NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

June 2026

With **all of us** in mind.

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

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Introduction

Welcome to the Trust's Integrated Performance Report (IPR) for June 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 metrics contained within the NHS oversight framework, operational planning guidance for 2026/27 and NHS standard contract items.

On 1st October 2024, the Trust acquired Cheswold Park Hospital, which is a 112-bed low and medium secure mental health hospital based in Doncaster, providing services to male and female patients with a diagnosis of mental illness, personality disorder or neurodevelopmental disorders. Cheswold Park provides services to patients from South Yorkshire Adult Secure Provider Collaborative and placements for patients who may be from out of the area and need the specific treatment pathways the hospital provides. Since this time, the Trust has been undertaking an integration programme to embed Cheswold Park Hospital Services into the Trust and reporting systems. This project was completed by the end of March 2026 and as a result, reporting for this service is now integrated in the main body of the report and in the Forensic Care group section.

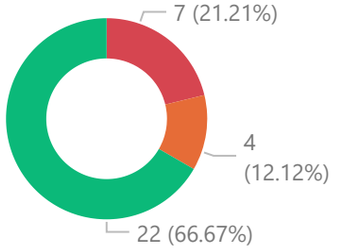
A review of the reducing inequalities section is to be undertaken over the next few months, this is linked to the Trust's equality, diversity and inclusion strategy it includes a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities. The strategy will guide us to being a more inclusive employer where everyone can be themselves and feel valued for their contribution. This reporting will align to the deployment of the Trusts Equality, diversity, and inclusion strategy.

Our Integrated Performance Report is publicly available on the internet.

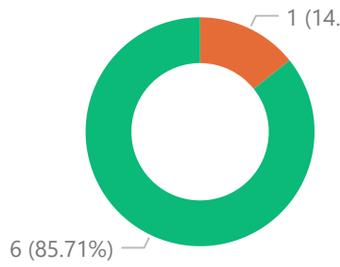
Headlines - Performance Rates Summary

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

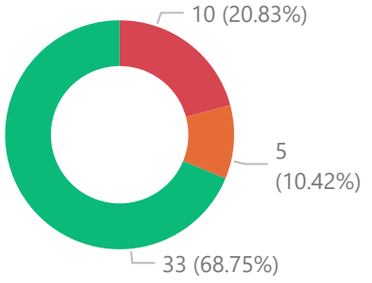
Quality & Safety Metrics Performance Rate



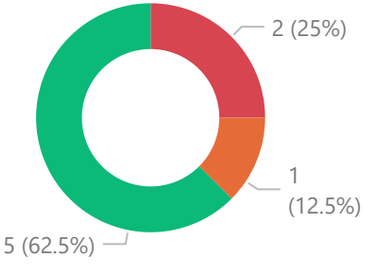
People Metrics Performance Rate



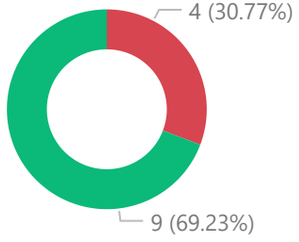
National Metrics Performance Rate



Finance Metrics Performance Rate

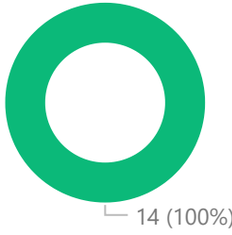


Barnsley Physical Health Metrics Performance Rate

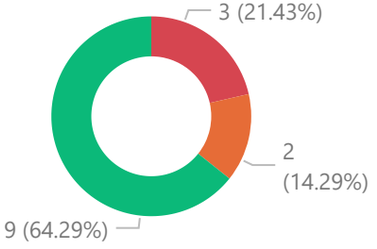


CAMHS Metrics Performance Rate

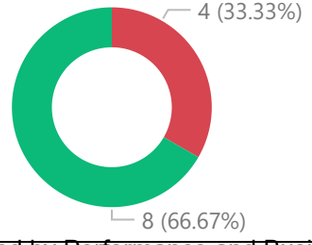
Mental Health Community Metrics Performance Rate



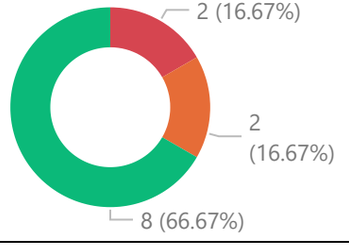
Mental Health Inpatient Metrics Performance Rate



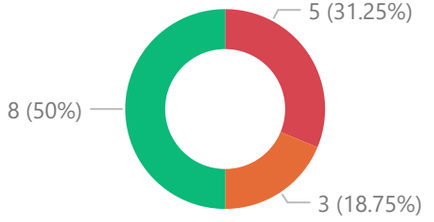
ASD/ADHD Metrics Performance Rate



Forensic SY Metrics Performance Rate



Forensic WY Metrics Performance Rate



Headlines

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

A hyperlink has been added to each section so the reader can look at the detail relating to the metrics in that section in the main body of the report as required.

Quality and Safety

Metric	Change from last month	Variation/ Assurance
Complaints - Number of responses provided within six months of the date a complaint received	↑	
% of inpatients clinically ready for discharge	↑	
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	↔	
Friends and Family Test - community	↓	
% of staff receiving supervision within policy guidance - Clinical	↓	
% of staff receiving supervision within policy guidance - Management	↓	
% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	↑	
% on community active caseload at month end with a care plan which has been reviewed within the last year	↑	
% inpatient risk assessment completed within 24hrs before or after admission	↓	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↑	
Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches	↓	

People

Metric	Change from last month	Variation/ Assurance
Sickness absence - Month	↓	

Finance

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

National metrics

Metric	Change from last month	Variation/ Assurance
The number of completed non-admitted Referral to Treatment (RTT) pathways	↔	
The number of incomplete Referral to Treatment (RTT) pathways	↑	
Total bed days of Children and Younger People aged under 18 in adult inpatient wards	↑	
Total number of Children and Younger People aged under 18 in adult inpatient wards	↑	
Inappropriate out of area bed days	↓	

Care Groups

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% of clients clinically ready for discharge	↑	
% Appraisal rate	↓	
% of staff receiving supervision within policy guidance - Clinical	↓	New Metric
% of staff receiving supervision within policy guidance - Management	↑	New Metric

Barnsley Physical Health and Wellbeing

Metrics	Change from last month	Variation/ Assurance
Sickness rate (Monthly)	↓	
% of staff receiving supervision within policy guidance - Clinical	↓	New Metric
% of staff receiving supervision within policy guidance - Management	↓	New Metric
% of feedback with staff values and behaviours as an issue	↓	

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% Bed occupancy (excl leave)	↓	
% inpatient risk assessment completed within 24hrs before or after admission	↓	
% of clients clinically ready for discharge	↑	
Sickness rate (monthly)	↓	
% of staff receiving supervision within policy guidance - Management	↑	New Metric

Forensic - West Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
Sickness rate (Monthly)	↑	
% Bed occupancy (incl leave)	↓	
Information Governance (IG) training compliance	↓	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	↑	
% of staff receiving supervision within policy guidance - Clinical	↑	New Metric
% of staff receiving supervision within policy guidance - Management	↑	New Metric
% with care plan that includes service user input/views	↑	New Metric
% inpatient risk assessment completed within 24hrs before or after admission	↑	

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↓	
% Bed occupancy	↑	
% of staff receiving supervision within policy guidance - Clinical	↓	New Metric
% of staff receiving supervision within policy guidance - Management	↓	New Metric

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
Information Governance training compliance	↑	

Children and Young Peoples Mental Health Services (CAMHS)

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

KEY

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

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

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

Quality & Safety

• **Performance for this section of the report shows 66.7% of the metrics are being fully achieved, this is only for metrics where we are measuring against a target or threshold.** This summary highlights some areas of improvement required and provides assurance regarding actions in place to ensure we maintain safety across our services for staff, patients and carers.

• The proportion of responses provided within six months of the date a complaint received remain consistently strong and was 92% in June.

• 19% of complaints were responded to within three months and focus is applied to those complaints not responded to within six months to identify areas for improvement.

• The total number of reported incidents in June was 1,454 which remains in line with normal range. All incidents continue to be subject to review by the patient safety team with relevant governance and learning within the care groups.

• The number of restraint incidents in June totalled 197 which is in line within normal range. The highest number of restraint incidents were on one of our adult mental health wards Nostell (30) - 80% of these incidents related to four individuals with complex needs and behaviours, there is a women's service review in progress to support better understanding of how to improve the women's services pathway. Crofton older people's mental health ward reported 20 incidents during the month which appears to be largely attributable to the presentation of one service user (11 incidents) alongside the challenges associated with a number of new admissions and heightened environmental pressures on the ward. All incidents are reviewed, and learning is shared.

• The Trust had 18 incidents involving race against staff on mental health wards during June taking place across 12 wards. We are very aware of the personal impact this has on our colleagues and are working with colleagues to identity further wellbeing offers to increase the support in addition to the existing personal and clinical support available to safeguard staff who experience racist abuse during their work.

• Our focus on reducing the use of prone restraint continues to shows on average a continued improvement, although there were six staff led prone restraints on our mental health wards during June. Five of these incidents related to the administration of intramuscular (IM) medication and were clinically led decisions made to manage risk safely and during the incidents. Alternative seclusion exit training is embedded in both four-day initial and two-day annual refresher RRPI training. There is a piece of work to support staff to administer IM medications in alternative routes which should prevent prone restraint requirements. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan.

• There were six information governance personal data breaches during June which remains at a lower level than historical averages.

• Sadly, there were three unexpected patient deaths during the month where the service users were known to the Trust's mental health services. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the families concerned in these tragic circumstances.

• There were 55 inpatient falls reported during June. 24 of these relate to service users aged 65 years and over. There were no red graded fall incidents reported this month. Across our older people mental health wards and stroke and neuro-rehabilitation wards, there were a total of 96 patients (61%) assessed as a high risk of falls. All fall incidents are reviewed regularly by the Trust's falls coordinator to ascertain any themes or actions required. Falls on inpatient wards per 1,000 bed days are notably lower than national averages.

• The Trust continues to work to improve the recording and collection of protected characteristics across all services to improve our service provision and experience of it. For the ethnicity indicator, the Trust is achieving 95.2%% against a target of 90%. Disability recording was at 57%, sexual orientation 56.7% and postcode at 99.6%. Work continues to ensure data capture across all services to support how we can improve our service offer.

• For risk assessments and care plans, the Trust's aim is to work towards achievement of 95% against each of these standards. The metrics show an increase in performance compared to last year, however work continues to meet the95% target across all five metrics in all areas – detail can be seen in the main body of the IPR. All risk assessments and care plans that have not been completed within the timescale have oversight and scrutiny from the Care Groups.

• Forensic risk assessments are completed prior to admission as part of the admission assessment and planning process. In line with good clinical practice these are then reviewed at the point of admission to ensure they are still clinically accurate.

• All services are focusing on continuing to improve performance for and the quality of risk assessments. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed and communicated to the service user and ward staff. Development work is occurring across all teams to ensure they update the risk assessment to ensure emerging risks are supported and mitigated.

• There were 11 sexual safety incidents against staff by patients and 6 sexual safety incidents by patients against patient in June. The most common theme for these incidents was inappropriate sexual behaviour. We are very aware of the personal impact this has on our colleagues and service users. In the event of an incident, a sexual safety panel is convened which includes individuals who have undertaken specialist training.

• The Trust has recently reviewed its supervision policy and from April 2026 moved to a new method of reporting splitting out management and clinical supervision and reporting against a 60-day standard and also widening the scope to include all clinical staff not just registered staff as previous. Targeted work is taking place to ensure the trajectory remains positive.

• Our bank fill rate for registered nurses has reduced to 81% in June due to various reasons such as an increase in sickness, higher acuity and availability for cover, however, redeployment across wards on a daily basis has occurred to ensure skill mix is safe.

Quality and Safety Continued...

Health Inequalities

The purpose of the health inequalities section of the IPR is to provide visibility of identified inequalities, supporting a shared understanding of where inequities exist and informing targeted action through our quality improvement approach.

We have undertaken a further review of the health inequalities section of the IPR and developed a revised draft for consideration as a separate document. The revisions ensure that, for 2026/27, this work is aligned to the 'Access and Waits' improvement area of focus, with measures centred on the review of:

• Ethnicity
• Socioeconomic deprivation

For the data included in this months report, key points to note include:

• Our review of inpatient length of stay (LoS) data highlights important patterns. 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. 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.

People

• **Performance for this section of the report shows 85.7% of the metrics are being fully achieved, this is only for metrics where we are measuring against a target or threshold.** Key points to note from this section of the report are as follows.
• The performance rates summary (page 5 of the IPR), shows 85.8% of the metrics are being fully achieved with 14.2% showing areas of improvement (1 metric). Key points to note from this section of the report are as follows.
• Our in-month sickness absence rate for June is 5.3% which is above our target of 5%. Our long-term and short-term sickness are both higher than the same period last year. Absences related to gastrointestinal illness and anxiety/stress increased during June 2026. Care group sickness absence levels can be seen in the care group section of the report. There are also some higher levels of absence across support services (estates and facilities, people directorate, nursing qualities and professions directorate). There is a focussed piece of work with the people directorate to support people to remain in or return to work.
• In June 2026, appraisal compliance was 93.5%, achieving the Trust's KPI target. This figure includes a number of employees who are currently transitioning to the new appraisal window system.
A new dashboard has been introduced to support the implementation of this process, and all appraisals are expected to be completed by the end of September 2026. There is a plan across all services to ensure appraisals are completed within the specified window and a weekly focus for care groups at Operational Management Group.
• Our statutory and mandatory training compliance remains above the Trust target at 95% (target greater than or equal to 80%). This represents strong commitment from all parts of the Trust.

National Metrics

• **Performance for this section of the report shows 68.7% of the metrics are being fully achieved, this is only for metrics where we are measuring against a target or threshold.** The following should be noted:
• 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, 93 out of 96 children (96.9%) received a diagnostic appointment within 6 weeks, this is now significantly above the revised national threshold. The demand in referrals consistently outweighs commissioned activity levels. Our quality improvement plan has clearly achieved a sustained improvement; this is fragile due to the small resource (2 whole time equivalent staff) within the team.
• Children & Younger People with an eating disorder – three routine referrals were not seen within the four-week national target, two of those were due to families declining an appointment within timescale and choosing a later appointment and one breach in Barnsley was linked to clinical capacity within the team.
• The Trust had one admission for a service user under 18 years of age to an adult ward which was due to lack of nationally available beds. The Trust has robust governance arrangements in place to safeguard young people when these situations arise.
• The Trust has set itself a target to reduce adult acute and psychiatric intensive care lengths of stay by 10% by the end of March 2027. Longer lengths of stay for people discharged in June in our West Yorkshire wards have impacted the monthly average for the Trust and we have exceeded slightly our forecast position. We have also exceeded our forecast for older people lengths of stay (90.2 days against a forecast of 79 days). Reported performance is affected by discharges of patients with particularly long lengths of stay, this is associated with the availability of external placements, particularly for older people and specialist mental health support. There are robust escalation processes in place to expedite those clinically ready for discharge.

Care Groups

• Child and adolescent mental health services (CAMHS) continue to prioritise children with high levels of need and if a child's/young person'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 June, 90.5% had been waiting for a period of 18 weeks or less which represents a sustained improvement. All of these cases have had some form of screening, consultation, or initial assessment before being placed on a treatment waiting list. This service is experiencing an increase in demand, particularly in Kirklees.
• Children's neurodevelopmental waits remain a significant issue given the exponential growth in demand in recent years, which has been further compounded by vacancies in the team. Neuro-development waits are part of a specific pathway review across places in line with commissioned models. There is an offer in place to support children and families whilst waiting.
• Improvement work on waiting list times in community learning disability services has led to a sustained improvement against the 18 weeks standard for patients having a completed assessment, care package and commenced service delivery within 18 weeks. Performance in June continued to exceed the local threshold reporting 95.6%.
• The number of out of area bed placements remains amongst the lowest nationally. At the end of June, the Trust had six service users placed in an inappropriate out of area bed with 137 bed days used over the month, which is an increase on recent months given particularly high demand which resulted in OPEL 4 status being declared. There is significant ongoing focus on patient flow and bed management to minimise out of area bed placements. 3 of the 6 have now either been discharged or returned to the Trust.
• Focus on patients clinically ready for discharge continues to take place across all services. At the end of June, 23 people were clinically ready for discharge but remained in a bed, accounting for a total of 674 bed days over the month. The main challenges to discharge continue to be specialist placements and housing and we are continually in dialogue with partners to identify solutions.
• Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels significantly higher than commissioned – cases, where agreed with commissioners, are triaged and prioritised according to need.
• The commissioned level for ADHD pathways in Barnsley, Wakefield and Kirklees is approximately 29 cases across all three areas per month. The average number of referrals for ADHD received for these areas in the last three months was 291. 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.
• Mental health bed occupancy (excluding leave) increased to 91.5% There are individual wards which have a much higher occupancy and increasing acuity of patients places further challenge on colleagues. The acuity of patients remains a challenge. Particularly with risk to self and others, therefore, requires enhanced observations to keep people safe, which has an impact on staffing and finance.
• 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 and bank staffing remains higher than plan. Agency spend has continued to be maintained at an overall low level (£138k in June). The use of agency staff largely relates to very limited number of medical staff although some pressures are expected in the coming weeks due to pending staff retirements. Use of bank staff continues to be scrutinised, and we are planning to recruit an increasing number of substantive health support workers over the course of the year.
• Single point of access (SPA) prioritises risk screening of all referrals to ensure any urgent demand is met within 24 hours. In June, the access standard for assessed within 14 days of referral has been met in all localities despite demand and staffing challenges. There have been challenges with vacancies in Calderdale & Kirklees SPA and an increased demand for urgent assessments. The service has implemented business continuity plans, with a focus on diverting increased resource towards triage.

Finance

• **Performance for this section of the report shows 62.5% of the metrics are being fully achieved, this is only for metrics where we are measuring against a target or threshold.**
• The financial performance in June 2026 is a deficit of £526k which is £120k adverse to plan in month. The year-to-date position remains in line with plan but the run rate needs to improve as the year progresses to achieve our break-even target. Although Trust actions are forecast to achieve a £5.0m reduction in bank staff the current run rate is to exceed that. For the year to date spend is £0.4m (14.1%) higher than plan.
• The Trust value for money programme is reported as ahead of plan at month 3. The largest contributors are the reduction in corporate costs and the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025 / 26. The trajectory includes the identification, and delivery, of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of breakeven is maintained.
• The current cash position remains positive.
• The capital programme is now behind plan due to the Older People's Inpatient scheme which continues to be developed. The forecast remains in line with allocation, including a new allocation for community hubs.

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Best Quality	Responsive	TBC	73.8%	76.1%	86.2%	85.7%	87.9%	90.5%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	Best Quality	Caring	< 20%	14% (6/43)	22% (6/27)	9% (3/33)	10% (3/30)	0% (0/33)	8% (3/38)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	101.6	109.8	134.8	101.3	119.7	131.3	N/A
	Complaints - Number of responses provided within six months of the date a complaint received [16]	Best Quality	Well led	100%	94% (15/16)	94% (16/17)	83% (19/23)	100% (14/14)	91% (10/11)	92% (24/26)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	91%	91%	92%	86%	93%	87%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	96%	99%	96%	91%	96%	94%	1
	Number of compliments received	Best Quality	Caring	N/A	25	60	41	40	33	55	N/A
Quality	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Best Quality	Safe	Trend monitor	3	2	6	2	2	5	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Best Quality	Safe	Trend monitor	0	0	1	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	1	1
	Number of Information Governance breaches [3]	Best Quality	Well led	<12	10	12	12	12	5	6	2
	% of inpatients clinically ready for discharge *	Person first and in the centre	Responsive	3.5%	5.3%	5.4%	5.4%	6.1%	4.8%	4.3%	3
	Total number of reported incidents	Best Quality	Safe	Trend monitor	1490	1332	1416	1448	1379	1454	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	34	39	41	33	30	38	
	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	0	0	1	0	0	3	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	0	1	4	2	1	3	
	Safer staff fill rates	Best Quality	Safe	90%	116.3%	113.8%	112.3%	114.0%	115.1%	115.0%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	100.2%	100.6%	98.3%	99.7%	98.6%	99.5%	1
	% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	84.8%	85.1%	85.0%	90.5%	86.7%	81.0%	
	% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	86.0%	91.1%	90.6%	95.3%	93.0%	93.0%	
	Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	87.2%	90.4%	90.1%	94.3%	91.7%	86.4%	
	Number of pressure ulcers which developed under SWYPFT care [1]	Best Quality	Safe	Trend monitor	68	47	62	55	57	51	
	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	59	45	61	53	65	55	
	Number of restraint incidents	Best Quality	Safe	Trend monitor	175	200	194	185	152	197	
	% of staff receiving supervision within policy guidance [15]	Best place to work and learn	Well led	80%	87.9%	90.3%	92.1%	N/A	N/A	N/A	1
	% of staff receiving supervision within policy guidance [15] - Clinical			80%	Reporting commenced April 26			74.7%	78.4%	77.3%	
	% of staff receiving supervision within policy guidance [15] - Management			80%	Reporting commenced April 26			64.6%	69.2%	69.0%	
	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%	97.4%	84.6%	87.1%	93.5%	100%	100%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	14	8	13	10	18	21	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%	68.8%			Due September 26			
	Number of incidents against staff on mental health wards involving race	Best place to work and learn	Safe	Trend Monitor	24	28	29	34	27	18	N/A
	Number of sexual safety incidents by patients against patients	Best Quality	Safe	Trend Monitor	Reporting commenced April 26			6	5	6	
	Number of sexual safety incidents against staff (patient on staff)	Best place to work and learn	Safe	Trend Monitor				16	8	11	
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0	7			7			
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	97.9%	95.6%	96.9%	99.0%	95.9%	99.4%	
	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%	*87.1%**	96.0%	

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Year End Forecast*
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	96.3%	96.4%	96.5%	96.5%	96.1%	95.2%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	59.7%	59.5%	59.1%	58.7%	58.0%	57.0%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	60.1%	59.8%	59.1%	58.7%	57.6%	56.7%	
	Percentage of service users who have had their equality data recorded - deprivation (postcode)	Best Quality	Responsive	90%	99.4%	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%	100% Service 100% Policy	98.4% Service 100% Policy	99.4% Service 100% Policy	95.2% Service 100% Policy	92.7% Service 100% Policy	92.7% Service 100% Policy	
	% on community active caseload at month end with a care plan which has been reviewed within the last year	Person first and in the centre	Caring	25/26 Interim trajectory: 75-80% April 26: 95%	91.1%	94.1%	92.6%	93.9%	94.3%	94.9%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring		94.5%	96.9%	96.5%	97.1%	96.7%	96.2%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring		97.8%	96.3%	96.8%	97.4%	96.7%	95.6%	
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe		90.5%	89.7%	86.0%	91.4%	92.0%	89.3%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe		93.9%	92.5%	94.1%	93.9%	93.8%	94.0%	
	Number of prone restraint incidents during the month - (where we have purposefully placed the person in the prone position)	Best Quality	Safe	Dec & Jan - 4, Feb & Mar - 2, 26/27 stretch target to reduce to zero	3	1	5	3	2	6	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor	187	97	98	73	144	54	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor	9,726	10,035	9,960	12,000	11,968	13,289	N/A
	Medical Devices compliance rate	Best Quality	Safe	Trend Monitor	Reporting commenced April 26			75%	75%	82%	
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Person first and in the centre	Safe	6	0	0	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 September 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 - June saw a further 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 four 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 26 complaints responded to during the month, 24 these were undertaken within six months of the complaints being received, and the average number of working days these complaints were open was 131.3 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.
• Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches - One breach was reported in Cheswold Park in June. A verbal apology was given to the service user within the 2 days after the incident, however, the letter wasn't completed until 2 days after the 10-day period. Learning has been identified following the after action review process.
• There were six information governance personal data breaches during June. 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 June, 23 people were clinically ready for discharge but remained in a bed. Delays are spread across all our places and services.
• The trust has recently reviewed its supervision policy and as a result from 1st April, has moved to a new method of reporting splitting out management and clinical supervision and reporting against a 60 day standard and also widened the scope to include all staff not just registered staff as previous. This now shows some under performance against the 80% standard and targeted work is taking place in care groups to address and ensure staff are fully supported.

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Year End Forecast*

• The total number of reported incidents in June increased compared to the previous month. A breakdown of this data can be seen in the care group dashboards. All incidents continue to be subject to review by the patient safety team with relevant governance within the care groups.
• Sadly, there were three patient safety related deaths during the month where the service user was known to the Trust's mental health services. These incidents are subject to review and any learning will be identified. Condolences and support have been offered to the family concerned in these tragic circumstances.
• The Trust had 18 incidents against staff on mental health wards involving race during June. Five incidents in Forensics Care Group across four wards/teams; nine incidents in MH inpatients across six wards/teams - ward 18 had the highest number (4); four incidents in Cheswold Park Hospital across two wards/teams. 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 six incidents of sexual safety incidents against patients in June. The most common themes for these incidents were inappropriate sexual behaviour and alleged sexual assault. 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 11 incidents of sexual safety incidents against staff (by patients) in June. The most common themes for these incidents were inappropriate sexual behaviour and sexual harassment. We are very aware of the personal impact this has on our colleagues. We are working closely with colleagues from the People Directorate to identify further wellbeing offers and strengthen support.
• Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations) - There were seven incidents in June, six of these were due to violence and aggression and one was due to manual handling. In each violence and aggression case, staff have been supported through their recuperation and follow ups made with occupational health and welcome back meetings with the Department Managers if they have returned.
• The percentage of ligature jobs completed within timeframe remained under threshold this month, this related to 2 jobs out of 50, these have now been completed.
• The number of restraint incidents increased this month from 152 reported in May to 197. The highest number of incidents were on Nostell (30), with 24 of these incidents relating to four complex service users. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain within expected range – all incidents are reviewed, and learning is shared.
• There were 55 inpatient falls reported during June 2026, this is a decrease from last month. Further detail can be seen in the falls section of the report.
• Our focus on reducing the use of prone restraint has shown significant improvement over the last few months, however there has been an increase in incidents in June with six staff led prone restraints on our mental health wards. Five incidents related to the administration of intramuscular (IM) medication and were clinically led decisions made to manage risk safely and during the incidents. The service user's physical health was monitored throughout, no concerns were identified, and all positions were maintained for the shortest duration necessary to ensure safety and dignity.
Alternative seclusion exit training is embedded in both four-day initial and two-day annual refresher RRPI training. Where required, the RRPI trainers attend the wards to offer support for individual cases that may require a bespoke care plan.
• 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 and ward level sections 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 Headlines Cont…

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.

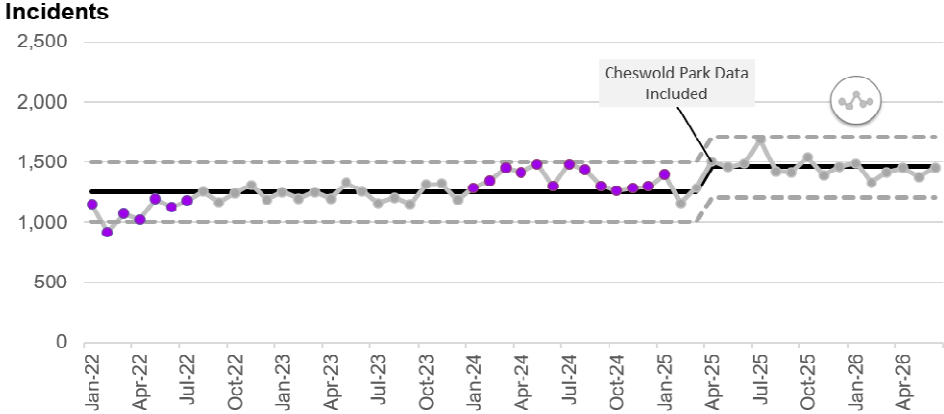
15 - % of Band 4 and above clinical staff who have received supervision in the previous 90 days.

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

* - figure may be refreshed in following month due to a potential duplication issue.

