. This work aims to ensure information is captured accurately and consistently, while continuing to embed the principles of a compassionate, therapeutic culture of care. Although this work is ongoing, early data from mental health inpatient services, as shown in the figure below, demonstrates sustained improvement in the completion of timely multidisciplinary team (MDT) independent reviews. This supports safer decision making, stronger oversight, and more effective planning to resolve seclusion episodes promptly.



A seclusion working group has also been established, providing a forum for clinicians and specialist advisors to share learning, explore challenges, identify what is working well, and promote consistent good practice across services. Seclusion review breaches and emerging themes are reviewed through the

Trust's reducing restrictive practice (RRP) Trust action group, ensuring appropriate challenge, escalation, and governance.

Data on the use of seclusion is routinely reviewed to monitor trends, identify variation, and assess the impact of improvement actions. This enables the Trust to understand where progress is being made and where further targeted interventions are required. Learning from this data is used to inform practice, training, and service development.

The perspectives of people with lived experience have been incorporated into current training programmes, supporting reflective practice and professional learning. While this represents an important foundation, further quality improvement work has been identified to strengthen co-production, ensuring lived experience perspectives are meaningfully embedded, sustained, and influential in shaping future practice and service improvement.

2.2 Quality governance and oversight

Our executive lead for quality improvement and quality governance is the chief nurse / director of quality and professions, providing clear senior leadership and accountability for quality across the Trust.

Central to our approach to quality governance and assurance is the **quality and safety committee** (QSC), a formal sub-committee of the Trust Board. The QSC provides oversight and assurance on the quality and safety of care delivered by the Trust. Reporting into the QSC is the clinical governance group, which ensures assurance on quality through close working with care group quality and governance colleagues.

During 2025/26, focused work was undertaken to strengthen governance arrangements and reporting pathways. This included enhancing the flow of information from key Trust action groups and care group governance groups, and strengthening escalation routes for emerging concerns to the clinical governance group and onward to the quality and safety committee.

The **clinical governance group** plays a key role in horizon scanning and risk identification, the interpretation and assurance of national and local quality and safety directives, and the critical review of organisational quality and safety improvements. It also supports information sharing, planning, and the monitoring of implementation of improvement actions across the Trust. Oversight is further strengthened through the **members' council quality group**, which supports and oversees the Trust's approach to quality governance.

Governance and quality assurance are integral to how we manage and improve quality across the organisation. At executive, care group, and service levels, the Trust operates a trio model of leadership, bringing together clinical, operational, and governance roles to provide coordinated leadership and accountability for quality.

We routinely monitor a range of quality indicators through our **integrated performance report** (IPR). This can be accessed at team, service, and Trustwide levels, and selected information is published externally on the Trust's website. Quality indicators include, but are not limited to, the NHS Friends and Family Test (FFT), infection prevention and control performance, Patient Safety Incident Response Framework (PSIRF) activity, safer staffing, pressure ulcers, restrictive interventions, and complaints. Each indicator has defined measures and targets that reflect our ambition for continuous improvement. The IPR is routinely reviewed by the executive management team (EMT), the Trust Board and its committees, and the members' council quality group.

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Learning and improvement are supported through a comprehensive clinical audit programme, alongside active engagement in research and development, including partnerships with universities and the Academic Health Science Network (AHSN). The Trust also contributes to and learns from external benchmarking and assurance programmes, including the National Confidential Inquiry into Suicide and Homicide (NCISH), mental health benchmarking initiatives, and workforce capacity and demand reporting.

To maintain a strong operational focus on quality, an enhanced clinical risk and performance report is presented to the operational management group (OMG). This, alongside the wider quality assurance framework, supports the identification of good practice, highlights areas requiring improvement, and maintains oversight of quality and risk across services.

Quality oversight is also embedded within routine governance meetings at care group level, with clear routes for escalation to the clinical governance group, the executive management team, and the quality and safety committee where required. This ensures a robust, transparent, and responsive system for managing quality and safety across the Trust.

2.3 Best quality – progress against the priority areas

In line with our best quality aim, the following information outlines our progress with meeting the four priorities.

- We will ensure equitable access, experience and outcomes for all
- We will ensure our services are consistently safe, responsive, personalised and effective
- We will ensure continuous inclusive improvement is integral to developing and delivering creative and innovative services
- We will consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation

2.3.1 We will ensure equitable access, experience and outcomes for all

2.3.1.1 Capturing patient experience



Patient experience is central to all Trust activity, ensuring care is person-centred and that the voices of patients, families, and carers are heard. Understanding these experiences helps us identify opportunities for improvement and supports our ambition to deliver outstanding care and outcomes.

Patient experience is captured across the Trust using a range of methods. Feedback is triangulated to provide a comprehensive view of the experiences of patients, families, and carers, and to demonstrate how this insight is used to drive improvements in the quality of care.

Our annual patient experience report brings together key feedback to support understanding, learning, and ongoing improvement.

During 2025/26, the Trust strengthened how patient experience is measured and used to drive improvement. **Service-specific patient experience surveys** were developed, in line with the Care Quality

Commission's (CQC) five key domains, ensuring feedback was relevant and directly linked to quality and regulatory expectations.

Feedback from **635 service users** across a wide range of services demonstrated high levels of satisfaction, with scores ranging from **91% to 98%**. Actions are underway to address slightly lower scores, which primarily related to awareness of how to raise concerns.

Surveys were also piloted within **child and adolescent mental health services (CAMHS)**, generating positive feedback and informing plans to increase participation from children and young people, strengthening how their views shape service development.

The Trust continued to support delivery of the **Patient and Carer Race Equality Framework (PCREF)** by using Friends and Family Test (FFT) data to monitor experience across ethnic groups. Quarterly reporting, volunteer engagement, and plans for new equality dashboards aim to ensure feedback highlights inequalities and supports culturally responsive improvement.

Friends and Family Test (FFT) response rates increased by 5% compared with the previous year, supported by improved collection methods, the introduction of QR code posters and preparation for future integration with Patients Know Best and the NHS App. **In total, 9,030 FFT responses were received in 2025/26.**

Overall, FFT results remained strong, with mental health services achieving 92% positive ratings against an 85% target, and community services achieving 97%, slightly below their 98% target.

Staff, communication and patient care featured as the most common positive themes, while access, waiting times and admission and discharge processes were identified as key areas for improvement. This feedback is shared with services and used to inform targeted quality improvement activity.

Looking ahead to **2026/27**, the Trust plans to expand feedback opportunities, implement the **Experience of Care Framework**, enhance patient experience dashboards, and develop a local community mental health survey to generate more detailed, locally relevant insight.

2.3.1.2 Cheswold Park Hospital integration

In October 2024, the Trust assumed responsibility for delivering services at Cheswold Park Hospital, a secure hospital in Doncaster providing medium and low secure forensic inpatient services. Throughout 2025/26, a comprehensive integration programme has been delivered to embed the hospital within the wider Trust.

This programme comprised **20 priority areas**, focusing on operational delivery, quality and safety, and people and workforce, and has supported the safe, effective, and sustainable integration of services.

Quality and safety improvements integrated into the wider Trust include:

- Mandatory training, achieving high levels of compliance across the hospital
- Introduction of physical health plans to support service users with physical health needs
- Establishment of processes to ensure medical devices meet Care Quality Commission (CQC) standards
- Implementation of the Trust's reducing restrictive practice training and processes
- Introduction of Datix and the Patient Safety Incident Response Framework (PSIRF)

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- Review of food provision against British dietetic standards, with regular input from the Trust's senior catering dietitian to promote healthy lifestyle choices
- Introduction of infection prevention and control (IPC) standards across the hospital, supported by regular walkarounds
- Implementation of Trust customer services, safeguarding and Freedom to Speak Up processes
- Review of the advocacy contract to ensure access to a positive and effective patient experience
- Introduction and implementation of the Trust's falls risk assessment

Monitoring and reporting are now embedded within wider forensic services and incorporated into Trustwide integrated performance reporting. All CQC actions issued to the previous provider have been completed, providing additional assurance regarding the improvement work undertaken and the delivery of improved standards of care.

2.3.1.3 Making data count

The Trust has continued to embed *making data count* through strong collaboration, ensuring that data and visualisations are co-designed with end users and presented in formats that enable timely, informed and effective decision-making.

Colleagues across intelligence and change (integrated change team), performance and business intelligence, research and development, equality, inclusion and involvement, and operational services have worked collaboratively to ensure data is used effectively to support quality improvement, assurance and decision-making. This includes identifying the most meaningful measures for specific areas of work and applying *making data count* principles to distinguish between normal variation and genuine change over time.

A key focus has been ensuring that data insights are actionable and clearly linked to improvement activity. This enables leaders and teams to understand whether changes in performance represent sustained improvement, emerging risk or expected variation. Data is increasingly presented in ways that support both local improvement efforts and organisational assurance.

Key achievements during **2025/26** include:

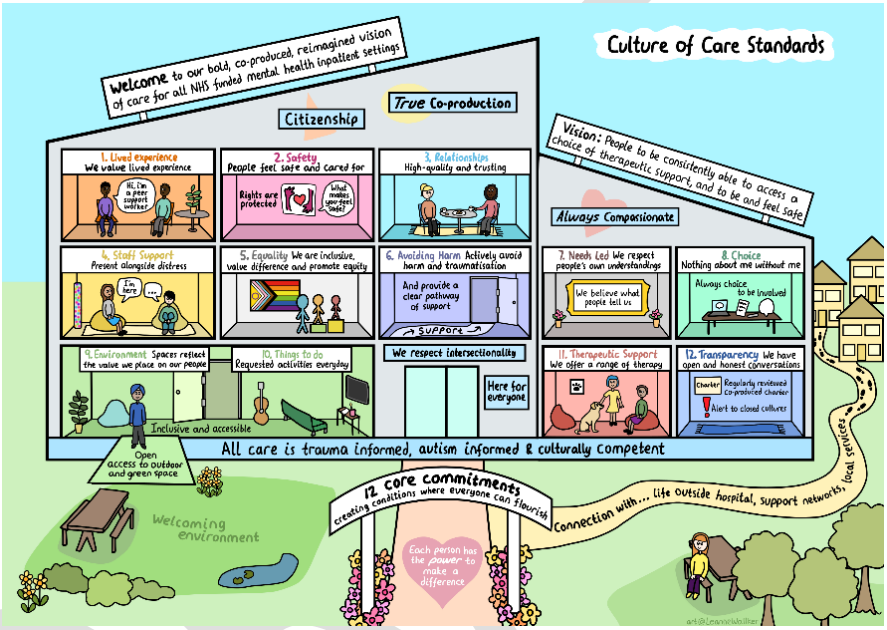
- Embedding *making data count* principles within the customer services team's complaints monitoring, with statistical process control (SPC) charts used to track monthly complaint levels, strengthening the Trust's ability to identify signals, respond proportionately, and provide assurance on patient experience trends
- Use of SPC charts to evidence improvement activity against CQC actions, ensuring improvement can be confidently demonstrated through data and supporting the closure of outstanding CQC actions

Building on these successes, a key component of our commitment to the strategy refresh is to further define how we measure progress. Understanding what success looks like - and what will be different if we are "getting it right" - will remain critical. This will involve not only consideration of Trust performance and risk information, but also a continued focus on improvement data and measures. This includes triangulating information from multiple sources and recognising the equal importance of quantitative data and experiential data (voice).

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We will continue to develop our understanding of how outcomes change over time, enabling us to clearly articulate whether improvement is occurring as a direct result of our actions. This is essential to providing assurance of impact, and we will maintain a collaborative approach to reporting data in ways that support this aim.

2.3.1.4 Culture of Care



The **Culture of Care programme** is an NHS England quality transformation initiative aimed at improving the culture of inpatient mental health, learning disability and autism wards, ensuring they are safe, therapeutic and equitable for patients, and fulfilling places to work for staff. The programme is built on 12 co-produced core commitments, supported by 76 standards, alongside three cross-cutting equity principles.

Simply put, a Culture of Care is one in which care is at the centre: patients, their loved ones and staff feel cared for, and staff are enabled to provide the care they want to deliver to others. In 2023, NHS England convened a sector-wide group with strong representation from lived experience leadership, involvement partners, and people who experience inequality in accessing and using mental health services. This collaboration led to the development of detailed Culture of Care standards that clearly describe what good looks like in practice.

The Trust set out to embed the Culture of Care standards on every inpatient ward. This ambition aligns directly with our people, clinical and equality strategies and commitments, supported by clear governance arrangements from **ward to Board**.

Our operating model included:

- **Ward-level quality improvement**, with four pilot wards using a six-step quality improvement methodology co-produced with service users and carers
- **Ward-level staff care and development**, focusing on anti-racism, psychological safety and relational safety
- **Staff care and development**, including protected time for reflective practice, skill-based training, routine coaching and supervision, and lived-experience-led development support
- **Leadership and management development**, with targeted support for ward managers to create person-centred cultures, alongside executive coaching
- **Insight**, using Culture of Care lived-experience resources to inform improvement
- **Organisational reflection**, focusing on how internal teams and services can best support ward staff and managers
- **Executive sponsorship**, including direct coaching and monitoring from the chief nurse and chief medical officer

Key themes emerging from the Culture of Care work included:

- Lived experience and involvement at every level
- Relational safety and the therapeutic day
- Staff support as an enabler of quality care
- Equity by design, rather than as an add-on
- Evidence-informed measurement

A defining success of the Culture of Care programme has been its ability to connect and align major Trust improvement priorities, creating a more coherent, values-driven approach across inpatient services. By embedding the 12 Culture of Care commitments and equity principles into existing programmes, the Trust has developed a shared language, shared expectations and shared momentum for change.

This integration is most clearly visible within the acute pathways and inpatient improvement priority programme, where Culture of Care insights directly inform quality, safety and experience workstreams. It is also evident within the Trust's **Triangle of Care** developments, where relational practice and meaningful carer involvement strongly reflect core Culture of Care principles.

The Trust remains committed to ensuring that the equity principles at the heart of the Culture of Care - including anti-racism practice, trauma-informed care and autism-informed care - are protected, strengthened and fully embedded at every level of the organisation. This commitment is enacted and safeguarded through the implementation of the EDI strategy and associated governance structures, ensuring that equity is a core organisational expectation rather than an add-on.

2.3.1.5 Caseload complexity tool

A complexity tool is being developed to support more effective caseload allocation and prioritisation, by indicating the level of clinical input and support required for each service user. Rather than relying solely on caseload numbers, this approach recognises the varying levels of time, complexity, and professional input needed to manage cases safely and effectively.

Ultimately, the tool aims to:

- Support practitioners and managers to better understand capacity and demand

- Inform establishment reviews for community services
- Provide a foundation for future enhancements, including discharge prediction and crisis likelihood modelling, subject to clinical validation and robust governance arrangements

It will also help to:

- Enable caseloads to be sorted by complexity
- Highlight service users requiring higher levels of intervention
- Support decision making without replacing clinical judgement

Our approach to implementation

Clinician-led and clinically validated

- The tool will not replace clinical judgement
- Clinicians will retain the ability to challenge, confirm or override algorithm-generated scores
- Clinical expertise will guide both the initial rollout and ongoing refinement of the tool

Phased development

Phase 1 (immediate):
The caseload management tool will be launched without complexity scoring. This phase is progressing well, with a number of practitioners already using the tool. Guidance materials and a crib sheet have been developed, and workshops have been delivered. Initial feedback suggests that the tool is effective, intuitive and well received by practitioners.

Phase 2 (future):
Complexity scoring will be introduced, initially with a strong manual component. An algorithm-led approach will only be implemented once the tool has been fully validated. This phase will include:

Collaboration and governance

- Development will be clinically led, with support from colleagues in research and development

Data quality and integration

- The accuracy of any future algorithm-led approach will depend on the quality of data recorded in SystmOne; focus will be required on improving data capture and exploring integration with FACT (Framework for Assessing Clinical Thinking) and FIRM risk assessment.
- Complexity scoring will draw on historical data and validated measures, with clinicians remaining central to interpretation

Sensitivity and engagement

- We recognise staff concerns regarding administrative burden and will ensure the tool is positioned as supportive rather than punitive
- Pilot testing will be undertaken with selected teams prior to wider rollout

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Key principles

- Clinician-led development first, with automation introduced later
- Algorithm development undertaken in the background and not visible to teams until clinically validated
- Clinical override always available
- R&D involvement to support evidence-based design
- Clinical validation required prior to full implementation

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2.3.1.6 Triangle of Care

During 2024/25, the Trust achieved its first star under the Triangle of Care (ToC) programme from the Carers Trust. Throughout 2025/26, the Trust has continued to strengthen its organisational approach to recognising, involving and supporting carers by maintaining Star 1 and progressing towards Star 2. This has involved ensuring that both community and inpatient services consistently embed carer-inclusive practice.

We have also prioritised improving the visibility of carers and young carers, strengthening support pathways, and ensuring that our commitments - such as the carers' charter and carers' passport - are meaningful and actively used in practice. This work is aligned with the Patient and Carer Race Equality Framework (PCREF), supporting equity, inclusion and culturally responsible engagement with carers and families.

Community mental health teams have completed self-assessments against the ToC standards, helping to identify areas of strong practice and where improvement actions are required. This has frequently highlighted the need for more consistent involvement of carers in care planning. Cheswold Park Hospital wards have also completed self-assessments to align practice with the rest of the Trust.

Throughout our ToC journey, we have seen a sustained improvement in support for carers through increased use of carers' passports. Experience data indicates that carers consistently report feeling more involved in the care of their loved ones. In addition, carers awareness training for staff has been developed into an electronic learning package, making it accessible to all staff, with consistently good uptake.

Looking ahead, we will continue to deepen inclusion, strengthen pathways to support carers, and better understand the real-world impact of the improvements made - both for carers and for the people they care for. A key priority will be to enhance engagement with carers from minority groups, ensuring that our approach is culturally responsible, accessible and aligned with PCREF principles.

We will continue to develop the young carers pathway, ensuring alignment with the 'no wrong door' approach. In addition, we will regularly review and analyse data and intelligence from staff feedback, carers' stories and insights from carers champions to evaluate impact, identify gaps and refine our approach.

2.3.2 We will ensure our services are consistently safe, responsive, personalised and effective

2.3.2.1 Learning disability services

The Trust delivers community services to people with a learning disability in four different geographical areas and runs a specialist in-patient assessment and treatment unit called the Horizon Centre. Each community service has a multidisciplinary model for routine care, and intensive support and psychiatry, which offers an immediate response to people who are experiencing a crisis. The service also operates an out-of-hours provision which ensures people in crisis have access to specialist learning disability advice and support.

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During 2025/26, learning disability (LD) services focused on reducing unwarranted variation in access, improving quality and safety of care, and addressing health inequalities for people with a learning disability and/or autism.

Key priorities included:

- Maintaining referral to treatment times within 18 weeks across all four community teams
- Improving the uptake and quality of annual health checks (AHCs) and health action plans (HAPs)
- Embedding improvements from the community and Horizon inpatient improvement programmes
- Improving clinical pathways (including behaviour, dementia, transitions, weight management and STOMP (stop over medication of people with a learning disability and autistic people)
- Implementing the Keep My Chest Healthy respiratory pathway
- Reviewing intensive support and access processes
- Improving communication and accessible information
- Embedding the greenlight toolkit principles
- Sharing learning from LeDeR (reviews of deaths of people with a learning disability and autistic people)
- Strengthening admission and discharge processes in the Horizon Assessment and Treatment Unit (ATU)

During 2025/26, waiting list management was further strengthened and the waiting well pathway was implemented. This significantly reduced waiting times, with the majority of people now seen within 18 weeks. Reduced waiting times have improved the experience of people using services, supported earlier intervention and enabled clinicians to manage caseloads more safely and effectively.

Annual health check delivery continued to exceed national targets, with all four localities achieving higher completion rates than the previous year. Strategic health facilitators worked closely with GP practices to improve the quality of AHCs and HAPs and to embed reasonable adjustments, supporting improved access to flu vaccinations and screening programmes.

The community improvement plan was completed and embedded, delivering tangible improvements, including revised referral forms, clearer duty arrangements, strengthened MDT clinical pathways, and locality and Trustwide safety huddles. These huddles have improved communication across services, supported proactive crisis management and improved coordination with the Horizon ATU for admissions and discharge planning.

The Keeping My Chest Healthy pathway was embedded in Kirklees and Wakefield and roll out has started in Calderdale. This helps to support early identification of respiratory issues.

Communication has also improved through the development of an Easy Read library.

Greenlight champions have driven improvements in Trustwide understanding of how services support people with a learning disability and/or autism, leading to better joint working and reduced inappropriate referrals.

Looking forwards to 2026/27, we will continue to sustain waiting times under 18 weeks and further embed greenlight toolkit principles. A focus will remain on improving uptake of AHCs, reduce delayed discharges from Horizon ATU and participating in research to support quality of life outcomes.

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2.3.2.2 Safer staffing

The Trust is working towards full alignment with national safer staffing policy, strengthening safeguards and governance systems to support the delivery of safe, sustainable, high-quality care. This work also ensures that workforce risks are effectively identified, mitigated and escalated.

Progress is being delivered through a number of key actions, including:

- Twice-yearly establishment reviews for inpatient services
- Monthly safer staffing reports to the Trust Board
- Development of an automated dashboard presenting key safer staffing indicators
- Implementation of training for the evidence-based Mental Health Optimal Staffing Tool (MHOST)
- Completion of the NHS England safer staffing fellowship programme by the assistant director of nursing (aligning with the national aim for each NHS organisation to have a safer staffing fellow to provide guidance, oversight and leadership)

Throughout 2025/26, the Trust made good progress in strengthening its approach to safer staffing. Establishment reviews, undertaken using NHS-approved staffing tools, have enabled the Trust to make evidence-based recommendations to support safe and appropriate staffing levels across inpatient wards. Monthly workforce analysis, triangulated with quality and safety outcomes, has supported a robust and proactive approach to identifying risks and ensuring timely mitigations are put in place where required.

Looking ahead, the Trust will continue to strengthen governance arrangements for safer staffing and complete establishment reviews within community services. Establishment reviews will move to a rolling programme across the Trust and will be supported by the rollout of MHOST at Cheswold Park Hospital.

In addition, SafeCare - a web-based application providing real-time staffing and safety data at unit, site, and organisational level - will be embedded across services. This will be supported by upskilling staff in safer staffing principles and the effective use of real-time data to support safe decision-making and workforce planning.

2.3.2.3 Patient safety

During 2025/26, the Trust undertook a comprehensive review of how our **Patient Safety Incident Response Framework (PSIRF)** operates in practice. Having implemented PSIRF for just over two years, this review aimed to assess how effectively our systems were working, whether incident responses were delivering meaningful learning and improvement, and whether our approach remained aligned with PSIRF principles. These include proportional responses, a focus on systems rather than individual blame, and the implementation of changes that genuinely improve patient safety.

As part of this work, we strengthened our **system-based learning** approaches to ensure that responses to patient safety incidents are more consistent, timely, and proportionate. Greater emphasis has been placed on understanding wider system factors and conditions that contribute to incidents, rather than focusing solely on individual actions.

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Our **being open** processes were reviewed and updated to ensure continued alignment with national expectations and to support compassionate, transparent, and meaningful involvement of patients and families following patient safety incidents.

Clear and accessible flowcharts were developed and refreshed to support staff in incident reporting, management, and PSIRF decision making. This has made processes easier to understand and apply consistently in practice.

To build organisational capability and confidence, the Trust invested in external training in **SWARM** (a collaborative approach undertaken soon after an incident to understand what happened and identify learning) and **after-action reviews**. This training was delivered to quality governance leads and matrons, supporting more consistent and effective application of these approaches across care groups.

The review also clarified where full patient safety incident investigations add the greatest value. In line with national guidance, we strengthened the use of **thematic reviews** in areas where issues are already well understood. This has reduced duplication, supported shared learning across services, and enabled more effective use of investigation capacity.

We removed response types and processes that did not add clear value, simplifying our overall approach and ensuring staff time is focused on activity that supports meaningful safety improvement.
Improvements were also made within Datix, including changes to how incidents are reviewed and the introduction of a new **service-learning review**, replacing the previous 48-hour manager review. This has strengthened early learning and improved clarity regarding the most appropriate and proportionate response to incidents.

Finally, a series of **stakeholder engagement sessions** were held to ensure that the updated PSIRF plan reflects the perspectives and needs of both those who use our services and those who deliver care.

Next steps
Over the coming year, the Trust will:

- Finalise the updated PSIRF plan and present it through Trust clinical governance structures
- Continue to embed and support the use of **SWARM**, **after-action reviews**, and **thematic review** approaches to strengthen system-based learning
- Maintain ongoing review of PSIRF decision making to ensure responses remain timely, proportionate, and aligned with national expectations

The review also identified the need to strengthen how PSIRF responses support **coroners' investigations**. Working closely with the Trust's legal team, further improvements will be made in this area to ensure consistency, clarity, and effective information sharing.

2.3.2.4 Electronic prescribing and medicines administration development

Joint project teams comprising multidisciplinary and multi-professional colleagues, alongside information management and technology (IM&T) specialists, were established to design and prepare for the implementation of electronic prescribing and medicines administration (EPMA) across a range of services and settings.

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EPMA was implemented within section 136 suites across Barnsley, Calderdale and Wakefield, as well as within working age adult intensive home-based treatment teams (IHBTT) across all localities. For these teams, the inpatient medicines chart was adapted for use within community settings. This phase of implementation took place between March and September 2025, followed by implementation at Cheswold Park Hospital between January and March 2026.

The introduction of electronic prescribing has delivered a range of benefits that support the Trust's values, priorities and strategic goals, including:

- A single, comprehensive view of a patient's current and historical medication record, accessible to clinicians regardless of location
- Real-time clinical decision support to assist prescribers in selecting appropriate medicines and reducing errors
- A real-time view of medicines administration
- Safer and more timely administration of medicines
- Clearer, more complete and more legible prescriptions
- A faster and more efficient medicines ordering process, reducing delays in supply
- Fewer reported missed doses
- A reduction in prescribing-related medication incidents
- A reduction in missed doses where no valid reason was recorded

A benefits realisation report has been produced for the implementation of EPMA within mental health inpatient services.

What happens next?

Mental health inpatient services

We will continue to monitor safety incidents and make system improvements where required, including within inpatient and working age adult IHBTT settings, to further enhance patient safety.

Community physical and mental health services

We will introduce the electronic prescription service (EPS) across community teams. This will enable prescribers to send prescriptions electronically to a community pharmacy of the service user's choice via the NHS Spine, making the process quicker and more efficient for both patients and staff.

The implementation of EPS will be delivered in three phases over a 12-month period. This will bring significant benefits to the Trust, including:

- Reduced paperwork and fewer paper prescriptions
- Improved visibility of prescriptions
- Less time spent managing prescriptions
- Reduced risk of errors, lost prescriptions or prescriptions being sent to the wrong pharmacy
- Overall cost savings for the Trust

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2.3.2.5 Care Closer to Home

The **Care Closer to Home** priority programme focuses on reducing the number of people placed inappropriately in out-of-area beds and improving patient flow across services. This aims to ensure that timely access to a local bed is available at the point of need, supporting better outcomes and continuity of care.

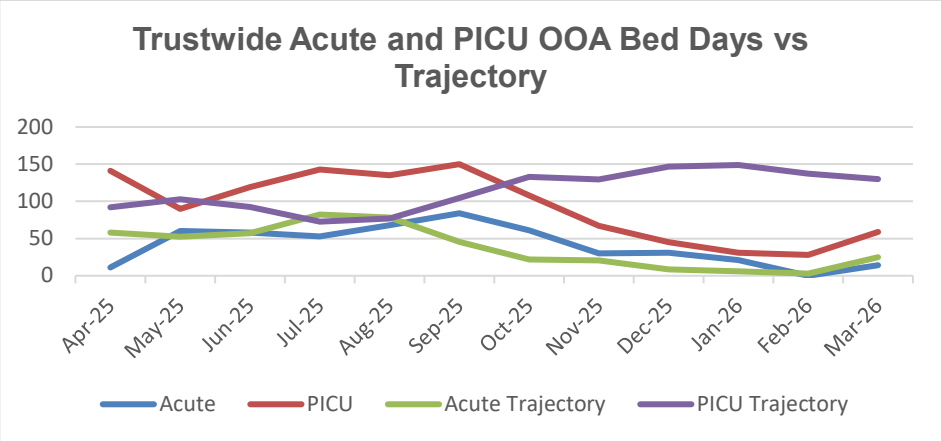
Throughout 2025/26, this programme has remained a key priority, with a range of targeted improvement projects and activities delivered. Collectively, these aim to increase productivity across pathways by:

- Enhancing patient experience
- Improving patient flow
- Reducing length of stay
- Reducing bed occupancy
- Reducing the number of days patients are clinically ready for discharge but experience delays

Through our well-established, data-driven improvement programme, we have achieved significant improvements in patient flow by:

- Implementing weekly system escalation meetings with partner organisations for patients who are clinically ready for discharge
- Introducing daily inpatient ward huddles to support timely decision making
- Embedding purposeful admissions, ensuring that admissions are appropriate and add value
- Introducing locality-focused working to improve coordination of care closer to home
- Strengthening weekly barriers to discharge processes and multi-agency discharge events
- Improving inreach from community teams to inpatient wards
- Working with commissioners to develop effective alternatives to admission
- Strengthening cross-system working with acute partners

Out of area bed days are reported weekly to the operational management group, alongside key metrics including bed occupancy, incidents of physical violence, restraint usage, safer staffing data, and intensive home-based treatment team (IHBTT) caseload and referral activity.



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2.3.3 We will ensure continuous, inclusive improvement is integral to developing and delivering creative and innovative services

2.3.3.1 Digital enablers

As a Trust, we are prioritising the development of digital solutions to enable patients and carers to access their own digital care records. This will be delivered through a patient engagement portal (PEP), using the **Patients Know Best (PKB)** digital platform, which offers patients the opportunity to self-manage and engage more actively in their own care. The platform also provides an alternative way for patients to communicate with healthcare professionals, offering greater flexibility and accessibility.

The patient engagement portal will deliver the following benefits:

- Improved communication between patients, carers and healthcare professionals
- Online access for patients (and, where appropriate, carers) to relevant parts of the clinical record
- Support for self-management through the use of online tools
- Support for recovery through signposting to support services and recovery resources
- Improved patient and carer awareness of, and engagement with, Trust initiatives, events, research opportunities and recovery college courses
- Improved consistency and quality of service user related data collection through direct online input by individuals, reducing administrative burden for staff

The Trust had previously implemented the Patients Know Best portal and, through participation in the NHS England Wayfinder programme, undertook further development to integrate the Patients Know Best platform with the NHS App. The Wayfinder programme supports the development of the NHS App as part of the NHS Long Term Plan ambition for the app to act as the digital front door to NHS services, improving access in a safe and secure way.

Following development work during 2024/25, the Trust launched the **patient care aggregator**, known as *Wayfinder*, on 1 July 2025. This enables patients to view all their mental health appointment bookings in one place through the NHS App. When patients access their appointment information, the NHS App retrieves a summary list from all connected booking systems via the patient care aggregator.

The Trust has also utilised the Patients Know Best portal to provide patients with secure digital access to health records requested through subject access requests. This functionality was launched on 1 December 2025.

Development of the Patients Know Best portal continued throughout the latter half of 2025/26. As part of the next phase of the NHS England Wayfinder programme, work commenced to use advanced questionnaire functionality within Patients Know Best to provide the Trust's Friends and Family Test digitally. This functionality is available through the NHS App and was completed at the end of March 2026 as planned.

Looking ahead, further work is underway to make care plans and a digital mood diary available through the Patients Know Best portal. This will further increase access to personal health record information and enhance digital accessibility for patients and carers.

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2.3.3.2 Staff survey improvements

The annual staff survey continues to serve as a fundamental diagnostic tool within our people strategy, providing essential insights that enable the organisation to translate colleague feedback into meaningful and sustainable improvement. With 2,874 colleagues taking part in the 2025 survey, we recognised an opportunity to build on this strong engagement by evolving the process into one that is more empowering, collaborative and responsive to the expectations of our workforce. Our priority was to move away from a traditional, top-down approach towards one that celebrates openness, shared ownership and continuous organisational learning.

We recognised that colleagues want their feedback to drive real, visible change. To support this, we prioritised creating a culture in which the staff survey is not a once-a-year event but an ongoing conversation. This involved giving managers and teams greater ownership of their results and moving from static action plans to collaborative, team-led improvement. By doing so, we aimed to strengthen trust, transparency and collective responsibility across the organisation.

To bring this new approach to life, colleagues from the people directorate increased their presence across all Trust sites, meeting colleagues where they work and encouraging open dialogue. Communications were refreshed and aligned with the NHS People Promise, reinforcing the message that every voice genuinely counts. This helped to create a more positive and inclusive tone around the survey and contributed to strong participation.

A key development was the introduction of a new staff survey dashboard accessible to all staff. This tool provides clearer, more intuitive insight into team-level results, enabling care groups and departments to explore their data in real time and identify both strengths and opportunities for growth. Early feedback indicates that teams find the dashboard helpful in understanding their results and planning next steps.

Through this work, we have learned that colleagues respond positively when they can see their feedback being acknowledged and acted upon within realistic timeframes. We have also learned that teams thrive when they are given the autonomy to shape their own priorities, supported by leaders who listen and empower rather than direct. Increased transparency and accessibility have helped build confidence in the shift towards a continuous *“You said, we’re doing”* culture.

Our next steps focus on embedding this positive and collaborative approach across the organisation. We will continue to build a culture in which staff experience is discussed openly throughout the year, and where improvements are tracked, shared and celebrated as they occur.

Two People Promise themes will guide our work:

1. We are compassionate and inclusive
We will strengthen the experience of colleagues from equality groups by working closely with our staff networks and drawing on insights from the staff survey, WRES, WDES and our refreshed *our behaviours* framework. This will help ensure every colleague feels valued, respected and able to thrive.

2. We are safe and healthy
We will enhance wellbeing support, including improved access to services such as the employee assistance programme and additional training for managers to support colleagues to stay well at work. Feedback from focus groups is informing the design of this offer.

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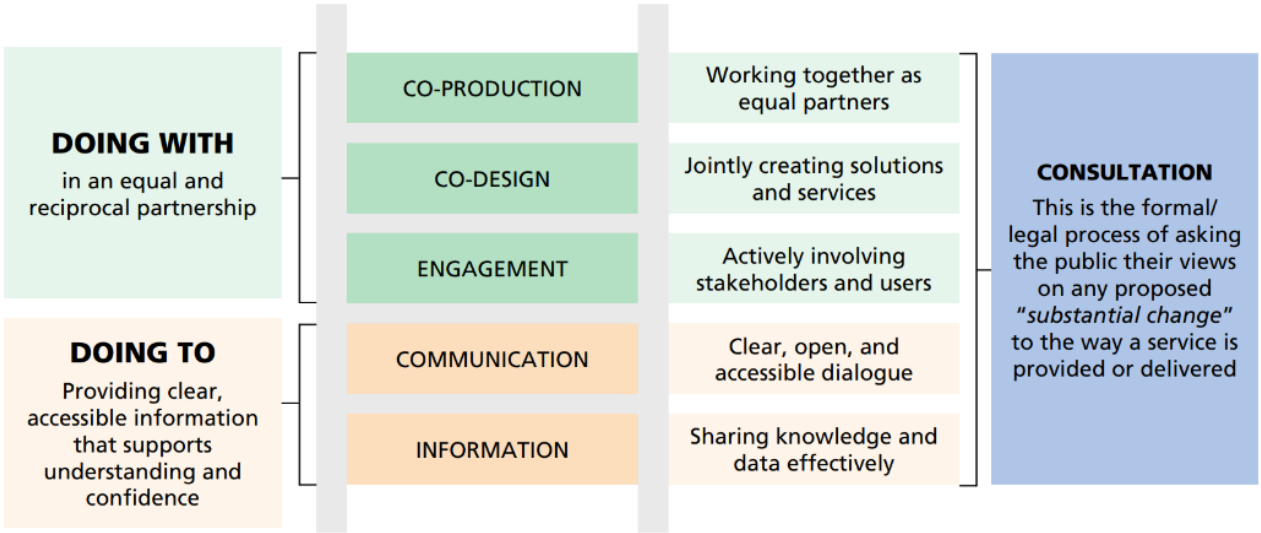
We will also provide targeted support to teams with below-average staff experience, helping each to identify one People Promise element on which to focus. To maintain clarity and impact, each part of the organisation will concentrate on no more than three improvement areas aligned to our overarching priorities.

2.3.3.3 Involvement

Within the Trust, a need was identified for a more consistent, equitable and meaningful approach to involving patients, carers and communities in the design and delivery of services. This aligns with the Health and Social Care Act (2022), the Equality Act (2010) and the NHS Constitution.

Previously, involvement processes lacked a standardised framework, which led to a risk of tokenism and inconsistency across care groups.

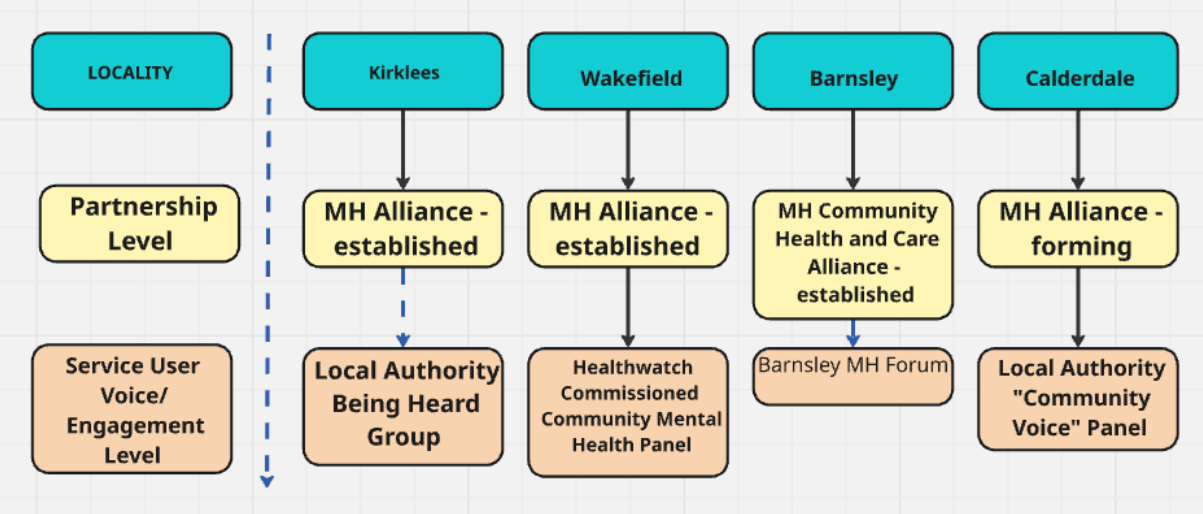
In response, improvement work focused on the co-design and launch of a comprehensive i**nvolvement guide**, providing a clear and structured framework for engagement. Central to this guide is the **ladder of involvement**, a five-stage conceptual model ranging from *information* to *co-production*. Each stage is supported by real case studies from across the Trust, helping to bring involvement to life and demonstrate how meaningful engagement can be achieved in practice.



- **Connecting People programme:**
  The Trust has an established network of over 124 trained *connectors* from partner organisations and local communities, held on a centralised database to support involvement activities. This approach has been used across a range of projects, including stakeholder panels aligned with the Patient and Carer Race Equality Framework (PCREF)
- **Stakeholder database:**
  The Trust maintains a stakeholder database containing details of partner organisations, voluntary, community and social enterprise (VCSE) groups, community representatives and Trust members. This resource was used during the Trust strategy refresh, working in combination with the connectors network
- **Internal service user community and dialogue groups:**
  The Trust has established ward-based community or dialogue groups, including groups such as *one*

voice within forensic services and more generic meetings on other inpatient wards. These groups are facilitated by a mix of staff (including nurses and occupational therapists) and lived-experience leads. This approach has been integral to Culture of Care ward-based quality improvement work

- **Peer educator approach:**
  The Trust employs peer educators on bank contracts across services, with further development planned over the coming year. The equality, diversity and inclusion (EDI) team supports Trust volunteers through a buddying approach to strengthen peer involvement and development
- **Carers' network:**
  The Trust hosts an external carers' network, providing a forum to ensure carers' voices are heard and their roles recognised and valued. The network also enables carers to raise barriers, challenges and inequalities they experience
- **External stakeholder service user groups:**
  Across localities, the Trust engages with a range of service user panels and Mental Health Alliance structures. These groups have been integral to involvement activity, including projects such as the a*utistic approach development day*, delivered with representatives from inpatient services



Looking ahead, the involvement approach will continue to evolve, with a focus on the following areas:

- Review and update resources, including intranet and website
- Continued engagement across the Trust with the involvement approach
- Developing a payment approach that compensates individuals directly to ensure equitable participation
- Developing robust feedback loops to demonstrate the impact of involvement to participants, ensuring they see how their insights shaped final decisions

2.2.3.4 Enhanced therapeutic observations of care (ETOC)

The Trust is engaged in the national programme of work on **enhanced therapeutic observations of care (ETOC)**. The overall aim of this programme is to develop and enhance ETOC provision across the Trust, ensuring patients receive the right care, at the right time, delivered by the right person. The programme uses the Model for Improvement and Plan–Do–Study–Act (PDSA) cycles, underpinned by engagement, co-production and just culture principles. This programme commenced in 2025/26 and will continue into 2026/27.

There are six phases to the programme:

- **Phase 1 – Governance and foundations:**
  Establishing clear oversight, consistency and accountability. An ETOC steering group has been established, clear reporting lines have been agreed, and governance arrangements are now operational
- **Phase 2 – Policy review and standardisation:**
  Ensuring a consistent, evidence-based ETOC policy. This includes reviewing the current policy, developing a one-page summary, and undertaking staff engagement sessions. Pre-and post-implementation surveys will be conducted to assess staff knowledge and confidence
- **Phase 3 – Training and workforce development:**
  Developing an ETOC training package, testing the content, and rolling out competency-based training.
- **Phase 4 – Integrated model of care:**
  Embedding therapeutic engagement and positive risk-taking into daily care. This includes developing an integrated model and piloting it across three wards, alongside culture and just culture support
- **Phase 5 – Data, insight and assurance:**
  Evidencing impact and supporting decision making through the development of an ETOC dashboard, triangulation of datasets, and completion of observation quality audits
- **Phase 6 – Embed, share and spread:**
  Ensuring sustained improvement and sharing learning across the Trust. This phase will focus on engagement, embedding multidisciplinary team huddles and reviews, and sharing learning through case studies and learning events

Measures to understand impact (qualitative and quantitative) will include:

- Use of ETOC, incident data, staffing levels and engagement time
- Reduction in incidents of violence and aggression
- Reduction in seclusion and use of intramuscular medication
- Reduction in length of stay
- Staff surveys assessing knowledge and understanding
- Completion of training
- Observation audits assessing quality of care and therapeutic engagement

Success indicators will include:

Patient outcomes
- Improved experience of observations and engagement
- Reduced harm and restrictive practices

Staff outcomes
- Increased confidence and satisfaction
- Improved wellbeing and culture

System outcomes
- Reduced agency usage
- Reduced length of stay and readmissions

Phase 1 is complete and phase 2 is underway. The programme of work is expected to continue throughout 2026/27, with full embedding of ETOC principles by the end of the year. Further detail and outcomes will be reported in the quality account for 2026/27.

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2.3.4 We will consistently address health inequalities across our services, ensuring we are inclusive and working to minimise the impact of deprivation

Our priority work on this best quality statement is covered in part 1 where the equality diversity and inclusion strategy is discussed, alongside our work on the Patient and Carer Race Equality Framework (PCREF). Other workstreams, such as Triangle of Care and Culture of Care all support delivery of this best quality statement. Some additional examples are shared below.

2.3.4.1 Wound care clinic for people experiencing homelessness and rough sleeping

Access to planned healthcare can be particularly challenging for people experiencing homelessness. Across our physical health services in Barnsley, it was identified that a significant number of people experiencing homelessness had unmet **wound care needs**, with multiple factors contributing to this risk. These include limited access to sanitation facilities to keep wounds clean and dry, poor nutritional intake impacting wound healing, exposure to extreme weather conditions, and the effects of substance or alcohol misuse. Without timely intervention, these factors can lead to deterioration in health and an increased reliance on unplanned and emergency care.

Due to the nature of homelessness, it is often unlikely that individuals will be able to attend conventional healthcare provision within traditional clinic settings. As a result, it was identified that specialist and flexible arrangements were required to ensure people experiencing homelessness could access appropriate care.

In response, a collaborative partnership was established involving neighbourhood nursing, the health inclusion service, community matrons, and the tissue viability service, working alongside colleagues from Waythrough (formerly Humankind), Barnsley Metropolitan Borough Council housing and welfare team, town centre wardens, and adult safeguarding teams. Together, these services developed a dedicated wound care drop-in clinic for people experiencing homelessness.

The clinic was established in May 2025 and is located within Waythrough's premises at the McLintock Building (Summer Lane, Barnsley). It is co-located with an established *breakfast club*, which is already accessed by people who are rough sleeping or experiencing homelessness, ensuring care is provided in a familiar and trusted environment. The clinic operates **once a week between 10am and 12pm**.

To date, 39 individuals have received treatment at the clinic for wound-related concerns. Since its inception, the clinic has supported recovery, minimised the risk of deterioration, and helped people to live well, while working to reduce the impact of deprivation within our communities.

Data analysis of these 39 individuals shows that, in the 12 months prior to their first attendance at the clinic, the average number of emergency department (ED) attendances for this cohort was 18.5. In contrast, the average number of ED attendances in the 12 months following their first clinic attendance reduced to 2.01. This demonstrates that the clinic is supporting a substantial reduction in ED attendances for this group.

This clinic is now business as usual. In addition, staff from the service undertake an outreach intervention service alongside the town centre wardens, where they approach the local rough sleeping community to enquire about their welfare and signpost people, where there is an identified need, to the wound care clinic.

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2.3.4.2 Suicide prevention

Suicide remains a significant public health concern. In England, **6,069 suicides were registered in 2023**, representing the highest number recorded since 1999. Men aged **45–49** were found to have the highest suicide rate, while among women the highest rate was observed in those aged **50–54**. Office for National Statistics (ONS) data shows that the male suicide rate reached **17.4 per 100,000** - the highest since 1999 - compared with a female suicide rate of **5.7 per 100,000**, the highest since 1994.

Suicide prevention has been a sustained priority for the Trust over a number of years. During **2025/26**, activity focused on updating the **suicide prevention strategy 2025–2028** and reviewing the associated programme of projects supporting its delivery. In parallel, collaborative work with the Trust's **workforce wellbeing group** prioritised support for staff following a suicide, including the development of access to suicide-specific supervision and the delivery of the annual suicide prevention conference.

The programme further strengthened a **whole-system approach** to suicide prevention by enhancing governance, collaboration, and culture. This included strengthened regional and Trustwide partnerships; updated policies aligned to the refreshed strategy; shared learning through forums and *Culture of Care* initiatives; and improved access to clear guidance and support for families and carers.

Training and education continued to develop through a programme of **in-house and bespoke training**, alignment with trauma-informed practice principles, regular drop-in sessions, and specialist **postvention training** focused on bereavement by suicide.

Family and carer involvement was prioritised through improved access to bereavement support, increased visibility of the **family liaison officer** role, structured feedback from bereaved families, and the embedding of lived experience insights into strategic planning and service development.

At a regional level, the Trust contributed to **multi-agency learning**, suicide surveillance, and death review activity across **West and South Yorkshire**, alongside strengthened links to research and development programmes.

Focus on **marginalised and vulnerable communities** was enhanced through improved data collection, the inclusion of deprivation data within reporting processes, and continued engagement with safeguarding and review structures to better understand and address inequality.

Support for staff was further strengthened through the development of **post-suicide support pathways**, promotion of national guidance and e-learning resources, practical support to care groups, and the creation of briefing papers covering **suicide prevention, intervention, and postvention**. This work supports staff wellbeing while reinforcing safe, compassionate, and learning-focused responses following suicide-related incidents.

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Part three: Other information on quality performance

In this section, we report on key national indicators from the Single Oversight Framework (SOF). This section will also share performance in relation to other indicators monitored by the Board and not already reported in parts 2 or 3 of the quality account. We also share some highlights of our successes throughout 2025/26, and the comments received from our stakeholders.

3.1. Key national indicators

There are three domains which the key national priorities fall under for the Trust to report on in part 3. This is explained in the table below.

The three domains for key national indicators

Domain	Indicator
Patient safety	Patient safety information (part 2); Learning from deaths (3.10)
Clinical effectiveness	Clinical audit (3.3); Performance against core indicators (3.11); Performance against national indicators (3.12)
Patient experience	Capturing patient experience (part 2); Community mental health survey (3.11.4)

3.2. Statements of assurance from the Board

This section is a series of statements from the Board for which the format and information required is set out in regulations and therefore it is set out verbatim.

1. During 2025/26 South West Yorkshire Partnership Teaching NHS Foundation Trust provided and/or subcontracted 248 relevant health services (123 service types relating to 248 individual service provided/sub-contracted) including those via SWYPFT as lead provider for the Adult Secure Provider Collaborative in West Yorkshire and South Yorkshire and Bassetlaw. These figures now include all service types (i.e. CAMHS and learning disability services), plus commissioned investment into new service types
2. The South West Yorkshire Partnership Teaching NHS Foundation Trust has reviewed all the data available to us on the quality of care in 248 of these relevant health services
3. The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership Teaching NHS Foundation Trust for 2025/26

3.3. Participation in clinical audits and national confidential enquiries

During 2025/26 15 national clinical audits and one national confidential enquiry covered relevant health services that South West Yorkshire Partnership Teaching NHS Foundation Trust provides.

During that period South West Yorkshire Partnership Teaching NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries that we were eligible to participate in.

The national clinical audits that South West Yorkshire Partnership Teaching NHS Foundation Trust was eligible to participate in during 2025/26 are as follows:

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- National audit of care at the end-of-life mental health spotlight (NAT02)
- National audit of cardiac rehabilitation (NAT05)
- National respiratory audit programme (NRAP) (NAT06)
- Sentinel stroke national audit programme (NAT08)
- Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) (NAT10)
- National audit of dementia 2025-27 (NAT12)
- National audit of seizures and epilepsies for children and young people (Epilepsy 12) (NAT13)
- National clinical audit of psychosis (NCAP) early intervention in psychosis (EIP) audit (NAT16)
- Learning disabilities improvement standards (NAT17)
- Parkinson's UK (NAT22)
- Prescribing Observatory for Mental Health (POMH) topic 22b: the use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services (NAT24)
- National audit of inpatient falls (NAT26)
- Prescribing Observatory for Mental Health (POMH) topic 18c: the use of clozapine (NAT30)
- National audit of eating disorders (NAT31)
- Prescribing Observatory for Mental Health (POMH) topic 20c: improving the quality of valproate prescribing in adult mental health services (NAT32)

The national clinical audits and national confidential enquiries that South West Yorkshire Partnership Teaching NHS Foundation Trust participated in, and for which data collection was completed during 2025/26 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The percentage of registered cases required by the terms of the audit is not specified in most cases. This is because the audits we participate in do not specify a minimum number in their sampling framework criteria.

National Clinical Audits 2025/26		Cases submitted (if applicable)
1	National audit of care at the end-of-life mental health spotlight (NAT02)	January 2025 – January 2026 included: Trust/health board overview: complete Case note review: one case submitted based on eligible criteria Staff reported measure: four staff surveys completed Annual death data collection: three cases submitted based on eligible criteria
2.	National audit for cardiac rehabilitation (NAT05)	Continuous clinical audit. In total 241 cases submitted based on eligible criteria. 18 cases saved awaiting further information.
3.	National respiratory audit programme (NRAP) (NAT06)	Continuous clinical audit. 98 cases submitted based on eligible criteria.
4.	Sentinel stroke national audit programme (SSNAP) (NAT08)	Continuous clinical audit. Issues with national reporting since the web tool was updated in October 2024 and currently on the ICB risk register.

National Clinical Audits 2025/26		Cases submitted (if applicable)
5.	Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) (NAT10)	Continuous data collection model. LeDeR report 2023 published January 2026.
6.	National audit of dementia 2025-27 (NAT12)	Service mapping exercise. No patient-level data collection in diagnostic services this year. Report to be published June 2026.
7.	National audit of seizures and epilepsies in children and young people (Epilepsy 12) (NAT13)	Continuous data collection model. Nine cases submitted for cohort 6 based on eligible criteria.
8.	National clinical audit of psychosis (NCAP) early intervention in psychosis (EIP) audit (NAT16)	NCAP has been transitioning to using routinely collected data from NHS England Mental Health Services Data Set (MHSDS). The last State of the nation report using bespoke data was published in February 2025.
9.	Learning disabilities improvement standards (NAT17)	Eight staff survey submissions. Service user survey submissions not required this year.
10.	Parkinson's UK audit (NAT22)	Patient audit: 20 cases submitted based on eligible criteria. Patient reported experience measure: 15 submissions received.
11.	Prescribing Observatory for Mental Health (POMH) topic 22b: the use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services (NAT24)	128 cases submitted to POMH based on eligible criteria.
12.	National audit of inpatient falls (NAT26)	Continuous data collection model. National report published October 2025.
13.	Prescribing Observatory for Mental Health (POMH) topic 18c: the use of clozapine (NAT30)	267 cases submitted to POMH based on eligible criteria.
14.	National audit of eating disorders (NAT31)	Service mapping exercise completed during 2025. Participating in staffing report in 2026.
15.	Prescribing Observatory for Mental Health (POMH) topic 20c: improving the quality of valproate prescribing in adult mental health services (NAT32)	85 cases submitted to POMH based on eligible criteria.

National clinical audit

The reports of 15 national clinical audits and one national confidential enquiry were reviewed by the provider in 2025/26, and South West Yorkshire Partnership Teaching NHS Foundation Trust intends to take the following actions to improve the quality of health care provided.

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- Each clinical audit has a project lead that is responsible for presenting the audit results to their care group
- Each audit enables identification of areas for improvement, and an action plan is developed to enable improvements following audits
- Any immediate areas of concern are highlighted to the relevant care group
- Following development and completion of an action plan, re-measurement/re-audit is planned to assess progress and determine outcomes
- The prioritised clinical audit programme has Trust Board oversight, to ensure that the audit cycle is complete and that there is organisation oversight and support to improvements

Implementation of the action plan is monitored by the care group as part of their governance systems.

Local clinical audit

The reports of 31 local clinical audits were reviewed by the provider in 2025/26, and South West Yorkshire Partnership Teaching NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Each clinical audit has a project lead that is responsible for presenting the audit results to their care group
- Each audit enables identification of areas for improvement and an action plan is developed to enable improvements following audits
- Any immediate areas of concern are highlighted to the relevant care group
- Following development and completion of an action plan, re-measurement/re-audit is planned to assess progress and determine outcomes
- The prioritised clinical audit programme has Trust Board oversight, to ensure that the audit cycle is complete and that there is organisation oversight and support to improvements

Implementation of the action plan is monitored by the care group as part of their governance systems.

3.4. Participation in clinical research

The Trust has successfully exceeded its annual recruitment target set by the National Institute for Health Research (NIHR) Regional Research Delivery Network (RRDN) of 525 and is seen as one of the key research partners within the Yorkshire and Humber region.

The number of patients receiving relevant health services provided or sub-contracted by South West Yorkshire Partnership Teaching NHS Foundation Trust in 2025/26, that were recruited by the research department to participate in research that had been approved by a research ethics committee is 770 (please note this figure excludes staff participation and any participant recruits which have been allocated to regional public health or primary care studies which would take this figure to over 850+).

