Board of Directors - Public

SUMMARY	Meeting Date:	January 2022
	Agenda Item:	10

Report Title:	**Integrated Performance and Quality Report (IPQR) November 2021**	
Author(s):	Deborah Cundey, Head of Performance Tania Baxter, Head of Clinical Governance and Risk	
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:	11,12 and 13 January 2022
Key Points recommendations to or previously agreed at:	See below	

The known areas of risk/concern for the attention of the Board are:

- Increased/High demand specifically noted in
  - Central AMHP Team/MHA Assessment
  - Memory Service
  - SAANS
  - STEP
- Waiting lists and waiting times for community services
- Increasing caseloads/open episodes of care in Older Adult community services and Highly specialist community services
- Increasing length of stay in PICU (Endcliffe Ward), Dovedale 2 and flow problems through acute system
- Failure to meet elimination/reduction in Out of Area placements in acute MH services
- Persistent underperformance on annual review for service users on CPA
- Waiting times from referral to assessment in START (Opiates and Alcohol) services not meeting <7day target.
- Use of restrictive practice (Physical Restraint and Rapid Tranquillisation) higher than usual on Dovedale 1, Endcliffe Ward and at Forest Lodge.
- Increasing sickness absence Trust-wide
- Numbers of unvaccinated staff in clinical areas with mandated vaccination deadline approaching

The Board is asked to note the following areas of positive performance or improvement:

- Waiting times to assessment for Specialist Psychotherapy PD and MAPPS services continue to decrease.
- Improvements to discharged length of stay averages on G1 and Dovedale 1
- IAPT exceeding 6- and 18-week waiting time targets, national benchmarks and meeting the recovery standard for the second consecutive month.

- Significant improvements to the management of incident reviews and completion of SI actions
- Reductions in overall restrictive practices on Stanage ward and G1
- Continued low use of restrictive practices in Forest Close.
- Continued improvement of supervision compliance across Corporate Directorate services and excellent rates in Rehab & Specialist Clinical Directorate services.
- Trust-wide compliance with mandatory training exceeding 80/90% targets.

Committee Recommendations

People Committee
The committee were pleased to see the continued development of the IPQR and attention at People Committee and welcomed the summary sheet specific to People for the first time.

Concerns escalated for attention of Board were:

- High level of turnover amongst staff, linking to ability to recruit and retain.
- Increasing high levels of sickness absence. There was a request to separate covid absence figures from overall figures in order to understand the trends of both absence types, given the ongoing nature of the pandemic. This will be actioned immediately for future IPQR reports.
- Numbers of unvaccinated frontline staff, with the mandatory vaccination deadline fast approaching (early February 2022)

There was a request to see use of temporary staffing as a proportion of total staffing figures, triangulated with vacancies and absence. This was reported as a work in progress, with information currently made available at service and directorate level. We are defining the appropriate metric for inclusion in the Trustwide IPQR.

The committee agreed with the proposal that People Directorate colleagues and Performance Team work together to continue to improve the IPQR and People Dashboards and to reconcile the information presented in both reports, removing duplication and ensuring appropriateness.

Quality Assurance Committee
The committee were pleased to see the evidence of excellent improvement however there is a mixed picture e.g., supervision. It was noted that this in itself provided a level of assurance that we understand where areas are having problems, and where they are not.

The Medical Director queried the use of statistical process charts (SPC) and when it is deemed appropriate to re-calculate limits. Further discussion outside of committee to take place, with reference to Trust Performance Framework.

The committee recommended that Recovery Plans on Waiting Times/ Waiting Lists are addressed as follows:

- The two Specialist Psychotherapy Service (MAPPS and PD) move into business as usual (BAU) as a result of the improvements that have been realised and ongoing monitoring occurs through the monthly Directorate IPQR meetings, and the service should assess the impact of the changes on the people using the service to close the loop.
- SAANS and Gender Identity Service are now matters to be addressed through the commissioning route – with the risks to the people waiting properly articulated in the Corporate Risk Register.
- The focus on EWS/SPA and Recovery Teams remains, and the committee will be asking for assurance or a level of confidence that the new operating model will deliver improvements.

Finance and Performance Committee
The committee noted the additional Estates & Facilities dashboard item, which had been included alongside the IPQR for the first time. They welcomed the information and agreed that the Estates and Performance Teams should work together to incorporate the KPIs within the IPQR as soon as possible.

The committee noted the presentation to QAC of the 6 Recovery Plans pertaining to Waiting Lists and Waiting Times, along with the recommendations detailed above. The committee agreed to synchronise the

presentation of Recovery Plans which are reviewed by more than one committee, so the next update on the SPA/EWS and Recovery Teams plans will be to March 22 FPC.

The committee also welcomed the proposal to streamline and improve the Recovery Plan process as part of continuous development of the Trust Performance Framework.

Concerns escalated for the attention of Board were:

- The continuing increase/high Length of Stay in our PICU ward
- The high proportion of total resource (12%) spent on agency staffing and Out of Area placements.

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 November 2021.

The report was presented and considered in detail to the People, Quality Assurance and Finance & Performance Committees in January with a revised format of presenting a summary of highlights and concerns welcomed by the committees.

Those areas are further summarised below and the detail can be found within the body of the report itself, or by reference to the respective committee Summary.

Good Performance							
Committee				**KPI/Area**	**Refer to (slide)**	**Current Performance**	**Trend/Trajectory**	**Recovery Plan?**
F	Q			Waiting Lists and Waiting Times	6		Decreasing trend in two areas	Recovery Plan x 2 (SPS MAPPS, SPS PD)
F	Q			Inpatient Length of Stay – Step Down	7		Drop below lower process limit for live LoS in Wainwright Crescent	
F	Q			Inpatient Length of Stay – Older Adults	9		Decreasing trend in Dovedale 1 and G1	Links to Out of Area Recovery Plans.
F	Q			IAPT	13	 	Sustained shift above average in Recovery Rate. Meeting/ Exceeding targets for waiting times	
	Q			Incident & Serious Incident management	17		Decreasing trend in Clinical Directorates/Trustwide	
	Q		M	Restrictive Practices	21-23		Decreasing trend Stanage & G1	
	Q	P		Supervision	29		Increasing trend Trustwide	
		P		Mandatory Training	30-31		Meeting/ Exceeding target Trustwide	

Performance Concern								
Committee				KPI/Area	Refer to (slide)	Performance	Trend/ Trajectory	Recovery Plan?
F	Q			Demand for Services	5		Sustained increasing trend in certain areas	Links to Waiting List/Times Recovery Plans
F	Q			Waiting Lists and Waiting Times	6		Increasing trend in certain areas	Recovery Plan x 4 (EWS, Recovery Teams, Gender, SAANS)
F	Q			Caseloads/Open Episodes	6		Increasing trend in older adult community services and Highly Specialist community services	
F	Q			Length of Stay (inpatient areas)	7-8		Increasing trend on Dovedale 2 and Endcliffe PICU	Linked to Out of Area Recovery Plan(s) x 3
F	Q			Out of Area Placements	7-9		Failing to meet reduction/elimination of inappropriate OAPs	Out of Area Recovery Plan(s) x 3
F	Q			Annual CPA Review	12		Failing to meet 95% target	Recovery Plan in place.
F	Q			START – Referral to Assessment Waiting Times	14		Performance since September below lower control limits.	
	Q		M	Restrictive Practice	21-23		Performance in October over upper control limits in three areas.	
		P		Sickness Absence	27	 	Increasing trend Trustwide Failing to meet Trust target	
	Q	P		Supervision	29		Failing to meet target in some areas	Recovery Plan for all areas under 80% target
		P		Mandatory Training	30-31		Underperformance against 80/90% targets in a number of areas	
	Q	P		Covid Vaccination	35		Underperformance against targets in some frontline service areas	

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 concerns to performance and quality in the identified areas.							

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.
Data Security Protection 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 November 2021

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Contents	Slide/Page		Slide/Page
Introduction	3	Safety & Quality	16
Service Delivery	4	Safe | All Incidents	17
Access & Demand | Referrals	5	Safe | Medication Incidents & Falls	18
Access & Demand | Community Services	6	Safe | Assaults, Sexual Safety & Missing Patients	19
Access & Demand | Inpatient Services	7	Safe | Deaths	20
Inpatient Wards | Adult Acute and Step Down	7	Safe | Restrictive Practice	21
Inpatient Wards | PICU	8	Caring | User Experience	24
Inpatient Wards | Older Adult	9	Our People	25
Inpatient Wards | Rehabilitation & Forensic	10	Well-Led | Workforce Metrics	26
Inpatient Wards | Learning Disabilities	11	Financial Performance	34
Effective | Treatment & Intervention	12	Covid 19	36
IAPT	13	Appendices | SPC Explained & KPI Committee Oversight	40
START (Sheffield Treatment & Recovery Team)	14		

Blue Underlined Text = Click to link to page

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 November 2021

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Responsive | Access & Demand | Referrals

Referrals	Nov-21		
Acute & Community Directorate Service	**n**	*mean*	**SPC variation**
SPA/EWS	795	*838*	• • •
AMHP	162	*118*	• H •
Out of Hours Team	888	*872*	• • •
Liaison Psychiatry	483	*513*	• • •
Decisions Unit	54	***59***	• • •
S136 HBPOS	35	*33*	• • •
Adult Home Treatment Service	130	*108*	• • •
MH Recovery North	39		
MH Recovery South	30		
Recovery Service TOTAL	**69**	***45***	• • •
Early Intervention in Psychosis	41	*42*	• L •
Memory Service	152	*121*	• H •
OA CMHT	270	*237*	• • •
OA Home Treatment	36	*31*	• • •

Referrals	Nov-21		
Rehabilitation & Specialist Directorate Service	**n**	*mean*	**SPC variation**
CERT	4		
SCFT	1		
Psychotherapy Screening (SPS)	37	49	• L •
Gender ID	22	*47*	• • •
STEP	120	*68*	• H •
Eating Disorders Service	29	*30*	• • •
SAANS	404	*201*	• H •
R&S	12	*20*	• • •
Perinatal MH Service (Sheffield)	48	*51*	• • •
HAST	14	*12*	• • •
Health Inclusion Team	179		
LTNC - NES	42		
LTNC - Case Management	15		
SCBIRT	14		
CFS/ME			
CLDT	59		
CISS	1		

Narrative

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

Memory Service
The memory service has experienced elevated demand during this reporting period. The service is examining the referral data to understand whether this is suppressed demand arising following the easing of restrictions in order to manage the change in flow as effectively as possible.

Specialist Services STEP/SAANS
The SAANS waiting list is being reviewed by the clinical director and head of nursing to consider alternative pathways. The service has recruited a new clinical lead and is actively recruiting into vacancies. Discussions are taking place with the CCG to consider different ways of working.
Short Term Education Programme (STEP) referrals have increased, in line with new courses being established. The BPD course continues to have a high demand. The service is working with psychology to increase capacity.

Demand is regularly discussed in monthly Directorate IPQR meetings and in CCG and SCC contract management and quality review meetings.

Responsive | Access & Demand | Community Services

November 2021											
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	795	•••	1289	•H•	23.4	•••	32.4	•L•	1155	•L•
AMHP	Assessment	162	•••	*N/A*		*N/A*		*N/A*		*N/A*	
Out of Hours Team	Assessment	888	•••								
Liaison Psychiatry	Assessment	483	•••								
Decisions Unit	Treatment	54	•••								
S136 HBPOS	Assess & Treat	35	•••								
Adult Home Treatment Service	Assess & Treat	130	•••							73	•H•
MH Recovery North	Treatment	39		64	•H•	6.0	•••	6.9	•••	965	•L•
MH Recovery South	Treatment	30		65	•H•	6.6	•••	9.3	•L•	1083	•H•
Recovery Service TOTAL	***Treatment***	69	•••	129	•H•	*N/A*		*N/A*		***2048***	•••
Early Intervention in Psychosis	Assess & Treat	41	•L•	10	•••			*N/A. Refer to EIP AWT Standard.*		347	•L•
Memory Service	Assess & Treat	152	•H•	396	•H•	14.5	•••	24.4	•••	4234	•H•
OA CMHT	Assess & Treat	270	•••	143	•H•	5.6	•••	13.2	•••	1273	•H•
OA Home Treatment	Assess & Treat	36	•••	*N/A*		*N/A*		*N/A*		56	•••

Rehab & Specialist 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**
IAPT	Assess & Treat			*N/A*		*N/A*		*N/A*		*N/A*	
SPS (Screening)	Assess	37	•L•								
SPS - MAPPS	Assess & Treat	*N/A*		55	•••	15.1	•••	57	•••	303	•L•
SPS - PD	Assess & Treat	*N/A*		28	•L•	11.1	•L•	64.3	•••	190	•L•
Gender ID	Assess & Treat	22	•••	1437	•H•	158.6	•••	Incomplete		2246	•H•
STEP	Treatment	120	•H•	75	•••	*N/A*		Incomplete		396	•H•
Eating Disorders Service	Assess & Treat	29	•••	40	•H•	7.5	•H•	Incomplete		237	•H•
SAANS	Assess & Treat	404	•H•	4385	•H•	22.3	•H•	Incomplete		4569	•H•
R&S	Assess & Treat	12	•••	220	•H•	*N/A*		Incomplete		226	•L•
Perinatal MH Service (Sheffield)	Assess & Treat	48	•••	16	•••	2.2	•••	Incomplete		124	•••
HAST	Assess & Treat	14	•••	33	•••	15.1	•••	Incomplete		97	•H•
Health Inclusion Team	Assess & Treat	179		63		1.2		Incomplete		1306	
LTNC - NES	Assess & Treat	42		33		3.8		Incomplete		304	
LTNC - Case Management	Assess & Treat	15		4		0.8		Incomplete		179	
SCBIRT	Assess & Treat	14		11		6.0		Incomplete		122	
CFS/ME	Assess & Treat	Incomplete		Incomplete		Incomplete		Incomplete		Incomplete	
CLDT	Assess & Treat	59		217		14.6		Incomplete		843	
CISS	Assess & Treat	1		*N/A*		*N/A*		*N/A*		25	
CERT	Treatment	Incomplete		0		Incomplete		23.8		48	
SCFT	Assess & Treat	Incomplete		0		Incomplete		Incomplete		23	

Narrative

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, and for the Acute & Community services to FPC in November 2021.

Safe | Inpatient Wards | Adult Acute & Step Down

Adult Acute (Burbage/Dovedale2, Stanage, Maple)	Benchmark/ Target	Nov-21 n	Nov-21 mean	Nov-21 SPC variation	Nov-21 SPC target
Admissions	/	26	39	• L •	/
Detained Admissions	/	22	33	• • •	/
% Admissions Detained	50%	85%	87.52%	• • •	/
Emergency Re-admission Rate (rolling 12 months)	10.3%	2.94%	4.25%	• L •	P
Discharges	/	27	38	• • •	/
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%	88.7%	94.4%	• • •	?
Bed Occupancy incl. Leave	/	92.6%	98.8%	• L •	?
Average beds admitted to	/	43			
Average Discharged Length of Stay (12 month rolling)	32	35.8	36.0	• L •	F
Average Discharged Length of Stay (discharged in month)	32	35.5	37.5	• • •	/
Live Length of Stay (as at month end)	/	63.8	45.0	• H •	/
Number of Out of Area Placements started in period (admissions)	0 Inappropriate	10	9	• • •	?
Total number of Out of Area bed nights in period	0 Inappropriate	323	339	• • •	F
Total number of people in Out of Area beds in period	0 Inappropriate	21	20	• • •	F
Cost of Out of Area bed nights in period	0 Inappropriate	Refer to Directorate Finance Report			

Benchmarking Out of Area Placements
(NEY Provider Trusts shared information April – Nov 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	Oct-21	Nov-21	Sparklines
Bradford District Care NHS Foundation Trust	19	24	22	17	25	25	28	24	
Sheffield Health and Social Care NHS Foundation Trust	**22**	**18**	**23**	**13**	**11**	**16**	**15**	**16**	
South West Yorkshire Partnership NHS Foundation Trust	5	8	6	5	13	12	17	14	
Humber NHS Foundation Trust	21	21	18	16	21	16	5	13	
Leeds and York Partnership NHS Foundation Trust	2	11	12	16	9	14	18	8	
Cumbria Northumberland, Tyne and Wear Partnership NHS FT	0	0	0	1	2	5	4	8	
Tees, Esk and Wear Valleys NHS Foundation Trust	16	27	20	26	30	40	4	4	
Rotherham Doncaster and South Humber NHS Foundation Trust	2	7	9	17	13	8	6	4	
Navigo (NE Lincs/Grimsby)	1	0	0	0	0	3	4	2	

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

Narrative (Acute Wards)
Low occupancy rates and admissions into Sheffield beds are an indication of the works being carried out on acute wards and resultant closures of a small number of beds.

High live length of stay of particular note on Dovedale 2 – with a service user awaiting a nursing home placement agreed in December 2021.