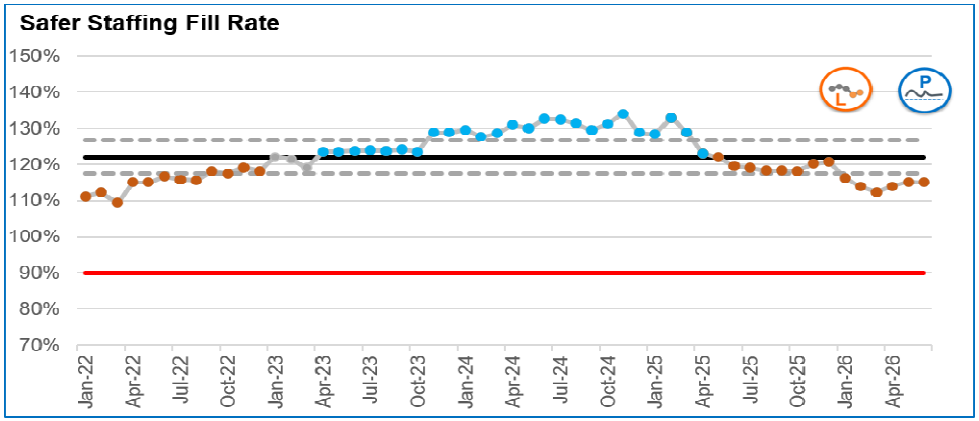
Statistical process control charts

Incidents

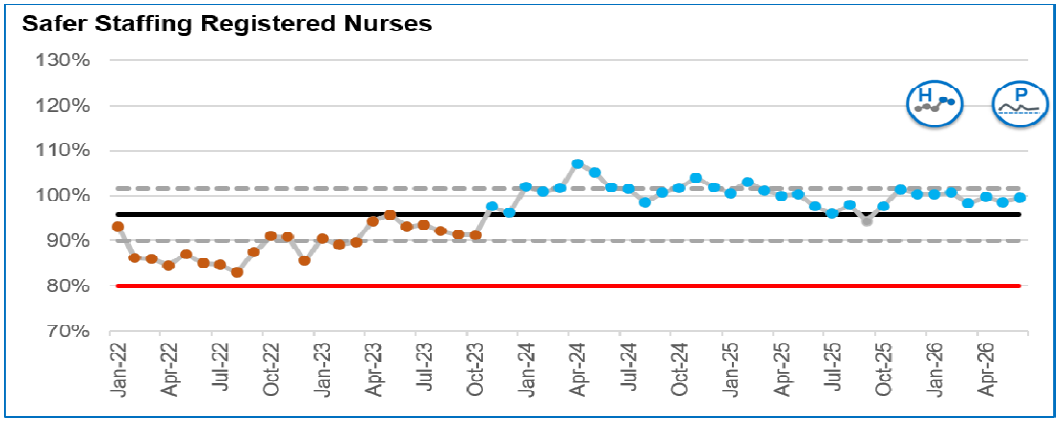


We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data. The chart shows that we are in a period of common cause variation (no concern).
It should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting 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



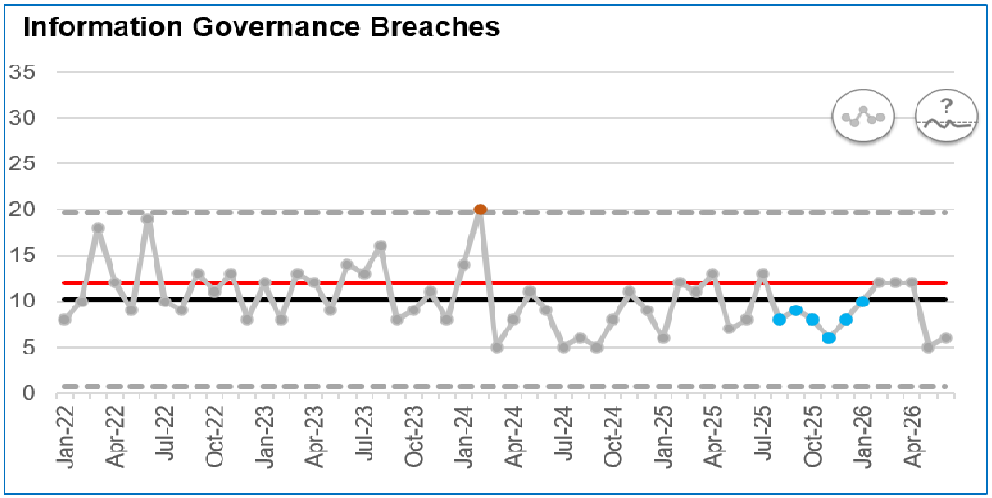
The chart above shows that in June 2026 we remain in a period of special cause concerning variation (something is happening and should be investigated). There has been an increase in demand which means more shifts are being requested, there has been a smaller increase in the number of shifts being filled 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 June 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.

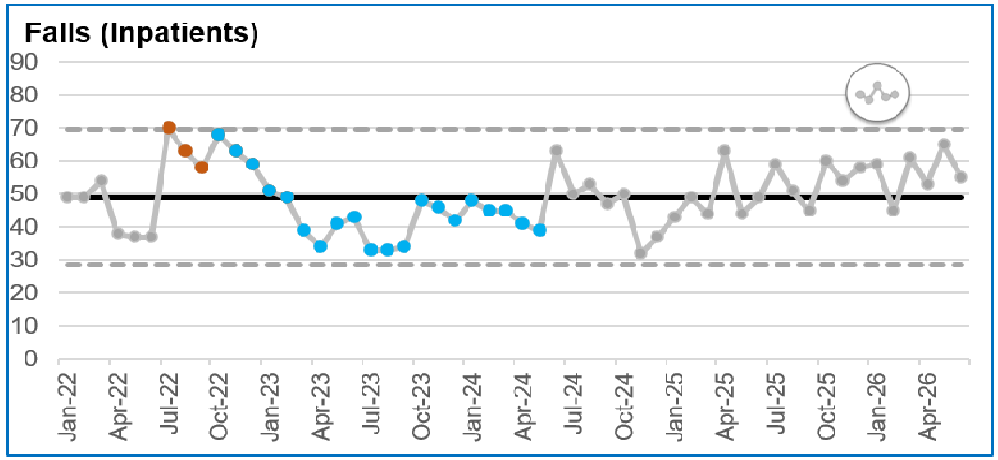
Statistical process control charts

Information Governance (IG)



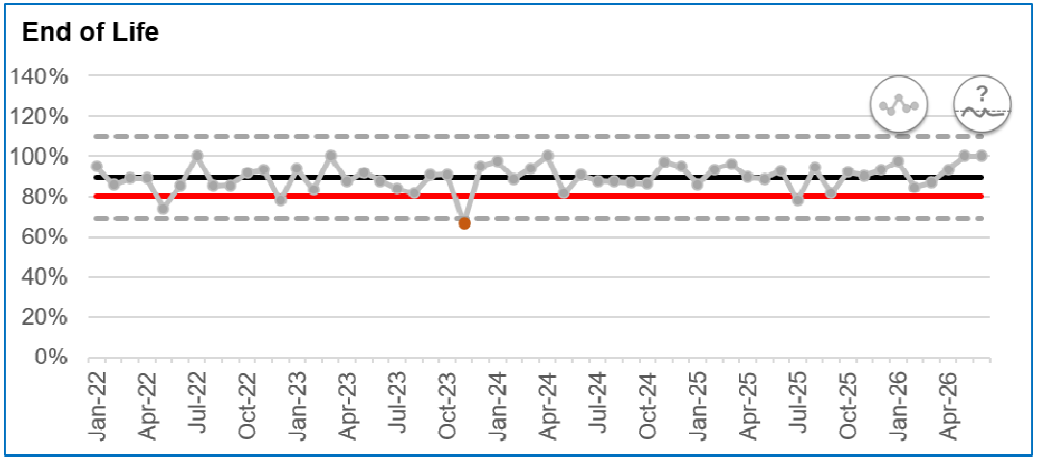
This SPC chart shows that as at June 2026 we have remain in a period of common cause variation (no concern).

Falls (Inpatient)



The SPC chart above shows that in June 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

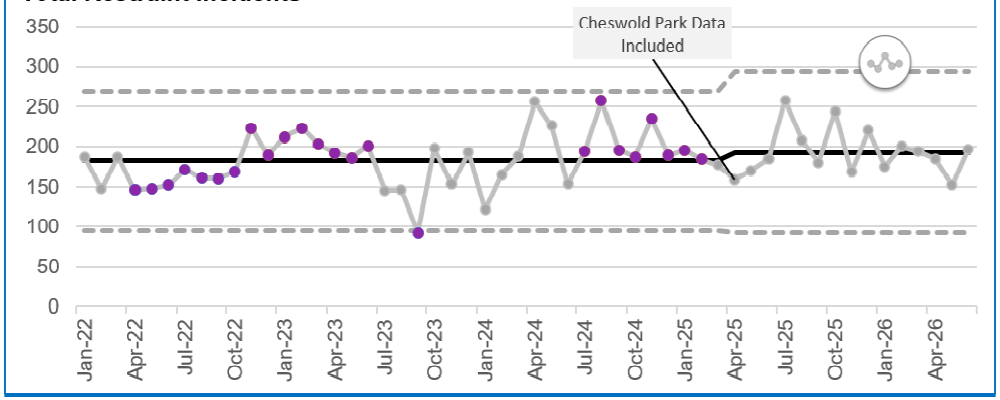


The chart above shows that in June 2026 the performance against this metric remains in common cause variation (no concern). The performance for the month remains above the target.

Statistical process control charts

Restraints

Total Restraint Incidents

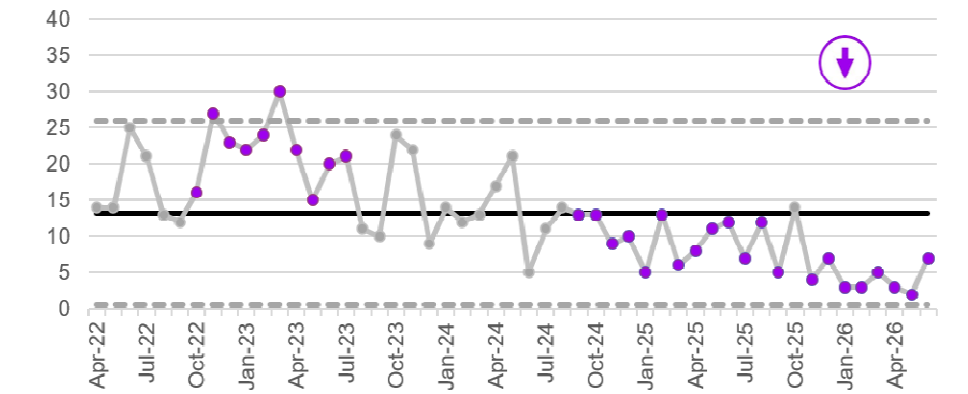


This SPC chart shows that in June 2026 we remain in a period of common cause variation (no concern).

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.

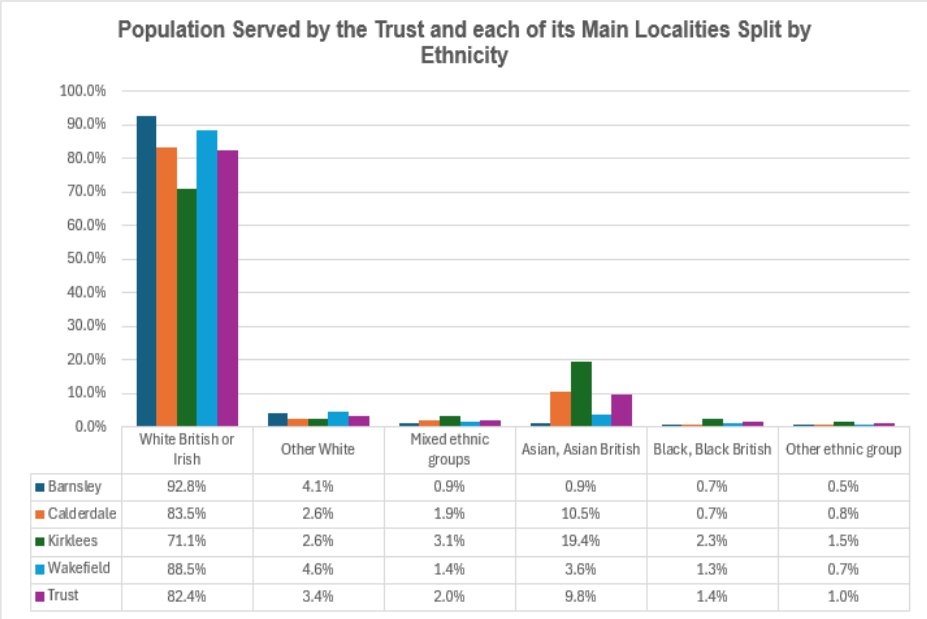
Prone Restraint (Total Number)



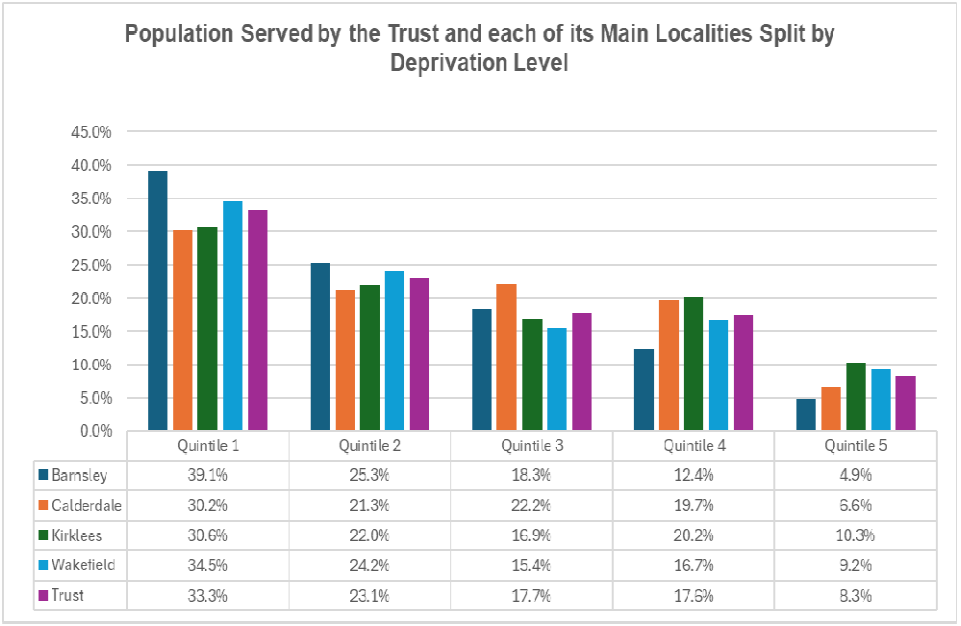
The total number of prone restraints continues to show a decreasing special cause variation in line with the continued work to reduce prone restraints. Six of the seven prone restraints in June 2026 were staff led.

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.



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

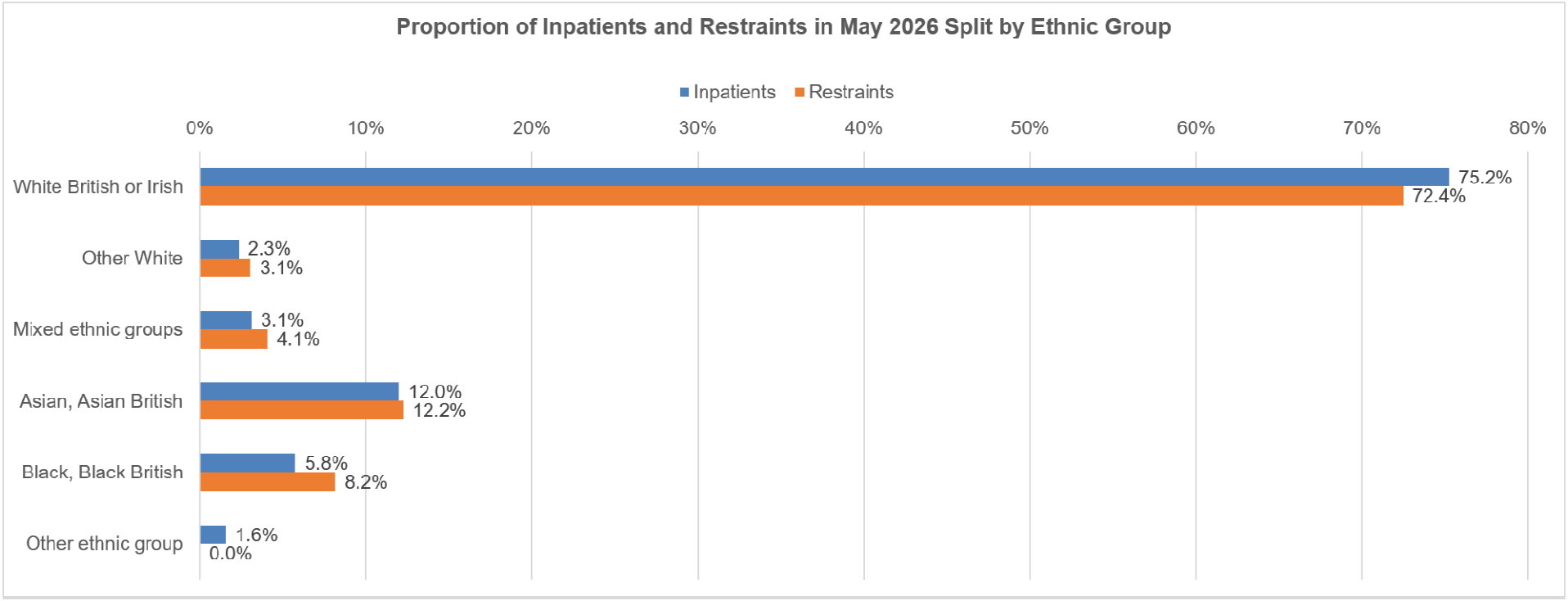


	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Barnsley	39.1%	25.3%	18.3%	12.4%	4.9%
Calderdale	30.2%	21.3%	22.2%	19.7%	6.6%
Kirklees	30.6%	22.0%	16.9%	20.2%	10.3%
Wakefield	34.5%	24.2%	15.4%	16.7%	9.2%
Trust	33.3%	23.1%	17.7%	17.6%	8.3%

The data on this page will not be refreshed except when population estimate data is published. However this page helps to provide important context about the varied population our Trust serves in terms of ethnic make-up and levels of deprivation. We can measure the relative deprivation of an area using 7 distinct domains of deprivation, which are: 1) Income 2) Employment 3) Health deprivation and disability 4) Education, skills & training 5) Crime, 6) Barriers to housing and services, 7) Living environment. These can be examined individually or collectively and as a collective these are known as Indices of Multiple Deprivation (IMD). IMD can be shown grouped as quintiles or deciles (5 levels or 10 levels respectively), with IMD 1 (quintile or decile) being the most deprived. From the Trust data it is possible to see that a significant proportion of all our populations experience higher levels of deprivation. The charts below show the populations of the main areas we serve as well as a Trust total split by Ethnicity and deprivation level.

Reducing Inequalities

The data on this page continues to be developed and in this edition only data for May 2026 is included. We are working to refresh this and looking to adopt a 12m rolling data review to provide more meaningful actions. The purpose of this data is to understand whether there is any disproportion in the proportional levels of restraint experienced by inpatients of different ethnic groups. The population of the Trust split by ethnic group is shown alongside for ease of comparison. Early conversations are underway to aid the identification and understanding of some of the some of the context around protected characteristics as part of restraint, seclusion, and other restrictive practices. Specific actions relating to this data will be formulated and held in governance via the EDI Operational Group.



Reducing Inequalities

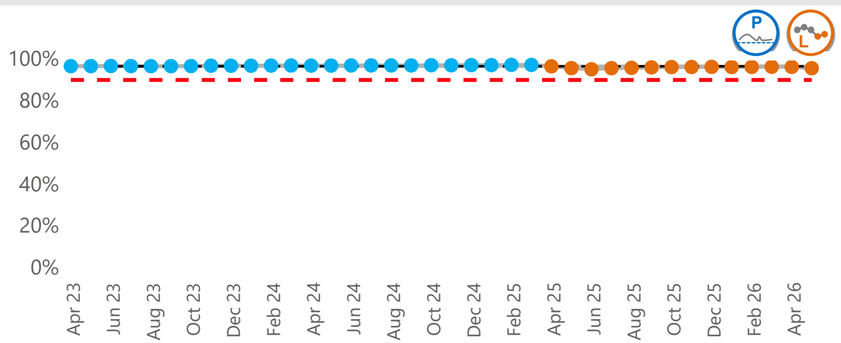
Data as of : 16/06/2026 12:02:49

NHS South West Yorkshire Partnership NHS Foundation Trust

In order to ensure equitable access to our services it is important to monitor the levels of our service users who have their equality data, such as ethnicity, disability status, sexual orientation, and postcode, completed. Data quality is vital to ensure we are able to offer services the meet the needs of the populations we serve. A priority area of equality diversity and inclusion has been agreed at EMT to align to strategic priority programmes to Improve our Clinical Pathways, apply the Patient Carer Race Equality Framework core actions to reduce the gap in inequalities and improve access, experience and outcomes for communities faring worse across all of our mental health, learning disability and community health services. This work involves the specific focus of improving the systematic collection and analysis of data (both numbers and voice) according to protected characteristics and continue to promote 'All of You' campaign. All services continue to work hard to maintain their data quality and future monitoring will form a standing agenda item in Care Group Data Quality meetings with specific actions held in governance via the EDI Operational Group.

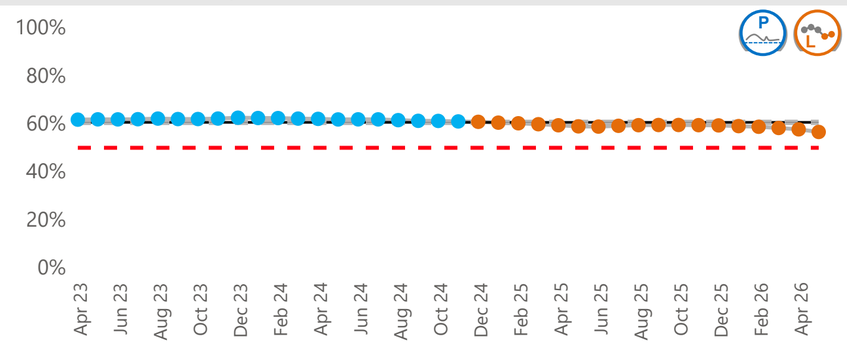
The SPC charts below show the completion rates for these measures.

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



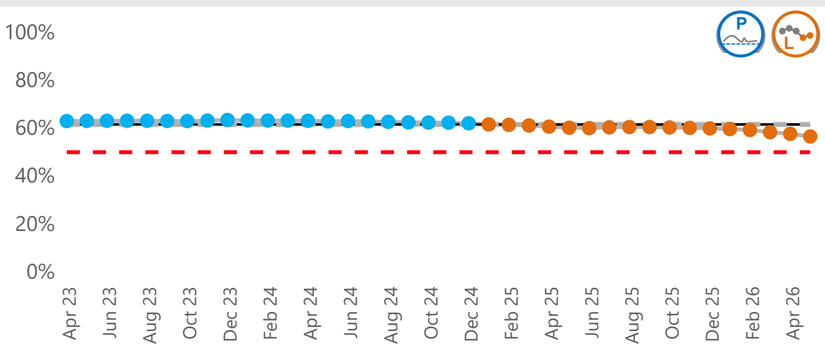
The Statistical Process Control (SPC) chart shows that in April 2026 due to the continued dip in performance we remain in a period of special cause deteriorating variation (something is happening and should be investigated). We are expected to meet the target against this metric.

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



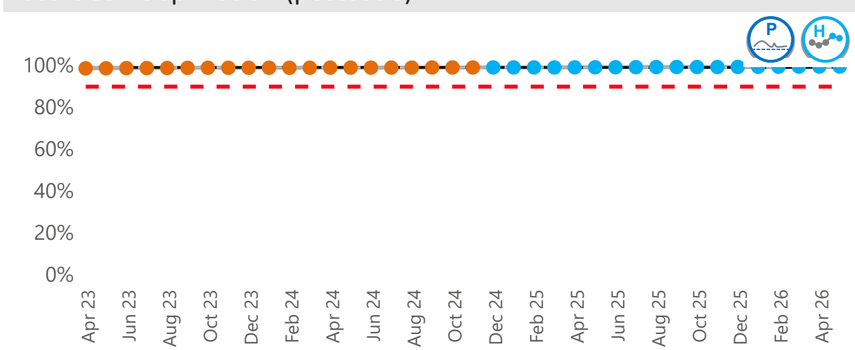
The SPC chart shows that in April 2026 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months. We are expected to meet the target against this metric. There are a number of service lines where data quality has reduced over the last 12 months and further work is being done to understand the contributing factors and direct improvement.

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



The SPC chart shows that in April 2026 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months. We are expected to meet the target against this metric. There are a number of service lines where data quality has reduced over the last 12 months and further work is being done to understand the reasons for this.

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



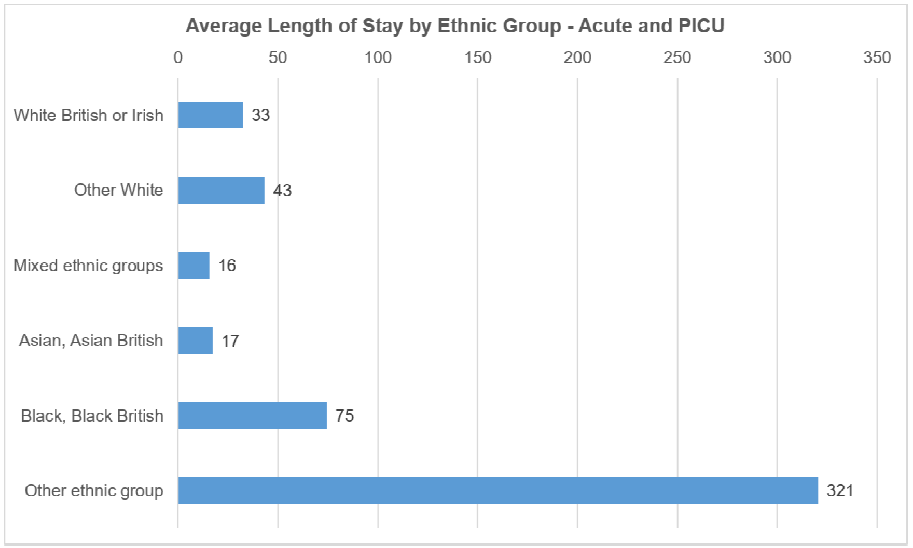
The SPC chart shows that in April 2026 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance. We are expected to meet the target against this metric.

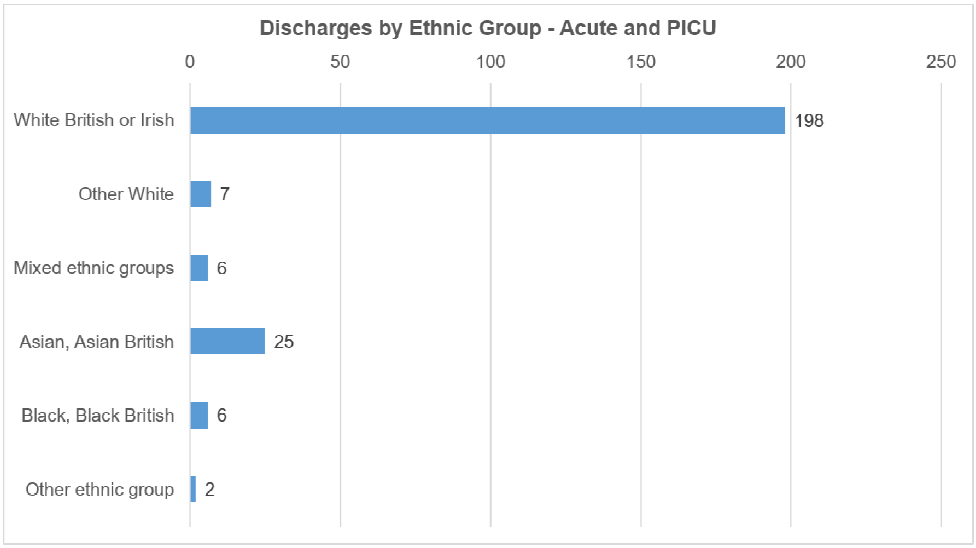
Reducing Inequalities

The charts show the average lengths of stay (ALOS) for our Acute and PICU, adult and older adults wards, for the financial year 2026/2027 (excluding 136 Suite and out of area stays). This data is calculated at the point of discharge and is therefore affected by skew where a patient is discharged following an extended LoS. It is noted that the data below only inlcudes data from April 26. We are working to refresh this and looking to adopt a 12m rolling average review.

