Sheffield Health and Social Care NHS Foundation Trust

BOARD OF DIRECTORS

Date:	10 March 2021	Item Ref:	10

TITLE OF PAPER	**Integrated Performance and Quality Report – Period ending December 2020**
TO BE PRESENTED BY	Phillip Easthope , Executive Director of Finance
ACTION REQUIRED	Members are asked to: • consider the risks identified and determine if mitigating actions provide sufficient assurance about the quality of care • use the report as a basis for assurance to the Board of Directors.
OUTCOME	To enable Board members to triangulate and assess the quality of care and to identify any concerns relating to this.
TIMETABLE FOR DECISION	For presentation to the Board of Directors in March 2021.
LINKS TO OTHER KEY REPORTS / DECISIONS	IPQR repot to the Quality Assurance Committee 22.02.21 IPQR report to the Finance and Performance Committee 22.02.21 Annual Quality Report & Accounts, Incident Management Reports, Mortality Reports, safeguarding reports, Getting Back to Good reports and Finance report.
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	CQC: Getting Back to Good BAF0003 - Risk that the Trust is unable to improve patient safety, resulting in a failure to comply with CQC requirements and achieve necessary improvements. BAF00004 - Risk that the Trust is unable to improve the quality of patient care, resulting in a failure to comply with CQC requirements and achieve necessary improvements.
LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	NHS Improvement's Single Oversight Framework CQC Fundamental Standards NHS England's Serious Incident Reporting Framework Quality Schedule with NHS Sheffield Clinical Commissioning Group Links to Corporate Risk Register and Care Network Risk Registers
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	If care is inadequate this may result in harm to service users and a poor experience of services. There may also be further contractual / legal implications from commissioners or regulatory bodies.
CONSIDERATION OF LEGAL ISSUES	None highlighted
Author of Report	Phillip Easthope
Designation	Director of Finance
Date of Report	March 2021

Integrated Performance & Quality Report
Period Ending December 2020

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information/ Assurance*	*Other (please state below)*
				✓	

1. Summary

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 December 2020.

The report was presented and considered in detail to the Quality Assurance Committee and to the Finance and Performance Committee on 22.02.21. For each issue the risk was explored and the paper offered mitigations and where necessary recovery plans were presented, notably in the February Quality Assurance Committee individual recovery plans were presented to address the time people are liable to wait for community services.

The Board can be assured that the report has been fully considered and that further assurances have been sought where risks and mitigations warrant further detail.

The summary offers the issues that were highlighted for consideration and any actions that the Committees requested.

Continued use of out of area placements were considered alongside the cause of the need for out of area placements and the planned trajectory of the improvement plan.

In the community, various issues were considered including one IAPT indicator (moving to recovery) being below the target of 50%. In the recovery teams CPA reviews at 85% is a flattening in the improving performance, thought to be related to acute shortness of staff in the recovery service. Two people were not assessed by the Home Treatment Team (referred to as being gate-kept) as required, which puts performance at 94% against a national target of 96%. The reasons for this were known.

The use of restrictive practices in inpatient care remains a concern, the Quality Assurance Committee will receive the revised approach to reducing restrictions in April 2021. This issue of concern will remain an area of focus.

Supervision compliance is improving although remains below the 80% target that has been reset to reach a more ambitious target of 8 supervision sessions per 12 months. Compliance overall with mandatory training achieves 90%, however three subjects remain below the target of 80% (Immediate Life Support and Respect level 2 and 3). Outbreaks in Covid have significantly impacted performance, full mitigations are in place.

Safer staffing was identified as a risk area, there is a need to have more specific vacancy information per team. In addition, the community recovery teams have had a period of significant turnover in staffing and have too many vacancies to allocate all service users a permanent care coordinator. There is a robust recovery plan in place which was shared with the Committee.

Reported incidents continue to demonstrate a reduction in the number of people in SHSC inpatient care that have fallen. The volume of racism / hate speech being reported is notable. Plans are in place to

work directly with South Yorkshire Police and the hate crime lead to strengthen the Trust's approach to supporting staff and patients subject to hate speech. Sexual safety incidents and the impacts were discussed and the imminent plans to move to single gender noted. Unreviewed incident reports and outstanding learning actions from serious incidents reports continue to improve. The number and nature of catastrophic incidents was reported, every catastrophic incident is subject to review, the National Reporting Learning System (NRLS) benchmarking information shows SHSC as comparable nationally regarding catastrophic incidents.

A 'Blue Light' bulletin was cascaded to all staff working in clinical areas to review any internally developed clinical guidance for patient use, to ensure that it meets with best practice standards.

Risks to quality previously reported and not yet resolved:

Electronic Patient Record (EPR) System
A recent IT security cyber penetration test was undertaken on the Insight system. The outcomes of this exercise highlighted a number of actions required to strengthen the INSIGHT system until a new system is available through the EPR replacement programme. An action plan is being developed to address key concerns, which will provide assurance for the organisation to continue the use of Insight until a new system is delivered via the EPR programme. Whilst the strengthening actions are being undertaken, there will be an impact on overall IMST resources in the Informatics and Architecture Service.

Acute Ward Environments
Remedial works completed on Burbage, Maple and Dovedale Wards. Further improvements including building seclusion room and providing additional suitable bedrooms will complete December 2021. The programme of works has been reported into the Acute Care Modernisation Board and will be notified to the Board via the Transformation report.

2. Next Steps

The risks and assurances within the Board Assurance Framework (BAF) have been reconsidered in relation to the details of this report. The BAF risks relating to quality were revised and presented to the Quality Committee for consideration. The Committee was in support of the revised risks. The risk mitigations, controls, gaps in control and assurances will need to be addressed and be represented to the Quality Assurance Committee.

It is recommended that the risk of poor patient experience and safety relating to the use of restraint and the risk of poor patient care in relation to short staffing of band 5 staff in acute services and care coordinators in the community are reviewed to consider whether an increased risk score is appropriate. It is also recommended that the Finance and Performance Committee considers the continued lack of predictability relating to the financial impact of closing wards to protect people from the spread of Covid-19 when an outbreak is suspected/confirmed.

Actions to mitigate the issues highlighted were set out to the Committees. Progress will be monitored via the appropriate governance structure and included within future reports.

Finance and Performance Committee noted the waiting times and received the Clinical Services Waiting Times paper previously reported to the Quality Assurance Committee in January. Following discussion it agreed the assurance requirements to understand how these issues were being taken forward through contract discussions and when Finance and Performance Committee would receive regular updates on contract negotiations as part of planning papers in the coming months.

3. Contact Details

For further information, please contact:

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NHS
Sheffield Health and Social Care
NHS Foundation Trust

Integrated Performance & Quality Report

Information up to and including December 2020

Proud to care in Sheffield

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Blue Underlined Text = Click to link to page

Overview | Summary KPIs 1

Statutory measures	Current Position
Organisation in Special Measures	Yes
CQC Inspection rating	Inadequate
NHSI Single Oversight Framework segmentation	4

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

KPI Assurance Key

✓	Good data quality, confident in information/metric.
?	Unconfirmed data quality, assurance on information/metric required.
✘	Known data quality issue. Work to be done.

Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	DEC 2020	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	COMMENTS	KPI Assurance
SAFE								
Adult Acute inpatient occupancy levels (KH03)*	Monthly	95%	93%	**90.27%**			See Acute Inpatient detail. This figure excludes leave and Out of Area placements.	✓
Functional Illness (Dovedale) occupancy levels (KH03)*	Monthly	95%	86%	**93.98%**			See Older Adult Inpatient detail. This figure excludes leave and Out of Area placements.	✓
Dementia Management (G1) occupancy levels (KH03)*	Monthly	95%	86%	**53.43%**			See Older Adult Inpatient detail. This figure excludes leave and Out of Area placements.	✓
Sickness absence	Monthly	5.10%	~	**5.33%**			See Workforce Detail	✓
Turnover	Monthly	10.0%	~	**11.31%**			See Workforce Detail	✓

Overview | Summary KPIs 2

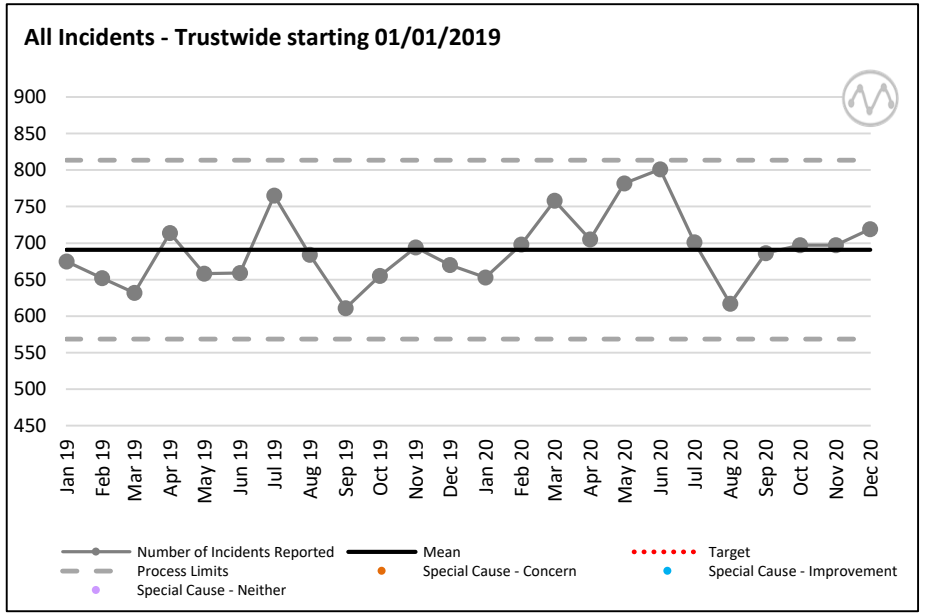
Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	DEC 2020	SPC VARIATION/ TREND ICON	SPC ASSURANCE ICON	Comments	KPI Assurance
RESPONSIVE								
Access to Home Treatment	Monthly	100	N/A	**108**			Numbers in to Home Treatment service. Old target - needs review.	?
Out of area acute admissions	Monthly	0	N/A	**10**	H		5 Adult and 5 Older Adult inappropriate placements. All OA placements due to temporary closure to admission due to Covid outbreaks. See Inpatient Detail	✓
Out of area PICU admissions	Monthly	0	N/A	**7**			One appropriate placement for safeguarding reasons. See Inpatient Detail	✓
7 Day follow up following discharge - people on CPA	Monthly	95.00%	93.00%	**100%**			Awaiting commissioner confirmation of new target for 72 hour follow up as per CQUIN 19/20.	?
Access to Early Intervention in Psychosis Services - new cases	Monthly	6	N/A	**8**		P	Old target - needs review.	?
Waiting Time Standard Early Intervention – % commencing treatment within 2 weeks	Monthly	53.00%	N/A	**68.75%**		P	EIP exceeding target for consecutive 24 months.	?
Access to IAPT - new clients entering treatment	Monthly	1000	N/A	**1023**			See IAPT Detail. Note reduced target in place until January 2021 when it will revert back to 1232.	✓
Waiting Time Standard IAPT - % entering treatment in 6 weeks	Monthly	75.00%	N/A	**92.84%**		P	See IAPT Detail	✓
Waiting Time Standard IAPT - % entering treatment in 18 weeks	Monthly	95.00%	N/A	**98.88%**		P	See IAPT Detail	✓
IAPT Moving to Recovery Rates	Monthly	50.00%	N/A	**43.27%**	L		See IAPT Detail	✓

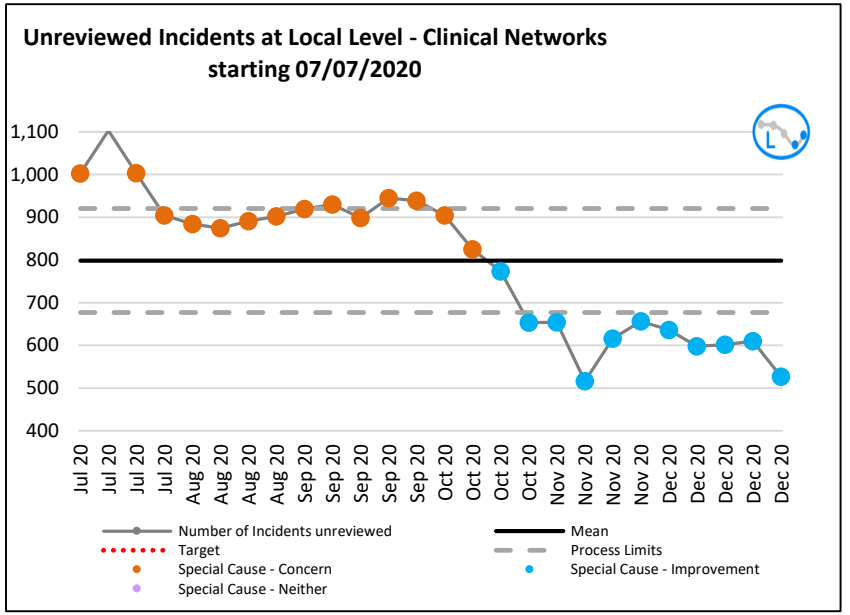
Overview | Summary KPIs 3

Trust Board Performance Report Key Performance Indicators (KPIs)	Usual Frequency	TARGET	National Benchmark	DEC 2020	SPC VARIATION/ TREND ICON	SPC ASSURANCE ICON	COMMENTS	KPI Assurance
EFFECTIVE								
Gatekeeping - Acute admissions assessed for HT	Monthly	95.00%	N/A	**94.12%**			Figure relates to 2 of 34 patients not reported as gatekept by Home Treatment. 1 was a repatriation from Out of Area bed to PICU. One was an informal admission to commence Clozapine medication for Early Intervention service user.	?
CPA - % with an Annual Review	Monthly	95.00%	N/A	**85.07%**			See CPA Review Detail	?
Data Quality - Client Outcome indicators x 3	Quarterly	50.00%	N/A	**33.92%**			Data available until end November 20 only. This is MHSDS reported data always a month behind. Significant drop below lower control limit in May/June 2020. Investigation with Information Dept. ongoing. There was a change in reporting system in April - current assumption is this is a data quality issue rather than a clinical issue.	?
Data Quality - Client Identifier indicators x 6	Quarterly	50.00%	N/A	**99.71%**			Data available until end November 20 only. This is MHSDS reported data always a month behind. Downward trend and shift below mean, but control limits are very small and metric consistently meeting target.	?
Use of Resources Rating	Monthly	1	N/A		N/A	N/A	See Finance Detail	N/A
Income & Expenditure (£000)	Monthly	N/A	N/A		N/A	N/A	See Finance Detail	N/A
Cash Balance (£000)	Monthly	N/A	N/A	**67,912**	N/A	N/A	See Finance Detail	N/A
CIP & Disinvestment Delivery Against Plan (£000)	Monthly	638	N/A	**212**	N/A	N/A	See Finance Detail	N/A

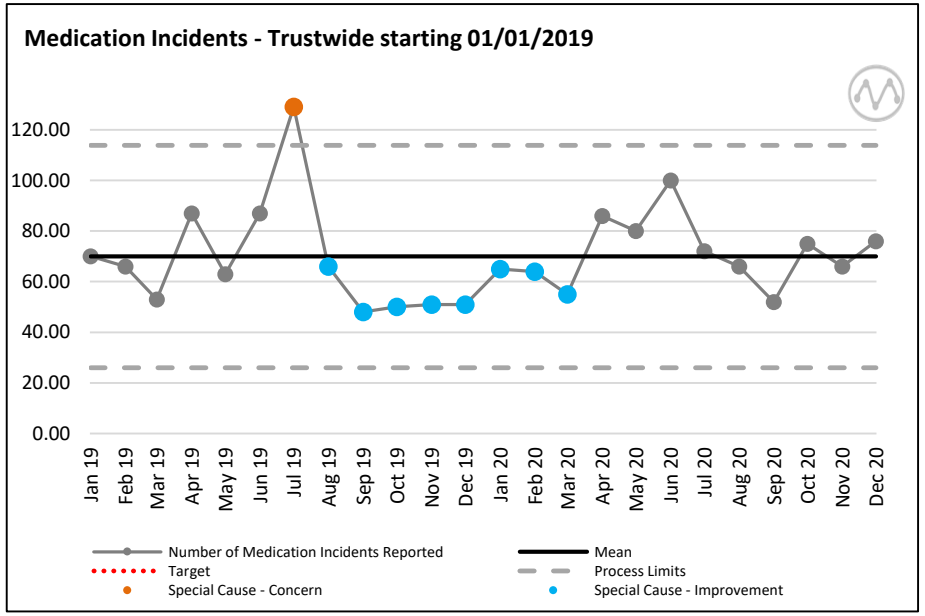
All Incidents | Medication Incidents

Incident Type	DEC 2020	VARIATION
ALL	719	
Catastrophic	21	
Major	8	
Moderate	23	
Minor	125	
Negligible	522	
Near Miss	20	



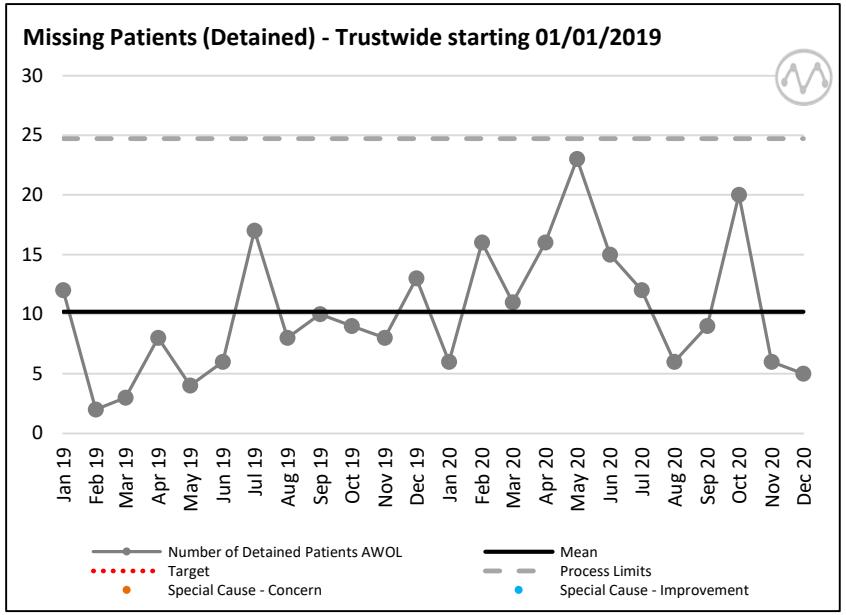


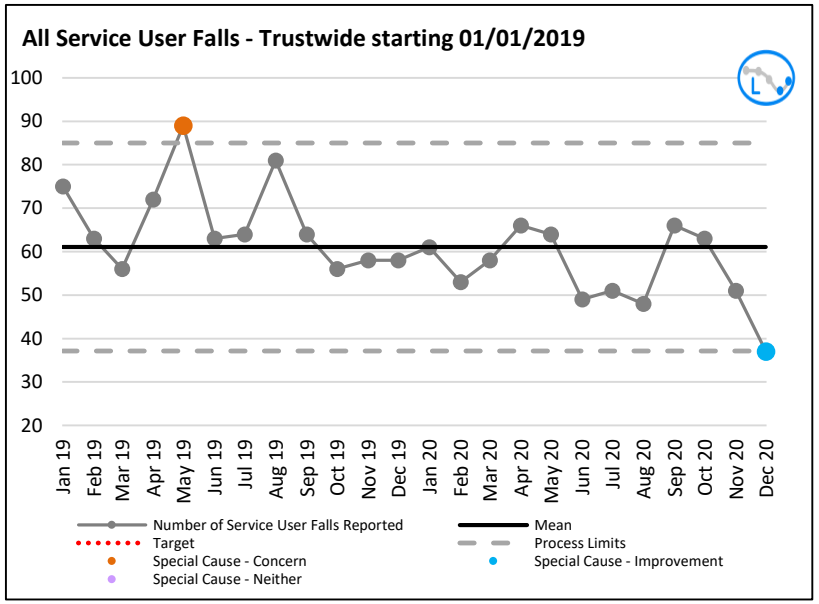
Incident Type	December 20	Variation
ALL	76	
Prescribing	3	
Dispensing	13	
Administration	16	
Management	44	

