Board of Directors - Public

SUMMARY	Meeting Date:	22 September 2021
	Agenda Item:	12

Report Title:	**Integrated Performance and Quality Report (IPQR) July 2021**	
Author(s):	Deborah Cundey/Tania Baxter	
Accountable Director:	Phillip Easthope, Executive Director of Finance, IMST & Performance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	People Committee Quality Assurance Committee Finance and Performance Committee
	Date:	7 September 2021 8 September 2021 9 September 2021
Key Points recommendations to or previously agreed at:	**Risks** One new risk was highlighted to both Quality Assurance and Finance and Performance Committees: • Service delivery & quality concerns due to problems with the estate at St George's, the base for both Specialist Psychotherapy Service teams and the Eating Disorders Service. The other known areas of risk/concern for the attention of the Board are: • Demand for Services at all access points • Community Waiting Times • Compliance with annual CPA reviews • Restrictive Practice Incidents • Inpatient Delayed Discharge and extended lengths of stay The focus of the concern is illustrated in the summary below, together with the mitigating factors and required improvements. **Improvements** The three indicators highlighted as 'improving' (Mandatory Training, Staff Supervision and Out of Area placements) continue on an improving trajectory whilst still falling below expected standards/targets at Trust level. **Positive performance** • 100% performance for Early Intervention in Psychosis Access & Wait Time standard. • IAPT meeting the Moving to Recovery standard for the second consecutive month and continuing to overachieve on waiting time standards. • The continued reduction in the number of open actions from past serious incidents.	

	• The reduction in the use of seclusion across the inpatient areas, and notably zero reports use of restrictive practice in the Rehabilitation & Specialist Directorate through the month. • There were no mechanical restraint incidents recorded in July 2021. **Committee Recommendations** **People Committee** • Inclusion of Equality, Diversity & Inclusion metrics (as per WRES) within IPQR/ People KPIs – to be defined and agreed • Inclusion of active vacancy fill rate within IPQR/ People KPIs – to be defined and agreed • Inclusion of Employee Relations casework data within IPQR/ People KPIs – to be defined and agreed • Inclusion of Staff Survey/People Pulse data within IPQR/ People KPIs – to be defined and agreed **Quality Assurance Committee** • Progress work to determine standards/trigger points for escalation of length of stay on inpatient wards • Inclusion of equality, Diversity & Inclusion metrics within IPQR/ People KPIs – to be defined and agreed • Quality Committee to have joint oversight with Finance & performance Committee for access and demand KPIs from Quality perspective • Review and refine the Recovery Plan process and documentation as part of the Performance Framework **Finance & Performance Committee** • Discussed the need to further embed the enacting of the Performance Framework, noting the progress re KPIs and Targets and the need to further develop these alongside the embedding of the recovery plan process.

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 July 2021. The report was presented and considered in detail to the People Committee, Quality Assurance Committee and Finance and Performance Committee in September. For each issue, the risk was explored, and the paper offered mitigations. **Risks Reported** **Community Estates concerns (Specialist Services) - NEW RISK** Issue: There is a quality concern because of the problems with the estate at St George's, the base for both Specialist Psychotherapy Service teams and the Eating Disorders Service. The roof is in a particularly poor state of repair. This issue impacts on service delivery and quality of care in a number of ways, including having to cancel or rearrange appointments at short notice due to premises being unsafe for purpose (consultation rooms closed due to leaks etc); potential to negatively impact the therapeutic interventions delivered. This can lead to lower activity levels and ultimately increase the numbers of people waiting for services and the time they have to wait. The quality of estate also impacts staff morale and wellbeing.

Mitigation: The service is looking at opportunities to move out of St George's and a project group has been established to identify options. Service leadership and estates all working together towards a solution.

Inpatient Delayed Discharges – known risk
(IPQR pages 7-11)

Issue: As highlighted in June IPQR report, we are increasingly focussed on the number of people who are in an inpatient bed who we are no longer able to provide meaningful treatment for. That is, that are ready to move on to either accommodation or care elsewhere and there has been a delay in this which is known as a delayed discharge.

A risk caused by delayed discharge is that we cannot achieve a 'flow' in our bed stock to ensure beds are available at the point of need. Being delayed in an inpatient service can mean care is overly restrictive and ultimately it is recognised that where a person is delayed in moving on, they may give up hope and this could impact on their mental health.

Mitigation: All people have individual plans of care that are reviewed. There is management oversight of all delayed discharges and we are working closely with health and social care partners to raise the issues and to ask for help. We are ensuring regular attendance at all system discharge meetings. We are thinking about schemes for the winter and will escalate issues to the contract management board and clinical quality group if help is not forthcoming.

Demand for Services – known risk No Targets
(IPQR page 5-6)
Issue: We continue to experience high levels of demand for access points (SPA, Liaison, Central AMHP for MHA assessment in particular), in many cases exceeding pre-Covid levels of referrals. This has a knock-on effect in community services and demand for inpatient admission. We are seeing a similar across some specialist services too. Increased demand increases the risk of our ability to manage and reduce waiting lists and times for services. For the first time since the start of the pandemic, Older Adult Services are showing a rise in demand higher than pre-covid levels
as is indicated in the OA CMHT (point of access for OA) and Memory Service referrals in July.

Mitigation: Increased demand is being raised to commissioners and the Clinical Directorate leadership are currently considering necessary mitigations.

Community Waiting Times – known risk Targets: Varying local and national
(IPQR page 6)
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 continue to improve the availability of information relating to our community teams in order to present as complete a picture as possible in future IPQR reports.

Mitigation: Recovery Plans for unacceptable waiting times were provided and discussed at March 21 Quality Assurance Committee. There is positive impact in some services notably in specialist psychotherapy and personality disorder services however as we have implemented plans referral rates have also increased. The services where we are not seeing improvement are SAANS, Gender Identity and SPA. An updated Recovery Plan for SPA/EWS and Recovery Service waits was presented to the Finance and Performance Committee in August 2021, and the updated recovery plans for specialist services are to be received at October 2021 Quality Assurance Committee.

CPA Reviews – known risk National Target: 95%
(IPQR page 12)
Issue: Persistent under performance against an annual review of care under the CPA Framework.

Mitigation: There is evidence that the recovery plan continues to have an impact across the Early Intervention in Psychosis Service and the North Recovery Service where performance is above mean average. South Recovery have slipped when compared to June.

Restrictive Practice Incidents – risk No Targets, performance measured by CQC

(IPQR pages 21-23)
Issue: High numbers of restraints and rapid tranquilisation reported by Dovedale 1 Ward in June and July 2021, breaching control limits. The vast majority of these incidents were recorded against the same individual service user who has severe physical and mental health conditions.

There were no mechanical restraint incidents recorded in July 2021.

Improvements Reported

Mandatory Training – improving Local Target 80%
(IPQR page 29)
Issue: Although the Trustwide mandatory training compliance is 91%, Respect Level 2 remains below the 80% target. Two services (PGME and Grenoside Facilities) remain below 80% compliance for the teams overall, this is due to small staff numbers and staff absences.

Mitigation: Two Respect update classes and one full course are being delivered during August 2021.

Staff Supervision – improving Local Target 80%
(IPQR page 35)
Issue: Supervision compliance continues to improve steadily, at 66% Trustwide and 68% in Clinical services, 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 new improvement plan needs to be considered as we have been consistently below the expected standard. Each service line and department will be asked for a recovery plan.

Acute Wards and Out of Area Placements (OOA) – **improving**
(IPQR page 7-9) National Target: Zero inappropriate OOA placements

Issues: A lack of 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 enabling essential estates improvement works we are now also evidencing people who are not in the right place for their care – a delayed discharge.

Having experienced very high admissions and numbers in out of area beds in June, the numbers admitted OOA reduced in July and at 31 July we reported a total of 13 service users placed inappropriately in OOA beds, compared with 23 at the end of June. The table on page 7 of the IPQR shows our figures alongside other inpatient MH providers across the North East & Yorkshire region. As at end July, 5 of the 9 providers reported more service users inappropriately out of area than we did.

Mitigation:
A recovery plan is in place and a progress report was provided to the Finance and Performance Committee in August 2021. An important part of this plan is ensuring we are addressing all delayed discharges and ensuring system support. Additional beds have been procured to replace beds lost due to environmental improvement works.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval		Assurance	✓	Information	✓

The summary offers the highlights and exceptions for Trust Board 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*	✓	

Integrated Performance & Quality Report

Information up to and including July 2021

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Blue Underlined Text = Click to link to page

Report Layout | Information and metrics are grouped 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.

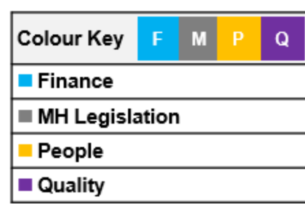
Ward	Month 1		
	n	*SPC variation*	*SPC target*
Ward 1	35.67	• L •	F
Ward 2	35.95	• • •	?
Ward 3	27.71	• • •	P
Ward 4	37.62	• • •	F
Ward 5	47.46	• • •	?
Ward 6	86.82	• • •	F
Ward 7	75.87	• L •	?
Ward 8	58.41	• H •	/

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.



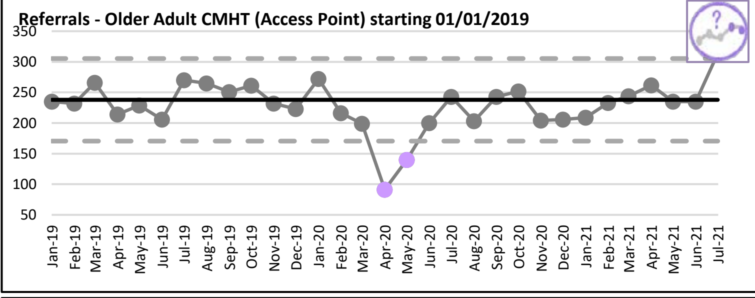
Board Committee Oversight
Please also note the addition of key, using colour coding to quickly identify which KPIs and metrics are of particular interest to a committee/which committee has oversight.

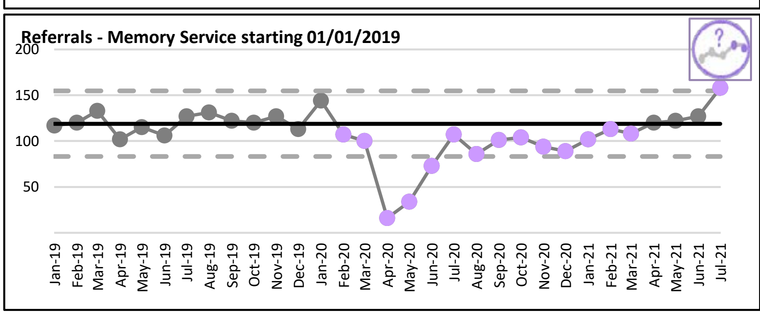
Refer to Appendix 3 for detail.

Service Delivery

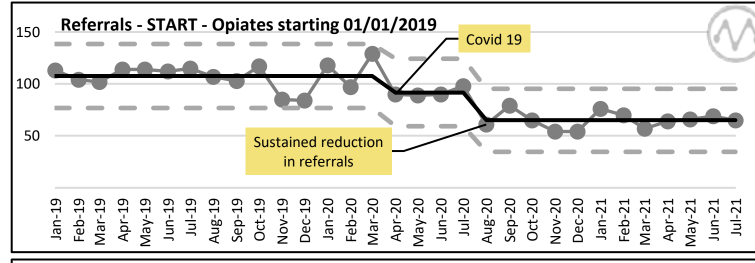
IPQR - Information up to and including July 2021

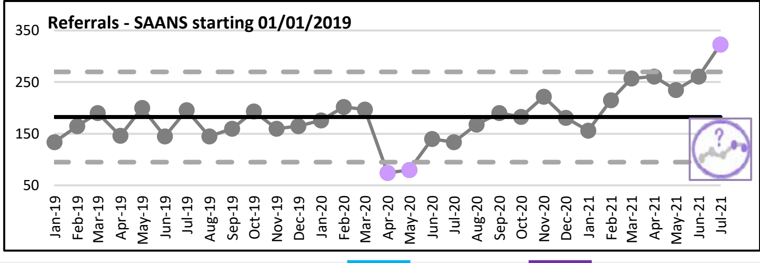
Referrals	Jul-21			
Acute & Community Directorate Service	**n**	*mean*	**SPC variation**	**SPC target**
SPA/EWS	831	*838*	• • •	?
AMHP	143	*118*	• ? •	/
Out of Hours Team	1051	*872*	• ? •	/
Liaison Psychiatry	504	*513*	• • •	/
Decisions Unit	66	***45***	• • •	/
S136 HBPOS	45	*33*	• ? •	/
Adult Home Treatment Service	119	*108*	• • •	/
Recovery Service TOTAL	***60***	***45***	• • •	/
Early Intervention in Psychosis	41	*44*	• • •	/
Memory Service	158	*105*	• ? •	/
OA CMHT	314	*238*	• ? •	/
OA Home Treatment	26	*28*	• ? •	/





Referrals	Jul-21			
Rehabilitation & Specialist Directorate Service	**n**	*mean*	**SPC variation**	**SPC target**
IAPT	**1302**	*1628*	• • •	/
START Opiates	**65**	*65*	• • •	/
START Non-Opiates	**58**	*60*	• • •	/
START Alcohol	**189**	*178*	• • •	/
Psychotherapy Screening (SPS)	**43**	*50*	• • •	/
SPS - MAPPS	**7**	*13*	• ? •	/
SPS - PD	**9**	*16*	• • •	/
Gender ID	**38**	*47*	• • •	/
STEP	**100**	*65*	• • •	/
Eating Disorders Service	**41**	*29*	• • •	/
SAANS	**323**	*182*	• ? •	/
R&S	**14**	*19*	• • •	/
Perinatal MH Service (Sheffield)	**45**	*51*	• • •	/
HAST	**12**	*12*	• • •	/





Narrative

We continue to see a sustained increase in demand across our crisis/adult mental health access points, in particular in SPA, the central AMHP team, calls into the current Out of Hours service and demand for S136 beds. The increases represent an increase against a baseline of 15 months data pre-Covid.

For the first time since the start of the pandemic, Older Adult Services are showing a rise in demand higher than pre-covid levels as is indicated in the OA CMHT (point of access for OA) and Memory Service referrals in July.

Significant sustained levels of demand into SAANS should be noted. Detail on the management of the demand along with other highly specialist services Gender Dysphoria Clinic, and Specialist Psychotherapy Services are laid out in the recovery plans updated and presented to Quality Assurance Committee in September 21.

Clinical Directorate leads and Covid command structure groups receive a weekly dashboard detailing the demand across a range of our access points and community services, along with acute admission and discharge information. Demand is also regularly discussed in monthly Directorate IPQR meetings.

Responsive | Access & Demand | Community Services

July 2021		Per month, by Source	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
Acute & Community Directorate	**Service Type**	**Referrals (Number)**	**Waiting List (Number)**	**Average Waiting Time (RtA)**	**Waiting Time RtT**	**Caseload (Service)**
SPA/EWS	Assessment	831	1094	11.57	26.81	1394
AMHP	Assessment	143	N/A	N/A	N/A	N/A
Out of Hours Team	Assessment	1,051	N/A	N/A	N/A	N/A
Liaison Psychiatry	Assessment	504	N/A	N/A	N/A	N/A
Decisions Unit	Treatment	66	N/A	N/A	N/A	N/A
S136 HBPOS	Assess & Treat	45	N/A	N/A	N/A	N/A
Adult Home Treatment Service	Assess & Treat	119	N/A	N/A	N/A	61
MH Recovery North	Treatment	34	49	2.50	12.50	975
MH Recovery South	Treatment	26	30	2.20	4.90	1088
Recovery Service TOTAL	***Treatment***	***60***	***79***	N/A	N/A	***2063***
Early Intervention in Psychosis	Assess & Treat	41	25	N/A	100.00%	372
Memory Service	Assess & Treat	158	396	13.25	25.37	4030
OA CMHT	Assess & Treat	314	110	4.74	7.29	1227
OA Home Treatment	Assess & Treat	26	N/A	N/A	N/A	68
Rehab & Specialist Directorate						
IAPT	Assess & Treat	1,416	N/A	N/A	N/A	N/A
SPS - MAPPS	Assess & Treat	7	36	26.10	61.10	274
SPS - PD	Assess & Treat	10	35	30.70	72.50	185
Gender ID	Assess & Treat	57	1364	124.00	Incomplete	2138
STEP	Treatment	103	96	N/A	Incomplete	462
Eating Disorders Service	Assess & Treat	40	39	4.70	Incomplete	228
SAANS	Assess & Treat	175	3225	105.90	Incomplete	4276
R&S	Assess & Treat	14	230	N/A	Incomplete	239
Perinatal MH Service (Sheffield)	Assess & Treat	57	38	4.90	Incomplete	150
HAST	Assess & Treat	14	19	22.70	Incomplete	101

Narrative

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

Safe | Inpatient Wards | Adult Acute & Step Down

Adult Acute (Dovedale 2, Stanage & Maple Wards)	Benchmark/ Target	July 2021			
			mean	SPC variation	SPC target
Admissions	/	37	41	• • •	/
Detained Admissions	/	34	34	• • •	/
% Admissions Detained	/	91.89%	87%	• • •	/
Emergency Re-admission Rate	7%	3.41%	3.82%	• L •	?
Discharges	/	41	40.25	• • •	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	4			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	75			
Bed Occupancy excl. Leave (KH03)	95%	91.43%	93.78%	• • •	?
Bed Occupancy incl. Leave	/	97.53%	98.40%	• • •	?
Average beds admitted to	/	46			
Average Discharged Length of Stay (12 month rolling)	35	34.65	36.72	• L •	F
Average Discharged Length of Stay (discharged in month)	35	37.65	36.44	• • •	/
Live Length of Stay (as at month end)	/	54.91	42.21	• H •	/
Number of Mental Health Out of Area Placements started in the period (admissions)	0	3	10	• • •	?
Total number of Out of Area bed nights in period	0	388	380	• • •	F
Total number of people in Out of Area beds in period	0	20	22	• • •	F
Cost of Out of Area bed nights in period	0	Refer to Directorate Finance Report			

Step Down – Wainwright Crescent	Benchmark/ Target	Jul-21			
			mean	SPC variation	SPC target
Admissions	/	6	8	• ? •	/
Discharges	/	6	8	• ? •	/
Bed Occupancy excl. Leave (KH03)	95%	90.03%	85.4%	• ? •	?
Bed Occupancy incl. Leave	95%	96.77%	94.5%	• • •	?
Average Discharged Length of Stay (12 month rolling)	/	51.09	45.99	• H •	/
Live Length of Stay (as at month end)	/	132.45	99.63	• H •	/

Narrative (Wainwright Crescent)

Overall average discharge length of stay slightly reduced but still have single longest length of stay of 967 days despite attempts to find a discharge pathway.

