Board of Directors - Public

SUMMARY	Meeting Date:	September 2023
	Agenda Item:	13

Report Title:	**Integrated Performance and Quality Report (IPQR) July 2023**	
Author(s):	Business and Performance Team	
Accountable Director:	Phillip Easthope, Executive Director of Finance, Digital & Performance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	People Committee Quality Assurance Committee Finance and Performance Committee
	Date:	12th September 2023 13th September 2023 14th September 2023
Key Points recommendations to or previously agreed at:	**Comments from People Committee** A report on stress related absence to be presented to People Committee in November. The supervision recovery plans will now be monitored through the People Committee. A review of mandatory training is in progress to ensure appropriate alignment with staff groups **Comments from Finance & Performance Committee** The committee received the IPQR for the period ending July 2023 at its meeting in September 2023. There were no specific areas of escalation during the meeting and noted that any emerging risks will be escalated outside of this routine report through the assurance reporting process. **Comments from Quality Assurance Committee** The recorded doctor's appraisal rate has been queried in committee as there are concerns about data accuracy given the drop in compliance that is not explained. The Clinical Directors will investigate this. The repurposing of the HBPOS was also discussed and noted that it has increased once again since the last report. Discussion took place about the potential for this practice to cease once the new facility opens however this is unclear and requires a view from MHLC. It was also noted that this could have an impact on breaches in A&E if flow is not addressed.	

Section 1: Analysis and supporting detail

Background

1.1 The IPQR is a monthly report that presents a full and detailed data set that is used to assure the Board about the performance and quality of service delivery. This report details data up to and including July 2023.

The report was presented and considered in detail to the People, Quality Assurance and Finance & Performance Committees in September 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			Waiting Lists	5		Reduced waiting list for SPA/EWS, Recovery South, Relationship & Sexual service and LTNC.
F	Q			Waiting Times	5		Sustained reductions in average wait time referral to assessment for Relationship & Sexual service and CLDT. Also notable reductions referral to treatment wait times for SPA/EWS and Recovery North.
F	Q			Average Discharged Length of Stay - Endcliffe	7		Decrease in discharged length of stay (12 month rolling) on Endcliffe ward – comfortably within national benchmarks.
F	Q			Average discharged Length of Stay – Forest Close & Forest Lodge	9		Performance above national benchmarks.
F	Q			Talking Therapies – wait times	12		Talking Therapies consistently achieving the 6 and 18 week wait targets.
	Q	P		Supervision	26	 	Rehabilitation & Specialist directorate are consistently achieving the 80% trust target. Corporate services have reached the target throughout July.
	Q	P		Mandatory Training	27		Consistently achieving the trustwide target of 80%.

Performance Concern								
Committee				**KPI/Area**	**Refer to (slide)**	**Performance**	**Trend/ Trajectory**	**Recovery Plan?**
F	Q			Waiting Times	5		Increasing trend/sustained high waits in certain areas noted Recovery North, SMS, Gender.	Recovery Plan x 2 (EWS, Recovery Teams)
F	Q			Waiting Lists	5		Increased waiting lists for SMS, OA CMHT, SPS PD, Gender, STEP, SAANS.	Recovery Plan x 3 (Gender, SAANS & HIT)
F	Q			Caseloads/Open Episodes	5		Increasing trend/high caseloads in OA CMHT, SMS and Highly Specialist community services (Gender, STEP, SAANS.)	Recovery Plan x 4 (OA CMHT, SMS, Gender & SAANS)
F	Q			Length of Stay and Delayed Discharge (inpatient areas)	6		Failing to meet target for average discharged length of stay (12 month rolling)	Linked to Out of Area Recovery Plan(s) x 3
F	Q			Out of Area Placements	6-7		Prolonged failure to meet reduction/elimination of inappropriate OAPs in acute.	Out of Area Recovery Plan(s) x 3
F	Q			Health Based Place of Safety repurposing	10		Repurposed for detained mental health admission 49/62 days (79%) of July.	Linked to Out of Area Recovery Plan(s) x 3
	Q	P		Staff sickness	24		Consistently failing to meet trust target of 5.1%.	Agency reduction project group
	Q	P		Supervision	26		Failing to meet 80% target trustwide.	CQC Back to Good Action Plan/Local Recovery Plans
	Q	P		PDR	26		Consistently failing to meet trustwide target of 90% for PDR compliance.	CQC Back to Good Action Plan/Local Recovery Plans
	Q	P		Medic Appraisal Rate	26		Sustained reduction in medic appraisal rate below 24-month mean.	CQC Back to Good Action Plan/Local Recovery Plans
F				Agency and Out of Area Placement spend	29		High agency and OOA spend.	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:							
Recover services and improve efficiency			***Yes***	✓	*No*		
Continuous quality 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 Fundamental Standards	***Yes***	✓	*No*		This report ensures compliance with NHS Regulation – CQC Regulation may be a by- product of this.
Data Security and Protection Toolkit	*Yes*		*No*	✓	
Any other Specific standards	*Yes*		*No*	✓	
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, Engagement and Experience	*Yes*	✓	*No*		Any impact is highlighted within relevant sections.
Financial (revenue &capital)	*Yes*	✓	*No*		CIP delivery is being offset by underspending on investments and COVID funding
Organisational Development/Workforce	*Yes*	✓	*No*		Any impact is highlighted within relevant sections.
Equality, Diversity & Inclusion	*Yes*	✓	*No*		Work looking at EDI concerns is underway which may suggest the inclusion of certain indicators as future developments occur.
Legal	*Yes*		*No*	✓	
Environmental Sustainability	*Yes*		*No*	✓	

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Integrated Performance & Quality Report

Information up to and including July 2023

Proud to care in Sheffield

Introduction

Report Layout | Information and metrics are grouped into the following themes in line with the KPIs for 22/23 and the Trust Performance Framework.

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

We use statistical process control (SPC) charts where possible 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 charts 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.

This report contains 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. 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 July 2023 reporting, we are using monthly figures from August 2021 to July 2023. 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 a colour-coded key to quickly identify which KPIs and metrics are of particular interest to a committee/which committee has oversight.

Colour Key	F	M	P	Q
Finance				
MH Legislation				
People				
Quality				

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Service Delivery

IPQR - Information up to and including July 2023

Proud to care in Sheffield

Responsive | Access & Demand | Referrals

Referrals	Jul-23			
Acute & Community Directorate Service	n	*mean*	SPC variation	Note
SPA/EWS	**667**	*674*	• • •	
Crisis Resolution and Home Treatment	**915**	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 will be able to accurately report on this when we have transferred to Rio.		
Liaison Psychiatry	**539**	*485*	• • •	
Decisions Unit	**63**	*57*	• • •	
S136 HBPOS	**14**	*32*	• • •	
Recovery Service North	**25**	*23*	• • •	
Recovery Service South	**30**	*23*	• • •	
Early Intervention in Psychosis	**36**	*37*	• • •	
Memory Service	**131**	*127*	• • •	
OA CMHT	**246**	*255*	• • •	
OA Home Treatment	**23**	*25*	• • •	

Referrals	Jul-23			
Rehab & Specialist Service	n	*mean*	SPC variation	Note
CERT	**2**	*2*	• • •	
SCFT	**2**	*2*	• • •	
CLDT	**56**	*57*	• • •	CLDT figures represent distinct individuals so does not include multiple referrals per service user.
CISS	**3**	*3*	• • •	
Psychotherapy Screening (SPS)	**62**	*50*	• • •	
Gender ID	**41**	*43*	• • •	
STEP	**116**	*106*	• H •	Referrals steadily increasing especially from GPs. This may be due to increased visibility and familiarity with STEP and its offer due to work both by the team and signposting by other SHSC services such as SPA/EWS.
Eating Disorders Service	**49**	*35*	• • •	
SAANS	**365**	*420*	• • •	
R&S	**17**	*19*	• • •	
Perinatal MH Service	**51**	*48*	• • •	
HAST	**9**	*15*	• • •	
HAST - Changing Futures	**1**			
Health Inclusion Team	**180**	*164*	• • •	
LTNC	**81**			
ME/CFS Long Covid	**2**			
ME/CFS	**74**			

Responsive | Access & Demand | Community Services

July 2023	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	**287**	*685*	• L •	**50.1**	*35.3*	• • •	**9.7**	*10.1*	• L •	**657**	*895*	• L •
MH Recovery North	**83**	*82*	• • •	**25.9**	*12.3*	• H •	**3.1**	*9.4*	• L •	**783**	*924*	• L •
MH Recovery South	**32**	*73*	• L •	**3.1**	*12.3*	• • •	**3.5**	*12.3*	• • •	**967**	*1062*	• L •
Recovery Service TOTAL	**115**	*156*	• L •	*N/A*			*N/A*			**1750**	*1986*	• L •
Early Intervention in Psychosis	**27**	*25*	• • •				**89.47%**	*71.62%*	• • •	**301**	*316*	• L •
Memory Service	**863**	*790*	• H •	**34.5**	*27.2*	• H •	**47.7**	*35.2*	• H •	**4182**	*4231*	• • •
OA CMHT	**296**	*194*	• H •	**8.2**	*7.6*	• • •	**12.9**	*10.3*	• • •	**1380**	*1258*	• H •
OA Home Treatment	*N/A*			*N/A*			*N/A*			**69**	*66*	• • •
Rehab & Specialist Services	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**	**n**	*mean*	**SPC variation**
SPS - MAPPS	**91**	*74*	• • •	**27.6**	*19.8*	• • •	**81.0**	*81*	• • •	**346**	*323*	• • •
SPS - PD	**46**	*41*	• H •	**17.0**	*15.1*	• • •	**45**	*61*	• • •	**187**	*191*	• • •
Gender ID	**2238**	*1775*	• H •	**252.4**	*147.0*	• H •				**3081**	*2660*	• H •
STEP	**321**	*148*	• H •	*N/A*						**599**	*432*	• H •
Eating Disorders	**26**	*29*	• • •	**2.2**	*4.3*	• • •				**193**	*216*	• L •
SAANS	**8095**	*5736*	• H •	**101.3**	*93.2*	• • •				**6211**	*5813*	• H •
Relationship & Sexual Service	**57**	*140*	• L •	**28.3**	*68.6*	• L •				**120**	*190*	• L •
Perinatal MH Service (Sheffield)	**28**	*24*	• • •	**2.3**	*3.1*	• • •				**173**	*147*	• • •
HAST	**22**	*28*	• • •	**21.7**	*12.9*	• • •				**82**	*81*	• • •
Health Inclusion Team	**544**			**5.7**						**1661**		
LTNC	**343**	*289*	• L •	*N/A*						*N/A*		
CFS/ME	*N/A*											
CLDT	**200**	*179*	• • •	**5.1**	*10.8*	• L •	**32**	*21*	• • •	**696**	*725*	• • •
CISS	*N/A*			*N/A*			*N/A*			**14**	*23*	• L •
CERT	**0**									**47**	*45*	• • •
SCFT	**0**									**22**	*24*	• L •

Narrative

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

ME/CFS – Data quality work underway, could be linked to risk identified at directorate level (risk no. 4508). Long term sickness impacting delivery of assessments.

LTNC – Data has become more accurate following data improvement work, This has shown an increase in numbers on the waitlist.

SEDS – reduction in RtA time due to ASERT assessment team and FREED initiative.

STEP – No admin resource is leading to longer times to process referrals and book them onto courses and therefore longer wait until treatment.

HIT – Caseload increased in Homeless & Migrant placements, large increase in number of referrals who are open to safeguarding increasing complexity. Workforce model proposed but requires investment, commissioners need to be identified. QEIA completed and presented at QAC.

SAANS – SAANS reported wait list currently includes both ASD and ADHD and includes those waiting for screening to be accepted for service as well as those waiting for diagnostic assessments and further interventions.

ADHD: referrals have around a 50% rate of acceptance from screening and there is work being undertaken to increase clinical capacity within SHSC to manage the volume of screening required. Future planned mitigations include collaboration with SPA/EWS and initial discussions with PCMHT and consultation model supporting other SHSC Teams.

ASD: Service provided to Sheffield and Derbyshire residents, and a number of mitigations are being looked at including waiting well project co-produced with VAS.

Inpatient Wards | PICU

PICU (Endcliffe)	July-23 n	mean	SPC variation	SPC target
Admissions	5	3.58	• • •	/
Transfers in	9			
Discharges	2	1.92	• • •	/
Transfers out	12			
Delayed Discharge/Transfer of Care (number of delayed discharges)	1			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	31			
Bed Occupancy excl. Leave (KH03)	99.35%	94.01%	• • •	/
Bed Occupancy incl. Leave	99.35%	96.46%	• • •	/
Average beds admitted to	9.94			
Average Discharged Length of Stay (12 month rolling)	34.61	43.68	• L •	?
Live Length of Stay (as at month end)	115.70	105.24	• • •	/
Number of People Out of Area at month end	8	5	• • •	F
Number of Mental Health Out of Area Placements started in the period (admissions)	4	3	• • •	?
Total number of Out of Area bed nights in period	167	147	• H •	F

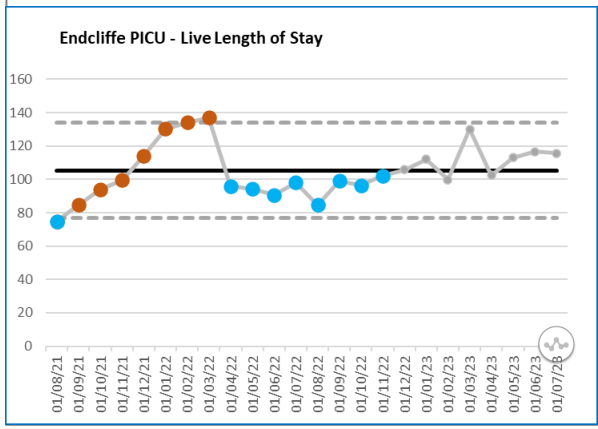
Narrative

Endcliffe – Length of Stay – July 23
Over national benchmark average (47)

Start Date	LOS
02/02/2021 17:38	909
13/04/2023 19:00	109
08/06/2023 18:20	53

As at 31/07/23, there were 3 service users on Endcliffe Ward with a length of stay over the national average (benchmarked) of 47 days.

LoS for PICU disproportionally affected by 1 patient who has been on the ward for 909 days (at month end).



