Board of Directors - Public

SUMMARY	Meeting Date:	March 2022
	Agenda Item:	10

Report Title:	**Integrated Performance and Quality Report (IPQR) January 2022**	
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:	8, 9 and 10 March 2022
Key Points recommendations to or previously agreed at:	The known areas of risk/concern for the attention of the Board are: • Increased/High demand specifically noted in the Memory Service • 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 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, particularly in the South Recovery Team • Underperformance against targets for Covid-19 and Flu vaccination in some frontline service areas • Overspend in areas associated with high out of area placement and agency costs The Board is asked to note the following areas of positive performance or improvement: • Improvements to discharged length of stay averages in older adult wards G1 and Dovedale 1 • Discharged length of stay on Forest Close rehabilitation wards has reduced below SHSC average and benchmarks favourably with other rehab/complex care beds nationally • IAPT exceeding 6- and 18-week waiting time targets, national benchmarks and meeting the recovery standard for the third consecutive month. • Continued low use of restrictive practices on Stanage ward and zero instances of restrictive practice across the Rehabilitation & Specialist Directorate. • Continued improvement of supervision compliance across the majority of Trust clinical and corporate services	

	Committee Recommendations **People Committee** The Committee noted the revised position on long- and short-term absence figures, following investigation into the data quality of figures shown in January report. Initial revisions indicate short term absence at 4.94% and long-term absence at 4.64%, indicative of a continuing upward trend. This is more in line with expectations given the high level of wave 4 covid absences. The Committee also noted the additional work to understand impact of covid absence on overall and short-term absence figures. This analysis indicates that covid absence was higher in December/January that in any other previous covid waves in the 2-year period, but that absences were shorter in length. The Committee would like to escalate to Trust Board: 1) The increasing trend of sickness absence overall as a significant cause for concern. **Quality Assurance Committee** The Committee noted the many areas of excellent or improving performance as important to celebrate, particularly the reduced restrictive intervention practices. Key points for escalation to Board are: 1) Lack of flow in the acute adult inpatient system. Concern remains over the persistent demand; increasing length of stay; low admission and discharge rates and number of delayed discharges across the adult acute system. 2) Poor rates of CPA annual review completion, particularly in the South Recovery Team. It should be noted that the disaggregation of social care staff from teams in line with Local Authority plans to bring social care functions back under their direct remit may adversely impact improvement actions in these teams. 3) Waiting times for routine assessment in EWS and allocation to a permanent care coordinator in Recovery. 4) Increased demand and consequent increases in numbers waiting and waiting times for the Memory Service. **Finance and Performance Committee** The Committee noted no further points for escalation in addition to those raised by People and Quality Assurance Committees. They requested that plans for assurance on the management of flow in the adult acute system are clear in next month's reports.

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 January 2022. The report was presented and considered in detail to the People; Quality Assurance and Finance & Performance Committees in March with a summary of highlights and concerns. 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			Inpatient Length of Stay – Older Adults	9		Decreasing trend in Older Adult inpatient areas	G1 quality improvement plan.
F	Q			Inpatient Length of Stay – Forest Close Rehab	9		Decreasing trend in Forest Close	
F	Q			IAPT	13		Sustained shift above average in Recovery Rate. Meeting/ Exceeding targets for waiting times	
	Q		M	Restrictive Practices	21-23		Decreasing trend and improvements on Stanage Ward Zero incidents in Rehab & Specialist Services	
	Q	P		Supervision	29		Increasing trend Trustwide	Recovery Plan for all areas under 80% target
	Q	P		Mandatory Training	29		Meeting/ Exceeding target Trustwide	

Performance Concern

Committee				KPI/Area	Refer to (slide)	Performance	Trend/ Trajectory	Recovery Plan?
F	Q			Demand for Services	5		Increasing trend noted for Memory Service	
F	Q			Waiting Lists and Waiting Times	6		Increasing trend/ sustained high waits in areas noted right	Recovery Plan x 2 (EWS, Recovery Teams)
F	Q			Caseloads/Open Episodes	6		Increasing trend in older adult community services and Highly Specialist community services	Recovery Plan x 2 (Gender & SAANS)
F	Q			Length of Stay (inpatient areas)	7-8		Increasing trend particularly in acute wards 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.
		P		Sickness Absence	27		Increasing trend Trustwide Failing to meet Trust target	People delivery plan actions for 22/23 and additional investment to support absence management and wellbeing actions.

	Q	P		Supervision	29		Underperformance against targets in some areas	Local Recovery Plan for all areas under 80% target
		P		Mandatory Training	30-31		Underperformance against 80/90% targets in some areas	
	Q	P		Covid Vaccination	35		Below 80% in some areas	
F				Agency and Out of Area Placement Spend	33	 	Increased levels of spend	Out of Area Recovery Plan(s) x 3

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.
IG Governance Toolkit	*Yes*		*No*	✓	
Have these areas been considered? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	*Yes*	✓	*No*		Any impact is highlighted within relevant sections.
Financial (revenue &capital)	*Yes*	✓	*No*		CIP delivery is being offset by underspending on investments and COVID funding
OD/Workforce	*Yes*	✓	*No*		Any impact is highlighted within relevant sections.
Equality, Diversity & Inclusion	*Yes*	✓	*No*		Work looking at EDI concerns is underway which may suggest the inclusion of certain indicators as future developments occur.
Legal	*Yes*		*No*	✓	

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Integrated Performance & Quality Report

Information up to and including January 2022

Proud to care in Sheffield

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Introduction

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

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

We use statistical process control (SPC) charts where possible in order to better understand what is natural variation (common cause) in performance and unusual patterns (special cause) in data which are unlikely to have occurred due to chance and require investigation. Using SPC can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting a target or standard without a change.

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

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

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

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

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

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

In some cases we have 'baselines' in the data so that the control limits are set by an initial range of Data points and then remain the same. We use this to identify if there have been changes in the system. Monitoring referrals to services is a good example of where this is useful. We use Jan 19 to Mar 20 as a baseline (pre-Covid) and then can see whether activity has been impacted, returned to pre-covid levels or changed significantly. We have begun using and looking at the information in this way in our 'Floor to Board' Performance & Quality reviews with Clinical Directorates, and will continue to develop that way of working so that the data is intelligently reviewed at source and services and teams are able to investigate and provide narrative which supports the information.

Colour Key	F	M	P	Q
Finance				
MH Legislation				
People				
Quality				

Board Committee Oversight

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

Refer to Appendix 3 for detail.

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Service Delivery

IPQR - Information up to and including January 2022

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Responsive | Access & Demand | Referrals

Referrals	Jan-22			
Acute & Community Directorate Service	**n**	*mean*	**SPC variation**	**Note**
SPA/EWS	**644**	*843*	• L •	The significant sustained reduction in referrals since July 2021 is due to safeguarding referrals being directed to the Safeguarding Team instead of SPA. SPC chart limits have been recalculated to take this into account.
AMHP	**123**	*150*	• • •	
Out of Hours Team	**909**	*878*	• • •	
Liaison Psychiatry	**496**	*517*	• L •	The last 8 months of referrals have been below the 36 month average calculated from January 2019, but remain close to the average.
Decisions Unit	**66**		• • •	
S136 HBPOS	**19**	*33*	• L •	Admissions to S136 Place of Safety beds have been artificially low in December 21 and January 22 due to the frequency of service users being detained to Maple Ward in these beds.
Adult Home Treatment Service	**126**	*109*	• • •	
Recovery Service (N&S)	**45**	*46*	• • •	
Early Intervention in Psychosis	**41**	*42*	• L •	The last 8 months of referrals have been below the 36 month average calculated from January 2019, but remain close to the average.
Memory Service	**160**	*120*	• H •	Memory Service referrals dropped significantly in the first Covid wave and did not recover to pre-covid levels until April/May 2021. Nationally there has been an increase in referrals in more recent months now that people are attending GPs etc. Service leads are working with CCG/NHS England about dementia care/delivery of model.
OA CMHT	**265**	*241*	• • •	
OA Home Treatment	**24**	*30*	• • •	

Referrals	Jan-22			
Rehabilitation & Specialist Directorate Service	**n**	*mean*	**SPC variation**	**Note**
Psychotherapy Screening (SPS)	**40**	*63*	• L •	Referrals to SPS have remained below the pre-covid average of 63 since April 2020.
Gender ID	**38**	*58*	• L •	Referrals to GI service have remained below the pre-covid average of 58 since April 2020.
STEP	**88**	*73*	• • •	
Eating Disorders Service	**17**	*28*	• • •	
SAANS	**388**	*170*	• H •	Continued upward trend of referrals to SAANS. Discussions are ongoing with commissioners on SAANS service model and offer.
R&S	**10**	*27*	• L •	
Perinatal MH Service (Sheffield)	**34**	*54*	• L •	The last 7 months of referrals have been below the 36 month average calculated from January 2019, but remain close to the average.
HAST	**18**	*9*	• H •	HAST referrals have been consistently above the pre-covid average of 18. This is to be further investigated and understood.
Health Inclusion Team	**113**	Insufficient data points to create SPC charts.		[redacted]
CLDT	**44**			
CISS	**3**			
CERT	**2**			
SCFT	**2**			

Responsive | Access & Demand | Community Services

January 2022	Per month		Number on wait list at month end		Average wait time referral to assessment (assessed in month)		Average wait time referral to first treatment contact ('treated' in month)		Total number open to Service	
Acute & Community Services	**Referrals (Number)**	**SPC variation**	**Waiting List (Number)**	**SPC variation**	**RtA in WEEKS**	**SPC variation**	**RtT in WEEKS**	**SPC variation**	**Caseload (Service)**	**SPC variation**
SPA/EWS	644	• L •	1178	• H •	29.2	• • •	30.4	• • •	995	• L •
Adult Home Treatment Service	126	• • •	*N/A*		*N/A*		*N/A*		60	• H •
MH Recovery North			77	• H •	4.3	• • •	39.7	• H •	961	• L •
MH Recovery South			78	• H •	7.0	• • •	13.9	• • •	1080	• H •
Recovery Service TOTAL	45	• • •	155	• H •	*N/A*		*N/A*		*2041*	• • •
Early Intervention in Psychosis	41	• L •	34	• • •	*N/A. Refer to EIP AWT Standard*				335	• L •
Memory Service	160	• H •	518	• H •	17.3	• • •	27.7	• • •	4434	• H •
OA CMHT	265	• • •	127	• H •	6.8	• • •	17.0	• • •	1237	• H •
OA Home Treatment	24	• • •	*N/A*		*N/A*		*N/A*		65	• • •

Rehab & Specialist Services	Referrals (Number)	SPC variation	Waiting List (Number)	SPC variation	RtA in WEEKS	SPC variation	RtT in WEEKS	SPC variation	Caseload (Service)	SPC variation
SPS - MAPPS	*N/A. See SPS Screening Referral Detail*		69	• H •	21.3	• • •	126.0	• H •	318	• H •
SPS - PD			23	• L •	11.9	• L •	72.4	• • •	178	• L •
Gender ID	38	• L •	1516	• H •	172.8	• H •	Incomplete		2355	• H •
STEP	88	• • •	85	• • •	*N/A*		Incomplete		420	• H •
Eating Disorders Service	17	• • •	24	• • •	6.6	• • •	Incomplete		223	• H •
SAANS	388	• H •	4579	• H •	100.7	• H •	Incomplete		4742	• H •
R&S	10	• L •	238	• H •	*N/A*		Incomplete		244	• H •
Perinatal MH Service (Sheffield)	34	• L •	24	• • •	2.9	• • •	Incomplete		140	• • •
HAST	18	• H •	30	• • •	7.4	• • •	Incomplete		101	• H •
Health Inclusion Team	113		30		1.0		Incomplete		Incomplete	
LTNC - NES	Incomplete		Incomplete		Incomplete		Incomplete		Incomplete	
LTNC - Case Management	Incomplete		Incomplete		Incomplete		Incomplete		Incomplete	
SCBIRT	Incomplete		Incomplete		Incomplete		Incomplete		Incomplete	
CFS/ME	Incomplete		Incomplete		Incomplete		Incomplete		Incomplete	
CLDT	44		156		15.2		31.9		879	
CISS	3		*N/A*		*N/A*		*N/A*		26	
CERT	2		0		Incomplete		Incomplete		44	
SCFT	2		0		Incomplete		Incomplete		23	

Narrative

In general, community services are experiencing high demand, increasing waits and high numbers of service users on service caseloads (the number of open episodes of care to our community teams). Demand is monitored regularly in the weekly produced Demand Monitoring dashboard, as well as being discussed in detail in Clinical Directorate performance and leadership meetings. Recovery Plans are in place for the services experiencing the biggest issues. Updates for the SPA/EWS and Recovery Services Recovery Plans are scheduled to be presented at April 2022 Quality Assurance and Finance & Performance Committees.

Safe | Inpatient Wards | Adult Acute & Step Down

	Benchmark/ Target	Jan-22 n	Jan-22 mean	Jan-22 SPC variation	Jan-22 SPC target
Admissions	/	27	38	• L •	/
Detained Admissions	/	25	33	• • •	/
% Admissions Detained	50%	93%	87.9	• • •	/
Emergency Re-admission Rate (rolling 12 months)	10.3%	3.96%	4.3	• L •	P
Discharges	/	25	37	• L •	
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	11			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	699			
Bed Occupancy excl. Leave (KH03)	95%	98.0%	94.1%	• • •	?
Bed Occupancy incl. Leave	/	100.1%	98.3%	• • •	?
Average beds admitted to	/	48			
Average Discharged Length of Stay (12 month rolling)	32	36.4	35.7	• • •	F
Average Discharged Length of Stay (discharged in month)	32	43.1	37.1	• • •	/
Live Length of Stay (as at month end)	/	71.9	46.3	• H •	/
Number of Mental Health Out of Area Placements started in the period (admissions)	0 Inappropriate	5	8	• • •	?
Total number of Out of Area bed nights in period	0 Inappropriate	324	338	• • •	F
Total number of people in Out of Area beds in period	0 Inappropriate	15	19	• • •	F
Cost of Out of Area bed nights in period	0 Inappropriate	Refer to Directorate Finance Report			

Narrative (Acute Wards)
Concern remains over the persistent demand; increasing length of stay; low admission and discharge rates and number of delayed discharges across the adult acute system. There is a real lack of flow in the system, which is evidenced in the use of out of area beds and detention into Section 136 Place of Safety beds.

Length of Stay Detail
Longest LoS (days) as at month end: 216 on Dovedale 2, 132 on Maple and 123 on Stanage
Range = 2 to 216 days
Number of discharges in month: 25
Longest LoS (days) of discharges in month: 187

Step Down (Wainwright Crescent)	Benchmark /Target	Jan-22 n	Jan-22 mean	Jan-22 SPC variation	Jan-22 SPC target
Admissions	/	8	6	• • •	/
Discharges	/	8	6	• • •	
Bed Occupancy excl. Leave (KH03)	95%	68.33%	82.9%	• L •	?
Bed Occupancy incl. Leave	95%	87.39%	92.2%	• • •	?
Average Discharged Length of Stay (12 month rolling)	/	64.84	65.24	• • •	?
Live Length of Stay (as at month end)	/	35.50	51.29	• • •	/

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	Nov-21	Dec-21	Jan-22	Sparklines (Apr-21 to Jan-22)
Bradford District Care NHS Foundation Trust	24	21	19	
South West Yorkshire Partnership NHS Foundation Trust	14	19	18	
Leeds and York Partnership NHS Foundation Trust	8	14	17	
Sheffield Health and Social Care NHS Foundation Trust	**16**	**11**	**17**	
Cumbria Northumberland, Tyne and Wear Partnership NHS FT	8	4	12	
Humber NHS Foundation Trust	13	13	8	
Tees, Esk and Wear Valleys NHS Foundation Trust	4	6	6	
Rotherham Doncaster and South Humber NHS Foundation Trust	4	3	5	
Navigo (NE Lincs/Grimsby)	2	0	0	

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 (Wainwright Crescent)

Length of Stay Detail
Longest LoS (days) as at month end: 126
Range = 7 to 126 days
Number of discharges in month: 8
Longest LoS (days) of discharges in month: 228

Inpatient Wards | PICU

PICU (Endcliffe)	Benchmark/ Target	Jan-22 n	Jan-22 mean	Jan-22 SPC variation	Jan-22 SPC target
Admissions	/	3	3	• • •	/
Discharges	/	5	2	• • •	
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	4			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	124			
Bed Occupancy excl. Leave (KH03)	95%	91.61%	91.0%	• • •	?
Bed Occupancy incl. Leave	95%	98.06%	93.8%	• • •	?
Average beds admitted to	/	10			
Average Discharged Length of Stay (12 month rolling)	47	52.50	48.76	• • •	?
Live Length of Stay (as at month end)	/	130.33	63.48	• H •	/
Number of Out of Area Placements started in the period (admissions)	ZERO Inappropriate	4	4	• • •	?
Total number of Out of Area bed nights in period	ZERO Inappropriate	150	152	• • •	F
Total number of people in Out of Area beds in period	ZERO Inappropriate	8	9	• • •	F
Cost of Out of Area bed nights in period	ZERO Inappropriate	Refer to Directorate Finance Report			

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

Narrative

Concern remains over the persistent demand; increasing length of stay; low admission and discharge rates and number of delayed discharges across the adult acute system. There is a real lack of flow in the system, which is evidenced in the use of out of area beds and detention into Section 136 Place of Safety beds.

