Sheffield Health and Social Care NHS Foundation Trust

Open BoD 12.08.20
Item 11

BOARD OF DIRECTORS MEETING (Open)

Date: 12 August 2020

TITLE OF PAPER	**Performance Report – Period Ending June 2020**
TO BE PRESENTED BY	**Phillip Easthope, Executive Director of Finance, IMST, Facilities & Performance**
ACTION REQUIRED	For the Board to: • receive and note the monthly performance report for the period ending June 2020. • Consider how the information in the report impacts on the assurance levels re delivery of our getting back to good objective and in relation to the contents of the BAF specifically BAF0002 Well led & BAF0003 Patient safety • consider the current new format (design and SPC charts particularly) and provide feedback (further opportunity) • feedback on the intended future developments;
OUTCOME	For the Board to be assured that the Trust is delivering the required standards of care, and that plans are in place to ensure on-going performance and performance improvement where required. In relation to changes to assurance & subject to deliberation at Board agree that: • BAF0002, the development of the performant report goes some way to improve the information at board level it isn't significant enough at this stage to improve assurance in relation to well led. • BAF0003, our current understanding of Patient safety has improved, noting the embedding of improvements re Supervision, however a number of indicators including Out of area placements, length of stay, CPA etc continue to be a significant concern.

TIMETABLE FOR DECISION	The Board should note the reporting position.
LINKS TO OTHER KEY REPORTS / DECISIONS	None highlighted.
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES	CQC Getting back to Good BAF0002 Non-delivery of Well led development plan BAF0003 unable to improve patient safety Service quality targets and indicators within this report are also identified as KPIs for the Clinical Commissioning Group and the Sheffield City Council.
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Nil
CONSIDERATION OF LEGAL ISSUES	None highlighted.

Presented by	Phillip Easthope
Designation	Executive Director of Finance
Date of Report	August 2020

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Board of Directors Performance Report August 2020

Revised Format – Version 2

Including information to June 2020

Proud to care in Sheffield

Introduction & Report Development Schedule

Following the PQF update and Board Development session in December 19 and January 20 respectively, we committed to work on the development of the Trust Board Performance report, to ensure that it included meaningful indicators that were data quality assured, accessibly presented with appropriate analysis, having gone through a 'Ward to Board' governance hierarchy. This will enable appropriate Board understanding, scrutiny and oversight of the operations of the Trust. This was further explored by the Board in its February meeting 2020.

This is the second iteration of a new and improved Performance Report for the organisation. We have converted RAG monitoring to Statistical Process Control (SPC) charts where possible, and replicated the previous performance report information in a new format. An explanation and guide for SPC is available at Appendix 1 of this report. Also included within the KPI Summary is a basic marker of the level of assurance we have in the metric or indicator. This is something we are looking to develop further through the Performance & Quality Framework Programme, and aim to introduce in later reports (see timeline below).

Developments achieved in this month's iteration are:

- Re-design of Workforce & Finance dashboards content to be consistent with overall Performance Report

For July 2020 Report (to September Trust Board)

1. Re-design of Finance dashboards to be consistent with overall Performance Report
2. Revision of the additional START dashboard to encompass the KPIs associated with the increased service and scope of service.
3. Integration of the revised Quality Report with the revised Performance Report
4. Restructure of KPI overview to include metrics grouped under the following categories
    - NHS Oversight Framework (19/20)
    - Strategic Objectives/NHS Long Term Plan
    - CQUIN
    - Well Led
    - Key Areas of Concern/for Improvement & Development

Requires engagement and collaboration with Services and Board members, and a commitment to progress

1. Review of required metrics in collaboration with Service areas and Board members, with Access & Waiting Times currently identified as a priority:
    - Access & Waiting Times – Referral to Assessment and Treatment times for all services, with associated standards and targets understood

For September 2020 Report (to November Trust Board)

1. Introduction of a newly developed Data Quality/KPI 'kitemark' – to enable an at a glance view of the confidence we have in the information provided. The kitemark will incorporate factors such as Definition, Accuracy, Source, Automation, Governance & Assurance.
2. Transfer of all the required information that supports the production of the integrated Performance & Quality Report into the Data Warehouse, enabling automation of a significant amount of process

Overview | Summary KPIs 1

Statutory measures	Current Position
Organisation in Special Measures	Yes
CQC Inspection rating	Inadequate
NHSI Single Oversight Framework segmentation	4

Protecting from avoidable harm	Target	YTD
Mixed Sex Accommodation (MSA) breaches	0	0
Never events declared	0	0
Methicillin-resistant Staphylococcus aureus (MRSA & MSSA)	0	0

KPI Assurance Key

✓	Good data quality, confident in information/metric.
?	Unconfirmed data quality, assurance on information/metric required.
✘	Known data quality issue. Work to be done.

Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	JUNE 2020	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	COMMENTS	KPI Assurance
SAFE								
Adult Acute inpatient occupancy levels	Monthly	95%	93%	**93.66%**			See Bed Occupancy Detail	✓
Functional Illness occupancy levels	Monthly	95%	86%	**91.48%**			See Bed Occupancy Detail	✓
Dementia Management occupancy levels	Monthly	95%	86%	**88.13%**			See Bed Occupancy Detail	✓
Sickness absence	Monthly	5.10%		**4.22%**	L		See Workforce Detail	?
Turnover	Monthly	10%		**10.75%**	L	F	See Workforce Detail	?

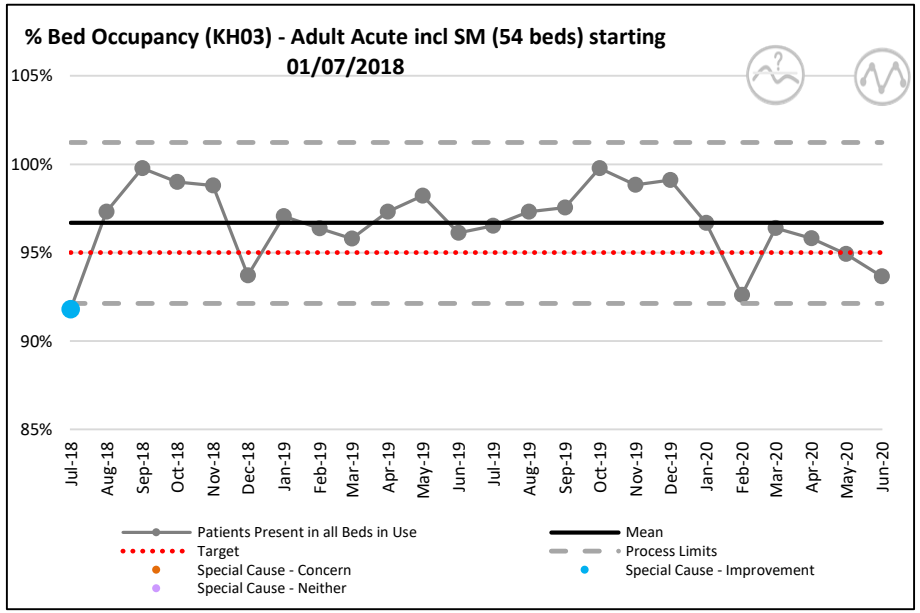
Overview | Summary KPIs 2

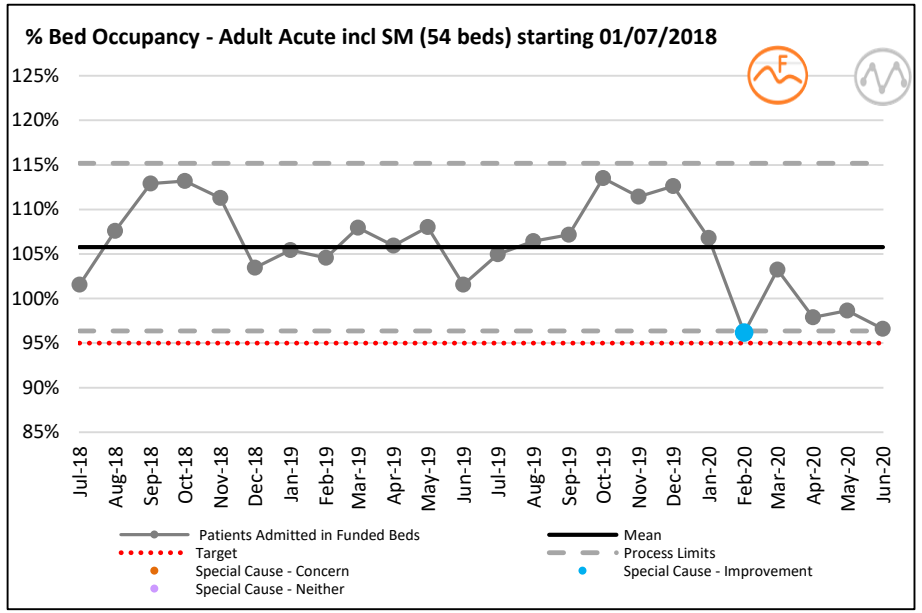
Trust Board Performance Report Key Peformance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	JUNE 2020	SPC VARIATION/ TREND ICON	SPC ASSURANCE ICON	Comments	KPI Assurance
RESPONSIVE								
Access to Home Treatment	Monthly	100	N/A	**121**			Old target - needs review.	?
Out of area for acute admissions	Monthly	0	N/A	**8**	H		See Bed Occupancy Detail	?
Out of area for PICU admissions	Monthly	0	N/A	**5**			See Bed Occupancy Detail	?
Delayed discharges - % of occupied bed days where patient is delayed	Monthly	7.50%	4.9% (Adult) 8.2% (Older Adult)	**0.00%**	N/A	N/A	Needs significant work to improve data quality on this indicator	✘
7 Day follow up following discharge - people on CPA	Monthly	95.00%	93.00%	**93.55%**			Awaiting commissioner confirmation of new target for 72 hour follow up as per CQUIN 19/20.	?
Access to Early Intervention in Psychosis Services - new cases	Monthly	6	N/A	**20**			Old target - needs review.	?
Waiting Time Standard Early Intervention – % commencing treatment within 2 weeks	Monthly	53.00%	N/A	**58.33%**		P	EIP exceeding target for consecutive 15 months. Current mean is 75%.	?
Access to IAPT - new clients accepted	Monthly	1232	N/A	**818**			See IAPT Detail	?
Waiting Time Standard IAPT - % entering treatment in 6 weeks	Monthly	75.00%	N/A	**83.00%**		P	See IAPT Detail	?
Waiting Time Standard IAPT - % entering treatment in 18 weeks	Monthly	95.00%	N/A	**99.41%**		P	See IAPT Detail	?
IAPT Moving to Recovery Rates	Monthly	50.00%	N/A	**38.03%**	L		See IAPT Detail	?
Access to all services - % of people with wait of less than 18 weeks	Monthly	95.00%	N/A	**N/A**	N/A	N/A	Needs significant work to improve data quality on this indicator. See Detail for Access & Waiting Time information for EWS, SAANS and Gender Services	✘

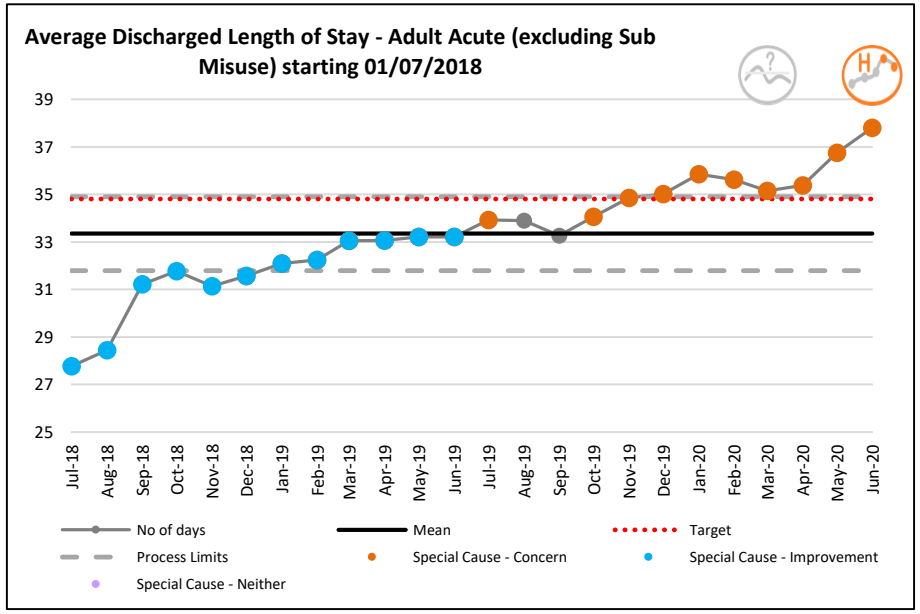
Overview | Summary KPIs 3

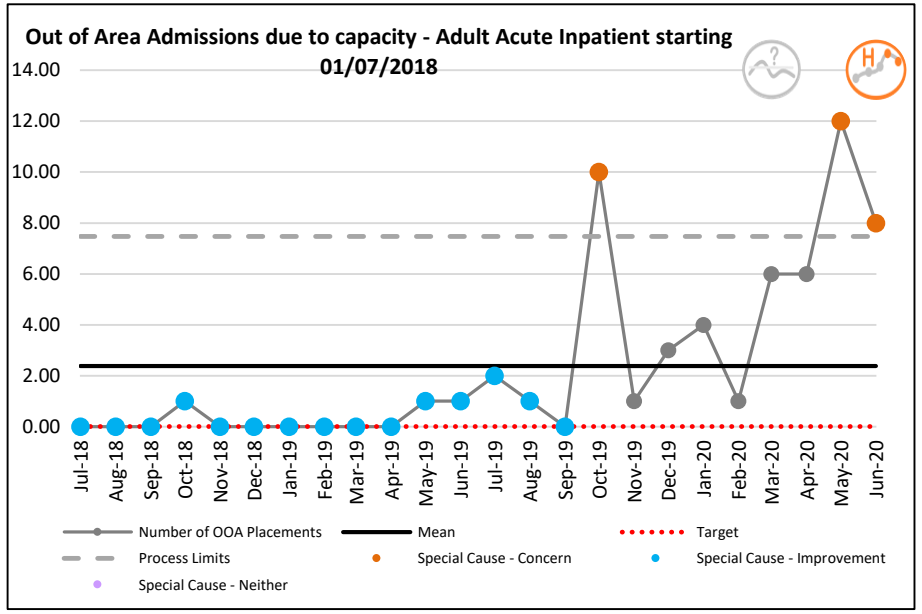
Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	JUNE 2020	SPC VARIATION/ TREND ICON	SPC ASSURANCE ICON	COMMENTS	KPI Assurance
EFFECTIVE								
Gatekeeping - Acute admissions assessed for HT	Monthly	95.00%	N/A	**92.50%**			June 20 92.5% recorded gatekept by Home Treatment represents 3/40 service users not gatekept - however, 2 were repatriations from out of area placements and one was a detention under MHA out of city for a Sheffield resident who was admitted to Stanage Ward.	?
CPA - % with an Annual Review	Monthly	95.00%	N/A	**73.94%**	L	F	See CPA Review Detail	?
CPA - % in Employment	Monthly	> 7%	N/A	**9.70%**		P	Needs significant work to understand and improve data quality on this indicator.	✘
CPA - % in settled accommodation	Monthly	>52%	N/A	**78.07%**		P	Needs significant work to understand and improve data quality on this indicator.	✘
Trust Membership - Numbers against plan	Monthly	12,200	N/A	**11,984**	L			?
WELL-LED								
Data Quality - Client Outcome indicators x 3	Quarterly	50.00%	N/A	**32.48%**	L		Data available until end May 20 only. Significant drop below lower control limit in May 2020. Investigation with Information Dept required.	?
Data Quality - Client Identifier indicators x 6	Quarterly	50.00%	N/A	**99.68%**	L	P	Data available until end May 20 only. Downward trend and shift below mean, but control limits are very small and metric consistently meeting target.	?
Use of Resources Rating	Monthly	1	N/A	**0**	N/A	N/A	See Finance Detail	N/A
Income & Expenditure (£000)	Monthly	N/A	N/A	**0**	N/A	N/A	See Finance Detail	N/A
Cash Balance (£000)	Monthly	N/A	N/A	**£59,100**	N/A	N/A	See Finance Detail	N/A
CIP & Disinvestment Delivery Against Plan (£000)	Monthly	N/A	N/A	**N/A**	N/A	N/A	See Finance Detail	N/A

Safe | Bed Occupancy, Length of Stay & OOA Admissions | Adult Acute









Benchmarking

(2019 NHS Benchmarking Network Report)

Bed Occupancy

Mean: 93%

Median: 95%

Length of Stay

Mean: 34.8 days

Median: 36 days

Narrative

Throughout the ongoing Covid-19 pandemic, pressure has remained constant across the Adult Acute system. This is reflected in high bed occupancy figures in March, April, May and June, with the continued need for out of area placements in order to safely care for patients who required an inpatient acute bed.