Length of Stay Detail
Longest LoS (days) as at month end: **154** on Dovedale 2
Range = 0 to 154 days
Number of discharges in month: 27
Longest LoS (days) of discharges in month: 111

Step Down (Wainwright Crescent)	Benchmark/ Target	Nov-21 n	Nov-21 mean	Nov-21 SPC variation	Nov-21 SPC target
Admissions	/	6	6	• L •	/
Discharges	/	4	6	• • •	
Bed Occupancy excl. Leave (KH03)	95%	80.00%	84.1%	• • •	?
Bed Occupancy incl. Leave	95%	89.09%	93.4%	• • •	?
Average Discharged Length of Stay (12 month rolling)	/	66.10	53.98	• H •	/
Live Length of Stay (as at month end)	/	55.50	113.13	• L •	/

Narrative (Wainwright Crescent)

Longest Length of Stay patient now discharged to care home following a change in needs. This discharge will adversely impact the discharged LoS figures and positively impact the live LoS figures. SPC charts will be adjusted from next month to account for this.

Length of Stay Detail
Longest LoS (days) as at month end: 187
Range = 8 to 187 days
Number of discharges in month: 6
Longest LoS (days) of discharges in month: 1067

Inpatient Wards | PICU

PICU (Endcliffe)	Benchmark /Target	Nov-21 n	Nov-21 mean	Nov-21 SPC variation	Nov-21 SPC target
Admissions	/	0	3	• • •	/
Discharges	/	0	2	• • •	
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%	93.33%	91.0%	• • •	?
Bed Occupancy incl. Leave	95%	97.67%	93.7%	• • •	?
Average beds admitted to	/	10			
Average Discharged Length of Stay (12 month rolling)	47	53.95	47.67	• H •	?
Live Length of Stay (as at month end)	/	99.60	57.29	• H •	/
Number of Out of Area Placements started in the period (admissions)	0 Inappropriate	1	4	• • •	?
Total number of Out of Area bed nights in period	0 Inappropriate	57	157	• • •	F
Total number of people in Out of Area beds in period	0 Inappropriate	3	9	• • •	F
Cost of Out of Area bed nights in period	0 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

Length of stay remains high due to a lack of flow and availability of beds on acute wards for step down as well as a shortage of acute and PICU beds nationally.

The highest live length of stay relates to delays in the forensic pathway. The delay is recognised and appropriate clinical reviews continue.

Length of Stay Detail

Longest LoS (days) as at month end: 301
Range = 8 to 301 days
Number of discharges in month: 0
Longest LoS (days) of discharges in month: N/A

Safe | Inpatient Wards | Older Adults

Older Adult Functional (Dovedale 1)	Benchmark /Target	Nov-21 n	Nov-21 mean	Nov-21 SPC variation	Nov-21 SPC target
Admissions	/	8	5	• • •	/
Discharges	/	7	6	• • •	
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%	87.33%	93.3%	• • •	?
Bed Occupancy incl. Leave	95%	92.22%	98.0%	• • •	?
Average beds admitted to	/	14			
Average Discharged Length of Stay (12 month rolling)	73	78.27	80.57	• • •	?
Live Length of Stay (as at month end)	/	46.33	102.67	• L •	?

Length of Stay Detail
Longest LoS (days) as at month end: **153**
Range = 5 to 153 days
Number of discharges in month: 7
Longest LoS (days) of discharges in month: 688

Older Adult Dementia (G1)	Benchmark /Target	Nov-21 n	Nov-21 mean	Nov-21 SPC variation	Nov-21 SPC target
Admissions	/	3	4	• • •	/
Discharges	/	6	4	• • •	
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	6			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	76			
Bed Occupancy excl. Leave (KH03)	95%	57.50%	68.7%	• • •	?
Bed Occupancy incl. Leave	95%	58.75%	70.7%	• • •	?
Average beds admitted to	/	9			
Average Discharged Length of Stay (12 month rolling)	73	67.25	75.70	• L •	?
Live Length of Stay (as at month end)	/	59.78	52.51	• • •	/

Length of Stay Detail
Longest LoS (days) as at month end: **181**
Range = 1 to 181 days
Number of discharges in month: 6
Longest LoS (days) of discharges in month: 133

Narrative

A number of discharges have been facilitated around covid outbreaks that have impacted positively on the live length of stay in Dovedale 1 and the discharged length of stay on G1. Of note in November is the discharge of particularly long stay patient who transferred to Endcliffe PICU in early November. This has a positive impact on Dovedale 1 live and discharged LoS, however, the service user remains in inpatient care and has since transferred back to Dovedale. This service user who presents with highly complex needs has been the subject of multiple MDT clinical reviews, including multiple second medical opinions as well as an opinion from the national tertiary centre for affective disorders. We will continue to carefully review their care.

Older Adult (Out of Area)	Benchmark /Target	Nov-21 n	Nov-21 mean	Nov-21 SPC variation	Nov-21 SPC target
Placements started in the period (admissions)	0 Inappropriate	1	1	• • •	?
Total number of Out of Area bed nights in period	0 Inappropriate	65	69	• • •	?
Total number of people in Out of Area beds in period	0 Inappropriate	3	4	• L •	
Cost of Out of Area bed nights in period	0 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	Nov-21 n	Nov-21 mean	Nov-21 SPC variation	Nov-21 SPC target
Admissions	/	0	1	• • •	/
Discharges	/	1	3	• • •	
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	2			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	34			
Bed Occupancy excl. Leave (KH03)	95%	78.53%	80.74%	• L •	?
Bed Occupancy incl. Leave	95%	85.20%	92.65%	• L •	?
Average Discharged Length of Stay (12 month rolling)	441	281.03	336.87	• L •	P
Live Length of Stay (as at month end)	/	362.28	372.77	• 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	180			
Total number of people in Out of Area beds in period	0	6			
Cost of Out of Area bed nights in period	0	Refer to Directorate Finance Report			

Forensic Low Secure (Forest Lodge)	Benchmark/ Target	Nov-21 n	Nov-21 mean	Nov-21 SPC variation	Nov-21 SPC target
Admissions	/	1	1	• • •	/
Discharges	/	1	1	• • •	
Bed Occupancy excl. Leave (KH03)	95%	76.06%	85.53%	• • •	?
Bed Occupancy incl. Leave	95%	91%	93%	• • •	?
Average Discharged Length of Stay (12 month rolling)	707	333.65	399.94	• L •	P
Live Length of Stay (as at month end)	/	490.80	448.39	• 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: 1993
Range = 12 to 1993 days
Number of discharges in month: 1
Longest LoS (days) of discharges in month: 50

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 November 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.

Length of Stay Detail
Longest LoS (days) as at month end: 1959
Range = 21 to 1959 days
Number of discharges in month: 1
Longest LoS (days) of discharges in month: 758

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)

Section intentionally blank.
Learning Disabilities Inpatient Service currently closed.

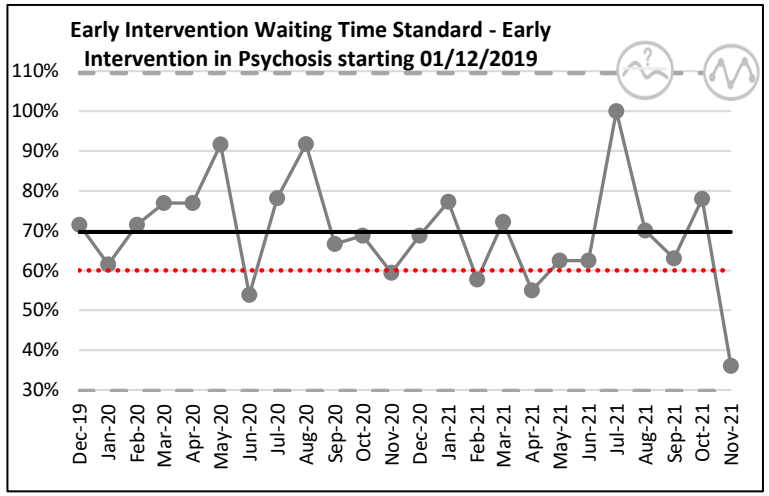
Narrative

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

Of note during November:

Recruitment commenced for the new Clinical Director post. The programme board has been established detailing timelines and subgroups. The service continues to recruit into vacancies.

Effective | Treatment & Intervention



EIP AWT Standard		Nov-21		
	Target 2021/22	n	SPC variation	SPC target
Trustwide	60%	36%	· · ·	?

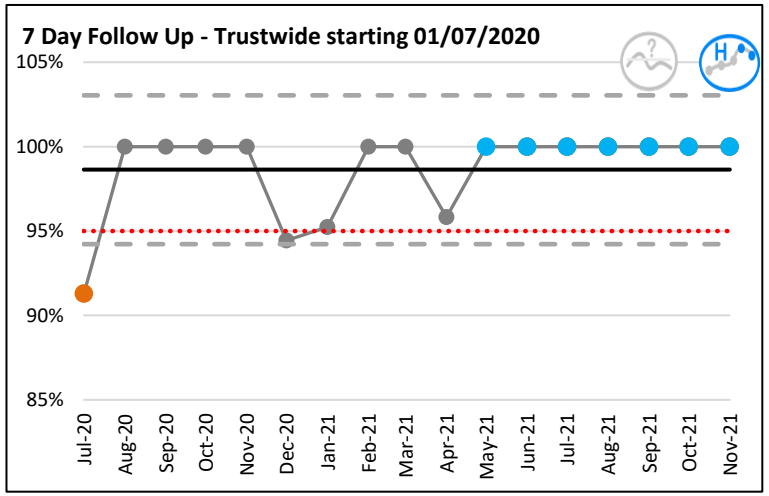
Narrative

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 November = 36% (4/11)

The service have noted the drop in performance against the target. This can be attributed to the severe staffing shortage over this month (14 in total) All 11 referrals have since been seen and added to caseload.



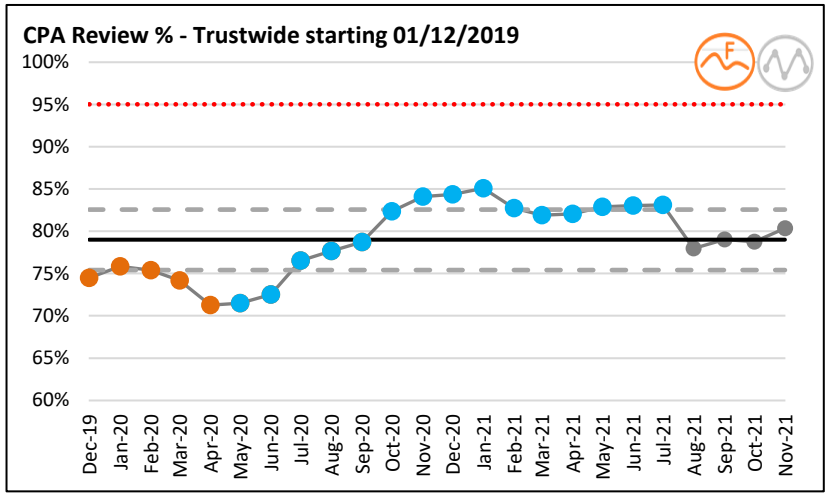
7 Day Follow Up		Nov-21		
	Target 2021/22	n	SPC variation	SPC target
Trustwide	**95%**	**100%**	· H ·	?

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%.



		Nov-21			
CPA Review % Completed within 12 months	Target 2021/22	n	Mean	SPC variation	SPC target
Trustwide	**95%**	80.35%	*78.99%*	• • •	F
Early Intervention	95%	84.26%	*89.88%*	• • •	?
MH Recovery North	95%	89.94%	*84.70%*	• • •	F
MH Recovery South*	95%	67.37%	*75.12%*	• • •	F

*Baseline recalculation from July 2020

Narrative

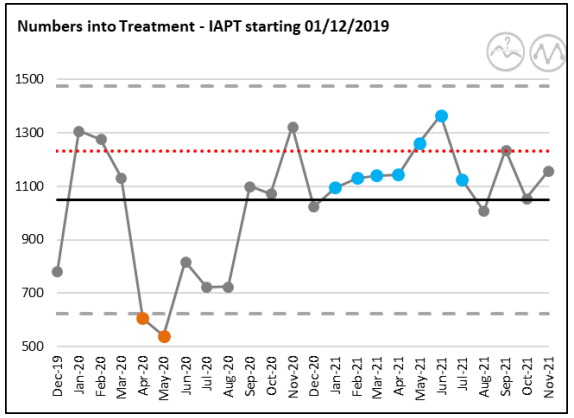
Compliance against the existing but now phased out target has a detailed recovery plan that has produced a positive impact in both Recovery Teams and Early Intervention Service. Weekly reports are in place and performance data supports the view that there are early indications of sustained improvement.

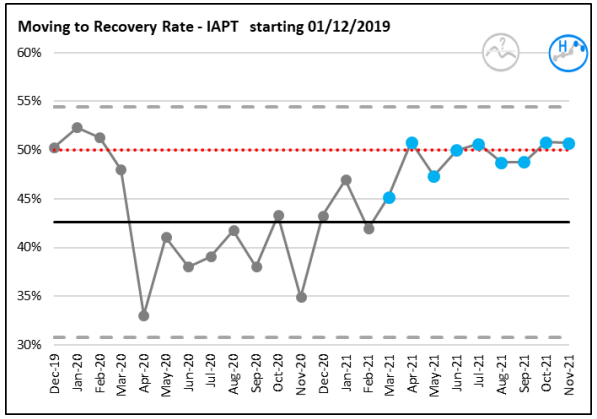
Development work has started on the process, systems and measurement of the 5 principles that have replaced CPA.

IAPT | Performance Summary

IAPT		Nov-21			
Metric	Target 2021/22	n	*mean*	SPC variation	SPC target
Referrals*	n/a	1792	*1628*	• • •	/
New to Treatment	1232	1158	*1047*	• • •	?
6 week Wait	75%	98%	*89.2%*	• H •	P
18 week Wait	95%	99.6%	*99.46%*	• • •	P
Moving to Recovery Rate	50%	50.7%	*42.6%*	• H •	?

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





Narrative

Access
1158 new to treatment. Delays in HR processes to recruit a 12 months comms role to develop and deliver on a communication, marketing and promotion strategy has had an impact

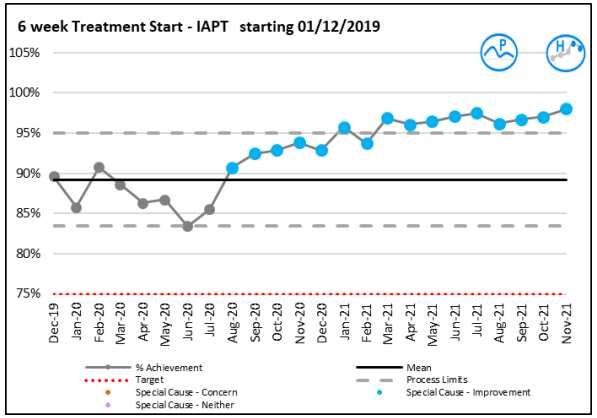
Waiting Times
98% of people entered treatment within 6 weeks against a 75% standard
99.6% of people entered treatment within 18 weeks against a 95% standard

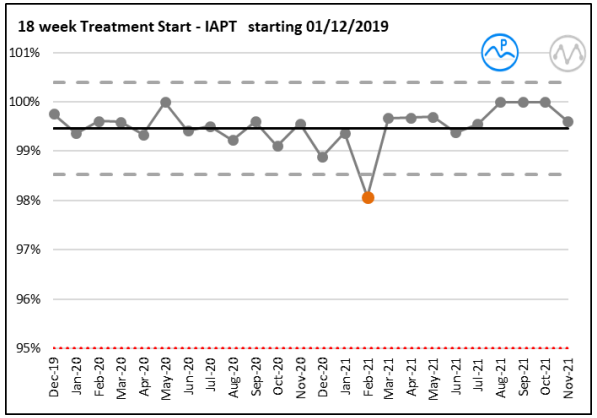
Benchmarking
National waiting times for IAPT continue to exceed targets and they have done so throughout the Covid-19 pandemic. Annual data for 2020/21 was 90% of referrals having waiting time less than 6 weeks and 98% less than 18 weeks. In Sheffield we are exceeding these national averages.