Actions

Accessing system support to expedite this complex delayed discharge

Length of Stay Detail

Longest LoS (days) as at month end: **967** (ID 76947)

Range = 3 to 967 days

Number of discharges in month: 6

Longest LoS (days) of discharges in month: 137

Narrative (Acute Wards)

There have been fewer admissions in July against the mean average, and very slightly more discharges than mean average, but both within control limits. Bed occupancy has reduced slightly. The average discharge length of stay within July is above average at 37 days due to the discharge of some longer stay patients.

Length of Stay Detail

Longest LoS (days) as at month end: **176** (ID 370010) on Maple, **169** on Stanage (ID 289418)

Range = 0 to 176 days

Number of discharges in month: 43

Longest LoS (days) of discharges in month: 144

Benchmarking Out of Area Placements

(NEY Provider Trusts shared information April – July 2021. This is snapshot position of service users in OOA beds of all types at the end of each month)

North East Yorkshire MH Providers	Apr-21	May-21	Jun-21	Jul-21	Sparkline
Humber NHS Foundation Trust	21	21	18	16	
Cumbria Northumberland, Tyne and Wear Partnership NHS FT	0	0	0	1	
Tees, Esk and Wear Valleys NHS Foundation Trust	16	27	20	26	
Bradford District Care NHS Foundation Trust	19	24	22	17	
Rotherham Doncaster and South Humber NHS Foundation Trust	2	7	9	17	
Leeds and York Partnership NHS Foundation Trust	2	11	12	16	
Sheffield Health and Social Care NHS Foundation Trust	**22**	**18**	**23**	**13**	
South West Yorkshire Partnership NHS Foundation Trust	5	8	6	5	
Navigo (NE Lincs/Grimsby)	1	0	0	0	

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%

PICU	Benchmark/Target	Jul-21 n	mean	SPC variation	SPC target
Admissions	/	4	4	• • •	/
Discharges	/	3	2	• • •	/
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%	92.26%	92.1%	• ? •	?
Bed Occupancy incl. Leave	95%	93.23%	94.0%	• • •	?
Average beds admitted to	/	9			
Average Discharged Length of Stay (12 month rolling)	47	50.36	46.06	• • •	?
Live Length of Stay (as at month end)	/	62.20	49.24	• H •	/
Number of Mental Health Out of Area Placements started in the period (admissions)	ZERO Inappropriate	2	4	• • •	?
Total number of Out of Area bed nights in period	ZERO Inappropriate	157	163	• • •	F
Total number of people in Out of Area beds in period	ZERO Inappropriate	9	9	• • •	F
Cost of Out of Area bed nights in period	ZERO Inappropriate	Refer to Directorate Finance Report			

Issues

Live length of stay high but has reduced since June following some discharges, difficulties finding a suitable discharge pathway for a client with personality disorder has resulted in a longer stay.

Bed Occupancy reduced slightly since June but still within control limits.

Actions

- Escalations are being made through the weekly medically fit for discharge meeting.
- A weekly DToC report is being shared with the Executive Director of Nursing and Professions for discussion.
- Utilising system discharge escalation and support processed to support delays.

Length of Stay Detail

Longest LoS (days) as at month end: 179
Range = 9 to179 days
Number of discharges in month: 4
Longest LoS (days) of discharges in month: 265

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

Older Adult Dovedale	Benchmark/ Target	Jul-21 n	mean	SPC variation	SPC target
Admissions	/	5	5	● ● ●	/
Discharges	/	7	5.5	● ● ●	/
Delayed Discharge/Transfer of Care (number of dd)	/	0			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	0			
Bed Occupancy excl. Leave (KH03)	95%	93.76%	93.4%	● ● ●	?
Bed Occupancy incl. Leave	95%	96.56%	98.3%	● ● ●	?
Average beds admitted to	/	15			
Average Discharged Length of Stay (12 month rolling)	74	70.30	89.20	● L ●	F
Live Length of Stay (as at month end)	/	87.60	102.31	● ● ●	/

Older Adult G1	Benchmark/ Target	Jul-21 n	Mean	SPC variation	SPC target
Admissions	/	6	4	● ● ●	/
Discharges	/	3	4.20833	● ● ●	/
Delayed Discharge/Transfer of Care (number of dd)	/	7			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	213			
Bed Occupancy excl. Leave (KH03)	95%	83.27%	70.9%	● ● ●	?
Bed Occupancy incl. Leave	95%	84.88%	72.9%	● ● ●	?
Average beds admitted to	/	14			
Average Discharged Length of Stay (12 month rolling)	74	67.61	81.87	● L ●	?
Live Length of Stay (as at month end)	/	49.00	54.79	● L ●	/

Length of Stay Detail
Longest LoS (days) as at month end: **588**
Range = 3 to 588 days
Number of discharges in month: 8
Longest LoS (days) of discharges in month: 480

Length of Stay Detail
Longest LoS (days) as at month end: **101**
Range = 1 to 101 days
Number of discharges in month: 5
Longest LoS (days) of discharges in month: 117

Issues
Dovedale – average discharged length of stay is low.
G1 - Covid on the ward has impacted on the processing of some discharges. There are also 3 patients who are medically fit for discharge but as yet do not have a placement.

Actions
- Escalations are being made through the weekly medically fit for discharge meeting
- Escalations involve the Local Authority who hold responsibility for social care for adults aged 65+ years.
- A weekly DToC report is being shared with the Executive Director of Nursing and Professions.

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.

Rehab	Benchmark/ Target	Jul-21 n	mean	SPC variation	SPC target
Admissions	/	2	1	• • •	/
Discharges	/	4	2.41667	• • •	/
Bed Occupancy excl. Leave (KH03)	95%	70.60%	82.50%	• ? •	?
Bed Occupancy incl. Leave	95%	86.70%	94.60%	• • •	?
Average Discharged Length of Stay (12 month rolling)	524	351.62	387.92	• L •	P
Live Length of Stay (as at month end)	/	326.93	396.05	• L •	/
Number of Mental Health Out of Area Placements started in the period (admissions)	0 Inappropriate	2			
Total number of Out of Area bed nights in period	0 Inappropriate	347			
Total number of people in Out of Area beds in period	0 Inappropriate	13			
Cost of Out of Area bed nights in period	0 Inappropriate	Refer to Directorate Finance Report			

Forensic (Low Secure)	Benchmark/ Target	Jul-21 n	mean	SPC variation	SPC target
Admissions	/	1	1	• • •	/
Discharges	/	1	1.5	• • •	/
Bed Occupancy excl. Leave (KH03)	95%	78.60%	86.70%	• ? •	?
Bed Occupancy incl. Leave	95%	90%	92%	• • •	?
Average Discharged Length of Stay (12 month rolling)	593	408	382	• H •	P
Live Length of Stay (as at month end)	/	474	439	• H •	/

Forest Close

It should be noted that length of stay within Forest Close benchmarks favourably against other Rehab/Complex Care facilities across the country.

Length of Stay Detail
Longest LoS (days) as at month end: 1871
Range = 1 to 1871 days
Number of discharges in month: 4
Longest LoS (days) of discharges in month: 416

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

Out of Area Rehab

Currently all Out of Area rehab admissions are deemed appropriate as are providing a specialist placement that Forest Close does not provide.
At the end of July 21 there were 12 patients OOA – all placed for a range of specialist needs. The team meet regularly to review service users in Out of Area beds and have expected discharge dates for all placements. The service is working hard to repatriate these service users and anticipates the number reducing to 7 OOA by the end of October 2021.

Forest Lodge

Again it should be noted that length of stay within Forest Lodge benchmarks favourably against other low secure facilities across the country, although current length of stay is above the 2 year SHSC average. Discharged LoS is also above the SHSC average, however this shift above the mean occurred in November 20, when a very long stay service user (2144 days) was discharged. This will continue to impact the discharged LoS until December 21.

Length of Stay Detail
Longest LoS (days) as at month end: 1837
Range = 4 to 1837 days
Number of discharges in month: 1
Longest LoS (days) of discharges in month: 323

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

Data Quality
Across both services, further checks need to be carried out to assure data quality of admission and discharge information and impact on length of stay figures. This work is progressing with Performance Team and Service leads.

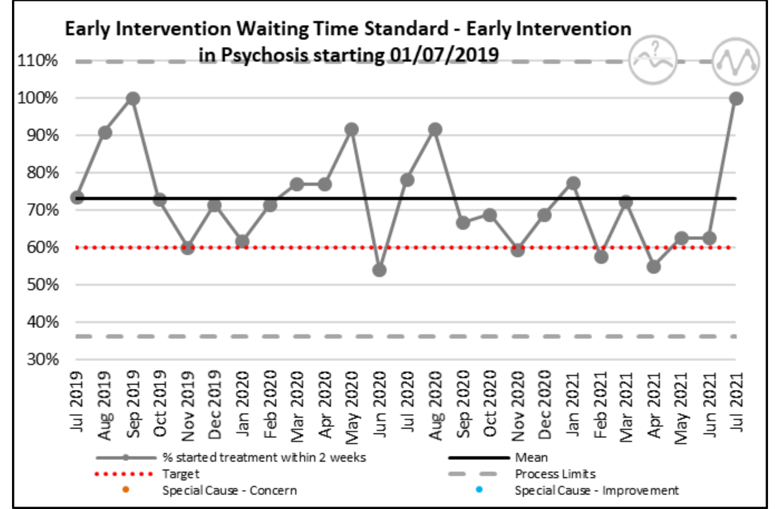
Learning Disabilities	Benchmark /Target	Jul-21 n	mean	SPC variation	SPC target
Admissions	/	0	*1*	· ? ·	/
Discharges	/	1	*1*	● ● ●	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	1			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	11			
Bed Occupancy excl. Leave (KH03)	95%	15.70%	*68.9%*	· ? ·	?
Bed Occupancy incl. Leave	95%	19.40%	*71.30%*	· ? ·	?
Average Discharged Length of Stay (12 month rolling)	301	325.38	*133*	· H ·	P
Live Length of Stay (as at month end)	/	197.00	*239*	● ● ●	/

Exception Update

As reported previously, further to the CQC inspection in May, Firshill Rise is currently closed to new admissions.

As at 23rd August 2021 there was one service user still at the unit who is a delayed discharge. We are waiting for suitable accommodation to become available to enable discharge. Planned discharge date is currently 2 September 2021.

There will be no inpatients from 2 September 2021 when the service will be commencing a programme of training and development to support the safe re-opening of the unit in line with CQC requirements.



EIP AWT Standard		Jul-21		
	Target 2021/22	N	SPC variation	SPC target
Trustwide	60%	100%	• • •	?

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.

In July 2021 the service achieved the wait time standard for 5 of 5 new entries to treatment. (100%)

7 Day Follow Up		Jul-21		
	Target 2021/22	N	SPC variation	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 September onwards.

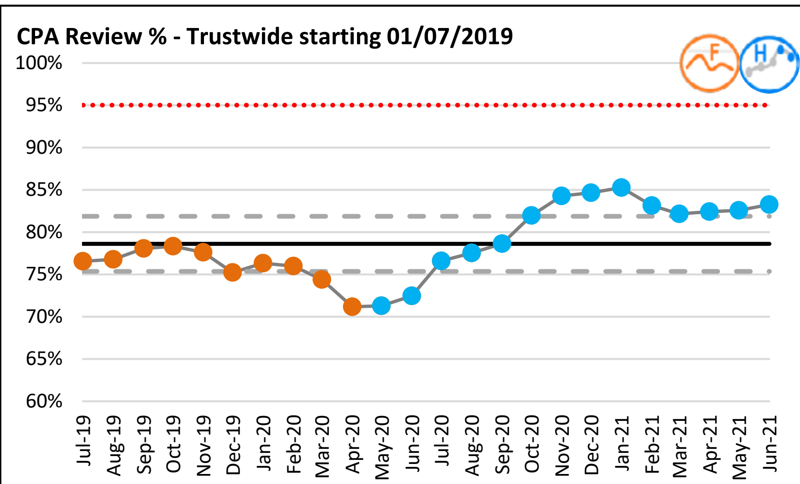
The 72 hour follow up has been in place operationally since 19/20 and is delivered by the Home Treatment Service, and will be delivered by the new Crisis Resolution Home Treatment function. The target is 80%.

Gatekeeping Admission		Jul-21		
	Target 2021/22	N	SPC variation	SPC target
Trustwide	95%	94%	• • •	?

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.



		Jul-21			
CPA Review % Completed within 12 months	Target 2021/22	n	*Mean*	SPC variation	SPC target
Trustwide	**95%**	**83.33%**	***78.88%***	• H •	F
Early Intervention	95%	94.92%	*90.78%*	• • •	?
MH Recovery North	95%	86.84%	*84.30%*	• H •	F
MH Recovery South*	95%	65.90%	*77.63%*	• L •	F

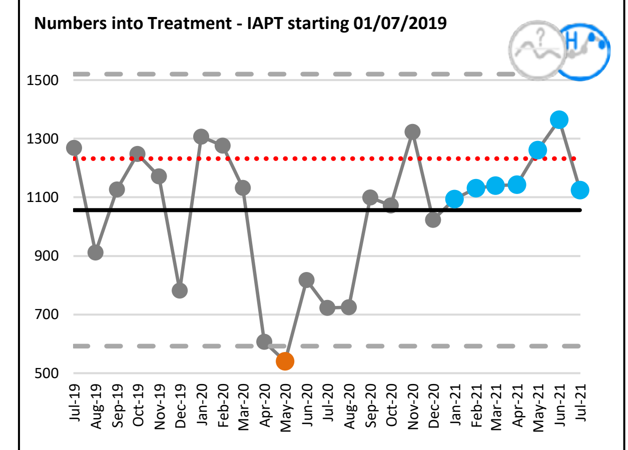
*Baseline recalculation from July 2020

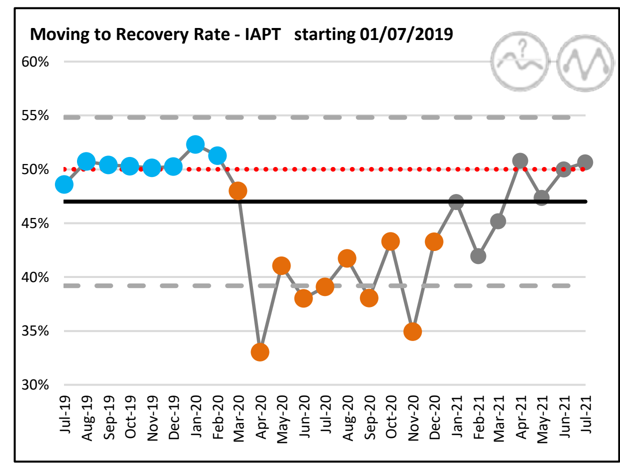
Issues
There is evidence that the recovery plan continues to to have an impact across the Early Intervention in Psychosis Service and the North Recovery Service where performance is above mean average. South Recovery have slipped when compared to June.

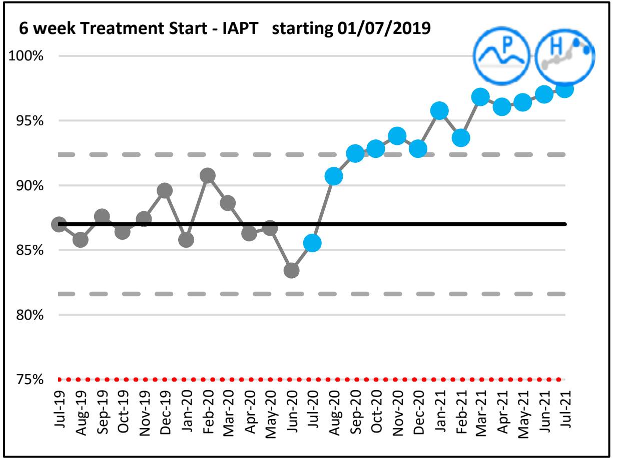
Actions
Further targeted efforts required to support the South Recovery Service.

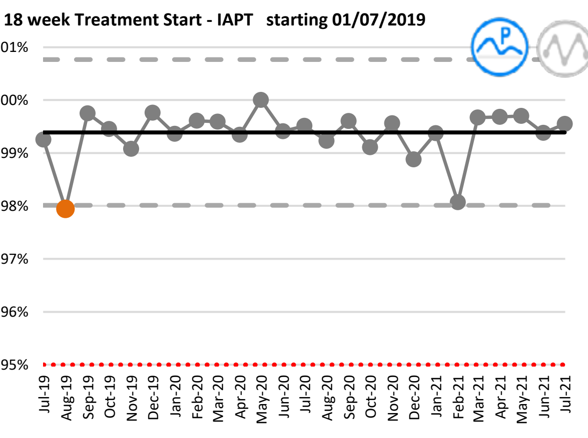
IAPT | Performance Summary

IAPT		Jul-21			
Metric	Target 2021/22	n	*mean*	SPC variation	SPC target
Referrals	n/a	1302	*1628*	• • •	/
New to Treatment	1232	1124	*1056*	• H •	?
6 week Wait	75%	97.46%	*87%*	• H •	P
18 week Wait	95%	99.55%	*99.4%*	• • •	P
Moving to Recovery Rate	50%	50.65%	*47%*	• • •	?









Narrative

Access

Target is 1232 per month people enter treatment, for July we submitted 1124 (-108). Throughout July there has been a spike in COVID infection rates nationally and we have noticed an impact on patients isolating/school closures impacting on childcare and cancelled appointment. There was also a slight dip in referrals last month to 1301 (compared to 1413 for June).

