Board of Directors – Public

SUMMARY REPORT	Meeting Date:	26 January 2022
	Agenda Item:	7

Report Title:	**Covid recovery and winter planning.**	
Author(s):	Jason Rowlands: Deputy Director of Strategy and Planning Neil Robertson: Director of Operations & Transformation	
Accountable Director:	Beverley Murphy, Director of Nursing, Professions and Operations	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	None
	Date:	N/a
Key Points recommendations to or previously agreed at:	N/a	

Summary of key points in report

1. **Omicron**: The Omicron strain which is highly transmissible strain of Covid has presented increasing staffing challenges during December and into January and has impacted on services.
2. **The impact has been managed and services have remained open**: We have mitigated the impact. There were only two incidents breaching safer staffing levels. Although wards have had outbreaks robust arrangements are in place to support admission were required, that fully involve the patient in decision making
3. **Service recovery:** Prior to the omicron surge services have generally returned to pre-pandemic ways of working. Levels of face-to-face activity have continued to rise and are around 10-15% lower than pre-pandemic levels although IAPT have maintained high levels of online contact.
4. **Access and waiting:** Challenges continue across several services in respect of numbers waiting or length of waits. Recovery plans are in place for all relevant services and not all delays are due to Covid.
5. **Service demand:** Demand levels across most services are in line with pre-covid levels. Crisis Services are experiencing sustained increased demand and recent expansion will provide support.
6. **Winter Plans:** Traditional winter demands have been low in December. Contingency plans have focussed on ensuring resilience of staff support and deployment in response to the omicron surge.
7. **Vaccination programmes:** Our vaccination plans have progressed well. Arrangements to implement Vaccination as a Condition of Deployment are in place. Currently 39 members of staff have not had a vaccine and a further 42 members of staff have not confirmed their status.
8. **Workforce wellbeing risks:** Absences due to covid have been high in December. There may be a cumulative impact on staff wellbeing into 2022 from the last 21 months of pandemic and recovery.
9. **Financial risks:** The primary risk is the ability to fully utilise the additional investments which has been challenging due to recruitment lag and the general impacts of Covid on clinical and non-clinical services. The additional delays in discharge from inpatient services due to omicron also creates a financial pressure as use of out of area bed provision is essential in this context with the people who are placed out of area being similar to the number of delays across our wards.

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**	**X**	**Assurance**	**X**	**Information**	

1. **Recommendation 1:** That the People Committee and the Staff Health and Wellbeing Group continue to review and consider the sustained impact upon staff of working through the pandemic, managing new needs, working through winter pressures and the impact of restricted workforce numbers. The People Committee to be assured that our plans to support staff wellbeing are reflective of the sustained challenges that we can expect to continue.

   BAF.0013: There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing, leading to ineffective interventions

2. **Recommendation 2:** That the Board considers the assurance it has that the impact of Vaccination as a Condition of Employment is understood and being acted upon.

   BAF.0019: There is a risk that our long-term view of workforce planning and/or management of change fails to ensure roles meet future service needs

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

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		***Safety and Good Governance***
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standard?	*Yes*		*No*	***X***	

Have these areas been considered? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*	***X***	*No*		Risk of bringing the virus into inpatient and residential areas, causing harm to service users Risk to safety and patient care from reduced access to services during omicron surge
Financial (revenue & capital)	*Yes*	***X***	*No*		Increased cost of overtime, bank and agency staff to cover staff absence Costs of managing increased demand for services as services recover
Organisational Development /Workforce	*Yes*	***X***	*No*		Risk of increased staff absence through contracting the virus or self-isolation Risk of increased challenges and pressures on staff in sustaining services impacting on wellbeing Plans for expansion of services to deliver improvements in line with LTP and demand forecasts
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		*See section 4.2*
Legal	*Yes*	***X***	*No*		Breach of regulatory standards and conditions of our provider licence.

Title	Covid recovery and impact of omicron.

Section 1: Analysis and supporting detail

1.1 Background

Our Annual Operational Plan 2021/22 confirmed our strategic priority in respect of Covid was to ensure that our services recovered effectively, as follows:

- Ensure staff are vaccinated and service users are protected
- Improve capacity and reduce waiting times in those services affected by increased Covid demand
- Implement new agile ways of working

1.2 Service recovery

1.2.1 Working differently because of Covid – service recovery

Most services have returned to delivering care in a way that is similar to pre Covid operation. Ongoing service challenges are generally no longer due to the changes adopted to manage the Covid pandemic and ensure the safety of service users and staff. This is evident by

- Activity levels have generally returned, or are close to pre-pandemic levels across most services, in some areas demand is higher.
- The percentage of contacts with service users held face-to-face is recovering and is now around 10-15% lower than pre-pandemic levels. The increased use of remote and virtual means of supporting service users has had benefits and bought more choice and flexibility for service users. We need to understand and monitor this area and understand the data carefully to ensure we have a good understanding about what is happening, and that choice is offered positively and where face-to-face contact is requested or deemed necessary then this is provided.
- Some services are experiencing challenges with access and waiting times, however these challenges largely existed pre-covid. No new areas of risk regarding access are highlighted because of the way services are now being delivered due to Covid, except for IAPT services.

APPENDIX 1: Demand and activity overview

1.2.2 Managing demand across services

Our Annual Operational Plan anticipated increased need during 2021/22, due to the pandemic. However, demand on services has remained broadly stable.

- Based on IPQR reporting to the period ending November 2021 demand across most services, based on new referrals, generally remains within previous ranges. Most services show normal variation when compared to a baseline of pre-covid activity.
- Services that are experiencing an increase in demand are Crisis Services (HBPoS, AMP, Out of Hours), SAANS. Recruitment to the CRHT Service was successful in Q2, with staff starting early Q3, and further expansion within Liaison and SPA/EWS using Spending Review Funding, will provide support.