Length of Stay Detail

Longest LoS (days) as at month end: 363
Range = 13 to 363 days
Number of discharges in month: 5
Longest LoS (days) of discharges in month:147

Safe | Inpatient Wards | Older Adults

Older Adult Functional (Dovedale 1)	Benchmark/ Target	Jan-22 n	Jan-22 mean	Jan-22 SPC variation	Jan-22 SPC target
Admissions	/	6	5	•••	/
Discharges	/	5	6	•••	
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	3			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	70			
Bed Occupancy excl. Leave (KH03)	95%	84.95%	92.3%	•••	?
Bed Occupancy incl. Leave	95%	89.25%	96.8%	•••	?
Average beds admitted to	/	13			
Average Discharged Length of Stay (12 month rolling)	73	73.49	77.34	•••	?
Live Length of Stay (as at month end)	/	46.93	98.10	•L•	?

Older Adult Dementia (G1)	Benchmark/ Target	Jan-22 n	Jan-22 mean	Jan-22 SPC variation	Jan-22 SPC target
Admissions	/	3	4	•••	/
Discharges	/	3	4	•••	
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	8			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	192			
Bed Occupancy excl. Leave (KH03)	95%	81.45%	68.4%	•••	?
Bed Occupancy incl. Leave	95%	82.26%	70.3%	•••	?
Average beds admitted to	/	13			
Average Discharged Length of Stay (12 month rolling)	73	61.25	71.62	•L•	?
Live Length of Stay (as at month end)	/	56.29	50.94	•••	?

Length of Stay Detail
Longest LoS (days) as at month end: **174**
Range = 4 to 174 days
Number of discharges in month: 5
Longest LoS (days) of discharges in month: 60

Length of Stay Detail
Longest LoS (days) as at month end: **150**
Range = 4 to 150 days
Number of discharges in month: 3
Longest LoS (days) of discharges in month: 26

Narrative

Both Older Adult wards continue to perform well, with reducing length of stays (both wards now have a 12 month average discharged length of stay on or below the 20/21 national average of 73 days and G1 increasing occupancy levels throughout January 2022.

There has been significant focus on reducing the LoS on Older Adults wards, the improvement aligns to the work undertaken, jointly with the Local Authority, to reduce the occurrence and duration of delayed discharges.

It should also be noted that no Older Adult out of area beds have been used in the period.

Older Adult (Out of Area)	Benchmark/Target	Jan-22 n	Jan-22 mean	Jan-22 SPC variation	Jan-22 SPC target
Number of Mental Health Out of Area Placements started in the period (admissions)	ZERO Inappropriate	0	1	•••	?
Total number of Out of Area bed nights in period	ZERO Inappropriate	0	64	•••	?
Total number of people in Out of Area beds in period	ZERO Inappropriate	0	4	•L•	?
Cost of Out of Area bed nights in period	ZERO Inappropriate	£0			

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	Jan-22 n	Jan-22 mean	Jan-22 SPC variation	Jan-22 SPC target
Admissions	/	2	1	•••	/
Discharges	/	4	3	•••	
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%	86.67%	79.84%	•••	?
Bed Occupancy incl. Leave	95%	96.99%	91.94%	•••	?
Average Discharged Length of Stay (12 month rolling)	441	305.31	320.77	•••	P
Live Length of Stay (as at month end)	/	374.55	363.98	•••	/
Number of Out of Area Placements started in the period (admissions)	0	1			
Total number of Out of Area bed nights in period	0	249			
Total number of people in Out of Area beds in period	0	9			
Cost of Out of Area bed nights in period	0	Refer to Directorate Finance Report			

Forensic Low Secure (Forest Lodge)	Benchmark/ Target	Jan-22 n	Jan-22 mean	Jan-22 SPC variation	Jan-22 SPC target
Admissions	/	0	1	•••	/
Discharges	/	2	1	•••	
Bed Occupancy excl. Leave (KH03)	95%	80.21%	85.21%	•••	?
Bed Occupancy incl. Leave	95%	86.07%	92.53%	•••	?
Average Discharged Length of Stay (12 month rolling)	707	402.22	396.91	•••	P
Live Length of Stay (as at month end)	/	478.72	452.24	•••	/

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: **2055**
Range = 3 to 2055 days
Number of discharges in month: 4
Longest LoS (days) of discharges in month: 712

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 January 2022 there were 9 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 very favourably against other low secure facilities across the country.

Length of Stay Detail
Longest LoS (days) as at month end: **2021**
Range = 40 to 2021 days
Number of discharges in month: 2
Longest LoS (days) of discharges in month: 479

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

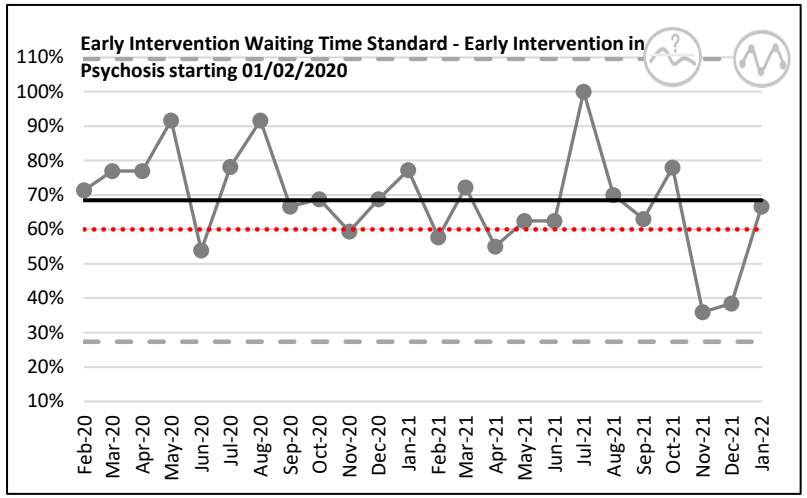
The final service user was discharged from Firshill ATS on 2 September 2021. The service is currently undergoing a period of review and training.

Of note during January 22:

The Learning Disability service is continuing to work on recruitment. The new Clinical Director has agreed a start date in May 2022 and has commenced engaging with the team. There have been new appointments in the nursing team.

The Programme Board discussed the regional strategy for learning disability which is in line with the paper that was discussed at Trust Board in January. This emphasises the need to further develop community services. The Learning Disability Programme Board also discussed the work the service has been doing with stakeholders to develop the community model for learning disability.

Effective | Treatment & Intervention



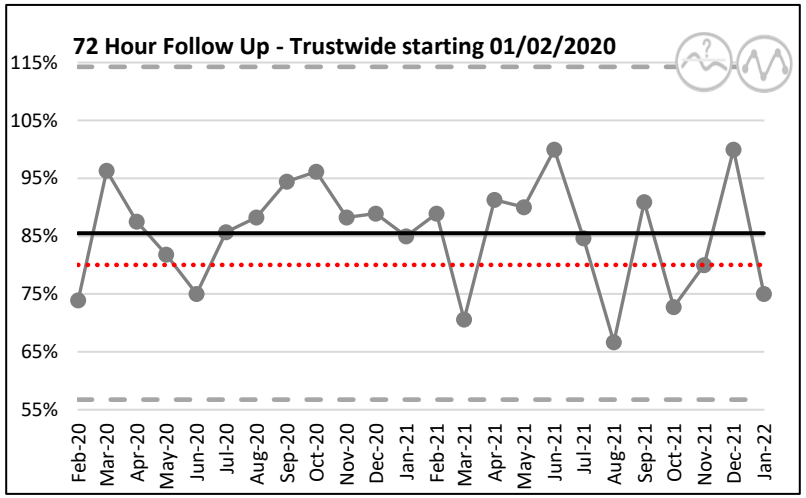
EIP AWT Standard	Jan-22			
	Target 2021/22	n	SPC variation	SPC target
Trustwide	60%	67%	• • •	?

Narrative

2021/22 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 to 60% with effect from 1 April 2021.

There is variation month on month, and the service failed to meet the target in November and December 2021, suffering with long and short term absences, but our average over the last 2 year period is 68.5% indicating the system is capable of achieving the 20/21 target.

In January 22 = 67% (2/3)



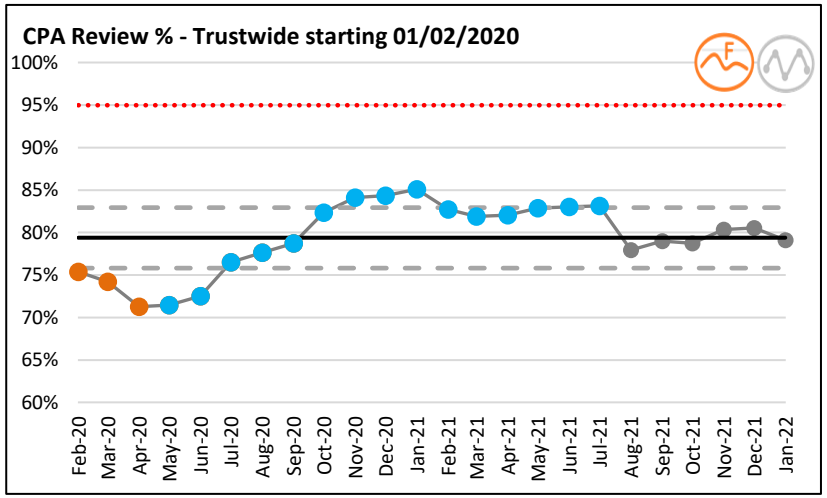
72-hour Follow Up	Jan-22			
	Target 2021/22	N	SPC variation	SPC target
Trustwide	80%	75%	• • •	?

Narrative

The aim is to deliver safe care through ensuring people on CPA are seen within 72 hours of being discharged.

Data quality is still being validated with IMST colleagues, however the charts above show SHSC 2 year average is 85.5%, indicating that the current operational model of Crisis Resolution Home Treatment providing follow up is capable of meeting the 80% target.

Performance in **January 22 was at 75% (6/8)**



CPA Annual Review % Compliance	Jan-22			
	Target 2021/22	N	SPC variation	SPC target
Trustwide	95%	79.10%	• • •	F
EIP	95%	75.25%	• L •	?
Recovery North	95%	92.51%	• H •	F
Recovery South	95%	69.48%	• L •	F

Narrative

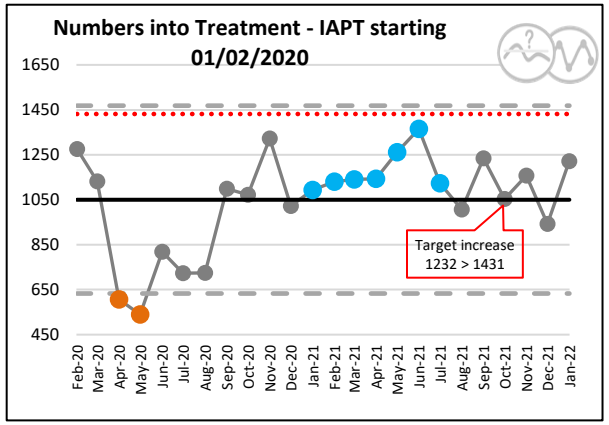
Weekly reports are in place and improvements are seen in Recovery North Team but have not been sustained in the South. Early intervention activity has dropped as a result of significant absence and vacancies within the service.

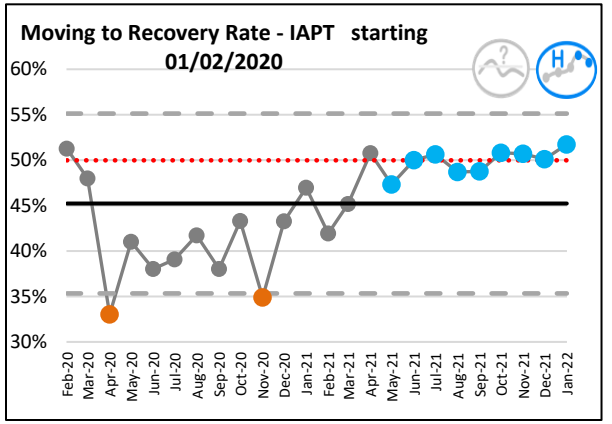
A time limited group has been set up to outline proposals for the process, systems and measurement of the 5 principles that have replaced CPA by end March 2022. However, the focus remains on ensuring completion of annual CPA reviews until alternative systems are in place.

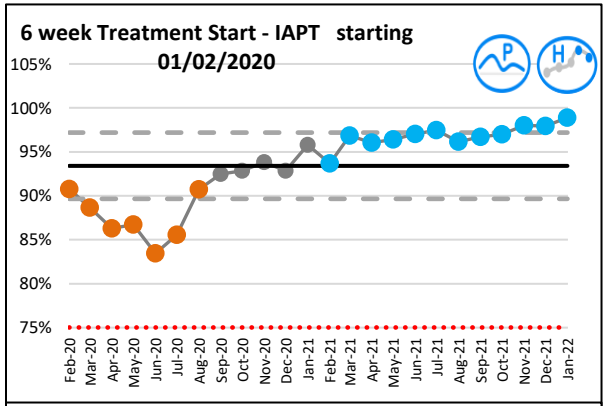
IAPT | Performance Summary

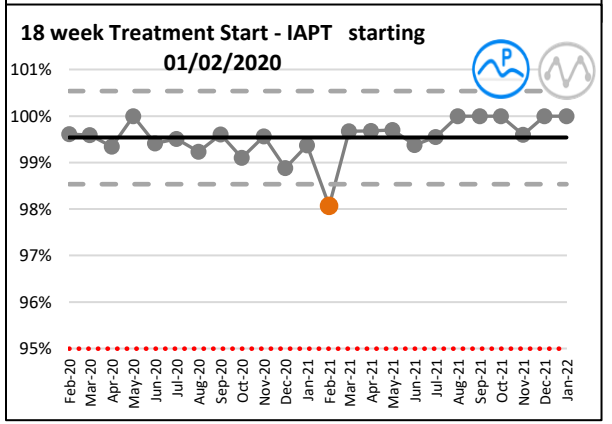
IAPT		Jan-22			
Metric	Target 2021/22	n	*mean*	SPC variation	SPC target
Referrals	n/a	1621	*1268**	• • •	/
New to Treatment	1232 (Apr - Sep 21) 1431 (Oct 21 - Mar 22)	1221	*1051*	• • •	?
6 week Wait	75%	98.90%	*93.4%*	• H •	P
18 week Wait	95%	100%	*99.5%*	• • •	P
Moving to Recovery Rate	50%	51.73%	*45.2%*	• H •	?

