Sheffield Health and Social Care NHS Foundation Trust

Board of Directors – Open

Date:	12th August 2020	Item Ref:	09

TITLE OF PAPER	Quality Report
TO BE PRESENTED BY	Dr Mike Hunter, Executive Medical Director
ACTION REQUIRED	Members are asked to: • receive the report; • consider any gaps and discuss additional requirements.
OUTCOME	To enable the Trust to triangulate and assess its quality related intelligence and to identify any concerns relating to this.
TIMETABLE FOR DECISION	Discussed at July's Quality Assurance Committee and reported to the Board of Directors in August 2020.
LINKS TO OTHER KEY REPORTS / DECISIONS	Links to annual Quality Report, Incident Management Reports, Mortality Reports, EMSA reports, safeguarding reports, CQC compliance updates and monthly Performance Reports. Also links to Board Assurance Framework, Corporate Risk Register and Care Network Risk Registers.
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	Strategic Aim: Create a great place to work Strategic Objective: CQC Getting Back to Good. BAF.00003 - There is a risk that the Trust is unable to improve patient safety resulting in a failure to comply with CQC requirements and achieve necessary improvements. BAF.00004 - There is a risk that the Trust is unable to improve the quality of patient care, resulting in a failure to comply with CQC requirements and achieve necessary improvements.
LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	NHS Improvement's Single Oversight Framework CQC Fundamental Standards NHS England's Serious Incident Reporting Framework
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	Inadequate quality and safety standards could result in an increase in harm to service users and staff and loss of staff morale which could increase staff absence and ultimately having a financial impact on the Trust. There may also be further contractual implications from commissioners or regulatory bodies.
CONSIDERATION OF LEGAL ISSUES	Inadequate service user safety standards could result in litigation, contractual penalties, non-compliance with regulatory body standards and could ultimately affect the Trust's ability to maintain Foundation Trust status.
Author of Report	Tania Baxter / Debbie Cundey
Designation	Head of Clinical Governance / Service Development Manager
Date of Report	13 July 2020

Assurance Summary

PURPOSE OF PAPER	To enable the Trust to triangulate and assess its quality related intelligence and to identify any concerns relating to this, understand the impact of any concerns and receive assurance on the actions being taken to address/mitigate any associated risks.
AREAS OF GOOD PRACTICE/POSITIVE OUTCOMES	• Benchmarking data included to identify any key issues • Incident reporting culture appears to be positive • Positive feedback received from staff re Trust's management of Covid-19, feeling safe, flexibility provided • Canvassing service user views during Covid-19 pandemic • Shared ownership of the report between clinical and corporate teams.
AREAS OF CONCERN	1. Staffing numbers on inpatient areas 2. Sexual safety on inpatient areas and use of dormitories 3. Recovery teams CPA reviews 4. EWS waiting times and lack of assurance of impact of plan to address 5. Current absence of understanding of service user feedback during Covid-19 6. Staff feedback during Board member visits
IMPACT ASSESSMENT	The above areas of concern suggest a negative impact on patient safety and patient experience. It also suggests an impact on the following CQC domains: Safety Well-led
ACTIONS TAKEN (to address areas of concern above)	1. Staffing levels and skill mix reviewed every shift to flexibly deploy staff across the Trust. 1. Decisions Unit partially closed to enable staff to be deployed flexibly 2. Work underway to eradicate dormitories 3. Dashboards developed for CPA reviews and additional admin resource secured to support the process. 3. Milestones set to ensure compliance is achieved by September 2020. 4. Plan to reduce waiting times developed.
ACTIONS BEING TAKEN (to address areas of concern above)	2. The elimination of dormitories is a programme of work that is being undertaken jointly with Clinical Operations and Estates. 2. Further consideration of single sex accommodation is currently underway. 3. Recovery action plans have been developed in line with the CQC required improvements for acute bedded services and recovery teams. 4. Recruitment of Clinical Associate Psychologists 4. Safeguarding team to be cited at SPA. 5. Feedback from questionnaires being collated to understand the positive and negative impacts on the service changes made during Covid-19. 6. Actions being developed to address challenges/areas of concern

Sheffield Health and Social Care NHS Foundation Trust

Summary Report

1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
✓			✓		

2. Summary

Attached is the monthly quality report that brings together a number of different elements from various reporting streams. Whilst wherever possible, the most recent monthly data has been used, where existing reporting requirements are not monthly, the most recent available data has been used.

This report has been refined following each presentation to the Quality Assurance Committee and Board of Directors. Discussions have been held between Phillip Easthope, Jonathan Burleigh, Deborah Cundey and Tania Baxter regarding incorporating this report into the current monthly Board of Directors Performance Report, creating an integrated performance and quality report. This will eradicate duplication, provide consistency of reporting statistical information and aide in the triangulation of data and intelligence.

All charts within this report have been developed using the Trust's Statistical Process Chart (SPC) tool, based on a NHSI template. Each chart displays an icon, which shows whether the chart shows common cause or special cause variation, or whether there has been an improvement or highlights concern in performance. Appendix 1 provides further information about SPC charts and defines the icons used within the charts in this report, which have been automatically generated by the tool. The observations table, displayed under each SPC chart is generated automatically and highlights whether there are any 'exceptions/special causes' that warrant further investigation, or is blank where this is not the case.

A more granular breakdown of restrictive interventions has been included within this report to enable the Committee to better understand this complex area. Additional benchmarking information has been included within this month's report at Appendix 2. This was previously presented separately to the Committee as the Regulation Dashboard.

A session was held with Clinical and Service Directors and Associate Directors in order to provide the narrative contained within this report, as well as to identify and understand areas that may warrant further examination during the meeting. This narrative has either been included within this, or will be provided during discussion.

Whilst not contained within this report, it should be noted that during July 2020, two homicides have been reported within the Trust. One is a suspected domestic homicide by a service user,

whose partner is a former service user of the Trust. The second is the homicide by one service user of another service user. The former case is subject to a citywide DHR process, the latter case is being investigated as an executive level serious incident. Both have been reported to Board members and appropriate bodies.

3. Next Steps

This report will be presented to the Board of Directors, following consideration by the Quality Assurance Committee. Work will continue to develop an integrated performance and quality report, which will replace this report, together with the current Board Performance Report. It is anticipated that this will be completed by the end of September 2020.

It should be noted that providing the different data sets contained within this report at Trust level is useful, however, it is imperative that this information is available for teams at team level. This is what the Performance and Quality Framework will enable the Trust to do.

4. Required Actions

The Board of Directors is asked to:

- receive the report;
- consider any gaps and discuss additional requirements;
- acknowledge the ongoing work to provide an integrated performance and quality report from September 2020.

5. Monitoring Arrangements

The different elements within this report are monitored through a variety of routes within the Trust. Patient safety (incidents) is monitored through the Service User Safety and Patient Safety Groups. Safeguarding is monitored through the Safeguarding Group. Mandatory training is monitored through the Education, Training Steering Group, reporting to the People Committee. Safer Staffing is monitored through the Safer Staffing Group. CQC compliance is currently monitored through CQC workstream sub-groups, into the Back to Good Board, Quality Assurance Committee and Board of Directors. Quality objectives are overseen by the Quality Assurance Committee.

6. Contact Details

For further information, please contact

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Tania Baxter, Head of Clinical Governance,
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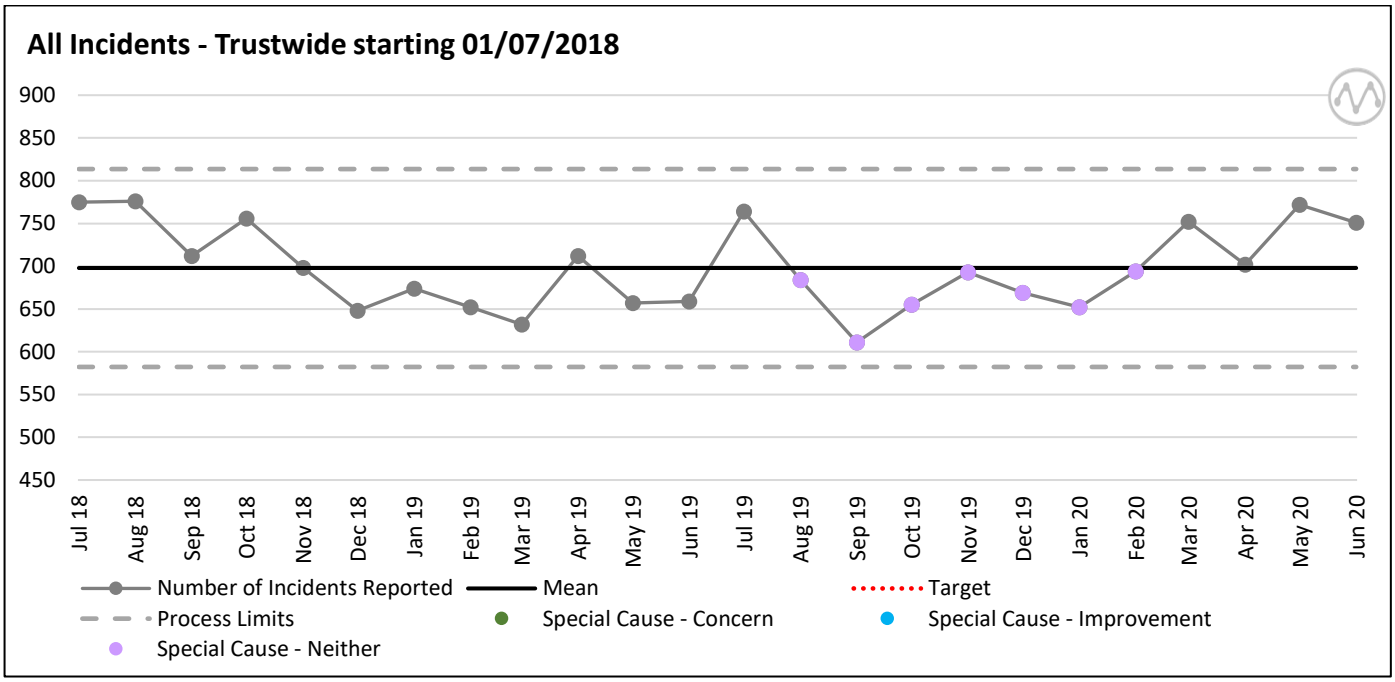
All Incidents



Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control.

751 incidents were reported in June 2020, the breakdown of these is given below.

Actual Impact	Number of Incidents	As % of Total Incidents
Near miss	25	3%
Negligible	551	73%
Minor	128	17%
Moderate	27	4%
Major	3	0.4%
Catastrophic	17	2%
Total	**751**	**100%**

Out of all the incidents reported this month 91% (n682) recorded 'no injury' associated with the incident. The three major incidents reported involved the failure of telephony systems, a fire on Burbage Ward and a knife-related incident involving a member of the public. The 17 catastrophic incidents are all deaths, further information on these is contained on page 15.

The breakdown of the incident impact above has been examined in detail to establish if there is any 'unnatural' variation. All impacts showed normal variation in reporting this month.

The latest nationally published incident reporting rate is 62.3 incidents per 1,000 bed days. Across the Yorkshire and the Humber region, incident reporting rates vary from the lowest (Leeds and York 45.6) to the highest (Bradford 94.8) per 1,000 bed days. SHSC is slightly lower than the national reporting rate of 62.9 incidents per 1,000 bed days.

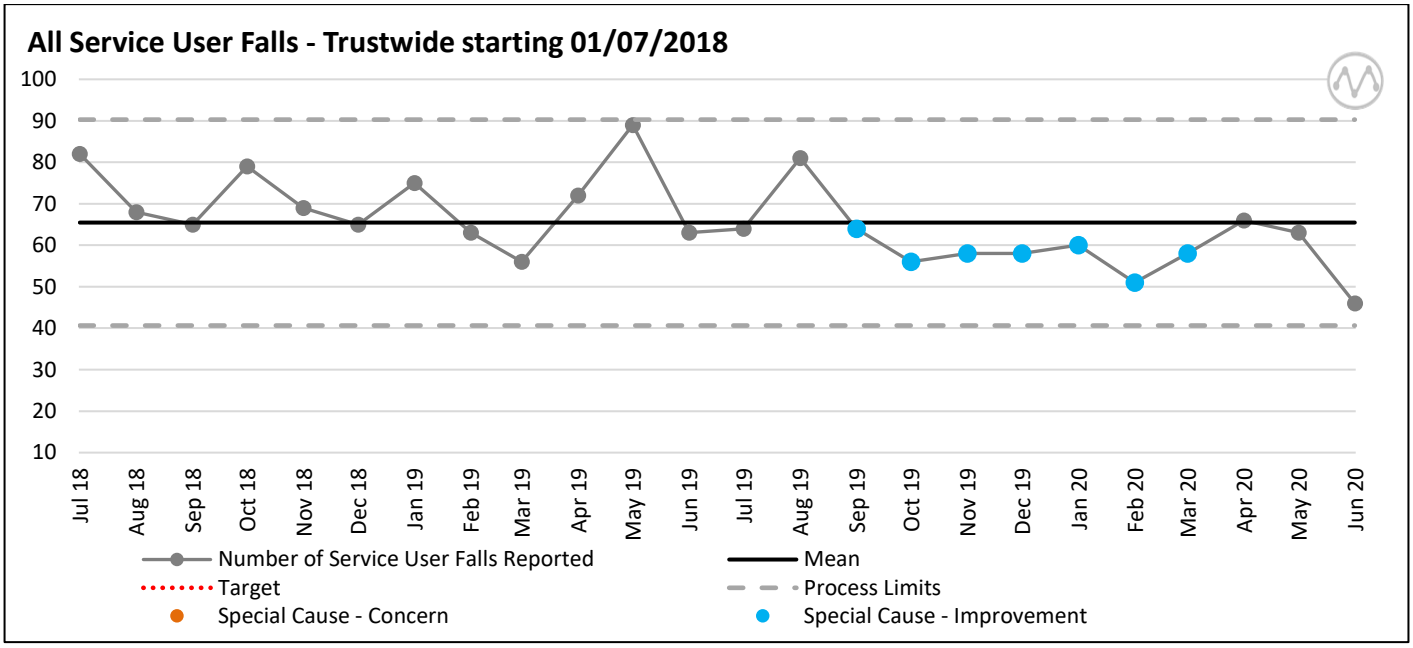
Conclusion: This indicator shows common cause variation.