We are aware of seasonal dips in access, particularly over July/August. We are putting many things in place and working with the communications team to boost referrals such as increasing our social media posts; a refresh of our website and service promotion on local radio.

Waiting Times

Continue to exceed service waiting time target with 97.5% seen in less than 6 weeks and 99.5% seen in less than 18 weeks. .

Recovery

The service continues to achieve the 50% IAPT Recovery rate standard and for July submitted: 50.65%. This will be communicated with the service and quality improvement work continues to place across the service.

START – Sheffield Treatment & Recovery Team | Performance Summary

START		Jul-21		
Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	65	• L •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	100%	• H •	?
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	100%	• • •	P
DNA Rate to Assessment	≤ 15%	25%	• L •	?
Recovery - Successful treatment exit	TBC	3	• • •	/
Non-Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	58	• H •	/
Waiting time Referral to Assessment	≥ 95%	100%	• • •	?
Waiting time Referral to Treatment	≥ 95%	100%	• • •	?
DNA Rate to Assessment	≤ 15%	18.9%	• L •	?
Recovery - Successful treatment exit	TBC	20	• H •	/
Alcohol	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	189	• • •	/
Waiting time Referral to Assessment	≥ 95%	88.7%	• L •	P
Waiting time Referral to Treatment	≥ 95%	100%	• H •	P
DNA Rate to Assessment	≤ 15%	18.24%	• • •	?
Recovery - Successful treatment exit	TBC	53	• H •	/

Narrative

Engagement

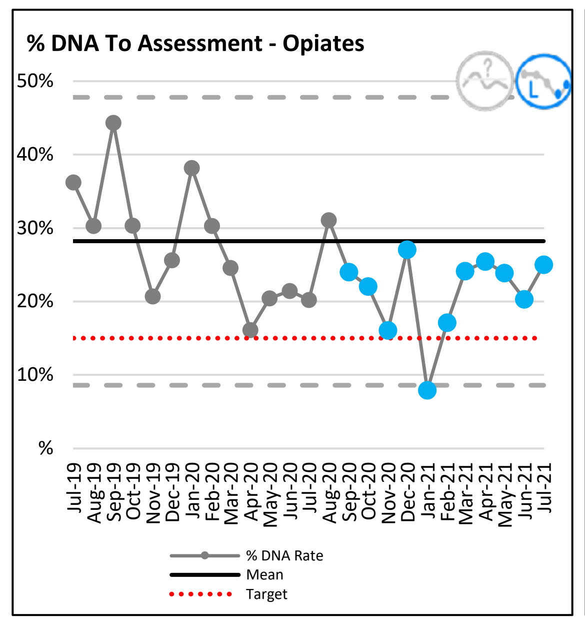
Referral numbers to the opiates, alcohol and non-opiates services are not currently working to a target but this is in discussion with the commissioner. The service provides open access to treatment regardless of any previous presentations or drop-outs. For this reason, there is a group of service users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

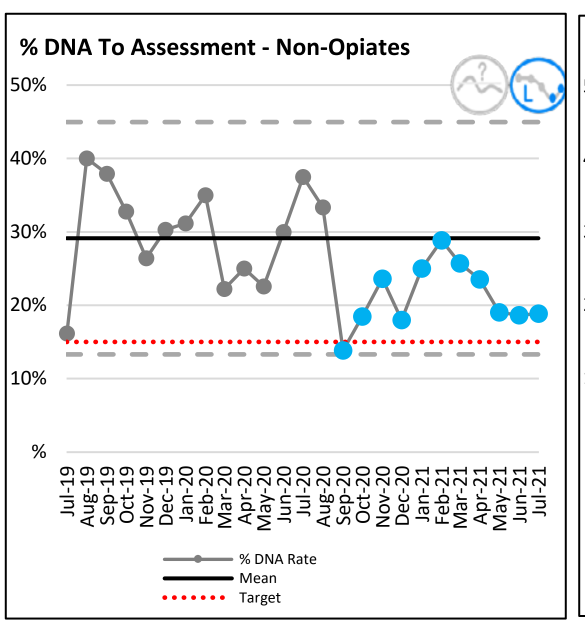
Waiting Times

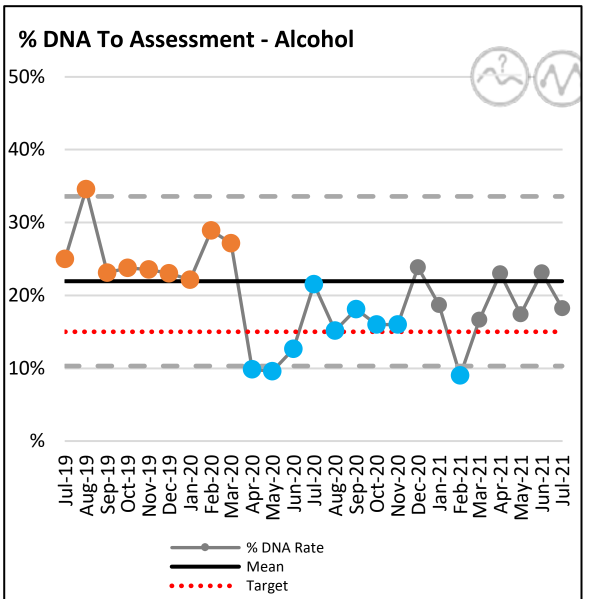
The service works towards a target of 95% of service users being assessed within 7 working days. Resource pressures meant that a small number of service users waited longer than 7 days for assessment with the alcohol service in July 2021, but no service user waited longer than 10 days. The average wait 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.







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.

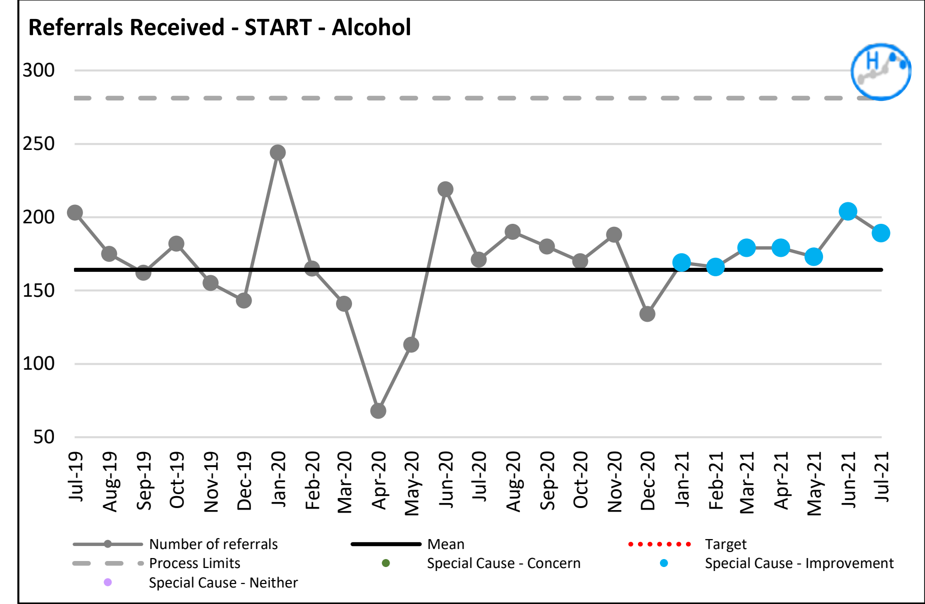
Covid 19 has led to an increase in telephone assessments which initially had a positive impact on the number completed, particularly in the alcohol service and more recently the opiates service. The service will be using learning from this to identify where improvements to the DNA rate can be made, in addition to targeted engagement work which is undertaken with those who repeatedly DNA to assessment.

Referrals Received - START - Opiates

150
140
130
120
110
100
90
80
70
60
50

Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21

Number of referrals
Mean
Target
Process Limits
Special Cause - Concern
Special Cause - Improvement



Referrals (Numbers In) Narrative

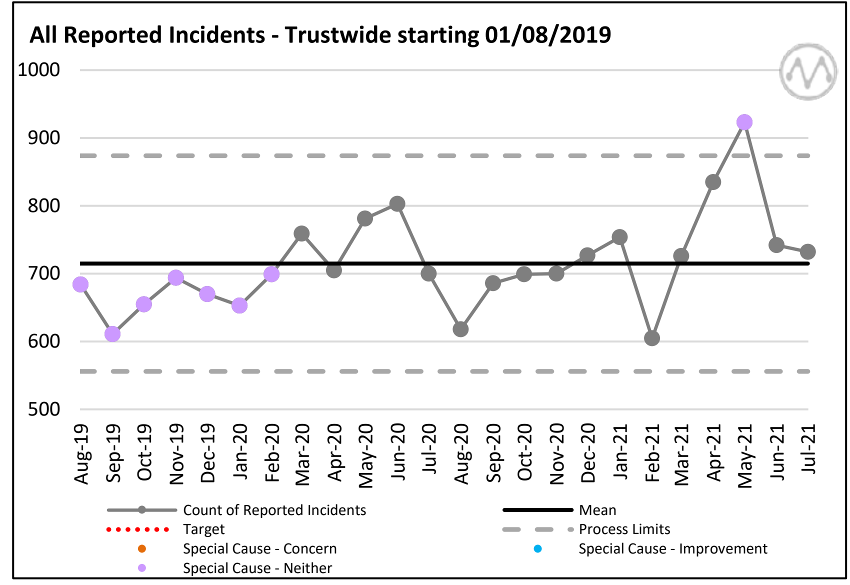
Low referrals to the Opiates service are a cause for concern; however, analysis shows that total numbers in treatment have remained stable, and fewer service users are dropping out and/or cycling in and out. This is also reflected in the numbers being discharged from the Opiates Service. This provides stability for vulnerable service users who may not be ready for abstinence but are engaging with treatment.

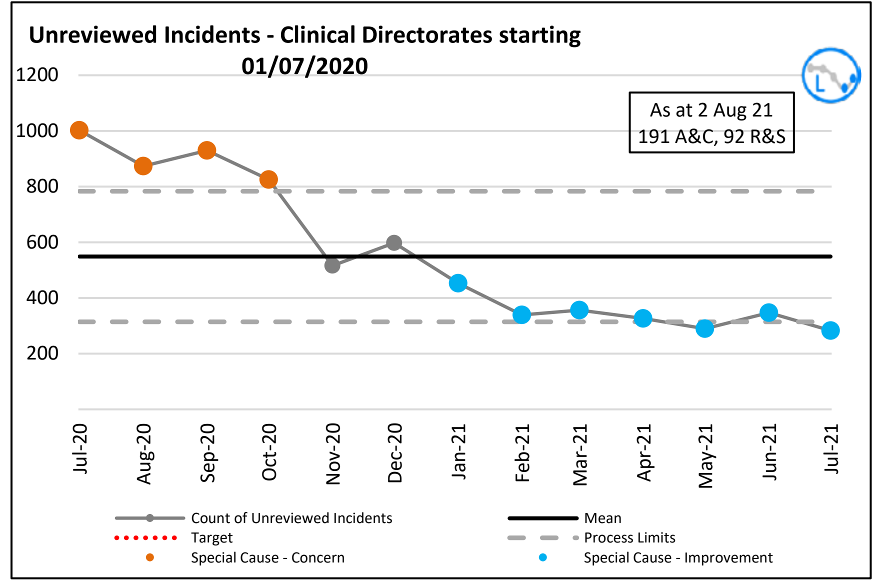
There were fewer referrals to the alcohol service in April 2020, coinciding with lockdown. The links between alcohol use and lockdown is something the service has been keen to address; there was a brief social media campaign in July aimed at encouraging people to seek help for lockdown drinking habits 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.

Safety & Quality

IPQR - Information up to and including July 2021

Safe | All Incidents





Trustwide	Jul-21		
	n	*mean*	SPC variation
ALL	**732**	*715*	• • •
5 = Catastrophic	10	*15*	• • •
4 = Major	4	*4*	• • •
3 = Moderate	47	*33*	• • •
2 = Minor	200	*152*	• ? •
1 = Negligible	463	*488*	• • •
0 = Near-Miss	8	*23*	• ? •

Serious Incident Actions Outstanding

As at 2nd August 2021, there were 102 outstanding SI actions overdue.

- 5 of these were from SIs in 2018
- 37 of these are from SIs in 2019
- 60 of these are from SIs in 2020

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

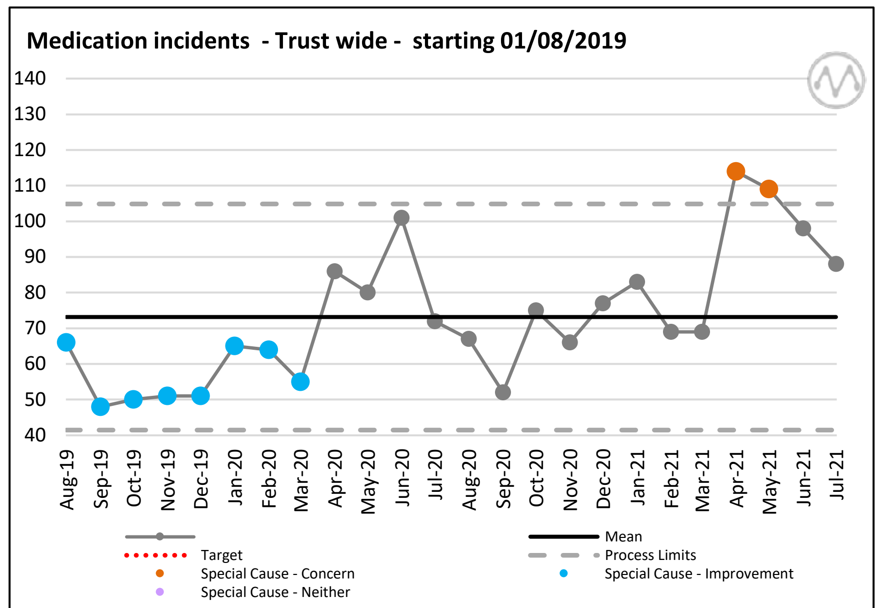
Protecting from avoidable harm	Target	YTD
Never events declared	0	0
Methicillin-resistant Staphylococcus aureus (MRSA & MSSA)	0	0

Narrative

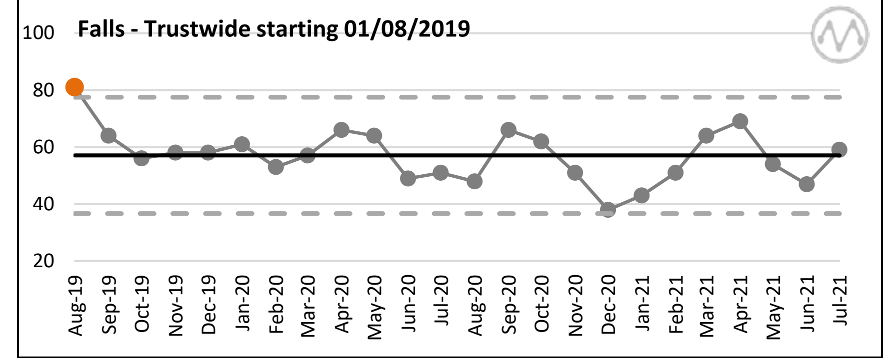
Patient safety incidents are reported to the National Reporting Learning System (NRLS). During the Covid-19 pandemic, no benchmarking information has been provided to Trusts. The latest information produced suggests that benchmarking will recommence, on an annual basis, commencing September 2021.

Clinical Directorates are working to reduce all outstanding actions (SI) and unreviewed incidents to a minimum. Both Directorates continue to make progress with an overall trajectory of fewer outstanding actions and unreviewed incidents.

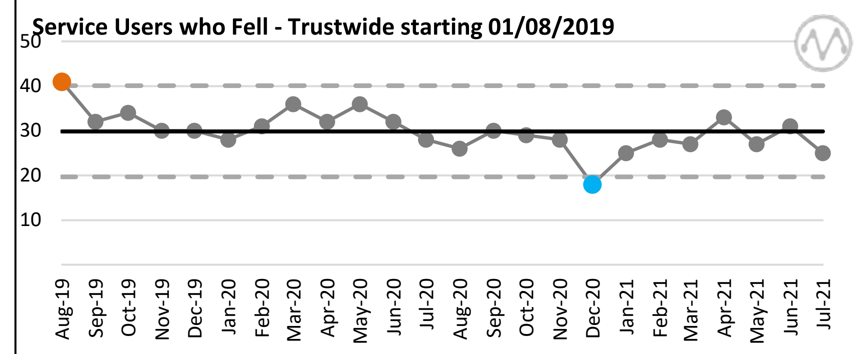
Review of the data is ongoing with the Quality Directorate to ensure actions are correctly identified against services, and do not remain open in error.



Trustwide	Jul-21		
	n	*mean*	SPC variation
ALL	88	*73*	● ● ●
Administration Incidents	17	*16*	● H ●
Meds Management Incidents	58	*45*	● ● ●
Pharmacy Dispensing Incidents	5	*6*	● ● ●
Prescribing Incidents	8	*6*	● ● ●
Meds Side Effect/Allergy Incidents	0	*0*	● ● ●



Trustwide	Jul-21		
	n	*mean*	SPC variation
Falls incidents	59	*57*	● ● ●
Acute & Community	59	*53*	● ● ●
Rehabilitation & Specialist Services	0	*4*	● ● ●

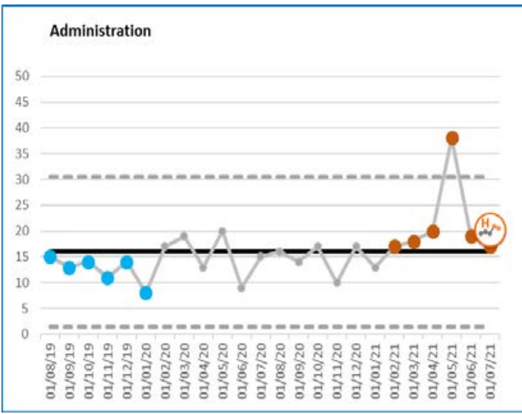


Trustwide			
	n	*mean*	SPC variation
Individuals who fell	25	*30*	● ● ●
Acute & Community	25	*27*	● ● ●
Rehabilitation & Specialist Services	0	*3*	● ● ●

Narrative

Medication Incidents

Medicines administration incidents Trustwide show special cause variation as there are 6 data points above the mean.