**Process limits recalculated from March 2020. Pre-covid average referrals per month were 1666. Post-covid average is 1268.*









Narrative

Access

- 1221 people entered treatment in January which is the highest access achieved since September 2021. Still ongoing issues with recruiting in to the comms role which impacts on service promotion. Considering options with Comms team on alternative options for comms role.

Waiting Times

- Consistently exceeding waiting time standard. 99% of people seen for treatment in less than 6 weeks (target 75%) and 100% of people seen for treatment in less than 18 weeks (target 95%)

Recovery

- Achieved the Recovery rate standard for last 4 months with January being: 51.7%

START – Sheffield Treatment & Recovery Team | Performance Summary

START		January-22		
Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	83	• L •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	78%	• L •	P
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	100%	• H •	P
DNA Rate to Assessment	≤ 15%	16%	• • •	?
Recovery - Successful treatment exit	TBC	7	• • •	/
Non-Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	63	• • •	/
Waiting time Referral to Assessment	≥ 95%	30%	• L •	?
Waiting time Referral to Treatment	≥ 95%	100%	• • •	P
DNA Rate to Assessment	≤ 15%	30%	• • •	?
Recovery - Successful treatment exit	TBC	15	• • •	/
Alcohol	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	180	• H •	/
Waiting time Referral to Assessment	≥ 95%	79%	• L •	P
Waiting time Referral to Treatment	≥ 95%	100%	• H •	P
DNA Rate to Assessment	≤ 15%	25%	• • •	?
Recovery - Successful treatment exit	TBC	37	• • •	/

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.

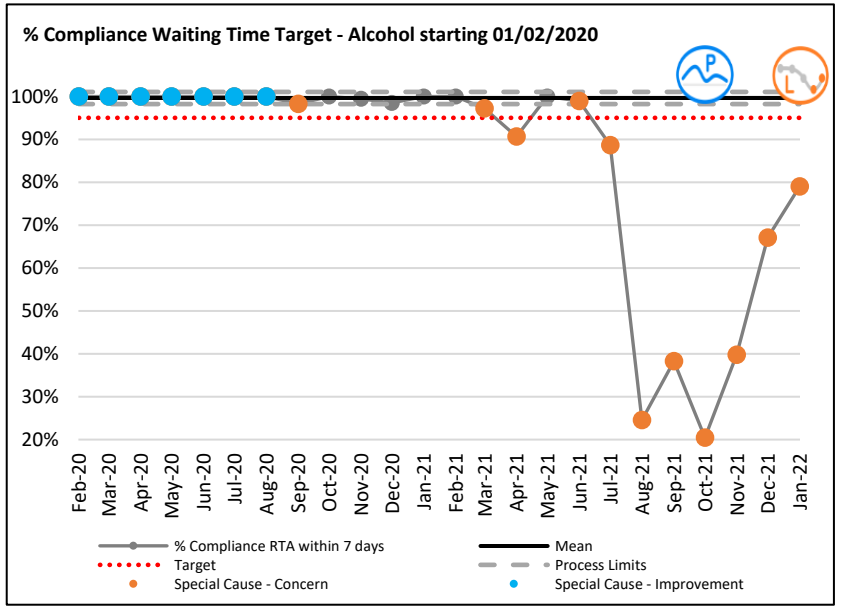
Staff absences continue to place a pressure on achieving the target for referral to assessment. Breaches to these timescales are agreed by management and every effort is made to rearrange appointments if a cancellation occurs or additional appointments are available sooner.

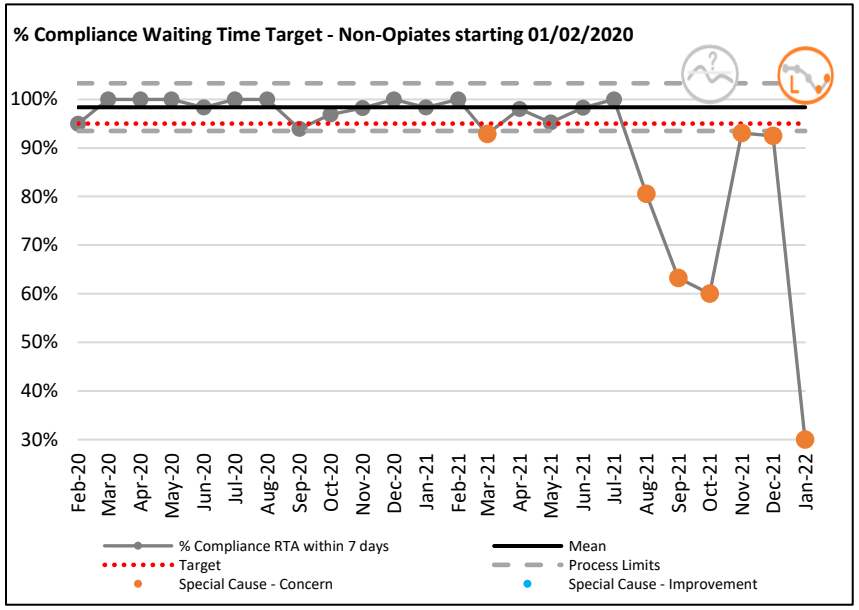
The service has historically overperformed on waiting times, with very few breaches. However a combination of annual leave, sickness and a covid outbreak have impacted on service ability to complete assessments within the 7 days. Access to treatment remains with no waiting list and the waiting times to start structured treatment are not impacted.

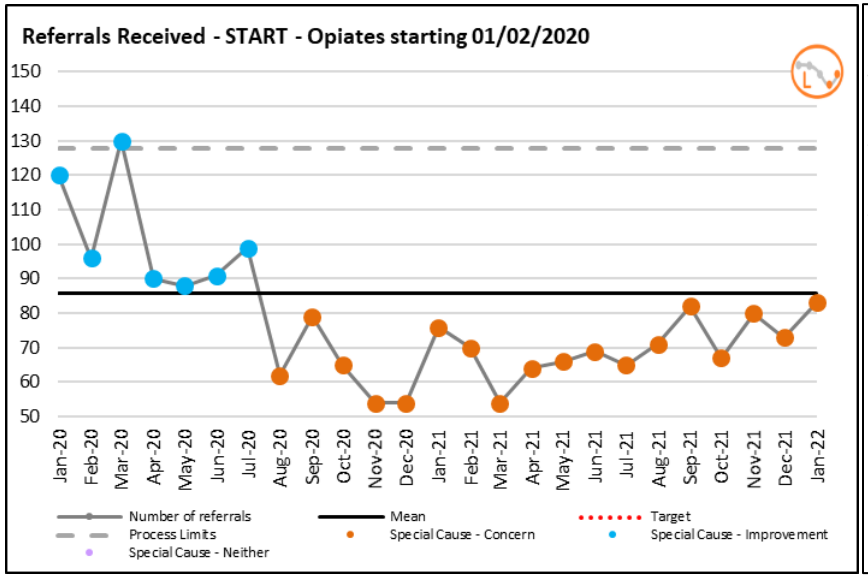
Recovery

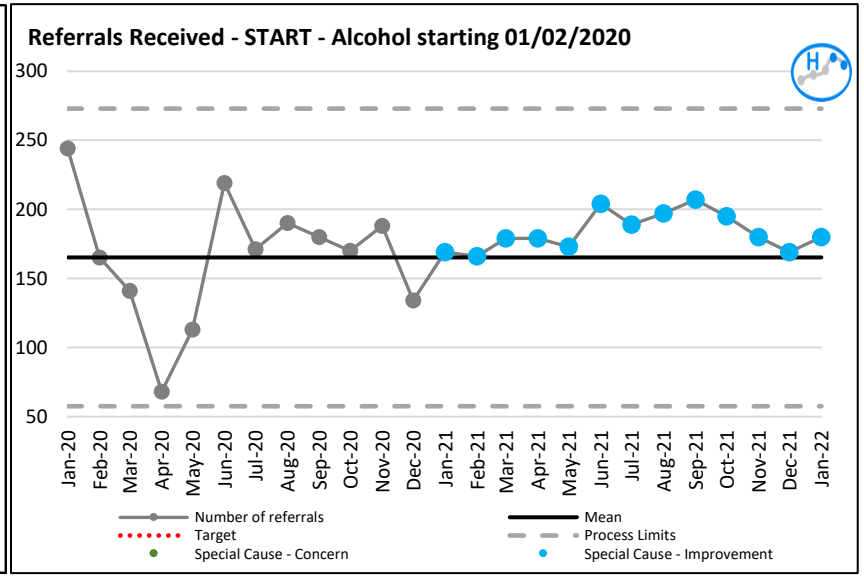
Due to the open access nature of the service, service users historically find it easier to drop out of treatment. The service has previously worked towards a target for the percentage of positive discharges (defined as discharge drug free/occasional user or a planned discharge with treatment goals met). We are reviewing this with commissioners for the current contract.

START Performance | Highlights & Exceptions









Wait times to assessment

Continuing effects of staff absences during January had a particular impact on wait times to assessment again.

In the Non-opiates service, 28 people waited longer than 7 days to be seen for assessment. The longest wait was 12 days.

Wait times to assessment in the alcohol service are improving but remain a concern for the service to monitor.

Wait times to starting structured treatment are not affected.

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.

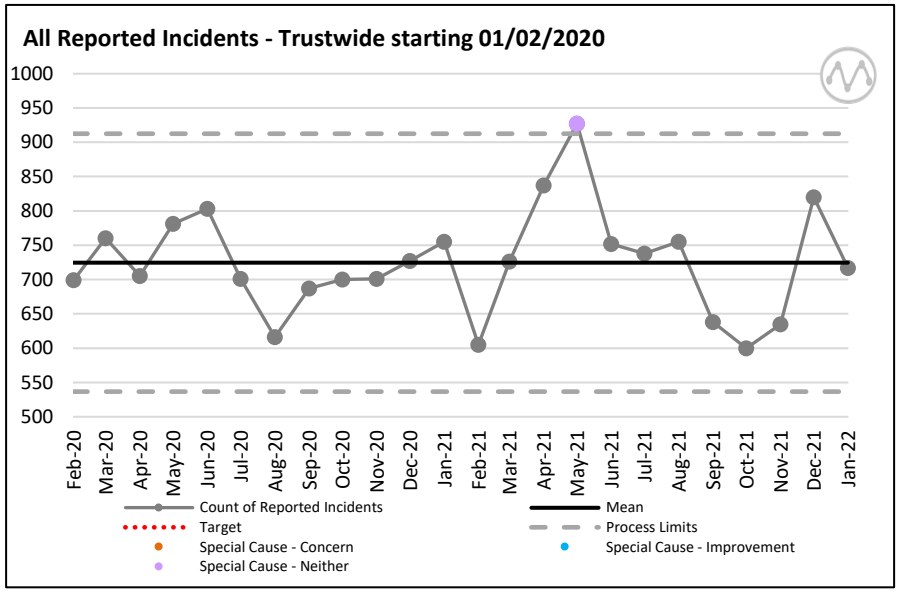
NHS
Sheffield Health and Social Care
NHS Foundation Trust

Safety & Quality

IPQR - Information up to and including January 2022

Proud to care in Sheffield

Safe | All Incidents



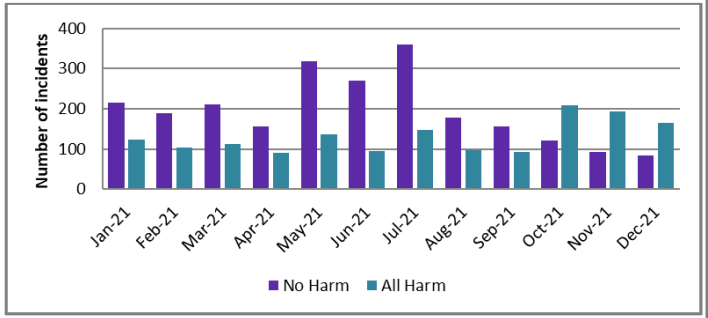
Trustwide	Jan-22		
	n	*mean*	SPC variation
ALL	**717**	*725*	• • •
5 = Catastrophic	25	*14*	• • •
4 = Major	11	*5*	• H •
3 = Moderate	119	*43*	• H •
2 = Minor	234	*186*	• H •
1 = Negligible	304	*457*	• • •
0 = Near-Miss	24	*19*	• • •

Narrative

Patient safety incidents are uploaded to the National Reporting Learning System (NRLS). Benchmarking information is released annually with the last covering the period April 2020 – March 2021. This shows SHSC's patient safety incident reporting rate at 76.6 incidents per 1000 bed days. Nationally, for mental health trusts, this rate varies from 21.6 to 235.8. Regionally, this rate varies from 45.1 to 114.6 patient safety incidents reported per 1,000 bed days.

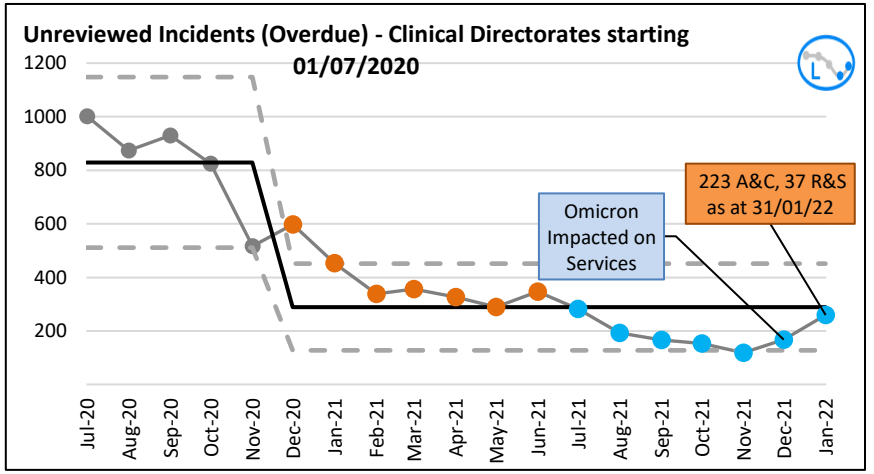
The chart below shows SHSC patient safety incidents reported where harm was caused compared to no harm caused from Jan 2021 to Dec 2021.

Patient Safety Incidents – Harm vs No Harm Jan – Dec 2021



Covid-19 outbreaks/positive cases accounted for 6 out of the 11 major incidents reported in January 2022 across acute, PICU and rehab settings.

Lack of beds/delayed assessments/closure of the 136 suite accounted for 30 moderate incidents reported during January 2022.



Narrative

There has been an increase in unreviewed incidents in the Acute & Community Directorate, predominantly in one ward area due to long term absence of the ward manager. The Directorate triumvirate are reallocating unreviewed incidents to clinical and non-clinical leaders depending upon nature of the incident. A temporary plan is being mobilised to support the ward in the absence of the ward manager.

Serious Incident Actions Outstanding

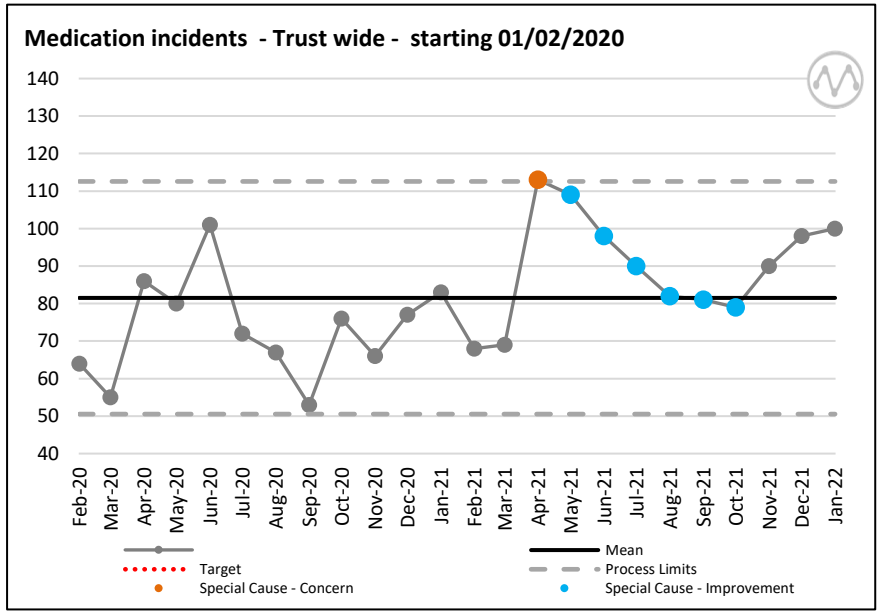
As at 31 January 2022, there were 60 outstanding SI actions overdue.

