NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

July 2026

With **all of us** in mind.

NHS
South West Yorkshire Partnership Teaching
NHS Foundation Trust

Table of Contents

Click on each section heading to navigate to that section

Introduction

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

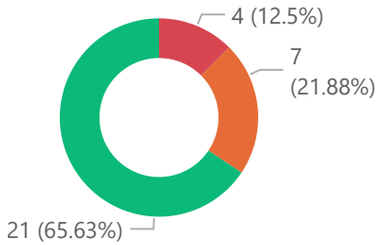
A review of the reducing inequalities section has been undertaken to ensure alignment with the Trust's equality, diversity and inclusion strategy which includes a number of metrics to evidence our progress towards delivering more responsive and equitable services for our communities. The strategy will 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. This section will be updated over the next month.

Our Integrated Performance Report is publicly available on the internet.

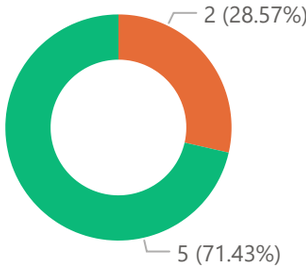
Headlines - Performance Rates Summary

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.

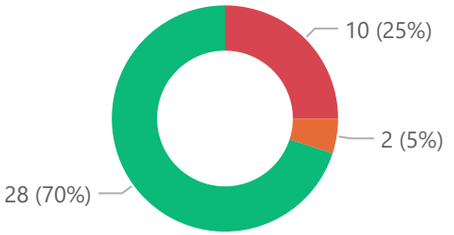
Quality & Safety Metrics Performance Rate



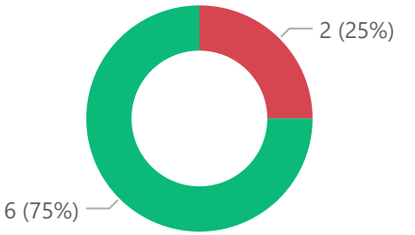
People Metrics Performance Rate



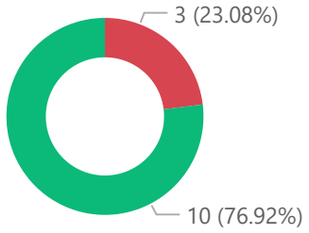
National Metrics Performance Rate



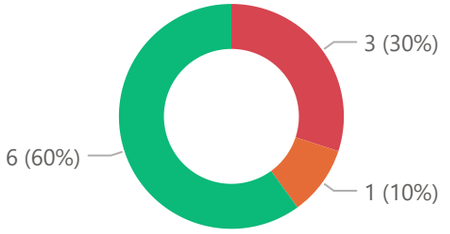
Finance Metrics Performance Rate



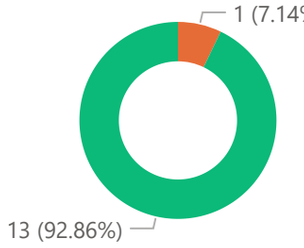
Barnsley Physical Health Metrics Performance Rate



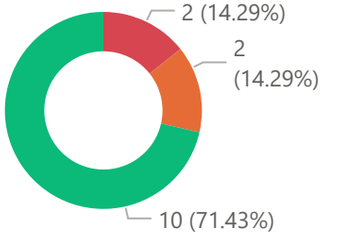
CAMHS Metrics Performance Rate



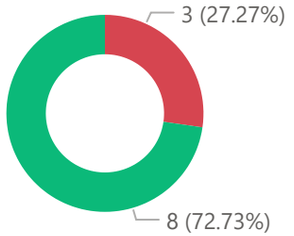
Mental Health Community Metrics Performance Rate



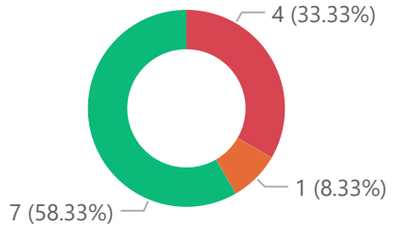
Mental Health Inpatient Metrics Performance Rate



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 data over time indicates that there is any action required.

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

Quality and Safety

Metric	Change from last month	Variation/ Assurance
Complaints - Number of responses provided within six months of the date a complaint received	↑	
% of inpatients clinically ready for discharge	↑	
Number of Information Governance breaches	↓	
% of inpatients clinically ready for discharge	↑	
Number of pressure ulcers which developed under SWYPFT care where there was an area for improvement	↓	
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	↓	

Quality and Safety cont…

Metric	Change from last month	Variation/ Assurance
% 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	↑	
E. Coli bloodstream infection rate	↓	

People

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

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	↑	
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	↓	
% of staff receiving supervision within policy guidance - Clinical	↑	
% of staff receiving supervision within policy guidance - Management	↓	New Metric
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↓	

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

Forensic - South Yorkshire

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% Bed occupancy	↑	
% of feedback with staff values and behaviours as an issue	↓	
% 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 - Management	↓	New Metric
Children & Younger People with eating disorder - % Routine cases accessing treatment within 4 weeks	↑	
Children & Younger People with eating disorder - % Urgent cases accessing treatment within 1 week	↓	
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	↔

	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 (I) 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 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 70% 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 total number of reported incidents in July was 1,325 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 July totalled 119 which is in line within normal range. The highest number of restraint incidents were on one of our adult acute mental health wards Elmdale (14) and Stanley ward (10), Older people Mental health Ward 19 Male (10). All incidents are reviewed, and learning is shared.
• The Trust had 45 incidents involving race against staff on mental health wards during June taking place across 16 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 three staff led prone restraints on our mental health wards during July. Two 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. 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 16 information governance personal data breaches during July. This is the highest number reported since February 2024. Information disclosed in error continues to be the highest reported category. 7 of those related to Children and adolescent mental health services spread across 5 teams and 4 across Mental health community services. Work taking place to review the incidents and ensure learning is embedded to prevent future occurrences.
• Sadly, there were two 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 circumstances.
• There were 48 inpatient falls reported during July 2026, this is a slight decrease from last month. 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 95.1%% against a target of 90%. Disability recording was at 56.5%, sexual orientation 55.4% 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 the 95% 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 13 sexual safety incidents against staff by patients and 9 sexual safety incidents by patients against patient in July. 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 was 81.2% in July 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. Work will take place over the next month to include the agreed additional proposals which was agreed at last month's Trust board meeting. 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 month's 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

• The performance rates summary (page 5 of the IPR), shows that 71% of the metrics are being fully achieved, with 29% showing areas of improvement (2 metrics). Key points to note from this section of the report are as follows.

• Sickness absence performance for the month (at 5.49%) is comparable to our position at the same time last year (5.4%). At 5.1% our current YTD performance is above the level required to deliver the year-end target set out in the Workforce Plan (5.0%). As a result of strong performance in the previous months, our year-to-date sickness absence rate is only slightly higher than the planned trajectory needed to achieve the agreed year-end position. While this variance is relatively small, it highlights the need for continued focus on attendance improvement activities. The sickness absence reduction plan sets out a range of targeted interventions designed to address the key drivers of absence, support employee wellbeing, and strengthen management of attendance aligned to our planned thresholds. These actions are intended to recover performance during the remainder of the year and bring sickness absence rates back in line with the planned year-end position.

• In July 2026, appraisal compliance was 93.1%, 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. All outstanding appraisals are expected to be completed by the end of September 2026. We are providing leadership teams with data showing their progress towards achieving this and they are routinely reviewing their progress as part of localised governance. The Forensic Care Group still remains below the KPI target, with a compliance rate of 81.7%, and continues to be a key area of focus.

• At trust level, we are achieving overall compliance in all individual topics. Information Governance does remain a hot spot within Forensics, LD, ASD and ADHD and Support Services where compliance is just below the threshold. A continued focus on improving compliance within these areas is expected to increase Information Governance compliance and further strengthen overall Trust performance.

National Metrics

• Performance for this section of the report shows 70% of the metrics are being fully achieved, this is only for metrics where we are measuring against a target or threshold.

• The Trust continues to perform well against most national metrics. The following should be noted:

• Children & Younger People with an eating disorder – three routine referrals were not seen within the four-week national target, this was due to a mixture of clinical capacity and patient availability where the family declined an appointment within timescale and chose a later appointment.

• 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 July in our West Yorkshire wards have impacted the monthly average for the Trust and we have slightly exceeded our forecast position. We have also exceeded our forecast for older people lengths of stay (82.5 days against a forecast of 80 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.

• Performance against the NHS Oversight Framework for quarter 1 is expected to be published in September.

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 July, 86.5% 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.
• At the end of July, the Trust had 3 service users placed in an inappropriate out of area bed with 116 bed days used over the month, which is a decrease on last month, this resulted in an OPEL 4 status being declared. There is significant ongoing focus on patient flow and bed management to minimise out of area bed placements.
• Focus on patients clinically ready for discharge continues to take place across all services. At the end of July, 24 people were clinically ready for discharge but remained in a bed, with an overall 608 bed days over the month being used by patients that were clinically ready for discharge. 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) reduced slightly 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 but has increased in July compared to the previous month (£162k in July). 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) is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. The access standard for assessed within 14 days of referral has been met in Barnsley and Wakefield. There have been challenges with 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 71% 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 July 2026 was a deficit of £185k which is £3k more than plan in month. The year to date position remains just ahead of plan (£5k). Delivery, in line with plan, continues to be supported by one off items, such as the in month revised calculation of PDC (Public Dividend Capital) payments. Further actions are required to ensure that the breakeven target can be achieved.
• 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	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Best Quality	Responsive	TBC	76.1%	86.2%	85.7%	87.9%	90.5%	86.9%	N/A
Complaints	% of feedback with staff values and behaviours as an issue [12]	Best Quality	Caring	< 20%	22% (6/27)	9% (3/33)	10% (3/30)	0% (0/33)	8% (3/38)	10% (4/39)	1
	Complaints - Average number of working days to sign off for closed complaints (in month)	Best Quality	Well led	Trend monitor	109.8	134.8	101.3	119.7	131.3	93.2	N/A
	Complaints - Number of responses provided within six months of the date a complaint received [16]	Best Quality	Well led	100%	94% (16/17)	83% (19/23)	100% (14/14)	91% (10/11)	92% (24/26)	100% (9/9)	
Service User Experience	Friends and Family Test - Mental Health	Best Quality	Caring	84%	91%	92%	86%	93%	87%	88%	1
	Friends and Family Test - Community	Best Quality	Caring	95%	99%	96%	91%	96%	94%	95%	1
Quality	Number of compliments received	Best Quality	Caring	N/A	60	41	40	33	55	53	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Best Quality	Safe	Trend monitor	2	6	2	5	5	2	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Best Quality	Safe	Trend monitor	0	1	0	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	Best Quality	Safe	0	0	0	0	0	1	0	1
	Number of Information Governance breaches [3]	Best Quality	Well led	<12	12	12	12	5	6	16	2
	% of inpatients clinically ready for discharge	Person first and in the centre	Responsive	3.5%	5.4%	5.4%	6.1%	4.8%	4.0%	3.8%	3
	Total number of reported incidents	Best Quality	Safe	Trend monitor	1332	1416	1449	1386	1535	1325	
	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	39	41	33	29	41	31	
	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	1	0	0	2	0	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Best Quality	Safe	Trend monitor	1	4	2	1	2	2	
	Safer staff fill rates	Best Quality	Safe	90%	113.8%	112.3%	114.0%	115.1%	115.0%	112.8%	1
	Safer Staffing % Fill Rate Registered Nurses	Best Quality	Safe	80%	100.6%	98.3%	99.7%	98.6%	99.5%	98.7%	1
	% Bank Fill Rates - Registered Nurses	Best Quality	Safe	-	85.1%	85.0%	90.5%	86.7%	81.0%	81.2%	
	% Bank Fill Rates - Health Care Assistants	Best Quality	Safe	-	91.1%	90.6%	95.3%	93.0%	93.0%	92.4%	
	Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)	Best place to work and learn	Safe	-	90.4%	90.1%	94.3%	91.7%	86.4%	89.4%	
	Number of pressure ulcers which developed under SWYPFT care [1]	Best Quality	Safe	Trend monitor	47	62	56	57	55	78	
	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	1	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	45	61	53	65	55	48	
	Number of restraint incidents	Best Quality	Safe	Trend monitor	200	194	185	152	197	119	
	% of staff receiving supervision within policy guidance [15]	Best place to work and learn	Well led	80%	90.3%	92.1%	N/A	N/A	N/A	N/A	1
	% of staff receiving supervision within policy guidance [15] - Clinical			80%	Reporting commenced April		74.7%	78.4%	78.6%	79.7%	
	% of staff receiving supervision within policy guidance [15] - Management			80%	Reporting commenced April		64.6%	69.2%	70.1%	71.2%	
	Potential under-reporting of patient safety incidents	Best Quality	Safe								
	% people dying in a place of their choosing [14]	Person first and in the centre	Responsive	80%	84.6%	87.1%	93.5%	100%	100%	90%	1
	Number of job start/work retention outcomes during month by individual placement and support service	Best Quality	Effective	Trend Monitor	8	13	10	18	21	11	N/A
	Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	Best Quality	Effective	55%	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	28	29	34	27	18	45	N/A
	Number of sexual safety incidents by patients against patients	Best Quality	Safe	Trend Monitor	Reporting commenced April 26		6	5	6	9	
	Number of sexual safety incidents against staff (patient on staff)	Best place to work and learn	Safe	Trend Monitor			16	8	11	13	

Quality & Safety Headlines

Section	KPI	Strategic Objective	CQC Domain	Target	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Year End Forecast*
	Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Best Quality	Safe	0	7		7			Due Oct 26	
	Estates Urgent Response Times - Service level agreement (SLA)	Best Quality	Well led	95%	95.6%	96.9%	99.0%	95.9%	99.4%	96.0%	
	Compliance with statutory requirements (Water, Gas, Electricity, Refrigeration, Pressure, Loler and Asbestos)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	% of ligature jobs completed within timeframe (Urgent SLA 2 ligature jobs screened)	Best Quality	Well led	100%	100.0%	100.0%	100.0%	87.1%*	96.0%	97.0%	
	Percentage of service users who have had their equality data recorded - ethnicity	Best Quality	Responsive	90%	96.4%	96.5%	96.5%	96.1%	95.2%	95.1%	
	Percentage of service users who have had their equality data recorded - disability	Best Quality	Responsive	50%	59.5%	59.1%	58.7%	58.0%	57.0%	56.5%	
	Percentage of service users who have had their equality data recorded - sexual orientation	Best Quality	Responsive	50%	59.8%	59.1%	58.7%	57.6%	56.7%	55.4%	
	Percentage of service users who have had their equality data recorded - deprivation (postcode)	Best Quality	Responsive	90%	99.5%	99.5%	99.6%	99.6%	99.6%	99.6%	
	Timely completion of equality impact assessments (EIAs) in services and for policies (snapshot figure) EIA policy reporting refers to policies signed off by the Executive Management Team (EMT) with an up to date EIA in place	Best Quality	Responsive	Service timely completion - 75% Policy - 95%	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	74.3% 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%	94.1%	92.6%	93.9%	94.3%	94.9%	94.7%	
	% with care plan that includes service user input/views	Person first and in the centre	Caring		96.9%	96.5%	97.1%	96.7%	96.2%	97.6%	
	% inpatient care plans commenced within 24hrs before or after admission	Person first and in the centre	Caring		96.3%	96.8%	97.4%	96.7%	95.6%	96.6%	
	% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe		89.7%	86.0%	91.4%	92.0%	89.3%	91.7%	
	% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe		92.5%	94.1%	93.9%	93.8%	94.0%	91.3%	
	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	1	5	3	2	6	3	
	No of times staff access Yorkshire & Humber care record / Interweave during month	Best Quality	Safe	Trend Monitor	97	98	73	144	54	117	N/A
	Number of Monthly Active Users (Patients accessing patient knows best system)	Best Quality	Safe	Trend Monitor	10,035	9,960	12,000	11,968	13,289	13,935	N/A
	Medical Devices compliance rate	Best Quality	Safe	Trend Monitor	Reporting commenced April 26		75%	75%	82%	88%	
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Person first and in the centre	Safe	6	0	0	0	0	0	1	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	1	
	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 Dashboard Footnotes:

1 - Number of pressure ulcers which developed under South West Yorkshire Partnership Teaching NHS Foundation Trust (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.

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

* - 6 out of 30 jobs not completed in timescale, this was predominantly due to access issues and mitigations have been put in place to prevent such future issues occurring.

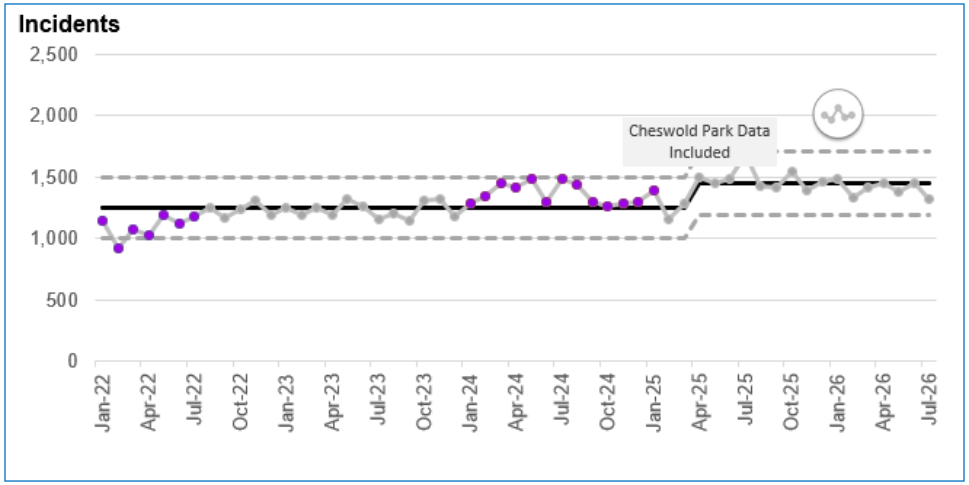
Quality & Safety Headlines

• Children and young people mental health services referral to treatment - July saw a slight dip in performance from previous month but an overall sustained positon 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 five months. Data for the metric will continue to be monitored to ensure we see a sustained improvement trend in the coming months.
• There were 16 information governance personal data breaches during July. This is the highest number reportted since February 2024. Information disclosed in error continues to be the highest reported category. 7 of those related to Children and adolescent mental health services spread across 5 teams and 4 across Mental health community services. 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 July, 24 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 though improvement is evident. Targeted work is taking place in care groups to address and ensure staff are fully supported.
• The total number of reported incidents in July decreased slightly but remains within usual variance. 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 two 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 45 incidents involving race in July - 19 incidents in Forensics Care Group across 5 wards/teams; 12 incidents in MH inpatients across 8 wards/teams; 14 incidents in Cheswold Park Hospital across 3 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 9 incidents of sexual safety incidents against patients in July. 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 13 incidents of sexual safety incidents against staff (by patients) in July. 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) - reported quarterly) - 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.
• In July there was one instance of a pressure ulcer that developed under SWYPFT care where there was an area for improvement which related to the ongoing improvement work in embedding the use of Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE-T) screening by all integrated Neighbourhood Team staff and appropriate scheduling of visits.
• The number of restraint incidents in July was 117. The highest number of incidents were on Elmdale (14). 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 48 inpatient falls reported during July 2026, this is a slight decrease from last month.
• Our focus on reducing the use of prone restraint has shown significant improvement over the last few months; there were three staff led prone restraints on our mental health wards. All 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.
• There was one case of E. coli bacteraemia in July 2026 which was identified in one of our Mental Health wards. A case review has been undertaken identifying the case as community onset, healthcare associated with no learning and improvement for the Trust to undertake.

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.

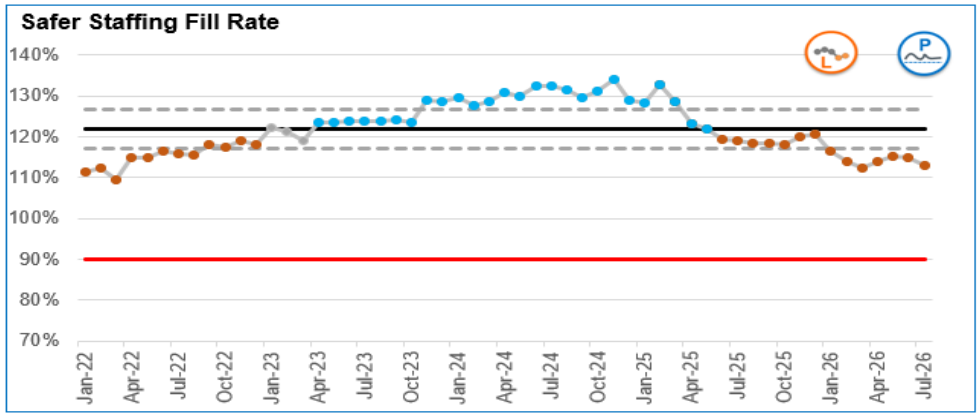
Statistical process control charts

Incidents

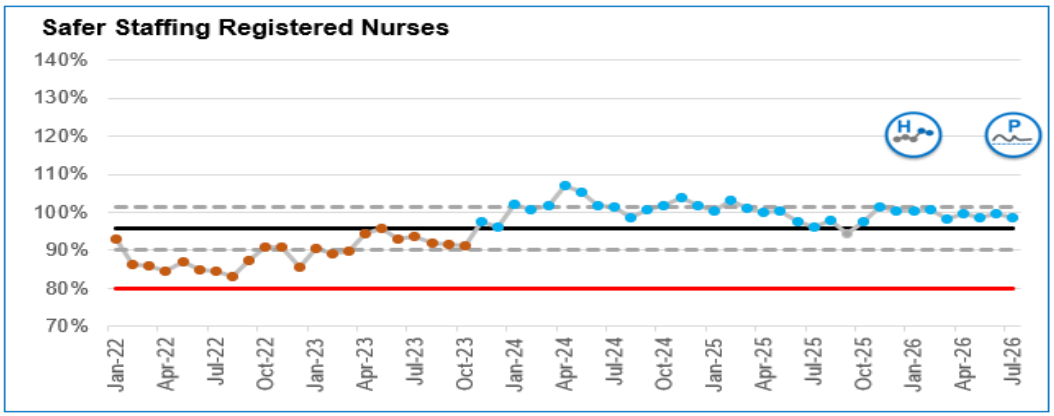


We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data. The chart shows that we are in a period of common cause variation (no concern).
It should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting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



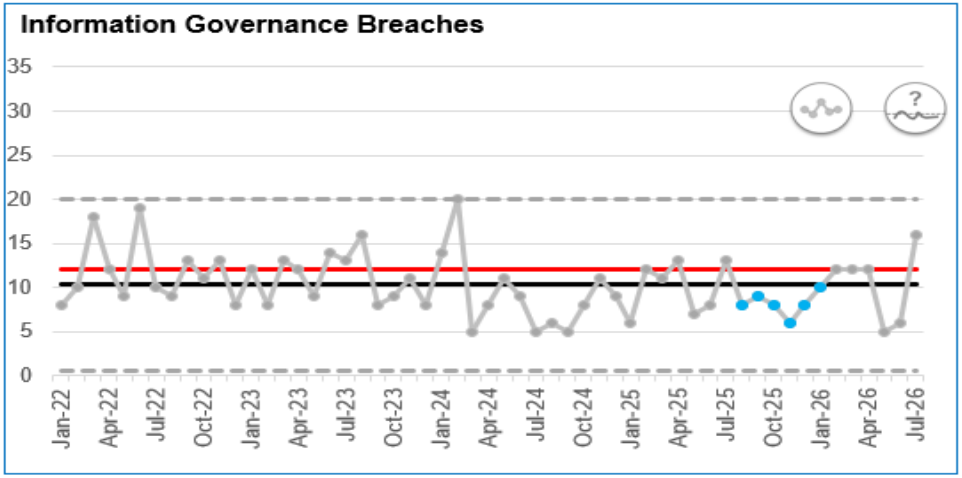
The chart above shows that in July 2026 we remain in a period of special cause concerning variation (something is happening and should be investigated). There has been an increase in demand which means more shifts are being requested, there has been a smaller increase in the number of shifts being filled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

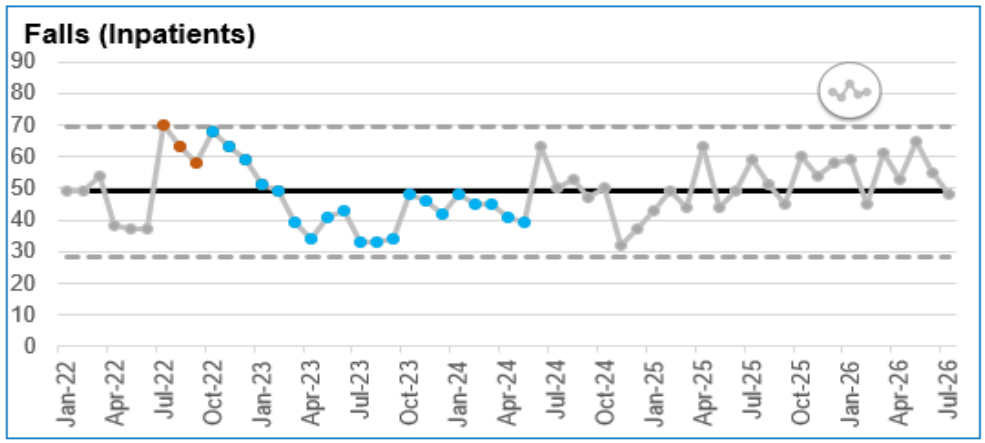
Statistical process control charts

Information Governance (IG)



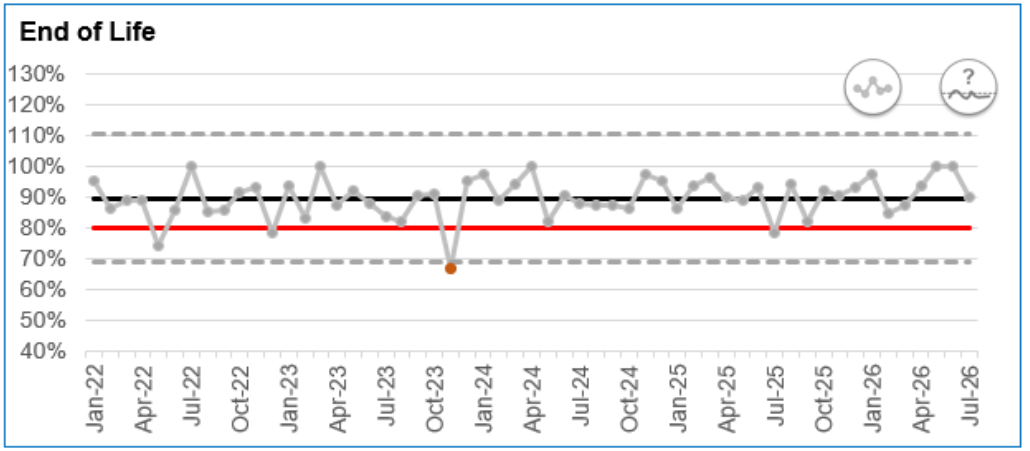
This SPC chart shows that as at July 2026 we remain in a period of common cause variation (no concern). Although the number of IG breaches reported in July is higher than it has been for a number of years and indeed higher than the target of 12, the variance is expected and well within the control limits based on the variation seen between previous data points.

