Sheffield Health and Social Care NHS Foundation Trust

Board of Directors - Public

Date: 26 May 2021 **Item Ref:** 10

TITLE OF PAPER	Integrated Performance and Quality Report March 2021
TO BE PRESENTED BY	Phillip Easthope, Director of Finance,
ACTION REQUIRED	Members are asked to: • To consider if the mitigating actions provide sufficient assurance to mitigate the risks identified.
OUTCOME	To enable Board members to triangulate and assess the quality of care and to identify any concerns relating to this.
TIMETABLE FOR DECISION	For presentation to the Board of Directors in May 2021.
LINKS TO OTHER KEY REPORTS / DECISIONS	IPQR report to Quality Assurance Committee and Finance and Performance Committee April 2021. Annual Quality Report & Accounts, Incident Management Reports, Mortality Reports, safeguarding reports, Getting Back to Good reports and Finance report.
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	CQC: Getting Back to Good BAF0002 Non-delivery of Well led development plan BAF0003 unable to improve patient safety BAF0004 unable to improve quality of patient care
LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	NHS Improvement's Single Oversight Framework CQC Fundamental Standards NHS England's Serious Incident Reporting Framework Quality Schedule with NHS Sheffield Clinical Commissioning Group Links to Corporate Risk Register and Care Network Risk Registers Performance Framework
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	If care is inadequate this may result in harm to service users and a poor experience of services. There may also be further contractual / legal implications from commissioners or regulatory bodies.
CONSIDERATION OF LEGAL ISSUES	None-highlighted
Author of Report	Phillip Easthope
Designation	Director of Finance
Date of Report	April 2021

Sheffield Health and Social Care NHS Foundation Trust

Integrated Performance and Quality Report

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

1. 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. This report details data up to and including March 2021.

The report was presented and considered in detail to the Quality Assurance Committee and to the Finance and Performance Committee in May. For each issue the risk was explored, and the paper offered mitigations, notably in the May 21 QAC reports were also received on Mortality, Learning Lessons, Safeguarding, Medicines Safety and the Reducing Restrictive Practice strategy with a review of existing recovery plans scheduled in the work plan.

The Finance and Performance committee received papers highlighting issues and their mitigation in relation to IAPT and Community waiting times, CPA reviews, Out Of Area (OOA) admissions and the Delivery of CIP. In separate papers the committee received an update on recovery plans for Single point of access / emotional wellbeing service, recovery service and Adult acute OOA and the new CIP planning process and timelines, these detailed reports whilst acknowledges the challenges provided assurance plans were in place detailing the trajectories for improvement.

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.

There are no new quality risks to highlight in this report. The areas of risk and improvement are indicated.

Related Highlights, Exceptions and Actions

Medication Management is an area of focus, we are exploring hotspots. **Learning from Incidents** has seen improvement with reported incidents being understood and closed down more rapidly as shown on page 6. Although we sit within the average for **Catastrophic Incidents** according to the NRLS benchmarking the QAC continues to receive data about the number and nature of incidents and has been assured that all incidents reported are reviewed daily and serious incident investigations are undertaken where required. All deaths are reviewed through weekly mortality review processes to ensure learning is gained and shared. The rate of **Falls** in inpatient services has maintained improvement**.** All falls reported in March 2021 were graded 'negligible'.

SHSC continues to be an outlier in the reliance of **Restrictive Practice Incidents** which continues to be a risk to the safety of staff and service users. The risk is captured in the BAF reviewed and presented at the QAC in April 2021. The medium to longer term mitigation is the strategy to reduce the use of restrictive practices has been co-produced and implemented with staff and people who use services. The Heads of Nursing, Matrons and Ward Managers are supporting teams to stop and reflect on practice as part of the strategy. Optimising the use of medication is a

current focus and the daily safety huddles increase oversight. There were no mechanical restraints reported in March 2021.

We have seen a consistent reduction over four months in **Sexual Safety** incidents. This may be related to SHSH rehabilitation service engagement with the national improvement collaborative focussing on sexual safety and that two of the three acute wards has moved to single gender with improvements commencing January 21 and full implementation from March 21 as well as Ward Manager leadership being strengthened.

Patient and Staff Assaults. There was one moderate rated patient to patient incident reported during March 2021, this related to an altercation caused by the misidentification of a service user and responding to unseen stimuli. There were no moderate rated or above staff assault incidents reported during March 2021.

The lower levels of **Service User and Staff feedback** remains a risk, the inpatient survey (Quality of Experience) has been revised and shortened to make more effective for volunteers and respondents to complete. Additional volunteers are being trained to ensure their safety and a safe return to the wards. IT equipment is being sourced to allow for 'office based' telephone surveys to be conducted.

The number of people who are **Out of Area Placements (OOA), Adult Acute Bed Occupancy and Length of Stay (LOS) in Acute & Community Directorate (Adult, Older Adult & PICU wards) remain areas of significant concern** due to quality and financial impacts. There is a full recovery plan in place which has been presented to both the QAC and also the Finance and Performance Committee. Although assured that action is being taken the committees will retain close oversight. The recovery plan is supported by a detailed Project Initiation Documents with a significant focus on people who are medically fit for discharge. This issue could further deteriorate with the move from Burbage ward to Dovedale 2 ward to enable essential estates works. To mitigate this we are proactively procuring additional beds.

The **Community Waiting times** remains a risk in some services. Some have clear national and contractual services and in others waits may be perceived as hidden**.** The QAC has requested a full waiting times data set, the interim Head of Performance has committed to this information being included in the report by the September IPQR. Recovery Plans for unacceptable waiting times were provided and discussed at March 21 Quality Assurance Committee and are provided at May 21 Finance & Performance Committee: SPA/EWS, Mental Health Recovery, Gender Identity Clinic, SAANS and Specialist Psychotherapy Services (MAPPS and PD Service). The impact of the recovery actions will be assessed in the Clinical Directorate monthly Quality and Performance reviews and will be presented at Quality Assurance Committee to provide assurance on progress.

Although **IAPT** meets 3 of 4 national targets we are below the moving to recovery rate of 50%, with March's performance at 45.19%. This is however on a slow and consistent improvement trajectory and therefore we will continue with the established recovery approach. A recovery plan for CPA Reviews was received by the QAC in March 21 as despite improvements we continue to remain below target. Progress has slowed due to rapid turnover of staff in the recovery service. Recovery Services appointed to 4 posts during February that will be in place by April/May and temporary agency workers were appointed at the beginning of March 2021.

Workforce

Whilst the overall **Safer staffing** reports show good progress the detailed review of vacancies shows there are hot spots across services with an unacceptable rate of vacancies for registered nurses and health care support workers which present risks to the quality of care. Hot spots include G1, Birch Avenue and Stanage ward. To mitigate the impact in care it was noted that all ward manager posts are recruited to with good support from band 6 nurses. Good skill mix with trainee advanced clinical practitioners and nursing associates. Use of known temporary staffing and daily oversight. People committee received detailed workforce information and seek assurances regarding recruitment activity and retention plans.

Supervision compliance is currently at 63%, against a target of 80% staff receiving minimum 8 supervisions in a 12 month period. There are excellent examples of improvement in some Crisis services, Rehab & Forensic inpatient and community services and some of our highly specialist community services and IAPT. Compliance with supervision policy will continue to be closely monitored and to improve compliance and therefore support to staff supervision workshops are scheduled to take place in May 2021 and provide an ideal opportunity to re-emphasise the importance of good quality supervision and the links with better quality of care for people who use services, job satisfaction and personal development.

Due to the impact of Covid **Mandatory Training** has dropped below the target of 80% in two subjects; Intermediate Life Support and Respect level 2 and 3. An interim plan is being developed to ensure the safety of all wards at all times, including the rapid training of identified areas where compliance is low and wards working together to identify how they would respond across services in an emergency. However we recognise this as a risk to quality.

Risks to quality previously reported and not yet resolved.

Electronic Patient Record (EPR) System/IMST Resources
Although actions to strengthen the Insight system continue in line with the developed action plan, there continues to be an increased demand on overall IMST resources in the Informatics and Architecture Service. If these demands are not met, there is likely to be a negative impact on quality, for example, reduced functionality in Insight which impacts teams/services.

The revised plan for the New EPR procurement is presented to the Finance and Performance Committee May 21.

Acute Ward Environments
The Trust continues to progress essential refurbishment work across our Acute ward environments at the Michael Carlisle Centre, which is scheduled to be complete by December 2021. Dovedale 2 will be handed over in May 2021 as a 12 bedded ward. Burbage ward is scheduled to decant to Dovedale 2, resulting in a reduction of 4 Acute beds. In the interim the risk to safety of in patients was discussed at the QAC, Julie Sheldon, Head of Nursing reported the work to improve clinical risks assessment as a mitigation to this risk and the risk is reflected in the description and rating of the estates risk presented in the BAF to QAC April 2021.

CIP delivery
Issue: CIP performance for the year has been disappointing with only 35% of CIP achieved recurrently resulting in £1.6m carried forward.

Mitigation: A revised CIP planning and QIA process are being reviewed. The QEIA process was agreed at April Quality and Assurance Committee and a revised CIP delivery programme and plan was agreed at the May Finance and Performance Committee.

2. Action Required

The Board is asked to consider the risks and assurances within the Board Assurance Framework (BAF) have been reconsidered in relation to the details of this report and to request further information and actions where necessary. The Board is asked to consider the risks and ratings in light of this report.

3. Contact Details

For further information, please contact:

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NHS
Sheffield Health and Social Care
NHS Foundation Trust

Integrated Performance & Quality Report

Information up to and including March 2021

Proud to care in Sheffield

Format Version 4. Report Final v1

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Blue Underlined Text = Click to link to page

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 i information/metric.
?	Unconfirmed d on inform
☐	K

Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	MARCH 2021	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	COMMENTS	KPI Assurance
SAFE								
Adult Acute inpatient occupancy levels (KH03)*	Monthly	95%	93%	**96.48%**			See Acute Inpatient detail. This figure excludes leave and Out of Area placements.	✓
Functional Illness (Dovedale) occupancy levels (KH03)*	Monthly	95%	86%	**93.55%**			See Older Adult Inpatient detail. This figure excludes leave and Out of Area placements.	✓
Dementia Management (G1) occupancy levels (KH03)*	Monthly	95%	86%	**68.15%**	?		See Older Adult Inpatient detail. This figure excludes leave and Out of Area placements.	✓
Sickness absence	Monthly	5.10%	~	**5.42%**			See Workforce Detail	✓
Turnover	Monthly	10.0%	~	**14%**	H	F	See Workforce Detail. Note Clover Group/GP Surgeries TUPE transfer of staff out of Trust adversely affects overall Turnover figure in March 21.	✓

Overvie w | Summary KPIs 2

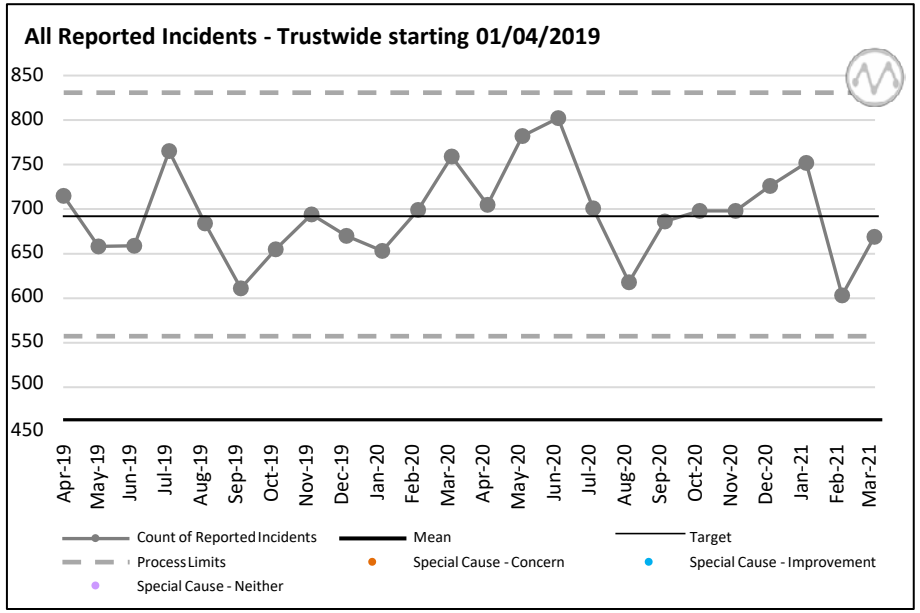
Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	MARCH 2021	SPC VARIATION/ TREND ICON	SPC ASSURANCE ICON	Comments	KPI Assurance
RESPONSIVE								
Out of area acute admissions	Monthly	0	N/A	**17**			15 Adult, 2 Older Adult admissions See Inpatient Detail. Recovery Plan in place.	✓
Out of area PICU admissions	Monthly	0	N/A	**6**			See Inpatient 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, and MH LTP KPIs for 21/22.	?
Access to Early Intervention in Psychosis Services - new cases	Monthly	6	N/A	**18**			Old target - needs review.	?
Waiting Time Standard Early Intervention – % commencing treatment within 2 weeks	Monthly	60.00%	N/A	**72.22%**				✓
Access to IAPT - new clients entering treatment	Monthly	1232	N/A	**1140**			See IAPT Detail	✓
Waiting Time Standard IAPT - % entering treatment in 6 weeks	Monthly	75.00%	N/A	**96.83%**			See IAPT Detail	✓
Waiting Time Standard IAPT - % entering treatment in 18 weeks	Monthly	95.00%	N/A	**99.67%**			See IAPT Detail	✓
IAPT Moving to Recovery Rates	Monthly	50.00%	N/A	**45.19%**			See IAPT Detail	✓

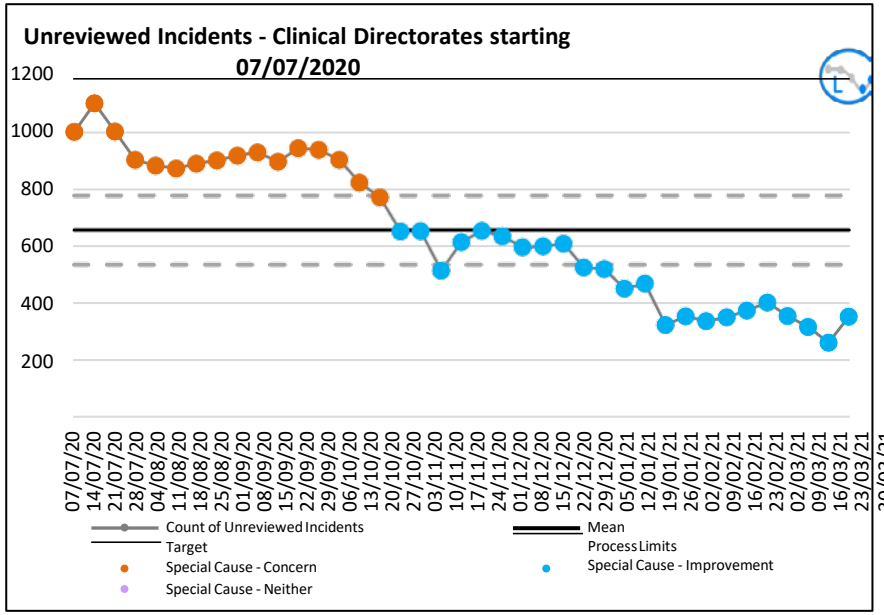
Overview | Summary KPIs 3

Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	MARCH 2021	SPC VARIATION/ TREND ICON	SPC ASSURANCE ICON	COMMENTS	KPI Assurance
EFFECTIVE								
Gatekeeping - Acute admissions assessed for HT	Monthly	95.00%	N/A	**100%**				?
CPA - % with an Annual Review	Monthly	95.00%	N/A	**85%**			See CPA Review Detail	?
Data Quality Maturity Index (DQMI) Score	Monthly	70%	82%	**88.7% (Jan 21)**	Newly reported metric. Variation & Assurance icons will be provided from 21/22 onwards. Trust has met 70% target throughout 20/21 to date.		Benchmark shown as national average score in January 21. Target for 21/22 is 80%. Full DQMI publication available at https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/data-quality	✓
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	**2,666**	N/A	N/A	See Finance Detail	N/A
Cash Balance (£000)	Monthly	N/A	N/A	**62,075**	N/A	N/A	See Finance Detail	N/A
CIP & Disinvestment Delivery Against Plan (£000)	Monthly	638	N/A	**638**	N/A	N/A	See Finance Detail	N/A

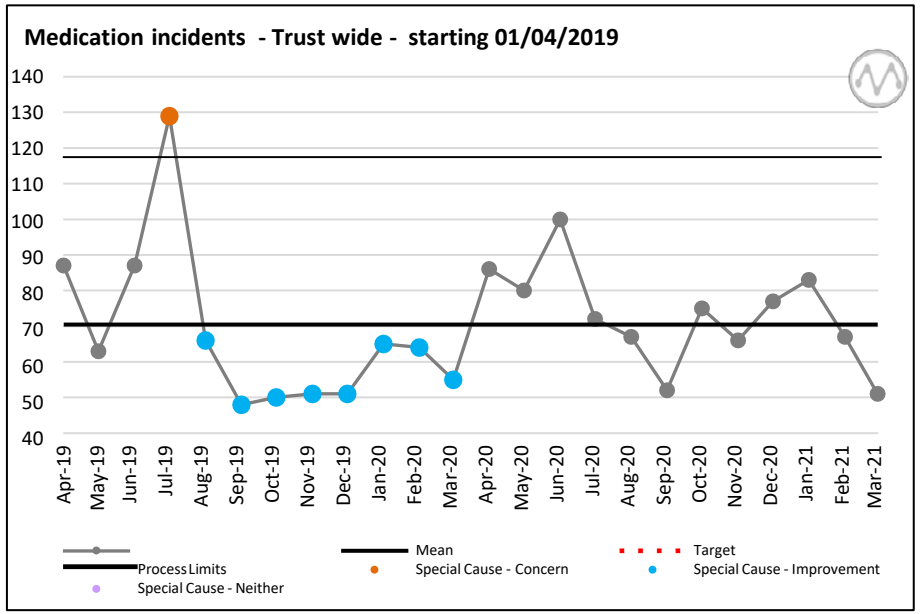
All Incidents | Medication Incidents

Incident Type	March 21	Variation
ALL	669	
Catastrophic	23	
Major	5	
Moderate	28	
Minor	184	
Negligible	418	
Near Miss	11	





Incident Type	March 21	Variation
ALL	51	
Prescribing	2	
Dispensing	3	
Administration	13	
Management	32	