The research and development department has successfully supported over 43 studies maintaining a balanced portfolio of complexity across the range of clinical specialties and care groups i.e. studies are recruiting from CAMHS, working age and older adult services, physical health, learning disabilities, inpatient, forensic and community services within all four of the Trust place areas.

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The research and development department continues to deliver and operationalise key aspirations of the Trust research strategy (which is under review to include the NHS 10-year plan as well as the life sciences plan 2025). Key developments for 2025/2026 were

- Major contributor to the successful development of the Teaching Trust accreditation
- The lead NHS provider for the new £11m NIHR Academic Research Centre at University of Huddersfield
- Key NHS research partner with the University of Durham – Institute of Medical Humanities (£9.5m) Wellcome funded award (which provides 5 dedicated research fellowships for the Trust)
- Utilised the research and innovation group (TRIG) to create a clearer pathway between corporate services supporting service evaluation, involvement, engagement and quality improvement to enhance the Trust's support offer
- Enhanced the profile of the research and development department as a vehicle in enabling patients and carers to become 'community connectors' - peer support workers, volunteers and lived experience practitioners within the Trust. The department has recruited over 25 volunteers, peer support workers and patient public involvement workers
- The department has also hosted 15 students from different clinical and academic backgrounds, providing them with an introduction into research and development and research governance
- The department is a key convener of the projects and discussions which are reviewing the implications, processes and management of artificial intelligence (AI), data, and data science research within the Trust
- As part of the wider strategic development of research capacity within the Trust, the research department continues to mentor and support over 28 clinical colleagues to submit funding applications and research bids to funding bodies including the National Institute for Health Research (NIHR). The department has supported the publication and development of 17 peer reviewed journal articles and has supported the development of a second poetry anthology (as part of a research collaboration with the National Poetry Centre in Leeds)
- The research department continues to work closely with higher education institutions and has working agreements and collaborations with over 38 institutions. As a result of which the Trust is listed as a key delivery partner and co-applicant on four major programme grant applications worth over £6.5 million, with research activity extending between five and nine years

As a key partner within the regional research delivery network (RRDN) and respective integrated care board structures, the research department is actively contributing to place based research collaborations within Kirklees, Calderdale, Wakefield and Barnsley. We continue to explore new and innovative ways to support engagement with communities and develop research champions and research ambassadors throughout our places, ensuring that our research activities are reflective of the population that we serve.

3.5. Care Quality Commission (CQC)

South West Yorkshire Partnership Teaching NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is that it is registered in respect of the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

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There are no conditions attached to the registration other than the specified locations from which the regulated activities may be carried on, at, or from.

South West Yorkshire Partnership Teaching NHS Foundation Trust's conditions of registration state that the three regulated activities listed above can only be carried out at the following locations:

- Fieldhead Hospital (Wakefield)
- The Dales (Calderdale Royal Hospital)
- Kendray Hospital (Barnsley)
- The Priestley Unit (Dewsbury District Hospital)
- Lyndhurst (Halifax)
- Enfield Down (Huddersfield)
- The Poplars (Hemsworth)
- Cheswold Park Hospital (Doncaster)

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership Teaching NHS Foundation Trust during 2025/26.

South West Yorkshire Partnership Teaching NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2025/26.

3.6. NHS number and general medical practice code validity

South West Yorkshire Partnership Teaching NHS Foundation Trust submitted records during 2025/26 to the secondary uses service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:
- 100% for admitted patient care

The percentage of records in the published data which included the patient's valid general medical practice code was:
- 100% for admitted patient care

3.7. Data security and protection toolkit

In 2024/25 the data security and protection toolkit (DSPT) changed significantly, which meant a different type of self-assessment and new outcomes for the Trust, plus new objectives for the internal audit review.

Previously the DSPT was based on the National Data Guardian's 10 data security standards but is now built around the National Cyber Security Centre's cyber assessment framework (CAF). The CAF profile is stricter, with raised levels of achievement, but brings the health and social care sector in line with other sectors to provide a standard security profile that can be scaled for changing national threats and capabilities.

Previously, the Trust was one of a very small number that consistently exceeded the DSPT standards; however, a major change is that the expected outcome for the CAF-aligned DSPT is "standards met" and that trusts will initially be unable to exceed the standards due to the raised achievement levels.

The Trust achieved a status of 'standards met' for the 2024/25 toolkit assessment. The internal audit review outputs were:

Overall risk assurance across all five objectives is **low**, which means no outcomes were rated as not meeting minimum achievement levels; and

Confidence level in the veracity of the Trust's DSPT self-assessment/final submission is **high.**

The Trust will submit the 2025/26 final assessment by 30 June 2026. An audit review is in progress (April/May 2026).

3.8. Clinical coding accuracy

South West Yorkshire Partnership Teaching NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2025/26 by the Audit Commission

3.9. Quality of data

Improving data quality remains one of South West Yorkshire Partnership Teaching NHS Foundation Trust's key priorities. There was continued focus in 2025/26 on improving the quality of clinical record keeping. With several areas routinely reported and monitored to the Trust's improving clinical information group. This underpins the delivery of safe effective care and assures the executive management team, the quality and safety committee and the Trust Board, that data taken from the clinical record and used for activity and performance monitoring and improvement is robust.

South West Yorkshire Partnership Teaching NHS Foundation Trust will be taking the following actions to improve data quality:

Data Quality	Actions
Bringing clarity to quality	• Continue to improve the training, guidance and support available to help staff and services to understand and improve data quality • A dedicated resource to work on data quality alongside working with operational staff was identified during 2025/26
Measuring quality	• Continue to develop a wide range of team, service line, care group and Trust level operational and performance reports, and monitor these reports in appropriate forums • Service line reporting and electronic dashboards will include key performance indicators and will enable users to look at performance at team, service line, care group and Trust levels • Team dashboards are available via the Trust intranet and will continue to be developed and further rolled out across all service areas • Internal and external benchmarking will be incorporated in dashboards. The Trust has established a benchmarking group to review benchmarking data and identify areas for opportunity to further increase quality and effectiveness and make comparisons with peers

Data Quality	Actions
Publishing quality	• Continue to publish its data to the secondary uses service, NHS England, the CQC, the Department of Health and Social Care, commissioners and partners and to the members' council
Partnership for quality	• Continue to work with partner organisations to ensure that all our respective quality and performance requirements are met, and that duplication of data collection and inputting is minimised
Leadership for quality	• The improving clinical information group will oversee the development and delivery of the data quality improvement programme and will provide a quarterly progress update to the executive management team • Care groups will ensure the development, monitoring and delivery of the individual care group level improvement plans
Innovation for quality	• The Trust continues to work to ensure innovation for quality is embedded within this as part of the continued development of the system • The Trust continues to exploit new technology to make these systems easy to access and use. Particular use of digital solutions for non-face-to-face activity was implemented during the Covid-19 pandemic which allowed continued service delivery in a challenging environment. This continues to be utilised where appropriate
Safeguarding quality	• The Trust's executive management team will ensure essential standards of safety and quality are maintained and monitored and will take action where data quality issues arise

3.10. Learning from deaths

3.10.1. The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

During 2025/26, 2,125 of South West Yorkshire Partnership Teaching NHS Foundation Trust patients died. This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. six months) prior to death, identified from our clinical systems. This includes services such as end-of-life care, district nursing and care home liaison services. There is a delay in information being updated from the national system, particularly for quarter four, and therefore the total figure is likely to increase as records are refreshed.

The following number of deaths occurred in each quarter of that reporting period:

Quarter	Deaths
One	517
Two	546
Three	567
Four	495

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3.10.2. The number of deaths included above which the provider has subjected to a case record review to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

By 2 April 2026, 262 case record reviews took place in relation to the deaths included above.
The number of deaths in each quarter for which a case record review was carried out was:

Quarter	Deaths reviewed/ investigated
One	73
Two	65
Three	69
Four	55

The figures for 2025/26 are not comparable with previous reports due to the introduction of Patient Safety Incident Response Framework (PSIRF) and use of different tools to help understand if there were problems in care.

3.10.3. An estimate of the number of deaths during the reporting period included above for which a case record review has been carried out which the provider judges as a result of the review were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

Quarter	Deaths reviewed/ investigated found to be due to problems in care
One	0 (0%)
Two	0 (0%)
Three	0 (0%)
Four	0 (0%)

Of the 262 case record reviews in the reporting period, none identified ‘a problem in care which resulted in death’ at the time of reporting. This is the wording used in the national Patient Safety Incident Response Framework (PSIRF) and Learning from Healthcare Deaths policy.

Understanding the data around the deaths of our patients is a vital part of our commitment to learning from all deaths.

These numbers have been estimated using the methodology below:

- All deaths which are reported on Datix (our incident reporting system) have a service-learning review completed by the teams involved and this includes an initial case record review. This helps to determine if there were any problems in the care provided to the patient leading up to the death occurring
- In some cases where further scrutiny is required, we will commission a structured judgement review (an enhanced case record review) by someone independent of the teams involved to provide an objective review of the records

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- Where we identify opportunities to gain new learning, we may commission a Learning Response under the Patient Safety Incident Response Framework (PSIRF) to explore the issue in more detail using systems thinking tools
- Through a case record review or learning response, if we identify a problem in care which led to a death occurring, we would report this to NHS England and undertake a patient safety incident investigation in line with national PSIRF requirements
- Deaths of those with a diagnosis of learning disability and/or autism, would be reported to the national system called Learning from Lives and Deaths Reviews (LeDeR) for an external review of the individual's care

3.10.4. The number of case record reviews finished in the reporting period (2025/26) which related to deaths during the previous reporting period (2024/25) but were not included above in the relevant document for that previous reporting period.

7 case record reviews and 5 learning responses were completed during 2025/26 which related to deaths which took place before the start of the reporting period.

3.10.5. An estimate of the number of deaths included above which the provider judges as a result of the review were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

0 representing 0% of the patient deaths in 2024/25, completed in 2025/26, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Trust mortality review processes described above.

3.10.6. A revised estimate of the number of deaths during the previous reporting period (2024/25) stated above of the relevant document for that previous reporting period, taking account of the deaths referred to above.

0 representing 0% of the patient deaths in 2024/25, completed in 2025/26, are judged to be more likely than not to have been due to problems in the care provided to the patient.

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3.11. Reporting against core indicators

South West Yorkshire Partnership Teaching NHS Foundation Trust is required to report performance against a core set of indicators using data made available to the Trust by NHS England. For each indicator, South West Yorkshire Partnership Teaching NHS Foundation Trust must also make assurance statements for which the format and information required is set out in regulations and therefore it is set out verbatim.

3.11.1. The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care (N.B. this metric has replaced follow up within 7 days).

As set out nationally South West Yorkshire Partnership Teaching NHS Foundation Trust is moving away from the care programme approach (CPA) as set out in the CPA position statement from NHS England. As such we are no longer required to report on data related to CPA. The Trust is working towards developing an approach which is based on the five broad principles within the position statement. Therefore, this data relates instead to all service users under adult mental illness specialties.

Indicator	NHS Outcomes Framework Domain	NHS Digital South West Yorkshire Partnership Teaching NHS Foundation Trust data					
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care **Performance indicator is 80%**	1: Preventing people from dying prematurely 2: Enhancing quality of life for people with long-term conditions		Q1	Q2	Q3	Q4	TOTAL
		2025/26	91.7%	89.1%	88.1%	88.6%	89.4%
		2024/25	91.4%	92.3%	92.4%	89.3%	90.1%
		2023/24	92.6%	91.6%	90.9%	90.9%	91.5%
		2022/23	86.2%	89.2%	88.7%	87.8%	88.0%
		2021/22	85.8%	82.7%	83.6%	84.3%	84.1%
		2020/21	82.7%	81.0%	83.9%	84.6%	83.0%

The South West Yorkshire Partnership Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- This information is taken from the electronic clinical record system
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training

- Data is clinically validated before it is submitted to NHS England
- Performance data is reviewed monthly by the executive management team and also reviewed regularly by the Trust Board

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage and therefore the quality of its services:

- The Trust has an established improving clinical information group, sponsored and chaired by the chief nurse and director of quality and professions. This meets quarterly to focus on the quality of clinical data
- Each care group has developed a robust process to improve the quality of their clinical data

Each care group is provided with performance and quality reports monthly. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent deterioration in quality.

3.11.2. Percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper

Indicator	NHS Outcomes Framework Domain	NHS Digital South West Yorkshire Partnership Teaching NHS Foundation Trust performance data					
			Q1	Q2	Q3	Q4	TOTAL
The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period **Performance target is 95%**	2: Enhancing quality of life for people with long-term conditions	2025/26	98.4%	98.4%	99.6%	99.6%	99.0%
		2024/25	97.5%	97.2%	99.2%	99.6%	98.3%
		2023/24	99.7%	98.6%	99.3%	97.5%	98.8%
		2022/23	96.2%	99.3%	99.6%	98.7%	99.0%
		2021/22	99.7%	99.4%	98.3%	97.8%	98.8%
		2020/21	100%	96.1%	98.7%	99.4%	98.9%
		2019/20	99.7%	100%	99.7%	97.9% *(local data)*	98.4% *(local data)*
		2018/19	97.6%	97.9%	98.9%	96.5%*	97.7%
		2017/18	98.4%	96.9%	96.9%	99.6%	98%
		2016/17	96.9%	99.3%	99.3%	99.3%	
		2015/16	95.81%	97.29%	96.04%	98.32%	

The South West Yorkshire Partnership Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- This information is taken from the electronic clinical record system
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training
- We have two specific gatekeeping activity codes that are used for all gatekept admissions - this information can be extracted directly from the electronic record system
- Data is clinically validated before it is submitted to NHS England
- Performance data is reviewed monthly by the executive management team

The South West Yorkshire Partnership Teaching NHS Foundation Trust has taken the following actions to improve this percentage, and therefore the quality of its services:

- The Trust has an established improving clinical information group, sponsored and chaired by the chief nurse and director of quality and professions. This meets quarterly to ensure a focus on the quality of clinical data
- Each care group has developed a robust process to improve the quality of their clinical data
- We undertake a weekly audit of our gate kept admissions to validate the gate keeping function

Each care group is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

3.11.3. Readmission rates

The data made available by NHS England with regard to the percentage of patients aged - (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital, which forms part of the Trust, within 28 days of being discharged from a hospital during the reporting period.

	NHS Outcomes Framework Domain	Indicator Readmission rates by age										
		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
0-15	3: Helping people to recover from episodes of ill health or following injury	0	0	0	0	0	0	0	0	0	0	0	0
16 and over		7.02 %	8.7 %	9.7 %	9.8 %	9.8 %	9.1 %	5.2 %	4.5 %	3.7 %	4.3 %	2.6 %	3.0 %

South West Yorkshire Partnership Teaching NHS Foundation Trust had no readmissions for patients aged 0-15 during this period. All data applies to people aged 16 or over.

The South West Yorkshire Partnership Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- 97% of people were not readmitted in 2025/26
- This information is taken from the electronic clinical record system
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training
- Data is clinically validated before it is submitted to NHS England

The South West Yorkshire Partnership Teaching NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- The Trust has an established improving clinical information group, sponsored and chaired by the chief nurse and director of quality and professions. This meets quarterly to ensure a focus on the quality of clinical data
- Each care group has developed a robust process to improve the quality of their clinical data

Each care group is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

3.11.4. The Trust's 'patient experience of community mental health services' indicator scores with regard to a patient's experience of contact with a health or social care worker during the reporting period

Indicator	NHS Outcomes Framework Domain	South West Yorkshire Partnership Teaching NHS Foundation Trust score	National score
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period 2: Enhancing quality of life for people with long-term conditions 4: Ensuring that people have a positive experience of care		2024 score	National 2024 score
			National comparison
		6.7	About the same as other trusts nationally (CQC website)
		2023 score	National 2023 score
			National comparison
		7.2	About the same as other trusts nationally (CQC website)
		2022 score	National 2022 score
			National comparison
		7.2	About the same as other trusts nationally

Indicator	NHS Outcomes Framework Domain	South West Yorkshire Partnership Teaching NHS Foundation Trust score	National score	
			(CQC website)	
		2021 score	National 2021 score	
			National comparison	
		5.8	About the same as other trusts nationally (CQC website)	
		2020 score	National 2020 score	
			National comparison	
		7.0	About the same as other trusts nationally (CQC website)	
		2019 score	National 2019 score	
			National comparison	
		7.0	About the same as other trusts nationally (CQC website)	
		2018 score	National 2018 score	
			National comparison	
		6.7	About the same as other trusts nationally (CQC website)	
		2017 score	National 2017 score	
			National comparison	
		7.9	About the same as other trusts nationally (CQC website)	
		2016 score	National 2016 score	
			Highest trust score	Lowest trust score
		7.5	8.5	6.8

The South West Yorkshire Partnership Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- This information was taken from the national CQC community patient survey, which uses approved survey contractors, external to the organisation and uses anonymous information

The South West Yorkshire Partnership Teaching NHS Foundation Trust intends to take the following actions to improve this percentage and therefore the quality of its services:

- This information will be triangulated with other sources of patient and staff experience feedback so that we can successfully focus our improvement action.

3.11.5. The number and percentage of such patient safety incidents that resulted in severe harm or death

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Financial Year	Number of patient safety incidents (at 01/04/26)	Number of patient safety incidents reported on LFPSE (at 01/04/26)	Severe harm	% severe	Death	% death
2025/26	9,139	4,260	15	0.16%	18	0.19%

The Trust considers that this data is as described for the following reasons:

- We record all incidents on our local risk management system (LMRS), including incidents affecting staff, visitors and incidents that have been identified by Trust staff that may have occurred in other settings e.g. acute Trust, patient home, care home
- We have included the figures of all our patient safety incidents reported on our LMRS and the percentages have been taken from this figure
- LFPSE data that has been submitted to NHS England is currently being validated and therefore cannot be used for patient safety incident planning or official statistics

In 2025/26, a total of 9,139 patient safety incidents were reported on our LRMS, Datixweb, with 33 resulting in severe harm and patient safety related death incidents. We ask staff to over-estimate the actual harm where this is not confirmed and this will be reflected in this figure.

95% of the 9,139 patient safety incidents resulted in no harm or low harm. Nationally (NHS 2021), it is believed that organisations that report more incidents usually have a better and more effective safety culture. If we understand what our incidents are, we can learn and improve our services.

The implementation of the Patient Safety Incident Response Framework (PSIRF) in the Trust from 1 December 2023 continues to support our strong focus on learning for improvement.

We have multiple methods of sharing learning from incidents including a learning library, bluelight alerts for sharing urgent learning and a learning network. Teams also share learning through care groups.

Plans in place to improve reporting to LFPSE during 2026/27

- Staff education and improved resources to support knowledge of which incidents are patient safety incidents and what is reportable to LFPSE

3.11.6. Guardian of safe working hours

The 2016 junior doctors' contract introduced stronger safeguards to prevent resident doctors from working excessive hours. The safety of patients is a paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. The new contract introduced the role of guardian of safe working hours who is responsible for protecting the safeguards outlined in the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The guardian ensures that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and provides assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The introduction of the contract for doctors in training impacted on the Trust in February 2017, with new employees moving onto the contract at that point. The Trust appointed a senior medical representative as the guardian of safe working and their 2025/26 annual report and quarterly reports, highlighted the following:

- The number of exception reports has remained low during this period which is in line with the majority of Trusts providing mental health care (table below). The most common issue has been pressure of work on inpatient areas, especially during colleagues' absence. Trainees have been encouraged to complete exception reports if they do stay late or miss breaks or educational opportunities. Trainees have raised concerns about not receiving their rota in a timely way and there being barriers to arranging annual or study leave. Work is on-going to try to resolve these issues

Exception reports by area				
Area	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Barnsley	0	2	2	0
Calderdale	0	0	0	0
Kirklees	0	0	0	0
Wakefield	0	9	9	0
Forensic	0	0	0	0
Total	**0**	**11**	**11**	**0**

- Rota gaps remain high, with 684 shifts being vacant and needing covering. The main reasons include vacancies, less than full-time trainees placed in full-time slots, and occupational health recommendations for trainees to come off the on-call rota. The industrial action taken by trainee doctors has been another factor. All the shifts were covered, and Trust bank doctors have been used to help fill gaps
- Rota coordinators managing the Trust medical bank, with the support of the trainees have done fantastic work to maintain the service despite these challenges
- There has been improved recruitment to core training in psychiatry, with an expansion of training numbers. There have been a number of vacancies across all schemes providing trainees to the Trust, although there were fewer vacancies from February

- The guardian of safe working hours continues to have sessions with all new trainees at induction to offer support and encourage trainees to raise any concerns that they may have. The guardian of safe working hours also meets trainees at the quarterly resident doctors' forum

3.12. Performance against indicators set out in the national metrics (previously the systems oversight framework)

The table below shows our performance against the indicators which are monitored by NHS Improvement, as required for our regulation process and set out in the national metrics.

Indicator		South West Yorkshire Partnership Teaching NHS Foundation Trust data					
	Target	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) approved care package within two weeks of referral	60%	89.5%	89.0%	89.1%	88.7%	92.3%	93.9%
NHS Talking Therapies (Formerly improving access to psychological therapies (IAPT)): a) proportion of people completing treatment who move to recovery (from IAPT dataset)	50%	52.2%	53.5%	52.2%	52.3%	52.8%	52.9%
b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral	75%	94.0%	94.0%	97.1%	98.7%	99.0%	99.2%
ii. within 18 weeks of referral	95%	99.4%	99.8%	99.9%	99.8%	99.9%	100%
Admissions to adult facilities of patients under 16 years old	0	1	1	2	0	2	1
Inappropriate out-of-area placements for adult mental health services	494	1691 bed days	3216 bed days	4982 bed days	3132 bed days	1358 bed days	1585 bed days

Appendix 1: Glossary

AHSN	**Academic Health Science Networks** are membership organisations within the NHS in England. They were created in May 2013 with the aim of bringing together health services, and academic and industry members
CAMHS	**Child and adolescent mental health service:** Treatment for children and young people with emotional and psychological problems.
Care groups	Formerly business delivery units (BDU). We have five care groups: Barnsley integrated services, adult and older people mental health, CAMHS and children, forensic, learning disabilities and adult ASD and ADHD.
CORE20Plus5	An NHS England approach to support the reduction in health inequalities.
CMHT	**Community mental health team:** A community based multi-disciplinary team who aim to help people with mental health problems receive an appropriate community environment for as long as possible, and in many cases preventing hospital admission.
CQC	**Care Quality Commission:** The health and social care regulator for England. Their aim is to ensure better care for everyone in hospital, in a care home and at home
CQUIN	**Commissioning for Quality and Innovation:** A payment framework that makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in high quality care for all (the NHS next stage review report) of an NHS where quality is the organising principle.
DATIX	**Datixweb** is the web-based version of the Trust's risk management system. It enables staff to report incidents that happen at the Trust, electronically
DoH/DHSC	**Department of Health and Social Care:** A government department which supports ministers in leading the nation's health and social care to help people live more independent, healthier lives for longer
EMT	Our **executive management team** (EMT) put into action the strategic direction and priorities set by the Trust Board. They are responsible for the day-to-day running of the Trust, making sure that resources are in the right place to provide high quality care and achieve our mission and objectives. They are held to account by our Trust Board.
EPMA	**Electronic prescribing and medicines administration:** Digital solution for prescribing and medicines administration.
ESR	**Electronic staff record:** A workforce solution for the NHS, supports the delivery of national workforce policy and strategy.
FFT	**Friends and Family Test:** A patient experience and quality improvement tool used across the NHS.
ICB	**Integrated Care Board:** A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing NHS budget and arranging provision of health services in the ICS area.
ICS	**Integrated Care System:** Partnerships of organisations that come together to plan and deliver joined-up health and care services, and to improve the lives of people who live and work in their area.
IG	**Information governance:** The legal framework governing the use of personal confidential data. It includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act and the Human Rights Act.

KPI/Key performance indicator	A performance indicator or **key performance indicator** is a type of performance measurement. KPIs evaluate the success of an organisation or of a particular activity in which it engages.
LeDeR	People with a learning disability and autistic people research
LGBT+	Lesbian, gay, bisexual, transgender, queer and any other sexual orientation or gender identity
MDT	Multi-disciplinary team
MHA	**Mental Health Act:** the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.
NCISH	The **national confidential inquiry into suicide and safety in mental health** (NCISH) has collected in-depth information on all suicides in the UK since 1996. Their recommendations have improved patient safety in mental health settings and reduced patient suicide rates, contributing to an overall reduction in suicide in the UK. Their evidence is cited in national policies and clinical guidance and regulation in all UK countries.
NHSE	**NHS England:** Leads the NHS in England. Includes NHS Improvement and working together as one organisation.
NICE	**National Institute for Health and Care Excellence:** A national group that works with the NHS to provide guidance to support healthcare professionals make sure that the care they provide is of the best possible quality and value for money
NIHR	**National Institute for Health Research**
PCREF	**Patient and Carer Race Equality Framework:** A mandatory framework to reduce racial inequalities in mental health services.
PC&S	**Personalised care and support**
SafeCare	A daily staffing software tool that matches staffing levels to patient acuity, providing control and assurance from bedside to board. The tool allows trusts to compare staff numbers and skill mix alongside actual patient demand in real time, allowing us to make informed decisions and create acuity driven staffing.
PSIRF	**Patient Safety Incident Response Framework:** Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Safety huddles	A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.
Schwartz round	A Schwartz round provides a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional challenges and social aspects of working in healthcare.
SystmOne	The electronic patient record system used within our Trust.
TIC	Trauma-informed care
TIPD	Trauma informed personality disorder
VCSE	Voluntary, community and social enterprise

Appendix 2: Statements from our stakeholders

1. Locala

Dear Caroline

Thank you for the opportunity for us at Locala to review your Quality Account for 2025/26.
This is a strong and comprehensive account which demonstrates a clear strategic direction, robust governance arrangements, and a well-embedded culture of continuous quality improvement. The report provides a credible and balanced overview of performance, priorities, and achievements.

Key strengths
We particularly note:

- Embedded quality improvement approach – A mature and systematic approach to improvement (#allofusimprove), supported by practical examples demonstrating delivery and learning
- Commitment to reducing inequalities – Clear and sustained focus on equality, diversity, and inclusion, including progress against PCREF
- Patient and carer involvement – Strengthened approaches to capturing and acting on patient and carer feedback
- Innovation and partnerships – Continued development in research, digital innovation and system working, supporting future sustainability

To further strengthen the Quality Account, we would suggest:

- Clearer articulation of impact and outcomes from improvement activity
- Continued development of co-production impact
- Consideration of a more concise summary to enhance accessibility

To summarise, your Quality Account reflects a high-performing organisation with strong leadership, a clear commitment to quality and safety, and an embedded improvement culture. The Trust is well positioned to continue delivering high-quality, equitable care for the populations it serves.

Yours sincerely,
Claire Naylor
Director of Quality & Professionals

Locala Health & Wellbeing

NHS Professional #teamCNO Nurse Advocate

Queen's Nurse

Claire Naylor | Director of Quality and Professionals | Locala Health & Wellbeing | The Eddercliffe Centre WF15 6LP | claire.naylor@locala.org.uk |Teams: 03033309494 Mobile:07720989839

2. Barnsley Hospital NHS Foundation Trust

Dear Caroline

Please find below cmments from Barnsley for your Quality account

Barnsley really values the strong and growing partnership with SWYPFT, with teams working more closely together to provide joined-up care. This closer working across acute, community and mental health services is making a difference: helping patients move through services more smoothly, supporting quicker discharges, and enabling more people to be cared for closer to home. It also shows how the relationship between organisations is becoming more open, collaborative and focused on doing what's best for patients.

As we look ahead to 2026/27, Barnsley Hospital is keen to keep building on this. There's a shared ambition to keep working together, recognising that strong partnership working is key to improving both the quality of care and the experience for patients and their families.'

Best wishes

Sarah

Sarah Moppett
Chief Nurse

Email: sarah.moppett@nhs.net

3. Healthwatch Barnsley

23 Queens Road
Barnsley
S71 1AN

9th June 2026

Dr Caroline Johnson
Chief Nurse/Director of Quality and Professions, Director of Infection Prevention & Control, Caldicott Guardian,South West Yorkshire Partnership Teaching NHS Foundation Trust
Sent via email to **QualityGovernanceTeam@swyt.nhs.uk**

Healthwatch Barnsley Response to SWYPFT Quality Account 2025–26

Healthwatch Barnsley welcomes the opportunity to review the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) Quality Account for 2025–26. We recognise the Trust's commitment to improving quality, safety, and patient experience, and we value the continued focus on community-based and mental health services.

Feedback from Barnsley residents highlights the importance of being listened to and involved in care. However, people report:

- Variable involvement in mental health care planning
- Carers not always being included or informed
- Barriers to engagement for those who are digitally excluded

Access remains a significant issue in Barnsley. With residents reporting:

- Long waits for mental health assessments and follow-up support
- Confusion around referral pathways between services
- Limited communication about support while waiting

We encourage the Trust to improve communication, especially when residents are waiting for assessments and to signpost residents to other support services whilst waiting.

Healthwatch Barnsley recognises the progress made by SWYPFT. Despite ongoing challenges around access, communication, inequalities, and continuity of care. We look forward to continuing to working in partnership with the Trust to ensure that the voices of Barnsley residents remain central to service improvement.

Yours sincerely



Lesley Cooper

Manager, Healthwatch Barnsley

4. **Barnsley Overview and Scrutiny Committee**

Feedback on Draft Quality Accounts – 2025-26

Comments from Barnsley Council's Overview & Scrutiny Committee

The Overview & Scrutiny Committee would like to thank South West Yorkshire Partnership NHS Foundation Trust for the services they continue to provide to the residents of Barnsley, and for the opportunity to contribute to the Quality Account for 2025-26.

Quality Goals/Priorities

The Committee is satisfied that the majority of priorities for 2025–26 have been successfully delivered or are on track. There is consistent reporting of measureable improvements across key areas including patient experience, patient safety, workforce, and service delivery.
There are a number of areas that have only been partially achieved, and some are currently still in development or in the early implementation phases with full impact expected in future years. These system pressures require continued focus to fully evidence sustained impact and outcomes.
The Committee welcomes developments locally in relation to improving access to services; addressing health inequalities; strengthening workforce and clinical safety; and investment in staff training and capability.

Important Omissions

There do not appear to be any important omissions in the Quality Account.

Public & Patient Involvement

The Trust demonstrates a structured approach to involving patients, carers and the wider public in service design and delivery. It is encouraging to see that work is being undertaken to ensure more inclusive participation so that the Trust can hear from hard to reach groups.

A formal involvement framework has been introduced to support consistent and meaningful engagement, with a strong emphasis on co-production. It is anticipated that this will ensure that lived experience influences service delivery and informs improvement priorities. However, it has been noted by the Committee that this is a work in progress and it will be interesting to see demonstrable impact as a result of this piece of work in the future.

5. West Yorkshire Integrated Care Board

NHS West Yorkshire
Integrated Care Board

Dr Caroline Johnson
Chief Nurse and Director of Quality and Professions
South West Yorkshire Partnership Teaching NHS Foundation Trust
Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP

Scorex House (West)
1 Bolton Road
Bradford
BD1 4AS
Tel: 01924 317659
westyorkshire.icb.nhs.uk

10 June 2026

Dear Caroline,

South West Yorkshire Partnership Teaching NHS Foundation Trust 2025/26 Quality Account

Thank you for the opportunity to review and comment on South West Yorkshire Partnership Teaching NHS Foundation Trust's 2025/26 Quality Account. This statement represents the views of Calderdale Cares Partnership, Kirklees Health and Care Partnership and Wakefield District Health and Care Partnership, on behalf of the NHS West Yorkshire Integrated Care Board.

To the best of our knowledge, the account provides a detailed and accurate overview of your service delivery, performance, and quality priorities.

We recognise South West Yorkshire Partnership Teaching NHS Foundation Trust's commitment to continue to deliver community, mental health and learning disability services that are safe, effective, caring, responsive and well-led; underpinned by the Trust's strategy and a clear organisational commitment to quality improvement, workforce development, reducing health inequalities and being a leading system partner through hosting the Kirklees Place Provider Partnership.

We would like to acknowledge and congratulate the Trust on its successes this year:

- The improvement work undertaken and continuing effort to achieve a segmentation rating of one with the Trust now being ranked fourth in the country, out of a total of sixty-one comparable organisations.
- The achievement of being approved by the University of Leeds to become a Teaching Trust.
- The Trust's commitment to supporting privacy, dignity, and wellbeing in care, with the Trust being recognised as one of the top five mental health trusts in the country for this.

- The maintenance of your first star under the Triangle of Care programme from the Carers Trust, and continued commitment to strengthen your organisational approach to recognising, involving, and supporting carers as you progress towards achieving Star 2.
- The embedding of the Patient Safety Incident Response Framework, strengthening system-based learning and proportionate incident response.
- The implementation of electronic prescribing to improve medication safety and reduce errors.
- The launch of the Trust's Quality Assurance System which enables the triangulation of data, information, and feedback to strengthen oversight of quality and culture across services.

The Integrated Care Board has assurance in strengthened patient safety systems through the implementation and review of the Patient Safety Incident Response Framework which is improving system-wide learning and proportional responses to incidents. There is evidence of your commitment to being trauma-informed and responsive with ongoing work to reduce restrictive practice and a Trust ambition to become a staff-led zero prone restraint organisation. We recognise the range of falls prevention quality improvements initiatives delivered which have strengthened consistency, reliability and effectiveness in falls prevention and management. The Integrated Care Board recognises an ongoing need to standardise safety practices across services where variation is noted and strengthen early identification and response to safety risks via data and dashboards.

We recognise the Trust's well-developed clinical strategy and strong evidence-based practice, research, and teaching infrastructure, including the recently attained Teaching Trust status. We note the continued need to address variation in clinical practice and patient experience and opportunities to strengthen outcome measurement on improvement programmes, increasing use of data analytics and digital innovation to support improvement and care delivery.

We are encouraged by high levels of reported patient satisfaction with the Trust putting significant emphasis on co-production and lived experience involvement and a strong person-centred, trauma-informed care approach. The Integrated Care Board considers further work is required to increase equitable experience of care for diverse groups and to continue to drive improvements in communication and engagement particularly with children, young people, and underrepresented, harder-to-reach groups.

The Trust demonstrates responsiveness through an active focus on access and flow, targeted activity to reduce waiting times, expansion of community-based and crisis services and digital innovation. The Integrated Care Board notes the ongoing work to address capacity and demand pressures across services and will continue to seek assurance regarding consistency of access and waiting time challenges and improved patient flow including admission and discharge processes.

The Integrated Care Board has assurance in the Trust's governance and oversight frameworks and strategic direction which is aligned to quality, safety, and equity. There is evidence of a positive organisational culture including embedding psychological safety and Freedom to Speak Up, a commitment to equity and inclusion and a strong focus on quality improvement culture. We recognise that further development is required to ensure learning from incidents is effectively translated into sustained change. Additional work is also needed to embed data quality and intelligence capabilities, enabling clearer articulation of outcomes from quality and improvement activities.

The Integrated Care Board supports your 2026/27 priorities. We also note the following overarching areas for your continued focus in 2026/27:

- Strengthen data quality and use of intelligence including linkage between data, outcomes, and improvement actions.
- Reducing variation in access, care, experience, and outcomes across services.
- Improve access, flow, and timeliness.
- Enhance patient, carer, and community involvement.

The Integrated Care Board values South West Yorkshire Partnership Teaching NHS Foundation Trust's positive contribution to the system and commitment to quality and looks forward to continuing our partnership through 2026/27.

Yours sincerely,



Debi Gibson

Director of Nursing and Quality – Calderdale, Kirklees, and Wakefield Place

NHS West Yorkshire Integrated Care Board

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 11.5

Private/Public paper:	**Public**		
Title:	**2025/26 Data Security & Protection Toolkit final submission**		
Lead Director:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Purpose/values:	All Trust objectives.		
Purpose:	To provide information to support the approval to submit the Data Security and Protection Toolkit (DSPT) final submission for 2025/26.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents. 5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The data security protection toolkit (DSPT) provides evidence to assure the Board and the wider system that the Trust is compliant with the principles set out in the National Cyber Security Centre's Cyber Assessment Framework (CAF).		
Any background papers / previously considered by:	Internal audit provides regular updates to the Audit Committee. Regular updates are received by the Executive Management Team, Operational Management Group, Digital TAG and Improving Clinical Information & Information Governance Group (ICIG). 23 June 2026 – Draft submission to the Audit Committee.		

With **all of us** in mind.

Executive summary:	The current DSPT includes four objectives, which are aligned to the four principles of the National Cyber Security Centre's Cyber Assessment Framework (CAF); plus, an additional objective that ensures all the information governance requirements in the previous DSPT are assessed. Meeting the objectives requires an assessment of a number of contributory outcomes. In previous years, the Trust has exceeded the DSPT expectations but, it should be noted that the CAF-aligned DSPT is not designed with an expectation that organisations should ever fully achieve all the contributory outcomes. Each contributory outcome has a minimum achievement level set, collectively known as the CAF profile. A level of "partially achieved" is proportionate for many outcomes and "not achieved" may be appropriate for some. The CAF profile will only be "achieved" if every outcome is individually achieved. A "partially achieved" CAF profile is acceptable and will not affect organisational reputation or ability to enter into contracts and agreements with third parties. An internal audit review of 8 contributing outcomes mandated by NHS Digital and a further 4 selected by the Trust from a recommended list has been completed and the output is: • Overall risk assurance across all five objectives is **low**, which means none of the reviewed outcomes were rated as not meeting minimum achievement levels; and • Confidence level in the veracity of the Trust's DSPT self-assessment/ final submission is **high.** For the sixth consecutive year, the Trust has achieved the highest levels of assurance in the audit assessment. The Trust has completed the self-assessment of the contributing outcomes that were not subject to the audit review and met the minimum achievement levels for each. On 26 May 2026 Trust Board approved delegated authority for the Chief Executive and Chair to approve the DSPT submission prior to the deadline of 30 June 2026. On 23 June 2026 the Audit Committee received the DSPT draft submission and recommended it for approval by the Chair and Chief Executive.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the Trust's final submission of the DSPT with a "partially achieved" CAF profile.

With **all of us** in mind.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Data Security & Protection Toolkit

2025/26 Final Submission

June 2026

Julie Hall, Deputy Director of Business Support

Rachael Smith, Information Governance Manager

Pav Kusmierski, Quality & Governance Manager

1. Introduction

The 2025/26 Data Security and Protection Toolkit (DSPT) is the second year that the submission has been based on the National Cyber Security Centre's Cyber Assessment Framework (CAF).

From 2018/19 to 2023/24 the DSPT was based on the ten data security standards recommended by the National Data Guardian.

Since 2024/25 the DSPT is based on the CAF and comprises 5 objectives, divided into 21 principles, further divided into 47 contributing outcomes. NHS England mandated 8 outcomes for internal audit review and a further 4 were selected by the Trust from a recommended list for inclusion.

A mandated interim submission was made in December 2025 to confirm the Truts interim assessment, and the final submission deadline is 30 June 2026.

Completing the self-assessment demonstrates that an organisation is working towards or meeting the required standard.

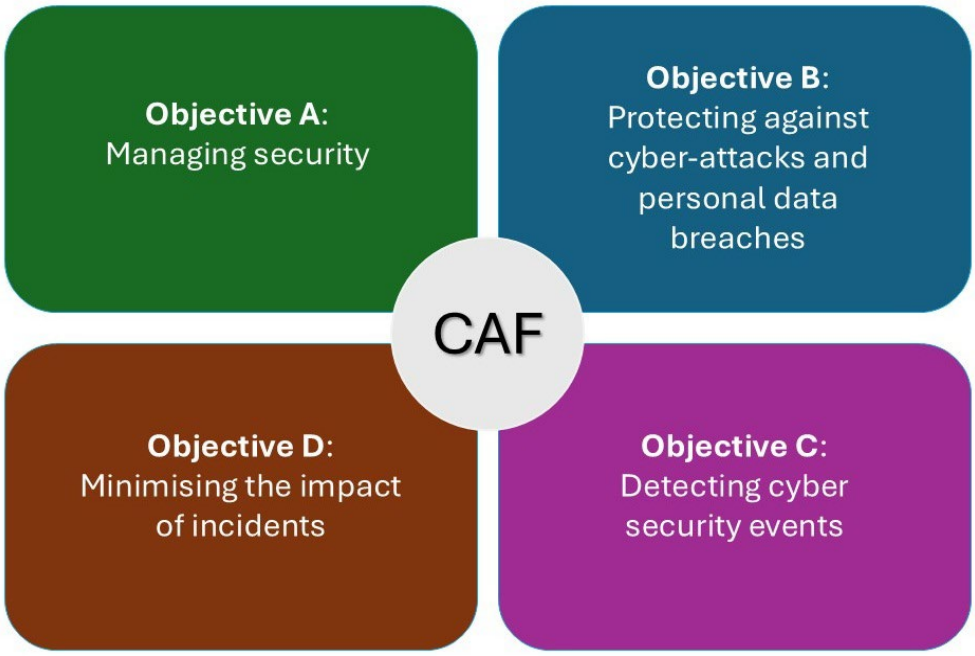
In previous years, the Trust has exceeded the DSPT expectations and achieved a significant level of assurance in the internal audit reviews: **it should be noted that the CAF aligned DSPT is not designed with an expectation that organisations should ever fully achieve all outcomes** and the approach to testing has been changed to reflect this.

Within the current DSPT, a minimum achievement level is set for each outcome, which is collectively known as the CAF profile. A level of "partially achieved" is proportionate for many outcomes and, for some, "not achieved" may be appropriate. The CAF profile will only be "achieved" if every outcome is individually achieved. A CAF outcome of "partially achieved" is acceptable and will not affect organisational reputation or ability to enter into contracts and agreements with third parties.

2. CAF-alignment

In 2023 the health and care cyber security strategy committed to adopting the CAF as the principal cyber standard, and the new DSPT has been developed to overlay CAF terminology and for organisations to self-assess their level of compliance against each contributing outcome.

The CAF profile will be made progressively more stringent over time and future expectations will be forecast much further in advance, allowing organisations to better plan. It will provide a standard framework for health and social care that is consistent with other sectors and allow scaling expectations based on changing threats and capabilities.



The underlying CAF principles for these objectives are:

- A Managing Risk - The organisation has appropriate structures, policies and procedures in place to understand, assess and systematically manage risks to the governance and security of information, networks and systems supporting essential functions.

- B Protecting against cyber-attacks and personal data breaches – Proportionate security measures are in place to protect information, networks and systems supporting essential functions.

- C Detecting cyber security events - Capabilities exist to ensure security defences remain effective and to detect cyber security events affecting, or with the potential to affect, essential functions.

- D Minimising the impact of incidents - Capabilities exist to minimise the adverse impact of an incident on the operation of essential functions, including the restoration of those functions where necessary and to uphold the rights of impacted individuals.

In most cases organisations have some flexibility to determine how to meet each contributing outcome; however, where the national risk is too great to permit flexibility, certain outcomes are constrained by directive national policy that requires certain approaches to be taken – or not to be taken – as part of the outcome. New policies will be integrated into each new DSPT launch. Currently, the only published directive national policy is for multi-factor authentication, which is a contributing outcome towards achieving objective B.

Where possible, the IG requirements of the former DSPT are aligned to the CAF principles; however, a further objective has been added to the new assessment to

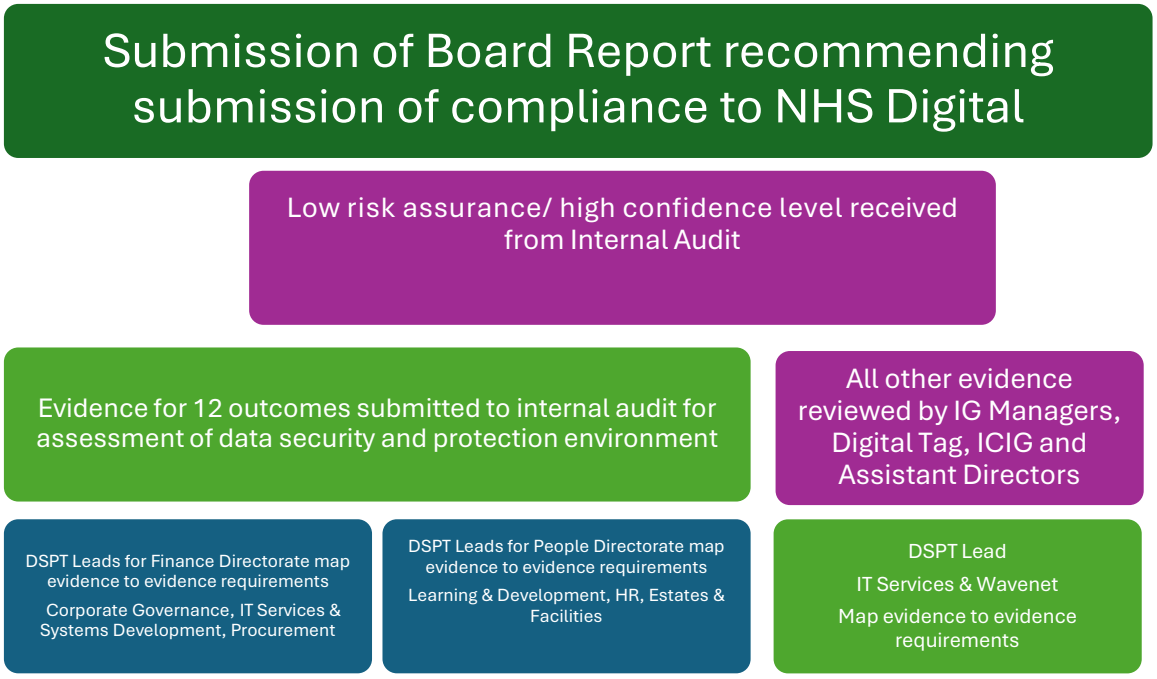
ensure all previous IG requirements are included. The minimum achievement level for seven of the eight contributing outcomes for this objective is “achieved”, as it is strictly aligned to the mandatory application of data protection laws and national policies, e.g.: consent.

- E Using and sharing information appropriately - The organisation ensures that information is used and shared lawfully and appropriately.

3. Evidence gathering

Documents and information provided as evidence to the Information Governance Manager and Quality & Governance Manager were overseen by the appropriate assistant or deputy director, chief officer or head of service

The full structure for evidence provision, assessment and sign off is below. This is a comprehensive and robust structure that provides strong assurance that the evidence compiled is solid and subject to review by the right people across the organisation.



4. Internal audit review (mandatory)

The above annual audit has been undertaken by the 360 Assurance, the overall objective of the review is to assess the effectiveness of the Trust’s data protection and security environment, as assessed through the DSPT. In order to achieve this objective, the following were assessed:

- the overall risk associated with the Trust's security and information governance control environment, i.e.: the level of risk associated with weak or failing controls and security and governance of information objectives not being achieved; and
- the veracity of the Trust's self-assessment/ final DSPT submission, providing a level of confidence that the submission reflects the Trust's risk and controls.

The draft internal audit report was shared by 360 for review on 6 June 2025, and an exit meeting was held on 15 June 2025, with the final draft report being published later that day, attached at appendix 1).

The assessment outputs are as follows:

	Overall risk assurance across all five CAF objectives	**Confidence level of the Independent Assessment ***
Independent auditor assessment	**Low risk**	**High confidence**

- Overall risk assurance across all five objectives is **low**, which means no outcomes were rated as not meeting minimum achievement levels; and
- Confidence level in the veracity of the Trust's DSPT self-assessment/ final submission is **high.**

For the sixth consecutive year, the Trust has achieved the highest levels of assurance in the audit assessment.

5. Action Plan

One low-risk finding and one non-reportable item require action but will not affect the final DSPT submission.

Risk rating	Risk
Low	If the Trust's business continuity plans do not contain detail around staff and information backup or escalation processes, then it risks that they will not be fully compliant with the expectations of the DSPT.
	Recommendations
	The Trust to update the SystmOne, Datix and Service desk business continuity plans in line with the updated BCMS template.
	Evidence to confirm implementation
	BCMS documents for Service desk, Datix and SystmOne.

	The Trust should utilise this recommendation to consider if any further IT/IG business continuity plans require priority updates.
	Responsible officer
	Jennie Byron, Emergency Preparedness Resilience and Response (EPRR) Adviser
	Target date
	30 November 2026

Non-reportable item

A1.a (A#2) - Regular board discussions on the security and governance of information, systems and networks supporting the operation of your essential function(s) take place, based on timely and accurate information and informed by expert guidance – The Trust has provided the terms of reference for the Improving Clinical Information & Information Governance Group (ICIG) which was last reviewed in Mach 2023. Whilst the terms of reference do not include a defined review date, we note that the current terms of reference has been operation for a long period of time. Through discussion with the Trust, we have been advised that it is currently reviewing the role of ICIG within the governance structure, therefore, has not updated the current terms of reference until the new roles for the group has been determined. The Trust is aiming to complete this by the end of September.

6. Final Review

The Information Governance Manager, Quality & Governance Manager and Deputy Director of Business Support have undertaken a final review of each evidence item and complete each outcome. If the submission were to be made, it was confirmed that the CAF profile would be partially achieved and the DSPT status will be Standards Met.

7. Horizon scan

NHS Digital have confirmed that the DSPT CAF profile is evolving and will continue to change over the next four years. This will allow the Trust to plan the evidence required to meet the additional levels of stringency each year; however, it must be noted that the CAF profile may also change at short notice to adapt to threats and outcomes may be identified as mandatory for the interim

8. Conclusion and Recommendation

The Trust has made excellent progress in its completion of the DSPT and currently has evidence that it meets the minimum achievement level for all contributing outcomes.

Following recommendation by the Audit Committee (on the 23 June 2026) the **Chair and Chief Executive** (on behalf of the Trust Board) **approved submission** of the final

assessment of the DSPT with a status of **Standards Met** and a **Partially Achieved** CAF profile. Submission was made to NHS England Digital on the date 29th June 2026.

Appendix 1 – final report of the DSPT audit

Data Security and Protection Toolkit

South West Yorkshire Partnership Teaching NHS Foundation Trust

19 June 2026

26-27/SWYPTFT/01

Final report



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Distribution

Name, Job Title	For action	For information
Adrian Snarr, Executive Director of Finance, Estates and Resources	✓	
Izzy Worswick, Deputy Director of Partnerships, Planning and Governance		✓
Paul Foster, Assistant Director of IT Services and Systems Development		✓
Julie Hall, Deputy Director Business Support		✓
Rachael Smith, IG & Records Manager		✓
Pawel Kusmierski, Quality & Data Protection Officer		✓
Jennie Byron, Emergency Preparedness Resilience and Response (EPRR) Adviser	✓	

The report has also been shared with the organisation's standard distribution list for internal audit reports.

Executive summary

Introduction and background

We have completed a review in respect of your 2025/26 Data Security and Protection Toolkit (DSPT) self-assessment. We examined the effectiveness of controls in place in accordance with the Global Internal Audit Standards in the UK Public Sector. We performed our review to provide an impartial and unbiased opinion.

Why data security and data protection issues require attention from Independent Assessors

Data and information are critical business assets that are fundamental to the continued delivery and operation of health and care services across the UK. The Health and Social Care sector must have confidence in the confidentiality, integrity and availability of their information assets and must ensure that any personal data collected, stored and processed by public bodies are aligned to specific legal and regulatory requirements.

The need to demonstrate an ability to defend against, block and withstand cyber-attacks and data breaches has been amplified by the introduction of the Network and Information Systems (NIS) Regulations and the UK General Data Protection Regulation (GDPR). As such, it is essential that Health and Social Care sector organisations that are impacted by those regulations take proactive measures to defend themselves from cyber-attacks and data breaches and evidence their ability to do so in line with regulatory and legal requirements.

The Cyber Assessment Framework (CAF) aligned DSPT is one of several mechanisms in place to support health and social care organisations in their ongoing journey to manage cyber security and information governance risk.

The CAF-aligned DSPT allows organisations that have access to NHS patient data and systems to measure their performance against the five objectives of the CAF-aligned DSPT, providing valuable insight into the technical and operational security and governance of information control environment and relative strengths and weaknesses of those controls. Another mechanism is to independently assess the security and governance of information control environments of health and social care organisations. Independent assessment providers help to strengthen the trust placed on the CAF-aligned DSPT submissions by health and social care organisations' boards, Department of Health and Social Care and NHS England by assessing the effectiveness of the organisation's security and governance of information controls. This approach ensures that the controls in place are effective in securing patient data throughout the organisation's estate, including staff handling of data and safe storage on the organisation's systems.

The role independent assessment providers play in helping to strengthen the reliance placed on the CAF-aligned DSPT submissions by health and social care organisations' boards, Department of Health and Social Care and NHS England is summarised in the National Data Guardian report, 'Review of Data Security, Consent and Opt-Outs and the Care Quality Commission report, Safe data, safe care'. Both reports include the following recommendation: 'Arrangements for internal data security audit and external validation should be reviewed and strengthened to a

level similar to those assuring financial integrity and accountability' (NDG 6, CQC 6 Table of recommendations). Therefore, it is essential that independent assessment providers, including internal auditors, focus on the assessment of the effectiveness of health and social organisations' security and governance of information controls, as opposed to simply focusing on the veracity of their CAF-aligned DSPT submissions.

Audit objective

The overall objective of our review was to assess the effectiveness of your data security and protection environment as assessed through the toolkit.

In order to achieve this objective, we have:

- assessed the overall risk associated with your security and information governance control environment, ie the level of risk associated with weak or failing controls and security and governance of information objectives not being achieved
- assessed the veracity of your self-assessment/DSPT submission, providing a level of confidence that the toolkit submission reflects your risk and controls.

The scope of the audit was partially determined by NHS England. There are nine mandatory outcomes, these are:

NHS England mandated in-scope outcomes for 2025/26 – NHS trusts, ICBs, CSUs and ALBs only

A1.a	You have effective organisational information assurance management led at board level and articulated in corresponding policies.
B1.a	You have developed and continue to improve a set of information assurance and resilience policies, processes and procedures that manage and mitigate the risk of adverse impact on your essential function(s).
B4.a	You design security into the network and information systems that support the operation of your essential function(s). You minimise their attack surface and ensure that the operation of your essential function(s) should not be impacted by the exploitation of any single vulnerability.
B5.a	You are prepared to restore the operation of your essential function(s) following adverse impact.
B5.c	You hold accessible and secured current backups of data and information needed to recover operation of your essential function(s).

Executive summary

C1.b	You hold log data securely and grant appropriate access only to accounts with business need. No system or user should ever need to modify or delete master copies of log data with an agreed retention period, after which it should be deleted.
D2.a	When an incident or near miss occurs, steps are taken to understand its root causes and ensure appropriate remediating action is taken.
E2.a	You appropriately assess and manage information rights requests such as subject access, rectification and objections.
E2.c	A robust policy and system is in place to ensure opt-outs are correctly applied to the information being used and shared by your organisation.

The Trust was also required to choose three additional outcomes from the remaining 39, to be reviewed as part of the audit. For this year's audit, the Trust selected the following discretionary outcomes:

Three additional outcomes selected by SWYPTFT for this review:

A1.c	You have senior-level accountability for the security and governance of information, systems and networks, and delegate decision-making authority appropriately and effectively. Risks to information, systems and networks related to the operation of your essential function(s) are considered in the context of other organisational risks.
D1.b	You have the capability to enact your incident response plan, including effective limitation of impact on the operation of your essential function(s). During an incident, you have access to timely information on which to base your response decisions.
D1.c	Your organisation carries out exercises to test response plans, using past incidents that affected your (and other) organisation, and scenarios that draw on threat intelligence and your risk assessment.

