Sheffield Health and Social Care NHS Foundation Trust

Board of Directors – Open

Date: 13 January 2021 **Item Ref:** 10

TITLE OF PAPER	**Integrated Quality & Performance Report**
TO BE PRESENTED BY	Beverley Murphy & Phillip Easthope, Executive Directors
ACTION REQUIRED	For the Board to: • Receive and note the monthly performance report for the period ending October 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 and BAF0003 Patient Safety.

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 and subject to deliberation at Board agree that: • BAF0002 - the development of the performance report goes some way to improve the information at board level but is not 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 etc continue to be a concern.
TIMETABLE FOR DECISION	The Board should note the reporting position at the January 2021 meeting.
LINKS TO OTHER KEY REPORTS / DECISIONS	• IPQR report to the Quality Assurance Committee 21.12.20 • IPQR report to the Finance & Performance Committee 30.12.20 • Electronic Patient Record Procurement Update to Board 09.12.20 • Electronic Patient Record Procurement Update to Finance & Performance Committee 30.11.20
LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	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 & FINANCIAL IMPACT	Nil
CONSIDERATION OF LEGAL ISSUES	None highlighted

Author of Report	Beverley Murphy & Phillip Easthope
Designation	Executive Directors
Date of Report	6 January 2021

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Integrated Quality & Performance Report

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
	✓					

The purpose of this summary report is to assure the Board that the data within the Integrated Quality and Performance report has been fully considered and actions are underway to mitigate the risks to quality and performance that may impact the delivery of our getting back to good objective and in relation to the contents of the BAF specifically BAF0002 Well Led and BAF0003 Patient Safety.

2. Summary

The IQPR is a monthly report that presents a full and detailed data set that is used to assure the Board about the performance and quality of service delivery. The December report details data up to and including October 2020.

The report was presented and considered in detail to the Quality Assurance Committee 21.12.20 and to the Finance & Performance Committee on 30.12.20. The Board can be assured that the report has been fully considered and that further assurances have been sought where risks and mitigations warrant further detail.

The following quality and performance risks were considered in detail:

- Continued challenges with recovery rates in IAPT.
- Quality challenges in the Acute Ward Environments including the seclusion rooms breaching in the code of practice, the risk to safety presented by ligature anchor points and the overall poor fabric of the wards.
- Continued challenges with bed occupancy which will be further impacted by planned work to improve the estate.
- Restrictive Practice in the in-patient settings and specific risks associated with using transport providers who have used mechanical restraint (handcuffs).
- Waiting times for community services.
- The impact of Covid on mandatory training compliance.
- The instability of the Electronic Patient Record (EPR) System.
- Potential gaps in learning from incidents.
- Short term risks of changes in senior leadership.
- £2.1m deficit forecast out turn financial year 20-21.

Detail was also given about the catastrophic incidents reported in month, the 11 incidents all related to deaths of people using services, of which 7 were natural cause deaths, 2 are subject to a serious incident investigation and 2 were being considered by HM Coroner.

<u>Mitigations and assurances</u>
The reduction in IAPT recovery rates is consistent with the national picture and understood to be related to Covid. A plan is in place to bring about improvement which is having a good impact.

The Quality Assurance Committee has requested a detailed review of the the delays in the estates programme, additional leadership has been secured to ensure the plan is clear, can be delivered and good governance is in place.

A financial recovery plan is in development for presentation to the Finance & Performance Committee January 2021, which includes plans to reduce unwarranted agency usage and inappropriate out-of-area bed use. The aim is to close the deficit gap. Improvements leadership capacity in quarter 4 will address the origin of the issues. Additionally, work is also underway to achieve financial support from commissioners during the period that beds will reduce, to enable improvements in estates.

The learning from 'Out of Sight' as the basis for a refreshed approach to reducing restrictive practice will be presented to the Quality Assurance Committee February 2021 and is being led by the Director of Quality.

Gaps in mandatory training are understood and their consistent oversight of the potential impact. The immediate risk is mitigated daily by deploying staff to ensure minimum standards are met, whilst longer term access to training has been improved.

A detailed report on waiting times is due to the Quality Assurance Committee January 2021, the report details a range of services with improvement actions detailed.

The Board and Finance & Performance Committee received detailed reports on the Electronic Patient Record (EPR) in November and December 2020 which explained the risks and mitigations.

The new Director of Quality is reviewing the structure, system and process of the Quality Directorate, to ensure it supports quality governance, including Trust-wide learning from incidents. In the interim the Trust-wide learning lessons events will recommence with the first in quarter 4 for 20-21.

The monthly clinical directorate quality and performance reviews chaired by the Director of Nursing, Professions and Operations are booked to commence January 2021. The reviews will ensure consistent oversight of performance.

3 Next Steps

Recovery plans and detailed reports to be presented to Quality Assurance Committee and Finance & Performance Committee as detailed above.

Implementation of Clinical Directorate quality and performance reviews.

Implementation of Directorate Performance Reviews – being scheduled in diaries from February 2021.

4 Required Actions

For the Board to:

- Receive and note the monthly performance report for the period ending October 2020

Consider how the information in the report impacts on the assurance levels regarding delivery of our getting back to good objective and in relation to the contents of the BAF, specifically BAF0002 Well Led and BAF0003 Patient Safety.

5 Monitoring Arrangements

Through regular receipt and consideration at the Quality Assurance Committee; Finance & Performance Committee and Board of Directors.

6 Contact Details

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Board of Directors Integrated Performance & Quality Report

December 2020

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Revised Format – Version 2

Including information to October 2020

Go To (Click to link)

Highlights & Exceptions | October 2020

Highlights

IAPT Access & Waiting Times
Service meeting recovery trajectory access target of 1000 in October.
Both the 6 and 18 week wait to treatment start times continue to consistently exceed the national targets and this has been maintained throughout the pandemic to date.

CPA Reviews
The Trust % for October 2020 is 83%, showing continuous improvement since April 20 and at its highest level since April 2019.

Early Intervention – Access & Waiting Time (AWT) Standard
The service continues to exceed the 53% 2 week AWT target, with October at 69% and the current mean at 74%.

7 day follow up
The 7 day follow up target ensures that patients discharged from inpatient wards are followed by community services no longer than 7 days after their discharge. This was 100% in August, September and October 2020.

Out of Area Placements – PICU
There were no admissions to out of area PICU beds in October, despite available beds for admission being capped at 8 throughout October.

Older Adult ward Length of Stay
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 was due to one long stay (674 days) individual being discharged in June. The knock on effect in the rolling 12 month LoS figure will continue, however the reduction is beginning to show and figures in September and October are now back within range.

Highlights

Service User Feedback
- We asked patients on Burbage Ward for new activity suggestions. Table tennis was suggested, which we have now introduced.
- Dovedale patients told us the TV controller was confusing. We have developed pictorial instructions which have been positively received.
- Stanage Ward asked for more international food choices. We have enabled this through OT cooking sessions.
- Maple Ward patients wanted more medicines advice. We have set up pharmacist drop-in sessions to facilitate this.
- Endcliffe patients said the ward was noisy and stressful. Radios and headphones have been procured to assist relaxation.
- Forest Lodge patients said food was often cold due to delays in receiving utensils. Cutlery is now provided before food is served.

Sheffield Treatment & Recovery Team (START)
Continued excellent performance on access to services with the average wait time from referral to assessment in all 3 services currently under 3 days.
The inclusion of a recovery rate metric is presented here for the first time, and indicates improving rates of ‘positive discharges’ in the Non-Opiate & Alcohol Services. The service will continue to develop how it measures this, and to understand actions that have led to the apparent improvements.

Flu Vaccination
As at 29/11/20, performance for all staff, frontline and non-frontline staff is ahead of stepped target of 85% in the first 8 weeks of the campaign.

Highlights & Exceptions | October 2020

Exceptions

Beds and Admissions
Numbers of admissions and those detained on admission have remained stable over recent period, but there have been fewer beds in the system to admit to and we see a concurrent increase in admissions out of area.
It should be noted that a number of beds have been closed through the system over the last few months for the following reasons:

- Enabling patients to isolate in the case of Covid outbreaks on the ward
- Maintaining a safe environment in times of significant staff shortages
- Refurbishment work being undertaken to eliminate dormitories

Adult Acute Wards
As at September 20 the system was operating with 6 fewer beds in the adult acute system, having lost 2 flex beds from Maple, Stanage and Burbage in April due to Covid and the need to minimise dormitory use to enable distancing and isolation. A further 2 beds were lost on Burbage in September, but 2 became available on Maple as works were completed.

Length of Stay
The average length of stay for service users on our adult acute wards has seen a gradual increase over the last months and is currently still breaching upper control limits. It should be noted that the Live length of stay has been reducing since April. A number of long stay patients on our acute wards have been successfully discharged over the last 6 months, which is bringing the live length of stay down, but has led to the gradual increase in discharged length of stay over the same period. PICU length of stay has increased in part due to the inability to step patients down to the acute wards as the number of beds has reduced.

Out of Area Placements
There were 10 out of area placements made for adult acute beds in October 2020. There have been an unusual number of admissions to out of area beds for older adults since April 2020, including 1 in October 2020; a direct impact of Covid, outbreaks on the older adult wards and dormitory work.
Work continues to avoid future out of area admissions and progress safe repatriation. This is monitored daily through Bronze command, and numbers out of area for all reasons are reported weekly to regional NHSE colleagues who are monitoring the situation regionally and nationally.

Exceptions

Restrictive Practice - Mechanical Restraint
There were two reported incidents of mechanical restraint recorded in October 2020, the details of which are being closely looked at as both cases related to patients being transferred into SHSC from other providers. The Director of Nursing and Medical Director will be able to give further details in December Board.

Mandatory Training
Subjects Below 80%
6 Subjects are below 80%, which are ILS, Mental Health Act, Respect Level 2 and 3, Safeguarding Children Level 3 and Moving and Handling Level 2. 3 of the 6 subjects (Mental Health Act, Moving and Handling, Safeguarding Children will be over 80% by the end of December. There are ongoing challenges with ILS and both levels of Respect training which will take longer to stabilise due to the impact of a 6 month postponement of face to face delivery; trainer and staff Covid related absence; and reduced numbers to maintain safety.

Waiting Times
Service user feedback through friends and family test has indicated concern around long waits for services, as well as our own identified concerns around services with long waits.
The Director of Nursing, Professions and Operations has requested a report on waiting times across the Trust to understand barriers and challenges before solutions to minimise long waits for services can be worked up. This report will be presented to January's Quality Committee. All the services identified in this report with long waits use a range of mitigating actions to try and address the impact of waits on individuals, including re-triaging; keeping in contact with people on waiting lists, offer of peer support and preparation groups (Gender Identity Service).

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	OCT 2020	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	COMMENTS	KPI Assurance
SAFE								
Adult Acute inpatient occupancy levels (KH03)*	Monthly	95%	93%				See Acute Inpatient detail. This figure excludes leave and Out of Area placements.	✓
Functional Illness (Dovedale) occupancy levels (KH03)*	Monthly	95%	86%				See Older Adult Inpatient detail. This figure excludes leave and Out of Area placements.	✓
Dementia Management (G1) occupancy levels (KH03)*	Monthly	95%	86%				See Older Adult Inpatient detail. This figure excludes leave and Out of Area placements.	✓
Sickness absence	Monthly	5.10%	~				See Workforce Detail	?
Turnover	Monthly	10.0%	~				See Workforce Detail	?

***Bed Occupancy**

KH03 bed occupancy is defined as the number of patients present overnight in the number of beds available, excluding patients on leave. The number of beds available is, as a minimum, the number of commissioned beds, plus any additional beds used on a day to day basis. Please note that for the purposes of the figures provided above the commissioned bed numbers are 54 (Adult Acute), 18 (Dovedale) and 16 (G1). There has been a number of temporary changes to bed numbers since March, relating to Covid 19, dormitory work/refurbishment and safer staffing numbers. The reductions per ward/bed type are shown to the right.

20/21 (By Month)	Adult Acute	Maple	Stanage	Burbage	Flex Beds	Sub Misuse (Burbage)	ALL Acute Adult Beds
Mar-20	*49*	*17*	*18*	*14*	*6*	*5*	***60***
Apr-20	49	17	18	14	0	**5**	**54**
May-20	49	17	18	14	0	**5**	**54**
Jun-20	49	17	18	14	0	**5**	**54**
Jul-20	49	17	18	14	0	**5**	**54**
Aug-20	49	17	18	14	0	**5**	**54**
Sep-20	49	19	18	12	0	**5**	**54**

20/21 (By Month)	G1	Dovedale	Older Adult (all types)
Mar-20	*16*	*18*	*34*
Apr-20	16	18	34
May-20	16	15	31
Jun-20	16	15	31
Jul-20	14	15	29
Aug-20	14	15	29
Sep-20	14	15	29

20/21 (By Month)	Section 136 (Maple)	PICU
Mar-20	*2*	*10*
Apr-20	**2**	**10**
May-20	**2**	**10**
Jun-20	**2**	**10**
Jul-20	**2**	**10**
Aug-20	**2**	**8**
Sep-20	**2**	**8**

Overview | Summary KPIs 2

Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	OCT 2020	SPC VARIATION/ TREND ICON	SPC ASSURANCE ICON	Comments	KPI Assurance
RESPONSIVE								
Access to Home Treatment	Monthly	100	N/A	**114**			Numbers in to Home Treatment service. Old target - needs review.	?
Out of area acute admissions	Monthly	0	N/A	**11**			See Bed Occupancy Detail	?
Out of area PICU admissions	Monthly	0	N/A	**0**			See Bed Occupancy Detail	?
7 Day follow up following discharge - people on CPA	Monthly	95.00%	93.00%	**100%**			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	**68.75%**			EIP exceeding target for consecutive 24 months.	?
Access to IAPT - new clients entering treatment	Monthly	1000	N/A	**1072**			See IAPT Detail. Note reduced target in place until January 2021 when it will revert back to 1232.	?
Waiting Time Standard IAPT - % entering treatment in 6 weeks	Monthly	75.00%	N/A	**92.84%**			See IAPT Detail	?
Waiting Time Standard IAPT - % entering treatment in 18 weeks	Monthly	95.00%	N/A	**99.11%**			See IAPT Detail	?
IAPT Moving to Recovery Rates	Monthly	50.00%	N/A	**43.32%**			See IAPT Detail	?

Overview | Summary KPIs 3

Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	OCT 2020	SPC VARIATION/ TREND ICON	SPC ASSURANCE ICON	COMMENTS	KPI Assurance
EFFECTIVE								
Gatekeeping - Acute admissions assessed for HT	Monthly	95.00%	N/A	**88.37%**			Figure relates to 5 individuals reported as not gatekept by Home Treatment. One was repatriation from out of area PICU to Endcliffe. All admissions were appropriately gatekept by other services.	?
CPA - % with an Annual Review	Monthly	95.00%	N/A	**83.01%**			See CPA Review Detail	?
WELL-LED								
Data Quality - Client Outcome indicators x 3	Quarterly	50.00%	N/A	**34.20%**			Data available until end September 20 only. This is MHSDS reported data always a month behind. Significant drop below lower control limit in May/June 2020. Investigation with Information Dept. ongoing. There was a change in reporting system in April - current assumption is this is a data quality issue rather than a clinical issue.	?
Data Quality - Client Identifier indicators x 6	Quarterly	50.00%	N/A	**99.73%**			Data available until end September 20 only. This is MHSDS reported data always a month behind. 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	**~**	N/A	N/A	See Finance Detail	N/A
Income & Expenditure (£000)	Monthly	N/A	N/A	**~**	N/A	N/A	See Finance Detail	N/A
Cash Balance (£000)	Monthly	N/A	N/A	**£62,560k**	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

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Quality Metrics

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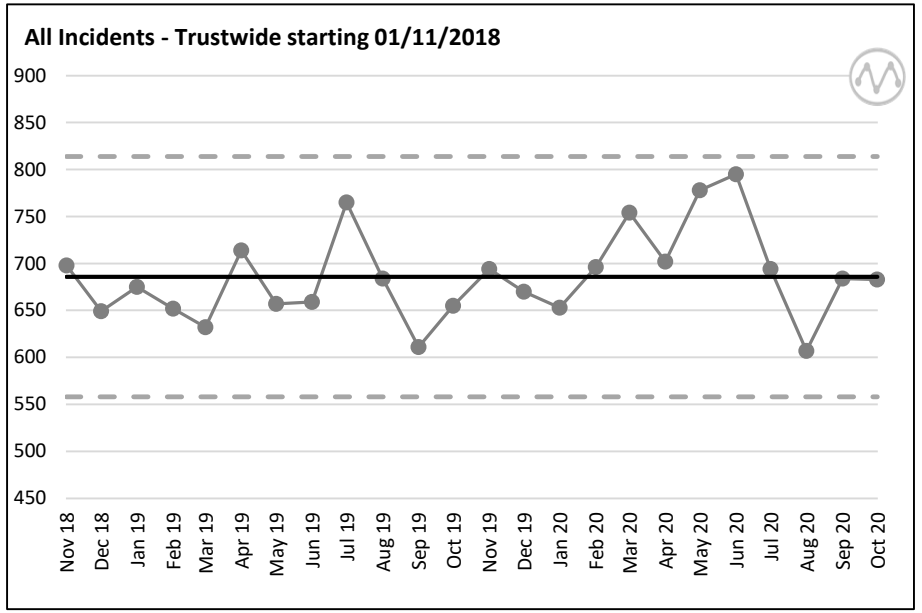
Incidents

Incident Type	OCT 2020	VARIATION	Comment
ALL	683		
Catastrophic	11		All 11 catastrophic incidents were deaths. Six of these were determined to be due to natural causes, the remaining five are awaiting further Coroner investigation (not necessarily to result in an inquest).
Major	0		
Moderate	24		
Minor	123		
Negligible	501		
Near Miss	24		

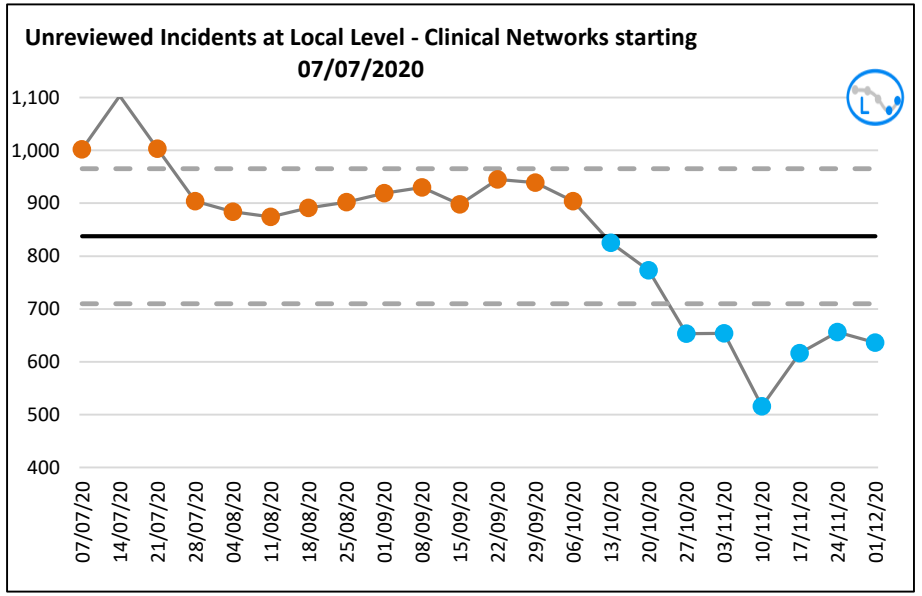


Narrative

Out of the 11 catastrophic incidents (deaths) two are subject to serious incident investigations. All have been reviewed through the Mortality Review Group.

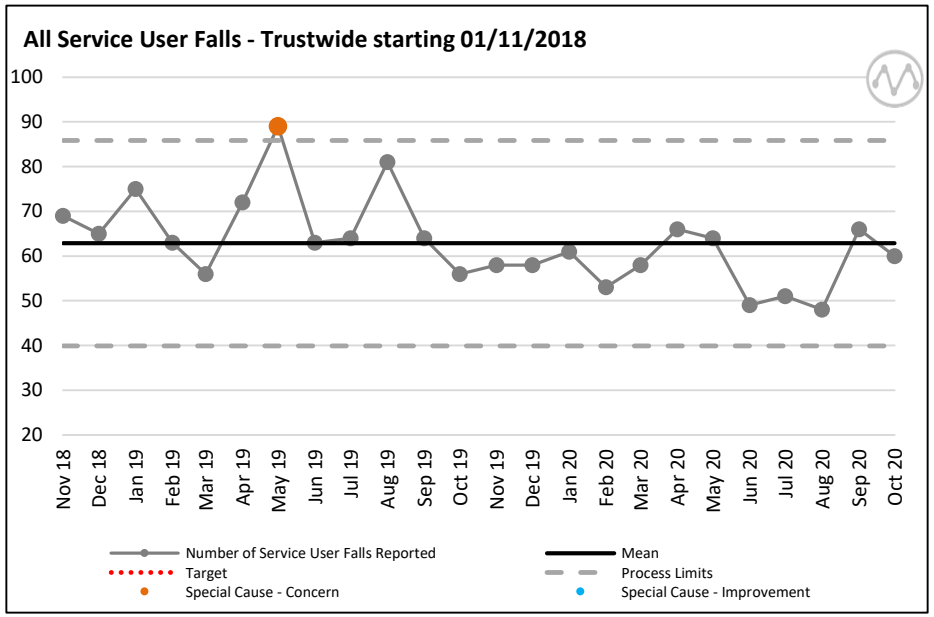
The actual impact of patient safety incidents reported by the Trust compares nationally in that 93% of all incidents are reported as negligible or minor, the national figure is 93.5%

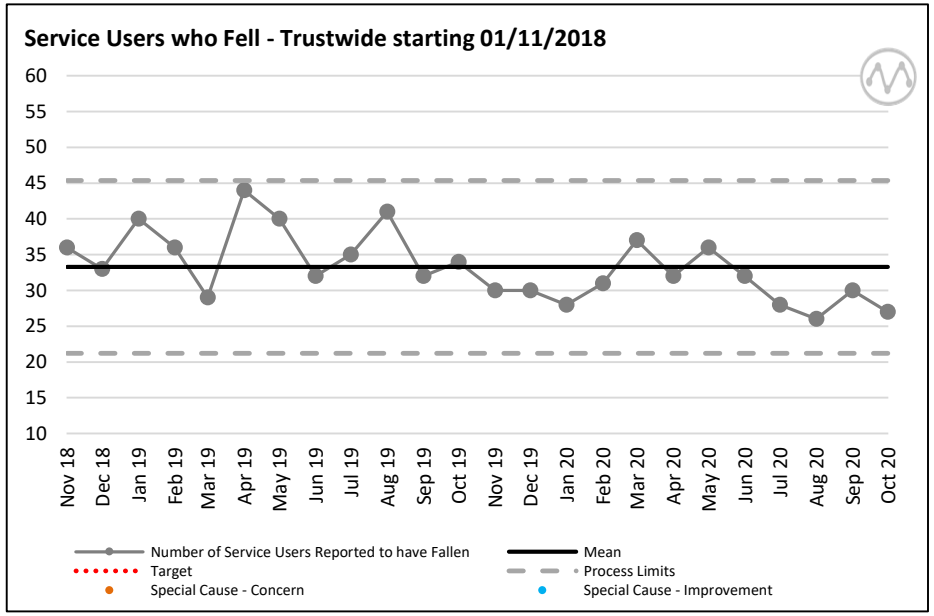
Work to ensure that all reported incidents are reviewed, the learning established and the incident closed down continues. At its most concerning the Crisis and Emergency Care Network had 884 unreviewed incidents, currently they have 534.