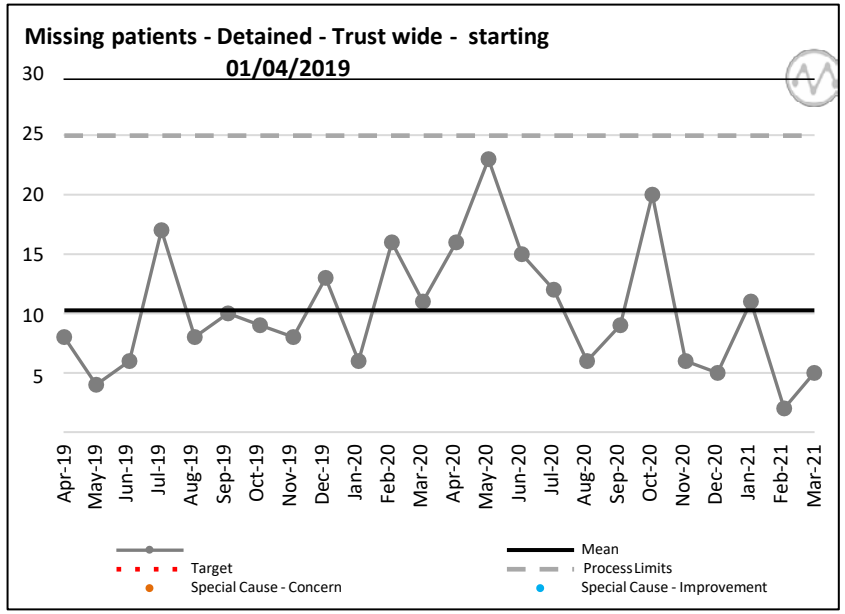
Unreviewed Incidents

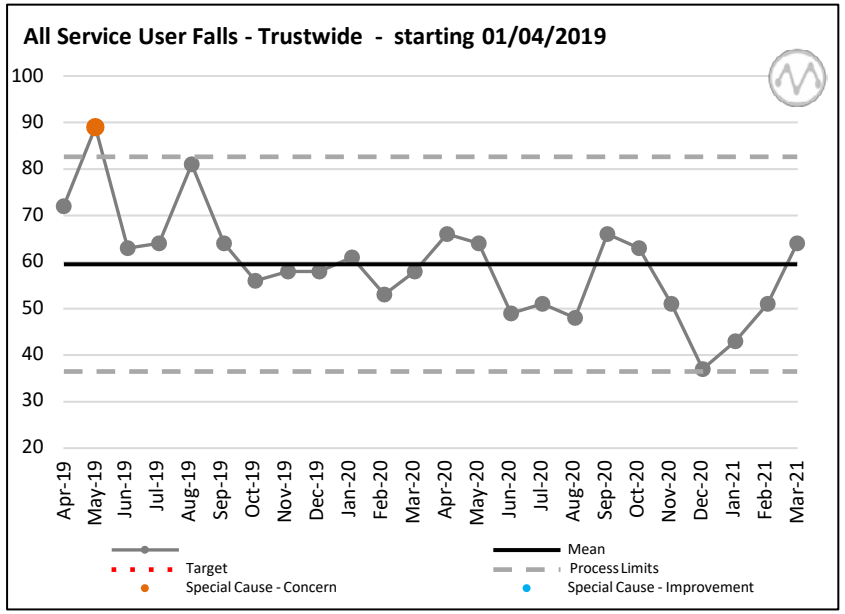
	2018	2019	2020	Total
3rd Feb	25	58	37	120
10th Feb	24	57	40	121
17th Feb	24	57	40	121
22nd Feb	24	57	40	121
1st Mar	24	57	43	124
8th Mar	24	57	43	124
15th Mar	5	37	41	83
22nd Mar	5	37	41	83
29th Mar	5	37	41	83

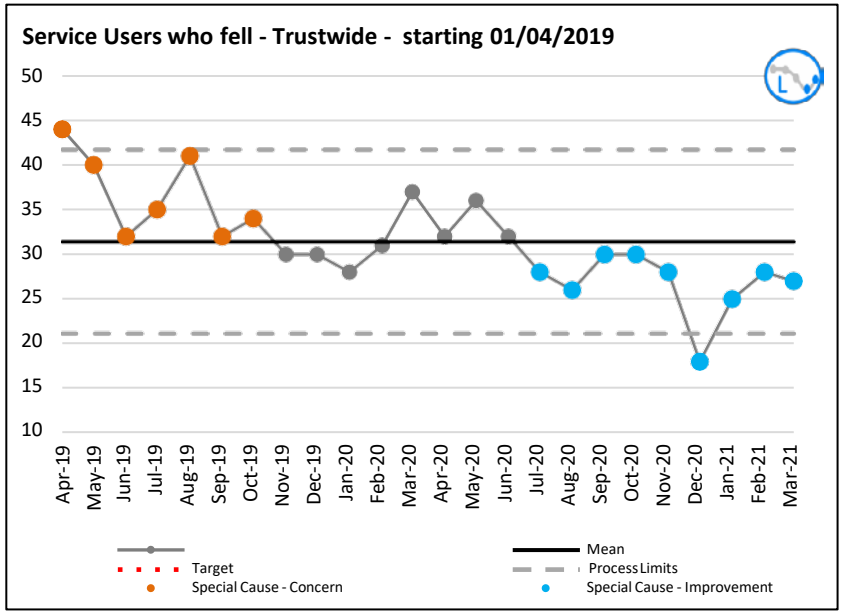
Serious Incident Actions Outstanding

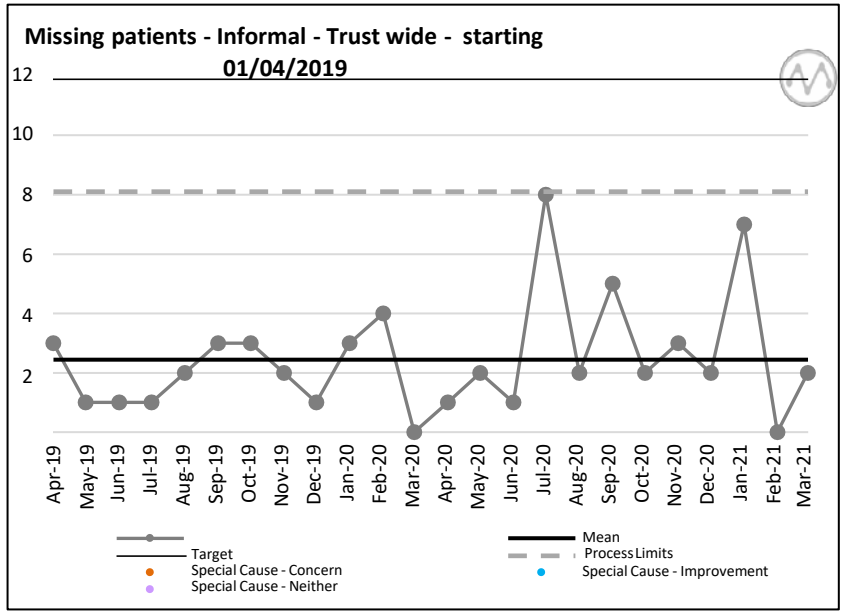
Falls | Missing Patients

Service/Ward	Number of Falls	March 21 Falls Icon	Number of Service Users	March 21 Service Users Icon
Trustwide	64		27	
G1 (Grenoside Grange)	21		9	
Dovedale Ward	3		2	
Birch Avenue	25		8	
Woodland View	8		3	

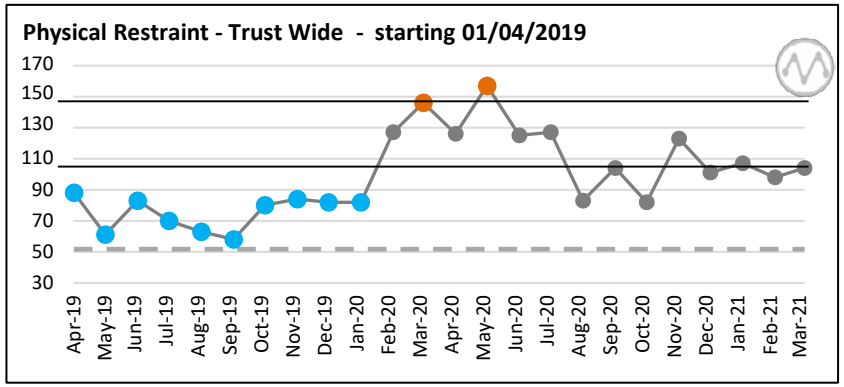


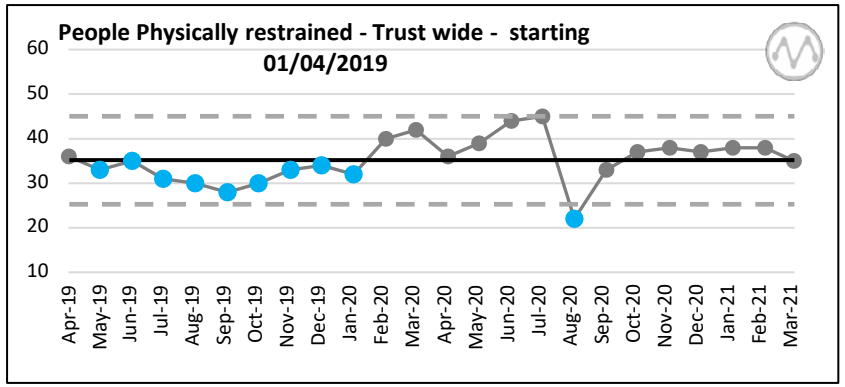






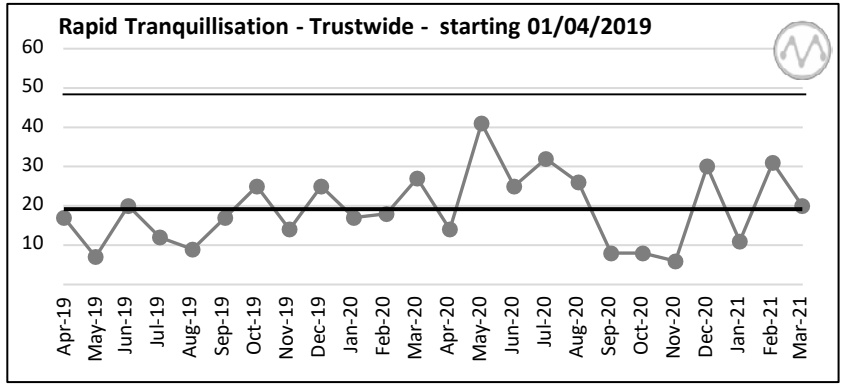
Physical Restraint

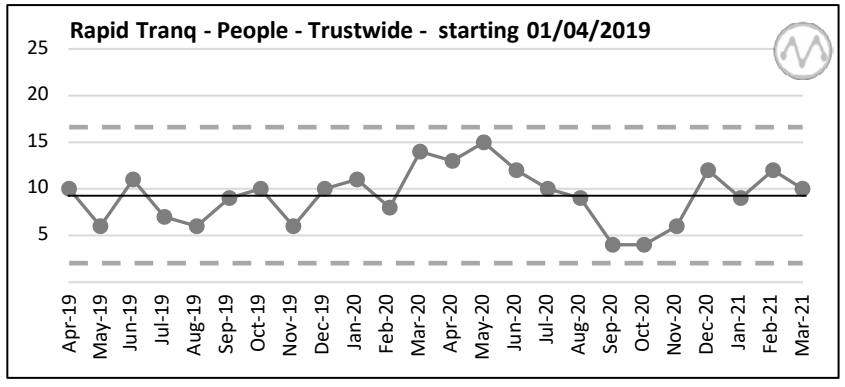




Service/Ward	Incidents	Variation Icon	People	Variation Icon
Trustwide	104		35	
G1	9		5	
Dovedale	2		2	
Firshill ATS	23		2	
Burbage	9		6	
Stanage	19		8	
Maple (inc 136)	10		3	
Endcliffe	24		5	

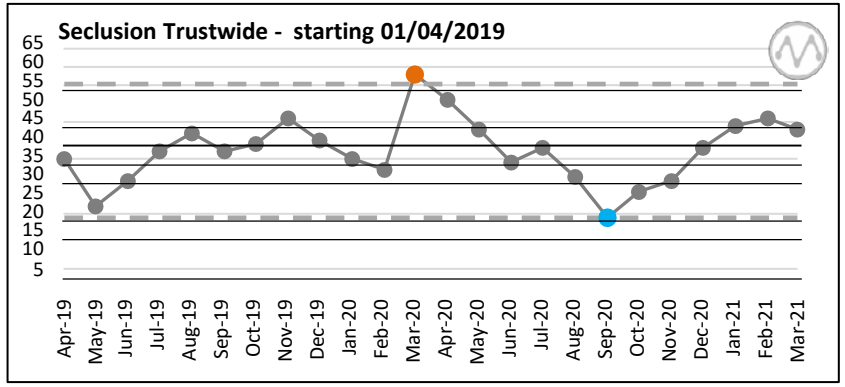
Rapid Tranquillisation

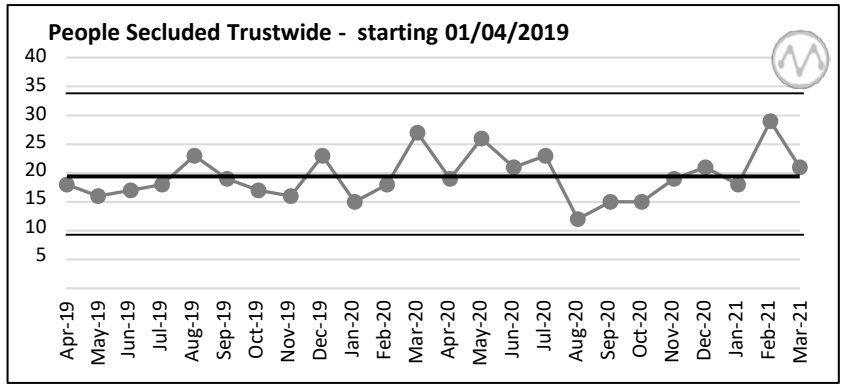




Service/Ward	Incidents	Variation Icon	People	Variation Icon
Trustwide	20		10	
G1	1		1	
Dovedale	0		0	
Firshill ATS	0	L	0	L
Burbage	3		2	
Stanage	5		4	
Maple (inc 136)	1	L	1	
Endcliffe	10		2	

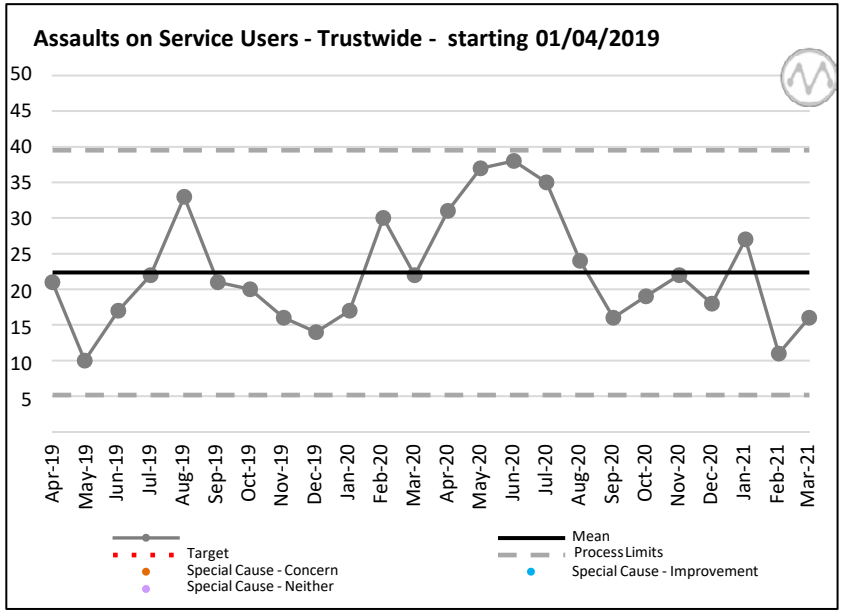
Seclusion

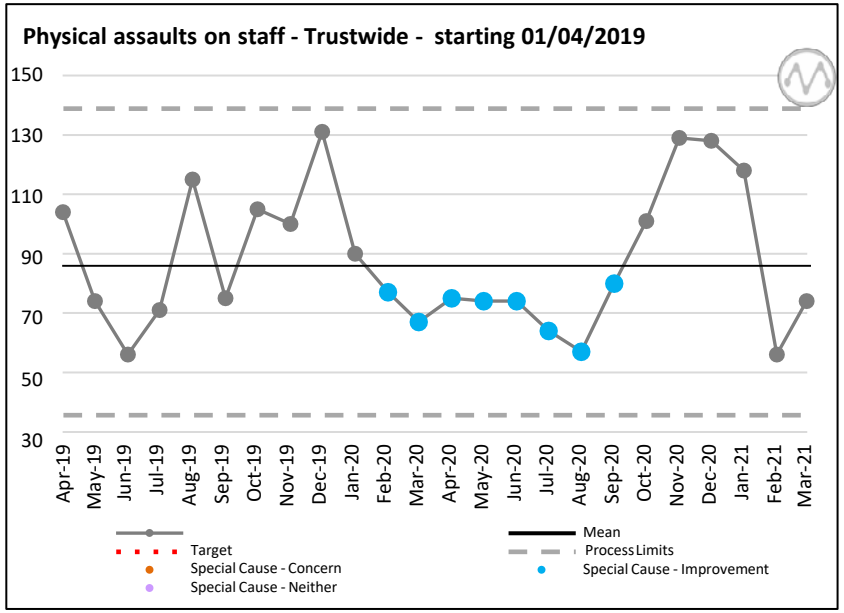


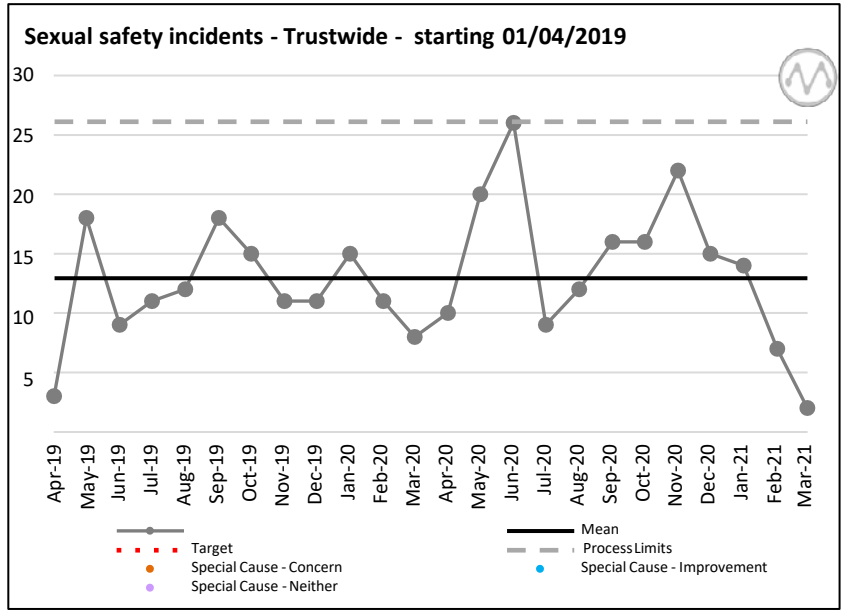


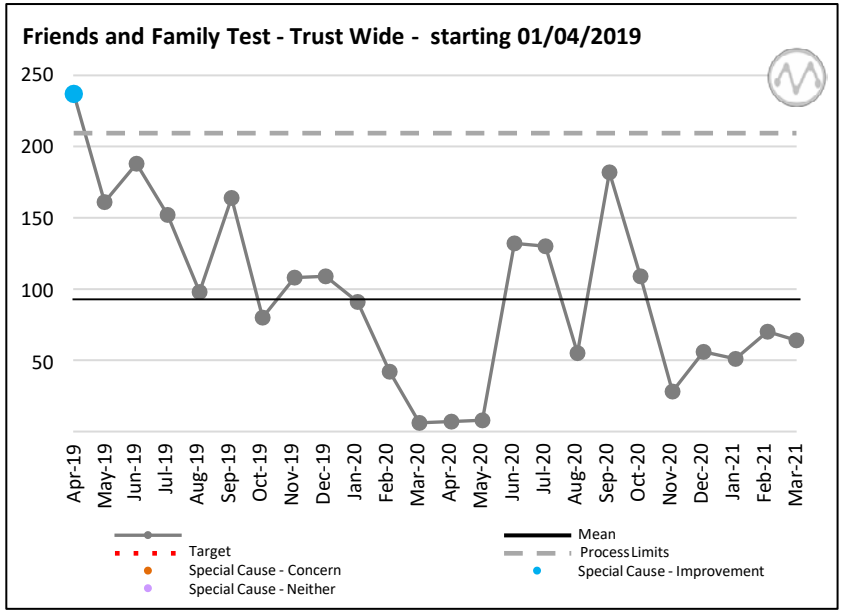
Service/Ward	Incidents	Variation Icon	People	Variation Icon
Trustwide	43		21	
G1	1		1	L
Firshill ATS	4		3	
Burbage	7		4	
Stanage	6		5	
Maple (inc 136)	6		4	
Endcliffe	17		5	

