NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

April 2026

With all of us in mind.

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Table of Contents

Click on each section heading to navigate to that section

Introduction

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

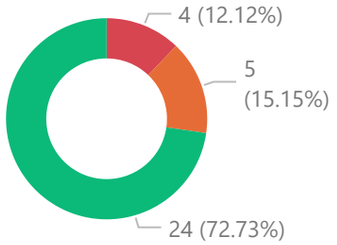
On 1st October 2024, the Trust acquired Cheswold Park Hospital, which is a 112-bed low and medium secure mental health hospital based in Doncaster, providing services to male and female patients with a diagnosis of mental illness, personality disorder or neurodevelopmental disorders. Cheswold Park provides 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.

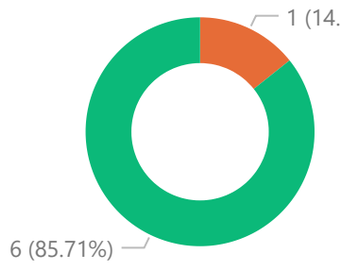
Headlines - Performance Rates Summary

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.

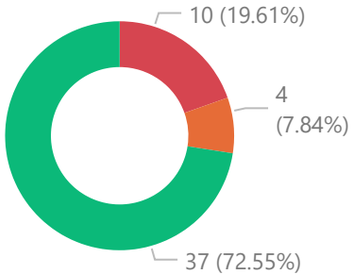
Quality & Safety Metrics Performance Rate



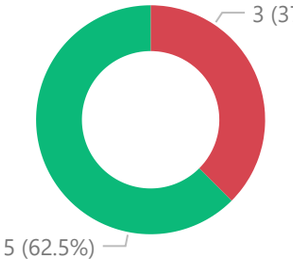
People Metrics Performance Rate



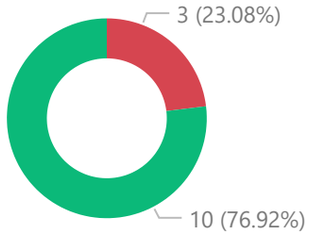
National Metrics Performance Rate



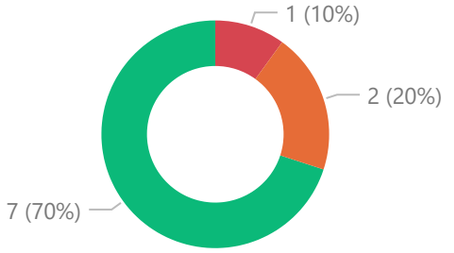
Finance Metrics Performance Rate



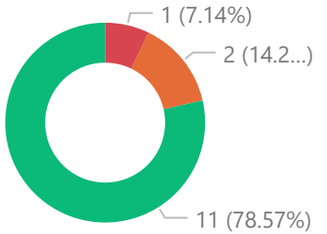
Barnsley Physical Health Metrics Performance Rate



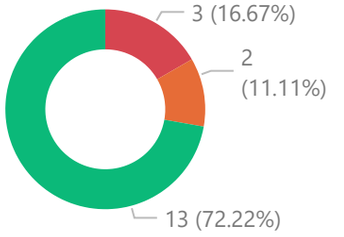
CAMHS Metrics Performance Rate



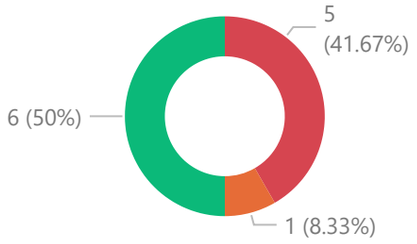
Mental Health Community Metrics Performance Rate



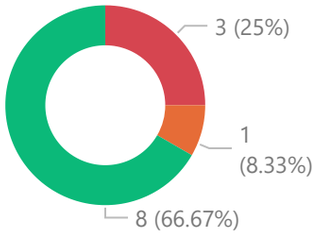
Mental Health Inpatient Metrics Performance Rate



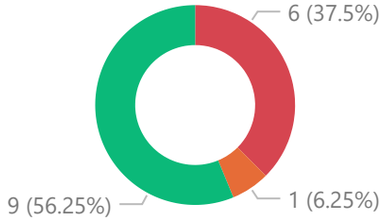
ASD/ADHD Metrics Performance Rate



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 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	↑	
Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	↑	

People

Metric	Change from last month	Variation/ Assurance
Sickness absence - YTD	↑	
Appraisals - rolling 12 months	↑	

National metrics

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

Finance

Metric	Change from last month	Variation/ Assurance
Bank spend	N/A	
Capital Spend	N/A	
Financial sustainability and efficiencies	N/A	

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	N/A	New Metric
% of staff receiving supervision within policy guidance - Management	N/A	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	N/A	New Metric

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)	↑	
Average length of stay - Acute and Psychiatric Intensive Care Unit - West Yorkshire (3 Months Rolling)	N/A	New Metric
Average length of stay - Older people - West Yorkshire (3 Months Rolling)	N/A	New Metric
% Appraisal rate	↑	

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	N/A	New Metric
% of staff receiving supervision within policy guidance - Management	N/A	New Metric
% with care plan that includes service user input/views	N/A	New Metric

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% Bed occupancy	↑	
Information Governance (IG) training compliance	↑	
% of staff receiving supervision within policy guidance - Clinical	N/A	New Metric
% of staff receiving supervision within policy guidance - Management	N/A	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	N/A	New Metric
% of staff receiving supervision within policy guidance - Management	N/A	New Metric
Children & Younger People with eating disorder - % Routine cases accessing treatment within 4 weeks	↑	

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
Sickness rate (Monthly)	↓	
Maximum 6 week wait for diagnostic procedures	↑	
% Appraisal rate	↑	
Information Governance (IG) training compliance	↑	
% of staff receiving supervision within policy guidance - Clinical	N/A	New Metric
% of staff receiving supervision within policy guidance - Management	N/A	New Metric

KEY

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

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

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

Quality & Safety

• The number of responses provided within six months of the date a complaint received increased to 100%, with all 14 incidents responded to during the month meeting this threshold. The average time to sign off for complaints closed during the month was 101.3 days and this has improved from last month.

• The total number of reported incidents in April was 1405 which is a similar level to March (1408). A breakdown of this data can be seen in the Care Group dashboards. Although there has been a slight increase in incidents overall, the numbers reported suggest data is in line with the number of incidents reported in previous months. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.

• The number of restraint incidents decreased slightly this month from 194 reported in March to 185. The highest number of incidents were at the Poplars older people mental health unit (27) and Nostell adult mental health ward (27). There were also 16 incidents reported on one of our psychiatric intensive care units. The majority of these incidents relate to service users with complex needs and reflect the levels of acuity being experienced across our wards. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain within expected range – all incidents are reviewed, and learning is shared.

• The Trust had 34 incidents against staff on mental health wards involving race during April. 9 incidents in Forensics Care Group across 6 wards/teams. Appleton and Newhaven wards had the highest number (3 and 2 respectively); 15 incidents in MH inpatients across 7 wards/teams, Walton PICU had the highest number (7). 10 incidents in Cheswold Park Hospital across 5 wards/teams. Hamilton ward had the highest number (5). We are very aware of the personal impact this has on our colleagues. We are working closely with colleagues from the People Directorate to identify further wellbeing offers and strengthen support. An executive led focus group is also in the process of being established to review all issues relating to harm to others.

• There were 3 staff led prone restraints on our wards during April. 1 of those related to an incident on one of our psychiatric intensive care units and 2 of those related to Stanley Adult Acute ward. 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 Reducing Restrictive Physical Interventions (RRPI) training. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan. Although the metric is reporting above our local threshold, there has been a considerable improvement in reducing the number of prone restraints across wards over the last 12 month period and this is evidenced in the low level of number of incidents reported.

• There were 12 information governance personal data breaches during April which is a slight decrease from the number reported last month and is just below the Trust threshold. 5 of these incidents relates to Children and Young people mental health services but across 5 different teams. Information disclosed in error continues to be the highest reported category. Work taking place to review the incidents and ensure learning is embedded to prevent future occurrences, alongside a quality improvement group to embed learning.

• Sadly, 2 patient safety related deaths where the service user was known or had been discharged from the Trust's mental health services occurred during the month. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the family concerned in these tragic circumstances.

• There were 53 inpatient falls reported during April 2026, this is a decrease from last month. 30 of the fall incidents relates to services users aged 65years and over; 6 patients had repeated falls and accounted for 25 of the total incidents. All patients with a history of falls had a multifactorial assessment completed and a good quality mobility plan in place. We actively risk assess those service users who are at high risk of falling and implement care plans. All fall incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. One fall was categorised as a red incident and related to an older adult with deteriorating physical health and sadly passed away following an admission to acute hospital. A service-to-service request was made to the acute hospital to undertake a patient safety learning response. There were no significant areas of learning identified for The Trust following review of the learning response. The case has been requested to go through coronial process.

• 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 96% against a target of 90%. Disability recording was at 56.9%, sexual orientation 57.4% and postcode at 99.6%. Work continues to ensure data capture across all services and further detail of these metrics can be seen in the equalities section of this month's report.

• The 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.

• There were 15 incidents of sexual safety incidents against staff (by patients) in April. The most common theme for these incidents was inappropriate sexual behaviour. 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. In the event of an incident, the Trust convene a sexual safety panel which includes individuals who have undertaken specialist training and who consider what is required to ensure there's a safety plan in place and that the issue is then considered through the appropriate 'process' . The Trust also has sexual safety allies who can offer additional support to individuals.

• There were 5 sexual safety incidents against patients reported during the month. 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.

Quality & Safety continued...

• For risk assessments and care plans, the Trust's aim is to work towards achievement of 95% against each of these standards. The metrics do show an overall increase in performance, however 95% has not been achieved across all 5 metrics in all areas – detail can be seen in the Quality dashboard and care group section of the report. care group and ward level detail can be seen in the detail of the report. All risk assessments and care plans that have not been completed within the timescale have oversight and scrutiny from the Care Groups.
• Forensic risk assessments are completed prior to admission as part of the admission assessment and planning process. In line with good clinical practice these are then reviewed at the point of admission to ensure they are still clinically accurate, the admitting clinician will record this review within the risk assessment going forwards, which will enable capture of risk assessment. This is alongside the required Historical, Clinical Risk Management 20 tool (HCR20) required for a patient in forensics.
• All services are focusing on continuing to improve performance for risk assessments. Staying Safe plans are now captured as part of the My Care and Safety Plan, rather than the FIRM risk assessment. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed and communicated to the service user and ward staff. There is development work is occurring across all teams to ensure they update the risk assessment to ensure emerging risks are supported and mitigated.

People

• Our overall sickness absence rate remains under our Trust target for April 26. Our long term and short term sickness are both comparative to previous years.
• In April 26 we are very close to achieving our Trust target of 90% with a current compliance rate of 89.9%. As we move into the new appraisal window (April to September), we will continue to monitor 12 month rolling compliance alongside how we are progressing the appraisal completion throughout the appraisal window period.
• Our statutory and mandatory training compliance remains above Trust target.

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, 87 out of 93 children (93.5%) received a diagnostic appointment within 6 weeks, this is now significantly above the revised national threshold and a local forecast of no more than 47.4% waiting more than 6 weeks. The demand in referrals consistently outweighs commissioned activity levels – which is a national issue. We continue to work with commissioning colleagues to achieve a solution. There is a quality improvement plan to ensure we are using the resource effectively and to meet the needs of our community the best we can.
• Children & Younger People with an eating disorder – all urgent referrals (6) were seen within national expected time frames of one week. For routine referrals, there were two patients that were not seen within the four week standard in the wakefield service, one related to patient choice of appointment date and the other related to clinical capacity within the team.
• The Trust had one admission for a service user under 18 years of age to an adult acute ward. It is recognised that any admission of an individual under 18 is due to the national unavailability of a bed for young people to meet their specific needs. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care, and treatment reviews.
• Community services waiting list - This metric reports the total number of people waiting across a range of physical health and wellbeing services in Barnsley. There continues to be a significant increase in demand for musculoskeletal services which is also reflected in the number of incomplete Referral to Treatment (RTT) pathways. It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting above threshold (18 weeks).
• Reduction in 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 (47.7 days against a forecast of 48 days) but have exceed our forecast for older people lengths of stay (89.1 days against a forecast of 82.2 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.
• Virtual Ward occupancy rate is at 108%. We have seen a significant improvement in virtual ward occupancy rates, exceeding our target and contributing to the overall improved patient flow and bed occupancy in the hospital and supporting hospital avoidance. The consultant geriatrician capacity position has improved with no pauses to onboarding during April. They have dedicated time to improving the position relating to discharge paperwork and ensuring onboardings for frailty do not exceed the cap of 55 patients at any time to ensure safe management of patients within current resource. We have also seen an increase in patients accessing the Acute Respiratory infection pathway during April, which has contributed to this improved position.
• Performance against number of patients accessing Individual Placement Support (IPS) 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 Trust activity and not activity for primary care workers – work is to take place to review this issue to ensure data flowing correctly. Wakefield performance is currently operating above target however focussed work is on-going in terms of developing secondary care referral rates, specifically for the unemployed cohort which may further improve the access numbers.

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 April, 85.7% of those waiting had been waiting for a period of 18 weeks or less which is a sustained improvement compared to previous months, however some young people are still waiting longer for treatment. All of these cases have had some form of screening, consultation or initial assessment before being placed on a treatment waiting list. The increased waiting time is linked to an increase in demand, focus on initial appointment and in particular a significant rise is Kirklees Keeping in Mind (KKiM) referrals. Commissioners have supported a new delivery model and this commenced in January 2026. There is a specific transformation programme for CAMHS to align services and make improvements across all places.
• Children's neurodevelopmental waits remain a major issue given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. Neuro-development waits are part of a specific pathway review across places in line with commissioned models. There is an offer in place to support children and families whilst waiting.
• There has been an increase in waiting list times for community learning disability services referrals that have had a completed assessment, care package and commenced service delivery within 18 week during April with 7 patients out of 60 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 and some recruitment has been undertaken to vacant post and this is expected to improve performance in future months.
• The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. At the end of April, the Trust had 3 service users placed in an inappropriate out of area bed at the end of the month, with 90 bed days used over the month in total. This has been supported by significant improvements with patient flow and bed management and focus on this remains.
• Focus on patients clinically ready for discharge continues to take place across mental health and learning disabilities, with support from colleagues within place with improvements recognised. The main challenges continue to be specialist placements and housing. At the end of April, 32 people were clinically ready for discharge but remained in a bed.
• Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels significantly higher than commissioned – cases, where agreed with commissioners, are triaged and prioritised according to need.
• The commissioned level for ADHD pathways in Barnsley, Wakefield and Kirklees is approximately 29 cases across all three areas per month. The average number of referrals for ADHD received for these areas in the last three months was 268. Calderdale does not block commission assessments, but we do assess 7-8 people from that locality via the Patient Choice framework. The average number of referrals received per month for Calderdale is 25.
• As demand in all areas is significantly more than capacity, this leads to lengthy waits, and the care remains with the referrer until accepted by the service. An innovative new step to offer face-to-face ADHD Triage is available to ensure that only clinically appropriate cases are offered an assessment. This is currently commissioned in Wakefield and Kirklees, and Calderdale has asked that we explore trialling this step for them, but Barnsley is still considering their preferred model.
• Whilst Mental health bed occupancy levels have seen an overall reduction from previous months, increased acuity remains a challenge. Particularly with risk to self and others, therefore requires enhanced observations to keep people safe.
• The temporary staffing group continues to have a focus on the use of temporary workforce, ensuring safe staffing whilst delivering a sustainable workforce to meet the patient needs. Bank and locum expenditure continues to fluctuate from month to month. Agency spend has continued to be maintained at an overall low level. Spend in April 2026 is £125k 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. Spend in other areas is less than £500 in month. 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 April the access standard for assessed within 14 days of referral has been met in all localities. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage and this is helping maintain performance.

Finance

• The Trust run rate has deteriorated in April 2026 due to the impact of pay awards being higher than the funding received for them and additional non pay pressures. Actions will continue to recover this position and deliver the planned breakeven position.
• Agency spend has continued to be maintained at an overall low level. Spend in April 2026 is £125k 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. Spend in other areas is less than £500 in month.
• The Trust continues to utilise bank and locum staff as part of it's overall workforce strategy. Spend remains higher than the target.
• National guidance, and as part of the Trust Value for Money programme, identified corporate expenditure as a key performance indicator. This value is total corporate expenditure, as per the Trust reporting hierarchy, with the RAG rating as a comparison against plan following agreed budgetary reductions.
• The value for money programme is £0.2m behind plan at month 1. The main reason is due to a shortfall in temporary staffing (as above bank is higher than planned). The forecast remains that the target will be delivered in full and additional mitigations are being identified.
• 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.
• Capital spend is ahead of plan in April 2026 due to the timing of updated lease contracts. This, as per previous years, were expected in June 2026. The main capital scheme is the continuation of the older people inpatient transformation scheme.

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-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%	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)	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	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)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	93%	93%	91%	91%	92%	86%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	97%	96%	96%	99%	96%	95%	1
	Number of compliments received	Best Quality	Caring	N/A	45	51	25	60	41	40	N/A
Quality	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Best Quality	Safe	Trend monitor	1	4	3	2	5	2	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Best Quality	Safe	Trend monitor	1	0	0	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	Best Quality	Safe	0	0	0	0	0	0	0	1
	Number of Information Governance breaches [3]	Best Quality	Well led	<12	6	8	10	12	12	12	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%	3
	Total number of reported incidents	Best Quality	Safe	Trend monitor	1391	1459	1487	1327	1408	1405	
	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	31	38	34	28	
	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	3	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	1	4	2	
	Safer staff fill rates *	Best Quality	Safe	90%	120.1%	120.6%	116.3%	113.8%	112.3%	114.0%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	101.3%	100.3%	100.2%	100.6%	98.3%	99.7%	1
	% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	84.9%	82.1%	84.8%	85.1%	85.0%	90.5%	
	% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	85.5%	87.4%	86.0%	91.1%	90.6%	95.3%	
	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%	
	Number of pressure ulcers which developed under SWYPFT care [1]	Best Quality	Safe	Trend monitor	47	66	68	47	58	44	
	Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement [2]	Best Quality	Safe	0	0	0	0	0	0	0	0
	Eliminating Mixed Sex Accommodation Breaches	Best Quality	Safe	0	0	0	0	0	0	0	1
	Number of Falls (inpatients) *	Best Quality	Safe	Trend monitor	54	58	59	45	61	53	
	Number of restraint incidents *	Best Quality	Safe	Trend monitor	168	220	175	200	194	185	
	% 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	1
	% of staff receiving supervision within policy guidance [15] - Clinical			80%	Reporting commenced April 26					74.7%	
	% of staff receiving supervision within policy guidance [15] - Management			80%	Reporting commenced April 26					64.6%	
	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%	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	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	N/A
	Number of sexual safety incidents against patients	Best Quality	Safe	Trend Monitor	Reporting commenced April 26					5	
	Number of sexual safety incidents against staff (patient on staff)	Best place to work and learn	Safe	Trend Monitor						15	
	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%	
	Compliance with statutory requirements (Water, Gas, Electricity, Refrigeration, Pressure, Loler and Asbestos)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	95.8%	95.8%	95.4%	95.8%	95.9%	96.0%	
	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%	
	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%	
	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%	
	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	

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-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%	93.7%	
	% 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%	94.4%	
	% 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%	
	% 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%	
	% 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%	94.0%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	Oct & Nov– 6, Dec & Jan – 4, Feb & Mar – 2, Apr 26 – 0	3	4	3	1	5	3	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor	134	122	187	97	98	73	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	N/A
	Medical Devices compliance rate	Best Quality	Safe	Trend Monitor	Reporting commenced April 26					75%	
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Person first and in the centre	Safe	6	0	1	0	0	0	0	1
	C Diff avoidable cases	Person first and in the centre	Safe	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	Person first and in the centre	Safe	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Person first and in the centre	Safe	0	0	0	0	0	0	0	
Improving Resource	NHS Oversight Framework segmentation	All	Well led	1/2	1		Due June 2026				
	Overall CQC rating	All	Well led		Good						
	CQC well - led rating	All	Well led		Good						

Quality & Safety Headlines

• Children and young people mental health services referral to treatment - April 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 30 complaints responded to during the month, all of these were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 101.3 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 11 information governance personal data breaches during April which is one 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 April, 27 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 Trust had 34 incidents against staff on mental health wards involving race during April. 9 incidents in Forensics Care Group across 6 wards/teams. Appleton and Newhaven wards had the highest number (3 and 2 respectively); 15 incidents in MH inpatients across 7 wards/teams, Walton PICU had the highest number (7). 10 incidents in Cheswold Park Hospital across 5 wards/teams. Hamilton ward had the highest number (5). We are very aware of the personal impact this has on our colleagues. We are working closely with colleagues from the People Directorate to identify further wellbeing offers and strengthen support. An executive led focus group is also in the process of being established to review all issues relating to harm to others.
• The total number of reported incidents in April remained similar to the previous month. A breakdown of this data can be seen in the care group dashboards. Although there has been a slight increase, the numbers reported suggest data is in line with the number of incidents reported in previous months. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.
• Sadly, there were two patient safety related deaths occurred during the month, one was for a service user who was known to the Trust's mental health services and one had been discharged from service. 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 34 incidents against staff on mental health wards involving race during April. 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 April. 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 15 incidents of sexual safety incidents against staff (by patients) in April. The most common theme for these incidents was inappropriate sexual behaviour. 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 number of restraint incidents decreased slightly this month from 194 reported in March to 185. The highest number of incidents were at the Poplars older people mental health unit (27) and Nostell adult acute mental health ward (25). The majority of these incidents relate service users with complex needs and reflect the levels of acuity being experienced across our wards. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain within expected range – all incidents are reviewed, and learning is shared.
• There were 53 inpatient falls reported during April 2026, this is a decrease from last month. 30 of the fall incidents relates to services users aged 65 years and over; 6 patients had repeated falls (2+ falls); and accounted for 25 (47%) inpatient falls. All patients with a history of falls had a multifactorial assessment completed and a good quality mobility plan in place. We actively risk assess those service users who are at high risk of falling and implement care plans. All fall incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required. Across our older people mental health services wards, stroke and neurological rehabilitation units there were 98 patients (66% of all patients) assessed as a high risk of falls. Of those patients, 16 (16%) experienced one or more falls. With 82 (84%) higher risk patients having no falls.
• There were three staff led prone restraints on our wards during April. 1 of those related to an incident on one of our psychiatric intensive care units and the other on Stanley ward. In all three cases, 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 now embedded in both four-day initial and two-day annual refresher Reducing Restrictive Physical Interventions (RRPI) training. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan.

Quality & Safety Headlines Cont…

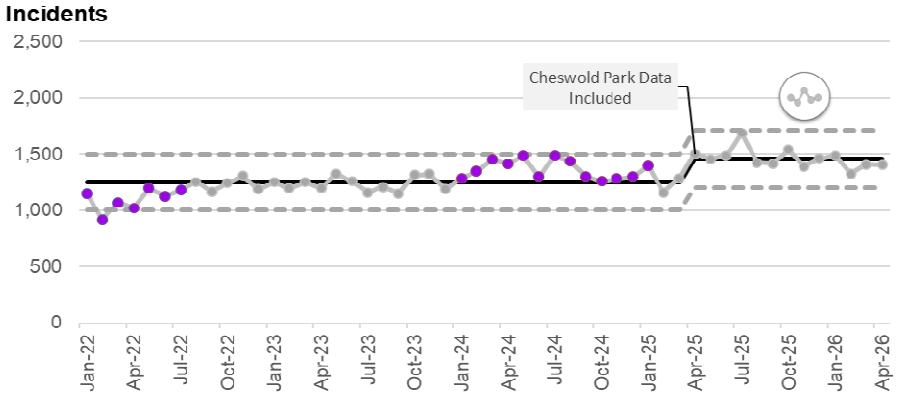
• For risk assessments and care plans, the Trust's aim is to work towards achievement of 95% against each of these standards. The metrics do show an overall increase in performance, however 95% has not been achieved across all 5 metrics in all areas – detail can be seen in the care group section of the 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.