Recovery
Met the recovery standard for November: 50.7%

Other Highlights/Achievements/Concerns
- Positive inspection from Appts regarding re-accreditation
- New IAPT branding agreed ready for website launch and comms post in place in January

- Any further HR delays in people starting in post (regular HR meeting to offset risks)
- Estates continue to be a risk for IAPT. 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 service delivery and staff wellbeing
- Room availability in primary care: room availability to be provided from primary care to support plans to return to primary care from April 2022 for f2f clinics. Currently patients are seen for f2f appointments based on need





START – Sheffield Treatment & Recovery Team | Performance Summary

START		November-21		
Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	80	• L •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	73%	• L •	P
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	100%	• H •	P
DNA Rate to Assessment	≤ 15%	29%	• • •	?
Recovery - Successful treatment exit	TBC	9	• • •	/
Non-Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	58	• H •	/
Waiting time Referral to Assessment	≥ 95%	93%	• • •	?
Waiting time Referral to Treatment	≥ 95%	100%	• • •	P
DNA Rate to Assessment	≤ 15%	29%	• • •	?
Recovery - Successful treatment exit	TBC	18	• • •	/
Alcohol	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	180	• H •	/
Waiting time Referral to Assessment	≥ 95%	40%	• L •	P
Waiting time Referral to Treatment	≥ 95%	100%	• H •	P
DNA Rate to Assessment	≤ 15%	26%	• • •	?
Recovery - Successful treatment exit	TBC	40	• 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.

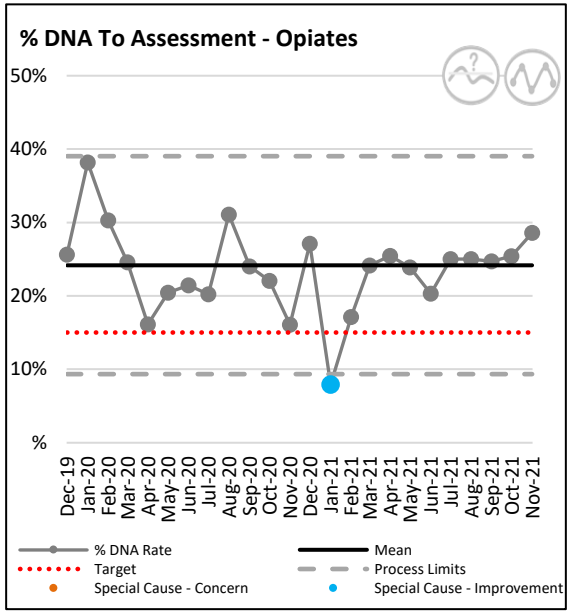
Staff absences continue to place a pressure on achieving the target for referral to assessment. Breaches to these timescales are agreed by management and every effort is made to rearrange appointments if a cancellation occurs or additional appointments are available sooner.

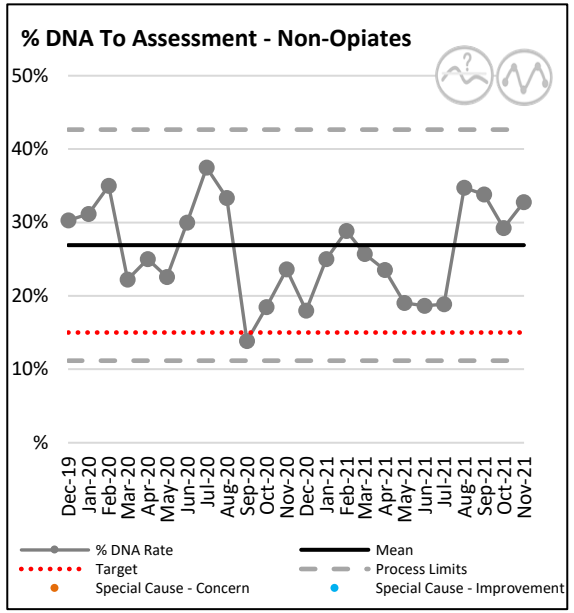
The service has historically overperformed on waiting times, with very few breaches. However a combination of annual leave, sickness and a covid outbreak have impacted on service ability to complete assessments within the 7 days. Data for November has shown the service has gradually improved on wait times although they are not yet back to expected levels. Access to treatment remains with no waiting list and the waiting times to start structured treatment are not impacted.

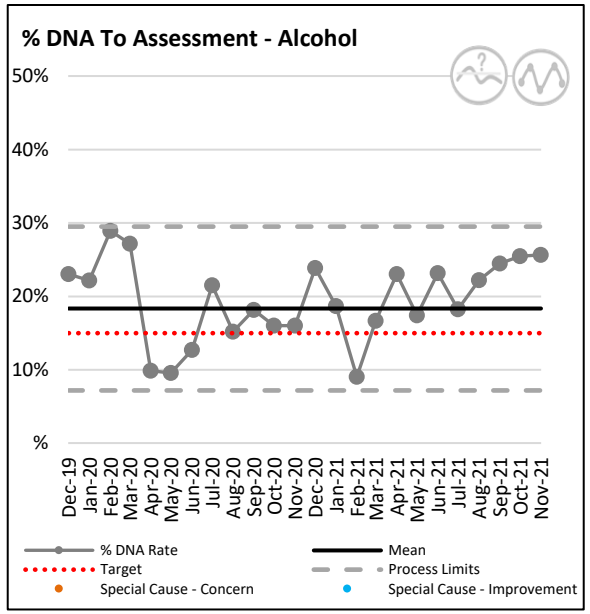
Recovery

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



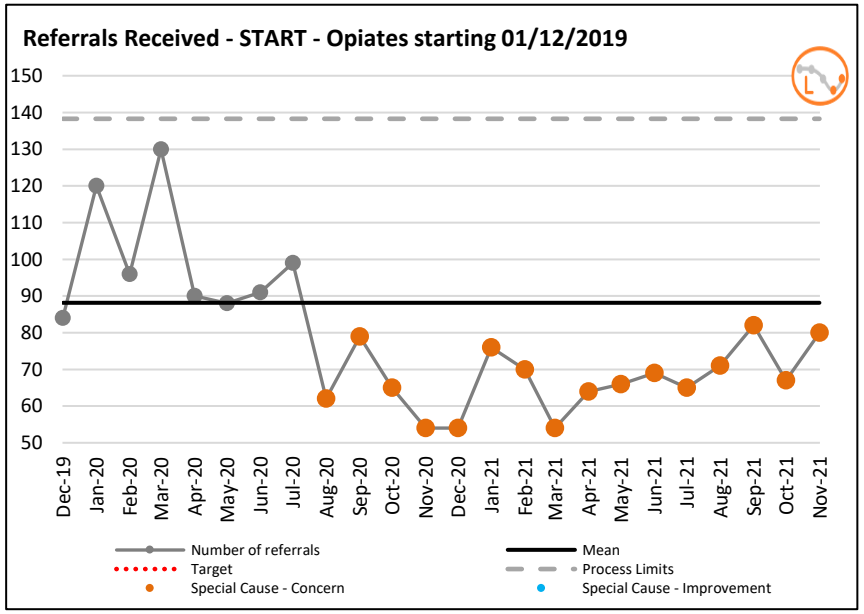


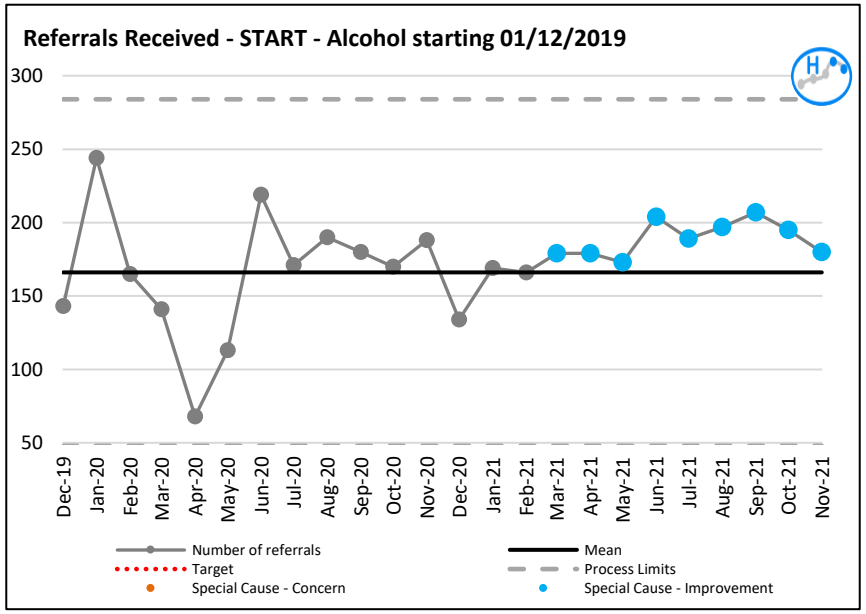


DNA Rate to Assessment Narrative

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.

Referrals to the alcohol service have been consistently higher during 2021 and the service welcomes the increase. However, staff absence continues to put pressure on ensuring timescales for triage are met.

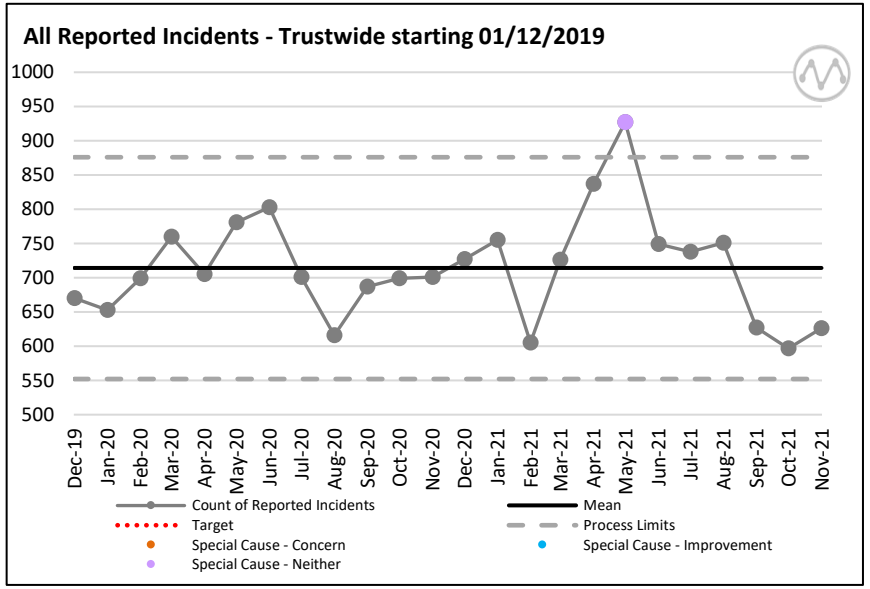
NHS
Sheffield Health and Social Care
NHS Foundation Trust

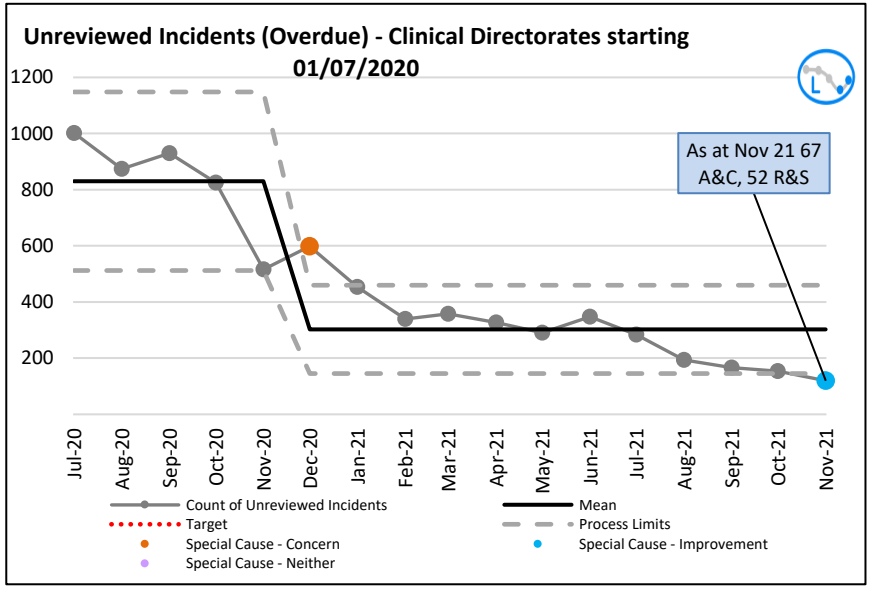
Safety & Quality

IPQR - Information up to and including November 2021

Proud to care in Sheffield

Safe | All Incidents



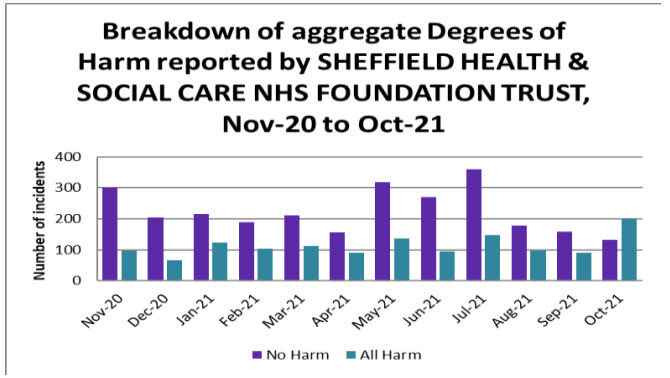


Narrative

We brought the way that we categorise incidents where harm is caused in line with national guidance, which means that from October 2021 we are categorising any incident where harm is caused as at least Minor. This accounts for the drop in negligible incidents in October 2021 and the increase in minor incidents.

The chart below shows patient safety incidents reported where harm was caused compared to no harm caused from Nov 2020 to Oct 2021.

Patient Safety Incidents – Harm vs No Harm



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.

Trustwide	Nov-21		
	n	*mean*	SPC variation
ALL	**626**	*715*	• • •
5 = Catastrophic	15	*14*	• • •
4 = Major	13	*5*	• • •
3 = Moderate	65	*36*	• • •
2 = Minor	288	*171*	• H •
1 = Negligible	214	*469*	• L •
0 = Near-Miss	31	*21*	• • •

Serious Incident Actions Outstanding

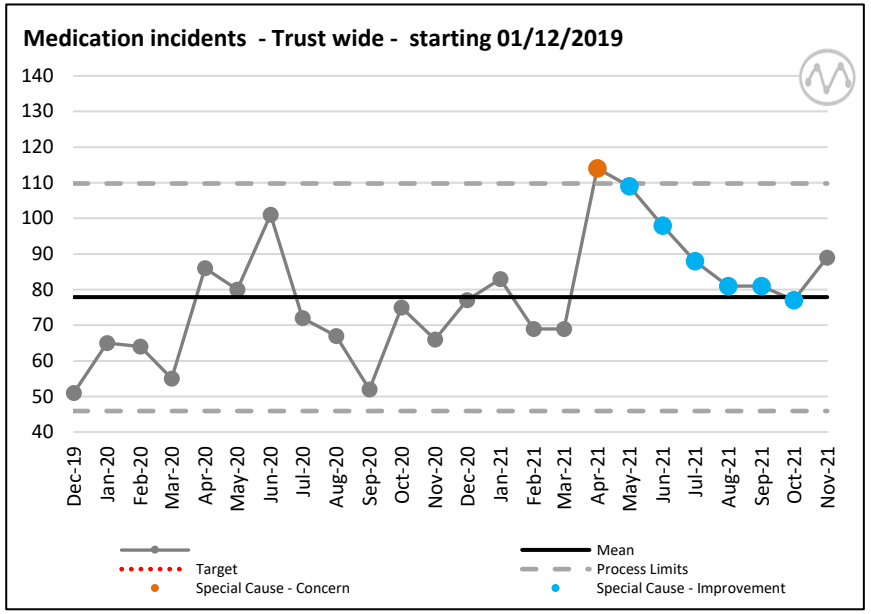
As at 29 November 2021, there were 71 outstanding SI actions overdue, reduced from 80 at the end October.

- 9 of these are from SIs in 2019
- 50 of these are from SIs in 2020
- 12 of these are from SIs in 2021

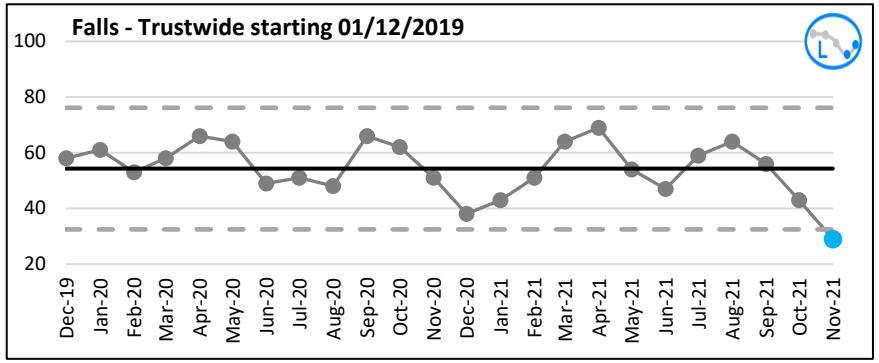
Weekly reports are being sent to identified matrons and general managers from July 2021 to oversee and complete all SI action plans.