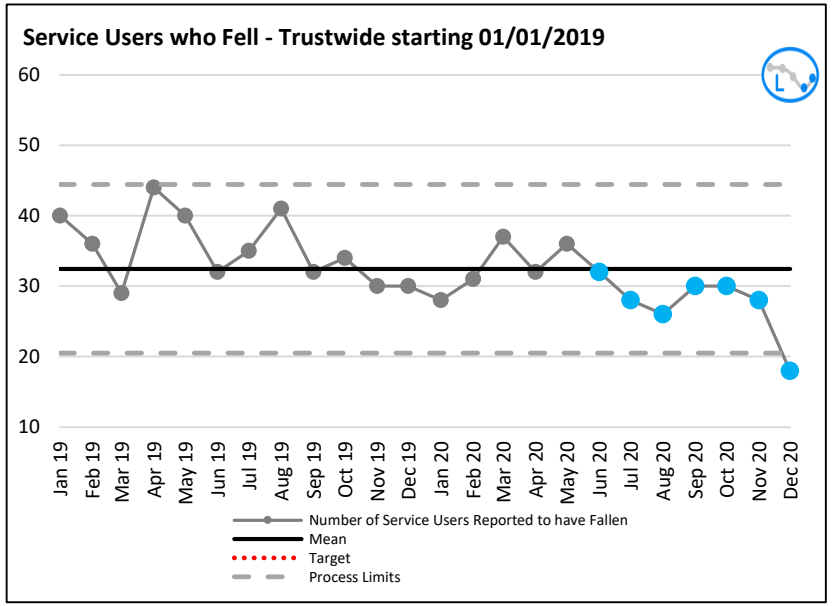


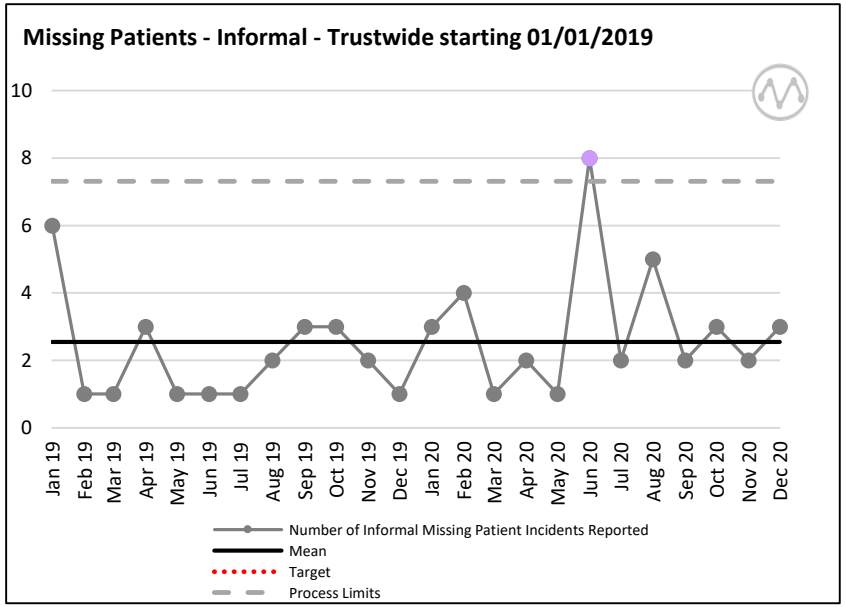
Falls | Missing Patients

Service/Ward	Number of Falls	December 20 Falls Icon	Number of Service Users	December 20 Service Users Icon
Trustwide	37		18	
G1 (Grenoside Grange)	15		7	
Dovedale Ward	1		1	
Birch Avenue	13		4	
Woodland View	6		4	

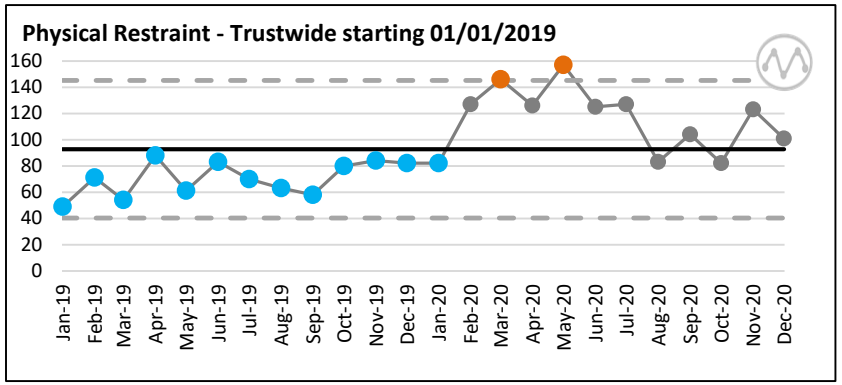


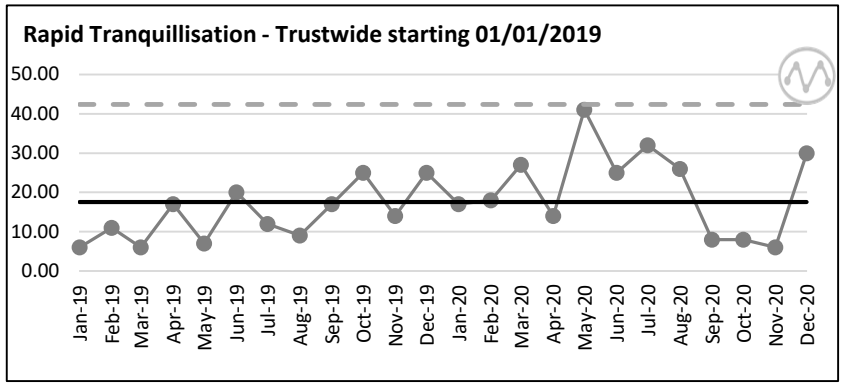


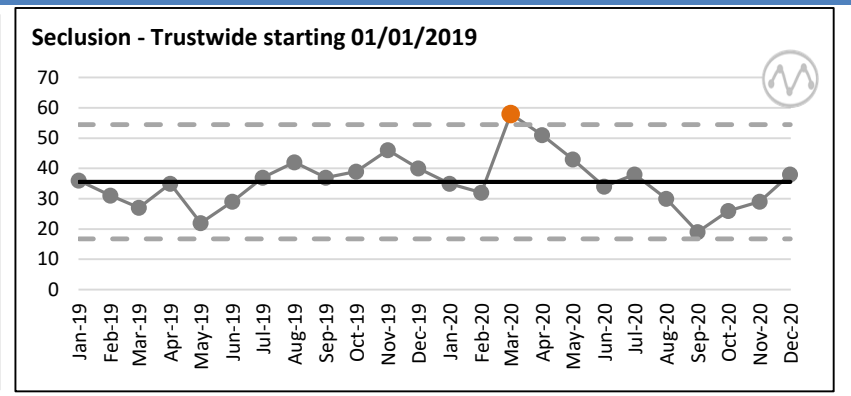


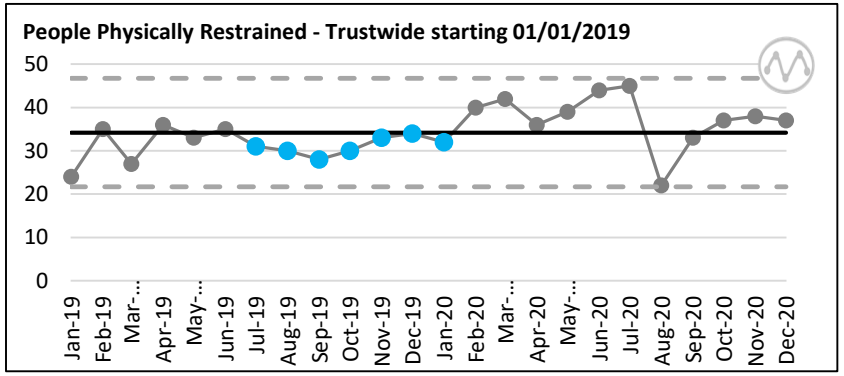


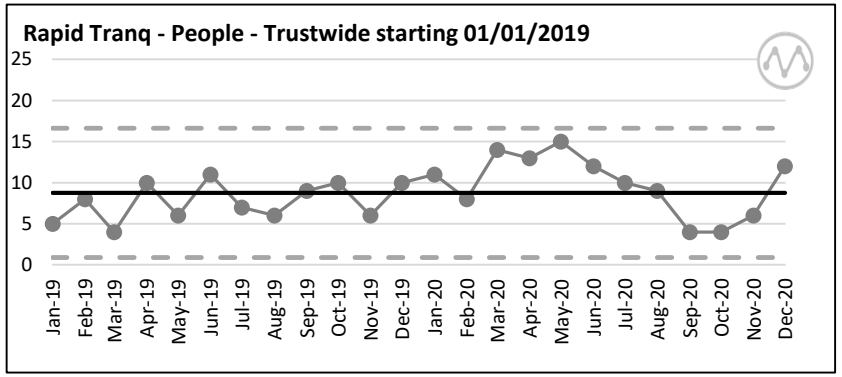
Restrictive Practice

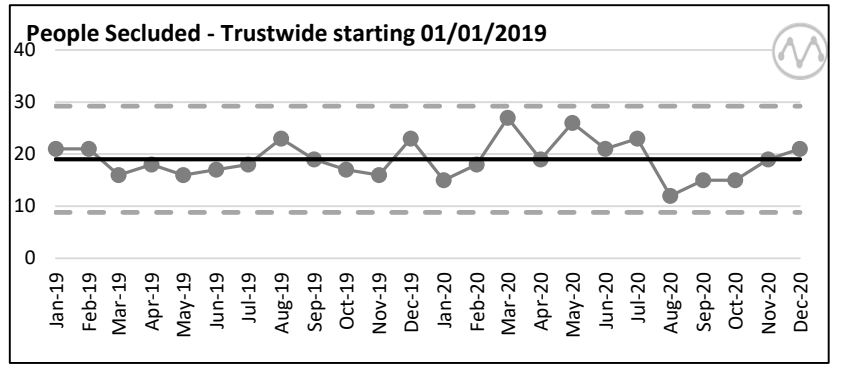










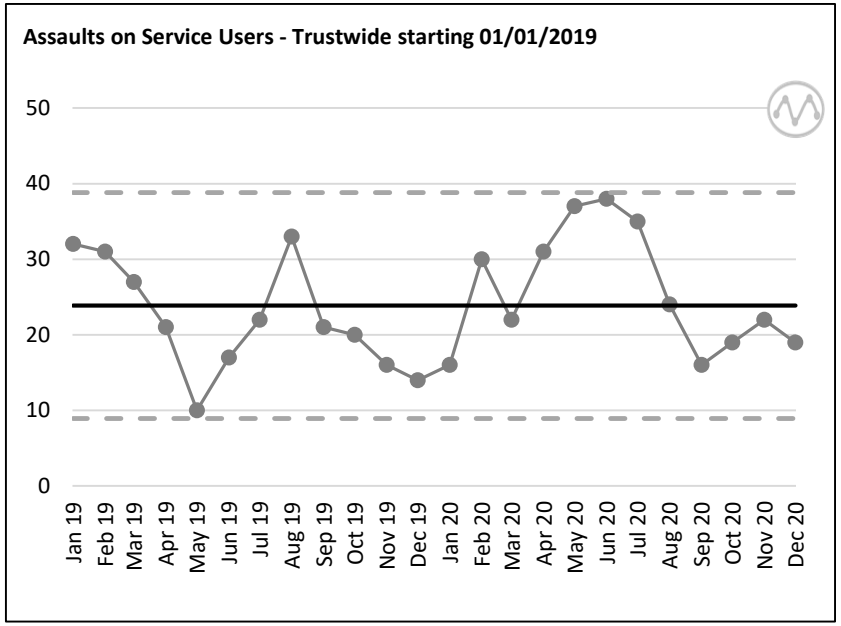


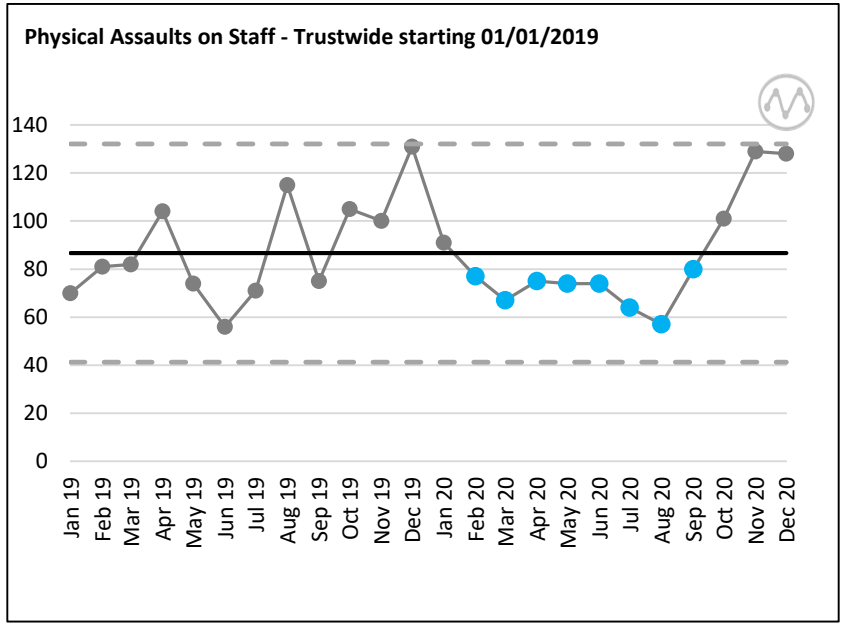
Service/Ward	Incidents	Variation Icon	People	Variation Icon
Trustwide	101		37	
G1	5		3	
Dovedale	6		3	
Firshill ATS	9		2	
Burbage	11		7	
Stanage	22		7	
Maple	5		5	
Endcliffe	37		8	

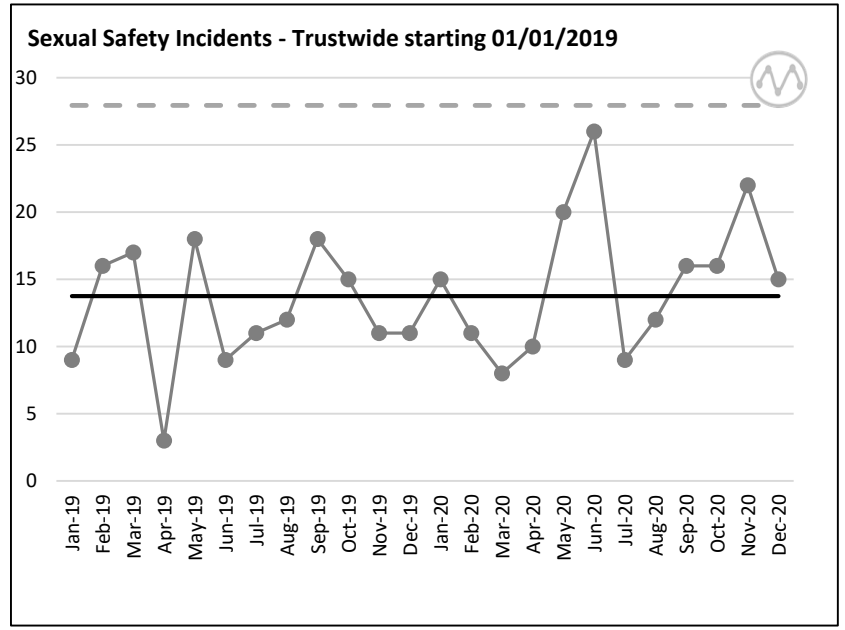
Service/Ward	Incidents	Variation Icon	People	Variation Icon
Trustwide	30		12	
G1	1		1	
Dovedale	13	H	1	
Firshill ATS	0		0	
Burbage	4		3	
Stanage	6		4	
Maple	0		0	
Endcliffe	6		3	

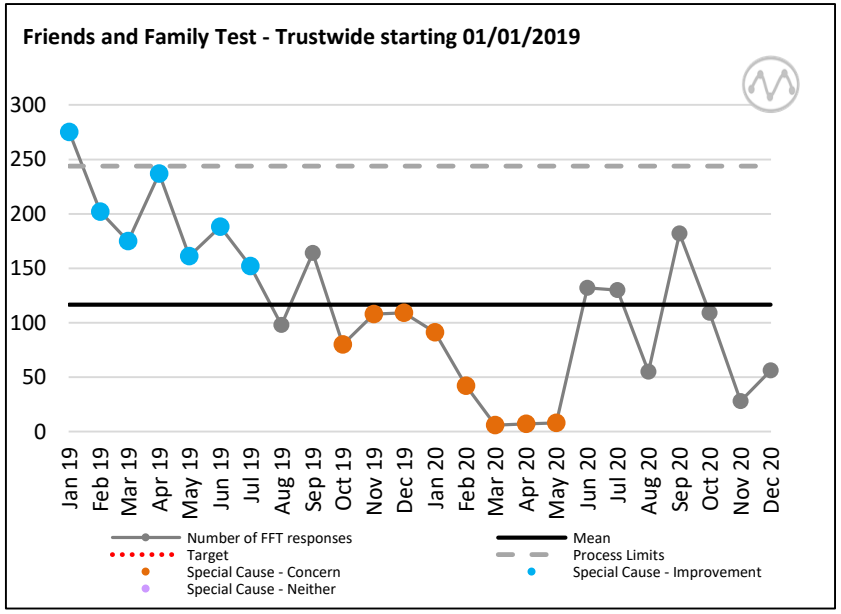
Service/Ward	Incidents	Variation Icon	People	Variation Icon
Trustwide	38		21	
G1	3		1	
Firshill ATS	1		1	
Burbage	4		4	
Stanage	6		3	
Maple	6		5	
Endcliffe	18		8	

Assaults | Sexual Safety & EMSA | Service User Experience





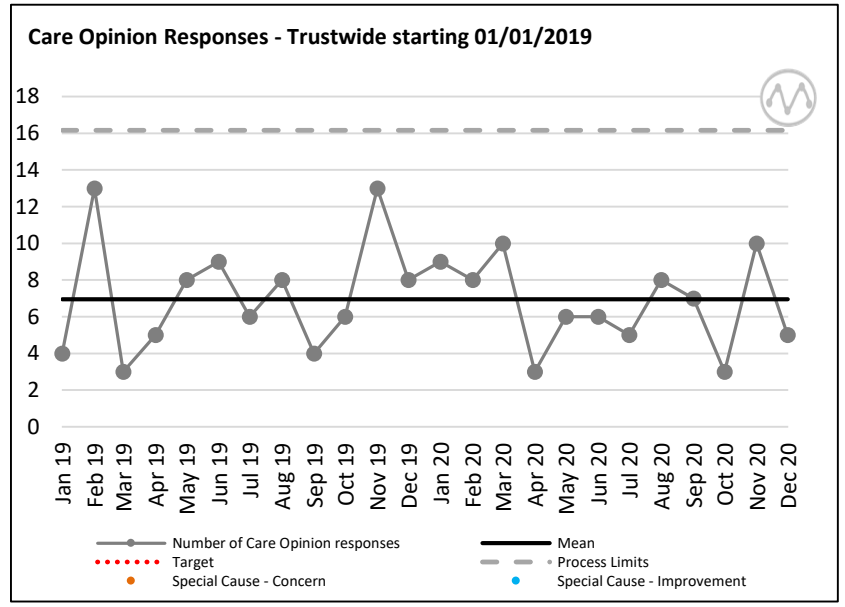




One complaint was received during December 2020, together with 29 compliments.

