Board of Directors - Public

SUMMARY	Meeting Date:	January 2023
	Agenda Item:	11

Report Title:	**Integrated Performance and Quality Report (IPQR) November 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:	10 January 2023 11 January 2023 12 January 2023
Key Points recommendations to or previously agreed at:	**Comments from People Committee** The committee was encouraged by the improvement in data which will support future reporting • Work is ongoing for the development of the workforce dashboard and what needs to be included in that and in the IPQR for example the committee asked that workforce data by service line be included to identify under resourced areas and any further risks • They were assured by plans for a new group to be established in the New Year to focus on improving workforce equalities data and that some focused work is taking place on work around improving service user data. They were concerned about • Reporting showed that 35% of sickness is related to stress/anxiety or depression. They require oversight of prevention and restorative work and have asked for detail on sickness hotspots to be included in the IPQR and workforce dashboard benchmarked against high performing trusts. • By way of triangulation, they have asked for wellbeing initiatives to be covered in future health and wellbeing reports and have suggested a sickness workstream be established to feed into the Agency reduction board.	

	Comments from Quality Assurance Committee IPQR was received alongside deep dives into the recovery plans for 4 key quality risk areas. QAC continued to note concern to the use of OOA beds and the associated poor patient experience and financial implications as a result of increasing numbers. Supervision across SHSC was also noted as an area of concern despite ongoing treatment plans which have failed to achieve impact. There was positive assurance in relation to the improvement plans for CPA, waiting times across a range of community services and the mitigations for interventions whilst patients await a care coordinator. The steady increase in waiting times for memory service was noted, reference to the new clinical model was made and the positive impact this will have on patients waiting. Older Adults CMHT has also seen a further rise in patients waiting for assessment, further detail on the recovery plans will be received in future Quality committees. **Comments from Finance and Performance Committee** There are no new risks of note. The summary of risks that are not fully managed or are persistent are: Flow across the acute care pathway which risks beds not being available in SHSC to ensure people have the right care at the point of need, impacting on out of area bed usage and delivery of CIP. Waits for treatment across a number of community services. Assurance was requested re how these conversations develop with commissioners during operation planning Increased high level of Agency spend – Significant concerns remain, and detail requested re expected timing of impact from improved controls The areas of highlighted performance which are cause for celebration or risk/concern for the attention of Finance & Performance are shown below.

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 November 2022.

The report was presented and considered in detail to the People Committee, Quality Assurance and Finance & Performance Committees in January 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
F	Q			Inpatient Length of Stay – Older Adults OOA – Older Adults	10		Decreasing trend in Older Adult inpatient ward Dovedale 1 G1 passing target for average discharged length of stay (12m rolling) No inappropriate OOA admissions since February 2022
F	Q			Average discharged Length of Stay – Forest Close & Forest Lodge	11		Performance above national benchmarks
F	Q			Annual CPA Review	14		Improving Performance in Recovery North. Early Intervention attained 100% for the last three months.
F	Q			Early Intervention Waiting Times Standard	14		9 months above target for EI Waiting Times Standard
F	Q			IAPT	15		Meeting/exceeding targets for waiting times 6 week wait times being met and increasing % meeting target
F	Q			START - RtT	16		Alcohol passing RtT target
	Q	P		Assaults on Staff	21		Trustwide – low number of Assaults on Staff reported (26 for A&C, 2 for R&S)

	Q	P		Restrictive Practice	23		Rehab and Specialist – low number of physical restraints reported
	Q		M	Restrictive Practice Incidents	24		Low number of rapid tranquillisation incidents on Dovedale 1.
	Q			Friends and Family Tests	26		High number of friends and family tests received trust wide. From the total 200 number of responses that will be submitted on the national return, 199 were positive.
	Q	P		Supervision	33		Rehabilitation & Specialist service area are exceeding target

Performance Concern							
Committee				KPI/Area	Refer to (slide)	Performance	Trend/ Trajectory	Recovery Plan?
F	Q			Demand for Services	4		Increasing trend noted for SAANS and Health Inclusion Team.	Recovery Plan for both. Board paper has been presented for SAANs.
F	Q			Waiting Times	5-7		Increasing trend/sustained high waits in certain areas noted EWS, Recovery teams, SMS, ME/CFS, STEP.	Recovery Plan x 2 (EWS, Recovery Teams)
F	Q			Waiting Lists	5		Increased waiting lists for Recovery teams, SMS, OACMHT, SPS MAPPS, Gender, STEP, SAANS and HIT.	
F	Q			Caseloads/Open Episodes	5		Increasing trend in OA CMHT, SMS and Highly Specialist community services (SPS MAPPS, Gender, Eating Disorders, SAANS, Perinatal, CLDT & SCFT).	Recovery Plan x 2 (Gender & SAANS)
F	Q			Bed Occupancy Length of Stay and Delayed Discharge (inpatient areas)	8		Increasing trend in acute wards.	Linked to Out of Area Recovery Plan(s) x 3
F	Q			Out of Area Placements	8-9		Failing to meet reduction/elimination of inappropriate OAPs in acute.	Out of Area Recovery Plan(s) x 3
F	Q			G1 Live length of stay	10		Live length of stay high in November.	
F	Q			HBPoS bed use	12		Not enough data points for SPC but high number of HBPoS beds being blocked due to mental health ward admissions. 27% in November.	
F	Q			A&E Breaches	12		There were 3 A&E Breaches in November 2022.	
F	Q			Delayed Care	12		High bed nights delayed in month for Adult Acute. 31.8% of bed nights available in month were used by delayed service users.	
F	Q			Annual CPA Review	14		Failing to meet 95% target Trustwide 91.5% Recovery South 80%.	Recovery Plan in place.
F	Q			START – DNA rates	16		Non-Opiates failing to meet <15% target for DNA rate to assessment (28% in November 2022).	

	Q			Missing patients (Detained)	21		High number of detained missing patients reported trustwide.	
	Q		M	Restrictive practice incidents	23-25		High number of physical restraints on Dovedale 2. High number of rapid tranquillisations on Dovedale 2.	
		P		Sickness Absence	30	 	Increasing trend Trustwide. Failing to meet Trust target.	People delivery plan actions for 22/23 and additional investment to support absence management and wellbeing actions.
		P		Staff Turnover Rate	30		Failing to meet 10% turnover target. 14.33% in November 2022.	
	Q	P		Supervision	33		Failing to meet 80% target Trustwide.	CQC Back to Good Action Plan/Local Recovery Plans.
		P		Mandatory Training	34		Underperformance against 80/90/95% targets in some areas.	
F				Agency and Out of Area Placement Spend	36		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

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	✓	**Information**	✓
The Trust Board is asked to accept the assurance provided by this report, whilst acknowledging the ongoing concerns to performance and quality in the identified areas.							

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

Is this report relevant to compliance with any key standards?					**State specific standard**
Care Quality Commission	***Yes***	✓	*No*		This report ensures compliance with NHS Regulation – CQC Regulation may be a by-product of this.

Data Security and Protection Toolkit				✓	
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
OD/Workforce	*Yes*	✓	*No*		Any impact is highlighted within relevant sections.
Equality, Diversity & Inclusion	*Yes*	✓	*No*		Work looking at EDI concerns is underway which may suggest the inclusion of certain indicators as future developments occur.
Legal	*Yes*		*No*	✓	

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Integrated Performance & Quality Report

Information up to and including November 2022

Proud to care in Sheffield

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.

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 November 2022 reporting, we are using monthly figures from December 2020 to November 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

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 November 2022

Proud to care in Sheffield

Responsive | Access & Demand | Referrals

Referrals	Nov-22			
Acute & Community Directorate Service	n	mean	SPC variation	Note
SPA/EWS	695	702	• L •	The baseline was re-calculated in July 2021 due to Safeguarding referrals being moved to the Safeguarding team.
AMHP	159	145	• • •	
Crisis Resolution and Home Treatment	856	In February 2022, 5 teams merged to create the Crisis Resolution & Home Treatment Team (4 Adult Home Treatment Teams & Out of Hours). Due to the limitations of reporting from Insight, we require the RiO implementation to get accurate data.		
Liaison Psychiatry	479	485	• • •	
Decisions Unit	51	56	• • •	The baseline was re-calculated for the full re-opening of DU in May 2021.
S136 HBPOS	46	35	• • •	
Recovery Service North	19	22	• • •	
Recovery Service South	17	23	• • •	
Early Intervention in Psychosis	54	39	• • •	
Memory Service	115	131	• • •	The baseline was re-calculated due to a sustained increase in referrals from April 2021.
OA CMHT	243	250	• • •	
OA Home Treatment	20	26	• • •	

Referrals	Nov-22			
Rehab & Specialist Service	n	mean	SPC variation	Note
CERT	3	3	• • •	
SCFT	1	1	• • •	
CLDT	79	57	• • •	CLDT figures represent distinct individuals so does not include multiple referrals per service user.
CISS	7	4	• • •	
Psychotherapy Screening (SPS)	56	45	• • •	
Gender ID	41	43	• • •	
STEP	112	94	• • •	
Eating Disorders Service	32	33	• • •	
SAANS	509	371	• H •	There has been exponential demand over the last two years, the baseline was recalculated in Jan 2021 to reflect this.
Relationship & Sexual Service	22	19	• • •	
Perinatal Service (Sheffield)	49	49	• • •	
HAST	16	16	• • •	
Health Inclusion Team	274	145	• H •	Demand has grown over the last few months.
LTNC	115	95	• • •	
ME/CFS	46	48	• • •	Data inaccuracy due to admin system inefficiency.

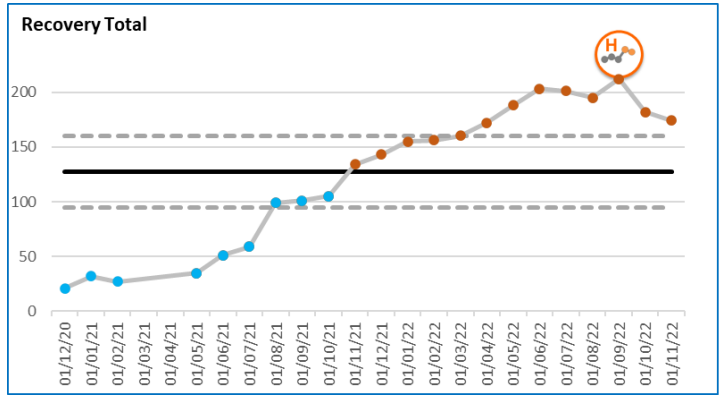
Responsive | Access & Demand | Community Services

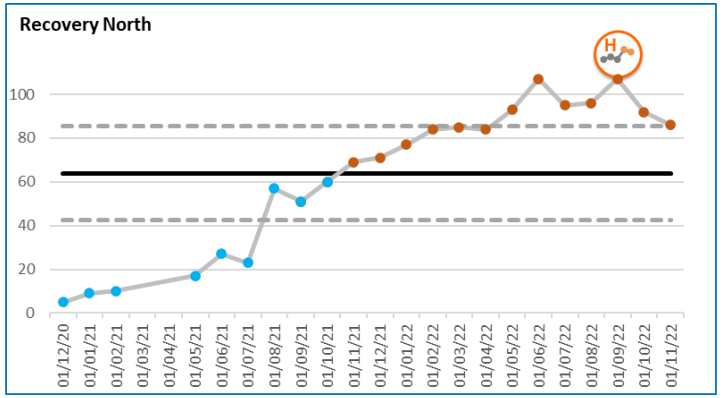
November 2022	Number on wait list at month end			Average wait time referral to assessment for those assessed in month			Average wait time referral to first treatment contact for those 'treated' in month			Total number open to Service		
	Waiting List			Average Waiting Time (RtA) in weeks			Average Waiting Time (RtT) in weeks			Caseload		
Acute & Community Services	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**
SPA/EWS	**519**	*804*	• L •	**31.6**	*26.7*	• H •	**7.3**	*10.2*	• • •	**818**	*1137*	• L •
MH Recovery North	**86**	*64*	• H •	**20.3**	*7.5*	• H •	**8.9**	*10.7*	• • •	**931**	*966*	• L •
MH Recovery South	**88**	*62*	• H •	**20.2**	*9.2*	• H •	**5.8**	*11.6*	• • •	**1078**	*1080*	• L •
Recovery Service TOTAL	**174**	*126*	• H •	*N/A*			*N/A*			**2009**	*2046*	• L •
Early Intervention in Psychosis	**26**	*22*	• • •				**84.6%**			**285**	*350*	• L •
Memory Service	**1012**	*581*	• H •	**37.3**	*20.0*	• H •	**43.1**	*29.0*	• H •	**4552**	*4236*	• H •
OA CMHT	**262**	*149*	• H •	**7.8**	*6.9*	• • •	**9.6**	*10.2*	• • •	**1366**	*1250*	• H •
OA Home Treatment	*N/A*			*N/A*			*N/A*			**64**	*63*	• • •
Rehab & Specialist Services	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**
SPS - MAPPS	**78**	*67*	• L •	**15.6**	*21.7*	• • •	**64.9**	*71.5*	• • •	**345**	*324*	• H •
SPS - PD	**34**	*43*	• • •	**11.5**	*23.5*	• L •	**51.5**	*69.6*	• • •	**192**	*193*	• • •
Gender ID	**1910**	*1547*	• H •	**109.3**	*118.0*	• • •	*N/A*			**2713**	*2337*	• H •
STEP	**229**	*100*	• H •	*N/A*			**3.8**	*3.0*	• H •	**427**	*395*	• • •
Eating Disorders	**29**	*32*	• • •	**4.4**	*4.9*	• L •				**229**	*215*	• H •
SAANS	**6046**	*4442*	• H •	**78.6**	*96.5*	• L •				**6300**	*5065*	• H •
R&S	**103**	*182*	• L •	**106.7**	*89.0*	• • •				**185**	*231*	• L •
Perinatal MH Service (Sheffield)	**23**	*24*	• • •	**4.4**	*3.1*	• • •	*N/A*			**145**	*139*	• H •
HAST	**17**	*29*	• L •	**8.2**	*11.7*	• • •				**71**	*81*	• • •
Health Inclusion Team	**224**	*193*	• H •	**4.1**	*5.3*	• • •				**1473**		
LTNC				*N/A*						*N/A*		
CFS/ME	*N/A*			**23.3**	*15.7*	• H •				**2812**		
CLDT	**137**	*187*	• L •	**9.4**	*13.0*	• L •	**14.6**	*21.6*	• • •	**710**	*759*	• H •
CISS	*N/A*			*N/A*			*N/A*			**17**	*30*	• L •
CERT	**3**									**42**	*45*	• • •
SCFT	**1**	*1*	• • •							**24**	*24*	• H •

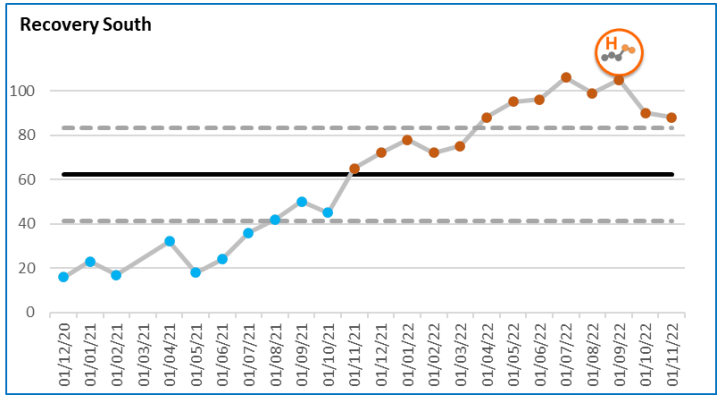
Narrative

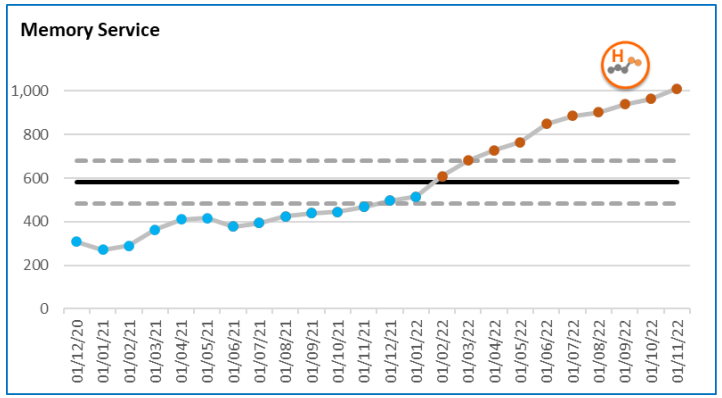
There are still increasing waits and high numbers of service users on service caseloads (the number of open episodes of care to our community teams). Recovery Plans are in place for the services experiencing the biggest issues although these aren't currently leading to improvement.