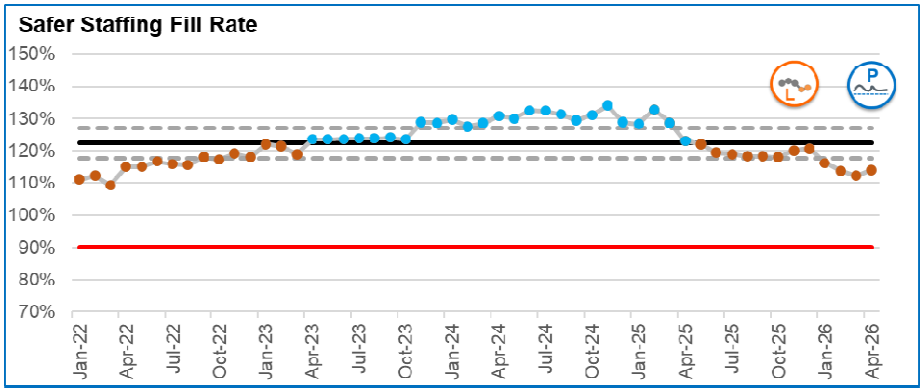
Statistical process control charts

Incidents

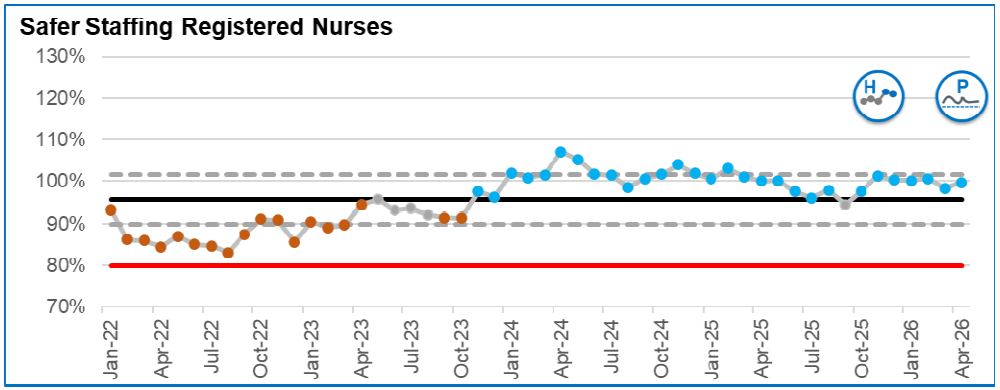


We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data. The chart shows that we are in a period of common cause variation (no concern).
It should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low harm incidents remains high as it does. All incidents are reviewed by the care group management team and then by the Patient Safety Datix team to review the actual degree of harm to ensure consistency with national reporting. All amber and red incidents are monitored through the weekly Trust Clinical Risk Panel and all serious incidents are investigated using systems analysis techniques. Learning is shared via a number of routes; care group learning events following a serious incident, specialist advisor forums, quarterly Trustwide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

Safer Staffing Inpatients



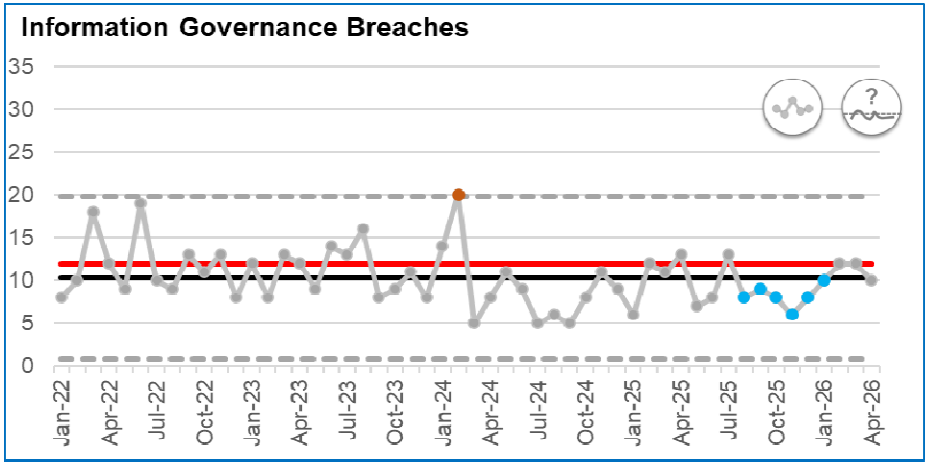
The chart above shows that in April 2026 we remain in a period of special cause concerning variation (something is happening and should be investigated). There has been an increase in demand which means more shifts are being requested, there has been a smaller increase in the number of shifts being filled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



The chart above shows that in April 2026 we remain in a period of special cause improving variation (something is happening and this should be investigated) and we are expected to meet the target.

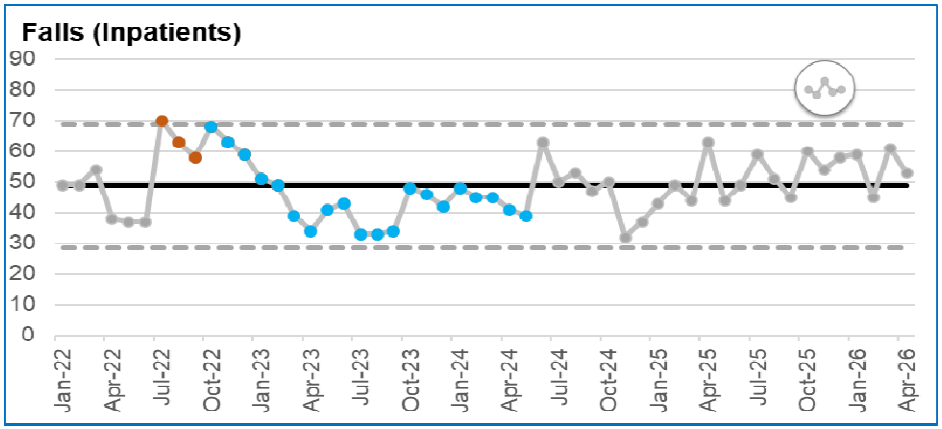
Statistical process control charts

Information Governance (IG)



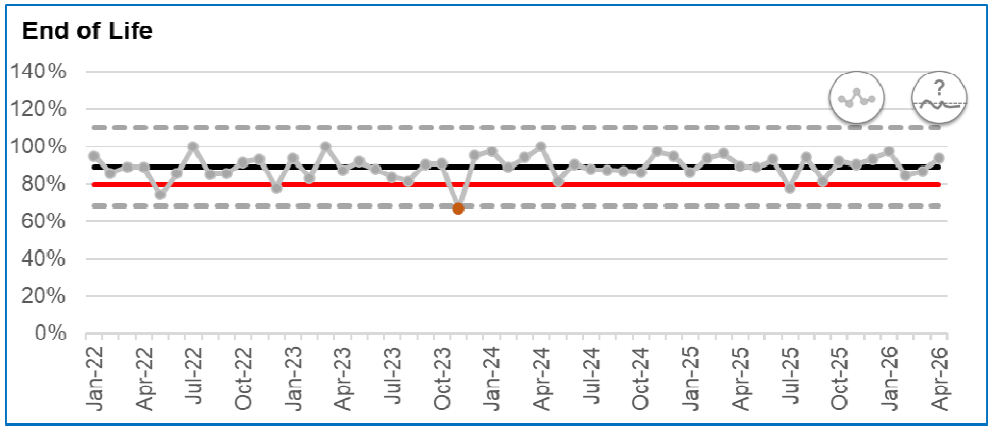
This SPC chart shows that as at March 2026 we have remain in a period of common cause variation (no concern).

Falls (Inpatient)



The SPC chart above shows that in April 2026 we remain in a period of common cause variation (no concern). All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

End of Life

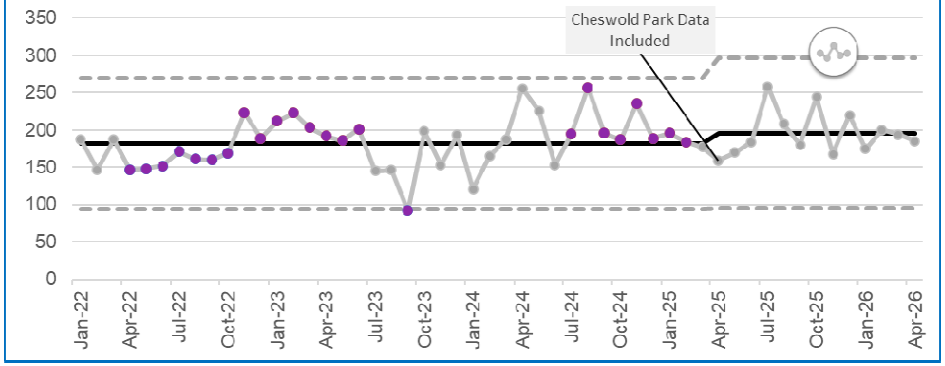


The chart above shows that in April 2026 the performance against this metric remains in common cause variation (no concern). The performance for the month remains above the target.

Statistical process control charts

Restraints

Total Restraint Incidents

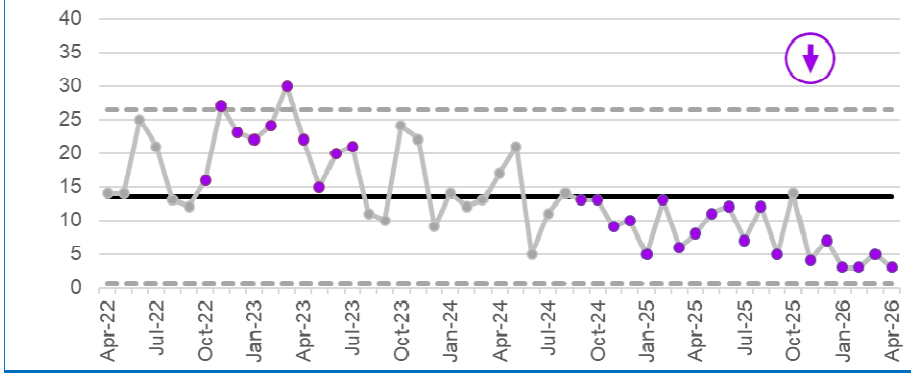


This SPC chart shows that in April 2026 we remain in a period of common cause variation (no concern).

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

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

Prone Restraint (Total Number)

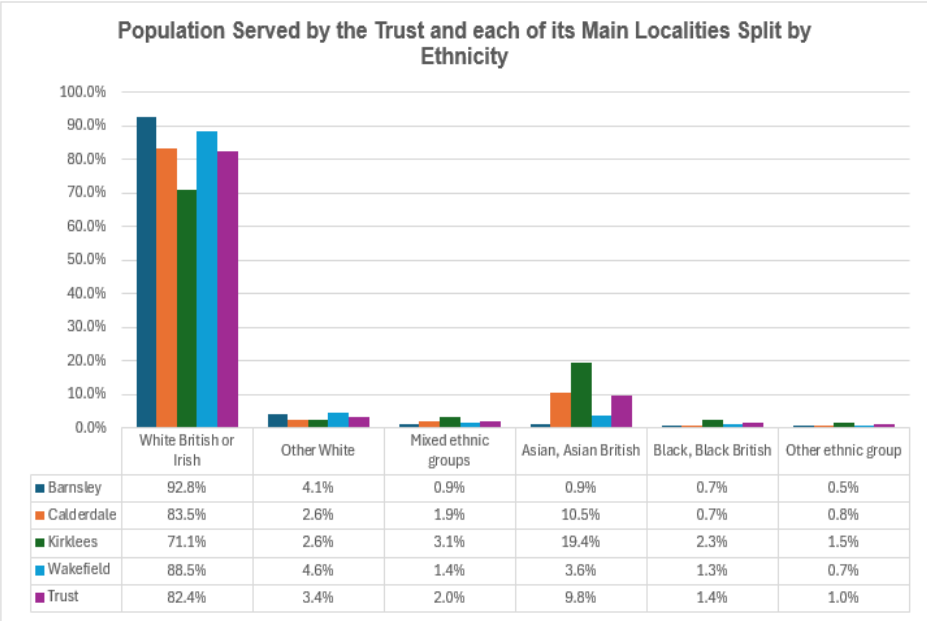


The total number of prone restraints continues to show a decreasing special cause variation in line with the continued work to reduce prone restraints. All of the three prone restraints in April 2026 were staff led.

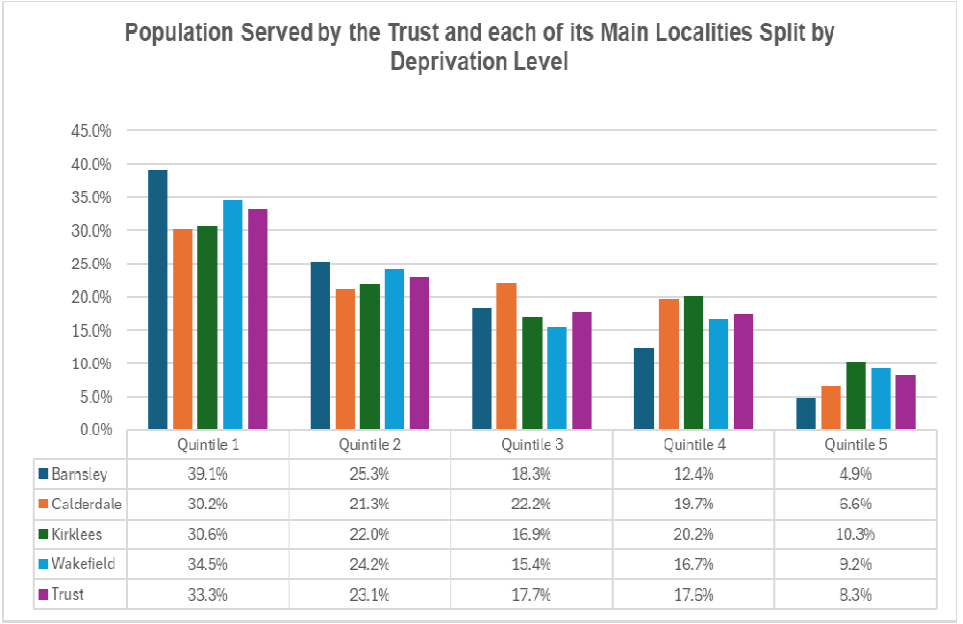
Reducing Inequalities

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

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



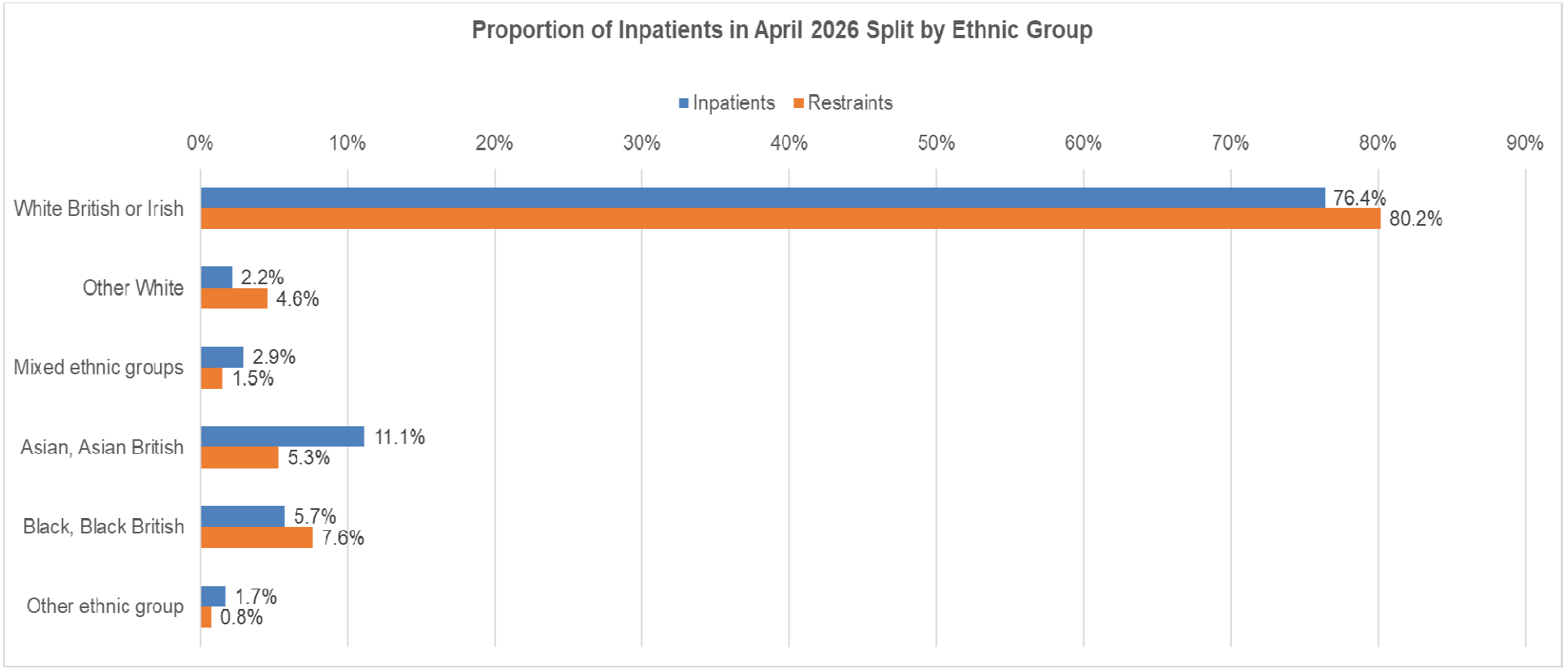
	White British or Irish	Other White	Mixed ethnic groups	Asian, Asian British	Black, Black British	Other ethnic group
Barnsley	92.8%	4.1%	0.9%	0.9%	0.7%	0.5%
Calderdale	83.5%	2.6%	1.9%	10.5%	0.7%	0.8%
Kirklees	71.1%	2.6%	3.1%	19.4%	2.3%	1.5%
Wakefield	88.5%	4.6%	1.4%	3.6%	1.3%	0.7%
Trust	82.4%	3.4%	2.0%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

Reducing Inequalities

The chart below shows the proportion of inpatients and proportion of restraints split by ethnic group. The population of the Trust split by ethnic group is shown alongside for ease of comparison. Early conversations are underway to aid the identification and understanding of some of the some of the context around protected characteristics as part of restraint, seclusion, and other restrictive practices.



Reducing Inequalities

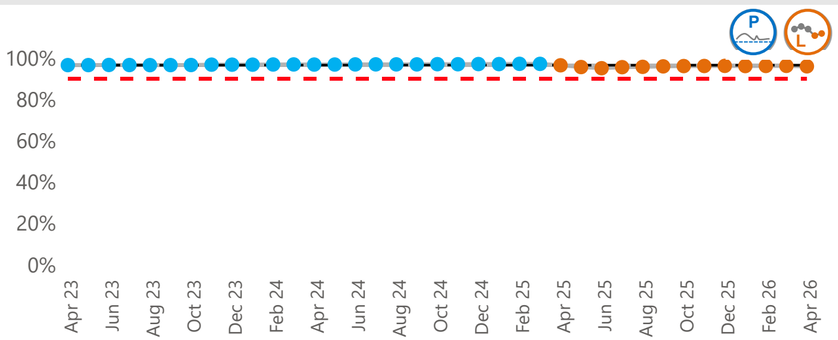
Data as of : 19/05/2026 08:45:03

NHS South West Yorkshire Partnership NHS Foundation Trust

In order to ensure equitable access to our services it is important to monitor the levels of our service users who have their equality data, such as ethnicity, disability status, sexual orientation, and postcode, completed. Data quality is vital to ensure we are able to offer services the meet the needs of the populations we serve. A priority area of equality diversity and inclusion has been agreed at EMT to align to strategic priority programmes to Improve our Clinical Pathways, apply the Patient Carer Race Equality Framework core actions to reduce the gap in inequalities and improve access, experience and outcomes for communities faring worse across all of our mental health, learning disability and community health services. This work involves the specific focus of improving the systematic collection and analysis of data (both numbers and voice) according to protected characteristics and continue to promote 'All of You' campaign. This will provide insights that can be used to develop understanding and as the basis for our decisions leading to improved performance and positive impact for people.

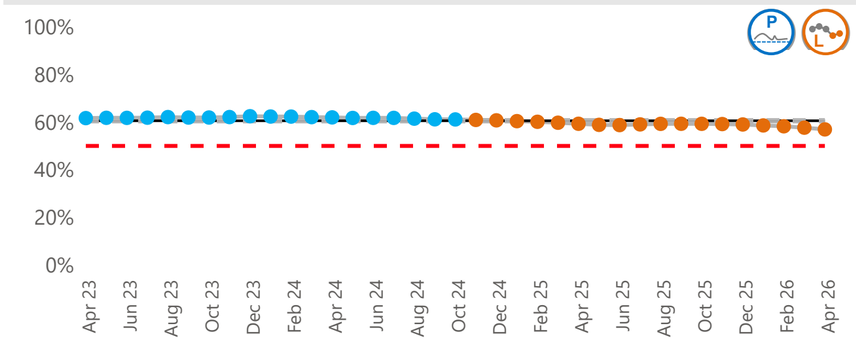
The SPC charts below show the completion rates for these measures.

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



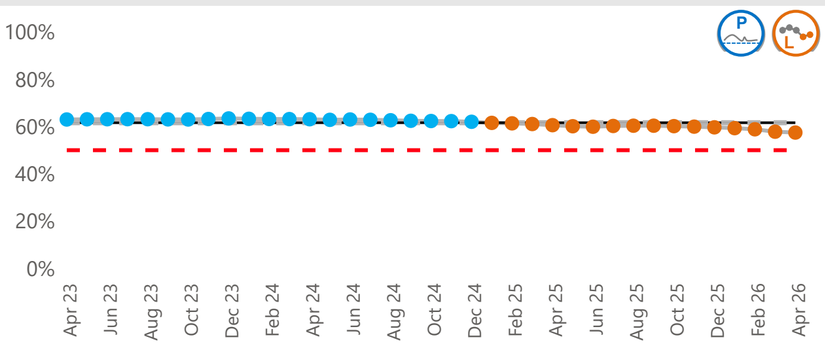
The Statistical Process Control (SPC) chart shows that in April 2026 due to the continued dip in performance we remain in a period of special cause deteriorating variation (something is happening and should be investigated). We are expected to meet the target against this metric. The data for service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

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



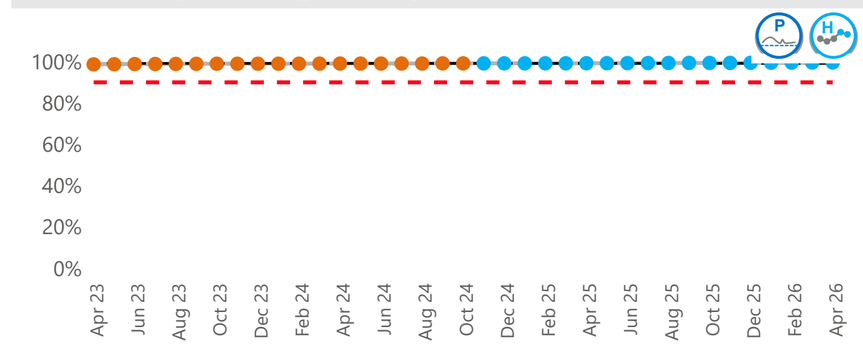
The SPC chart shows that in April 2026 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months. We are expected to meet the target against this metric. The data for service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

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



The SPC chart shows that in 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)



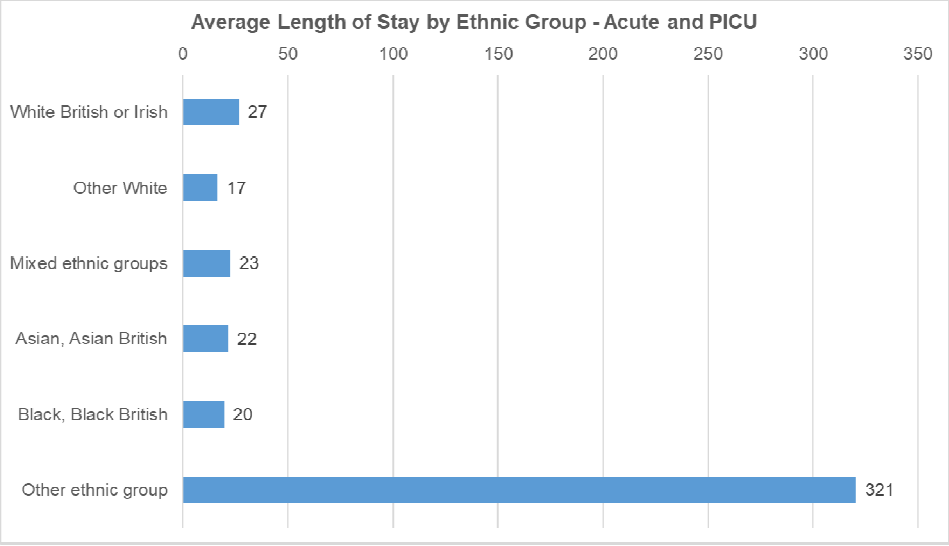
The SPC chart shows that in April 2026 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance. We are expected to meet the target against this metric.