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

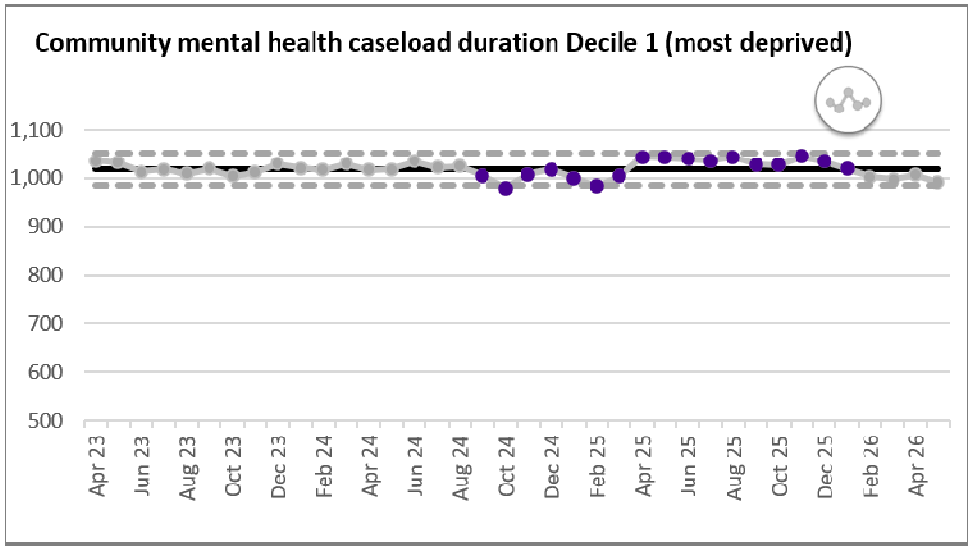
Differences in admission practices i.e. formal (compulsory) and informal (voluntary) also appear to influence LoS, with compulsory admissions tending to require more intensive interventions and longer discharge planning. Similarly, discharge approaches differ, with patients facing socioeconomic challenges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

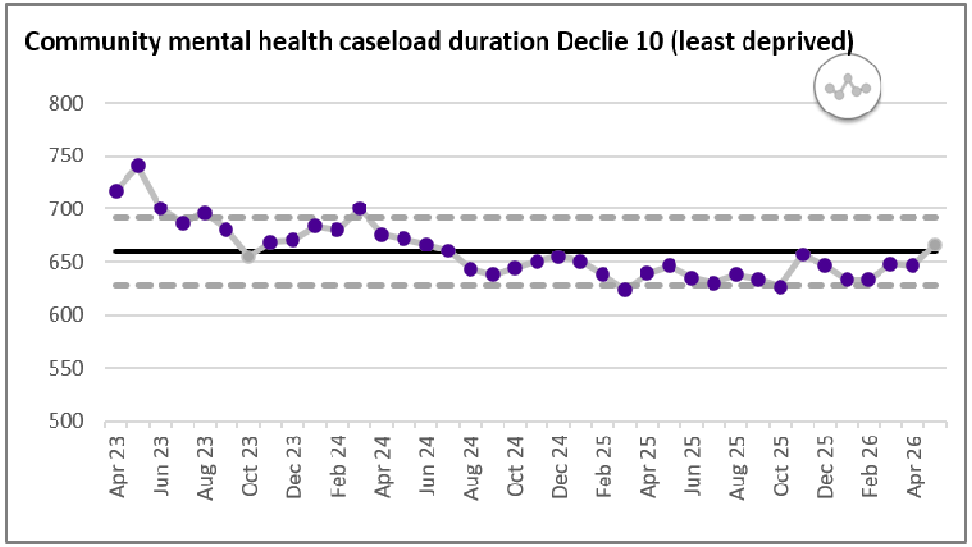




Reducing Inequalities

The charts below show the average caseload length for patients on the caseload of a community health team by those with a post code in the most deprived areas (Declie 1) and those with a post code in the least deprived areas (Decile 10). This data has remained consistent since 2023 and work is underway to understand the service areas for which there is the greatest variance. This work will also encompass and expand on our place data shown on the next page. Work is underway to understand the May increase in caseload duration for those in IMD10, however early indications are that this may be part of a subtle annual variation linked to service user choice, rather than servcie change.

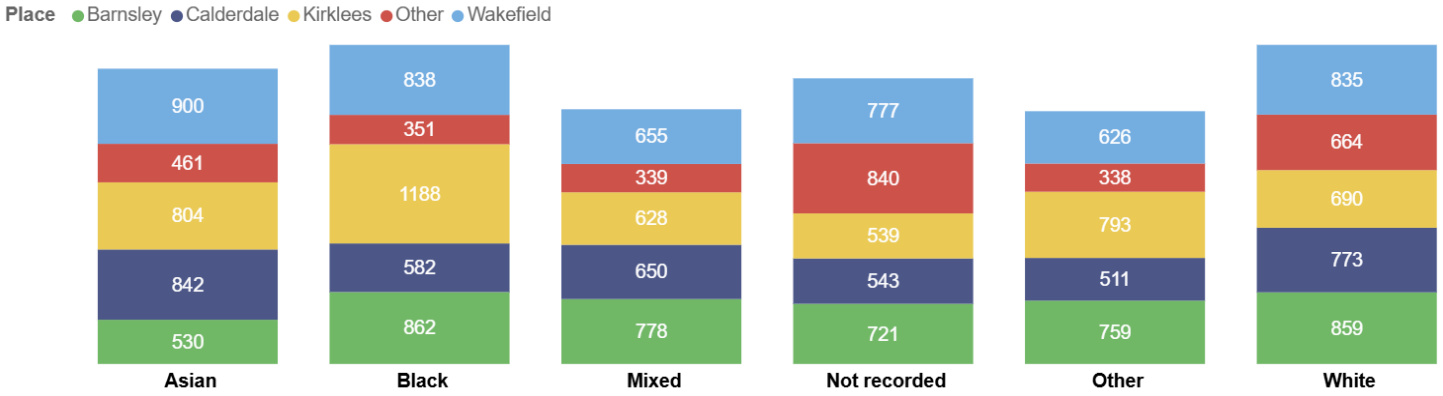




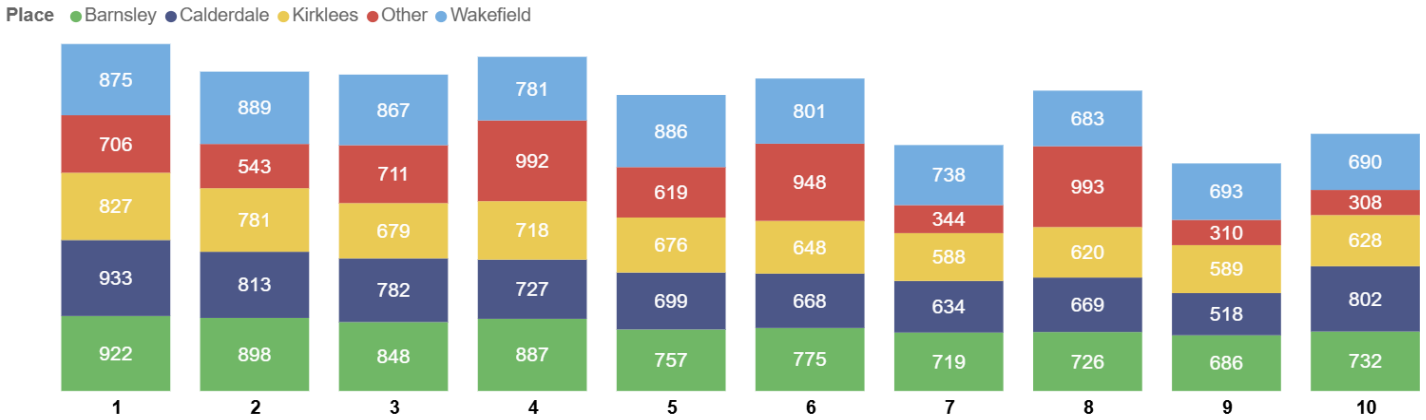
Reducing Inequalities

The charts below show the average caseload length (days) for the group of patients on a community mental health caseload split by ethnic group, and deprivation decile, and also split by Place. We can see that the pattern of lower duration on caseload in IMD10 is mirrored accross all our places. Further work is underway to direct future work but it is important to remember that for the data on this page, the dfferent number of service users in each group (IMD or ethnicity) is different in each place and comparisons are therefore representative, rather than a direct comparison.

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



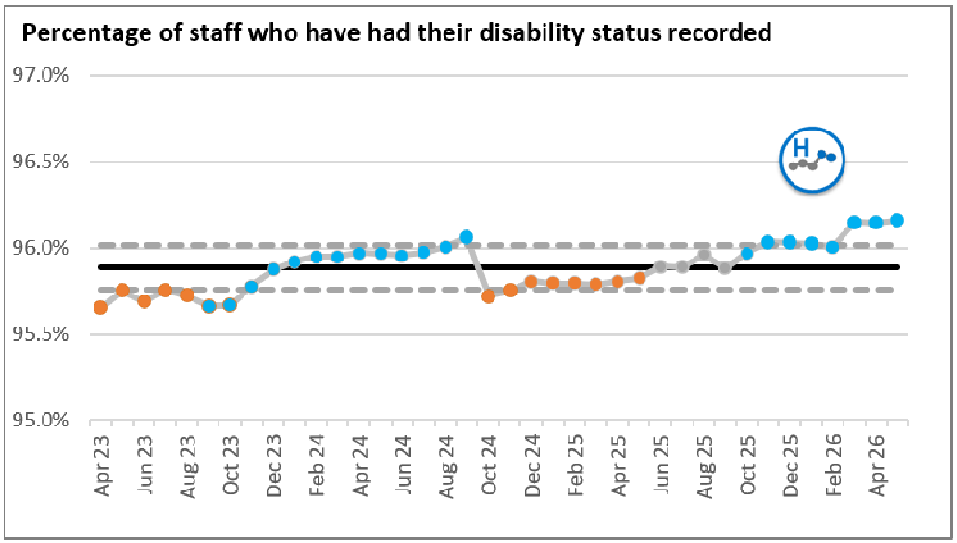
Average Days on Caseload Split by Deprivation Decile and Place - Mental Health Rolling 12 Months

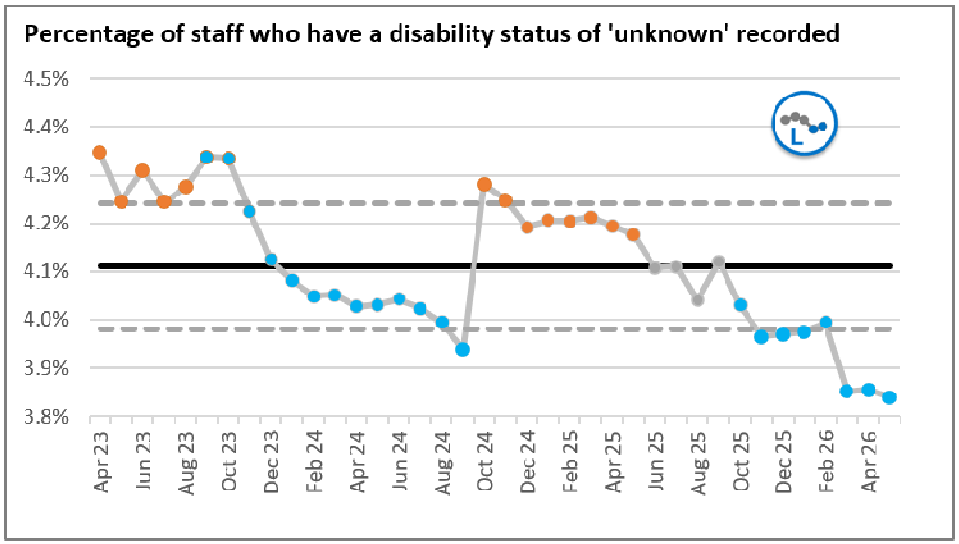


Reducing Inequalities

Disability Confidence and Data Transparency

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





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

People - Performance Wall

Trust Performance Wall

	Strategic Objective	CQC Domain	Threshold	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Vacancy Rate	Best place to work and learn	Well led	8%	Reporting Commenced April 2026			6.4%	6.6%	6.2%
Turnover external (12 months rolling)	Best place to work and learn	Well led	25/26 - 13% 26/27 - 10%	9.1%	9.0%	8.2%	8.4%	9.3%	9.0%
Starters	Best place to work and learn	Well led	-	51.4	47.5	39.0	37.3	14.8	39.6
Leavers	Best place to work and learn	Well led	-	29.0	35.6	36.2	28.9	39.3	25.7
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	-	125 (10.8%)	125 (10.8%)	131 (11.2%)	132 (11.2%)	134 (11.4%)	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	-	962 (71.8%)	975 (72.1%)	986 (72.2%)	985 (72.3%)	985 (72.3%)	985 (72.4%)
Sickness absence - Year-to-Date (YTD)	Best place to work and learn	Well led	<=5%	5.5%	5.5%	5.4%	4.9%	4.9%	5.0%
Sickness absence - Month	Best place to work and learn	Well led		5.8%	5.2%	4.9%	4.9%	4.8%	5.3%
Appraisals - rolling 12 months	Best place to work and learn	Well led	90%	89.2%	87.8%	88.7%	92.2%	92.8%	93.5%
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	69	66	60	64	65	64
Sexual Safety Incidents - Staff	Best place to work and learn	Safe	Trend Monitor	Reporting Commenced April 2026			0	0	0
Mandatory Training - TOTAL	Best place to work and learn	Well led	>=80%	95.4%	95.3%	95.3%	95.2%	95.4%	95.0%

Our workforce supply

Turnover

June 2026 turnover was 9.0%, which is below the target. However, turnover in the Support Services (10.5%) and Forensic Services (12.1%) Care Groups remained above the target. Turnover has decreased across all Care Groups compared with the previous month.

Vacancy Rate

The vacancy rate decreased slightly in June 2026, driven by a higher number of starters than leavers. As a result, the overall workforce increased during the month. Within the Forensic Care Group, the CPH teams continue to experience a high level of vacancies, particularly within the CSW workforce. A targeted recruitment campaign is currently underway to help reduce these vacancies.

We are safe and healthy

Sickness Absence

The overall monthly sickness absence rate increased in June 2026; however, the year-to-date rate remains within the KPI target at 5.0%. Both long-term and short-term sickness absence levels are slightly higher than those recorded at the same point last year. Absences related to gastrointestinal illness and anxiety/stress increased during June 2026. People Business Partners (PBPs) are working closely with areas reporting sickness absence rates below the KPI target, in partnership with the People Relations team, to strengthen the management of long-term absence and improve overall attendance performance. Care group sickness absence levels can be seen in the care group section of the report. There are some higher levels of absence across support services (estates and facilities, people directorate, nursing qualities and professions directorate).

Employee Relations

Although there are currently three suspensions exceeding 90 days, all cases are being actively managed by the Deputy Chief People Officer in collaboration with the People Relations team to ensure appropriate oversight and progress.

We are compassionate and inclusive

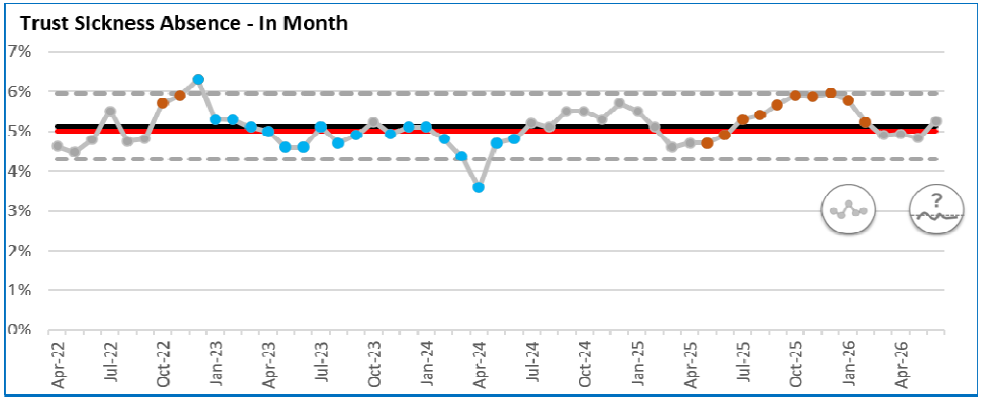
Appraisal Compliance

In June 2026, appraisal compliance was 93.5%, achieving the Trust's KPI target. This figure includes a number of employees who are due an appraisal and are currently transitioning to the new appraisal window system. A new dashboard has been introduced to support the implementation of this process, and all outstanding appraisals are expected to be completed by the end of September 2026. The Forensic Care Group remains below the KPI target, with a compliance rate of 80.9%, and continues to be a key area of focus.

Training Compliance

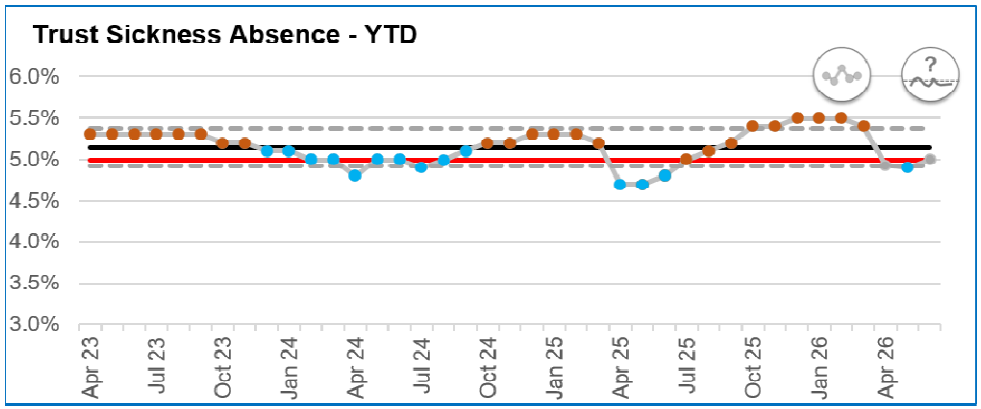
Overall compliance across the Trust remains above the KPI target. However, while Information Governance compliance improved to 94.7% in June 2026, it remains below the required KPI target. A continued focus on improving compliance within the Support Services Care Group is expected to increase Information Governance compliance and further strengthen overall Trust performance.

Statistical process control charts



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

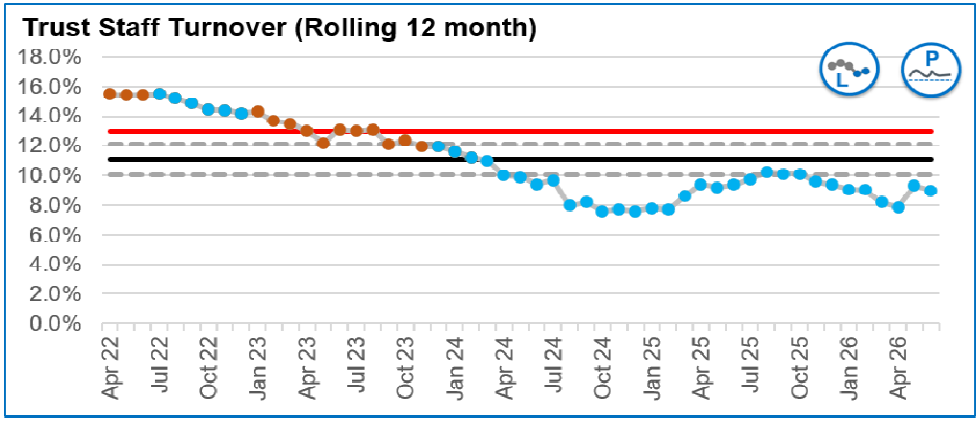
From April 2025 this data includes Cheswold Park Hospital.



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

From April 2025 this data includes Cheswold Park Hospital.

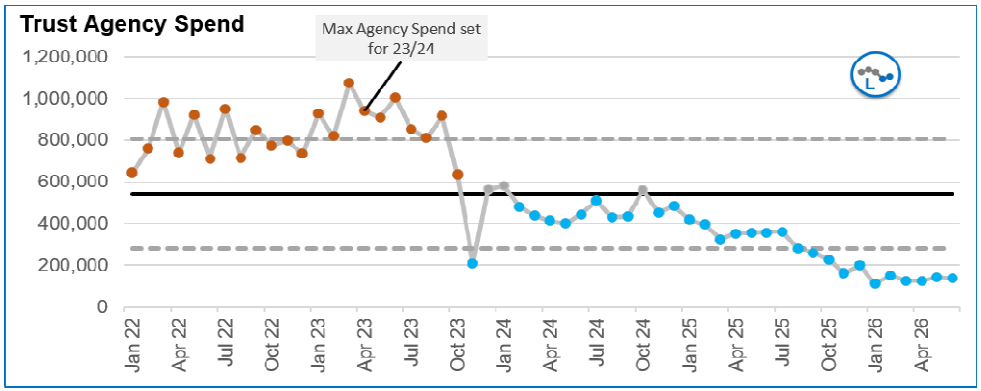
Statistical process control charts



In June 2026 overall Trust turnover was 9.0%, which is below the target of 10%. There are some areas experiencing a higher level of turnover such as Support Services (10.5%) and Forensic care group (12.1%) . Turnover has decreased across all Care Groups compared with the previous month.

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

From April 2025 this data includes Cheswold Park Hospital.



Agency spend is currently being maintained at a historically low level. Spend in June 2026 is £138k, within plan and is constricted to a limited number of medical posts. This is forecast to increase over the coming months due to pending staff retirements.

The SPC chart shows that due to the sustained overall reduction in spend, in June 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

- 88% of the medics that were due to have an appraisal in quarter 1 were appraised within the timeframe.
  - Of the 4 medics that were not appraised in time, the main themes were sickness, imminent retirement and lack of time of the appraiser.
- 100% of revalidation recommendations were made.
- No active concerns under the Maintain High Professional Standards procedures.

MEDICAL APPRAISALS	Q1
Number of doctors due to have an appraisal meeting in the reporting period	44
Number undertaken in period	40
Number not undertaken for which the RO accepts postponement is reasonable	4
Percentage of appraisals taken place and submitted on time	88%

MEDICAL REVALIDATIONS	Q1
Number of revalidation recommendations due in period	10
Number of positive recommendations	10
Number of deferrals	0
Number of non-engagements	0
Percentage of revalidation recommendations made	100%

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

National Metrics

Data as of : 22/07/2026 15:26:13

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.

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 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	L	97.7%	97.5%	97.2%	97.1%	97.8%	97.5%	96%	95.6%	96.4%	97.5%	97.5%	97.1%
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680	?		4151	4319	4554	4641	4514	4287	3868	3946	4162			
					4043	?											4273	4354	4454
M206	Diagnostic test activity	Best Quality	Responsive		190	?		206	239	305	273	247	263	294	235	265			
					193	?											249	205	277
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%	P		98.7%	96.3%	100%	98.9%	100%	100%	100%	100%	99.1%	100%	100%	98.2%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0	F	L	196	203	234	155	97	76	52	28	73	90	82	137
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5	?	L	7	8	7	3	4	2	1	1	2	2	2	6
M7	72 hour follow-up from psychiatric in-patient care	Best Quality	Safe		80%	?	H	91.1%	88.6%	88.2%	89.0%	87.8%	87.6%	91.1%	87.7%	87.3%	86.5%	87.2%	86.7%
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%	P		95.5%	87.5%	93.3%	94.7%	96.4%	96.9%	89.7%	96.4%	96.2%	85.3%	86.8%	90%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%	?	H	96.0%	96.1%	96.4%	96.9%	96.7%	97.4%	97.0%	96.6%	96.5%	95.9%	96.7%	97.1%
M34	% Clients in settled accommodation	Best Value	Effective	⚠	60%	P	L	82.9%	76.0%	82.8%	82.9%	83.3%	83.0%	83.0%	83.2%	83.2%	82.9%	83.4%	82.7%
M35	% Clients in employment	Best Value	Effective	⚠	10%	P	H	13.3%	12.6%	13.3%	13.6%	14.0%	13.7%	14.0%	14.1%	14.2%	14.1%	14.2%	13.6%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		0	0	6	16	2	4	0	2	4	12	25	1
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		0	0	1	1	1	1	0	1	1	1	2	1

National Metrics

Data as of : 22/07/2026 15:26:13

NHS South West Yorkshire Partnership NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%	?	H	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks	Best Quality	Effective		95%	?	H	81.4%	88.2%	83.8%	94.4%	94.4%	92.9%	91.2%	100%	89.7%	95%	100%	92.3%
M47	Virtual ward occupancy	Best Quality	Responsive		80%	?		84%	89.3%	92%	74.7%	70.7%	72%	70.7%	85.3%	62.7%	108%	78.7%	86.7%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0	F	L	0	0	0	0	0	0	0	0	0	0	0	0
M30	Number of detentions under the Mental Health Act (MHA)	Best Quality	Safe					87	99	102	102	83	106	98	101	116	113	122	132
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					23.0%	24.2%	24.5%	22.5%	16.9%	17.0%	22.4%	13.9%	22.4%	24.8%	23.8%	22.0%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%	P		99.7%	99.4%	99.5%	99.3%	99.4%	98.9%	97.7%	98.9%	98.6%	99.8%	99.6%	98.1%
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%	99.6%	99.5%	99.5%	99.4%	98.1%	99.1%	99.3%	99.5%	99.3%	99.0%	99.1%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%	?		53.4%	47.2%	52.5%	52.9%	48.7%	50.2%	50.1%	50.5%	54.0%	56.8%	54.2%	52.6%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%	?		71.8%	65.8%	70.4%	70.5%	72.2%	68.5%	69.0%	69.7%	71.7%	73.2%	72.8%	70.1%
M15	Data Quality Maturity Index	Best Quality	Well Led		95%	P		99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.5%	99.5%	99.6%	99.7%	99.7%	99.1%
M43	Community health services two hour urgent response standard	Best Quality			70%	F	H	91.4%	92.1%	92.0%	87.3%	89.5%	88.5%	88.1%	88.7%	91.2%	89.9%	90.7%	88.9%

National Metrics

Data as of : 22/07/2026 15:26:13

NHS South West Yorkshire Partnership NHS Foundation Trust

The following metrics have Place based targets which have been updated for the 2026/2027 financial year. Data for the previous financial year therefore is no longer shown.

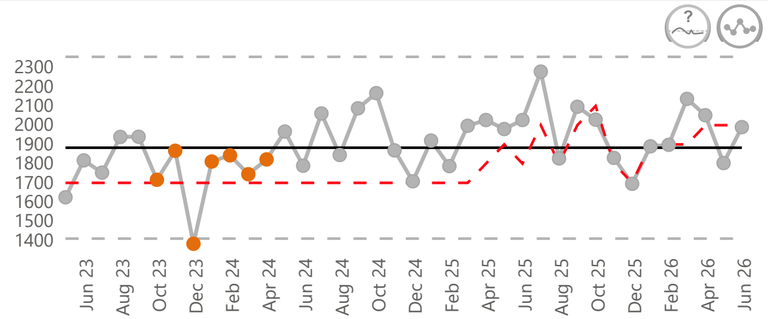
MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Apr 26	May 26	Jun 26
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%	?		59.9%	55.4%	55.1%
				Place	Barnsley	50%	?		59.4%	50.5%	52.8%
					Kirklees	50%	?		60.1%	58.9%	56.6%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				571	514	578
				Place	Barnsley	2451 Year end			219	206	218
					Kirklees	tbc			352	308	360
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	15100	15082	15069
				Place	Barnsley	2900	?	L	2747	2689	2615
					Calderdale	1400	?	H	1501	1469	1483
					Kirklees	4800	?	H	5248	5300	5372
					Wakefield	4300	P	H	4775	4798	4765
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust			H	2098	2030	1968
				Place	Barnsley	283	F	H	344	333	334
					Calderdale	247	?	H	311	287	282
					Kirklees	541	?	H	760	738	711
					Wakefield	406	?	H	573	560	535

National Metrics

Data as of : 22/07/2026 15:26:13

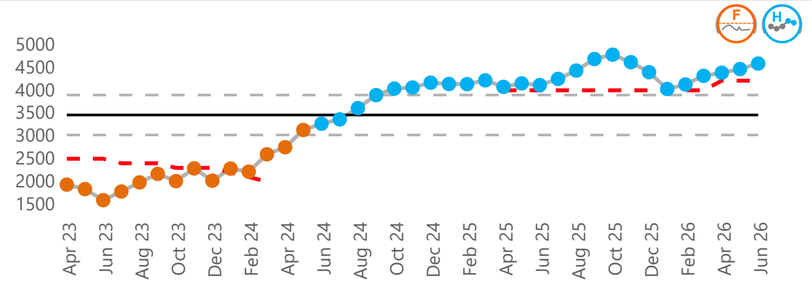
NHS South West Yorkshire Partnership NHS Foundation Trust

M184 - New RTT pathways (clock starts)



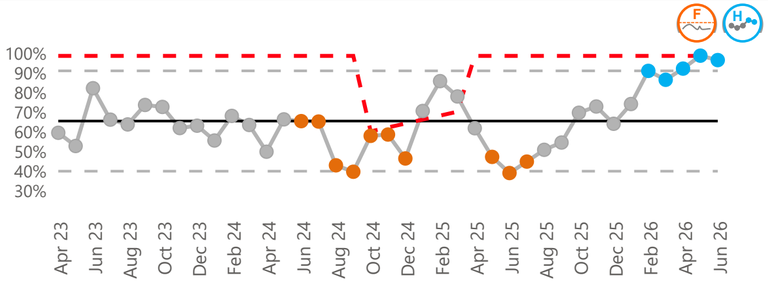
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers. A new moving target is in place for 2025/26.