- 4 of these are from SIs in 2019
- 31 of these are from SIs in 2020
- 25 of these are from SIs in 2021

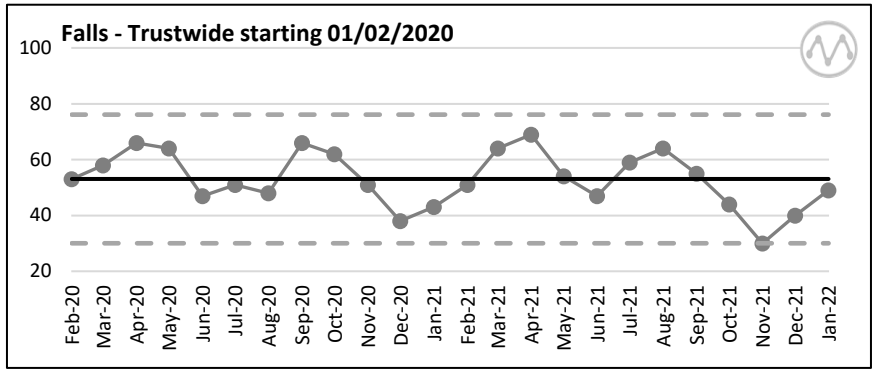
Weekly reports are being sent to identified matrons and general managers to oversee and complete all SI action plans.

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

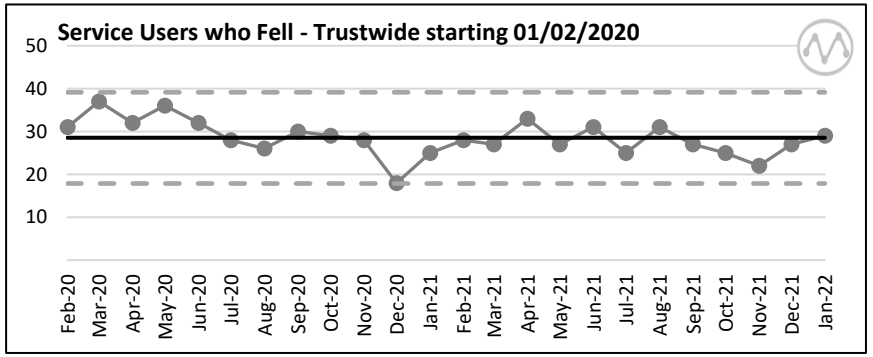
Safe | Medication Incidents & Falls



Trustwide	Jan-22		
	n	*mean*	SPC variation
ALL	**100**	*81*	• • •
Administration Incidents	15	*17*	• • •
Meds Management Incidents	65	*51*	• • •
Pharmacy Dispensing Incidents	12	*7*	• • •
Prescribing Incidents	8	*6*	• • •
Meds Side Effect/Allergy Incidents	0	*0*	• • •



Trustwide	Jan-22		
	n	*Mean*	SPC variation
Falls incidents	**49**	*54*	• • •
Acute & Community	**46**	*50*	• • •
Rehabilitation & Specialist Services	**3**	*4*	• • •



Trustwide	Jan-22		
	n	*mean*	SPC variation
People who fell	**29**	*28*	• • •
Acute & Community	**27**	*26*	• • •
Rehabilitation & Specialist Services	**2**	*3*	• • •

Narrative

Medication Incidents

There were 3 moderate medication incidents reported in January 2022. One involved a fridge temperature being out of range within the South Recovery Team, one involved a prescription for the wrong person within START and one involved a missed medication within the CERT Team.

Medicines Management Incidents

33 out of the 65 medicines management incidents reported relate to controlled drug stock discrepancies or second signatures missing.

Falls Incidents

No moderate or above incidents reported in the month, with 33 out of the 49 falls in January 2022 resulting in no recorded injury to the service user.

Safe | Assaults, Sexual Safety & Missing Patients

Assaults on Service Users	Jan-22		
	n	mean	SPC variation
Trustwide	17	23	• • •
Acute & Community	14	20	• • •
Rehab & Specialist	1	2	• • •

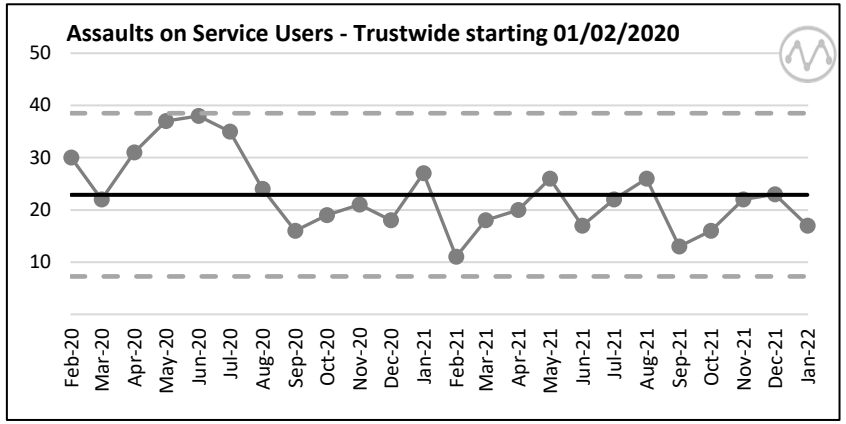
Assaults on Staff	Jan-22		
	n	mean	SPC variation
Trustwide	70	85	• • •
Acute & Community	66	67	• • •
Rehab & Specialist	2	16	• L •

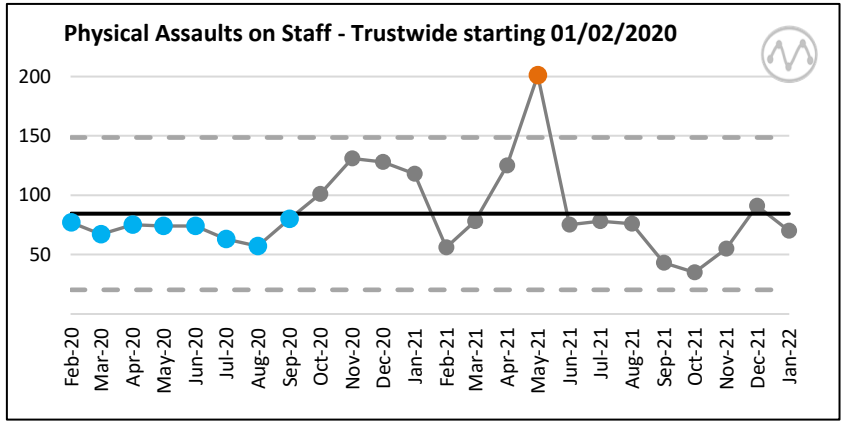
Narrative

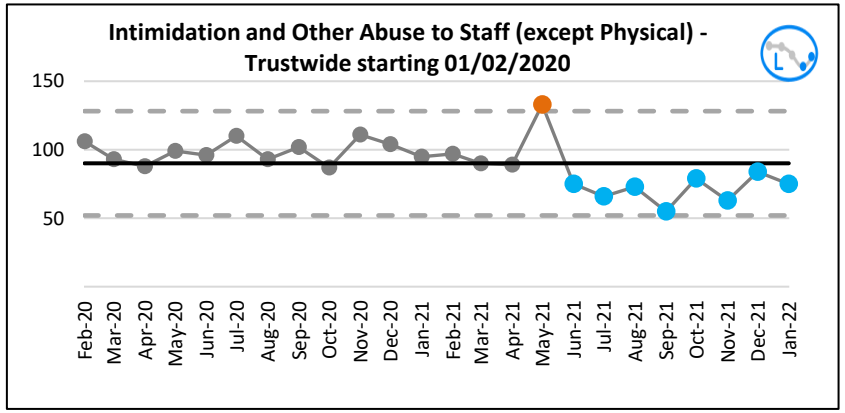
Assault to Staff
There were 23 moderate incidents reported in January 2022. It should be noted that any incident that results in a service user being secluded is classified as a moderate incident, irrespective of the level of harm (if any) caused as a result of the assault.

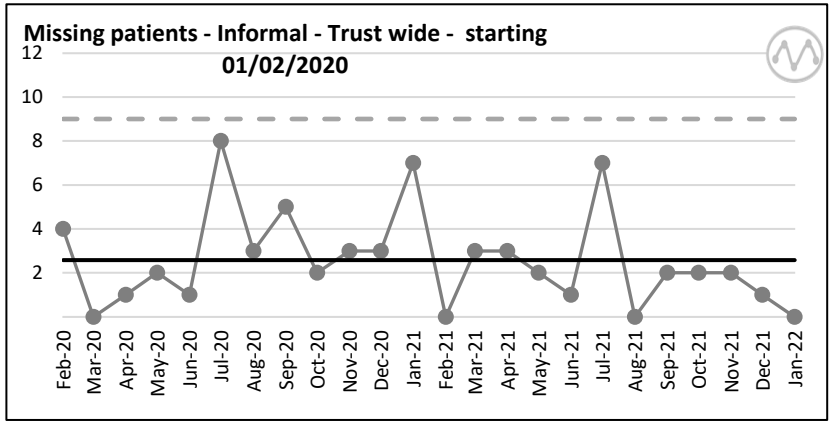
Assault on Service Users
There was 1 moderate incident reported on Dovedale 2 Ward in January 2022 which involved physical assault of a sexual nature. The service user did not wish for the police to be contacted in relation to this incident.

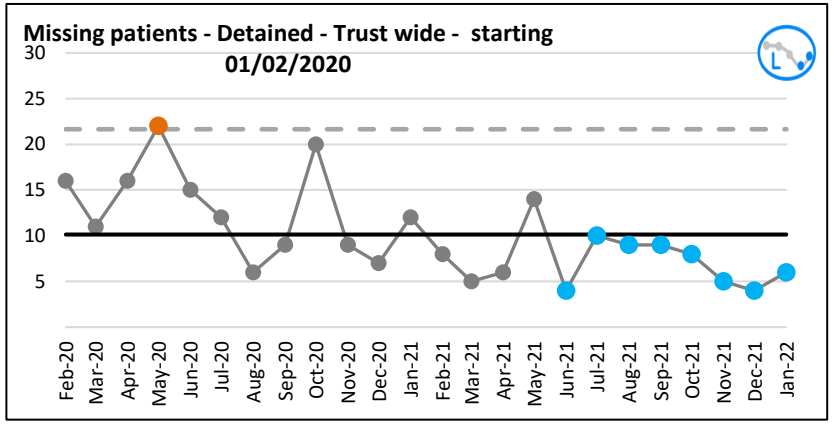
Protecting from avoidable harm	Target	YTD
Reportable Mixed Sex Accommodation (MSA) breaches	0	0







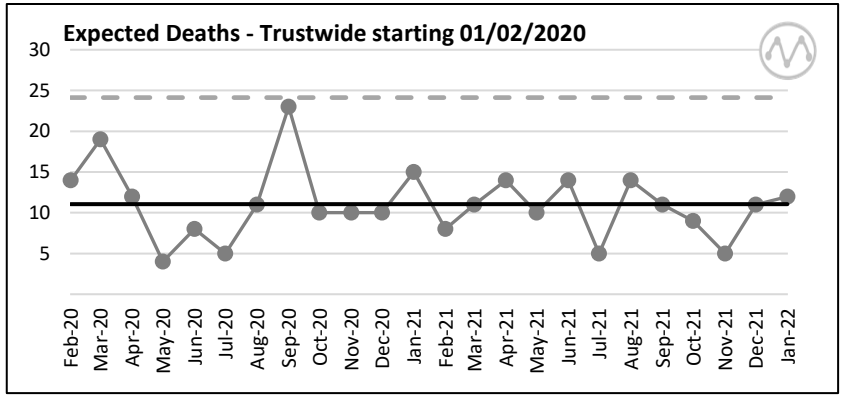


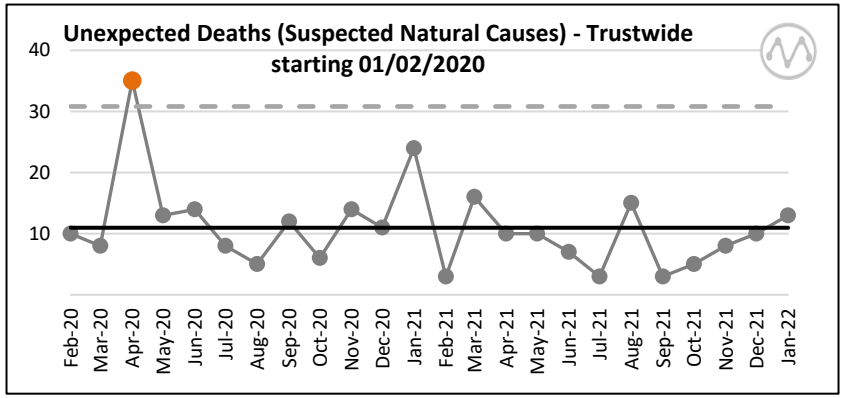


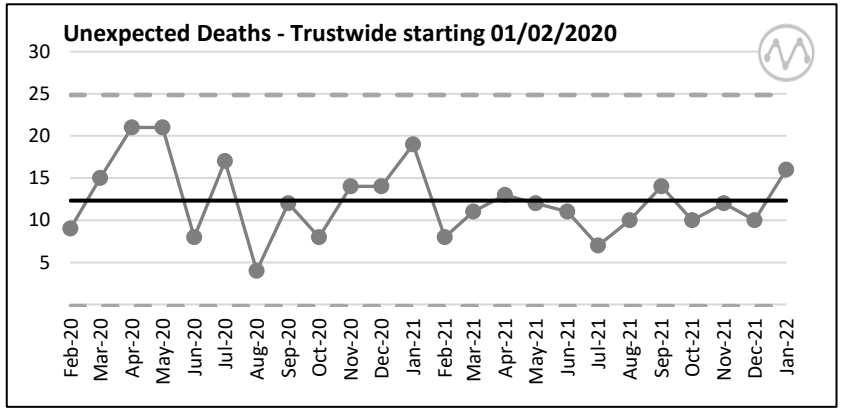
Trustwide	Jan-22		
	n	mean	SPC variation
Missing Patients (Informal)	0	3	• • •
Missing Patients (Detained)	6	10	• L •

Narrative
The intimidation SPC chart shows special cause variation as there are over 7 data points recorded below the mean.

Deaths

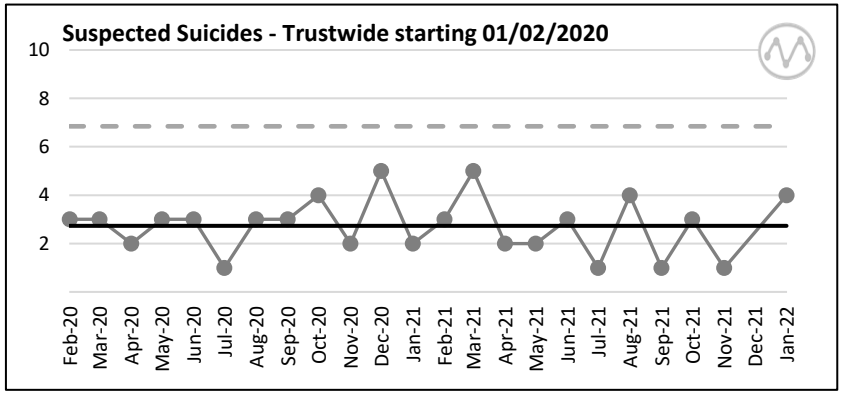






Quarterly mortality reports are presented to the Quality Assurance Committee and Board of Directors.