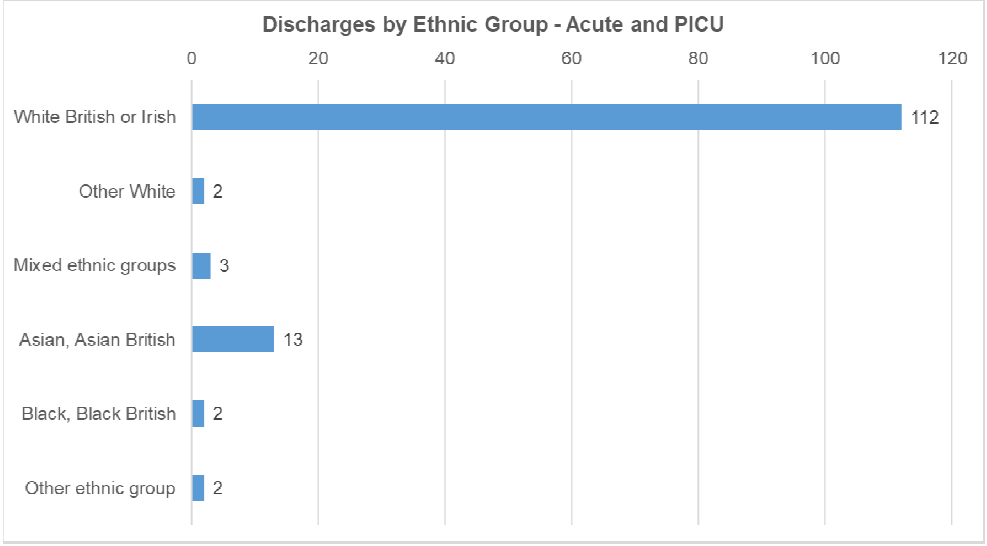
Reducing Inequalities

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).

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

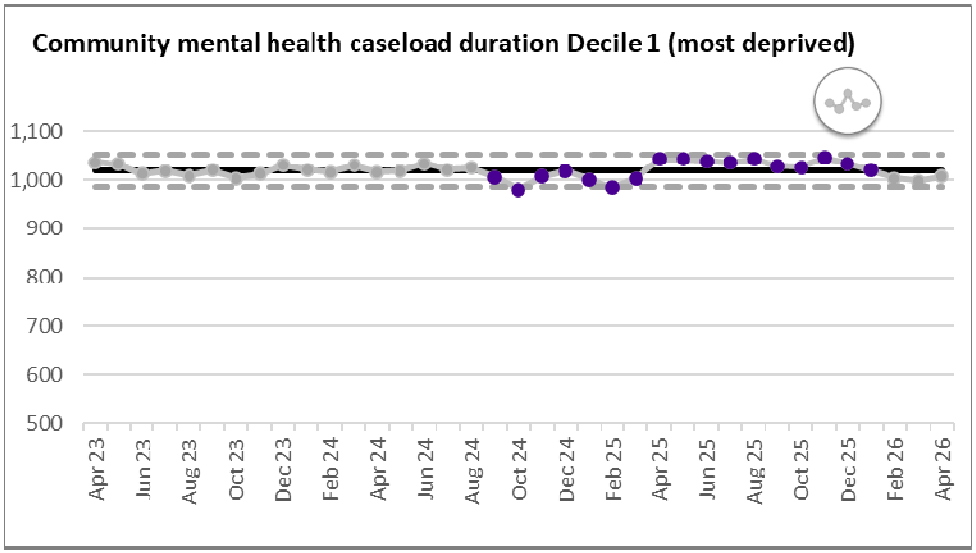
Differences in admission practices i.e. formal (compulsory) and informal (voluntary) also appear to influence LoS, with compulsory admissions tending to require more intensive interventions and longer discharge planning. Similarly, discharge approaches differ, with patients facing socioeconomic challenges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

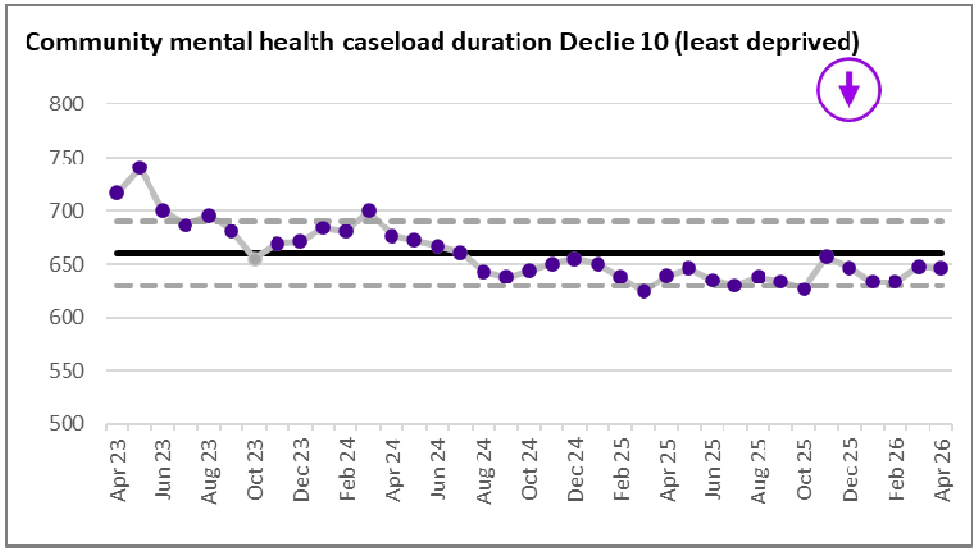




Reducing Inequalities

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

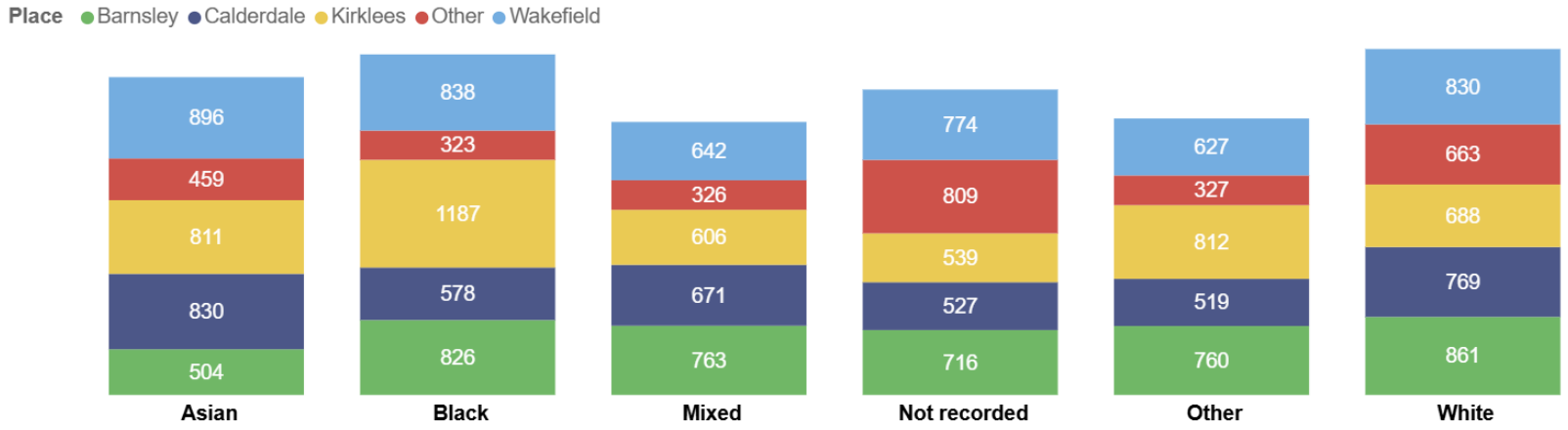




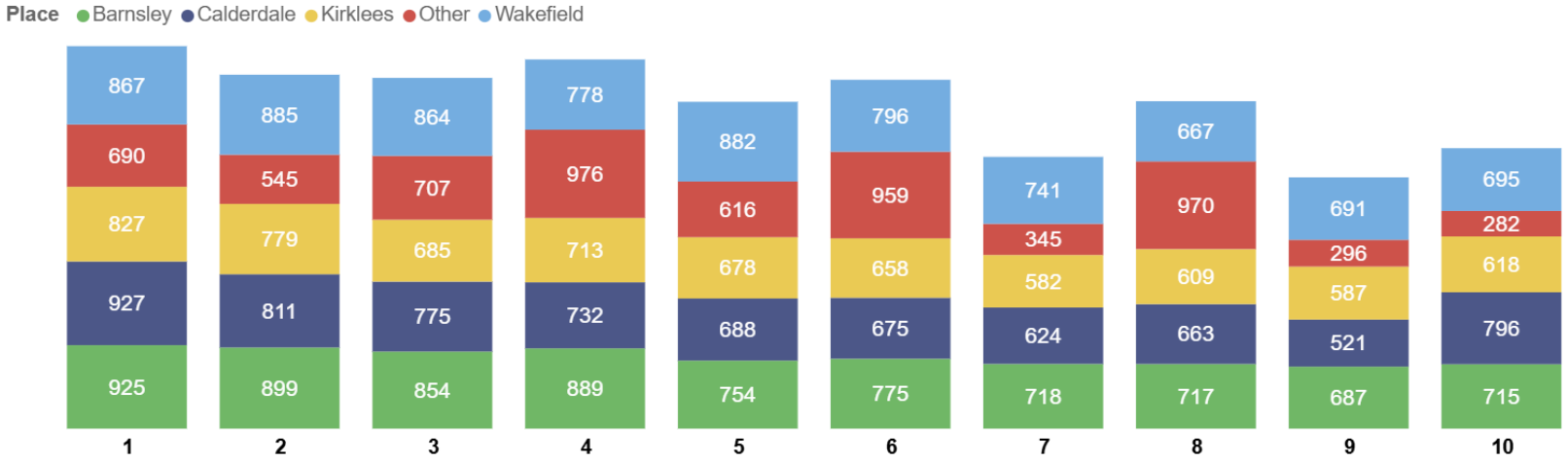
Reducing Inequalities

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

Average Days on Caseload Split by Ethnic Group and Place - Mental Health Rolling 12 Months



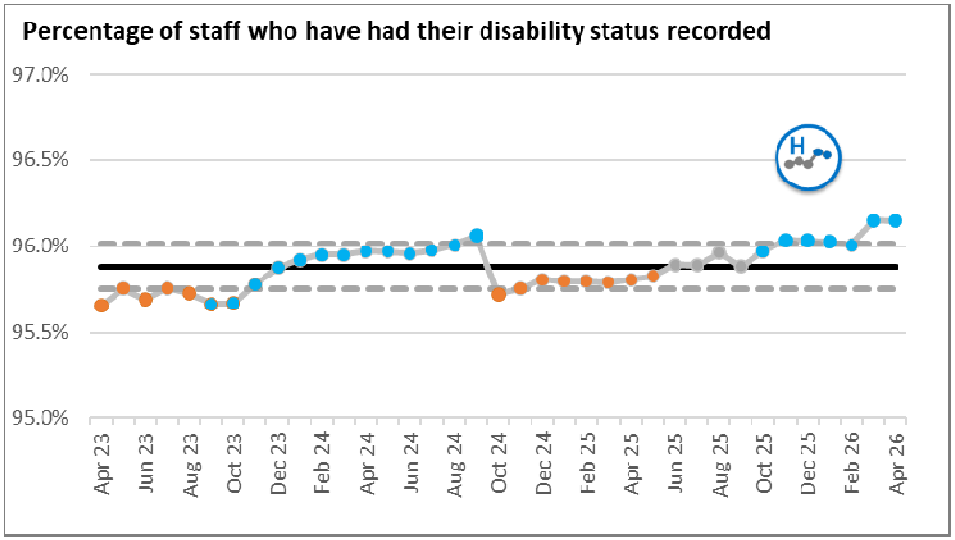
Average Days on Caseload Split by Deprivation Decile and Place - Mental Health Rolling 12 Months

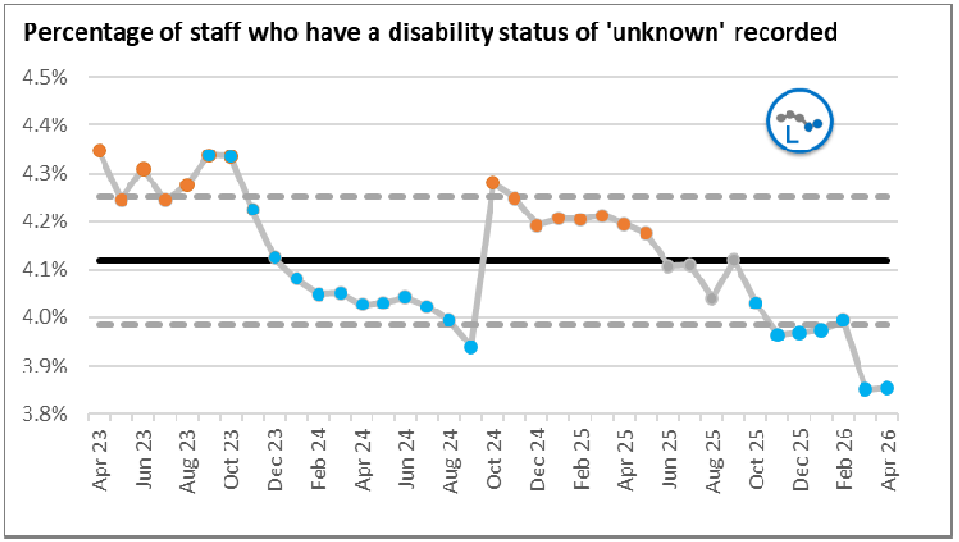


Reducing Inequalities

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	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Vacancy Rate	Best place to work and learn	Well led	8%	Reporting Commenced April 2026					6.4%
Turnover external (12 months rolling)	Best place to work and learn	Well led	25/26 - 13% 26/27 - 10%	9.6%	9.4%	9.1%	9.0%	8.2%	8.4%
Starters	Best place to work and learn	Well led	-	36.6	21.3	51.4	47.5	39.0	37.3
Leavers	Best place to work and learn	Well led	-	21.3	28.8	29.0	35.6	36.2	28.9
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	-	120 (10.6%)	121 (10.6%)	125 (10.8%)	125 (10.8%)	131 (11.2%)	132 (11.2%)
Proportion of staff in senior leadership roles who were women (relates to staff in posts band 7 and above, excludes bank staff)	Best place to work and learn	Well led	-	946 (71.5%)	952 (71.7%)	962 (71.8%)	975 (72.1%)	986 (72.2%)	985 (72.3%)
Sickness absence - Year-to-Date (YTD)	Best place to work and learn	Well led	<=5%	5.4%	5.5%	5.5%	5.5%	5.4%	4.9%
Sickness absence - Month	Best place to work and learn	Well led		5.9%	6.0%	5.8%	5.2%	4.9%	4.9%
Appraisals - rolling 12 months	Best place to work and learn	Well led	90%	86.5%	88.3%	89.2%	87.8%	88.7%	89.9%
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	75	60	69	66	60	64
Sexual Safety Incidents - Staff	Best place to work and learn	Safe	Trend Monitor	Reporting Commenced April 2026					1
Mandatory Training - TOTAL	Best place to work and learn	Well led	>=80%	95.6%	95.7%	95.4%	95.3%	95.3%	95.2%

Our workforce supply
Turnover
In April the overall Turnover percentage has dropped again to 8.4%. This is as a result of more new starters than leavers in April 26.

Vacancy Rate
Our vacancy rate has also dropped in April 26 due to the new Financial year budgeted FTE reducing and our overall staff in post increasing only very slightly

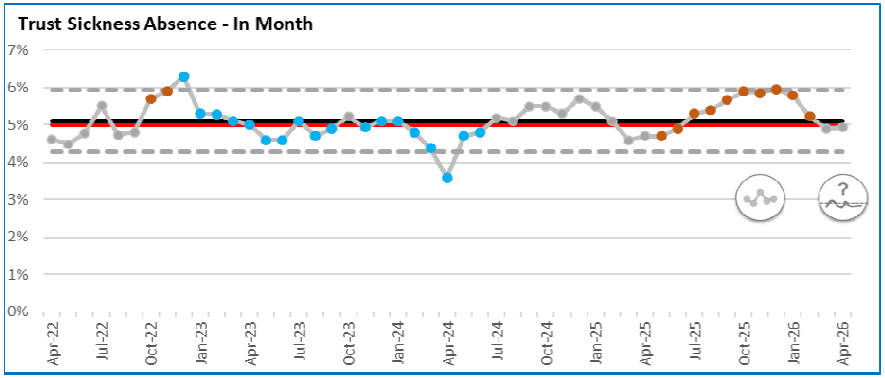
We are safe and healthy
Sickness Absence
Our overall sickness absence rate remains under our KPI target for April 26. Our Long Term and Short term sickness are both comparative to previous years.

We are compassionate and inclusive
Appraisal Compliance
In April 26 we are very close to achieving our KPI target with a current compliance rate of 89.9%.
n.b. As we move into the new appraisal window (April to September), we will continue to monitor 12 month rolling compliance alongside how we are progressing the appraisal completion throughout the appraisal window period.

Sexual Safety Incidents staff - 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. In the event of an incident, the Trust convene a sexual safety panel which includes individuals who have undertaken specialist training and who consider what is required to ensure there's a safety plan in place and that the issue is then considered through the appropriate 'process' . The Trust also has sexual safety allies who can offer additional support to individuals.

Training Compliance
All our training is compliant and above our Trust target. Individual care group and ward level training can be seen in the relevant sections of the report.

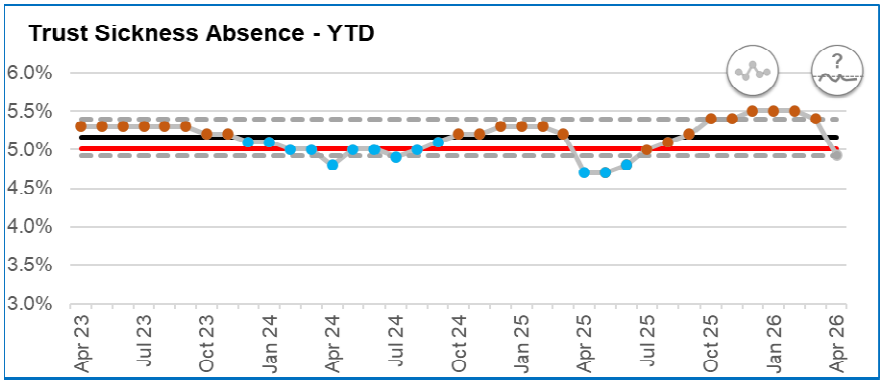
Statistical process control charts



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

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

From April 2025 this data includes Cheswold Park Hospital.

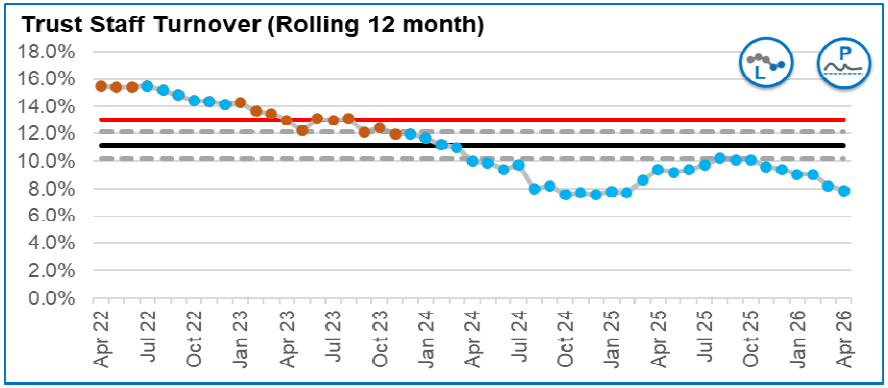


The SPC chart shows that in April 2026 we have entered a period of common cause variation (no concern) following a sustained increase in the sickness rate.

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

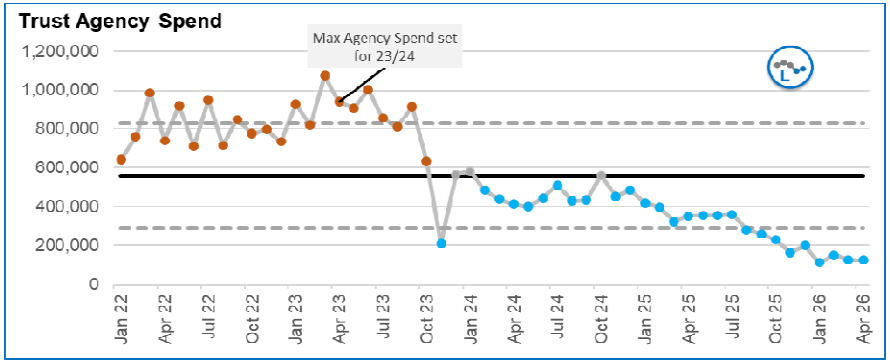
From April 2025 this data includes Cheswold Park Hospital.

Statistical process control charts



The SPC chart shows that in April 2026, we remain a period of special cause improving variation (something is happening and this should be investigated) following a sustained decrease in the turnover percentage.

From April 2025 this data includes Cheswold Park Hospital.



Agency spend has continued to be maintained at an overall low level. Spend in April 2026 is £125k 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. Spend in other areas is less than £500 in month.

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

From April 2025 this data includes Cheswold Park Hospital.

Please see the Finance Report for further information.

Headlines

- 92% of the medics that were due to have an appraisal in quarter 4 2025/26 were appraised within the timeframe.
  - Of the 4 medics that were not appraised in time, the main themes were sickness of the medic or appraiser during the appraisal due window.
- 100% of revalidation recommendations were made.
- No active concerns under the Maintain High Professional Standards procedures.

MEDICAL APPRAISALS	Q1	Q2	Q3	Q4
Number of doctors due to have an appraisal meeting in the reporting period	40	45	49	53
Number undertaken in period	35	36	44	49
Number not undertaken for which the RO accepts postponement is reasonable	5	8	5	4
Percentage of appraisals taken place and submitted on time	88%	80%	90%	92%

MEDICAL REVALIDATIONS	Q1	Q2	Q3	Q4
Number of revalidation recommendations due in period	2	2	1	3
Number of positive recommendations	1	2	1	3
Number of deferrals	1	0	0	0
Number of non-engagements	0	0	0	0
Percentage of revalidation recommendations made	100%	100%	100%	100%

RESPONDING TO CONCERNS	Q1	Q2	Q3	Q4
Number of active cases under Maintaining High Professional Standards procedures	0	0	0	0

National Metrics

Data as of : 20/05/2026 12:03:11

NHS South West Yorkshire Partnership NHS Foundation Trust

This section of the report includes the Trust performance against a range of national operational metrics including national priorities, operational planning and NHS Oversight Framework performance.