Serious Incidents

Six new serious incidents were reported in during June 2020. Four of these were within the Crisis and Emergency Care Network and two were within the Scheduled and Planned Care Network.

There is no benchmarking information available regarding serious incidents through the Strategic Executive Information System (StEIS), as Trusts can only view their own data.

Service User Falls



Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

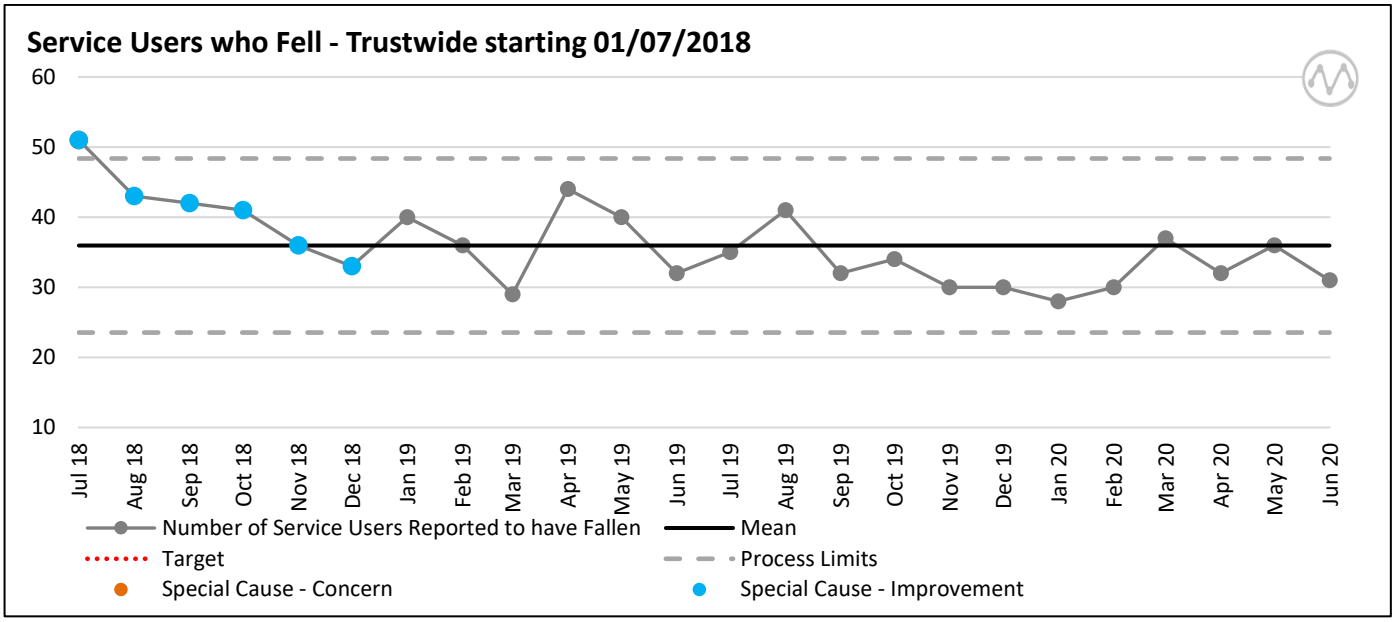
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control.

46 falls occurred in June 2020, with one 'moderate' incident reported. This incident occurred on Dovedale Ward and involved a service user sustaining a sternal fracture. This is being investigated as a Duty of Candour serious incident. A consultant led Falls Prevention Group is being established, led by the older adult inpatient services.

This Group will report into the Trust's Service User Safety Group and will routinely consider falls incidents across the Trust and will review and oversee the falls screening process and management plans. The Trust now has multi-factorial risk assessments being undertaken by physiotherapists following each admission to inpatient areas.

Conclusion: This indicator shows common cause variation.

Service Users who Fell



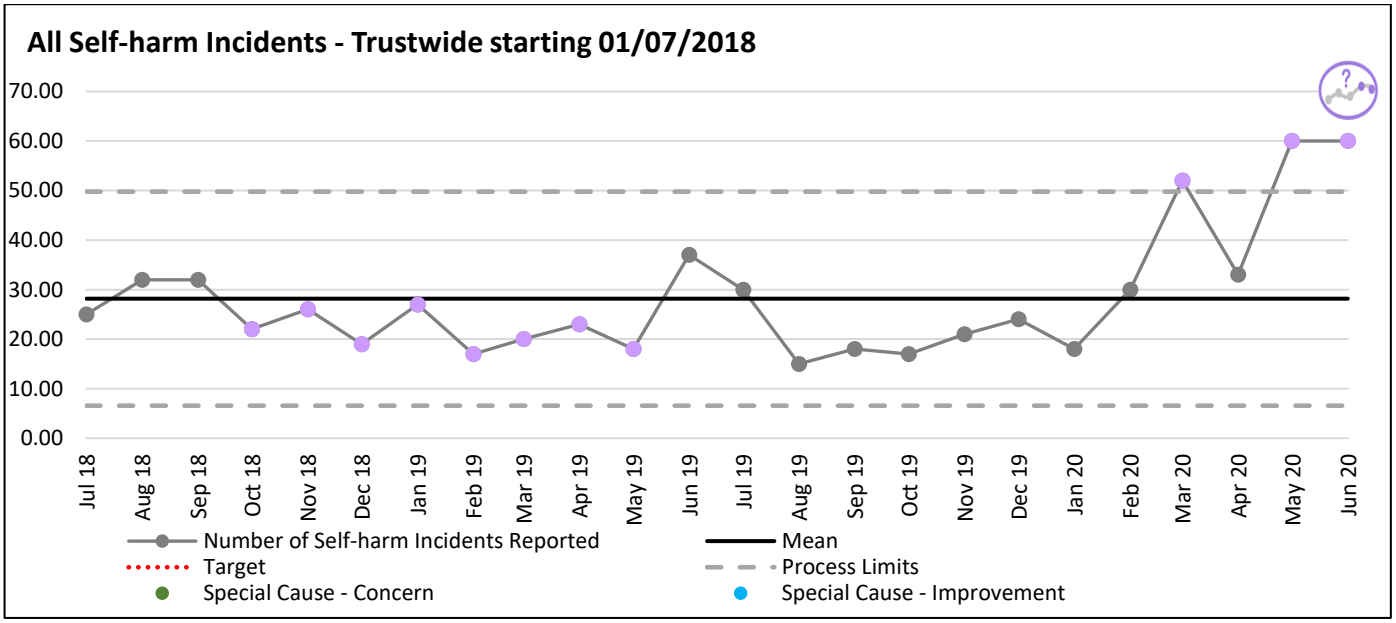
Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

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 is 1 point above the UCL.
Trend	When there is a run of 6 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control.

Conclusion: This indicator shows common cause variation.

Self-harm



Observations

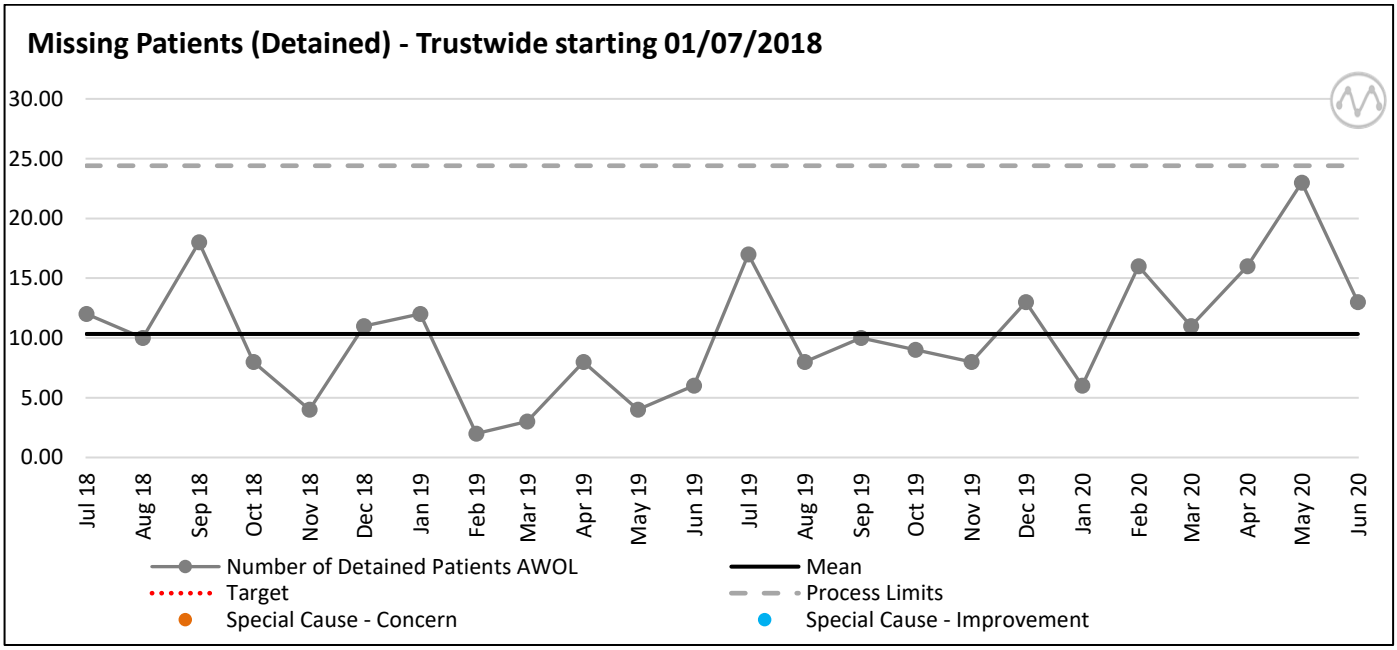
Based on the data from latest calculation date (data point 1 - 01/07/18).

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 3 points above the UCL.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control.

60 self-harm incidents were recorded in June 2020. 24 of these involved the same service user on Forest Close. There were no moderate rated incidents this month.

Conclusion: The special cause spike in self-harm incidents has been predominantly caused by one individual.

Missing Patients (Detained)



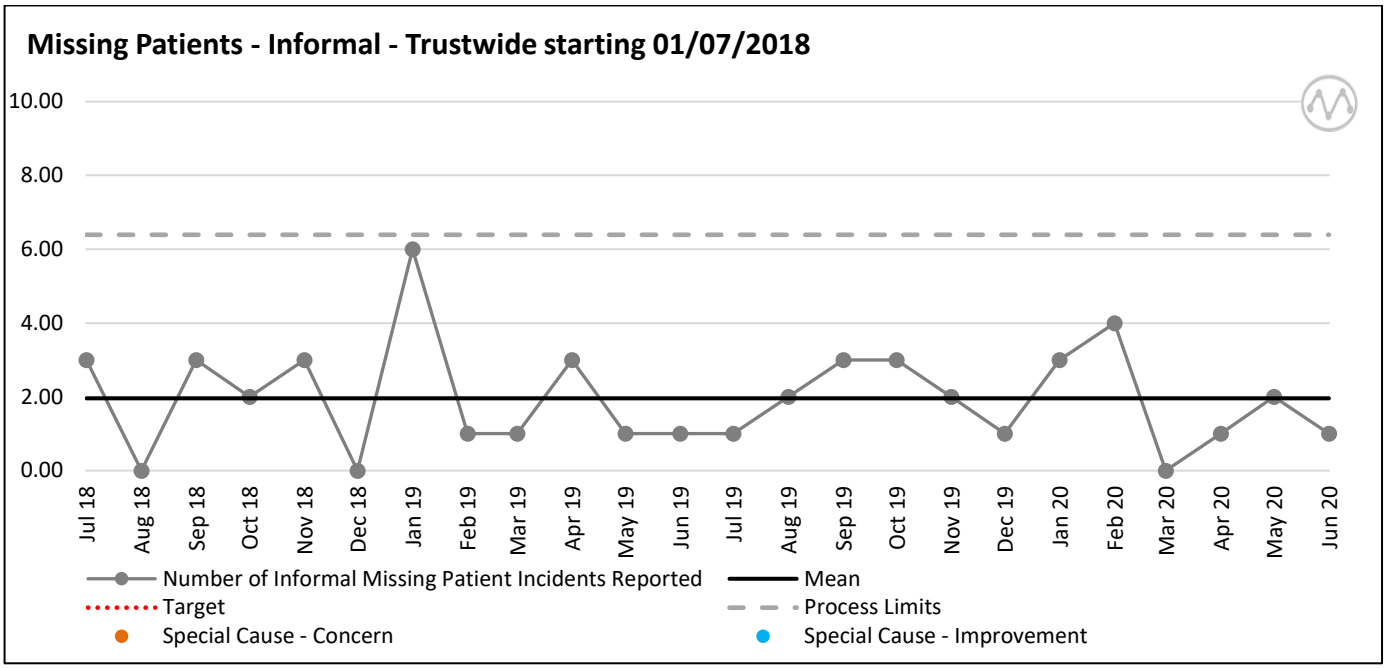
Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

13 patients were recorded as AWOL during June 2020, 3 were patients going AWOL, 5 went AWOL during escorted leave and 5 failed to return at their allocated time.

Conclusion: This indicator shows common cause variation.

