Board of Directors - Public

SUMMARY REPORT	Meeting Date:	September 2022
	Agenda Item:	12

Report Title:	**Integrated Performance and Quality Report (IPQR) July 2022**	
Author(s):	Business and Performance Team	
Accountable Director:	Phillip Easthope, Executive Director of Finance, IMST & Performance	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee Finance and Performance Committee People Committee
	Date:	13 September 2022 14 September 2022 15 September 2022
Key points/ recommendations from those meetings	**Quality Assurance Committee** The Committee noted the persistent risks in relation to waiting lists, completion of CPA reviews and out-of-area placements. The Committee was incompletely assured of the impact of the interventions underway and raised an alert to the Board. The Committee was pleased to note more timely reviewing of incidents and reduced assaults on staff during the reporting period, and that there were no A&E breaches in June 2022. The Committee requested that information in the report be presented in a way to show progress against the Long-Term Plan. **Finance & Performance Committee** noted the static nature of existing issues and risks and were assured that recovery plans are in place. However progress was challenging, noting links to key CIP programmes and patient safety risks. Further work was required to identify expected impact and to provide assurance regarding contractual governance arrangements through Business Planning Group. **People Committee** Supervision and mandatory training remain an issue. Performance data is much improved and the TRAC recruitment system is indicating where there are blocks in the process to enable action to be taken to reduce time to hire. Committee noted the overall reduction in long term absence and need to continue focused action on reduction in short term absence.	

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 July 2022.

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

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	***Yes***	✓	*No*	
CQC Getting Back to Good – Continuing to improve	***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 Fundamental Standards	***Yes***	✓	*No*		This report ensures compliance with NHS Regulation – CQC Regulation may be a by- product of this.
Data Security and Protection Toolkit	*Yes*		***No***	✓	
Any other specific standard?					

Have these areas been considered? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*	✓	*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
Organisational Development /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*	✓	
Sustainability	*Yes*		*No*	✓	

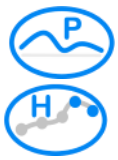
Integrated Performance and Quality Report (IPQR) July 2022

Section 1: Analysis and supporting detail

Background

1.1 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 July 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	4		Increasing referrals to Short Term Education Programme (STEP) and the Homeless Assessment Service (HAST)	
F	Q			Inpatient Live Length of Stay – Older Adults OOA – Older Adults	8		Decreasing trend in Older Adult inpatient ward Dovedale 1 No inappropriate OOA admissions since February 2022	
F	Q			Inpatient Length of Stay – Forest Close & Forest Lodge	9		Performance above national benchmarks	
F	Q			HBPoS bed use	10		Not enough data points for SPC but reduction in the number of HBPoS beds being blocked due to mental health ward admissions.	
F	Q			A&E Breaches	11		There were no A&E Breaches in July 2022.	
F	Q			Annual CPA Review	12		Improving Performance in Recovery North and Recovery South	
F	Q			IAPT	13		Meeting/exceeding targets for waiting times 6 week wait times being met and increasing % meeting target	

Good Performance						
Committee				KPI/Area	Refer to (slide)	Current Performance	Trend/Trajectory	Recovery Plan?
	Q	P		Open Serious Incidents & Unreviewed Incidents	17		Improvement to number of unreviewed incidents and decrease in outstanding SI actions overdue.	
	Q	P		Assaults on Staff	19		Trustwide – low number of Assaults of Staff reported	
		P		Long term sickness	26		Low long term sickness Trustwide	
	Q	P		Supervision	29		Rehabilitation & Specialist service area meeting target	

Areas of interest								
Committee				KPI/Area	Refer to (slide)	Performance	Trend/ Trajectory	Recovery Plan?
F	Q			Referrals	4		Liaison Psychiatry referrals – the last 12 months of referrals are below the 36 month average SPS & Gender referrals low Referrals into AMHP service low	
F	Q			Caseloads/ Open Episodes	5		Recovery North, Early Intervention, SPS PD and MAPPS all low.	
F	Q			Bed Occupancy excl. Leave	6		Across adult acute wards bed occupancy excl. leave is high	
F	Q			Inappropriate OOA bed nights	7		Low for PICU	
F	Q			Live Length of Stay – Forest Lodge Bed Occupancy incl. leave	9	 	Current live length of stay higher than normal Bed Occupancy low on Forest Lodge	
	Q			Incidents reported as Catastrophic impact	17		High number of catastrophic incidents reported	
		P		Headcount/WTE	26		Increase in staff numbers	
	Q	P		COVID-19	34		There were 7 outbreaks in July 2022.	

Section 2: Risks

Performance Concern							
Committee				**KPI/Area**	**Refer to (slide)**	**Performance**	**Trend/ Trajectory**	**Recovery Plan?**
F	Q			Demand for Services	4		Increasing trend noted for SAANS	
F	Q			Waiting Lists and Waiting Times	5		Increasing trend/sustained high waits in certain areas noted	Recovery Plan x 2 (EWS, Recovery Teams)
F	Q			Caseloads/Open Episodes	5		Increasing trend in older adult CMHT and Highly Specialist community services	Recovery Plan x 2 (Gender & SAANS)
F	Q			Admissions & Discharges	6		Adult Acute Admissions and Discharges low	
F	Q			Bed Occupancy	6		Bed Occupancy at Beech – (Wainwright Crescent) low - Related to planned premises move.	
F	Q			Length of Stay and Delayed Discharge (inpatient areas)	6-7		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	6-7		Failing to meet reduction/elimination of inappropriate OAPs in acute	Out of Area Recovery Plan(s) x 3
F	Q			Annual CPA Review	12		Failing to meet 95% target EIP 88.3% Recovery N 87.5% Recovery S 79.8%	Recovery Plan in place.
F	Q			START	14		Not meeting the target for opiate assessments to be completed within 7 days.	
	Q		M	Restrictive practice incidents	21-23		High number of physical restraints on Maple Ward. High number of HBPoS seclusion incidents	
		P		Sickness Absence	26		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	30		Underperformance against 80/90/95% targets in some areas	
F				Agency and Out of Area Placement Spend	32		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

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Integrated Performance & Quality Report

Information up to and including July 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 July 2022

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Responsive | Access & Demand | Referrals

Referrals	Jul-22			
Acute & Community Directorate Service	n	mean	SPC variation	Note
SPA/EWS	611	708	• • •	The baseline has been re-calculated twice. Once for Covid and once for Safeguarding referrals being moved to the Safeguarding team.
AMHP	152	155	• L •	Central AMHP team baseline was re-calculated May 2020 due to the sustained increase in referrals. The AMHP team were significantly impacted by the availability of other services due to Covid as well as increased Police availability. Referrals look to be returning to pre-Covid levels and we will consider the need to re-calculate the baseline again.
Crisis Resolution and Home Treatment	1030	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	508	517	• L •	
Decisions Unit	51	57	• • •	The baseline has been re-calculated twice. Once for partial re-opening during Covid and once for full re-opening.
S136 HBPOS	40	33	• • •	
Recovery Service North	21	28	• • •	
Recovery Service South	30	27	• • •	
Early Intervention in Psychosis	40	43	• • •	
Memory Service	134	132	• • •	The baseline has been re-calculated twice. Once for Covid and once for sustained increase in referrals.
OA CMHT	256	241	• • •	
OA Home Treatment	28	29	• • •	

Referrals	Jul-22			
Rehab & Specialist Service	n	mean	SPC variation	Note
CERT	1	3	• • •	
SCFT	0	1	• • •	
CLDT	60	50	• • •	CLDT figures represent distinct individuals so does not include multiple referrals per service user.
CISS	2	4	• • •	
Psychotherapy Screening (SPS)	45	63	• L •	
Gender ID	31	58	• L •	
STEP	97	71	• H •	
Eating Disorders Service	30	28	• • •	
SAANS	401	344	• H •	There has been exponential demand over the last two years, the baseline has been recalculated from Jan 2021 to reflect this
R&S	19	26	• • •	
Perinatal Service (Sheffield)	66	54	• • •	
HAST	15	10	• H •	
Health Inclusion Team	159	Insufficient data points to create SPC charts.		
LTNC - NES	26			
LTNC - Case Management	14			
SCBIRT	2			

Responsive | Access & Demand | Community Services

July 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	611	*708*	•••	1088	*1028*	•H•	34.5	*24.8*	•H•	23	*28.2*	•••	900	*921*	•••
AMHP	152	*155*	•L•												
Liaison Psychiatry	508	*517*	•L•												
Decisions Unit	51	*57*	•••		*N/A*			*N/A*			*N/A*			*N/A*	
S136 HBPoS	40	*33*	•••												
Crisis Resolution Home Treatment	1030														
MH Recovery North	21	*28*	•••	95	*40*	•H•	10.3	*4.9*	•H•	*9.6*	*10.1*	•••	959	*976*	•L•
MH Recovery South	30	*27*	•••	106	*49*	•H•	9.2	*7.1*	•••	11.5	*12.2*	•••	1080	*1074*	•H•
Recovery Service TOTAL	51			201	*86*	•H•		*N/A*			*N/A*		2039	*2050*	•L•
Early Intervention in Psychosis	40	*43*	•••	13	*21*	•••				95.0%			304	*364*	•L•
Memory Service	134	*132*	•••	911	*442*	•H•	25.3	*17.5*	•••	27.6	*26.0*	•H•	4744	*4129*	•H•
OA CMHT	256	*241*	•••	224	*122*	•H•	6.9	*6.1*	•••	10.7	*10.4*	•••	1275	*1217*	•H•
OA Home Treatment	28	*29*	•••		*N/A*			*N/A*			*N/A*		60	*61*	•••
Rehab & Specialist Services	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**
IAPT	1219	*1484*	•••												
SPS (Screening)	45	*63*	•L•		*N/A*			*N/A*			*N/A*			*N/A*	
SPS - MAPPS				66	*62*	•H•	17.1	*21.6*	•L•	82.9	*73.8*	•••	279	*305*	•L•
SPS - PD		*N/A*		32	*58*	•L•	12.3	*16.8*	•••	82.8	*69.3*	•••	189	*205*	•L•
Gender ID	31	*58*	•L•	1716	*1399*	•H•	78.8	*112.3*	•••		*N/A*		2558	*2184*	•H•
STEP	97	*71*	•H•	100	*81*	•••		*N/A*		2.9	*3.7*	•L•	349	*360*	•••
Eating Disorders	30	*28*	•••	25	*28*	•••	4.4	*4.6*	•••				221	*200*	•H•
SAANS	401	*174*	•H•	5315	*3739*	•H•	106.6	*90.1*	•H•				5713	*4489*	•H•
R&S	19	*26*	•••	97	*191*	•H•							203	*222*	•••
Perinatal MH Service (Sheffield)	*66*	*54*	•••	29	*21*	•••	3.2	*2.6*	•••				168	*136*	•H•
HAST	15	*10*	•H•	31	*31*	•••	5.3	*9.2*	•••				81	*84*	•••
Health Inclusion Team	159			159			6.7				*N/A*		1487		
LTNC - NES	26			37			16.3						418		
LTNC - Case Management	14			15			2.0						137		
SCBIRT	2			10			7.4						141		
CFS/ME	82				*N/A*		19.6						2831		
CLDT	60	*50*	•••	172	*196*	•L•	25.8	*21.2*	•••	25.0	*24.2*	•••	789	*856*	•••
CISS	2	*4*	•••		*N/A*			*N/A*					39	*32*	•••
CERT	1	*3*	•••								*N/A*		47	*46*	•••
SCFT	0	*1*	•••	1									24	*23*	•H•

Narrative

Whilst 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). Recovery Plans are in place for the services experiencing the biggest issues although these aren't currently leading to improvement. There is a detailed set of reports on waiting times in the August QAC.

Safe | Inpatient Wards | Adult Acute & Step Down

Adult Acute (Burbage/Dovedale 2, Stanage, Maple)	Target or Benchmark	Jul-22 n	Jul-22 mean	Jul-22 SPC variation
Admissions	TBC	**33**	*35*	• L •
Detained Admissions	/	**31**	*30*	• • •
% Admissions Detained	50%	**93.9%**	*88.9%*	• • •
Emergency Re-admission Rate (rolling 12 months)	10.3%	**5.4%**	*4.2%*	• H •
Discharges	TBC	**31**	*35*	• L •
Delayed Discharge/Transfer of Care (number of delayed discharges)	TBC	**12**		
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	TBC	**166**		
Bed Occupancy excl. Leave (KH03)	86.4%	**95.5%**	*94.0%*	• H •
Bed Occupancy incl. Leave	95%	**100.5%**	*98.3%*	• • •
Average beds admitted to	/	**48**		
Average Discharged Length of Stay (12 month rolling)	32	**40.9**	*36.9*	• H •
Live Length of Stay (as at month end)	/	**66.6**	*54.2*	• H •
Number of People Out of Area at month end	/	**12**	*12*	• • •
Number of Mental Health Out of Area Placements started (admissions)	/	**9**	*8*	• • •
Total number of Out of Area bed nights in period (Inappropriate)	258	**335**	*311*	• • •

Length of Stay Detail
Longest LoS (days) as at month end: **243** on Dovedale 2, **243** on Maple and **273** on Stanage
Range = 0 to 273 days
Number of discharges in month: 31, plus 6 transfers out
Longest LoS (days) of discharges in month: **221** on Dovedale 2, **190** on Maple and **183** on Stanage

Narrative

Stanage longest stay looking to support independent living (with 24 hour care). Discussed in Needs & Risk forum.
Dovedale 2 Accepted at Forest close for rehab, waiting for bed to come available.
Maple longest Stay – 24/7 placement agreed by high cost panel. Awaiting assessment from providers.

Step Down (Beech formerly Wainwright Crescent)	Target or Benchmark	Jul-22 n	Jul-22 mean	Jul-22 SPC variation
Admissions	/	**5**	*5*	• • •
Discharges	/	**0**	*6*	• • •
Bed Occupancy excl. Leave (KH03)	/	**67.2%**	*77.4%*	• • •
Bed Occupancy incl. Leave	/	**72.0%**	*85.9%*	• L •
Average Discharged Length of Stay (12 month rolling)	/	**66.0**	*65.2*	• • •
Live Length of Stay (as at month end)	/	**30.2**	*39.6*	• • •

Length of Stay Detail
Longest LoS (days) as at month end: **66**
Range = 6 to 66 days
Number of discharges in month: 0
Longest LoS (days) of discharges in month: **N/A**

Narrative

Wainwright moved to Beech on 5th July.

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

PICU (Endcliffe)	Target or Benchmark	Jul-22 n	Jul-22 mean	Jul-22 SPC variation
Admissions	TBC	**6**	*3*	• • •
Discharges	TBC	**3**	*2*	• • •
Delayed Discharge/Transfer of Care (number of delayed discharges)	TBC	**1**		
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	**31**		
Bed Occupancy excl. Leave (KH03)	84%	**93.5%**	*90.3%*	• • •
Bed Occupancy incl. Leave	95%	**93.5%**	*93.0%*	• • •
Average beds admitted to	/	**9**		
Average Discharged Length of Stay (12 month rolling)	47	**48.0**	*51.7*	• • •
Live Length of Stay (as at month end)	/	**98.1**	*83.3*	• H •
Number of People Out of Area at month end	/	**3**	*5*	• • •
Number of Mental Health Out of Area Placements started (admissions)	/	**3**	*3*	• • •
Total number of Out of Area bed nights in period (Inappropriate)	111	**0**	*118*	• L •

Narrative

As at 31/7/22, there were 4 service users on Endcliffe Ward with a length of stay over the national average (benchmarked) of 47 days.

The significant long stay is being regularly reviewed. A funding application was rejected for long term placement but this still remains the most suitable placement.

The long term segregation for one person was ended on the 4th July 2022.