Falls

Service/Ward	Number of Falls	October 20 Falls Icon	Number of Service Users	October 20 Service Users Icon
Trustwide	**60**		**27**	
G1 (Grenoside Grange)	**26**		**8**	
Dovedale Ward	**8**		**5**	
Birch Avenue	**8**		**4**	
Woodland View	**10**		**4**	



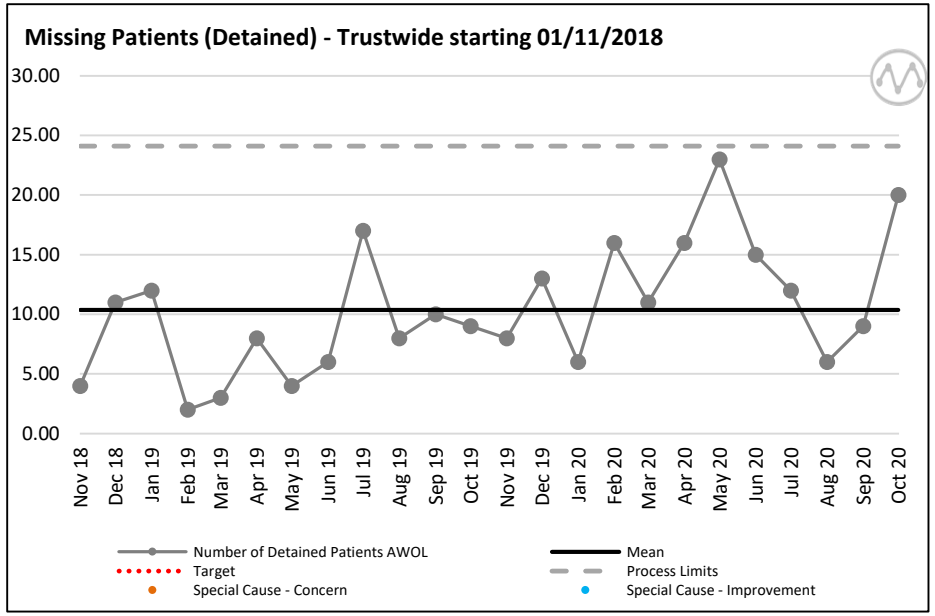


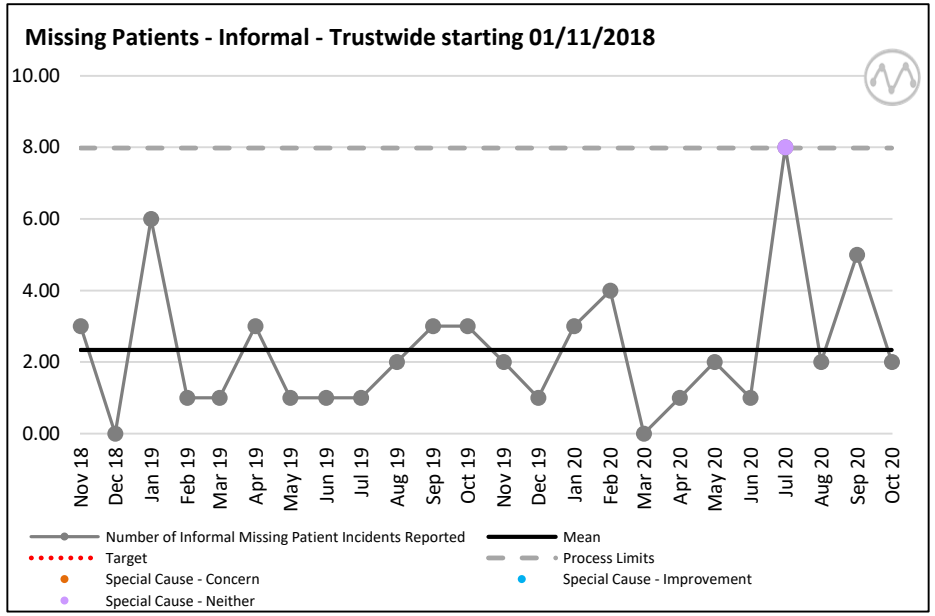
Narrative

A person, who is an inpatient on G1 (Grenoside Grange), has had 9 falls. A falls risk assessment is in place and subject to regular review.

Out of the 60 falls reported in October 2020, 46 of these had no injury reported. 55 were negligible incidents, with 5 minor. Where injuries occurred, these were tenderness/pain and bruise/swelling type injuries.

Safe | Missing Patients | Medication Incidents

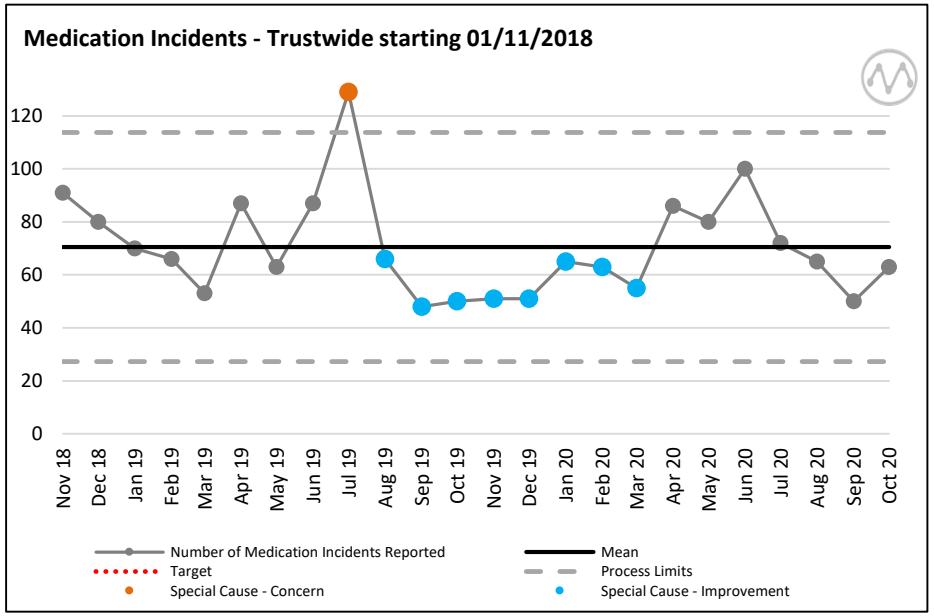




Narrative

Missing patients falls under the category of "Access, admission, transfer, discharge " within the National Reporting Learning System. The national average of this type of incident reported as a percentage of all patient safety incidents reported is 8.9%. For SHSC, 7.6% of all patient safety incidents reported are within this category.

During October 2020 16 out of the 22 recorded missing patient incidents occurred at Forest Close.



Incident Type	October 20	Variation
ALL	63	
Prescribing	3	
Dispensing	6	
Administration	15	
Management	38	

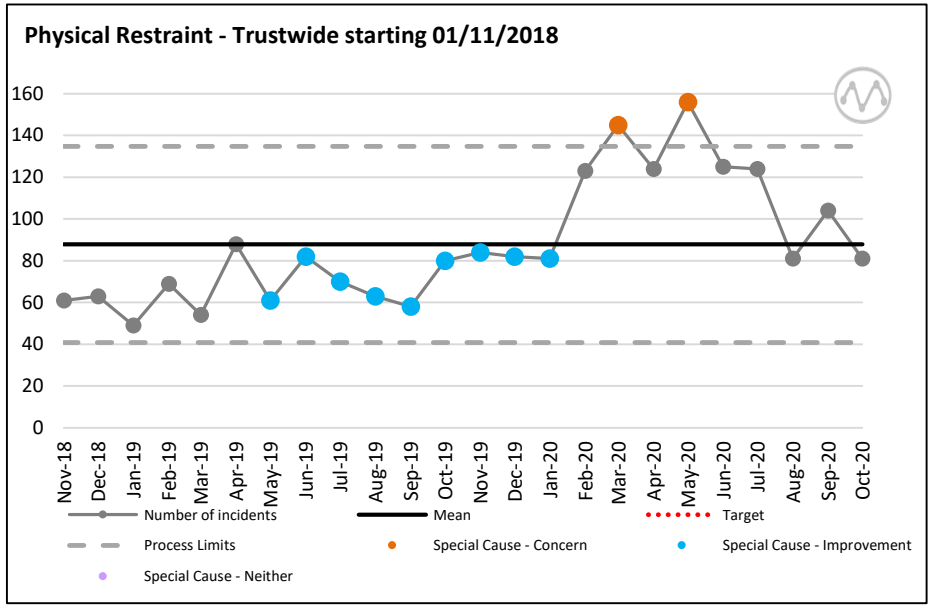
Narrative

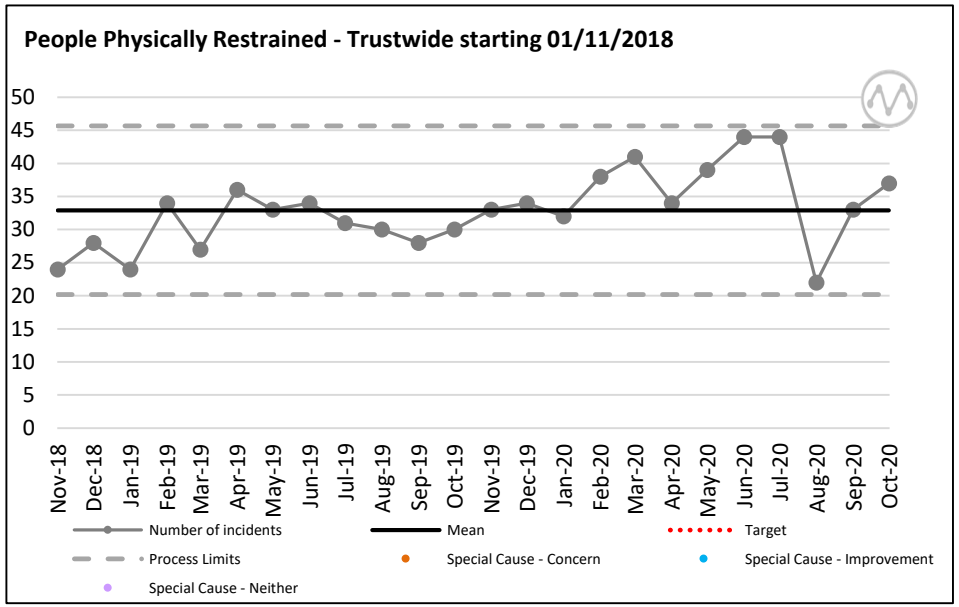
Nationally, 7% of incidents reported by mental health trusts are medication incidents. SHSC's rate is 5.5%. Out of the 63 incidents reporting during October 2020, there were 5 moderate incidents reported:

- One involved a community pharmacist giving a supervised dose of methadone that was double what was intended
- One involved an empty, expired insulin pen found in the fridge at Forest Close
- One involved a methadone continuity problem
- One involved quarantined flu vaccinations
- One involved several controlled drug stock discrepancies on Burbage Ward.

The remaining incidents were near misses (n3), negligible (n43) and minor (n12).

Restrictive Intervention | Physical Restraint





Service/Ward	No	October 20 PR Icon	No	October 20 Service Users Icon
Trustwide	**81**		**37**	
G1	**9**		**4**	
Dovedale	**7**		**4**	H
Firshill ATS	**10**		**4**	

Service/Ward	No	October 20 PR Icon	No	October 20 Service Users Icon
Burbage	**20**		**7**	
Stanage	**3**		**2**	
Maple	**4**		**4**	
Endcliffe	**20**		**6**	

Narrative

One person was restrained 12 times on Burbage ward. Restrictive practice was used to protect themselves and others from harm. Following a medication review, significant improvements have been seen in their presentation.

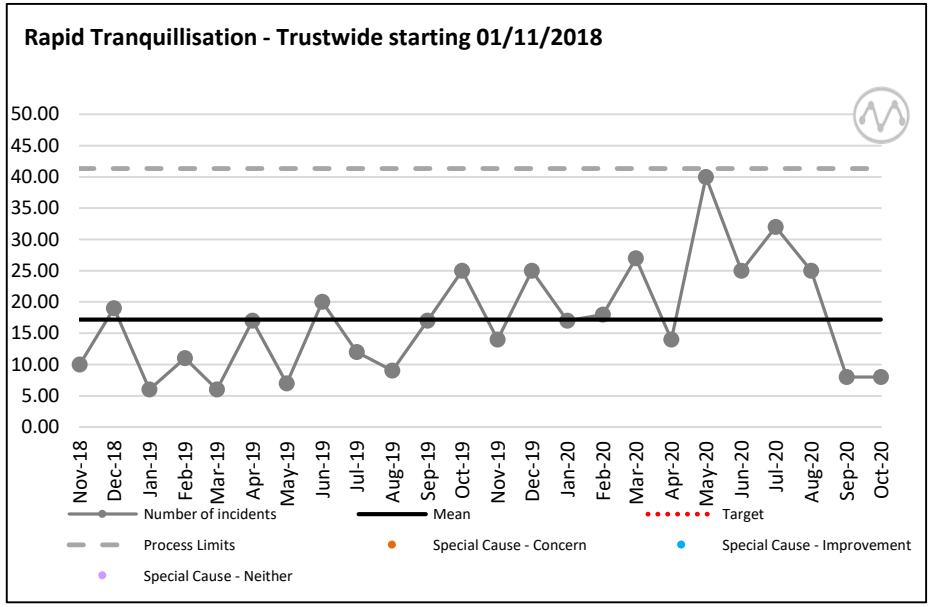
One person was restrained six times on ATS. This person's complex care needs were discussed at a previous Board of Directors meeting.

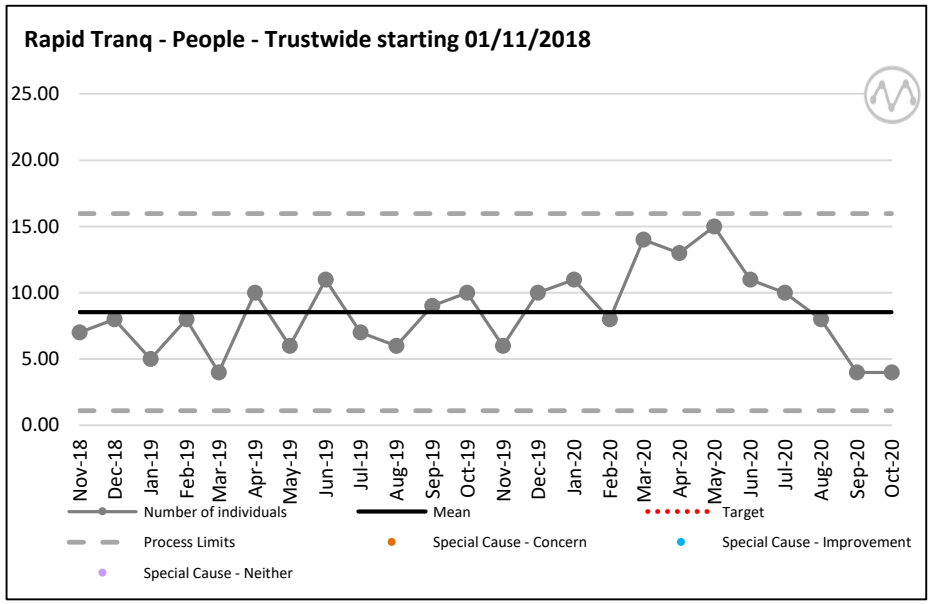
One person was restrained 12 times on Endcliffe Ward. This patient is awaiting transfer to a specialist personality disorder inpatient facility.

The SPC chart for the number of people restrained on Dovedale Ward shows an upward shift, with 7 consecutive data points above the mean. This continues to be reviewed, however, does not currently suggest this is of concern.

There were two reported incidents of mechanical restraint recorded in October 2020, the details of which are being closely looked at as both cases related to patients being transferred into SHSC from other providers. The Director of Nursing and Medical Director will be able to give further details in December Board.

Restrictive Intervention | Rapid Tranquillisation





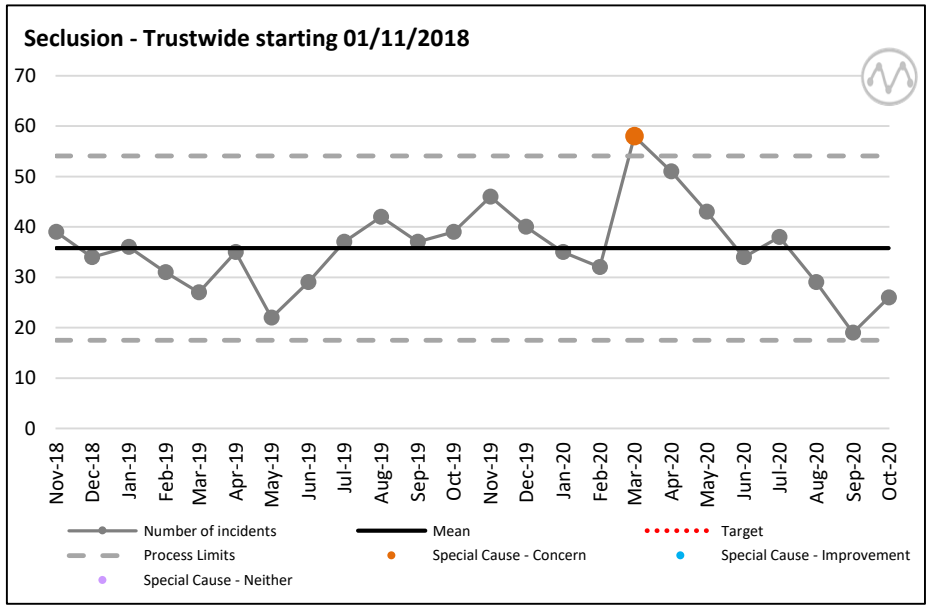
Service/Ward	No	October 20 RT Icon	No	October 20 Service Users Icon
Trustwide	**8**		**4**	
G1	**2**		**1**	
Dovedale	**0**		**0**	
Firshill ATS	**0**		**0**	

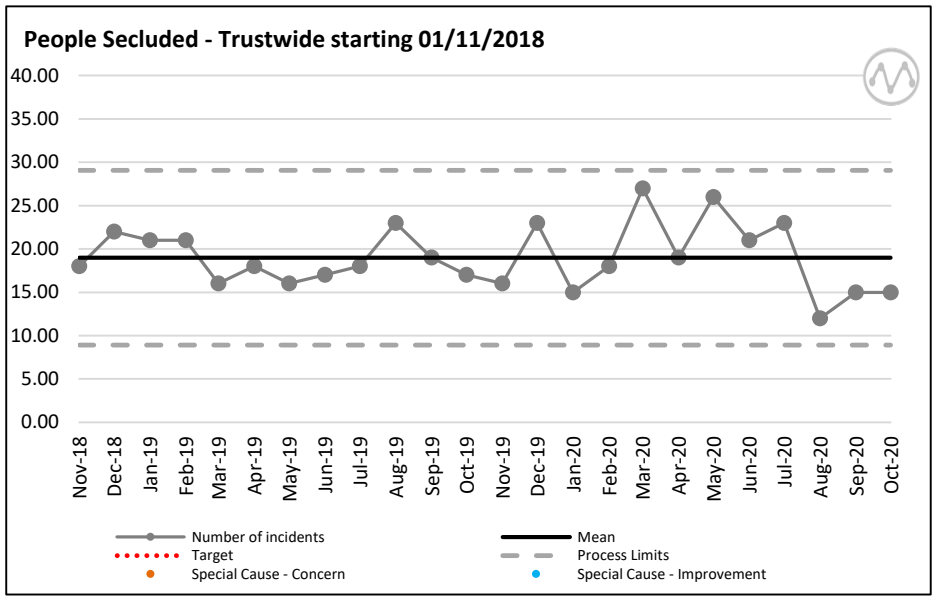
Service/Ward	No	October 20 RT Icon	No	October 20 Service Users Icon
Burbage	**4**		**1**	
Stanage	**1**		**1**	
Maple	**0**		**0**	
Endcliffe	**1**		**1**	

Narrative

One patient on Burbage Ward received rapid tranquilisation four times in October 2020. This is the same person highlighted within the restraints and seclusion slides. Significant improvements have been seen subsequently in their presentation.