In June there were 2 occasions when 1 additional bed was required to accommodate patients across the system. All wards are still making efforts to keep to commissioned bed numbers or reduce to minimise multiple occupancy in dormitories. Two additional en-suite beds were opened up on Maple Ward from the beginning of June to reduce reliance on dormitory accommodation.

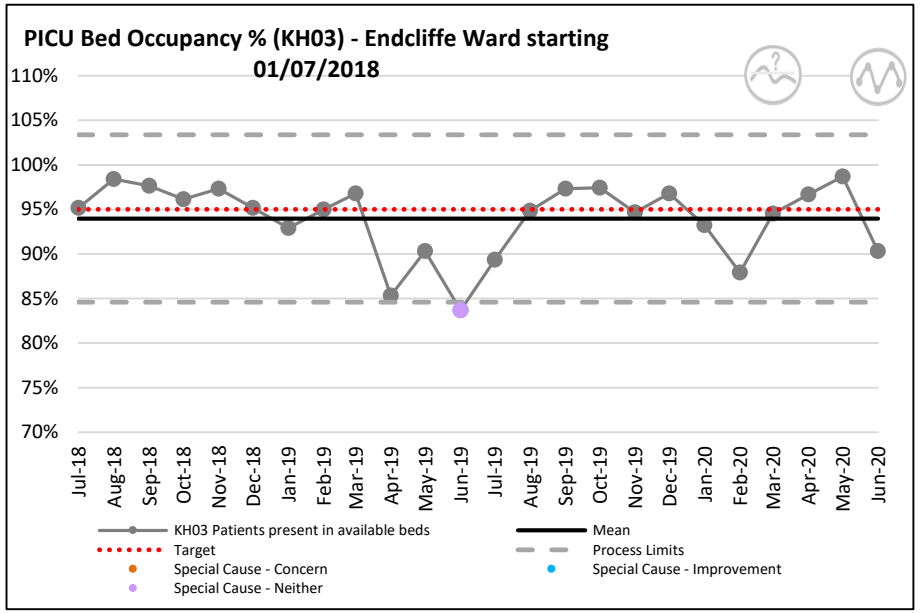
Discharged length of stay continues to show a steady increase across acute inpatient areas. (NB target line is national mean from benchmarking data).

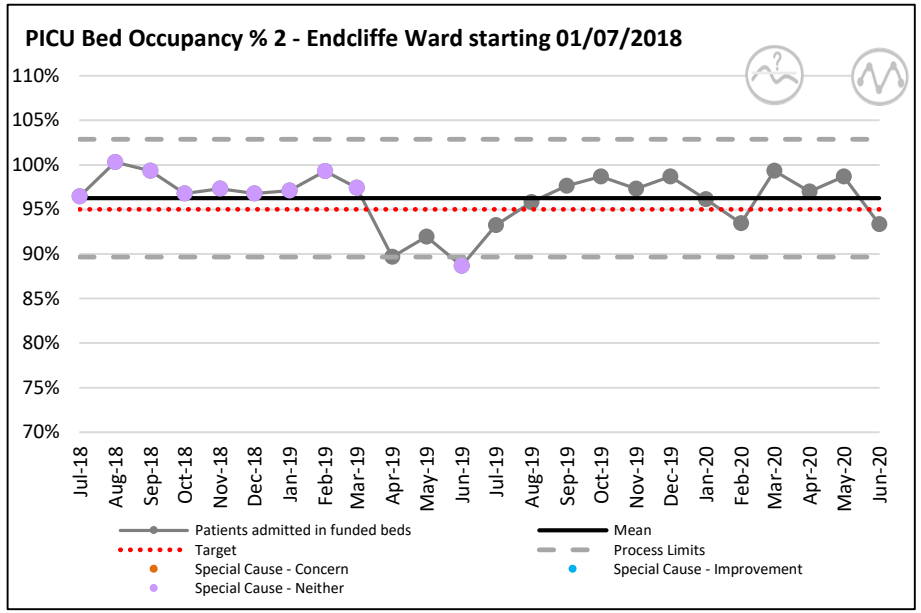
Bed Occupancy and Out of Area Placements are currently being monitored daily and weekly through Covid SitRep reporting and live information is available via the Ward Occupancy Dashboard.

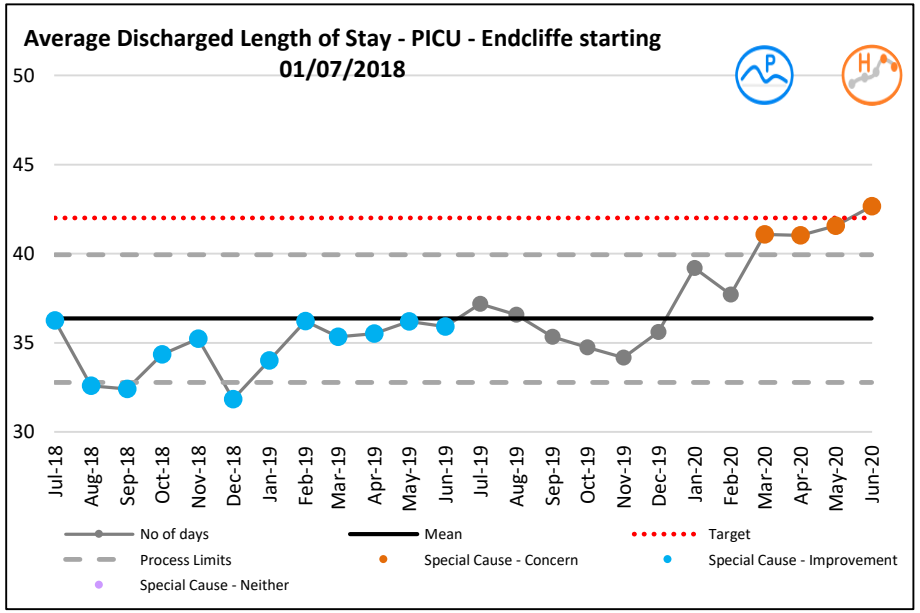
The weekly Bed Management meeting reviews a range of contemporaneous information including admissions, discharges and detention status, along with community intelligence to support flow through the system.

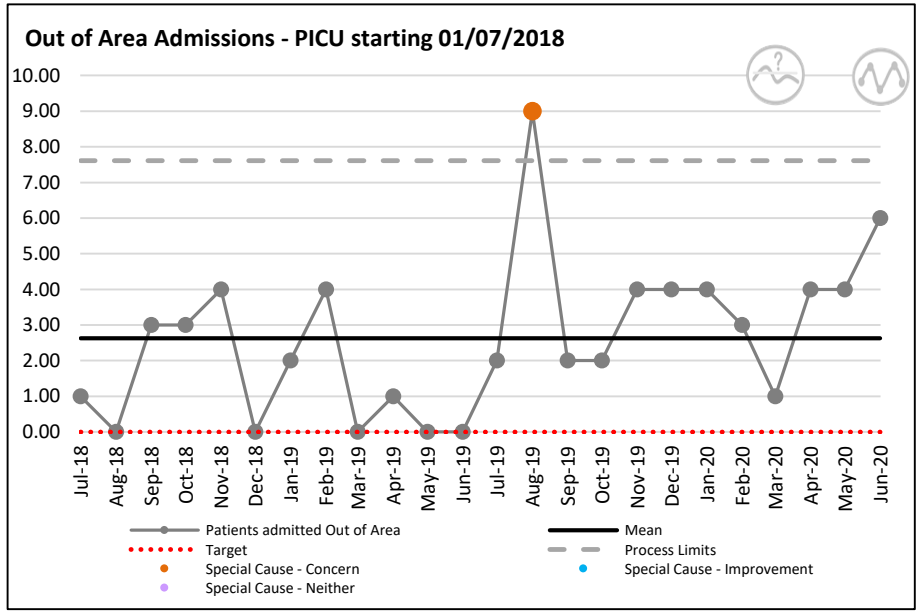
A twice weekly At Risk of Admission and Out of Area Management Meeting has been set up to meet from end of July in order to closely monitor and manage the inpatient situation.

Safe | Bed Occupancy, Length of Stay & OOA Admissions | PICU









Benchmarking

(2019 NHS Benchmarking Network Report)

Bed Occupancy

Mean: 86%

Median: 90%

Length of Stay

Mean: 42

Median: 36

Narrative

Throughout the ongoing Covid-19 pandemic, pressure has remained constant across the Adult Acute system including our PICU unit Endcliffe. Bed occupancy figures reduced slightly in June after being consistently March, April & May, but there were still a number of out of area placements in order to safely care for patients who required a PICU bed.

Discharged length of stay is currently showing an increase after a sustained period of lower than average LoS, and there are now 4 points (March, April, May & June 20) above the upper control limit.

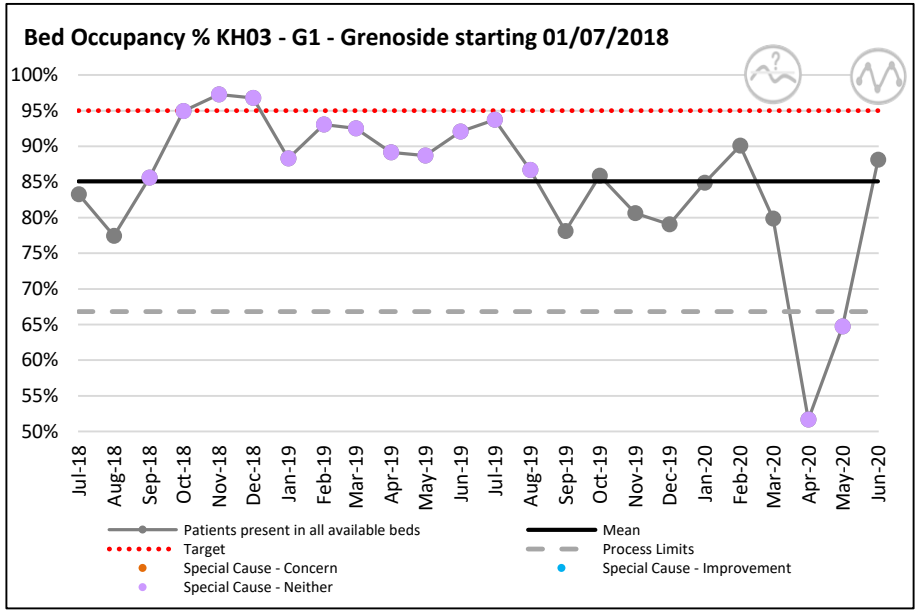
All other metrics are within the control limits, indicating no special cause variation.

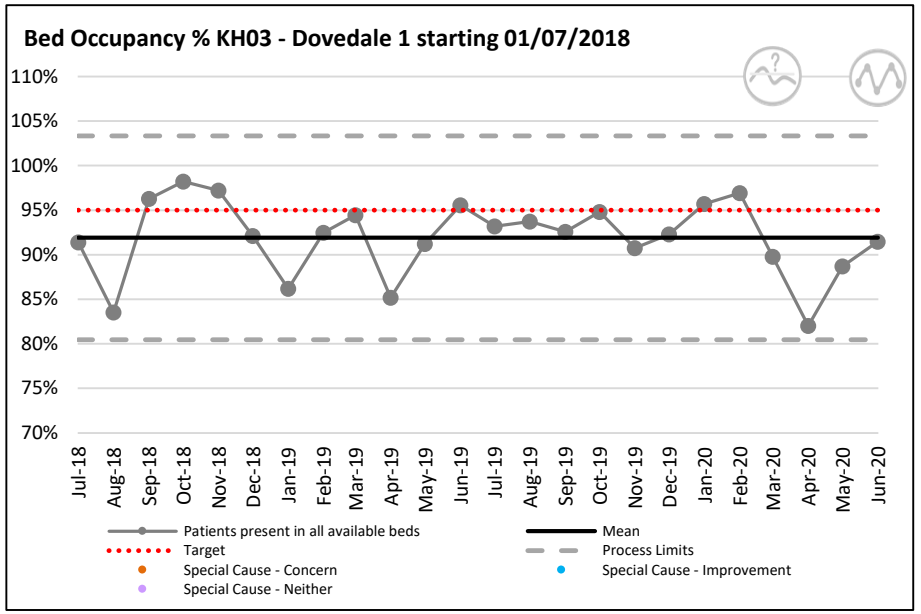
Bed Occupancy and Out of Area Placements are currently being monitored daily and weekly through Covid SitRep reporting and live information is available via the Ward Occupancy Dashboard.

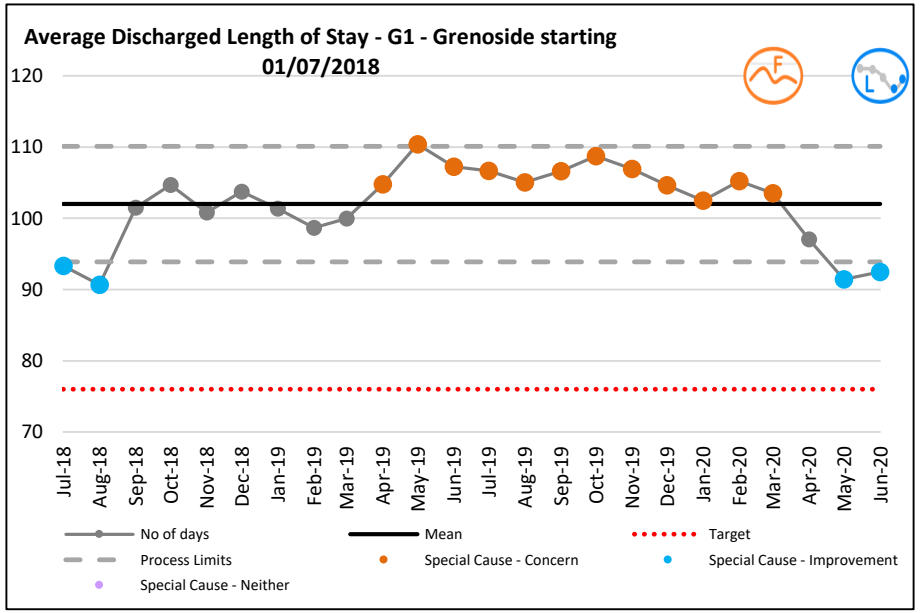
The weekly Bed Management meeting reviews a range of contemporaneous information including admissions, discharges and detention status, along with community intelligence to support flow through the system.

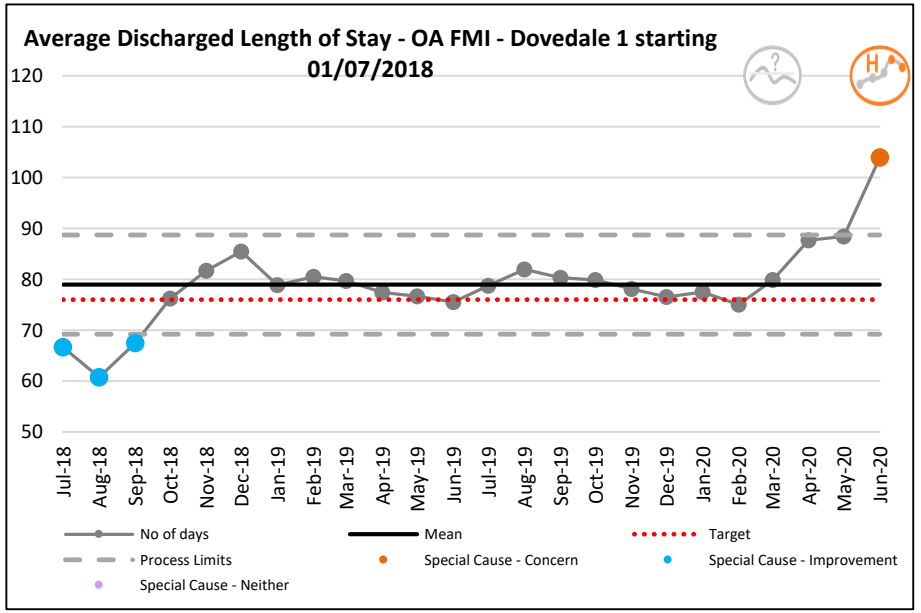
A twice weekly At Risk of Admission and Out of Area Management Meeting has been set up to meet from end of July in order to closely monitor and manage the inpatient situation.