Missing Patients (Informal)



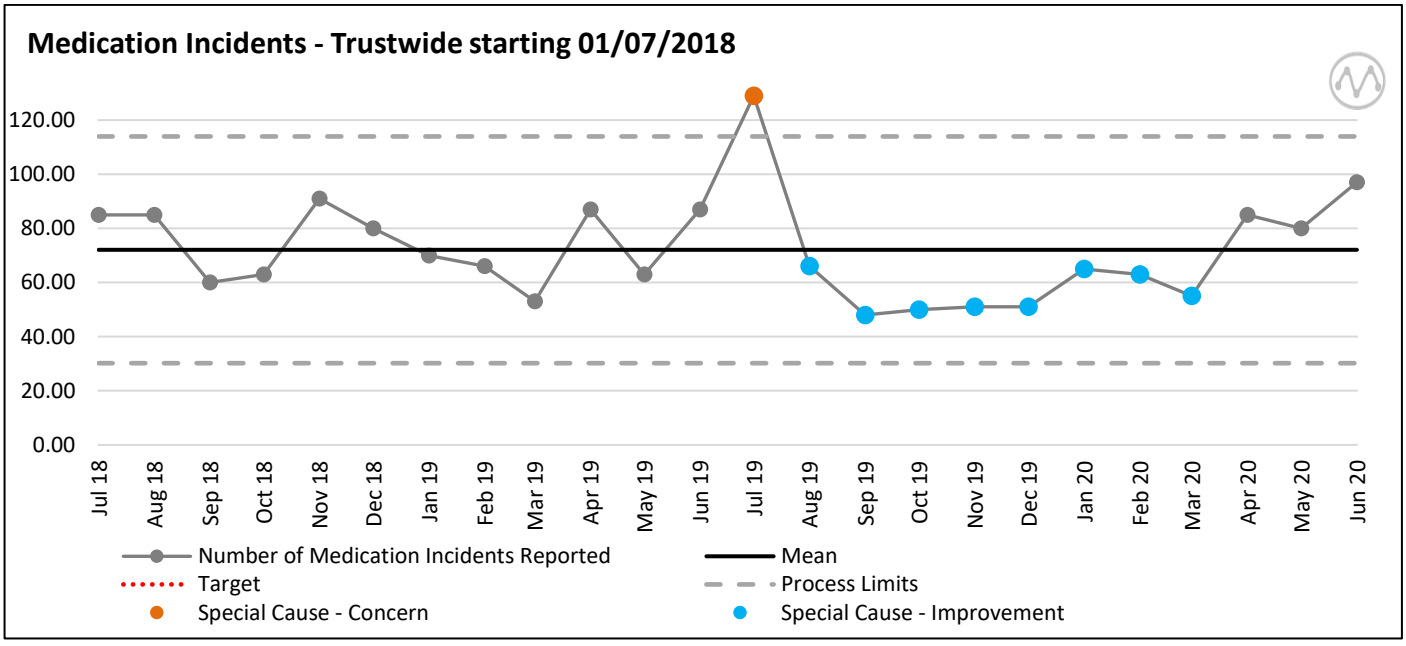
Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

1 informal patient was reported missing in June 2020.

Conclusion: This indicator shows common cause variation.

Medication Incidents



Observations

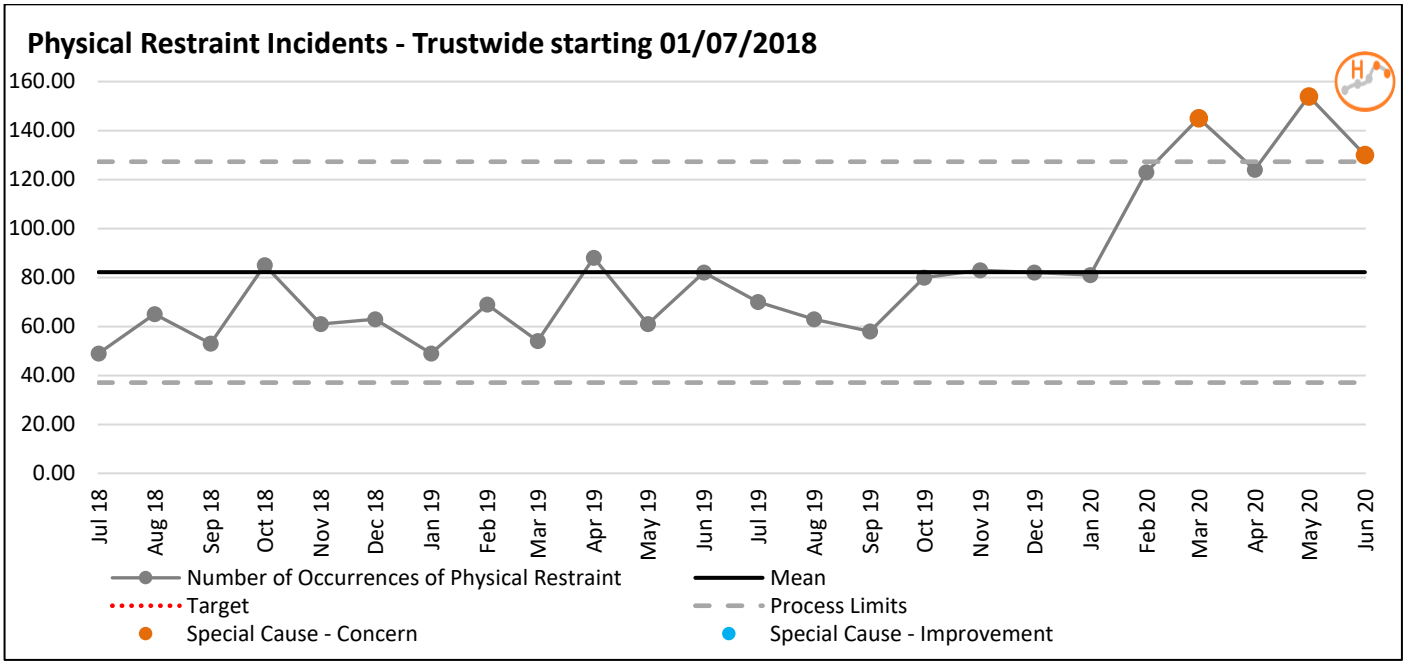
Based on the data from latest calculation date (data point 1 - 01/07/18).

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 is 1 point above the UCL.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control.

97 medication incidents were reported in June 2020, with no moderate rated incidents recorded. These were broken down as 9 administration incidents, 80 management incidents, 3 dispensing incidents and 5 prescribing incidents. Out of the 80 medication management incidents, 44 of these related to temperature error/storage incidents, with a further 15 relating to controlled drug stock discrepancies and a further 11 relating to incomplete/unsigned documentation. The Medicines Optimisation Committee reviews all medicines related incidents with corrective actions monitored through the pharmacists working into clinical areas.

Conclusion: This indicator shows common cause variation.

Restraints

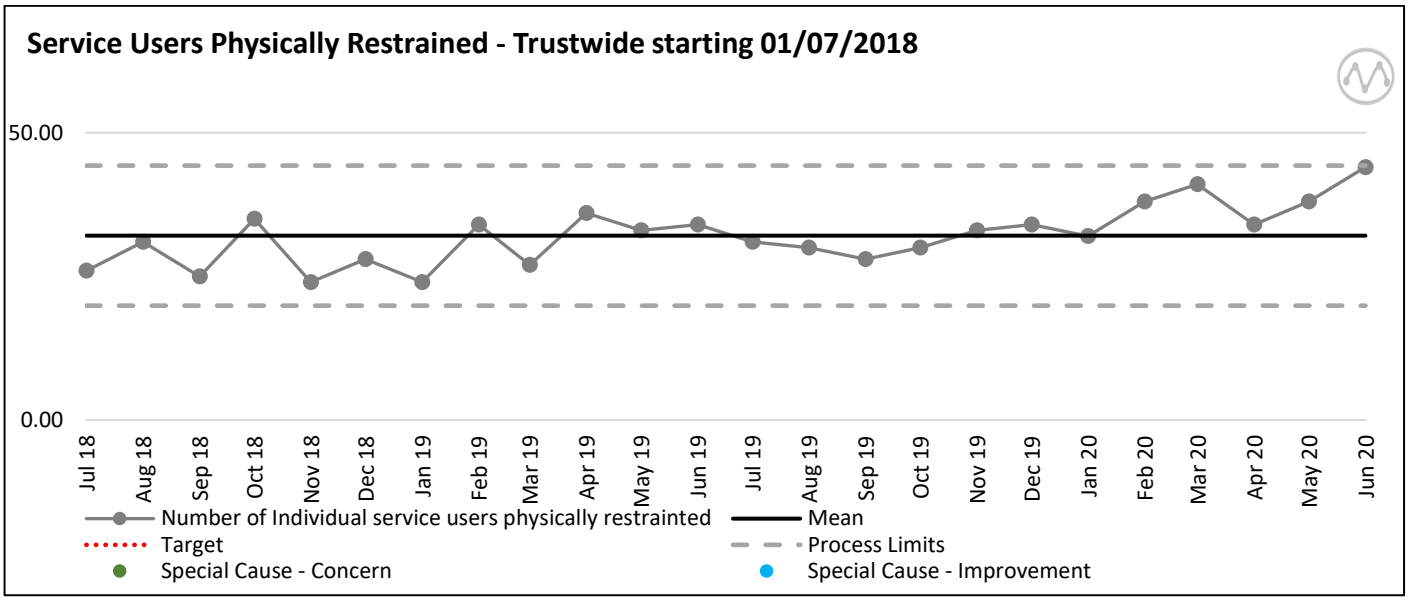


Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

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 3 points above the UCL.

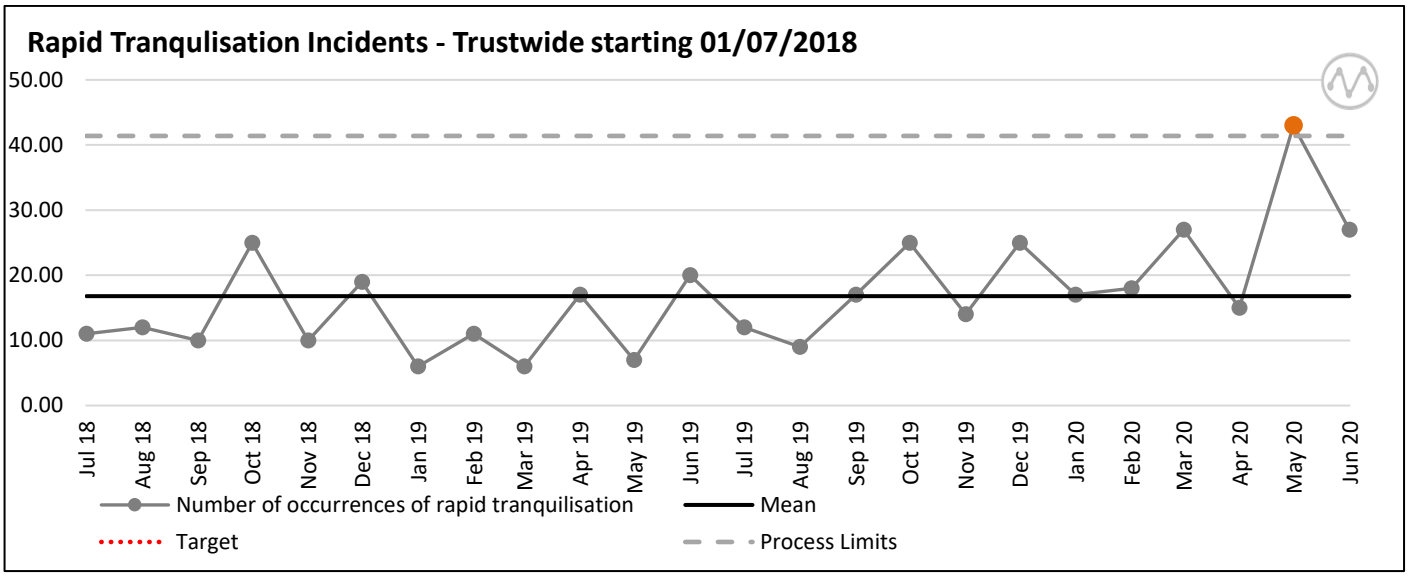
During June 2020 130 restraints were recorded, a reduction from May 2020. 43 of these were reported on Endcliffe Ward (25 of which were an individual service user (formerly on Stanage Ward)). A further 29 physical restraints occurred on Stanage Ward and 20 on Burbage Ward. The chart below shows the number of individuals who have been physically restrained. This shows common cause variation in the number of people restrained.



Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

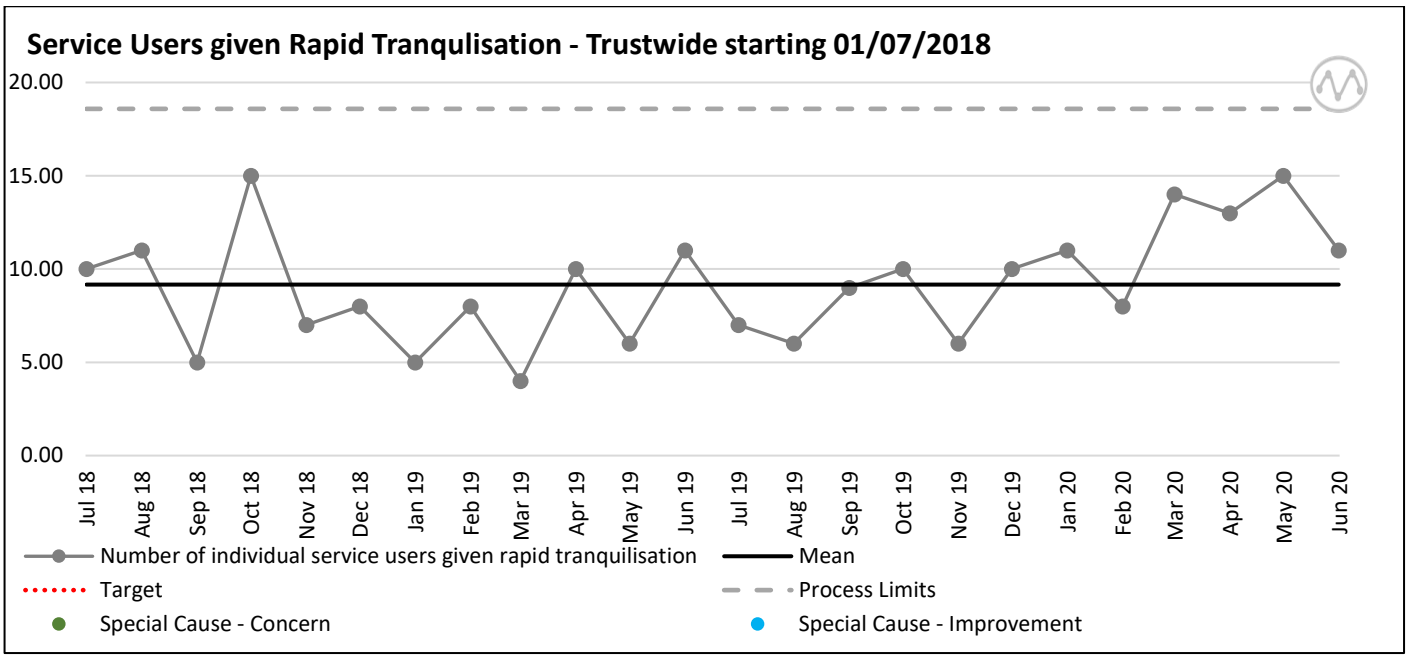
Conclusion: This indicator shows common cause variation.



Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

Conclusion: This indicator shows common cause variation.

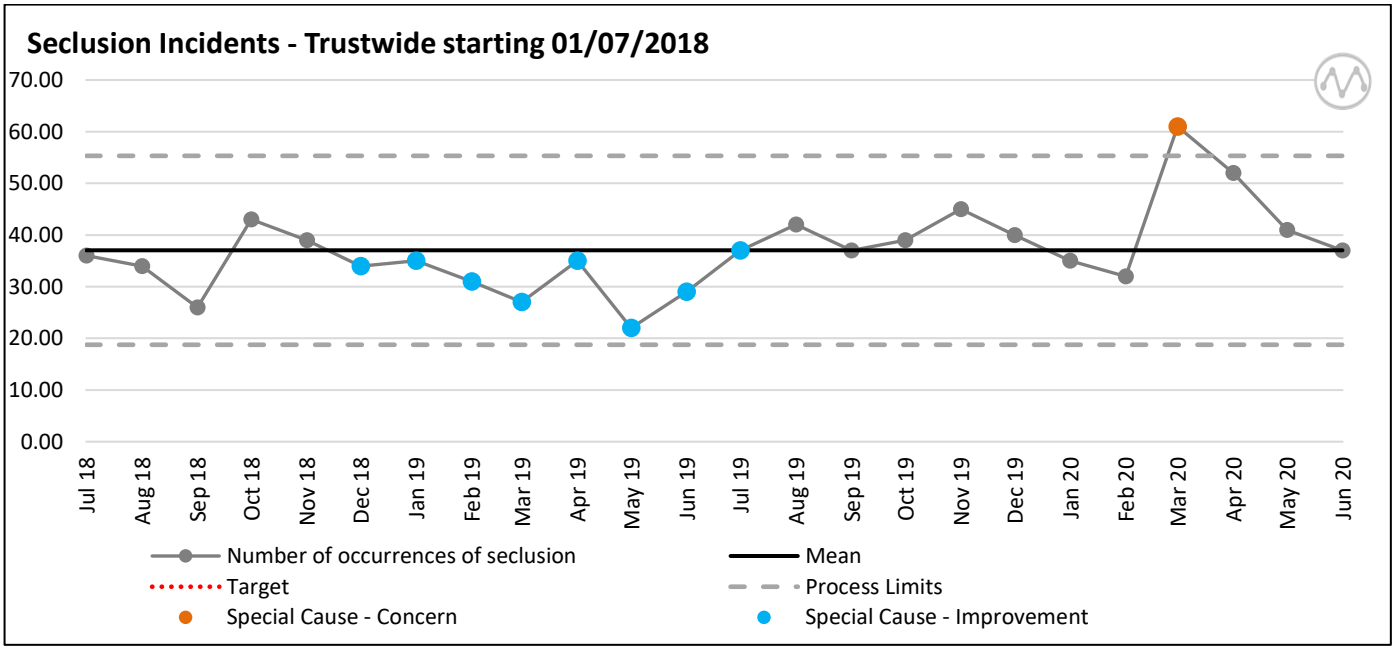


Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

Conclusion: This indicator shows common cause variation.

Seclusions



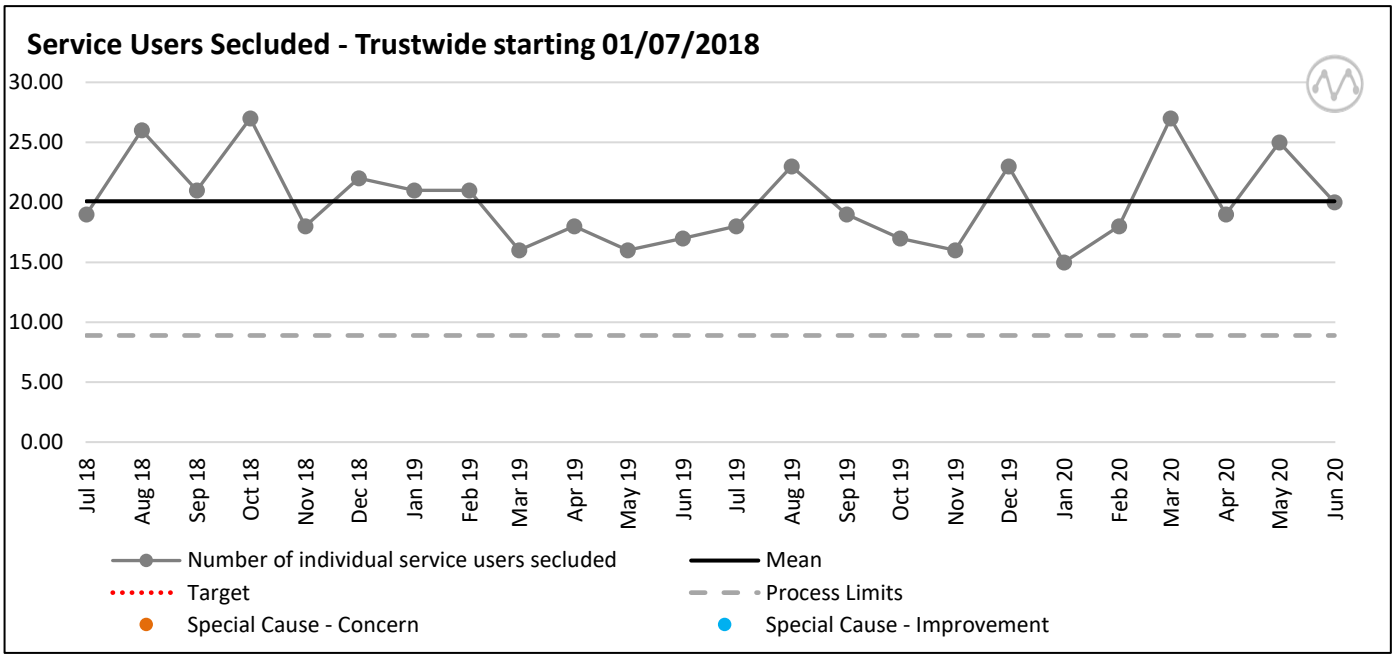
Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

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 is 1 point above the UCL.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control.

37 seclusions were reported in June 2020. 11 seclusions occurred on Endcliffe Ward, 9 on Stanage Ward and a further 8 on G1.

Conclusion: This indicator shows common cause variation.

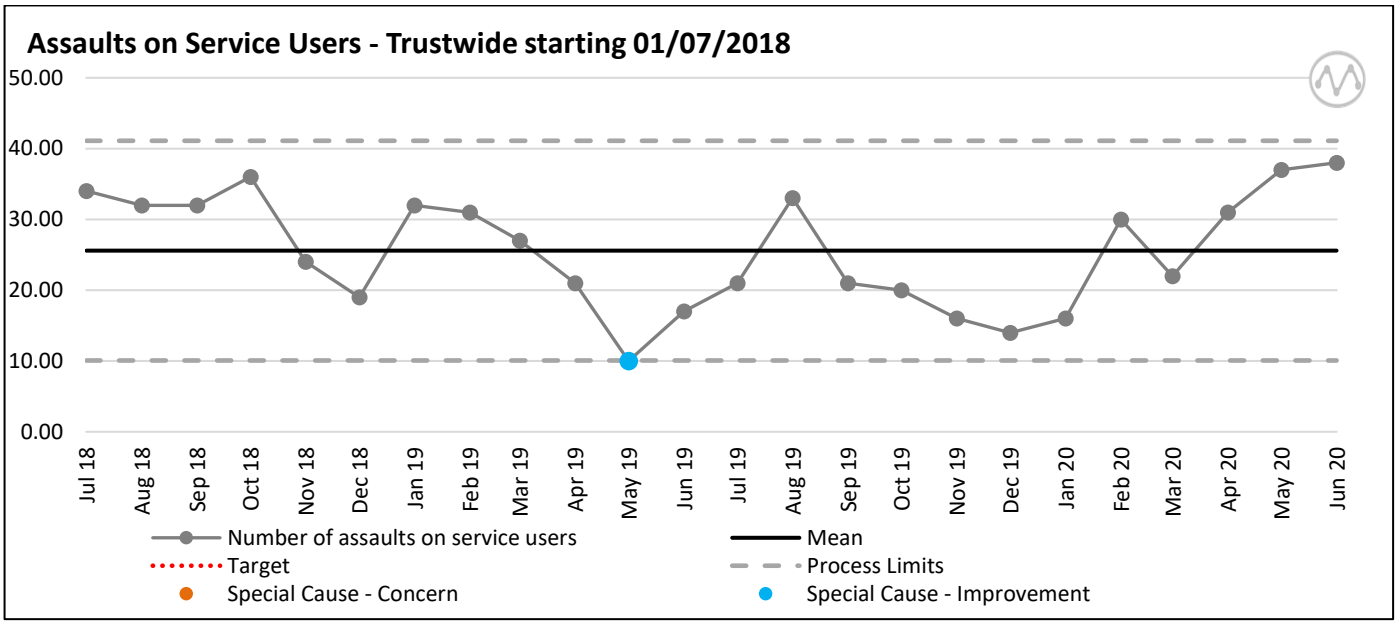


Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

Conclusion: This indicator shows common cause variation.

Assaults on Service Users



Observations

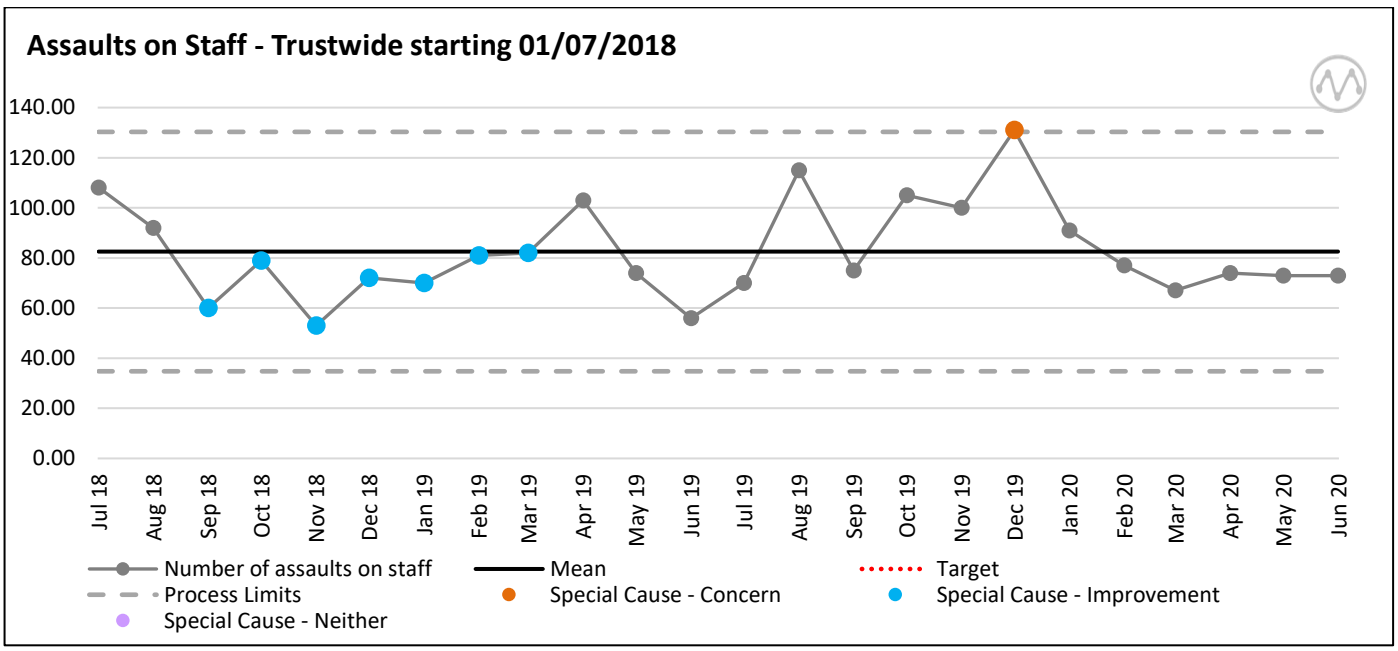
Based on the data from latest calculation date (data point 1 - 01/07/18).