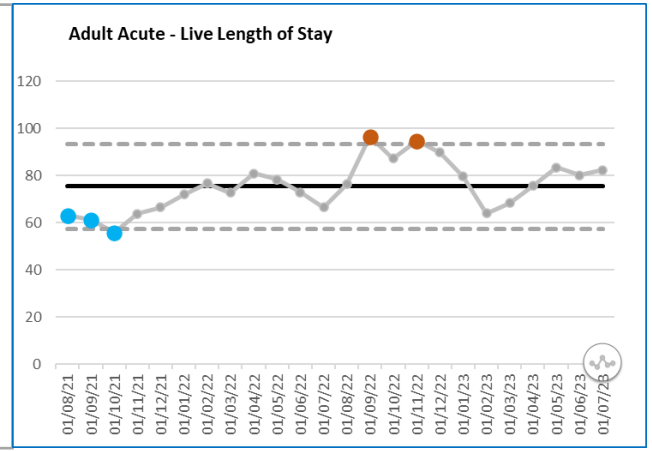
Benchmarking PICU
(2021 NHS Benchmarking Network Report – Weighted Population Data)

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

Safe | Inpatient Wards | Adult Acute & Step Down

Adult Acute (Burbage/Dovedale 2, Stanage/Burbage, Maple)	July-23 n	mean	SPC variation	SPC target
Admissions	26	29.83	• • •	/
Detained Admissions	24	27.29	• • •	/
% Admissions Detained	92.31%	91.52%	• • •	/
Emergency Re-admission Rate (rolling 12 months)	2.80%			
Transfers in	22			
Discharges	32	30.21	• H •	/
Transfers out	19			
Delayed Discharge/Transfer of Care (number of delayed discharges)	11			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	291			
Bed Occupancy excl. Leave (KH03)	97.53%	94.31%	• • •	/
Bed Occupancy incl. Leave	100.40%	98.40%	• • •	/
Average beds admitted to	48.5			
Average Discharged Length of Stay (12 month rolling)	37.96	40.34	• L •	F
Average Discharged Length of Stay (discharged in month)	42.23	39.76	• • •	?
Live Length of Stay (as at month end)	82.24	75.32	• • •	/
Number of People Out of Area at month end	11	12	• • •	F
Number of Mental Health Out of Area Placements started in the period (admissions)	9	9	• • •	?
Total number of Out of Area bed nights in period	258	362	• • •	F

Adult Acute Length of Stay Detail – July 23
Longest LoS (days) as at month end:
308 on Dovedale 2 Difficulties finding suitable specialist supported accommodation. Discussed regularly at weekly CRFD meeting
582 on Maple Requires specialist placement, discussed at CRFD and Head of Nursing A&C is overseeing next steps.
145 on Burbage Awaiting Rehab bed, transferred to Forest Close on 1 August
Longest LoS (days) of discharges in month:
Dovedale 2 = 146
Maple = 62
Burbage = 227



Step Down (Beech)	July-23 n	mean	SPC variation	SPC target
Admissions	5	5.13	• • •	/
Transfers in	0			
Discharges	6	5.21	• • •	/
Transfers out	0			
Bed Occupancy excl. Leave (KH03)	78.06%	75.16%	• H •	/
Bed Occupancy incl. Leave	89.35%	83.71%	• H •	/
Average Discharged Length of Stay (12 month rolling)	51.93	52.55	• L •	/
Live Length of Stay (as at month end)	47.33	44.86	• H •	/

Length of Stay Detail – July 23
Longest LoS (days) as at month end: 153
Range = 4 to 153 days
Longest LoS (days) of discharges in month: 119

Narrative
Metrics for Adult Acute within expected limits.

Out of area recovery plan in place.

Beech discharged length of stay low, likely due to several short-term placements before moving on to final destinations.

Benchmarking Adult Acute
(2021 NHS Benchmarking Network Report – Weighted Population Data)

Bed Occupancy Mean: 86.4%
Length of Stay (Discharged) Mean: 32
Emergency readmission rate Mean: 10.3%

NB – No benchmarking available for Step Down beds

Safe | Inpatient Wards | Older Adults

Older Adult Functional (Dovedale 1)	Jul-23 n	mean	SPC variation	SPC target
Admissions	3	4.92	• • •	/
Transfers in	2			
Discharges	4	5.58	• • •	/
Transfers out	2			
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)	96.99%	89.92%	• • •	/
Bed Occupancy incl. Leave	98.28%	95.91%	• • •	/
Average beds admitted to	14.74			
Average Discharged Length of Stay (12 month rolling)	81.16	72.41	· H ·	?
Live Length of Stay (as at month end)	46.07	64.00	• • •	/

Length of Stay Detail July 23 – Dovedale 1
Longest LoS (days) as at month end: 95
Range = 5 to 95 days
Longest LoS (days) of discharges in month: 222

Longest LoS not clinically ready for discharge

Older Adult Dementia (G1)	Jul-23 n	mean	SPC variation	SPC target
Admissions	5	4.96	• • •	/
Transfers in	1			
Discharges	2	4.38	• • •	/
Transfers out	2			
Delayed Discharge/Transfer of Care (number of delayed discharges)	5			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	155			
Bed Occupancy excl. Leave (KH03)	85.89%	75.42%	• • •	/
Bed Occupancy incl. Leave	86.49%	77.28%	• • •	/
Average beds admitted to	13.84			
Average Discharged Length of Stay (12 month rolling)	80.69	71.00	· H ·	/
Live Length of Stay (as at month end)	44.06	56.35	• • •	/

Length of Stay Detail July 23– G1
Longest LoS (days) as at month end: 117
Range = 0 to 117 days
Longest LoS (days) of discharges in month: 120

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)	Jul 23 n	mean	SPC variation	SPC target
Admissions	1	1.04	• • •	/
Transfers in	1			
Discharges	2	2.08	• L •	/
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)	92.37%	84.36%	• H •	/
Bed Occupancy incl. Leave	97.85%	93.36%	• • •	/
Average Discharged Length of Stay (12 month rolling)	387.45	282.57	• H •	P
Live Length of Stay (as at month end)	349.70	352.20	• • •	/
Number of Out of Area Placements started in the period (admissions)	0			
Total number of Out of Area bed nights in period	155			
Number of People Out of Area at month end	5			

Forensic Low Secure (Forest Lodge)	Jul 23 n	mean	SPC variation	SPC target
Admissions	1	0.79	• • •	/
Transfers in	0			
Discharges	1	0.83	• • •	/
Transfers out	0			
Bed Occupancy excl. Leave (KH03)	82.99%	86.22%	• • •	/
Bed Occupancy incl. Leave	94.72%	92.62%	• • •	/
Average Discharged Length of Stay (12 month rolling)	632.56	422.47	• H •	P
Live Length of Stay (as at month end)	645.00	573.73	• H •	/

The point at which someone is CRFD is reached when:

- The multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in the current inpatient setting.
- To enable this decision:
  - There must be **a clear plan for the ongoing care and support that the person requires after discharge**, which covers their pharmacological, physical health, psychological, social, cultural, housing and finances, and any other individual needs or wishes.
  - The MDT must have **explicitly considered the person and their chosen carer/s' views and needs** about discharge and involved them in co-developing the discharge plan.
  - The MDT must also have **involved any services external to the trust in their decision making**, e.g. social care teams, where these services will play a key role in the person's ongoing care.

Forest Close

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

Long stays – Forest Close July 23

Service user under S37(41) – Has a property, still engaging with CERT, next step will be to apply for overnight leave and then there will be the tribunal process to follow.

Service user under S37 (41) – Prior to Christmas he was using illicit substances so unescorted S17 leave was stopped by MOJ, will be applying for unescorted leave in the next couple of weeks but he has been unable to sustain periods without drug use for us to explore accommodation/discharge.

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 are discussed within Horizon on a weekly basis, there are also risk assessments for appropriate placements.

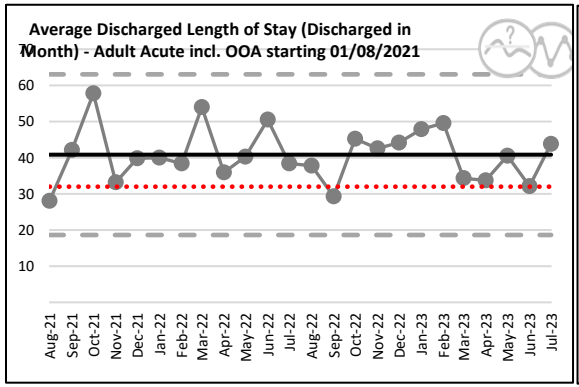
Long stays – Forest Lodge July 23

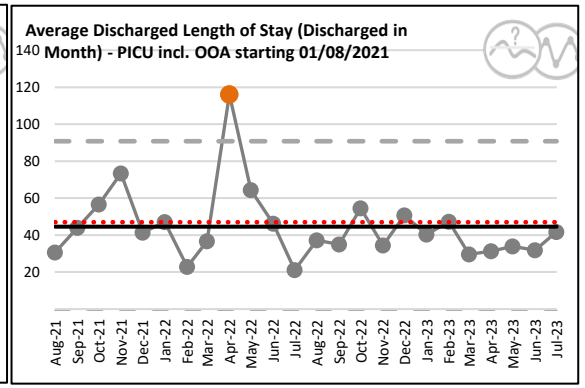
2294, 2123 and 2025 are the three top longest stays at Forest Lodge. The rationale for LoS remains the same due to clinical presentation and this is likely to be unchanged until the service users are likely to be discharged, their risk changes or another placement is required, and this would go through the MoJ / NHS England i.e., medium secure is found.

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

UEC (Urgent & Emergency Care) Dashboard

Length of Stay





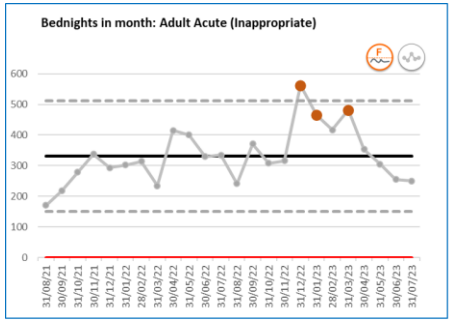
Adult Acute Discharged LoS (Rolling 12 month average)

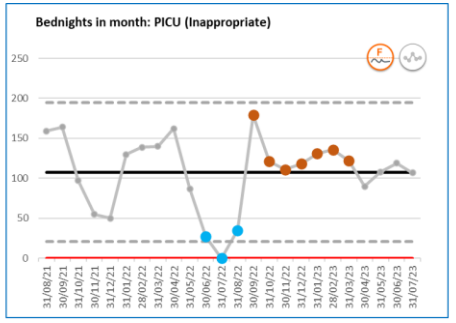
Location	Total Discharges	Average Discharged LoS
Sheffield	444	38
OOA	111	43
Contracted	109	45
Combined	**664**	**40**

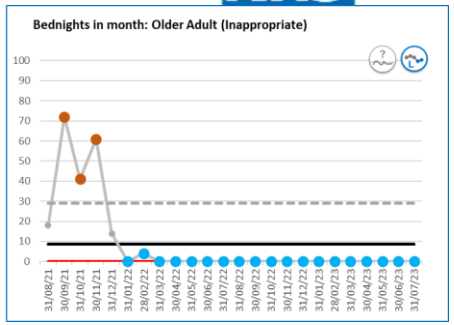
PICU Discharged LoS (Rolling 12 month average)

Location	Total Discharges	Average Discharged LoS
Sheffield	95	35
OOA	34	48
Combined	**129**	**38**

Out of Area

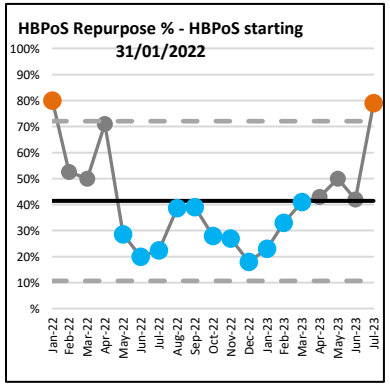






Provider	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Sparklines (Aug-22 to Jul-23)
Sheffield Health and Social Care NHS Foundation Trust	**12**	**19**	**14**	**20**	**20**	**20**	**20**	**20**	**15**	**7**	**9**	**10**	
Bradford District Care NHS Foundation Trust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

HBPoS Repurposing



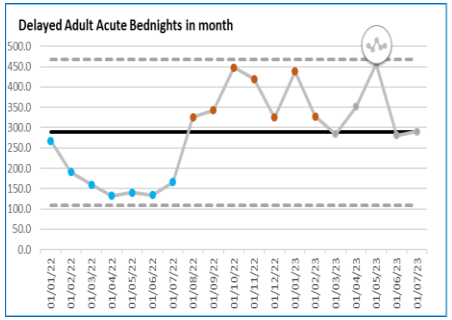
Health Based Place of Safety (HBPoS/136 Beds)	Jul-23
Occasions repurposed	49
Occasions repurposed %	79%

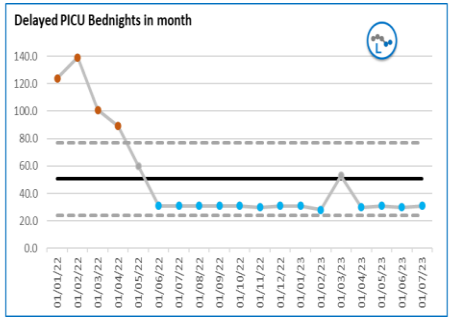
July 2023		
Weekday Beds Available	31	31
Days Repurposed	18	31
% Repurposed	79%	
Days Occupied	7	0
% Occupied	11%	
Days Available	6	0
% Available	10%	

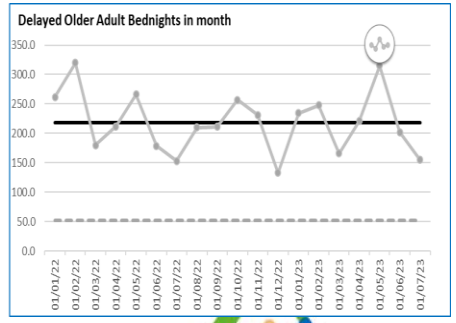
Delayed Care

Delayed Care narrative

% of bednights occupied by delayed patients is 20.0% 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.





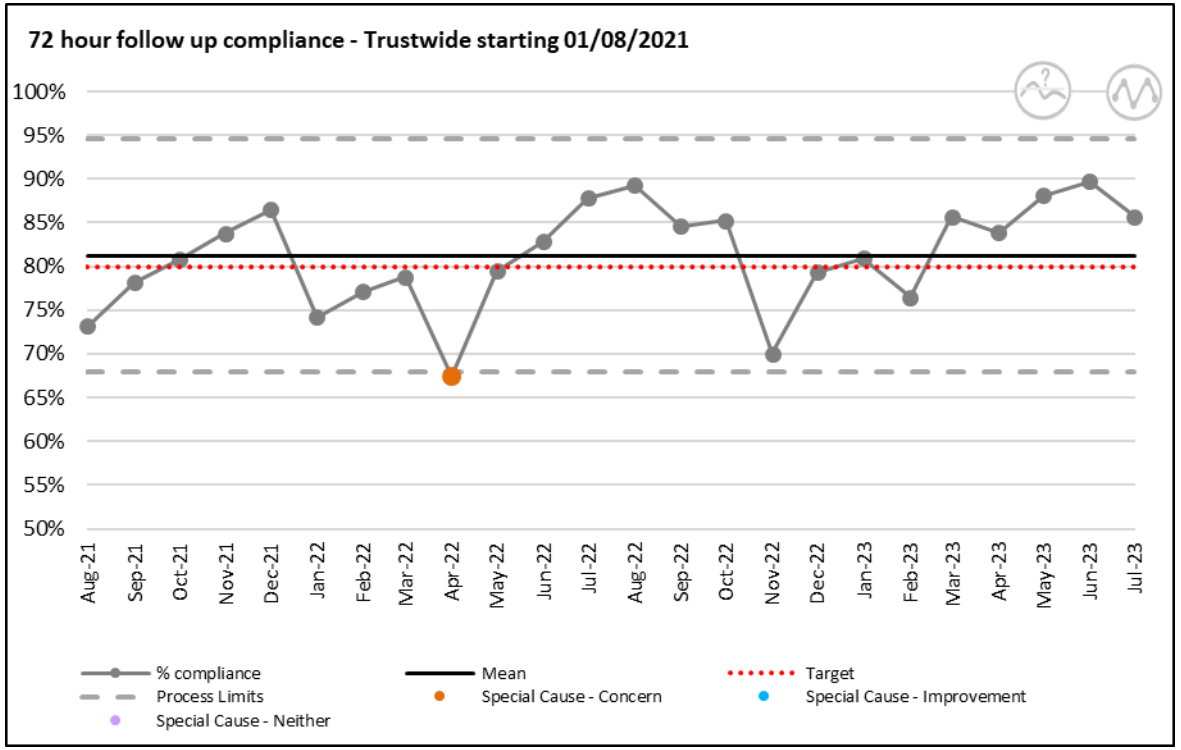


Delayed Discharges Adult Acute		
Jul 23	Sum of Delayed Bednights	% Bednights occupied by DD
Adult Acute Total	291	20.0%

Delayed Discharges PICU		
Jul 23	Sum of Delayed Bednights	% Bednights occupied by DD
Endcliffe	31	10.0%

Delayed Discharges Older Adult		
Jul 23	Sum of Delayed Bednights	% Bednights occupied by DD
Older Adult Total	155	16.1%

Effective | Treatment & Intervention – 72 hour follow up



72 hour Follow Up		July 23		
	Target	%	No.	SPC Variation
Trustwide	80%	85.17%	30/35	• • •

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.