Limitations of scope: The scope of our work was limited to assessment of the evidence to support the 12 outcomes required to be assessed for this review, as detailed above. The review does not provide assurance that the entire DSPT return is accurate and complete. Our work did not include detailed testing of IT systems and does not cover the submission of the DSPT to NHSE.

As independent assessors, we have used our professional judgement when assessing compliance against each control objective. Where necessary, we may have recognised alternative ways to meet each of the control objective, based on the specific controls in place, local context and reference to supplementary guidance, such as the Big Picture Guides.

Executive summary

Audit assessment

Our review followed the CAF-aligned DSPT Independent Assessment Framework and Guidance published by NHS England. We have reviewed 12 outcomes across the five objectives in the Cyber Assessment Framework. NHS England has mandated nine outcomes to be audited for 2025/26, organisations are required to select a further three outcomes to be audited which should be approved by South West Yorkshire Partnership Teaching NHS Foundation Trust (SWYPTFT) Board. The scope of the audit has been approved by SWYPTFT and the independent assessor.

We produced this report as an output of this review. As a result of our evidence assessment and interviews with key stakeholders, we have raised one low risk finding in total. All findings and associated management actions have been discussed and accepted by SWYPTFT.

Objective	Outcome	Minimum achievement level (as per the profile set for 25/26)	High	Medium	Low	Outcome result	Minimum achievement level met?	Overall Risk Assurance
A	A1.a	Achieved	-	-	-	Achieved	Met	Low risk
	A1.c	Achieved	-	-	-	Achieved	Met	
B	B1.a	Achieved	-	-	-	Achieved	Met	
	B4.a	Partially achieved	-	-	-	Partially achieved	Met	
	B5.a	Partially achieved	-	-	-	Partially achieved	Met	
	B5.c	Achieved	-	-	-	Achieved	Met	
C	C1.b	Partially achieved	-	-	-	Partially achieved	Met	
D	D1.b	Achieved	-	-	A#3 A#5	Achieved	Met	
	D1.c	Achieved	-	-	-	Achieved	Met	
	D2.a	Achieved	-	-	-	Achieved	Met	
E	E2.a	Achieved	-	-	-	Achieved	Met	
	E2.c	Achieved	-	-	-	Achieved	Met	

Executive summary

Assessment outputs

	Overall risk assurance across all five CAF objectives	Confidence level of the Independent Assessment *
Independent auditor assessment	**Low risk**	**High confidence**

*** Understanding your report ratings**

Assurance level

The overall risk assurance rating for SWYPTFT (based on the overall risk across all five objectives) is 'low'.

This means that no outcomes were rated as not meeting minimum achievement levels.

Assessing the veracity of your DSPT self-assessment

We have assessed 12 outcomes, and found that, for all outcomes, our rating aligned with the organisation's self-assessment, resulting in a low level of deviation between the independent and self-assessment. The confidence level in the veracity of the DSPT self-assessment is therefore 'high'.

Areas of good practice

- **A1.a (A#4) –** the Trust has the 'Digital Strategy 2024-2030' in operation. We have seen that there are mechanisms for routine reporting of updates and progress to the Trust Board bi-annually
- **B1.a (PA#1)** – the Trust has recently updated key policies to ensure alignment to the CAF aligned DSPT. The terms of reference for the Digital TAG group state that it will "oversee the alignment of the Trust's relevant policies and procedures with the DSPT and the National Cyber Security Centre (NCSC) Cyber Assessment Framework (CAF)"
- **B4.a (PA#1)** – the Trust utilises third party services via Wavenet for network design. Wavenet holds various positive accreditations, demonstrating expertise in network design
- **B5.c (PA#1)** – the Trust has developed a document which details the processes for backup and recovery of key systems in the event of extreme scenarios.

Executive summary

Summary findings/direction of travel

We identified one area where the Trust needs to strengthen the arrangements in place to ensure full, embedded and ongoing compliance with the requirements of the DSPT.

We sample tested the SystmOne, Datix and Service desk business continuity plans against the requirements of the DSPT. We found current business continuity plans did not cover:

- identification of staff named as backups
- escalation processes and chain of command

The Trust has an updated business continuity management system (BCMS) template which does cover these DSPT requirements. We have raised a low-risk recommendation for the Trust to update the SystmOne, Datix and Service desk business continuity plans using the new BCMS template.

Further details on all risk areas identified are set out within the detailed report.

Summary of actions

	High	Medium	Low	Total
Proposed actions	-	-	1	**1**
Agreed	-	-	1	**1**

Follow up

Individual actions agreed in this report will be followed up via our online action tracking system, K10 Vision. Action owners are responsible for ensuring actions are completed by the agreed implementation dates and for providing relevant supporting evidence. Actions not completed by their agreed date are regularly reported to the Audit Committee and impact on the organisation's Head of Internal Audit Opinion.

Key Findings

The following sections of the report summarise the findings of our review. Our risk assessment process aligns with the ISO 31000 principles and generic guidelines on risk management. The risk matrix and scoring methodology used is prescribed by NHS England.

D1.b	Findings
You have the capability to enact your incident response plan, including effective limitation of impact on the operation of your essential function(s). During an incident, you have access to timely information on which to base your response decisions.	*D1.b (A#3) – Your response team members have the skills and knowledge required to decide on the response actions necessary to limit harm, and the authority to carry them out.* *D1.b (A#5) – Back-up mechanisms are available that can be readily activated to allow continued operation of your essential function(s) (although possibly at a reduced level) if primary networks and information systems fail or are unavailable.* For the purpose of our audit, we have reviewed the following sample of business continuity plans held by the Trust: • SystmOne (S1) • Datix • Service desk We have reviewed the plans and identified areas where these could be strengthened in line with the Trust's new business continuity management system (BCMS) template, as follows: • identification of business as usual and minimum staffing, premises, IT and data and suppliers and resource arrangements – the DSPT requires that the Trust has staff named as backups within plans, which would be achieved via the updated BCMS template • escalation processes and defined chain of command – the DSPT requires that plans have a clear escalation process in place, with a defined chain of command dictating the authority of each member of the response team, this is within the updated BCMS template. The Trust has advised that it is working towards updating its business continuity plans in line with the updated BCMS template.

Risk rating	Risk
Low	If the Trust's business continuity plans do not contain detail around staff and information backup or escalation processes, then it risks that they will not be fully compliant with the expectations of the DSPT.
	Recommendations
	The Trust to update the SystmOne, Datix and Service desk business continuity plans in line with the updated BCMS template.
	Evidence to confirm implementation
	BCMS documents for Service desk, Datix and SystmOne. *The Trust should utilise this recommendation to consider if any further IT/IG business continuity plans require priority updates.*
	Responsible officer
	Jennie Byron, Emergency Preparedness Resilience and Response (EPRR) Adviser
	Target date
	30 November 2026

Non-reportable items

A1.a (A#2) - Regular board discussions on the security and governance of information, systems and networks supporting the operation of your essential function(s) take place, based on timely and accurate information and informed by expert guidance – The Trust has provided the terms of reference for the Improving Clinical Information & Information Governance Group (ICIG) which was last reviewed in Mach 2023. Whilst the terms of reference do not include a defined review date, we note that the current terms of reference has been operation for a long period of time. Through discussion with the Trust, we have been advised that it is currently reviewing the role of ICIG within the governance structure, therefore, has not updated the current terms of reference until the new roles for the group has been determined. The Trust is aiming to complete this by the end of September.

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

The tables below summarise the evidence items within scope, setting out your self-assessment and our risk assessment. This detailed assessment supports the overall audit assessment presented within the executive summary:

Agree	Understated	Overstated	Agree but insufficient
From the evidence available we are able to agree with the organisation's self-assessment as a reasonable assessment of current performance	From the evidence provided it is our assessment that the organisation is performing at a level higher than recorded	From the evidence available we are not able to agree the self-assessment as a reasonable assessment of current performance.	From the evidence provided it is our opinion the organisation has been accurate with its self-assessment, but it has not currently completed the mandatory outcomes as required by NHSE.

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
A1.a	You have effective organisational information assurance management led at board level and articulated clearly in corresponding policies.	A#1	Achieved	Agree	✓ Reviewed ownership and approach	**Agree**
		A#2	Achieved	Agree	✓ Reviewed board discussions	
		A#3	Achieved	Agree	✓ Reviewed board level accountability	
		A#4	Achieved	Agree	✓ Reviewed how board sets the direction	

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B1.a	You have developed and continue to improve a set of information assurance and resilience policies, processes and procedures that manage and mitigate the risk of adverse impact on your essential function(s).	PA#1	Partially achieved	Agree	✓ Reviewed policies, processes and procedures	**Agree**
		PA#2	Partially achieved	Agree	✓ Reviewed process for updating policies, processes and procedures in response to cyber security incidents	
		PA#3	Partially achieved	Agree	✓ Verified IG policies, processes and procedures align to national policies and legal frameworks	

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B4.a	You design security into the network and information systems that support the operation of your essential function(s). You minimise their attack surface and ensure that the operation of your essential function(s) should not be impacted by the exploitation of any single vulnerability.	PA#1	Partially achieved	Agree	✓ Reviewed policies, processes and procedures	**Agree**
		PA#2	Partially achieved	Agree	✓ Verified strong boundary differences in place	
		PA#3	Partially achieved	Agree	✓ Reviewed data flow documentation	
		PA#4	Partially achieved	Agree	✓ Verified organisations design decisions	
		PA#5	Partially achieved	Agree	✓ Verified that all inputs are checked/validated at the network boundary	

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B5.a	You are prepared to restore the operation of your essential function(s) following adverse impact.	PA#1	Partially achieved	Agree	✓ Validated that all networks, information system and underlying technologies required for restoration are documented	**Agree**
		PA#2	Partially achieved	Agree	✓ Reviewed documentation that confirms the organisation understands the order in which networks can be brought back online	

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
B5.c	You hold accessible and secured current backups of data and information needed to recover	A#1	Achieved	Agree	✓ Reviewed the organisations backup procedures and testing regime	**Agree**
		A#2	Achieved	Agree	✓ Verified that backup testing is regular conducted	

	operation of your essential function(s).					

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
C1.b	You hold log data securely and grant appropriate access only to accounts with business need. No system or user should ever need to modify or delete master copies of log data within an agreed retention period, after which it should be deleted.	PA#1	Partially achieved	Agree	✓ Verified user access controls for logs	**Agree**
		PA#2	Partially achieved	Agree	✓ Sample tested authorised users to confirm controls operating as designed	
		PA#3	Partially achieved	Agree	✓ Validated access to logs is monitored	

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
D2.a	When an incident or near miss occurs, steps must be taken to understand its root causes and ensure appropriate remediating action is taken.	A#1	Achieved	Agree	✓ Reviewed incident response policy and process to confirm inclusion of lessons learned and root cause analysis	**Agree**
		A#2	Achieved	Agree	✓ Confirmed the comprehensiveness of policy	
		A#3	Achieved	Agree	✓ Tested a sample of incidents and near misses to confirm lessons learned and root cause analysis had been completed	

Appendix A: Summary of work undertaken and risks reviewed – Mandatory outcomes

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
E2.a	You appropriately assess and manage information rights requests such as subject access, rectification and objections.	A#1	Achieved	Agree	✓ Reviewed documented process for responding to information rights requests	**Agree**
		A#2	Achieved	Agree	✓ Reviewed staff training material to confirm staff responsibilities adequately covered	
		A#3	Achieved	Agree	✓ Reviewed documentation provided in respect of managing information sharing for direct care and assessed for comprehensiveness.	

Req. #	Description	IGP#	SCFT's Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
E2.c	A robust policy and system is in place to ensure opt-outs are correctly applied to the information being used and shared by your organisation.	A#1	Achieved	Agree	✓ Reviewed internal Trust processes for national data opt out including recording on information assets and data flows.	**Agree**
		A#2	Achieved	Agree	✓ Reviewed public facing guidance for national data opt out.	
		A#3	Achieved	Agree	✓ Reviewed procedures to ensure that opt outs are correctly applied.	

Appendix B: Summary of work undertaken and risks reviewed – Discretionary outcomes

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
A1.c	You have senior-level accountability for the security and governance of information, systems and networks, and delegate decision-making authority appropriately and effectively. Risks to information, systems and networks related to the operation of your essential function(s) are considered in the context of other organisational risks.	A#1	Achieved	Agree	✓ Reviewed the processes for risk escalation to IG group up to the Board of Directors	**Agree**
		A#2	Achieved	Agree	✓ Reviewed the decision-making processes including the risk appetite statement	
		A#3	Achieved	Agree	✓ Reviewed risk decision making at delegated groups including the IG Group	
		A#4	Achieved	Agree	✓ Reviewed evidence of risk register review at IG group and above	
		A#5	Achieved	Agree	✓ Reviewed Trust processes to ensure risk decisions are not siloed	

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
D1.b	You have the capability to enact your incident response plan, including effective limitation of impact on the operation of your essential function(s). During an incident, you have access to timely information on which to base your response decisions.	A#1	Achieved	Agree	✓ Reviewed the resources needed to carry out required response arrangements	**Agree**
		A#2	Achieved	Agree	✓ Reviewed documented and source of information used to carry out plans	
		A#3	Achieved	Agree Low risk finding raised	✓ Reviewed the skills and knowledge of response team members	
		A#4	Achieved	Agree	✓ Verified for a sample of scenario tests that knowledge has been shared with key staff	
		A#5	Achieved	Agree Low risk finding raised	✓ Enquired with the Trust around the processes for staff named as backups. Reviewed the Trust's essential functions against its BCPs	
		A#6	Achieved	Agree	✓ Enquired with the Trust if it is aware of cyber incident response services provided by NHSE	

Appendix B: Summary of work undertaken and risks reviewed – Discretionary outcomes

Req. #	Description	IGP#	SWYPTFTs Assessment	Independent Assessor's Assessment	Comment	Overall Assessment
D1.c	Your organisation carries out exercises to test response plans, using past incidents that affected your (and other) organisation, and scenarios that draw on threat intelligence and your risk assessment.	A#1	Achieved	Agree	✓ Reviewed documentation for supporting tabletop exercises carried out by the Trust over the last 12 months	**Agree**
		A#2	Achieved	Agree	✓ Evaluated Trust processes for documenting, reviewing and validation scenarios	
		A#3	Achieved	Agree	✓ Reviewed processes for scenarios informing updates to response plans	
		A#4	Achieved	Agree	✓ Reviewed the Trust's scenario schedule to confirm if it aligns to all parts of the response cycle	

Appendix C: Risk assurance rating and confidence level methodology

Risk assurance ratings

How to determine the indicator of good practice achievement level

The CAF-aligned DSPT Independent Assessor must assess the achievement level for each in-scope DSPT indicator of good practice assessed as part of their DSPT review. The Independent Assessor leverages knowledge and subject matter expertise alongside observations made during the assessment to evaluate each indicator of good practice against the Not Achieved, Partially Achieved or Achieved statements of the Cyber Assessment Framework. These statements are used to assign an achievement level to each indicator of good practice.

This achievement level reflects the maturity of the organisation in being able to meet the expected outcomes through implementation of controls and processes.

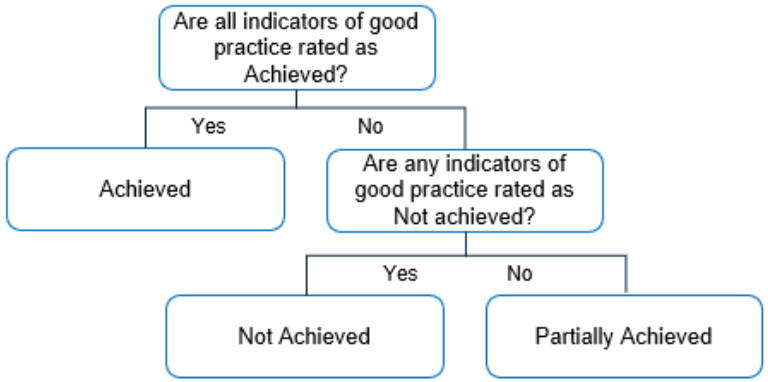
How to determine the outcome level achievement level

The DSPT Independent Assessor must then follow the CAF requirements to assign an achievement level at the outcome level. The CAF states that an outcome will be rated as Achieved if every underlying indicator of good practice is rated as Achieved. An outcome with be rated as Not Achieved if one or more underlying indicator of good practice is rated as Not Achieved. Finally, an outcome will be rated as Partially Achieved if no indicator of good practice is rated as Not Achieved, but not all indicators of good practice are rated as Achieved.

How to determine the overall risk rating for the organisation

The DSPT Independent Assessor then uses the table on the right-hand side to assign an overall risk rating to the organisation.

How to determine the outcome level of the achievement level



Overall Risk Rating across all tested outcomes	
Very High	More than four outcomes are rated as not meeting minimum achievement levels required and/or the organisation cannot comply with mandatory policy requirements.
High	Between two and four outcomes are rated as not meeting minimum achievement levels required.
Moderate	No more than one outcome is rated as not meeting minimum achievement levels required.
Low	All minimum achievement levels have been met.
Very Low	All minimum achievement levels have been met and achievement levels have been exceeded for at least one outcome.

Appendix C: Risk assurance rating and confidence level methodology

Overall Confidence and Risk Levels

The confidence-level in the veracity of the organisation's DSPT self-assessment submission has been determined by comparing our assessment findings against the self-assessment made by the organisation. The following NHS England definitions were used for aiding the decision of applying a confidence-level.

Level of deviation between self and independent assessment	Confidence level
High level of deviation - the organisation's self-assessment against the Toolkit differs significantly from the Independent Assessment. For example, the organisation has declared as "Standards Met" (meeting the expected achievement levels across all outcomes) but the independent assessment has found multiple outcomes as not meeting minimum levels of achievement.	Low
Medium level of deviation - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment. For example, the Independent Assessor has exercised professional judgement in comparing the self-assessment to their independent assessment and there is a non-trivial deviation or discord between the two.	Medium
Low level or no deviation - the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment.	High

Appendix D: 360 Assurance standing information

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Reports prepared by 360 Assurance and addressed to South West Yorkshire Partnership Teaching NHS Foundation Trust's directors or officers are prepared for the sole use of South West Yorkshire Partnership Teaching NHS Foundation Trust, and no responsibility is taken by 360 Assurance or the auditors to any director or officer in their individual capacity. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose and a person who is not a party to the agreement for the provision of Internal Audit between South West Yorkshire Partnership Teaching NHS Foundation Trust and 360 Assurance dated 1 April 2025 shall not have any rights under the Contracts (Rights of Third Parties) Act 1999.

The appointment of 360 Assurance does not replace or limit South West Yorkshire Partnership Teaching NHS Foundation Trust's own responsibility for putting in place proper arrangements to ensure that its operations are conducted in accordance with the law, guidance, good governance and any applicable standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

The matters reported are only those which have come to our attention during the course of our work and that we believe need to be brought to the attention of South West Yorkshire Partnership Teaching NHS Foundation Trust. They are not a comprehensive record of all matters arising and 360 Assurance is not responsible for reporting all risks or all internal control weaknesses to South West Yorkshire Partnership Teaching NHS Foundation Trust.

This report has been prepared solely for your use in accordance with the terms of the aforementioned agreement (including the limitations of liability set out therein) and must not be quoted in whole or in part without

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 11.6

Private/Public paper:	**Public**		
Title:	**Trust Strategic Overview: PESTLE & SWOT**		
Lead Director:	**Dawn Lawson, Deputy Chief Executive, Director of Strategy, Inclusion and Change**		
Purpose/values:	This report provides a strategic overview of the external environment and internal strengths and weaknesses		
Purpose:	The purpose of this report is to provide an analysis of the current high level business and associated risks for the Trust.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	All		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust Strategic Overview considers the external environment of the Trust and provides analysis on our relationships with the integrated care system and all four of our places		
Any background papers / previously considered by:	Considered at strategic Trust Board in May 2026.		

With **all of us** in mind.

Executive summary:	Our PESTLE register contains an analysis of the macro environment (external forces) that impact on the Trust's ability to plan and operate. Our SWOT register contains an analysis of the internal capability of the Trust as well as opportunities and threats that the external environment poses for the organisation. The main body of the document references the current key issues identified within the PESTLE and SWOT and considers the implications of these for the Trust. The full PESTLE and SWOT registers are presented for reference.
Recommendation:	**Trust Board members are asked to:** • **APPROVE** the Trust Strategic Overview: PESTLE & SWOT

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Trust Strategic Overview:

PESTLE & SWOT

June 2026

Dawn Lawson, Executive Director of Strategy, Inclusion and Change



1. Purpose and structure of the Report

This report provides an analysis of the current high level business and associated risks for the Trust. It provides an update on the key issues since the last analysis was presented to Trust Board March 2025. The analysis is based on a review of the PESTLE (political, economic, socio-cultural, technological, legal, and environmental factors), and SWOT (strengths, weaknesses, opportunities and threats). It has been developed through discussions with the Executive Management Team and in the Strategic Trust Board in May 2026

The main body of the document references the current key issues identified within the PESTLE and SWOT and considers the implications of these for the Trust. The full PESTLE and SWOT registers are presented in Appendix A for reference.

Section three below identifies the key items from our environment (the PESTLE) and section four identifies the key items from our SWOT. All items in these sections have been reviewed and update/added to.

2. Information and Analysis

Our PESTLE and SWOT registers from March 2026 are attached at Appendix A for reference. The registers gather information including:

- **The date when the entry was first added to the register.**
  This is referenced to help indicate where long term issues may require additional and specific attention.
- **The date the record was last updated** to ensure register entry is current and valid
- **Cross reference to the Trust's strategic aims and best statements** using colour coding for the relevant strategic objective to indicate how this issue links into the current strategy and priority areas of work

3. PESTLE Key current issues

Our PESTLE register contains an analysis of the macro environment (external forces) that impact on the Trust's ability to plan and operate.

The main current issues (June 2026) are set out in the table below.

Table one Key current PESTLE issues

Category	Description
Political	Continued emphasis on collaborative place-based approaches to improvement and development of integrated neighbourhood models, provider collaboratives and alliances, and place provider partnerships. Trust is playing a key role in each of the neighbourhood health models and partnerships for all four places.
Political	The NHS 10 year plan sets out the direction of travel for the NHS. We have undertaken analysis of the plan and noted a strong alignment with the trust strategy
Political	The NHS is under extreme pressure with consequences on patient experience and outcomes. Demand and acuity have increased, investment in the NHS has been flat over consecutive years and a lack of long term workforce planning, has had a significant impact on waiting times across the NHS. Planning guidance for 2026/27 onwards sets

	out a 2% efficiency requirement for the NHS each year. Public satisfaction with the NHS is low and political pressure to reduce waiting times is increasing. There have been several high profile incidents in mental health leading to concerns nationally about the perception of the sector.
Political	There are proposed changes in national and regional structures such as NHS England and Integrated Care Boards. We are also moving towards more Provider Collaboratives, Provider Alliances and Integrated Health Organisations. In West Yorkshire, the Trust is fully engaged in the development of emerging Provider Alliances across Calderdale, Kirklees and Wakefield and taking a lead role in the development of the Kirklees Provider Alliance. There are delays in ICB changes with resulting strategic uncertainty
Political	The results of recent local government elections could lead to a changing emphasis on health and social care, and the mental health, learning disability and autism agenda.
Economic	Major Cost Improvement Programme requirements, for the Trust which are greater than we have recently delivered coupled with financially challenged health and social care providers. This could lead to sub-optimal approaches to pathways and partnerships within local health economies, and unintended consequences associated with services stopping/ failing and risk of deterioration in quality of care provided.
Economic	Economic situation is challenging leading to reduced funding for the NHS. Increasing demand has impacted upon investment decisions by ICBs. The increasing cost of living including the increased risk of fuel poverty in some of our communities and the tightening of funding, is contributing to widening inequalities and impacting on people in lower income communities including some of our staff. This is impacting on health outcomes and inequalities and subsequently demand and acuity The impact of poverty is already evident in the increased acuity of patients, some patients unable to attend appointments due to travel costs and less resilience in communities impacting upon acuity and readmission.
Economic	Broader global context of conflict and the impact on national politics, cost of living, cost and availability of fuel and materials affecting individuals and services. Increase in defence spending and subsequent impact on funding available for the NHS
Socio-Cultural	Increasing likelihood of people seeing help for their mental health, particularly younger people which is leading to increasing demand. Increased likelihood of people seeking help earlier leading to more opportunities for effective early intervention. This is all exacerbated by the increase in cost of living
Socio-Cultural	The benefits of new health approaches – social prescribing, self-management, co-production, asset based approaches (placing people's skills, networks and community resources alongside their needs to improve care and support) are helping to reduce dependency on health professionals and encourage sustainable development of a community's health. This has been acknowledged in our Involvement and equality strategy and the Social Responsibility and Sustainability strategy and annual plans for our charities that enable us to deliver this aspect.
Socio-Cultural	Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to health inequalities.
Socio-Cultural	The population of people accessing our services is changing. There is greater societal awareness of ASD/ADHD, leading to surging demand for diagnosis and increasing pressure on already stretched services. There are high expectations from a new group of people who do not have the other co-determinants that many of our service users have
Socio-Cultural	Increase in racial tensions leading to threats and hostility to our colleagues.
Technological	Increased threat from cyber-crime impacting on NHS bodies – resulting in additional continuous cost of defence and prevention, and heightened risk of disruption to service provision and/or theft of personal data. (mitigated by business continuity plans).
Technological	Rapid developments in the use of Artificial Intelligence have the potential to transform the way we work. We are aware we may need to set up differently to take advantage of the opportunities in a co-ordinated way that supports us to deliver our priorities. This

	impacts on our colleagues. The NHS 10 year plan identifies technology as one of the key areas for development
Technological	Analogue to digital is one of the three shifts identified by the government. The Trust have to provide services in a way which accommodates public expectations in both and ensures that our access and engagement approaches are open to all
Legal/ Regulatory	There is a new operating environment of increased oversight and focus on performance and delivery emerging. The NHS 10 year plan for Health sets out planned changes to the NHS Operating Model and upcoming regulatory changes, such as a new Foundation Trust Model. The Trust Chief Executive is a member of the national group developing the new FT process. Details of the new regulatory framework is uncertain. Our performance against this framework is likely to have consequences on the public perception of the Trust, the views of our regulators and the attention of the media
Legal/ Regulatory	We are expecting a well led inspection from the CQC in the near future
Legal/ Regulatory	Changes in the Mental Health Act are being introduced which will require additional training and the development of new processes and systems of working
Legal/ Regulatory	There is an increase in calls for public enquiries. These are high profile and increase public concerns. They also provide an opportunity for learning so we can reduce the risk of these incidents being repeated
Environmental	Climate change is something that affects us all, both now and in the future. Several local authorities across the Trust footprint have declared a climate emergency and have prioritised environmental sustainability. The Trust is a partner in these activities to support local improvements to be more environmentally sustainable. Work has commenced on environmental sustainability across the ICS which we are a part of. Sustainability continues as part of the Board approved green plan to address the Net Zero agenda at the Trust. Changes in the political landscape may have an impact on our work as there is a different view of net zero and the actions we should take

4. SWOT Key current issues

Our SWOT register contains an analysis of the internal capability of the Trust as well as opportunities and threats that the external environment poses for the organisation. These are presented under the headings of:

- Strengths: characteristics of the Trust that gives it an advantage over others
- Weaknesses: characteristics of the Trust that places the Trust at a disadvantage relative to others
- Opportunities: elements in the environment that the Trust could exploit to its advantage
- Threats: elements in the environment that could cause challenge for the Trust

The main **current issues** (June 2026) are set out in the table below.

Table two Key current issues in SWOT

Category	Description
Strength	Clear commitment to the Trust's mission, good values base, and increased understanding and alignment around strategic priorities within all parts of the Trust as evidenced in the strategy refresh and the staff survey results. Staff 'living the values' as evidenced through values into excellence awards. We have a strong strategic alignment and delivery and reference to culture as evidenced by staff survey

Strength	Compelling model for alternative capacity – Creative Minds, Recovery Colleges, Arts & Health, Social Prescribing, Mental Health Museum and Altogether Better is well aligned to national direction and offers opportunities for partnership in local place-based solutions and developments in neighbourhoods. The Trust's linked charity Creative Minds is well placed in local systems
Strength	Partnership relationships and track record of collaborative working, providing leadership where appropriate and moving arrangements forward are a key strength. and place-based delivery structure underpinned by clear FT governance arrangements for system leadership and place based integrated care partnerships. We have strong expertise in this area and a track record of leading provider collaboratives/alliances. A range of executive and board arrangements with trusts, commissioners, and other stakeholders in each of the places we operate. We have demonstrated a clear commitment to supporting wider system issues and challenges in the best interest of services users. This was demonstrated by the acquisition of Cheswold Park.
Strength	Teaching Trust status demonstrates our commitment to supporting training and development of the workforce, being a great place to work and ensuring quality care. It provides a broader opportunity for strategic relationships with universities in our localities to support and enable us to engage with our communities, improve our ability to evaluate the impact on our programs and to participate in bids we wouldn't otherwise have the ability or capacity to consider.
Strength	External assessment and internal performance measures indicate that our performance is strong
Weakness	There are some Trust services where people have to wait too long for help. There is a risk that people will be adversely affected because of waiting for treatment - in particular child and adolescent mental health services, and child neuro-developmental waits. This requires changes within services as well as improvements supported by commissioners to achieve the right level of capacity.
Weakness	Our most recent CQC report (2023) identified the need for continued improvement across adult acute inpatient, PICU, and forensic services. While comprehensive improvement plans are in place, and progress has been made following the previously inadequate rating at Cheswold Park Hospital (pre-transfer), there remains a requirement to fully embed these improvements into consistent, sustainable practice across services. This continues to require focused leadership, time, and resource.
Weakness	Whilst some investment in analytical capability has been made, there has been very limited and there is an increasing need to expand the ability of the organisation to provide analytical data that is usable for front line colleagues.
Weakness	Whilst the Trust has a unique charitable offer, this is not financially sustainable in its current model.
Opportunity & Threat	We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health, born out by the selection of SWYPFT as regional coordinating provider in forensics in both West Yorkshire and South Yorkshire, and our acquisition of Cheswold Park Hospital, which places us as a key provider in South Yorkshire. We have been asked to share our learning on this. This opportunity is built into our strategic objectives and is also a threat.
Opportunity	We have an opportunity to transform the approach to the delivery of our services through innovation that makes greater use of our unique approaches e.g., Creative Minds, Recovery Colleges, Arts & Health, Social Prescribing, Mental Health Museum and Altogether Better. We have commenced work to embed these approaches as an integral part of our offer in inpatient and community services and neighbourhoods and could be a national exemplar. This is a unique ability and would enable SWYPFT to lead the conversations about the role of creativity in routine service planning and delivery and support the conversations about mental health services of the future and the shift to prevention . This is built into our strategic objectives
Opportunity	Opportunity to use the publication of the NHS 10 year plan and long term workforce plan as

	a framework to drive the strategic agenda for the Trust and for it to be a great place to work, research
Opportunity	Opportunity to lead Place Provider Collaboratives , in line with move towards Integrated Health Organisations. Shadow year for Place Provider Partnerships provides opportunity and threats, but either way is also a potentially significant challenge for strategic and operational capacity to be the 'Best Partner' and undertake due diligence
Opportunity	Opportunity to become an early wave early Foundation Trust which will bring additional flexibilities
Opportunity	Focus on neighbourhoods highlighted in NHS 10 year plan, Darzi report and in the 'Neighbourhood health guidelines 2025/26', 29 January 2025. Provides us opportunities, especially in Barnsley.
Threat	Impact of continued austerity on public spending (particularly Local Authorities) leading to additional unplanned pressures on the Trust. This manifests in terms of additional demand for Trust mental health services (e.g., because of benefit restrictions). The financial position of Councils is challenged; this could impact on support for vulnerable people who are service users (or potential service users) of our services.
Threat	Impact on financial performance. of non-delivery of Cost Improvement Programmes (CIPs), non-recurrent CIPs, out of area placements, reductions in cash, and regulator intervention, could impact on our ability to improve services and meet our objectives. This could have a negative impact on our NHS oversight framework ratings. Provider Selection Regime and Choice guidance - risk of greater competition all seeking the same funding.
Threat	Concern that national priorities will focus on acute and primary care due to pressures within these systems and therefore there will be less attention paid to Mental health, Learning disability and general community services. This has the potential to be exacerbated by wider ICB partner funding concerns .and fewer references to parity of esteem in national documents
Threat	There are likely to be different arrangements in each of our 4 places moving forward. There are increasing challenges on our capacity to engage in these new arrangements across all our areas
Threat	Increasing threat of industrial action leading to workforce challenges and quality and financial implications

5. Analysis and Implications – So what?

The PESTLE and SWOT provide important analysis that we will use in our annual planning to ensure that we

- Respond to the ley issues identified in our external environment and referenced in the PESTLE
- Build on our strengths, address our weaknesses, reduce our threats and size our opportunities, in line with our Trust strategy

There is a strong alignment between the PESTLE and the BAF and ORR providing assurance that these key management processes are identifying the same issues in the environment. In addition, there is strong alignment between the SWOT and the strategic aims and objectives within the Trust strategy and the proposed priorities within the annual plan. Consequently, we can be confident that our refreshed Trust Strategy and annual plans are set out to respond to our environment, build on our strengths and address our weaknesses. This ensures that we are in a good place to mitigate our threats and make the most of our opportunities.

6. Summary and recommendations

This document provides an analysis of the current high-level business and associated risks for the Trust, reviewed in May/June 2026 through discussions in the EMT and strategic Trust Board. It is presented to Trust Board for consideration and adoption.

Appendix A – Full PESTLE and SWOT from June 2026 presented for reference purposes only

Key: Link to strategic aims by number (one or three) and colour coding relating to Best Statements (all under strategic aim two)

 Best Partner  Best quality  Best value  Best place to work and learn

To note, items from the full PESTLE and SWOT registers presented in this Appendix which also feature in Section three or Section four of the main body of the report are indicated with a * following the reference number

PESTLE

Below is an analysis of the macro environment (external forces) that impact on the Trust's ability to plan and operate:

Category	Ref.	Description	Date First Added	Date Last Updated	Link to Strategic Objectives
Political	1.1	The NHS Long Term Plan (LTP) was introduced in January 2019 with greater emphasis on better access to mental health services to help achieve the government's commitment to parity of esteem between mental and physical health; better integration of health and social care so that care does not suffer when patients are moved between systems. It has greater emphasis on collaboration through Integrated Care Systems (ICS) place based intervention; greater role for primary care and community services focusing on the prevention of ill-health so people live longer, healthier lives; and with a strong focus on workforce and technology. SWYPFT have a strong position given SWYPFT engaged well in the production of the LTP and used our membership of both the mental health network of NHS Confed and NHS Providers to engage. We also used our roles in our ICSs to influence messages and engagement with systems which was very relevant.	Mar 19	Jan 25	

Political	1.4*	Continued emphasis on collaborative place-based approaches to improvement and development of integrated neighbourhood models, provider collaboratives and alliances, and place provider partnerships. Trust is playing a key role in each of the neighbourhood health models and partnerships for all four places.	Pre Apr 16	Jun 26	
Political	1.7	The NHS Long Term Plan requires commissioners to grow investment in mental health services faster than the NHS budget overall, aligned to specific service requirements that will be common across all districts. Ongoing contractual growth is in line with mental health investment standard, recognises demographic growth and some specific service pressures. Mental health investment standard funding provided by each commissioner in line with national requirements.	Jan 21	Jan 23	
Political	1.8	Assessment of place-based plans in each Integrated Care System (ICS) will take place as part of the annual planning process. The Trust inputs into the development of place based plans in all four places	Jan 21	Jan 23	
Political & Economic	1.9	Additional demands being placed on Trust resource during the year over and above planning assumptions, particularly in respect of place-based developments and transition to system working at operational and clinical level Ongoing engagement through place based Integrated Care Partnerships to agree capacity and resources to deliver on agreed change programmes. The impact of the reduction on ICB costs could have an impact on SWYPTFT.	Jan 21	Jan 25	
Political	1.10*	There are proposed changes in national and regional structures such as NHS England and Integrated Care Boards. We are also moving towards more Provider Collaboratives, Provider Alliances and Integrated Health Organisations. In West Yorkshire, the Trust is fully engaged in the development of emerging Provider Alliances across Calderdale, Kirklees and Wakefield and taking a lead role in the development of the Kirklees Provider Alliance. There are delays in ICB changes with resulting strategic uncertainty	Jan 21	Jun 26	
Political & Economic	1.14	Inflation and volatility in the building sector means that Capital planning is difficult and costs are increasing. The capital regime and approach mean that we are not always able to adapt to this volatile environment	Jan 23	Jan 23	
Political	1.15	Increased scrutiny and high profile media reporting on the NHS system and its delivery. This includes regular highlighting of pressures and impacts related to access, waiting times, capacity to deliver, and reports of system failures	Jan 23	Jan 23	

Political	1.16	New government in place during 2024 with subsequent change in health and care policy and approach. Increased focus on managers and performance and development of a new 10 year plan	Jan 24	Jan 25	
Political	1.17*	The NHS is under extreme pressure with consequences on patient experience and outcomes. Demand and acuity have increased, investment in the NHS has been flat over consecutive years and a lack of long term workforce planning, has had a significant impact on waiting times across the NHS. Planning guidance for 2026/27 onwards sets out a 2% efficiency requirement for the NHS each year. Public satisfaction with the NHS is low and political pressure to reduce waiting times is increasing. There have been several high profile incidents in mental health leading to concerns nationally about the perception of the sector.	Jan 24	Jun 26	
Political	1.19	The political environment is volatile and can change very quickly. The NHS is therefore required to be flexible and respond to these changes	Jan 24	Jan 24	
Political	1.20	The UK government's recent white paper on English devolution, titled "Power and Partnership: Foundations for Growth," outlines several key initiatives aimed at enhancing health and wellbeing across the country. The white paper introduces a bespoke duty focused on health improvement and reducing health inequalities which includes the mayoral Combined Authorities. A central goal of the white paper is to tackle regional disparities in health outcomes. By granting local authorities greater control over areas such as economic development, skills training, and transport infrastructure, the government seeks to address the underlying determinants of health and promote equitable health improvements across regions. SY Yorkshire is identified as a leader in adopting this approach through the Integrated Partnership whose Board is chaired by the South Yorkshire mayor.	Jan 25	Jan 25	
Political	1.21*	The NHS 10 year plan sets out the direction of travel for the NHS. We have undertaken analysis of the plan and noted a strong alignment with the trust strategy	Jun 26	Jun 26	
Political	1.22*	The results of recent local government elections could lead to a changing emphasis on health and social care, and the mental health, learning disability and autism agenda.	Jun 26	Jun 26	
Economic	2.3	The impact of NHS financial control measures means there is stronger financial interdependence across health systems through integrated care systems-level control totals, as underlined in the FYFV and in the NHS long term plan.	Oct-16	Jan 24	

Economic	2.4	Impact of current employment market for many staff groups, manifesting in buoyant agency market, driving cost growth for Trusts in excess of plans. Risk that wards are not adequately staffed, leading to increased temporary staffing and potential negative impact on quality of care provided. Potential threat of losing staff (more specifically lower graded staff) to other sectors for higher pay.	Oct-16	Jan 24	
Economic	2.5*	Major Cost Improvement Programme requirements, for the Trust which are greater than we have recently delivered coupled with financially challenged health and social care providers. This could lead to sub-optimal approaches to pathways and partnerships within local health economies, and unintended consequences associated with services stopping/ failing and risk of deterioration in quality of care provided.	Jul-16	Jun 26	
Economic	2.7	Due to higher inflation, pay awards are also increasing. There is a funding shortfall for the trust as it was not fully funded, this may well repeat	Sep-17	Jan 25	
Economic	2.8	The viability and maturity of the third sector to operate fully in the competitive market place impacts on the degree of flexibility that the Trust can partner to provide flexible and diverse services within health enabling us to reach into and benefiting communities .The third sector is particularly affected by financial constraints making it more vulnerable	Apr-18	Jan 23	
Economic	2.11	At present, demand and capacity issues across West Yorkshire and nationally have meant that children and young people requiring a CAMHs bed are, on occasions, temporarily located in a bed assigned for adults. Planned investment outlined in the Long-Term Plan can support improvements to services. Transformation funding through the ICSs to support MH community services and children and young people's services have been secured.	Mar-19	Jan 24	
Economic	2.12*	Economic situation is challenging leading to reduced funding for the NHS. Increasing demand has impacted upon investment decisions by ICBs. The increasing cost of living including the increased risk of fuel poverty in some of our communities and the tightening of funding, is contributing to widening inequalities and impacting on people in lower income communities including some of our staff. This is impacting on health outcomes and inequalities and subsequently demand and acuity The impact of poverty is already evident in the increased acuity of patients, some patients unable to attend appointments due to travel costs and less resilience in communities impacting upon acuity and readmission.	Jan 21	Jun 26	
Economic	2.14	The financial context we are operating within is challenging. The economic growth is poor and the treasury are reluctant to provide additional funding	Jan 24	Jan 24	

Economic	2.15*	Broader global context of conflict and the impact on national politics, cost of living, cost and availability of fuel and materials affecting individuals and services. Increase in defence spending and subsequent impact on funding available for the NHS	Jun 26	Jun 26	
Socio-Cultural	3.1*	Increasing likelihood of people seeing help for their mental health, particularly younger people which is leading to increasing demand. Increased likelihood of people seeking help earlier leading to more opportunities for effective early intervention. This is all exacerbated by the increase in cost of living	Jan-17	Jun 26	
Socio-Cultural	3.2	Impact of demographic change on the demand for services and on workforce age profiles.	Pre Apr 16	Mar-19	
Socio-Cultural	3.3	Changing expectations of services, greater expectation of personalisation, higher standards of customer service and responsiveness, greater level of co-production. Policy makers and commissioners expect more self-care and emphasis on prevention all supported by the NHS long term plan. This requires changes in workforce requirements with new skills, new roles, and new psychological contracts at work. Risk of not being able to recruit qualified clinical staff and impact of medical workforce retention / turnover in certain specialities and assessment is being mitigated through recruitment and retention strategy. This includes safer staffing review, development of new roles such as Advanced Nurse Practitioner, and an international recruitment campaign.	Pre Apr 16	Mar-19	
Socio-Cultural	3.4	The national shortages of clinical staff ~~i~~has affected the Trust's ability to recruit suitably qualified clinical staff which impacts on: the safety and quality of our services and the effective delivery of the Trust strategy, particularly in the ability for future development in services and increases our expenditure on bank and agency staff to fill the shortage gap. This position is slowly changing and we are seeing an early increase in headcount and downturn in agency use	Feb-18	Jan 24	
Socio-Cultural	3.6*	The benefits of new health approaches – social prescribing, self-management, co-production, asset based approaches (placing people's skills, networks and community resources alongside their needs to improve care and support) are helping to reduce dependency on health professionals and encourage sustainable development of a community's health. This has been acknowledged in our Involvement and equality strategy and the Social Responsibility and Sustainability strategy and annual plans for our charities that enable us to deliver this aspect.	Apr-18	Jun 26	
Socio-Cultural	3.7*	Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to health inequalities.	Jan 21	Jun 26	

Socio-Cultural	3.8	Social and community impact of poverty, domestic violence, safeguarding, employment which will have an impact on the complexity and number of people requiring help from our services, particularly mental health.	Jan 21	Jan 24	
Socio-Cultural	3.9	Increasing evidence of, and focus on, the health inequalities has exposed significant challenges to the way we think about and design our service offers. This requires us to work effectively and in a coordinated way with partners across all our systems to address inequity in a sustainable way.	Jan 21	Jan 21	
Socio-Cultural	3.10*	The population of people accessing our services is changing. There is greater societal awareness of ASD/ADHD, leading to surging demand for diagnosis and increasing pressure on already stretched services. There are high expectations from a new group of people who do not have the other co-determinants that many of our service users have	Jan 24	Jun 26	
Socio-Cultural	3.11	Recent examples of political decisions and media presentations suggest a hardening of views against some vulnerable groups which has a potential impact on communities and staff.	Jan 24	Jan 24	
Socio-Cultural	3.12	Changing attitude to work. Evidence that people entering the workforce are not considering the NHS as a lifetime career opportunity but are expecting portfolio careers with opportunities to develop in different ways	Jan 24	Jan 24	
Socio-Cultural	3.13	The impact of the cost of living crisis upon society leading to increasing division. Given political developments in the USA this is likely to increase. We will see the ripples of any societal changes in our colleagues and service users which will make our inequalities and health inequalities work more important to focus on but much more challenging to deliver	Jan 25	Jun 26	Strategic aim one
Socio-Cultural	3.14	Increased use of social media/you tube shorts and Instagram reels in the population - creating potentially false self-diagnosis potential to increase demand on services, but also as an opportunity for support for self-care. Speed of social media/feedback etc means we need to rethink our comms model and approach to different groups	Jan 25	Jan 25	
Socio-Cultural	3.15	Greater number of people accessing private healthcare options self-funded, through choice or personal health budgets	Jan 25	Jan 25	
Socio-Cultural	3.16*	Increase in racial tensions leading to threats and hostility to our colleagues.	Jun 26	Jun 26	
Technological	4.1*	Increased threat from cyber-crime impacting on NHS bodies – resulting in additional continuous cost of defence and prevention, and heightened risk of disruption to service provision and/or theft of personal data. (mitigated by business continuity plans).	Jan-17	Jun 26	
Technological	4.2	Digital technologies, and the continued direction of travel in public service towards “digital by choice” are a key enabler for change. In addition, “political will”, individuals and communities drive demand for health and care providers to keep pace with their use of technology as in	Pre Apr 16	Jan 23	

		other aspects of their lives. This increasing demand and expectation for digitally enabled services requires significant focus and emphasis on expanding sustainable digital transformation and change capabilities This has been adopted by the Trust and is central to the digital strategy The Trust has established a modern and resilient infrastructure to support agile working. The use of NHS apps and digital technology is emphasised in the NHS LT Plan and the What Good Looks Like (WGLL) framework. The Trust is also working with partners at place and, at wider ICS system level as part of the WY&H and SY&B ICSs. The Trust is also implementing the Patient Knows Best solution for people to access their own records. The pandemic has led to a step change in the use of digital approaches across the whole organisation.			
Technological	4.3	Inequalities in technology access, literacy, and acceptance are slowly being eroded, but persist as a factor impacting on service design and access. Technology inequalities mirror broader socio-economic inequalities, and as such are of relevance to deliver the Trust mission and objectives. Inequality in access to technology is impacting on service user choice of assessment and treatment. The Trust is actively working across the health and care ecosystem with partners to reduce the digital divide.	Jul-16	Jan 22	
Technological	4.4	Continued growth in use of social media by a wide range of demographic groups, changes the way in which customer experience and service quality is evaluated – becoming more open, faster, and comparable Technology is also supporting the speed in which we receive friends and family feedback, as we use text messages and handheld devices.	Pre Apr 16	Jan 23	
Technological	4.5	Technology enables improved access and use of data – telehealth/remote monitoring of vital signs, self-reported well-being etc. Creates a different dialogue between service user and healthcare service provider – supports personal control, education, self-care, and movement towards coaching approaches. As supported in the long term plan.	Pre Apr 16	Mar-19	
Technological	4.6	Interoperability of clinical systems, and enhanced analytical functions (population health management, data warehouses, big data etc.) support evidence-based care at system level and in relation to integrated care planning at an individual level. Creates demand for cross-organisational platforms for integrated working. The LTP and success measures within the WGLL framework accelerates opportunities to integrate and standardise health care information across care systems and actively supports collaborative digital opportunities across the regions. Following the work undertaken to implement and optimise the Trust's clinical record system, Systmone, the Trust is now able to share service user's records to other health organisations via Systmone.	Pre Apr 16	Jan 22	

Technological	4.7	Platform technology potentially allows Trust's to widen the range of offers available to service users e.g., digitally held personal records from which to access correspondence, complete assessments and access care plans etc., mobile apps, enables more peer to peer support, promotes innovation and provides data on choice. The Trust is utilising digital innovations such as Chat Pads on ward areas,	Jul-16	Jan 23	
Technological	4.8	Increased use of communications technology for consultation – engagement of carers/ Multi-Disciplinary Teams etc. Investment in technology has enabled an increase in clinical activity with service users.	Pre Apr 16	Jan 24	
Technological	4.9	The provision of agile/hybrid working (using communications and information technologies to enable staff to work in ways which best suit their needs) offers the capacity to help the Trust become a more responsive, efficient and effective organisation, improving performance. Covid-19 pandemic led to a step change increase in agile working and opportunities in support of the sustainability agenda	Apr-18	Jan 24	
Technological	4.10*	Rapid developments in the use of Artificial Intelligence have the potential to transform the way we work. We are aware we may need to set up differently to take advantage of the opportunities in a co-ordinated way that supports us to deliver our priorities. This impacts on our colleagues. The NHS 10 year plan identifies technology as one of the key areas for development	Jan 24	Jun 26	
Technological	4.11*	Analogue to digital is one of the three shifts identified by the government. The Trust have to provide services in a way which accommodates public expectations in both and ensures that our access and engagement approaches are open to all	Jan 25	Jun 26	
Legal/ Regulatory	5.1	Increased pace of movement towards new organisational forms and partnership vehicles suitable for place-based solutions (e.g., Integrated Care System, Multi-specialty Community Provider), and for service line specific collaboration (e.g., mental health). Gap emerging between regulatory and legal frameworks and the intended future structures for integrated place-based care provision	Jan-17	Mar-18	
Legal/ Regulatory	5.4	The amended Mental Capacity Act (deprivation of Liberty safeguards) received Royal Assent on the 16th of May 2019. The implementation date was delayed due to the Covid 19 and in Spring 2024 the then government confirmed there would be no further progress within the life of their government. No update has been provided by the new government, though aspects of the MHA Bill are reliant on a timely and effective deprivation of liberty process being operational. We are awaiting a refreshed Code of Practice and Regulations. No implementation timetable has been set at this time. Work has begun on a gap and impact analysis for the Trust to support an implementation plan and supporting training. The Trust will continue to implement elements of the new Act in practice as the opportunity arises through a	Apr-18	Jan 25	

		quality improvement cycle.			
Legal/ Regulatory	5.5	The national view to develop an NHS estates strategy to achieve best value from NHS estate; target the sale of surplus or inefficiently used NHS property; release land to build new homes on NHS land; support the realisation of the LTP and enable clinical transformation to deliver world class care have brought changes to the Trusts estate strategy. We have been asked to develop an ics level infrastructure plan. Our new estates strategy has very little in with regards disposals as most have already been delivered.	Apr-18	Jan 24	
Legal/ Regulatory	5.6	There is a legal regulatory framework provided through health and safety legislation for employers to provide employees with a safe and secure workplace in which to work. The legal remedies to provide appropriate management specifically on aggression and violence and on manual handling for the Trust are considerable.	Jan-17	Jan 23	
Legal/ Regulatory	5.7	In May 2021 a new CQC strategy and approach was introduced which also looks at how the care provided in a local system is improving outcomes for people and reducing inequalities in their care. This means looking at how services are working together within an integrated system, as well as how systems are performing as a whole.	Mar 22	Mar 22	
Legal/ Regulatory	5.9	The Trust is to provide evidence that it has mitigated against or addressed health inequalities in both the provision and restoration of services. In line with our Public Sector Equality Duty, Equality Duty, NHS constitution and the Health and Social Care Act.	Jan 22	Jan 24	
Legal/ Regulatory	5.10	Increasing scrutiny from the regulators, coroners and other legal bodies. There is a hardening of approach due to high profile examples of incidents within the NHS and subsequent impact on public confidence. There have been changes in the CQC and the inclusion of well led inspections	Jan 24	Jan 25	
Legal/ Regulatory	5.11	introduction of the Provider Selection Regime Commissioning Process which will have implications for the Trust. The direct award process B means all providers (including private) of consultant or mental health professional led services that meet the definition of choice have a right to a contract if they can pass the Integrated Care Boards' (ICB) accreditation process and are able to deliver the ICBs' service specification for that service.	Jan 24	Jan 24	
Legal/ Regulatory	5.12*	There is a new operating environment of increased oversight and focus on performance and delivery emerging. The NHS 10 year plan for Health sets out planned changes to the NHS Operating Model and upcoming regulatory changes, such as a new Foundation Trust Model. The Trust Chief Executive is a member of the national group developing the new FT process. Details of the new regulatory framework is uncertain. Our performance against this framework is likely to have consequences on the public perception of the Trust, the views of our regulators and the attention of the media	Jun 26	Jun 26	

Legal/ Regulatory	5.13*	We are expecting a well led inspection from the CQC in the near future	Jun 26	Jun 26	
Legal/ Regulatory	5.14*	Changes in the Mental Health Act are being introduced which will require additional training and the development of new processes and systems of working	Jun 26	Jun 26	
Legal/ Regulatory	5.15*	There is an increase in calls for public enquiries. These are high profile and increase public concerns. They also provide an opportunity for learning so we can reduce the risk of these incidents being repeated	Jun 26	Jun 26	
Environmental	6.1	Change in travel patterns as part of new service models and technological change – e.g., more home-based care but fewer trips back to base. More support staff using video conferencing.	Pre Apr 16	Jan 24	
Environmental	6.2	Opportunities around renewable energy are emerging. The Trust has built this into the revised Green Plan. COP 26, COP 27 and a range of climate change networks and guidance have raised awareness of the climate agenda. NHS Trusts have carbon reduction targets and reporting requirements.	Pre Apr 16	Jan 23	
Environmental	6.3*	Climate change is something that affects us all, both now and in the future. Several local authorities across the Trust footprint have declared a climate emergency and have prioritised environmental sustainability. The Trust is a partner in these activities to support local improvements to be more environmentally sustainable. Work has commenced on environmental sustainability across the ICS which we are a part of. Sustainability continues as part of the Board approved green plan to address the Net Zero agenda at the Trust. Changes in the political landscape may have an impact on our work as there is a different view of net zero and the actions we should take.	Oct-19	Jun 26	
Environmental	6.4	Work has commenced across the ICSs to look at the wider determinants of sustainability. The Trust has a Board approved green plan and a Social Responsibility and Sustainability Strategy with supporting action plans. Five headline initiatives have been developed as areas of focus for this work. There are increasing expectations and opportunities for the Trust to use its role as an anchor institution	Jan 22	Jan 24	
Environmental	6.5	Recent examples of resources being unavailable due to environmental issues impacting on supply of essential items such as drugs and electronica equipment	Jan 24	Jan 24	

SWOT

In the context of an analysis of the external environment and the Trust's strategic objectives and priorities, the following strengths, weaknesses, opportunities and threats are highlighted:

Please note, the cross-reference columns for the ORR and BAF have been blanked out for the strengths and opportunities sections as they are not relevant

