# Integrated Performance & Quality Report

**Information up to and including May 2023**

# Introduction

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

- Service Delivery
- Safety & Quality
- Tendable
- Our People
- Financial Performance
- CQuINs
- 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 May 2023 reporting, we are using monthly figures from June 2021 to May 2023. Where 24 months data is not available, we use as much as we have access to.

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

**Variation**

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

**Target**

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

We have begun using and looking at the information in this way in our 'Floor to Board' Performance & Quality reviews with Clinical Directorates, and will continue to develop that way of working so that the data is intelligently reviewed at source and services and teams are able to investigate and provide narrative which supports the information.

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

Refer to Appendix 3 for detail.

| Colour Key | F | M | P | Q |
|---|---|---|---|---|
| ■ Finance | | | | |
| ■ MH Legislation | | | | |
| ■ People | | | | |
| ■ Quality | | | | |

# Service Delivery

**IPQR - Information up to and including May 2023**

# Responsive | Access & Demand | Referrals

| Referrals | May-23 | | | |
|---|---|---|---|---|
| **Acute & Community Directorate Service** | **n** | *mean* | **SPC variation** | **Note** |
| SPA/EWS | **586** | *698* | ● ● ● | |
| Crisis Resolution and Home Treatment | **917** | In February 2022, 5 teams merged to create the Crisis Resolution & Home Treatment Team (4 Adult Home Treatment Teams & Out of Hours). Due to the limitations of reporting from Insight, we require the RiO implementation to get accurate data. | | |
| Liaison Psychiatry | **569** | *482* | ● ● ● | |
| Decisions Unit | **70** | *56* | ● ● ● | |
| S136 HBPOS | **28** | *33* | ● ● ● | |
| Recovery Service North | **13** | *23* | ● ● ● | |
| Recovery Service South | **18** | *23* | ● ● ● | |
| Early Intervention in Psychosis | **35** | *38* | ● ● ● | |
| Memory Service | **115** | *128* | ● ● ● | |
| OA CMHT | **247** | *256* | ● ● ● | |
| OA Home Treatment | **27** | *25* | ● ● ● | |

| Referrals | May-23 | | | |
|---|---|---|---|---|
| **Rehab & Specialist Service** | **n** | *mean* | **SPC variation** | **Note** |
| CERT | **2** | *3* | ● ● ● | |
| SCFT | **0** | *2* | ● ● ● | |
| CLDT | **55** | *57* | ● ● ● | CLDT figures represent distinct individuals so does not include multiple referrals per service user. |
| CISS | **4** | *3* | ● ● ● | |
| Psychotherapy Screening (SPS) | **46** | *49* | ● ● ● | |
| Gender ID | **44** | *42* | ● ● ● | |
| STEP | **132** | *105* | ● H ● | Referrals steadily increasing especially from GPs. This may be due to increased visibility and familiarity with STEP and its offer due to work both by the team and signposting by other SHSC services such as SPA/EWS. |
| Eating Disorders Service | **39** | *34* | ● ● ● | |
| SAANS | **436** | *414* | ● ● ● | |
| R&S | **11** | *19* | ● ● ● | |
| Perinatal MH Service | **43** | *48* | ● ● ● | |
| HAST | **12** | *15* | ● ● ● | |
| HAST - Changing Futures | **4** | | | |
| Health Inclusion Team | **156** | *161* | ● ● ● | |
| LTNC | **56** | *86* | ● L ● | |
| ME/CFS Long Covid | **1** | *66* | ● L ● | The service has stopped accepting referrals from Sheffield from March '23 as this has been transferred to the Long Covid hub within STH. |
| ME/CFS | **54** | *50* | ● ● ● | As above |