Falls (Inpatient)



The SPC chart above shows that in July 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.

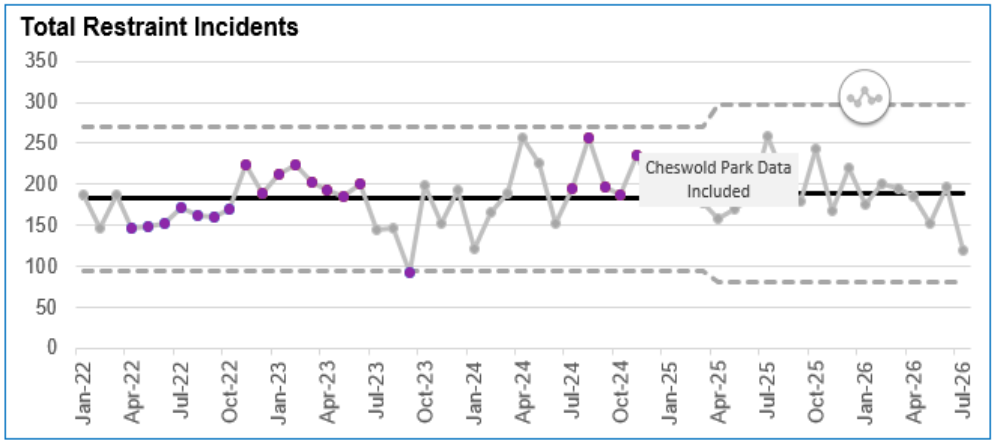
End of Life



The chart above shows that in July 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

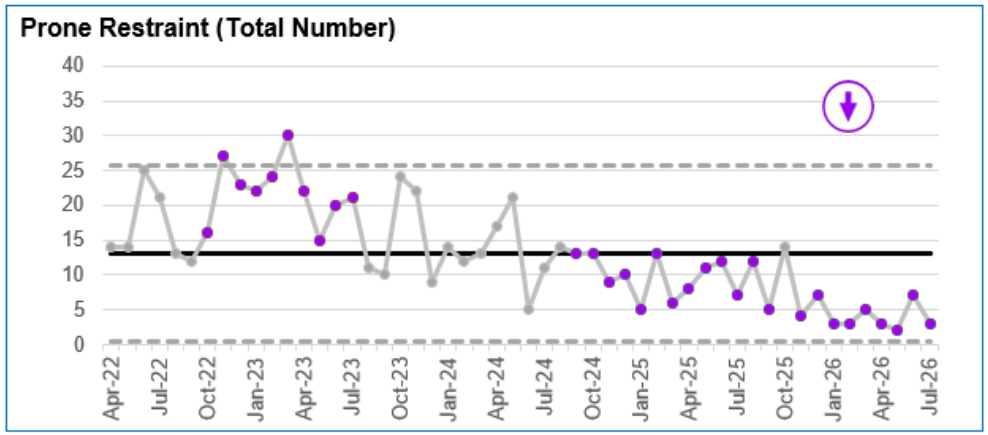
Restraints



This SPC chart shows that in July 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.

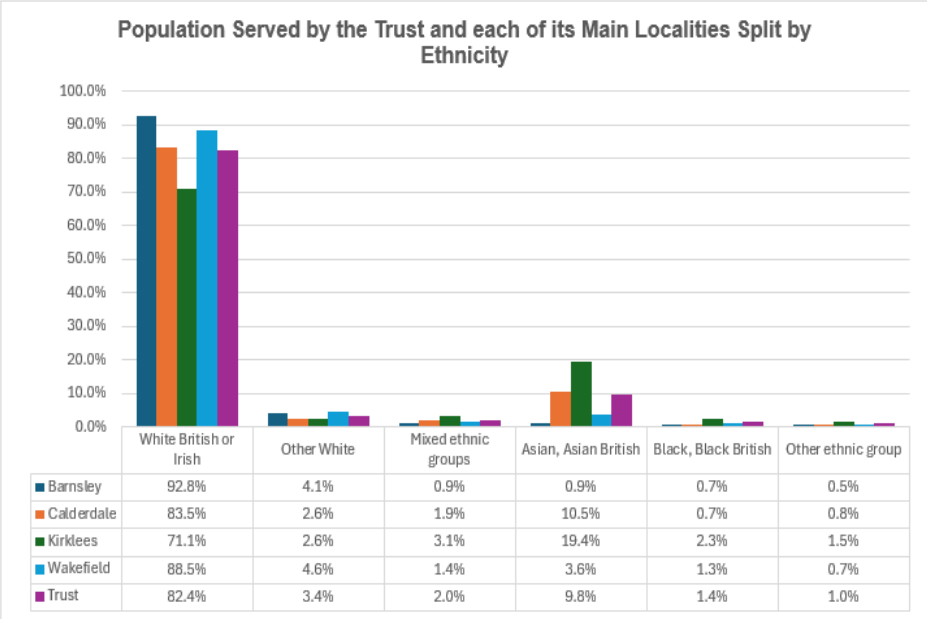
We have recalculated the chart from April 2025 due to the inclusion of Cheswold Park Hospital data.



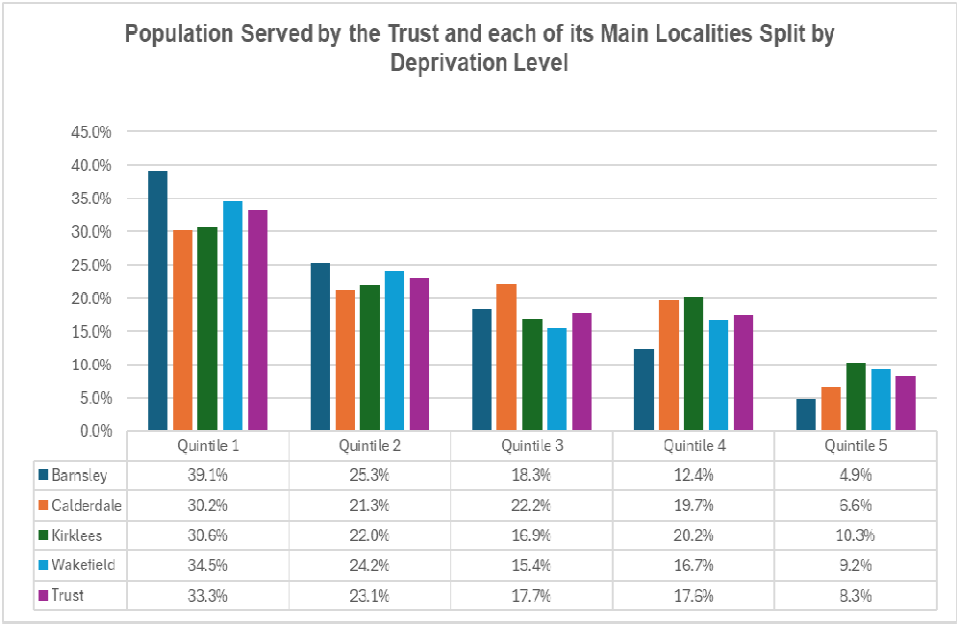
The total number of prone restraints continues to show special cause reducing variation in line with the continued work to reduce prone restraints. All three of the prone restraints in June 2026 were staff led and due to intramuscular medication needing to be administered.

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%

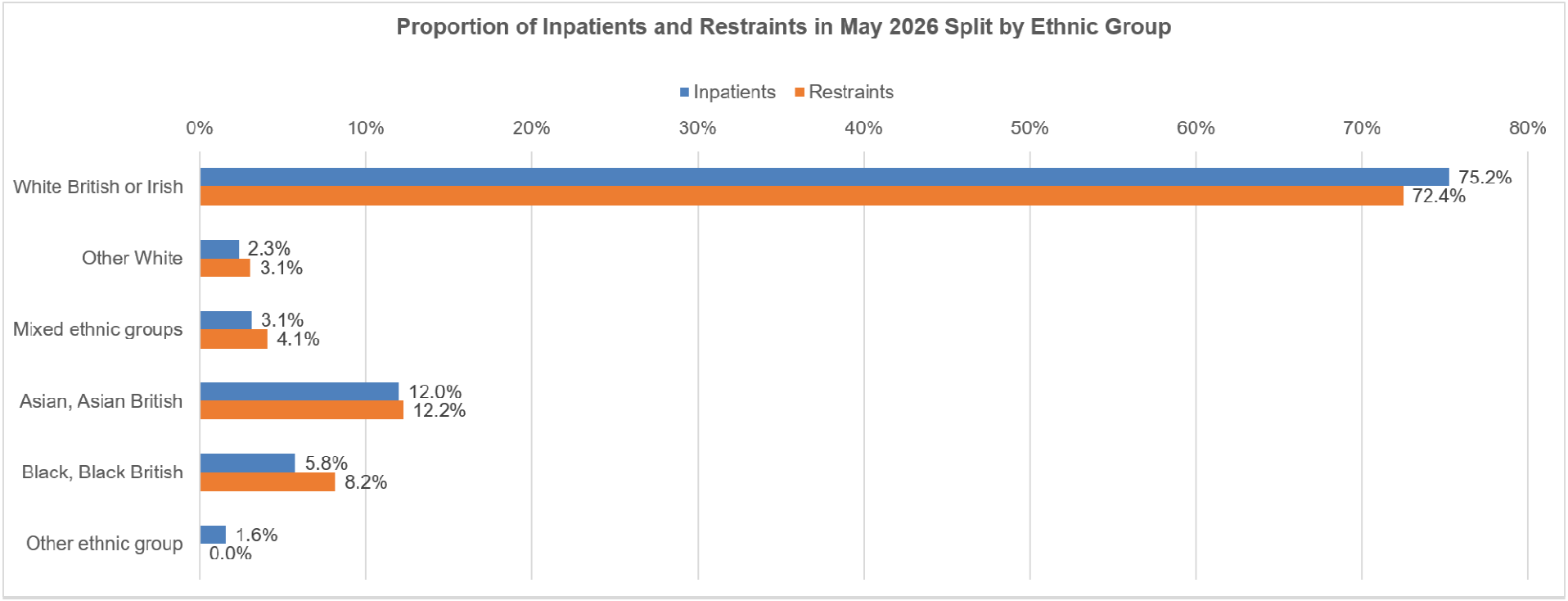


	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Barnsley	39.1%	25.3%	18.3%	12.4%	4.9%
Calderdale	30.2%	21.3%	22.2%	19.7%	6.6%
Kirklees	30.6%	22.0%	16.9%	20.2%	10.3%
Wakefield	34.5%	24.2%	15.4%	16.7%	9.2%
Trust	33.3%	23.1%	17.7%	17.6%	8.3%

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

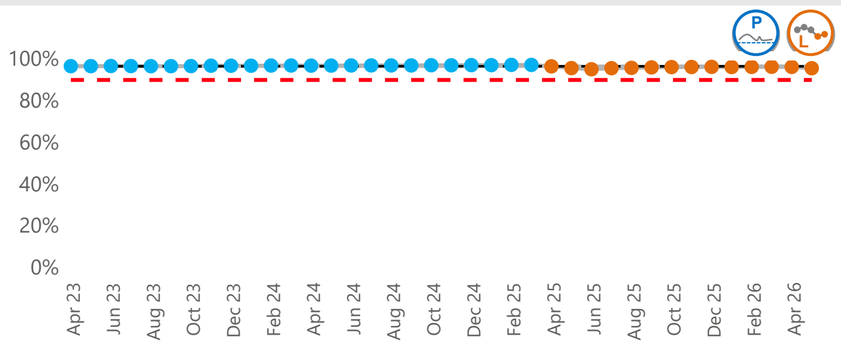
Data as of : 16/06/2026 12:02:49

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.

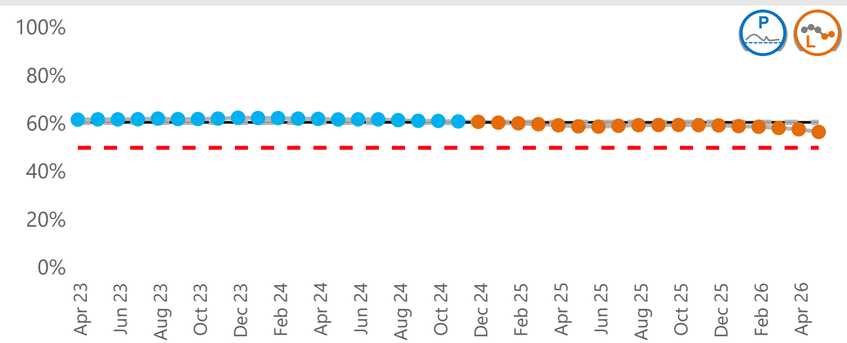
The SPC charts below show the completion rates for these measures.

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



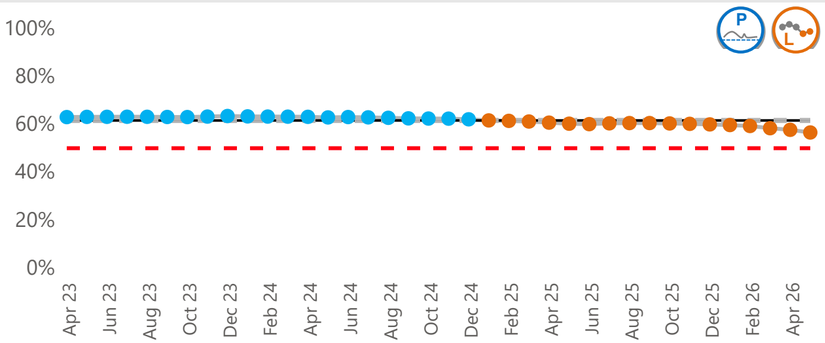
The Statistical Process Control (SPC) chart shows that in April 2026 due to the continued dip in performance we remain in a period of special cause deteriorating variation (something is happening and should be investigated). We are expected to meet the target against this metric.

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



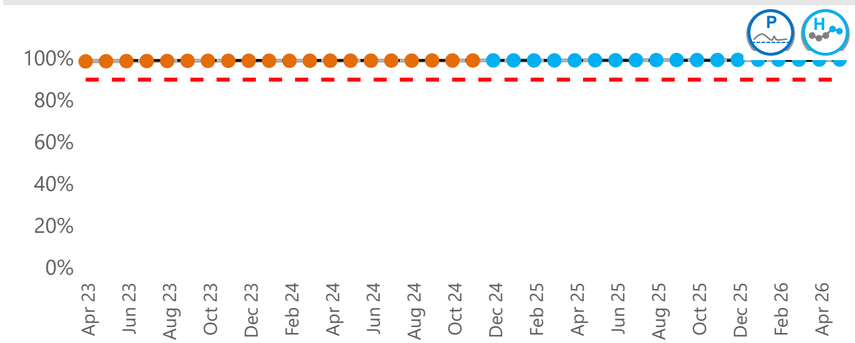
The SPC chart shows that in April 2026 we remain in a period of special cause deteriorating variation (something is happening and should be investigated) following a sustained decline in performance over the past 12 months. We are expected to meet the target against this metric. There are a number of 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)



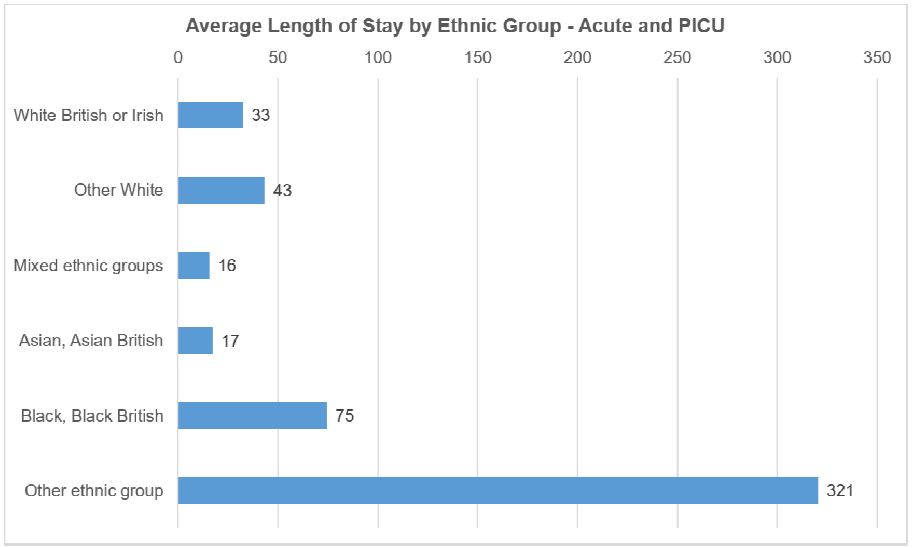
The SPC chart shows that in April 2026 we remain in a period of special cause improving variation (something is happening and should be investigated) following a sustained increase in performance. We are expected to meet the target against this metric.

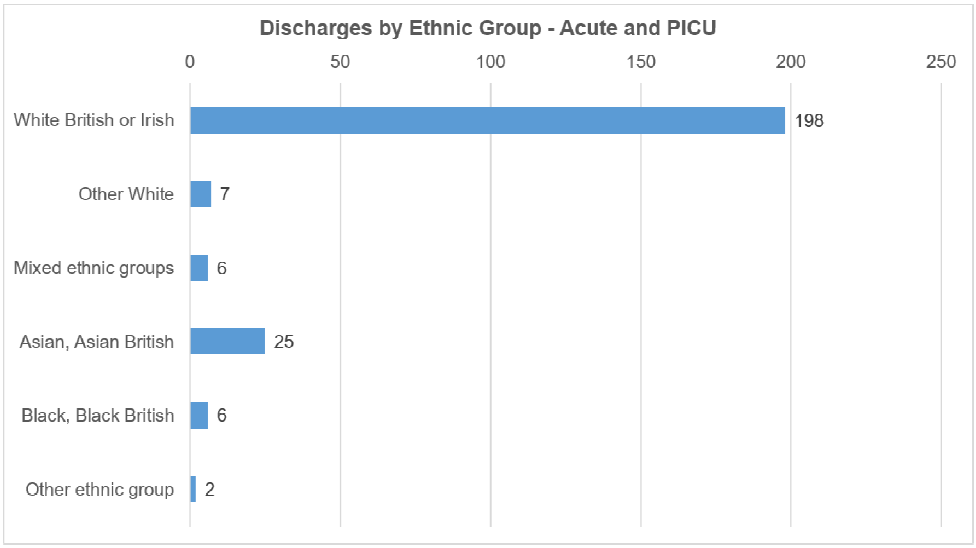
Reducing Inequalities

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.

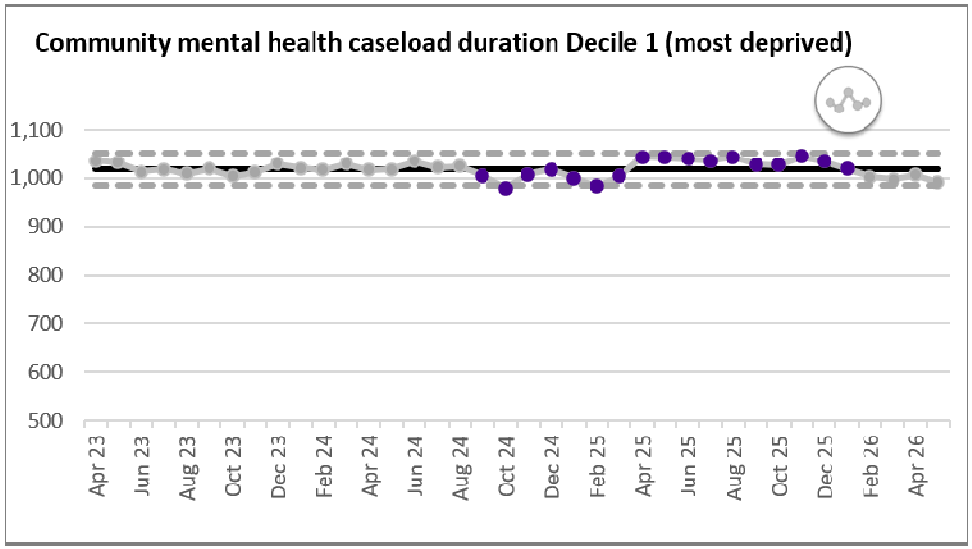
Differences in admission practices i.e. formal (compulsory) and informal (voluntary) also appear to influence LoS, with compulsory admissions tending to require more intensive interventions and longer discharge planning. Similarly, discharge approaches differ, with patients facing socioeconomic challenges 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.

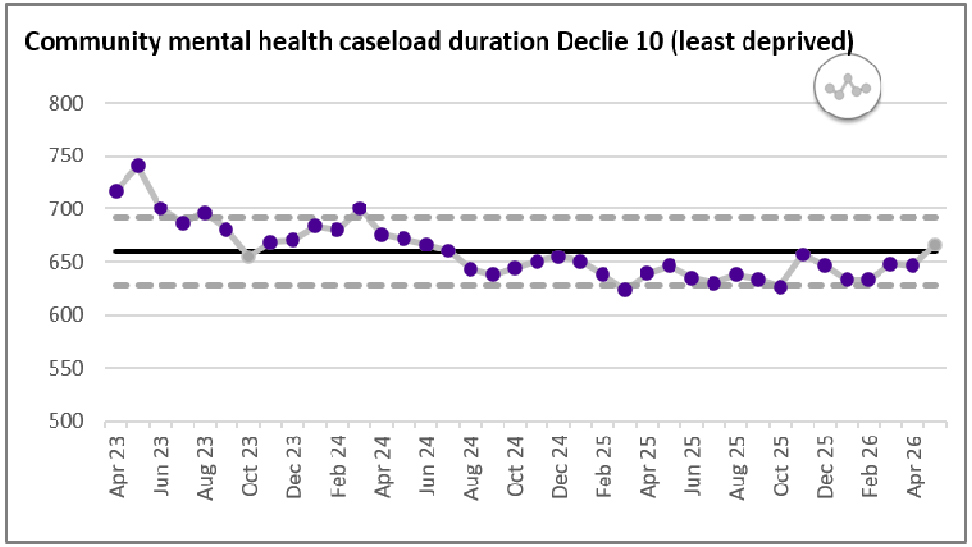




Reducing Inequalities

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.