Length of Stay Detail
Longest LoS (days) as at month end: **544**
Range = 1 to 544 days
Number of discharges in month: 3 discharge plus 4 transfers
Longest LoS (days) of discharges in month: **60**

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)	@ Benchmark	Jul-22 n	Jul-22 mean	Jul-22 SPC variation
Admissions	/	5	5	• • •
Discharges	/	7	6	• • •
Delayed Discharge/Transfer of Care (number)	TBC	1		
Delayed Discharge/Transfer of Care (bed nights occupied)	TBC	31		
Bed Occupancy excl. Leave (KH03)	75.8%	91.0%	91.8%	• • •
Bed Occupancy incl. Leave	95%	96.3%	96.7%	• • •
Average beds admitted to	/	14		
Average Discharged Length of Stay (12 month rolling)	73	69.2	70.7	• • •
Live Length of Stay (as at month end)	/	67.6	89.3	• L •

Length of Stay Detail – Dovedale 1
Longest LoS (days) as at month end: **355**
Range = 3 to 355 days
Number of discharges in month: 7 plus 1 transfer
Longest LoS (days) of discharges in month: **148**

Older Adult Dementia (G1)	Target or Benchmark	Jul-22 n	Jul-22 mean	Jul-22 SPC variation
Admissions	/	6	5	• • •
Discharges	/	4	4	• • •
Delayed Discharge/Transfer of Care (number)	TBC	6		
Delayed Discharge/Transfer of Care (bed nights occupied)	TBC	122		
Bed Occupancy excl. Leave (KH03)	75.8%	64.1%	68.5%	• • •
Bed Occupancy incl. Leave	95%	67.5%	70.4%	• • •
Average beds admitted to	/	11		
Average Discharged Length of Stay (12 month rolling)	73	65.2	65.2	• • •
Live Length of Stay (as at month end)	/	68.8	50.2	• • •

Length of Stay Detail – G1
Longest LoS (days) as at month end: **158**
Range = 1 to 158 days
Number of discharges in month: 4 plus 2 transfers
Longest LoS (days) of discharges in month: **68**

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 February 2022.

Older Adult Out of Area Placements	Target or Benchmark	Jul-22 n	Jul-22 mean	Jul-22 SPC variation
Number of People Out of Area at month end	/	0	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	57	• 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	Jul-22 n	mean	SPC variation	SPC target
Admissions	/	1	1	• • •	/
Discharges	/	2	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%	88.4%	80.7%	• • •	?
Bed Occupancy incl. Leave	95%	93.7%	92.5%	• • •	?
Average discharged length of stay (12 month rolling)	441	279.9	300.7	• • •	P
Live Length of Stay (as at month end)	/	315.0	332.6	• • •	/
Number of people in Out of Area beds at month end	0	8			
Number of Mental Health Out of Area Placements started (admissions)	0	1			
Total number of Out of Area bed nights in period (Inappropriate)	0	0			

Forensic Low Secure (Forest Lodge)	Target or Benchmark	Jul-22 n	mean	SPC variation	SPC target
Admissions	/	2	1	• • •	/
Discharges	/	2	1	• • •	/
Bed Occupancy excl. Leave (KH03)	89%	85.6%	84.3%	• • •	?
Bed Occupancy incl. Leave	95%	87.1%	91.1%	• L •	?
Average discharged length of stay (12 month rolling)	707	465.0	419.9	• • •	P
Live Length of Stay (as at month end)	/	577.6	475.6	• H •	/

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

Long stays - Close
Two people have a length of stay over the national average (benchmarked) of 441 days. The Director of Nursing will provide the committee with further information.

Out of Area Rehab
All Out of Area rehab admissions are deemed appropriate. At the end of July 2022 there were 8 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. There is consideration for another from Forest Close and are awaiting assessment from Cygnet due to family member working in the clinical area.

Length of Stay Detail - Forest Close (all)
Longest LoS (days) as at month end: **746**
Range = 19 to 746
Number of discharges in month: 2 plus 3 transfers
Longest LoS (days) of discharges in month: **528**

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

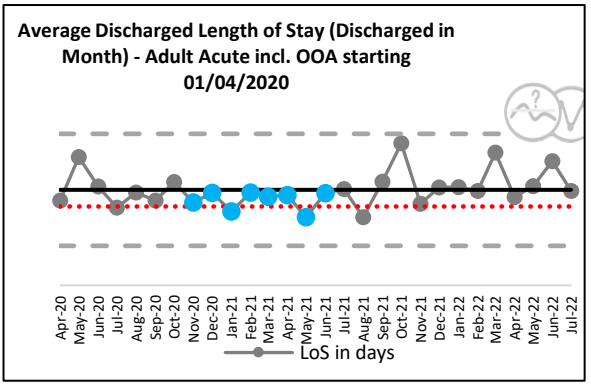
Forest Lodge
Length of stay within Forest Lodge benchmarks very favourably against other low secure facilities across the country.

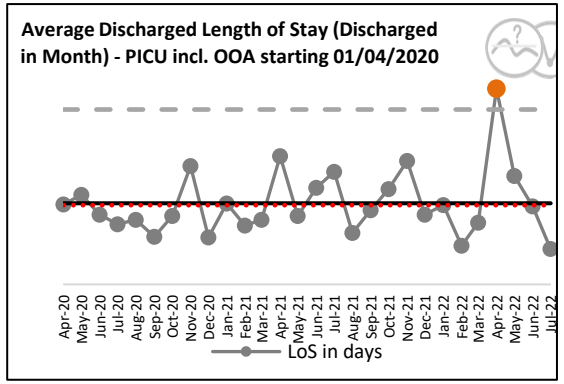
Length of Stay Detail – Forest Lodge
Longest LoS (days) as at month end: **832**
Range = 2 to 832 days
Number of discharges in month: 2 plus 2 transfers
Longest LoS (days) of discharges in month: **793**

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

UEC Dashboard

Length of Stay

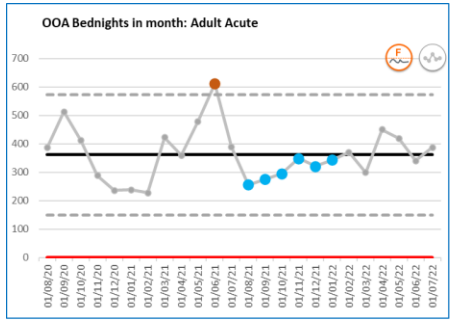


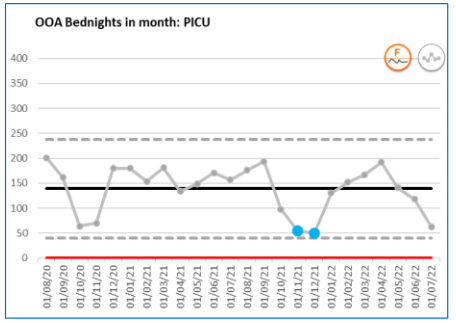


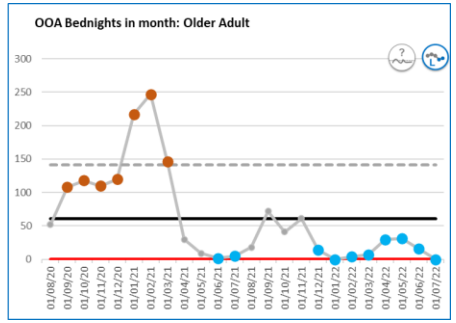
Adult Acute Discharged LoS (Rolling 12 month average)		
Location	**Total Discharges**	**Average Discharged LoS**
Sheffield	389	41
OOA	94	40
Contracted	88	45
Combined	**571**	**41**

PICU Discharged LoS (Rolling 12 month average)		
Location	**Total Discharges**	**Average Discharged LoS**
Sheffield	67	48
OOA	38	43
Combined	**105**	**46**

Out of Area

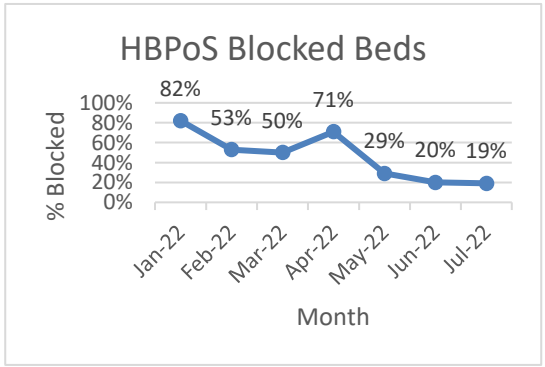


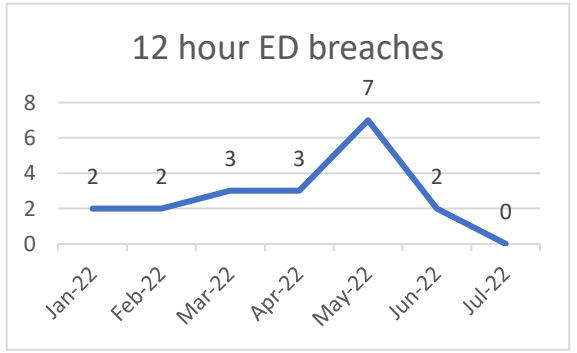




Provider	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Sparklines (Jul-21 to Jun-22)
Sheffield Health and Social Care NHS Foundation Trust	**11**	**16**	**15**	**16**	**11**	**17**	**13**	**13**	**21**	**14**	**11**	**11**	
Bradford District Care NHS Foundation Trust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

Blocks and Breaches

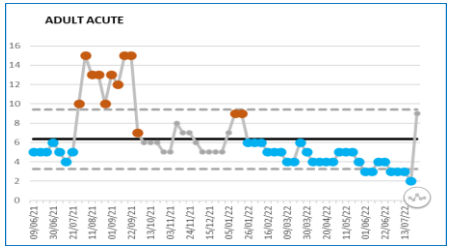


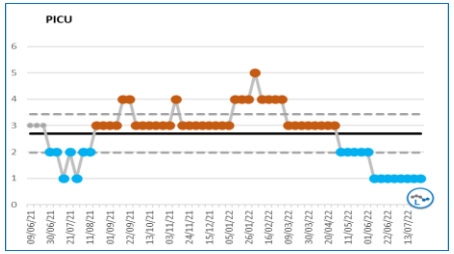


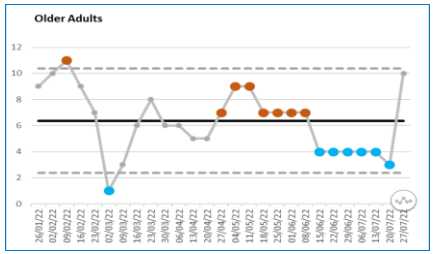
Health Based Place of Safety (HBPoS/136 Beds)	Jul-22
Weekday beds blocked	8
Weekday beds blocked %	19%

Emergency Department (ED)	Jul-22
ED 12 hour Breaches	0

Delayed Care







Delayed Discharges Adult Acute			
	Count of Delayed Patients	Sum of Delayed Bednights	% Bednights occupied by DD
Dovedale 2	4	46	12.4%
Maple Ward	3	47	8%
Stanage Ward	5	73	14.7%
Adult Acute Total	12	166	11.4%

Delayed Discharges PICU			
	Count of Delayed Patients	Sum of Delayed Bednights	% Bednights occupied by DD
Endcliffe	1	31	10%

Delayed Discharges Older Adult			
	Count of Delayed Patients	Sum of Delayed Bednights	% Bednights occupied by DD
Dovedale 1	1	31	6.7%
G1	6	122	24.6%
Older Adult Total	7	153	15.9%

Safe | Inpatient Wards | Learning Disabilities (Firshill)

Section intentionally blank.
Learning Disabilities Inpatient Service currently closed.

Narrative

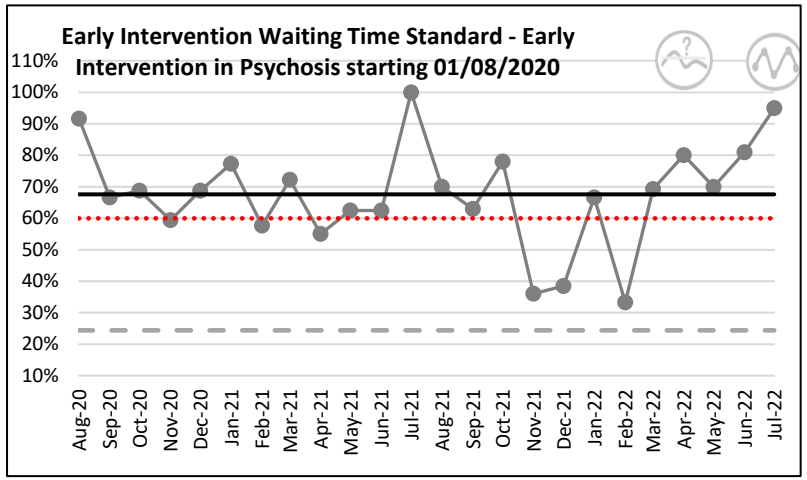
The final service user was discharged from Firshill ATS on 2 September 2021. The service is currently undergoing a period of review and training.

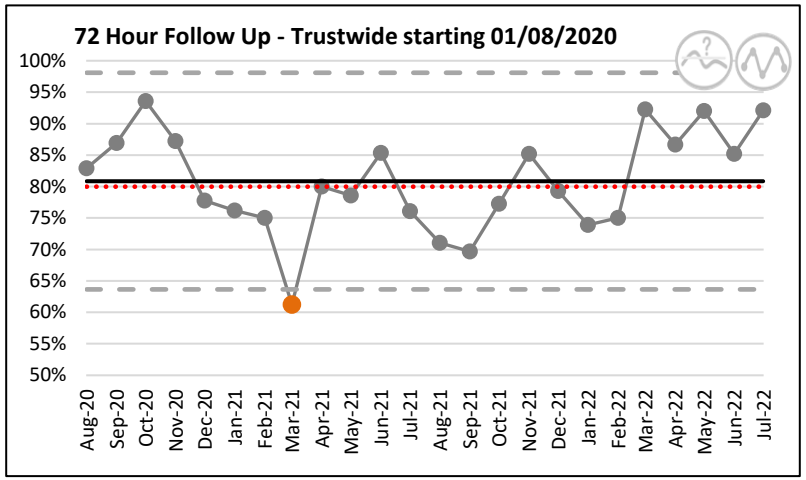
Of note during July 22:

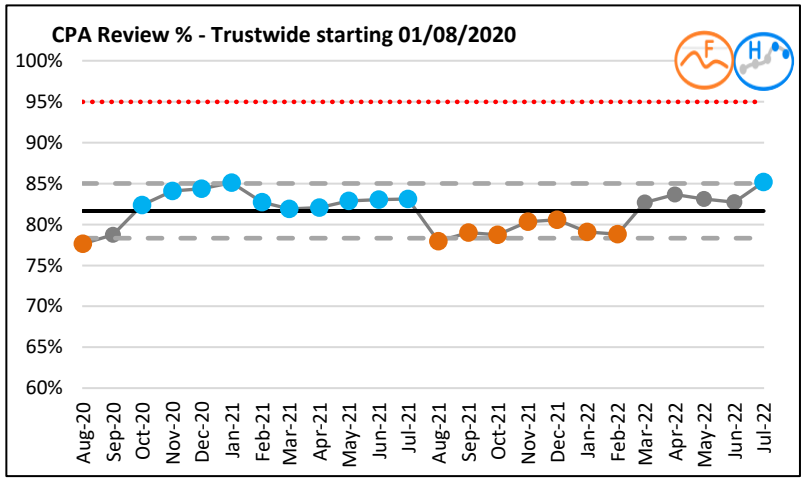
The new clinical model has been co-produced and co designed with workforce planning and modelling currently ongoing. The proposed model has been presented at QAC and Trust Board with full support and a final paper will be taken to Finance committee in September.