Assaults | Sexual Safety & EMSA | Service User Experience



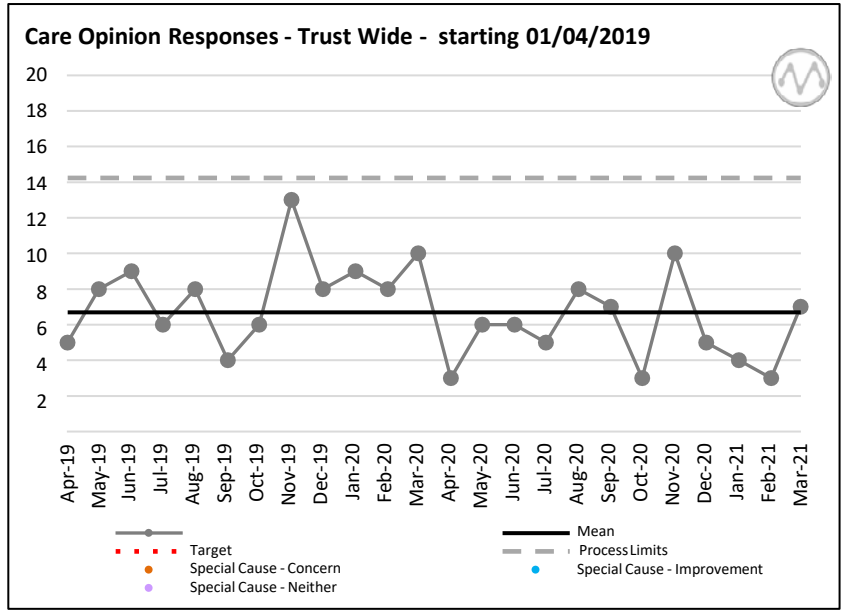






Service user feedback is reported on a quarterly basis to the Quality Assurance Committee as part of a 'learning from experience' report. The most recent is being presented in May 2021.

There were 20 complaints and 13 compliments recorded in March 2021. The complaints were mainly categorised as 'communications', 'values and behaviours', 'prescribing' and 'appointments'.



Deaths | Covid-19

Service User Deaths 1 – 31 March 2021	
Community Learning Disability Team	1
Community Intensive Support Service	1
Birch Avenue	1
Neuro Enablement Service/Brain Injury Team/Neuro Case Management/LTNC	6
Older Adult Community Mental Health Teams	8
Mental Health Recovery Teams	3
Older Adult Home Treatment Team	2
Memory Service	2
G1	1
Liaison Service	4
START Alcohol and Opiates Services	4
SPA/EWS	1
Total	**34**

Classification of Deaths 1 – 31 March 2021	
Expected Death	7
Unexpected Death - SHSC Community	10
Unexpected Death – Inpatient/Residential	1
Suspected Suicide (Community)	2
Unexpected Death (Suspected Natural Causes)	14
Grand Total	**34**

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

Deaths Reported 1 April 2020 – 31 March 2021	
Awaiting Coroners Inquest/Investigation	132
Conclusion - Narrative	1
Conclusion - Suicide	6
Conclusion – Accidental	2
Natural Causes/No Inquest	321
Alcohol/Drug related	2
Ongoing/Suspected Homicide	2
Grand Total	**466**

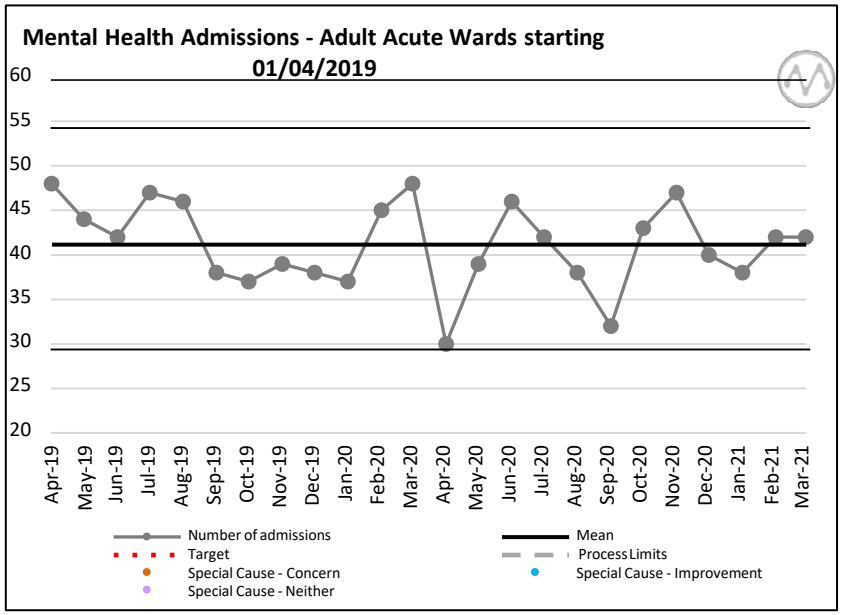
The table above shows the number of deaths that have been recorded YTD 1 April 2020 to 31 March 2021.

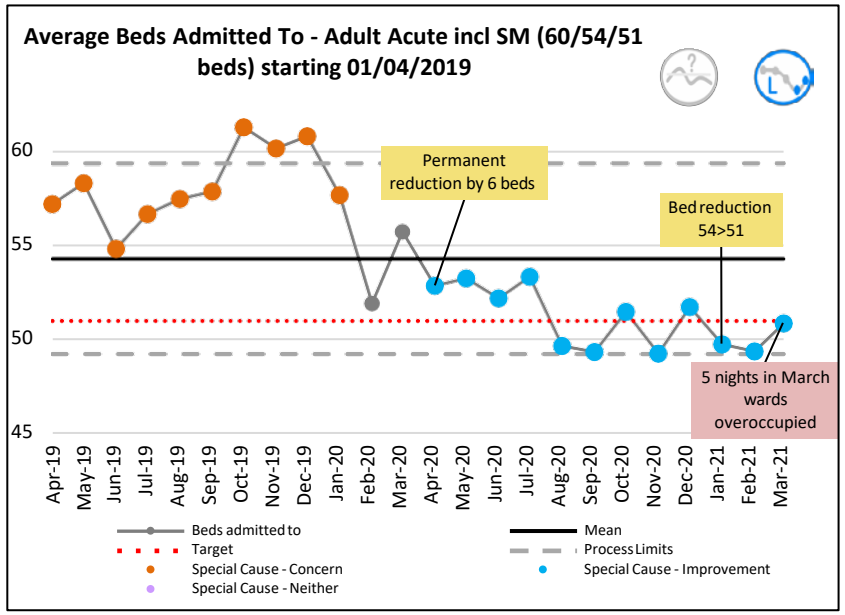
Out of the 34 patient deaths recorded in the month, 22 of these were natural causes deaths and required no inquest. All the 23 catastrophic graded incidents in March 2021 were deaths. 7 deaths were expected deaths, with a further 14 suspected natural causes. 10 were unexpected community deaths with 2 suspected community suicides. 1 was an unexpected inpatient/residential death.

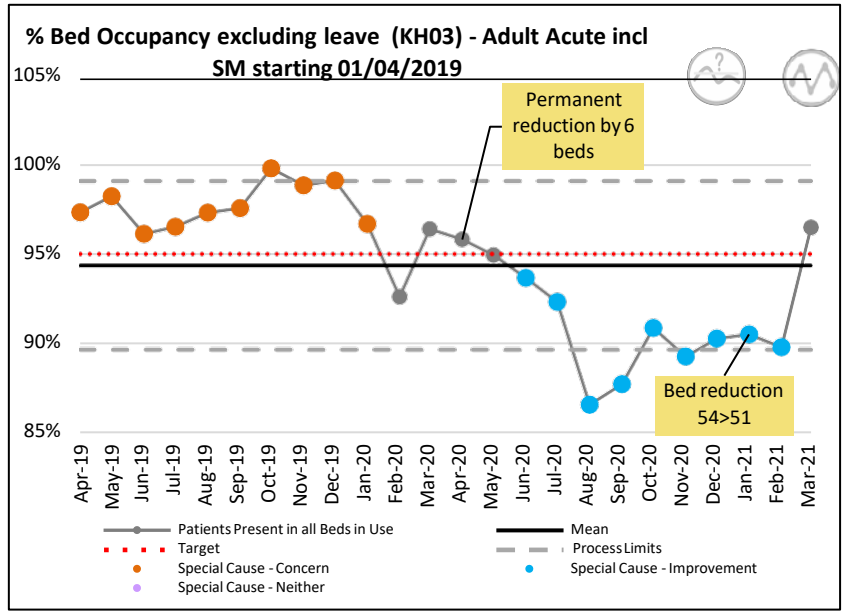
Covid-19 Deaths 1 March 2020 – 31 March 2021	
Birch Avenue	6
Learning Disability Team	5
G1 Ward	5
Liaison Psychiatry	3
Long-term Neurological Conditions	2
Memory Service	7
Neuro Case Management Team	1
Neuro Enablement Service	3
Older Adult Community Mental Health Teams	36
Older Adult Home Treatment Service	3
START Opiates Service	1
Woodland View	1
Total	**73**

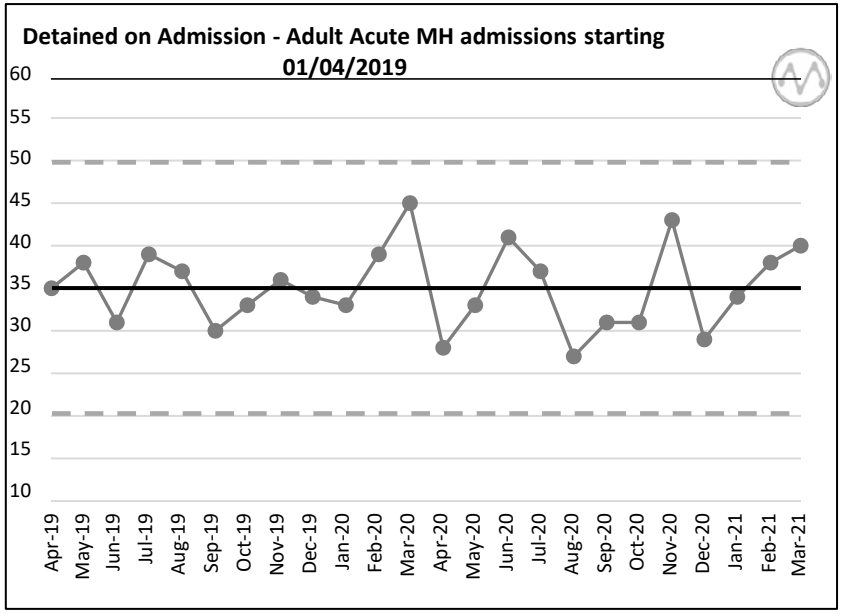
Covid-19 Outbreaks
There were no local outbreaks of positive cases amongst patients and staff in March 2021.

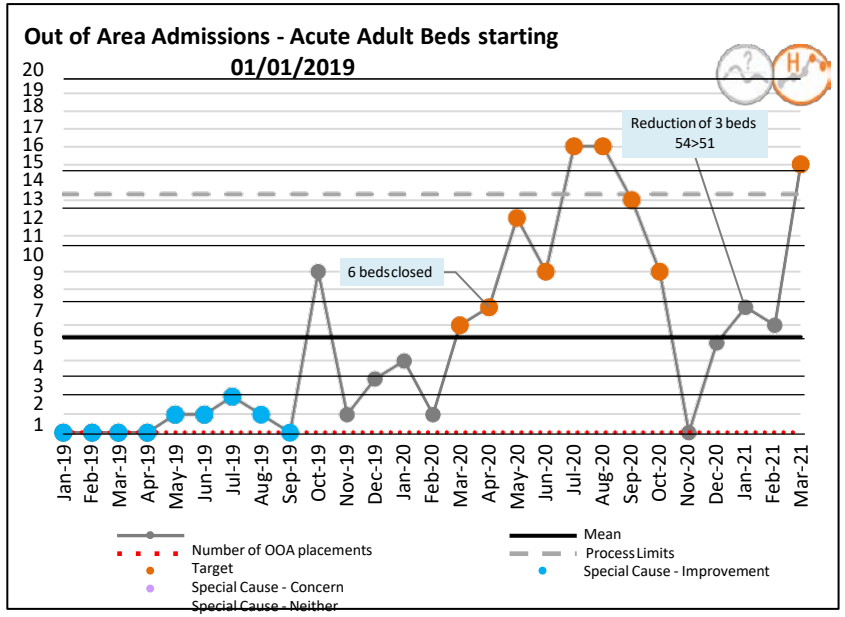
Inpatient Wards | Adult Acute







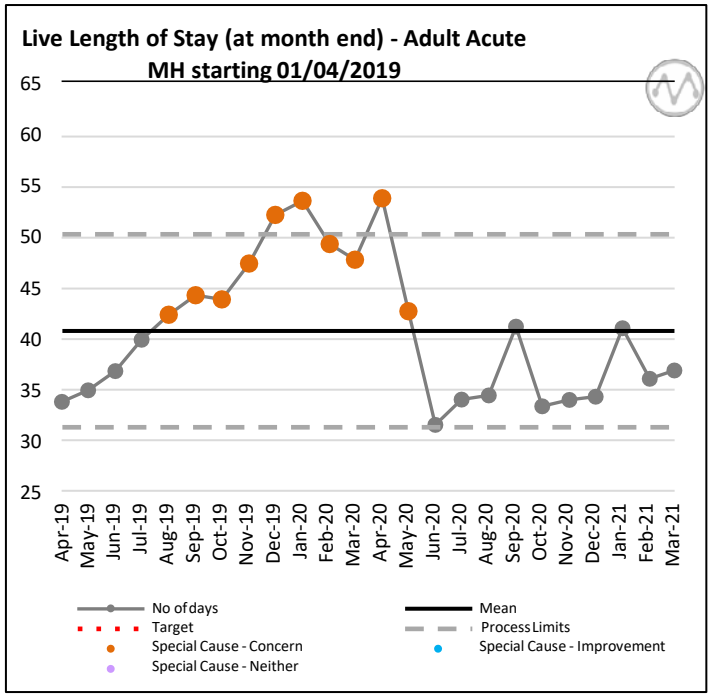


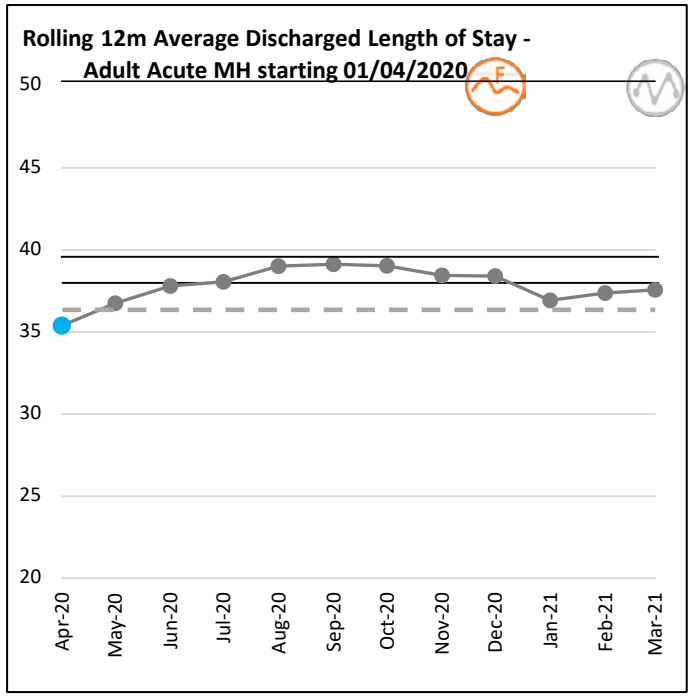


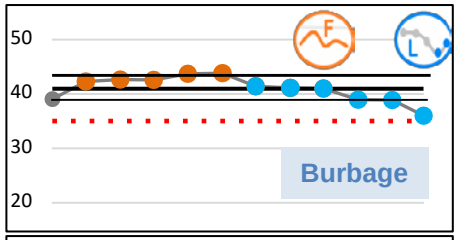
Adult Acute OOA - 2020/21

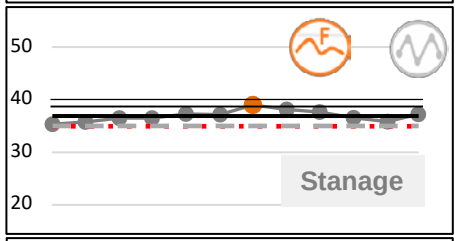
Length of Stay	
Number of Discharges	**95**
Average Discharged Length of Stay (Days)	**35**
Max Length of Stay (Days)	**128**
Min Length of Stay (Days)	**0**
Bednights	
Total Bednights spent OOA	**3829**
Average Bednights OOA per Month	**319**
Appropriate/Inappropriate	
Number of appropriate OOA placements/admissions	**17**
Number of inappropriate OOA placements/admissions	**96**
% Placements Inappropriate	**85%**
Total appropriate OOA bednights	**851**
Total inappropriate OOA bednights	**2978**
% bednights Inappropriate	**78%**

