Board of Directors – Public

SUMMARY	Meeting Date:	28 July 2021
	Agenda Item:	11

Report Title:	**Integrated Performance and Quality Report (IPQR) May 2021**	
Author(s):	Deborah Cundey/Tania Baxter	
Accountable Director:	Phillip Easthope, Director of Finance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Quality Assurance Committee Finance and Performance Committee
	Date:	14 July 2021 15 July 2021
Key Points recommendations to or previously agreed at:	No recommendations There are no new risks highlighted in the report. The Quality Assurance Committee discussed waiting times across a range of community services and requested an update against the agreed recovery plan in September 2021. The Committee noted that progress with mandatory training was generally maintained, although Respect Level 2 training remained below 80% due to difficulties with face-to-face training during pandemic restrictions. Supervision in the Acute and Community Directorate is currently below the 80% target and the Committee received reassurance that a recovery plan was in place. The Committee noted a recent increase in assaults against colleagues and questioned whether factors related to equality, diversity and inclusion were considered within the IPQR. The Committee requested that this information be provided in future reports. The Committee enquired regarding the assurance of quality in Out-of-Area placements and received reassurance of the processes undertaken by the Acute and Community Directorate to track the progress of people in Out-of-Area placements and review the quality of their care. Finance and Performance Committee where assured that there were no new risks. In discussing the forward agenda of the committee and the scheduling of the recovery plans as where expected, its was recognised further embedding of this process was required and further assurance was required regarding the contract management processes to evidence the outcome of discussions through business planning into the committee.	

Summary of key points in report

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 April 2021.

The report was presented and considered in detail to the Quality Assurance Committee and to the Finance and Performance Committee in July. For each issue, the risk was explored, and the paper offered mitigations.

Continued risks reported to Quality Assurance Committee

Community Waiting times – risk Targets: Varying local and national
Issue: some community services have an unacceptable waiting time for people to access assessment and treatment. Historically a full data set on waits has not been available thereby reducing oversight and assurance. We aim to produce waiting time, caseload and DNA rates across the full set of community services as applicable over June/July/August so that September services and committees are receiving July data in full.

Mitigations: Recovery Plans for unacceptable waiting times were provided and discussed at March 21 Quality Assurance Committee and May 21 Finance & Performance Committee.
Due to not meeting the trajectory for core community services, different approaches are being explored that will be presented to the Finance & Performance Committee in August 2021.

Out of Area Placements (OOA) – risk National Target: Zero OOA
Adult Acute Bed Occupancy Local Target: 95%
Length of Stay (LOS) – Acute & Community Directorate (Adult, Older Adult & PICU wards)

Issues: A lack of available beds at the point of need results in people being sent away from their home area (OOA placements) for treatment. This can lead to lengthy periods away from home, family and all that is familiar. SHSC has reduced the overall number of acute and older persons beds available to enable dormitories to be eradicated with a further reduction planned to enable essential estates improvement works.

Mitigation:
- Increased operational and clinical leadership across inpatient wards which is intended to result in improved efficiency and quality of care. Expected outcomes include a reduction in restrictive interventions, reduced LoS and reduced reliance on out-of-area beds.
- A Recovery Plan is in place around Out of Area bed use across Acute, PICU and Older Adults and has been presented to the Quality Assurance Committee and Finance & Performance Committee.
- The plan includes improving length of stay, a relentless focus on discharging people who are delayed discharges or Medically Fit for Discharge (MFFD) and active clinical management of all patients placed out of area daily to consider care quality and opportunities for repatriation or alternatives to admission.

- We are in the final stages of a procurement exercise to secure additional acute and PICU bed capacity to replace the SHSC reductions due to the 2021 environmental improvements.
- As an interim measure, pending full procurement outlined above, 6 block booked female beds are available to SHSC from Cygnet Acer, Chesterfield from 29 June 2021. These beds provide a safe and therapeutic environment, within a reasonable distance of Sheffield.

Highlight: Acute readmission rate low

CPA Reviews – risk National Target: 95%
Issue: Persistent under performance against an annual review of care under the CPA Framework.

Mitigation: A recovery plan was presented to Finance & Performance Committee in June 2021 which will be reviewed again in August 2021. The revised recovery plan sets out a significantly different approach to how we record reviews of care under the CPA framework, that is more reflective of clinical practice.

Opiate Services – risk

Issue : The number of referrals received into the START Opiate service has reduced during the pandemic period.

Mitigation: A detailed investigation of national and local data was undertaken by START in June. This found a reduction in referrals to the Opiates service since mid-2020, national and local data from April 2018 to Mar 2021 was reviewed. The number of opiates service users in treatment has increased during the same period that referrals have fallen, and the rate of treatment "drop-outs" (Early Unplanned Exits) has fallen from a Sheffield average of 18.5% in the two years preceding Covid, to an average of 15% in the year 2020/21.

There have also been fewer service users who repeat self-refer (at least 3 times in the year) into the service. The monthly average over 2018/19 and 2019/20 was 6 referrals each month who had previously referred in 3 or more times, to an average of 2.5 per month for 2020/21. This suggests that those who previously may have dropped out and re-referred themselves have not done so.

The combination of fewer repeat referrals, DNAs to assessment and unplanned early exits, along with more service users in treatment overall makes the service feel assured that there is not currently a hidden barrier to treatment, although this will continue to be monitored as Covid restrictions ease.

Learning from Incidents – improvement SHSC target: Review incidents within 5 days
This continues to be an area of improvement, following historical delays in achieving the 5-day limit to review reported incidents and rapidly implement learning. Daily incident huddles centrally ensures oversight of all incidents. Revised governance processes are being established within clinical services to improve monitoring of performance and support clinical leaders to improve patient safety. These arrangements will be in place by the end of July 2021.

Catastrophic Incidents No Targets – catastrophic patient safety incidents benchmarked in NRLS
23 incidents were graded as catastrophic during May 2021, all of which were deaths. Six were unexpected but suspected natural causes, twelve were unexpected community deaths and five suspected community suicides.

Mitigations: All incidents reported are reviewed centrally 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. A new quarterly lessons learned report was presented to the Quality Assurance Committee in May 2021 to support learning. Work to improve our learning from mortality has commenced, in collaboration with Better Tomorrow's and work on developing our clinical risk processes and improving our understanding of suicide and self-harm has also commenced.

Medication incidents – risk
Issue: accurate reporting of medication errors can lead to a perception of a high error rate when some can be near misses and most have no patient impact and a good reporting culture is a feature of a good safety culture.

Mitigation: A deep dive into medication errors for quarter one will be undertaken to establish learning to guide practice change. This will be presented to the Quality Assurance Committee in August 2021.

Restrictive Practice Incidents – risk No Targets, performance measured by CQC
Issue: High numbers of restraints reported during May 2021, breaching control limits.

There were three mechanical restraints in month, two by the police and one by an approved secure transport company, regarding an admission.

Mitigations: Work on co-producing a new strategy to reduce the use of restrictive practices began in June 2021, involving internal and external stakeholders, experts by experience and subject experts. Six key priorities have been identified as part of the strategy across a 3-year period that supports the overall outcome of least restrictive practice and improved patient and staff experience. The launch event is due to take place in November 2021.

Safer staffing - risk National target : fill rate above 85% for inpatient wards
Issue: Staff turnover and staff sickness rates remain high. Staff sickness for May 2021 was 5.39% against a target of 5.1%. Staff turnover in May 2021 was 13.67% against a target of 10%. Staffing vacancies across

community and specialist services are impacting on waiting times, throughput within community services and potentially impacts on length of stay.

Mitigations: The People Committee receives detailed workforce information and seek assurances regarding recruitment activity and retention plans. Active recruitment is underway to address the shortages. Staffing shortages are incident reported to ensure any impact on patient safety is escalated and addressed.

Supervision - improved Local Target: 80% Supervision compliance continues to improve 65%, against a target of 80% staff receiving minimum 8 supervisions in a 12 month period.
Compliance varies across teams.

Mitigations: Compliance with supervision policy is monitored and reported weekly. The monthly Quality and Performance reviews look closely at this performance. A recovery plan to improve supervision rates, targeting poor performing teams is being presented to the Quality Assurance Committee in July 2021.

Mandatory Training - improved Local Target: 80% Issue: Overall compliance with mandatory training exceeds 90%, with only one subject remaining below the target of 80% (Respect level 2). Grenoside Facilities is the only team below 80% compliance. Additional staff have been added to those requiring Respect Level 2 (eg junior rotational medics). In response to this challenge, we are mapping numbers required against available sessions to establish whether more training is required. The Grenoside Facilities Management Team is actively working on addressing the gaps in training.

Continued risks reported to Finance and Performance Committee

As highlighted above some recovery plans for community waiting times are being monitored via QAC, where these plans are not able to meet existing demand and where plans for investment have not been identified, these areas will be escalated through to contract management meetings with the CCG and reported via routine contract monitoring through business planning and Finance and Performance Committee.

Issue: CIP Planning and Delivery

Mitigation: A revised CIP planning and QIA process are in place. More plans are going through QEIA process and significant progress is expected next month.

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	✓	**Information**	✓
The summary offers the highlights and exceptions for the Finance and Performance Committee to consider.							

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Getting through safely	***Yes***	✓	*No*	
CQC Getting Back to Good	***Yes***	✓	*No*	
Transformation – Changing things that will make a difference	***Yes***	✓	*No*	
Partnerships – working together to make a bigger impact	*Yes*		***No***	✓

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission	***Yes***	✓	*No*		This report ensures compliance with NHS Regulation – CQC Regulation may be a by-product of this.
IG Governance Toolkit	*Yes*		*No*	✓	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	*Yes*	✓	*No*		Any impact is highlighted within relevant sections.
Financial (revenue &capital)	*Yes*	✓	*No*		CIP delivery is being offset by underspending on investments and COVID funding
OD/Workforce	*Yes*	✓	*No*		Any impact is highlighted within relevant sections.
Equality, Diversity & Inclusion	*Yes*		*No*	✓	
Legal	*Yes*		*No*	✓	

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Integrated Performance & Quality Report

Information up to and including May 2021

Proud to care in Sheffield

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Introduction

Information and metrics are groped into the following themes in line with the proposed KPIs for 21/22 and the Trust Performance Framework.

- Service Delivery
- Safety & Quality
- Our People
- Financial Performance
- Covid-19

We use statistical process control (SPC) charts where possible in order to better understand what is 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. Using SPC can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting a target or standard without a change.

In this report we have introduced a variation on the SPC icons we are using in SPC charts to easily identify improvement or cause for concern, so that we can look at more information but still identify the points of interest.

You will see tables like this throughout the report, and there is further information on how to interpret the charts and icons in Appendices 1 and 2.

Unless otherwise stated the control limits (the range within which normal variation will occur) are set by 24 months of data points, for example in the case of April 2021 reporting, we are using monthly figures from May 2019 to April 2021. Where that much data is not available we use at least back to April 2020.

Ward	Month 1		
	n	*SPC variation*	*SPC target*
Ward 1	35.67	• L •	F
Ward 2	35.95	• • •	?
Ward 3	27.71	• • •	P
Ward 4	37.62	• • •	F
Ward 5	47.46	• • •	?
Ward 6	86.82	• • •	F
Ward 7	75.87	• L •	?
Ward 8	58.41	• H •	/

SPC variation	
• • •	Common cause
• L •	Improvement - where low is good
• H •	Improvement - where high is good
• L •	Concern - where high is good
• H •	Concern - where low is good
• ? •	Special cause - where neither high nor low is good

SPC target	
?	Target Indicator – Pass/Fail
P	Target Indicator – Pass
F	Target Indicator – Fail

In some cases we have ‘baselines’ in the data so that the control limits are set by an initial range of data points and then remain the same. We use this to identify if there have been changes in the system. Monitoring referrals to services is a good example of where this is useful. We use Jan 19 to Mar 20 as a baseline (pre-Covid) and then can see whether activity has been impacted, returned to pre-covid levels or changed significantly.

We have begun using and looking at the information in this way in our ‘Floor to Board’ Performance & Quality reviews with Clinical Directorates, and will continue to develop that way of working so that the data is intelligently reviewed at source and services and teams are able to investigate and provide narrative which supports the information.

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Service Delivery

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IPQR - Information up to and including May 2021

Responsive | Access & Demand | Referrals

Referrals	May-21			
Acute & Community Directorate Service	n	*mean*	SPC variation	SPC target
SPA/EWS	961	*838*	• • •	?
AMHP	162	*118*	• ? •	/
Out of Hours Team	1205	*872*	• ? •	/
Liaison Psychiatry	568	*513*	• • •	/
Decisions Unit	68	*42*	• • •	/
S136 HBPOS	48	*33*	• ? •	/
Adult Home Treatment Service	97	*106*	• • •	/
OA Home Treatment	28	*29*	• • •	/

Referrals	May-21			
Acute & Community Directorate Service	n	*mean*	SPC variation	SPC target
MH Recovery North	18			/
MH Recovery South	20			/
Recovery Service TOTAL	***38***	*43*	• • •	/
Early Intervention in Psychosis	46	*45*	• • •	/
Memory Service	122	*103*	• • •	/
OA CMHT	235	*238*	• • •	/

Referrals	May-21			
Rehabilitation & Specialist Directorate Service	n	*mean*	SPC variation	SPC target
IAPT	1561	*1628*	• • •	/
START Opiates	66	*108*	• ? •	/
START Non-Opiates	56	*60*	• • •	/
START Alcohol	172	*178*	• • •	/
CERT	2			
CLDT	44	*44*	• • •	/
SPS - MARD	2	*8*	• • •	/
SPS - PD	9	*10*	• • •	/
Gender ID	41	*45*	• • •	F
STEP	112	*53*	• ? •	/
Eating Disorders Service	30	*27*	• • •	/
SAANS	111	*168*	• ? •	/
R&S	8	*12*	• • •	/
Perinatal MH Service (Sheffield)	50	*50*	• • •	/
HAST	17	***15***	• • •	/

Narrative

We continue to see significant demand into various access points, including Crisis services (SPA, Liaison, Central AMHP function) with a knock on effect into community services. There is a similar picture in specialist community services. Increasing referrals corresponds with increasing caseloads. Demand for access services, acute inpatient and out of area use, along with community service caseload sizes is monitored in a weekly Demand Monitoring Dashboard reviewed by colleagues in the Clinical Directorates.

