Board of Directors - Public

SUMMARY	Meeting Date:	27th July 2022
	Agenda Item:	11

Report Title:	**Integrated Performance and Quality Report (IPQR) May 2022**	
Author(s):	Business and Performance Team	
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:	12 July 2022 13 July 2022 14 July 2022
Key Points recommendations to or previously agreed at:	The Board is asked to note the following areas of positive performance or improvement: • Increased demand/referrals into Highly Specialist services as a result of positive new offers (Insomnia course in the Short Term Education Programme STEP) and improved integration with Council and non-statutory providers in the Homeless Assessment Team (HAST) • Significant improvements to length of stay averages in older adult ward 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 • Reduction in the number of Health Based Place of Safety beds being blocked by acute mental health admissions. • IAPT exceeding 6-week waiting time targets, national benchmarks and meeting the recovery standard since October 2021 • Continued low use of restrictive practices on G1 and low instances of restrictive practice across the Rehabilitation & Specialist Directorate. • Reduced used of seclusion Trustwide • Supervision – Rehab and Specialist directorate meeting target • Mandatory training – meeting/exceeding target Trustwide The known areas of risk/concern for the attention of the Board are: • 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 – admissions and discharges low	

- Bed occupancy at step down unit Wainwright Crescent low – related to a being closed to admissions due to a covid case and planned move to Beech
- 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 Early Intervention Team & Recovery South.
- Incidents - assaults on service users high
- Short term sickness absence rates are high
- Not currently meeting the trust wide supervision target
- Overspend in areas associated with high out of area placement and agency costs

Areas of interest

- Liaison Psychiatry, SPS & Gender referrals low
- Caseload/open episodes – SPA/EWS, Recovery North, Early Intervention and SPC PD all low
- Live length of stay at Forest Lodge is high
- High number of negligible and near miss incidents
- Headcount/WTE is high due to a recent increase in staff numbers

The Board is also asked to note the inclusion of a summary of performance against the Long Term Plan Mental Health Delivery Plan for 2022/23.

Committee Recommendations

Quality Assurance Committee

The three top risks are stubborn although it was considered there may be improvement in out of area placements and flow generally – it was also said that it was too soon to be confident that this was sustainable and will continue to monitor closely. The improving picture with CPA was discussed and the need to be confident we have a way of measuring the five principles in the future. Also noted a growing concern with waits as despite best efforts they are not improving and we know that they are impacting the experience of people and are possibly a risk to service user safety.

On the latter point we decided that in the August QAC we will take a detailed paper on all community waits and seek to understand the risks to people in our care and discuss solutions before this matter is taken to Board in August.

We acknowledged the growing list of positive improvements in performance and quality and specifically noted the reduction in restrictive practice which we must continue to focus on.

Finance and Performance Committee

Out of area placement spend continues to be an ongoing area of concern

Noting that recovery plans are in place and monitored by both the Quality Assurance Committee and Finance & Performance Committee

The Committee noted no further points for escalation.

	People Committee People Committee highlighted that Supervision rates are not where the Trust wants them to be (70% vs 80% target) and that mandatory training, whilst overall on target, is not where we want with respect to Safeguarding, Information Governance and Respect Level 2. In terms of positive trends, the Committee noted that, although sickness is still a concern, there are signs of improvement and an approximation to our target, whereas other local Trusts are reporting continuous increase. In addition, turnover has reduced and recruitment has improved, enabling a steady state in terms of overall headcount. Also, there is very good management of employee relations cases: the number of cases is reducing and is at the lowest on record; the average case length has now declined to SHSC's target level.

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 May 2022.

The report was presented and considered in detail to the Quality Assurance and Finance & Performance Committees in June 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			Referrals to Community Services	5		Increasing referrals to Short Term Education Programme (STEP) and the Homeless Assessment Service (HAST)	
F	Q			Inpatient Length of Stay – Older Adults OOA – Older Adults	9		Decreasing trend in Older Adult inpatient areas – Dovedale 1 No inappropriate OOA admissions since December 21	
F	Q			Inpatient Length of Stay – Forest Close & Forest Lodge	10		Performance above national benchmarks	
F	Q			HBPoS bed use	12		Not enough data points for SPC but reduction in the number of HBPoS beds being blocked due to mental health ward admissions.	
F	Q			Annual CPA Review	15		Improving Performance in Recovery North	
F	Q			IAPT	16		Meeting/exceeding targets for waiting times	

	Q		M	Restrictive Practices	24-26		Decreasing trend and improvements on G1 Low numbers of Seclusion incidents Trustwide	
	Q	P		Supervision	29		Rehabilitation & Specialist service area meeting target	
		P		Mandatory Training	33		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 SAANS	
F	Q			Waiting Lists and Waiting Times	6		Increasing trend/sustained high waits in certain areas noted	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			Admissions & Discharges	7		Adult Acute Admissions and Discharges low	
F	Q			Bed Occupancy	7		Bed Occupancy at Wainwright Crescent low - Related to planned premises move.	
F	Q			Length of Stay and Delayed Discharge (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	7-8		Failing to meet reduction/elimination of inappropriate OAPs in acute and PICU beds	Out of Area Recovery Plan(s) x 3
F	Q			Annual CPA Review	15		Failing to meet 95% target Low performance in Early Intervention Service	Recovery Plan in place.
	Q	P		Incidents – Assaults on Service Users	22		Assaults on Service Users high	
		P		Sickness Absence	27		Increasing trend Trustwide, with particular concern over Short Term sickness rates. 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		Failing to meet 80% target Trustwide	CQC Back to Good Action Plan/Local Recovery Plans
		P		Mandatory Training	33		Underperformance against 80/90/95% targets in some areas	

F				Agency and Out of Area Placement Spend	34		Increased high levels of spend Failing to meet reduction/elimination of inappropriate OAPs	Out of Area Recovery Plan(s) x 3 CIP Plans 22/23

Areas of interest								
Committee				**KPI/Area**	**Refer to (slide)**	**Performance**	**Trend/ Trajectory**	**Recovery Plan?**
		P		Headcount/WTE	31		Increase in staff numbers	
F	Q			Referrals	5		Liaison Psychiatry referrals – the last 12 months of referrals are below the 36 month average SPS & Gender referrals low	
F	Q			Caseloads/ Open Episodes	6		SPA/EWS, Recovery North, Early Intervention & SPS PD all low.	
F	Q			Live Length of Stay – Forest Lodge	10		Current live length of stay higher than normal	
	Q			Incidents – Trustwide Negligible & Near Miss	20		Negligible & Near miss Incidents both high	

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 May 2022

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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 2022 reporting, we are using monthly figures from May 2020 to April 2022. Where 24 months data is not available, we use as much as we have access to.

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 Feb 20 as a baseline (pre-Covid) and then can see whether activity has been impacted, returned to pre-covid levels or changed significantly. We have begun using and looking at the information in this way in our 'Floor to Board' Performance & Quality reviews with Clinical Directorates, and will continue to develop that way of working so that the data is intelligently reviewed at source and services and teams are able to investigate and provide narrative which supports the information.

Board Committee Oversight

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

Refer to Appendix 3 for detail.

Colour Key	F	M	P	Q
Finance				
MH Legislation				
People				
Quality				

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Service Delivery

IPQR - Information up to and including May 2022

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Responsive | Access & Demand | Referrals

Referrals	May-22			
Acute & Community Directorate Service	**n**	*mean*	**SPC variation**	**Note**
SPA/EWS	**731**	*727*	• • •	The significant sustained reduction in referrals since July 2021 was due to safeguarding referrals being directed to the Safeguarding Team instead of SPA. SPC charts and limits have now been recalculated to take this into account.
AMHP	**139**	*155*	• • •	
Crisis Resolution and Home Treatment	**1081**	The implementation of the new Crisis Resolution & Home Treatment Team has resulted in a merge of 5 existing teams in Insight (Out of Hours Team and 4 Adult Home Treatment Teams). This happened mid February 2022. We are considering how we present the information in relation to this new team and its functions (i.e. Crisis Resolution >72hrs and longer term Home Treatment).		
Liaison Psychiatry	**501**	*517*	• L •	The last 12 months of referrals have been below the 36 month average calculated from January 2019, but remain close to the average.
Decisions Unit	**52**	*57*	• • •	
S136 HBPOS	**35**	*33*	• • •	Admissions to S136 Place of Safety beds had been artificially low since November/December 2021 due to the frequency of service users being detained to Maple Ward in these beds. Numbers normalised from May 22 due to improved flow through the system.
Recovery Service North	**35**	*28*	• • •	
Recovery Service South	**26**	*27*	• • •	
Early Intervention in Psychosis	**43**	*43*	• • •	Referrals had been below the 36 month average calculated from January 2019, but returned to average in May 2022.
Memory Service	**135**	*132*	• • •	
OA CMHT	**255**	*241*	• • •	
OA Home Treatment	**26**	*29*	• • •	

Referrals	May-22			
Rehab & Specialist Service	***n***	*mean*	***SPC variation***	**Note**
CERT	4	*3*	• • •	
SCFT	0	*1*	• • •	
CLDT	46	*50*	• • •	CLDT figures represent distinct individuals so does not include multiple referrals per service user.
CISS	1	*4*	• • •	
Psychotherapy Screening (SPS)	43	*63*	• L •	
Gender ID	47	*58*	• L •	
STEP	122	*71*	• H •	
Eating Disorders Service	32	*28*	• • •	
SAANS	462	*174*	• H •	
R&S	17	*26*	• • •	
Perinatal Service (Sheffield)	58	*54*	• • •	
HAST	15	*10*	• H •	
Health Inclusion Team	151	Insufficient data points to create SPC charts.		
LTNC - NES	30			
LTNC - Case Management	15			
SCBIRT	1			

Responsive | Access & Demand | Community Services

May 2022	Per month			Number on wait list at month end			Average wait time referral to assessment for those assessed in month			Average wait time referral to first treatment contact for those 'treated' in month			Total number open to Service		
	Referrals			Waiting List			Average Waiting Time (RtA) in weeks			Average Waiting Time (RtT) in weeks			Caseload		
Acute & Community Services	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**
SPA/EWS	731	*727*	• • •	1203	*1022*	• H •	34.6	*23.8*	• • •	29.56	*28.6*	• • •	854	*929*	• L •
MH Recovery North	35	*28*	• • •	93	*36*	• H •	7.9	*4.6*	• • •	5.86	*9.8*	• • •	959	*978*	• L •
MH Recovery South	26	*27*	• • •	95	*45*	• H •	10.9	*6.9*	• • •	8.43	*12.2*	• • •	1079	*1073*	• H •
Early Intervention in Psychosis	43	*43*	• • •	13	*21*	• • •	*N/A*			70%			304	*369*	• L •
Memory Service	135	*132*	• • •	794	*406*	• H •	29.7	*16.7*	• • •	32.95	*25.6*	• • •	4801	*4083*	• H •
OA CMHT	255	*241*	• • •	153	*115*	• H •	9.6	*6.2*	• • •	10.8	*10.6*	• • •	1288	*1212*	• H •
OA Home Treatment	26	*29*	• • •	*N/A*			*N/A*			*N/A*			80	*60*	• H •

May 2022	Per month			Number on wait list at month end			Average wait time referral to assessment for those assessed in month			Average wait time referral to first treatment contact for those 'treated' in month			Total number open to Service		
	Referrals			Waiting List			Average Waiting Time (RtA) in weeks			Average Waiting Time (RtT) in weeks			Caseload		
Rehab & Specialist Services	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**
SPS - MAPPS	*N/A*			78	*61*	• H •	17.1	*21.9*	• • •	104.0	*73.5*	• • •	321	*305*	• H •
SPS - PD				37	*60*	• L •	14.5	*27.4*	• L •	108.3	*67.5*	• • •	187	*207*	• L •
Gender ID	47	*58*	• L •	1642	*1376*	• H •	135.7	*113.6*	• H •	*N/A*			2483	*2157*	• H •
STEP	122	*71*	• H •	114	*79*	• • •	*N/A*			1.9	*3.8*	• L •	406	*360*	• H •
Eating Disorders	32	*28*	• • •	29	*28*	• • •	2.6	*4.7*	• • •				227	*198*	• H •
SAANS	462	*174*	• H •	5277	*3612*	• H •	122.3	*88.2*	• H •				5297	*4406*	• H •
R&S	17	*26*	• • •	123	*197*	• H •	129.6						230	*223*	• H •
Perinatal MH Service (Sheffield)	*58*	*54*	• • •	23	*21*	• • •	3.4	*2.6*	• • •				167	*134*	• H •
HAST	15	*10*	• H •	39	*31*	• • •	4.3	*9.4*	• • •	*N/A*			88	*84*	• • •
Health Inclusion Team	151			100			1.1						1146		
LTNC - NES	30			42			12.5						432		
LTNC - Case Management	15			15			2.3						124		
SCBIRT	1			11			2.3						135		
CLDT	46	*50*	• • •	192	*196*	• • •	34.1	*21.8*	• • •	25.8	*24.1*	• • •	925	*857*	• H •
CISS	1	*4*	• • •	*N/A*									20	*31*	• • •
CERT	4	*3*	• • •	0	*0*	• L •	*N/A*			*N/A*			47	*46*	• • •
SCFT	0	*1*	• • •	4	*1*	• H •							25	*23*	• H •

Narrative

While demand in community services has settled to expected levels for most services, there are still 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.

Safe | Inpatient Wards | Adult Acute & Step Down

Adult Acute (Burbage/Dovedale 2, Stanage, Maple)	Target or Benchmark	May-22 n	May-22 mean	May-22 SPC variation
Admissions	TBC	34	36	• L •
Detained Admissions	/	31	31	• • •
% Admissions Detained	50%	91.2%	88.8%	• • •
Emergency Re-admission Rate (rolling 12 months)	10.3%	5.17%		
Discharges	TBC	31	36	• L •
Delayed Discharge/Transfer of Care (number of delayed discharges)	TBC	5		
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	140		
Bed Occupancy excl. Leave (KH03)	86.4%	94.1%	94.1%	• • •
Bed Occupancy incl. Leave	95%	98.4%	98.4%	• • •
Average beds admitted to	/	46		
Average Discharged Length of Stay (12 month rolling)	32	38.2	35.8	• H •
Live Length of Stay (as at month end)	/	78.3	51.1	• H •
Number of People Out of Area at month end	/	12		
Number of Mental Health Out of Area Placements started (admissions)	/	6	9	• • •
Total number of Out of Area bed nights in period (Inappropriate)	280	400	305	• • •

Length of Stay Detail
Longest LoS (days) as at month end: **336** on Dovedale 2, **189** on Maple and **212** on Stanage
Range = 0 to 336 days
Number of discharges in month: 31, plus 5 transfers out
Longest LoS (days) of discharges in month: 724

Narrative

DD2 patient is being assessed for Forest Close
Maple patient Individual package of care is being planned with CCG/private providers
Stanage: Now an informal patient and ready for discharge, delay in finding suitable placement

Recent increase in discharges on Stanage

Step Down (Wainwright Crescent)	Target or Benchmark	May-22 n	May-22 mean	May-22 SPC variation
Admissions	/	9	5	• • •
Discharges	/	6	6	• • •
Bed Occupancy excl. Leave (KH03)	/	48.7%	80.4%	• L •
Bed Occupancy incl. Leave	/	54.6%	89.5%	• L •
Average Discharged Length of Stay (12 month rolling)	/	66.0	65.2	• • •
Live Length of Stay (as at month end)	/	21.9	44.3	• • •

Length of Stay Detail
Longest LoS (days) as at month end: **110**
Range = 1 to 110 days
Number of discharges in month: 6
Longest LoS (days) of discharges in month: 192

Narrative

Our step down facility will move to Beech in June 2022 and has reduced from 11-10 bed occupancy in preparation.

Benchmarking Adult Acute
(2021 NHS Benchmarking Network Report – Weighted Population Data)
% Admissions Detained Mean: 50%
Emergency readmission rate Mean: 10.3%
Delayed Transfer of Care: 4.9%
Bed Occupancy Mean: 86.4%
Length of Stay (Discharged) Mean: 32

NB – No benchmarking available for Step Down beds

Inpatient Wards | PICU & Out of Area placements

PICU (Endcliffe)	Target or Benchmark	May-22 n	May-22 mean	May-22 SPC variation
Admissions	TBC	1	*3*	• • •
Discharges	TBC	1	*2*	• • •
Delayed Discharge/Transfer of Care (number of delayed discharges)	TBC	2		
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	60		
Bed Occupancy excl. Leave (KH03)	84%	90.7%	*90.8%*	• • •
Bed Occupancy incl. Leave	95%	93.5%	*93.6%*	• • •
Average beds admitted to	/	9		
Average Discharged Length of Stay (12 month rolling)	47	56	*51*	• • •
Live Length of Stay (as at month end)	/	94	*78*	• H •
Number of People Out of Area at month end	/	4		
Number of Mental Health Out of Area Placements started (admissions)	/	3	*4*	• • •
Total number of Out of Area bed nights in period (Inappropriate)	120	119	*135*	• • •

Narrative

As at 31/5/22, there were 2 service users on Endcliffe Ward with a length of stay over the national average (benchmarked) of 47 days. One is being regularly reviewed and remains in Long Term Segregation. One was transferred to a specialist Cygnet placement at the end of May.