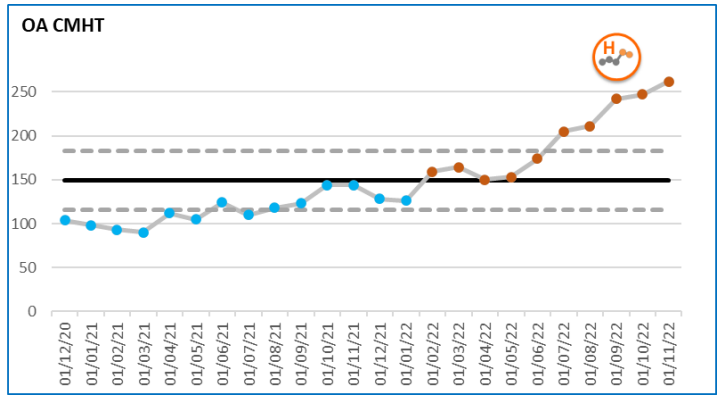
Responsive | Access & Demand | Wait Lists SPC Charts | Acute & Community











Narrative

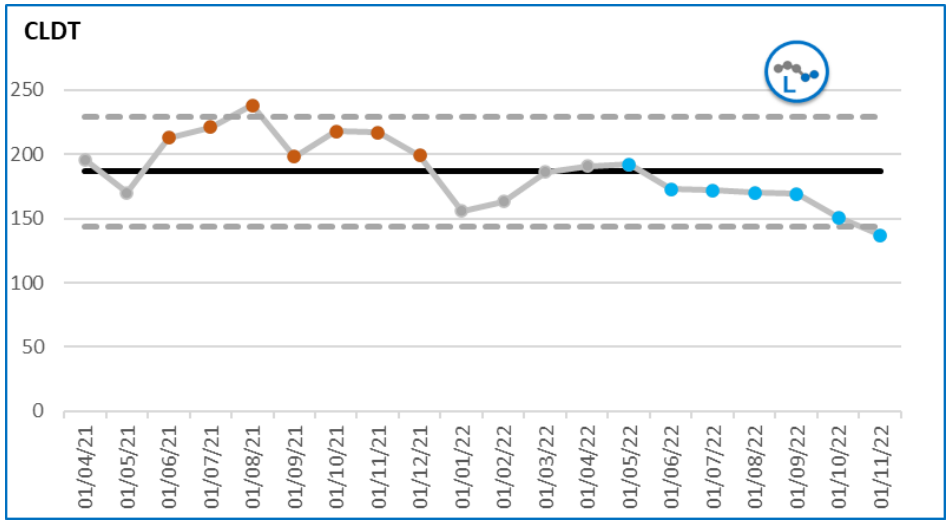
*Only showing SPCs showing special cause variation

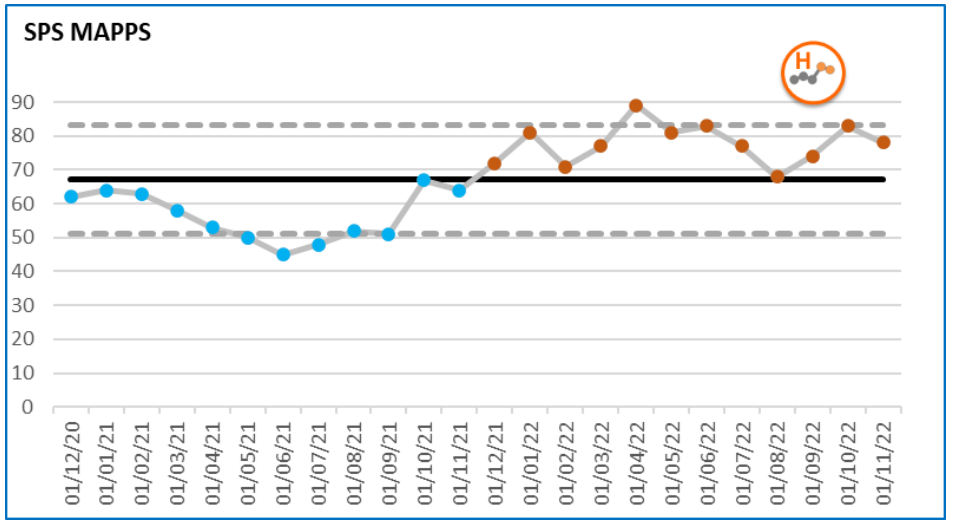
Memory Service – There has been an increased demand and they are unable to complete as many initial assessments due to vacancy and sickness rates. Recovery plan in place.

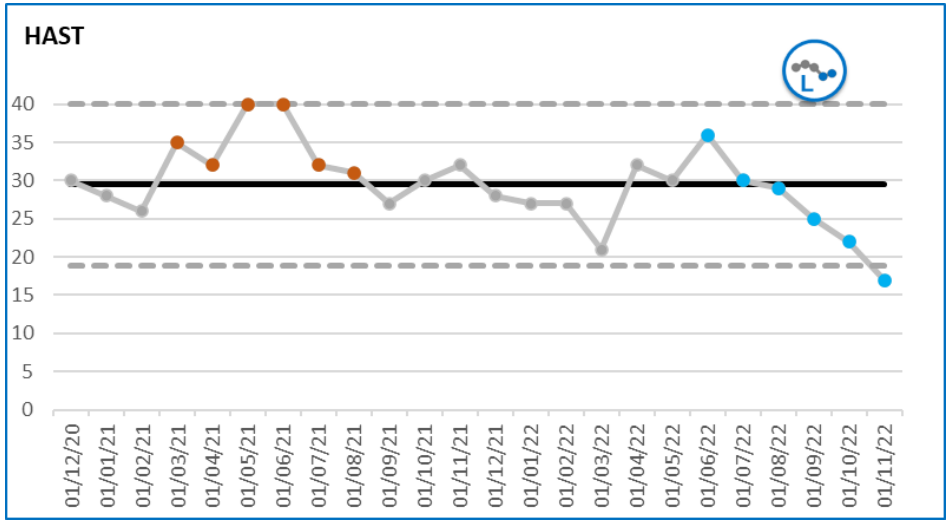
OA CMHT – Increase attributed to staff vacancies and complex cases. The team have higher caseloads than previously worked with.

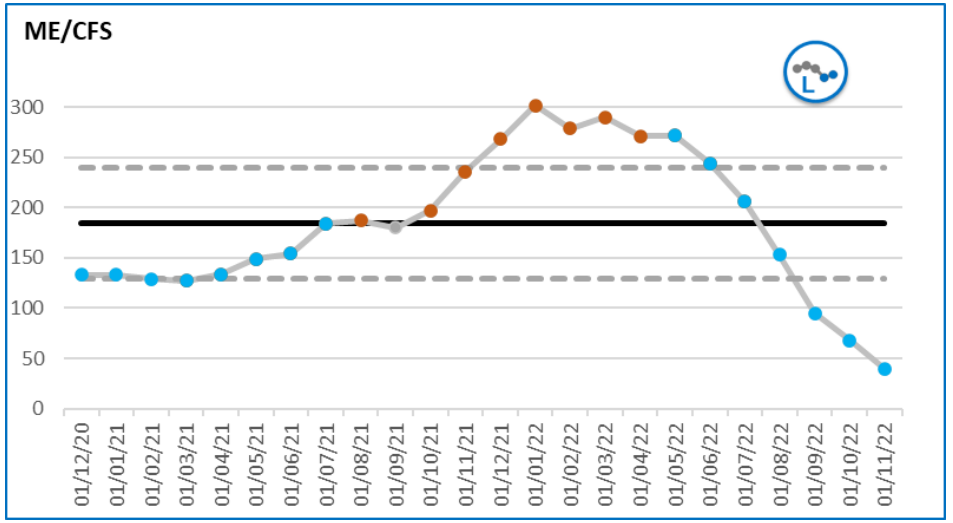
SPA/EWS – improved data quality, improved functionality within Insight referrals module which means more accurate recording, Senior Practitioners reviewing waiting list and checking intervention still required, as well as reviewing whether patients can move to voluntary sector. Some of those are then satisfied and don't require further intervention. It is not a consequence of increased capacity to deliver assessments. Length of time people waiting has not reduced.

Responsive | Access & Demand | Wait Lists SPC Charts | Rehab & Specialist









Narrative

**Only showing SPCs showing special cause variation*

CLDT figures represent distinct individuals so does not include multiple waits per service user.

ME/CFS – Querying data for SystmOne teams as data doesn't pass the eye test, could be linked to risk identified at directorate level (risk no. 4508). Deep dive underway to unpick and resolve.

Safe | Inpatient Wards | Adult Acute & Step Down

Adult Acute (Burbage/Dovedale 2, Stanage/Burbage, Maple)	Nov-22 n	mean	SPC variation	SPC target
Admissions	25	32	• • •	/
Detained Admissions	24	29	• • •	/
% Admissions Detained	96.00%	90.21%	• • •	/
Emergency Re-admission Rate (rolling 12 months)	4.95%			
Transfers in	15			
Discharges	28	32	• • •	/
Transfers out	26			
Delayed Discharge/Transfer of Care (number of delayed discharges)	18			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	420			
Bed Occupancy excl. Leave (KH03)	95.7%	93.70%	• H •	/
Bed Occupancy incl. Leave	99.8%	97.99%	• • •	/
Average beds admitted to	48.0			
Average Discharged Length of Stay (12 month rolling)	39.54	38.52	• • •	F
Average Discharged Length of Stay (discharged in month)	39.23	37.99	• • •	?
Live Length of Stay (as at month end)	94.64	62.98	• H •	/
Number of People Out of Area at month end	17	12	• • •	F
Number of Mental Health Out of Area Placements started in the period (admissions)	13	9	• • •	?
Total number of Out of Area bed nights in period	358	355	• • •	F

Length of Stay Detail – November 22

Longest LoS (days) as at month end: 365 on Dovedale 2 , 365 on Maple, Longest LoS (days) of discharges in month: Dovedale 2 = 61, Maple = 135

Stanage ward move to Burbage has reset LoS to 1 for new ward

Dovedale 2 Planned transfer to Forest Close 8Dec
Maple longest Stay - Had a spell at NGH, currently looking at residential homes

Step Down (Beech Formerly Wainwright Crescent)	Nov-22 n	mean	SPC variation	SPC target
Admissions	4	6	• • •	/
Transfers in	0			
Discharges	6	5.6	• • •	/
Transfers out	0			
Bed Occupancy excl. Leave (KH03)	78.0%	76.40%	• • •	/
Bed Occupancy incl. Leave	86.3%	85.33%	• • •	/
Average Discharged Length of Stay (12 month rolling)	48.62	63.49	• L •	/
Live Length of Stay (as at month end)	41.43	39.14	• • •	/

Length of Stay Detail – Nov 22
Longest LoS (days) as at month end: 111
Range = 9 to 111 days
Longest LoS (days) of discharges in month: 125

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)	Nov-22 n	mean	SPC variation	SPC target
Admissions	4	3	•••	/
Transfers in	2			
Discharges	2	2	•••	/
Transfers out	4			
Delayed Discharge/Transfer of Care (number of delayed discharges)	1			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	30			
Bed Occupancy excl. Leave (KH03)	93.3%	93.7%	•••	/
Bed Occupancy incl. Leave	95.0%	96.2%	•••	/
Average beds admitted to	9.5			
Average Discharged Length of Stay (12 month rolling)	47.09	50.89	•••	?
Live Length of Stay (as at month end)	102.11	92.20	•••	/
Number of People Out of Area at month end	4	5	•••	F
Number of Mental Health Out of Area Placements started in the period (admissions)	0	3	•••	?
Total number of Out of Area bed nights in period	141	145	•••	F

Narrative

As at 30/11/22, there were 3 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. The patient has been referred to rehabilitation pathway.

Endcliffe – Length of Stay – November 22
Over national benchmark average (47)

Start Date	LOS
02/02/2021 17:38	666
13/09/2022 17:15	78
11/10/2022 21:20	50

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)	Nov-22 n	mean	SPC variation	SPC target
Admissions	6	5	● ● ●	/
Transfers in	0			
Discharges	5	6	● ● ●	/
Transfers out	1			
Delayed Discharge/Transfer of Care (number of delayed discharges)	2			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	38			
Bed Occupancy excl. Leave (KH03)	70.7%	90.3%	● L ●	/
Bed Occupancy incl. Leave	79.1%	95.7%	● L ●	/
Average beds admitted to	12			
Average Discharged Length of Stay (12 month rolling)	67.00	71.56	● ● ●	?
Live Length of Stay (as at month end)	44.85	83.88	● L ●	/

Length of Stay Detail November 22 – Dovedale 1
Longest LoS (days) as at month end: **102**
Range = 0 to 102 days
Longest LoS (days) of discharges in month: 463

Narrative

Longest LoS – highly complex patient that was distressed requiring restraining for long periods of time. Discharge/best interests meeting held 8th November with potential discharge date of 16th November. If leave goes well they will be discharged under a Community Team Order.

Older Adult Dementia (G1)	Nov-22 n	mean	SPC variation	SPC target
Admissions	2	5	● ● ●	/
Transfers in	1			
Discharges	7	4	● ● ●	/
Transfers out	1			
Delayed Discharge/Transfer of Care (number of delayed discharges)	10			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	193			
Bed Occupancy excl. Leave (KH03)	73.5%	70.2%	● ● ●	/
Bed Occupancy incl. Leave	76.3%	72.1%	● ● ●	/
Average beds admitted to	12.2			
Average Discharged Length of Stay (12 month rolling)	67.41	63.88	● ● ●	P
Live Length of Stay (as at month end)	70.09	51.79	● H ●	/

Length of Stay Detail November 22 – G1
Longest LoS (days) as at month end: **280**
Range = 9 to 280 days
Longest LoS (days) of discharges in month: 138

Narrative

Longest LoS – highly complex needs requiring intensive nursing on 2:1 observation with high level of restraint to maintain safety of patient and staff

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)	Nov-22 n	mean	SPC variation	SPC target
Admissions	1	1	• L •	/
Transfers in	0			
Discharges	3	3	• • •	/
Transfers out	0			
Delayed Discharge/Transfer of Care (number of delayed discharges)	0			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	0			
Bed Occupancy excl. Leave (KH03)	84.7%	81.7%	• H •	?
Bed Occupancy incl. Leave	93.3%	92.5%	• • •	
Average Discharged Length of Stay (12 month rolling)	268.56	293.31	• L •	P
Live Length of Stay (as at month end)	388.15	338.06	• H •	/
Number of Out of Area Placements started in the period (admissions)	0			
Total number of Out of Area bed nights in period	150			
Number of People Out of Area at month end	5			
Cost of Out of Area bed nights in period	Refer to Directorate Finance Report			

Forensic Low Secure (Forest Lodge)	Nov-22 n	mean	SPC variation	SPC target
Admissions	0	1	• • •	/
Transfers in	3			
Discharges	1	1.1	• • •	/
Transfers out	3			
Bed Occupancy excl. Leave (KH03)	95.9%	85.2%	• H •	?
Bed Occupancy incl. Leave	99.7%	91.5%	• H •	
Average Discharged Length of Stay (12 month rolling)	354.00	428.93	• L •	P
Live Length of Stay (as at month end)	644.81	504.53	• H •	/

Forest Close

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

Long stays – Forest Close Nov 22

1407 – IC 37(41) – engaging well with CERT and has looked at a property and is likely to accept
650 – WC 37 (41) – agreed funding for residential and looking at Together, Lister and Bowden, however, currently has no S17 unescorted leave

Length of Stay Detail Nov 22 - Forest Close (all)

Longest LoS (days) as at month end: 868
Range = 34 to 868
Number of discharges in month: 3
Longest LoS (days) of discharges in month: 468

Benchmarking Rehab/Complex Care

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

Forest Lodge

Again, it should be noted that length of stay within Forest Lodge benchmarks very favourably against other low secure facilities across the country.

Long stays – Forest Lodge Nov 22

2123 - The rhetoric remains the same, as far as I am aware there are no current plans of transfer/discharge etc.
2025 – ED currently have got S62 in place for the ECT
2294 - Turned down for medium secure, plans are for him to continue to do substance misuse work, whilst appropriate placement is sought for him.

Length of Stay Detail Nov 22 – Forest Lodge

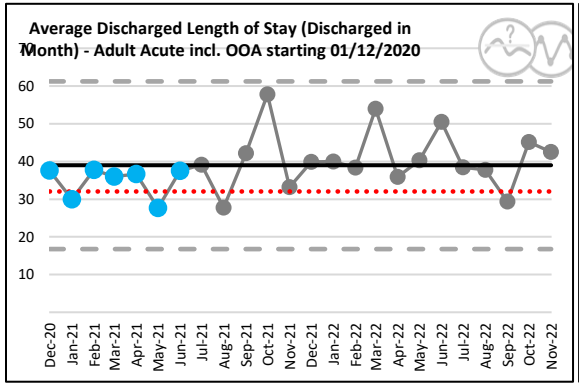
Longest LoS (days) as at month end: 954
Range = 0 to 954 days
Number of discharges in month: 1
Longest LoS (days) of discharges in month: 238

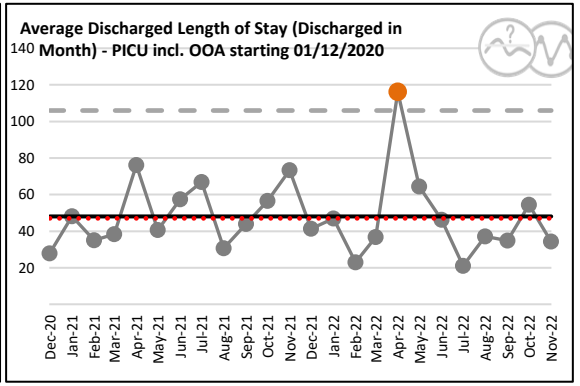
Benchmarking Low Secure Beds

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

UEC Dashboard

Length of Stay

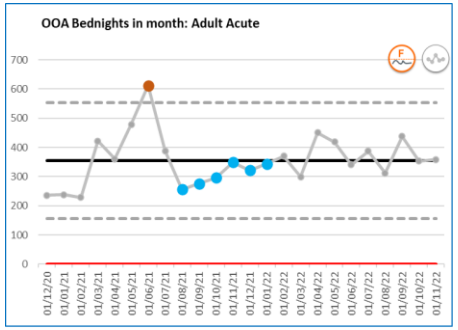


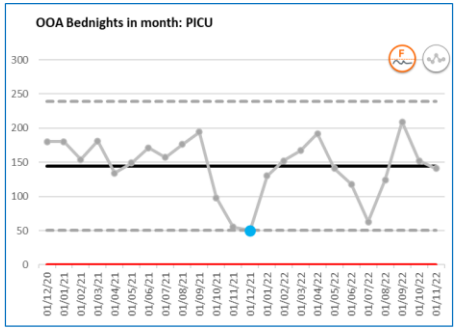


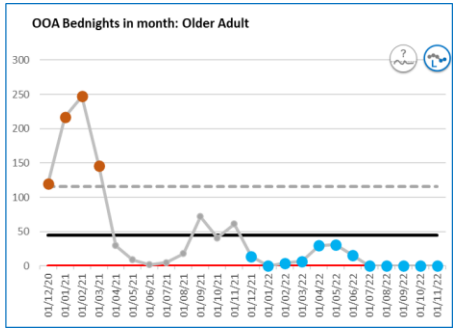
Adult Acute Discharged LoS (Rolling 12 month average)		
Location	**Total Discharges**	**Average Discharged LoS**
Sheffield	395	40
OOA	100	43
Contracted	119	45
Combined	**614**	**41**

PICU Discharged LoS (Rolling 12 month average)		
Location	**Total Discharges**	**Average Discharged LoS**
Sheffield	76	47
OOA	37	40
Combined	**113**	**45**

Out of Area

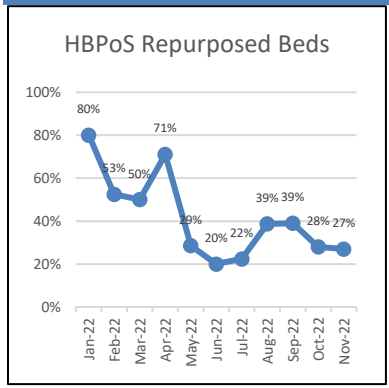


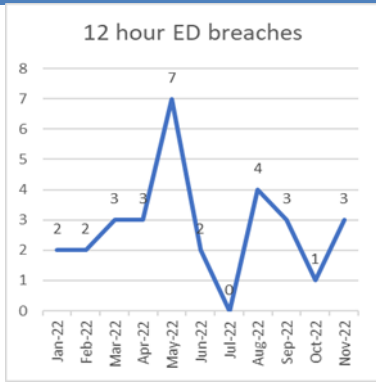




Provider	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Sparklines (Dec-21 to Nov-22)
Sheffield Health and Social Care NHS Foundation Trust	**11**	**17**	**13**	**13**	**21**	**14**	**11**	**11**	**12**	**19**	**14**	**20**	
Bradford District Care NHS Foundation Trust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

Blocks and Breaches





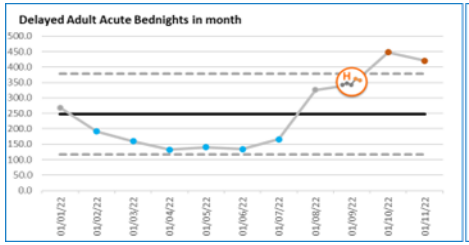
Health Based Place of Safety (HBPoS/136 Beds)	Nov-22
Days repurposed	16
Days repurposed %	27%

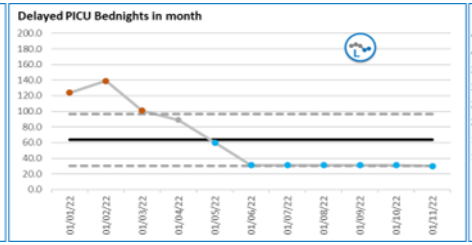
Emergency Department (ED)	Nov-22
ED 12 hour Breaches	3

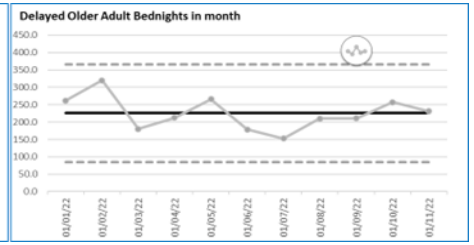
Delayed Care

Delayed Care Narrative

% of bed nights occupied by delayed patients is 29.8% across adult acute wards. Weekly Clinically Ready for Discharge meeting membership has been extended to include social care colleagues to support earlier information sharing and discharges for those delayed.







