Board of Directors - Public

SUMMARY	Meeting Date:	24 November 2021
	Agenda Item:	9

Report Title:	**Integrated Performance and Quality Report (IPQR) September 2021**	
Author(s):	Tania Baxter, Head of Clinical Governance and Risk Deborah Cundey, Head of Performance	
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:	9 November 2021 10 November 2021 11 November 2021
Key Points recommendations to or previously agreed at:	**Risks** • No new risks were presented for the attention of any Committees or Board. The known areas of risk/concern for the attention of the Board are: • Demand for services at all access points • Community Waiting Times • 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. • Compliance with annual CPA reviews • Inpatient Delayed Transfer of Care (DToC) and extended length of stay/Inappropriate Out of Area placements The focus of the concern is illustrated in the summary below, together with the mitigating factors and required improvements. The Board is asked to note the following areas of positive performance or improvement: • Out of Area placements in Rehab (p10) - Currently all Out of Area rehab admissions are deemed appropriate as they are providing a specialist placement that Forest Close is not able to. At the end of September 2021 there were 6 patients OOA which exceeds the ambition of reducing those placements to 7 by October. Expected discharge dates for the six placements are in place and the service continues to focus on appropriate repatriation where possible.	

	• IAPT (p13) – meeting 3 of their 4 targets in September for the first time since June 2021, (usually meeting 2 out of 4) and Moving to Recovery target with sustained focus. • Incidents (p17) - Continued reduction in the number of unreviewed incidents in Clinical Directorates attributed to an effective process and maintained focus. • Reducing Restrictive Practice (p21-23) - Stanage Ward and G1 have reported very low restrictive practice incidents during September and are showing a downward trend, as a result of the excellent engagement of staff in the reducing restrictive practice work underway. **Committee Recommendations** **People Committee** • Noted the concerns re workforce data (capacity and systems) **Quality Assurance Committee** The committee reviewed the three deep dive areas as they continue to be risks within the IPQR and noted: • Assurance of improvement re G1 • Received assurance that the right processes are in place re Nursing medication to support improvement, but that outcomes had not yet been seen/ evidenced. • The committee was assured that the Community service transformation plans have traction and a clear trajectory. Recognising the risk of waiting lists remain and transformation will address them. **Finance and Performance Committee** • Noted overdue action around Equality, Diversion & Inclusion metrics and the action agreed was for plan including timescales for next developments.

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 September 2021. The report was presented and considered in detail to the Quality Assurance Committee and Finance and Performance Committee in October. For each issue, the risk was explored, and the paper offered mitigations. **Risks Reported** **1 Demand for Services – known risk** No Targets (See page 5) **Issue**: This risk was first reported in April 2021. We continue to experience high levels of demand for access points, in many cases exceeding pre-Covid levels of referrals. Increased demand compounds the challenge of being able to reduce waiting times for services. We are seeing a similar across some specialist services too, with demand and capacity to meet demand in the SAANS and Gender Identity service a particular issue, this being more of a contracting issue.

Mitigation: Increased demand is being raised to commissioners and the Clinical Directorate leadership continue to consider necessary mitigations. Service Recovery Plans for waiting times take the historic, current and predicted demand into account. Transformation plans underway for the core community services will impact the waits.

2 Community Waiting Times – known risk Targets: Varying local and national

(See page 6)

Issue: This risk was reported in February 2021. Some community services have an unacceptable waiting time for people to access assessment and treatment. This report includes a number of metrics for community services previously missing, notably Learning Disability, Rehab & Forensic Community Teams and some Highly Specialist Services. All waiting times have plans to address, impact is being seen in specialist psychotherapy and personality disorders. Significant improvements in SPA / EWS and Recovery Services is expected as the community transformation plan continues to be implemented. Highly specialist services delays are related to commissioned service not meeting need in the context of ongoing growth in demand.

Mitigation: Recovery Plans for unacceptable waiting times were provided and discussed at March 21 Quality Assurance Committee. An updated Recovery Plan for SPA/EWS and Recovery Service waits will be presented to the Finance and Performance Committee in November 2021, and the updated recovery plans for specialist services including SAANS were received at October 2021 Quality Assurance Committee. Service transformation plans will impact on this poor performance with phased implementation underway.

3 Community Estates concerns (Specialist Services) – known risk

Issue: First reported in September 2021. 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 issue impacts on service delivery and quality of care. One impact is 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: Estates has now commissioned work to identify alternative accommodation based on the needs analysis carried out with the teams currently using St George's. Additional temporary clinical space has been identified within the Trust that is supporting the service to maintain activity.

4 Delayed transfers of care – known risk

(See pages 7-11 Inpatient Wards)

Issue: First reported in August 2021. We continue our focus 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 care (DC).

A risk caused by DC is that we cannot achieve steady '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.

Throughout September 2021 DCs were recorded on Insight as follows:

	Number of delayed patients	Number of bednights delayed
Adult Acute	4	116
Endcliffe	1	30
G1	9	187
Forest Close	2	44

Mitigation: All people have individual plans of care that are reviewed. There is management oversight of all DToCs 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.

5 CPA Reviews – known risk

(See page 12)

Issue: Historical risk for many years. There is persistent under performance against an annual review of care under the CPA Framework, particularly in Recovery Services and CPA reviews have dropped considerably in Recovery South. This coincides with gap in service manager appointment and 3 maternity leave absences over the previous 2 months. EIP performance has plateaued just under target which can be attributed to a significant level of sickness absence in the service.

There are delays in amendments to Insight to capture the new ways of working with CPA and care review.

To be noted is the absence of a target in 21/22 as reference to CPA is removed from the standard NHS contract (see NHS England Position Statement).

Mitigation: Targeted work is taking place to bring Early Intervention back on track.
A recovery plan is in place to address the low performance in the recovery teams and although an increase has been achieved from last month the service acknowledges that the improvement needs greater pace. In addition to the recovery plan actions, both teams have since set individual workers a target to achieve outstanding reviews within the next month. This has been framed as a management instruction and will be monitored on a weekly basis.

6 Acute Wards and Out of Area Placements (OOA) – known risk/improvement

(See page 7) National Target: Zero inappropriate OOA placements

Issue: A lack of available beds results in people being placed 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 transfer of care. We have also needed to close admissions to older peoples wards during outbreaks of Covid which has led to admissions OOA which is unusual for this service.

A sustained focus on the avoidance of inappropriate out of area admission continues as we work towards the eradication of out of area placements as per Long Term Plan ambitions by March 22. The procurement of the 6 female beds at Cygnet Chesterfield, and 6 male beds at Elysium Surrey has positively impacted on the numbers we are placing out of area, however Estates works at Michael Carlisle and Longley Centre mean that we continue to reduce internal beds capacity.

At 30 September we reported a total of 16 service users placed inappropriately in OOA beds, which does not support our improvement trajectory. There is a continued reduction in out of area PICU placements. There have been Older Adults placed out of area in August and September 2021 as a result of closures due to covid and staffing difficulties. The table on page 7 of the IPQR and copied below shows regional performance.

Provider	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Sparklines
Tees, Esk and Wear Valleys NHS Foundation Trust	16	27	20	26	30	40	
Bradford District Care NHS Foundation Trust	19	24	22	17	25	25	
Humber NHS Foundation Trust	21	21	18	16	21	16	
Sheffield Health and Social Care NHS Foundation Trust	**22**	**18**	**23**	**13**	**11**	**16**	
Leeds and York Partnership NHS Foundation Trust	2	11	12	16	9	14	
South West Yorkshire Partnership NHS Foundation Trust	5	8	6	5	13	12	
Rotherham Doncaster and South Humber NHS Foundation Trust	2	7	9	17	13	8	
Cumbria Northumberland, Tyne and Wear Partnership NHS FT	0	0	0	1	2	5	
Navigo (NE Lincs/Grimsby)	1	0	0	0	0	3	

Mitigation: A recovery plan is in place and a progress report will be provided to the Finance and Performance Committee in November 2021. An important part of this plan is ensuring we are addressing all delayed transfers of care and ensuring system support.

7 CIP Delivery – known risk

Issue: CIP performance, whilst improving to £471K (16%) recurrently identified, significant recurrent gaps in plans remain.

Mitigation: CIP recovery plans need developing further, current processes are not impacting on developing plans significantly.

Approach was reviewed at October Finance & Performance Committee and is expected to impact for 2022/23 CIP planning.

Benchmarking

Benchmarking information has been included where possible within each indicator. National benchmarking data has been updated in various metrics throughout this report as the NHS Benchmarking Network 2020/21 report for Mental Health was received in early October.

Patient safety incidents are reported to the National Reporting Learning System (NRLS). In October 2021, the first annual benchmarking information was released for Trusts, covering the period April 2020 – March 2021. This shows SHSC's patient safety incident reporting rate at 76.6 incidents per 1000 bed days. Nationally, for mental health trusts, this rate varies from 21.6 to 235.8. Regionally for North East and Yorkshire, this rate varies from 45.1 to 114.6 patient safety incidents reported per 1,000 bed days.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval		Assurance	✓	Information	✓

The Trust Board is asked to accept the assurance provided by this report, whilst acknowledging the ongoing risks to performance and quality.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering Effectively	***Yes***	✓	*No*	
CQC Getting Back to Good – Continuous Improvement	***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***		Work looking at EDI concerns is underway which may suggest the inclusion of certain indicators as future developments occur
Legal	***Yes***		***No***	✓	

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Integrated Performance & Quality Report

Information up to and including September 2021

Proud to care in Sheffield

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Introduction

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 •	/

Variation		
Icon Pic	Cell Format	Description
	• • •	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
	• H •	Special cause - where neither high nor low is good **- point(s) above UCL or mean, increasing trend**
	• L •	Special cause - where neither high nor low is good **- point(s) below UCL or mean, decreasing trend**

Target		
Icon Pic	Cell Format	Description
	?	Pass/Fail: the system may achieve or fail the the target subject to random variation
	P	Pass: the system is expected to consistently pass the target
	F	Fail: the system is expected to consistently fail the target
	/	No target identified

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.

Colour Key	F	M	P	Q
Finance				
MH Legislation				
People				
Quality				

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.

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Service Delivery

IPQR - Information up to and including September 2021

Proud to care in Sheffield

Responsive | Access & Demand | Referrals

20/21 TOTAL	Acute & Community Directorate	n	*mean*	SPC variation
9973	SPA/EWS	**749**	*749*	• • •
1833	AMHP	**140**	*126*	• H •
12411	Out of Hours Team (calls)	**865**	*867*	• • •
5819	Liaison Psychiatry	**441**	*434*	• • •
386	Decisions Unit	**59**	*49*	• • •
543	S136 HBPOS	**40**	*36*	• • •
1293	Adult Home Treatment Service	**96**	*89*	• • •
518	***Recovery Service TOTAL***	***42***	*45*	• • •
532	Early Intervention in Psychosis	**31**	*43*	• • •
1027	Memory Service	**124**	*120*	• • •
2469	OA CMHT	**268**	*241*	• • •
352	OA Home Treatment	**21**	*30*	• L •

20/21 TOTAL	Rehabilitation & Specialist Directorate	n	*mean*	SPC variation
8	CERT	**2**		
~	SCFT	**3**		
452	Psychotherapy Screening (SPS)	**40**	50	• • •
443	Gender ID	**35**	*48*	• • •
555	STEP	**90**	*66*	• H •
324	Eating Disorders Service	**36**	*29*	• • •
1978	SAANS	**324**	*191*	• H •
142	R&S	**21**	*20*	• • •
603	Perinatal MH Service (Sheffield)	**43**	*51*	• • •
179	HAST	**13**	*12*	• • •
~	Health Inclusion Team	**178**		
~	LTNC - NES	**40**		
~	LTNC - Case Management	**10**		
~	SCBIRT	**14**		
~	CFS/ME	**40**		
513	CLDT	**51**		
62	CISS	**5**		

Narrative

There are sustained elevated levels of demand into crisis services, particularly for the AMHP service as has been previously noted.

Referrals into OAHTT remain at a slighter lower level. The service has looked at where OAHTT referral sources and noted reduced numbers from both OACMHT and Memory Service, which is currently being explored.

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 presented to Quality Assurance Committee in October 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 and in CCG and SCC contract management and quality review meetings.

Responsive | Access & Demand | Community Services

September 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 Service	**Service Type**	**Referrals (Number)**	**SPC variation**	**Waiting List (Number)**	**SPC variation**	**Average Waiting Time (RtA) in WEEKS**	**SPC variation**	**Average Waiting Time (RtT) in WEEKS**	**SPC variation**	**Caseload (Service)**	**SPC variation**
SPA/EWS	Assessment	749	• • •	1161	• H •	23.6	• • •	21.2		1427	• • •
AMHP	Assessment	140	• H •	*N/A*		*N/A*		*N/A*		*N/A*	
Out of Hours Team	Assessment	865	• • •								
Liaison Psychiatry	Assessment	441	• • •								
Decisions Unit	Treatment	59	• • •								
S136 HBPOS	Assess & Treat	40	• • •								
Adult Home Treatment Service	Assess & Treat	96	• • •							61	• H •
MH Recovery North	Treatment	18		Incomplete		5.4		7.1		979	• • •
MH Recovery South	Treatment	24		Incomplete		8.2		3.6		1093	• H •
Recovery Service TOTAL	***Treatment***	42	• • •	Incomplete		*N/A*		*N/A*		***2072***	• H •
Early Intervention in Psychosis	Assess & Treat	31	• • •	Incomplete				*N/A. Refer to EIP AWT Standard.*		373	• • •
Memory Service	Assess & Treat	124	• • •	Incomplete		15.1		23.4		4151	• H •
OA CMHT	Assess & Treat	268	• • •	Incomplete		6.4		9.3		1273	• H •
OA Home Treatment	Assess & Treat	21	• L •	*N/A*		*N/A*		*N/A*		53	• • •

Rehab & Specialist Service	Service Type	Referrals (Number)	SPC variation	Waiting List (Number)	SPC variation	Average Waiting Time (RtA)	SPC variation	Waiting Time RtT	SPC variation	Caseload (Service)	SPC variation
IAPT	Assess & Treat	1,440	• • •	*N/A*		*N/A*		*N/A*		*N/A*	
SPS (Screening)	Assess	40	• • •								
SPS - MAPPS	Assess & Treat	*N/A*	• L •	36	• L •	22.1	• • •	91.2	• • •	276	• L •
SPS - PD	Assess & Treat	*N/A*	• • •	30	• L •	19.0	• • •	94.4	• H •	186	• L •
Gender ID	Assess & Treat	35	• • •	1407	• H •	110.3	• • •	Incomplete		2188	• H •
STEP	Treatment	90	• H •	48	• • •	*N/A*		Incomplete		378	• H •
Eating Disorders Service	Assess & Treat	36	• • •	45	• H •	5.9	• H •	Incomplete		239	• H •
SAANS	Assess & Treat	324	• H •	4189	• H •	97.5	• H •	Incomplete		4472	• H •
R&S	Assess & Treat	21	• • •	239	• H •	*N/A*		Incomplete		246	• • •
Perinatal MH Service (Sheffield)	Assess & Treat	43	• • •	22	• H •	3.9	• H •	Incomplete		130	• • •
HAST	Assess & Treat	13	• • •	26	• • •	16.6	• • •	Incomplete		95	• H •
Health Inclusion Team	Assess & Treat	178		64		0.9		Incomplete		1219	
LTNC - NES	Assess & Treat	40		50		4.0		Incomplete		278	
LTNC - Case Management	Assess & Treat	10		3		2.0		Incomplete		170	
SCBIRT	Assess & Treat	14		17		5.4		Incomplete		109	
CFS/ME	Assess & Treat	40		Incomplete		Incomplete		Incomplete		Incomplete	
CLDT	Assess & Treat	51		198		36.7		20.5		826	
CISS	Assess & Treat	5		*N/A*		*N/A*		*N/A*		29	
CERT	Treatment	2		1		1.0		Incomplete		46	
SCFT	Assess & Treat	3		0		0.0		Incomplete		21	

Narrative

Note the addition of a number of metrics for services previously missing from this information, notably Learning Disability, Rehab & Forensic Community Teams and some Highly Specialist Services. Work continues to accurately define, record and collate information (where you see 'incomplete'). The SPC variation column gives an indication of the changes over time for these indicators. 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 for Specialist Services were provided to QAC in October 2021.