Responsive | Access & Demand | Community Services

May 2021	*Number on wait list at month end*	*Average wait time referral to assessment for those assessed in month.*	*Average wait time referral to first treatment contact for those 'treated' in month.*	*Total number open to Service*
SHSC Team	**Waiting List (Number)**	**Average Waiting Time (RtA)**	**Waiting Time RtT**	**Caseload (Service)**
SPA/EWS	865	19.26	21.78	1446
MH Recovery North	17	4.10	9.00	986
MH Recovery South	17	8.00	5.30	1075
Early Intervention in Psychosis	34	*N/A*	0.63	391
Memory Service	421	14.02	27.87	3960
OA CMHT	106	12.18	12.91	1238
CLDT	170	18.50	22.50	1075
SPS - MAPPS	40	18.10	129.10	283
SPS - PD	45	34.20	68.70	186
Gender ID	1294	156.70	*N/A*	2079
STEP	103	*N/A*	3.14	453
Eating Disorders Service	32	5.14	Incomplete	216
SAANS	2944	96.86	Incomplete	4143
R&S	199	Incomplete	Incomplete	213
Perinatal MH Service (Sheffield)	29	3.71	Incomplete	148
HAST	20	10.71	Incomplete	104

Narrative

The Quality Assurance Committee received a paper in June 2021 sharing the intention to produce and assure the following metrics (where applicable) over June/July/August so that September 2021 services and committees are able to receive July 2021 data in full.

Demand (Referrals) | Activity – Assessments/Treatment Appointments delivered | Waiting Lists and Waiting Times for Assessment and Treatment | DNA/Cancellation Rates to first assessment/appointment | Caseload – service and per Care Co-ordinator (if applicable)

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 community service metrics across both Clinical Directorates is key in the above work plan.

Recovery Plans for the significant waiting lists and unacceptable waiting times for SPA, Recovery Service Care Coordination and some of our Specialist Community Services are reviewed with regular frequency by Quality Assurance Committee and Finance & Performance Committee.

Safe | Inpatient Wards | Adult Acute & Step Down

Adult Acute	Benchmark/ Target	May-21 n	May-21 mean	May-21 SPC variation	May-21 SPC target
Admissions	/	38	41	• • •	/
Detained Admissions	/	38	35	• • •	/
% Admissions Detained	/	100%	86%	• • •	/
Emergency Re-admission Rate	7%	0.0%	3.9%	• L •	?
Discharges	/	28			
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	4			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	87			
Bed Occupancy excl. Leave (KH03)	95%	93.49%	94.03%	• • •	?
Bed Occupancy incl. Leave	/	96.84%		• • •	?
Average beds admitted to	/	49			
Average Discharged Length of Stay (12 month rolling)	35	35.67	37.91	• L •	F
Average Discharged Length of Stay (discharged in month)	35	26.42	36.59	• • •	?
Live Length of Stay (as at month end)	/	38.5	40.73	• • •	/
Out of Area Placements started in the period (admissions)	0	6		• • •	?
Total number of Out of Area bed nights in period	0	479		• • •	F
Total number of people in Out of Area beds in period	0	23		• • •	F
Cost of Out of Area bed nights in period	0	Not yet available			

Narrative

Issues
- High bed occupancy across acute
- Variance in admission and discharge rates (LoS).
- High use of Out of Area beds

Actions
- Home First Programme including actions already mobilised around acute pathway
- More stable medical and leadership provision across wards to support a plan to reduce variance in LoS
- Recovery Plan in place around Out of Area bed use across Acute, PICU and Older Adults

Highlights
- Acute readmission rate low

Step Down	Benchmark/Target	May-21 n	May-21 mean	May-21 SPC variation	May-21 SPC target
Admissions	/	7	10	• ? •	/
Discharges	/	6			
Bed Occupancy excl. Leave (KH03)	95%	93.71%	90.76%	• • •	?
Bed Occupancy incl. Leave	95%	102.52%		• • •	?
Average Discharged Length of Stay (12 month rolling)	/	55.4	40.78	• H •	/
Live Length of Stay (as at month end)	/	113.45	93.17	• H •	/

Narrative
Issues
- Wainwright – low admissions / increased LoS – ? impact of Covid ?

Actions
- A plan to discharge the one patient at Wainwright who has been there in excess of 2 years.
- A plan to re-launch Wainwright Crescent with a more clearly defined purpose.

Benchmarking Adult Acute
(2020 NHS Benchmarking Network Report – Weighted Population Data)
Bed Occupancy Mean: 93%
Length of Stay (Discharged) Mean: 35
Emergency readmission rate Mean: 7%

NB – No benchmarking available for Step Down beds

Inpatient Wards | PICU

PICU	Benchmark/Target	May-21 n	May-21 mean	May-21 SPC variation	May-21 SPC target
Admissions	/	5	4	• • •	/
Discharges	/	4			
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	0			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	0			
Bed Occupancy excl. Leave (KH03)	95%	94.84%	*91.38%*	• • •	?
Bed Occupancy incl. Leave	95%	94.84%		• • •	?
Average beds admitted to	/	9			
Average Discharged Length of Stay (12 month rolling)	47	45.35	*44.89*	• • •	?
Live Length of Stay (as at month end)	/	64.7	*46.69*	• H •	/
Number of Mental Health Out of Area Placements started in the period (admissions)	ZERO Inappropriate	5		• • •	?
Total number of Out of Area bed nights in period	ZERO Inappropriate	149		• • •	F
Total number of people in Out of Area beds in period	ZERO Inappropriate	10		• • •	F
Cost of Out of Area bed nights in period	ZERO Inappropriate	Not yet available			

Narrative

Issues

- A lack of SHSC available beds results in people being sent away from their home area (OOA placements) for treatment. This can lead to lengthy periods away from home, family and all that is familiar.
- SHSC has reduced the overall number of acute and older persons beds available to enable dormitories to be eradicated with a further reduction planned to enable essential estates improvement works.

Actions

- A recovery plan is in place that has been presented to the Quality Committee and Finance & Performance Committee. The plan includes improving length of stay, a relentless focus on discharging people who are delayed discharges or Medically Fit for Discharge (MFFD) and active clinical management of all patients placed out of area daily to consider care quality and opportunities for repatriation or alternatives to admission.
- We are in the process of procuring additional bed capacity to replace the SHSC reductions due to the 2021 environmental improvements.

Benchmarking PICU
(2020 NHS Benchmarking Network Report – Weighted Population Data)
Bed Occupancy Mean: 88%
Length of Stay (Discharged) Mean: 47

Safe | Inpatient Wards | Older Adults

Older Adult Dovedale	Benchmark /Target	May-21 n	mean	SPC variation	SPC target
Admissions	/	7	5	• • •	/
Discharges	/	10			
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	0			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	0			
Bed Occupancy excl. Leave (KH03)	95%	83.23%	93.47%	• • •	?
Bed Occupancy incl. Leave	95%	94.84%		• • •	?
Average beds admitted to	/	14			
Average Discharged Length of Stay (12 month rolling)	74	85.06	95.02	• • •	F
Live Length of Stay (as at month end)	/	106.08	101.19	• H •	/

Older Adult G1	Benchmark /Target	May-21 n	mean	SPC variation	SPC target
Admissions	/	7	4	• • •	/
Discharges	/	4			
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	6			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	112			
Bed Occupancy excl. Leave (KH03)	95%	59.07%	71.90%	• ? •	?
Bed Occupancy incl. Leave	95%	63.51%		• ? •	?
Average beds admitted to	/	10			
Average Discharged Length of Stay (12 month rolling)	74	74.96	85.54	• L •	?
Live Length of Stay (as at month end)	/	31.67	56.71	• • •	/

Narrative

Issues

- Low bed occupancy at G1
- Delayed Transfers of Care recorded on G1.

Actions

- The Terms of Reference for a review of G1 have been agreed and the improvement actions are being implemented around length of stay, use of restrictive practice to manage falls, and the funded staffing establishment.
- Delayed Transfers of Care reviewed on a weekly basis and escalated to Housing and Social Care leaders.

Benchmarking Older Adults
(2020 NHS Benchmarking Network Report – Weighted Population Data)
Bed Occupancy Mean: 86%
Length of Stay (Discharged) Mean: 74
NB - Benchmarking figures are for combined Older Adult inpatient bed types, they are not available split into functional and organic mental illness.

Safe | Inpatient Wards | Rehabilitation & Forensic

Rehab	Benchmark /Target	May-21 n	mean	SPC variation	SPC target
Admissions	/	1	/	• • •	/
Discharges	/	3			
Bed Occupancy excl. Leave (KH03)	95%	82.26%	*82.67%*	• • •	F
Bed Occupancy incl. Leave	95%	**94.69%**	*93.74%*	• • •	?
Average Discharged Length of Stay (12 month rolling)	524	316.88	*393*	• L •	P
Live Length of Stay (as at month end)	/	314.97	*410.54*	• L •	/
Number of Mental Health Out of Area Placements started in the period (admissions)	0 Inappropriate	0			
Total number of Out of Area bed nights in period	0 Inappropriate	310			
Total number of people in Out of Area beds in period	0 Inappropriate	10			
Cost of Out of Area bed nights in period	0 Inappropriate	Not yet available			

Forensic (Low Secure)	Benchmark /Target	May-21 n	mean	SPC variation	SPC target
Admissions	/	0	/	• • •	/
Discharges	/	0			
Bed Occupancy excl. Leave (KH03)	95%	79.33%	*87.10%*	• • •	?
Bed Occupancy incl. Leave	95%	92.96%	*91.52%*	• • •	?

Forest Close
Data quality is impacted by the absence of data for the beds on Bungalow 3 in Forest Close which were made available in 2020 initially to allow for isolation of patients in the case of Covid outbreaks, and then used as a step down facility. This has been addressed and will be provided from next reporting period (to end June 21) onwards.
It should be noted that length of stay within Forest Close benchmarks favourably against other Rehab/Complex Care facilities across the country
Currently all Out of Area rehab admissions are deemed appropriate as are providing a specialist placement that Forest Close does not provide.
The team meet regularly to review service users in Out of Area beds and have expected discharge dates for all placements.

Benchmarking Rehab/Complex Care
(2020 NHS Benchmarking Network Report – Weighted Population Data)
Bed Occupancy Mean: 81%
Length of Stay (Discharged) Mean: 524

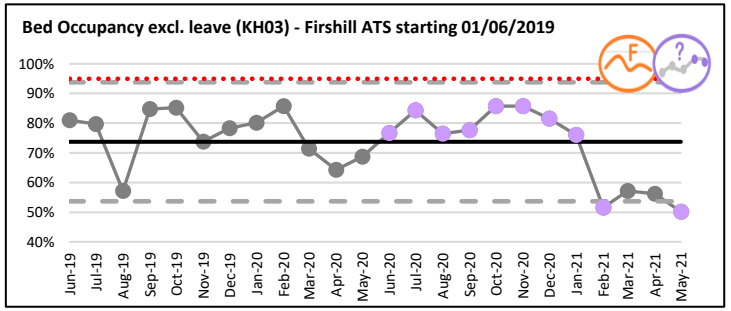
Forest Lodge
Further development of the reporting for Forensic (Low Secure) inpatient services is required to include Length of Stay data.

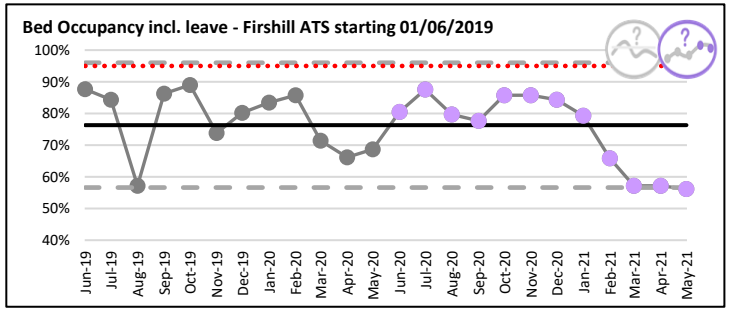
Benchmarking Low Secure Beds
(2020 NHS Benchmarking Network Report – Weighted Population Data)
Bed Occupancy Mean: 91%
Length of Stay (Discharged) Mean: 593

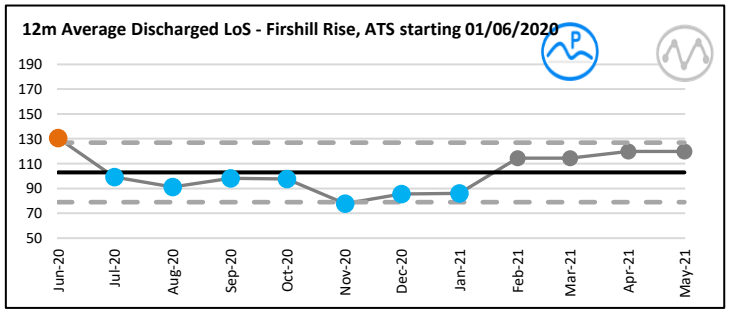
Across both services, further checks need to be carried out to assure data quality of admission and discharge information.

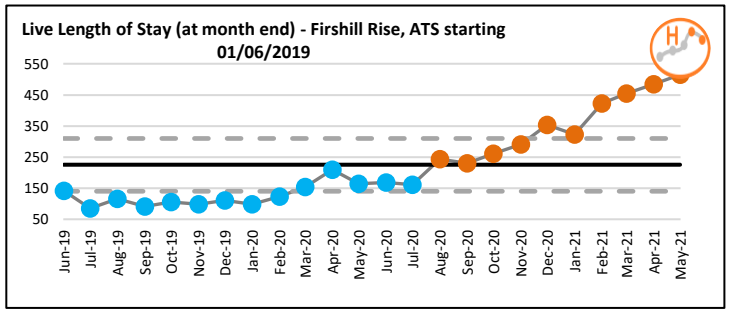
Safe | Inpatient Wards | Learning Disabilities (Firshill)

Learning Disabilities	Benchmark /Target	May-21 n	May-21 mean	May-21 SPC variation	May-21 SPC target
Admissions	/	0	*0*	• • •	/
Discharges	/	0			
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	3			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	93			
Bed Occupancy excl. Leave (KH03)	95%	50.23%	*73.73%*	• ? •	F
Bed Occupancy incl. Leave	95%	57.14%	76.26%	• ? •	?
Average Discharged Length of Stay (12 month rolling)	301	119.86	*103*	• • •	P
Live Length of Stay (as at month end)	/	515.25	*225.46*	• H •	/









Narrative

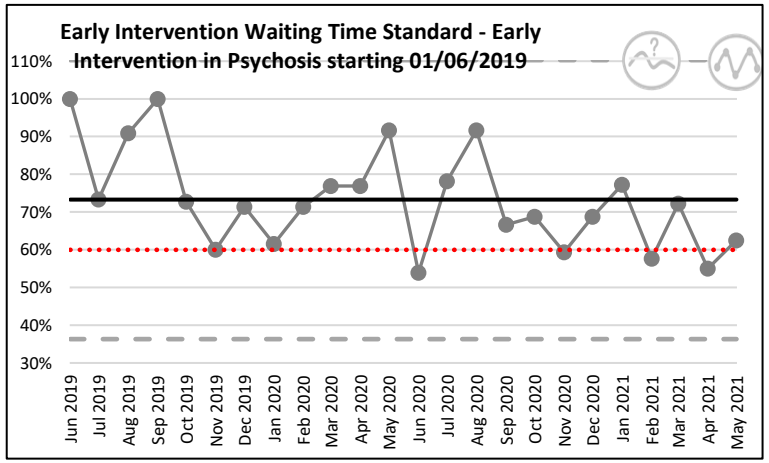
Further to the CQC inspection in May, Firshill Rise is closed to new admissions.