- Following successful recruitment in Q2, IAPT, Crisis Resolution and Home Treatment services have been able to expand capacity through Q3 in line with plans for the MHIS priority areas.

APPENDIX 1: Demand and activity overview

1.2.3 MHIS Workforce expansion plan

- Following successful recruitment in Q2 services have been able to expand capacity through Q3 in line with plans for the MHIS priority areas for IAPT and the Crisis Resolution and Home Treatment services.
- The development of the new Assertive Outreach service is behind schedule. A recruitment programme was completed through Q3 however further recruitment is still required to support the establishment of the service.

APPENDIX 2: Mental Health Investment Standard workforce expansion trajectory

1.3 Winter, seasonal pressures and omicron

1.3.1 Winter Plan

Sheffield's Gold and Silver command have implemented a risk-based plan for managing pressure, demand, and risk over winter. This was reported to the Board in November. Sheffield's Gold and Silver commands manage the risks as a system, thereby minimising the latent harm caused by ongoing challenges affecting our health and care system.

The Director of Nursing, Professions and Operations with the Director of Operations and Transformation represents the Trust and the needs of our service users and services at city silver. Silver has met consistently and there is commitment to partnership working.

The SHSC Plan identified risks and mitigations in the following areas

Identified risks	Plan impact
Inpatient capacity: impacted by delayed discharges, reduced bed stock due to estate challenges	Omicron outbreaks have resulted in delays to patients being discharged from inpatient care. • As part of the winter planning additional step-down capacity for older adult wards has been established and the Council has ensured services can access emergency housing if required. • Inpatient capacity has not been unduly impacted by seasonal winter pressures. • The increase in omicron has impacted on inpatient capacity due to patients not being able to move onto discharge because they are on a ward that has a covid outbreak (1 patient unable to be discharged in Adult Acute), or they are on a ward that has a covid outbreak/ or the intended care home of discharge has a covid outbreak (5 patient on Older Adult Wards) • The above pressures of delayed discharges and a national shortage of spot purchase beds impacted in capacity and led to a cluster of breaches in the Emergency Department (STH) and temporary use of the Place of Safety beds for inpatient care.

Workforce: impacted by winter sickness, covid, vacancy rates for inpatient nurses, plans to deploy staff to support winter pressure areas.	Traditional 'winter challenges' have not had an impact on services so far. • Flu has not been an issue for patients and staff within inpatient services. • There has been one outbreak of D&V one Ward. Staff absences have been high due to the omicron surge (see below)
Vulnerable client groups: impacted by increased likelihood of delayed care.	There have been covid outbreaks 7 of our inpatient services, 1 D&V outbreak, and 4 services have been unaffected. Testing of patients and staff following a first case has found more cases within the ward environment of people with asymptomatic systems. Inpatient services have remained open to admissions with clear risk-based plans in place to review and consider an admission to a ward where there is an outbreak. This approach has been discussed at place and SYB. All patients being considered for admission to a ward where there is a covid outbreak are involved in the decision with staff following clear duty of candour principles.

1.3.2 Winter demand

December activity indicates any increased winter demand is yet to materialise.

- Service demand in December 2021, as measured by referrals, was in line with the same period for the previous two years.
- Admissions to Adult Acute and PICU services in December was in line with the previous year. While there was a higher number of older adult admissions compared to December 2020, the numbers admitted in December 2021 indicate no variation to the expected range.

Referrals to	Dec-19	Dec-20	Dec-21	SPC Variation
IAPT	1283	1375	**1230**	● ● ●
Adult MH SPA	712	838	**674**	● ● ●
Older Adult SPA	223	206	**224**	● ● ●
CRHTT (Adult Home Treatment)	93	103	**113**	● ● ●
Older Adult Home Treatment	32	39	**23**	● ● ●
Central AMHP Team (MHA Assessment)	133	143	**140**	● ● ●
Liaison Psychiatry	472	469	**402**	● L ●
Decisions Unit	48	37	**47**	● ● ●

APPENDIX 1: Demand and activity overview

1.3.3 Vaccinations – Flu and Covid boosters

Our vaccination plans have progressed well.

a) Flu vaccination

The 'Flu campaign started on the 5 October, and as of 4 January 2022

- 2,092 of our staff (73.3%) are recorded as having a 'flu vaccination, with 761 unvaccinated. This is the highest flu vaccination rate achieved by SHSC staff.
- In line with NHS Guidance we have planned to achieve 85% Flu vaccination rate by the end of January 2022. We are currently behind plan.
- The number of clinics has been maintained in line with our plan, however, uptake from staff decreased through December (and into January). This may be due to several factors, the cumulative motivation of staff over several vaccination campaigns and the demands on staff to sustain services during the omicron surge.

b) Covid vaccinations

By the 4 January 2022

- 2,674 of our staff (93.3%) have had two covid doses and 49 (1.8%) of staff have had 1 dose.
- 144 members of staff (5%) have had no covid vaccine.

c) Covid boosters

The Covid booster programme started on the 11th October, and as of 4 January 2022

- 2,292 members of staff (79.9%) are recorded as having a covid booster.
- Of those staff who are eligible to have a booster, 87.9% have received one.

1.3.4 Impact of regulations requiring care staff to be vaccinated - Vaccination as a Condition of Deployment (VCOD).

Staff working in clinical services, or who come into face-to-face contact with service users are now required to be vaccinated to continue employment. Gold Command has initiated a review of where current non-vaccinated staff work and is assessing the impact against minimum staffing levels and business continuity plans and is also ensuring a range of approaches to support people to understand the implications of not being vaccinated.

