Board of Directors - Public

SUMMARY	Meeting Date:	25 May 2022
	Agenda Item:	11

Report Title:	**Integrated Performance and Quality Report (IPQR) March 2022**	
Author(s):	Deborah Cundey, Head of Performance Tania Baxter, Head of Clinical Governance and Risk	
Accountable Director:	Phillip Easthope, Executive Director of Finance, IMST & Performance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Quality Assurance Committee Finance and Performance Committee People Committee
	Date:	11 May 2022 12 May 2022 13 May 2022
Key Points recommendations to or previously agreed at:	The known areas of risk/concern for the attention of the Board are: • Waiting lists and waiting times for community services • Increasing caseloads/open episodes of care in Older Adult community services and Highly specialist community services • Increasing length of stay and flow problems through acute system • Failure to meet elimination/reduction in Out of Area placements in acute MH services • Persistent underperformance on annual review for service users on CPA, particularly in the South Recovery Team • Sickness absence rates are high • Overspend in areas associated with high out of area placement and agency costs The Board is asked to note the following areas of positive performance or improvement: • Increased demand/referrals into Highly Specialist services as a result of positive new offers (Insomnia course in the Short Term Education Programme STEP) and improved integration with Council and non-statutory providers in the Homeless Assessment Team (HAST) • Significant Improvements to length of stay averages in older adult wards G1 and Dovedale 1, as well as increased occupancy rates on G1. • Discharged length of stay on Forest Close rehabilitation wards has reduced below SHSC average and benchmarks favourably with other rehab/complex care beds nationally • IAPT exceeding 6- and 18-week waiting time targets, national benchmarks and meeting the recovery standard since October 2021	

	• Continued low use of restrictive practices on G1 and low instances of restrictive practice across the Rehabilitation & Specialist Directorate. • Low seclusion incidences across the Trust **Committee Recommendations** **Quality Assurance Committee** The Committee noted the significant amount of excellent performance as detailed in the summary and the improvements in the 72-hour follow up data quality and compliance. The committee recognises the particularly 'stuck' issues which continue to be raised as risks and highlight these again for the attention of the Board: 1. Flow in the acute adult system - a complex and complicated issue with significant quality; financial and reputational risks. 2. Unacceptable waiting lists and waiting times to assessment and treatment in a number of community services. There are services, for example, SAANS where we know we are working with commissioners on improved service models but we still need to be aware of the risks of the long waits. **Finance and Performance Committee** The Committee requested that all Recovery Plans contain improvement trajectories that align to future CIP plans, particularly in relation to the Out of Area use and spend. The Committee noted no further points for escalation in addition to those raised by Quality Assurance Committee. **People Committee** The Committee noted no further points for escalation from the IPQR in addition to those raised by Quality Assurance Committee.

Summary of key points in report

The IQPR is a monthly report that presents a full and detailed data set that is used to assure the Board about the performance and quality of service delivery. This report details data up to and including March 2022.

The report was presented and considered in detail to the Quality Assurance; Finance & Performance and People Committees in May with a summary of highlights and concerns. Those areas are further summarised below, and the detail can be found within the body of the report itself, or by reference to the respective committee Summary.

Good Performance									
Committee				KPI/Area	Refer to (slide)	Current Performance	Trend/Trajectory	Recovery Plan?
F	Q			Referrals to Community Services	5	H	Increasing referrals to Short Term Education Programme (STEP) and the Homeless Assessment Service (HAST)	
F	Q			Inpatient Length of Stay – Older Adults	9	L	Decreasing trend in Older Adult inpatient areas	G1 quality improvement plan.

F	Q			Inpatient Length of Stay – Forest Close Rehab	9	L P	Decreasing trend in Forest Close. Performance above national benchmarks	
F	Q			Annual CPA Review	12	H	Improving Performance in Recovery North	
F	Q			IAPT	13	H P	Sustained shift above average in Recovery Rate. Meeting/ Exceeding targets for waiting times	
	Q		M	Restrictive Practices	21-23	L	Decreasing trend and improvements on G1 Zero incidents in Rehab & Specialist Services Low numbers of Seclusion incidents Trustwide	
		P		Headcount/WTE	28	H	Increase in staff numbers	
	Q	P		Supervision	29	H P	Increasing trend in corporate and Rehabilitation & Specialist service areas	
	Q	P		Mandatory Training	31-32	P	Meeting/ Exceeding target Trustwide	

Performance Concern								
Committee				KPI/Area	Refer to (slide)	Performance	Trend/ Trajectory	Recovery Plan?
F	Q			Demand for Services	5	H	Increasing trend noted for Memory Service and SAANS	
F	Q			Waiting Lists and Waiting Times	6	H	Increasing trend/ sustained high waits in certain areas noted	Recovery Plan x 2 (EWS, Recovery Teams)
F	Q			Caseloads/Open Episodes	6	H	Increasing trend in older adult community services and Highly Specialist community services	Recovery Plan x 2 (Gender & SAANS)
F	Q			Length of Stay and Delayed Discharge (inpatient areas)	7-8	H	Increasing trend particularly in acute wards and Endcliffe PICU	Linked to Out of Area Recovery Plan(s) x 3
F	Q			Out of Area Placements	7-9	F	Failing to meet reduction/elimination of inappropriate OAPs	Out of Area Recovery Plan(s) x 3
F	Q			Annual CPA Review	12	F	Failing to meet 95% target	Recovery Plan in place.
F	Q			START – Referral to Assessment Waiting Times	14-15	L	RtA times below local target, December 21 improvements not sustained.	

	Q	P		Supervision	29	F	Failing to meet 80% target in some acute and community service areas.	CQC Back to Good Action Plan/Local Recovery Plans
		P		Sickness Absence	27	H F	Increasing trend Trustwide, with particular concern over Long Term sickness rates. Failing to meet Trust target	People delivery plan actions for 22/23 and additional investment to support absence management and wellbeing actions.
		P		Mandatory Training	31-32	F	Underperformance against 80/90/95% targets in some areas	
F				Agency and Out of Area Placement Spend	34	H F	Increased high levels of spend Failing to meet reduction/elimination of inappropriate OAPs	Out of Area Recovery Plan(s) x 3 CIP Plans 22/23

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

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

Is this report relevant to compliance with any key standards?					**State specific standard**
Care Quality Commission	**Yes**	✓	No		This report ensures compliance with NHS Regulation – CQC Regulation may be a by-product of this.
IG Governance Toolkit	Yes		No	✓	
Have these areas been considered? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	Yes	✓	No		Any impact is highlighted within relevant sections.
Financial (revenue &capital)	Yes	✓	No		CIP delivery is being offset by underspending on investments and COVID funding
OD/Workforce	Yes	✓	No		Any impact is highlighted within relevant sections.
Equality, Diversity & Inclusion	Yes	✓	No		Work looking at EDI concerns is underway which may suggest the inclusion of certain indicators as future developments occur.
Legal	Yes		No	✓	

Integrated Performance & Quality Report

Information up to and including March 2022

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Blue Underlined Text = Click to link to page

Report Layout | Information and metrics are grouped into the following themes in line with the proposed KPIs for 21/22 and the Trust Performance Framework.

- Service Delivery
- Safety & Quality
- Our People
- Financial Performance
- Covid-19

We use statistical process control (SPC) charts where possible in order to better understand what is natural variation (common cause) in performance and unusual patterns (special cause) in data which are unlikely to have occurred due to chance and require investigation. Using SPC can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting a target or standard without a change.

In this report we have introduced a variation on the SPC icons we are using in SPC charts to easily identify improvement or cause for concern, so that we can look at more information but still identify the points of interest.

You will see tables like this throughout the report, and there is further information on how to interpret the charts and icons in Appendices 1 and 2.

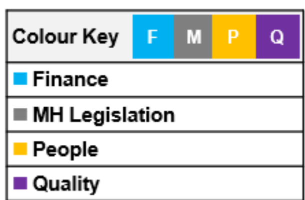
Unless otherwise stated the control limits (the range within which normal variation will occur) are set by 24 months of data points, for example in the case of April 2021 reporting, we are using monthly figures from May 2019 to April 2021. Where that much data is not available we use at least back to April 2020.

Ward	Month 1		
	n	*SPC variation*	*SPC target*
Ward 1	35.67	• L •	F
Ward 2	35.95	• • •	?
Ward 3	27.71	• • •	P
Ward 4	37.62	• • •	F
Ward 5	47.46	• • •	?
Ward 6	86.82	• • •	F
Ward 7	75.87	• L •	?
Ward 8	58.41	• H •	/

Variation		
Icon Pic	Cell Format	Description
	• • •	Common cause
	• L •	Improvement - where low is good
	• H •	Improvement - where high is good
	• L •	Concern - where high is good
	• H •	Concern - where low is good
	• ? •	Special cause - where neither high nor low is good
	• H •	Special cause - where neither high nor low is good - **point(s) above UCL or mean, increasing trend**
	• L •	Special cause - where neither high nor low is good - **point(s) below UCL or mean, decreasing trend**

Target		
Icon Pic	Cell Format	Description
	?	Pass/Fail: the system may achieve or fail the the target subject to random variation
	P	Pass: the system is expected to consistently pass the target
	F	Fail: the system is expected to consistently fail the target
	/	No target identified

In some cases we have 'baselines' in the data so that the control limits are set by an initial range of Data points and then remain the same. We use this to identify if there have been changes in the system. Monitoring referrals to services is a good example of where this is useful. We use Jan 19 to Mar 20 as a baseline (pre-Covid) and then can see whether activity has been impacted, returned to pre-covid levels or changed significantly. We have begun using and looking at the information in this way in our 'Floor to Board' Performance & Quality reviews with Clinical Directorates, and will continue to develop that way of working so that the data is intelligently reviewed at source and services and teams are able to investigate and provide narrative which supports the information.



Colour Key	F	M	P	Q
Finance				
MH Legislation				
People				
Quality				

Board Committee Oversight

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

Refer to Appendix 3 for detail.

Service Delivery

IPQR - Information up to and including March 2022

Responsive | Access & Demand | Referrals

Referrals	Mar-22			
Acute & Community	**n**	*mean*	**SPC variation**	**Note**
SPA/EWS	**808**	*741*	• • •	The significant sustained reduction in referrals since July 2021 was due to safeguarding referrals being directed to the Safeguarding Team instead of SPA. SPC charts and limits have now been recalculated to take this into account.
AMHP	**135**	*149*	• • •	
Crisis Resolution and Home Treatment	**903**	The implementation of the new Crisis Resolution & Home Treatment Team has resulted in a merge of 5 existing teams in Insight (Out of Hours Team and 4 Adult Home Treatment Teams). This happened mid February 2022. We are considering how we present the information in relation to this new team and its functions (i.e. Crisis Resolution >72hrs and longer term Home Treatment).		
Liaison Psychiatry	**488**	*517*	• L •	The last 9 months of referrals have been tracking just below the 36 month average calculated from January 2019. Service is investigating to understand if there is any underlying causes for the reduction, or reduced referrals from particular areas.
Decisions Unit	**56**	*59*	• • •	
S136 HBPOS	**20**	*33*	• L •	Admissions to S136 Place of Safety beds have been artificially low since November/December 2021 due to lack of system flow and the frequency of service users being detained to Maple Ward in these beds.
Recovery Service North	**20**	*22*	• • •	
Recovery Service South	**18**	*23*	• • •	
Early Intervention in Psychosis	**38**	*41*	• L •	The last 9 months of referrals have been tracking just below the 36 month average calculated from January 2019.
Memory Service	**118**	*134*	• • •	Memory Service referrals dropped significantly in the first Covid wave and did not recover to pre-covid levels until April/May 2021. Nationally there has been an increase in referrals in more recent months now that people are attending GPs etc. Service leads are working with CCG/NHS England about dementia care/delivery of model.
OA CMHT	**241**	*241*	• • •	
OA Home Treatment	**31**	*30*	• • •	

Referrals	Mar-22			
Rehabilitation & Specialist	**n**	*mean*	**SPC variation**	**Note**
Psychotherapy Screening (SPS)	**52**	*64*	• L •	Referrals to SPS have remained below the pre-covid average of 64 since April 2020.
Gender ID	**40**	*58*	• L •	Referrals to GI service have remained below the pre-covid average of 58 since April 2020.
STEP	**95**	*71*	• H •	Above the mean for 7 consecutive months. Positive indicator, majority referrals from primary care with popular course offers.
Eating Disorders Service	**34**	*28*	• • •	
SAANS	**438**	*170*	• H •	Continued upward demand, alternative service models being tested from May 22
R&S	**26**	*27*	• L •	Still below the pre-covid average.
Perinatal MH Service (Sheffield)	**58**	*56*	• • •	
HAST	**14**	*9*	• H •	Covid and service co location with the council has impacted referral rates.
CLDT	**53**	Insufficient data points to create SPC charts.		
CISS	**3**			
CERT				
SCFT				

Responsive | Access & Demand | Community Services

March 2022	*Per month*		*Number on wait list at month end*		*Average wait time referral to assessment for those assessed in month.*		*Average wait time referral to first treatment contact for those 'treated' in month.*		*Total number open to Service*	
Acute & Community Services	**Referrals (Number)**	**SPC variation**	**Waiting List (Number)**	**SPC variation**	**Average Waiting Time (RtA) in WEEKS**	**SPC variation**	**Average Waiting Time (RtT) in WEEKS**	**SPC variation**	**Caseload (Service)**	**SPC variation**
SPA/EWS	808	• • •	1317	• H •	34.6	• H •	30.8	• • •	760	• • •
AMHP	135	• • •	*N/A*		*N/A*		*N/A*		*N/A*	
Adult Home Treatment Service	Incomplete								60	• H •
MH Recovery North	20	• • •	81	• H •	11.1	• H •	17.6	• • •	959	• L •
MH Recovery South	19	• • •	74	• H •	17.6	• H •	14.9	• • •	1086	• H •
Recovery Service TOTAL	***38***		***155***	• H •	*N/A*		*N/A*		***2045***	• • •
Early Intervention in Psychosis	38	• L •	15	• • •	**69.2%**	• • •	*N/A. Refer to EIP AWT Standard.*		330	• L •
Memory Service	118	• • •	692	• H •	19.8	• • •	27.1	• • •	4561	• H •
OA CMHT	241	• • •	175	• H •	6.2	• • •	7.8	• • •	1273	• H •
OA Home Treatment	31	• • •	*N/A*		*N/A*		*N/A*		83	• H •
Rehabilitation & Specialist Services	**Referrals (Number)**	**SPC variation**	**Waiting List (Number)**	**SPC variation**	**Average Waiting Time (RtA) in WEEKS**	**SPC variation**	**Average Waiting Time (RtT) in WEEKS**	**SPC variation**	**Caseload (Service)**	**SPC variation**
SPS - MAPPS	*N/A*		69	• H •	18.4	• L •	68.0	• • •	308	• • •
SPS - PD	*N/A*		30	• L •	16.3	• L •	61.4	• • •	187	• L •
Gender ID	40	• L •	1577	• H •	147.2	• • •	Incomplete		2422	• H •
STEP	95	• H •	82	• • •	*N/A*		Incomplete		391	• H •
Eating Disorders Service	34	• • •	21	• • •	3.6	• • •	Incomplete		219	• H •
SAANS	438	• H •	4990	• H •	99.8	• H •	Incomplete		4881	• H •
R&S	26	• L •	233	• H •	*N/A*		Incomplete		239	• H •
Perinatal MH Service (Sheffield)	58	• • •	35	• H •	2.3	• • •	Incomplete		153	• H •
HAST	14	• H •	22	• • •	15.2	• • •	Incomplete		79	• • •
Health Inclusion Team	150		46		1.1		Incomplete		1264	
CFS/ME	127		Incomplete		16.0		Incomplete		Incomplete	
CLDT	53		186		19.4		16.6		888	
CISS	3		*N/A*		*N/A*		*N/A*		30	
CERT	4		0		0.0		0.0		47	
SCFT	2		0		0.0		0.0		23	

Narrative

In general, community services are experiencing high demand, increasing waits and high numbers of service users on service caseloads (the number of open episodes of care to our community teams). Demand is monitored regularly in the weekly produced Demand Monitoring dashboard, as well as being discussed in detail in Clinical Directorate performance and leadership meetings. Recovery Plans are in place for the services experiencing the biggest issues. A piece of work to understand service caseload numbers in detail and impact on staff wellbeing and service user experience across all our community services is underway.