There was 1 discharge from Endcliffe in May, plus 5 transfers out.

Length of Stay Detail
Longest LoS (days) as at month end: **483**
Range = 13 to 483 days
Number of discharges in month: 1 discharge plus 5 transfers
Longest LoS (days) of discharges in month: 297

Benchmarking PICU
(2021 NHS Benchmarking Network Report – Weighted Population Data)

Bed Occupancy Mean: 84%
Length of Stay (Discharged) Mean: 47

Safe | Inpatient Wards | Older Adults

Older Adult Functional (Dovedale 1)	Target or Benchmark	May-22 n	May-22 mean	May-22 SPC variation
Admissions	/	6	5	• • •
Discharges	/	7	6	• • •
Delayed Discharge/Transfer of Care (number)	TBC	3		
Delayed Discharge/Transfer of Care (bed nights occupied)	TBC	47		
Bed Occupancy excl. Leave (KH03)	75.8%	88.4%	92.3%	• • •
Bed Occupancy incl. Leave	95%	95.3%	97.1%	• • •
Average beds admitted to	/	14		
Average Discharged Length of Stay (12 month rolling)	73	69	70	• • •
Live Length of Stay (as at month end)	/	70	89	• L •

Length of Stay Detail – Dovedale 1
Longest LoS (days) as at month end: **294**
Range = 1 to 294 days

Number of discharges in month: 7
Longest LoS (days) of discharges in month: 183

Narrative

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.

Of note is there has been no reliance on inappropriate Out of Area placements for Older Adults since December 2021.

The person with the longest length of stay in our Older Adult wards remains unwell and an external doctor has been identified to provide a second opinion.

Maintenance work completed on Dovedale which has resulted in lower bed occupancy on Dovedale but higher bed occupancy on G1.

Older Adult Dementia (G1)	Target or Benchmark	May-22 n	May-22 mean	May-22 SPC variation
Admissions	/	2	5	• • •
Discharges	/	4	4	• • •
Delayed Discharge/Transfer of Care (number)	TBC	10		
Delayed Discharge/Transfer of Care (bed nights occupied)	TBC	219		
Bed Occupancy excl. Leave (KH03)	75.8%	81.3%	69.9%	• • •
Bed Occupancy incl. Leave	95%	83.1%	71.8%	• • •
Average beds admitted to	/	13		
Average Discharged Length of Stay (12 month rolling)	73	64	66	• • •
Live Length of Stay (as at month end)	/	73	49	• • •

Length of Stay Detail – G1
Longest LoS (days) as at month end: **158**
Range = 13 to 158 days

Number of discharges in month: 4
Longest LoS (days) of discharges in month: 157

Older Adult Out of Area Placements	Target or Benchmark	May-22 n	May-22 mean	May-22 SPC variation
Number of People Out of Area at month end	/	1		
Number of Mental Health Out of Area Placements started (admissions)	/	0	1	• L •
Total number of Out of Area bed nights in period (Inappropriate)	0	0	58	• L •

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)	Target or Benchmark	May-22 n	mean	SPC variation	SPC target
Admissions	/	1	1	• • •	/
Discharges	/	6	3	• • •	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/				
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/				
Bed Occupancy excl. Leave (KH03)	75%	75.5%	80.1%	• • •	?
Bed Occupancy incl. Leave	95%	89.4%	92.7%	• • •	?
Average discharged length of stay (12 month rolling)	441	314.9	310.4	• • •	P
Live Length of Stay (as at month end)	/	337.9	340.2	• • •	/
Number of Out of Area Placements started in the period (admissions)	0	0			
Total number of Out of Area bed nights in period	0	217			
Number of people in Out of Area beds at month end	0	7			

Forensic Low Secure (Forest Lodge)	Target or Benchmark	May-22 n	mean	SPC variation	SPC target
Admissions	/	0	1	• • •	/
Discharges	/	1	1	• • •	/
Bed Occupancy excl. Leave (KH03)	89%	87.1%	84.4%	• • •	?
Bed Occupancy incl. Leave	95%	89.0%	91.5%	• • •	?
Average discharged length of stay (12 month rolling)	707	441.5	408.4	• • •	P
Live Length of Stay (as at month end)	/	557.2	466.9	• H •	/

Forest Close
The length of stay within Forest Close benchmarks favourably against other Rehab/Complex Care facilities across the country.

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 May 2022 there were 7 patients OOA – all placed for a range of specialist needs.

Length of Stay Detail - Forest Close (all)
Longest LoS (days) as at month end: 2175
Range = 0 to 2175
Number of discharges in month: 6
Longest LoS (days) of discharges in month: 876

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

Forest Lodge
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: 2141
Range = 61 to 2141 days
Number of discharges in month: 1
Longest LoS (days) of discharges in month: 323

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

Sheffield Health and Social Care NHS Foundation Trust

Urgent and Emergency Care Recovery

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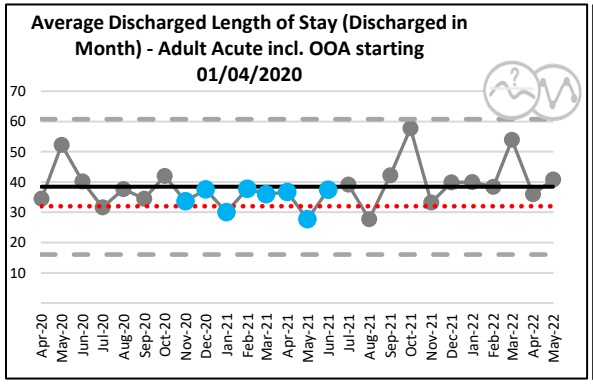
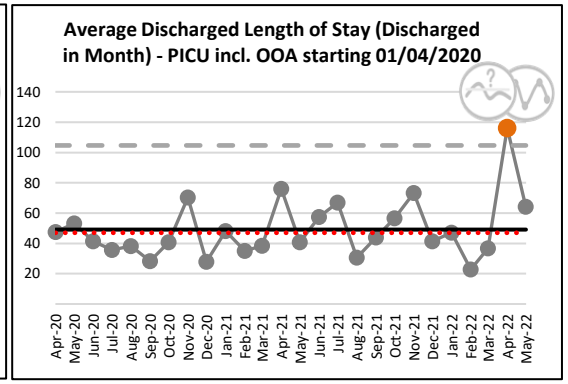
UEC Dashboard

Length of Stay





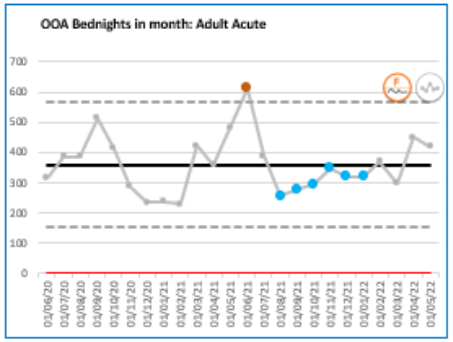
Adult Acute Discharged LoS (Rolling 12 month average)

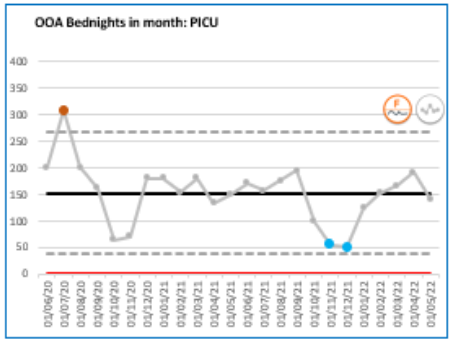
Location	Total Discharges	Average Discharged LoS
Sheffield	398	38
OOA	107	44
Contracted	75	46
Combined	**580**	**40**

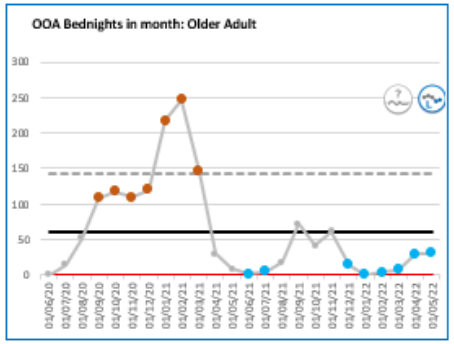
PICU Discharged LoS (Rolling 12 month average)

Location	Total Discharges	Average Discharged LoS
Sheffield	61	56
OOA	41	44
Combined	**102**	**51**

Out of Area

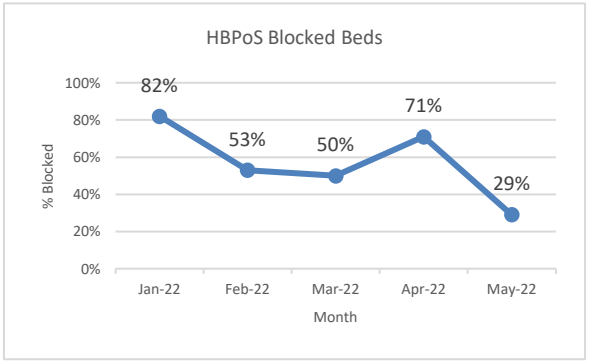


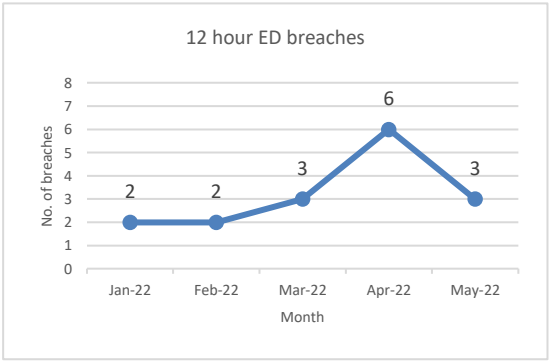




Provider	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Sparklines (Jun-21 to May-22)
Sheffield Health and Social Care NHS Foundation Trust	**23**	**13**	**11**	**16**	**15**	**16**	**11**	**17**	**13**	**13**	**21**	**14**	
Bradford District Care NHS Foundation Trust	22	17	25	25	28	24	21	19	25	15	16	14	
Tees, Esk and Wear Valleys NHS Foundation Trust	20	26	30	40	4	4	6	6	10	6	16	15	
South West Yorkshire Partnership NHS Foundation Trust	6	5	13	12	17	14	19	18	18	20	12	19	
Leeds and York Partnership NHS Foundation Trust	12	16	9	14	18	8	14	17	13	17	9	6	
Cumbria Northumberland, Tyne and Wear Partnership NHS FT	0	1	2	5	4	8	4	12	12	4	7	8	
Humber NHS Foundation Trust	18	16	21	16	5	13	13	8	10	9	7	4	
Rotherham Doncaster and South Humber NHS Foundation Trust	9	17	13	8	6	4	3	5	4	3	4	1	
Navigo (NE Lincs/Grimsby)	0	0	0	3	4	2	0	0	0	0	0	0	

Blocks and Breaches

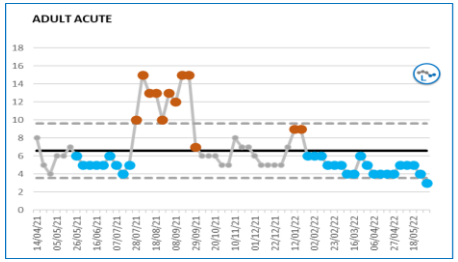


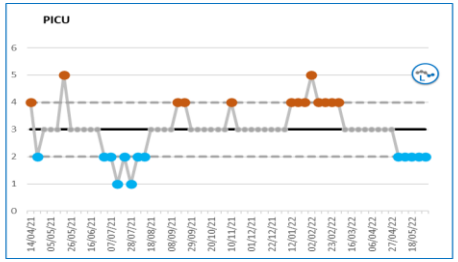


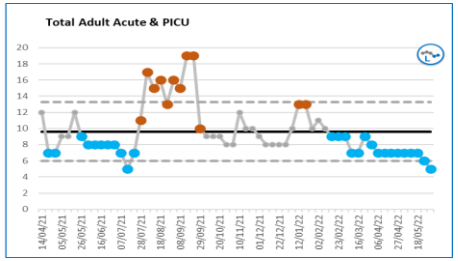
Health Based Place of Safety (HBPoS/136 Beds)	May-22
Weekday beds blocked	12
Weekday beds blocked %	29%

Emergency Department (ED)	May-22
ED 12 hour Breaches	3

Delayed Care







Delayed Discharges Adult Acute	Count of Delayed Patients	Sum of Delayed Bednights	% Bednights occupied by DD
Dovedale 2	1	31	8%
Maple Ward	0	0	0%
Stanage Ward	4	109	22%
Adult Acute Total	5	140	10%

Delayed Discharges PICU	Count of Delayed Patients	Sum of Delayed Bednights	% Bednights occupied by DD
Endcliffe	2	60	19%

Delayed Discharges Older Adult	Count of Delayed Patients	Sum of Delayed Bednights	% Bednights occupied by DD
Dovedale 1	3	47	10%
G1	10	219	44%
Older Adult Total	13	266	28%

Urgent and Emergency Care - analysis

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- Our Flow Improvement Programme is increasing the rate of patient flow through our acute and crisis services and is ensuring that the right care is available at the point of need. The programme has resulted in fewer people inappropriately placed in hospital away from home, fewer 12-hour ED breaches, and fewer occasions when the Health Based Place of Safety has been repurposed to an acute hospital bed.

- Some of our patients continue to experience in excess of 12 hour waits in an Emergency Department before receiving care in a mental health hospital bed. Some of these delays are attributed to the availability of hospital transport. We are working with our transport providers to improve response times.

- We continue to have higher than desirable length of stay across our acute and PICU hospital wards, including our contracted and spot purchase out of area beds. A high number of these delays are attributed to specialist social care or specialist hospital placements. We are bringing focus to this through our Place based delayed care system

- We are taking learning from the improvements achieved for our Older Adult service users, who have reduced out of area hospital care significantly since January 2022, through engagement with Older Adult Crisis and Community Services, and by reaching out for help from Sheffield City Council.

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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.

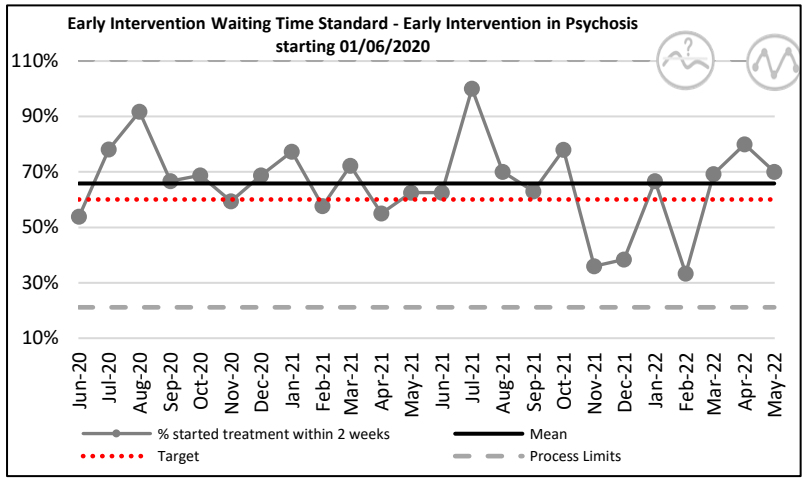
Of note during May 22:

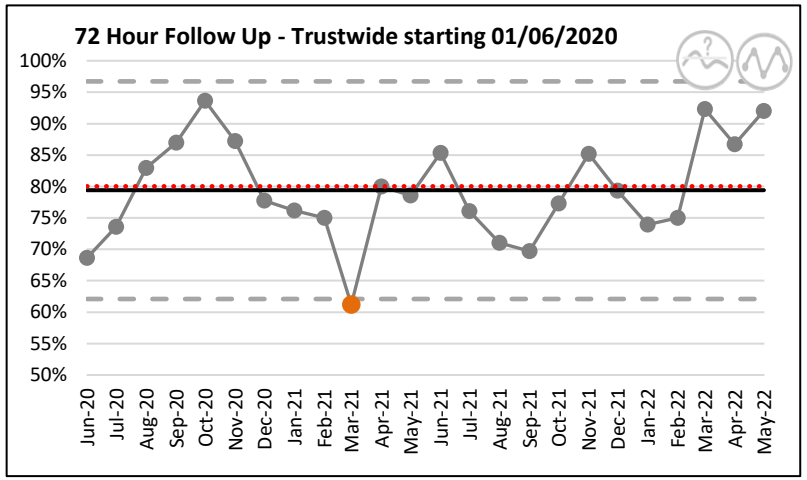
The Learning Disability Board is meeting on a regular basis with representation from key stakeholders including the CCG and the ICB.