Restrictive Intervention | Seclusion Episodes





Service/Ward	No	October 20 Seclusion Icon	No	October 20 Service Users Icon
Trustwide	26		15	
G1	7		2	
Firshill ATS	1		1	

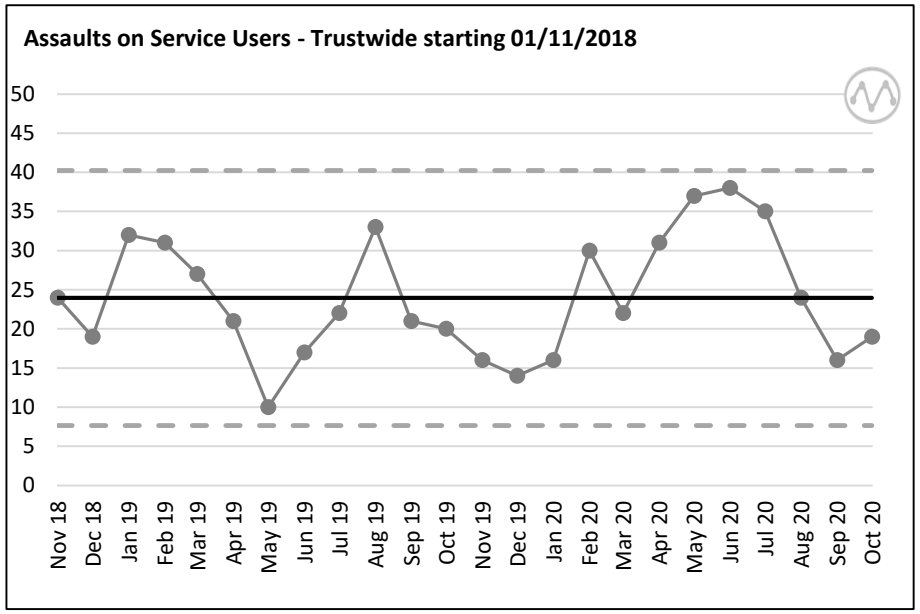
Service/Ward	No	October 20 Seclusion Icon	No	October 20 Service Users Icon
Burbage	10		5	
Stanage	1		1	
Maple	1		1	
Endcliffe	6		5	

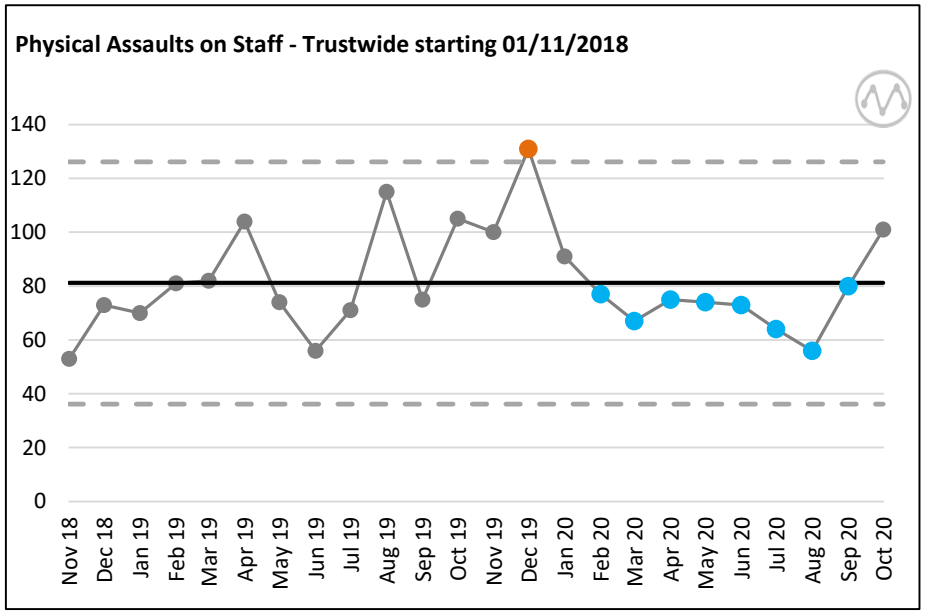
Narrative

One person was secluded six times during October on Burbage ward. This is the same person highlighted within the restraints and seclusion slides. Significant improvements have been seen subsequently in their presentation.

One person was secluded six times on G1. This is a person with complex, challenging behaviour whose care plan was discussed at a previous Board of Directors meeting by the Executive Director of Nursing, Professions and Operations.

Safe | Assaults | Sexual Safety & EMSA





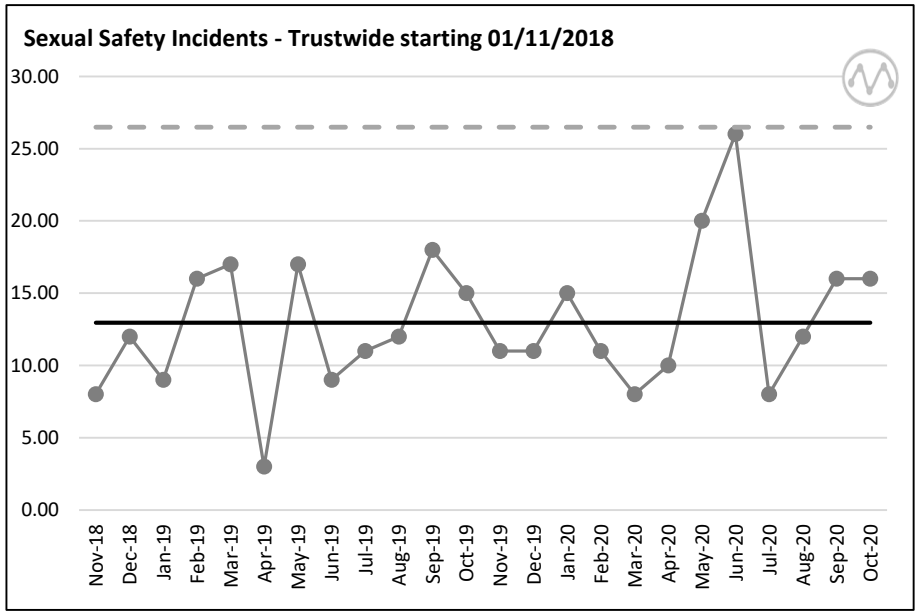
Narrative

SHSC's reporting rate of patient safety aggressive/violent behaviour incidents is 32.5% of incidents reported, the national average is 11%.

All assaults on patients during October 2020, were from other patients. Two incidents were reported as moderate incidents, although only superficial harm/tenderness was caused. 11 had no resulting injury. The remaining incidents recorded bruise/swelling, abrasion/graze and tenderness type injuries.

There was one physical assault of a racial/cultural nature reported by staff during October 2020.

All staff assault incidents reported were patient assaults.



Narrative

Sexual Safety

There were 16 sexual safety incidents reported during October across Maple Ward, Stanage Ward, Burbage Ward and ATS (Firshill Rise). All incidents were graded as negligible or minor incidents. 13 incidents were towards staff, the remaining 3 were patient to patient. Although the incidents reported are recorded as having minor or negligible impact, we are checking that adequate support has been given to the affected individuals following the incidents.

Eliminating Mixed Sex Accommodation (EMSA) Compliance

There have been no EMSA Reportable Breaches in October 2020.

Service User Deaths 1 – 31 October 2020	
Birch Ave	1
Community Learning Disability Team	1
G1	1
Mental Health Recovery Teams	3
Neuro Enablement Service/Brain Injury Team	3
Older Adult Community Mental Health Teams	6
Memory Service	2
Out of Hours Team	1
Long-Term Neurological Team	1
START Criminal Justice Team	1
Total	**20**

Classification of Deaths 1 – 31 October 2020	
Expected Death (Information Only)	9
Unexpected Death - SHSC Community	7
Unexpected Death – SHSC Inpatient (G1)	1
Unexpected Death (Suspected Natural Causes)	3
Grand Total	**20**

Quarterly mortality reports are presented to the Quality Assurance Committee and Board of Directors.

Deaths Reported 1 April – 31 October 2020	
Awaiting Coroners Inquest/Investigation	74
Conclusion - Narrative	1
Conclusion - Suicide	2
Natural Causes - No Inquest	201
Ongoing	2
Grand Total	**280**

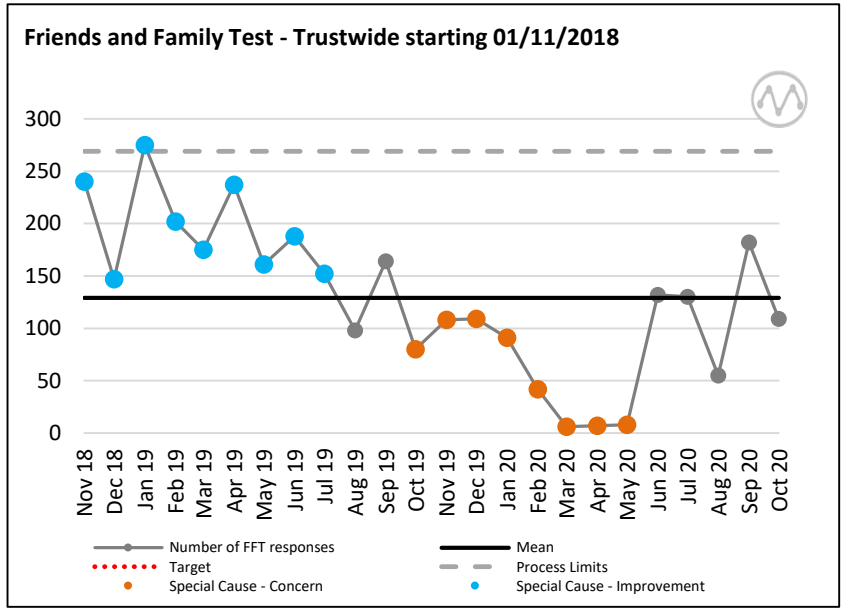
The table above shows the number of deaths that have been recorded YTD 1 April 2020 to 31 October 2020.

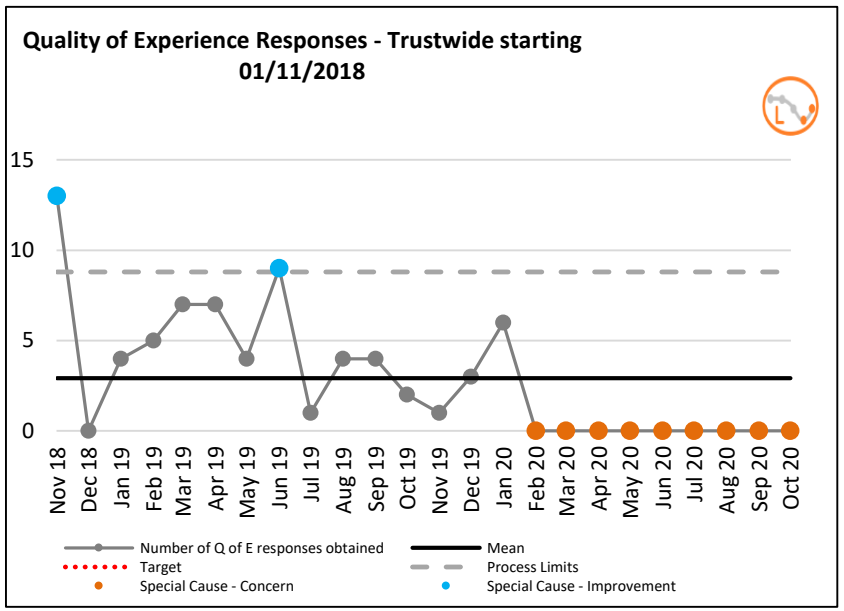
From the unexpected deaths, six were determined to be due to natural causes, the remaining five are awaiting further Coroner investigation (not necessarily to result in an inquest).

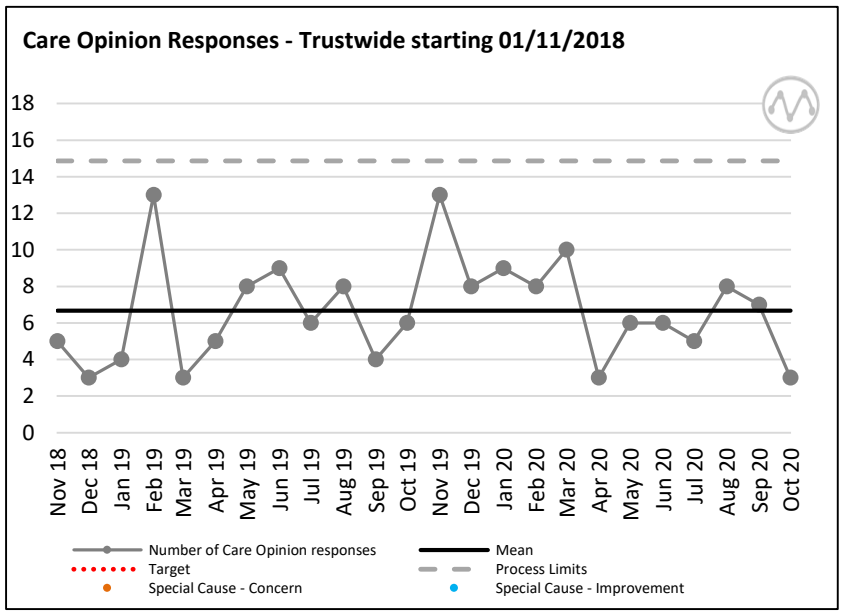
Covid-19 Deaths 1 March 2020 – 31 October 2020	
Birch Avenue	2
Community Learning Disability Team	3
G1 Ward	3
Liaison Psychiatry	1
Long-term Neurological Conditions	2
Memory Service	4
Neuro Case Management Team	1
Neuro Enablement Service	2
Older Adult Community Mental Health Team North	9
Older Adult Community Mental Health Team South East	7
Older Adult Community Mental Health Team South West	3
Older Adult Community Mental Health Team West	1
START Opiates Service	1
Total	**39**

Covid-19 Outbreaks
In October, we were managing local outbreaks of positive cases amongst patients and staff in the following services:
Birch Avenue
Buckwood View
Woodland View
G1 (Grenoside Grange)
Older Adult Home Treatment Team
Sheffield Treatment & Recovery Team (START)

Service User Experience







Narrative

Feedback received during October raised accessing specialist services as an issue, together with thoughts of being dismissed. Positive feedback received includes from the COVID-19 pandemic restrictions. Positive feedback received includes support and understanding during the pandemic. Key areas for improvement include lengthy waiting times across many services, feelings of being left alone whilst waiting and using alternative contact methods.

Quality of Experience surveys have not been carried out on inpatient areas since the start of the Covid-19 restrictions. We have developed a possible alternative method to capture feedback from our inpatient areas and are currently looking to establish the resources to pilot this approach.

Ward Community Meetings – October Highlights

Burbage – Service users were asked for new activity suggestions. As a result a table tennis table has been introduced.
Dovedale – Pictorial instructions of the TV remote control operation have been produced, which has been welcomed by service users.
Stanage - Service users requested more international food choices, which they are now able to cook during therapy sessions.
Maple – Pharmacist now providing drop-in sessions to enable service users to seek medication advice.
Endcliffe – Radios and headphones have been procured to assist relaxation.
Forest Lodge – Cutlery is now being provided in advance of food being served, to avoid delays.

Complaints and Compliments

One complaint and four compliments were received during October 2020.

The complaint relates to clinical treatment within the Single Point of Access Team and is currently under investigation.

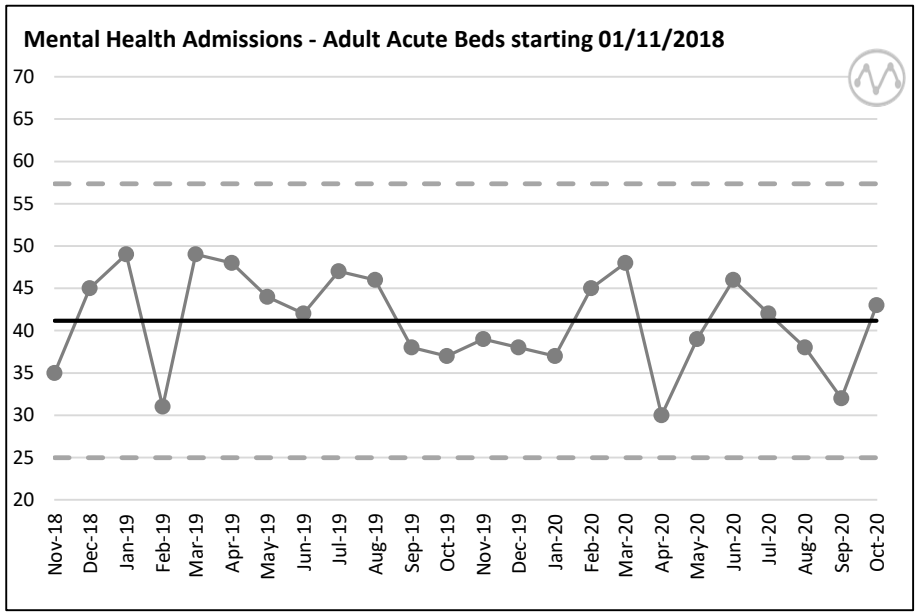
The compliments relate to support given to a service user during a care programme approach assessment, gaining the trust and confidence of a service user to undergo a blood test, guidance and professional support given during a locum placement and showing empathy and professionalism managing a concern. There were 2 compliments for the Mental Health Recovery Teams and 2 for the Community Learning Disability Team.

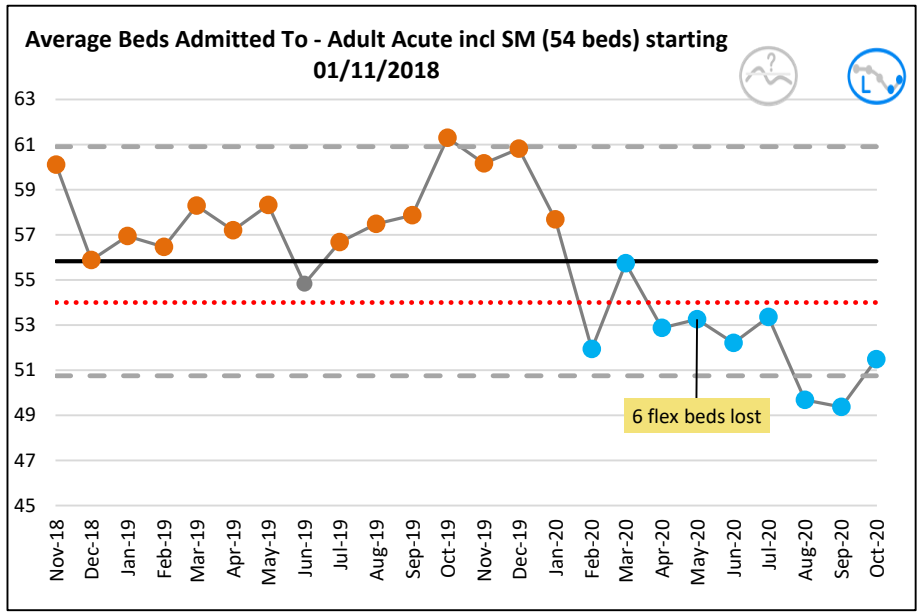
NHS
Sheffield Health and Social Care
NHS Foundation Trust

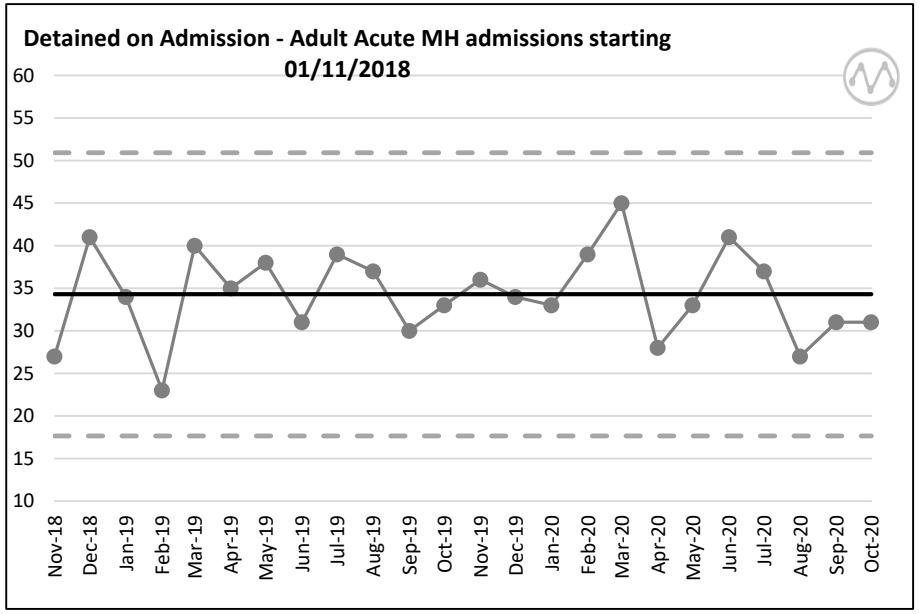
Performance Metrics

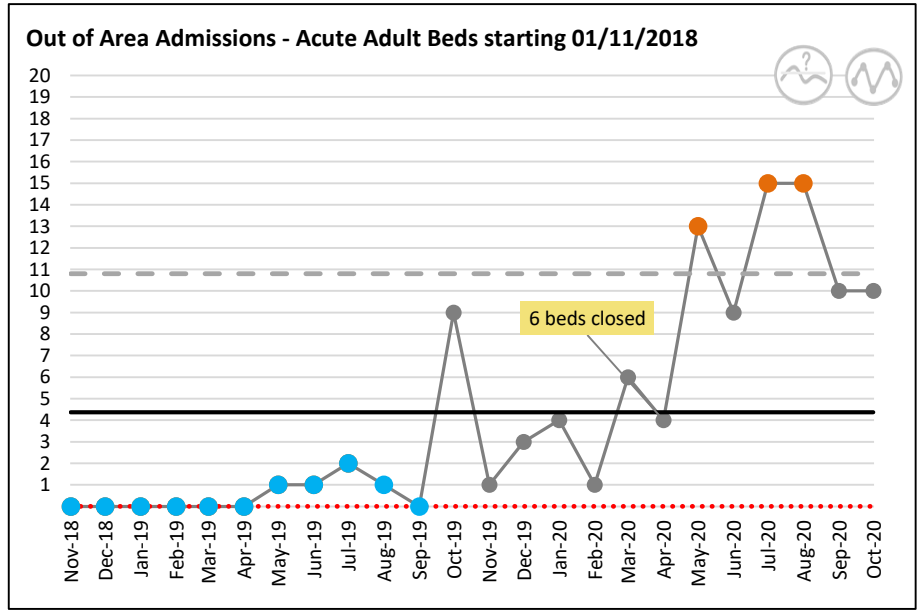
Proud to care in Sheffield

Safe | Inpatient Wards | Adult Acute









Narrative

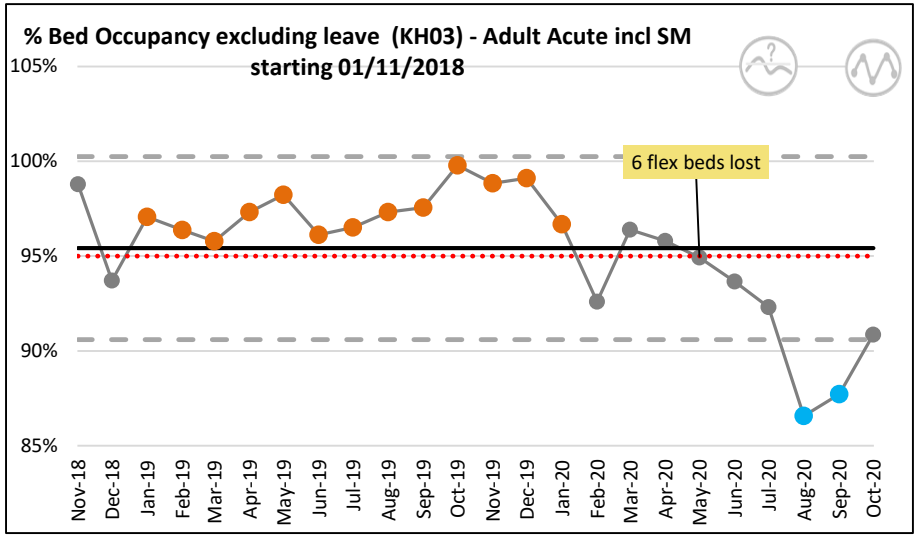
Numbers of admissions and those detained on admission have remained stable over recent period, but there have been fewer beds in the system to admit to and we see a concurrent increase in admissions out of area.