# Responsive | Access & Demand | Community Services

| May 2023 | Number on wait list at month end | | | Average wait time referral to assessment for those assessed in month | | | Average wait time referral to first treatment contact for those 'treated' in month | | | Total number open to Service | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Waiting List | | | Average Waiting Time (RtA) in weeks | | | Average Waiting Time (RtT) in weeks | | | Caseload | | |
| **Acute & Community Services** | n | mean | SPC variation | n | mean | SPC variation | n | mean | SPC variation | n | mean | SPC variation |
| SPA/EWS | 364 | 733 | ●L● | 33.1 | 32.3 | ●●● | 9.9 | 9.9 | ●L● | 694 | 956 | ●L● |
| MH Recovery North | 80 | 78 | ●H● | 22.1 | 10.9 | ●●● | 5.9 | 10.2 | ●L● | 809 | 940 | ●L● |
| MH Recovery South | 22 | 74 | ●L● | 22.8 | 12.2 | ●H● | 21.2 | 12.2 | ●●● | 984 | 1072 | ●L● |
| **Recovery Service TOTAL** | 102 | 151 | ●L● | N/A | | | N/A | | | 1793 | 2012 | ●L● |
| Early Intervention in Psychosis | 23 | 25 | ●●● | | | | 84.6% | | | 308 | 322 | ●L● |
| Memory Service | 959 | 749 | ●H● | 39.1 | 25.3 | ●H● | 40.5 | 33.3 | ●H● | 4517 | 4374 | ●H● |
| OA CMHT | 270 | 180 | ●H● | 15.9 | 7.2 | ●H● | 10.6 | 9.7 | ●●● | 1350 | 1251 | ●H● |
| OA Home Treatment | N/A | | | N/A | | | N/A | | | 67 | 65 | ●●● |
| **Rehab & Specialist Services** | n | mean | SPC variation | n | mean | SPC variation | n | mean | SPC variation | n | mean | SPC variation |
| SPS - MAPPS | 55 | 70 | ●●● | 27.2 | 20.1 | ●●● | 122.4 | 80.5 | ●●● | 314 | 317 | ●●● |
| SPS - PD | 48 | 41 | ●H● | 16.1 | 16.6 | ●●● | 68.9 | 64.1 | ●●● | 194 | 191 | ●●● |
| Gender ID | 2063 | 1710 | ●H● | 192.1 | 135.6 | ●●● | N/A | | | 2890 | 2514 | ●H● |
| STEP | 191 | 132 | ●H● | N/A | | | | | | 502 | 421 | ●H● |
| Eating Disorders | 18 | 30 | ●●● | 3.9 | 4.5 | ●●● | | | | 183 | 218 | ●L● |
| SAANS | 7735 | 5385 | ●H● | 81.8 | 92.2 | ●L● | | | | 6249 | 5687 | ●H● |
| R&S | 62 | 154 | ●L● | 33.1 | 74.1 | ●L● | | | | 117 | 200 | ●L● |
| Perinatal MH Service (Sheffield) | 20 | 25 | ●●● | 2.8 | 3.2 | ●●● | | | | 153 | 145 | ●●● |
| HAST | 25 | 29 | ●●● | 32.7 | 12.8 | ●●● | | | | 84 | 81 | ●L● |
| Health Inclusion Team | 425 | 316 | ●H● | 5.4 | 9.4 | ●●● | | | | 1924 | | |
| LTNC | 301 | 631 | ●L● | N/A | | | | | | N/A | | |
| CFS/ME | N/A | | | 25.8 | 18.2 | ●H● | | | | 1416 | | |
| CLDT | 164 | 181 | ●●● | 9.7 | 11.5 | ●L● | 27.4 | 20.4 | ●●● | 744 | 738 | ●●● |
| CISS | N/A | | | | | | | | | 14 | 25 | ●L● |
| CERT | 2 | | | N/A | | | N/A | | | 45 | 45 | ●L● |
| SCFT | 0 | | | | | | | | | 22 | 25 | ●L● |

**Narrative**

**See next slides for SPC chart detail.**

**CLDT** figures represent distinct individuals so does not include multiple waits per service user. – add specific narrative to month.

**ME/CFS** – Data quality work underway (See slide 10) could be linked to risk identified at directorate level (risk no. 4508). Long term sickness impacting delivery of assessments.