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



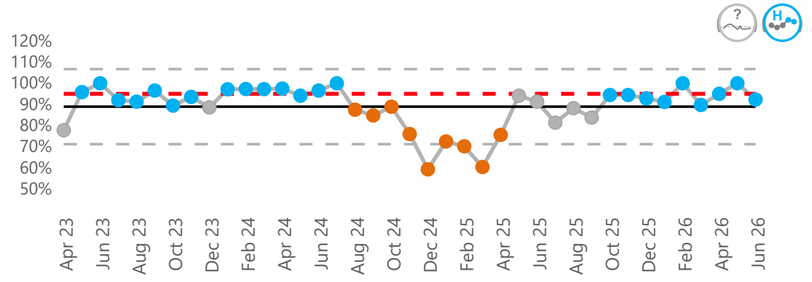
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months. We are not currently forecast to meet the target though current performance is above the target.

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



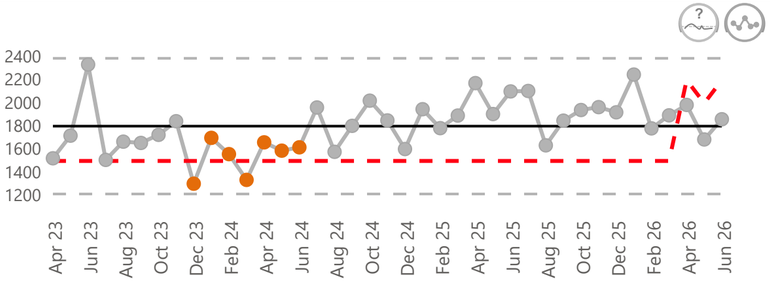
The SPC chart shows that we have entered a period of special cause improving variation (something is happening and should be investigated). Though we are not expected the meet the target of 99%.

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



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

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



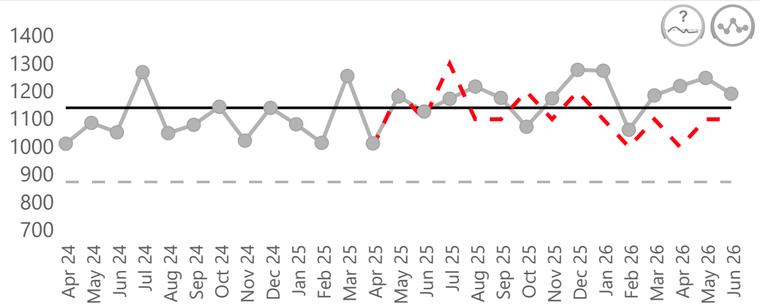
The SPC chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers this time last year.

National Metrics

Data as of : 22/07/2026 15:26:13

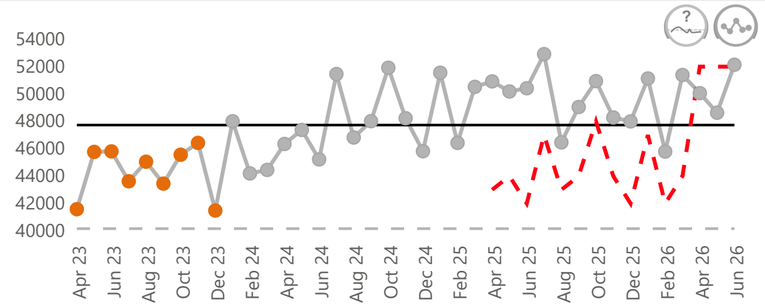
NHS South West Yorkshire Partnership NHS Foundation Trust

M187 - Urgent Community Response (UCR) referrals



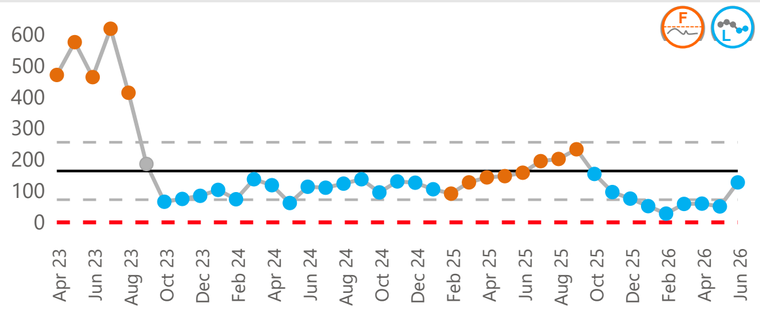
The SPC chart shows that we remain in a period of common cause variation (no concern).

M207 - Attended Community Care Contacts



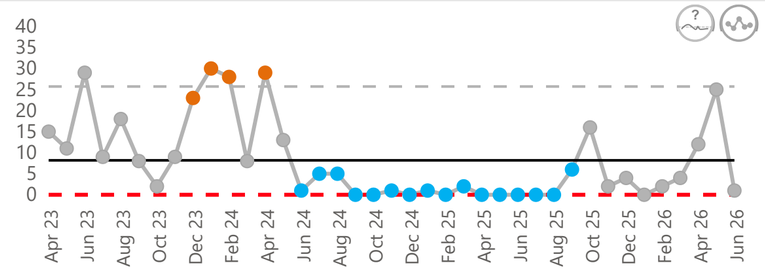
The SPC chart shows that we remain in a period of common cause variation (no concern).

M2 - Inappropriate out of area bed days



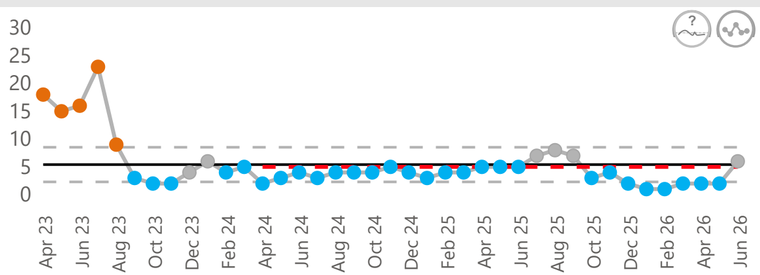
The SPC chart shows that due to the continued improvement in the number of out of area bed days we remain in a period of special cause improving variation (something is happening and should be investigated). Though we are still not anticipated to achieve the target of zero.

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



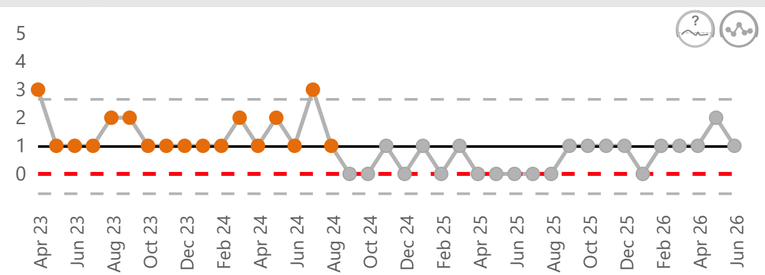
The SPC chart shows that although there has been an increase in this month in the number of under 18s admitted we remain in common cause variation (no concern).

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



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

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



There was one admission of an under 18 year old to an adult ward in June 2026. Their length of stay was 1 day.

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.

KPI	Strategic Objective	CQC Domain	Target	Apr-26	May-26	Jun-26
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Trust	Best Quality	Responsive	Apr - 455 May - 451 Jun - 447	Due August 26		
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Barnsley	Best Quality	Responsive	Apr - 83 May & Jun - 82			
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Calderdale	Best Quality	Responsive	44			
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Kirklees	Best Quality	Responsive	Apr - 258 May - 256 Jun - 254			
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period - Wakefield	Best Quality	Responsive	35			
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - Trust	Best Quality	Responsive	Apr - 48.0 May - 49.1 Jun - 47.1	47.7	45.6	47.7
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - South Yorkshire	Best Quality	Responsive	Apr - 58.1 May - 60.0 Jun - 56.7	44.6	48.7	46.0
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - West Yorkshire	Best Quality	Responsive	Apr - 44.7 May - 45.7 Jun - 43.8	46.4	42.9	44.1
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - Trust	Best Quality	Responsive	Apr - 82.2 May - 81.7 Jun - 79.0	89.1	92.9	90.2
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - South Yorkshire	Best Quality	Responsive	Apr - 76.8 May - 79.3 June - 76.8	72.4	73.3	64.2
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - West Yorkshire	Best Quality	Responsive	Apr - 77.4 May - 78.7 Jun - 76.2	96.0	100.0	97.8
Access to Mental Health Support Teams Mental Teams in schools and colleges - Kirklees	Best Quality	Responsive	Apr - 800 May - 830 Jun - 860	995	1004	1018
Access to Mental Health Support Teams Mental Teams in schools and colleges - Wakefield	Best Quality	Responsive	1300	1802	1833	1834
Number of patients accessing Individual Placement Support services - rolling 12-month - Calderdale	Best Quality	Responsive	Apr - 158 May - 160 Jun - 162	128	131	126
Number of patients accessing Individual Placement Support services - rolling 12-month - Kirklees	Best Quality	Responsive	Apr - 296 May - 304 Jun - 311	255	253	248
Number of patients accessing Individual Placement Support services - rolling 12-month - Wakefield	Best Quality	Responsive	Apr - 279 May - 281 Jun - 285	401	395	406
Percentage of people on entire waiting lists who are waiting 18 weeks or less	Best Quality	Responsive	78% by March 27	87.5%	89.0%	90.4%
Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	Best Quality	Responsive	78% by March 27	97.5%	97.8%	97.4%
Percentage of people on waiting lists for CYP Community Services per system who are waiting 18 weeks or less as proportion of entire CYP waiting list	Best Quality	Responsive	78% by March 27	58.0%	61.0%	65.9%

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 June the following data quality issue has been identified in the reporting:
• The reporting for employment and accommodation shows 14.7% of records have missing employment and/or accommodation status with a further 1.7% that have an unknown employment status and 1.2% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

Operational Planning
Monthly performance against the national activity metrics for operational services can be seen in the dashboard. Where metrics have carried forward into 2026/27, 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 for 2026/27 and these can also be seen in this section.

NHS Oversight Framework
The 2026/27 framework was published by NHS England on 11th June 2026. A greater number of metrics are applicable to the Trust for this year and work is underway to review the metrics and interpret the new national guidance. Quarter 1 performance is expected to be published in September. A further update will be provided as more information becomes available.

National Metrics

Data as of : 22/07/2026 15:26:13

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.

• M8 & M9 - There was one admission to an adult mental health ward where the person was under 18 years old; they were admitted for one night. 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.

• M2 - The number of out of area bed placements remains amongst the lowest in the North-East, Yorkshire and Humber region. At the end of June, the Trust had six service users placed in an inappropriate out of area bed with 137 bed days used over the month. This has been supported by significant ongoing focus and improvements on patient flow and bed management, however, during June the service were under considerable pressure which impacted on out of area use and were reporting OPEL 4 (integrated operational pressures escalation level); level 4 indicates very high clinical risk levels. The Trust also places patients on behalf of the commissioner for Barnsley place which also contributes to provider placement numbers, and for June this related to five service users.

• M13 & M14 - The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within four weeks was 100% in June. The routine access to treatment measure achieved 92.3%, which related to 3 children and young people not seen in time.

• M47 - Virtual Ward occupancy rate is 86.7% in June achieving the target of 80%.

• M6 - The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks remains above the threshold at 96.9% in June. The continued increased in performance has meant that we remain in a period of special cause improving variation (something is happening and should be investigated).

• Reduction in our mental health length of stays are 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 slightly above our forecast position for June for adult and PICU lengths of stay (47.7 days against a forecast of 47.1 days) but have exceeded our forecast for older peoples' lengths of stay (90.2 days against a forecast of 79.0 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 focused work is on-going in terms of developing secondary care referral rates, specifically for the unemployed cohort which may further improve the access numbers.

• As a whole our community services are achieving the national expectation of 78% of being seen within 18 weeks, achieving 90.4% for June. We do however, continue to 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.

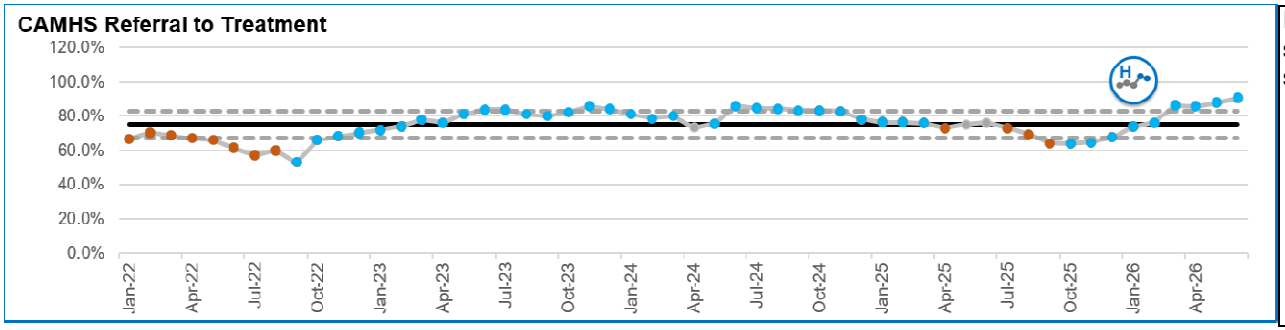
The following section of the report has been created to give assurance regarding the quality and safety of the care we provide. A number of key metrics have been identified for each care group, and performance for the reporting month is stated along with variation/assurance for each metric where applicable. 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. Medical staffing issues related to long-term sickness and leavers are impacting on medical capacity within the team, directorate are undertaking recruitment and exploring alternatives with workforce colleagues.

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	94.2%	93.2%	93.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/7)	0% (0/3)	0% (0/5)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	73.5%	76.2%	86.5%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	75.1%	75.7%	79.4%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	100.0%	98.1%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.9%	82.2%	81.9%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	94.9%	100.0%	92.3%	
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%	96.4%	90.9%	91.6%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.4%	91.8%	92.1%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.2%	5.2%	4.8%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	590	648	732	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	1,065	1,156	1,084	
Total number of reported incidents	Best Quality	Safe	Trend monitor	70	42	53	



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

Alert/Action

• Kirklees & Calderdale medical workforce is currently running at 57% of establishment due to leavers and long-term sickness. Working with Directors of service and Workforce colleagues to focus on recruitment of both substantive vacancies and temporary staffing. Reduced capacity for routine & emergency appointment and to cover medical on call.
• Kirklees CAMHS ADHD waiting list continues to rise due to increased referrals, Kirklees ICB RtC decision making, medical staffing vacancies and limited NMP support (0.6wte). Current longest wait (non-allocated appointment) is 75 weeks. Escalated to DoS and contracting colleagues.
• Kirklees Keeping in Mind (KKiM) MHST (mental health support into schools) is still experiencing significant challenges around referral numbers and recruitment and retention. The service continues develop its offer to align with its provision with the national model, working collaboratively with schools, local authority and ICB. Wave 16 funding has been agreed in principle, and a decision tree is being prepared for EMT.
• Wakefield 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 – discussions have been undertaken with NHSE to determine the responsibilities and associated finance for the prescribing of mental health medications in the secure children's homes in accordance with contractual arrangements. A business case submitted in relation to this was rejected. Further discussions are taking place internally with our contracting and finance colleagues.
• 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.

Advise

• Barnsley CAMHS- The business proposal approved by commissioners for two posts for learning disability nursing will positively impact health inequalities and service user experience. Mobilisation plans are in place, and the service have successfully recruited into post. Funding has been approved for phase 2 of the model, which is a more comprehensive team for CAMHS LD. Staff members have been recruited and funding has flowed since the beginning of the finance year.
• Calderdale & Kirklees CAMHS experiencing increased referrals and reduced resources which are impacting waiting times for ADHD medication activity. Increased prevalence of ADHD has led to SWYFT receiving an increased number of referrals for medication assessment and titration from Right to Choose (RtC) providers specifically within Calderdale. Kirklees numbers are directly related to the number of diagnosed assessments undertaken by the Neuro Developmental assessment team in Kirklees. Calderdale commissioners are considering business proposal for increasing capacity with Calderdale ADHD. Kirklees ICB commissioners have instructed GPs wishing to pursue Right to Choose pathway for ASD/ADHD assessments that these will need to be first screened by Kirklees CAMHS Neuro Assessment Service. This has led to an increase in referrals to the service and changes in practice for allocation to SWYFT ND assessment waiting list. Additionally, the increasing use of right to choose by GPs will have a direct impact on Kirklees CAMHS ADHD medication waiting list.
• Calderdale & Kirklees CAMHS Crisis team continues to receive in the region of 100 referrals per month for CYP requiring emergency or urgent support. In addition, the C&K CAMHS Crisis line receives in the region of 100 calls per month and also a further 20calls per month from NHS 111. The Service continues to work with IM&T to maximise telephony provision to streamline calls more productively.
• Calderdale & Kirklees CAMHS Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees continue to remain challenging. This is further impacted by staff vacancies. This has been recorded on the risk register. Commissioners are sighted on these challenges.
• The rate of clinical supervision was 86.5% and 79.4% for management supervision across the care group. This is an improvement on the May 2026 figures.

Assure

• The sickness level across children young people services in June was 3.6%.
• Medical devices servicing across the children and young people services stands at a 94% compliance rate.
• The work of the weekly rapid improvement group established to reduce CAMHS treatment waits continues to have a positive impact on the services.

Mental Health Care Group

Headlines

Acute wards have continued to manage high levels of acuity. During June sustained pressure triggering OPEL level 4 for a period of 2 weeks. .

General managers have a firm grip on sickness absence with staff being supported and managed in line with Trust policies. Community services sickness has been maintained under local threshold but there has been an increase in across Mental Health inpatient services.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	94.9%	96.4%	96.5%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	87.9%	85.8%	87.4%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	100.0%	99.1%	97.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	7% (1/15)	0% (0/15)	0% (0/15)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	83.1%	88.1%	87.1%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	73.4%	83.0%	85.0%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	86.5%	87.2%	85.4%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	94.6%	95.8%	96.2%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	97.4%	96.7%	96.2%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.8%	86.2%	85.6%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	97.7%	97.5%	97.8%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.7%	94.1%	95.1%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	90.6%	92.0%	92.6%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.3%	4.8%	5.0%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,221	13,206	13,194	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	120	122	129	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	96.9%	96.8%	96.1%	
% Bed occupancy (excl leave)	Best Quality	Safe	85%	85.2%	89.6%	91.5%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (1/3)	0% (0/7)	14% (1/7)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	83.5%	83.1%	81.0%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	81.8%	75.7%	79.1%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.8%	86.7%	84.4%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	9.9%	7.3%	6.8%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	92.5%	93.0%	89.6%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	150 (June)	90	82	137	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.8%	95.2%	97.1%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	11	14	22	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	60	52	69	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	90.3%	90.1%	89.8%	
Restraint incidents	Best Quality	Safe	Trend Monitor	128	106	*136*	
Safer staffing (Overall)	Best Quality	Safe	90%	119.0%	121.3%	122.6%	
Safer staffing (Registered)	Best Quality	Safe	80%	102.4%	100.8%	101.5%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	4.8%	5.4%	6.3%	
Readmissions within 28 days	Best Quality	Safe	Trend Monitor	11	13	13	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	581	584	631	

Alert/Action

• Acute wards have continued to manage high levels of acuity. During June sustained pressure triggering OPEL level 4 for a period of two weeks.
• 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 June 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 June and the pressure to meet the demand for admissions in a timely way has intensified. The impact of reduced usage of out of area beds on inpatient wards, Intensive Home-Based Treatment Teams, and community teams is triangulated and monitored.
• Intensive Home-Based Treatment (IHBT) teams in Calderdale and Kirklees are experiencing ongoing workforce challenges, recruitment is underway.
• Barnsley and Kirklees IHBT are amber for 4hr assessment in June. Barnsley were under the locally agreed 95% target at 90.91%. This was one breach due to operational pressures and service user choice, and they were seen the same day. Kirklees did not achieve their 90% target at 87.5%. In the first instance, the 4hr assessment was carried out by the police liaison practitioner who is part of IHBTT, and P&BI are looking at why this contact did not get reflected in reporting. The other instance was a breach by 20 minutes, and this was due to service pressures.
• All areas are focussing on continuing to improve performance for FIRM risk assessments. FIRM percentage compliance for inpatient services is significantly impacted due to the relatively small number of admissions. There is a high level of scrutiny when a FIRM risk assessment is not completed or reviewed and updated within 24 hours pre or post admission. At the point of admission, a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed. A Staying Safe risk management care plan is also implemented within 24hrs of admission. The care group are reviewing the locally agreed standards for documenting the review of FIRM risk assessments on admission, and this work will be shared into the trust wide risk assessment quality improvement work.
• Care plan metrics for community capture the whole community caseload rather than only individuals on CPA. The care group are working with P&BI to ensure the metric reflects practice. Continued improvement in June in all areas. Care Programme Approach (CPA) review performance is above target in Calderdale, Kirklees and Wakefield. Barnsley are under the 95% target this month 92.1% respectively. Action plans and support from Quality and Governance Leads remain in place and all areas are expected to be above threshold in July.
• The sickness rate is above the Trust threshold on some wards. Wards and teams with high sickness are where there are a number of people with long term sickness in addition to short term sickness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
• The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administrating intra-muscular medication. Matrons attend the monthly restraint oversight meeting chaired by RRPI specialist advisors and includes an in-depth review of all prone restraint incidents for learning.
• SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. In June the access standard for routine assessment 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 Calderdale and Kirklees Community which has dipped under the 80%. There is an action plan in place and an expectation of improvement to above target at the end of July.
• The Talking Therapies recovery rate for June is 52.78% for Barnsley and 56.63% 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 four incidents of prone restraint in June. One incident was service user led and three incidents were staff led for clinical reasons specific to the individuals and related to administration of medication. All prone restraints are reviewed by RRP specialist advisors and any identified learning shared to the clinical team. The care group continue to work collaboratively with colleagues in Nursing, Quality, and Professions to support the Trusts ambition for zero staff led prone restraint.

Assure

• IHBT teams continue to perform well in gatekeeping admissions to our inpatient beds.
• Mandatory training compliance for the care group is 95.1%.
• The care group achieved 95.4% of appraisals completed within 12 months.

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

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

Learning disability services:
There has been an improved position in waiting list times for community learning disability services referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks. The Learning Disability team continue to have robust oversight of all waits and are carrying out profession specific actions to address waits within individual disciplines.

LD, ADHD & ASD

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	88.5%	91.0%	80.1%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (1/3)	0% (0/2)	0% (0/2)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	69.2%	69.0%	68.8%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	64.1%	62.4%	62.8%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	50.0%	42.3%	45.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.5%	88.4%	85.7%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	100.0%	100.0%	81.8%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	95.1%	95.2%	96.3%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	Best Quality	Responsive	90%	81.7%	98.1%	95.6%	
Physical Violence - Against Patient by Patient	Best Quality	Safe	Trend Monitor	0	1	0	
Physical Violence - Against Staff by Patient	Best Quality	Safe	Trend Monitor	11	12	6	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.7%	91.4%	92.1%	
Safer staffing (Overall)	Best Quality	Safe	90%	133.7%	120.2%	121.6%	
Safer staffing (Registered)	Best Quality	Safe	80%	167.9%	162.0%	161.1%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.0%	3.1%	2.8%	
Restraint incidents	Best Quality	Safe	Trend Monitor	8	8	*5*	
Average length of stay	Best Quality	Safe	Trend Monitor	N/A	524	N/A	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	49	53	44	

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

Alert/Action

ICB West Yorkshire Neurodiversity Project
A number of commissioning developments are taking place across the region which may shape the future delivery of neurodevelopmental and specialist services. This includes ongoing work to review support pathways and strengthen alignment across systems. The Trust continues to engage proactively with commissioners and partners to support service development, share learning and ensure local services remain responsive to the needs of children, young people and families. Developments will continue to be monitored through established governance arrangements.

Waiting Times ADHD
ADHD waiting times continue to increase across a number of localities, reflecting sustained growth in demand for assessment, diagnosis and intervention. Referral rates remain significantly above commissioned and operational capacity, resulting in a widening gap between demand and service availability. The position is being further influenced by increasing public awareness of neurodevelopmental conditions, changes in referral patterns and growing complexity within the population accessing services. Actions are underway to maximise available clinical capacity, review pathways and explore opportunities for system-wide solutions with commissioners and partner organisations. However, without additional sustainable investment and wider pathway transformation, waiting times are expected to remain under significant pressure.

Compliance with Annual Risk Assessment Reviews
Reported compliance with annual risk assessment reviews remains an area of focus. A review of current processes has identified opportunities to improve recording and reporting arrangements, ensuring performance data more accurately reflects clinical activity. Some of the issues identified span multiple services and will require changes to recording practices and processes across a wider range of clinical teams to support consistency and assurance. Work is progressing to strengthen data quality and documentation standards, with ongoing oversight through governance structures to ensure continued improvement in reporting and compliance.

Advise

Data Quality - The service is working with the business intelligence team to strengthen data quality and reporting arrangements, with a number of proposed solutions currently under review. This work is intended to improve the accuracy of performance reporting, provide greater assurance regarding compliance, and support targeted improvement activity where required.

Potential Opportunities - Discussions continue with commissioners and system partners regarding the development of neurodevelopmental pathways, including potential screening and triage arrangements in Calderdale, to support sustainable service delivery and improve access to appropriate support.

Regional neurodevelopmental commissioning developments are being monitored through established governance arrangements to ensure the Trust remains well positioned to respond to emerging opportunities, support service development and manage changes in demand.

Assure

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

Learning disability services:

Alert/Action

Community
• Learning Disability Services continue to operate with reduced psychiatry capacity, impacting the timeliness of specialist assessments, formulations and clinical reviews, and creating additional pressure across community pathways. Mitigating actions are in place, including workforce planning and prioritisation of clinical activity, although capacity constraints continue to affect service delivery and responsiveness.
• LeDeR Report (delayed 2024 Report) has now been published following resolution of technical data issues. The report shows a reduction in the proportion of avoidable deaths among adults with a learning disability, from 46.3% in 2021 to 39.0% in 2024. While this represents improvement, the rate remains significantly higher than that seen in the general population and highlights the continued need to address health inequalities.

Horizon – Assessment and Treatment Unit (ATU)
• ATU Review -A comprehensive review of Assessment and Treatment Unit (ATU) provision across West Yorkshire is progressing in partnership with system partners through established collaborative workstreams. The review is nearing completion, with the options appraisal in its final stages to support the development of a sustainable, system aligned model that reflects demand, quality expectations and financial considerations.
• Patient Flow: Four service users currently in the service. Three patients are currently identified as ready for discharge, with discharge destinations agreed and planned discharge dates in place, supporting continued patient flow through the pathway.

Advise

Community
• Waiting Times: Performance against waiting time standards has improved, with recent data showing compliance has returned above the required target. This reflects the impact of focused operational oversight and actions taken to manage demand and capacity across the service.
• ICONIC Research Project: The ICONIC research project has now commenced. Participation in this programme strengthens the service's contribution to the national evidence base for learning disability services and provides opportunities to further develop research activity, innovation and best practice.
• STOMP: STOMP remains well embedded across all localities and continues to support the safe and appropriate use of psychotropic medication. A number of local teams have reported positive outcomes, including reductions in medication and, in some cases, successful discharge from specialist services where needs can be managed through mainstream or community-based support.

Horizon – Assessment and Treatment Unit (ATU)
• Medication Safety: A comprehensive review of medication errors reported over the last 12 months has been completed. Findings have informed a targeted action plan, which is now being implemented to strengthen practice, reduce recurrence and support ongoing improvements in medication safety.
• Post-Incident Debriefs: The ward has reviewed and strengthened its arrangements for staff debriefs following incidents of violence and aggression. Improvements to documentation and processes have been introduced to ensure staff receive timely support, learning is captured consistently, and actions are followed through.