The complaint was logged within the 'communication' category and related to Stanage Ward.

A quarterly report on the learning from experience is presented to the Quality Assurance Committee.



Deaths | Covid-19

Service User Deaths 1 – 31 December 2020	
Home Treatment Teams (adult and older)	3
Community Learning Disability Team	7
SPA/EWS	**3**
G1	2
Mental Health Recovery Teams	1
Neuro Enablement Service/Brain Injury Team	3
Older Adult Community Mental Health Teams	6
Memory Service	3
IAPT	1
Liaison Service	3
Early Intervention Service	1
START Opiates Service	3
START Alcohol Service	1
Total	**37**

Classification of Deaths 1 – 31 December 2020	
Expected Death	10
Unexpected Death - SHSC Community	15
Suspected Suicide (Community)	4
Unexpected Death (Suspected Natural Causes)	8
Grand Total	**37**

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

Deaths Reported 1 April – 31 December 2020	
Awaiting Coroners Inquest/Investigation	92
Conclusion - Narrative	1
Conclusion - Suicide	4
Natural Causes/No Inquest	247
Alcohol/Drug related	1
Ongoing	2
Grand Total	**347**

The table above shows the number of deaths that have been recorded YTD 1 April 2020 to 31 December 2020.

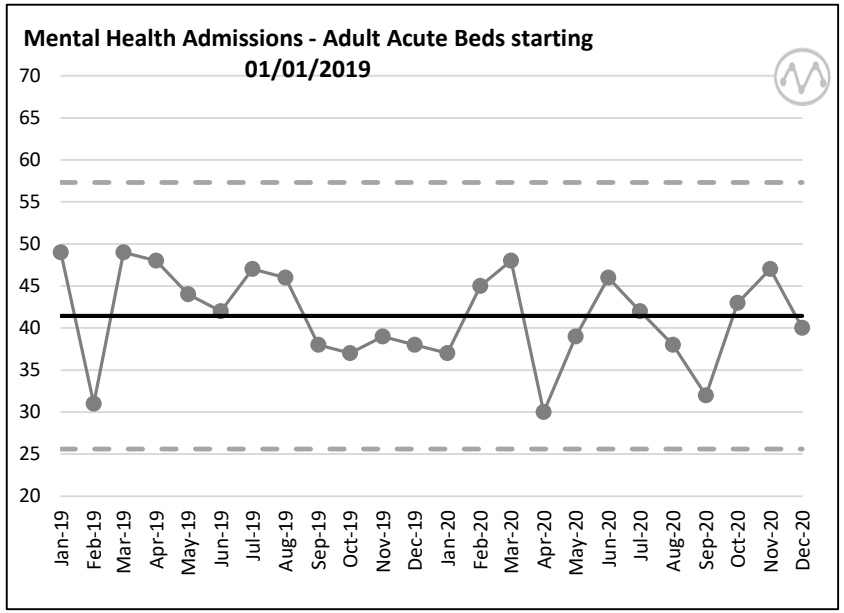
Out of the 37 patient deaths recorded in the month, 21 of these were graded as 'catastrophic'. 12 of these were unexpected community deaths with 4 suspected community suicides. 4 were unexpected but suspected natural causes and the remaining death was expected but reportable to HM Coroner.

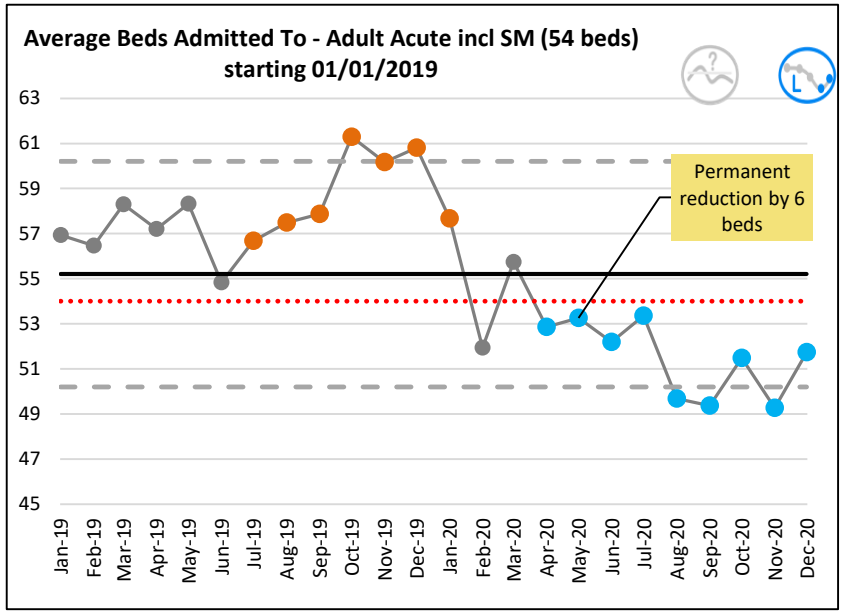
From the 15 unexpected deaths, three are thought to be from natural causes (hence not graded as catastrophic) the remaining 12 are awaiting further information/Coroner investigation (not necessarily to result in an inquest).

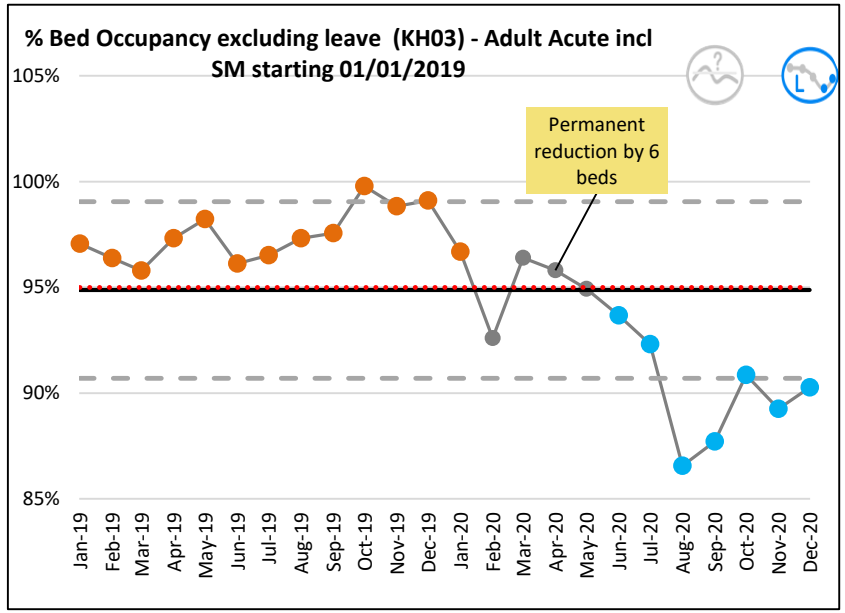
Covid-19 Deaths 1 March 2020 – 31 December 2020	
Birch Avenue	4
Community Learning Disability Team	4
G1 Ward	4
Liaison Psychiatry	2
Long-term Neurological Conditions	2
Memory Service	6
Neuro Case Management Team	1
Neuro Enablement Service	2
Older Adult Community Mental Health Teams	26
Older Adult Home Treatment Service	1
START Opiates Service	1
Woodland View	1
Total	**54**

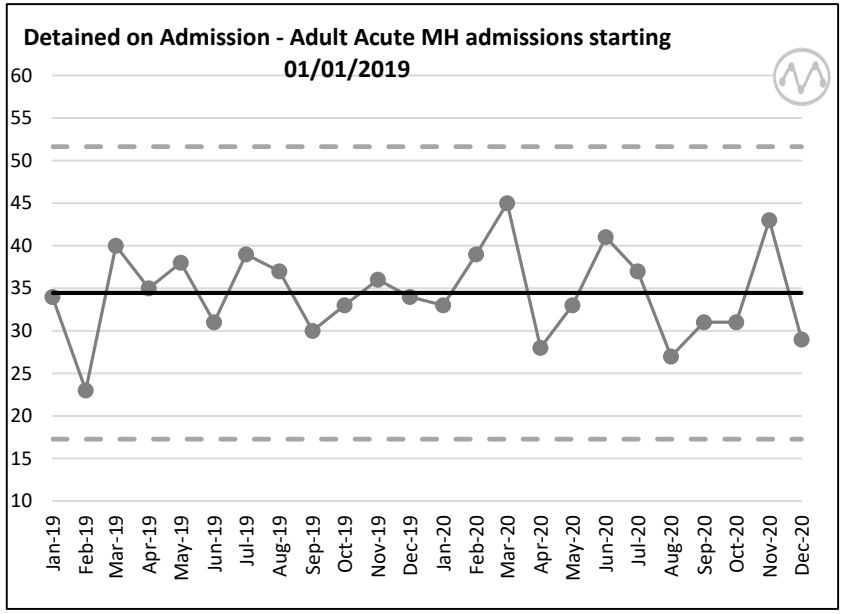
Covid-19 Outbreaks
In December, we were managing local outbreaks of positive cases amongst patients and staff in the following services:
Dovedale Ward
G1 (Grenoside Grange)
Perinatal Mental Health

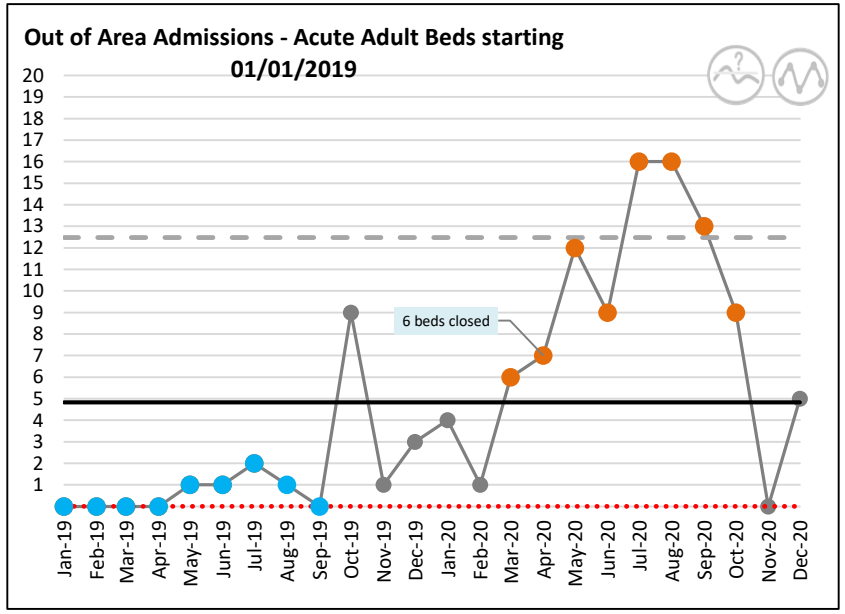
Inpatient Wards | Adult Acute

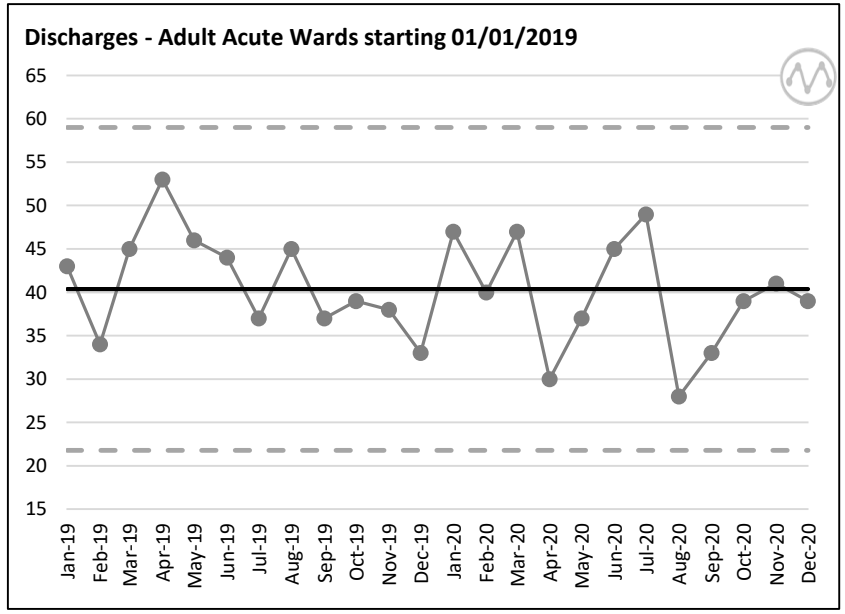




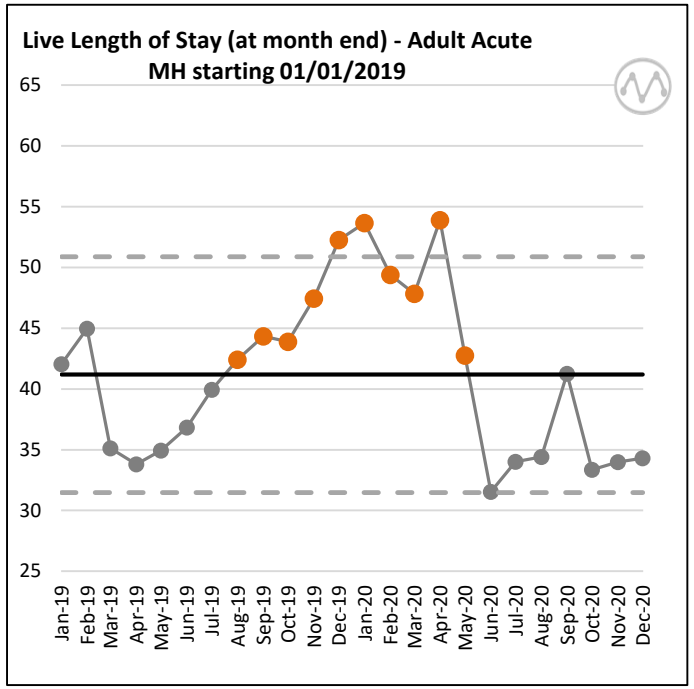


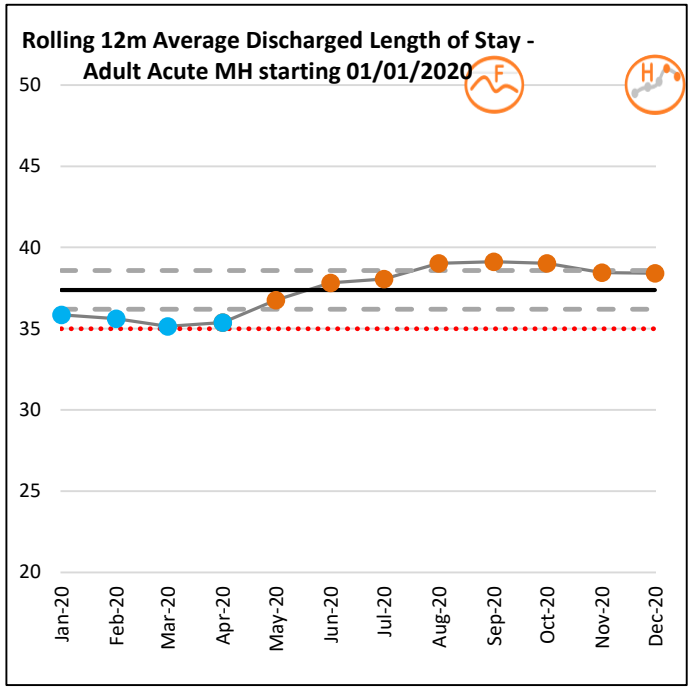


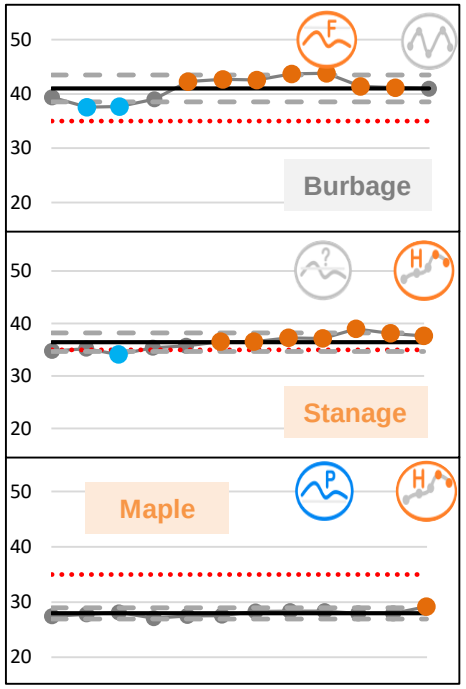




Inpatient Wards | Adult Acute



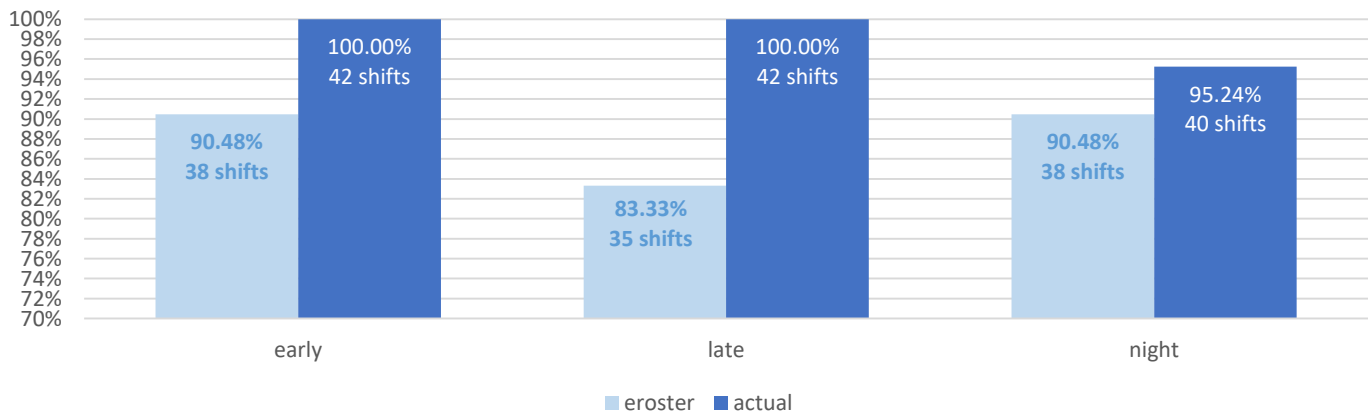




Benchmarking
(2020 NHS Benchmarking Network Report – Registered Population Data)