NHS Oversight Framework 2025/26 - Quarter 4 results are expected late May/Early June and will be added to the report once available.

The Trust awaits confirmation of the framework for 2026/27 and an update will be provided next month.

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 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		97.2%	97.8%	97.7%	97.5%	97.2%	97.1%	97.8%	97.5%	96%	95.6%	96.4%	97.5%
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680			4035	4025	4151	4319	4554	4641	4514	4287	3868	3946	4162	
					4043														4273
M206	Diagnostic test activity	Best Quality	Responsive		190			70	128	206	239	305	273	247	263	294	235	265	
					193														249
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%	?	H	97.9%	100%	98.7%	96.3%	100%	98.9%	100%	100%	100%	100%	99.1%	100%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0	F	L	148	159	196	203	234	155	97	76	52	28	73	90
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5	?	L	5	5	7	8	7	3	4	2	1	1	3	3
M7	72 hour follow-up from psychiatric in-patient care	Best Quality	Safe		80%	?	H	95.7%	90.7%	91.1%	88.6%	88.2%	89.0%	87.8%	87.6%	91.1%	87.7%	87.3%	86.5%
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%	P	H	88%	97.4%	95.5%	87.5%	93.3%	94.7%	96.4%	96.9%	89.7%	96.4%	96.2%	87.5%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%	?	H	97.4%	95.3%	96.0%	96.1%	96.4%	96.9%	96.7%	97.3%	96.8%	96.5%	96.3%	95.4%
M34	% Clients in settled accommodation	Best Value	Effective	⚠	60%	P	L	83.5%	83.0%	82.9%	76.0%	82.8%	82.9%	83.3%	83.0%	83.0%	83.2%	83.2%	82.9%
M35	% Clients in employment	Best Value	Effective	⚠	10%	P	H	13.2%	13.0%	13.3%	12.6%	13.3%	13.6%	14.0%	13.7%	14.0%	14.1%	14.2%	14.1%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		0	0	0	0	6	16	2	4	0	2	4	12
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?	L	0	0	0	0	1	1	1	1	0	1	1	1
M41	Completion of a valid NHS number - MHSDS	Best Value	Well Led		99%	P		100.0%	100%	99.9%	99.7%	99.6%	99.7%	99.7%	99.9%	99.9%	99.9%	99.9%	99.9%
M42	Completion of ethnicity coding for all service users - MHSDS	Best Value	Well Led		90%	P		99.5%	99.0%	99.6%	99.8%	99.0%	98.9%	99.0%	98.9%	98.9%	98.9%	99.6%	99.6%

National Metrics

Data as of : 20/05/2026 12:03:11

NHS South West Yorkshire Partnership NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%	?		50%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%	?	H	94.1%	91.3%	81.4%	88.2%	83.8%	94.4%	94.4%	92.9%	91.2%	100%	89.7%	94.9%
M47	Virtual ward occupancy	Best Quality	Responsive		80%	?		81.3%	90.7%	84%	89.3%	92%	74.7%	70.7%	72%	70.7%	85.3%	62.7%	108%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0	F	L	0	0	0	0	0	0	0	0	0	0	0	0
M30	Number of detentions under the Mental Health Act (MHA)	Best Quality	Safe					109	106	87	99	102	102	83	105	98	101	116	112
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					21.1%	25.5%	23.0%	24.2%	24.5%	22.5%	16.9%	17.1%	22.4%	14.9%	21.6%	24.1%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%	P	H	99.8%	99.8%	99.7%	99.4%	99.5%	99.3%	99.4%	98.9%	97.7%	98.9%	98.6%	99.8%
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		99.7%	99.2%	99.7%	99.6%	99.5%	99.5%	99.4%	98.1%	99.1%	99.3%	99.5%	99.3%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%	?	H	51.9%	47.3%	53.4%	47.2%	52.5%	52.9%	48.7%	50.2%	50.1%	50.5%	53.9%	56.8%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%	?	H	68.7%	65.4%	71.8%	65.8%	70.4%	70.5%	72.2%	68.5%	69.0%	69.7%	71.8%	73.3%
M15	Data Quality Maturity Index - MHSDS	Best Quality	Well Led		95%	P	H	99.6%	99.7%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.5%	99.5%	99.6%	99.7%
M43	Community health services two hour urgent response standard	Best Quality			70%	P		91.6%	91.5%	91.5%	92.2%	92.0%	87.4%	89.5%	88.3%	88.2%	88.8%	91.5%	90.5%

National Metrics

Data as of : 20/05/2026 12:03:11

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
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%	?	H	59.9%
				Place	Barnsley	50%	?	H	59.4%
					Kirklees	50%	?		60.2%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				569
				Place	Barnsley				219
					Kirklees				350
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
				Place	Barnsley	2900	?	L	2747
					Calderdale	1400	?	H	1500
					Kirklees	4800	?	H	5250
					Wakefield	4300	P	H	4774
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust			H	2098
				Place	Barnsley	283	F	H	344
					Calderdale	247	?	H	311
					Kirklees	541	?	H	760
					Wakefield	406	?	H	573
M194	Number of people accessing individual placement and support (IPS) services (rolling 12 months)	Best Quality	Responsive	Trust	Trust			H	788
				Place	Calderdale			H	128
					Kirklees			H	256
					Wakefield			H	401

KPI	Strategic Objective	CQC Domain	Target	Apr-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	455	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	83	
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	258	
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	48.0	47.7
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - South Yorkshire	Best Quality	Responsive	58.1	44.6
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - West Yorkshire	Best Quality	Responsive	44.7	46.4
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - Trust	Best Quality	Responsive	82.2	89.1
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - South Yorkshire	Best Quality	Responsive	76.8	72.4
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - West Yorkshire	Best Quality	Responsive	77.4	96.0
Access to Mental Health Support Teams Mental Teams in schools and colleges - Kirklees	Best Quality	Responsive	800	848
Access to Mental Health Support Teams Mental Teams in schools and colleges - Wakefield	Best Quality	Responsive	1300	1561
Number of patients accessing Individual Placement Support services - rolling 12-month - Calderdale	Best Quality	Responsive	158	128
Number of patients accessing Individual Placement Support services - rolling 12-month - Kirklees	Best Quality	Responsive	296	256
Number of patients accessing Individual Placement Support services - rolling 12-month - Wakefield	Best Quality	Responsive	279	401
Percentage of people on entire waiting lists who are waiting 18 weeks or less	Best Quality	Responsive	93.2%	87.5%
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	97.7%	97.5%
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	78.0%	58.0%

Data quality
An additional column has been added to the national metrics dashboards to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included. For the month of April the following data quality issue has been identified in the reporting:
• The reporting for employment and accommodation shows 15.7% of records have missing employment and/or accommodation status with a further 1.9% that have an unknown employment status and 1.5% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

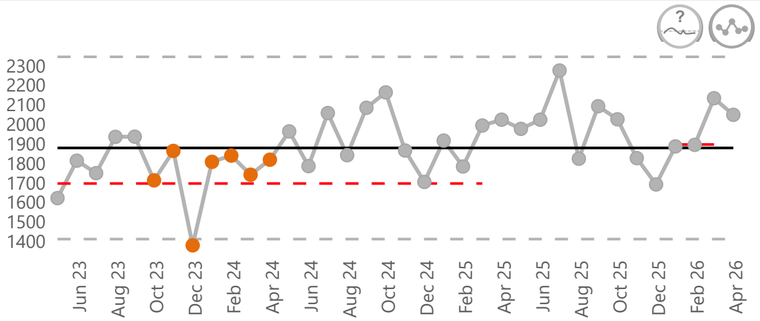
Operational Planning
Monthly performance against the national activity metrics for operational services can be seen in the dashboard. Where metrics have carried forward into 26/27, there may have been a change in threshold, this is reflected in the dashboard. There are a number of new metrics related to operational planning and these can also be seen in this section.

National Metrics

Data as of : 20/05/2026 12:03:11

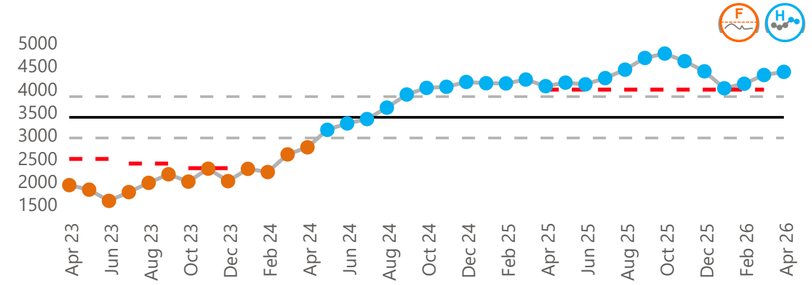
NHS South West Yorkshire Partnership NHS Foundation Trust

M184 - New RTT pathways (clock starts)



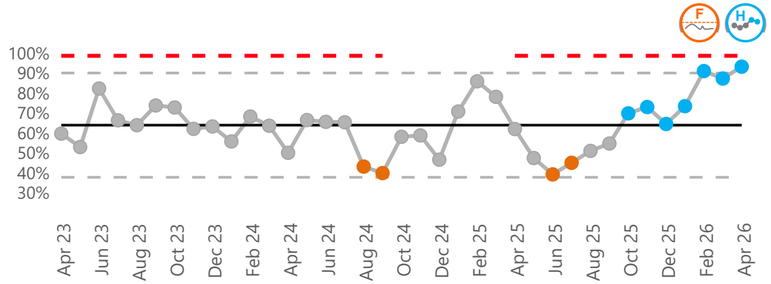
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers. A new target is in place for 2025/26.

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



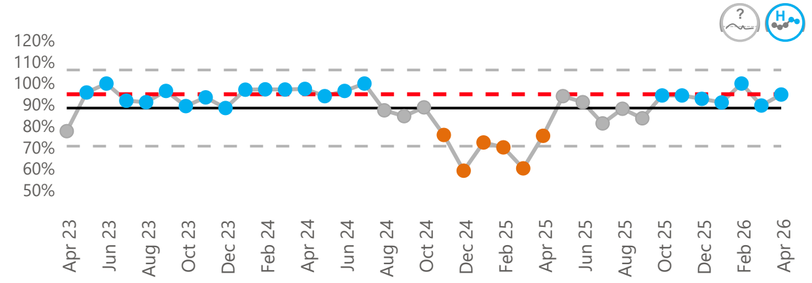
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months.

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



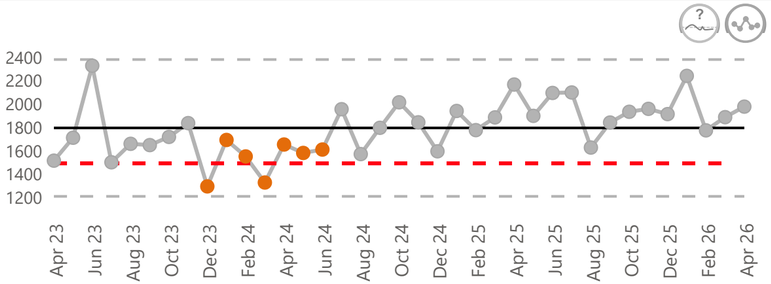
The SPC chart shows that we have entered a period of special cause improving variation (something is happening and should be investigated).

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



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

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



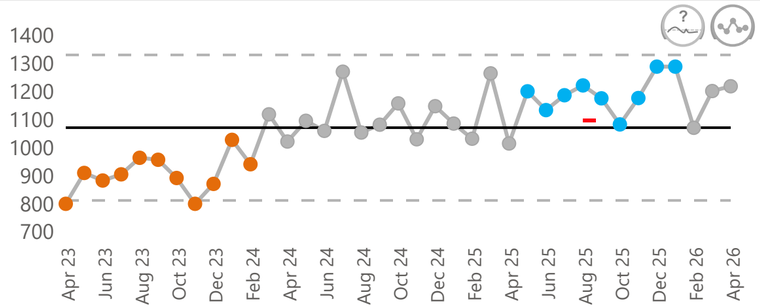
The SPC chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers this time last year.

National Metrics

Data as of : 20/05/2026 12:03:11

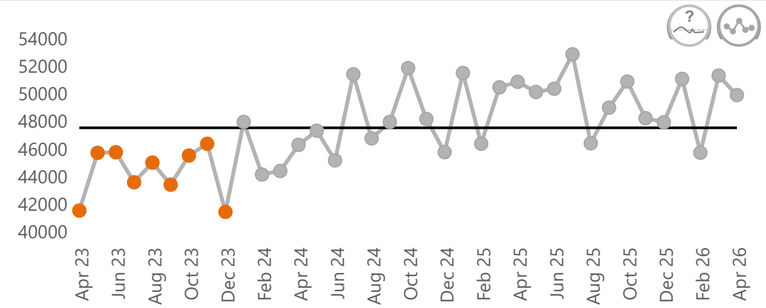
NHS South West Yorkshire Partnership NHS Foundation Trust

M187 - Urgent Community Response (UCR) referrals



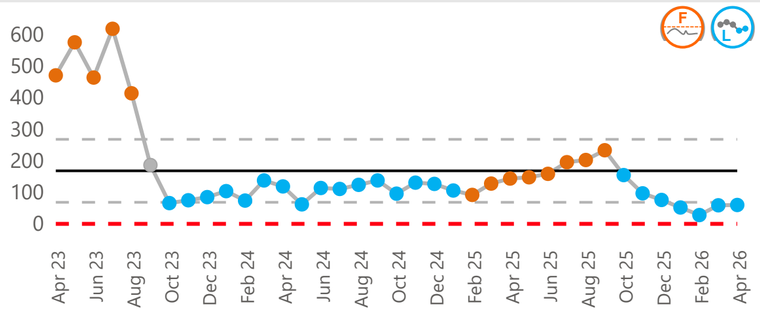
The SPC chart shows that we remain in a period of common cause variation (no concern).

M207 - Attended Community Care Contacts



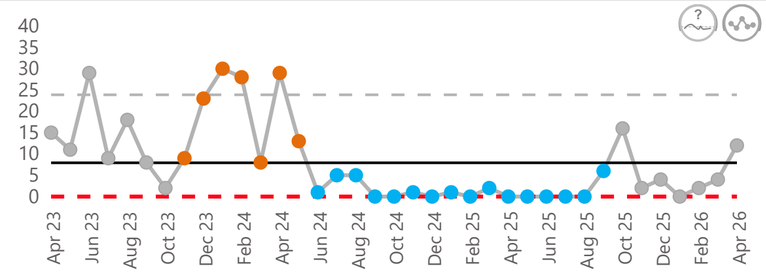
The SPC chart shows that we remain in a period of common cause variation (no concern).

M2 - Inappropriate out of area bed days



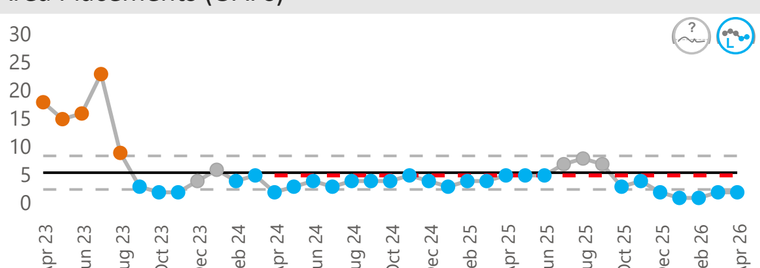
The SPC chart shows that due to the continued improvement in the number of out of area bed days we remain in a period of special cause improving variation (something is happening and should be investigated). Though we are still not anticipated to achieve the target of zero.

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



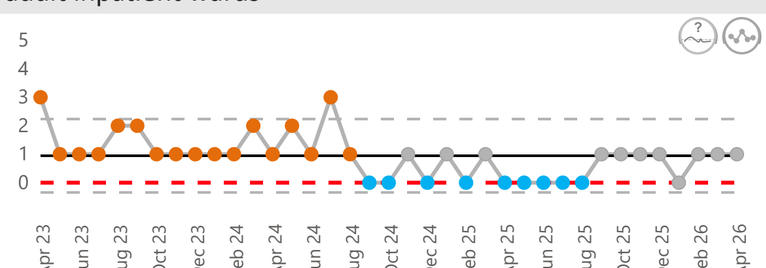
The SPC chart shows that we have entered a period of common cause variation (no concern).

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



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

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



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

Whilst the SPC chart shows us that this is an improving position when we compare it to the range of admissions we have had in the past, it is recognised that any admission of an individual under 18 is due to the national unavailability of a bed for young people to meet their specific needs. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care, and treatment reviews.

National Metrics

Data as of : 20/05/2026 12:03:11

NHS South West Yorkshire Partnership NHS Foundation Trust

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

• There was one admission to an adult mental health ward where the person was under 18 years old. The person was an inpatient for 12 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 increase in out of area bed usage to 90 days used in April 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 94.9% in April with two people not seen within four weeks. For the two people not seen, one related to patient choice of appointment date and the other related to clinical capacity within the team. The urgent access to treatment measure achieved 100% in April.

• Average Length of Stay (ALOS). We continue to see an overall reduction in lengths of stay.

• The percentage of clients in employment and percentage of clients in settled accommodation - there are some data completeness issues that may be impacting on the reported position of these indicators however both are above their respective thresholds.

• Virtual Ward occupancy rate has increased to 108% in April which is above the target of 80%.

• 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 to 93.5% in April and is above the revised threshold of 52.6% for 2026/27.

• 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 (47.7 days against a forecast of 48 days) but have exceed our forecast for older people lengths of stay (89.2 days against a forecast of 82.2 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 flowing correctly. Wakefield performance is currently operating above target however focussed work is on-going in terms of developing secondary care referral rates, specifically for the unemployed cohort which may further improve the access numbers.

• As a whole our community services are achieving the national expectation of 78% of being seen within 18 weeks, achieving 87.5% for April. We do however, have some long waiters in our Children's Speech and language (SALT) 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 CYP waiting list. This is linked to an increase in complex patients requiring a longer stay on the caseload. A full review of the Children's SALT 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 time

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.

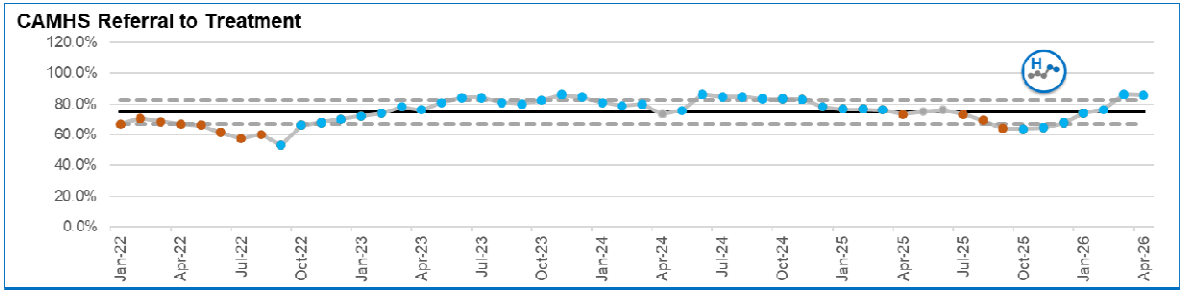
Child and Adolescent Mental Health Services (CAMHS)

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.

Child and Adolescent Mental Health Services (CAMHS)

Metrics	Strategic Objective	CQC Domain	Threshold	Feb-26	Mar-26	Apr-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	91.1%	92.8%	91.5%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/2)	0% (0/6)	0% (0/7)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		73.5%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%			75.1%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	100.0%	98.5%	86.6%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.7%	85.5%	84.9%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	100.0%	89.7%	94.9%	
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%	96.0%	95.4%	96.4%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.5%	89.8%	91.4%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.4%	4.0%	4.2%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	565	595	590	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	1081	1137	1065	
Total number of reported incidents	Best Quality	Safe	Trend monitor	51	66	64	



In April 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 CAMHS Attention deficit hyperactivity disorder (ADHD) waiting list continues to rise due to increased referrals, this is as a result of 'right to choose', medical staffing vacancies and limited non medical prescribers support. Current longest wait (non-allocated appointment) is 75 weeks. This has been escalated within the Trust as to how to progress.
• 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 Integrated Care Board. We are currently awaiting confirmation of Wave 16 funding to be allocated for January 2027. Once confirmation provided service will need to commence workforce recruitment planning to meet tight timescales for trainee education mental health practitioners academic alignment.
• Wakefield CAMHS 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 –The installation of SWYFT IT system access within the three settings has been approved, and the majority of the work has been completed. Adel Beck and Aldine House Secure Children's Homes now have the SWYFT network; however, installation in Wetherby Young offenders institute continues to remain outstanding.
• Secure CAMHS – Work continues to determine the responsibilities and associated finance for the prescribing of mental health medications in the secure children's homes in accordance with contractual arrangements.
• The care plan metrics for community are now capturing the whole community caseload including Children, Young People & Families. Work continues to review the metric against clinical 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.
• A weekly rapid improvement group has been established to reduce CAMHS treatment waits and each locality has an action plan. Actions include streamlining meeting attendance, job planning reviews to increase clinical appointment capacity, streamlining clinical pathways including allocation and data quality improvement work.

Advise

• Barnsley CAMHS - The business proposal approved by commissioners for two posts for learning disability nursing will positively impact health inequalities and service user experience. Mobilisation plans are in place, and the service have successfully recruited into post funding has been approved for phase 2 of the model, which is a more comprehensive team for CAMHS learning disability. Staff members have been recruited and funding has flowed since the beginning of the finance year.
• Calderdale & Kirklees (C&K) 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 neuro diversity 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 children and young people (CYP) requiring emergency or urgent support. In addition, the C&K CAMHS Crisis line receives in the region of 100 calls per month and also a further 25 calls per month from NHS 111. The service 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.
• Calderdale and Barnsley C&YP Services have been part of the area SEND inspection the outcome of which we will learn after to May elections.
• Supervision reporting changed as of 1st April with separate 60-day targets for clinical and management supervision compliance is under target in April with clinical supervision at 74% and management at 75.6%. Action plans are in place to improve overall performance.

Assure

• The appraisal rate for the Children young people (CYP) element of the care group in April was 90.9%.
• Overall mandatory training compliance for C&YP in April was 96%
• The sickness level across C&YP in April was 3.5%.

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 but high acuity remains. The work underway in the Intensive Home Based Treatment teams to gatekeep admissions and support people at home significantly helps to manage the overall position.