The delayed discharges are actively being managed and discharge dates have been agreed for all the service users.

The service is developing a detailed plan to re-open for admissions in autumn 2021 when all the actions in response to the service concerns have been addressed.

Benchmarking
(2019 NHS Benchmarking Network Report – Specialist LD Report)
Bed Occupancy Mean: None available
Length of Stay (Discharged) Mean: 301

Effective | Treatment & Intervention



EIP AWT Standard	Target 2021/22	May-21 N	May-21 SPC variation	May-21 SPC target
Trustwide	60%	62.50%	• • •	?

Narrative

2020/21 Standard: More than 60% of people experiencing a first episode of psychosis will be treated with a NICE approved care package.

The standard has increased from 53% (18/19) to 56% (19/20) and now to 60% with effect from 1 April 2021.

There is variation month on month, but our average over the last 2 year period is 73%, indicating the system is more than capable of achieving the 20/21 target.

7 Day Follow Up	Target 2021/22	May-21 N	May-21 SPC variation	May-21 SPC target
Trustwide	95%	100%	• • •	?

Narrative

The aim is to deliver safe care through ensuring people on CPA are seen within 7 days of being discharged.

The 7 day follow up target remained in place throughout 20/21 although a CQUIN was in place in 19/20 with the intention to moving towards measuring 72 hour follow up. That measure is now in place for FY 21/22. We are working with Information Dept colleagues to provide the 72 hr follow up figure and will report on that from next month onwards.

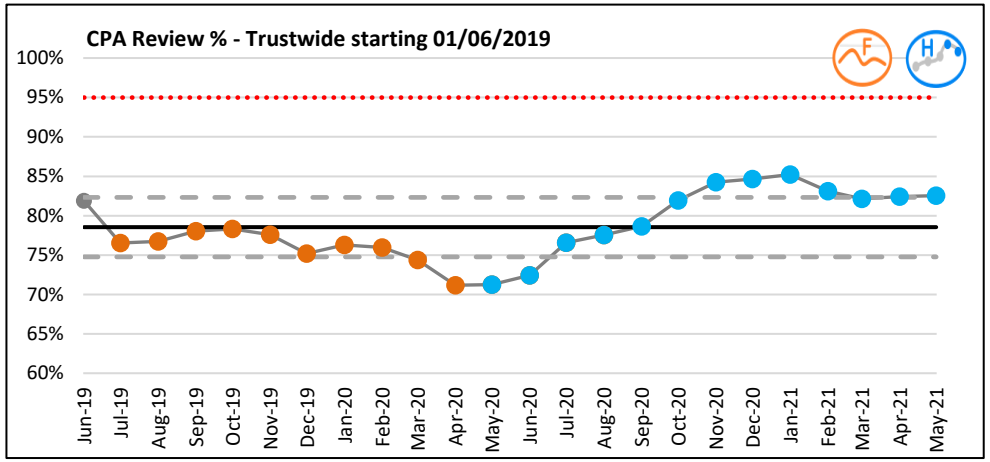
The 72 hour follow up has been in place operationally since 19/20 and is delivered by the Home Treatment Service, and will be delivered by the new Crisis Resolution Home Treatment function. The target is 60%.

Gatekeeping Admission	Target 2021/22	May-21 N	May-21 SPC variation	May-21 SPC target
Trustwide	95%	94.44%	• • •	?

Narrative

There is work to do to improve data quality around gatekeeping admissions – particularly in relation to eligibility for inclusion (e.g. when service user repatriated to Sheffield from out of area bed)

This will be a focus as the operational model moves to be delivered by the new Crisis Resolution Home Treatment function.



CPA Review % Completed within 12 months	Target 2021/22	May-21 n	May-21 Mean	May-21 SPC variation	May-21 SPC target
Trustwide	95%	82.56%	*78.54%*	• H •	F
Early Intervention	95%	88.89%	*90.22%*	• • •	?
MH Recovery North	95%	85.56%	*83.86%*	• H •	F
MH Recovery South	95%	78.56%	*68.67%*	• H •	F

Narrative

Improved performance shown over previous quarter has since levelled out. Gaps in staffing have continued to impact on the performance in particular in the recovery service.

Issues

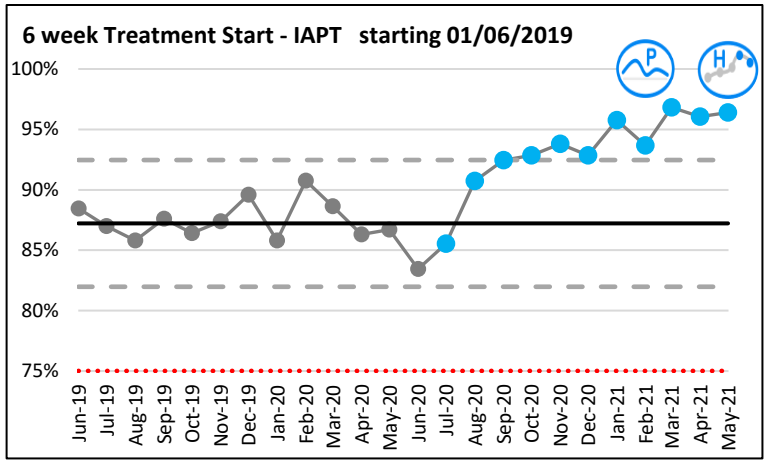
- Persistent under performance against an annual review of care under the CPA Framework.

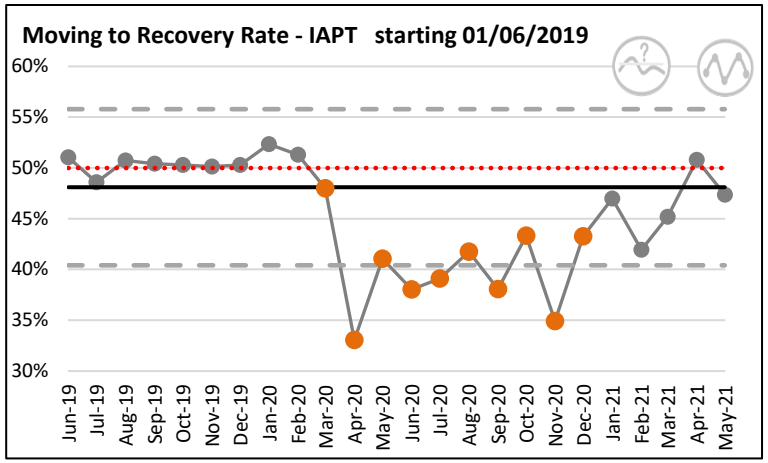
Actions

- Engagement with clinical teams through QPR process.
- Amended guidance has been distributed around the review of care plans under the CPA framework which will improve compliance.
- A Recovery Plan has been presented to Finance & Performance Committee in June 2021 to be reviewed again in August.

IAPT | Performance Summary

IAPT		May-21			
Metric	Target 2021/22	n	*mean*	SPC variation	SPC target
Referrals	n/a	1561	*1628*	• • •	/
New to Treatment	1232	1261	*1041*	• • •	?
6 week Wait	75%	96.41%	*87.22%*	• H •	P
18 week Wait	95%	99.70%	*99.34%*	• • •	P
Moving to Recovery Rate	50%	47.34%	*48%*	• • •	?





Narrative

Access

Service access target is 1232 new people to enter treatment each month. Exceeded standard in May with 1262 people entering treatment. We are on track to meet the access standard for Q1.

Waiting Times

Continue to exceed service waiting time target with 96.5% of people accessing treatment within 6 weeks and 99.7% in 18 weeks.

Recovery

Service achieved 47.34% recovery in May, with the following actions in place to address:

- A detailed recovery rates plan to improve service recovery which continues to be implemented. All staff are working on individual recovery rate development plans in line management and in clinical supervision which is being reviewed. Clinical leads are tasked with identifying any CPD needed for anyone identified in recovery rate development plans.
- Review calls offered to anyone who attends a course and benefitted from the course but not moved in to recovery to identify if any other intervention is required. We have noticed an impact from increased DNA of these appointments. We have set up a weekly course steering group to assess the impact of this and have also reviewed capacity to provide more review calls to ensure a short waiting time to access one in case this has impacted on DNA rate.
- Established a monthly recovery rates performance meeting with managers only to explore contributing factors recovery and look at support needed. This meeting is also opportunity to share across teams learning around achieving service recovery rates.

Other Highlights and Achievements

- Referrals continue to increase, service received 1561 new referrals in May. We have been promoting a new ‘Life after Lockdown’ online session on social media and have been on BBC radio Sheffield live to promote this.
- Established a patient experience working group

START – Sheffield Treatment & Recovery Team | Performance Summary

START		May-21		
Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	66	• L •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	98.51%	• H •	?
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	100%	• • •	P
DNA Rate to Assessment	≤ 15%	23.88%	• L •	?
Recovery - Successful treatment exit	TBC	6	• • •	/
Non-Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	56	• H •	/
Waiting time Referral to Assessment	≥ 95%	95.24%	• • •	• • •
Waiting time Referral to Treatment	≥ 95%	100%	• • •	• • •
DNA Rate to Assessment	≤ 15%	19.05%	• L •	• • •
Recovery - Successful treatment exit	TBC	15	• H •	/
Alcohol	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	173	• • •	/
Waiting time Referral to Assessment	≥ 95%	100%	• • •	P
Waiting time Referral to Treatment	≥ 95%	100%	• H •	P
DNA Rate to Assessment	≤ 15%	18.01%	• • •	• • •
Recovery - Successful treatment exit	TBC	51	• H •	/

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 increasing activity levels where safe to do so.

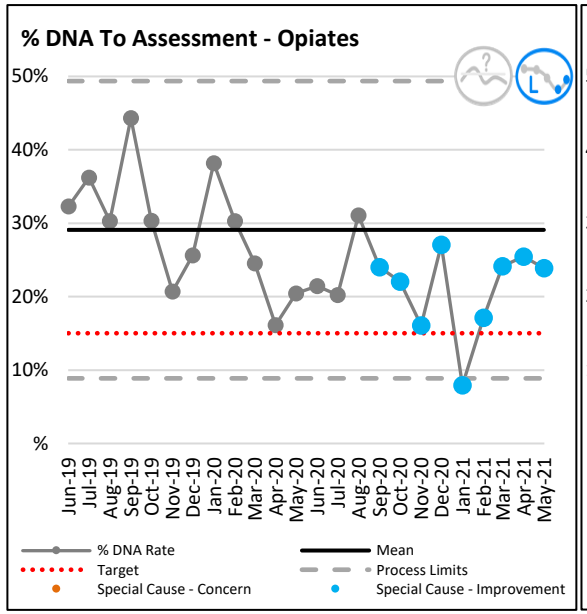
Waiting Times

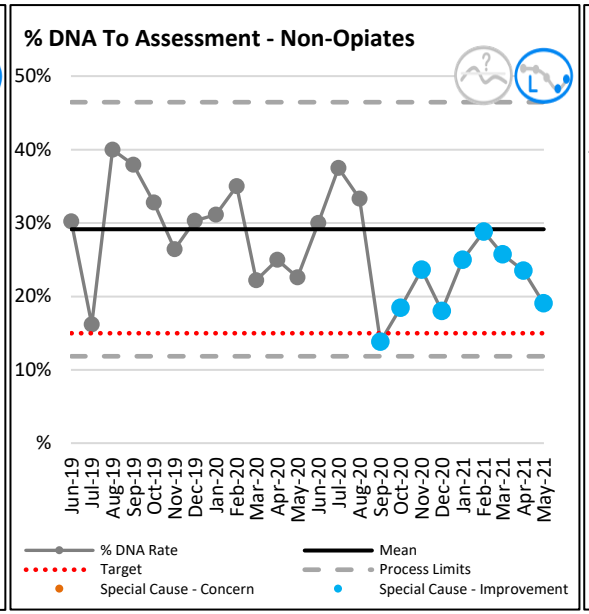
The service works towards a target of 95% of service users being assessed within 7 working days. 3 service user waited longer than 7 days for assessment with the Non-opiates service in May 2021. The average wait time from referral to assessment is just over 2 days in the Opiates service, and 5 days in the alcohol and non-opiates services.

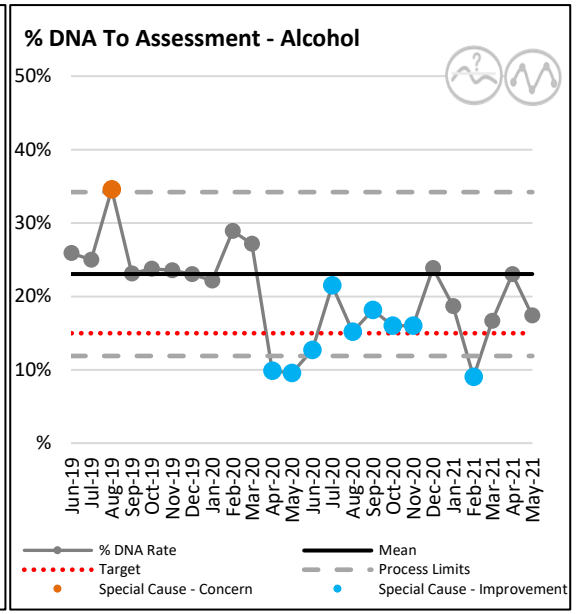
Recovery

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



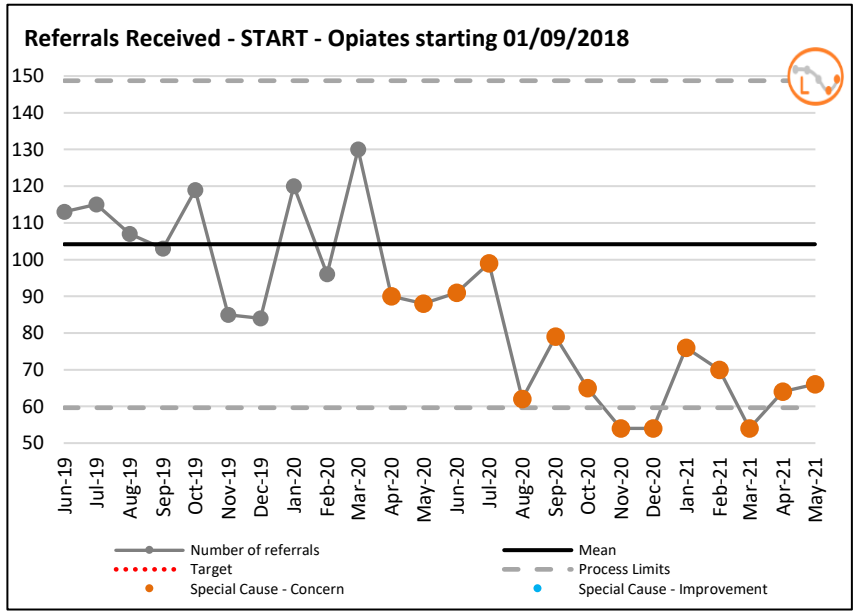


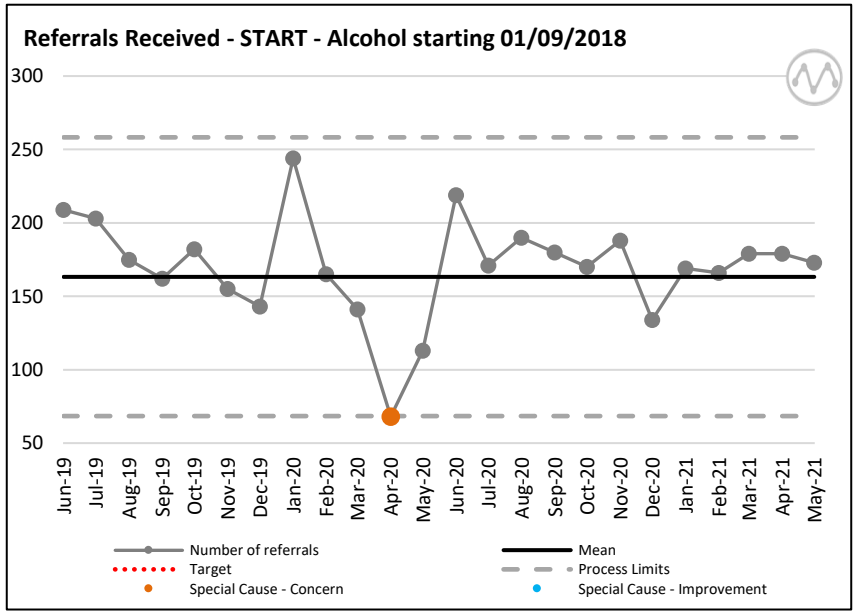


DNA Rate to Assessment

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)