Delayed Discharges Adult Acute			
Nov 22	Count of Delayed Patients	Sum of Delayed Bednights	% Bednights occupied by DD
Dovedale 2	6	163	45.3%
Maple Ward	10	204	35.8%
Stanage Ward	2	53	11.0%
Adult Acute Total	18	420	31.8%

Delayed Discharges PICU			
Nov 22	Count of Delayed Patients	Sum of Delayed Bednights	% Bednights occupied by DD
Endcliffe	1	30	10.0%

Delayed Discharges Older Adult			
Nov 22	Count of Delayed Patients	Sum of Delayed Bednights	% Bednights occupied by DD
Dovedale 1	2	38	8.4%
G1	10	193	40.2%
Older Adult Total	12	231	24.8%

Safe | Inpatient Wards | Learning Disabilities (Firshill)

Section intentionally blank.
Learning Disabilities Inpatient Service currently closed.

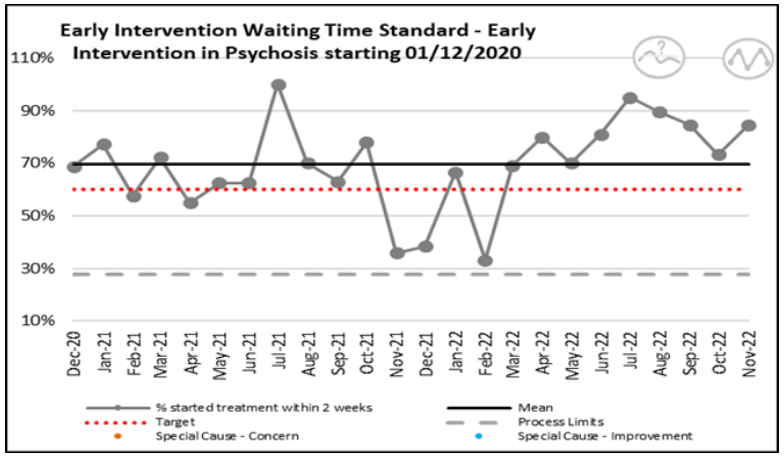
Narrative

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 October 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		Nov-22		
	Target 2022/23	N	SPC variation	SPC target
Trustwide	60%	**85.0%**	• • •	?

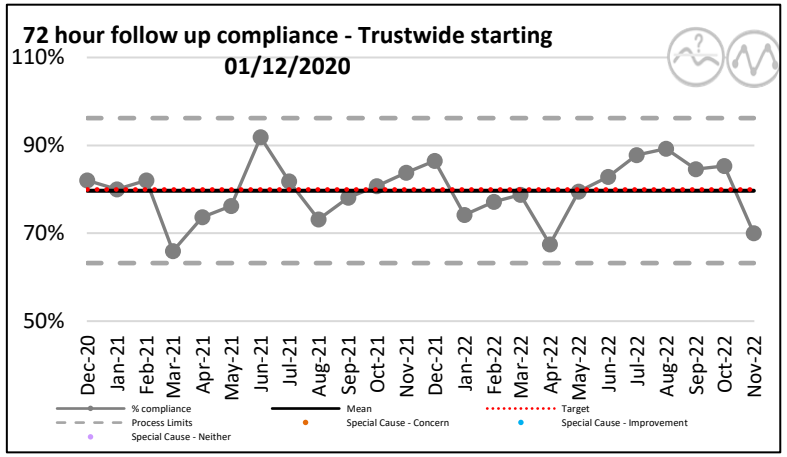
Narrative

2020/21 Standard: More than 60% of people experiencing a first episode of psychosis will be treated with a NICE approved care package.

The standard has increased from 53% (18/19) to 56% (19/20) and now to 60% with effect from 1 April 2021.

There is variation month on month, but our average over the last 2 year period is 69.3% indicating the system is capable of achieving the 20/21 target.

In November = 85% (21/27)



72-hour Follow Up		Nov-22		
	Target 2022/23	N	SPC variation	SPC target
Trustwide	80%	**70.0%**	• • •	?

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 November 22 was 70.0% (28/40) against the 80% target.

5 x Acute
2 people had follow up on day 3, recorded outside 72 hours
2 people had follow up on day 4
1 person had dx destination recorded incorrectly and should have been excluded – this has been fed back to the ward

7 x Older Adult
1 x person had a follow up on day 4
2 x people had a follow up on day 7 and 9 – not notified currently investigating
4 x people had no contact – not notified currently investigating.

CPA Review % Completed within 12 months	Target 2022/23	Nov-22 N	Nov-22 mean	Nov-22 SPC variation	Nov-22 SPC target
Trustwide	95%	**91.5%**	*83.2%*	• H •	F
Early Intervention	95%	**100.0%**	*88.8%*	• H •	?
MH Recovery North	95%	**94.6%**	*88.8%*	• H •	F
MH Recovery South	95%	**80.0%**	*74.5%*	• H •	F

Recovery South CPA percentage has reduced slightly month on month but is still showing as an improvement over time.

Quarter 1

With 3 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	0	(0 booked)
RECOVERY NORTH	12	(13 booked)
RECOVERY SOUTH	80	(23 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	0	AVERAGE: 2
RECOVERY NORTH	5	AVERAGE: 7
RECOVERY SOUTH	31	AVERAGE: 8

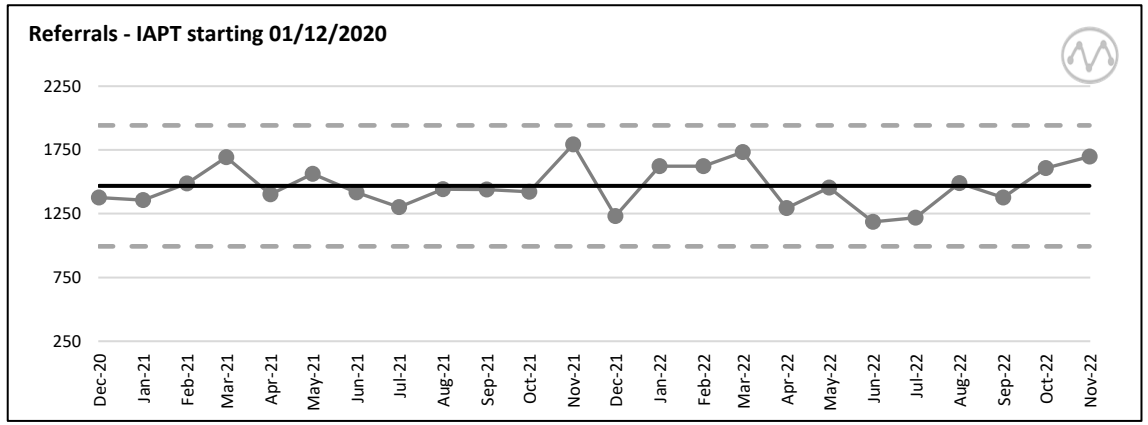
(Average per week - rolling 12 months)

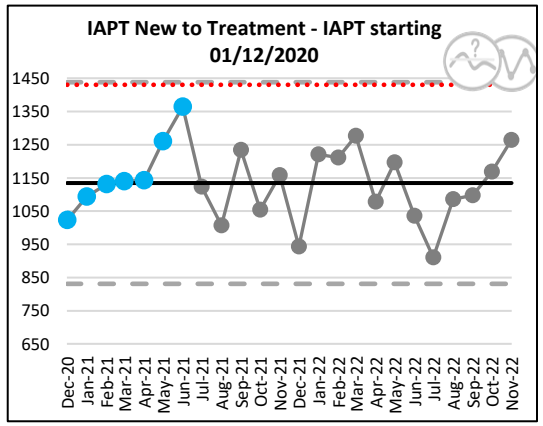
IAPT | Performance Summary

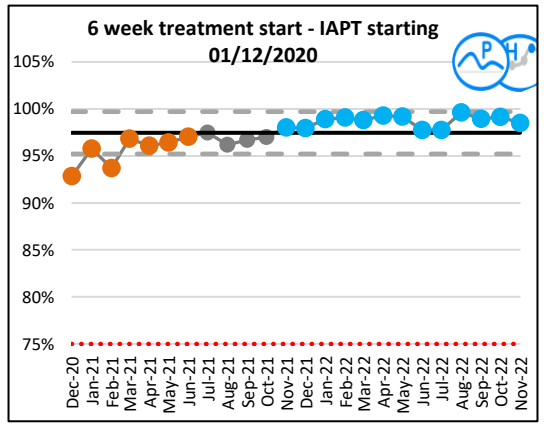
IAPT		Nov-22			
Metric	Target 2022/23	*n*	*mean*	*SPC variation*	*SPC target*
Referrals	/	**1698**	*1467*	• • •	/
New to Treatment	1431	**1264**	*1134*	• • •	?
6 week Wait	75%	**98.50%**	*97.45%*	• H •	P
18 week Wait	95%	**99.62%**	*99.66%*	• • •	P
Moving to Recovery Rate	50%	**50.88%**	*50.59%*	• • •	?

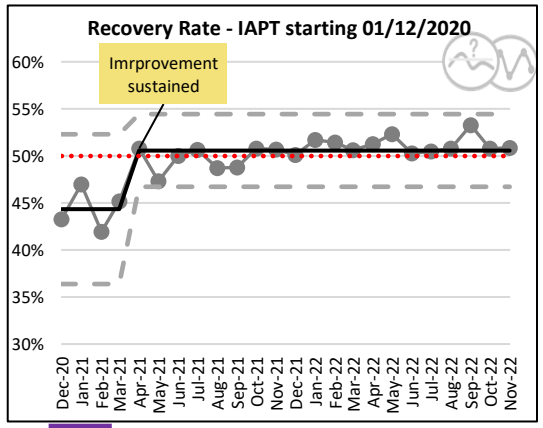
Narrative

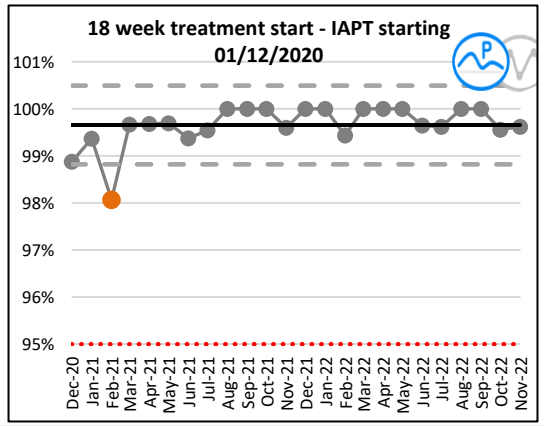
- We have achieved the Recovery rate standard for last 14 months with November hitting 50.88%. This is shared across the service each month and includes SPC charts we have developed.
- Continue to consistently exceed waiting time standard.
- Referrals are starting to increase on an upward trajectory into the service due to the many ways IAPT are implementing the promotional strategy and the return to Primary Care. Referrals still need to increase further, and work is underway to ensure this happens, see below.
- 3 month Hallam FM website takeover
- Billboards in Meadowhall
- 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		November-22		
Opiates	**Target 2022/23**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	93	• • •	/
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	100%	• • •	• • •
DNA Rate to Assessment	≤ 15%	26%	• • •	• • •
Recovery - Successful treatment exit	TBC	4	• • •	/
Non-Opiates	**Target 2022/23**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	100	• H •	/
Waiting time Referral to Treatment	≥ 95%	74%	• L •	• • •
DNA Rate to Assessment	≤ 15%	28%	• • •	• F •
Recovery - Successful treatment exit	TBC	12	• • •	/
Alcohol	**Target 2022/23**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	164	• • •	/
Waiting time Referral to Treatment	≥ 95%	100%	• H •	• P •
DNA Rate to Assessment	≤ 15%	25%	• • •	• • •
Recovery - Successful treatment exit	TBC	43	• • •	/
Criminal Justice Caseload	**Target 2022/23**	**November 2022**		
Numbers on caseload (NDTMS)	250	212		

Narrative

Engagement in treatment

Referral numbers to the opiates, alcohol and non-opiates services are not currently working to a target but the treatment places are closely monitored by 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.

Average waiting times for treatment assessment

November 22

Average wait time from referral to assessment in the opiates pathway was 3.7 days
Average wait time from referral to assessment in the non-opiates pathway was 8.7 days
Average wait time from referral to assessment in the alcohol pathway was 9.1 days

Waiting times from referral to treatment

In November 22 there were 5 people who waited longer than 21 days to start formal PSI treatment. These people were engaged with regular appointments with recovery workers at the same time as waiting for their PSI.

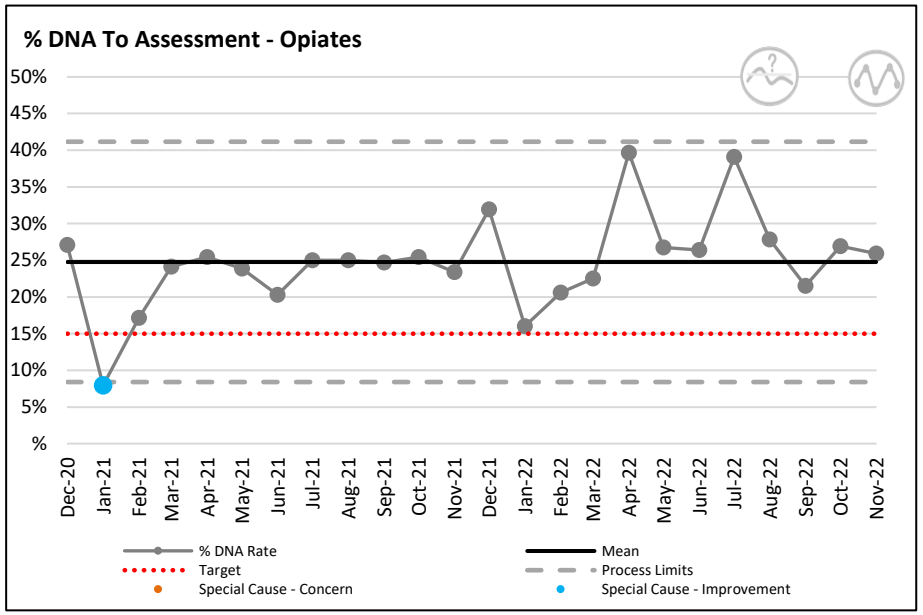
Criminal Justice

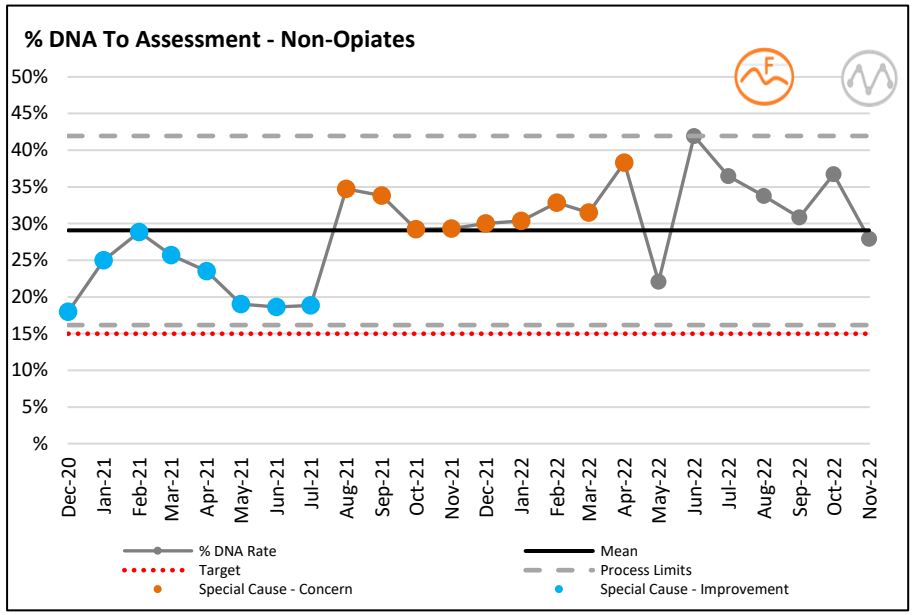
The service works with people who come into contact with the criminal justice system as a result of substance misuse. This includes arrest referrals, court orders and prison releases. A high number of people are referred in to the service, with smaller numbers taken “onto caseload” once engaging.