Currently 39 members of staff have not had a vaccine and have so far refused to have one, and a further 42 have not responded to requests to confirm their vaccination status. A supportive approach has been taken with members of staff, combining line management and HR support and advice along with briefings and workshops to support staff with decision making.

The deadline for people to have received the first dose of the vaccine to enable them to remain deployed is 3 February 2022. Where we are unable to facilitate staff members accepting the vaccine within the legally mandated timeframe a formal review processes will be required, the process is being finalised in line with regulation. Further information is provided in the People Report.

Refer to the People Report, item 15 on the Board Agenda

1.3.5 Omicron - impact on service users and access to services

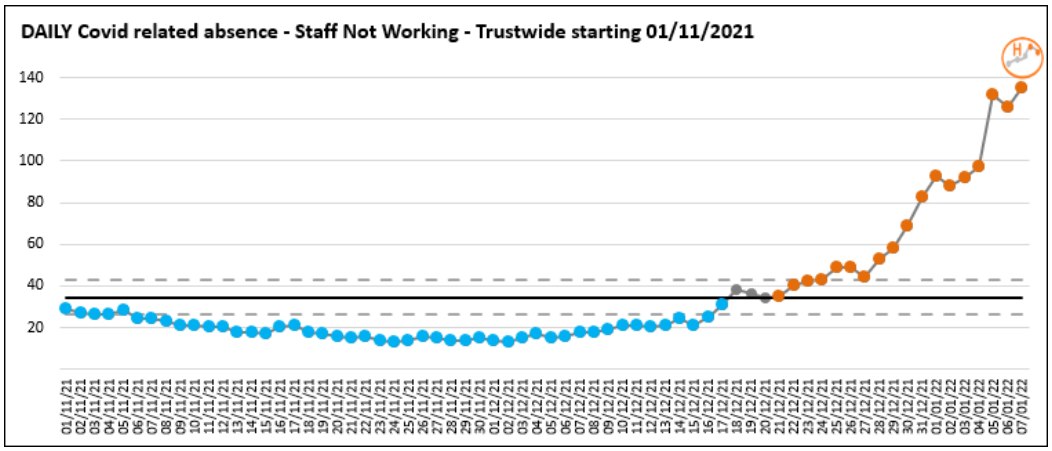
The omicron strain of Covid and wave 4 of the pandemic is expected to subside towards the end of January. It has already seen the highest numbers of patients with covid at any one time across our inpatient wards. Key points to note are

- All services have remained open
- 7 of 12 in patient services have experienced a covid outbreak
- The numbers of patients experiencing a delay in being discharged has increased due to omicron outbreaks
- Clear risk-based approaches ensure that patients are fully involved in decisions to admit them to a ward where there is a covid outbreak, ensuring our duty of candour commitments and responsibilities are fully implemented
- Staff absences have been high resulting in pressures on remaining staff.

a) Highest number of inpatients with Covid during each wave of the pandemic

Wave	Date	Peak Number of Covid Inpatients
1	March/April 2020	16
2	September/October 2020	20
3	January/February 2021	17
4	December 2021-> Current Ongoing	22 as at 12/01/2022

b) Staff absences due to covid



1.3.6 Service contingency plans

Services have reviewed contingency plans and have established a community network approach to support business continuity. This focusses on ensuring effective contingencies are in place through the organisation of training, rostering of an on-call rota and arrangements for mobilisation. The contingency plan consists of:

- Phase 1 – training and calling upon colleagues on e-roster (typically inpatient colleagues or bank) to work additional hours
- Phase 2 – training and calling upon colleagues not on e-roster (typically community or crisis colleagues) to work additional hours
- Phase 3 – establishing self-sufficient communities of services which meet daily and agree where to temporarily assign staff to maintain safe minimum staffing in priority clinical areas.

Engagement across services has supported the development of an improved blue-print for future contingency planning and management.

1.4 Legislation updates

Legislation and guidance updates over the past two months has centred around

- the Omicron variant of the COVID-19 pandemic and
- the recently passed legislation that healthcare workers in both the NHS and the private sector, with few exceptions, must be fully vaccinated to continue in their role beyond 1st April 2022. Fully vaccinated in this context is defined as having had a first and second Covid vaccination of a UK recognised vaccine.

Changes to isolation guidance indicate the learning from the Omicron variant. There has been a reduction in hospitalisations with Omicron, a higher percentage being those admitted to hospital for other conditions who have tested positive, this being incidental to the reason for admission.

APPENDIX 3: Summary of Guidance issued November-December 2021

Section 2: Risks

2.1 **Service demand:** There is a risk that challenges across the crisis care pathway are further compounded by the efforts and requirements to sustain services through the omicron surge and manage a range of contingencies to staff absences. Demand on services generally and through winter so far has been stable and within usual variation. Crisis care services continue to operate under pressure. A range of plans are in place to improve the pathway for service users, address blockages within the pathway and increase capacity and resilience at key access points. However sustained pressure on services is expected to remain until the plans have the desired and intended impact.

BAF.0024: There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care

2.2 **Access:** There is a risk that current access challenges across several services are further compounded as we move through the winter period in respect of staff wellbeing, winter illnesses, omicron and broader service resilience.

BAF.0024: There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care

2.3 **Workforce expansion:** There is a risk that planned recruitment may not result in the required workforce increases to support service expansions over the medium to longer term. Looking ahead further workforce expansions are required to support the development of Primary Care Mental Health Services and the Assertive Outreach Service.