Trustwide: 30/35 patients seen within 72 hours: 5 seen outside the target

3 x contacted on day 4

Discharged from DD2 – attempted contact day 3 phone switched off
Discharged Maple – attempted contact day 2 no connection to phone number
Discharged Maple – contact day 4 however CRHTT involved day after discharge, delayed due to awaiting referral meeting outcome

1 x contacted day 5

Discharged Burbage, no discharge destination on report & delay in discharge summary.
Discharged to Beech. Contacted by South recovery team.

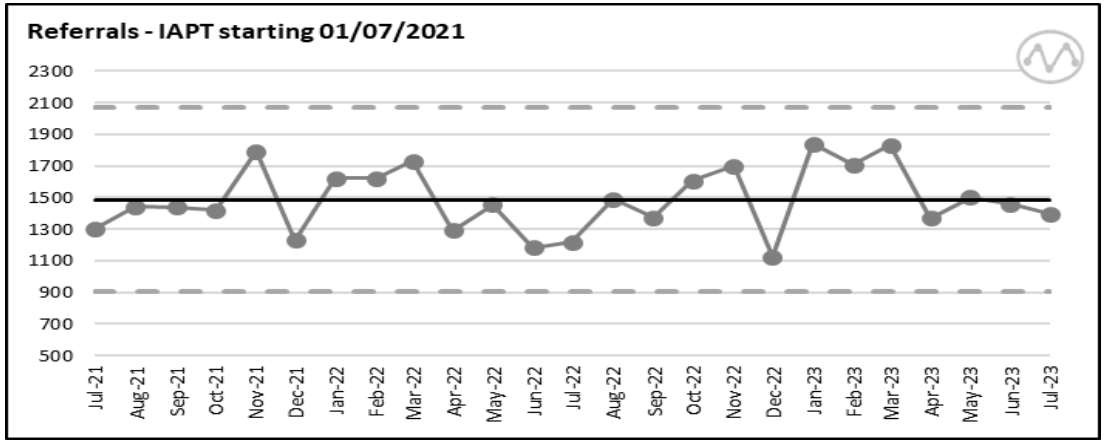
1 x discharged from Forest Close, contact day 5

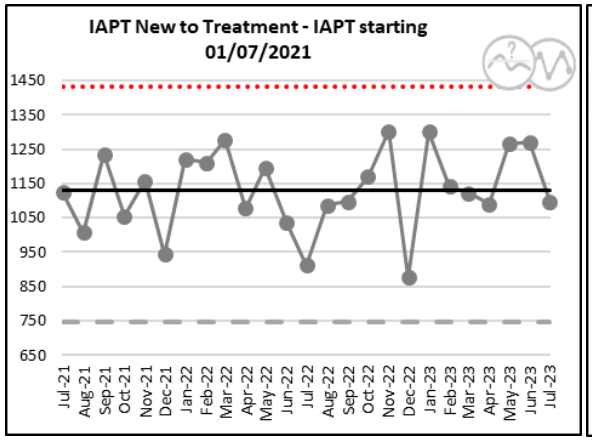
Sheffield Talking Therapies | Performance Summary

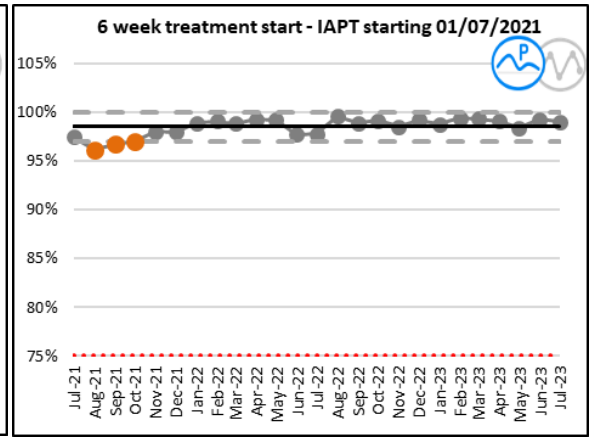
Sheffield Talking Therapies		July-23			
Metric	Target 2022/23	*n*	*mean*	*SPC variation*	*SPC target*
Referrals	/	**1395**	*1486*	• • •	/
New to Treatment	1352	**1098**	*1131*	• • •	?
6 week Wait	75%	**99%**	*98.5%*	• H •	P
18 week Wait	95%	**99.8%**	*99.83%*	• • •	P
Moving to Recovery Rate	50%	**51.6%**	*51.12%*	• • •	?

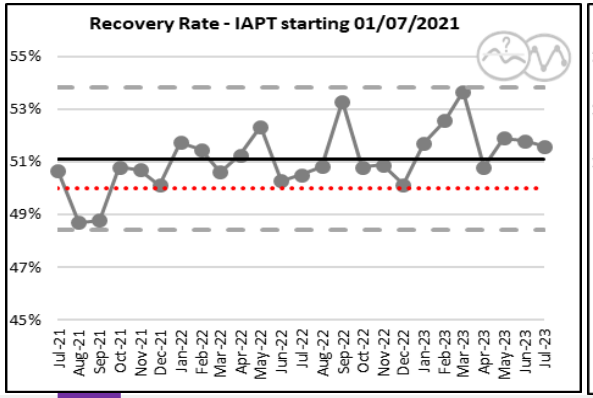
Narrative

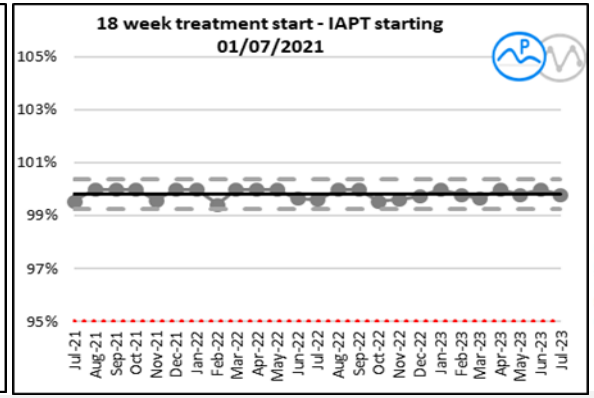
- Monthly Access Target from April 23 is now 1352
- Service has achieved the recovery rate standard for 22 consecutive months
- Continue to exceed the waiting time standard for people receiving their first treatment appointment











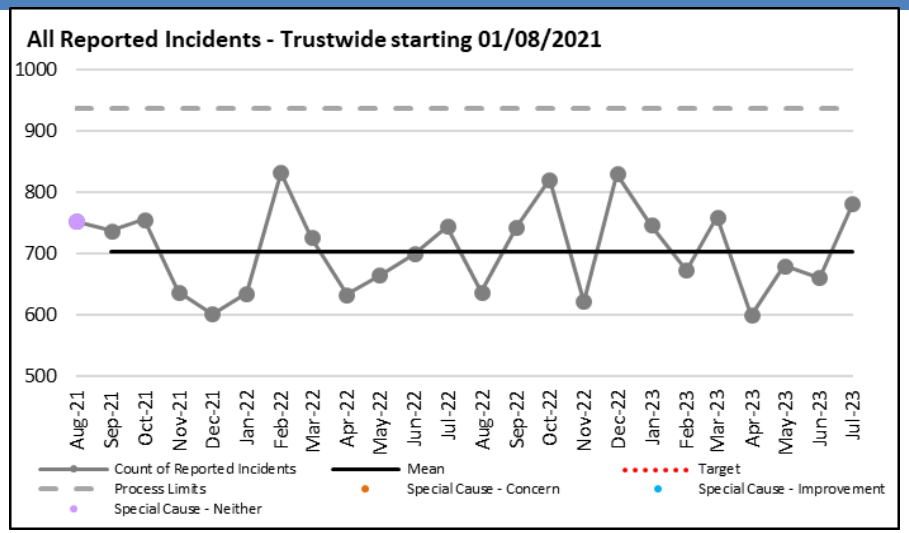
NHS
Sheffield Health and Social Care
NHS Foundation Trust

Safety & Quality

IPQR - Information up to and including July 2023

Proud to care in Sheffield

Safe | All Incidents



Trustwide	Jul-23		
	n	*mean*	SPC variation
ALL	**909**	718	• • •
5 = Catastrophic	**24**	25	• • •
4 = Major	**3**	4	• • •
3 = Moderate	**83**	54	• • •
2 = Minor	**389**	273	• • •
1 = Negligible	**393**	372	• L •
0 = Near-Miss	**17**	19	• L •

Narrative

During July 2023, 3 incidents were rated as Major. This was in relation to resource issues for number of staff, sexual safety incident and the third was Fire – equipment related.

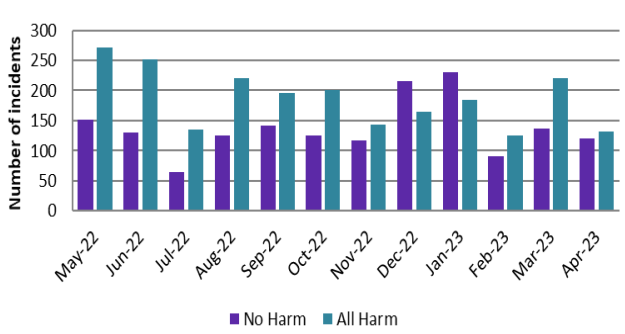
Of the 24 Catastrophic incidents, 19 were for Acute and Community services and 5 for Rehabilitation and Specialist services. All Catastrophic incidents were service user deaths, with the majority expected or suspected natural causes and will be reviewed in the mortality review group. No death related incidents have been identified as a S.I during this month.

Narrative

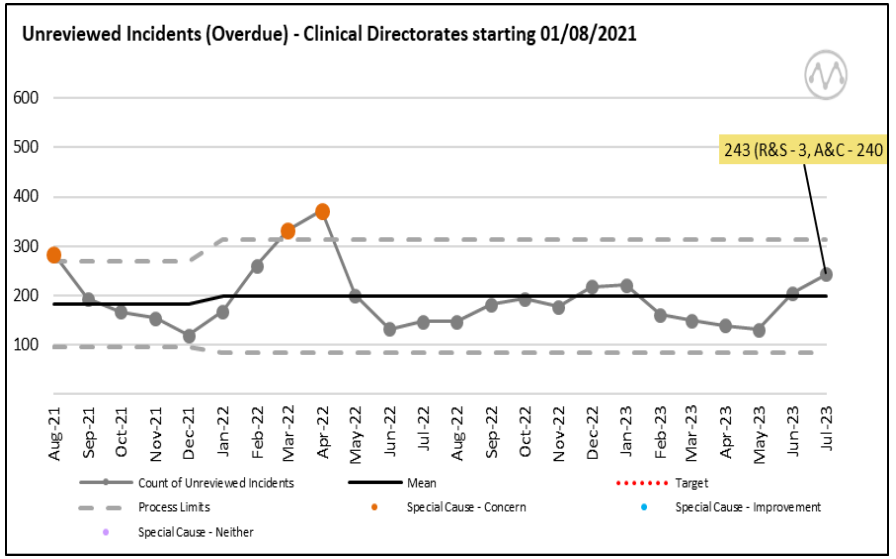
Patient safety incidents are currently uploaded to the National Reporting Learning System (NRLS). The NHS is moving to a new platform, the Learning from Patient Safety Events (LFPSE) from 1 April 2023. All patient safety incidents will be uploaded to this from August 2023. The latest benchmarking information 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 May 2022 to April 2023

Patient Safety Incidents – Harm vs No Harm May 22 – Apr 23



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



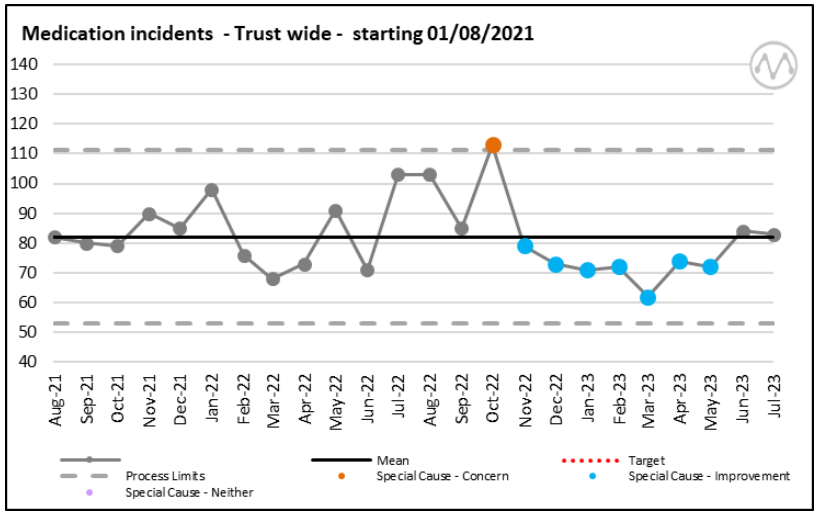
Narrative

The unreviewed incidents are predominantly accounted for by the Acute and Community Directorate. 179 incidents remain unreviewed prior to July 2023.

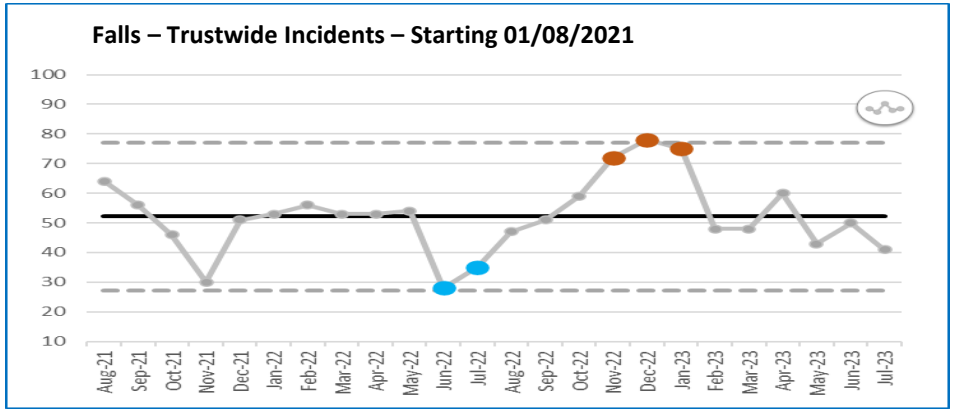
Of the 243 unreviewed incidents, no incidents occurred prior to January 2023.