Safe | Inpatient Wards | Adult Acute & Step Down

Adult Acute (Burbage/Dovedale2, Stanage, Maple)	Benchmark /Target	Sep-21 n	Sep-21 mean	Sep-21 SPC variation	Sep-21 SPC target
Admissions	/	28	40	• • •	/
Detained Admissions	/	28	34	• • •	/
% Admissions Detained	50%	100.0%	87.7%	• • •	F
Emergency Re-admission Rate (rolling 12 months)	10.3%	3.2%	4.2%	• L •	P
Discharges	/	29	40	• • •	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	4			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	116			
Bed Occupancy excl. Leave (KH03)	95%	91.5%	95.4%	• • •	?
Bed Occupancy incl. Leave	/	95.8%	100.0%	• • •	?
Average beds admitted to	/	45			
Average Discharged Length of Stay (12 month rolling)	32	34.8	36.6	• L •	F
Average Discharged Length of Stay (discharged in month)	32	46.9	36.8	• • •	/
Live Length of Stay (as at month end)	/	61.3	43.8	• H •	/
Number of Mental Health Out of Area Placements started in the period (admissions)	ZERO Inappropriate	11	9	• • •	?
Total number of Out of Area bed nights in period	ZERO Inappropriate	276	343	• • •	F
Total number of people in Out of Area beds in period	ZERO Inappropriate	18	20	• • •	F
Cost of Out of Area bed nights in period	ZERO Inappropriate	Refer to Directorate Finance Report			

Narrative (Acute Wards)
High live length of stay owing to delayed discharges that have been escalated to Head of Service and LA and continued need for inappropriate admissions to Out of Area beds due to unavailability of Sheffield beds.
Issues – High length of stay linked to delayed discharges
Actions – Escalation structure established to draw support from social care and local authority.

Length of Stay Detail
Longest LoS (days) as at month end: **229** on Stanage
Range = 0 to 229 days
Number of discharges in month: 32
Longest LoS (days) of discharges in month: 234

Benchmarking Out of Area Placements
(NEY Provider Trusts shared information April – Sept 2021. This is snapshot position of service users inappropriately placed in OOA beds of all types at the end of each month)

Provider	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Sparklines
Tees, Esk and Wear Valleys NHS Foundation Trust	16	27	20	26	30	40	
Bradford District Care NHS Foundation Trust	19	24	22	17	25	25	
Humber NHS Foundation Trust	21	21	18	16	21	16	
Sheffield Health and Social Care NHS Foundation Trust	**22**	**18**	**23**	**13**	**11**	**16**	
Leeds and York Partnership NHS Foundation Trust	2	11	12	16	9	14	
South West Yorkshire Partnership NHS Foundation Trust	5	8	6	5	13	12	
Rotherham Doncaster and South Humber NHS Foundation Trust	2	7	9	17	13	8	
Cumbria Northumberland, Tyne and Wear Partnership NHS FT	0	0	0	1	2	5	
Navigo (NE Lincs/Grimsby)	1	0	0	0	0	3	

Benchmarking Adult Acute
(2021 NHS Benchmarking Network Report – Weighted Population Data)

Bed Occupancy Mean: 86.4%
Length of Stay (Discharged) Mean: 32
Emergency readmission rate Mean: 10.3%

NB – No benchmarking available for Step Down beds

Step Down (Wainwright Crescent)	Benchmark /Target	Sep-21 n	Sep-21 mean	Sep-21 SPC variation	Sep-21 SPC target
Admissions	/	4	7	• L •	/
Discharges	/	4	7	• • •	/
Bed Occupancy excl. Leave (KH03)	95%	80.30%	85.2%	• • •	?
Bed Occupancy incl. Leave	95%	86.67%	94.5%	• • •	?
Average Discharged Length of Stay (12 month rolling)	/	52.28	50.09	• H •	/
Live Length of Stay (as at month end)	/	150.30	108.43	• H •	/

Narrative (Wainwright Crescent)

Length of Stay Detail
Longest LoS (days) as at month end: **1027**
Range = 1 to 1027 days
Number of discharges in month: 4
Longest LoS (days) of discharges in month: 182

Inpatient Wards | PICU

PICU (Endcliffe)	Benchmark /Target	Sep-21 n	Sep-21 mean	Sep-21 SPC variation	Sep-21 SPC target
Admissions	/	2	4	• • •	/
Discharges	/	1	4	• • •	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	1			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	30			
Bed Occupancy excl. Leave (KH03)	95% (commissioned)	86.67%	91.3%	• • •	?
Bed Occupancy incl. Leave	84% (benchmark)	97.67%	93.7%	• • •	?
Average beds admitted to	/	10			
Average Discharged Length of Stay (12 month rolling)	47 (benchmark)	50.49	46.63	• • •	?
Live Length of Stay (as at month end)	/	84.78	53.34	• H •	/
Number of Out of Area Placements started in the period (admissions)	ZERO Inappropriate	3	4	• • •	?
Total number of Out of Area bed nights in period	ZERO Inappropriate	194	165	• • •	F
Total number of people in Out of Area beds in period	ZERO Inappropriate	9	10	• • •	F
Cost of Out of Area bed nights in period	ZERO Inappropriate	Refer to Directorate Finance Report			

Benchmarking PICU
(2021 NHS Benchmarking Network Report – Weighted Population Data)
Bed Occupancy Mean: 84%
Length of Stay (Discharged) Mean: 47

Narrative
High live length of stay associated with delayed discharge.
There have been a reduced number requiring inappropriate admission out of area due to local availability.

Issues – delayed discharge

Actions – Additional clinical input has been mobilised and escalation structure established to draw support from social care and local authority for delayed discharges.

Length of Stay Detail

Longest LoS (days) as at month end: 789 (ID 68267)
Range = 3 to 789 days
Number of discharges in month: 4
Longest LoS (days) of discharges in month: 138

Safe | Inpatient Wards | Older Adults

Older Adult Functional (Dovedale 1)	Benchmark /Target	Sep-21 n	mean	SPC variation	SPC target
Admissions	/	6	5	• • •	/
Discharges	/	7	4	• H •	/
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%	92.67%	93.4%	• • •	?
Bed Occupancy incl. Leave	95%	99.33%	98.4%	• • •	?
Average beds admitted to	/	15			
Average Discharged Length of Stay (12 month rolling)	73	65.58	83.98	• L •	?
Live Length of Stay (as at month end)	/	111.64	104.20	• • •	/

Length of Stay Detail
Longest LoS (days) as at month end: **648**
Range = 3 to 648 days
Number of discharges in month: 8
Longest LoS (days) of discharges in month: 177

Older Adult Dementia (G1)	Benchmark /Target	Sep-21 n	mean	SPC variation	SPC target
Admissions	/	5	4	• • •	/
Discharges	/	3	4	• • •	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	9			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	187			
Bed Occupancy excl. Leave (KH03)	95%	72.50%	70.2%	• • •	?
Bed Occupancy incl. Leave	95%	73.75%	72.1%	• • •	?
Average beds admitted to	/	12			
Average Discharged Length of Stay (12 month rolling)	73	70.02	78.53	• L •	?
Live Length of Stay (as at month end)	/	51.15	53.38	• • •	/

Length of Stay Detail
Longest LoS (days) as at month end: **171**
Range = 5 to 171 days
Number of discharges in month: 6
Longest LoS (days) of discharges in month: 111

Narrative

The average discharged length of stay has been reducing over the last few months on both Older Adult Wards, and is currently lower than the most recent benchmarking figure available (2020/21 NHS Benchmarking Network report) which is positive. Live length of stay (the average length of stay of those admitted to the wards on the last day of the month) is currently within expected norms for both wards.

Older Adult (Out of Area)	Benchmark/Target	Sep-21 n	mean	SPC variation	SPC target
Placements started in the period (admissions)	ZERO Inappropriate	2	2	• • •	?
Total number of Out of Area bed nights in period	ZERO Inappropriate	72	71	• • •	?
Total number of people in Out of Area beds in period	ZERO Inappropriate	3	4	• L •	/
Cost of Out of Area bed nights in period	ZERO Inappropriate	Refer to Directorate Finance Report			

Benchmarking Older Adults
(2021 NHS Benchmarking Network Report – Weighted Population Data)
Bed Occupancy Mean: 75.8%
Length of Stay (Discharged) Mean: 73
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 (Forest Close)	Benchmark/ Target	Sep-21 n	Sep-21 mean	Sep-21 SPC variation	Sep-21 SPC target
Admissions	/	1	1	• • •	/
Discharges	/	2	1	• • •	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	2			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	44			
Bed Occupancy excl. Leave (KH03)	95%	77.60%	81.30%	• • •	?
Bed Occupancy incl. Leave	95%	82.60%	93.20%	• • •	?
Average Discharged Length of Stay (12 month rolling)	441	285.50	357.93	• L •	P
Live Length of Stay (as at month end)	/	317.07	382.22	• L •	/
Number of Out of Area Placements started in the period (admissions)	0	0			
Total number of Out of Area bed nights in period	0	238			
Total number of people in Out of Area beds in period	0	8			
Cost of Out of Area bed nights in period	0	Refer to Directorate Finance Report			

Forensic Low Secure (Forest Lodge)	Benchmark /Target	Sep-21 n	Sep-21 mean	Sep-21 SPC variation	Sep-21 SPC target
Admissions	/	0	1	• • •	/
Discharges	/	3	1	• • •	/
Bed Occupancy excl. Leave (KH03)	95%	83.30%	86.40%	• • •	?
Bed Occupancy incl. Leave	95%	96%	93%	• • •	?
Average Discharged Length of Stay (12 month rolling)	707	415.18	398.94	• • •	P
Live Length of Stay (as at month end)	/	493.21	445.08	• H •	/

Forest Close

The 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: 1932
Range = 0 to 1932 days
Number of discharges in month: 3
Longest LoS (days) of discharges in month: 587

Benchmarking Rehab/Complex Care
(2021 NHS Benchmarking Network Report – Weighted Population Data)
Bed Occupancy Mean: 75%
Length of Stay (Discharged) Mean: 441

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 September 2021 there were 6 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.

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: 1898
Range = 44 to 1898 days
Number of discharges in month: 3
Longest LoS (days) of discharges in month: 666

Benchmarking Low Secure Beds
(2021 NHS Benchmarking Network Report – Weighted Population Data)
Bed Occupancy Mean: 89%
Length of Stay (Discharged) Mean: 707

Safe | Inpatient Wards | Learning Disabilities (Firshill)

Learning Disabilities (Firshill Rise)	Benchmark/Target	Sep-21 n	Sep-21 mean	Sep-21 SPC variation	Sep-21 SPC target
Admissions	/	0			
Discharges	/	1			
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	1			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	1			
Bed Occupancy excl. Leave (KH03)	90%	0.56%			
Bed Occupancy incl. Leave	90%	0.50%			
Average Discharged Length of Stay (12 month rolling)	298	392.43			
Live Length of Stay (as at month end)	/	-			

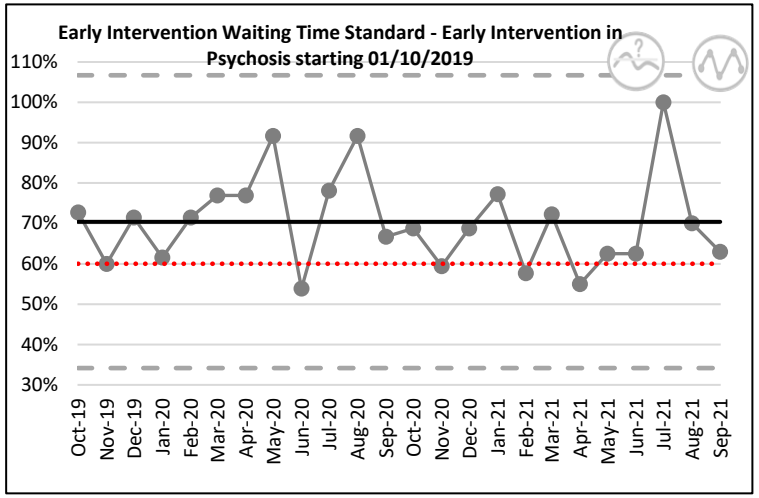
Narrative

Final service user was discharged from Firshill ATS on 2 September 2021. The service is currently undergoing a period of review and training.

It should be noted that one service user was admitted to an out of area LD bed in September, as we currently do not have the Firshill inpatient facility in operation.

Benchmarking
(2020 NHS Benchmarking Network Report – Specialist LD Report)
Bed Occupancy Mean: 65%
Length of Stay (Discharged) Mean: 298

Effective | Treatment & Intervention



EIP AWT Standard	Sep-21			
	Target 2021/22	N	SPC variation	SPC target
Trustwide	60%	63%	• • •	?

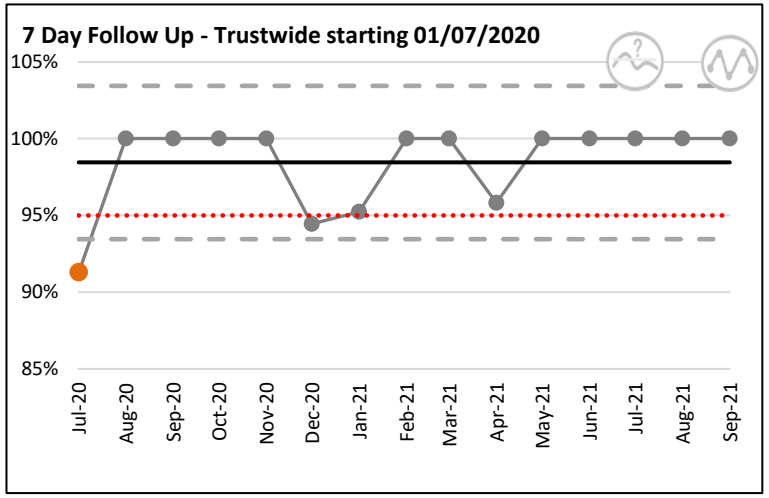
Narrative

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 70% indicating the system is capable of achieving the 20/21 target.

In September 63% = 8/11



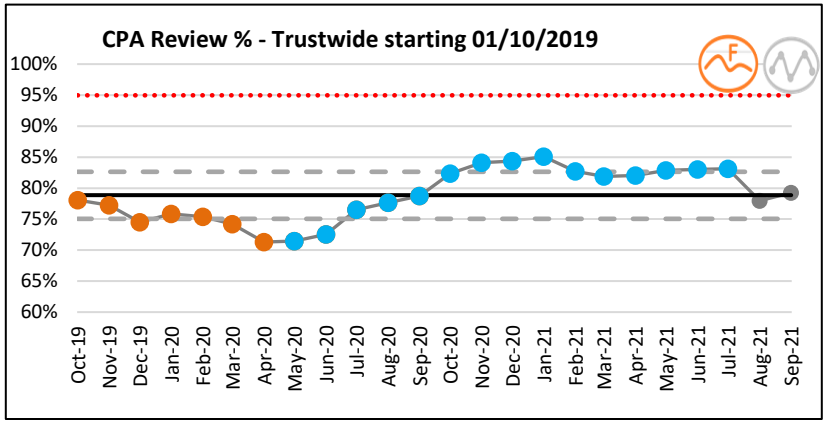
7 Day Follow Up	Sep-21			
	Target 2021/22	N	SPC variation	SPC target
Trustwide	**95%**	**100%**	• • •	?

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 still working with Information Dept colleagues to validate the data quality in order to provide the 72 hr follow up figure.