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 is 1 point below the LCL.

38 assaults on service users were reported during June 2020. There were no moderate or above graded incidents this month. 31 out of the 38 incidents were reported as having resulted in no injuries, 5 injuries of tenderness/pain were reported with 1 reported as a superficial wound and 1 burn/scald. All incidents were reported as negligible or minor this month.

Conclusion: This indicator shows common cause variation.

Assaults on Staff



Observations

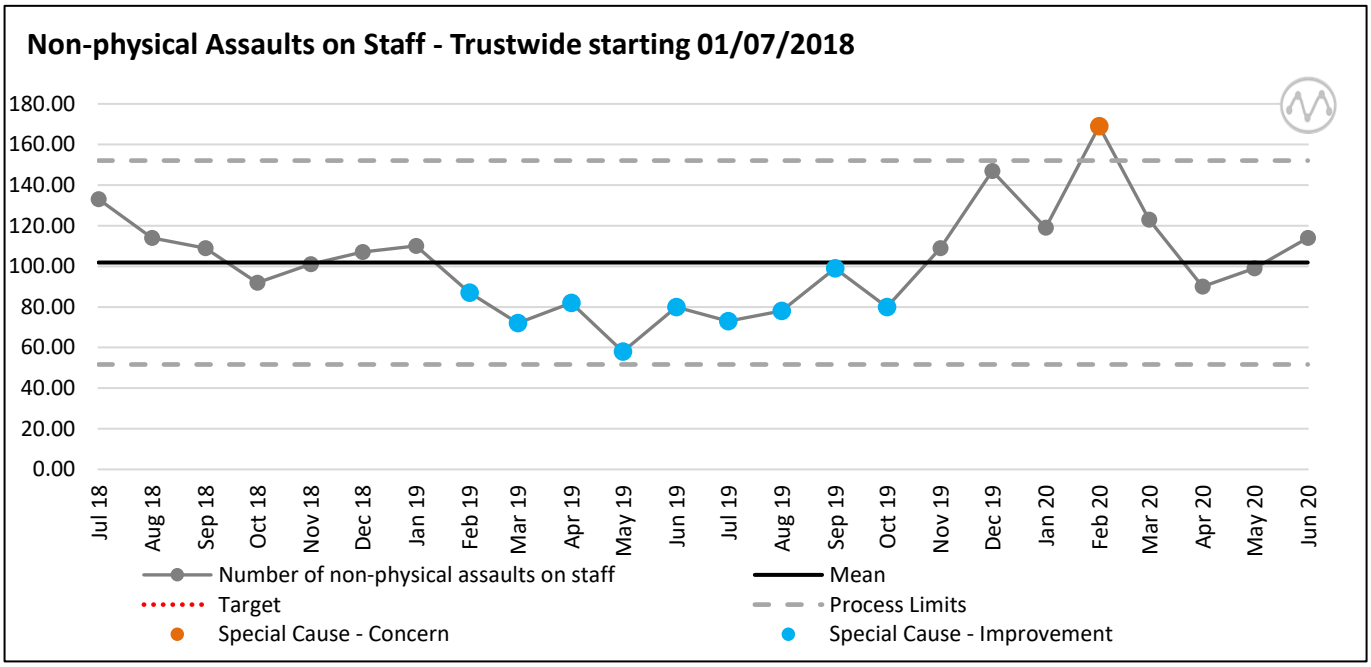
Based on the data from latest calculation date (data point 1 - 01/07/18).

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 is 1 point above the UCL.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control.

73 assaults on staff occurred during June 2020. Three of these were rated as 'moderate' incidents, all of which involved the same service user on Endcliffe Ward and resulted in the service users being restrained and secluded for entering female areas on the ward. The majority of these 73 incidents did not cause harm to staff members, where harm was caused it was reported as bruise/swelling, tenderness/pain and abrasion/graze as the most common injuries.

Conclusion: This indicator shows common cause variation.

Non-Physical Assaults/Abuse on Staff



Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

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 is 1 point above the UCL.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control.

114 incidents were reported in June 2020. There were three 'moderate' rated incidents this month. Two of these involved the same service user on Endcliffe Ward reported under the staff assaults data, the third incident involved a sexual accusation being made against a staff member (under investigation). There were 11 racial/cultural abuse incidents reported in June 2020.

Conclusion: This indicator shows common cause variation.

Deaths

33 deaths occurred during June 2020. All deaths are subject to review at the Mortality Review Group. The table below shows the teams where the deaths occurred.

Service/Team	No. of Deaths
Birch Avenue	2
Forest Close	1
IAPT	1
Older Adults CMHTs/Home Treatment	11
LTNC/Neuro-Enablement Services	7
SPA/EWS	2
Liaison Psychiatry	2
Mental Health Recovery Teams	2
Home Treatment Team	1
START Opiates	1
START Alcohol	2
Woodland View	1
Grand Total	33

Of the 33 deaths that occurred, 8 were expected deaths, 6 within the community and 2 within our inpatient/residential settings. 14 were unexpected deaths in the community, but suspected of being of natural causes. A further 9 were unexpected deaths in the community, with 2 of these within our inpatient/residential settings. 2 were suspected suicides in the community.

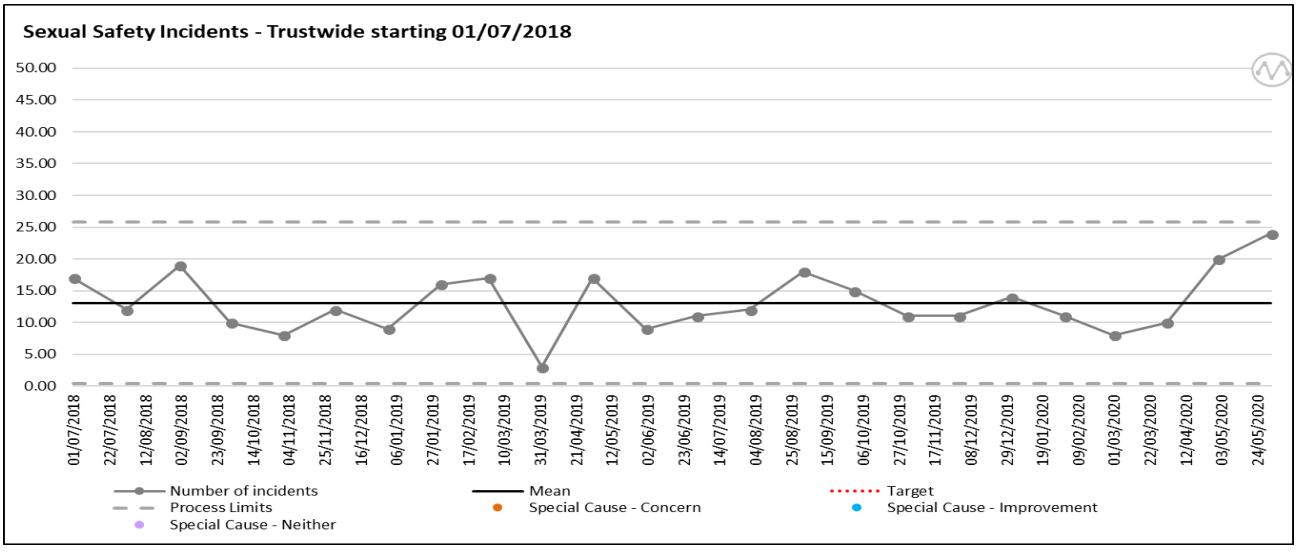
Infection Control Incidents

During June 2020 only one patient was Covid-19 positive on our inpatient areas (Maple Ward). This patient was admitted to Maple Ward overnight on 25/26th June having suspected Covid-19 and subsequently tested positive from 29th June to 5th July 2020. Since this time, the wards have been Covid-19 free again.

27 infection control related incidents were reported during quarter 4 (January – March 2020).

The infection prevention and control annual report was presented to June's Quality Assurance Committee meeting.

Sexual Safety



Sexual safety incidents over the past two years show common cause variation within process. June 2020 has shown an increase in sexual safety incidents against the previous month.

There were 24 incidents related to sexual safety reported within the Trust in June 2020.
12 of these occurred on the Acute Adult and PICU: Maple, Burbage, Stanage and Endcliffe. No incidents were recorded for Dovedale.

Note: 6 of the 12 incidents occurred on Stanage Ward and 3 of these incidents are attributed to the same service user.

Based on the National Sexual Safety Collaborative Operational Definitions:

- 6 incidents were defined as Sexual Assault (when a person is coerced or physically forced to engage in sexual activity against their will);

- 4 incidents were defined as Sexual Harassment (characterised by inappropriate sexual remarks or gestures or physical advances which are unwanted and make a person feel uncomfortable, intimidated or degrade their dignity).

- 2 incidents were defined as Other Sexual Incident (where an individual may have witnessed or experienced something of a sexual nature that does not fit with the above categories).

The breakdown of the 12 incidents are outlined below:

Breakdown Summary of June 2020 Incidents on the Acute Wards

Patient to Patient	5
Patient to Staff	5
Staff to Patient (alleged)	2
Male to Female	6
Female to Male	2
Male to Male	2
Male to Undisclosed Staff	1
Male to Various Staff	1

Following these incidents observations were increased or enhanced, individual treatment plans were reviewed, in some cases interpreters were used more frequently and where appropriate/required safeguarding referrals were made. The move to single sex accommodation may reduce, but will not eradicate the number of sexual safety incidents occurring, given that almost half of them are to staff, not patients.

EMSA Compliance

There have been no EMSA Reportable Breaches in June 2020.

For awareness – in July 2020 on 1 occasion a male service user was admitted to a single room in the female area on Endcliffe Ward. The male patient was on constant 1:1 observations during their stay. This was reported internally as an incident but is not considered a breach using the September 2019 EMSA guidelines.

EMSA Audit

Upon their admission, every service user is informed that the wards are mixed sex and asked if they have any concerns around this. Clinicians can also indicate if they have any concerns, based on service user knowledge. A sample audit of 50% of the ward population is gathered. The results are below for June 2020.

Ward	Number Audited (50% of the ward population)	% asked about EMSA Concerns & recorded on DRAM	Are there any concerns identified with accommodation on the ward?	Are there any concerns about being on a ward with members of the opposite sex?
Burbage	10	100%	0	0
Stanage	10	100%	0	0
Dovedale	9	100%	0	0
Endcliffe	5	100%	0	0
Maple	9	100%	0	0

On-going EMSA Management

- National Sexual Safety Collaborative is currently on hold due to COVID-19 Pandemic. Data still being collected to feedback into this group when reinstated. It is anticipated that this collaborative will inform the production of standard metrics to help benchmark our sexual safety performance.

- Estates department working with Clinical Operations to deliver a capital programme of work to eliminate dormitories.

Service User Feedback

- No formal feedback or 'fastrack' complaints were received in June.

Safe Staffing

From 13th April 2020, staffing is monitored against the new safe minimum staffing levels as shown below.

Ward	Day Shift		Night Shift	
	Registered	Unregistered	Registered	Unregistered
Burbage	2	4	2	2
Stanage	2	4	2	2
Dovedale	2	4	2	2
G1	2	4	2	2
Maple	3	4	3	3
Endcliffe	3	3	2	4

Our e-rostering system is used to match identified patient need on these shifts (care hour per patient day, CHPPD), to see if the available staffing was sufficient to meet patient need.

Incidents occurring on the shift has also be included to triangulate all available information sources to establish if patients were kept safe in the absence of the required safe minimum. It is hoped that this gives a more detailed position to support improved Board assurance.

Shifts meeting the minimum requirement on our acute inpatient wards are as below:

Acute and Older Adult Wards	% of shifts meeting minimum requirement		
Week Ending Date	% of shifts meeting new minimum requirement specific to each individual ward		
	Early/Long Day	Late/Long Day	Night
w/e 07/06/2020	100.00%	100.00%	97.62%
w/e 14/06/2020	97.62%	100.00%	97.62%
w/e 21/06/2020	100.00%	100.00%	100.00%
w/e 28/06/2020	100.00%	100.00%	85.71%

Shifts that did not meet minimum requirements are detailed below.

Early shifts:

G1 Ward: 13/06/2020 - 1 nurse plus 8 support workers. 2nd nurse did not attend for shift. Nurse on duty was very experienced

Night shifts:

G1 Ward: 01/06/2020 - 1 nurse plus 7 support workers. Agency nurse had been booked for the night shift but unfortunately did not attend.

Dovedale Ward: 09/06/2020 & 28/06/20 - 1 nurse plus 6 support workers (including extremely competent band 4 aspirant nurse). Nurse works nights on a regular basis and well versed in running the shift routine. 2nd nurse off due to sickness.

Burbage Ward: 24/06/2020 & 25/06/2020 - 1 nurse plus 9 support workers. Nurse bank cover was cancelled at short notice.

Stanage Ward: 22/06/2020 & 28/06/2020 - 1 nurse plus 7 support workers. Vacancies on the rota unable to be covered by Bank / Agency or surplus from other wards.

Maple Ward: 23/06/2020 - 2 nurses plus 5 support workers (including band 4 aspirant nurse).

The above shifts were supported by the Flow Coordinator. For Maple Ward, an arrangement was in place via the Decisions Unit to support if there was a 136 admission.

There were no incidents reported coinciding with the shifts above where staffing was compromised.

Conclusion: Staffing numbers and skill mix is monitored on a daily basis as part of the Trust's SitRep reporting and actively managed to address any shortfalls identified. As a result, there does not appear to have been any impact on patient safety during the period of time reported.