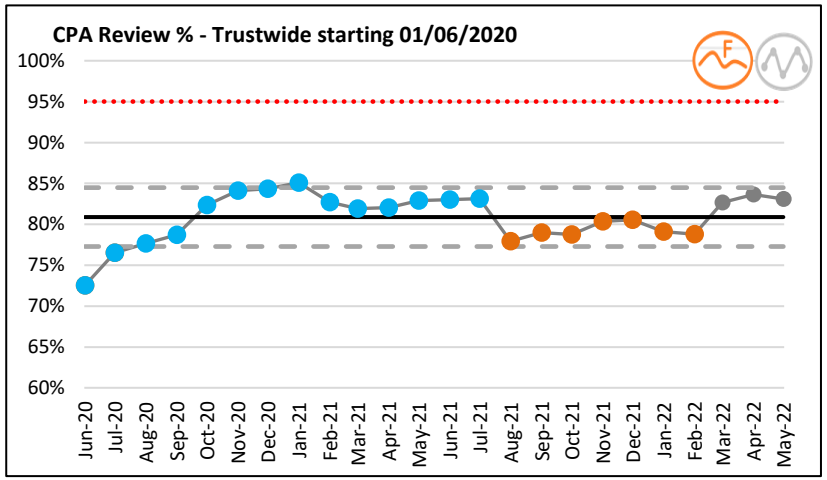
The unit would require regional commissioning to be sustainable. The ICB strategy is for services to develop a full and more robust community offer before commission beds.

The service has developed the community model and is currently detailing the make up of a service which will be discussed within SHSC and would need agreement from commissioners.

Effective | Treatment & Intervention







EIP AWT Standard		May-22		
	Target 2022/23	n	SPC variation	SPC target
Trustwide	60%	**70%**	• • •	?

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. It remains at 60% into the 2022/23 year.

There is variation month on month, but our average over the last 2 year period is 65.3% indicating the system is capable of achieving the 22/23 target.

In May = 70% (14/20)

72-hour Follow Up		May-22		
	Target 2022/23	n	SPC variation	SPC target
Trustwide	80%	**92.0%**	• • •	?

Narrative

The aim is to deliver safe care through ensuring people leaving inpatient services are seen within 72 hours of being discharged. Data shown above is for ALL eligible discharges from inpatient areas. Previously this has been reported as discharged patients on CPA.
Performance in May 22 was 92.0% against the 80% target. There were 25 eligible discharges. 23 of the 25 were followed up within 72 hours.
The other 2 not followed up within 72 hours were both followed up on day 4. Ensuring the discharge destinations are correctly recorded and reported is the data quality work to be progressed.

CPA Annual Review % Compliance		May-22		
	Target 2022/23	n	SPC variation	SPC target
Trustwide	95%	**83.11%**	• • •	F
EIP	95%	**85.23%**	• L •	?
Recovery North	95%	**91.38%**	• H •	F
Recovery South	95%	**72.71%**	• • •	F

Narrative
Learning was taken from the North improved position. Action was taken over February which highlighted gaps in systems and individual skills. Further actions have been taken to incorporate this new learning.

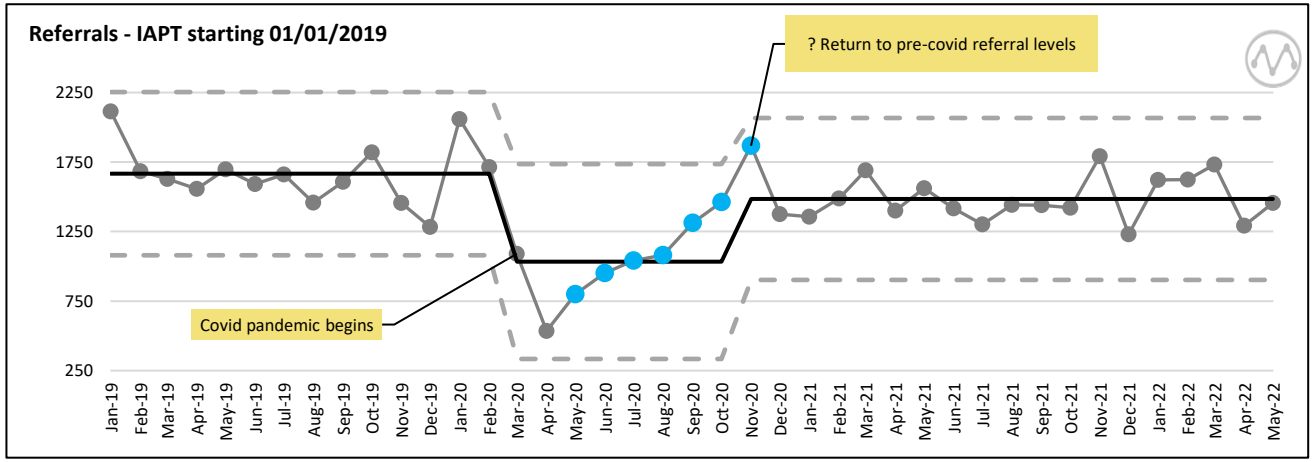
IAPT | Performance Summary

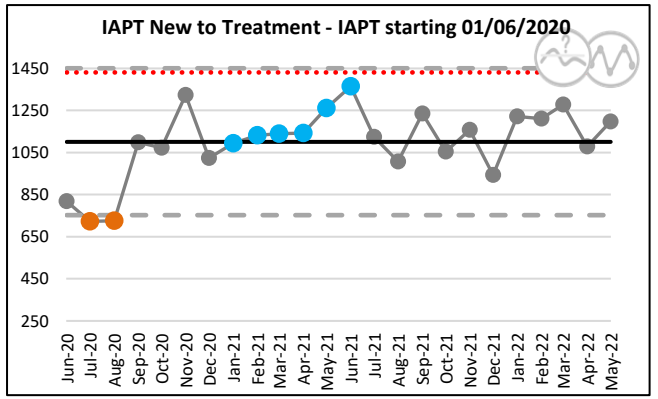
IAPT		May-22			
Metric	Target 2022/23	*n*	*mean*	*SPC variation*	*SPC target*
Referrals	/	1455	*1484*	• • •	/
New to Treatment	1431	1197	*1101*	• • •	?
6 week Wait	75%	99.18%	*95.25%*	• H •	P
18 week Wait	95%	100.00%	*99.57%*	• • •	P
Moving to Recovery Rate	50%	52.33%	*50.38%*	• • •	?

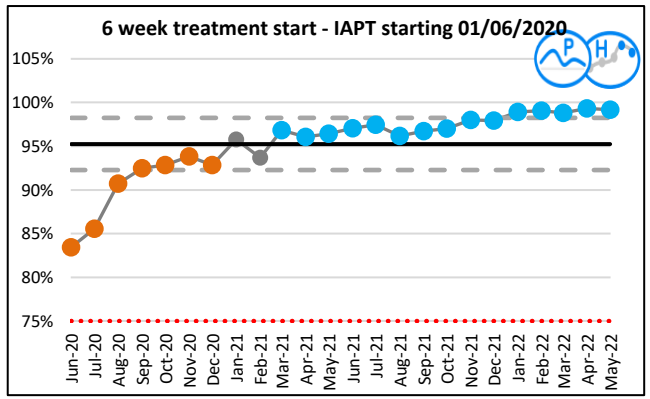
**Process limits recalculated from March 2020 and November 2020. Pre-covid average referrals per month were 1666. Post-covid average is 1484.*

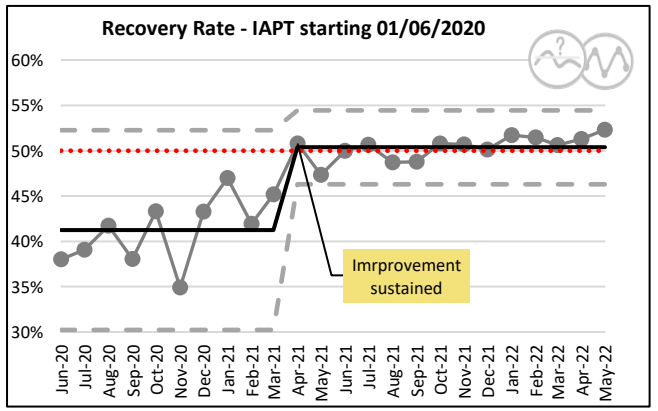
Narrative

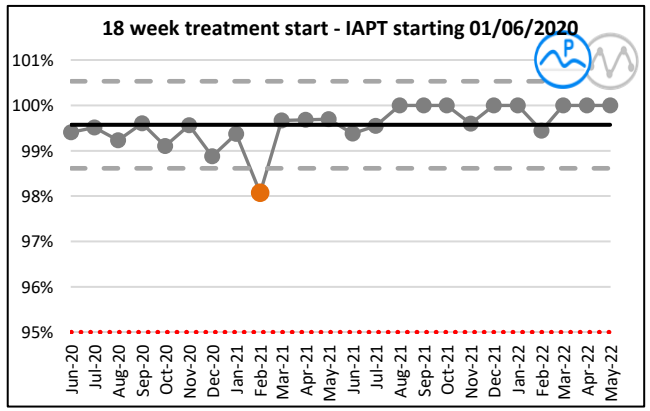
IAPT continues to significantly exceed the 6 week and 18 week waiting time standards and has met the recovery rate standard over the last 8 months indicating a sustained improvement. Work is ongoing to increase referrals with a fixed term comms role to help implement a marketing, promotion and communication strategy











START – Sheffield Treatment & Recovery Team | Performance Summary

START		May-22		
Opiates	**Target 2022/23**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	81	• • •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	84%	• • •	?
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	94%	• L •	P
DNA Rate to Assessment	≤ 15%	27%	• • •	?
Recovery - Successful treatment exit	TBC	6	• • •	/
Non-Opiates	**Target 2022/23**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	87	• • •	/
Waiting time Referral to Assessment	≥ 95%	97%	• • •	?
Waiting time Referral to Treatment	≥ 95%	100%	• • •	?
DNA Rate to Assessment	≤ 15%	22%	• • •	?
Recovery - Successful treatment exit	TBC	16	• • •	/
Alcohol	**Target 2022/23**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	213	• • •	/
Waiting time Referral to Assessment	≥ 95%	97%	• • •	?
Waiting time Referral to Treatment	≥ 95%	100%	• H •	P
DNA Rate to Assessment	≤ 15%	29%	• • •	?
Recovery - Successful treatment exit	TBC	54	• • •	/

Narrative

Waiting Times

Wait times to assessment are improving but remain a challenge across the service.

Average waiting times between referral to assessment remain below 7 days across all treatment services.

Breaches by exception are agreed by team leaders and if earlier slots become available these will be offered to service users.

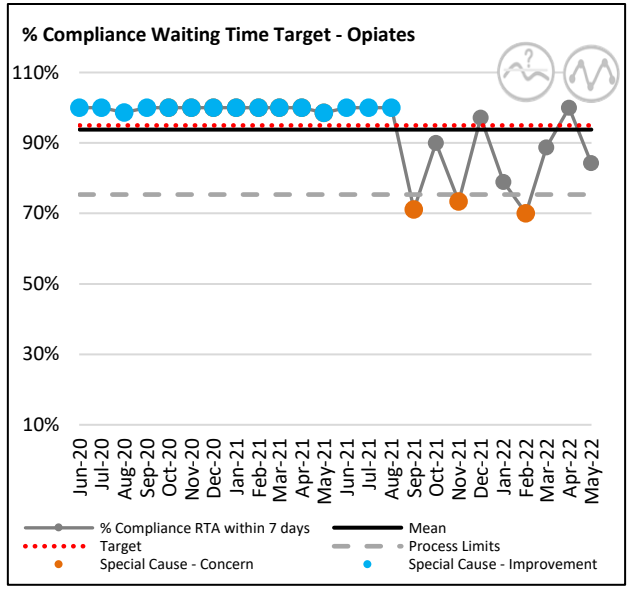
Recovery

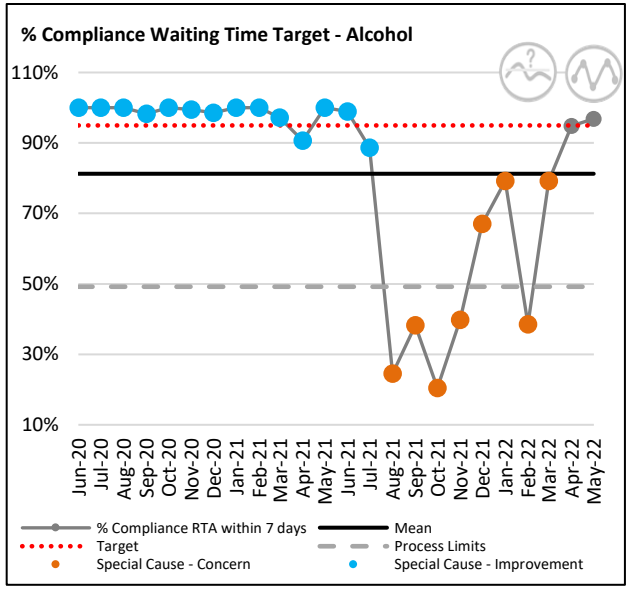
Due to the open access nature of the service, service users historically find it easier to drop out of treatment. The service has previously worked towards a target for the percentage of positive discharges (defined as discharge drug free/occasional user or a planned discharge with treatment goals met).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

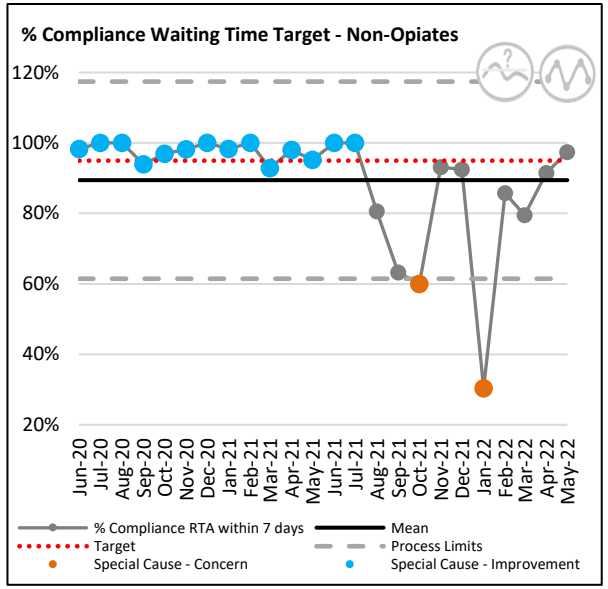
Engagement

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.

START Performance | Highlights & Exceptions





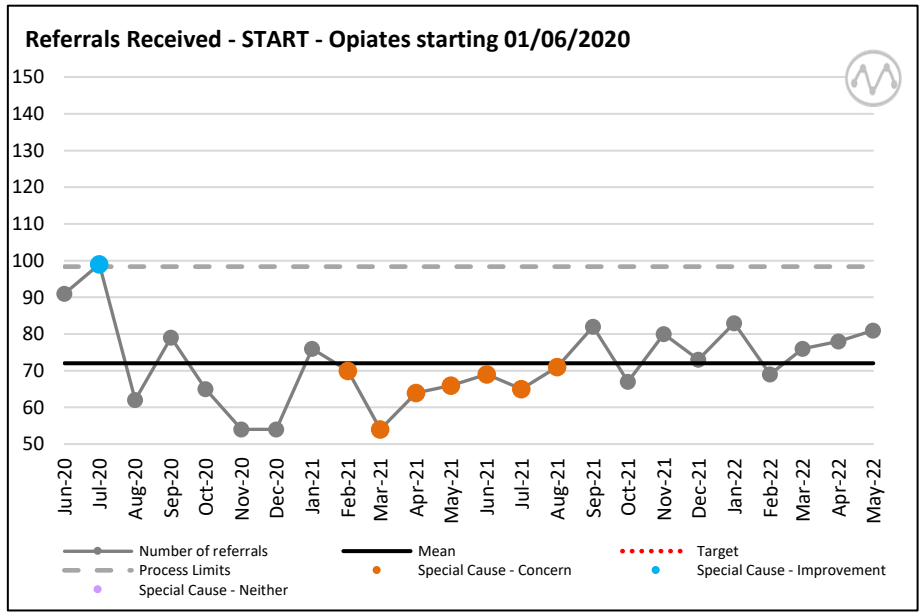


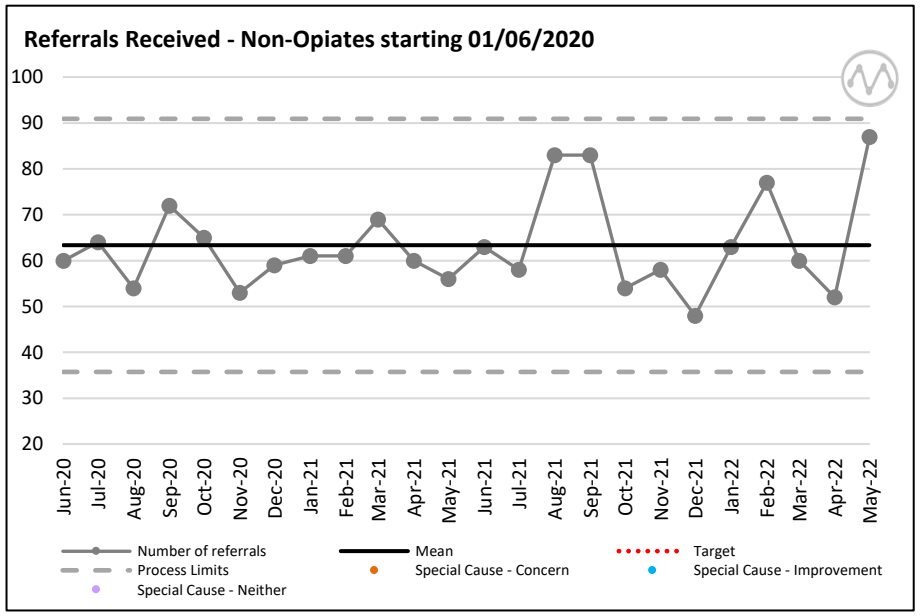
Wait times to assessment

Wait times to assessment continue to be a challenge, although this is being addressed by team leaders.