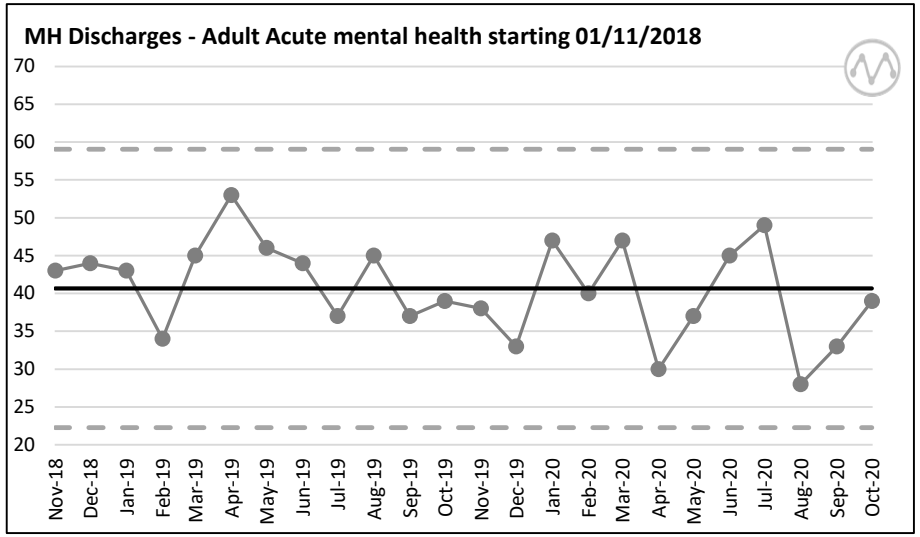
It should be noted that a number of beds have been closed through the system over the last few months for the following reasons:

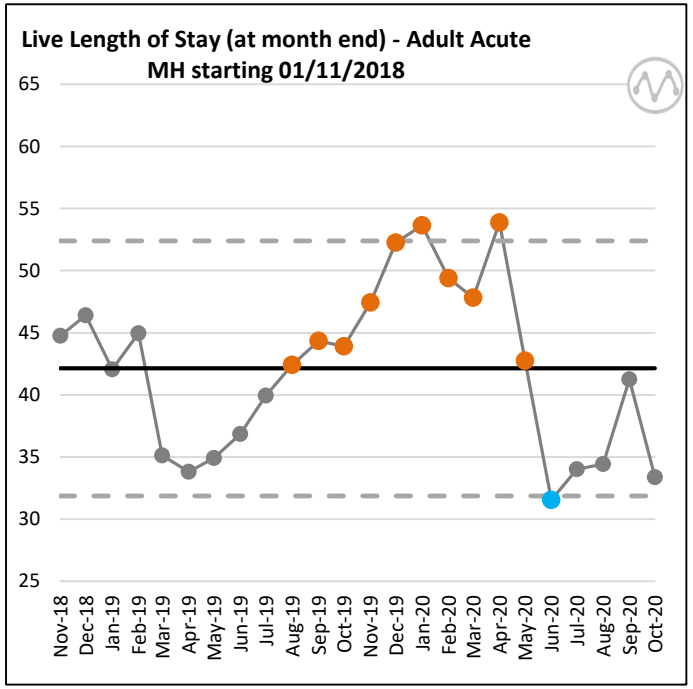
- Enabling patients to isolate in the case of Covid outbreaks on the ward
- Maintaining a safe environment in times of significant staff shortages
- Refurbishment work being undertaken to eliminate dormitories

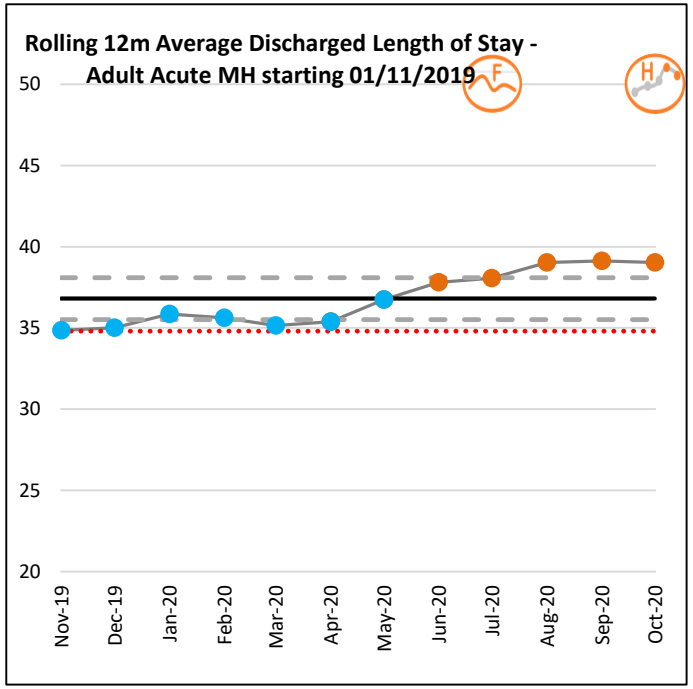
The work undertaken by the Heads of Service and Clinical Directors to understand the challenges we are facing in our adult acute system, and what we need to do to address them, both in the short to medium and long term was presented to November's Quality and Finance & Performance Committees. Our aim is to work to have admissions that are purposeful, ensuring that people do not experience delays in discharge home. As a result, in recent weeks there has been a reduction in numbers of patients being admitted out of area beds. There is further work to do, and this is ongoing.

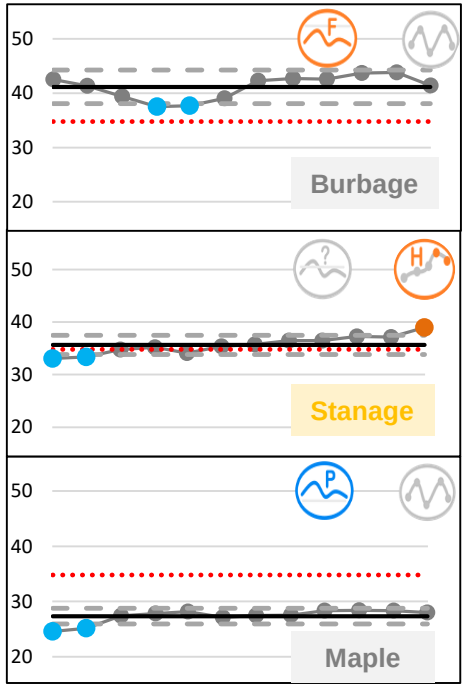
Safe | Inpatient Wards | Adult Acute











Benchmarking
(2020 NHS Benchmarking Network Report – Registered Population Data)
Bed Occupancy
Mean: 93%
Median: 96%
Length of Stay
Mean: 35
Median: 34

Narrative

Bed Occupancy

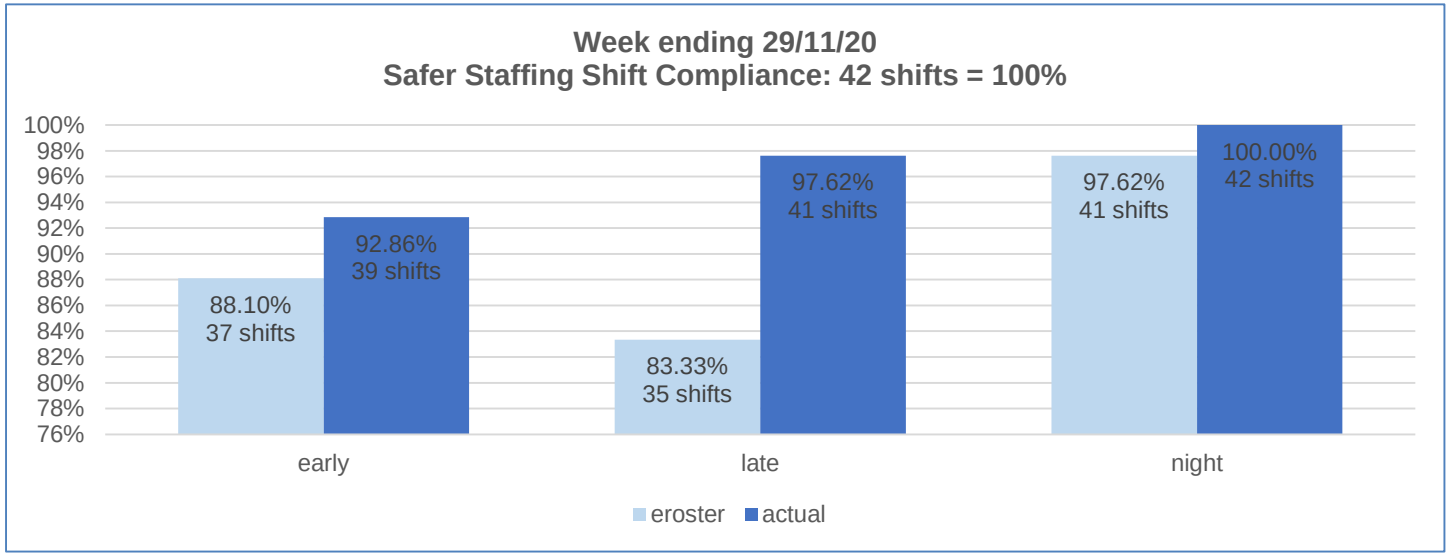
Bed Occupancy begins to drop below usual norms from March 2020, as expected due to the reduction in available beds for Covid and refurbishment works.

Length of Stay

The average length of stay for service users on our adult acute wards has seen a gradual increase over the last months and is currently still breaching upper control limits. It should be noted that the Live length of stay has been reducing since April. A number of long stay patients on our acute wards have been successfully discharged over the last 6 months, which is bringing the live length of stay down, but has led to the gradual increase in discharged length of stay over the same period. The variation in average length of stay on each of the 3 adult acute wards is highlighted here to the left.

The work undertaken to understand the challenges we are facing in our adult acute system that was presented to November's Quality and Finance & Performance Committees proposes a model that ensures people have supported discharge at the earliest opportunity and that we address the gradual increase in length of stay as it does not meet patient needs and doesn't allow us to manage the demands.

Staffing – Acute Inpatient Wards



EXCEPTIONS

For the period w/e 29th November 2020, the following exceptions to minimum staffing compliance are noted:

****4 non-compliant shifts****

			Shortfall:	Reason / Mitigation
Stanage	23/11/2020	Early	1 SW	1x SW mitigated with additional registered. Further mitigation with 2x band 6 on day shift.
	23/11/2020	Late	1 SW	No reason / mitigation provided
	24/11/2020	Early	1 registered	No reason provided – mitigation with 2x band 6 on mid / day shift
Maple	23/11/2020	Early	1 registered	2x registered on shift – 1x admission to 136 DU unable to support (closed due to Covid outbreak) Mitigation with band 6 on mid shift.

NB – In addition, ward managers are available Monday-Friday, 9-5 and Advanced Nurse Practitioners, Band 6 and 7 nurses also provide additional support.

NARRATIVE

Information is provided from the most recent weekly Improvement Dashboard, and it should be noted that this has recently been amended to include staffing compliance figures according to eRoster and actual staffing. This is driving our efforts to ensure that assurance around staffing compliance can be taken from a single source.

We plan our staffing according to the Actual Funded Establishment and monitor this using Safe Care Analysis. We work on agreed minimum safe staffing numbers for the acute wards which are noted as follows:

Burbage, Stanage, Dovedale and G1 wards: 2:4 day shifts / 2:2 night shifts
Maple ward: 3:4 day shifts / 3:3 night shifts
Endcliffe ward: 3:3 day shifts / 2:4 night shifts

TAKE CHARGE NURSE

For the period w/e 29th November 2020, the following exceptions are noted:

Preceptor as TAKE CHARGE NURSE

Early	0%
Late	0%
Night	0%

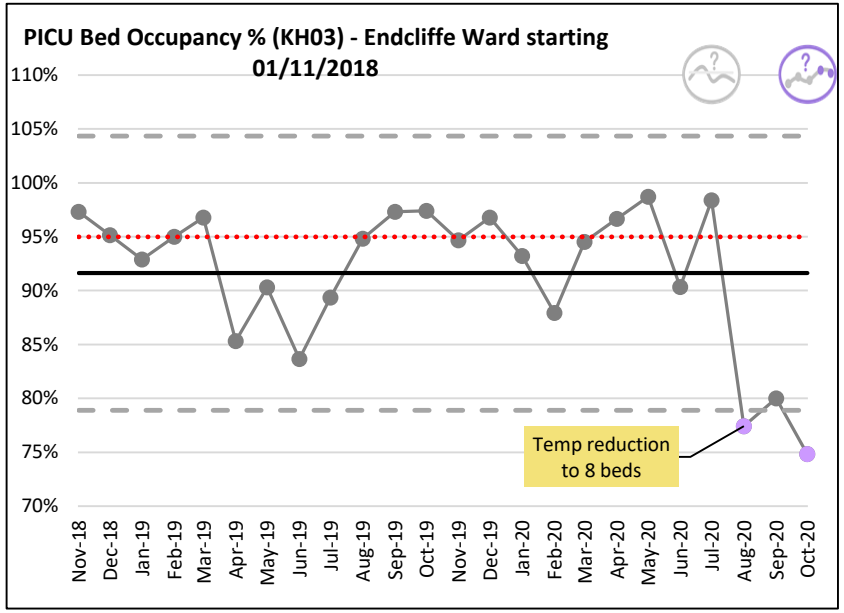
Bank & Agency as TAKE CHARGE NURSE

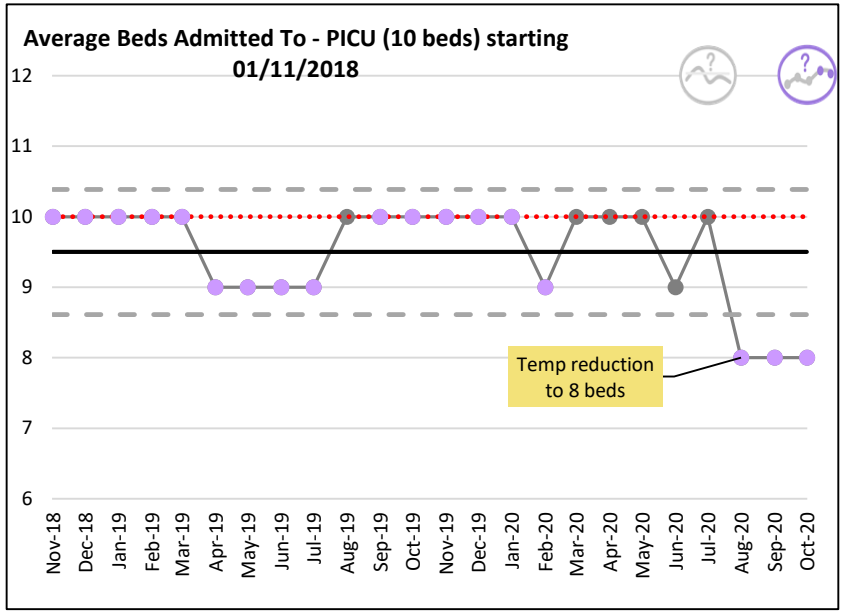
Early	No issues - 3 shifts by regular agency
Late	No issues - 3 shifts by regular agency and bank
Night	No issues - 7 shifts by regular agency and bank

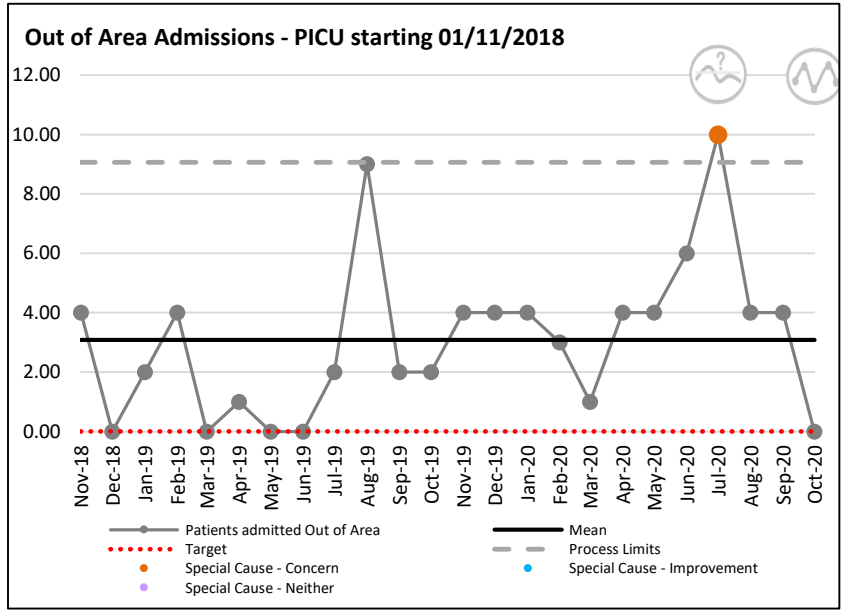
Regular bank & agency defined by following criteria:

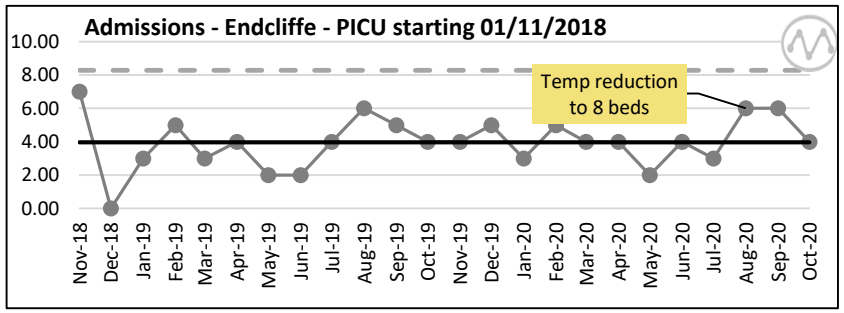
- Worked 5 or more shifts on the ward they are assigned
- Staff on bank who are substantive permanent

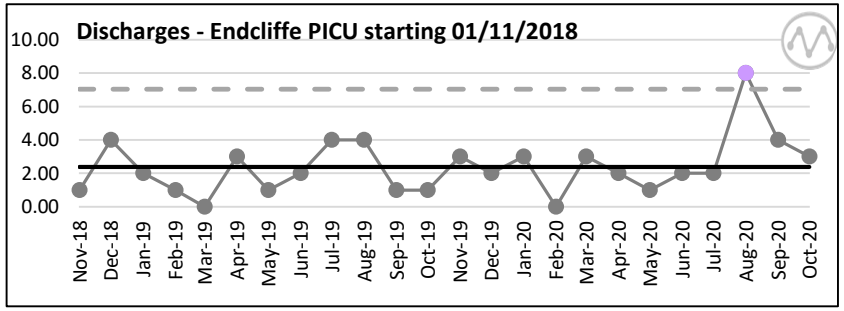
Safe | Inpatient Wards | PICU

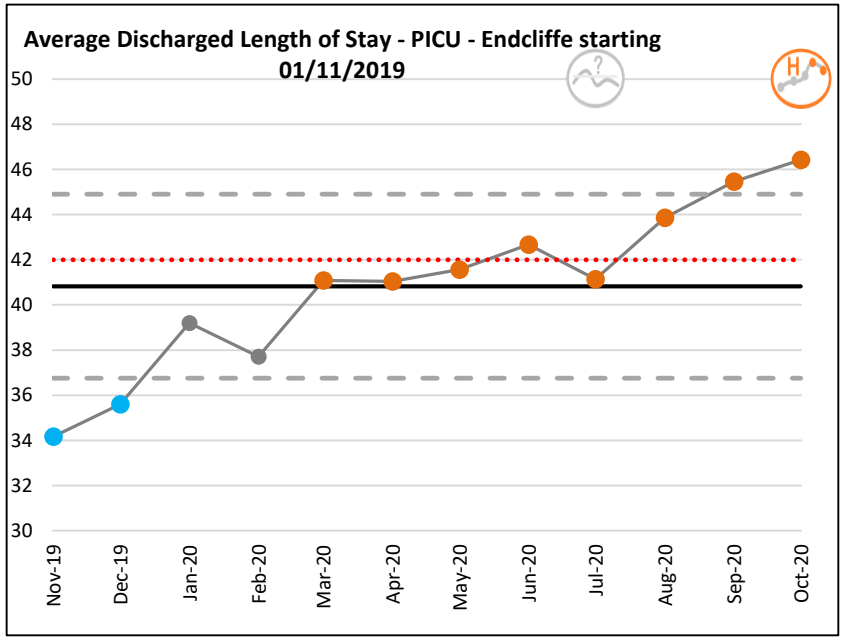












Benchmarking

(2020 NHS Benchmarking Network Report – Registered Population Data)

Bed Occupancy	Length of Stay
Mean: 88%	Mean: 48
Median: 90%	Median: 44

Narrative

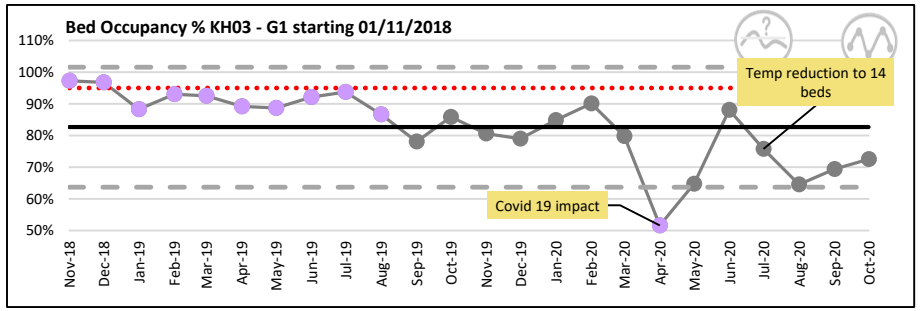
Note temporary closure of 2 beds on Endcliffe in August 2020 due to staffing shortages and to maintain safety and quality. This impacts on admissions and bed occupancy levels.

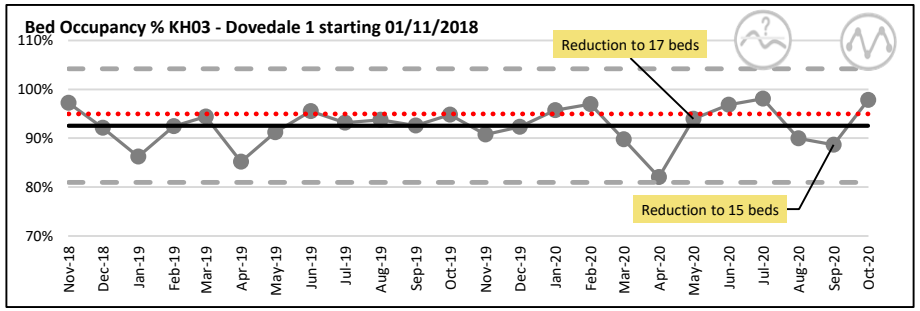
There were no out of area placements in October.