Feedback from service users

287 responses were received during an online survey of service users between June – August 2022
66% were very or extremely satisfied with their care
88% would recommend the service to their family or friends

START Performance | Highlights & Exceptions

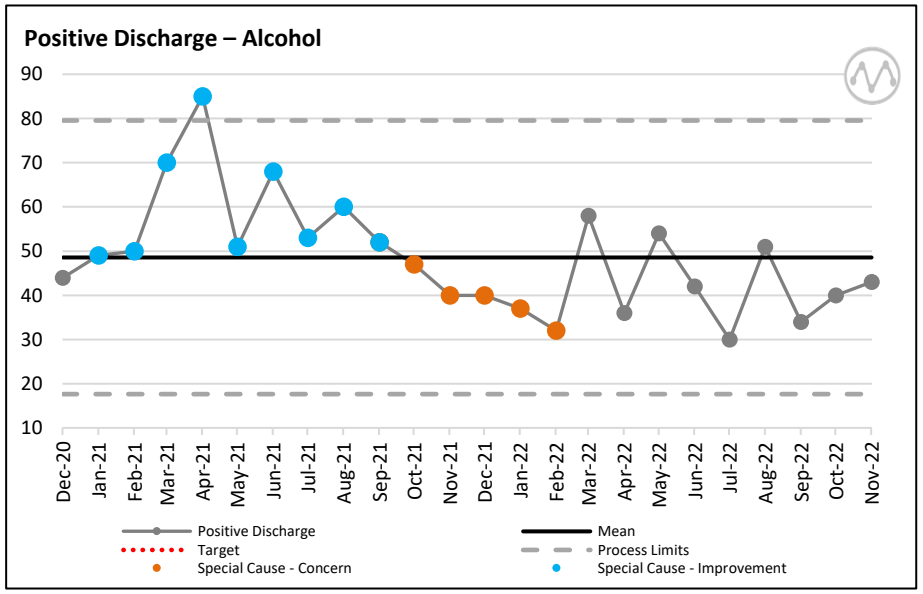


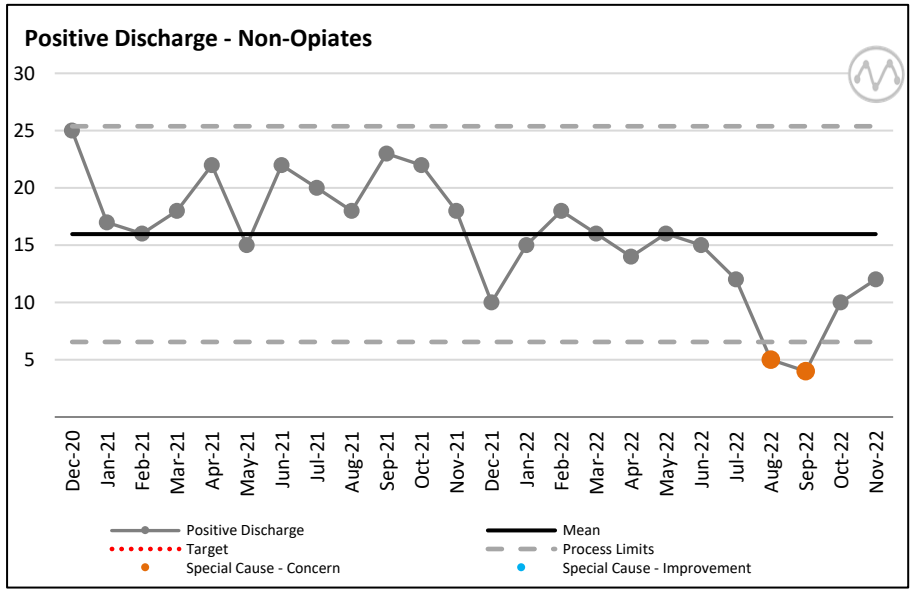


DNA to Assessment

DNA rates across the service fluctuate and are monitored to identify any patterns.

DNA rates were lower during Covid 19 anecdotally because of telephone appointments but are now increasing.





Recovery Successful treatment exits

Discharges from treatment are classed as positive if the service user is drug/alcohol free or an occasional user (not opiate or cocaine).

Recent months have seen long term sickness absence of staff in the non-opiates pathway. The impact of this can often be that service users who have built up relationships with individual workers may disengage from treatment when the worker is absent.
This can be seen in the chart, with more service users recorded as “dropped out” and fewer recorded as positive discharges.

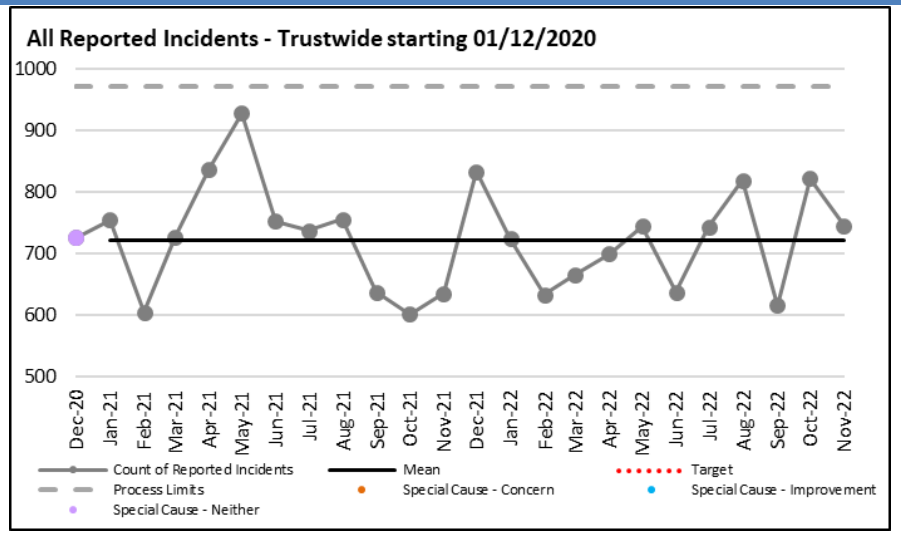
NHS
Sheffield Health and Social Care
NHS Foundation Trust

Safety & Quality

IPQR - Information up to and including November 2022

Proud to care in Sheffield

Safe | All Incidents



Trustwide	Nov-22		
	n	*mean*	SPC variation
ALL	**746**	724	• • •
5 = Catastrophic	29	19	• • •
4 = Major	8	5	• • •
3 = Moderate	71	68	• • •
2 = Minor	246	284	• • •
1 = Negligible	352	306	• • •
0 = Near-Miss	40	20	• H •

Narrative

8 Major incidents reported in November 2022.

- Delay/difficult Obtaining Specialist Services
- Fall - Whilst Mobilising
- Number of Staff
- Intimidation – Patient to Staff
- Physical Assault – Other to Patient
- Beds Lack Of/Delayed Availability (2 incidents)
- Fire - Arson/Doubtful Origin

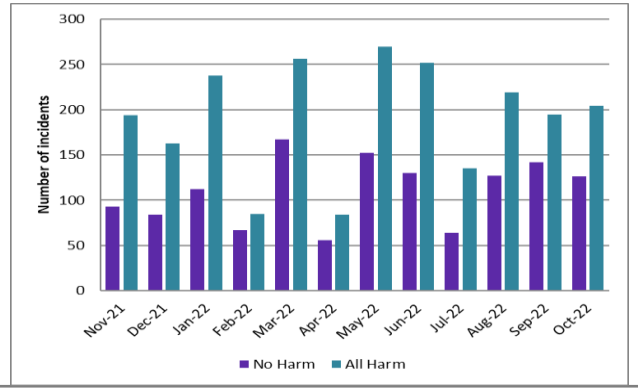
Of the 29 Catastrophic incidents, 11 were for Acute and Community services and 18 for Rehabilitation and Specialist services. 28 were reported due to death of a service user and 1 for non-patient death.

Narrative

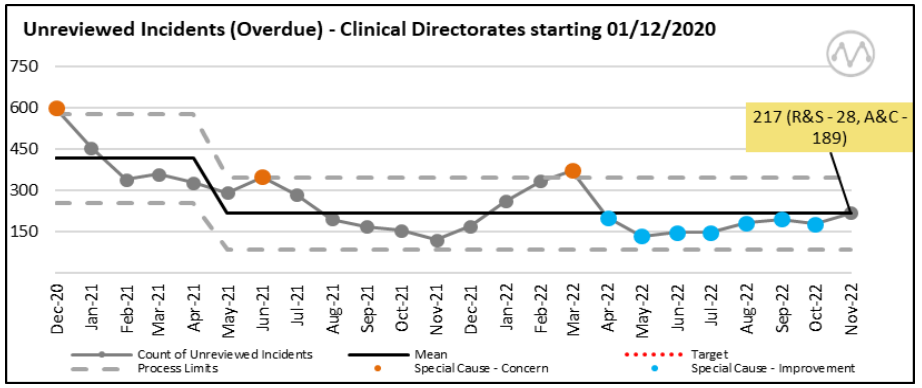
Patient safety incidents are uploaded to the National Reporting Learning System (NRLS). The NHS is moving to a new platform, the Learning from Patient Safety Events (LFPSE) over the next 12-18 months. All patient safety incidents will be uploaded to this in the next 9 months. The latest benchmarking information released from the NRLS covers the period April 2021 – March 2022 and was released on 13 October 2022. This shows SHSC's patient safety incident reporting rate at 83.0 incidents per 1000 bed days. Nationally, for mental health trusts, this rate varies from 7 to 222. Regionally (Yorkshire and the Humber), this rate varies from 42.7 to 132.6 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 November 2021 to October 2022.

Patient Safety Incidents – Harm vs No Harm Nov 21 – Oct 22

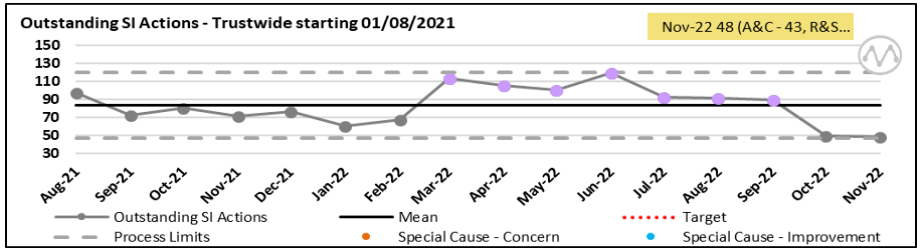


Protecting from avoidable harm	Target	YTD
Never events declared	0	0
Methicillin-resistant Staphylococcus aureus (MRSA & MSSA)	0	0



Narrative

The unreviewed incidents are predominantly accounted for by the Acute and Community Directorate. There is 1 outstanding incident from 2021. 44 incidents remain unreviewed prior to November 2022.

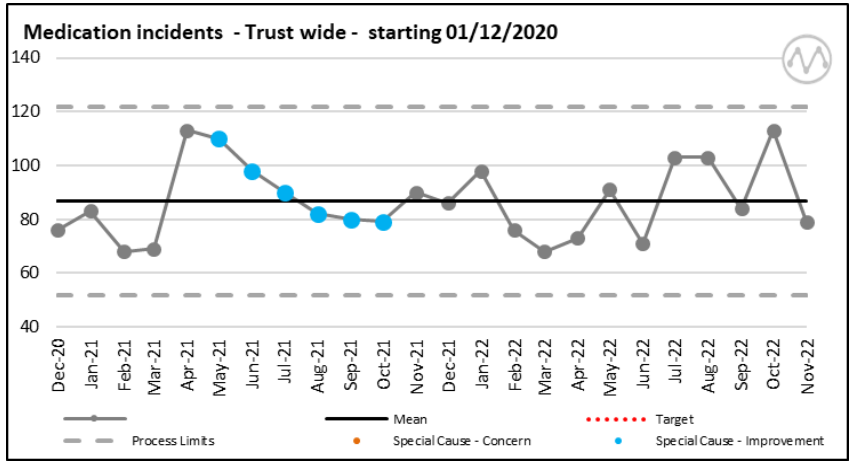


Serious Incident Actions Outstanding

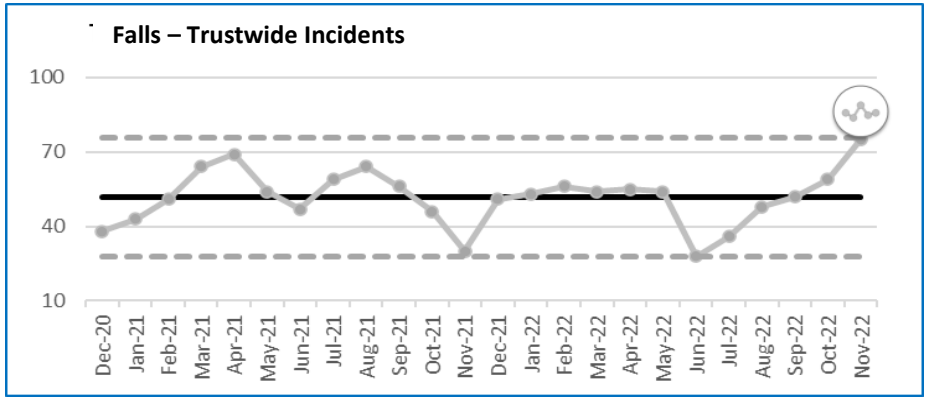
As at 12 December 2022, there were 48 outstanding SI actions overdue, which is a decrease from the previous months' 49. Sessions are being held with General Managers in order to support progress and closure of the actions. Further improvements are expected to be seen.

- 11 actions were due in 2021
- 37 actions were due in 2022
- 2 current ongoing Prevention of Future Deaths (PFD) Reports (issued by H M Coroner following an inquest) containing 11 actions across the 2 plans (Feb and March 2022). Assurance processes are established for PFD action plans and all actions are currently in 'sign-off' processes.

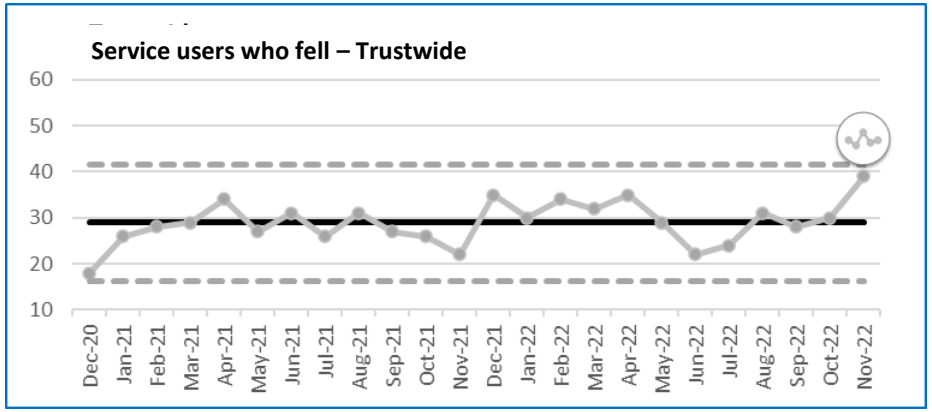
Safe | Medication Incidents & Falls



Trustwide	Nov-22		
	n	mean	SPC variation
ALL	79	87	•••
Administration Incidents	11	16	•••
Meds Management Incidents	52	56	•••
Pharmacy Dispensing Incidents	6	8	•••
Prescribing Incidents	10	6	•••
Meds Side Effect/Allergy Incidents	0	0	•••



Trustwide FALLS INCIDENTS	Nov-22		
	n	mean	SPC variation
Trustwide Totals	75	52	•••
Acute & Community	72	49	•••
Rehabilitation & Specialist Services	2	2	•••



Trustwide FALLS PEOPLE	Nov-22		
	n	mean	SPC variation
Trustwide Totals	39	29	•••
Acute & Community	36	26	•••
Rehabilitation & Specialist Services	2	2	•••

Narrative

Medication Incidents

There were no moderate incidents reported in November 2022 for Medication incidents.

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

Safe | Assaults, Sexual Safety & Missing Patients

Assaults on Service Users	Nov-22		
	n	mean	SPC variation
Trustwide	21	23	• • •
Acute & Community	20	20	• • •
Rehabilitation & Specialist	1	3	• • •
Assaults on Staff	**Nov-22**		
	n	mean	SPC variation
Trustwide	28	76	• L •
Acute & Community	26	61	• • •
Rehabilitation & Specialist	2	13	• L •

Narrative

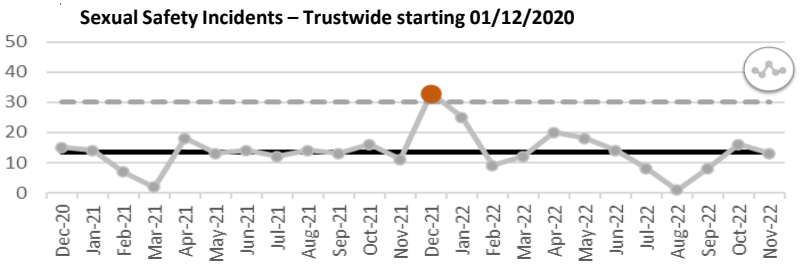
Out of the 21 assaults on patients' incidents reported in November 2022, 4 incidents were reported as moderate and 1 reported as major. The major incident occurred in the Health Based Place of Safety.

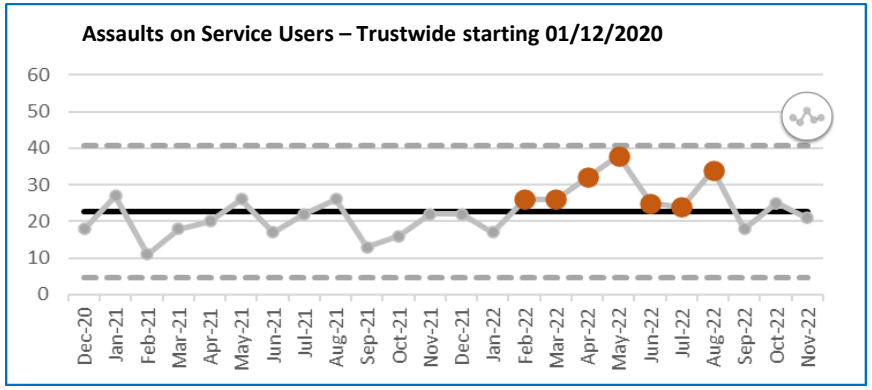
Out of the 28 assaults on staff reported incidents (which is showing as low for another month), 26 were reported for Acute and Community Services and 2 incidents were reported for Rehabilitation & Specialist services in November 2022.

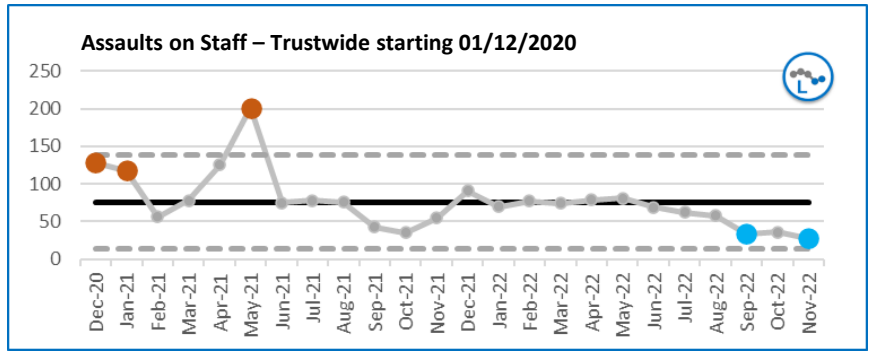
2 incidents were reported as Moderate, both occurring on Forest Lodge, low secure service.