BAF.0019: There is a risk that our long-term view of workforce planning and/or management of change fails to ensure roles meet future service needs

BAF.0026: There is a risk that there is slippage or failure in projects comprising our transformation plans

2.4 **Workforce capacity:** There is a risk that workforce continuity is impacted by staff refusal to be vaccinated and the Vaccination as a Condition of Deployment regulations.

BAF.0019: There is a risk that our long-term view of workforce planning and/or management of change fails to ensure roles meet future service needs

2.5 **Workforce wellbeing:** There is a risk to staff wellbeing from the sustained impact upon staff of working through the pandemic, managing new needs, working through winter pressures and the impact of restricted workforce numbers. We need to ensure that our plans to support staff wellbeing are reflective of the sustained challenges that we can expect to continue.

BAF.0013: There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing, leading to ineffective interventions

2.6 **Delay to improvements:** There is a risk that the omicron strain could have an impact on contractors' ability to undertake planned work across our inpatient services, delaying improvement work in response to CQC Requirement Actions and as part of the Therapeutic Environment programme. There is a risk that the omicron strain could divert leadership resources away from improvement work to deliver the Requirement Actions.

BAF.0024: There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care

BAF.0026: There is a risk that there is slippage or failure in projects comprising our transformation plans

2.7 **Financial pressures:** The primary risk is the ability to fully utilise the additional investments which has been challenging due to recruitment lag and the general impacts of Covid on clinical and non-clinical services.

The additional delays in discharge from inpatient services due to omicron also creates a financial pressure as use of out of area bed provision is essential in this context with the people who are placed out of area being similar to the number of delays across our wards.

BAF.0022: There is a risk that we fail to deliver a break-even position in 2021/22

2.8 **Partnership and system working: SHSC** is positively engaged with the city wide Gold command structures. This active approach will ensure cross system working supports a co-ordinated approach.

BAF.0027: There is a risk that engagement with systems partners is ineffective or lacking; caused by weaknesses in partnership relationships or supporting governance arrangements; resulting in a poorer quality of services, missed opportunities and potential costs

Section 3: Assurance

Triangulation

3.1 a) Recovery Plans reported to Quality Committee

b) Trust wide IPQR reporting through the SHSC performance process, reviewed by service leadership, Board Committees

c) SHSC weekly updates on service demand and covid pressures

d) Winter Plan developed and agreed by Sheffield ACP

e) Ten Point Plan for UEC assured through SY ICS

f) Daily sitrep to NHS Digital staff absences and numbers of patients with Covid

g) National Immunisations Management System (NIMS) provides nationally validated information regarding uptake on Covid and Flu vaccine uptake

h) Major Incident Control structure of Gold (Strategic), Silver (Tactical) and Bronze (operational)

Section 4: Implications

4.1 Strategic Aims and Board Assurance Framework

Implications and risks are highlighted in the above sections.

4.2 Equalities, diversity and inclusion

It is important to note that the Global Pandemic has further worsened the inequalities experienced by some communities, making some services more difficult to access due to digital poverty and worsening social determinants that can impact on mental health.

Investments through the Mental health Investment Standard and Spending Review Funding are focussed on key service area across homeless, drugs and alcohol, community mental health and crisis care services. This brings significant opportunity to ensure we design our services in line with the NHS Advancing Mental Health Equalities Strategy

We need to develop our data sets to ensure we understand, monitor and take necessary action regarding access, experience and outcomes. Supporting performance related information in respect of access and waiting times and protective characteristics is being produced to ensure access is understood in respect of equalities, diversity and inclusion.

Through Quarter 3 the Inclusion and Equality Group has been established which will provide the leadership and governance for the Trust developments of the design and implementation of the Patient and Carer Race Equalities Framework (PCREF). As part of the wider Trust developments, the design and implementation of the Patient and Carer Race Equalities Framework (PCREF), will provide a framework to examine what we change through an anti-discriminatory lens and ensure check and challenge is embed in the process to prevent racialised and discriminatory practice.

At the centre of redesign will be the aligned to the new Clinical and Social Care Strategy, which is committed to addressing inequality. Our developing partnerships, especially with the VCS, will be critical to ensuring we get our service offer right for the communities we serve.

Recognising the above risks for our service users proactive measures are in place to raise awareness, promote opportunities and encourage service users to get vaccinated. Vaccines are offered to all our inpatients and services are reaching out to service users in the community, with specific efforts to reach and support people with a learning disability.

4.3 Culture and People

There is a sustained impact upon staff of working through the pandemic, managing new needs, working through winter pressures and the impact of restricted workforce numbers. We should ensure that our plans to support staff wellbeing are reflective of the sustained challenges that we can expect to continue.

4.4 Integration and system thinking

Effective joint working is demonstrated through the development of the winter plan and the urgent and emergency care Ten Point Plan. This provides good opportunities to continue building integrated approaches on a multi-agency basis.

4.5 Financial

None highlighted directly through this report in respect of recommendations and decisions. The Contract governance processes between the Trust and Sheffield CCG ensure that the financial plan is aligned with the delivery plan in respect of additional in-year investments.

MHIS investments for 2021/22 have been clear. However finalising plans for the best use of the Spending Review Funding to support services with Covid recovery has been delayed and this will impact on when the benefits within services and for the people of Sheffield will be experienced.

The need to ensure in-year investments become recurrent and supported with additional investments in line with the MHIS and Long-Term plan programme are clear and we will continue to work with commissioning leads across the ACP and ICS to maximise investments for the people we serve.

Covid has impacted on our capacity to fully commit all investments due to recruitment lag and general impacts across the Trust. Omicron has seen an increase in delayed discharge rates with creates additional pressures on inpatient capacity and use of out-of-town beds.

4.6 Compliance - Legal/Regulatory

Continuing to follow the guidance will ensure compliance with our constitutional rules and regulatory requirements.