**LTNC** – SQL query has been rebased to better capture true picture following data improvement work, this has shown an increase in numbers on the waitlist.

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

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

**HIT** – Caseload increased in Homeless (temporary accommodation) and Migrant placements, large increase in number of referrals who are open to safeguarding increasing complexity. Workforce model proposed but requires investment, commissioners need to be identified. QEIA completed and presented at QAC. We are escalating through commissioning management group & board.

**SAANS-** Significant staffing issues. No ADHD assessments currently taking place, this is leading to a further increase in numbers on wait list. Mitigations include development of waiting list initiative with VAS and service users. Collaboration with SPA/EWS and initial discussions with PCMHT and Consultation model supporting other SHSC Teams.

# Performance – Community Services – Wait Lists
## Recovery Teams Clients awaiting allocation to care coordination
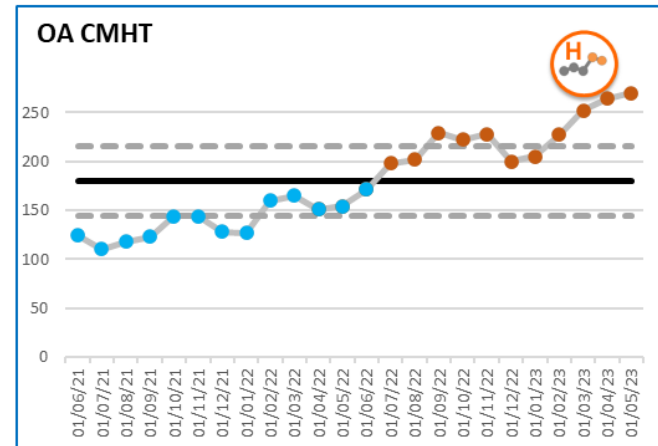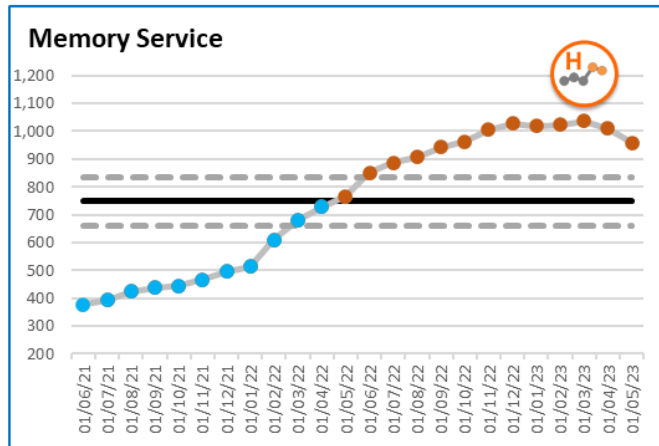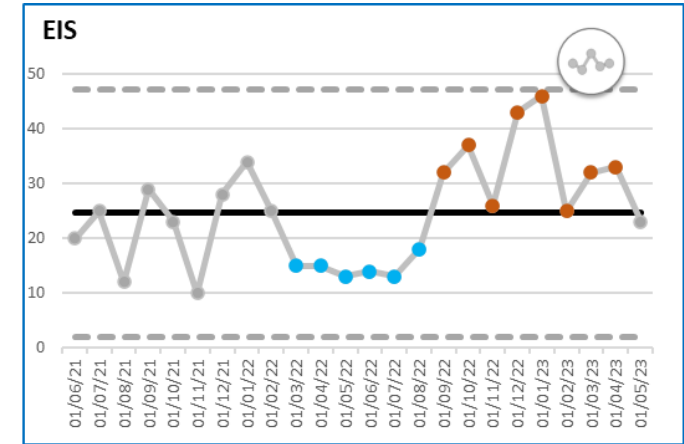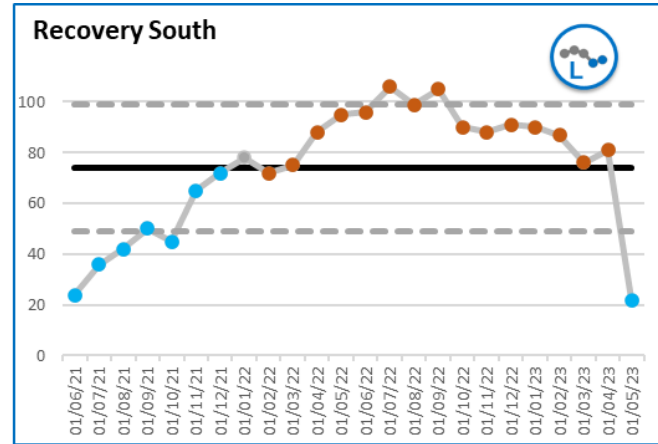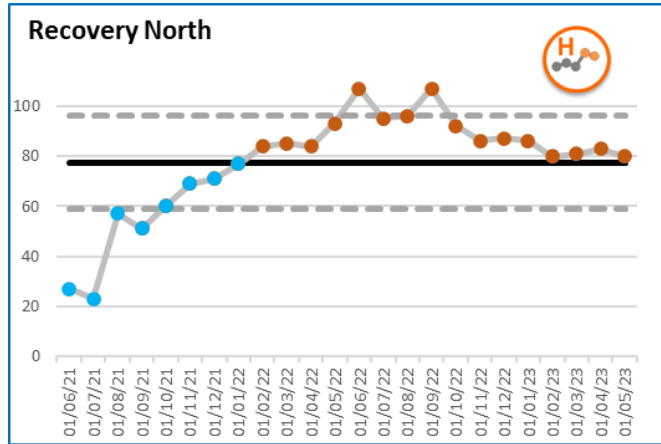