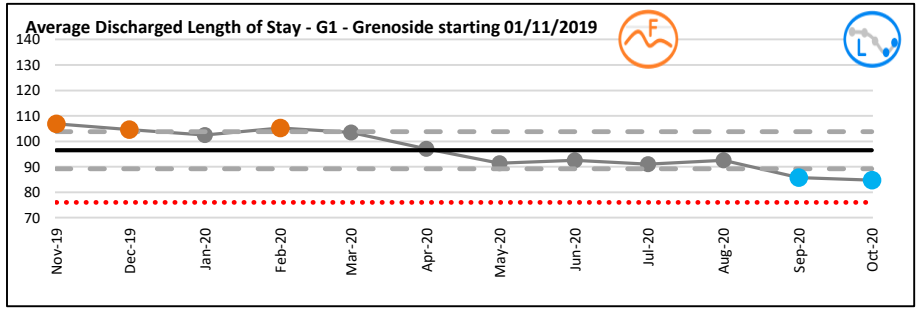
Discharged length of stay has shown a steady increase since March 20, a shift above the mean, and is above the upper control limit in September and October. A number of factors influence the length of stay, including

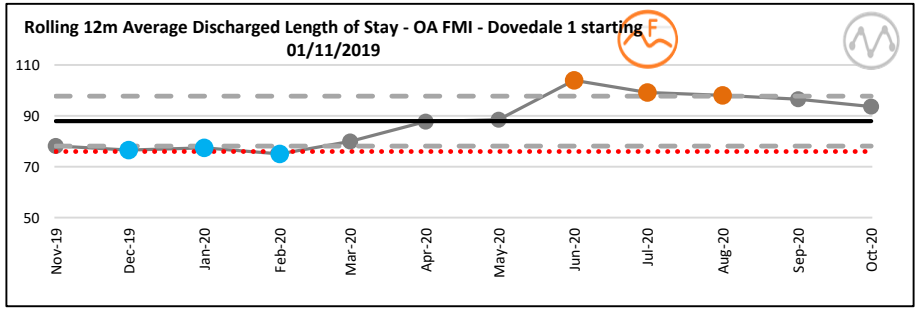
- unavailability of acute beds, meaning patients are not stepped down when they could be
- 2 patients with exceptional long stays
- Absence within leadership team, including consultant, ward manager and senior nursing staff

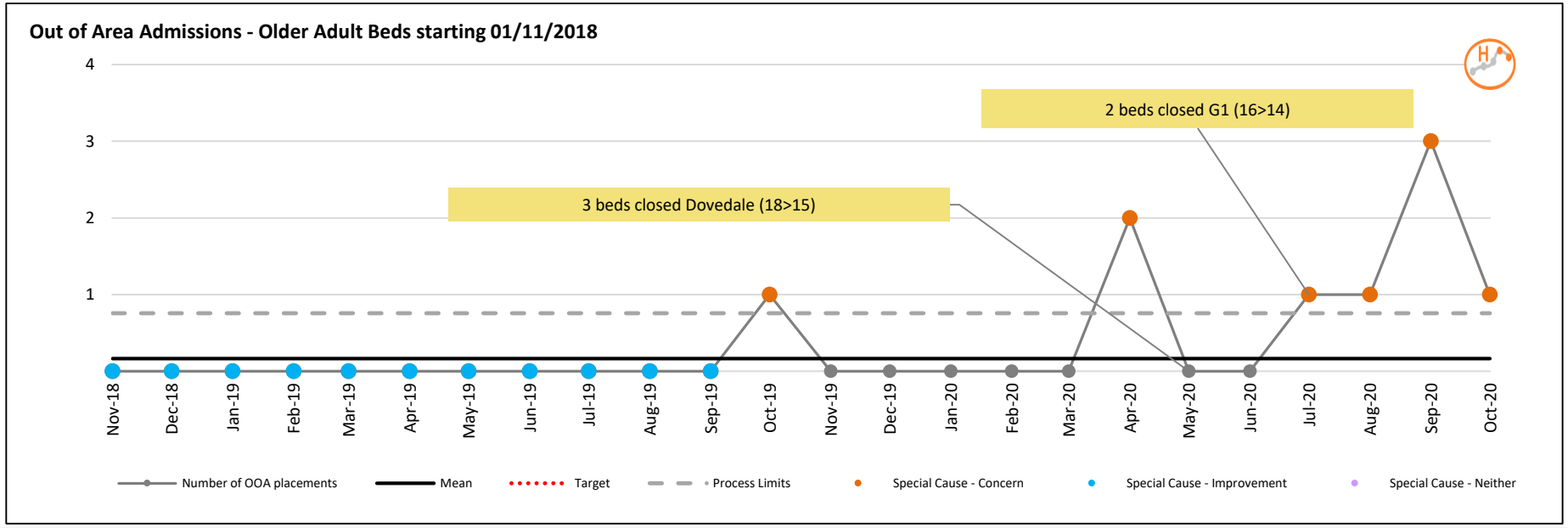
Safe | Inpatient Wards | Older Adults











Benchmarking
(2020 NHS Benchmarking Network Report – Registered Population Data)
Bed Occupancy
Mean: 86%
Median: 88%
Length of Stay
Mean: 74
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

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.

Currently bed numbers available for admission are:
Dovedale – 15 (3 beds lost as a result of dormitory work)
G1 – 14 (2 beds not in use for a number of months to support safer staffing)

Length of Stay

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 was due to one long stay (674 days) individual being discharged in June. The knock on effect in the rolling 12 month LoS figure will continue, however the reduction is beginning to show and figures in September and October are now back within range.

Out of Area Admissions

There have been an unusual number of admissions to out of area beds for older adults since April 2020; a direct impact of Covid, outbreaks on the older adult wards and dormitory work.

Responsive | Waiting Times

Narrative

We know there are areas of adverse performance, or concerns over lengths of wait times in some of our service areas:

- EWS – Emotional Wellbeing Service
- SAANS – Adult Autism and Neurodevelopmental Service
- Gender Identity Service
- Specialist Psychotherapy Services
- STEP – Short Term Education Programme – access to Borderline Personality Disorder group interventions
- Eating Disorders
- Relationship and Sexual Services

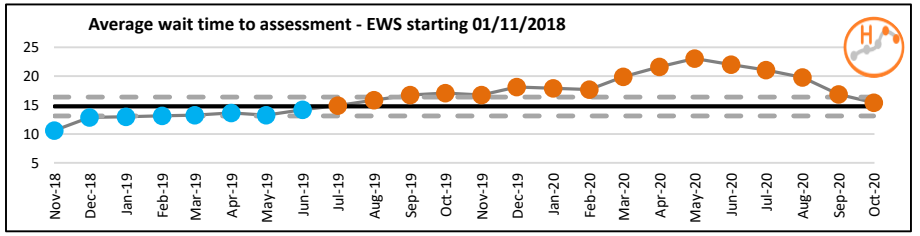
The Director of Nursing, Professions and Operations has requested a report on waiting times across the Trust to understand barriers and challenges before solutions to minimise long waits for services can be worked up. This report will be presented to January's Quality Committee.

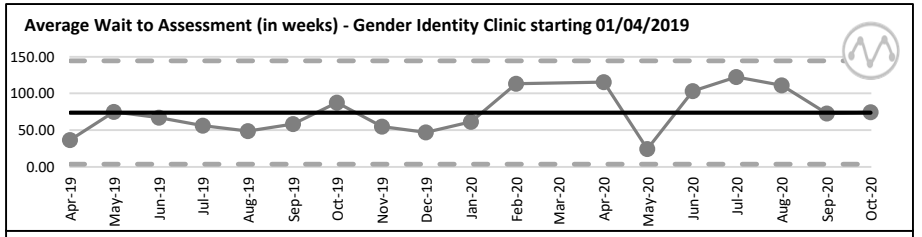
All the services identified in this report with long waits employ a range of mitigating actions to try and address the impact of waits on individuals, including re-triaging; keeping in contact with people on waiting lists, offer of peer support and preparation groups.

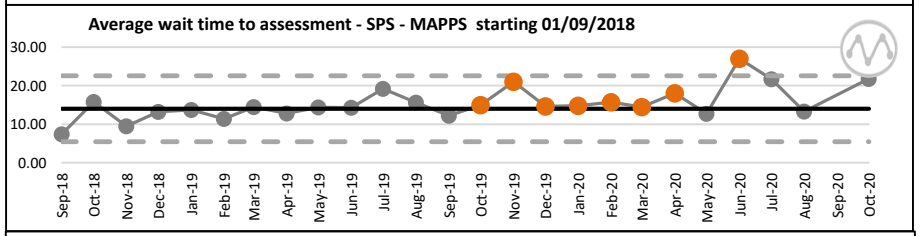
In addition, in SAANS a whole service review is taking place to support reduced wait times amongst other issues In Eating Disorders the development of an all age citywide pathway for Sheffield is currently being managed as a programme involving partner providers and commissioners. Concerns around access and waiting times are being picked up through that programme via a Project Manager employed by the CCG.

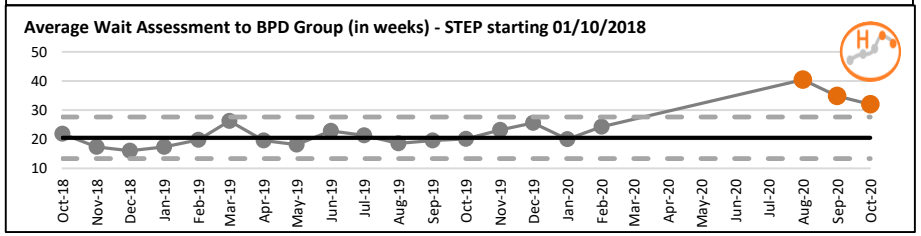
Service	Numbers Waiting
EWS – Routine mental health assessment	824
SAANS – ADHD SAANS - ASD	312 271
Gender Identity	1,222
SPS MAPPS	58
STEP BPD Group	68 NB September figure. October figure unavailable at time of report
Eating Disorders	16
R&S	128

Average Waiting Times

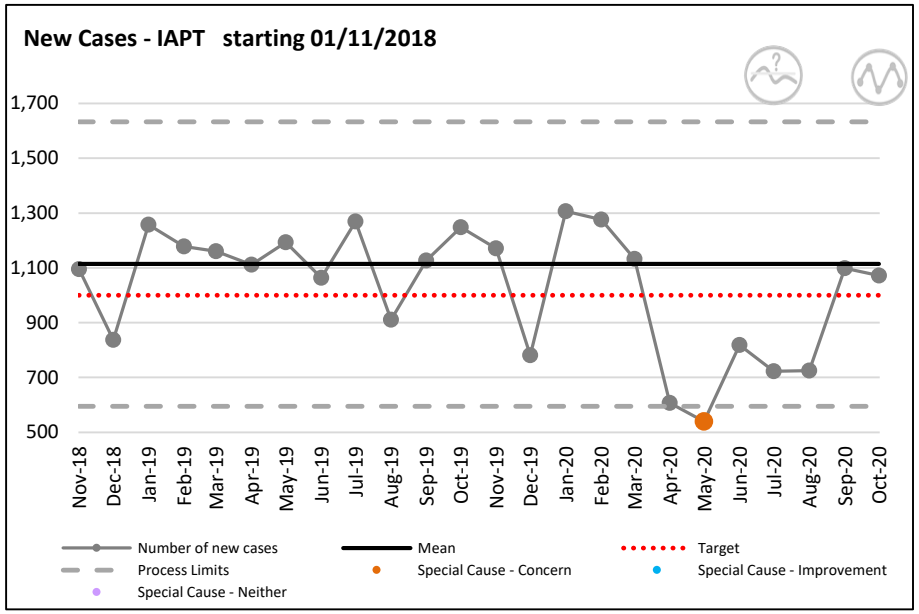


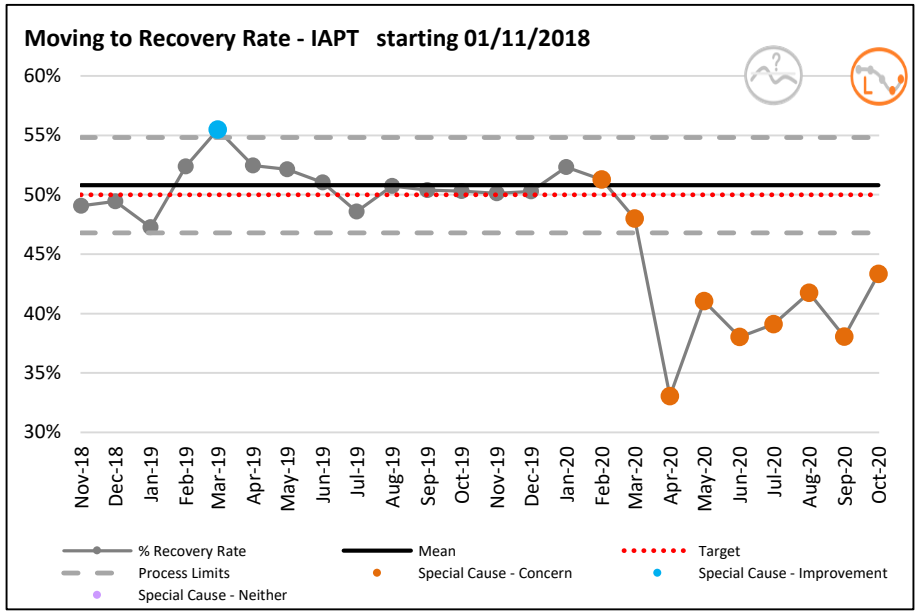


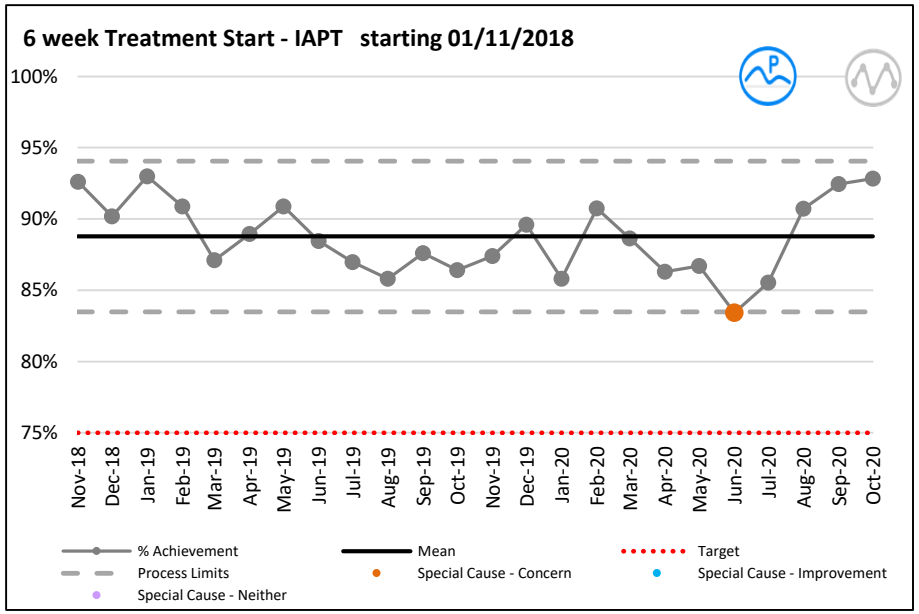


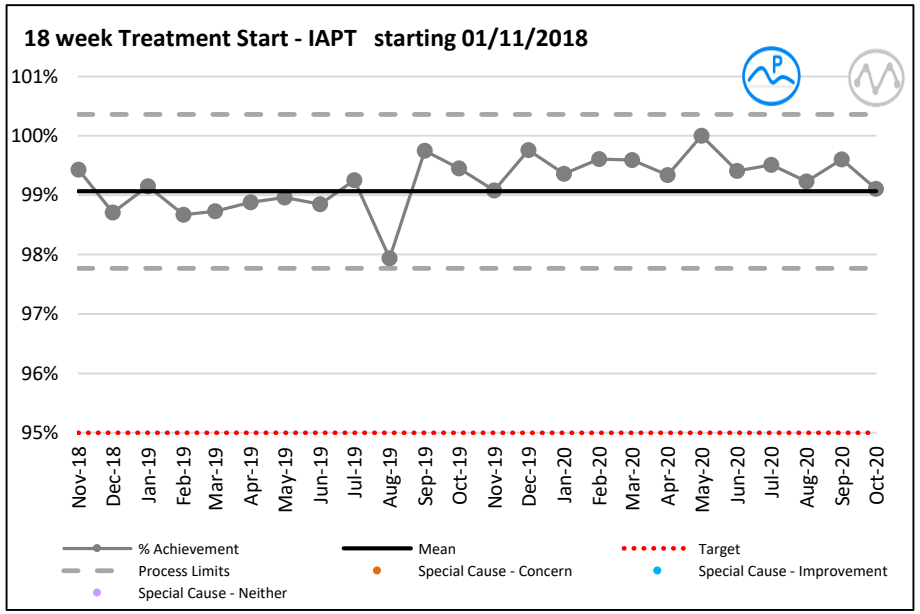


Responsive | Improving Access to Psychological Therapies (IAPT)









Narrative

For reasons previously outlined in reports Covid has had a significant impact on IAPT services nationally and in Sheffield as our IAPT service had to move from GP practice co-location to a centralised model whilst Covid is ongoing.

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. The number of referrals locally is increasing and plans are in place to accelerate this and offset the impact of a temporarily centralised service.

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.

Access
The number of people entering treatment is rising each month in line with increased demand and outreach work. Figures for September, October and November are over the agreed temporary 1000 access target so we are on trajectory. Note reduced target in place until January 2021 when it will revert back to 1232 per month.

Waiting Times
Both the 6 and 18 week wait to treatment start times continue to consistently exceed the national targets and this has been maintained throughout the pandemic to date.

Moving to Recovery
Moving to Recovery rates are expected to be lower as some people drop 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.

START Performance | October 2020

Key Performance Indicator (KPI)	TARGET	OCT 2020	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	TARGET	OCT 2020	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	TARGET	OCT 2020	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON
Service	**Opiates**				**Non-Opiates**				**Alcohol**			
Access – Waiting time referral to assessment (≤7 days)	≥ 95%	**100.00%**	H	?	≥ 95%	**96.92%**		?	≥ 95%	**100%**		P
Access – Waiting time referral to treatment start (≤21 days)	≥ 95%	**100.00%**		P	≥ 95%	**100.00%**		?	≥ 95%	**100%**		P
Access – DNA rate to assessment	≤ 15%	**22.06%**		?	≤ 15%	**18.46%**		?	≤ 15%	**16.02%**	L	?
Engagement – Numbers in	TBC	**65**	L	N/A	TBC	**65**		N/A	TBC	**170**		N/A
Recovery – Successful exits from treatment	TBC	**19%**		N/A	TBC	**57%**	H	N/A	TBC	**53%**	H	N/A

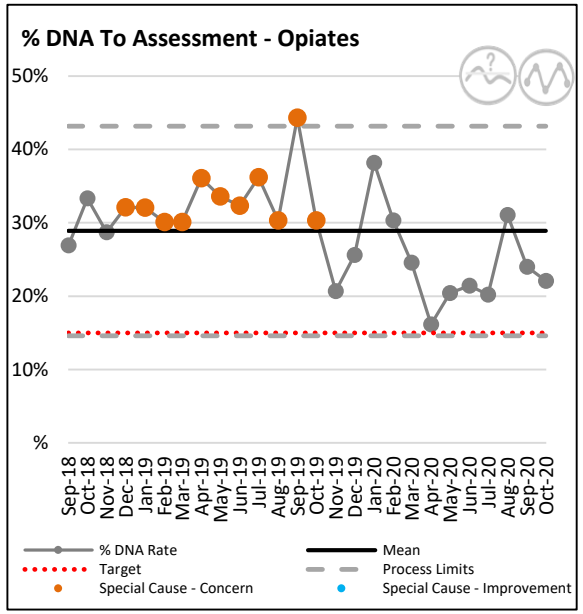
Narrative

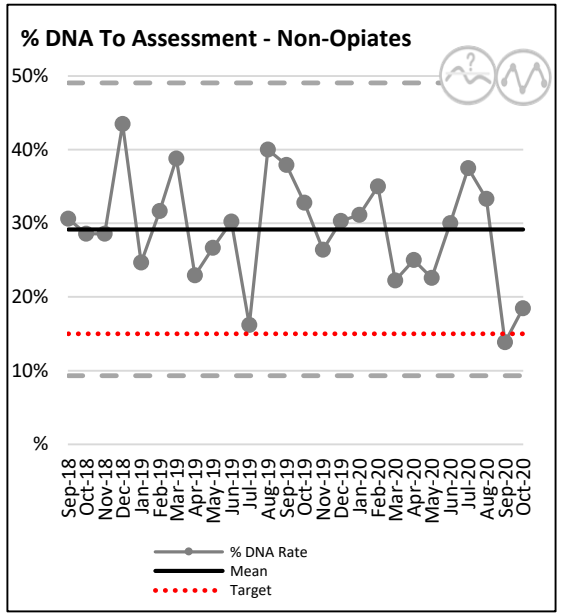
Engagement Referral numbers to the opiates, alcohol and non-opiates services are not currently working to a target but this is in discussion with the commissioner. The service provides open access to treatment regardless of any previous presentations or drop-outs. For this reason, there is a group of service users who can cycle in and out of treatment. We work on addressing this through focussed engagement approaches with those who are repeat presentations, without denying treatment to anyone who needs it.
Access to criminal justice substance misuse interventions has been affected by the lockdown due to Covid 19, with a period of no drug testing in the SYP custody suite, reduced court capacity and withdrawal of prison pick-ups. The service continues to engage with those on caseload to reduce offending behaviour and is starting to increase activity levels where safe to do so.

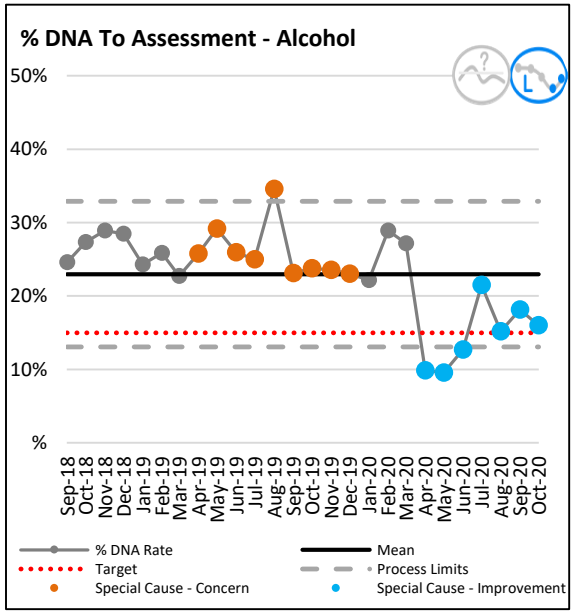
Waiting Times The service works towards a target of 95% of service users being assessed within 7 working days, which is consistently achieved. The average wait time from referral to assessment in all 3 services is currently under 3 days. In October 2 people waited 10 days for assessment with the Non-opiates Service.