Inpatient services level of sickness has improved compared to previous months and is now below Trust threshold. General managers have a firm grip on absence with staff being supported and managed in line with Trust policies. Community services sickness has also increased and remains above Trust threshold.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Feb-26	Mar-26	Apr-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	91.0%	93.0%	92.5%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	88.8%	88.8%	87.9%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	99.1%	98.4%	100.0%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	31% (5/16)	13% (2/16)	7% (1/15)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		83.1%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%			73.4%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	87.7%	87.3%	85.7%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	95.3%	95.4%	94.6%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	96.5%	96.3%	97.4%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.9%	86.5%	85.8%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	96.5%	97.1%	97.5%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.9%	96.8%	96.7%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	88.6%	90.7%	90.6%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.3%	5.1%	5.3%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,221	13,227	13,221	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	132	117	114	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Feb-26	Mar-26	Apr-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	84.7%	89.1%	96.0%	
% Bed occupancy (excl leave)	Best Quality	Safe	85%	88.8%	86.8%	85.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/5)	0% (0/4)	33% (1/3)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		83.5%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%			81.8%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.2%	89.6%	87.8%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.7%	10.1%	9.9%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	90.9%	86.4%	92.5%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	150 (April)	28	73	90	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.3%	97.3%	97.8%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	25	16	11	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	53	43	60	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	89.9%	89.0%	90.3%	
Restraint incidents	Best Quality	Safe	Trend Monitor	154	148	*107*	
Safer staffing (Overall)	Best Quality	Safe	90%	119.1%	117.3%	119.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	99.9%	100.1%	102.4%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	5.3%	5.2%	4.8%	
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds - South Yorkshire	Best Quality	Safe	58.1	Reporting Commenced April 2026		44.6	
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds - West Yorkshire	Best Quality	Safe	44.7			46.4	
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds - South Yorkshire	Best Quality	Safe	76.8			72.4	
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds - West Yorkshire	Best Quality	Safe	77.4			96.0	
Readmissions within 28 days						14	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	590	548	571	

Alert/Action

• Acute wards have continued to manage high levels of acuity.
• High occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on safety of high occupancy such as increased staffing levels.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.
• There continues to be people who are clinically ready for discharge but are delayed. This is an area of focus as part of the priority programme work and is being addressed with the ICB's through the MADE meetings as well as a weekly Director of Services led challenge meeting with general managers.
• Workforce challenges have led to continued use of temporary staffing, primarily bank. Throughout April 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 April and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is triangulated and monitored.
• Intensive Home-Based Treatment teams in Calderdale and Kirklees are experiencing ongoing workforce challenges, recruitment is underway.
• All areas are focussing on continuing to improve performance for FIRM risk assessments. FIRM percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions. There is a high level of scrutiny when a FIRM risk assessment is not completed or reviewed and updated within 24 hours pre or post admission. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. A Staying Safe risk management care plan is also implemented within 24hrs of admission. 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 Care Plan Approach (CPA). Work continues to review the metric against clinical practice. Continued improvement in April 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 Reducing Restrictive Practice Intervention specialist advisors and includes an in-depth review of all prone restraint incidents for learning.
• 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 April 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. This has been identified as a data quality issue and an action plan is in place.
• The Talking Therapies recovery rate for April is 59.43% for Barnsley and 60.54% 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 three incidents of prone restraint in April, all were under 3 minutes duration. The prone restraints were staff led for clinical reasons specific to the individuals. All prone restraints are reviewed by Reducing Restrictive Practice Interventions 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

• Intensive home based treatment teams continue to perform well in gatekeeping admissions to our inpatient beds.
• The care group is above target in all areas of mandatory training.

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) / Learning Disability (LD) Care Group

Headlines
Attention Deficit Hyperactivity Disorder (ADHD) / Autistic Spectrum disorder (ASD) services:
In line with the national picture, ADHD demand continues to exceed commissioned capacity.
Referral rates remain high across both pathways and the service try to minimise waiting times as far as possible.

Learning disability services:
There has been an increase 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 has reached 100% and the service are working with partners to facilitate safe discharge to appropriate settings.

LD, ADHD & ASD

Metrics	Strategic Objective	CQC Domain	Threshold	Feb-26	Mar-26	Apr-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	91.7%	92.1%	87.1%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/2)	0% (0/2)	33% (1/3)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		69.2%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%			64.1%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	50.0%	50.0%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.5%	89.9%	89.5%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	75.0%	100.0%	100.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	96.8%	98.2%	95.1%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	88.0%	87.1%	79.4%	
Physical Violence - Against Patient by Patient	Best Quality	Safe	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Best Quality	Safe	Trend Monitor	4	9	11	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.7%	91.6%	92.7%	
Safer staffing (Overall)	Best Quality	Safe	90%	122.1%	121.5%	133.7%	
Safer staffing (Registered)	Best Quality	Safe	80%	188.0%	171.8%	167.9%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.2%	4.4%	3.0%	
Restraint incidents	Best Quality	Safe	Trend Monitor	8	6	*8*	
Average length of stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	42	39	45	

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

Alert/Action

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

South Yorkshire 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 capacity challenges within the service.
In contrast, autism assessment waiting times remain within 18 weeks, except where delays are due 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 invested in a Neurodiversity Single Point of Access (SPA). All referrals from this area are routed to the Trust for a decision regarding clinical appropriateness before individuals are able to exercise choice of provider for assessment under the Right to Choose framework. Referrals assessed as not clinically appropriate are not progressed to assessment, in line with Kirklees commissioning arrangements.
There remains a backlog within ADHD triage; however, additional investment from April 2026 is expected to support backlog reduction over the next 12 months, subject to referral rates remaining consistent.

Calderdale ADHD & Autism
Calderdale commissioners have advised Business Development colleagues of their intention to move towards a block contract for both ADHD and Autism services, capped at current activity levels. The service is currently reviewing this proposal to ensure it is operationally deliverable and can be achieved within the proposed financial envelope and discussions continue with the commissioner.

Wakefield ADHD
Wakefield have secured additional investment to enhance the ADHD Triage. With this investment this current meets the current demand, however if demand continues to increase this may continue to provide challenges. The Service is reviewing options to explore how they meet clinical need and balance this with the current financial envelope. On going collaboration with commissioner to improve capacity and demand continues.

Assure

- All key performance targets continue to be met.
- Excellent levels of supervision, appraisal and mandatory training.
- Low level of vacancies.
- All mandatory training meeting the threshold.

Learning disability services:

Alert/Action

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

Community
Learning Disability Services continue to experience challenges in psychiatry capacity, which are impacting the timeliness of specialist clinical input, including assessment, formulation, and review. This presents ongoing pressures across community pathways.
Work is ongoing to mitigate these pressures through workforce planning and service prioritisation; however, capacity constraints remain a significant factor influencing service delivery and responsiveness.

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

Advise

Learning Disability
Appraisal, Supervision & Training
Appraisal compliance remains above the required threshold. Information Governance is the only mandatory training area currently below target, at 94.7%; however, a system is in place to support improvement in compliance.
The separation of management and clinical supervision within reporting has led to an apparent reduction in performance; however, this is understood to reflect the implementation phase of the revised policy as it continues to embed across services.

Community
Recurrent funding has been secured for the Learning Disability ADHD diagnostic service following a successful six-month pilot.
Waiting lists are being effectively managed, with clear oversight of pressures. Delays are primarily linked to vacancy or absence in single post-holder roles rather than systemic issues.
Routine audits of risk assessments and care plans are embedded, with action plans in place and demonstrable improvement.
Revised service specifications are in place for Calderdale, Kirklees and Wakefield, with discussions ongoing with Barnsley commissioners.

Horizon – Assessment and Treatment Unit (ATU)
There are currently three patients within the service, all of whom are clinically ready for discharge (CRFD). Active, multi-agency plans are in place for each individual, involving all relevant organisations to identify and progress appropriate discharge pathways. One discharge is expected by the end of May, with the remaining pathways progressing through placement identification and decision-making processes.
Talking care plans have been introduced within Horizon, supporting more person-centred engagement and improved involvement of patients in the planning and delivery of their care.

Assure

Support for the primary care measure for annual health checks for people with learning disabilities in all four localities have exceeded the 75% threshold.
Appraisal compliance is now meeting the Trust threshold.

Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue though there has been a slight decrease - hotspot areas can be seen in the ward level breakdown of the report. The people directorate business partner continues to work closely with the care group regarding sickness and actions are underway in line with the policy. Individual ward sickness performance is also impacted by the allocation of staff with long term conditions into less acute areas.
Work on pathways with the collaborative is underway to address the underoccupancy in medium secure services.
Focus remains on ensuring staff have a timely and comprehensive appraisal, although external issues with access to the appraisal system are impacting on reported performance.
Liaison with the collaborative is underway to find appropriate solutions for the patients waiting for high secure placements.

Forensic - West Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Feb-26	Mar-26	Apr-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	76.3%	74.4%	77.6%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	86.4%	87.8%	89.0%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/0)	0% (0/0)	0% (0/0)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		64.2%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%			46.2%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	100.0%	99.1%	97.3%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.7%	82.0%	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%	100.0%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95.0%	81.7%	83.9%	86.6%	
% with care plan that includes service user input/views	Best Quality	Safe	95.0%			84.5%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	93.8%	94.0%	96.1%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	2	7	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	9	3	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.4%	91.0%	90.1%	
Restraint incidents	Best Quality	Safe	Trend Monitor	13	20	*18*	
Safer staffing (Overall)	Best Quality	Safe	90%	104.4%	105.4%	111.8%	
Safer staffing (Registered)	Best Quality	Safe	80%	102.4%	99.9%	101.3%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	6.1%	6.0%	6.4%	
Average length of stay	Best Quality	Safe	Trend Monitor	540	660	1,049	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	149	181	175	

Forensic - West Yorkshire:

Alert/Action

Future Capacity & Demand
Work is progressing through the West Yorkshire Provider Collaborative, in partnership with colleagues across the wider region, to model future demand and strengthen system-wide planning for specialised services. This includes detailed analysis of activity, length of stay, patient flow and projected demand trends to support a more proactive and evidence-based approach to service configuration.

Bed Occupancy
Occupancy across Newton Lodge and Bretton remains broadly unchanged this month with a slight increase in occupancy in both, with the most notable variance in the learning disability (LD) pathway. Four of the eight learning disability beds remain unoccupied, with some utilisation continuing to support out of area placements. Discharges have progressed within the male pathway, while the women's pathway is now operating at full occupancy following recent admissions.
Pathway-specific pressures continue to impact operational efficiency and resource utilisation. A detailed bed modelling exercise is underway, in partnership with the commissioning hub, to ensure future capacity and configuration are aligned to current activity and projected demand.
• Newton Lodge: 89.9%
• Bretton Centre: 92.6%
• Newhaven: 75%

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

Advise

Sickness Absence – Sickness absence continues to be a key area of focus across the service. A targeted programme of work is now underway, supported by the people directorate, to support teams in understanding and addressing the underlying drivers of absence and to strengthen overall attendance.
Sickness absence has reduced at Newton Lodge (4%) and Newhaven (1%). However, a significant hotspot remains at the Bretton Centre (13%), and the management team is actively reviewing the underlying causes and identifying appropriate actions.
Mandatory training overall compliance: Compliance remains strong overall, with identified hotspots including CPR at Newton Lodge (78.4%) and at Newhaven (77.5%) IG training is also below the threshold (94.1%).
Targeted actions are in place to address these areas, including focused follow up with staff, planned training sessions, and local management oversight. Compliance is monitored through established governance arrangements, and the service is confident that these actions will bring performance back within required thresholds over the coming reporting period, with appropriate assurance maintained in the interim.
Forensic Improvement Programme – The programme continues to 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.
FIRM Risk Assessment and Care Planning – Targeted quality improvement work has been implemented to strengthen compliance with FIRM risk assessment and care planning standards. Compliance has now reached the required threshold, with ongoing audit and governance arrangements in place to sustain improvement and provide continued assurance.
Appraisal – 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.

Assure

• High levels of data quality across the care group.
• 100% compliance for HCR20 completed within 3 months of admission.
• % service users on care programme approach with a formal review within the previous 12 months continues to evidence a good level of compliance.

Forensic - South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Feb-26	Mar-26	Apr-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	71.1%	63.3%	72.5%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	82.4%	84.8%	85.3%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/0)	0% (0/1)	0% (0/1)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		69.8%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%			54.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.6%	82.4%	84.6%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	95.3%	94.8%	97.3%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	3	0	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	9	5	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	82.6%	89.5%	83.3%	
Restraint incidents	Best Quality	Safe	Trend Monitor	9	10	*7*	
Safer staffing (Overall)	Best Quality	Safe	90%	114.9%	112.2%	107.9%	
Safer staffing (Registered)	Best Quality	Safe	80%	98.9%	89.9%	87.9%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	3.3%	3.3%	2.8%	
Average length of stay	Best Quality	Safe	Trend Monitor	700	1,273	1,075	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	101	158	164	

Forensic - South Yorkshire:

Alert/Action

Bed occupancy is currently at 79. There is a waiting list for admission and will be resolved once RC capacity has been established.

Supervision policies are scheduled for transfer in Q1 and Q2 2026/27, aligned to Trust review cycles and identified training needs.

Appraisal – Performance has improved however this will fluctuate with the new appraisal timeline. There is operational oversight for all appraisals and when these are due.

Turnover – Turnover is 17.1% following a recent workforce deep dive. Further analysis is underway to understand the drivers and inform targeted retention actions.

Advise

Wentbridge Ward - remains closed; however, roof repair works are progressing well and continue to be closely monitored.

Restrictive Practice Reduction (RRP) – Training has now been completed and will transition into business as usual.

EPMA – Electronic prescribing and medicines administration is now well embedded across all wards.

FIRM Risk Assessment – Implementation is progressing well following completion of training.

Benchmarking and Learning – A benchmarking exercise has been undertaken against the St Andrew's CQC inspection findings, with system-wide comparison to support shared learning and improvement.

Annual Quality Review – The visit by the South Yorkshire Hub was positive and provided assurance on progress.

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

Assure

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

SWYPFT policy integration continues.

Barnsley Physical Health and Wellbeing Care Group

Headlines

The Care Group continue to perform well against most metrics, 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 increased in month.

Barnsley Physical Health and Wellbeing

Metrics	Strategic Objective	CQC Domain	Threshold	Feb-26	Mar-26	Apr-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	88.0%	89.4%	92.3%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	50% (1/2)	0% (0/2)	0% (0/1)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	84.6%	87.1%	93.5%	
% of staff receiving supervision within policy guidance - Clinical	Best Quality	Safe	80%	Reporting Commenced April 2026		65.2%	
% of staff receiving supervision within policy guidance - Management	Best Quality	Safe	80%			42.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.7%	86.2%	88.2%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	94.6%	94.0%	97.5%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	95.6%	96.4%	97.5%	
Safer staffing (Overall)	Best Quality	Safe	90%	94.6%	93.8%	96.4%	
Safer staffing (Registered)	Best Quality	Safe	80%	98.3%	93.4%	90.2%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	6.0%	5.4%	5.9%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	25/26 - 99% 26/27 - 52.6%	91.3%	87.7%	93.5%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	6,659	7,038	7,070	
Total number of reported incidents	Best Quality	Safe	Trend monitor	252	287	250	

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 April against the target of 80% are:
Clinical supervision – 65.2%
Management supervision – 42.2%
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 remain outside compliance for the month of April at 5.9%. We continue to have some instances of long-term sicknesses relating to serious illnesses. The care group 12-month rolling figure is 5.19%. 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.
• Friends and Family Test (FFT) – 91% of people would recommend community services which is outside compliance for the month of April, as our compliance rates are 95% compared with 90% for the rest of the organisation. There was a reduction in the number of friends and family test responses collected during April, (160 compared with around 300 for the care group). This may be due to the new Trust wide in-house system being implemented from the 1st April and the functionality to collect information from patient experience surveys being unavailable. The previous Healthcare Communications contract which supported the collection of this data ended on 31.3.2026.

Assure

• Paediatric Audiology 6-week target for diagnostic procedures has seen a significant increase during April from 87.6% to 93.5%.
The total number on the waiting list continues to reduce and as at 3.5.26 this figure was down to 95 patients, with only 6 waiting over 6 weeks.
The 2026/27 Diagnostic Waiting Times and Activity Measure (DM01) threshold has been realigned with national expectation and Operational Planning / NHS interim trajectories of 52.56% within 6 weeks, which has further contributed to achieving compliance.
• Virtual Ward occupancy rate is at 108%. We have seen a significant improvement in virtual ward occupancy rates, exceeding our target and contributing to the overall improved patient flow and bed occupancy in the hospital and supporting hospital avoidance. The consultant geriatrician capacity position has improved with no pauses to onboarding during April. They have dedicated time to improving the position relating to discharge paperwork and ensuring onboardings for frailty do not exceed the cap of 55 patients at any time to ensure safe management of patients within current resource. We have also seen an increase in patients accessing the Acute Respiratory infection pathway during April, which has contributed to this improved position.
• Appraisals - for April, the overall care group figure is 92% which achieves compliance. The Trust is transitioning to a new appraisal system with a specific time window of April to September so there may be some impact with upcoming appraisals in some teams as they re-align with the new timeframes.
• Information Governance training has achieved 97.5% for April. Focused effort by managers working with their teams has led to achieving compliance in completing information governance training.
• Urgent Community Response Service 2-hour target has achieved 90.3% for April which continues to be well above the 70% threshold.
• Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 97.45% for April.
• People dying in their place of choosing remains compliant and has further risen to 93.55% in April, exceeding the 80% threshold.
• Cardiopulmonary resuscitation training maintains compliance at 88.2% for April.

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 Feb-26	Beamshaw Suite Mar-26	Beamshaw Suite Apr-26	Clark Suite Feb-26	Clark Suite Mar-26	Clark Suite Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	88.9%	100.0%	100.0%	95.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.1%	5.2%	3.5%	0.6%	1.9%	0.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		89.3%	Reporting Commenced April 2026		89.3%
Supervision - Management	Best place to work and learn	Well led	80%			89.3%			78.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.0%	91.7%	100.0%	88.0%	96.0%	96.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	68.0%	75.0%	88.9%	92.0%	88.0%	89.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.0%	91.7%	96.3%	92.0%	92.0%	96.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.0%	87.5%	92.6%	92.0%	96.0%	100.0%
Bed occupancy**	Best Quality	Safe	85%	94.3%	92.3%	93.7%	94.3%	92.3%	93.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	30	110	79	50	17	37
Safer staffing (Overall)	Best Quality	Safe	90%	112.9%	108.1%	108.3%	106.4%	103.7%	110.9%
Safer staffing (Registered)	Best Quality	Safe	80%	99.2%	96.8%	98.3%	100.8%	97.9%	100.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	6.5%	0.9%	16.3%	11.0%	10.6%	11.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	50.0%	100.0%	100.0%	75.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	1	4	0	7
Restraint incidents	Best Quality	Safe	Trend Monitor	5	0	*3*	7	2	*8*
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	Reporting Commenced April 2026		0% (0/17)	Reporting Commenced April 2026		0% (0/18)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	3	3	7	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 Feb-26	Melton Suite Mar-26	Melton Suite Apr-26	Nostell Feb-26	Nostell Mar-26	Nostell Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	96.4%	96.2%	83.3%	82.4%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.6%	7.9%	11.8%	5.3%	1.7%	1.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		97.0%	Reporting Commenced April 2026		60.0%
Supervision - Management	Best place to work and learn	Well led	80%			97.0%			73.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.9%	93.8%	96.9%	100.0%	88.5%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.8%	93.8%	90.6%	96.2%	96.2%	96.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	93.8%	93.8%	87.5%	84.6%	88.5%	89.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.8%	90.6%	96.9%	96.2%	92.3%	89.3%
Bed occupancy	Best Quality	Safe	85%	104.2%	93.0%	97.2%	98.6%	96.8%	99.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	237	33	15	50	27	29
Safer staffing (Overall)	Best Quality	Safe	90%	111.4%	108.2%	111.2%	111.2%	113.1%	104.8%
Safer staffing (Registered)	Best Quality	Safe	80%	95.8%	94.8%	91.6%	107.6%	116.7%	122.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	12.2%	0.0%	0.0%	0.6%	6.1%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	93.8%	70.6%	84.6%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	0	0	5	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	0	0	2	8	4
Restraint incidents	Best Quality	Safe	Trend Monitor	6	0	*0*	19	21	*24*
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	1	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	Reporting Commenced April 2026		N/A	Reporting Commenced April 2026		0% (0/110)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	4	3	14	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			Walton		
				Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	84.0%	91.7%	100.0%	100.0%	93.8%	96.7%
Sickness	Best place to work and learn	Well led	5.0%	2.3%	3.0%	9.3%	4.4%	3.0%	4.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		87.5%	Reporting Commenced April 2026		87.8%
Supervision - Management	Best place to work and learn	Well led	80%			90.6%			87.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	97.0%	100.0%	95.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.7%	96.8%	97.0%	97.4%	92.5%	97.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.7%	96.8%	93.9%	71.1%	80.0%	82.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.3%	90.3%	90.9%	97.4%	95.0%	95.0%
Bed occupancy**	Best Quality	Safe	85%	98.6%	96.8%	99.6%	95.4%	96.3%	94.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	64	34	58	N/A	49	159
Safer staffing (Overall)	Best Quality	Safe	90%	115.6%	105.5%	100.0%	118.1%	113.2%	124.0%
Safer staffing (Registered)	Best Quality	Safe	80%	90.2%	91.9%	96.5%	91.0%	93.5%	95.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	21.9%	19.9%	15.4%	14.7%	14.9%	29.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	1	1	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	4	3	1	2	4
Restraint incidents	Best Quality	Safe	Trend Monitor	4	8	*6*	7	21	*15*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	1	2	1	3	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	Reporting Commenced April 2026		0% (0/165)	Reporting Commenced April 2026		0% (0/165)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	12	8	1	5	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			Ward 18		
				Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	73.9%	80.0%	91.7%	85.7%	38.1%	95.2%
Sickness	Best place to work and learn	Well led	5.0%	8.4%	4.5%	4.6%	1.3%	5.5%	3.4%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		78.8%	Reporting Commenced April 2026		62.2%
Supervision - Management	Best place to work and learn	Well led	80%			75.8%			62.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.3%	93.9%	100.0%	100.0%	100.0%	94.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	86.7%	78.8%	88.2%	93.5%	83.9%	91.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	80.0%	87.5%	84.8%	87.1%	83.9%	80.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	80.0%	81.8%	94.1%	100.0%	96.8%	94.3%
Bed occupancy	Best Quality	Safe	85%	99.4%	95.7%	94.0%	98.1%	99.9%	98.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	58	41	53	30	38	20
Safer staffing (Overall)	Best Quality	Safe	90%	98.9%	101.8%	123.1%	101.2%	101.4%	114.4%
Safer staffing (Registered)	Best Quality	Safe	80%	104.6%	102.3%	103.1%	104.4%	104.1%	114.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.7%	12.4%	13.8%	4.6%	3.6%	0.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	54.5%	80.0%	57.1%	88.9%	85.2%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	2	6	1	0	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	2	3	3	0	8
Restraint incidents	Best Quality	Safe	Trend Monitor	10	10	*6*	13	3	*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	Reporting Commenced April 2026		0% (0/663)	Reporting Commenced April 2026		0% (0/562)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	2	3	1	5	8

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale Feb-26	Elmdale Mar-26	Elmdale Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	90.5%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	10.6%	8.3%	4.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		94.1%
Supervision - Management	Best place to work and learn	Well led	80%			94.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	95.8%	93.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.7%	95.7%	96.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.8%	95.8%	90.3%
Bed occupancy	Best Quality	Safe	85%	92.6%	88.8%	89.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	29	100	37
Safer staffing (Overall)	Best Quality	Safe	90%	112.6%	110.2%	99.3%
Safer staffing (Registered)	Best Quality	Safe	80%	97.4%	97.5%	101.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	6.2%	8.0%	6.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	92.9%	76.5%	95.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	3	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	10	6	4
Restraint incidents	Best Quality	Safe	Trend Monitor	14	5	*3*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	1	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	Reporting Commenced April 2026		0% (0/275)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	9	5

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton			Poplars CUE		
				Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	43.8%	38.9%	77.8%	86.2%	96.6%	93.3%
Sickness	Best place to work and learn	Well led	5.0%	9.2%	6.6%	9.4%	8.4%	6.7%	3.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		76.9%	Reporting Commenced April 2026		93.9%
Supervision - Management	Best place to work and learn	Well led	80%			73.1%			93.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	96.2%	100.0%	97.0%	97.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	95.5%	87.5%	83.3%	84.8%	84.4%	84.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.8%	79.2%	79.2%	84.8%	90.6%	90.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.7%	92.3%	96.2%	82.4%	81.8%	84.8%
Bed occupancy	Best Quality	Safe	85%	93.8%	92.1%	76.5%	75.7%	77.2%	69.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	70	145	105	116	88	114
Safer staffing (Overall)	Best Quality	Safe	90%	174.0%	178.7%	169.8%	205.8%	200.5%	207.7%
Safer staffing (Registered)	Best Quality	Safe	80%	130.2%	140.1%	123.7%	99.0%	102.4%	108.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	6.2%	6.4%	12.9%	21.0%	43.5%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	4	0	7	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	6	3	1	10	8	13
Restraint incidents	Best Quality	Safe	Trend Monitor	25	20	*6*	27	32	*18*
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	Reporting Commenced April 2026		0% (0/5)	Reporting Commenced April 2026		7% (1/14)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	15	15	10	18	23	31