Adult Acute (Burbage/Dovedale2, Stanage, Maple)	Benchmark/ Target	Mar-22 n	mean	SPC variation	SPC target
Admissions	/	29	36	• L •	/
Detained Admissions	/	29	31	• L •	/
% Admissions Detained	50%	100.0%	88.4%	• • •	/
Emergency Re-admission Rate (rolling 12 months)	10.3%	4.2%	4.3%	• L •	P
Discharges	/	28	36	• L •	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	5			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	121			
Bed Occupancy excl. Leave (KH03)	95%	97.6%	94.2%	• • •	?
Bed Occupancy incl. Leave	/	101.9%	98.4%	• • •	?
Average beds admitted to	/	48			
Average Discharged Length of Stay (12 month rolling)	32	37.3	36	• • •	F
Average Discharged Length of Stay (discharged in month)	32	51.3	38	• • •	/
Live Length of Stay (as at month end)	/	72.7	48	• H •	/
Number of Mental Health Out of Area Placements started in the period (admissions)	0 Inappropriate	10	9	• • •	?
Total number of Out of Area bed nights in period	0 Inappropriate	299	338	• • •	F
Total number of people in Out of Area beds in period	0 Inappropriate	20	20	• • •	F
Cost of Out of Area bed nights in period	0 Inappropriate	Refer to Directorate Finance Report			

Step Down (Wainwright Crescent)	Benchmark/ Target	Mar-22 n	mean	SPC variation	SPC target
Admissions	/	3	5.00	• • •	/
Discharges	/	7	6	• • •	
Bed Occupancy excl. Leave (KH03)	95%	70.97%	82.31%	• L •	?
Bed Occupancy incl. Leave	95%	78.01%	91.70%	• L •	?
Average Discharged Length of Stay (12 month rolling)	/	67.56	65.35	• • •	?
Live Length of Stay (as at month end)	/	33.71	45.70	• • •	/

Length of Stay Detail
Longest LoS (days) as at month end: **83**
Range = 0 to 83 days
Number of discharges in month: 7
Longest LoS (days) of discharges in month: 170

Length of Stay Detail
Longest LoS (days) as at month end: **275** on Dovedale 2
Range = 0 to 275 days
Number of discharges in month: 28
Longest LoS (days) of discharges in month: 453

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%

Benchmarking Out of Area
NEY Region monitor the number of service users placed inappropriately in Out of Area beds on the last day of each month. Figures below.

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

Narrative

Adult Acute Wards
Of those service users with the longest current length of stay, the longest on Dovedale 2 is awaiting outcome of assessment for Rehab (Forest Close) which took place on 28 April and another on Stanage Ward has complex onward care needs.

The Clinical Director is leading the flow improvement plan.

Step Down (Wainwright Crescent)
Occupancy at Wainwright has reduced during February & March in preparation for the move to new and improved environment at Beech (Lightwood Lane). The triumvirate leadership structure are supporting the programme of work to define the operational model, including length of stay, engagement with the VCSE and other organisations.

Inpatient Wards | PICU

		Mar-22			
PICU (Endcliffe)	Benchmark/ Target	n	*mean*	SPC variation	SPC target
Admissions	/	**4**	*3*	• • •	/
Discharges	/	**4**	*2*	• • •	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	**3**			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	**93**			
Bed Occupancy excl. Leave (KH03)	95%	**90.32%**	*91.24%*	• • •	?
Bed Occupancy incl. Leave	95%	**91.61%**	*93.63%*	• • •	?
Average beds admitted to	/	**9**			
Average Discharged Length of Stay (12 month rolling)	47	**48.58**	*49.87*	• • •	?
Live Length of Stay (as at month end)	/	**137.00**	*72.29*	• H •	/
Number of Out of Area Placements started in the period (admissions)	ZERO Inappropriate	**3**	*4*	• • •	?
Total number of Out of Area bed nights in period	ZERO Inappropriate	**167**	*151*	• • •	F
Total number of people in Out of Area beds in period	ZERO Inappropriate	**9**	*9*	• • •	F
Cost of Out of Area bed nights in period	ZERO Inappropriate	Refer to Directorate Finance Report			

Length of Stay Detail
Longest LoS (days) as at month end: **422**
Range = 6 to 422 days
Number of discharges/transfers in month: 8
Longest LoS (days) of discharges in month: 112

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

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

Narrative

In addition to the 4 discharges there were 4 transfers out of Endcliffe to other wards:-
2 x Stanage
1 x Dovedale 1
1 x Dovedale 2

Flow created with more PICU appropriate patients being admitted and discharged as per care plans and mutual step-up/step-down with internal Acute Wards to best respond to presenting need.

Of the three service users experiencing delayed discharge from Endcliffe ward, one has since moved on to Forest Close. We are engaging other system leaders to mobilise onward pathways of care for other long stay patients, including those identified as delayed discharges.

Safe | Inpatient Wards | Older Adults

Older Adult Functional (Dovedale 1)	Benchmark/ Target	Mar-22			
		n	mean	SPC variation	SPC target
Admissions	/	0	5	•••	/
Discharges	/	3	6	•••	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	2			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	40			
Bed Occupancy excl. Leave (KH03)	95%	90.11%	92.16%	•••	?
Bed Occupancy incl. Leave	95%	98.71%	96.83%	•••	?
Average beds admitted to	/	15			
Average Discharged Length of Stay (12 month rolling)	73	70.02	73.21	•••	?
Live Length of Stay (as at month end)	/	67.53	92.33	•••	/

Length of Stay Detail – Dovedale 1
Longest LoS (days) as at month end: **233**
Range = 6 to 233 days
Number of discharges in month: 3 discharges and 1 transfer
Longest LoS (days) of discharges in month: 77

Narrative

Both Older Adult wards continue to perform really well, with reducing length of stays (both wards now have a 12 month average discharged length of stay on or below the 20/21 national average of 73 days. There has been significant focus on reducing the LoS on Older Adults wards, the improvement aligns to the work undertaken, jointly with the Local Authority, to reduce the occurrence and duration of delayed discharges.
We are currently exploring social care placement discharge options for the service user with the longest length of stay on Dovedale 1 of 233 days.

G1 occupancy rates were low throughout March. During March there were 5 admissions who all required 1:1s for isolation with a further number of service users throughout the month who required 2:1 and 4 staff for personal care.

The one out of area admission was an appropriate placement (staff/family member).

Older Adult Dementia (G1)	Benchmark/ Target	Mar-22			
		n	mean	SPC variation	SPC target
Admissions	/	8	5.00	•••	/
Discharges	/	4	4	•••	/
Delayed Discharge/Transfer of Care (number of delayed discharges)	/	4			
Delayed Discharge/Transfer of Care (bed nights occupied by dd)	/	92			
Bed Occupancy excl. Leave (KH03)	95%	68.15%	67.78%	•••	?
Bed Occupancy incl. Leave	95%	68.75%	69.64%	•••	?
Average beds admitted to	/	11			
Average Discharged Length of Stay (12 month rolling)	73	60.89	67.79	• L •	?
Live Length of Stay (as at month end)	/	39.86	47.57	•••	/

Length of Stay Detail – G1
Longest LoS (days) as at month end: **115**
Range = 0 to 115 days
Number of discharges in month: 4 discharges and 3 transfers
Longest LoS (days) of discharges in month: 86

Older Adult (Out of Area)	Benchmark/ Target	Mar-22			
		n	mean	SPC variation	SPC target
Number of Mental Health Out of Area Placements started (admissions)	0 Inappropriate	1	1	• L •	?
Total number of Out of Area bed nights in period	0 Inappropriate	7	58	•••	?
Total number of people in Out of Area beds in period	0 Inappropriate	1	3	• L •	?
Cost of Out of Area bed nights in period	0 Inappropriate	Refer to Directorate Finance Report			

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)	Benchmark/ Target	Mar-22 n	mean	SPC variation	SPC target
Admissions	/	4	1.00	•••	/
Discharges	/	5	3	•••	/
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)	95%	84.41%	79.50%	•••	?
Bed Occupancy incl. Leave	95%	98.60%	91.93%	• H •	?
Average Discharged Length of Stay (12 month rolling)	441	325.65	315.45	•••	P
Live Length of Stay (as at month end)	/	348.24	352.10	•••	/
Number of Out of Area Placements started in the period (admissions)	0	0			
Total number of Out of Area bed nights in period	0	0			
Total number of people in Out of Area beds in period	0	0			
Cost of Out of Area bed nights in period	0	Refer to Directorate Finance Report			

Forensic Low Secure (Forest Lodge)	Benchmark/ Target	Mar-22 n	mean	SPC variation	SPC target
Admissions	/	2	1	•••	/
Discharges	/	0	1	•••	/
Bed Occupancy excl. Leave (KH03)	95%	82.11%	84.46%	• L •	?
Bed Occupancy incl. Leave	95%	85%	92%	•••	?
Average Discharged Length of Stay (12 month rolling)	707	453.07	400.87	•••	P
Live Length of Stay (as at month end)	/	485.05	456.34	•••	/

Forest Close

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

Length of Stay Detail - Forest Close (all)
Longest LoS (days) as at month end: 2114
Range = 15 to 2114 days
Number of discharges in month: 5
Longest LoS (days) of discharges in month: 783

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

Long stays

All service users with LoS over the average are actively monitored. The service user with the longest length of stay is awaiting admission to Sandford House. In turn, they are awaiting pending discharges to enable this admission.

Out of Area Rehab

Currently all Out of Area rehab admissions are deemed appropriate as are providing a specialist placement that Forest Close does not provide. At the end of March 2022 there were 7 patients OOA – all placed for a range of specialist needs. The team meet regularly to review service users in Out of Area beds and have expected discharge dates for all placements.

Forest Lodge

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

Long stays

All service users with LoS over the average are actively monitored. The service user with the longest length of stay is not ready for discharge are present. The team are working with commissioning colleagues and are happy at present with progress.

Length of Stay Detail
Longest LoS (days) as at month end: 2080
Range = 0 to 2080 days
Number of discharges in month: 0
Longest LoS (days) of discharges in month: N/A

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

Section intentionally blank.
Learning Disabilities Inpatient Service currently closed.

Narrative

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

Of note during March 22:

Achievements and good practice examples
- Engagement work
- Community productivity activity
- Community model development
- Learning disability in reach to inpatient services to support brief admissions

Concerns/Risks
- Forest Close admission
- Uncertainty around inpatient provision – communication with staff

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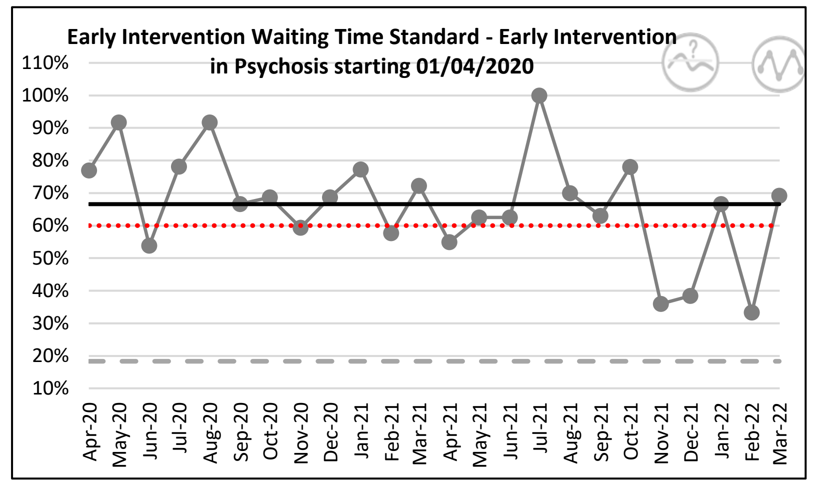
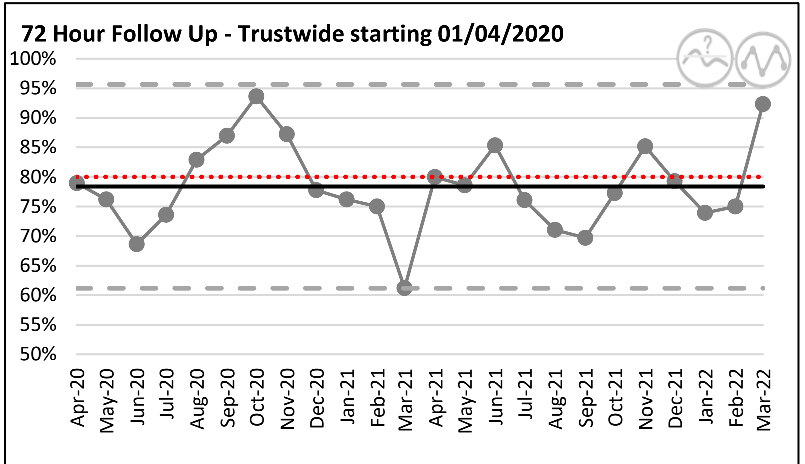
Effective | Treatment & Intervention





CPA Review % - Trustwide starting 01/04/2020

100% 95% 90% 85% 80% 75% 70% 65% 60%

Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22

EIP AWT Standard		Mar-22		
	Target 2021/22	n	SPC variation	SPC target
Trustwide	60%	**69%**	• • •	?

72-hour Follow Up		Mar-22		
	Target 2021/22	n	SPC variation	SPC target
Trustwide	80%	**92.3%**	• • •	?

CPA Annual Review % Compliance		Mar-22		
	Target 2021/22	n	SPC variation	SPC target
Trustwide	95%	**83%**	• • •	F
EIP	95%	**81%**	• L •	?
Recovery North	95%	**94%**	• H •	F
Recovery South	95%	**73%**	• L •	F

Narrative

2021/22 Standard: More than 60% of people experiencing a first episode of psychosis will be treated with a NICE approved care package. The standard has increased from 53% (18/19) to 56% (19/20) and to 60% with effect from 1 April 2021. It remains at 60% into the 2022/23 year.

There is variation month on month, and the average over the last 2 year period is 67% indicating the system is capable of achieving the 60% target.

Performance in:
March 22 - 69% (3/9)
Full Year 20/21 - 57% (70/122)
Q1 56% | Q2 74% | Q3 48% | Q4 56%

Narrative

The aim is to deliver safe care through ensuring people leaving inpatient services are seen within 72 hours of being discharged. Data shown above is for ALL eligible discharges from inpatient areas. Previously this has been reported as discharged patients on CPA.

Performance in March 22 was 92% against the 80% target. There were 26 discharges. 24 of the 26 were followed up within 72 hours. The 2 not followed up within 24 hours were followed up within working hours on day 4 and 5 respectively.

We are actively addressing data quality issues to ensure the accuracy of data.

Narrative

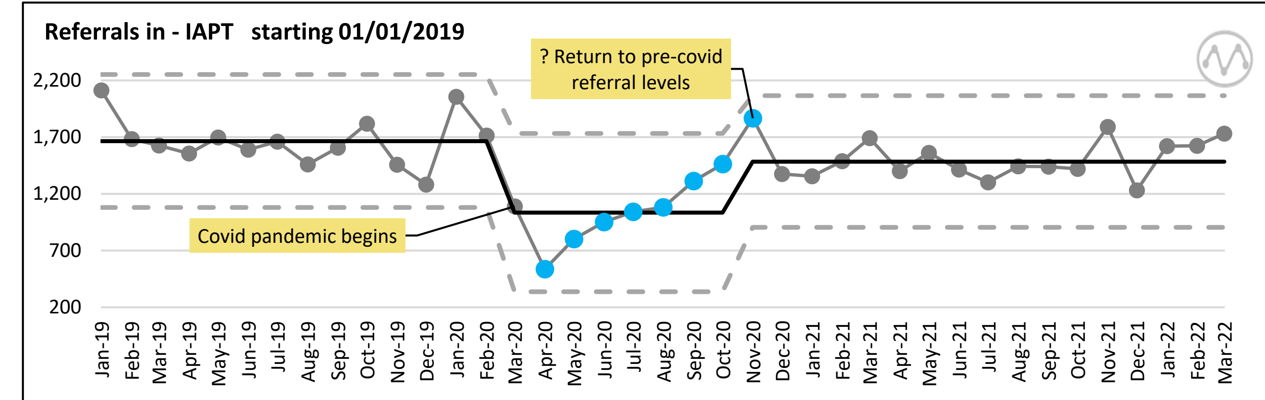
Weekly reports are in place and improvements are seen in Recovery North Team but have not been sustained in the South. Early intervention activity has dropped as a result of significant absence and vacancies within the service.

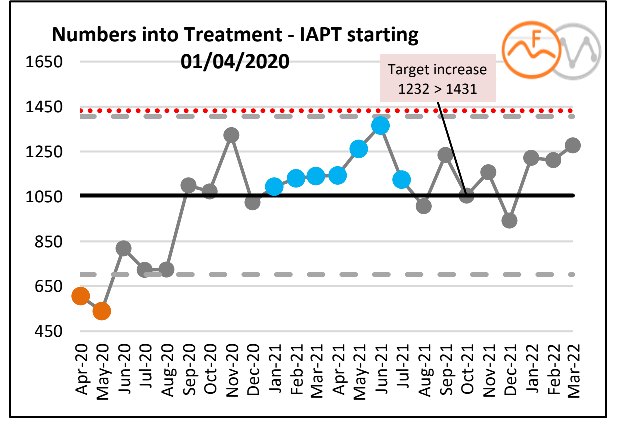
A time limited group has been set up to outline proposals for the process, systems and measurement of the 5 principles that have replaced CPA by end March 2022. However, the focus remains on ensuring completion of annual CPA reviews until alternative systems are in place.