Section 5: List of Appendices

APPENDIX 1: Demand and activity overview

APPENDIX 2: Mental Health Investment Standard workforce expansion trajectory and demand summary at Quarter 3

APPENDIX 3: Summary of Guidance issued November-December 2021

APPENDIX 1: Demand and activity overview

Key messages: Referral numbers generally haven't increased, are in line with pre-covid levels and below what we expected.

A) Service overview against plan – activity, access and waiting

	PLANNING ASSUMPTIONS								CURRENT STATUS (as at November 21)								
	Expected challenges		Investments		Workforce		Activity		Workforce	Activity			Access & waiting times				
	Covid demand	Access/ waiting	MHIS 2020/21 + 2021/22	Spending Review Funds (SRF)	Staff expansion	Q3-Q4 plan + extra agreed with SRF	Pre covid (2019/20)	2021/22 Plan assumptions	Workforce recruitment	Actual activity ending November	If at pre-covid level	If in line with Plan	Access challenges	Wait List	Wait Time RtA	Wait Time RtT	
Improving Access to Psychological Therapies (IAPT)	Y		£900,000	£155,000	20 wte by Q2	+ 12 Q3 (SRF) + 40 Q4	13,591 entered treatment	15,982 treatments 8.7% increase	**ON PLAN** + C30 appointed Q2 - Q3 **MORE PLANNED**	9,347 into treatment	9,061 **Yes**	10,254 **No**	**No**	N/A	*6 week* 98.0% • H • P	*18 week* 99.6% • • • P	Refer to November 2021 IPQR P13 IAPT Performance Summary
Liaison services within A&E and general hospitals	Y		Nil	£109,000	Nil	+ 2.5 wte (SRF)	6,092 referrals	7,000 referrals 15% increase	**NEW RECRUITMENT UNDERWAY**	3,977 referrals	4,062 **No** Lower	4,667 **No** Lower	**No**	N/A	N/A	N/A	
Single point of access/ Emotional wellbeing service	Y	Y	Nil	£183,000	Nil	+ 6 wte (SRF)	10,036 referrals	12,000 referrals 19.5% increase	**NEW RECRUITMENT UNDERWAY**	6,763 referrals to SPA	6,862 **No** Lower	8,000 **No** Lower	**No** wait for SPA triage response **Yes** Wait for routine assessment and treatment in EWS	Wait List 1289 • H • Wait list and average wait times in weeks for routine assessment/follow up in month in EWS.	Wait Time RtA 23.4 • H •	Wait Time RtT 32.4 • H •	Refer to November 2021 IPQR P6 Access & Demand Community Services
Primary and community mental health services	Y		£3.3 million	Nil	8 wte by Q2 (SHSC employed)	Nil	1,026 referrals	1,239 treatments 20% increase	**DELAYED** Recruitment underway				No				
Recovery Services: Assertive Outreach	Y		£924,000	Nil	16 wte by Q2	Nil	N/a	N/a	**DELAYED** Recruitment underway	N/a	N/a	N/a	N/a To be mobilised				
Crisis services and access to home treatment across the 24/7 period	Y		£1.5 million	£325,858 Crisis Cafe	21 wte by Q2	Nil	1,292 referrals	1,551 referrals 20% increase	**COMPLETED** + c20-22 appointed Q2-Q3	862 referrals to Adult Home Treatment	861 **Yes** Same	1034 **No** Lower	**No** Crisis response, no waits	N/A	N/A	N/A	
People detained under Section 136 and need for access to a Place of Safety	Y	Y	Nil	Nil	Nil	Nil	412 admissions	543 admissions 31% increase	**None planned**	330 admissions to SHSC S136 suite	269 **Yes** Higher	362 **No** Lower	**Yes** 136 beds blocked with admissions	N/A	N/A	N/A	

Positive	We use blue to identify positive performance, improvement, achievement of plan or target, on track etc.
Concern	We use orange to identify concern, poor performance, deterioration, lack of progress, not on plan etc.
Query	We use purple to identify something is unusual, off plan, not where we expected it to be, but it's not necessarily identified as good or bad.

Statistical Process Control (SPC) Chart Icons

Variation

SPC Icon	Simple Icon	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

SPC Icon	Simple Icon	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

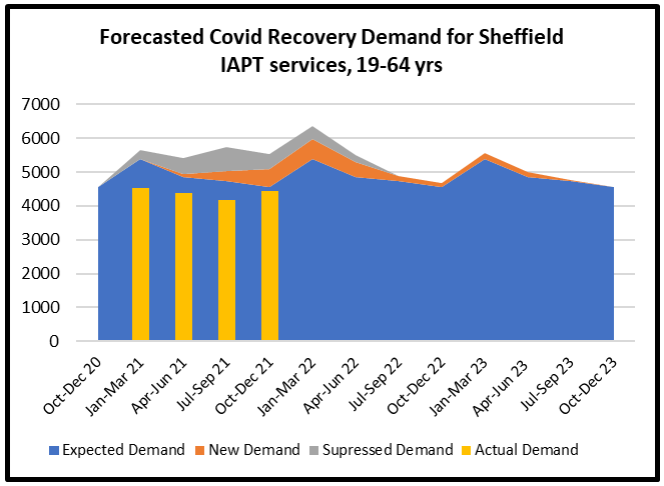
B) Demand and activity forecast comparisons – regional model

This forecasting tool uses prevalence data, historical demand data (referrals) from each mental health provider in SY ICS and estimates of suppressed demand, to forecast what the impact of the Covid pandemic may have on forthcoming demand for services. We have used referrals to services in 2019/20 as our baseline for expected demand for:

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

Key messages: Demand is generally below what the forecasting models suggest we should have expected.