Bed Occupancy
Mean: 93%
Median: 96%

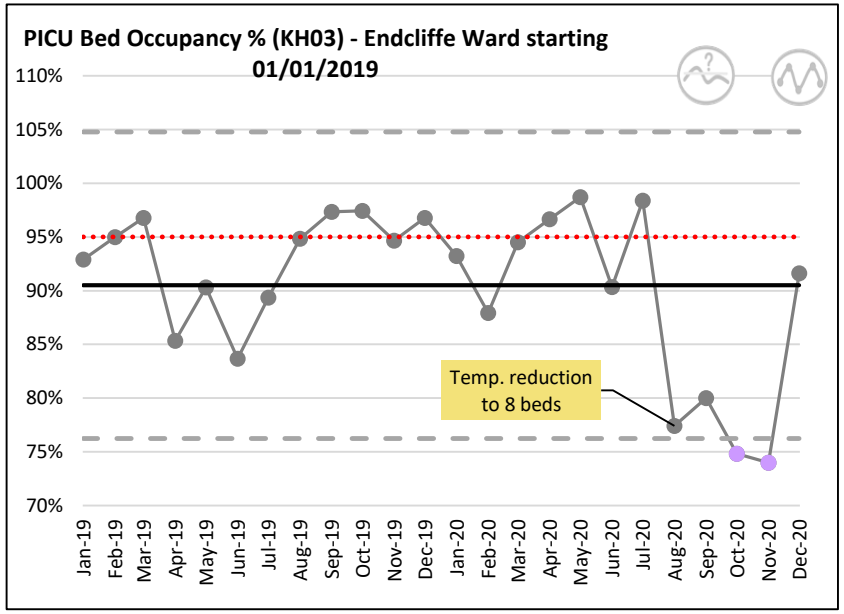
Length of Stay (Discharged)
Mean: 35
Median: 34

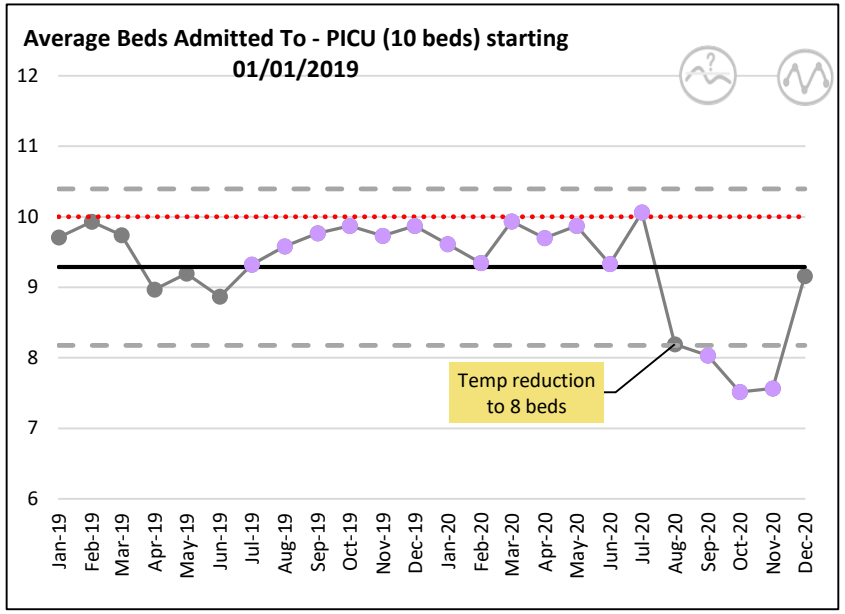


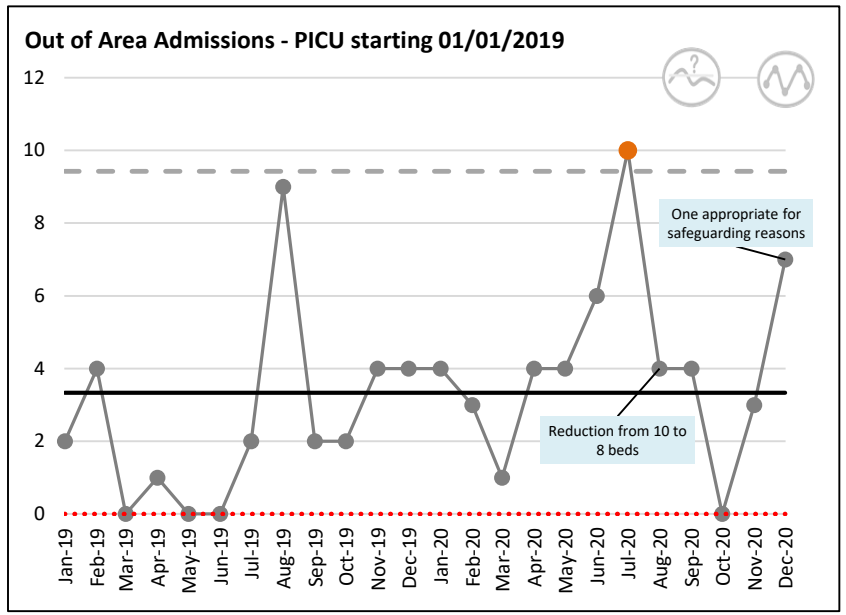
Safer Staffing Shift Compliance

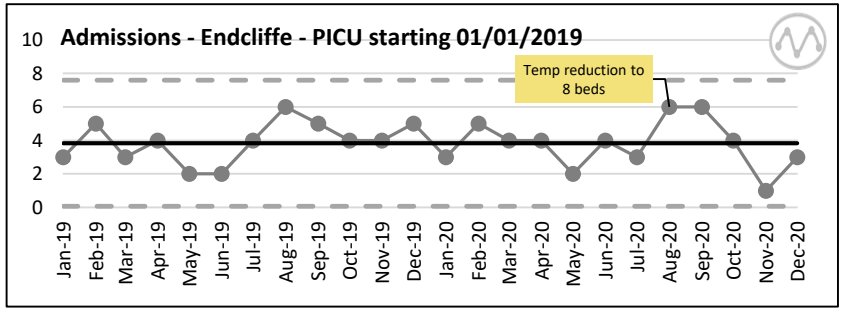
Information is provided from the weekly Improvement Dashboard for the last full available week in December 2020. The dashboard has been amended to include staffing compliance figures according to eRoster and actual staffing. This is driving our efforts to ensure that assurance around staffing compliance can be taken from a single source.

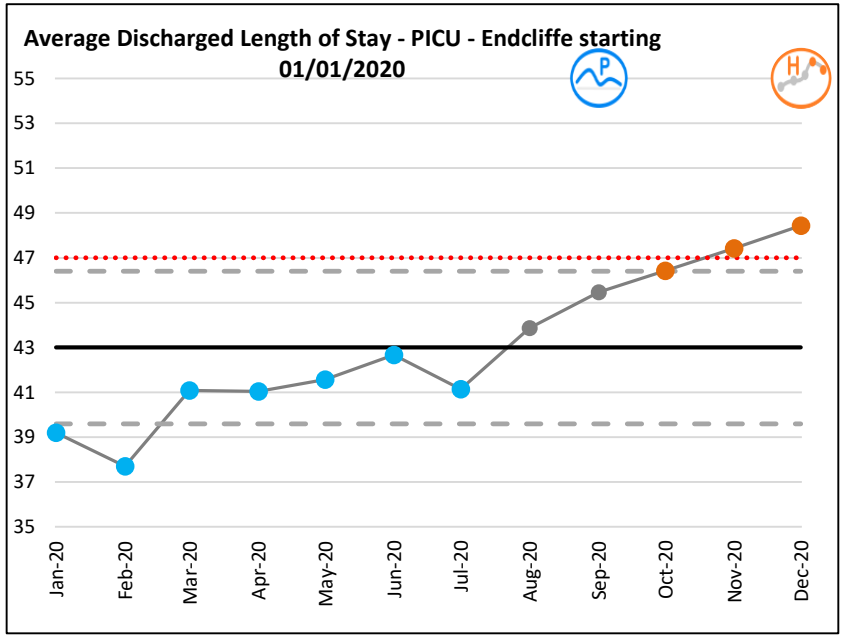
Inpatient Wards | PICU

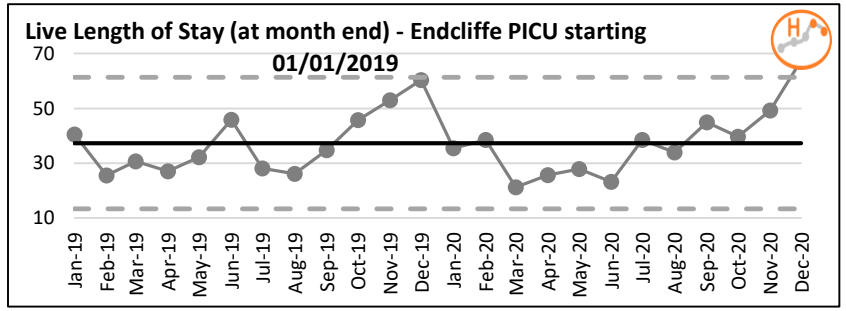


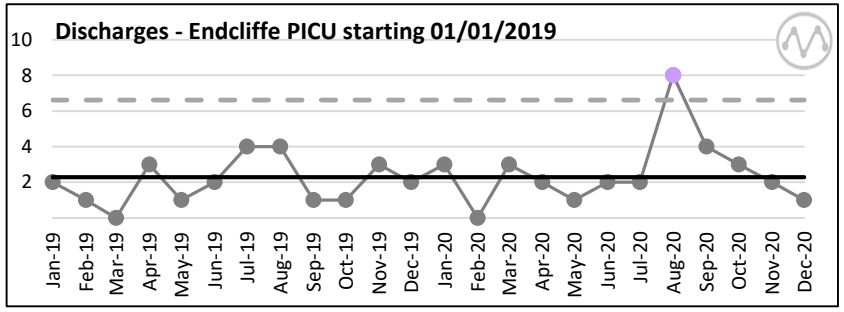












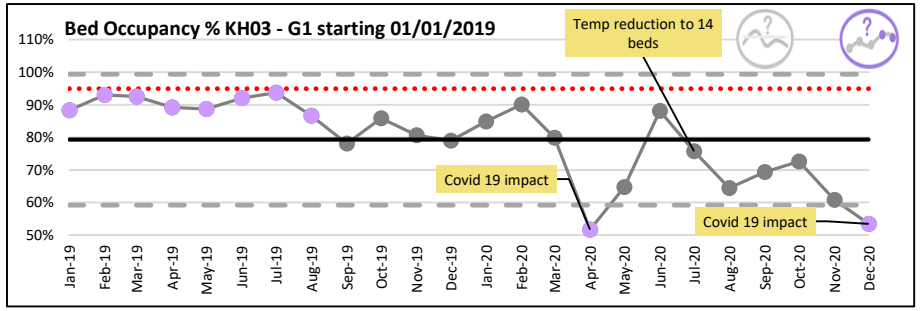
Benchmarking

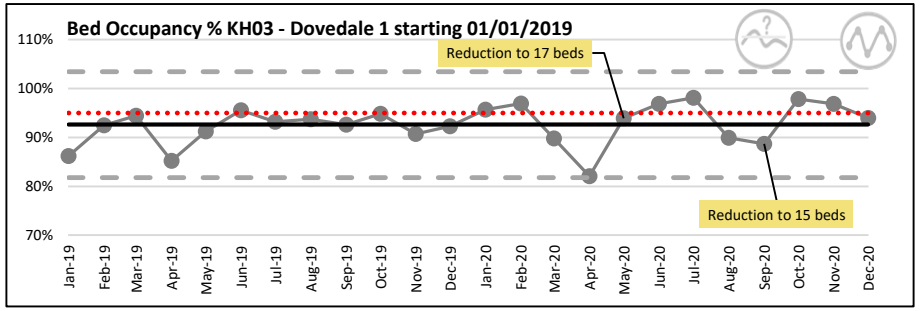
(2020 NHS Benchmarking Network Report – Weighted Population Data)

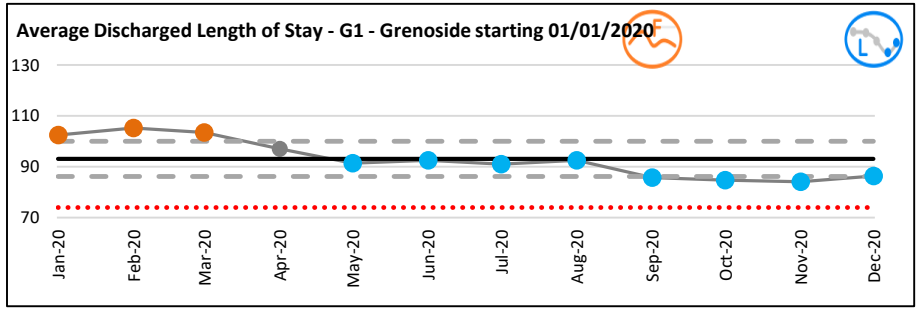
Bed Occupancy
Mean: 88%
Median: 90%

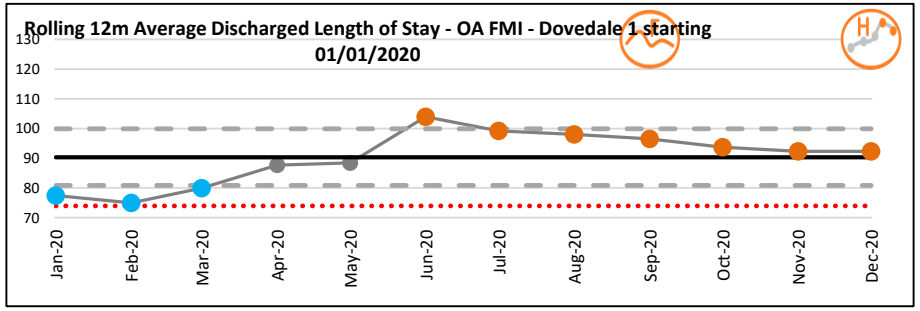
Length of Stay
Mean: 47
Median: 43

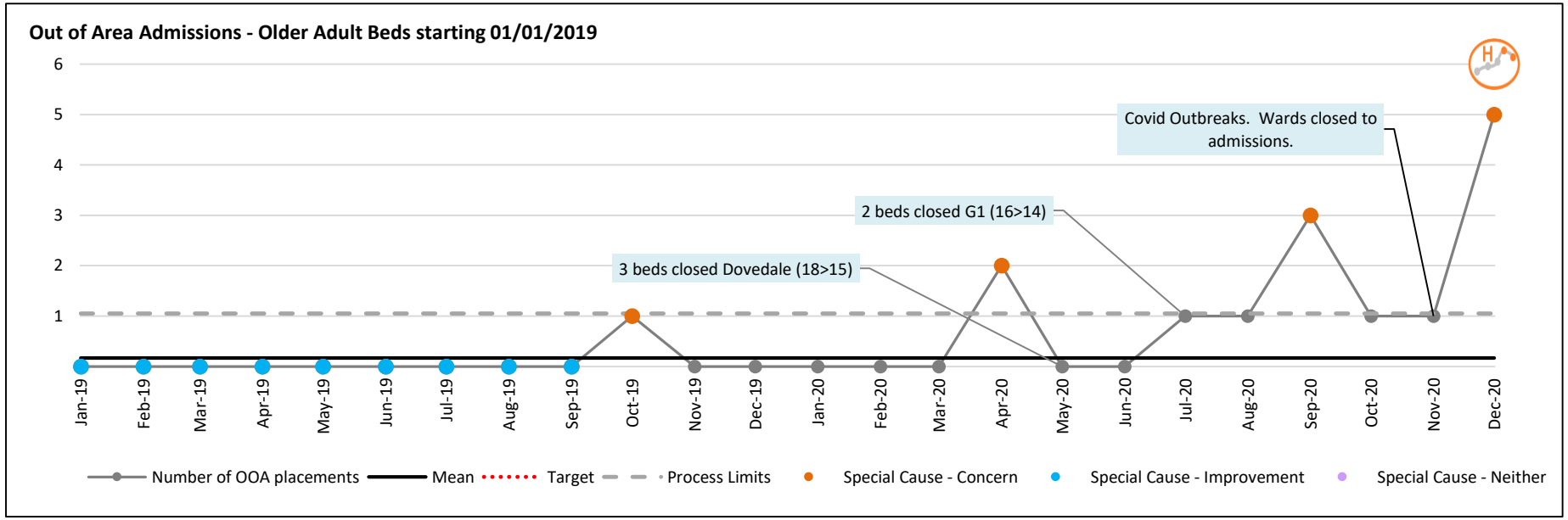
Safe | Inpatient Wards | Older Adults











Benchmarking
(2020 NHS Benchmarking Network Report – Registered Population Data)

Bed Occupancy
Mean: 86%
Median: 88%

Length of Stay
Mean: 74
Median: 76

NB - Benchmarking figures are for combined Older Adult inpatient bed types, they are not available split into functional and organic mental illness.

Responsive | Waiting Times | December 20

Service	Waiting List (Numbers Waiting for 1st Appt at month end)	Average Wait to Assessment/First Contact in weeks (seen in month)
EWS - Routine mental health assessment	**781**	**20.2**
SAANS	**2808**	**105.7**
Gender Identity	**1271**	**105.1**
SPS MAPPS	**59**	**24.2**
STEP Courses (Short Term Education Programme)	**89**	**3.8**
Eating Disorders	**10**	**4**
R&S	**134**	**~**

Narrative

Service users experience unacceptably long wait times for assessment or treatment intervention in a small number of our services, predominantly in our highly specialist services:

- Specialist Psychotherapy Services
- SAANS
- Gender Identity Service
- Relationship & Sexual Service

but also for routine mental health assessment provided by the Single Point of Access/Emotional Wellbeing Service (SPA/EWS).