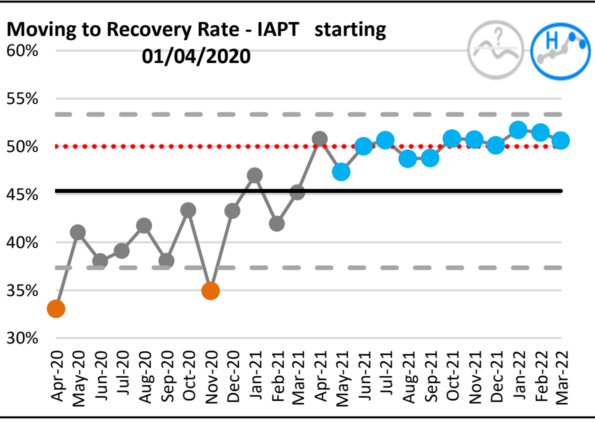
IAPT | Performance Summary

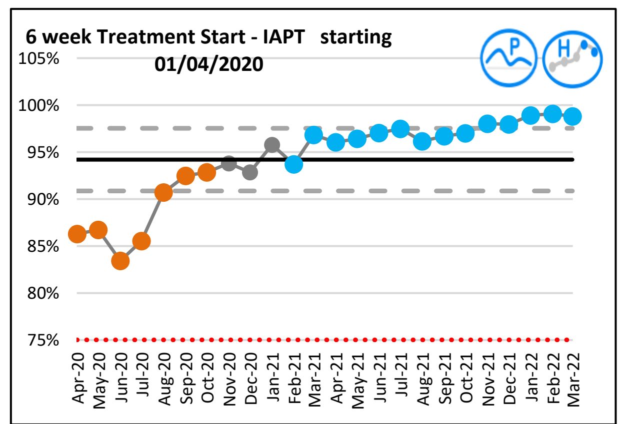
IAPT		Mar-22			
Metric	Target 2021/22	n	*mean*	SPC variation	SPC target
Referrals	n/a	**1732**	*1484*	• • •	/
New to Treatment	1232 (Apr - Sep 21) 1431 (Oct 21 - Mar 22)	**1277**	*1054*	• • •	?
6 week Wait	75%	**98.8%**	*94.2%*	• H •	P
18 week Wait	95%	**100.0%**	*99.6%*	• • •	P
Moving to Recovery Rate	50%	**50.6%**	*45.4%*	• H •	?

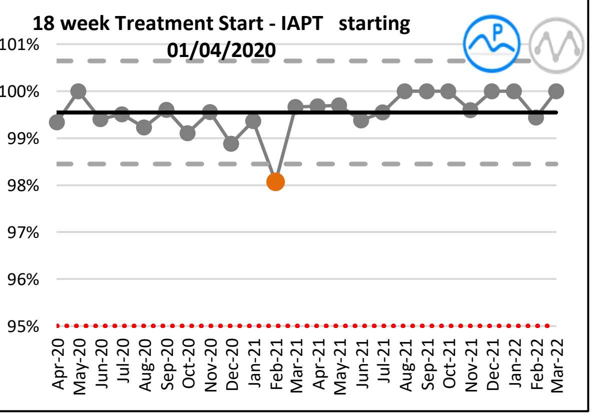
**Process limits recalculated from March 2020 and November 2020. Pre-covid average referrals per month were 1666. Post-covid average is 1484.*











Narrative

Access
Referrals in to IAPT are increasing month by month with a total of 1732 referrals in March. Access in to treatment is also increasing monthly too which is a positive for the service.

Waiting Times
Continue to consistently exceed waiting time standard. 98% of people seen for treatment in less than 6 weeks (target 75%) and 100% of people seen for treatment in less than 18 weeks (target 95%).

Recovery
Achieved the Recovery rate standard for last 6 months with March being: 50.6%

START – Sheffield Treatment & Recovery Team | Performance Summary

START		March-22		
Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	76	• • •	/
Waiting time Referral to Assessment ≤ 7 days	≥ 95%	89%	• L •	P
Waiting time Referral to Treatment ≤ 21 days	≥ 95%	100%	• • •	P
DNA Rate to Assessment	≤ 15%	23%	• • •	• • •
Recovery - Successful treatment exit	TBC	2	• • •	/
Non-Opiates	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	60	• • •	/
Waiting time Referral to Assessment	≥ 95%	78%	• L •	• • •
Waiting time Referral to Treatment	≥ 95%	100%	• • •	• • •
DNA Rate to Assessment	≤ 15%	32%	• H •	• • •
Recovery - Successful treatment exit	TBC	16	• • •	/
Alcohol	**Target 2021/22**	**n**	**SPC variation**	**SPC target**
Referrals	TBC	187	• • •	/
Waiting time Referral to Assessment	≥ 95%	79%	• L •	P
Waiting time Referral to Treatment	≥ 95%	100%	• H •	P
DNA Rate to Assessment	≤ 15%	29%	• H •	• • •
Recovery - Successful treatment exit	TBC	58	• • •	/

Narrative

Waiting Times

Wait times to assessment are improving but remain a challenge across the service. In Opiates, all breach waits were 8 days. In Alcohol, 90% of breaches were 8 days. In Non-opiates the breach waits were between 8 to 10 days. Average waiting times between referral to assessment remain below 7 days across all treatment services.
Breaches by exception are agreed by team leaders and if earlier slots become available these will be offered to service users.

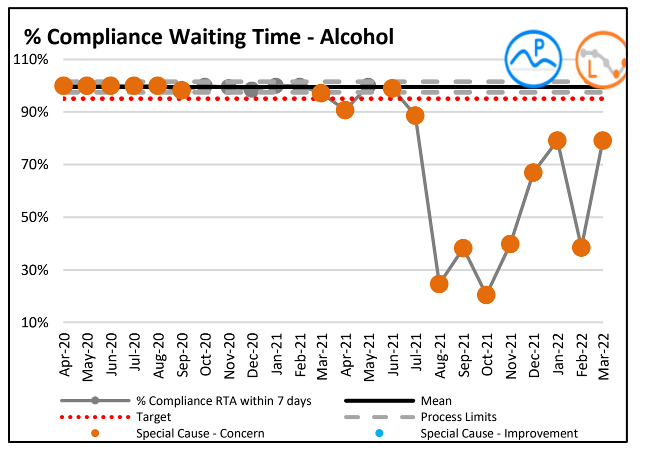
Recovery

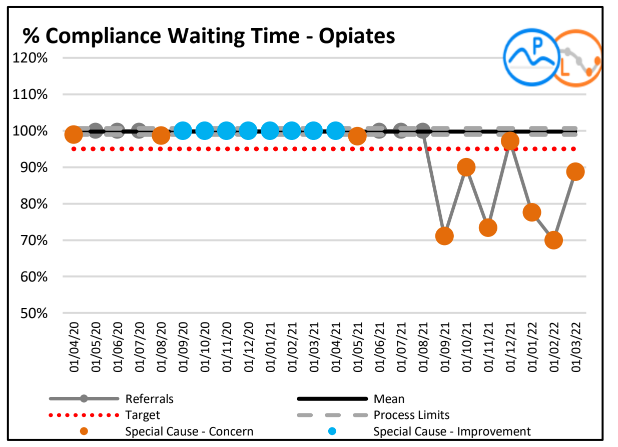
Due to the open access nature of the service, service users historically find it easier to drop out of treatment. The service has previously worked towards a target for the percentage of positive discharges (defined as discharge drug free/occasional user or a planned discharge with treatment goals met).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

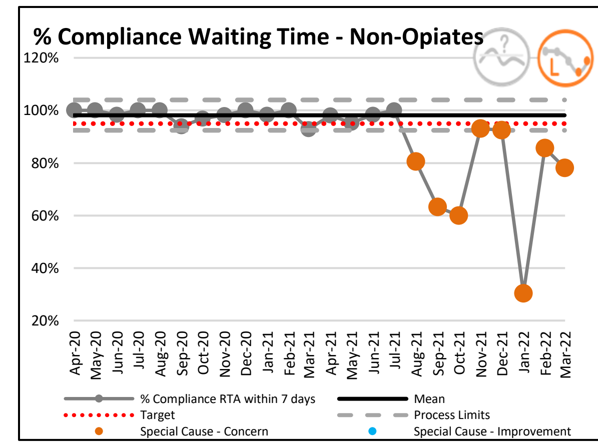
Engagement

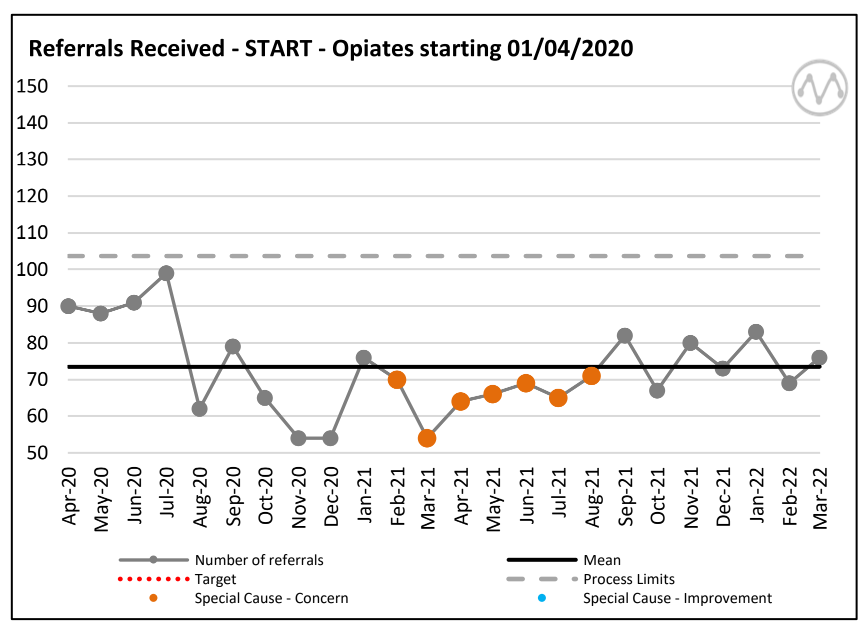
Referral numbers to the opiates, alcohol and non-opiates services are not currently working to a target but this is in discussion with the commissioner. The service provides open access to treatment regardless of any previous presentations or drop-outs. For this reason, there is a group of service users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

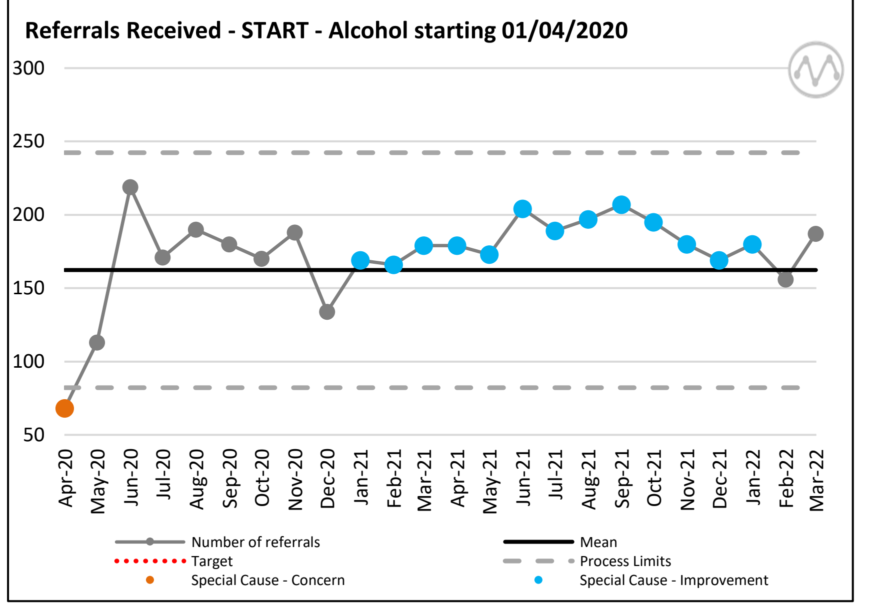
START Performance | Highlights & Exceptions











Narrative

Wait times to assessment

Wait times to assessment have improved in March.

Vacancies (recruitment is underway) and leave in the services have both affected the service ability to maintain low wait times to assessment during March.

Assessment slots are often overbooked to take advantage of the DNA rate.

Wait times to starting structured treatment are not affected, with 100% of service users seen for first treatment contact within 21 days of referral.

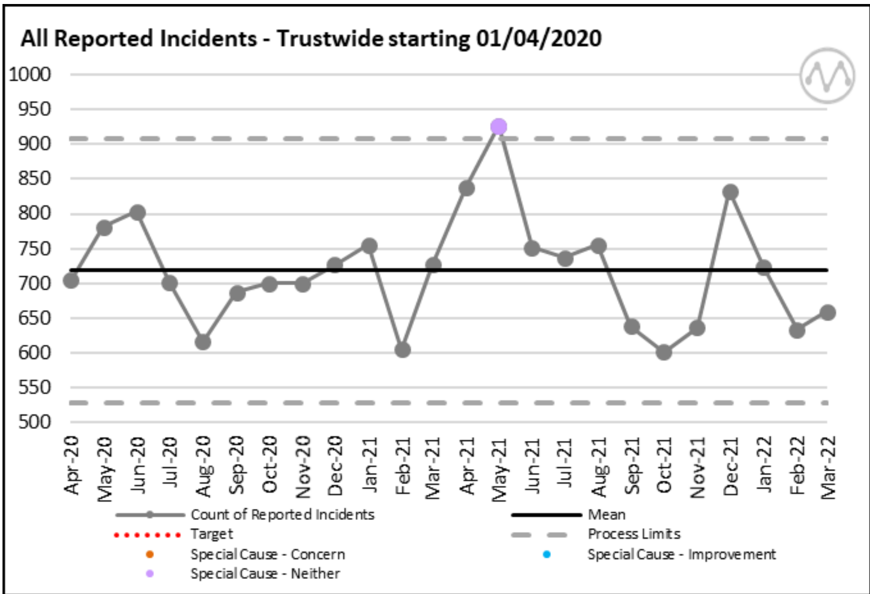
Referrals (Numbers In) Narrative

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

Safety & Quality

IPQR - Information up to and including March 2022

Safe | All Incidents

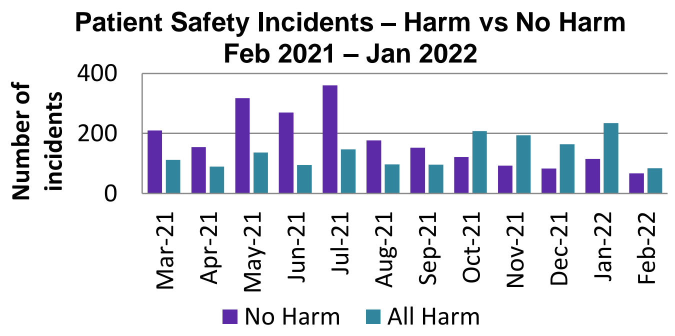


Trustwide	Mar-22		
	n	mean	SPC variation
ALL	**659**	718	•••
5 = Catastrophic	20	15	•••
4 = Major	3	5	•••
3 = Moderate	58	45	•••
2 = Minor	280	198	•••
1 = Negligible	277	437	•••
0 = Near-Miss	21	19	• H •

Narrative

Patient safety incidents are uploaded to the National Reporting Learning System (NRLS). Benchmarking information is released annually with the last covering April 2020 – March 2021. This shows SHSC's patient safety incident reporting rate at 76.6 incidents per 1000 bed days. Nationally, for mental health trusts, this rate varies from 21.6 to 235.8. Regionally, this rate varies from 45.1 to 114.6 patient safety incidents reported per 1,000 bed days.

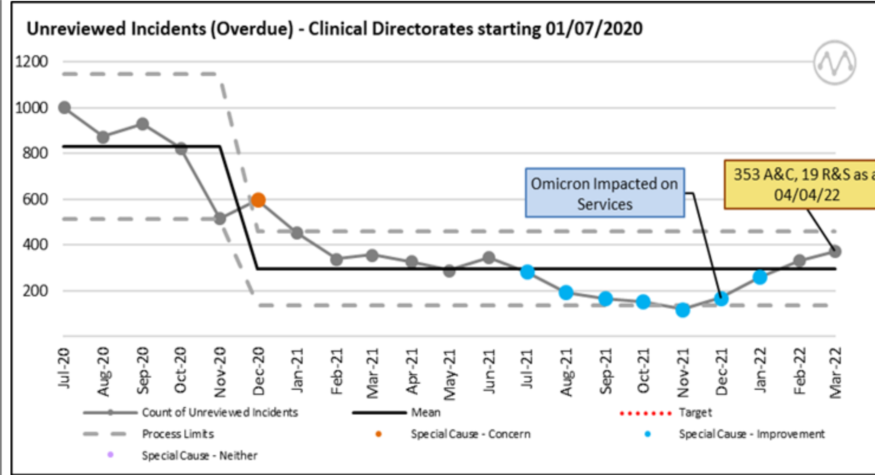
The chart below shows SHSC patient safety incidents reported where harm was caused compared to no harm caused from Mar 2021 to Feb 2022.



There were 3 major incidents reported in March 2022:

1. Service user testing positive for Covid-19
2. 16 year-old requiring admission
3. Service user admitted to general hospital having a cardiac arrest.

Near miss incidents are showing as special cause variation and is caused by a small number of security and clinical records errors. This will continue to be monitored to understand any potential changes in reporting.



Narrative

The unreviewed incidents can be accounted for by one ward (Acute and Community) which is being addressed.

Serious Incident Actions Outstanding

As at 4 April 2022, there were 113 outstanding SI actions overdue.

- 58 of these are from SIs in 2020
- 55 of these are from SIs in 2021

Weekly reports are being sent to identified matrons and general managers to oversee and complete all SI action plans.