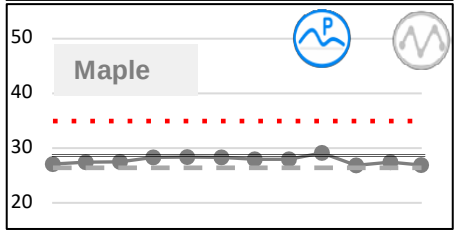
Inpatient Wards | Adult Acute







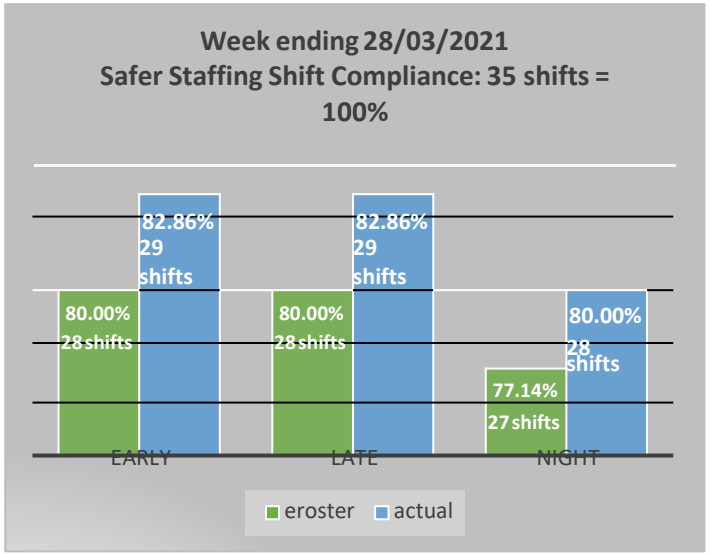


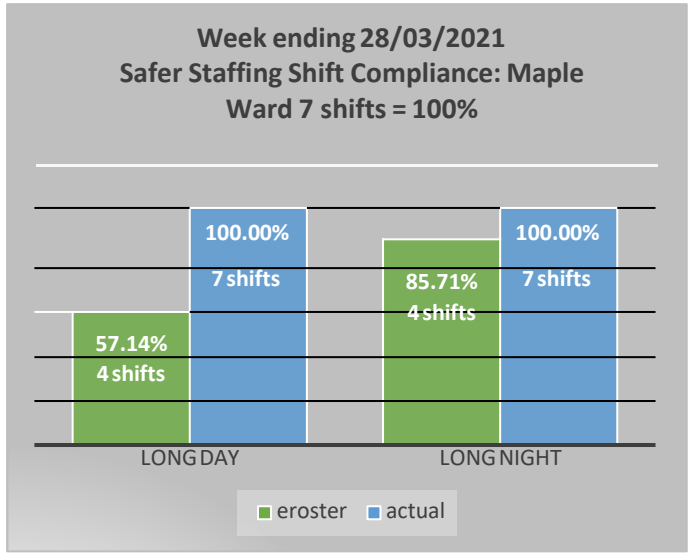


Benchmarking
(2020 NHS Benchmarking Network Report – Registered Population Data)

Bed Occupancy
Mean: 93%
Median: 96%

Length of Stay (Discharged)
Mean: 35
Median: 34





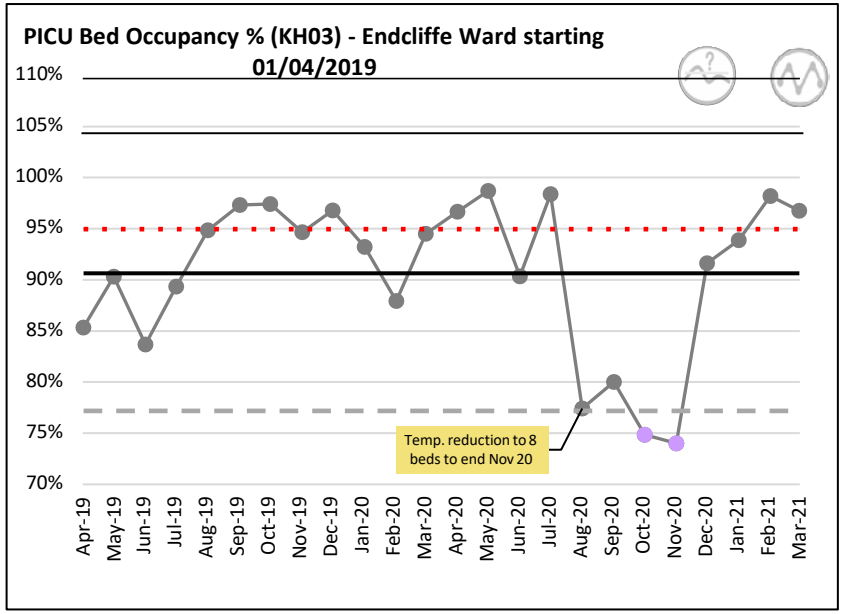
Safer Staffing Shift Compliance

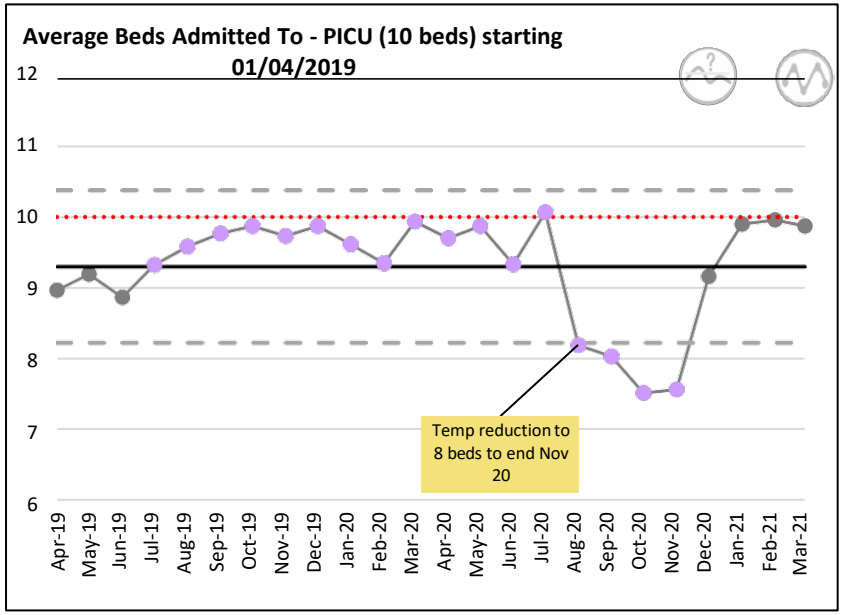
Information is provided from the Trust Improvement Dashboard for the last full available week in March 2021, week ending 28/3/21.

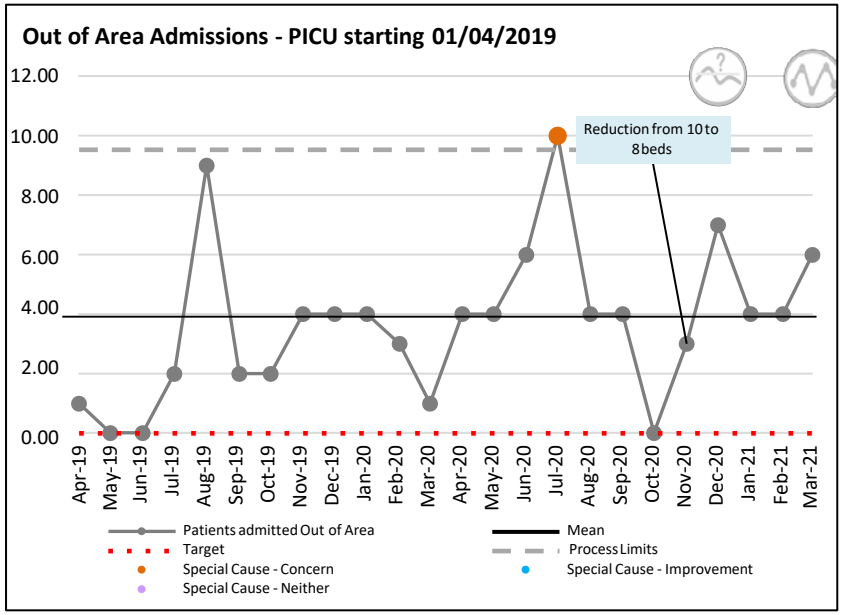
There are two charts left; one to represent Burbage, Stanage, G1, Endcliffe and Dovedale, whilst the other reflects the change to shift pattern of 2 long shifts per 24 hours on Maple Ward. Charts include staffing compliance figures according to eRoster and actual staffing. This is driving our efforts to ensure that assurance around staffing compliance can be taken from a single source.

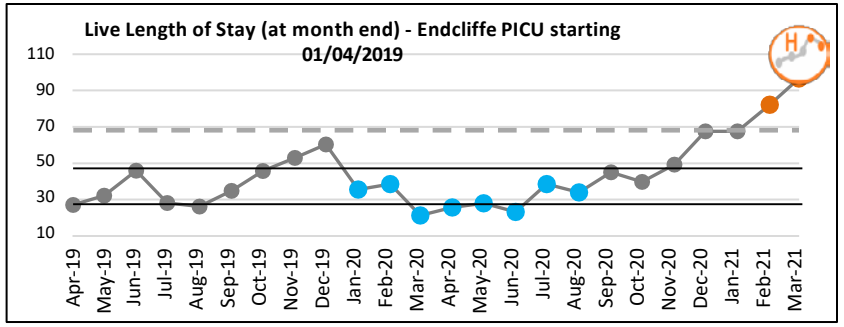
For the period w/e 28 March 2021, there were 19 non-compliant shifts noted. Details can be found in the Improvement Dashboard w/e 04/04/21.

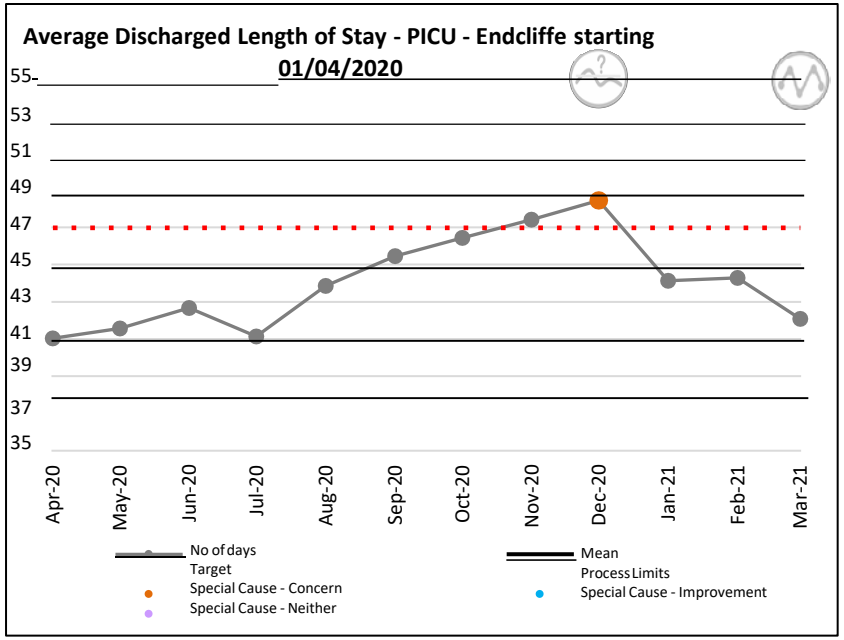
Inpatient Wards | PICU











Benchmarking

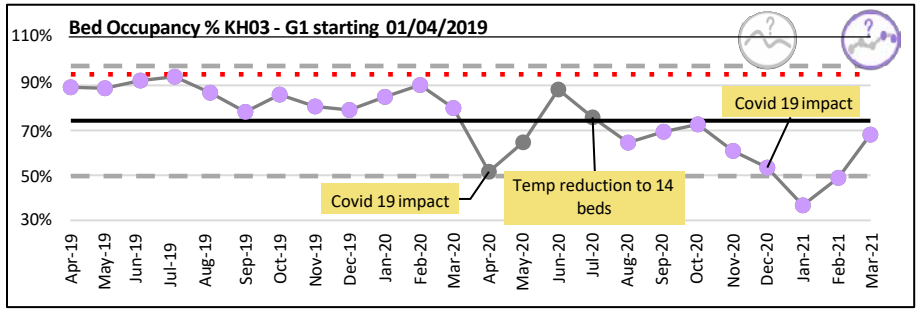
(2020 NHS Benchmarking Network Report – Weighted Population Data)

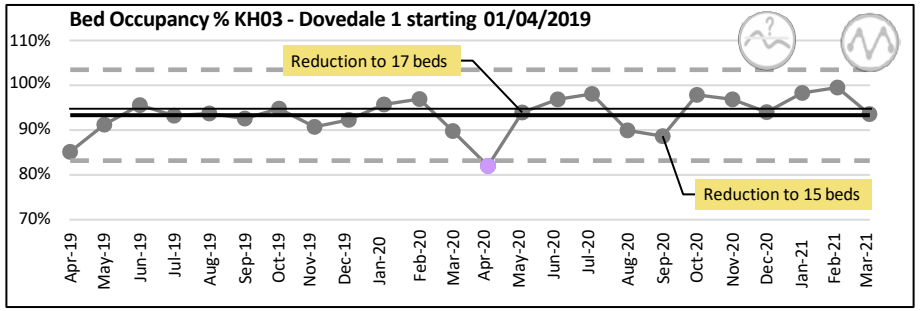
Bed Occupancy
Mean: 88%
Median: 90%

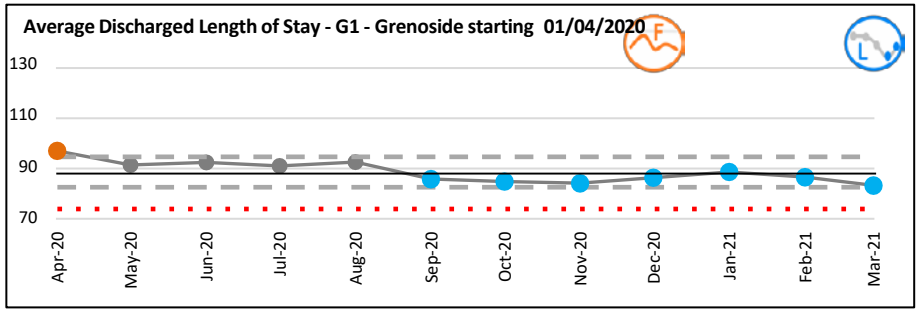
Length of Stay
Mean: 47
Median: 43

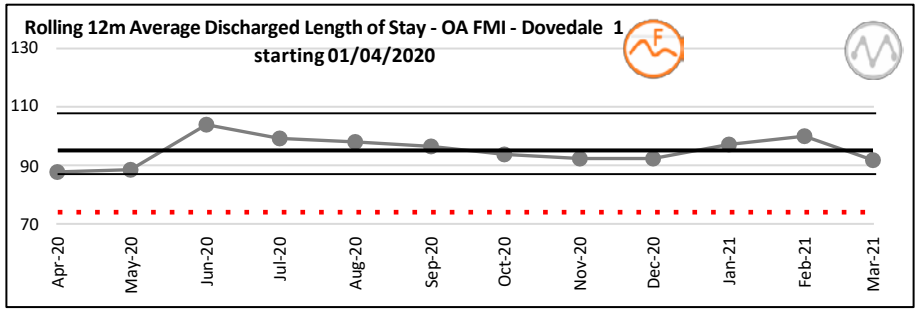
PICU OOA - 2020/21	
Length of Stay	
Number of Discharges	52
Average Discharged Length of Stay (Days)	38
Max Length of Stay (Days)	127
Min Length of Stay (Days)	1
Bednights	
Total Bednights spent OOA	1995
Average Bednights OOA per Month	166
Appropriate/Inappropriate	
Number of appropriate OOA placements/admissions	9
Number of inappropriate OOA placements/admissions	48
% Placements Inappropriate	84%
Total appropriate OOA bednights	296
Total inappropriate OOA bednights	1699
% bednights Inappropriate	85%

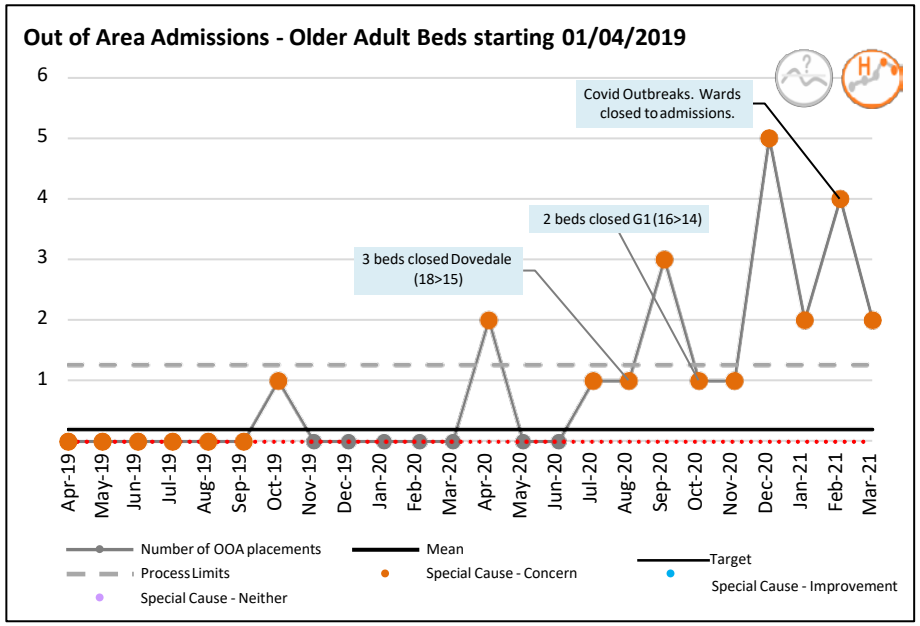
Safe | Inpatient Wards | Older Adults











Older Adult OOA - 2020/21	
Length of Stay	
Number of Discharges	**17**
Average Discharged Length of Stay (Days)	**46**
Max Length of Stay (Days)	**189**
Min Length of Stay (Days)	**4**
Bednights	
Total Bednights spent OOA	**1140**
Average Bednights OOA per Month	**95**
Appropriate/Inappropriate	
Number of appropriate OOA placements/admissions	**0**
Number of inappropriate OOA placements/admissions	**21**
% Placements Inappropriate	**100%**
Total appropriate OOA bednights	**0**
Total inappropriate OOA bednights	**1140**
% bednights Inappropriate	**100%**

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.