**Narrative**

*Charts shown are those teams showing special cause variation*

- Recovery North and South receive a weekly report providing information that enables the teams to take action against the RAG rating in terms of contact frequency and presence of risk assessments and any care and treatment plans for those waiting. The continues to evolve to include additional information to further support the identification of risk and priority. The service is working with BPMs to provide live access to the data rather than a report.
- Work started to implement new ways or working as defined in the new clinical model. Cases being moved from 'WL' to named workers through transfer of step one service users to other roles in the teams
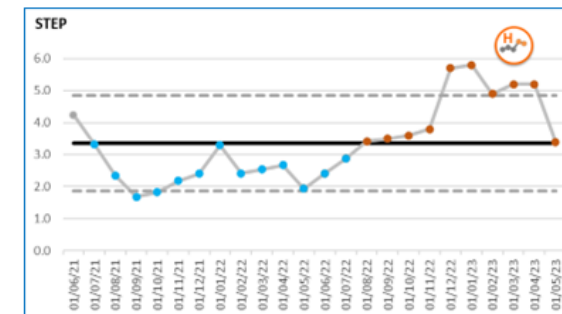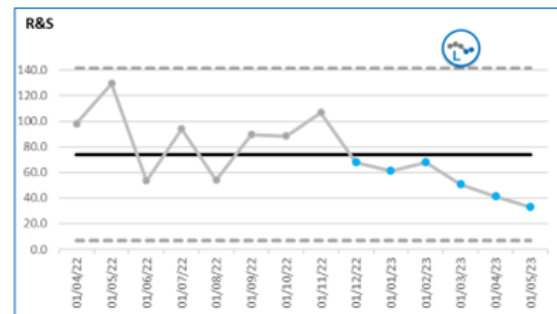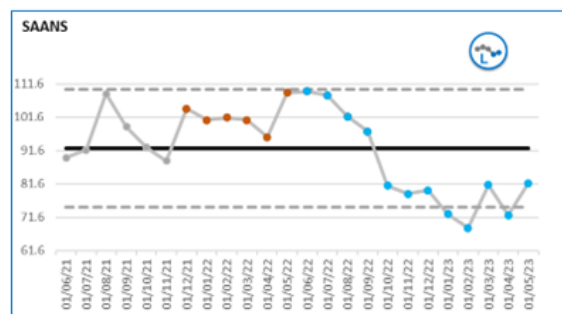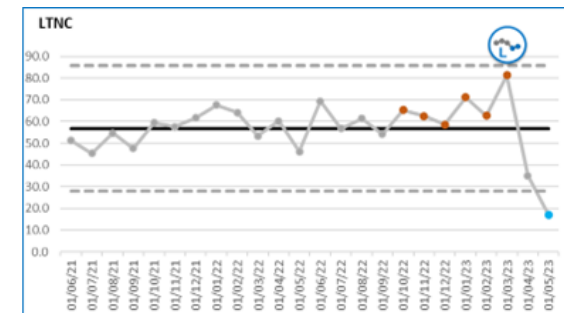
# Performance – Community Services – Wait Lists
## Highly Specialist Teams
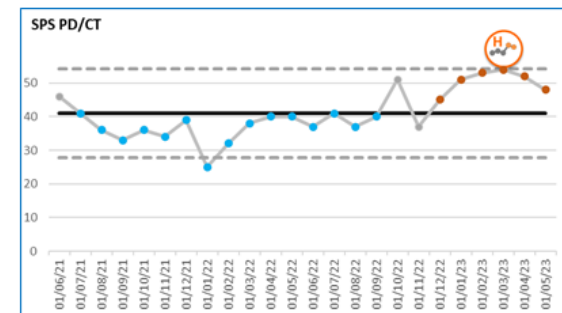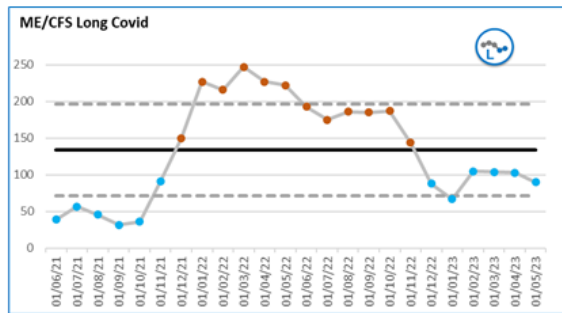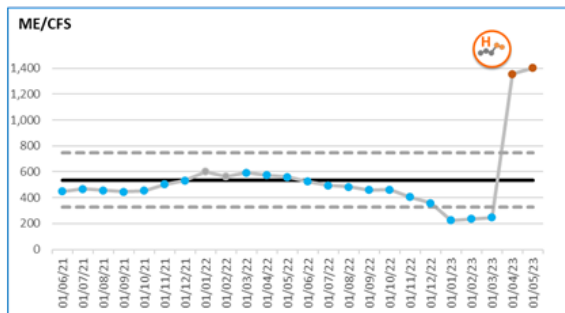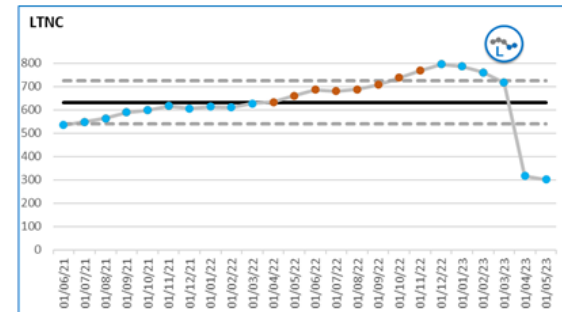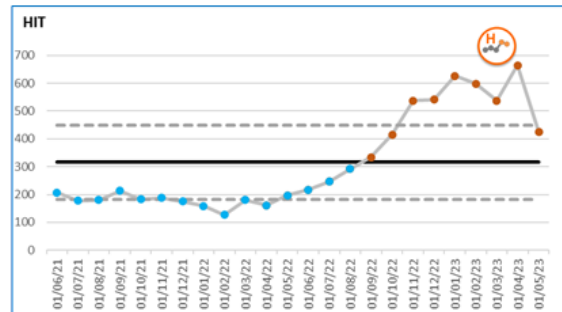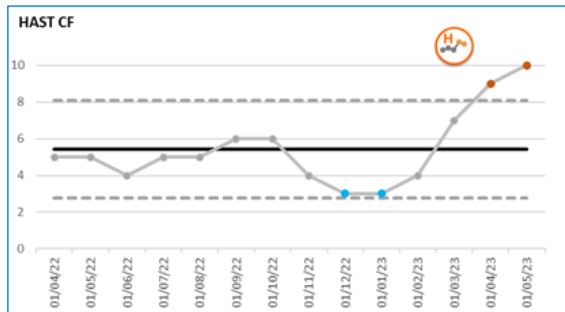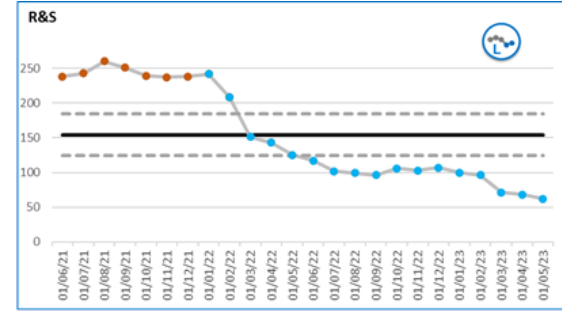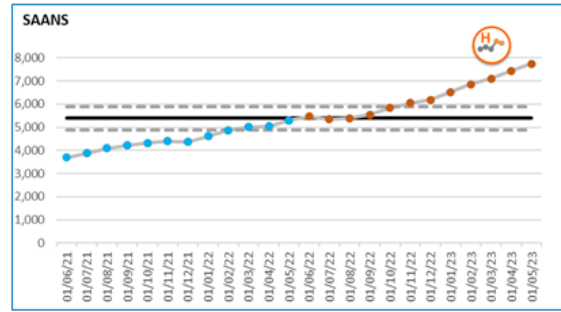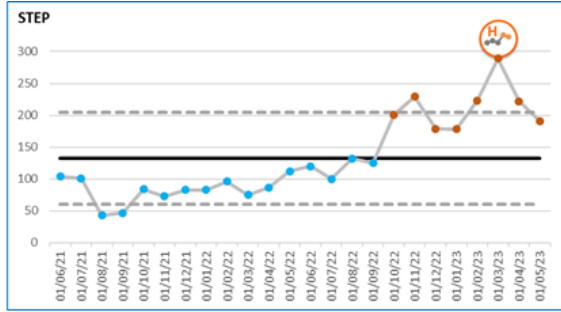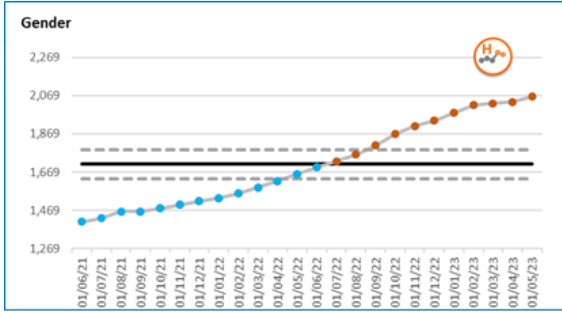