Medication incidents continue to be reviewed by both Clinical Directorates. Learning is reviewed with each member of staff when any medication errors are reported.

Falls Incidents

Nothing to note.

Safe | Assaults, Sexual Safety & Missing Patients

Assaults on Staff	Jul-21		
	n	*mean*	SPC variation
Trustwide	66	*94*	• • •
Acute & Community	54	*70*	• • •
Rehab & Specialist	12	*24*	• • •

Assaults on Service Users	Jul-21		
	n	*mean*	SPC variation
Trustwide	22	*23*	• • •
Acute & Community	20	*21*	• • •
Rehab & Specialist	2	*3*	• • •

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

Narrative

Assault to Staff

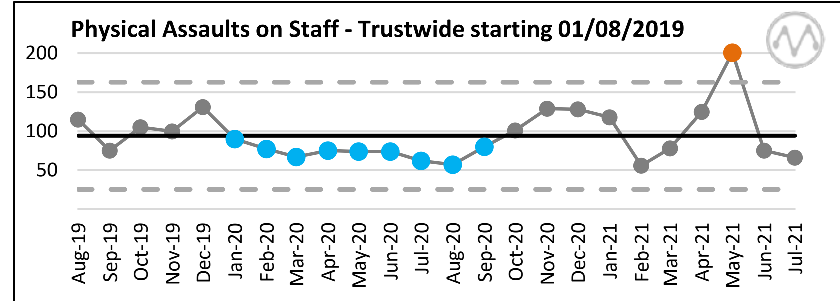
No moderate or above incidents recorded in July 2021.

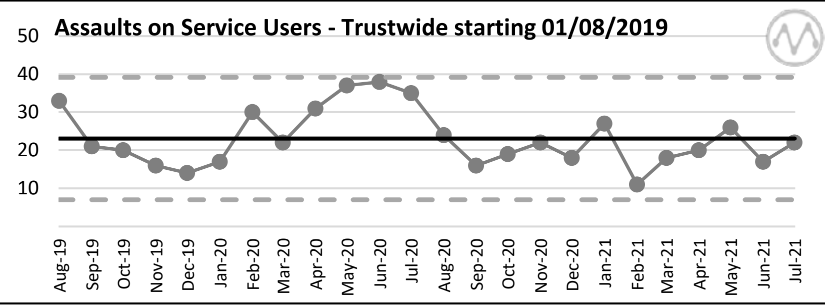
Assault on Service Users

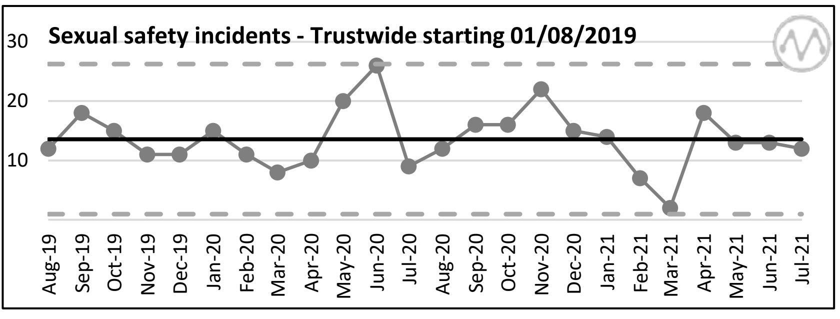
No moderate or above incidents recorded in July 2021

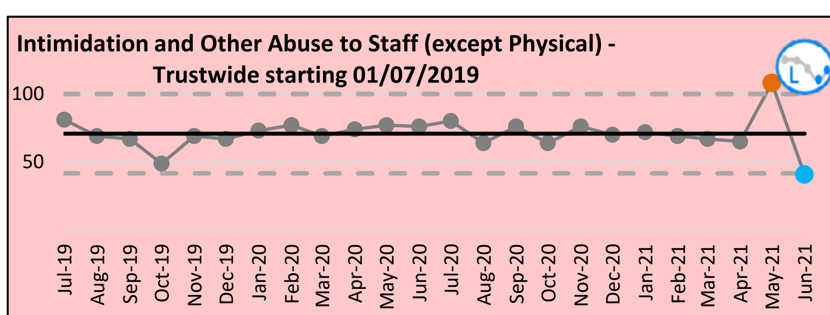
Sexual Safety Incidents

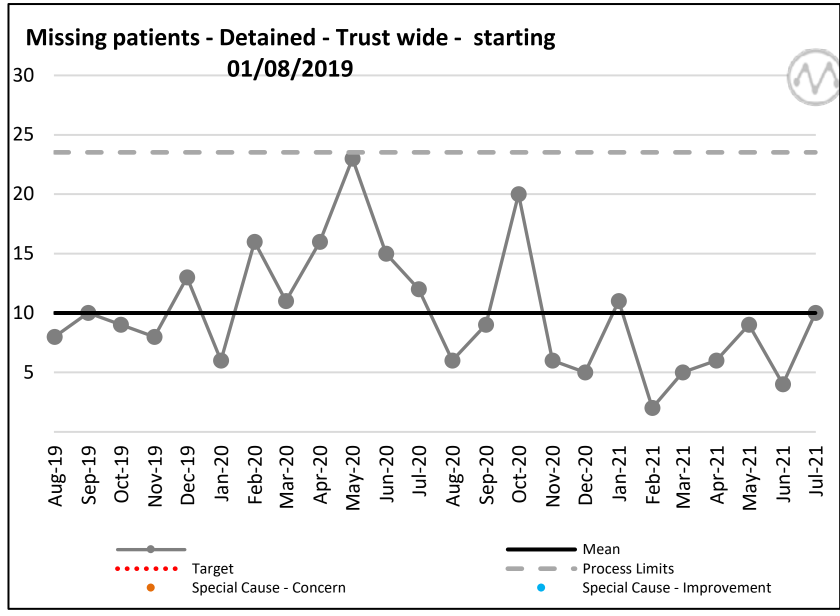
No moderate or above incidents recorded in July 2021











Trustwide	Jul-21		
	n	*mean*	SPC variation
Missing Patients (Informal)	7	*3*	• • •
Missing Patients (Detained)	10	*10*	• • •

Deaths

Service User Deaths 1 – 31 July 2021	
Dovedale 2 (Burbage) Ward	1
Neuro Enablement Service/Brain Injury Team/Neuro Case Management/LTNC	3
Mental Health Recovery Teams	2
Older Adult Community Mental Health Teams	4
Out of Hours Team	1
Liaison Service	1
START Alcohol and Opiates/Non-opiates Services	5
Total	**17**

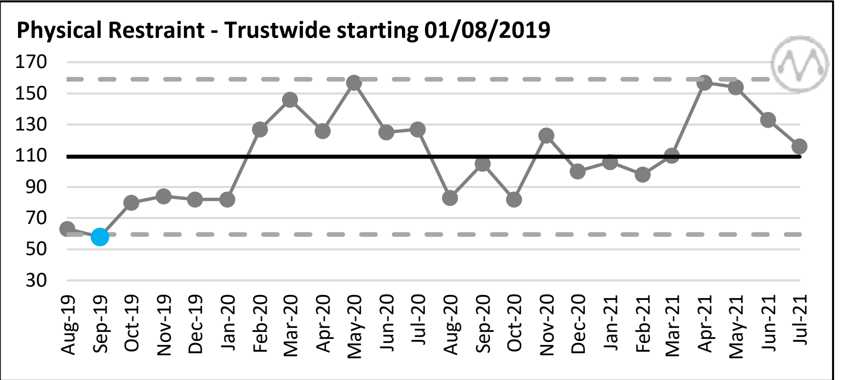
Classification of Deaths 1 – 31 July 2021	
Expected Death	5
Unexpected Death - SHSC Community	7
Suspected Suicide (Community)	2
Unexpected Death (Suspected Natural Causes)	1
Unexpected Death (Inpatient/Residential)	1
Suspected Homicide	1
Grand Total	**17**

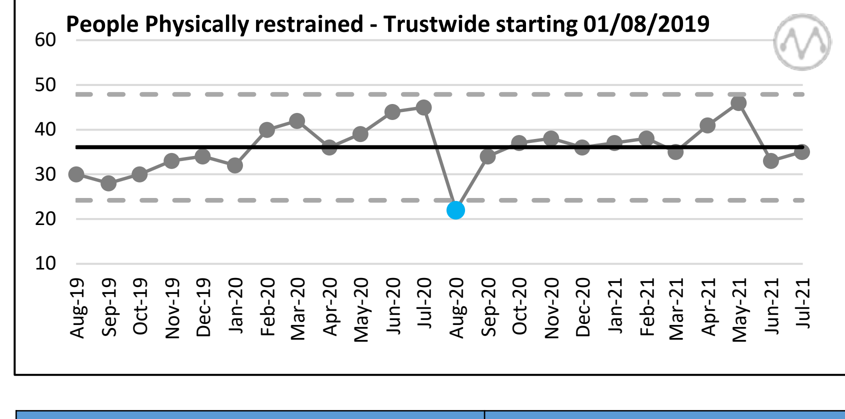
Quarterly mortality reports are presented to the Quality Assurance Committee and Board of Directors.

Deaths Reported 1 April 2020 – 31 July 2021	
Awaiting Coroners Inquest/Investigation	161
Conclusion - Narrative	3
Conclusion - Suicide	7
Conclusion – Accidental	2
Conclusion – Misadventure	1
Natural Causes/No Inquest	415
Alcohol/Drug related	7
Ongoing/Suspected Homicide	2
Grand Total	**598**

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

Out of the 17 patient deaths recorded in the month, 7 of these were natural causes deaths and required no inquest, nine are awaiting an inquest/investigation) one is closed. 9 out of the 10 catastrophic incidents during July 2021 were deaths, 1 was a suspected homicide, 5 were unexpected community deaths, 1 unexpected inpatient/residential death and 2 suspected community suicides. The final catastrophic incident relates to safeguarding oversight concerns on Maple Ward.





Physical Restraint INCIDENTS	Jul-21		
	n	*mean*	SPC variation
TRUSTWIDE	116	*109*	•••
Acute & Community	116	*95*	•••
Services			
Burbage Ward	11	*13*	•••
Stanage Ward	11	*21*	•••
Maple incl 136	12	*13*	•••
Endcliffe Ward	19	*26*	•••
Dovedale	57	*11*	• H •
G1 Ward	6	*10*	•••
Birch Ave	0	*1*	•••
Woodland View	0	*1*	•••
Rehabilitation & Specialist Services	0	*14*	•••
Services			
ATS (Firshill Rise)	0	*12*	•••
Forest Close	0	*1*	•••
Forest Lodge	0	*1*	•••

Physical Restraint INDIVIDUALS	Jul-21		
	n	*mean*	SPC variation
TRUSTWIDE	35	*36*	•••
Acute & Community	35	*32*	•••
Services			
Burbage Ward	5	*6*	•••
Stanage Ward	4	*7*	•••
Maple incl 136	12	*7*	•••
Endcliffe Ward	5	*6*	•••
Dovedale	4	*3*	•••
G1 Ward	6	*4*	•••
Birch Ave	0	*1*	•••
Woodland View	0	*1*	•••
Rehabilitation & Specialist Services	0	*4*	•••
Services			
ATS (Firshill Rise)	0	*2*	•••
Forest Close	0	*1*	•••
Forest Lodge	0	*1*	•••

Narrative

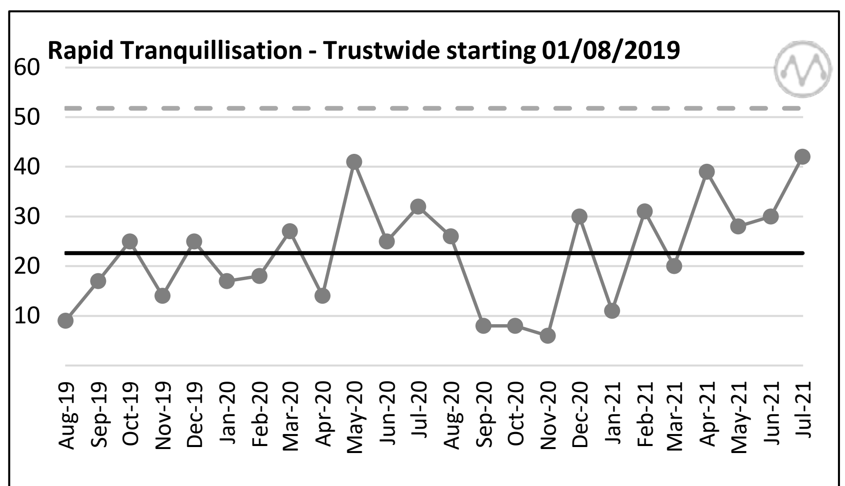
The high levels of restrictive practice on Dovedale 1, including physical restraint and rapid tranquillisation, for one particular service user continue from last month. 53 of the 57 incidents on Dovedale are accounted for by this service user.

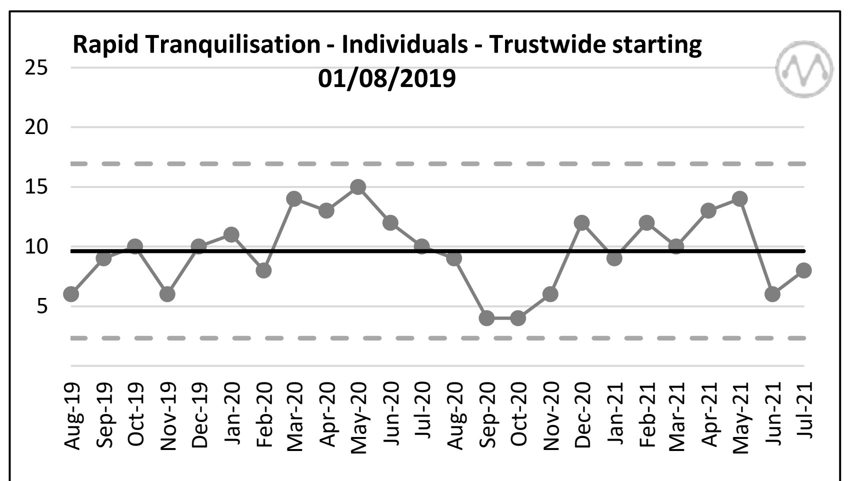
The service user involved has many complex problems around their mental and physical health. At times they need assistance to be supported in a private space in relation to privacy and dignity and at others to be administered medication which is essential for a physical health problem or to de-escalate distress using rapid tranquillisation. Regular consultation with the nurse consultant reducing restrictive practice and RESPECT team is in situ, ECT is planned and a professionals meeting convened. The Head of Nursing has asked the Consultant Psychiatrist to seek a second opinion to ensure a full and comprehensive assessment of care needs. The team regularly reflect on practice and seek to use the least restrictive practice in a very challenging situation.

No restrictive practice incidents recorded for Rehab & Specialist services in month.

No use of mechanical restraint recorded in July 21, by internal or external staff.

Safe | Restrictive Practice | Rapid Tranquillisation





Rapid Tranquillisation INCIDENTS	Jul-21		
	n	mean	SPC variation
TRUSTWIDE	42	23	• • •
Acute & Community	42	22	• • •
Services			
Burbage Ward	3	3	• • •
Stanage Ward	0	5	• • •
Maple incl 136	0	3	• • •
Endcliffe Ward	7	6	• • •
Dovedale	28	4	• H •
G1 Ward	4	2	• • •
Rehabilitation & Specialist	0	*0*	• L •
Services			
ATS (Firshill Rise)	0	*0*	• L •
Forest Close	0	*0*	• L •
Forest Lodge	0	*0*	• L •

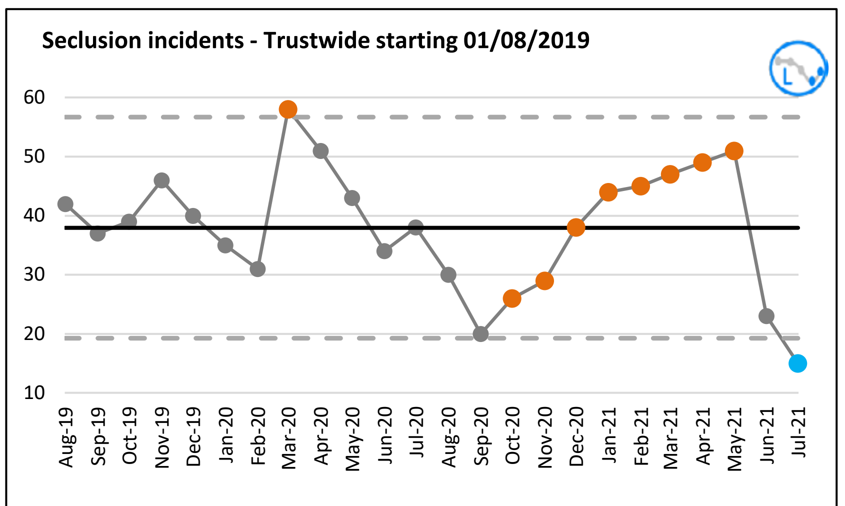
Rapid Tranquillisation INDIVIDUALS	Jul-21		
	n	mean	SPC variation
TRUSTWIDE	8	10	• • •
Acute & Community	8	9	• • •
Services			
Burbage Ward	1	2	• • •
Stanage Ward	0	2	• • •
Maple incl 136	0	2	• • •
Endcliffe Ward	3	1	• • •
Dovedale	2	2	• • •
G1 Ward	2	1	• • •
Rehabilitation & Specialist	0	0	• L •
Services			
ATS (Firshill Rise)	*0*	*0*	• L •
Forest Close	*0*	*0*	• L •
Forest Lodge	*0*	*0*	• L •

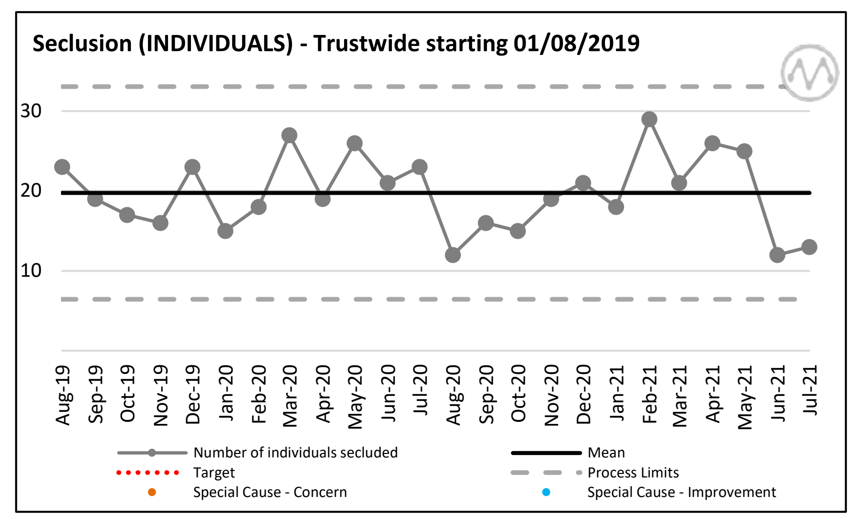
Narrative

The high levels of restrictive practice on Dovedale 1, including physical restraint and rapid tranquillisation, for one particular service user continue from last month. 27 of the 28 incidents on Dovedale are accounted for by this service user.