Responsive | Community Services | March 2021

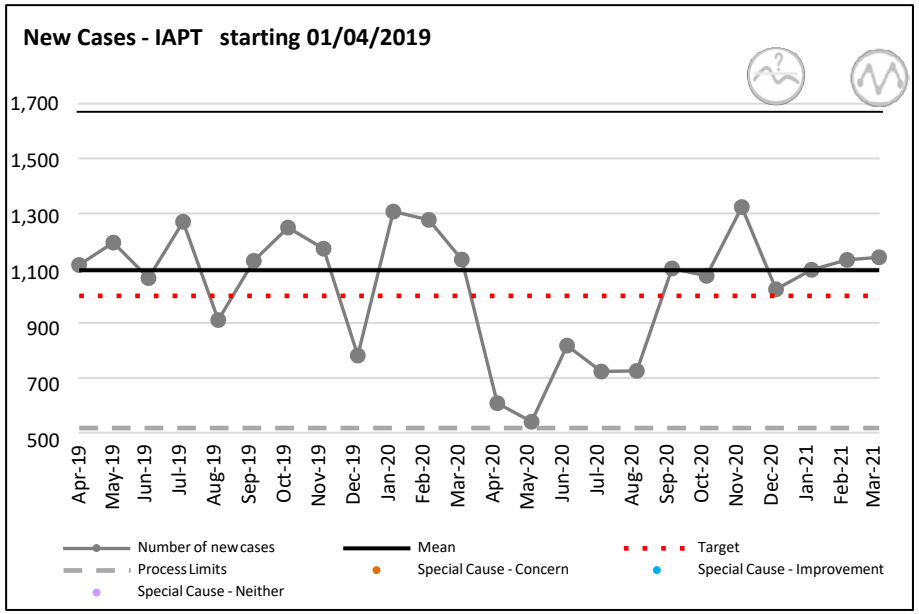
March 2021					*Number on defined wait list at month end*	*Average wait time referral to assessment for those assessed in month. (weeks)*	*Average wait time referral to first treatment contact for those 'treated' in month. (weeks)*	*Total number open to Service*
SHSC Team	**Directorate**	**Pathway**	**Service Type**	**Referrals (Number)**	**Waiting List (Number)**	**Average Waiting Time (RtA)**	**Waiting Time RtT**	**Caseload (Service)**
IAPT	Rehab & Specialist	Mental Health	Assess & Treat	1,691	*N/A*	*N/A*	*N/A*	*N/A*
SPA/EWS	Acute & Community	Mental Health (Crisis)	Assessment	1,032	762	15.85	26.44	1422
AMHP	Acute & Community	Mental Health (Crisis)	Assessment	159	*N/A*	0.00	*N/A*	*N/A*
Out of Hours Team	Acute & Community	Mental Health (Crisis)	Assessment	1,066	*N/A*	*N/A*	*N/A*	*N/A*
Liaison Psychiatry	Acute & Community	Mental Health (Crisis)	Assessment	585	*N/A*	0.00	*N/A*	*N/A*
Decisions Unit	Acute & Community	Mental Health (Crisis)	Treatment	39	*N/A*	*N/A*	*N/A*	*N/A*
S136 HBPOS	Acute & Community	Mental Health (Crisis)	Assess & Treat	33	*N/A*	*N/A*	*N/A*	*N/A*
Adult Home Treatment Service	Acute & Community	Mental Health (Crisis)	Assess & Treat	124	*N/A*	*N/A*	0.00	68
MH Recovery North	Acute & Community	Mental Health	Treatment	11	4	3.40	7.14	986
MH Recovery South	Acute & Community	Mental Health	Treatment	30	Unavailable	6.40	21.30	1076
Recovery Service TOTAL	***Acute & Community***	***Mental Health***	***Treatment***	41	4	*N/A*	*N/A*	2062
Early Intervention in Psychosis	Acute & Community	Mental Health	Assess & Treat	39	23	*N/A*	0.00	398
Memory Service	Acute & Community	Older Adult Mental Health	Assess & Treat	108	369	16.83	26.50	3906
OA CMHT	Acute & Community	Older Adult Mental Health	Assess & Treat	244	Unavailable	9.78	11.37	Unavailable
OA Home Treatment	Acute & Community	Older Adult Mental Health	Assess & Treat	27	*N/A*	*N/A*	0.00	56
CLDT	Rehab & Specialist	Learning Disabilities	Assess & Treat	54	336	9.00	2.80	1046
SPS - MARD	Rehab & Specialist	Specialist Service	Assess & Treat	4	48	24.10	51.90	295
SPS - PD	Rehab & Specialist	Specialist Service	Assess & Treat	12	47	46.30	79.70	196
Gender ID	Rehab & Specialist	Specialist Service	Assess & Treat	38	1265	104.00	Unavailable	2032
STEP	Rehab & Specialist	Specialist Service	Treatment	100	49	*N/A*	2.43	385
Eating Disorders Service	Rehab & Specialist	Specialist Service	Assess & Treat	23	31	5.14	Unavailable	200
SAANS	Rehab & Specialist	Specialist Service	Assess & Treat	101	2726	108.43	Unavailable	3950
R&S	Rehab & Specialist	Specialist Service	Assess & Treat	18	187	Unavailable	Unavailable	217
Perinatal MH Service (Sheffield)	Rehab & Specialist	Specialist Service	Assess & Treat	58	24	3.29	Unavailable	129
HAST	Rehab & Specialist	Specialist Service	Assess & Treat	26	13	18.71	Unavailable	89

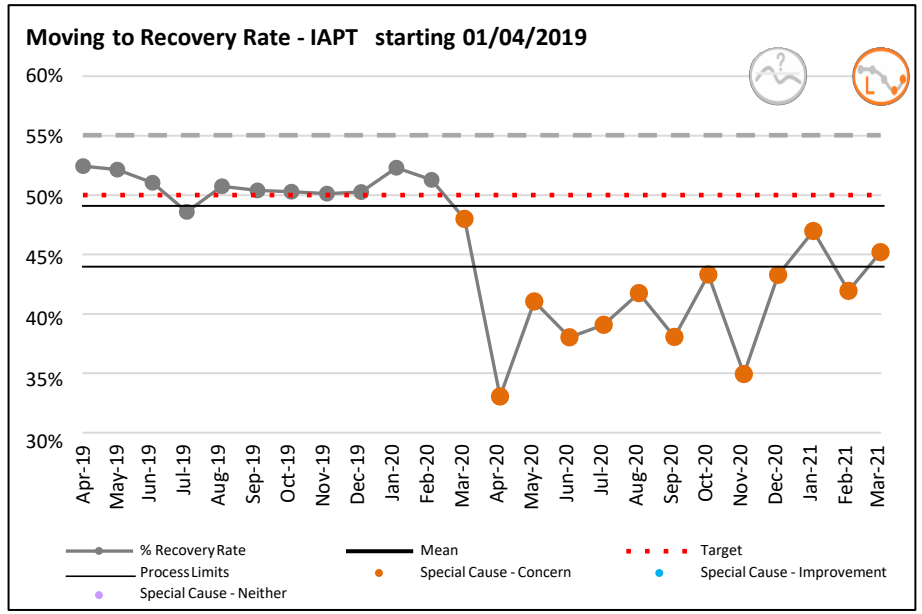
Narrative

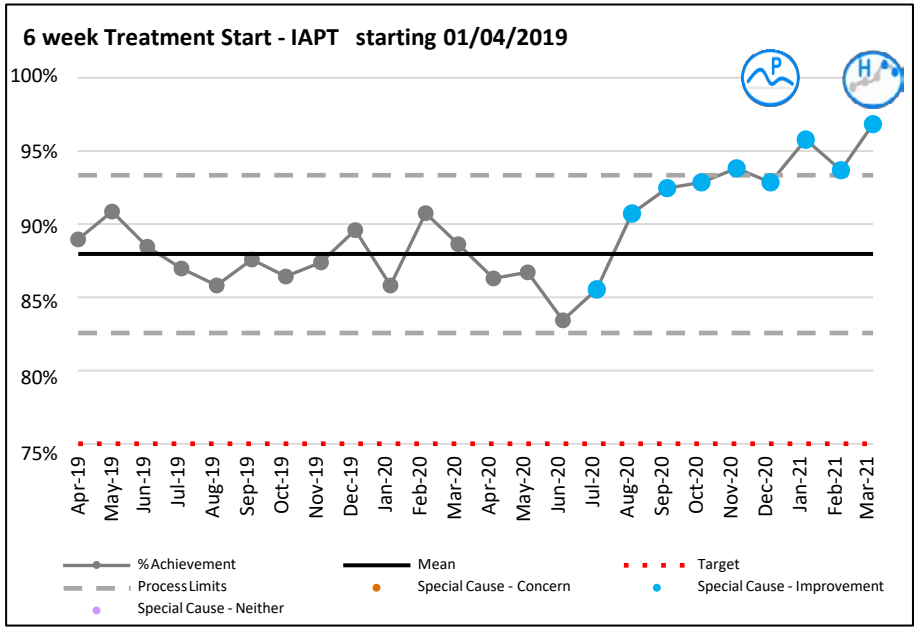
It should be noted that the list above is currently missing information for CERT, Learning Disabilities Community Intensive Support Service (CISS) and a number of highly specialist services who use SystmOne for patient record keeping. The development of these key community service metrics across both Clinical Directorates is key in our work plan for 21/22.

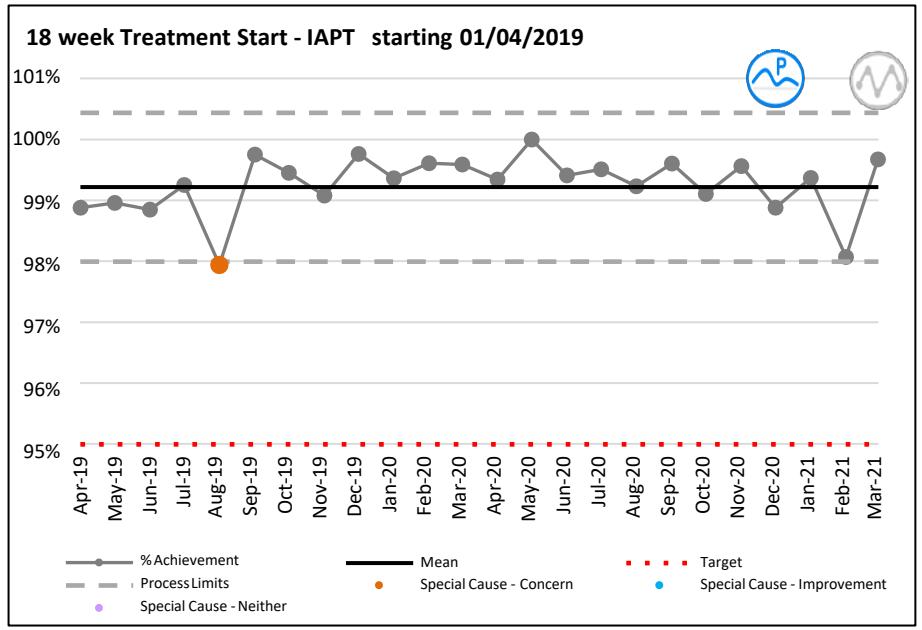
Recovery Plans for unacceptable waiting times in the following services were provided and discussed at March 21 Quality Committee and are provided at May 21 Finance & Performance Committee: SPA/EWS, Mental Health Recovery, Gender Identity Clinic, SAANS and Specialist Psychotherapy Services (MAPPS and PD Service).

Responsive | Improving Access to Psychological Therapies (IAPT)









Narrative

Access

Referrals and numbers entering treatment have steadily increased since December 20, which is positive.

Waiting Times

Both the 6 and 18 weeks 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 (MtR)

The moving to recovery rate remains below the 50% target as it has done since the beginning of the pandemic last year.

The service, teams and individuals all have improving recovery rates as an objective for this year, with performance monitoring in place through supervision and team governance structures.

The self reporting of outcome measures completion rate has started to see improvement since the service moved from sending the online link via email to sending via SMS. This is one of the things that contributes to the MtR metric.

START Performance | March 2021

Key Performance Indicator (KPI)	TARGET	MAR 2021	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	TARGET	MAR 2021	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	TARGET	MAR 2021	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON
Service	**Opiates**				**Non-Opiates**				**Alcohol**			
Access – Waiting time referral to assessment (≤7 days)	≥ 95%	**100%**			≥ 95%	**92.86%**			≥ 95%	**97.22%**		
Access – Waiting time referral to treatment start (≤21 days)	≥ 95%	**100%**			≥ 95%	**100%**			≥ 95%	**100%**		
Access – DNA rate to assessment	≤ 15%	**24.14%**			≤ 15%	**25.71%**			≤ 15%	**16.67%**		
Engagement – Numbers in	TBC	**54**		N/A	TBC	**69**		N/A	TBC	**179**		N/A
Recovery – Successful exits from treatment	TBC	**3**		N/A	TBC	**18**		N/A	TBC	**70**		N/A

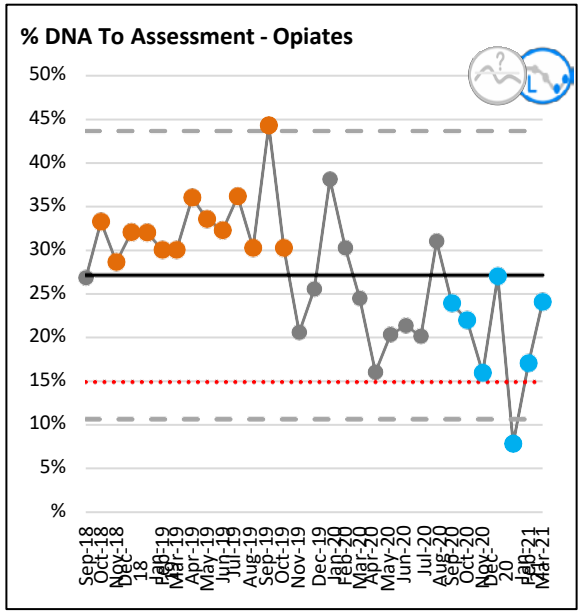
Narrative

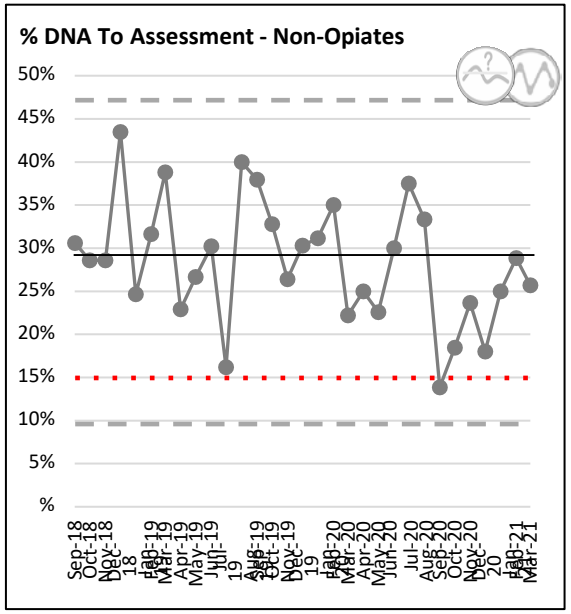
Engagement Referral numbers to the opiates, alcohol and non-opiates services are not currently working to a target but this is in discussion with the commissioner. The service provides open access to treatment regardless of any previous presentations or drop-outs. For this reason, there is a group of 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.

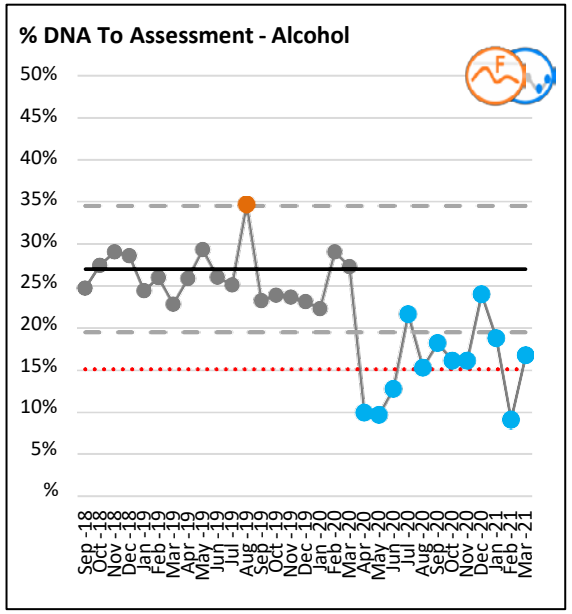
Waiting Times The service works towards a target of 95% of service users being assessed within 7 working days, which is consistently achieved. The average wait time from referral to assessment in all 3 services is currently under 3 days.

Recovery Due to the open access nature of the service, service users historically find it easier 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 | March 2021



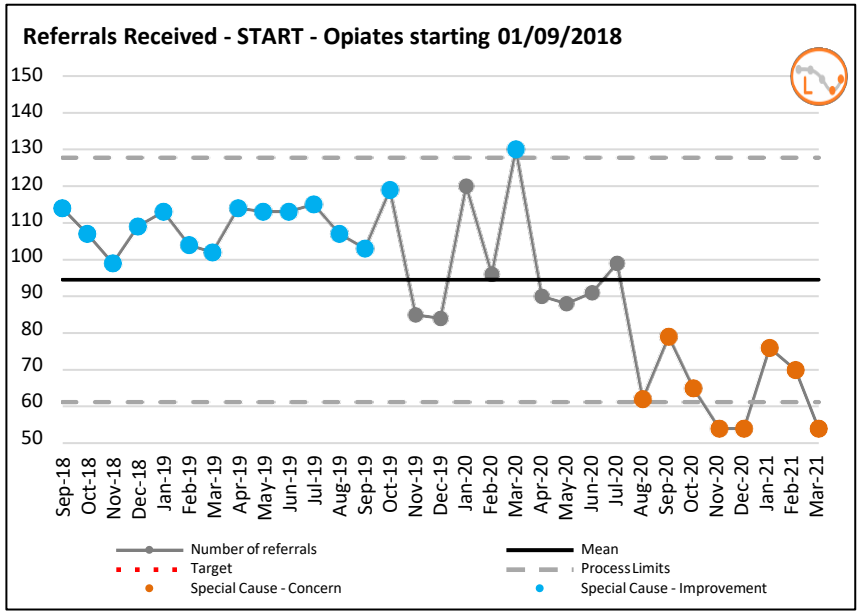


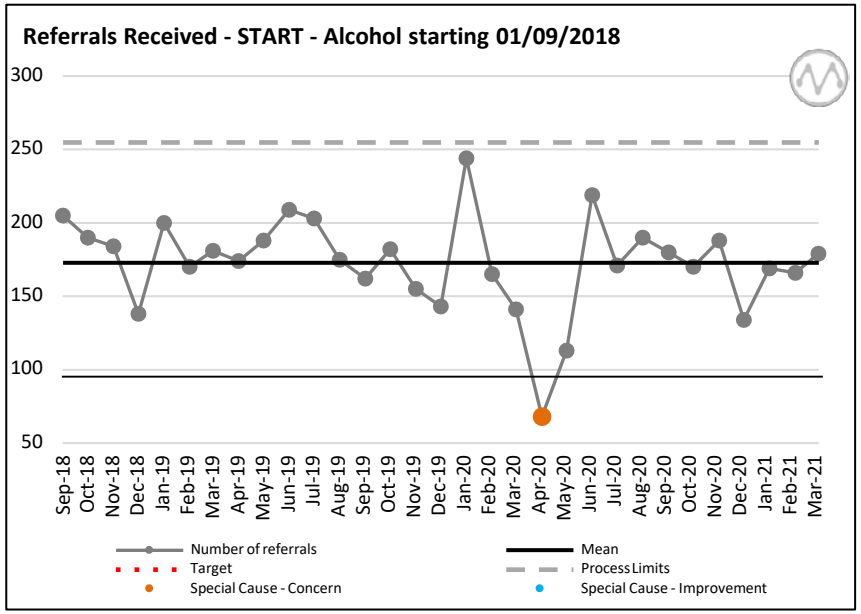


DNA Rate to Assessment Narrative

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, except in the Alcohol Service.

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 and more recently the opiates service. The service will be using learning from this to identify where improvements to the DNA rate can be made, in addition to targeted engagement work which is undertaken with those who repeatedly DNA to assessment.