Directorate leads are working towards reducing the number of unreviewed incidents below 160.

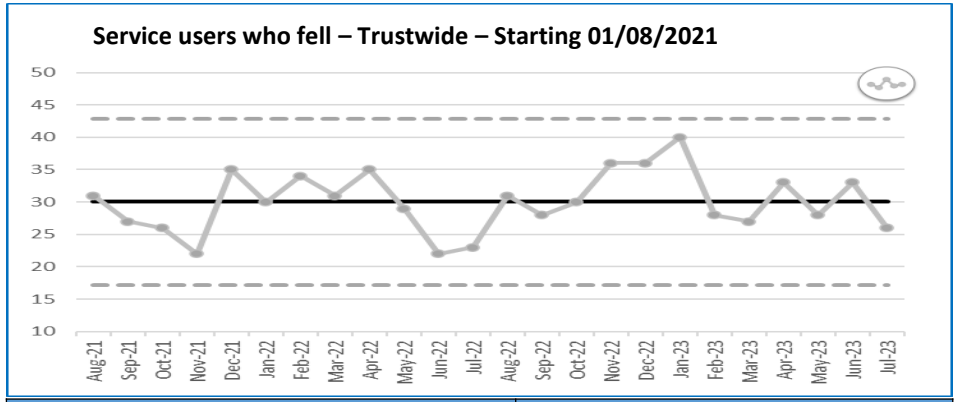
Safe | Medication Incidents & Falls



Trustwide	Jul-23		
	n	*mean*	SPC variation
ALL	**83**	*82*	• • •
Administration Incidents	**9**	*14*	• • •
Meds Management Incidents	**62**	*54*	• • •
Pharmacy Dispensing Incidents	**3**	*7*	• • •
Prescribing Incidents	**9**	*7*	• • •
Meds Side Effect/Allergy Incidents	**0**	*0*	• L •



Trustwide FALLS INCIDENTS	Jul-23		
	n	*mean*	SPC variation
Trustwide Totals	41	*52*	• • •
Acute & Community	39	*50*	• • •
Nursing Homes	31	*30*	• • •
Rehabilitation & Specialist Services	2	*2*	• • •



Trustwide FALLS - PEOPLE	Jul-23		
	n	*mean*	SPC variation
Trustwide Totals	26	*30*	• • •
Acute & Community	24	*28*	• • •
Nursing Homes	18	*16*	• • •
Rehabilitation & Specialist Services	2	*2*	• • •

Narrative

Medication Incidents

During July 2023, there were 2 incidents rated as moderate. 1 reported for a duplicated prescription in Mental Health Recovery Team North and the other for a Controlled Drug stock discrepancy occurring on Maple Ward.

Falls Incidents

Of the 41 incidents reported, 31 were in our Nursing homes. Birch Avenue continue to be the highest reporting of incidents, 23 for 11 people.

Safe | Assaults, Sexual Safety & AWOL Patients

Assaults on Service Users	Jul-23		
	n	mean	SPC variation
Trustwide	32	25	• • •
Acute & Community	28	21	• • •
Rehabilitation & Specialist	0	2	• • •
Assaults on Staff	**Jul-23**		
	n	mean	SPC variation
Trustwide	58	51	• • •
Acute & Community	58	46	• • •
Rehabilitation & Specialist	0	5	• • •

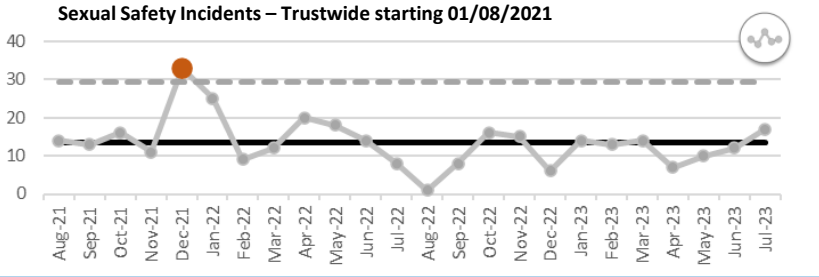
Narrative

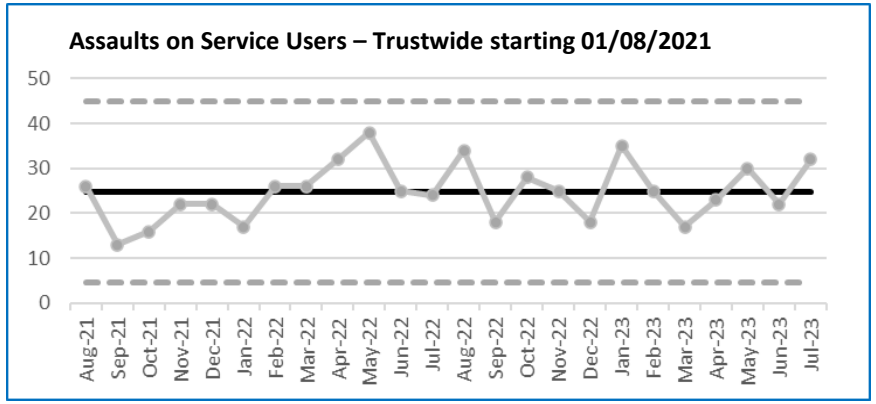
Of the 32 reported incidents of assaults on service users, 3 were rated as moderate, all involving the assault of a service user by another service user. 1 incident on Endcliffe ward and 2 on Maple ward. While the number of incidents remains within expected variance, there has been a steady incline in incidents reported.

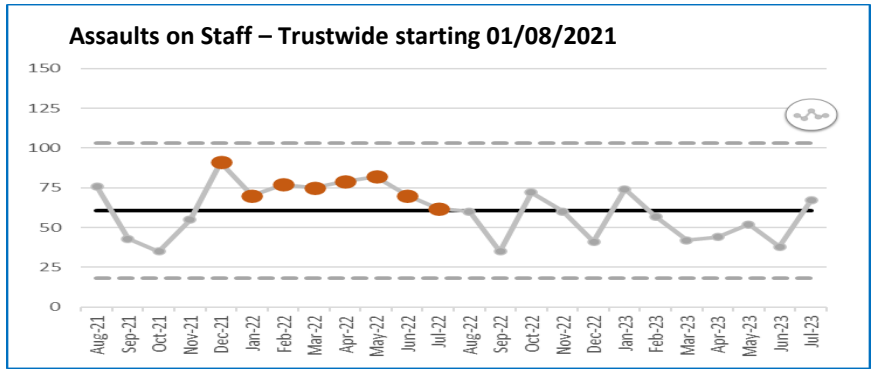
Out of the 58 assaults on staff reported incidents, 9 incidents were reported as Moderate, 1 occurring on Dovedale 1, 1 on Dovedale 2, 4 on Maple ward and 3 on Endcliffe ward.

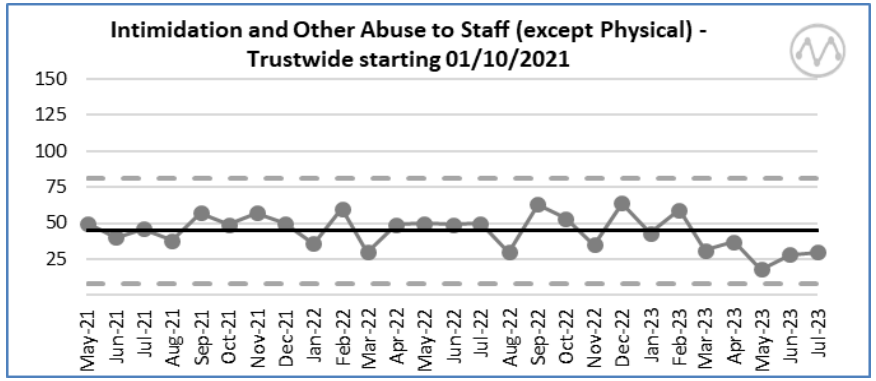
Sexual Safety

There were 17 sexual safety incidents reported in July 2023. All sexual safety incidents are reviewed in the sexual safety group. Any incidents involving staff are managed through the staff safeguarding policy. Whilst there has been no statistical change in the number of sexual safety incidents, we still consider this to be a priority area and a workplan is being developed.

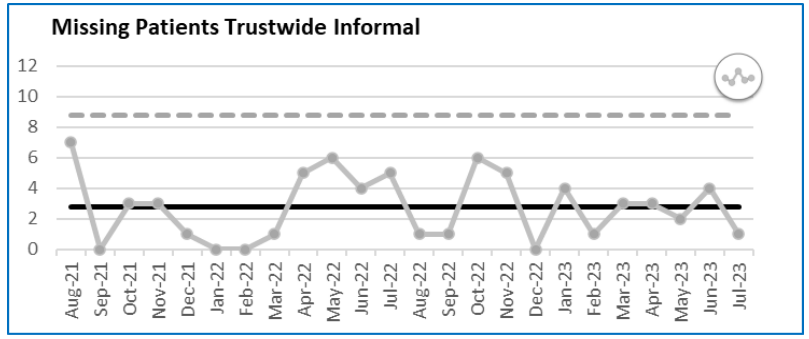


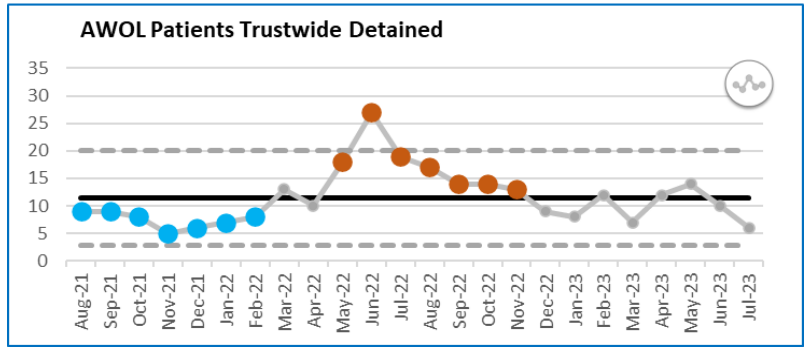






Protecting from avoidable harm	Target	YTD
Reportable Mixed Sex Accommodation (MSA) breaches	0	0





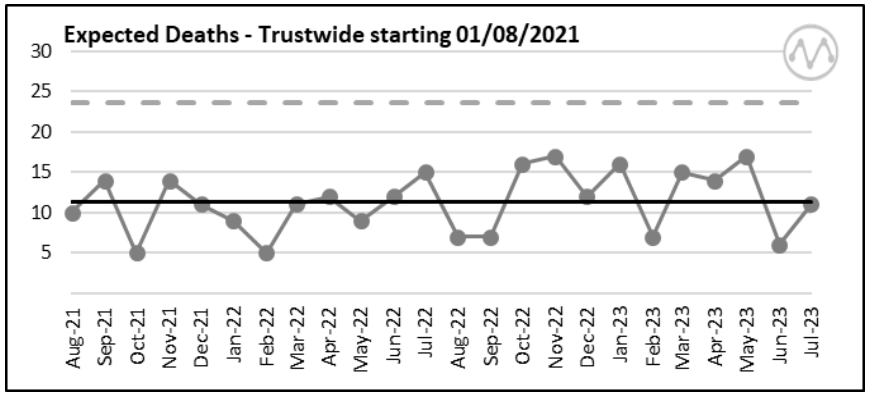
Trustwide	Jul-23		
	n	mean	SPC variation
Detained	6	11	• • •
Informal	1	3	• • •

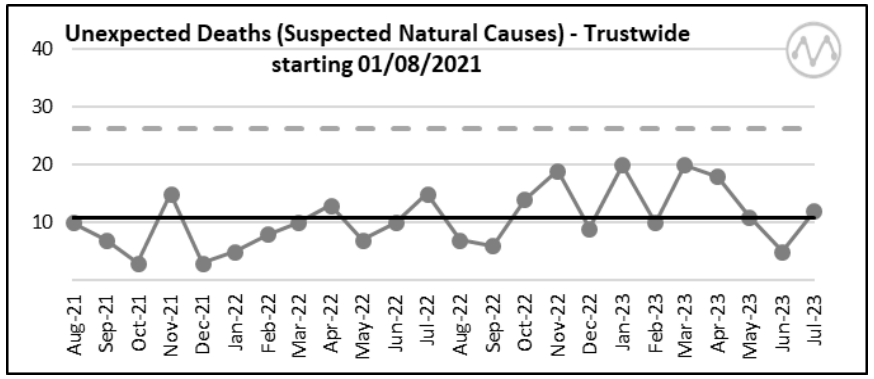
Narrative

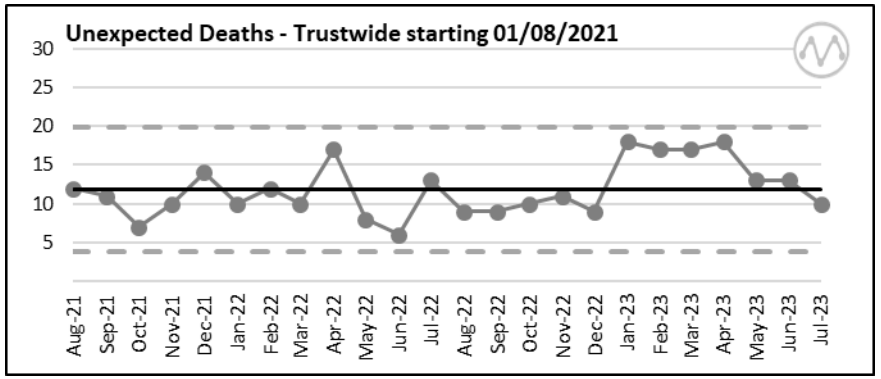
6 reported incidents in July 2023 of people under formal admission being AWOL. 1 incident for Rehabilitation & Specialist Services for 1 person and 5 incidents for Acute & Community for 5 people. At time of reporting:

- 1 person was on a Section 2,
- 5 people were on a Section 3

Deaths

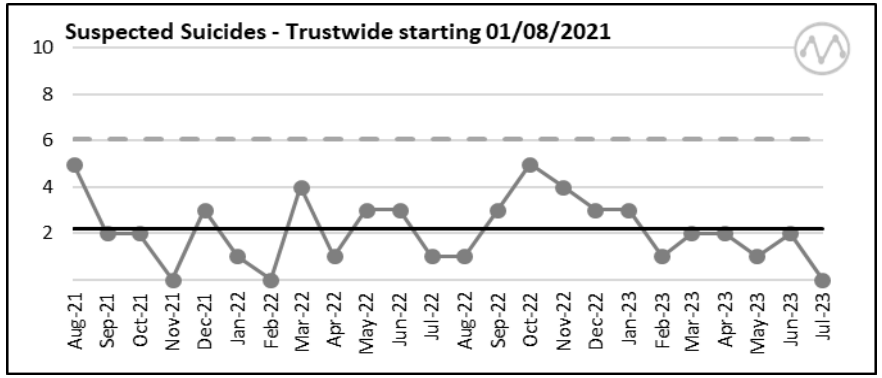






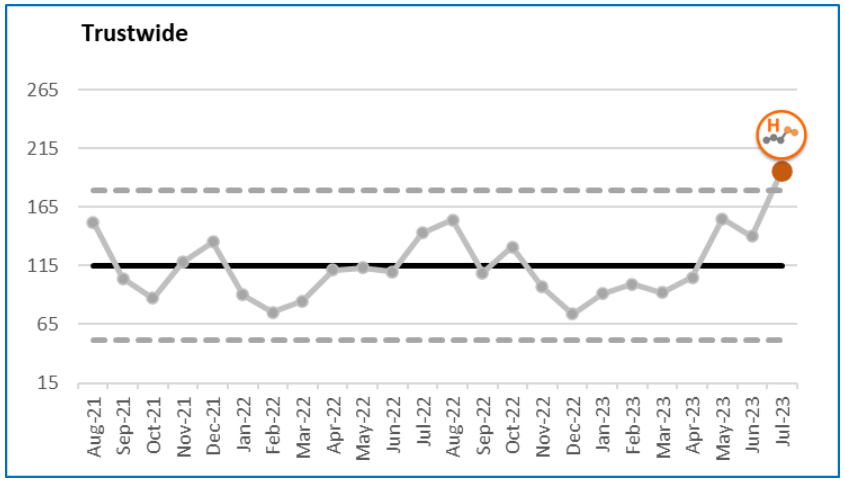
Quarterly mortality reports are presented to the Quality Assurance Committee and Board of Directors.