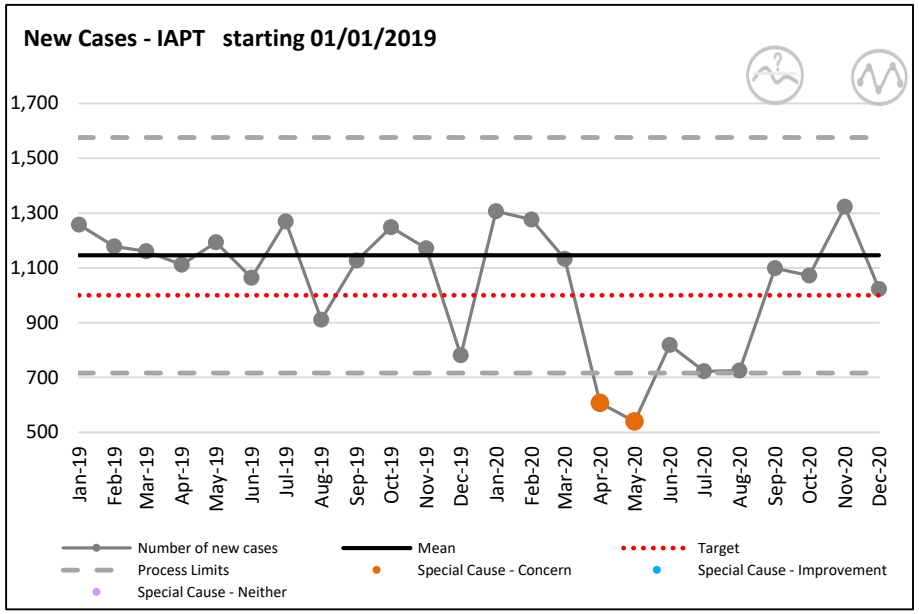
Contributing factors to long waits include:

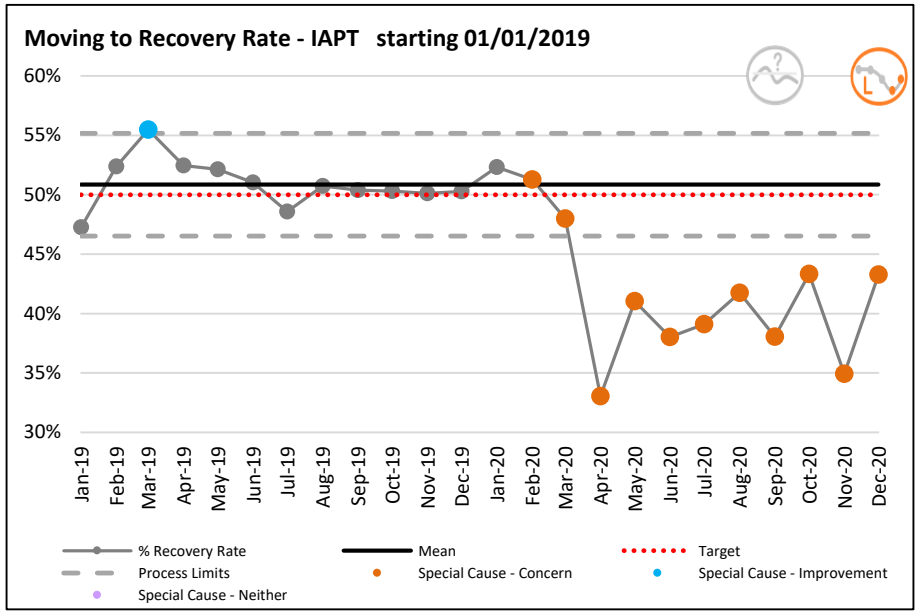
- Demand outstrips capacity without changes to commissioned provision
- Challenges with unit cost/capacity expectations > services under-resourced to deliver expected volumes
- Vacancy management impacts on clinical efficiency and slows throughput
- SPA/EWS specific – original capacity planning projected higher assessment activity than is currently possible due to vacancy factor, and industrial dispute/current CMHT review processes which limits volume of activity

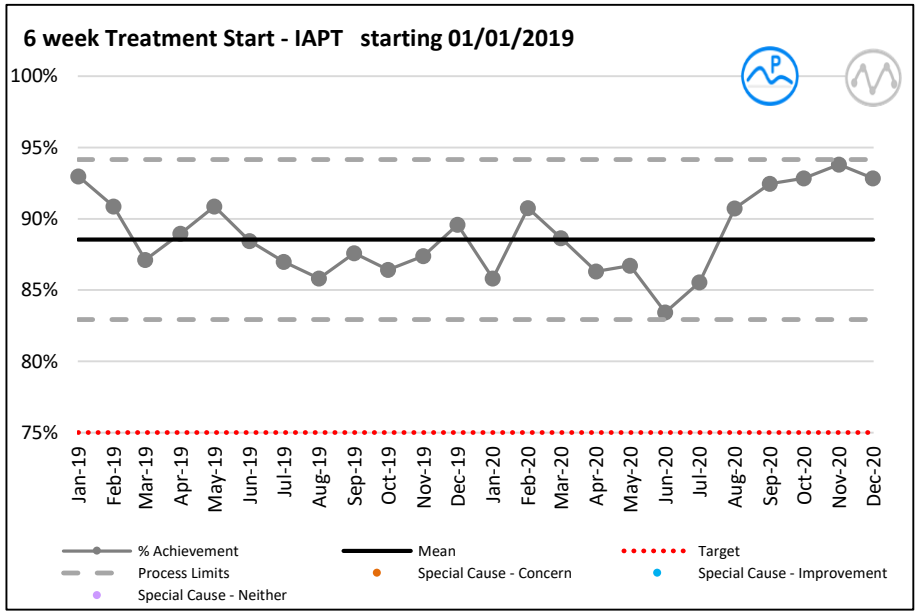
Covid specific

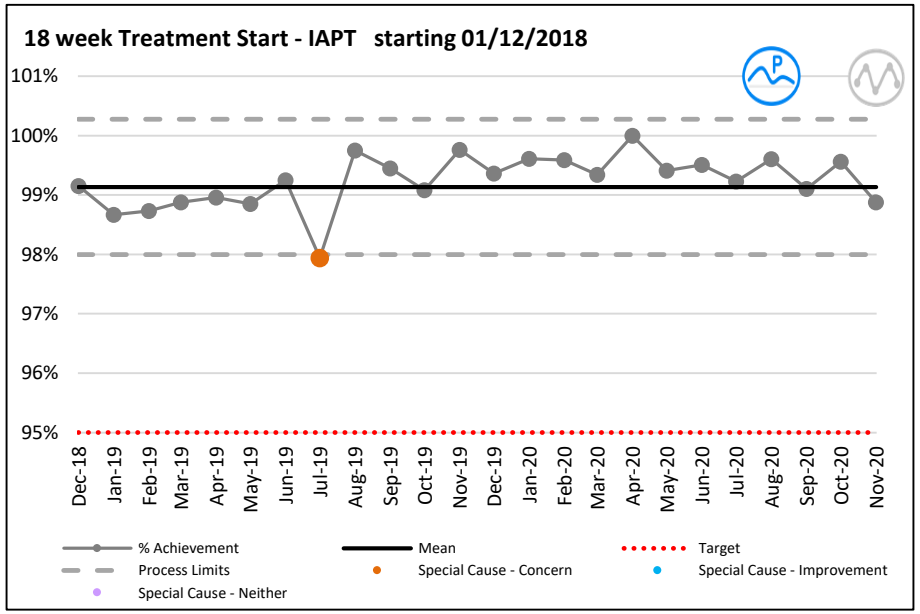
- Necessary operational changes slowing access to services while remote technologies were set up
- Remote interventions not clinically indicated
- Technological challenges > appointments take longer > fewer patients seen

Responsive | Improving Access to Psychological Therapies (IAPT)









Narrative

Access
There was a slight decrease in December of new referrals in to the service. The service planned in numerous courses starting in December to help increase access and ensure patients had opportunities to attend online courses over the Christmas period, in addition to our usual treatment offer. We are pleased the access was above the target of 1,000.

Waiting Times
Both the 6 and 18 weeks wait to treatment start times continue to consistently exceed the national targets and this has been maintained throughout the pandemic to date.

Moving to Recovery
There was an increase in recovery rate in December compared to November however the following issues continue to still impact:

1. National restrictions increasing people dropping out of treatment impacting on recovery rate calculation.
2. Patients not completing outcome measures for online courses for each session (automatically generated online outcome measures sent as a web form), negatively impacting on recovery rate calculations

Mitigations:

- Revised administrative processes to offer follow up reviews to people who drop out of courses to review the most appropriate interventions for them
- Weekly meetings with group facilitators across the service to monitor and review completion of outcome measures
- Implementation of new slide in each course emphasising the value of outcome measures and attending all sessions
- Using the text message reminders to include request to complete outcome measures during each online course

START Performance Summary | December 2020

Key Performance Indicator (KPI)	TARGET	DEC 2020	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	TARGET	DEC 2020	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON	TARGET	DEC 2020	SPC VARIATION / TREND ICON	SPC ASSURANCE ICON
Service	**Opiates**				**Non-Opiates**				**Alcohol**			
Access – Waiting time referral to assessment (≤7 days)	≥ 95%	**100%**	H	P	≥ 95%	**100%**	H	P	≥ 95%	**98.51%**		P
Access – Waiting time referral to treatment start (≤21 days)	≥ 95%	**100%**	H	P	≥ 95%	**100%**	H	P	≥ 95%	**100%**	H	P
Access – DNA rate to assessment	≤ 15%	**27.08%**		?	≤ 15%	**18.00%**		?	≤ 15%	**23.88%**		?
Engagement – Numbers in	TBC	**54**	L	N/A	TBC	**59**		N/A	TBC	**134**		N/A
Recovery – Successful exits from treatment	TBC	**9**		N/A	TBC	**25**		N/A	TBC	**44**		N/A

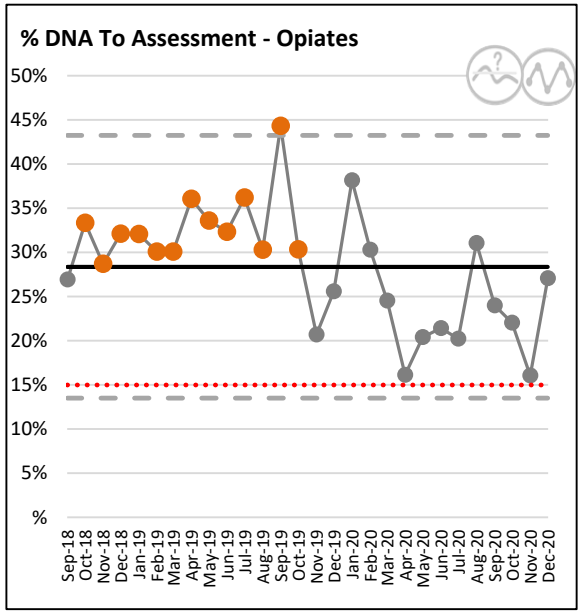
Narrative

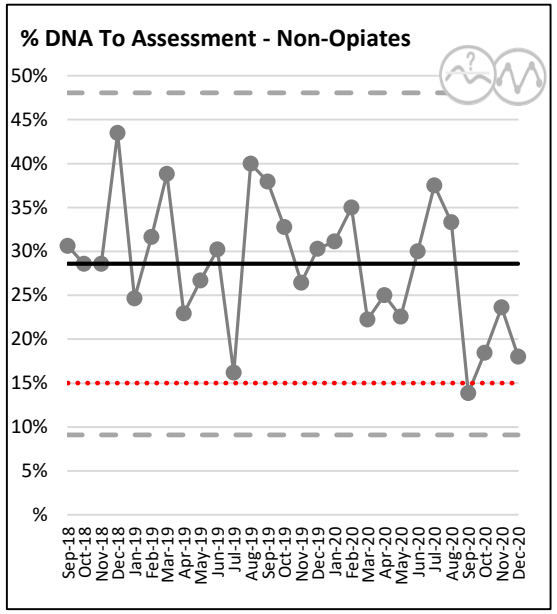
Engagement Referral numbers to the opiates, alcohol and non-opiates services are not currently working to a target but this is in discussion with the commissioner. The service provides open access to treatment regardless of any previous presentations or drop-outs. For this reason, there is a group of service users who can cycle in and out of treatment. We work on addressing this through focussed engagement approaches with those who are repeat presentations, without denying treatment to anyone who needs it.
Access to criminal justice substance misuse interventions has been affected by the lockdown due to Covid 19, with a period of no drug testing in the SYP custody suite, reduced court capacity and withdrawal of prison pick-ups. The service continues to engage with those on caseload to reduce offending behaviour and is starting to increase activity levels where safe to do so.

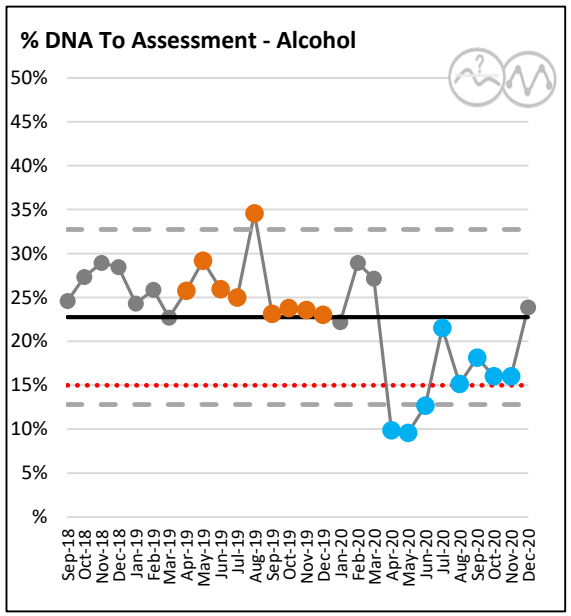
Waiting Times The service works towards a target of 95% of service users being assessed within 7 working days, which is consistently achieved. The average wait time from referral to assessment in all 3 services is currently under 3 days.

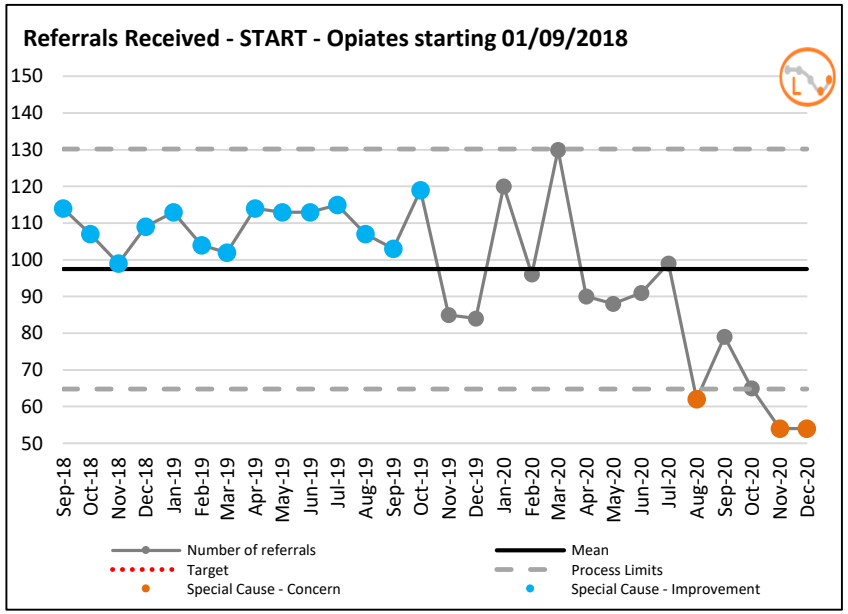
Recovery Due to the open access nature of the service, service users find it easy to drop out of treatment. The service has previously worked towards a target for the percentage of positive discharges (defined as discharge drug free/occasional user or a planned discharge with treatment goals met). We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

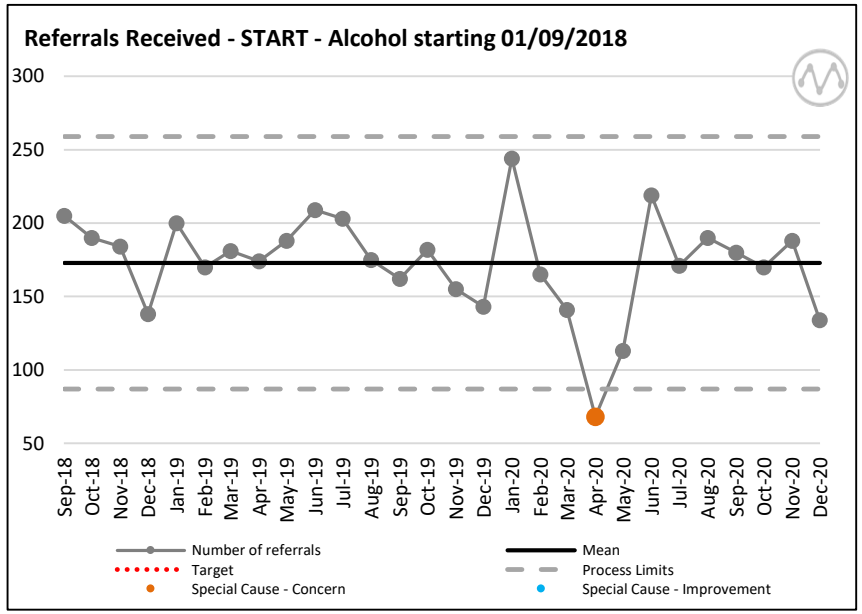
START Performance | Highlights & Exceptions | December 2020











Narrative

DNA Rate to Assessment

During the last contract period, the service has worked towards a target of 15% DNA rate to assessment, which is within the control limits of the data and therefore achievable under current systems.

However, it is important to note that the DNA rate reflects the service's open access policy, and the target has not been achieved in the last 24 months in the opiates service. Targeted engagement work is undertaken with those who repeatedly DNA to assessment.

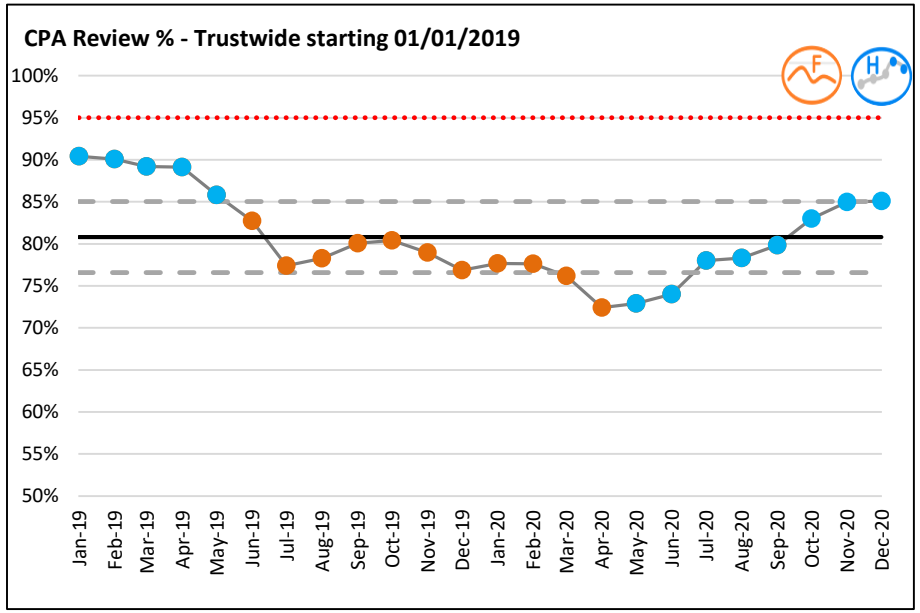
Covid 19 has led to an increase in telephone assessments which initially had a positive impact on the number completed, particularly in the alcohol service. The service will be using learning from this to identify where improvements to the DNA rate can be made.