Category	Ref.	Description	Date First Added	Date Last Updated	Link to Strategic Objectives
Strength	1.1*	Compelling model for alternative capacity – Creative Minds, Recovery Colleges, Arts & Health, Social Prescribing, Mental Health Museum and Altogether Better is well aligned to national direction and offers opportunities for partnership in local place-based solutions and developments in neighbourhoods. The Trust's linked charity Creative Minds is well placed in local systems	Pre Apr 16	Jun 26	
Strength	1.3*	Partnership relationships and track record of collaborative working, providing leadership where appropriate and moving arrangements forward are a key strength. and place-based delivery structure underpinned by clear FT governance arrangements for system leadership and place based integrated care partnerships. We have strong expertise in this area and a track record of leading provider collaboratives/alliances. A range of executive and board arrangements with trusts, commissioners, and other stakeholders in each of the places we operate. We have demonstrated a clear commitment to supporting wider system issues and challenges in the best interest of services users. This was demonstrated by the acquisition of Cheswold Park.	Oct-16	Jun 26	
Strength	1.4	Developing partnerships with neighbouring providers of mental health and learning disability services, aligned to achievement of ICS aims. For example, The Trust has worked with partners in West Yorkshire to agree lead provider collaboratives for eating disorders, CAMHS and secure care. The Trust is Lead Provider for secure care in West Yorkshire and South Yorkshire. Strong and robust partnership working with local partners, such as Locala to deliver the Care Close to Home contract.	Oct-16	Jan 23	
Strength	1.5	'Centres of excellence' within services recognised internally and externally examples include: Our adult attention deficit hyperactivity disorder (ADHD) and autism service received the prestigious ACOMHS accreditation awarded by the Royal College of Psychiatrists. Our Calderdale memory assessment service being accredited by the Royal College of Psychiatrists for the care they	Jan-17	Jan 22	

		provide to local people with memory problems or dementia and their families. The Trust was accredited as a Veteran Aware NHS organisation by the Veterans Covenant Healthcare Alliance (VCHA).			
Strength	1.6*	Clear commitment to the Trust's mission, good values base, and increased understanding and alignment around strategic priorities within all parts of the Trust as evidenced in the strategy refresh and the staff survey results. Staff 'living the values' as evidenced through values into excellence awards. We have a strong strategic alignment and delivery and reference to culture as evidenced by staff survey	Jul-17	Jun 26	Strategic aim one
Strength	1.8	The Care Quality Commission report confirmed that staff treat people with kindness, care and compassion, and that we are respectful and warm. Our inspection in 2023 confirmed that "We observed positive and caring interactions between staff and patients on all the acute/PICU wards we visited"	Jul-16	Jan 24	Strategic aim one
Strength	1.12	Our partnership relationships and the way in which we conduct ourselves when working collaboratively and co-producing with others demonstrates a real focus on the needs of the people who use our services and on partnerships. This has been further enhanced through the refresh of the trust strategy and the equality, diversity and inclusion strategy.	Jul-16	Jan 25	Strategic aim one
Strength	1.14	Recognition of our services through local, regional, and national awards raises the profile of the trust and celebrates outstanding achievements. Our achievements include: • an Investing in Volunteers award for our good practice in volunteer management. • Triangle of Care Star 1 for our work to improve engagement between carers and health professionals to ensure carers are supported. • 100% of our inpatient wards and crisis teams completed a Triangle of Care self-assessment – a vital way to look at how each service currently supports carers. • In a Patient-Led Assessment of the Care Environment (PLACE), we were one of only three mental health trusts to score 100% for cleanliness. • More than 1,000 responses to our older people's mental health inpatient services consultation survey, with representation from across our staff, patients, families, carers and the wider population. • One staff member in Barnsley neighbourhood nursing services, was awarded the Queen's Nurse title in recognition of her commitment to high standards of patient care. • QUIT teams in South Yorkshire were shortlisted for an NHS Parliamentary Award in the Health Equalities category for their work to re-frame tobacco addiction into a treatable condition. • The community specialist palliative care team in Barnsley were nominated as Hospital Heroes in the Proud of Barnsley 2024 awards.	May-18	Jan 25	

		• Shortlisted as a finalist at the NHS Providers Quality and Improvement Showcase in London for our #allofusimprove work. We were one of just six NHS trusts chosen to present our best practice and learning. • Carers UK highlighted our Trust as a good practice example for our work in making carers a core part of the work we do. • 95% of respondents in the friends and family test rated our general community services either good or very good. • Our Wakefield CAMHS eating disorder team was named as the 'Psychiatric team of the year 2024 – children and adolescents' at the 2024 Royal College of Psychiatrists' RCPsych awards.			
Strength	1.15	Partnership working by the Trust with the 3rd sector VCS (voluntary and community sector) and faith sector aiming to improve access to services and ensure those from our most deprived neighbourhoods have equal access to pathways of care for example, partnership working with Nova and Living Well Service in Wakefield. Additional work to identify key partners in VCS and faith sector has taken place resulting in 200+ groups and individuals organisations identified as partners. Work to strengthen these relationships continues.	Jan-19	Jan 22	
Strength	1.18	The Trust has made significant investment in modern and high-quality estates and digital infrastructure, evidenced by hubs such as Drury Lane and the development of the Unity Centre; agile working; and the Trust-wide Systmone implementation. Our digital journey and approach has been recognised in an NHS confederation publication titled Integration and Innovation in action: virtual care. We have recently refreshed our Digital Strategy	Aug-19	Jun 26	
Strength	1.19	The Trust is taking active steps to support local improvements to be more environmentally sustainable. For example, to reduce waste and help the environment by reducing the use of single use plastics across all catering, encouraging use of electric cars and electric car charging points added to Fieldhead site. The Social Responsibility and Sustainability strategy builds on this foundation with key actions in place to take this forward	Aug-19	Jan 23	
Strength	1.20	Range of integrated services now delivered through an Alliance Contract. The service provides an integrated pathway for patients in Barnsley delivered by SWYPFT, Barnsley CCG, Barnsley Hospital NHS Foundation Trust, Barnsley Healthcare Federation, and the Local Authority. Pulmonary Rehab pathways, and Stroke provision, are also both provided via integrated pathways.	Aug-19	Jan 23	
Strength	1.21	The Trust has high performing stop smoking services across a wide geography	Aug-19	Jun 26	
Strength	1.22	SWYPFT have continued delivery of the schools' flu programme in Barnsley We have also	Aug-19	Jan 23	

		helped deliver a successful vaccination programme through the alliance in Barnsley			
Strength	1.23	The Trust is viewed as a trusted provider for services by our commissioners. Most of the feedback on our Friends and Family Test is positive and this has been maintained over several years	Jan 21	Jan 24	
Strength	1.26	Quality Improvement culture becoming embedded and good examples have emerged on safety huddles, reducing restricted practices, flu vaccination programme, out of area bed, e-discharge and patient flow .	Jan 21	Jan 23	Strategic aim one
Strength	1.27	Strength in our work on Creativity and arts in health. Lead on the development of a system wide approach in Calderdale. Working with the National Centre for Creativity and Health and supporting the WY ICS Creative Health hub aligned to the WY mayoral priorities West Yorkshire has been identified as the first Creative Health System	Jan 21	Jun 26	
Strength	1.28	Using data and insight in place and within the Trust to understand the population we serve. This includes working with our communities to capture voice and ensure greater involvement. Working with partners to align our approaches, use the data and insight we already have to plan collaborative activities to increase reach into our grassroots communities.	Jan 22	Jan 22	
Strength	1.31	Strong approach to capturing insight and building capacity for involvement. For example, engaging with our communities using volunteering, developing carers passports, increasing peer support workers, and building capacity and capability through development sessions and diversity training. Inclusive employment is a key priority for the Trust	Jan 22	Jan 24	
Strength	1.32	In Barnsley we are part of a formal Health and Care Alliance with the GP federation which is providing a vehicle for increased integration of primary and community care services It is a unique approach that brings primary and secondary care services together to create a seamless package of care for local people. This means local GPs, nurses, healthcare staff and other professionals bringing community and mental health services together to ensure that everyone receives the highest possible quality of care This is being shared as best practice regionally and nationally	Jan 23	Jan 23	
Strength	1.33	Established governance in place in order to ensure separation of the Trust's commissioning responsibilities from its role as a provider of services where appropriate. To be kept under regular review as commissioning role of Trust develops.	Jan 23	Jan 24	
Strength	1.34	Developing expertise and experience in provider collaboratives and alliances as either a host or a partner. This means we can be a strong and influential partner and take forward potential strategic opportunities for leading Collaboratives/Partnerships.	Jan 23	Jan 24	
Strength	1.35	Significant progress made on developing Trust wide approach to equalities and inequalities including data and insight including BI interactive tool, EQIA, and community reports There has been some investment in business intelligence which is helping to target hotspot for intervention	Jan 23	Jan 24	

Strength	1.36	The mental health museum in Wakefield provides information and artifacts that detail the history of mental health, dating back over 200 years since the Stanley Royd Asylum was first established in the same grounds as the museum is based. The museum also reaches out to local schools, community groups and individuals and runs events and courses to highlight the changing approach to mental health through the ages.	Jan 23	Jan 23	
Strength	1.37	Our Trust recognises the importance of maintaining good physical health as well as positive mental wellbeing. Our Unity Centre in Wakefield and Dales wards in Halifax have gyms and exercise equipment, funded through our EyUp Charity which supports service users to stay well. We also run physical health programmes, including Watsu water therapy in Wakefield. In addition, our Move More SWYPFTly programme supports staff to exercise and live healthily. We have improved accessibility of physical health checks for people with sever mental illness	Jan 23	Jan 24	
Strength	1.38	The Trust is the regional co-ordinating provider for forensic CAMHs services and is able to use this position of strength to influence this area of provision	Jan 24	Jan 24	
Strength	1.39*	Teaching Trust status demonstrates our commitment to supporting training and development of the workforce, being a great place to work and ensuring quality care. It provides a broader opportunity for strategic relationships with universities in our localities to support and enable us to engage with our communities, improve our ability to evaluate the impact on our programs and to participate in bids we wouldn't otherwise have the ability or capacity to consider.	Jun 26	Jun 26	
Strength	1.40*	External assessment and internal performance measures indicate that our performance is strong	Jun 26	Jun 26	
Weakness	2.1*	There are some Trust services where people have to wait too long for help. There is a risk that people will be adversely affected because of waiting for treatment - in particular child and adolescent mental health services, and child neuro-developmental waits. This requires changes within services as well as improvements supported by commissioners to achieve the right level of capacity.	Pre Apr 16	Jun 26	
Weakness	2.2	We experience difficulties in ensuring that we have the right workforce across many disciplines. e.g., staff grade doctors, ward-based nursing staff, Psychological Wellbeing Practitioners in Improving Access to Psychological Therapies.	Pre Apr 16	Jan 24	
Weakness	2.3*	Our most recent CQC report (2023) identified the need for continued improvement across adult acute inpatient, PICU, and forensic services. While comprehensive improvement plans are in place, and progress has been made following the previously inadequate rating at Cheswold Park Hospital (pre-transfer), there remains a requirement to fully embed these improvements into	Jul-16	Jun 26	

		consistent, sustainable practice across services. This continues to require focused leadership, time, and resource.			
Weakness	2.6	In some of our place based/integrated care system discussions with partners our broad geography can be portrayed as a lack of 'belonging' to each specific place and community. Being a partner in two ICSs and four places requires significant resources	Apr-17	Jan 24	
Weakness	2.7	The Trust has a number of contracts with Local Authorities and a small number with ICB places that may still be subject to competitive market testing upon expiry of current contracts. The majority of “core” trust services are now considered as part of a system approach and so the risk posed by competitive testing is present, but diminished	Feb-18	Jan 23	
Weakness	2.8	The CQC report 2019 identified that Children and young people were waiting over 18 weeks to receive treatment in some areas. There were significant delays in accessing assessment for children and young people with autism spectrum disorder in all locations that offered this service. Improvement has been noted from waiting list initiatives in Wakefield and Barnsley. Calderdale and Kirklees neurodevelopmental pathways still have excessive waits and are now included in the CAMHS improvement work. Impact of covid on waiting lists is evident	Aug-19	Jan 22	
Weakness	2.13	Out of area bed use usage increased during the pandemic. An improvement plan is in place which has resulted in significant improvement however it remains an area that we are monitoring closely	Jan 23	Jan 24	
Weakness	2.14*	Whilst some investment in analytical capability has been made, this is limited and there is an increasing need to expand the ability of the organisation to provide analytical data that is usable for front line colleagues.	Jan 24	Jun 26	
Weakness	2.15	Prior to transfer of services at Cheswold Park, the hospital had significant financial pressures. Intensive work will be required to increase income and reduce expenditure	Jan 25	Jan 25	
Weakness	2.16	Feedback from strategy conversations suggest we need to protect time for colleagues to think rather than just being busy	Jan 25	Jan 25	Strategic aim one
Weakness	2.17*	Whilst the Trust has a unique charitable offer, this is not financially sustainable in its current model.	Jun 26	Jun 26	
Opportunity	3.1*	We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health, born out by the selection of SWYPFT as regional coordinating provider in forensics in both West Yorkshire and South Yorkshire, and our	Jan-17	Jun 26	

		acquisition of Cheswold Park Hospital, which places us as a key provider in South Yorkshire. We have been asked to share our learning on this. This opportunity is built into our strategic objectives and is also a threat.			
Opportunity	3.2	The integrated nature of our organisation, with reach into several localities across many different services, means we are well placed to play a leading role in the changing shape of health and care provision, in which further integration is anticipated, of both a place based and a service-specific nature. We are leading and partners in a number of alliances which will further support integration	Pre Apr 16	Jan 23	
Opportunity	3.4	We can use the learning from our stakeholder engagement work on brand and strategy to forge excellent relationships with primary care as the bed rock of place-based care systems. Our connections into Primary Care Networks provides a vehicle to do this	Jan-17	Jan 21	
Opportunity	3.5	The Trust's objective to be the best place to work and learn provides an opportunity to understand the key challenges faced by the services regarding workforce and the changes in workforce required to meet increasing service demands and acuity levels through maximising productivity and new ways of working. We can use our skills in health and wellbeing and health coaching to support our revised workforce strategy with a focus on retention and wellbeing. This will enable us to focus on actions to address staffing shortfalls that lead to agency use.	Jan-17	Jan 21	
Opportunity	3.7*	We have an opportunity to transform the approach to the delivery of our services through innovation that makes greater use of our unique approaches e.g., Creative Minds, Recovery Colleges, Arts & Health, Social Prescribing, Mental Health Museum and Altogether Better. We have commenced work to embed these approaches as an integral part of our offer in inpatient and community services and neighbourhoods and could be a national exemplar. This is a unique ability and would enable SWYPFT to lead the conversations about the role of creativity in routine service planning and delivery and support the conversations about mental health services of the future and the shift to prevention . This is built into our strategic objectives	Jan-17	Jun 26	Strategic aim three
Opportunity	3.8	The result of our Care Quality Commission inspection provides opportunities to improve from 'good to outstanding' with a collective and coordinated plan to achieve this.	Apr-17	Jan 24	
Opportunity	3.9	We can use our strategic aim of co-production to explore arts and health, sports, and health and wellbeing tender and bid opportunities.	Mar-18	Mar-18	Strategic aim three
Opportunity	3.10	There is an opportunity for the Trust to implement the NHS long term plan and help shape the ambitions for improvement in the NHS.	Aug-18	Jan21	
Opportunity	3.11	We continue to pursue collaborative partnership working by the Trust with 3rd sector organisations such as 'Live Well Wakefield', and the opportunities presented through the development of primary care networks, aligning our services to be well placed to meet changing	Mar-19	Oct-19	

		population and workforce requirements.			
Opportunity	3.13	Opportunity to build capability to enhance capacity for change within the organisation to meet strategic objectives through programme such as IHI and Board development programmes	Mar-19	Oct-19	
Opportunity	3.14	Opportunity to be leader/exemplar in equality and inclusion and employer of choice in region. Ensuring our Staff equality networks have significant involvement in developing measures to ensure we comply with the Workforce Race Equality Standard, Workforce Disability Equality Standard and to improve diversity.	Oct-19	Oct-19	
Opportunity	3.17	Through the ICS's digital strategies, there is the opportunity to actively support and participate in collaborative digital opportunities across the regions and places as appropriate. This provides an opportunity to collaboratively address cyber security.	Oct-19	Jan 23	
Opportunity	3.21	There is an opportunity to work with staff from the 'hot spot' areas identified through staff survey, to improve staff health and wellbeing at work.	Jan 21	Jan 21	
Opportunity	3.24	Opportunity to develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care. With potential to review staffing mix and safer staffing levels following new ways of working implemented during covid 19 pandemic. Opportunity to re-think models of care and develop new roles.	Jan 21	Jan 21	
Opportunity	3.25	Opportunity to explore new ways of working which can reduce waiting lists delaying treatment and recovery, and activity to reduce admissions and plans to reduce length of stay, following new ways of working implemented during covid 19 pandemic.	Jan 21	Jan 21	
Opportunity	3.26	Opportunity with the confirmation of continuation of the Mental Health Investment Standard and the subsequent continued investment in Mental Health services and a basis for working with Primary Care Networks	Jan 21	Jan 21	
Opportunity	3.27	Opportunity with developments in Integrating Care to explore new arrangements in each place e.g. Building on what we are already achieving in 'hosting' Alliances and provider collaboratives to strengthen joined up care and support to individuals, families and communities Our expertise gives us the opportunity to share our impact and be seen as a leading organisation for working in this way.	Jan 21	Jan 25	
Opportunity	3.30	Opportunity with the refresh of the equality, diversity and inclusion strategy to ensure organisational leaders develop and embed clear leadership standards, strengthen race forward and equality guardian roles and further develop an inclusive culture, to help sustain an equality	Jan 22	Jan 25	Strategic aim one

		competent organisation that demonstrates inclusive and diverse leadership.			
Opportunity	3.31	We have established partnership with universities and opportunity to strengthen these through innovation and research links as well as through training and development opportunities. There is a specific opportunity to work with Huddersfield University with regard to the development of a Health Innovation campus	Jan 22	Jan 23	
Opportunity	3.32	Opportunity through the social responsibility and sustainability strategy to add greater social value in places working with partners and to reduce inequalities.	Jan 22	Jan 22	
Opportunity	3.33	Opportunity to improve data quality, including equality data for anyone who works in or uses our services, collection and use of data and insight to improve services and reduce inequalities with a more focused approach to addressing health inequalities.	Jan 22	Jan 24	
Opportunity	3.34	Opportunity to become a national leader in shaping the future provision of Forensic CAMHS provision, through SWYPFT as regional co-ordinating provider of these services.	Jan 23	Jan 24	Strategic aim three
Opportunity	3.35	Opportunity to further expand our role at place and our commissioning role, and to take on further responsibilities for commissioning of adult mental health services through Mental Health Alliance arrangements (particularly Wakefield and Kirklees).	Jan 23	Jan 24	
Opportunity	3.36	Opportunity to further develop and deliver an integrated community services offer in Barnsley.	Jan 23	Jan 23	
Opportunity	3.38	Using data and insight in place and within the Trust to understand the population we serve. This includes working with our communities to capture voice and ensure greater involvement. Working with partners to align our approaches, use the data and insight we already have to plan collaborative activities to increase reach into our grassroots communities.	Jan 23	Jan 23	
Opportunity	3.39	We have opportunity to become a national leader in Maternal Mental Health provision through SWYPFT's role as Coordinating Provider.	Jan 24	Jan 24	
Opportunity	3.40	Expansion of service delivery to new areas e.g., prison healthcare.	Jan 24	Jan 24	
Opportunity	3.41*	Opportunity to use the publication of the NHS 10 year plan and long term workforce plan as a framework to drive the strategic agenda for the Trust and for it to be a great place to work, research	Jan 24	Jun 26	
Opportunity	3.42	Opportunity for genomics to transform the way the NHS supports health and delivers care We are already involved in studies with public health and ones looking at genetic mapping and depression/anxiety. We have plans to get involved in commercial studies and therapeutic studies.	Jan 24	Jan 24	

Opportunity	3.43	Opportunity for the Trust to contract directly more with the Third Sector, in line with other local Trusts. This could support our own services (demand alleviation) and the VCSE sustainability.	Jan 24	Jan 24	
Opportunity	3.43	Opportunity to use PSIRF (patient safety incident response framework) to improve our patient safety . We have analysed learning from our former processes to inform and shape our PSIRF plan and associated improvement plans for major patient safety system quality improvement projects which draw learning from our former and current learning.	Jan 24	Jan 24	
Opportunity	3.44	The UK government's recent white paper on English devolution, titled "Power and Partnership: Foundations for Growth," outlines several key initiatives aimed at enhancing health and wellbeing across the country. SY Yorkshire is identified as a leader in adopting this approach through the Integrated Partnership whose Board is chaired by the South Yorkshire mayor. This provides SWYPFT with a potential opportunity to be involved and influence this work	Jan 25	Jan 25	
Opportunity	3.45	Opportunity to showcase our work and expand our market/funding avenues through Choice, Research/trials and independent sector.	Jan 25	Jan 25	
Opportunity	3.46	Acquisition of Cheswold Park provides opportunity to accelerate strategic commissioning intentions for Adult Secure services in South Yorkshire.	Jan 25	Jan 25	
Opportunity	3.47	'Permissive' governance environment in West Yorkshire enables Trust to take forward 'Lead Provider' opportunities at Place.	Jan 25	Jan 25	
Opportunity	3.48	Acquisition of Cheswold Park provides opportunity to create corporate synergies and potential cost reduction and improvements in patient flows.	Jan 25	Jan 25	
Opportunity	3.49	Trusted partner in systems creates opportunity for greater leadership role, and ability to attract quality workforce.	Jan 25	Jan 25	
Opportunity	3.50*	Focus on neighbourhoods highlighted in NHS 10 year plan, Darzi report and in the 'Neighbourhood health guidelines 2025/26', 29 January 2025. Provides us opportunities, especially in Barnsley.	Jan 25	Jun 26	Strategic aim three
Opportunity	3.51	Our thorough strategic approach identifies clear objectives, measurables and feedback loops. We are clear about our true north and have been honest about being the best we can be rather than promising excellence or bring world leading.	Jan 25	Jan 25	
Opportunity	3.52*	Opportunity to lead Place Provider Collaboratives , in line with move towards Integrated Health Organisations. Shadow year for Place Provider Partnerships provides opportunity and threats, but either way is also a potentially significant challenge for strategic and operational capacity to	Jun 26	Jun 26	

		be the 'Best Partner' and undertake due diligence			
Opportunity	3.53*	Opportunity to become an early wave early Foundation Trust which will bring additional flexibilities	Jun 26	Jun 26	
Threat	4.1	Loss of autonomy arising from failure to achieve key financial and service delivery measures – resulting in increased regulatory attention, increased ICB scrutiny and diversion of effort away from progressive activities.	Jan 22	Jan 23	
Threat	4.3*	Impact of continued austerity on public spending (particularly Local Authorities) leading to additional unplanned pressures on the Trust. This manifests in terms of additional demand for Trust mental health services (e.g., because of benefit restrictions). The financial position of Councils is challenged; this could impact on support for vulnerable people who are service users (or potential service users) of our services.	Pre Apr 16	Jun 26	
Threat	4.5	Data quality and information governance issues may lead to regulatory action and reputational damage.	Pre Apr 16	Sep-17	
Threat	4.6	Threat that the under-delivery of cost improvements reduces funding available for investment in required capital schemes including IM&T	Jan-17	Sep-17	
Threat	4.7	Threat that the under-delivery of cost improvements impacts negatively on cash flow, necessitating undesirable urgent cost control measures, and negatively impacting on key operating measures that trigger regulatory action	Apr-17	Oct-17	
Threat	4.8	Threat of cyber-attack impacting on operational continuity and stakeholder confidence. Increased threat from cyber-crime impacting on NHS bodies – resulting in additional continuous cost of defence and prevention, and heightened risk of disruption to service provision and/or theft of personal data. Russian/Ukrainian conflict has increased potential threat levels.	Apr-17	Mar 22	
Threat	4.10	Trusts reputation could be adversely affected by long waiting lists delaying treatment and recovery	Feb-18	Feb-18	
Threat	4.12	There is a threat to the safety and quality of current services, ability for future development in services, and the effective delivery of the Trust strategy due to recruitment challenges, retention concerns and national shortages of staff, especially clinical staff.	Feb-18	Jan 22	
Threat	4.15	The ageing workforce who can retire in the next five years brings a potential loss of knowledge, skills, and experience	Mar-18	Mar-18	
Threat	4.16	The impact of universal credit has the potential for some groups to lose out financially due to reduced benefits income or delays in claims for benefits may have an increased negative affect on people's mental health and therefore an increased pressure on Trust resources. This places	Mar-18	Jan 24	

		greater emphasis on the need to continue to work with partners and Health and Wellbeing Boards to address the wider determinants of health and social care.			
Threat	4.18	Cuts in local authority budgets, and social care budgets specifically, could adversely affect health services, particularly in delays in discharges from hospital, due to problems accessing social care services. Reduction in Local Authority budgets negatively impacting on financial resource available to commission staff / deploy social care resource.	Mar-18	Jan 21	
Threat	4.19	The development of integrated care and services and the development of Primary Care Networks aligned to neighbourhoods will require the Trust to realign its services in each place and clarify and strengthening the Trusts role within primary care networks and partnerships. There is a threat of a lack of capacity to support partnership working across a wide geography.	Jul-18	Jan 21	
Threat	4.22*	Impact on financial performance. of non-delivery of Cost Improvement Programmes (CIPs), non-recurrent CIPs, out of area placements, reductions in cash, and regulator intervention, could impact on our ability to improve services and meet our objectives. This could have a negative impact on our NHS oversight framework ratings. Provider Selection Regime and Choice guidance - risk of greater competition all seeking the same funding.	Apr-19	Jun 26	
Threat	4.24	Failure to reduce CO2 emissions and use of single-use plastics results in the Trust not achieving its environment sustainability targets.	Oct-19	Oct-19	
Threat	4.28	The integrated nature of our organisation, with reach into several localities across many different services, means we. are sometimes viewed as not fully belonging to a particular place	Jan 21	Jan 21	
Threat	4.31	Threat of increased staff fatigue due to dealing with increased demand and acuity. This will have an impact on current and future staff wellbeing and affect service delivery and performance. It could also limit our capacity to innovate our service offer and think creatively about future models of care.	Jan 21	Jan 24	
Threat	4.32	Threat of losing staff (more specifically lower graded staff) to other sectors for higher pay.	Jan 22	Jan 22	
Threat	4.33	Restrictions on Trust ability to spend our cash reserves on capital projects means we may be unable to meet our capital plans	Jan 23	Jan 23	
Threat	4.34*	Concern that national priorities will focus on acute and primary care due to pressures within these systems and therefore there will be less attention paid to Mental health, Learning disability and general community services. This has the potential to be exacerbated by wider ICB partner funding concerns .and fewer references to parity of esteem in national documents	Jan 23	Jun 26	
Threat	4.35	Rapid political policy changes which mean the Trust need to be flexible to respond, but also have an underlying consistent approach about certain key principles e.g. addressing health inequalities	Jan 24	Jan 24	

Threat	4.36	Risk about the response of all organisations to the environment and that we may encounter leadership behaviours that do not prioritise or support system leadership, especially with the significant changes to key leaders in several of our places.	Jan 25	Jan 25	
Threat	4.37*	There are likely to be different arrangements in each of our 4 places moving forward. There are increasing challenges on our capacity to engage in these new arrangements across all our areas	Jun 26	Jun 26	
Threat	4.38*	Increasing threat of industrial action leading to workforce challenges and quality and financial implications	Jun 26	Jun 26	

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 11.7

Private/Public paper:	**Private**		
Title:	**Assurance and Learning from St Andrew's Healthcare**		
Lead Director:	**Caroline Johnson, Chief Nurse / Director of Quality and Professions**		
Mission/values:	The report demonstrates commitment to all the Trust's values, which are fundamental to delivering safe and high-quality health care: • We put the person first and, in the centre, • We know that families and carers matter • We are respectful, honest, open and transparent • We improve and aim to be outstanding • We are relevant today and ready for tomorrow		
Purpose:	The purpose of the paper is to reflect on key lessons from CQC findings at St Andrew's Healthcare, assess the Trust's current position against these risks, and outline actions to strengthen safety, governance, and quality of care.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience. 1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience. 2.1 Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy. 2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents. 3.1 Inability to effectively recruit, train, support the wellbeing of, and retain a skilled and engaged workforce leads to poor service user and staff experience. 4.3 Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve		

With **all of us** in mind.

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Each provider trust within an Integrated Care System is governed by regulatory bodies, and production of a Quality Account is a formal requirement of each trust. It is important that regulatory activity is monitored, learning is taken from feedback, and action is taken to remedy any findings. Quality of care is a key priority for our Integrated Care Boards and the information provided in the Quality Account supports and describes the delivery of quality care.
Any background papers / previously considered by:	Not Applicable.
Executive summary:	Recent CQC findings at St Andrew's Healthcare highlight significant and persistent risks relating to patient safety, safeguarding, staffing, culture, and governance, alongside a failure to embed learning and sustain improvement. These issues provide important system-wide learning for mental health services. The Trust routinely reviews national reports, publications, and regulatory findings to ensure that learning from other organisations is systematically identified, critically appraised, and embedded within our governance, quality improvement, and patient safety processes. This approach supports continued strengthening of organisational learning and assurance from ward to Board. The Trust has undertaken a comprehensive review of the St Andrew's CQC report this demonstrates broadly robust arrangements across key domains, including established governance structures, implementation of PSIRF, strong incident reporting culture, and improving quality oversight. There is evidence of positive ward cultures, effective escalation processes, and proactive quality improvement approaches. However, identified gaps in assurance mirror known risks and include variability in risk assessment and care planning, workforce pressures (particularly unregistered vacancies) and clinical documentation burden. Observation practices and therapeutic engagement also remain areas of focus in line with regional and national identified areas of improvement. A clear programme of improvement is underway, including strengthening PSIRF processes, enhancing safeguarding oversight, embedding safer staffing tools, improving clinical risk management, developing cultural intelligence, and increasing leadership visibility from ward to Board. Focus is also being placed on workforce development, psychological safety, and strengthening clinical risk assessment and personalised care and support. Overall, the Trust is well-positioned with strong systems in place but must maintain focus on consistency, workforce capacity, and the effective translation of learning into sustained practice. Continued executive oversight and targeted improvement as outlined in the report will be critical to ensuring high-quality, safe, and person-centred care across all services.

Recommendation:	**The Trust Board members are asked to:** **RECEIVE** the Assurance and Learning from St Andrew's Healthcare report.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Assurance and Learning from St Andrew's Healthcare

1. Introduction

The Care Quality Commission (CQC) has published a series of inspection reports relating to St Andrew's Healthcare (Northampton), which collectively describe a pattern of significant and persistent concerns. The most recent report was published on 13 March 2026 and can be found here: **https://www.cqc.org.uk/location/1-121538260**. These reports identify failures to protect patients from harm, unsafe staffing levels, poor risk management, evidence of closed ward cultures, and a lack of effective organisational oversight. Importantly, inspectors noted that many of these issues had been raised previously but had not been resolved, indicating weaknesses in organisational learning, challenge, and leadership grip.

Although these findings relate to a specific provider, the nature of the concerns is highly relevant across mental health services nationally and provides a clear opportunity for shared learning. The risks identified—particularly in relation to safeguarding, observation practices, staffing pressures, and organisational culture—are inherent to the delivery of complex, high-risk care. This report is therefore intended to support constructive challenge, reflection, and informed assurance within the Trust, rather than comparison or judgement of another organisation.

As part of the Trust's internal response, current practice has been reviewed against the learning identified, and improvements have been proposed where appropriate. In addition, the Trust routinely reviews national reports, publications, and regulatory findings to ensure that learning from other organisations is systematically identified, critically appraised, and embedded within our governance, quality improvement, and patient safety processes. This approach supports continued strengthening of organisational learning and assurance from ward to Board.

2. Summary of Issues Identified at St Andrew's Healthcare

Recent Care Quality Commission inspections at St Andrew's Healthcare (Northampton) identified a prolonged pattern of significant failings affecting patient safety, quality of care, and organisational oversight. The concerns highlighted were not isolated incidents but represented systemic weaknesses that persisted despite previous regulatory action, repeated inspections, and formal requirements for improvement. Where vulnerabilities or reliance on sustained behaviours were identified, these are explicitly acknowledged within the report.

St Andrew's Area for improvement 1 – Patient Safety and Safeguarding

The most serious concerns related to failures to adequately protect patients from harm. Inspectors identified ongoing safeguarding incidents, including allegations of abuse and inappropriate use of restraint by staff. In some cases, CCTV evidence was reviewed which

showed practices that were unsafe, disproportionate, or inconsistent with the organisation's own policies and training expectations.
The CQC found that safeguarding processes were not consistently effective in identifying risk, responding to concerns, or ensuring timely escalation to protect patients. There was evidence that safeguarding incidents were not always recognised as such, contributing to under-escalation and delayed intervention. The persistence of abuse-related allegations was considered indicative of wider cultural and leadership issues rather than sporadic individual behaviour.

Current Trust Position

The Trust implemented the Patient Safey Incident Response Framework (PSIRF) in December 2023, this forms the framework for all patient safety investigations. A review of Trust PSIRF processes has recently been completed focusing on strengthening patient safety systems, learning, and improvement across the Trust, with work progressing across four key areas:

- **Incident Reporting and Management Procedure**
  The incident reporting procedure is being refreshed to promote open and transparent reporting and align with PSIRF principles. Learning response types will move from the procedure into the PSIRF policy. Supporting flowcharts will be developed to guide staff through reporting and oversight processes, alongside Datix revisions to better support PSIRF ways of working. This work was completed by the 1 June 2026.
- **PSIRF Plan and Policy**
  The PSIRF plan has been refreshed and will be approved by EMT in June and QSC in July. The PSIRF policy is being refreshed to reflect the learning from practical implementation. This includes reassessing patient safety priorities, improvement workstreams, organisational capacity for learning responses, and oversight processes. Learning response methods, templates, and decision-making flowcharts will be refined, incorporating feedback from the SIRAN accreditation process. This work was completed by the 1 June 2026.
- **Compassionate Engagement and Involvement**
  Flowcharts have been developed and implemented to support Being Open principles with patients and families, alongside work to align and strengthen support available to staff following patient safety incidents. This work was completed by the 1 June 2026. The Trust intranet pages are currently being updated and Trustwide comms to share updates will be completed by the 30 June 2026.
- **PSIRF Training**
  External After-Action Review and SWARM approach training (NHS England–accredited) was delivered in March/April 2026 for quality and governance leads and matrons, with a condensed internal training programme to follow.

From April 2025 to March 2026, 56 safeguarding concerns and referrals were recorded across forensic services (21 in West Forensic Services, 35 at Cheswold Park Hospital). Advice is accessed via the Trust Safeguarding Team, with referrals made to local authorities where needed.
Quarterly safeguarding reports are provided to the Quality and Safety Committee, while the Patient Safety Oversight Group (PSOG) reviews incidents weekly with specialist

safeguarding input to ensure a safeguarding perspective. Risk assessments and care plans are updated following incidents.
Overall, existing governance—including safeguarding advice, safeguarding training aligned to intercollegiate guidance, and PSOG scrutiny—demonstrates oversight. Strengthening the integration of safeguarding into care and safety planning, alongside a continuous improvement approach to assurance reporting, would further enhance oversight. This will be achieved by ensuring the involvement of the Trust Safeguarding Team in the care plan and risk assessment improvement work by June 2026 and reviewing the safeguarding assurance reporting structure and frequency of the Joint Safeguarding Strategic Group by the end of July 2026.

Wards have access to Freedom to Speak Up processes and we have evidence that staff are using this route. Staff on occasion raise concerns directly with CQC and the Trust fully investigates all concerns raised. There is a programme of Quality walk rounds which incorporate known concerns and cultural themes, with action plans monitored through care group governance and escalated to the Quality Governance Team (QGT).
Cultural assurance is supported through Freedom to Speak Up routes and through the Quality Assurance System (QAS) which includes structured quality visits, with monitoring at a routine, enhanced and intensive level, as appropriate. The QAS looks at the triangulation of data from incidents, customer services, safeguarding incidents etc. as well as soft intelligence alongside outcomes of visits to determine monitoring levels. Where emerging themes of potential cultural issues are identified the Trust will respond appropriately, a recent example of this is the culture review in forensic services. The report from this review is expected by the end of June 20206, learning will be shared wider as appropriate.

Next Steps

- Ensure safeguarding is captured within current patient safety and risk management developments.
- Identify emerging patient safety incident and safeguarding themes and trends to support early intervention and harm prevention. The Patient Safety Team attend weekly care group incident meetings in order to triangulate incident data and identify any emerging themes or trends. This will be further strengthened through the introduction of daily incident huddles within Nursing, Quality and Professions (NQP) by the end of June 2026 which will allow co-ordinated and timely specialist advisor support to care groups.
- Share thematic learning from patient safety incident and safeguarding incidents and advice line activity across services to support consistent understanding and application, to consider utilising safeguarding newsletter and learning network events. In order to further strengthen assurance, evidence of learning will be shared in care group reports into Clinical Governance group from July 2026.
- Link patient safety incident and safeguarding learning more explicitly to existing QI activity where recurring themes are identified.
- Ensure patient safety and safeguarding principles are embedded within induction, supervision and ongoing professional development.
- Continue to promote Freedom to Speak Up routes and direct access to regulators as part of an open and transparent safeguarding culture.

- Use the quality assurance system to test cultural themes related to safety, safeguarding and psychological safety, ensuring actions are monitored and escalated appropriately.
- Review content and governance processes for quarterly safeguarding reports prior to senior committees and the Board, to strengthen assurance including incorporating triangulating incident data, audit findings, themes and improvement actions.
- Ensure safeguarding and patient safety intelligence informs strategic discussions on quality, safety and risk at Clinical Governance Group.

Overall aim:
To move from robust patient safety incident and safeguarding processes to demonstrable, consistent triangulation and effectiveness in practice—ensuring early identification, timely action, learning and prevention of harm, supported by a strong, open culture from ward to Board.

Executive Lead: Caroline Johnson

St Andrew's Area for improvement 2 – Risk Management, Observation, and Care Planning
Risk assessment and risk management processes were found to be inconsistent and, in some areas, ineffective. Inspectors identified concerns about how risks of harm were assessed, reviewed, and documented, particularly for patients requiring enhanced observation or presenting with complex or fluctuating needs.
There were instances where observation practices were not carried out in accordance with plans or were undertaken in a way that lacked professional curiosity and vigilance. Failures in observation were described by the CQC as posing a serious risk to patient safety, particularly in secure and high acuity environments.
Care planning was not always sufficiently individualised, risk informed, or reflective of current patient needs, limiting its effectiveness as a safety tool.

Current Trust Position
The Trust has an established and comprehensive formulation informed risk management (FIRM) approach to clinical risk assessment, which as part of formulation will include the views of other agencies. However, a recent 360 audit delivered limited assurance regarding risk assessment and work has commenced to strengthen risk assessment policy and training in response. As a response to the audit findings work is underway to address actions identified in the audit with an overall completion date for all actions of the 31 August 2026. In addition to this work will continue through the reducing clinical administration burden workstream to March 2027 to strengthen person centred and collaboratively produced care and safety planning.
The Trust is part of the regional Enhanced Therapeutic Care Observations and Care (ETOC) Group and as part of this work , self-assessments have been completed and an action plan developed that includes policy, training and governance processes to standardise language and expectations for staff undertaking ETOC, ensure that ETOC is understood as a restrictive practice so it is only used for the shortest time appropriate and is regularly reviewed and develop training to ensure clinical colleagues have the skills and confidence to deliver ETOC in a consistent, safe and therapeutic way.

Next Steps
The Trust's care planning and clinical risk assessment improvement group is the vehicle for ongoing focus and improvement in risk assessment, with updates provided to the Quality and Safety Committee. Next steps will include the following:

- the actions from the recent 360 audit of risk assessment are part of a rapid improvement plan due to be completed by 31 August 2026 and learning from the St Andrews report will be shared with the group to ensure the improvement approach is joined up and delivered in a timely manner.
- ETOC work will continue to ensure observations are completed in accordance with best practice and Trust policy. As part of this workstream self-assessment audits are completed for NHSE and this audit tool will continue to be used to provide internal assurance.

Executive Lead: Caroline Johnson

St Andrew's Area for improvement 3 -Staffing Levels, Capacity, and Competence
Inadequate staffing levels were a recurring theme across inspection reports. The CQC concluded that staffing shortages adversely affected the safe delivery of care, including the ability to carry out appropriate observations, respond to incidents promptly, and engage therapeutically with patients.
Inspectors heard testimony from staff that low staffing levels resulted in:

- Reduced patient engagement and meaningful activity
- Cancellation of planned leave and therapeutic interventions
- Increased stress, fatigue, and risk of error
- Reliance on temporary or unfamiliar staff

The impact of staffing pressures extended beyond workforce metrics and directly influenced patient experience, safety, and ward culture.

Current Trust Position
The Trust has a safer staffing rolling bi-annual process and governance structure in line with Developing Workforce Safeguards (NHSE, 2018) which sets out how NHS organisations should ensure safe, effective and sustainable staffing and the National Quality Board Guidance (2016). This is achieved by using a triangulated approach of evidence-based tools, professional judgement and patient outcomes. A quality dashboard for safer staffing is in the final stages of development, and this will strengthen oversight ward to board of the triangulated approach.

There is a monthly Safer Staffing Group chaired by the Deputy Chief Nurse and as part of this meeting there is triangulation of fill rates (both establishment and clinically required) with total Datix, cancelled section 17 leave and missed staff breaks. Across all inpatient wards there are approximately 2,500 episodes of escorted leave occur each month, between 1-3% of leave is cancelled due to staffing shortages. During May 2026 there were 217 cancelled staff breaks across all services, a reduction of 8 from the previous month. Missed breaks were highest in working age adult wards (59), and forensic low secure (56).

Additionally, one registered nurse on duty that is unplanned is monitored on a monthly basis through the safer staffing group, this is a nationally recognised indicator as there are both safety and quality implications for one lone registrant working on a ward.

Staffing fill rates trust wide are consistently above 90% of establishment, with the exception of Barnsley Physical Health Care Group, the reduction is to effectively manage a reduction in clinical need, however further work is required to ensure shifts are cancelled on health roster to ensure accurate reporting.

Clinically required fill rates were introduced in August 2025 to strengthen safer staffing oversight, being able to view current establishment fill rates and clinically required fill rates provides better assurance for patient safety and staff wellbeing.

The Trust bank continues to perform strongly, filling approximately 90% of vacant shift requests. Over the last 12 months, temporary staffing has made up 37.74% of inpatient staffing. Temporary staffing figures include substantive staff working bank shifts. This is broken down further in the table below:

Month and Year	Substantive	Bank	Agency
Apr-25	60.98%	37.04%	1.98%
May-25	60.96%	37.61%	1.43%
Jun-25	59.09%	38.45%	2.46%
Jul-25	57.81%	39.78%	2.41%
Aug-25	57.37%	39.97%	2.66%
Sep-25	64.24%	33.21%	2.54%
Oct-25	64.96%	32.75%	2.29%
Nov-25	64.15%	33.97%	1.89%
Dec-25	64.72%	33.74%	1.55%
Jan-26	64.98%	34.30%	0.72%
Feb-26	64.12%	35.18%	0.70%
Mar-26	63.69%	35.81%	0.51%
Grand Total	**62.26%**	**35.98%**	**1.76%**

Table 1: Substantive v Bank v Agency

As the table above demonstrates over the year 205-26 there has been minimally use of agency staff and most temporary staffing needs have been met by Trust bank staff, many of whom work substantively within the Trust and are more familiar with wards and current patients. This provides assurance that where additional temporary staffing is required the use of agency staff who are unfamiliar with wards and patients is minimal. The Trust bank also has mandatory training expectations in line with permanent colleagues; this provides assurance as to the skill mix of colleagues undertaking temporary work.
However unregistered vacancies remain high, with 18 wards exceeding a total vacancy rate of 20% for unregistered posts.

There is a workstream being led by the Chief Allied Health Professional to review and strengthen the input of allied health professionals into wards to support therapeutic engagement and strengthen multi-disciplinary team working.

Next Steps
The embedding of SafeCare across all inpatient wards is essential to give live oversight of potential staffing hotspots and oversight of resources and acuity Trustwide. This will allow evidence based, Trust wide redeployment of resource to mitigate risk, fully embedding the National Quality Board expectation of the right staff, with the right skills, at the right time and ensuring that inpatient wards are safe, delivering high quality care and financially responsible. A revised implementation plan is under development with an expected completion date of December 2026.
The ongoing recruitment to both unregistered and registered posts particularly across inpatient wards is a key enabler to reduce reliance on temporary staffing.

Executive Lead: Adele Fox

St Andrew's Area for improvement 4- Ward Culture and Psychological Safety

The CQC identified evidence of closed or inconsistent ward cultures across parts of the organisation. In such environments, staff did not always feel able to raise concerns, challenge poor practice, or speak openly about risks. Inspectors noted variable levels of psychological safety, with some staff expressing fear of blame or reprisal.

Closed cultures were associated with:

- Normalisation of poor practice
- Failure to challenge unsafe behaviour
- Under-reporting of incidents or safeguarding concerns
- Limited learning from adverse events

Where positive cultures did exist, these were not consistently embedded or sustained across wards, suggesting uneven leadership influence and oversight.

Current Trust Position
Across inpatient and forensic wards, multiple data sources indicate that ward-level cultures are generally open, supportive and psychologically safe. Data has been reviewed across the sources from April 2025 to March 2026. Freedom to Speak Up (FTSU) data shows a significant proportion of concerns raised by inpatient staff, alongside positive staff survey findings, suggesting staff feel able to speak up.

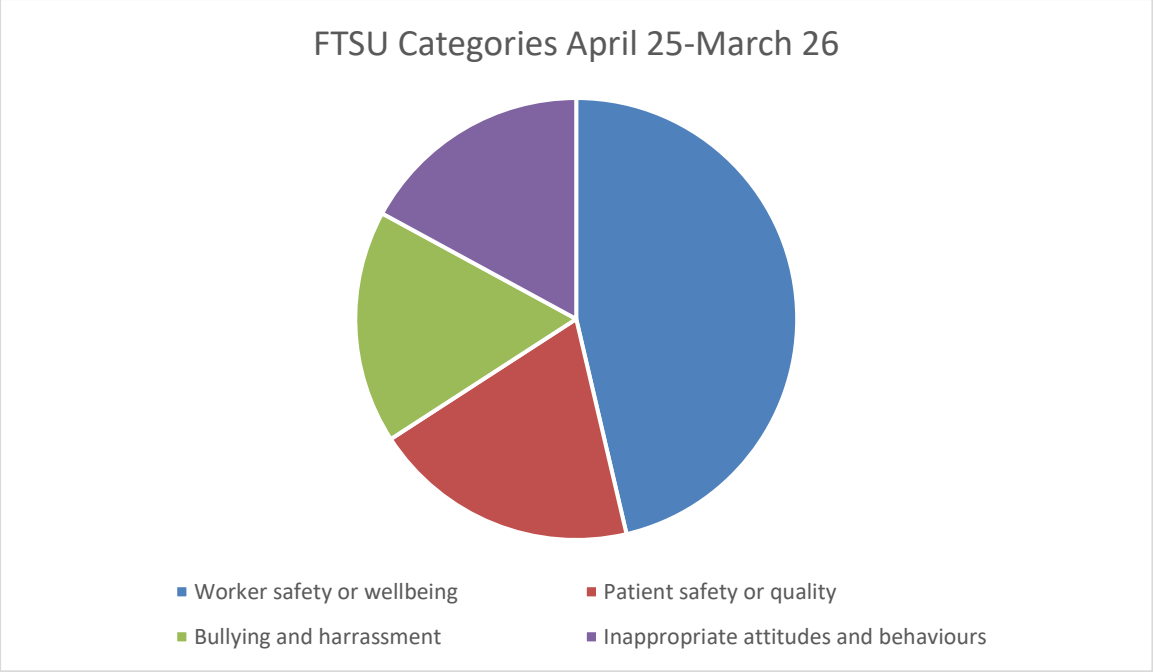


Table 2: Freedom to Speak Up Reporting Categories 2025-26.

Quality walkarounds consistently described strong teamwork, approachable leadership and inclusive, supportive environments, with service users reporting feeling cared for and involved. Isolated issues relating to blame culture and variation in care planning quality were identified but were in the minority.

Complaints data demonstrated learning from feedback, particularly in relation to values, behaviours, communication and patient care, reinforcing a learning-focused culture. Patient safety processes have been strengthened through PSIRF activity, just culture training and human-factors-based investigation approaches, with positive staff feedback on reflective and supportive review processes. Targeted work in forensic services has further supported psychological safety, particularly in response to staff experiences of racism.

Evaluation of staff support following a death confirmed strong peer and local management support, which aligns with walkaround findings. However, there still remains some staff reporting experiencing inconsistent, process-driven support and perceived blame. This indicates there are further opportunities to strengthen organisational and senior leadership responses through consistent messaging in existing work streams.

Overall, ward-level cultures are positive and psychologically safe, but greater consistency and alignment at organisational level is required. A more joined-up, visible and compassionate Trust-wide approach would help address perceived disconnects and ensure staff wellbeing is prioritised from ward to Board. There has been a deep dive into Forensic Inpatient wards in West Yorkshire, the report is due at the end of June 2026, and the Women's Pathway provides an opportunity to share learning form this report once received.

Next Steps

There is already work in progress to support staff psychological safety led by the Chief Psychological Professions Officer. The work identified as part of this includes the following:

- to establish a Trust-wide baseline of ward culture and psychological safety by developing and implementing a consistent framework for assessing ward culture, openness and psychological safety across all inpatient and forensic wards. This baseline can then be used to identify variation, target support and track improvement over time. This approach will be piloted as part of the women's pathway before wider rollout and timescales for this pilot will be agreed as part of feedback from external review. The external review report is due by the end of June 2026.
- to triangulate existing data (FTSU, walkarounds, complaints, incidents, staff survey) into a single ward-level cultural dashboard to support oversight and early identification of risk.
- to strengthen alignment between organisational leadership and frontline teams
- improve the visibility and consistency of senior leadership engagement following incidents, deaths and serious concerns, ensuring staff experience a compassionate and supportive organisational response. The Chief Psychological Professions Officer has completed an evaluation of staff support following a death, including focus groups across service lines and a Trust wide survey. The data has now been collated and analysed and a report with is due to be shared with Operational Management Group by the end of July 20026.
- introduce clear expectations for Senior Leadership Team involvement in post-incident support, communication and follow-up, complementing strong local leadership.
- ensure messages consistently reinforce learning, fairness and wellbeing rather than blame or reputational concern.

In addition to the above there is also work underway to develop a consistent Trust-wide approach to staff support following adverse events and deaths, that includes:

- finalising and implementing recommendations from the staff support following a death evaluation.
- defining a clear, trauma-informed support pathway for staff that includes proactive check-ins, psychological support, timely communication and signposting, rather than relying on individuals to seek help.
- ensuring this approach is embedded alongside PSIRF and just culture principles and is well understood by managers and staff.
- embed and sustain a just and learning culture by building capability in human factors, PSIRF and just culture through targeted development for ward managers, senior leaders and investigators.
- reinforce expectations that reviews focus on system learning, reflection and improvement, with individual accountability considered only where appropriate.
- share positive examples of learning-focused incident reviews and PSII feedback to build confidence in the process.

This will enable Board and committee oversight to be strengthened through regular reporting on cultural intelligence, psychological safety and staff wellbeing alongside traditional quality and safety metrics, ensuring staff feel valued, supported and safe to speak up from ward to Board.

Executive Lead: Caroline Johnson

St Andrew's Area for improvement 5- Leadership Visibility and Ward-Level Oversight

Inspectors found that leadership presence and engagement at ward level was inconsistent. In some services, leaders were insufficiently sighted on day-to-day operational risks, staffing pressures, and cultural issues affecting patient care.

There was limited evidence that leaders had a strong, real-time understanding of frontline conditions, or that early warning signs of deterioration were being identified and acted upon. This lack of visibility contributed to delayed recognition of risk and missed opportunities for early intervention.

Current Trust Position

There are daily huddles in care groups that report back ward/ clinical areas of risk, any staffing and resource implications and the potential impact upon safety and/or quality. As part of the Trust's staffing model for inpatient wards there are Clinical Leads alongside Ward Managers to provide senior clinical leadership and strengthen the presence of senior leadership availability at the point of care. There are well embedded senior leadership meetings within care groups, these are held weekly to ensure a timely ad robust response to any emerging issues. The Trust has established escalation processes both within care groups and to obtain support from corporate support services such as Nursing, Quality and Professions.

Patient safety oversight groups are held weekly in each care group to review and identify any learning from incidents, these meetings then feed into Trust wide PSOG and an update is shared at Executive Management Team weekly, providing ward to board oversight.

The Trust has an established Ward Manager Forum that meets monthly and provides an opportunity for peer-to-peer learning and feedback as well as a learning forum for Trust wide development, an example of this was a recent presentation on the Patient and Carer Race Equality Framework (PCREF).

Next Steps

As part of ongoing quality improvement work there is a governance review within care groups to identify opportunities for strengthening oversight from ward to board.

Executive Lead: Adele Fox

St Andrew's Area for improvement 6- Governance, Escalation, and Organisational Grip

Governance and quality oversight arrangements were identified as weak, fragmented and ineffective, and the service remained in breach of Regulation 17 (Good Governance). The CQC judged that governance systems did not assure safe, high-quality, person-centred care. The CQC identified weaknesses in how information flowed from wards to senior leadership and the Board, limiting organisational grip.
Key concerns included:

- Recurrent issues persisting across inspections without resolution
- Limited evidence of learning translated into sustainable improvement
- Action plans that did not result in meaningful change
- Insufficient challenge within governance structures

The failure to address known risks over time was a critical factor in the continued regulatory escalation, including the imposition of conditions on registration and restrictions on new admissions.

Current Trust Position

At the 2019 CQC Well Led inspection, the Trust demonstrated strong Board-level governance, with clear ward-to-Board structures, effective committee oversight, and a skilled Board with a clear focus on quality, staff wellbeing and reduction of restrictive practice. Systems supported openness, staff engagement, incident reporting, safeguarding, and effective partnership working.

The main area for improvement was inconsistency at service level, with variable governance, escalation and middle management capability affecting assurance that risks were consistently managed.

Since 2019, the Trust has strengthened governance and organisational grip by improving care group-to-Board structures, enhancing the Integrated Performance Report, and implementing a Quality Assurance System for better oversight and early risk identification. Quality walkarounds, stronger CQC action plan governance, improved quality improvement processes using the #all of us improve methodology, and more open relationships with the CQC have further enhanced visibility, consistency and assurance, although continued embedding is required.

All must and should do actions from the previous well led inspection in 2023 are addressed and closed.

There is also a structured Trust wide programme underway of well led work underway from Board to Ward with input from non-executive directors, the Executive Team and the Quality Governance Team.

Next Steps

The Quality Governance Team have clear oversight of previous CQC must and should do actions and continue to work with operational and clinical colleagues to monitor changes made as a consequence of these.

Ward-to-Board visibility will continue to be strengthened through further refinement of the Integrated Performance Report and consistent use of the Quality Assurance System to identify, escalate and respond to emerging risks.

The Trust Clinical Governance Group terms of reference have been strengthened and from July will be chaired by the Chief Nurse and Director of Quality and Professions, further strengthening the Board to Ward oversight of the clinical governance process.

Quality walkarounds will continue to provide visible leadership and real-time intelligence, with findings systematically linked to governance and quality systems. Quality improvement capability will be further embedded through a Trust-wide methodology, supporting sustainable, data-driven improvement.