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

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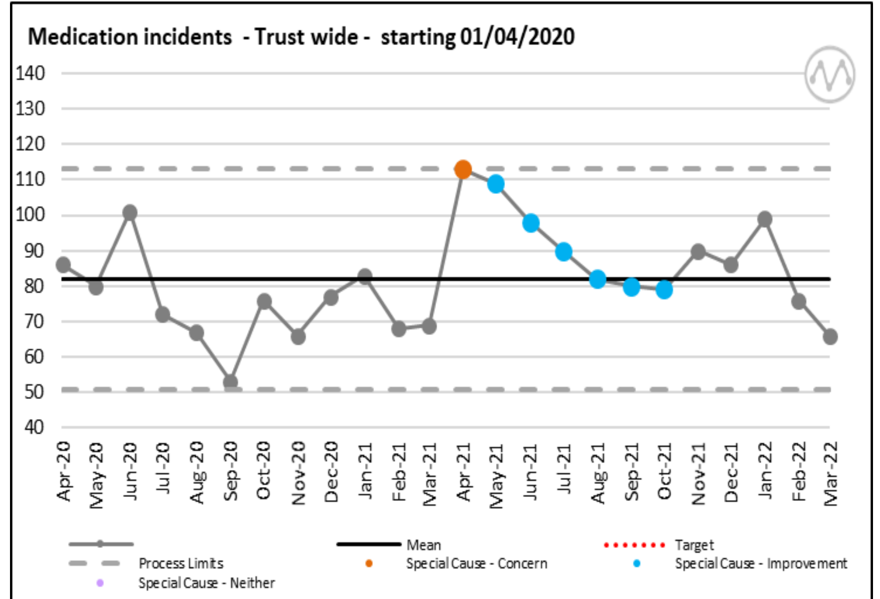
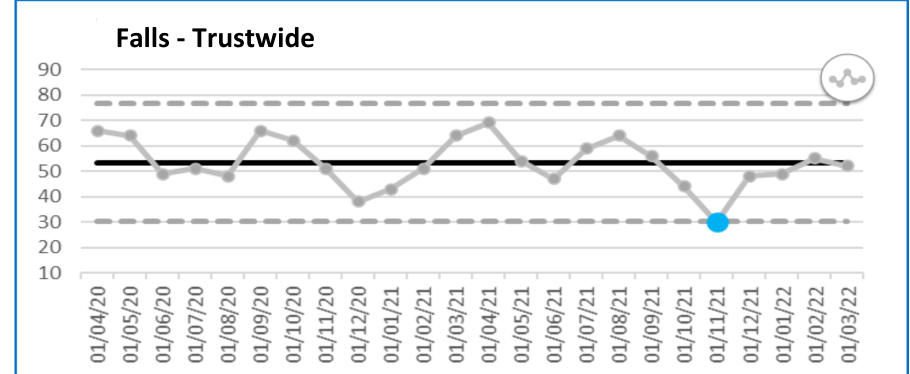
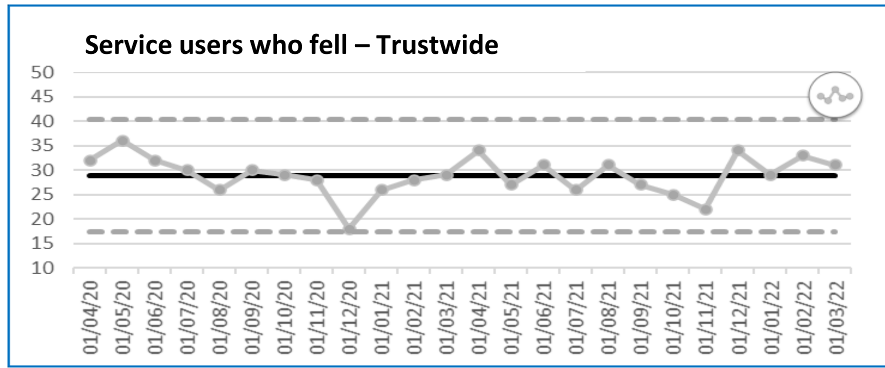
Safe | Medication Incidents & Falls



Trustwide	Mar-22		
	n	*mean*	SPC variation
ALL	66	*82*	•••
Administration Incidents	13	*16*	•••
Meds Management Incidents	41	*52*	•••
Pharmacy Dispensing Incidents	8	*7*	•••
Prescribing Incidents	4	*6*	•••
Meds Side Effect/Allergy Incidents	0	*0*	•••



Trustwide FALLS INCIDENTS	Mar-22		
	n	*mean*	SPC variation
Trustwide Totals	52	*53*	•••
Acute & Community	50	*50*	•••
Rehabilitation & Specialist Services	2	*3*	•••



Trustwide FALLS INDIVIDUALS	Mar-22		
	n	*mean*	SPC variation
Trustwide Totals	31	*29*	•••
Acute & Community	29	*26.5*	•••
Rehabilitation & Specialist Services	2	*3*	•••

Narrative

Medication Incidents

There was 1 moderate medication incident reported in March 2022, at one of SHSC's residential homes and involved a service user being found with two pain relief patches at the same time. These are applied every 7 days, and were applied at different times, however, the old one was not removed. A significant event analysis has been undertaken following this.

Falls Incidents

No moderate or above falls incidents were reported in the month. 16 out of the 52 falls during March 2022 resulted in bruising/swelling, tenderness, grazing/abrasion or superficial wounds to service users.

Safe | Assaults, Sexual Safety & Missing Patients

Assaults on Service Users	Mar-22		
	n	*mean*	SPC variation
Trustwide	**25**	*21*	• • •
Acute & Community	**22**	*18*	• • •
Rehab & Specialist	**3**	*3*	• • •

Assaults on Staff	Mar-22		
	n	*Mean*	SPC variation
Trustwide	**74**	*84*	• • •
Acute & Community	**64**	*66*	• • •
Rehab & Specialist	**10**	*17*	• • •

Narrative

Assault to Staff

There were 10 moderate incidents reported this month. Incidents that result in a service user being secluded, or where mechanical restraint is used, are classified as moderate, irrespective of the level of harm (if any) caused as a result of the assault.

Assault on Service Users

No moderate or above assaults on service users were reported during March 2022.

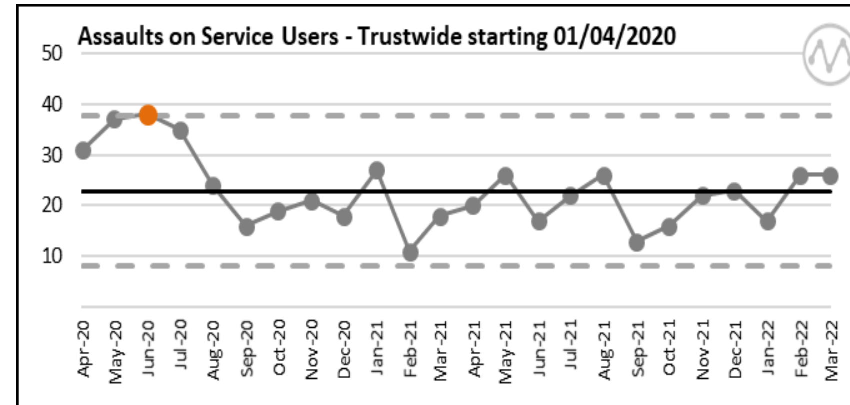
Sexual Safety

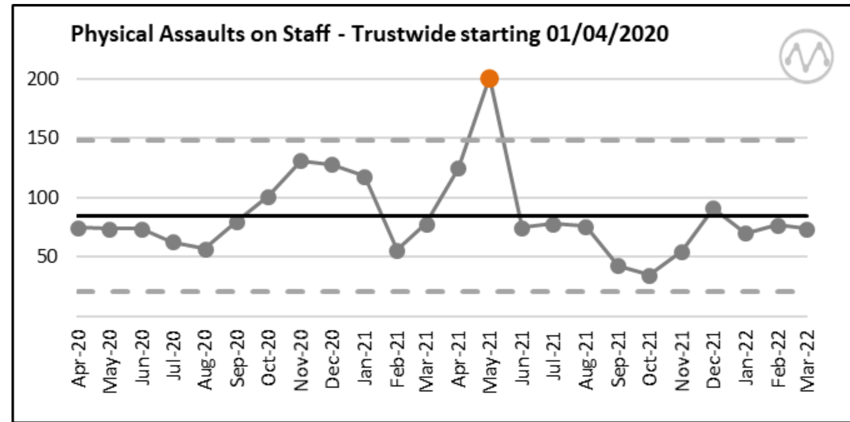
There were 2 moderate sexual safety incidents reported in March 2022. One was an alleged historical allegation, the other involved inappropriate touching. Both were referred to Safeguarding.

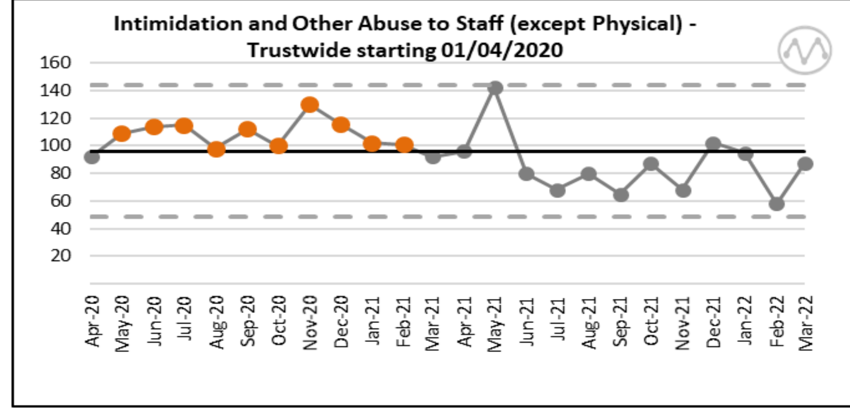
Missing Patients

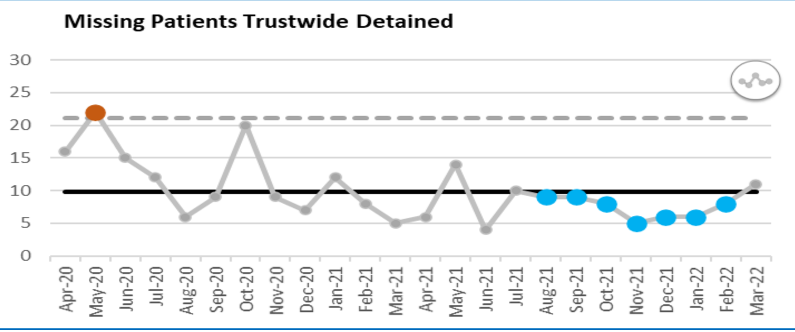
Low numbers of informal patients across SHSC is causing this to drop below the mean, suggesting special cause variation..

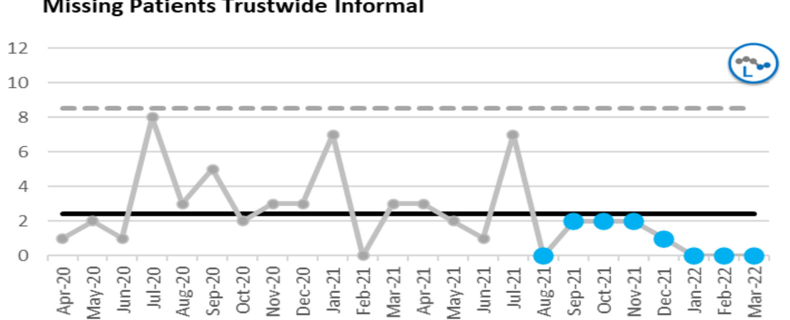
Protecting from avoidable harm	Target	YTD
Reportable Mixed Sex Accommodation (MSA) breaches	0	0



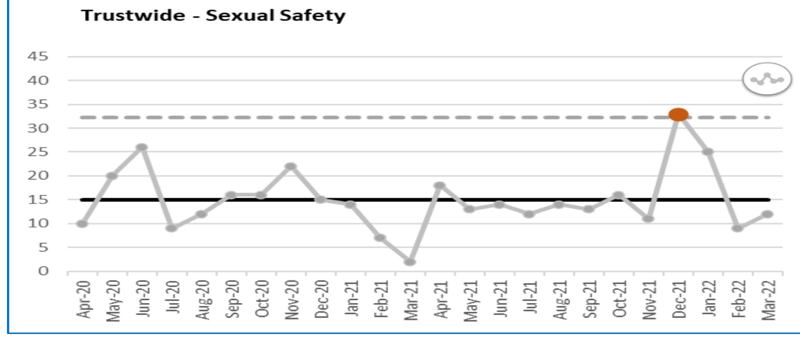




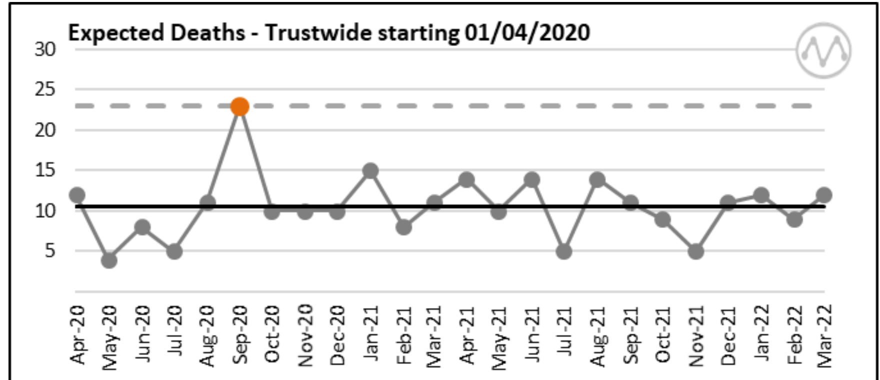


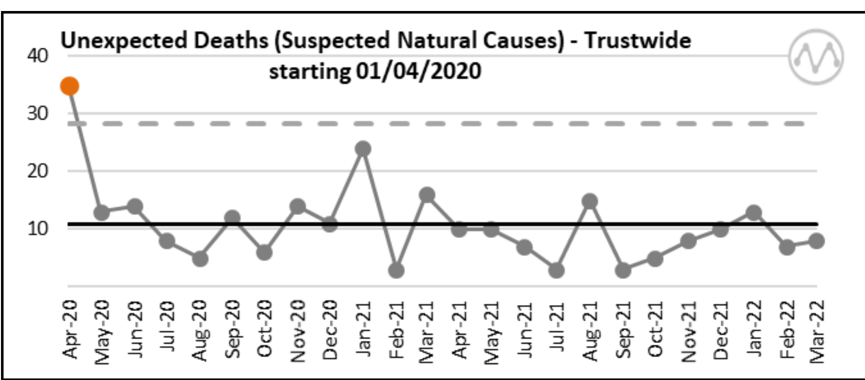


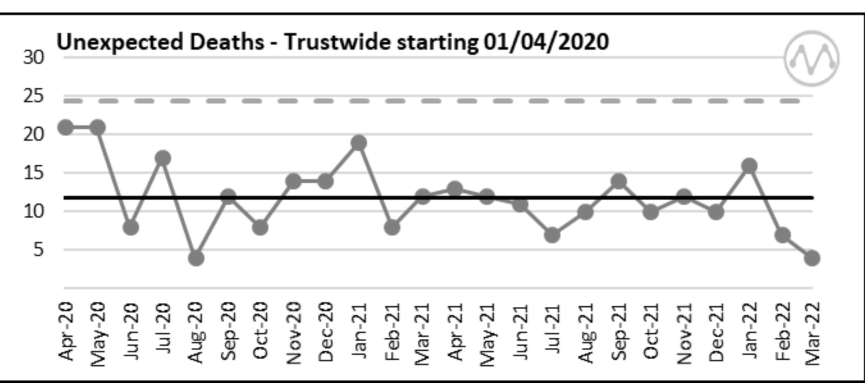
Missing Patients	Mar-22		
	n	mean	SPC variation
Detained	11	*10*	• • •
Informal	0	*2*	• L •



Deaths

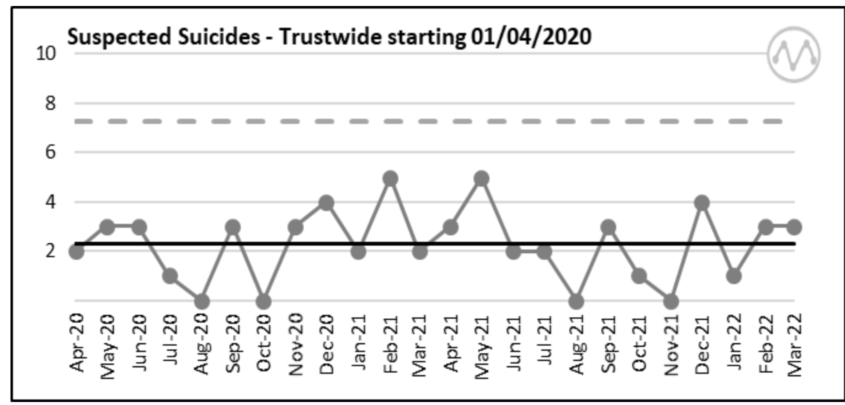






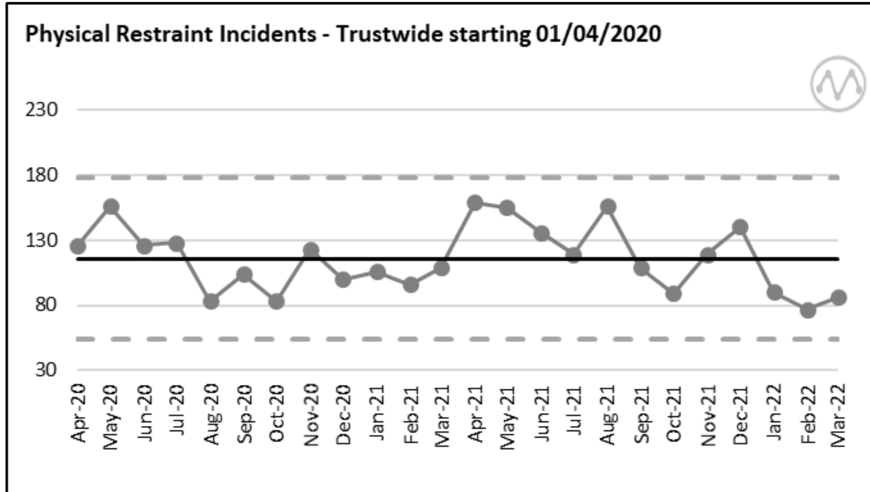
Quarterly mortality reports are presented to the Quality Assurance Committee and Board of Directors.