As vacancies across the pathways are filled and the impact of the pandemic on service delivery eases, the service aims to restore an above 95% compliance rate. Assessment slots are often overbooked to take advantage of the DNA rate.

Wait times to starting structured treatment are not affected.





Referrals (Numbers In) Narrative

Referrals to all services are positive, and the service continues to ensure there are no barriers to accessing treatment experienced by anyone who needs it.

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Safety & Quality

IPQR - Information up to and including May 2022

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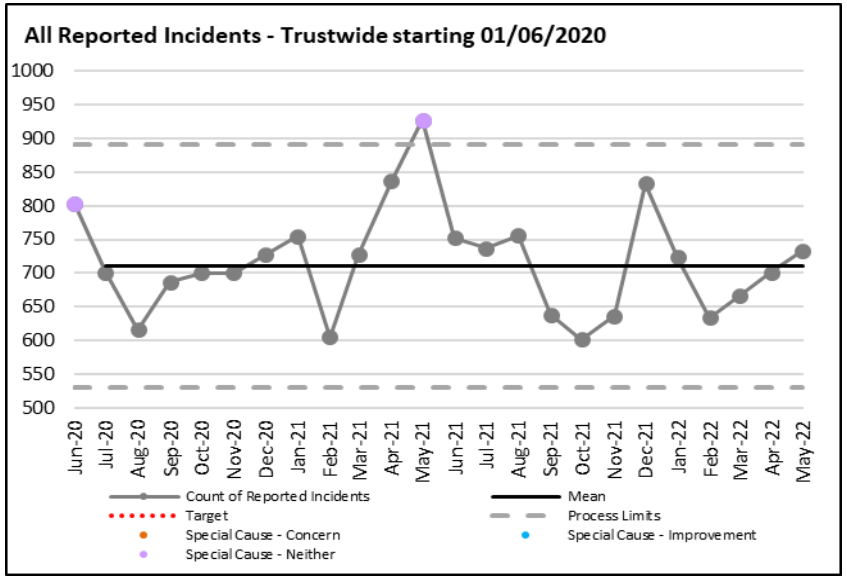
Safe | All Incidents



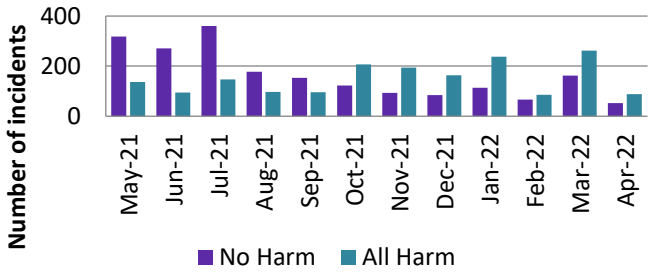
Trustwide	May-22		
	n	*mean*	SPC variation
ALL	**733**	717	• • •
5 = Catastrophic	16	15	• • •
4 = Major	2	4	• • •
3 = Moderate	61	95	• • •
2 = Minor	300	316	• • •
1 = Negligible	331	210	• H •
0 = Near-Miss	23	20	• H •

Narrative

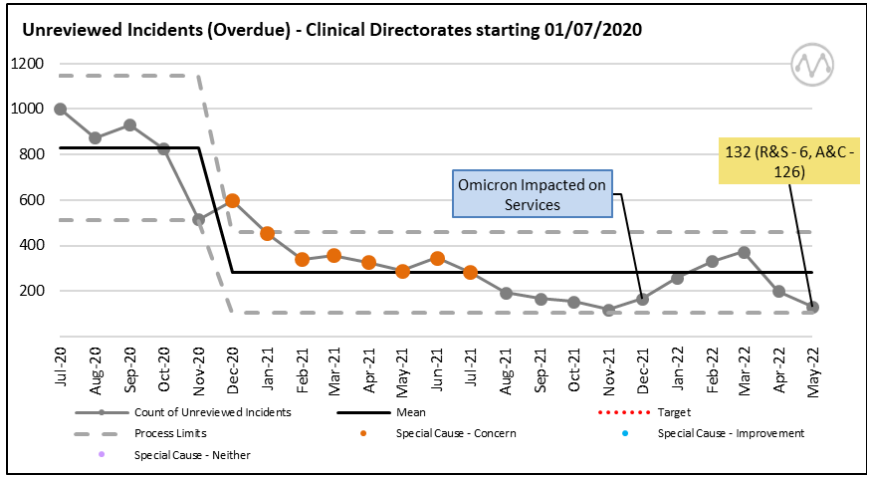
Patient safety incidents are uploaded to the National Reporting Learning System (NRLS). The NHS is moving to a new platform, the Learning from Patient Safety Events (LFPSE) over the next 12-18 months. All patient safety incidents will be uploaded to this going forwards. The latest benchmarking information released from the NRLS covers 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 May 2021 to April 2022.

Patient Safety Incidents – Harm vs No Harm



There were 2 major incidents reported in May 2022: 1 related to patients testing positive for Covid-19 on Dovedale 1 and the other regarding a service being provided with information about a service user being arrested for sexual assault.



Narrative

The unreviewed incidents are predominantly accounted for by the Acute and Community Directorate. The plan in place since March to reduce the unreviewed incidents is achieving the anticipated gradual reduction.

Serious Incident Actions Outstanding

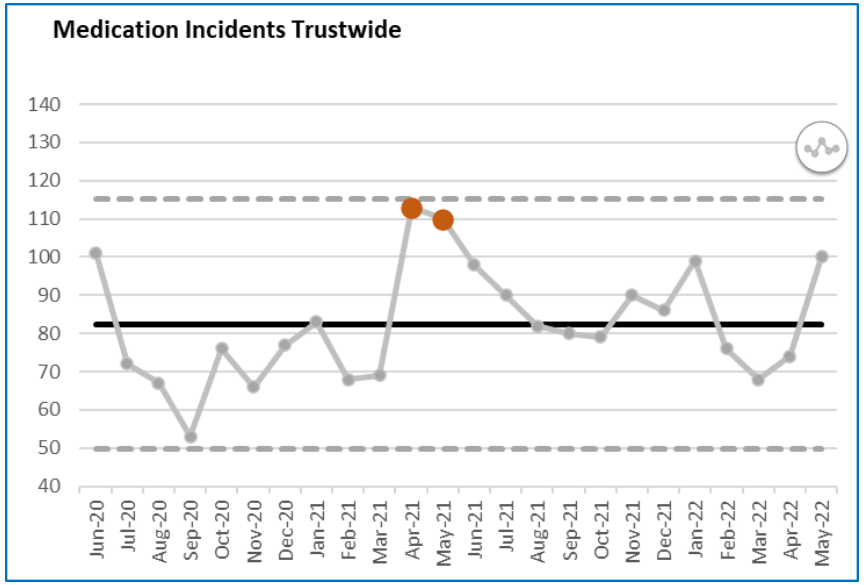
As at 30 May 2022, there were 100 outstanding SI actions overdue, which is a reduction from the previous months' 105.

- 11 actions were due in 2020
- 42 actions were due in 2021
- 47 actions were due in 2022

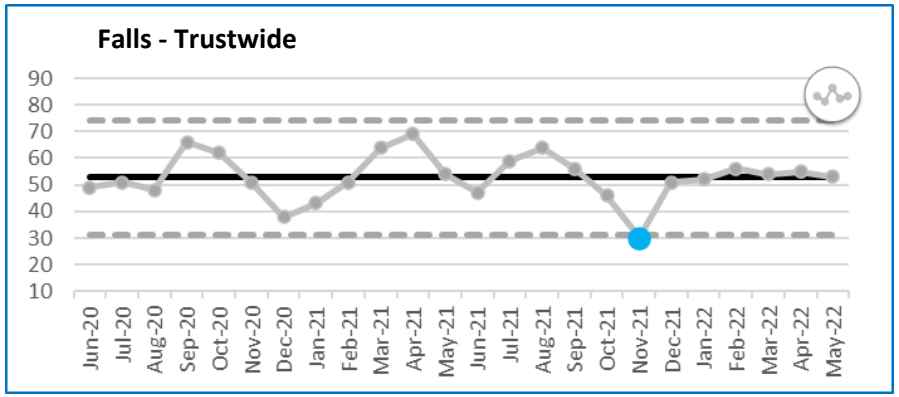
The numbers outstanding are reducing consistently. 30 actions relate to Firshill Rise/ATS which we are working with commissioners to close.

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

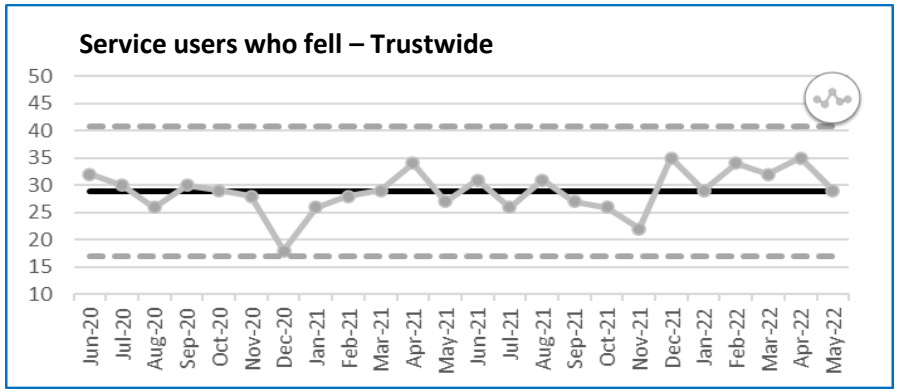
Safe | Medication Incidents & Falls



Trustwide	May-22		
	n	mean	SPC variation
ALL	100	82	• • •
Administration Incidents	27	17	• • •
Meds Management Incidents	57	52	• • •
Pharmacy Dispensing Incidents	5	7	• • •
Prescribing Incidents	11	6	• • •
Meds Side Effect/Allergy Incidents	0	0	• • •



Trustwide FALLS INCIDENTS	May-22		
	n	mean	SPC variation
Trustwide Totals	53	53	• • •
Acute & Community	50	50	• • •
Rehabilitation & Specialist Services	2	3	• • •



Trustwide FALLS INDIVIDUALS	May-22		
	n	mean	SPC variation
Trustwide Totals	29	29	• • •
Acute & Community	26	26	• • •
Rehabilitation & Specialist Services	2	3	• • •

Narrative

Medication Incidents

There was 1 moderate medication incident reported in May 2022 which involved the wrong dose of medication administered.

Falls Incidents

No moderate or above falls incidents were reported in the month. 9 out of the 53 falls during May 2022 resulted in bruising/swelling, tenderness, grazing/abrasion or superficial wounds to service users.

- Woodland View aware of higher falls incidents due to general population of the ward.
- HUSH (Huddling up for safer healthcare) huddles commenced on Dovedale June 2022.

Safe | Assaults, Sexual Safety & Missing Patients

Assaults on Service Users	May-22		
	n	mean	SPC variation
Trustwide	39	23	• H •
Acute & Community	31	20	• • •
Rehabilitation & Specialist	8	3	• • •

Assaults on Staff	May-22		
	n	mean	SPC variation
Trustwide	79	85	• • •
Acute & Community	68	68	• • •
Rehabilitation & Specialist	11	17	• • •

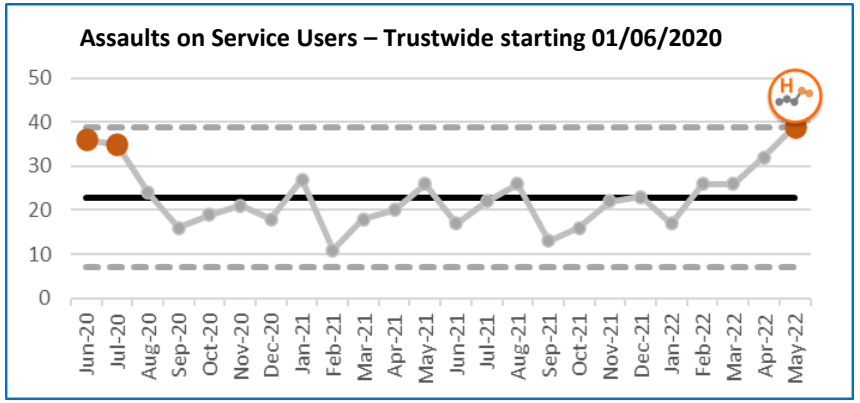
Narrative
Assaults on service users showing high variation from the mean. These occurred in different services, Stanage Ward, G1 Ward, Maple Ward, Forest Close, Woodland View, Dovedale 1, Dovedale 2 and Forest Lodge.

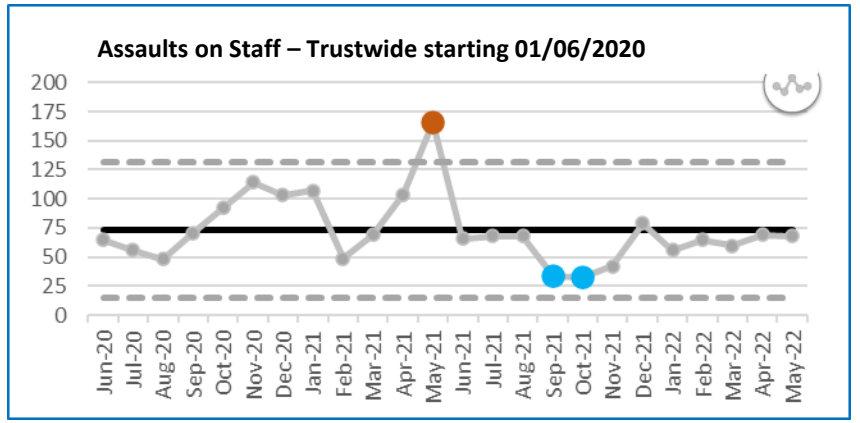
G1 Ward and Forest Close have showed an increase in assaults on service users, G1 going from 1 incident reported in April to 9 reported in May 2022 and Forest Close going from 2 in April to 7 incidents in May 2022

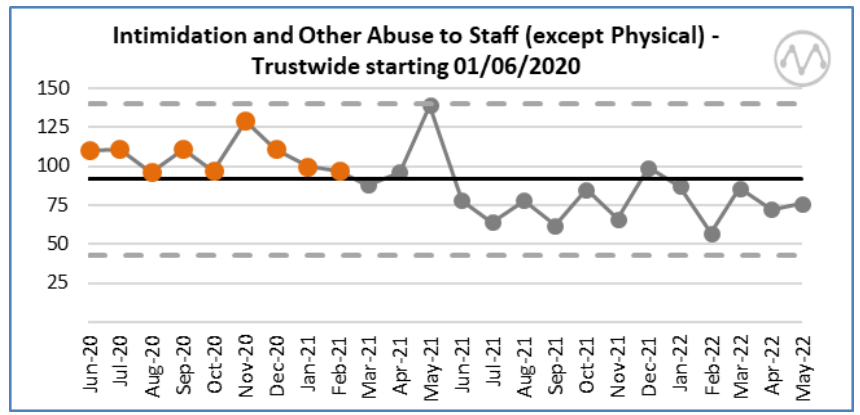
Out of the 39 incidents reported, 2 were rated as moderate incidents. 1 at Maple Ward and the other at Forest Lodge.