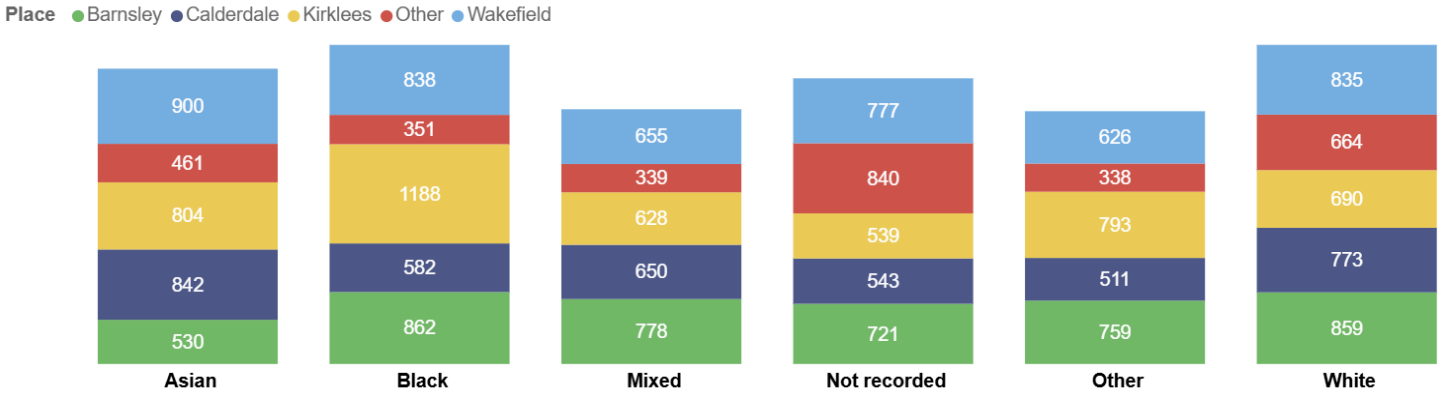




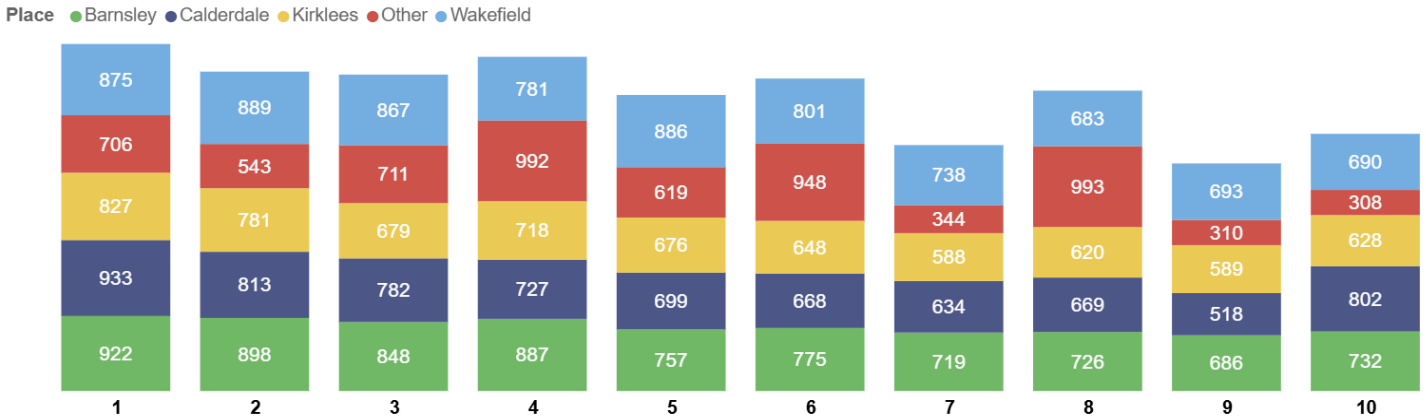
Reducing Inequalities

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



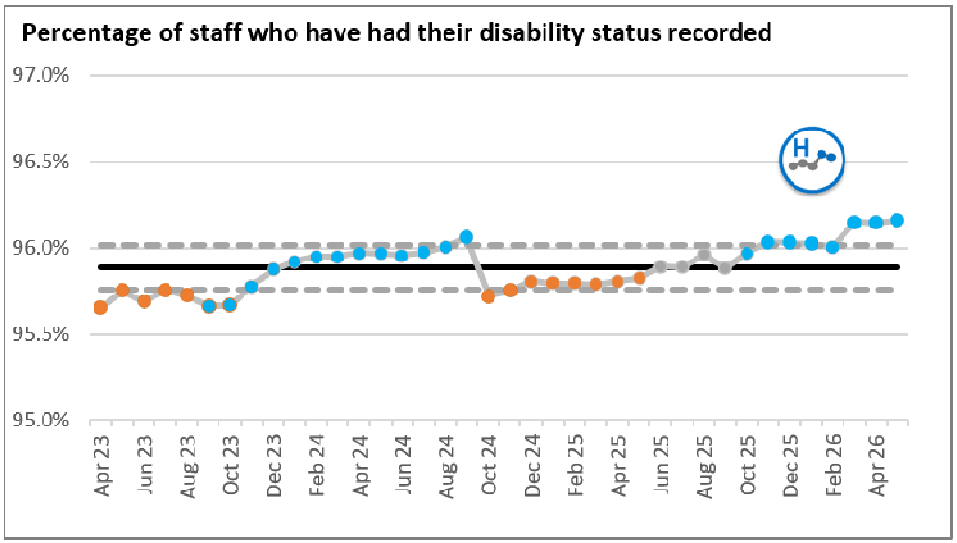
Average Days on Caseload Split by Deprivation Decile and Place - Mental Health Rolling 12 Months

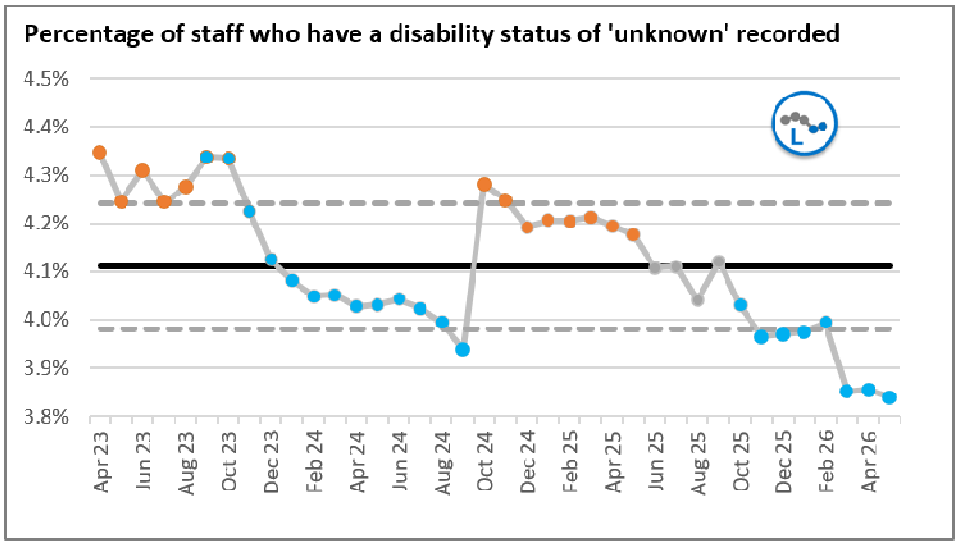


Reducing Inequalities

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	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Vacancy Rate	Best place to work and learn	Well led	8%	Reporting Commenced April 2026		6.4%	6.6%	6.2%	5.9%
Turnover external (12 months rolling)	Best place to work and learn	Well led	25/26 - 13% 26/27 - 10%	9.0%	8.2%	8.4%	9.3%	9.0%	8.7%
Starters	Best place to work and learn	Well led	-	47.5	39.0	37.3	14.8	39.6	38.9
Leavers	Best place to work and learn	Well led	-	35.6	36.2	28.9	39.3	25.7	36.2
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%)	131 (11.2%)	132 (11.2%)	134 (11.4%)	132 (11.2%)	133 (11.3%)
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	-	975 (72.1%)	986 (72.2%)	985 (72.3%)	985 (72.3%)	985 (72.4%)	987 (72.5%)
Sickness absence - Year-to-Date (YTD)	Best place to work and learn	Well led	<=5%	5.5%	5.4%	4.9%	4.9%	5.0%	5.1%
Sickness absence - Month	Best place to work and learn	Well led		5.2%	4.9%	4.9%	4.8%	5.3%	5.5%
Appraisals - rolling 12 months	Best place to work and learn	Well led	90%	87.8%	88.7%	92.2%	92.8%	93.5%	93.3%
Carbon Impact (tonnes CO2e) - business miles	Best use of resources	Well led	<76	66	60	64	65	64	68
Sexual Safety Incidents - Staff	Best place to work and learn	Safe	Trend Monitor	Reporting Commenced April 2026		0	0	0	1
Mandatory Training - TOTAL	Best place to work and learn	Well led	>=80%	95.3%	95.3%	95.2%	95.4%	95.0%	95.4%

Our workforce supply

Turnover

July 2026 turnover was 8.7%, which is below the KPI target. Although our Forensics Care group is still above our KPI target (10.7%) this has reduced since last month (12.1%) as a result of legacy turnover associated with planned workforce reduction at Cheswold Park Hospital (CPH) last year.

Vacancy Rate

The vacancy rate decreased again in July 2026 (5.9%), driven by a higher number of starters than leavers and a reduction in funded establishment. 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 Community Support Worker (CSW) workforce. Our ongoing recruitment campaign is continuing to reduce our vacancies.

We are safe and healthy

Sickness Absence

Sickness absence performance for the month (at 5.49%) is comparable to our position at the same time last year (5.4%). At 5.1% our current Year-To-Date (YTD) performance is above the level required to deliver the year-end target set out in the Workforce Plan (5.0%). As a result of strong performance in the previous months, our year-to-date sickness absence rate is only slightly higher than the planned trajectory needed to achieve the agreed year-end position. While this variance is relatively small, it highlights the need for continued focus on attendance improvement activities. The Sickness Absence Reduction Plan sets out a range of targeted interventions designed to address the key drivers of absence, support employee wellbeing, and strengthen management of attendance aligned to our planned thresholds. These actions are intended to recover performance during the remainder of the year and bring sickness absence rates back in line with the planned year-end position.

Employee Relations

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

We are compassionate and inclusive

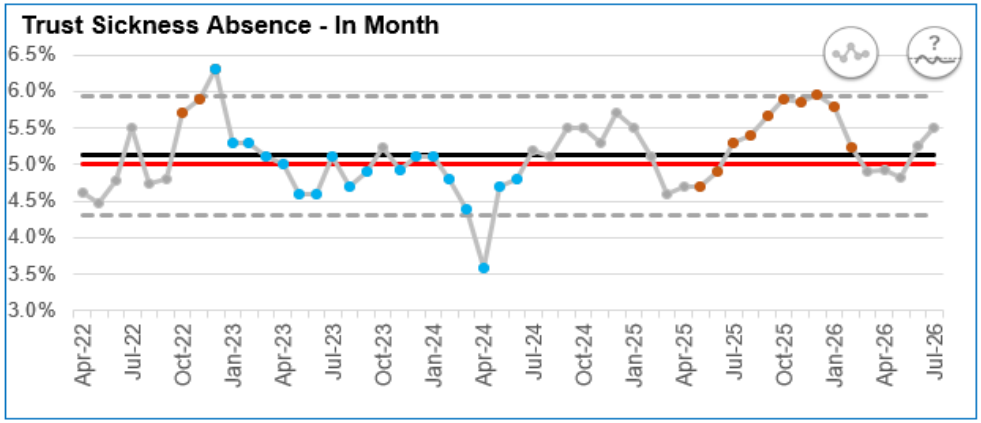
Appraisal Compliance

In July 2026, appraisal compliance was 93.1%, 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. All outstanding appraisals are expected to be completed by the end of September 2026. We are providing leadership teams with data showing their progress towards achieving this and they are routinely reviewing their progress as part of localised governance. The Forensic Care Group still remains below the KPI target, with a compliance rate of 81.7%, and continues to be a key area of focus.

Training Compliance

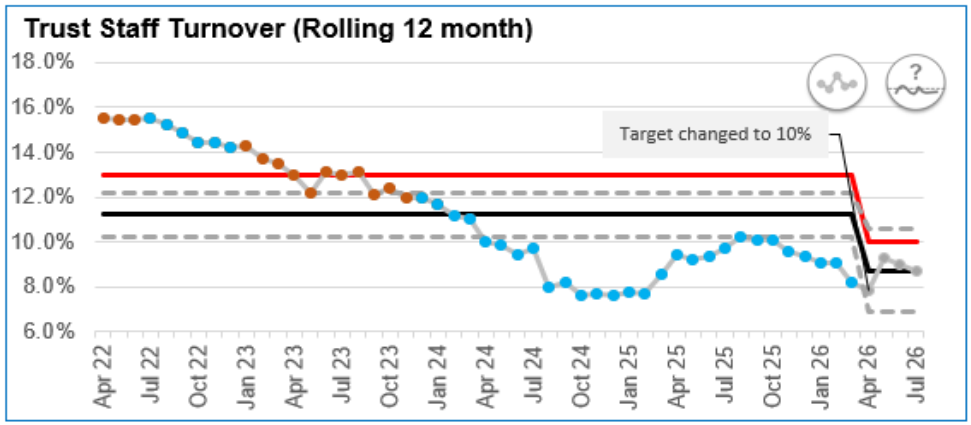
At Trust level, we are achieving overall compliance and following a focus on Information Governance we are now achieving compliance in all individual topics. Information Governance does remain a hot spot within Forensics, LD, ASD and ADHD and Support Services where compliance is just below the threshold. A continued focus on improving compliance within these areas is expected to increase Information Governance compliance and further strengthen overall Trust performance.

Statistical process control charts



The SPC chart shows that in July 2026 we remain in a period of common cause variation (no concern). Sickness absence performance for the month (at 5.49%) is comparable to our position at the same time last year (5.4%). At 5.1% our current Year-To-Date (YTD) performance is above the level required to deliver the year-end target set out in the Workforce Plan (5.0%). Please see previous page for detail and actions beign undertaken.

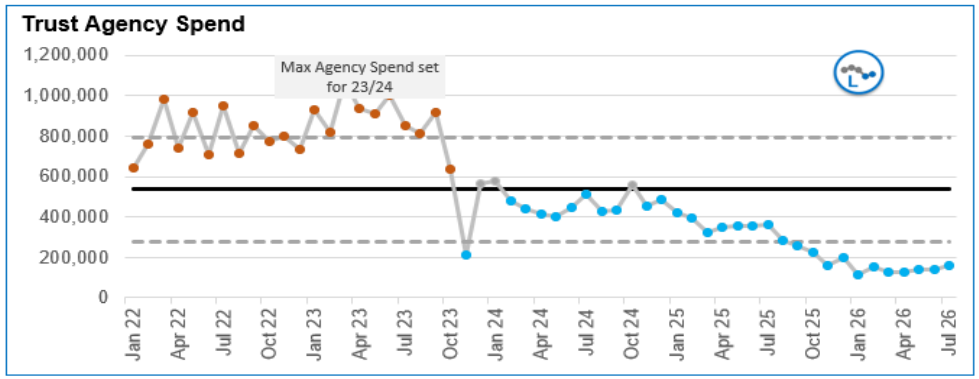
From April 2025 this data includes Cheswold Park Hospital.



In July 2026 turnover was 8.7%, which is below the target of 10%. Although our Forensics Care group is still above the target (10.7%) this has reduced since last month (12.1%) as a result of legacy turnover associated with planned workforce reduction at Cheswold Park last year.

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

From April 2025 this data includes Cheswold Park Hospital.



Agency spend, which continues to be limited to a small number of medical posts, has increased from £138k to £162k in month. This is equivalent to 7.72 worked WTE. As monitored within the National Oversight Framework this is 0.5% of the Trust's year to date total pay bill.

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

From April 2025 this data includes Cheswold Park Hospital.

Please see the Finance Report for further information.

National Metrics

Data as of : 19/08/2026 17:37:51

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	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 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	97.5%	97.2%	97.1%	97.8%	97.5%	96%	95.6%	96.4%	97.5%	97.5%	97.1%	97.1%
M204	RTT waiting list within 18 weeks (monthly RTT data)	Best Quality	Responsive		3680	?	H	4319	4554	4641	4514	4287	3868	3946	4162				
					4043	?	H									4273	4354	4454	4513
M206	Diagnostic test activity	Best Quality	Responsive		190	?		239	305	273	247	263	294	235	265				
					193	?										249	205	277	218
M171	% Admissions gate kept by crisis resolution teams	Best Quality	Safe		95%	P		96.3%	100%	98.9%	100%	100%	100%	100%	99.1%	100%	100%	98.2%	99.0%
M2	Inappropriate out of area bed days	Best Quality	Responsive		0	F	L	203	234	155	97	76	52	28	73	90	82	137	116
M182	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Best Quality	Responsive		5	?	L	8	7	3	4	2	1	1	2	2	2	6	3
M7	72 hour follow-up from psychiatric in-patient care	Best Quality	Safe		80%	?	H	88.6%	88.2%	89.0%	87.8%	87.6%	91.1%	87.7%	87.3%	86.5%	87.2%	86.8%	90%
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Best Quality	Effective		60%	P		87.5%	93.3%	94.6%	96.4%	96.9%	89.7%	96.4%	96.2%	85.3%	86.8%	90%	90%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months	Best Quality	Effective		95%	?	H	96.1%	96.4%	96.9%	96.7%	97.4%	97.0%	96.6%	96.5%	95.9%	96.6%	97.2%	96.3%
M34	% Clients in settled accommodation	Best Value	Effective	⚠	60%	P	L	76.0%	82.8%	82.9%	83.3%	83.0%	83.0%	83.2%	83.2%	82.9%	83.4%	82.7%	83.0%
M35	% Clients in employment	Best Value	Effective	⚠	10%	P	H	12.6%	13.3%	13.6%	14.0%	13.7%	14.0%	14.1%	14.2%	14.1%	14.2%	13.6%	13.7%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		0	6	16	2	4	0	2	4	12	25	1	1
M9	Total number of Children and Younger People under 18 in adult inpatient wards	Best Quality	Safe		0	?		0	1	1	1	1	0	1	1	1	2	1	1

National Metrics

Data as of : 19/08/2026 17:37:51

NHS South West Yorkshire Partnership NHS Foundation Trust

MetricID	Metric	Strategic Objective	CQC Domain	Data Quality Rating	Target	Assurance	Variation	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	Best Quality	Effective		95%			100%	100%	100%	75%	100%	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%			88.2%	83.8%	94.4%	94.4%	92.9%	91.2%	100%	89.7%	95%	100%	92.3%	93.0%
M47	Virtual ward occupancy	Best Quality	Responsive		80%			89.3%	92%	74.7%	70.7%	72%	70.7%	85.3%	62.7%	108%	78.7%	86.7%	88%
M188	Community services waiting list, over 52 weeks	Best Quality	Responsive		0			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					99	102	102	83	106	98	101	116	113	124	132	99
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin	Best Quality	Responsive					24.2%	24.5%	22.5%	16.9%	17.9%	23.5%	13.9%	22.4%	24.8%	25%	21.2%	15.2%
M10	Talking Therapies - Treatment within 6 Weeks of referral	Best Quality	Effective		75%			99.4%	99.5%	99.3%	99.4%	98.9%	97.7%	98.9%	98.6%	99.8%	99.6%	98.1%	99.0%
M11	Talking Therapies - Treatment within 18 weeks of referral	Best Quality	Effective		95%			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%			99.6%	99.5%	99.5%	99.4%	98.1%	99.1%	99.3%	99.5%	99.3%	99.0%	99.1%	98.6%
M178	Talking Therapies - Reliable Recovery	Best Quality	Effective		48%			47.2%	52.5%	52.9%	48.7%	50.2%	49.9%	50.6%	54.0%	56.8%	54.2%	52.5%	55.0%
M179	Talking Therapies - Reliable Improvement	Best Quality	Effective		67%			65.8%	70.4%	70.5%	72.2%	68.5%	68.9%	69.8%	71.7%	73.2%	72.8%	70.1%	72.1%
M43	Community health services two hour urgent response standard	Best Quality			70%			92.1%	92.0%	87.5%	89.6%	88.4%	88.2%	88.6%	91.2%	89.9%	90.5%	88.6%	88.8%

National Metrics

Data as of : 19/08/2026 17:37:51

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.

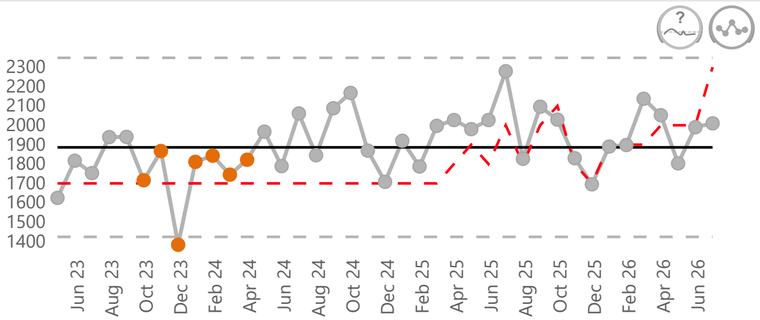
MetricID	Metric	Strategic Objective	CQC Domain	GroupCategory	GroupName	Target	Assurance	Variation	Apr 26	May 26	Jun 26	Jul 26
M4	Talking Therapies - proportion of people completing treatment who move to recovery	Best Quality	Effective	Trust	Trust	50%	?		59.9%	55.4%	55.0%	56.2%
				Place	Barnsley	50%	?	H	59.4%	50.5%	52.8%	59.9%
					Kirklees	50%	?		60.1%	58.9%	56.5%	53.7%
M185	NHS Talking Therapies for anxiety and depression - number of adults and older adults completing treatment	Best Quality	Effective	Trust	Trust				571	514	579	628
				Place	Barnsley				219	206	218	236
					Kirklees				352	308	361	392
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact - Rolling 12 months	Best Quality	Responsive	Trust	Trust	13400	P	H	15099	15081	15076	14924
				Place	Barnsley	2900	F	L	2746	2688	2614	2561
					Calderdale	1400	?	H	1501	1469	1482	1470
					Kirklees	4800	P	H	5250	5301	5381	5372
					Wakefield	4300	P	H	4774	4797	4765	4687
M181	Women Accessing Specialist Community Perinatal Mental Health Services	Best Quality	Responsive	Trust	Trust			H	2098	2030	1968	1911
				Place	Barnsley	283	F	H	344	333	334	322
					Calderdale	247	?	H	311	287	282	280
					Kirklees	541	?	H	760	738	711	684
					Wakefield	406	?	H	573	560	535	513

National Metrics

Data as of : 19/08/2026 17:37:51

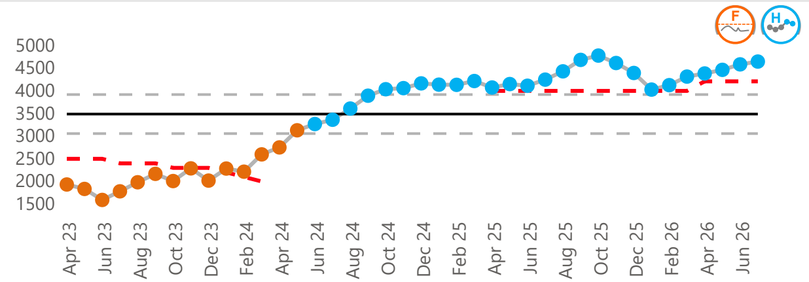
NHS South West Yorkshire Partnership NHS Foundation Trust

M184 - New RTT pathways (clock starts)



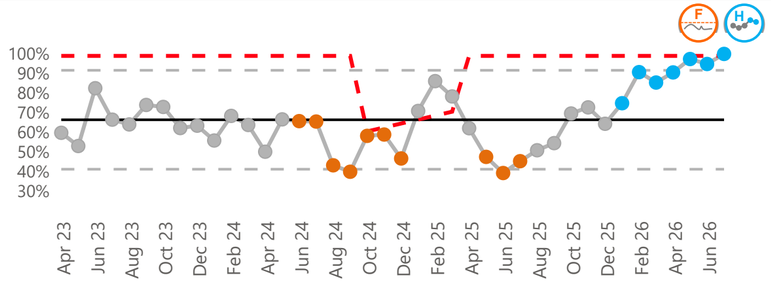
The Statistical Process Control (SPC) chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers. A new moving target is in place for 2025/26.

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



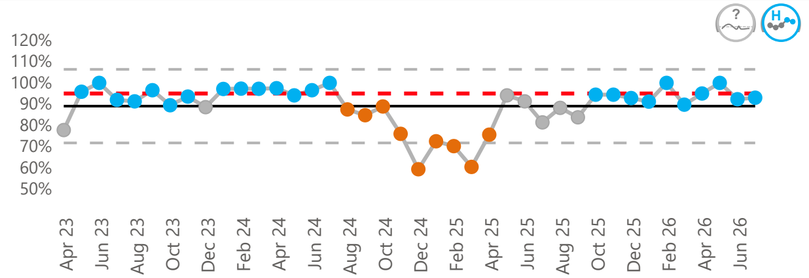
The SPC chart shows that we remain in a period of special cause concerning variation (something is happening and should be investigated) following a sustained increase in numbers of incomplete pathways over the past 12 months. We are not currently forecast to meet the target though current performance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

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



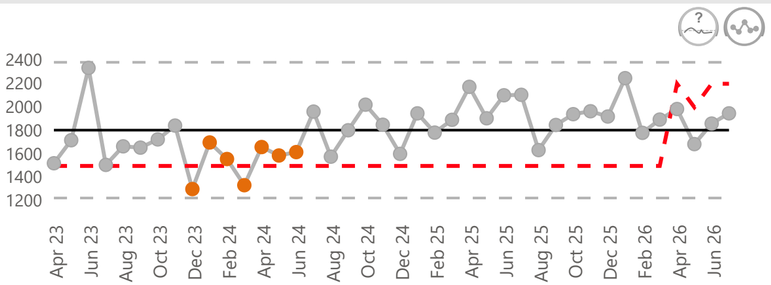
The SPC chart shows that we have entered a period of special cause improving variation (something is happening and should be investigated). Though we are not expected the meet the target of 99%.

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



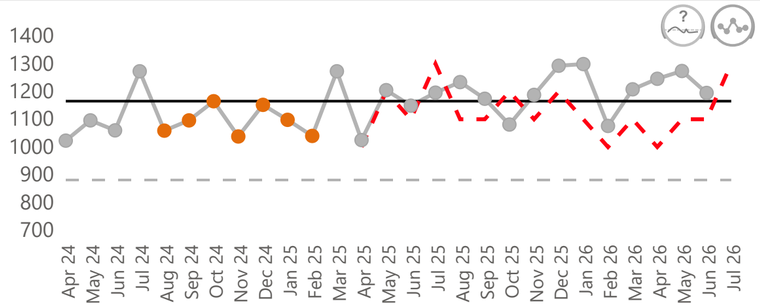
The SPC chart shows that we remain in a period of common cause variation (no concern). Whether we will meet the target cannot be established due to the previous fluctuations in numbers this time last year.