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%.



		Sep-21			
CPA Review % Completed within 12 months	Target 2021/22	n	Mean	SPC variation	SPC target
Trustwide	**95%**	79.23%	*78.85%*	• • •	F
Early Intervention	95%	90.43%	*90.93%*	• • •	?
MH Recovery North	95%	81.63%	*84.53%*	• • •	F
MH Recovery South*	95%	65.95%	*68.57%*	• L •	F

*Baseline recalculation from July 2020

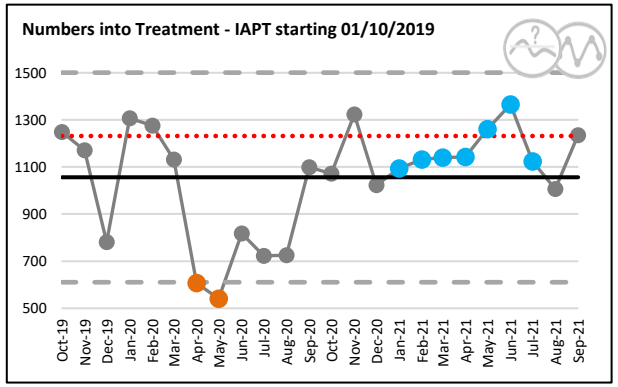
Narrative

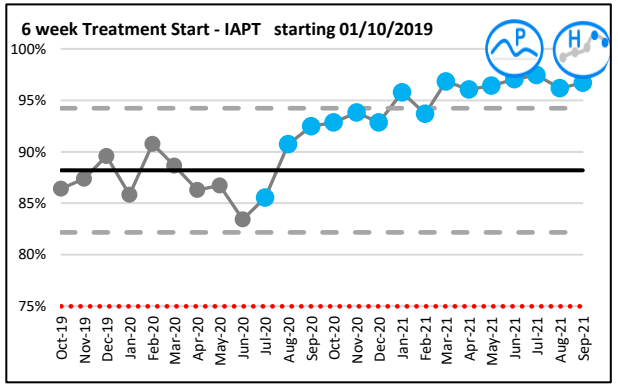
EIP performance has plateaued just under target which can be attributed to a significant level of sickness absence in the service. Targeted work is taking place to bring back in line.
A recovery plan is in place to address the low performance in the recovery teams and although an increase has been achieved from last month the service acknowledges that the improvement needs greater pace. In addition to the recovery plan actions, both teams have since set individual workers a target to achieve outstanding reviews within the next month. This has been framed as a management instruction and will be monitored on a weekly basis.

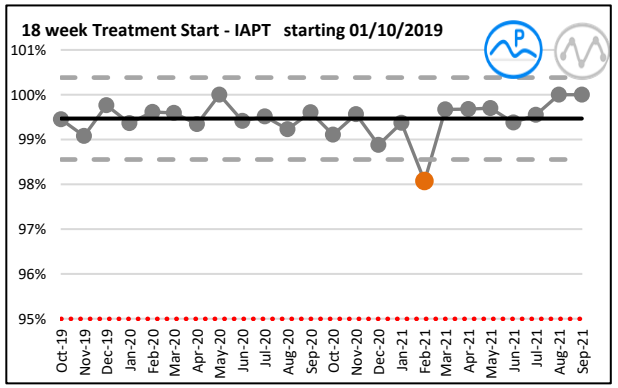
IAPT | Performance Summary

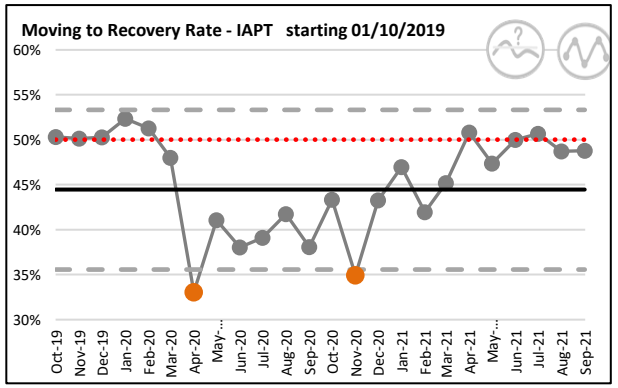
IAPT		Sep-21			
Metric	Target 2021/22	n	*mean*	SPC variation	SPC target
Referrals*	n/a	1440	*1627*	• • •	/
New to Treatment	1232	1235	*1056*	• • •	?
6 week Wait	75%	96.7%	*88.2%*	• H •	P
18 week Wait	95%	100%	*99.5%*	• • •	P
Moving to Recovery Rate	50%	48.8%	*44.4%*	• • •	?

**Referrals chart and icons use data from Jan 19 – Mar 20 as baseline to measure covid impact.*









Narrative

Access

Met the monthly access standard (target is 1232) with 1235 new people entering treatment in October. The ongoing work to promote the service has helped to enable this following a dip in referrals over the summer which is an expected seasonal trend.

Waiting Times

Target 75% seen in less than 6 weeks and 95% seen in less than 18 weeks. In September the service submitted: 96% seen in less than 6 weeks and 100% seen in less than 18 weeks.

Recovery

48.8% Recovery rates are expected to fluctuate over Autumn and Winter. There continues to be a comprehensive programme of work on improving recovery rates. There are multiple counsellors engaging in training at the moment as mandated by NHS England which has seen a fluctuation in recovery rates however this is showing signs of stabilising. Plans continue to be in place to improve recovery rates in courses.

Other Highlights/Achievements/Concerns

- **Recruitment** for service expansion continues to be a service highlight due to the numbers of staff being recruited across different professions, however ongoing delays in HR progressing a dedication Comms role for 12 months to develop a communication, marketing and promotion strategy to help deliver on the increased access standard. Delays in Admin team recruitment has a direct impact on the access standard as we are struggling with capacity to process incoming referrals. Due to delays in recruitment with the agenda for change panel this will mean a cost pressure on the IAPT budget next year.
- **Estates** continue to be a risk. There are still two IAPT teams displaced from Argyll House with no regular base. IAPT is expanding to meet the Long-Term plan and so this continues to pose a challenge. Uncertainty regarding the use of Grenoside could impact on the services ability to move forward to a face to face model by patient choice rather than need in April 2022 and would leave the majority of the IAPT service displaced and would significantly impact on being able to provide a service for patients in the North of the city.

START – Sheffield Treatment & Recovery Team | Performance Summary

START		September-21		
Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	82	• L •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	71.08%	• L •	?
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	100%	• • •	P
DNA Rate to Assessment	≤ 15%	24.69%	• • •	?
Recovery - Successful treatment exit	TBC	6	• L •	/
Non-Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	83	• H •	/
Waiting time Referral to Assessment	≥ 95%	63.24%	• L •	?
Waiting time Referral to Treatment	≥ 95%	100%	• • •	?
DNA Rate to Assessment	≤ 15%	33.82%	• • •	?
Recovery - Successful treatment exit	TBC	23	• H •	/
Alcohol	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	207	• H •	/
Waiting time Referral to Assessment	≥ 95%	38.30%	• L •	P
Waiting time Referral to Treatment	≥ 95%	100%	• H •	P
DNA Rate to Assessment	≤ 15%	22.34%	• • •	?
Recovery - Successful treatment exit	TBC	52	• 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 locally agreed target of 95% of service users being assessed within 7 working days of referral. The nationally monitored target for referral to start of treatment is 21 days.

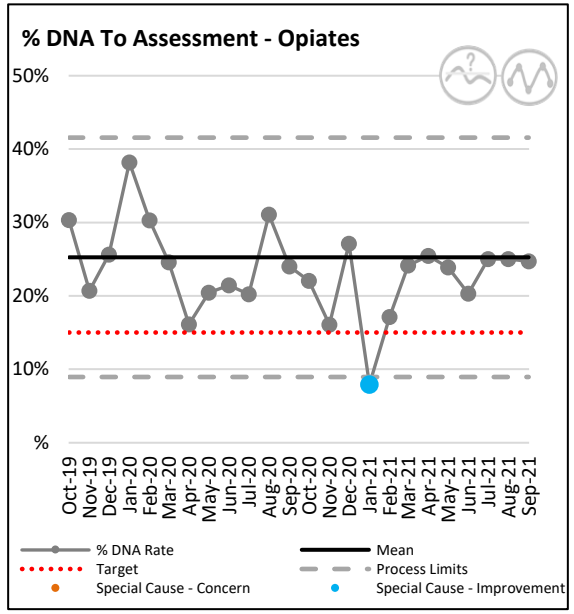
Staff absences during August and September 2021 have had an impact on waiting times to assessment across the treatment services. Waiting times to start structured treatment are not impacted.

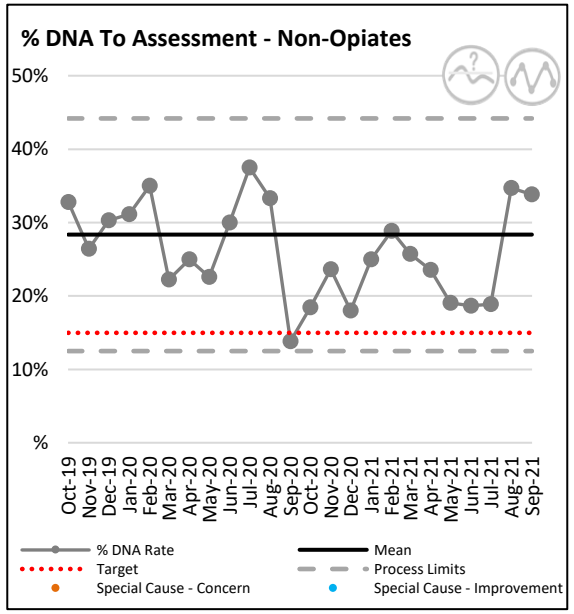
The service has historically overperformed on waiting times, with very few breaches. However a combination of annual leave, sickness and a covid outbreak have impacted on service ability to complete assessments within the 7 days. Operational processes are now being reviewed in light of the effect on waiting times and it is anticipated they will improve for next month.

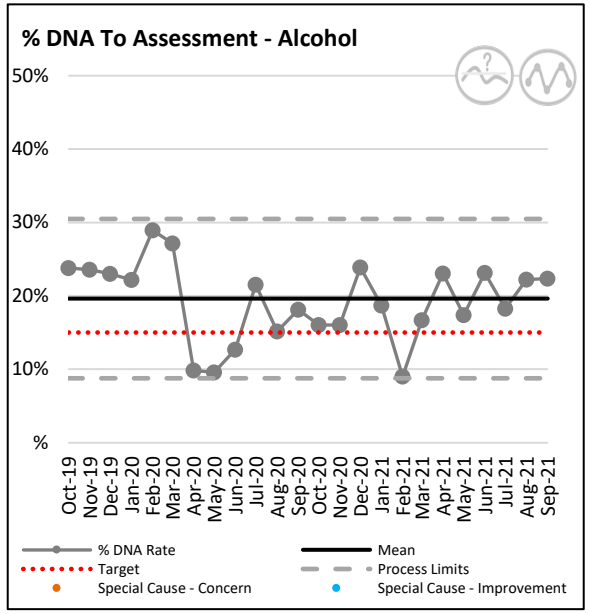
Recovery

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



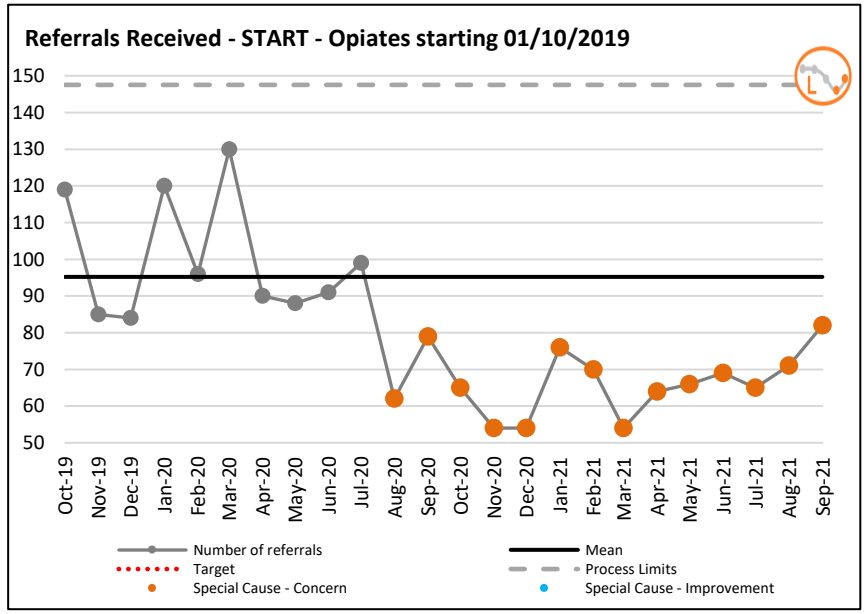


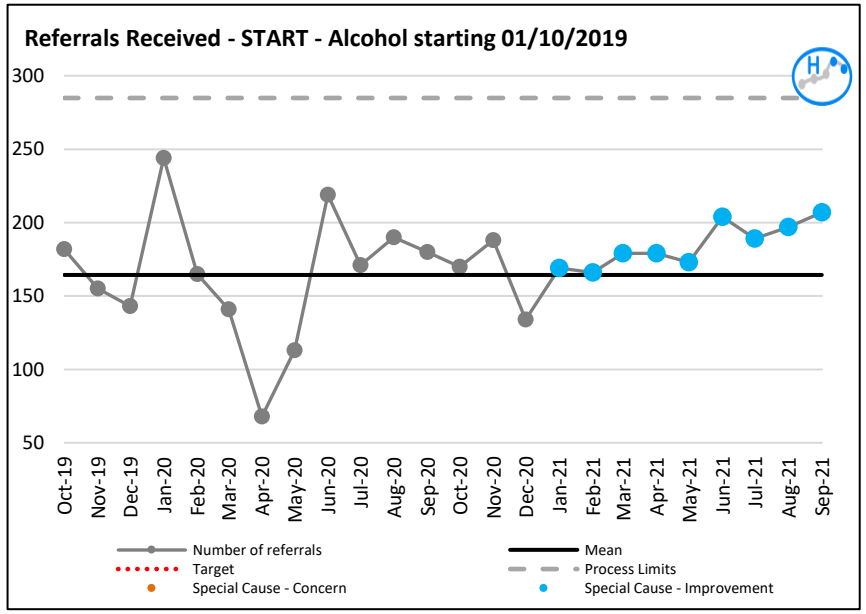


DNA Rate to Assessment Narrative

During the last contract period, the service has worked towards a target of 15% DNA rate to assessment.

Despite improvements to the DNA rates during the pandemic with the take-up of phone appointments for assessment, the DNA rate has increased in August in the Non-opiates service and the process will fail to meet the target. This will be investigated and addressed within service.





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.