No restrictive practice incidents recorded for Rehab & Specialist services in month.

Safe | Restrictive Practice | Seclusion



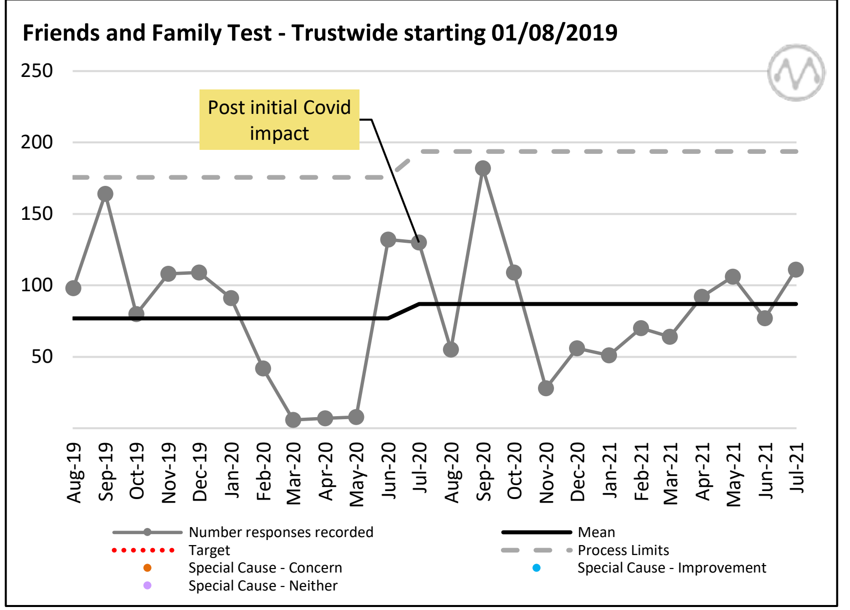


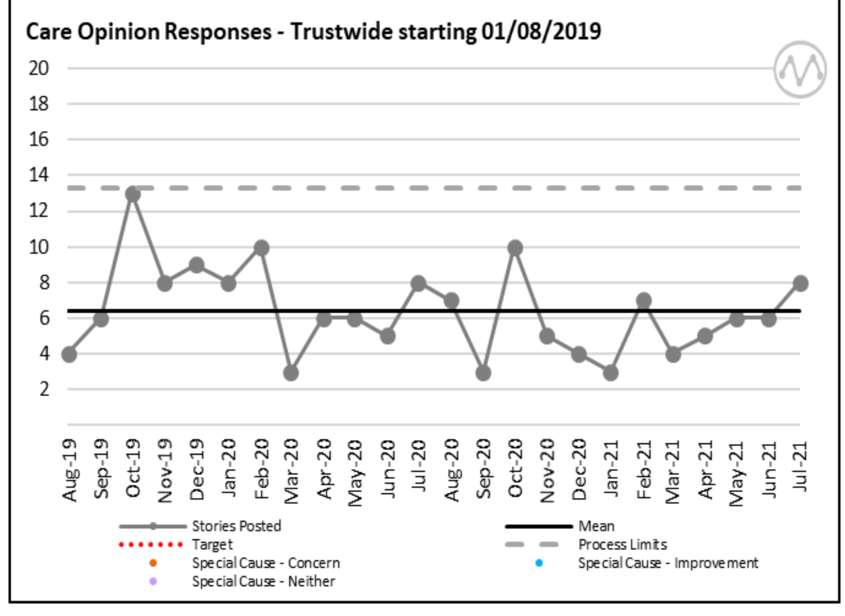
Narrative

There has been a significant reduction in the use of seclusion which coincides with the removal of seclusion facilities on Burbage and the transition to Dovedale 2.

Seclusion INCIDENTS	Jul-21		
	n	*mean*	SPC variation
Trustwide	15	*38*	• L •
Acute & Community	15	*36*	• L •
Services			
Burbage	0	*2*	• • •
Stanage	2	*5*	• • •
Maple incl. 136	6	*6*	• • •
Endcliffe PICU	7	*11*	• • •
G1	0	*8*	• • •
Rehabilitation & Specialist	0	*2*	• • •
Services			
Firshill	0	*1*	• • •
Forest Lodge	0	*0*	• • •

Seclusion INDIVIDUALS	Jul-21		
	n	*mean*	SPC variation
Trustwide	13	*20*	• • •
Acute & Community	13	*18*	• • •
Services			
Burbage	0	*3*	• • •
Stanage	2	*4*	• • •
Maple incl. 136	6	*5*	• • •
Endcliffe PICU	5	*5*	• • •
G1	0	*2*	• • •
Rehabilitation & Specialist	0	*1*	• • •
Services			
Firshill	0	*1*	• • •
Forest Lodge	0	*0*	• • •





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 was presented and accepted at July's Committee meeting.

Quality of Experience

For the first time since the start of the pandemic, a volunteer has been working into the inpatient wards to undertake the Quality of Experience survey with service users.

Work to refresh the current survey has been planned, together with the procurement of ipads/laptops to enable results to be automatically entered into the Qualtrics software.

Narrative

95% of the 111 responses received in July 2021 gave positive feedback.

Narrative

The 8 stories posted in July 2021 gave feedback on START,STEP, Community Mental Health Team, OA CMHT and Adult Home Treatment Service. Common tags around areas where authors felt things were good included: Educational.
When asked what could be improved, responses included: communication; support; access; waiting times and care planning.

Improvement Plan

The Engagement Team have done significant work in increasing the number of responders who can reply to stories. Of a subscription capacity of 100, we now have 85 subscribed responders. Service alerts for new staff have been created and staff who were already on the subscription have had their alerts reviewed.

Complaints & Compliments

July 21 update requested from Corporate Affairs

There were [illegible] complaints received in June 2021, however 5 of these are awaiting consent, hence only 11 are live complaints, categorised below:

Clinical Treatment	[illegible]
Prescribing	3
Privacy and Dignity	1
Values and Behaviours	2
Facilities	1
Admission & Discharge	1
Appointments	1

19 compliments were received in June 2021 for a range of community & inpatient services.

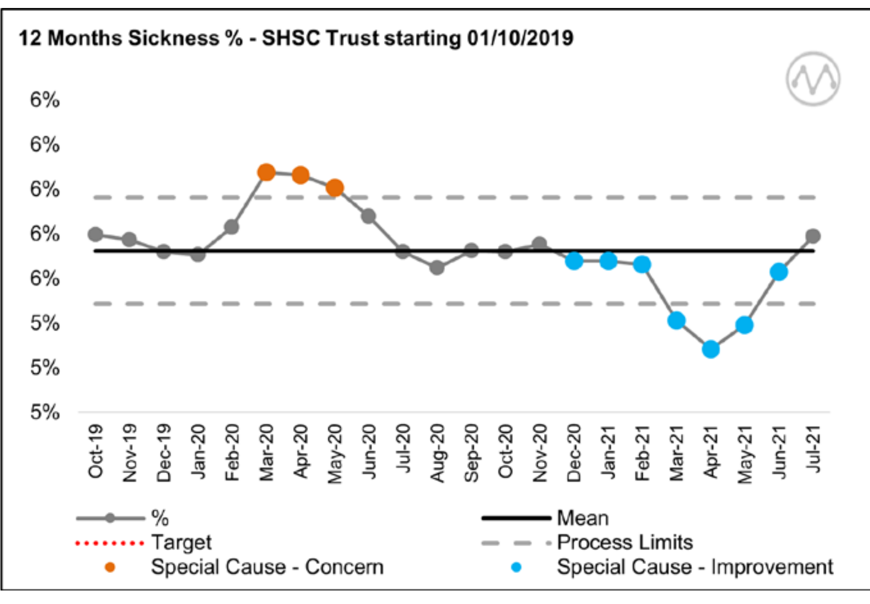
Our People

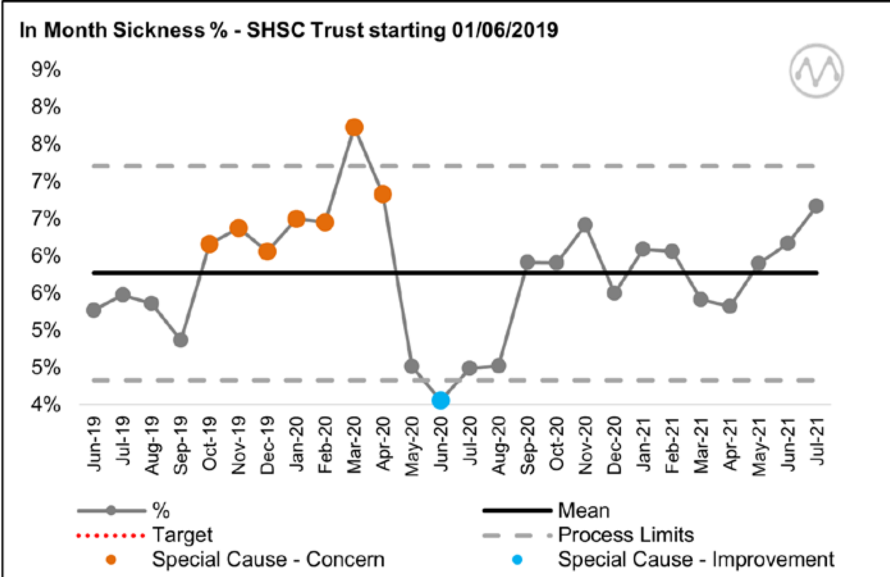
IPQR - Information up to and including July 2021

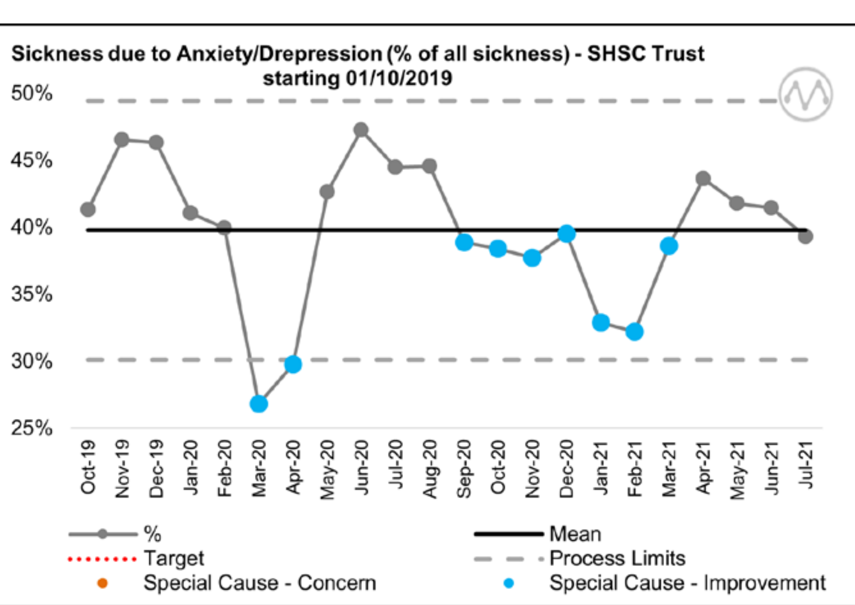
Well-Led | Workforce Summary

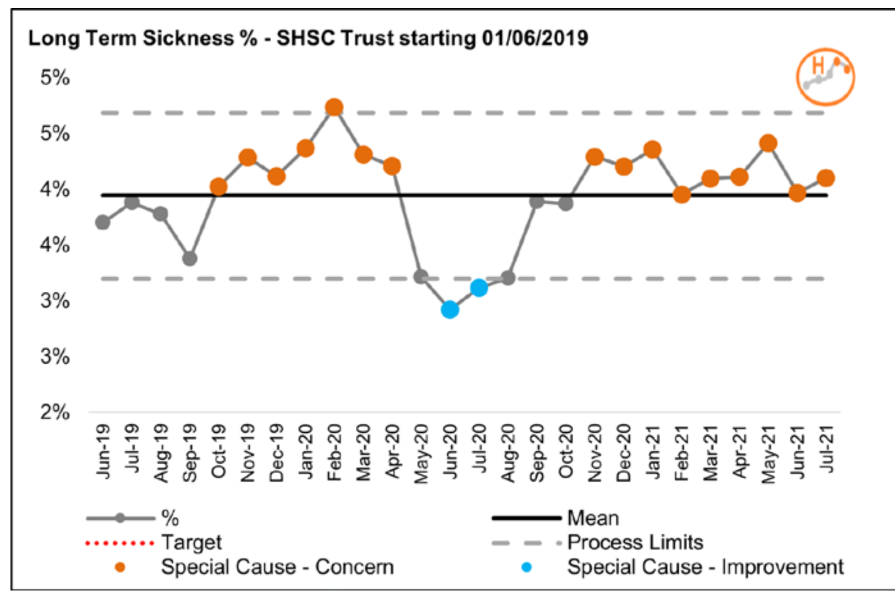
		Directorates			Trust Total		
Indicator	**Target**	**Clinical Services**	**Medical**	**Corporate Services**	**2021 / 07**	**2021 / 06**	**Change**
Staff in Post (Headcount)	**-**	2,024	162	306	**2,514**	**2,521**	**-7**
Staff in Post (FTE)		1,737.06	145.55	289.28	**2,165.12**	**2,171.61**	**-6**
Vacancy (%)		11.2%	12.9%	6.6%	**11.4%**	**12.4%**	**-1.0%**
Turnover 12 months FTE (%)	**10%**	11.09%	6.88%	19.43%	**13.76%**	**13.81%**	**-0.1%**
Sickness In Month (%)	**5.1%**	7.52%	3.98%	3.04%	**6.67%**	**6.17%**	**+0.5%**
Sickness 12 Month (%)	**5.1%**	6.44%	3.00%	3.40%	**5.39%**	**5.63%**	**-0.2%**
Long Term Sickness (%)		4.99%	2.66%	5.61%	**4.10%**	**3.97%**	**+0.1%**
Short Term Sickness (%)		7.52%	3.77%	8.65%	**6.67%**	**6.17%**	**+0.5%**
PDR Compliance (%)	**90%**	97.3%	100.0%	98.6%	**97.5%**	**96.7%**	**+0.8%**
Training Compliance (%)	**80%**	91.0%	89.5%	86.2%	**90.0%**	**90.8%**	**-0.8%**

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 rotation









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

1. **IAPT (20)**
2. **Woodland View (20)**
3. **Birch Avenue (19)**

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

1. **Birch Avenue (10)**
2. **Woodland View (9)**
3. **IAPT (7)**

Top 4 Sickness Absence Reasons July 2021 (No. of occurrences)

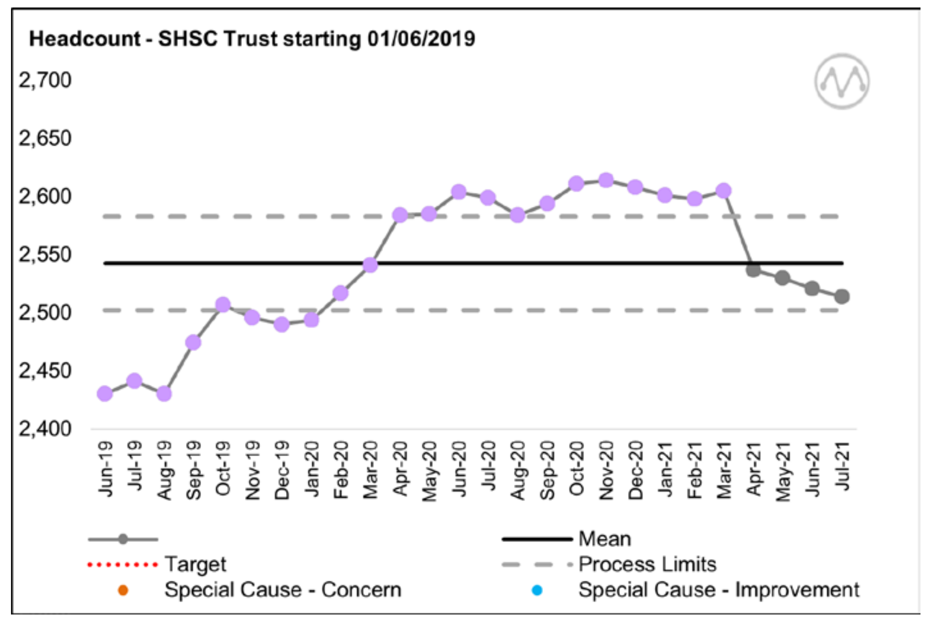
1. Anxiety/stress/depression/other psychiatry illness (111)
2. Gastrointestinal problems (67)
3. Musculoskeletal problems (48)
4. Infectious diseases (47)