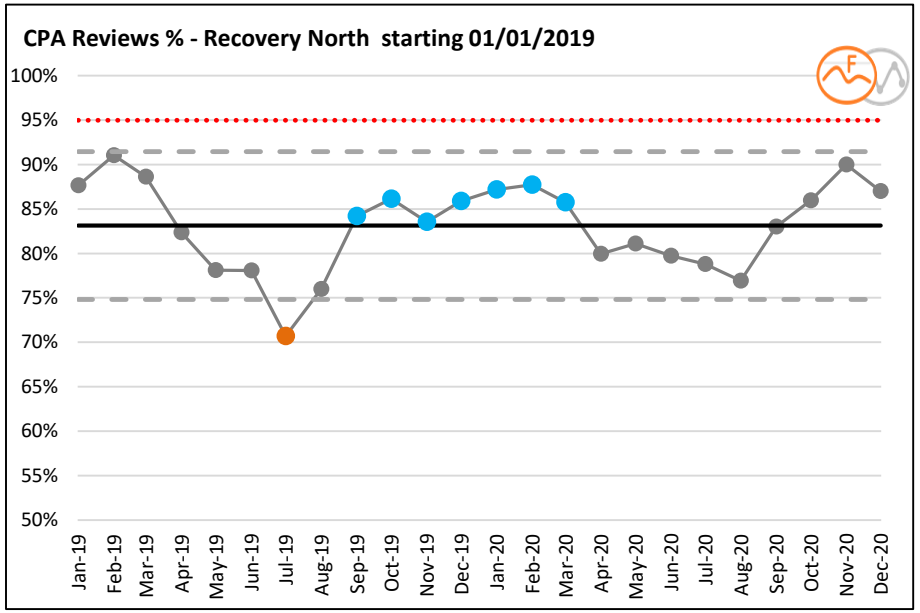
Referrals (Numbers In)

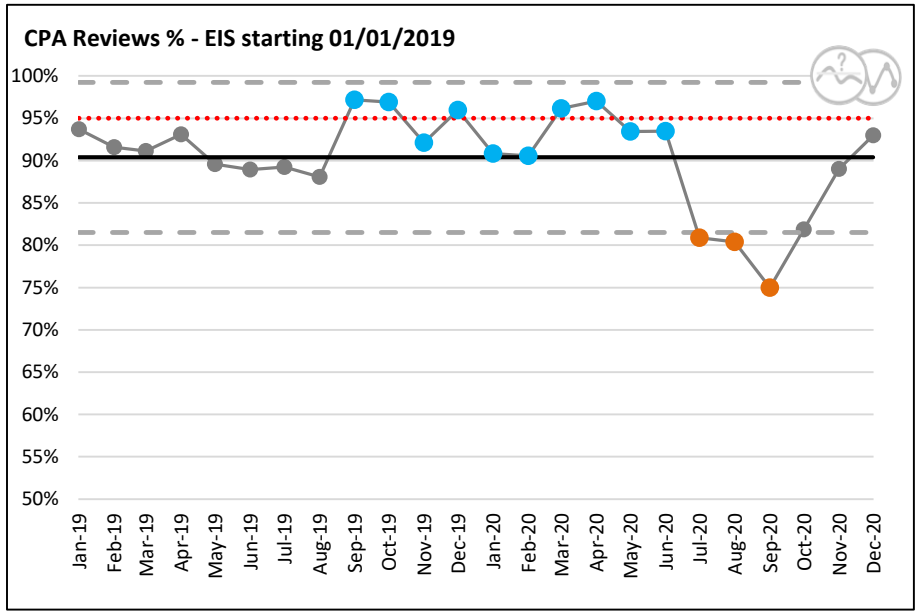
There continues to be a reduction in referrals to Opiates. It is likely that many have remained in treatment and therefore some who would have dropped out and re-presented have not needed to because they are successfully engaging with treatment. However, as this continues the service will be investigating reasons for this further to ensure people are not facing barriers to accessing treatment.

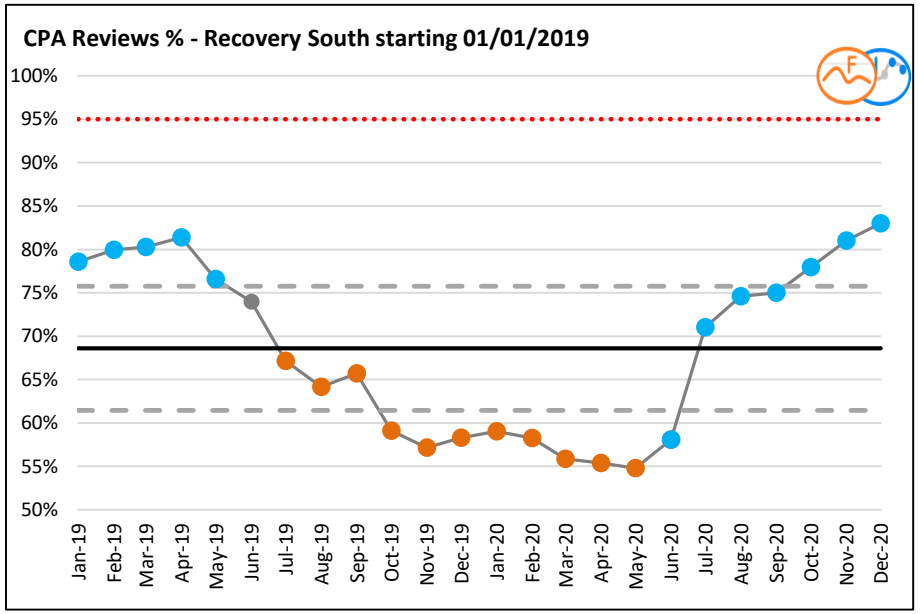
There were fewer referrals to the alcohol service in April, coinciding with lockdown. The links between alcohol use and lockdown is something the service has been keen to address; there was a brief social media campaign in July aimed at encouraging people to seek help for lockdown drinking habits and there will be a campaign in January aimed at those who are making resolutions to be healthier in the new year.

Effective | CPA Review









Narrative

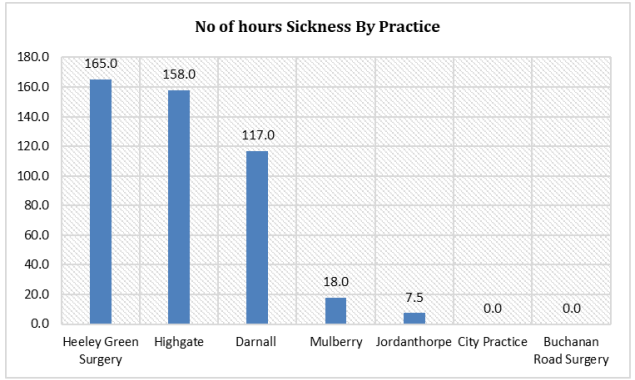
Improved performance shown over previous quarter has levelled out over December. This coincides with a significant shortage of staff across all services and in particular in the recovery service.

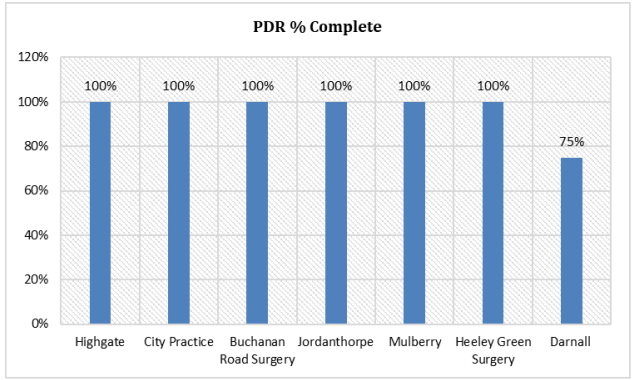
Short term measures are in place to bridge 12 vacancies in care coordination staff and systems are in place to ensure care is provided in line with the needs of the service users. Formal reviews of care, however are more difficult where staff (often agency) are unfamiliar with the case.

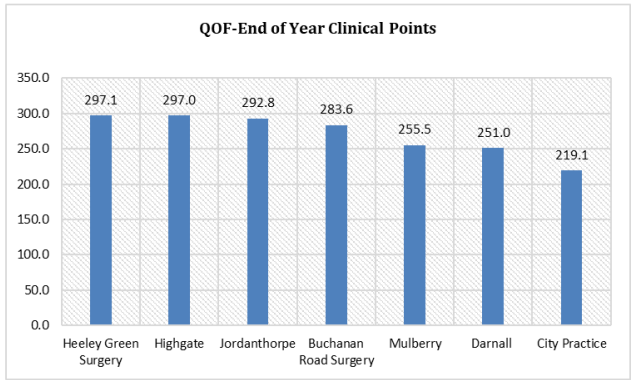
Recruitment into vacancies is being pursued proactively and the service is confident that posts will be filled by the end of March 2020.

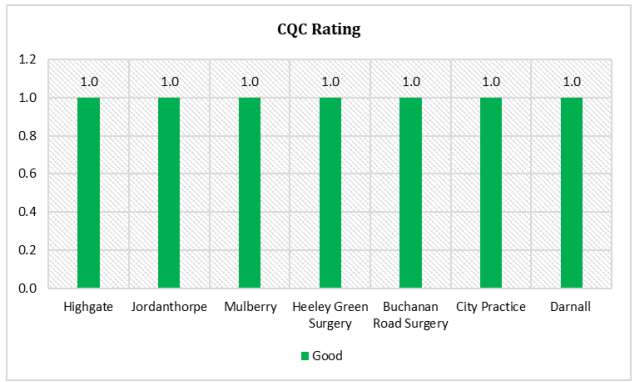
It should be noted that EI continue to show improvement.

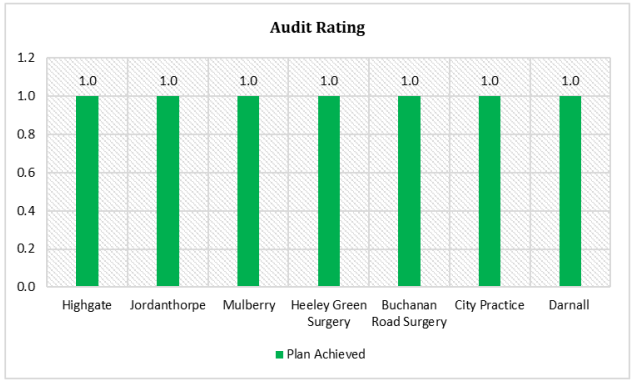
Clover Group & Primary Care Practice Dashboard – December 2020

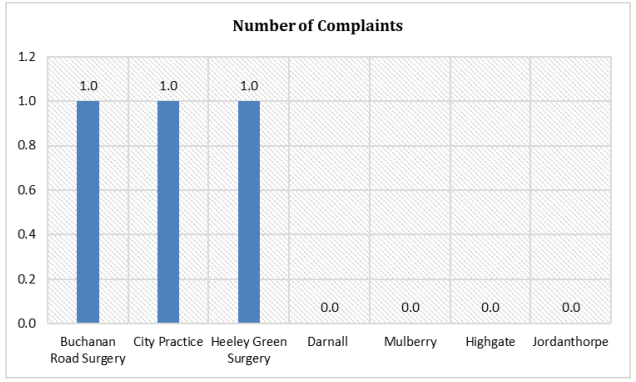


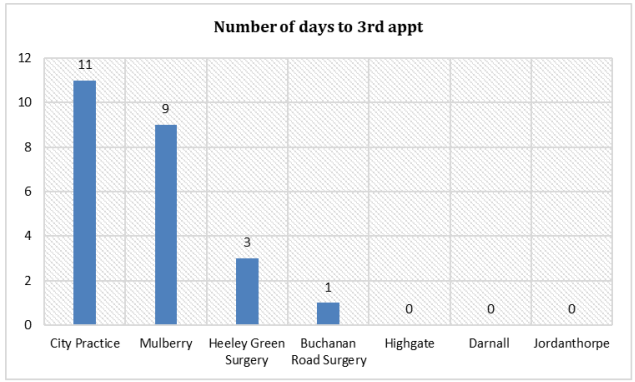


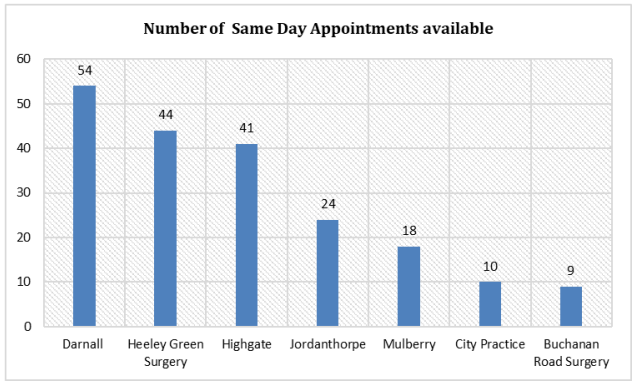


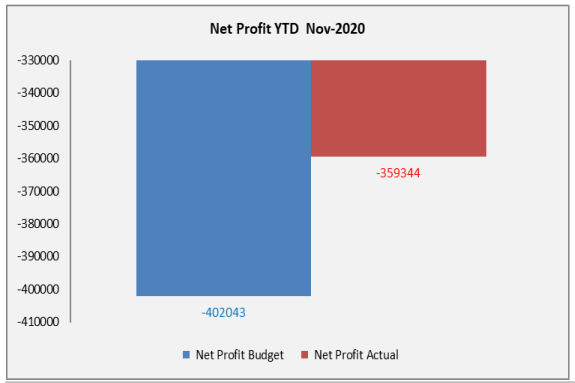


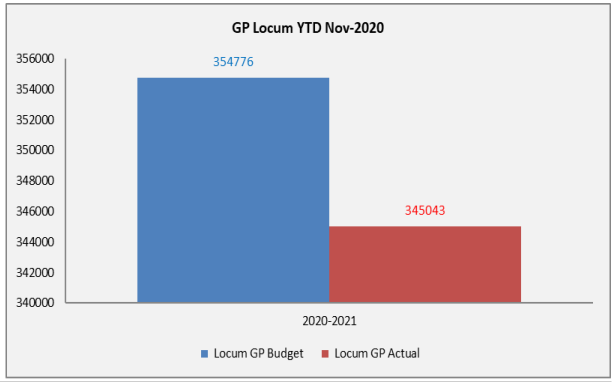












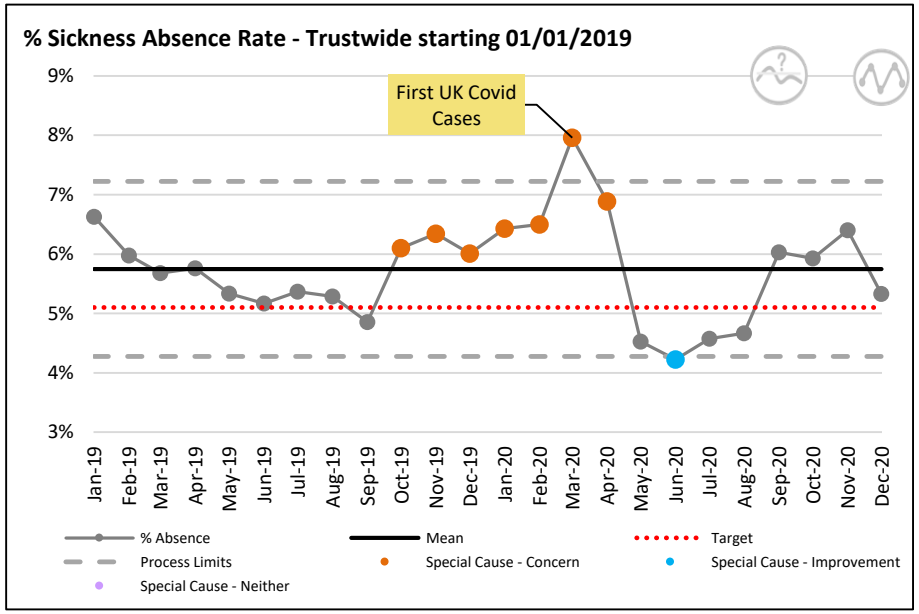
Finance Data is always one month in arrears . This is due to reporting lags within finance.