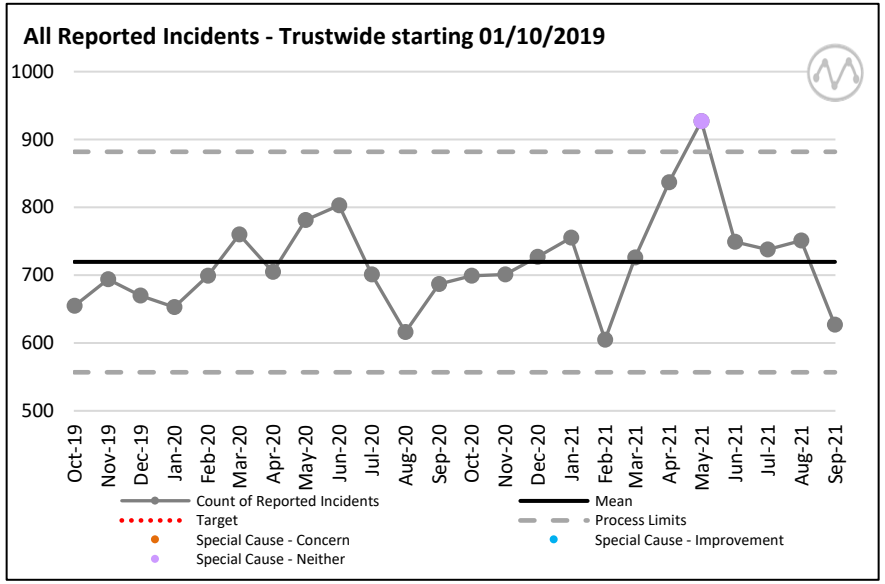
NHS
Sheffield Health and Social Care
NHS Foundation Trust

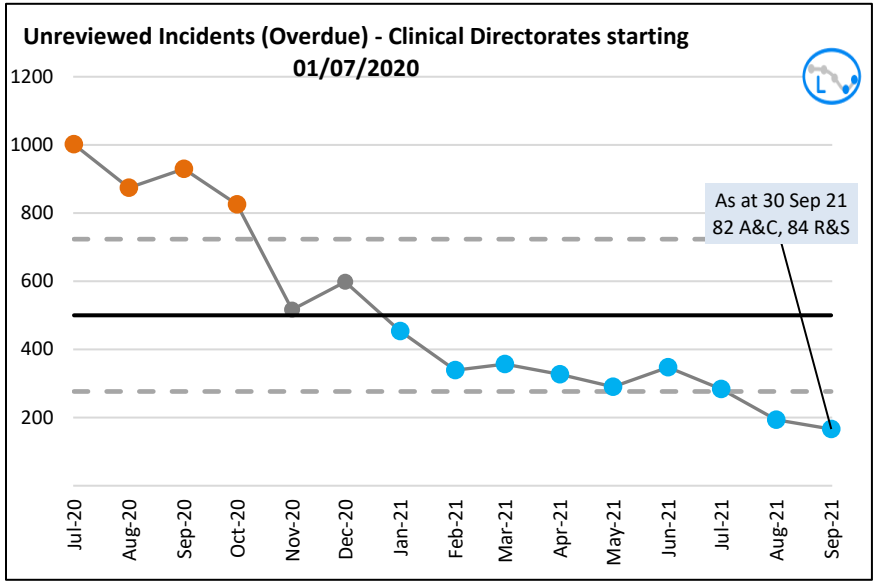
Safety & Quality

IPQR - Information up to and including September 2021

Proud to care in Sheffield

Safe | All Incidents



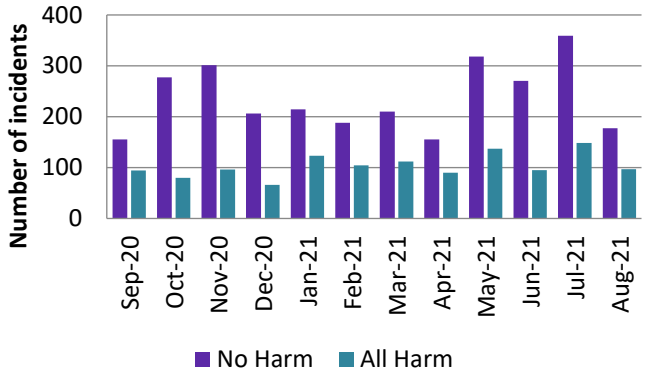


Narrative

Patient safety incidents are reported to the National Reporting Learning System (NRLS). In October 2021, the first annual benchmarking information was released for Trusts, covering the period April 2020 – March 2021.

This shows SHSC's patient safety incident reporting rate at 76.6 incidents per 1000 bed days. Nationally, for mental health trusts, this rate varies from 21.6 to 235.8. Regionally, this rate varies from 45.1 to 114.6 patient safety incidents reported per 1,000 bed days.

The chart below shows patient safety incidents reported where harm was caused compared to no harm caused from Sept 2020 to Aug 2021. A recent exercise has been undertaken to ensure that harm is being accurately mapped to the NRLS.



Trustwide	Sep-21		
	n	mean	SPC variation
ALL	**627**	*719*	• • •
5 = Catastrophic	18	*15*	• • •
4 = Major	5	*4*	• • •
3 = Moderate	49	*34*	• • •
2 = Minor	215	*160*	• H •
1 = Negligible	320	*484*	• L •
0 = Near-Miss	20	*23*	• • •

Serious Incident Actions Outstanding

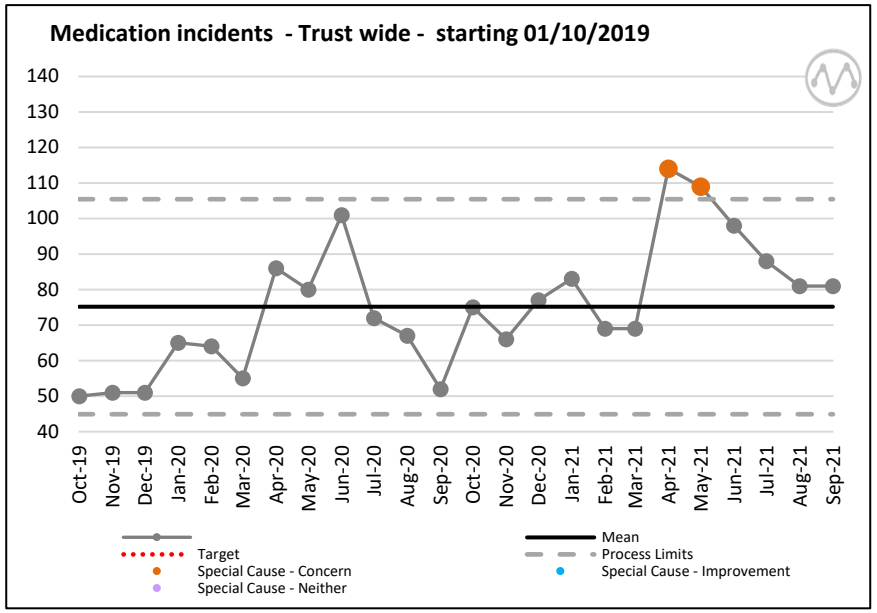
As at 27 September 2021, there were 101 outstanding SI actions overdue.

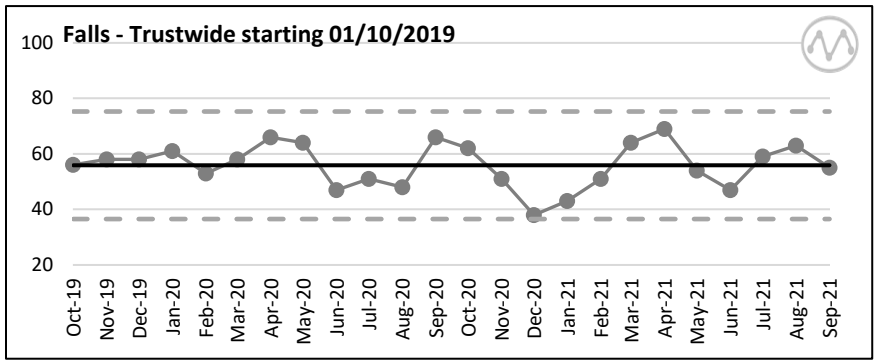
- 2 of these were from SIs in 2018
- 33 of these are from SIs in 2019
- 62 of these are from SIs in 2020
- 4 of these are from SIs in 2021

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

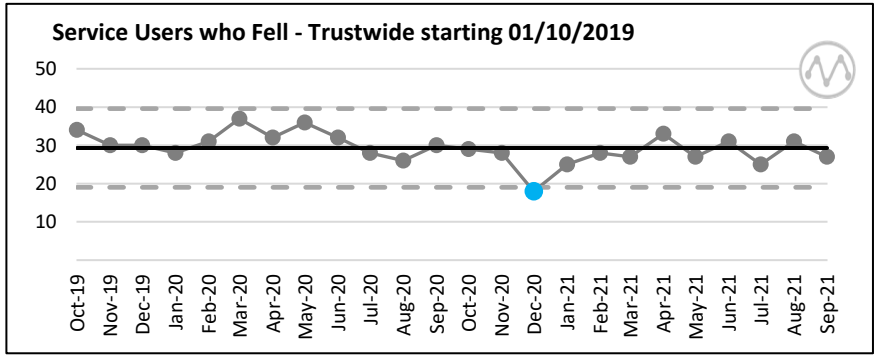
Safe | Medication Incidents & Falls





Trustwide	Sep-21		
	n	Mean	SPC variation
Falls incidents	55	56	• • •
Acute & Community	52	52	• • •
Rehabilitation & Specialist Services	2	3	• • •

Trustwide	Sep-21		
	n	mean	SPC variation
ALL	81	75	• • •
Administration Incidents	15	16	• • •
Meds Management Incidents	51	47	• • •
Pharmacy Dispensing Incidents	7	6	• • •
Prescribing Incidents	7	6	• • •
Meds Side Effect/Allergy Incidents	1	0	• • •

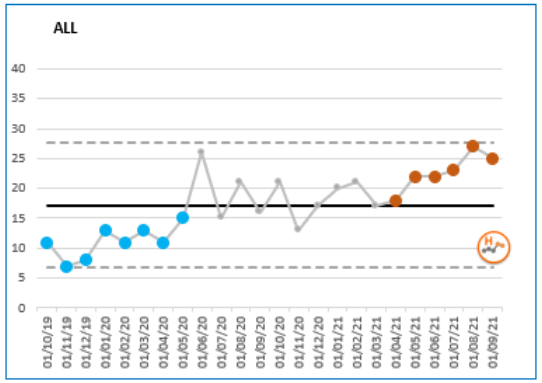


Trustwide	Sep-21		
	n	mean	SPC variation
Individuals who fell	27	29	• • •
Acute & Community	24	26	• • •
Rehabilitation & Specialist Services	2	3	• • •

Narrative

Medication Incidents

Note increasing trend in *All medication incidents* in Rehab & Specialist Directorate, masked by an overall Trustwide downward trend over the last 5 months.



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, no moderate or above incidents reported in the month.

Safe | Assaults, Sexual Safety & Missing Patients

Assaults on Staff	Sep-21		
	n	*mean*	SPC variation
Trustwide	42	*91*	• • •
Acute & Community	38	*69*	• • •
Rehab & Specialist	4	*22*	• • •

Assaults on Service Users	Sep-21		
	n	*mean*	SPC variation
Trustwide	13	*23*	• • •
Acute & Community	12	*20*	• • •
Rehab & Specialist	1	*2*	• • •

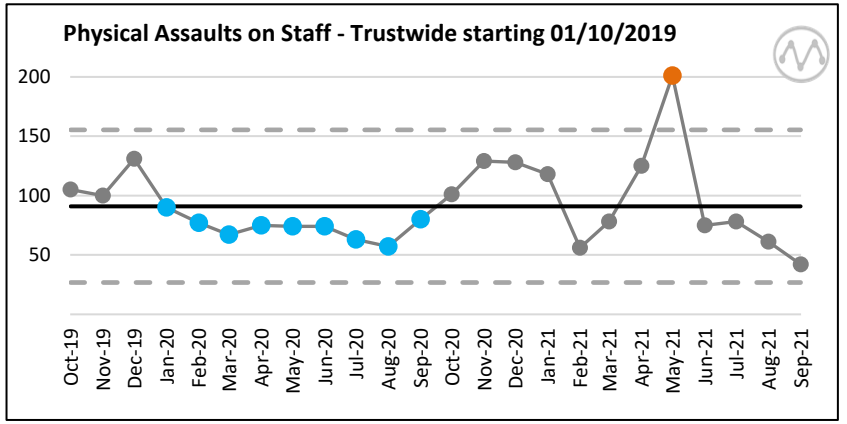
Narrative

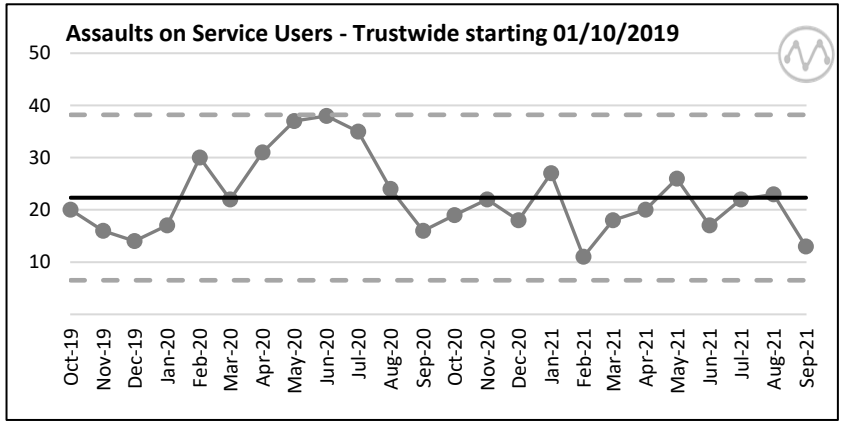
Assault to Staff
Four moderate incidents were recorded in September 2021, one was from Endcliffe Ward, the other three were from Maple Ward.

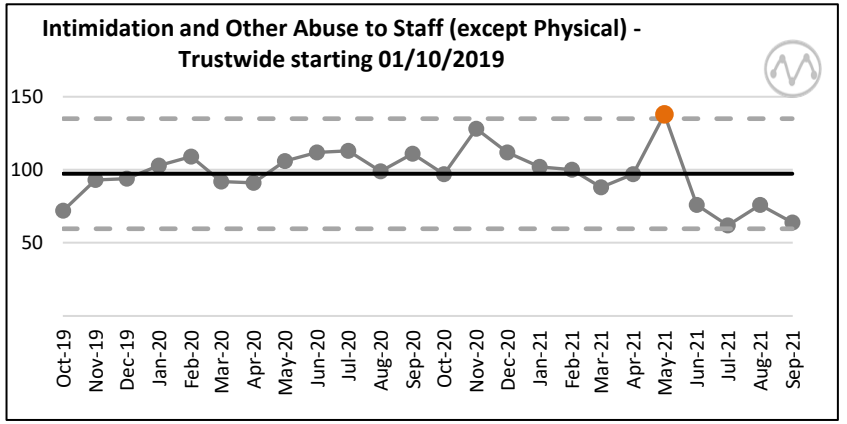
Assault on Service Users
Three moderate incidents were recorded in September 2021, two from Endcliffe Ward, the other from North Recovery Team.

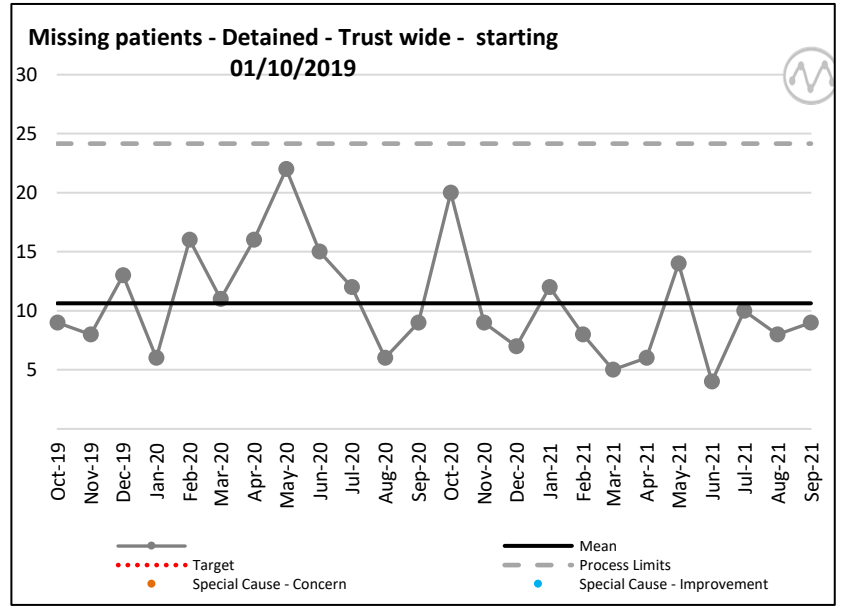
Sexual Safety Incidents
One moderate incident was reported by Maple Ward, involving an allegation of rape to a service user prior to admission to the ward. The service user has been supported in reporting this to the police, a safeguarding referral was made and support offered from the Sheffield Rape and Sexual Abuse Centre.