The Trust will maintain transparent and proactive engagement with the CQC, building relationships based on honesty and transparency with new CQC colleagues, due to recent changes in CQC personnel. This will be supported by robust governance structures, to ensure the Board receives blended assurance so that that known risks are consistently identified, escalated and controlled across services.
An identified area for further development is ensuring middle-management colleagues, such as ward managers and team leaders have capacity, capability and consistency supported by targeted leadership development and peer learning, to further strengthen organisational grip at service level**.**

Executive Lead: Caroline Johnson

St Andrew's Area for improvement 7- Failure to Learn and Improve
A particularly significant finding was the organisation's limited ability to learn effectively from previous inspections, incidents, and external scrutiny. Many of the issues identified had been raised previously but remained unresolved, indicating systemic barriers to improvement rather than lack of awareness.
The CQC concluded that this reflected a combination of fragile leadership grip, cultural challenges, and governance arrangements that were not sufficiently focused on sustained improvement or accountability.

Current Trust Position
The trust currently demonstrates a structured and continually evolving approach to organisational learning, demonstrated by the following:

- a Trust-wide quality improvement methodology (#allofusimprove) with a dedicated improvement team to support quality improvement initiatives driven by learning and clinical improvement
- the Patient Safety Incident Response Framework (PSIRF) has been in place in the Trust since December 2023, aligning with the national shift toward system-based learning and improvement, followed by a review in 2026, with the Trust PSIRF plan available on the Trust website. Regular reports to Quality and Safety Committee (QSC) demonstrate a closed-loop learning cycle, consistent with PSIRF principles, using recognised PSIRF tools and training e.g. after-action review and SWARM training.
- A strong reporting culture with a high proportion of no or low harm, supported by a variety of learning responses including After Action Reviews, Patient Safety Incident Investigations (PSIIs) and thematic reviews and debriefs
- learning is triangulated across incidents, feedback, audit, external review, and workforce insight, although there are ways to further strengthen this
- implementation of electronic prescribing (EPMA) across inpatient wards to improve medication safety
- Quality governance structures are well embedded care group patient safety oversight groups aligned to PSIRF feed into the Trust wide PSOG. Also, committee structures to support governance and oversight are well embedded with Quality and Safety Committee (QSC)receiving quarterly Patient Safety Oversight Reports and annual Quality Account, PSIRF Plan and the Annual Patient Safety Oversight Report. These

clear governance arrangements support organisational learning, alongside Board oversight of patient safety.

Next Steps

- The Trust learning system is established but embedding and consistency remain key improvement priorities, as part of this further improvements are needed to consistently embed the use of systems thinking and reflective practice in teams. The introduction of the daily patient safety huddle within Nursing, Quality and Professions will enable specialist advisors to be identified in a timely way to link with clinical teams to support this.
- Safer staffing pressures that result in key leaders such as ward managers and matrons working clinically may potentially affect learning implementation, therefore, the recruitment plan and workforce annual planning will be key to supporting embedding change.
- Overall cultural indicators align with a just and learning culture, though consistency may vary across services. There is further work to be done to ensure ward managers are supported, skilled and confident in maintaining psychologically safe environments, particularly during periods of stress or following incidents. The Ward Manager Forum will develop a programme of educational slots at forum meetings based on priorities decided by the ward managers. The Trust may wish to consider the use of continued professional development (CPD) monies to fund a bespoke ward manager clinical leadership programme.

Executive Lead: Caroline Johnson

3. Recommendations

The Trust Board are asked to receive assurance that the Executive Trio have reviewed the learning from the CQC inspection of St Andrew's Healthcare and are assured that the appropriate systems and processes are in place. However, the review has highlighted further improvements that are required to further strengthen this assurance. These improvements will be overseen by the Executive Management Team and reported to Clinical Governance Group, Executive Management Team and Quality and Safety Committee.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 12.1

<table>
<tr><td>Private/Public paper:</td><td colspan="3">Public</td></tr>
<tr><td>Title:</td><td colspan="3">South Yorkshire Integrated Care System (SY ICS) Update including Mental Health, Learning Disability and Autism Provider Collaborative (MHLDA)</td></tr>
<tr><td>Lead Director:</td><td colspan="3">Mark Brooks - Chief Executive
Dawn Lawson – Executive Director of Strategy, Inclusion and Change/ Deputy Chief Executive</td></tr>
<tr><td>Mission/values:</td><td colspan="3">The development of joined-up care through Place and system working is central to the Trust's strategy and is supportive of our mission to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.</td></tr>
<tr><td>Purpose:</td><td colspan="3">The purpose of this paper is:
• To update the Trust Board on key developments in SY ICS and the SY MHLDA provider collaborative and linked programmes.
• To update on partnership developments in Barnsley.</td></tr>
<tr><td rowspan="3">Strategic aims:</td><td>Live Our Values</td><td>✓</td><td rowspan="3">The Trust's partnership working at system and Place supports it to be the 'Best Partner' and to achieve its ambitions.</td></tr>
<tr><td>Be the best we can be:
• Best quality
• Best partner
• Best value
• Best place to work and learn</td><td>✓</td></tr>
<tr><td>Be ambitious</td><td>✓</td></tr>
<tr><td>BAF Risk(s):</td><td colspan="3">4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place'

4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust.

4.3 Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve

6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of</td></tr>
</table>

	the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience. 6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place - based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	The Trust Board receive regular updates on the progress and developments in the SY ICS, including the development of the provider collaborative. The last update was received by Trust Board on 28 April 2026.
Executive summary:	The Trust is an active participant in the South Yorkshire Integrated Care System and this report provides a summary of key points from the main meetings and forums which have taken place in that system during the reporting period. Work continues with our partners in Barnsley to evolve and develop place - based partnership governance arrangements and neighbourhood health.
Recommendation:	**Trust Board members are asked to:** • **NOTE** the SY ICS and Barnsley Place updates.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item – 12.1
South Yorkshire update including South Yorkshire Integrated Care System (SY ICS)

1. Introduction

The purpose of this paper is to update the Trust Board on key developments in the South Yorkshire Integrated Care System (SY ICS) and the South Yorkshire Mental Health, Learning Disability & Autism Provider Collaborative (SY MHLDA) and linked programmes, and also on partnership developments in Barnsley.

Regarding partnership development in Barnsley, meetings are taking place with partners to develop a place provider partnership and determine its role and priorities given the changes that are taking place with the Integrated Care Board. The Trust is well represented in these discussions.

The paper summarises key developments from recent Integrated Care Board (ICB) and place-based meetings.

2. South Yorkshire Integrated Care Board

South Yorkshire Integrated Care Board

Member	Chief Executive
Items discussed	<u>Update from meeting held on 6 May 2026</u> Key agenda items included: • Chair's Matters- the Chair confirmed their planned departure (end of June 2026) but remains in post temporarily to support transition. The process for a new chair will be led by NHS England and will also be appointed as the Health Commissioner reporting to the Mayor of South Yorkshire. • Chief Executive's Report- key themes discussed included: o Organisational change- NHS South Yorkshire, in partnership with Trade Union representatives, agreed to re-open the Organisation Change consultation for a limited period of four weeks from 30 March 2026. The consultation closed as planned on Friday 24 April 2026. it was reported that the ICB workforce needs to reduce from approximately 850 to approximately 510 whole

	time equivalents (wte). A significant voluntary redundancy programme is underway. o Financial position- the Integrated Care Board achieved a year-end deficit of £48.9m, which is adverse to the planned full-year break-even position. NHS South Yorkshire managed to deliver its highest efficiency plan as an ICB of £97m. o Planning and Priorities for 2026/27 and Annual Assessment- the annual assessment process for integrated care board performance in the 2025/26 financial year has been released. o Neighbourhood health centres- NHS South Yorkshire has been selected to host one of the new neighbourhood health centres. Nationally, a first wave of 27 centres will share up to £50m of Government funding that aims to bring care closer to home. Once completed, people will be able to access a wider range of NHS services such as urgent care, GP and pharmacy services, under one roof and on their doorstep. o Industrial Action- it was updated that resident doctors took industrial action over six days in early April 2026. o NHS South Yorkshire Board changes- Chris Edwards was appointed substantively as Chief Executive of NHS South Yorkshire, having held the post on an interim basis since October 2025. o NHS Staff Survey Results- response rate was 67%. The scores in several areas are noticeably lower than last year which is reflective of the significant organisational change and role reduction required o Place updates- Barnsley Hospital has announced the latest outpatient services to move into the Alhambra Shopping Centre's health and wellbeing hub as part of the trailblazing 'Health on the High Street' initiative. Dermatology, Rheumatology and Orthotics are the latest services to transfer from the hospital into the Alhambra. • Board Assurance Framework & Risk Register- the Board reviewed key risks including financial sustainability, organisational change capacity, urgent care performance, estates risk • Strategic Commissioning Plan- it was reported that feedback on the Strategic Commissioning Plan was awaited from NHSE. • Integrated Performance Report (IPR)- it was reported that there has been a further increase in access for Children and Young People. The latest available data for health checks for patients with a serious mental illness published is for December 2025, shows the ICB achieving a 64% completion rate against a target of 60%.

	• Health and Growth Accelerator- this has seen early positive impact and demonstrates a strong partnership model (health, employers, VCSE). • Running Cost Reductions / Organisational Change- the programme is on track for July 2026 implementation, aligning with £19 per head cost requirement. • Review of the ICB Constitution- this was received and agreed prior to submission to NHSE. Updates reflected the new operating model and governance arrangements. • Financial Delivery Report- significant pressures were noted in Continuing Healthcare, Mental Health (ADHD/autism demand) and acute activity. The efficiency target for 2025/26 was achieved. • Corporate Assurance & Governance- the Board reviewed and approved: Remuneration Committee Terms of Reference and noted governance compliance, internal audit and complaints oversight and key policies (e.g. Freedom to Speak Up). • Assurance Items (Committee Reports)- Minutes were received from: ICP, Place Committees, Assurance Committees.
Date of next meeting	Next meeting scheduled for 1 July 2026.
Further information:	https://southyorkshire.icb.nhs.uk/our-information/meetings-and-papers

3. South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board

Member	Chief Executive
Items discussed	Update from meeting held on 13th May 2026 Key agenda items included: • Mental Health Investment Standard (MHIS) settlement in South Yorkshire. • Positive progress on out of area bed placements, particularly in Sheffield. • Update on Eating Disorders work. • Update on Adult Secure work.
Date of next meeting	Next meeting scheduled for 9th September 2026

4. South Yorkshire Eating Disorder Joint Committee (EDJC)

Member	Director of Strategy, Inclusion and Change/ Deputy Chief Executive
Items discussed	Update from meeting on 11 May 2026 Key agenda items included: • Medical emergencies in eating disorder (MEED) update.

	• Community Eating Disorder Service expansion.
	• Eating Disorders Integrated Inpatient/Community.
	  o Children and young people's update and timeline.
	  o Feedback on Sheffield Health Partnership University NHS FT development.
	  o Procurement responsibilities.
	• Physical health monitoring – workshop summary.
	• South Yorkshire Eating Disorder Joint Committee evaluation.
	• Risk Register.
	• Performance Report.
	
	<u>Update from meeting on 8 June 2026</u>
	
	Key agenda items included:
	
	• Medical emergencies in eating disorder (MEED) update.
	• Community Eating Disorder Service expansion.
	• Eating Disorders Integrated Inpatient/Community.
	  o Children and young people's update and timeline.
	  o Feedback on Sheffield Health Partnership University NHS FT development.
	  o Procurement responsibilities.
	• South Yorkshire Eating Disorder Joint Committee evaluation.
	• Risk Register.
	• Performance Report.

Date of next meeting	Next meeting scheduled for 13th July 2026

5. Barnsley Place

Barnsley Provider Partnership (BPP)

Member	Chief Executive
Items discussed	<u>Update from meeting on 28th May 2026</u> Key agenda items included: • Terms of reference discussion and approval. • Provider partnership priorities and work plan 2026/27. • Discussion on governance supporting provider partnership.
Date of next meeting	Next meeting of Barnsley Place Partnership is scheduled for 30th July 2026

Barnsley Place Partnership Delivery Group

Member	Deputy Director of Strategy and Director of Strategy and Change/Deputy Chief Executive
Items discussed	<u>Update from meeting on 12th May 2026</u> Key agenda items included: o Echo Report.

	○ Review of the VW Doccla contract. ○ Urgent Response, Night Service. ○ Final update from the April Next Steps for Barnsley's Provider Partnership Session. ○ New arrangement for oversight and delivery of the wider Neighbourhood agenda on behalf of the H&WB Board and Provider Partnership. ○ Standing down PPDG in its current form and future roles of other Delivery Groups and Sub-groups.
Date of next meeting	This was the last meeting of Barnsley Place Partnership Delivery Group in its current form.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Director of Strategy, Inclusion and Change/ Deputy Chief Executive
Items discussed	Update from meeting on 29th April 2026 Key agenda items included: • Update on neighbourhood development • Updates on transformational work - 0-19 service integration community - Mental additional roles resource (ARs) • Reviewing of ongoing workstreams highlight reports - Connecting Care
Date of next meeting	Next meeting scheduled for 24 June 2026

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change/Deputy Chief Executive
Items discussed	Update from meeting on 30th April 2026 Key agenda items included: • Barnsley Dementia Pathway. • Priority 4: Older people move more, enabling them to stay physically and socially active for as long as possible. • Active in Barnsley Strategy 2026-2031. • Barnsley Older People Physical Activity Alliance. • Barnsley Premier Leisure (BPL) helping older people move more. • Better Care Fund 2026/27.
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143
Date of next meeting	Next meeting scheduled for 23rd July 2026

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 12.2

Private/Public paper:	**Public**		
Title:	**West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update.**		
Lead Director:	**Mark Brooks - Chief Executive**		
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy and is supportive of our mission to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire where the Trust provides services (Calderdale, Wakefield, Kirklees).		
Strategic aims:	Live Our Values		The Trust's partnership working at system and Place supports being the 'Best Partner' and the Trust to achieve our ambitions.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	✓	
	Be ambitious	✓	
BAF Risk(s):	4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place' 4.2 Differing roles and levels of influence across our places and systems could lead to inequity in service provision and service user outcomes across the Trust. 4.3 Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve 6.2 System pressures and changes in operating environment could lead to a lack of focus on established positive partnerships and proactive promotion of the Trusts role, impacting on opportunities to provide high-quality joined-up care and positive staff experience. 6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions.		

With all of us in mind.

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	Strategic discussions and updates on the West Yorkshire Health & Care Partnership developments and place-based developments have taken place regularly at Trust Board. The last update was received by Trust Board on 28 April 2026.
Executive summary:	West Yorkshire Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the voluntary community and social enterprise sector to improve the health and wellbeing of people living in West Yorkshire's five districts. NHS West Yorkshire Integrated Care Board (ICB) became a statutory organisation on 1 July 2022. The ICB has responsibility to commission the majority of NHS services for the West Yorkshire (WY) population. Each of the five place-based partnerships in WY has an integrated care board committee to make decisions, similar to the NHS West Yorkshire Integrated Care Board. Work continues in each of the Trust's three districts' partnerships to evolve and develop place-based partnership governance arrangements. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements. Meetings of Place Provider Partnerships in shadow form commenced April 2026 in Calderdale, Kirklees and Wakefield. The paper summarises key developments from recent ICB and place-based partnership meetings.

Recommendation:	**Trust Board members are asked to:**
	• **NOTE** the update on the development of Integrated Care Systems and collaborations:
	  ○ West Yorkshire Health and Care Partnership.
	  ○ Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.
	• **NOTE** the minutes of relevant partnership boards/committees.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 12.2

West Yorkshire Health & Care Partnership (WYHCP) - including the Mental Health, Learning Disability and Autism Collaborative and Place-Based Partnerships Update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership (WYHCP), focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire (WY) where the Trust provides services (Calderdale, Wakefield, Kirklees).

West Yorkshire Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the voluntary community and social enterprise sector to improve the health and wellbeing of people living in West Yorkshire's five districts.

The ICB has responsibility to commission the majority of NHS services for the WY population. Each of the five place-based partnerships in WY has an integrated care board committee to make decisions, similar to the NHS West Yorkshire Integrated Care Board. The role of these committees is changing given the reorganisation of the ICB in 26/27 and there will only be one meeting per quarter for decision-making purposes.

Work continues in each of the Trust's three districts' partnerships to evolve and develop place-based partnership governance arrangements. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements. Meetings of Place Provider Partnerships in shadow form commenced April 2026 in Calderdale, Kirklees and Wakefield.

This paper summarises key developments from recent ICB and place-based partnership meetings. A key focus of system discussions has been the organisational change in each of our ICBs, and the role ICBs play in the future as strategic commissioners.

2. West Yorkshire Health and Care Partnership

Updates from key recent meetings of the West Yorkshire Health and Care Partnership are summarised below.

West Yorkshire Integrated Care Board

Member	Mental Health, Learning Disability and Autism services are represented by Sara Munro, Chief Executive of Leeds and York Partnership NHS Foundation Trust, as partner member of the Integrated Care Board.

Items discussed	There has been no further meeting of the NHS West Yorkshire ICB Board since the last report to Trust Board
Date of next meeting	Next meeting scheduled for 23rd June 2026. An update from this meeting will be shared at the next Board meeting.
Further information:	Integrated Care Board : West Yorkshire Health & Care Partnership

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	There has been no further meeting of the West Yorkshire Health & Care Partnership Board since the last update to Trust Board.
Date of next meeting	The next meeting date of the West Yorkshire Partnership Board is to be confirmed.
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard Meeting papers are available here: https://www.wypartnership.co.uk/meetings/partnershipboard/papers

West Yorkshire Mental Health, Learning Disability and Autism Partnership Board

Members	Chief Operating Officer and Medical Director.
Items discussed	Update from meeting on 12 May 2026 Agenda items included: • Chair's update- the Chair shared information regarding the national work into the development of a modern service framework for mental health and highlighted the opportunities to influence through the recent call for evidence. • Adult Secure- Steven Dilks, Clinical Lead for the West Yorkshire Adult Secure Provider Collaborative provided an update on the work of the collaborative including a review of waiting times into secure care. • Mental Health, Learning Disability and Autism Programme. • Disordered eating- a presentation was given on developing a West Yorkshire–wide programme for Disordered Eating. • CONNECT Service- an update was given on the service which is a specialist service for adults aged 18 and over living in West Yorkshire who are experiencing eating disorders. • Planning and Performance update. • Standard Operating Procedures.

	• AAA reports and escalations. <u>Update from meeting on 9 June 2026</u> • Perinatal Mental Health update. • Integrated Neighbourhood Health. • West Yorkshire Mental Health Crisis Line Service Review. • Digital Dynamic Support Register. • GIRFT (Getting It Right First Time) • Planning and Performance update. • Standard Operating Procedures. • AAA reports and escalations.
Date of next meeting	Next meeting scheduled for 16 July 2026

<u>Wakefield</u>

The Trust continues to be a pro-active partner in the Wakefield District Health and Care Partnership (WDHCP) and associated work, leading in specific areas, for example, the Wakefield Mental Health Alliance. Since the last report to Board, the initial meeting of the Wakefield Place Provider Partnership has taken place.

Wakefield District Health and Care Partnership Committee

Member	Chief Executive
Items discussed	<u>Update from meeting on 12th May 2026</u> A new Chair of the meeting has been appointed – Majid Hussein. Agenda items included: • Terms of reference and work plan- these were approved. • Risk Register – closure report. • Better Care Fund (BCF) - a discussion was held and it was agreed to submit the Better Care Fund plan in line with timescales. There is ongoing intention to review and align BCF with the Neighbourhood Health Framework during 2026/27, to inform a refreshed approach for 2027/28. • Neighbourhood Health Centre- national capital funding has been confirmed to support development of neighbourhood health centres. In Wakefield priority areas are Castleford Health Centre, Ossett Health Centre and Trinity Health Centre. It was confirmed a proposal would be submitted mid- May with NHS England review expected to take place by end of May. It was noted that at this stage these are initial proposals, with opportunity for further refinement.
Date of next meeting	Next meeting scheduled for 11 August 2026
Further information	Meeting papers are available here:

	Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk)

Wakefield Mental Health Alliance

Member	Deputy Director of Partnerships, Planning and Governance (Chair) Associate Director of Operations, Mental Health Care Group
Items discussed	Update from meeting on 13th May 2026 Agenda items included: • Mental Health Alliance Dashboard. • Mental Health Emergency Department Strategy Group. • Disordered Eating Procurement. • Healthy & Sustainable Community feedback. • Multiagency suicide prevention. • Drugs and alcohol. • West Yorkshire all age 24/7 crisis text service. • SWYPFT data sharing review update. • Partner updates. Update from meeting on 17th June 2026 Agenda items included: • Mental Health Alliance Dashboard. • Mental Health Emergency Department Strategy Group. • Disordered Eating Procurement. • Combined PMHN/MHA Meeting. • Healthy & Sustainable Community feedback. • Call for evidence on the Mental Health Strategy- this was discussed and a collective response will be submitted from the Alliance. • Clinical Quality Measures- an updated was provided by Turning Point on Talking Therapies and work that has taken to improve waits and reliable recovery. • Further feedback re transitions/young people (Task & Finish Group meeting 10th June). • Economic accelerator update. • Partner updates.
Date of next meeting	Next meeting scheduled for 17th June 2026

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Programme Director for Mental Health Transformation- Wakefield)
Items discussed	No meeting of the Wakefield Health and Wellbeing Board has been held since last report to Board

Date of next meeting	Next meeting scheduled for 16 July 2026.
Further information	Papers and draft minutes are available at: www.wakefield.gov.uk: Browse meetings - Health and Wellbeing Board

Calderdale

SWYPFT is a partner in delivering Calderdale Cares. We have continued to work with partners to develop a place-based approach.

Calderdale Cares Partnership Board

Member	Chief Executive
Items discussed	Update from meeting on 14th May 2026 Agenda items included: • Deep Dive- Reducing Inequalities. • Place Lead report. • 2026/27 financial planning. • Quality and Safety report.
Date of next meeting	Next meeting scheduled for 13th August 2026
Further information	Further information and meeting minutes can be found here: Calderdale Cares Partnership Board Papers - Calderdale Cares Partnership

Calderdale Cares Community Programme Board

Member	Associate Director of Operations, Adults and Older People Mental Health Care Group
Items discussed	Update from meeting on 14th May 2026 The main agenda item was building a shared understanding of the Calderdale Provider Collaborative and the Neighbourhood Health Plan. Update from meeting on 11th June 2026 The main agenda items was the Neighbourhood Health Plan (NHP). This included: • Calderdale in Context – a presentation on the Health of the People of Calderdale. • NHP – Continued Development update and outcome measures.
Date of next meeting	Next meeting scheduled for 9th July 2026.
Further information	Papers are available on the Future NHS platform for those with an account.

	https://future.nhs.uk/CalderdaleCCPBoard/view?objectId=36472912 Accounts can be set up at: https://future.nhs.uk/system/register

Calderdale Health and Wellbeing Board

Invited Observer	Chief Nurse/Director of Quality and Professions
Items discussed	No meeting of the Calderdale Health and Wellbeing Board has been held since last report to Board.
Date of next meeting	Next meeting is scheduled for 16 July 2026.
Further information	Papers and minutes are available at: https://calderdale.moderngov.co.uk/ieListMeetings.aspx?CId=148&Year=0

Kirklees

Kirklees ICB Committee

Member	Chief Executive
Items discussed	Update from meeting on 13 May 2026 Key Agenda items included: • Risk and Board Assurance Framework Close Down Report • Financial and Operating Planning 2026/27- it was submitted that West Yorkshire ICB has submitted a balanced financial plan for 2026/27 and that Kirklees Place draft plan was a £4.2m surplus but was subject to final budget setting alignments. • Neighbourhood Health Centres Update- neighbourhood capital bids were received for ratification. • Items and Risks for Escalation.
Date of next meeting	Next meeting scheduled for 12 August 2026.
Further information	Further information and papers are available at: Kirklees Integrated Care Board Committee - NHS Kirklees HCP

Kirklees Health and Wellbeing Board

Invited Observer	Deputy Director of Partnerships, Planning and Governance
Items discussed	No meeting of the Kirklees Health and Wellbeing Board has been held since last report to Board.
Date of next meeting	16th July 2026
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Kirklees Partnership Executive meeting

Member	Deputy Director of Partnerships, Planning and Governance
Items discussed	Update from meeting on 14 May 2026 Key Agenda items included: • Update on elections • Kirklees partnership framework review- an update was given on the Kirklees Partnership Framework, building on previous development work and partner engagement. The update focused on four key areas: outcomes and indicators, the engagement plan, terms of reference, and proposed deep dives. It was emphasised that the framework continues to evolve through ongoing collaboration with partners.
Date of next meeting	Next meeting scheduled for 9 July 2026.

Kirklees Delivery Collaborative

Member	General Manager Adult Community and Recovery Services Kirklees and Calderdale
Items discussed	The meetings have currently been paused.
Date of next meeting	Next meeting to be confirmed.

Kirklees Mental Health Alliance

Member	Chief Executive with Associate Director of Operations, Mental Health Care Group as a member
Items discussed	There has been no further meeting of the Kirklees Mental Health Alliance since the last update to Board as the meeting of 27 March 2026 was cancelled. Discussions have taken place at Place Provider Partnership Board as to the oversight of key priorities, and meeting structures will be established.
Date of next meeting	Next meeting to be confirmed.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 12.3

Private/Public paper:	**Public**		
Title:	**Provider Collaboratives and Alliances**		
Lead Director:	**Adrian Snarr (Director of Finance and Resources)**		
Purpose/values:	The development of joined- up care through partnership working is central to the Trust's strategy and is supportive of our mission- to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The paper provides an update on Specialised NHS-Led Provider Collaboratives, focusing on developments that are of importance or relevance to the Trust. The paper includes updates on the West Yorkshire and South Yorkshire & Bassetlaw Provider Collaboratives where the Trust is a Co-ordinating Provider or partner, and an update on the national Phase 2 Provider Collaboratives.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.1 Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy. 2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes. 4.1 Financial pressures and changes in our systems and operating environment could result in less focus on mental health, learning disability and autism, community services and/or Place' 4.3 Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve 6.1 Lack of effective commissioning impacts on the provision of high quality, inclusive and responsive adult secure mental health care.		
Contribution to the objectives of the	The paper provides an update on the work of the Provider Collaboratives and their relationship to ICB, and Place based organisations.		

With **all of us** in mind.

Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The paper provides an overview of the work being undertaken through the provider collaboratives, highlighting quality improvement initiatives including service user involvement, pathway improvements and commissioning activity, leading to improved patient experience, partnerships. Reference is made to any pressure, capacity and demand within the provider collaboratives, noting the impact on out of area placements, impact on waits to access care, and the improvement work to address these areas. The paper also provides a financial update in relation to each provider collaborative highlighting any potential financial risk for the Trust.
Any background papers / previously considered by:	Updates on Provider Collaboratives are a standing item on the Trust Board agenda. The last update to Board was April 2026.
Executive summary:	The paper includes updates on the West Yorkshire and South Yorkshire & Bassetlaw Provider Collaboratives where the Trust is a Co-ordinating Provider or partner, and an update on the national Phase 2 Provider Collaboratives. Where the Trust is the co-ordinating provider, the paper provides insights into the areas of improvement being undertaken. These include in West Yorkshire and South Yorkshire, projects to address challenges in patient pathways and flow (out of area and clinically ready for discharge), health inequalities and work to improve our insights and sharing of patient experiences. Updates relating to environmental changes in services are also shared that impact on the access to services/patient experience and quality. Financial updates are provided for all Provider Collaboratives and the impact on the Trust through agreed risk shares.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the updates provided within the paper.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
Agenda item 11.3
30 June 2026

Specialised NHS-Led Provider Collaboratives and Alliances

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the Specialised NHS-Led Provider Collaboratives, focusing on developments that are of importance or relevance to the Trust. The paper includes updates on the West Yorkshire and South Yorkshire & Bassetlaw Provider Collaboratives where the Trust is a Co-ordinating Provider or partner, and an update on the national Phase 2 Provider Collaboratives.

2. Phase 1 Provider Collaboratives

In **West Yorkshire**, Provider Collaboratives are established for national Phase 1 services:

- Adult Low and Medium Secure Services - co-ordinated by South West Yorkshire Partnership Teaching NHS Foundation Trust (SWYPFT).
- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - co-ordinated by Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Adult Eating Disorder Services - co-ordinated by LYPFT.

In addition to being Co-ordinating Provider for Adult Secure, the Trust is a partner in both the Adult Eating Disorder and CYPMH Provider Collaboratives.

The Adult Eating Disorder Collaborative went live on 1 October 2020, and the CAMHS and Adult Secure Collaboratives 1 October 2021 (with transitional support from NHSE/I until 31 March 2022).

In **South Yorkshire and Bassetlaw**, Provider Collaboratives have also been established for all national Phase 1 Services:

- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - co-ordinated by Sheffield Children's Hospital.
- Adult Eating Disorder Services - co-ordinated by Rotherham Doncaster and South Humber NHS Foundation Trust.
- Adult Secure Services - co-ordinated by SWYPFT.

The Adult Eating Disorder and CYPMH Provider Collaboratives went live on 1 October 2021, and the Adult Secure Provider Collaborative on 1 May 2022.

Although the South Yorkshire Integrated Care System does not include the Bassetlaw population, for the purpose of the Phase 1 services the Provider Collaboratives continue to include the Bassetlaw population and will link with Nottinghamshire Integrated Care System as required.

3. Phase 1 Provider Collaboratives - West Yorkshire

3.1 West Yorkshire Adult Secure Provider Collaborative (WY PC)

The Adult Secure Provider Collaborative Board has continued to meet monthly. A summary of the key areas of activity includes:

- In response to the quality concerns at St Andrews Hospital, Northampton, the WY PC have worked to identify placements for the two patients from West Yorkshire who were receiving care in St Andrews. One patient has now been discharged to a non-secure placement in Bradford, with the second patient awaiting transfer to a low secure service, where he is currently first on the waiting list. We anticipate this move will have happened by September 2026.
- The three Adult Secure provider Collaboratives covering the Yorkshire and Humber region, have initiated a series of workstreams to improve collaboration, patient pathways, experience and efficiencies. The West Yorkshire Clinical Lead is leading a project exploring options for a regional SPA (Single Point of Access) functions and improved coordination of secure beds across West Yorkshire, South Yorkshire and Humber and North Yorkshire.
- The WY PC are currently experiencing the highest number of patients cared for in secure services since the PC went live, at 275. This is because of demand into secure care, and recent slowing of discharges. The main pressure is on the medium secure male mental illness (MI) pathway. All male services are working between 90- 96% occupancy levels which highlights the challenges both with clinical demand and the potential impact on waits.
- The total numbers waiting for secure care has reduced in recent months.
- A full thematic review has been produced of waits, and this is due to be presented to the Wakefield Safeguarding Board. A task and finish group has been established with all providers to address the recommendations noted in the review, with the aim to improve the assessment and admission processes and timescales.
- The overall number of our of area (OOA) cases has increased to 57 which is the highest number since 2022. Whilst some cases are within their natural clinical flow, some are OOA purely due to lack of capacity in West Yorkshire. 24 men are currently OOA due to no bed availability within medium secure.
- The PC has worked with colleagues in Rampton to establish a conference-style event planned for July, bringing together medium secure providers and high secure services to explore admission/discharge pathways and improve relationships.
- The PC continues to progress the wider improvement work to the women's pathways and community services, reducing variation in the service offer across West Yorkshire and improving pathways/service user experience.
- The PC Clinical Lead is part of a national project group led by NHSE to improve the use of and reporting of CRFD (clinically ready for discharge) in line with the definition. National variance is currently significant, and indications are that the definition is challenging to apply and may be revised by NHSE.
- Following the review of physical health care across WY secure services, all providers have developed specific actions plans to address areas of improvement. Plans are being monitored through service level contract meetings with the commissioning Hub/PC.
- The Involvement network have produced a video showcasing how the PC captures patient experience and how feedback influences service improvement, both locally and nationally.

The operational activity pressures continue to have a financial pressure on the West Yorkshire Adult Secure collaborative with expenditure on out of area placements and

exceptional packages of care. For 2026 / 27 an element of funding has been received to compensate this under the banner of growth funding. Despite this, the forecast is a deficit of £437k.

3.2 West Yorkshire Adult Eating Disorders Provider Collaborative

The Adult Eating Disorder Provider Collaborative business case assumed a level of income generation from other provider collaboratives placing patients in West Yorkshire. The national ambition for provider collaboratives to place patients close to home has resulted in a reduction of referrals and admissions from out of area, which negatively impacts on income.

As such the PC is reviewing the service offer, both in view of reduced income generation opportunities, and increased local referrals and complexity. An implementation plan is being developed.

At month 12 2025/ 26, a £191k surplus was reported. This was due to an underspend against the out of area budget. Surpluses delivered are held in an investment reserve and could be made available for investment or held to manage future financial risk. The current forecast for 2026 / 27 is a surplus of £73k.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

In line with the national developmental specifications, and inclusion of a service development improvement plan (SDIP) varied into Lead Provider contracts nationally, the PC are developing several priority workstreams to maximise viable alternatives to hospital admission, and/ or facilitated discharge, and further development of inpatient provision.

At month 12 2025/26, a surplus of £2,603k was reported. Underspends against the EPC (exceptional packages of care) and secure budgets are driving the surplus position. Surpluses delivered are held in an investment reserve and will be made available for investment against the developmental service specifications and/ or held to manage future financial risk

The current forecast for 2026 / 27 is a surplus of £1.8m.

4. Phase 1 Provider Collaboratives - South Yorkshire

4.1 South Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Oversight Group receives monthly updates and continues to provide oversight of the Trust's commissioning responsibilities, this reports into the Trust's Commissioning Committee and key areas of focus have been as follows.

- There has been an increase in the South Yorkshire and Bassetlaw (SYB) inpatient forensic population for the reporting period (+3) with 158 patients in inpatient treatment in total. This is 4 patients higher than planning estimated and one of the highest levels of occupancy seen since go live. Referrals continue to be dominated for the prison population and from Sheffield's PICU (psychiatric intensive care) ward. This trend is equally being observed in other parts of the region and across the country and will form a key consideration in the planning for an expanded Community Forensic Service in SYB in 2026/27.

- As at the end of May 2026, 15 patients were out of area (+1), 7 patients were within natural clinical flow (-4) and 3 are appropriate for repatriation (0 movement). Of the 3 patients appropriate for repatriation 2 will be prioritised for beds as they become available at Forest Lodge and Cheswold Park Hospital for low secure male services and 1 prioritised for a bed at Wathwood on the medium secure pathway.
- Whilst it is positive that overall live length of stay has reduced within the last 12 months, since the Provider Collaborative's "go live" in October 2021, cumulative length of stay is showing an increasing trend. As previously reported, a Task & Finish group is working to review each individual patient and to understand what the challenges to discharge might be. This includes a review of demographics to understand health inequalities. This is being overseen by the SYB Provider Collaborative Clinical Director and the Adult Secure Clinical Lead. This will report to the Commissioning Committee in September 2026.
- 2026/27 Annual Quality Reviews have commenced with Cheswold Park Hospital's review taking place in April 2026, Amber Lodge in May 2026 and Cygnet Sheffield's on 18th June 2026.
- Consideration is being taken on expansion of the Community Forensic Service within 2026/27 following funding being identified through growth monies.
    - An event was held with SYB Provider partners and regional colleagues in June 2026.
    - Current service provision and wider regional provision were showcased alongside more focussed discussions on expansion options, clinical models and mobilisation options.
    - Existing providers of Community services within South Yorkshire and Bassetlaw have been tasked with considering how the current provision in place could be expanded to cover a wider geography.
    - This work will continue at pace with an agreed position deadline for end of August 2026 to ensure required governance for all parties involved can be completed in September 2026.
    - Mobilisation is planned in year within 2026/27.

- The 'Enhanced Packages of Care working group' continues to both clinically and financially manage all Enhanced Packages of Care in place to ensure least restrictive care and in turn support financial efficiency. The work of this group has positively impacted the spend on enhanced packages of care and ensuring the least restrictive practices are used for our patients and continues to do so.
- Following a regional event held with West Yorkshire and Humber & North Yorkshire Provider Collaboratives and a follow up local event held with South Yorkshire and Bassetlaw providers, 4 priority workstream have been agreed upon, collaboratively led by the 3 Provider Collaboratives. These are as follows:-

    - SPA Task and Finish Group to explore existing strengths and opportunities across the local single points of Access with a view to focussing on patients from Yorkshire & Humber being considered for placement first within region. This will also strengthen collaboration and mutual aid for access assessment / assessment and patient placement for specific complexity/complex pathways.
    - Out of Area Patient Repatriation Group to review all out of area patients across Yorkshire and Humber with a focus on repatriation to local beds.
    - Understanding patient demography through a deep dive into data across the Yorkshire and Humber region to inform future commissioning and develop a region wide weekly SitRep.
    - Learning Disabilities and Autism pathway review to explore current provision and bed usage to identify opportunities for alternative commissioning arrangements, making best use of estate, skill and expertise.

- Negotiations are ongoing with Providers on 26/27 contract terms with 3 out of 5 now finalised and the remaining 2 being worked on at pace to secure final agreement.

The SYB Provider Collaborative is reporting a deficit position of £877k as at month 2 for 2026/27, this is primarily driven by;

- An increase in demand for inpatient services which has increased costs for both in areas providers and out of area providers with a forecast pressure of £1m. Work is ongoing to review estimated discharge dates to ensure accurate financial forecasting and the working group reviewing barriers to discharge continues through the length of stay task and finish group.
- There is also a £97k pressure in relation to higher than national inflation multi-site provider uplifts that the SYB Provider Collaborative do not negotiate. This is being monitored and reported to NHS England regional team as on ongoing annual pressure which may increase.

5. Phase 2 Provider Collaboratives

5.1 Forensic CAMHS

Commissioning oversight of Yorkshire and Humber FCAMHS transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1 January 2024.

To ensure all Yorkshire and Humber Specialised Provider Collaborative commissioners remain updated on the service, developments and quality activity, a Yorkshire and Humber Provider Collaborative Oversight Meeting has been established between the three Commissioning Hubs, chaired by West Yorkshire Commissioning Hub. The minutes and content are shared with SWYFT Commissioning Committee

Regular reporting and governance structures have been established, alongside quality oversight arrangements.

A Learning Disabilities and Autism business case has been developed and approved. This utilises the full £90,000 funding from central NHSE and £103,000 from Forensic CAMHS surplus investment fund.

5.2 Perinatal Mental Health

The Collaborative went live on 1st October 2024, in shadow form, and live on 1st April 2025,

Commissioning oversight of Yorkshire and Humber (inpatient) PMH PC transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1st April 2025

West Yorkshire ICB retain responsibility for commissioning local community specialist PMH services, delivery of access target and joint work to enable a trauma-informed maternity system across WY.

The Yorkshire and Humber PMH Provider Collaborative Board has been established. SWYPFT as a named partner, have representation at the board level, and as such will be in receipt of updated positions, partnership agreements and finance and activity reporting.

The PMH PC commissioning and quality activity will be shared at the established Yorkshire and Humber Oversight Group (detailed above).

A full business case for the provider collaborative has been shared with all partners; further work is being undertaken to progress the partnerships agreements to signature.

The PMH PC, in line with the national approach for this service line, operates within a “steady state” arrangement.

At month 12 the Provider Collaborative (PC) reported a £267k deficit with an annual forecast deficit of £267k. The 2025/26 deficit position was expected due to the lack of funding for infrastructure support. Prior approval has been obtained for LYPFT to support this deficit subject to managing slippage on the revenue support for the additional MBU (mother and baby unit) beds.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 13.1

Private/Public paper:	**Public**		
Title:	**Trust compliance with NHS provider licence conditions**		
Lead Director:	**Dawn Lawson – Director of Strategy, Inclusion and Change/ Deputy Chief Executive**		
Mission/values:	Effective governance, and compliance with the conditions of the NHS provider licence support the Trust to deliver its mission and adhere to its values.		
Purpose:	The purpose of this paper is to provide an overview of the process the Trust has gone through to self- assess against the conditions of the NHS provider licence and to provide assurance of compliance.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	Given the requirement for the Trust to comply with its provider licence conditions, all risks on the Board Assurance Framework are relevant to this paper.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	This self-assessment process provides evidence to assure the Board that the Trust is operating in line with its licence. It also provides assurance to partners and the system of adherence to the conditions of our licence and is published on the Trust website.		
Any background papers / previously considered by:	The Trust completes a self-assessment on an annual basis. The last self-assessment against the NHS provider licence was received by Trust Board in June 2025. The assessment was received by the Executive Management Team at its meeting on 4 June 2026.		

With **all of us** in mind.

Executive summary:	NHS foundation trusts are no longer required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), or that they have the required resources available if providing commissioner requested services, and have complied with governance requirements. However, in the interests of good governance, and in support of the Chief Executive's Annual Governance Statement, this assessment has been undertaken by the corporate governance team. This retrospective report (1 April 2025 to 31 March 2026) considers compliance with the licence provider requirements for the year 2025/26 and conditions as shown below: Section 1 – Integrated care. Section 2 - Trusts working in systems. Section 3 – General conditions. Section 4 – Trust Conditions. Section 5 – NHS controlled provider conditions. Section 6 – Continuity of services. Section 7 – Costing conditions. Section 8 – Pricing conditions. Section 9 – Interpretations and definitions. Key changes in our assessment this year include: • Updated narrative in sections where required. • IC2 – Personalised care and patient choice – this section has been fully updated to include the Trust's work towards alignment with the national personalised care and support framework. • WS2 – The triple aim – this section has been updated to reflect Trust's performance metrics being aligned to the five national themes of the NHS System Oversight Framework and inclusion of reducing inequalities metrics in the integrated performance report (IPR). • WS3 – Digital transformation – this section has been updated in alignment with the Trusts digital strategy and digital maturity assessment • CoS 1: Continuing provision of Commissioner Requested services (CRS) – this section has been updated to note that under the Trust's 25/26 and 26/27 contracts with each integrated care board (ICB), Barnsley physical health services are classified as a "hard to replace service. The Trust also provides secure adult services which fall under CRS criteria and the Trust is complaint with the terms of the licence. • CoS 2 - Restriction of the disposal of assets – updated as per CoS 1. The updates for 2025/26 were presented to the Executive Management Team on 4 June 2026 and recommended to Trust Board for approval, subject to further narrative being included in WS2 in relation to the Trust's processes for monitoring performance via the IPR which has now been added. Trust Board can be assured that the Trust has a sound system of corporate and clinical governance in place to meet the requirements of its licence.

Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the outcome of the self-assessment against the Trust's compliance with the terms of its Licence.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board 30 June 2026

NHS provider licence

This paper is intended to provide assurance that the Trust complies with the terms of its licence and sets out a broad outline of the licence conditions and any issues for Trust Board to note. The NHS provider licence was first introduced for NHS foundation trusts in 2013 and extended to NHS trusts from April 2023. The licence has now been modified following a statutory consultation to bring it up to date to reflect current statutory and policy requirements. These modifications also merge the NHS provider licence and the NHS controlled provider licence.

The provider licence is split into nine sections:

Section 1 – Integrated care.
Section 2 - Trusts working in systems.
Section 3 – General conditions.
Section 4 – Trust Conditions.
Section 5 – NHS controlled provider conditions.
Section 6 – Continuity of services.
Section 7 – Costing conditions.
Section 8 – Pricing conditions.
Section 9 – Interpretations and definitions.

Section	Provision	Comments
Section 1 – Integrated Care IC1: Provision of integrated care	1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS: i) is integrated with the provision of such services by others, and ii) is integrated with the provision of health-related services or social care services by others and iii) enables co-operation with other providers of health care services for the purposes of the NHS where this would achieve one or more of the objectives referred to in paragraph	The Trust actively works with its partners, through formal and informal mechanisms to enable integrated care and is involved in several provider collaboratives with formalised ways of working and models of delivery. A number of services are provided through partnership working with local stakeholders. The Trust has played an active role in Integrated Care Systems in West Yorkshire and South Yorkshire in recent years. Following national changes the Trust is now fully engaged in place-based arrangements to develop place
	2. The objectives are: a. improving the quality of health care services provided for the purposes of the NHS (including	

With all of us in mind.

	the outcomes that are achieved from their provision) or the efficiency of their provision, b. reducing inequalities between persons with respect to their ability to access those services, and c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.	provider partnerships in our respective localities. The Trust remains lead/coordinating provider for adult secure services in West Yorkshire and South Yorkshire and is lead provider for Forensic CAMHS across Yorkshire and Humber. Reducing health inequalities is part of the Trust's strategic aims under "Best quality". The Trust works with each of our partners in all four of our places to address health inequalities. Examples include our work with partners on annual physical health checks for people with a learning disability and severe mental illness and using data and insight to identify communities for focused work on waiting lists and times.
	3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition	
	4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.	
IC2: Personalised Care and Patient Choice	1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.	The Trust has developed a programme to improve personalised care and support addressing the national requirements to move away from the standards of the Care Programme Approach (CPA) and align to the national Personalised Care and Support Framework. This is currently in draft. The Trust has adopted a continuous improvement approach to ensure plans of care are co-produced and the voices of the communities we serve are at the heart of our improvement work. During 2026-27 the Trust is reviewing the person-centred care plan along with the strengthening of the use of DIALOG, which is an 11-point scale that can be used as a person reported outcome measure (prom) or person reported experience measure (prem). DIALOG and the person-centred care plan work on a strengths-based approach, working with the person to identify what is important to them and how these outcomes can be achieved.
	2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.	
	3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.	
	4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.	
	5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another	

	and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services. 6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.	Historically health outcome measures have been captured in paper form. However, the Trust has implemented a solution to improve and streamline collecting and reporting health outcomes digitally. This aids in improving timeliness offering real time insight into patient wellbeing and quality of life, providing quicker decision making and ability to tailor treatment, offering more personalised care and support through service user identified needs and goals. For points 4 and 5 choice of secondary care provider is offered through primary care and is therefore not applicable to the Trust. Where the Trust utilises external providers for the provision of services on its behalf, patients are informed of this in an open and transparent way and offered the choice to accept this service or be referred back to primary care.
Section 2 – Trusts Working in Systems WS1: Cooperation	1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS. 2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities. 3. Without prejudice to the generality of paragraph 2, the Licensee shall: a. consistently co-operate with: • other providers of NHS services; and • other NHS bodies, including any Integrated Care Board of which it is a partner; i. as necessary and appropriate for the purposes of developing and delivering system plan(s). ii. ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year. iii. iii. as necessary and appropriate for the purposes	The Trust has undertaken a significant amount of work in place provider partnerships in each of our four local areas, in order to develop and formalise arrangements following national changes in the scope and responsibilities of integrated care systems and integrated care boards. The Trust has participated in the development of the transformation of community mental health services in both West and South Yorkshire regions. The Trust responds to guidance issued by NHSE. Submissions and information provided to NHSE are approved through relevant and appropriate authorisation processes.

	of delivering agreed people and workforce plans. b. consistently co-operate with: • other providers of NHS services; • other NHS bodies, including any Integrated Care Board of which it is a partner; and • any relevant local authority in England i. as necessary and appropriate for the purposes of delivering NHS services. ii. ii. as necessary and appropriate for the purposes of improving NHS services.	The Trust has in place a system for the review and dissemination of guidance/information to the executive management team and senior managers.
	4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either: a. the Secretary of State for Health and Social Care; or b. NHS England. For the purposes of this condition, cooperation is considered synonymous to collaboration	
WS2: The Triple Aim	1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	The Trust oversees performance via a monthly Integrated Performance Report, reviewed by Operational Management Group, Executive Management Team and Board. Performance metrics are aligned to the five national themes of the NHS System Oversight Framework which include: quality of care, access, and outcomes, preventing ill health and reducing inequalities, people, finance and use of resources, and leadership and capability. These metrics are used to identify potential issues and prompt further investigation of support needs. The Trust has recently received the detail of the 2026/27 NHS Oversight Framework. The latest position for the 2025/26 NHS Oversight Framework is quarter 3, the Trust achieved a rating of level 1 which is the highest rating and was ranked 12 out of 61 providers evidencing a strong performance against all applicable metrics. These metrics along with other national metrics
	2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.	
	3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.	
	4. In this condition, “the triple aim” refers to the aim of achieving: a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) c. more sustainable and efficient use of resources by NHS bodies,	

	and “duty relating to the triple aim” means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.	are monitored monthly in the Trust integrated performance report in the national metrics section and can be found at this link: Performance reports - South West Yorkshire Partnership NHS Foundation Trust. The Trust has continued to focus on out of area bed placements in 2025/26 and has maintained the reduction in such placements in year compared to previous years. Reducing health inequalities is included in the Quality and Safety section of the Trust’s Integrated Performance Report (IPR). 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. Data in relation to financial sustainability and efficiency is included in the Finance and Contracts section.
WS3: Digital Transformation	1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS. 2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2). 3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	We rely on digital technology every day in our working lives. It is therefore essential that the systems and technologies the Trust uses are safe, resilient, efficient, effective, and contribute to better outcomes for the people who use our services. Embracing digital innovation within the NHS is crucial for enhancing patient care and by adopting new and emerging digital technologies, we can streamline processes, enable better data management and information sharing, support increased productivity, and foster a culture of continuous improvement and adaptability. This ensures we can meet the evolving needs of the communities we care for and deliver high-quality person-centric healthcare services. The views of our staff, service users and carers from their day-to-day experiences continue to be critical in driving the Trust’s digital agenda and in designing fit-for-purpose, secure and robust digital capabilities that provide equitable access. Within our approach, the

		Trust persistently takes stock of the national digital strategic direction, associated standards, and wider digital priorities, which blend together with organisational priorities forming our work programmes to drive forward the digital agenda. The Trust complies with the annual digital maturity assessment requirements, which serves to evidence and demonstrate organisational progress, whilst identifying areas for focus to improve our overall organisational digital maturity, ensuring the Trust is perpetually assuring the Board of our constant strategic alignment, both nationally and regionally, and digital standards compliancy obligations.
Section 3 – General Conditions G1 – Provision of Information	1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.	The Trust is currently obliged to provide NHSE with any information it requires and, within reasonable parameters, to publish any information NHSE requires it to. The Trust has systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust. Conditions are broad, so there is a potential risk of increased burden in the future. All NHSE mandatory performance indicators are reported through the Finance, Investment and Performance Committee and to Trust Board through the monthly integrated performance report (IPR).
	2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require	
	3. The Licensee shall take all reasonable steps to ensure that information is: a. in the case of information or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested	
	4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	
G2: Publication of information	1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the	See G1 – as above.

	health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct 2. For the purposes of this Condition, "publish" includes making available to the public at large, to any section of the public or to particular individuals	
G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)	1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is: a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986); c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it; d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person. 2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper. 3. For the purposes of paragraph 2, a person is not fit and proper if that person is: a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or b. an organisation which is a body corporate, or a body corporate with a parent body corporate: i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);	NHS England published a revised fit and proper persons framework to the Kark review (2019). This came into effect in September 2023, and the Trust updated its fit and proper persons process accordingly. There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for directors. All Board members and, for Foundation Trusts, governors must meet the 'fit and proper' persons test as described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts must also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors. With which the Trust is fully compliant for 2025/26.

	ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986; iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking; iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; v. which passes any resolution for winding up; vi. vi. which becomes subject to an order of a Court for winding up; or vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.	The Trust considers the membership of the Trust Board to be appropriate having the balance of skills, experience, and knowledge it needs to act as an effective unitary board of a Foundation Trust. It regularly reviews the balance, completeness, and appropriateness of the Board to meet such requirements through the Nominations Committee. Where appropriate, the Trust will look to recruit and / or retain individuals with certain skills and experience to ensure that this is maintained.
	4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.	
G4: NHS England guidance	1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.	The Trust responds to guidance issued by NHSE. Submissions and information provided to NHSE are approved through relevant and appropriate authorisation processes.
	2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.	
G5: Systems for compliance with licence conditions and related obligations	1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: a. the Conditions of this Licence, b. any requirements imposed on it under the NHS Acts, and c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	The Trust has systems and processes in place to ensure it complies with its Licence and this is co-ordinated by the Director of Strategy, Inclusion and Change and the Corporate Governance Team.
	2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and	

	b. regular review of whether those processes and systems have been implemented and of their effectiveness	
G6: Registration with the Care Quality Commission	1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.	The Trust is registered with the CQC and understands its duties in terms of notification and has systems and processes in place to manage these, should they occur.
	2. The Licensee shall notify NHS England promptly of: a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.	
	3. A notification given by the Licensee for the purposes of paragraph 2 shall: a. be made within 7 days of: i. the making of an application in the case of paragraph (a), or ii. becoming aware of the cancellation in the case of paragraph (b), and b. contain an explanation of the reasons (in so far as they are known to the Licensee) for: i. the making of an application in the case of paragraph (a), or ii. the cancellation in the case of paragraph (b).	
G7: Patient eligibility and selection criteria	1. The Licensee shall: a. set transparent eligibility and selection criteria, b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them	The Trust's website sets out the service directories for each Care Group (CG) and the relevant access criteria for the services.
	2. "Eligibility and selection criteria" means criteria for determining: a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and	

	b. if the person is selected, the manner in which the services are provided to the person	
G8: Application of section 6 (Continuity of Service)	1. The Conditions in Section 6 shall apply: a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service, b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2, c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension), d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service), e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider	Covers all services which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS). See CoS1.
	2. A service is designated as a Commissioner Requested Service if: a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4	
	3. A notice in accordance with this paragraph is a notice: a. in writing,	

	b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.	
	4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable	
	5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.	
	6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either: a. an instruction of the sort referred to in paragraph 7, or b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.	
	7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service	
	8. A service shall cease to be a Commissioner Requested Service if: a. all current Commissioners of that service as a	

	Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.	
	9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.	
	10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.	
	11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.	
	12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.	
	13. In this Condition “NHS contract” has the meaning given	

	to that term in Section 9 of the 2006 Act	
Section 4 – Trust Conditions NHS1: Information to update the register	1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	The Trust has provided all necessary documentation to NHS England as required and will make any necessary documentation available on request. Formal articulation of this Condition, therefore, does not present any issues for the Trust.
	2. The Licensee shall make available to NHS England written and electronic copies of the following documents: a. the current version of Licensee's constitution; b. the Licensee's most recently published annual accounts and any report of the auditor on them, and c. the Licensee's most recently published annual report, and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published	
	3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.	
	4. The obligation in paragraph 3 shall not apply to: a. any document provided pursuant to paragraph 2; b. any document originating from NHS England; or c. any document required by law to be provided to NHS England by another person	
	5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.	
	6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.	
NHS2: Governance arrangements	1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality	There are a number of areas to provide assurance that the Trust applies the principles, systems and

	of the other conditions in this Licence. 2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS 3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d. comply with the following paragraphs of this Condition 4. The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c. clear reporting lines and accountabilities throughout its organisation. 5. The Licensee shall establish and effectively implement systems and/or processes: a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems	standards of good corporate governance. • The Trust's Constitution, based on NHS England's model constitution, underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution. • A review of the Trust's Constitution was undertaken in December 2024. This was approved by Trust Board 28 January 2025 and ratified by the Members' Council on 14 February 2025. The constitution was updated in August 2025 to reflect the Trust's Teaching Trust status. The next review will be January 2027, or before this date if required. • The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. • Each committee of the Trust Board is required to prepare an annual report, which is presented to the Audit Committee. The Audit Committee reviews overall effectiveness of committee structures. This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in

	and/or processes to ensure the Licensee's ability to continue as a going concern); e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements.	April. • Each group and committee of the Members' Council is required to prepare an annual report and review of the terms of reference, which is reported to the Member's Council annually in April / May and provides assurance that each group / committee is meeting its terms of reference and work programme. • The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually. Directors and Governors are expected to declare any additions or changes to their declarations as and when they arise. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration. • See section G3 for fit and proper persons requirements and compliance. • All elections made to the Members' Council are held in accordance with the Model Election Rules in the Trust's Constitution and are overseen by an external organisation (currently Civica Election Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties. • The Trust has held a Licence since 1 April 2023. • The most recent Care Quality Commission (CQC) rating overall is good (which includes a rating of good for the well-led domain). • During 2025/26, the Board continued its development programme which included amongst other items, Trust strategy development, strategy measurement, , Trust Board effectiveness survey, and strategy
	6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	
	7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place	

	personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	alignment sessions. For 2025/26 the Head of Internal Audit Opinion is one of significant assurance on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Board Assurance Framework and Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Board's risk appetite statement which has been comprehensively updated in 2025/26
Section 5 – NHS Controlled Providers Conditions CP1: Governance arrangements for NHS-controlled providers	1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence. 2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS. 3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d. comply with the following paragraphs of this Condition. 4. The Licensee shall establish and implement: a. effective board and committee structures;	Not applicable.

	b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).	
	5. The Licensee shall establish and effectively implement systems and/or processes: a. to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements	
	6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes	

	take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	
	7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	
Section 6 – Continuity of Services CoS 1: Continuing provision of Commissioner Requested services	1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.	Under the Trust's 25/26 & 26/27 contracts with each integrated care board (ICB), Barnsley physical health services are classified as a Hard to Replace service. The Trust also provides secure adult services that are commissioner requested services, and the Trust is compliant with the terms of the licence.
	2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.	
	3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except: a. with the agreement in writing of all Commissioners to	

	which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.	
	4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.	
	5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in: a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.	
CoS 2: Restriction of the disposal of assets	1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")	Under the Trust's 25/26 & 26/27 contracts with each integrated care board (ICB), Barnsley physical health services are classified as a Hard to

	2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.	Replace service. The Trust also provides secure adult services that are commissioner requested services, and the Trust is compliant with the terms of the licence.
	3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.	
	4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern	
	5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except: a. with the consent in writing of NHS England, and b. in accordance with the paragraphs 6 to 8 of this Condition.	
	6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.	
	7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.	
	8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where: a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to: i. transactions of a specified description; or ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset	
	9. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding:	

	a. the manner in which asset registers should be established, maintained and updated, and b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.	
CoS 3: Standards of corporate governance, financial management and quality governance	1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as: a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider, b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress	The Trust has robust and comprehensive corporate and financial governance arrangements in place. Any adjustments have been approved through Trust Board during the year. Corporate and Financial governance arrangements remain subject to both internal and external audit annually. All audit plans are agreed by the Audit Committee and the outcome of all audit reports are received and reviewed at the Audit Committee. Where the outcome is of limited assurance, executive leads report back to Audit Committee on progress against action plans.
	2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance; b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.	
CoS 4: Undertaking from the ultimate controller	1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"): a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be	Not applicable to the Trust.

	likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.	
	2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.	
	3. The Licensee shall: a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it; b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and c. comply with any request which may be made by NHS England to enforce any such undertaking.	
	4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if: a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others	
	5. A person is not an ultimate controller if they are: a. a health service body, within the meaning of section 9 of the 2006 Act; b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;	

	c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or d. a trustee of the Licensee and the Licensee is a charity	
CoS 5: Risk pool levy	1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.	There is currently no risk pool levy in place.
	2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.	
CoS 6: Cooperation in the event of financial or quality stress	1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about: a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or c. the ability of the Licensee to carry on as a going concern.	The Trust submits monthly financial returns in line with all NHS providers. The Trust has been fully engaged in regular finance meetings with both West and South Yorkshire systems throughout 2025/26 and this will continue during 2026/27. For 2026/27 the Trust is now also engaging in regional finance business and development meetings. As a provider currently placed within Segment one, we continue to follow the single oversight framework requirements.
	2. When this paragraph applies the Licensee shall: a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct; b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.	
CoS 7: Availability of resources	1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources	The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver Commissioner Requested Services.
	2. The Licensee shall not enter into any agreement or	

	undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	
	3. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate	
	4. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.	
	5. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.	
	6. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.	
	8. In this Condition: “distribution” includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital; “Financial Year” means the period of twelve months over which the Licensee normally prepares its accounts; “Required Resources” means such: a. management resources including clinical leadership, b. appropriate and accurate information pertinent to the governance of quality c. financial resources and financial facilities, d. personnel, e. physical and other assets including rights, licences and consents relating to their use, f. subcontracts , and g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.	