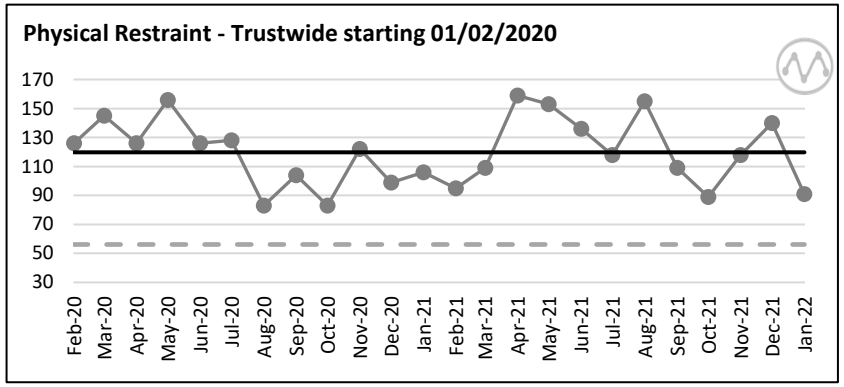
Deaths Reported 1 April 2020 – 31 January 2022	
Awaiting Coroners Inquest/Investigation	178
Conclusion - Narrative	9
Conclusion - Suicide	18
Conclusion – Accidental	4
Conclusion – Misadventure	2
Conclusion – Open	1
Natural Causes/No Inquest	641
Alcohol/Drug related	29
Suspected Homicide/Closed	2
Ongoing	2
Grand Total	**886**

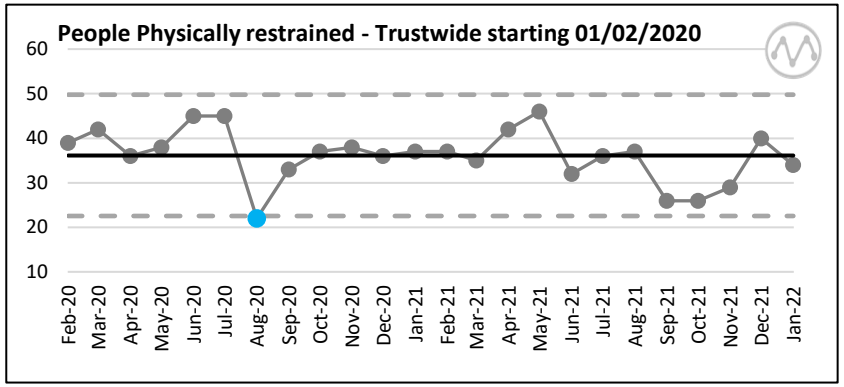


Covid-19 Deaths 1 March 2020 – 31 January 2022	
ATS (Firshill Rise)	1
Community Intensive Support Service (CISS) (LD)	1
Birch Avenue	6
Community Learning Disability Team	6
G1 Ward	6
Liaison Psychiatry	6
Long-term Neurological Conditions	3
Memory Service	7
Mental Health Recovery Team	2
Neuro Case Management Team	1
Neuro Enablement Service	3
Older Adult Community Mental Health Teams	45
Older Adult Home Treatment Service	3
START Alcohol Service	1
START Opiates Service	1
Woodland View	2
Total	**94**

Suicides over longer time period will be incorporated from next month's IPQR.

Safe | Restrictive Practice | Physical Restraint





Physical Restraint Incidents	Jan-22		
	n	*mean*	SPC variation
Trustwide people physically restrained	**91**	*120*	• • •
Acute & Community Services			
Burbage Ward	**24**	15	• • •
Stanage Ward	**7**	19	• L •
Maple Ward	**27**	13	• H •
Endcliffe Ward	**14**	28	• • •
Dovedale	**9**	20	• • •
G1 Ward	**7**	9	• • •
Birch Ave	**1**	1	• • •
Woodland View	**0**	1	• • •
Rehabilitation & Specialist Services	ZERO RESTRICTIVE PRACTICE INCIDENTS REPORTED FOR REHAB & SPECIALIST SERVICES IN JANUARY 2022.		

Physical Restraint (People)	Jan-22		
	n	*mean*	SPC variation
Trustwide people physically restrained	**34**	*36*	• • •
Acute & Community Services			
Burbage Ward	**7**	*6*	• • •
Stanage Ward	**4**	*6*	• • •
Maple	**11**	*8*	• • •
Endcliffe Ward	**4**	*6*	• • •
Dovedale	**2**	*3*	• • •
G1 Ward	**6**	*4*	• • •
Birch Ave	**1**	*1*	• • •
Woodland View	**0**	*1*	• • •
Rehabilitation & Specialist Services	ZERO RESTRICTIVE PRACTICE INCIDENTS REPORTED FOR REHAB & SPECIALIST SERVICES IN JANUARY 2022.		

Narrative

Physical Restraint

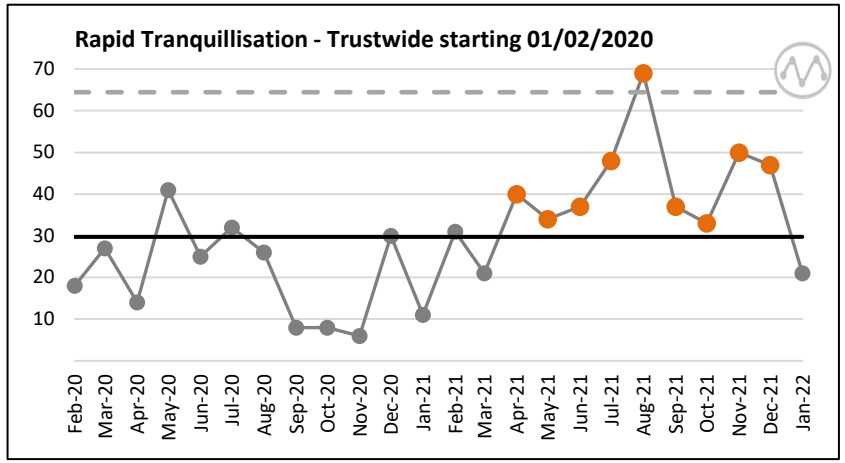
Numbers of physical restraints are higher than usual for January on Maple Ward. This increase is primarily due to the transfer in at the end of December of a service user with complex care needs who has previously been cared for on Dovedale 1 and Endcliffe Ward.

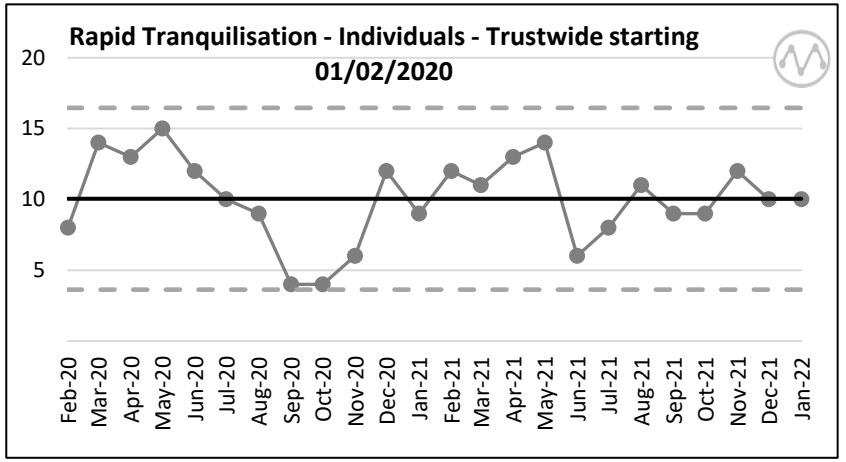
Despite an increase in incident numbers during January, use of restrictive practices remained low on Stanage Ward. The lower number of restrictive practice incidents are attributed to all the work which is being done on the ward; safety huddles, Purposeful Inpatient Admission (PIPA), including service users in MDTs, patient-led care plans and DRAMs and having therapy staff on the ward.

Mechanical Restraint

During January 2022 there was one reported instance of mechanical restraint. This was police restraint using handcuffs involving a hospital recall to Endcliffe Ward.

Safe | Restrictive Practice | Rapid Tranquillisation





Rapid Tranquillisation Incidents	Jan-22		
	n	mean	SPC variation
TRUSTWIDE	21	30	• • •
Acute & Community Services			
Burbage/Dovedale 2 Ward	6	5	• • •
Stanage Ward	1	3	• • •
Maple	9	3	• H •
Endcliffe Ward	3	6	• • •
Dovedale	1	10	• • •
G1 Ward	1	2	• L •
Rehabilitation & Specialist Services	ZERO RESTRICTIVE PRACTICE INCIDENTS REPORTED FOR REHAB & SPECIALIST SERVICES IN JANUARY 2022.		

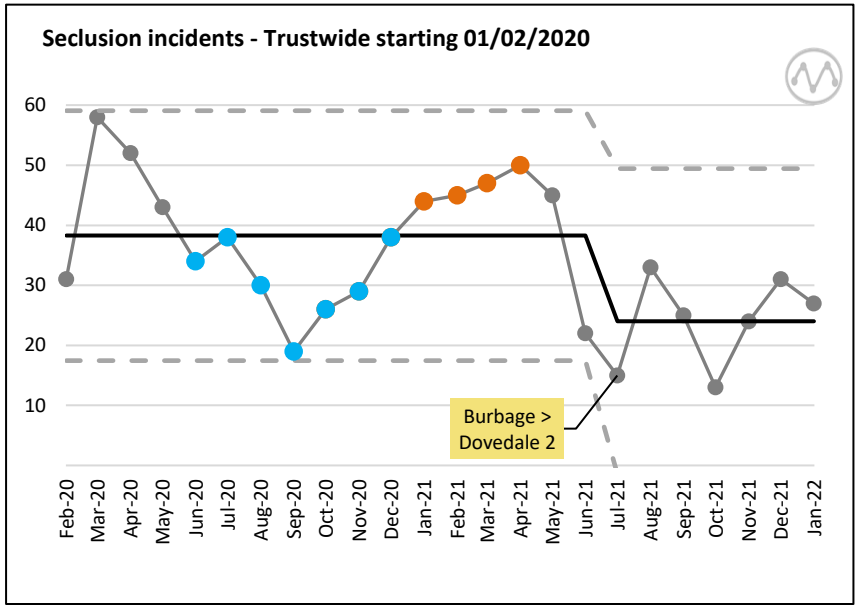
Rapid Tranquillisation (People)	Jan-22		
	n	mean	SPC variation
TRUSTWIDE	10	10	• • •
Acute & Community Services			
Burbage/Dovedale 2 Ward	2	2	• • •
Stanage Ward	1	2	• L •
Maple	3	2	• • •
Endcliffe Ward	2	2	• • •
Dovedale	1	1	• • •
G1 Ward	1	1	• • •
Rehabilitation & Specialist Services	ZERO RESTRICTIVE PRACTICE INCIDENTS REPORTED FOR REHAB & SPECIALIST SERVICES IN JANUARY 2022.		

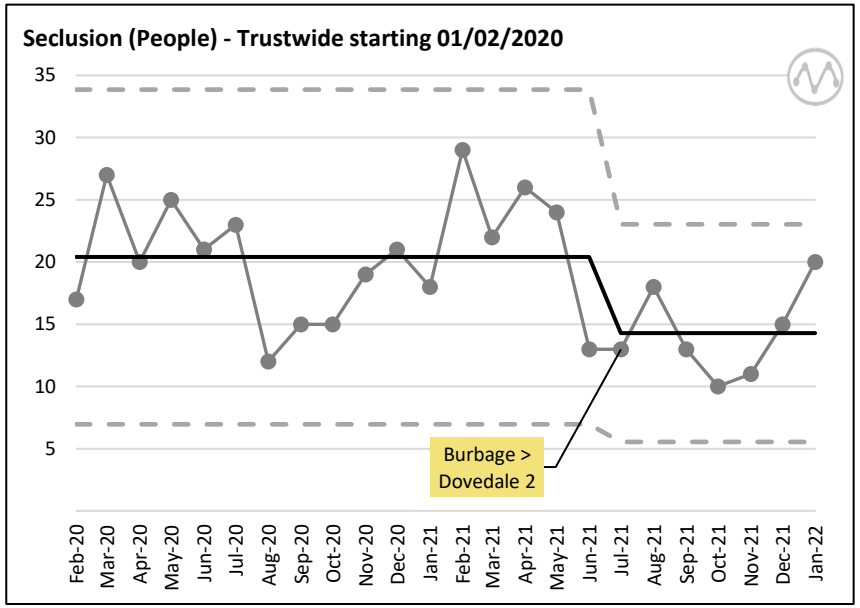
Narrative

Numbers of rapid tranquillisations were high on Maple Ward in January. This increase is primarily due to a service user with complex care needs who has previously been cared for on Dovedale 1 and Endcliffe Ward.

Despite an increase in incident numbers during January, use of restrictive practices remained low on Stanage Ward. The lower number of restrictive practice incidents are attributed to all the work which is being done on the ward; safety huddles, PIPA, including service users in MDTs, patient-led care plans and DRAMs and having therapy staff on the ward.

Safe | Restrictive Practice | Seclusion





Seclusion Incidents	Jan-22		
	n	*mean*	SPC variation
Trustwide	27	*34*	• L •
Acute & Community Services			
Stanage	5	*6*	• L •
Maple	8	*6*	• • •
Endcliffe PICU	10	*11*	• • •
G1	4	*6*	• • •
Rehabilitation & Specialist Services	ZERO RESTRICTIVE PRACTICE INCIDENTS REPORTED FOR REHAB & SPECIALIST SERVICES IN JANUARY 2022.		

Seclusion (People Secluded)	Jan-22		
	n	*mean*	SPC variation
Trustwide	20	*18*	• • •
Acute & Community Services			
Stanage	4	*4*	• • •
Maple	6	*4*	• • •
Endcliffe PICU	7	*6*	• • •
G1	3	*2*	• • •
Rehabilitation & Specialist Services	ZERO RESTRICTIVE PRACTICE INCIDENTS REPORTED FOR REHAB & SPECIALIST SERVICES IN JANUARY 2022.		