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

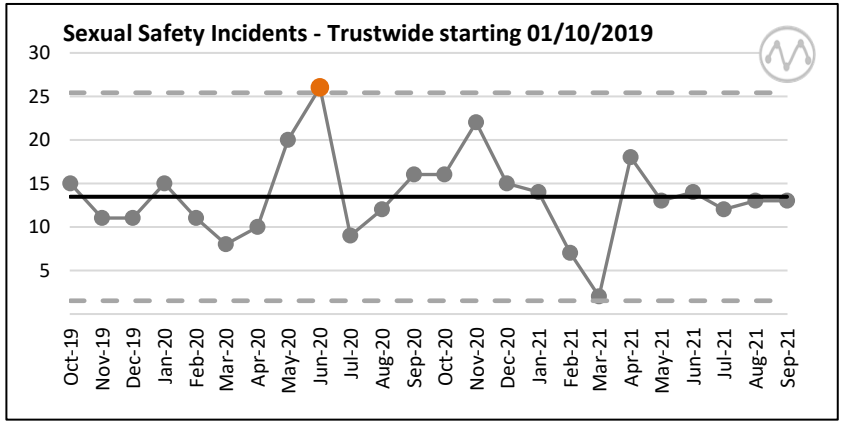








Trustwide	Sep-21		
	n	*mean*	SPC variation
Missing Patients (Informal)	2	*3*	• • •
Missing Patients (Detained)	9	*11*	• • •



Deaths

Service User Deaths 1 – 30 September 2021	
Birch Avenue	1
Community Learning Disability Team	2
Long Term Neurological Conditions	2
Neuro Enablement Service/Brain Injury Team/Neuro Case Management/LTNC	3
Mental Health Recovery Teams	2
Adult & Older Adult Home Treatment Teams	2
Older Adult Community Mental Health Teams	4
Early Intervention Service (EIS)	1
Dovedale Ward	1
Memory Service	1
IAPT	1
Liaison Service	2
Homeless & Assessment Support Team (HAST)	1
START Alcohol and Opiates/Non-opiates Services	3
Eating Disorders Service	2
Woodland View	1
SPA/EWS	1
Total	**30**

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

Deaths Reported 1 April 2020 – 30 September 2021	
Awaiting Coroners Inquest/Investigation	155
Conclusion - Narrative	6
Conclusion - Suicide	8
Conclusion – Accidental	2
Conclusion – Misadventure	1
Conclusion – Open	1
Natural Causes/No Inquest	479
Alcohol/Drug related	19
Suspected Homicide/Closed	1
Ongoing	2
Grand Total	**674**

The table above shows the number of deaths that have been recorded YTD 1 April 2020 to 30 September 2021.

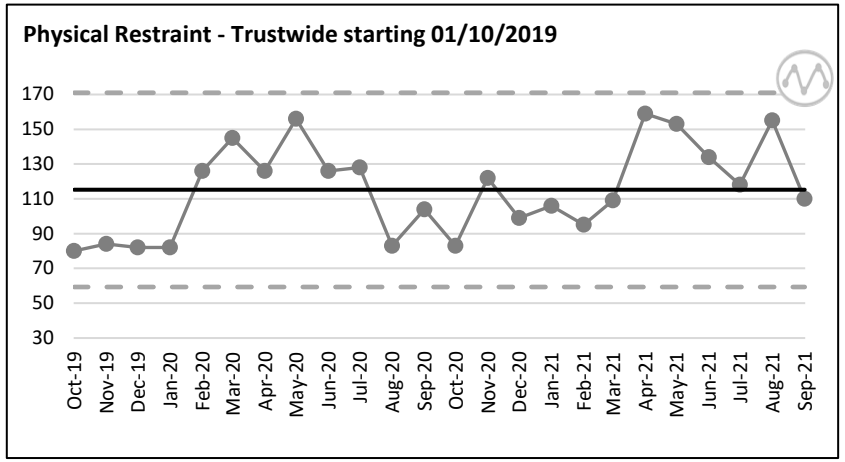
Covid-19 Deaths 1 March 2020 – 30 September 2021	
ATS (Firshill Rise)	1
Community Intensive Support Service (CISS) (LD)	1
Birch Avenue	6
Community Learning Disability Team	5
G1 Ward	5
Liaison Psychiatry	5
Long-term Neurological Conditions	2
Memory Service	7
Mental Health Recovery Team	1
Neuro Case Management Team	1
Neuro Enablement Service	3
Older Adult Community Mental Health Teams	41
Older Adult Home Treatment Service	2
START Opiates Service	1
Woodland View	1
Total	**82**

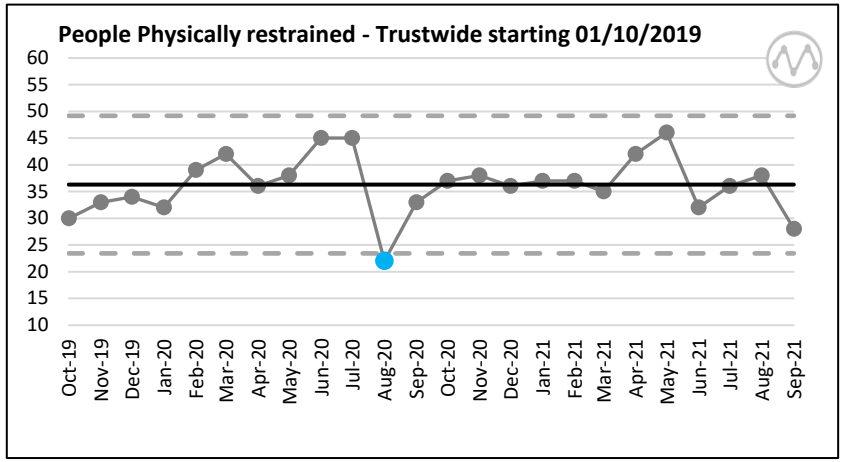
Classification of Deaths 1 – 30 September 2021			
Expected Death	10	Unexpected Death (Suspected Natural Causes)	3
Unexpected Death - SHSC Community	13	Suspected Suicide - Community	3
Unexpected Death - SHSC Inpatient/Residential			1
		Grand Total	**30**

Out of the 30 patient deaths recorded in the month, 15 of these were natural causes deaths and required no inquest and 15 are awaiting an inquest/investigation.

All 18 catastrophic incidents during September 2021 were deaths. 3 were suspected community suicides, 13 were unexpected community deaths and 2 were unexpected deaths but suspected natural causes.

Safe | Restrictive Practice | Physical Restraint





Physical Restraint INCIDENT	Sep-21		
	n	mean	SPC variation
TRUSTWIDE	110	115	• • •
Acute & Community	105	101	• • •
Burbage Ward	14	14	• • •
Stanage Ward	1	21	• L •
Maple incl 136	14	13	• • •
Endcliffe Ward	21	26	• • •
Dovedale	50	16	• H •
G1 Ward	3	10	• • •
Birch Ave	0	1	• • •
Woodland View	0	1	• • •
Rehabilitation & Specialist	5	14	• • •
ATS (Firshill Rise)	0	11	• • •
Forest Close	3	2	• • •
Forest Lodge	2	1	• • •

Physical Restraint INDIVIDUALS	Sep-21		
	N	mean	SPC variation
TRUSTWIDE	28	36	• • •
Acute & Community	24	33	• • •
Burbage Ward	6	6	• • •
Stanage Ward	1	7	• • •
Maple incl 136	7	8	• • •
Endcliffe Ward	6	6	• • •
Dovedale	3	3	• • •
G1 Ward	2	4	• • •
Birch Ave	0	1	• • •
Woodland View	0	1	• • •
Rehabilitation & Specialist	4	4	• • •
ATS (Firshill Rise)	0	2	• L •
Forest Close	2	1	• • •
Forest Lodge	2	1	• • •

Narrative

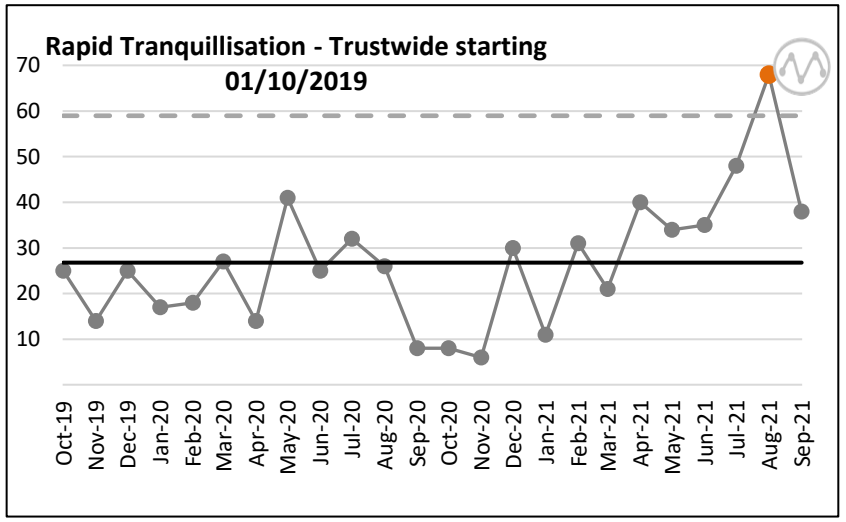
In September 2021, two individual service users accounted for 47 out of the 50 recorded physical restraints on Dovedale Ward. These complex cases have previously been reported through the Quality Assurance Committee and frequent reviews of their care takes place.

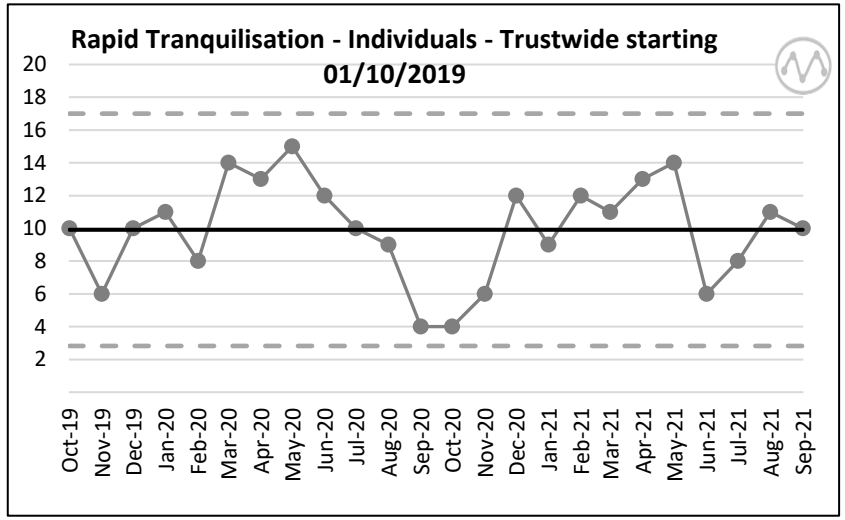
Stanage Ward have reported very low restrictive practice incidents during September, as a result of the engagement of staff in the reducing restrictive practice work underway.

Two mechanical restraints were reported in September 2021. One was reported by Dovedale 2, the other the Health Based Place of Safety. Both incidents involved the mechanical restraint of service users by the police.

Over the two-year period this data is recorded, 46% of service users physically restrained were female and 54% were male. 47% of people restrained were of white/British ethnicity, 31% of all restraints ethnicity was either not stated or blank. 4% were Black or Black British African and a further 4% Black or Black British Caribbean.

Safe | Restrictive Practice | Rapid Tranquillisation





Rapid Tranquillisation INCIDENTS	Sep-21		
	n	*mean*	SPC variation
TRUSTWIDE	38	27	• • •

Rapid Tranquillisation INDIVIDUALS	Sep-21		
	n	*mean*	SPC variation
TRUSTWIDE	10	10	• • •

Acute & Community	Sep-21		
	n	*mean*	SPC variation
Acute & Community	38	26	• • •
Services			
Burbage Ward	4	4	• • •
Stanage Ward	0	4	• • •
Maple incl 136	7	3	• • •
Endcliffe Ward	5	6	• • •
Dovedale	22	7	• H •
G1 Ward	0	2	• • •

Acute & Community	Sep-21		
	n	*mean*	SPC variation
Acute & Community	10	10	• • •
Services			
Burbage Ward	2	2	• • •
Stanage Ward	0	2	• • •
Maple incl 136	4	2	• • •
Endcliffe Ward	1	2	• • •
Dovedale	3	1	• • •
G1 Ward	0	1	• • •

Narrative

It is notable that there were no incidents of rapid tranquilisation reported in September 2021 within the Rehabilitation and Specialist Services Directorate.

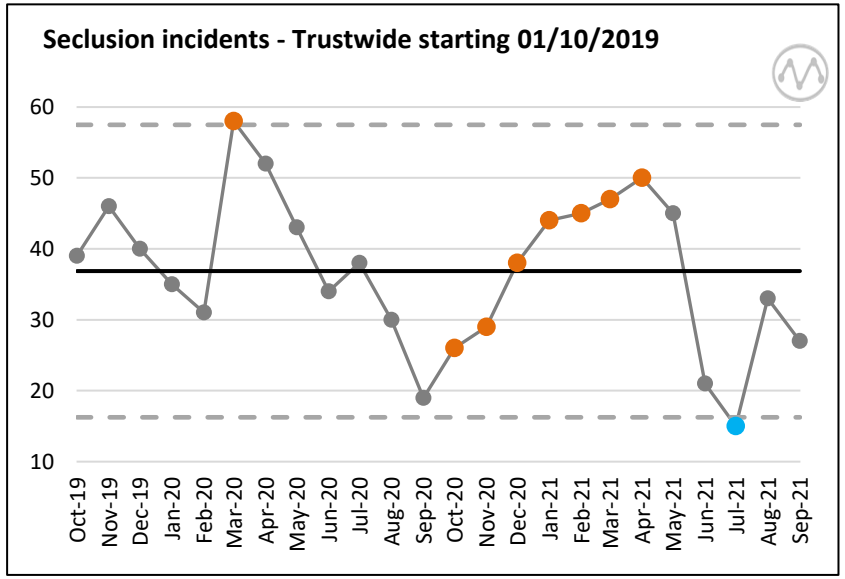
The incidents reported on Dovedale In September 2021 involve the same two individual service users reported within the physical restraints slide within this report.

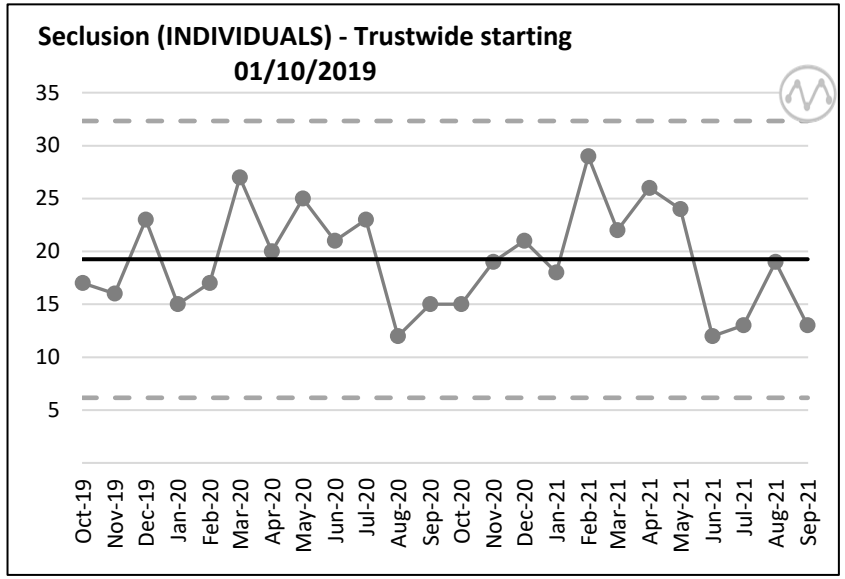
The zero incidents of rapid tranquillisation on both Stanage and G1 in September should be noted and the teams' excellent engagement with the least restrictive practice strategy.