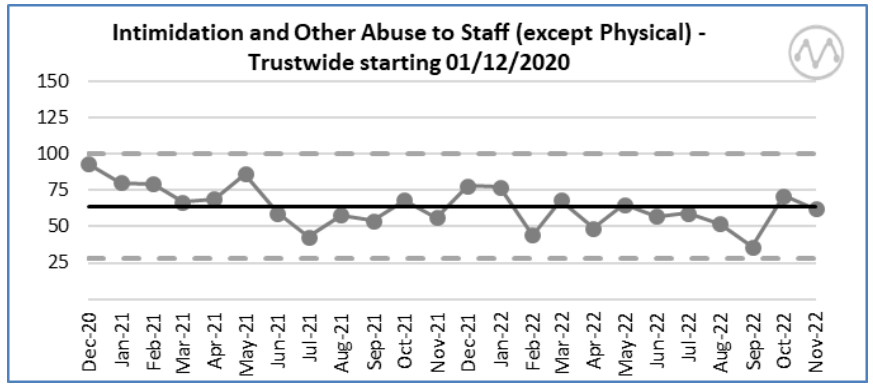
Sexual Safety

There were 13 sexual safety incidents reported in November 2022, 1 was reported as moderate Acute and Community Services. This incident reports to two service users having had sexual relations while in SHSC.

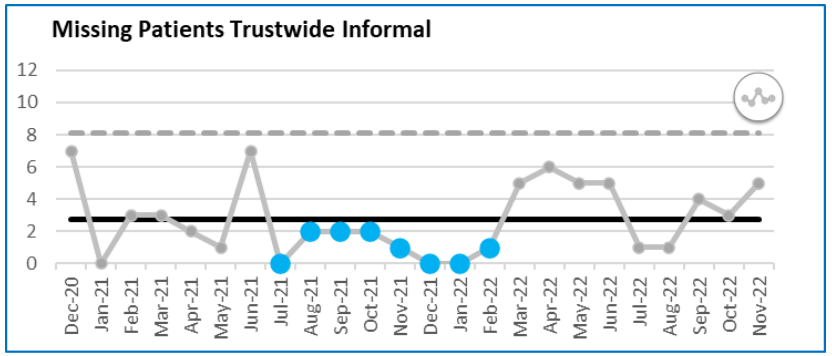


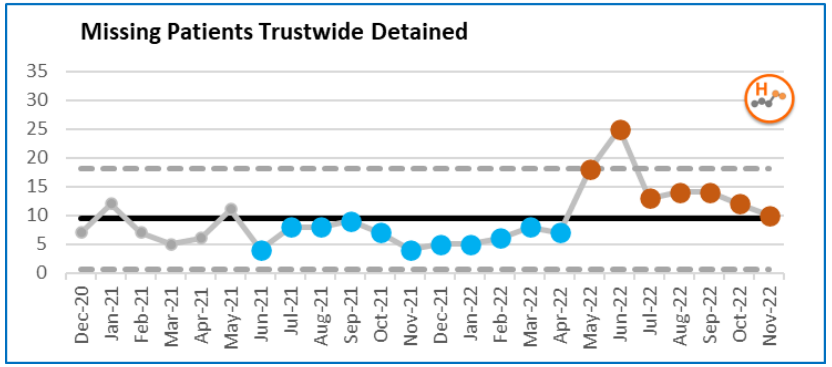






Protecting from avoidable harm	Target	YTD
Reportable Mixed Sex Accommodation (MSA) breaches	0	0





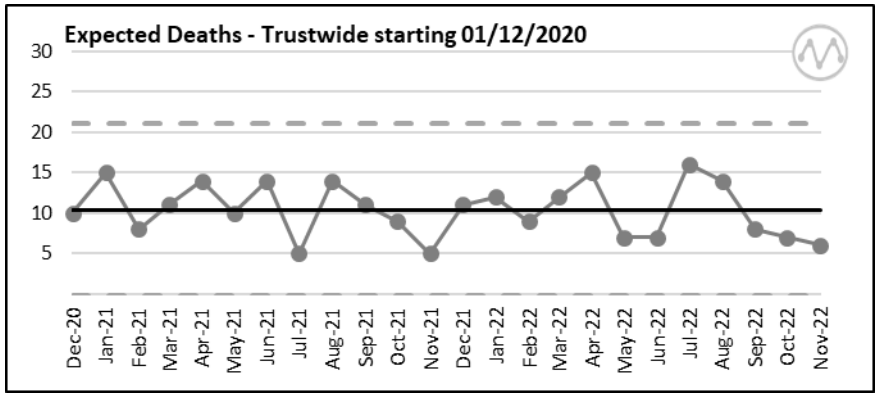
Trustwide	Nov-22		
	n	mean	SPC variation
Detained	10	9	• H •
Informal	5	3	• • •

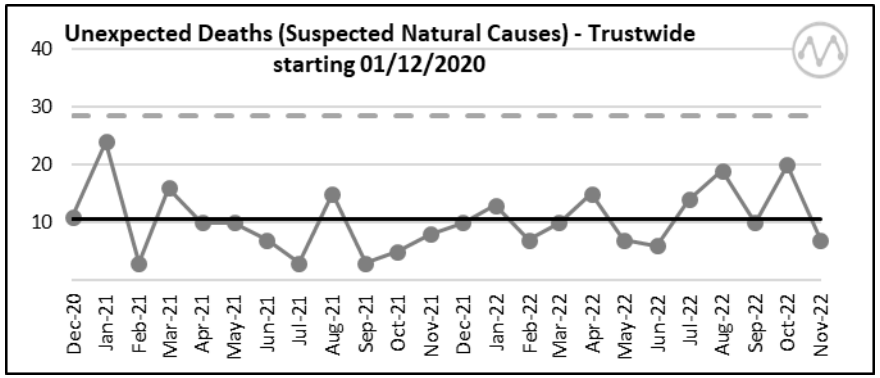
Narrative

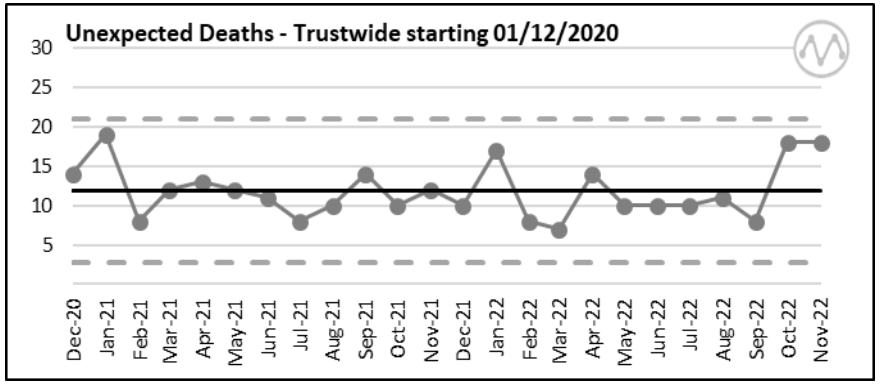
10 reported incidents in November 2022 of people under formal admission. 4 incidents were for Rehabilitation & Specialist Services for 4 people. 6 incidents for Acute & Community for 5 people.

- 7 people on a Section 3,
- 1 people on section 2,
- 1 on section 37.

Deaths

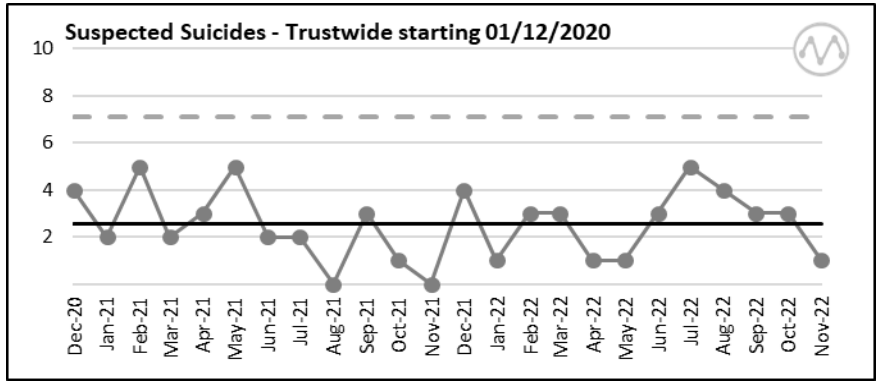






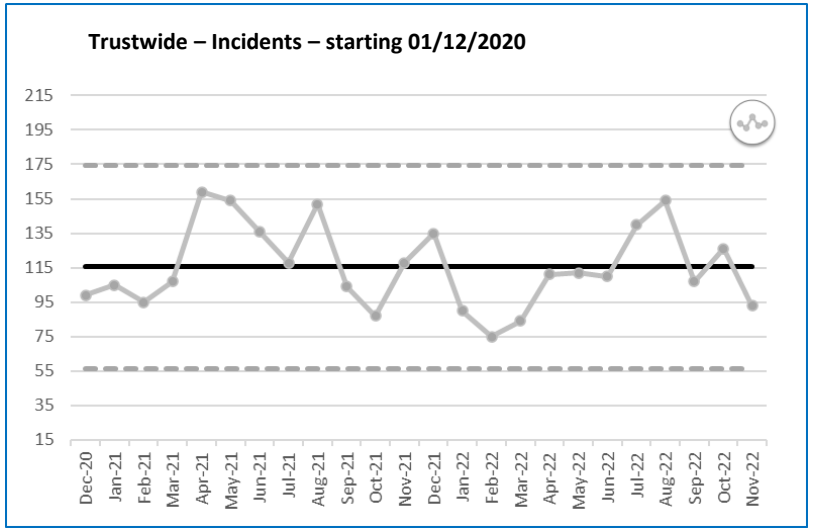
Quarterly mortality reports are presented to the Quality Assurance Committee and Board of Directors.

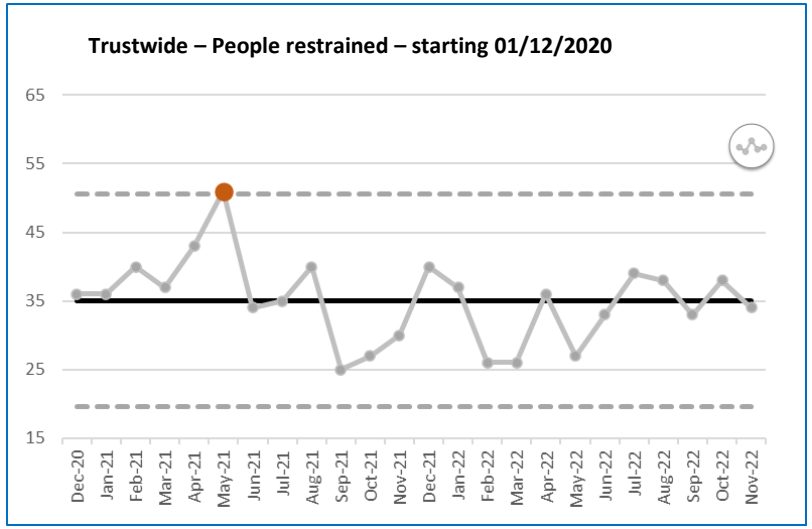
Deaths Reported 1 November 2020 to 30 November 2022	
Awaiting Coroners Inquest/Investigation	232
Conclusion - Narrative	3
Conclusion - Suicide	10
Conclusion – Accidental	1
Conclusion – Misadventure	1
Conclusion – Open	1
Natural Causes/No Inquest	576
Alcohol/Drug related	14
Suspected Homicide/Closed	0
Ongoing	0
Grand Total	**839**



COVID-19 Deaths 1 April 2020 – 30 November 2022	
ATS (Firshill Rise)	1
Birch Ave	5
CISS (LDS)	1
CLDT	6
G1 Ward	6
Liaison Psychiatry	9
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	9
OA CMHT West	5
OA Home Treatment	3
SPA / EWS (Netherthorpe)	1
START Alcohol Service	1
START Opiates Service	2
Woodland View	2
Grand Total	**106**

Safe | Restrictive Practice | Physical Restraint





Physical Restraint INCIDENTS	Nov-22		
	n	*mean*	SPC variation
TRUSTWIDE	**93**	115	• • •
Acute & Community	**86**	102	• • •
Dovedale 2	**30**	14	• H •
Stanage Ward	**10**	11	• • •
Maple Ward	**16**	22	• • •
HBPoS (136 Suite)	**1**	0	• • •
Endcliffe Ward	**9**	22	• • •
Dovedale 1	**9**	23	• L •
G1 Ward	**6**	7	• • •
Birch Ave	**4**	2	• • •
Woodland View	**0**	1	• • •
Rehabilitation & Specialist	**7**	9	• L •
Forest Close	**5**	2	• • •
Forest Lodge	**2**	1	• • •

Physical Restraint PEOPLE	Nov-22		
	n	*mean*	SPC variation
TRUSTWIDE	**34**	35	• • •
Acute & Community	**30**	31	• • •
Burbage Ward	**8**	4	• • •
Stanage Ward	**4**	5	• • •
Maple Ward	**4**	7	• • •
HBPoS (136 Suite)	**1**	0	• • •
Endcliffe Ward	**4**	6	• • •
Dovedale	**1**	3	• • •
G1 Ward	**3**	4	• • •
Birch Ave	**4**	1	• • •
Woodland View	**0**	1	• • •
Rehabilitation & Specialist	**4**	2	• • •
Forest Close	**2**	1	• • •
Forest Lodge	**2**	1	• • •

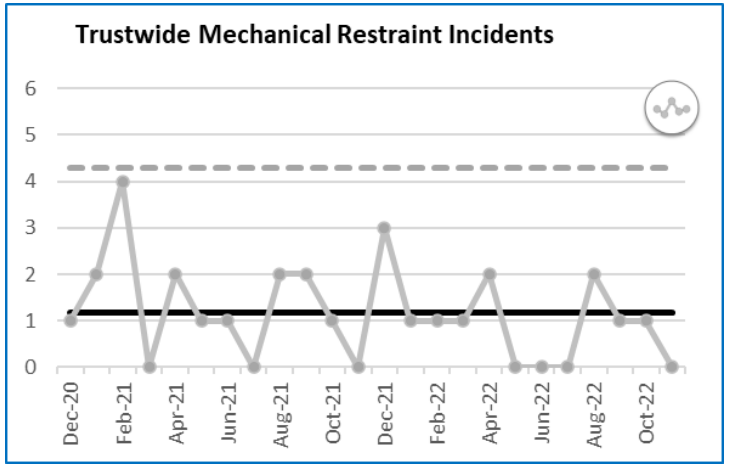
Narrative

Physical Restraint
93 physical restraints were recorded in November 2022.

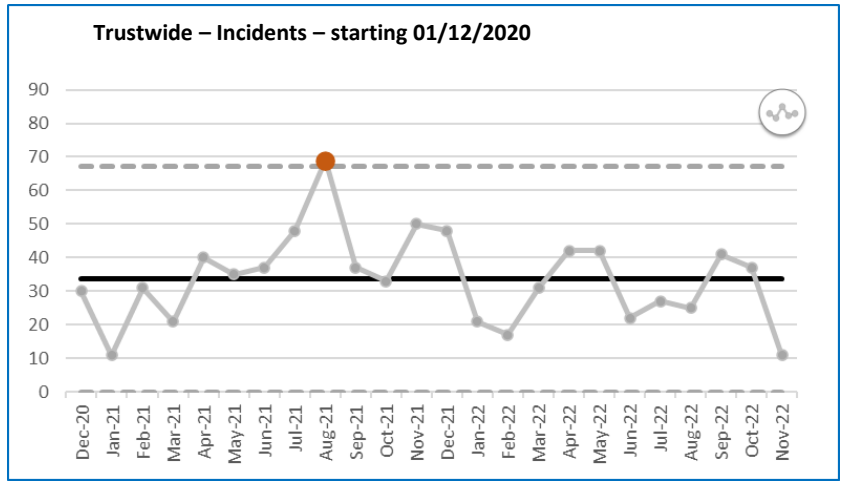
Dovedale 2 continue to report a high number of physical restraints. 33 out of 46 incidents were for 1 person.

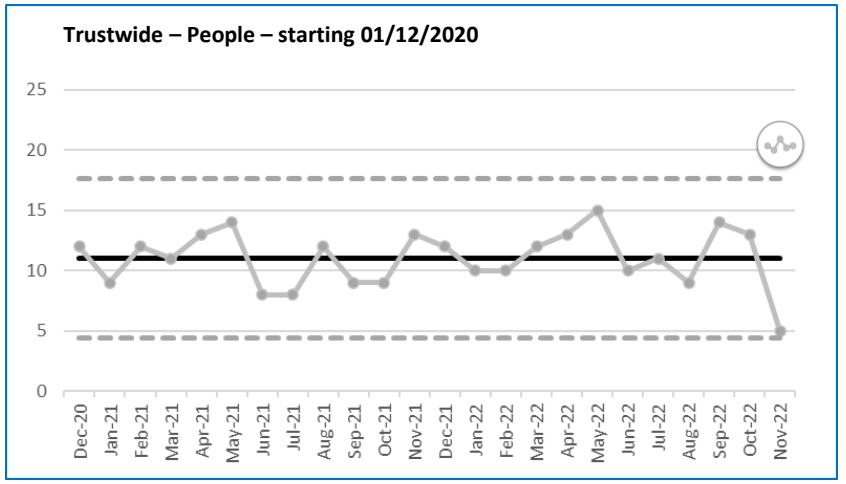
On Maple ward 13 of the 25 incidents reported were for 1 person.

Mechanical Restraint
There were 2 incidents reported for the use of Mechanical Restraint by Police on Maple Ward.