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

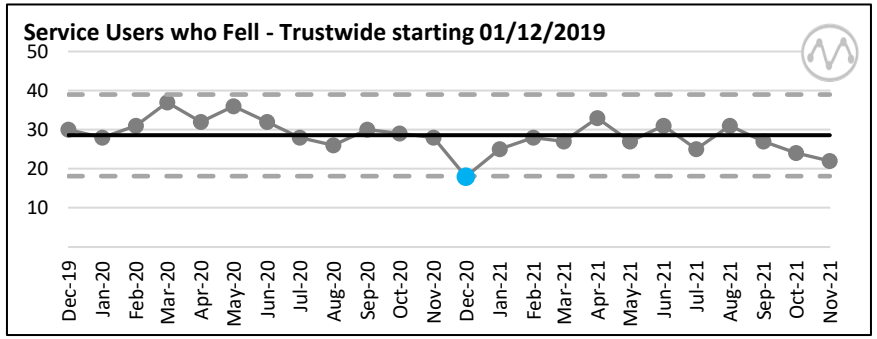
Safe | Medication Incidents & Falls



Trustwide	Nov-21		
	n	*mean*	SPC variation
ALL	**89**	*78*	• H •
Administration Incidents	**12**	*16*	• • •
Meds Management Incidents	**60**	*49*	• H •
Pharmacy Dispensing Incidents	**9**	*7*	• • •
Prescribing Incidents	**7**	*6*	• • •
Meds Side Effect/Allergy Incidents	**1**	*0*	• H •



Trustwide	Nov-21		
	n	*Mean*	SPC variation
Falls incidents	**29**	*54*	• L •
Acute & Community	**27**	*51*	• L •
Rehabilitation & Specialist Services	**2**	*3*	• • •



Trustwide	Nov-21		
	n	*mean*	SPC variation
Individuals who fell	**22**	*29*	• • •
Acute & Community	**20**	*26*	• • •
Rehabilitation & Specialist Services	**2**	*3*	• • •

Narrative

Medication Incidents

Until November 2021, the number of reported medication incidents showed a downward trend since a peak in April 2021. Special cause variation is shown as numbers were above the 24-month average for a 7-month period.

There were 3 moderate medication incidents in November 2021. One of the incidents involved expired medication, one involved medication being transferred between wards due to insufficient stocks and one involved a missed dose (not on SHSC premises).

Falls Incidents

No moderate or above incidents reported in the month, with 22 of the 29 incidents classed as Negligible. Trustwide in November falls incidents were low, which looks mainly to have been caused by a drop in numbers across Acute & Community Directorate, particularly the Older Adult inpatient and residential areas. The low occupancy rates on G1 in November may also contribute.

Safe | Assaults, Sexual Safety & Missing Patients

Assaults on Staff	Nov-21		
	n	mean	SPC variation
Trustwide	53	87	• • •
Acute & Community	48	68	• • •
Rehab & Specialist	4	19	• • •

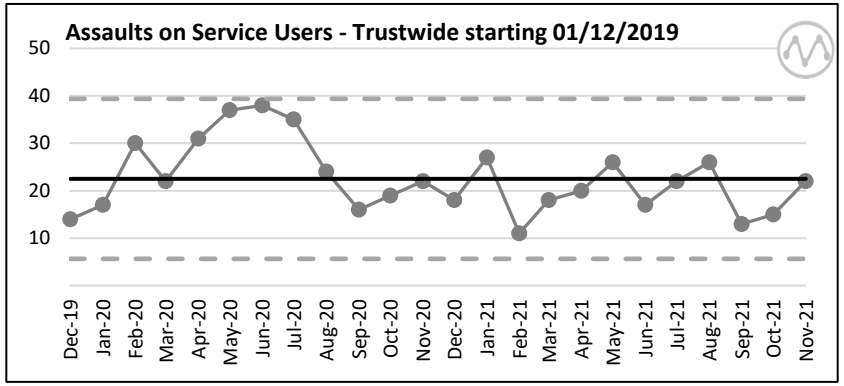
Assaults on Service Users	Nov-21		
	n	mean	SPC variation
Trustwide	22	23	• • •
Acute & Community	12	20	• • •
Rehab & Specialist	10	3	• H •

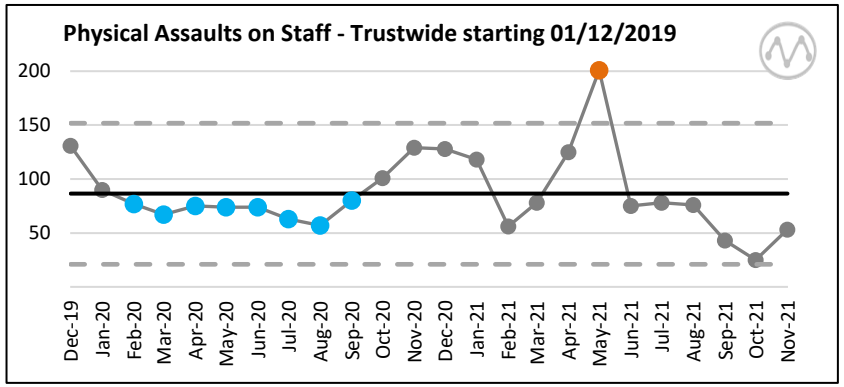
Narrative

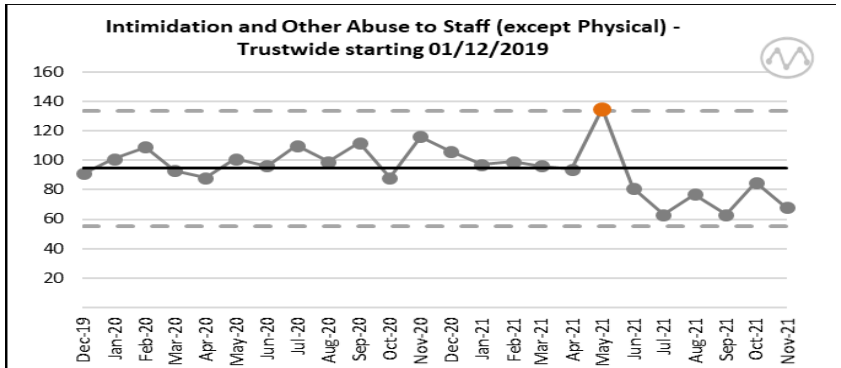
Assault to Staff
15 moderate incidents recorded in November 2021 – 11 on Endcliffe, 1 on G1, 2 on Maple, 1 in R&S (Forest Lodge). All of these incidents were Physical Assault Patient to Staff. It should be noted that any incident which results in a service user being secluded is classified as a moderate incident (as a minimum), irrespective of the severity of the assault.

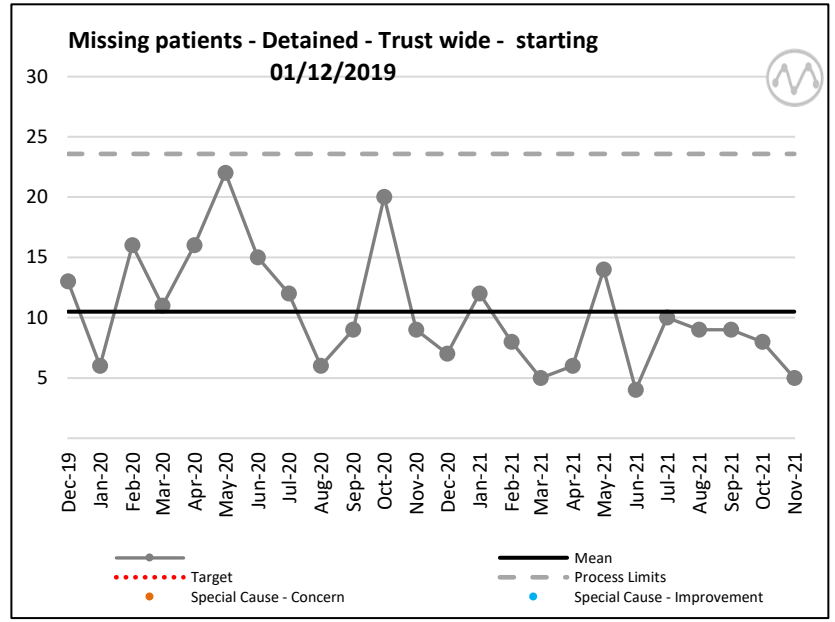
Assault on Service Users
2 moderate incidents recorded in November 2021 – 1 on Endcliffe, 1 on Maple, both resulted in the service user being secluded (hence the moderate grading). 1 major incident recorded in IAPT in the community, which was a historic alleged sexual assault that was reported to the police and a safeguarding concern raised.

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









Trustwide	Nov-21		
	n	mean	SPC variation
Missing Patients (Informal)	2	3	• • •
Missing Patients (Detained)	5	11	• • •

Deaths

Service User Deaths 1 – 30 November 2021	
Community Learning Disability Team	1
G1 Ward	1
IAPT	1
Long Term Neurological Conditions	2
Mental Health Recovery Teams	1
Older Adult Community Mental Health Teams	10
Memory Service	1
Liaison Service	2
START Alcohol and Opiates/Non-opiates Services	2
Woodland View	1
Total	**22**

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

Deaths Reported 1 April 2020 – 30 November 2021	
Awaiting Coroners Inquest/Investigation	155
Conclusion - Narrative	7
Conclusion - Suicide	13
Conclusion – Accidental	3
Conclusion – Misadventure	1
Conclusion – Open	1
Natural Causes/No Inquest	515
Alcohol/Drug related	23
Suspected Homicide/Closed	2
Ongoing	1
Grand Total	**721**

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

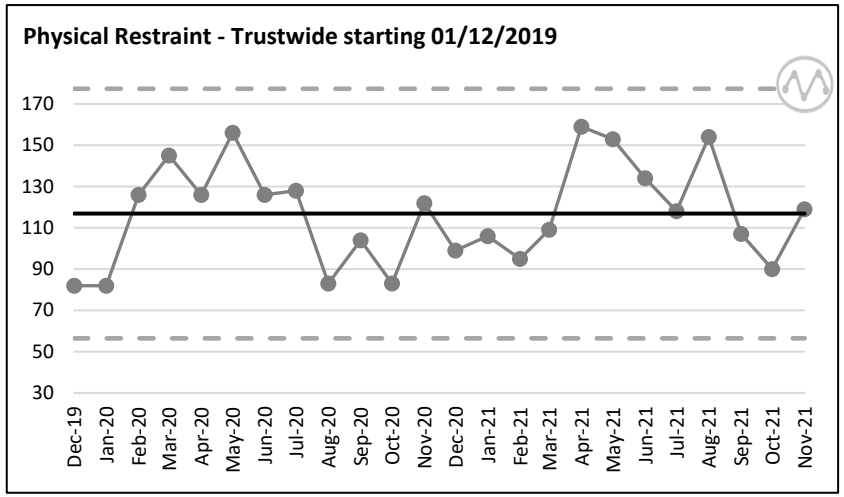
Covid-19 Deaths 1 March 2020 – 30 November 2021	
ATS (Firshill Rise)	1
Community Intensive Support Service (CISS) (LD)	1
Birch Avenue	5
Community Learning Disability Team	5
G1 Ward	5
Liaison Psychiatry	5
Long-term Neurological Conditions	2
Memory Service	7
Mental Health Recovery Team	2
Neuro Case Management Team	1
Neuro Enablement Service	3
Older Adult Community Mental Health Teams	42
Older Adult Home Treatment Service	3
START Alcohol Service	1
START Opiates Service	1
Woodland View	1
Total	**85**

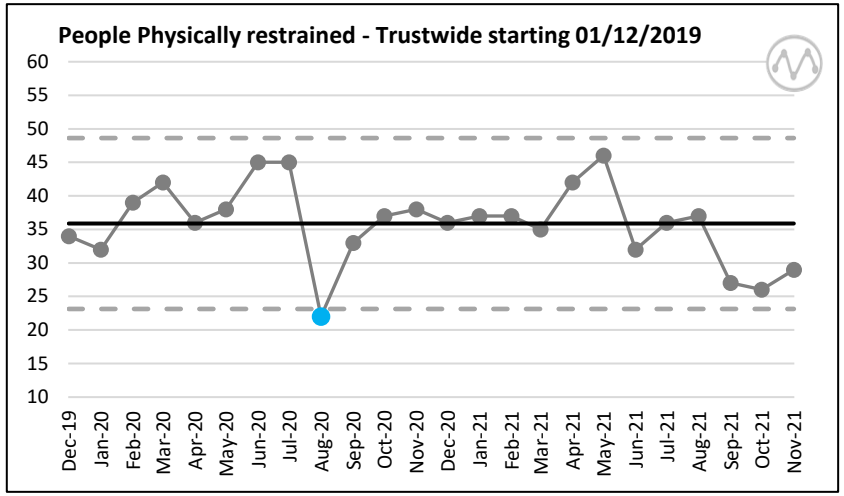
Classification of Deaths 1 – 30 November 2021	
Expected Death	5
Unexpected Death - SHSC Community	9
Unexpected Death (Suspected Natural Causes)	8
Grand Total	22

Out of the 22 patient deaths recorded in the month, 13 of these were natural causes deaths and required no inquest and 9 are awaiting an inquest/investigation.

All 15 catastrophic incidents during November 2021 were deaths. 8 were unexpected community deaths, 2 were expected deaths and 5 were unexpected deaths but suspected natural causes.

Safe | Restrictive Practice | Physical Restraint





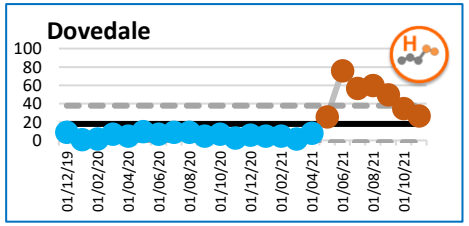
Physical Restraint INCIDENTS	Nov-21		
	n	*mean*	SPC variation
TRUSTWIDE	119	*117*	• • •
Acute & Community	115	*103*	• • •
Burbage Ward	11	*14*	• • •
Stanage Ward	2	*20*	• L •
Maple incl 136	21	*14*	• • •
Endcliffe Ward	50	*28*	• • •
Dovedale	27	*18*	• H •
G1 Ward	4	*9*	• • •
Birch Ave	0	*1*	• • •
Woodland View	0	*1*	• • •
Rehabilitation & Specialist Services	3	*13*	• • •
ATS (Firshill Rise)	0	*11*	• • •
Forest Close	0	*2*	• • •
Forest Lodge	3	*1*	• • •

Physical Restraint INDIVIDUALS9.5	Nov-21		
	n	*mean*	SPC variation
TRUSTWIDE	29	*36*	• • •
Acute & Community	27	*32*	• • •
Burbage Ward	4	*6*	• • •
Stanage Ward	2	*6*	• • •
Maple incl 136	9	*8*	• • •
Endcliffe Ward	5	*6*	• • •
Dovedale	5	*3*	• • •
G1 Ward	2	*4*	• • •
Birch Ave	0	*1*	• • •
Woodland View	1	*1*	• • •
Rehabilitation & Specialist Services	2	*4*	• • •
ATS (Firshill Rise)	0	*2*	• • •
Forest Close	0	*1*	• • •
Forest Lodge	2	*1*	• • •

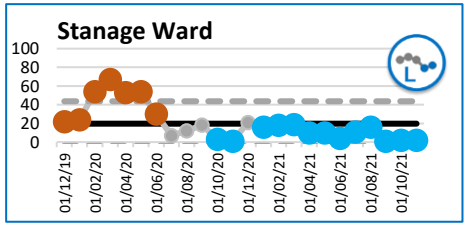
Narrative

High levels of physical restraint in Dovedale 1 remain above the average with same pattern of use of rapid tranquilisation on Dovedale 1.

The service user transfer from Dovedale 1 to Endcliffe on 8 November (refer to detail on p9) shows in the continued physical restraint reduction on Dovedale 1 and increase on Endcliffe.



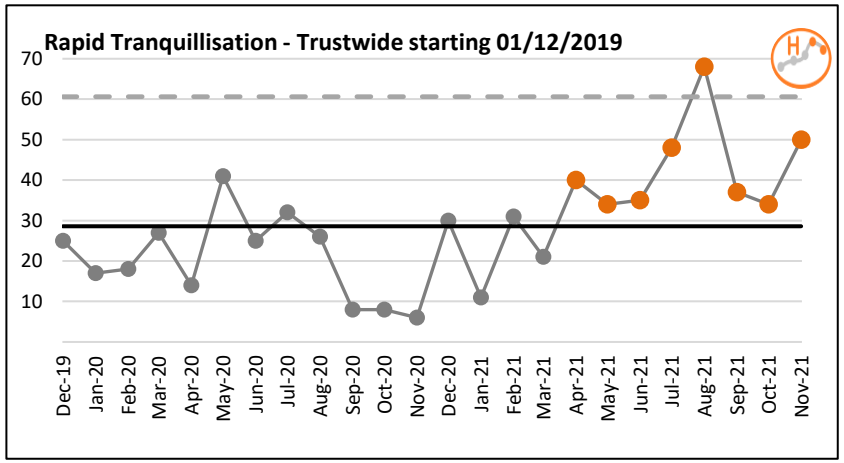
Continuing low use of restrictive practices on Stanage ward.