Narrative

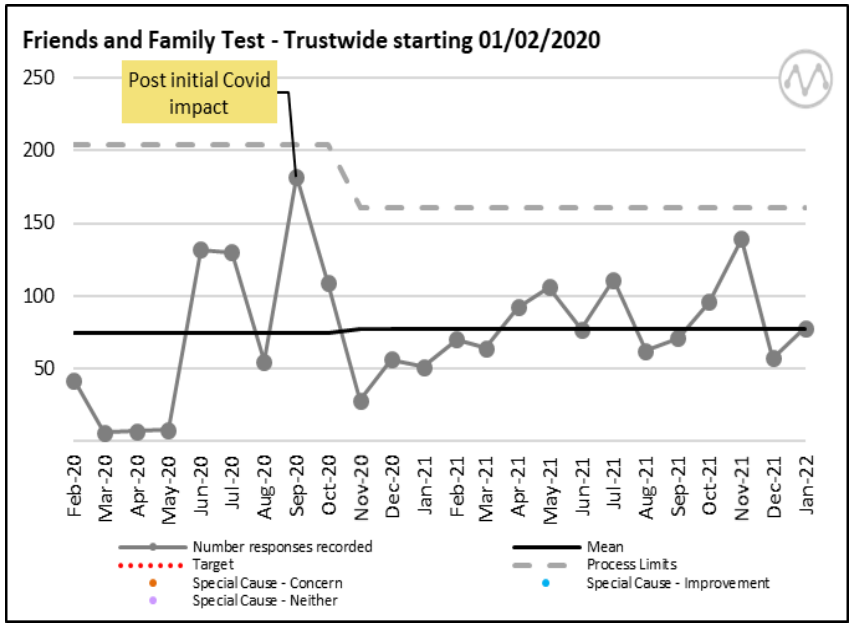
Seclusion

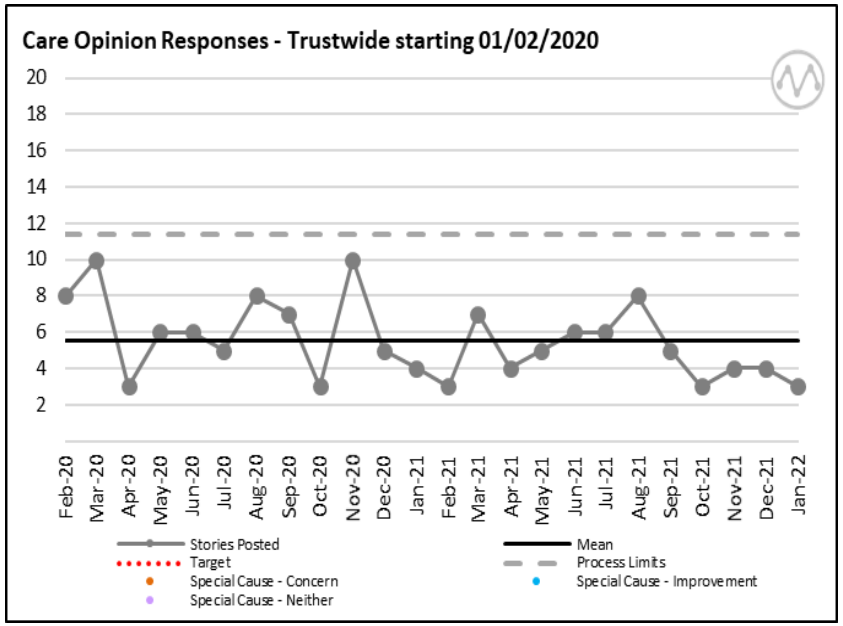
It should be noted that since Dovedale 2 decanted from Burbage Ward at the end of June 2021, there have been no seclusions, as there is no seclusion room. Care is being delivered in a less restrictive way. SPC charts have had limits recalculated from July 2021 to take this system change into account.

Long-Term Segregation

There were zero incidences of long-term segregation reported Trustwide in January 2022.

Caring | User Experience





User Experience
Service user and carer feedback is reported on a quarterly basis to the Quality Assurance Committee as part of a 'learning from experience' report. The last quarterly report is being presented in March 2022.

Quality of Experience
There were no Quality of Experience (QoE) surveys undertaken during January 2022.

Comments from the ward community meetings include clarity around named nurse, food variety, activity suggestions, use of Section 17 leave, vaping and ward visitors in relation to Covid-19 outbreaks.

Narrative.
In January 2022, the Trust received a total of 78 responses to the Friends and Family Test (FFT). 70 of these being positive in response to the FFT question.

Positive responses included comments about:
- Staff being very accommodating
- Staff making the service user feel like they care about their experience, that they feel listened to, and involved in the process.

Negative comments were received in connection with:
- Waiting times for assessment and treatment
- Lack of service user choice for appointments

The majority of FFT responses related to the Memory Service, Gender Identity Service and SAANS.

Narrative
Three stories were published on Care Opinion in January 2022, one related to the to START Opiates Service and two related to the Eating Disorders Service.

The authors of these stories identified themselves as service users in two stories and a relative in one story.

Care Opinion moderators rated the criticality of the 3 stories as follows; 1 minimally critical, 2 not critical.

When asked what could be improved, authors responded "some staff attitudes".

Complaints and Compliments

There were 18 formal complaints received in January 2022, 2021, 14 for the Acute and Community Directorate and 4 for the Rehabilitation and Specialist Services Directorate. The most frequent category types were 'access to treatment and/or drugs' and 'patient care'.

2 compliments were recorded to have been received in January 2022. It is likely that this number will increase as further compliments are received from clinical services. Both were for the Acute & Community Directorate and involved the SPA Team and Out of Hours Team.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Our People

IPQR - Information up to and including January 2022

Proud to care in Sheffield

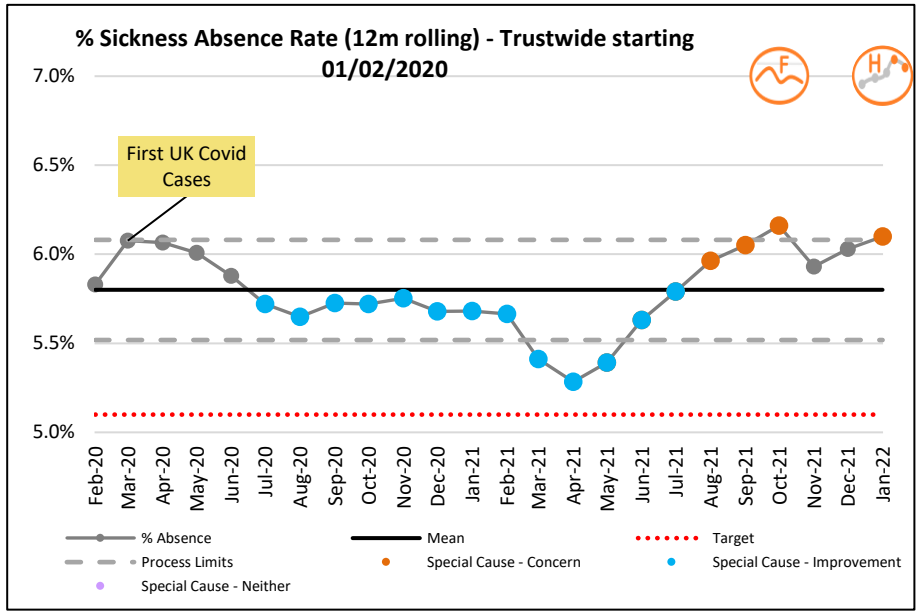
Well-Led | Workforce Summary

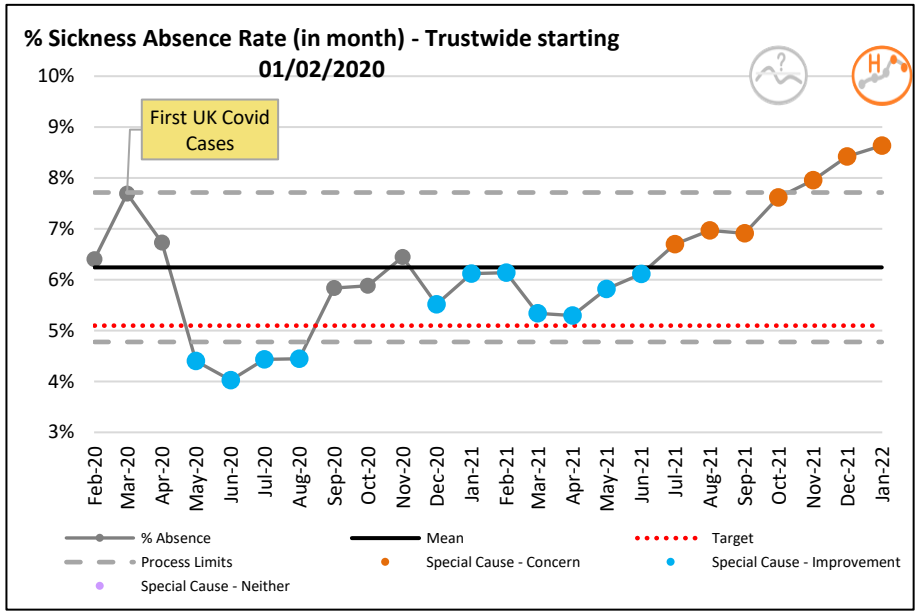
		Clinical Services	Medical	Corporate Services	*Trustwide Dec-21*	Jan-22			
Metric	**Target**	n	n	n	*n*	**n**	*mean*	**SPC variation**	**SPC target**
Sickness 12 Month (%)	5.10%	6.80%	2.93%	3.63%	*6.03%*	**6.10%**	*5.85%*	• H •	F
Sickness In Month (%)	5.10%	9.86%	2.33%	5.45%	*8.42%*	**8.63%**	*6.24%*	• H •	?
Long Term Sickness (%)	~	8.94%	1.42%	4.91%	*5.95%*	**7.78%**	*4.43%*	• H •	/
Short Term Sickness (%)	~	0.92%	0.71%	0.55%	*2.46%*	**0.85%**	*1.81%*	• • •	/
Headcount Staff in Post	~	2038	200	320	*2552*	**2558**	*2561*	• • •	/
WTE Staff in Post	~	1750.0	183.1	299.5	*2229.2*	**2232.5**	*2225.4*	• • •	/
Turnover 12 months FTE (%)	10%	12.49%	5.09%	17.20%	*16.18%*	**16.23%**	*13.33%*	• H •	F
Vacancy Rate (%)	~	***Data Unavailable***			*11.43%*	**11.19%**	*11.24%*	• • •	/
PDR Compliance (%)*	90%	***Data Unavailable***				***83.78%****	*94.12%**	• L •	?
Training Compliance (%)	80%	***Data Unavailable***			*90.3%*	**89.77%**	*90.44%*	• • •	P
Supervision Compliance (%)	80%	73.22%	78.38%	73.14%	*73.62%*	**73.44%**	*62.34%*	• H •	F

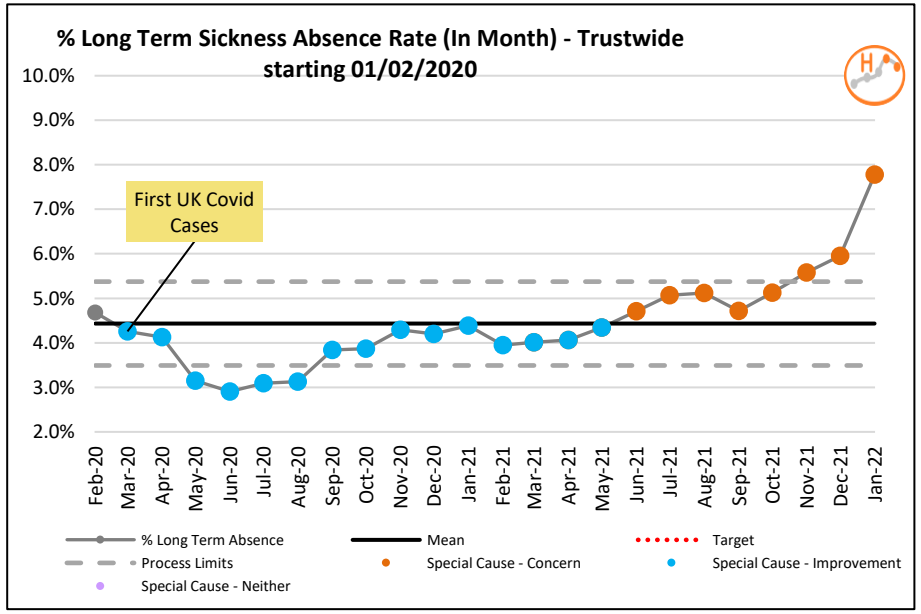
Notes:
- Vacancy based on establishment (FTE) data compared with staff in post (FTE) figures
- Turnover figures exclude 'Employee Transfer' as reason for leaving
- Medical turnover also excludes fixed term rotation

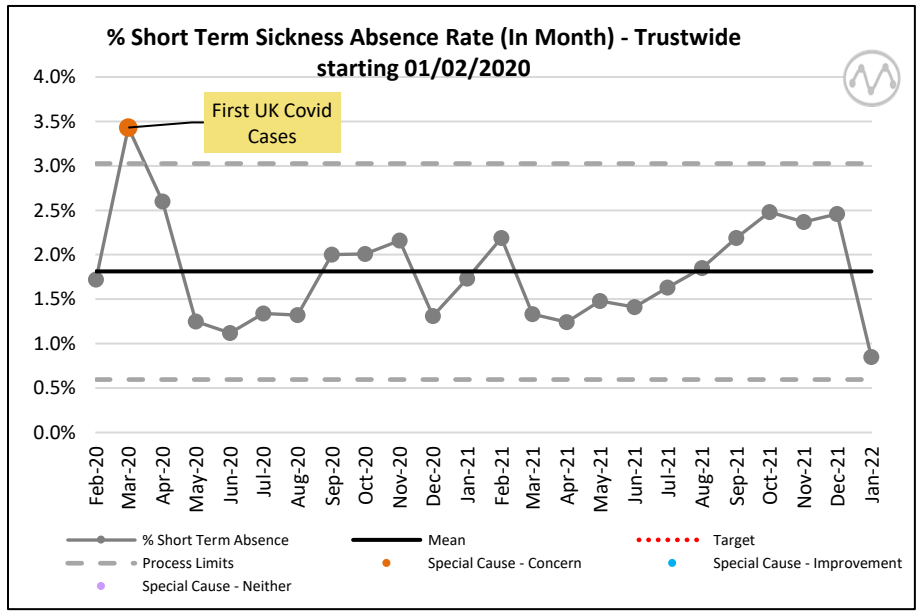
* PDR Report has been inaccurate and work has progressed to rectify this. Discussion around back dating this report is ongoing.

Well-Led | Sickness Absence









Narrative

Long term sickness has increased and short term has reduced. This is not what was expected given the number of absences with Covid infection know to have happened in December and January.

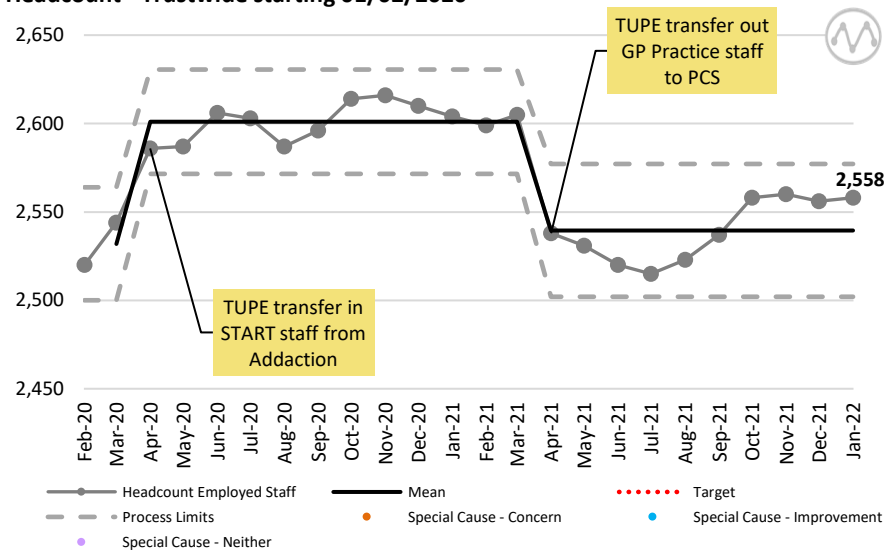
We have already identified 27 cases which have now been closed down, but further work is being undertaken to understand the route cause of this anomaly.

Stress, anxiety and depression still remains the highest reason for absence with over 35%, followed by Covid at 15.3%.