**Narrative**

*Charts shown are those teams showing special cause variation*

# Performance – Community Services – Average Wait Time RtA
## Highly Specialist Teams
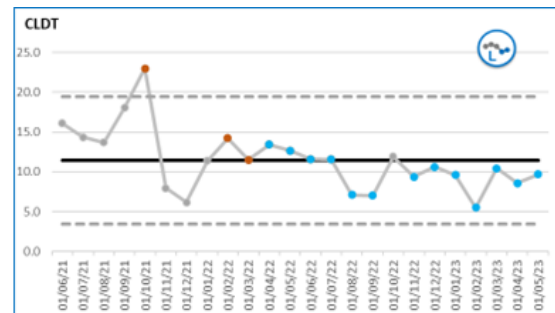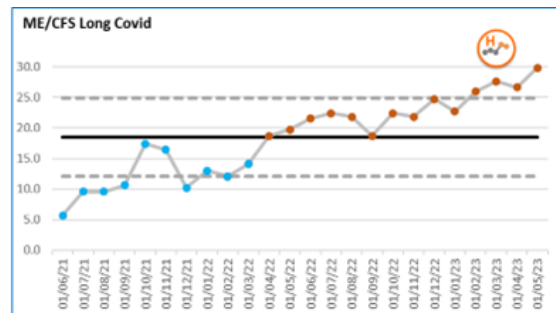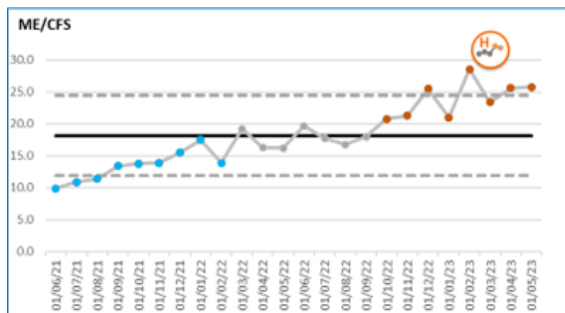


**Narrative**

*Charts shown are those teams showing special cause variation*

**NOTE: Average wait time in weeks from referral to assessment, for those ASSESSED IN MONTH.**

Different measure to the LIVE wait time for those on the waiting list at snapshot point in time.

An increase in demand (increased referrals) will artificially lower the LIVE wait time as there will be an increased number newly on the wait list.

| Adult Acute (Burbage/Dovedale 2, Stanage/Burbage, Maple) | May-23 | | | |
|---|---|---|---|---|
| | n | mean | SPC variation | SPC target |
| Admissions | 27 | 30 | ● ● ● | / |
| Detained Admissions | 24 | 27 | ● ● ● | / |
| % Admissions Detained | 88.89% | 90.73% | ● ● ● | / |
| Emergency Re-admission Rate (rolling 12 months) | 2.26% | | | |
| Transfers in | 10 | | | |
| Discharges | 31 | 31 | ● ● ● | / |
| Transfers out | 8 | | | |
| Delayed Discharge/Transfer of Care (number of delayed discharges) | 18 | | | |
| Delayed Discharge/Transfer of Care (bed nights occupied by dd) | 458 | | | |
| Bed Occupancy excl. Leave (KH03) | 95.66% | 94.09% | ● ● ● | / |
| Bed Occupancy incl. Leave | 100.54% | 98.39% | ● ● ● | / |
| Average beds admitted to | 47.9 | | | |
| Average Discharged Length of Stay (12 month rolling) | 39.64 | 40.79 | ● ● ● | F |
| Average Discharged Length of Stay (discharged in month) | 35.17 | 39.34 | ● ● ● | ? |
| Live Length of Stay (as at month end) | 82.60 | 73.07 | ● ● ● | / |
| Number of People Out of Area at month end | 7 | 12 | ● ● ● | F |
| Number of Mental Health Out of Area Placements started in the period (admissions) | 3 | 9 | ● ● ● | ? |
| Total number of Out of Area bed nights in period | 303 | 382 | ● ● ● | F |

| Step Down (Beech) | May-23 | | | |
|---|---|---|---|---|
| | n | mean | SPC variation | SPC target |
| Admissions | 8 | 5 | ● ● ● | / |
| Transfers in | 2 | | | |
| Discharges | 7 | 4 | ● ● ● | / |
| Transfers out | 0 | | | |
| Bed Occupancy excl. Leave (KH03) | 86.45% | 76.25% | ● ● ● | / |
| Bed Occupancy incl. Leave | 88.06% | 84.56% | ● ● ● | / |
| Average Discharged Length of Stay (12 month rolling) | 50.50 | 54.82 | ● L ● | / |
| Live Length of Stay (as at month end) | 47.57 | 44.52 | ● ● ● | / |

**Length of Stay Detail – May 23**

Longest LoS (days) as at month end: **92**
Range = 9 to 92 days
Longest LoS (days) of discharges in month: **272**

**Narrative**
Metrics for Adult Acute within expected limits.
Beech discharged length of stay low, likely due to a number of short-term placements before moving on to final destinations.