National Metrics

Data as of : 19/08/2026 17:37:51

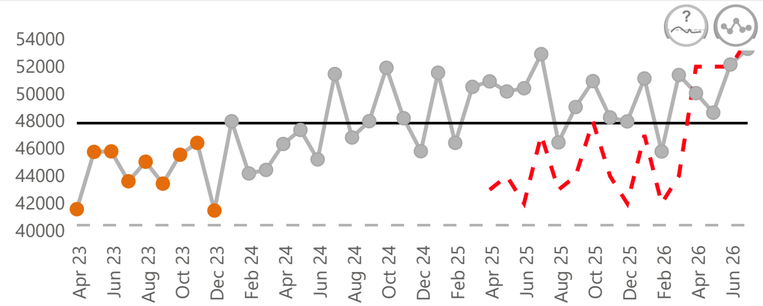
NHS South West Yorkshire Partnership NHS Foundation Trust

M187 - Urgent Community Response (UCR) referrals



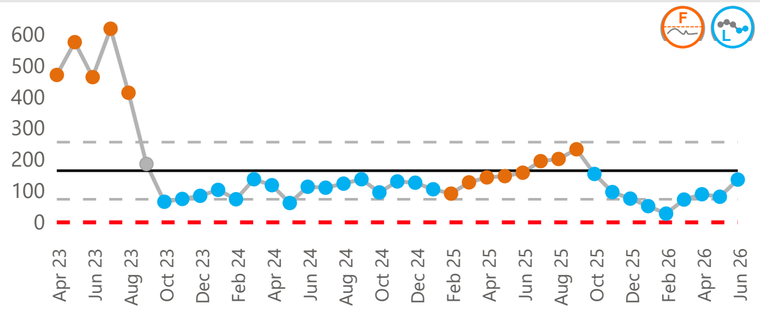
The SPC chart shows that we remain in a period of common cause variation (no concern).

M207 - Attended Community Care Contacts



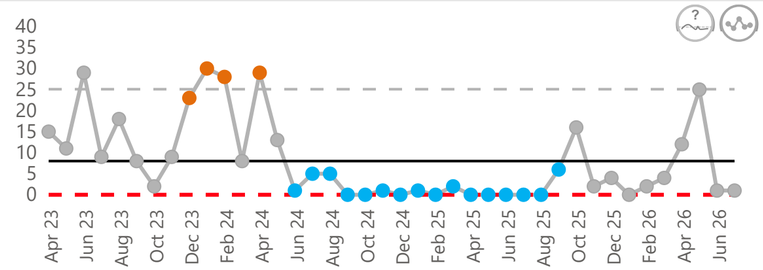
The SPC chart shows that we remain in a period of common cause variation (no concern).

M2 - Inappropriate out of area bed days



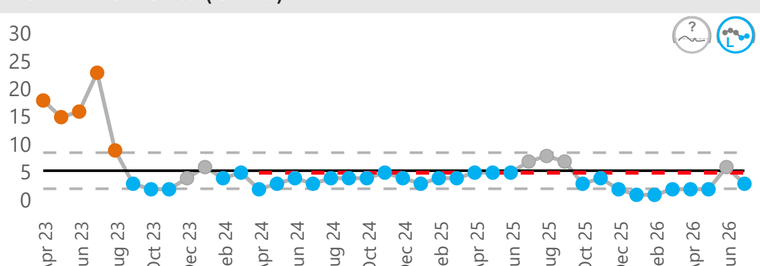
The SPC chart shows that due to the continued improvement in the number of out of area bed days we remain in a period of special cause improving variation (something is happening and should be investigated). Though we are still not anticipated to achieve the target of zero.

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



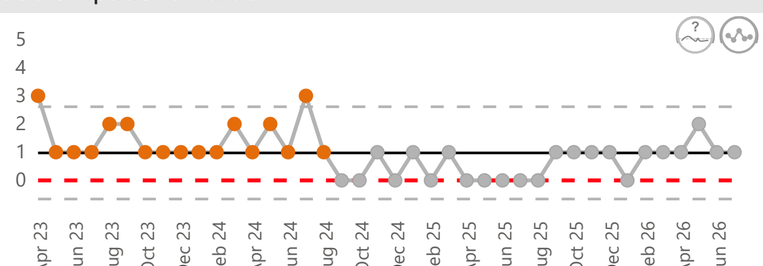
The SPC chart shows we remain in common cause variation (no concern).

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 July 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	May-26	Jun-26	Jul-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 July - 443	435 (16%)	445 (16%)	Due Sept 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 July - 81			78
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	Apr-Jun -44 July - 43			73
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 - 244 May - 234 Jun - 223 July - 213			244
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			20
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 July - 48.3	45.6	47.7	47.6
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 months rolling) - South Yorkshire	Best Quality	Responsive	Apr - 58.1 May - 60.0 Jun - 56.7 July - 56.7	48.7	46.0	37.5
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 July - 44.7	42.9	44.1	47.8
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 July - 80.1	92.9	90.2	82.5
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 July - 70.8	73.3	64.2	62.1
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 months rolling) - West Yorkshire	Best Quality	Responsive	May - 78.7 Jun - 76.1 July - 77.5	100.0	97.8	86.7

KPI	Strategic Objective	CQC Domain	Target	May-26	Jun-26	Jul-26
Access to Mental Health Support Teams Mental Teams in schools and colleges - Kirklees	Best Quality	Responsive	May - 830 Jun - 860 July - 890	1004	1018	1017
Access to Mental Health Support Teams Mental Teams in schools and colleges - Wakefield	Best Quality	Responsive	1300	1833	1834	1801
Number of patients accessing Individual Placement Support services - rolling 12-month - Calderdale	Best Quality	Responsive	May - 164 Jun - 168 July - 174	131	126	121
Number of patients accessing Individual Placement Support services - rolling 12-month - Kirklees	Best Quality	Responsive	May - 304 Jun - 311 July - 318	253	248	253
Number of patients accessing Individual Placement Support services - rolling 12-month - Wakefield	Best Quality	Responsive	May - 281 Jun - 285 July - 304	395	406	414
Percentage of people on entire waiting lists who are waiting 18 weeks or less	Best Quality	Responsive	78% by March 27	89.0%	90.4%	92.7%
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	97.8%	97.4%	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	61.0%	65.9%	71.1%

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 14.8% of records have missing employment and/or accommodation status with a further 1.7% that have an unknown employment status and 1% 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 : 19/08/2026 17:37:51

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 - At the end of July, the Trust had three service users placed in an inappropriate out of area bed with 116 bed days used over the month. Work to maintain effective patient flow continues, with the use of out of area beds being closely managed. The situation remains challenging in July 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.

• M14 - The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks achieved 93%, which related to three people not seen in time.

• M6 - The percentage of service users waiting for a diagnostic appointment (Paediatric Audiology service only) within 6 weeks has achieved 100% in July. 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).

• Reporting against the 'Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period' is available at Place level. There are more people waiting over 104 weeks than planned in both Calderdale and Kirklees.

• 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 an August 2025 baseline. At Trust level, we are slightly below our forecast position for July for adult and PICU lengths of stay (47.6 days against a forecast of 48.3 days) but are above our forecast for older peoples' lengths of stay (82.5 days against a forecast of 80.1 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 92.7% for July. 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.

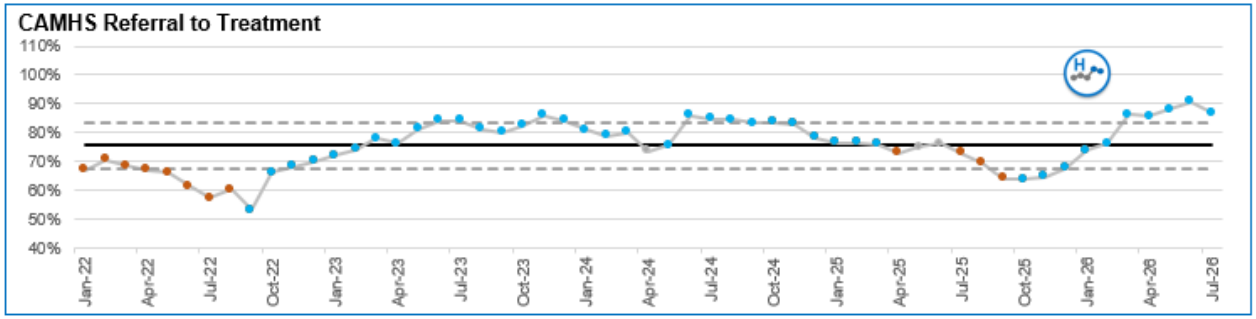
NB: data in *italics* is provisional, this will be refreshed in the next report once final.

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.

Metrics	Strategic Objective	CQC Domain	Threshold	May-26	Jun-26	Jul-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	93.2%	93.2%	93.0%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/3)	0% (0/5)	0% (0/4)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	76.2%	86.5%	82.1%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	75.7%	79.4%	67.3%	
CAMHS - Crisis Response 4 hours	Best Quality	Responsive	N/A	98.1%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.2%	81.9%	83.7%	
Eating Disorder - Routine clock stops	Best Quality	Effective	95%	100.0%	92.3%	92.9%	
Eating Disorder - Urgent/Emergency clock stops	Best Quality	Effective	95%	100.0%	100.0%	87.5%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.9%	91.6%	95.0%	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	91.8%	92.1%	94.6%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.2%	4.8%	5.5%	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	Best Quality	Responsive	126 days	648	732	711	
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	Best Quality	Responsive	126 days	1,156	1,084	1,208	
Total number of reported incidents	Best Quality	Safe	Trend monitor	42	64	53	



In July 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 director of services and people directorate 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 Integrated Care Board (ICB) Right to Choose (RtC) decision making, medical staffing vacancies and limited non medical prescriber support (0.6wte). Current longest wait (non-allocated appointment) is 75 weeks. Escalated to director of service 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.
• Wakefield CAMHS ReACH Team and Primary Intervention Team (SPA), continues to experience challenges recruiting to posts. Both pathways remain red on the risk register due to long term sickness and vacancies awaiting recruitment. The Psychotherapy offer remains closed to internal referrals. The action plan remains in place and is monitored in the wait's improvement group. Solid progress is being made with all long waiters allocated and all cases risk assessed and care plans in place. Paediatric Liaison has recruitment and retention challenges – a review will be undertaken with Mid Yorkshire NHS Hospitals Teaching Foundation Trust to agree next steps.
• 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.
• Care plan metrics for community capture the whole community caseload rather than only individuals on care plan approach. The care group are working with P&BI to ensure the metric reflects practice. Barnsley have achieved the 95% target with Calderdale at 90.8%, Kirklees 94.4% and Wakefield 94%. Improvement plans are in place, supported by quality governance leads.
• The completion of appraisals across all services with C&YP are unsatisfactory and therefore a robust improvement plan is in development and will be implemented in August across all services.

Advise

• Calderdale & Kirklees CAMHS experiencing increased referrals and reduced resources which are impacting waiting times for ADHD medication activity. Increased prevalence of ADHD has led to SWYPFT 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 Integrated Care Board (ICB) commissioners have instructed GPs wishing to pursue Right to Choose (RtC) 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 SWYPFT 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 20 calls per month from NHS 111. The Service continues to work with IM&T to maximise telephony provision to streamline calls more productively.
• Calderdale & Kirklees CAMHS Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees continue to remain challenging. This is further impacted by staff vacancies. This has been recorded on the risk register. Commissioners are sighted on these challenges.
• The rate of clinical staff who met the 60-day target in July was: clinical supervision 83.9% and 76.7% for management supervision across C&YP. Supervision data indicates improvement action is required in some teams. We have a weekly performance meeting where this is monitored, and actions are underway to improve this, with a robust improvement plan being developed.

Assure

• The sickness level across Children and young people mental health services have improved to 3.4% at the time of writing this report.
• The work of the weekly rapid improvement group established to reduce CAMHS treatment waits continues to have a positive impact on the services.
• Aldine House- (one of our Children's Secure Care Homes) had a very positive joint OFSTED/ CQC inspection
• Adel Beck (one of our Children's Secure Care Homes) had some very positive feedback from the Senior Commissioning Manager regarding the Health Teams commitment to collaborative partnership work.
• Mandatory training – overall training compliance across all mandatory training requirements for C&YP Services was 95.75%

Mental Health Care Group

Headlines

Acute wards have continued to manage high levels of acuity. During July, 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 across Mental Health inpatient services.

Mental Health Community

Metrics	Strategic Objective	CQC Domain	Threshold	May-26	Jun-26	Jul-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	96.4%	96.5%	96.0%	
% Assessed within 14 days of referral (Routine)	Best Quality	Responsive	75%	85.8%	87.4%	70.3%	
% Assessed within 4 hours (Crisis)	Best Quality	Responsive	90%	99.1%	97.2%	97.8%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/15)	0% (0/15)	17% (3/18)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	88.1%	87.1%	87.8%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	83.0%	85.0%	83.6%	
% service users followed up within 72 hours of discharge from inpatient care	Best Quality	Safe	80%	87.2%	85.4%	90.0%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	95.8%	96.2%	96.1%	
% Treated within 6 weeks of assessment (routine)	Best Quality	Responsive	70%	96.7%	96.2%	97.5%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.2%	85.6%	86.4%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95%	97.5%	97.8%	97.4%	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.1%	95.1%	97.3%	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	92.0%	92.6%	94.4%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	4.8%	5.0%	5.2%	
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - Trust	Best Quality	Responsive	Trend Monitor	13,206	13,194	13,147	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	123	155	122	

Mental Health Inpatient

Metrics	Strategic Objective	CQC Domain	Threshold	May-26	Jun-26	Jul-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	96.8%	96.1%	95.8%	
% Bed occupancy (excl leave)	Best Quality	Safe	85%	89.6%	91.5%	89.9%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/7)	14% (1/7)	0% (0/7)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	83.1%	81.0%	86.5%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	75.7%	79.1%	84.9%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.7%	84.4%	87.3%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	7.3%	6.8%	5.9%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	93.0%	89.6%	91.7%	
Inappropriate Out of Area Bed days	Best Quality	Responsive	150 (June)	82	137	116	
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.2%	97.1%	98.4%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	14	22	21	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	52	69	45	
Reducing Restrictive Practice Interventions (RRPI) training compliance	Best place to work and learn	Well led	>=80%	90.1%	89.8%	91.3%	
Restraint incidents	Best Quality	Safe	Trend Monitor	106	139	*29*	
Safer staffing (Overall)	Best Quality	Safe	90%	121.3%	122.6%	118.1%	
Safer staffing (Registered)	Best Quality	Safe	80%	100.8%	101.5%	100.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5%	5.4%	6.3%	6.5%	
Readmissions within 28 days	Best Quality	Safe	Trend Monitor	13	13	11	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	586	641	531	

Alert/Action

• Acute wards have continued to manage high levels of acuity.
• High occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on safety of high occupancy such as increased staffing levels.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.
• There continues to be people who are clinically ready for discharge but are delayed. This is an area of focus as part of the priority programme work and is being addressed with the Integrated Care Board (ICB) 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 July 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 July 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.
• 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 Performance and Business Intelligence (P&BI) to ensure the metric reflects practice. Continued positive performance in July.
• Care Programme Approach (CPA) review performance is above target in Barnsley, Calderdale, Kirklees and Wakefield. Action plans and support from Quality and Governance Leads remain in place to sustain performance.
• The sickness rate is above the Trust threshold on some wards. Wards and teams with high sickness are where there are a number of people with long term sickness in addition to short term sickness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
• The service is actively engaged in the trust wide improvement work with regards to minimising prone restraints during seclusion exit and when administrating intra-muscular medication. Matrons attend the monthly restraint oversight meeting chaired by Reducing Restrictive Physical Interventions (RRPI) specialist advisors and includes an in-depth review of all prone restraint incidents for learning.
• SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment remains at risk of being delayed in all areas. The access standard for assessed within 14 days of referral has been met in Barnsley and Wakefield. There have been challenges with 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 demand and capacity pressures on inpatient services, this is being 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 Wakefield 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 August.
• The Talking Therapies recovery rate for July is 59.91% for Barnsley and 56.63% for Kirklees, both achieving the national standard of 53.61%.
• The care group holds monthly meetings to track and review progress of Equality Impact Assessments (EIAs). Performance remains strong. Delay in completion of EIAs in some areas have been due to manager changes/sickness and the service line Trios are supporting the teams in their completion.
• Equality data – we are working with a trust wide quality improvement group to enhance how equality information is captured on System One. Completeness of equality data is on our data quality improvement action plan.
• There were three incidents of prone restraint in July, all staff led for clinical reasons specific to the individuals. Two incidents related to administration of medication, one related to the exit from seclusion (alternative exit techniques attempted without success). 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

• Intensive Home Based Treatment 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 95.7% 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:
Performance against the % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks dropped below target during July, 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	Jul-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	88.5%	91.0%	93.3%	94.4%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	33% (1/3)	0% (0/2)	0% (0/2)	0% (0/4)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	69.2%	69.0%	69.8%	70.1%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	64.1%	62.4%	62.8%	61.7%	
Bed occupancy (excluding leave) - Commissioned Beds	Best Quality	Safe	N/A	50.0%	42.3%	45.0%	44.0%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.5%	88.4%	85.7%	86.2%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	100.0%	100.0%	81.8%	85.3%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	95.1%	95.2%	96.3%	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%	83.6%*	
Physical Violence - Against Patient by Patient	Best Quality	Safe	Trend Monitor	0	1	0	0	
Physical Violence - Against Staff by Patient	Best Quality	Safe	Trend Monitor	11	12	6	3	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.7%	91.4%	92.1%	92.1%	
Safer staffing (Overall)	Best Quality	Safe	90%	133.7%	120.2%	121.6%	115.7%	
Safer staffing (Registered)	Best Quality	Safe	80%	167.9%	162.0%	161.1%	151.5%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	3.0%	3.1%	2.8%	3.5%	
Restraint incidents	Best Quality	Safe	Trend Monitor	8	8	6	*3*	
Average length of stay	Best Quality	Safe	Trend Monitor	N/A	524	N/A	20	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	49	53	44	33	

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

Alert/Action

Risk Assessment Reporting
Reported compliance with risk assessments reduced to 71.8% in July. A review of the data has identified that the current reporting methodology does not fully reflect the service model, particularly in relation to triage activity and long waits for assessment.
Of 519 reported breaches, 28 were identified as requiring follow-up action by the service.
Business Intelligence colleagues have recommended the development of a bespoke reporting approach that better reflects the Adult ADHD and Autism pathway and supports oversight of genuine compliance concerns. Formal approval will be required before any changes to reporting arrangements can be implemented.

Transfer of Waiting List Patients
Discussions are ongoing regarding the potential transfer of some patients from existing neurodevelopmental waiting lists to alternative assessment providers.
Initial scoping has identified that this process would require clinical review and decision-making to determine suitability for transfer and therefore requires a greater level of resource than originally anticipated.
Consideration is being given to the operational impact of any transfer programme, including the effect on delivery of commissioned activity, waiting list management, referral processing and existing triage functions.
Further work is underway to understand the resource implications and agree a sustainable approach before any decisions are made.

Advise

Barnsley ADHD Triage Proposal
A proposal has been submitted to Barnsley commissioners to introduce an ADHD triage model. The proposed investment of approximately £125k per annum is estimated to generate annual system savings of £312k through improved pathway management and reduced assessment demand, while also supporting reductions in waiting times.
Commissioners have acknowledged receipt of the proposal and a decision is awaited.

Calderdale ADHD and Autism Triage Project
Calderdale commissioners have provided £432k non recurrent funding to support an 18-month programme aimed at reducing neurodevelopmental waiting lists. The project will provide triage for approximately 1,100 people awaiting ADHD assessment and 250 people awaiting Autism assessment, alongside management of new referrals received during the project period.
Delivery is dependent upon successful recruitment and training of staff. Requests have been submitted to recruit four fixed-term posts to support implementation.

Wakefield ADHD Triage Funding
Wakefield commissioners have agreed recurrent funding of £203k to sustain the ADHD triage service. The service has continued from April 2026 in line with agreed arrangements; however, the funding has not yet been incorporated into the Trust's block contract payment. Finance colleagues are working with commissioners to resolve this matter.

Waiting Lists
ADHD
Demand for ADHD assessments continues to exceed commissioned capacity. There are currently more than 7,200 people awaiting assessment, with the longest waits exceeding four years.
Demand remains high; however, there are indications that waiting list growth is beginning to slow. This is being supported through triage arrangements in commissioned areas, increased use of alternative assessment pathways, and greater public awareness of available referral options.
All referrals continue to be clinically reviewed and prioritised according to individual need and risk, ensuring patients requiring a more urgent response are prioritised appropriately.
Autism
Autism waiting lists remain comparatively stable across most areas served by the service.
There are currently 245 people awaiting assessment in Calderdale, where the longest waits are approaching 800 days. Across all other localities, 24 people are awaiting assessment, with most waiting less than 12 weeks.
The recently commissioned Calderdale triage project is expected to support a reduction in waiting times and improve flow through the assessment pathway.

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

• ADHD Recruitment to the new Learning Disability ADHD Diagnostic Service has taken longer than anticipated. Recruitment activity is now progressing positively and the service is expected to commence in the near future (Community Services).
• Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD) continue to be embedded within routine clinical practice to support outcome measurement and service evaluation (inpatient services).
• Quality Network Staff have been enrolled onto the Quality Network for Learning Disabilities (QNLD) development programme, commencing on 7 September, further strengthening quality improvement capability and supporting alignment with recognised standards of care (Community Services).
• LD Community Care Plan Review within the last year – 78.1%↑ Performance continues to improve, with care plans being reviewed and updated through routine care review processes.
• Supervision – Management supervision has decreased to 58.5%, although clinical supervision has improved to 67.3%. Both measures remain below threshold and recovery actions are being implemented, including protected supervision time, strengthened oversight, and improved monitoring arrangements.
• CPR – Horizon compliance has dipped significantly to 72.2%. The roster system ensures that there will always be compliant staff on duty and staff have been booked onto courses.

* % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks - July data is provisional and will be refreshed next month once data cleansing has been undertaken.

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: Participation in the ICONIC research programme has commenced, supporting the service's commitment to research, innovation and evidence-based practice (Community Services).
• 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)
• Mental Health Act CQC visit to Horizon: Minor concerns were raised regarding maintenance in one courtyard area. No major concerns were identified in relation to inpatient care, and actions are underway to address the environmental issues highlighted.
• Bed Occupancy – Bed Occupancy is 44% with 85.3% of service users clinically ready for discharge.

Assure

• Annual health checks in all four localities have exceeded the 75% threshold.
• Friend and Family Test – 100%
• Prone Restraints – Horizon had no prone restraints.

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	May-26	Jun-26	Jul-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	79.9%	81.0%	82.1%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	90.8%	89.4%	89.5%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/1)	0% (0/3)	0% (0/1)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	66.5%	68.1%	71.6%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	45.7%	52.4%	52.7%	
% Service Users on CPA with a formal review within the previous 12 months	Best Quality	Effective	95%	100.0%	100.0%	96.4%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.1%	81.5%	83.4%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95.0%	80.0%	100.0%	100.0%	
% on community active caseload at month end with a risk assessment which has been reviewed within the last year	Best Quality	Safe	95.0%	89.5%	89.6%	91.3%	
% with care plan that includes service user input/views	Best Quality	Safe	95.0%	90.0%	92.1%	93.7%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	94.6%	94.3%	94.7%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	1	3	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	6	10	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.8%	94.0%	95.8%	
Restraint incidents	Best Quality	Safe	Trend Monitor	8	17	*1*	
Safer staffing (Overall)	Best Quality	Safe	90%	119.5%	116.0%	110.1%	
Safer staffing (Registered)	Best Quality	Safe	80%	100.8%	99.3%	99.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	5.6%	7.1%	7.6%	
Average length of stay	Best Quality	Safe	Trend Monitor	1,389	949	1278	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	157	166	134	

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.

Sickness Absence – Sickness absence has increased significantly in a number of wards and remains a key concern. Rates are highest in Chippendale (17.0%), Ryburn (16.8%), Waterton (16.3%), Newhaven (11.6%) and Hepworth (10.7%), all well above the Trust target. Work is underway with the People Directorate and ward teams to better understand the reasons for the increase and identify any common themes. Particular focus is being given to the wards with the highest levels of absence to support managers in improving attendance and reducing the impact on staffing and service delivery.

Vacancies
Health Care Assistant (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.

Supervision
Supervision compliance remains mixed across the service. Newhaven has demonstrated significant improvement in clinical supervision 88.5% and 80.8% for management supervision. 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.
In Newton Lodge Clinical Supervision, compliance is 74% and Management Supervision 64%. The Bretton Centre clinical supervision is 60.4% and management supervision 36.3%. The Bretton Centre appears to be struggling with higher sickness levels and acuity.

Appraisal
Planning is underway to improve appraisal compliance alongside the implementation of the new appraisal system. This is being supported through targeted training, management briefings and enhanced support for both staff and managers. In addition, each ward and department has developed a clear trajectory and action plan to achieve compliance, with progress being monitored through local and corporate governance arrangements. The phased rollout of the new system, combined with strengthened oversight, is expected to improve compliance rates, increase timeliness and support the delivery of sustainable performance as the system becomes fully embedded.

Advise

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: 89.21%
• Bretton Centre: 93.80%
• Newhaven: 81.25%

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.

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.

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.

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**	**May-26**	**Jun-26**	**Jul-26**	**Variation/ Assurance**
% Appraisal rate	Best place to work and learn	Well led	90%	80.5%	80.2%	81.7%	
% Bed occupancy (incl leave)	Best Quality	Safe	90%	86.2%	86.8%	84.0%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/2)	0% (0/1)	50% (1/2)	
% of staff receiving supervision within policy guidance - Clinical	Best place to work and learn	Well led	80%	86.0%	75.0%	66.2%	
% of staff receiving supervision within policy guidance - Management	Best place to work and learn	Well led	80%	79.6%	70.9%	58.6%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.7%	84.7%	92.3%	
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	Best place to work and learn	Well led	>=95%	95.7%	95.8%	97.3%	
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	2	0	
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	6	8	
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.5%	88.0%	88.6%	
Restraint incidents	Best Quality	Safe	Trend Monitor	8	18	*17*	
Safer staffing (Overall)	Best Quality	Safe	90%	109.0%	108.2%	105.3%	
Safer staffing (Registered)	Best Quality	Safe	80%	87.3%	85.9%	87.7%	
Sickness rate (Monthly)	Best place to work and learn	Well led	25/26 - 5.4% 26/27 - 5%	2.3%	3.4%	3.9%	
Average length of stay	Best Quality	Safe	Trend Monitor	2,449	1,894	464	
Total number of reported incidents	Best Quality	Safe	Trend Monitor	151	170	165	

Forensic - South Yorkshire:

Alert/Action

Capacity & Flow - Overall patient flow has improved significantly over the last six months. Through collaborative working across the hospital and regular oversight via weekly operational meetings, the service has developed a more coordinated and proactive approach to patient movement. This has reduced unnecessarily multiple ward moves, supporting more purposeful and recovery focussed transfers, and will contribute to shorter lengths of stay whilst maintaining person centred decision making.