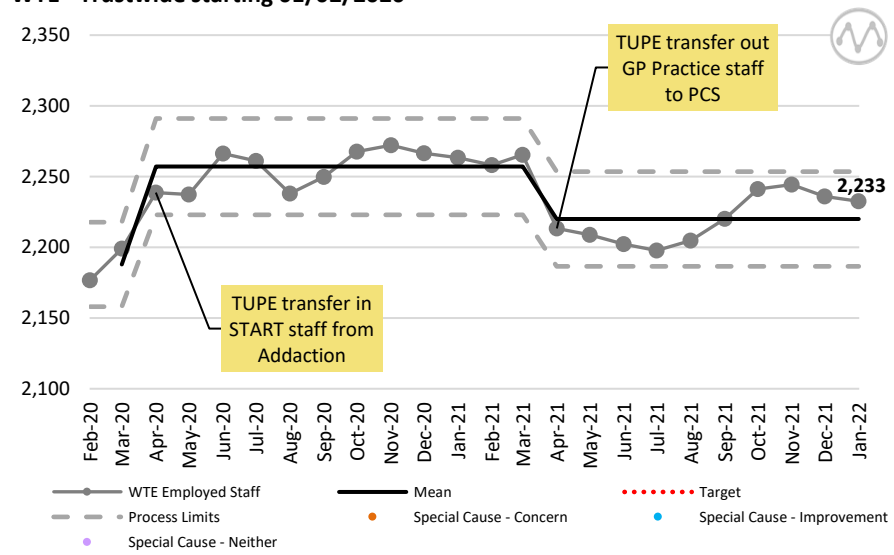
In addition to some work around early intervention and wellness, we are reviewing the pathway/process for sickness recording, reporting and management to see where more focus is needed. We will have this mapped out by end of March with tasks allocated within the new structure to ensure that effective support is available to effectively managed attendance.

Well-Led | Staffing

Headcount - Trustwide starting 01/02/2020

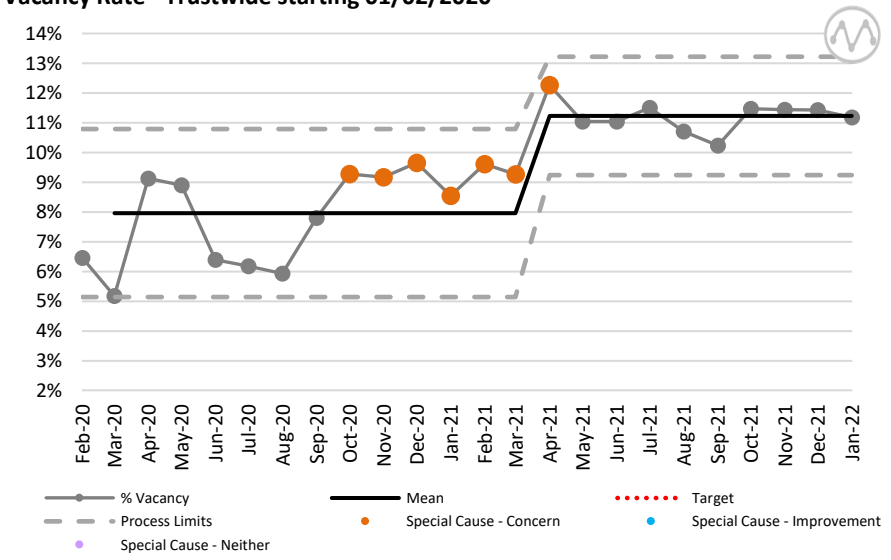


WTE - Trustwide starting 01/02/2020

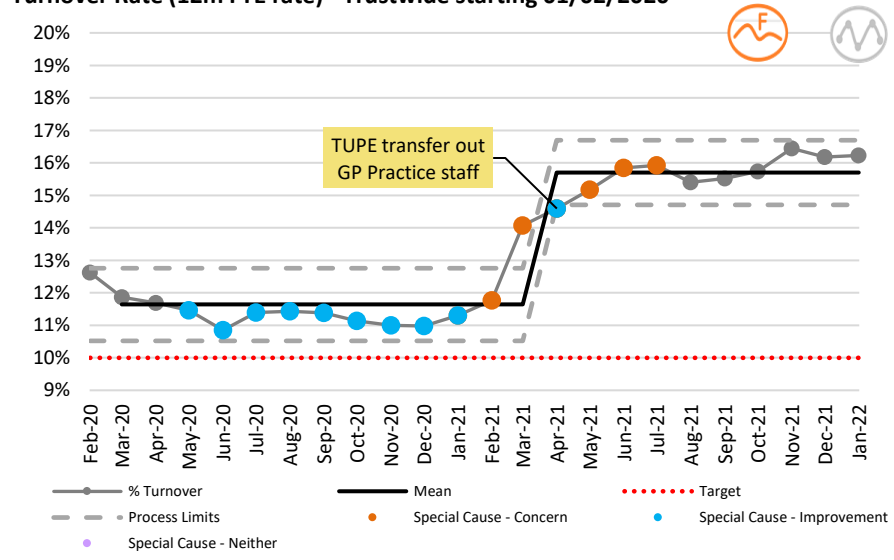


Narrative

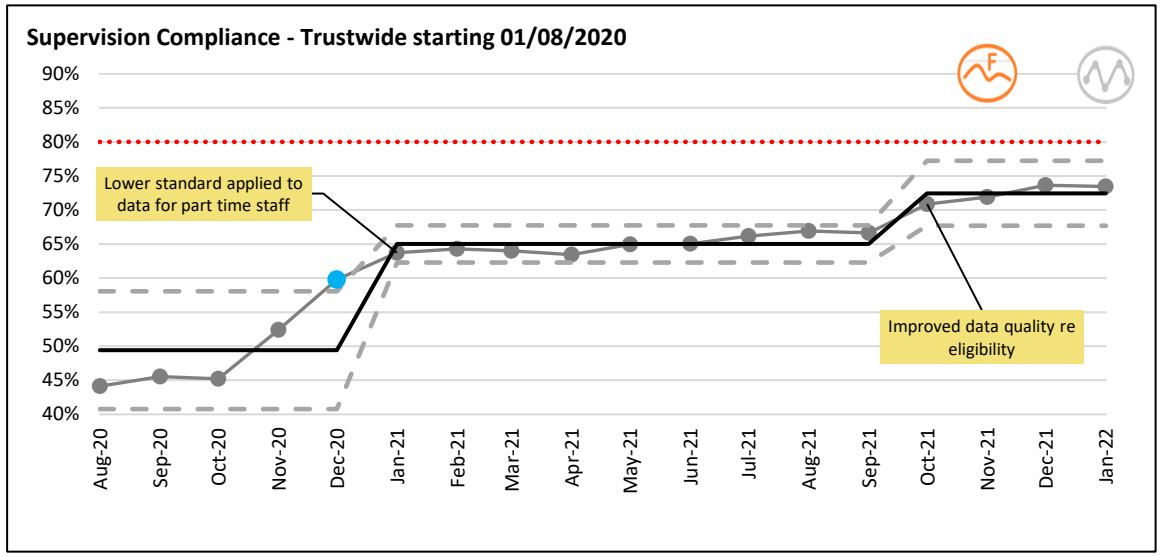
Vacancy Rate - Trustwide starting 01/02/2020

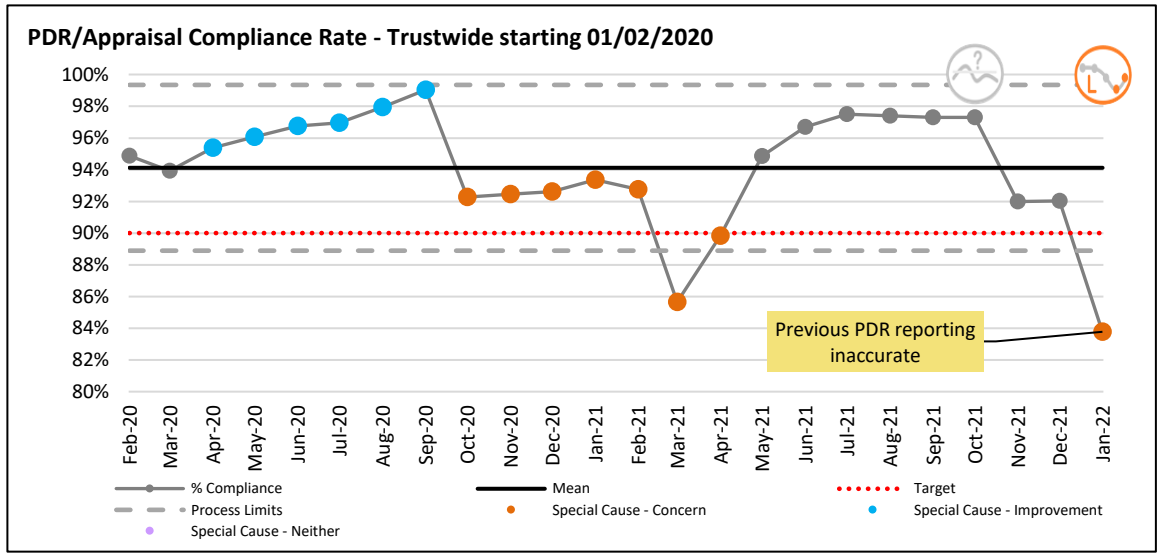


Turnover Rate (12m FTE rate) - Trustwide starting 01/02/2020



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 30 January 2022, average compliance with the 8/12 target is:

Trustwide	**73.44%**
Clinical Services	**73.22%**
Corporate Services	**74.37%**

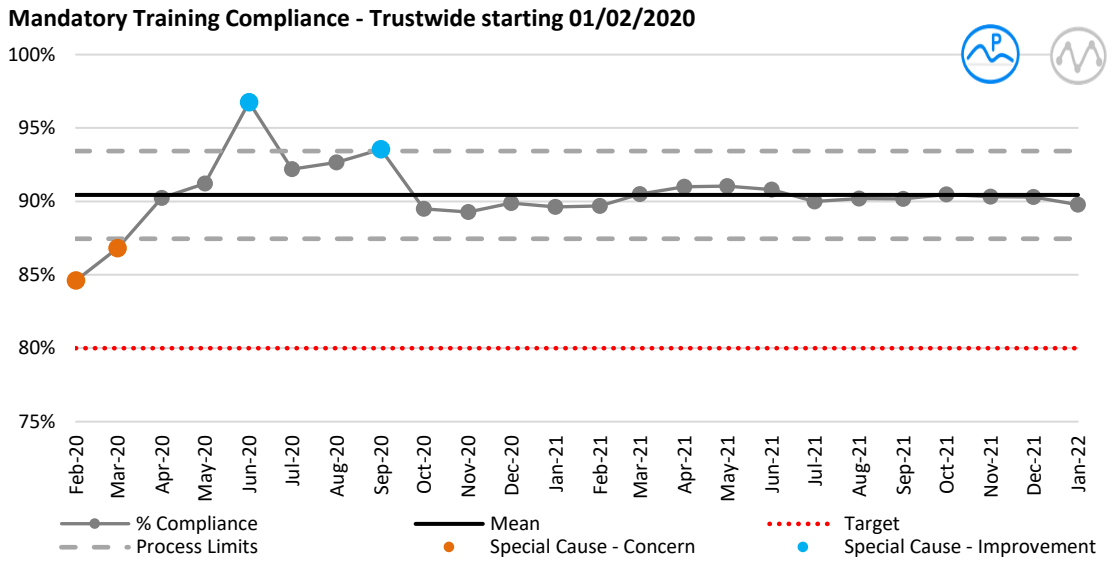
Weekly updated information is monitored and reviewed weekly by Directors and Service Leads. A recovery plan is in action for a number of teams within the Acute & Community Directorate, and the small minority of services in the Rehab & Specialist Directorate who are not consistently compliant.

PDR Compliance

****PDR Report has been inaccurate and work has progressed to rectify this. Discussion around back dating this report is ongoing.****

January 2022 Trustwide PDR Compliance **83.78%**

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 23/01/22

Trustwide compliance **89.77%**

EXCEPTIONS

Subjects Below 80/90%

Respect Level 2 & 3
Immediate Life Support
Mental Health Act
Safeguarding Children Level 1 and 3

Services Below 80%

Grenoside Facilities
Chair/Chief Exec Office

Sheffield Health and Social Care Mandatory Training Compliance @

23 January 2022

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	23 January 2022 No Requiring	No Achieved	No NOT Achieved	Compliance	Current Compliance against Previous Compliance %	
Equality, Diversity and Human Rights		3 Years	2638	2478	160	93.93%	Decrease	-0.02%
Hand Hygiene		3 Years	2638	2409	229	91.32%	Decrease	-0.53%
Health and Safety		3 Years	2638	2507	131	95.03%	Decrease	-0.07%
Information Governance (aka Data Security Awareness)		1 Year	2638	2272	366	86.13%	Decrease	-1.90%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2638	2502	136	94.84%	Decrease	-0.11%
Fire Safety		2 Years	2638	2317	321	87.83%	Increase	0.46%
Resuscitation	1	1 Year	2638	2255	383	85.48%	Increase	1.43%
Resuscitation (BLS)	2	1 Year	1559	1283	276	82.30%	Increase	0.14%
Immediate Life Support		1 Year	234	164	70	***70.09%***	Decrease	-2.24%
Clinical Risk Assessment		3 Years	1032	928	104	89.92%	Decrease	-0.29%
Dementia Awareness		No Renewal	2638	2555	83	96.85%	Decrease	-0.16%
Autism Awareness		No Renewal	2638	2559	79	97.01%	Decrease	-0.13%
Mental Capacity Act	1	3 Years	1067	908	159	85.10%	Decrease	-0.36%
	2	3 Years	1160	1056	104	91.03%	Decrease	-0.92%
Deprivation of Liberty Safeguards	1	3 Years	2128	1948	180	91.54%	Decrease	-0.81%
	2	3 Years	123	108	15	87.80%	Decrease	-4.57%
Mental Health Act		3 Years	182	145	37	79.67%	Decrease	-3.57%
Medicines Management Awareness		3 Years	552	445	107	80.62%	Decrease	-2.47%
Rapid Tranquilisation		3 Years	299	252	47	84.28%	Decrease	-3.26%
Respect	1	3 Years	1182	1061	121	89.76%	Decrease	-0.34%
	2	2 Years	868	593	275	***68.32%***	Decrease	-0.85%
	3	1 Year	345	249	96	***72.17%***	Decrease	-4.52%
Safeguarding Children	1	3 Years	2638	2337	301	88.59%		
	2	3 Years	1116	1008	108	90.32%	Decrease	-1.42%
	3	3 Years	1107	811	296	***73.26%***	Decrease	-5.20%
Safeguarding Adults	1	3 Years	2638	2387	251	90.49%		
	2	3 Years	1142	1034	108	90.54%	Decrease	-1.57%
Domestic Abuse	2	3 Years	2228	1992	236	89.41%	Decrease	-1.08%
Prevent Radicalisation		3 Years	2223	2011	212	90.46%	Decrease	-1.93%
Moving and Handling	1	3 Years	2638	2532	106	95.98%	Increase	0.11%
	2	3 Years	689	578	111	83.89%	Decrease	-1.51%
Overall compliance						**89.77%**	Decrease	-0.53%

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																	
	02/01/2022																100.00%	98.33%
	23/01/2022																100.00%	98.33%
Moving and Handling Level 2 (People)	31/12/2019																	
	02/01/2022	87.88%	88.89%	82.35%	95.83%	77.42%	94.29%	96.72%	62.90%	94.74%	80.00%	100.00%	96.88%	100.00%	70.00%	100.00%		
	23/01/2022	85.29%	90.63%	80.56%	95.65%	79.31%	93.94%	95.16%	63.33%	90.48%	100.00%	100.00%	96.77%	N/A	67.50%	100.00%		
DOLs Level 2	31/12/2019	80%	29%	75%	80%	43%	36%	14%	56%	38%	67%	67%	100%	50%	50%			
	02/01/2022	100.00%	83.33%	75.00%	100.00%	100.00%	93.33%	92.86%	92.86%	100.00%	100.00%	100.00%	100.00%	100.00%	80.00%			
	23/01/2022	100.00%	80.00%	60.00%	100.00%	100.00%	93.33%	92.86%	92.86%	100.00%	50.00%	100.00%	100.00%	N/A	80.00%			
Safeguarding Children L2	31/12/2019																88%	70%
	02/01/2022																100.00%	82.61%
	23/01/2022																100.00%	82.61%
Domestic Abuse	31/12/2019																73%	83%
	02/01/2022																94.44%	82.46%
	23/01/2022																98.18%	78.95%
MCA Level 2	31/12/2019		81%														60%	76%
	02/01/2022		90.00%														100.00%	88.24%
	23/01/2022		88.89%														100.00%	88.24%
Info Gov	31/12/2019		71%														67%	70%
	02/01/2022		89.80%														93.10%	78.33%
	23/01/2022		86.67%														91.53%	78.33%
Clinical Risk	31/12/2019		85%															
	02/01/2022		80.95%															
	23/01/2022		84.21%															
Fire 2 Year	31/12/2019		75%															
	02/01/2022		91.84%															
	23/01/2022		95.56%															
Respect Level 2	31/12/2019		94%												94%			
	02/01/2022		94.74%												86.67%			
	23/01/2022		94.74%												81.25%			
Respect Level 3	31/12/2019		88%															
	02/01/2022		93.33%															
	23/01/2022		80.77%															
Mental Health Act	31/12/2019		71%															
	02/01/2022		82.35%															
	23/01/2022		80.00%															
Basic Life Support	31/12/2019																65%	70%
	02/01/2022																96.55%	86.67%
Now Resuscitation Level 2	23/01/2022																90.91%	85.42%
ILS	31/12/2019														71%			
	02/01/2022														81.25%			
	23/01/2022														76.47%			

Subject	Date	Recovery North	Recovery South	CERT	Early Intervention	Adlt Hm Tr
Community Mental Health Act	02/01/2022	97.44%	90.48%	84.21%	89.19%	85.71%
	23/01/2022	97.50%	90.48%	84.21%	89.19%	77.42%

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
- **DOLS Level 2**
  - Dovedale 1
  - Forest Close Central
- **Domestic Abuse**
  - Recovery South
- **Information Governance**
  - Recovery South
- **ILS**
  - Forest Lodge

NB – Date shown in table to left is position as at w/c 23/01/22, compared with the 2 January position and December 2019 baseline where available.