A meeting is to take place with NHS South Yorkshire ICB to discuss inpatient beds for LD and/or Autism and to discuss the wider CLDT developments.

Effective | Treatment & Intervention







EIP AWT Standard		Jul-22		
	Target 2022/23	n	SPC variation	SPC target
Trustwide	60%	**95.0%**	• • •	?

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. The last 5 months have met or exceeded the mean, if this continues in the same trajectory it will trigger a SPC variation change next month.

There is variation month on month, but our average over the last 2 year period is 67.6% indicating the system is capable of achieving the 22/23 target.

In July = 95% (19/20)

72-hour Follow Up		Jul-22		
	Target 2022/23	n	SPC variation	SPC target
Trustwide	80%	**92.1%**	• • •	?

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 July 22 was 92.1% against the 80% target. There were 38 eligible discharges. 35 of the 38 were followed up within 72 hours.
Of the other 3 not followed up within 72 hours, all 3 were followed up on day 4 post discharge. One was delayed as the discharge summary was finalised by the ward 3 days post discharge.
Ensuring the discharge destinations are correctly recorded and reported is the data quality work to be progressed.

CPA Annual Review % Compliance		Jul-22		
	Target 2022/23	n	SPC variation	SPC target
Trustwide	95%	**85.2%**	• H •	F
EIP	95%	**88.3%**	• • •	?
Recovery North	95%	**87.5%**	• H •	F
Recovery South	95%	**79.8%**	• H •	F

Narrative

Quarter 1

With 8 week(s) remaining in the quarter, the teams will need to book the following number of due CPA's to hit the target:

EARLY INTERVENTION	21	(25 booked)
RECOVERY NORTH	59	(59 booked)
RECOVERY SOUTH	118	(59 booked)

Based on the current clients open to the team, the teams will need to complete the following number of CPA's per week to achieve this by the end of the quarter :

EARLY INTERVENTION	3	AVERAGE: 2
RECOVERY NORTH	8	AVERAGE: 8
RECOVERY SOUTH	16	AVERAGE: 9

(Average per week - rolling 12 months)

IAPT | Performance Summary

IAPT		Jul-22			
Metric	Target 2022/23	*n*	*mean*	*SPC variation*	*SPC target*
Referrals	/	**1219**	*1484*	• • •	/
New to Treatment	1431	**911**	*1118*	• • •	?
6 week Wait	75%	**97.75%**	*96.35%*	• H •	P
18 week Wait	95%	**99.62%**	*99.59%*	• • •	P
Moving to Recovery Rate	50%	**50.50%**	*50.38%*	• • •	?

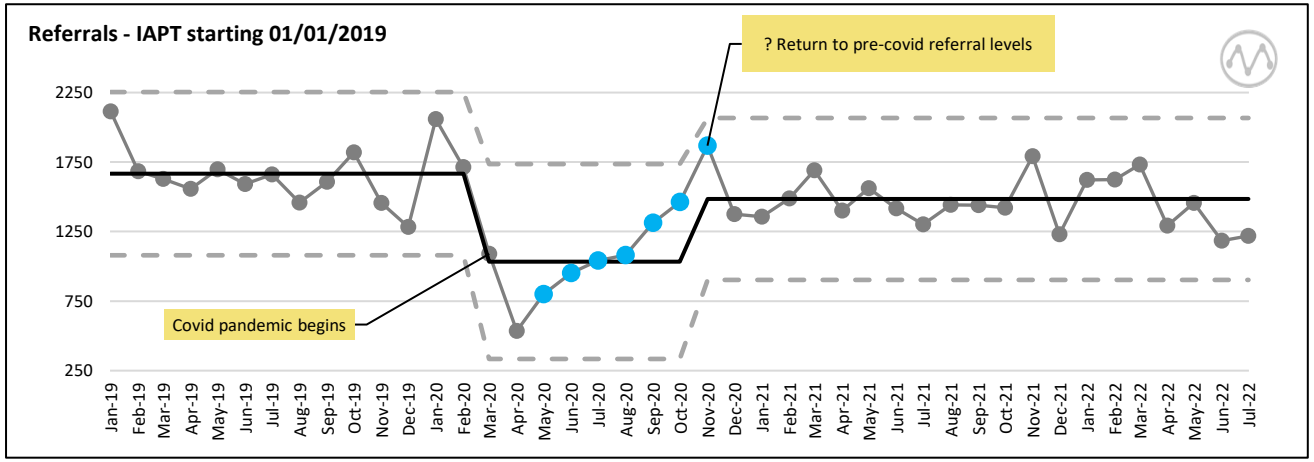
**Process limits recalculated from March 2020 and November 2020. Pre-covid average referrals per month were 1666. Post-covid average is 1484.*

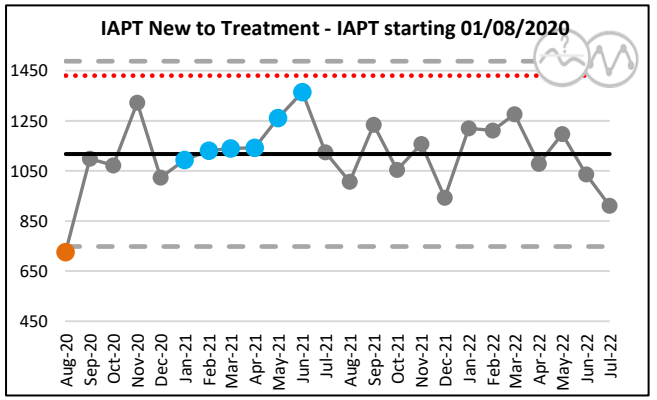
Narrative

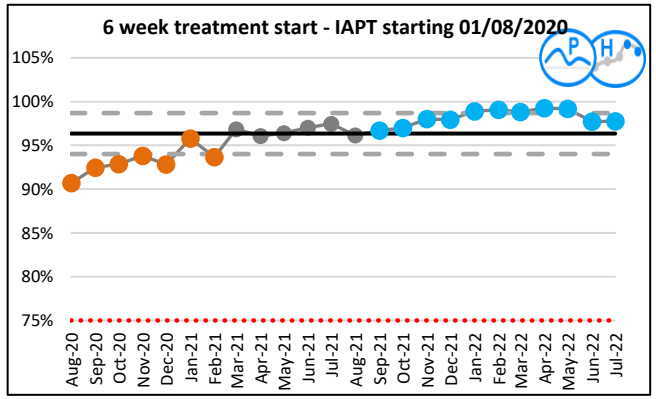
Referrals are likely to be lower during summer months due to seasonal variation which is impacting on achieving the access standard, this is also still reflected regionally and nationally. A number of actions are in place to mitigate this:

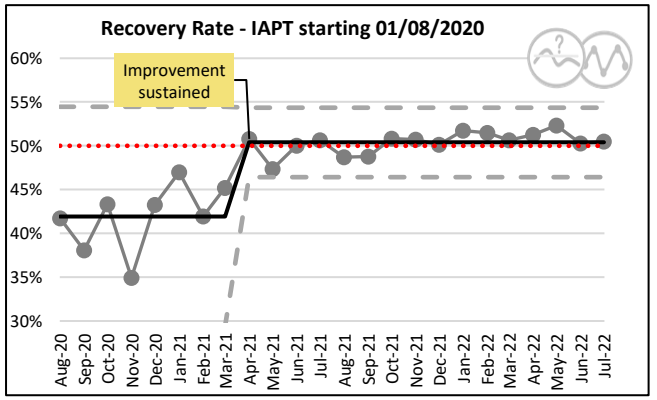
Access:

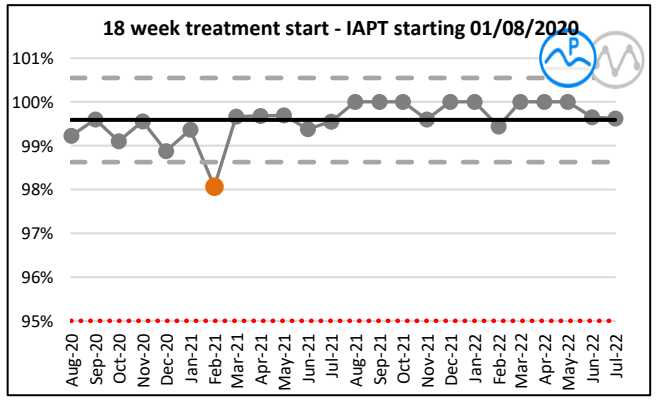
- Comms role now in place and implementing a number of pieces of work to increase referrals such as:
  - 3 month Hallam FM website takeover
  - Mail drop across Sheffield with new leaflet developed to promote service
  - Advertising IAPT on bus shelters and billboards across Sheffield
  - A suite of animations developed to use across social media
  - GP Practice engagement plan
  - In addition to the ongoing advertising and promotion plans such as using all available social media platforms to promote the service.











START – Sheffield Treatment & Recovery Team | Performance Summary

START		July-22		
Opiates	**Target 2022/23**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	66	• • •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	83%	• • •	• • •
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	97%	• • •	• P •
DNA Rate to Assessment	≤ 15%	39%	• • •	• • •
Recovery - Successful treatment exit	TBC	7	• • •	/
Non-Opiates	**Target 2022/23**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	78	• • •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	14%	• L •	• • •
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	100%	• H •	• • •
DNA Rate to Assessment	≤ 15%	37%	• • •	• • •
Recovery - Successful treatment exit	TBC	12	• • •	/
Alcohol	**Target 2022/23**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	158	• • •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	13%	• L •	• • •
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	100%	• H •	• P •
DNA Rate to Assessment	≤ 15%	27%	• • •	• • •
Recovery - Successful treatment exit	TBC	30	• • •	/

Narrative

DNA rate

DNA rate to assessment in the opiates part of the service has been higher during July 22. This does fluctuate and will be monitored to identify if there are any specific reasons for this, including barriers to treatment.

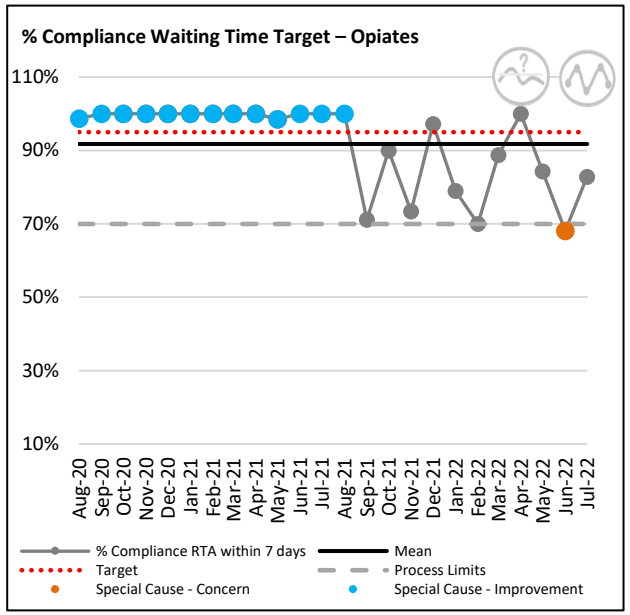
Recovery

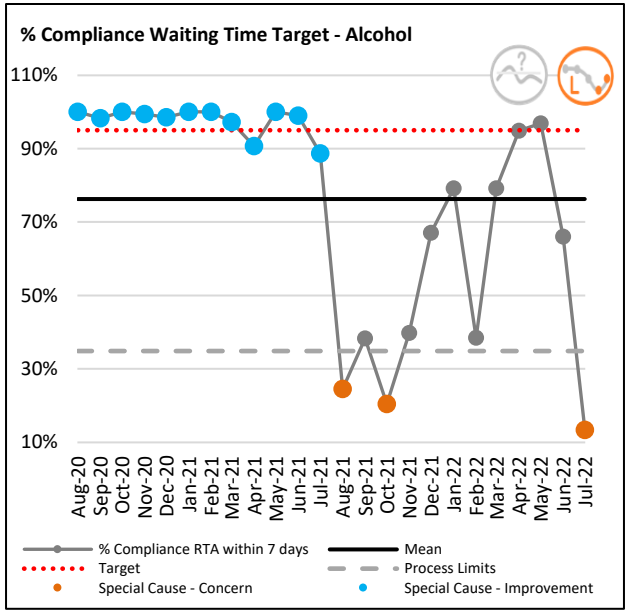
Due to the open access nature of the service, service users historically find it easier to drop out of treatment. The service has previously worked towards a target for the percentage of positive discharges (defined as discharge drug free/occasional user or a planned discharge with treatment goals met).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

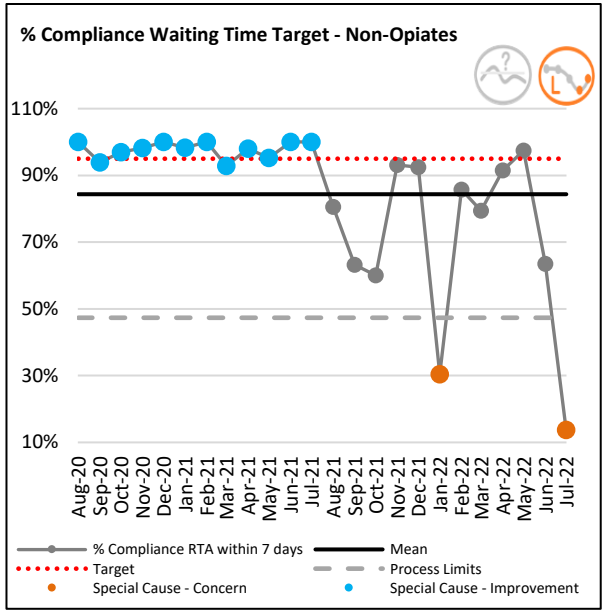
Engagement

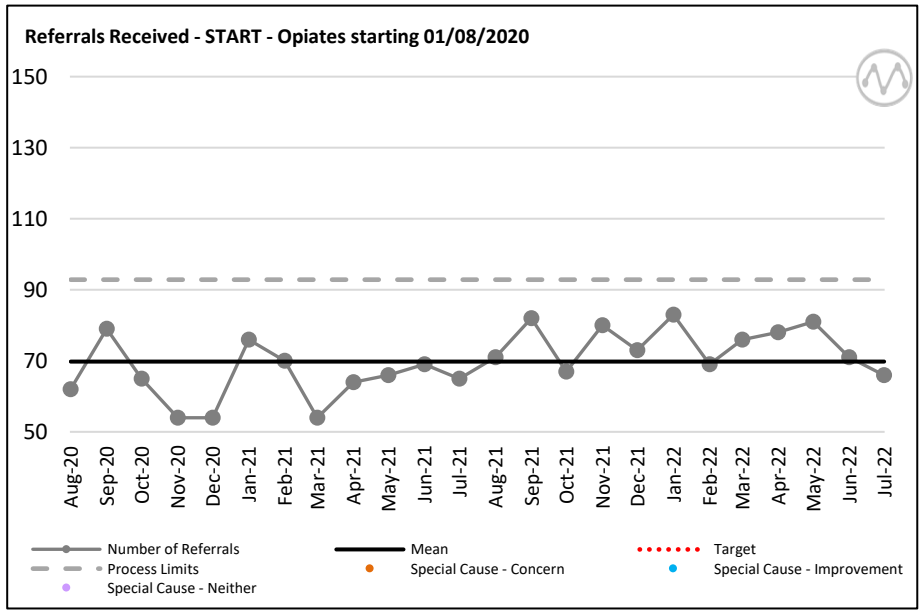
Referral numbers to the opiates, alcohol and non-opiates services are not currently working to a target but this is in discussion with the commissioner. The service provides open access to treatment regardless of any previous presentations or drop-outs. For this reason, there is a group of service users 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.