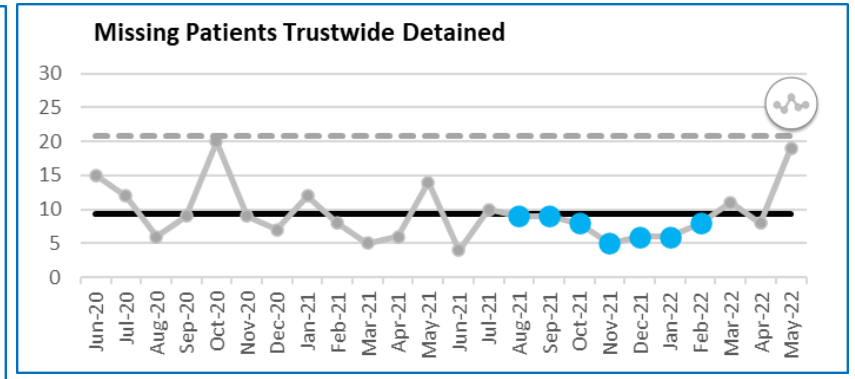
Sexual Safety
There was 1 moderate sexual safety incident reported in May 2022 on Stanage Ward in relation to service user disclosing past sexual assault.

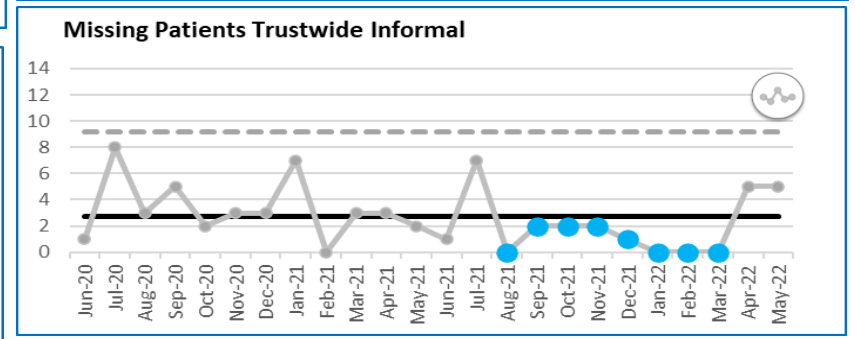
Protecting from avoidable harm	Target	YTD
Reportable Mixed Sex Accommodation (MSA) breaches	0	0



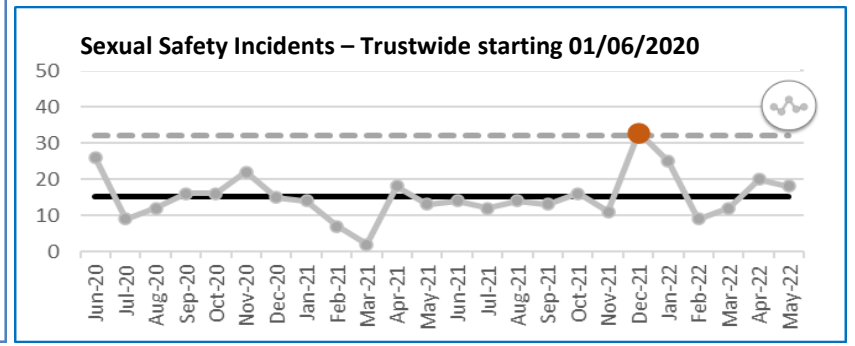




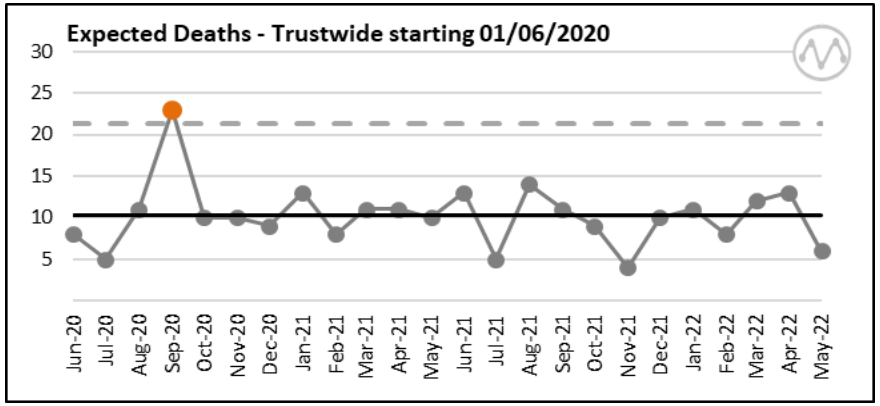


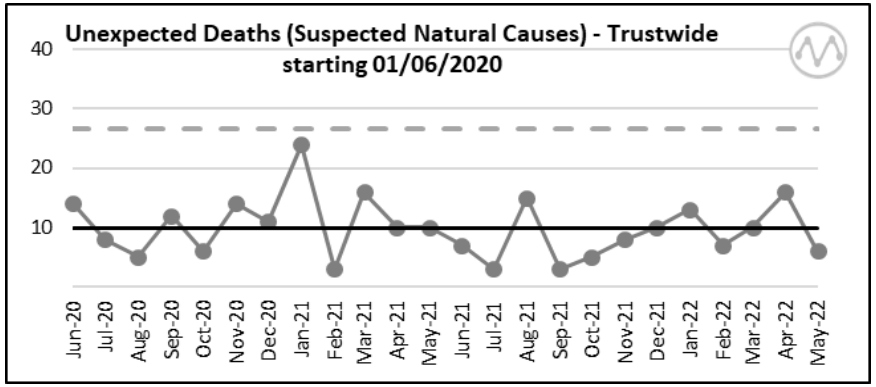


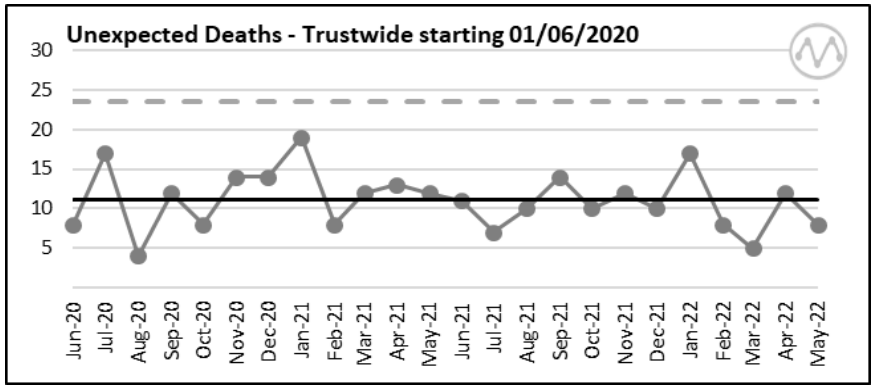
Trustwide	May-22		
	n	mean	SPC variation
Detained	19	9	• • •
Informal	5	3	• • •



Deaths

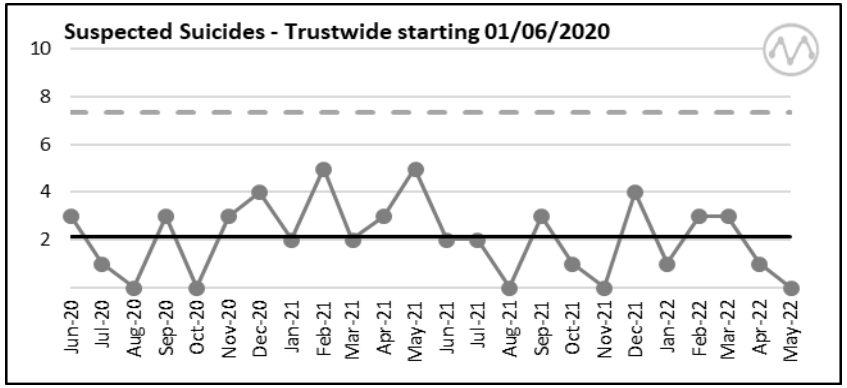






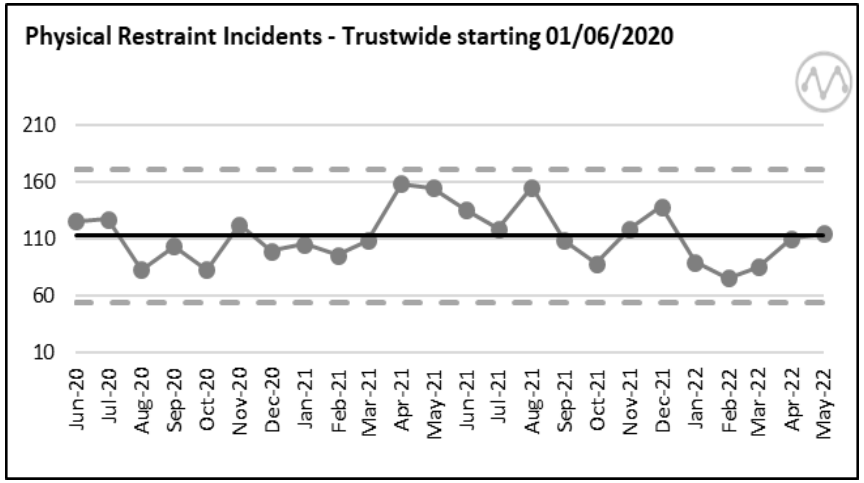
Quarterly mortality reports are presented to the Quality Assurance Committee and Board of Directors.

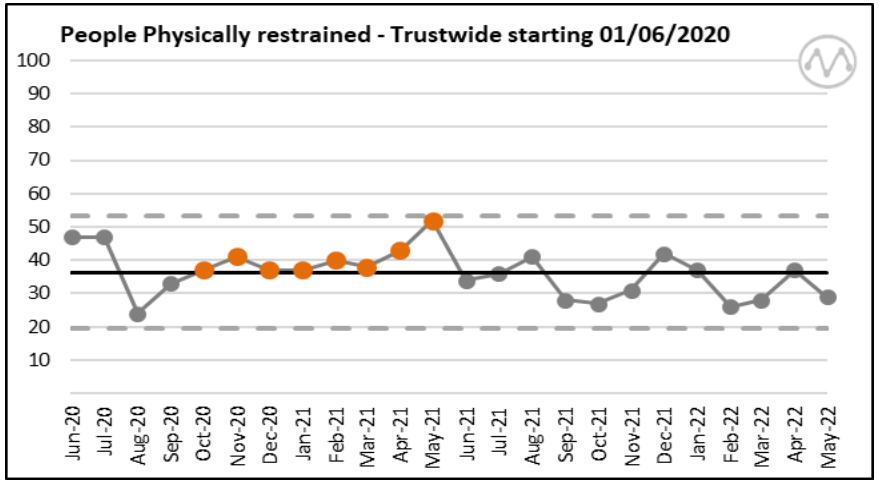
Deaths Reported 1 June 2020 – 31 May 2022	
Awaiting Coroners Inquest/Investigation	188
Conclusion - Narrative	7
Conclusion - Suicide	14
Conclusion – Accidental	2
Conclusion – Misadventure	1
Conclusion – Open	1
Natural Causes/No Inquest	581
Alcohol/Drug related	20
Suspected Homicide/Closed	2
Ongoing	3
Grand Total	**820**



COVID-19 Deaths 1 April 2020 - 31 May 2022	
ATS (Firshill Rise)	1
Birch Ave	5
CISS (LDS)	1
CLDT	6
G1 Ward	6
Liaison Psychiatry	8
LTNC	3
Memory Service	7
Mental Health Recovery Team (South)	2
Neuro Enablement Service	4
Neuro Case Management Team	1
OA CMHT North	22
OA CMHT South East	15
OA CMHT South West	7
OA CMHT West	5
OA Home Treatment	3
SPA / EWS (Netherthorpe)	1
START Alcohol Service	2
Woodland View | Oak Cottage	2
Grand Total	**101**

Safe | Restrictive Practice | Physical Restraint





Physical Restraint INCIDENTS	May-22		
	n	*mean*	SPC variation
TRUSTWIDE	**115**	113	• • •
Acute & Community	**111**	102	• • •
Burbage Ward	**14**	15	• • •
Stanage Ward	**26**	12	• • •
Maple Ward	**36**	16	• • •
HBPoS (136 Suite)	**0**	1	• • •
Endcliffe Ward	**9**	26	• • •
Dovedale	**19**	22	• • •
G1 Ward	**5**	8	• L •
Birch Ave	**1**	1	• • •
Woodland View	**1**	1	• • •
Rehabilitation & Specialist Services	**4**	11	• • •
Forest Close	**4**	2	• • •
Forest Lodge	**0**	1	• • •

Physical Restraint PEOPLE	May-22		
	n	*mean*	SPC variation
TRUSTWIDE	**29**	36	• • •
Acute & Community	**26**	33	• • •
Burbage Ward	**4**	6	• • •
Stanage Ward	**6**	6	• • •
Maple Ward	**4**	6	• • •
HBPoS (136 Suite)	**0**	1	• • •
Endcliffe Ward	**3**	6	• • •
Dovedale	**4**	3	• • •
G1 Ward	**3**	4	• • •
Birch Ave	**1**	1	• • •
Woodland View	**1**	1	• • •
Rehabilitation & Specialist Services	**3**	3	• L •
Forest Close	**3**	1	• • •
Forest Lodge	**0**	1	• • •

Narrative

Physical Restraint

115 physical restraints were recorded in May 2022.

We continue to encourage and promote the reduced used of restraint continues, safety huddles, Purposeful Inpatient Admission (PIPA), including service users in MDTs, patient-led care plans and DRAMs and having therapy staff on the ward are all a part of this approach.

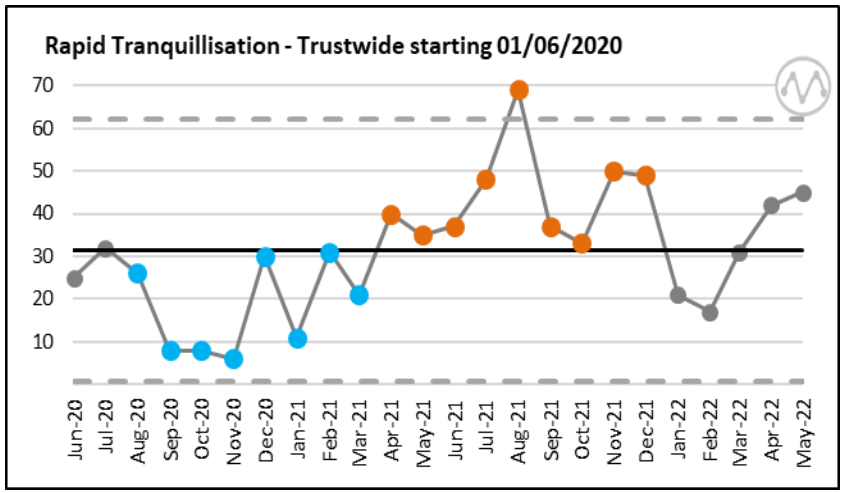
Stanage ward have not maintained previous progress with restraint and the team are being supported to understand the rate of restraints. 18 of the 26 physical restraints on Stanage Ward were for two people. 19 of the 36 physical restraints on Maple Ward were recorded for one person and another 13 incidents reported for another person.

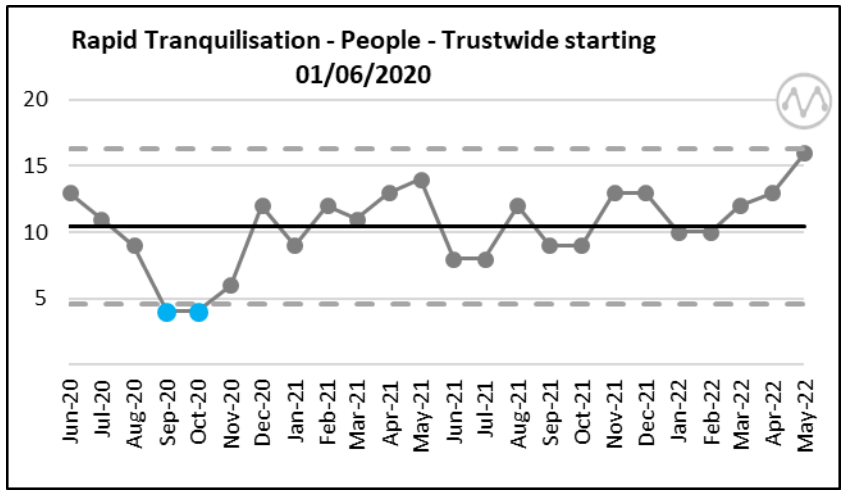
There have been 4 reported incidents of physical restraint in the Rehab & Specialist Directorate in May 22 on Forest Close.