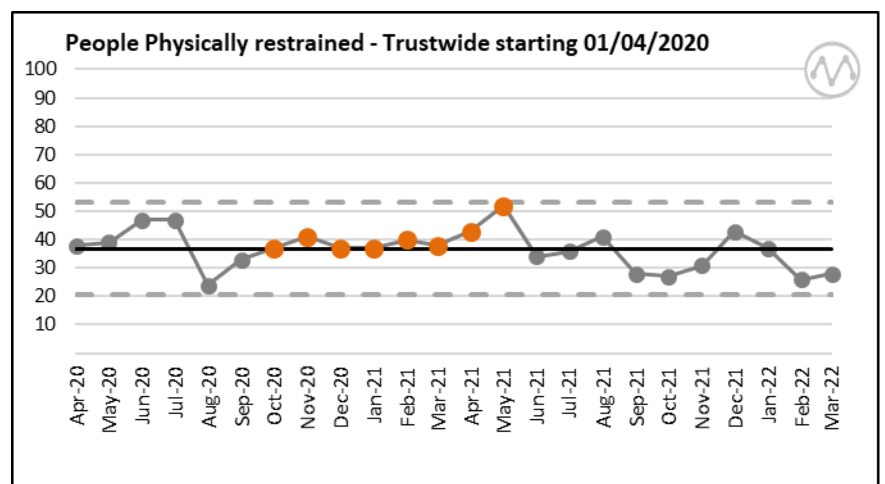
Deaths Reported 1 April 2020 – 28 February 2022	
Awaiting Coroners Inquest/Investigation	178
Conclusion - Narrative	8
Conclusion - Suicide	16
Conclusion – Accidental	3
Conclusion – Misadventure	2
Conclusion – Open	1
Natural Causes/No Inquest	613
Alcohol/Drug related	25
Suspected Homicide/Closed	2
Ongoing	1
Grand Total	**853**



COVID-19 Deaths 1 March 20 - 28 February 2022	
ATS (Firshill Rise)	1
Birch Ave	5
CISS (LDS)	1
CLDT	6
G1 Ward	6
Liaison Psychiatry	6
LTNC	3
Memory Service	7
Mental Health Recovery Team	2
Neuro Case Management Team	1
Neuro Enablement Service	3
OA CMHT North	20
OA CMHT South	22
OA CMHT West	5
OA Home Treatment	3
START Alcohol Service	1
START Opiates Service	1
Woodland View | Oak Cottage	2
Grand Total	**93**

Safe | Restrictive Practice | Physical Restraint





Physical Restraint INCIDENTS	Mar-22		
	n	*mean*	SPC variation
Trustwide Totals	**86**	*119*	• • •
Acute & Community	**86**	*103*	• • •
Burbage Ward	**13**	*15*	• • •
Stanage Ward	**27**	*15*	• • •
Maple Ward	**18**	*14*	• • •
HBPoS (136 Suite)	**0**	*1*	• • •
Endcliffe Ward	**12**	*27*	• • •
Dovedale	**11**	*21*	• • •
G1 Ward	**2**	*8*	• L •
Birch Ave	**2**	*1*	• • •
Woodland View	**0**	*1*	• • •
Rehabilitation & Specialist Services	**0**	*0*	• • •
Forest Close	**0**	*1*	• • •
Forest Lodge	**0**	*1*	• • •

Physical Restraint INDIVIDUALS	Mar-22		
	n	*mean*	SPC variation
Trustwide Totals	**28**	*21*	• • •
Acute & Community	**28**	*17*	• • •
Burbage Ward	**5**	*2*	• • •
Stanage Ward	**8**	*3*	• • •
Maple Ward	**3**	*3*	• • •
HBPoS (136 Suite)	**0**	*1*	• • •
Endcliffe Ward	**7**	*5*	• • •
Dovedale	**1**	*0*	• • •
G1 Ward	**2**	*2*	• • •
Birch Ave	**1**	*0*	• • •
Woodland View	**0**	*0*	• • •
Rehabilitation & Specialist Services	**0**	*0*	• • •
Forest Close	**0**	*0*	• • •
Forest Lodge	**0**	*1*	• • •

Narrative

Physical Restraint

86 physical restraints were recorded in March 2022. Numbers remain low on G1 after showing another decrease this month. The work to encourage and promote the reduced used of restraint continues and is discussed through the safety huddles, Purposeful Inpatient Admission (PIPA), including service users in MDTs, patient-led care plans and DRAMs and having therapy staff on the ward.

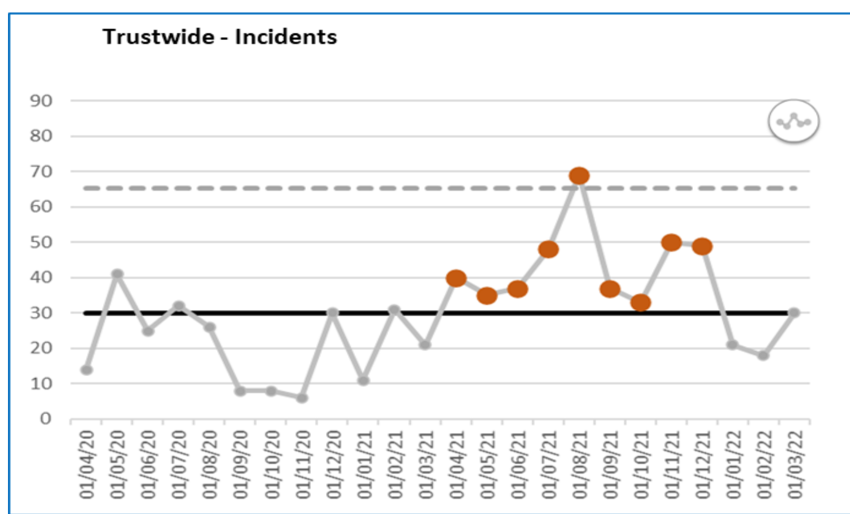
Stanage ward have not maintained previous progress with restraint and the team are being supported to reflect on approach.

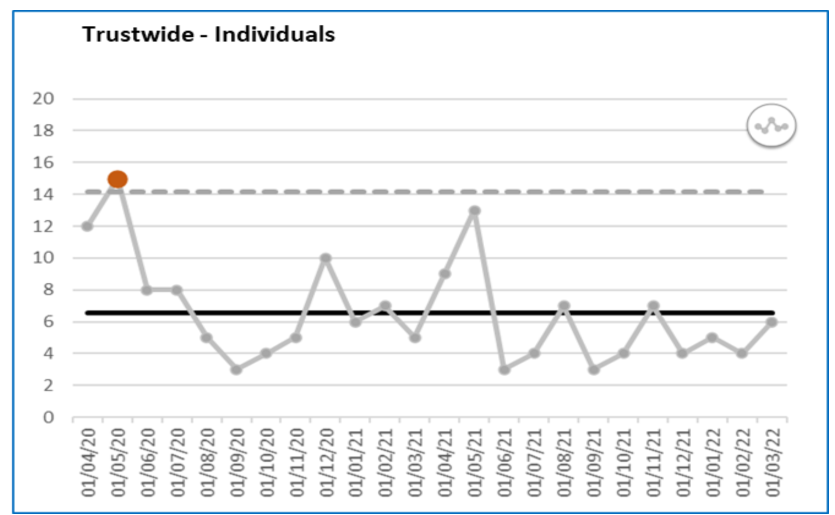
There have been no reported incidents of any type of restrictive practice in the Rehab & Specialist Directorate in March 22.

Mechanical Restraint

During March 2022 there were four reported instances of mechanical restraint. Two of these involved secure transport services transferring patients, one involved the police assisting the transfer of a patient, the other involved the use of a bed sheet to slide a service user from a communal area into a more private location due to their vulnerabilities and exposing themself. The use of a sheet has been carefully considered to establish if it was appropriate. The CQC have been informed.

Safe | Restrictive Practice | Rapid Tranquillisation





Rapid Tranquillisation INCIDENTS	Mar-22		
	n	*mean*	SPC variation
Trustwide	30	*30*	• • •
Acute & Community	30	*30*	• • •
Burbage Ward	13	*6*	• • •
Stanage Ward	4	*3*	• • •
Maple Ward	6	*4*	• • •
HBPoS (136 Suite)	0	*0*	• • •
Endcliffe Ward	1	*6*	• • •
Dovedale	5	*10*	• • •
G1 Ward	0	*1*	• L •
Rehabilitation & Specialist	0	*0*	• • •
Forest Close	0	*0*	• L •
Forest Lodge	0	*0*	• • •

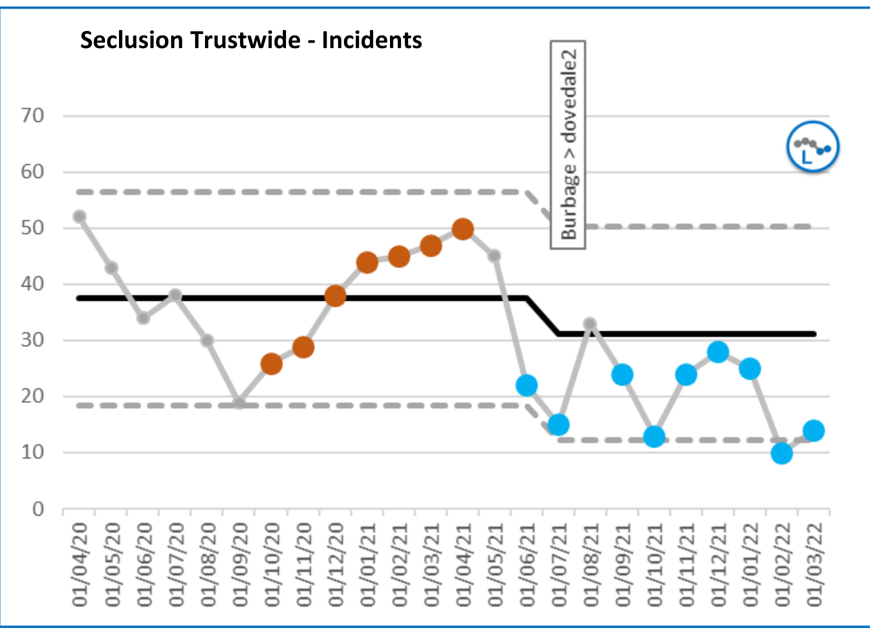
Rapid Tranquillisation INDIVIDUALS	Mar-22		
	n	*mean*	SPC variation
Trustwide	12	*11*	• • •
Acute & Community	12	*10*	• L •
Burbage Ward	5	*3*	• • •
Stanage Ward	2	*2*	• • •
Maple Ward	2	*2*	• • •
HBPoS (136 Suite)	0	*0*	• • •
Endcliffe Ward	1	*2*	• • •
Dovedale	1	*1*	• • •
G1 Ward	0	*1*	• • •
Rehabilitation & Specialist	0	*0*	• • •
Forest Close	0	*0*	• L •
Forest Lodge	0	*0*	• • •

Narrative

Endcliffe Ward has 1 reported incident and G1 has no reported incidents of rapid tranquillisation during March 2022. This is a testament to the work being undertaken on the wards relating to safety huddles, PIPA, including service users in MDTs, patient-led care plans and DRAMs and having therapy staff on the ward.

There have been no reported incidents of any type of restrictive practice in the Rehab & Specialist Directorate in March 22.

Safe | Restrictive Practice | Seclusion



Seclusion Trustwide - Individuals

Burbage > dovedale2

45 40 35 30 25 20 15 10 5 0

01/04/20 01/05/20 01/06/20 01/07/20 01/08/20 01/09/20 01/10/20 01/11/20 01/12/20 01/01/21 01/02/21 01/03/21 01/04/21 01/05/21 01/06/21 01/07/21 01/08/21 01/09/21 01/10/21 01/11/21 01/12/21 01/01/22 01/02/22 01/03/22

Seclusion INCIDENTS	Mar-22		
	n	*mean*	SPC variation
Trustwide	14	*37*	• L •
Acute & Community	14	*29*	• L •
Stanage	6	*5*	• • •
Maple Ward	1	*4*	• • •
HBPoS (136 Suite)	0	*1*	• • •
Endcliffe PICU	6	*11*	• • •
G1	1	*5*	• • •
Rehabilitation & Specialist	0	*0*	• • •

Seclusion INDIVIDUALS	Mar-22		
	n	*mean*	SPC variation
Trustwide	9	*21*	• • •
Acute & Community	9	*17*	• • •
Stanage	**4**	*3*	• • •
Maple Ward	**1**	*3*	• • •
HBPoS (136 Suite)	**0**	*1*	• • •
Endcliffe PICU	**3**	*5*	• • •
G1	1	*2*	• • •
Rehabilitation & Specialist	0	*0*	• • •

Narrative

Seclusion

Following the move of Burbage to Dovedale 2 and the absence of seclusion room, SPC charts have had limits recalculated from July 2021 to take this into account.

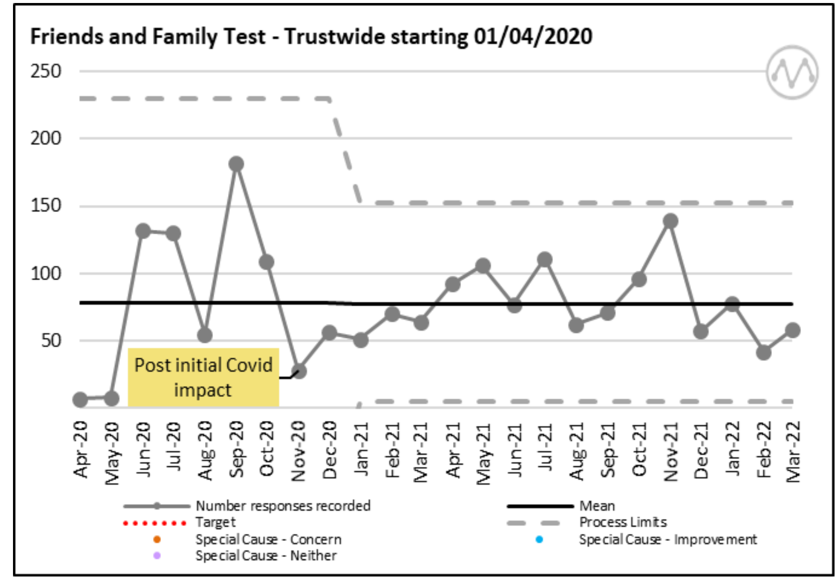
March 2022 shows a continuation of the shift below average in the number of seclusions reported across all the wards. It is clear from the daily incident huddles that alternative mechanisms are being utilised to good effect, such as using green rooms or other spaces for de-escalation.

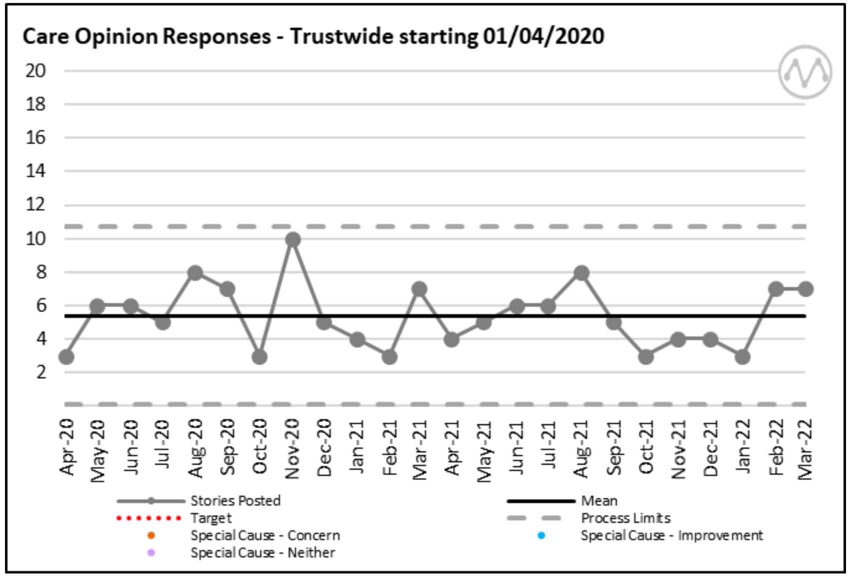
There have been no reported incidents of any type of restrictive practice in the Rehab & Specialist Directorate in March 22.

Long-Term Segregation

There were zero incidences of long-term segregation reported Trustwide in March 2022.

Caring | User Experience





User Experience
Service user and carer feedback is reported on a quarterly basis to the Quality Assurance Committee as part of a 'learning from experience' report. The last quarterly report was presented in March 2022.

Quality of Experience
There was no Quality of Experience (QoE) survey undertaken during March 2022.

Comments from the ward community meetings include requesting a hairdresser and chiropodist, spare clothes, electronic tablets, bigger variety of food, clearer staff identification and ward information and faster wi-fi.

Narrative.
In March 2022, the Trust received a total of 58 responses to the FFT, with 54 positive responses, 2 negative responses and 2 neutral responses.