Assure

• Annual health checks in all four localities have exceeded the 75% threshold.
• FFT – 100%

Forensic Care Group

Headlines

The monthly sickness rate continues to be an issue for our West Yorkshire services, 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	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	78.5%	79.9%	81.0%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	89.0%	90.8%	89.4%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/0)	0% (0/1)	0% (0/3)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	64.2%	66.5%	68.1%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	46.2%	45.7%	52.4%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	97.3%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.1%	81.1%	81.5%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	100.0%	80.0%	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%	86.6%	89.5%	89.6%	
% with care plan that includes service user input/views	Best Quality	Safe	95.0%	90.6%	90.0%	92.1%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	96.1%	94.6%	94.3%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	7	2	1	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	2	6	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.1%	89.8%	94.0%	
Restraint incidents	Best Quality	Safe	Trend Monitor	24	8	*17*	
Safer staffing (Overall)	Best Quality	Safe	90%	111.8%	119.5%	116.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	101.3%	100.8%	99.3%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	6.4%	5.6%	7.1%	
Average length of stay	Best Quality	Safe	Trend Monitor	1,049	1,389	949	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	176	156	162	

Forensic - West Yorkshire:

Alert/Action

Future Capacity & Demand
Work continues through the West Yorkshire Provider Collaborative, in partnership with regional colleagues, to model future demand and strengthen system-wide planning for specialised services. This includes detailed analysis of activity, length of stay, patient flow, bed utilisation, and emerging demand trends, enabling a more proactive and evidence-based approach to service configuration, workforce planning, and capacity management. The collaborative is using this intelligence to support sustainable service development and ensure future provision is aligned to population need and anticipated system pressures.

The Best Place to Work and Learn
Programme delivery continues, with a focused review of culture across West Yorkshire Forensic Services. Staff engagement has been positive and has provided valuable insight into current culture and areas for improvement. Communication with staff has commenced, with targeted improvement actions being developed and governance and oversight arrangements being established under Executive leadership to support delivery and assurance.

Bed Occupancy
Occupancy across Newhaven, Newton Lodge and the Bretton Centre remain broadly stable. Variation continues to be most evident within the learning disability pathway, where four of the eight beds remain unoccupied, reflecting the ongoing challenges in demand across this service area.
- Newton Lodge: 89.04%
- Bretton Centre: 93.52%
- Newhaven: 81.25%

Vacancies
HCA vacancies remain a challenge and continue to place pressure on rota coverage and operational resilience, contributing to the ongoing reliance on temporary staffing. However, recruitment activity is beginning to have a positive impact, with vacancy levels showing gradual improvement. While turnover within this staff group continues to offset some of the gains made, targeted recruitment and retention actions are helping to stabilise the workforce and reduce overall vacancy numbers.

Risk Assessment
Compliance with completion of risk assessments within 24 hours has improved and returned to 100% this month. While this provides assurance that required assessments are being completed in a timely manner, performance will continue to be monitored closely to ensure improvements are sustained and embedded within routine practice.

Supervision
Supervision compliance remains mixed across the service. Newhaven has demonstrated significant improvement in clinical supervision, increasing from 67.7% to 90.3% and exceeding the 80% target. Newton Lodge has shown modest improvements in both management and clinical supervision, although performance remains below target. Compliance at the Bretton Centre remains below the expected standard, with only marginal improvement recorded this month.
Management supervision at Newhaven has reduced from 83.9% to 71.0% and will continue to be closely monitored. Targeted recovery actions remain in place across all areas below target, with oversight through local performance management arrangements. Despite the current variation, supervision compliance has historically been strong across West Yorkshire Forensic Services and work is underway to restore performance to expected levels and ensure sustained improvement.

Advise

Sickness Absence – Sickness absence continues to be a key area of focus across the service. A targeted programme of work remains underway, supported by the People Directorate, to enable teams to better understand and address the underlying drivers of absence and to strengthen overall attendance.
Sickness absence has increased slightly at Newton Lodge (5.1%), while Newhaven continues to report low levels at 0.8%. Absence at the Bretton Centre has reduced to 10.1%, though this area remains a relative hotspot. The management team is continuing to review contributory factors and implement targeted actions to support improvement.

Forensic Improvement Programme – The programme continues to progress, with workstreams focused on enhancing service user experience, improving outcomes, and strengthening operational effectiveness. Delivery is coordinated across the Care Group and monitored through established governance structures, including the Operational Management Group, providing oversight of progress, risk management, and delivery against agreed objectives and milestones.

Mandatory Training Compliance – Overall compliance remains strong. Areas below the required threshold include CPR at Newton Lodge (78.4%) and Information Governance training (93.8%), with Newhaven also slightly below target for IG at 94.1%.
Targeted actions are in place, including focused follow-up with staff, planned training sessions, and oversight from local management. Compliance continues to be monitored through established governance processes, with improvement expected over the next reporting period.

Appraisal – Planning is underway to improve appraisal compliance alongside the implementation of the new system. This is being supported through targeted training, management briefings, and enhanced support for staff and managers. A phased rollout and improved oversight arrangements are expected to strengthen compliance, improve timeliness, and support sustainable performance as the new system becomes embedded.

Turnover – Below 10% across all service lines.

Assure

- High levels of Data Quality across the Care Group.
- 100% compliance for HCR20 completed within 3 months of admission.
- CPA – 100%
- 25 hrs meaningful activity 100%
- Positive relationships with West Yorkshire Provider Collaborative partners

Forensic - South Yorkshire							
Metrics	**Strategic Objective**	**CQC Domain**	**Threshold**	**Apr-26**	**May-26**	**Jun-26**	**Variation/ Assurance**
% Appraisal rate	Best place to work and learn	Well led	90%	75.4%	80.5%	80.2%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	85.3%	86.2%	86.8%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	0% (0/2)	0% (0/1)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	69.8%	86.0%	75.0%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	54.2%	79.6%	70.9%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.6%	89.7%	84.7%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	97.3%	95.7%	95.8%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	2	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	5	1	6	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.3%	87.5%	88.0%	
Restraint incidents	Best Quality	Safe	Trend Monitor	7	8	*23*	
Safer staffing (Overall)	Best Quality	Safe	90%	107.9%	109.0%	108.2%	
Safer staffing (Registered)	Best Quality	Safe	80%	87.9%	87.3%	85.9%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	2.8%	2.3%	3.4%	
Average length of stay	Best Quality	Safe	Trend Monitor	1,075	2,449	1,894	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	164	151	163	

Forensic - South Yorkshire:

Alert/Action

Capacity and Demand Modelling
A system-wide capacity and demand modelling exercise is underway across South Yorkshire, West Yorkshire and the Humber to inform future service configuration and support longer-term strategic planning across forensic pathways. Bringing together activity, patient flow, acuity and population demand data, the work aims to develop a shared understanding of current and future service need. This will support evidence-based planning across the pathway, taking account of national policy direction, including the Provider Collaborative agenda and the continuing emphasis on community-based care. Current forensic bed capacity across the service is 81 beds.

Appraisal
Appraisal compliance is 80.2%, a slight reduction from the previous month and below the organisational target. This reflects the current position within the annual appraisal cycle. Actions are in place to improve compliance, including strengthened management oversight, enhanced monitoring, and the introduction of a new appraisal system, which is expected to improve completion rates, quality, and visibility of performance.

Turnover
Turnover is 17% following a recent workforce deep dive. Further analysis is underway to understand the drivers and inform targeted retention actions.

Advise

FIRM Risk Assessment & Care Planning – Implementation continues following completion of staff training. Compliance remains at 50%, with progress slower than anticipated. Additional oversight and support are being provided to understand barriers to implementation and improve uptake, with performance continuing to be closely monitored through governance arrangements.

Cheswold Park – Integration into the Forensic Care Group continues, with Trust governance and operational frameworks embedding. Quality and safety remain key priorities, supported through the internal Quality Improvement Group and ongoing external assurance. Strategic focus remains on stabilisation, service development, and future planning, including development of a clear clinical and operational model.

Supervision – Compliance remains below target following the introduction of separate managerial and clinical supervision arrangements. Current performance is 70.9% for managerial supervision and 75.0% for clinical supervision. Recovery actions are in place across all services, supported by local management oversight, improved monitoring and clearer expectations. Performance will continue to be closely monitored to ensure recent improvements are sustained and compliance returns to expected levels.

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. Achieving the Trust targets for supervision remain challenging despite work to share information on types of supervision and standardised documentation and continued focussed work is taking place within the care group to improve this position.

The sickness rate remains above threshold and the care group has a firm grip of sickness and the management of sickness absence policy is being followed in all cases, however, the care group are experiencing a number of long term sickness issues.

Barnsley Physical Health and Wellbeing

Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	95.9%	97.7%	88.2%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	0% (0/3)	40% (2/5)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	93.5%	100.0%	100.0%	
% of staff receiving supervision within policy guidance - Clinical	Best Quality	Safe	80%	65.2%	67.4%	61.3%	
% of staff receiving supervision within policy guidance - Management	Best Quality	Safe	80%	42.2%	44.5%	37.8%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.2%	86.8%	88.7%	
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%	97.5%	96.4%	96.6%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	97.5%	97.5%	97.1%	
Safer staffing (Overall)	Best Quality	Safe	90%	96.4%	95.7%	93.0%	
Safer staffing (Registered)	Best Quality	Safe	80%	90.2%	91.9%	93.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.9%	5.3%	5.4%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	25/26 - 99% 26/27 - 52.6%	93.5%	99.1%	96.9%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	7,070	7,029	7,012	
Total number of reported incidents	Best Quality	Safe	Trend monitor	265	261	265	

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 June against the target of 80% are showing a small reduction:
Clinical supervision – 61.3%
Management supervision – 37.8%
Achieving the targets for supervision remain challenging despite work to share information on types of supervision and standardised documentation. Supervision targets are also discussed with each general manager in their governance and performance meetings. The care group Professional Lead is visiting all teams to discuss supervision, understand and address barriers. This has highlighted that access to supervision data is restricted due to reporting hierarchies and management of information. This has been escalated to the Assistant Director for Nursing, Quality and Professions and to the Chief Nurse, and steps are being taken to resolve. Each individual responsible for a team who are below target are being contacted.
• Overall sickness rates have increased slightly for the month of June at 5.4%. We continue to have some instances of long-term sicknesses relating to serious illnesses. The care group 12-month rolling figure is 5.39%. 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 and diagnosis of cancer. In terms of short-term sickness, we are also looking at any correlation between high levels of staff up taking bank shifts alongside increased short-term sickness. We are also ensuring we use the resources available to us in respect of staff off work sick due to stress & anxiety, whether this be home or work related. We have done some significant work to understand the impacts of Musculo-skeletal issues as a cause for sickness within our care group and are supporting good health & safety practices including lifting and handling, back care and the use of equipment.

Advise

• 2 instances of feedback with staff values and behaviours as an issue has been recorded during June. The instances relate to one of our Neighbourhood Nursing Team (NNS) and the other to Urgent Community Response (UCR) team. We are currently awaiting consent from the patient/family via the Trust's Customer Services team and will be investigating further once the scope has been agreed.
• 18-week waiters - Overall, our community services are achieving the national expectation of 78% of being seen within 18 weeks, with a slight increase to 90.4% for June.
We continue to undertake focussed work on the long waiters in our Children's SALT (Speech and Language Therapy) service which are impacting the percentage of people on waiting lists. However the number of C&YP waiting over 18 weeks is reducing. Longer wait times are linked to an increase in complex patients requiring a longer stay on the caseload. Ongoing work includes the remedial action plan and the full review of the Children's SALT service. This is part of the Trust's Value for Money workstream which has identified and escalated a financial shortfall across Children's Therapy services. In addition, the review will look to improve service efficiencies alongside a reduction in waiting times.
• Medical devices – compliance has improved substantially to approximately 81%, close to the Trust-wide level of 82%. Assurance has been provided that out-of-date medical devices are not being used and contingency arrangements are in place. One of the challenges in achieving compliance that the care group is experiencing recently is that staff have been taking their kit for servicing and the provider has been running out of time to complete these during the advertised session. These instances have been reported via Datix.
• Friends and Family Test (FFT) – 94% of people would recommend community services; this is very slightly below the target of 95%. The total number of responses is still lower than previous years following the introduction of the new system in April but has seen a good increase in volume during June 2026.

Barnsley Physical Health and Wellbeing Care Group

Assure

Assure to provide positive news on performance, best practice or celebrate awards!

• Appraisal reporting is transitioning from the requirement to have an appraisal in the last 365 days to being based on having an appraisal within the financial year with a completion date of the end of September. The first target was for Bands 8a and above to have a completed appraisal by 30 June.
To note: Appraisal compliance using the previous system is at 96.9% for June (as at 21.7.26).
The overall care group figure for progress against the new timelines as at 21.7.26 is > Band 8a - 98.2%
The next target is for Bands 7 and below to have a completed appraisal by 30 September.

• Paediatric Audiology 6-week target for diagnostic procedures is maintaining compliancy with the national trajectory, achieving 96.9% for June.
The total number on the waiting list as at 12.7.26 was further reduced to 84 patients, with only 1 waiting over 6 weeks.

• Virtual Ward occupancy levels for June are achieving compliance at 86.7%. We are continuing to closely monitor occupancy levels moving into quarter 2 based on capacity to safely support patients on both pathways.

• Information Governance training has achieved 96.6% for June, maintaining compliancy with a continued focussed effort on monitoring by managers.

• Urgent Community Response Service 2-hour target has achieved 81.8% for June 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) – 97.12% for June.

• People dying in their place of choosing remains fully compliant and has sustained 100% for June, exceeding the 80% threshold.

• CPR training maintains compliance at 88.7% for June.

• Clinically Ready for Discharge – the Care Group is fully compliant at 0%. Sustained compliance on our 2 wards is due to most admissions/discharges being planned. Anticipated discharge dates are set on admission and discussed at the weekly MDT, adjusting when clinically appropriate.

• 52-week waiters – the care group continues to achieve compliance at 0%.

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

During June the service operated at OPEL level 3, with the pressure being sustained and triggering OPEL level 4 for a 2-week period. Lead nurses, ward managers, and matrons have prioritised support of the clinical pressures and as a consequence, we are noting some impact on performance oversight. Nostell is red in a number of performance areas. This is linked to a high number of registered staff being on preceptorship and Band 5 absence (sickness, maternity leave). The ward manager and lead nurse have worked in clinical numbers to support, and this is impacting on their ability to maintain oversight of both performance and quality (e.g. risk assessment compliance). The Mental Health Nursing Lead for the Care Group is meeting with the matron and leadership team to discuss a plan to provide additional support to the preceptees. Additionally, the Senior Leadership Team has met with colleagues from NQ&P to review the support offer from the Non-Medical Education Team, including restorative supervision. Nostell will also link into the quality improvement group work being undertaken on Elmdale with Chief Nurse oversight to share data insights, learning, and improvement ideas.

Appraisal
- Several wards are outside of the 90% compliance threshold in June.
- Reporting is based on appraisals completed within the last 12months and there will be variance in appraisal compliance rates due to ward teams transitioning to the new fixed appraisal window and aligning with timeframes for cascading appraisals.
- Ward teams are working to have all appraisals completed by 30th September as per the newly implemented appraisal window.
- Oversight of appraisal performance is maintained by the senior leadership team at the weekly inpatient quality and performance meeting.

Sickness
- 8 wards have sickness rates below 5% compliance threshold.
- Sickness improved to below threshold in June on Willow, Ward 19 Male, Enfield Down and Lyndhurst.
- Sickness increased to above threshold on Beamshaw (7.3%), Nostell (5.2%), Ashdale (6.4%), and Beechdale (5.8%) due to both short-term and long-term sickness. A theme in short-term sickness is both cold/flu and gastrointestinal issues. A theme in long-term sickness is anxiety/stress/depression – a mix of both personal and work-related factors.
- Walton sickness has increased above threshold to 16.3% due to both short-term and long-term sickness. A theme in the short-term sickness is work-related injury following incidents of violence and aggression.
- Although still above threshold, sickness on Stanley (8.7%) and Crofton (8.4%) has reduced following the return of staff from long-term sickness.
- Sickness remains above threshold and has increased on Poplars (14.5%) and Ward 19 Female (7.5%) due to both long-term and short-term sickness absences (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
- 11 wards are above the 80% compliance target for clinical supervision in June.
- 10 wards are above the 80% compliance target for management supervision in June.
- Nostell are considerably below compliance for both clinical (59.4%) and management (53.1%) supervision because of both the ward manager and lead nurse working in clinical numbers on multiple occasions to support safer staffing and ensure registered nurse cover to support preceptees. The care group are working closely with NQ&P colleagues to review the support offer to Nostell, including restorative supervision delivered by the NMET team.
- Clark is below compliance for both clinical (63%) and management (66.7%) due to both acuity and ward manager absence. Oversight is being supported by the matron.
- Stanley is below compliance for both clinical (66.7%) and management (63.9%) due to clinical acuity. Efforts have been made by the leadership team to prioritise staff outside compliance and current compliance is 79.5% for both clinical and management (as of 20.7.26).
- Walton and Ashdale are below the 80% supervision compliance for both clinical and managerial but are above 70% and have been impacted by high clinical pressures. Ashdale are also impacted by ward manager absence, and oversight is being supported by the matron.
- Crofton are above compliance for clinical supervision but remain below compliance for management supervision (69.6%) impacted by ongoing ward manager absence. However, performance has improved compared to May following focused efforts from the ACP and Band 6 supported by the matron.
- Lyndhurst compliance for both clinical (76.9%) and management (76.9%) is still under compliance but has improved compared to May following the return of the ward manager who is overseeing a plan to target staff outside of compliance.
- The senior leadership team maintain close oversight of supervision compliance via the weekly inpatient quality and performance meeting – a theme identified from this oversight is the impact of increased acuity (both on delivery of supervision and in terms of releasing staff to attend).

Mandatory Training
Information Governance (IG)
- 14 wards are above 95% compliance target for June.
- Enfield Down (94.1%) performance has improved comparative to May. Further focused work has been undertaking to target the 3 staff members outstanding and current compliance is 100% (as of 20/07/26).
- Clark (92.9%) and Ashdale (94.6%) have all dropped under threshold. Staff outside of compliance are being supported to complete the e-learning training as a priority.
- The senior leadership team maintain close oversight of information governance training compliance via the weekly inpatient quality and performance meeting.

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

Mandatory Training Continued

Cardiopulmonary resuscitation (CPR)

• 13 wards are at or above the CPR training compliance threshold in June.
• Ward 18 (68.4%) remains below compliance. The Ward Manager has booked staff onto the earliest available dates and all staff outside compliance are booked to attend training throughout July, August, and September.
• Ward 19 Female (68.2%) remain below compliance impacted by long-term sickness and maternity leave. Staff able to attend training have either recently attended a July training date or are booked onto dates in August. Current compliance is 72.7% (as of 20/07/26).
• Melton (79.4%) and Lyndhurst (74.1) have dropped just below compliance with staff booked on courses in July and August.

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.

Fire Safety

• 14 wards are above fire safety training compliance threshold.
• Stanley (83.3%) remains below compliance in June. Staff have attended recent training sessions and current compliance is above threshold at 89.3% (as of 20/07/26).
• Ward 19 Female (77.3%) remain below compliance impacted by long-term sickness. Current performance is 82.6% (as of 20/07/26) with staff who are able to attend training booked on dates in August.
• Poplars (78.8%) dropped outside compliance in June. A bespoke training session has been arranged at the Poplars on 6th August, and staff outside compliance will be attending.

Bed Occupancy

• Beamshaw (115.5%) overoccupancy is reflective of their use of swing beds shared with Clark and over admissions into non-designated bedroom (e.g. quiet lounge) of service users whose risk couldn't be safely managed by alternatives to admission.
• Melton (109.4%) overoccupancy reflects over admissions into non-designated bedroom (e.g. Extra Care Area) of service users whose risk couldn't be safely managed by alternatives to admission.
• Stanley (107%) overoccupancy is reflective of their use of swing beds shared with Nostell and admissions into the bed of a service users nursed in Extra Care Area.
• Where wards are overoccupancy, staffing levels are reviewed and where necessary increased to maintain wards safety.
• 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 calculations at Poplars is based on 15 beds, however they operate with a maximum capacity of 12 beds, agreed with commissioners several years ago.
• 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 June:
  • Melton ALOS was 337 days. This relates to 3 discharges – 2 of those had a LOS under 40 days, 1 service user was subject to MoJ restrictions and had a LOS of 977 days.
  • Enfield Down ALOS in June relates to 1 discharge – LOS for this service user was 432 days.
• The nature and function of Rehab and Recovery Units mean service users will have longer length of stays.
• Rehab and Recovery length of stays also include any acute/PICU ward stays.

Safer Staffing

• There has been no approved review of older adult staffing establishments since 2016. Overall safer staffing rates being above 100% on OPS wards reflects wards being staffed to maintain patient safety in relation to service users: at risk of falls and with frailty; escorts to the acute trust due to complex physical health; complex dementia diagnoses and associated increased levels of violence and aggression. This is particularly pertinent for Poplars who are an isolated unit and whose service user population is people diagnosed with dementia.
• The high overall safer staffing rates in June for Poplars (219.3%) reflects staffing increases for the reasons outlined above.
• Crofton (159.1%) safer staffing reflects staffing increases to support a small number of service users with complex needs requiring enhanced observation levels for a sustained period. The service is undertaking a deep dive into temporary staffing use on Crofton to increase our understanding and plan appropriate actions.

Clinically Ready for Discharge (CRFD)

• CRFD rates are significantly above threshold on:
  • Poplars CRFD is 19.5% and is reflective of a number of service users awaiting placements.
  • Ward 19 Male CRFD is 16.0% and is reflective of 2 service users, one who has been recently discharged. The other is awaiting placement.
• 10 other wards are above the threshold for CRFD with Walton above 10%. This is due to the number of service users with complex needs who are awaiting placement or suitable accommodation and also one service user awaiting MoJ permissions.
• Across all wards the multi-disciplinary team continue to collaborate to progress pathways as timely as possible.
• There is a weekly check and challenge meeting led by the Director of Service to ensure senior oversight and focus and timely external escalations.

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

FIRM Risk assessments

• To understand the breaches, the inpatient SLT have recently reviewed and mapped the process for completing a risk assessment within 24hours of admission. As a result of this QI work, we have reviewed and agreed practice standards for documenting the review of FIRM risk assessments on admission. These locally agreed standards were implemented on 22nd June and have been shared into the trust wide risk assessment quality improvement work. It is anticipated that performance results should start to improve in July data and be above compliance threshold in August data.
• Overall compliance in June was 89.6% (16 breaches) for 24hr target and 93.5% (10 breaches) completed within 48hrs.
• During June, Elmdale, Ward 19 Female, and Crofton had 1 FIRM breach each. Clark and Ward 19 Male had 2 breaches. Nostell ,Ashdale, and Ward 18 have 3 breaches each.
• Several June 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.
• 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.

Physical violence (Patient on Patient)

• 22 incidents of patient-on-patient physical violence throughout June across multiple wards.
• 7 incidents on Ashdale and 5 incidents on Ward 18, related to a small number of service users and reflective of 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.

Physical violence (Patient on Staff)

• 12 incidents on Clark; 10 incidents on Walton; 8 incidents on Ward 18 and Elmdale. Relate to a small number of service user with a risk profile of violence and aggression.
• 10 incidents on Poplars (16) relate to a small number of service users with behavioural and psychological symptoms of dementia and 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 RRP 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 Clark (11), Walton (13), Ward 18 (14) and Elmdale (14) 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 (23) is reflective of current patient population and the presentation and risk profile of service users, including restraint to prevent self-harm.
• High incidence on Crofton (21) relate to a small number of service users where restraint has been used to manage risk of violence and aggression or administer intramuscular medication.
• Ward teams seek advice and support from RRPI specialist advisors as needed to inform individualised and person-centred care planning for those service users with a known risk of violence and aggression.

Prone restraint incidents

• 4 incidents of staff led prone restraint in June:
  • Nostell (1) Service user led. Incident of violence and aggression. SU placed self in prone – supine position increases distress/aggression.
  • Walton (1); Stanley (1); Elmdale (1) – All staff led to administer intramuscular medication. Prone position assessed as safest option due to level of aggression. All incidents reviewed by RRP Team specialist advisors and feedback provided to ward teams.
• Prone restraint as an emergency intervention is still taught within RRP 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.

Cancelled S17 Leave

• Beamshaw (1) and Nostell (1) - cancellations due to staffing.
• Clark (4) – 2 cancellations due to staff. 2 cancellations due to patients being unwell.
• Crofton (1) – Cancellation due to availability of accessible taxi.
• Poplars (1), Willow (1) and Enfield Down (2) - cancelled due to patients being unwell.