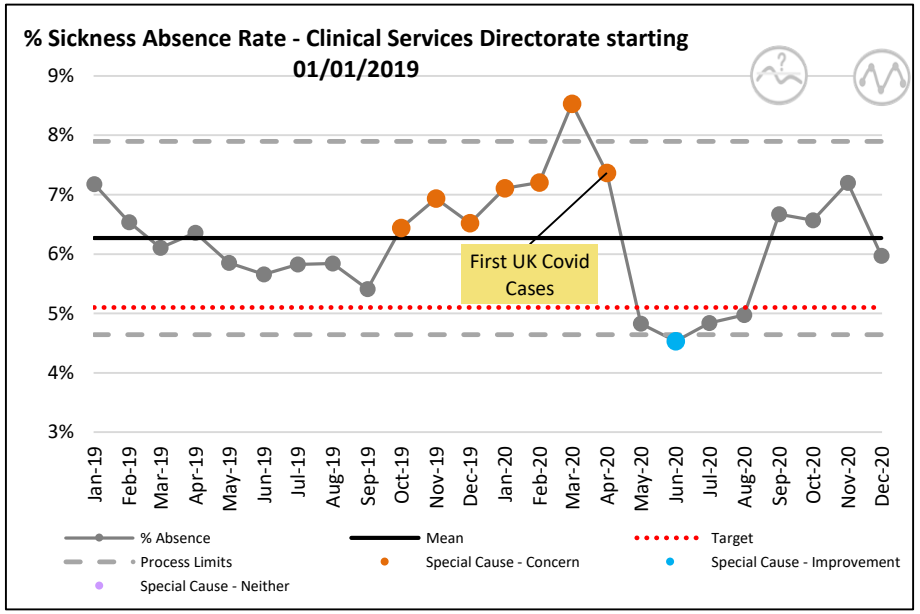
Workforce 1 | Summary – December 2020

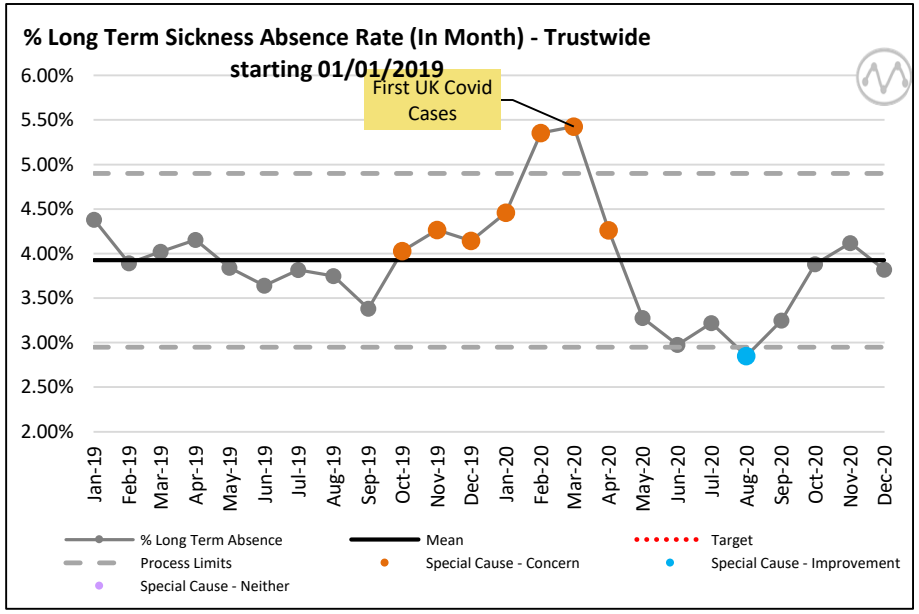
December 2020		Directorates				Trust Total		
Indicator	**Target**	**Clinical Services**	**Medical**	**Non Med Support**	**GP Surgeries**	**Nov-20**	**Dec-20**	**Change**
Staff in Post (Headcount)	**-**	2069	157	304	68	**2609**	**2598**	**-11**
Vacancy (%)		10.1%	-1.2%	14.4%	0.0%	**9.2%**	**9.7%**	**+0.5%**
Turnover (%)	**10%**	9%	10%	14%	10%	**11%**	**11%**	**+0.0%**
Sickness In Month (%)	**5.1%**	5.97%	2.20%	3.34%	4.45%	**6.40%**	**5.33%**	**-1.1%**
Sickness 12 Month (%)	**5.1%**	6.21%	2.84%	3.85%	6.66%	**5.75%**	**5.68%**	**-0.1%**
Long Term Sickness (%)		4.22%	1.87%	2.36%	4.45%	**4.12%**	**3.82%**	**-0.3%**
Short Term Sickness (%)		1.75%	0.33%	0.98%	0.00%	**2.29%**	**1.51%**	**-0.8%**
PDR Compliance (%)	**90%**	92.4%	97.1%	96.2%	71.7%	**92.4%**	**92.6%**	**+0.2%**
Training Compliance (%)		92.5%	87.2%	90.9%	66.1%	**89.3%**	**89.9%**	**+0.6%**

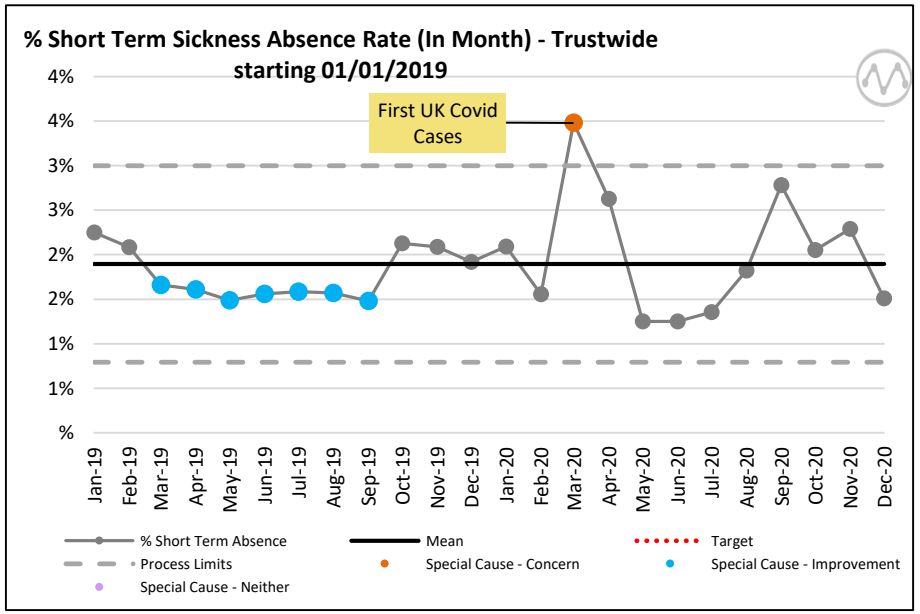
Notes:
- Medical turnover excludes fixed term rotations.
- Vacancy based on establishment (FTE) data compared with staff in post (FTE) figures.

Workforce 2 | Sickness Absence







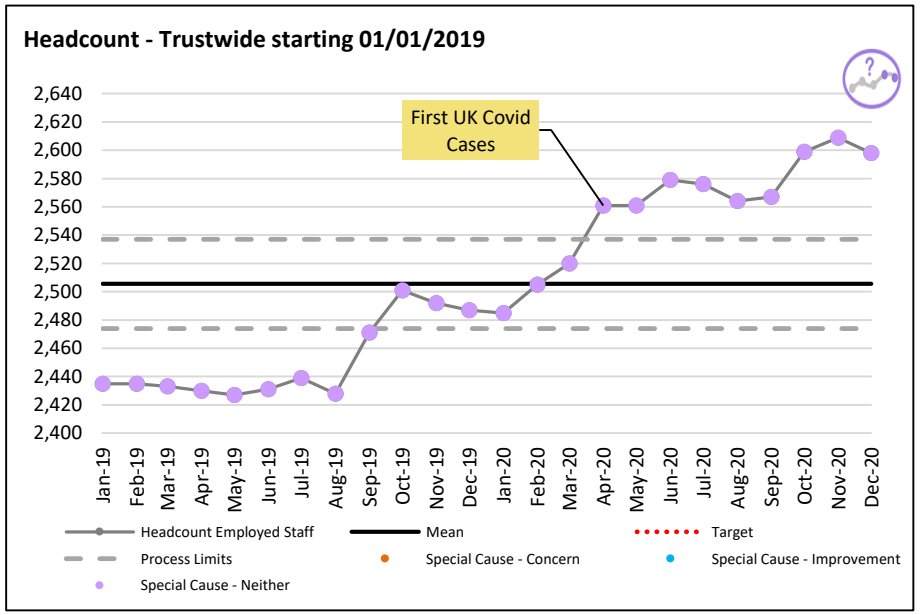


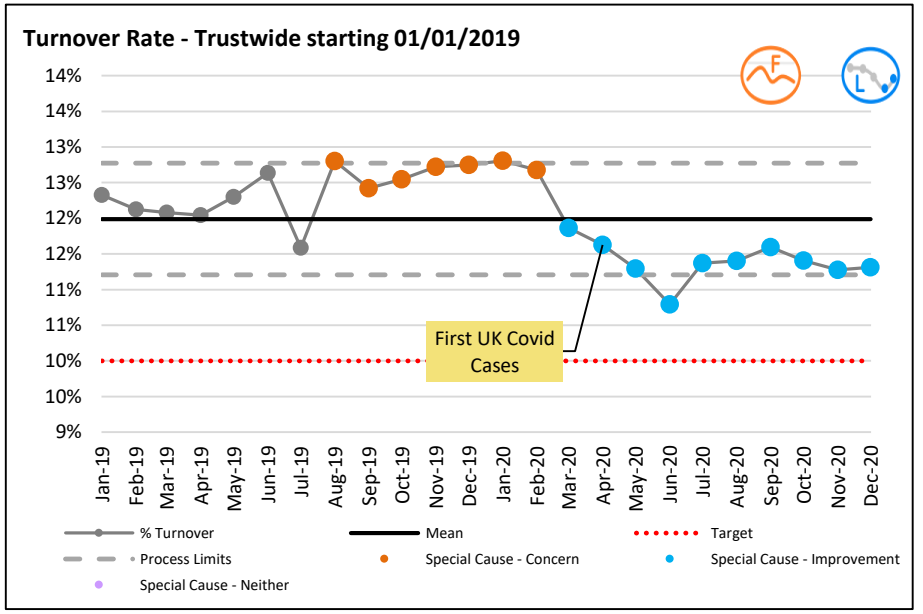
Narrative

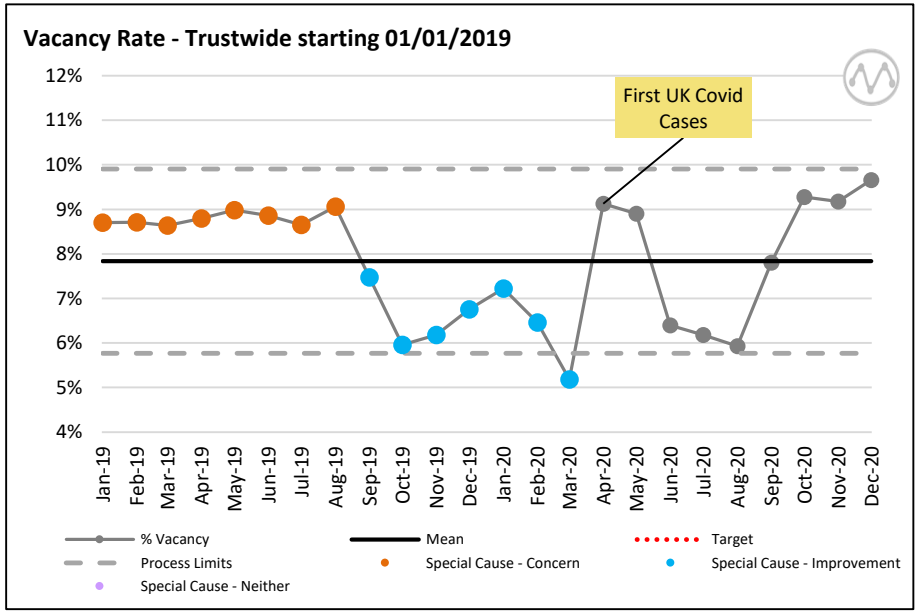
The COVID-related absence occurrences in Buckwood View have reduced considerably this month – as a result of this, we have seen a reduction in the Additional Clinical Services and Nursing and Midwifery sickness rates – as well as the overall trust absence rate for December 2020.

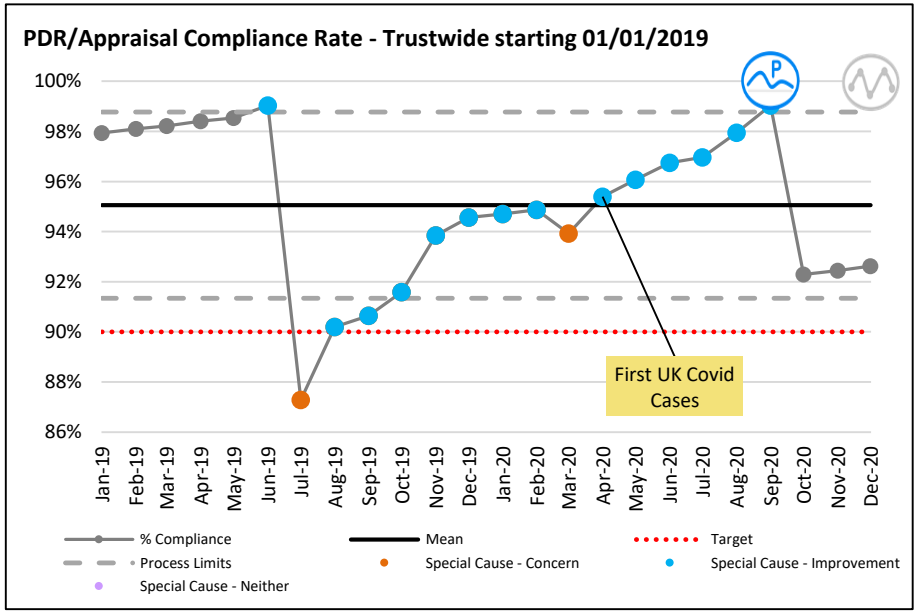
We have also seen a significant reduction in the absence rate for Allied Health Professionals.

Workforce 3 | Staffing & Appraisal









Narrative

Headcount
The decrease in headcount this month can be attributed to a slight increase in turnover for December 2020.

Turnover Rate
Medical Directorate has had an increase of turnover by 1.5% - and has had a significant reduction in headcount this month due to the implementation of the clinical restructure.

Nursing Turnover rates have continued to remain stable over the last 6 months, and remains well under the target for the trust.

Medical and Dental turnover rates here include fixed term contracts – and hence rotational doctors. This results in an inflated figure.

Vacancy Rate
The overall vacancy rate has remained stable this month, following the increase in October 2020.

Estates and Ancillary vacancy has increased further to 15.2%.

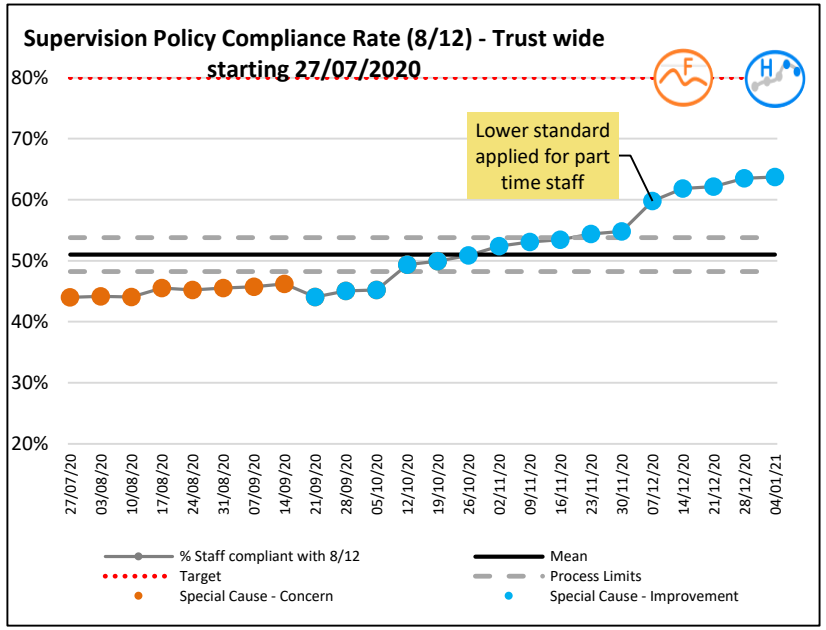
PDR Compliance
PDR compliance remains static and above target at 92.4%

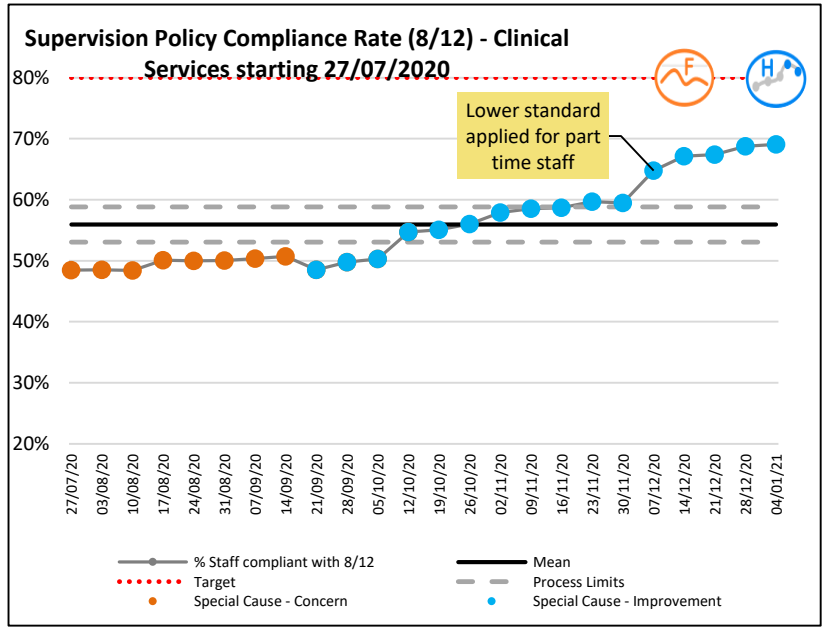
Medical Appraisal compliance has increased significantly to 91.3% this month, following an update of the backlog of records that was discovered in November.

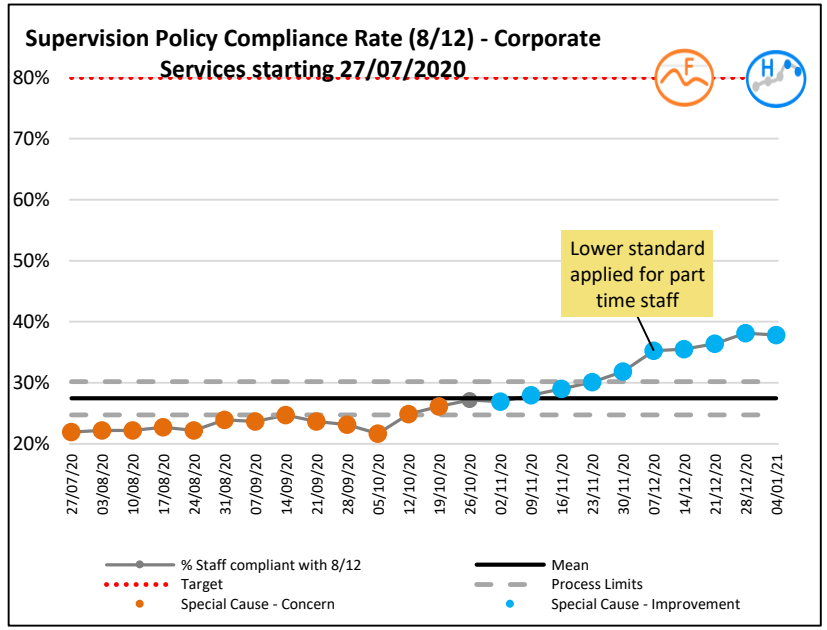
The PDR Compliance rate in Add Prof Scientific continues to increase.

We have also seen increases in Additional Clinical Services and Administrative and Clerical staff groups.

Supervision







AIM

We will ensure that 80% staff have received at least the required minimum of 8 supervisions in a 12-month period, and that it is recorded in and reported on from a single source – the Supervision webform.

NARRATIVE

As at 3 January 2021, compliance with the 8/12 target was at 64%, with Clinical services at 69% and Corporate services at 38%.

To note –

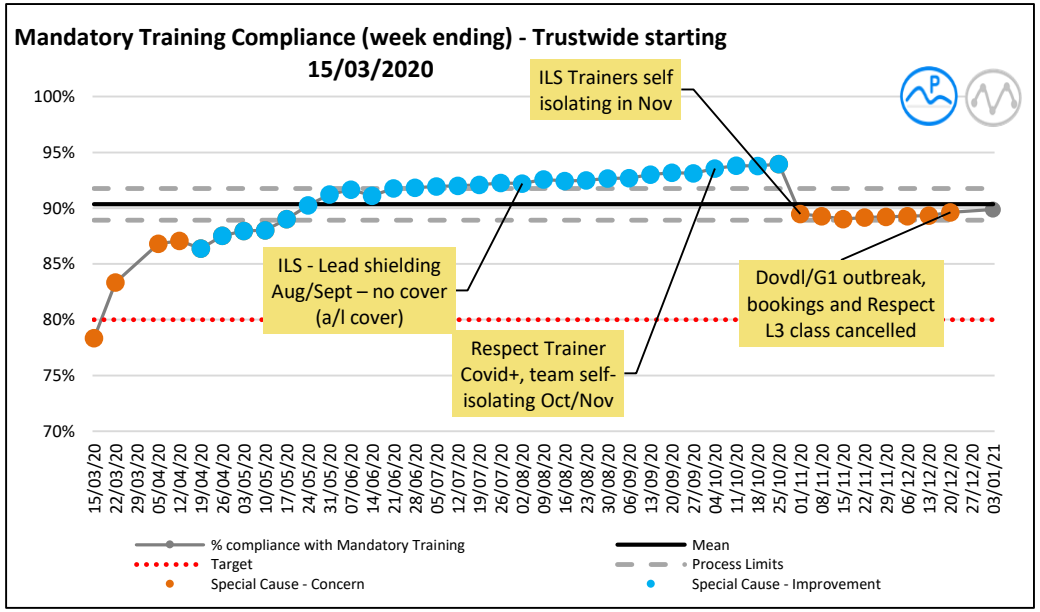
1. ***the vertical axes display the same range for the purposes of comparison.***
2. ***the metric has been updated to apply a lower standard (minimum of 6 supervisions in 12 months) for any staff working less than 0.8 WTE.***

Changes to the Supervision Policy were agreed in June 2020. This included the setting of the 80% compliance for a minimum of 8 supervision sessions in 12 months. This information is shown here from w/e 1 August 2020 for Trust wide, Clinical and Corporate Services.