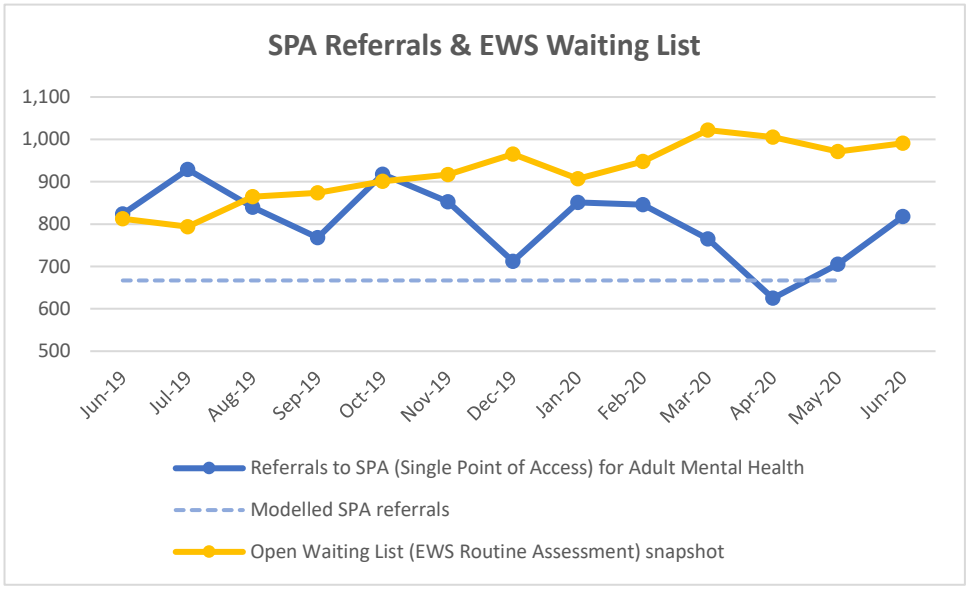
Physical Health Monitoring

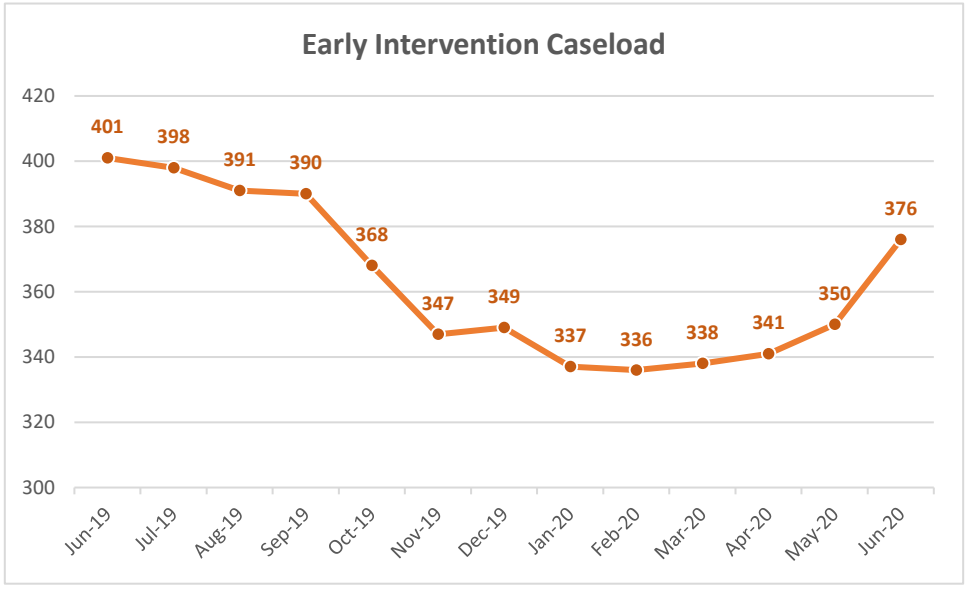
All inpatient services continue to report each day their compliance with monitoring physical health observations including medication related, condition related and rapid tranquilisation. Compliance with this is being tracked through the CQC weekly dashboard. This shows that during June 2020, performance has ranged from 92% (one day) to 100% of checks being carried out.

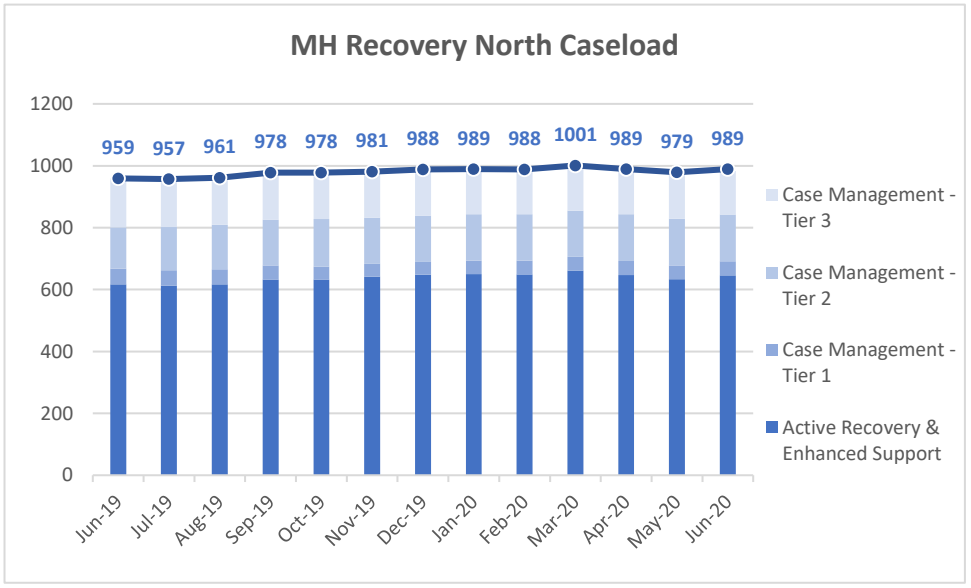
Non-compliance in this period was due to physical health checks being missed on Stanage Ward, Burbage Ward, Endcliffe Ward and Forest Lodge Assessment Ward, post Clozapine physical health checks being missed on Stanage Ward, blood monitoring being missed on Stanage Ward and Burbage Ward and bowel charts being missed on Stanage Ward and Burbage Ward.

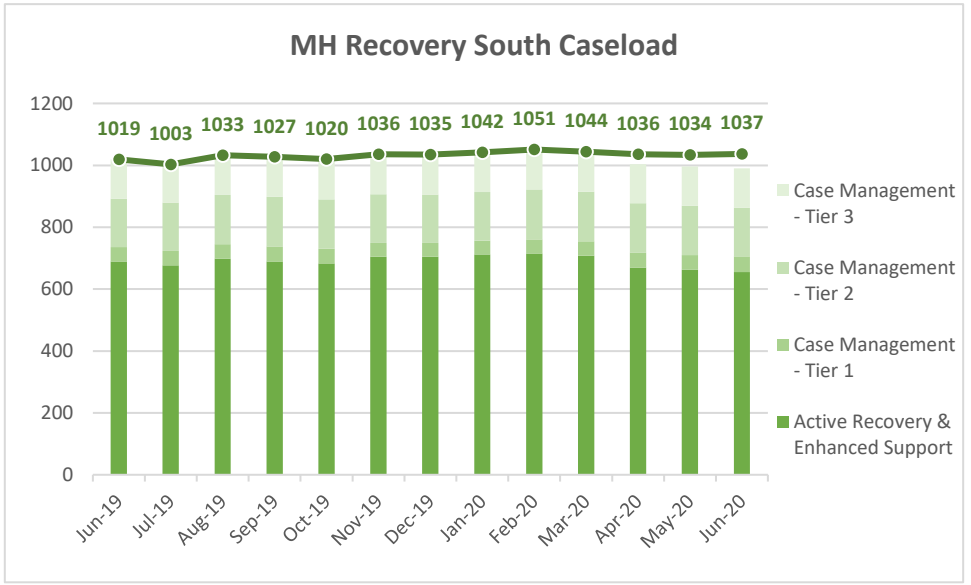
All other wards were 100% compliant for this period.

Adult Mental Health Community Services









SPA/EWS

A detailed review for the June Quality Assurance Committee looked at a range of quantitative indicators to widen understanding of the management of the Single Point of Access and Emotional Wellbeing Service waiting lists and response times and its current position. Information provided in the Performance Report is weekly referral, wait list and routine assessment data.

Issues

SPA/EWS was established on the basis of managing 8,000 referrals per annum. Referrals now exceed 10,000 per annum.
EWS capacity was based on 99 patient assessments per week but staff vacancies resulted in this never being achieved.
The collective dispute memorandum of understanding (MoU) which details that assessment staff can only undertake one assessment per day has further compromised activity.
DNA numbers are higher than desirable as a result of long wait times and anxieties created by Covid-19.

EWS Waiting List

Since our report to Quality Committee last month, the following actions have been taken:

- Arrangements for safeguarding referrals to be received and screened will move to the Trust's Safeguarding function. This will mean a reduction of 200 referrals per month.
- Arrangements for ADHD referrals to be received and care provided will move to the Trust's Sheffield Adult Autism Service. This will mean a reduction of 340 patients waiting for treatment
- We are piloting the use of Attend Anywhere. This Pilot will run as soon as equipment is available. We have asked patients who are happy to be contacted at short notice. Where planned patient appointments are not attended (DNA) we will contact patients on this list to offer a service, using the appointment slot wherever possible.
- We are reviewing our clinical model, this started in June and will conclude by the end of November 2020.
- We have reviewed our skill mix. We are recruiting 4 Clinical Associate Psychologists to this role. Psychology Graduates that we have assessed have the skills to meet the patient needs waiting.
- Discussions have taken place with Executive colleagues to understand how they can best support the service with the current interim measures agreed through the industrial dispute. A sub-group for SPA has been formed, representative of staff, local leaders and staff side representatives. This is identified as the key place to seek resolution of the patient and service needs. This sub-group will report to the Programme Board (and in turn to the Transformation Board).

Whilst these actions have taken/are taking place, we are not yet assured that these measures will have the desired impact. We therefore recommend that there is an update provided to Quality Assurance Committee against progress, each month, or until this moves into the Trust's Performance Report.

Next Steps

Plans for the reduction in waiting times and elimination of the current waiting list are being overseen by the 'Back to Good' Programme, and improvement plan objectives include:

- Actively increase our mental health practitioner workforce through a recruitment campaign
- Implement the CQC action plan targeted at waiting list/time reduction
- Trial the Attend Anywhere software to facilitate provision of remote clinics
- Review of governance structures.

North and South Recovery Teams

CPA Review compliance - South Recovery Team.

A new caseload dashboard has been created and is now in use All care co-ordinators have had an up-to-date copy of their caseload dashboard, which highlights what is overdue and imminently due.

The additional weekly reports as noted in May's report are now in use and are being used to follow up in supervision as a performance management approach.

Internal milestones are being used to keep track of the pace of progress and Performance against these is and reported into the Care Network senior team.
The recently reported figure does not capture the work that has taken place over the last two weeks. Early indication in July's data does reflect an upturn in the percentage of reviewed care plans, in line with the improvement plan.

The overall plan for the service is for all care plans, risk assessments and CPA reviews to be up to date by the end of September 2020. To note, however, community teams have been instructed to support the current staffing shortage on the adult in -patient wards through nurses being asked to cover shifts on the wards. This may have an impact on the speed of progress and potentially its target completion date.

Early Intervention Service

The Early Intervention Service is performing over the required target for care plans reviews and risk management plans.
Completed and reviewed PROMs (Dialog/QPR) is the area requiring most attention with only one third of service users having at least one DIALOG recorded. Supervision is being used to target improvement in this area.

The service caseload is higher than the required number for RCP accreditation, recent vacancies have had an impact. There continues to be a high number of service users over the 3-year limit for EI but are unable to transfer over to Recovery Services due to current demand. Service caseload and individuals are reviewed weekly with Recovery Senior Operational Managers.