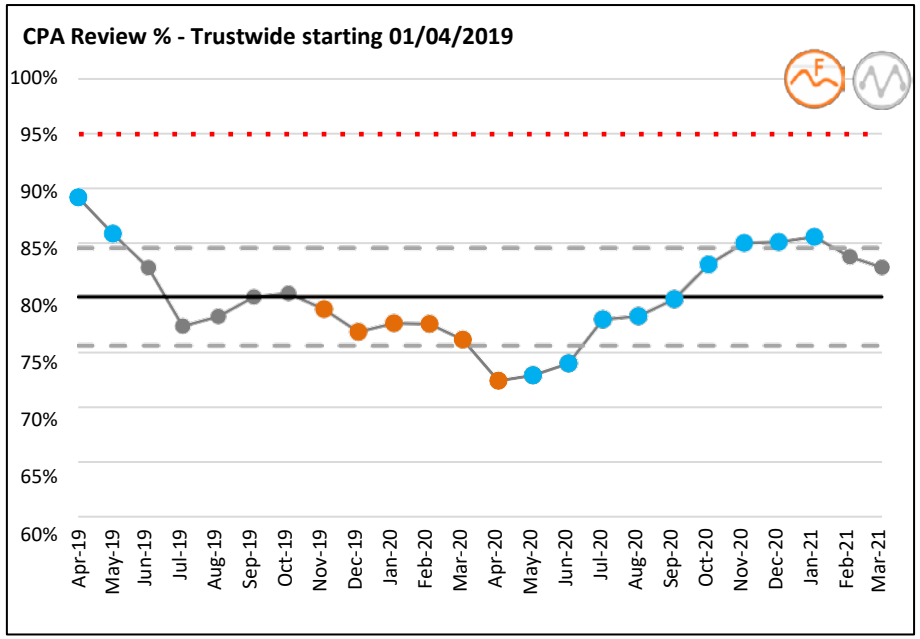


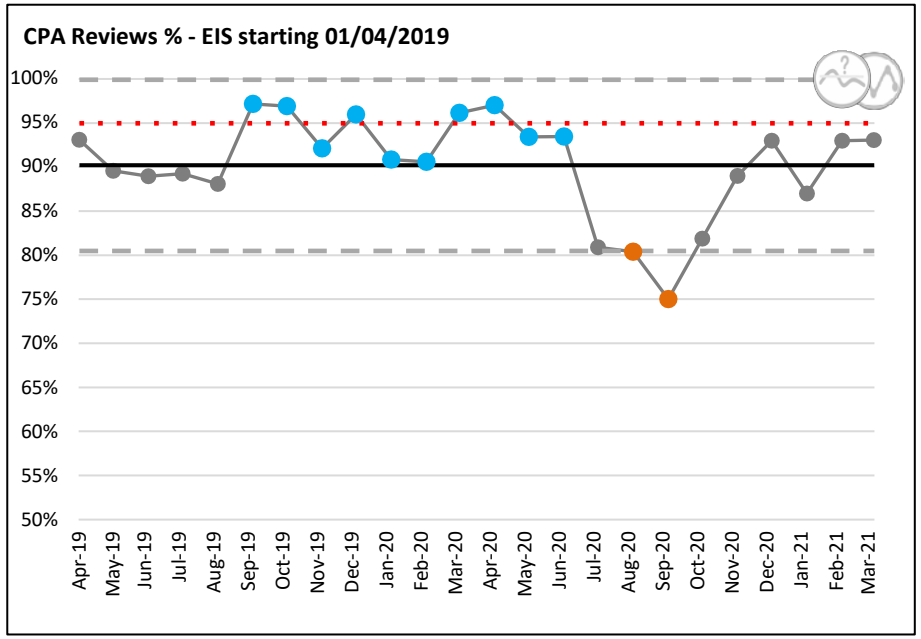
Referrals (Numbers In) Narrative

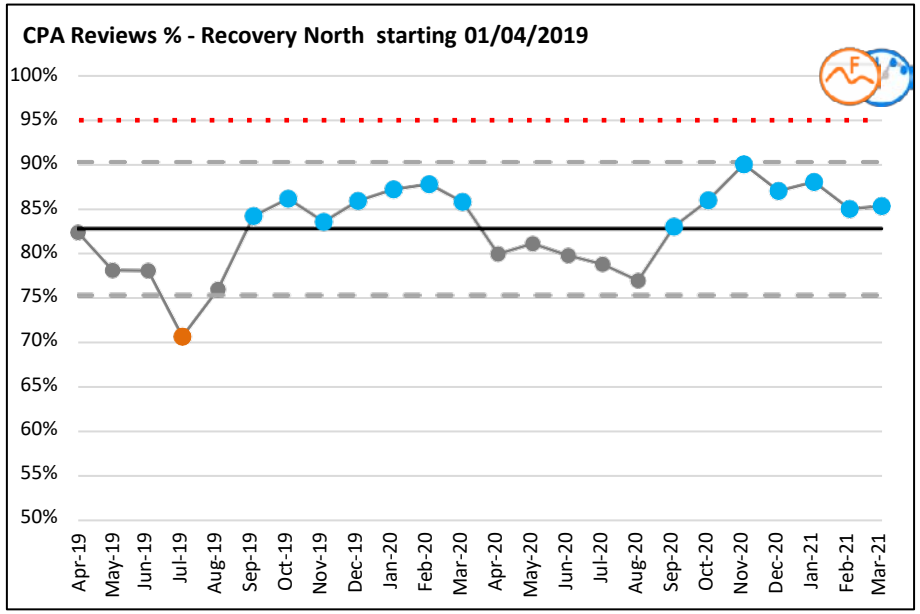
Low referrals to the Opiates service are a cause for concern; however, total numbers in treatment indicate that fewer service users are leaving treatment and/or cycling in and out during 2020 and early 2021. This is also reflected in the numbers being discharged from the Opiates Service. This provides stability for vulnerable service users who may not be ready for abstinence but are engaging with treatment.

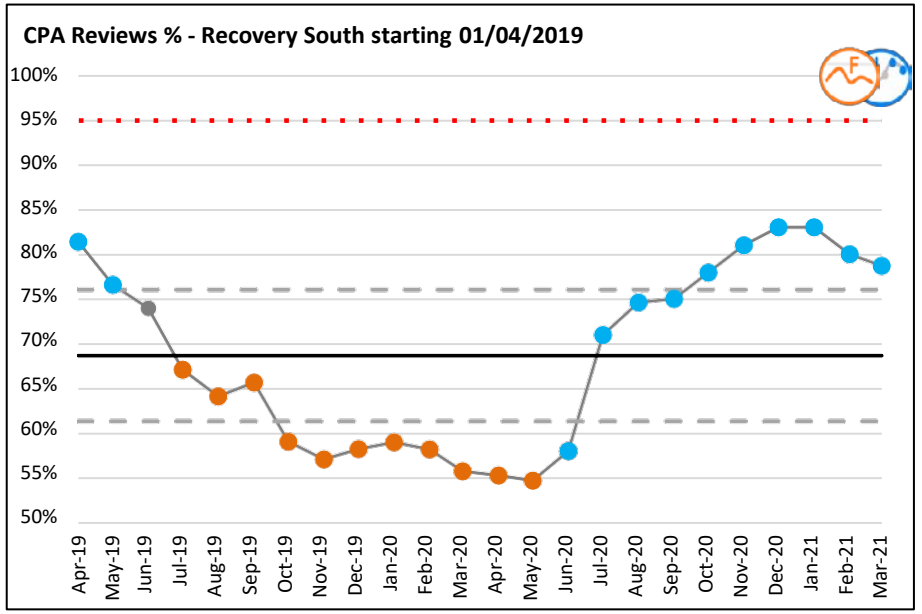
There were fewer referrals to the alcohol service in April 2020, coinciding with lockdown. The links between alcohol use and lockdown is something the service has been keen to address; there was a brief social media campaign in July aimed at encouraging people to seek help for lockdown drinking habits and this was refreshed just after Christmas. Website hits for the alcohol service have indicated that these communications have been successful in encouraging people to seek information on the service.

Effective | CPA Review







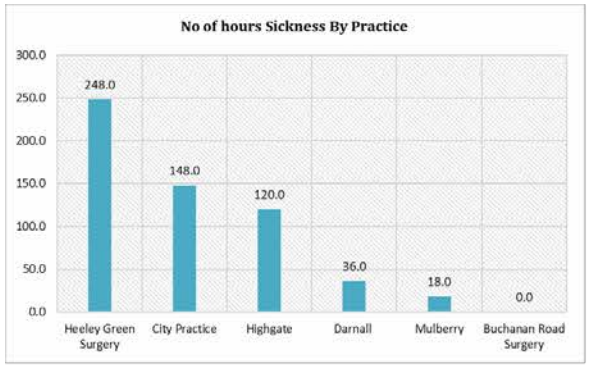


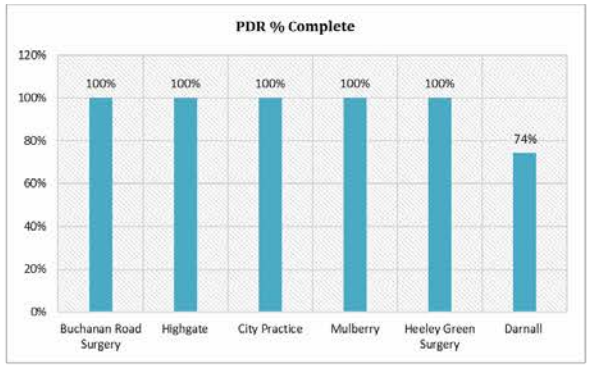
Narrative

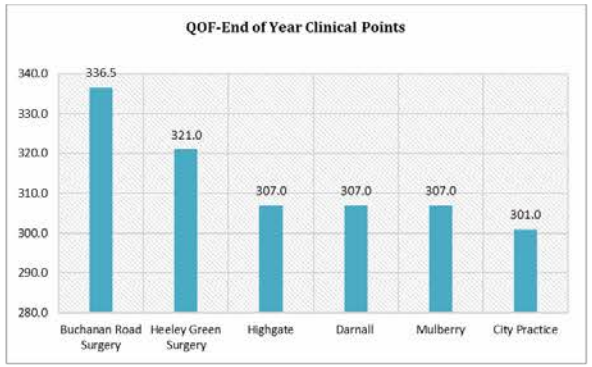
No change from last month's report. Improved performance shown over previous quarter has since levelled out. This coincides with a significant shortage of staff across all services and in particular in the recovery service.

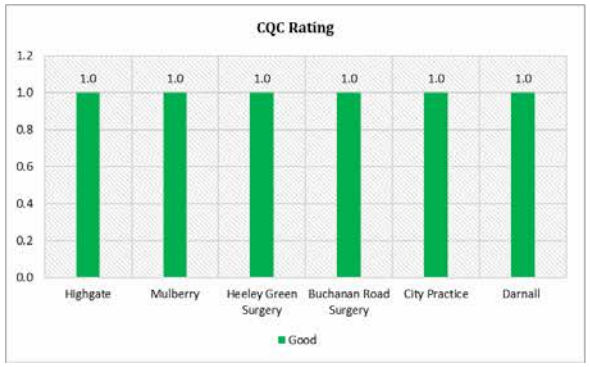
Gaps in staffing have continued to impact on the performance. Recovery Services appointed to 4 posts during February that will be in place by April/May and temporary agency workers were appointed at the beginning of March 2021.

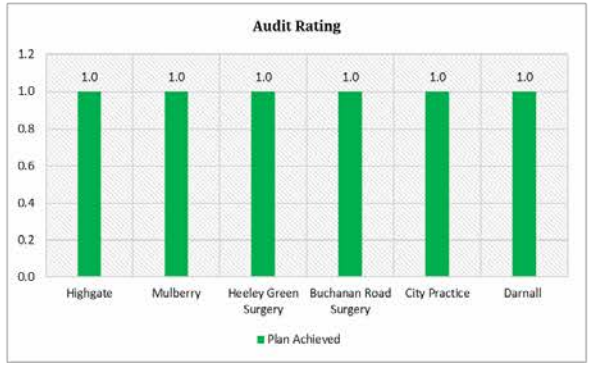
Clover Group & Primary Care Practice Dashboard – March 2021

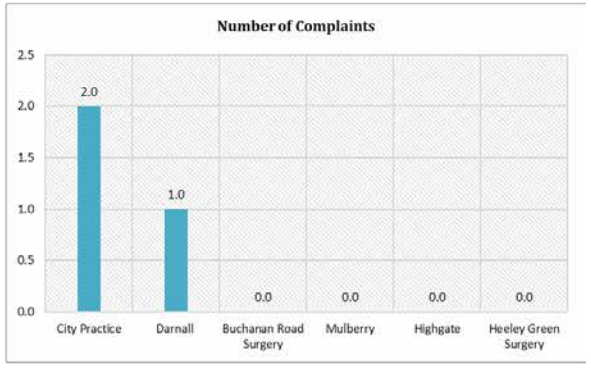






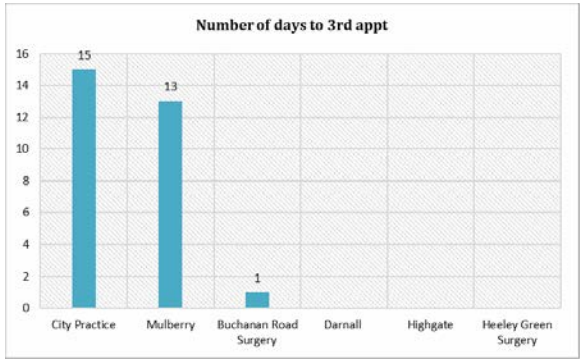


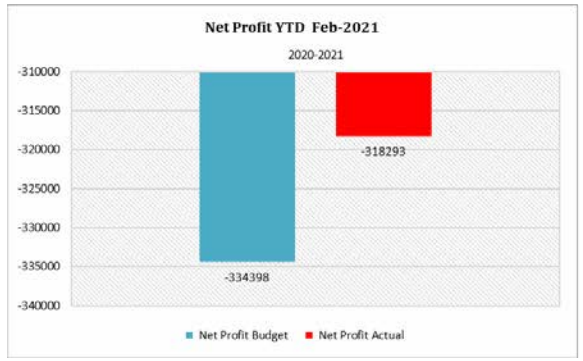


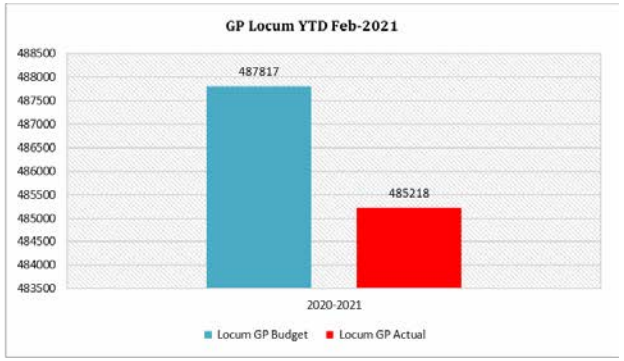


Narrative

The partnership between SHSC and PCS for provision of primary care GP services ceased on 31st March 2021, PCS are now the sole provider of these services. Staff employed by SHSC as part of this partnership arrangement have been TUPE'd over to PCS from the 1st April 2021.







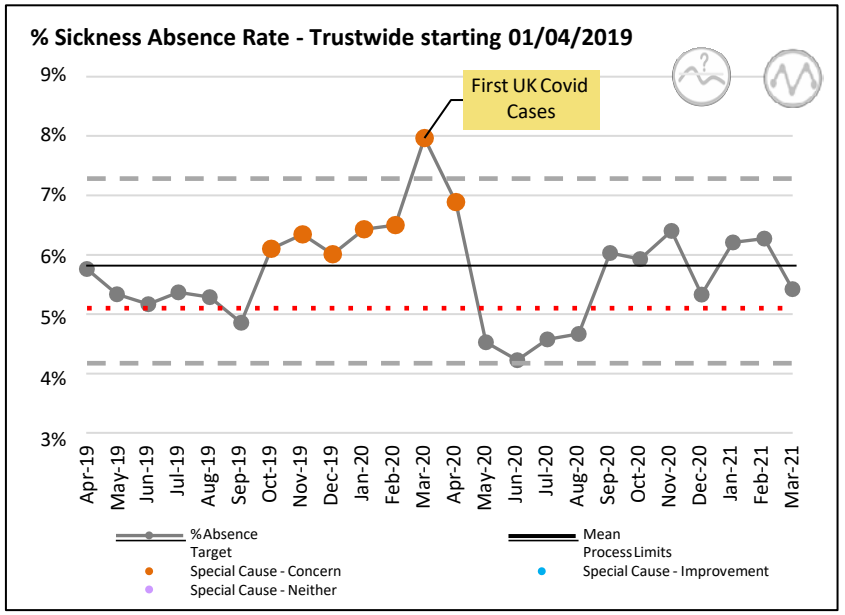
Finance Data is always one month in arrears . This is due to reporting lags within finance.