Low referrals to the Opiates service are a cause for concern; however, analysis shows that total numbers in treatment have remained stable, and fewer service users are dropping out and/or cycling in and out. 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.

NHS
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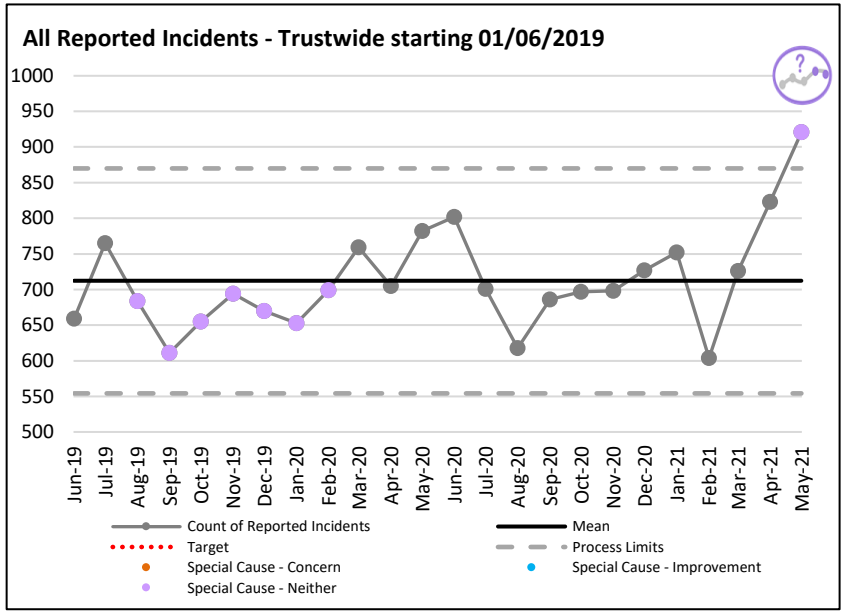
Safety & Quality

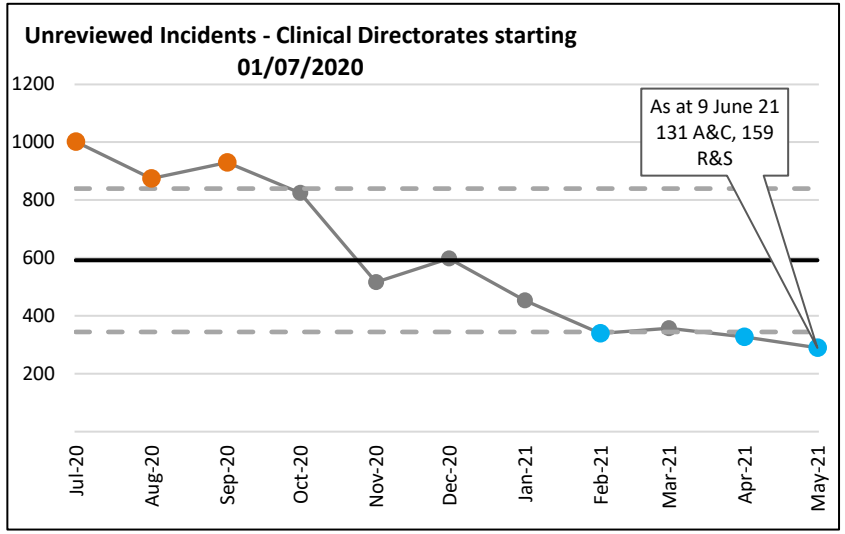
Proud to care in Sheffield

IPQR - Information up to and including May 2021

Safe | All Incidents



Trustwide	May-21		
	n	*mean*	SPC variation
ALL	**921**	*713*	· ? ·
5 = Catastrophic	23	*15*	· · ·
4 = Major	2	*4*	· · ·
3 = Moderate	32	*31*	· · ·
2 = Minor	215	*151*	· ? ·
1 = Negligible	609	*485*	· · ·
0 = Near-Miss	40	*27*	· · ·



Serious Incident Actions Outstanding

As at 31st May 2021, there were 87 outstanding SI actions overdue.

3 of these were from 2 SIs in 2018 (action dates 2019).
33 of these are from 14 SIs in 2019 (action dates 2020)
51 of these are from 18 SIs in 2020 (action dates 2020 and 2021).

Weekly reports are being sent to identified matrons and general managers from July 2021 to oversee and complete all SI action plans.

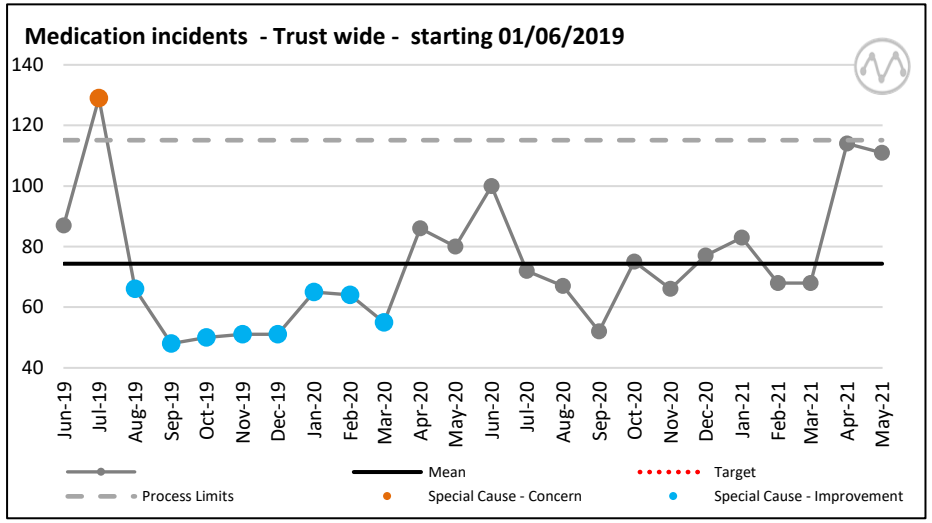
Protecting from avoidable harm	Target	YTD
Never events declared	0	0
Methicillin-resistant Staphylococcus aureus (MRSA & MSSA)	0	0

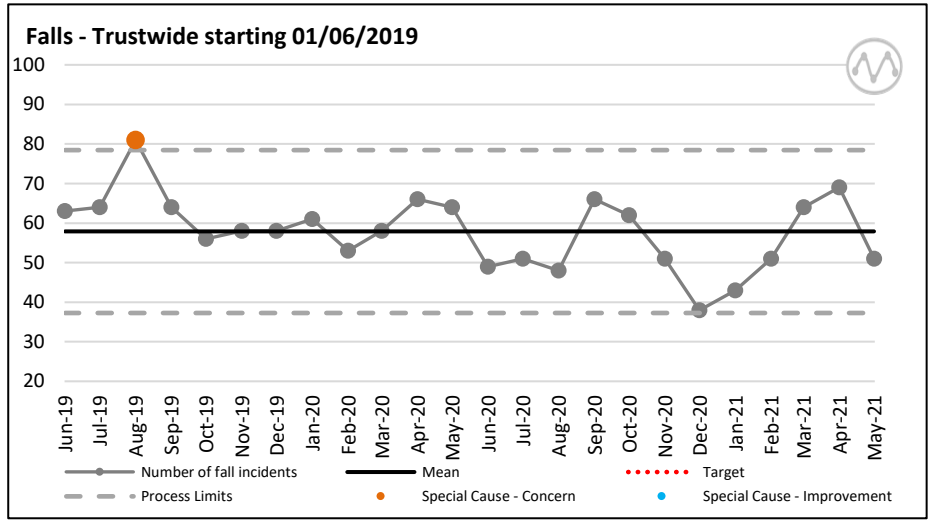
Narrative

May update:
Patient safety incidents are reported to the National Reporting Learning System (NRLS). During the Covid-19 pandemic, no benchmarking information has been provided to Trusts. Recent announcements have advised that benchmarking will now recommence, but on an annual, rather than 6-month basis.

May 2021 has seen the total number of incidents reported breaching the upper control limit. This is due to an increase in minor graded incidents being reported (also breaching the upper control limit) across both clinical directorates.

Safe | Medication Incidents & Falls





Trustwide	May-21		
	n	mean	SPC variation
ALL	111	74	• • •
Administration Incidents	36	16	• ? •
Meds Management Incidents	62	46	• • •
Pharmacy Dispensing Incidents	7	7	• • •
Prescribing Incidents	6	5	• • •
Meds Side Effect/Allergy Incidents	0	0	• • •

FALLS Incidents	May-21		
	n	mean	SPC variation
TRUST WIDE	51	58	• • •
Acute & Community	50	54	• • •
Rehabilitation & Specialist Services	1	4	• • •

INDIVIDUALS who fell	May-21		
	n	mean	SPC variation
TRUST WIDE	27	30	• • •
Acute & Community	26	27	• • •
Rehabilitation & Specialist Services	1	3	• • •
Services			
Burbage	3	0	• H •
Dovedale	7	3	• H •
Birch Avenue	7	9	• L •

Narrative

May update:
The number of medication administration incidents across the Trust has breached the upper control limit in May 2021. This is due to unusually high numbers of incidents reported across Forest Lodge (7), Stanage Ward (6) and Dovedale Ward (4). Local limits have not breached the upper control limits, but collective high numbers have caused the total to breach.

Five moderate medication incidents were reported during May 2021 across Forest Lodge, Adult and Older Adult Home Treatment Teams, Recovery Team South and START Opiates service. The incidents involved duplicated or missed medication, incorrect storage or controlled drug discrepancies.

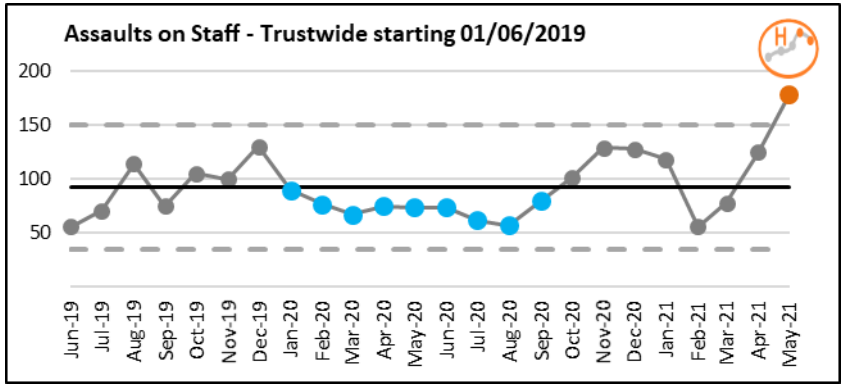
One major fall occurred on G1 during May 2021 and resulting in the service user sustaining a fractured rib and a small pneumothorax A 48hr report was undertaken and concluded nothing further was required.

.

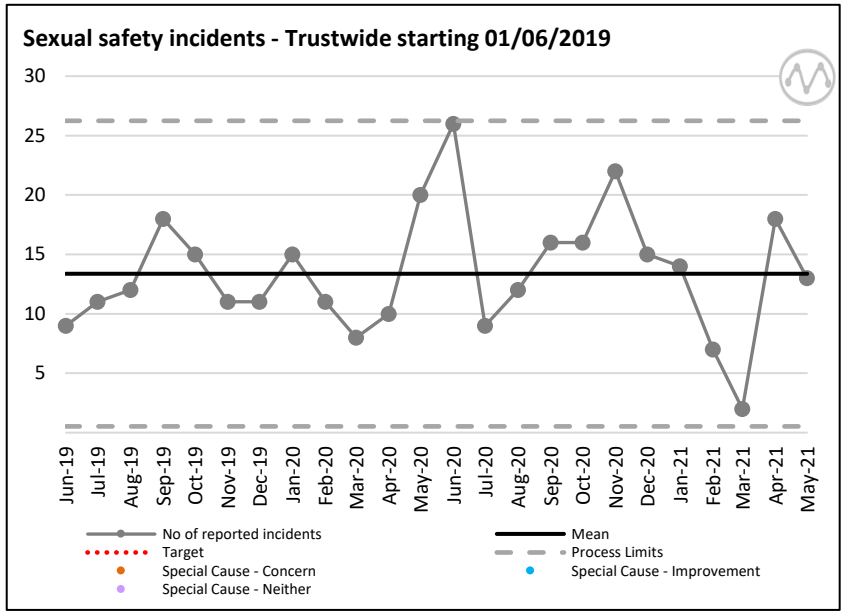
Safe | Assaults, Sexual Safety & Missing Patients

Assaults on Patients	May-21		
	n	*mean*	SPC variation
Trustwide	20	*23*	• • •
Acute & Community	17	*20*	• • •
Rehab & Specialist	3	*3*	• • •

Assaults on Staff	May-21		
	n	*mean*	SPC variation
Trustwide	178	*88*	• H •
Acute & Community	129	*66*	• H •
Rehab & Specialist	49	*27*	• • •



Narrative
May Update:
Seven exploitation/abuse incidents graded moderate were reported during May 2021 Four physical assaults (or alleged physical assaults) were reported on Maple Ward, Endcliffe Ward, CERT Team and Neuro Case Management Team, one alleged sexual abuse incident was recorded on Burbage Ward and one racial/cultural abuse incident was reported within the Early Intervention Service.