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow			Beechdale		
				Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	84.2%	94.1%	93.8%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	8.8%	14.0%	7.0%	1.9%	5.6%	6.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		83.3%	Reporting Commenced April 2026		100.0%
Supervision - Management	Best place to work and learn	Well led	80%			83.3%			100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	88.9%	87.5%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.4%	94.4%	81.3%	91.3%	95.5%	95.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.4%	94.4%	87.5%	81.8%	90.5%	95.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	88.9%	93.8%	73.9%	72.7%	95.7%
Bed occupancy	Best Quality	Safe	85%	98.6%	91.0%	77.7%	99.1%	92.3%	90.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	70	57	57	109	117	139
Safer staffing (Overall)	Best Quality	Safe	90%	127.8%	112.7%	112.9%	151.1%	134.5%	144.3%
Safer staffing (Registered)	Best Quality	Safe	80%	103.2%	85.7%	93.3%	102.8%	100.9%	101.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	6.0%	11.5%	8.4%	10.3%	12.1%	14.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	88.9%	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	0	0	0	1	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	2	*3*	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	Reporting Commenced April 2026		N/A	Reporting Commenced April 2026		0% (0/17)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	8	4	0	4	3

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male Feb-26	Ward 19 - Male Mar-26	Ward 19 - Male Apr-26	Ward 19 - Female Feb-26	Ward 19 - Female Mar-26	Ward 19 - Female Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	93.8%	100.0%	100.0%	94.4%	88.2%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.9%	1.5%	4.2%	13.7%	11.9%	7.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		95.7%	Reporting Commenced April 2026		94.4%
Supervision - Management	Best place to work and learn	Well led	80%			95.7%			100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.2%	95.5%	92.3%	85.7%	84.2%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	90.9%	88.5%	85.7%	89.5%	85.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.0%	77.3%	69.2%	76.2%	84.2%	65.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	85.7%	81.8%	76.9%	76.2%	68.4%	70.0%
Bed occupancy	Best Quality	Safe	85%	99.8%	92.7%	88.2%	96.2%	98.5%	85.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	97	95	76	38	87	96
Safer staffing (Overall)	Best Quality	Safe	90%	119.0%	145.4%	129.0%	127.1%	133.5%	119.6%
Safer staffing (Registered)	Best Quality	Safe	80%	97.5%	87.1%	88.3%	90.0%	101.3%	106.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	9.4%	12.0%	1.3%	25.3%	26.0%	11.6%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	1	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	8	4	4	2	6
Restraint incidents	Best Quality	Safe	Trend Monitor	4	15	*5*	11	9	*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	Reporting Commenced April 2026		0% (0/50)	Reporting Commenced April 2026		0% (0/10)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	9	3	19	12	17

Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down			Lyndhurst		
				Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	83.3%	100.0%	97.9%	82.1%	92.6%	92.3%
Sickness	Best place to work and learn	Well led	5.0%	3.8%	5.1%	4.2%	5.6%	6.5%	8.1%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		89.1%	Reporting Commenced April 2026		74.1%
Supervision - Management	Best place to work and learn	Well led	80%			87.0%			74.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	98.1%	100.0%	96.3%	100.0%	96.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.0%	86.3%	84.3%	81.5%	82.1%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	91.1%	93.5%	95.7%	96.3%	89.3%	81.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.1%	90.4%	96.2%	96.3%	89.3%	92.6%
Bed occupancy	Best Quality	Safe	Trend Monitor	47.1%	49.2%	53.8%	55.6%	50.9%	56.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	766	120	18	961	315	69
Safer staffing (Overall)	Best Quality	Safe	90%	97.1%	97.5%	99.1%	102.2%	97.9%	101.6%
Safer staffing (Registered)	Best Quality	Safe	80%	96.8%	97.1%	97.6%	99.5%	97.0%	103.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	100.0%	N/A	0.0%	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	Reporting Commenced April 2026		0% (0/102)	Reporting Commenced April 2026		0% (0/22)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	1	1	0

Inpatients - Forensic West Yorkshire - Medium Secure

Medium Secure

• 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.

• Sickness absence continues to improve overall. While one area (Waterton) remains above target at 7.6%, and Chippendale (5.3%) and Priestley (5.2%) 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.

• A continued focus on high-quality appraisals remains a priority for the service, with focused intervention to ensure all staff have a quality appraisal. Six wards, Appleton (93.3%), Bronte (95%), Hepworth (100%), Chippendale (94.4%), Johnson (100%) and Waterton (100%) currently are at above target. One ward (Priestley 76.5%) is currently below the required threshold. This has been reviewed, and current outstanding appraisals are related to long term sickness absence and staff aligned to other managers: with a plan in place for completion.

• Challenges in mandatory training compliance have been identified and are under active review. Mitigating actions are being developed to improve compliance and provide appropriate assurance. Fire Safety training is delivered through the annual security update with some recent decline in compliance. This has improved with hotspots now remaining on Appleton (77.8%) and Hepworth (84.2%). IG Training on Appleton (94.4%) and Johnson (90.9%) is a further hotspot that is recognised annual pressure point, reflecting the time of year when a large number of staff are due for their update. A RRPI hotspot on Johnson (78.8%) is under review by the Ward Manager. Challenges with CPR training have been evident with compliance on Johnson (75.8%), Hepworth (78.9%) and Bronte (66.7%). The service has had challenges in the release of staff from shift for this ½ day, mid-day training and have requested staff to not book this whilst on shift to support attendance. The Care Group is reviewing these areas and determining the support required to enable the ward to reach the expected standards.

• Bed occupancy on Appleton remains low at 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 make pathway, although overall occupancy appears reduced within the data, our capacity is within our admission wards and rehabilitation wards are at full capacity (Waterton 100% and Priestley 100%). This demonstrates a positive position for patient flow. Where there is reduced occupancy, this is often to support process for new admissions. All unoccupied beds do have identified service users within the admission process.

• 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. The service is currently compliant (100%) and will continue to monitor this closely to maintain high standards.

• 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 (1.0%) is now within expected compliance range. Sandal (7.0%), Thornhill (15.2%) and Ryburn (19.4%) 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 showing improvement remains at 94.1% and Thornhill IG which is 93.8%. Sandal CPR which is 65% 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. The current increase in outstanding appraisals reflects a cyclical peak in the appraisal schedule alongside transition to new reporting; however, an improving trajectory is evident, with recovery actions in place. Current compliance stands at 81.5% on Thornhill, 88.0% on Sandal and 74.2% on Newhaven. Ryburn is within compliance at 90.9%. Work has taken place to address data quality issues, and the service remains committed to ensuring that all staff receive a timely and high-quality appraisal.

• 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 100% (Sandal) for risk assessments completed within 24 hours.

• The service continues to work closely with the provider collaborative to support effective use of bed occupancy across West Yorkshire. The Bretton Centre currently has good occupancy with Sandal (95.4%), Thornhill (94.7%) with processes in place to support admissions. Ryburn (81.9%) currently has service users working towards transition. Newhaven (75.0%) continues to experience lower level of referrals and has no waiting list. It has one service user within the referral / admission process.

• There were no prone restraint incidents, and Incidents of restraint show broad consistency in line with patient flow and new admissions.

• Safer staffing levels are within the expected compliance range. Increased acuity on Sandal (105.4%) 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			Bronte		
				Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	78.6%	85.7%	93.3%	100.0%	94.7%	95.0%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	7.7%	5.5%	3.0%	9.7%	4.6%	0.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		66.7%	Reporting Commenced April 2026		65.2%
Supervision - Management	Best place to work and learn	Well led	80%			53.5%			4.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	83.3%	83.3%	94.4%	95.0%	90.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%	95.0%	90.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	77.8%	77.8%	88.9%	60.0%	65.0%	66.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	66.7%	72.2%	77.8%	90.0%	80.0%	90.5%
Bed occupancy	Best Quality	Safe	90%	62.5%	56.0%	50.0%	74.5%	84.3%	88.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	355	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	146.3%	143.7%	134.8%	106.0%	103.6%	98.2%
Safer staffing (Registered)	Best Quality	Safe	80%	105.8%	103.4%	96.1%	96.5%	96.4%	99.1%
% 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	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	1	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	1	0	3	0
Restraint incidents	Best Quality	Safe	Trend Monitor	5	7	*6*	3	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	Reporting Commenced April 2026		0% (0/4)	Reporting Commenced April 2026		0% (0/6)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	12	5	2	1	2	0

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale Feb-26	Chippendale Mar-26	Chippendale Apr-26	Hepworth Feb-26	Hepworth Mar-26	Hepworth Apr-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	25/26 - 5.4% 26/27 - 5%	2.6%	5.3%	5.3%	2.0%	1.6%	1.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		90.0%	Reporting Commenced April 2026		50.0%
Supervision - Management	Best place to work and learn	Well led	80%			90.0%			35.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	95.2%	90.5%	100.0%	89.5%	89.5%	89.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	76.2%	90.5%	85.0%	84.2%	78.9%	78.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.2%	90.5%	95.0%	89.5%	84.2%	84.2%
Bed occupancy	Best Quality	Safe	90%	88.4%	88.7%	91.7%	89.0%	76.1%	80.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	140	813	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	94.0%	96.0%	99.0%	96.8%	97.4%	99.2%
Safer staffing (Registered)	Best Quality	Safe	80%	104.4%	114.9%	111.8%	89.2%	85.5%	86.1%
% 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	100.0%	N/A	N/A	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	1	0	*0*
Prone Restraint incidents - 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	Reporting Commenced April 2026		8% (2/26)	Reporting Commenced April 2026		40% (2/5)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	1	0	1

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson			Priestley		
				Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	78.6%	85.2%	100.0%	73.7%	70.6%	76.5%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	2.5%	1.3%	2.6%	7.5%	5.2%	5.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		96.7%	Reporting Commenced April 2026		61.1%
Supervision - Management	Best place to work and learn	Well led	80%			50.0%			55.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.6%	96.9%	90.9%	95.0%	94.6%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.4%	84.4%	78.8%	89.5%	88.9%	94.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.0%	75.0%	75.8%	94.7%	88.9%	88.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.5%	84.4%	90.9%	85.0%	84.2%	89.5%
Bed occupancy	Best Quality	Safe	90%	90.2%	97.4%	100.0%	97.3%	100.0%	98.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	939	N/A	775
Safer staffing (Overall)	Best Quality	Safe	90%	132.5%	124.6%	131.0%	93.7%	95.1%	107.8%
Safer staffing (Registered)	Best Quality	Safe	80%	102.8%	95.5%	100.6%	104.5%	103.8%	101.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	1	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	2	*1*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	1	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	Reporting Commenced April 2026		6% (2/34)	Reporting Commenced April 2026		21% (6/28)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	13	6	6	1	0	4

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton Feb-26	Waterton Mar-26	Waterton Apr-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	25/26 - 5.4% 26/27 - 5%	12.0%	6.2%	7.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		44.0%
Supervision - Management	Best place to work and learn	Well led	80%			24.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	87.0%	83.3%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.0%	91.7%	91.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.6%	83.3%	73.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	87.0%	83.3%	91.3%
Bed occupancy	Best Quality	Safe	90%	100.0%	100.0%	99.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	1359
Safer staffing (Overall)	Best Quality	Safe	90%	105.2%	106.2%	107.9%
Safer staffing (Registered)	Best Quality	Safe	80%	99.5%	92.3%	96.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Prone Restraint incidents - 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	Reporting Commenced April 2026		0% (0/72)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	5	1

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill			Sandal		
				Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	82.8%	75.9%	81.5%	81.3%	75.0%	88.0%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	7.8%	8.2%	15.2%	3.1%	7.5%	7.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		45.5%	Reporting Commenced April 2026		36.4%
Supervision - Management	Best place to work and learn	Well led	80%			33.3%			21.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	96.9%	93.8%	96.4%	100.0%	96.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.9%	96.9%	90.6%	92.9%	89.7%	89.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.8%	81.3%	84.4%	71.4%	69.0%	65.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	93.8%	96.4%	93.1%	89.7%
Bed occupancy	Best Quality	Safe	85%	99.8%	100.0%	94.7%	81.3%	89.7%	95.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	1900	N/A	N/A	162
Safer staffing (Overall)	Best Quality	Safe	90%	99.0%	98.2%	95.7%	98.9%	107.0%	138.1%
Safer staffing (Registered)	Best Quality	Safe	80%	101.7%	98.6%	102.1%	104.0%	103.1%	105.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	1	0	1	4
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*2*	0	0	*6*
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	Reporting Commenced April 2026		7% (10/135)	Reporting Commenced April 2026		8% (6/74)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	7	6	0	7	6	20

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn Feb-26	Ryburn Mar-26	Ryburn Apr-26	Newhaven Feb-26	Newhaven Mar-26	Newhaven Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	90.9%	70.6%	69.7%	74.2%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	4.5%	19.9%	19.4%	7.6%	5.4%	1.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		58.3%	Reporting Commenced April 2026		67.7%
Supervision - Management	Best place to work and learn	Well led	80%			58.3%			83.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	94.3%	88.2%	94.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	90.9%	96.8%	96.7%	93.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	81.8%	93.5%	86.7%	87.1%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	90.9%	94.3%	91.2%	94.1%
Bed occupancy	Best Quality	Safe	85%	71.9%	71.4%	81.9%	69.9%	75.0%	75.0%
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%	99.1%	100.3%	96.3%	125.6%	120.4%	113.0%
Safer staffing (Registered)	Best Quality	Safe	80%	101.8%	101.4%	96.7%	102.5%	100.7%	102.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	3	2	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	3	2	*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	Reporting Commenced April 2026		100% (1/1)	Reporting Commenced April 2026		3% (1/39)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	0	0	11	6	3

Inpatients - Non-Mental Health

• **Appraisal rate (90%):**
NRU rate is below compliance at 85.7% for April. As of 13 May there has been a good improvement towards compliance at 91.4%. 12 members of staff were out of date during April. Dates booked in for all staff to have appraisals within timeframes; unfortunately staff sickness resulted in dip in compliance. Appraisals re-booked once staff retuned from sickness and a marked improvement to 91.4%.
SRU rate continues to maintain compliance at 94% for April.

• **Supervision (80%):**
Staff receiving supervision – following the introduction of the separate 60-day targets for clinical and management supervision, the wards are undergoing a period of monitoring and reviewing the revised statistics and their impact on the achievement of compliance for this measure. See narrative in care group section of the report for wider Care Group and work that has taken place to focus on supervision; this also applies to both wards.

• **Sickness (5%):**
NRU – sickness for April has continued to increase and is outside compliance at 7.7%. The current position includes some instances of long term sickness.
SRU – Sickness for April has continued to increase and is outside compliance at 6.5%. The current position includes several instances of long term sickness.
Sickness on both units is being monitored and managed via Supporting Wellbeing (Sickness and Attendance Procedure). Some staff are not due to return to work until mid-May, therefore this will continue to impact figures next month.

• **Information Governance (95%):**
NRU compliance has fallen below threshold this month and is at 92.7% for April.
SRU compliance has fallen slightly below threshold this month and is at 94.2% for April.
The reductions are related to the high levels of sickness. In addition, the Unit Manager post on SRU has been vacant for a few weeks but the new post holder will be starting on 1 June 2026 which will bring additional oversight back into the senior team.

• **CPR (80%):**
NRU has seen a good increase towards compliance during April at 79.5% from 74.4%.
SRU is below compliance at 69.2% for April.
Sickness (on SRU in particular) 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 – has fallen below compliance at 80.5% for April
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. All staff out of date have been booked onto future sessions at the earliest opportunity.

• **Safer Staffing - overall (90%):**
NRU – within compliance – at 100.4%
SRU – within compliance – at 93.9%
Safer staffing (registered 80%) is within compliance for both units.
To note: the establishment figures for both wards were reviewed in November 2025 and work continues to realign this on e-roster following 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 for mid-June.

Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit (NRU) Feb-26	Mar-26	Apr-26	Stroke Rehabilitation Unit (SRU) Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	80.6%	97.1%	85.7%	98.6%	97.1%	94.0%
Sickness	Best place to work and learn	Well led	5.0%	4.6%	5.3%	7.7%	2.0%	5.5%	6.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		61.5%	Reporting Commenced April 2026		55.7%
Supervision - Management	Best place to work and learn	Well led	80%			53.8%			48.6%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.1%	95.1%	92.7%	95.8%	97.1%	94.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	68.4%	74.4%	79.5%	80.9%	71.2%	69.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	85.4%	85.4%	80.5%	93.1%	92.9%	94.2%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	88.7%	97.0%	95.3%	90.2%	96.2%	97.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	39	90	69	30	23	23
Safer staffing (Overall)	Best Quality	Safe	90%	106.1%	102.6%	100.4%	85.6%	86.7%	93.1%
Safer staffing (Registered)	Best Quality	Safe	80%	103.3%	97.9%	86.7%	93.7%	89.0%	93.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	12	5	24	19	30

Inpatients - Mental Health - Learning Disability

Headlines

• Appraisal compliance (77.8%) remains closely managed, with a proactive approach across the service. Current outstanding appraisals reflect a small number of staff, including individuals recently returned from sick leave, with all reviews now scheduled. A clear process is in place to support transition to the new appraisal framework, supported by strong management oversight to ensure timely completion and sustained quality.
• Sickness has now reduced to 4.7%, and remains with compliance.
• 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.
• 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 (133.7%) and registered staffing (167.9%).
• There are no prone restraints and restraint incidents remain broadly consistent.
• Cancelled leave is routinely monitored across the service, with no cancellations reported in this period.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon		
				Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	94.1%	77.8%
Sickness	Best place to work and learn	Well led	5.0%	3.5%	7.3%	4.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		88.4%
Supervision - Management	Best place to work and learn	Well led	80%			79.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.3%	100.0%	97.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.7%	87.2%	92.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.1%	97.4%	94.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.3%	92.7%	92.7%
Bed occupancy	Best Quality	Safe	N/A	50.0%	50.0%	50.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	122.1%	121.5%	133.7%
Safer staffing (Registered)	Best Quality	Safe	80%	188.0%	171.8%	167.9%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	75.0%	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	4	9	11
Restraint incidents	Best Quality	Safe	Trend Monitor	8	6	*8*
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	Reporting Commenced April 2026		0% (0/196)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	18	21	30

Inpatients - Forensic South Yorkshire

Medium Secure

• Supervision recording has changed since the last report, work is ongoing to embed new reporting. Compliance is below threshold however this is related to change of recording and splitting clinical and management supervision.
• Sickness absence has reduced on Foss from 8.2% to 6.7% and on Skipton remains within threshold.
• Safer staffing is within compliance and is reviewed by service management on a daily basis. Fill rate of registered staff on Skipton is related to a change of how 4-1 bespoke package is recorded on Skipton Healthroster. Issue has been resolved since and should see improvement next month.
• Mandatory training compliance is a mixed picture and there remains issues with training being recorded consistently due to the change from local training to Trustwide training offer. Both areas requiring improvement in Cardiopulmonary resuscitation (CPR) and fire safety (plans in place to mitigate low compliance)
• Bed occupancy on Skipton (80.9%) and Foss (78.6%), whilst below compliance is in relation to the mobilisation of Cheswold Park Hospital and plans are in place to increase. Skipton continues to have a bespoke package of care taking up two beds. As todays date Skipton is now fully occupied. Foss has a long term segregation which is reducing capacity as well as one bedroom closed due to water quality.
• Prone restraints - none across the service

Low Secure

• Appraisal: Ongoing recording issues related to historical recording on the electronic staff record (ESR), plan in place to address. Local data indicates that Esk is 86.9%, Wentbridge is 87.8%, Aire is 78.5%, Don is 85.7% and Calder is 100%.
• Supervision recording has changed since the last report, work is ongoing to embed new reporting. Compliance is below threshold however this is related to change of recording and splitting clinical and management supervision.
• Sickness: Within compliance on all wards except Esk where there is ongoing long-term sickness (managed and plans in place with support from people directorate).
• Mandatory training: Generally strong, though some local reporting vs Trust reporting mismatches persist due to system alignment issues post Cheswold transfer. Compliance against Information Governance training has dropped on Aire this month (88.9%). Training plans are in place to target individuals who require training
• Bed occupancy: Referrals in place to increase occupancy, awaiting court orders/warrants to allow transfer. Three bedrooms still closed across low secure wards due to water quality.
• No prone restraints across all low secure wards.