A few positive responses are listed below:
- Excellent Service, Committed, dedicated staff who provided the quality care required,
- Friendly and supportive. Realistic and honest advice.
- Kind and understanding.

A few of the negative responses were as follows:
- Waitlist times and times between appointments

The majority of FFT responses related to the Gender Identity Service, SAANS and STEP.

Narrative
7 stories that were published on Care Opinion which have been viewed a total of 258 times.

The authors of these stories identified themselves as service users in 4 stories, a carer in 1 story, a staff member posting for a patient/service user in in 1 story, and unknown in 1 story. Care Opinion moderators rated the critically of the 7 stories as follows: 2 not critical, 4 moderately critical, and 1 unknown.

The stories report feeling dismissed, upset, frustrated, helpless and scared. When asked 'what could be improved' respondents quoted staff attitude, understanding, not listening, inconsistent care and follow-up as areas to work on.

Complaints and Compliments

There were 13 formal complaints received in March 2022, 8 for the Acute and Community Directorate and 5 for the Rehabilitation and Specialist Services Directorate. The most frequent category type reported was 'patient care' with 'inadequate support provided' being cited as the most common cause under this.

22 compliments were recorded to have been received in March 2022. Four compliments were received for Dovedale Ward, two for SPA/EWS, four for the Recovery Teams, three for OA CMHT one for Perinatal Service, one was for Early Intervention service, one for Maple ward and one for ECT Suite.

Our People

IPQR - Information up to and including March 2022

Well-Led | Workforce Summary

Metric	Target	Clinical Services	Medical	Corporate Services	*SHSC Feb-22*	Mar-22			
		n	n	n	*n*	**n**	*mean*	**SPC variation**	**SPC target**
Sickness 12 Month (%)	5.10%	6.98%	3.24%	3.77%	*6.17%*	**6.27%**	*5.82%*	• H •	F
Sickness In Month (%)	5.10%	7.84%	3.98%	5.78%	*7.84%*	**7.39%**	*6.87%*	• H •	?
Long Term Sickness (%)	~	4.47%	3.67%	3.72%	*5.10%*	**4.30%**	*4.34%*	• • •	/
Short Term Sickness (%)	~	3.38%	1.95%	2.06%	*2.74%*	**3.09%**	*2.03%*	• H •	/
Headcount Staff in Post	~	2066	179	321	*2593*	**2590**	*2549*	• H •	/
WTE Staff in Post	~	1778	162	304	*2268*	**2267**	*2229*	• H •	/
Turnover 12 months FTE (%)	10%	12.39%	7.30%	15.55%	*15.93%*	**14.13%**	*15.57%*	• • •	F
Vacancy Rate (%)	~	*Unavailable split at this level. See Trustwide figure.*			*9.4%*	**9.5%**	*10.82%*	• • •	/
PDR Compliance (%)*	90%	Revised data. See PDR Section.							
Training Compliance (%)	80%	91.44%	90.81%	87.13%	*89.61%*	**89.79%**	*90.77%*	• L •	P
Supervision Compliance (%)	80%	71.38%	81.82%	73.03%	*73.95%*	**72.09%**	*72.65%*	• • •	F

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

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

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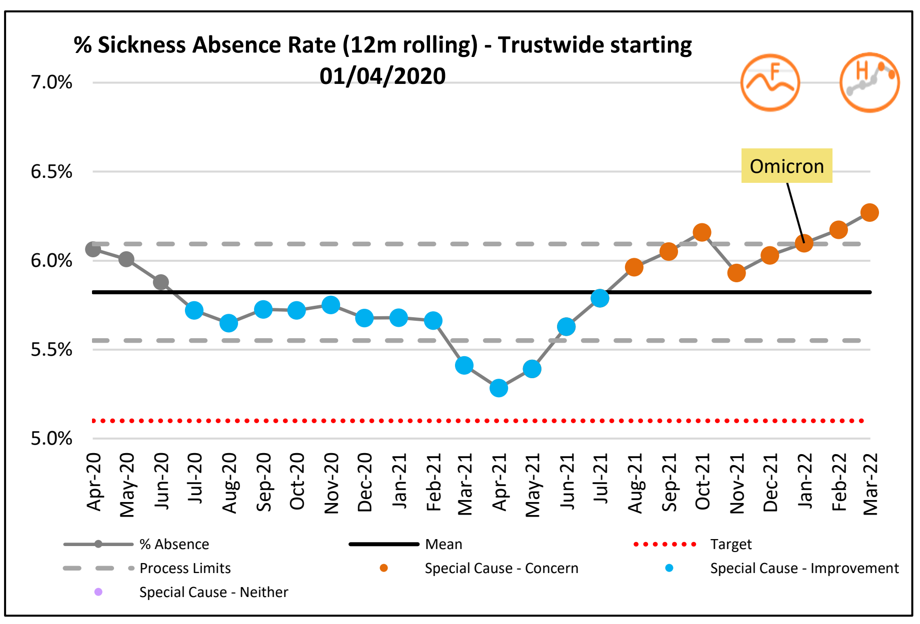
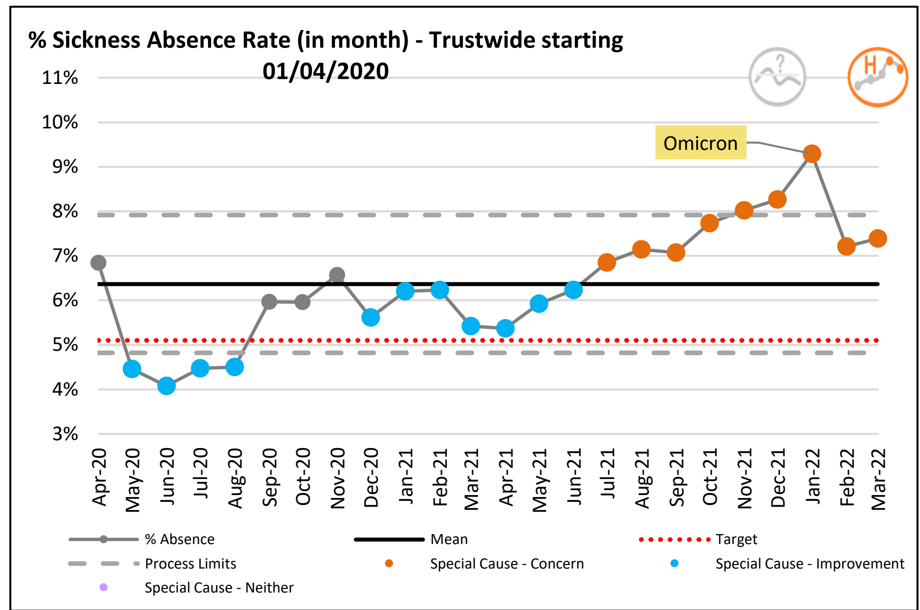
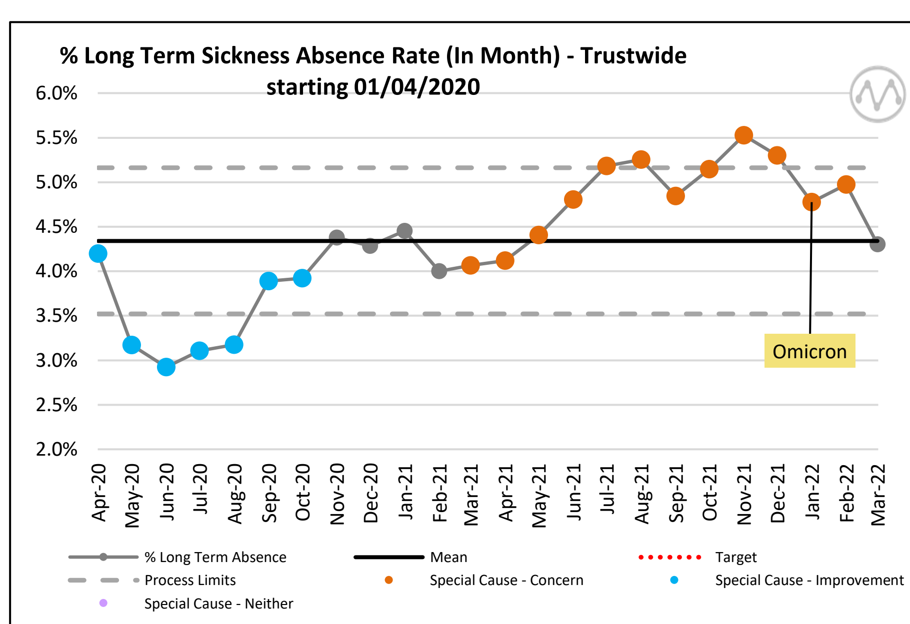
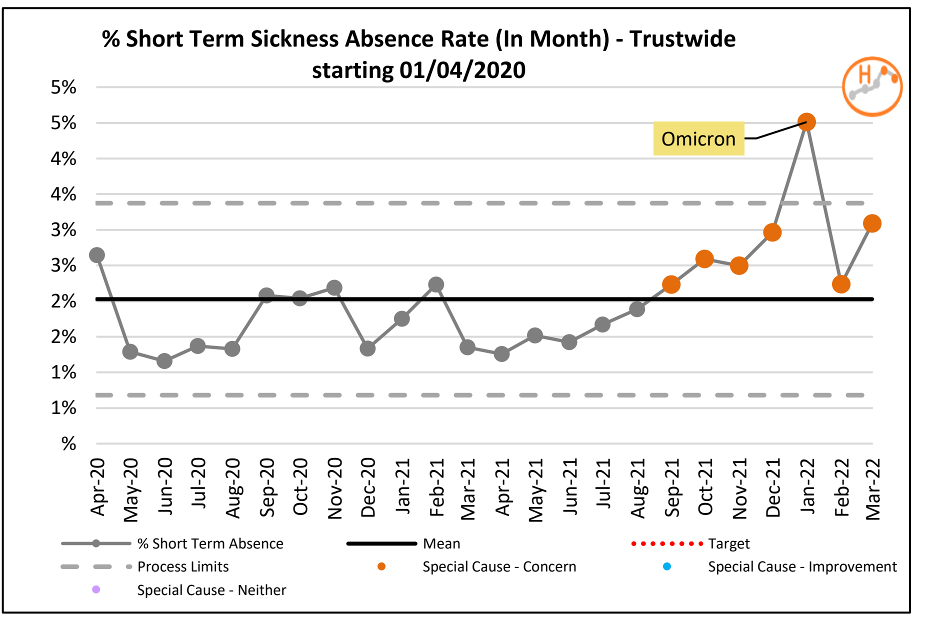
Well-Led | Sickness Absence









March

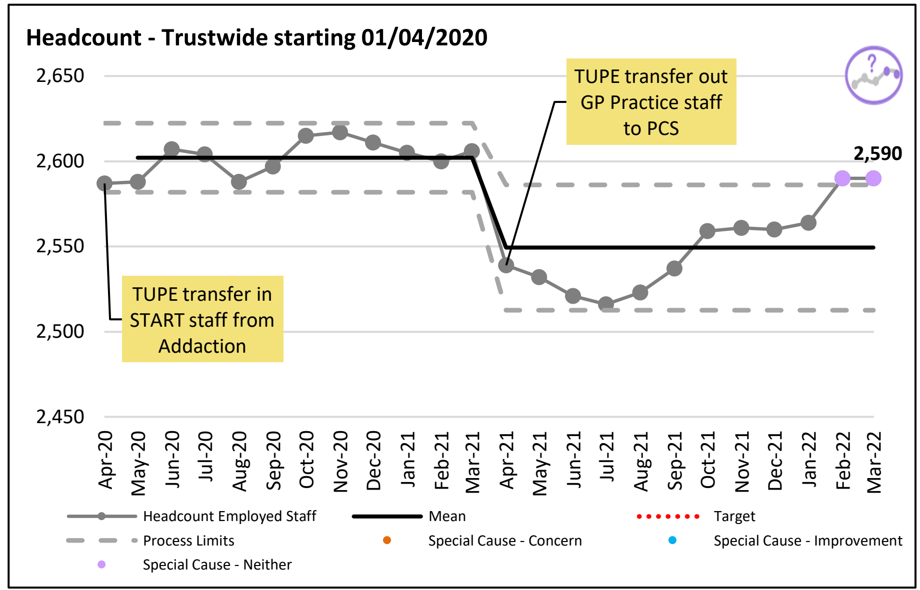
Long Term sickness is reducing. Sickness records are being investigated where records are open ended and in turn closed or updated accordingly.

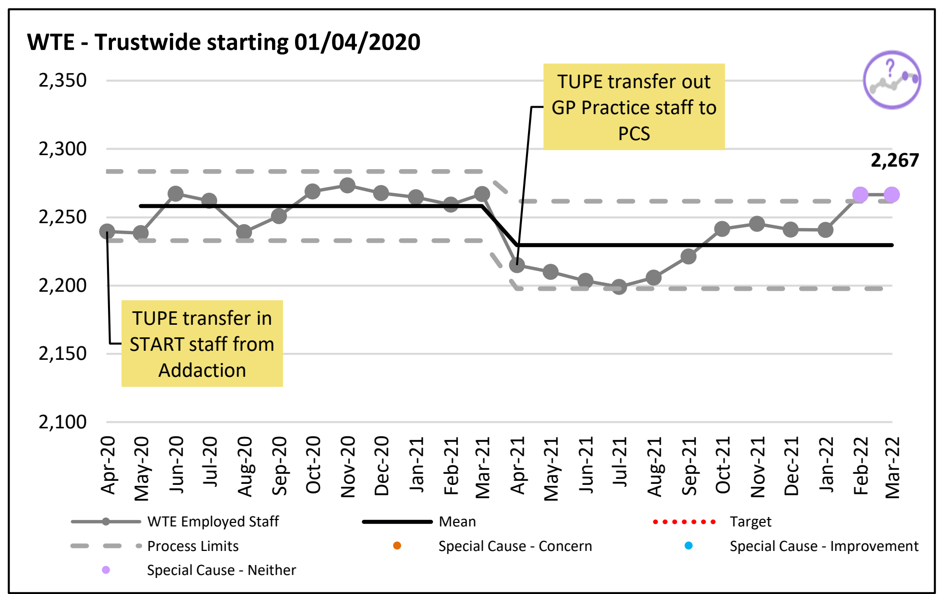
It is clear all entries into health roster and ESR (payroll) have not been performed in a timely manner.

Work is ongoing to establish the role managers and payroll have which impact reporting due to the timeliness of recording. Long term absence appears to have decreased due closure of absence records that were late to be closed in the previous month.

HR are using the monthly absence reporting data to identify areas of concern, and updating the workforce, e-rostering teams for amendments to be made where necessary.