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Financial Performance

IPQR - Information up to and including January 2022

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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	1,186	2,434
Covid Expenditure	6,596	5,497	1,586
Agency	5,904	4,866	4,909
Cash	62,075	60,976	59,740
Efficiency Savings	2,650	2,249	2,286
Capital	8,584	7,071	4,859
Better Payments Practice Code	99.5% by Number 99.7% by Value		

Summary at January 2022

- The Organisation wide surplus of £2.4m at the end of M10 (Jan 22), £1.2m favourable to plan. This is a £200k adverse movement on M9's underspend of £2.6m. The organisation continues to spend greater amounts in H2 than H1.
- Non-recurrent spending plans are now materialising resulting in an adverse movement in the financial position for January.
- MHIS spend has remained consistent in M10 with minimal deviations from M9 spend.
- Covid underspend is £3.9m as expected. 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 £12.4m which equates to 10% 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 •	/
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 January 2022

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Well-Led | Covid-19 Response

Covid-19 Outbreaks

During January 2022, as a result of the omicron wave, outbreaks were declared in a number of community teams as well as 8 of our Inpatient/Residential areas (Older Adult wards Dovedale 1 and G1, Acute Wards Stanage, Maple and Endcliffe, one of the Forest Close wards and both care homes Woodland View and Birch Avenue). In terms of inpatients/residents with covid positive status, January saw the highest numbers we have experienced throughout the entire pandemic.

Covid-19 Deaths

3 deaths recorded in January 2022, one of which was Woodland View service user.

Covid-19 Related Staff Absence

As at 31 January, 43 staff were absent from the workplace for Covid related reasons.
7 were working and 36 were unable to work.

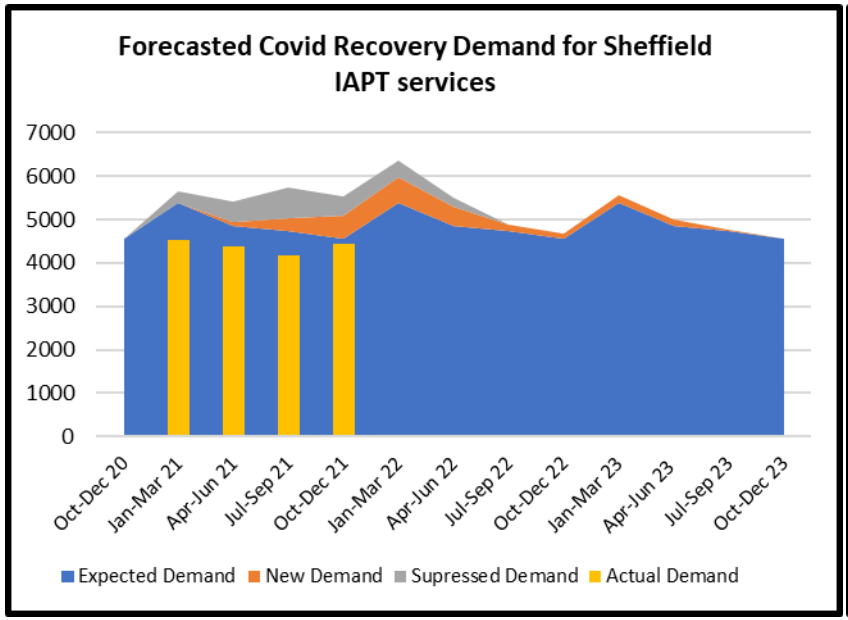
Staff Vaccination (as at 17 January 2022)

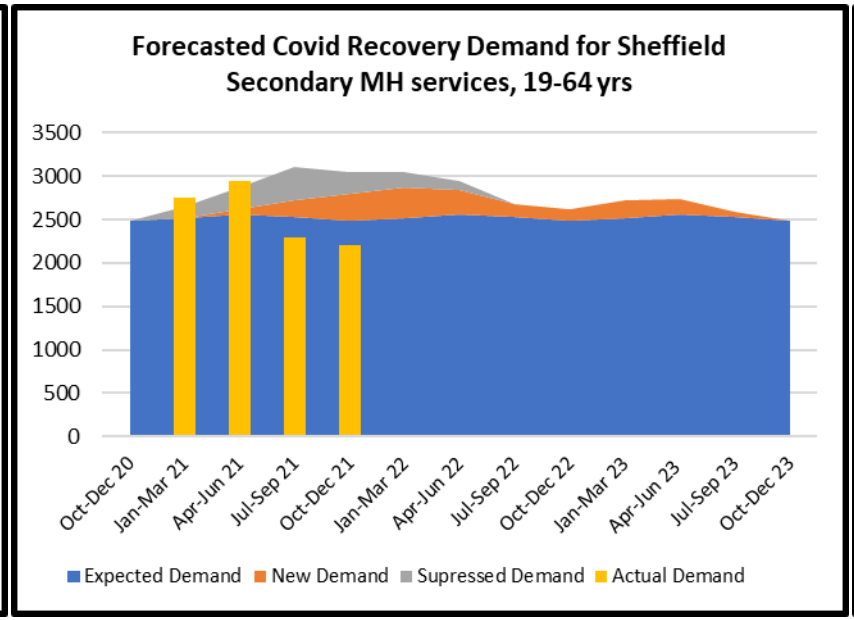
This report's primary data sources are the National Immunisation Management System (NIMS) Reporting and our Electronic Staff Record (ESR). NIMS Reporting should include all vaccination records for our staff, no matter where they have received them. Data for agency staff, students, locum doctors and volunteers who do not have ESR records has also been manually captured from a variety of sources.
This report does not include vaccination records for 38 staff (1.3%) where we do not have their NHS numbers and NIMS has not been able to obtain them for us.

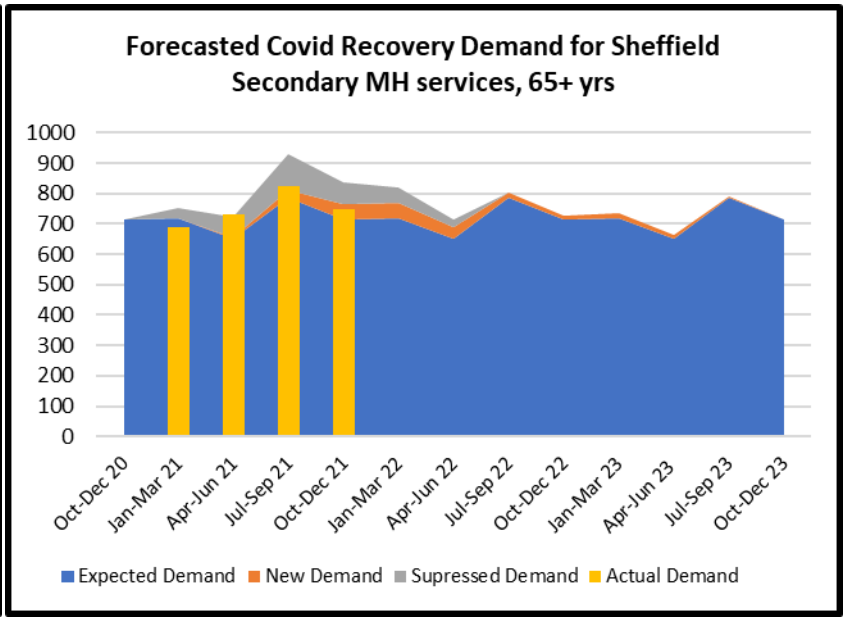
	Total	% of total	Priority staff	Non-priority staff
Staff records uploaded by SHSC to NIMS	3014	100.0%	2635	379
Staff matched to at least one vaccination record	2831	93.9%	2470	361
Staff matched to at least two vaccination records	2771	91.9%	2411	360
Staff matched to two vaccination records + booster	2406	79.8%	2067	339
Staff that could not be matched due to missing NHS number	38	1.3%	34	4
Staff that have either not received at least one vaccination dose or whose NHS number is missing from their vaccination record(s)	183	6.1%	165	18

	Not yet vaccinated		Received first dose only		Received both doses only		Received both doses & booster	
	Count	%	Count	%	Count	%	Count	%
457 Clinical Operations (L3)	85	4.2%	40	2.0%	263	13.0%	1640	80.9%
457 Chair/Chief Exec Office (L5)	1	3.6%		0.0%	1	3.6%	26	92.9%
457 Finance (L5)	1	4.2%		0.0%	3	12.5%	20	83.3%
457 IMST (L5)		0.0%	1	2.5%	2	5.0%	37	92.5%
457 Performance (L5)		0.0%		0.0%		0.0%	7	100.0%
457 Nursing & Professions (L5)	3	3.8%	2	2.6%	5	6.4%	68	87.2%
457 People Directorate (L5)	22	6.5%	8	2.4%	52	15.3%	258	75.9%
457 Bank Staff (017777)	17	6.1%	8	2.9%	49	17.6%	204	73.4%
457 Reg Nurse Degree Apprentices (017414)		0.0%		0.0%	1	20.0%	4	80.0%
457 Facilities (L5)	3	4.1%		0.0%	5	6.8%	65	89.0%
457 Strategy & Planning (L5)		0.0%		0.0%		0.0%	10	100.0%
457 Clinical Strategy & Partnerships (L5)	2	40.0%		0.0%	1	20.0%	2	40.0%
457 Medical Management Team (L5)		0.0%		0.0%		0.0%	2	100.0%
457 Medical PGME (L5)	2	1.8%	3	2.7%	3	2.7%	103	92.8%
457 Pharmacy Dept (L5)		0.0%	1	2.4%	3	7.3%	37	90.2%
457 Quality (L5)		0.0%		0.0%		0.0%	3	100.0%
457 Research & Development Dept (L5)		0.0%		0.0%	1	5.6%	17	94.4%
457 MH Community Transformation (8244)	1	4.8%		0.0%		0.0%	20	95.2%
Agency Staff (L5)	25	22.1%	3	2.7%	21	18.6%	64	56.6%
Locum Doctors (L5)	5	41.7%		0.0%	1	8.3%	6	50.0%
Medical Students (L5)	24	70.6%	1	2.9%	1	2.9%	8	23.5%
Student Nurses (L5)	7	100.0%		0.0%		0.0%		0.0%
Volunteers (L5)	2	14.3%	1	7.1%	2	14.3%	9	64.3%
Grand Total	183	6.1%	60	2.0%	365	12.1%	2406	79.8%

Well-Led | Covid-19 Demand Impact | Q3 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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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:

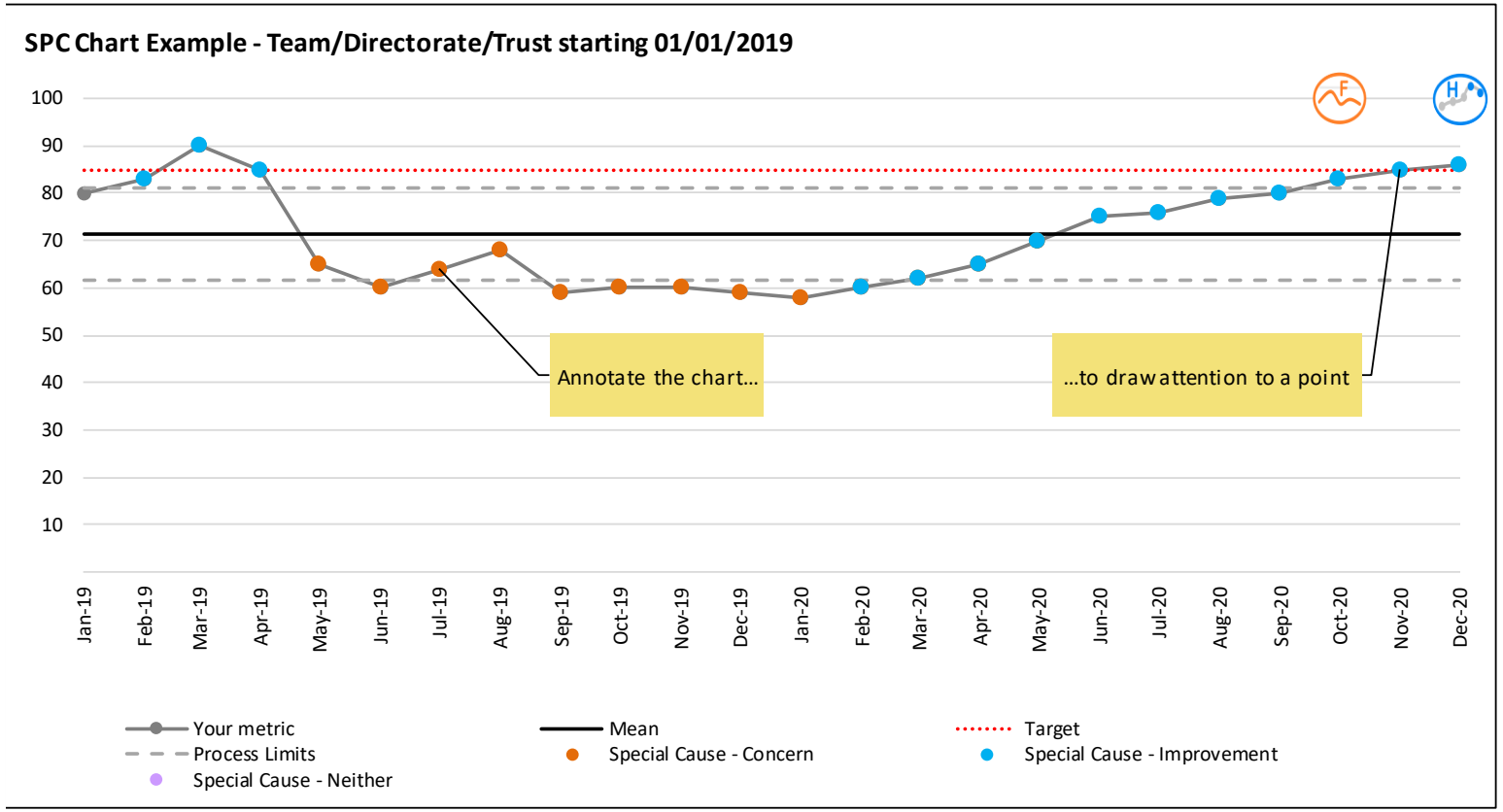
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	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