Safe | Bed Occupancy & Length of Stay | Older Adult Wards









Benchmarking

(2019 NHS Benchmarking Network Report)

Bed Occupancy

Mean: 90%

Median: 92%

Length of Stay

Mean: 76

Median: 76

NB - Benchmarking figures are for combined Older Adult inpatient bed types, they are not available split into functional and organic mental illness.

Narrative

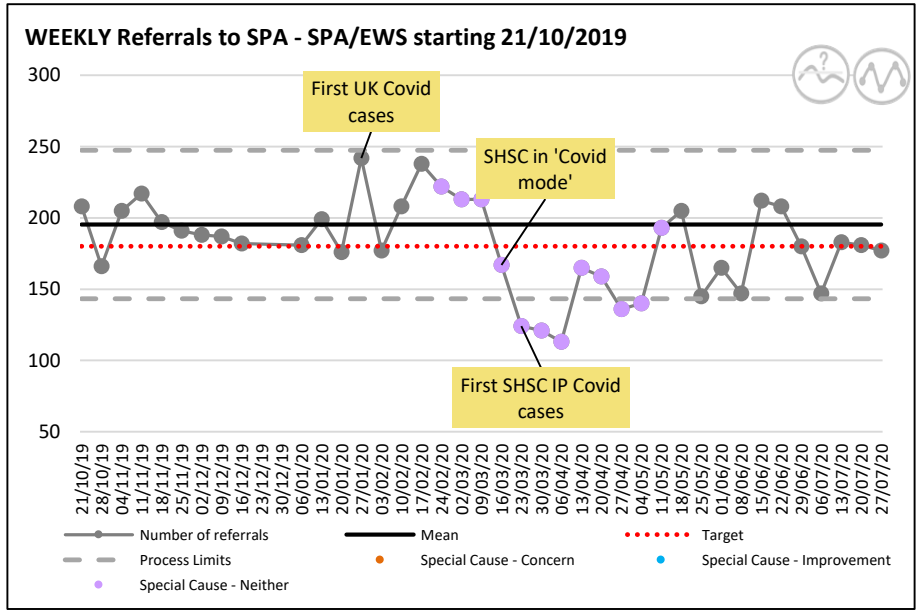
Our older adult wards Dovedale & G1 suffered the worst of the initial Covid impact. To date there have been a total of 4 cases (2 recoveries and 2 deaths) on G1 and 12 cases (all recovered) on Dovedale. All were in March and April and these wards have now remained Covid free since the end of April.

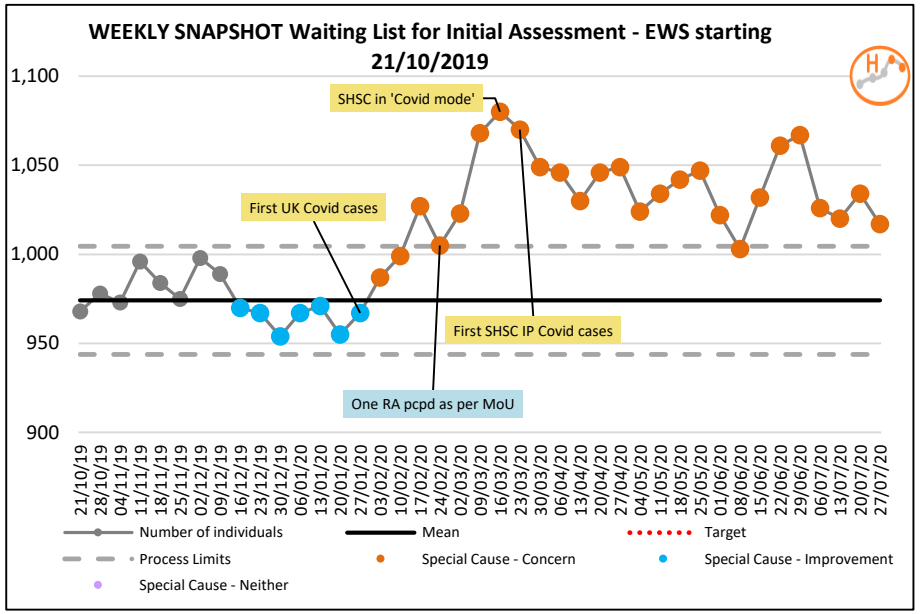
Covid impacted significantly on bed occupancy on both wards as the wards operated with fewer beds where possible to absorb the impact felt in staffing levels and to better enable patient isolation. In April & May, G1 capped the admissions to 14 rather than 16 beds as attempts were made to ensure isolation for Covid patients. Alternatives to admission were found where possible.

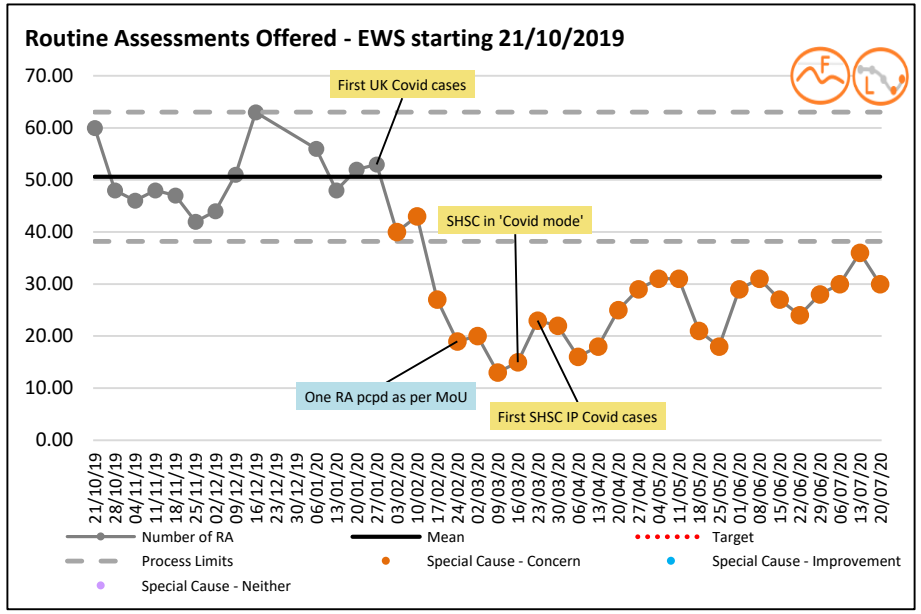
Discharged length of stay is currently showing below the lower control limits for G1, more than likely a Covid impact as a result of attempts to expediate discharge where safe to do so in order to free space up on the ward. In June, Dovedale 1 breached the upper control limit with a particularly high average discharged LoS. This is due to one long stay (674 days) individual being discharged in June.

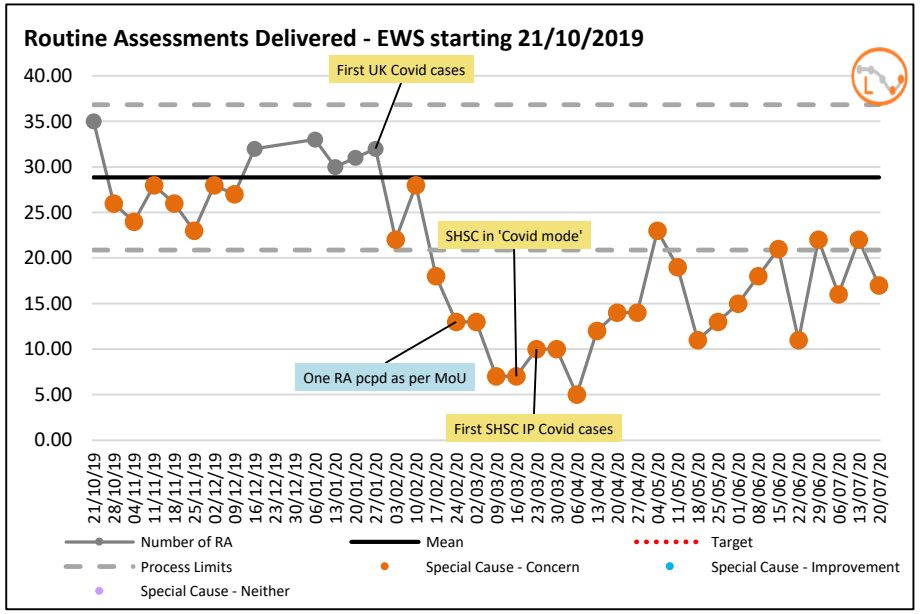
The weekly Bed Management meeting reviews a range of contemporaneous information via the Ward Occupancy Dashboard, including admissions, discharges, length of stay and detention status, along with community intelligence to support flow through the system.

Responsive | Waiting Times | Emotional Wellbeing Service (EWS)









Narrative

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. The information provided here 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.

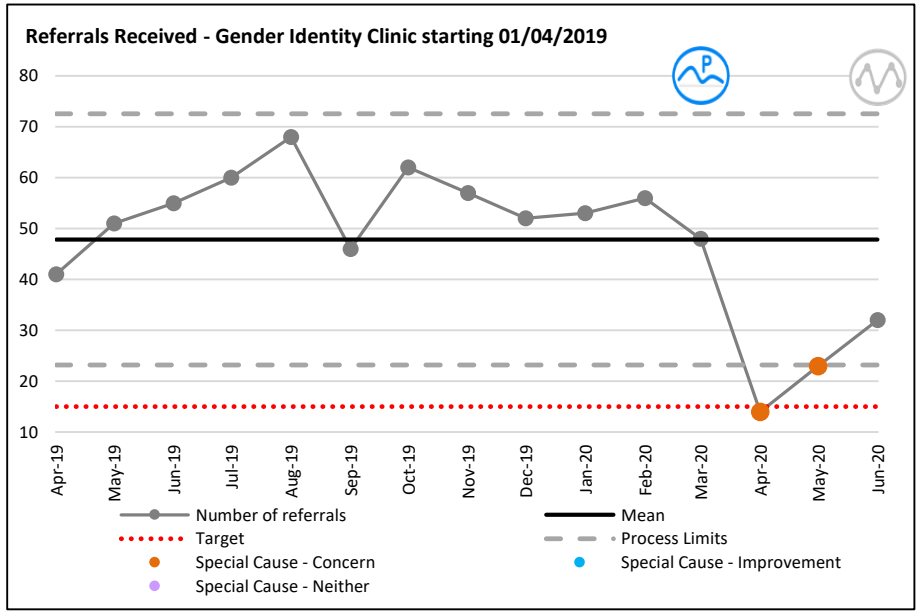
Next Steps/*Progress*

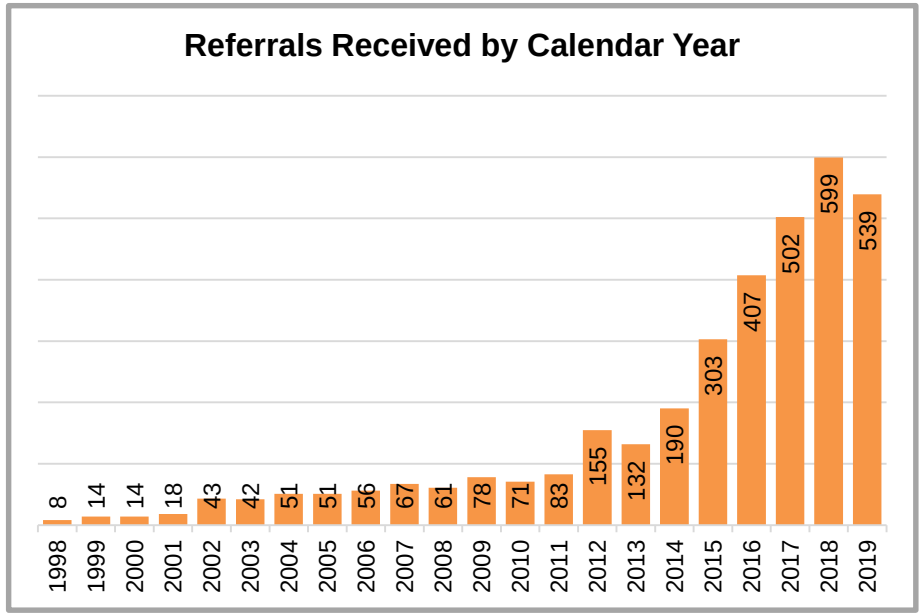
Plans for the reduction in waiting times and elimination of the current waiting list are being overseen by the 'Back to Good' Programme, and improvement plan objectives include:

- Actively increase our mental health practitioner workforce - ***Currently recruiting additional Clinical Associate Psychologist posts (CAPs) to work specifically on backlog and wait list.***
- Implement the CQC action plan targeted at waiting list/time reduction - ***In progress.***
- Transition of Safeguarding referrals to the safeguarding team - ***In progress. Dependent on the Safeguarding team having newly appointed staff in place.***
- ADHD referrals transferred to SAANS – *Complete.*
- Trial the Attend Anywhere software to facilitate provision of remote clinics. – ***In progress. To be in place no later than the end of August.***
- Review of governance structures. - ***Completed. Now includes greater MDT involvement and the provision of weekly performance and data information.***

Responsive | Waiting Times | Gender Identity Services (GIS)

As at 7 July 2020	
Waiting List	1064
Average Wait Time (weeks)	66
Number of Open Episodes	744





Narrative

As at 7 July 2020, GIS had 1,064 on the waiting list for assessment, having received 649 new referrals last year. We remain commissioned under the pre-tender model to deliver 169 new per year; running at nearly 4 times the pre-tender referral rate. The demographic is changing to an increase in young people and we are facing significant growth in referrals from GIDS; the children's service who transfer at 17. We have to prioritise these cases and inherit the waiting time they have for GIDS, which has a further negative impact on our service waiting times.

There are also circa 700 active cases in the system currently. A significant positive development is a sub-contracted collaboration with a non-statutory provider called Gender Intelligence based in London who now provide telephone support and enquiry line work for us. This is very positive in maintaining contact with people while they wait and moves to a more active waiting and preparation process. The system has not been in place long enough yet to analyse any metrics, but we are working on that with Gender Intelligence. We are also effectively using our peer support worker and developing web and Attend Anywhere platforms to deliver group work.

Activity through the Attend Anywhere platform is now increasing. To date, video appointments have been offered for initial assessments, appropriate follow up interventions but not final diagnostic appointment. This is due to the complexities and potential impact on individuals and the trust if any error is made. For many the outcome of assessment is that it leads to life changing surgery. With a significantly changing patient referral demographic, clinical opinion is that patients need to be seen face to face (as per NHSE service specification). This has a negative impact on waiting times from referral to pathway completion. We reported last month that NHSE had indicated they would like video assessments extended to include diagnostic appointments. There has been a meeting of the lead medical staff, and in line with other specialist service providers and with current clinical guidelines it has been decided that a diagnostic appointment will continue to only be offered on a face to face basis. It is felt that in the best interests of patient safety, diagnostic confirmation cannot be given via video link. The first assessment can still be offered by alternative means.

Current Infection Control advice is complicating the ability of the service to offer diagnostic appointments. The time taken in such assessments is typically greater than 2 hours. We understand that this period of time is not recommended without significant PPE and environmental cleaning. The nature of the assessment would preclude the wearing of the enhanced level of PPE that is recommended. We will be addressing other options that it may be possible for clinicians to take to reduce the period of time that it is necessary to spend in an assessment, so that the face to face option is limited to the timespan of 1 hour maximum. Environmental risk assessments have now been completed and the option of face to face engagement will now start to be offered in the clinic. This will be phased over August/September, depending on government guidelines.