Over the two-year period this data is recorded, 56% of service users given rapid tranquilisation (RT) were female and 46% were male.

44% of people receiving RT were of white/British ethnicity, 33% was either not stated or blank. 7% were Black or Black British African and a further 4% Black or Black British Caribbean.

Safe | Restrictive Practice | Seclusion





Seclusion INCIDENTS	Sep-21		
	n	mean	SPC variation
Trustwide	27	*37*	• • •
Acute & Community	25	*35*	• • •
Stanage	0	*7*	• • •
Maple incl. 136	7	*6*	• • •
Endcliffe PICU	17	*11*	• • •
G1	1	*8*	• • •
Rehabilitation & Specialist	2	*2*	• • •
Forest Lodge	2	*0*	• • •

Seclusion INDIVIDUALS	Sep-21		
	n	mean	SPC variation
Trustwide	13	*19*	• • •
Acute & Community	11	*18*	• • •
Stanage	0	*4*	• • •
Maple incl. 136	4	*4*	• • •
Endcliffe PICU	6	*5*	• • •
G1	1	*3*	• • •
Rehabilitation & Specialist	2	*1*	• • •
Forest Lodge	2	*0*	• • •

Narrative

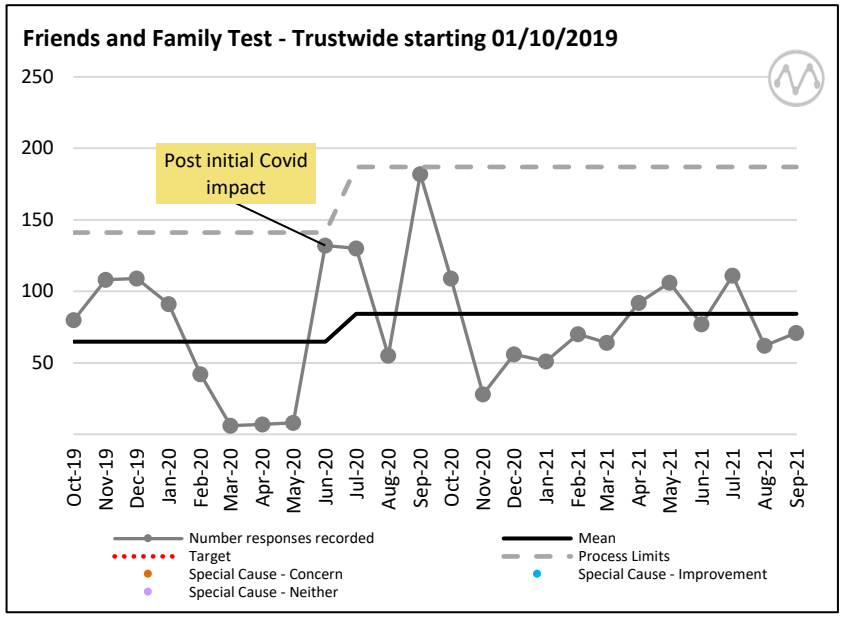
It should be noted that since Dovedale 2 decanted from Burbage Ward at the end of June 2021, there have been no seclusions, as there is no seclusion room.

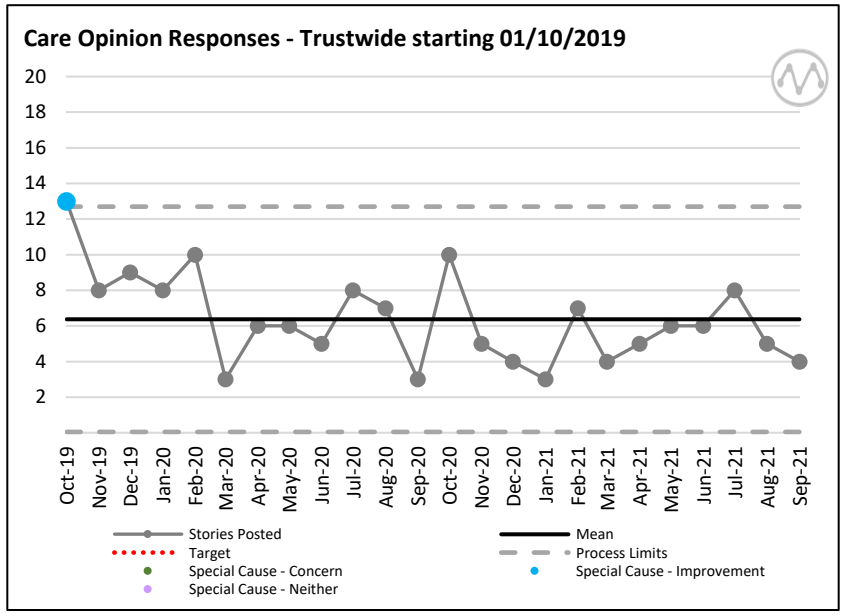
As with the reduction in use of physical restraint and rapid tranquillisation, the zero incidents of seclusion on Stanage and one on G1 in September should be noted and the teams' excellent engagement with the least restrictive practice strategy.

Over the two-year period this data is recorded, 48% of service users secluded were female and 52% were male.

49% of people secluded were White/British ethnicity, 34% were either not stated or blank. 4% were Black or Black British African, 2% were Black or Black British Caribbean, 2% were Black other, 2% were Mixed White & Black Caribbean and 1% were either Asian or Asian British Pakistani, Mixed Other, Somali or Other Ethnicity.

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 to October's meeting.

Quality of Experience

The new Engagement and Experience Liaison Officers will start to undertake Quality of Experience surveys, as part of their ward presence. This had been ceased since June 2021 due to resourcing issues.

Narrative

From the total of 71 FFT responses in September 2021, 68 were positive, 1 was negative and 2 were neutral. The negative comment unfortunately did not leave a reason for their response. When asked what could have gone better, comments requesting a quicker time from referral to appointment and sending out the slides following sessions were quoted.

Two additional staff members have been successfully recruited and will have a physical presence on the wards. Their responsibility is to support active communication between clinical services as well as providing support to patients and carers in sharing their experiences and gathering and analysing feedback.

Narrative

Four stories were published on Care Opinion in September 2021. Two were deemed to be moderately critical, one was mildly critical and one was not critical. Positive comments cited relate to lovely staff, making a difference and understanding. Negative comments include feeling frustrated, abandoned, not listened to, not taken seriously, visiting restrictions and staff attitude.

As part of the improvement plan to increase service user feedback, a new Care Opinion QR code poster is being used across those services that requested this.

Complaints and Compliments

There were 19 formal complaints received in September 2021, 14 for the Acute and Community Directorate and 5 for the Rehabilitation and Specialist Services Directorate.

19 compliments were received in September 2021 for a range of community & inpatient services. The majority of compliments received were from service users, with one coming from a staff member and one from a relative.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Our People

IPQR - Information up to and including September 2021

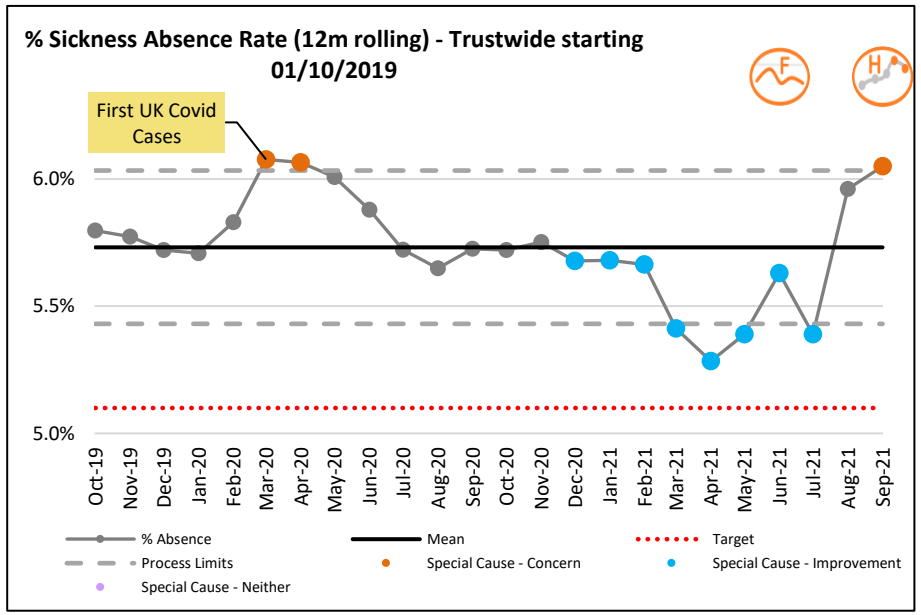
Proud to care in Sheffield

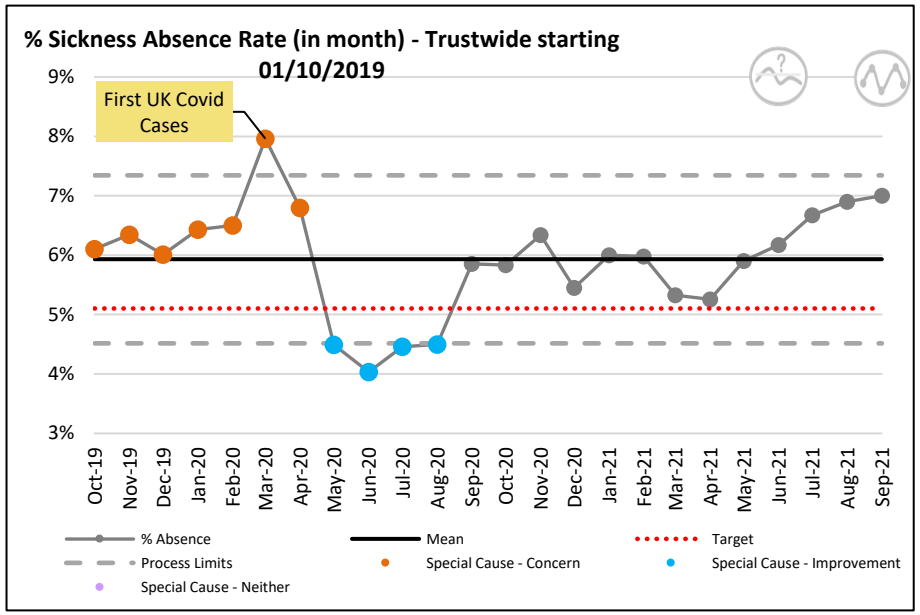
Well-Led | Workforce Summary

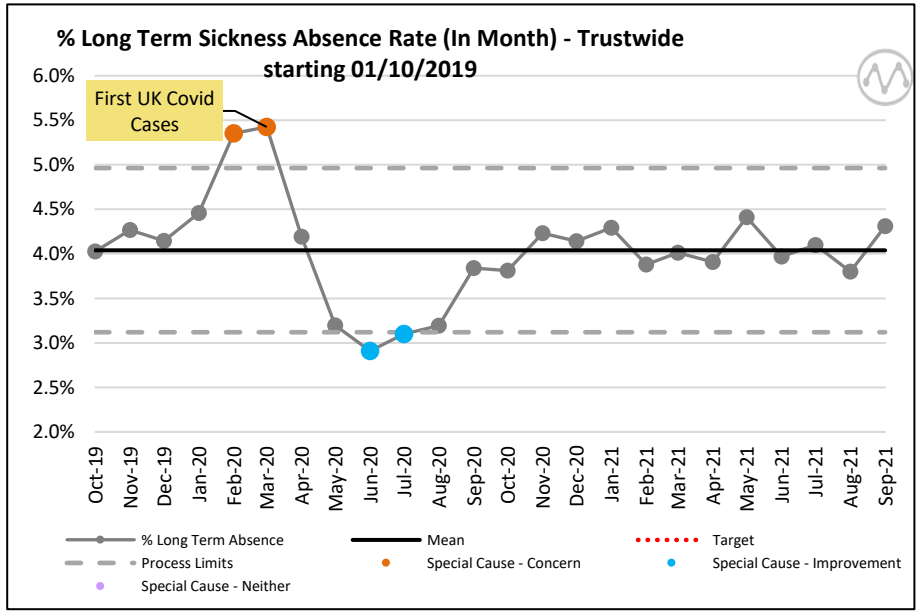
		Clinical Services	Medical	Corporate Services	*Trustwide Aug-21*	Sep-21			
Metric	**Target**	n	n	n	*n*	**n**	*mean*	**SPC variation**	**SPC target**
Sickness 12 Month (%)	5.10%	6.74%	3.35%	3.37%	*5.39%*	**6.05%**	*5.73%*	• H •	F
Sickness In Month (%)	5.10%	7.73%	4.48%	4.05%	*6.90%*	**7.00%**	*5.93%*	• • •	?
Long Term Sickness (%)	~	4.71%	2.69%	2.37%	*3.80%*	**4.31%**	*4.04%*	• • •	/
Short Term Sickness (%)	~	3.03%	1.79%	1.71%	*3.10%*	**1.74%**	*1.90%*	• • •	/
Headcount	~	2030	198	306	*2523*	**2538**	*2525*	• • •	/
WTE	~	1745.18	180.2	283.89	*2202.0*	**2217.7**	*2220.0*	• • •	/
Turnover	10%	11.5%	5.8%	16.1%	*15.54%*	**15.50%**	*12.42%*	• H •	F
Vacancy Rate	~		**Not available**		*10.00%*	**12.00%**	*8.54%*	• H •	/
PDR Compliance (%)	90%	97%	99%	99%	*97.40%*	**97.30%**	*94.52%*	• • •	P
Training Compliance (%)	80%	~	~	~	*90.20%*	**90.18%**	*90.48%*	• • •	P
Supervision Compliance (%)	80%	67.17%	82.14%	58.43%	*66.94%*	**66.62%**	*65.02%*	• • •	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 also excludes fixed term rotation

Well-Led | Sickness Absence







Sickness # of occurrences: The top three areas with the highest number of absence occurrences in **September 2021** were:

1. **Woodland View (14)**
2. **IAPT(14)**
3. **Adult Home Treatment (14)**

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

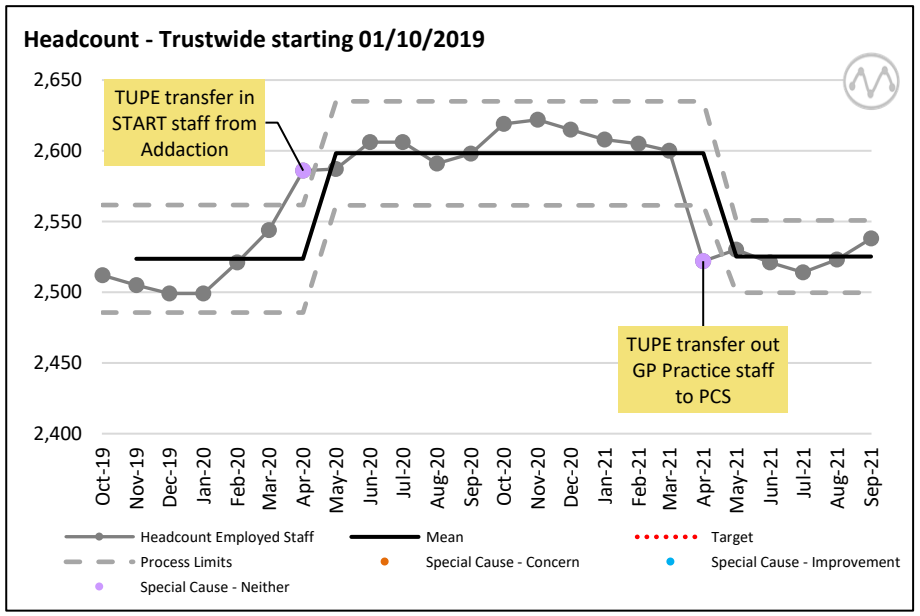
1. **Birch Avenue (8)**
2. **Woodland View (8)**
3. **IAPT (8)**