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Suite			Clark Suite		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	94.4%	88.2%	100.0%	100.0%	94.7%
Sickness	Best place to work and learn	Well led	5.0%	3.5%	4.8%	7.3%	0.7%	4.2%	4.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	89.3%	100.0%	92.6%	89.3%	100.0%	63.0%
Supervision - Management	Best place to work and learn	Well led	80%	89.3%	100.0%	92.6%	78.6%	89.3%	66.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	96.6%	96.6%	92.9%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.9%	92.9%	96.2%	89.7%	93.1%	96.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.3%	92.9%	88.5%	96.6%	96.4%	96.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.6%	89.3%	88.5%	100.0%	100.0%	92.9%
Bed occupancy**	Best Quality	Safe	85%	93.7%	103.2%	115.5%	93.7%	103.2%	88.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	79	35	70	37	51	20
Safer staffing (Overall)	Best Quality	Safe	90%	108.3%	117.2%	110.9%	110.9%	114.2%	119.9%
Safer staffing (Registered)	Best Quality	Safe	80%	98.3%	97.3%	89.9%	100.8%	102.0%	99.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	16.3%	5.4%	5.7%	11.8%	13.9%	7.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	100.0%	90.0%	81.8%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	0	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	1	7	4	12
Restraint incidents	Best Quality	Safe	Trend Monitor	3	2	*2*	9	9	*11*
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	0% (0/17)	0% (0/38)	3% (1/31)	0% (0/18)	10% (3/30)	14% (4/29)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	4	10	4	3	14

*** 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 Apr-26	Melton Suite May-26	Melton Suite Jun-26	Nostell Apr-26	Nostell May-26	Nostell Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	96.2%	100.0%	85.2%	100.0%	100.0%	75.0%
Sickness	Best place to work and learn	Well led	5.0%	11.8%	3.3%	3.8%	1.0%	1.7%	5.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	97.0%	96.9%	87.5%	60.0%	79.3%	59.4%
Supervision - Management	Best place to work and learn	Well led	80%	97.0%	96.9%	87.5%	73.3%	93.1%	53.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.9%	93.8%	97.1%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.6%	84.4%	94.1%	96.4%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	84.4%	79.4%	89.3%	96.6%	96.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.9%	100.0%	94.1%	89.3%	86.2%	85.7%
Bed occupancy	Best Quality	Safe	85%	97.2%	104.3%	109.4%	99.6%	98.8%	93.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	15	37	337	29	50	43
Safer staffing (Overall)	Best Quality	Safe	90%	111.2%	114.4%	112.0%	104.8%	117.1%	111.7%
Safer staffing (Registered)	Best Quality	Safe	80%	91.6%	95.0%	90.6%	122.2%	123.7%	126.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	15.1%	1.5%	0.0%	4.8%	8.2%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	84.6%	70.0%	75.0%
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	1	4	6	6
Restraint incidents	Best Quality	Safe	Trend Monitor	5	2	*6*	27	17	*23*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	N/A	0% (0/38)	0% (0/3)	0% (0/110)	0% (0/110)	1% (1/87)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	7	12	7	12	33

*** 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 Apr-26	Stanley May-26	Stanley Jun-26	Walton Apr-26	Walton May-26	Walton Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	90.9%	96.7%	96.8%	83.3%
Sickness	Best place to work and learn	Well led	5.0%	9.3%	8.7%	7.2%	4.6%	5.0%	16.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	87.5%	87.5%	66.7%	87.8%	95.0%	74.4%
Supervision - Management	Best place to work and learn	Well led	80%	90.6%	81.3%	63.9%	87.8%	87.5%	76.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.0%	93.9%	97.2%	100.0%	97.5%	97.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	97.0%	93.9%	94.4%	97.5%	97.5%	92.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	93.9%	90.9%	86.1%	82.5%	85.0%	87.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	84.8%	83.3%	95.0%	95.0%	92.3%
Bed occupancy**	Best Quality	Safe	85%	99.6%	98.8%	107.0%	94.3%	94.0%	96.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	58	42	50	159	22	42
Safer staffing (Overall)	Best Quality	Safe	90%	100.0%	108.2%	104.6%	124.0%	115.9%	123.1%
Safer staffing (Registered)	Best Quality	Safe	80%	96.5%	95.1%	93.9%	95.2%	88.1%	89.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	15.4%	14.7%	9.3%	29.3%	13.4%	14.4%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	4	3	4	5	10
Restraint incidents	Best Quality	Safe	Trend Monitor	6	6	*10*	15	27	*13*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	2	0	1	1	1	1
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/165)	0% (0/131)	0% (0/226)	0% (0/165)	0% (0/99)	N/A
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	9	21	6	6	16

*** 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		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	91.7%	100.0%	91.7%	95.2%	87.0%	75.0%
Sickness	Best place to work and learn	Well led	5.0%	4.6%	4.0%	6.4%	3.4%	1.8%	3.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	78.8%	74.3%	76.5%	62.2%	60.6%	92.1%
Supervision - Management	Best place to work and learn	Well led	80%	75.8%	74.3%	73.5%	62.2%	66.7%	92.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	97.1%	94.6%	94.3%	86.5%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.2%	88.6%	86.5%	91.4%	89.2%	92.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.8%	82.4%	83.3%	80.0%	73.0%	68.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.1%	94.3%	91.9%	94.3%	81.1%	92.1%
Bed occupancy	Best Quality	Safe	85%	94.0%	98.1%	99.2%	98.3%	99.9%	100.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	53	52	59	20	24	32
Safer staffing (Overall)	Best Quality	Safe	90%	123.1%	117.2%	119.0%	114.4%	119.3%	112.6%
Safer staffing (Registered)	Best Quality	Safe	80%	103.1%	101.0%	106.4%	114.9%	110.2%	112.6%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	13.8%	11.1%	6.9%	0.3%	1.8%	0.9%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	57.1%	72.7%	81.3%	100.0%	100.0%	86.4%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	6	3	7	2	1	5
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	1	3	8	3	8
Restraint incidents	Best Quality	Safe	Trend Monitor	6	3	*3*	7	5	*14*
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	0% (0/663)	0% (0/630)	0% (0/636)	0% (0/562)	0% (0/604)	0% (0/588)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	6	7	8	4	10

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale Apr-26	Elmdale May-26	Elmdale Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	100.0%	95.5%
Sickness	Best place to work and learn	Well led	5.0%	4.6%	3.5%	3.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	94.1%	94.1%	91.7%
Supervision - Management	Best place to work and learn	Well led	80%	94.1%	94.1%	88.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	97.1%	97.2%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.5%	97.1%	86.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	96.7%	90.9%	82.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.3%	91.2%	97.2%
Bed occupancy	Best Quality	Safe	85%	89.7%	92.7%	94.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	37	51	52
Safer staffing (Overall)	Best Quality	Safe	90%	99.3%	108.9%	111.9%
Safer staffing (Registered)	Best Quality	Safe	80%	101.9%	101.0%	103.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	6.3%	7.6%	7.4%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	95.0%	100.0%	95.2%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	4	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	7	8
Restraint incidents	Best Quality	Safe	Trend Monitor	3	13	*14*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	1
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/275)	0% (0/239)	0% (0/252)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	5	9	15

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton			Poplars CUE		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	77.8%	78.9%	73.7%	93.3%	100.0%	89.3%
Sickness	Best place to work and learn	Well led	5.0%	9.4%	15.0%	8.4%	3.2%	8.3%	14.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	76.9%	50.0%	87.0%	93.9%	88.2%	85.7%
Supervision - Management	Best place to work and learn	Well led	80%	73.1%	41.7%	69.6%	93.9%	85.3%	85.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.2%	100.0%	100.0%	97.0%	96.9%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.3%	100.0%	92.6%	84.4%	87.5%	81.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	79.2%	81.8%	80.0%	90.6%	93.5%	96.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.2%	95.8%	88.9%	84.8%	87.5%	78.8%
Bed occupancy	Best Quality	Safe	85%	76.5%	89.9%	100.8%	69.3%	64.7%	72.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	105	29	57	114	109	114
Safer staffing (Overall)	Best Quality	Safe	90%	169.8%	158.5%	159.1%	207.7%	210.6%	219.3%
Safer staffing (Registered)	Best Quality	Safe	80%	123.7%	110.4%	120.3%	108.6%	112.5%	110.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	6.4%	0.0%	0.0%	43.5%	27.9%	19.5%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	90.9%	N/A	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	2	0	1	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	4	13	16	10
Restraint incidents	Best Quality	Safe	Trend Monitor	7	2	*21*	27	17	*12*
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	0% (0/5)	0% (0/23)	5% (1/20)	7% (1/14)	33% (2/6)	9% (1/11)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	10	29	22	31	55	68

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow			Beechdale		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	93.8%	94.1%	81.3%	100.0%	100.0%	83.3%
Sickness	Best place to work and learn	Well led	5.0%	7.0%	5.2%	2.5%	6.8%	3.9%	5.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	83.3%	68.8%	88.2%	100.0%	100.0%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	83.3%	68.8%	88.2%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	87.5%	93.8%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	81.3%	81.0%	94.1%	95.7%	95.7%	95.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	93.8%	82.4%	95.5%	95.5%	95.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.8%	100.0%	100.0%	95.7%	100.0%	95.7%
Bed occupancy	Best Quality	Safe	85%	77.7%	95.8%	94.3%	90.6%	98.0%	99.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	57	61	50	139	120	170
Safer staffing (Overall)	Best Quality	Safe	90%	112.9%	114.2%	121.7%	144.3%	136.1%	155.8%
Safer staffing (Registered)	Best Quality	Safe	80%	93.3%	80.3%	87.1%	101.7%	102.6%	103.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	8.4%	2.1%	5.0%	14.3%	10.7%	4.6%
% 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	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	3	0	*4*	0	1	*1*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	N/A	0% (0/23)	2% (1/67)	0% (0/17)	0% (0/32)	0% (0/27)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	7	18	3	5	7

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male			Ward 19 - Female		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	93.8%	100.0%	100.0%	100.0%	94.4%
Sickness	Best place to work and learn	Well led	5.0%	4.2%	8.5%	4.0%	7.8%	6.4%	7.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	95.7%	95.5%	95.8%	94.4%	94.7%	95.0%
Supervision - Management	Best place to work and learn	Well led	80%	95.7%	100.0%	100.0%	100.0%	100.0%	95.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.3%	88.0%	100.0%	100.0%	100.0%	95.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.5%	88.0%	87.5%	85.0%	85.7%	90.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	69.2%	72.0%	83.3%	65.0%	76.2%	68.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	76.9%	80.0%	95.8%	70.0%	71.4%	77.3%
Bed occupancy	Best Quality	Safe	85%	88.2%	101.3%	96.2%	85.3%	95.7%	94.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	76	96	109	96	73	82
Safer staffing (Overall)	Best Quality	Safe	90%	129.0%	132.1%	122.4%	119.6%	130.8%	152.3%
Safer staffing (Registered)	Best Quality	Safe	80%	88.3%	93.7%	90.9%	106.0%	106.6%	109.8%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	1.3%	2.7%	16.0%	11.6%	2.4%	9.7%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	71.4%	85.7%	100.0%	83.3%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	0	0	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	2	0	6	1	2
Restraint incidents	Best Quality	Safe	Trend Monitor	5	1	*1*	5	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	0% (0/50)	0% (0/54)	0% (0/42)	0% (0/10)	0% (0/14)	0% (0/13)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	1	0	17	5	11

Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down			Lyndhurst		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	97.9%	100.0%	89.4%	92.3%	92.3%	80.0%
Sickness	Best place to work and learn	Well led	5.0%	4.2%	6.1%	3.2%	8.1%	7.6%	2.4%
Supervision - Clinical	Best place to work and learn	Well led	80%	89.1%	95.7%	97.8%	74.1%	69.2%	76.9%
Supervision - Management	Best place to work and learn	Well led	80%	87.0%	30.4%	97.8%	74.1%	57.7%	76.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	90.4%	94.1%	96.3%	92.3%	96.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.3%	84.6%	84.3%	88.9%	92.3%	81.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.7%	89.1%	87.0%	81.5%	84.6%	74.1%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.2%	96.2%	92.2%	92.6%	96.2%	92.6%
Bed occupancy	Best Quality	Safe	Trend Monitor	53.8%	56.4%	63.1%	56.0%	52.3%	51.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	18	307	432	69	1161	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.1%	98.0%	98.3%	101.6%	102.7%	98.5%
Safer staffing (Registered)	Best Quality	Safe	80%	97.6%	97.5%	99.2%	103.5%	101.2%	97.7%
% 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	50.0%	N/A	N/A	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	1	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*1*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/102)	0% (0/104)	2% (2/121)	0% (0/22)	4% (1/25)	0% (0/30)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	4	0	0	1	0

Inpatients - Forensic West Yorkshire - Medium Secure

Medium Secure

• A continued focus on high-quality appraisals remains a priority for the service, with focused intervention to ensure all staff have a quality appraisal. As the service moves into the new appraisal compliance window, some expected variation in compliance data has been observed. Positively, Bronte, Hepworth and Waterton remain at 100% compliance. Compliance levels on Appleton (80%), Johnson (80.8%), Chippendale (84.2%), and Priestley (87.5%) are lower but remain under review as teams continue to adapt to the revised appraisal cycle.

• Separation of supervision recording has highlighted inconsistencies in distinguishing management and clinical supervision. A targeted QI programme, led by Ward Managers, is underway to strengthen supervision structures, quality and recording. This includes clarifying supervision trees to ensure all staff receive appropriate management, clinical, and primary nursing support. Current focus is on embedding clear, consistent recording systems and improving capture of group supervision (e.g. reflective practice) to strengthen oversight. Overall, an improving trajectory is noted.

• Sickness absence continues to improve overall with five wards (Johnson, Priestley, Hepworth, Bronte and Appleton) within compliance. Chippendale (7.1%) and Waterton (18.3%) continue to experience high sickness absence. Targeted interventions remain in place, addressing both short- and long-term absence to sustain improvement. Waterton continues to report individual challenges with the number of staff requiring long-term sickness absence, with a notable proportion of staff requiring surgery. Due to the extended nature of these absences, this continues to present a challenge; however, improvement has been seen in short-term sickness absence, and work remains ongoing.

• There have been improvements in mandatory training, however hotspots remain in Information Governance (IG), on Appleton (88.9%), Chippendale (94.7%) and Waterton (94.4%). This is considered to be a seasonal issue, reflecting the number of staff requiring updates during this period and all Ward Managers have a plan in place to improve compliance. A further hotspot in relation to CPR has shown overall improvement; however, Hepworth (76.2%) and Priestley (77.8%) continue to require focused attention and monitoring. We do understand that the Challenges have been identified in releasing staff from shifts to attend CPR training. Staff have therefore been advised not to book onto sessions during shifts.

• Bed occupancy on Appleton remains low at 50.0%, reflecting a continued reduction in learning disability referrals to secure care. Occupancy in the women's service has seen a period of unusual variation, with Johnson Ward (medium secure) at 100%. On the male pathway, although overall occupancy appears reduced within the data, our capacity is within our admission wards and rehabilitation wards are at full capacity. This demonstrates a positive position for patient flow. Where there is reduced occupancy on Hepworth (79.8%), this is to support process for new admissions. The service has a waiting list for our male pathway.

• There were three prone restraints with the service. All these related to one service user, with individual complexities and risks. Prone restraint was due to medication and seclusion exit. All have been reviewed by RRPI and ongoing advice and support to reduce prone restraint where possible is in place. Incidents of restraint show broad consistency.

•The service continues to experience high levels of acuity, during June both Chippendale and Bronte were 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 100% compliant in this review period and this will be continued to be monitored.

• 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 absence levels continue to be monitored closely, with Ward Managers working alongside the People Directorate and Occupational Health to support staff and improve attendance. Newhaven remains within compliance (4.9%). Current sickness absence rates for, Sandal (6.9%) and Thornhill (5.9%) remain above the compliance target, reflecting a combination of both short- and long-term sickness absence.

A particular hotspot has been identified on Ryburn (28.4%). Given the small size of the service, sickness levels can be disproportionately affected by a small number of absences and there are currently several staff members on long term sickness absence.

Ward Managers, with support from the People Directorate, continue to actively review the position and implement appropriate support measures. Planned return to work arrangements are expected to contribute to further improvements in long term sickness absence levels over the coming months.

• Mandatory training compliance remains positive across the service. Hotspots for this month are IG training, which is recognised as an annual pressure point, and remains at Newhaven (93.3%) and Thornhill (76.5%). CPR is an additional hotspot on Sandal (65.5%) and Thornhill (76.5%). The service has had challenges in the release of staff from shift for this ½ day training and have requested staff to not book this whilst on shift to support attendance. Targeted actions are in place to improve compliance.

• A continued focus on high quality appraisals remains a priority for the service. Thornhill (96.7%) and Ryburn (100%) are within agreed performance standards. Current compliance stands at 74.2% for Newhaven and 83.8% for Sandal with a clear plan for an improving trajectory in place and lead by the Ward Manager. Work has taken place to address data quality issues, and the service remains committed to ensuring that all staff receive a timely and high-quality appraisal.

• Separation of supervision recording has highlighted inconsistencies in distinguishing management and clinical supervision. A targeted quality improvement programme, led by Ward Managers, is underway to strengthen supervision structures, quality and recording. This includes clarifying supervision trees to ensure all staff receive appropriate management, clinical, and primary nursing support. Current focus is on embedding clear, consistent recording systems and improving capture of group supervision (e.g. reflective practice) to strengthen oversight. The impact of the actions implemented to date is evidenced by improving compliance On Newhaven. Progress on Ryburn has been slower than anticipated due to a period of leadership absence, which has affected the pace of improvement. To mitigate this, temporary leadership support has been identified and is being implemented to provide additional oversight and drive further improvement in compliance.

• 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.

• The service continues to work closely with the provider collaborative to support effective use of bed occupancy across West Yorkshire. The Bretton Centre currently has good occupancy with processes in place to support admissions. Newhaven (81.3%) has noted unusual variation with some increased occupancy but overall continues to experience lower level of referrals and has no waiting list.

• There were no prone restraint incidents, and Incidents of restraint show broad consistency.

• Safer staffing levels are within the expected compliance range. Increased acuity on Sandal (183.9%) 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 Apr-26	Appleton May-26	Appleton Jun-26	Bronte Apr-26	Bronte May-26	Bronte Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	93.3%	93.3%	80.0%	95.0%	95.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.0%	5.3%	4.4%	0.9%	0.0%	0.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	66.7%	70.6%	83.3%	65.2%	95.7%	90.9%
Supervision - Management	Best place to work and learn	Well led	80%	53.5%	58.8%	66.7%	4.3%	13.0%	54.5%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.4%	88.9%	88.9%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	94.4%	100.0%	100.0%	95.5%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	88.9%	83.3%	83.3%	66.7%	68.2%	81.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	77.8%	88.9%	88.9%	90.5%	90.9%	85.7%
Bed occupancy	Best Quality	Safe	90%	50.0%	50.0%	50.0%	88.1%	88.5%	98.6%
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%	134.8%	125.0%	93.8%	98.2%	98.6%	122.8%
Safer staffing (Registered)	Best Quality	Safe	80%	96.1%	89.7%	91.6%	99.1%	98.0%	112.4%
% 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	100.0%	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	0	0	1	4
Restraint incidents	Best Quality	Safe	Trend Monitor	6	2	*2*	2	1	*11*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	3
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	0% (0/4)	N/A	N/A	0% (0/6)	0% (0/8)	100% (6/6)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	8	1	0	0	5

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale			Hepworth		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	94.4%	89.5%	84.2%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	5.3%	5.2%	7.1%	1.3%	1.2%	4.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	90.0%	84.2%	78.9%	50.0%	75.0%	55.0%
Supervision - Management	Best place to work and learn	Well led	80%	90.0%	68.4%	42.1%	35.0%	40.0%	10.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	94.7%	94.7%	100.0%	95.0%	95.2%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	84.2%	100.0%	89.5%	75.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.0%	94.7%	84.2%	78.9%	85.0%	76.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.0%	94.7%	94.7%	84.2%	80.0%	95.2%
Bed occupancy	Best Quality	Safe	90%	91.7%	98.4%	96.1%	80.9%	83.9%	79.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	814	N/A	N/A	66
Safer staffing (Overall)	Best Quality	Safe	90%	99.0%	97.6%	122.1%	99.2%	95.3%	95.9%
Safer staffing (Registered)	Best Quality	Safe	80%	111.8%	107.5%	125.0%	86.1%	87.1%	89.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	66.7%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	1	1	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	*1*	0	2	*1*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	8% (2/26)	13% (4/31)	10% (3/31)	40% (2/5)	0% (0/4)	50% (1/2)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	2	14	1	0	1

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson			Priestley		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	96.2%	80.8%	76.5%	88.2%	87.5%
Sickness	Best place to work and learn	Well led	5.0%	2.6%	3.7%	2.7%	5.2%	5.1%	4.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	96.7%	66.7%	62.5%	61.1%	66.7%	78.9%
Supervision - Management	Best place to work and learn	Well led	80%	50.0%	51.5%	65.6%	55.6%	55.6%	57.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.9%	90.6%	96.9%	100.0%	94.7%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	78.8%	90.6%	93.8%	94.4%	88.9%	94.4%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	75.8%	87.5%	87.5%	88.9%	83.3%	77.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	90.6%	93.8%	89.5%	89.5%	89.5%
Bed occupancy	Best Quality	Safe	90%	100.0%	100.0%	100.0%	98.0%	94.1%	93.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	775	1389	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	131.0%	112.8%	103.9%	107.8%	134.7%	90.9%
Safer staffing (Registered)	Best Quality	Safe	80%	100.6%	96.8%	99.5%	101.5%	92.3%	88.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% 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	1	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	*0*	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	6% (2/34)	12% (3/26)	13% (5/39)	21% (6/28)	0% (0/14)	52% (11/21)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	1	3	4	2	1

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton Apr-26	Waterton May-26	Waterton Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	93.3%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	7.6%	22.9%	18.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	44.0%	40.0%	75.0%
Supervision - Management	Best place to work and learn	Well led	80%	24.0%	32.0%	62.5%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	94.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.3%	90.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	73.9%	85.0%	88.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	91.3%	90.0%	88.9%
Bed occupancy	Best Quality	Safe	90%	99.6%	97.6%	92.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	1359	N/A	1514
Safer staffing (Overall)	Best Quality	Safe	90%	107.9%	109.2%	97.8%
Safer staffing (Registered)	Best Quality	Safe	80%	96.3%	103.1%	99.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/72)	1% (1/80)	20% (5/25)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	3	5

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill Apr-26	Thornhill May-26	Thornhill Jun-26	Sandal Apr-26	Sandal May-26	Sandal Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	81.5%	96.7%	96.7%	88.0%	91.3%	83.3%
Sickness	Best place to work and learn	Well led	5.0%	15.2%	7.5%	5.9%	7.0%	3.1%	6.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	45.5%	47.1%	52.9%	36.4%	46.9%	48.5%
Supervision - Management	Best place to work and learn	Well led	80%	33.3%	38.2%	41.2%	21.2%	34.4%	33.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	96.9%	94.1%	96.6%	96.4%	96.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.6%	96.9%	97.1%	89.7%	92.9%	93.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.4%	87.5%	76.5%	65.5%	67.9%	65.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.8%	100.0%	97.1%	89.7%	85.7%	93.1%
Bed occupancy	Best Quality	Safe	85%	94.7%	96.3%	96.0%	95.4%	91.3%	93.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	1900	N/A	1400	162	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	95.7%	97.5%	95.4%	138.1%	151.3%	183.9%
Safer staffing (Registered)	Best Quality	Safe	80%	102.1%	101.4%	100.3%	105.4%	105.0%	105.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	100.0%	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	1	0	0	4	2	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	0	2	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	2	0	*0*	7	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	7% (10/135)	20% (34/168)	32% (34/108)	8% (6/74)	5% (1/20)	10% (4/39)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	0	20	15	20

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn Apr-26	Ryburn May-26	Ryburn Jun-26	Newhaven Apr-26	Newhaven May-26	Newhaven Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	100.0%	74.2%	74.2%	81.5%
Sickness	Best place to work and learn	Well led	5.0%	19.4%	17.6%	28.4%	1.0%	0.5%	4.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	58.3%	23.1%	30.8%	67.7%	90.3%	92.3%
Supervision - Management	Best place to work and learn	Well led	80%	58.3%	30.8%	23.1%	83.9%	71.0%	88.5%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	94.1%	94.1%	93.3%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.9%	81.8%	90.0%	93.5%	91.2%	90.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.8%	90.9%	100.0%	87.1%	90.3%	92.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.9%	100.0%	100.0%	94.1%	94.1%	96.7%
Bed occupancy	Best Quality	Safe	85%	81.9%	85.7%	87.6%	75.0%	77.2%	81.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.3%	99.0%	97.4%	113.0%	114.8%	104.6%
Safer staffing (Registered)	Best Quality	Safe	80%	96.7%	99.5%	97.6%	102.7%	102.1%	102.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	N/A	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	2
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	6	2	*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	100% (1/1)	100% (2/2)	0% (0/4)	3% (1/39)	8% (3/37)	3% (1/32)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	1	3	2	4

Inpatients - Non-Mental Health

• **Appraisal rate (90%):**
Appraisal compliance against new thresholds shows 100% compliance during June for band 8a and above (the ward breakdown below shows comipliance against rolling 12 months).

• **Supervision (80%):**
Work continues to improve clinical and managerial supervision; both uptake and recording. Plan in place on both units to improve trajectory by undertaking clinical and managerial supervision during handovers and recording this daily.
See also narrative on page 1 for wider Care Group; this also applies to both wards.

• **Sickness (5%):**
NRU – sickness for June has continued to increase and is outside compliance at 11.3%. The current position includes some instances of long term sickness.
SRU – Sickness for June has shown a further improvement and achieved compliance at 3.8%. The current position includes several instances of long term sickness.
Sickness on both units is being monitored and managed via Supporting Wellbeing (Sickness and Attendance Procedure). As noted last month, some staff were not due to return to work until mid-June, therefore this has impacted this month's figures.

• **Information Governance (95%):**
NRU compliancy has seen a good increased to compliance in June and is at 100%.
SRU has maintained compliance at 95.8% for June.

• **CPR (80%):**
NRU has seen a slight increase during June to 77.8%.
SRU has shown a good increase and is now achieving compliance at 80.9% for June.
Sickness on NRU continues to impact attendance this month as a number of staff who were booked on future sessions were unable to attend due to sickness absence. In addition, we had to cancel some attendances in order to ensure safe staffing levels on the ward. All staff who are out of date are re-booked to attend future dates of ILS and BLS.

In addition, Learning and Development colleagues are exploring the use of local venues to enable Barnsley staff to attend this training more easily and reduce the amount of travel time.

• **Fire Safety Training (85%):**
NRU – remains slightly below compliance but showing an increase to 84.2% for June.
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 110.9%
SRU – below compliance – at 79.97% - this correlates with our reduced occupancy level during June which fell to 67.8%. This meant the unit could allow additional staff to take annual leave during the periods when we had less patients on the ward.
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 early 2026. Additional meetings took place during May and June and the recommendations to correct the roster fill rate for SRU will take effect from 28.9.26. Until this date, there may be ongoing instances where the figures do not show as compliant.

Metrics	Strategic Objective	CQC Domain	Threshold	Neuro Rehabilitation Unit (NRU)			Stroke Rehabilitation Unit (SRU)		
				Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	85.7%	100.0%	97.1%	94.0%	97.1%	88.4%
Sickness	Best place to work and learn	Well led	5.0%	7.7%	8.9%	11.3%	6.5%	6.0%	3.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	61.5%	55.3%	23.7%	55.7%	40.8%	42.9%
Supervision - Management	Best place to work and learn	Well led	80%	53.8%	50.0%	21.1%	48.6%	43.7%	10.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.7%	92.5%	100.0%	94.2%	95.6%	95.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	79.5%	76.3%	77.8%	69.2%	74.6%	80.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	80.5%	80.0%	84.2%	94.2%	89.7%	90.3%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	95.3%	96.0%	97.8%	97.2%	91.1%	67.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	69	67	67	23	28	26
Safer staffing (Overall)	Best Quality	Safe	90%	100.4%	106.2%	110.9%	93.1%	87.0%	79.9%
Safer staffing (Registered)	Best Quality	Safe	80%	86.7%	86.3%	92.3%	93.7%	97.5%	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	2	30	58	18

Inpatients - Mental Health - Learning Disability

Headlines

• Appraisal compliance has reduced slightly to 88.2% this month. All outstanding appraisals relate to a very small number of staff, with reviews now scheduled, including for those recently returning from sick leave. Clear processes remain in place to support transition to the new appraisal framework, with robust governance ensuring timely completion and sustained quality.
• There has been a slight increase in sickness absence (5.7%), which remains above the compliance target. This appears to be normal variation rather than a concerning trend. Proactive processes are in place with managers to support attendance, and the position will continue to be closely monitored.
• Supervision continues to meet expected compliance levels, with clinical supervision at 100% and management supervision at 97.2%. This reflects a strong culture of support, accountability, and effective clinical oversight across the service.
• Mandatory training remains within target, reflecting strong compliance and a continued focus on maintaining required standards across the service.
• Low occupancy is understood and aligned with wider Assessment Treatment Unit (ATU) workstream.
• Clinically ready for discharge (CRFD), has noted improvement albeit currently at 81.8% and understood and in relation to pathway challenges. The service continued to support system wider working to identify appropriate packages of care. As previous report, placements have been identified for service users but complex packages including build work results in delay.
• 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 (121.6%) and registered staffing (161.1%). Following template changes this would more accurately reflect proposed staffing.
• There have been no prone restraints this period and restraint levels remain broadly consistent with usual service parameters and reflect the acuity of a small number of service users.
• Cancelled leave is routinely monitored across the service.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	77.8%	97.1%	88.2%
Sickness	Best place to work and learn	Well led	5.0%	4.7%	4.2%	5.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	88.4%	97.3%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	79.1%	94.6%	97.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.6%	100.0%	97.5%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.3%	95.1%	92.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.9%	92.3%	81.6%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	92.7%	95.1%	90.0%
Bed occupancy	Best Quality	Safe	N/A	50.0%	42.3%	45.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	524	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	133.7%	120.2%	121.6%
Safer staffing (Registered)	Best Quality	Safe	80%	167.9%	162.0%	161.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	100.0%	100.0%	81.8%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	11	12	6
Restraint incidents	Best Quality	Safe	Trend Monitor	8	8	*5*
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	0% (0/196)	0% (0/166)	0% (0/176)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	30	16	36

Inpatients - Forensic South Yorkshire

Low Secure Services

• Appraisals: Strong performance in Calder (90.5%) and Esk (90.5%), meeting the 90% target. Aire (64.3%), Don (69.6%) and Wentbridge (78.1%) remain below target despite gradual improvement.
• Supervision: Calder demonstrates strong compliance with both clinical and management supervision and Wentbridge has recovered above target. Aire and Don remain below the 80% target for both clinical and management supervision, while Esk's clinical supervision fell below target in June (72.7%).
• Bed Occupancy: Don is operating at near full occupancy (98.3%) and Calder achieved target occupancy (92.9%). Aire (87.2%), Wentbridge (87.5%) and Esk (78.1%) remain below the 90% target, with Esk showing a continued decline.
• Mandatory Training: Compliance is generally strong across all wards. The main exception is Don's Reducing Restrictive Practice training compliance (78.3%), which remains below target.
• Restrictive Practice: No prone restraint incidents were reported across any ward. Restraint use remains low overall, although Don recorded an increase in restraint incidents during June, while Esk reported low-level but consistent restraint use.
• Staffing: Safer staffing and registered staffing levels exceed target across all wards. However, high levels of unfilled shifts, particularly in Wentbridge, Don, Aire and Esk, indicate ongoing workforce pressures.
• Section 17 Leave: Wentbridge is a significant outlier, with leave cancellations increasing to 76% (29/38) in June and requiring urgent review.
• Patient Flow: Esk and Calder have exceptionally long lengths of stay, highlighting ongoing challenges with patient progression and discharge pathways.