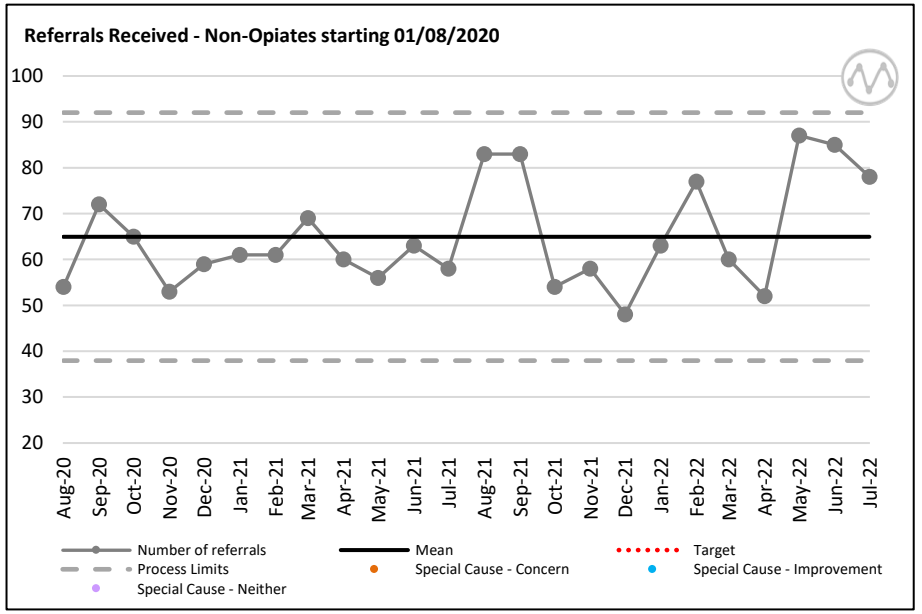
START Performance | Highlights & Exceptions











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.

In July the further drop in wait times has been escalated within the service and an improvement plan is in place.

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.

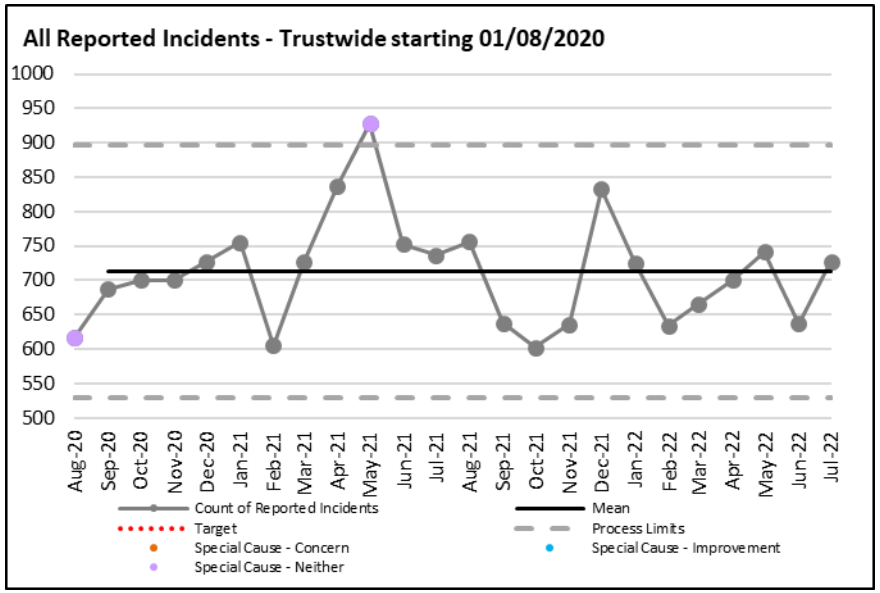
NHS
Sheffield Health and Social Care
NHS Foundation Trust

Safety & Quality

IPQR - Information up to and including July 2022

Proud to care in Sheffield

Safe | All Incidents



Trustwide	Jul-22		
	n	mean	SPC variation
ALL	**727**	*711*	• • •
5 = Catastrophic	**24**	*15*	• H •
4 = Major	**0**	*4*	• • •
3 = Moderate	**79**	*70*	• • •
2 = Minor	**280**	*295*	• • •
1 = Negligible	**324**	*276*	• • •
0 = Near-Miss	**20**	*19*	• • •

Narrative

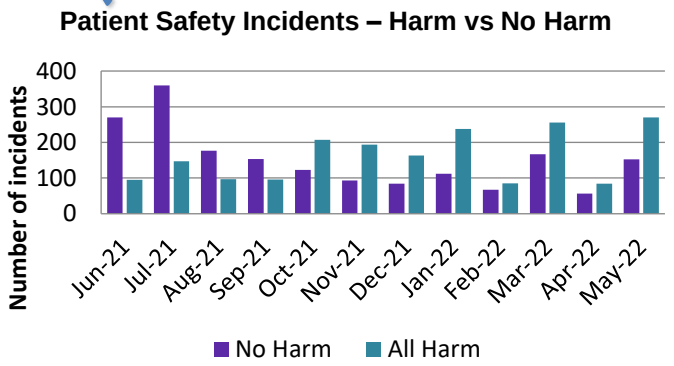
No Major incidents reported in July 2022. Of the 24 Catastrophic incidents, 7 were for Rehabilitation and Specialist Services and 17 were for Acute and Community. All reported catastrophic incidents were related to deaths. 9 of the 18 were suspected natural cause deaths, 1 was a homicide incident and 4 were suspected suicides.

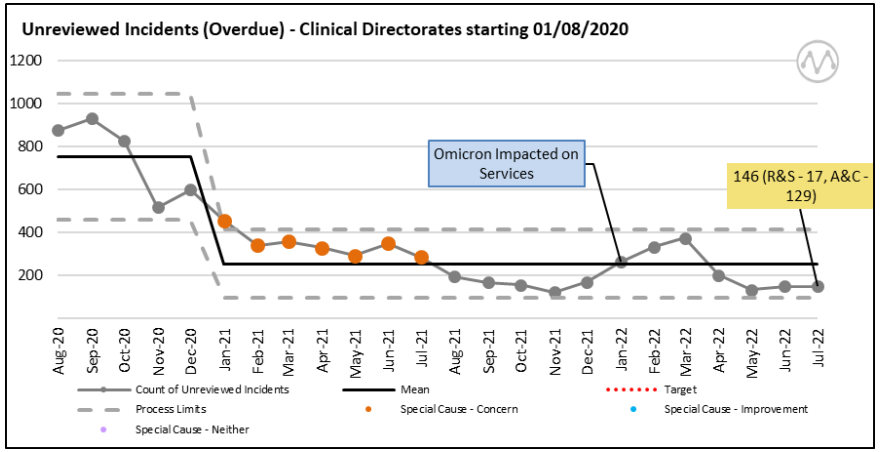
Narrative

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 forward. 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 June 2021 to May 2022.

Awaiting update





Narrative

The unreviewed incidents are predominantly accounted for by the Acute and Community Directorate. At the time of publication, there were 7 unreviewed incidents from 2021 (subsequently reviewed). 37 incidents remain unreviewed from pre-July 2022.

Serious Incident Actions Outstanding

As at 01 August 2022, there were 92 outstanding SI actions overdue, which is an decrease from the previous months' 119.

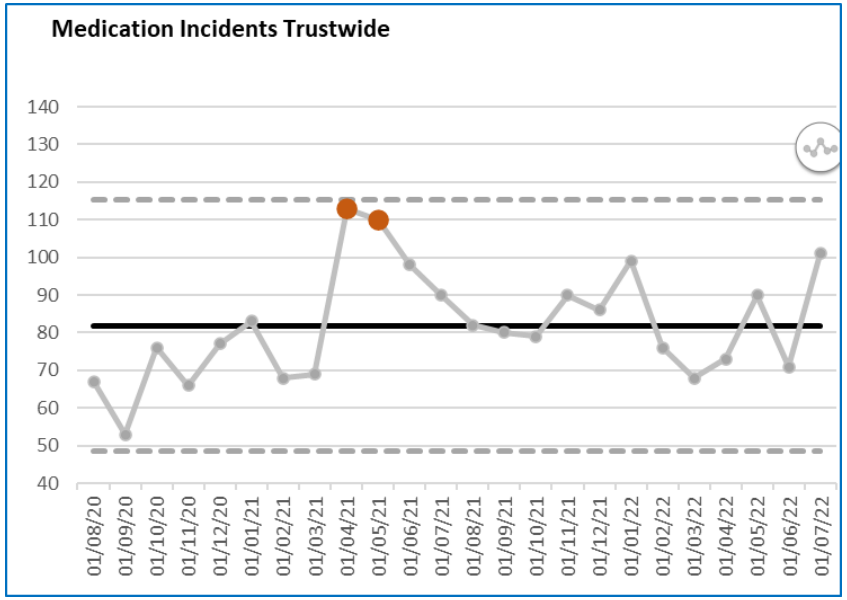
- 2 actions were due in 2020
- 39 actions were due in 2021
- 51 actions were due in 2022

Actions from 2020 and 2021 are reducing, of which 30 actions relate to Firshill Rise/ATS have subsequently been closed following Commissioner agreement.

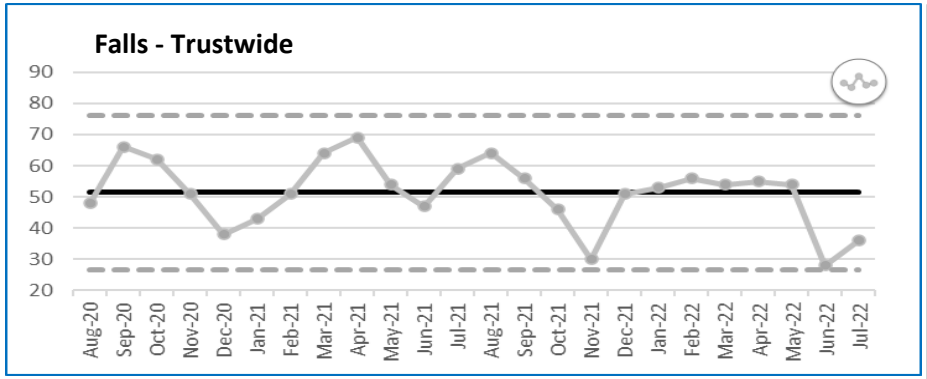
As requested in July's QAC meeting, actions following Coronial inquests (Prevention of Future Death Reports (PFDs) will be incorporated into the IPQR from July's data.

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

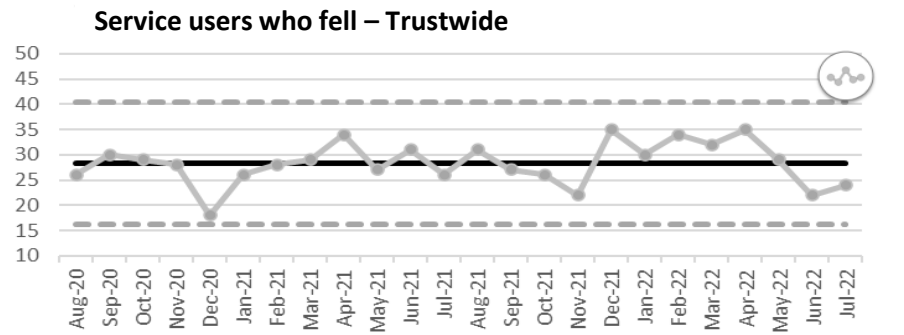
Safe | Medication Incidents & Falls



Trustwide	Jul-22		
	n	*mean*	SPC variation
ALL	**101**	*82*	• • •
Administration Incidents	**10**	*16*	• • •
Meds Management Incidents	**68**	*51*	• • •
Pharmacy Dispensing Incidents	**17**	*8*	• • •
Prescribing Incidents	**6**	*6*	• • •
Meds Side Effect/Allergy Incidents	**0**	*0*	• • •



Trustwide FALLS INCIDENTS	Jul-22		
	n	*mean*	SPC variation
Trustwide Totals	**36**	*51*	• • •
Acute & Community	**35**	*49*	• • •
Rehabilitation & Specialist Services	**1**	*3*	• • •



Trustwide FALLS INDIVIDUALS	Jul-22		
	n	*mean*	SPC variation
Trustwide Totals	**24**	*28*	• • •
Acute & Community	**23**	*26*	• • •
Rehabilitation & Specialist Services	**1**	*3*	• L •

Narrative

Medication Incidents

3 incidents were reported as Moderate in July 2022 involving a non-SHSC Pharmacy Dispensing issue for Birch Avenue. Another incident was reported as Moderate in July 2022 for START Opiates Service for Pharmacy Dispensing.

We are paying attention to the number of medication incidents in nursing homes due to non SHSI pharmacy dispensing not meeting service user needs in a timely way, this is currently being explored and may need to be raised with commissioners.

Falls Incidents

- Woodland View aware of higher falls incidents due to general population of the ward.
- HUSH huddles commenced on Dovedale in June 2022.
- Two incidents rated as moderate following a falls were reported at Dovedale 1 in July 2022. Injuries reported as laceration/cut and abrasion/graze.

Safe | Assaults, Sexual Safety & Missing Patients

Assaults on Service Users	Jul-22		
	n	mean	SPC variation
Trustwide	23	22	• • •
Acute & Community	22	19	• • •
Rehabilitation & Specialist	1	3	• • •

Assaults on Staff	Jul-22		
	n	mean	SPC variation
Trustwide	61	85	• L •
Acute & Community	60	69	• • •
Rehabilitation & Specialist	1	16	• • •

Narrative

Out of the 23 assaults on patients incidents reported, 0 incidents were reported as moderate in July 2022.

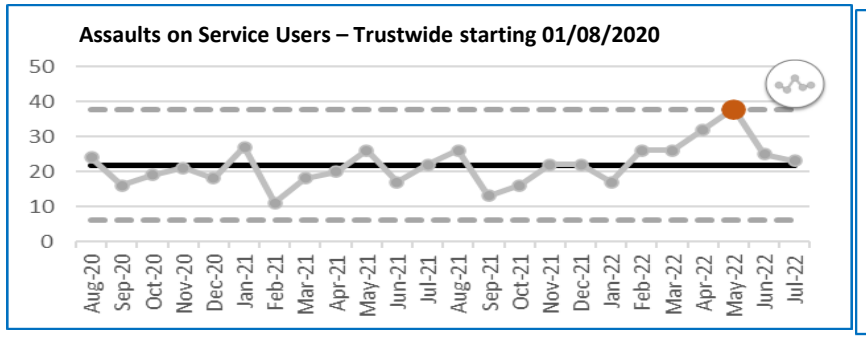
Out of the 61 assaults on staff incidents reported (which is showing as low this month), 60 were reported for Acute and Community Services and 1 reported for Rehabilitation & Specialist services in July 2022. The majority of incidents reported were for Endcliffe Ward (16 incidents), Maple Ward (13 incidents) and Stanage Ward (12 incidents). Other incidents occurred on Birch Avenue, Dovedale 1 & 2, Forest Close, Maple Ward, G1 Ward and Woodland View.

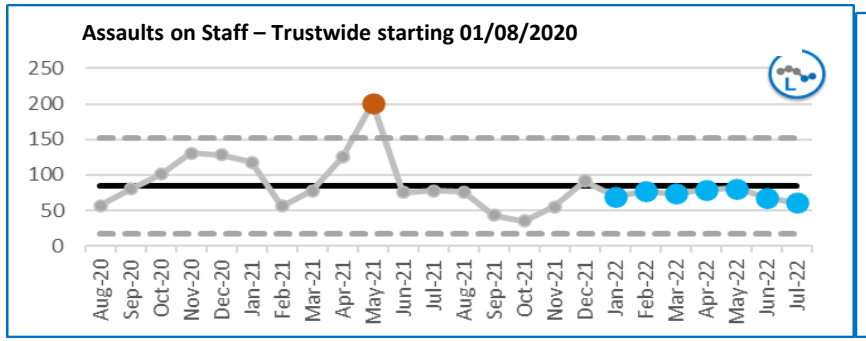
10 incidents reported as Moderate in July 2022. 1 reported for Maple Ward, 2 reported for Stanage Ward, 2 for Dovedale 1 and 5 reported on Endcliffe Ward.