Medium Secure Services - maintained stable performance during July. Appraisal and mandatory training compliance remained strong across both wards, with occupancy above target and no prone restraint incidents recorded. Workforce pressures continue, with ongoing unfilled shifts, elevated restraint activity and reduced supervision compliance on Skipton Ward. Sickness absence on Foss Ward remains above target.

Low Secure Services - Fire Safety compliance achieved 100% and no prone restraint incidents were reported. Calder Ward continues to perform well across key workforce, quality and safety measures. However, appraisal and supervision compliance remain below target on several wards, particularly Aire, Don and Hamilton/Wentbridge. Patient-on-staff assaults and restraint activity were highest on Hamilton/Wentbridge during the reporting period.

Advise

Supervision & Appraisal - The key area requiring continued management attention is workforce compliance, particularly supervision and appraisal completion. Whilst performance issues are concentrated within a small number of wards, sustained non-compliance could impact staff support, governance processes and assurance arrangements.

Workforce pressures - including unfilled shifts and sickness absence in some areas, continue to place demands on operational teams. Restrictive intervention activity and incidents of violence remain within expected levels for the clinical population but require ongoing oversight.

Compliance with care plans & Risk Assessments - that include service user views remains strong and above the 95% target, achieving 97.6% in the latest reporting period.
Performance relating to the completion of inpatient care plans and risk assessments within 24 hours of admission remains below target. However, care plan compliance improved during the month, increasing from 0% in the previous reporting period to 80%, demonstrating positive progress.
Risk assessment compliance within 24 hours of admission remains below the expected standard at 40%. Given the relatively small number of admissions, performance can fluctuate significantly month to month, with individual cases having a disproportionate effect on reported compliance.

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.
- All mandatory training is compliant.

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	May-26	Jun-26	Jul-26	Variation/ Assurance
% Appraisal rate	Best place to work and learn	Well led	90%	97.7%	95.4%	96.9%	
% of feedback with staff values and behaviours as an issue	Best Quality	Caring	< 20%	0% (0/3)	40% (2/5)	0% (0/3)	
% people dying in a place of their choosing	Person first and in the centre	Responsive	80%	100.0%	100.0%	90.3%	
% of staff receiving supervision within policy guidance - Clinical	Best Quality	Safe	80%	67.4%	61.3%	73.0%	
% of staff receiving supervision within policy guidance - Management	Best Quality	Safe	80%	44.5%	37.8%	49.8%	
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	86.8%	88.7%	88.6%	
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%	96.4%	96.6%	96.8%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Best Quality	Responsive	92%	97.5%	97.1%	97.1%	
Safer staffing (Overall)	Best Quality	Safe	90%	95.7%	93.0%	97.3%	
Safer staffing (Registered)	Best Quality	Safe	80%	91.9%	93.0%	100.0%	
Sickness rate (Monthly)	Best place to work and learn	Well led	5.0%	5.3%	5.4%	5.5%	
Maximum 6 week wait for diagnostic procedures	Best Quality	Responsive	25/26 - 99% 26/27 - 52.6%	99.1%	96.9%	100.0%	
Community services waiting list - All	Best Quality	Responsive	Trend monitor	7,029	7,012	7,008	
Total number of reported incidents	Best Quality	Safe	Trend monitor	261	265	277	

Barnsley Physical Health and Wellbeing Care Group

Alert/Action

• Staff receiving supervision – Achieving targets for supervision remains challenging in the care group but continues to be an area of focus and we are seeing incremental increases with a view to achieving the target by the end of Quarter 2. Leaders are still unable to see their team data, and this is preventing them from taking a proactive targeted approach with individual staff. This has been escalated.
Figures for July against the target of 80% are showing a good increase:
Clinical supervision – 73%
Management supervision – 49.8%
• Overall sickness rates have increased slightly for the month of July at 5.5%. We are continuing to see some instances of long-term sickness relating to serious illnesses which are unavoidable. The care group 12-month rolling figure is 5.51%. People Directorate colleagues continue to support the care group in reviewing trends and triangulating with other data which may impact, whilst excluding some reasons e.g. elective surgery and diagnosis of cancer. Further targeted work on short term sickness is taking place to review areas of higher sickness levels, whether this be at team or individual level, in order to understand the background to these. We continue to ensure that 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.

Advise

• 18-week waiters - Overall, our community services are achieving the national expectation of 78% of being seen within 18 weeks, with a further increase to 92.7% for July.
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. The number of C&YP waiting over 18 weeks is continuing to steadily reduce month on month. 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 continued to improve and is now at 86%, close to the Trust-wide level of 88%. 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. Management team continue to promote Medical Equipment servicing sessions
• In July there was one instance of a pressure ulcer that developed under SWYPFT care where there was an area for improvement which related to the ongoing improvement work in embedding the use of Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE-T) screening by all integrated Neighbourhood Team staff and appropriate scheduling of visits.

Assure

• Appraisal reporting has now transitioned from the requirement to have an appraisal in the last 365 days to having an appraisal within the financial year with a completion date of the end of September.
To note: Appraisal compliance using the previous system is at 96.9% for July and is showing a continuing increase into August's figures.
Following completion of the Bands 8a and above measure by 30 June 2026, the next target is for Bands 7 and below to have a completed appraisal by 30 September. Progress towards target is currently at 52.4% for the care group as at 14.8.26.
• Paediatric Audiology 6-week target for diagnostic procedures is maintaining compliancy with the national trajectory, including an increase to 100% for July (as at 2.8.26).
The total number on the waiting list as at 2.8.26 was 84 patients, with an improvement in terms of the number waiting over 6 weeks being at zero.
• Virtual Ward occupancy levels for July are achieving compliance at 86.7%. We are continuing to closely monitor occupancy levels during quarter 2 based on capacity to safely support patients on both pathways.
• Information Governance training has achieved 96.8% for July, maintaining compliancy with a continued focussed effort on monitoring by managers.
• Urgent Community Response Service 2-hour target has achieved 82.5% for July 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) – 97.1% for July.
• People dying in their place of choosing remains compliant at 90.32% for July, exceeding the 80% threshold.
• CPR training maintains compliance at 88.6% for July.
• Friends and Family Test (FFT) – July has seen an increase to compliance levels at 95%.
• 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

Nostell performance in areas of appraisal, supervision, and risk assessment has improved in July. The Matron and General Manager are working closely with the ward leadership to ensure ongoing oversight of care. Additional support to preceptees, including restorative supervision, is being provided by the Non-Medical Education Team and the Mental Health Nursing Lead for the Care Group is meeting with the matron and leadership team to review any additional support needs for the ward team. Nostell continue to have 2 registered staff on long-term sickness absence due to work related stressors. They are both referred to occupational health. The increase in July is due to short-term sickness absence, not work-related, and no themes.

Both Nostell and Elmdale are involved in the quality improvement group work with Chief Nurse oversight to share data insights, learning, and improvement ideas.

As is noted in the narrative below, some sickness on Walton and Clark has been related to incidents of violence and aggression - staff have been supported by ward leadership teams, and psychology, and referrals have been made to occupational health. All these staff have now returned to work.

Appraisal

• Ward 18 and Crofton are outside of the 90% compliance threshold in July. Outstanding appraisals are scheduled to take place prior to the appraisal window deadline of 30th September.
• 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

• 5 wards have sickness rates below 5% compliance threshold.
• Sickness improved to below threshold in July on Beamshaw following 1 staff member returning from long-term sickness and a reduction in short-term sickness.
• Sickness increased to above threshold on Clark (6.8%), Willow (8.5%), Ward 19 Male (7.6%), and Lyndhurst (5.6%) due to both short-term and long-term sickness. A theme in short-term sickness is gastrointestinal issues. Two long-term sickness absences on Clark related to anxiety/stress/depression following a significant incident of violence and aggression – support has been provided by the ward leadership team, psychologist and occupational health. Both staff have now returned to work.
• Although still above threshold, sickness on Walton (6.2%) and Poplars (12.9%) has reduced following a reduction in short-term sickness.
o Staff on Walton whose absence related to work-related injury following incidents of violence and aggression have all returned to work with support from the ward leadership team and also occupational health as required.
o Only 1 sickness absence on Poplars is work-related and this is following an injury sustained during restraint. The staff member is referred to occupational health.
• Sickness remains above threshold and has increased on Nostell (7.2%), Stanley (8.0%), Ashdale (7.2%), Crofton (8.8%), Beechdale (8.6%), and Ward 19 Female (9.4%) due to both long-term and short-term sickness absences.
o A theme for long-term absence on Crofton is physical health conditions – unrelated to work.
• Ward managers are supported by People Directorate colleagues to actively manage long term sickness and timely referrals to occupational health are made.

Supervision

• 14 wards are above the 80% compliance target for clinical supervision in July.
• 13 wards are above the 80% compliance target for management supervision in July.
• Clark is below compliance for both clinical (66.7%) and management (74.1%) due to both acuity and ward manager absence. Oversight is being supported by the matron and compliance has improved comparative to June. The ward manager has recently returned to work and will prioritise staff outside of compliance.
• Melton has dropped just under compliance for both clinical (79.4%) and management (79.4%) due to clinical acuity.
• Ashdale remain below the 80% supervision compliance for both clinical (67.6%) and managerial (67.6%) and continue to be impacted by ward manager absence, and oversight is being supported by the matron and neighbouring ward manager.
• Crofton are above compliance for clinical supervision but remain below compliance for management supervision (69.2%) impacted by ongoing ward manager absence. ACP and Band 6 oversight and ability to deliver supervision has been impacted by clinical acuity. A conclusion to the ward manager absence is expected by mid-September and support continues to be provided by the matron.
• 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).

Bed Occupancy

• Where wards are over-occupancy, 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 July:
o Ashdale ALOS was 189 days. This relates to 8 discharges – 1 of those had a LOS of 1,202 days which included the stay with rehab and recovery services.

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

Safer Staffing

• There have been recent establishment reviews for the OPS wards – 2 throughout 2025 and 1 in April 2026 however these are pending EMT approval.
• 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 July for Poplars (186.1%) reflects staffing increases for the reasons outlined above.
• Crofton (169.9%) 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.

Mandatory Training

IG

• 16 wards are above 95% compliance target for July.
• Melton (92.9%) and Ashdale (94.1%) have dropped under threshold. 2 staff are outside of compliance and 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.

CPR

• 13 wards are at or above the CPR training compliance threshold in July.
• Ward 18 (57.5%) 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 August and September. Current compliance has increased to 67.6% (as of 14.08.26). Mitigation is in place through roster planning and shared ILS cover across the unit (inclusive of Ward 19 Male and Female). Improvement work is captured on the Ward 18 Quality Improvement Plan.
• Ward 19 Female (79.2%) remain just below compliance impacted by long-term sickness and maternity leave.
• Melton (73.5%) remain below compliance, but staff have attended recent training dates and current compliance is above threshold (as of 14.08.26).
• Lyndhurst compliance (77.8%) although still below threshold has improved comparative to June with staff booked on courses in August, September, and October.

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

• 13 wards are above fire safety training compliance threshold.
• Nostell (82.8%) have dropped below compliance, and staff are booked to attend training in September and October.
• Stanley (81.6%) remains below compliance in July. A number of staff competency has recently expired, and they are booked onto training throughout August, September, and October.
• Ward 19 Female (79.2%) remain below compliance impacted by long-term sickness and staff who can attend training are booked on dates in August.
• Poplars (78.8%) remain below compliance in July, but a bespoke training session was delivered on 6th August and current compliance is above threshold at 97.2% (as of 14/08/26).

Unfilled Shifts

• Headroom does not account for people on maternity leave. Consistently across the inpatient service we have 10 staff on maternity leave every month. To maintain safer staffing and roster requirements these shifts all require back fill.
• Ad hoc but consistent workforce gaps also arise from staff being allocated 'other leave' in line with trust policy and phased return to work recommendations.
• Following a deep dive analysis into working age adult budgets and roster alignment it has been identified that the current funding for the inpatient wards is in deficit by 10WTE's, therefore, every time a roster is produced, we need an equivalent of 10 staff to produce the rosters that the service has had agreed via previous establishment review (March 2024).
• Staff who are being supported to train as registered nurses are not available in the roster. Again, to maintain roster and safer staffing requirements back fill is required. There are currently 10 people in WAA undertaking this training.
• Ward leadership teams adhere to the Rostering, Work Time, and Attendance Policy. Where shifts remain unfilled, support will be sought from neighbouring wards and ward managers will work clinically to maintain ward safety.

Clinically Ready for Discharge (CRFD)

• CRFD rates are significantly above threshold on:
o Clark CRFD is 22.6% and is reflective of 3 service users awaiting placement.
o Nostell CRFD is 15.1% and is reflective of 5 service users, 4 of whom have recently been discharged.
o Poplars CRFD is 16.7% and is reflective of 5 service users awaiting placements, 2 of whom have now been discharged. To note, whilst Poplars CRFD is consistently high each month, it is not the same service users that remain CRFD for protracted periods of time. Most service users, on discharge from Poplars, are transferred to other care providers, involving lengthy placement searches and local authority processes. The Poplars leadership team and matron are actively engaged with colleagues in local authority and ICB to ensure that delays are highlighted early, barriers are worked through, and challenges escalated timely.
• 5 other wards are above the threshold for CRFD with Walton and Stanley at 10% or above. 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 July 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 July (93.4%) is improved compared to June.
• There was a total of 9 breaches for 24hr target, 3 of which were completed within 48hrs.
• During July, Clark, Ward 18, Elmdale, Ashdale, Nostell, and Stanley had 1 FIRM breach each. Crofton had 3 breaches.
• On the wards where 1 breach occurred – this related to embedding of the implemented process and individual learning for the staff undertaking the admission. This has been addressed through reflective discussions.
• 1 of Crofton's breaches related to it being a bank nurse leading the admission process – the Staying Safe risk management care plan was completed and this referenced current risk, demonstrating that the risk assessment had been reviewed, but not updated to evidence the review. The other 2 breaches for Crofton related to embedding of the implemented process and again this has been addressed in reflective discussion with the 2 staff who undertook the admissions.
• 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)

• 19 incidents of patient-on-patient physical violence throughout July across multiple wards.
• 6 incidents on Crofton, 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)

• Overall reduction in patient on staff physical violence incidents compared to June.
• 7 incidents on Ward 19 Male. These relate to a service user who has a diagnosis of dementia and a risk profile of violence and aggression, particularly on intervention (e.g. during self-cares).
• 8 incidents on Poplars 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 Stanley (10) relates to 3 service users with a risk profile of violence and aggression.
• High incident on Elmdale (14) is reflective of current patient population and the presentation and risk profile of service users, including restraint to prevent self-harm.
• High incidence on Ward 19 Male (10) correlates with incidents of physical violence outlined above.
• 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

• 3 incidents led to prone restraint in July:
o Stanley (2)
 1 incident to administer intramuscular medication to service user in seclusion. Prone position assessed as safest option due to level of aggression (use of safety pod was considered, but not risk assessed as safe). Prone lasted less than 45 seconds.
 1 incident to exit seclusion. Prone position assessed as safest option due to level of aggression following alternative exit techniques been tried unsuccessfully. Prone lasted less than 60 seconds.
o Walton (1) to administer intramuscular medication to service user on his bed. Prone lasted less than 45 seconds.

• All incidents were 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.

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Beamshaw Suite May-26	Beamshaw Suite Jun-26	Beamshaw Suite Jul-26	Clark Suite May-26	Clark Suite Jun-26	Clark Suite Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	94.4%	88.2%	100.0%	100.0%	94.7%	95.2%
Sickness	Best place to work and learn	Well led	5.0%	4.8%	7.3%	2.4%	4.2%	4.7%	6.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	100.0%	92.6%	92.9%	100.0%	63.0%	66.7%
Supervision - Management	Best place to work and learn	Well led	80%	100.0%	92.6%	92.9%	89.3%	70.4%	74.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	96.4%	96.6%	92.9%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	92.9%	96.2%	89.3%	93.1%	96.4%	96.3%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.9%	88.5%	85.7%	96.4%	96.4%	96.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	89.3%	88.5%	92.9%	100.0%	92.9%	96.3%
Bed occupancy**	Best Quality	Safe	85%	103.2%	101.7%	98.8%	103.2%	101.7%	98.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	35	70	59	51	20	28
Safer staffing (Overall)	Best Quality	Safe	90%	117.2%	110.9%	115.6%	114.2%	119.9%	102.3%
Safer staffing (Registered)	Best Quality	Safe	80%	97.3%	89.9%	93.5%	102.0%	99.6%	93.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	5.4%	5.7%	5.8%	13.9%	7.9%	22.6%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	90.0%	81.8%	85.7%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	0	0	0	1	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	3	1	0	4	12	1
Restraint incidents	Best Quality	Safe	Trend Monitor	2	2	*2*	9	10	*4*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/38)	3% (1/31)	0% (0/17)	10% (3/30)	14% (4/29)	12.5% (5/40)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	10	5	3	14	9

*** 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 May-26	Melton Suite Jun-26	Melton Suite Jul-26	Nostell May-26	Nostell Jun-26	Nostell Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	85.2%	93.3%	100.0%	75.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	3.3%	3.8%	4.8%	1.7%	5.2%	7.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	96.9%	87.5%	79.4%	79.3%	59.4%	87.1%
Supervision - Management	Best place to work and learn	Well led	80%	96.9%	87.5%	79.4%	93.1%	53.1%	83.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	97.1%	94.1%	100.0%	100.0%	96.6%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.4%	94.1%	97.1%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	84.4%	79.4%	73.5%	96.6%	96.4%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	94.1%	94.1%	86.2%	85.7%	82.8%
Bed occupancy	Best Quality	Safe	85%	104.3%	109.4%	84.9%	98.8%	93.9%	93.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	37	337	46	50	43	25
Safer staffing (Overall)	Best Quality	Safe	90%	114.4%	112.0%	125.6%	117.1%	111.7%	106.7%
Safer staffing (Registered)	Best Quality	Safe	80%	95.0%	90.6%	93.0%	123.7%	126.8%	124.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	15.1%	1.5%	0.0%	4.8%	8.2%	15.1%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	70.0%	75.0%	90.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	4	6	6	2
Restraint incidents	Best Quality	Safe	Trend Monitor	2	6	*2*	17	25	*8*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	1	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	1	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/38)	0% (0/3)	32.5% (13/40)	0% (0/110)	1% (1/87)	1.4% (1/74)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	7	12	15	12	33	8

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

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Stanley			Walton		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	90.9%	100.0%	96.8%	83.3%	93.3%
Sickness	Best place to work and learn	Well led	5.0%	8.7%	7.2%	8.0%	5.0%	16.3%	6.2%
Supervision - Clinical	Best place to work and learn	Well led	80%	87.5%	66.7%	94.9%	95.0%	74.4%	89.7%
Supervision - Management	Best place to work and learn	Well led	80%	81.3%	63.9%	92.3%	87.5%	76.9%	89.7%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.9%	97.2%	100.0%	97.5%	97.4%	97.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	93.9%	94.4%	97.4%	97.5%	92.3%	87.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.9%	86.1%	92.1%	85.0%	87.2%	94.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	84.8%	83.3%	81.6%	95.0%	92.3%	92.3%
Bed occupancy**	Best Quality	Safe	85%	98.8%	107.0%	97.7%	94.0%	96.0%	92.9%
Average Length of Stay	Best Quality	Safe	Trend Monitor	42	50	31	22	42	57
Safer staffing (Overall)	Best Quality	Safe	90%	108.2%	104.6%	105.1%	115.9%	123.1%	114.4%
Safer staffing (Registered)	Best Quality	Safe	80%	95.1%	93.9%	96.4%	88.1%	89.7%	88.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	14.7%	9.3%	10.0%	13.4%	14.4%	10.1%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	87.5%	100.0%	95.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	1	0	2	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	4	3	1	5	10	4
Restraint incidents	Best Quality	Safe	Trend Monitor	6	11	*10*	27	13	*7*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	1	2	1	1	1
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	2	0	0	1
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/131)	0% (0/226)	0% (0/220)	0% (0/99)	N/A	0% (0/122)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	21	11	6	16	5

*** 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		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	91.7%	100.0%	87.0%	75.0%	82.6%
Sickness	Best place to work and learn	Well led	5.0%	4.0%	6.4%	7.2%	1.8%	3.6%	1.5%
Supervision - Clinical	Best place to work and learn	Well led	80%	74.3%	76.5%	67.6%	60.6%	92.1%	87.8%
Supervision - Management	Best place to work and learn	Well led	80%	74.3%	73.5%	67.6%	66.7%	92.1%	87.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.1%	94.6%	97.3%	86.5%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.6%	86.5%	89.2%	89.2%	92.1%	95.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	82.4%	83.3%	83.3%	73.0%	68.4%	57.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.3%	91.9%	94.6%	81.1%	92.1%	95.0%
Bed occupancy	Best Quality	Safe	85%	98.1%	99.2%	98.7%	99.9%	100.4%	98.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	52	59	189	24	32	37
Safer staffing (Overall)	Best Quality	Safe	90%	117.2%	119.0%	102.3%	119.3%	112.6%	100.5%
Safer staffing (Registered)	Best Quality	Safe	80%	101.0%	106.4%	106.1%	110.2%	112.6%	110.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	11.1%	6.9%	8.5%	1.8%	0.9%	0.6%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	72.7%	81.3%	90.9%	100.0%	86.4%	94.7%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	3	7	0	1	5	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	3	2	3	8	2
Restraint incidents	Best Quality	Safe	Trend Monitor	3	4	*5*	5	14	*8*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/630)	0% (0/636)	0% (0/653)	0% (0/604)	0% (0/588)	0% (0/337)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	6	7	2	4	10	4

Inpatients - Mental Health - Working Age Adults

Metrics	Strategic Objective	CQC Domain	Threshold	Elmdale May-26	Elmdale Jun-26	Elmdale Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	95.5%	95.5%
Sickness	Best place to work and learn	Well led	5.0%	3.5%	3.3%	3.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	94.1%	91.7%	90.9%
Supervision - Management	Best place to work and learn	Well led	80%	94.1%	88.9%	90.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	97.1%	97.2%	97.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	97.1%	86.1%	88.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.9%	82.9%	87.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	91.2%	97.2%	97.1%
Bed occupancy	Best Quality	Safe	85%	92.7%	94.4%	95.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	51	52	20
Safer staffing (Overall)	Best Quality	Safe	90%	108.9%	111.9%	108.9%
Safer staffing (Registered)	Best Quality	Safe	80%	101.0%	103.1%	99.7%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	7.6%	7.4%	1.2%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	95.2%	95.7%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	4	2	1
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	7	8	5
Restraint incidents	Best Quality	Safe	Trend Monitor	13	16	*14*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	1	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/239)	0% (0/252)	0% (0/290)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	9	15	9

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Crofton			Poplars CUE		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	78.9%	73.7%	83.3%	100.0%	89.3%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	15.0%	8.4%	8.8%	8.3%	14.5%	12.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	50.0%	87.0%	80.8%	88.2%	85.7%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	41.7%	69.6%	69.2%	85.3%	85.7%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	96.9%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	92.6%	92.6%	87.5%	81.8%	86.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	81.8%	80.0%	80.0%	93.5%	96.9%	82.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.8%	88.9%	85.2%	87.5%	78.8%	80.6%
Bed occupancy	Best Quality	Safe	85%	89.9%	100.8%	97.4%	64.7%	72.7%	74.6%
Average Length of Stay	Best Quality	Safe	Trend Monitor	29	57	49	109	114	119
Safer staffing (Overall)	Best Quality	Safe	90%	158.5%	159.1%	169.9%	210.6%	219.3%	186.1%
Safer staffing (Registered)	Best Quality	Safe	80%	110.4%	120.3%	115.1%	112.5%	110.2%	105.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	3.4%	27.9%	19.5%	16.7%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	90.9%	62.5%	100.0%	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	2	6	1	1	3
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	4	2	16	10	8
Restraint incidents	Best Quality	Safe	Trend Monitor	2	21	*7*	17	12	*3*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/23)	5% (1/20)	0% (0/8)	33% (2/6)	9% (1/11)	20% (1/5)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	29	22	11	55	68	15

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Willow			Beechdale		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	94.1%	81.3%	100.0%	100.0%	83.3%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	5.2%	2.5%	8.5%	3.9%	5.8%	8.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	68.8%	88.2%	83.3%	100.0%	100.0%	100.0%
Supervision - Management	Best place to work and learn	Well led	80%	68.8%	88.2%	83.3%	100.0%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	81.0%	94.1%	84.2%	95.7%	95.7%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	93.8%	82.4%	89.5%	95.5%	95.5%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	94.7%	100.0%	95.7%	100.0%
Bed occupancy	Best Quality	Safe	85%	95.8%	94.3%	94.2%	98.0%	99.4%	99.2%
Average Length of Stay	Best Quality	Safe	Trend Monitor	61	50	75	120	170	50
Safer staffing (Overall)	Best Quality	Safe	90%	114.2%	121.7%	122.1%	136.1%	155.8%	164.9%
Safer staffing (Registered)	Best Quality	Safe	80%	80.3%	87.1%	84.3%	102.6%	103.4%	96.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	2.1%	5.0%	3.8%	10.7%	4.6%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	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	4	*0*	1	1	*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	0% (0/23)	2% (1/67)	2.9% (2/68)	0% (0/32)	0% (0/27)	0% (0/33)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	7	18	27	5	7	9

Inpatients - Mental Health - Older People Services

Metrics	Strategic Objective	CQC Domain	Threshold	Ward 19 - Male			Ward 19 - Female		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	93.8%	100.0%	100.0%	100.0%	94.4%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	8.5%	4.0%	7.6%	6.4%	7.5%	9.4%
Supervision - Clinical	Best place to work and learn	Well led	80%	95.5%	95.8%	96.2%	94.7%	95.0%	95.2%
Supervision - Management	Best place to work and learn	Well led	80%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	88.0%	100.0%	100.0%	100.0%	95.5%	95.8%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	88.0%	87.5%	85.2%	85.7%	90.9%	87.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	72.0%	83.3%	92.6%	76.2%	68.2%	79.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	80.0%	95.8%	92.6%	71.4%	77.3%	79.2%
Bed occupancy	Best Quality	Safe	85%	101.3%	96.2%	96.3%	95.7%	94.7%	93.8%
Average Length of Stay	Best Quality	Safe	Trend Monitor	96	109	60	73	82	80
Safer staffing (Overall)	Best Quality	Safe	90%	132.1%	122.4%	129.5%	130.8%	152.3%	126.9%
Safer staffing (Registered)	Best Quality	Safe	80%	93.7%	90.9%	94.6%	106.6%	109.8%	104.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	2.7%	16.0%	0.0%	2.4%	9.7%	2.2%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	100.0%	71.4%	100.0%	100.0%	83.3%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	0	2	0	2	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	2	0	7	1	2	3
Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	*10*	1	0	*8*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/54)	0% (0/42)	0% (0/90)	0% (0/14)	0% (0/13)	0% (0/11)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	0	1	5	11	16

Inpatients - Mental Health - Rehab

Metrics	Strategic Objective	CQC Domain	Threshold	Enfield Down			Lyndhurst		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	89.4%	95.8%	92.3%	80.0%	95.8%
Sickness	Best place to work and learn	Well led	5.0%	6.1%	3.2%	3.7%	7.6%	2.4%	5.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	95.7%	97.8%	93.9%	69.2%	76.9%	96.4%
Supervision - Management	Best place to work and learn	Well led	80%	30.4%	97.8%	93.9%	57.7%	76.9%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.4%	94.1%	100.0%	92.3%	96.3%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.6%	84.3%	83.1%	92.3%	81.5%	81.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.1%	87.0%	88.9%	84.6%	74.1%	77.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	96.2%	92.2%	96.1%	96.2%	92.6%	92.6%
Bed occupancy	Best Quality	Safe	Trend Monitor	56.4%	63.1%	62.5%	52.3%	51.7%	59.4%
Average Length of Stay	Best Quality	Safe	Trend Monitor	307	432	N/A	1161	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	98.0%	98.3%	101.0%	102.7%	98.5%	98.1%
Safer staffing (Registered)	Best Quality	Safe	80%	97.5%	99.2%	98.3%	101.2%	97.7%	98.4%
% 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%	50.0%	N/A	N/A	N/A	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	1	1	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	0% (0/104)	2% (2/121)	5.1% (5/98)	4% (1/25)	0% (0/30)	0% (0/44)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	4	0	4	1	0	0

Inpatients - Forensic West Yorkshire

Medium Secure

• No prone restraint incidents were recorded across any medium secure ward during July 2026.
• Workforce pressures remain the principal risk, particularly sickness and supervision compliance. No apparent correlation between Incidents and sickness absence.
• Four wards were below target for Information Governance compliance: Appleton, Chippendale, Hepworth and Johnson.
• Hepworth was the only ward below CPR compliance target (78.9%).
• Clinical supervision was below target in Chippendale, Hepworth, Johnson and Priestley.
• Management supervision was below target in Chippendale, Hepworth, Priestley and Waterton.
• Highest sickness rates were recorded in Chippendale (17.0%), Waterton (16.3%), Hepworth (10.7%) and Priestley (7.3%).
• Bronte and Johnson demonstrated the strongest overall performance profiles.