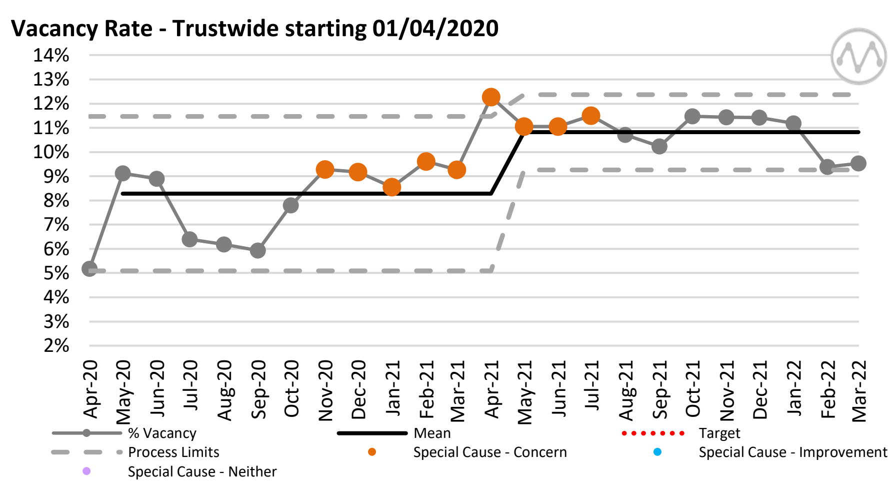
Well-Led | Staffing

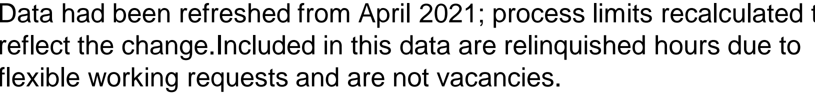




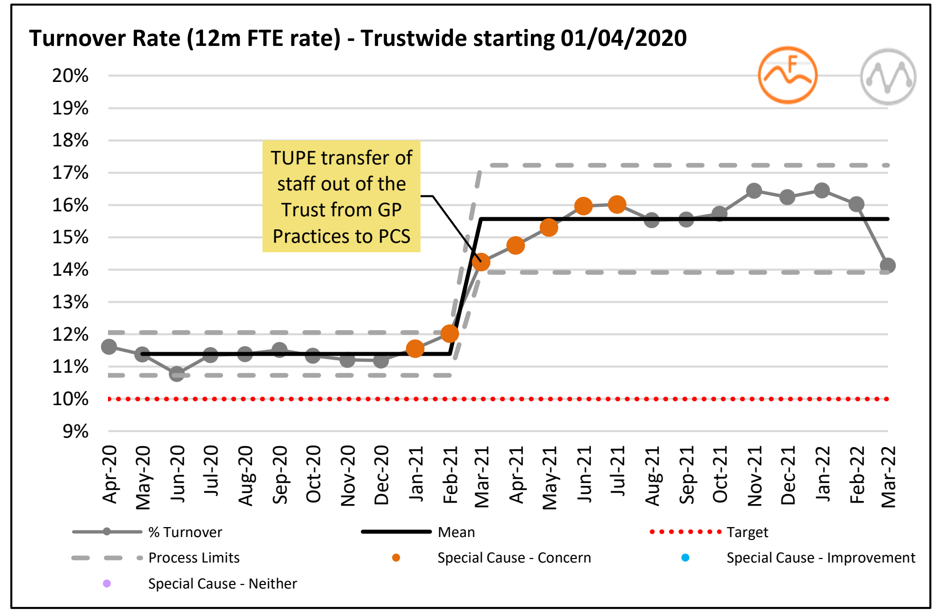
March 2022

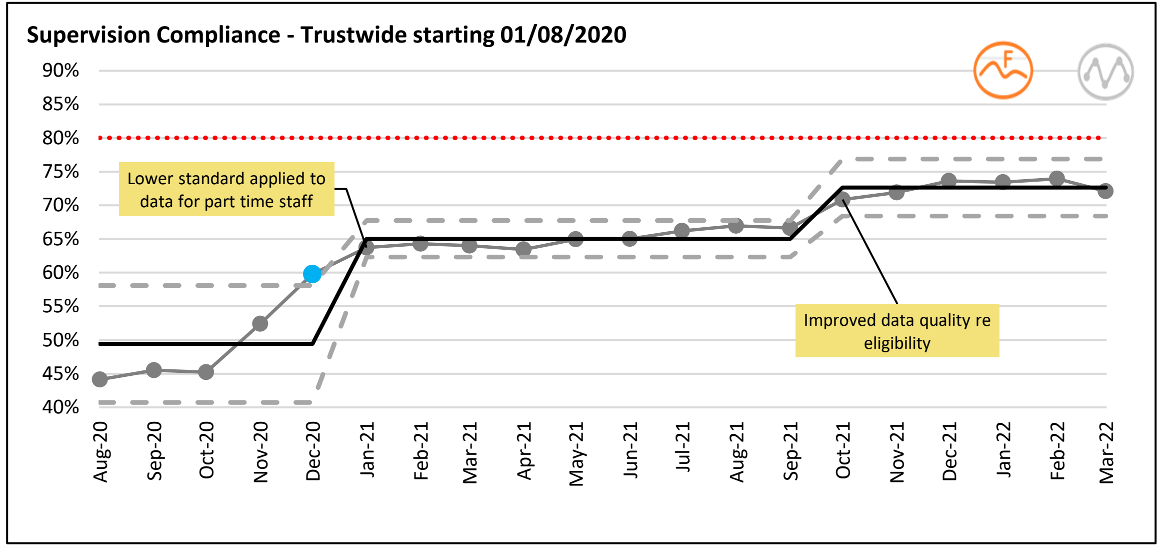
There were twice the number of new starters than leavers in February, and 5 more leavers than starters in March.
There has been almost 2% reduction in vacancies in the period from January and turnover has decreased for the last 2 months.





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





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

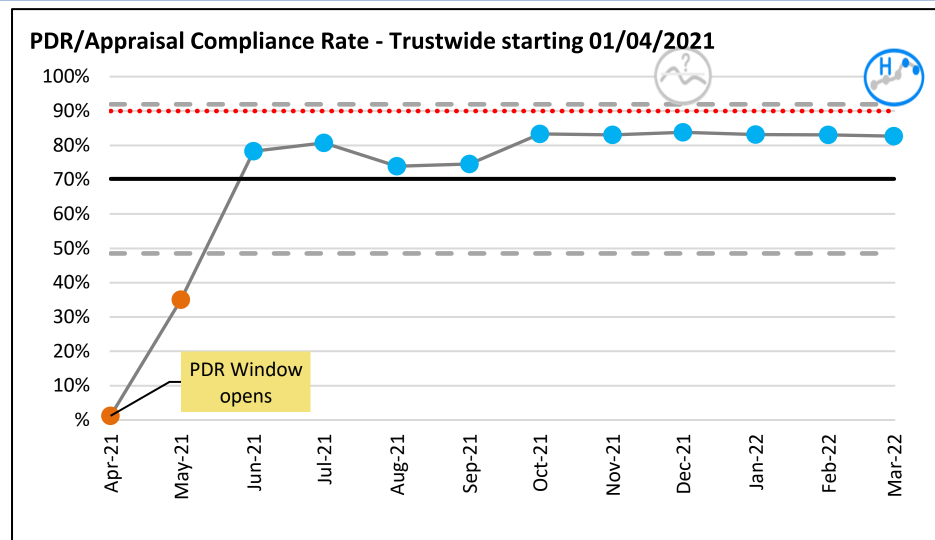
As at 27 March 2022, average compliance with the 8/12 target is:

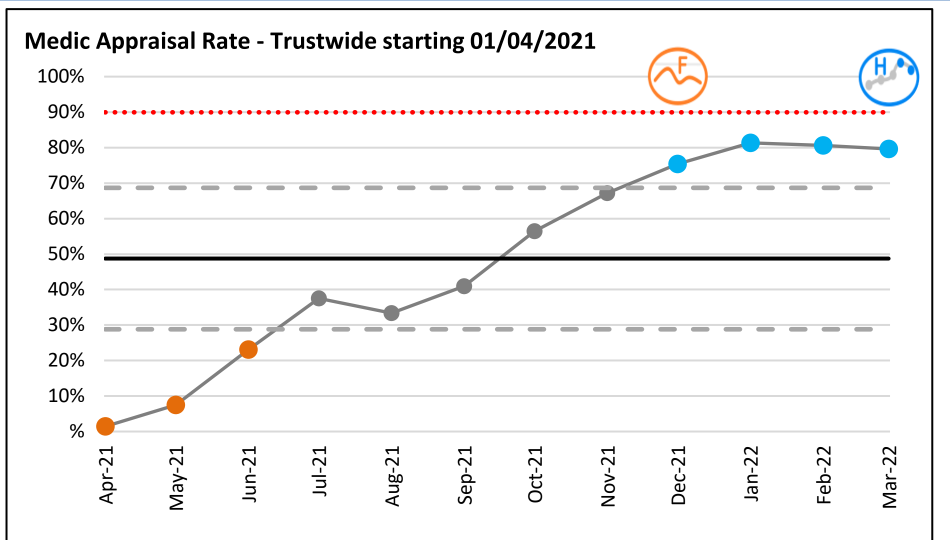
Trustwide	**72.09%**
Clinical Services	**71.38%**
Corporate Services	**75.16%**

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.

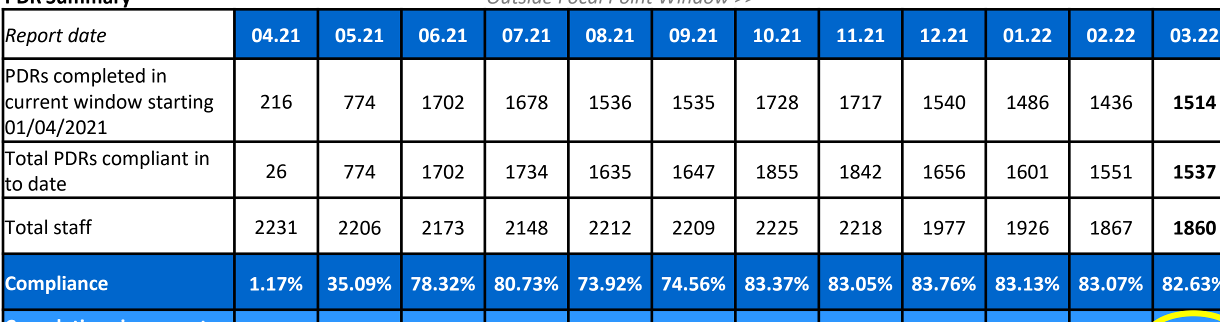
Well-Led | PDR and Appraisal Compliance





PDR Summary

Outside Focal Point Window >>



Report date	04.21	05.21	06.21	07.21	08.21	09.21	10.21	11.21	12.21	01.22	02.22	03.22
PDRs completed in current window starting 01/04/2021	216	774	1702	1678	1536	1535	1728	1717	1540	1486	1436	**1514**
Total PDRs compliant in to date	26	774	1702	1734	1635	1647	1855	1842	1656	1601	1551	**1537**
Total staff	2231	2206	2173	2148	2212	2209	2225	2218	1977	1926	1867	**1860**
Compliance	**1.17%**	**35.09%**	**78.32%**	**80.73%**	**73.92%**	**74.56%**	**83.37%**	**83.05%**	**83.76%**	**83.13%**	**83.07%**	**82.63%**
Completions in current window	**1.17%**	**35.09%**	**78.32%**	**78.12%**	**69.44%**	**69.49%**	**77.66%**	**77.41%**	**77.90%**	**77.15%**	**76.91%**	**81.40%**

Medical Appraisals Summary

Report date	04.21	05.21	06.21	07.21	08.21	09.21	10.21	11.21	12.21	01.22	02.22	03.22
Total medical staff	68	67	65	64	66	66	62	61	61	59	**62**	**59**
Completed Within Focal Point Window Apr - Jun 21	1	5	15	15	12	12	15	12	11	11	**12**	**11**
Compliance	**1.47%**	**7.46%**	**23.08%**	**23.44%**	**18.18%**	**18.18%**	**24.19%**	**19.67%**	**18.03%**	**18.64%**	**19.35%**	**18.64%**
Completed Including Outside Focal Point Window Jul21 to monthend	0	0	0	24	22	27	35	41	46	48	**50**	**47**
Compliance	**0.00%**	**0.00%**	**0.00%**	**37.50%**	**33.33%**	**40.91%**	**56.45%**	**67.21%**	**75.41%**	**81.36%**	**80.65%**	**79.66%**

Reporting Parameters

- Assignment status of Maternity and Adoption is removed from the parameters
- Open ended sickness records less than or equal to the month the report is run are automatically excluded using the NHS Appraisals Review Dashboard.

PDRs

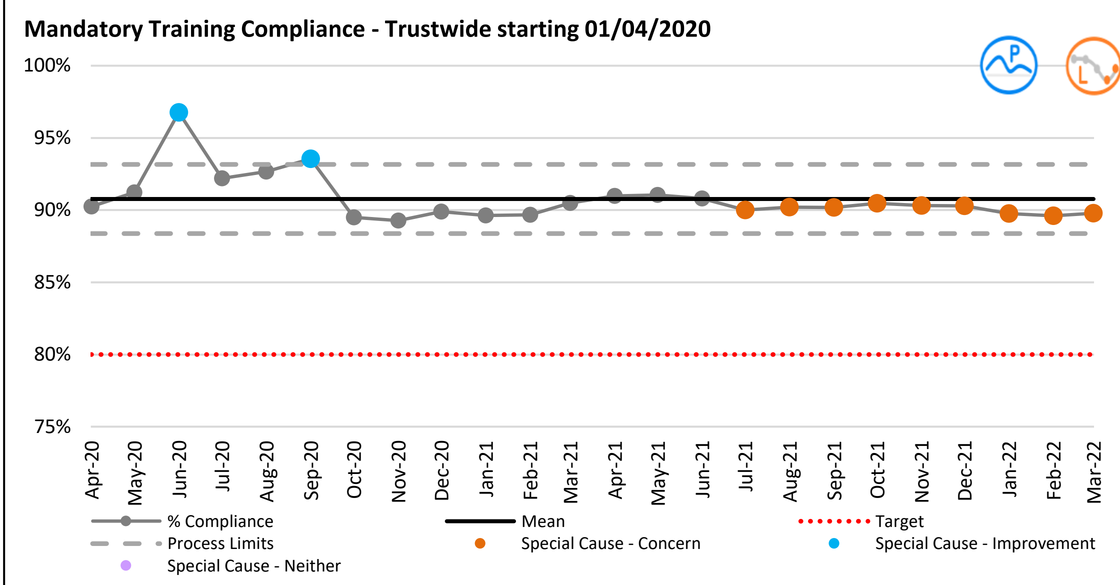
- Trust Board is removed as this cost centre holds all information on Directors and Non Execs who have a different PDR plan
- Band 6 Trainee Clinical Psychologists are excluded from the Focal Point window reporting figures as these staff members have a slightly different PDR plan in place. They are however included in the Outside Focal Point Window which begins on 01-Jul-2021.

Reporting Parameters

Medical Appraisals

- PGME Sheffield and PGME Outside Sheffield are removed from the Appraisal figures due to these members of staff having to complete an ARCP with the Deanery to remain on their chosen career path.
- Trust board is also removed as this cost centre holds all information on Directors and Non Execs who have a different PDR plan
- General Medical Practitioners are also excluded as these have a different PDR plan in place

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..

NARRATIVE

Week ending 03/04/22

Trustwide compliance **89.79%**

EXCEPTIONS

Subjects Below 80/90%

Respect Level 2 & 3

Resuscitation - Basic Life Support

Immediate Life Support

Safeguarding Children Level 3

Services Below 80%

Grenoside Facilities

PGME Sheffield

Chair/CEO

Woodland View

Sheffield Health and Social Care Mandatory Training Compliance @

03 April 2022

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

			06 March 2022				03 April 2022					
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	2299	2141	158	93.13%	2615	2452	163	93.77%	Increase	0.64%
Infection Prevention and Control	1	3 Years	2299	2011	288	87.47%	2615	2308	307	88.26%	Increase	0.79%
Health and Safety		3 Years	2299	2171	128	94.43%	2615	2473	142	94.57%	Increase	0.14%
Information Governance (aka Data Security Awareness)		1 Year	2299	1933	366	84.08%	2615	2172	443	83.06%	Decrease	-1.02%
Preventing Falls (was Slips,Trips and Falls)		3 Years	2299	2167	132	94.26%	2615	2466	149	94.30%	Increase	0.04%
Fire Safety		2 Years	2299	1955	344	85.04%	2615	2292	323	87.65%	Increase	2.61%
Resuscitation	1	1 Year	2299	1900	399	82.64%	2615	2257	358	86.31%	Increase	3.67%
Resuscitation (BLS)	2	1 Year	1357	1064	293	78.41%	1527	1244	283	81.47%	Increase	3.06%
Immediate Life Support		1 Year	185	127	58	68.65%	217	157	60	72.35%	Increase	3.70%
Clinical Risk Assessment		3 Years	894	811	83	90.72%	1007	899	108	89.28%	Decrease	-1.44%
Dementia Awareness		No Renewal	2299	2248	51	97.78%	2615	2540	75	97.13%	Decrease	-0.65%
Autism Awareness		No Renewal	2299	2254	45	98.04%	2615	2542	73	97.21%	Decrease	-0.83%
Mental Capacity Act	1	3 Years	936	785	151	83.87%	1039	863	176	83.06%	Decrease	-0.81%
	2	3 Years	1006	929	77	92.35%	1140	1027	113	90.09%	Decrease	-2.26%
Deprivation of Liberty Safeguards	1	3 Years	1827	1665	162	91.13%	2064	1853	211	89.78%	Decrease	-1.36%
	2	3 Years	108	94	14	87.04%	119	102	17	85.71%	Decrease	-1.32%
Mental Health Act		3 Years	154	130	24	84.42%	174	141	33	81.03%	Decrease	-3.38%
Medicines Management Awareness		3 Years	502	423	79	84.26%	536	440	96	82.09%	Decrease	-2.17%
Rapid Tranquilisation		3 Years	243	216	27	88.89%	271	231	40	85.24%	Decrease	-3.65%
Respect	1	3 Years	1032	924	108	89.53%	1181	1055	126	89.33%	Decrease	-0.20%
	2	2 Years	736	509	227	69.16%	822	578	244	70.32%	Increase	1.16%
	3	1 Year	301	206	95	68.44%	326	229	97	70.25%	Increase	1.81%
Safeguarding Children	1	3 Years	2299	2103	196	91.47%	2615	2390	225	91.40%		
	2	3 Years	957	870	87	90.91%	1085	990	95	91.24%	Increase	0.34%
	3	3 Years	960	713	247	74.27%	1079	797	282	73.86%	Decrease	-0.41%
Safeguarding Adults	1	3 Years	2299	2124	175	92.39%	2615	2412	203	92.24%		
	2	3 Years	982	898	84	91.45%	1115	1024	91	91.84%	Increase	0.39%
Domestic Abuse	2	3 Years	1924	1755	169	91.22%	2170	1984	186	91.43%	Increase	0.21%
Prevent Radicalisation		3 Years	1917	1770	147	92.33%	2164	1990	174	91.96%	Decrease	-0.37%
Moving and Handling	1	3 Years	2299	2221	78	96.61%	2615	2517	98	96.25%	Decrease	-0.35%
	2	2 Years	610	506	104	82.95%	656	535	121	81.55%	Decrease	-1.40%

Mandatory Training

Area Specific data for CQC	The December figures have been included as this was first data for CQC, this will help set a benchmark to measure improvements. Greyed out cells data has not been pulled as part of this table.
	Figures are highlighted in red if they are under 80%