Protecting from avoidable harm	Target	YTD
Reportable Mixed Sex Accommodation (MSA) breaches	0	0

Narrative
May Update:
There was one sexual abuse incident graded moderate reported in May 2021 by Burbage Ward. This involved a historic allegation of rape. A safeguarding alert was made and the service user encouraged to report this to the police, although has declined to do so.

Trustwide	May-21		
	n	*mean*	SPC variation
Missing Patients (Informal)	1	*3*	• • •
Missing Patients (Detained)	9	*10*	• • •

Narrative
May Update:
Missing Patients – 9 incidents were categorised as having minor or negligible impact. One was moderate and involved a service user absconding from escorted grounds leave on Endcliffe Ward.

Deaths

Service User Deaths 1 – 31 May 2021	
Community Learning Disability Team	2
Early Intervention Service	2
Neuro Enablement Service/Brain Injury Team/Neuro Case Management/LTNC	1
Birch Avenue	1
Mental Health Recovery Teams	6
Older Adult Community Mental Health Teams	7
Older Adults Home Treatment Team	3
Homeless & Assessment Support Team	1
Memory Service	2
Woodland View	1
Liaison Service	2
START Alcohol and Opiates/Non-opiates Services	7
SPA/EWS	1
Total	**36**

Classification of Deaths 1 – 31 May 2021	
Expected Death	10
Unexpected Death - SHSC Community	12
Suspected Suicide (Community)	5
Unexpected Death (Suspected Natural Causes)	9
Grand Total	**36**

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

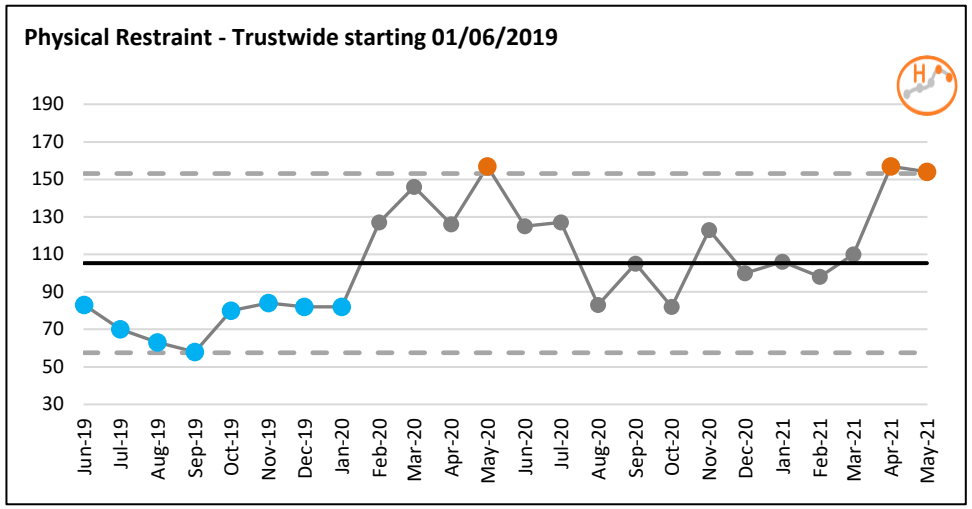
Deaths Reported 1 April 2020 – 31 May 2021	
Awaiting Coroners Inquest/Investigation	147
Conclusion - Narrative	1
Conclusion - Suicide	7
Conclusion – Accidental	2
Natural Causes/No Inquest	380
Alcohol/Drug related	4
Ongoing/Suspected Homicide	2
Grand Total	**543**

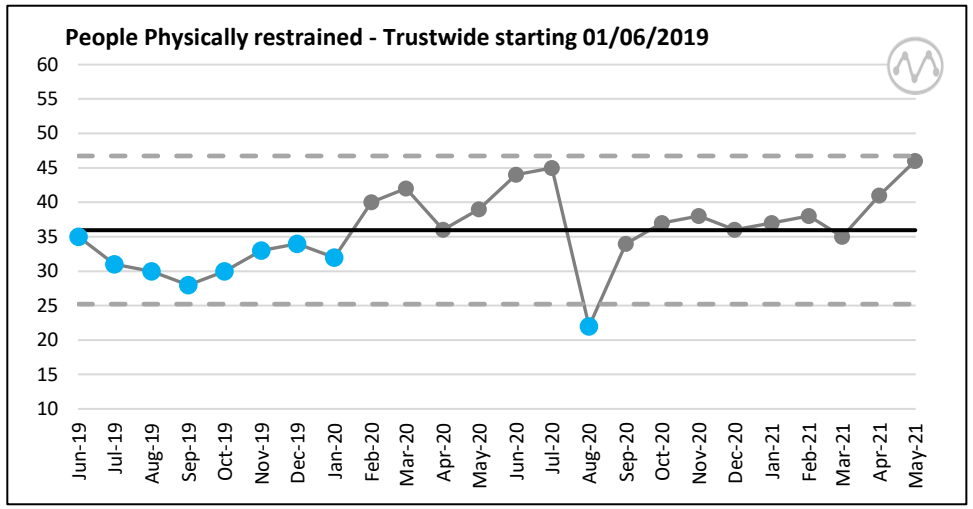
The table above shows the number of deaths that have been recorded YTD 1 April 2020 to 31 May 2021.

Out of the 36 patient deaths recorded in the month, 23 of these were natural causes deaths and required no inquest. All 23 incidents graded as catastrophic during May 2021 were deaths, 0 recorded as expected, 6 unexpected but suspected natural causes, 12 unexpected community deaths and 5 suspected community suicides.

Covid-19 Deaths 1 March 2020 – 31 May 2021	
ATS (Firshill Rise)	1
Community Intensive Support Service (CISS) (LD)	1
Birch Avenue	6
Community Learning Disability Team	4
Dovedale Ward	1
G1 Ward	5
Liaison Psychiatry	4
Long-term Neurological Conditions	2
Memory Service	7
Mental Health Recovery Team	1
Neuro Case Management Team	1
Neuro Enablement Service	3
Older Adult Community Mental Health Teams	38
Older Adult Home Treatment Service	2
SPA/EWS	1
START Opiates Service	1
Woodland View	1
Total	**79**

Safe | Restrictive Practice | Physical Restraint





Physical Restraint INCIDENTS	May-21			
	n	mean	SPC variation	SPC target
TRUSTWIDE	154	105	• H •	/
Rehab & Specialist	35	15	• • •	
Acute & Community	119	90	• • •	/
Services				
Burbage Ward	27	12	• H •	/
Stanage Ward	11	21	• L •	/
Dovedale	26	6	• H •	/

Physical Restraint INDIVIDUALS	May-21			
	n	mean	SPC variation	SPC target
TRUSTWIDE	46	36	• • •	/
Rehab & Specialist	6	5	• • •	
Acute & Community	42	32	• • •	/
Services				
Burbage Ward	13	6	• H •	/

Narrative

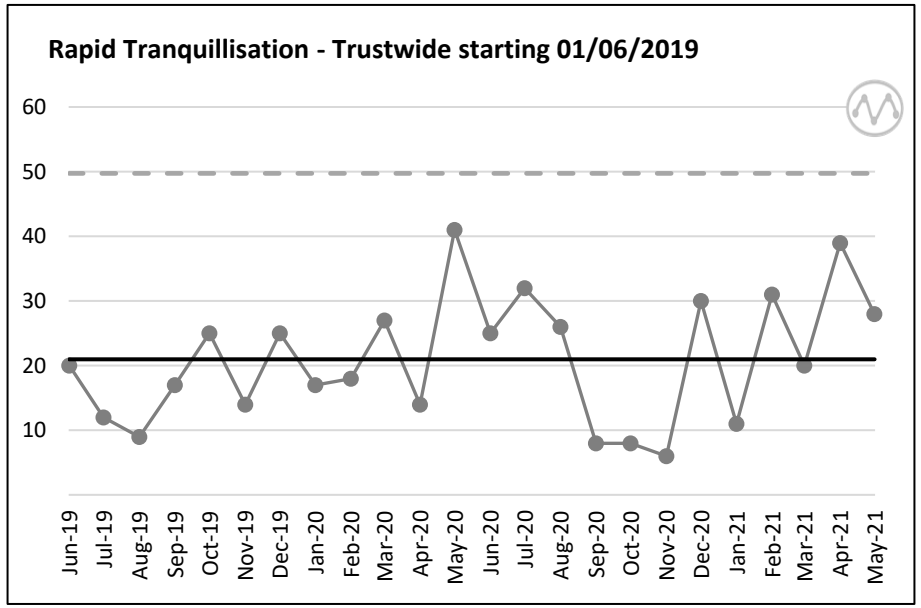
May Update:

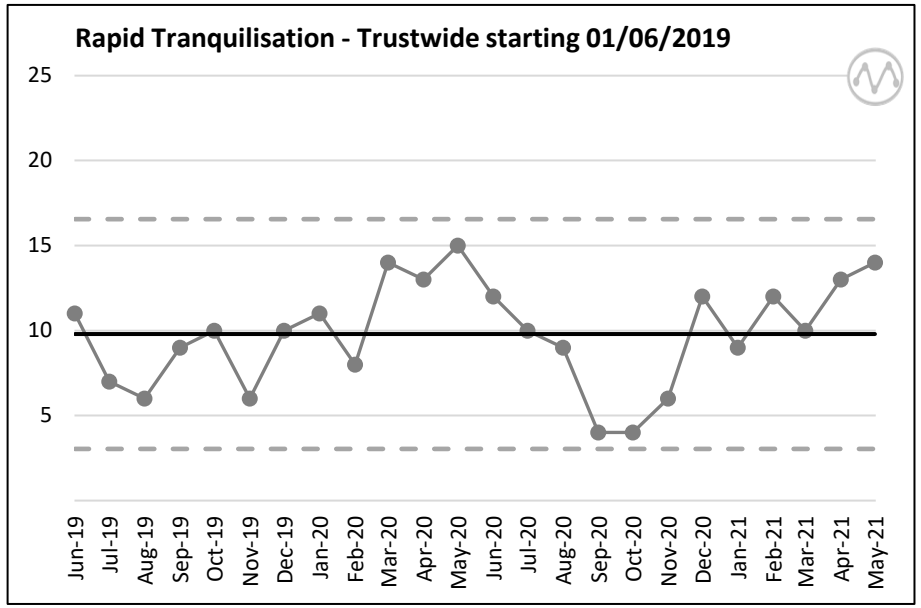
The number of reported physical restraint incidents has breached the upper control limit in May 2021. This has been caused by breaches of the upper control limit on Burbage Ward and Dovedale Ward.

One service user was restrained 21 times on Dovedale Ward, as part of their physical and mental health medication management.

Three mechanical restraints were reported in May 2021. Two were police restraint and one was by a secure transport provider during an admission.

Safe | Restrictive Practice | Rapid Tranquillisation





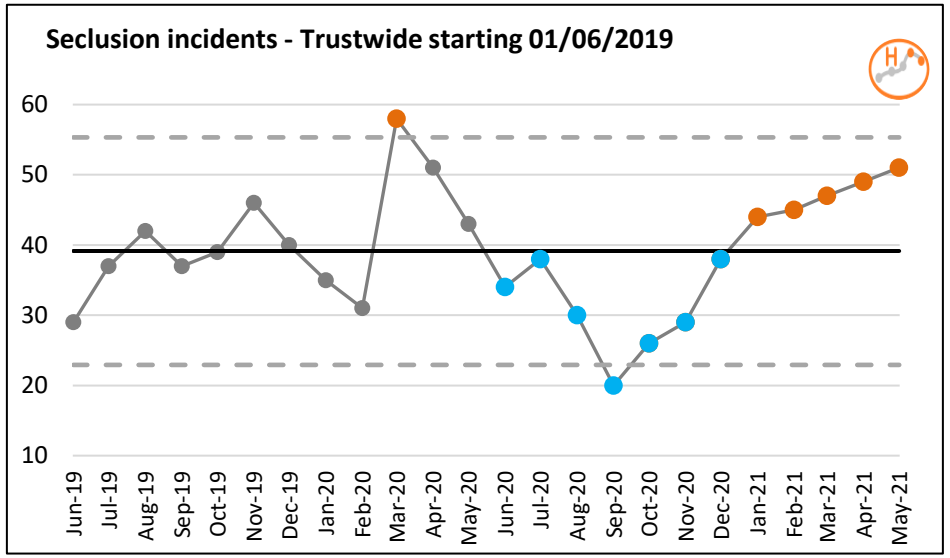
Rapid Tranquillisation INCIDENTS	May-21		
	n	*mean*	SPC variation
TRUSTWIDE	28	*21*	• • •
Acute & Community	28	*21*	• • •
Rehabilitation & Specialist	0	*0*	• L •
Services			
Dovedale	13	*2*	• H •

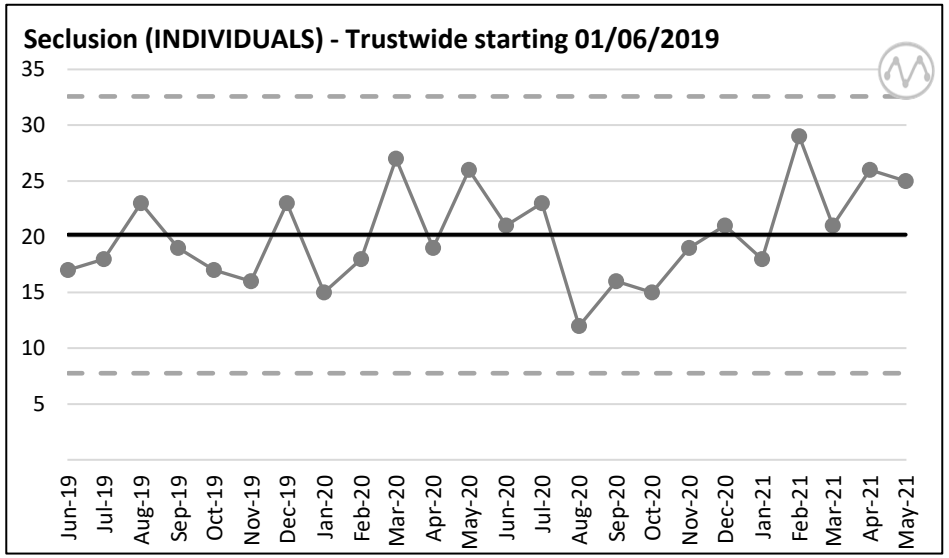
Rapid Tranquillisation INDIVIDUALS	May-21		
	n	*mean*	SPC variation
TRUSTWIDE	14	*10*	• • •
Acute & Community	14	*10*	
Rehabilitation & Specialist	1	*1*	• L •
Services			
Burbage Ward	4	*2*	• H •
Endcliffe Ward	0	*2*	• L •
Dovedale	3	*1*	• H •

Narrative
May Update:
Dovedale Ward has breached the upper control limit in May 2021 for rapid tranquilisation incidents. This is due to the management of a service user with complex needs requiring physical and mental health medication.