Section 7 – Costing Conditions C1: Submission of costing information	1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall: a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.	The Trust responds to guidance and requests from NHSE. The Trust responds to guidance issued by NHSE. Submissions and information provided to NHSE are approved through relevant and appropriate authorisation processes. The Trust has in place a system for the review and dissemination of guidance/information to the executive management time and senior managers.
	2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.	
	3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors: a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and b. provides that information to NHS England in a timely manner.	
	4. Records required to be maintained by this Condition shall be kept for not less than six years	
C2: Provision of costing and costing related information	1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1	The Trust responds to requests from NHS England as required. Also see C1 above.

	consistent with the approved costing guidance in the form, manner and the timetable as prescribed.	
	2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that: a. in the case of information (data) or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested;	
	3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	
C3: Assuring the accuracy of pricing and costing information	1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.	See C1 and C2
	2. This may include but is not limited to a. Regular assessments by the providers internal and/or external auditor b. specific work by NHS England or NHS England nominated representative on costing related issues and c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information. d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.	
Section 8 – Pricing Conditions P1: Compliance with the NHS payment scheme	1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever	See above C1, C2 and C3.

<table>
<tr><td></td><td>applicable.</td><td></td></tr>
<tr><td>Section 9 – Interpretation and Definitions
Condition D1: Interpretation and Definitions</td><td>1. In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right-hand column of the table.

<table>
<tr><td>“the 2006 Act”</td><td>the National Health Service Act 2006 c.41;</td></tr>
<tr><td>“the 2008 Act”</td><td>the Health and Social Care Act 2008 c.14;</td></tr>
<tr><td>“the 2009 Act”</td><td>the Health Act 2009 c.21;</td></tr>
<tr><td>“the 2012 Act”</td><td>the Health and Social Care Act 2012 c.7;</td></tr>
<tr><td>“the 2022 Act”</td><td>The Health and Care Act 2022;</td></tr>
<tr><td>“the Care Quality Commission”</td><td>the Care Quality Commission established under section 1 of the 2008 Act;</td></tr>
<tr><td>“Commissioner Requested Service”</td><td>a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition;</td></tr>
<tr><td>“Commissioners”</td><td>NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB;</td></tr>
<tr><td>“Director”</td><td>includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of:
(i) an NHS foundation trust,
(ii) an NHS Trust or
(iii) a company constituted under the Companies Act 2006;</td></tr>
</table></td><td>This section determines NHSE interpretation and definitions and is for the Board to note and this document in its entirety complies with the guidance and conditions.</td></tr>
</table>

"Governor"	a Governor of an NHS foundation trust;
"Hard to replace provider"	has the meaning given in condition G8 of the licence;
"Integrated Care Board"	a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act;
"the NHS Acts"	the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act;
NHS Controlled provider	An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where 'control' is defined on the basis of IFRS 10;
"NHS England"	the body named as NHS England in section 1 of the 2022 Act;
"NHS foundation trust"	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act;
"NHS Trust"	an NHS trust established under section 25 of the 2006 Act;
"Relevant bodies"	NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act;
"Trusts"	means NHS foundation trusts and NHS trusts.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body

3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 13.2

Private/Public paper:	**Public**		
Title:	**Use of Trust Seal**		
Lead Director:	**Mark Brooks – Chief Executive** **Presented by: Andy Lister – Head of Corporate Governance/ Company secretary**		
Mission/values:	Effective governance, and compliance with the Trust's Constitution support the Trust to deliver its mission and adhere to its values.		
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal to the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.		
Strategic aims:	Live Our Values	✓	
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	Risk 5.2 - Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	Compliance with the Trust's Standing Orders provides assurance to systems and partners of the Trust's adherence to the framework within which the Trust operates and how its officers conduct Trust business.		

With **all of us** in mind.

Any background papers / previously considered by:	Quarterly reports on the use of the Trust Seal are presented to Trust Board. The last report to Trust Board was 31 March 2026.
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance and Resources of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The Trust Seal has not been used one occasion since the last report to Board in March 2026: • Renewal of lease agreement for 170 Sheffield Road, Barnsley. The property accommodates the Health Integration Team.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the update to the Trust Seal since the last report in March 2026.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board
30 June 2026
Agenda item 14.1

Private/Public paper:	**Public**		
Title:	**Digital Strategy 2024-30 – Strategy Progress Report**		
Lead Director:	**Adrian Snarr - Director of Finance, Estates and Resources**		
Mission/values:	Embedding a culture that embraces digital solutions within our approaches, ensures an integral way of supporting our staff and enabling our service users, carers, and wider communities to achieve their potential and live well based on value, need, risk, choice, and preference. Becoming a digitally mature organisation through innovation and continuous improvement is a priority for the Trust.		
Purpose:	The purpose of this report is to inform the Board of the progress, and developments made during the second half of 2025/26 and planned activities during first six months of 2026/27 in respect of the Trust's digital strategy delivery.		
Strategic aims:	Live Our Values	✓	The Trust's digital strategic agenda and programmes of work are aligned with Trust strategies and priorities. Digital spans all our strategic aims.
	Be the best we can be: • Best quality • Best partner • Best value • Best place to work and learn	 ✓ ✓ ✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	2.1 Services are not accessible to, nor effective, for all communities, especially those who are most disadvantaged, leading to inequality in health outcomes or life expectancy. 5.1 Inability to deliver efficiency and productivity improvements could adversely impact on staff experience and culture and our ability to provide services effectively. 5.2 Inability to develop digital and physical infrastructure and embed creative innovations, results in reduced ability to meet increasing demand, reduced accessibility to services and less efficient service provision. 6.3 Inability to build and sustain the right organisational capability, capacity and accountability, adversely impacts on our ability to deliver our strategic objectives and ambitions. Digital is an enabler and together with digital transformation activities supports the Trust in providing robust digital technologies, solutions, services, information, and insights, which assists in delivering services, productivity, and efficiency improvements, whilst bettering experiences for all and improving/maintaining quality.		

With all of us in mind.

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships and partner organisation objectives at national regional or local level.	The Trust's digital strategy spanning 2024-30 remains fully aligned with the digital priorities and objectives of our Integrated Care Systems, Integrated Care Boards and Place-based partnerships across West and South Yorkshire, and in-step with national strategic digital direction. Continued good progress is being made as presented in this report which serves to demonstrate our overall improving levels of digital maturity, providing the Trust Board with the assurances that our existing digital strategy and plans remain fit for purpose and relevant at all levels, especially given the emphasis placed on digital innovation and digital transformation within the three fundamental shifts in how the NHS is to be modernised over the coming decade as stated in the Fit for the Future: 10-year health plan.
Any background papers / previously considered by:	Digital Strategy 2024–30 approved by Board in January 2025 and the last progress update report provided in November 2025.
Executive summary:	**Summary of progress** The purpose of this report is to inform the Board of the good progress being made to date in delivering against the 2024-30 Digital Strategy during the second half of 2025/26 (Year 1). The report also provides a summary of the planned key activities for the next six months during 2026/27. The report highlights key achievements in 2025/26 and summarises progress against each digital domain, and the dashboard on page 17 provides a holistic view of the key initiatives across the broad spectrum of work in support of our ever-broadening digital agenda which also aligns with supporting delivery against the 10-year health plan. Below are some notable updates on progress by digital domain: - **Digital Accessibility** • *Patient Engagement Portal:* Good progress is being made enhancing the Trust's patient portal, Patients Know Best (PKB). Local developments have introduced Subject Access Requests (SARs) and the new Mental Health care plan, now available digitally within the PKB platform. • The Trust was successful in securing NHS England Wayfinder Programme funding in 2025/26 to further strengthen PKB integration with the NHS App, enabling the provision of the Friends & Family Test questionnaire via the NHS App. This initiative drives forward this initiative in line with the 10-Year Health Plan. **Digital Enabled Workforce** • *Trust-wide Digital Dictation Solution:* Following completion of the Trust-wide digital dictation solution (Lexacom) deployment, a smooth transition from project state to business-as-usual operations has been completed. • *Automated Minute Taking:* Following completion of the Microsoft Copilot proof-of-concept to aid with corporate meeting minute-taking, Digital & Technology Services have established the Microsoft Copilot licence request/approval process and have recently issued out Trust wide communications. A small number of Microsoft Copilot licence requests have been received and processed, with licences being issued. Weekly usage activity is being tracked and monitored on an ongoing basis in support of ensuring efficiencies are realised and delivering value for money. • *Ambient Voice Technology:* Robust and diligent clinical safety testing activities are progressing in support of the deployment of the Lexacom ambient voice technology (Lexacom ambient.ai) solution which builds on the

Trust-wide digital dictation Lexacom solution deployed. Lexacom ambient.ai integrates with the Trust's SystmOne EPR. Once clinical safety testing activities have been completed, deployment into the identified early adopter services will commence which will inform the subsequent wider-deployment approach across the Trust.

Digital Insights

- *Performance & Business Intelligence Work Programme 2025/26:* Significant progress has been made on activities and initiatives that formulate the Performance & Business Intelligence function's 2025/26 work programme in support of the Trust's priorities, digital strategy, and national direction. This work spans business as usual reporting, compliance with national reporting requirements and local development priorities.
- *Integrated Neighbourhood Teams Reporting:* Developments have been completed in line with the implementation plan and routine reporting is now complete which supports new ways of working in Barnsley Community Services.
- *Caseload Management Tool:* Following exploration of commercial solutions in the marketplace, the Trust opted to develop a caseload management capability internally, with initial development work completed and positive feedback from initial usage from services.

Digital information Sharing

- *Yorkshire & Humber Care Record (YHCR) Awareness Campaign:* The Systems Development team are continuing to focus on an awareness raising campaign to increase uptake and usage of the YHCR across the Trust, which remains relatively low.
- *ICE Integration with SystmOne:* All activities have been completed within Forensics services linked to Mid-Yorkshire NHS Foundation Trust ICE instance with results reported feeding back into SystmOne directly.
- *Data Security & Protection Toolkit (DSPT) 2026:* At the time of writing the report, evidence gathering activities are progressing as planned and nearing completion in support of the Trust's Data Security & Protection Toolkit submission in 2026.

Digital Care Records

- *Electronic Patient Record System Developments (SystmOne):* This is a major digital work programme that focuses on the optimisation and transformation of the Trust's electronic patient record (EPR), SystmOne. This work programme spans the introduction of new functionality, service redesign, systems integration and reducing the clinical administrative burden, with wraparound training and support. During the latter half of 2025/26 a significant amount of progress has been made, most notably conclusion of the integrated neighbourhood teams initiative.
- *Electronic Prescriptions & Medicines Administration (EPMA) & Electronic Prescription Service (EPS):* EPMA has been implemented in all inpatient areas at Cheswold Park Hospital. In response to system pressures, EPS was implemented in Barnsley care group virtual wards in Autumn 2025.

Cyber Security

- *Cyber Security Work Programme 2025/26:* The activities within the programme of work for cyber security in 2025/26 have been completed as planned following availability of required capital funding in-year being made

	available to support key digital infrastructure priorities due to Older People's development slippage. Notable activities successfully undertaken in the reporting period were Board cyber security awareness training, annual cyber security survey, cyber security tabletop exercise, penetration testing, and standards compliance. **Digital Infrastructure** • *Infrastructure Modernisation:* Activities to support the progression of the digital infrastructure work programme for 2025/26 have been completed as planned following availability of required capital funding in-year being made available to support key digital infrastructure priorities due to Older People's development slippage. • *Microsoft Developments 2026/27:* The annual review and renewal of the Trust's Microsoft enterprise-wide agreement have been completed slightly ahead of plan. This has realised a financial saving in 2026/27 resulting from licence rationalisation activities and a reduction in unit costs for some Microsoft licencing components. **Key risks** The key risks associated with the digital agenda are subject to constant review, with mitigating actions put in place, as necessary. **Financial investment** Capital underspend that became available in-year from the Older People's scheme during quarters 2 and 3 has enabled identified priority digital schemes to be completed during 2025/26. The Trust also submitted a number of bids for national Frontline Productivity funding in 2026/27, several of which have been supported following NHS England Regional team review and included as part of the regional submission for national review. Outcomes are expected to be communication from July onwards. **Overall summary rating** This report demonstrates that overall good incremental progress is being made against priorities across all digital domains. This puts the Trust in an advantageous position from which to further expand our digital capabilities during 2026/27 and beyond. The reported position is rated as Green overall.
Recommendation:	**Trust Board members are asked to:** **RECEIVE** the update and achievements made to date in respect of the digital focus areas.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Digital Strategy 2024-30

6-Month Progress Report



Chief Digital & Technology Officer

Chief Clinical Information Officer

May 2026

With **all of us** in mind.

www.southwestyorkshire.nhs.uk

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Purpose of report

The purpose of this report is to inform the Board of the progress made during the second half of 2025/26 detailing the end of year position with notable updates and achievements in how we are driving forward the Trust's digital agenda, since the last reported update was produced in October 2025.

Introduction

This report focuses on the progress in the last six months regarding the digital priority areas for 2025/26 that underpin delivery against the aims and objectives of the 2024-30 digital strategy. Given the nature of the various work programmes, work will continue during 2026/27 as reflected in the report. To provide a forward-looking view, the digital domains within the report have been mapped to the Trust's priorities for 2026/27. All key initiatives are incorporated into the digital strategy roadmap presented at the end of this report in Appendix A. The supporting detailed milestone delivery plan is contained separately within Appendix B.

Our continuous digital evolution journey

Digital services, technologies and solutions are becoming ever more prevalent both in the workplace and in everyday lives, and it is expected that reliance on digital and its continuous evolution will persist at an ever-increasing and accelerating pace, especially in respect of Artificial Intelligence (A.I.) opportunities and capabilities.

The 10-Year Health Plan released in July 2025 places greater emphasis on digital and data in enabling and supporting the delivery of the three key shifts. The 10-Year Health Plan recognises that the NHS is well placed to embrace and harness technological advances in A.I. and genomics science with the ambition for the NHS to become a global leader in digital health innovation.

Whilst the 10-Year Health Plan is aspirational and ambitious in nature, it is worth highlighting that some elements will be delivered at pace, whereas other components will take longer to come to fruition during the life of the plan. From a digital perspective, whilst digital transcends all three key shifts, the main focus is on the drive from analogue to digital, focusing on: -

- Developing the NHS App to become the NHS's front door for access, advice, and guidance. Development of a single patient record (SPR).
- Scalable adoption and use of A.I. and automation to release staff from administrative duties.
- Embracing A.I. ambient voice technologies to release time to care for clinicians and to improve clinical system user experiences.
- Better use of data and health intelligence, assisted by A.I., genomics and predictive analytics to inform population health needs (sickness to prevention).

We remain part of an NHS which is under pressure, dealing with changes in demand/acuity and longer waiting lists. We also have increased financial constraints and fundamental restructuring within a challenging economic climate. Through our Value for Money programme, there is an enduring expectation that digital will serve to provide opportunities for high quality service improvement, enhancing experiences for staff, service users, carers, and those accessing care,

whilst delivering efficiencies and productivity gains. However, it is worth remembering that digital is an enabler, but the ability and degree in which we can leverage service improvement and efficiencies from digital will be determined by our transformation approach from assessment, implementation, wider application potential, and adoption. It will be equally important that we ensure equitable access to services for all in line with individual preferences. Our quality improvement approach remains central in safeguarding how we deliver our priorities and strategic objectives in keeping with Trust values.

The ever-broadening digital landscape and increasing demand for digital brings its own challenges as there is a need to focus finite resources in line with the Trust's strategic aims and objectives. This requires balancing our internal priority programmes with those of our integrated care systems and places, whilst ensuring compliance with regulatory standards, and adherence with national direction and policy.

Across the NHS and within the Trust, we need to improve how we safely consider the potential application of digital technologies, and how we exploit digital innovation, including A.I., at pace. This will be key in how we drive forward the Trust's strategic objectives and demonstrate alignment to the 10-Year Health Plan. Our approach continues to be encouraging, supportive and enabling, underpinned with embedded robust governance to ensure that new and emerging digital opportunities are clinically led. Our Chief Clinical Information Officer continues to play a key role in engaging staff from across the organisation in key digital improvement and change programmes, retaining an emphasis on clinical and patient safety. Our digital priorities serve to deliver the aims and objectives set out in the 2024-30 digital strategy by: -

- Advocating improvements in **equitable access** to services for all by supporting a collective approach to understanding, addressing, and **overcoming accessibility challenges** digitally or otherwise, ensuring equity for all.
- Working collaboratively across our systems, at place and within the Trust to support the improvement of **digital literacy** and skills for all.
- Improve the digital skills, competencies, and confidence, nurturing a **digitally aware and capable workforce**, embracing flexibility and work-life balance in keeping with Trust values.
- **Better use of data and information in decision making** to improve how we deliver services and provide better care in keeping with needs.
- Providing a safe, supportive, and collaborative environment that openly encourages **a culture of digital opportunity** exploration at all levels.
- Excelling in exploiting **new and emerging digital innovation** opportunities that bolster quality service improvements and individual experiences, in a safe, sustainable, and efficient manner, underpinned by digital transformation and user-centred design.
- Keeping our staff, service users and carers' information **safe, protected, secure** and legitimately accessible in line with legislation and regulatory obligations.
- Sharing and adopting learning encourages **digital best practices**, reducing duplication and waste in processes to provide better care whilst improving quality and service user, carer, and staff experiences.

These are central themes that span all our digital domains and digital initiatives that are supported through an integrated approach to change.

How the digital strategy domains map to the Trust priorities for 2026/27

To support the implementation of the 2024-30 digital strategy, the digital domains are mapped against the Trust's current priorities as shown in the matrix below (Figure 1).

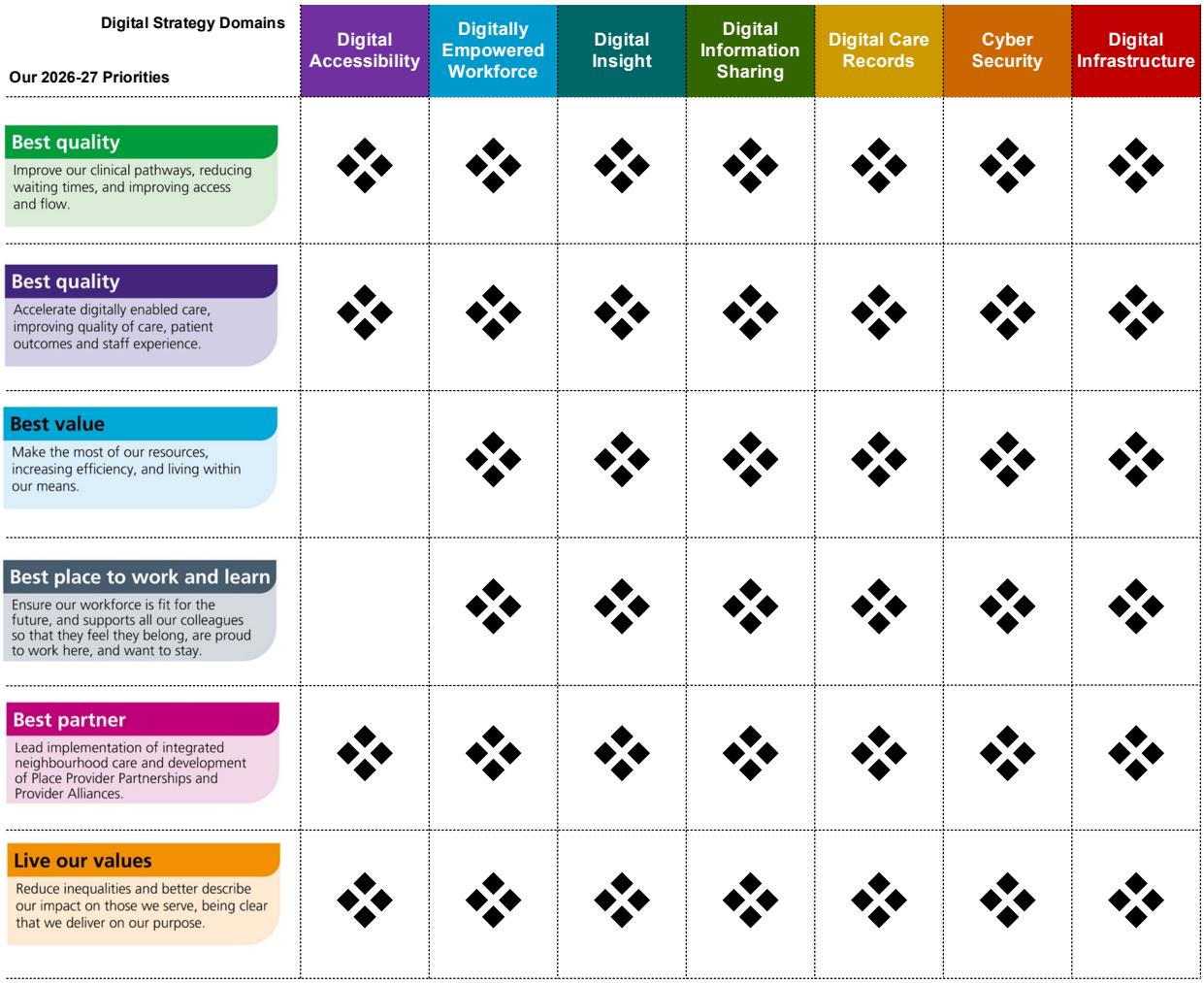


Figure 1

Summary of achievements in 2025/26

Below is a summary of the key achievements from the 2025/26 digital work programme.

Digital Accessibility

Achievements	Outcomes
★ Development & Provision of Friends & Family Test via the NHS App	✓ Improves communications
★ Appointment management	✓ Provides online access to relevant parts of the digital clinical record
★ Provision of Subject Access Requests in a digitally secure manner via Patients Know Best	✓ Supports self-management
★ Provision of Mental Health Care Plans from SystmOne available in PKB	✓ Improves consistency and data quality of service user related data collection through online input by individuals themselves, saving staff time
★ Significant progress and uptake in CAMHS using the IMX Digital Outcomes tool	

Digitally Empowered Workforce

Achievements	Outcomes
★ Completion of the Trust-wide Digital Dictation solution LEXACOM	✓ Improves standardisation
★ Automated minute taking proof of concept utilising Microsoft Copilot	✓ Supports the paperless agenda
★ Established and operationalised a process for requesting/approving Microsoft Copilot licences	✓ Improves service effectiveness and efficiency
	✓ Provides economies of scale
	✓ Improves administrative capacity and operational efficiencies
	✓ Makes best use of available resources and supports value for money

Digital Insight

Achievements	Outcomes
★ Neighbourhood Teams Service reporting	✓ Improves performance reporting
★ Datawarehouse Developments specifically Datix data feeds and incident data mapping for reporting	✓ Improves data quality
★ Replacement of the reporting server environment	✓ Improves service effectiveness and efficiency
★ Caseload Management Tool development	✓ Effective caseload management
	✓ Caseload acuity
	✓ Support productivity and enabling staff to work in line with good/best practice

Digital Information Sharing

Achievements	Outcomes
★ Yorkshire & Humber Care Record data provision	✓ Enhances holistic patient record view
★ SystmOne integration with ICE (Mid-Yorks NHS FT) in Forensics	✓ Supports informed clinical decision-making and patient care delivery through access to information in a timelier manner
★ Data Security & Protection Toolkit 2025 compliance	✓ Ability to update the test results directly into SystmOne
	✓ All toolkit mandatory standards met

Digital Care Records

Achievements	Outcomes
★ Integrated Neighbourhood Teams service deployment	✓ SystmOne is used more consistently & effectively
★ Deployment of EPMA across the Trust	✓ Supports development of new integrated models of care
★ Deployment of EPS within the Integrated Neighbourhood Teams service	✓ Supports reducing the administrative burden for staff
	✓ Reduces risks associated with medicines prescribing & dispensing
	✓ Prescribers can process prescriptions more efficiently
	✓ Improves service user experience and choice

Cyber Security

Achievements	Outcomes
★ SIEM Enhanced monitoring capabilities	✓ Continued vigilance and awareness of the risks that cyber security poses
★ Cyber security communications	✓ Proactive monitoring that counters potential cyber threats
★ Board cyber security awareness training	✓ Adoption of industry standards and best practice
★ Cyber Security standards compliancy and assurance achievements	✓ Improves the defence capabilities against a cyber attack

Digital Infrastructure

Achievements	Outcomes
★ Completion of the infrastructure modernisation programme for 2025/26	✓ Improved network resilience and availability
★ Completion of the Windows 11 migration	✓ A scalable infrastructure that can flex to meet changing needs
★ Email platform re-accreditation	✓ Improved enhanced software monitoring aiding licence management
★ Replacement of the telephony platform at Cheswold Park Hospital	✓ Ensures that we make the best use of available resources
★ LIFT building telephony platform replacement (Barnsley)	✓ Improved end user experiences

Summary of progress against each of the digital domains (May 2026 position)

Below is a summary of the main notable updates during this reporting period for each digital domain together with respective key activities planned over the next 6 months and associated key risks

Digital Accessibility

Overall Status	Trend	Aims & Objectives
		We will ensure that access to services either digitally or otherwise delivers the best outcomes and experiences for all, making sure that everyone has a voice in how they wish to interact and engage in their care based on individual preferences.

Our priorities for 2026-2027 that are supported



Notable updates	***Patient Engagement Portal & NHS App developments:*** Local developments have progressed with Subject Access Requests (SARs) and the new Mental Health care plans being made available digitally within the Patients Know Best (PKB) platform. In terms of national developments, the Trust was successful in securing NHS England Wayfinder Programme funding in 2025/26 to further strengthen integration with the NHS App, enabling the provision of the Friends & Family Test questionnaire via the NHS App. This initiative drives forward this initiative in line with the 10-Year Health Plan. ***Collecting & Reporting Health Outcomes:*** We have made enormous progress in CAMHS as previously reported, whereas uptake in adult mental health remains low.
Key Activities in the next 6 months	***Digital Inclusion:*** Finalise the revised paper in respect of the potential re-use/re-sale of decommissioned end user devices navigating the legal liability limitations. (**Oct 2026**) ***Patient Engagement Portal & NHS App developments*** ***Trust Digital Priority 2026/27:*** Development of the digitised mood dairy within PKB and planning for a service user/stakeholder feedback campaign based on the use of the PKB platform to inform future development plans and priorities. (**Dec 2026**) ***Collecting & Reporting Health Outcomes:*** Embedding use of outcome measures into practice through actions being put in place to support this (**Oct 2026**), explore the potential for completed outcome measures being visualised within PKB (**Oct 2026**) and continue to explore opportunities to develop additional digital patient reported outcome measures (PROMs) (**Ongoing**).

Key Risks	***Risk***	***Actions & Controls***	***Risk Score***
	Uptake of digital patient reported outcome measures (PROMs) in some services is relatively low.	• Plans are being put in place to raise awareness. • New care process training being implemented.	**9**

Digitally Empowered Workforce

Overall Status	Trend	Aims & Objectives
		To ensure that our staff are equipped with the requisite and optimised digital technology resources which are coupled with digital skills, competencies, and confidence from which to undertake their duties most effectively and efficiently. By improving such capabilities all staff will be supported in exploring new and emergent digital innovation opportunities, in line with our priorities, changing needs and demands.

Our priorities for 2026-2027 that are supported



Notable updates	***Trust-wide Digital Dictation Solution***: The accelerated deployment of the Trust-wide digital dictation solution has been completed with the project formally ending mid-November 2025. As part of formal project closure, activities have been completed to support the effective transition from project state to business-as-usual operations. ***Automated Microsoft Copilot Minute Taking:*** The Microsoft Copilot proof-of-concept initiative in response to capacity challenges within the Executive Management Team PAs team has been completed. Microsoft Copilot has proved to be extremely beneficial, with positive insights and feedback from staff involved in the proof-of-concept. This has helped to inform the wider deployment opportunities and potential efficiencies which are being carried forward in 2026/27. ***Microsoft Copilot Automated Minute Taking Wider Rollout:*** A proposal outlining the approach together with recommendations was presented to EMT, which was approved. Digital & Technology Services have established the Microsoft Copilot licence request/approval process based on the agreed approach and have recently issued out Trust wide communications. A small number of Microsoft Copilot licence requests have been received and processed, with licences being issued. Weekly usage activity is being tracked and monitored on an ongoing basis in support of ensuring efficiencies are realised and delivering value for money. ***Ambient Voice Technology (AVT):*** Preparatory activities are progressing in support of the deployment of the Lexacom ambient voice technology (Lexacom ambient.ai) solution which builds on the Trust-wide digital dictation Lexacom solution deployed. Lexacom ambient.ai integrates with the Trust's SystmOne EPR. Once clinical safety testing activities have been completed and service readiness confirmed, deployment into the identified early adopter services will commence. This will inform the subsequent wider-deployment approach across the Trust.
Key Activities in the next 6 months	***Microsoft Copilot Automated Minute Taking Wider Rollout*** ***Trust Digital Priority 2026/27*****:** A review of output from weekly feedback, analysis of benefits and time saved will be conducted, initially driven from weekly diary sheet (post deployment). It is anticipated that this will evolve further to drive richer datasets, track, and evidence the quantitative and qualitative benefits based on areas of application of Microsoft Copilot (**Mar 2027**). In addition to this, additional potential areas of application for using Microsoft Copilot will be explored, potentially via time-limited proof-of-concepts which will inform the potential business cases and wider deployment opportunities (**Mar 2027**).

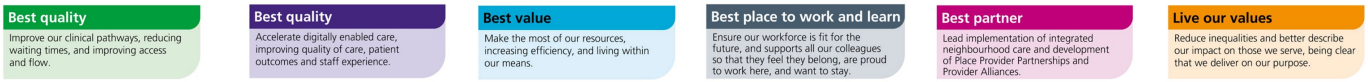
	Ambient Voice Technology (AVT) *Trust Digital Priority 2026/27:* Conclude and sign-off clinical safety activities (**Jun 2026**), enabling early adopter deployments to be undertaken. The insights from this will inform the planning and wider deployment of this capability across the Trust, with priorities determined by care group management (**Jul/Aug 2026 onwards**). ***Trust Workforce Digital Competencies:*** Explore ways in which we can determine the digital skills, learning requirements and aspirations via a digital competency self-assessment for staff, and from this develop a digital competency workforce plan (**Timescales to be confirmed**). ***New Workforce Solution (ESR Replacement):*** The Trust is currently mapping our existing people systems and interface landscape as part of early adopter in principle activities, identifying system and domain functionality benefits to confirm Trust intentions for functionality implementation. Included in this work will be a risk and impact assessment of 3rd party contract and the implications and resource considerations to enable the Trust to continue provision of payroll and occupational health services to 3rd parties where contracts are in place (**Jun 2026**).		
Key Risks	***Risk***	***Actions & Controls***	***Risk Score***
	Microsoft Copilot: Additional costs associated with provisioning of licences.	• Ongoing review of licence allocations/usage to be conducted with budget holders, managed by the IT team.	**12**
	AVT: Limited clinical safety capacity & capability within the Trust.	• The Trust has engaged a 3rd party specialist service provider to support the Trust's Clinicl Clinical Information Officer in completing requisite clinical safety activities.	**9**
	AVT: Demand for AVT outweighs capacity and resources.	• Effective planning and prioritisation, engagement and commmunications • The Trust has submitted a bid for national frontline productivity funding to supplement its AVT requirements during 2026/27.	**9**
	New Workforce Solution: Funding and resource commitments to enable the Trust to take forward this opportunity.	• Discussions ongoing with NHS England regarding the availability/release of the proposed funding to support resources (June 2026). • Draw down funding to initiative recruitment activities following early adopter confirmation.	**16**
	New Workforce Solution: Impact on potential double running of solutions to mitigate and manage continuation of payroll services to 3rd parties.	• Assessment of the potential implications and resource constraints to mitigate the risk	**16**

Digital Insight

Overall Status	Trend	Aims & Objectives

		We will make better use of data and information that underpins considered decision-making in how we design and deliver services that provide the best care and experiences for all, now and in the future. This will help to promote forecasting, benchmarking, and statistical analysis techniques that delivers information rather than data, garnering intelligence aiding effective decision making, improved data quality and accuracy, and better care.

Our priorities for 2026-2027 that are supported



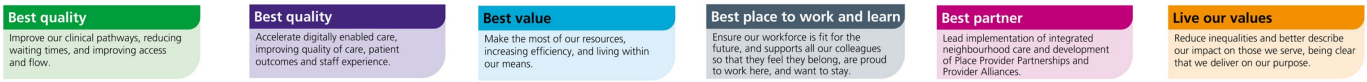
Notable updates	***Performance & Business Intelligence Work Programme 2025/26***: Significant progress has been made on activities and initiatives that formulate the Performance & Business Intelligence function's 2025/26 work programme in support of the Trust's priorities, digital strategy and national direction. This work spans business as usual reporting, compliance with national reporting requirements and local development priorities. ***Performance & Business Intelligence Work Programme 2026/27***: Given the nature of this work programme, there are areas of development which are ongoing and have been carried forward to be included in the 2026/27 work programme. Activities are ongoing. ***Caseload Management Tool:*** Following exploration of commercial solutions in the marketplace, the Trust opted to develop a caseload management capability internally, with initial development work completed and positive feedback from initial usage from services. ***EPR Data Mining Pilot Study:*** NHS England is funding a pilot with four NHS Trusts to improve Electronic Patient Record (EPR) usability and staff training through process mining, in partnership with the University of Leeds Data Science/Health Informatics team who will conduct process mining activities from October 2025 to February 2026. However, activities have been carried over into Quarter 1 2026/27. The project aims to identify and address challenges in EPR usage, improve productivity, and enhance care pathways using data analytics. The Trust put forward an expression of interest and was successful in being selected as one of the four NHS provider organisations to take part in this pilot study. Activities are ongoing.
Key Activities in the next 6 months	***Performance & Business Intelligence Work Programme 2026/27:*** To progress the work spanning business as usual reporting, compliance with national reporting requirements and local development priorities during 2026/27. ***Caseload Management Tool*** ***Trust Digital Priority 2026/27:*** Continue to deploy the solution across the Trust and identify potential future development enhnacements (**Ongoing**). ***EPR Data Mining Pilot Study:*** Conclude activities in relation to this study (**Jun 2026**).

Key Risks	***Risk***	***Actions & Controls***	***Risk Score***
	Performance & Business Intelligence Work Programme 2026/27: Capacity limitations within the team to continue to provide the necessary capability to support this key Trust programme of work.	• Effective prioritisation and review of the work programme in line with available resources and available capacity.	**9**

Digital Information Sharing

Status	Trend	Aims & Objectives
		The intensifying need for integrated pathway models of care necessitates the demand for ever-increasing information sharing and timely access to data, to inform clinical interventions, high quality care and decision making, founded on legitimate and appropriate levels of access. Interoperability and systems integration together with appropriate standards are fundamental components for this.

Our priorities for 2026-2027 that are supported



Notable updates	***Yorkshire & Humber Care Record (YHCR) Consumption Awareness Campaign***: The Systems Development team are continuing to focus on an awareness raising campaign to increase uptake and usage of the YHCR across the Trust, which remains relatively low. ***ICE Integration with SystmOne:*** All activities have been completed within Forensics services linked to Mid-Yorkshire NHS Foundation Trust ICE instance. ***Data Security & Protection Toolkit 2026:*** Evidence gathering activities are progressing as planned and nearing completion in support of the Trust's Data Security & Protection Toolkit submission in 2026.
Key Activities in the next 6 months	***Yorkshire & Humber Care Record (YHCR) Consumption Awareness Campaign***: An awareness campaign to raise the relatively usage of the YHCR across the Trust is in progress which is being co-ordinated by the Systems development team, incorporating awareness and engagement, training and support, Trust-wide communications, feedback and continuous improvement, liaision with partners, communication of new and available data. (**Mar 2027**) ***ICE Integration with SystmOne:*** Conclude deployment providing access to all remaining inpatient wards linked to Mid-Yorkshire NHS Foundation Trust ICE instance (**Aug 2026**). Following this, we will assign resource to the BHNFT Laboratory configuration and SystmOne set up (**Sep 2026**). ***Data Security & Protection Toolkit 2026:*** Conclude the work in support of the Trust's Data Security & Protection Toolkit submission in 2026 (**Jun 2026**) ***Data Security & Protection Toolkit 2027:*** Planning activities to commence the preparatory work in readiness for the Data Security & Protection Toolkit submission in 2027 (**Jun 2027**). ***Consent to Share Re-Engagement:*** Conclude the review of the revised paper detailing the Trust's approach and approvals via Trust governance mechanisms, enabling implementation activities to commence (**Jun 2026**).

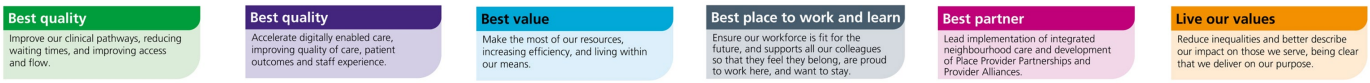
Key Risks	*Risk*	*Actions & Controls*	*Risk Score*
	Yorkshire & Humber Care Record (YHCR) Consumption Awareness Campaign: Continued low	• Focused awareness, communications, and engagement campaign activities to promote	**9**

	uptake and usage of the YHCR across the Trust.	opportunities and benefits through this information sharing platform. • Usage activity monitoring and reporting into the Digital Innovation Programme Board.	
	ICE Integration with SystmOne: Dependencies on external parties (ICE system supplier and Acute hospital partners) impacting the ability to move this forward in as timelier manner as the Trust requires.	• Liaise and collaborate with local acute partners and system suppliers to explore having access to their ICE systems and to work through clinical, operational, and technical challenges for mutual benefits.	**12**
	Consent to Share Re-Engagement: Failure to meet Trust agreement to give patients choice in sharing their sensitive data.	• Working group to consider options and develop a plan for Trust governance and approval. • Regular updates to the Improving Clinical Information Group (ICIG) for oversight and monitoring.	**9**

Digital Care Records

Status	Trend	Aims & Objectives
		A well-established and optimised electronic care records system is a cornerstone of an organisation's digital maturity. To realise this, it is imperative that the system functionality available is utilised to its full potential, so that benefits from its application can be maximised coupled with streamlined digitally enabled business processes.

Our priorities for 2026-2027 that are supported



Notable updates	***Electronic Patient Record System Developments***: This is a major digital work programme that focuses on the optimisation and transformation of the Trust's electronic patient record (EPR), SystmOne. This work programme spans the introduction of new functionality, service redesign, systems integration and reducing the clinical administrative burden, with wraparound training and support. During the latter half of 2025/26 a significant amount of progress has been made, most notably conclusion of the integrated neighbourhood teams initiative. ***EPMA & EPS Community:*** EPMA has been implemented in all inpatient areas at Cheswold Park Hospital. In response to system pressures, EPS was implemented in Barnsley care group virtual wards in Autumn 2025. ***Records Scanning Bureau System Implementation:*** The legacy scanners have been replaced and the contract for the new digital solution finalised.

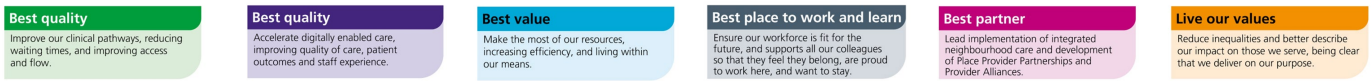
Key Activities in the next 6 months	***Electronic Patient Record System Developments***: Continuing to progress the introduction of new functionality, service redesign, systems integration and activities focused on reducing the clinical administrative burden through deploying functionality such as the Brigid App ***Trust Digital Priority 2026/27*** (**Ongoing to Mar 2027**). ***EPMA & EPS Community:*** Deployment of EPS SystmOne functionality within Community Services (Mental Health and Physical Health Community Services) (**Ongoing to Mar 2028**). ***Records Scanning Bureau System Implementation:*** Following replacement of the legacy scanners, activities are underway for the implementation of the Trust's new digital records management solution. A go live for the system is being scheduled (**July 2026**). ***EPR Procurement Collaborative*** ***Trust Digital Priority 2026/27:*** The Trust together with Bradford District Care NHS Foundation Trust (BDCT) are leading an EPR procurement collaborative with NHS provider partners across West and South West Yorkshire (circa 10 organisations potentially), for the reprovisioning of an EPR to support Mental Health Services and Physical Health & Wellbeing Services. Progress pre-procurement activities spanning establishment of the governance mechanism, stakeholder engagement and requirements gathering (**Sep 2026**).		
Key Risks	***Risk***	***Actions & Controls***	***Risk Score***
	Electronic Patient Record System Developments: Dependency on Systems Development team available resources and capacity to deliver the priorities and initiatives within the systems development work programme and roadmap timelines, as well as meeting operational service expectations.	• Ensure robust planning, resource development/assignment opportunities and prioritisation activities that are aligned with the work programme. • Working in close partnership with operational service management colleagues to align plans and prioritise requirements within the work programme.	**9**
	EPMA & EPS Community: Functionality does not work as expected or is not enabled by supplier.	• Utilising escalation pathway with supplier • Testing with community pharmacy in pilot unit	**8**
	Records Scanning Bureau System Implementation: Staffing capacity issues within the records management function.	• Activities are ongoing to address and alleviate service pressures. New staff members have been appointed to the wider records team which should aid with capacity challenges, enabling the risk score to reduce from 16 to 12.	**12**
	EPR Procurement Collaborative: Procurement activities are subject to delay resulting from the collaborative arrangements.	• Ensure agreement in the approach as detailed in the MOU to ensure that the procurement activities remain on track in line with the plan and timescales.	**12**

Cyber Security

Status	Trend	Aims & Objectives

		Cyber security is a significant organisational risk that could impact our ability of providing safe care and quality services to our service users and carers and adversely affect the Trust's ability to conduct its business operations effectively. Effective cyber security requires a balance between reactive capabilities and proactive measures, together with industry recognised good practice, which provides confidence and assurances.

Our priorities for 2026-2027 that are supported



Notable updates	***Cyber Security Work Programme 2025/26***: The activities within the programme of work for cyber security in 2025/26 have been completed as planned following availability of required capital funding in-year being made available to support key digital infrastructure priorities due to Older People's development slippage. Notable activities successfully undertaken in the reporting period were Board cyber security awareness training, annual cyber security survey, cyber security tabletop exercise, penetration testing and cyber essentials plus reaccreditation.
Key Activities in the next 6 months	***Cyber Security Work Programme 2026/27***: Preparatory activities are underway in respect of the cyber security work Programme for 2026/27 (**Ongoing to Mar 2027**).

Key Risks

Risk	*Actions & Controls*	*Risk Score*
Cyber Security Programme 2026/27: Limited capital funding available during 2026/27 may significantly impact the Trust's cyber security posture.	• Frontline Productivity investment fund expression of interest bids submitted to NHS England to supplement the cyber security investment plan.	**12**

Digital Infrastructure

Status	**Trend**	**Aims & Objectives**
		Ensures that the Trust has a strategically aligned, resilient and robust digital infrastructure that guarantees end user accessibility and performance, underpinned by enhanced business continuity and disaster recovery measures. The digital infrastructure provides the foundations from which all other digital domains and digital innovations are built upon.

Our priorities for 2026-2027 that are supported



Notable updates	***Infrastructure Modernisation Programme 2025/26***: Activities to support the progression of the digital infrastructure work programme for 2025/26 have been completed as planned following

<table>
<tr><td></td><td colspan="3">availability of required capital funding in-year being made available to support key digital infrastructure priorities due to Older People's development slippage.

Windows 11 Migration: All the Trust's end user computer estate now operates on Windows 11 which relies on Microsoft technologies, including Microsoft BitLocker for encryption. Whilst there remains a handful of non-standard Windows 10 devices in use in the Trust, there are appropriate mitigations, controls, and plans in place to address these.

Microsoft Developments 2026/27: The review and renewal of the Trust's Microsoft enterprise-wide agreement have been completed slightly ahead of plan. This has realised a financial saving in 2026/27 resulting from licence rationalisation activities and a reduction in unit costs for some Microsoft licencing components. (May 2026).</td></tr>
<tr><td>Key Activities in the next 6 months</td><td colspan="3">Infrastructure Modernisation Programme 2026/27: Preparatory activities have commenced with regards to the digital infrastructure work programme for 2026/27 (Ongoing to Mar 2027).

Decommissioning of the legacy Cheswold Park Hospital digital infrastructure: Only the OneTouch system used by Pharmacy remains but there are activities being progressed to remove this dependency and notice to terminate the contract has been served to the supplier, pending Pharmacy to complete and confirm decommissioning (Jul 2026).

Email Platform Re-Accreditation 2026/27: The planning, scheduling and re-accreditation activities have been completed as planned, confirming that the Trust's @swyt.nhs.uk email platform meets the required standards for the next 12 months (Dec 2026).

Microsoft Developments 2026/27: Evaluate and consider opportunities to further enhance the Trust's use of its Microsoft Office365 platform entitlement (Ongoing to Mar 2027).

CAMHS Secure Estate Infrastructure: Activities are in progress awaiting installation of the data/network circuits for the establishment of the Trust network infrastructure at Wetherby Young Offenders Institution, Adel Beck (Leeds), and Aldine House (Sheffield) (Sep 2026).</td></tr>
<tr><td>Key Risks</td><td>Risk</td><td>Actions & Controls</td><td>Risk Score</td></tr>
<tr><td></td><td>Infrastructure Modernisation Programme 2026/27: Limited capital funding available during 2026/27 may significantly impact the Trust's digital infrastructure programme.</td><td>• Frontline Productivity investment fund expression of interest bids submitted to NHS England to supplement the Trust's digital infrastructure investment plan.</td><td>12</td></tr>
</table>

Digital strategy progress - metrics

Table 1 presents the metrics based for the 2025/26 digital priorities and Table 2 provides the operational 'business as usual' quarterly volumetrics that underpin Digital & Technology services.

MARCH 2026 POSITION		2025/26					
Digital Domain & Initiative	Metric	Q1	Q2	Q3	Q4	Annual Total	Key supporting comments by exception
DIGITAL INFRASTRUCTURE							
Cyber Security & Threat Monitoring	% of NHS England high severity CareCert threat notifications acknowledged by the Trust within 48 hours of receipt (Target 100%)	100% (4)	100% (5)	100% (6)	100% (7)	100% (22)	All high severity CareCerts issued have been responded to within the requisite timeframes.
	% of NHS England high severity CareCert threat notifications issued that the Trust has completed remediation for within 14 days (Target 100%)	100% (4)	100% (5)	100% (6)	100% (7)	100% (22)	All high severity CareCerts issued have been investigated and remediated as appropriate within the required 14 days.
DIGITAL INFORMATION SHARING							
Yorkshire & Humber Care Record (YHCR) data consumption	Number of staff accessing the YHCR/Interweave shared care record portal	95	90	95	143	423	Work is ongoing internally to raise awareness and usage of the YHCR shared care record.
	Number of YHCR records accessed by staff	242	218	132	218	810	
DIGITALLY ENABLED WORKFORCE							
Trust-wide Digital Dictation	Number of clinicians able to use Trust-wide digital dictation solution	983	1,432	1398	1362		The project formally ended in November 2025 and ongoing support and development transitioned to business as usual as part of the project closure process.
DIGITALLY ENABLING SERVICE USERS & CARERS							
Digital Patient Engagement Portal Access	Number of service users registered to access their digital personal health records through Patients Know Best (PKB)	17,628	22,748	27,189	32,517		The number of service user registrations continues to increase month on month
Mental Health Annual Physical Health Checks	Number of APHCs undertaken at point of care within the Trust	452	508	539	537	2036	
Collecting and Reporting Health Outcomes	Number of service user completed digital health outcome questionnaires returned to the Trust.	389	758	674	778	2599	

Table 1

MARCH 2026 POSITION	2024/25					2025/26					Annual Totals Variation (2025/26 - 2024/25)	
IT OPERATIONS VOLUMETRICS	Q1	Q2	Q3	Q4	Annual Total	Q1	Q2	Q3	Q4	Annual Total		
Total numbers of tickets logged with Service Desk	16,630	16,808	14,074	14,450	61,962	12,985	13,915	12,267	12,788	51,955	-10,007	↓
Average time taken to resolve IT services requests/incidents**				2.89		2.38	2.76	3.38	2.89			
Total tickets emailed to service desk	11,743	12,246	9,418	10,044	43,451	9,205	9,805	8,741	9,443	37,194	-6,257	↓
Total tickets phoned to service desk	4,887	4,562	4,656	4,406	18,511	3,780	4,110	3,526	3,345	14,761	-3,750	↓
Total phone calls to service desk	6,688	7,574	6,146	6,175	26,583	5,695	6,378	5,259	5,671	23,003	-3,580	↓
Number of new registrations on NHS Wi-Fi (Patient Wi-Fi)	1,096	954	1,034	1,344	4,428	1,494	2,112	2,578	1,507	7,691	3,263	↑
New network accounts created	501	650	418	395	1,964	338	318	404	461	1,521	-443	↓
Number of SystmOne tickets (system requests/amendments)	1,018	1,005	939	970	3,932	879	937	926	1,017	3,759	-173	↓
Number of Smartcard related tickets	1,698	1,464	1,441	1,543	6,146	1,390	1,490	1,293	1,590	5,763	-383	↓
Number of staff with VPN at present	4,465	4,458	4,474	4,471		4,454	4,367	4,368	4,341			
Average number of daily VPN connections	3,597	3,809	3,885	4,044		3,731	3,281	2,010	860			
Number of Microsoft Teams 1:1 Calls	29,103	30,917	31,994	37,253	129,267	29,763	29,350	30,195	32,246	121,554	-7,713	↓
Number of Microsoft Teams meetings participated in	50,985	56,955	56,264	65,075	229,279	60,353	59,926	59,669	65,473	245,421	16,142	↑
Number of Microsoft Teams Messages (Chat function)	488,562	514,427	596,881	596,057	2,195,927	543,157	537,019	570,672	596,325	2,247,173	51,246	↑
New/replacement Smartphones provided to end users	241	449	247	444	1,381	284	243	188	155	870	-511	↓
New/replacement voice-only mobile phones provided to end users	107	28	28	52	215	36	61	35	55	187	-28	↓

**This is based on raw data and includes the time taken waiting on end users to respond and become available for visits.

Table 2

Digital strategy dashboard (April 2026 position)

Figure 2 presents the dashboard summarising all the digital initiatives by digital strategy domain.