Responsive | Waiting Times | Sheffield Adult Autism & Neuro Services (SAANS)

CCG	Referral Date of Next Appt To Be Made	Current Waiting Time
Sheffield	28/01/20	6.5 Months
Rotherham	25/03/19	16 Months
Derby & Derbyshire	02/07/18	25 Months
Doncaster	07/06/20	2 Months
PTT/Stockport	19/11/18	19.5 Months
Sheffield RoNs	25/01/19	7 Months
National RoNs	15/07/19	13 Months
ADHD Waiting List	25/09/17	34 Months

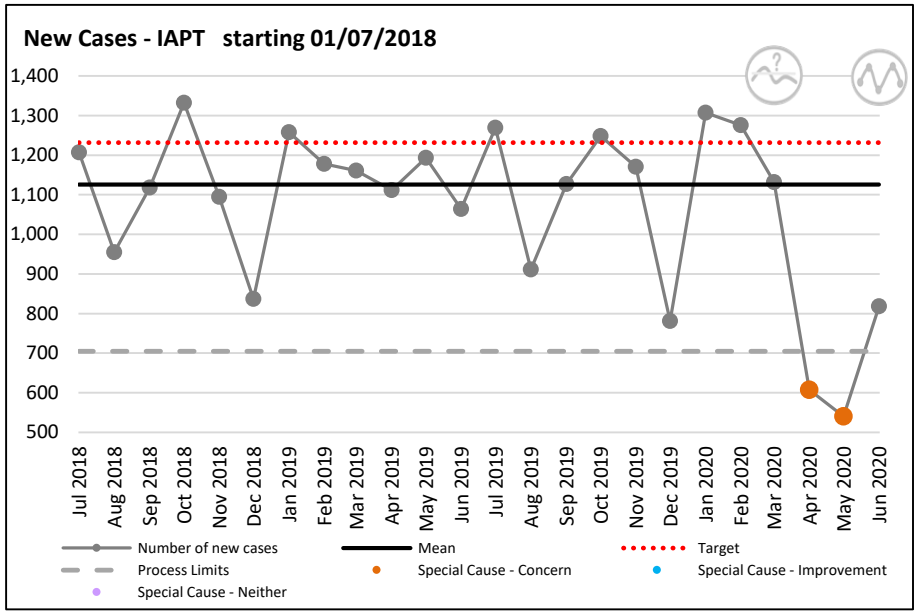
Narrative

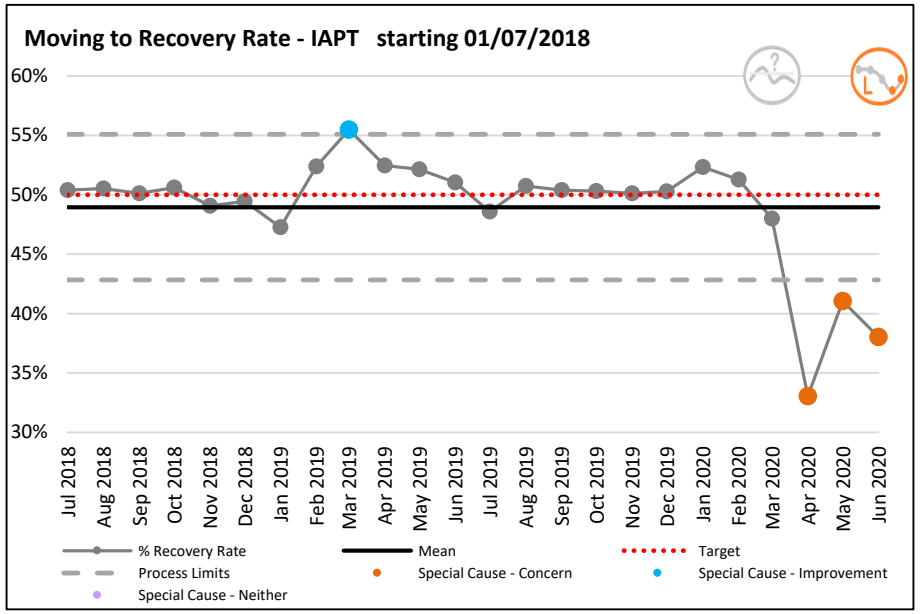
In SAANS the system is complicated by the bifurcation of the ADHD and ASD pathways and the provision of a service to multiple areas.

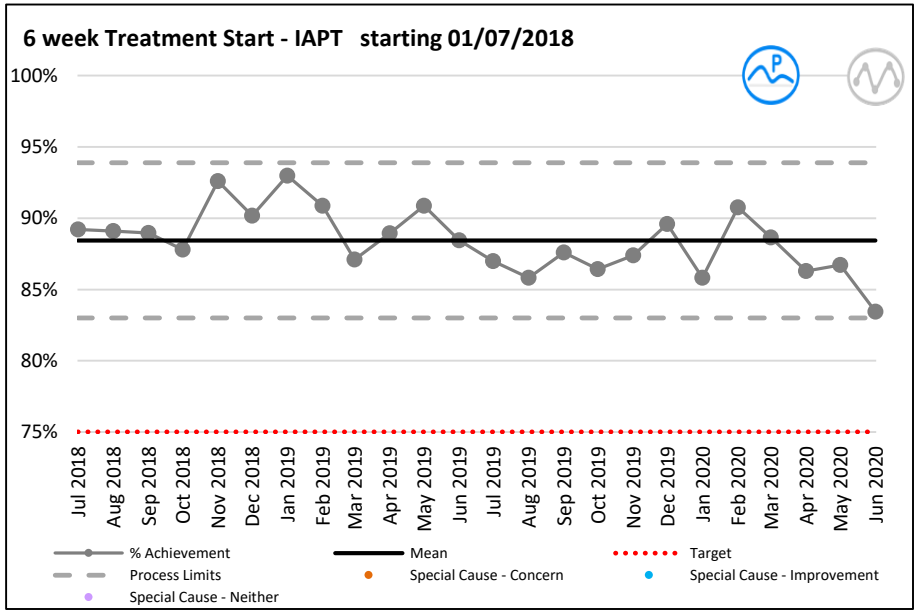
As at 31st July 2020 there were 889 on the ADHD (this has recently increased as a result of SPA/EWS transferring their ADHD clients to the SAANS waiting list) and 840 on the ASD list. We are working with a nurse consultant and medical colleagues to build the delivery model for ADHD which is starting to come together. Circa 600 of the ADHD referrals are from out of Sheffield areas and represent a potential £1,400 per assessment in income. We need to progress this income stream rapidly to fund the attention on local needs. A model is being proposed to address the needs of ADHD that includes ACP, NMP, Medical and nursing associates. This proposal has been discussed with SCCG commissioners who are in agreement with the initial proposals. Once the business case has been completed and agreed resource to fund the recruitment and appropriate estates will be required prior to the operationalisation of the service.

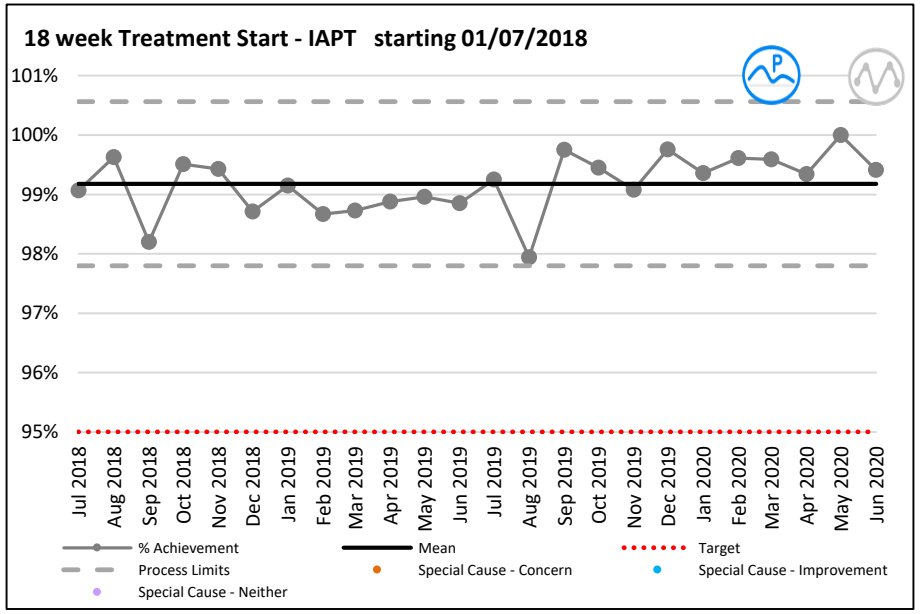
The ASD pathway is complicated and there have been significant challenges which have significantly hampered the service's ability to meet demand, therefore a change programme is being established to provide the service with the an opportunity to address the on-going problems. SCCG commissioners are satisfied with the willingness of the service to address the issues but are clearly frustrated at the repeated reassurance that has been provided to no avail. The CCG are prepared to delay or forego a further external review of the service for a limited time to establish a clear plan that will provide assurance that effective working practices will be implemented.

Responsive | Improving Access to Psychological Therapies (IAPT)









Narrative

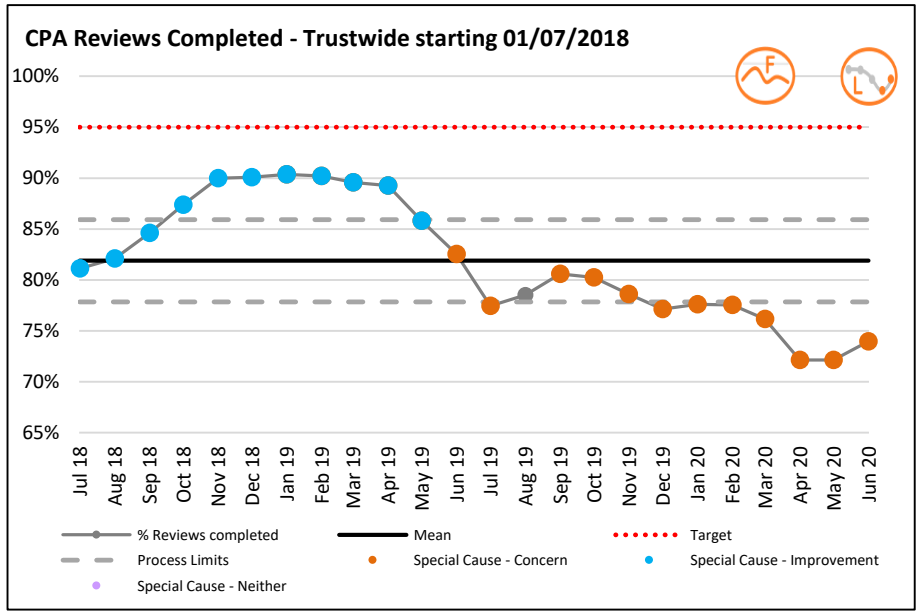
IAPT were on track and exceeding all 3 standards before Covid hit in March. All groups as per government guidance were stopped. All staff had to immediately stop working in GP practices and the service had to facilitate homeworking and/or safe base working. Despite lower numbers accessing the service in April and May than we would normally see, and despite the numerous demands and challenges of significant change, the service has still delivered on over 90% of contacts it would expect to see.

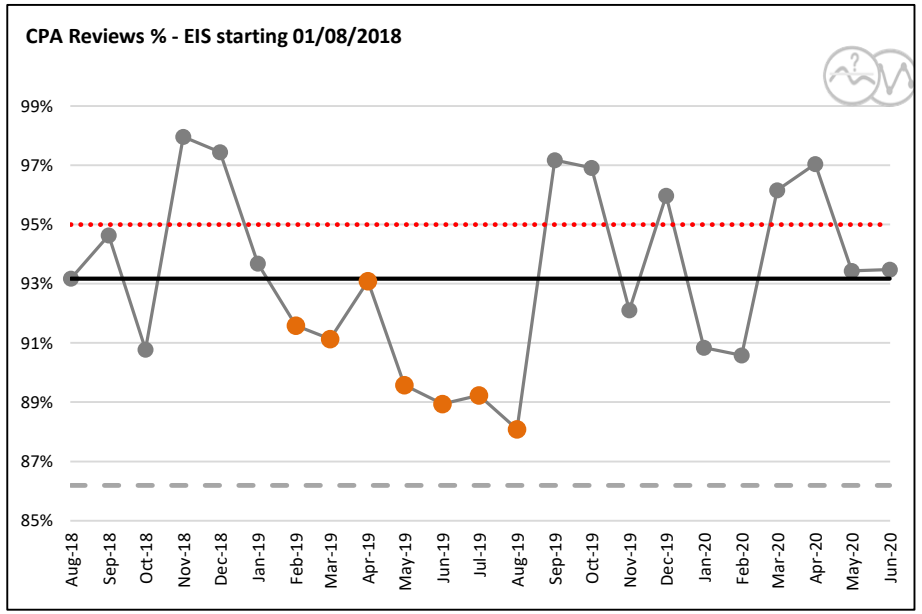
Moving to Recovery rates are expected to be lower as some people dropped out of treatment due to Covid. As we are in a pandemic it is normal for the general public to experience impact on sleep, worry, a lack of interest and pleasure in doing things therefore it is not appropriate to expect the same recovery rate pre-Covid as these are the questions asked in the outcome measures that calculate recovery rates. **Although NHS England have restored national standards it has been made clear from the National IAPT team that they are not enforcing performance management of these standards.**

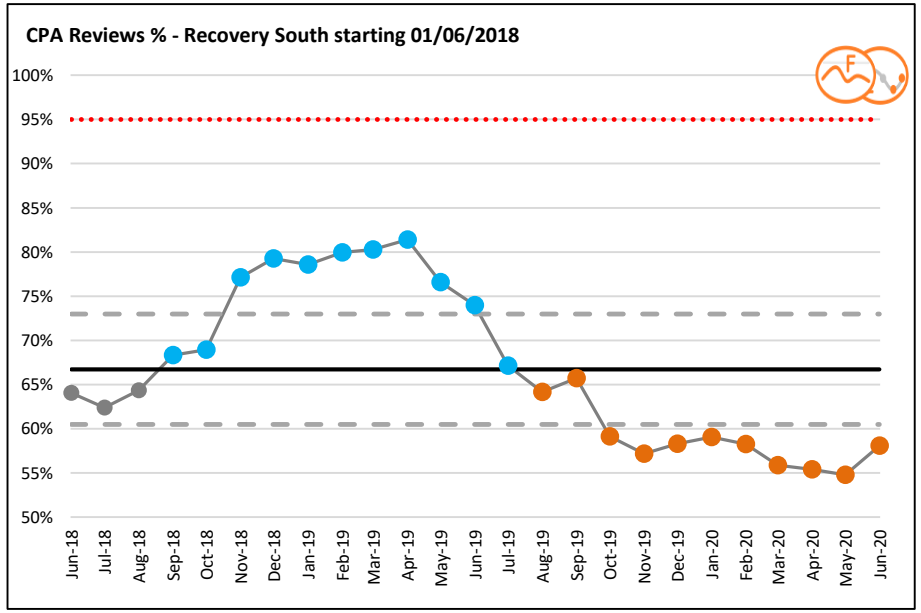
There has been a drop in referrals due to the pandemic and due to the centralisation of IAPT. Work is underway with Clinical Directors in primary care to train receptionists to book patients in using the IAPT on line self referral form and staff are starting to attend virtual GP meetings. National predictions are a significant increase in demand for IAPT services as a proportion of the local population not having previously experienced anxiety and depression are expected to need this support post Covid.

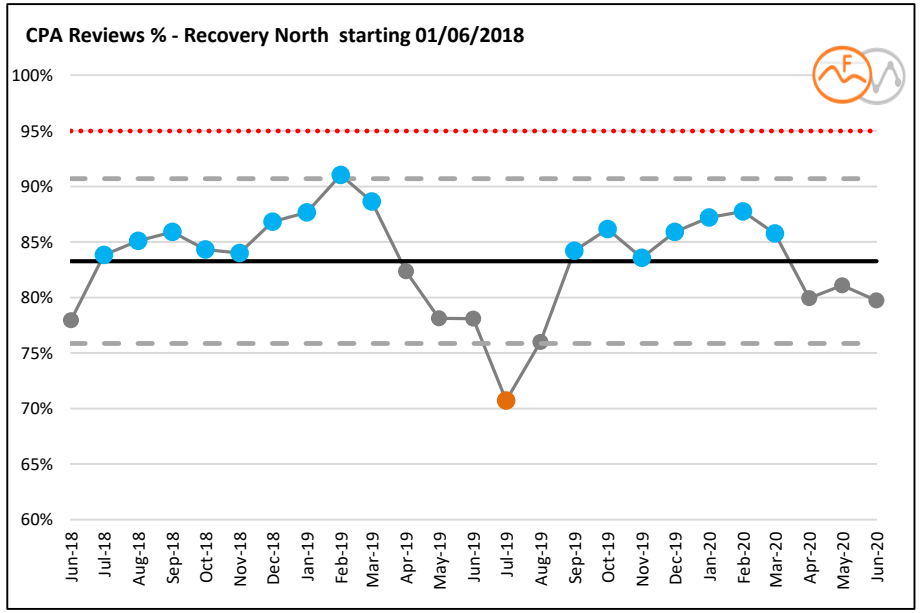
It is worthy of note that both the 6 and 18 week wait to treatment start times consistently exceed the national targets and this has been maintained throughout the pandemic to date.