Burbage and Dovedale wards also breached the upper control limit for the number of people receiving rapid tranquilisation. However, the numbers recorded are not a cause for concern.

Safe | Restrictive Practice | Seclusion





Seclusion INCIDENTS	May-21			
	n	*mean*	SPC variation	SPC target
Trustwide	51	*39*	• H •	/

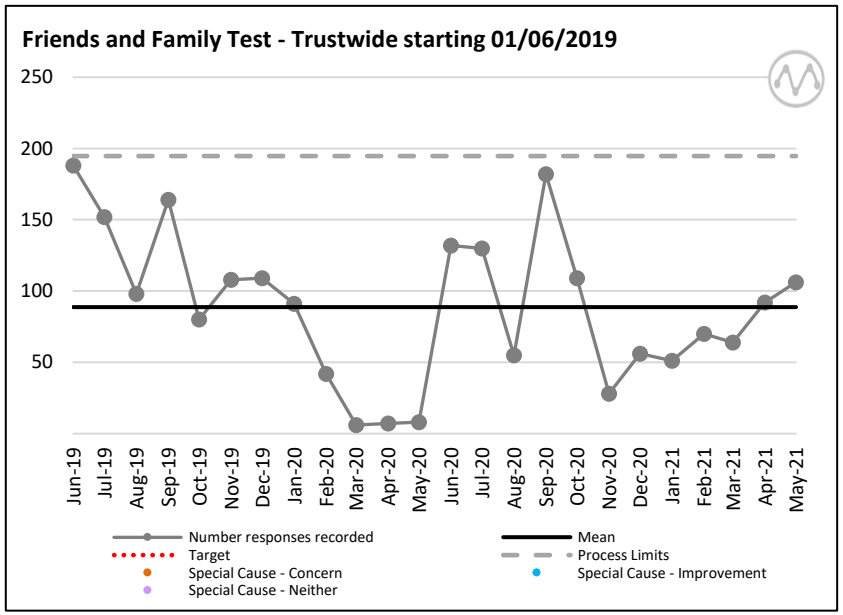
Seclusion INDIVIDUALS	May-21			
	n	*mean*	SPC variation	SPC target
Trustwide	25	*20*	• • •	/
Burbage	4	*3*	• H •	/

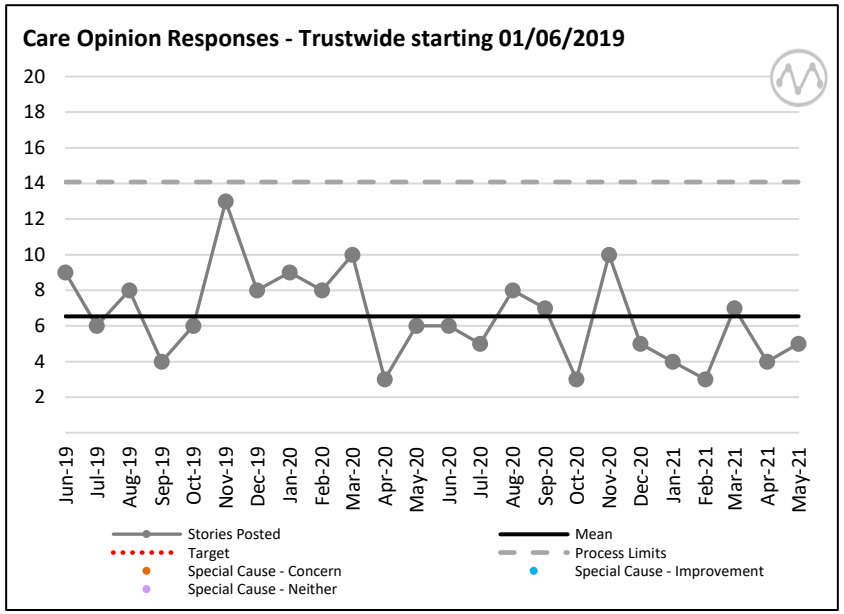
Narrative

May Update:

The number of seclusions reported is suggesting a statistical shift upwards. 51 seclusions were recorded during May 2021, with 19 of these recorded on Endcliffe ward, with two service users secluded 6 times each.

Caring | User Experience





User Experience

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

An improvement plan to increase service user feedback is being presented to the Quality Assurance Committee in July 2021.

Narrative

92% of the 106 responses received in May 2021 gave positive feedback.

SHSC compares favourably nationally to the percentage of people who would recommend services to others. Benchmarking data is available monthly, but has a 6 week time delay. The latest information available is April 2021 which shows 86% nationally would recommend mental health services to others.

Narrative

The 5 stories posted in May gave feedback on SPA/EWS (2), Community Mental Health Team (1), Eating Disorders Service (1) and the Gender Identity Service (1).
Common tags around areas where authors felt things were good included: CBT, follow up care and therapy staff.
When asked what could be improved, responses included: Access to mental health services; Assessments; Care; Follow ups; communication; diagnosis; funding; staffing and waiting times.
Authors also expressed feelings of: Betrayal, crisis, disappointment, feeling dismissed and ignored; dissatisfaction and dread.

Complaints & Compliments

There were 10 complaints received in May 2021, however 4 of these are awaiting consent, hence only 6 are live complaints, categorised below:

Patient Care	1
Prescribing	1
Privacy and Dignity	1
Values and Behaviours	2
Waiting Times	1

17 compliments were received in May 2021 for a range of community & inpatient services.

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Our People

Proud to care in Sheffield

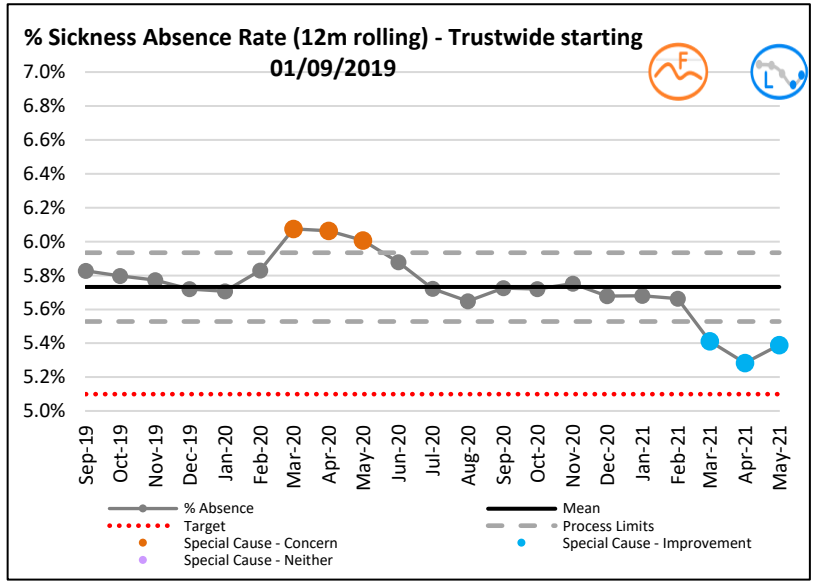
IPQR - Information up to and including May 2021

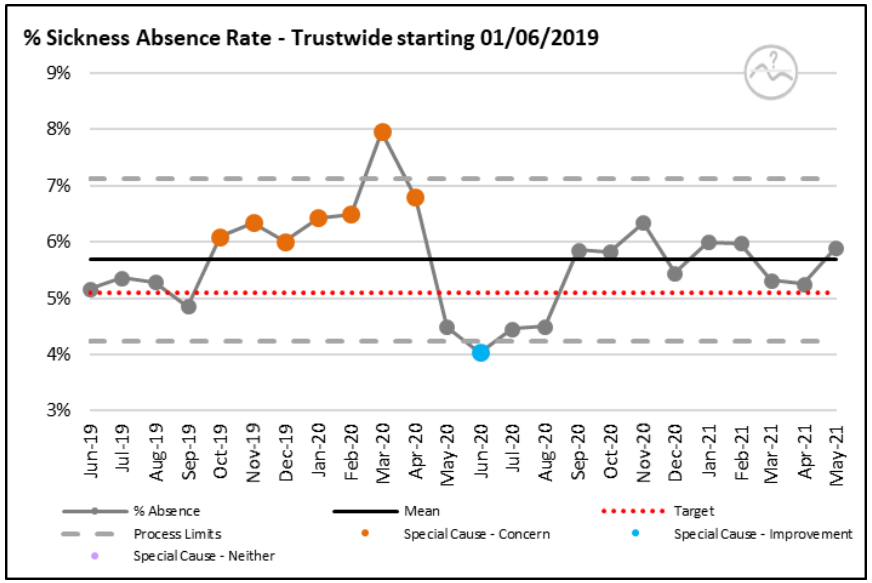
Well-Led | Workforce Summary

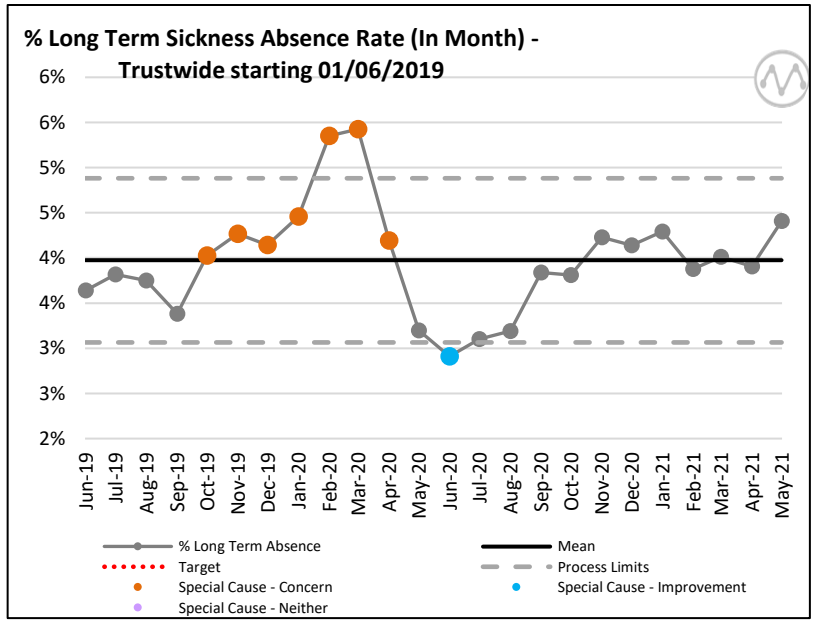
	Clinical Services	Medical	Non Med Support	Target	May-21 Trustwide n	May-21 Trustwide *mean*	May-21 Trustwide SPC variation	May-21 Trustwide SPC target
Sickness 12 Month (%)	5.93%	3.05%	3.38%	5.10%	5.39%	*5.73%*	• L •	F
Sickness In Month (%)	6.44%	4.47%	3.26%	5.10%	5.90%	*5.69%*	• • •	?
Long Term Sickness (%)	4.81%	2.34%	4.87%	~	4.41%	*3.97%*	• • •	/
Short Term Sickness (%)	6.44%	3.15%	6.84%	~	1.48%	*1.76%*	• • •	/
Headcount	2,063	160	307	~	2530	*2548*	• • •	/
Turnover	10.47%	7.66%	17.76%	10%	13.67%	*12.04%*	• H •	F
Vacancy Rate	11.5%	13.3%	6.7%	~	11.27%	*8.10%*	• H •	/
PDR Compliance (%)	98.7%	94.9%	0.0%	90%	94.85%	*93.61%*	• • •	?
Training Compliance (%)	~	~	~	80%	91.04%	*90.53%*	• • •	P
Supervision Compliance (%)	~	~	~	80%	64.94%	*56.75%*	• H •	F

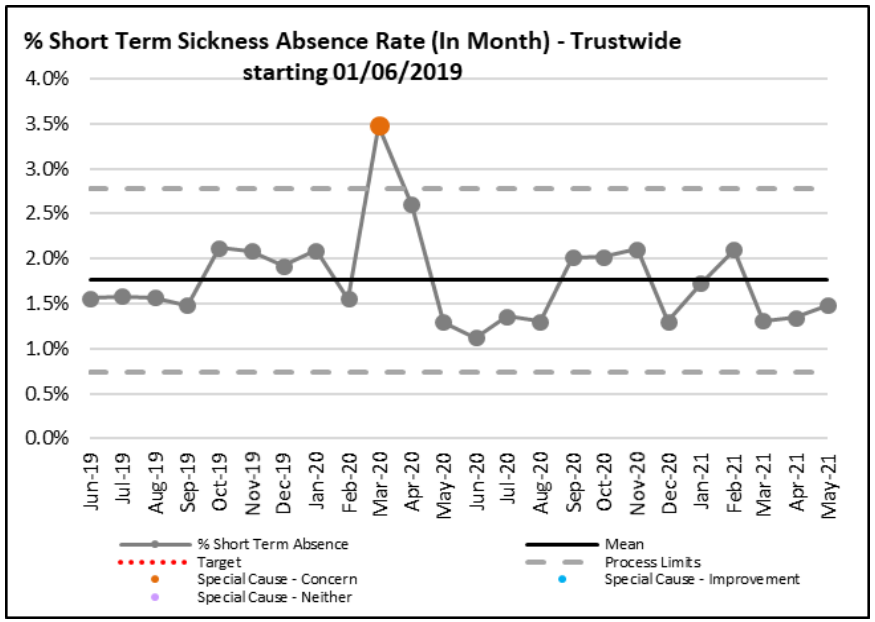
Notes:
- Vacancy based on establishment (FTE) data compared with staff in post (FTE) figures
- Turnover figures exclude 'Employee Transfer' as reason for leaving
- Medical turnover excludes fixed term rotations