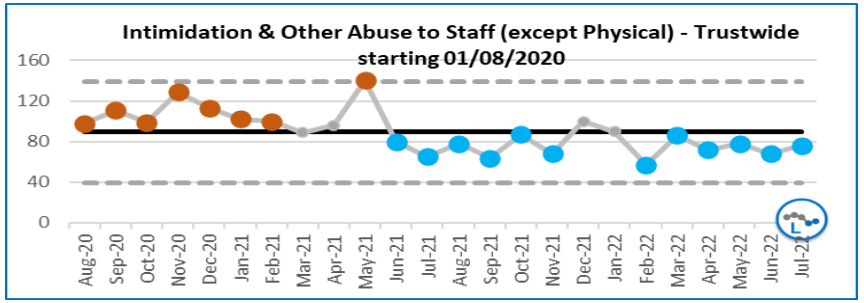
Sexual Safety

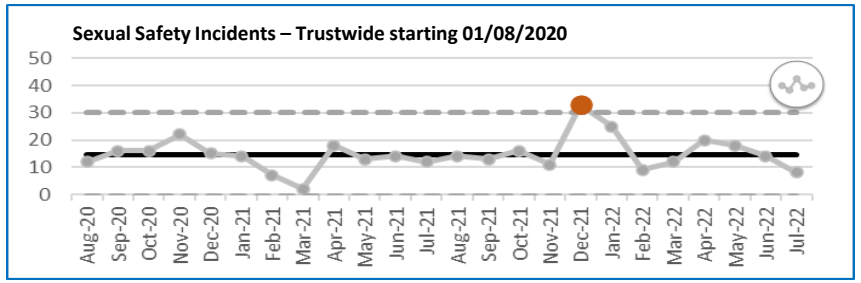
There were 0 moderate sexual safety incidents reported in July 2022. 1 Minor incident reported on Stanage Ward following inappropriate physical contact from service user to staff member.

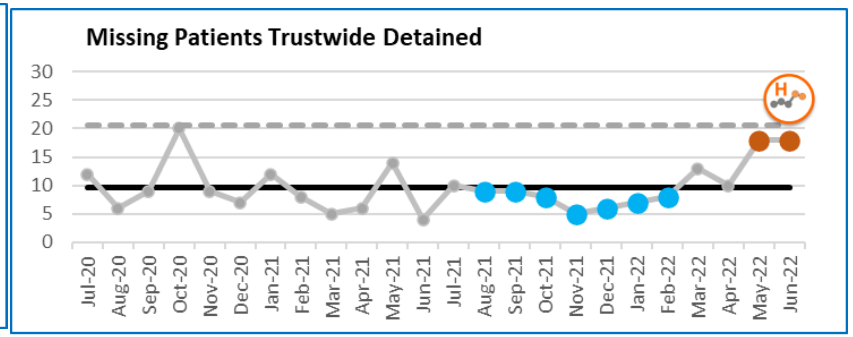
Protecting from avoidable harm	Target	YTD
Reportable Mixed Sex Accommodation (MSA) breaches	0	0

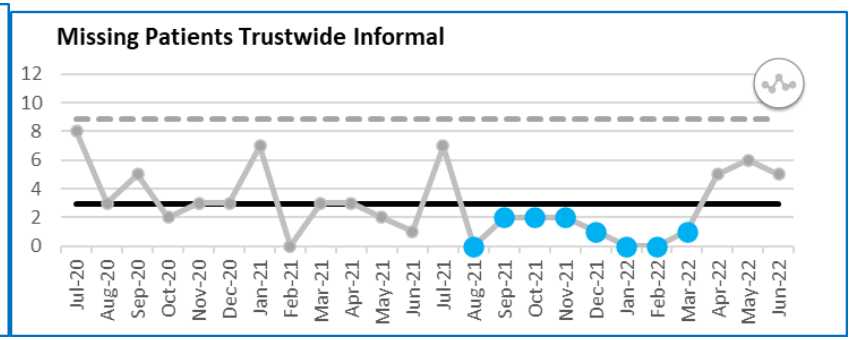










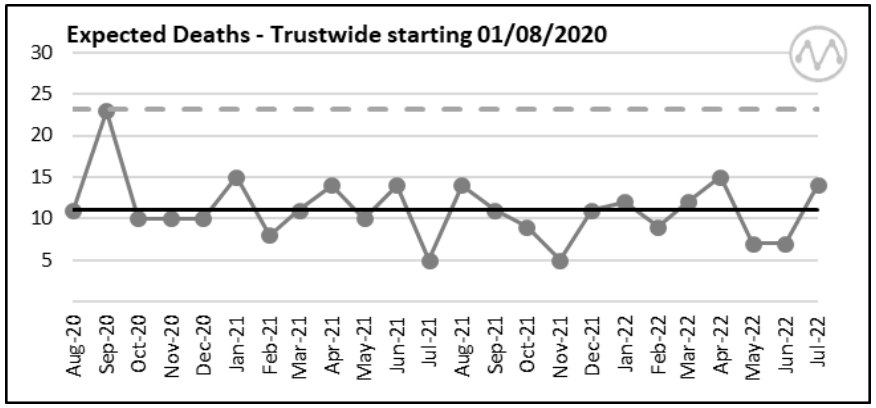


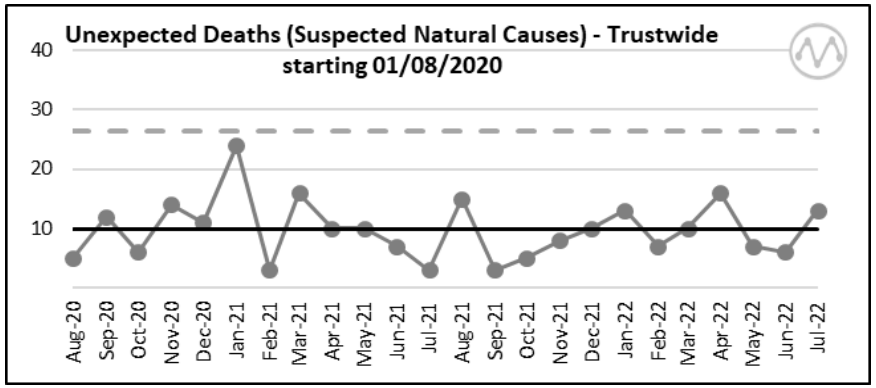
Trustwide	Jul-22		
	n	mean	SPC variation
Detained	18	10	• H •
Informal	6	3	• • •

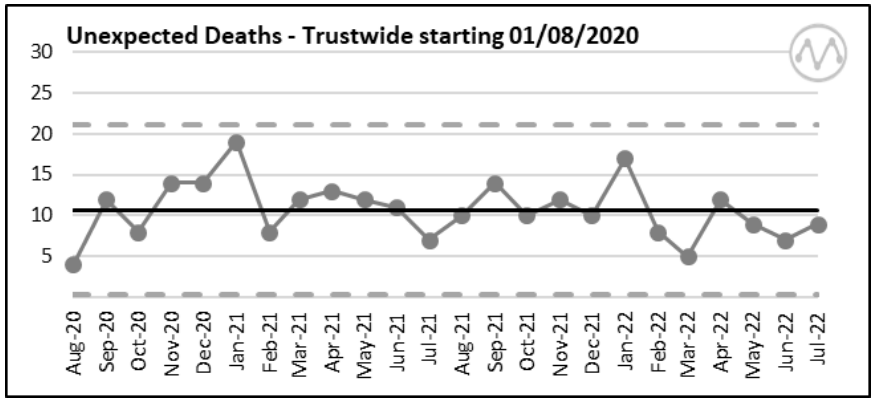
Narrative

18 reported incidents in July 2022. 4 incidents were for Rehabilitation & Specialist Services for 4 individuals.
14 incidents for Acute & Community for 9 individuals. 14 out of the 18 report incidents were for service users on a Section 3.

Deaths

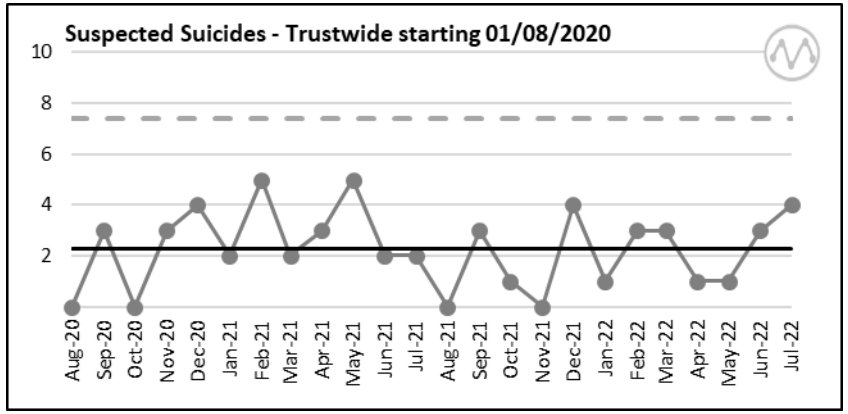






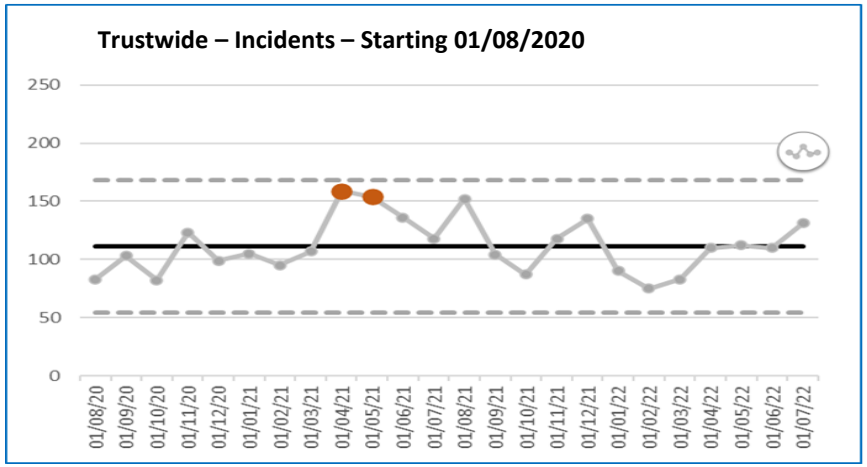
Quarterly mortality reports are presented to the Quality Assurance Committee and Board of Directors.

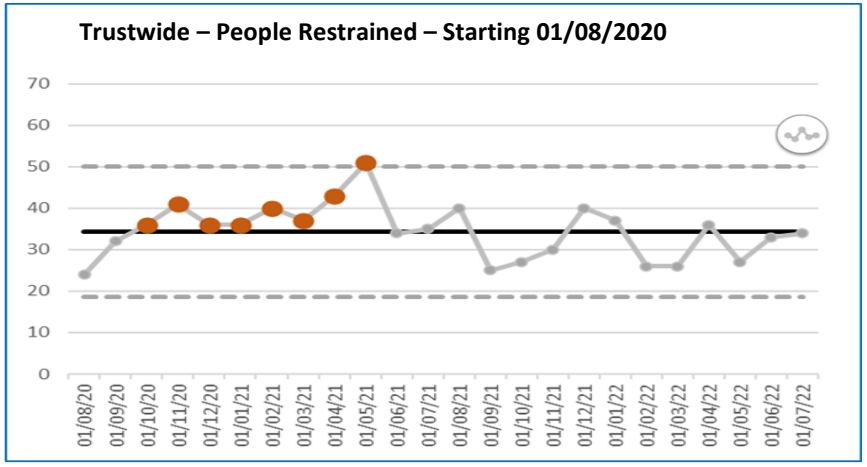
Deaths Reported 1 August 2020 to 31 July 2022	
Awaiting Coroners Inquest/Investigation	197
Conclusion - Narrative	7
Conclusion - Suicide	13
Conclusion – Accidental	1
Conclusion – Misadventure	1
Conclusion – Open	1
Natural Causes/No Inquest	579
Alcohol/Drug related	18
Suspected Homicide/Closed	2
Ongoing	1
Grand Total	**820**



COVID-19 Deaths 1 April 2020 - 31 July 2022	
ATS (Firshill Rise)	1
Birch Ave	5
CISS (LDS)	1
CLDT	6
G1 Ward	6
Liaison Psychiatry	7
LTNC	3
Memory Service	7
Mental Health Recovery Team (South)	2
Neuro Case Management Team	1
Neuro Enablement Service	4
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	1
START Opiates Service	2
Woodland View | Oak Cottage	2
Grand Total	**101**

Safe | Restrictive Practice | Physical Restraint





Physical Restraint INCIDENTS	Jul-22		
	n	*mean*	SPC variation
TRUSTWIDE	**131**	*111*	• • •
Acute & Community	**127**	*101*	• • •
Dovedale 2	**31**	*14*	• • •
Stanage Ward	**6**	*11*	• • •
Maple Ward	**38**	*18*	• H •
HBPoS (136 Suite)	**1**	*1*	• • •
Endcliffe Ward	**31**	*24*	• • •
Dovedale	**13**	*22*	• • •
G1 Ward	**3**	*7*	• • •
Birch Ave	**3**	*1*	• • •
Woodland View	**1**	*1*	• • •
Rehabilitation & Specialist Services	**4**	*11*	• L •
Forest Close	**4**	*2*	• • •
Forest Lodge	**0**	*1*	• • •

Physical Restraint PEOPLE	Jul-22		
	n	*mean*	SPC variation
TRUSTWIDE	**34**	*34*	• • •
Acute & Community	**32**	*32*	• • •
Dovedale 2	**5**	*5*	• • •
Stanage Ward	**4**	*5*	• • •
Maple Ward	**8**	*6*	• • •
HBPoS (136 Suite)	**1**	*1*	• • •
Endcliffe Ward	**4**	*5*	• • •
Dovedale	**3**	*3*	• • •
G1 Ward	**3**	*4*	• • •
Birch Ave	**3**	*1*	• • •
Woodland View	**1**	*1*	• • •
Rehabilitation & Specialist Services	**2**	*3*	• • •
Forest Close	**2**	*1*	• • •
Forest Lodge	**0**	*1*	• • •

Narrative

Physical Restraint

127 physical restraints were recorded in July 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.

Maple Ward continue to have high number of physical restraint incidents, primarily due to one service user, the same service user as previous months.