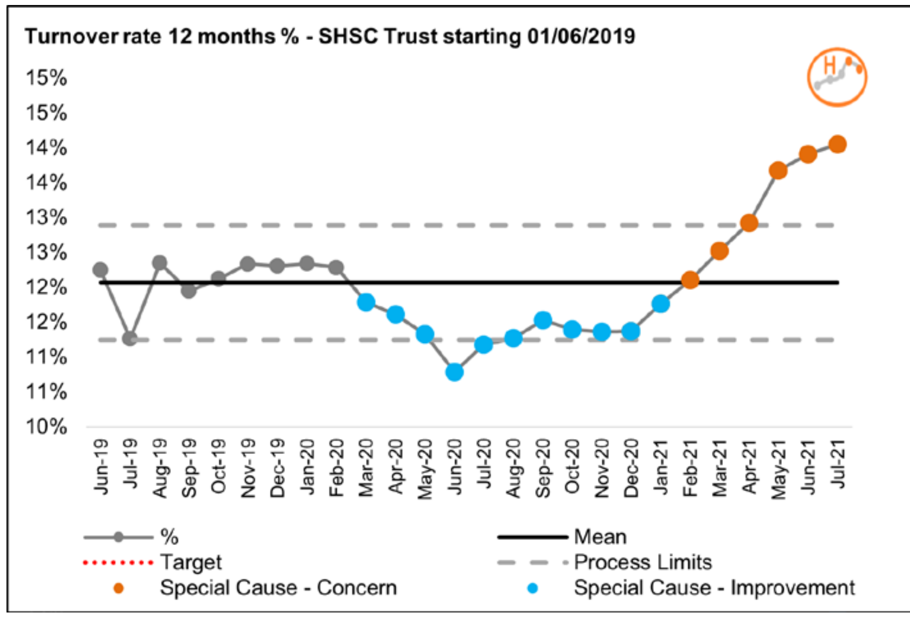
Covid absences

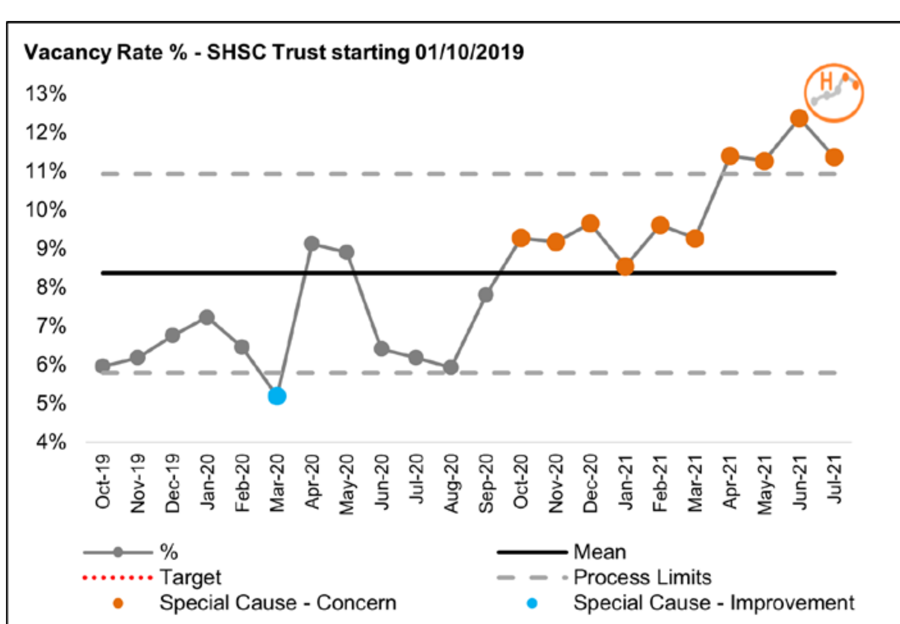
45 in total for July

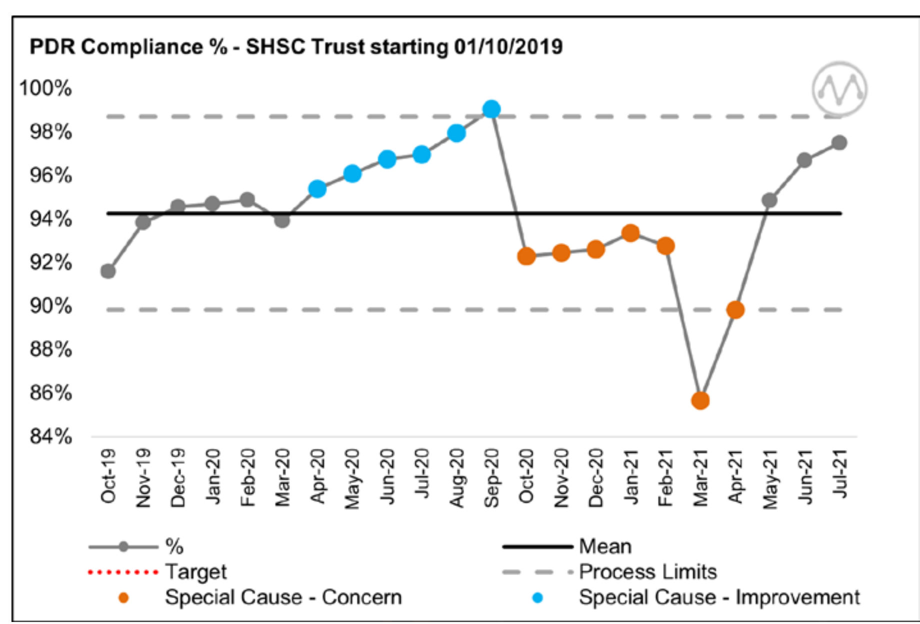
12 of which are still open, of these 7 are longer than 6 months duration

Well-Led | Staffing and PDR Compliance







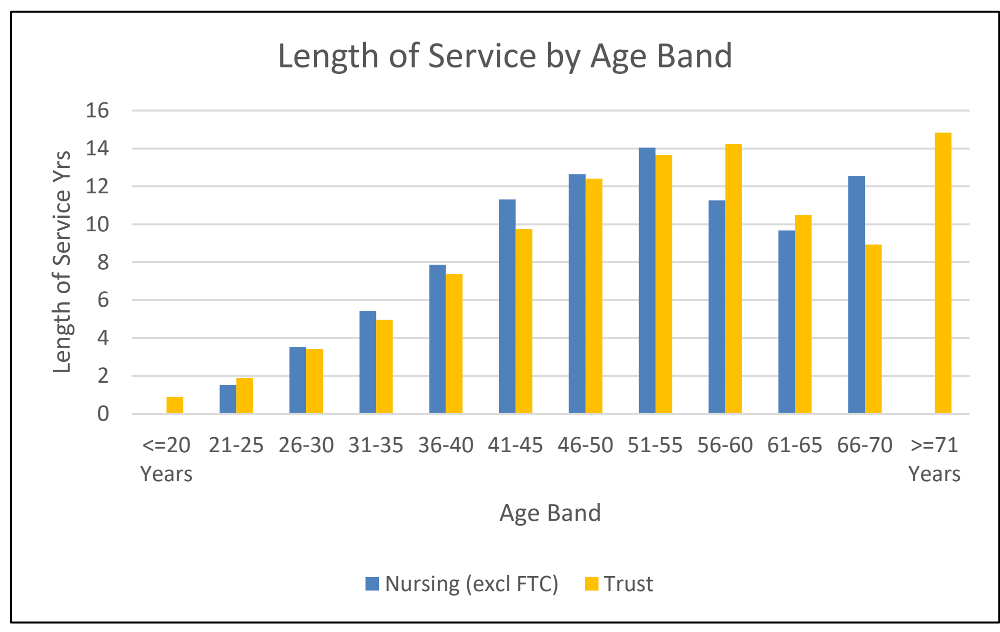


Headcount
The drop of headcount was expected in April due to the GP surgeries TUPE transfer out of the organisation on 1 April 2021.

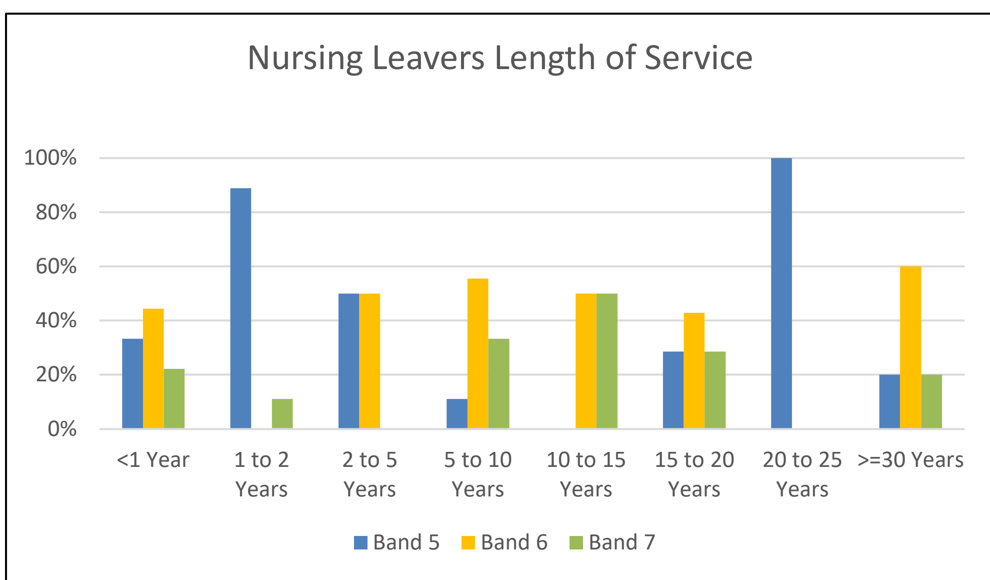
Turnover Rate (%)
The rate is slowing though continues to rise as the new joiner numbers are being offset by the number of leavers.

Vacancy rate (%)
Work is ongoing with Finance, HR and managers to review vacancy data on a more granular level and establish a more accurate way of reporting vacancies

PDR Compliance
All Staff groups are above 95% compliance in July with the largest increase from Estates & Ancillary staff.



- Length of service for Nursing bands 5 – 7 is above the Trust numbers in all age bands except the extremes - newly qualified and those in the retirement bands
- Band 5 leavers make up the majority of leavers up to 5 years service
- Looking at the leaving reasons in the control of the Trust to change (grey highlights of the left hand table below)
  - 76% of band 5 nurse leavers are potentially within the Trust's gift of changing
    - 44% unknown
    - 24% promotion externally
    - 8% work-life balance
  - For the more experienced nurses this potential is progressively less:
    - Band 6 nurses 52%
    - Band 7 nurses 30%
- Destination on leaving for Band 5s is at least 35% to another NHS Organisation, with the Unknown/blank standing at 22%.
- HR is looking at ways to improve the leavers dataset with managers



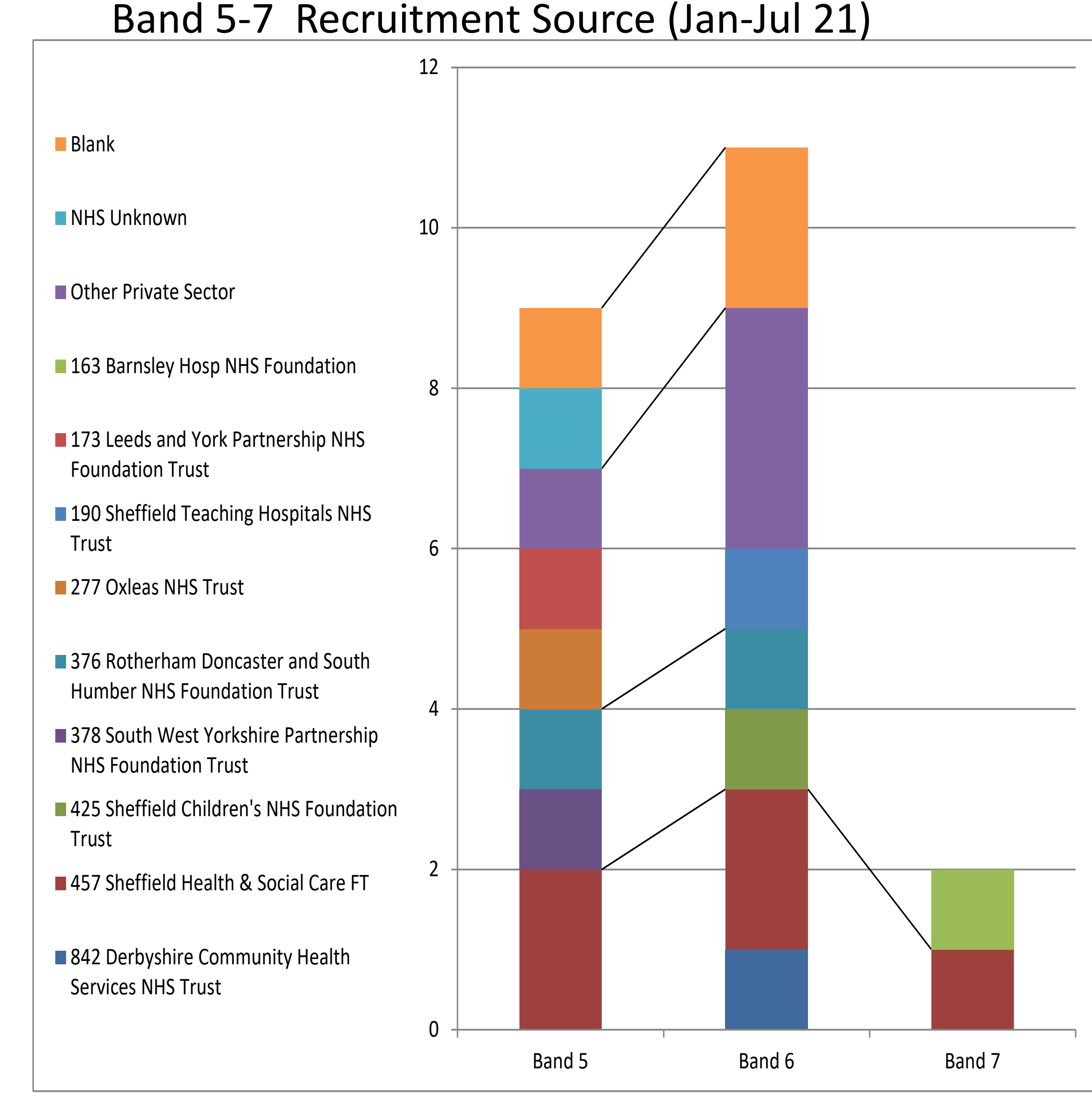
Leaving Reason	Band 5	Band 6	Band 7	Total
Other/Not Known	11	3	1	15
Promotion	6	4		10
Work Life Balance	2	5	2	9
Employee Transfer		4	5	9
Flexi Retirement	1	4	1	6
Retirement Age	1	2	1	4
Relocation	2	1		3
Lack of Opportunities		1		1
Health		1		1
Dismissal	1			1
Death in Service	1			1

Destination on leaving	Band 5	Band 6	Band 7	Grand Total
NHS Organisation	10	9	2	21
Unknown	6	4	2	12
General Practice		5	5	10
No Employment	4	4	1	9
Private Health/Social Care	1	2		3
Other Public Sector	1	1		2
(blank)	1			1
Death in Service	1			1
Social Services	1			1

	Recruitment Source			
Pay band	NHS Organisation	Other Private Sector	(blank)	Grand Total
5	7	1	1	9
6	6	3	2	11
7	2			2

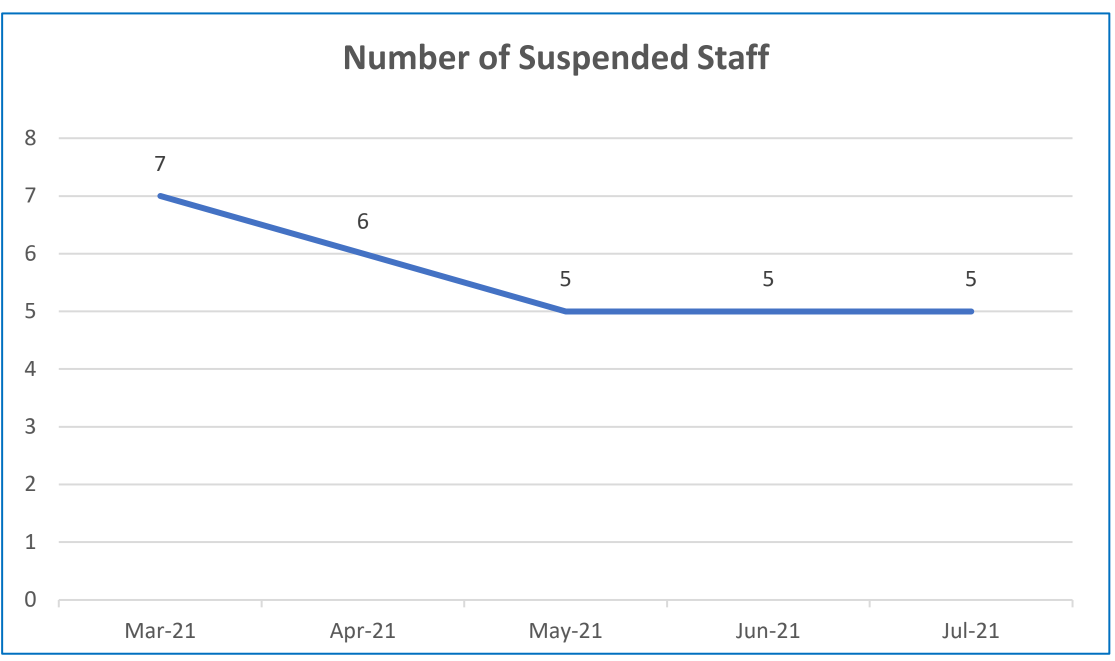
Looking at Recruitment Sources for Band 5 – 7 nurses since January 2021 allows us to see a usual set of data, discounting the Covid recruitment activity of last year.

As expected, most nursing comes from other NHS organisations for all 3 bands, with the vast majority form the local region and surrounding areas. Some data gaps do exist and the data suggests some amount of conversion from bank employment to permanent contract within the Trust itself.



Well-Led | Focus on staff suspension trend

Date	Mar-21	Apr-21	May-21	Jun-21	Jul-21
No. of Suspended Staff	7	6	5	5	5



No new suspensions in place, as at end of July 2021.