Mechanical Restraint

During May 2022 there were no reported incidents of Mechanical Restraint.

Safe | Restrictive Practice | Rapid Tranquillisation





Rapid Tranquillisation INCIDENTS	May-22		
	n	mean	SPC variation
TRUSTWIDE	45	31	• • •
Acute & Community	45	31	• • •
Burbage Ward	13	6	• • •
Stanage Ward	6	3	• • •
Maple Ward	19	4	• • •
HBPoS (136 Suite)	0	0	• • •
Endcliffe Ward	1	7	• • •
Dovedale	6	10	• • •
G1 Ward	0	0	• • •
Rehabilitation & Specialist	0	0	• • •
Forest Close	0	0	• • •
Forest Lodge	0	0	• • •

Rapid Tranquillisation PEOPLE	May-22		
	n	mean	SPC variation
TRUSTWIDE	16	10	• • •
Acute & Community	16	10	• • •
Burbage Ward	4	3	• • •
Stanage Ward	3	2	• • •
Maple Ward	4	2	• • •
HBPoS (136 Suite)	0	0	• • •
Endcliffe Ward	1	2	• • •
Dovedale	4	1	• H •
G1 Ward	0	0	• • •
Rehabilitation & Specialist	0	0	• • •
Forest Close	0	0	• • •
Forest Lodge	0	0	• • •

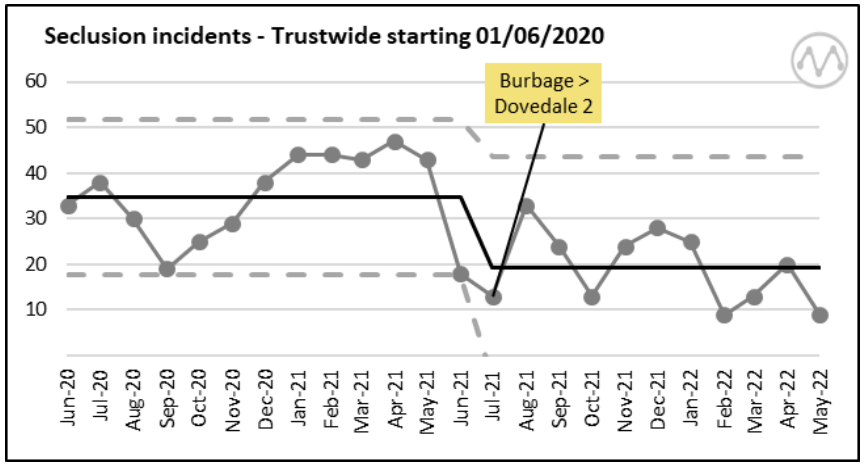
Narrative

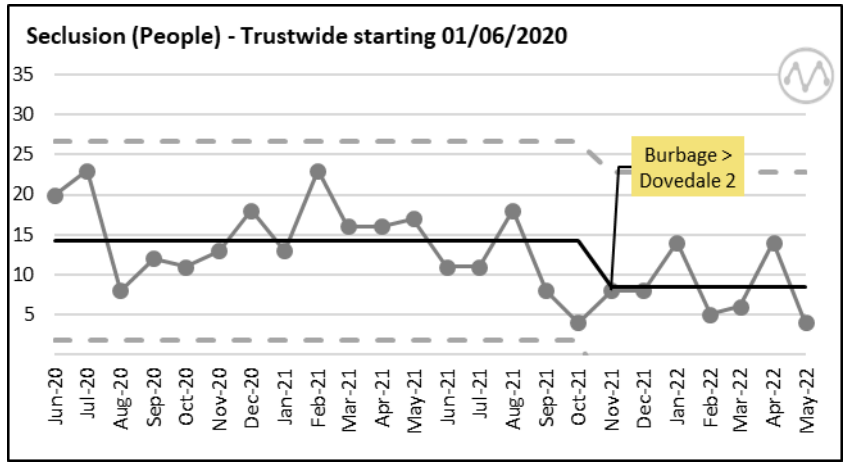
G1 has no reported incidents of rapid tranquillisation during May 2022.

On Maple Ward, one service user accounts for 10 incidents of rapid tranquillisation. This is the same person with 19 physical restraints. This person's care is subject to monthly executive oversight.

There have been no reported incidents of rapid tranquilisation in the Rehab & Specialist Directorate in May 2022.

Safe | Restrictive Practice | Seclusion





Seclusion INCIDENTS	May-22		
	n	*mean*	SPC variation
Trustwide	9	*23*	• L •
Acute & Community	9	*17*	• • •
Stanage	2	*4*	• • •
Maple Ward	2	*4*	• • •
HBPoS (136 Suite)	0	*0*	• • •
Endcliffe PICU	5	*10*	• • •
G1 Ward	0	*1*	• • •
Rehabilitation & Specialist	0	*1*	• L •
Forest Lodge	0	*1*	• • •

Seclusion PEOPLE	May-22		
	n	*mean*	SPC variation
Trustwide	4	*16*	• • •
Acute & Community	4	*7*	• • •
Stanage	**2**	*3*	• • •
Maple Ward	**1**	*3*	• • •
HBPoS (136 Suite)	**0**	*0*	• • •
Endcliffe PICU	**1**	*3*	• • •
G1	0	*1*	• • •
Rehabilitation & Specialist	0	*1*	• • •
Forest Lodge	0	*0*	• • •

Narrative

Seclusion

Dovedale 2 continue to operate without a seclusion facility.

May 2022 shows a shift below average in the number of seclusions reported across all the wards. It is clear from the daily incident huddles that alternative mechanisms are being utilised to good effect, such as using green rooms or other spaces for de-escalation.

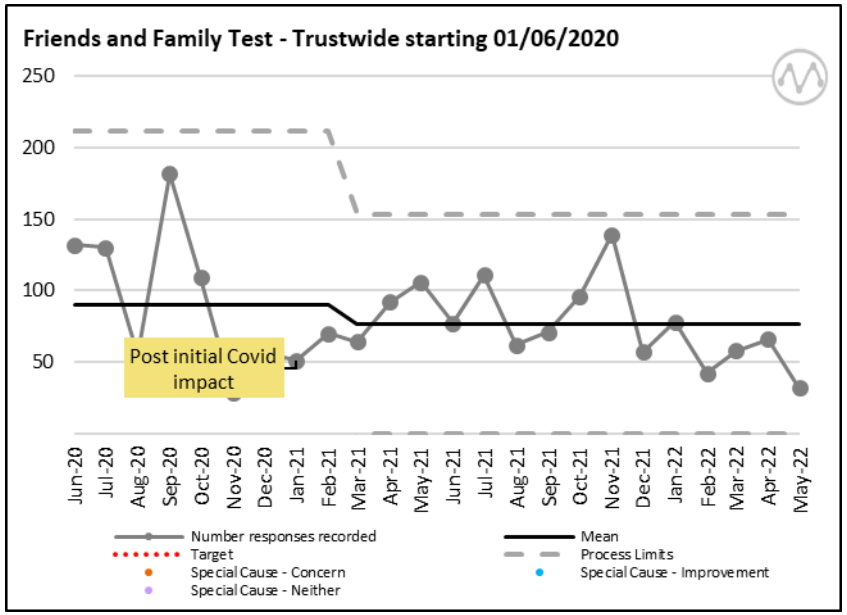
The work on G1 to encourage and promote the reduced used of restraint continues and seclusion was not used in May 2022.

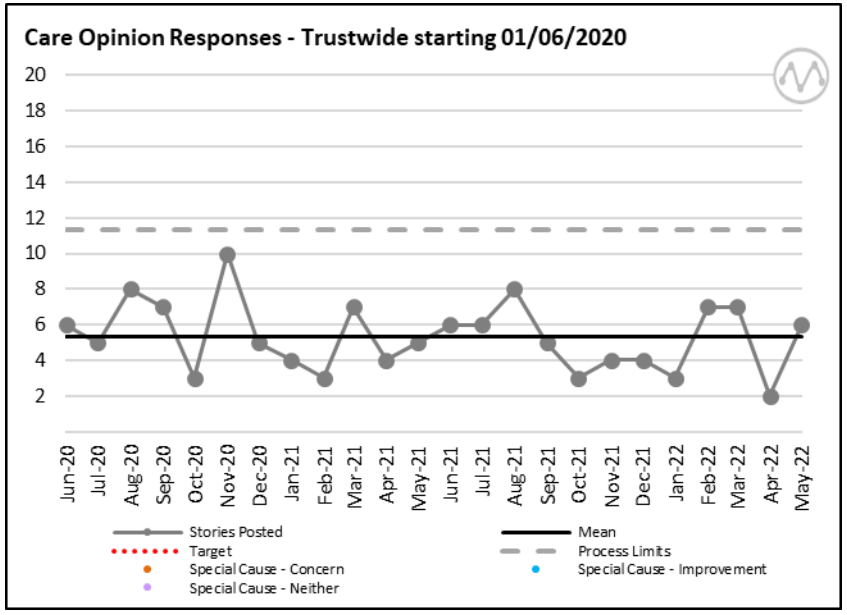
There have been no reported episodes of seclusion in the Rehabilitation & Specialist Directorate in May 2022.

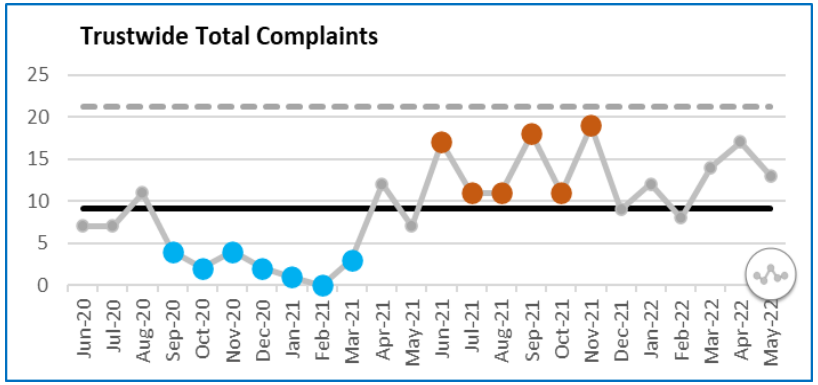
Long-Term Segregation

There were zero new incidences of long-term segregation reported to have started Trustwide in May 2022. However one service user remains in long-term segregation from February 2022. This was terminated at the beginning of July.

Caring | User Experience







Narrative.

The Trust received 32 responses in May 2022. Of which:
31 positive
0 negative
1 neither positive or negative.

There was no further feedback for the negative response received.

Some of the positive feedback received includes:
Very supportive and informative
Caring and efficient
Helpful

A neutral response provided:
Communication with the service can be partially difficult

Narrative

This month's report summarises 6 stories that were published on Care Opinion which have been viewed a total of 49 times at the time of writing the monthly quality report. The table to the left shows story activity for each service, including the number of stories that have received a response/awaiting a response and planned change.

The authors of these stories identified themselves as service users in 3 of the 6 stories. Care Opinion moderators rated the critically of 1 story as not critical, and 1 story and mildly critical, with 4 stories as 'unknown'. All 6 stories were submitted via the Care Opinion website.

Areas for Improvement:
Appointments & Waiting Times

Complaints and Compliments

There were 18 formal complaints received in May 2022, 16 for the Acute and Community Directorate and 2 for the Rehabilitation and Specialist Services Directorate. The most frequent category type reported was 'Access to Treatment and Drugs'.

30 compliments were recorded to have been received in May 2022. 18 compliments were received for Older Adult Home Treatment Teams, 2 for Crisis Team, 1 for Home Treatment Team and 4 for SPA/EWS, 2 for Community Learning Disability Team, 1 for Health Inclusion Team and 1 for Community Intensive Support Service.

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.

Quality of Experience

There was no Quality of Experience (QoE) survey undertaken during May 2022. The updated QoE survey has now been relaunched on Tendable. Volunteers have been recruited and assigned with the task of promoting the survey on the wards. Volunteers to assist with gathering feedback through this mechanism to gain a more comprehensive overview of good practice and service level improvements which need to take place.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Our People

IPQR - Information up to and including May 2022

Proud to care in Sheffield

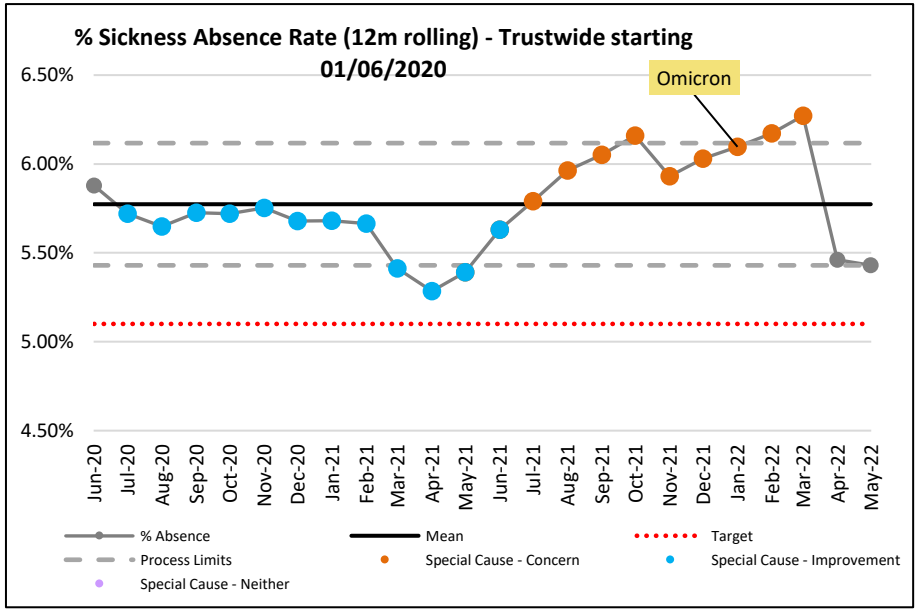
Well-Led | Workforce Summary

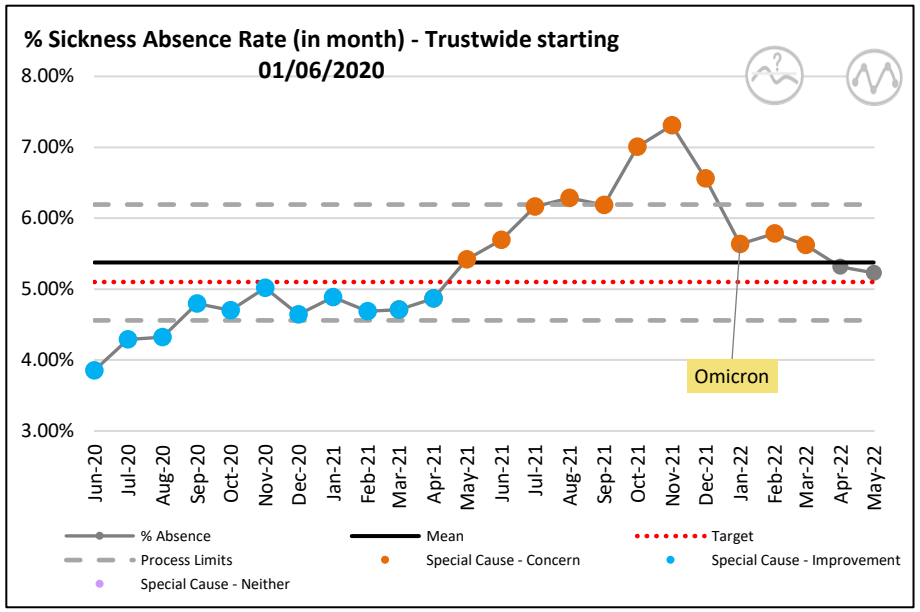
		Clinical Services	Medical	Corporate Services	SHSC Apr-22	May-22			
Metric	Target	n	n	n	*n*	**n**	*mean*	SPC variation	SPC target
Sickness 12 Month (%)	5.10%	5.95%	2.52%	3.30%	*5.46%*	**5.43%**	*5.77%*	• • •	F
Sickness In Month (%)	5.10%	5.95%	2.81%	2.40%	*5.32%*	**5.23%**	*5.37%*	• • •	?
Long Term Sickness (%)	~	4.45%	1.64%	1.70%	*3.58%*	**4.24%**	*3.97%*	• • •	/
Short Term Sickness (%)	~	2.89%	1.86%	1.52%	*2.66%*	**2.05%**	*2.05%*	• H •	/
Headcount Staff in Post	~	2062	195	319	*2573*	**2577**	*2547*	• H •	/
WTE Staff in Post	~	1779	176	303	*2253*	**2258**	*2228*	• H •	/
Turnover 12 months FTE (%)	10%	12.7%	9.13%	15.3%	*14.7%*	**14.59%**	*15.45%*	• • •	F
Vacancy Rate (%)	~	*Unavailable split at this level. See Trustwide figure.*			*10.85%*	**TBA**	***TBA***	• • •	/
PDR Compliance (%)*	90%	Revised data. See PDR Section.							
Training Compliance (%)	80%	See Service Line breakdown	92.74%	86.86%	*89.54%*	**89.88%**	*90.7%*	• L •	P
Supervision Compliance (%)	80%	See Supervision Section			*69.65%*	**69.57%**	*71.89%*	• • •	F