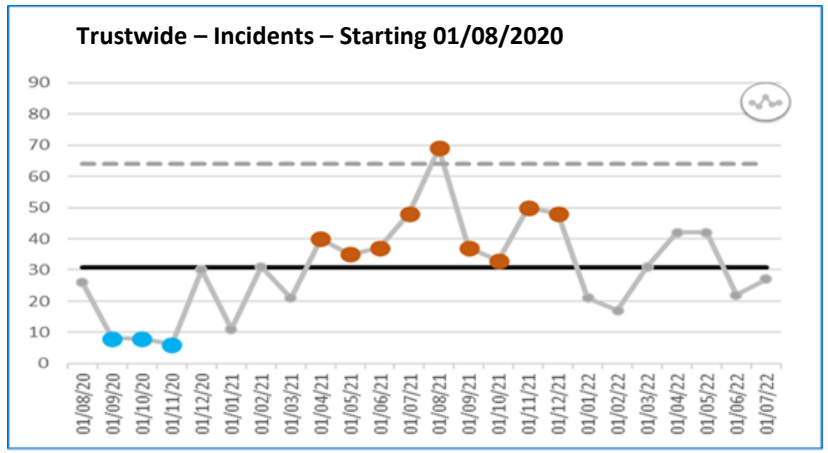
Dovedale 2 had 31 physical restraints, split between 5 individuals (5/8/1/9/8)

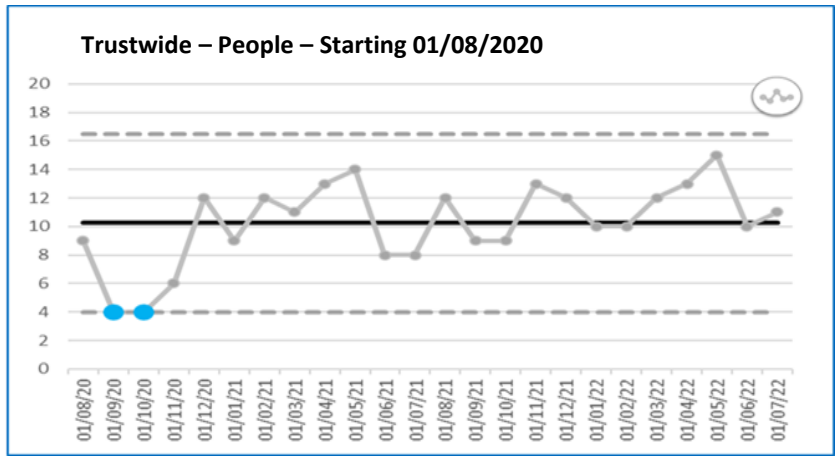
There has been 4 reported incidents of physical restraint in the Rehabilitation & Specialist Directorate in July 22 on Forest Close.

Mechanical Restraint

During July 2022 there were no reported incidents of the use of Mechanical Restraints.

Safe | Restrictive Practice | Rapid Tranquillisation





Rapid Tranquillisation INCIDENTS	Jul-22		
	n	mean	SPC variation
TRUSTWIDE	27	31	• • •
Acute & Community	27	31	• • •
Burbage Ward/Dovedale 2	13	6	• • •
Stanage Ward	1	2	• • •
Maple Ward	3	4	• • •
HBPoS (136 Suite)	0	0	• L •
Endcliffe Ward	8	7	• • •
Dovedale	1	11	• • •
G1 Ward	1	0	• • •
Rehabilitation & Specialist	0	0	• • •
Forest Close	0	0	• • •
Forest Lodge	0	0	• • •

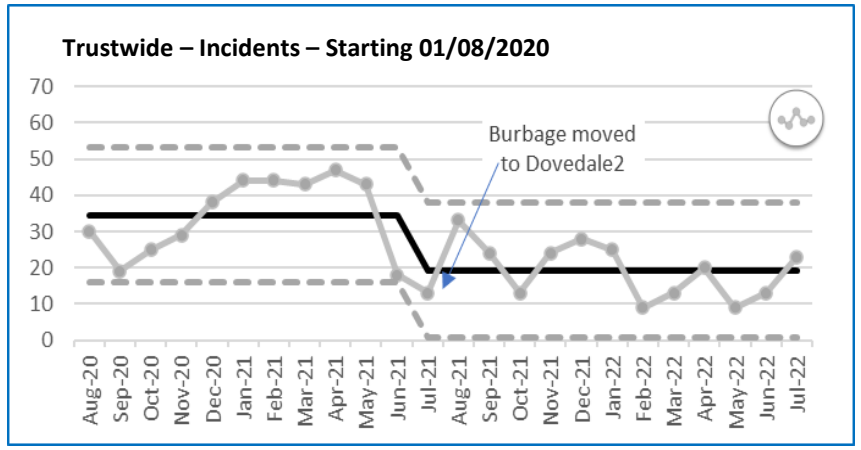
Rapid Tranquillisation PEOPLE	Jul-22		
	n	mean	SPC variation
TRUSTWIDE	11	10	• • •
Acute & Community	11	10	• • •
Burbage Ward/Dovedale 2	3	3	• • •
Stanage Ward	1	2	• • •
Maple Ward	2	2	• H •
HBPoS (136 Suite)	0	0	• L •
Endcliffe Ward	3	2	• • •
Dovedale	1	1	• • •
G1 Ward	1	0	• • •
Rehabilitation & Specialist	0	0	• • •
Forest Close	0	0	• • •
Forest Lodge	0	0	• • •

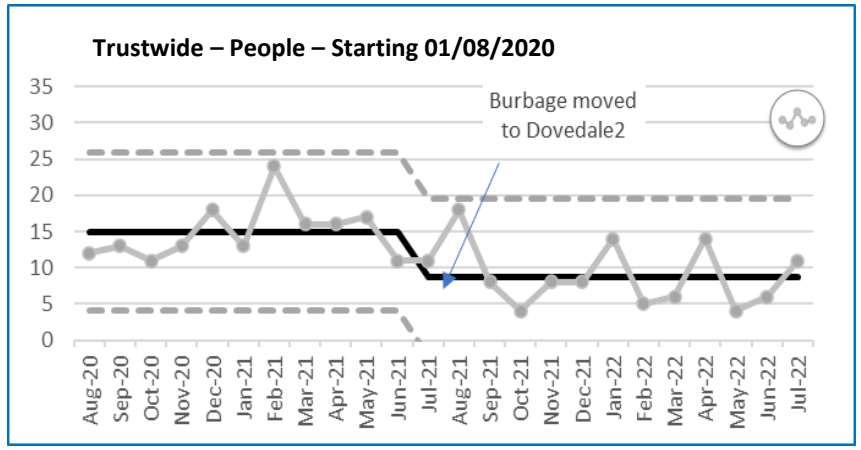
Narrative

Of the 27 incidents reported in July 2022, 9 were for 1 service user on Dovedale 2 and 6 for another service user on Endcliffe ward.

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

Safe | Restrictive Practice | Seclusion





Seclusion INCIDENTS	Jul-22		
	n	*mean*	SPC variation
Trustwide	**23**	*19*	• • •
Acute & Community	**23**	*18*	• • •
Stanage	**2**	*4*	• • •
Maple Ward	**2**	*5*	• • •
HBPoS (136 Suite)	**4**	*1*	• H •
Endcliffe PICU	**14**	*10*	• • •
G1 Ward	**1**	*0*	• • •
Rehabilitation & Specialist	**0**	*2*	• L •
Forest Lodge	**0**	*1*	• • •

Seclusion INDIVIDUALS	Jul-22		
	n	*mean*	SPC variation
Trustwide	**11**	*9*	• • •
Acute & Community	**11**	*8*	• • •
Stanage	**2**	*3*	• • •
Maple Ward	**2**	*3*	• • •
HBPoS (136 Suite)	**3**	*1*	• H •
Endcliffe PICU	**3**	*3*	• • •
G1	**1**	*0*	• • •
Rehabilitation & Specialist	**0**	*1*	• • •
Forest Lodge	**0**	*0*	• • •

Narrative

Seclusion

Dovedale 2 continue to operate without a seclusion facility – the annotation on the chart highlights when this happened and the baseline has been re-calculated

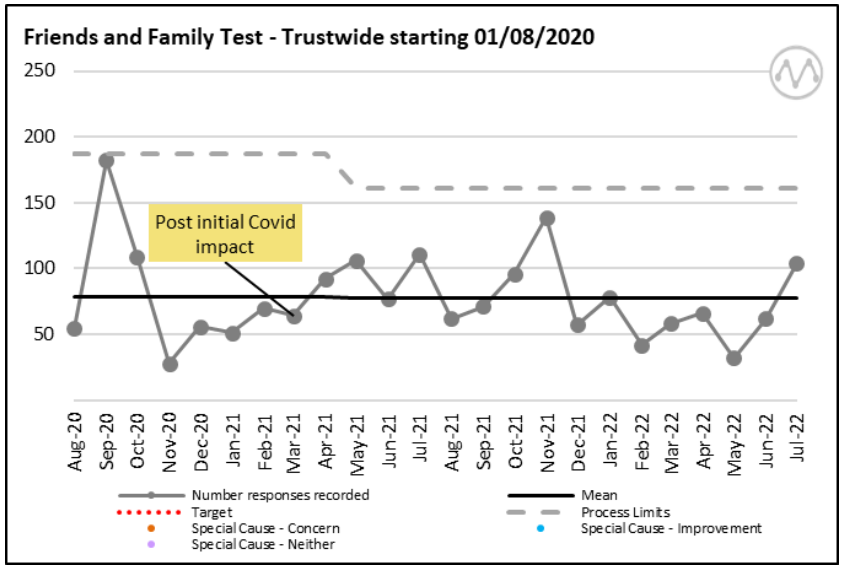
G1 have seen their first seclusion since April 22. The ward are continuing to work towards having no seclusion room

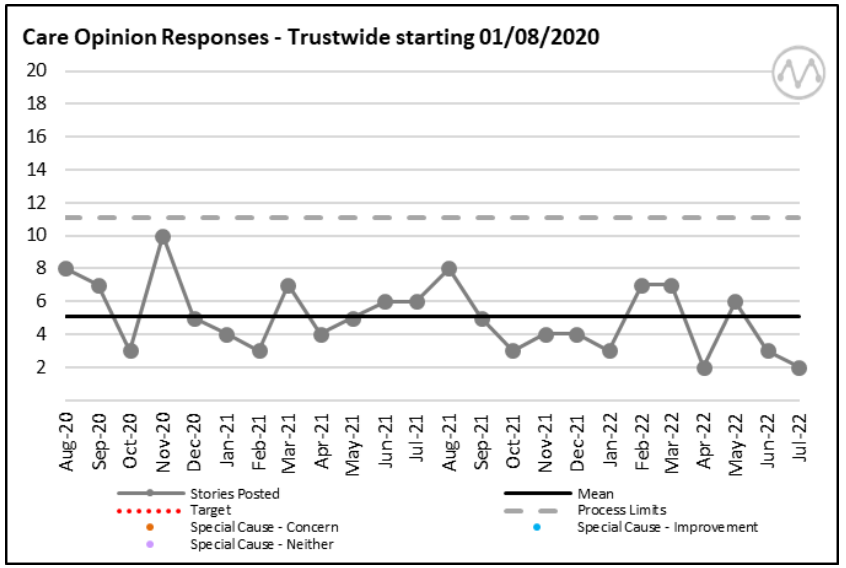
There have been no reported episodes of seclusion in the Rehabilitation & Specialist Directorate in July 2022.

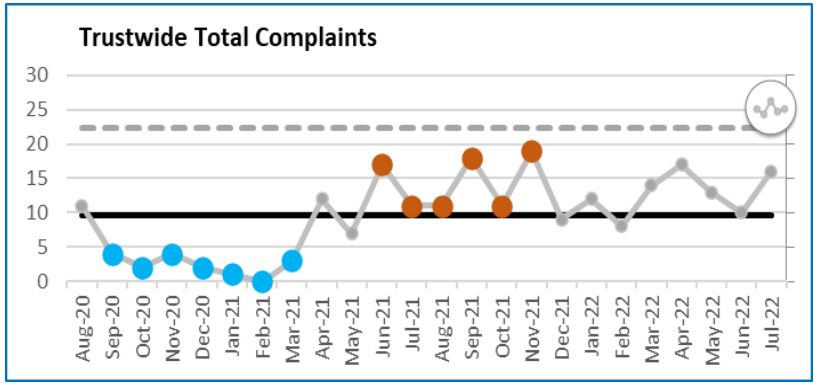
Long-Term Segregation

There were zero new incidences of long-term segregation reported to have started Trustwide in July 2022.

Caring | User Experience







Narrative.
The Trust received 104 responses in July 2022. From the total number of responses 101 were positive, 1 was neutral and 2 did not answer. There was no further feedback for the negative response received.

Some of the positive feedback received includes:
- Staff were very helpful, caring, and friendly
- Felt listened to and understood for the first time
- My mind was set at ease. Explanations were very clear.
- Has been extremely beneficial in helping me obtain a diagnosis, manage symptoms, and plan recovery.
- Totally comfortable chatting to the practitioner, non-judgemental in her approach, not rushed, nice to talk to someone who 'gets it', no hassle parking.

Areas for improvement:
- Quicker process
- Less waiting time for first assessment

Narrative

This month's report summarises 2 stories that were published on Care Opinion.

Of the 2 responses published this month 1 was moderated as minimally critical and the other mildly critical.

What was good?
Friendly, Kind staff and Safe environment

Areas for Improvement
- Appointments & Waiting Times
- Access
- Food
- Outdoor gardens
- More staff/funding

Complaints and Compliments

There were 16 formal complaints received in July 2022, 11 for the Acute and Community Directorate and 4 for the Rehabilitation and Specialist Services Directorate. The most frequent category type reported was 'Access to Treatment and Drugs'.

13 compliments were recorded to have been received in July 2022. In the Acute & Community Directorate, 3 were received for Crisis Home Treatment Team, 2 for Dovedale 2, 1 for SPA/EWS and 1 for the Recovery Team South. In Rehabilitation and Specialist, 1 was received for START, 1 for Community Learning Disabilities 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 July 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 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

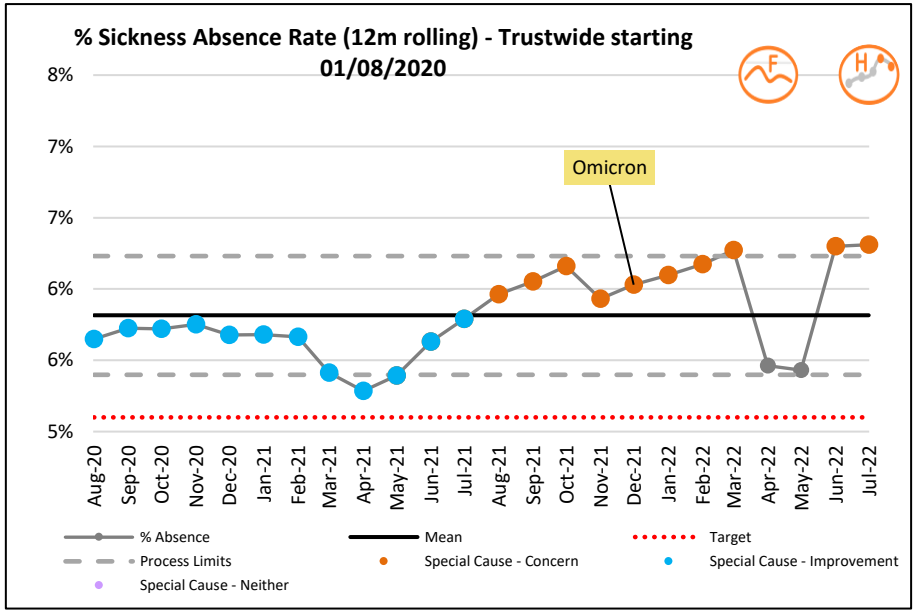
IPQR - Information up to and including July 2022