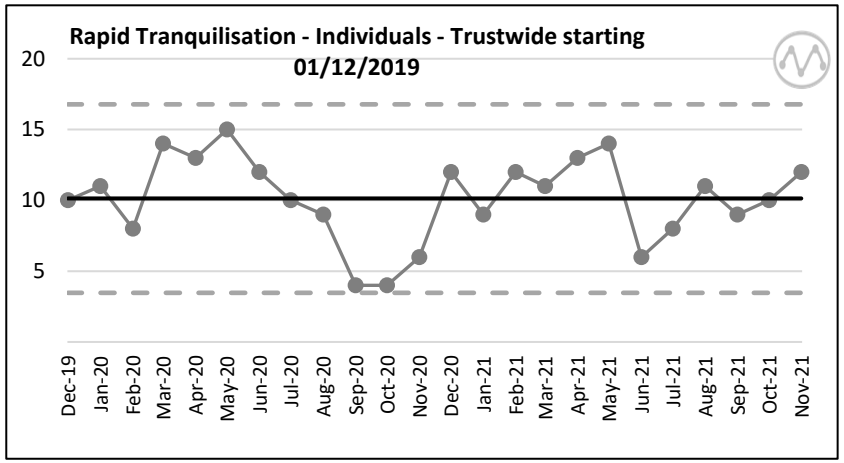


Continued low use of restrictive practices in Forest Close.

There were no mechanical restraints reported during November 2021.

Safe | Restrictive Practice | Rapid Tranquillisation





Rapid Tranquillisation INCIDENTS	Nov-21		
	N	*mean*	SPC variation
TRUSTWIDE	50	29	• H •
Acute & Community			
Acute & Community	48	28	• H •
Services			
Burbage/Dovedale 2 Ward	3	4	• • •
Stanage Ward	1	4	• L •
Maple incl 136	3	3	• • •
Endcliffe Ward	26	7	• H •
Dovedale	15	9	• H •
G1 Ward	0	2	• • •
Rehabilitation & Specialist	2	0	• H •
Services			
Forest Lodge	2	0	• H •

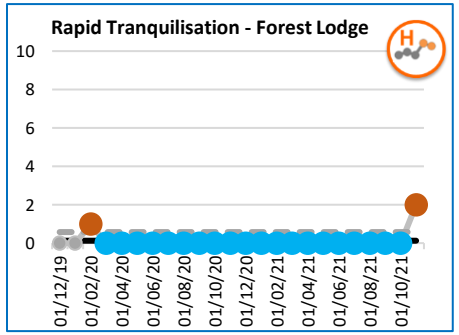
Rapid Tranquillisation INDIVIDUALS	Nov-21		
	N	*mean*	SPC variation
TRUSTWIDE	12	10	• • •
Acute & Community			
Acute & Community	11	10	• • •
Services			
Burbage/Dovedale 2 Ward	3	2	• • •
Stanage Ward	1	2	• • •
Maple incl 136	3	2	• • •
Endcliffe Ward	3	2	• • •
Dovedale	2	1	• • •
G1 Ward	0	1	• • •
Rehabilitation & Specialist	1	0	• • •
Services			
Forest Lodge	1	0	• H •

Narrative

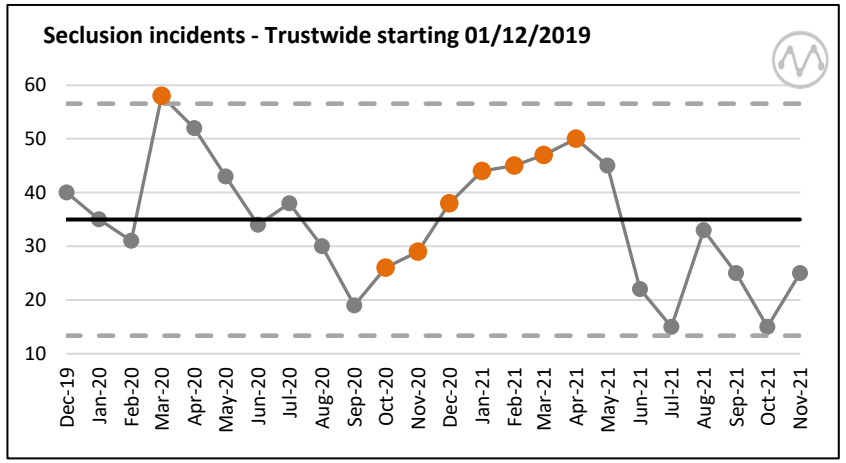
The zero/very low incidents of rapid tranquillisation on both G1 and Stanage since September can be linked to the implementation of the Least Restrictive Strategy plans for the wards.

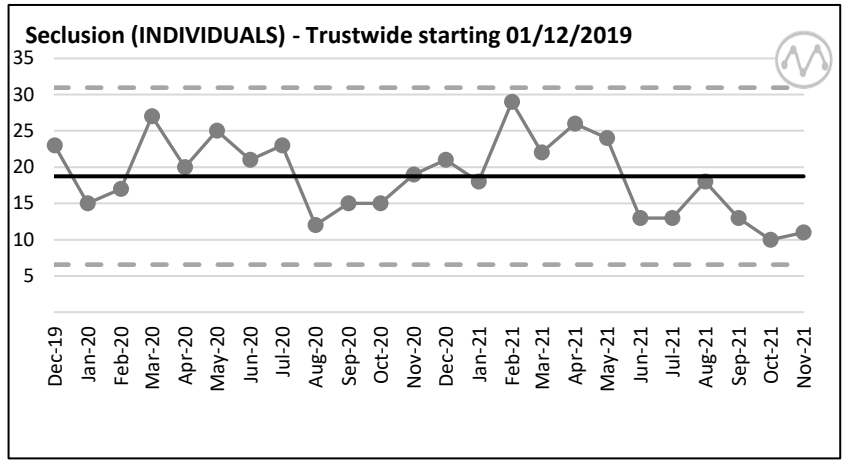
Dovedale 1 and Endcliffe are the main contributors to number of incidents of RT in November. The service user with complex needs referred to earlier in the report (page 9) who receives high levels of RT for the administration of physical health medication transferred from Dovedale 1 to Endcliffe on 8/11/21.

The unusual use of rapid tranquilisation on Forest Lodge in November 2021 related to 2 individuals. There has been use of restrictive practices but also examples of work to step away and use of de-escalation. The directorate triumvirate were alerted in order to support clinical management plan and staff if needed.



Safe | Restrictive Practice | Seclusion

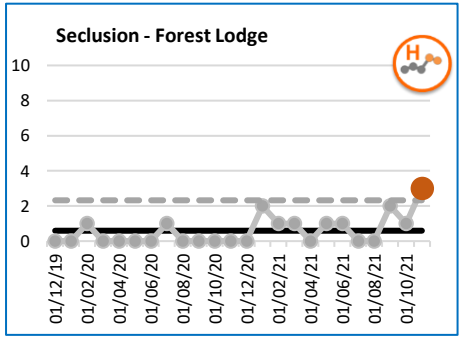




Narrative

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.

The unusual number of seclusion incidents in Forest Lodge in November 2021 related to 1 individual. The matron is proactive and has completed seclusion audits identifying any gaps in standards. Whilst there has been use of restrictive practices there are also many examples of work to step away and use of de-escalation. The directorate triumvirate were alerted in order to support clinical management plan and staff if needed.



Seclusion INCIDENTS	Nov-21		
	N	Mean	SPC variation
Trustwide	25	35	• • •

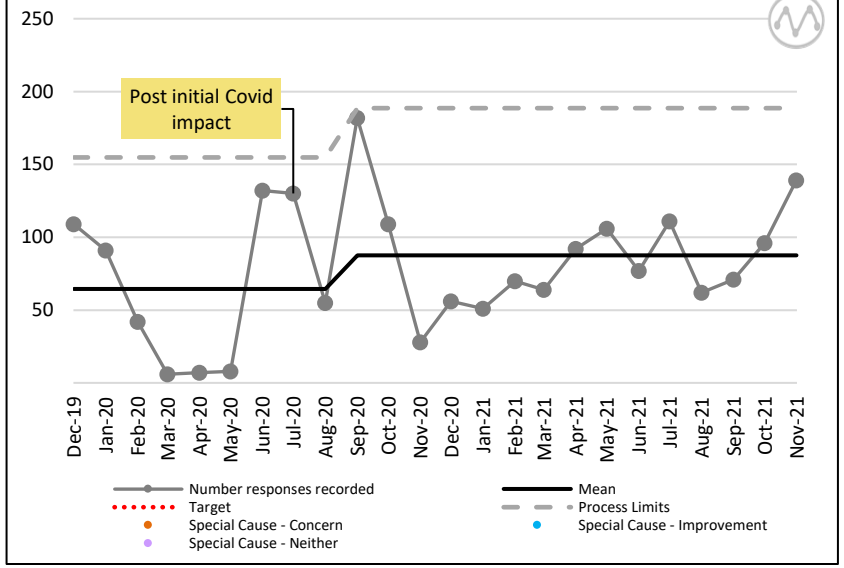
Seclusion INDIVIDUALS	Nov-21		
	N	Mean	SPC variation
Trustwide	11	19	• • •

Acute & Community	Nov-21		
	N	mean	SPC variation
Acute & Community	22	33	• • •
Services			
Burbage	0	4	• L •
Stanage	2	6	• • •
Maple incl. 136	6	5	• • •
Endcliffe PICU	12	11	• • •
G1	1	6	• • •
Rehabilitation & Specialist	3	2	• • •
Services			
Forest Lodge	3	1	• H •

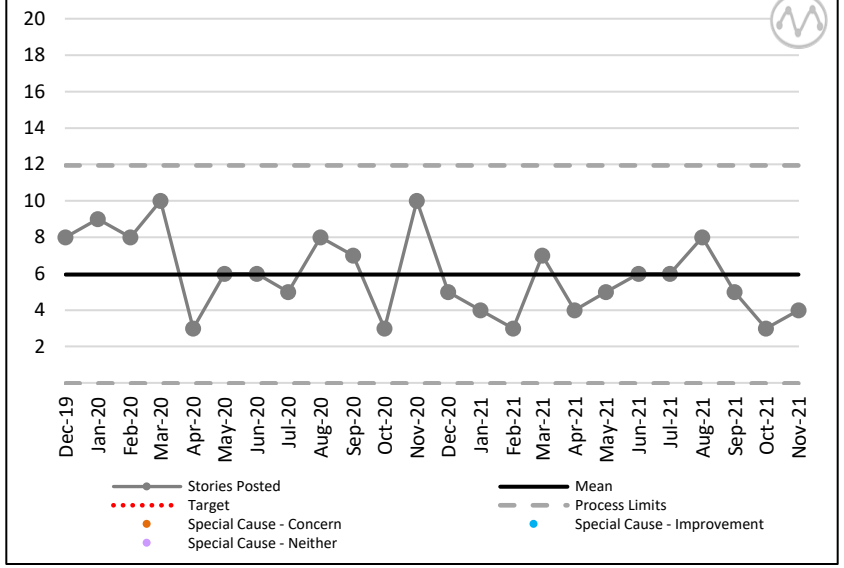
Acute & Community	Nov-21		
	N	mean	SPC variation
Acute & Community	10	18	• • •
Services			
Burbage	0	3	• L •
Stanage	1	4	• • •
Maple incl. 136	5	4	• • •
Endcliffe PICU	3	5	• • •
G1	1	2	• • •
Rehabilitation & Specialist	1	1	• • •
Services			
Forest Lodge	1	1	• • •

Caring | User Experience

Friends and Family Test - Trustwide starting 01/12/2019



Care Opinion Responses - Trustwide starting 01/12/2019



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 last quarterly report was being presented in November 2021.

Quality of Experience

The new Engagement and Experience Liaison Officers have commenced undertaking the Quality of Experience survey, starting with Forest Lodge, Forest Close and Maple Wards in November 2021. The average scores received for these three areas was 83%.

Comments from the ward community meetings include activity suggestions, such as walking groups and gel paints, trialling different vegetable options and improvements to the green rooms and sensory rooms.

Narrative

From the total of 138 FFT responses in November, 130 were positive, 2 negative and 6 were neutral.

A number of positive responses are listed below:

- Welcoming, friendly, very informative about what to expect, fully informed. Lovely, understanding staff.
- The team were so helpful, friendly and helpful if needed to answer questions.
- Pleasant people when we arrived offering good hospitality and reassurance.

Negative comments were received in connection with:

- Waiting lists
- Better communication with patients regarding appointment delays

Narrative

Four stories were published on Care Opinion in November 2021. These relate to Eating Disorders Service, South Recovery Team, Long Term Neurological Conditions and Specialist Psychotherapy Services,

Two of the stories were mildly critical relating to waiting times, trauma informed care and listening to patients. Positive comments were received about understanding and kind staff.

Complaints and Compliments

There were 17 formal complaints received in November 2021, 11 for the Acute and Community Directorate and 6 for the Rehabilitation and Specialist Services Directorate. The most frequent category types were 'access to treatment and/or drugs', 'clinical treatment' and 'patient care'.

24 compliments were received in November 2021 from service users, carers and staff. The majority of these were for community services (Home Treatment Team and Older Adult CMHT). Compliments take many forms including verbal 'thank you's', cards, boxes of chocolates and soft toys.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Our People