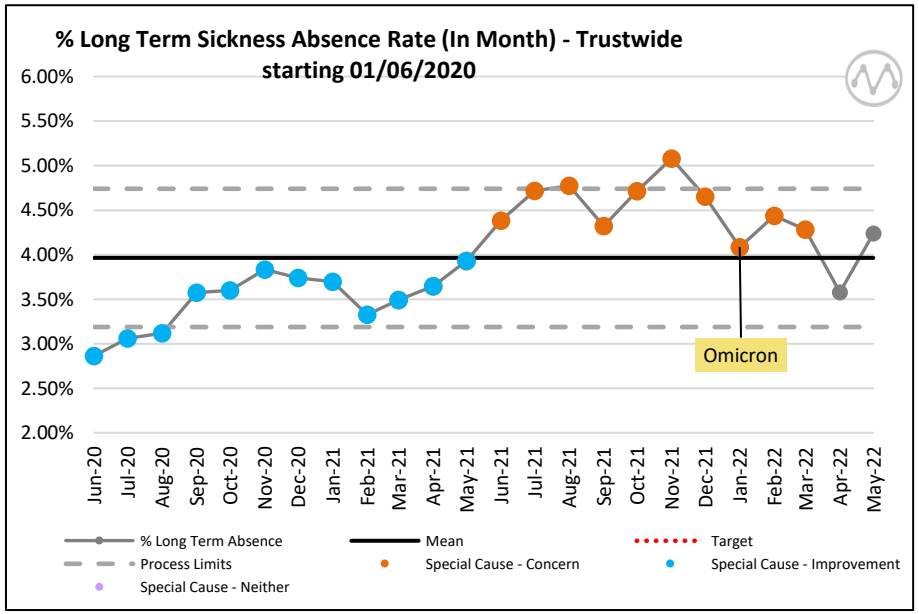
Notes:
- Vacancy based on establishment (FTE) data compared with staff in post (FTE) figures
- Turnover figures exclude 'Employee Transfer' as reason for leaving
- Medical turnover also excludes fixed term rotation

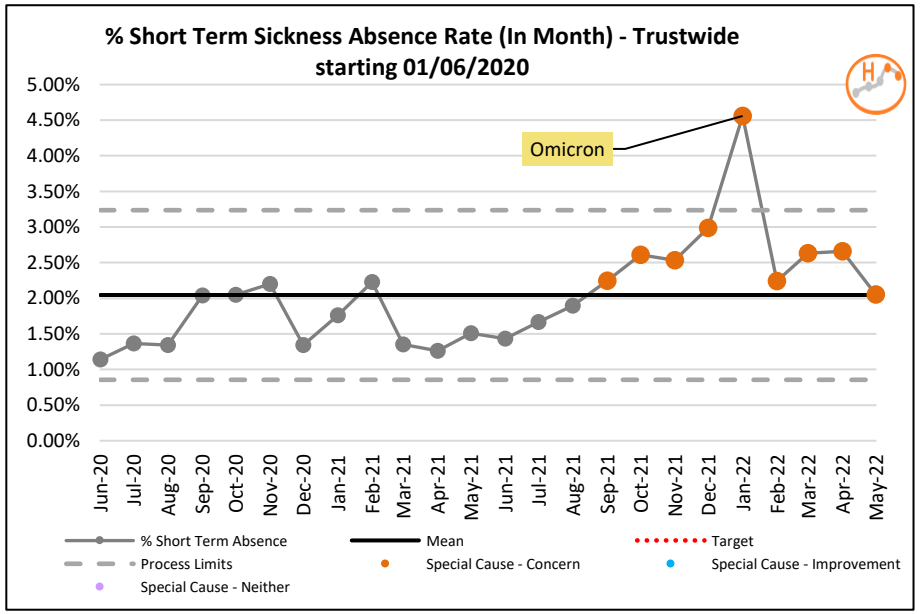
* PDR Report has been inaccurate and work has progressed to rectify this

Well-Led | Sickness Absence









Narrative

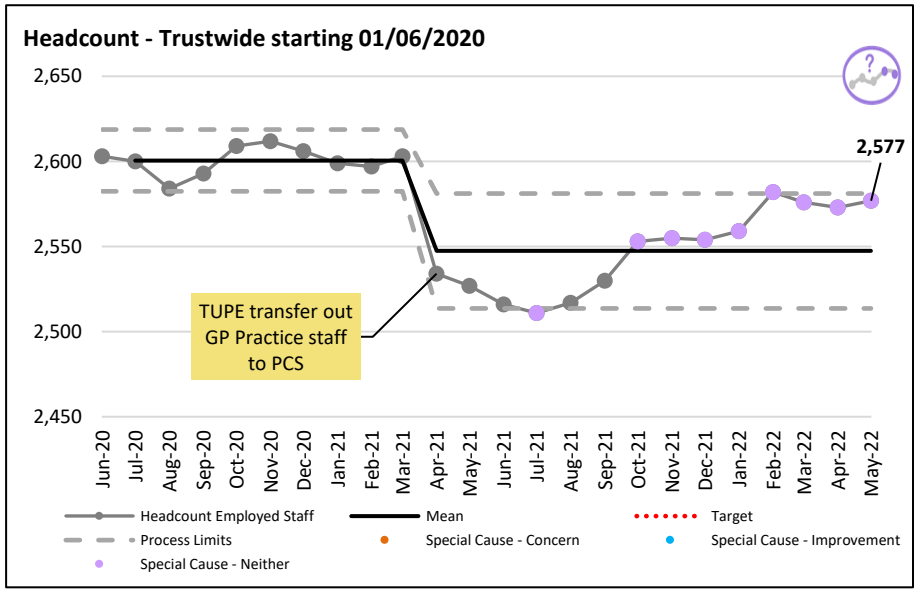
Sickness absence rates have been decreasing since November 2021 and we are now only slightly above the Trust target of 5.1%. We saw a spike in short term sickness in January due to the Omicron variant which has now settled. Long term sickness absence levels remain above pre pandemic levels however it is on an overall downward trend. Focussed work is being undertaken within clinical areas for services with consistently high sickness absence levels to ensure that cases are being managed and staff are supported as well as ensuring managers feel confident and are equipped to manage sickness absence.

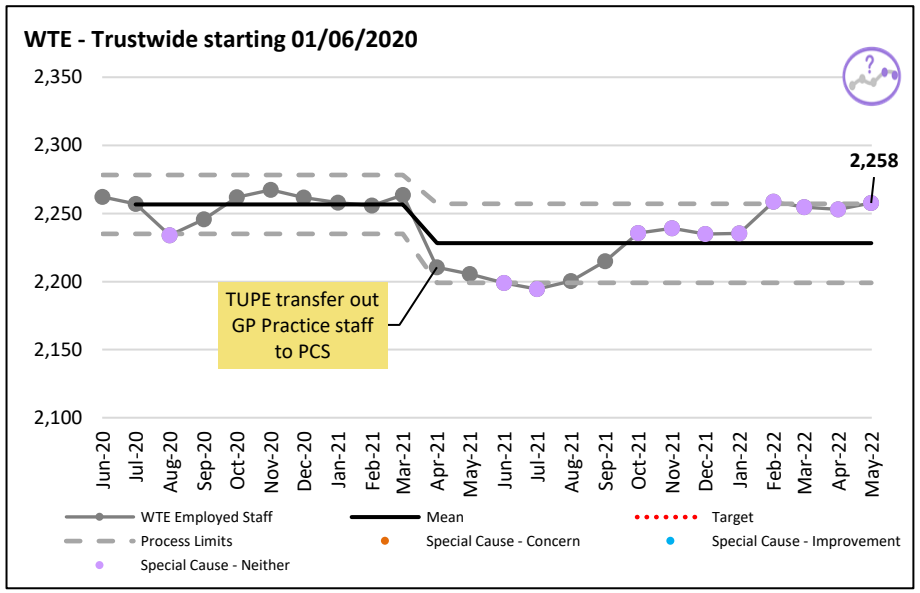
Top 3 reasons for absence remain:

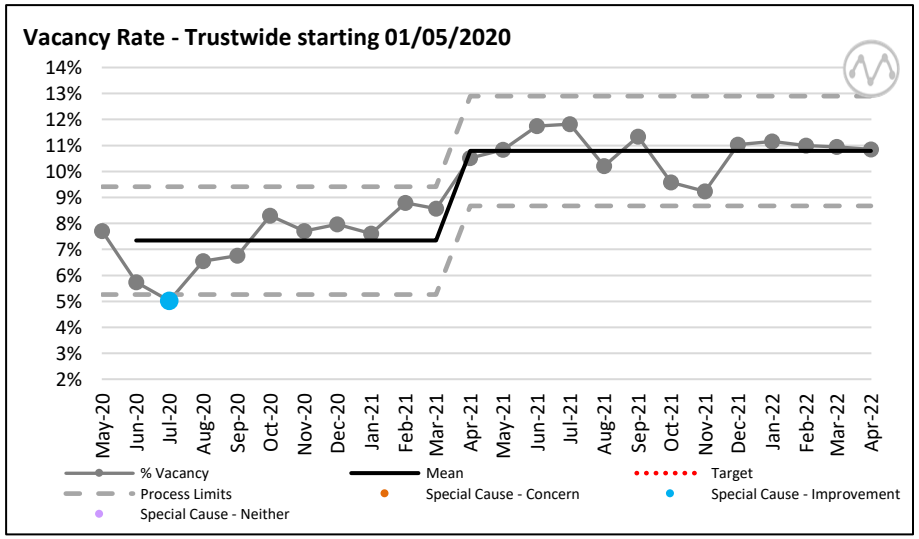
1. Anxiety/depression/stress
2. Infectious diseases
3. Musculoskeletal

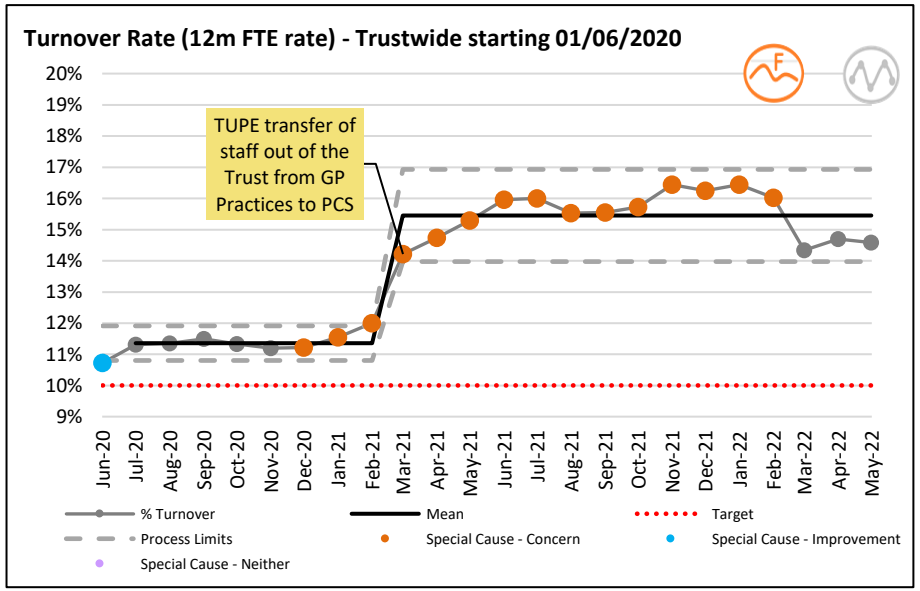
Our overall monthly absence rates track closely with the average for North East Yorkshire in June 2021 at 5.2%

Well-Led | Staffing









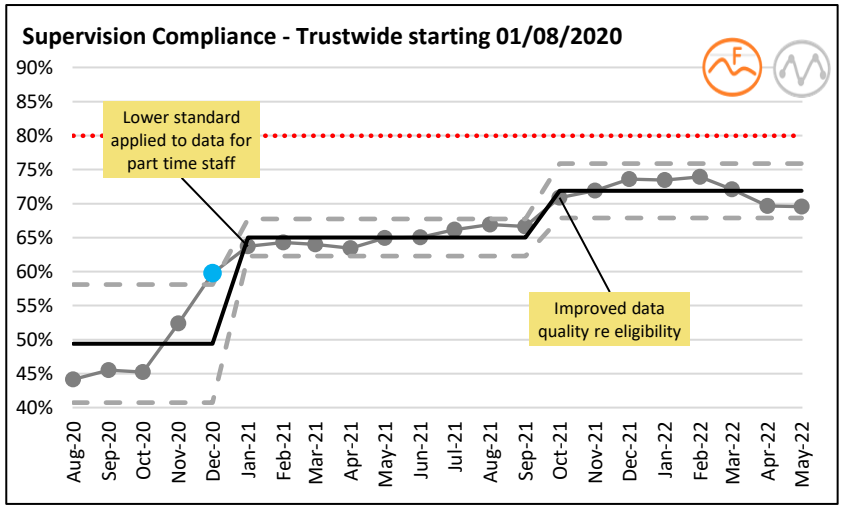
Data had been refreshed from April 2021; process limits recalculated to reflect the change. Included in this data are relinquished hours due to flexible working requests and are not vacancies.

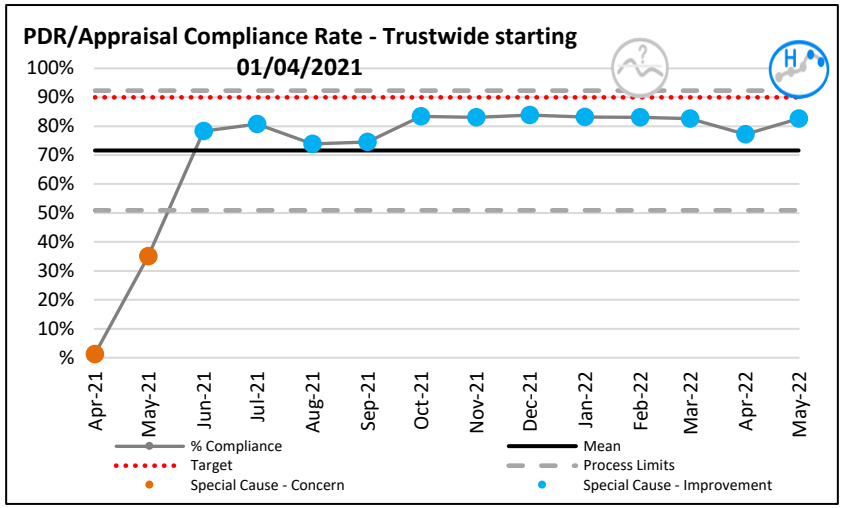
Narrative

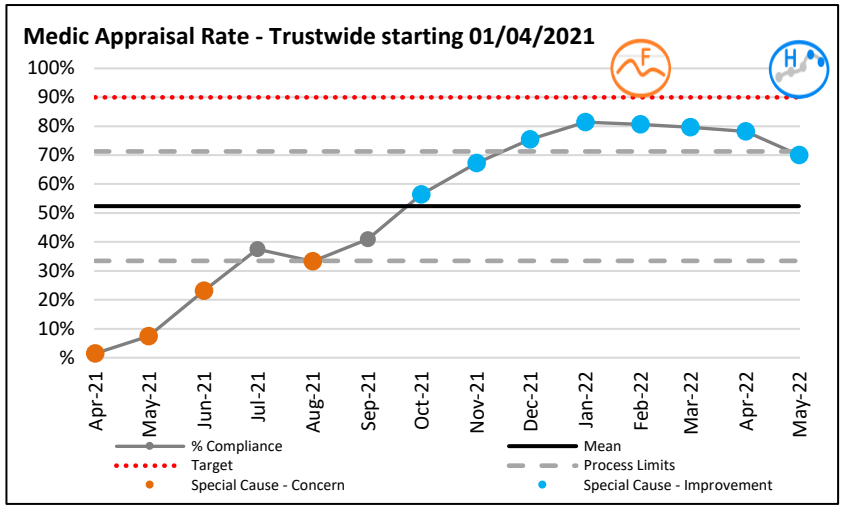
The headcount and vacancy rate remains stable across the Trust. Turnover has reduced over the last quarter however remains higher than the Trust target. As headcount remains stable this demonstrates that we are managing to recruit to fill the gap left by turnover.

There continues to be a focus to improve data quality for reporting to support strategic decision making on recruitment strategies.