Subject	Date	Endcliffe	Maple	Dovedale	Stanage	Burbage	G1	Birch Avenue	Woodland View	Firshill	Forest Close Central	Forest Close W1	Forest Close W1a	Forest Close W2	Forest Lodge	Wainwright	Recovery North	Recovery South
Moving and Handling Level 1	31/12/2019																	
	06/03/2022																100.00%	100.00%
	03/04/2022																100.00%	98.46%
Moving and Handling Level 2 (People)	31/12/2019																	
	06/03/2022	87.50%	93.55%	80.00%	90.48%	81.48%	94.12%	96.30%	63.16%	94.74%	100.00%	100.00%	96.30%	100.00%	68.97%	100.00%		
	03/04/2022	87.50%	87.50%	79.41%	91.67%	80.00%	89.47%	94.92%	63.79%	85.71%	100.00%	100.00%	96.55%	N/A	66.67%	100.00%		
DOLs Level 2	31/12/2019	80%	29%	75%	80%	43%	36%	14%	56%	38%	67%	67%	100%	50%	50%			
	06/03/2022	80.00%	66.67%	66.67%	100.00%	100.00%	81.25%	100.00%	92.86%	50.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
	03/04/2022	83.33%	66.67%	71.43%	100.00%	85.71%	77.78%	92.86%	100.00%	75.00%	100.00%	100.00%	100.00%	N/A	75.00%			
Safeguarding Children L2	31/12/2019																88%	70%
	06/03/2022																100.00%	91.30%
	03/04/2022																100.00%	87.50%
Domestic Abuse	31/12/2019																73%	83%
	06/03/2022																98.08%	81.48%
	03/04/2022																96.55%	81.97%
MCA Level 2	31/12/2019		81%														60%	76%
	06/03/2022		94.44%														100.00%	90.32%
	03/04/2022		88.89%														100.00%	89.19%
Info Gov	31/12/2019		71%														67%	70%
	06/03/2022		88.37%														98.18%	70.69%
	03/04/2022		91.11%														96.72%	72.31%
Clinical Risk	31/12/2019		85%															
	06/03/2022		84.21%															
	03/04/2022		84.21%															
Fire 2 Year	31/12/2019		75%															
	06/03/2022		97.67%															
	03/04/2022		97.78%															
Respect Level 2	31/12/2019		94%												94%			
	06/03/2022		89.47%												90.91%			
	03/04/2022		86.36%												89.47%			
Respect Level 3	31/12/2019		88%															
	06/03/2022		66.67%															
	03/04/2022		73.91%															
Mental Health Act	31/12/2019		71%															
	06/03/2022		92.31%															
	03/04/2022		83.33%															
Basic Life Support	31/12/2019																65%	70%
	06/03/2022																92.73%	89.66%
Now Resuscitation Level 2	03/04/2022																93.33%	90.57%
ILS	31/12/2019														71%			
	06/03/2022														75.00%			
	03/04/2022														75.00%			

Subject	Date	Recovery North	Recovery South	CERT	Early Intervention	Adlt Hm Tr
Community Mental Health Act	06/03/2022	97.30%	90.48%	88.57%	85.71%	82.14%
	03/04/2022	97.56%	90.91%	88.37%	84.21%	75.86%

Narrative

CQC focus topics and areas
Cells in red indicate less than 80% compliance.

Areas of Concern
Slippage or no improvement since previous reporting period 2 weeks prior

- **Moving & Handling Level 2**
  - Dovedale 1
  - Woodland View
  - Forest Lodge
- **DOLS Level 2**
  - Maple Ward
  - Dovedale 1
  - G1
  - Firshill
  - Forest Lodge
- **Information Governance**
  - Recovery South
- **ILS**
  - Forest Lodge
- **Respect Level 3**
  - Maple Ward

NB – Date shown in table to left is position as at w/c 03/04/22, compared with the 06/03/22 position and December 2019 baseline where available.

Financial Performance

IPQR - Information up to and including March 2022

Well-Led | Financial Overview

KPI	Annual Plan £'000	Year to Date Plan £'000	Year To Date Actual £'000
Surplus/Deficit	0	0	1,811
Covid Expenditure	6,596	6,596	1,895
Agency	5,904	5,904	5,899
Cash	62,075	62,075	58,757
Efficiency Savings	2,650	2,650	2,650
Capital	8,197	8,197	8,191
Better Payments Practice Code	99.4% by Number 99.6% by Value		

Summary at March 2022:

- The Organisation wide surplus of £1.8m at the end of M12 (Mar 22), £2.2m favourable to plan. This is a £1.1m adverse movement on M11's underspend of £2.9m. The large movement is largely due to technical adjustments not originally in the forecast such as Gift of Time and other provisions.
- MHIS spend rates continue to increase marginally each month. The total spend in 21-22 was £3.3m against an investment of £5.7m. Assuming current staff in post values the forecast spend in 23-24 will be £4.5m. This suggests there remains approximately £1.2m vacancies associated with MHIS funds.
- Covid underspend is £4.7m as expected. This is marginally lower than the forecast underspend of £4.8m.
- Agency and Out of Area Costs remain high risk. Total spend for the year on these areas is £15m which equates to 11% of the total organisational spend.
- Capital spend increased significantly in M12 and resulted in £8.2m being spent in 21-22 which is in line with the Organisations CDEL expectations.
- Figures reported are pre-audit and while no adjustments are anticipated this should be noted.

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

SPC variation	
• • •	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

SPC target	
?	Target Indicator – Pass/Fail
P	Target Indicator – Pass
F	Target Indicator – Fail

Covid-19

IPQR - Information up to and including March 2022

Well-Led | Covid-19 Response

Covid-19 Outbreaks
During March 2022 an outbreak was declared at Birch Avenue, this was staff only and no service users were affected. The outbreak was officially declared over on 19th April.

Covid-19 Deaths
There was 1 death recorded in March 2022.

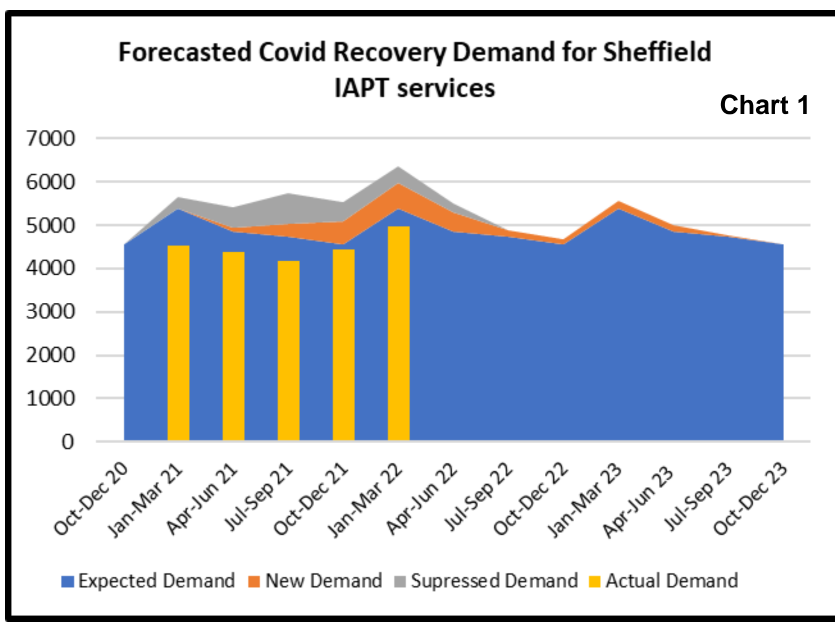
Covid-19 Related Staff Absence
As 31 March, 60 staff were absent from the workplace for Covid related reasons. 3 were working and 57 were unable to work.

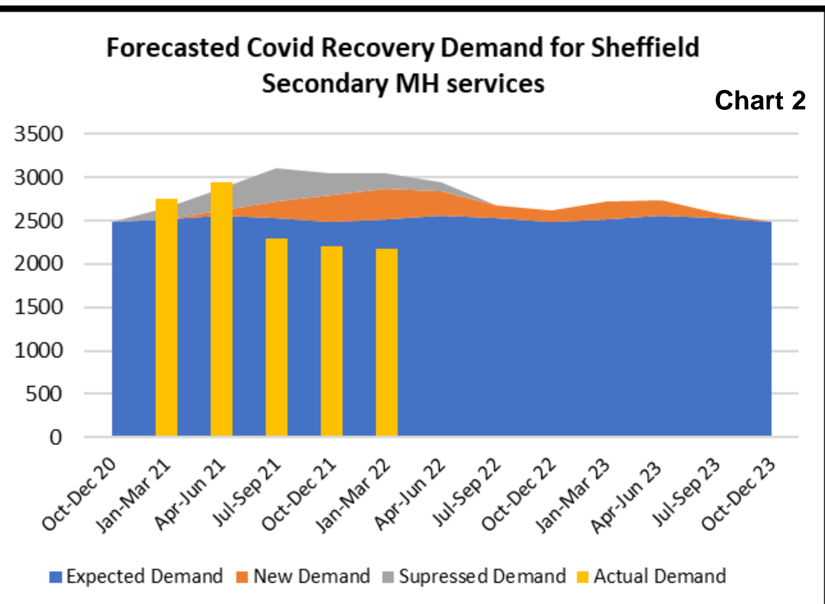
Staff Vaccination (lates data available as at 17 January 2022)
This report's primary data sources are the National Immunisation Management System (NIMS) Reporting and our Electronic Staff Record (ESR). NIMS Reporting should include all vaccination records for our staff, no matter where they have received them. Data for agency staff, students, locum doctors and volunteers who do not have ESR records has also been manually captured from a variety of sources.
This report does not include vaccination records for 38 staff (1.3%) where we do not have their NHS numbers and NIMS has not been able to obtain them for us.

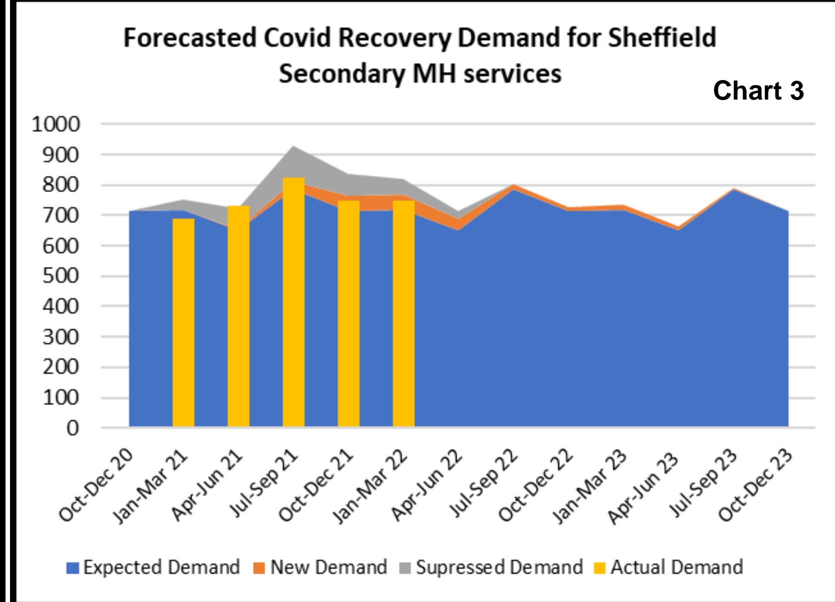
	Total	% of total	Priority staff	Non-priority staff
Staff records uploaded by SHSC to NIMS	3014	100.0%	2635	379
Staff matched to at least one vaccination record	2831	93.9%	2470	361
Staff matched to at least two vaccination records	2771	91.9%	2411	360
Staff matched to two vaccination records + booster	2406	79.8%	2067	339
Staff that could not be matched due to missing NHS number	38	1.3%	34	4
Staff that have either not received at least one vaccination dose or whose NHS number is missing from their vaccination record(s)	183	6.1%	165	18

	Not yet vaccinated		Received first dose only		Received both doses only		Received both doses & booster	
	Count	%	Count	%	Count	%	Count	%
457 Clinical Operations (L3)	85	4.2%	40	2.0%	263	13.0%	1640	80.9%
457 Chair/Chief Exec Office (L5)	1	3.6%		0.0%	1	3.6%	26	92.9%
457 Finance (L5)	1	4.2%		0.0%	3	12.5%	20	83.3%
457 IMST (L5)		0.0%	1	2.5%	2	5.0%	37	92.5%
457 Performance (L5)		0.0%		0.0%		0.0%	7	100.0%
457 Nursing & Professions (L5)	3	3.8%	2	2.6%	5	6.4%	68	87.2%
457 People Directorate (L5)	22	6.5%	8	2.4%	52	15.3%	258	75.9%
457 Bank Staff (017777)	17	6.1%	8	2.9%	49	17.6%	204	73.4%
457 Reg Nurse Degree Apprentices (017414)		0.0%		0.0%	1	20.0%	4	80.0%
457 Facilities (L5)	3	4.1%		0.0%	5	6.8%	65	89.0%
457 Strategy & Planning (L5)		0.0%		0.0%		0.0%	10	100.0%
457 Clinical Strategy & Partnerships (L5)	2	40.0%		0.0%	1	20.0%	2	40.0%
457 Medical Management Team (L5)		0.0%		0.0%		0.0%	2	100.0%
457 Medical PGME (L5)	2	1.8%	3	2.7%	3	2.7%	103	92.8%
457 Pharmacy Dept (L5)		0.0%	1	2.4%	3	7.3%	37	90.2%
457 Quality (L5)		0.0%		0.0%		0.0%	3	100.0%
457 Research & Development Dept (L5)		0.0%		0.0%	1	5.6%	17	94.4%
457 MH Community Transformation (8244)	1	4.8%		0.0%		0.0%	20	95.2%
Agency Staff (L5)	25	22.1%	3	2.7%	21	18.6%	64	56.6%
Locum Doctors (L5)	5	41.7%		0.0%	1	8.3%	6	50.0%
Medical Students (L5)	24	70.6%	1	2.9%	1	2.9%	8	23.5%
Student Nurses (L5)	7	100.0%		0.0%		0.0%		0.0%
Volunteers (L5)	2	14.3%	1	7.1%	2	14.3%	9	64.3%
Grand Total	**183**	**6.1%**	**60**	**2.0%**	**365**	**12.1%**	**2406**	**79.8%**

Well-Led | Covid-19 Demand Impact | Q3 21/22







Narrative

Forecasting work has been taking place across the region and the country, with South Yorkshire & Bassetlaw ICS choosing to use a demand modelling tool developed by South West Yorkshire Partnerships FT (SYWFT). The forecasting uses prevalence data, historical demand data (referrals) from each organisation and estimates of suppressed demand to forecast what the impact of the covid pandemic may have on future demand for services.

The charts above show the forecasted modelled demand for SHSC on that basis. We have used referrals to services 2019/20 as baseline for expected demand:

- Chart 1 | IAPT – referrals to IAPT (all ages)
- Chart 2 | Secondary MH (18-64) – referrals to SPA
- Chart 3 | Secondary MH (65+) – referrals to Older Adult CMHT

We will continue to overlay the actual number of referrals at each quarter end.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Report ends
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Appendix 1 | SPC Explained

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

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

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

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

Appendix 2 | SHSC SPC Chart Anatomy

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

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

SPC Chart Example - Team/Directorate/Trust starting 01/01/2019

100
90
80
70
60
50
40
30
20
10

Annotate the chart...

...to draw attention to a point

Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Your metric
Mean
Target
Process Limits
Special Cause - Concern
Special Cause - Improvement
Special Cause - Neither

Observations

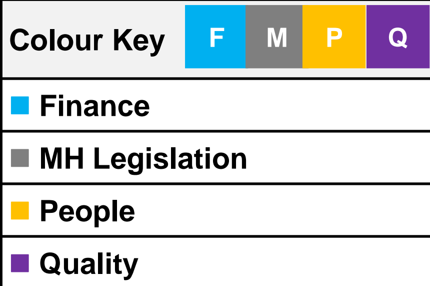
Based on the data from latest calculation date (data point 1 - 01/01/19).

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.

Appendix 3 | Board Committee KPIs

KPI	Slide/ Page	Committee Oversight
Access & Demand | Referrals	5	Finance/ Quality
Access & Demand | Community Services	6	Finance/ Quality
Inpatient Wards | Adult Acute and Step Down	7	Finance/ Quality
Inpatient Wards | PICU	8	Finance/ Quality
Inpatient Wards | Older Adult	9	Finance/ Quality
Inpatient Wards | Rehabilitation & Forensic	10	Finance/ Quality
Inpatient Wards | Learning Disabilities	11	Finance/ Quality
Effective | Treatment & Intervention	12	Finance/ Quality
IAPT	13	Finance/ Quality
START	14-15	Finance/ Quality
Safe | All Incidents	17	Quality
Safe | Medication Incidents & Falls	18	Quality
Safe | Assaults, Sexual Safety & Missing Patients	19	Quality
Safe | Deaths	20	Quality
Safe | Restrictive Practice | Physical Restraint	21	Quality/ MH Legislation
Safe | Restrictive Practice | Rapid Tranquillisation	22	Quality/ MH Legislation
Safe | Restrictive Practice | Seclusion	23	Quality/ MH Legislation
Caring | User Experience	24	Quality

KPI	Slide/ Page	Committee Oversight
Well-Led | Our People | Workforce Summary	26	People
Well-Led | Our People | Sickness Absence	27	People
Well-Led | Our People | Staffing	28	People
Well-Led | Our People | Supervision & PDR	29-30	People
Well-Led | Our People | Mandatory Training	31-32	People
Well-Led | Financial Performance | Overview	34	Finance
Well-Led | Covid 19 Response	36	Quality
Well-Led | Covid 19 Demand Impact	37	Finance/ Quality



Colour Key	F	M	P	Q
Finance				
MH Legislation				
People				
Quality				

Blue Underlined Text = Click to link to slide/page