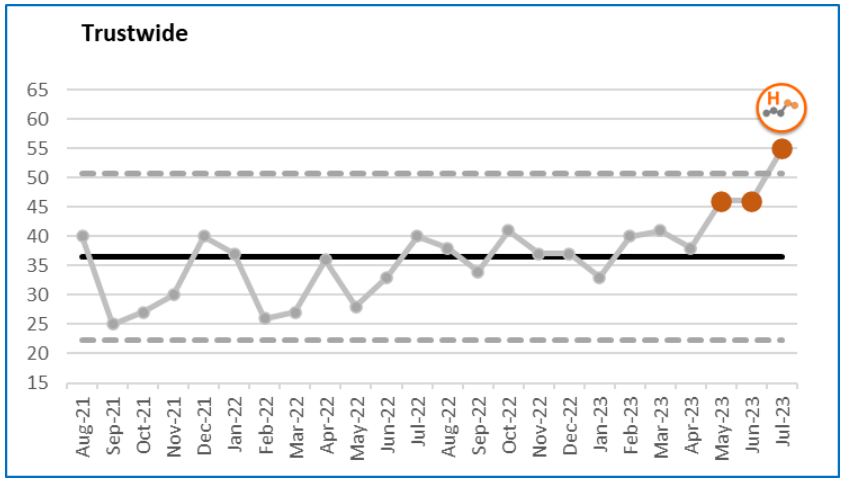
Deaths Reported 1 August 2021 to 31st July 2023	
Awaiting Coroners Inquest/Investigation	102
Closed	3
Conclusion - Accidental	1
Conclusion - Alcohol/Drug Related	2
Conclusion - Misadventure	1
Conclusion - Other	1
Conclusion - Natural Causes	2
Conclusion - Open	1
Conclusion - Suicide	8
Natural Causes - No Inquest	433
Grand Total	**554**

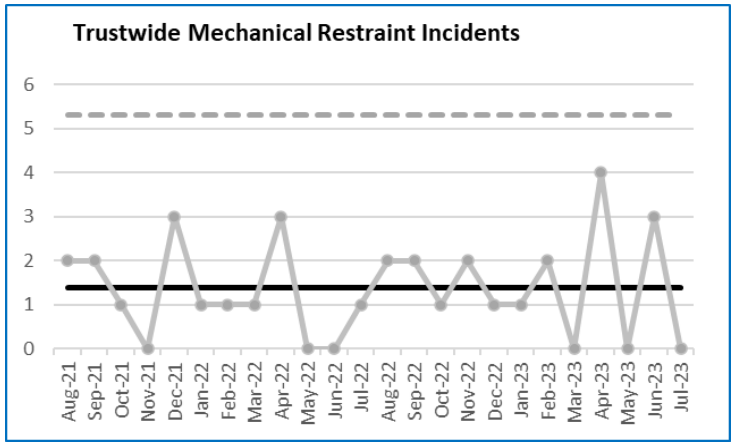


COVID-19 Deaths 1 April 2020 – 31 July 2023	
ATS (Firshill Rise)	1
Birch Ave	5
CISS (LDS)	1
CLDT	6
G1 Ward	6
Liaison Psychiatry	10
LTNC	3
Memory Service	7
Mental Health Recovery Team (South)	2
Neuro Case Management Team	1
Neuro Enablement Service	4
OA CMHT North	22
OA CMHT South East	15
OA CMHT South West	9
OA CMHT West	5
OA Home Treatment	3
SPA / EWS (Netherthorpe)	1
START Alcohol Service	1
START Opiates Service	2
Woodland View | Oak Cottage	2
Grand Total	**107**

Safe | Restrictive Practice | Physical Restraint







Physical Restraint INCIDENTS	Jul-23		
	n	mean	SPC variation
TRUSTWIDE	196	115	• H •
Acute & Community	196	112	• H •
Dovedale 2 Ward	68	24	• H •
Burbage Ward	18	10	• • •
Maple Ward	37	28	• • •
HBPoS (136 Suite)	1	1	• • •
Endcliffe Ward	47	20	• • •
Dovedale 1	14	19	• • •
G1 Ward	5	6	• • •
Birch Ave	4	4	• H •
Woodland View	1	1	• • •
Rehabilitation & Specialist	0	3	• • •
Forest Close	0	2	• • •
Forest Lodge	0	1	• • •

Physical Restraint PEOPLE	Jul-23		
	n	mean	SPC variation
TRUSTWIDE	55	36	• H •
Acute & Community	55	35	• H •
Dovedale 2 Ward	10	6	• H •
Burbage Ward	8	5	• • •
Maple Ward	11	7	• • •
HBPoS (136 Suite)	1	1	• • •
Endcliffe Ward	14	6	• H •
Dovedale	3	3	• • •
G1 Ward	3	4	• • •
Birch Ave	3	2	• • •
Woodland View	1	1	• • •
Rehabilitation & Specialist	0	2	• • •
Forest Close	0	1	• • •
Forest Lodge	0	1	• • •

Narrative

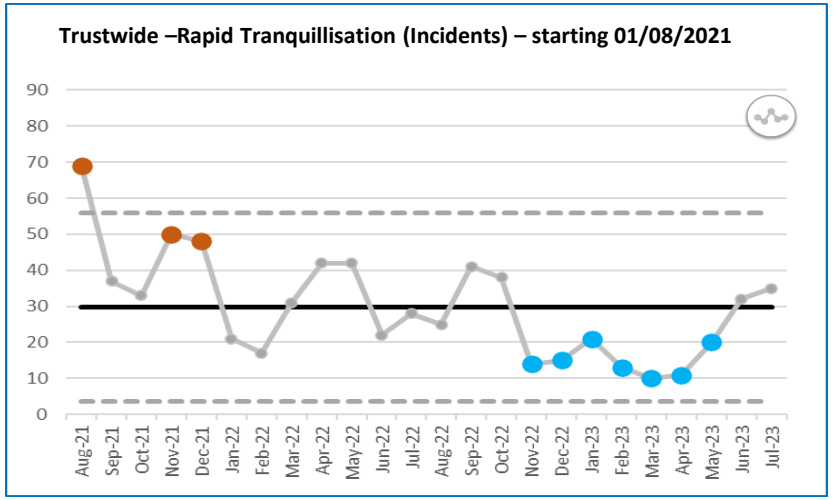
Physical Restraint
There were 196 incidents of restraint recorded for 55 people, a significant increase to previous months.

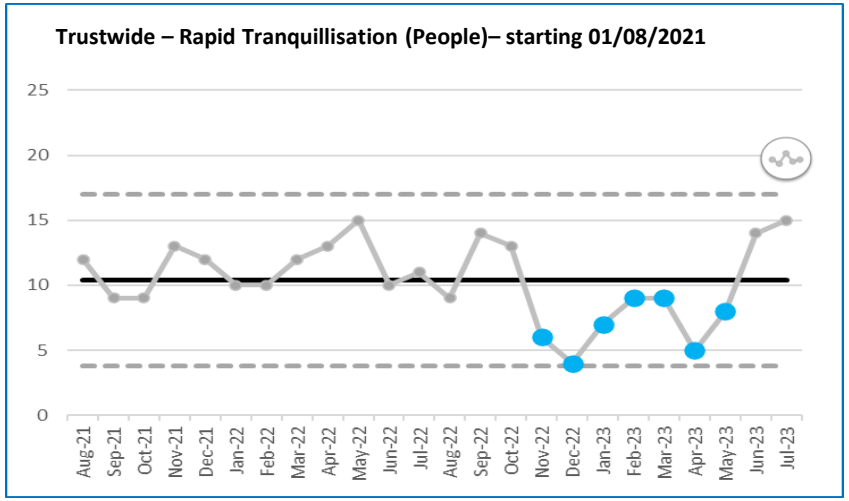
Dovedale 2 has shown a significant increase in the number of incidents reported. 43 of the 68 restraints occurred for 1 person.

Detailed review of physical restraint incidents indicates that staff are intervening to support and manage self-harm as opposed to managing physical aggression.

Mechanical Restraint
There have been no incidents reported for the use of mechanical restraints in July 2023.

Safe | Restrictive Practice | Rapid Tranquillisation





Rapid Tranquillisation INCIDENTS	Jul-23		
	n	*mean*	SPC variation
TRUSTWIDE	**35**	*30*	• • •
Acute & Community	**35**	*30*	• • •
Dovedale 2	**21**	*10*	• • •
Burbage Ward	**1**	*2*	• • •
Maple Ward	**5**	*6*	• L •
HBPoS (136 Suite)	**0**	*0*	• L •
Endcliffe Ward	**4**	*4*	• • •
Dovedale 1	**3**	*7*	• • •
G1 Ward	**1**	*0*	• H •
Rehabilitation & Specialist	**0**	*0*	• L •
Forest Close	**0**	*0*	• L •
Forest Lodge	**0**	*0*	• L •

Rapid Tranquillisation PEOPLE	Jul-23		
	n	*mean*	SPC variation
TRUSTWIDE	**15**	*10*	• • •
Acute & Community	**15**	*10*	• • •
Dovedale 2	**3**	*3*	• • •
Burbage Ward	**1**	*1*	• • •
Maple Ward	**4**	*2*	• • •
HBPoS (136 Suite)	**0**	*0*	• L •
Endcliffe Ward	**4**	*2*	• • •
Dovedale	**2**	*1*	• • •
G1 Ward	**1**	*0*	• H •
Rehabilitation & Specialist	**0**	*0*	• L •
Forest Close	**0**	*0*	• L •
Forest Lodge	**0**	*0*	• L •

Narrative

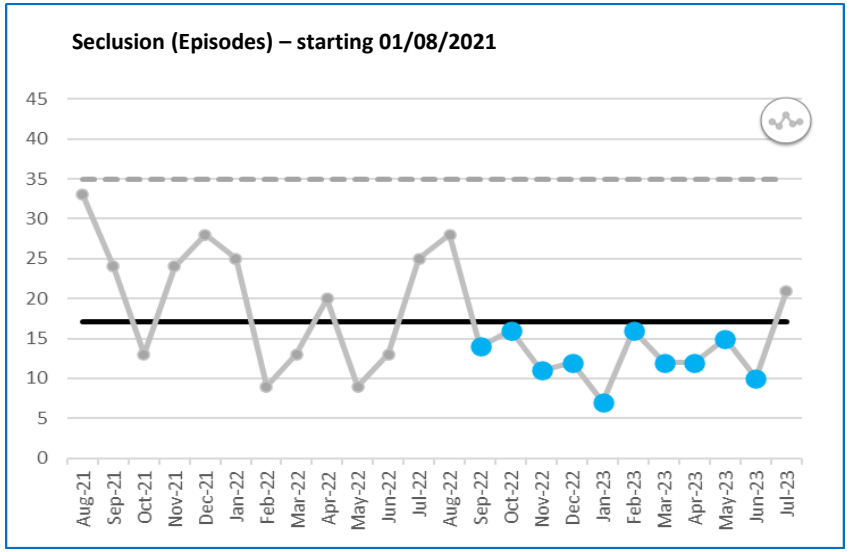
Rapid Tranquillisation
35 incidents of rapid tranquillisations used were recorded during July for 15 people.

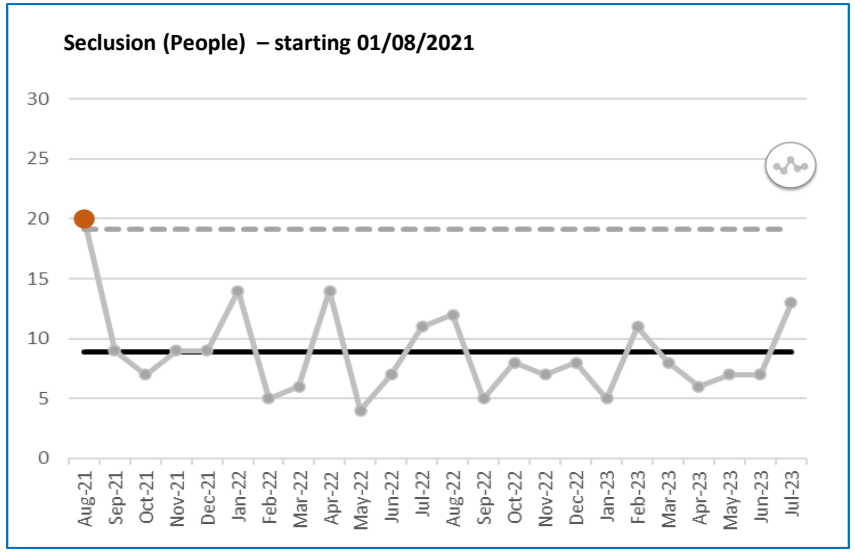
There continues to have been no reported incidents of rapid tranquillisation in the Rehabilitation & Specialist Directorate.

16 of the 21 incidents for rapid tranquillisation on Dovedale 2 were for 1 person.

The use of rapid tranquillisation is an appropriate alternative to physical restraint/seclusion as a treatment.

Safe | Restrictive Practice | Seclusion





Seclusion INCIDENTS	Jul-23		
	n	*mean*	SPC variation
Trustwide	**21**	*17*	• • •
Acute & Community	**21**	*14*	• • •
HBPoS (136 Suite)	**0**	*1*	• • •
Maple Ward	**5**	*4*	• • •
Endcliffe Ward	**10**	*8*	• • •
Rehabilitation & Specialist	**0**	*1*	• • •
Forest Lodge	**0**	*1*	• • •

Seclusion PEOPLE	Jul-23		
	n	*mean*	SPC variation
Trustwide	**13**	*9*	• • •
Acute & Community	**13**	*8*	• • •
HBPoS (136 Suite)	**0**	*0*	• • •
Maple Ward	**2**	*3*	• • •
Endcliffe Ward	**7**	*3*	• • •
Rehabilitation & Specialist	**0**	*0*	• • •
Forest Lodge	**0**	*0*	• • •

Narrative

Seclusion
21 Seclusion episodes recorded for 13 people in July 2023.

G1 Ward, Dovedale 2 and Burbage continue to operate without a seclusion facility.