Work is ongoing as part of the Back to Good Programme to implement improved reporting and assurance of the Supervision Form.

The addition of a measure of quality of supervision is also being explored in consultation with staff across the Trust.

Mandatory Training



AIM

We will ensure a Trust wide compliance rate of at least 80% in Mandatory Training.

NARRATIVE

Trust Compliance 89.89%

As at 3rd January 82.85% of staff are 80% compliant or above.

EXCEPTIONS

Subjects Below 80%

3 Subjects still below 80%, which are ILS and Respect Level 2 and 3.

Of the 87 staff who are non-compliant in ILS, 56 (64.37%) are compliant with BLS.

Services Below 80%

Grenoside Facilities are below 80% compliance.

Sheffield Health and Social Care Mandatory Training Compliance @

03 January 2021

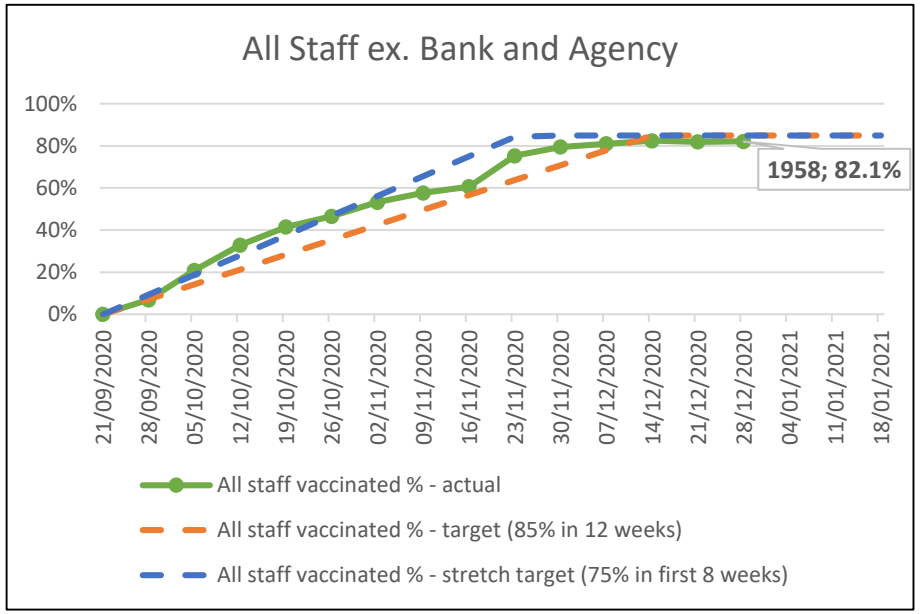
Compliance % highlighted in orange is between 75-79.99% meaning it below but close to the 80% target.

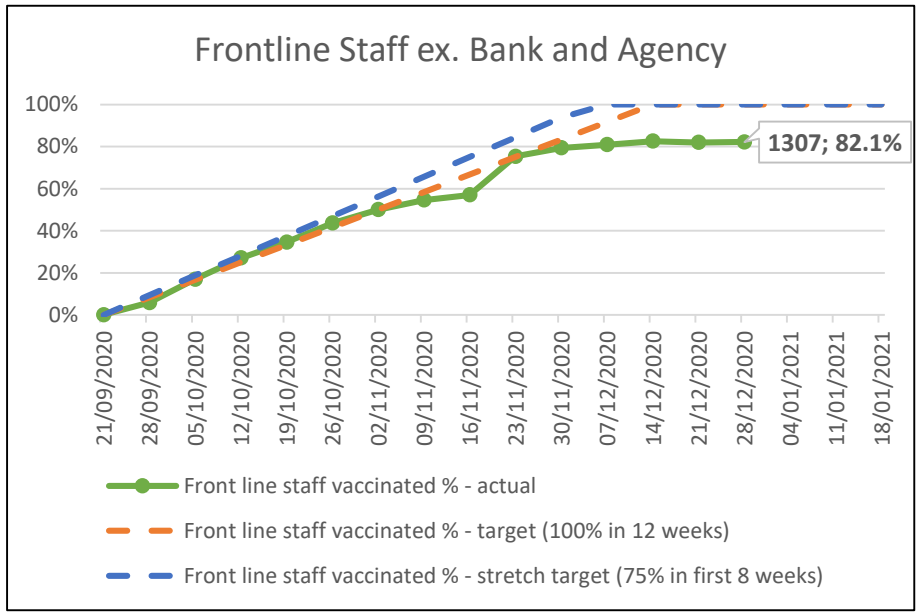
Compliance % highlighted in red is between 0-74.99%

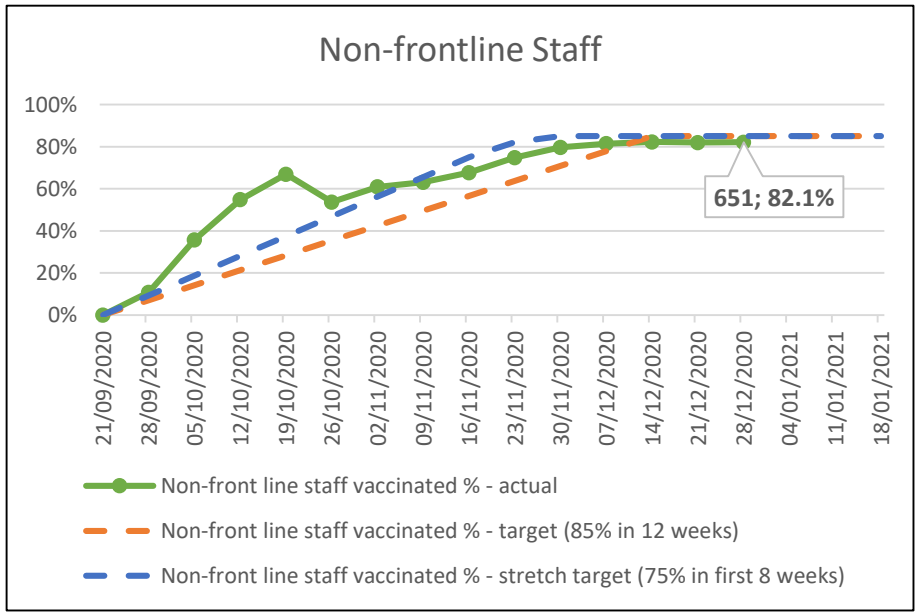
This does not include new starters for 3 months after their start date

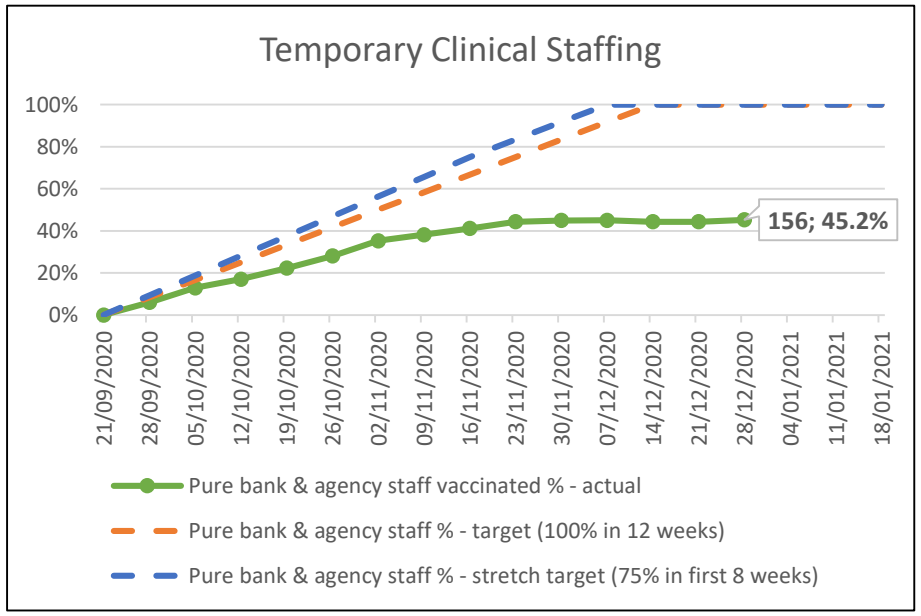
			20 December 2020				03 January 2021					
Subject	**Level**	**Frequency**	No Requiring	No Achieved	No NOT Achieved	Compliance	No Requiring	No Achieved	No NOT Achieved	Compliance	Current Compliance against Previous Compliance %	
Equality, Diversity and Human Rights		3 Years	2581	2419	162	93.72%	2613	2453	160	93.88%	Increase	0.15%
Hand Hygiene		3 Years	2581	2458	123	95.23%	2613	2482	131	94.99%	Decrease	-0.25%
Health and Safety		3 Years	2581	2446	135	94.77%	2613	2479	134	94.87%	Increase	0.10%
Information Governance (aka Data Security Awareness)		1 Year	2581	2275	306	88.14%	2612	2320	292	88.82%	Increase	0.68%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2581	2454	127	95.08%	2613	2484	129	95.06%	Decrease	-0.02%
Adult Basic Life Support		1 Year	2581	2114	467	81.91%	2613	2175	438	83.24%	Increase	1.33%
Fire Safety		2 Years	1295	1169	126	90.27%	1303	1176	127	90.25%	Decrease	-0.02%
		3 Years	1283	1215	68	94.70%	1308	1239	69	94.72%	Increase	0.02%
Immediate Life Support		1 Year	266	175	91	***65.79%***	264	177	87	***67.05%***	Increase	1.26%
Clinical Risk Assessment		3 Years	978	894	84	91.41%	982	898	84	91.45%	Increase	0.03%
Dementia Awareness		No Renewal	2310	2233	77	96.67%	2344	2263	81	96.54%	Decrease	-0.12%
Autism Awareness		No Renewal	2306	2241	65	97.18%	2340	2272	68	97.09%	Decrease	-0.09%
Mental Capacity Act	1	3 Years	1101	961	140	87.28%	1105	963	142	87.15%	Decrease	-0.13%
	2	3 Years	1121	991	130	88.40%	1150	1014	136	88.17%	Decrease	-0.23%
Deprivation of Liberty Safeguards	1	3 Years	2102	1948	154	92.67%	2132	1980	152	92.87%	Increase	0.20%
	2	3 Years	110	94	16	85.45%	112	96	16	85.71%	Increase	0.26%
Mental Health Act		3 Years	196	159	37	81.12%	198	160	38	80.81%	Decrease	-0.31%
Medicines Management Awareness		3 Years	538	454	84	84.39%	544	457	87	84.01%	Decrease	-0.38%
Rapid Tranquilisation		3 Years	299	262	37	87.63%	302	263	39	87.09%	Decrease	-0.54%
Respect	1	3 Years	1162	1033	129	88.90%	1190	1053	137	88.49%	Decrease	-0.41%
	2	2 Years	830	563	267	***67.83%***	837	567	270	***67.74%***	Decrease	-0.09%
	3	1 Year	391	224	167	***57.29%***	392	236	156	***60.20%***	Increase	2.92%
Safeguarding Children	2	3 Years	1121	978	143	87.24%	1147	1007	140	87.79%	Increase	0.55%
	3	3 Years	1100	882	218	80.18%	1107	902	205	81.48%	Increase	1.30%
Safeguarding Adults	2	3 Years	2220	1944	276	87.57%	2253	1985	268	88.10%	Increase	0.54%
Domestic Abuse	2	3 Years	2224	1919	305	86.29%	2257	1955	302	86.62%	Increase	0.33%
Prevent WRAP		3 Years	2219	1930	289	86.98%	2252	1976	276	87.74%	Increase	0.77%
Overall compliance						**89.61%**				**89.89%**	Increase	0.28%
Moving and Handling	1	3 Years	2581	2423	158	93.88%	2613	2445	168	93.57%	Decrease	-0.31%
	2	3 Years	737	599	138	81.28%	742	600	142	80.86%	Decrease	-0.41%

Flu Vaccination









AIM

We will protect our service users and colleagues by vaccinating our staff against flu.

Targets: 100% of frontline staff and 85% of all staff by 24 December (12 weeks from beginning of campaign).

NARRATIVE

Performance as at week ending 3rd January 21 is presented here.

- We have not hit our challenging targets.
- However, our flu vaccination campaign continues until the end of February 2021 and even at this stage, it has been our most successful vaccination effort for many years.
- We will continue to target teams and individuals to vaccinate as many people as possible.

Financial Overview as at 31 December 2020

PERFORMANCE INDICATORS		Annual Plan	Year to Date	Forecast 20/21
		£000s	£000s	£000s
1	Reported Surplus/ (Deficit) Position	(4,625)	340	(1,141)
2	Covid-19 reimbursement	7,216	5,310	6,351
3	Agency	5,025	3,580	4,772
4	Cash	62,868	67,912	54,103
4	Efficiency Savings (1% Cost Improvement from M7)	638	212	638
5	Capital	15,557	1,951	5,616
6	Better Payments Practice Code (BPPC) - % of bills paid in target		by number	98.6%
			by value	99.0%

NARRATIVE

The forecast outturn position has significantly improved from £2.1m as at November 2020 to £1.1m (47% reduction). This is due to continued mitigation work to reduce Out of Town (OOT) expenditure, reduced Covid-19 costs and a number of other non-recurrent items. Please see the Financial Overview and Forecast sections for further detail.

The Trust's recovery plans, stabilisation of Covid costs and reduced admission activity are contributing to the mitigation of the remaining deficit and its possible that further developments of these plans could see future reductions in forecast.

The forecast is moving in a positive direction, but it remains sensitive to the implementation and delivery of the recovery plans, and in particular to the ongoing impairment review of 2 major capital projects.

The Trust remains in a strong financial standing evidenced by its cash position, no debt facility and compliance with the Better Payments Practice Code (BPPC).

The Trust continues to exploit external income opportunities and has recently secured a £875k capital award from NHSE/I to facilitate a 10 bedded step down unit.

The current capital programme remains under tight review to ensure that effective use of the Capital Delegated Limit within this financial year. A revised capital plan was requested by the ICS in December which reflects the current understanding of plans across the organisation, however, this is likely to change as a result of the developing Acute modernisation plans and revised Estates strategy.

It is possible that during the final months of the year, that central national and/or local system funding may become available, which would impact our overall financial position.

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:

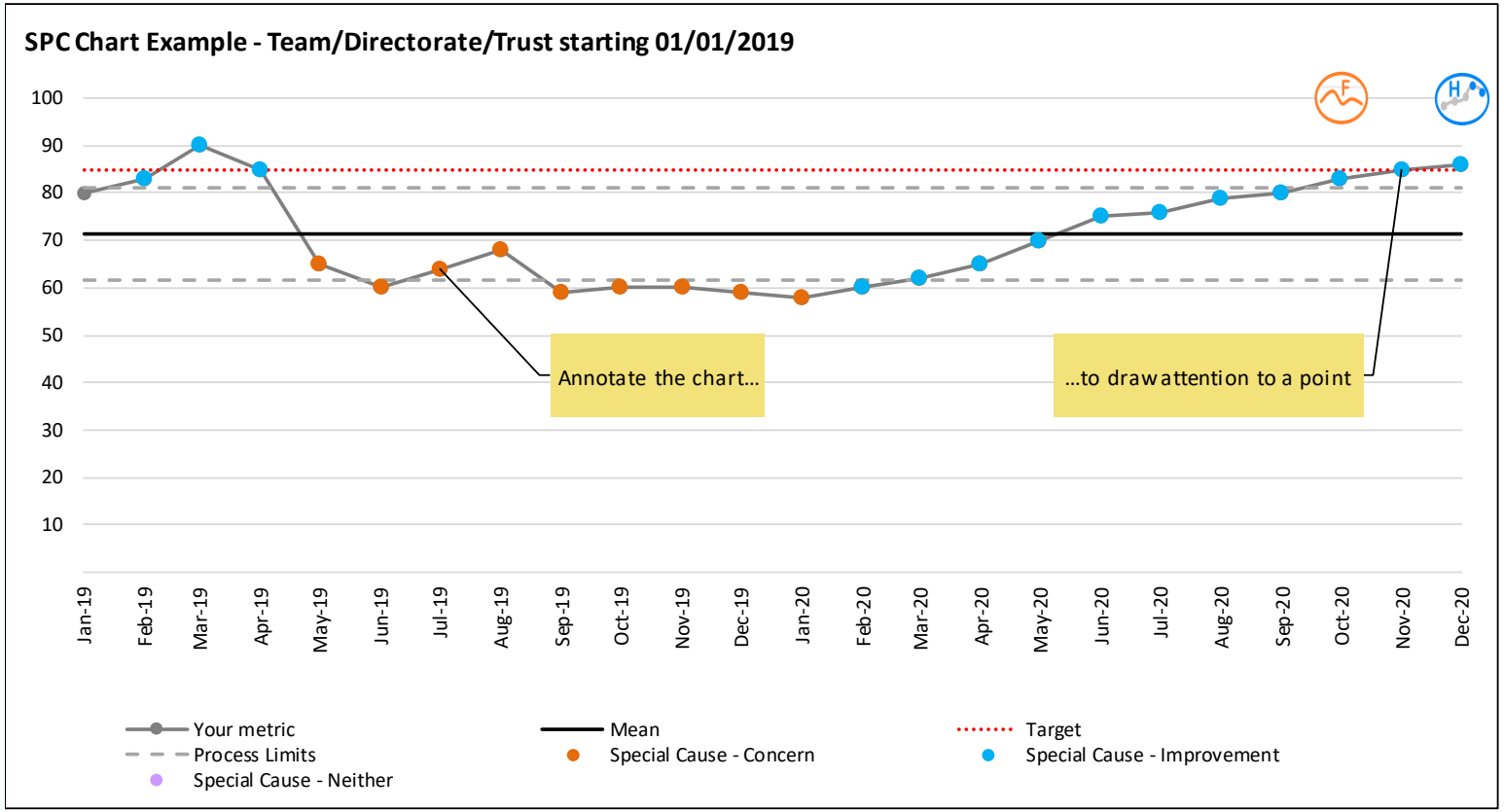
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

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									
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.