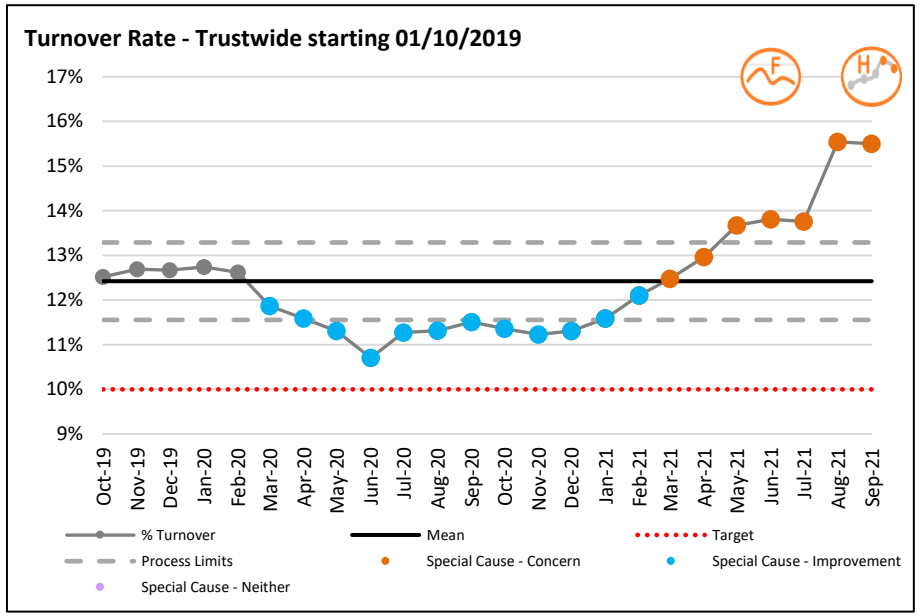
Top 4 Sickness Absence Reasons September 2021 (No. of occurrences)

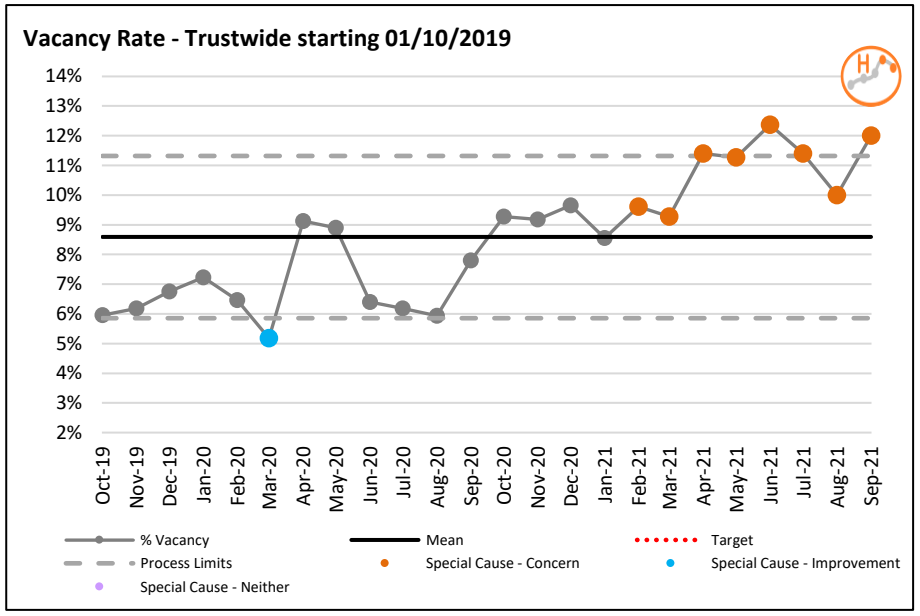
1. Anxiety/stress/depression/other psychiatry illness (102)
2. Infectious diseases (104)
3. Gastrointestinal problems (46)
4. S13 Cold, Cough, Flu – Influenza (39)

Covid absences
95 in total for September
25 of which are still open, of these 5 are longer than 6 months duration

Well-Led | Staffing





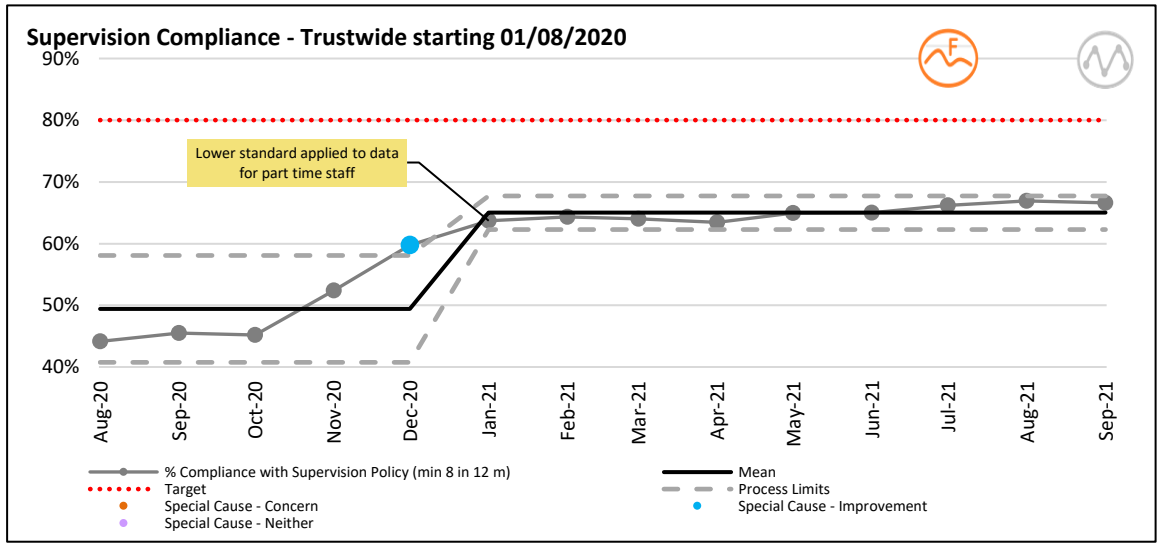


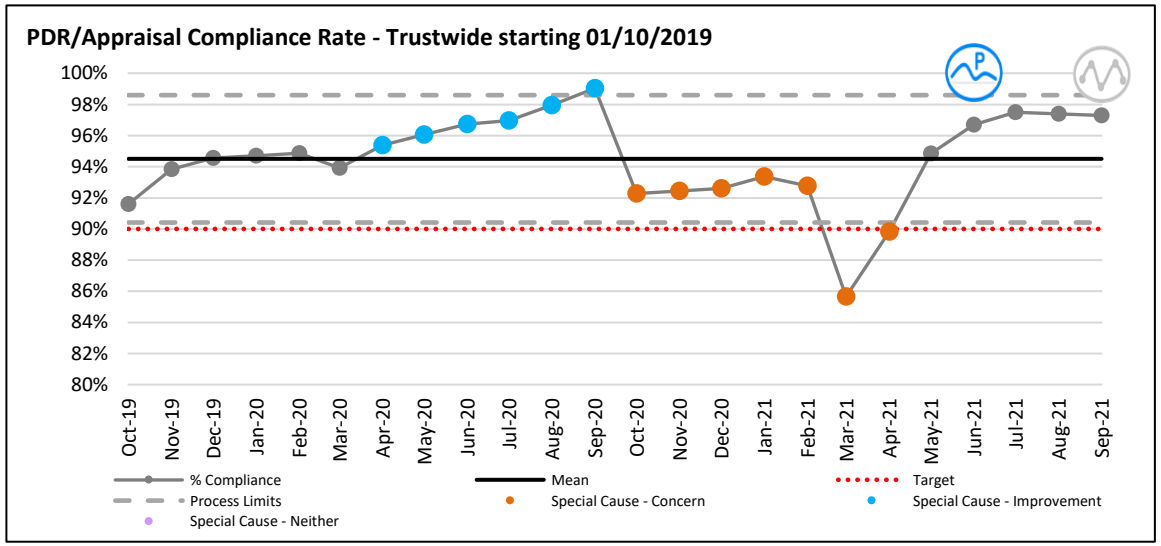
Headcount
The drop of headcount was expected in April due to the GP surgeries TUPE transfer out of the organisation on 1 April 2021.

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, vacancy rate is starting to drop due to the work being undertaken.

Well-Led | Supervision and PDR Compliance





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 4 October 2021, average compliance with the 8/12 target is:

Trustwide	**66.62%**
Clinical Services	**67.17%**
Corporate Services	**64.10%**

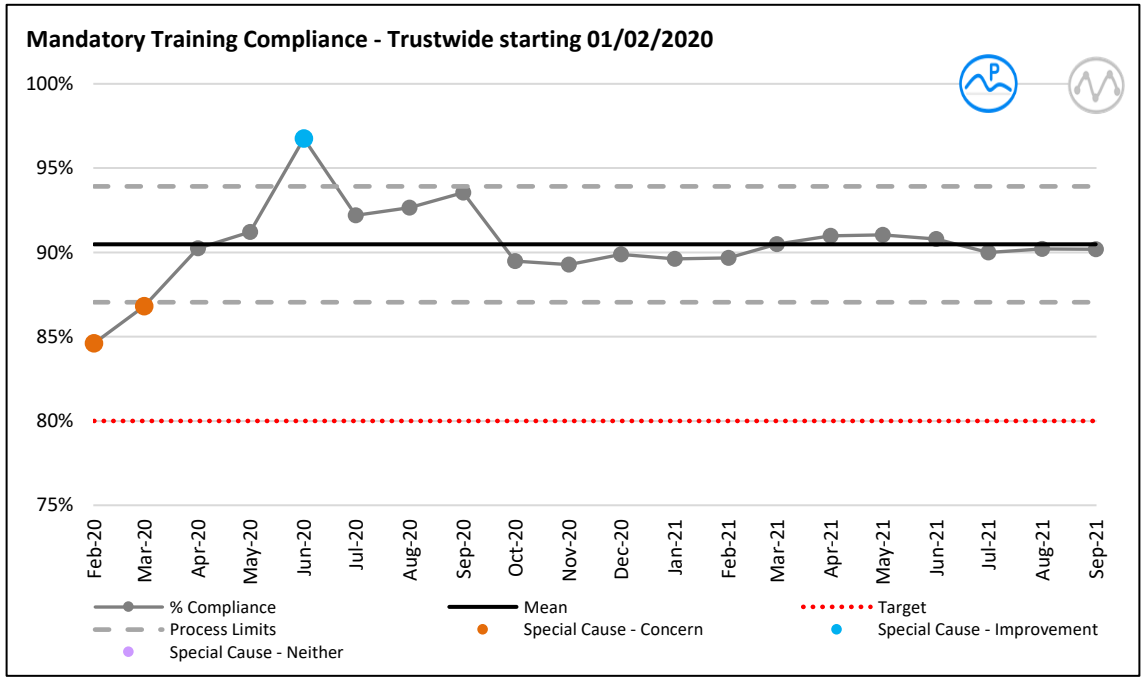
Weekly updated information is monitored and reviewed weekly by Directors and Service Leads. Improvement plan in START (R&S) is already having significant impact with improved rates. A recovery plan is in action for a number of teams within the Acute & Community Directorate, and the small minority of services in the Rehab & Specialist Directorate who are not consistently compliant.

Narrative

PDR Compliance

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

Mandatory Training



AIM

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

NARRATIVE

Week ending 03/10/21

Trustwide compliance 90.02%

EXCEPTIONS

Subjects Below 80%

Respect Level 2 & 3

Immediate Life Support

Services Below 80%

Grenoside Facilities 64.75%

Clinical Services Management Team 76.8%

PGME Personnel 71.9%

PGME Sheffield 77.5%

Sheffield Health and Social Care Mandatory Training Compliance @

03 October 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%

			03 October 2021					
Subject	**Level**	**Frequency**	No Requiring	No Achieved	No NOT Achieved	Compliance	Current Compliance against Previous Compliance %	
Equality, Diversity and Human Rights		3 Years	2559	2387	172	93.28%	Increase	0.02%
Hand Hygiene		3 Years	2559	2359	200	92.18%	Decrease	-0.61%
Health and Safety		3 Years	2559	2425	134	94.76%	Decrease	-0.28%
Information Governance (aka Data Security Awareness)		1 Year	2559	2222	337	86.83%	Decrease	-0.96%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2559	2420	139	94.57%	Decrease	-0.20%
Adult Basic Life Support		1 Year	2559	2187	372	85.46%	Decrease	-1.98%
Fire Safety		2 Years	2559	2080	479	81.28%	Decrease	-0.31%
Immediate Life Support		1 Year	220	175	45	79.55%	Decrease	-1.01%
Clinical Risk Assessment		3 Years	1007	888	119	88.18%	Decrease	-0.62%
Dementia Awareness		No Renewal	2559	2452	107	95.82%	Increase	0.08%
Autism Awareness		No Renewal	2559	2459	100	96.09%	Increase	0.24%
Mental Capacity Act	1	3 Years	1058	914	144	86.39%	Increase	0.46%
	2	3 Years	1117	1000	117	89.53%	Decrease	-0.32%
Deprivation of Liberty Safeguards	1	3 Years	2059	1910	149	92.76%	Decrease	-0.13%
	2	3 Years	117	108	9	92.31%		0.00%
Mental Health Act		3 Years	178	145	33	81.46%	Decrease	-1.97%
Medicines Management Awareness		3 Years	555	455	100	81.98%	Decrease	-1.84%
Rapid Tranquilisation		3 Years	281	233	48	82.92%	Decrease	-3.68%
Respect	1	3 Years	1147	1001	146	87.27%	Decrease	-0.45%
	2	2 Years	841	591	250	70.27%	Increase	2.36%
	3	1 Year	361	288	73	79.78%	Decrease	-3.51%
Safeguarding Children	1	3 Years	2229	2143	86	96.14%		
	2	3 Years	1079	993	86	92.03%	Decrease	-0.22%
	3	3 Years	1096	893	203	81.48%	Decrease	-2.19%
Safeguarding Adults	1	3 Years	2559	2164	395	84.56%		
	2	3 Years	2175	1989	186	91.45%	Increase	0.22%
Domestic Abuse	2	3 Years	2181	1952	229	89.50%	Increase	0.23%
Prevent WRAP		3 Years	2175	1992	183	91.59%	Increase	0.04%
Moving and Handling	1	3 Years	2559	2442	117	95.43%	Increase	0.23%
	2	3 Years	701	597	104	85.16%	Decrease	-0.08%
Overall compliance						**90.02%**	Decrease	-0.16%