Safe | Restrictive Practice | Rapid Tranquillisation





Rapid Tranquillisation INCIDENTS	Nov-22		
	n	mean	SPC variation
TRUSTWIDE	11	34	• • •
Acute & Community	11	33	• • •
Burbage Ward/Dovedale 2	6	7	• H •
Stanage Ward	0	4	• • •
Maple Ward	5	5	• • •
HBPoS (136 Suite)	0	0	• • •
Endcliffe Ward	0	6	• • •
Dovedale 1	0	11	• L •
G1 Ward	0	1	• • •
Rehabilitation & Specialist	0	0	• L •
Forest Close	0	0	• L •
Forest Lodge	0	0	• L •

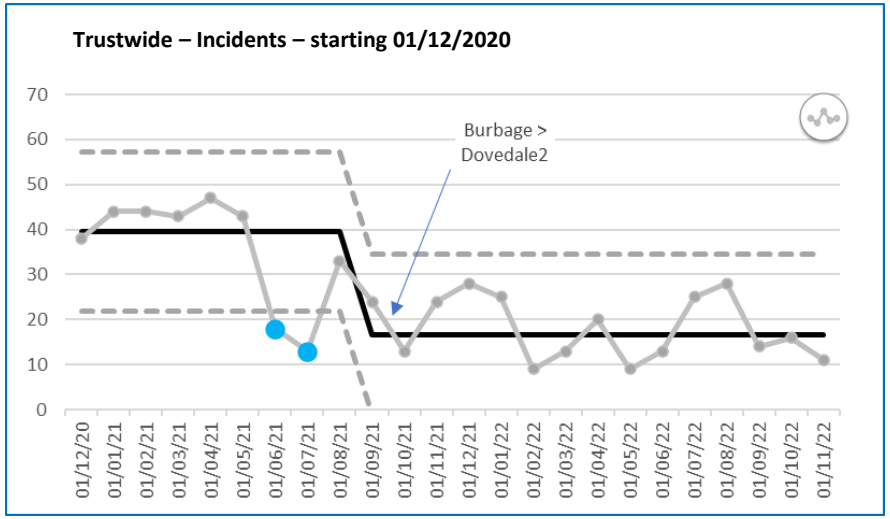
Rapid Tranquillisation PEOPLE	Nov-22		
	n	mean	SPC variation
TRUSTWIDE	5	11	• • •
Acute & Community	5	11	• • •
Burbage Ward/Dovedale 2	2	2	• • •
Stanage Ward	0	2	• • •
Maple Ward	3	2	• • •
HBPoS (136 Suite)	0	0	• • •
Endcliffe Ward	0	2	• • •
Dovedale	0	1	• • •
G1 Ward	0	1	• • •
Rehabilitation & Specialist	0	0	• • •
Forest Close	0	0	• • •
Forest Lodge	0	0	• • •

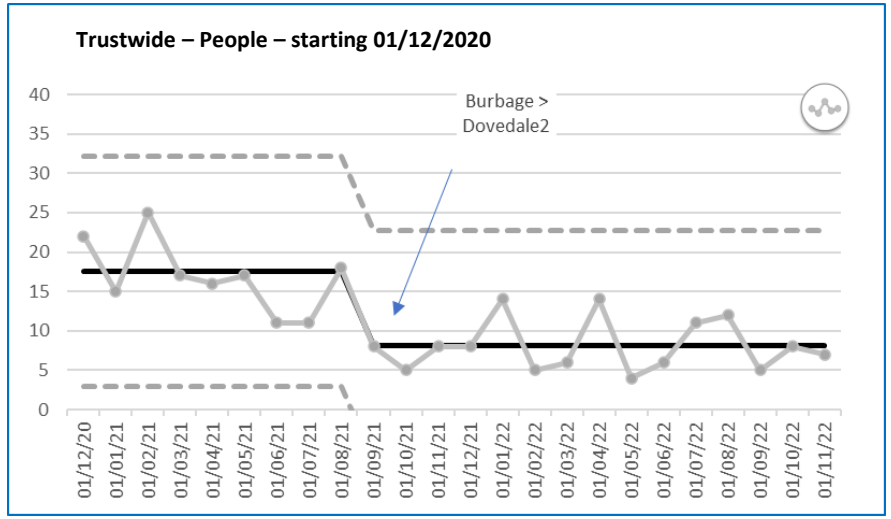
Narrative

Rapid Tranquillisation
11 incidents of rapid tranquillisations used were recorded in November 2022.

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

Safe | Restrictive Practice | Seclusion





Seclusion INCIDENTS	Nov-22		
	n	*mean*	SPC variation
Trustwide	11	*17*	• • •
Acute & Community	9	*16*	• • •
Stanage	0	*5*	• • •
Maple Ward	5	*5*	• • •
HBPoS (136 Suite)	1	*1*	• • •
Endcliffe PICU	2	*10*	• • •
G1 Ward	1	*3*	• • •
Rehabilitation & Specialist	2	*2*	• L •
Forest Lodge	2	*1*	• • •

Seclusion PEOPLE	Nov-22		
	n	*mean*	SPC variation
Trustwide	7	*8*	• • •
Acute & Community	5	*8*	• • •
Stanage	0	*4*	• • •
Maple Ward	2	*3*	• • •
HBPoS (136 Suite)	1	*1*	• • •
Endcliffe PICU	1	*3*	• • •
G1	1	*1*	• • •
Rehabilitation & Specialist	2	*2*	• • •
Forest Lodge	2	*0*	• • •

Narrative

Seclusion

11 seclusion episodes were recorded in November 2022.

Dovedale 2 continue to operate without a seclusion facility.

G1 ward are continuing to work towards having no seclusion room from January 2023

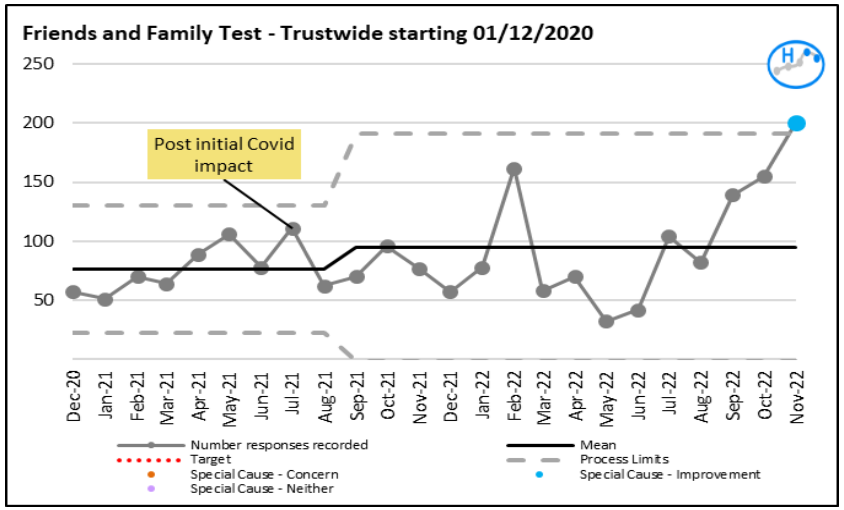
Long-Term Segregation

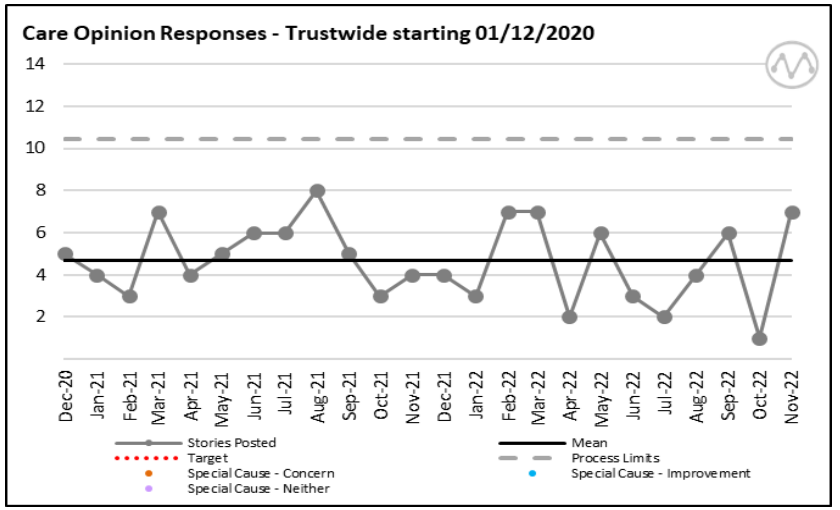
There were 3 episodes of prolonged seclusion for 3 people in November 2022.

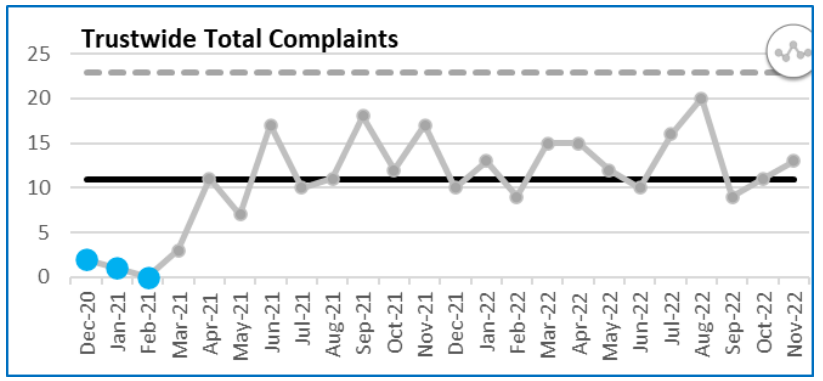
One episode was on Endcliffe ward and two were on Forest Lodge.

Policy was followed for all instances of prolonged seclusion.

Caring | User Experience







Narrative

In November 2022, the Trust received a total of 200 responses to the Family Friends Test (FFT). From the total 200 number of responses that will be submitted on the national return, 199 were positive, 1 was neutral (declined for anonymous comment to be shared), and 0 negative responses.

A sample of positive responses are listed below:

- "Not knowing what to expect on arrival - both myself and my husband were very pleased with the assessment. Staff were very thorough in their explanations of the process."
- "The service itself is excellent, but it has taken almost a year from referral."
- "All staff friendly and polite and clear communication. Staff member had amazing patience with my mother."

Overall, results for November 2022 were positive across the services that received FFT feedback, with 99% respondents reporting an overall positive experience in our services. As previously reported, as the new FFT cards have been rolled out and are now contributing to all returns, we will no longer be reporting on the "would recommend the Trust" metric as in previous reports.

Narrative

7 stories were published on Care Opinion during November 2022.

The stories on Care Opinion were rated as:

- Not Critical: 3
- Mildly Critical: 1
- Moderately Critical: 1
- Unknown: 2

Negative responses were regarding:

- Long wait
- Communication
- Discrimination

Positive responses were regarding:

- Flexibility
- Skilled staff
- Caring and helpful

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.

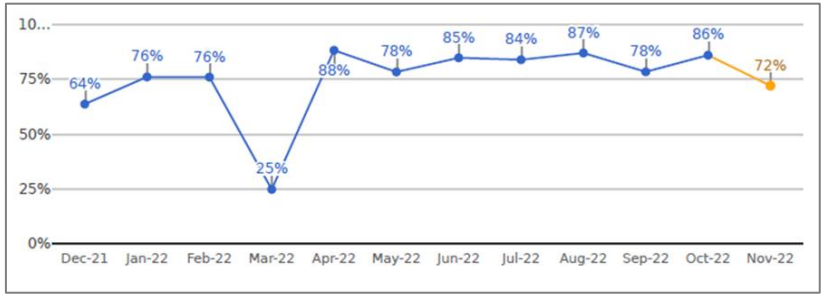
Complaints and Compliments

There were 13 formal complaints received in November 2022, 8 for the Acute and Community Directorate and 5 for the Rehabilitation and Specialist Services Directorate. The most frequent category type reported was 'Access to Treatment and Drugs'.

6 compliments were recorded to have been received in November 2022 for the clinical directorates. 3 for Rehabilitation and Specialist Services and 3 for Acute and Community Services.

Quality of Experience

In November 2022, 8 inspections were carried out across 3 areas – Forest Close, Forest Lodge, and Maple Ward - an average of 2 inspections per area. The average score across the organisation this month is 72%. An illustrative comparative of the past 12 months can be seen below.



Tendable

About Tendable

Tendable is an app and web based quality assurance solution to provide health and social care professionals the appropriate tools they need for quality audit inspection, insight and assurance from ward to board, committee and regulator. Sheffield Health and Social Care (SHSC) begun implementing this software as a way of replacing existing paper/electronic audit tools to make audits quicker, easer and more effective in how we view results.

The inspections (listed right) have been created by SHSC subject leads from Policy, NICE Guidance, Health and Safety to support services in meeting fundamental standards of care.

Measure of service user experience and Fundamental Standards of care being met

Service, directorate and organisation level thematic reviews

Actions identified for meeting standards

Thematic reviews for service improvements and developments

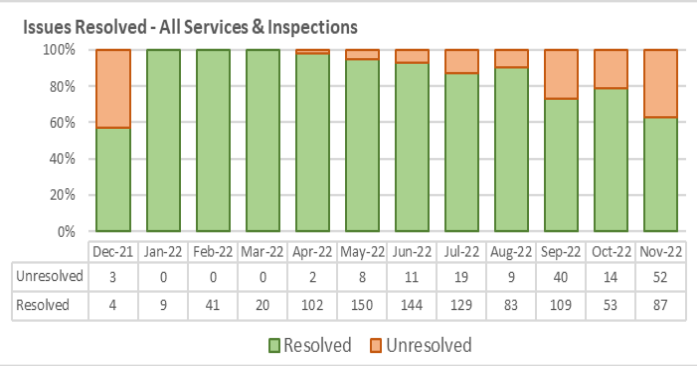
Parent Inspection Type	Inspection Type	Inspection Frequency and Number Required
Experience	Quality of Care Experience Survey	3 audits per month
Effective	Physical Health Monitoring – Care Delivery (PHM-CD)	3 audits per month
	Physical Health Monitoring – Equipment Check (PHM-EC)	1 audit per month
Safe	Environmental Safety	1 audit per month
	Infection Prevention and Control	1 audit per month
	Seclusion	Audit for each episode - Audit to be completed within 7 days of the seclusion ending, or midway if seclusion continues for more than 7 days.
	Rapid Tranquilisation	Audit to be completed within 3 days of the Rapid Tranquilisation being given. Where a service user is requiring multiple Rapid Tranquilisations' per day/week, and is supported by MDT & Care plan, only 2 of the instances per week need to be audited.
	Physical Restraint	Weekly – up to 5 audits

Tendable Governance

Back to Contents

Tendable Overview

Summary	12m	Nov-22
Total Inspections Completed	733	64
Overall Average Score	78.3%	80.6%
Number of Issues Raised	1127	90
Number of Issues Resolved	969	38
Number of Issues Unresolved	158	52

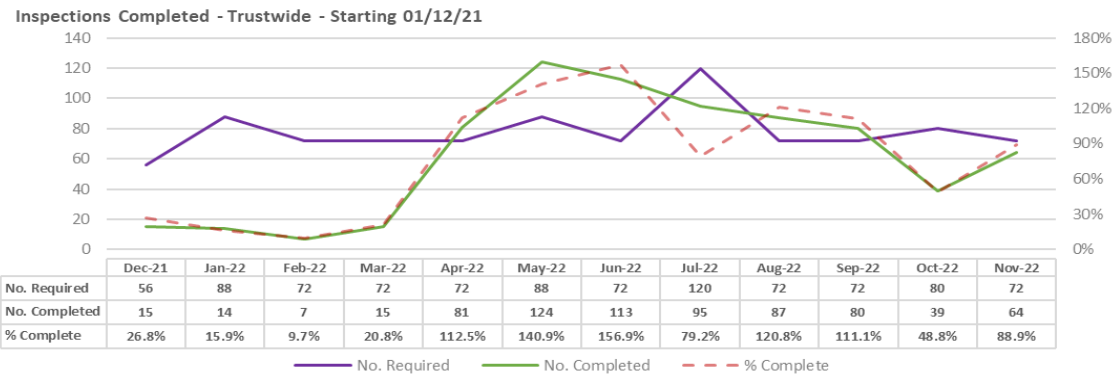


	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Unresolved	3	0	0	0	2	8	11	19	9	40	14	52
Resolved	4	9	41	20	102	150	144	129	83	109	53	87

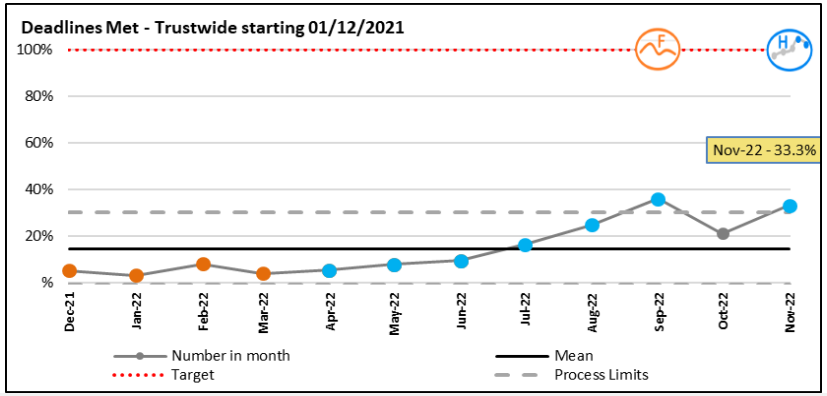
Number of Outstanding Unresolved Issues	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total
Environmental Safety	1	0	0	0	4	0	0	0	5
Infection Prevention & Control	1	4	3	1	0	4	0	3	16
Physical Restraint	0	0	0	2	0	0	0	3	5
Seclusion	0	0	2	0	4	3	0	16	25
Rapid Tranquilisation	0	1	0	4	0	1	0	0	6
Physical health monitoring - Care Delivery	0	2	3	3	1	10	5	6	30
Physical health monitoring - Equipment Check	0	0	3	0	0	11	4	3	21
Quality of Care Experience Survey	0	1	0	9	0	11	8	20	49

Inspection Average Scores	12m	Nov-22
Environmental Safety	93.5%	97.78%
Infection Prevention & Control	94.5%	99.11%
Physical Restraint	81.8%	82.41%
Seclusion	80.3%	49.80%
Rapid Tranquilisation	56.5%	71.96%
Physical health monitoring - Care Delivery	81.0%	78.95%
Physical health monitoring - Equipment Check	84.0%	85.05%
Quality of Care Experience Survey	78.7%	72.09%

Areas Fundamental Standards of Care not met November 2022	Inspection	Performance	No. Inspections
Has the use of Rapid Tranquilisation been reviewed and included in the care plan at the next MDT?	Rapid Tranquilisation	0.00	6
Was search undertaken and is this recorded in the notes and a list of any items taken from the SU recorded?	Seclusion	0.00	5
Has Covid screening/test been taken on admission, day 2 and 5-7 days after admission	PHM - CD	12.50	8
Have vital signs and the patient been reviewed in person after 1 hour by trained staff (or earlier if indicated) and requirement for on-going monitoring has been decided?	Rapid Tranquilisation	16.67	6
Has a post incident review taken place with the patient?	Rapid Tranquilisation	16.67	6
Was there any evidence during any of the reviews that the careplan was updated?	Seclusion	20.00	5
Was there a record of a copy of the careplan being discussed and given to the SU?	Seclusion	20.00	5
Has the service user contributed to the post seclusion care plan?	Seclusion	20.00	5
Did subsequent careplan reviews after MDT reviews and following independent reviews take place?	Seclusion	20.00	5
Do you know who your contact nurse is for the day?	QoCE Survey	28.57	7



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
No. Required	56	88	72	72	72	88	72	120	72	72	80	72
No. Completed	15	14	7	15	81	124	113	95	87	80	39	64
% Complete	26.8%	15.9%	9.7%	20.8%	112.5%	140.9%	156.9%	79.2%	120.8%	111.1%	48.8%	88.9%