The organisation is seeing a downward trend in the number of suspended staff. A new disciplinary policy and SOP is due to be launched over the summer.

Well-Led | Focus on CQC Specific Areas

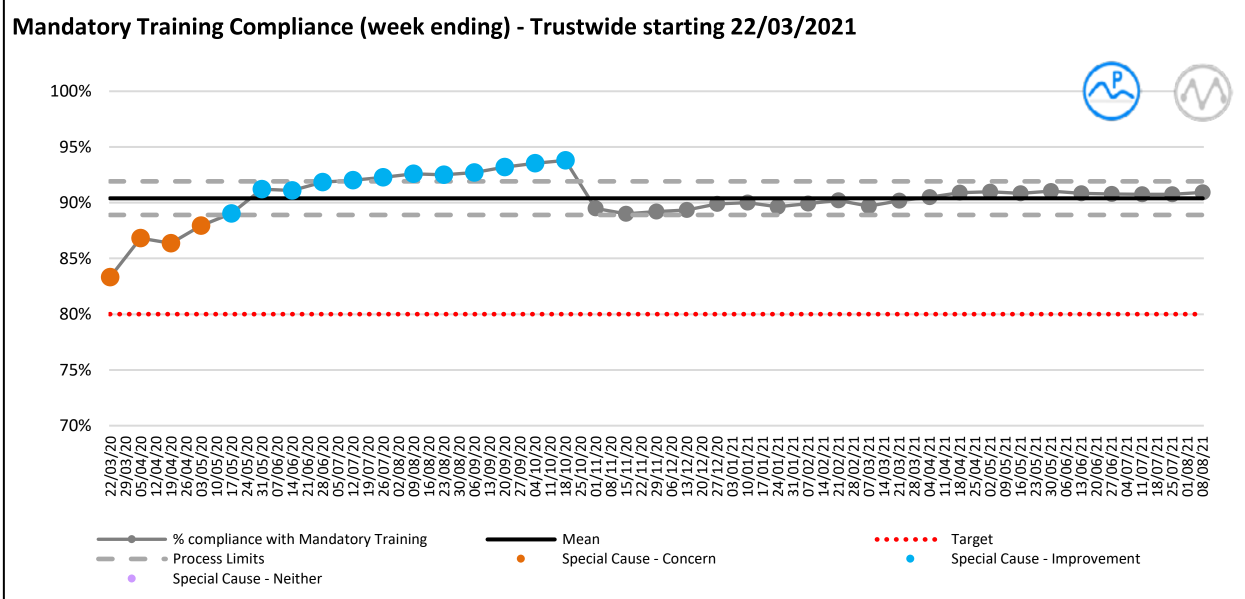
Subject	Date	Endcliffe	Maple	Dovedale	Stanage	Burbage	G1	Birch Avenue	Woodland View	Firshill	Forest Close Central	Forest Close W1	Forest Close W1a	Forest Close W2	Forest Lodge	Wainwright	Recovery North	Recovery South
Moving and Handling Level 1	31/12/2019																	
	25/07/2021																100.00%	93.85%
	08/08/2021																100.00%	93.65%
Moving and Handling Level 2 (People)	31/12/2019																	
	25/07/2021	78.95%	94.29%	86.36%	83.87%	65.71%	93.75%	95.08%	70.31%	96.15%	100.00%	96.15%	100.00%	100.00%	76.32%	100.00%		
	08/08/2021	77.14%	91.89%	86.05%	83.87%	66.67%	90.91%	95.08%	70.31%	95.83%	100.00%	96.15%	100.00%	100.00%	75.68%	100.00%		
DOLs Level 2	31/12/2019	80%	29%	75%	80%	43%	36%	14%	56%	38%	67%	67%	100%	50%	50%			
	25/07/2021	85.71%	87.50%	100.00%	60.00%	85.71%	100.00%	92.86%	85.71%	100.00%	100.00%	83.33%	100.00%	100.00%	100.00%			
	08/08/2021	83.33%	87.50%	100.00%	60.00%	83.33%	100.00%	92.86%	92.86%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
Safeguarding Children L2	31/12/2019																88%	70%
	25/07/2021																100.00%	86.36%
	08/08/2021																100.00%	89.47%
Domestic Abuse	31/12/2019																73%	83%
	25/07/2021																90.91%	80.95%
	08/08/2021																92.73%	81.36%
MCA Level 2	31/12/2019		81%														60%	76%
	25/07/2021		91.30%														100.00%	87.80%
	08/08/2021		88.00%														100.00%	87.50%
Info Gov	31/12/2019		71%														67%	70%
	25/07/2021		91.84%														98.28%	84.62%
	08/08/2021		96.08%														98.36%	84.13%
Clinical Risk	31/12/2019		85%															
	25/07/2021		87.50%															
	08/08/2021		84.62%															
Fire 2 Year	31/12/2019		75%															
	25/07/2021		97.96%															
	08/08/2021		96.08%															
Respect Level 2	31/12/2019		94%												94%			
	25/07/2021		85.00%												93.75%			
	08/08/2021		85.00%												93.33%			
Respect Level 3	31/12/2019		88%															
	25/07/2021		89.66%															
	08/08/2021		83.87%															
Mental Health Act	31/12/2019		71%															
	25/07/2021		92.86%															
	08/08/2021		87.50%															
Basic Life Support	31/12/2019																65%	70%
	25/07/2021																98.28%	89.23%
	08/08/2021																98.36%	92.06%
ILS	31/12/2019														71%			
	25/07/2021														86.67%			
	08/08/2021														86.67%			

CQC focus topics and areas
Cells in red indicate less than 80% compliance

Areas of Concern
Slippage or no improvement since previous reporting period 2 weeks prior

Moving & Handling Level 2
- Endcliffe
- Woodland View
- Forest Lodge

Deprivation of Liberty Level 2
- Stanage



NB – Chart above plots compliance rate fortnightly as at the last Sunday in the fortnight, from week ending 22/3/21.

AIM

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

NARRATIVE Week ending 08/08/21

Trustwide compliance 90.92%

Staff compliance 85.04% of staff are 80% compliant or above

EXCEPTIONS

Subjects Below 80%

Respect Level 2

Services Below 80%

PGME Sheffield 76.54%

Grenoside Facilities 74.38%

Sheffield Health and Social Care Mandatory Training Compliance @

08 August 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%

Subject	Level	Frequency	No Requiring	No Achieved	No NOT Achieved	Compliance	Current Compliance against Previous Compliance %	
			08 August 2021					
Equality, Diversity and Human Rights		3 Years	2613	2436	177	93.23%	Decrease	-0.13%
Hand Hygiene		3 Years	2613	2427	186	92.88%	Increase	0.29%
Health and Safety		3 Years	2613	2479	134	94.87%	Increase	0.03%
Information Governance (aka Data Security Awareness)		1 Year	2613	2362	251	90.39%	Decrease	-0.06%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2613	2473	140	94.64%	Decrease	-0.12%
Adult Basic Life Support		1 Year	2613	2305	308	88.21%	Increase	0.55%
Fire Safety		2 Years	1286	1103	183	85.77%	Increase	0.10%
		3 Years	1301	1248	53	95.93%	Increase	0.20%
Immediate Life Support		1 Year	237	193	44	81.43%	Decrease	-2.04%
Clinical Risk Assessment		3 Years	1021	896	125	87.76%	Decrease	-0.24%
Dementia Awareness		No Renewal	2613	2488	125	95.22%	Increase	0.87%
Autism Awareness		No Renewal	2613	2496	117	95.52%	Increase	0.72%
Mental Capacity Act	1	3 Years	1074	904	170	84.17%	Decrease	-0.84%
	2	3 Years	1151	1029	122	89.40%	Increase	0.82%
Deprivation of Liberty Safeguards	1	3 Years	2122	1955	167	92.13%	Decrease	-0.40%
	2	3 Years	113	105	8	92.92%	Increase	3.27%
Mental Health Act		3 Years	183	152	31	83.06%	Decrease	-0.72%
Medicines Management Awareness		3 Years	547	461	86	84.28%	Decrease	-0.09%
Rapid Tranquilisation		3 Years	293	256	37	87.37%	Decrease	-1.02%
Respect	1	3 Years	1212	1067	145	88.04%	Increase	0.66%
	2	2 Years	825	562	263	*68.12%*	Decrease	-1.31%
	3	1 Year	367	313	54	85.29%	Decrease	-0.20%
Safeguarding Children	2	3 Years	1119	1030	89	92.05%	Increase	0.34%
	3	3 Years	1114	929	185	83.39%	Decrease	-0.46%
Safeguarding Adults	2	3 Years	2233	2039	194	91.31%	Increase	0.33%
Domestic Abuse	2	3 Years	2238	1992	246	89.01%	Increase	0.48%
Prevent WRAP		3 Years	2233	2051	182	91.85%	Increase	0.43%
Moving and Handling	1	3 Years	2613	2469	144	94.49%	Increase	0.26%
	2	3 Years	702	591	111	84.19%	Decrease	-0.45%
Overall compliance						**90.92%**	Increase	0.17%

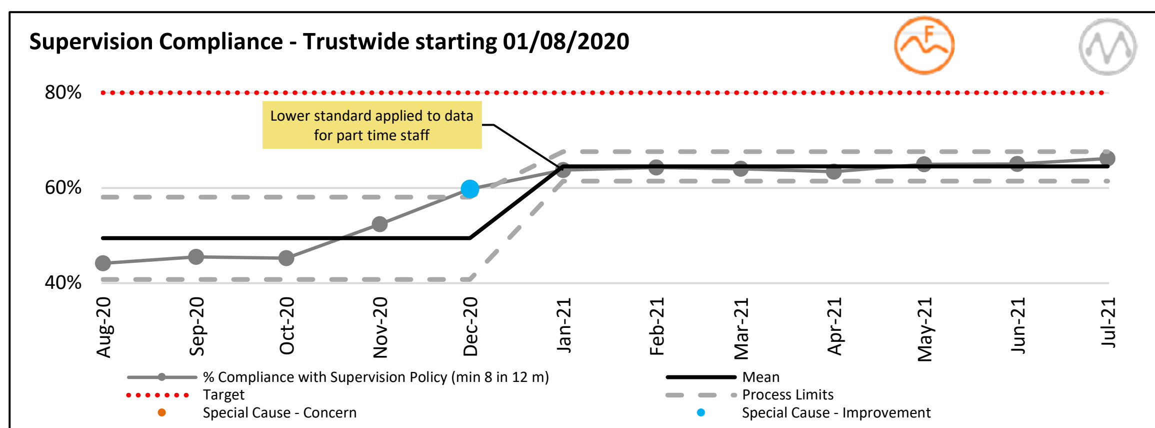
Mandatory Training

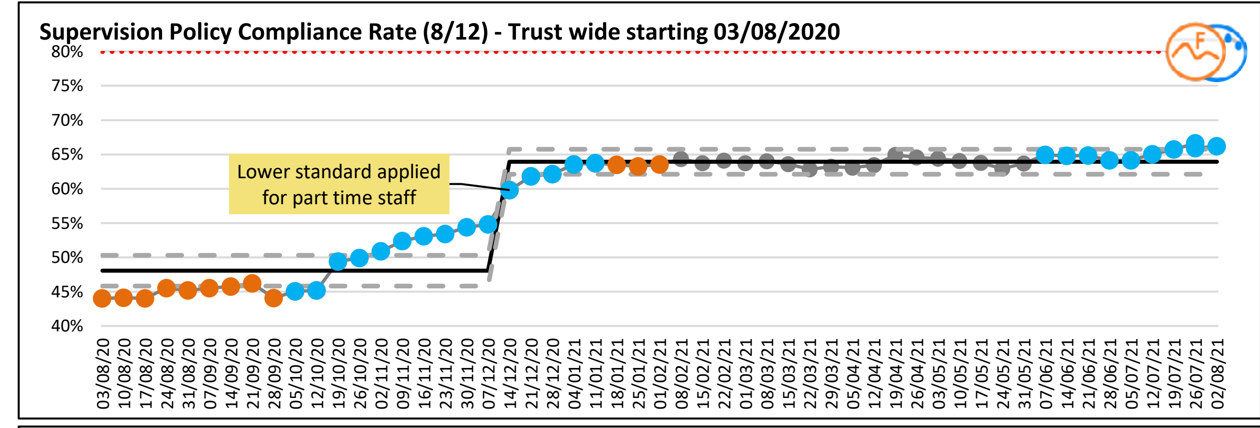
Area Specific data for CQC	The December figures have been included as this was first data for CQC, this will help set a benchmark to measure improvements. Greyed out cells data has not been pulled as part of this table. Figures are highlighted in red if they are under 80%																	
Subject	**Date**	Endcliffe	Maple	Dovedale	Stanage	Burbage	G1	Birch Avenue	Woodland View	Firshill	Forest Close Central	Forest Close W1	Forest Close W1a	Forest Close W2	Forest Lodge	Wainwright	Recovery North	Recovery South
Moving and Handling Level 1	31/12/2019																	
	25/07/2021																100.00%	93.85%
	08/08/2021																100.00%	93.65%
Moving and Handling Level 2 (People)	31/12/2019																	
	25/07/2021	78.95%	94.29%	86.36%	83.87%	65.71%	93.75%	95.08%	70.31%	96.15%	100.00%	96.15%	100.00%	100.00%	76.32%	100.00%		
	08/08/2021	77.14%	91.89%	86.05%	83.87%	66.67%	90.91%	95.08%	70.31%	95.83%	100.00%	96.15%	100.00%	100.00%	75.68%	100.00%		
DOLs Level 2	31/12/2019	80%	29%	75%	80%	43%	36%	14%	56%	38%	67%	67%	100%	50%	50%			
	25/07/2021	85.71%	87.50%	100.00%	60.00%	85.71%	100.00%	92.86%	85.71%	100.00%	100.00%	83.33%	100.00%	100.00%	100.00%			
	08/08/2021	83.33%	87.50%	100.00%	60.00%	83.33%	100.00%	92.86%	92.86%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
Safeguarding Children L2	31/12/2019																88%	70%
	25/07/2021																100.00%	86.36%
	08/08/2021																100.00%	89.47%
Domestic Abuse	31/12/2019																73%	83%
	25/07/2021																90.91%	80.95%
	08/08/2021																92.73%	81.36%
MCA Level 2	31/12/2019		81%														60%	76%
	25/07/2021		91.30%														100.00%	87.80%
	08/08/2021		88.00%														100.00%	87.50%
Info Gov	31/12/2019		71%														67%	70%
	25/07/2021		91.84%														98.28%	84.62%
	08/08/2021		96.08%														98.36%	84.13%
Clinical Risk	31/12/2019		85%															
	25/07/2021		87.50%															
	08/08/2021		84.62%															
Fire 2 Year	31/12/2019		75%															
	25/07/2021		97.96%															
	08/08/2021		96.08%															
Respect Level 2	31/12/2019		94%												94%			
	25/07/2021		85.00%												93.75%			
	08/08/2021		85.00%												93.33%			
Respect Level 3	31/12/2019		88%															
	25/07/2021		89.66%															
	08/08/2021		83.87%															
Mental Health Act	31/12/2019		71%															
	25/07/2021		92.86%															
	08/08/2021		87.50%															
Basic Life Support	31/12/2019																65%	70%
	25/07/2021																98.28%	89.23%
	08/08/2021																98.36%	92.06%
ILS	31/12/2019														71%			
	25/07/2021														86.67%			
	08/08/2021														86.67%			

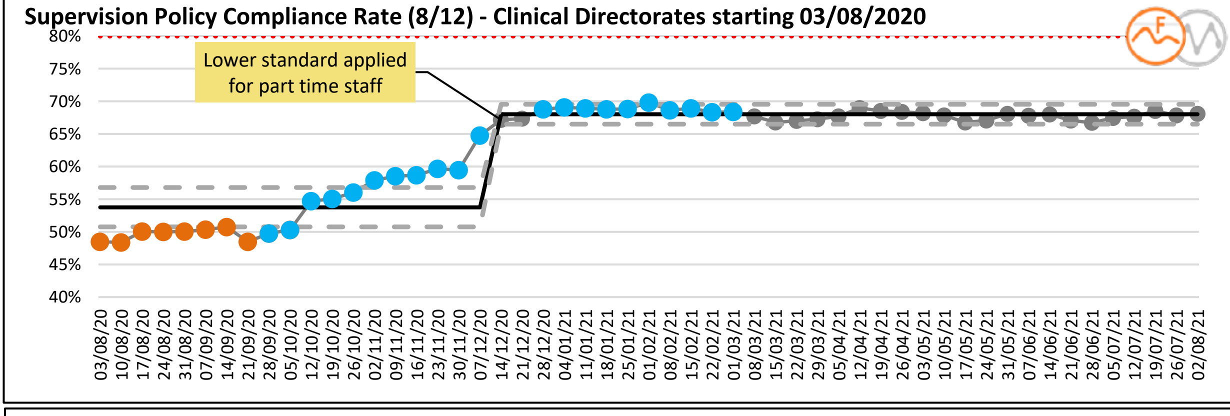
Subject	**Date**	Recovery North	Recovery South	CERT	Early Intervention	Adlt Hm Tr
Community Mental Health Act	25/07/2021	95.35%	92.00%	91.89%	89.19%	93.55%
	08/08/2021	95.24%	91.49%	86.49%	89.19%	93.33%

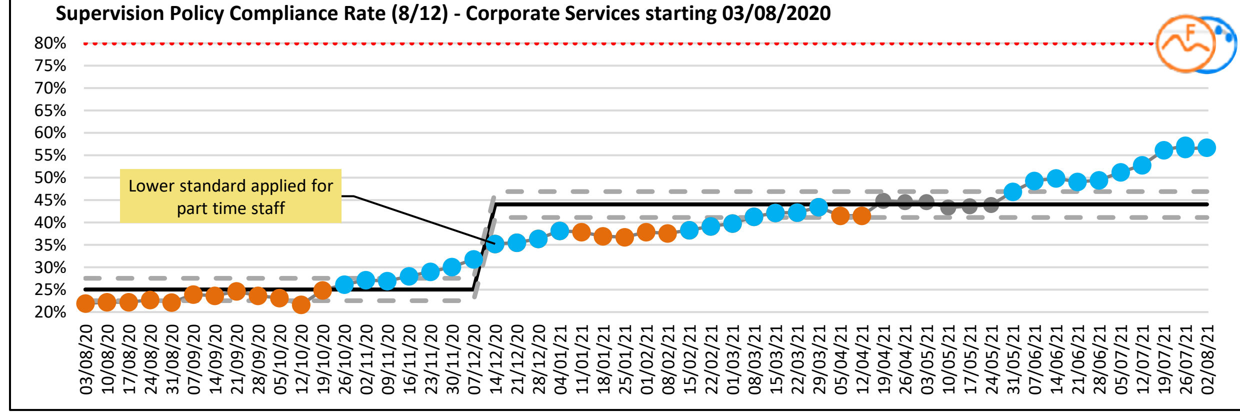
Narrative (from June 21)

- Figures below 80% indicates poor compliance level
- Of concern are those depts and topics where progress has stalled or dipped over the past 2 weeks:
- Moving and Handling Level 2 (People)
  - Endcliffe
  - Burbage
  - Woodland View
- Deprivation of Liberty (DOLS) Level 2
  - Stanage
  - Burbage
- Information Governance
  - Recovery South









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 beginning 1 August 2021, average compliance with the 8/12 target is:

Trustwide	**66.19%**
Clinical Services	**68.10%**
Corporate Services	**56.71%**

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 updated information is published in the Trust Improvement Dashboard and monitored and reviewed weekly by Directors and Service Leads. Improvement plan in START (R&S) is already having significant impact with improved rates.