Recovery Team [North] - Performance and Governance Dashboard

Run Date 08-July-2020

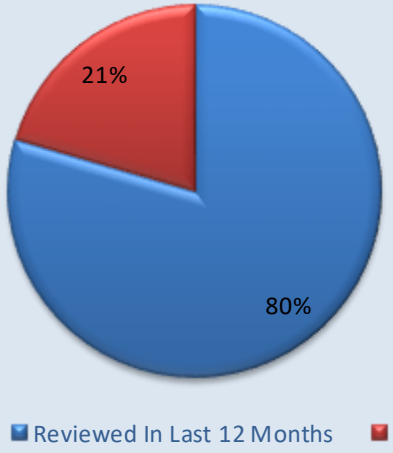
Service Breakdown

989 Open Episodes

- 6 Awaiting Allocation (waiting list)
- 337 Case Management Service
- 646 Active Recovery

- 45 Tier 1 - Recovery Case Management
- 151 Tier 2 - Recovery Case Management
- 141 Tier 3 - Recovery Social Care Only

CPA Clients



615 clients on CPA

400 clients on CPA over 12 months

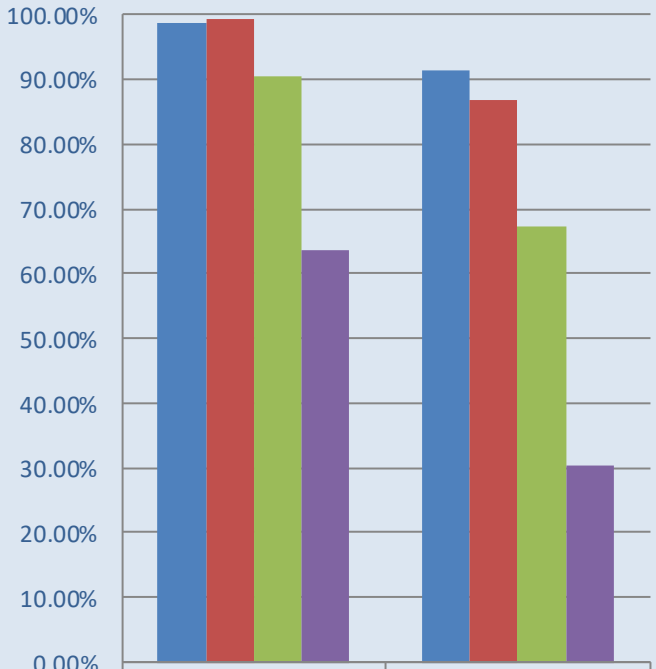
79.50% of which reviewed in last 12 months

Action Required:	
82	- Overdue CPA Reviews
206	- CPA reviews due by end of current quarter

Care Records

Where client not on waiting list or Tier 3
CMS:(854 clients in range)

Action Required:	
10	- No Collaborative Care Plan
72	- Last Updated over 12 months ago
6	- No DRAM V3 Community
112	- Last Updated over 12 months ago
80	- No MH Cluster
252	- Last Updated over 12 months ago
311	- No Physical Health Review Form
378	- Last Updated over 12 months ago
n/a	- No ReQoL
n/a	- Last Updated over 12 months ago
178	- No Community Diagnosis V2
58	- No C01 recorded in last 90 days



	On Care Record	Where Review In Last 12 Months
CCP	98.83%	91.47%
DRAMS	99.30%	86.79%
Clusters	90.63%	67.44%
PH Reviews	63.58%	30.39%

Recovery Team [South] - Performance and Governance Dashboard

Run Date 08-July-2020

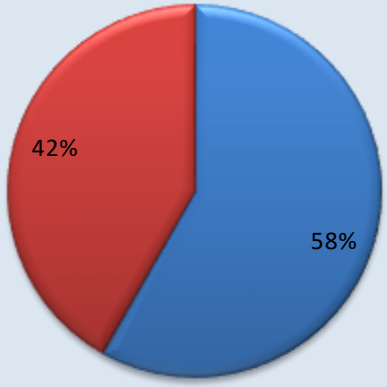
Service Breakdown

1037 Open Episodes

- 47 Awaiting Allocation (waiting list)
- 335 Case Management Service
- 655 Active Recovery

- 51 Tier 1 - Recovery Case Management
- 157 Tier 2 - Recovery Case Management
- 127 Tier 3 - Recovery Social Care Only

CPA Clients



620 clients on CPA

481 clients on CPA over 12 months

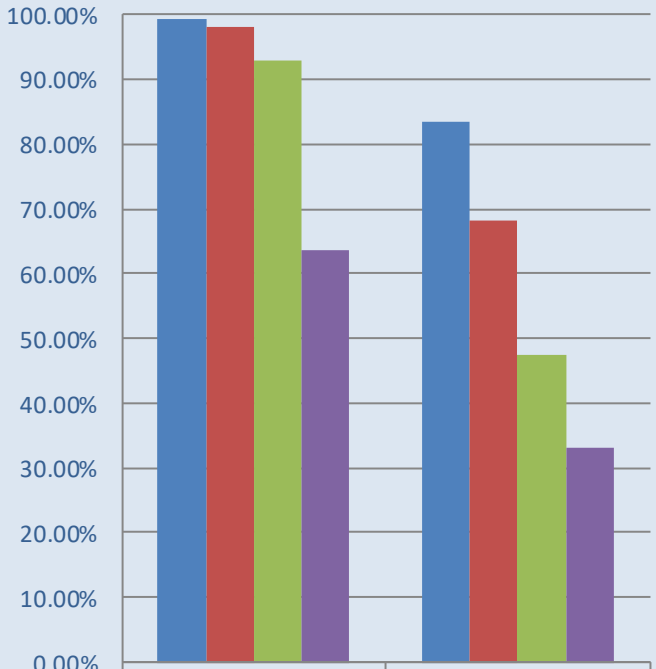
58.21% of which reviewed in last 12 months

Action Required:	
201	- Overdue CPA Reviews
299	- CPA reviews due by end of current quarter

Care Records

Where client not on waiting list or Tier 3
CMS:(910 clients in range)

Action Required:	
6	- No Collaborative Care Plan
148	- Last Updated over 12 months ago
16	- No DRAM V3 Community
284	- Last Updated over 12 months ago
65	- No MH Cluster
444	- Last Updated over 12 months ago
330	- No Physical Health Review Form
388	- Last Updated over 12 months ago
n/a	- No ReQoL
n/a	- Last Updated over 12 months ago
96	- No Community Diagnosis V2
147	- No C01 recorded in last 90 days



	On Care Record	Where Review In Last 12 Months
CCP	99.34%	83.63%
DRAMS	98.24%	68.23%
Clusters	92.86%	47.46%
PH Reviews	63.74%	33.10%

Early Intervention Service - Performance and Governance Dashboard

Run Date 20-July-2020

Referral Module:

0	Triage (Screening)
12	Awaiting Allocation (Community WLs)
376	Open Episodes

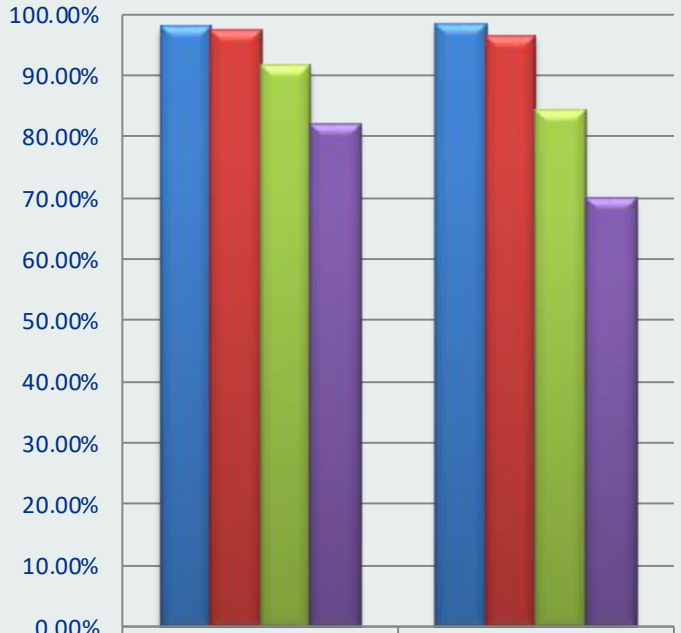
Action Required:

16	- Overdue CPA Reviews
63	- CPA reviews overdue @ end current quarter
8	- No Collaborative Care Plan
6	- Last Updated over 12 months ago
10	- No DRAM V3 Community
13	- Last Updated over 12 months ago
32	- No MH Cluster
54	- Last Updated over 12 months ago
68	- No Physical Health Review Form
93	- Last Updated over 12 months ago
132	- No CPA Dialog, open under 12 months
198	- 1 or no CPA Dialog, open over 12 months
92	- No Community Diagnosis V2
158	- No C01 recorded in last 14 days

CPA Review Status

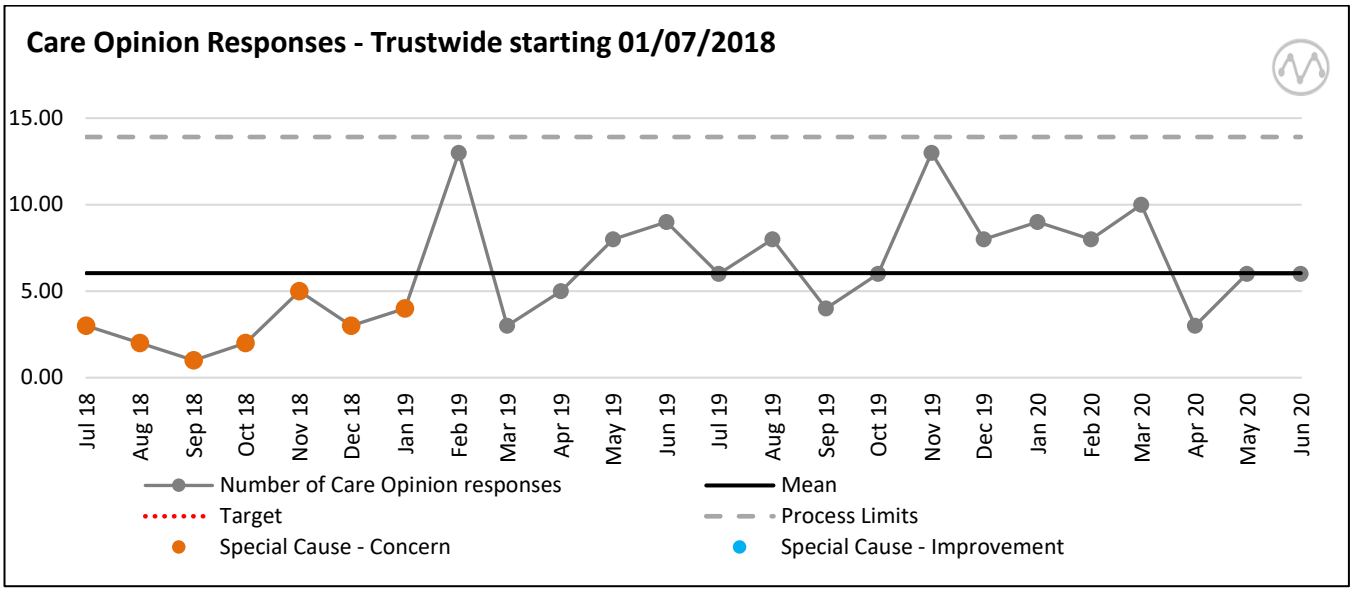
Number of clients on CPA	226
Number of clients on CPA over 12m's	138
% of CPA Reviews in last 12 ms	88.41%

Care Records



	On Care Record	Where Review In Last 12 Months
CCP	97.87%	98.37%
DRAMS	97.34%	96.45%
Clusters	91.49%	84.30%
PH Reviews	81.91%	69.81%

Patient Experience - Care Opinion



Observations

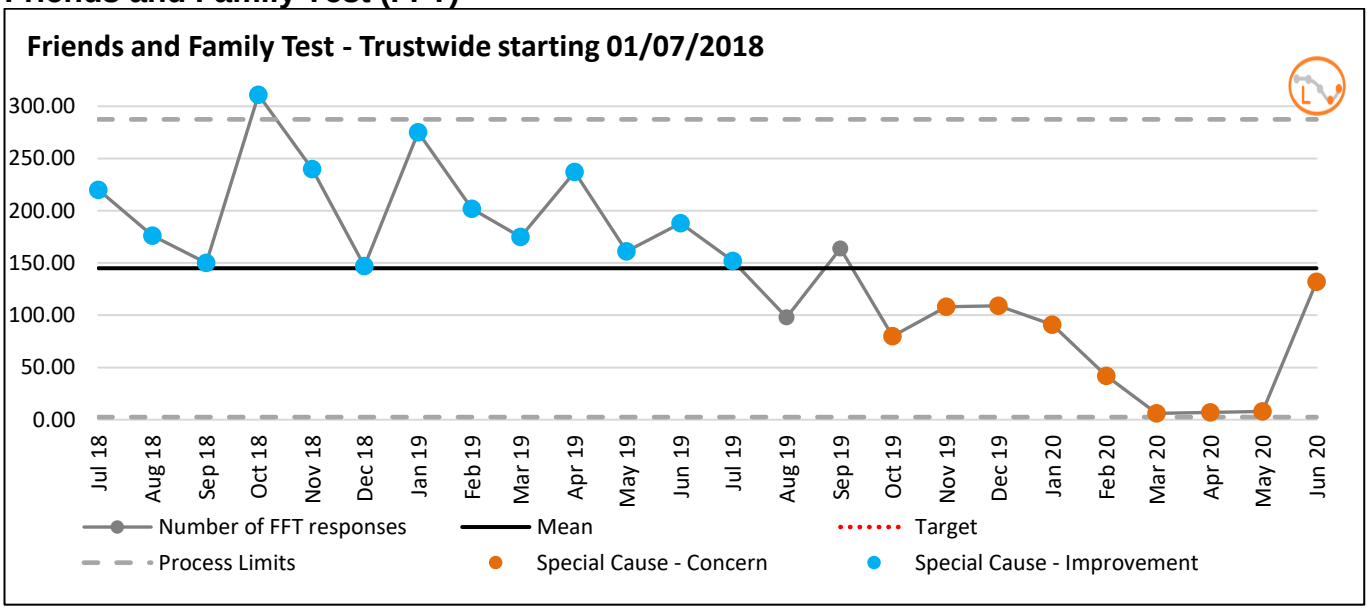
Based on the data from latest calculation date (data point 1 - 01/07/18).

Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control.

6 stories were submitted via Care Opinion in June 2020. As new ways of delivering many of our services have started to settle following the outbreak of the COVID-19 pandemic, so has the focus to reengage with our service users and carers to encourage feedback on their experiences.

Conclusion: This indicator shows common cause variation.