Key to Performance

- **Black** – 0% demonstration of meeting standard
- **Red** – Standards met up to 70% of cases
- **Amber** – Standards met up to 70-90% of cases
- **Green** – Standards met up to 90-100% of cases

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Our People

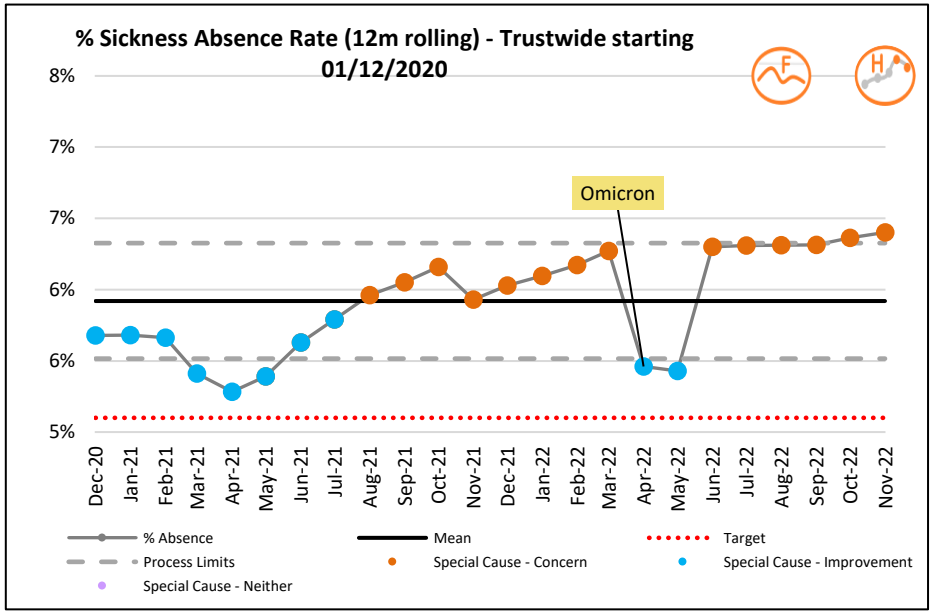
IPQR - Information up to and including November 2022

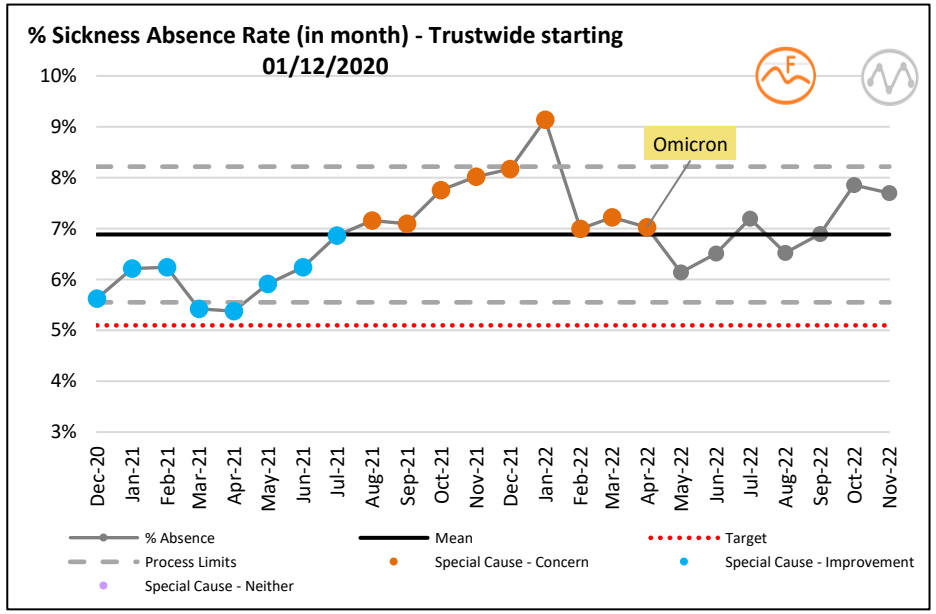
Proud to care in Sheffield

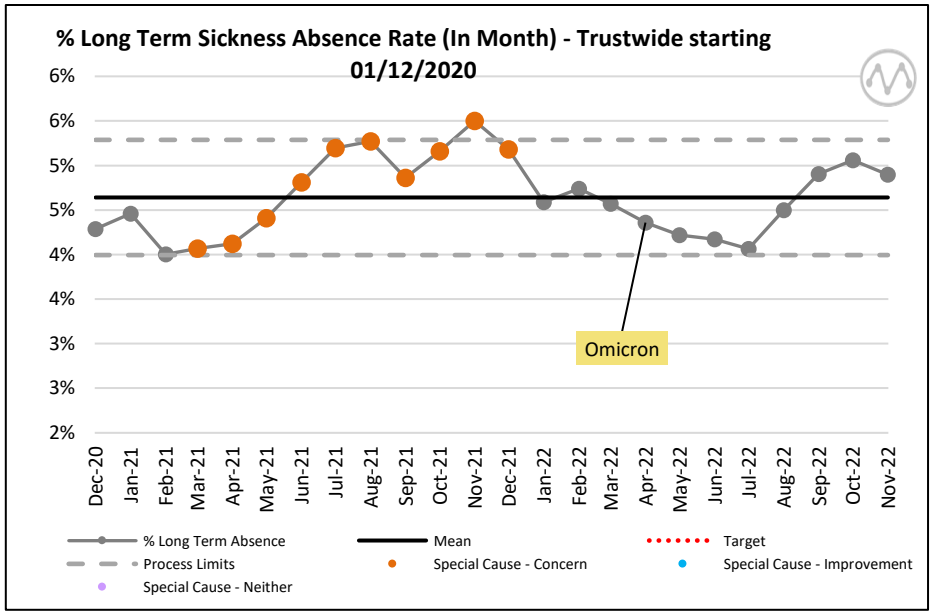
Well-Led | Workforce Summary

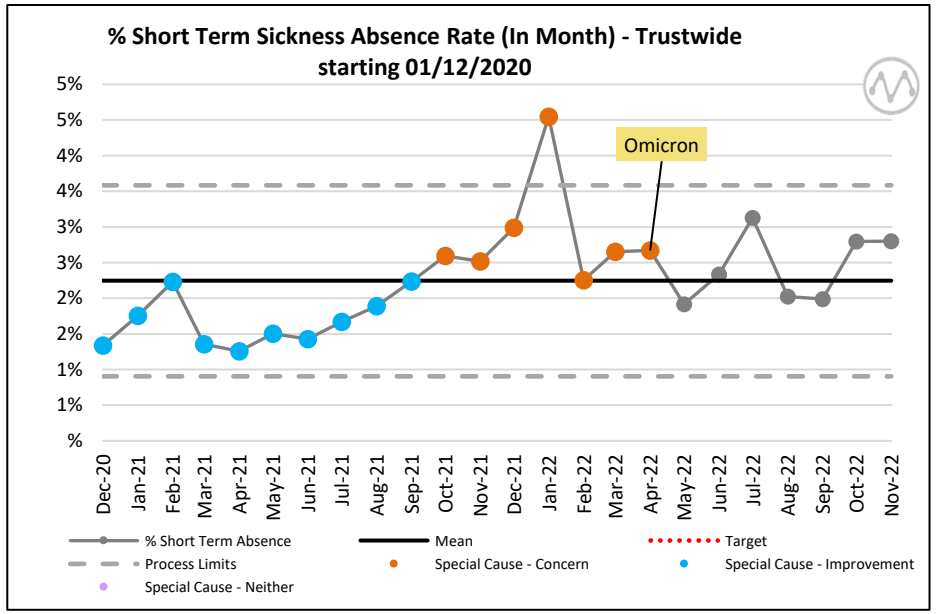
		Nov-22			
Metric	Target	n	*mean*	SPC variation	SPC target
Sickness 12 Month (%)	5.10%	**6.40%**	*5.92%*	• H •	F
Sickness In Month (%)	5.10%	**7.70%**	*6.89%*	• • •	F
Long Term Sickness (%)	~	**4.90%**	*4.64%*	• • •	/
Short Term Sickness (%)	~	**2.80%**	*2.24%*	• • •	/
Headcount Staff in Post	~	**2665**	*2576*	• H •	/
WTE Staff in Post	~	**2344**	*2257*	• H •	/
Turnover 12 months FTE (%)	10%	**14.33%**	*15.52%*	• • •	F
Vacancy Rate (%)	~	**10.77%**	*11.04%*	• • •	/
Training Compliance (%)	80%	**86.47%**	*89.62%*	• L •	P
Supervision Compliance (%)	80%	**72.49%**	*71.33%*	• • •	F

Well-Led | Sickness









Narrative

Sickness Absence rate remains above the average for the year and total trust-wide sickness is recorded as 7.70% - above the 5.1% target and within working parameters.

Long-Term sickness has decreased slightly within working parameters.

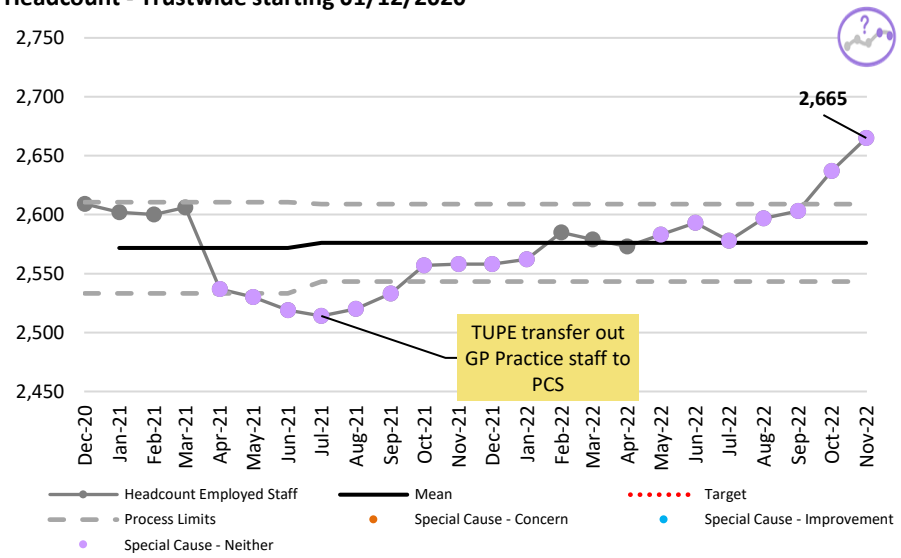
HRBPs Continue to manage cases across the organisation in partnership with service managers.

Short-Term sickness has remained around 2.8% from last month.

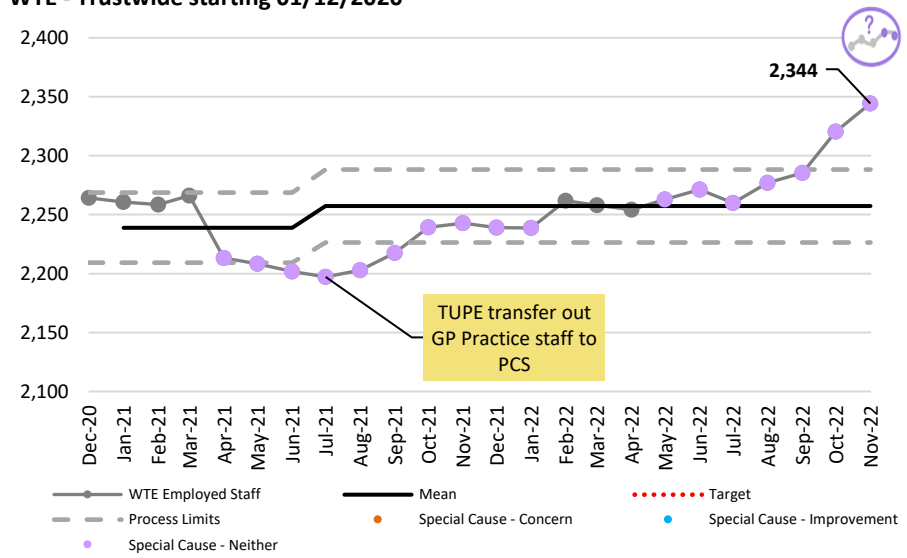
Promoting attendance workshops have just completed and a learning needs analysis self-assessment is to be launched to collate the learning needs of all managers.

Well-Led | Staffing

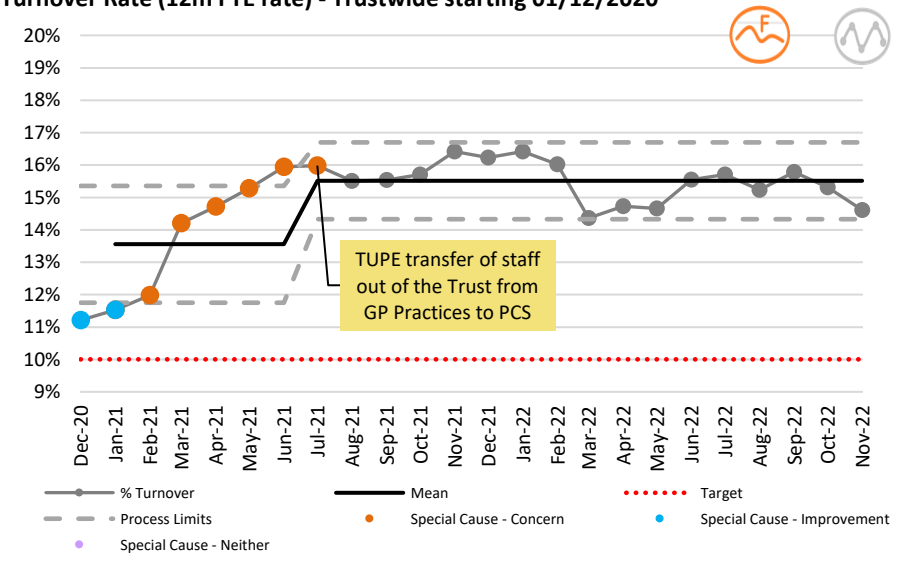
Headcount - Trustwide starting 01/12/2020



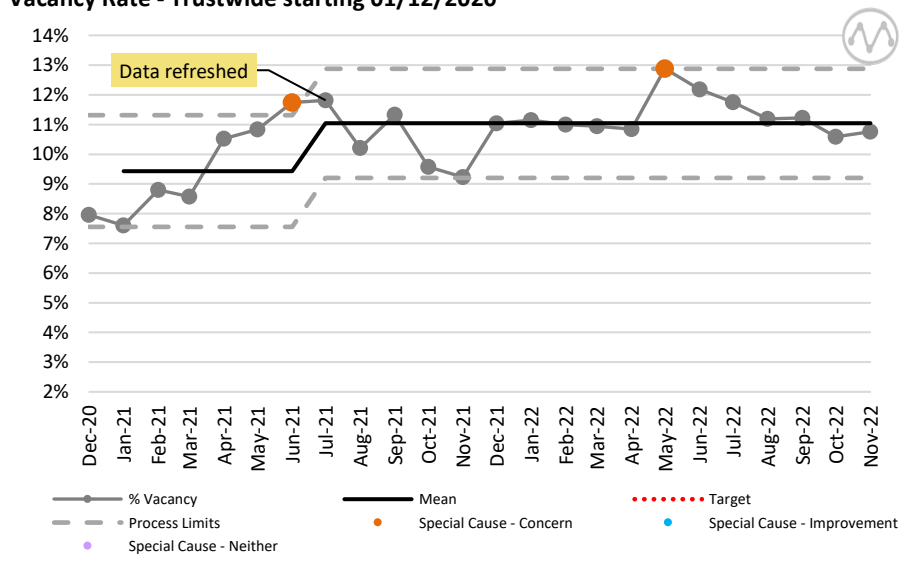
WTE - Trustwide starting 01/12/2020



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



Vacancy Rate - Trustwide starting 01/12/2020



Narrative

Turnover rate is reducing alongside the headcount and WTE increase. Headcount is now above working parameters as is WTE.

Turnover rate is above the 10% target. Outliers are pushing up the average across the organisation.

Vacancy rates are dropping in line with the increased recruitment and on-boarding activity.

Effective recruitment campaigns, reduced time to hire and targeted recruitment campaigns have increased appointments

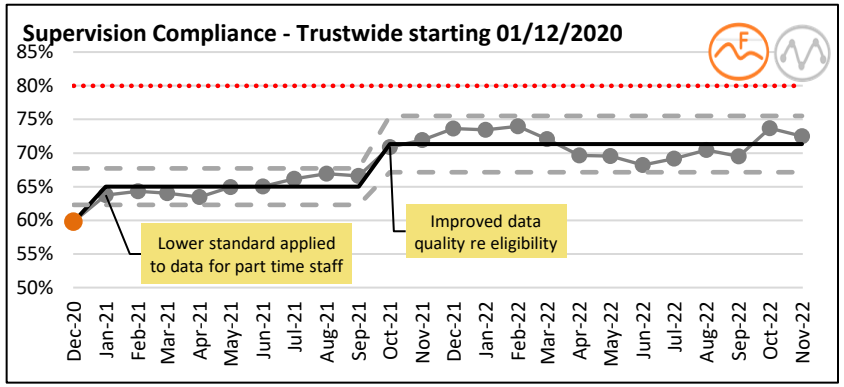
Action being taken

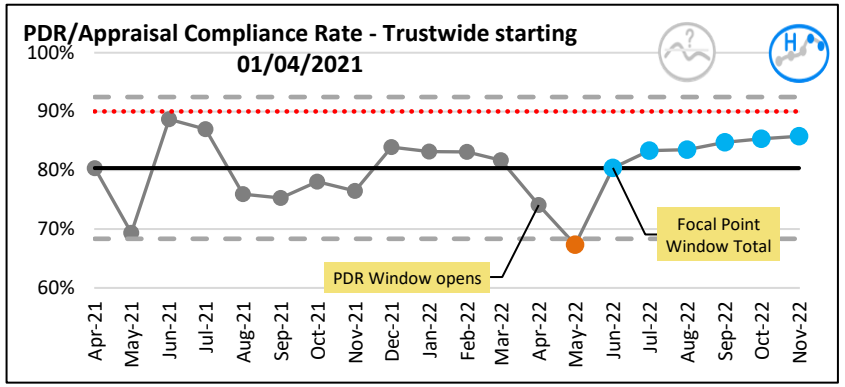
Building our temporary staffing bank WTE at a rate of an initial 9 WTE over M9 and M10 in line with a recruitment campaign and the increase in bank pay rate to top of scale for all staff groups and grades.