Medium Secure Services (Foss and Skipton)

• Appraisals: Skipton (96.6%) continues to exceed the 90% target, while Foss (83.3%) remains below target and has declined over the quarter.
• Supervision: Both wards have improved significantly and are now exceeding the 80% target for both clinical and management supervision.
• Bed Occupancy: Skipton achieved target occupancy (91.7%), while Foss remains significantly below target (74.8%), indicating available capacity and flow challenges.
• Mandatory Training: Compliance is generally strong across both wards. The main concern is Information Governance compliance in Foss (92.3%), which is below target.
• Restrictive Practice: No prone restraint incidents were reported. However, Skipton experienced a significant increase in restraint incidents, rising to 19 in June, representing the most notable safety concern within Medium Secure Services.
• Staffing: Overall safer staffing remains above target. However, Skipton continues to operate below the registered staffing target (70.3%), and both wards report high numbers of unfilled shifts.
• Violence and Safety: No patient-on-patient violence was reported. Skipton recorded two patient-on-staff assaults in June, whereas Foss reported none throughout the quarter.
• Patient Flow and Workforce: Foss continues to experience high sickness (7.1%), a very long average length of stay (1,894 days) and increasing Section 17 leave cancellations (27%), indicating ongoing challenges with workforce resilience and patient progression.

				Medium Secure Services					
				Foss			Skipton		
Metrics	Strategic Objective	CQC Domain	Threshold	Apr-26	May-26	Jun-26	Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	86.4%	87.0%	83.3%	90.0%	96.7%	96.6%
Sickness	Best place to work and learn	Well led	5.0%	6.7%	7.2%	7.1%	3.6%	2.1%	4.1%
Supervision - Clinical	Best place to work and learn	Well led	80%	70.4%	96.3%	88.9%	77.1%	97.1%	93.9%
Supervision - Management	Best place to work and learn	Well led	80%	63.0%	88.9%	85.2%	74.3%	100.0%	87.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.8%	95.8%	92.3%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.5%	87.5%	84.6%	82.9%	85.3%	84.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	62.5%	87.5%	80.8%	71.4%	80.0%	82.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	75.0%	100.0%	92.3%	82.9%	94.1%	97.0%
Bed occupancy	Best Quality	Safe	90%	78.6%	78.6%	74.8%	83.3%	86.8%	91.7%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	1894	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	125.3%	119.3%	105.3%	99.7%	100.8%	103.7%
Safer staffing (Registered)	Best Quality	Safe	80%	104.1%	97.9%	104.6%	70.2%	68.8%	70.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	2
Restraint incidents	Best Quality	Safe	Trend Monitor	1	2	*1*	4	5	*19*
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	14% (6/44)	11% (4/35)	27% (10/37)	18% (7/38)	14% (4/29)	16% (6/37)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	16	20	23	31	23	34

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Esk Apr-26	Low Secure Services Esk May-26	Low Secure Services Esk Jun-26	Wentbridge Apr-26	Wentbridge May-26	Wentbridge Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	90.5%	53.1%	78.1%	78.1%
Sickness	Best place to work and learn	Well led	5.0%	5.4%	2.0%	3.9%	1.5%	1.0%	3.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	83.3%	91.3%	72.7%	73.5%	97.1%	91.2%
Supervision - Management	Best place to work and learn	Well led	80%	41.7%	73.9%	81.8%	58.8%	94.1%	88.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.7%	100.0%	100.0%	100.0%	100.0%	97.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	82.6%	81.8%	81.8%	97.1%	97.1%	97.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.0%	85.7%	95.2%	91.2%	97.1%	97.1%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	73.9%	100.0%	100.0%	97.1%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	85.0%	79.0%	78.1%	87.5%	87.5%	87.5%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	1075	3080	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.0%	99.9%	102.2%	112.9%	119.3%	121.4%
Safer staffing (Registered)	Best Quality	Safe	80%	90.5%	96.7%	81.4%	95.9%	91.8%	94.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	0	0	0	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	0	0	0	0	3
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	*1*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	15% (4/26)	19% (6/32)	18% (8/44)	0% (0/28)	8% (3/40)	76% (29/38)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	10	3	15	17	28

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire Apr-26	Low Secure Services Aire May-26	Low Secure Services Aire Jun-26	Low Secure Services Don Apr-26	Low Secure Services Don May-26	Low Secure Services Don Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	48.3%	59.3%	64.3%	56.5%	68.2%	69.6%
Sickness	Best place to work and learn	Well led	5.0%	2.2%	3.4%	5.2%	0.6%	1.1%	1.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	77.4%	75.9%	73.3%	30.4%	69.6%	50.0%
Supervision - Management	Best place to work and learn	Well led	80%	29.0%	62.1%	60.0%	26.1%	69.6%	45.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	95.7%	95.5%	95.7%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	83.3%	89.3%	89.3%	78.3%	77.3%	78.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.3%	89.3%	92.9%	91.3%	86.4%	87.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	93.3%	100.0%	100.0%	91.3%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	75.6%	84.7%	87.2%	100.0%	99.7%	98.3%
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%	99.4%	96.7%	90.3%	102.0%	104.3%	106.4%
Safer staffing (Registered)	Best Quality	Safe	80%	91.3%	92.7%	90.9%	87.8%	90.8%	86.9%
% 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	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	1	1
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*2*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	9% (2/22)	14% (5/36)	5% (1/20)	11% (5/45)	12% (6/52)	12% (5/42)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	7	11	11	10	11	8

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Calder Apr-26	May-26	Jun-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.9%	90.5%
Sickness	Best place to work and learn	Well led	5.0%	0.0%	1.5%	5.4%
Supervision - Clinical	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	86.4%	90.9%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	100.0%	95.5%	95.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.5%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	88.3%	89.7%	92.9%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	1818	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.1%	95.7%	91.6%
Safer staffing (Registered)	Best Quality	Safe	80%	86.7%	91.8%	90.2%
% 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	1	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	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	4% (1/23)	16% (8/51)	2% (1/57)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	8	7

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 - finance metric	Best Value	Well Led	1	1	The score of 1 means that the financial override is not applied against the Trust National Oversight Framework score for the finance metrics. This will be reviewed in line with any changes to the National Oversight Framework and the calculation of financial metrics.
1	Surplus / (Deficit)	Best Value	Well Led	(£1.8m)	£0m	The financial performance in June 2026 is a deficit of £526k which is £120k more than plan in month. The year to date position remains just ahead of plan (£8k) due to the performance in April and is also supported by one off items. This means that further actions are required to ensure that the breakeven target can be achieved.
2	Agency Spend	Best Value	Well Led	£0.4m	£2m	Agency spend is currently being maintained at a historically low level. Spend in June 2026 is £138k, within plan and is constricted to a limited number of medical posts. This is forecast to increase over the coming months due to pending staff retirements.
3	Bank Spend	Best Value	Well Led	£5.8m	£20.2m	Bank spend has increased in June 2026 to £1,937k and remains higher than plan. The increase is within unregistered nursing, primarily within inpatient areas, to support operational pressures. The forecast includes a reducing run rate and this continues to be triangulated with the Trust workforce plan and strategy. At June the forecast is that the bank target will be exceeded.
4	Financial sustainability and efficiencies	Best Value	Well Led	£2.3m	£17.7m	The Trust value for money programme is reported as ahead of plan at month 3. The largest contributors are the reduction in corporate costs and the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025 / 26. The trajectory includes the identification, and delivery, of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of breakeven is maintained.
5	Cash	Best Value	Well Led	£57.7m	£61.4m	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	£2.4m	£14.7m	As highlighted previously, in June 2026, the capital programme has switched from being ahead of plan to behind. The main change is the profile of the Older People Inpatient scheme which continues to be developed. The forecast remains in line with allocation, including a new allocation for community hubs, and schemes are progressing. Any revisions to timescales or forecasts will be agreed through Trust Board.
7	Better Payment Practice Code	Best Value	Well Led	98%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

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

South West Yorkshire Partnership Teaching
NHS Foundation Trust

Finance Report

Month 3 (2026 / 27)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0	Executive Summary / Key Performance Indicators			
Key Performance Indicator		**Year to Date**	**Forecast 2026 / 27**	**Narrative**
NOF 1	**National Oversight Framework**	1	1	The score of 1 means that the financial override is not applied against the Trust National Oversight Framework score. This will be reviewed in line with any changes to the National Oversight Framework and the calculation of financial metrics.
1	**Surplus / (Deficit)**	(£1.8m)	£0m	The financial performance in June 2026 is a deficit of £526k which is £120k more than plan in month. The year to date position remains just ahead of plan (£8k) due to the performance in April and is also supported by one off items. This means that further actions are required to ensure that the breakeven target can be achieved.
2	**Agency Spend**	£0.4m	£2m	Agency spend is currently being maintained at a historically low level. Spend in June 2026 is £138k, within plan and is constricted to a limited number of medical posts. This is forecast to increase over the coming months due to pending staff retirements.
3	**Bank Spend**	£5.8m	£20.2m	Bank spend has increased in June 2026 to £1,937k and remains higher than plan. The increase is within unregistered nursing, primarily within inpatient areas, to support operational pressures. The forecast includes a reducing run rate and this continues to be triangulated with the Trust workforce plan and strategy. At June the forecast is that the bank target will be exceeded.
4	**Financial sustainability and efficiencies**	£2.3m	£17.7m	The Trust value for money programme is reported as ahead of plan at month 3. The largest contributors are the reduction in corporate costs and the maintained run rate reduction of spend on temporary staffing and out of area placements which commenced in 2025 / 26. The trajectory includes the identification, and delivery, of new schemes later in the year. These need to be recurrent in nature to ensure that the Trust medium term financial plan of breakeven is maintained.
5	**Cash**	£57.7m	£61.4m	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**	£2.4m	£14.7m	As highlighted previously, in June 2026, the capital programme has switched from being ahead of plan to behind. The main change is the profile of the Older People Inpatient scheme which continues to be developed. The forecast remains in line with allocation, including a new allocation for community hubs, and schemes are progressing. Any revisions to timescales or forecasts will be agreed through Trust Board.
7	**Better Payment Practice Code**	98%		This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.

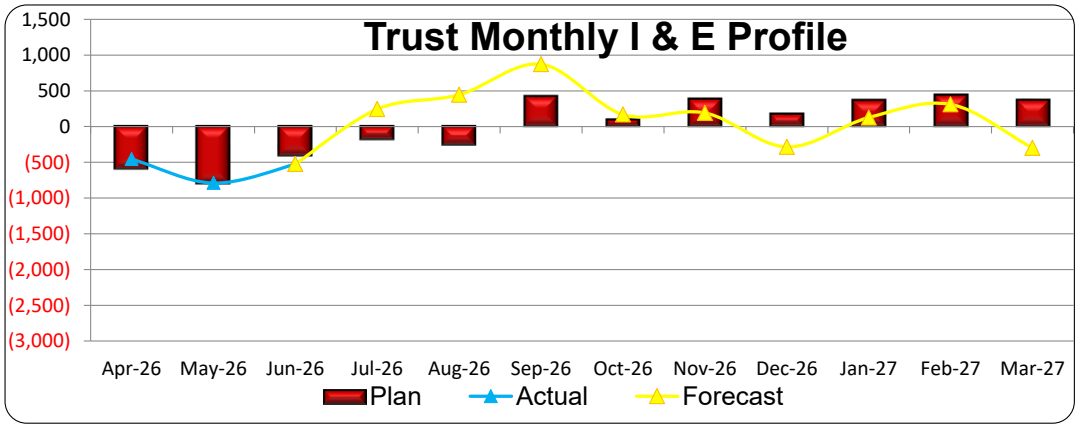
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

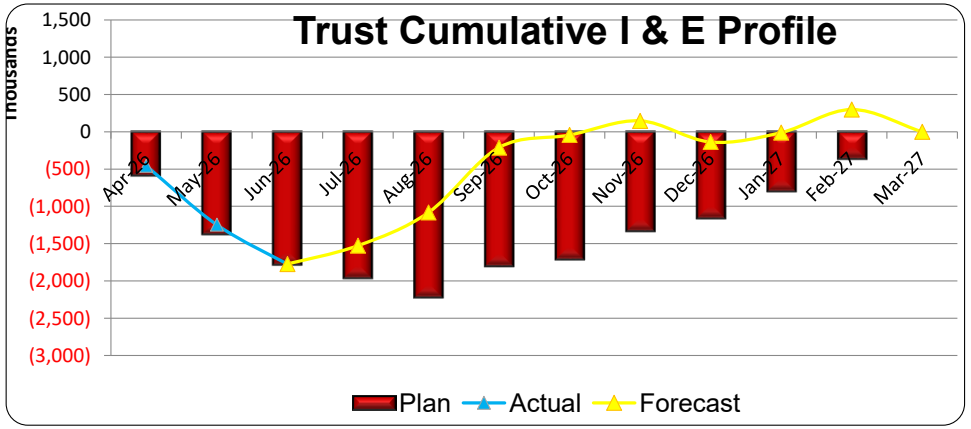
2.0 Income & Expenditure Position 2026 / 27

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

Total Financial Position

Description	Budget Staff	Actual Worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Healthcare contracts					35,329	35,488	160	104,642	104,838	196	418,836	417,019	(1,817)
Other Operating Revenue					1,328	1,349	21	3,906	4,019	113	15,688	16,013	326
Total Revenue					**36,657**	**36,837**	**181**	**108,548**	**108,857**	**309**	**434,524**	**433,033**	**(1,491)**
Employee expenses	5,387	5,397	10	0.2%	(25,966)	(26,423)	(456)	(77,257)	(78,559)	(1,301)	(306,001)	(315,632)	(9,631)
Operating expenses exc. Employee expenses					(10,828)	(10,768)	60	(32,299)	(31,553)	747	(125,290)	(115,217)	10,073
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**5,387**	**5,397**	**10**	**0.2%**	**(36,794)**	**(37,191)**	**(397)**	**(109,557)**	**(110,112)**	**(555)**	**(431,291)**	**(430,849)**	**442**
Operating Surplus / (Deficit)	**5,387**	**5,397**	**10**	**0.2%**	**(138)**	**(354)**	**(216)**	**(1,009)**	**(1,255)**	**(246)**	**3,233**	**2,184**	**(1,049)**
Finance expense					(57)	(59)	(2)	(168)	(178)	(10)	(673)	(672)	1
PDC Paid					(362)	(362)	0	(1,086)	(1,086)	0	(4,343)	(4,343)	(0)
Finance income					140	241	101	448	722	274	1,645	2,747	1,102
Surplus / (Deficit) - Total	**5,387**	**5,397**	**10**	**0.2%**	**(417)**	**(534)**	**(117)**	**(1,815)**	**(1,797)**	**18**	**(138)**	**(84)**	**54**
Adjusted Financial Performance													
Depn Peppercorn Leases (IFRS16)					11	8	(3)	34	24	(10)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB performance measure	**5,387**	**5,397**	**10**	**0.2%**	**(406)**	**(526)**	**(120)**	**(1,781)**	**(1,772)**	**8**	**(0)**	**(0)**	**(0)**





Income & Expenditure Position 2026 / 27

The consolidated Trust deficit in June 2026 is £526k.
This is £120k worse than plan.

In line with national guidance the Trust submitted a risk assessed breakeven financial plan for 2026 / 27. Within this position there were identified risks and opportunities and these will be continually assessed as the year progresses. These are discussed monthly at the Trust Finance, Investment and Performance Committee.

NHS England - monthly submission

The actual financial performance reported here is consistent with the monthly return made to NHS England. The corresponding declaration is made within the return itself.

The submission is for the total consolidated financial position which operates as a single segment for the purpose of providing healthcare services. Within this report the financial information is split into core Trust, Provider Collaboratives and budgets held centrally. Financial performance is summarised in the table below.

	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
Description	**WTE**	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Trust (core)	5,364	5,376	11	0.2%	(531)	(533)	(2)	(2,545)	(1,707)	837	(4,315)	(12,926)	(8,611)
Provider Collaboratives	23	21	(2)	8.4%	42	(115)	(158)	29	(202)	(232)	20	(1,917)	(1,937)
Budgets held centrally	0	0	0	0.0%	83	123	39	735	137	(598)	4,295	14,843	10,548
Total - Consolidated position (ICB performance measure)	**5,387**	**5,397**	**10**	**0.2%**	**(406)**	**(526)**	**(120)**	**(1,781)**	**(1,772)**	**8**	**(0)**	**(0)**	**(0)**

Although the run rate has improved, the in month deficit reducing from £791k in May to £526k in June, this remains in deficit and continues to be higher than plan. This is both the core Trust and also the provider collaboratives. This is supported by some small non-recurrent benefits as shown against the budgets held centrally line and the timing of income. The year to date position is just ahead of plan.

Overall the Trust (core) run rate has remained relatively constant with June 2026 marginally below the average of £569k per month. As discussed later in this paper the main pressure remains on workforce (worked WTE and expenditure) which are greater than plan in month. Non pay expenditure has increased, but alongside the timing of income, continues to reduce the reported level of deficit.

The Adult Secure provider collaboratives (both South Yorkshire and West Yorkshire) continue to report operational and financial pressures with South Yorkshire reporting a £161k deficit in month.

Budgets held centrally remains for items that are not able to be coded through care groups. Actual expenditure remains limited, although there are c. £100k of non recurrent benefits reported in month, but the budget requires additional value for money schemes to be allocated against it. The forecast is significant improvement in order to achieve the breakeven target. The action plan, and forecast scenarios, is presented to the Trust Finance, Investment and Performance Committee.

2.0 Income & Expenditure Position 2026 / 27

This section focusses on the financial performance of South West Yorkshire Partnership Teaching NHS Foundation Trust. This excludes the financial impact of Provider Collaboratives and budgets held centrally which are presented separately. The movement between the total consolidated financial position and the table below is reconciled on the previous page for ease.

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

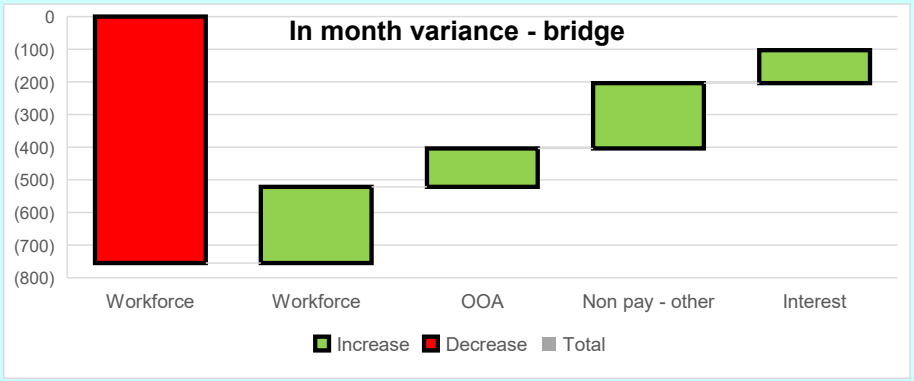
Total Financial Position - Core Trust only

	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
Description / Heading	**WTE**	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Healthcare contracts					25,394	25,499	104	75,380	75,394	14	301,790	299,314	(2,476)
Other Operating Revenue					1,287	1,286	(1)	3,740	3,802	62	14,732	15,169	436
Total Revenue					**26,681**	**26,784**	**103**	**79,120**	**79,196**	**76**	**316,522**	**314,482**	**(2,040)**
Employee expenses	5,364	5,376	11	0.2%	(25,764)	(26,286)	(521)	(76,705)	(78,160)	(1,455)	(303,792)	(313,949)	(10,157)
Operating expenses exc. Employee expenses					(1,180)	(859)	321	(4,188)	(2,225)	1,962	(13,812)	(11,276)	2,536
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	**5,364**	**5,376**	**11**	**0.2%**	**(26,944)**	**(27,145)**	**(201)**	**(80,893)**	**(80,385)**	**508**	**(317,604)**	**(325,225)**	**(7,621)**
Operating Surplus / (Deficit)	**5,364**	**5,376**	**11**	**0.2%**	**(263)**	**(361)**	**(97)**	**(1,773)**	**(1,189)**	**583**	**(1,082)**	**(10,742)**	**(9,660)**
Finance expense					(57)	(59)	(2)	(168)	(178)	(10)	(673)	(672)	1
PDC Paid					(362)	(362)	0	(1,086)	(1,086)	0	(4,343)	(4,343)	(0)
Finance income					140	241	101	448	722	274	1,645	2,747	1,102
Surplus / (Deficit) - Total	**5,364**	**5,376**	**11**	**0.2%**	**(543)**	**(541)**	**1**	**(2,579)**	**(1,731)**	**848**	**(4,453)**	**(13,010)**	**(8,557)**
Depn Peppercorn Leases (IFRS16)					11	8	(3)	34	24	(10)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB	**5,364**	**5,376**	**11**	**0.2%**	**(531)**	**(533)**	**(2)**	**(2,545)**	**(1,707)**	**837**	**(4,315)**	**(12,926)**	**(8,611)**

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 continues to exceed planned assumptions including the delivery of Value for Money schemes. Primarily mental health care group and Forensics.	(755)
Workforce - continuation of utilisation of less staffing than plan. Support care group	234
Non pay - Out of area placements have continued, despite significant operational pressures, to be maintained less than planned.	118
Non pay - general reductions across the Trust	200
Finance income - due to cash position, and maintained interest rates, interest receivable is higher than planned	101

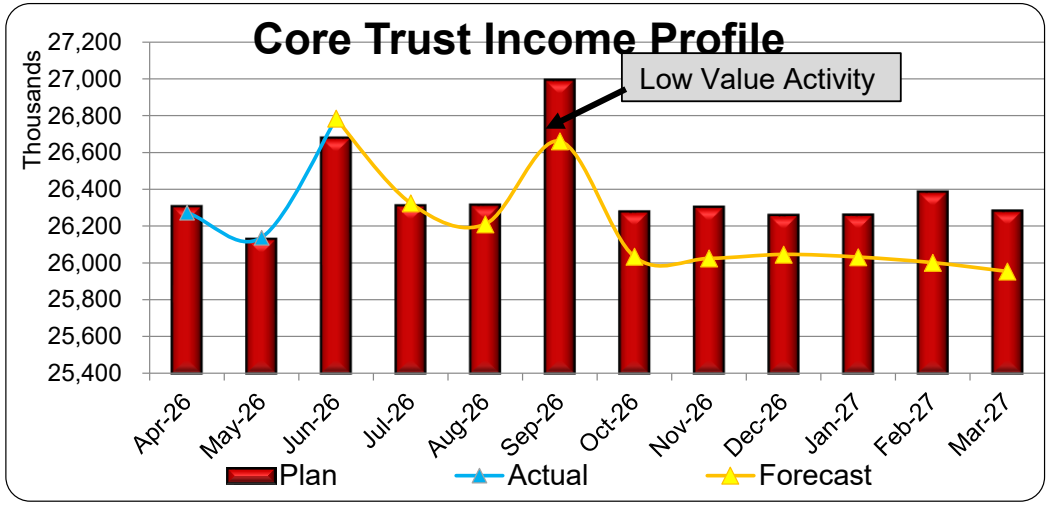


2.1 Income Information

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	23,817	23,808	(9)	70,812	70,785	(27)	283,610	283,332	(278)
Specialised Commissioning (NHS E)	656	693	36	1,989	2,062	73	7,148	6,157	(991)
Local Authorities	434	491	57	1,294	1,353	58	5,210	5,201	(9)
Partnerships	251	297	46	713	740	27	3,533	2,780	(753)
Other Healthcare income	125	78	(47)	356	241	(115)	1,423	1,009	(414)
Other non clinical income	1,393	1,412	19	3,941	4,000	59	15,538	15,943	405
Total - Trust core income	**26,676**	**26,779**	**103**	**79,105**	**79,181**	**76**	**316,463**	**314,422**	**(2,041)**
Provider Collaboratives	9,934	9,990	55	29,262	29,444	182	117,046	117,705	659
Budgets held centrally	41	63	22	167	217	50	955	845	(110)
Total - Consolidated income	**36,652**	**36,833**	**181**	**108,533**	**108,842**	**309**	**434,465**	**432,973**	**(1,492)**



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	£367k
* Yorkshire Smokefree - prescribing & activity	£22k
* Any qualified provider activity	£110k

Other income variances include:

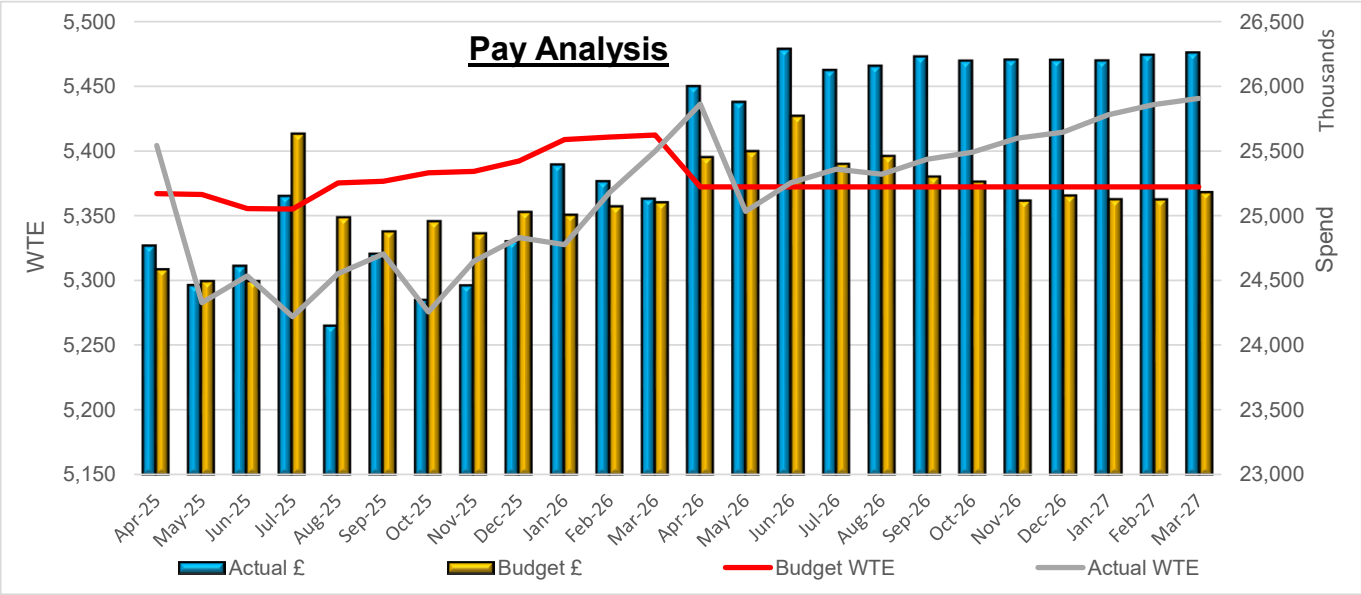
* Income received for bed sales inc. Provider Collabs	£409k

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	4,937	24,211	71,996	5,081	291,794	(8)	286
Bank & locum	432	1,937	5,758	352	20,176	29	129
Agency	6	138	407	8	1,979	1	(6)
Total	**5,376**	**26,286**	**78,160**	**5,441**	**313,949**	**22**	**410**
Budget	**5,364**	**25,764**	**76,705**	**5,372**	**303,792**	**0**	**271**
Over / (Under)	**11**	**521**	**1,455**	**68**	**10,157**	**22**	**139**



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

Substantive worked WTE has continued to reduce month on month in small increments. The Trust workforce action plan will address this. Agency continues to be maintained at a low level. Bank staff, however, has continued to fluctuate month on month. This was a peak of 479 in April 2026 but reduced to 402 in May 2026. This has increased by 29 WTE in June.

Actual expenditure in June 2026 includes the medical staff pay award with arrears paid back to April 2026. This was higher than the original 2% planning assumption and budgets have been updated accordingly.

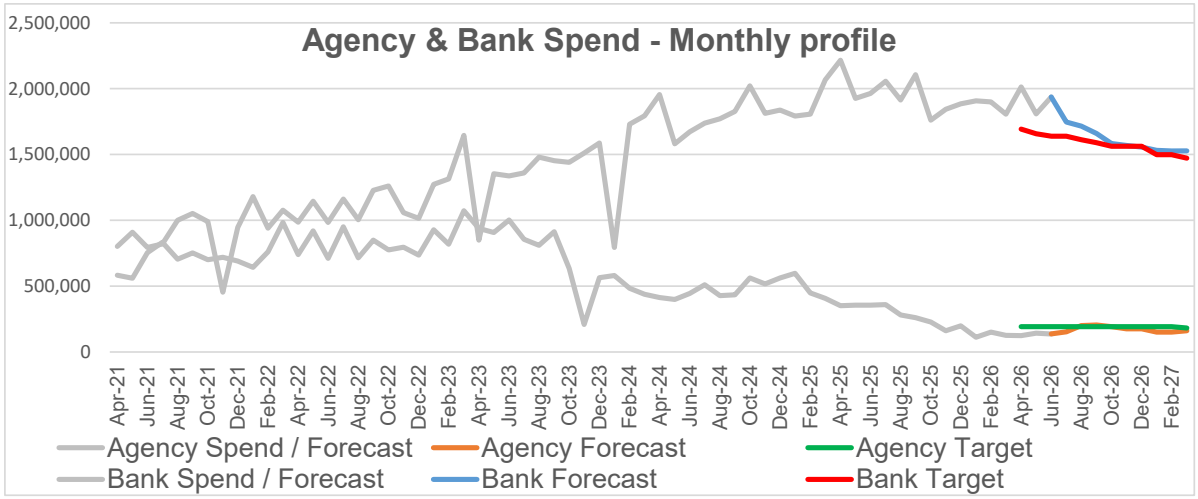
Pay budgets, which include the largest elements of the Trust Value for Money programme, are profiled to reduce whilst workforce is forecast to increase. This continues to be triangulated and the impact considered within the Trust forecast scenarios.