Friends and Family Test (FFT)



Observations

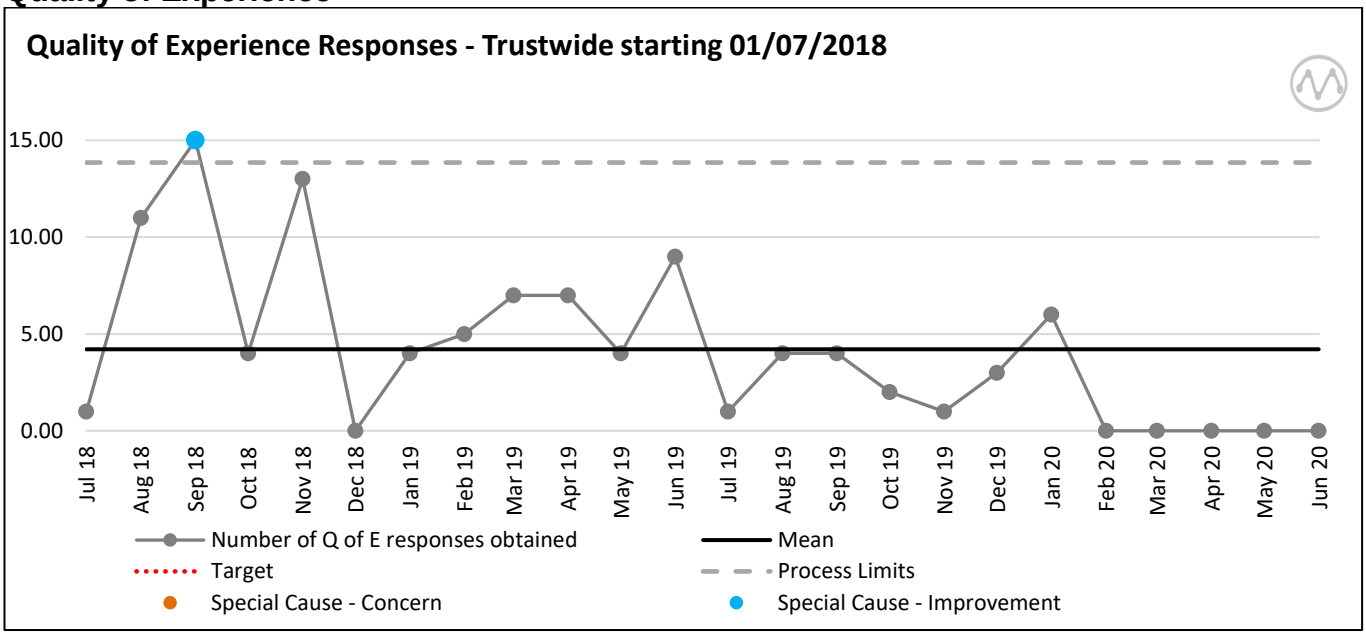
Based on the data from latest calculation date (data point 1 - 01/07/18).

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 is 1 point above the UCL.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control.

Due to the impact of Covid-19, national guidance was to 'pause' encouraging FFT submissions since March 2020, especially as the FFT is predominantly a paper-based survey. As part of the Trust's intelligence gathering on the impact on service users regarding the changes made to services as part of Covid, questionnaires have been undertaken in many teams. The FFT question has been included as part of this, hence our figures in June have risen sharply.

Conclusion: Collection of FFT cards is currently on hold in line with national guidance, but different methods of collection have shown a recent increase.

Quality of Experience



Observations

Based on the data from latest calculation date (data point 1 - 01/07/18).

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 is 1 point above the UCL.

Data for June 2020 again indicates no further Quality of Experience surveys have been completed since January 2020. As with FFT and Care Opinion, the impact of Covid-19 has prevented encouraging volunteers to visit wards to complete these surveys until it is advised safe to do so. Whilst service user feedback is vital, it is important that we do not put our volunteers at risk.

Conclusion: Alternative approaches for receiving service user feedback from our wards continues to be explored by the Engagement & Experience Team in collaboration with teams on the wards.

Patient Experience – Complaints

Three complaints were received during June 2020. Two of these related to the Crisis and Emergency Care Network, one related to the Scheduled and Planned Care network. The three complaints were received from:

- 1 x SPA Service
- 1 x Stanage Ward
- 1 x Mental Health Recovery South

NHS Improvement Categories	Trust Values	No of complaints
Admissions To Treatment and Drugs	Fairness	2
Values and Behaviours	Respect	1
	Total	**3**

Conclusion: Complaint investigations are underway. No initial themes/trends can be seen from the breakdowns of type and services the complaints have been raised within.

Patient Experience – Compliments

Five compliments were received within the Trust in June 2020. Three of these were emails, one passing on a message from a service user complimenting team/nurses, one containing a message from a CBT Therapist complimenting the team she is now working with and one from a member of staff complimenting a team. One was a card received from a service user's wife complimenting the team and praising the service and a letter was received from a service user thanking and praising the team they were under. The Teams receiving the compliments were East Glade (1), Home Treatment Team South (1), Stanage Ward (1) and Burbage Ward (2).

Conclusion: No analysis can be drawn from the compliments received. All were given due to staff going 'above and beyond, in particular in light of the current Covid-19 pandemic.

It should be noted that a quarterly 'experience' report is presented to the Quality Assurance Committee. This contains a more in-depth look at this area, triangulating information across the various feedback mechanisms and the improvements/changes made as a result.

Board Visits

During June 2020, five visits to services were undertaken by members of the Board of Directors. These visits occurred at Endcliffe Ward, G1, Forest Close, South Recovery Team and Older Adults Community Mental Health Service. A full report on these visits will be presented to August's Board of Directors meeting. However, a summary is provided below on the findings.

Positive Feedback:

- Good support mechanisms in place during COVID, staff felt happy coming to work
- Supervision monthly for everyone
- Service user and staff engagement re quality improvement, including local collaboration in developing CQC plans
- Patients felt safe, glad they had not been discharged.
- All agreed that many meetings were more productive on line, no need for travel e.g. to Fulwood, MDTs worked well. They would like this to continue post-COVID
- Staff testing experience positi
- Mandatory training compliance, some courses easy on-line, some better via group discussion. Appreciate the learning that can come from group discussions during face-to-face training -would want a mix and possibly a choice of delivery method for individuals going forward.
- Services being more independent, when things don't work they get together and make changes

Negative feedback:

- Empowerment, or lack of, and the general feeling among the teams, including the ward management, that they were "done to" rather than being part of a decision;
- A wider disconnect with senior management, and a feeling that it was different part of the organisation rather than all being part of the same team.
- Bed management and delayed discharge meetings are seen as administrative, rather than clinically focussed and adds tension between teams
- Level of staffing deemed to be at critical stage in some areas
- The capacity within particular professional groups
- Technology - group work external to the Trust was not possible, only 1:1 remote access.

Next Steps

Each visit has identified actions that need to be taken forward to address the issues raised. These will feed into the larger report for the Board of Directors oversight and monitoring.

Mandatory Training

Due to the impact of Covid-19, the period of update training for face to face subjects for those staff expiring or about to expire has been extended to 31 October 2020. Due to social distancing, it is currently not possible to safely deliver Immediate Life Support, Respect Levels 2 and 3 and the practical element of Moving and Handling Level 2 due to the close personal contact needed to undertake the hands on elements of these courses. There are however different methods of training in place to cover the knowledge and theory and provide part compliance. Once face to face training for these subjects resumes these learners will be prioritised to complete the practical elements of the training.

As at 28 June 2020, the Trust has achieved 91.8% compliance with mandatory training, with 100% of services achieving over 80% in all mandatory training subjects.

Appendix 1 - Statistical Process Control (SPC) Charts

What is an SPC Chart?

An SPC chart is a time series graph comprising of three reference lines - the mean, upper and lower control limits. The limits help you understand the variability of the data. The variance of the data determines the process limits and in normal circumstances you can expect 99% off the data points to fall between them.

Why do we use SPC Charts?

SPC charts are used to distinguish between natural variation ('common cause' not caused by anything in particular) in performance and unusual patterns ('special cause', unexpected events) in data which are unlikely to have occurred due to chance and require investigation.

SPC charts can also provide assurance on whether a target will reliably be met or whether the process is incapable of meeting the target without a change. They can also show the impact of any changes made to improve performance or quality.
Using SPC charts helps us to visualise and understand data variation over time to allow us to identify significant patterns requiring investigation. The charts provide us with a small set of rules that when consistently applied can support quality improvement and enable teams to develop improvement actions where appropriate.

Special Cause Variation

These are statistically significant patterns in data which may require investigation and includes the following:

- 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 observation is beyond upper or lower control limits

Use of a 'step-change' in SPC charts

Where performance has been affected by a change in process (and the process change is known) then a step-change should be applied to the chart. For example, the implementation of an improvement plan. In these cases the mean, upper and lower control limits are recalculated following the change in process.

Understanding SPC Icons in SHSC

Variation Icons The icon which represents the last data point on an SPC chart is displayed.						
ICON						
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
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.
ACTION REQUIRED	**Nothing**	**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.

Assurance Icons If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.			
ICON			
DEFINITION	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	The system will randomly meet and not meet the target/expectation due to common cause variation. Sometimes you meet the target, sometimes you don't.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	**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

Regulatory/Statutory Dashboard – July 2020

Title	Frequency	Assessment Date	Current position	Benchmarking	Trend	Comments
CQC - CMHT Patient Survey	Annual	Jun-19	6.7 / 10	About the same	↔	The 2019 survey results were published in November 2019, with the overall rating for the Trust being 6.7 out of 10 (a slight increase from 6.6 in 2018's survey). SHSC's results benchmark as 'about the same' as national results, across all areas of the survey. The full survey results were presented to the Quality Assurance Committee in January 2020.
CQC - NHS Staff Survey	Annual	Dec-19	Red	Below Average in 10 out of 11 themes	↓	The most recent national staff survey results are from the 2019 survey. Of the 11 x themes, SHSC matched the national average in one area, worse than average in 7 and worst in 3.
CQC - All Healthcare	Ad Hoc	Feb-20	Inadequate	N/A	↓	The Trust was rated 'Inadequate' overall in the 2020 inspection, with Safety and Well-led rated as 'Inadequate'. Effective and Responsive were rated as 'Requires Improvement' and Caring was rated as 'Good'. Monthly monitoring of this is undertaken at the Quality Assurance Committee and through the Back to Good Board arrangements established.
CQC All Social Care	Ad Hoc	Nov-18	Good	N/A	↔	Wainwright Crescent was inspected in November 2018 and was rated as 'Good' across all domains.
	Ad Hoc	Nov-19	Good	N/A	↔	Woodland View was inspected in November 2019 and was rated as 'Good' across all domains.
CQC City Clover	Ad Hoc	Nov-17	Good	N/A	↔	The Clover City Practice was last inspected in November 2017 and was rated as 'Good' across all domains.
CQC Jordanthorpe Health Centre	Ad Hoc	Nov-17	Good	N/A	↔	The Clover Group Practice (4 practices registered) was rated as 'Good' across all domains in November 2017.
CQC Mental Health Act	Ad Hoc	Jul-20	Actions Ongoing	N/A	↔	There has been one 'virtual' visit since the last quarterly update. The MH Legislation Committee receives a progress report against actions on a monthly basis. The main themes for this series of visits have been seclusion facilities and evidence of service user collaboration in care planning. The actions for seclusion have been largely superseded by those developed in response to the main CQC inspection, and local action is being taken to address training in collaborative care planning in the absence of face-to-face training. Deadlines have been extended for the continuing actions affected by Covid-19.
Single Oversight Framework	Monthly	Apr-20	4	Only a handful of Trusts are Level 4	↓	Ratings are from 1 to 4, with the lower the score the better. A score of 4 signifies the provider is in special measures. In SHSC's case, this was in relation to the Quality of Care.
Health & Safety Executive	Ad Hoc	Dec-18	Actions ongoing	N/A	↔	An inspection focussing on violence and aggression and moving and handling took place in December 2018. The Trust submitted an action plan, which the HSE accepted.

Title	Frequency	Assessment Date		Current position	Benchmarking	Trend	Comments
Fire Service Visits	Ad Hoc	Jul-20		Compliant	N/A	↔	Recent small fires on the wards were caused by lighters and smoking related items. No change to the Trust's compliance.
NHS Resolution	Annual	Dec-19		Red	N/A	↔	This rating is based on on-going claims that the Trust has with NHS Resolution. This is an annual rating updated each December and influences the Trust's annual contribution.
Patient Led Assessments of the Care Annual (PLACE)	Annual	Aug-19	Cleanliness	99.46	98.5	↓	Results given opposite are based on the 2019 assessment. In all the areas SHSC scored higher than the national average. Only for Dementia did we improve upon last year's score. The PLACE report advises that comparisons between this year and last year's results should be avoided, due to the large scale national review and question set changes.
			Food Overall	95.46	92.10	↓	
			Organisational Food	91.73	90	↓	
			Ward Food	98.47	94	↓	
			Privacy, Dignity & Wellbeing	91.64	92.40	↓	
			Condition, Appearance & Maintenance	96.75	95.7	↓	
			Dementia	97.22	90.60	↑	
			Disabilities	89.46	87.50	↓	
Equality Act Reporting	Monthly	Jul-20		Compliant	N/A	↔	Equality objectives have been refreshed and sent to the Board of Directors.
Accessible Information Standard	Monthly	Jul-20		Compliant	N/A	↑	All outstanding actions have been completed.
Workforce Race Equality Standard	Monthly	Jul-20		Compliant	N/A	↔	The 2020 national report is now available. This will be presented to the Board of Directors in September with an updated action plan.
Gender Pay Gap Reporting Requirements	Monthly	Jul-20		Compliant	N/A	↔	This report was presented to the Trust's People Committee and Board of Directors with data published as required by 31 March 2020.
Workforce Disability Equality Standard	Monthly	Jul-20		Compliant	N/A	↔	The 2020 national report is now available. This will be presented to the Board of Directors in September with an updated action plan.

Title	Frequency	Assessment Date	Current position	Benchmarking	Trend	Comments
Data Security and Protection Toolkit – National Data Guardian Standards (Previously Information Governance Toolkit)	Annual	Mar-19	94% Complete Standards not fully met (Plan Agreed)	Not yet available as first year	N/A	The March 2020 assessment date has been delayed to September 2020 due to Covid-19. Previous non-compliant issues from 2018/19 are now all compliant.