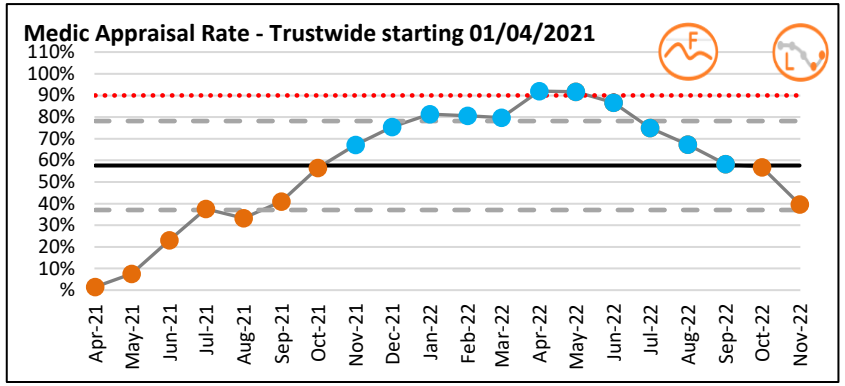
Rolling recruitment campaign which is predicted to grow the bank by between 6 and 10 Bank workers per month until M12 2024 to Eradicate all HCSW Agency and reduce Registered Agency.

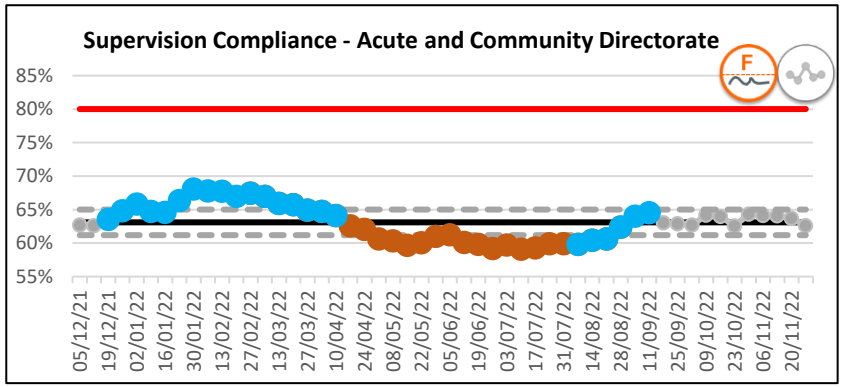
Introduction of the retention premium for B5 nurses Conversion from agency and other incentives, such as refer a friend.

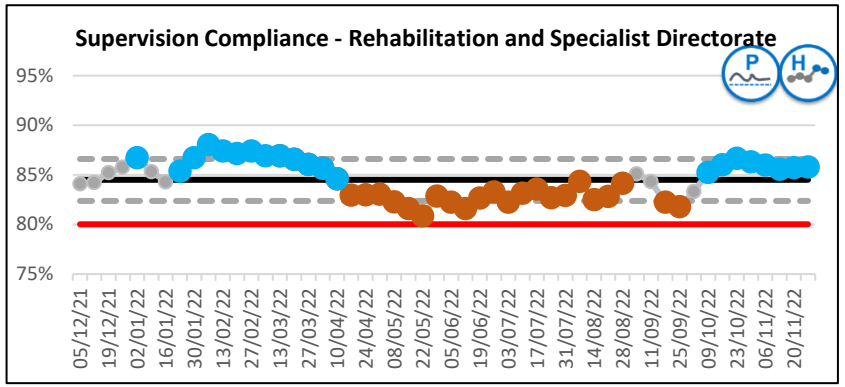
Well-Led | Supervision & PDR/Appraisal

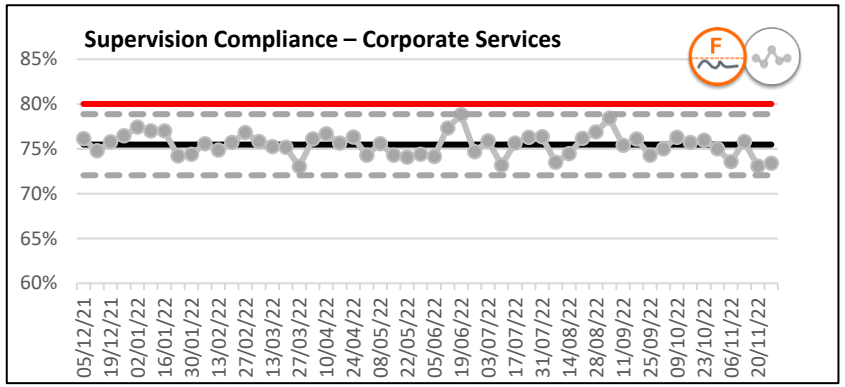












AIM

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

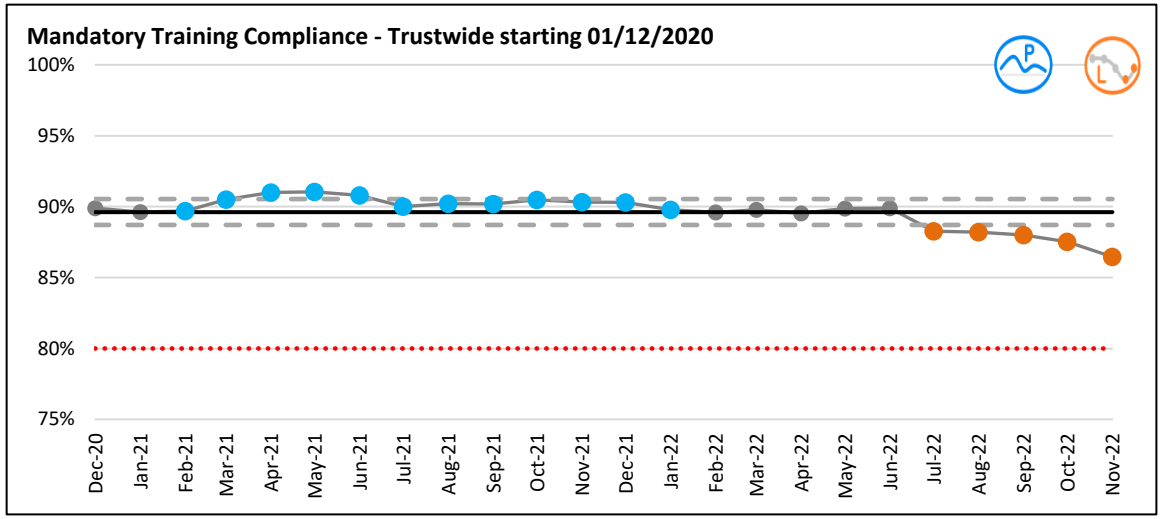
As at 30 November 2022, average compliance with the 8/12 target is:

Trustwide **72.49%**
Clinical Services **72.30%**

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



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 Resuscitation (BLS), 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. Safeguarding Children L3 is delivered by the Local Authority via multi agency training – meeting between LA, Director of Quality, SHSC Safeguarding team and Mandatory Training Lead on 18th November to look at improvement plan

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 – As at date	18/10/2022	14/11/2022
Trustwide	**87.52%**	**86.47%**
Directorate/Service Line		
Corporate Services	83.91%	82.75%
Medical Directorate	87.46%	83.05%
Acute & Community – Crisis	89.24%	88.41%
Acute & Community – Acute	88.53%	87.74%
Acute & Community – Community	90.66%	89.04%
Acute & Community – Older Adults	83.95%	83.26%
Rehab & Specialist – Forensic & Rehab	92.07%	90.99%
Rehab & Specialist – Highly Specialist	90.51%	89.54%
Rehab & Specialist – Learning Disabilities	92.90%	91.42%
Rehab & Specialist – IAPT	91.04%	90.08%
Rehab & Specialist – START	88.06%	85.83%

		18 October 2022		14 November 2022		
Subject	**Level**	No NOT Achieved	Compliance	No NOT Achieved	Compliance	Comments
Information Governance (aka Data Security Awareness)	-	442	83.05%	491	81.36%	95% target
Resuscitation (BLS)	2	360	74.30%	418	71.01%	80% target
Respect L3	3	189	68.50%	202	67.83%	80% target
Safeguarding Children	3	406	60.92%	461	57.82%	90% target

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Financial Performance

IPQR - Information up to and including November 2022

Proud to care in Sheffield

Executive Summary

KPI	Year to Date Plan £'000	Year To Date Actual £'000	Variance £'000	Annual Plan £'000	Forecast £'000	Variance £'000
Surplus/(Deficit) #	(338)	(2,260)	(1,922)	0	(3,940)	(3,940)
Covid Expenditure	(785)	(782)	3	(1,178)	(903)	275
Agency	3,073	6,332	3,259	(4,348)	(9,131)	(4,783)
Cash	61,248	52,961	(8,287)	61,938	55,383	(6,555)
Efficiency Savings	3,087	1,378	(1,709)	5,168	3,169	(1,999)
Capital # *	(6,999)	(4,071)	2,928	(12,057)	(12,392)	(335)

KPI		Target	Number	Value
Invoices paid within 30 days	NHS	95%	100%	100%
(Better Payments Practice Code)	Non-NHS	95%	99.2%	99.7%

The forecast deficit shown differs from the position reported to NHSI to meet ICB requirements. The report narrative gives further details.

* The capital plan has changed from that originally submitted to NHSI due to the approval of additional national funding of £0.6m for Electronic Patient Records (EPR) and £1.9m for the Health Based Place of Safety projects.

Summary at November 2022:

The position at November is a YTD deficit of £2.260m and is forecasting a deficit of £3.940m. The deficits are predominantly driven by pressures from agency (£4.8m) as the key driver behind a net (£3.9m) pay overspend and out of area purchase of healthcare (£3m) expenditure. The funding gap on the planned pay award is also contributing significantly to the deficit. The worst case forecast is £4.9m recognising the risks that the local authority may not pay the 22/23 management fee in a breach of contract (£0.7m) and efficiency savings may not be achieved (£0.3m). The best case forecast is £2.8m reflecting the possibility of prior year benefits not yet recognised.

It should be noted that non-recurrent prior year benefits of £1m are included in the forecast, therefore the underlying deficit is being masked by this.

Delivery of recurrent efficiency savings is significantly lower than the revised plan. The current forecast shows a Cost Improvement Programme (CIP) gap/ under delivery of £2m. This and the reliance on £1m non-recurrent savings in 22/23 results in a carry forward efficiency requirement of £3m for 23/24.

Cash balances remains healthy. Debt owed to SHSC remains higher than expected at £7.4m but it should be noted that £4m of this has been received at the time of reporting. There are no working capital concerns except the local authority debt risk noted above. The cash forecast is less than plan as: cash receipts are no longer expected from the Fulwood disposal in this financial year; other working capital movements are anticipated; and the forecast deficit I&E position, which includes unplanned interest cash receipts following interest rate increases of circa £1m.

Capital is underspending YTD against plan from a profile and timing perspective, however emerging needs and cost pressures associated with inflation result in a £0.335m forecast overspend. SHSC cannot breach the annual plan limit (CDEL), which was reduced by the South Yorkshire Integrated Care Board (ICB) as the allocation across the system has been exceeded. SHSC is expected to manage the pressure internally; recovery options are being considered including delaying lower priority schemes until 2023/24. The ICB have escalated the risk to NHSI having recognised that Trusts had been allowed to develop capital programmes at 105% of allocation. There is a risk however that spend will not be incurred this year to the extent planned on the Therapeutic Environments Programme, which would result in the funding being lost to the Trust and increased pressure on the 23/24 capital programme when ICB funding is expected to reduce significantly.

A breakeven forecast has been reported to NHSE/I for M8 as required by the ICB. The ICB has asked us to report breakeven as part of the system reporting on plan. Additional inflationary pressure funding may become available nationally and other providers will achieve surpluses as it is expected that Elective Recovery Funding (ERF) will not be clawed back. This could allow the system to achieve breakeven overall. Discussions are taking place within the Integrated Care System (ICS) to determine how surpluses and deficits are managed at individual organisation and system level. The narrative reporting to NHSE/I explains this position.

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CQuINs 2022/23

IPQR - Information up to and including November 2022

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Well-Led | CQuIN Performance Monitoring

CQUIN Ref	CQuIN	Description	Target	Payment Min Max thresholds	National Reporting interval	Directorate Service Line Team	Accountable Committee	Internally Reported Performance																
								Apr-22	May-22	Jun-22	Q1	Jul-22	Aug-22	Sep-22	Q2	Oct-22	Nov-22	Dec-22	Q3	Jan-23	Feb-23	Mar-23	Q4	Full Year
CCG1	Staff flu vaccinations	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	90%	70% 90%	Monthly	Trustwide	People Committee																	
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	35%	20% 35%	Quarterly	Clinical Directorates All inpatient units	Quality Assurance Committee	6 service users met the criteria, 0 were referred			0%	4 service users met the criteria, 0 were referred			0%									
CCG10a	Routine outcome monitoring in CYP and perinatal mental health services	Achieving 40% of […] women in the perinatal period accessing mental health services, having their outcomes measured at least twice.	40%	10% 40%	Quarterly	Rehab & Specialist Highly Specialist Perinatal	Quality Assurance Committee	Data is automatically uploaded extracted and submitted. We will update once received.																
CCG10b	Routine outcome monitoring in community mental health services	Achieving 40% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice.	40%	10% 40%	Quarterly	Acute & Community Community & Older Adult Adult & Older Adult CMHTs	Quality Assurance Committee																	
CCG11	Use of anxiety disorder specific measures in IAPT	Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).	65%	55% 65%	Quarterly	Rehab & Specialist IAPT	Quality Assurance Committee																	
CCG12	Biopsychosocial assessments by MH liaison services	Achieving 80% of self-harm referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	80%	60% 80%	Quarterly	Acute & Community Crisis Liaison Psychiatry	Quality Assurance Committee	93 service users out of a sample of 100 had an assessment			93%	96 service users out of a sample of 100 had an assessment			96%									

Narrative

This page is added for the first time to demonstrate how performance against CQuIN targets for 2022/23 is progressing throughout the year. Currently the Quality Directorate and service leads are working together to ensure that information is recorded and reported robustly and accurately internally so that external reporting can be submitted as required in line with the CQuIN programme.

CQuIN CCG9 – this target has not been met. Performance is particularly related to the low numbers of service users that fall within the range applicable for this CQUIN. Discussions are underway with service leads.

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Covid-19

IPQR - Information up to and including November 2022

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Well-Led | Covid-19 Outbreaks

November 2022 Covid Outbreaks				
Ward	Outbreak Start Date	Outbreak End Date	Patients Affected	Staff Affected
Buckwood View	17/10/2022	03/11/2022	3	5

Narrative
There we no new outbreaks that commenced in November 2022.
One outbreak in the R&S directorate continued into November before being closed on 03/11/2022.

Covid Status as at 30/11/2022				
	COVID-19 Status			
Acute and Community	Outbreak Start Date	Open for admissions	Positive Patients	Positive Staff
Dovedale 2 (F)	-	YES	0	1
Stanage (M)	-	YES	0	0
Maple	-	YES	0	0
Endcliffe	-	YES	0	0
Beech	-	YES	0	0
Dovedale 1	-	YES	0	0
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	-	YES	0	0
Forest Lodge	-	YES	0	0
Buckwood View	-	YES	0	0

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Report ends
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Proud to care in Sheffield

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:

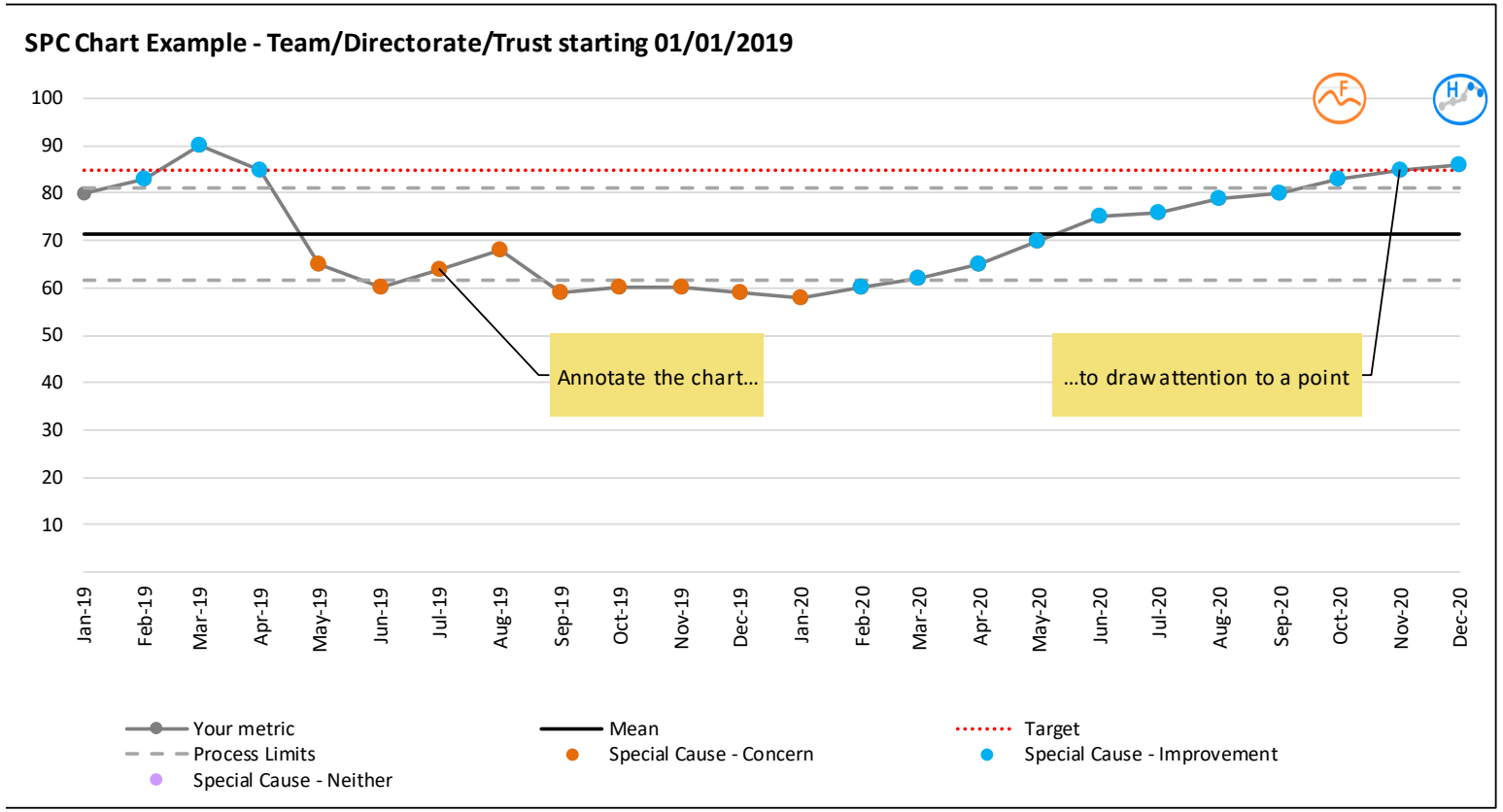
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

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.