September 2025 Position		DIGITAL DOMAINS & INITIATIVES	2025/26 - APRIL 2026 REPORTED POSITION		
RAG Status	Progress Indicator		RAG Status	Progress Indicator	Key supporting comments by exception
DIGITAL ACCESSIBILITY					
G	↗	Digital Inclusion	A	↗	The paper being prepared regarding the potential re-use/re-sale of decommissioned end user devices navigating the legal liabilities has been delayed.
G	↗	Patient Engagement Portal Developments (PKB & NHS App)	G	↗	
G/A	↗	Collecting and Reporting Health Outcomes	A	↗	Whilst significant progress has been made in CAMHS, adult mental health service uptake remains low and a series of actions are being put in place to address this.
DIGITALLY EMPOWERED WORKFORCE					
G	↗	Microsoft SharePoint365 Developments 2025/26	C	✓	
G	↗	Trust-wide Digital Dictation Solution	C	✓	The project formally ended in November 2025 and ongoing support transitioned to business as usual.
A	↗	Automated Microsoft Teams Minute Taking (Proof of Concept)	C	✓	The proof of concept has been completed and copilot has proved to be extremely beneficial, with positive insights and feedback from staff involved.
P	→	Microsoft Copilot automated minute taking wider rollout	G	↗	
P	↗	Ambient Voice Technology (AVT)	G	↗	Clinical safety testing is nearing completion and once governance approvals confirmed, early adopter service deployment will commence ahead of wider Trust-wide deployment.
P	→	Trust Workforce Digital Competencies	G	↗	
		Trust Workforce Digital Competencies	G	↗	The Trust is engaging in the early adopter in principle activities.
DIGITAL INSIGHT					
G	↗	Performance & Business Intelligence Work Programme 2025/26	G	↗	Significant progress has been made on the work programme during 2025/26
G	↗	Performance & Business Intelligence Work Programme 2026/27	G	↗	
G	↗	Caseload Management	C	✓	Initial development work has been completed and the tool is being actively deployed.
G	↗	EPR Data Mining Pilot Study	G	↗	Following being selected as one of four NHS Trusts to take part in this pilot study, mobilisation activities are being established
P	→	Federated Data Platform Onboarding - Costings	P	→	
DIGITAL INFORMATION SHARING					
A	↗	Yorkshire & Humber Care Record (YHCR) Consumption Awareness Campaign	A	↗	An awareness raising campaign to increase uptake and usage of the YHCR across the Trust is continuing.
A	↗	ICE Integration with SystmOne	A	↗	All activities have been completed for Forensics and we are rolling out access to remaining inpatient wards linked to Mid-Yorks ICE instance. Activities remain on going.
G	↗	Information Goverance 2026	G	↗	Evidence gathering activities are progressing as planned and nearing completion in support of the Trust's Data Security & Protection Toolkit submission in 2026.
		Information Goverance 2027	P	→	
A	→	Consent to Share Re-Engagement	A/R	↗	A revision of the previous paper detailing the Trust's approach is currently undergoing review prior to formal governance approvals.
DIGITAL CARE RECORDS					
G	↗	Electronic Patient Record System Developments	G	↗	During the latter half of 2025/26 a significant amount of progress has been made, most notably conclusion of the integrated neighbourhood teams initiative.
G/A	↗	EPMA & EPS Community	G	↗	
R	↗	Records Scanning Bureau System Implementation	G/A	↗	Legacy scanners have been replaced and the implementation of the new system is being scheduled for go live in July 2026.
		EPR Procurement Collaborative	G	↗	The Trust together with Bradford District Care Trust are leading an EPR procurement collaborative across West & South Yorkshire with preparatory activities underway.
CYBER SECURITY					
G	↗	Cyber Security Programme 2025/26	C	✓	The activities within the programme of work for cyber security in 2025/26 have been completed as planned, following availability of capital funding in-year.
		Cyber Security Programme 2025/26	G	↗	Preparatory activities are underway in respect of the cyber security work Programme for 2026/27.
DIGITAL INFRASTRUCTURE					
G	↗	Infrastructure Modernisation Programme 2025/26	C	✓	The planned activities within the digital infrastructure work programme for 2025/26 have been completed following availability of required capital funding in-year.
		Infrastructure Modernisation Programme 2026/27	G	↗	Preparatory activities have commenced with regards to the digital infrastructure work programme for 2026/27.
G	↗	Decommissioning of the legacy Cheswold Park Hospital Digital Infrastructure	G	↗	
G	↗	Microsoft Developments	G	↗	The review and renewal of the Trust's Microsoft enterprise-wide agreement have been completed slightly ahead of plan. This has realised a financial saving in 2026/27.
C	✓	Windows 11 Migration	C	✓	All the Trust's end user computer estate is now Windows 11 .
		Email Platform Re-Accreditation 2026	G	↗	Activities have been completed and re-accreditation confirmed.
A/R	↗	CAMHS Secure Estate Infrastructure	A/R	↗	Activities are in progress awaiting installation of the data/network circuits for the establishment of the Trust network infrastructure at the three sites.

Dashboard Key

C	Completed	G	On track	G/A	On track but management of risk needed	A	Off track but in control	A/R	Off track with urgent action being taken to address risk/issue	R	Off track major issues impacting overall viability
P	Planned for the future	↗	Improving position	→	No progress	↘	Deteriorating position	✓	Completed activities	➢	Ongoing activities

Figure 2

Financial Investment

2025/26 Digital Capital Allocation Requested

Due to the financial position across the system, the entire Trust's capital allocation for 2025/26 was allocated to the Older Peoples development scheme as the main priority. Therefore, no capital was allocated for digital schemes in 2025/26. However, due to underspend that became available in-year from the Older People's scheme during quarter 2, this enabled identified priority digital schemes to progress, as reported in Table 3 below, together with additional digital schemes mobilised in quarter 3 to account for further underspend. The Trust was also successful in securing external digital capital funding via the NHS England Wayfinder Programme, which focused on NHS App integration with the Trust's patient engagement portal, Patients Know Best (PKB), in support of the 10-Year Health Plan.

Digitial Capital Schemes	2025/26 (£'000s)				Scheme Owner
	Capital Allocation Requested	Capital Allocated	Capital Expenditure	Variation	
Digital Schemes (Allocated)					
Digital Infrastructure	664	0	1,275	1,275	IM&T
Cyber Security	75	0	14	14	IM&T
Pharmacy System Upgrade	50	0	25	25	Pharmacy
Sub Total	***789***	***0***	***1,314***	***1,314***	
Additional Digital Schemes (currently being finalised)					
Digital Accessibility	0	0	263	263	IM&T
Digital Information Sharing	0	0	650	650	IM&T
Electronic Document Management System Replacement Scanners	0	0	123	123	Records Management
Sub Total	***0***	***0***	***1,036***	***1,036***	
External Digital Capital Funding Secured					
NHS England WayFinder Programme (NHS App Integration)	148	148	148	0	IM&T
Sub Total	***148***	***148***	***148***	***0***	
Overall Trust Digital Capital Total	**937**	**0**	**2,498**	**2,350**	

Table 3

2026/27 Digital Capital Allocation Requested

For 2026/27, a capital allocation of £2.5m has been confirmed to support the digital priorities, with the schemes summarised below in Table 4. Activities in currently in the planning stage.

Digitial Capital Schemes	2026/27 (£'000s)				Scheme Owner
	Capital Allocation Requested	Capital Allocated	Capital Expenditure	Variation	
Digital Schemes (Allocated)					
Digital Infrastructure	1,650	1,650	0	(1,650)	Digital & Technology
Cyber Security	250	250	0	(250)	Digital & Technology
Digital Care Records	200	200	0	(200)	Digital & Technology
Digital Information Sharing	100	100	0	(100)	Digital & Technology
Digital Insights	200	200	0	(200)	Digital & Technology
Digitally Empowered Workforce	100	100	0	(100)	Digital & Technology
Sub Total	***2,500***	***2,500***	***0***	***(2,500)***	
Overall Trust Digital Capital Total	**2,500**	**2,500**	**0**	**(2,500)**	

Table 4

Frontline Productivity Investment Fund

The National Frontline Productivity Investment Fund serves to allocate circa £250m to the North East & Yorkshire region over the next four years commencing in 2026/27 and split 50/50 between acute and non-acute services (mental health, community and primary care). The funding will also be split between capital and revenue over the term, with funding allocated against specific digital categories, namely Infrastructure, Cyber Security, EPR Optimisation, EPR Systems and Digital Medicines.

Bids are focused on 2026/27 priorities presently, and all funding must be matched 50/50 and used solely for transformational change, except for cyber security. All bids must show how they will meet productivity improvements and deliver measurable benefits. The total allocation for 2026/27 for the North East & Yorkshire Region is circa £39m. NHS England regional team received over 500 bids and the funding allocation was oversubscribed, so bids have been prioritised and RAG rated.

GREEN	included in the 2026/27 submission
AMBER	not included in the 2026/27 submission but may be considered in future year funding opportunities
RED	not included as this is considered out of scope for the programme

The region has submitted the initial Frontline Productivity return for 2026/27 funding. The regional submission is based on the 2026/27 allocations only and is now subject to national approval which is expected in July 2026. Table 5 below summarises the Trust's submitted bids and RAG status.

Frontline Productivity Category	Summary of proposal	Bid value	Funding type	RAG Status
EPR Optimisation	**Ambient Voice Technology** To support the accelerated deployment of the Trust's Lexacom Ambient.AI solution spanning licences, handheld microphones,	£80,000	Revenue	G
EPR Optimisation	**Clinical Safety Officer Capability & Capacity Improvement Programme** To increase clinical safety officer capabilities and capacity within the Trust to aid digital innovation and transformation activities by engaging a 3rd party specialist services partner to provide a CSO training course, clinical safety documentation review, provision of a hazard log production tool and enhanced clinical risk management process	£25,000	Revenue	G
Digital Medicines	**EPS Implementation** Potentially to offset the costs approved for the recently approved business case to support the EPS implementation across the Trust	£75,000	Revenue	G
Infrastructure	**Wireless Network Modernisation & Coverage** To support the modernisation of the Trust's wireless network spanning upgrades, Wi-Fi coverage surveys to inform and increase network coverage through additional access point (AP) deployment.	£250,000	Capital	G
Cyber Security	**SIEM Solution transitioning** Tactical positioning - to support the transition and migration from Trust's existing Rapid7 SIEM solution to Microsoft Sentinel to enable the Trust to onboard to the National Microsoft Sentinel environment down stream	150,000	Capital	G
Cyber Security	**Multi-Factor Authentication** To enable the Trust further implement MFA across the Trust for the remaining department systems not comprehensively covered via the existing MFA established environment	£150,000	Capital	G
Cyber Security	**VEEAM Backup Enhancements** To enable the Trust to further enhance its backup resiliency improving its immutable backup and recovery capabilities to minimise the impact to the organisation as a result of a cyber-attack. The focus is for accessing the backup review service and recovering testing.	£75,000	Capital	G

Frontline Productivity Category	Summary of proposal	Bid value	Funding type	RAG Status
EPR Optimisation	**Caseload Management Tool Development** To develop and implement an internally led Caseload Management Tool to improve productivity, caseload oversight, clinical flow, and equitable allocation across community mental health services	£60,000	Revenue	A
EPR Optimisation	**Time-to-Care Productivity & Capacity Insight** Trust-designed programme to understand how staff use time, surface operational friction, and release capacity back into patient care without increasing cost or workload. Combines a standardised activity framework, a simple digital capture app (Time to Care), and automated analytics (Power BI) to show how work is done across services.	£50,000	Revenue	A
EPR Optimisation	**Digital Screening & Triage Tool development** Sets out an approach to replicate and scale the successful AI/Machine Learning screening tool—originally developed for Adult ASD/ADHD assessments—across additional clinical pathways	£35,000	Revenue	A
EPR Optimisation	Single Point of Access (SPA) Phased Digital Front Door, Adults, Neuro Diversity and CAMHs This proposal implements a Trust wide Single Point of Access (SPA) Digital Front Door—a cloud hosted electronic referral and workflow platform replacing email based, manual intake across	£118,000 £120,000	Revenue Capital	A
EPR Systems	**EPR Procurement Collaborative** To support the WY/SY NHS Providers (Mental Health & Community) collaborative in preparing and undertaking the EPR procurement exercise – currently spanning potentially 9 organisations – led by SWYPFT and BDCT	£600,000	Revenue	A
Infrastructure	**Network Hardware & SD-WAN Modernisation** To support the modernisation of the Trust's network spanning upgrades to network hardware, SD-WAN upgrades	£300,000	Capital	A
EPR Optimisation	**Development & maximising utilisation of SystmOne visualisations** To further develop and maximise the utilisation of 'about me' dashboards for each care group that present key patient and clinical information in a clear and easy to navigate format to enable clinicians to rapidly understand key patient information without having to navigate complex and lengthy records to improve productivity and efficiency and release capacity back into patient care.	£75,000	Revenue	R
Infrastructure	**End User device refresh & optimisation** To support the provision of tablet/smartphone devices for use with the Trust's EPR SystmOne Brigid App in support of digital transformation	£120,000	Revenue	R
Cyber Security	**Cyber Incident Response Exercise Service & Cyber Incident Grab Bags** To improve the Trust effectiveness in its response as a result of a cyber-attack incident. Reviewing, revising and improving its processes, documentation, management and governance as part of crisis management planning	£75,000	Capital	R

Table 5

Key risks

The provision of digitally enabled services remains vital in enabling Trust staff to deliver safe care. Whilst the progress set out in this report continues to reduce the likelihood of risk associated with digital system failure, Table 6 highlights the key risks that require sustained focus and advancement of remedial controls and measures. The overall risk appetite is considered low with a target score of 1-6.

Risk	Summary	Actions, controls, and measures
Cyber Security. (ORR 1080)	Risk that the Trust's Digital/IT infrastructure and corporate/clinical information systems could be the target of cyber-crime leading to theft of personal data or loss of service availability.	• Persistent infrastructure modernisation programme spanning proactive strategic roadmap planning, replacement/decommissioning; business continuity & disaster recovery; network resilience and application availability. • This incorporates stringent service management and cyber security enhancements, establishing further controls, measures and safeguards to mitigate the risk and likelihood of the threat of cyber-attacks.
Capacity & capability to deliver on all digital priorities.	Dependency on limited available resources and capacity to deliver against all digital priorities.	• Exploration of options to expand scarce specialist resources available, such as graduate schemes, apprenticeships, internal development opportunities, and engagement of third-party professional services suppliers.

		• Careful management and prioritisation of the digital work programmes aligned with Trust priorities, national direction, and associated timelines.
Capacity within Care Group services to consider digital innovation	There is a dependency on frontline operational services staff to collaborate in exploring the potential deployment and adoption opportunities to drive forward frontline digital innovations, due to existing operational service pressures.	• Collaborate with Care Group management regarding timing/scope to ascertain impact on services and explore avenues that enable consideration of digital innovations that could aid in reducing clinical admin burden and increasing time-to care. • Digital aspirations are being captured as part of the planning process and will help to inform the priorities for the digital work programme for 2026/27 and beyond.
Ever-increasing demand and reliance upon digital technologies (including A.I.)	The ability to continue to meet expectations brought about by significantly heightened digital needs/aspirations to aid productivity & efficiency gains and potential cost savings.	• Careful management of expectations through robust communications and engagement planning. • Appropriate governance and assurance, and key lines of enquiry to support the Value for Money programme. • Revised digital governance arrangements incorporating A.I. considerations.
Increased costs due to the current economic climate	As in all walks of life, we are experiencing an increase in costs associated with digital technologies, solutions, and services.	• Ensure that increased costs avoidance opportunities are explored consistently. • Ensure procurement frameworks and collaborative purchasing arrangements are exploited where possible to enable best value outcomes. • Exploit market opportunities to extend current contracts on existing terms where possible and in the best interests of the Trust. • Ensure that value for money is clearly demonstrated through benefits realisation and return on investment.
Potential risks associated with the introduction of digital health innovations including apps and solutions that have built-in artificial intelligence (A.I.) capabilities	Digital health innovations that are clinical and/or service user focused are considered to be medical devices. Whilst the Trust has robust governance mechanisms in place, there is a need to ensure close alignment of the respective assessment processes and governance to minimise potential clinical risks.	• The Trust has developed a governance framework for digital innovation incorporating A.I. capabilities that provides approach co-ordination considering robust procurement, IT, IG, clinical safety, and medical devices governance mechanisms in place. • Revised digital governance arrangements incorporating A.I. considerations. • An A.I. community of interest group has been established chaired by the Trust's Chief Clinical Information Officer (CCIO) with stakeholder representation to discuss and explore potential need and areas of application.
Limited clinical safety resource capacity & capabilities	Impacting the Trust's ability to clinically assess, evaluate and test digital innovation opportunities (including A.I.) in a comprehensively robust and timely manner, impacting deployment and adoption.	• Specialist 3rd party service provider commissioned to support CSO activities specifically for ambient voice technology. • A paper is being readied for Trust consideration regarding expanding CSO capacity and capabilities by establishing a network of clinical digital leads across different care settings/disciplines incorporating CSO activities. • A Frontline Productivity funding bid has been submitted to establish a CSO training programme, endorsed by NHS England Regional team and submitted for national panel review.

Table 6

Digital Maturity Assessment (DMA) 2025

NHS England has now published the 2025 digital maturity assessment (self-assessment) results. The Trust completed separate DMA submissions for Mental Health and Community Services. This activity was co-ordinated and managed by Digital & Technology services management who involved relevant subject matter experts in curating the submission response. Table 7 presents the scores for each of the 'What Good Looks Like' (WGLL) pillars, comparing the Trust's position with that of our peers across South and West Yorkshire.

Region	North East & Yorkshire									
ICS	NHS South Yorkshire Integrated Care Board			NHS West Yorkshire Integrated Care Board						
Provider	Rotherham, Doncaster and South Humber NHS Foundation Trust		Sheffield Health & Social Care Foundation Trust	Bradford District Care NHS Foundation Trust		Leeds and York Partnership NHS Foundation Trust	Leeds Community Healthcare NHS Trust		South West Yorkshire Partnership NHS Foundation Trust	
WGLL Pillars	Community	Mental Health	Mental Health	Community	Mental Health	Mental Health	Community	Mental Health	Community	Mental Health
Well Led	2.3	2.3	2.5	3.5	3.5	2.5	2.0	2.0	2.8	2.8
Ensure Smart Foundations	2.9	3.0	2.4	2.7	2.8	2.1	2.4	2.3	3.1	3.2
Safe Practice	3.0	3.0	2.3	1.8	1.8	2.3	3.8	3.8	3.0	3.0
Support Workforce	2.8	2.8	2.5	2.5	2.5	1.8	2.0	2.0	3.5	3.5
Empower People	1.6	1.6	1.6	1.4	1.4	1.7	1.7	1.7	2.1	2.1
Improve Care	2.6	2.8	1.5	1.6	1.5	2.3	2.4	2.5	2.0	1.8
Health Populations	2.0	2.0	1.8	1.6	1.6	2.4	1.8	1.8	3.0	3.0
Overall Total	2.5	2.5	2.1	2.2	2.3	2.1	2.3	2.3	2.8	2.8

Table 7

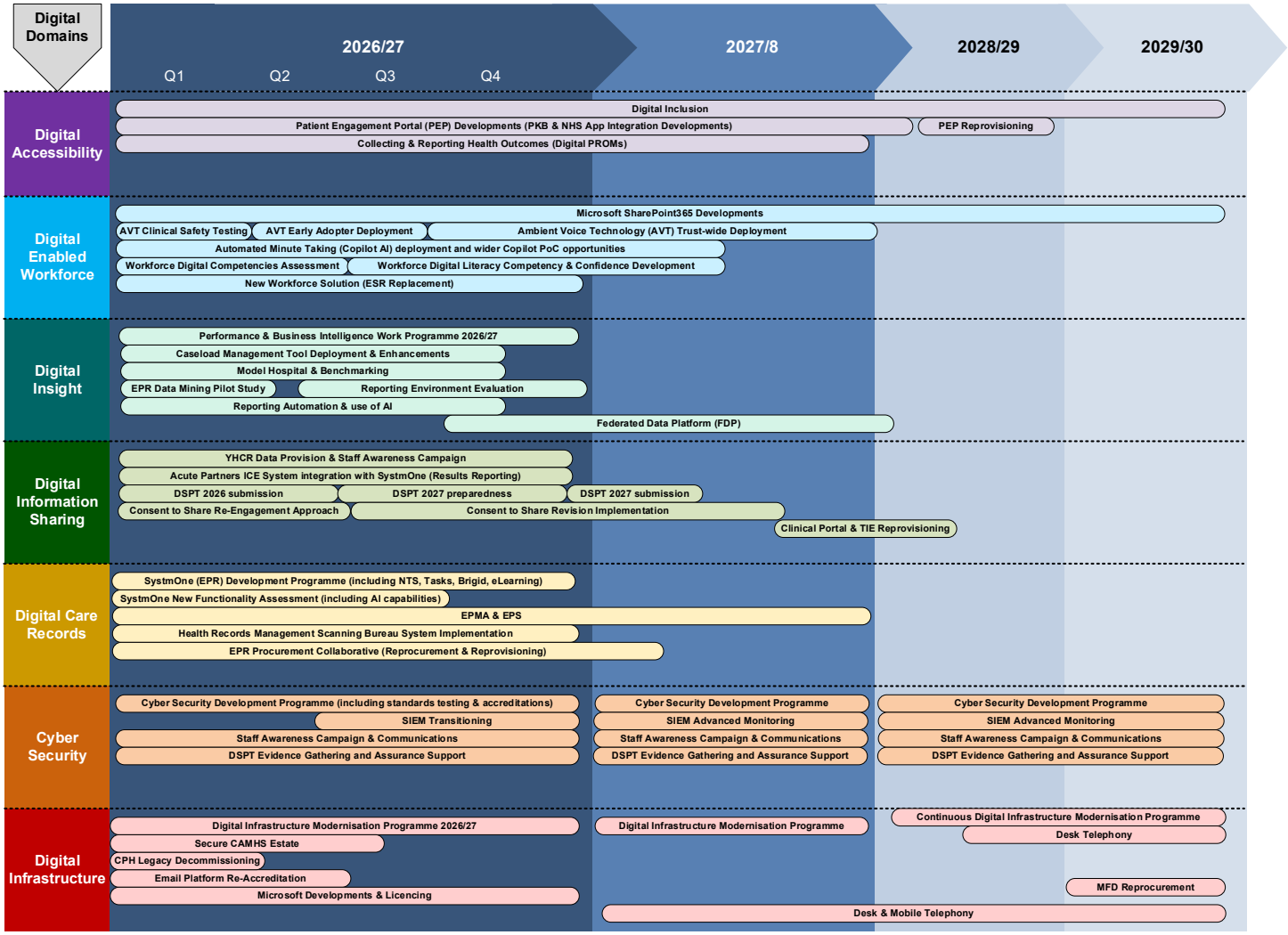
Organisational Summary

The Trust's digital strategy, roadmap, plans, and programmes of work remain comprehensively aligned with National direction. However, there is a constant need to develop, enhance, and expand our digital landscape further, to better support and empower our staff, ensuring that we make best use of available resources. We will do this by perpetually evolving our digital posture through horizon scanning across the digital technologies, solutions, and services to assess potential, and by networking at all levels to share insights, experiences, and learning. We will continue to explore collaborative/partnership working opportunities, especially in the challenging economic climate.

Given the ever-increasing pace of change, persistently emerging digital innovations, and relentless interest in exploring the potential of digital, it is critical for us to carefully formulate and plan our digital agenda through annual planning cycles accounting for the organisation's priorities and constantly review. This approach ensure that we remain dynamic and attune to the organisation's needs and wider environmental influences, whilst also maintaining realistic and achievable timescales, based on allocated/available resources, capacity, and associated risk management.

This update is a culmination of the collective work by all involved in continuing to drive forward the Trust's broadening strategic digital agenda, with individual contributions acknowledged in respective digital initiatives listed within Appendix B. Hopefully, this report serves to provide the Trust with assurances that our current digital journey, priorities and plans remain fit for purpose and relevant for today and in the future, as demonstrated by the overall continued good progress being made, which is a great achievement given the diverse, complex and challenging environments that we operating within. The reported position remains rated as **GREEN** overall.

Appendix A – Digital Strategy Milestone Delivery Plan (May 2026)



South West Yorkshire Partnership Teaching NHS Foundation Trust

Digital Strategy 2024-30

Appendix B for the Progress Report

(2025/26 End of Year Reporting Period)

Chief Digital & Technology Officer

Chief Clinical Information Officer

May 2026

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

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Key

	**COMPLETED**		**AMBER: Off track but in control**
	**GREEN: On track**		**AMBER\RED: Off track with urgent action being taken to address risk/issue**
	**GREEN/AMBER: On track but management of risk needed**		**RED: Off track major issues impacting overall viability**

✓	**COMPLETED**	⬆	**PROGRESSING**
➡	**NO CHANGE**	⬇	**DETERIORATING**

Organisational Risk Matrix

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Green	1 – 3	Low risk
Yellow	4 – 6	Moderate risk
Amber	8 – 12	High risk
Red	15 – 25	Extreme / SUI risk

Digital Accessibility

Our priorities for 2026-2027 that are supported



Digital Inclusion

Overall Status:		Lead:	Digital & Technology Services
		Start Date:	Ongoing
		End Date:	Ongoing

Overall Summary

The Trust continues to actively participate in digital inclusion networks at both system and place levels. Whilst organisational liability remains a constraining factor preventing the re-purposing of the Trust's decommissioned IT equipment within our local communities, a revised options paper is being prepared for Trust consideration. However, this has been delayed due to other pressing and competing priorities.

Purpose

Championing digital inclusion and in addressing digital inequalities in terms of access and capability for our service users, carers, their families, and the wider communities that we serve. Digital inclusion remains a key area of focus within the Trust, across both ICSs and in all our places.

Expected Outcomes

- Service users and carers are more informed about their care, the options available and what they can expect from accessing services digitally.
- Needs, wishes, preferences, and aspirations of our service users are comprehensively considered, and they feel listened to and are actively in control of the care they receive.
- Service users and carers can use digital technology available to them to access services and information in ways that are preferable.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Exploration/monitoring of the potential repurposing of Trust decommissioned IT equipment	*Background* A briefing paper was presented to EMT in February 2023 recommending that the Trust continues with its existing IT equipment decommissioning, disposal, and recycling processes. Whilst this means that redundant Trust IT equipment is not repurposed for reuse, the process is considered sustainable due to the associated recycling elements included in the			A

	WEEE guidelines. The overriding factor preventing the Trust from donating redundant IT equipment to a 3rd party provider is that the Trust does not release or relinquish its liability obligations associated with the IT equipment and their future use. Whilst it may represent a relatively minimal risk to the Trust, should a circumstance arise where a previously issued Trust device develops a fault which potentially leads to a fire for example, this could have a significant consequence, financial liabilities, and result in organisation reputational damage. The Trust together with WY ICS engaged specialist legal advice and at the time there was no avenue open that would relinquish the Trust's responsibilities and liabilities, hence the recommendation. *Current position* The Trust's IT services have well-established ethical and environmentally friendly recycling processes in placed for decommissioned IT equipment and continue to explore opportunities to enhance this further and consider reuse within our communities. IT services are currently producing a revised paper in respect of the potential opportunities for Trust consideration, which may help to navigate the legal liability barrier in terms of a potential re-sale and data security position. This work has been subject to delays resulting from other more pressing priorities.	~~Dec 2025~~ Oct 2026	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
There are several challenges as outlined above to overcome with regards to repurposing decommissioned Trust owned devices for re-use within our local communities.	3	3	**9**	• Exploring opportunities with partners and digital service providers to establish mechanisms to reduce barriers to digital inclusion through device repurposing whilst considering the legal/liability implications for this.

Patient Engagement Portal Developments (PKB & NHS App)			**Overall Summary**
	Lead:	Kelly Williams	Good progress is being made regarding uptake and registration by service users prompted and promoted by Trust communications. Development work is making
	Start Date:	Ongoing	

Overall Status: ⬆		End Date:	Ongoing	headway in respect of adding new functionality and accessible data to the platform. Local developments progressed in this reporting period have provisioned the new Mental Health care plans and enabling Subject Access Requests (SARs) to be made available digitally within the Patients Know Best platform. In terms of national developments, the Trust was successful in securing NHS England Wayfinder Programme funding in 2025/26 to further strengthen integration with the NHS App, which drives forward this initiative in line with the 10-Year Health Plan

Purpose	Expected Outcomes
To provide service users and carers with access to their own digital care record via a patient engagement portal (PEP) solution. They are utilising the Patients Know Best (PKB) digital platform which offers the potential to self-manage and engage more readily in the delivery of their care and an alternative means to communicate with care professionals offering greater flexibility.	• Improve communication between service users, carers, and care professionals. • Providing service users (and, where appropriate their carers) with online access to relevant parts of the clinical record. • Support self-management using online self-management tools. • Supports recovery through signposting to support and recovery resources. • Improve service user and carer awareness of and engagement with Trust related initiatives, events, research opportunities, and Recovery College courses. • Improve the consistency and quality of service user-related data collection through direct online input by individuals themselves, saving staff considerable time.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
PKB development – Subject Access Requests (SARs)	Development work focussing on providing Subject Access Requests (SARs) in a secure digital manner via the PKB platform. This work was completed and went live on 1 December 2025.	Dec 2025	Dec 2025	C
Phase 2 NHS England's national Wayfinder programme	The Trust successfully secured national funding via the NHS England Wayfinder Programme to further support the development of the NHS App via the Trust's patient engagement portal solution PKB. Within this phase, the Trust is to make questionnaires available within the NHS App by expanding the integration with PKB utilising PKB advanced questionnaire functionality. The Trust focussed on utilising this platform for the provision of the Friends and Family test patient feedback form. The work was completed in March 2026 and the launch of its use to commence from Aprill 2026.	Mar 2026	Mar 2026	C
PKB development - Mental Health Care Plans	Development work focusing on the provision of Mental Health care plans from SystmOne to be made available within the PKB platform.	Mar 2026	Apr 2026	C
PKB development - Mood Diaries	Developments focusing on the provision of a digital mood diary to be made available within the PKB platform. The work was paused as the key	Sep 2026		A

	Trust clinician instrumental in driving this forward was away from work. However, activities have now recommenced from the end of March 2026, and timescales are currently being revised. Work continuing 2026/27.			
Stakeholder feedback	Capture feedback from stakeholders and users of the PKB platform and use the insight to inform future development plans and priorities	Dec 2026		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Work with developing the digital mood diary within PKB has been subject to delays due to the key Trust clinician instrumental in driving this forward unavailability.	3	3	9	• The PKB project board agreed to pause this work due to the clinician critical to this development being away from work.

Collecting & Reporting Health Outcomes

Overall Status:



Lead:	M.Garnham
Start Date:	01/04/2026
End Date:	31/03/2027

Overall Summary

Whilst we have made enormous progress in CAMHS as previously reported, uptake in adult mental health remains slow and return rates for ReQOL have dropped from over 100 in Q1 to less than 30 in Q4. Return rates for DIALOG (a link to which is included on the Health and Wellbeing Plan) have increased over the last 12 months but remain low, and the majority of completed DIALOG measures have been completed in in SystmOne, which suggests further training and awareness raising is required highlighting the benefits of using the IMX Digital Outcomes tool. A series of actions are being put in place to support the uptake and usage

Purpose

There is no consistent approach to outcome measure collection presently within the Trust. Clinical outcomes can be measured by data such as hospital re-admission rates, or by the five domains set out in The NHS outcomes framework indicators. Therefore, the Trust has developed a solution to enable collecting and reporting health outcomes digitally.

Expected Outcomes

- Improved efficiency by ensuring the delivery of the appropriate questionnaire, at the right time, to the right patient.
- Improved timeliness, offering real time insight into patients' wellbeing and quality of life, providing quicker decision making and ability to tailor treatment.
- Automatic analysis, scoring and reporting in real time at clinical, service, and organisational level.
- More personalised care and support through service user identified needs and goals.
- Better understanding of clinical needs and effectiveness of services.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Enhancements & developments: Email notification to clinicians	When automatically sending an outcome ahead of an appointment the clinician will not necessarily know that an outcome has been sent or if it has been completed without going into the clinical record system and	Mar 2026	Mar 2026	C

	checking. We have built an automatic email notification process to let the allocated HCP know if a ReQoL outcome has been completed.			
Embedding use of outcome measures into practice	A review of usage of IMX Digital Outcomes solution shows it is being widely used in CAMHS, but completion rates in mental health services are poor. Most concerningly, despite the new My Health and Wellbeing directing people to complete DIALOG with their service user as part of the care planning process, completion rates are very low. The actions are being put in place to support this work. • Together with Quality and Governance Leads it is proposed that in mental health services we focus on embedding one outcome measure into practice. The exception is for those teams who are already routinely using ReQOL where we will focus all efforts on using DIALOG. This approach should also be more efficient and stop the sending of automatic text messages inviting service users to complete that measure. This will be reviewed as the use of outcome measures is better understood and routinely being used by both staff and service users. • Work with Practice Governance Coaches to look at new approaches to embedding use of outcomes measures into practice, by revisiting team training sessions, adding outcomes to the caseload management tool, communication to practitioners that outcomes are going to be part of National Outcomes Framework and Clock Stop	Oct 2026		**A**
New Care Process Training	New Care Process training started in February 2026 and response to training around using DIALOG was positive. However, the training has temporarily been put on hold as part of a training review. Use of DIALOG and the four step (DIALOG +) approach will be part of the future care plan training when it recommences.	~~Mar 2026~~ Oct 2026		**A**
Wider development & deployment opportunities	Continue to explore opportunities to develop additional patient reported outcome measures (PROMs) questionnaires and deploy across the Trust as applicable.	Ongoing		**P**
	Explore the possibility of completed outcome measures being visualised in Patients Know Best to increase service user engagement	Oct 2026		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Uptake of digital outcomes in some services is relatively low	3	3	**9**	• Plans are being put in place to raise awareness and confidence in collecting outcomes digitally. • New care process training being implemented.

Digitally Empowered Workforce

Our priorities for 2026-2027 that are supported



Microsoft SharePoint365 Developments 2025/26

Overall Status:		Lead:	SharePoint Development Group
✓	COMPLETED	Start Date:	01/04/2025
		End Date:	31/03/2026

Overall Summary

No major SharePoint developments have taken place during 2025/26 beyond supporting business as usual operations.

Purpose

Enhancements and new developments to the Trust's Microsoft SharePoint365 environment and constituent SharePoint365 sites (Intranet, Payroll forms and processes, Business Intelligence dashboards and performance reporting, Criteria led discharge dashboard and processes, Supervision database, Membership database, Emergency planning, and IT and systems access forms.

Actual Outcomes

- To continue to improve access to corporate systems and information in a timely and responsive manner.
- Ensuring that the Trust corporate assets as listed above are continually developed, maintained and services/information is accessible across the workforce.
- Continues to support information asset management, integrity, and confidentiality to comply with GPDR requirements.
- Establish a robust and strategic approach for ongoing maintenance & support and continuous development (strategic roadmap) of the SharePoint environment, subject to Trust governance and approvals.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status

Development work programme for 2025/26	Focus on maintaining existing SharePoint environments and scoping of potential new development. No major new developments have been evident during 2025/26.	Mar 2026	Mar 2026	C

Trust-wide Digital Dictation Solution			Overall Summary
Overall Status: ✓		Lead: R. Hutchison Start Date: 01/07/2024 End Date: 14/11/2025	The accelerated deployment of the Trust-wide digital dictation solution has been completed with the project formally ending mid-November 2025. A total of 1,432 licences issued to staff with online training provided.

Purpose	Actual Outcomes
Deployment of the Trust's preferred strategic Trust-wide digital dictation solution following conclusion of the procurement exercise, Trust approval, and award of contract.	• To deployment of the chosen solution Trust-wide, offering standardisation. • Supports the paperless agenda. • Improves service effectiveness and efficiency. • Potential economies of scale

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Deployment and adoption of Trust-wide digital dictation solution	Effective planning, deployment, and adoption of the Trust-wide digital dictation solution Lexacom.	Oct 2025	Oct 2025	C
Project Closure Report	Report formally closing the project based on the project aims and objectives, and delivery to date against the indicated/stated benefits approved by the Digital Dictation Project group	Nov 2025	Nov 2025	C
Transition arrangements from project to business-as-usual operations	As part of the formal project closure, activities have concluded to support the effective transition from project state (Integrated Change team) to business-as-usual operations (IM&T). Resourcing requirements are currently being reviewed as part of project closure.	Nov 2025	Nov 2025	C

Automated Microsoft Copilot Minute Taking (Proof of Concept)			Overall Summary
Overall Status:		Lead: R. Tyas Start Date: 01/04/2025	In response to capacity challenges within the Executive Management Team PAs, digital options were considered and trialed through this proof-of-concept initiative to determine

✓		End Date:	28/02/2026	if such digital assistive interventions help to address the challenges faced. Microsoft Copilot has proved to be extremely beneficial, with positive insights and feedback from staff involved in the proof-of-concept. This has helped to inform the wider deployment opportunities and potential efficiencies which are being carried forward in 2026/27.

Purpose	Actual Outcomes
To improve capacity and operational efficiencies through digital enabled opportunities.	• Ensures that the Trust makes best use of the available digital technologies, solutions, and functionality, in the most appropriate and cost-effective strategic way forward to support the wider digital agenda. • Supports the value for money programme.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Baselining of resource commitments	Reviewing and baselining of existing resource commitments (PAs time) for administering meetings, recording, and transcribing minutes.	Feb 2025	Feb 2025	C
Exploration of options to be considered	Technical, security and governance assessment within the Trust network environment and setup for proof-of-concept options being considered. ▪ Microsoft CoPilot (Exec PAs) ▪ Enhanced transcribing of Microsoft Teams utilising A.I. capabilities utilising iThink365's SmartFlow solution (Corporate Governance)	Apr 2025	July 2025	C
Conduct time-limited proof of concept with Exec. PAs	Conduct proof of concept trials of the above stated digital solutions, capturing feedback and insights	~~May 2025~~ Nov 2025	Nov 2025	C
Evaluate findings	Evaluate findings from the proof of concept, benefits and potential limitations of each solution, demonstrable return-on-investment (value for money), potential wider areas for application and recommendations.	~~Jun 2025~~ Dec 2025	Dec 2025	C
Next steps discussion paper for EMT	This is a follow-on paper that proposes how we take forward the use of Microsoft Copilot further within the organisation, whilst accounting for the practical next steps ensuring that we have a robust approach and processes to facilitate and manage wider deployment opportunities. The proposed recommended actions were approved by EMT, subject to the approach and process being agreed by the Value for Money Group.	Feb 2026	Feb 2026	C

Microsoft Copilot automated minute taking wider rollout	**Overall Summary**

Overall Status:		Lead:	Digital & Technology Services	Based on the insights and findings from the earlier mentioned proof-of-concept focusing on Microsoft Copilot. A proposal outlining the approach together with recommendations was presented to EMT, which was approved. Digital & Technology Services have established the process based on the agreed approach and have recently issued out Trust wide communications. Several Microsoft Copilot licence requests have been received and processed, with licences being issued.
		Start Date:	01/04/2026	
		End Date:	31/03/2027	

Purpose	Expected Outcomes
This follows on from the completed Microsoft Copilot automated minute taking proof-of-concept and focused on the wider rollout of Microsoft Copilot for supporting with minute taking and determines the approach for wider potential areas of application for the use of Microsoft Copilot within the Trust.	• To improve administrative capacity and operational efficiencies through digital enabled opportunities. • Ensures that the Trust makes best use of the available digital technologies, solutions, and functionality, in the most appropriate and cost-effective strategic way forward to support the wider digital agenda. • Ensures a robust and evidenced approach to demonstrating improved efficiencies and productivity gains • Supports the value for money programme.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Microsoft Copilot approach	A summary paper detailing the approach and processes for requesting Microsoft Copilot and managing the allocation of licences once approved to be provided to the Value for Money Group prior to establishing operationally.	May 2026	May 2026	C
Establishing a process to support the requesting of Microsoft Copilot licences for automated minute taking	A process has been established to enable requests for Microsoft Copilot to be made for assisting with minute taking activities. Following receipt of requests, Digital & Technology services review the requests weekly, and once approved, a Microsoft Copilot licence is allocated to the individual in question. As part of this process, individuals allocated a licence are required to complete a weekly diary sheet (Microsoft Forms) to capture activity where Copilot has been used. This allows for the tracking of activity against initial baselining information provided as part of the Copilot licence request process, so we can continue to track and evidence insights (quantitative and qualitative) from which to analyse and derive benefits and monitor usage.	From Jun 2026	From May 2026	C
Ongoing review of the usage of Microsoft Copilot following licence allocations	Review of output from weekly feedback, analysis of benefits and time saved. Initially driven from weekly diary sheet (post deployment) which will evolve further to drive richer datasets, track, and evidence the	Mar 2027		G

	quantitative and qualitative benefits based on areas of application of Microsoft Copilot.			
Additional areas of application for the use of Microsoft Copilot	Where additional areas of application for the use of Microsoft Copilot are identified beyond the use for automated minute taking, once considered, time-limited proof-of-concepts will be conducted to inform the potential business cases and wider deployment opportunities. This will be determined as part of the Copilot licence request process.	Mar 2027		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Additional costs associated with Microsoft Copilot licencing	4	3	**12**	• Whilst there is no specific budget to fund Microsoft Copilot licences from, it has been agreed via EMT that where there is a clearly defined need, the funding necessary is sourced from individual department budgets annually via recharge mechanisms. This will require budget holders/general managers and finance to identify and approve where defined Microsoft Copilot licences are to be funded from and accounted for upfront. • A review of Microsoft Copilot licence allocations/usage to be conducted annually with budget holders in advance of renewal timelines, managed by the IT Team.

Ambient Voice Technology (AVT)

Overall Status:



Lead:	R. Tyas K. Williams
Start Date:	01/01/2026
End Date:	31/03/2027

Overall Summary

Preparatory activities are progressing in support of the deployment of the Lexacom ambient voice technology (Lexacom ambient.ai) solution which builds on the deployed Trust-wide digital dictation Lexacom solution. Lexacom ambient.ai integrates with the Trust's SystmOne EPR. Once clinical safety testing activities have been completed and service readiness confirmed, deployment into the identified early adopter services will commence. This will inform the subsequent wider-deployment approach across the Trust.

Purpose

AVT offers the capability to automatically record and transcribe healthcare professional and service user/carer discussions during interventions into structured notes using A.I., aiming to significantly reduce the admin burden of clinical staff, thus providing more time to focus on direct patient care. The plans and activities for the deployment of

Expected Outcomes

- Offers significant potential to help reduce the admin burden for staff, potentially increasing clinical capacity
- Improving work life balance and reducing staff burnout
- Improved data collection at the point of care
- Improve patient experience
- Improve timeliness of contemporaneous clinical record-keeping

AVT form part of the Trust's digital priorities for 2026/27 and aligns with the 10-Year Health Plan as this is also a key national priority in 2026/27.	• Improves data quality and accuracy • Improves service effectiveness, workflow, efficiency, and productivity. • Faster communications

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Technical testing	Conduct technical and integration capabilities with SystmOne testing	Feb 2026	Mar 2026	C
Identify early adopter services	Early adopter services identified and confirmed. Namely: • CAMHS Neuro • ADHD & Autism • Barnsley Inpatients Mental Health • Barnsley Talking Therapy • Barnsley Frailty Service	Mar 2026	Mar 2026	C
Clinical safety activities & testing	Establish clinical safety approach and conduct clinical safety activities and testing (including the review of the supplier's DCB0129 clinical safety documentation, completion of DCB0160 and Data Protection Impact Assessment (DPIA) documentation. Clinical safety testing is ongoing with 2nd iteration of testing progressing and aiming for completed by end of May 2026.	Jun 2026		G
Baselining activities	Establish baseline activity approach and conduct baseline data capture for early adopter services. Baselining information being provided by services in readiness for early adopter deployment.	Jun 2026		G
Develop KPIs and reporting mechanisms	Development KPIs, ongoing data capture and reporting mechanisms	Jun 2026		G
Clinical Safety Activities Sign-off	Sign-off clinical safety testing including review of the completed DCB0160, DPIA and medical device evaluation in line with governance and assurance mechanisms	Jun 2026		G
Early Adopter Service Readiness	Establish early adopter service readiness criteria and confirm early adopter service readiness	Jun 2026		G
Training development	Development of training materials and guidance ongoing.	Jun 2026		G
Stakeholder engagement and communications	Conduct stakeholder engagement activities and development of the communications plan ongoing	Jun 2026		G
Deliver training	Deliver training to early adopter services	Jul 2026		P
Deploy solution	Issue solution licences and devices to early adopter services	Jul 2026		P
Deployment data capture activities	Commence data capture activities from point of deployment.	Jul 2026		P

Early adopter service evaluation	Conduct early adopter service evaluation from findings and feedback and compare against baseline. Determine outcomes and benefits	Aug 2026		P
Business Case development	Develop business case for ongoing self-sustainability	Sep 2026		P
Deployment & Rollout Planning	Planning activities for the wider deployment of this capability across the Trust where appropriate and subject to prioritisation	Oct 2026		P
Deployment & Rollout of ambient voice capabilities	Deployment of ambient voice capabilities across the Trust where appropriate.	Mar 2027		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Limited clinical safety capacity & capability within the Trust (Clinical Safety Officer (CSO) role)	3	3	9	• The Trust has engaged a 3rd party specialist service provider to support clinical safety activities and the Trust's CCIO/CSO.
Demand for AVT outweighs capacity and resources	3	3	9	• Effective planning/prioritisation, engagement and communications.

Trust Workforce Digital Competencies

Overall Status:



Lead:	P. Foster D. Macdonald-Bloomfield
Start Date:	01/01/2026
End Date:	31/03/2027

Overall Summary

Initial discussions have been held to consider the approach to taking this initiative forward in 2026/27. Initiative was deferred to 2026/27 due to in-year organisational changes within the People Directorate key functions. However, discussions are progressing regarding Library Services establishing AI awareness training and support for staff service offer, in conjunction with other key corporate functions.

Purpose

Our workforce is our greatest asset and to be truly digitally excellent, our staff need to be fully conversant, competent, capable, and confident in their use of digital solutions which promote high quality care provision. Exhibiting good digital knowledge, skills and capabilities is not about developing technical proficiency but in recognising that when coupled with an assured outlook, it is how digital solutions can be applied during effective care delivery which improves care and creates positive health outcomes. This requires a cultural shift throughout the Trust's workforce.

Expected Outcomes

- Supports in making this a great place to work, also improving staff retention.
- Enables a digital capable workforce that embraces flexible and adaptable work-life balance.
- Improve access, timeliness and availability of training and development opportunities in support of identified needs.
- Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience, and capabilities.
- Adopting and learning from digital best practices.
- Better use of Trust resources.
- Helps to nurture a continuously evolving digital culture throughout the organisation.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
AI awareness training & support for staff	Library Services together with other key corporate functions are looking at establishing and providing AI awareness training and support offer for staff. Discussions are ongoing.	Jul 2027		G
Digital Competency Staff Self-Assessment	Explore ways in which we can determine the digital skills, learning requirements and aspirations via a digital competency self-assessment for staff	TBD		P
Develop a Digital Competency Workforce Plan	From the insights and findings from the above activities, devise a plan focusing on key priority areas across the Trust.	TBD		P
Implement the Digital Competency Workforce Plan	Implement initiatives and actions in respect of the digital competency workforce plan	TBD		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Staff do not honestly complete the individual self-assessment, which does not provide a true representation of digital skills and competency needs.	3	3	9	• Ensure robust awareness, engagement and consultation approach and communication campaigns across all stakeholder groups, forums and networks in the design and development of digital education and training opportunities. • Develop key principles for digital education and training that are built upon ethical, positive, sensitive, and appropriate attitudes and behaviours
Staff resistance to digital education, training, and development service changes and in adopting new ways of learning due to service pressures and capacity limitations.	3	4	12	• Establish digital champions and supportive networks with positive attitudes, seeking out appropriate and innovative digital technologies to enhance learning for self and others.
Implementation of the requisite digital competency workforce plan is impacted by capacity and available resources	3	4	12	• Ensure plans are realistic and aligned with available resources/capacity which are closely aligned with identified/agreed priorities.

New Workforce Solution (ESR Replacement)

Overall Status:



Lead:	E. Valentine
Start Date:	01/04/2026
End Date:	31/03/2027

Overall Summary

The Trust put forward an expression of interest to become an early adopter of the future workforce solution and is engaging in the targeted kick-off sessions as part of the early adopter in principle arrangements.

Purpose	Expected Outcomes
To replace the existing Electronic Staff Record (ESR) system with the new and modernised workforce solution (currently termed as future workforce solution) and digitally enabling national target operating model and future people services.	• Adoption of a new integrated HR and payroll system • Improved staff experience (modernised people services offer) and increased self-serve opportunities • Improved portability of data and intelligence across the system • Improved workflow and operational processes • Future opportunities to rationalise and centrally manage people systems and processes through a single integrated system

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Early Adopter engagement and confirmation	The Trust is currently mapping our existing people systems and interface landscape as part of early adopter in principle activities, identifying system and domain functionality benefits to confirm Trust intentions for functionality implementation.	Jun 2026		G
Risk assessment of 3rd party contracts (continuation of payroll and occupational health services)	Risk and impact assessment of the implications and the resource considerations to enable the Trust to continue to provision these services	Jun 2026		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Funding/resource commitments to enable the Trust to take forward this opportunity	4	4	16	• Discussions ongoing with NHS England regarding the availability/release of the proposed funding to support resources (June 2026). • Draw down funding to initiative recruitment activities following early adopter confirmation.
Impact on potential double running of solutions to mitigate and manage continuation of payroll services to 3rd party partners	4	4	16	• Assessment of the potential implications and resource constraints to mitigate the risk.

Digital Insight

Our priorities for 2026-2027 that are supported



Performance & Business Intelligence Work Programme 2025/26

Overall Status:



Lead:	M.Wood
Start Date:	01/04/2025
End Date:	31/03/2026

Overall Summary

Significant progress has been made on activities and initiatives that formulate the Performance & Business Intelligence function's 2025/26 work programme, in line with the Trust's priorities, digital strategy and national direction. Given the nature of this work programme, there are areas of development which are ongoing so activities will be carried forward and form part of the 2026/27 work programme, as depicted in the respective activities target date where C/F is stated.

Purpose

The development of business intelligence, performance management and reporting capabilities that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs service line reporting through key performance indicators to aid service improvements and delivery.

Expected Outcomes

- Improve availability of information to support operational services and transformation agendas.
- Improve performance reporting.
- Improve data quality.
- Identification of additional key performance indicators and associated metrics

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Neighbourhood Teams Developments	Continued development work to support new ways of working in Barnsley Community Services (NTS) and ensure suitable reporting outputs available. Developments continued in line with the implementation plan and routine reporting are now complete.	Oct 2025	Oct 2025	C
Business As Usual (BAU) Reporting	Ongoing additional reporting and reporting enhancements to support the performance management agenda and operational service delivery/management, spanning: -			G

	▪ Supporting the Value for Money (VfM) programme.
	  ○ Safer staffing dashboard – some delays in completion of this piece of work due to validation issues.
	  ○ Productivity dashboard – work ongoing carried forward
	  ○ Caseload management tool development – tool deployed.
	▪ Supporting Trust priorities.
	  ○ Further develop analytical support to inpatient improvement project – meeting paused due to review of Trust priorities.
	  ○ Further develop analytical support to improving access to care
	▪ Supporting new contracts (e.g. secure CAMHS).
	  ○ Secure CAMHS – a significant amount of work required to flow reporting requirements for new contract.
	▪ Supporting the Trusts Quality Assurance Framework system – a draft has been shared and awaiting sign off.
	▪ Health intelligence analytics – working with integrated change team:
	  ○ Increase organisational insight
	  ○ Data visualisation
	▪ Neighbourhood teams – support to team on new developments following implementation onto the NTS unit.
	▪ Freedom of information requests
	▪ Ad-hoc requests – variety of sources.
		
		C/F
		
		C/F
		May 2026
		
		Mar 2026
		
		C/F
		
		Dec 2025
		
		C/F
		
		Apr 2027
		C/F
		C/F
		
		C/F
		C/F
			
			May 2026
			
			Mar2026
			
			Dec 2025	

National Reporting Requirements	Reporting developments to support: - ▪ Readiness for MHSDS (version 6.1) to meet national standards – national implementation date awaited. ▪ Community Mental Health National waiting times meaningful interventions reporting – work required in house to replicate the national reporting to allow drill down to review data. Delayed due to other priorities in team. ▪ Faster data flows reporting for community services. Daily flow commenced from 27/09/24. Developments ongoing. ▪ OPEL for mental health – new daily metrics commenced flowing from February 2025 with automation work ongoing. ▪ Virtual ward SitRep reporting daily – automated process.	 C/F Dec 2025 Mar 2026 Jun 2025 Nov 2025 C/F	 Mar 2026 Mar 2026 Jun 2025 Nov 2025	**G**

	▪ EPMA national data collection (delayed due to system extract being unavailable) ▪ NHS Oversight framework – analysis and build of Trust NOF dashboard to allow local monitoring and forecasting. ▪ Work with partners and internal colleagues to support the national priority for removing block contracts. ▪ Operational planning – provision of activity and forecasting for 26-29. o Monitoring of performance against forecast - ongoing ▪ Annual Planning – support for provision of activity and forecasting for 26-29. o Monitoring against local plan in place.	C/F TBD as part of annual planning process. Mar 2026 C/F C/F	Mar 2026	
Datawarehouse Developments	Data warehouse development efficiencies continued work on feeds of data from other Trust sources such as Datix, eExpenses. ▪ Datix o Work completed for the data feed o Reporting work continues with the identification of reporting requirements and standardisation in progress (IPR, contracts and other reporting to be defined) o Work ongoing with incident data to map this for reporting. Some delays due to capacity within the Quality team. o BAU for further developments	Mar 2026	Mar 2026	**C**
Integrated performance report developments & automation	▪ Continued development of the IPR. ▪ Finalisation of people metric reporting and output automated. ▪ Quality section of the IPR being automated. o Quality data from SystmOne, reporting activities complete and currently undergoing validation. Some delay in automation of quality metrics linked to validation issues. Work ongoing. o Development of outputs for Care Group and Ward level section of the IPR. Delayed as linked to the above. Work ongoing. o Revisions of metrics to meet 2026/27 requirements	C/F Sep 2025 C/F C/F C/F	Sep 2025	**G**
Process Automation	Piece of work to review and automate existing manual processes to improve efficiency and allow more capacity for data analysis. This will be reviewed with priority for 2026/27.	C/F		**G**

New reporting server hardware implementation	Replacement of the reporting infrastructure	Jun 2025	Jun 2025	C
Performance Monitoring	▪ Review of current Trust performance framework for 2026/27 and annual thereafter. Delayed due to NOF finalisation. ▪ Ensure monthly monitoring of NHS NOF metrics are incorporated into performance monitoring processes. ○ Ensure any changes in the NOF are reflected in local reporting. ▪ Ensure all Trust national, strategic, and contractual routine reporting requirements are met to timescale.	C/F C/F C/F		G
Health Intelligence	▪ Continued development of NHS Benchmarking reporting, analysis, and use. ▪ Explore use of Model Hospital data, identify priority areas for deep dive and work via the Trust benchmarking group to review. ▪ Continued development of Health Intelligence function to help identify priorities for service improvement and development and understanding the populations we serve. Work started on priority areas of inpatient improvement programme and improving access to care.	C/F C/F C/F		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Capacity limitations within the team to continue to provide the necessary capability to support this key Trust programme of work	3	3	9	• Effective prioritisation and review of the work programme in line with available resources and available capacity.

Performance & Business Intelligence Work Programme 2026/27

Overall Status:



Lead:	M.Wood
Start Date:	01/04/2026
End Date:	31/03/2027

Overall Summary

Activities are ongoing with regards to the initiatives that formulate the Performance & Business Intelligence function's 2026/27 work programme, in line with the Trust's priorities, digital strategy and national direction.