				Medium Secure Services Foss			Skipton		
Metrics	Strategic Objective	CQC Domain	Threshold	Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	63.6%	61.9%	86.4%	58.1%	43.3%	90.0%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	6.4%	8.2%	6.7%	5.7%	4.7%	3.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		70.4%	Reporting Commenced April 2026		77.1%
Supervision - Management	Best place to work and learn	Well led	80%			63.0%			74.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.0%	89.7%	95.8%	96.6%	93.1%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.0%	93.1%	87.5%	51.7%	79.3%	82.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	68.0%	58.6%	62.5%	69.0%	69.0%	71.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.0%	93.1%	75.0%	89.7%	93.1%	82.9%
Bed occupancy	Best Quality	Safe	90%	78.6%	78.6%	78.6%	69.9%	80.9%	83.3%
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%	92.9%	112.1%	125.3%	179.4%	123.6%	99.7%
Safer staffing (Registered)	Best Quality	Safe	80%	97.0%	97.7%	104.1%	118.6%	89.7%	70.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	2	0	1	3	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*1*	6	*8*	*4*
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	Reporting Commenced April 2026		14% (6/44)	Reporting Commenced April 2026		18% (7/38)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	25	16	72	60	31

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Esk			Wentbridge		
				Feb-26	Mar-26	Apr-26	Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	86.4%	86.4%	81.3%	50.0%	53.1%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	6.3%	4.3%	5.4%	1.0%	1.0%	1.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		83.3%	Reporting Commenced April 2026		73.5%
Supervision - Management	Best place to work and learn	Well led	80%			41.7%			58.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	96.2%	95.7%	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%	82.6%	85.3%	94.1%	97.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.7%	91.7%	87.0%	94.1%	88.2%	91.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	86.4%	92.3%	73.9%	97.1%	97.1%	97.1%
Bed occupancy	Best Quality	Safe	90%	68.8%	74.4%	85.0%	75.0%	80.2%	87.5%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	1075	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	102.6%	105.4%	99.0%	96.4%	107.4%	112.9%
Safer staffing (Registered)	Best Quality	Safe	80%	88.4%	85.7%	90.5%	90.4%	88.4%	95.9%
% 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	3	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	2	1	2	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	*1*	1	1	*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	Reporting Commenced April 2026		15% (4/26)	Reporting Commenced April 2026		0% (0/28)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	10	2	25	30	15

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire Feb-26	Aire Mar-26	Aire Apr-26	Don Feb-26	Don Mar-26	Don Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	54.8%	48.4%	48.3%	65.2%	54.5%	56.5%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	0.9%	2.3%	2.2%	2.0%	2.1%	0.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		77.4%	Reporting Commenced April 2026		30.4%
Supervision - Management	Best place to work and learn	Well led	80%			29.0%			26.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.6%	88.9%	100.0%	100.0%	100.0%	95.7%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	77.8%	89.3%	83.3%	90.0%	90.9%	78.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.8%	82.8%	83.3%	90.0%	85.0%	91.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.3%	96.3%	93.3%	100.0%	95.0%	91.3%
Bed occupancy	Best Quality	Safe	90%	81.3%	87.1%	75.6%	100.0%	100.0%	100.0%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	700	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	92.7%	92.4%	99.4%	112.0%	107.9%	102.0%
Safer staffing (Registered)	Best Quality	Safe	80%	87.5%	86.3%	91.3%	100.5%	87.5%	87.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	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	Reporting Commenced April 2026		9% (2/22)	Reporting Commenced April 2026		11% (5/45)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	9	7	6	14	10

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Calder Feb-26	Mar-26	Apr-26
Appraisal rate	Best place to work and learn	Well led	90%	86.4%	81.8%	90.9%
Sickness	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	0.3%	0.6%	0.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	Reporting Commenced April 2026		100.0%
Supervision - Management	Best place to work and learn	Well led	80%			86.4%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	90.5%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	95.5%
Bed occupancy	Best Quality	Safe	90%	100.0%	92.7%	88.3%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	1273	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	92.8%	91.0%	96.1%
Safer staffing (Registered)	Best Quality	Safe	80%	74.5%	64.9%	86.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	2	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*1*
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	Reporting Commenced April 2026		4% (1/23)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	7	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 required for the Trust National Oversight Framework score.
1	Surplus / (Deficit)	Best Value	Well Led	(£0.5m)	£0	The Trust run rate has deteriorated in April 2026 due to the impact of pay awards being higher than the funding received for them and additional non pay pressures. Actions will continue to recover this position and deliver the planned breakeven position.
2	Agency Spend	Best Value	Well Led	£0.1m	£1.9m	Agency spend has continued to be maintained at an overall low level. Spend in April 2026 is £125k 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. Spend in other areas is less than £500 in month.
3	Bank Spend	Best Value	Well Led	£2m	£20.5m	The Trust continues to utilise bank and locum staff as part of it's overall workforce strategy. Spend remains higher than the target.
4	Financial sustainability and efficiencies	Best Value	Well Led	£0.9m	£17.7m	The value for money programme is £0.2m behind plan at month 1. The main reason is due to a shortfall in temporary staffing (as above bank is higher than planned). The forecast remains that the target will be delivered in full and additional mitigations are being identified.
5	Cash	Best Value	Well Led	£62.6m	£68.8m	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	£0.8m	£13.9m	Capital spend is ahead of plan in April 2026 due to the timing of updated lease contracts. This, as per previous years, were expected in June 2026. The main capital scheme is the continuation of the older people inpatient transformation scheme.
7	Better Payment Practice Code	Best Value	Well Led	99%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

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

South West Yorkshire Partnership Teaching NHS Foundation Trust

Finance Report

Month 1 (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 required for 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)**	(£0.5m)	£0m	The Trust run rate has deteriorated in April 2026 due to the impact of pay awards being higher than the funding received for them and additional non pay pressures. Actions will continue to recover this position and deliver the planned breakeven position.
2	**Agency Spend**	£0.1m	£1.9m	Agency spend has continued to be maintained at an overall low level. Spend in April 2026 is £125k 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. Spend in other areas is less than £500 in month.
3	**Bank Spend**	£2m	£20.5m	The Trust continues to utilise bank and locum staff as part of it's overall workforce strategy. Spend remains higher than the target.
4	**Financial sustainability and efficiencies**	£0.9m	£17.7m	The value for money programme is £0.2m behind plan at month 1. The main reason is due to a shortfall in temporary staffing (as above bank is higher than planned). The forecast remains that the target will be delivered in full and additional mitigations are being identified.
5	**Cash**	£62.6m	£68.8m	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**	£0.8m	£13.9m	Capital spend is ahead of plan in April 2026 due to the timing of updated lease contracts. This, as per previous years, were expected in June 2026. The main capital scheme is the continuation of the older people inpatient transformation scheme.
7	**Better Payment Practice Code**	99%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

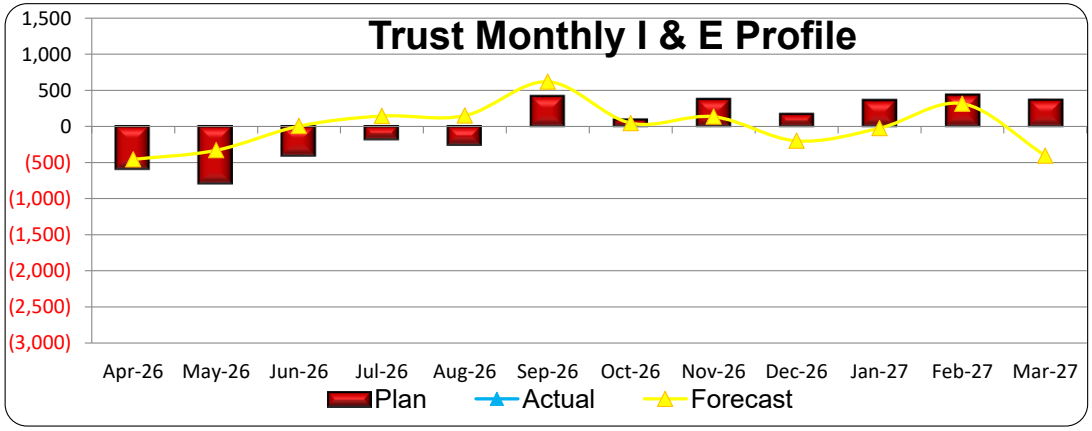
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

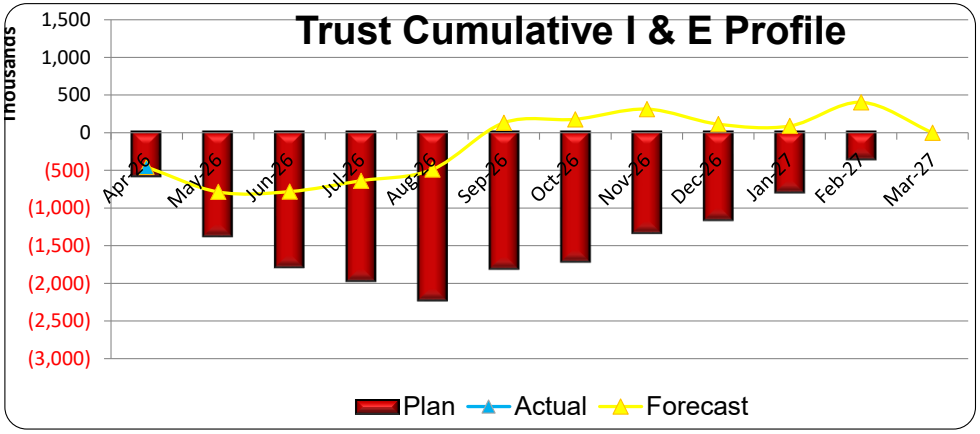
2.0 Income & Expenditure Position 2026 / 27

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					34,747	34,725	(22)	34,747	34,725	(22)	415,692	415,217	(475)
Other Operating Revenue					1,303	1,319	16	1,303	1,319	16	15,463	15,714	251
Total Revenue					**36,051**	**36,044**	**(6)**	**36,051**	**36,044**	**(6)**	**431,155**	**430,931**	**(224)**
Employee expenses	5,399	5,458	59	1.1%	(25,622)	(26,129)	(507)	(25,622)	(26,129)	(507)	(304,432)	(316,946)	(12,514)
Operating expenses exc. Employee					(10,761)	(10,202)	559	(10,761)	(10,202)	559	(123,498)	(111,781)	11,716
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	**5,399**	**5,458**	**59**	**1.1%**	**(36,383)**	**(36,331)**	**52**	**(36,383)**	**(36,331)**	**52**	**(427,930)**	**(428,727)**	**(798)**
Operating Surplus / (Deficit)	**5,399**	**5,458**	**59**	**1.1%**	**(333)**	**(287)**	**46**	**(333)**	**(287)**	**46**	**3,225**	**2,204**	**(1,022)**
Finance expense					(55)	(59)	(3)	(55)	(59)	(3)	(665)	(664)	1
PDC Paid					(362)	(362)	0	(362)	(362)	0	(4,343)	(4,343)	(0)
Finance income					151	244	93	151	244	93	1,645	2,719	1,074
Surplus / (Deficit) - Total	**5,399**	**5,458**	**59**	**1.1%**	**(599)**	**(464)**	**135**	**(599)**	**(464)**	**135**	**(138)**	**(84)**	**54**
Adjusted Financial Performance													
Depn Peppercorn Leases (IFRS16)					11	8	(3)	11	8	(3)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB performance measure	**5,399**	**5,458**	**59**	**1.1%**	**(588)**	**(456)**	**132**	**(588)**	**(456)**	**132**	**0**	**(0)**	**(0)**





Income & Expenditure Position 2026 / 27

The consolidated Trust deficit in April 2026 is £456k.
Due to the Trust plan profile this is £132k better 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, Investm4net 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)	5,376	5,436	60	1.1%	(874)	(583)	291	(874)	(583)	291	(4,880)	(16,727)	(11,847)
Provider Collaboratives	23	22	(2)	8.0%	42	119	77	42	119	77	20	953	933
Budgets held centrally	0	0	0	0.0%	244	9	(235)	244	9	(235)	4,860	15,774	10,914
Total - Consolidated position (ICB performance measure)	**5,399**	**5,458**	**59**	**1.1%**	**(588)**	**(456)**	**132**	**(588)**	**(456)**	**132**	**0**	**(0)**	**(0)**

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 deficit recognised the increased inflationary pay and non pay costs which would not be fully funded by national tariff increases. This has materialised, and been increased by, an increase in worked WTE (and therefore payroll costs) when compared to the previous financial year. This will need to be offset in year through the delivery of Value For Money schemes to improve the underlying run rate.

As at April 2026 the Trust (core), whilst in deficit, is ahead of plan. There is pressure on pay with more staff than planned. This is offset by underspends on non pay although these are forecast to be spent later in the year such as IM & T equipment.

This is partially offset by the current position on provider collaboratives. There is a surplus in month 1 but it must be flagged that remains particularly volatile and a change in either exceptional packages of care or out of area placements, even a single instance could have a material impact on this position.

Budgets held centrally remains for items that are not able to be coded through care groups. The actuals are limited but the budget requires additional value for money schemes to be allocated against. 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.

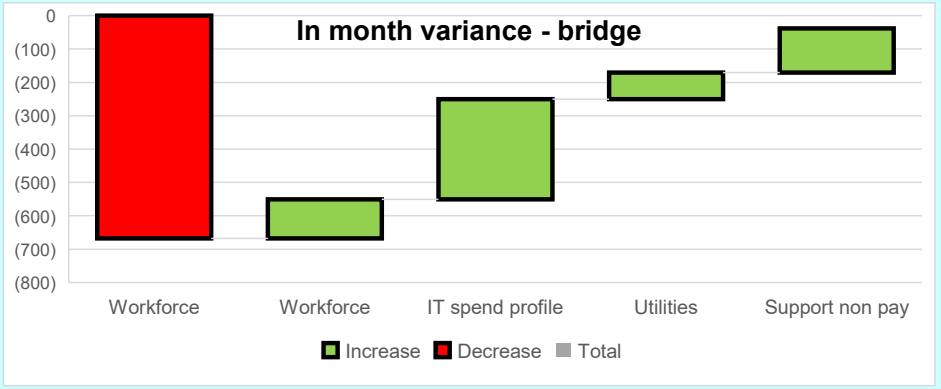
To confirm that the individual analysis within this report highlights the Trust only values unless explicitly stated otherwise.

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					25,084	25,027	(57)	25,084	25,027	(57)	299,728	299,118	(610)
Other Operating Revenue					1,224	1,247	22	1,224	1,247	22	14,508	14,906	398
Total Revenue					**26,308**	**26,274**	**(34)**	**26,308**	**26,274**	**(34)**	**314,236**	**314,024**	**(212)**
Employee expenses	5,376	5,436	60	1.1%	(25,448)	(25,998)	(551)	(25,448)	(25,998)	(551)	(302,334)	(315,296)	(12,963)
Operating expenses exc. Employee expenses					(1,480)	(690)	790	(1,480)	(690)	790	(13,557)	(13,251)	306
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	**5,376**	**5,436**	**60**	**1.1%**	**(26,927)**	**(26,688)**	**239**	**(26,927)**	**(26,688)**	**239**	**(315,891)**	**(328,548)**	**(12,657)**
Operating Surplus / (Deficit)	**5,376**	**5,436**	**60**	**1.1%**	**(619)**	**(415)**	**205**	**(619)**	**(415)**	**205**	**(1,655)**	**(14,524)**	**(12,869)**
Finance expense					(55)	(59)	(3)	(55)	(59)	(3)	(665)	(664)	1
PDC Paid					(362)	(362)	0	(362)	(362)	0	(4,343)	(4,343)	(0)
Finance income					151	244	93	151	244	93	1,645	2,719	1,074
Surplus / (Deficit) - Total	**5,376**	**5,436**	**60**	**1.1%**	**(885)**	**(591)**	**294**	**(885)**	**(591)**	**294**	**(5,018)**	**(16,811)**	**(11,794)**
Depn Peppercorn Leases (IFRS16)					11	8	(3)	11	8	(3)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB	**5,376**	**5,436**	**60**	**1.1%**	**(874)**	**(583)**	**291**	**(874)**	**(583)**	**291**	**(4,880)**	**(16,727)**	**(11,847)**

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.	(668)
Workforce - continuation of utilisation of less staffing than plan. Specialist and Support care groups	117
Non pay - IM & T equipment expenditure forecast later in the year	300
Non pay - utilities expenditure less than planned	80
Non pay - other support non pay underspends in month	133

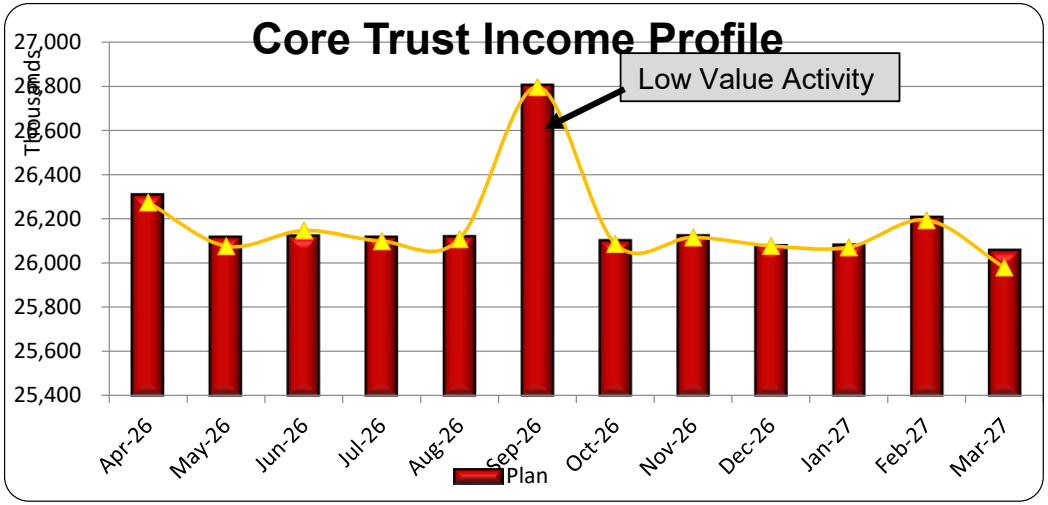


2.1 Income Information

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	23,541	23,524	(17)	23,541	23,524	(17)	281,998	281,785	(213)
Specialised Commissioning (NHS E)	728	727	(1)	728	727	(1)	7,112	7,296	184
Local Authorities	428	427	(1)	428	427	(1)	5,133	5,020	(113)
Partnerships	218	218	(0)	218	218	(0)	3,475	3,476	0
Other Healthcare income	115	78	(37)	115	78	(37)	1,382	947	(435)
Other non clinical income	1,277	1,300	23	1,277	1,300	23	15,136	15,501	365
Total - Trust core income	**26,308**	**26,274**	**(34)**	**26,308**	**26,274**	**(34)**	**314,236**	**314,024**	**(212)**
Provider Collaboratives	9,664	9,698	34	9,664	9,698	34	115,963	116,099	135
Budgets held centrally	79	73	(6)	79	73	(6)	955	808	(147)
Total - Consolidated income	**36,051**	**36,044**	**(6)**	**36,051**	**36,044**	**(6)**	**431,155**	**430,931**	**(224)**



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.

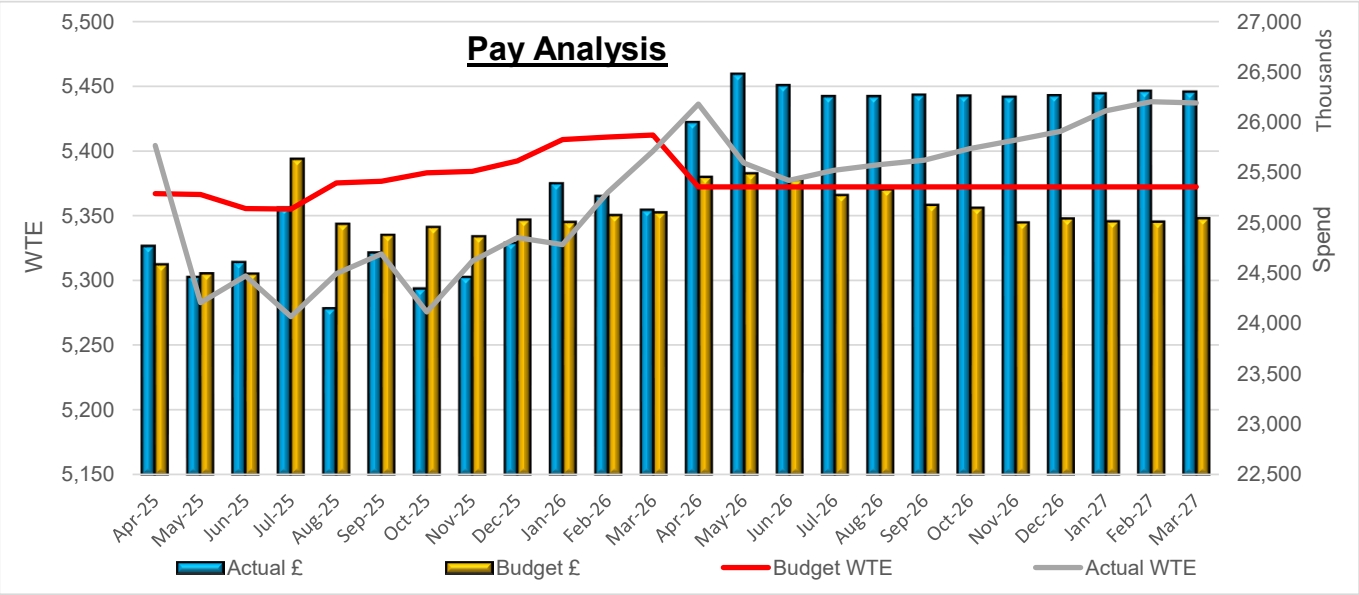
* Additional roles reimbursement	£380k
* Yorkshire Smokefree - prescribing & activity	£113k
* Any qualified provider activity	£110k
* Other income - additional salary sacrifice	(£477k)

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	4,952	23,860	23,860	5,050	292,947	(18)	665
Bank & locum	479	2,013	2,013	377	20,468	58	207
Agency	5	125	125	10	1,882	(4)	(2)
Total	**5,436**	**25,998**	**25,998**	**5,437**	**315,296**	**36**	**869**
Budget	**5,376**	**25,448**	**25,448**	**5,372**	**302,334**	**(40)**	**350**
Over / (Under)	**60**	**551**	**551**	**65**	**12,963**	**76**	**520**



The table to the left, and graph below, show the breakdown of Trust pay expenditure.

During 2025 / 26 expenditure, and worked WTE, were less than planned and this contributed to delivery of the Trust financial target. It was, however, highlghted that worked WTE and pay costs were increasing during the second half of the year.

This has continued into April 2026 with an overall increase in worked WTE. In conjunction with the budget reduction this means an overall 76 WTE movement.

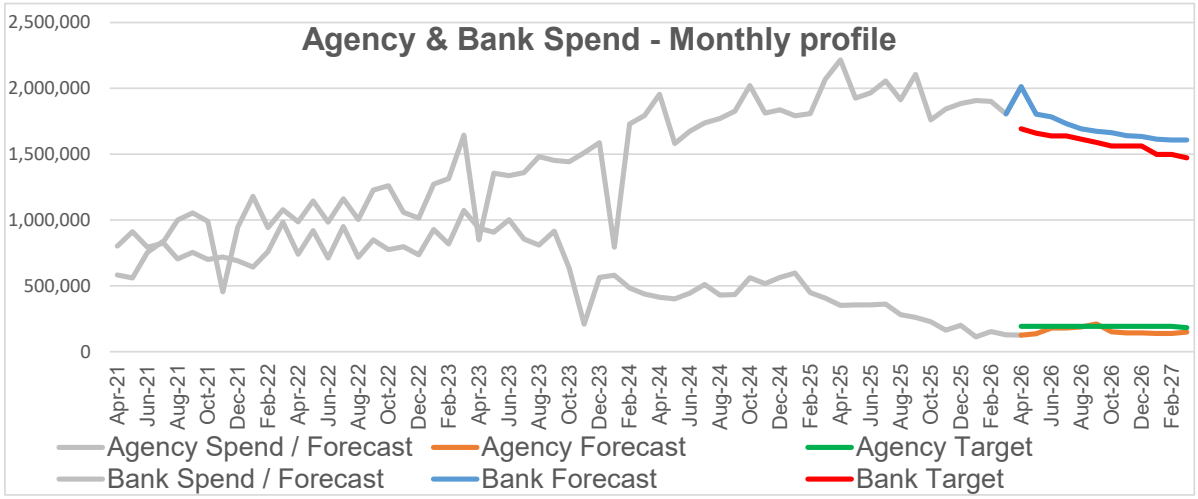
Pay expenditure, and budgets, have been increased for the pay awards. Agenda for Change has been paid from April 2026, medical staff is estimated in line with planning guidance until formally confirmed.

2.2 Temporary Staffing Focus

Trust spend in April 2026:
Agency £125k
Bank £2,013k

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	97	12	**109**
Other Medical	28	41	**69**
Reg Nursing	0	641	**641**
UnReg Nursing	0	1,221	**1,222**
Other Clinical	0	46	**46**
A & C	0	51	**51**
Other	0	0	**0**
Total	**125**	**2,013**	**2,138**
Lead Provider Collaborative		1	**1**
Budgets held centrally		0	**0**
Total	**125**	**2,014**	**2,140**

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. Maintained 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 focussed on medical staffing. Spend on others is £218 only and therefore does not show on the table above. Future pressures have been identified in this area especially relating to staffing retirements.

Bank spend has continued to fluctuate and has increased in April 2026. The currrent forecast trajectory has this reducing but remaining above the target requirement.

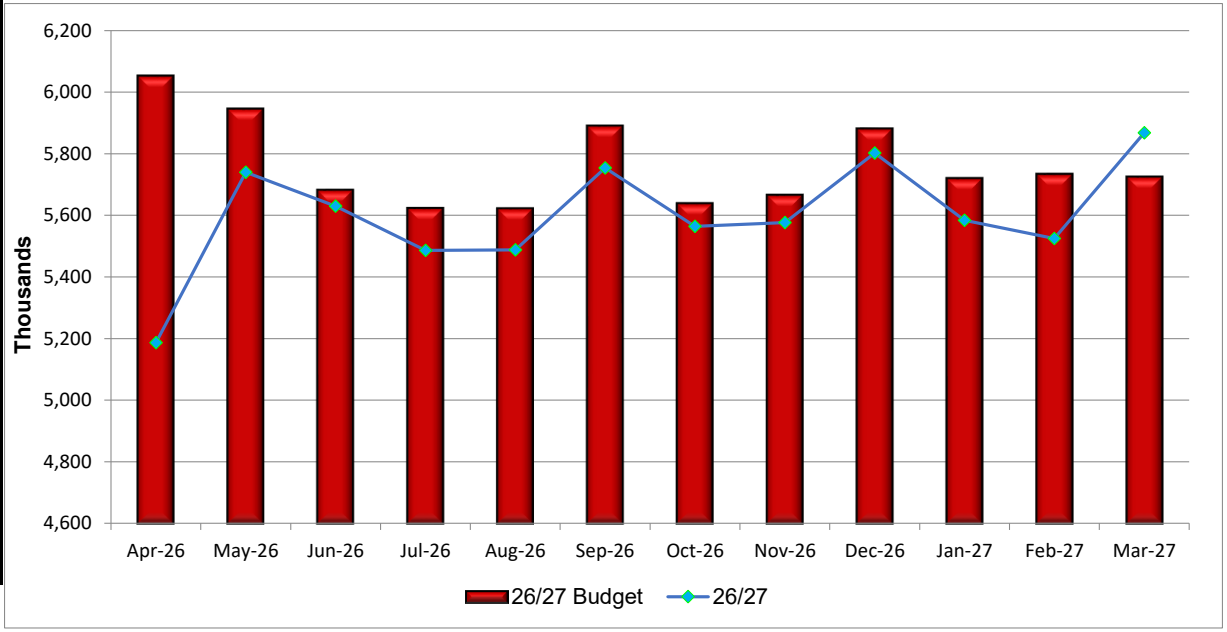
Action plans continue to be developed through the Trust temporary staffing group.