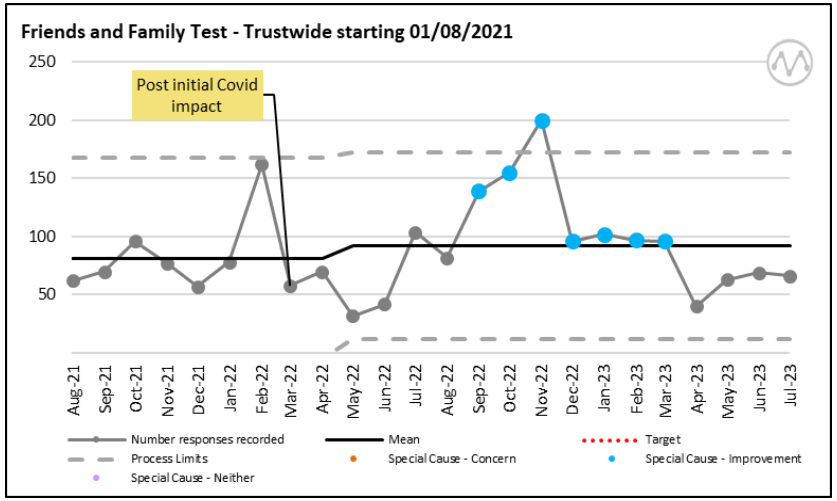
There continues to be no seclusion episodes reported in Rehabilitation & Specialist services.

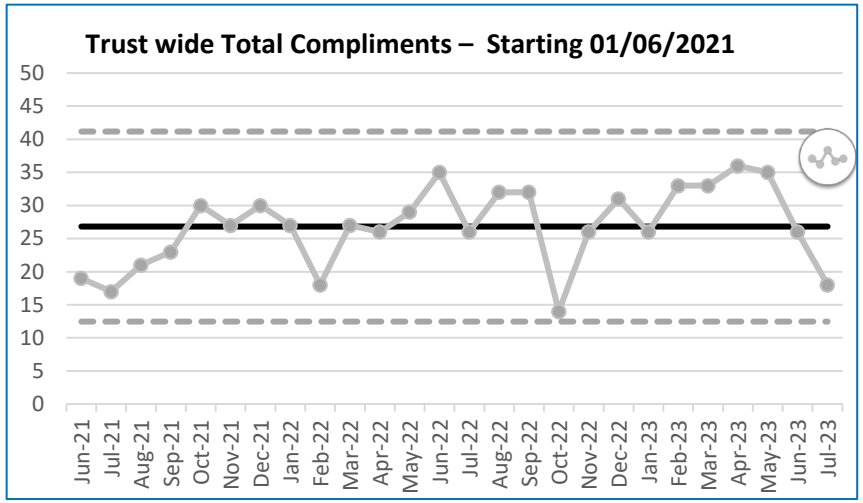
1 Seclusion episode was recorded as a prolonged episode in July 2023 for Maple ward, lasting 220 hours (9.16 days).

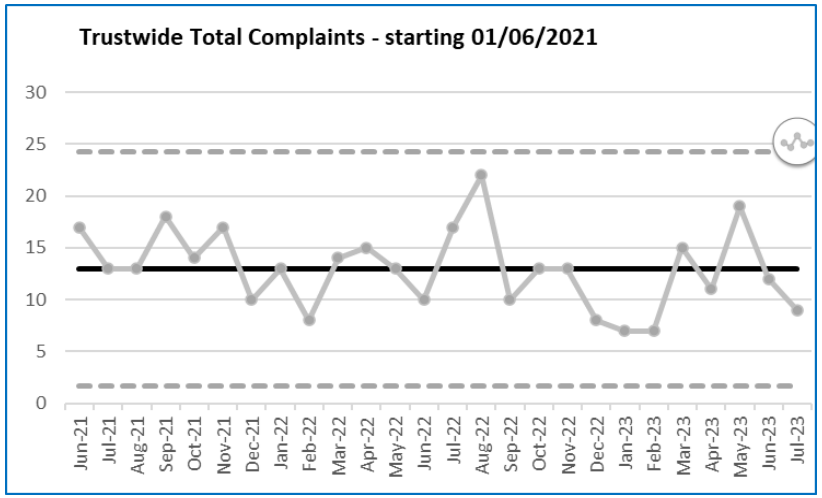
Policy was followed this episode of prolonged seclusion, with directorate leadership reviews and clinical executive reviews. Findings from this review indicate that delay in admission resulted in the service user being very unwell at the point of admission.

Long-Term Segregation
No long-term segregation in July 2023.

Caring | User Experience







Narrative

In July 2023, the Trust received a total of 66 responses to the FFT questions; 61 of the responses were positive, 4 stated their experience as 'Neither good nor poor', and 1 stated their experience as 'Very Poor'. This equates to 92.42% positive responses received in July 2023.

With 66 responses and 6797 active clients, the observed response rate for July 2023 is 0.97%, below the Trust Aspiration Response Rate at 5%.

A few positive responses are listed below:

-"This place and the staff are so lovely and understanding to all of us." – Memory Service

-"It was full of essential ingredients to help me in caring for my partner and understanding my own emotions." – (STEP)

-"Been very accommodating and understanding." – (SAANS)

A few neutral responses are listed below:

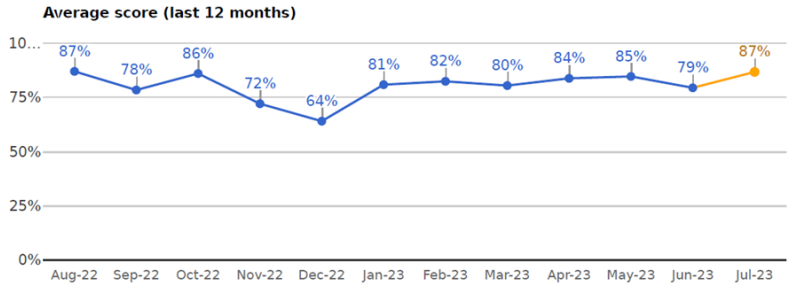
-"I felt they didn't have enough understanding of how challenging it is being an unpaid carer. I barely have 5 minutes to myself a day." –(STEP)

-"Previous support from Home Treatment team was fantastic. This time I was in crisis but filtered through to STEP which did not address the acute issues. However, it was a way of touching base - but I felt if I didn't attend, I would be rejected from the service altogether. Crisis has lessened now but I had to seek private psychotherapy for support - at one point taking over half my monthly income. So, I appreciated STEP, but it did not match my need." – (STEP)

Compliments

There have been 16 compliments recorded as received in July. 8 received for Acute and Community and 8 for Rehabilitation and Specialist services.

Quality of Care Experience Survey



Complaints

There were 9 new formal complaints received in July 2023. Access to Treatment remains as the most frequent complaint type.

9 formal complaints closed: -

- 2 within agreed timescale – partially upheld
- 1 within agreed timescale – not upheld
- 1 within agreed timescale – upheld
- 5 after agreed timescale – partially upheld

Quality of Care Experience

In July 2023, a total of 16 inspections were carried out across 7 areas – Forest Lodge, Forest Close – Ward 1a, Forest Close – Ward 1, Forest Close – Ward 2, Burbage, Beech, G1, Birch Avenue - at an average of 2.29 inspections per area. The average score across the organisation this month is 87%.

This utilises the Tendable audit system and identifies areas of good practice as well as areas that require change/improvement.

NHS
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Our People

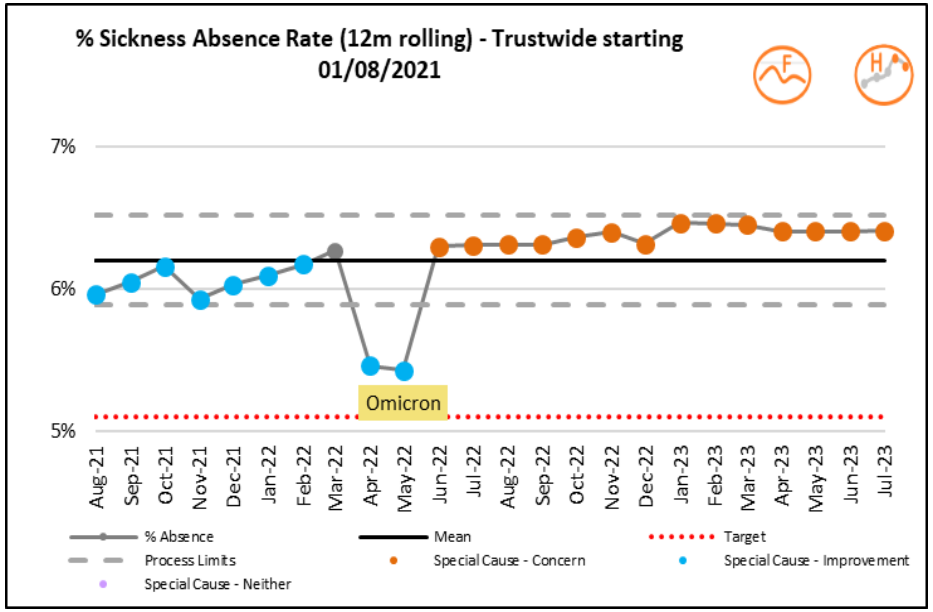
IPQR - Information up to and including July 2023

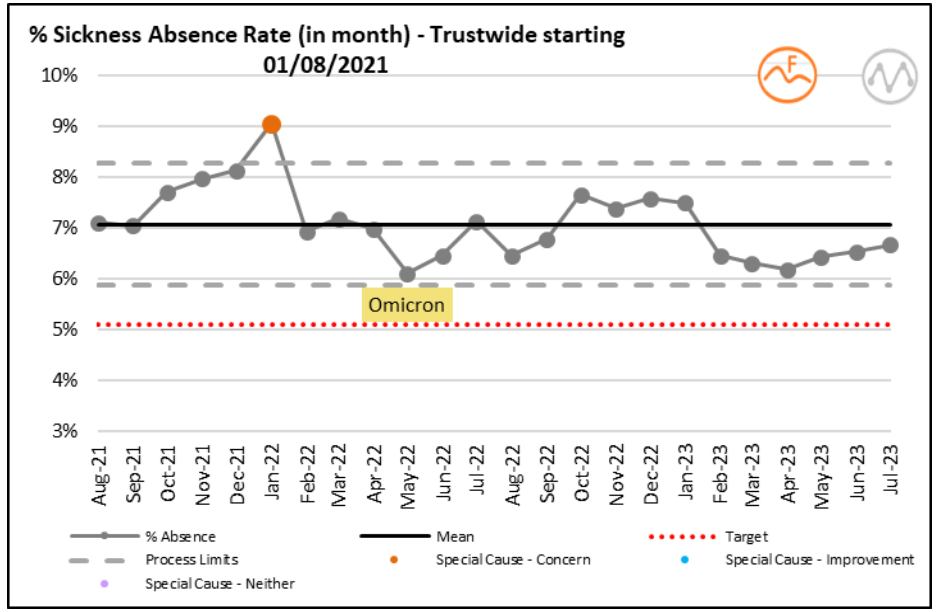
Proud to care in Sheffield

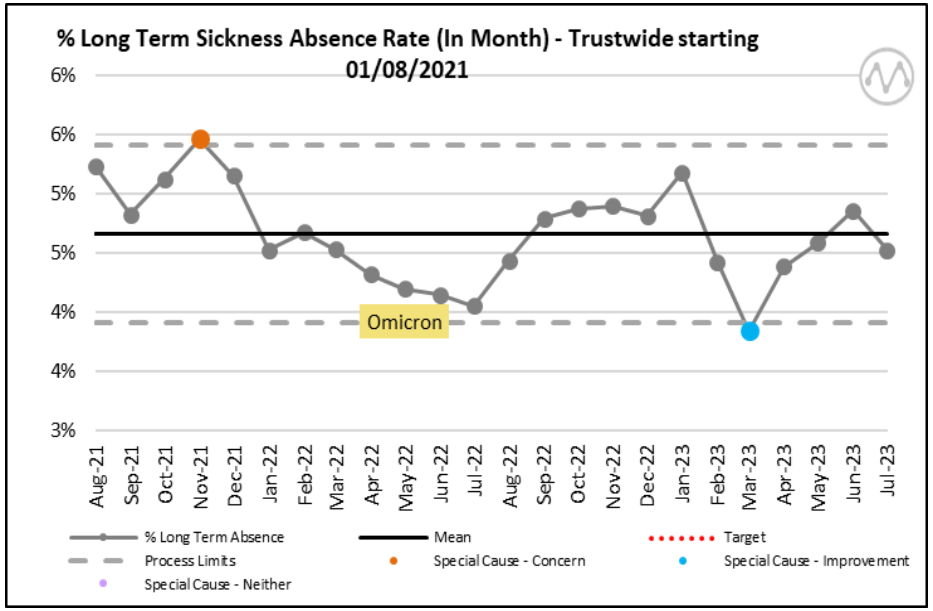
Well-Led | Workforce Summary

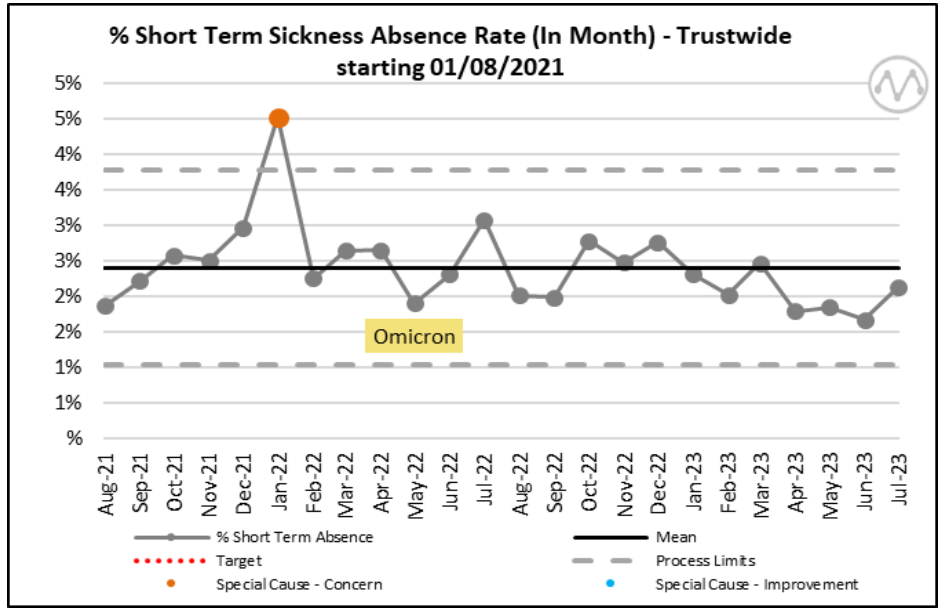
		Jul-23			
Metric	**Target**	**n**	***mean***	**SPC variation**	**SPC target**
Sickness 12 Month (%)	5.10%	**6.41%**	*6.20%*	• H •	F
Sickness In Month (%)	5.10%	**6.67%**	*7.08%*	• • •	F
Long Term Sickness (%)	~	**4.52%**	*4.66%*	• • •	/
Short Term Sickness (%)	~	**2.14%**	*2.41%*	• • •	/
Headcount Staff in Post	~	**2742**	*2636*	• H •	/
WTE Staff in Post	~	**2414**	*2367*	• H •	/
Turnover 12 months FTE (%)	10%	**18.16%**	*15.63%*	• H •	F
Training Compliance (%)	80%	**89.37%**	*88.67%*	• • •	P
Supervision Compliance (%)	80%	**73.25%**	*71.93%*	• • •	F