IPQR - Information up to and including November 2021

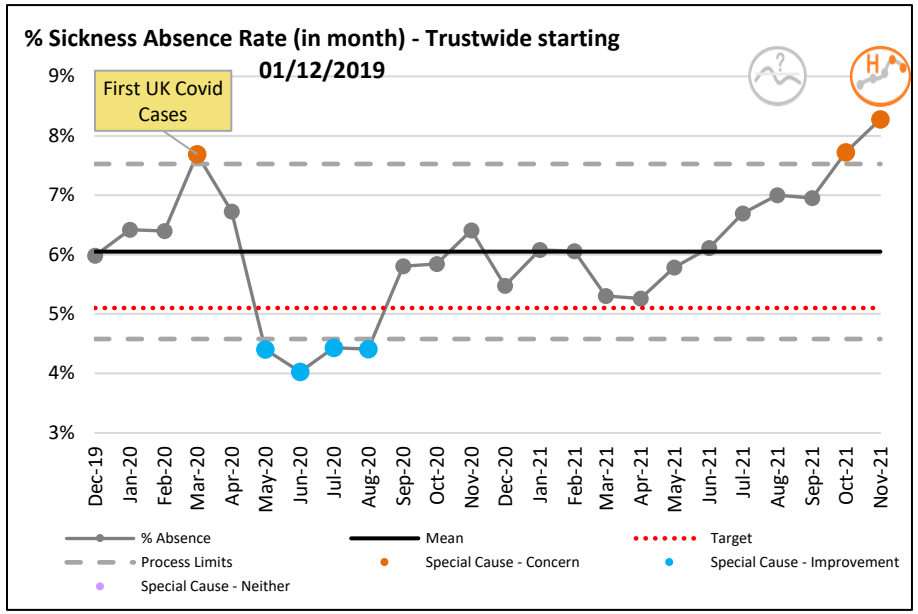
Proud to care in Sheffield

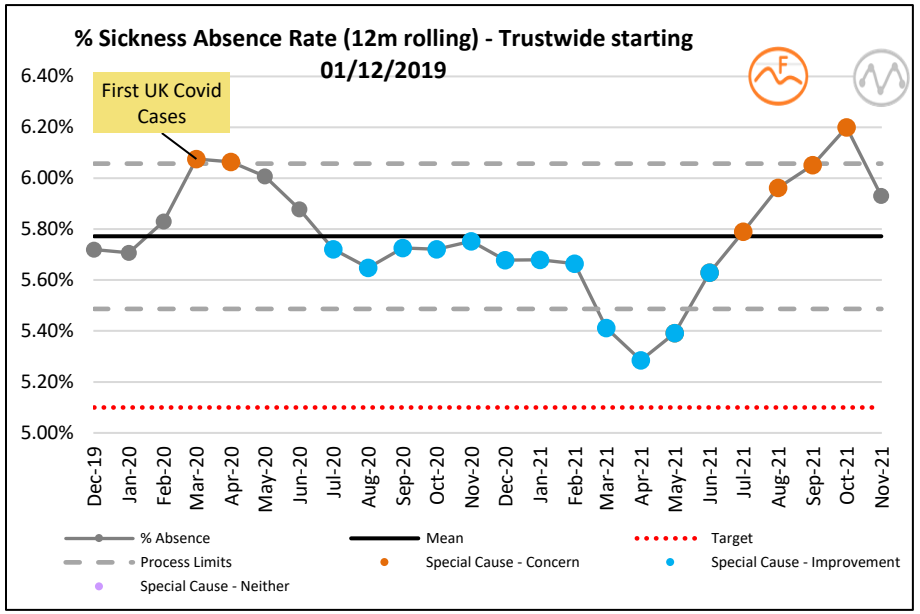
Well-Led | Workforce Summary

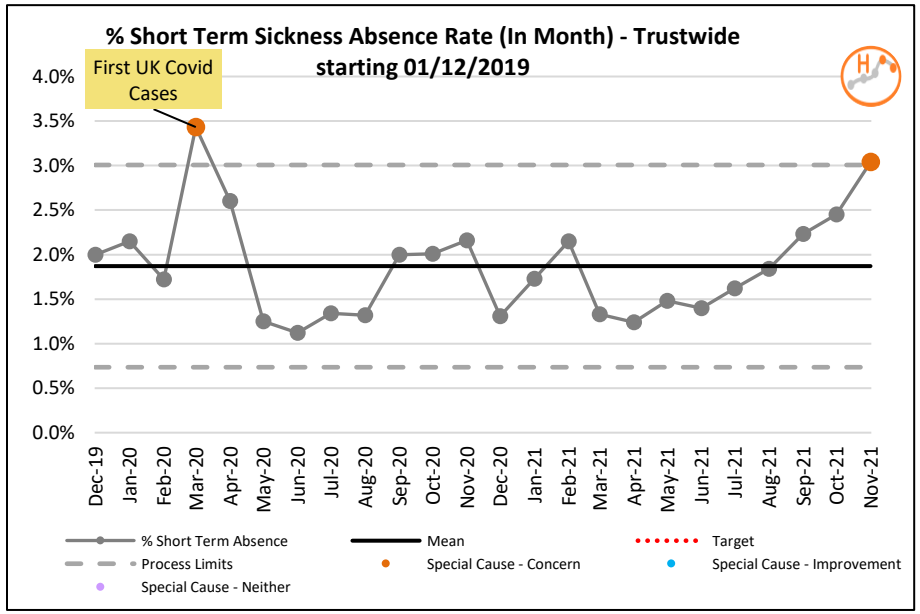
		Clinical Services	Medical	Corporate Services	*Trustwide Oct-21*	Nov-21			
Metric	**Target**	n	n	n	*n*	**n**	*mean*	**SPC variation**	**SPC target**
Sickness 12 Month (%)	5.10%	7.19%	2.97%	3.49%	*6.2%*	**5.9%**	*5.8%*	• • •	F
Sickness In Month (%)	5.10%	4.2%	2.54%	9.55%	*7.48%*	**8.3%**	*6.23%*	• H •	?
Long Term Sickness (%)	~	4.55%	1.89%	2.48%	*4.23%*	**5.2%**	*4.28%*	• H •	/
Short Term Sickness (%)	~	2.05%	1.09%	1.02%	*3.25%*	**3.0%**	*1.95%*	• • •	/
Headcount Staff in Post	~	2038	203	314	*2561*	**2560**	*2563*	• L •	/
WTE Staff in Post	~	1759.2	185.04	296.13	*2243*	**2244.3**	*2229.8*	• • •	/
Turnover 12 months FTE (%)	10%	12.15%	4.81%	18.14%	*15.62%*	**16.4%**	*13.43%*	• H •	F
Vacancy Rate (%)	~				*11.48%*	**9.04%**	*8.94%*	• H •	/
PDR Compliance (%)	90%	95.10%	89.36%	94.10%	*97.30%*	**92.46%**	*94.70%*	• • •	P
Training Compliance (%)	80%	~	86.61%	85.62%	*90.48%*	**90.3%**	*90.5%*	• • •	P
Supervision Compliance (%)	80%	70.83%	79.22%	75.19%	*70.86%*	**71.91%**	*62.34%*	• H •	F

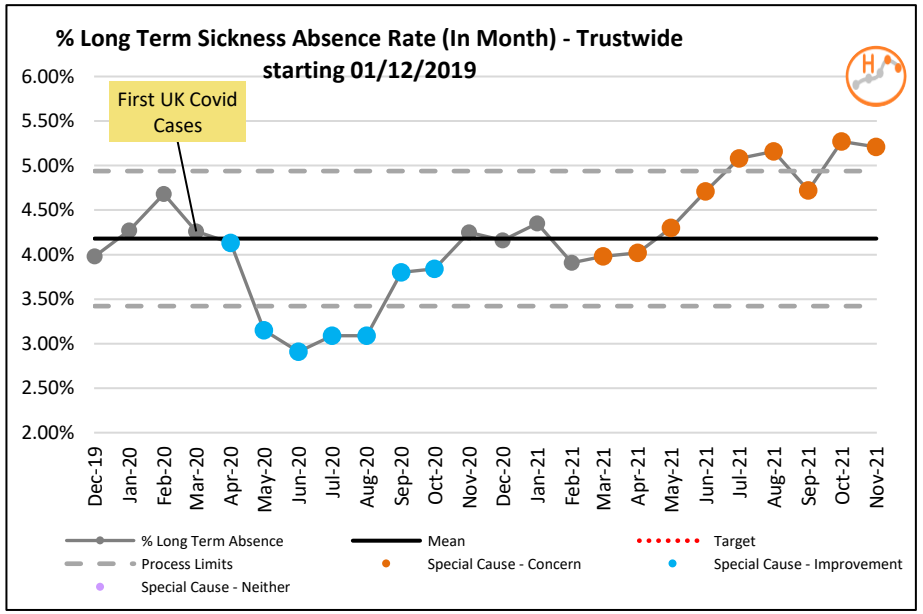
Notes:
- Vacancy based on establishment (FTE) data compared with staff in post (FTE) figures
- Turnover figures exclude 'Employee Transfer' as reason for leaving
- Medical turnover also excludes fixed term rotation

Well-Led | Sickness Absence









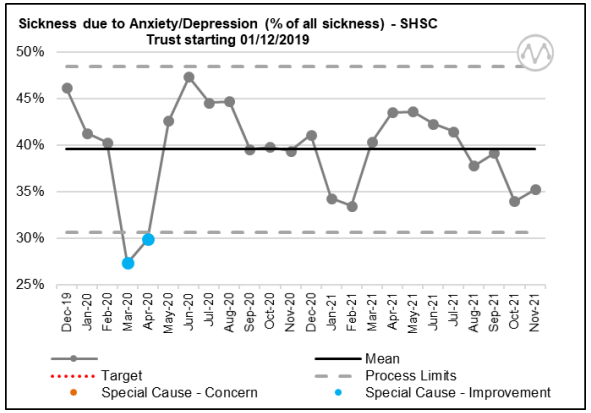
Narrative

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

1. Woodland View (11)
2. Early Intervention (9)
3. IAPT (8)

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

1. Cold, Cough, Flu – Influenza (158)
2. Anxiety/Stress/Depression/Other psychiatric illnesses (128) – ***see chart below***
3. Gastrointestinal problems (74)
4. Infectious diseases (45)

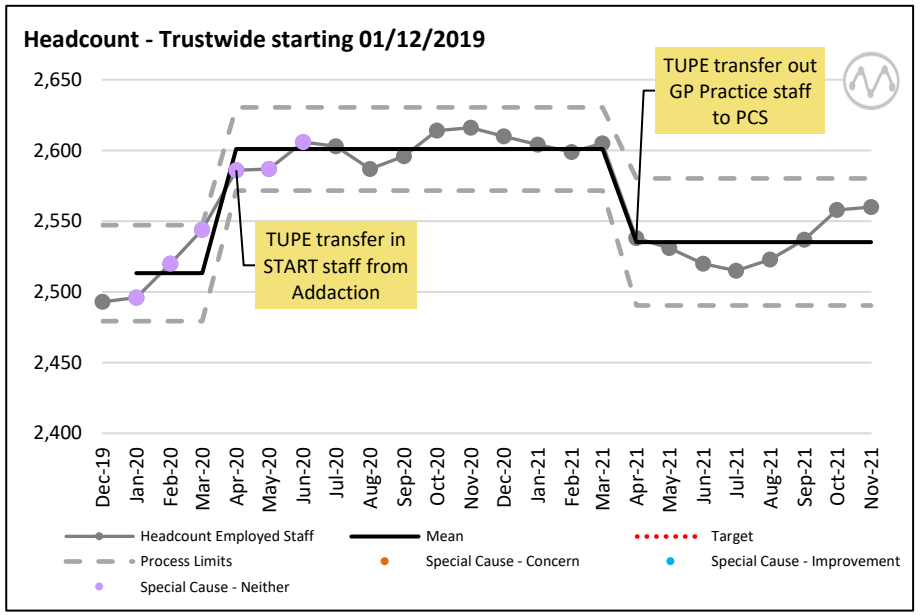


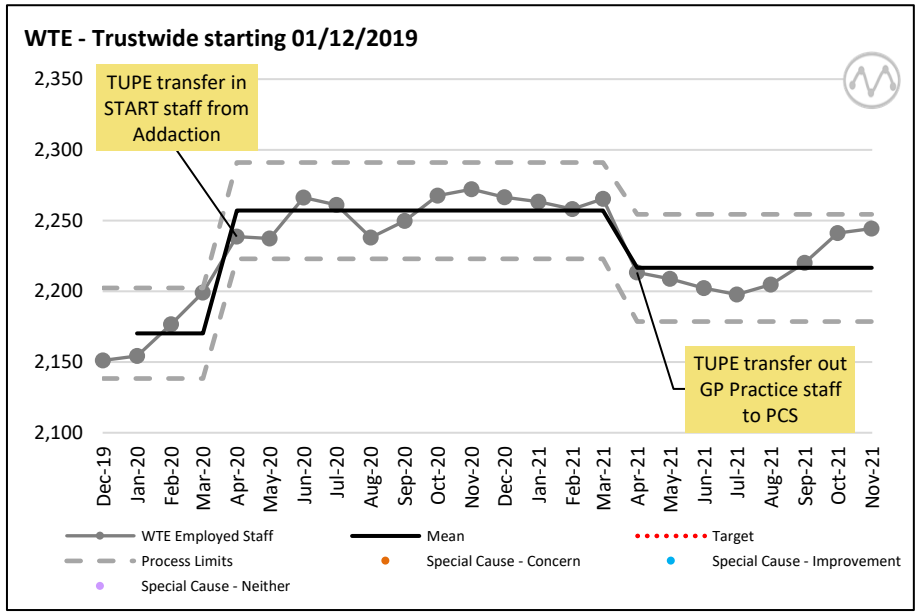
Covid absences

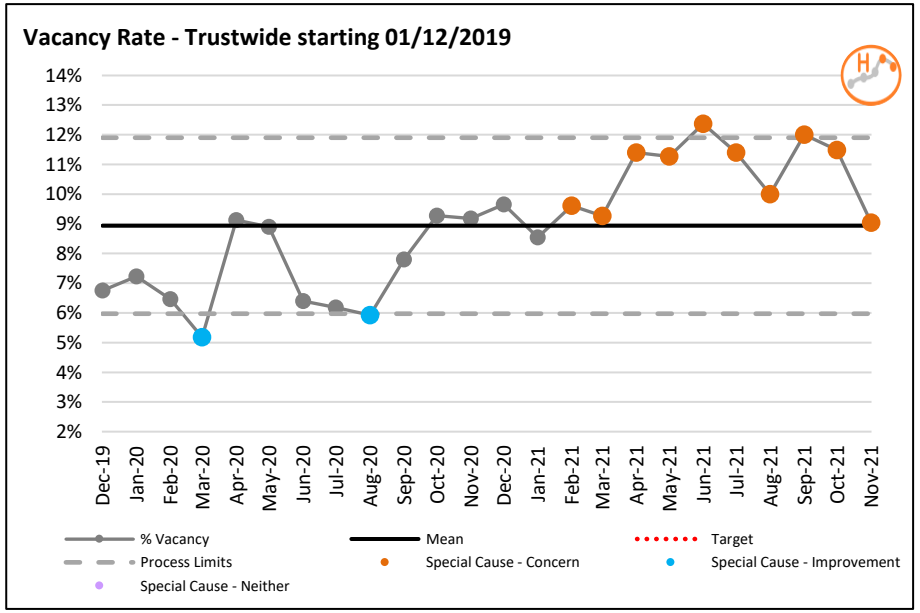
75 in total for November

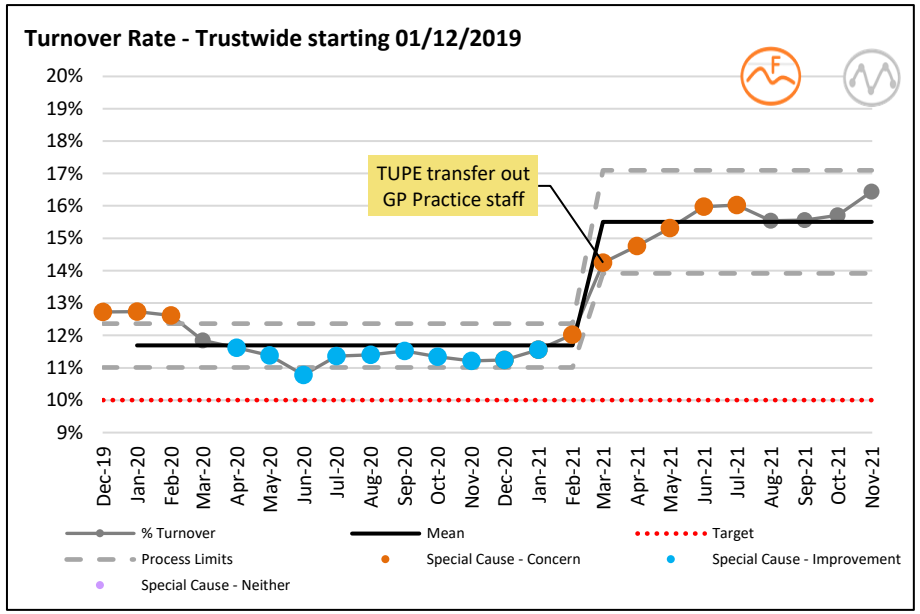
17 of which are still open, of these 5 are longer than 6 months duration

Well-Led | Staffing









Narrative

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 (%)

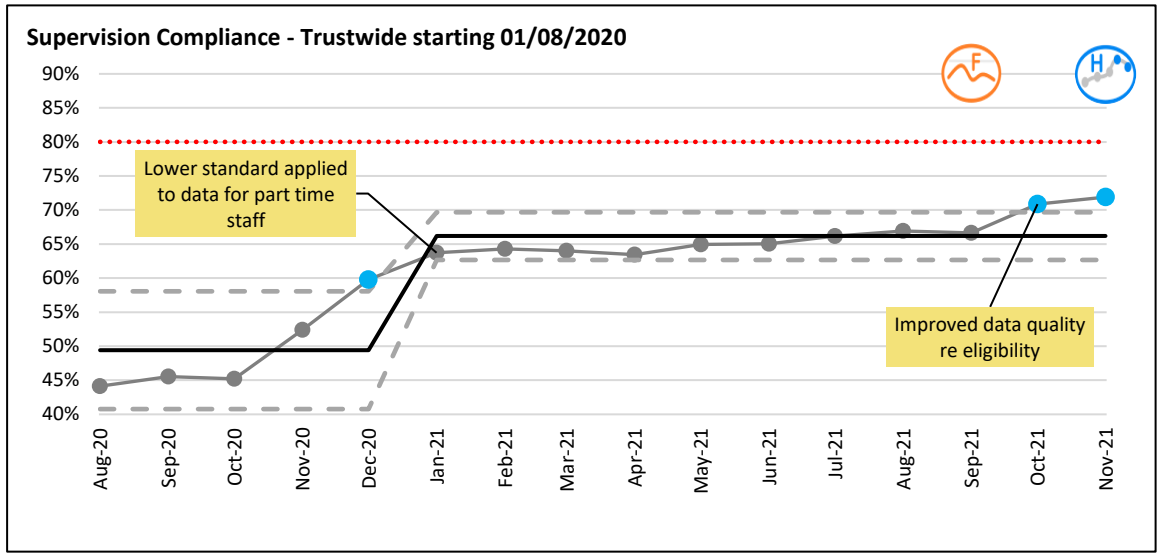
Data had been refreshed from April to November 2021.