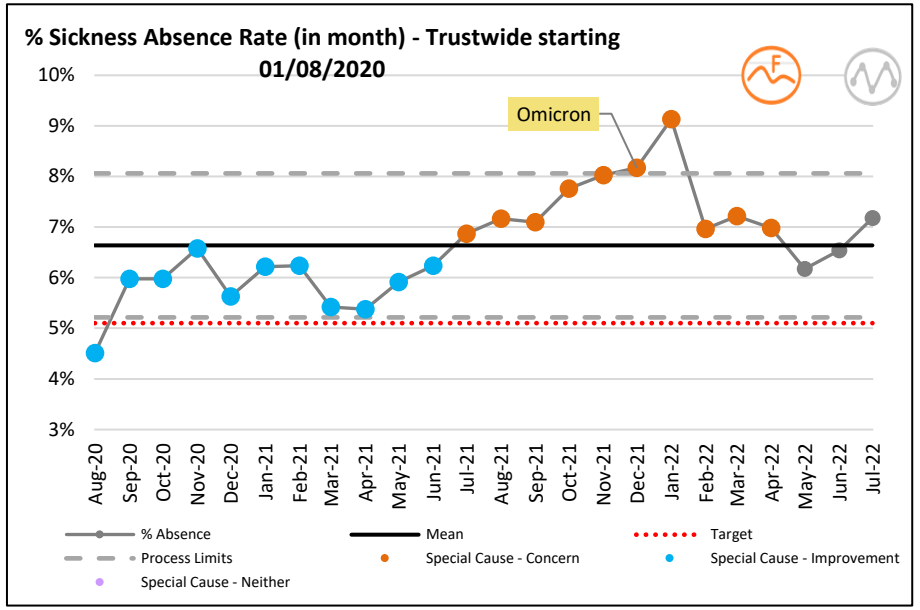
Proud to care in Sheffield

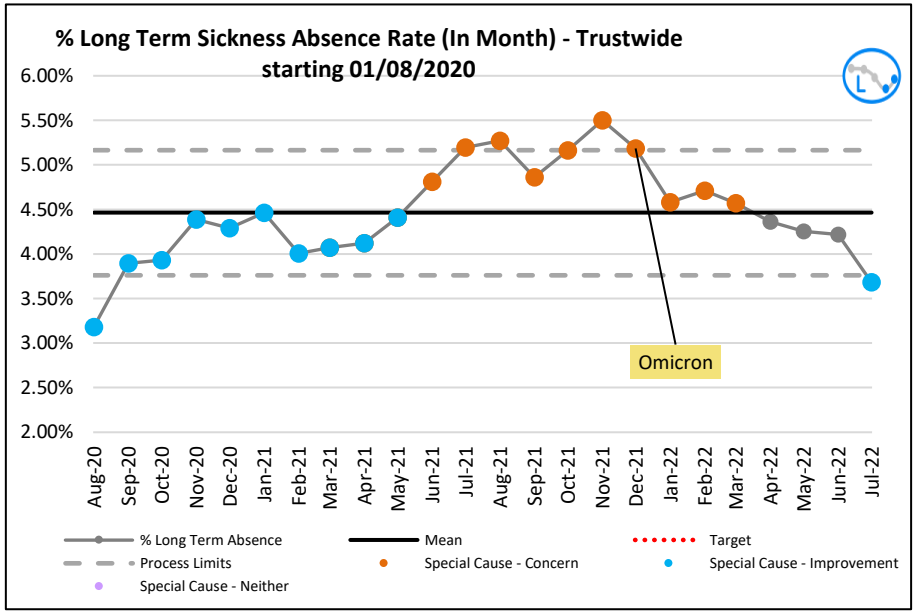
Well-Led | Workforce Summary

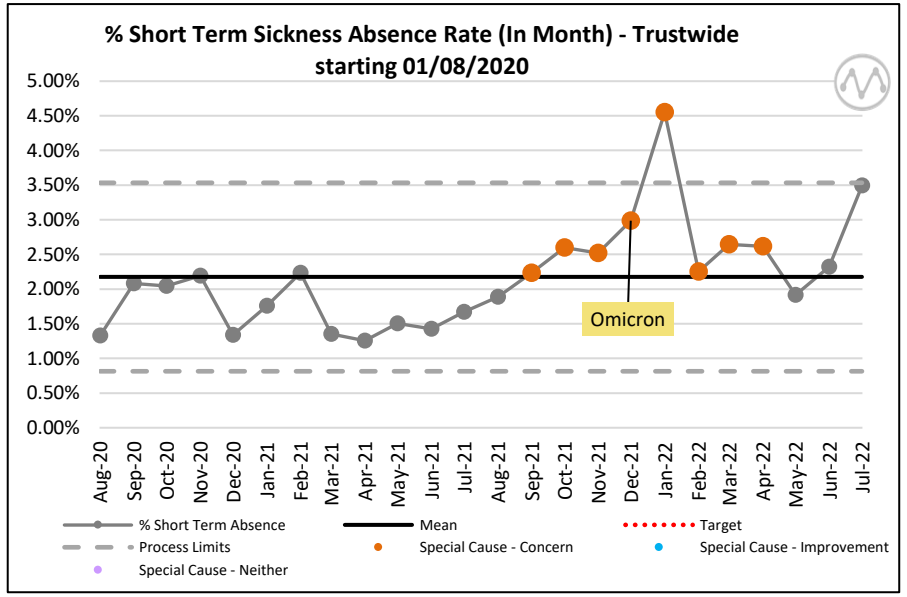
		Jul-22			
Metric	**Target**	**n**	***mean***	**SPC variation**	**SPC target**
Sickness 12 Month (%)	5.10%	**6.31%**	*5.81%*	• H •	F
Sickness In Month (%)	5.10%	**7.17%**	*6.64%*	• • •	F
Long Term Sickness (%)	~	**3.68%**	*4.46%*	• L •	/
Short Term Sickness (%)	~	**3.53%**	*2.18%*	• H •	/
Headcount Staff in Post	~	**2583**	*2555*	• H •	/
WTE Staff in Post	~	**2266**	*2236*	• H •	/
Turnover 12 months FTE (%)	10%	**15.53%**	*15.54%*	• • •	F
Vacancy Rate (%)	~	**11.07%**	*11.75%*	• • •	/
Training Compliance (%)	80%	**88.26%**	*90.24%*	• L •	P
Supervision Compliance (%)	80%	**69.16%**	*71.25%*	• • •	F

Well-Led | Sickness









Narrative

Target is outside of process limits which will make it difficult to reach. Sickness target 5.1% by the organisation.

In month sickness rate is static which is in line with the reduction of long term sickness and increase in short term sickness.

Long term sickness has significantly reduced due to focused action planning and support to managers across the organisation. There has been additional support given to areas with higher sickness rate. Short term sickness is static. Increasing withing the process limits. Focus is now turning to short term sickness after a continued effort to manage long term sickness.

Sessions will be taking place with managers on how to properly interpret ESR and manage sickness more effectively.

HR Business Partners are creating clinics for managers to attend and form a working partnership to resolve sickness issues.

Reviewing the attendance management training and will be offering more bite sized workshops to meet the needs of the services.

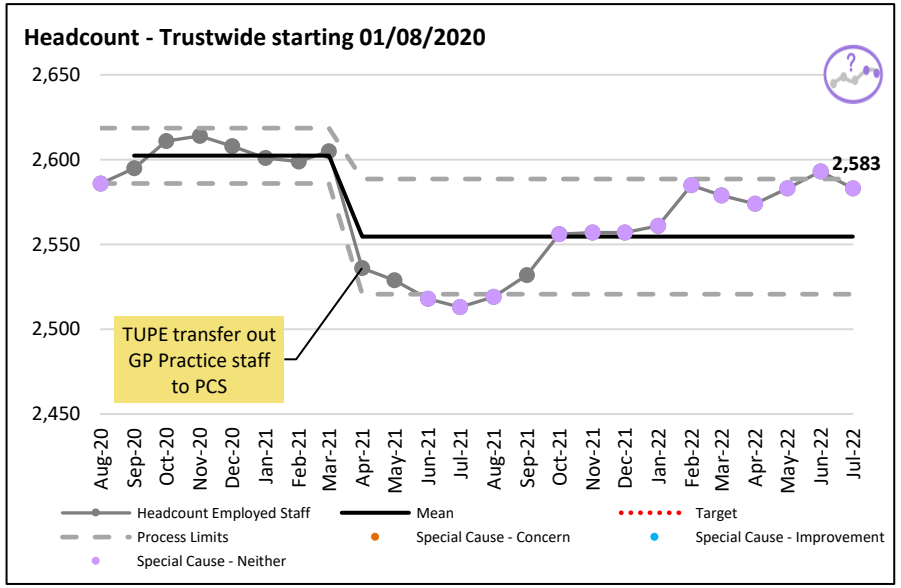
The top 3 reasons remain the same ad include covid related absence.

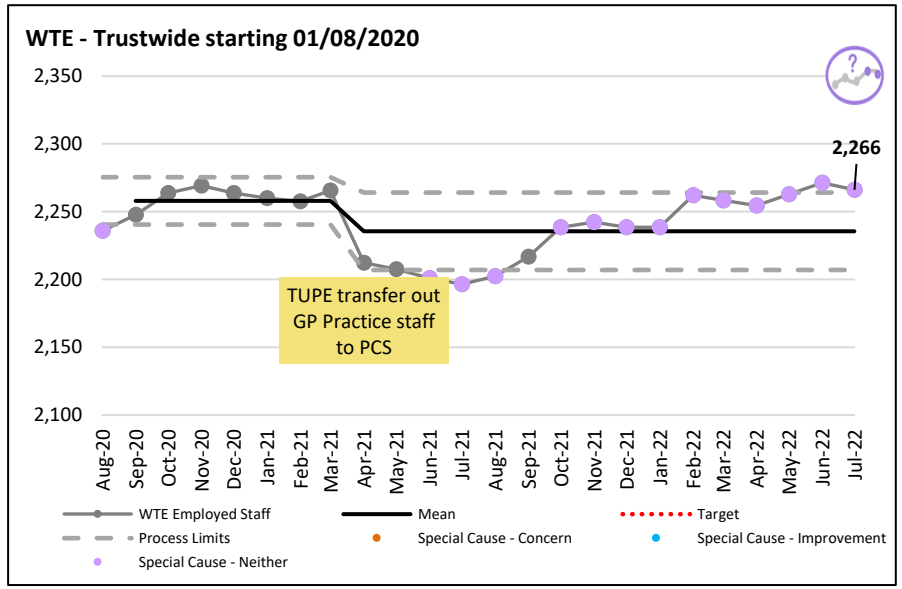
S10 Anxiety/stress/depression/other psychiatric illnesses

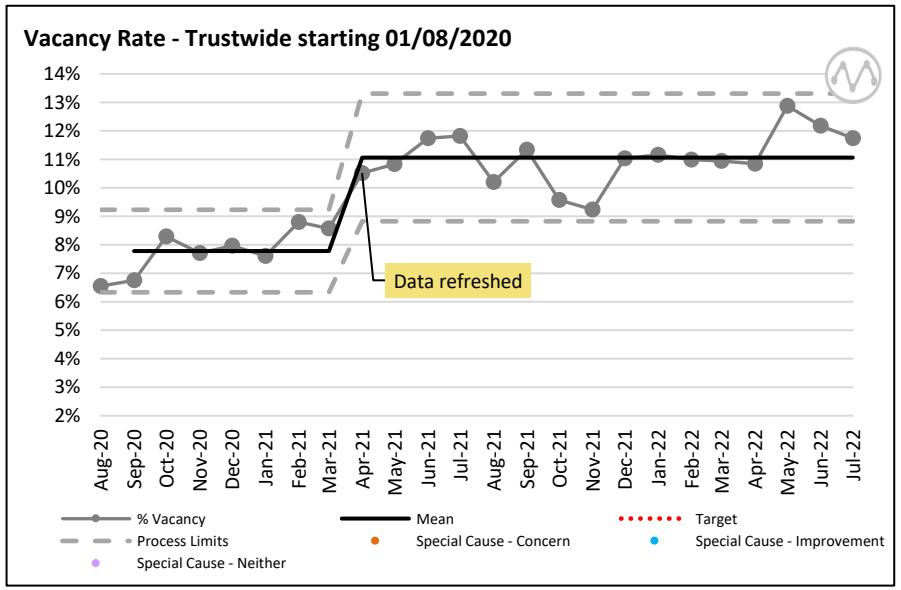
S27 Infectious diseases

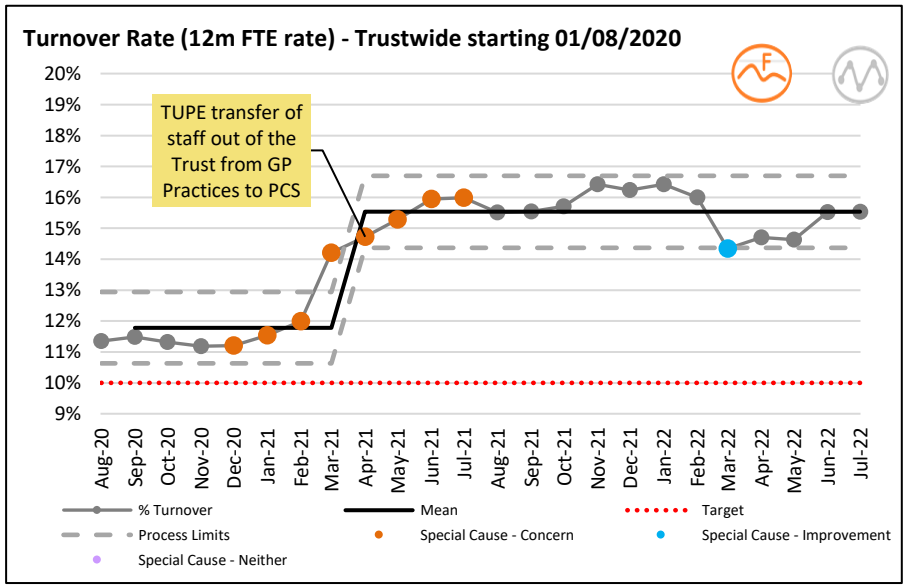
S25 Gastrointestinal problems

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

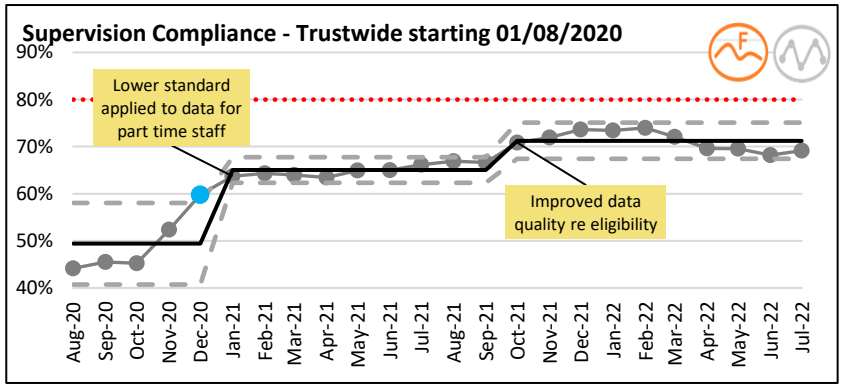
Headcount and WTE is on an upward trend. There has been an increase in resource in recruitment to support recruitment strategies.

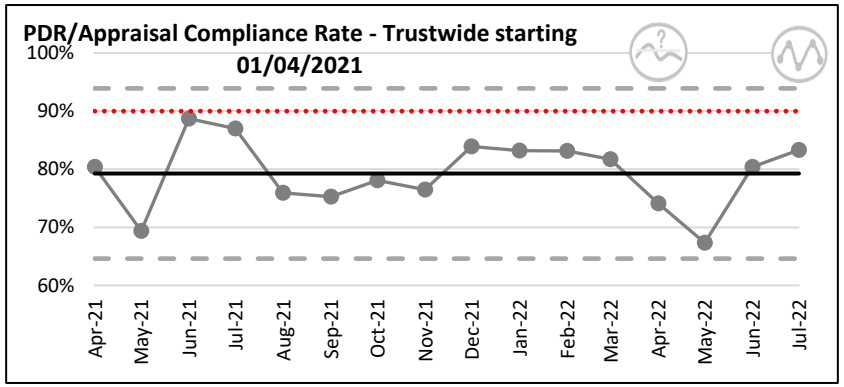
A new structure has been introduced allowing the team to concentrate on improving processes and strategy within the team which will make recruitment and on-boarding more streamlined and efficient.