Well-Led | Sickness Absence



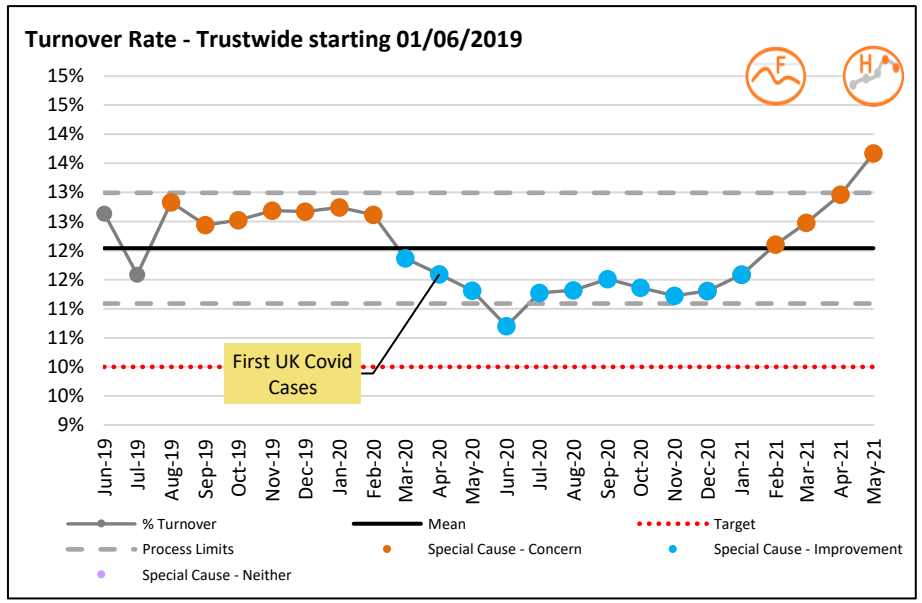


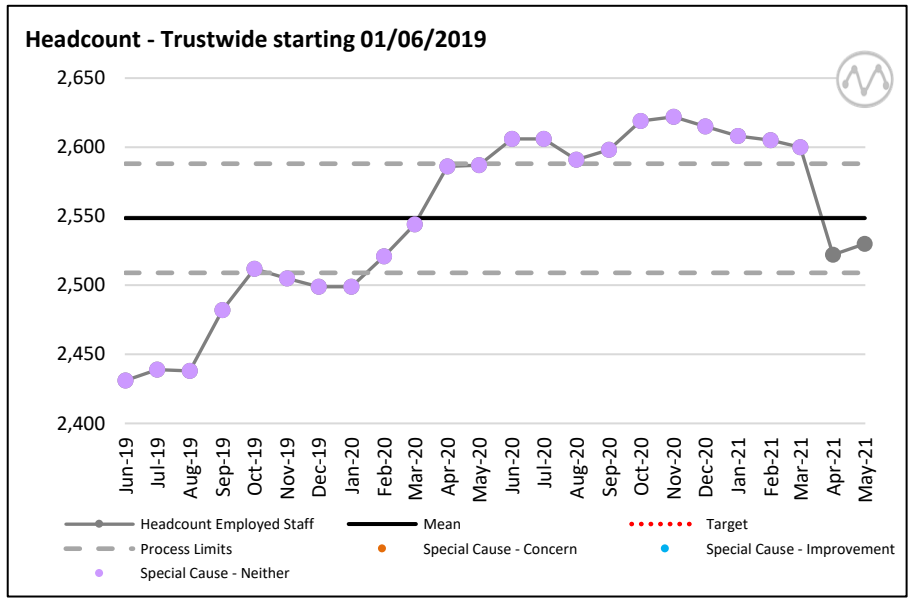


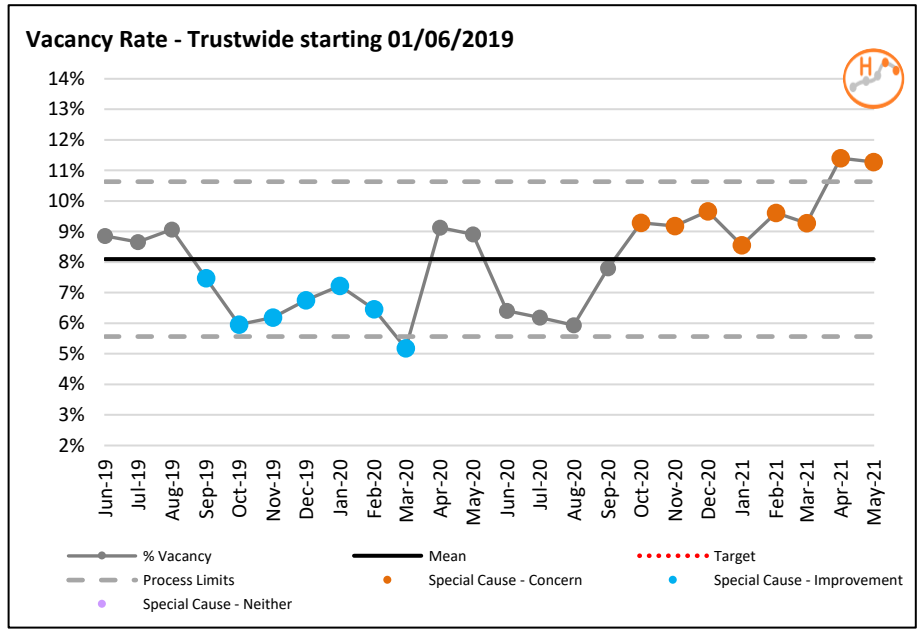


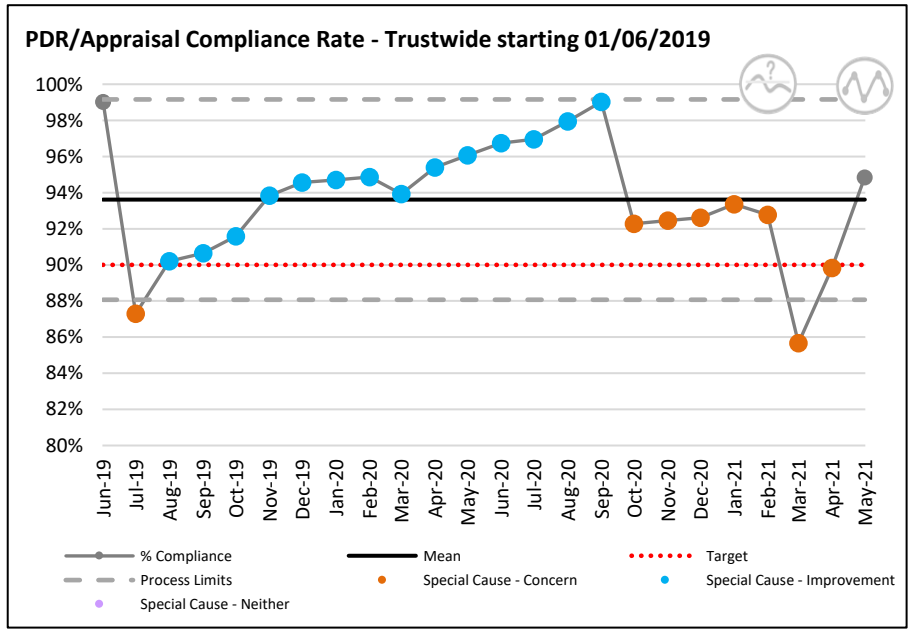
Sickness Absence

Well-Led | Staffing and PDR Compliance









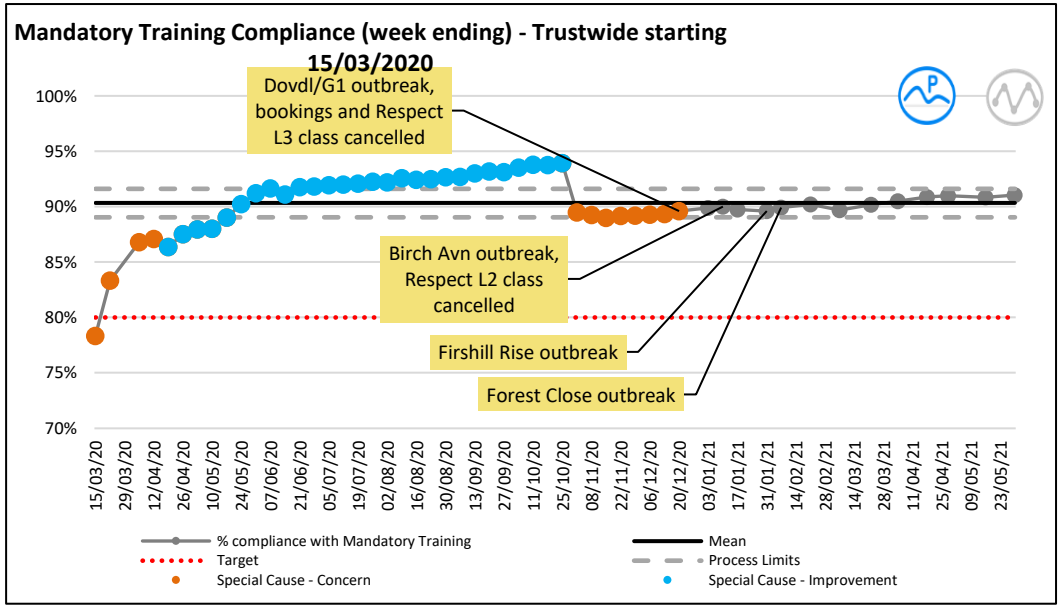
Headcount

Turnover Rate (%)

Vacancy per Staff groups

PDR Compliance

Well-Led | Mandatory Training



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

NARRATIVE
As at 30/05/21, Trust compliance was at 91.04%

EXCEPTIONS

Subjects Below 80%
1 Subject still below 80%, which is Respect Level 2.

Services Below 80%
Grenoside Facilities is below 80%
No services are below 80%

Sheffield Health and Social Care Mandatory Training Compliance @

31 May 2021

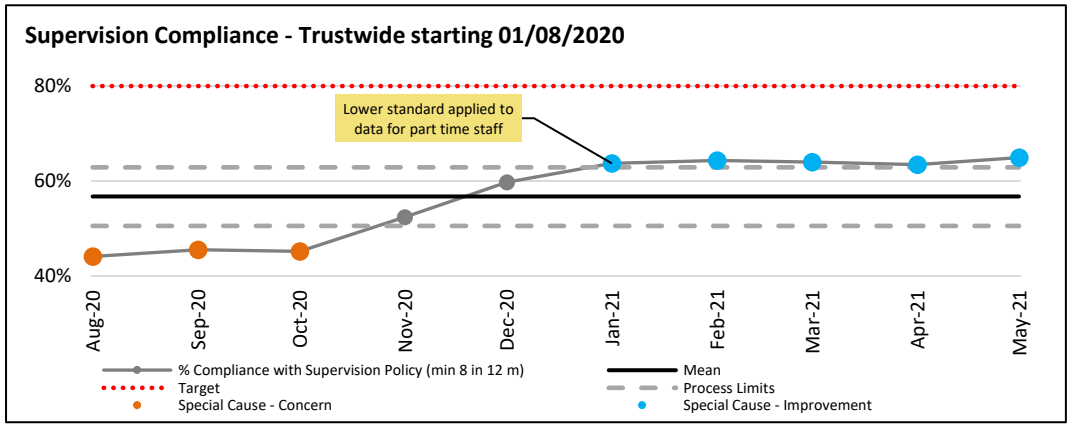
Compliance % highlighted in orange is between 75-79.99% meaning it below but close to the 80% target.

Compliance % highlighted in red is between 0-74.99%

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

			16 May 2021				31 May 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	2605	2431	174	93.32%	2605	2446	159	93.90%	Increase	0.58%
Hand Hygiene		3 Years	2605	2463	142	94.55%	2605	2464	141	94.59%	Increase	0.04%
Health and Safety		3 Years	2605	2483	122	95.32%	2605	2489	116	95.55%	Increase	0.23%
Information Governance (aka Data Security Awareness)		1 Year	2605	2308	297	88.60%	2605	2275	330	87.33%	Decrease	-1.27%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2605	2484	121	95.36%	2605	2488	117	95.51%	Increase	0.15%
Adult Basic Life Support		1 Year	2605	2248	357	86.30%	2605	2242	363	86.07%	Decrease	-0.23%
Fire Safety		2 Years	1291	1154	137	89.39%	1290	1154	136	89.46%	Increase	0.07%
		3 Years	1304	1258	46	96.47%	1313	1271	42	96.80%	Increase	0.33%
Immediate Life Support		1 Year	230	185	45	80.43%	231	194	37	83.98%	Increase	3.55%
Clinical Risk Assessment		3 Years	1002	904	98	90.22%	1016	910	106	89.57%	Decrease	-0.65%
Dementia Awareness		No Renewal	2327	2264	63	97.29%	2329	2271	58	97.51%	Increase	0.22%
Autism Awareness		No Renewal	2322	2267	55	97.63%	2324	2272	52	97.76%	Increase	0.13%
Mental Capacity Act	1	3 Years	1095	926	169	84.57%	1090	922	168	84.59%	Increase	0.02%
	2	3 Years	1147	1018	129	88.75%	1155	1027	128	88.92%	Increase	0.16%
Deprivation of Liberty Safeguards	1	3 Years	2129	1958	171	91.97%	2135	1973	162	92.41%	Increase	0.44%
	2	3 Years	112	104	8	92.86%	112	105	7	93.75%	Increase	0.89%
Mental Health Act		3 Years	189	156	33	82.54%	188	157	31	83.51%	Increase	0.97%
Medicines Management Awareness		3 Years	548	460	88	83.94%	553	464	89	83.91%	Decrease	-0.04%
Rapid Tranquilisation		3 Years	286	244	42	85.31%	287	260	27	90.59%	Increase	5.28%
Respect	1	3 Years	1220	1075	145	88.11%	1227	1090	137	88.83%	Increase	0.72%
	2	2 Years	815	551	264	***67.61%***	817	571	246	***69.89%***	Increase	2.28%
	3	1 Year	381	297	84	77.95%	378	310	68	82.01%	Increase	4.06%
Safeguarding Children	2	3 Years	1142	1033	109	90.46%	1139	1033	106	90.69%	Increase	0.24%
	3	3 Years	1102	935	167	84.85%	1113	937	176	84.19%	Decrease	-0.66%
Safeguarding Adults	2	3 Years	2243	2040	203	90.95%	2251	2052	199	91.16%	Increase	0.21%
Domestic Abuse	2	3 Years	2247	1963	284	87.36%	2254	1974	280	87.58%	Increase	0.22%
Prevent WRAP		3 Years	2242	2038	204	90.90%	2250	2048	202	91.02%	Increase	0.12%
Overall compliance						**90.84%**				**91.04%**	Increase	0.20%
Moving and Handling	1	3 Years	2604	2463	141	94.59%	2605	2471	134	94.86%	Increase	0.27%
	2	3 Years	718	600	118	83.57%	718	607	111	84.54%	Increase	0.97%

Well-Led | Supervision



AIM

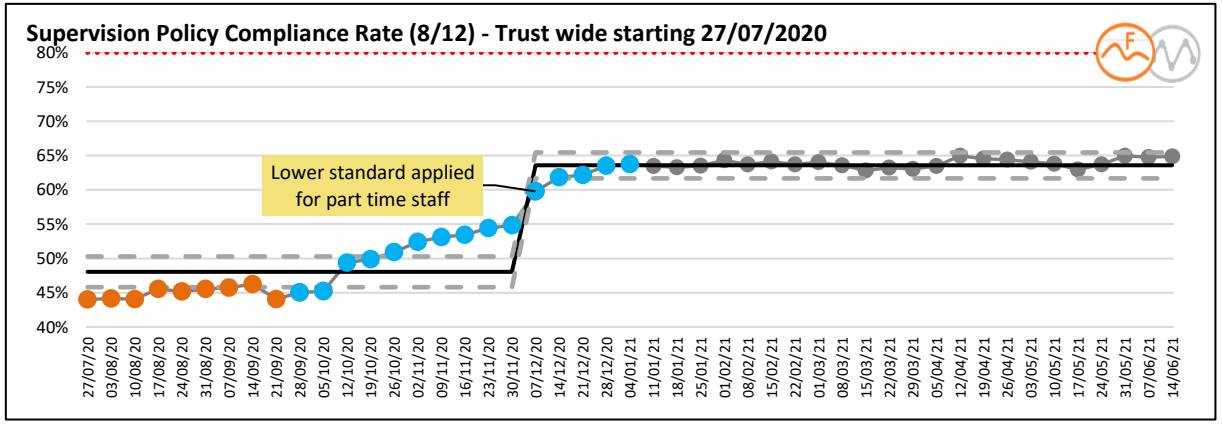
We will ensure that 80% staff have received at least the required minimum of 8 supervisions in a 12-month period (6 for part time staff), and that it is recorded in and reported on from a single source – the Supervision webform.