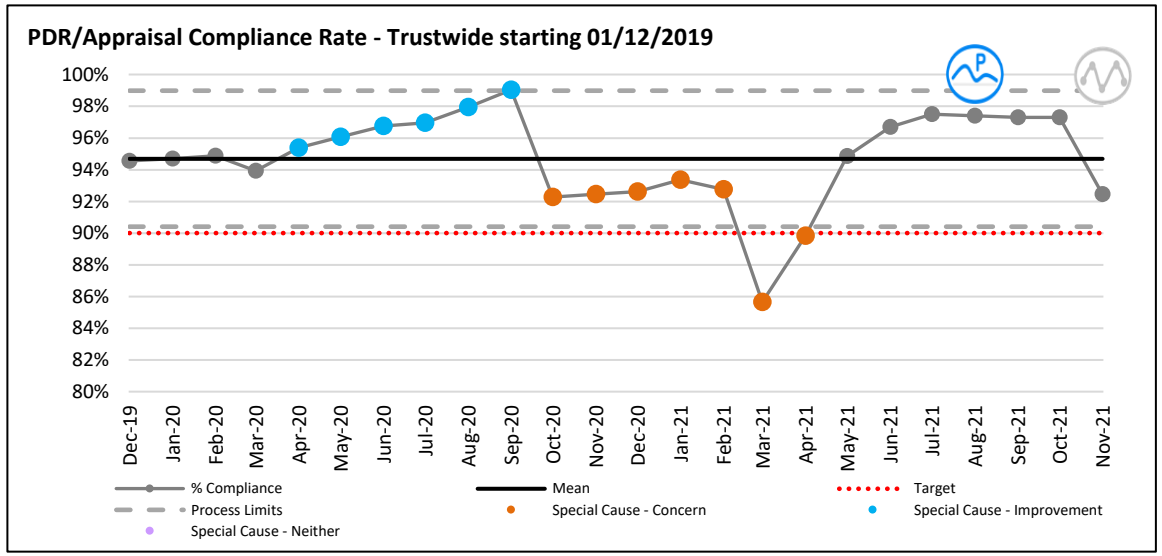
Included in this data are relinquished hours due to flexible working requests and are not vacancies.

There are 20+ WTE of HCSW funding which the organisation is not yet recruiting to as the services are not yet live, therefore these are not actual vacancies but are included in the figures.

Work is still ongoing with Finance, HR and managers to review vacancy data on a more granular level to establish a more accurate way of reporting vacancies.

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 5 December 2021, average compliance with the 8/12 target is:

Trustwide	**71.91%**
Clinical Services	**70.83%**
Corporate Services	**76.12%**

Weekly updated information is monitored and reviewed weekly by Directors and Service Leads. 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.

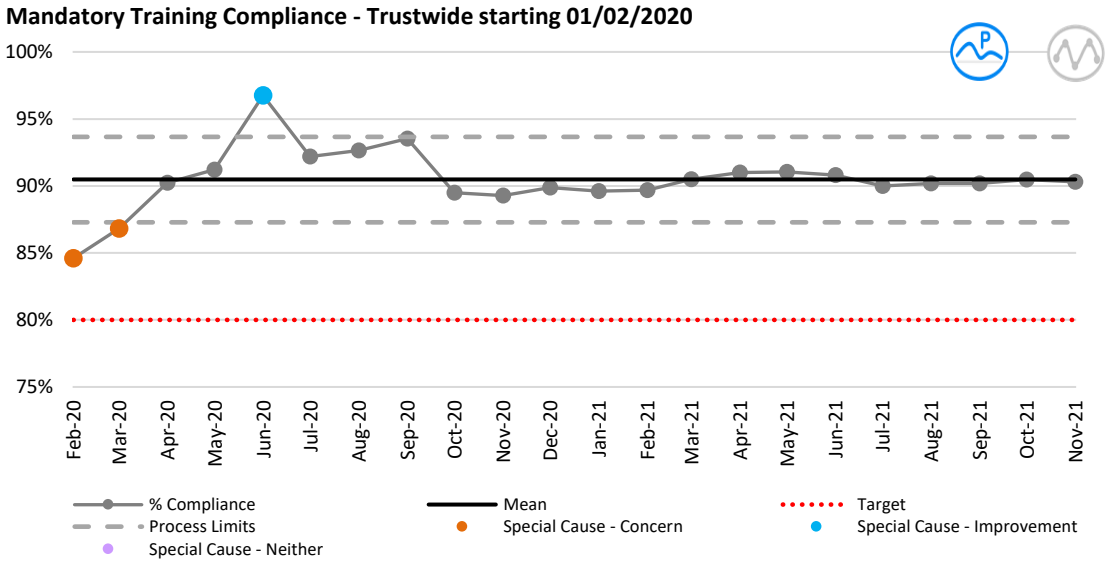
PDR Compliance

The PDR process is currently being reviewed to ensure data that has been previously provided is accurate.

November's figure is accurate and previous months will be revised as soon as possible.

November 2021 Trustwide PDR Compliance **92.5%**

Mandatory Training



AIM

We will ensure a Trust wide compliance rate of at least 80% in all Mandatory Training, except Safeguarding where compliance of at least 90% is required..

NARRATIVE

Week ending 21/11/21

Trustwide compliance **90.32%**

EXCEPTIONS

Subjects Below 80/90%

Respect Level 2 & 3
Immediate Life Support
Safeguarding Children Level 3

Services Below 80%

Grenoside Facilities 55.7%
Chair/Chief Exec Office 76.6%
PGME Personnel 72.6%
PGME Sheffield 75.3%

Sheffield Health and Social Care Mandatory Training Compliance @

21 November 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	21 November 2021 No Requiring	No Achieved	No NOT Achieved	Compliance	Current Compliance against Previous Compliance %	
Equality, Diversity and Human Rights		3 Years	2586	2420	166	93.58%	Decrease	-0.15%
Hand Hygiene		3 Years	2586	2369	217	91.61%	Decrease	-0.76%
Health and Safety		3 Years	2586	2451	135	94.78%	Decrease	-0.08%
Information Governance (aka Data Security Awareness)		1 Year	2586	2275	311	87.97%	Decrease	-0.08%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2586	2450	136	94.74%	Decrease	-0.05%
Fire Safety		2 Years	2586	2173	413	84.03%	Decrease	-1.15%
Resuscitation	1	1 Year	2586	2182	404	84.38%	Decrease	-0.56%
Resuscitation (BLS)	2	1 Year	1536	1282	254	83.46%	Decrease	-0.53%
Immediate Life Support		1 Year	239	185	54	77.41%	Decrease	-1.13%
Clinical Risk Assessment		3 Years	1020	912	108	89.41%	Increase	0.79%
Dementia Awareness		No Renewal	2586	2505	81	96.87%	Increase	0.29%
Autism Awareness		No Renewal	2586	2507	79	96.95%	Increase	0.06%
Mental Capacity Act	1	3 Years	1065	916	149	86.01%	Decrease	-0.48%
	2	3 Years	1129	1006	123	89.11%	Decrease	-0.63%
Deprivation of Liberty Safeguards	1	3 Years	2092	1930	162	92.26%	Decrease	-0.66%
	2	3 Years	115	110	5	95.65%	Increase	0.82%
Mental Health Act		3 Years	174	144	30	82.76%	Increase	1.04%
Medicines Management Awareness		3 Years	553	466	87	84.27%	Increase	1.15%
Rapid Tranquilisation		3 Years	298	263	35	88.26%	Increase	3.06%
Respect	1	3 Years	1149	1006	143	87.55%	Decrease	-0.83%
	2	2 Years	865	603	262	***69.71%***	Increase	0.83%
	3	1 Year	349	275	74	78.80%	Increase	2.49%
Safeguarding Children	1	3 Years	2586	2261	325	87.43%		
	2	3 Years	1078	988	90	91.65%	Decrease	-0.99%
	3	3 Years	1112	884	228	79.50%	Decrease	-0.07%
Safeguarding Adults	1	3 Years	2586	2294	292	88.71%		
	2	3 Years	2188	2001	187	91.45%	Decrease	-0.44%
Domestic Abuse	2	3 Years	2195	1980	215	90.21%	Increase	0.21%
Prevent Radicalisation		3 Years	2189	2013	176	91.96%	Decrease	-0.21%
Moving and Handling	1	3 Years	2586	2477	109	95.78%	Decrease	-0.05%
	2	3 Years	692	587	105	84.83%	Decrease	-0.60%
Overall compliance						**90.32%**	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%

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																	
	31/10/2021																100.00%	98.41%
	21/11/2021																100.00%	100.00%
Moving and Handling Level 2 (People)	31/12/2019																	
	31/10/2021	89.47%	91.43%	85.00%	85.71%	66.67%	87.50%	98.39%	68.25%	95.24%	100.00%	100.00%	96.88%	100.00%	83.78%	100.00%		
	21/11/2021	88.57%	91.18%	85.00%	92.31%	70.97%	91.67%	98.31%	57.38%	95.00%	100.00%	100.00%	96.88%	100.00%	74.36%	100.00%		
DOLs Level 2	31/12/2019	80%	29%	75%	80%	43%	36%	14%	56%	38%	67%	67%	100%	50%	50%			
	31/10/2021	100.00%	85.71%	100.00%	100.00%	83.33%	100.00%	93.33%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
	21/11/2021	100.00%	85.71%	100.00%	100.00%	100.00%	100.00%	92.86%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
Safeguarding Children L2	31/12/2019																88%	70%
	31/10/2021																100.00%	95.24%
	21/11/2021																100.00%	95.24%
Domestic Abuse	31/12/2019																73%	83%
	31/10/2021																96.43%	81.67%
	21/11/2021																96.30%	84.75%
MCA Level 2	31/12/2019		81%														60%	76%
	31/10/2021		90.91%														100.00%	84.62%
	21/11/2021		90.48%														100.00%	86.84%
Info Gov	31/12/2019		71%														67%	70%
	31/10/2021		92.00%														90.00%	76.19%
	21/11/2021		92.00%														94.83%	80.65%
Clinical Risk	31/12/2019		85%															
	31/10/2021		91.30%															
	21/11/2021		86.36%															
Fire 2 Year	31/12/2019		75%															
	31/10/2021		86.00%															
	21/11/2021		88.00%															
Respect Level 2	31/12/2019		94%												94%			
	31/10/2021		95.00%												93.75%			
	21/11/2021		95.24%												93.33%			
Respect Level 3	31/12/2019		88%															
	31/10/2021		86.67%															
	21/11/2021		89.66%															
Mental Health Act	31/12/2019		71%															
	31/10/2021		92.86%															
	21/11/2021		92.31%															
Basic Life Support	31/12/2019																65%	70%
	31/10/2021																93.33%	82.54%
Now Resuscitation Level 2	21/11/2021																93.18%	88.00%
ILS	31/12/2019														71%			
	31/10/2021														86.67%			
	21/11/2021														87.50%			

Subject	Date	Recovery North	Recovery South	CERT	Early Intervention	Adlt Hm Tr
Community Mental Health Act	31/10/2021	97.50%	91.30%	82.50%	82.50%	96.30%
	21/11/2021	97.44%	90.91%	84.62%	82.05%	86.67%

Narrative

CQC focus topics and areas

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

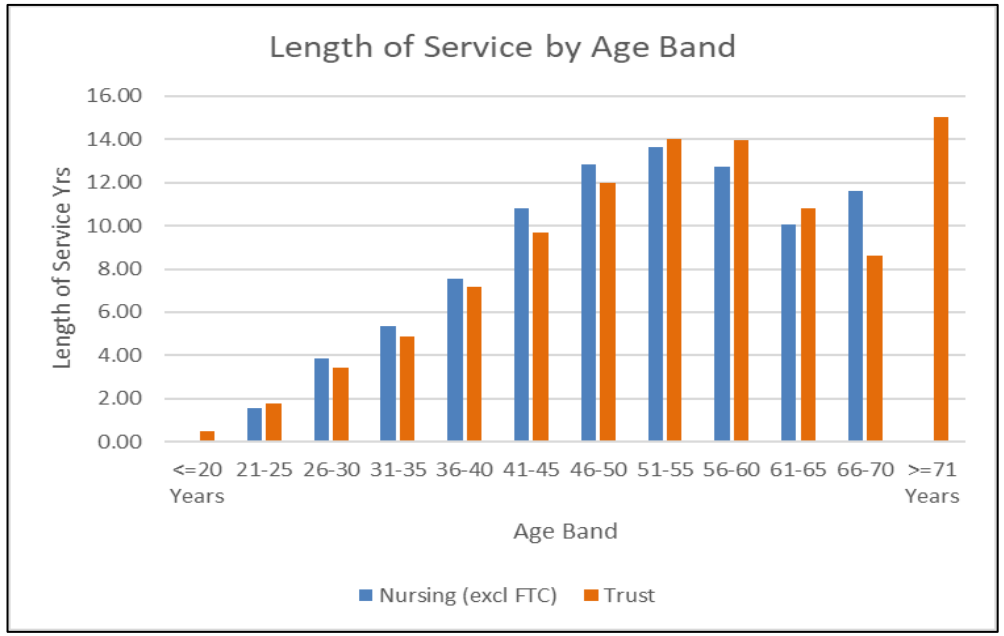
Areas of Concern

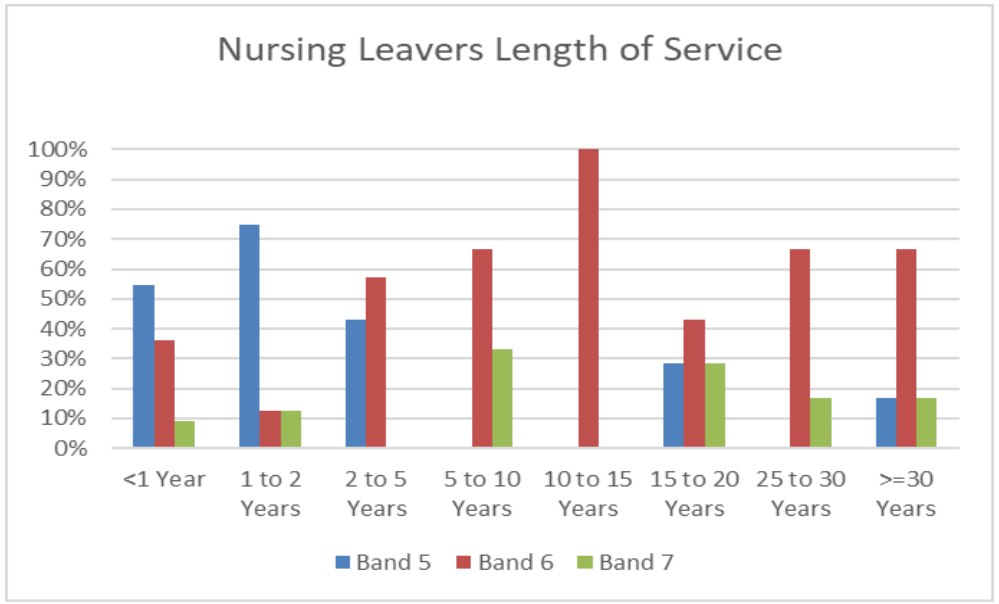
Slippage or no improvement since previous reporting period 2 weeks prior

- Moving & Handling Level 2
  - Burbage/Dovedale 2
  - Woodland View
  - Forest Lodge

NB – Date shown in table to left is position as at w/c 21/11/21, compared with the 31 October 2021 position and December 2019 baseline where available.