IAPT

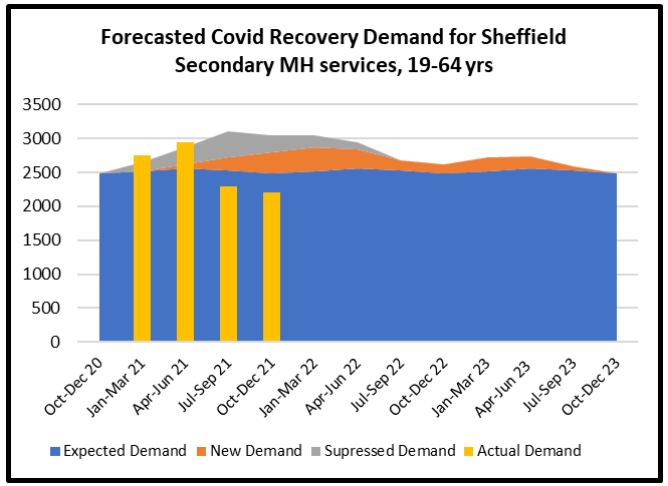


Note

IAPT activity at exceeding pre-covid levels for Apr-December, but below forecast tool levels

No access issues: Access standard achieved at 97.5% in 6 wks

Referrals to SPA

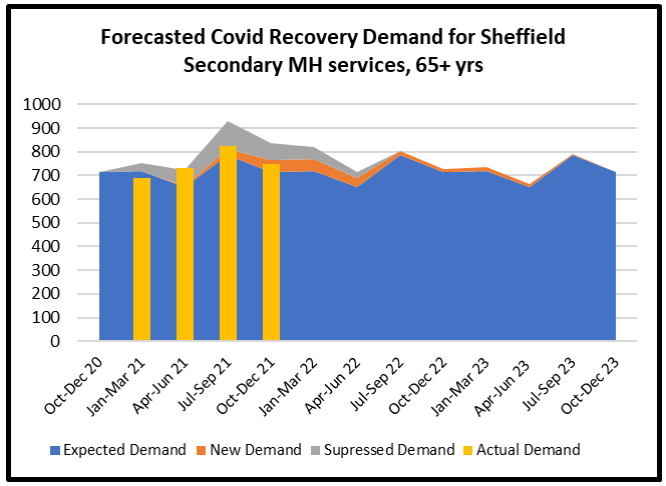


Note

Activity is lower than pre-covid levels and lower than forecast tool levels.

Access challenges: 1,289 on list, average wait of 23.4 wks

Referrals to Older Adult CMHT



Note

Activity/ demand increasing, mainly via Memory Services

No access issues: Average waiting time of 4.7 weeks

What demand would be if we repeated 2019/20 activity

New demand caused by the impact/ aftermath of the pandemic

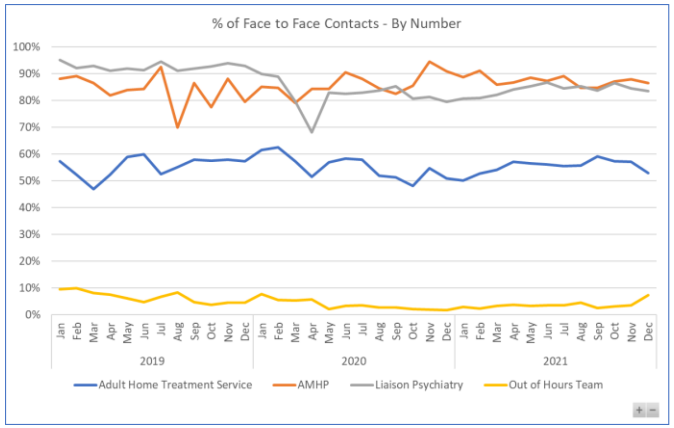
Demand that existed from the pandemic but couldn't access services and now needs seeing

Actual activity that has happened

C) Face to face activity levels – increasing return to pre-pandemic levels

Key messages: The percentage of contacts with service users held face-to-face is recovering and is now around 10-15% lower than pre-pandemic levels. The increased use of remote and virtual means of supporting service users has had benefits and bought more choice and flexibility for service users. We need to understand and monitor this area and understand the data carefully to ensure we have a good understanding about what is happening, and that choice is offered positively and where face-to-face contact is requested or deemed necessary then this is provided.

Crisis Services



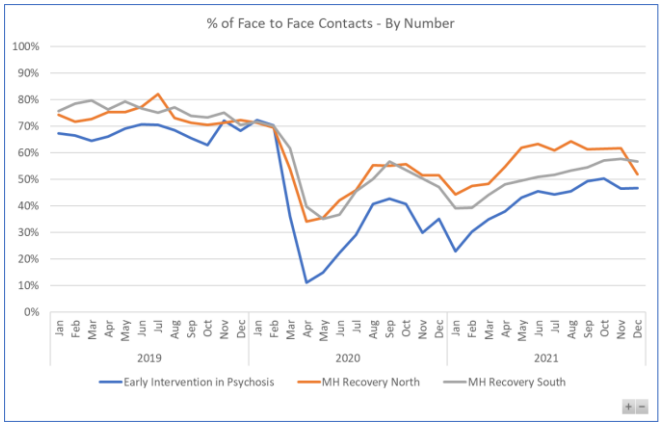
The graph shows the percentage of all contacts with service users that were held face-to-face.

The levels of face-to-face activity for the core crisis services has remained stable throughout the pandemic periods.

For the grey line above (Liaison services), through 2021 around 80-85% of contacts with service users were held face-to-face. Conversely around 15-20% of contacts with service users were held remotely by phone or video conferencing.