2.2 Temporary Staffing Focus

Trust spend in June 2026:
Agency £138k
Bank £1,937k

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	301	103	**404**
Other Medical	105	166	**271**
Reg Nursing	(0)	1,697	**1,697**
UnReg Nursing	0	3,504	**3,504**
Other Clinical	0	141	**141**
A & C	0	147	**147**
Other	0	0	**0**
Total	**407**	**5,758**	**6,164**
Lead Provider Collaborative		3	**3**
Budgets held centrally		0	**0**
Total	**407**	**5,760**	**6,167**

In line with national guidance the Trust financial plan for 2026 / 27 included spend reduction targets; c. 30% reduction in agency and 15% reduction in bank. Further reductions are required for future financial years. The target levels of expenditure per month are shown in the graph above.

Performance measurement of these targets is based upon total consolidated agency and bank expenditure and are reported as part of the Trust value for money programme and as overall key financial performance indicators (KPI). These are considered as absolute values and not in the context of other pay expenditure movements.

As shown above agency spend has been maintained at a low level and, in June 2026, the Trust has continued to only utilise medical staffing agency. Future pressures have been identified in this area especially relating to staffing retirements. The current forecast remains that the target can be achieved.

Bank spend has continued to fluctuate and has increased from May to June 2026. This is within the unregistered nursing category to support inpatient ward pressures. The current forecast trajectory has usage reducing but remaining above the target requirement.

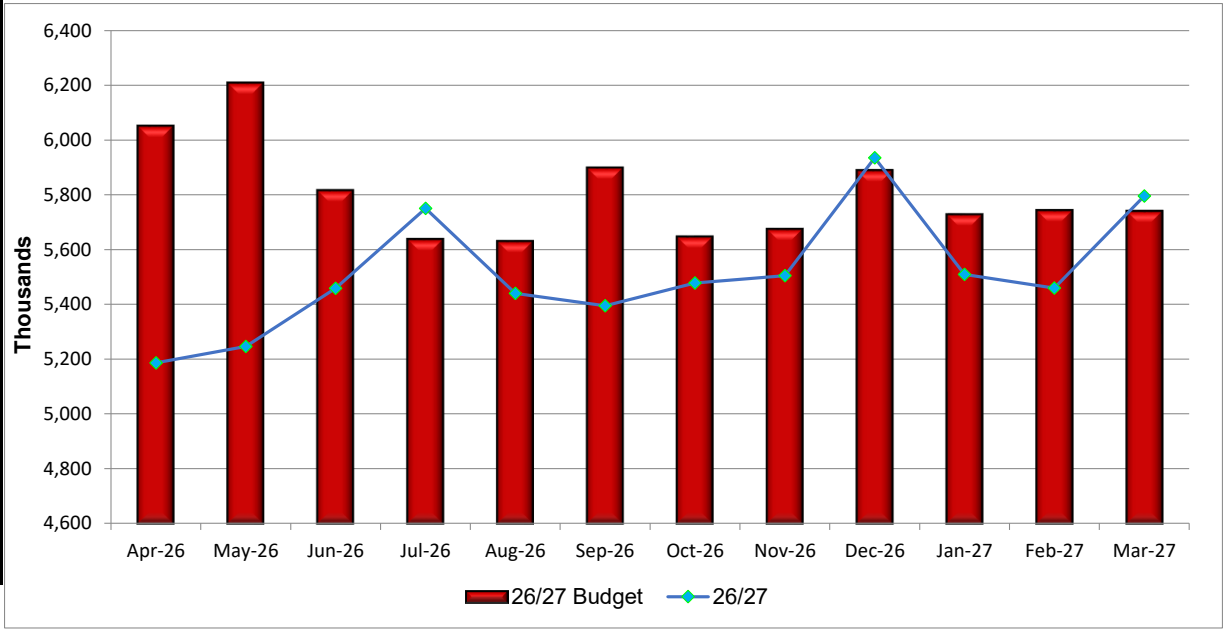
Action plans continue to be developed through the Trust temporary staffing group.

2.3 Non Pay Expenditure

Whilst pay expenditure is the majority of Trust costs, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the care groups and corporate services, To re-confirm that this presentation excludes non pay expenditure relating to the provider collaboratives and budgets held centrally.

Non pay spend	Apr-26 £k	May-26 £k	Jun-26 £k	Jul-26 £k	Aug-26 £k	Sep-26 £k	Oct-26 £k	Nov-26 £k	Dec-26 £k	Jan-27 £k	Feb-27 £k	Mar-27 £k	Total £k
2026 / 27	5,186	5,246	5,458	5,751	5,440	5,394	5,478	5,504	5,935	5,509	5,459	5,796	**66,157**
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	1,154	1,029	(125)
Establishment	2,988	2,295	(693)
Lease & Property Rental	2,208	2,186	(23)
Premises (inc. rates)	1,505	1,457	(48)
Utilities	814	688	(125)
Purchase of Healthcare	1,976	1,464	(512)
Travel & vehicles	1,531	1,482	(49)
Supplies & Services	2,228	2,119	(109)
Training & Education	337	128	(209)
Clinical Negligence & Insurance	362	358	(5)
Capital Charges Depn, PDC,	2,585	2,291	(294)
Other non pay	386	394	7
Total	**18,075**	**15,891**	**(2,184)**
Total Excl OOA and Drugs	**14,945**	**13,398**	**(1,547)**



Key Messages

Non pay expenditure, being less than plan, continues to support the overall Trust financial position but, as shown by the graph above, has been increasing in the first three months of the financial year.

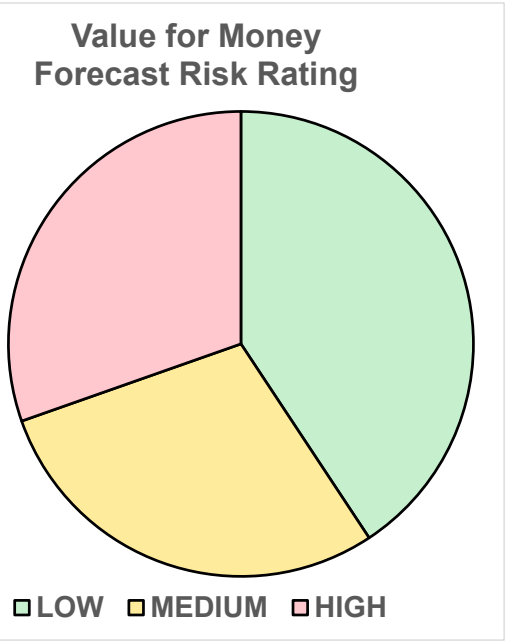
All categories continue to have spent less than plan for the year to date. The categories with the biggest increases in month are travel and transport, purchase of healthcare and premises costs. These have been partially offset by reductions in the establishment category.

3.0 Value for Money & Financial sustainability

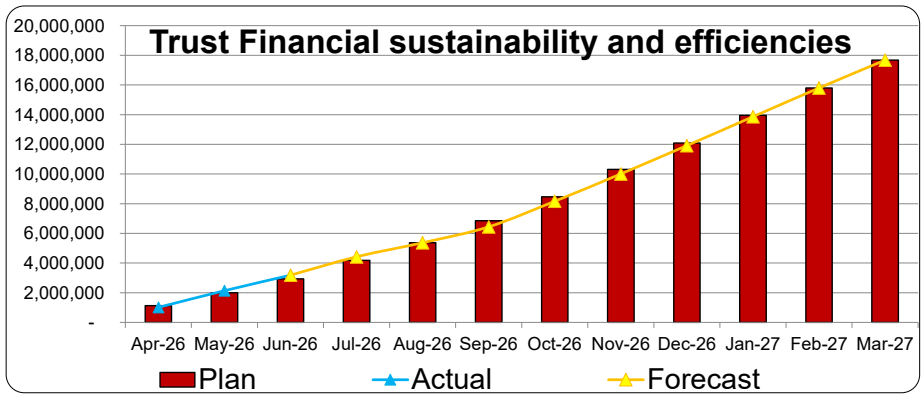
The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial 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	LOW £k	MEDIUM £k	HIGH £k	Variance £k
Pay	Workforce	0	176	21	197	3,689	197	1,643	5,370	3,521
	Temporary Staffing	1,333	1,042	0	(291)	4,412	1,042	2,945		(425)
	Corporate Pay	498	96	818	415	1,991	2,776			785
	Productivity	0	0	0	0	1,400				(1,400)
	Difficult Decisions	150	29	0	(121)	2,138	183			(1,955)
Non Pay	Non Pay	24	25	2	3	248	100			(148)
	Drugs optimisation	54	0	0	(54)	220	0	144		(76)
	Digitial optimisation	9	75	3	69	35	310			275
	Out of Area placements	90	270	0	180	357	270	194		106
	Difficult Decisions	0	16	0	16	0	84			84
	Non pay - establishment	51	12	12	(27)	265	27	47		(191)
Other	Provider Collaboratives	540	540	0	0	2,160	2,160			0
	Bed Sales	0	0	0	0	0				0
	Income	192	29	17	(146)	760	46	137		(577)
	Misc income - overage	0	0	0	0	0				0
Total		**2,941**	**2,309**	**873**	**241**	**17,675**	**7,194**	**5,110**	**5,370**	**(0)**
Recurrent		2,752	2,309		(443)	16,925	4,618	5,110	0	(7,197)
Non Recurrent		189		873	684	750	2,576	0	5,370	7,197



LOW	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.
MEDIUM	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.
HIGH	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. At the end of quarter 1 £3,182k has been reported. This is £241k ahead of plan.

The largest driver of this relates to corporate pay savings. These have been reviewed in month and as such this has been updated to reflect the current recurrent / non-recurrent split. Work is continuing to maxmise the recurrent value. The second largest relates to out of area placements which have been maintained at a lower level than for the same time period last year.

Based on current forecasts additional schemes and mitigations will need to be delivered to achieve the Trust financial targets. In the table above this is identified as high risk as well as ensuring that the medium risk schemes deliver.

4.0 Statement of Financial Position (SOFP) 2026 / 27

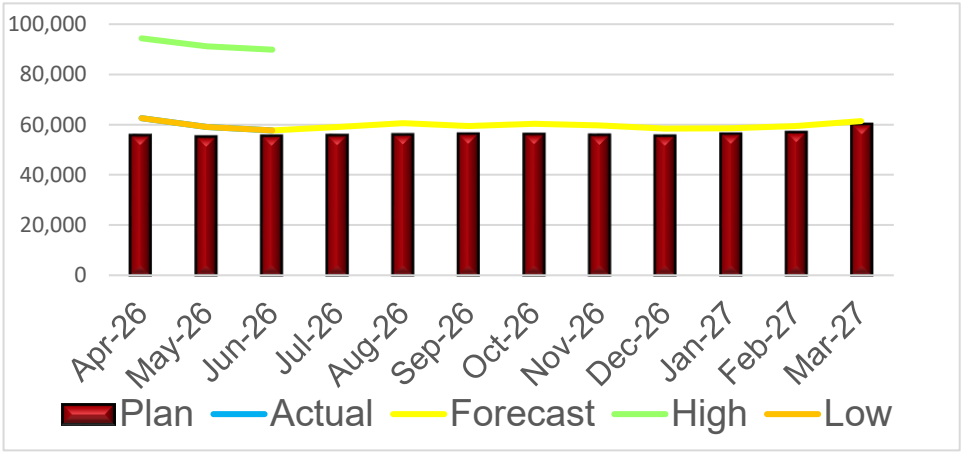
Whilst the focus is traditionally on the Trust income and expenditure position, the Statement of Financial Position (SOFP - balance sheet) presents a key snapshot of the Trusts overall financial health, stability and can provide important early warning flags of potential financial issues.

The balance sheet shows that the Trust owns (assets) and what it owes (liaiblities).

Balance Sheet / Statement of Financial Position (SOFP)	Current £k	Note
Assets		
Non-Current (Fixed) Assets	191,102	Pg 13
Inventories & Work in Progress	209	
Trade receivables (Debtors)	1,499	
Accrued Income	4,102	Pg 14
Prepayments	5,982	
Cash and Cash Equivalents	57,696	
Total Assets	**260,590**	
Liabilities		
Payables (Creditors)	(17,216)	
Accruals	(18,470)	
Deferred Income	(1,751)	Pg 14
Provisions	(3,305)	
IFRS 16 / leases liabilities	(45,209)	
Total Liabilities	**(85,951)**	
Total Net Assets/(Liabilities)	**174,639**	
Taxpayers' Equity		
Public Dividend Capital	(79,119)	
Revaluation Reserve	(12,067)	
Other Reserves	(5,220)	
Income & Expenditure Reserve	(78,233)	
Total Taxpayers' Equity	**(174,639)**	

Non Current (Fixed assets): The value of Trust assets is impacted by additional capital purchases and disposals (page 13), reduced by the impact of depreciation and amortisation and annual revaluation exercises.

Cash: The Trust cash position is shown below. The graph shows the position at the end of each month and also the highest / lowest cash point during that month. This is monitored to highlight any risk or opportunity. Actual cash has reduced to £57.7m but remains ahead of plan.

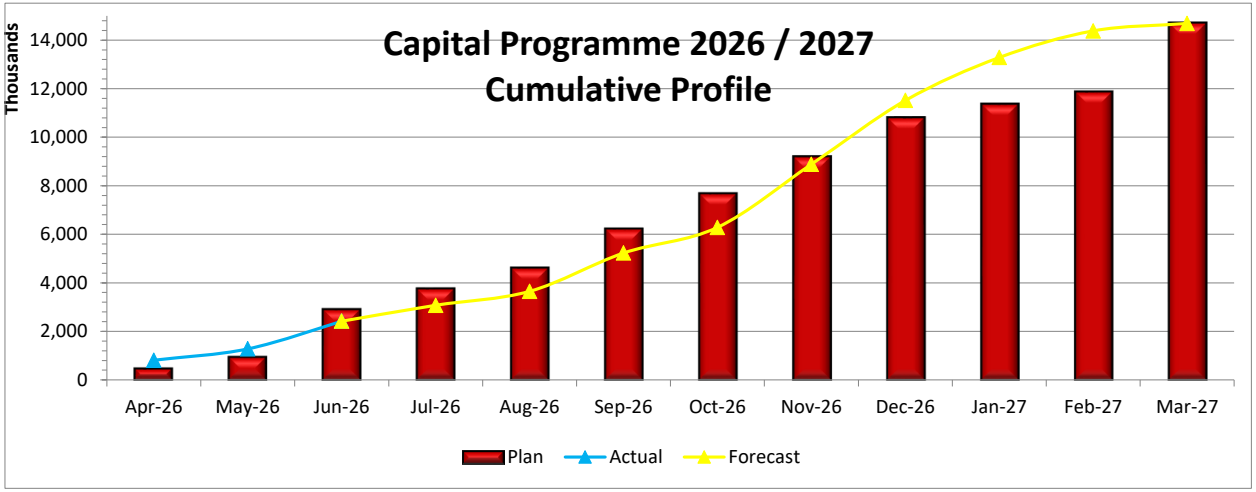


Overall the Trust balance sheet remains strong with assets greater than liabilities.

The taxpayers equity section, similar to shareholders equity, illustrates that Trust funding is entirely from public taxation.

4.1 Capital Programme 2026 / 27

Capital schemes	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Annual Budget £k	2026 / 27 Outturn £k	Variance £k
Major Capital Schemes						
Older People Transformation	1,305	217	(1,088)	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	48	0	(48)	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	901	901	0	1,908	1,908
Other	0	(371)	(371)	0	(1,693)	(1,693)
Leases (IFRS 16)	1,497	1,664	167	3,011	2,795	(216)
TOTALS	**2,850**	**2,411**	**(439)**	**10,939**	**10,939**	**(0)**
Additional allocations						
Cheswold	60	7	(53)	3,000	3,000	0
Community hub	0	0	0	750	750	0
			0			0
TOTALS	**2,910**	**2,418**	**(492)**	**14,689**	**14,689**	**(0)**



Capital Expenditure 2026 / 27

The table,left, summarises the Trust capital programme for 2026 / 27. This is split between the Trust core capital allocation and additional allocations which have been secured. The core allocation includes leases (IFRS 16). The main scheme is the continuation of the Older People Inpatient Transformation project.

An additional allocation has been secured for both 2026 / 27 and 2027 / 28 in relation to improvements for Cheswold Park Hospital. In May 2026 the Trust also received confirmation of additional £750k funding to develop a community hub.

For April and May 2026 Trust spend was greater than plan due to the timing. This was planned for June 2026 and, as now included in the year to date position, we have reverted to being behind plan. This is primarily due to the plan profile for the older people scheme.

Work continues to finalise the pricing, and spend profile, for the main schemes and as such the plan and forecast currently reflects those included in the February 2026 plan submission. This will be updated as each is agreed.

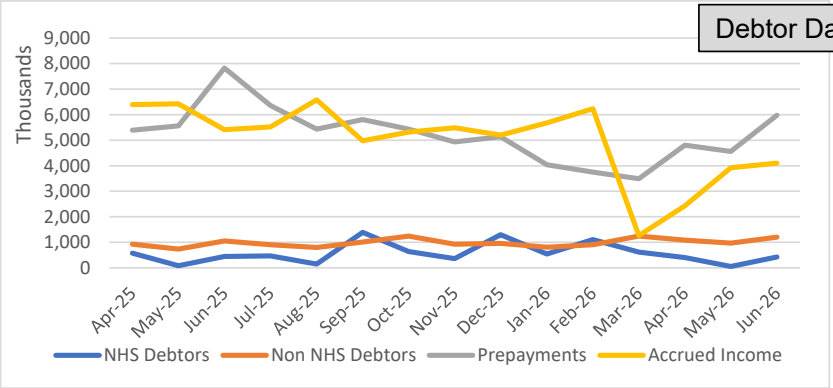
The impact of profile changes if being considered on the multi-year Estates plan.

Agreed profiles will need to consider, and mitigate, the impact of the net zero carbon scheme which commenced in 2025 / 26

4.2 Balance sheet analysis

The presentation of this data, and supporting narrative, has been revised in order to enhance the awareness of potential future risk areas and the actions being taken to manage them.

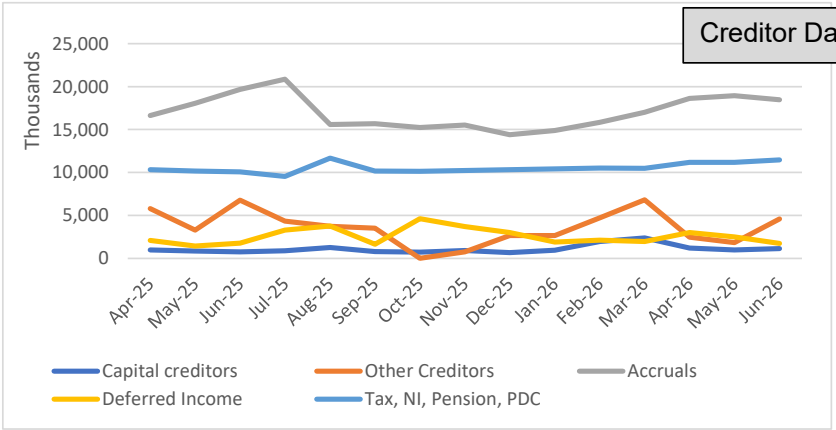
Debtors: A debtor is an indiviudal or company who owes money to the Trust for services provided. This directly impacts on cashflow. The action is to minimise these balances as far as possible and ensure that debts are recovered in a timely manner. Both the value and age is shown below.



	Not Due £k	1 - 30 days £k	31 - 60 days £k	61 + days £k	Total £k
NHS	198	33	1	0	233
Non NHS	611	4	14	227	857
Total	**809**	**37**	**16**	**227**	**1,090**

Both prepayments and accrued income have continued to rise. The priority is on ensuring that invoices are raised and paid as soon as possible or that direct cash payments are received in a timely fashion.

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	420	163	(7)	0	576
Non NHS	3,123	96	140	428	3,786
Total	**3,543**	**259**	**133**	**428**	**4,363**

Overall levels have been maintained.. Other creditors have increased although no issues have been identified and is mainly due to timing / invoices are not yet due.

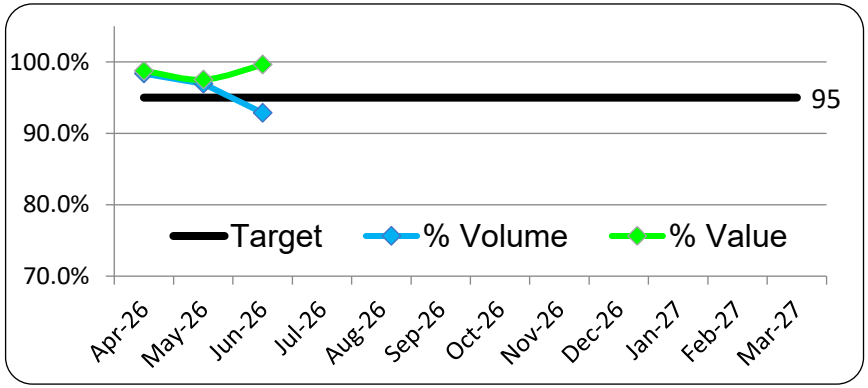
5.0 Better Payment Practice Code

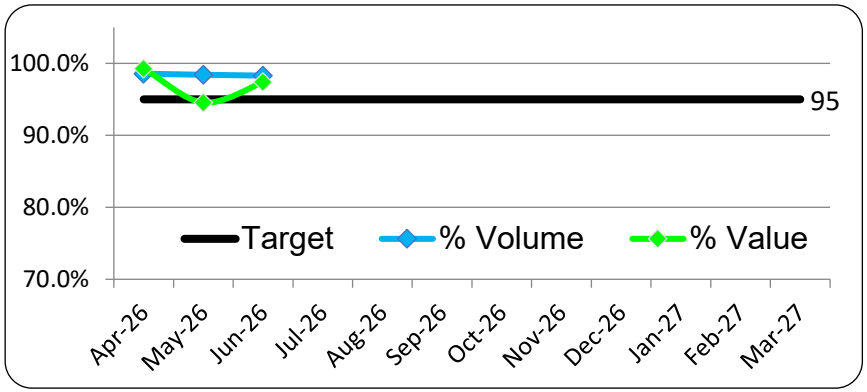
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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	93%	100%
Cumulative Year to Date	96%	99%

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





5.1 Transparency Disclosure

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

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

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

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

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
08-Jun-26	Computer Licence	Trustwide	Trustmarque Solutions Ltd	2429279	1,417,491
05-Jun-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1007387	730,955
15-Jun-26	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	2000033591	704,131
23-Jun-26	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	206964	667,943
23-Jun-26	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	206968	667,943
02-Jun-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011254	403,660
22-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS71	400,000
16-Jun-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002393	351,604
22-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS48	240,000
04-Jun-26	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HONHSLS317	231,566
26-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898647	168,791
02-Jun-26	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600040358	154,538
11-Jun-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34072299	147,577
08-Jun-26	Computer Licence	Trustwide	Trustmarque Solutions Ltd	2429277	146,105
02-Jun-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004466	136,217
10-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS069INV	132,775
17-Jun-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34072723	120,000
11-Jun-26	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6029771	117,600
02-Jun-26	IT Services	Trustwide	Wavenet Ltd	1547745	106,816
02-Jun-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011250	100,067
10-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC049INV	99,895
07-Jun-26	Staff Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	1007382	84,281
09-Jun-26	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	333010	73,682
05-Jun-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1007386	71,198
09-Jun-26	Drugs	Trustwide	Rowlands Pharmacy	1800006296	71,002
10-Jun-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS069SN	67,544
18-Jun-26	Purchase of Healthcare	Kirklees	My Happy Mind Ltd	INV4022	66,110
04-Jun-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004497	64,727
26-Jun-26	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	333135	64,670
11-Jun-26	Computer Licence	Barnsley	Pcmis Health Technologies Ltd	151508	61,168
04-Jun-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34071445	53,810

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
13-Jun-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002388	51,249
23-Jun-26	IT Services	Trustwide	Wavenet Ltd	N021924	47,734
30-Jun-26	Lease Cars	Trustwide	Arval Uk Ltd	RI0015132633	47,642
11-Jun-26	Utilities	Trustwide	Edf Energy Customers Ltd	000028316386	42,984
04-Jun-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001566EPC	41,813
05-Jun-26	Purchase of Healthcare	Forensics	Humber Teaching NHS Foundation Trust	59898614	37,014
01-Jun-26	Rent	Kirklees	Bradbury Investments Ltd	19991	32,589
10-Jun-26	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	WKE0466573	32,094
05-Jun-26	Drugs	Doncaster	Speeds Healthcare Ltd	INV173305	27,147
23-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898624	26,143
23-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898625	26,143
23-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898626	26,143
23-Jun-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898627	26,143
19-Jun-26	Internal Audit	Trustwide	University Hospitals Of Derby & Burton NHS Foundation Trust	800049325	25,380

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

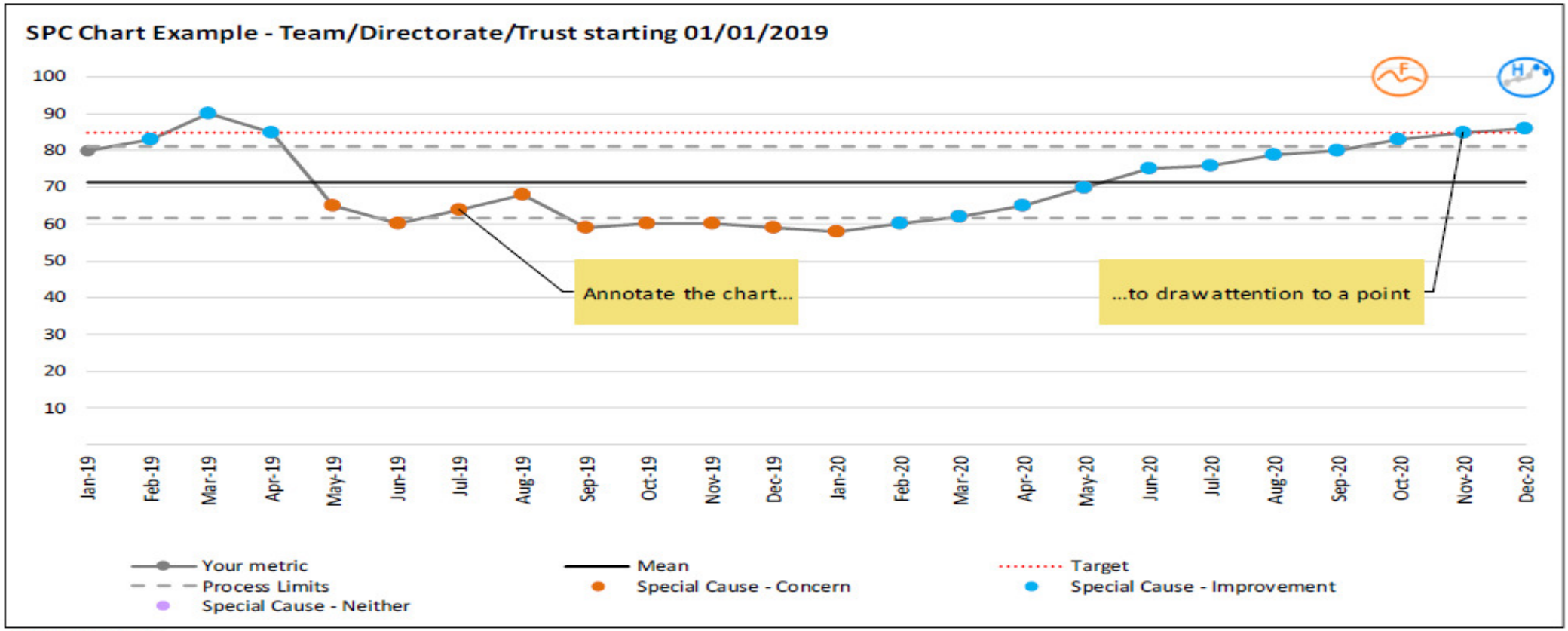
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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