Recovery Due to the open access nature of the service, service users find it easy to drop out of treatment. The service has previously worked towards a target for the percentage of positive discharges (defined as discharge drug free/occasional user or a planned discharge with treatment goals met). We are reviewing this with commissioners for the current contract.

START Performance | Highlights & Exceptions | October 2020





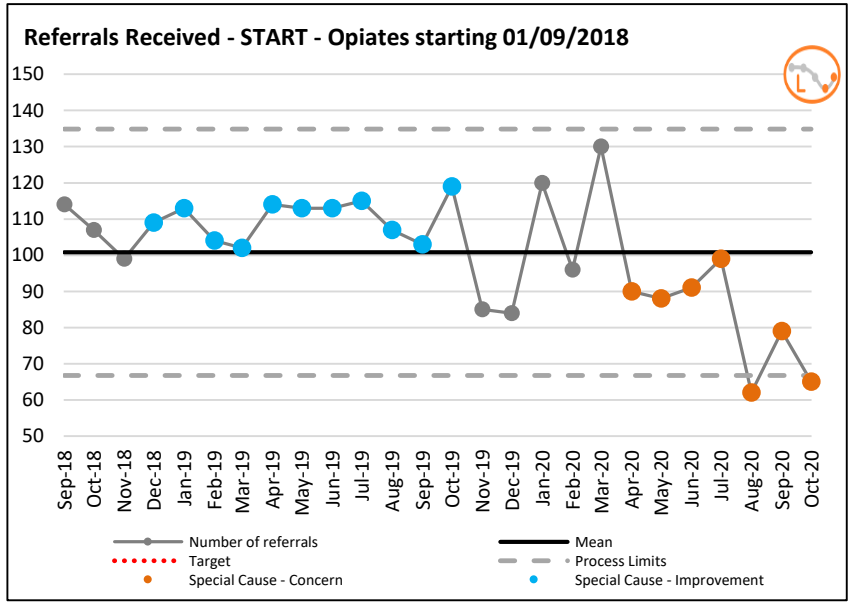


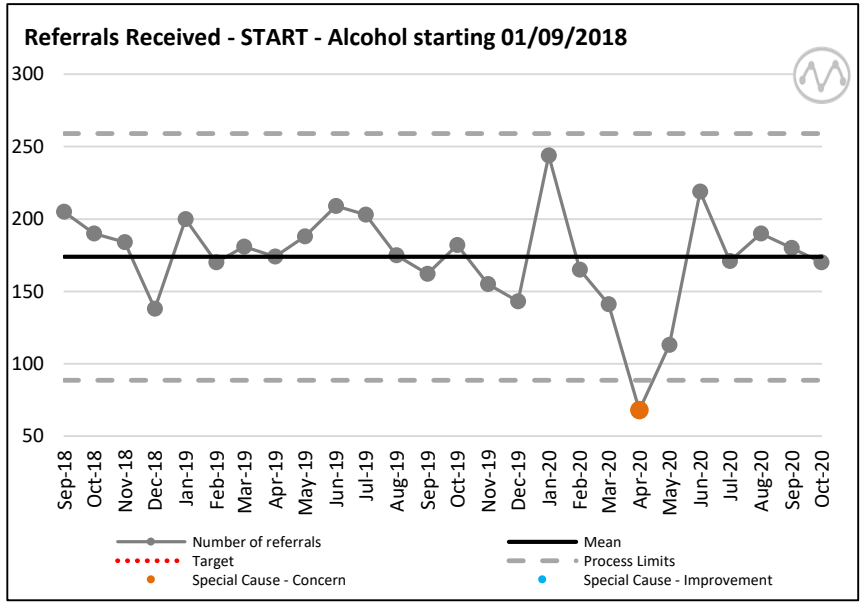
DNA Rate to Assessment Narrative

During the last contract period, the service has worked towards a target of 15% DNA rate to assessment, which is within the control limits of the data and therefore achievable under current systems.

However, it is important to note that the DNA rate reflects the service's open access policy, and the target has not been achieved in the last 24 months in the opiates service. Targeted engagement work is undertaken with those who repeatedly DNA to assessment.

Covid 19 has led to an increase in telephone assessments which initially had a positive impact on the number completed, particularly in the alcohol service. The service will be using learning from this to identify where improvements to the DNA rate can be made.

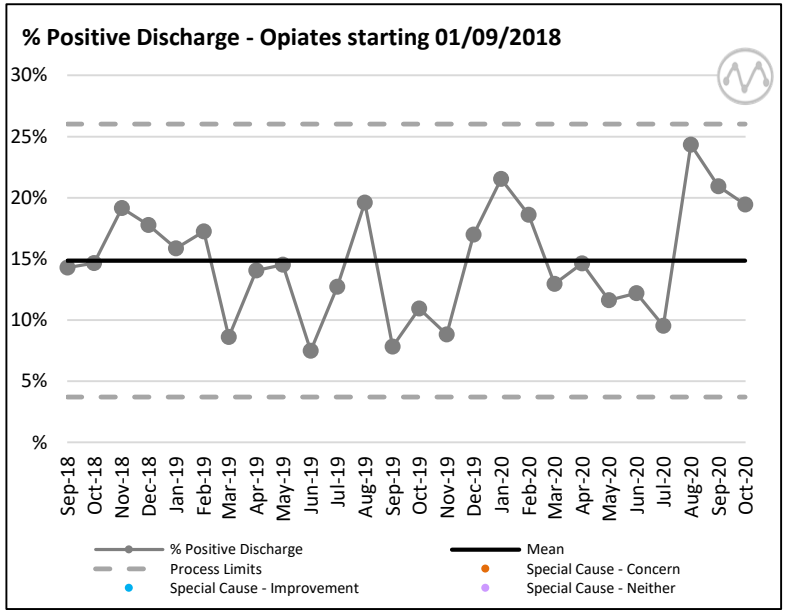


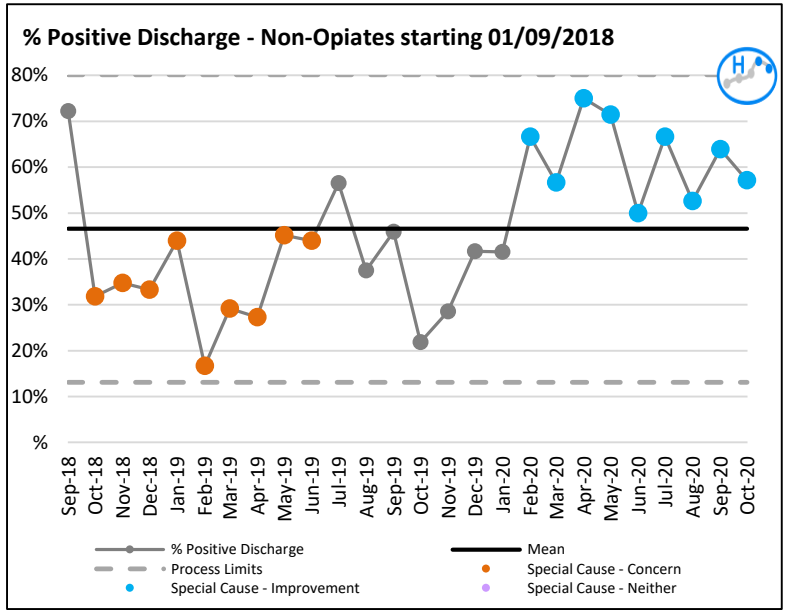


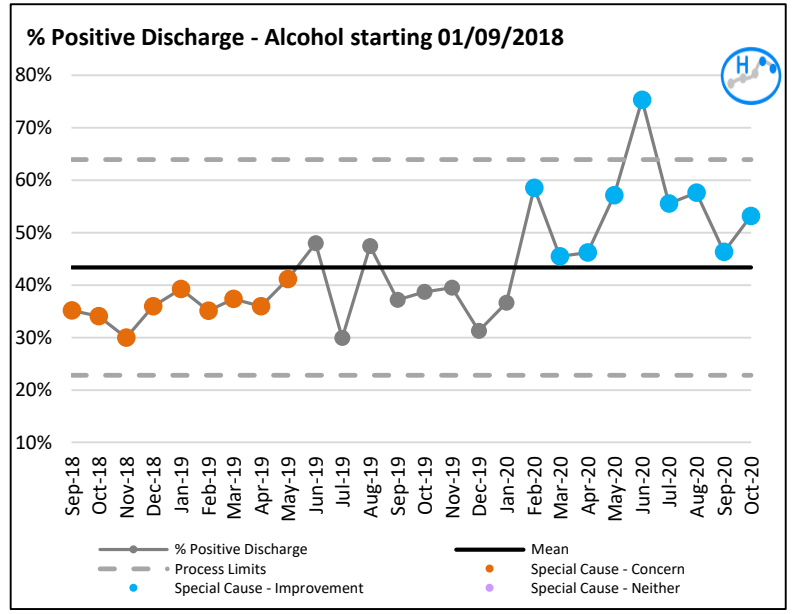
Referrals (Numbers In) Narrative

There was a drop in referrals to Opiates in August which is likely to be attributable to the evening out of an increase in referrals in March as coronavirus was escalating. It is likely that many have remained in treatment and therefore some who would have dropped out and re-presented have not needed to because they are successfully engaging with treatment.

There were fewer referrals to the alcohol in April, coinciding with lockdown. The links between alcohol use and lockdown is something the service has been keen to address; there was a brief social media campaign in July aimed at encouraging people to seek help for lockdown drinking habits and there will be a similar campaign in the coming months targeted at dependent drinkers.







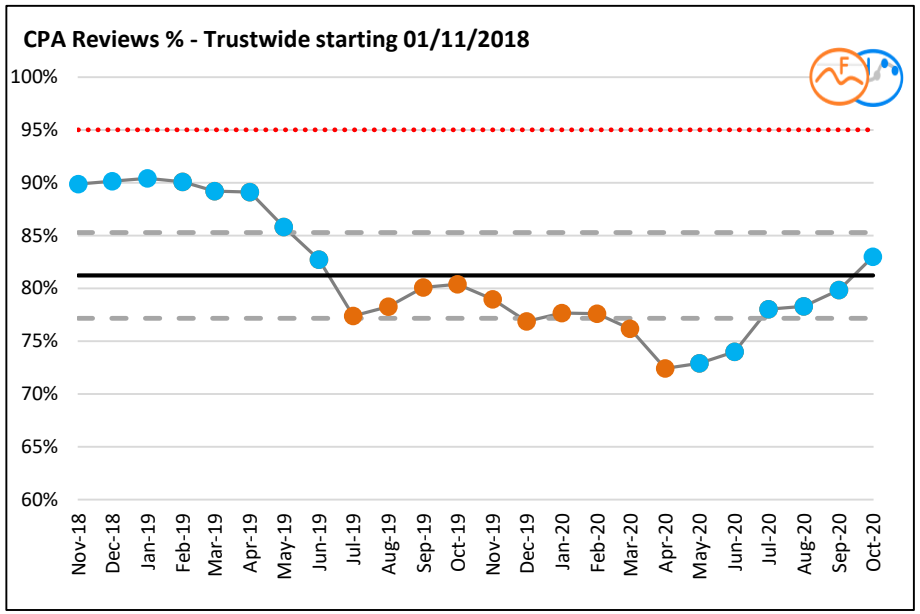
% Positive Discharge Rates

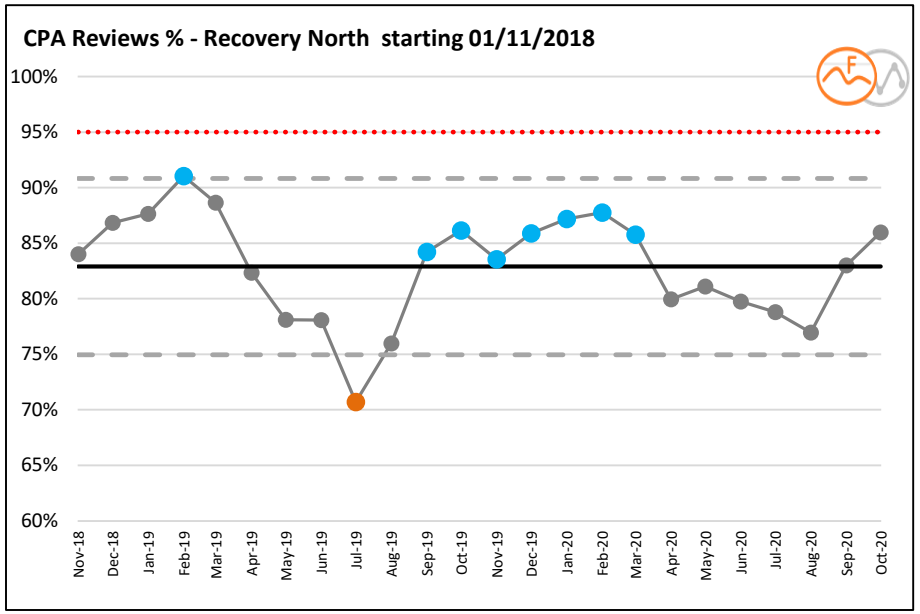
The rate shown is the percentage of positive discharges out of all START episode discharges where service user has attended an assessment appointment and at least one other appointment. Episodes that were empty (e.g. where there is an open/closed episode on the same date, where the SU has DNA assessment or first follow up appointment, did not respond to opt-in letter after first appointment) were removed before calculating the rate because the individual can be considered to have not engaged in that episode.

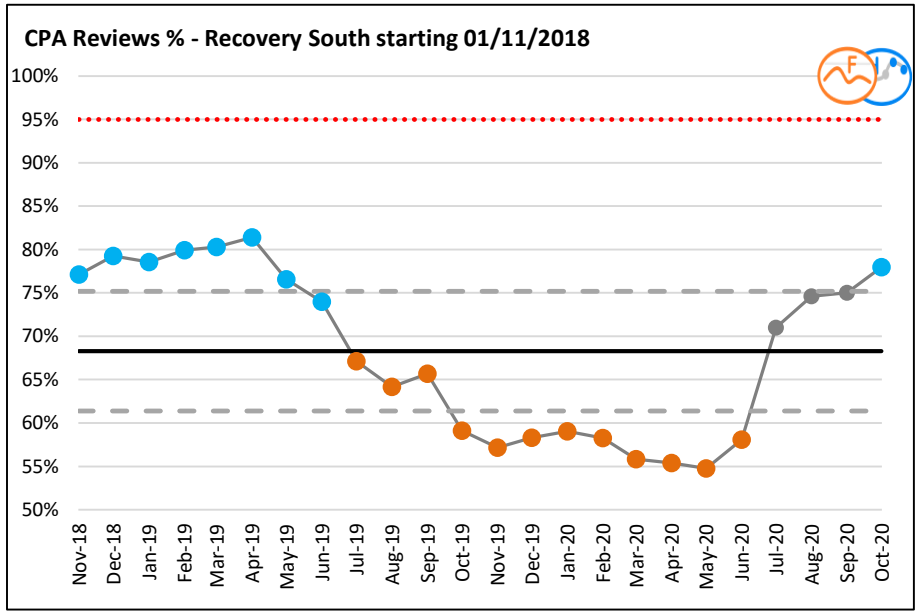
This gives a more accurate reflection of the proportion of people who are engaging in treatment before leaving treatment having met their goals.
“Positive” discharge = Planned discharge, drug/alcohol free or occasional user.

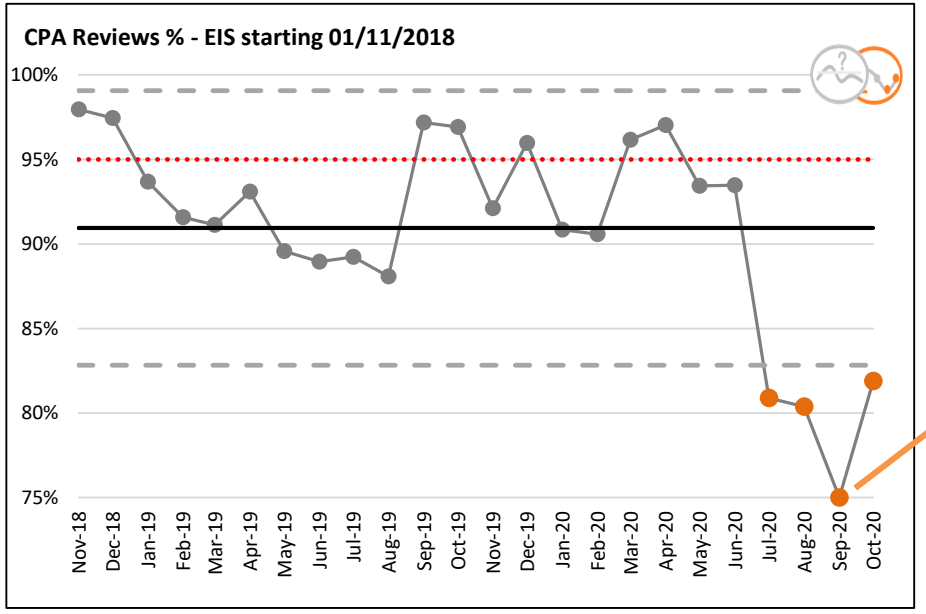
However, as can be seen on the above charts, the process limits for calculating a recovery rate using the above methodology become extremely wide, and there are likely to be a number of reasons for this variation (such as individual service users who may engage for a few appointments but subsequently drop out of treatment, multiple times over a few months). We are therefore looking into whether this metric may be better presented as volume of positive discharges instead of rate.

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, however the Trust % for October 2020 is 83%, showing continuous improvement since April 20 and at its highest level since April 2019.

Improvement Plan

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

Additional weekly reports are 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.

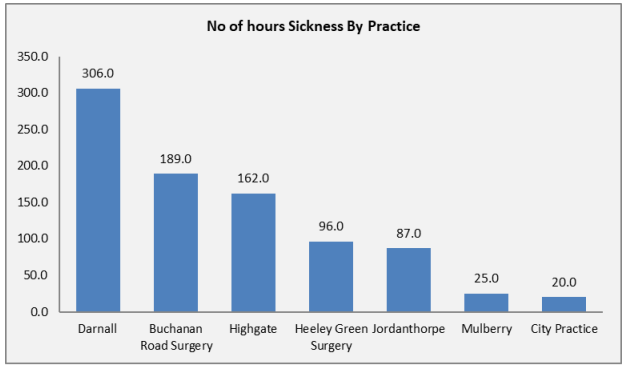
Recovery Teams

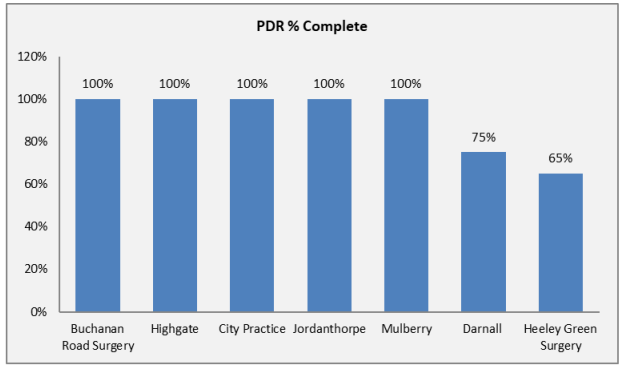
The increased performance across the recovery services coincides with specific actions taken within both teams.

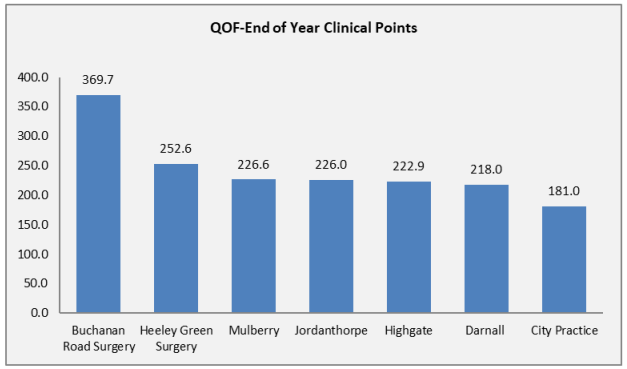
Early Intervention (EIS)

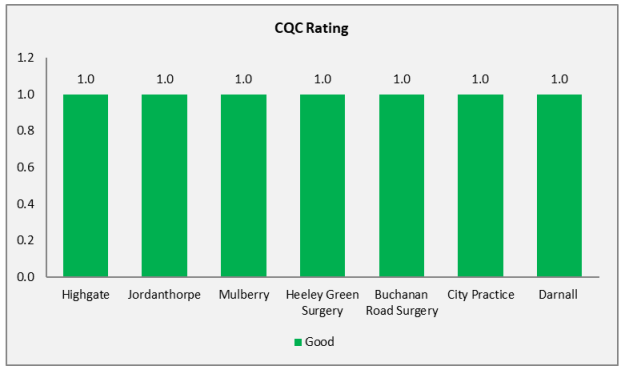
The dip in performance is directly linked to a significant staff shortage that peaked during September. Although gaps still remain throughout October the situation has eased slightly which has seen the figures start to rise again.