Purpose	Expected Outcomes
The development of business intelligence, performance management and reporting capabilities that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs	• Improve availability of information to support operational services and transformation agendas. • Improve performance reporting. • Improve data quality.

service line reporting through key performance indicators to aid service improvements and delivery.	• Identification of additional key performance indicators and associated metrics

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Business As Usual (BAU) Reporting	Ongoing additional reporting and reporting enhancements to support the performance management agenda and operational service delivery/management, spanning: - ▪ Supporting the Value for Money (VfM) programme. o Safer staffing dashboard – validation underway o Productivity dashboard o Caseload management tool development enhancements ▪ Supporting Trust priorities. o Further develop analytical support to improving access to care o Support to new Trust priorities for 26/27 to be determined. ▪ Supporting new contracts o To be determined ▪ Supporting the Trusts Quality Assurance Framework system – a draft has been shared, awaiting feedback and sign off. ▪ Health intelligence analytics – working with integrated change team: o Increase organisational insight o Data visualisation ▪ Neighbourhood teams – support to team on new developments following implementation onto the NTS unit. ▪ Freedom of information requests ▪ Ad-hoc requests – variety of sources. ▪ Electronic prescribing – support reporting for the roll out of this project.	 Jul 2026 Dec 2026 Ongoing Ongoing TBD TBD TBD Ongoing Ongoing Ongoing Ongoing Mar 2027		G
National Reporting Requirements	Reporting developments to support: - ▪ Readiness for MHSDS (version 6.1) to meet national standards – national implementation date awaited. ▪ Faster data flows reporting for community services. Daily flow commenced from 27/09/24. Developments ongoing. ▪ EPMA national data collection (delayed due to system extract being unavailable)	 TBD Ongoing Ongoing Ongoing		G

	▪ NHS Oversight framework – analysis and build of Trust NOF dashboard to allow local monitoring and forecasting. ▪ Work with partners and internal colleagues to support the national priority for removing block contracts.	Mar 2028		
Datawarehouse Developments	Data warehouse development efficiencies continued work on feeds of data from other Trust sources such as Datix, eExpenses. ▪ Datix o Feed established and reporting available for some metrics. Further developments as data warehouse BAU. ▪ Future NHS Workforce Solution – replacement of ESR system will require work to ensure data flow and reporting in place from go live. Scope and timescales to be determined.	 Ongoing Ongoing		**G**
Integrated performance report developments & automation	▪ Continued development of the IPR – to meet 26/27 reporting requirements. ▪ Quality section of the IPR being automated. o Quality data from SystmOne, reporting activities complete and currently undergoing validation. o Development of outputs for Care Group and Ward level section of the IPR	Ongoing Jun 2026 Jul 2026		**G**
Process Automation	Piece of work to review and automate existing manual processes to improve efficiency and allow more capacity for data analysis. This will be reviewed with priority for 2026/27.	Ongoing		**G**
Performance Monitoring	▪ Review of current Trust performance framework for 2026/27 and annual thereafter. ▪ Ensure monthly monitoring of NHS NOF metrics are incorporated into performance monitoring processes. o Ensure any changes in the NOF are reflected in local reporting. o Establish performance monitoring system for 26/27 NOF metrics ▪ Ensure all Trust national, strategic, and contractual routine reporting requirements are met to timescale. o Performance monitoring of the above embedded in monthly / quarterly reporting.	Jun 2026 TBD TBD TBD Jun 2026		**G**
Health Intelligence	▪ Continued development of NHS Benchmarking reporting, analysis, and use. ▪ Explore use of Model Hospital data, identify priority areas for deep dive and work via the Trust benchmarking group to review.	Ongoing Ongoing		**G**

	▪ Continued development of Health Intelligence function to help identify priorities for service improvement and development and understanding the populations we serve. Work started on priority areas of inpatient improvement programme and improving access to care.	Ongoing		
Cloud-based Reporting	▪ Explore the potential use of cloud-based reporting in collaboration with IT Services.	TBD		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Capacity limitations within the team to continue to provide the necessary capability to support this key Trust programme of work	3	3	**9**	• Effective prioritisation and review of the work programme in line with available resources and available capacity.

Caseload Management Tool Development

Overall Status: ✓		Lead:	M Wood
		Start Date:	01/09/2025
		End Date:	31/03/2026

Overall Summary

Following exploration of commercial solutions in the marketplace, the Trust opted to develop a caseload management capability internally, with work development work progressing and good feedback from initial usage from services.

Purpose

To provide a digital solution that supports effective caseload management, is flexible, scalable, and accessible.

Actual Outcomes

- A system that enables the effective management of caseloads.
- That the right service users are on the right caseloads and staying for the right amount of time and going to the right onward pathways.
- To support with ensuring all staff caseloads are manageable.
- To give evidence of acuity of caseloads and acuity overall.
- To have oversight of total team capacity compared to demand.
- To highlight people that might be appropriate for discharge.
- To support productivity and enabling staff to work in line with good/best practice relating to contact management.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Continued development of the caseload management tool	This work is linked to VFM workstream but a significant project in its own right. Business Intelligence will technically develop the tool using PowerBI	May 2026	May 2026	**C**

	and work alongside operational and clinical colleagues to identify a specification and work programme for the project.			

EPR Data Mining Pilot Study				Overall Summary
Overall Status: 		Lead:	TBC	The Trust put forward an expression of interest and was successful in being selected as one of the four NHS provider organisations to take part in this pilot study. Activities are ongoing.
		Start Date:	01/11/2025	
		End Date:	30/06/2026	

Purpose	Expected Outcomes
NHS England is funding a pilot with four NHS Trusts to improve Electronic Patient Record (EPR) usability and staff training through process mining, in partnership with the University of Leeds Data Science/Health Informatics team who will conduct process mining activities from October 2025 to February 2026. The project aims to identify and address challenges in EPR usage, improve productivity, and enhance care pathways using data analytics. We are the only region to undertake this pilot in England for this funding, which will help to shape future blueprinting of national programmes for next year.	• Based on the findings, solutions will be sought to enhance the user experience of the EPR system. • The output will be the production of a board-level report to feed into the upcoming national digitisation and optimisation programmes. • Development of a universal toolkit which will support health leaders regarding EPR usage optimisation. The toolkit will be distributed across our region and to national programme leads. • Supports the Trust's VfM agenda and may yield opportunities to improve productivity.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Pilot study	Work to support Trusts involvement in the project to review Electronic Patient Record processes which is linked to VFM workstream. NHS England co-ordinated project extended to end June 2026.	~~Mar 2026~~ Jun 2026		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

Federated Data Platform Onboarding				Overall Summary
Overall Status:		Lead:	TBC	This initiative forms part of the national direction and whilst timescales for the Trust to onboard to the Federated Data Platform have yet to be determined, it remains on our strategic digital agenda and roadmap for the future.
		Start Date:	TBC	
		End Date:	TBC	

Purpose	Expected Outcomes
The NHS Federated Data Platform connects vital health information securely across the NHS, helping staff to make better decisions to deliver better care for patients and supports care planning more efficiently.	• The Trust has its own instance of the NHS Federated Data Platform for which we are the data controller and provides the ability to connect and share information between different instances and for personal information, where data protection law allows. • Improved care co-ordination. • Has the potential to aid staff in reducing the admin burden.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Exploration and review	Review use of and implementation within the Trust from a P&BI perspective to align with national strategic planning guidance and 10-year plan.	Align to national timescales		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

Digital Information Sharing

Our priorities for 2026-2027 that are supported



Yorkshire & Humber Care Record (YHCR) Consumption Awareness Campaign	Overall Summary

Overall Status:		Lead:	Kelly Williams	The Systems Development team are continuing to focus on an awareness raising campaign to increase uptake and usage of the YHCR across the Trust, which remains relatively low.
		Start Date:	01/04/2026	
		End Date:	31/03/2027	

Purpose	Expected Outcomes
The Trust has completed the onboarding (“connecting”) to the Yorkshire & Humber Care Record (YHCR) via the Trust’s clinical portal solution which enables the Trust to bring together information from different clinical information systems both internally and externally into a single integrated “shared” record view. This is being achieved via the Trust’s existing clinical portal solution “PORTIA” (IMX) which is the Trust’s channel for consuming available YHCR datasets.	• Enhances integrated holistic patient record view. • Helping to reduce the admin burden for staff by reducing the time spent locating the relevant clinical information they need. • Sourcing data from Trust internal systems and externally with partners leveraged via the YHCR. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner. • The richness of the YHCR will increase as more partner organisations onboard and additional datasets defined and become available. This is a strategic priority across both West Yorkshire & South Yorkshire ICS regions and constituent places. • Supports the 10-Year Health Plan with the YHCR forming a component part of the Single Patient Record.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
YHCR Awareness Campaign	An awareness campaign to raise the relatively usage of the YHCR across the Trust is in progress which is being co-ordinated by the Systems development team. This involves: - ▪ **Awareness & Engagement**: Promoting YHCR in team meetings at all levels, forums, and via intranet resources. ▪ **Training & Support**: Delivering short demos at meetings, plus offering bookable short course sessions for staff. ▪ **Trust-Wide Communication**: Email communications to all staff to raise constantly awareness and using SystmOne noticeboards. ▪ **Feedback & Continuous Improvement**: Contact regular portal users for feedback on what they find useful, benefits to share and promote wider as well as suggestions for enhancements and any potential barriers/information gaps that if addressed would make more beneficial.	Mar 2027		G

	▪ **Liaison with our partners/peers:** On insights into their approaches and benefits to weave into our plans. ▪ **Communication of new available data:** Working with the ICB/YHCR teams regarding onboarding of additional partners data and ensuring this is communicated internally accordingly.				

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Continued low uptake and usage of the YHCR across the Trust	3	3	**9**	• Focused awareness, communications, and engagement campaign activities to promote opportunities and benefits through this information sharing platform. • Usage activity monitoring and reporting into the Digital Innovation Programme Board.

ICE Integration with SystmOne

Overall Status:	Lead:	L Maden
	Start Date:	01/04/2026
	End Date:	31/03/2027

Overall Summary

Technical and testing activities have been completed between the Trust and Mid-Yorkshire NHS Foundation Trust that provides systems integration enabling ICE results to be received directly into SystmOne at the Trust. The Systems Development team are liaising with Trust services to initiate trial areas prior to wider deployment. Once this work has been completed, activities will focus on enabling the same integration with our other acute partners.

Purpose

To improve accessibility and arrangements for accessing ICE to request and receive order communications and results reporting information with our acute partners (Mid-Yorkshire NHS Foundation Trust, Calderdale & Huddersfield NHS Foundation Trust, and Barnsley Hospital NHS Foundation Trust.

Expected Outcomes

- Improved ability to access and make requests e.g., blood test via the ICE systems(s) in place with our acute partners.
- Improve timeliness of access to results information electronically.
- Ability to update the results directly into the SystmOne record.
- Improve user set up time on the ICE system as we move to a structured process covered by a Service Level Agreement (SLA)
- Enabling users to electronically add Pathology test results from within the Trust's Clinical information system (SystmOne)
- Reduce the risk of manually adding Pathology test results to the wrong record.
- Save clinicians time by not having to log-in to numerous applications.
- Improved visibility of all Pathology test results for all three Laboratories in the Trust's area including those submitted by other organisations for a complete diagnostic history

Key Milestones

Activity	Summary	Target Date	Completion Date	Status

Mid Yorkshire Hospitals NHS Trust (MYHT) ICE integration	All activities have been completed for Forensics. The System Development team are currently completing the final wards, rolling out access to remaining inpatient wards.	~~May 2025~~ Aug 2026		A/G
Barnsley Hospitals NHS Foundation Trust (BHFT) ICE integration	Once work at Mid-Yorks is completed and goes live, the Systems Development team will be able to assign resource to the BHNFT Laboratory configuration and SystmOne set up.	~~Dec 2025~~ Sep 2026		A
Calderdale & Huddersfield NHS Foundation Trust (CHFT) ICE integration	Once work at BHNFT is completed and goes live, the Systems Development team will be able to assign resource to the CHFT Laboratory configuration and SystmOne set up.	~~Sep 2025~~ Dec 2026		P
Doncaster & Bassetlaw Teaching Hospitals NHS Trust ICE integration	Initial engagement has been made to commence the journey to establish ICE integration with SystmOne. This follows on from the successful deployment of SystmOne at the Cheswold Park Hospital site.	Mar 2027		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Challenges across the wider system impacting the ability to improve access to ICE for requesting/receiving order communications.	4	3	**12**	• Options explored and proposal depicting a way forward approved by the Trust. • Continue to liaise and collaborate with local acute partners and system suppliers. • Arrange appropriate training for staff to use the proposed new functionality.
Dependencies on external parties (ICE system supplier and Acute hospital partners) impacting the ability to move this forward in as timelier manner as the Trust requires	4	3	**12**	• Liaise and collaborate with local acute partners and system suppliers to explore having access to their ICE systems and to work through clinical, operational, and technical challenges for mutual benefits.

Data Security & Protection Toolkit 2026

Overall Status:



Lead:	R. Smith
Start Date:	01/07/2025
End Date:	30/06/2026

Overall Summary

Evidence gathering activities are progressing as planned and nearing completion in support of the Trust's Data Security & Protection Toolkit submission in 2026.

Purpose	Expected Outcomes
To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations.	• Mandatory IG training target achieved. • The Data Protection & Security toolkit target of meeting all mandatory standards is maintained.

	• Ongoing compliance with GDPR is assured and processes established which are reviewed regularly.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Data Security & Protection Toolkit (DSPT) for 2026	Activities are underway in respect of the 2026 DSPT submission which has been amended to incorporate Cyber Assurance Framework (CAF)	Jun 2026		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Failure to meet the Data Security & Protection Toolkit standards due to low compliance with mandatory information governance training	2	3	6	• Organisational, operational, and individual communications and monitoring in place. • Classroom session(s) offer available. • Where completion is via e-learning, advice is to screen shot for evidence due to risk that ESR may not update automatically.

Data Security & Protection Toolkit 2027

Overall Summary

Planning activities set to commence the preparatory work in readiness for the Data Security & Protection Toolkit submission in 2027.

Overall Status:



Lead:	R. Smith
Start Date:	01/07/2026
End Date:	30/06/2027

Purpose	Expected Outcomes
To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations.	• Mandatory IG training target achieved. • The Data Protection & Security toolkit target of meeting all mandatory standards is maintained. • Ongoing compliance with GDPR is assured and processes established which are reviewed regularly.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Data Security & Protection Toolkit (DSPT) for 2027	Activities are underway in respect of the 2026 DSPT submission which has been amended to incorporate Cyber Assurance Framework (CAF)	Jun 2027		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Failure to meet the Data Security & Protection Toolkit standards due to low compliance with mandatory information governance training	2	3	**6**	• Organisational, operational, and individual communications and monitoring in place. • Classroom session(s) offer available. • Where completion is via e-learning, advice is to screen shot for evidence due to risk that ESR may not update automatically.

Consent to Share Re-Engagement

Overall Status:		Lead:	Dr. A. Abbas R. Smith
		Start Date:	01/04/2026
		End Date:	30/06/2027

Overall Summary

Activities have been deferred to 2026/27 due to key staff unavailability, but work has recently been recommenced. A revision of the previous paper detailing the Trust's approach has been conducted and is currently undergoing review prior to formal governance approvals.

Purpose

A project that focuses on reviewing the Trust's approach to gaining/confirming consent to share out from existing patients, and on implementing a process based on the agreed approach to be taken, including the management and of exclusions and withdrawals of consent, whilst embedding this within clinical practice.

The review will be based around the Trust's agreed position that consent would continue to be the lawful basis to share, providing a sensitive approach with patient centredness. It should be noted that sharing out can be turned on at short notice where another lawful basis applies, e.g., to protect vital interests, reasons of substantial public interest, etc., so there is no risk attached to patients refusing to share. This follows the expiry of the COPI notice in July 2021.

Expected Outcomes

- All existing patients will have been asked if they consent to share out.
- All new patients will be asked if they will consent to share out.
- All patients will be aware of the right to withdraw consent at any time and how to do so.
- All responses are recorded, and system settings amended as required.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Revision of the paper previously produced outlining the Trust approach	A review of the paper previously drafted stating the Trust approach has been conducted and is undergoing review, prior to making recommendations to be considered via appropriate Trust governance routes.	~~Dec 2025~~ Jun 2026		**R/A**

Implement recommendations for agreed Trust approach	Implement recommendations in line with the agreed Trust approach with comprehensive staff engagement, communication, and guidance to support operational adoption. This will involve communication and training for all SystmOne users (staff) and engagement sessions with service users ahead of a formal system configuration change to reflect the change to the consent model.	Jun 2027		**P**
Exploration & development of a digital solution to capture consent to share	The Systems development team are exploring functionality available within SystmOne that could potentially meet this need (please refer to Communications Annex in the Clinical Records System update below). The output from this work will then determine if there is a need to explore alternative digital options to meet the Trust's requirements, determine route to market and development of a case for Trust governance and approvals. This work will be coordinated via the Consent to Share working group.	TBD		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Failure to meet Trust agreement to give patients choice in sharing their sensitive data	2	3	**6**	• Working group to consider options and develop a plan for Trust governance and approval. • Regular updates to the Improving Clinical Information Group (ICIG) for oversight and monitoring.
Capacity issues within the Information Governance function	3	3	**9**	• Planning and prioritisation of activities within the function to address operational capacity issues.

Digital Care Records

Our priorities for 2026-2027 that are supported



Electronic Patient Record System Developments				Overall Summary
		Lead:	L.Maden	

Overall Status:		Start Date:	01/04/2026	This is a major digital work programme that focuses on the optimisation and transformation of the Trust's electronic patient record (EPR), SystmOne. This work programme spans the introduction of new functionality, service redesign, systems integration and reducing the clinical administrative burden, with wraparound training and support. During the latter half of 2025/26 a significant amount of progress has been made, most notably conclusion of the integrated neighbourhood teams initiative.
		End Date:	31/03/2027	

Purpose	Expected Outcomes
SystmOne is the Trust's main electronic clinical record system spanning both mental health and physical health services. This programme of work ensures that the Trust continues to use SystmOne to its full potential, improving how services work both now and in the future, presenting opportunities and challenges faced by an ageing population with changing health needs, linked long-term conditions and those triggered by lifestyle choices. Supported through constantly adapting and enhancing integrated care pathways.	• SystmOne is used more consistently and effectively. • Processes and workflows that help staff and improve outcomes for our service users. • Supports the development of new integrated models of care. • Contribute to the drive towards digitisation of the NHS. • Ensures continuity of care with key clinical documentation re-designed to meet service needs and providing easier access to clinical information. • To ensure that all services are fully optimised in their usage of SystmOne. • Serves to contribute towards reducing the admin burden for staff.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
SystmOne Local Developments	***Integrated Neighbourhood Teams Service deployment:*** This major programme of work is now complete following the final service being migrated into the Integrated Neighbourhood Teams SystmOne unit.	Mar 2026	Mar 2026	C
	SystmOne eLearning training development: Continued development of tailored and bespoke training materials and course packages being created specifically for services, teams, and roles. The Systems Development team has also replaced its previous training development solution with Articulate software. This is already paying dividends in enabling the team to enhance its training materials and has used this solution to issue a training package for SystmOne/ICE interoperability.	Mar 2027		G
	Task management implementation: Steady progress continues to be made in the deployment of task management within Mental Health services with sustainable ongoing support being provided. Tasking training video created and now available on ESR for all staff. Dr. Abida Abbas, Trust CCIO, is leading on this project.	Mar 2027		G

	Integrated Neighbourhood Teams Service lessons learnt: It is planned that this major programme undertaking will now have a lesson's learnt exercise carried out by the Service Development Manager.	Jun 2026		**G**
	Exploration of TPP Brigid App use in Inpatient and Community settings: The Systems Development team are currently piloting Brigid with NEWS2 assessment on four inpatient wards. The pilot due to end mid-June when a decision will be made on the approach to roll out wider. Concurrently the Systems Development team are set to explore the potential for the use of the Brigid App for use out in the community for the uploading of patient photos via Trust issued smartphones in Physical Health & Wellbeing services.	Dec 2026		**P**
SystmOne Functionality Enhancements	***TPP SystmOne enhancements – Communications Annex:*** The Communications Annex brings together SystmOne functionality that enables messages to be sent to service users via SMS or email. This includes the added capability to attach templates or questionnaires for completion. Service users can also reply directly to messages, including returning completed documents, which are received into SystmOne as tasks and can then be uploaded to the patient's record. Work has begun with the SystmOne Clinical Lead to explore the use of this functionality for sending Protected Characteristics and Consent to Share information directly to patients. Deployment is being planned in a phased manner, on a service-by-service basis over the coming year. CAMHS have already gone live with this functionality, and Trust-wide communications have been issued to encourage staff to make use of the basic digital messaging features. There has also been interest from other areas in using the more advanced questionnaire functionality, with work currently underway with the MSK service as the next phase.	Dec 2026		**G**
	TPP SystmOne enhancements – Remote Appointment Booking: Mental health and Hospital services can now make appointment slots available to be booked into electronically by service users via the remote booking functionality. Trust-wide communications have been issued, and services are starting to show interest with some services already now live with this functionality.	Mar 2027		**G**
New SystmOne Functionality (Planned)	***Exploration of SystmOne AutoPlanner:*** SystmOne AutoPlanner is a new functionality designed to support automated scheduling. Work is	Aug 2026		**G**

	currently underway to map out plans and timelines. However, there is a key dependency on integration between SystmOne and Allocate eRostering. Development of this integration is ongoing and will form part of the wider rollout, with further engagement planned with Payroll. In parallel, initial work has begun using AutoPlanner as a standalone solution, with progress currently being made within the Physical Health District Nurse Services.			
	Exploration of Autofiling (Pathology results): This SystmOne functionality enables automatic review/filing of blood results within SystmOne, with rules set/defined locally. There is a dependency on ICE integration with SystmOne which is currently being rolled out, with results reporting from Mid-Yorks now live, so clinicians aligned to this ICE service provider can utilise this functionality and provide feedback on its effectiveness. A training package will follow in due course if necessary.	Aug 2026		**G**
	Physical Health Text Messaging via Healthcare Communications: We are working in collaboration with Physical Health & Wellbeing service leads to ensure that each service has tailored text messaging configurations that meet their specific service requirements. The Systems Development team is partnering closely with service leads, alongside Performance & Business Intelligence (P&BI) colleagues, to update the Strategic Reporting Extract (SRE) from SystmOne so that it supports these needs effectively. Initial work began with the Children's Therapy team. However, this was temporarily paused due to the Healthcare Communications and Webex migration, which was completed in February 2026. This work has now resumed, with current focus on progressing the Children's Therapy team and expanding into MSK services. Other services will follow on a service-by-service basis.	Aug 2026		**G**
	TPP DNA levels utilising AI: TPP have developed an AI capability within SystmOne that is reporting to aid with reducing DNA levels proactively. The initial focus has been on primary care and TPP are planning to explore this capability within Mental Health and Community care settings. The Systems Development team has registered interest	Timescales awaited from TPP		**P**

	with TPP in wanting to explore this further as a potential early adopter site.			
	System Connect: Work ongoing by TPP to integrate SystmOne with the NHS App, which will enhance capabilities for providing service users within appointment reminders via NHS App (as an alternative to text messaging), plus other capabilities. This has the potential to reduce the costs incurred by sending text messages and appointment reminders as the NHS App does not incur a cost. The Trust has expressed interest in this as a potential early adopter.	Timescales awaited from TPP		**P**
Reducing the impact on the clinical administrative burden	The initiatives outlined above collectively supports a significant reduction in clinical administrative workload by streamlining communication, documentation, and scheduling processes across services. Enhanced digital communication tools within SystmOne, including SMS, email, and questionnaire functionality, reduce reliance on manual processes such as paper forms, outbound calls, and follow-up administration. Automated responses and direct integration into patient records minimise duplication and improve data accuracy. **The implementation of Brigid** will remove the need for manual paper-based data entry by enabling real-time data capture at the patient's bedside. This will reduce duplication of effort associated with dual data entry, resulting in improved efficiency and time savings for clinical staff. Additionally, the initiative is aligned to the Trust's 3P's (printing, postage & paper) project in support of the value for money programme. **The introduction of Ambient Voice (AI)** capabilities that integrates with SystmOne has the potential to further transform clinical workflows by reducing the time spent on manual notetaking and transcription. This enables clinicians to focus more on patient interaction while ensuring timely and structured documentation within SystmOne. **Auto-scheduling functionality** through SystmOne AutoPlanner will support more efficient workforce utilisation, reducing the administrative effort required for appointment planning and coordination. Once integrated with Allocate eRostering, this will further streamline workforce management processes and reduce manual intervention across scheduling and payroll interfaces.			**G**

	SystmOne Integration with ICE (Integrated Clinical Environment) systems will reduce the administrative burden associated with ordering and reviewing diagnostics. By enabling more seamless electronic requesting and results management within core clinical systems, this minimises duplication, reduces the need for manual entry or reconciliation of information, and improves the timeliness and accuracy of clinical data. **Tailored text messaging solutions** via Healthcare Communications also improve patient engagement and reduce missed appointments, while decreasing the administrative time associated with contacting patients and managing follow-ups. These developments are being progressed in collaboration with other support services such as the Integrated Change team, ensuring that solutions are not only clinically effective but also aligned to organisational priorities, enabling and delivering efficiency, service transformation, and making best use of available resources. Overall, these developments support a shift towards more automated, integrated, and user-friendly systems, enabling clinical and administrative staff to work more efficiently. This not only reduces administrative burden but also enhances data quality, improves patient experience, and supports more effective use of clinical time.				

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Risk that the SystmOne training leads to inconsistencies in usage, impacting data quality	2	3	**6**	• Comprehensive assessment of training needs conducted during service deployment and introduction of new functionality has training, learning and development aspects incorporated into the approach. • Adopts a co-design, co-produced approach following best practice in the development of bespoke training programmes, materials in collaboration with services leads to aid successful uptake, improved data quality, and optimal system usage. • The introduction of eLearning capabilities has improved training access equity across the Trust and virtual short courses serve to aid good practice and message

				reinforcement, especially where areas requiring data quality improvement are highlighted.
Risk that data quality is impacted through ineffective use of the system and application of available functionality	2	3	**6**	• As well as improved and appropriate systems training for staff, several additional initiatives are pursuing improvements in data quality, specifically relating to correctly recording outcomes on SystmOne, the waiting lists project and other targeted interventions.
Dependency on Systems Development team available resources and capacity to deliver the priorities and initiatives within the systems development work programme and roadmap timelines, as well as meeting operational service expectations	3	3	**9**	• Ensure robust planning, resource development/assignment opportunities and prioritisation activities that are aligned with the work programme. • Working in close partnership with operational service management colleagues to align plans and prioritise requirements within the work programme.

EPMA & EPS Community

Overall Status:		Lead:	K. Dewhirst
		Start Date:	01/04/2024
		End Date:	31/03/2028

Overall Summary

Prioritisation for EPMA and EPS in the community was agreed at OMG. A detailed business case has been prepared to support this plan and has been approved by the Value for Money Group. EPMA has been implemented in all inpatient areas at Cheswold Park Hospital. The next milestone after that will be the pilot of EPS in Adult ADHD which is planned for go live June 2026 with a pilot and evaluation before the wider rollout to CAMHS and community mental health teams in Barnsley, Calderdale, Kirklees and Wakefield by September 2026. In response to system pressures, EPS was implemented in Barnsley care group virtual wards in Autumn 2025.

Purpose

Electronic Prescribing and Administration of Medications (EPMA) together with the Electronic Prescription Service (EPS) are key developments which are designed to improve patient safety, efficiency in service delivery, quality of data and deliver financial benefits for the organisation. It converts the traditional paper prescription and administration card into an electronic record accessible by an authorised user from any device with the requisite software. Many Trusts are taking this approach. The inclusion of EPS also further enhances this capability by enabling the electronic transfer of prescriptions between the Trust and community

Expected Outcomes

- Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve.
- Reduce risks associated with medicines prescribing and dispensing.
- This provides the opportunity for shared learning and development, for SWYPFT to provide systems leadership and work with partners to influence national changes required within the digital solution.
- Improves the Trust's overall digital maturity.
- Enables service user choice and improves the service user experience.
- Prescribers can process prescriptions more efficiently.
- Dispensers can reduce paper use and improve stock control.

pharmacies that allows the streamlining of prescription services to service users and carers.	• Dispensers reduce the risk of dispensing errors compared to hand-written prescriptions. • Service users can collect repeat prescriptions from a local pharmacy without visiting their GP. • Service users can manage their nominated pharmacy and track prescriptions in the NHS App.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Deployment of EPMA in IHBTT and all inpatient areas including 136 suites and Cheswold Park Hospital	Completed the deployment in IHBTT, section 136 suites and Cheswold Park Hospital.	Mar 2026	Mar 2026	C
Deployment EPS into Community Services (Mental Health & Physical Health Services)	Deployment of EPS SystmOne functionality within Community Services (Mental Health and Physical Health Community Services).	Mar 2028		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Functionality does not work as expected or is not enabled by supplier	2	4	8	• Utilising escalation pathway with supplier • Testing with community pharmacy in pilot unit
Service pressures reduce attendance at training sessions	2	3	6	• Working closely with operational colleagues • Development of e-learning capabilities

Records Scanning Bureau System Implementation

Overall Status:



Lead:	C.Doran
Start Date:	01/04/2025
End Date:	30/09/2026

Overall Summary

The legacy scanners have been replaced and the contract for the new digital solution finalised, enabling the implementation activities to progress for the new digital records management system, with a currently planned go live scheduled for July 2026.

Purpose	Expected Outcomes
To implement the chosen electronic records management system to replace the existing life expiring system. This	• Improve scanning bureau workflow and processes.

follows the completion of the procurement exercise and subsequent contract award to the preferred supplier completed in 2024/25.	• Increase ability to target key areas and monitor KPI performance against data-drive insights. • Reduce reliance on off-site storage (avoidance of increased costs and to reduce associated costs) • Improve governance through having easy, electronic access to all records related to a Trust client, through seamless integration with the Trust's electronic care record system. • Supports the digitisation and paperless NHS agenda

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Replacement of the legacy scanners	Replacement scanners have been specified and funded from available capital in 25/26 to help mitigate the risks associated with the risks associated with the legacy hardware.	Q3 25/26	Jan 2026	C
Planning and implementation solution	Following completion of the contract finalisation, activities are underway for the implementation of the Trust's new digital records management solution. A go live for the system is being scheduled for the end of July 2026.	Jul 2026		G

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Staffing capacity issues within the records management function	3	4	12	• Activities are ongoing to address and alleviate service pressures. New staff members have been appointed to the wider records team which should aid with capacity challenges, enabling the risk score to reduce from 16 to 12.

EPR Procurement Collaborative

Overall Status: ⬆



Lead:	P. Foster T. Rycroft (BDCT)
Start Date:	01/10/2025
End Date:	30/06/2027

Overall Summary

The Trust together with Bradford District Care NHS Foundation Trust (BDCT) are leading an EPR procurement collaborative with NHS provider partners across West and South West Yorkshire, for the reprovisioning of an EPR to support Mental Health Services and Physical Health & Wellbeing Services. Preparatory activities are underway, with a procurement framework partner (London Procurement Partnership – LPP) secured and a tender issued via BDCT to commission specialist resources to oversee and undertake the pre-procurement/procurement activities through to contract award.

Purpose

Expected Outcomes

To formally establish arrangements to facilitate and conduct a joint procurement exercise for the re-provisioning of the Trust's Electronic Patient Record (EPR) system (SystmOne), through a collaborative arrangement with partners across West and South Yorkshire whose EPR contract is set to expire in the near future.	• Development of a shared and comprehensive output-based specification for the EPR system • Shared costs for procurement in terms of commercial and legal advice, as well as assurance mechanisms • Reduced duplication of effort in terms of the required activities providing economies of scale throughout the procurement phase, sharing of expertise and specialist requisite resources • Potentially leverage stronger synergies and commercial bargaining with prospective suppliers, underpinned by joint contractual arrangements.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Establish a formal procurement collaborative arrangement	Development of a memorandum of understanding (MOU) for all partners to formally sign up following initial expressions of interest from circa 10 organisations providing Mental Health and/or Community Services	Jun 2026		G
Procurement to secure specialist independent resources to oversee and co-ordinate the procurement activities	BDCT are leading this element of work and have issued out a tender via the G-Cloud framework. Initial expressions of interest have been received and clarification questions responded to. Formal tender responses are expected by 5 June 2026.	Jun 2026		G
Commence preparatory procurement activities	Establishing governance arrangements, ensuring appropriate and consistent stakeholder representation and involvement in the activities	TBC		P
Develop the Statement of Need and associated documentation	Development of the formal tender document articulating the statement of requirements and associated documentation to support the Invitation to Tender (ITT)	TBC		P
Approval to Proceed to Invitation to Tender (ITT)	Secure respective organisation approvals to proceed to enable the issuing of the Invitation to Tender (ITT)	TBC		P
ITT Issuance	Co-ordinate and respond to supplier clarification questions, schedule supplier demonstrations/reference site visits and conclude the evaluation and scoring activities.	TBC		P
Evaluation Report	Produce the evaluation report detailing the findings from the procurement exercise and recommendations for preferred solution/supplier	TBC		P
Agree Preferred Solution/Supplier	Secure respective organisation approvals from the outputs from the procurement exercise and recommendations.	TB		P
Contract negotiations and award	Following period of standstill, initiate contractual negotiations and finalise the contract to enable award	TBC		P

Key Risks	Likelihood	Impact	Risk Score	

Procurement activities are subject to delay resulting from the collaborative arrangements	4	3	**12**	• Ensure agreement in the approach as detailed in the MOU to ensure that the procurement activities remain on track in line with the plan and timescales.

Cyber Security

Our priorities for 2026-2027 that are supported



Cyber Security Programme 2025/26

Overall Status: ✓	COMPLETED	Lead:	C. Crocker
		Start Date:	01/04/2025
		End Date:	31/03/2026

Overall Summary

The activities within the programme of work for cyber security in 2025/26 have been completed as planned following availability of required capital funding in-year being made available to support key digital infrastructure priorities due to Older People's development slippage.

Purpose

Given that the threat of a cyber-attack remains constant, the Trust continues to take such threats extremely seriously and has established several steps to safeguard against the likelihood, impact, and consider cyber security in all aspects of the digital agenda.

Actual Outcomes

- Continued vigilance and awareness of the threat of cyber-attack.
- Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats.
- Adoption of industry standard best practices, as appropriate.
- Improve the defence against cyber-attack.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
SIEM enhanced monitoring	Security Information and Event Management (SIEM) enhanced monitoring capabilities.	Jul 2025	Aug 2025	C
Cyber security communications plan	Undertake a review of the cyber security communications plan in collaboration with the Trust's Communications team to improve awareness of cyber phishing.	Aug 2025	Aug 2025	C

Board cyber security awareness training	NHS England commissioned Board cyber awareness training to provide Trust Board members with raised awareness and insights to aid with organisational assurances	Oct 2025	Oct 2025	**C**
Cyber security survey	An annual phishing survey to further gauge staff awareness, and understanding, to determine if vigilance is improving. The results of the survey will inform an action plan.	Nov 2025	Oct 2025	**C**
Cyber tabletop exercise	Annual cyber security tabletop exercise to be scheduled during 2025 in line with the cyber programme.	~~Nov 2025~~ Feb 2026	Mar 2026	**C**
Penetration testing	The Trust undertakes an independent annual infrastructure, server, and client penetration (PEN) test to ensure and provide further assurances that the services being provided are being proactively managed. In November 2025, the Trust selected a supplier to conduct the annual PEN and the test took place in December 2025 with the completed report arriving in January 2026. The output of this work was positive, and a workplan was established for a small number of recommended actions, which have since been resolved by the Trust's IT team working alongside Wavenet.	Jan 2026	Jan 2026	**C**
Cyber security survey findings action plan	To develop and deliver a programme of guidance and communications to set out how to identify a phishing email, and what staff should (and should not) do if they receive them.	Dec 2025	Dec 2025	**C**
Cyber Essentials Plus reaccreditation compliance	Annual review of the Trust's cyber security measures and controls to ensure continued accreditation compliance. The activities were brought forward to December 2025 and reaccreditation successfully awarded in January 2026.	Jan 2026	Jan 2026	**C**

Cyber Security Programme 2026/27

Overall Status:



Lead:	C. Crocker
Start Date:	01/04/2026
End Date:	31/03/2027

Overall Summary

Preparatory activities are underway in respect of the cyber security work Programme for 2026/27.

Purpose

Given that the threat of a cyber-attack remains constant, the Trust continues to take such threats extremely seriously and has established several steps to safeguard against the

Expected Outcomes

- Continued vigilance and awareness of the threat of cyber-attack.
- Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats.

likelihood, impact, and consider cyber security in all aspects of the digital agenda.	• Adoption of industry standard best practices, as appropriate. • Improve the defence against cyber-attack.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Cyber security communications plan	Undertake a review of the cyber security communications plan in collaboration with the Trust's Communications team to improve awareness of cyber phishing.	Aug 2026		**P**
Cyber security survey	An annual phishing survey to further gauge staff awareness, and understanding, to determine if vigilance is improving. The results of the survey will inform an action plan.	Nov 2026		**P**
Penetration testing	The Trust undertakes an independent annual infrastructure, server, and client penetration (PEN) test to ensure and provide further assurances that the services being provided are being proactively managed. This has taken place in November 2025 as planned, further output from this work to be reviewed before completion.	Dec 2026		**P**
Cyber security survey findings action plan	To develop and deliver a programme of guidance and communications to set out how to identify a phishing email, and what staff should (and should not) do if they receive them.	Jan 2027		**P**
Cyber Essentials Plus reaccreditation compliance	Annual review of the Trust's cyber security measures and controls to ensure continued accreditation compliance. This was planned for January 2026 but has been brought forward to December 2025.	Jan 2027		**P**
Cyber tabletop exercise	Annual cyber security tabletop exercise to be scheduled during 2025 in line with the cyber programme.	Feb 2027		**P**
SIEM Transitioning	Transitioning of the Trust's Security Information and Event Management (SIEM) enhanced monitoring capabilities from Rapid 7 to Microsoft Sentinel.	Mar 2027		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Limited capital funding available during 2026/27 may significantly impact the Trust's cyber security posture	3	4	**12**	• Frontline Productivity investment fund expression of interest bids submitted to NHS England to supplement the cyber security investment plan.

Digital Infrastructure

Our priorities for 2026-2027 that are supported



Infrastructure Modernisation Programme 2025/26

Overall Status: ✓

COMPLETED

Lead:	C. Crocker
Start Date:	01/04/2025
End Date:	31/03/2026

Overall Summary

Activities to support the progression of the digital infrastructure work programme for 2025/26 have been completed as planned following availability of required capital funding in-year being made available to support key digital infrastructure priorities due to Older People's development slippage.

Purpose

Continuous programme of replacement, modernisation, and enhancement of the Trust's IT infrastructure. The purpose being to ensure the Trust has a strategic, robust, and secure IT environment which is maintained, providing the necessary assurances of business resilience and disaster recovery capabilities to support the digital footprint now and in the future.

Actual Outcomes

- Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g., from Fieldhead to Kendray).
- A more readily scalable infrastructure that can flex to meet changing demands.
- No requirement for major short-term investment in the event of a disaster.
- Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licences (potentially reducing costs).
- Proven disaster recovery position with confirmed recovery points and associated timelines.
- Enhanced cyber security position would bring about improved resilience and reduce the risk from cyber-attack, malicious or otherwise.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Digital infrastructure capital programme	Detailed programme planning, and mobilisation of planned 2025/26 capital expenditure focusing on: - ▪ Server and network hardware enhancements and replacements.	Mar 2026	Mar 2026	C

	▪ Corporate Wi-Fi modernisation programme replacing end of life approaching Wi-Fi controllers and access points. ▪ Partner Wi-Fi access (Govroam/Eduroam) upgrades ▪ Virtual Private Network (VPN) enhancements ▪ Local area network (LAN) and wide area network (WAN) enhancements.			

Decommissioning of the legacy Cheswold Park Hospital digital infrastructure			**Overall Summary**
Overall Status: ⬆		Lead: P. Foster I. Ahmed Start Date: 01/01/2025 End Date: 31/07/2026	Most decommissioning activities for the legacy IT/digital estate has been completed, with minimal residual elements remaining and the legacy OneTouch system, which is used by Pharmacy, but measures have been put in place to address this, until decommissioning has been completed.

Purpose	**Expected Outcomes**
To manage the safe and controlled decommissioning of the legacy Cheswold Park Hospital digital infrastructure (IT network and systems) following the integration and transition over to the Trust network environment and systems.	• Safe and smooth transition of services into the Trust. • Reduction of potential digital related risks spanning operational, clinical, technical, cyber, service user dimensions. • Reduction/removal of risks associated with end-of-life approaching IT equipment and information. systems conducted in a safe and supportive manner. • Legacy costs reduction/negation offsetting costs for Trust digital infrastructure.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Legacy Corporate systems	Supporting the relevant Cheswold Park Hospital programme workstreams in the decommissioning of legacy systems following the transition to Trust corporate systems. This will involve procurement and information governance and the relevant asset owners. Only the OneTouch system used by Pharmacy remains but there are activities being progressed to remove this dependency and notice to terminate the contract has been served to the supplier, pending Pharmacy to complete and confirm their activities to finalise decommissioning.	~~Mar 2026~~ Jul 2026		A
Legacy Clinical System	Decommissioning of the CareNotes electronic care record system following the successful introduction of SystmOne.	Oct 2025	Apr 2025	C

Legacy Cheswold Park Hospital IT network infrastructure	Decommissioning of the legacy IT network infrastructure and telephony at Cheswold Park Hospital	Jul 2025	Jul 2025	C

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Residual reliance on legacy systems may impact the ability to decommission the CPH IT/digital infrastructure and services incurring additional costs.	3	3	**9**	• Working closely with all workstreams and asset owners to ensure robust and timely exit plans are in place to affect the safe and efficient decommissioning of the legacy IT/digital estate at Cheswold Park Hospital. • Cheswold Park Hospital integration programme is overseeing this work.

Microsoft Developments 2025/26

Overall Status: ✓



Lead:	C.Crocker
Start Date:	01/04/2025
End Date:	31/03/2026

Overall Summary

Activities were completed for the annual review and renewal of the Trust's enterprise-wide licencing agreement with Microsoft, together with subsequent Microsoft environment enhancements as planned.

Purpose

To ensure that the Trust makes optimal use of existing and future Microsoft products available via the Trust's enterprise-wide agreement with Microsoft.

Actual Outcomes

- Ensures that the Trust makes best use of the available Microsoft products and functionality, in the most appropriate and cost-effective strategic way forward to support the wider digital agenda.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Renewal of the Trust's Enterprise-Wide Agreement with Microsoft	Review the Trust's requirements and complete the timely renewal of the organisation's enterprise-wide agreement for the Microsoft suite of software and products. The revised agreement to take account of and be based on the NHS England nationally negotiated contract with Microsoft.	Jun 2026	Jun 2026	C
Office365 platform enhancements	Evaluate and consider opportunities to further enhance the Trust's use of its Microsoft Office365 platform entitlement.	Mar 2026	Mar 2026	C

Windows 11 Migration

Overall Summary

Overall Status:		Lead:	C.Crocker	All the Trust's end user computer estate now operates on Windows 11 which relies on Microsoft technologies, including Microsoft BitLocker for encryption. Whilst there remains a handful of non-standard Windows 10 devices in use in the Trust, there are appropriate mitigations, controls, and plans in place to address these.
✓	COMPLETED	Start Date:	01/04/2023	
		End Date:	30/06/2025	

Purpose	Actual Outcomes
A programme of work was initiated during 2023/24 to commence the upgrade/migration of the Trust's end user computing estate (desktops and laptops) from the existing Microsoft Windows 10 to Microsoft Windows 11 operating system ahead of the October 2025 deadline for when Windows 10 goes out of support.	• Enables the Trust to provision new and replacement end user computing devices in a strategic and planned manner, making better use of available resources through centralised control of assets. • Improves end user experience and general computing performance. • Provides greater assurance and controls from which to minimise the risk of cyber threats through continuous availability to software security updates.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Upgrading of Windows 10 devices to the Windows 11 operating system	Upgrading to the Windows 11 operating system for all Trust issued devices (laptops and desktops) from Windows 10 ahead of the October 2025 deadline. The accelerated migration approach within the Trust has resulted in 99% of all Trust devices running the Windows 11 operating system. This places the Trust at the forefront nationally, when compared to national statistics by region as depicted below.	Jun 2025	Aug 2025	C

Infrastructure Modernisation Programme 2026/27

Overall Status:		Lead:	C. Crocker	Overall Summary
↑		Start Date:	01/04/2026	Preparatory activities have commenced with regards to the digital infrastructure work programme for 2026/27.
		End Date:	31/03/2027	

Purpose	Expected Outcomes
Continuous programme of replacement, modernisation, and enhancement of the Trust's IT infrastructure. The purpose being to ensure the Trust has a strategic, robust, and secure IT environment which is maintained, providing the necessary	• Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g., from Fieldhead to Kendray). • A more readily scalable infrastructure that can flex to meet changing demands.

assurances of business resilience and disaster recovery capabilities to support the digital footprint now and in the future.	• No requirement for major short-term investment in the event of a disaster. • Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licences (potentially reducing costs). • Proven disaster recovery position with confirmed recovery points and associated timelines. • Enhanced cyber security position would bring about improved resilience and reduce the risk from cyber-attack, malicious or otherwise.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Digital infrastructure capital programme	Detailed programme planning, and mobilisation of planned 2025/26 capital expenditure focusing on: - ▪ Server and network hardware enhancements and replacements. ▪ Corporate Wi-Fi modernisation programme replacing end of life approaching Wi-Fi controllers and access points. ▪ Partner Wi-Fi access (Govroam/Eduroam) upgrades ▪ Virtual Private Network (VPN) enhancements ▪ Local area network (LAN) and wide area network (WAN) enhancements.	Mar 2027		**P**

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Limited capital funding available during 2026/27 may significantly impact the Trust's digital infrastructure modernisation programme	3	4	**12**	• Frontline Productivity investment fund expression of interest bids submitted to NHS England to supplement the Trust's digital infrastructure investment plan.

Email Platform Re-Accreditation 2026/27

Overall Status: ⬆



Lead:	A. Siddle
Start Date:	01/04/2026
End Date:	31/12/2026

Overall Summary

The planning, scheduling and re-accreditation activities have been completed as planned, confirming that the Trust's @swyt.nhs.uk email platform meets the required standards for the next 12 months.

Purpose	Expected Outcomes
To oversee the re-accreditation and compliance with NHS Digital's advanced security protocols, meaning that emails can then be sent and received containing	• Staff can use their Trust's Microsoft Office365 email accounts to send and receive emails containing sensitive and confidential information. The sending of sensitive and confidential information via this means to external third parties require the organisation in question to confirm that their email platform complies with the

sensitive/confidential information using the Trust's Microsoft Office365 email platform. Background The Trust achieved accreditation status in August 2021 which enabled the decommissioning of NHSMail (NHS.Net) email accounts that were in use across the Trust. The Trust subsequently achieved re-accreditation status in August 2022.	requirement of DCB 1596 Secure Email Standards and Transport Layer Security (TLS) encryption. • Removes the need for Trust staff to use multiple email platforms for Trust business purposes. Please note that there will be a requirement for a small number of Trust staff to retain their NHSMail email accounts for specific external correspondence purposes.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Email platform compliancy	The Trust's Microsoft Office365 email environment complies with the NHS Digital standards. Confirmation of re-accreditation achievement provided by NHS Digital.	Sep 2026		P
Develop remediation action plan	Development of a remediation action plan stemming from the findings, suggestions, and recommendations from the email platform accreditation review process.	Dec 2026		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

Microsoft Developments 2026/27

Overall Status: 		Lead:	A. Siddle
		Start Date:	01/04/2026
		End Date:	31/03/2027

Overall Summary

The review and renewal of the Trust's Microsoft enterprise-wide agreement have been completed slightly ahead of plan. This has realised a financial saving in 2026/27 resulting from licence rationalisation activities and a reduction in unit costs for some Microsoft licencing components.

Purpose	Expected Outcomes
To ensure that the Trust makes optimal use of existing and future Microsoft products available via the Trust's enterprise-wide agreement with Microsoft.	• Ensures that the Trust makes best use of the available Microsoft products and functionality, in the most appropriate and cost-effective strategic way forward to support the wider digital agenda.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status

Renewal of the Trust's Enterprise-Wide Agreement with Microsoft	Review the Trust's requirements and complete the timely renewal of the organisation's enterprise-wide agreement for the Microsoft suite of software and products. The revised agreement to take account of and be based on the NHS England nationally negotiated contract with Microsoft.	Jun 2026	May 2025	C
Office365 platform enhancements	Evaluate and consider opportunities to further enhance the Trust's use of its Microsoft Office365 platform entitlement.	Ongoing		P

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
				•

CAMHS Secure Estate Infrastructure

Overall Summary

Activities are in progress awaiting installation of the data/network circuits for the establishment of the Trust network infrastructure at Wetherby Young Offenders Institution, Adel Beck (Leeds), and Aldine House (Sheffield).

Overall Status:



Lead:	R. Tyas
Start Date:	01/04/2025
End Date:	30/09/2026

Purpose

To install and implement the SWYT network infrastructure within the CAMHS Secure estate enabling access to Trust corporate systems and Intranet, following the successful tender outcome to continue to provision and enhance Mental Health services.

Expected Outcomes

- Enhanced service provision through improved access to SWYPFT systems and infrastructure and organisational autonomy.
- Improves end user experience.
- Provides service staff with equitable access to wider Trust services and support.

Key Milestones

Activity	Summary	Target Date	Completion Date	Status
Establishment of the SWYT network infrastructure across the CAMHS Secure estate stated sites.	Place order for the wide area network links to connect the sites to the Trust network, install network hardware, implement, and configure the SWYT network and provision of end user computing into the environment for service staff.	Sep 2026		A/R

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Due to the extremely limited capital funding available to the Trust during 2025/26, this may significantly impact on the ability to complete the activities in a timely manner during 2025/26.	3	2	6	• Capital requirements for this initiative (£92k) were identified as part of annual planning cycle for 2025/26, but there are no digital capital schemes in 2025/26 to enable this, due to priority on Older People's estate developments.

				• The digital programme in 2025/26 and key priorities will have first call against any capital underspend, or additional capital that may become available, in year as a contingency. • This is being escalated to explore funding to enable the necessary works to proceed.
Preparatory activities to start mobilisation work were delayed due to the focus and priority assigned to Cheswold Park Hospital programme, raising concerns on timeline expectations with Leeds Community Healthcare NHS Trust who are currently supporting elements of this service.	3	3	**9**	• This position was made clear during the service tendering process and due to the required capital funding necessary in 2025/26.
Network links potential for delay	3	3	**9**	• There is never a guaranteed lead time on the delivery of a data/network circuit, timeline has been pushed out due to circuit delivery delays

South West Yorkshire Partnership Teaching NHS Foundation Trust

Trust Board annual work programme 2026-27

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✖	Item deferred

Note that some items may be verbal

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
Standing Items												
Welcome, Introduction and Apologies	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
Declarations of Interest	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
Minutes from the previous meeting	✖		✖	✖		✖	✖	✖		✖		✖
Action log and matters arising from previous meeting	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
Service User/Staff Member/Carer Story	✖		✖	✖		✖	✖	✖		✖		✖
Chair's remarks	✖		✖	✖		✖	✖	✖		✖		✖

With **all of us** in mind.

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
Chief Executive's Report	✘		✘	✘		✘	✘	✘		✘		✘
Questions from the public (item 3)	✘		✘	✘		✘	✘	✘		✘		✘
Any other business (public and private)	✘		✘	✘		✘	✘	✘		✘		✘
Assurance from Trust Board committees and Members' Council and Joint Partnership Board (Teaching Trust)	✘		✘	✘		✘	✘	✘		✘		✘
Risk and Assurance												
Board Assurance Framework	✘			✘			✘			✘		
Corporate / organisational risk register	✘			✘			✘			✘		
Strategic overview of business and associated risk											✘	✘
Review of Risk Appetite statement												✘
Complex Clinical Matters update (private session)	✘		✘	✘		✘	✘	✘		✘		✘
Patient Safety Oversight Report (formerly Incident management quarterly report (public))			✘ (annual)			✘		✘				✘
Guardian of safe working hours annual report							✘					
Workforce Equality Standards						✘						
Medical appraisal / revalidation annual report						✘						
Ligature Annual Report								✘				
Freedom to Speak Up Annual report (October Annual report and April 6 monthly update)	✘						✘					
Medical Education Annual Board report								✘				
Data Security and Protection toolkit (delegated authority required for submission for 30 June)		✘		✘								
Cyber Board training (TBC)												

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
Annual report and accounts (private)		✘	✘									
Quality Account			✘									
Annual Governance Statement	✘											
Equality and diversity annual report				✘								
Incident management annual report			✘									
Health and safety annual report				✘								
Patient Experience annual report			✘									
Sustainability annual report						✘						
Premises Assurance Model annual report				✘								
PLACE assessment annual report				✘								
EPRR Compliance report							✘					
IPC BAF				✘								✘
NHS Staff Survey results												✘
Safer Staffing report			✘	✘						✘		
Committee private risk exception reports (private session)	✘		✘	✘		✘	✘	✘		✘		✘
Integrated Care Systems and Partnerships												
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	✘		✘	✘		✘	✘	✘		✘		✘
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	✘		✘	✘		✘	✘	✘		✘		✘
Provider Collaboratives and Alliances	✘		✘	✘		✘	✘	✘		✘		✘
<u>Performance reports</u>												

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
Care Group Performance report	✘		✘	✘		✘	✘	✘		✘		✘
CQC action plan updates			✘			✘		✘				✘
Strategic Direction												
Board Development		✘			✘				✘		✘	
Investment Appraisal Framework (private)	✘							✘				
Strategic Objectives/Priority Programmes												✘
Trust Board Annual Work Programme												✘
Trust Plan (private)						✘ (draft / private)	✘ (draft / private)	✘ (1st draft)		✘ (final draft)		
Finance and value for money updates (private)	✘		✘	✘		✘	✘	✘		✘		✘
Strategy Measurement				✘								
Governance												
Constitution (including Standing Orders) and Scheme of Delegation (every 2 years – next Jan 2027)										✘		
Compliance with NHS provider licence conditions and code of governance			✘									
Going Concern Statement	✘											
Assessment against NHS Constitution				✘								
Audit Committee annual report including committee annual reports and terms of reference	✘											
Use of Trust Seal			✘			✘		✘				✘
Internal governance structure review												✘
Stakeholder map (private)			✘									

Agenda item / issue	28 Apr	26 May	30 June	28 July	25 Aug	29 Sep	27 Oct	1 Dec (Nov)	15 Dec	26 Jan	23 Feb	30 Mar
Strategies and Policies												
Digital strategy (including IMT) **update**			✘							✘		
Estates strategy **update**				✘						✘		
Customer Services Policy						✘						
Trust Board declaration and register of fit and proper persons, interests and independence policy						✘						
Quality Strategy (date to be TBC after March 2026)												
Research and Development Strategy (TBC)												

Policy / strategy review dates:

- Trust Strategy *(July 2030)*
- Standing Financial Instructions *(delegated approval authority to Audit Committee, reviewed as required)*
- Treasury management strategy and policy (delegated approval authority to Audit Committee, reviewed as required)
- Constitution (Jan 2027) (or as required)
- Equality, Diversity and Inclusion Strategy (March 2028)
- Emergency Preparedness Resilience and Response Policy (October 2027)
- Customer Services Policy *(September 2026)*
- Digital Strategy *(January 2030)*
- Clinical Strategy *(March 2030)*
- Estates Strategy *(July 2033)*
- Learning from Healthcare Deaths Policy *(June 2027)*
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(April 2027)*
- Quality Strategy *(TBC- subject to review by QSC)*
- Risk management governance framework *(next due for review in April 2028)*
- Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in April 2029)*
- Sustainability and Social Responsibility Strategy *(July 2027)*
- Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in September 2026)*
- People Strategy *(December 2028)*
- Research and Development Strategy *(TBC)*