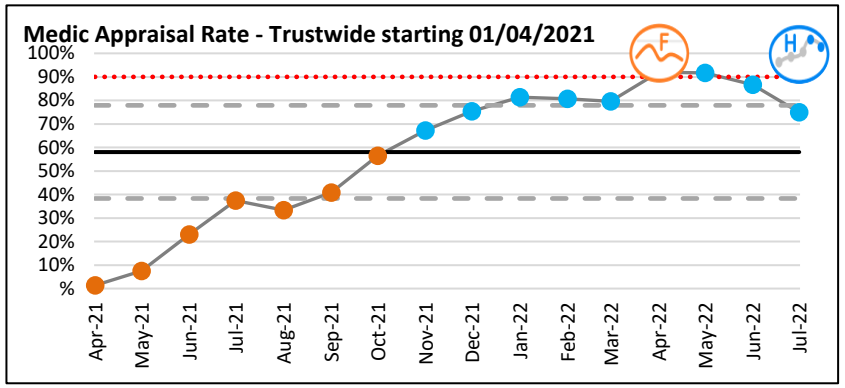
Wellbeing initiatives are being introduced for staff. Career pathways are being developed for support workers and there is a focus on supervision to increase retention.

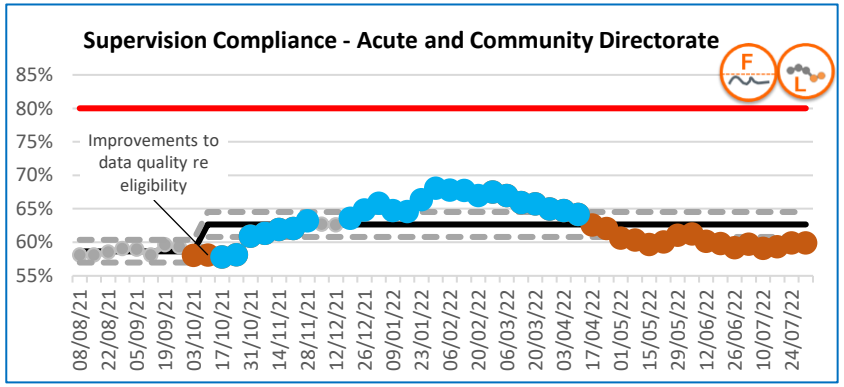
PDR Template has been refreshed to encourage holistic conversations to support career objectives and well-being.

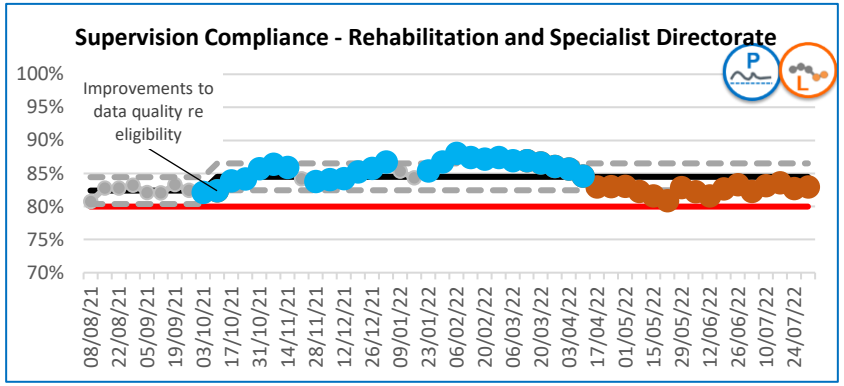
Well-Led | Supervision & PDR/Appraisal

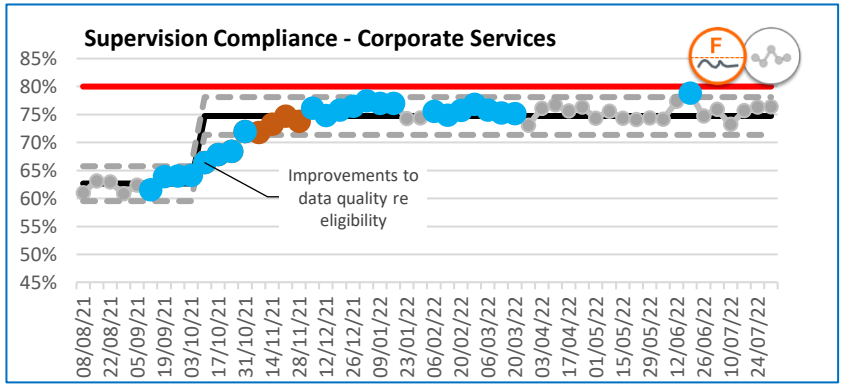












AIM

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

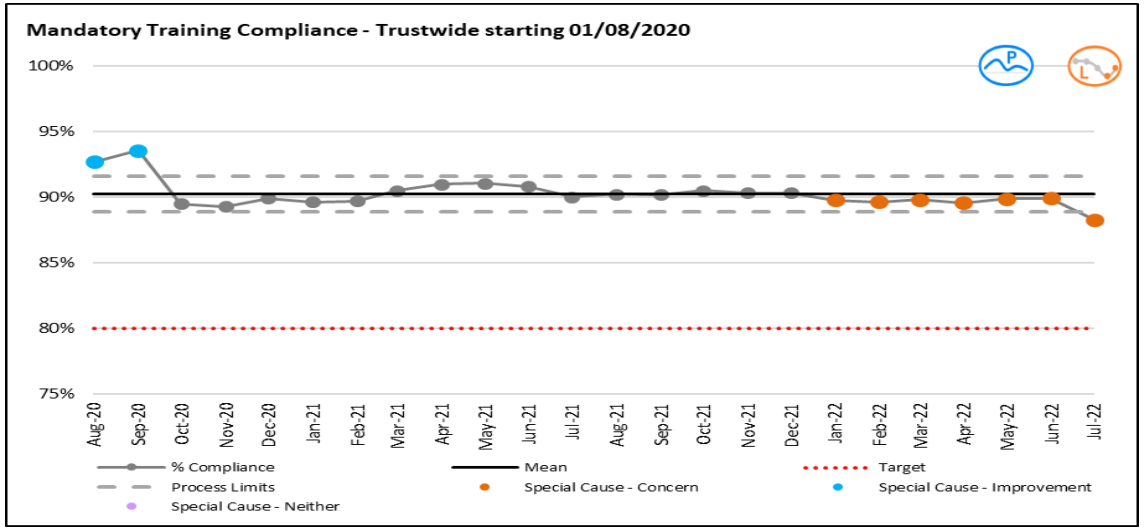
As at 31 July 2022, average compliance with the 8/12 target is:

Trustwide	**69.16%**
Clinical Services	**67.60%**

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 31/07/22**
Trustwide	**88.26%**
Directorate/Service Line	
Corporate Services	85.17%
Medical Directorate	77.69%
Acute & Community – Crisis	90.78%
Acute & Community – Acute	91.01%
Acute & Community – Community	92.69%
Acute & Community – Older Adults	84.42%
Rehab & Specialist – Forensic & Rehab	91.79%
Rehab & Specialist – Highly Specialist	93.14%
Rehab & Specialist – Learning Disabilities	92.96%
Rehab & Specialist – IAPT	93.15%
Rehab & Specialist – START	89.21%

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

EXCEPTIONS
There are three subjects below 75% compliance which are Immediate Life Support, Respect Level 3 and Safeguarding Children L3. Information Governance is below the national target of 95%. Decrease in Respect L3 and ILS was expected following agreed changes to the requirements for staff at Woodland View and Birch Avenue from the 1st of July – there is a plan in place to get staff trained and therefore compliant.

		26 June 2022		31 July 2022		
Subject	**Level**	No NOT Achieved	Compliance	No NOT Achieved	Compliance	Comments
Information Governance (aka Data Security Awareness)	-	382	85.45%	436	83.84%	95% target
Resuscitation (BLS)	2	288	81.19%	338	76.91%	80% target
Immediate Life Support	-	37	82.13%	72	74.19%	80% target
Mental Health Act	-	31	80.98%	34	79.64%	80% target
Rapid Tranquilisation	-	37	85.77%	63	78.93%	80% target
Respect L3	3	60	82.30%	182	67.09%	80% target
Safeguarding Children	3	310	71.66%	348	69.01%	90% target

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Financial Performance

IPQR - Information up to and including July 2022

Proud to care in Sheffield

Executive Summary

KPI	Annual Plan £'000	Year to Date Plan £'000	Year To Date Actual £'000
Surplus/(Deficit)	0	(344)	(1,039)
Covid Expenditure	1,161	393	459
Agency	4,348	1,622	2,997
Cash	61,938	59,017	59,736
Efficiency Savings	5,166	1,368	1,368
Capital	10,500	3,529	2,014
Better Payments Practice Code		99% by Number 99% by Value	

Summary at July 2022:

- The reported deficit of £1.039m at M4 was £0.695m adverse to the plan. This is not unexpected and reflects the movement in the Trust's annual plan from a £2.7m deficit to a break even position. Approximately £1m additional income has been received from the ICB with the remaining £1.7m due to be found through further efficiency savings not identified recurrently at the planning stage. This extra efficiency requirement was expected to be mitigated by underspends from vacancies and other non recurrent slippage whilst more recurrent plans are developed.
- Covid expenditure continues to be monitored in the current financial year. It is currently adverse to plan. This is not considered to be a significant risk and is expected to return in line with the plan going forward.
- Planned agency spend for 22-23 is approximately £1.5m lower than 21-22 full year spend as this is an agreed targeted area for CIP plans. The Trust is currently spending almost £1.4m more than plan for the YTD, with significant pressures for consultants, career/ staff grades and support to nursing staff. Agency caps will be reintroduced by NHSI later in the financial year. The YTD overspend is offset by underspends on substantive and bank staff costs. Agency costs are expected to reduce going into quarter 3 as the action plans are implemented to make savings in this area.
- SHSC has reported achievement against the YTD efficiency plan to NHSI as a result of non-recurrent vacancy mitigations. This is as expected as schemes have not yet been developed to deliver the £5.166m plan but is a risk going forward as the mitigation is unlikely to be sustainable as recruitment activity progresses. Recurrent CIP savings have commenced delivery but are significantly short to date. It is imperative that recurrent schemes are identified and implemented at pace to ensure a breakeven position at year-end.
- Capital is underspending against plan from a profile and timing perspective, however emerging needs and cost pressures associated with inflation mean this remains an area of focus and close monitoring. Functions are collaborating and working towards compliant and timely delivery.
- The cash balance remains healthy and we continue to achieve the Better Payments Practice code standards of at least 95%. Debt owed to SHSC remains within expected levels and there are no working capital concerns.

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Covid-19

IPQR - Information up to and including July 2022

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Well-Led | Covid-19 Outbreaks

July 2022 Covid Outbreaks				
Ward	Outbreak Start Date	Outbreak End Date	Patients Affected	Staff Affected
Dovedale 2	10/07/2022	27/07/2022	2	5
Maple	12/06/2022	09/07/2022	7	8
Dovedale 1	15/06/2022	14/07/2022	1	7
Dovedale 1	22/07/2022	02/08/2022	1	4
G1	28/06/2022	04/07/2022	1	3
Woodland View	23/06/2022	20/07/2022	15	17
Forest Close	25/06/2022	05/08/2022	3	14

Covid Status as at 01/08/2022				
	COVID-19 Status			
Acute and Community	Outbreak Start Date	Open for admissions	Positive Patients	Positive Staff
Dovedale 2 (F)	-	YES	0	0
Stanage (M)	-	YES	0	1
Maple	-	YES	0	1
Endcliffe	-	YES	0	0
Beech	-	YES	1	0
Dovedale 1	22/07/2022	Risk Ass Req.	0	1
G1	-	YES	0	0
Birch Avenue	-	YES	0	0
Woodland View	-	YES	0	0
Rehab and Specialist	Outbreak Start Date	Open for admissions	Positive Patients	Positive Staff
Forest Close	25/06/2022	Risk Ass Req.	0	3
Forest Lodge	-	YES	0	0
Buckwood View	-	YES	0	0

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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:

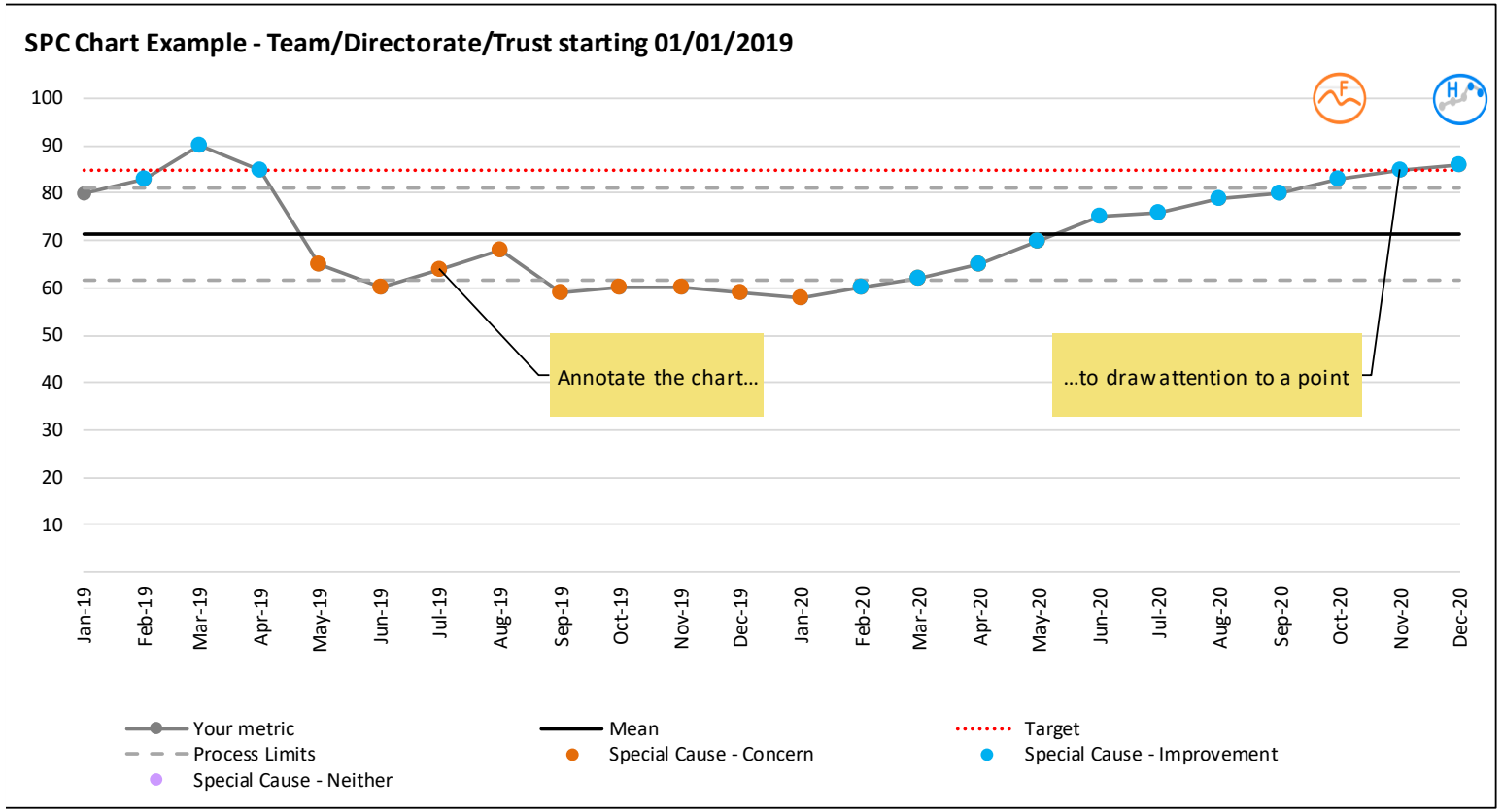
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	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