Effective | CPA Review









Narrative

Overall performance to meet the 95% target continues to be a challenge particularly following the impact of the restrictions on the community teams as a result of Covid 19.

The Trust % for June 2020 is 73.94%, showing another small increase in % from previous months. This is in line with the network's projections as key staffing appointments are in place and new monitoring systems have been implemented.

Recovery Teams Improvement Plan

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.

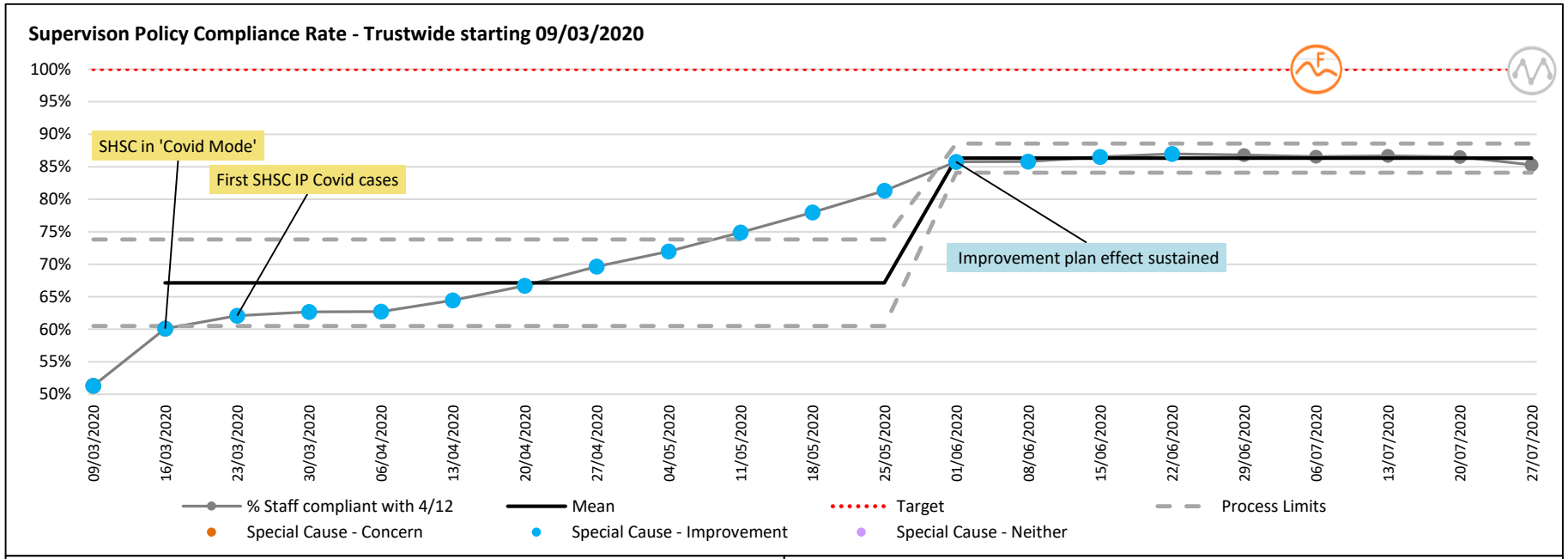
Additional weekly reports are also now in use and being used in supervision as a performance management approach.

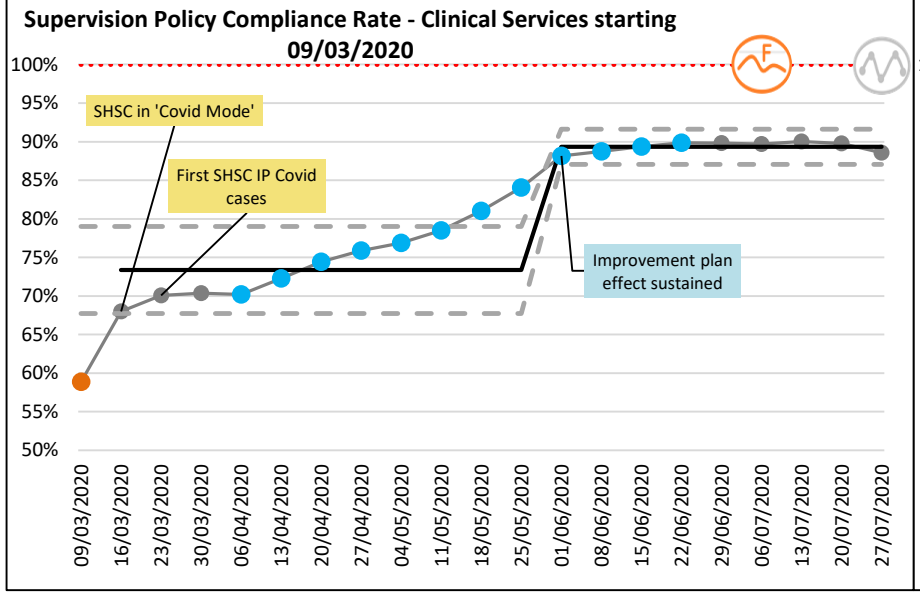
Internal milestones are being used to keep track of the pace of progress and performance against these is reported into the Care Network senior team.

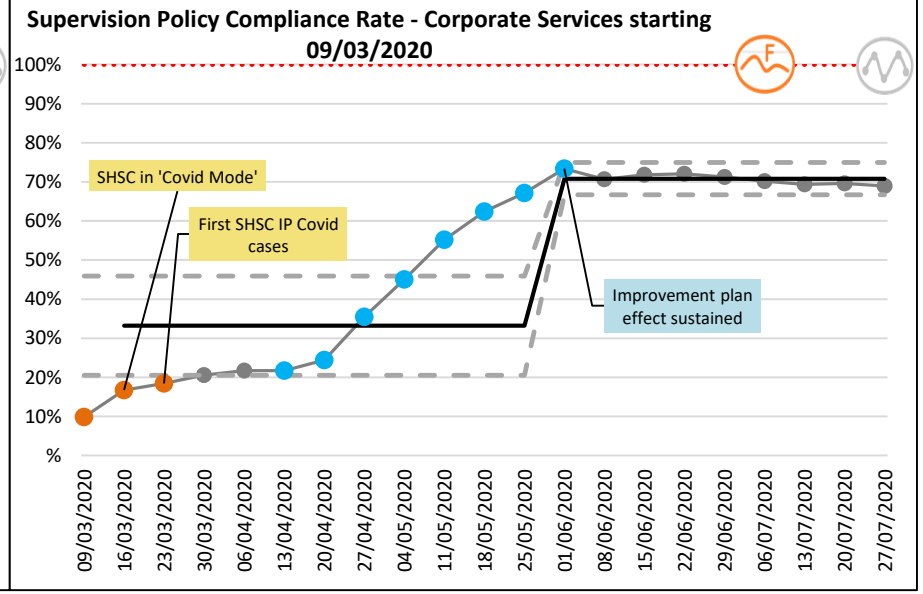
Early indication in July's data does reflect an upturn in the percentage of reviewed care plans, in line with the improvement plan.

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.

Supervision







Narrative

As a result of the CQC Section 29A notice served in February 2020, we have been monitoring Supervision compliance and reporting in to the Executive on a weekly basis.

We committed to ensuring that all staff have received at least the required minimum of 4 supervisions in a 12-month period, and that it is recorded in and reported on from a single source – the Supervision webform. The information below is taken from the latest position for the week ending 26 July 2020.

Significant improvements were made throughout March, April and May, despite the impact of Covid on staffing and activity levels. We have amended the control limits in the SPC charts from 1/6/20 to reflect the new norm, as the improvement has been sustained. This significantly reduces the variation in the compliance, and current mean compliance is now at 86%, with clinical services at 89% and Corporate services at 71%.

Changes to the Supervision Policy are being proposed and have been consulted on throughout Rapid Improvement Week. Reporting is beginning to reflect those policy changes as they come in to effect. This includes the setting of a new target of 80% compliance for a minimum of 8 supervision sessions in 12 months; reporting of clinical/management supervision and taking part time working into account.

BACK TO GOOD

Mandatory Training

Mandatory Training Compliance

02 August 2020

Compliance % highlighted in orange is between 75-79.99% meaning it below but close to the 80% target.

Compliance % highlighted in red is between 0-74.99%

This does not include new starters for 3 months after their start date

Subject	Level	Frequency	26 July 2020				02 August 2020				Current Compliance against Previous Compliance %	
			No Requiring	No Achieved	No NOT Achieved	Compliance	No Requiring	No Achieved	No NOT Achieved	Compliance		
Equality, Diversity and Human Rights		3 Years	2604	2413	191	92.67%	2618	2416	202	92.28%	Decrease	-0.38%
Hand Hygiene		3 Years	2604	2495	109	95.81%	2618	2506	112	95.72%	Decrease	-0.09%
Health and Safety		3 Years	2604	2569	35	98.66%	2618	2583	35	98.66%	Increase	0.01%
Information Governance (aka Data Security Awareness)		1 Year	2604	2297	307	88.21%	2618	2316	302	88.46%	Increase	0.25%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2604	2416	188	92.78%	2618	2429	189	92.78%	Increase	0.00%
Adult Basic Life Support		1 Year	2604	2459	145	94.43%	2618	2475	143	94.54%	Increase	0.11%
Fire Safety		2 Years	1335	1274	61	95.43%	1364	1298	66	95.16%	Decrease	-0.27%
		3 Years	1250	1220	30	97.60%	1254	1224	30	97.61%	Increase	0.01%
Immediate Life Support		1 Year	310	247	63	79.68%	310	246	64	79.35%	Decrease	-0.32%
Clinical Risk Assessment		3 Years	982	923	59	93.99%	991	930	61	93.84%	Decrease	-0.15%
Dementia Awareness		No Renewal	2320	2211	109	95.30%	2349	2232	117	95.02%	Decrease	-0.28%
Autism Awareness		No Renewal	2316	2227	89	96.16%	2345	2246	99	95.78%	Decrease	-0.38%
Mental Capacity Act	1	3 Years	1094	978	116	89.40%	1112	972	140	87.41%	Decrease	-1.99%
	2	3 Years	1128	1031	97	91.40%	1137	1040	97	91.47%	Increase	0.07%
Deprivation of Liberty Safeguards	1	3 Years	2117	1967	150	92.91%	2144	1972	172	91.98%	Decrease	-0.94%
	2	3 Years	104	97	7	93.27%	103	95	8	92.23%	Decrease	-1.04%
Mental Health Act		3 Years	202	186	16	92.08%	201	185	16	92.04%	Decrease	-0.04%
Medicines Management Awareness		3 Years	545	492	53	90.28%	548	493	55	89.96%	Decrease	-0.31%
Rapid Tranquilisation		3 Years	312	293	19	93.91%	315	295	20	93.65%	Decrease	-0.26%
Respect	1	3 Years	1081	948	133	87.70%	1099	972	127	88.44%	Increase	0.75%
	2	2 Years	955	745	210	78.01%	955	743	212	77.80%	Decrease	-0.21%
	3	1 Year	352	302	50	85.80%	367	304	63	82.83%	Decrease	-2.96%
Safeguarding Children	2	3 Years	1098	995	103	90.62%	1126	1014	112	90.05%	Decrease	-0.57%
	3	3 Years	1129	944	185	83.61%	1129	943	186	83.53%	Decrease	-0.09%
Safeguarding Adults	2	3 Years	2228	2026	202	90.93%	2256	2044	212	90.60%	Decrease	-0.33%
Domestic Abuse	2	3 Years	2232	2018	214	90.41%	2260	2038	222	90.18%	Decrease	-0.24%
Prevent WRAP		3 Years	2312	2077	235	89.84%	2255	2094	161	92.86%	Increase	3.02%
Overall compliance						**92.26%**				**92.20%**	Decrease	-0.06%
Moving and Handling	1	3 Years	2604	2387	217	91.67%	2618	2395	223	91.48%	Decrease	-0.18%
	2	3 Years	766	470	296	*61.36%*	782	486	296	*62.15%*	Increase	0.79%

Overall Trust official reporting figures which includes the 02/8/2020 weekly data against the 26/7/2020 weekly data. The below 80% figures have been highlighted to make easier to spot and includes the percentage of the decrease/increase

Narrative

As a result of the CQC Section 29A notice served in February 2020, we have been monitoring Mandatory Training compliance and reporting in to the Executive on a weekly basis.

We committed to reaching a target of 80% compliance across all Trust services. The information below is taken from the latest position for the week ending Friday 5 July 2020.

Highlights

- As of 2nd August 86.78% of staff are 80% compliant or above.
- There are no services below 80%.
- 100 members of staff have been through the Respect Awareness for new/reassigned staff going to inpatient areas.
- ILS training started Monday 3 August 2020.

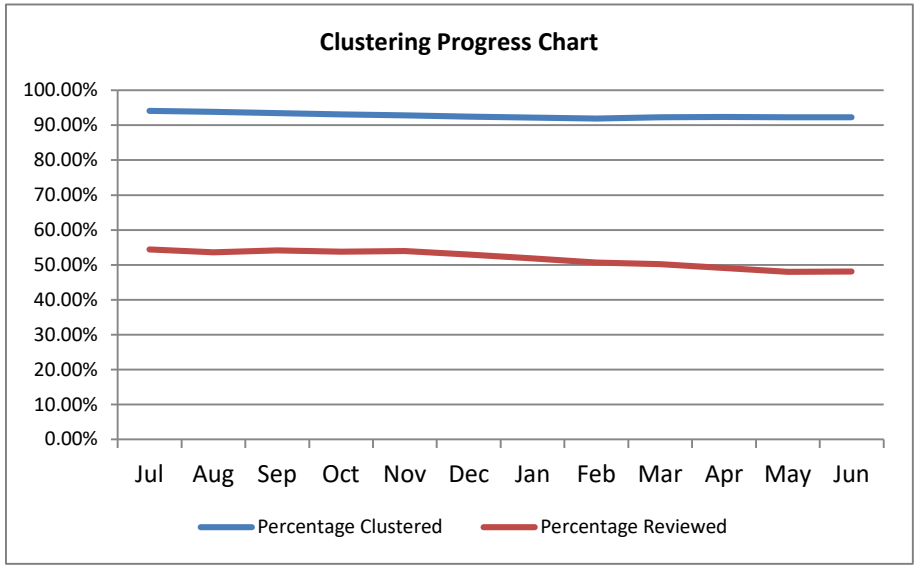
Exceptions

- Of the 296 staff who are non-compliant in Moving and Handling Level 2, 249 (83.45%) of those who have not done the training have the knowledge/achieved level 1.
- Of the 64 staff who are non-compliant in ILS, 57 (89.06%) are compliant with BLS.

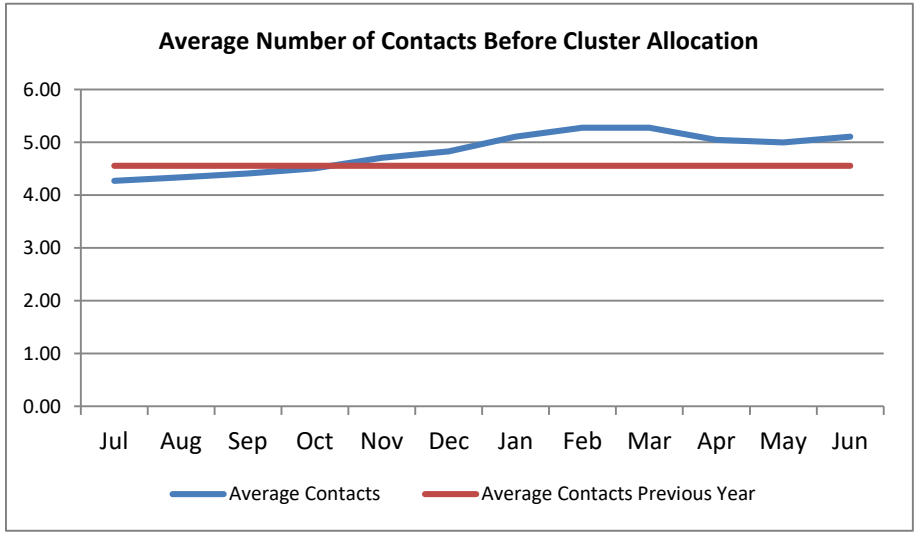
NB: Due to the impact of COVID-19, the period of update training for face to face subjects for those staff expiring or about to expire has been extended to 31 October 2020.