Leadership Actions

• Ward managers to develop and implement recovery plans where sickness absence remains high, with particular focus on Chippendale, Waterton, Hepworth and Priestley.
• Outstanding clinical and management supervision to be prioritised and monitored through local governance arrangements until compliance returns to target.
• Appleton, Chippendale, Hepworth and Johnson to complete outstanding Information Governance training and provide assurance that compliance is improving.
• Hepworth to increase uptake of CPR training and maintain appropriate skill mix arrangements until compliance is restored.
• Performance discussions to continue with wards experiencing a combination of high sickness and low supervision compliance to ensure risks are understood and managed.
• Learning from Bronte and Johnson's performance to be shared across the service to support improvement in other ward areas.
• Progress against all actions to be monitored through monthly performance and quality meetings.

Low Secure Service

• No prone restraint incidents were recorded across Low Secure services during July 2026.
• Workforce pressures remain the key area of concern, particularly supervision compliance and sickness absence. Ryburn presents the greatest workforce risk due to high sickness levels and poor supervision compliance, while Newhaven remains the main safety concern following six patient-on-staff assaults and three restraint incidents during the month.
• Thornhill remains the strongest overall performer, achieving 100% appraisal compliance, sickness of 1.5%, and occupancy of 96.6%. No violence, restraint or prone restraint incidents were reported. However, clinical supervision (48.5%), management supervision (36.4%), and Information Governance compliance (93.9%) remain below target.
•Sandal has improved appraisal compliance to 92.0%, but continues to experience workforce pressures, with sickness at 6.7% and 20 unfilled shifts, the highest across Low Secure services. Management supervision (24.2%) and CPR compliance (69.0%) remain significantly below target. Acuity has accounted for an overall reduction in performance. Mitigating actions are in place to ensure there are CPR trained staff on every shift.
•Ryburn achieved 90.9% appraisal compliance, 100% compliance across all mandatory training standards, and improved occupancy to 95.4%. No violence or restraint incidents were reported. However, sickness remains very high at 16.8%, with clinical supervision at 41.7% and management supervision at 25.0%.
•Newhaven remains the most challenged ward, with appraisal compliance at 80.8%, sickness increasing to 11.6%, occupancy at 81.3%, six patient-on-staff assaults, and three restraint incidents during the month. Supervision compliance was stronger than elsewhere in the service, with clinical supervision at 88.5% and management supervision at 80.8%, although both remain below target.

Leadership Actions

• Implement targeted recovery plans in Ryburn and Newhaven to reduce sickness absence and improve workforce resilience.
•Ward managers requested to develop improvement plans for clinical and management supervision compliance, with progress reviewed through monthly governance arrangements.
• Restore mandatory training compliance through completion of outstanding Information Governance training in Thornhill and Sandal, and CPR training in Sandal.
• Review staffing pressures, vacancy management and rostering arrangements within Sandal, given the continued level of unfilled shifts.
• Complete a review of violence and restraint incidents in Newhaven to identify learning and strengthen prevention and staff safety measures.
• Share learning from Thornhill's positive performance on appraisals, sickness management and ward stability across the wider Low Secure service.

Metrics	Strategic Objective	CQC Domain	Threshold	Appleton			Bronte		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	93.3%	80.0%	93.3%	95.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	5.3%	4.4%	4.0%	0.0%	0.6%	0.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	70.6%	83.3%	88.9%	95.7%	90.9%	86.4%
Supervision - Management	Best place to work and learn	Well led	80%	58.8%	66.7%	88.9%	13.0%	54.5%	90.9%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	88.9%	88.9%	94.4%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	94.4%	100.0%	94.4%	95.5%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	83.3%	83.3%	83.3%	68.2%	81.0%	90.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	88.9%	88.9%	88.9%	90.9%	85.7%	85.7%
Bed occupancy	Best Quality	Safe	90%	50.0%	50.0%	50.0%	88.5%	98.6%	100.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	125.0%	93.8%	93.5%	98.6%	122.8%	196.0%
Safer staffing (Registered)	Best Quality	Safe	80%	89.7%	91.6%	86.1%	98.0%	112.4%	137.7%
% 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	100.0%	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	1	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	1	1	4	2
Restraint incidents	Best Quality	Safe	Trend Monitor	2	2	*2*	1	11	*2*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	3	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	N/A	N/A	0% (0/8)	100% (6/6)	0% (0/7)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	8	1	1	0	5	9

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Chippendale			Hepworth		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	89.5%	84.2%	82.2%	100.0%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	5.2%	7.1%	17.0%	1.2%	4.5%	10.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	84.2%	78.9%	65.0%	75.0%	55.0%	66.7%
Supervision - Management	Best place to work and learn	Well led	80%	68.4%	42.1%	30.0%	40.0%	10.0%	50.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	94.7%	94.7%	94.4%	95.0%	95.2%	94.7%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	84.2%	100.0%	94.4%	75.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	94.7%	84.2%	83.3%	85.0%	76.2%	78.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	94.7%	94.7%	88.9%	80.0%	95.2%	94.7%
Bed occupancy	Best Quality	Safe	90%	98.4%	96.1%	91.7%	83.9%	79.8%	83.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	814	N/A	N/A	66	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	97.6%	122.1%	96.7%	95.3%	95.9%	96.3%
Safer staffing (Registered)	Best Quality	Safe	80%	107.5%	125.0%	106.1%	87.1%	89.7%	89.5%
% 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	66.7%	100.0%	100.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	1	1	0	1	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	1	*2*	2	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	13% (4/31)	10% (3/31)	0% (0/23)	0% (0/4)	50% (1/2)	0% (0/4)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	2	14	3	0	1	2

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Johnson			Priestley		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	96.2%	80.8%	100.0%	88.2%	87.5%	93.8%
Sickness	Best place to work and learn	Well led	5.0%	3.7%	2.7%	2.0%	5.1%	4.2%	7.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	66.7%	84.4%	77.4%	66.7%	78.9%	57.1%
Supervision - Management	Best place to work and learn	Well led	80%	51.5%	84.4%	87.1%	55.6%	57.9%	38.1%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	90.6%	96.9%	93.9%	94.7%	100.0%	95.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.6%	93.8%	90.9%	88.9%	94.4%	94.7%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	87.5%	81.8%	83.3%	77.8%	84.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.6%	93.8%	90.9%	89.5%	89.5%	85.0%
Bed occupancy	Best Quality	Safe	90%	100.0%	100.0%	100.0%	94.1%	93.5%	94.1%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	N/A	1389	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	112.8%	103.9%	99.9%	134.7%	90.9%	94.2%
Safer staffing (Registered)	Best Quality	Safe	80%	96.8%	99.5%	96.4%	92.3%	88.4%	84.9%
% 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	1	0	0	2
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	1	0	*0*	0	0	*0*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	12% (3/26)	13% (5/39)	5.4% (2/37)	0% (0/14)	52% (11/21)	9.1% (1/11)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	1	3	1	2	1	0

Inpatients - Forensic West Yorkshire - Medium Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Waterton May-26	Waterton Jun-26	Waterton Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	93.3%	100.0%	100.0%
Sickness	Best place to work and learn	Well led	5.0%	22.9%	18.3%	16.3%
Supervision - Clinical	Best place to work and learn	Well led	80%	40.0%	75.0%	75.0%
Supervision - Management	Best place to work and learn	Well led	80%	32.0%	62.5%	54.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	94.4%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	90.0%	100.0%	89.5%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.0%	88.9%	89.5%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	90.0%	88.9%	89.5%
Bed occupancy	Best Quality	Safe	90%	97.6%	92.7%	92.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1514	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	109.2%	97.8%	96.9%
Safer staffing (Registered)	Best Quality	Safe	80%	103.1%	99.1%	95.3%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	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	1% (1/80)	20% (5/25)	0% (0/71)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	3	5	1

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Thornhill			Sandal		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	96.7%	96.7%	100.0%	91.3%	83.3%	92.0%
Sickness	Best place to work and learn	Well led	5.0%	7.5%	5.9%	1.5%	3.1%	6.9%	6.7%
Supervision - Clinical	Best place to work and learn	Well led	80%	47.1%	52.9%	48.5%	46.9%	48.5%	72.7%
Supervision - Management	Best place to work and learn	Well led	80%	38.2%	41.2%	36.4%	34.4%	33.3%	24.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	96.9%	94.1%	93.9%	96.4%	96.6%	93.1%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	96.9%	97.1%	100.0%	92.9%	93.1%	93.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	76.5%	84.8%	67.9%	65.5%	69.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	97.1%	97.0%	85.7%	93.1%	96.6%
Bed occupancy	Best Quality	Safe	85%	96.3%	96.0%	96.6%	91.3%	93.8%	90.5%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	1400	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	97.5%	95.4%	98.3%	151.3%	183.9%	133.0%
Safer staffing (Registered)	Best Quality	Safe	80%	101.4%	100.3%	98.3%	105.0%	105.3%	97.1%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	N/A	N/A	100.0%	N/A	N/A
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	2	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	1	0	0	0	0	0
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	0	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	20% (34/168)	32% (34/108)	10.8% (16/148)	5% (1/20)	10% (4/39)	13.3% (4/30)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	0	3	15	20	7

Inpatients - Forensic West Yorkshire - Low Secure

Metrics	Strategic Objective	CQC Domain	Threshold	Ryburn			Newhaven		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	100.0%	90.9%	74.2%	81.5%	80.8%
Sickness	Best place to work and learn	Well led	5.0%	17.6%	28.4%	16.8%	0.5%	4.9%	11.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	23.1%	30.8%	41.7%	90.3%	92.3%	88.5%
Supervision - Management	Best place to work and learn	Well led	80%	30.8%	23.1%	25.0%	71.0%	88.5%	80.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	94.1%	93.3%	95.8%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	81.8%	90.0%	100.0%	91.2%	90.0%	95.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	90.9%	100.0%	100.0%	90.3%	92.3%	91.3%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	94.1%	96.7%	100.0%
Bed occupancy	Best Quality	Safe	85%	85.7%	87.6%	95.4%	77.2%	81.3%	81.3%
Average Length of Stay	Best Quality	Safe	Trend Monitor	N/A	N/A	1278	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.0%	97.4%	99.1%	114.8%	104.6%	108.7%
Safer staffing (Registered)	Best Quality	Safe	80%	99.5%	97.6%	98.3%	102.1%	102.5%	102.3%
% 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%	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	2	6
Restraint incidents	Best Quality	Safe	Trend Monitor	0	0	*0*	2	2	*3*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	100% (2/2)	0% (0/4)	0% (0/1)	8% (3/37)	3% (1/32)	3.6% (1/28)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	0	1	0	2	4	2

Inpatients - Non-Mental Health

• **Appraisal rate (90%):**
Both units have seen an increase during July. Appraisal compliance using the previous system for July:
NRU 97%; SRU 97.1%. With ongoing increases showing into August.

• **Supervision (80%):**
Work is ongoing to improve clinical and managerial supervision; both uptake and recording. As a result of plans put in place last month on both units to improve the trajectory by undertaking clinical and managerial supervision during handovers and recording this daily, we are seeing a significant increase in both teams – early figures for August are showing this improvement is continuing.
See also narrative on page 1 for wider Care Group; this also applies to both wards.

• **Sickness (5%):**
NRU – sickness for July remains outside compliance but the position has improved down to 9.4%.
The current position continues to include some instances of LTS:
•1 cancer long term
•1 stress
•1 work related stress - resolution panel took place. The sick note runs up to 9.8.26 then this will cease as staff member will be back at work.
•1 knee replacement long term.
•1 heart problems – due back mid-August.
•2 short term gastro absences both returned during July.

SRU – Sickness for July has increased but remains within compliance at 4.9%.
The current position includes several instances of LTS:
•1 stroke long term
•1 musculoskeletal - long term due to return late August with phased return.
•1 short term pregnancy related – did return to work but has since has further absence.
•2 further short-term absences – both returned to work during July.

Sickness on both units is being monitored and managed via Supporting Wellbeing (Sickness and Attendance Procedure). As noted last month, some staff continue to be off work on a long-term basis and therefore continue to impact this month's figures.

• **Information Governance (95%):**
NRU compliancy remains at 100% for July. SRU has maintained compliance at 95.8% for July.

• **CPR (80%):**
NRU has seen an increase to achieve compliancy during July to 80%.
SRU has shown a further increase and maintained compliancy, achieving 82.4% for July.
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.
In addition, Learning and Development colleagues are exploring the use of local venues to enable Barnsley staff to attend this training more easily and reduce the amount of travel time.

• **Fire Safety Training (85%):**
NRU – has seen an increase to achieve compliancy during July to 86.5%.
SRU – continues to maintain compliancy.

• **Safer Staffing - overall (90%):**
NRU – within compliance – at 118%.
SRU – below compliance but with an improvement to 82.7% (see note below).
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 the first half of 2026. 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)		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	100.0%	97.1%	97.0%	97.1%	88.4%	97.1%
Sickness	Best place to work and learn	Well led	5.0%	8.9%	11.3%	9.4%	6.0%	3.8%	4.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	55.3%	39.5%	75.0%	40.8%	47.7%	68.7%
Supervision - Management	Best place to work and learn	Well led	80%	50.0%	21.1%	44.4%	43.7%	12.3%	37.3%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	92.5%	100.0%	100.0%	95.6%	95.8%	95.8%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	76.3%	77.8%	80.0%	74.6%	80.9%	82.4%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	80.0%	84.2%	86.5%	89.7%	90.3%	93.1%
Bed occupancy (Barnsley Commissioned beds only)	Best Quality	Safe	80%	96.0%	97.8%	90.1%	91.1%	67.8%	88.7%
Average Length of Stay	Best Quality	Safe	Trend Monitor	67	67	71	28	26	37
Safer staffing (Overall)	Best Quality	Safe	90%	106.2%	110.9%	118.0%	87.0%	79.9%	82.7%
Safer staffing (Registered)	Best Quality	Safe	80%	86.3%	92.3%	106.9%	97.5%	93.7%	94.3%
% 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	0	0	0
Unfilled Shifts	Best Quality	Safe	Trend Monitor	12	2	4	58	18	11

Inpatients - Mental Health - Learning Disability

Headlines

- Strong overall quality and governance position with appraisals, supervision and most mandatory training standards achieved.
- Positive reduction in patient-on-staff assaults and restraint incidents.
- No prone restraints and strong risk assessment compliance provides assurance regarding safety processes.
- Appraisal compliance recovered to 97.0%, exceeding target.
- Sickness increased to 7.9%, above the 5% target.
- Clinical supervision (86.5%) and management supervision (83.8%) remained above target.
- Information Governance, RRPI and Fire Safety training all exceeded required standards.
- CPR compliance fell below target to 72.2% and is the principal training hotspot. Plans are in place to ensure trained staff are always on duty and staff non-compliant are booked on training.
- No prone restraint incidents were recorded during July.
- Patient-on-staff assaults and restraint incidents continued a positive downward trend.
- 85.3% of patients were clinically ready for discharge, indicating ongoing discharge pathway pressures.

Metrics	Strategic Objective	CQC Domain	Threshold	Horizon		
				May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	97.1%	88.2%	97.0%
Sickness	Best place to work and learn	Well led	5.0%	4.2%	5.7%	7.9%
Supervision - Clinical	Best place to work and learn	Well led	80%	97.3%	100.0%	86.5%
Supervision - Management	Best place to work and learn	Well led	80%	94.6%	97.2%	83.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	97.5%	97.4%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	95.1%	92.5%	92.1%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	92.3%	81.6%	72.2%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	95.1%	90.0%	97.4%
Bed occupancy	Best Quality	Safe	N/A	42.3%	45.0%	44.0%
Average Length of Stay	Best Quality	Safe	Trend Monitor	524	N/A	20
Safer staffing (Overall)	Best Quality	Safe	90%	120.2%	121.6%	115.7%
Safer staffing (Registered)	Best Quality	Safe	80%	162.0%	161.1%	151.5%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	100.0%	81.8%	85.3%
% inpatient risk assessment completed within 24hrs before or after admission	Best Quality	Safe	95%	N/A	100.0%	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	12	6	3
Restraint incidents	Best Quality	Safe	Trend Monitor	8	6	*3*
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% (0/166)	0% (0/176)	0% (0/138)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	16	36	36

Inpatients - Forensic South Yorkshire

• 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.

Low Secure Services

• Bed Occupancy: Don is operating at near full occupancy (93.8%), Calder achieved target occupancy (93.8%) as did Hamilton (96.5%). Aire (76.9%) and Esk (87.3%) remain below the 90% target, with Esk showing a significant improvement in July.
• Supervision: Calder demonstrates strong compliance with both clinical and management supervision. Aire, Don, Wentbridge and Esk remain below the 80% target for both clinical and management supervision. Further work underway with ward managers regarding recording on Trust supervision database. Don ward is extremely low at 8% however upon investigation is a recording issue.
• Appraisals: Strong performance in Calder (90.5%) and Esk (90.5%), meeting the 90% target. Aire (64.4%), Don (70.8%) and Wentbridge (74.2%) remain below target despite gradual improvement.
• Mandatory Training: Compliance is generally strong across all wards. The main exception is Don's Reducing Restrictive Practice training compliance (79.2%), which remains below target but has shown some slight improvement.
• Staffing: Safer staffing and registered staffing levels exceed target across all wards with the exception of Aire that has dipped very slightly below target (89.9%). However, high levels of unfilled shifts, particularly in Wentbridge, Don, Aire and Esk, indicate ongoing workforce pressures.
• Section 17 Leave: Wentbridge cancelled leave has reduced significantly in July from 76% to 5.9% however cancelled leave on Esk has increased to 37.9% requiring review.
• Restrictive Practice: No prone restraint incidents were reported across any ward. Restraint use remains low overall, although Hamilton recorded a slight increase in restraint incidents during July (5).

Medium Secure Services (Foss and Skipton)

• Staffing: Overall safer staffing remains above target. However, Skipton continues to operate below the registered staffing target (70.3%) This is related to the increased staffing required for the extra package of care for one female.
• Patient Flow and Workforce: Foss continues to experience high sickness (7.2%) with staffing also having an impact on the amount of cancelled Section 17 leave (27%)
• Supervision: Foss exceeds target for both clinical and management supervision. This has dipped below threshold on Skipton (74.2%)
• Bed Occupancy: Both wards exceed occupancy target due to Foss pod/seclusion area being vacated by LTS.
• Violence and Safety: No patient-on-patient violence was reported. Skipton recorded one patient-on-staff assault in July, whereas Foss has reported none throughout the quarter.
• Appraisals: Both wards exceed target with significant improvement on Foss (now 100%)
• Mandatory Training: Compliance is strong across both wards. All areas are now above target.
• Restrictive Practice: No prone restraint incidents were reported.