The total amount of time spent in face-to-face contacts is higher, suggesting remote contact is often for shorter periods of time. Reporting on this area is being developed and now forms part of the IPQR reporting.

Recovery Teams (N&S) & Early Intervention

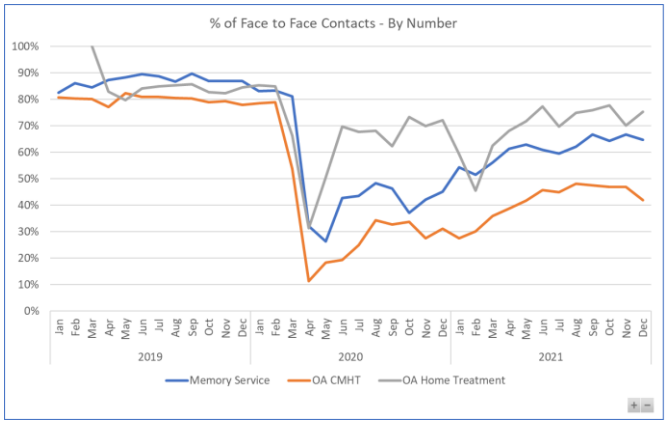


The graph shows the percentage of all contacts with service users that were held face-to-face.

Pre-pandemic contacts with service users was face-to-face c65-75% of the time. It has recovered to around c55-65% for Recovery Teams and 50% for Early Intervention in Psychosis Service.

The total amount of time spent in face-to-face contacts is higher. Pre-pandemic data suggests 90% of time in contact with a service user was spend face-to-face. This has recovered to 70-80% of time. This suggests remote contact is often for shorter periods of time. Reporting on this area is being developed and now forms part of the IPQR reporting.

Older Adult Services



The graph shows the percentage of all contacts with service users that were held face-to-face.

Pre-pandemic contacts with service users was face-to-face c80-90% of the time. It has recovered to around c65-75% for Home Treatment and Memory Services and 45% for OA CMHT Services.

The total amount of time spent in face-to-face contacts is higher. Pre-pandemic data suggests 95% time in contact with a service user was spend face-to-face. This has recovered to 80-90% of time for Home Treatment and Memory Services, and 65% for OA CMHT Services. This suggests remote contact is often for shorter periods of time. Reporting on this area is being developed and now forms part of the IPQR reporting.

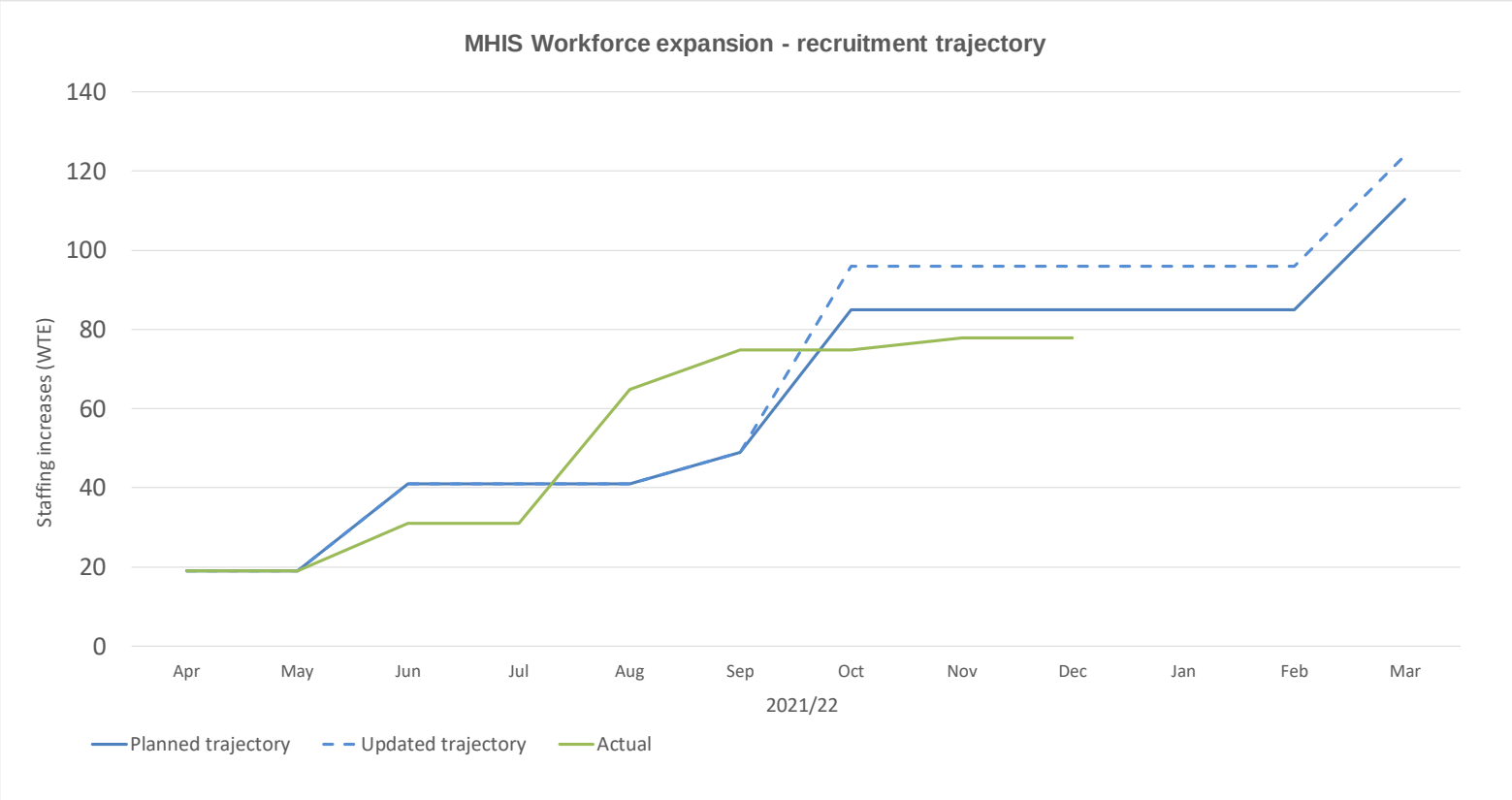
APPENDIX 2: Mental Health Investment Standard workforce expansion trajectory and demand summary at Quarter 3