BACK TO GOOD

Clustering Analysis for period to June 2020



In-scope service users = Service users with an open episode with a clustering team who have had at least 1 day on an inpatient ward or 2 or more contacts with the clustering team. To avoid double counting, this dashboard only counts each service user once.



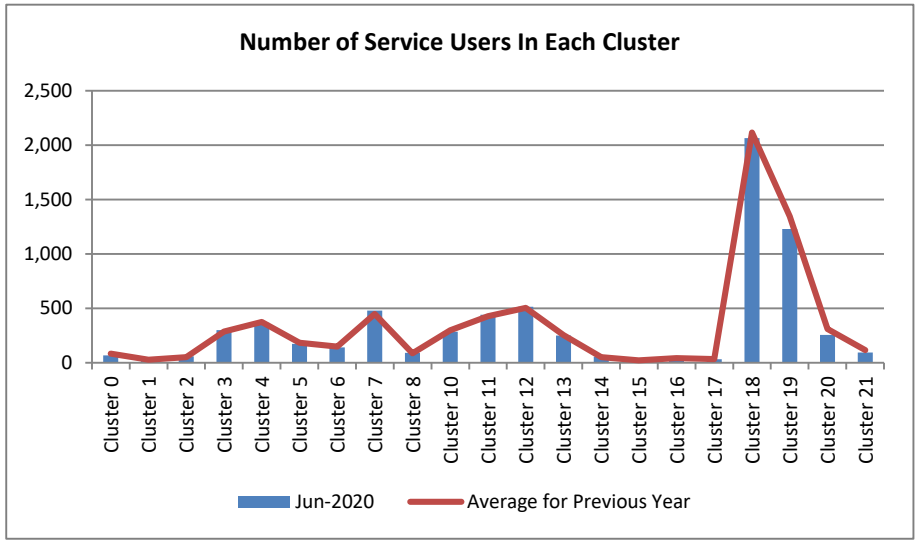
< Clustering Progress

The proportion of service users allocated to a cluster as a proportion of all 'in-scope' service users who have had 2 or more contacts, and whether service users have had their cluster allocation reviewed within the mandated periods. It is an expectation that all service users have their cluster reviewed within the maximum limit for that cluster. A review of cluster allocation should take place as part of a review of care.

Consistent high levels for these indicators, without significant fluctuation, should provide assurance that the related systems are working in a way that achieves expected performance. A persistent decrease on either of these indicators would be a cause for concern due to the financial/contractual implications.

Service Users In Each Cluster >

The number of service users allocated to each cluster at the time of reporting. The data presented here uses 'unique client' rules which result in each service user only being counted once, as opposed to multiple times across all teams they may be open to. It includes all service users within SHSC clustering services, and is not limited to Sheffield patients. The bar chart shows figures for the number of service users in each cluster at a single point in time in the most recent month. The line shows the average number of service users allocated to each cluster over the last financial year.



< Contacts Before Cluster Allocation

Those not assigned to a cluster are assumed to be in 'assessment stage'. This is defined as service users who have had contact with services but have not yet been allocated to a cluster, and are therefore not regarded as being in receipt of treatment. The currency model assumes that service users who have not yet been clustered are undergoing 'initial assessment'.

Numerator: Number of contacts made with the service user, by any in-scope team, prior to the service user being clustered or discharged. Denominator: Number of service users at the end of the reporting period who had an open episode with an in-scope team and do not have a valid cluster recorded.

There are no formally agreed contractual targets or thresholds attached to the number of initial assessment contacts undertaken per service user.

START Performance Report June 2020

Opiates Service

Since October 2014, SHSC is commissioned to provide an end-to-end pathway for Opiate users. The service's open access referral pathway to specialist structured treatment (specialist substitute prescribing, psychosocial interventions), community and inpatient detox options and a supported offer to sustain recovery. The service also has a nurse-led specialist wound care clinic and needle exchange.

	Annual Target	June 2020	May 2020	Quarter 1, 2020/21	Year to Date, June 2020
Referrals In	-	91	89	269	269
Assessments	800	60	67	200	200
DNA Rate to Assessment	15.00%	21.4%	20.4%	31.0%	19.3%

Service comment:
The Opiates service has assessed 200 clients as of June 2020. Operational changes due to the impact of the COVID-19 pandemic have meant that a majority of service users are currently being assessed over the telephone. 21.4% of clients did not make themselves available or attend for an assessment appointment in May. The service continues to engage with individuals seeking to access treatment in particular those who do not attend assessments, and a high proportion of Opiate users in Sheffield access treatment.

Please note, the number of referrals received and number of assessments completed are not linked. Please note, 2020/21 targets not yet confirmed by Commissioner.

Non-Opiates Service

Since October 2014, SHSC is the commissioned to provide an end-to-end pathway for Non-Opiate users. The service's open access referral pathway offers specialist structured treatment (psychosocial interventions) and a supported offer to sustain recovery. The service also provides a needle exchange and a drop-in Steroid Clinic.

	Annual Target	June 2020	May 2020	Quarter 1, 2020/21	Year to Date, June 2020
Referrals In	-	62	36	130	130
Triage Assessments	-	46	28	95	95
Immediate Referral to Formal PSI	25%	13.0%	21.4%	17.9%	17.9%

Service comment:
Early identification and referral of clients who may benefit from PSI at initial assessment facilitates clients to receive offer of specialist support in a timely manner - YTD the service is at 17.9.5% against a target of 25% for immediate referrals to PSI.

There is a greater level of engagement with clients at Tr2, before entering formal PSI treatment. Referrals to thw Non Opiates service saw a reduction during April and May but have increased to normal levels in June.

Alcohol Service

Since 2010, SHSC is the commissioned provider of open access Alcohol triage service and specialist structured treatment for people addicted to Alcohol. Service users have access to specialist structured treatment (specialist substitute prescribing, Psycho-Social Interventions), community and inpatient detox options and a supported offer to sustain recovery. The service has developed a successful electronic Alcohol Screening Tool.

Access	Annual Target	June 2020	May 2020	Quarter 1, 2020/21	Year to Date, June 2020
Referrals In	-	219	113	400	400
Triage Assessments	2,400	117	87	274	274
DNA Rate to Triage Assessment	15%	12.7%	9.5%	25.7%	11.4%

Service comment:
The Alcohol service has assessed 274 clients as of June 2020. Operational changes due to the impact of the COVID-19 pandemic have meant that a majority of service users are now being assessed over the telephone. 12.7% of clients did not make themselves available or attend for a triage assessment appointment in June. The service continues to engage with individuals seeking to access treatment in particular those who do not attend assessments.

Please note targets are for 2019/20; targets for this year not yet set by Commissioner.

Opiate Clients in Treatment

	Annual Target	New in June 2020	New in May 2020	Quarter 1, 2020/21	Year to Date, June 2020
Receiving Specialist Prescribing	2,450	62	55	186	1,998
Receiving Formal PSI	670	38	22	88	185

Service comment:
The Opiates Service delivers specialist prescribing (i.e. substitute prescribing) to Opiate users in Sheffield. With the carry over of clients in treatment at the start of the new financial year (2020/21) as well as new presentations as of end of June 2020, the Opiates service has engaged 1,998 people into prescribing treatment. Please note the target of 2,450 is 2019/20's target; new target not yet set by Commissioner.

The annual target to deliver Psycho-Social Interventions to 670 clients, comprises of standard-intensity and high-intensity work: 600 clients to receive standard-intensity PSI and 70 clients to receive high-intensity PSI. Although the offer of PSI treatment, including over the telephone, is made appropriately, uptake rates have been poor, although improving. 38 clients have started PSI in June 2020 and 97

Non-Opiate Clients in Treatment

	Annual Target	New in June 2020	New in May 2020	Quarter 1, 2020/21	Year to Date, June 2020
Receiving Formal PSI	400	20	10	53	129
Engagement with Tier 2 Treatment	400	40	25	86	86

Service comment:
The Non Opiates service offers Tr2 and Tr3 structured support. With 76 client carried from last year, at the end of June 2020, the service has engaged 129 service users in formal PSI treatment.

86 clients have accessed Tr2 support as of end of June 2020. This is low intensity support delivered by a drug worker. If a client requires additional formal PSI, they are transferred into the care of a PSI worker.

Please note targets are for 2019/20; targets for this year not yet set by Commissioner.

Alcohol Clients in Treatment

Clients in Treatment	Annual Target	New in June 2020	New in May 2020	Quarter 1, 2020/21	Year to Date, June 2020
Receiving Specialist Prescribing	780	46	13	86	244
Receiving Formal PSI	533	42	40	131	262

Service comment:
244 clients in the Alcohol Service are in receipt of specialist prescribing. This includes 158 clients who started their treatment pre 1st April 2020 (i.e. in 19/20).

As of end of June 2020, 262 clients have received formal PSI interventions. This includes 131 clients who started PSI pre- 1st April 2020.

Waiting Times in the Opiates Service

Waiting Time Standards	Target	New in June 2020	New in May 2020	Quarter 1, 2020/21	Year to Date, June 2020
Referral to booked assessment ≤7 days	monitoring only	100%	100%	100%	99.6%
Assessment to start of Tr3 treatment ≤ 21 days	≥95%	100%	100%	100%	100.0%

Service comment:
No breaches to waiting time standards

Waiting Times in Non-Opiates Service

Waiting Time Standards	Target	New in June 2020	New in May 2020	Quarter 1, 2020/21	Year to Date, June 2020
Referral to booked assessment ≤7 days	monitoring only	98%	100%	99%	99.2%
Assessment to start of Tr3 treatment ≤ 21 days	≥95%	100%	93%	98%	98.4%

Service comment:
One service user waited longer than 7 days from referral to assessment.

Waiting Times in the Alcohol Service

Waiting Time Standards	Target	New in June 2020	New in May 2020	Quarter 1, 2020/21	Year to Date, June 2020
Referral to booked assessment ≤7 days	100%	100%	100%	100%	100%
Assessment to start of Tr3 treatment ≤ 21 days	≥95%	100%	100%	100%	100%

Service comment:
No breach to waiting time standards.

Tier 4 Treatment for Opiate Clients

In Patient Detox & Residential Rehab	Target	Year to Date June 2020
Inpatient detox Successful Completions %	monitoring only	75%
Opiate clients currently undergoing a detox (end of June 20)	-	0
Residential Rehab Placement Successful Completions %	monitoring only	0%
Opiate Clients currently in Residential Rehabilitation (end of June 20)	-	2

Service comment:
Residential Rehabiliation Placements are typically funded for 26 weeks. Given the length of the placement, the number of clients exiting each month is small. For this reason, an aggregate Year to Date Position is provided.

Needle Exchange Provision, Juice Clinics and IPS-AD

Needle Exchange and Juice clinic	Annual Target	Year to Date June 2020
Unique needle exchange users seen	400	40
Unique clients accessing Juice clinic YTD (qtrly)		-
IPS trial enrolments (since May 2018)		231

Service comment:
Needle exchange provision via Sidney Street site and mobile exchange van. The needle exchange at Sidney Street is well established and receives many repeat visitors. This provision has continued during the COVID-19 pandemic, although presentations have been lower than usual.
Juice clinic, which can be used to access support for use of Image and Performance Enhancing Drugs has not been running during April 2020 due to COVID-19. IPS-AD trial has been running since May 2018, and ceased to take referrals in September 2019.The trial enrolled

Tier 4 Treatment for Alcohol Clients

In Patient Detox & Residential Rehab	Target	Year to Date May 2020
Inpatient detox Successful Completions %	73%	0%
Alcohol clients currently undergoing a detox (end of June 20)	-	1
Residential Rehab Placement Successful Completions %	62%	0%
Alcohol Clients currently in Residential Rehabilitation (end of June 20)	-	1

Service comment:
Residential Rehabiliation Placements are typically funded for 26 weeks. Given the length of the placement, the number of clients exiting each month is small. For this reason, an aggregate Year to Date Position is provided.
Targets for 20/21 not yet set by Commissioner.

Public Health Outcomes Framework Indicator C19a

Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months

Baseline period: Completion 01/10/2017 to 30/09/2018, Representations up to: 31/03/2019

Latest period: Completion period: 01/10/2018 to 30/09/2019, representations up to: 31/03/2020

(n) = number successfully completed and did not re-present/all in treatment

	Baseline Period		Latest Period - Q4 2019/20	
	(%)	(n)	(%)	(n)
Sheffield Opiate	2.9%	65/2233	3.0%	67/2203
National Opiate	6.0%		5.7%	

Service comment:
The service is working to improve the levels of clients who complete treatment and do not re-present
The Opiates Service is open access, has high levels of engagement, allowing clients to re-access treatment quickly.

Public Health Outcomes Framework Indicator C19b

Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months

Baseline period: Completion 01/10/2017 to 30/09/2018, Representations up to: 31/03/2019

Latest period: Completion period: 01/10/2018 to 30/09/2019, representations up to: 31/03/2020

(n) = number successfully completed and did not re-present/all in treatment

	Baseline Period		Latest Period - Q4 2019/20	
	(%)	(n)	(%)	(n)
Sheffield Non-Opiate	28.0%	114/400	30.2%	122/404
National Non-Opiate	35.2%		34.2%	

Service comment:
The service has seen an improvement on this PHOF target when compared to it's baseline period. The service is working to improve the levels of clients who complete treatment and do not re-present
The Non-Opiates Service is open access, has high levels of engagement, allowing clients to re-access treatment quickly.

Public Health Outcomes Framework Indicator C19c

Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months

Baseline period: Completion 01/10/2017 to 30/09/2018, Representations up to: 31/03/2019

Latest period: Completion period: 01/10/2018 to 30/09/2019, representations up to: 31/03/2020

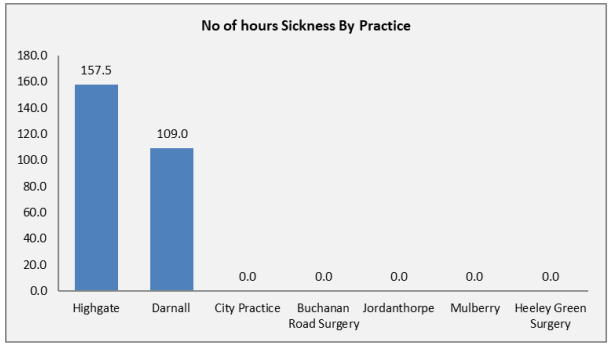
(n) = number successfully completed and did not re-present/all in treatment

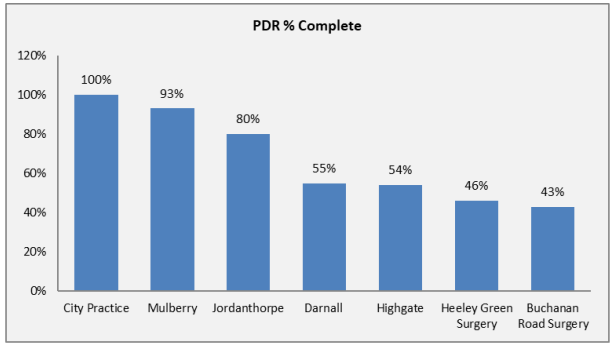
	Baseline Period		Latest Period - Q4 2019/20	
	(%)	(n)	(%)	(n)
Sheffield Alcohol	26.9%	191/710	29.4%	224/762
National Alcohol	37.8%		37.9%	

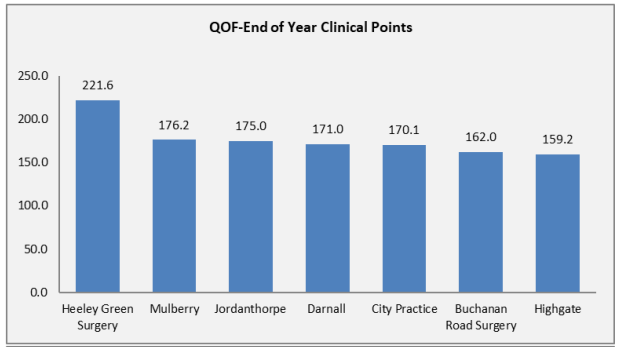
Service comment:
The service has seen a 2.5% increase on this PHOF target when compared to it's baseline period. The service is working to improve the levels of clients who complete treatment and do not re-present
The Alcohol Service is open access, has high levels of engagement, allowing clients to re-access treatment quickly.