Metrics	Strategic Objective	CQC Domain	Threshold	Medium Secure Services Foss			Skipton		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	87.0%	83.3%	100.0%	96.7%	96.6%	96.3%
Sickness	Best place to work and learn	Well led	5.0%	7.2%	7.1%	7.2%	2.1%	4.1%	3.8%
Supervision - Clinical	Best place to work and learn	Well led	80%	96.3%	88.9%	92.6%	97.1%	93.9%	74.2%
Supervision - Management	Best place to work and learn	Well led	80%	88.9%	85.2%	85.2%	100.0%	87.9%	74.2%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	95.8%	92.3%	96.3%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	87.5%	84.6%	88.9%	85.3%	84.8%	83.9%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	87.5%	80.8%	96.3%	80.0%	82.8%	92.9%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	92.3%	96.3%	94.1%	97.0%	96.8%
Bed occupancy	Best Quality	Safe	90%	78.6%	74.8%	92.6%	86.8%	91.7%	91.7%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	1894	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	119.3%	105.3%	107.8%	100.8%	103.7%	100.8%
Safer staffing (Registered)	Best Quality	Safe	80%	97.9%	104.6%	101.1%	68.8%	70.3%	69.4%
% 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	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	0	2	1
Restraint incidents	Best Quality	Safe	Trend Monitor	2	1	*4*	5	14	*5*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	11% (4/35)	27% (10/37)	27% (10/37)	14% (4/29)	16% (6/37)	5.1% (2/39)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	20	23	17	23	34	19

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Esk			Hamilton/Wentbridge		
				May-26	Jun-26	Jul-26	May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.5%	90.5%	78.1%	78.1%	74.2%
Sickness	Best place to work and learn	Well led	5.0%	2.0%	3.9%	0.8%	1.0%	3.2%	4.6%
Supervision - Clinical	Best place to work and learn	Well led	80%	91.3%	72.7%	68.2%	97.1%	91.2%	76.5%
Supervision - Management	Best place to work and learn	Well led	80%	73.9%	81.8%	50.0%	94.1%	88.2%	58.8%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	81.8%	81.8%	81.8%	97.1%	97.1%	97.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	85.7%	95.2%	95.2%	97.1%	97.1%	84.8%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	79.0%	78.1%	87.3%	87.5%	87.5%	96.5%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	3080	N/A	N/A	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	99.9%	102.2%	96.4%	119.3%	121.4%	132.9%
Safer staffing (Registered)	Best Quality	Safe	80%	96.7%	81.4%	85.6%	91.8%	94.4%	92.0%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	2	0	0	0	2	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	1	0	3	6
Restraint incidents	Best Quality	Safe	Trend Monitor	1	1	*1*	0	0	*5*
Prone Restraint incidents - Staff Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Prone Restraint incidents - Patient Led	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
% Section 17 Leave Cancelled	Best Quality	Safe	Trend Monitor	19% (6/32)	18% (8/44)	37.9% (11/29)	8% (3/40)	76% (29/38)	5.9% (1/17)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	10	3	5	17	28	55

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Aire May-26	Aire Jun-26	Aire Jul-26	Don May-26	Don Jun-26	Don Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	59.3%	64.3%	65.4%	68.2%	69.6%	70.8%
Sickness	Best place to work and learn	Well led	5.0%	3.4%	5.2%	10.3%	1.1%	1.8%	2.0%
Supervision - Clinical	Best place to work and learn	Well led	80%	75.9%	73.3%	63.3%	69.6%	50.0%	8.0%
Supervision - Management	Best place to work and learn	Well led	80%	62.1%	60.0%	63.3%	69.6%	45.8%	8.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	92.6%	95.5%	95.7%	91.7%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	89.3%	89.3%	88.9%	77.3%	78.3%	79.2%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	89.3%	92.9%	88.9%	86.4%	87.0%	91.7%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	84.7%	87.2%	76.9%	99.7%	98.3%	93.8%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	N/A	N/A	464	N/A	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	96.7%	90.3%	89.9%	104.3%	106.4%	107.4%
Safer staffing (Registered)	Best Quality	Safe	80%	92.7%	90.9%	94.1%	90.8%	86.9%	90.2%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	0	1	1	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	14% (5/36)	5% (1/20)	14.8% (4/27)	12% (6/52)	12% (5/42)	17.3% (9/52)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	11	11	8	11	8	13

Inpatients - Forensic South Yorkshire

Metrics	Strategic Objective	CQC Domain	Threshold	Low Secure Services Calder May-26	Jun-26	Jul-26
Appraisal rate	Best place to work and learn	Well led	90%	90.9%	90.5%	90.5%
Sickness	Best place to work and learn	Well led	5.0%	1.5%	5.4%	4.9%
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%	90.9%	100.0%	100.0%
Information Governance training compliance	Best place to work and learn	Well led	>=95%	100.0%	100.0%	100.0%
Reducing Restrictive Practice Interventions training compliance	Best place to work and learn	Well led	>=80%	100.0%	100.0%	100.0%
Cardiopulmonary resuscitation (CPR) training compliance	Best place to work and learn	Well led	>=80%	95.5%	95.2%	100.0%
Fire Safety training compliance	Best place to work and learn	Well led	>=85%	100.0%	100.0%	100.0%
Bed occupancy	Best Quality	Safe	90%	89.7%	92.9%	93.8%
Average Length of Stay (days)	Best Quality	Safe	Trend Monitor	1818	N/A	N/A
Safer staffing (Overall)	Best Quality	Safe	90%	95.7%	91.6%	94.8%
Safer staffing (Registered)	Best Quality	Safe	80%	91.8%	90.2%	90.4%
% of clients clinically ready for discharge	Best Quality	Responsive	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Best Quality	Safe	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Best Quality	Safe	Trend Monitor	0	0	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	16% (8/51)	2% (1/57)	7.1% (4/56)
Unfilled Shifts	Best Quality	Safe	Trend Monitor	8	7	3

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	From July 2026 the NHS Oversight Framework (NOF) finance rating has been incorporated into the monthly provider finance return (PFR). This includes the main finance rating and temporary staffing metrics. At July, as the Trust remains ahead of plan this rating is 1.
1	Surplus / (Deficit)	Best Value	Well Led	(£2m)	£0m	The financial performance in July 2026 is a deficit of £185k which is £3k more than plan in month. The year to date position remains just ahead of plan (£5k). Delivery, in line with plan, continues to be supported by one off items, such as the in month revised calculation of PDC (Public Dividend Capital) payments. Further actions are required to ensure that the breakeven target can be achieved.
2	Agency Spend	Best Value	Well Led	£0.6m	£1.9m	Agency spend, which continues to be limited to a small number of medical posts, has increased from £138k to £162k in month. This is equivalent to 7.72 worked WTE. As monitored within the NOF this is 0.5% of the Trust year to date total pay bill.
3	Bank Spend	Best Value	Well Led	£7.6m	£19.6m	Bank spend has continued fluctuate with a £72k reduction in month (5.80 less worked WTE). The year to date £7.6m represents 7.3% of the total Trust pay bill. The majority of expenditure continues to be on nursing staff, primarily within inpatient areas, to support operational pressures. The forecast continues to be reviewed and updated to reflect actions taken. As such the forecast has been updated to amber, being £0.6m more than target.
4	Financial sustainability and efficiencies	Best Value	Well Led	£4.6m	£17.7m	Bank spend has continued fluctuate with a £72k reduction in month (5.80 less worked WTE). The year to date £7.6m represents 7.3% of the total Trust pay bill. The majority of expenditure continues to be on nursing staff, primarily within inpatient areas, to support operational pressures. The forecast continues to be reviewed and updated to reflect actions taken. As such the forecast has been updated to amber, being £0.6m more than target.
5	Cash	Best Value	Well Led	£58m	£60.1m	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	£3m	£14.9m	The Trust continues to progress with it's capital programme. Pricing, and profiles, are expected to be agreed shortly for the main schemes. Mitigations to manage within the in year allocation are being developed to ensure that this can be fully and appropriately utilised.
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 4 (2026 / 27)

www.southwestyorkshire.nhs.uk

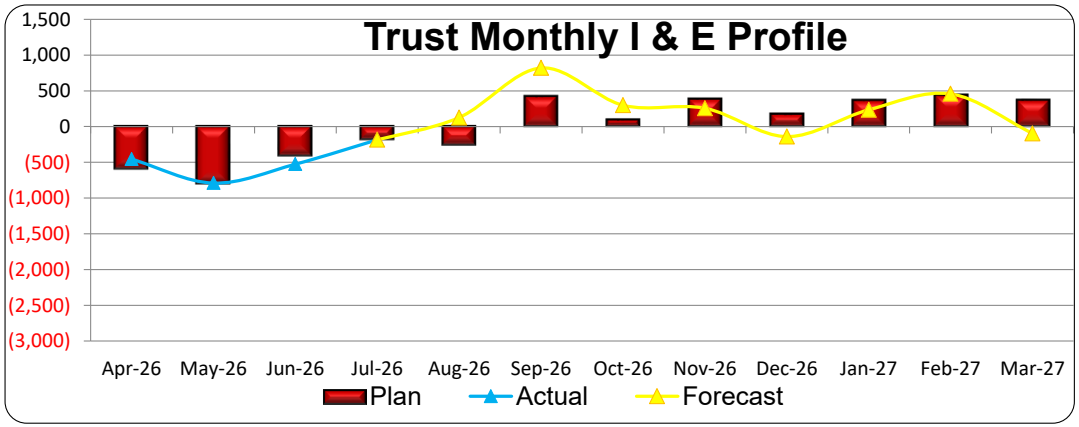
With **all of us** in mind.

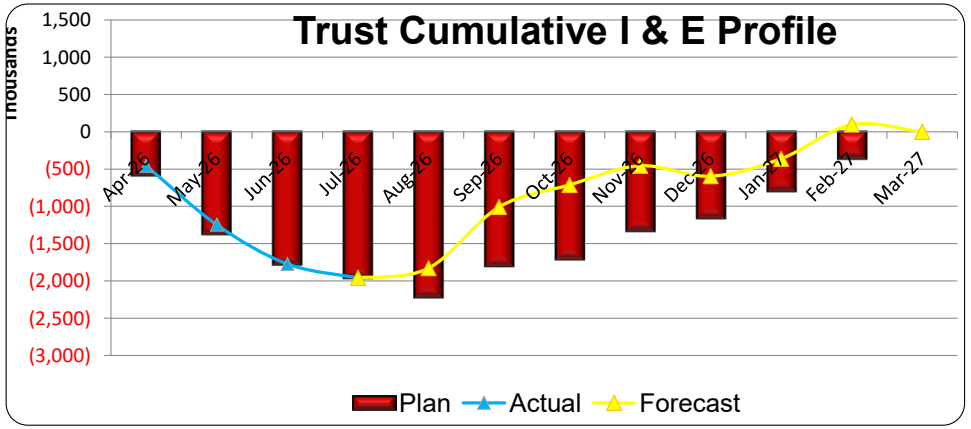
2.0 Income & Expenditure Position 2026 / 27

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

Total Financial Position

Description	Budget Staff	Actual Worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Healthcare contracts					34,881	34,938	57	139,523	139,776	253	418,974	416,986	(1,988)
Other Operating Revenue					1,327	1,462	135	5,233	5,481	248	15,816	16,211	395
Total Revenue					**36,208**	**36,400**	**192**	**144,756**	**145,256**	**500**	**434,790**	**433,196**	**(1,593)**
Employee expenses	5,381	5,406	25	0.5%	(25,676)	(25,855)	(179)	(102,934)	(104,414)	(1,481)	(306,315)	(314,522)	(8,207)
Operating expenses exc. Employee expenses					(10,452)	(10,760)	(309)	(42,751)	(42,313)	438	(125,241)	(117,149)	8,092
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	**5,381**	**5,406**	**25**	**0.5%**	**(36,128)**	**(36,616)**	**(488)**	**(145,684)**	**(146,727)**	**(1,043)**	**(431,557)**	**(431,671)**	**(115)**
Operating Surplus / (Deficit)	**5,381**	**5,406**	**25**	**0.5%**	**80**	**(216)**	**(296)**	**(929)**	**(1,471)**	**(542)**	**3,233**	**1,525**	**(1,708)**
Finance expense					(56)	(59)	(3)	(224)	(237)	(13)	(673)	(672)	1
PDC Paid					(362)	(142)	220	(1,448)	(1,228)	220	(4,343)	(3,684)	659
Finance income					145	225	80	592	946	354	1,645	2,746	1,102
Surplus / (Deficit) - Total	**5,381**	**5,406**	**25**	**0.5%**	**(193)**	**(193)**	**0**	**(2,008)**	**(1,989)**	**19**	**(138)**	**(84)**	**54**
Adjusted Financial Performance													
Depn Peppercorn Leases (IFRS16)					11	8	(3)	46	32	(14)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB performance measure	**5,381**	**5,406**	**25**	**0.5%**	**(182)**	**(185)**	**(3)**	**(1,962)**	**(1,957)**	**5**	**(0)**	**(0)**	**(0)**





Income & Expenditure Position 2026 / 27

The consolidated Trust deficit in July 2026 is £185k.
This is £3k worse than plan.

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

NHS England - monthly submission

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

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

	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
Description	**WTE**	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Trust (core)	5,358	5,385	27	0.5%	(345)	(373)	(27)	(2,890)	(2,080)	810	(4,304)	(10,292)	(5,988)
Provider Collaboratives	23	21	(2)	8.8%	(56)	(215)	(159)	(26)	(417)	(391)	18	(1,927)	(1,945)
Budgets held centrally	0	0	0	0.0%	220	403	183	954	540	(414)	4,286	12,218	7,932
Total - Consolidated position (ICB performance measure)	**5,381**	**5,406**	**25**	**0.5%**	**(182)**	**(185)**	**(3)**	**(1,962)**	**(1,957)**	**5**	**(0)**	**(0)**	**(0)**

As shown above, both Trust (core) and provider collaboratives have reported deficits in month, which is consistent with the deficit run rate reported in quarter 1. This has been reduced by non-recurrent mitigations, reported through the budgets held centrally line, although these are only sufficient to reduce to a deficit of £185k deficit overall in month. With in month performance the year to date position remains marginally ahead of plan.

The Trust (core) run rate quarter 1 average was £569k. July 2026 performance, at £373k, is £196k lower than this. As outlined in the bridge on page 5 workforce variance to plan remains the biggest pressure. There has also been increased non pay expenditure in month, the largest of which is IM & T equipment which has been incurred later than originally planned.

The Adult Secure provider collaboratives (both South Yorkshire and West Yorkshire) continue to report operational and financial pressures with South Yorkshire reporting an increased in month deficit of £221k.

Budgets held centrally remains for items that are not able to be coded through care groups. Actual expenditure remains limited; £396k of non recurrent benefits have been realised in month. 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.

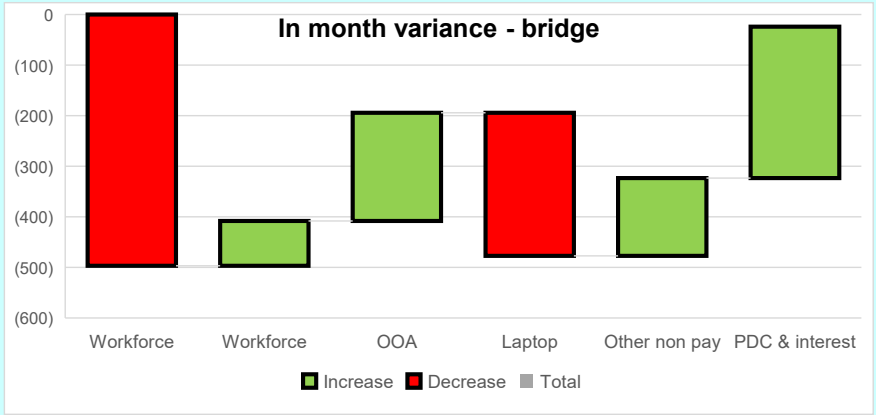
Total Financial Position - Core Trust only

	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					25,127	25,166	39	100,508	100,560	52	301,927	299,335	(2,592)
Other Operating Revenue					1,289	1,391	102	5,028	5,193	164	14,861	15,378	517
Total Revenue					**26,416**	**26,557**	**141**	**105,536**	**105,752**	**216**	**316,788**	**314,713**	**(2,075)**
Employee expenses	5,358	5,385	27	0.5%	(25,492)	(25,831)	(339)	(102,197)	(103,991)	(1,794)	(304,106)	(312,953)	(8,847)
Operating expenses exc. Employee expenses					(1,008)	(1,130)	(122)	(5,195)	(3,355)	1,840	(13,753)	(10,527)	3,226
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	**5,358**	**5,385**	**27**	**0.5%**	**(26,500)**	**(26,961)**	**(461)**	**(107,392)**	**(107,346)**	**46**	**(317,859)**	**(323,479)**	**(5,620)**
Operating Surplus / (Deficit)	**5,358**	**5,385**	**27**	**0.5%**	**(84)**	**(404)**	**(320)**	**(1,857)**	**(1,594)**	**263**	**(1,071)**	**(8,767)**	**(7,695)**
Finance expense					(56)	(59)	(3)	(224)	(237)	(13)	(673)	(672)	1
PDC Paid					(362)	(142)	220	(1,448)	(1,228)	220	(4,343)	(3,684)	659
Finance income					145	225	80	592	946	354	1,645	2,746	1,102
Surplus / (Deficit) - Total	**5,358**	**5,385**	**27**	**0.5%**	**(357)**	**(381)**	**(24)**	**(2,936)**	**(2,112)**	**824**	**(4,442)**	**(10,376)**	**(5,934)**
Depn Peppercorn Leases (IFRS16)					11	8	(3)	46	32	(14)	138	84	(54)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - ICB	**5,358**	**5,385**	**27**	**0.5%**	**(345)**	**(373)**	**(27)**	**(2,890)**	**(2,080)**	**810**	**(4,304)**	**(10,292)**	**(5,988)**

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; more staff than planned utilised on inpatient wards	(497)
Workforce - continuation of utilisation of less staffing than plan. Support care group	89
Non pay - Out of area placements have continued, despite significant operational pressures, to be maintained less than planned.	214
Non pay - timing of IM & T purchases. Plan was profiled earlier in the year	(283)
Non pay - additional spend in month including training costs	154
PDC (Public dividend capital) and interest - updated calculation for the year to date based on current capital profile and cash position	300

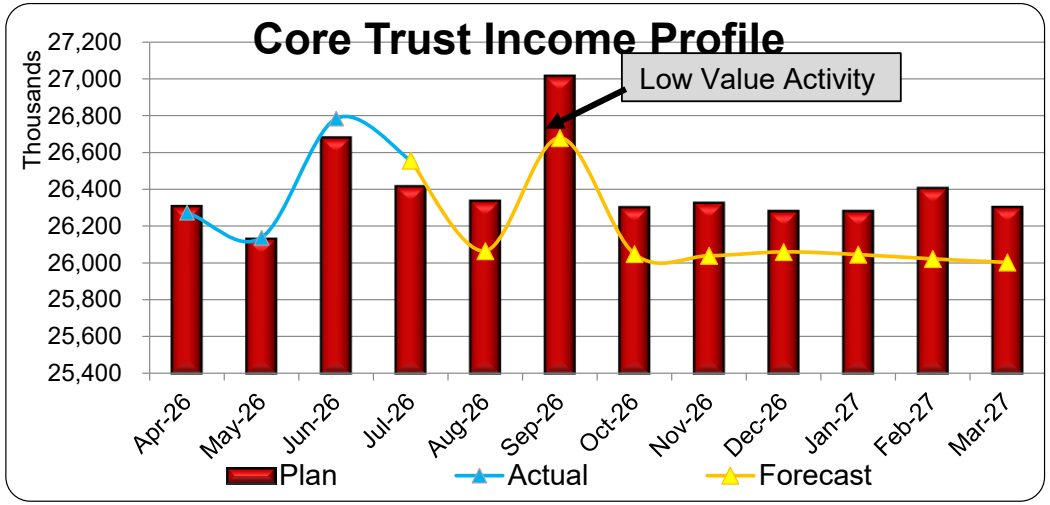


2.1 Income Information

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	23,615	23,481	(134)	94,427	94,266	(161)	283,745	283,275	(470)
Specialised Commissioning (NHS E)	637	833	196	2,626	2,895	269	7,148	6,147	(1,001)
Local Authorities	437	445	9	1,731	1,798	67	5,213	5,219	6
Partnerships	249	231	(17)	962	971	9	3,533	2,775	(759)
Other Healthcare income	119	105	(14)	474	346	(129)	1,423	1,067	(357)
Other non clinical income	1,361	1,462	101	5,316	5,477	161	15,725	16,230	505
Total - Trust core income	**26,416**	**26,557**	**141**	**105,536**	**105,752**	**216**	**316,788**	**314,713**	**(2,075)**
Provider Collaboratives	9,754	9,772	18	39,015	39,216	200	117,046	117,650	604
Budgets held centrally	38	71	33	205	288	84	955	833	(122)
Total - Consolidated income	**36,208**	**36,400**	**192**	**144,756**	**145,256**	**500**	**434,790**	**433,196**	**(1,593)**



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	£324k
* Yorkshire Smokefree - prescribing & activity	£5k
* Any qualified provider activity	£110k

Other income variances include:

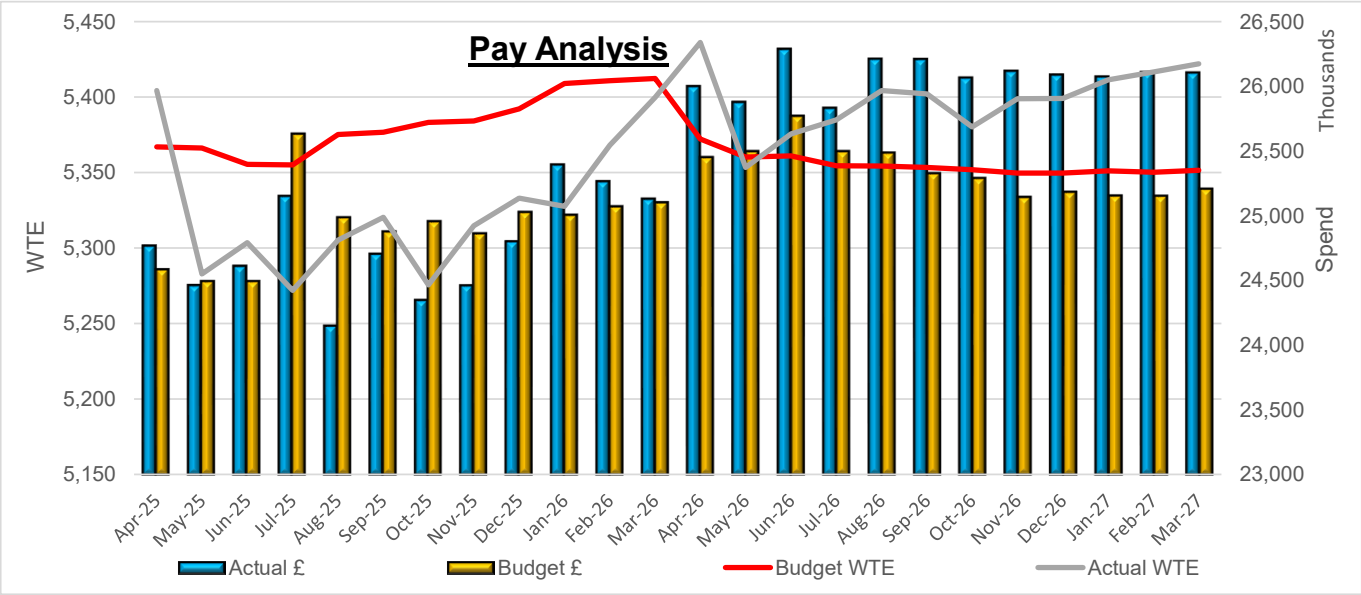
* Income received for bed sales inc. Provider Collabs	£604k

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	4,951	23,804	95,799	5,098	291,430	14	(407)
Bank & locum	426	1,865	7,622	317	19,582	(6)	(72)
Agency	8	162	569	7	1,940	1	25
Total	**5,385**	**25,831**	**103,991**	**5,422**	**312,953**	**9**	**(455)**
Budget	**5,358**	**25,492**	**102,197**	**5,352**	**304,106**	**(6)**	**(272)**
Over / (Under)	**27**	**339**	**1,794**	**71**	**8,847**	**16**	**(182)**



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

Following a run rate of small incremental reductions substantive worked WTE has increased by 14 in month. Agency continues to be maintained at a low level and is medical posts only. Bank staff has continued to fluctuate month on month with a 6 WTE reduction in July 2026. The Trust workforce plan continues to be implemented.

The budget has reduced by 6 WTE in month reflecting the Trust Value for Money programme.

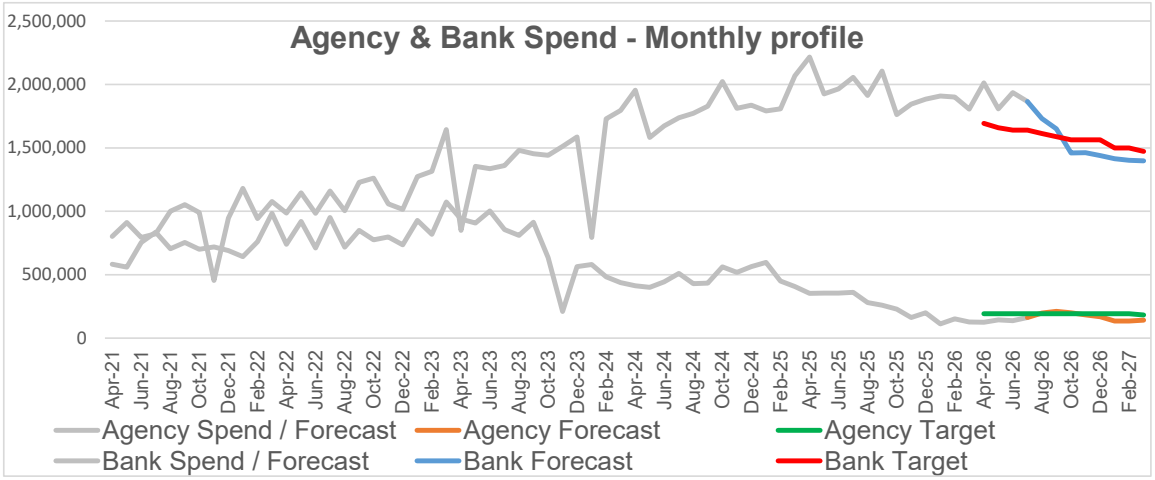
As actual spend in June 2026 included the medical staff pay award, with arrears to April 2026, the actual spend in month is reported as a reduction.

2.2 Temporary Staffing Focus

Trust spend in July 2026:
Agency £162k
Bank £1,865k

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	388	146	**534**
Other Medical	180	228	**409**
Reg Nursing	(0)	2,243	**2,243**
UnReg Nursing	0	4,616	**4,617**
Other Clinical	0	191	**191**
A & C	0	198	**198**
Other	0	0	**0**
Total	**569**	**7,622**	**8,191**
Lead Provider Collaborative		3	**3**
Budgets held centrally		0	**0**
Total	**569**	**7,625**	**8,194**

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. Delivery against these targets is monitored as part of the NHS Oversight Framework (NOF) alongside existing NHS England oversight.

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 although this has increased by £24k in month due to additional medical staffing utilised (additional 1.35 WTE). This continues to be minimised as far as possible whilst ensuring appropriate staffing levels. The current forecast remains that the target can be achieved.

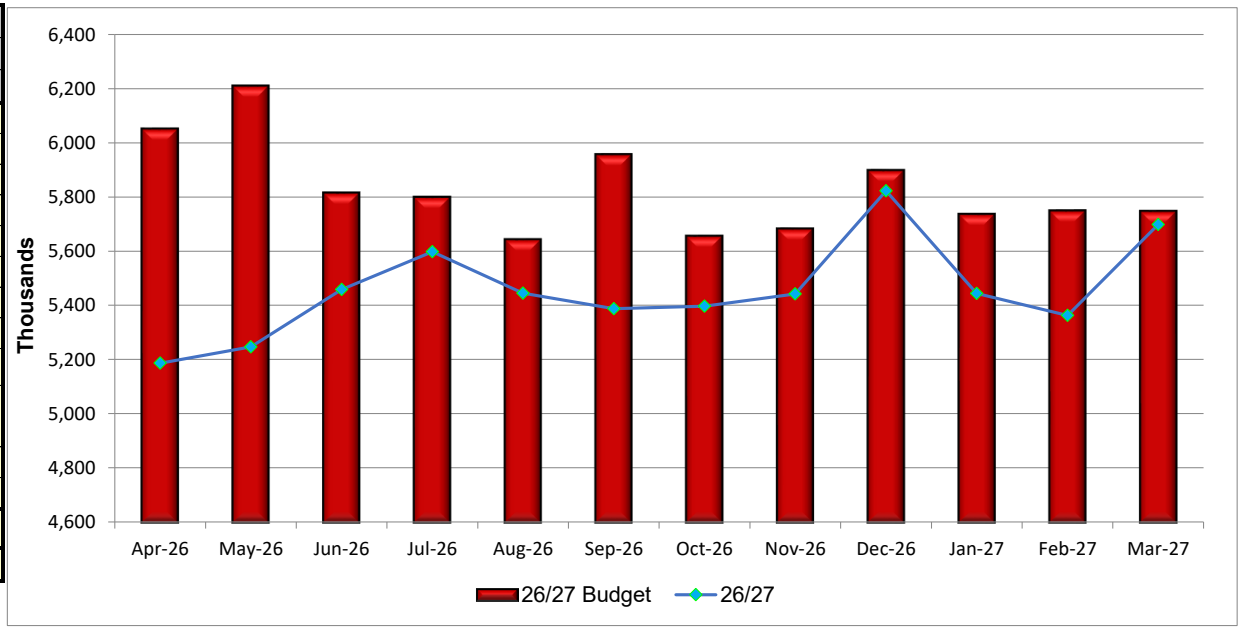
Bank spend has continued to fluctuate and has reduced by £72k in month to £1,865k. As per the NOF this represents 7.3% of our total year to date pay bill. Of this £1,658k relates to nursing staff (£1,112k unregistered) as part of the operational response to inpatient ward pressures. With actions being taken as part of the Trust workforce plan, such as focussed recruitment and retention, the run rate is forecast to reduce. Based on this current trajectory the national target will be exceeded by £0.6m.