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%/Safeguarding under 90%

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																	
	16/09/2021																100.00%	93.75%
	03/10/2021																100.00%	93.55%
Moving and Handling Level 2 (People)	31/12/2019																	
	16/09/2021	89.47%	91.43%	87.50%	83.33%	66.67%	90.63%	96.72%	68.25%	95.45%	100.00%	100.00%	96.67%	100.00%	81.58%	100.00%		
	03/10/2021	89.74%	88.89%	84.62%	86.21%	66.67%	87.50%	98.33%	68.25%	95.24%	100.00%	100.00%	96.67%	100.00%	83.78%	100.00%		
DOLs Level 2	31/12/2019	80%	29%	75%	80%	43%	36%	14%	56%	38%	67%	67%	100%	50%	50%			
	16/09/2021	85.71%	85.71%	100.00%	100.00%	71.43%	100.00%	92.31%	92.31%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
	03/10/2021	83.33%	85.71%	100.00%	100.00%	71.43%	100.00%	100.00%	92.31%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
Safeguarding Children L2	31/12/2019																88%	70%
	16/09/2021																100.00%	90.48%
	03/10/2021																100.00%	90.48%
Domestic Abuse	31/12/2019																73%	83%
	16/09/2021																96.55%	80.65%
	03/10/2021																96.43%	76.67%
MCA Level 2	31/12/2019		81%														60%	76%
	16/09/2021		86.36%														100.00%	85.37%
	03/10/2021		86.96%														97.22%	82.05%
Info Gov	31/12/2019		71%														67%	70%
	16/09/2021		93.88%														98.39%	78.13%
	03/10/2021		94.12%														98.33%	77.42%
Clinical Risk	31/12/2019		85%															
	16/09/2021		86.96%															
	03/10/2021		83.33%															
Fire 2 Year	31/12/2019		75%															
	16/09/2021		91.84%															
	03/10/2021		92.16%															
Respect Level 2	31/12/2019		94%												94%			
	16/09/2021		84.21%												93.75%			
	03/10/2021		85.00%												93.75%			
Respect Level 3	31/12/2019		88%															
	16/09/2021		83.33%															
	03/10/2021		83.87%															
Mental Health Act	31/12/2019		71%															
	16/09/2021		85.71%															
	03/10/2021		80.00%															
Basic Life Support	31/12/2019																65%	70%
	16/09/2021																96.77%	87.50%
	03/10/2021																98.33%	83.87%
ILS	31/12/2019														71%			
	16/09/2021														73.33%			
	03/10/2021														80.00%			

Subject	Date	Recovery North	Recovery South	CERT	Early Intervention	Adlt Hm Tr
Community Mental Health Act	16/09/2021	97.67%	89.58%	84.21%	86.84%	96.55%
	03/10/2021	97.56%	89.58%	82.05%	84.62%	96.30%

Narrative

CQC focus topics and areas

Cells in red indicate less than 80% compliance, or less that 90% compliance for Safeguarding training

Areas of Concern

Slippage or no improvement since previous reporting period 2 weeks prior

- Moving & Handling Level 2
  - Burbage/Dovedale 2
  - Woodland View
- Deprivation of Liberty Level 2
  - Burbage/Dovedale 2
- Domestic Abuse
  - MH Recovery South
- Information Governance
  - MH Recovery South

NB – Date shown in table to left is position as at w/c 04/10/21, compared with the 16 September 2021 position and December 2019 baseline where available.

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Financial Performance

IPQR - Information up to and including September 2021

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Well-Led | Financial Overview

KPI	Annual Plan £'000	Year to Date Plan £'000	Year To Date Actual £'000
Surplus/Deficit	0	0	2,336
Covid Expenditure	6,596	3,298	968
Agency	2,959	2,700	2,959
Cash	62,279	62,860	61,538
Efficiency Savings	3,028	1,514	1,402
Capital	7,707	4,270	2,509
Better Payments Practice Code	99.1% by Number 99.5% by Value		

Summary at September 2021:

- Trust wide surplus of £2.3m at the end of M6/H1 (Sept 21) as expected.
- Draft H2 income allocations received. Initial indication around £73m, in line with H1 allocation.
- The Trust has submitted a BE plan to the ICS. This position relies on a significant amount of recruitment. An upside position reflecting recruitment challenges is currently being prepared and will be shared shortly.
- MHIS spend shows initial signs of increasing as plans to repurpose slippage take effect. The underspend at H1 is around £1m as expected. The forecast underspend for the year has reduced to £1.1m.
- Covid underspend is £2.3m as expected. Covid funding for H2 confirmed at £3.3m, in line with the H1 allocation and £6.6m estimate for the year. Covid costs remain low and support an estimated £4.8m surplus at year end.
- Agency and Out of Area Costs remain high risk. Out of Area costs show early signs of stabilising, due to the contracts put in place to provide additional capacity while estates projects are completed.
- Agency costs now show a significant trend of sustained high levels of spending. Costs are forecast to hit £5.9m by year end.

SPC Metrics	SPC Variation	SPC Target
Covid Costs	• L •	n/a
Agency Staff £	• H •	F
Out of Area £	• H •	F

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

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Covid-19

IPQR - Information up to and including September 2021

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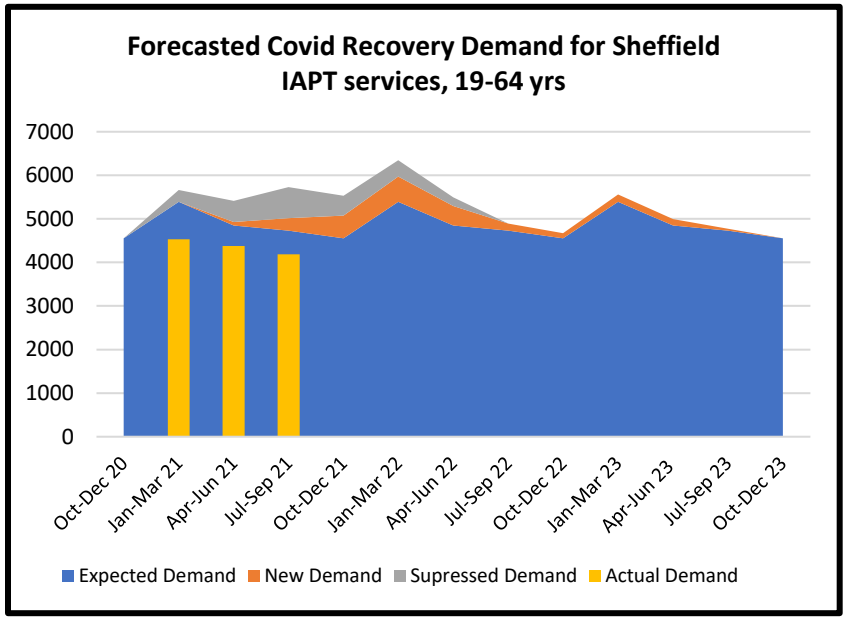
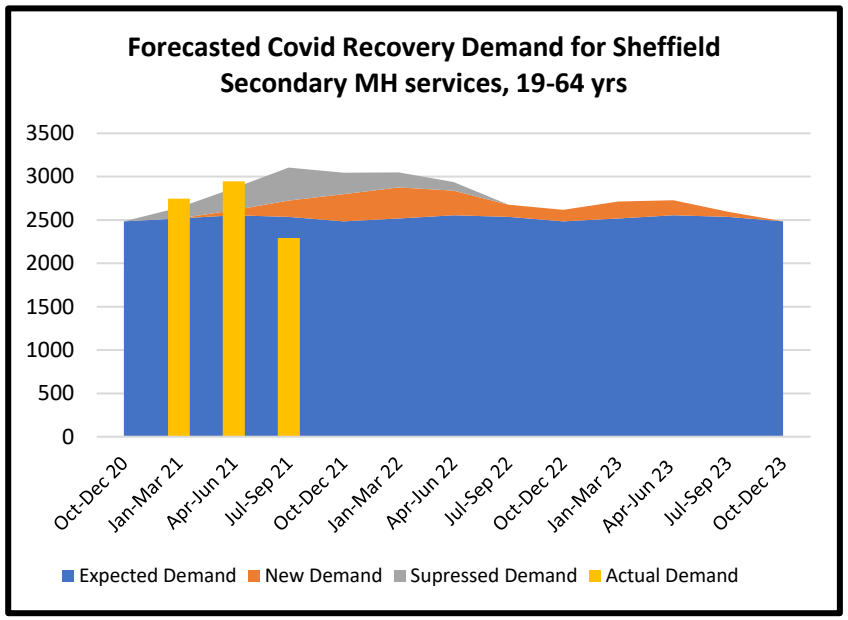
Covid-19 Outbreaks
There was a cluster outbreak amongst staff at START (Fitzwilliam Centre site) services in September 2021.
Inpatients with Covid-19
There were isolated inpatients at Forest Close and Dovedale 2 with Covid-19 during September 2021.
Covid-19 Deaths
No deaths of service users due to Covid-19 were reported in September 2021.
Covid-19 Related Staff Absence
As at 30 September, **30** staff were absent from the workplace for Covid related reasons. **6** were working and **24** were unable to work.

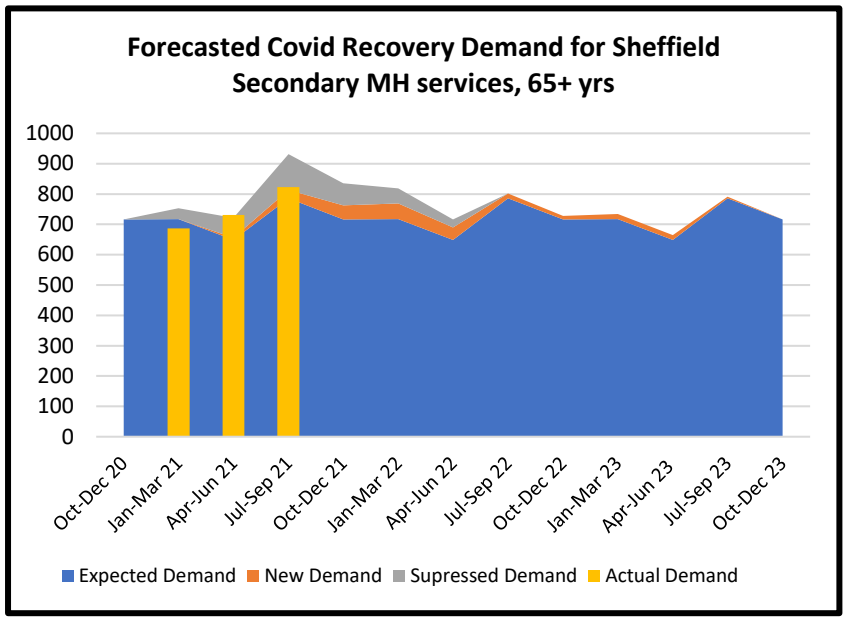
Staff Vaccination (as at 27th September 2021)
The primary data sources for the reports below are the National Immunisation Management System (NIMS) Reporting and our Electronic Staff Record (ESR). NIMS Reporting should include the vast majority of vaccination records for our staff, no matter where they 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	3048	100%	2649	399
Staff matched to at least one vaccination record	2685	88.1%	2329	356
Staff matched to two vaccination records	2631	**86.3%**	2278	353
Staff that could not be matched due to missing NHS number	155	5.1%	136	19
Staff that have not received at least one dose or missing NHS number	363	11.9%	320	43

	Not yet vaccinated		Received first dose only		Received both doses	
	Employee Count	%	Employee Count	%	Employee Count	%
457 Clinical Operations (L3)	196	9.8%	38	1.9%	1770	88.3%
457 Acute and Community Services (L4)	106	10.4%	23	2.2%	894	87.4%
457 Rehabilitation & Specialist Services (L4)	79	9.6%	15	1.8%	726	88.5%
457 Clinical Ops Directorate Management/Central (L4)	11	6.8%		0.0%	150	93.2%
457 Medical (L3)	40	20.1%	3	1.5%	156	78.4%
457 Corporate Services (L3)	75	13.1%	7	1.2%	490	85.7%
457 Chair/Chief Exec Office (L4)	3	11.5%		0.0%	23	88.5%
457 Director of Finance (L4)	4	5.3%	2	2.7%	69	92.0%
457 Nursing & Professions (L4)	9	15.5%	1	1.7%	48	82.8%
457 People Directorate (L4)	53	16.4%	3	0.9%	268	82.7%
457 Special Projects (L4)	6	7.1%	1	1.2%	78	91.8%
Volunteers (L3)	2	13.3%		0.0%	13	86.7%
Agency Staff (L3)	35	21.9%	4	2.5%	121	75.6%
Locum Doctors (L3)		0.0%		0.0%	6	100.0%
Medical Students (L3)	14	19.7%		0.0%	57	80.3%
Student Nurses (L3)	1	4.8%	2	9.5%	18	85.7%
Grand Total	363	11.9%	54	1.8%	2631	86.3%







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.

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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:

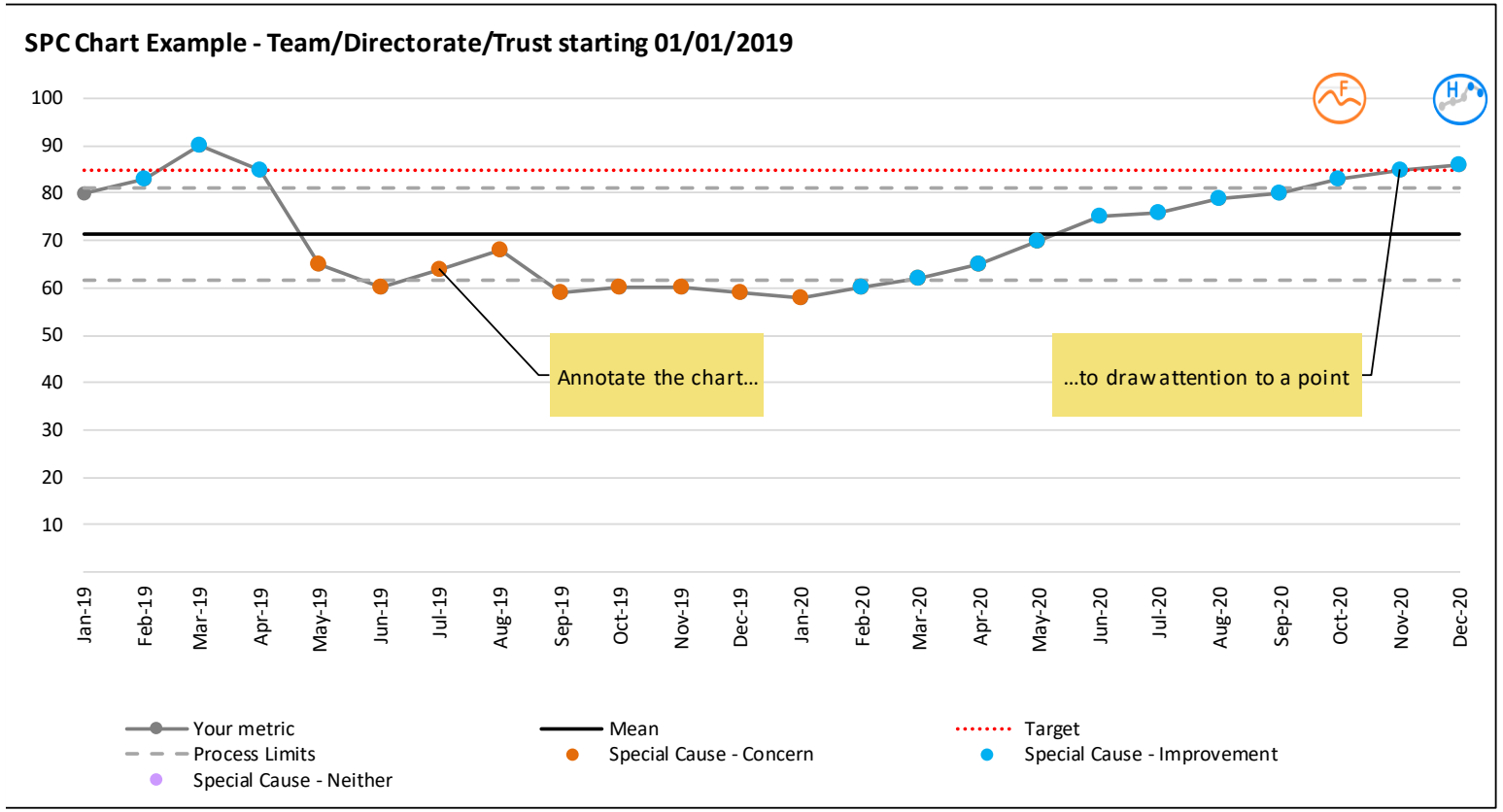
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	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 ●	● 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