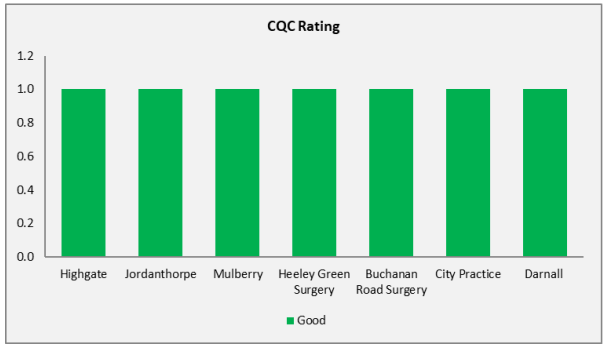
start
Sheffield Treatment and Recovery Team

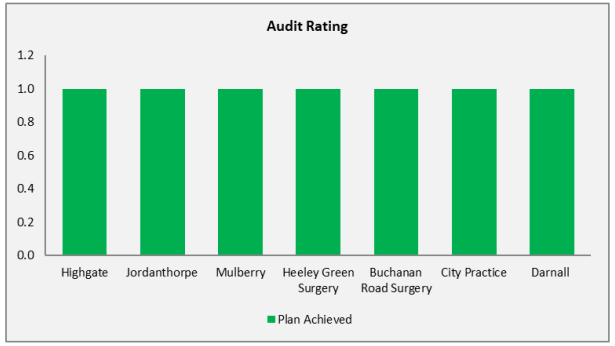
Clover Group & Primary Care Practice Dashboard – June 2020

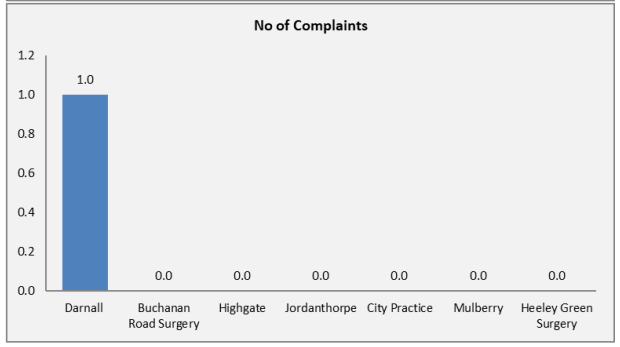


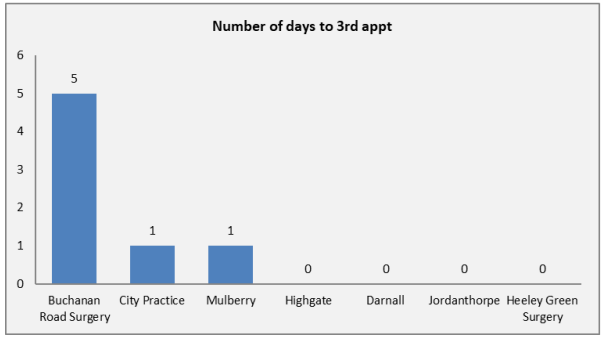


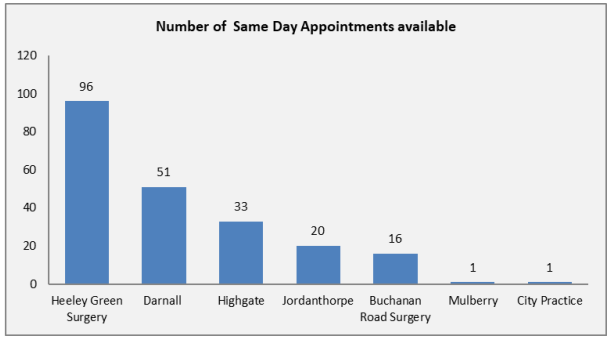


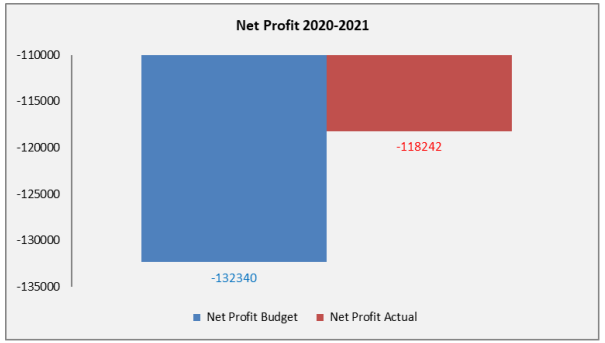


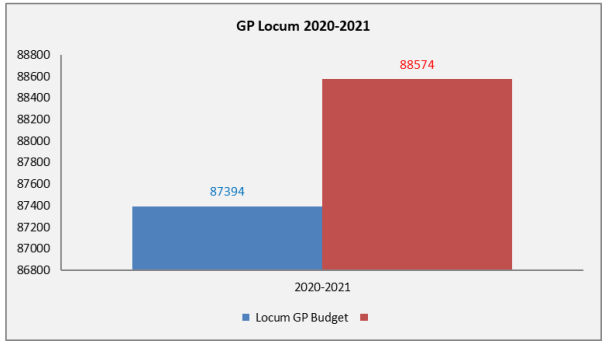












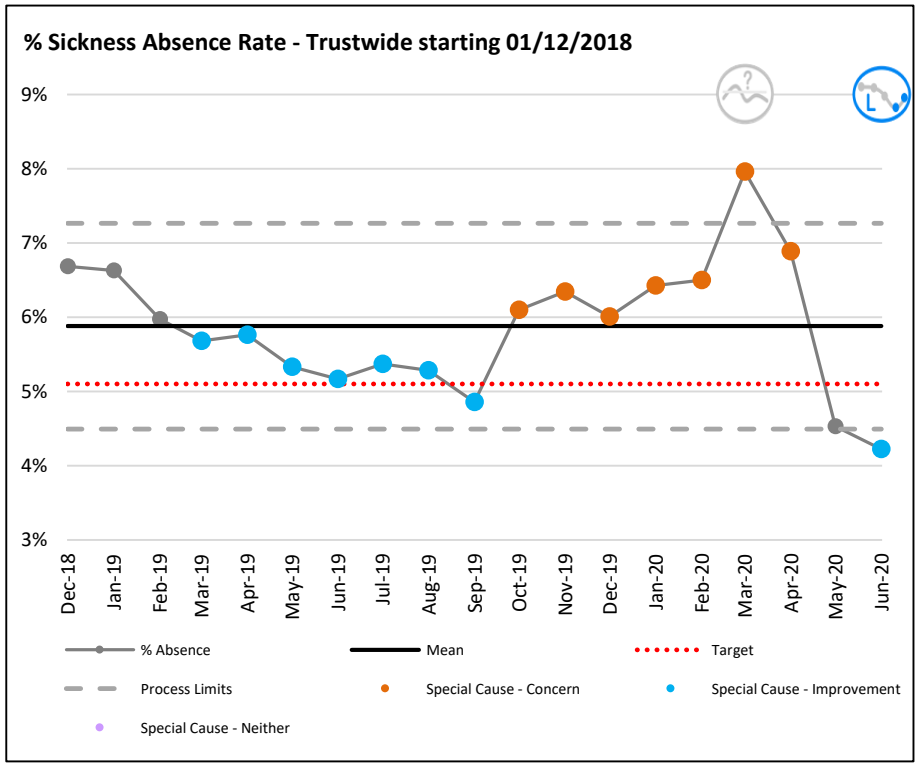
Finance Data is always one month in Arrears . This is due to reporting lags within finance.

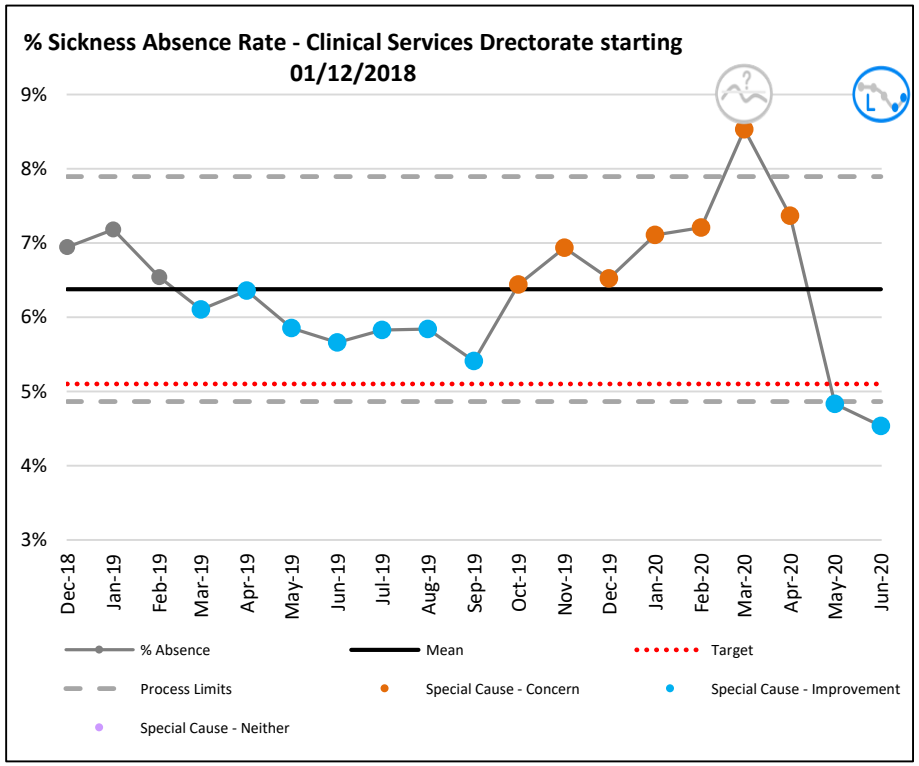
Workforce 1 | Summary - June 2020

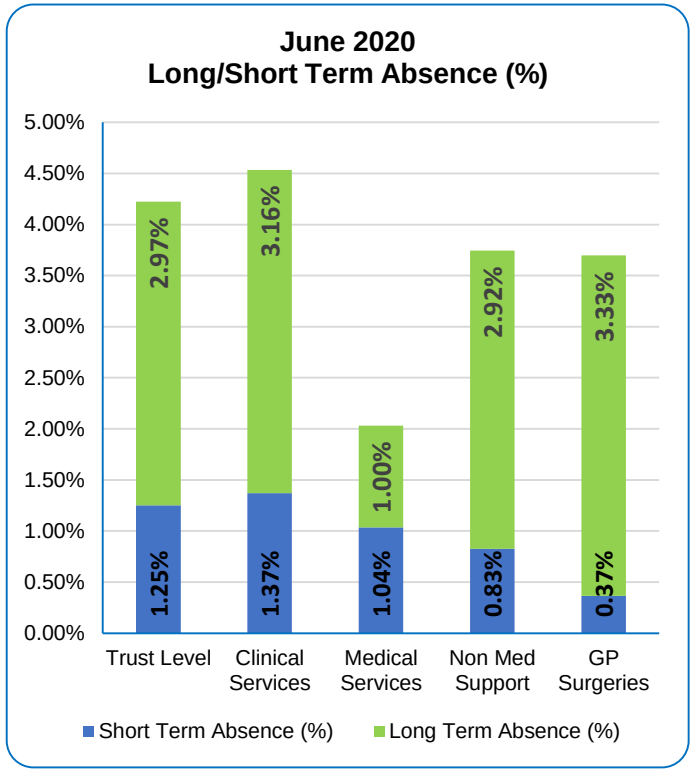
		Directorates				Trust Total		
Indicator	**Target**	**Clinical Services**	**Medical**	**Non Med Support**	**GP Surgeries**	**May-20**	**Jun-20**	**Change**
Staff in Post (Headcount)	**-**	1997	180	314	75	**2555**	**2566**	**+11**
Vacancy (%)		7.1%	6.8%	2.8%	0.0%	**8.9%**	**6.4%**	**-2.5%**
Turnover (%)	**10%**	9%	12%	12%	9%	**11%**	**11%**	**-0.6%**
Sickness In Month (%)	**5.10%**	4.53%	2.03%	3.75%	3.70%	**4.53%**	**4.22%**	**-0.3%**
Sickness 12 Month (%)	**5.10%**	6.38%	2.82%	3.80%	8.84%	**6.01%**	**5.88%**	**-0.1%**
Long Term Sickness (%)	**-**	3.16%	1.00%	2.92%	3.33%	**3.28%**	**2.97%**	**-0.3%**
Short Term Sickness (%)	**-**	1.37%	1.04%	0.83%	0.37%	**1.25%**	**1.25%**	**+0.0%**
PDR Compliance (%)	**90%**	97.1%	96.8%	95.4%	94.1%	**96.1%**	**96.8%**	**+0.7%**
Training Compliance (%)	**80%**	93.6%	90.1%	91.1%	71.2%	**91.2%**	**96.8%**	**+5.5%**

Notes:
- Medical turnover excludes fixed term rotations.
- Vacancy based on establishment (FTE) data compared with staff in post (FTE) figures.

Workforce 2 | Sickness Absence







Narrative

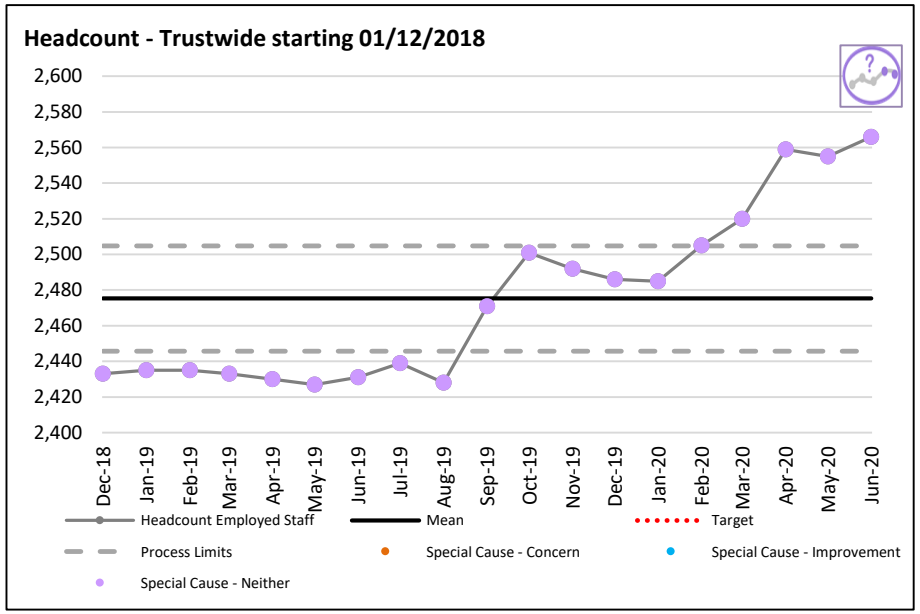
Overall

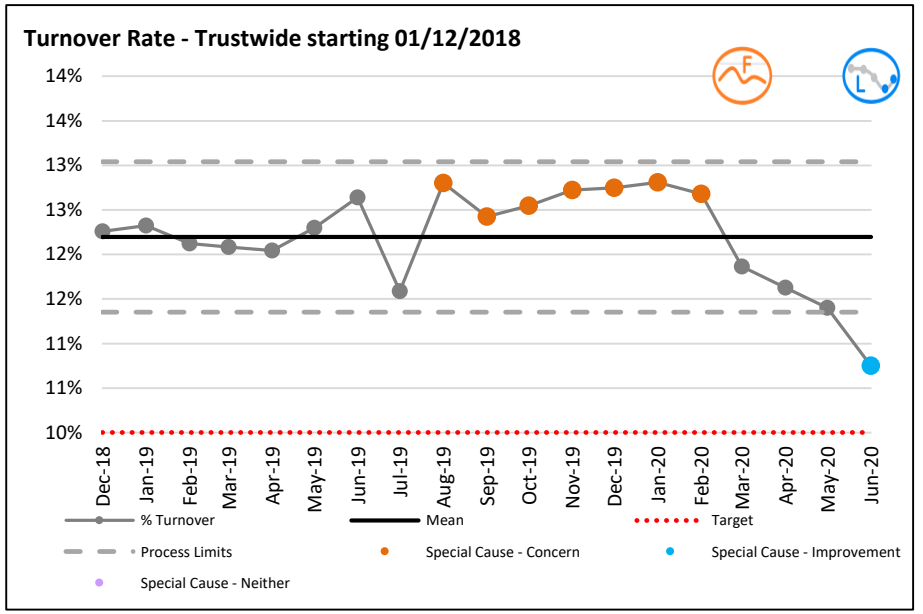
Sickness absence continues to fall both in month and over 12 months.
This reduction may be impacted by the number of staff Shielding until 31st July 2020