Well-Led | Supervision & PDR/Appraisal







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.

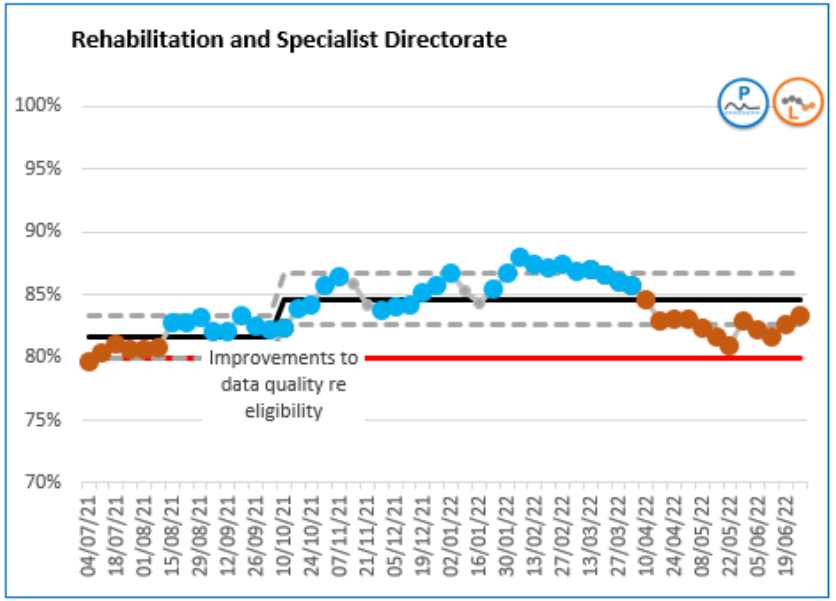
NARRATIVE

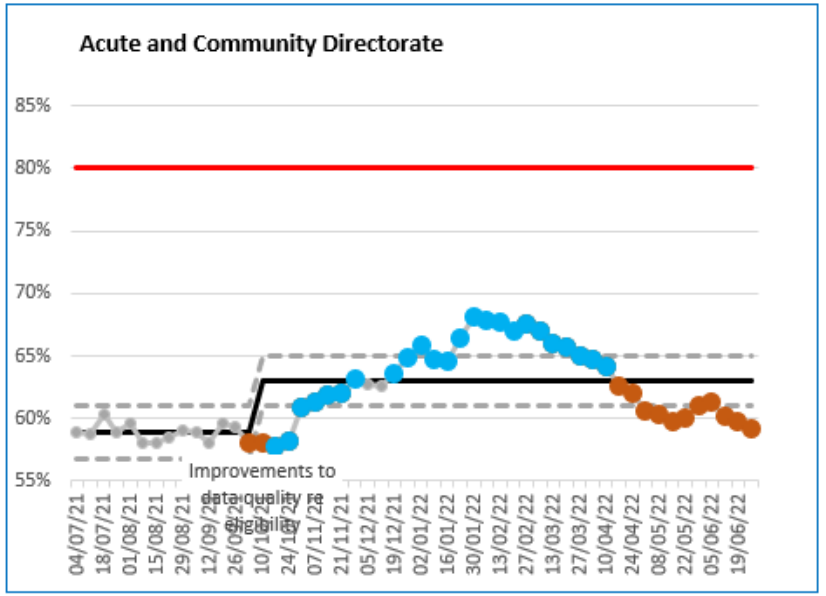
As at 29 May 2022, average compliance with the 8/12 target is:

Trustwide	**69.57%**
Clinical Services	**68.38%**

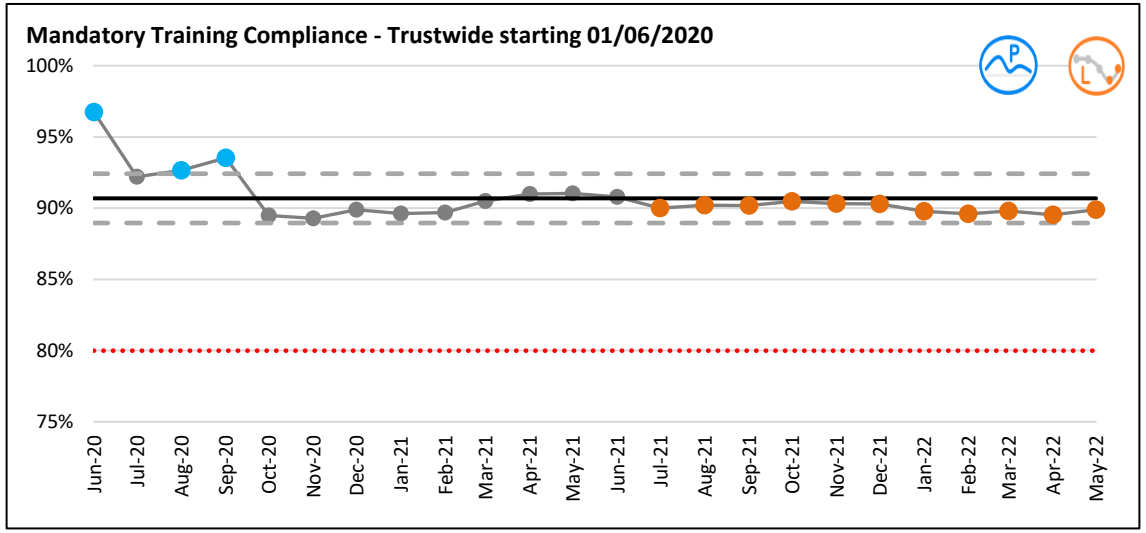
Weekly updated information is monitored and reviewed weekly by Directors and Service Leads. Clinical Directorate Service Lines and teams performance is monitored each month at Directorate IPQR reviews; Corporate Services at triannual performance reviews.

A recovery plan is in action for our acute and PICU wards, monitored through the Back to Good Programme Board.





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 and Information Governance where 95% compliance is required.

COMPLIANCE	**Week ending 29/05/22**
Trustwide	**89.88%**
Directorate/Service Line	
Corporate Services	86.86%
Medical Directorate	92.74%
Acute & Community – Crisis	91.18%
Acute & Community – Acute	90.88%
Acute & Community – Community	93.73%
Acute & Community – Older Adults	86.11%
Rehab & Specialist – Forensic & Rehab	91.69%
Rehab & Specialist – Highly Specialist	94.23%
Rehab & Specialist – Learning Disabilities	94.58%
Rehab & Specialist – IAPT	94.01%
Rehab & Specialist – START	88.66%

NARRATIVE
Mandatory training compliance is monitored closely at clinical team governance and through clinical Directorate IPQR meetings. Corporate services report their mandatory training position in to triannual Performance Reviews.

EXCEPTIONS
The teams or services detailed below are under 80% compliance target as at 29 May 2022. The following subjects are also below targeted compliance levels.
We have a target of getting back to above compliance targets for the 5 subjects below by end of June through the Back to Good programme which is closely monitored.

Date of Data >	**03-Apr**	**01-May**	**29-May**
Team/Service	Compliance	Compliance	Compliance
Chair, Chief Exec Office	76.82%	77.42%	78.98%
Grenoside Facilities	71.20%	61.81%	55.97%
Woodland View	79.44%	79.47%	78.58%

		01 May 2022		**29 May 2022**		
Subject	**Level**	No NOT Achieved	Compliance	No NOT Achieved	Compliance	Comments
Information Governance (aka Data Security Awareness)		466	82.24%	424	83.81%	95% target
Immediate Life Support		45	78.67%	46	78.20%	80% target
Respect	2	223	72.64%	208	74.35%	80% target
	3	92	73.41%	72	79.25%	80% target
Safeguarding Children	3	290	73.66%	273	75.05%	90% target

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Financial Performance

IPQR - Information up to and including May 2022

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Executive Summary

KPI	Annual Plan £'000	Year to Date Plan £'000	Year To Date Actual £'000
Surplus/Deficit	(2,718)	(684)	(329)
Covid Expenditure	1,178	196	232
Agency	4,424	853	1,364
Cash	61,938	59,016	57,392
Efficiency Savings	3,540	590	251
Capital	10,500	1,759	942
Better Payments Practice Code	99.1% by Number 99.6% by Value		

Summary at May 2022:

- Initial reporting in M2 was to a planned annual deficit position of £2.7m. This figure has driven the YTD planned deficit of £684k. However, the plan has subsequently changed to £1.7m deficit and then a further change was made to break even. The planned YTD figure will be updated in M3 to reflect this.
- A reported deficit of £329k at m2 was favourable to the initial plan but is likely to be adverse to the revised plan.
- Covid expenditure will still be monitored in the current financial year. It is currently adverse to plan.
- Planned agency spend for 22-23 is approximately £1.5m lower than 21-22 plan. This is primarily due to CIP aspirations. The Trust is currently spending £511k more than plan. Agency caps have not yet been determined by NHSIE but will be reintroduced later in the financial year.
- CIP savings have commenced delivery but are significantly short when compared to plan. Most schemes are planned to deliver towards the latter end of the year. The CIP requirement will be increased following the revised plan to break even.
- Capital is underspending against plan, but this trend has been seen in previous financial years with schemes spending significantly more int eh second half of the financial year.

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

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Mental Health Delivery Plan 2022/23

IPQR - Information up to and including May 2022

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Well-Led | Long Term Plan Delivery

			National Reporting					Local Reporting					
Indicator Ref	**Measure Name**	**Responsible Provider (Sheffield)**	**Level reported at**	**Reporting interval**	**National Report Source**	**National Reported Performance**	**Data as at**	**Target 22/23**	**Monthly Target (where applicable)**	**May 22 (where applicable)**	**IPQR Ref**	**Target 21/22**	**Reported Performance**
E.A.3a	Total access to IAPT services	SHSC	ICS	Quarterly	IAPT Dataset	N/A	Not yet available for 22/23	17,183	1432	1197	IAPT	14782	13999
E.H.4	First Episode Psychosis treatment with NICE recommended package of care within two weeks of referral	SHSC	ICS	Rolling 3 month	MHSDS	N/A	Not yet available for 22/23	≥ 60%	60%	70%	Treatment & Intervention	≥ 60%	57%
E.H.12	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	SHSC	Provider/ICS	Rolling 3 month	CAP and MHSDS	N/A	Not yet available for 22/23	Reduce total bednights in year to 4165 from 5556	[May 22] 400	519	Inpatient Services	2478	5556
E.H.15	Women Accessing Specialist Community Perinatal Mental Health Services	SHSC	ICS	Cumulative financial year to date	MHSDS	N/A	Not yet available for 22/23	TBC	TBC	TBC	Access & Demand	TBC	TBC
E.H.22	Mental Health Services Dataset - Data Quality Maturity Index Score	SHSC	Provider/ICS	Monthly	MHSDS	N/A	Not yet available for 22/23	≥ 90%	≥ 90%	National Reports available 2-3 months in arrears	N/A	≥ 80%	91.3% (Mar 22 National Reported)
E.H.27	Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Multiple Partners including SHSC	ICS	Rolling 12 month	MHSDS	N/A	Not yet available for 22/23	TBC	TBC	TBC	Access & Demand	TBC	TBC
E.H.30	Adult mental health inpatients receiving a follow up within 72hrs of discharge	SHSC	Provider/ICS	Monthly	MHSDS	N/A	Not yet available for 22/23	≥ 80%	≥ 80%	92%	Treatment & Intervention	≥ 80%	78.50%

Narrative

This page demonstrates how performance against the targets in the Mental Health Delivery Plan for 2022/23 is progressing throughout the year. The metrics displayed above are those that SHSC is responsible for delivery of, either as the single provider or in partnership with other providers. The Performance Team, Planning and Informatics colleagues are working together to ensure that internally information is recorded and reported accurately so that external reporting is submitted as required in line with the national reporting requirements.

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Report ends
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Appendix 1 | SPC Explained

An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data which are unlikely to have occurred due to chance and require investigation. They can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting the target without a change.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

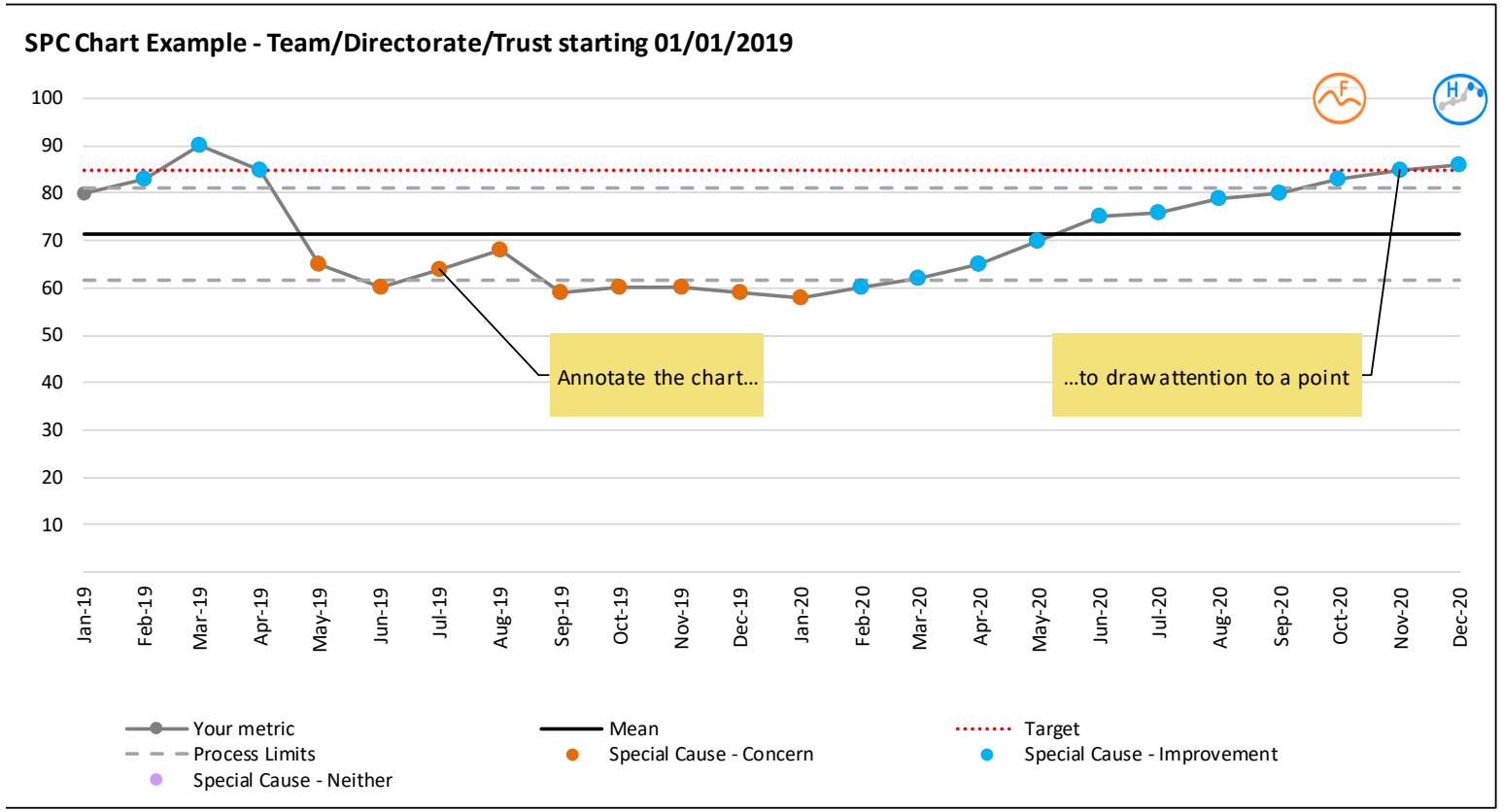
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	Variation Icons **The icon which represents the last data point on an SPC chart is displayed.**						**Assurance Icons** **If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.**		
ICON									
SIMPLE ICON	● ● ●	● ? H L ●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2 | SHSC SPC Chart Anatomy

Chart Title	SPC Chart Example
Team/Service	Team/Directorate/Trust
Your Measure	Your metric
Improvement Indicator	High is Good
Target	85

Start Date	01/01/2019	
Duration	24	Months
Baseline		
Min Value	0	
Max Value	100	



Observations

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

Single Point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There are 6 points above the UCL and 7 points below the LCL.
Trend	When there is a run of 6 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control.

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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	People
Well-Led | Financial Performance | Overview	32	Finance
Well-Led | Covid 19 Response	34	Quality
Well-Led | Covid 19 Demand Impact	35	Finance/ Quality
Well-Led | Mental Health Delivery Plan	37	Finance/ Quality
Well-Led | CQUiN	39	Quality

Colour Key	F	M	P	Q
Finance				
MH Legislation				
People				
Quality				

Blue Underlined Text = Click to link to slide/page