Well-Led | Sickness







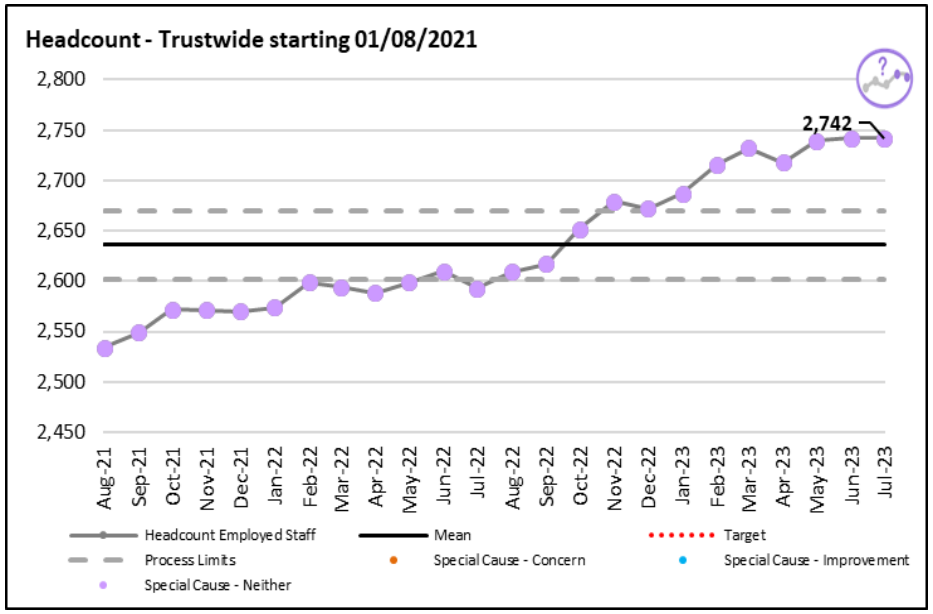


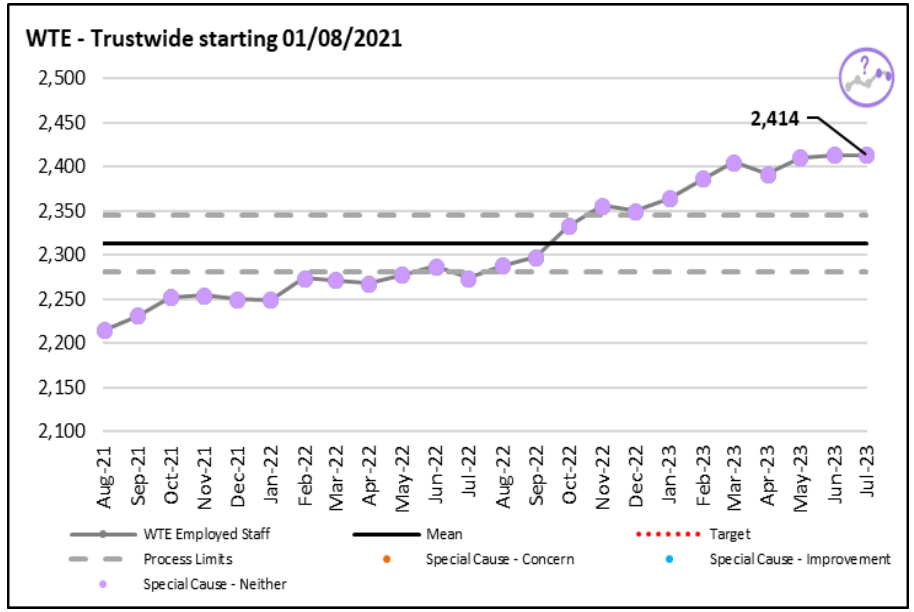
Narrative

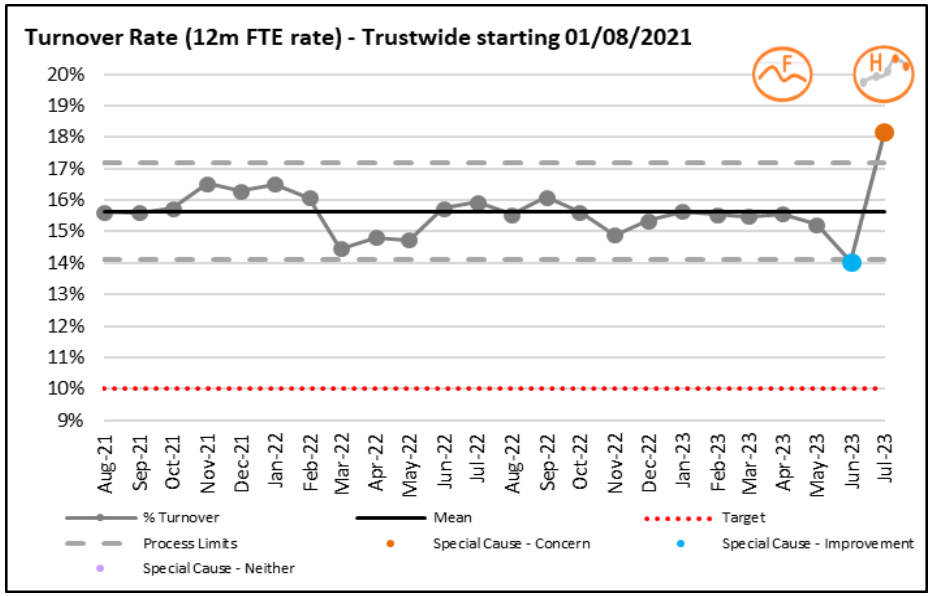
Overall Sickness % has slightly increased from 6.5% in June to July's 6.66%. This is predominately due to LTS increasing from 3.98% to 4.52%. All areas of SHSC apart from 2, LTS increased slightly. The high areas remain the Clinical areas and Special Projects. A number of cases have come to a closure throughout June and July, with further cases proceeding to closure over the next couple of months. On a positive, STS has decreased to 2.14%.

A staff survey will be on Jarvis throughout September 23 for staff to 'tell us what additional support/tools they would like to see available'. Also, to understand why staff are not utilising the free support/tools we currently have to support health & wellbeing. This is part of the 'Reducing Sickness Absence Workstream Project'. Also, further work needs to be done on increasing our data on reporting 'Welcome Back to Work Interviews'.

Well-Led | Staffing







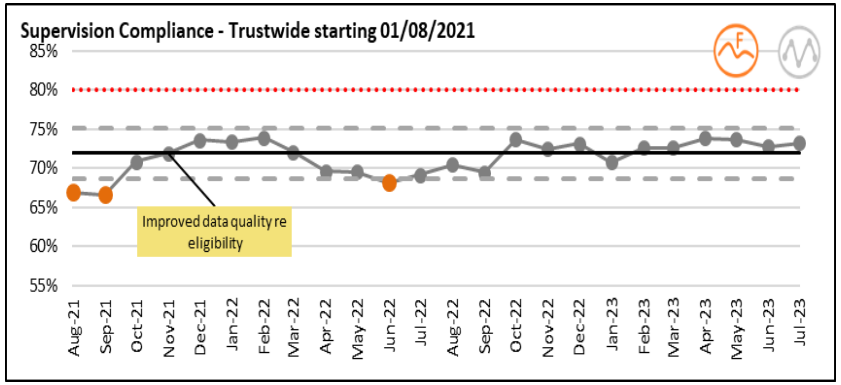
Narrative

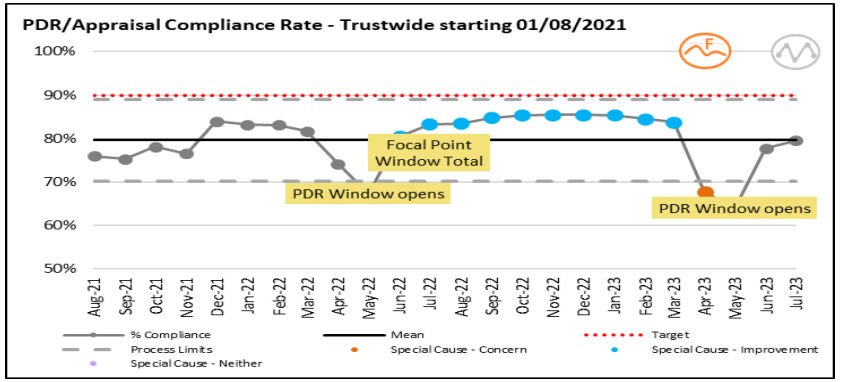
Headcount and WTE continue to rise and are above the upper threshold once again. Turnover has increased to 18.16% which is an increase on previous 12 months and the highest turnover we have seen over the past 24 months. This is due to the TUPE of Buckwood and substance misuse.

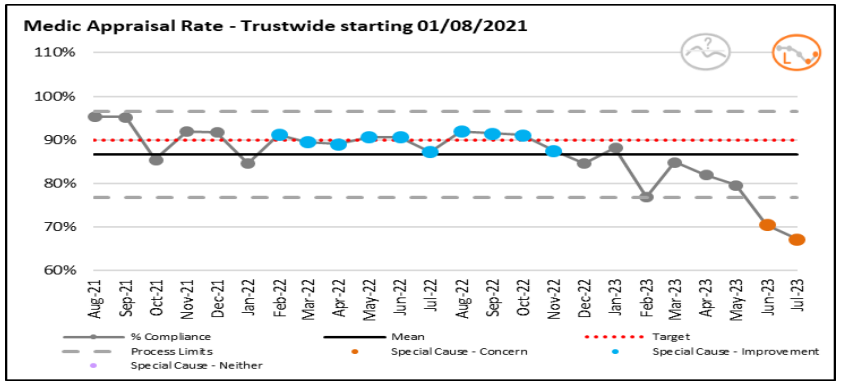
A continued effort to recruit and retain staff through various incentives such as upskilling staff, particularly HCSW staff, the band 5 premia scheme which progresses newly qualified staff up the pay scale quicker if they remain with us for 2 years and the focused effort on recruiting HCSW.

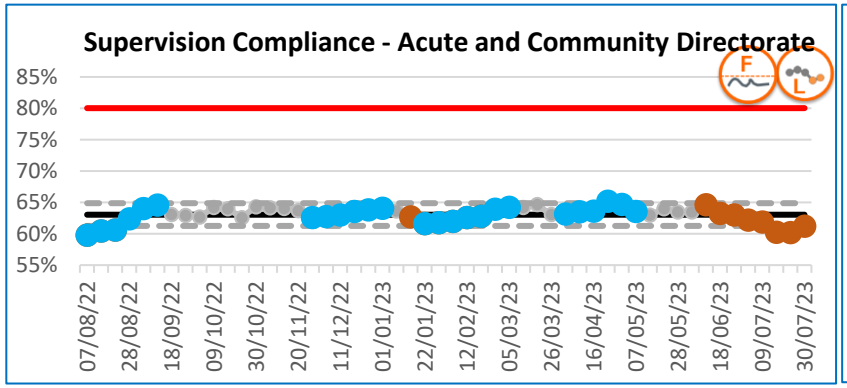
Our vacancy rate remains low, due to the above efforts, of around 5.9% for the organisation.

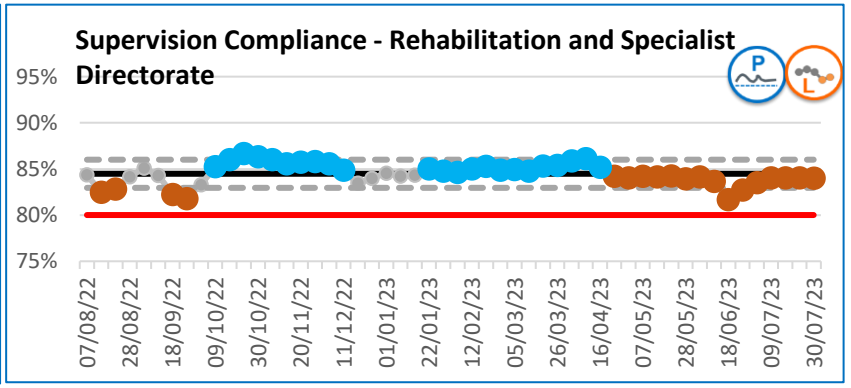
Well-Led | Supervision & PDR/Appraisal

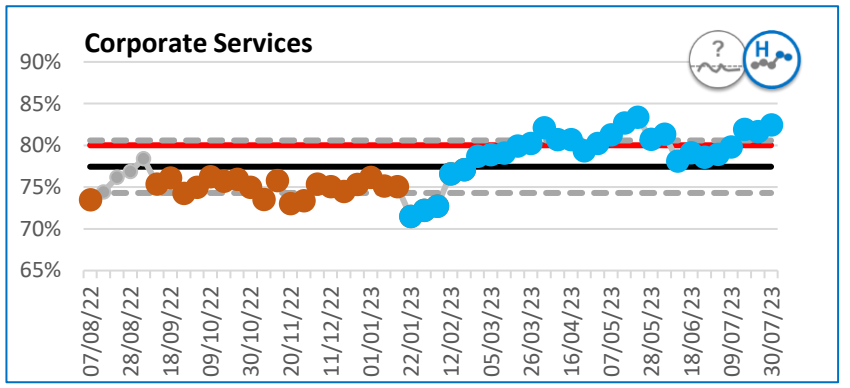












AIM

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 July 2023, average compliance with the 8/12 target is:

Trustwide **73.25%**

Clinical Services **71.12%**

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.

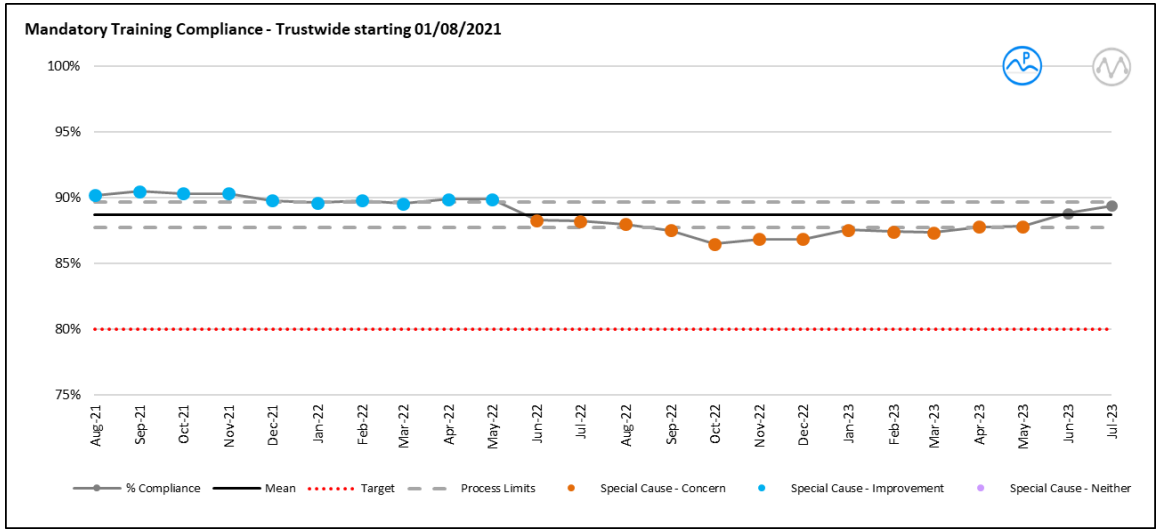
A recovery plan is in action for our acute and PICU wards, monitored through the Back to Good Programme Board.