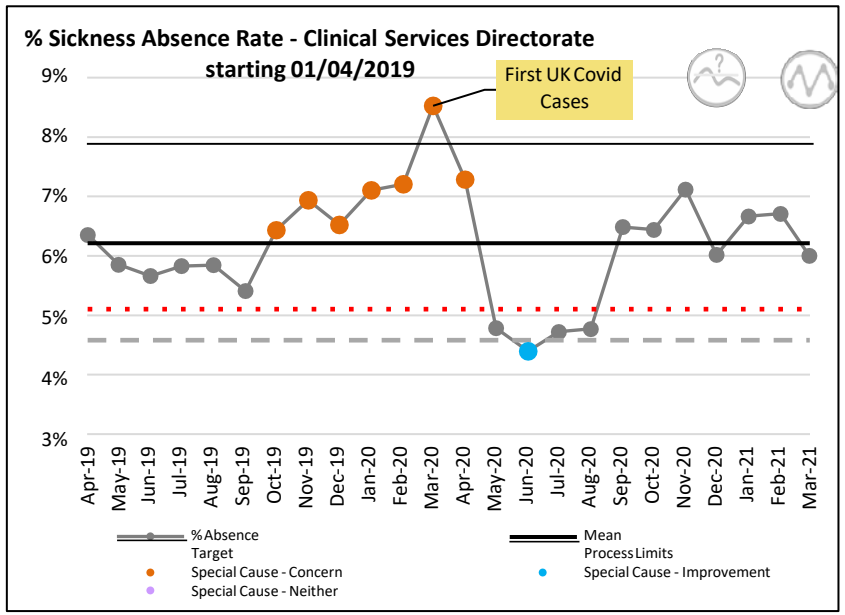
Workforce 1 | Summary

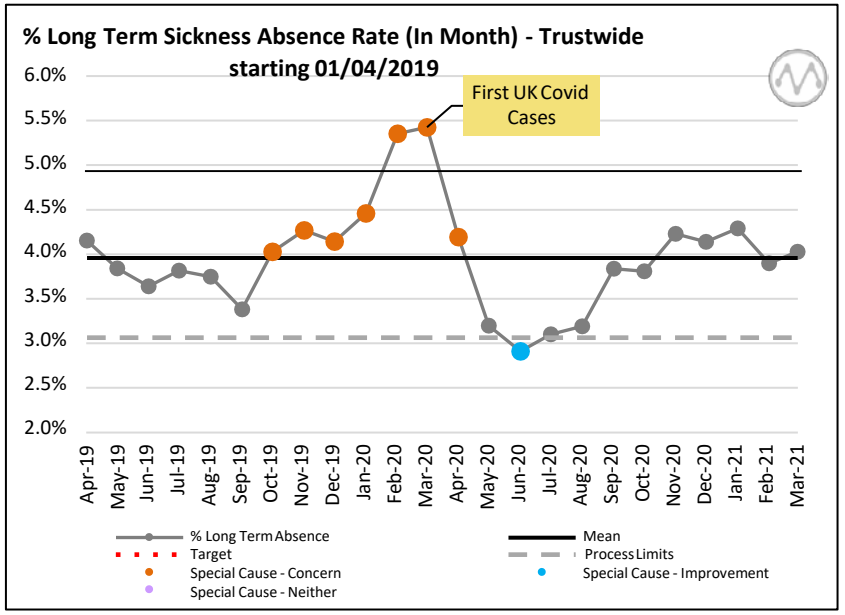
March 2021		Directorates				Trust Total		
Indicator	**Target**	**Clinical Services**	**Medical**	**Non Med Support**	**GP Surgeries**	**Feb-21**	**Mar-21**	**Change**
Staff in Post (Headcount)	**-**	2067	159	310	65	**2606**	**2601**	**-5**
Vacancy (%)		10.2%	3.1%	7.6%	0.0%	**9.6%**	**9.3%**	**-0.3%**
Turnover (%)	**10%**	10%	9%	16%	100%	**12%**	**14%**	**+2.1%**
Sickness In Month (%)	**5.1%**	6.00%	2.49%	2.18%	5.70%	**6.00%**	**5.28%**	**-0.7%**
Sickness 12 Month (%)	**5.1%**	5.95%	2.63%	3.55%	5.92%	**5.66%**	**5.41%**	**-0.3%**
Long Term Sickness (%)		4.58%	2.01%	1.39%	5.66%	**3.90%**	**4.03%**	**+0.1%**
Short Term Sickness (%)		1.42%	0.48%	0.79%	3.65%	**2.10%**	**1.25%**	**-0.8%**
PDR Compliance (%)	**90%**	90.7%	96.9%	89.6%	N/A	**92.8%**	**85.7%**	**-7.1%**
Training Compliance (%)		91.4%	84.7%	86.0%	N/A	**89.7%**	**90.5%**	**+0.8%**

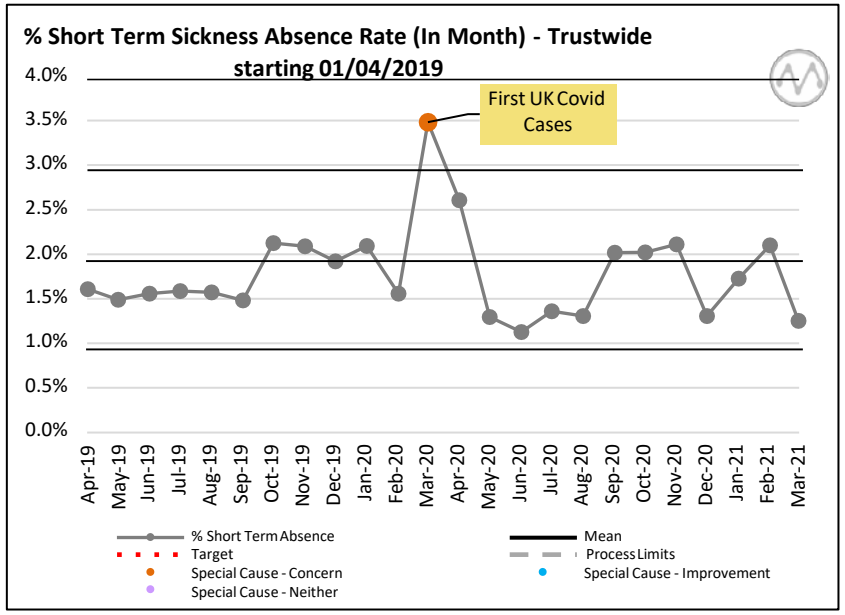
Notes:
- Medical turnover excludes fixed term rotations.
- Vacancy based on establishment (FTE) data compared with staff in post (FTE) figures.
- Establishment data excludes bank, agency, and turnover factor figures.
- GP surgeries TUPE is to be noted, this affects the total trust turnover.

Workforce 2 | Sickness Data









Sickness # of occurrences: The top three areas with the highest number of absence occurrences in March were:

1. IAPT 2. Birch Avenue 3. Dovedale

IAPT has 26 occurrences of sickness absence, this is mainly for Anxiety/Stress/depression/psychiatric illnesses reasons (10 ocurences),

Birch Avenue has 24 occurrences of sickness absence, the main reasons are Musculoskeletal (6) and Anxiety/Stress/depression/psychiatric illnesses reasons (5).

COVID Absences have reduced from 7 in February to 3 in March.

Dovedale has 24 occurrences, Main reasons are: Anxiety/Stress/depression/psychiatric illnesses (6), Headache/Migraine (5), Cold, cough and Flu (4) and Gastrointestinal problems (4).

Long Term Sickness: The top three areas with the highest number of Long term absence occurrences were:

1. Birch Avenue 2. IAPT 3. Woodland View

Birch Avenue has 11 long term sickness cases, Main reasons: Anxiety/stress/depression/other psychiatric illnesses and Chest & respiratory problems

IAPT has 10 long term absences, the main reason is Anxiety/Stress/depression/psychiatric illnesses reasons.

Woodland View has 8 long term absences, the main reason is Anxiety/Stress/depression/psychiatric illnesses reasons.

Top 4 Sickness Absence Reasons by Occurrence Mar 2021

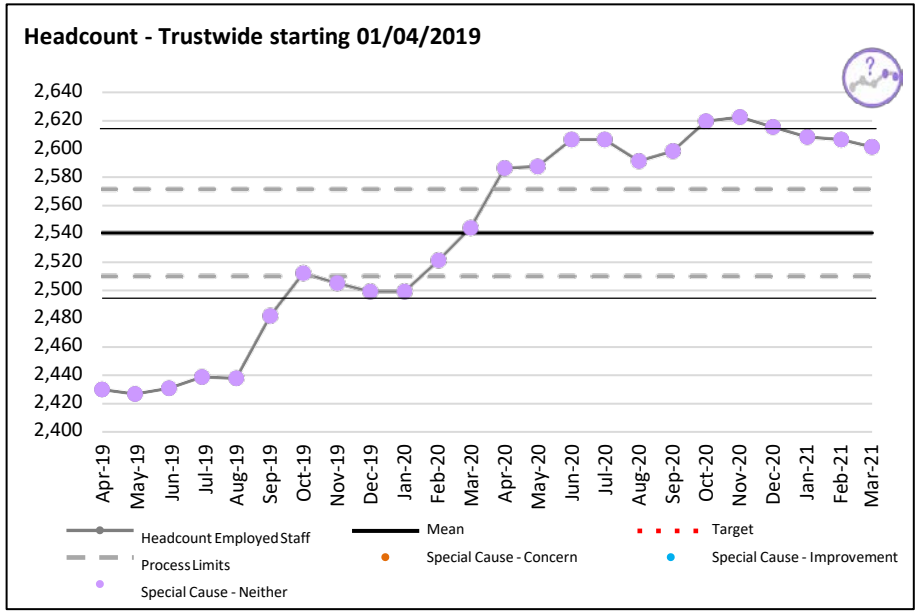
1. Anxiety/stress/depression/other psychiatry illness (108)
2. Cold, Cough, Flu (this includes absences due to COVID vaccines side effects (56)
3. Gastrointestinal problems (43)

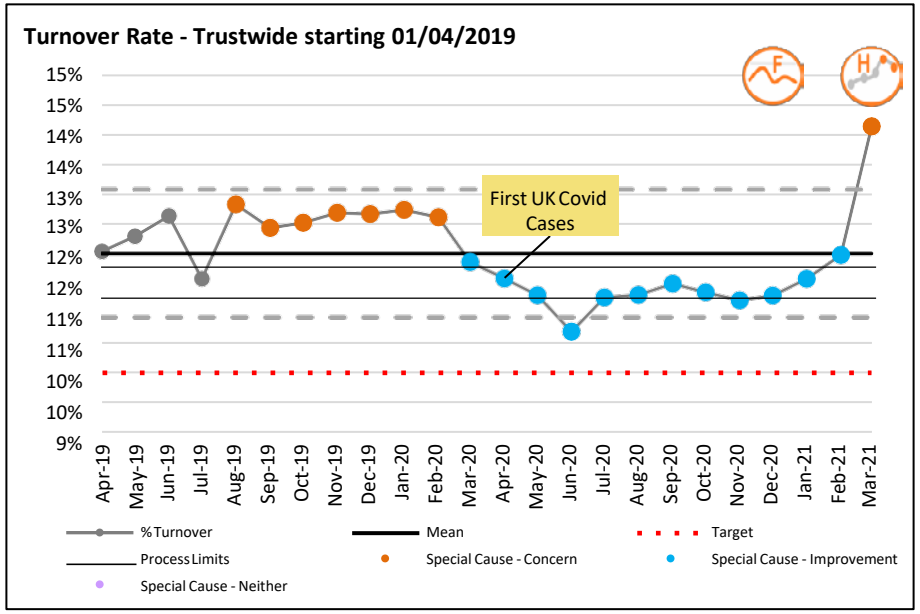
4.a COVID (38) and 4.b Headache / migraine (38)

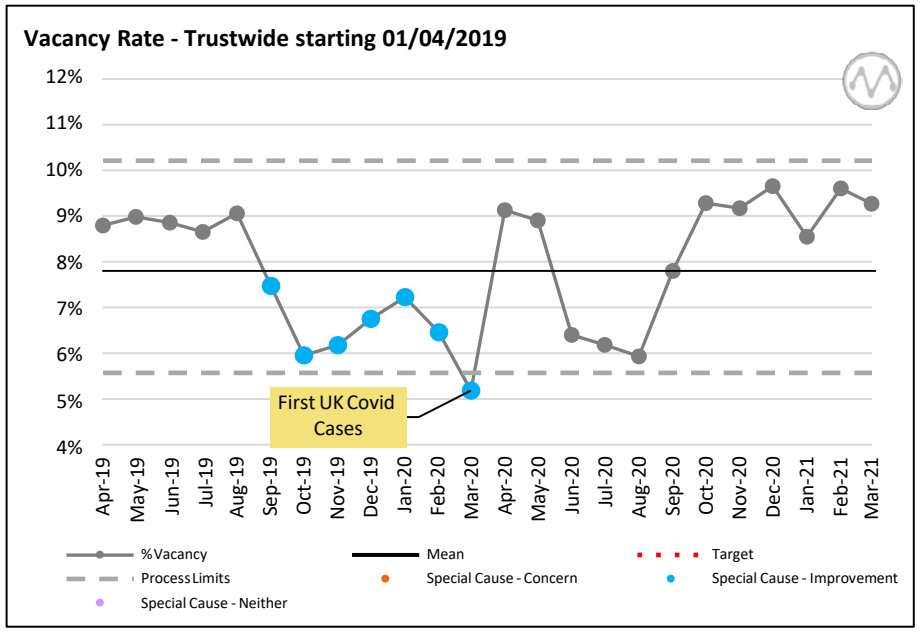
Top 4 Sickness Absence Reasons by Occurrence Feb 2021

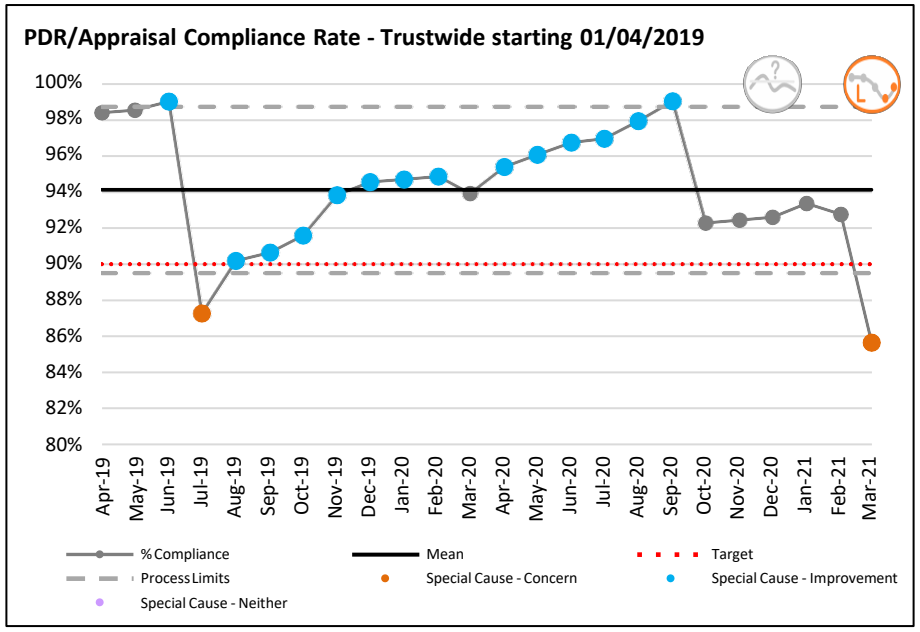
1. Anxiety/stress/depression/other psychiatry illness (90)
2. COVID (90)
3. Cold, Cough, Flu (39)
4. Gastrointestinal problems (33)

Workforce 3 | Staffing and PDR Compliance









Headcount
Headcount remains stable. A drop of headcount is expected in April due to the GP surgeries TUPE.

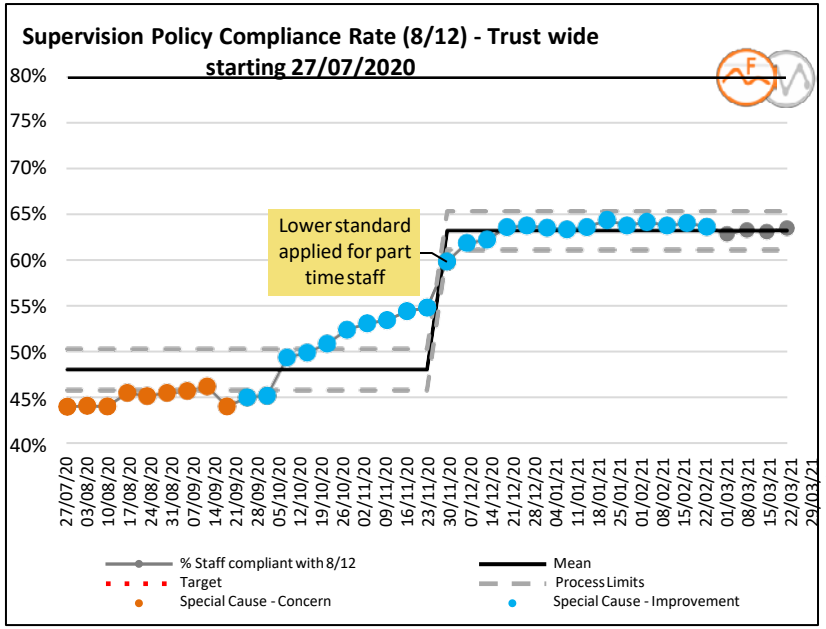
Turnover Rate (%)
Turnover rate has increased to 14.14%. This is above the 10% target, and is due to the GP surgeries TUPE transfer.

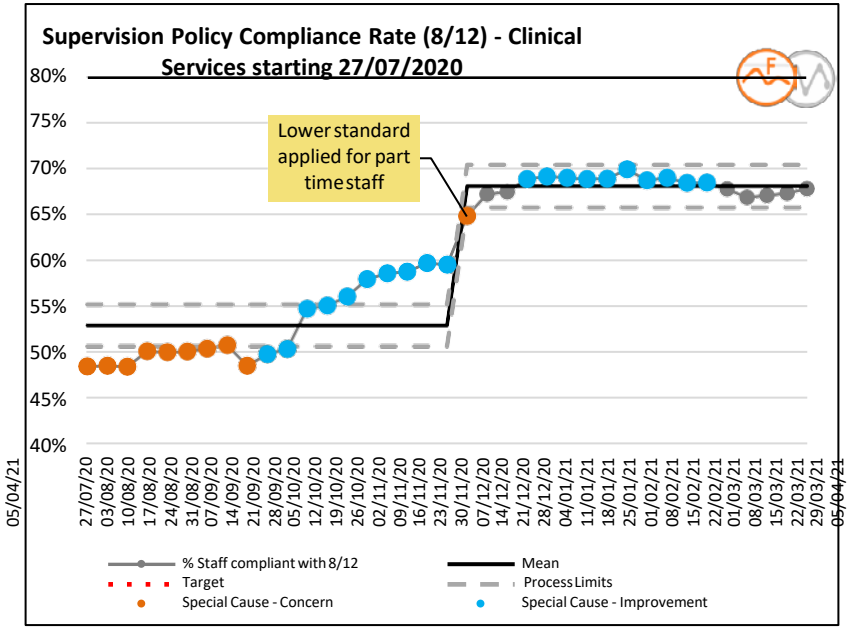
The Turnover rate excluding employee transfers is 12.41%.

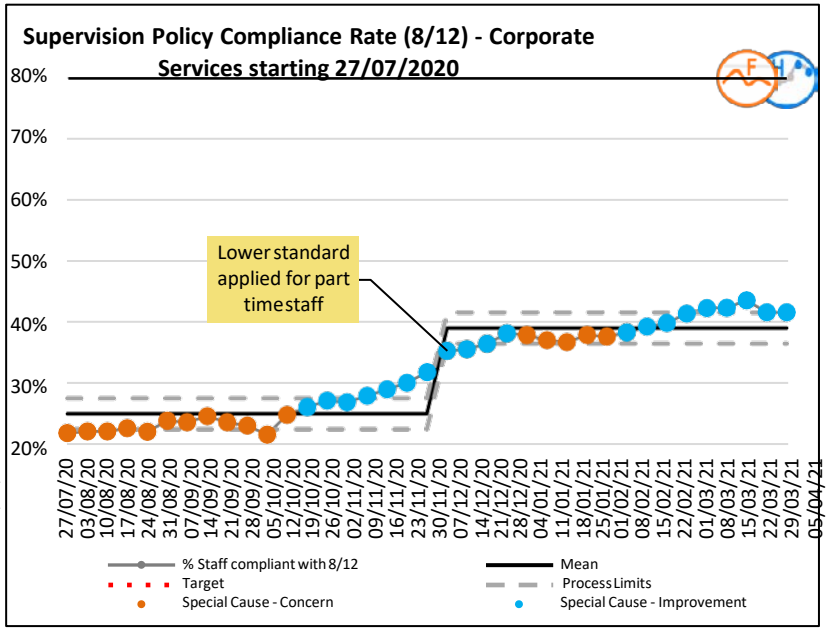
Vacancy per Staff groups
Staff Groups with the highest vacancy rates are in Nursing (81.62 FTE vacant, or a 13.77% vacancy)
and Estates & Ancillary (25.43 FTE vacant or 15.15% vacancy rate).

PDR Compliance
PDR compliance is 85.66%. The drop is due to the introduction of a different report which is more accurate.
The PDR window is now open and on 20/04/2021, 65 staff had a PDR completed and recorded (2.37% of total PDRs to be completed in the window). This will be reported on fortnightly and communicated to managers along with training information reports.

Supervision







AIM

We will ensure that 80% staff have received at least the required minimum of 8 supervisions in a 12-month period (6 for part time staff), and that it is recorded in and reported on from a single source – the Supervision webform.