Financial Performance

IPQR - Information up to and including July 2021

Well-Led | Financial Overview

PERFORMANCE INDICATORS			
		Annual Plan	Year to Date
		£000s	£000s
1	Reported Surplus/ (Deficit) Position	0	1,636
2	Covid-19	6,596	681
3	Agency	2,619	1,798
4	Cash	64,483	63,084
4	Efficiency Savings	3,028	767
5	Capital	8,584	1,344
6	Better Payments Practice Code (BPPC) - % of bills paid in target	by number	99.1%
		by value	99.5%

NARRATIVE

The position at Month 4 (M4) is a surplus of £1,636k. This is the surplus after technical accounting adjustments. The in-month reported surplus of £379k is in line with M1-M3 run rate.

Previously reported drivers regarding Mental Health Investment Standard (MHIS) expenditure slippage and Covid underspend continue to influence the year-to-date bottom line. Continued overspends on Out-of-Area (OOA) commissioned beds is the third significant influencer in the M4 position.

MHIS funding has been flat profiled (equal 12ths) in the Plan, although recruitment activity is ramping up steadily as the year progresses. The £825k YTD underspend is forecast to be absorbed in H2.

Covid-19 YTD underspend of £1.5m at Month 4 is consistent with a continuing monthly underspend of circa £380k/mth within this financial year. The H1 out-turn position is forecast to be circa £2m underspend.

Year to date OOA placement costs of £2.2m are £1.1m higher than plan and offset some of the gains in MHIS slippage and Covid underspend.

The Trust has reported a forecast surplus for H1 of £1.2m, a £500k increase on M3's forecast out-turn of £0.7m. This has potential to grow further (up to £2m), if no further investments are made.

The Trust continues to work alongside commissioners to invest slippage in priority non-recurrent improvement projects. This includes digital, IMST and environmental works of an estate nature. We are also anticipating some extraordinary exit costs and further increases in OOA costs linked to ward closures. Procurement activities continue to secure capacity for 12 additional beds for 12 months from August 2021.

The Trusts' Cash position remains strong and the Capital Programme continues to progress with slippage (£920k) relating mainly to the expanded scope of dormitory works. Forecast spend at present remains in line with plan at £8,584k.

Covid-19

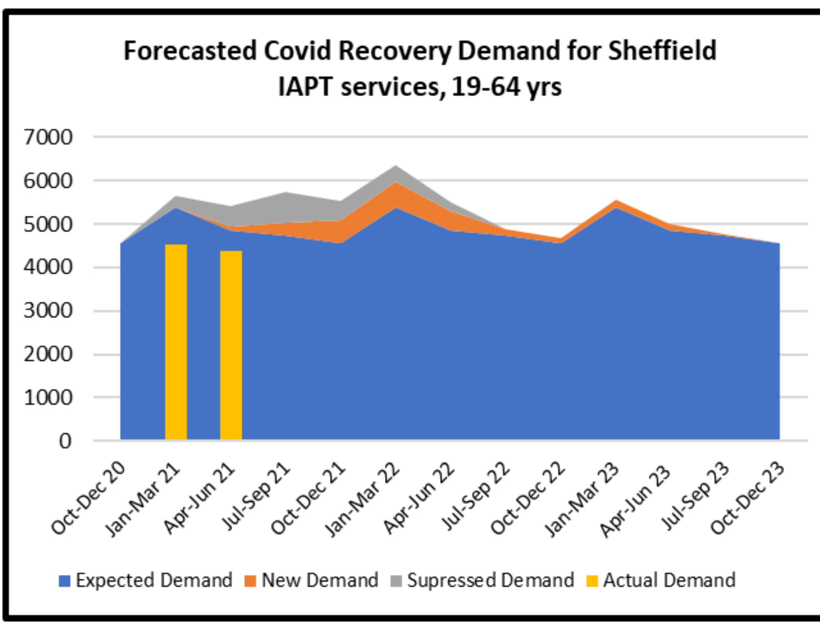
IPQR - Information up to and including July 2021

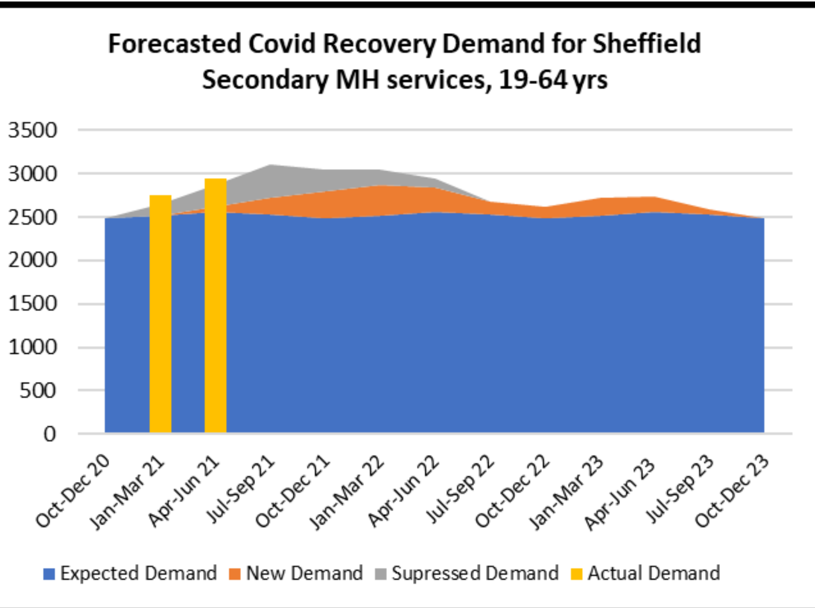
Covid-19 Outbreaks
There have been no outbreaks in the Trust in July 2021.
Inpatients with Covid-19
There have been no inpatients with Covid-19 during July 2021.
Covid-19 Deaths
No deaths of service users due to Covid-19 were reported in July 2021.
Covid-19 Related Staff Absence
As at 31 July 2021, staff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

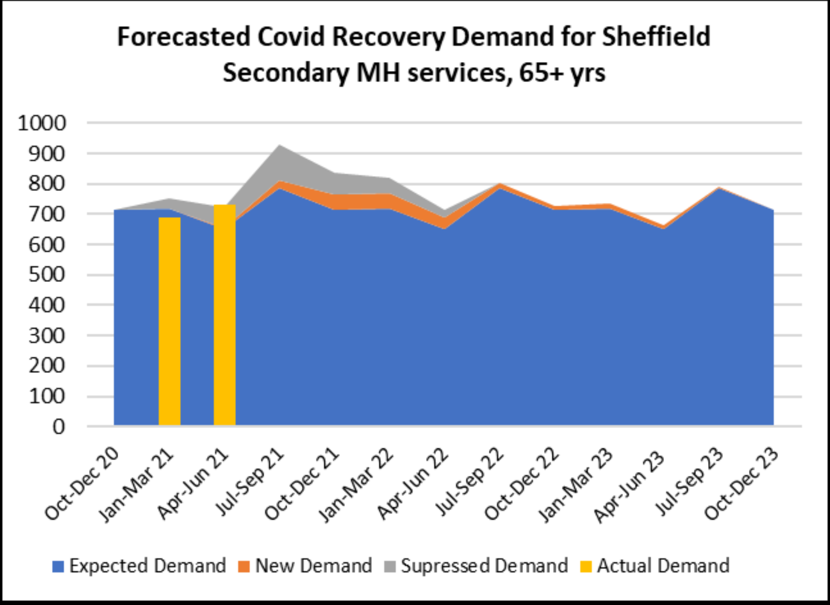
Staff Vaccination (as at week commencing 2nd August 2021)
The primary data sources for the reports below are the National Immunisation Management System (NIMS) Reporting and our Electronic Staff Record (ESR). NIMS Reporting should include the vast majority of vaccination records for our staff, no matter 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.

	Total	% of total	Priority staff	Non-priority staff
Staff records	3060	100%	2664	396
Staff matched to at least one vaccination record	2768	90.5%	2403	365
Staff matched to two vaccination records	2666	87.1%	2312	354
Staff that could not be matched due to missing NHS number	63	2.1%	55	8
Staff that have either not received at least one vaccination dose or whose NHS number is missing from their vaccination record(s)	292	9.5%	261	31

	Not yet vaccinated		Received first dose only		Received both doses	
	Employee Count	%	Employee Count	%	Employee Count	%
457 Clinical Operations (L3)	170	8.4%	50	2.5%	1805	89.1%
457 Acute and Community Services (L4)	99	9.6%	28	2.7%	900	87.6%
457 Rehabilitation & Specialist Services (L4)	64	7.8%	19	2.3%	736	89.9%
457 Medical (L3)	12	6.5%	6	3.2%	167	90.3%
457 Corporate Services (L3)	57	9.9%	29	5.0%	491	85.1%
457 Chair/Chief Exec Office (L4)	2	8.3%		0.0%	22	91.7%
457 Director of Finance (L4)	4	5.3%	3	3.9%	69	90.8%
457 Nursing & Professions (L4)	4	8.9%	2	4.4%	39	86.7%
457 People Directorate (L4)	41	12.0%	21	6.1%	280	81.9%
457 Special Projects (L4)	6	7.0%	3	3.5%	77	89.5%
457 Reg Nurse Degree Apprentices (017414)		0.0%		0.0%	4	100.0%
Volunteers (L3)	2	13.3%		0.0%	13	86.7%
Agency Staff (L3)	36	22.5%	12	7.5%	112	70.0%
Locum Doctors (L3)		0.0%		0.0%	6	100.0%
Medical Students (L3)	14	19.7%	1	1.4%	56	78.9%
Student Nurses (L3)	1	4.8%	4	19.0%	16	76.2%
Grand Total	292	9.5%	102	3.3%	2666	87.1%







Narrative

Forecasting work has been taking place across the region and the country, with South Yorkshire & Bassetlaw ICS choosing to use a demand modelling tool developed by South West Yorkshire Partnerships FT (SYWFT). The forecasting uses prevalence data, historical demand data (referrals) from each organisation and estimates of suppressed demand to forecast what the impact of the covid pandemic may have on future demand for services.

The charts above show the forecasted modelled demand for SHSC on that basis. We have used referrals to services 2019/20 as baseline for expected demand:

- IAPT – referrals to IAPT (all ages)
- Secondary MH (18-64) – referrals to SPA
- Secondary MH (65+) – referrals to Older Adult CMHT

Work is still ongoing within the Trust and the ICS to refine and improve the modelling, including scrutiny and challenge from clinical service leads. We will continue to overlay the actual number of referrals at each quarter end.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

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:

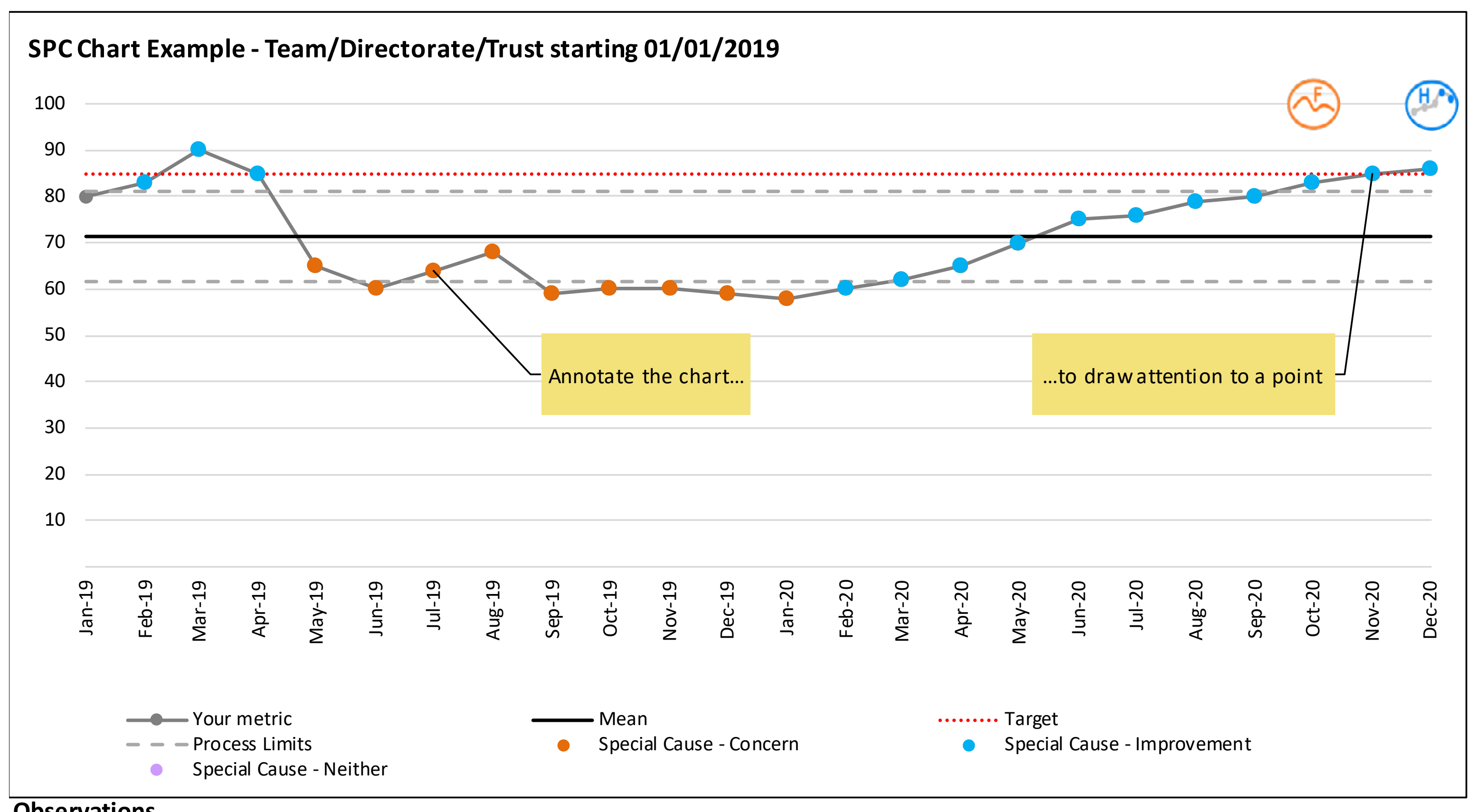
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	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		?	H	L	H	L	?	F	P
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

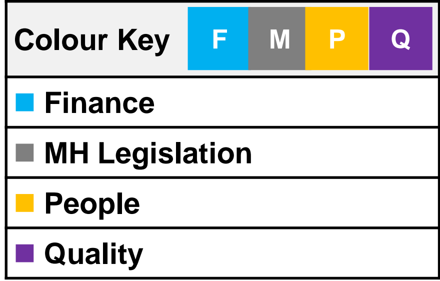
Based on the data from latest calculation date (data point 1 - 01/01/19).

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.

Appendix 3 | Board Committee KPIs

KPI	Slide/ Page	Committee Oversight
Access & Demand | Referrals	5	Finance/ Quality
Access & Demand | Community Services	6	Finance/ Quality
Inpatient Wards | Adult Acute and Step Down	7	Finance/ Quality
Inpatient Wards | PICU	8	Finance/ Quality
Inpatient Wards | Older Adult	9	Finance/ Quality
Inpatient Wards | Rehabilitation & Forensic	10	Finance/ Quality
Inpatient Wards | Learning Disabilities	11	Finance/ Quality
Effective | Treatment & Intervention	12	Finance/ Quality
IAPT	13	Finance/ Quality
START	14-15	Finance/ Quality
Safe | All Incidents	17	Quality
Safe | Medication Incidents & Falls	18	Quality
Safe | Assaults, Sexual Safety & Missing Patients	19	Quality
Safe | Deaths	20	Quality
Safe | Restrictive Practice | Physical Restraint	21	Quality/ MH Legislation
Safe | Restrictive Practice | Rapid Tranquillisation	22	Quality/ MH Legislation
Safe | Restrictive Practice | Seclusion	23	Quality/ MH Legislation
Caring | User Experience	24	Quality

KPI	Slide/ Page	Committee Oversight
Well-Led | Our People | Workforce Summary	26	People
Well-Led | Our People | Sickness Absence	27	People
Well-Led | Our People | Staffing	28	People
Well-Led | Our People | Mandatory Training	29-30	People
Well-Led | Our People | Supervision	31	People
Well-Led | Financial Performance | Overview	33	Finance
Well-Led | Covid 19 Response	35	Quality
Well-Led | Covid 19 Demand Impact	36	Finance/ Quality



Colour Key F M P Q
Finance
MH Legislation
People
Quality

Blue Underlined Text = Click to link to slide/page