Well-Led | Focus on Nursing





- 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)
  - 92.86% of band 5 nurse leavers are potentially within the Trust's gift of changing
    - 28.57% unknown
    - 42.86% promotion externally
    - 21.43% work-life balance
  - For the more experienced nurses this potential is progressively less:
    - Band 6 nurses 33.33%
    - Band 7 nurses 18.18%
- Destination on leaving for Band 5s is at least 55.56% to another NHS Organisation, with the Unknown/blank standing at 16.67%.
- HR is looking at ways to improve the leavers dataset with managers

Leaving Reason	Band 5	Band 6	Band 7
Other/Not Known	4	3	0
Promotion	6	4	1
Work Life Balance	3	3	1
Employee Transfer	0	4	5
Flexi Retirement	1	5	1
Retirement Age	0	4	0
Relocation	0	4	3
Lack of Opportunities	0	1	0
Health	0	0	0
Dismissal	0	1	0
Death in Service	0	0	0
Adult Dependants	0	1	0

Destination on Leaving	Band 5	Band 6	Band 7
NHS Organisation	10	14	2
Unknown	3	2	1
General Practice	0	5	5
No Employment	3	4	0
Private Health/Social Care	2	2	0
Other Public Sector	0	1	0
(Blank)	0	0	0
Death in Service	0	0	0
Social Services	0	1	0

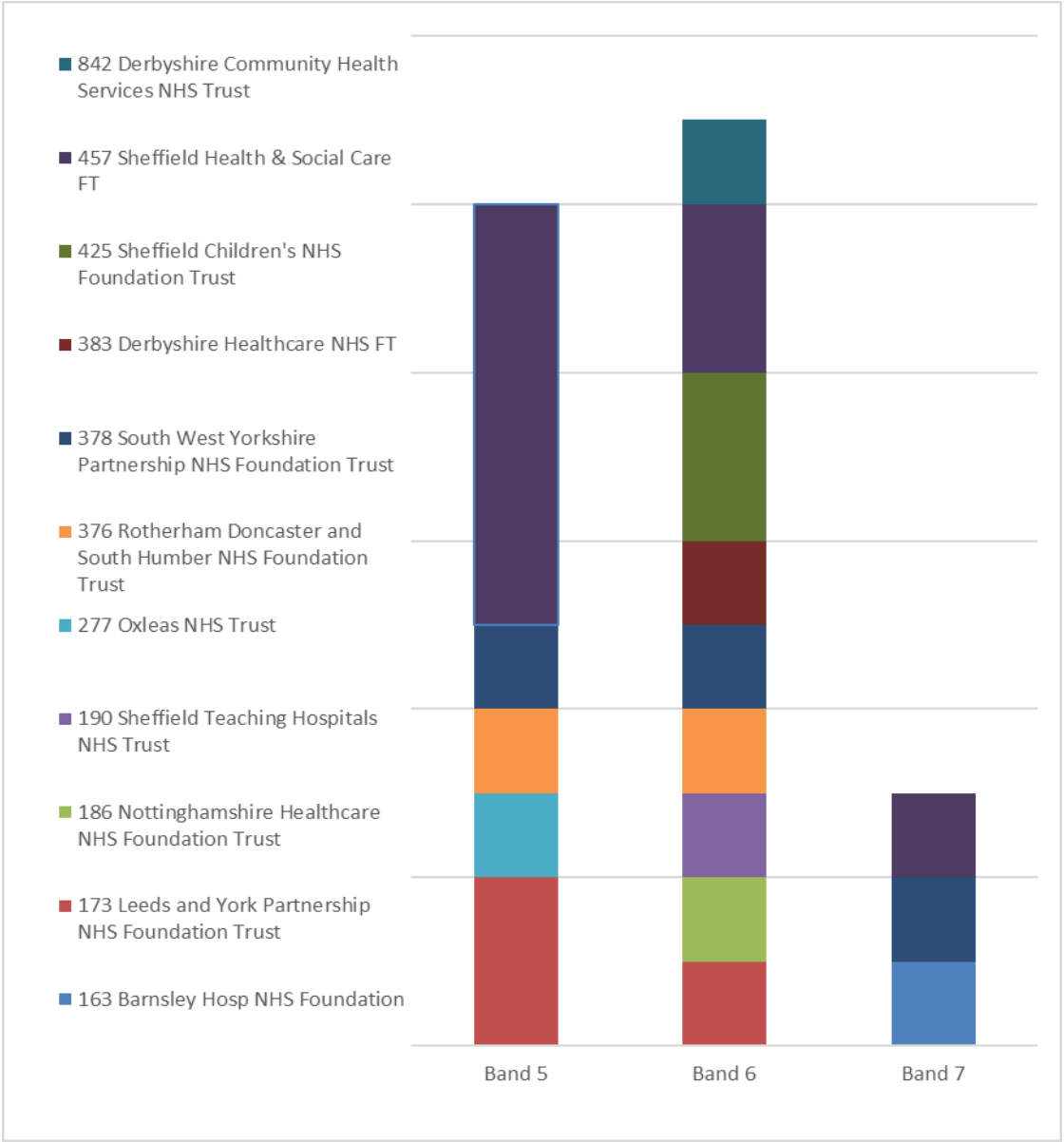
Well-Led | Focus on Nursing

Recruitment Source					
Pay Band	NHS Organisation	Other Private Sector	Education/Training	Blank	Total
5	11	2	1	3	17
6	11	2	0	3	16
7	3				3

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.

Band 5-7 Recruitment Source (January - November 21)



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Financial Performance

IPQR - Information up to and including November 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	1,993	2,345
Covid Expenditure	6,596	4,397	1,245
Agency	5,904	3,790	4,004
Cash	62,075	61,772	63,140
Efficiency Savings	2,650	1,847	1,844
Capital	8,584	5,606	3,557
Better Payments Practice Code	99.4% by Number 99.6% by Value		

Summary at November 2021:

- The Organisation wide surplus of £2.3m at the end of M8 (Nov 21), £300k favourable to plan. The organisation continues to spend greater amounts in H2 than H1, there has been no further underspends on the H1 outturn position of £2.3m.
- Further non-recurrent spending plans have been approved in M8 which will assist the Trust to deliver it's planned break even position.
- Further work is being carried out on the H2 income position and adjustments will be made where applicable.
- MHIS spend in M8 shows a small increase in run rate over M7 suggesting that recruitment is ongoing and new starters commencing albeit at a reduced rate than planned.
- Covid underspend is £3.2m as expected. Covid funding for H2 was 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 underspend at year end.
- Agency and Out of Area Costs remain high risk. Total spend to date on these areas stands at £10.4m which equates to 12% of the total organisational spend.
- Capital spend is currently underspending against plan, however a large increase in spend is anticipated in the final few months of the financial year.

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 November 2021

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Well-Led | Covid-19 Response

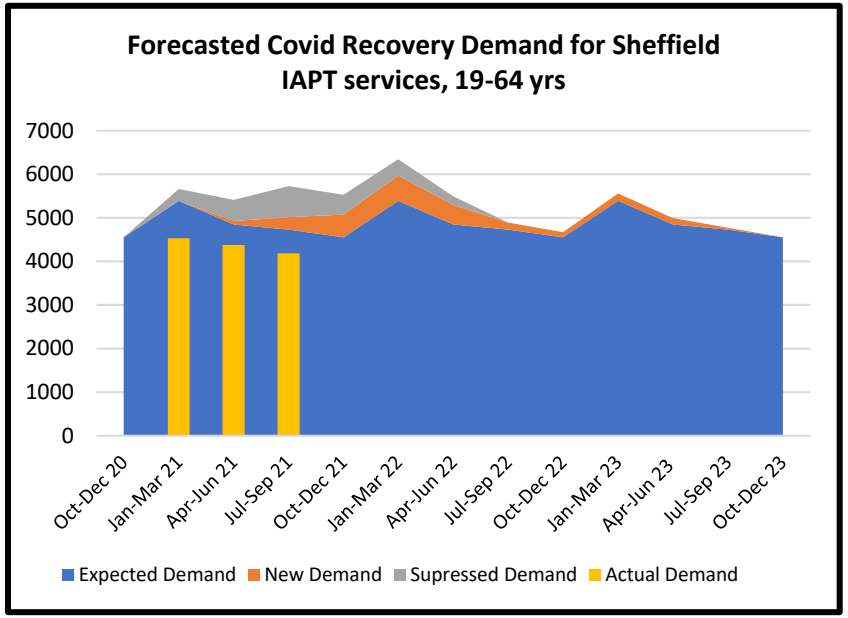
Covid-19 Outbreaks
Covid outbreak on G1 and Birch Avenue during November 2021.
Inpatients with Covid-19
A total of 7 patients on G1 and Birch Avenue were Covid-19 positive in November 2021.
Covid-19 Deaths
Death of one of the Covid-19 positive patients on G1 reported.
Covid-19 Related Staff Absence
As at 30 November, **18** staff were absent from the workplace for Covid related reasons.
3 were working and **15** were unable to work.

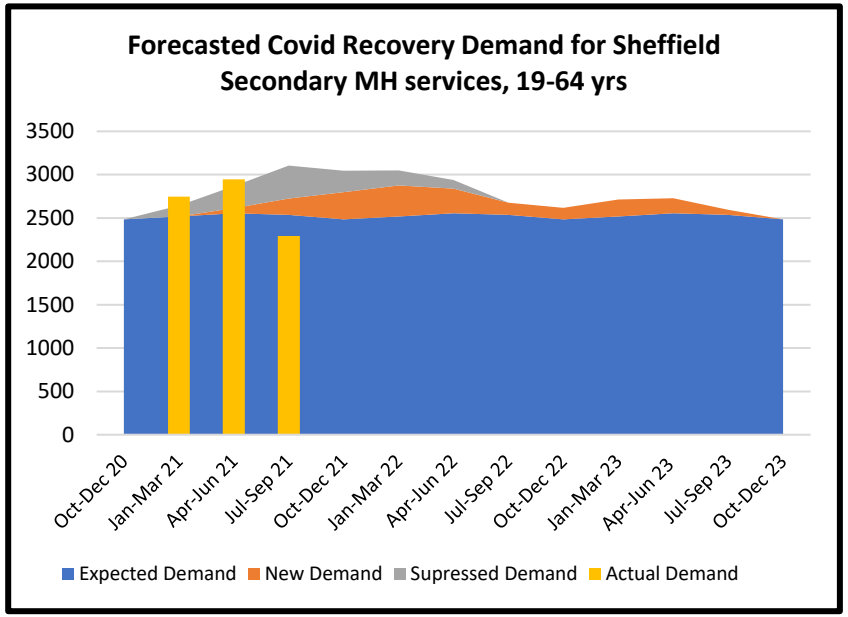
Staff Vaccination (as at 22 November 2021)
This report's primary data sources are the National Immunisation Management System (NIMS) Reporting and our Electronic Staff Record (ESR). NIMS Reporting should include the vast majority of vaccination records for our staff, no matter where they have received 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. This report does not include vaccination records for 50 staff where we do not have their NHS numbers and NIMS has not been able to obtain them for us.

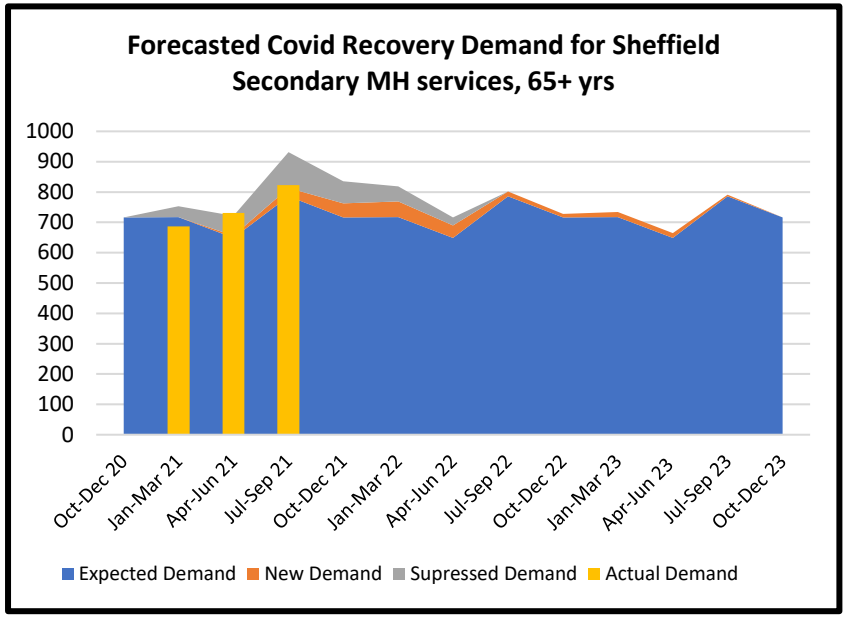
	Total	% of total	Priority staff	Non-priority staff
Staff records uploaded by SHSC to NIMS	3101	100%	2696	405
Staff matched to at least one vaccination record	2884	93.00%	2499	385
Staff matched to at least two vaccination records	2835	91.42%	2454	381
Staff matched to two vaccination records + booster	1884	60.75%	1620	264
Staff that could not be matched due to missing NHS number	50	1.6%	46	4
Staff that have either not received at least one vaccination dose or whose NHS number is missing from their vaccination record(s)	217	7.0%	197	20

	Not yet vaccinated		Received first dose only		Received both doses only		Received both doses & booster	
	Employee Count	%	Employee Count	%	Employee Count	%	Employee Count	%
Clinical Operations	119	5.82%	31	1.52%	564	27.58%	1331	65.09%
Corporate Services	40	6.88%	6	1.03%	195	33.56%	340	58.52%
Chair/Chief Exec Office (L4)	3	11.11%		0.00%	8	29.63%	16	59.26%
Director of Finance (L4)	2	2.70%	2	2.70%	21	28.38%	49	66.22%
Nursing & Professions (L4)	5	7.81%		0.00%	13	20.31%	46	71.88%
People Directorate (L4)	27	8.23%	4	1.22%	134	40.85%	163	49.70%
Special Projects (L4)	3	3.61%		0.00%	18	21.69%	62	74.70%
Medical (L3)	9	4.46%	4	1.98%	49	24.26%	140	69.31%
Agency Staff (L3)	31	19.38%	7	4.38%	88	55.00%	34	21.25%
Locum Doctors (L3)		0.00%		0.00%	1	16.67%	5	83.33%
Medical Students (L3)	16	22.54%		0.00%	31	43.66%	24	33.80%
Student Nurses (L3)		0.00%	1	4.76%	16	76.19%	4	19.05%
Volunteers (L3)	2	13.33%		0.00%	7	46.67%	6	40.00%
Grand Total	217	7.0%	49	1.6%	951	30.7%	1884	60.8%

Well-Led | Covid-19 Demand Impact | Q2 21/22







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:

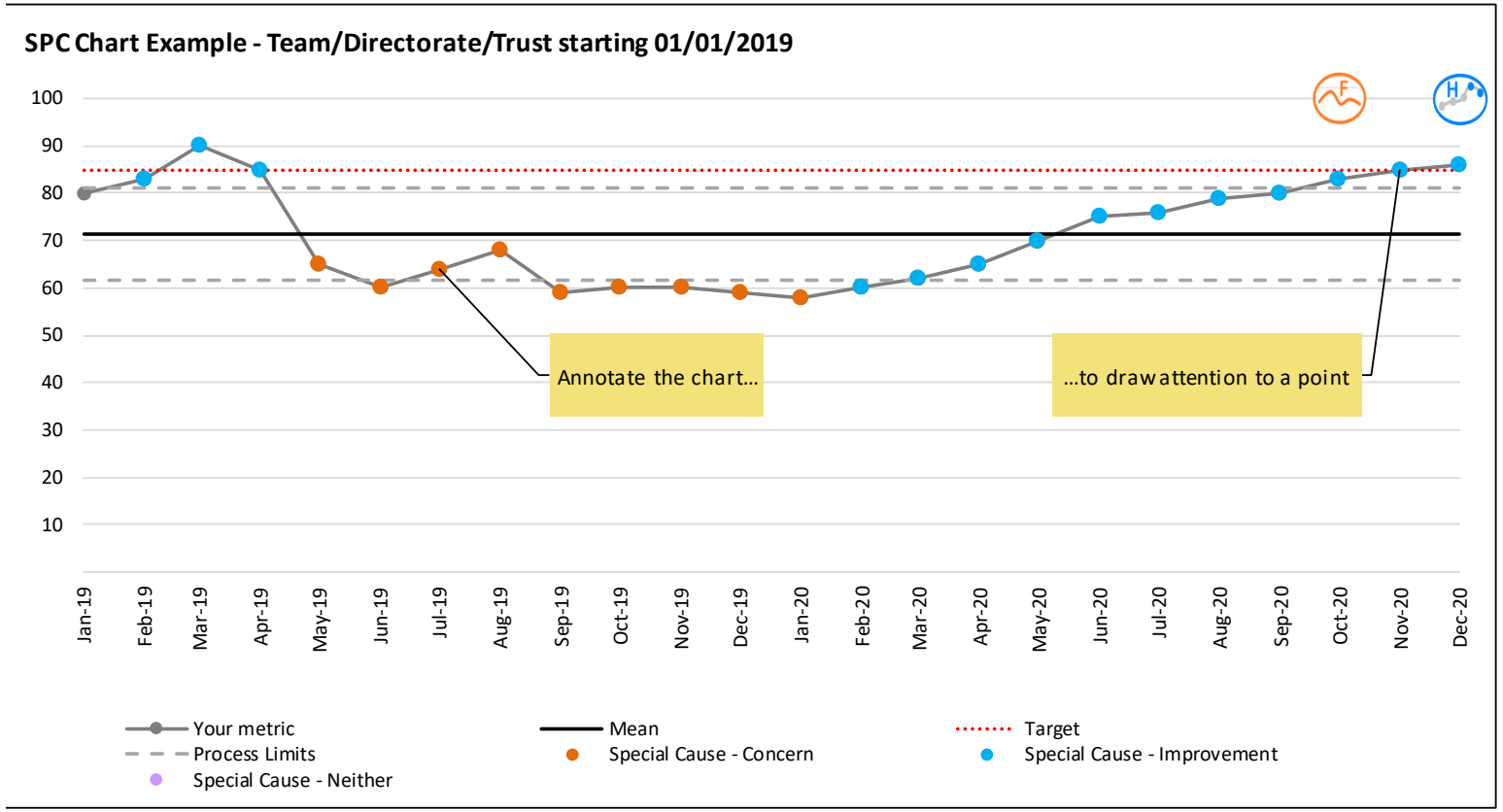
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	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 | Supervision & PDR	29	People
Well-Led | Our People | Mandatory Training	30-31	People
Well-Led | Our People | Focus on Nursing	32-33	People
Well-Led | Financial Performance | Overview	35	Finance
Well-Led | Covid 19 Response	37	Quality
Well-Led | Covid 19 Demand Impact	38	Finance/ Quality

Colour Key	F	M	P	Q
Finance				
MH Legislation				
People				
Quality				

Blue Underlined Text = Click to link to slide/page