NARRATIVE

As at week commencing 05/04/21, mean compliance with the 8/12 target is at 63%, with Clinical services at 67% and Corporate services at 41%.

To note –

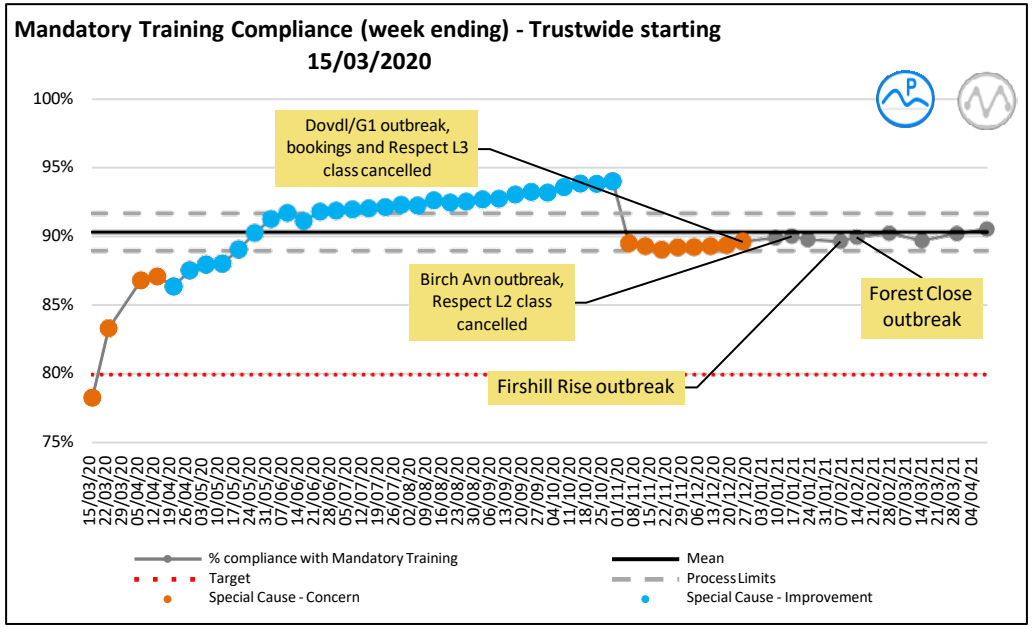
1. ***the vertical axes display the same range for the purposes of comparison.***
2. ***the metric has been updated to apply a lower standard (minimum of 6 supervisions in 12 months) for any staff working less than 0.8 WTE.***

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 improved reporting and assurance of the Supervision Form.

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 90.50%

As at 4th April 84.48% of staff are 80% compliant or above.

EXCEPTIONS

Subjects Below 80%

3 Subjects still below 80%, which are ILS and Respect Level 2, Level

Of the 74 staff who are non-compliant in ILS, 44 (59.46%) are compliant with BLS.

Services Below 80%

PGME Medical & Dental are below 80% compliance.

Sheffield Health and Social Care Mandatory Training Compliance @

04 April 2021

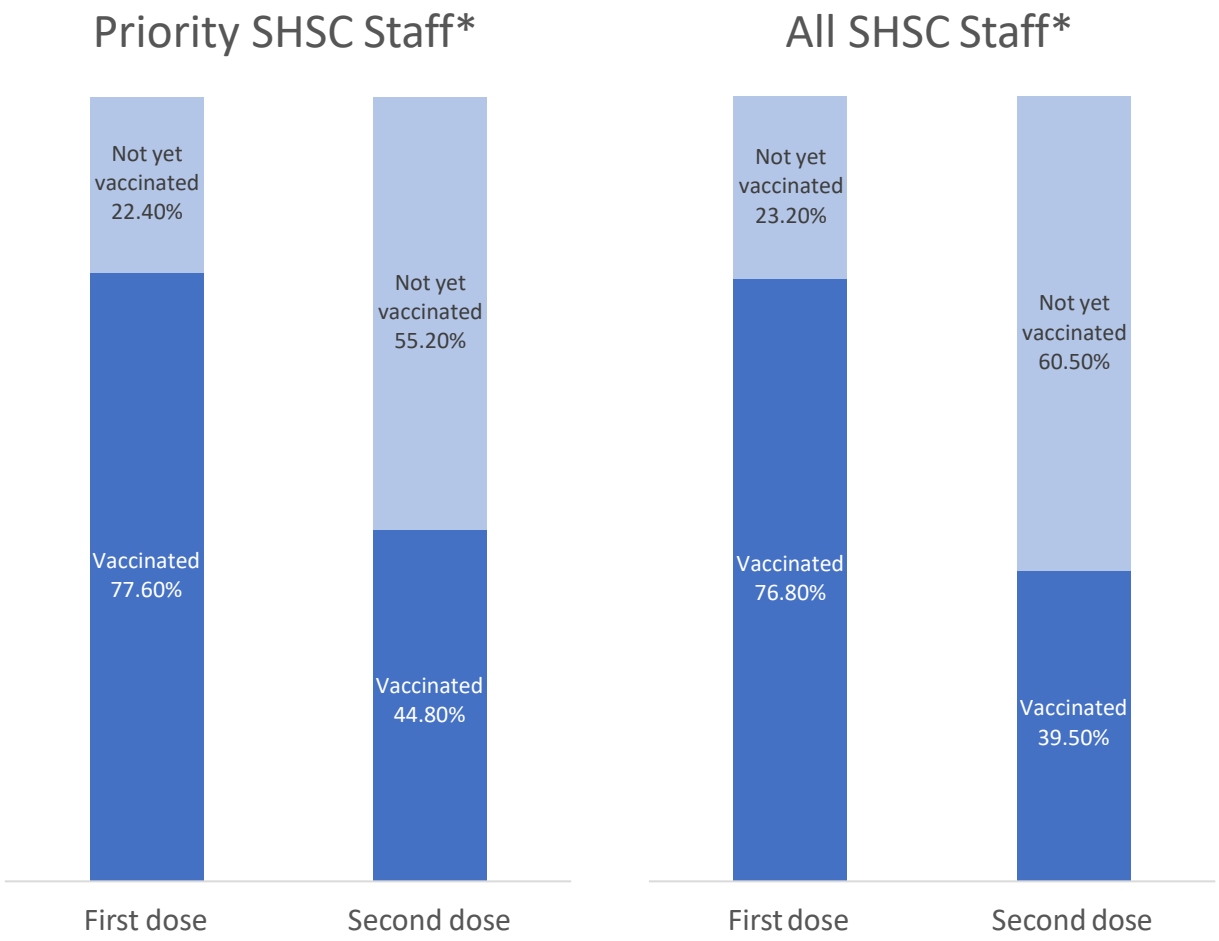
Compliance % highlighted in orange is between 75-79.99% meaning it below but close to the 80% target.

Compliance % highlighted in red is between 0-74.99%

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

			21 March 2021				04 April 2021					
Subject	**Level**	**Frequency**	No Requiring	No Achieved	No NOT Achieved	Compliance	No Requiring	No Achieved	No NOT Achieved	Compliance	Current Compliance against Previous Compliance %	
Equality, Diversity and Human Rights		3 Years	2637	2474	163	93.82%	2622	2448	174	93.36%	Decrease	-0.45%
Hand Hygiene		3 Years	2637	2511	126	95.22%	2623	2499	124	95.27%	Increase	0.05%
Health and Safety		3 Years	2637	2526	111	95.79%	2623	2498	125	95.23%	Decrease	-0.56%
Information Governance (aka Data Security Awareness)		1 Year	2637	2347	290	89.00%	2622	2344	278	89.40%	Increase	0.39%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2637	2528	109	95.87%	2623	2501	122	95.35%	Decrease	-0.52%
Adult Basic Life Support		1 Year	2637	2198	439	83.35%	2622	2221	401	84.71%	Increase	1.35%
Fire Safety		2 Years	1314	1168	146	88.89%	1300	1170	130	90.00%	Increase	1.11%
		3 Years	1320	1256	64	95.15%	1276	1230	46	96.39%	Increase	1.24%
Immediate Life Support		1 Year	236	149	87	***63.14%***	233	159	74	***68.24%***	Increase	5.10%
Clinical Risk Assessment		3 Years	1003	903	100	90.03%	981	881	100	89.81%	Decrease	-0.22%
Dementia Awareness		No Renewal	2361	2283	78	96.70%	2313	2249	64	97.23%	Increase	0.54%
Autism Awareness		No Renewal	2357	2291	66	97.20%	2309	2254	55	97.62%	Increase	0.42%
Mental Capacity Act	1	3 Years	1114	963	151	86.45%	1105	944	161	85.43%	Decrease	-1.02%
	2	3 Years	1162	1016	146	87.44%	1122	991	131	88.32%	Increase	0.89%
Deprivation of Liberty Safeguards	1	3 Years	2159	1986	173	91.99%	2115	1941	174	91.77%	Decrease	-0.21%
	2	3 Years	115	102	13	88.70%	111	100	11	90.09%	Increase	1.39%
Mental Health Act		3 Years	191	154	37	80.63%	184	148	36	80.43%	Decrease	-0.19%
Medicines Management Awareness		3 Years	549	437	112	79.60%	523	432	91	82.60%	Increase	3.00%
Rapid Tranquilisation		3 Years	296	242	54	81.76%	292	240	52	82.19%	Increase	0.44%
Respect	1	3 Years	1212	1092	120	90.10%	1179	1060	119	89.91%	Decrease	-0.19%
	2	2 Years	854	553	301	***64.75%***	844	563	281	***66.71%***	Increase	1.95%
	3	1 Year	384	269	115	***70.05%***	377	275	102	***72.94%***	Increase	2.89%
Safeguarding Children	2	3 Years	1166	1041	125	89.28%	1157	1034	123	89.37%	Increase	0.09%
	3	3 Years	1116	930	186	83.33%	1078	920	158	85.34%	Increase	2.01%
Safeguarding Adults	2	3 Years	2281	2053	228	90.00%	2234	2011	223	90.02%	Increase	0.01%
Domestic Abuse	2	3 Years	2285	1979	306	86.61%	2239	1936	303	86.47%	Decrease	-0.14%
Prevent WRAP		3 Years	2280	2044	236	89.65%	2233	2001	232	89.61%	Decrease	-0.04%
Overall compliance						**90.18%**				**90.50%**	Increase	0.32%
Moving and Handling	1	3 Years	2637	2462	175	93.36%	2623	2455	168	93.60%	Increase	0.23%
	2	3 Years	743	601	142	80.89%	721	592	129	82.11%	Increase	1.22%

Covid 19 Vaccination



Staff Vaccinations in the SHSC Hub by Week

15/02/21	22/02/21	01/03/21	08/03/21	15/03/21	22/03/21
87	78	30	40	0	22

AIM

We will protect our service users and colleagues by offering Covid 19 vaccinations to all eligible staff.

NARRATIVE

Vaccinations have been offered to all staff in the JCVI groups 1 to 4 and all SHSC staff have the opportunity to join the reserve list to be offered a vaccination if there is capacity in our hub. Vaccinations have primarily been carried out through Sheffield Teaching Hospitals and Sheffield Children's Hospital, as well as through primary care networks.
We have observed vaccine hesitancy in some staff groups; we have run a series of Q&A sessions on the vaccine and have taken a targeted approach to communicating with staffto help increase uptake.

As at 29 March 2021, we estimate 77.6% (1799) of our priority staff and 76.8% (2263) of all staff have received their first dose vaccination.

*There were data quality issues because of the number of systems that are being used to capture vaccination record. However, we are now using NIMS (National Immunisation Monitoring System) Reporting which allows us to obtain all vaccination records for our staff, no matter where the vaccination was administered.
However, we have not been able to obtain vaccination records for all staff due to missing NHS numbers and there is more work to be done before we can report on agency staff, trainee medics and student nurses. We therefore have more confidence in the data than previously but there is still work to do.
It's possible that the vaccination rates may fall in the coming weeks as more staff are included and the numerators and denominators increase.

SHSC Hub

Our own vaccination hub opened on 17 February with an offer sent out to all priority staff inviting them for a vaccine. Some other SHSC staff have also been vaccinated as part of a reserve list. The first round of clinics finished on Friday 26 March and clinics for second doses are due to commence in May.

As at 29 March 2021, there have been a total of 257 members of SHSC staff vaccinated in our hub.

Financial Overview | March 2021

PERFORMANCE INDICATORS				NARRATIVE
		Annual Plan	Year to Date	The forecast out -turn position has improved from a surplus of £0.754m at February 2021 to an actual £2.483k surplus as at the end of March 2021. A favourable movement of £1.7m.
		£000s	£000s	
1	Reported Surplus/ (Deficit) Position	(4,625)	2,483	As anticipated, the significant improvement is largely the result of recognition of national and local system funding flowing in Month 12. Material elements of this are largely exceptional and/or related to the temporary finance regime: such as £1.2m received for lost income, £0.2m annual leave carry forward funding and £0.18m of Flowers income. At the end of the year, income received (when the pension adjustment discussed below is removed) was £6m (4%) higher than originally planned.
2	Covid-19 reimbursement	7,216	6,199	The trust was required to reflect the notional cost of £4.5m re the increase in employers pension contribution in Month 12. This pay cost is centrally funded and is fully offset by additional income so has no impact on the bottom line surplus. This is consistent with the approach taken in 2019/20.
3	Agency	5,025	4,721	Throughout the year, longer timescales for recruitment have driven lower than anticipated staff costs. There are known difficulties recruiting within the sector and internal recruitment also delays increases to the staff base and the associated costs being incurred. With significant MHIS funded recruitment planned, this has a material impact. At the end of the year, when the pension cost above has been removed, staff costs were £2.9m (3%) less than originally planned.
4	Cash	47,385	62,075	Non pay costs also remained at lower than expected levels, primarily due to recovery plans for Out of Town (OOT) costs which supported reduced spend in Quarter three and Quarter four. Alongside this, continued stabilisation of Covid costs and lower non pay costs were experienced trust wide due to extended period of remote working and delays in returning to BAU. In total, non pay costs were £2.3m (7%) lower than originally planned, with the majority (£1.3m) relating to reduced spend on OOT costs.
4	Efficiency Savings (1% Cost Improvement from M7)	638	638	The surplus position was in part offset by the realisation of impairments for the Acute Care Modernisation project (£2,629k) and the EPR Insight 2 project (£754k) due to their abandonment in the course of construction. These impairments totalling £3,383k are part of the Trust accounts 2020/21.
5	Capital	15,557	7,359	The actual capital expenditure out turn was £171k higher than planned at £7,359k (FOT £7,188k) which includes the full utilisation of external PDC funding or £4,062k. These are reflected on the year -end Trust accounts along with the results of the desktop revaluation of the Trust properties which produced a net increase of £7,249k at 31 March 2021.
6	Better Payments Practice Code (BPPC) - % of bills paid in target	by number	98.6%	The Trust remains in a strong financial standing evidenced by its cash position, no debt facility and compliance with the Better Payments Practice Code (BPPC).
		by value	99.1%	

Appendix 1 | 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:

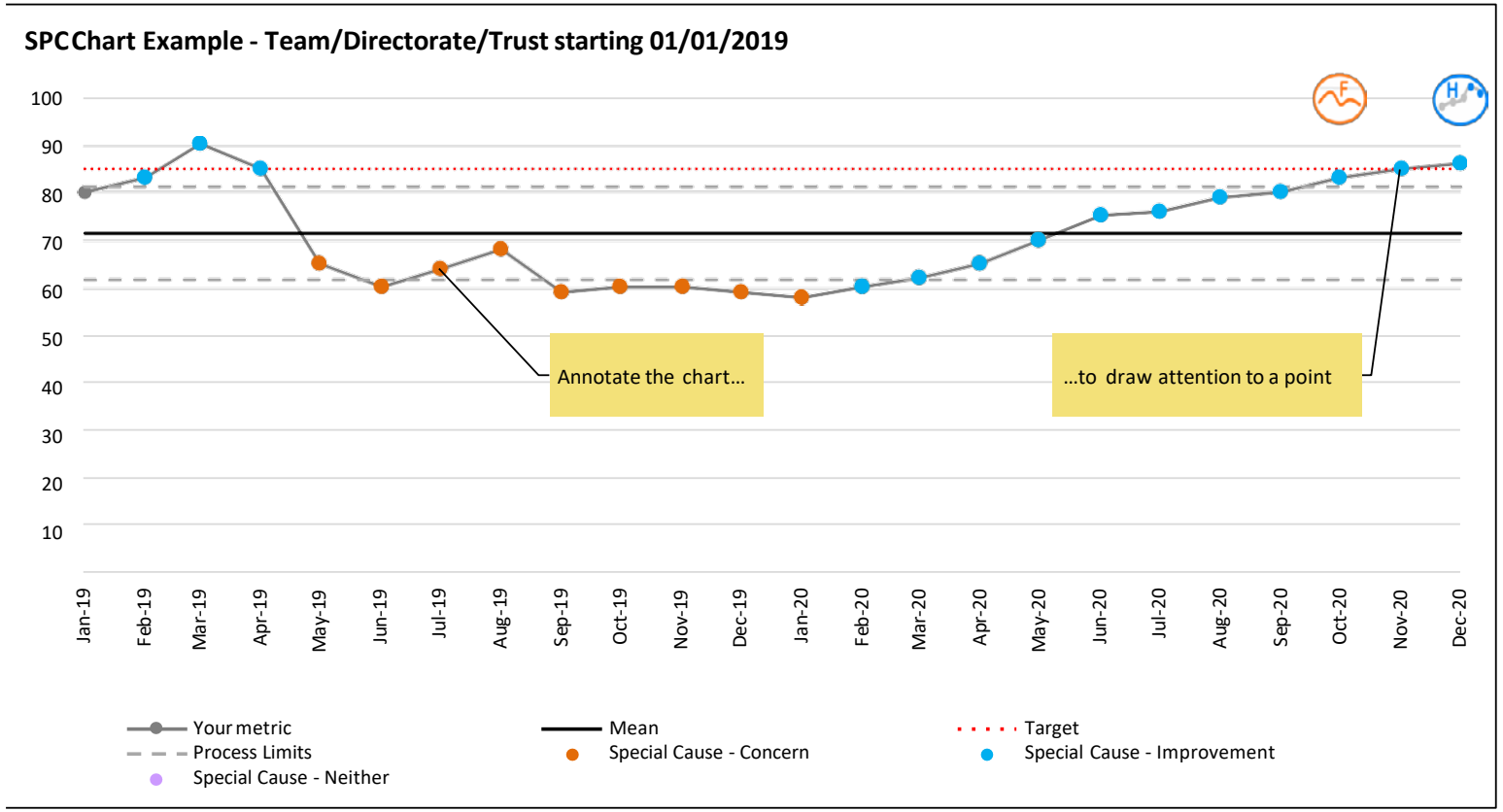
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

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.

Appendix 2 | SHSC SPC Chart Anatomy

Chart Title	SPC Chart Example
Team/Service	Team/Directorate/Trust
Your Measure	Your metric
Improvement Indicator	High is Good
Target	85

Start Date	01/01/2019	
Duration	24	Months
Baseline		
Min Value	0	
Max Value	100	



Observations

Based on the data from latest calculation date (data point 1 - 01/01/19).

Single Point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There are 6 points above the UCL and 7 points below the LCL.
Trend	When there is a run of 6 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control.