The supervision policy has been revised and from the 16th of October the reporting will be changing to reflect this.

The policy can be found here:- Supervision Policy (NP 019 V4 July 23) | JARVIS (shsc.nhs.uk)

The Director of Psychological Services has emailed directorate leads to explain the changes.

Mandatory Training



AIM

We will ensure a Trust wide compliance rate of at least 80% in all Mandatory Training, except Safeguarding where compliance of at least 90% is required and Information Governance where 95% compliance is required.

COMPLIANCE – As at date	04/07/23	15/08/23
Trustwide	**88.92%**	**89.37%**
Directorate/Service Line		
Corporate Services	84.01%	83.88%
Medical Directorate	88.54%	87.94%
Acute & Community – Crisis	89.90%	89.28%
Acute & Community – Acute	90.39%	91.46%
Acute & Community – Community	93.09%	94.08%
Acute & Community – Older Adults	85.52%	87.30%
Rehab & Specialist – Forensic & Rehab	92.46%	92.66%
Rehab & Specialist – Highly Specialist	91.51%	90.97%
Rehab & Specialist – Learning Disabilities	89.94%	90.89%
Rehab & Specialist – IAPT	95.34%	94.96%

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.

As at 15/08/2023 the nearest training report to end of July position
There are currently 10 subjects below 80% - one less than reported on June IPQR

Deprivation of Liberty Standards Level 1 is now at 80.39%

Safeguarding Children Level 3 66.91%
Mental Health Act 66.84%
Medicines Management 68.49%
Deprivation of Liberty Standards Level 2 74.77%
Rapid Tranquilisation 76.59%
Moving and Handling Level 2 70.64%
Resus Level 2 (BLS) 72.75%
Resus Level 3 (ILS) 75.19%
Respect Level 3 69.76%
Clinical Risk 79.41%

We continue to work closely with clinical areas and subject leads to ensure these subjects return to a minimum of 80% as soon as possible. We continue to run the training reports every 3 weeks.

Clinical risks related to Mandatory Training compliance issues, will also now go Monthly to the Clincal Quality and Safety from September

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Financial Performance

IPQR - Information up to and including July 2023

Proud to care in Sheffield

Executive Summary

Summary at July 2023:

At month 4, we are reporting on plan with a YTD deficit of £1.182m and a forecast deficit of £3.262m.

There are variances compared to plan from pay award additional costs and funding, increased depreciation costs following year-end asset revaluations, improved interest receipts and unplanned costs in services.

Delivery of recurrent efficiency savings is on plan. Additional interest receipts are not shown in the forecast savings as the income is offsetting cost pressures that were unknown during planning.

Cash balances remains healthy. Debt owed to SHSC totals £3.211m with £0.762m (23.7%) more than 30 days overdue. Of this, £0.72m relates to NHS bodies and work is ongoing to resolve queries on the unpaid invoices. No material bad debt risks to highlight at present.

The revised capital plan is underspent by £0.28m YTD due to timing of works. The total plan for the year is unchanged at £12.791m and it is forecast to be spent in full. This assumes £1.810m additional national funding and a £4m receipt from the sale of Fulwood. This funding uncertainty is a planned and accepted risk hence the amber rating. The situation is monitored very closely and will be reported promptly if the risk increases or materialises.

At month 4, South Yorkshire Integrated Care System (the ICS) planned for a YTD system deficit of £27.5m, of which £2.9m related to the ICB and £24.6m to providers. The actual deficit is £29.9m, caused by £2.4m overspends by providers.

The forecast for the ICS remains at breakeven but to achieve this, the ICB and providers must deliver efficiency savings of £241m. The YTD achievement is behind plan by £28.3m. It is important to be aware of the system position as the level of SHSC's capital and revenue funding in 2024/25 is dependent on the ICS achieving its overall financial targets.

KPI	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	23/24 Forecast £'000	Variance £'000
Surplus/(Deficit)	(1,203)	(1,182)	21	(3,262)	(3,262)	0
Out of Area spend *	(2,990)	(3,036)	(46)	(8,496)	(8,298)	197
Agency spend #	(2,271)	(2,151)	120	(6,479)	(5,893)	587
Cash	48,125	50,337	2,212	47,405	49,074	1,669
Efficiency Savings #	1,245	1,246	1	5,734	5,734	0
Capital ~	(2,351)	(2,071)	280	(12,791)	(12,791)	0

KPI		Target	Number	Value
Invoices paid within 30 days	NHS	95%	100%	100%
(Better Payments Practice Code)	Non-NHS	95%	99.3%	98.9%

YTD: Year To Date

* Includes Purchase of Healthcare only, excludes travel costs.

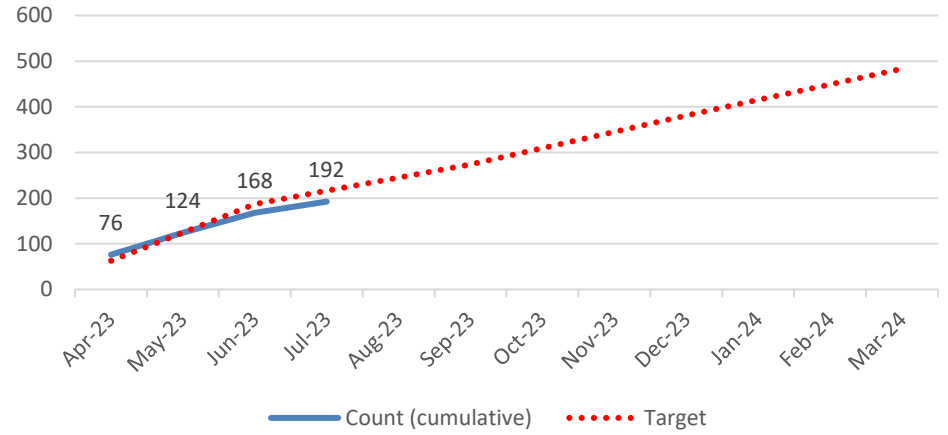
Differs to NHSE reporting as this has been updated to reflect further work undertaken after ICB reporting deadlines.

~ The capital plan was rephased in M3 to reflect the updated expenditure profile. Total for the year is unchanged.

NHS Long Term Plan – national metrics for 2023/24

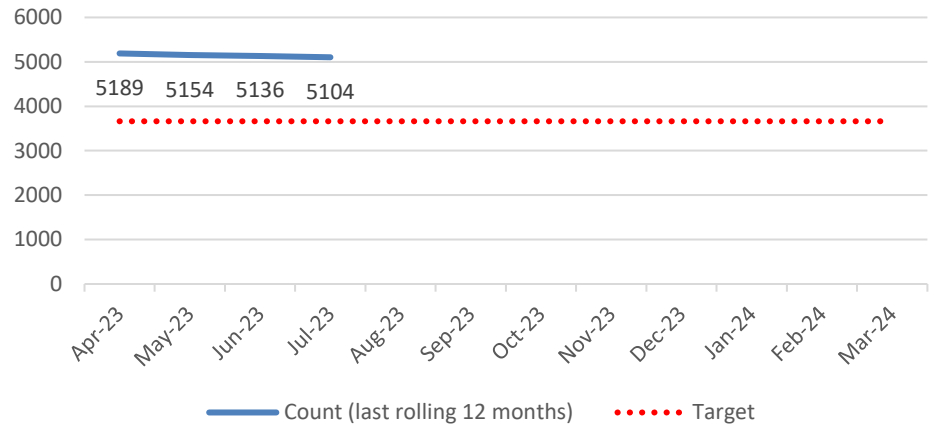
Perinatal: number of women accessing specialist community Perinatal MH services in the reporting period (cumulative)

Our target = 483 by March



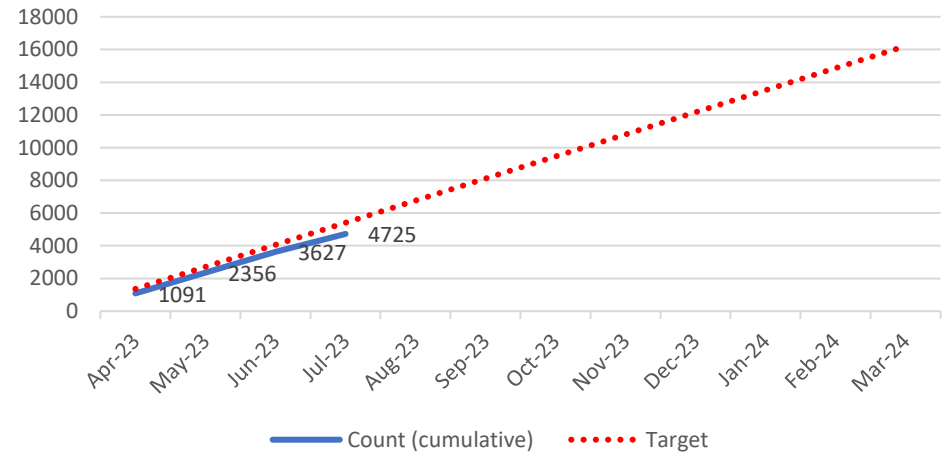
Community: Number of adults & older adults who receive two or more contacts from community mental health services

Our target = 3,666 each quarter



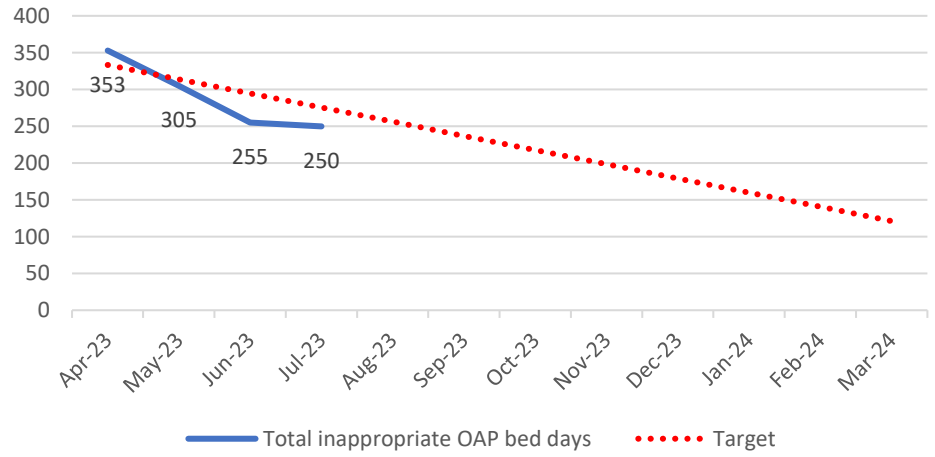
Talking Therapies: number of people first receiving Talking Therapies services (cumulative).

Our target = 16,220 by March



Out of Area: Number of inappropriate adult acute OAP bed days (does not include PICU or older adult)

Our target = 2,500 bed nights



Narrative

Perinatal
The service expansion plan and increased activity is scheduled for Q3-Q4. Activity levels in Q1 are below trajectory. The service is exploring the re-introduction of a short-term intervention pathway to increase activity. The service plans to achieve the 7.1% access standard by the end of Q4.

Community
Combined activity across all community services exceed the national target.

Talking Therapies
Activity levels are increasing each month. In April 1,091 people accessed treatment and in June this had increased to 1,271. The service is expecting to be on track through Q3 onwards.

Out of Area Beds
We are achieving our plan to reduce levels of OAP activity.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

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:

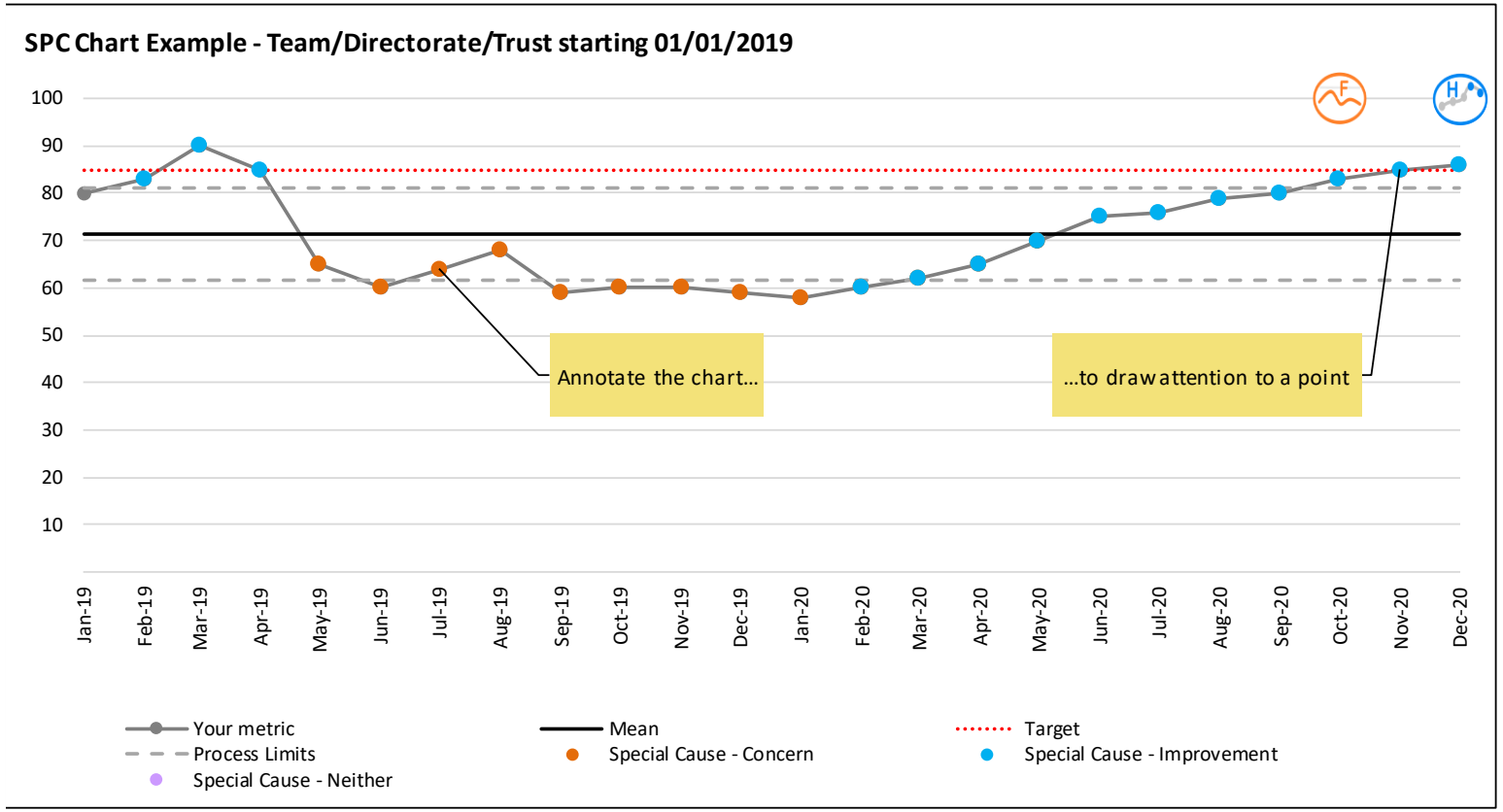
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

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.