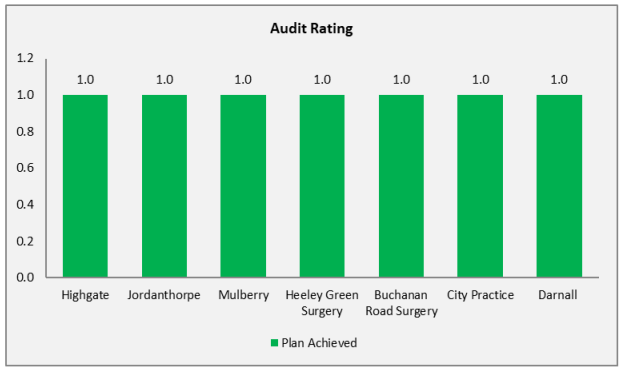
Clover Group & Primary Care Practice Dashboard – October 2020

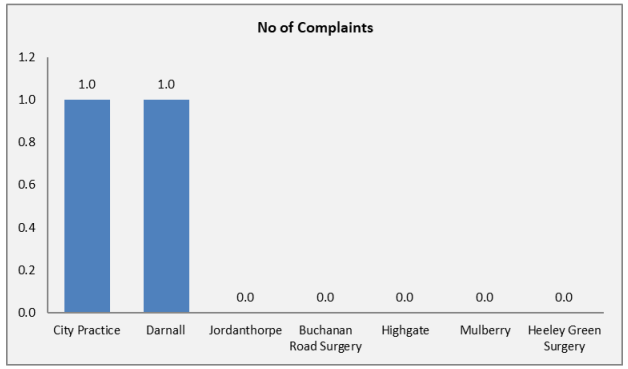


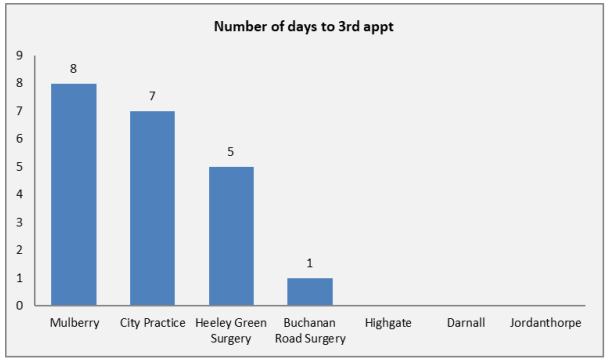


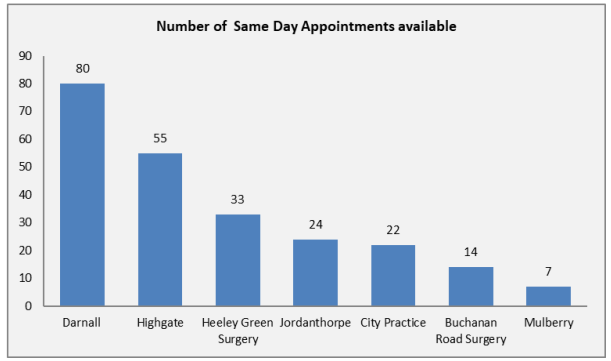


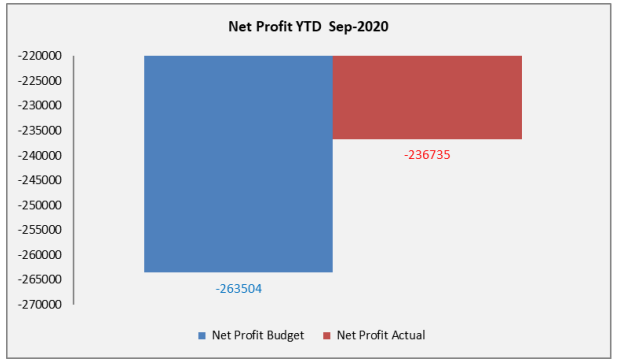


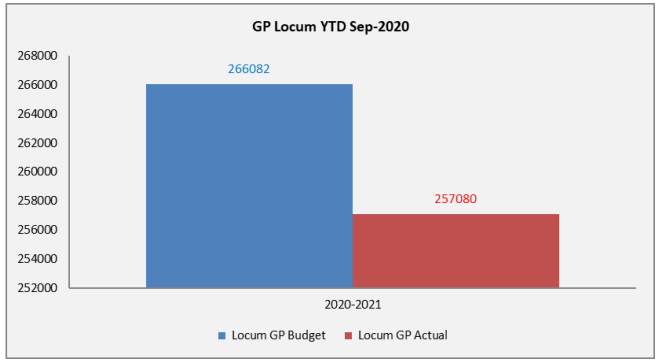












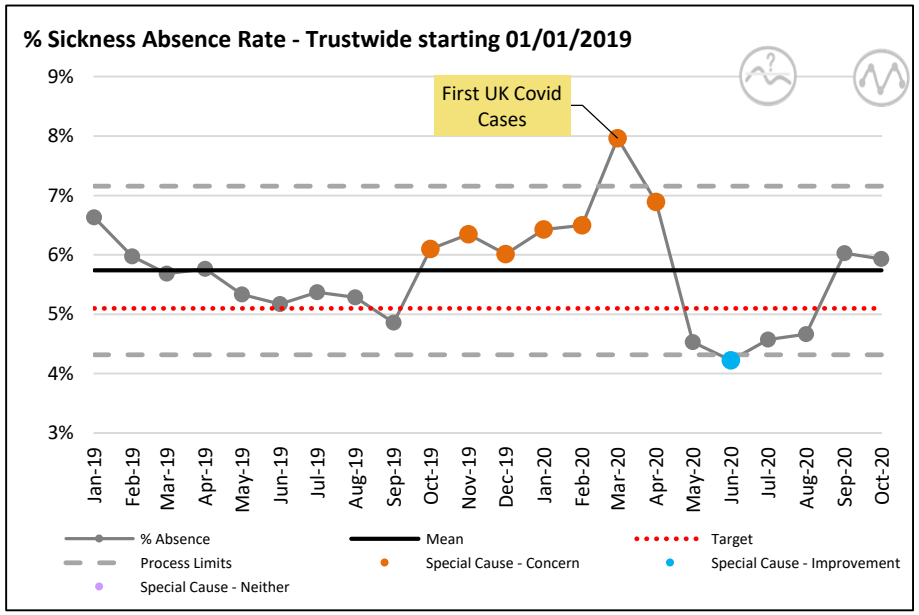
Finance Data is always one month in arrears . This is due to reporting lags within finance.

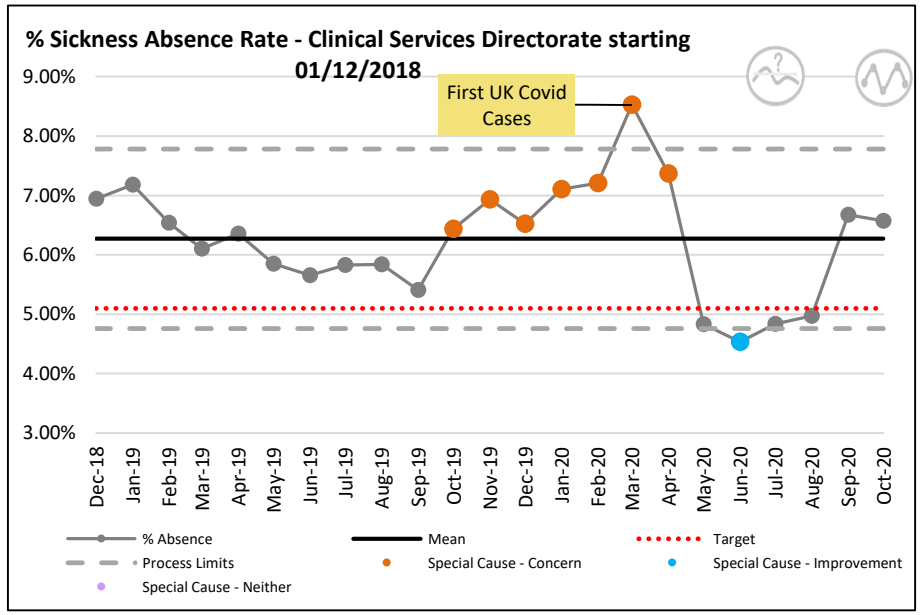
Workforce 1 | Summary – October 2020

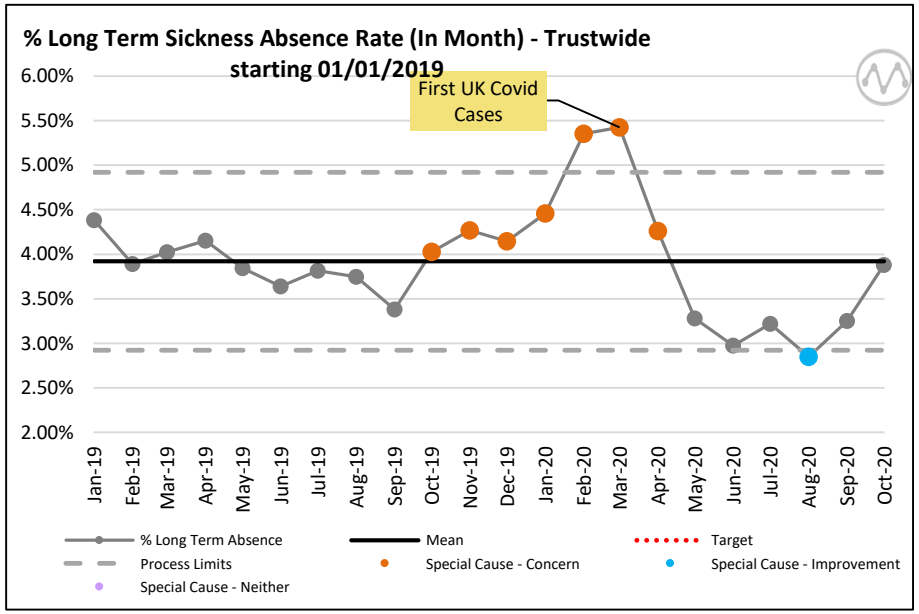
October 2020		Directorates				Trust Total		
Indicator	**Target**	**Clinical Services**	**Medical**	**Non Med Support**	**GP Surgeries**	**Sep-20**	**Oct-20**	**Change**
Staff in Post (Headcount)	**-**	2047	191	291	70	**2567**	**2599**	**+32**
Vacancy (%)		10.0%	5.4%	8.1%	0.0%	**7.8%**	**9.3%**	**+1.5%**
Turnover (%)	**10%**	9%	9%	15%	8%	**11%**	**11%**	**-0.2%**
Sickness In Month (%)	**5.1%**	6.57%	2.35%	3.85%	7.11%	**6.03%**	**5.93%**	**-0.1%**
Sickness 12 Month (%)	**5.1%**	6.24%	2.88%	3.85%	7.63%	**5.73%**	**5.72%**	**-0.0%**
Long Term Sickness (%)		4.27%	1.41%	2.45%	6.64%	**3.25%**	**3.88%**	**+0.6%**
Short Term Sickness (%)		2.30%	0.94%	1.39%	0.48%	**2.78%**	**2.05%**	**-0.7%**
PDR Compliance (%)	**90%**	92.0%	97.1%	95.9%	70.8%	**99.0%**	**92.3%**	**-6.8%**
Training Compliance (%)		90.4%	87.0%	90.8%	67.6%	**93.5%**	**89.5%**	**-4.1%**

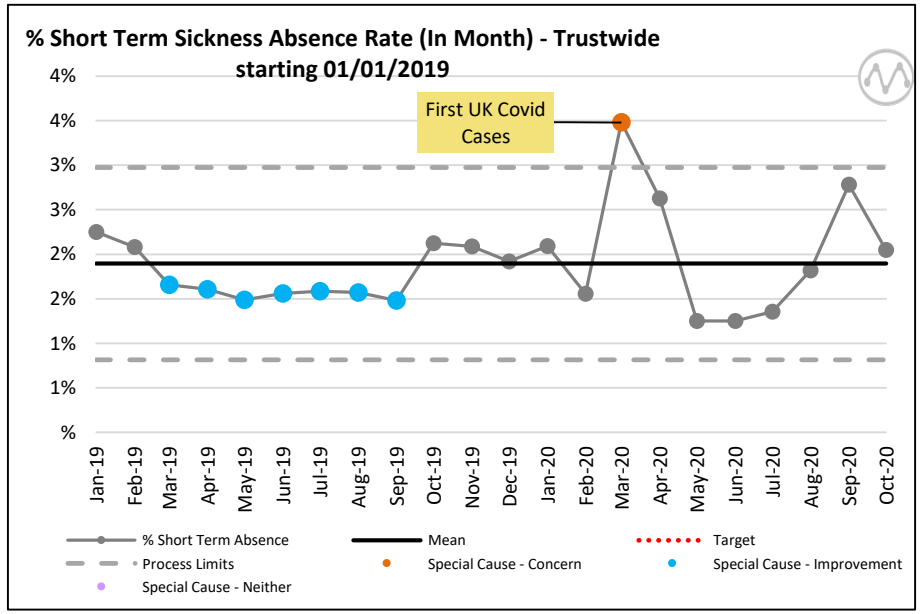
Notes:
- Medical turnover excludes fixed term rotations.
- Vacancy based on establishment (FTE) data compared with staff in post (FTE) figures.
- Establishment data excludes bank, agency, and turnover factor figures.

Workforce 2 | Sickness Absence









Narrative

The absence rate for October 2020 is 5.93%, shows a downward trajectory as the rate Sep 19 was 6.06% a decrease of 0.13%.
The top three areas with the highest number of absence occurrences in October were:

1. Buckwood View
2. Woodland View
3. IAPT

Long/Short Term Sickness

The trust short term absence rate decreased to 2.05%.
The top three areas with the highest number of Long term absence occurrences were:

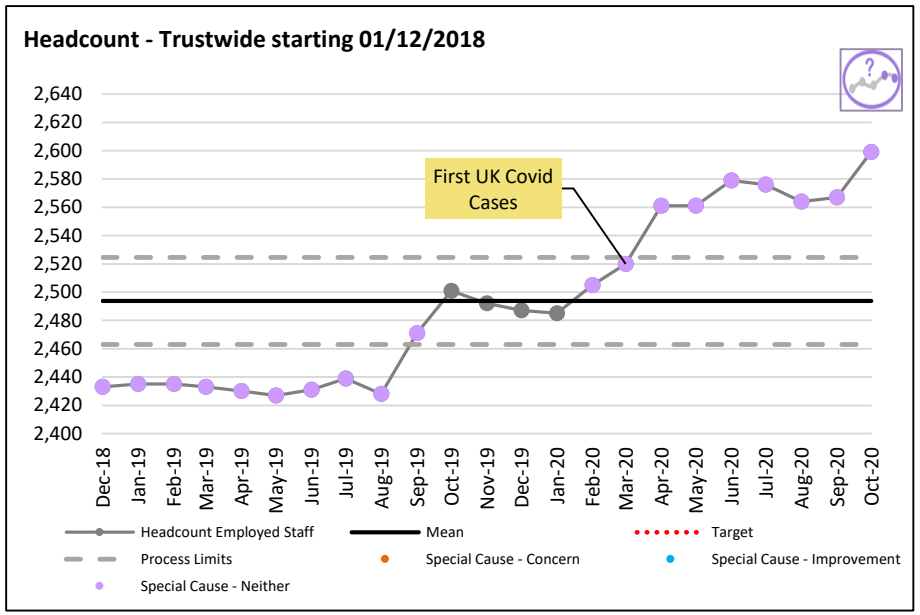
1. Birch Avenue
2. Woodland View
3. Buckwood View

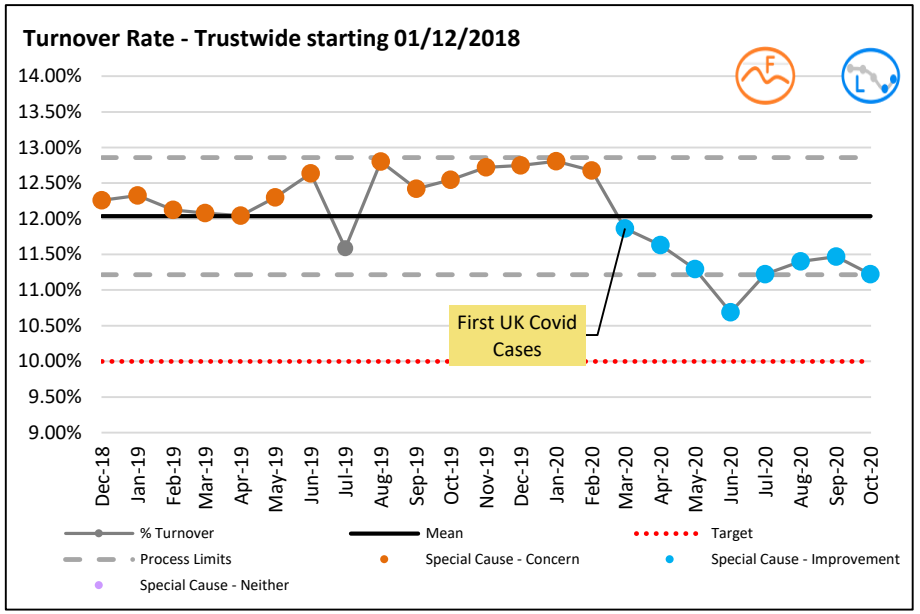
All of these areas have seen a significant spread of the COVID-19 virus, which explains why they are currently seeing an increase in sickness absence.

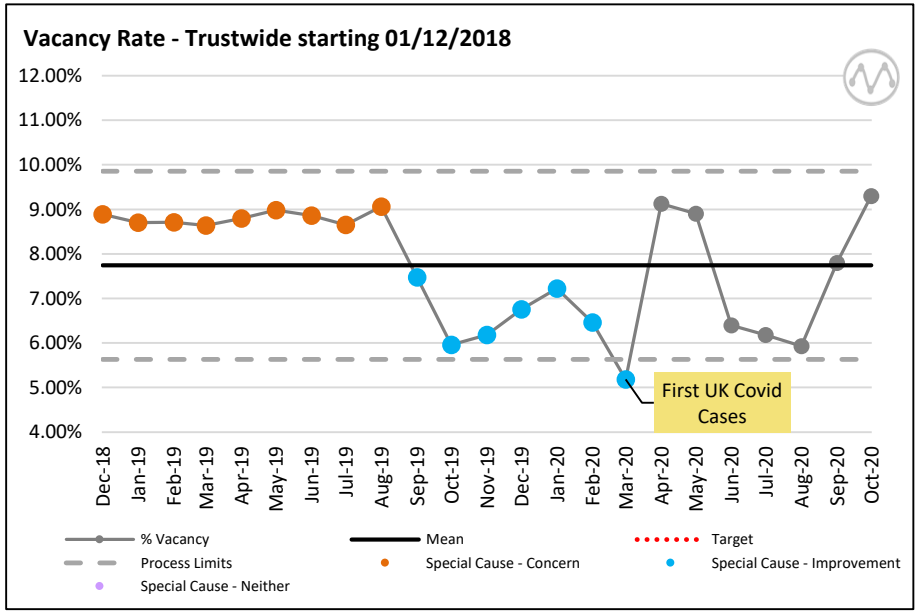
Sickness Absence reasons by Occurrence

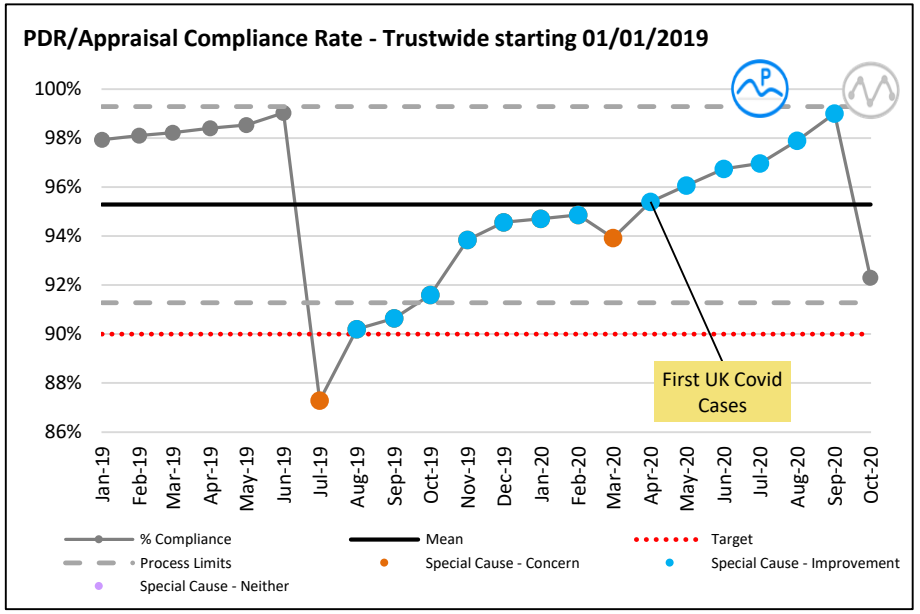
	October 20	October 19
1	Infectious Diseases	Cold, Cough, Flu
2	Anxiety/stress/depression/other psychiatry illness	Anxiety/stress/depression/other psychiatry illness
3	Gastrointestinal problems	Gastrointestinal problems
4	Cold, Cough, Flu	Other Musculoskeletal problems

Workforce 3 | Staffing & Appraisal









Narrative

Headcount
Trust Headcount has increased by 30 employees during October 2020.

A large part of this is the recruitment of 10 trainee practitioners into our IAPT service.

Turnover Rate (%)
Trust Turnover has slightly decreased this month, and shows a significant downward trend since March 2020.

This is mostly due to a reduction in Turnover for Admin and Clerical posts within Non Med Support.

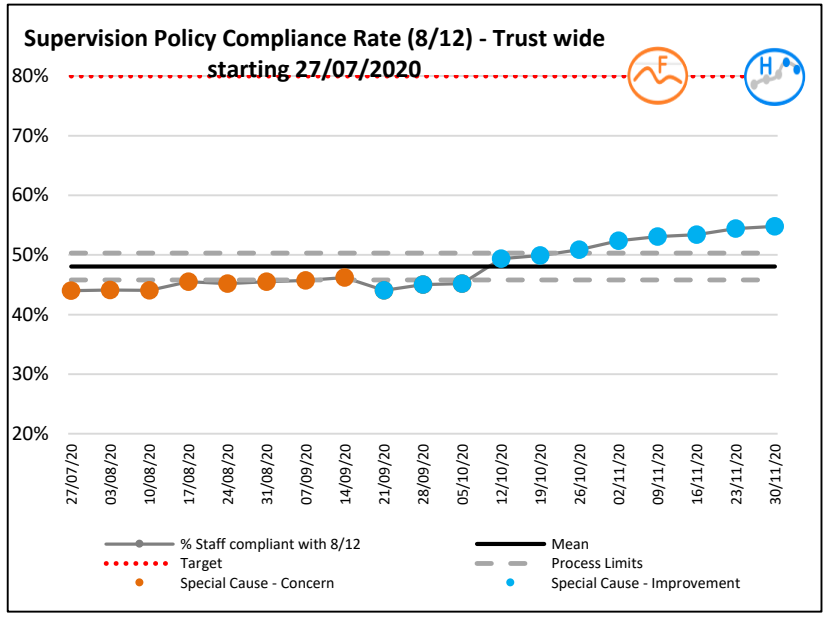
Vacancy Rate (%)
Vacancy rate has increased again this month, to 9.3%. This is due to a significant increase in establishment for Clinical Services, raising their vacancy rate to 10%.