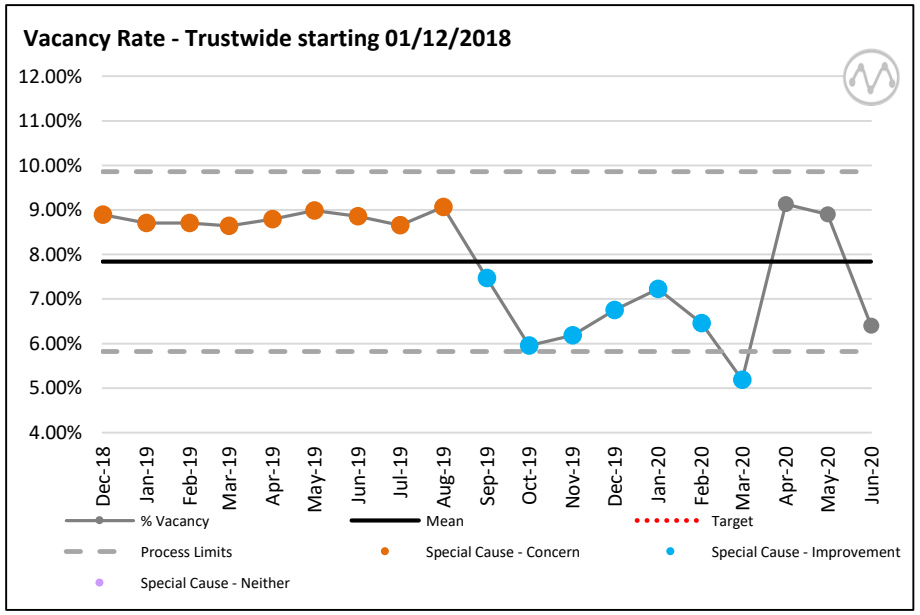
Long/Short Term Absence

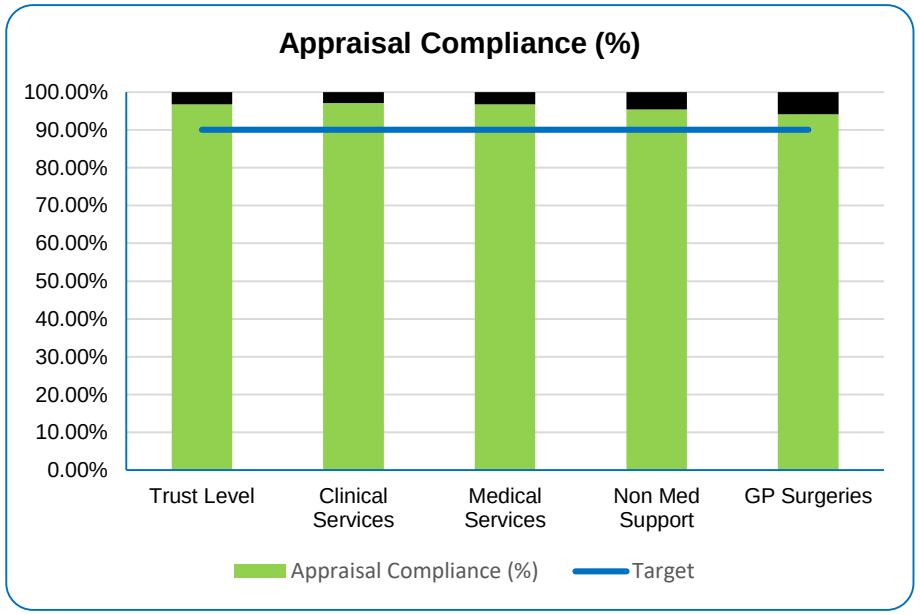
Long and short term absence trends remain static with no significant variation from May to June.

Workforce 3 | Staffing & Appraisal









Narrative

Headcount
Headcount has increased slightly in June. There have been 27 new starters in June including second year student nurses.

Turnover Rate
Turnover remains above the target of 10% However, Turnover is the lowest it has been in the last 12 months.
The data continues to suggest a downward trend that needs to be monitored over the coming months.

Vacancy Rate
Vacancy rate has significantly reduced in June compared to May.
Investigations are underway with Finance colleagues to ascertain the reason behind the decrease.

Appraisal Compliance
Appraisal compliance remains above target in all areas

Notes

- *Medical turnover excludes fixed term rotations.*
- *Vacancy based on establishment (FTE) data compared with staff in post (FTE) figures.*

Financial Overview as at 30 June 2020

Key Ratios

Due to the COVID-19 pandemic NHSI/E have provided guidance that all Trusts should show an "Adjusted financial performance surplus/(deficit)" figure of breakeven.

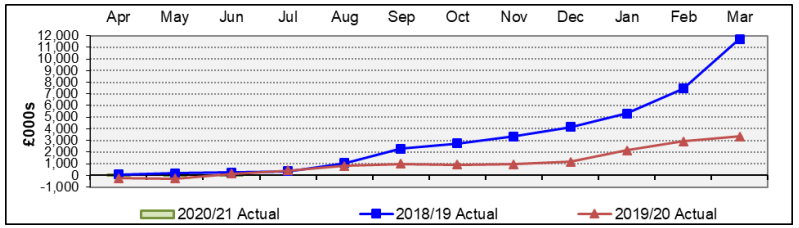
This is achieved by :-

- The Trust recovering all costs associated as related to Covid-19 and a
- Subsequent top up to recover additional income to offset any remaining pressures following the block arrangement and payments.

Income and Expenditure £000s

Position to date	Plan	Achieved	Variance	
I&E Surplus/(Deficit)	0	0	0	Green
EBITDA	588	1,089	501	Green
	Under-Spend	Under-Spend	Under-Spend	
Forecast (April - July)	**Plan**	**Achieved**	**Variance**	
I&E Surplus/(Deficit)	4	4	0	Green
EBITDA	1,180	1,180	0	Green
	Under-Spend	Under-Spend	Under-Spend	

Control Total	YTD	FYE
Surplus/(deficit) for the period/year	0	
Adjusted financial performance surplus/(deficit)	0	
Control total		
Performance against control total		
Top-Up Funding included	**3,146**	
Relating to COVID-19	1,354	
Subsequent top up to offset remaining presures	1,792	



Payment of Suppliers (New Standard)

	Trade	NHS	Target	
BPPC (YTD by number)	98.62%	100.00%	95.00%	Green
BPPC (YTD by value)	99.01%	100.00%	95.00%	Green

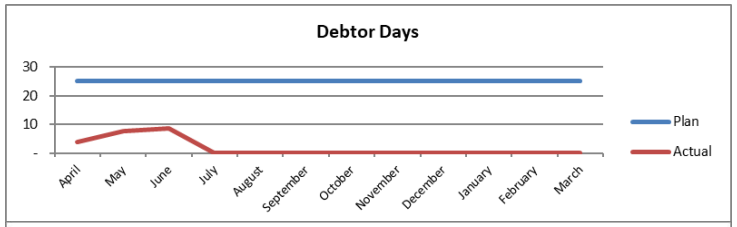
Trade Creditor Days for June are 5.35 days.

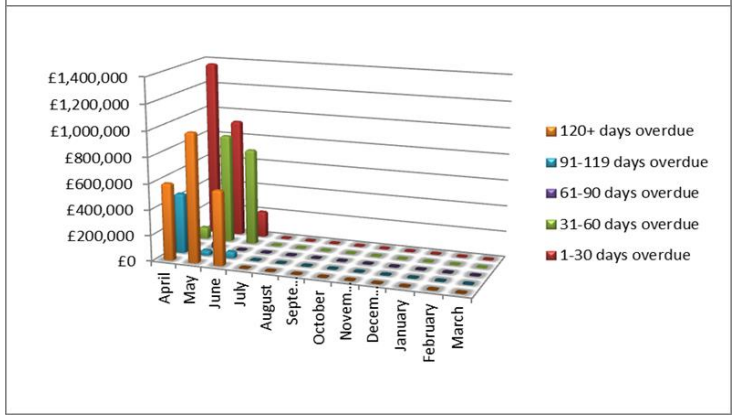
Better Payment Policy Compliance (>95%=Green;>90%<95%=Amber;<90%=Red

Income Received Within Planned Days

	Plan Target Number of Days	Actual to Date Number of Days	
Total debtor days	25	9	Green
Debtor days (incl. accruals)	37	17	Green

See Appendix 8 for an outline of the main six debtors of the Trust.





Cash Current Month £000s

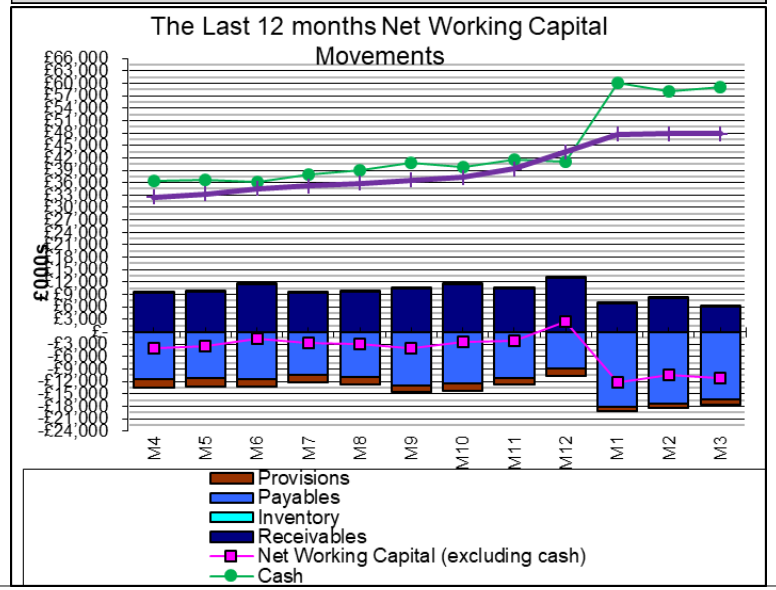
(See Appendix 7 & 7A)

	Plan	Actual	Variance	Flag - 15%
Cash balance	51,531	59,100	7,569	Green
Away from plan "Red" but +ive position "Green"			14.69%	Green

Cash Monitoring Variance (<0.85%=Red;<0.95%=Amber; Within 5%=Green)

The positive Cash variance to plan is due to the interim financial arrangement from the DoHSC, w here Providers have received payments in advance of contracts for June 2020. This is expected to be normalised from August 2020

Net Working Capital



At the end of June 2020 the Trust reports a positive cash variance to plan. This is mainly due to the impact of the DoHSC financial arrangements in response to the on-going pandemic. Providers like SHSC are on receipt of cash advances in relation to block contract payments for July 2020. However net working capital excluding cash compared to plan is positive, this is due to the balance between assets and liabilities, which again is a result of the temporary financial arrangement. Receivables is reporting positive movements as this is normalised in relation to cash and payables items by £3m. Noting that within the Receivables balances there is still a legacy of aged debts which resolution is expected before the end of Q2 2020/21. At present the Trust enjoys a healthy cash balance which will be reinvested in Capital and Revenue projects to improve the services provided by SHSC over the next 5 years.

Financial Overview as at 30 June 2020

2020/21 Cost Improvement Programme

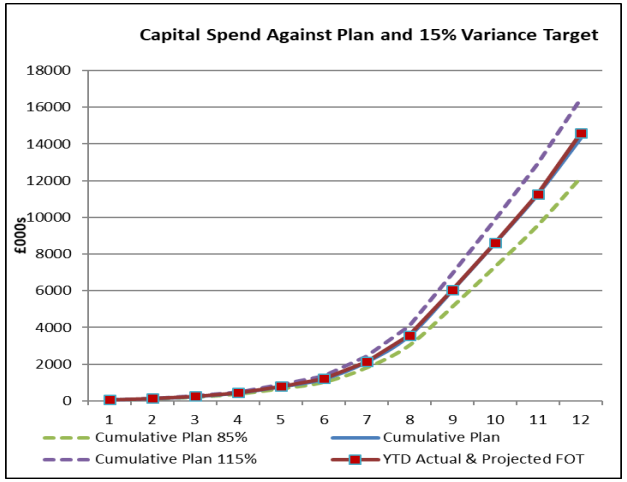
(see appendix 4A)

As at M03 2020/21	Total 2020/21 Target £'000s	Scheme Status: Unidentified £'000s	Opportunity £'000s	Plans in progress £'000s	Plan Identified £'000s	Total £'000s
CIPS						
Clinical Directorates	1,979	1,773	0	76	130	1,979
Medical	102	62	0	0	40	102
Chair/Chief Exec Office	42	6	0	0	36	42
Nursing & Professions	17	17	0	0	0	17
Human Resources	95	89	0	0	6	95
Finance	419	182	0	0	237	419
Reserves	14	0	0	0	14	14
Total	**2,668**	**2,129**	**0**	**76**	**463**	**2,668**
Delivery as a %of Target		80	0	3	17	100

Includes B/F from 1920 IMST £136k and HR £25k / Full year reduced by CCG suspension M1-4 (£312k)

Capital Spend £000s

Capital Position to Date	Plan	Actual	Variance	
In-month spend	114	109	(5)	Green
Cumulative spend	226	252	26	Green
Capital expenditure is <85% or >115% of plan for year to date				Amber
Capital Forecast Outturn	**Plan**	**Actual**	**Variance**	
Cumulative spend	14,558	14,558	0	Green
Capital expenditure is <85% or >115% of plan for year to date				Green



Key Ratios

Whilst not formally tracked or relevant during the COVID 19 pandemic, there is an expectation that the trust will continue with a risk rate of 1 against all metrics with the exception of agency spend, which will be a 2.

Income and Expenditure

The reported position at M03 is a deficit of £9k, which allows, after the reinstatement of the donated assets the Trust to show a breakeven position. This is further explained within the Confidential Finance Report to be received under separate cover.

Cost Improvement Programme

As with the general theme CIPs for the NHS will neither be implemented nor expected between M1-M4 for all CCG commissioned services. The impact of this is further explained within the Confidential Finance Report, however, it must be noted that only the tariff based element of CIPs based on via CCG contracts is no longer required for M1- M4, CIPs driven by inflation pressures, Capital Investments and revenue investment internal decisions still stand.

Capital Programme

The on-going review of the Capital programme 2020/21 identified 27% of capital reduction from anticipated slippages and low priority schemes. The current plan is deemed achievable; however, the risk exists in relation to the covid-19 pandemic affecting the construction industry and the supply chain. Therefore, the current plan is under constant scrutiny while some tenders are being finalised to assess their impact in relation to allocated budgets for financial year 2020/21.

The main capital schemes this FY are still the overall Leaving Fulwood Project including the Data Centre relocation, ACM II and Insight II. There are also the urgent investments as a result of the CQC report which the Trust is in the process to resolve providing the conditions are met in terms of the availability of labour and its related supply chain.

Overall the Trust must ensure it stays within its revised five years capital programme of £58.8m to afford cash and revenue implications in the coming years. This will be monitored closely in conjunction with Business Managers.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Contact

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Proud to care in Sheffield

SPC Explained

Sheffield Health and Social Care NHS Foundation Trust

- 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
- ***Please note that all the SPC charts in this report are created without a baseline, unless otherwise indicated. This means that the process limits are set using the 24 months data that is displayed in the charts. This decision has been taken on advice from NHS Improvement in May 2020.***

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SPC 'the SHSC way' Icon Guide

Sheffield Health and Social Care NHS Foundation Trust

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.

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SPC ‘the SHSC way’ Icon Guide

Sheffield Health and Social Care NHS Foundation Trust

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.

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