Annual Operational Plan 2021/22: Workforce trajectory (Services: CRHT, IAPT, PCMH, AoT) - Quarter 3

Position for the Period: End December 2021

(1) Crisis Resolution Services - recruitment completed
(2) IAPT recruitment on track over Q2-Q3 for LTP expansion plus additional Covid Spending Review Funding (see revised trajectory on graph)
(3) Assertive outreach delayed against plan. Recruitment round completed but un-sucessful (4 of c17 posts appointed). Further recruitment underway.
(4) PCMH plan agreed and recruitment now being progressed (behind original assumed plan)

Expansion Gap represented in graph: due to delayed progress in Assertive outreach and PCMH recruitment.



Key message:

(1) IAPT recruitment on track over Q2-Q3

(2) CRHT expansion completed and arrangements to extend to 24hr home treatment being finalised.

(3) As expected through Q3 we are behind the original plan due to delays in progressing expansion in PCMH services and Assertive Outreach Services.

Note:
Updated trajectory due (blue dotted line) to increased investment into IAPT services re Covid & Long Covid support services

Recruitment tracking:
Focus has been on tracking workforce plan expansion against the four key service lines in the Operational Plan and MHIS funding.

Future reports will define position at service line level.

APPENDIX 3: Summary of Guidance issued November-December 2021

Legislation and guidance updates over the past two months has centred around

- the Omicron variant of the COVID-19 pandemic and
- the recently passed legislation that with few exceptions, healthcare workers in both the NHS and the private sector must be fully vaccinated to continue in their role beyond 1st April 2022. Fully vaccinated in this context has been defined as having had a first and second Covid vaccination from any of the UK recognised vaccines.

Changing in isolation guidance indicate the learning from the Omicron variant. There has been a reduction in hospitalisations with Omicron, a higher percentage being those admitted to hospital for other conditions who have tested positive, this being incidental to the reason for admission.

Date of Issue	What does this mean for SHSC?	Compliance statement
28/11/21 – Variant of concern - Omicron	Potential risk to service users and staff; more transmissible than previous variants.	Standard met. Communications to staff; IPC/PPE guidance reinforced.
06/12/21 – Updated advice from JCVI allowing Covid booster vaccinations to be booked after 3 months following a second Covid vaccination.	Enabled staff and service users to receive their booster vaccination earlier, the original guidance being 6 months, to provide the best defence against the Omicron variant	Standard in place. Facility for staff to receive both their booster vaccination and flu vaccination in Trust, continuing until 31/03/2022.
09/12/21 – Government announcement to move to Plan B reintroducing face coverings, working from home, lateral flow testing in response to rising infection rates.	Little change for our Trust. Face masks remain compulsory in healthcare; agile working remains in place, managers to risk assess whether current arrangements should change.	Standard met.
15/12/21 – Level 4 incident status reintroduced – ICC 7 days per week	Guidance determined nationally; requirement for increased situation reporting.	Standard met.
17/12/21 – Omicron operational letter from NHS England re: surge plans, maximise discharges, preparation for new vaccination legislation in healthcare, ensure access to community based MHLDA services	Prepare for increased levels of staff sickness absence, support of Acute partners in discharge, set up task and finish group to plan for staff compulsory vaccination legislation, access to services.	Standard in place. Surge plans in place, maintaining winter pressures support to partners, Task and Finish Group established working with Staff Side.
16/12/21 / 22/12/21/ 11/01/22 / 17/01/22 – UKHSA changes in isolation guidance	Guidance on when PCR or LFD tests are required to confirm COVID infection or contact of someone with COVID, together with how long LFD's are required before returning to work. Each date has seen a relaxation of isolation rules.	Standard communicated, updated guidance held on the JARVIS internet/extranet page.
22/12/21 – winter planning guidance to ensure plans for staff absence with increasing rise in infections.	Plan in place to maintain critical services, Inpatient and Crisis utilising staff from other services with transferrable skills.	Standard met.
01/01/22 – updated visitor guidance enabling visiting to inpatient settings safely.	Guidance makes little change to the procedures already in place for managing visiting.	Standard in place.

Date of Issue	What does this mean for SHSC?	Compliance statement
06/01/22 – Legislation for vaccination as a condition of deployment (VCOD) passed in parliament. Phase 2 guidance issued 14/01/22 on stages to implementation.	Potential impact on safe delivery of our services should patient facing staff refuse to be vaccinated before the 31/03/22 deadline.	Task and Finish Group in place; affected roles and staff identified; programme of advice to encourage vaccination, deployment opportunities and prepare for termination of contracts if necessary.
13/01/22 – Decision making support tool for managing Covid-19 contacts and closed wards/bays during times of extreme bed pressures.	Published for Acute Trust's with promise of MHLDA guidance coming out shortly. Provides advice on cohorting to reduce further infection and considerations for admissions.	Recognising demand for beds, process in place for admissions based upon a clinical consultant decision having considered the risks to both the service user and ward, the proposal shared with partners in SCCG and the Director of Public Health at SCC.