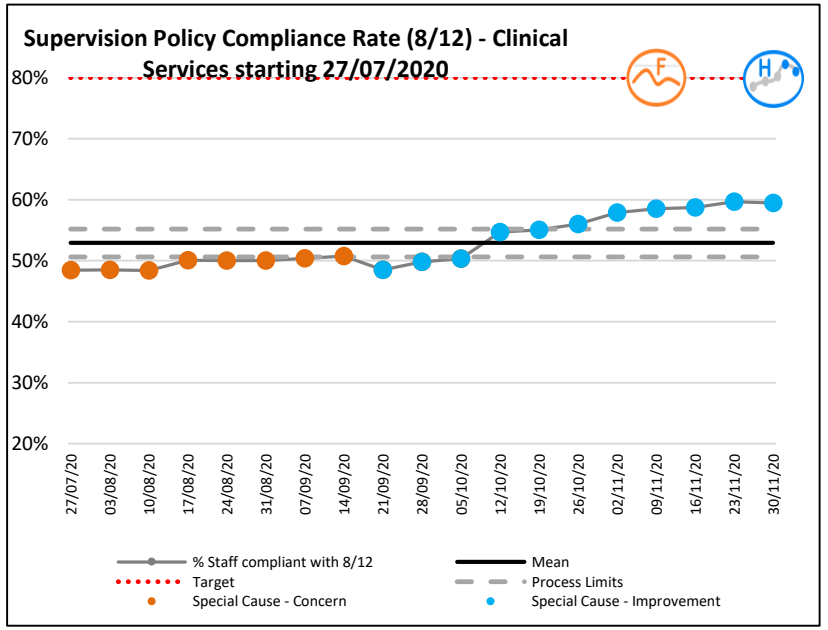
The staff group with the highest vacancy rate is Additional Professionals and Scientific at 15.4%. Allied Health Professionals has the lowest vacancy rate at 2.4%

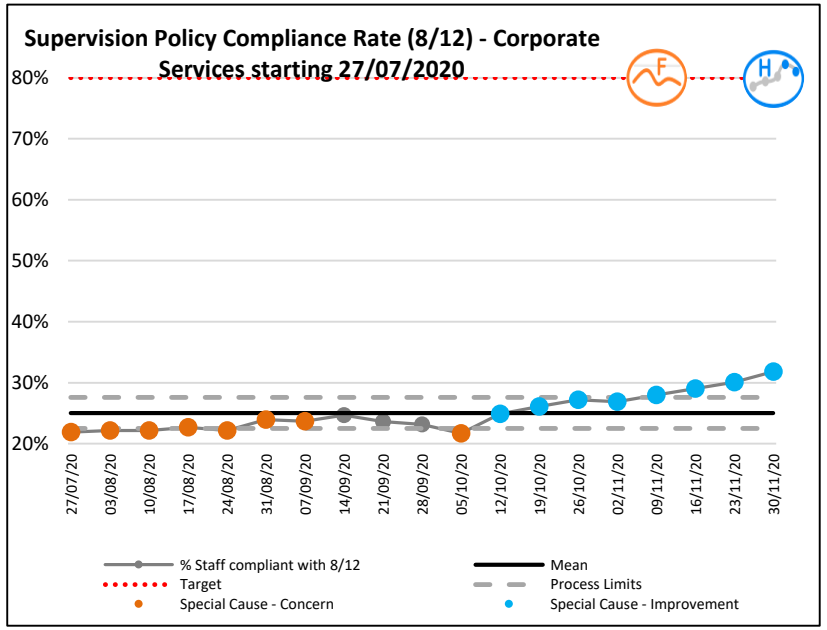
PDR Compliance
PDR Compliance has reduced, as anticipated, due to the end of the focal point window. However, due to the Weekly PDR Completion reminders to managers and staff, we have been able to keep the rate above the trust target of 90%.

Last year, PDR Compliance reduced to 87.3% after the focal point window was finished.

Supervision







AIM

We will ensure that 80% staff have received at least the required minimum of 8 supervisions in a 12-month period, and that it is recorded in and reported on from a single source – the Supervision webform.

NARRATIVE

Current mean compliance with the 8/12 target is at 55%, with Clinical services at 59% and Corporate services at 32%.

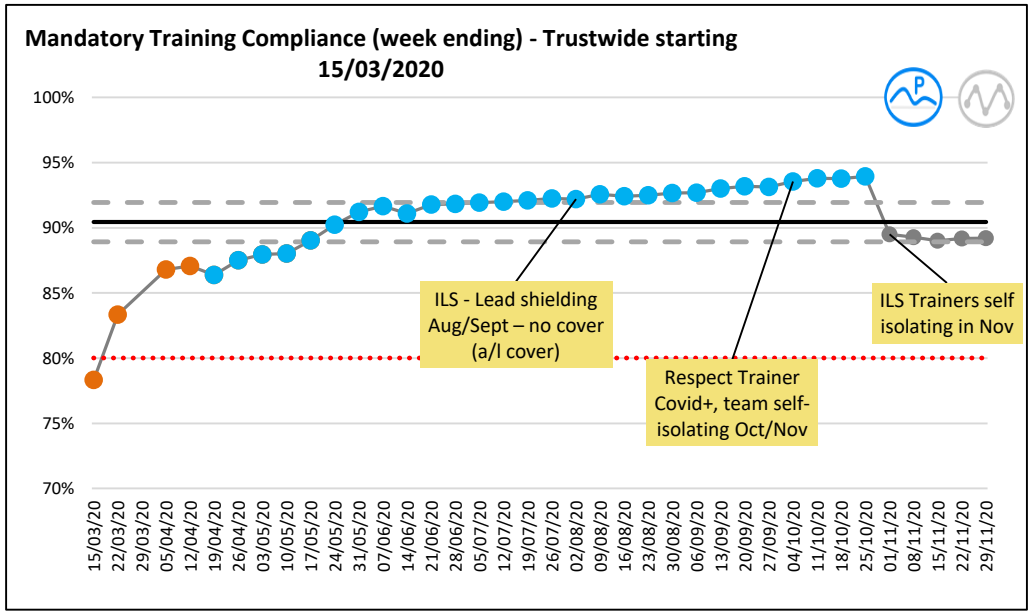
To note – the vertical axes display the same range for the purposes of comparison.

Changes to the Supervision Policy were agreed in June 2020. This included the setting of the 80% compliance for a minimum of 8 supervision sessions in 12 months. This information is shown here from w/e 1 August 2020 for Trust wide, Clinical and Corporate Services.

Work is ongoing as part of the Back to Good Programme to implement additional and improved monitoring and reporting to take working patterns (e.g. part time) and eligibility (e.g. new starters) into account.

The addition of a measure of quality of supervision is also being explored in consultation with staff across the Trust.

Mandatory Training



AIM

We will ensure a Trust wide compliance rate of at least 80% in Mandatory Training.

NARRATIVE

Trust Compliance 89.21%

As at 30th November 81.77% of staff are 80% compliant or above.

EXCEPTIONS

Subjects Below 80%

6 Subjects are below 80%, which are ILS, Mental Health Act, Respect Level 2 and 3, Safeguarding Children Level 3 and Moving and Handling Level 2.

Of the 148 staff who are non-compliant in Moving and Handling Level 2, 119 (80.41%) of those who have not done the training have the knowledge/achieved level 1.

Of the 117 staff who are non-compliant in ILS, 76 (64.96%) are compliant with BLS.

Services Below 80%

Grenoside Facilities and PGME Medic & Dental are below 80% compliance.

Sheffield Health and Social Care Mandatory Training Compliance @

29 November 2020

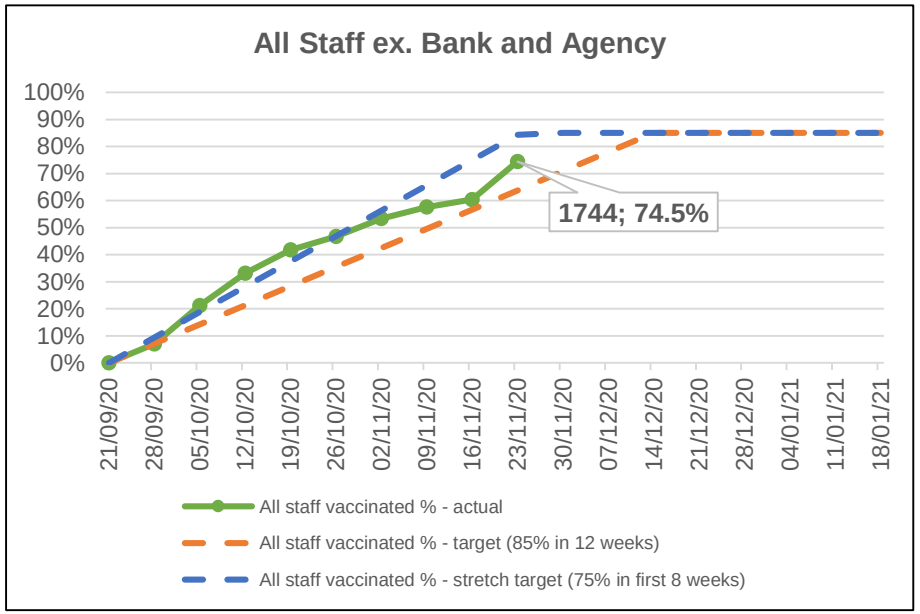
Compliance % highlighted in orange is between 75-79.99% meaning it below but close to the 80% target.

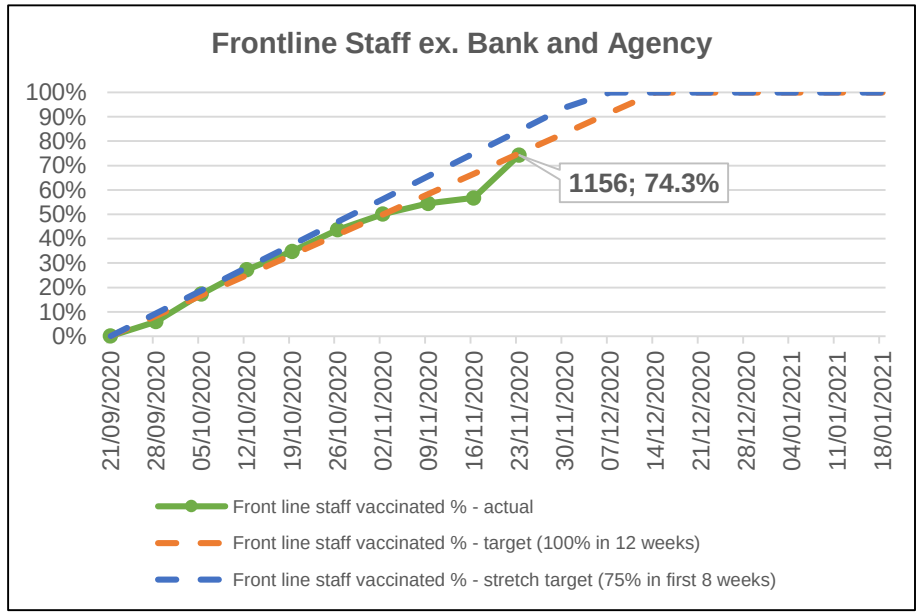
Compliance % highlighted in red is between 0-74.99%

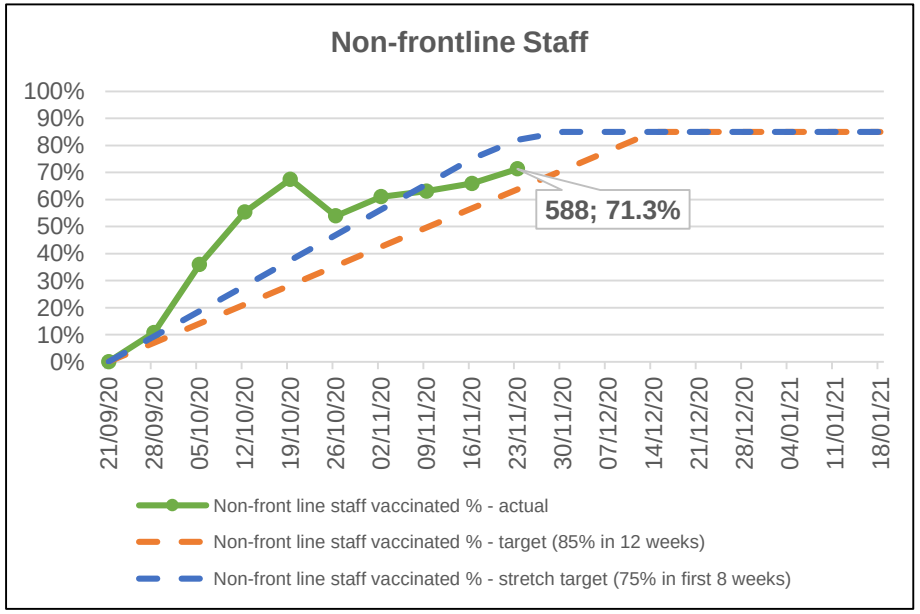
This does not include new starters for 3 months after their start date

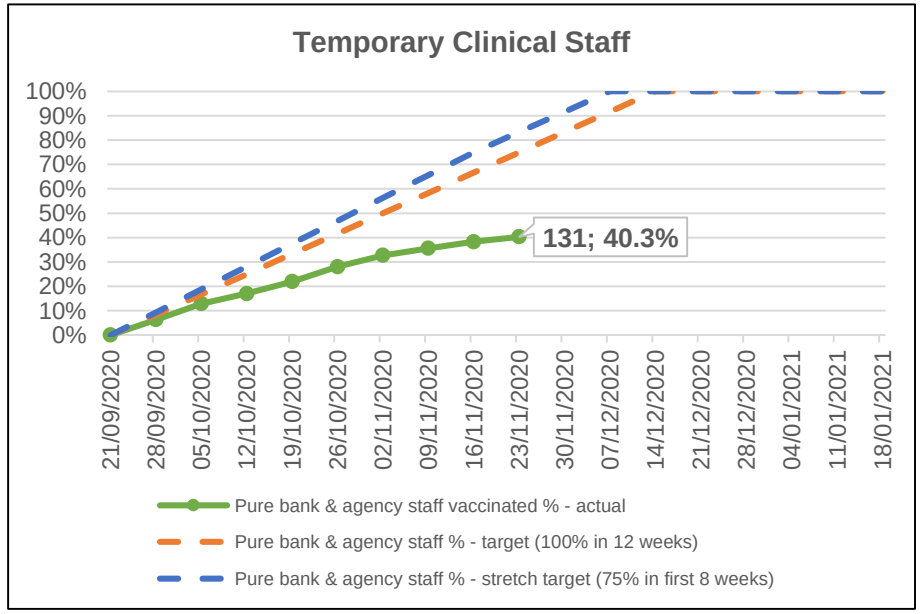
			22 November 2020				29 November 2020				Current Compliance against Previous Compliance %	
Subject	**Level**	**Frequency**	No Requiring	No Achieved	No NOT Achieved	Compliance	No Requiring	No Achieved	No NOT Achieved	Compliance		
Equality, Diversity and Human Rights		3 Years	2561	2401	160	93.75%	2572	2405	167	93.51%	Decrease	-0.25%
Hand Hygiene		3 Years	2561	2444	117	95.43%	2572	2445	127	95.06%	Decrease	-0.37%
Health and Safety		3 Years	2561	2425	136	94.69%	2572	2431	141	94.52%	Decrease	-0.17%
Information Governance (aka Data Security Awareness)		1 Year	2561	2300	261	89.81%	2572	2311	261	89.85%	Increase	0.04%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2561	2431	130	94.92%	2572	2437	135	94.75%	Decrease	-0.17%
Adult Basic Life Support		1 Year	2561	2089	472	81.57%	2572	2103	469	81.77%	Increase	0.20%
Fire Safety		2 Years	1288	1171	117	90.92%	1294	1172	122	90.57%	Decrease	-0.34%
		3 Years	1272	1207	65	94.89%	1276	1208	68	94.67%	Decrease	-0.22%
Immediate Life Support		1 Year	274	153	121	***55.84%***	272	155	117	***56.99%***	Increase	1.15%
Clinical Risk Assessment		3 Years	981	893	88	91.03%	983	889	94	90.44%	Decrease	-0.59%
Dementia Awareness		No Renewal	2290	2214	76	96.68%	2301	2225	76	96.70%	Increase	0.02%
Autism Awareness		No Renewal	2287	2223	64	97.20%	2298	2231	67	97.08%	Decrease	-0.12%
Mental Capacity Act	1	3 Years	1084	949	135	87.55%	1091	954	137	87.44%	Decrease	-0.10%
	2	3 Years	1122	979	143	87.25%	1125	989	136	87.91%	Increase	0.66%
Deprivation of Liberty Safeguards	1	3 Years	2093	1936	157	92.50%	2102	1945	157	92.53%	Increase	0.03%
	2	3 Years	105	96	9	91.43%	105	96	9	91.43%		0.00%
Mental Health Act		3 Years	196	149	47	76.02%	194	155	39	79.90%	Increase	3.88%
Medicines Management Awareness		3 Years	536	433	103	80.78%	538	442	96	82.16%	Increase	1.37%
Rapid Tranquilisation		3 Years	306	262	44	85.62%	304	262	42	86.18%	Increase	0.56%
Respect	1	3 Years	1118	987	131	88.28%	1122	994	128	88.59%	Increase	0.31%
	2	2 Years	855	559	296	***65.38%***	860	562	298	***65.35%***	Decrease	-0.03%
	3	1 Year	396	229	167	***57.83%***	396	224	172	***56.57%***	Decrease	-1.26%
Safeguarding Children	2	3 Years	1098	950	148	86.52%	1105	960	145	86.88%	Increase	0.36%
	3	3 Years	1106	858	248	77.58%	1108	858	250	77.44%	Decrease	-0.14%
Safeguarding Adults	2	3 Years	2204	1900	304	86.21%	2213	1921	292	86.81%	Increase	0.60%
Domestic Abuse	2	3 Years	2208	1882	326	85.24%	2217	1904	313	85.88%	Increase	0.65%
Prevent WRAP		3 Years	2203	1895	308	86.02%	2212	1896	316	85.71%	Decrease	-0.30%
Overall compliance						**89.17%**				**89.21%**	Increase	0.04%
Moving and Handling	1	3 Years	2561	2411	150	94.14%	2572	2417	155	93.97%	Decrease	-0.17%
	2	3 Years	734	573	161	78.07%	736	588	148	79.89%	Increase	1.83%

Flu Vaccination









AIM

We will protect our service users and colleagues by vaccinating our staff against flu.

Targets: 100% of frontline staff and 85% of all staff by 24 December (12 weeks from beginning of campaign).

NARRATIVE

- Performance for all staff, frontline and non-frontline staff ahead of stepped targets (85% in the first 8 weeks of the campaign).
- Performance of agency and pure bank staff is behind target. We are actively engaging with our agencies to implement interventions to improve performance.

Financial Overview as at 31 October 2020

	Performance Indicator	Current Month Plan	Current Month Actual	Prior Month Actual
	Surplus/(Deficit)			
1	Covid-19 reimbursement	£0.525m	£0.611m	£0.931m
1	Reported Surplus/ (Deficit) Position	(£0.707m)	(£0.202m)	£0m
		Annual Plan	**Year to Date**	**Forecast 20/21**
2	Agency	£5.025m	£2.634m	£5.085m
3	Cash	£47.385m	£62.560m	£47.644m
4	Efficiency Savings (Cost Improvement)	£0.638m	£0.179m	£0.638m
5	Capital	£15.557m	£1.026m	£6.449m

Narrative

The confirmed funding envelope for Patient Care activities is £111.8m; the original forecast plan was a deficit financial position of £4.6m which has now been reduced in part by £0.5 due to a material change in Out of Area activity.

Strategic Risks
The Trust currently has no mitigation strategy for the remaining forecast £4.1m deficit, therefore, a break-even position is unlikely at this point.

The overall income allocation for 2020/21 includes an annual investment provision for projects which fall under the Trust's Transformation agenda totalling £4.9m; although this allows projects to continue, it is unlikely to be fully utilised in year. Sheffield Clinical Commissioning Group (SCCG) have agreed that the Trust can in part retain slippage (surplus) totalling c £1.2m accrued the during months 1 to 6.

Operational Risks
Out of Area expenditure has been on an upward trend all year, October is this first month to see a reduction (down by £0.224m), which is due to a material change in activity, 12 service users repatriated into area - this has a significant impact on the forecast (reduction £0.5m). Overall the system pressures causing the significant increase in cost compared to prior years is unlikely to dissipate materially this Financial Year (FY). The estimated cost this FY is £8.9m, expenditure to date is £4.6m (Prior FY £4.6m).

Agency and Bank spend remains volatile whilst the Trust strives to stabilise the workforce during the pandemic. The estimated cost this FY is £11.4m, expenditure to date is £6.2m (Prior FY £8.7m).

Legacy overspending areas in Clinical Operations remain and outstanding Cost Improvement Plans in HR result in a forecast overspend in the Corporate area.

Key Messages

- The Trust needs to have a tight grip and control of the financial position; it's imperative that delegated budgets break-even.
- Performance Management meetings have been stepped up to address overspending areas.
- The COVID envelope for months 7 – 12 is £3.1m which is significantly less than the actual profile of expenditure for the first of half of the FY which totalled £4.1m.
- The Top-up envelope for month 7 -12 is £1.9m which is significantly less than the actual profile of expenditure for the first half of the FY which totalled £5m.
- There will be some mitigation of the £4.1m deficit from the Trust's central reserves for planned Capital charges; this is a direct result of the reduced Capital programme, this will be a one off exceptional item once realised.
- The Cost Improvement Programme needs to be progressed, and closely monitored. The Framework for this needs ratification.
- The Investment monies from the SCCG will need to be closely monitored to enable productive conversations with regard to any future slippage and use of resources.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

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Appendix 1 | Report Development

We have committed to work on the development of the Trust Board report, to ensure that it includes meaningful indicators that are data quality assured, accessibly presented with appropriate analysis, having gone through a 'Floor to Board' governance hierarchy. This will enable appropriate Board understanding, scrutiny and oversight of the operations of the Trust. This is the first iteration of an integrated Performance & Quality Report for the organisation. We have converted RAG monitoring to Statistical Process Control (SPC) charts where possible, and replicated the previous performance and quality reports information in a new format. An explanation and guide for SPC is available here.

Plans for continued development

- Work with Workforce Team and People Committee to ensure the information presented in the IPQR is a summarised picture of more detailed information presented at People Committee and that exceptions and highlights are identified as necessary.
- Review of the preparation schedule, and timely presentation of report to Board committees and Trust Board as per Performance Framework.
- Restructure of KPI overview and report layout to include metrics grouped under the following categories
    - NHS Oversight Framework (19/20)
    - Better alignment with Strategic Objectives/NHS Long Term Plan and Quality Objectives
    - CQUIN
    - Well Led
    - Key Areas of Concern/Key areas for Improvement & Development
- Access & Waiting Times – Referral to Assessment and Treatment times for all services, with associated standards and targets
- Review of all required metrics in collaboration with Service areas and Board members, as part of the Floor to Board review process currently led by Executive Director of Nursing, Professions and Operations
- Development of 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.
- 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 manual processing.

Appendix 2 | SPC Explained

An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data which are unlikely to have occurred due to chance and require investigation. They can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting the target without a change.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

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