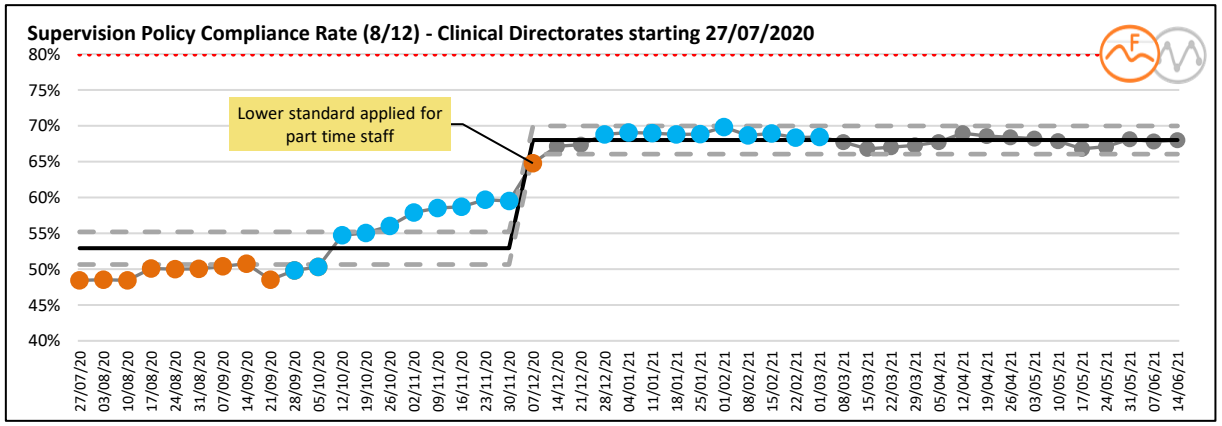
NARRATIVE

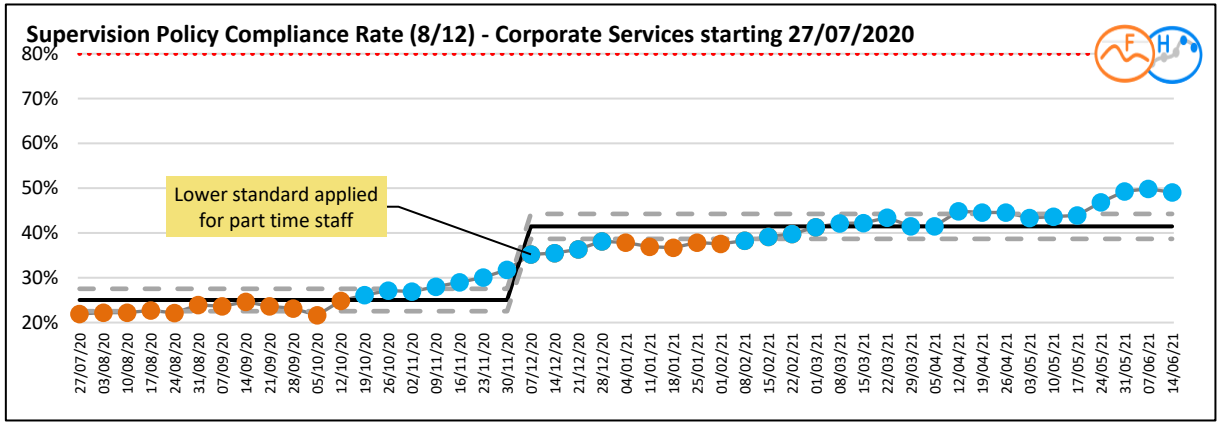
As at 30/5/21, overall Trust compliance with the 8/12 target was at 65%, with Clinical Operations at just over 68% and Corporate Services just over 49%.

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 on the right from w/e 1 August 2020 for Trust wide, Clinical and Corporate Services. The metric was updated, and control limits recalculated to apply a lower standard (minimum of 6 supervisions in 12 months) for any staff working less than 0.8 WTE, in December 2020.

Weekly information is published fortnightly in the Trust Improvement Dashboard and monitored and reviewed weekly by Directors and Service Leads.







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Financial Performance

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IPQR - Information up to and including May 2021

Well-Led | Financial Overview | May 2021 (M2)

PERFORMANCE INDICATORS		Annual Plan	Year to Date
		£000s	£000s
1	Reported Surplus/ (Deficit) Position	0	795
2	Covid-19	6,596	372
3	Agency	1,593	760
4	Cash	64.8	61.2
4	Efficiency Savings	3,028	340
5	Capital	8,584	484
6	Better Payments Practice Code (BPPC) - % of bills paid in target	by number	98.8%
		by value	99.5%

NARRATIVE

The position at Month 2 (M2) is a surplus of £0.795m.

Drivers remain lower than planned pay against Mental Health Investment Standard (MHIS) funding and Covid funding. This is the result of full year funding being provided despite anticipated recruitment lead times.

The Trust continues to work alongside commissioners to invest slippage in priority non recurrent improvement projects. The challenge of securing the best value for money from H1 funding has to be balanced carefully with long term sustainability. The Trust has a number of large scale projects on the horizon that will require significant resources. Approval of investments now, that collectively have a significant recurrent element, could impact on our ability to deliver key transformation projects in the future. (EPR and new HQ being two on the near horizon)

In line with all ICS partners, the Trust continues to forecast a break even position until Q1 from which time more robust forecasting will be reported. It is very likely that the Trust will remain in a surplus position (at least £1m) at the end of H1 (Sept 21). It remains unclear how the position at H1 will shape funding for the remainder of the year and the sector continues to push for more clarity on this.

The Trusts' Cash position remains strong and the capital programme continues to progress with slippage (£193k) relating to the expanded scope of dormitory works. Forecast spend at present remains in line with plan at £8,584k.

There is no meaningful increase in Cost Improvement Plans in place at Month 2. Plans are being developed and the formal QEIA process is underway. Of the £1.8m assigned to directorates, 12% (£0.22m) has been identified recurrently and progressed via the full QEIA process. More plans are currently going via the QEIA process and significant progress is expected for next month. A formal CIP progress report is planned post Q1 reporting.

Out of Town and Agency costs continue to be monitored closely but it is too early to identify meaningful cost changes from recovery plans at present. A final iteration of the Financial Plan is due to be submitted to NHSi in June and this is likely to adjust plan levels of spend. Forecasts will also be updated to include the impact of contractual arrangements put in place for OOA bed capacity.

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Covid-19

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IPQR - Information up to and including May 2021

Well-Led | Covid-19 Response

Covid-19 Outbreaks
There have been no outbreaks in the Trust in May 2021.
Inpatients with Covid-19
There have been no inpatients with Covid-19 during May 2021.
Covid-19 Deaths
No deaths of service users due to Covid-19 were reported in May 2021.
Covid-19 Related Staff Absence
As at 31 May 2021, 17 staff were absent from the workplace for Covid related reasons. 15 were working and 2 were unable to work.

Staff Vaccination (as at week commencing 10th May 2021)
The primary data sources for the reports below are the National Immunisation Management System (NIMS) Reporting and our Electronic Staff Record (ESR). NIMS Reporting should include the vast majority of vaccination records for our staff, no matter where they have received their vaccinations. Data for agency staff, students, locum doctors and volunteers who do not have ESR records has also been manually captured from a variety of sources.

Week commencing 7 June 2021	Total	% of total
Staff records uploaded by SHSC to NIMS	3012	100%
Staff matched to at least one vaccination record	**2692**	**89.4%**
Staff matched to two vaccination records	**2546**	**84.5%**
Staff that could not be matched due to missing NHS number	11	0.4%
Staff that have either not received at least one vaccination dose or whose NHS number is missing from their vaccination record(s)	320	10.6%

	Not yet vaccinated		Received first dose only		Received both doses	
Row Labels	Employee Count	%	Employee Count	%	Employee Count	%
457 Clinical Operations (L3)	190	9.2%	79	3.8%	1799	87.0%
457 Acute and Community Services (L4)	106	10.3%	45	4.4%	881	85.4%
457 Rehabilitation & Specialist Services (L4)	68	8.2%	30	3.6%	730	88.2%
457 Medical (L3)	9	5.6%	10	6.3%	141	88.1%
457 Corporate Services (L3)	75	13.2%	40	7.0%	455	79.8%
457 Chair/Chief Exec Office (L4)	1	4.5%		0.0%	21	95.5%
457 Director of Finance (L4)	8	10.1%	2	2.5%	69	87.3%
457 Nursing & Professions (L4)	2	4.5%	1	2.3%	41	93.2%
457 People Directorate (L4)	55	16.2%	36	10.6%	248	73.2%
457 Bank Staff (017777)	48	17.9%	33	12.3%	187	69.8%
457 Special Projects (L4)	9	10.5%	1	1.2%	76	88.4%
457 Facilities (L5)	7	9.0%	1	1.3%	70	89.7%
457 Strategy & Planning (L5)	2	25.0%		0.0%	6	75.0%
Volunteers (L3)	2	13.3%		0.0%	13	86.7%
Agency Staff (L3)	24	23.8%	12	11.9%	65	64.4%
Locum Doctors (L3)		0.0%	1	16.7%	5	83.3%
Medical Students (L3)	15	21.1%	3	4.2%	53	74.6%
Student Nurses (L3)	5	23.8%	1	4.8%	15	71.4%
Grand Total	320	10.6%	146	4.8%	2546	84.5%

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Report ends
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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:

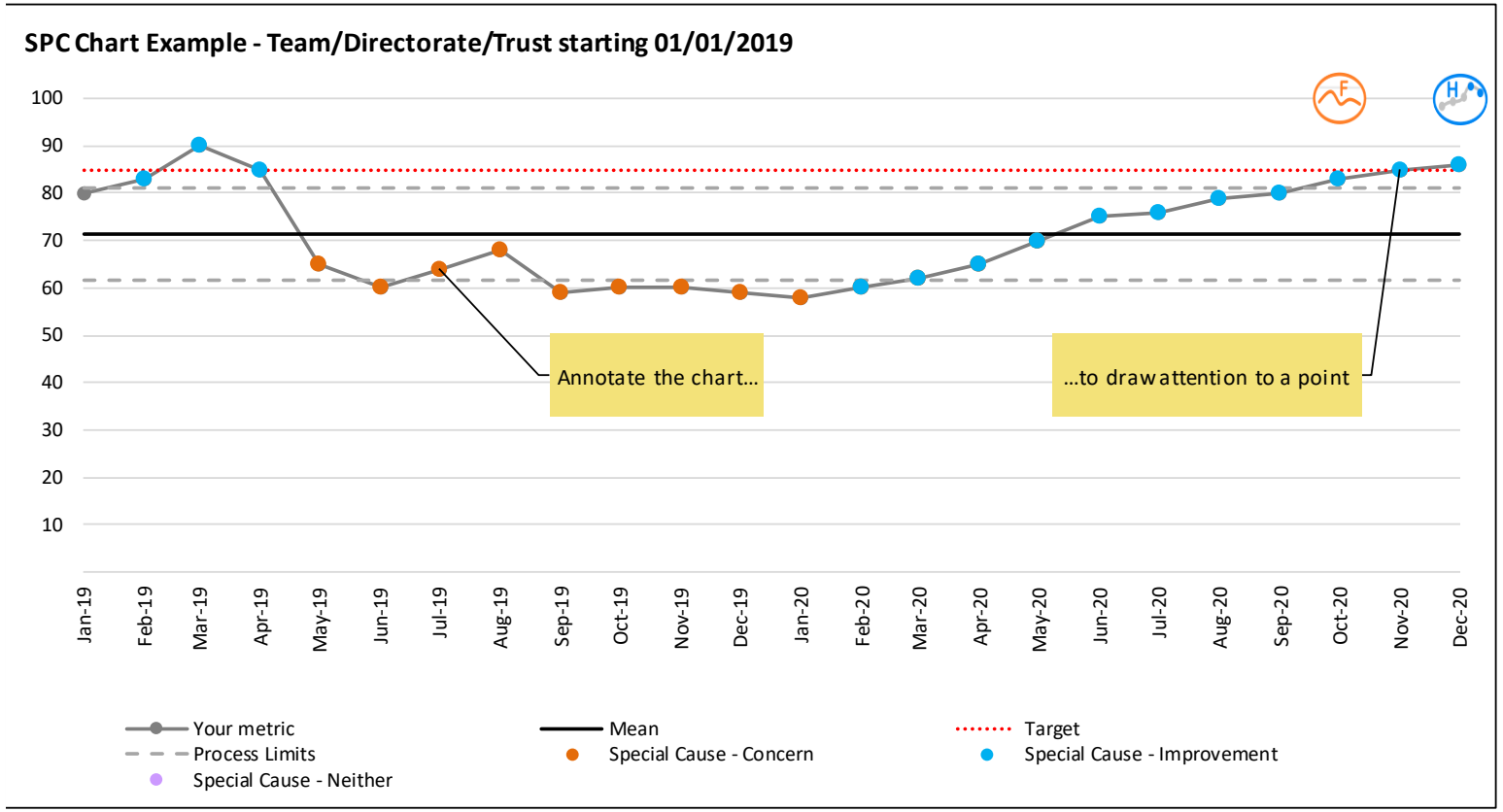
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	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									
SIMPLE ICON	● ● ●	● ? ●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2 | 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.