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	5,598	5,444	5,387	5,397	5,442	5,823	5,444	5,363	5,698	**65,487**
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	1,586	1,418	(168)
Establishment	3,737	3,323	(414)
Lease & Property Rental	2,944	2,911	(33)
Premises (inc. rates)	2,000	1,989	(12)
Utilities	1,036	835	(201)
Purchase of Healthcare	2,633	1,885	(748)
Travel & vehicles	2,040	1,983	(57)
Supplies & Services	2,977	2,943	(34)
Training & Education	471	333	(139)
Clinical Negligence & Insurance	483	480	(3)
Capital Charges Depn, PDC,	3,451	2,876	(574)
Other non pay	515	511	(5)
Total	**23,875**	**21,488**	**(2,387)**
Total Excl OOA and Drugs	**19,656**	**18,185**	**(1,471)**



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 since April 2026. The largest increase in July 2026 relates to the purchase of replacement IM & T equipment. This was originally planned for earlier in the year which contributed to that initial underspend.

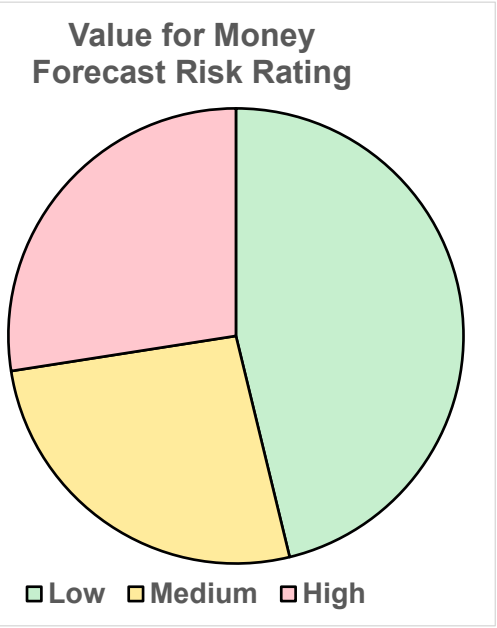
All categories continue to have spent less than plan for the year to date. In addition to IM & T equipment there has also been increased expenditure in training & education and drugs. The impact of these has been reduced with the revised PDC calculation and reduction of spend on the purchase of healthcare.

3.0 Value for Money & Financial sustainability

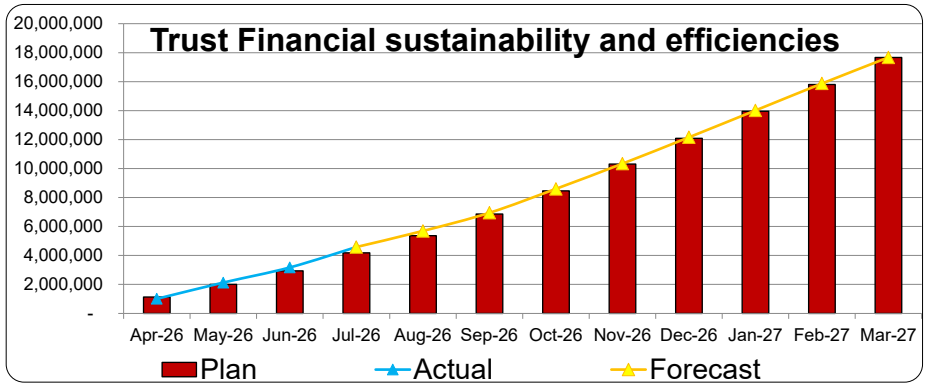
The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial 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	100	362	28	290	3,689	390	900	4,855	2,456
	Temporary Staffing	1,818	1,432	0	(385)	4,412	1,432	3,172		193
	Corporate Pay	664	128	1,070	534	1,991	2,822			831
	Productivity	70	0	0	(70)	1,400				(1,400)
	Difficult Decisions	250	37	0	(213)	2,138	166			(1,972)
Non Pay	Non Pay	32	33	3	5	248	100			(148)
	Drugs optimisation	72	0	0	(72)	220	0	144		(76)
	Digitial optimisation	12	100	3	91	35	310			275
	Out of Area placements	120	554	0	434	357	554	273		470
	Difficult Decisions	0	20	0	20	0	135			135
	Non pay - establishment	68	21	12	(35)	265	36	42		(187)
Other	Provider Collaboratives	720	720	0	0	2,160	2,160			0
	Bed Sales	0	0	0	0	0				0
	Income	256	38	23	(195)	760	61	122		(577)
	Misc income - overage	0	0	0	0	0				0
Total		**4,182**	**3,446**	**1,140**	**404**	**17,675**	**8,167**	**4,653**	**4,855**	**(0)**
Recurrent		3,930	3,446		(484)	16,925	5,544	4,653	945	(5,782)
Non Recurrent		252		1,140	888	750	2,623	0	3,910	5,782



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 c. £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 July 2026 / month 4 £4,586k has been reported. This is £404k ahead of plan.

The two largest drivers of this positive position continues to relate to corporate pay savings and reduced out of area placements. These are forecast to be maintained.

Development of schemes profiled later in the year continue. At this stage the largest risk relates to productivity and difficult decision schemes and a mitigation will be required for these should they fail to deliver in line with target. This is currently highlighted as red against workforce schemes.

4.0 Statement of Financial Position (SOFP) 2026 / 27

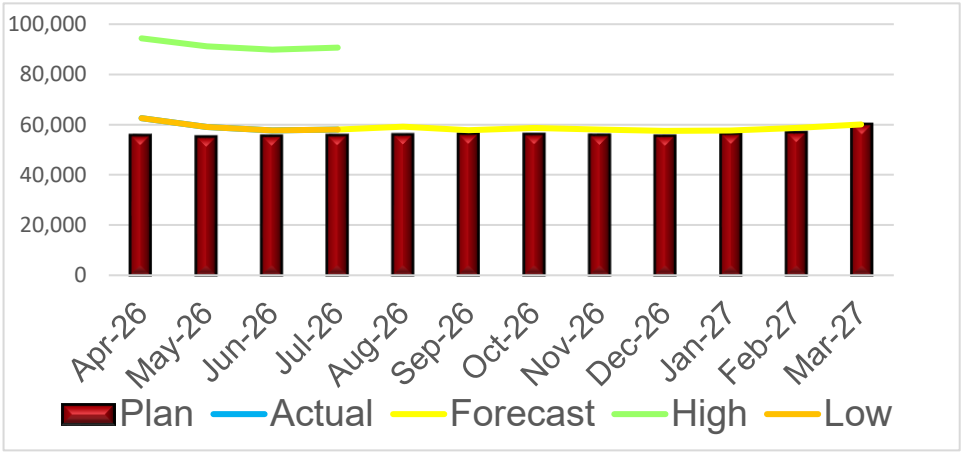
Whilst the focus is traditionally on the Trust income and expenditure position, the Statement of Financial Position (SOFP - balance sheet) presents a key snapshot of the Trusts overall financial health, stability and can provide important early warning flags of potential financial issues.

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	190,250	Pg 13
Inventories & Work in Progress	209	
Trade receivables (Debtors)	1,204	
Accrued Income	4,462	Pg 14
Prepayments	6,276	
Cash and Cash Equivalents	58,016	
Total Assets	**260,417**	
Liabilities		
Payables (Creditors)	(14,396)	
Accruals	(18,312)	
Deferred Income	(3,658)	Pg 14
Provisions	(3,276)	
IFRS 16 / leases liabilities	(46,329)	
Total Liabilities	**(85,971)**	
Total Net Assets/(Liabilities)	**174,447**	
Taxpayers' Equity		
Public Dividend Capital	(79,119)	
Revaluation Reserve	(12,067)	
Other Reserves	(5,220)	
Income & Expenditure Reserve	(78,040)	
Total Taxpayers' Equity	**(174,447)**	

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

Cash: The Trust cash position is shown below. The graph shows the position at the end of each month and also the highest / lowest cash point during that month. This is monitored to highlight any risk or opportunity. Actual cash is £58.0m and remains ahead of plan.

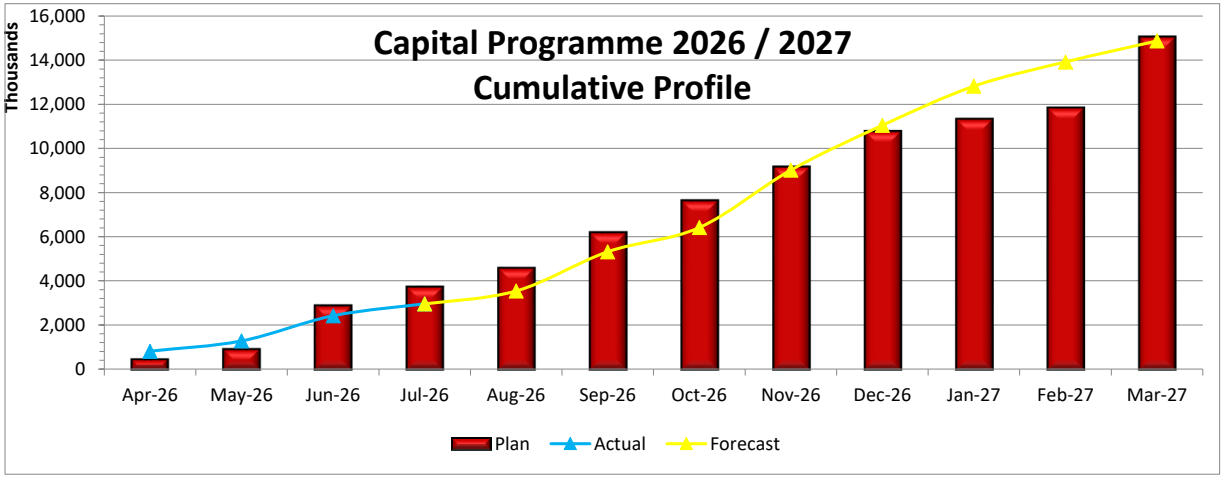


Overall the Trust balance sheet remains strong with assets greater than liabilities.

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	1,740	336	(1,404)	5,428	4,077	(1,351)
IM & T - Digital Infrastructure	0	216	216	1,650	1,275	(375)
IM & T - Cyber Security	0	0	0	250	250	0
IM & T - Digital Care Records	64	0	(64)	200	200	0
IM & T - Digital Information Sharing	50	0	(50)	100	100	0
IM & T - Digital Insights	0	0	0	200	200	0
IM & T - Digitally Empowered Workforce	50	0	(50)	100	100	0
Net Zero Carbon	0	1,205	1,205	0	1,913	1,913
Critical risk	0	0	0	0	85	85
Other	0	(557)	(557)	0	(247)	(247)
Leases (IFRS 16)	1,497	1,724	227	3,011	2,791	(220)
TOTALS	**3,401**	**2,923**	**(478)**	**10,939**	**10,744**	**(195)**
Additional allocations						
Cheswold	360	30	(330)	3,000	3,000	0
Community hub	0	0	0	750	750	0
Additional IM & T	0	0	0	375	375	0
Additional revenue incentive						
TOTALS	**3,761**	**2,952**	**(809)**	**15,064**	**14,869**	**(195)**
Expenditure outside allocations						
Intra NHS Leases (IFRS 16)	1,442	1,251	(191)	1,442	1,251	(191)
TOTALS - AFTER EXCLUSION	**2,319**	**1,701**	**(618)**	**13,622**	**13,618**	**(4)**



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. Further funding was confirmed in July 2026 with £375k of digital frontline productivity funding and £2,207k in relation to the NHS revenue incentive scheme (financial position better than planned). At this stage the latter is profiled to be utilised in 2027 / 28.

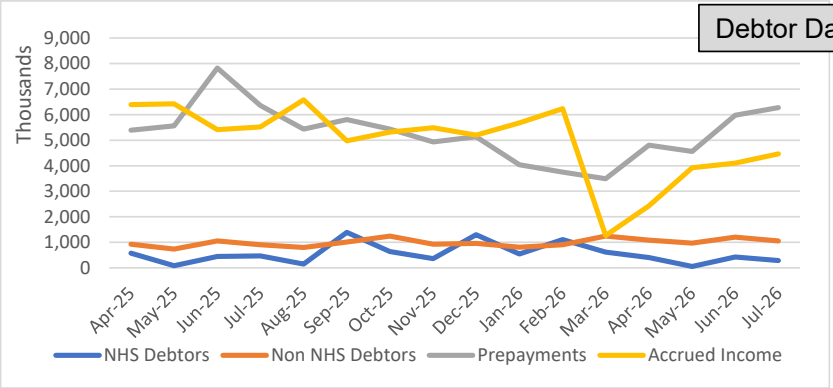
The main Older Peoples scheme continues to be developed with our construction partner. This will culminate in an agreed price and spend profile. It is important to ensure that this stage is complete and comprehensive, and as a result, this is taking longer than originally intended. As such it is forecast that less will be spent in 2026 / 27. This means that the previous large negative value, reported against the other line, has now been resolved which mitigates the impact of the solar panel scheme. The remaining negative relates to VAT rebates on previous schemes.

The £191k relates to differences on the intra NHS leases. These are excluded from our allocation. The actual rent increases were less than planned.

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.

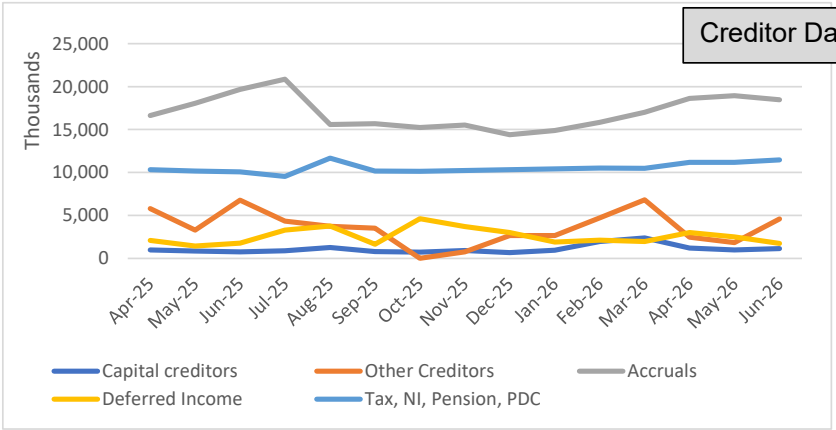
Debtors: A debtor is an individual or company who owes money to the Trust for services provided. This directly impacts on cashflow. The action is to minimise these balances as far as possible and ensure that debts are recovered in a timely manner. Both the value and age is shown below.



Debtors	Not Due £k	1 - 30 days £k	31 - 60 days £k	61 + days £k	Total £k
NHS	253	15	4	0	272
Non NHS	291	295	4	239	828
Total	**544**	**309**	**9**	**239**	**1,100**

Both prepayments and accrued income have continued to rise. The priority remains 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.



Creditors	Not Due £k	1 - 30 days £k	31 - 60 days £k	61 + days £k	Total £k
NHS	1,314	146	95	(9)	1,546
Non NHS	1,952	64	(2)	420	2,433
Total	**3,266**	**210**	**92**	**411**	**3,979**

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.

re c

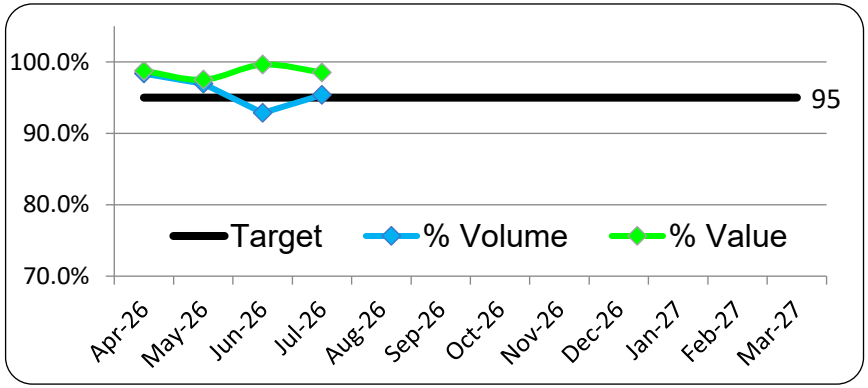
5.0 Better Payment Practice Code

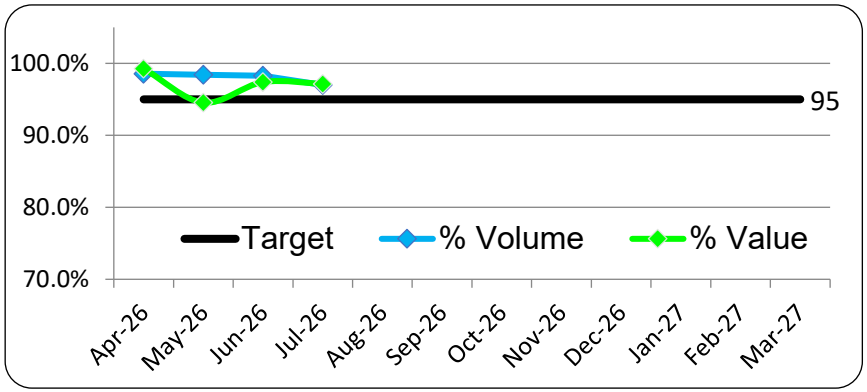
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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

NHS	Number %	Value %
In Month	95%	98%
Cumulative Year to Date	96%	99%

Non NHS	Number %	Value %
In Month	97%	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 (£)
17-Jul-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1007685	730,955
14-Jul-26	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	2000033727	697,767
09-Jul-26	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	207016	680,143
02-Jul-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011350	417,115
21-Jul-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS72	400,000
30-Jul-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002470	346,580
21-Jul-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS49	240,000
03-Jul-26	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HONHSLS318	239,285
15-Jul-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC050INV	233,052
08-Jul-26	Membership	Trustwide	Care Quality Commission	INV00072792	224,840
14-Jul-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS070INV	206,080
15-Jul-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34075865	143,429
03-Jul-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004673	131,823
29-Jul-26	Purchase of Healthcare	Trustwide	Diabetes Digital Media Ltd	INV8041	131,488
15-Jul-26	Computer Software	Trustwide	Softcat Plc	INVUK2309452	130,570
17-Jul-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34075932	120,000
03-Jul-26	IT Services	Trustwide	Wavenet Ltd	1563775	108,300
02-Jul-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510011346	103,403
08-Jul-26	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	34074784	101,064
22-Jul-26	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6029866	84,614
23-Jul-26	NHS Recharge	Kirklees	Mid Yorkshire Hospitals NHS Trust	1600040804	73,491
21-Jul-26	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trust	333385	73,439
21-Jul-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1007684	71,198
08-Jul-26	Drugs	Barnsley	Rowlands Pharmacy	1800006553	68,523
14-Jul-26	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS070SN	65,657
02-Jul-26	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Foundation Trust	4400004652	64,727
03-Jul-26	Computer Hardware	Trustwide	Dell Corporation Ltd	7403184027	61,740
03-Jul-26	Computer Hardware	Trustwide	Dell Corporation Ltd	7403184028	61,740
03-Jul-26	Computer Hardware	Trustwide	Dell Corporation Ltd	7403184029	61,740
04-Jul-26	Computer Hardware	Trustwide	Dell Corporation Ltd	7403184386	61,740
02-Jul-26	Purchase of Healthcare	Forensics	Spectrum Community Health Cic	SINV10192	53,992

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
03-Jul-26	Computer Hardware	Trustwide	Dell Corporation Ltd	7403184030	53,096
30-Jul-26	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Trust	0000002471	50,517
01-Jul-26	Purchase of Healthcare	Forensics	Sheffield Childrens NHS Foundation Trust	2400011959	45,840
04-Jul-26	Lease Cars	Trustwide	Athlon Mobility Services Uk Ltd	202680020550	45,483
21-Jul-26	Drugs	Trustwide	NHS Business Services Authority	1000088574	44,717
21-Jul-26	Drugs	Trustwide	NHS Business Services Authority	1000088904	43,992
09-Jul-26	Purchase of Healthcare	Kirklees	Kirklees Council	8610495463	43,750
09-Jul-26	Purchase of Healthcare	Kirklees	Kirklees Council	8610495476	43,750
10-Jul-26	Purchase of Healthcare	Kirklees	Invictus Wellbeing Services Cic	646	42,433
02-Jul-26	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001591EPC	40,464
06-Jul-26	Purchase of Healthcare	Calderdale	Invictus Wellbeing Services Cic	645	39,500
08-Jul-26	Rent	Kirklees	Bradbury Investments Ltd	19997	32,927
10-Jul-26	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1007580	31,933
13-Jul-26	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	WKE0470126	31,050
27-Jul-26	Rent	Barnsley	Bhf Corporate Services Ltd	1073	30,747
27-Jul-26	Rent	Barnsley	Bhf Corporate Services Ltd	1088	30,747
23-Jul-26	MFD's	Trustwide	Annodata Ltd	1447879	29,384
06-Jul-26	Insurance	Trustwide	Aon Uk Ltd	555836308	26,413
13-Jul-26	Maintenance	Trustwide	Swegon Ltd	INV51624	25,908
15-Jul-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898787	25,299
15-Jul-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898788	25,299
15-Jul-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898789	25,299
15-Jul-26	Purchase of Healthcare	AS Collaborative	Humber Teaching NHS Foundation Trust	59898790	25,299
02-Jul-26	Purchase of Healthcare	Forensics	Tees Esk & Wear Valleys NHS Foundation Trust	4810029749	25,249
30-Jul-26	Staff Recharge	Calderdale	Calderdale Metropolitan Borough Council	IN26079634	25,218

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

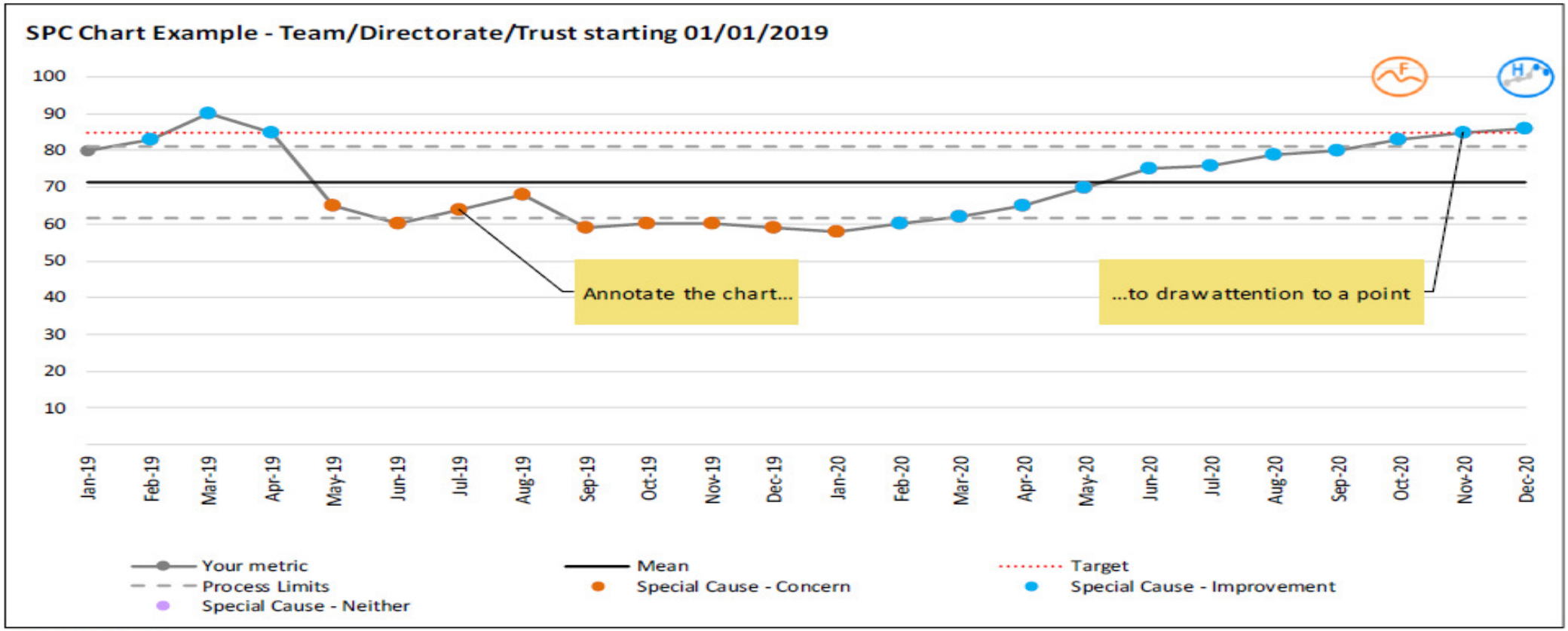
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data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