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, and excludes capital charges (depreciation and PDC) which are shown separately in the Trust Income and Expenditure position. To re-confirm that this also excludes expenditure relating to the provider collaboratives and budgets held centrally.

Non pay spend	Apr-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	5,740	5,630	5,486	5,488	5,754	5,564	5,577	5,803	5,584	5,525	5,868	**67,204**
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	385	354	(31)
Establishment	1,033	691	(342)
Lease & Property Rental	728	721	(7)
Premises (inc. rates)	497	436	(62)
Utilities	285	240	(45)
Purchase of Healthcare	655	487	(168)
Travel & vehicles	509	453	(56)
Supplies & Services	740	680	(59)
Training & Education	111	61	(50)
Clinical Negligence & Insurance	121	119	(2)
Capital Charges Depn, PDC,	860	789	(70)
Other non pay	129	155	26
Total	**6,051**	**5,186**	**(864)**
Total Excl OOA and Drugs	**5,011**	**4,345**	**(665)**



Key Messages

As highlighted within the overall financial position a key variance, supporting acheivement of a position that is better than plan, is the non pay underspend. As per the table above this has been reported in most categories with the largest as establishment (timing of IM & T expenditure) and purchase of healthcare (less out of area placements than planned).

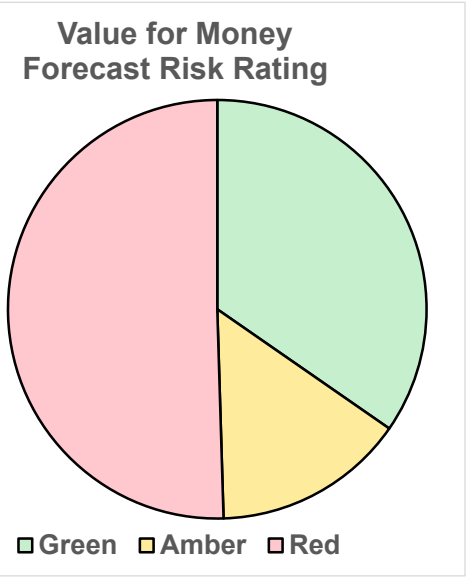
As shown in the graph this is forecast to increase in May although this, and actions being taken, will continue to be monitored as part of the Trust Value for Money programme.

3.0 Value for Money & Financial sustainability

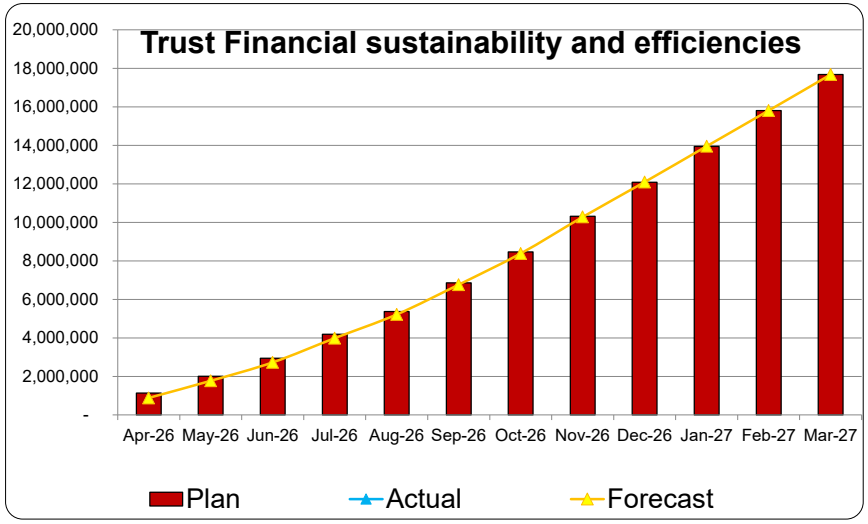
The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial 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	0		0	3,689	244	2,000	1,445	0
	Temporary Staffing	593	436		(157)	4,412	994		3,261	(157)
	Corporate Pay	166	166		(0)	1,991	1,991			0
	Productivity	0	0		0	1,400			1,400	0
	Difficult Decisions	50	2		(48)	2,138	155		1,935	(48)
Non Pay	Non Pay	8	8		0	248	100		194	46
	Drugs optimisation	18	32		14	220	32	202		14
	Digitial optimisation	3	18		15	35	216	32		213
	Out of Area placements	30	22		(8)	357	22	328		(7)
	Non pay - establishment	17	18		1	265	200	67		2
Other	Provider Collaboratives	180	180		0	2,160	2,160			0
	Bed Sales	0	0		0	0				0
	Income	64	0		(64)	760	10		688	(62)
	Misc income - overage	0	0		0	0				0
Total		**1,129**	**882**	**0**	**(247)**	**17,675**	**6,124**	**2,629**	**8,922**	**0**
Recurrent		1,066	882		(184)	16,925	6,124	2,629	8,234	62
Non Recurrent		63		0	(63)	750	0	0	688	(62)



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.

Temporary staffing has delivered significant reductions in comparison to April 2025. Whilst operational pressures exist, resulting in continued levels of bank and locum as covered elsewhere in this report, this is lower than previously experienced. This is forecast to continue as actions develop further and embed.

Non pay schemes are on track with some examples where targets have been exceeded such as drugs and digital optimisation schemes.

A level of risk, as highlighted by the RAG rating, exists but the Trust has a good track record of delivery. Actions are managed through the weekly Value for Money group.

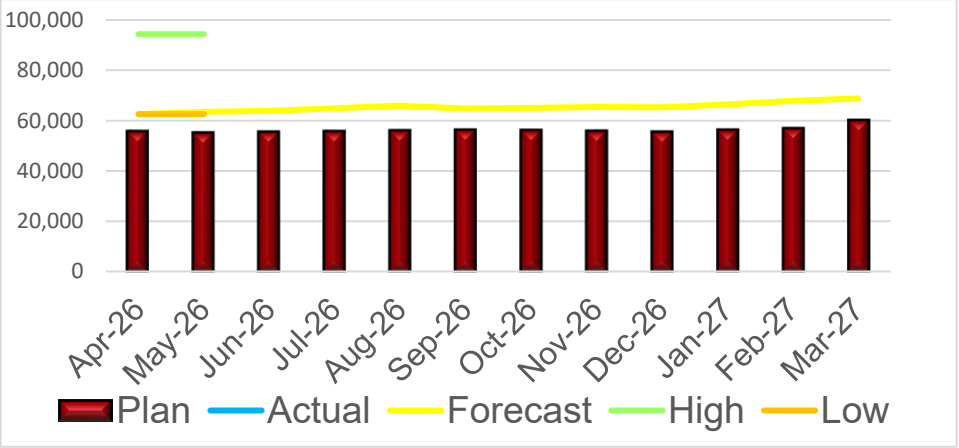
4.0 Statement of Financial Position (SOFP) 2026 / 27

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).

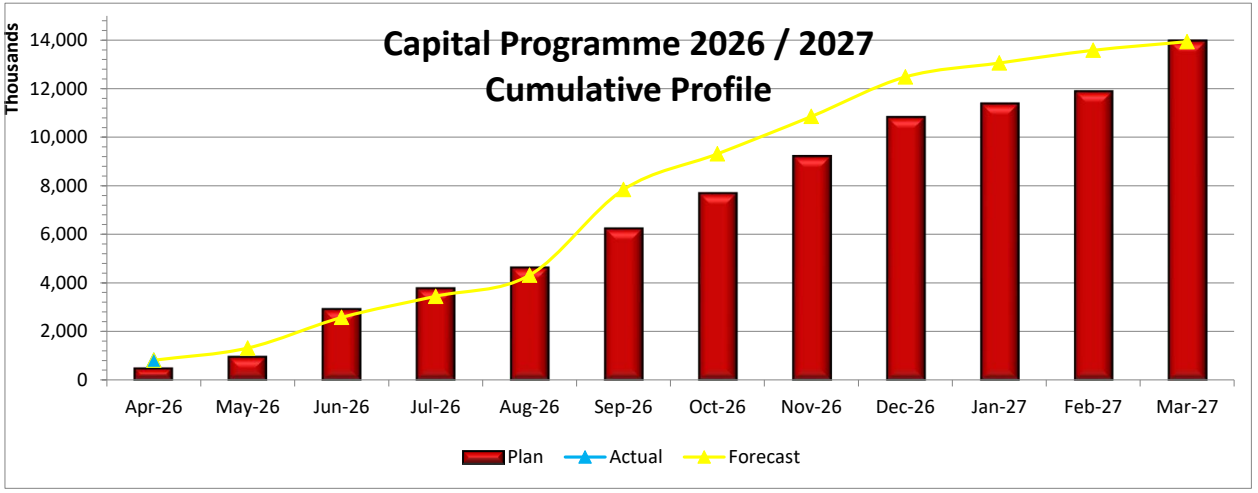
Balance Sheet / Statement of Financial Position (SOFP)	Current £k	Note
Assets		
Non-Current (Fixed) Assets	192,237	Pg 13
Inventories & Work in Progress	209	
Trade receivables (Debtors)	1,360	
Accrued Income	2,427	Pg 14
Prepayments	4,808	
Cash and Cash Equivalents	62,570	
Total Assets	**263,612**	
Liabilities		
Payables (Creditors)	(14,855)	
Accruals	(18,619)	
Deferred Income	(3,008)	Pg 14
Provisions	(3,325)	
IFRS 16 / leases liabilities	(47,832)	
Total Liabilities	**(87,640)**	
Total Net Assets/(Liabilities)	**175,972**	
Taxpayers' Equity		
Public Dividend Capital	(79,119)	
Revaluation Reserve	(12,067)	
Other Reserves	(5,220)	
Income & Expenditure Reserve	(79,565)	
Total Taxpayers' Equity	**(175,972)**	

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.



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	435	96	(339)	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	16	0	(16)	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	0	0	0	1,898	1,898
Other	0	(318)	(318)	0	(1,916)	(1,916)
Leases (IFRS 16)	0	1,032	1,032	3,011	3,029	18
TOTALS	**451**	**810**	**359**	**10,939**	**10,939**	**(0)**
Additional allocations						
Cheswold	20	0	(20)	3,000	3,000	0
			0			0
			0			0
TOTALS	**471**	**810**	**339**	**13,939**	**13,939**	**(0)**



Capital Expenditure 2026 / 27

The table on the 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

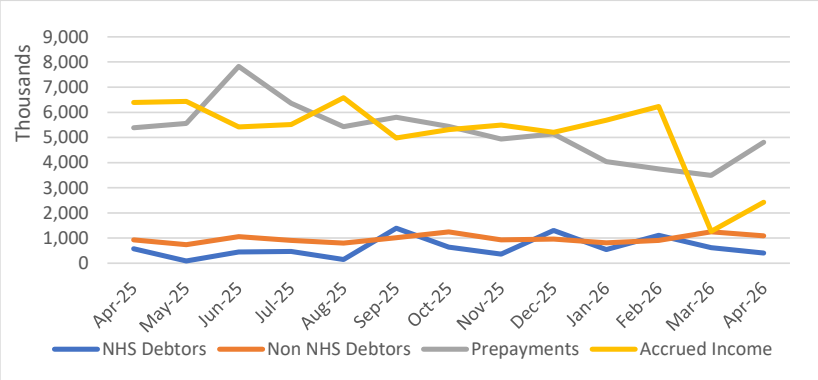
In April 2026 spend has been higher than plan due to the timing of leases (was expected, as per previous years, in June 2026). This has been offset partially by the credit, shown on the other line, for previous year VAT rebates.

The plan and forecast currently aligns with the February 2026 plan submission. As the detail, and financial values, of schemes are finalised this will be updated. This will need to include actions to mitigate the current negative value primarily arising from the net zero carbon scheme running into 2026 / 27.

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.

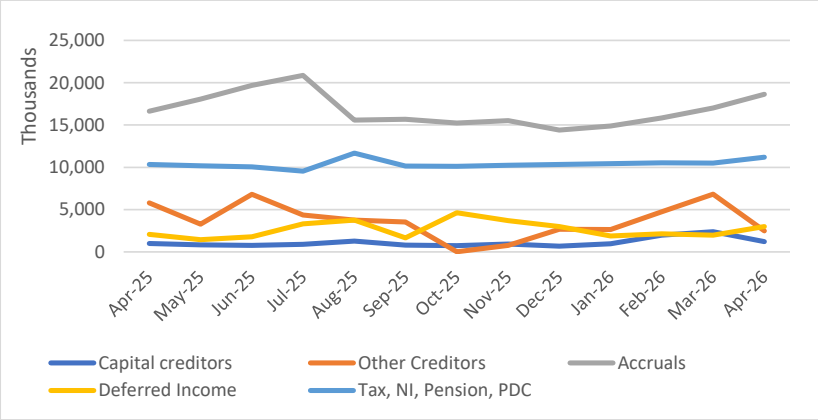
Debtors: A debtor is an indiviudal or company who owes money to the Trust for services provided. This directly impacts on cashflow. The action is minimise these balances as far as possible and ensure that debts are recovered in a timely manner. Both the value and age is shown below.



	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. Accrued income reduced, as normal, in March and has increased slightly in April. Prepayments have also increased in April, as normal ,with annual charges.

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	191	34	0	0	225
Non NHS	2,257	548	218	211	3,233
Total	**2,448**	**581**	**218**	**211**	**3,458**

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).

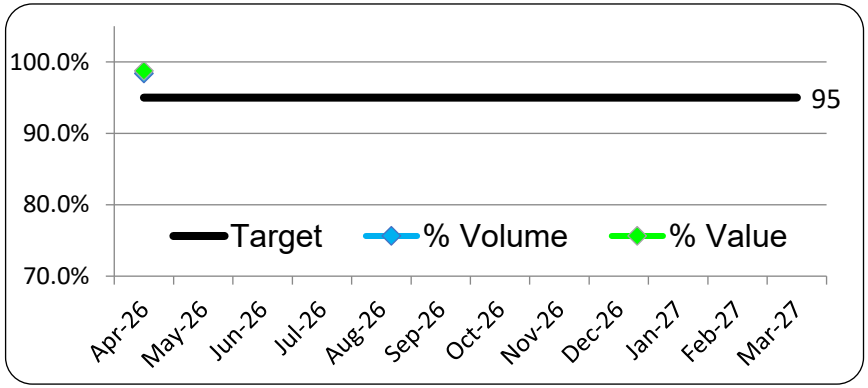
5.0 Better Payment Practice Code

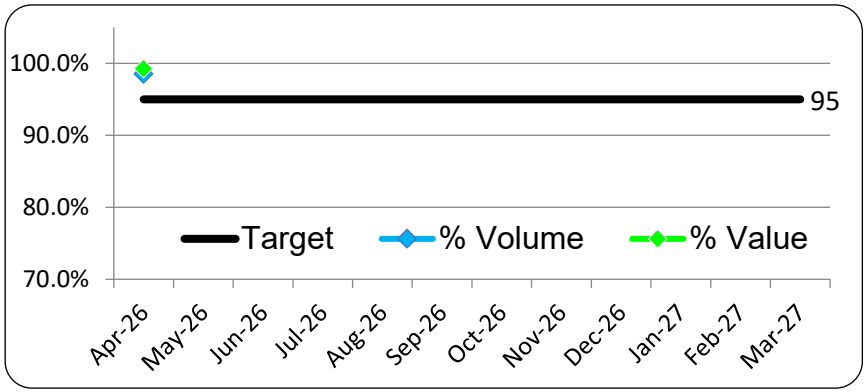
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently.

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

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





"

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 (£)
09-Apr-26	Computer Maintenance	Trustwide	Phoenix Partnership (Leeds) Ltd	17356	781,884
15-Apr-26	Vehicle Insurance	Trustwide	Willis Ltd	11738GP26000001PRM	720,076
14-Apr-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1006964	717,325
22-Apr-26	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	206792	663,103
01-Apr-26	Rates	Wakefield	Wakefield Council	8885115809532026	458,430
20-Apr-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS69	400,000
02-Apr-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011074	385,601
20-Apr-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS46	240,000
01-Apr-26	Rates	Barnsley	Barnsley Metropolitan Borough Council	5602653012026	226,625
15-Apr-26	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HONHSLS314	225,217
13-Apr-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS067INV	179,328
13-Apr-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS067SN	152,558
14-Apr-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34066772	130,229
01-Apr-26	Rates	Doncaster	City Of Doncaster Council	94005800652026	120,050
17-Apr-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34067509	120,000
14-Apr-26	IT Services	Trustwide	Wavenet Ltd	1514691	108,300
01-Apr-26	Rates	Kirklees	Kirklees Council	9691650732026	103,390
02-Apr-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011070	100,067
01-Apr-26	Mobile Phones	Trustwide	Vodafone Ltd	SQ05050	90,605
22-Apr-26	Staff Recharge	Barnsley	Barnsley Hospital Nhs Foundation Trust	6029608	89,717
09-Apr-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34066395	82,247
01-Apr-26	Purchase of Healthcare	Barnsley	Barnsley Metropolitan Borough Council	9000345181	79,959
16-Apr-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC047INV	78,727
14-Apr-26	Lease Cars	Trustwide	Athlon Mobility Services Uk Ltd	202680010461	78,438
29-Apr-26	Drugs	Trustwide	Bradford Teaching Hospitals Nhs Foundation Trust	332644	71,131
16-Apr-26	Drugs	Trustwide	Rowlands Pharmacy	1800005706	70,819
02-Apr-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1006914	69,872
14-Apr-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1006962	69,872
22-Apr-26	Staff Recharge	Trustwide	Sheffield Health & Social Care Nhs Foundation Trust	0000002304	69,229
07-Apr-26	Advocacy	Doncaster	Cloverleaf Advocacy 2000 Ltd	15744	62,603

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
14-Apr-26	Computer Maintenance	Kirklees	Limbic Ltd	INV0244	61,866
15-Apr-26	Computer Software	Barnsley	American Well Corporation Ireland Ltd	INV72482	60,814
17-Apr-26	Staff Recharge	Barnsley	Barnsley Hospital Nhs Foundation Trust	6029613	60,437
10-Apr-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34066430	50,556
08-Apr-26	Drugs	Trustwide	Nhs Business Services Authority	1000087592	48,949
20-Apr-26	Utilities	Trustwide	Edf Energy Customers Ltd	000027649006	45,851
13-Apr-26	Lease Cars	Trustwide	Arval Uk Ltd	R10014843144	43,015
28-Apr-26	Insurance	Trustwide	Willis Ltd	10958GP26000001PRM	42,463
01-Apr-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001536EPC	40,950
27-Apr-26	Training	Calderdale	Invictus Wellbeing Services Cic	597	39,500
10-Apr-26	Training	Trustwide	Leeds Beckett University	6100145	36,000
08-Apr-26	Subscription	Trustwide	Nhs Confederation	SIMB102278	34,161
14-Apr-26	Computer Software	Barnsley	Limbic Ltd	INV0243	33,816
27-Apr-26	Utilities	Trustwide	Totalenergies Gas & Power Ltd	41166443426	32,845
13-Apr-26	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	WKE0461034	31,465
01-Apr-26	Staff Recharge	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1006844	31,040
01-Apr-26	Staff Benefits	Trustwide	Reward Gateway Uk Ltd	ES000018	29,500
22-Apr-26	MFDs	Trustwide	Annodata Ltd	1438463	29,384
09-Apr-26	Drugs	Trustwide	Speeds Healthcare Ltd	INV171092	27,170
14-Apr-26	Staff Recharge	Trustwide	Calderdale Metropolitan Borough Council	IN26022689	26,967
29-Apr-26	Interpretation	Trustwide	Word360 Ltd	133150	25,279
07-Apr-26	Purchase of Healthcare	Forensics	Tees Esk & Wear Valleys Nhs Foundation Trust	4810029178	25,249

5.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

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

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

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

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

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

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

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

Appendix 2 - Statistical Process Control (SPC) Charts Explained

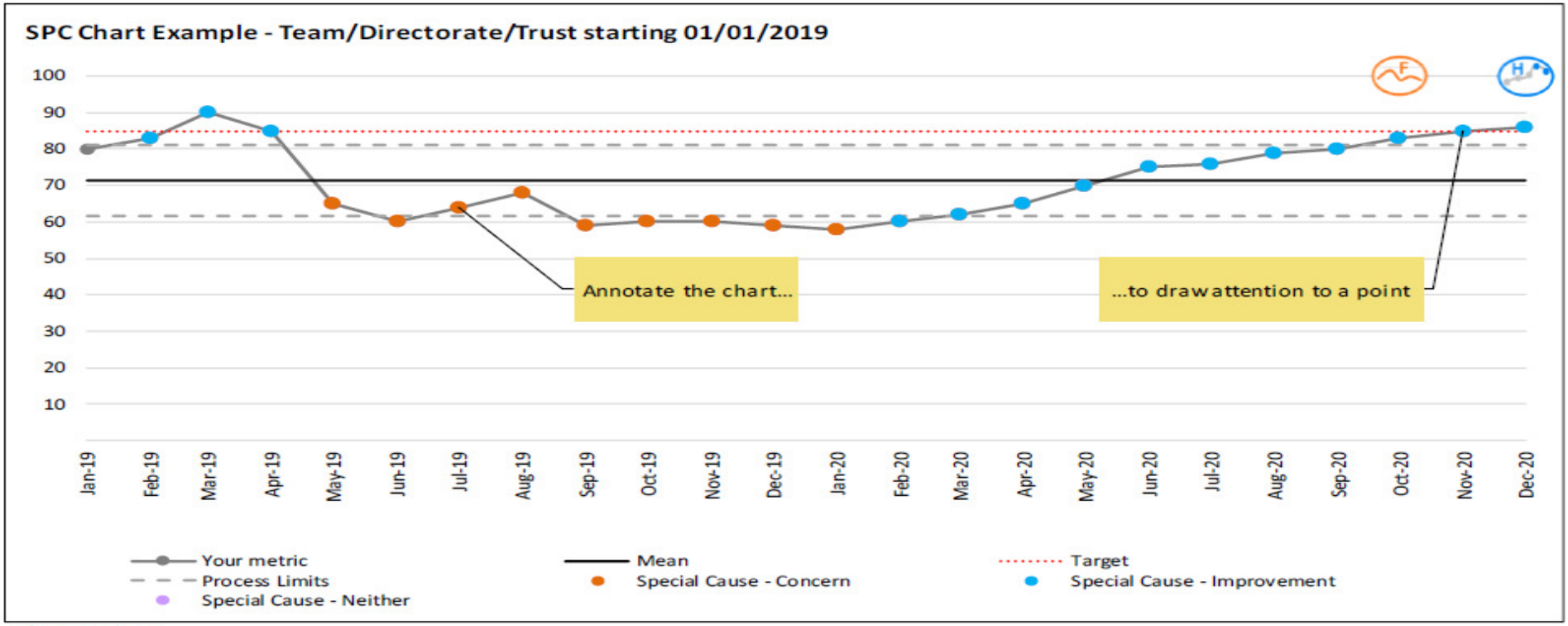
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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