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

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

*NB – No benchmarking available for Step Down beds*

**Length of Stay Detail – May 23**
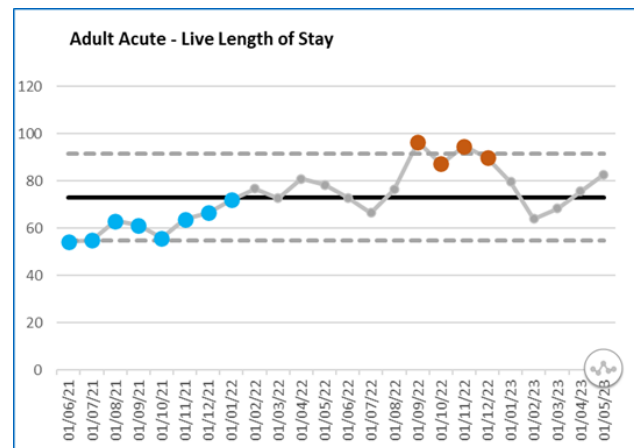
Longest LoS (days) as at month end:
247 on Dovedale 2
521 on Maple
183 on Burbage

Longest LoS (days) of discharges in month:
Dovedale 2 = 85
Maple = 201
Burbage = 60



Adult Acute - Live Length of Stay

# Inpatient Wards | PICU

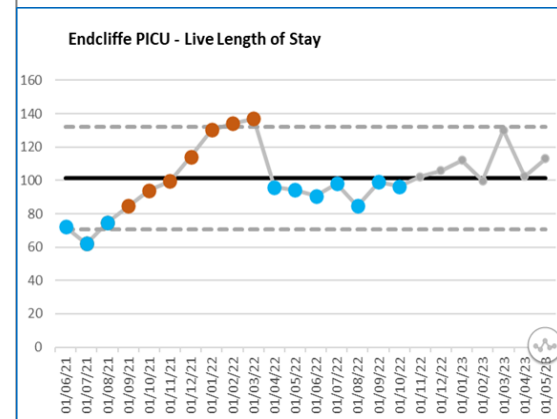| PICU (Endcliffe) | May-23 | | | |
|---|---|---|---|---|
| | n | mean | SPC variation | SPC target |
| Admissions | 4 | 4 | ● ● ● | / |
| Transfers in | 4 | | | |
| Discharges | 1 | 2 | ● ● ● | / |
| Transfers out | 7 | | | |
| Delayed Discharge/Transfer of Care (number of delayed discharges) | 1 | | | |
| Delayed Discharge/Transfer of Care (bed nights occupied by dd) | 31 | | | |
| Bed Occupancy excl. Leave (KH03) | 97.10% | 93.98% | ● ● ● | / |
| Bed Occupancy incl. Leave | 98.06% | 96.16% | ● ● ● | / |
| Average beds admitted to | 9.81 | | | |
| Average Discharged Length of Stay (12 month rolling) | 35.51 | 46.42 | ● L ● | ? |
| Live Length of Stay (as at month end) | 113.00 | 101.16 | ● ● ● | / |
| Number of People Out of Area at month end | 6 | 5 | ● ● ● | F |
| Number of Mental Health Out of Area Placements started in the period (admissions) | 4 | 3 | ● ● ● | ? |
| Total number of Out of Area bed nights in period | 166 | 146 | ● ● ● | F |

**Narrative**

**Endcliffe – Length of Stay – May 23**
As at 31/05/23, there were 3 service users on Endcliffe Ward with a length of stay over the national average (benchmarked) of 47 days.

Over national benchmark average (47)

| Start Date | LOS |
|---|---|
| 02/02/2021 17:38 | 848 |
| 01/02/2023 13:38 | 119 |
| 13/04/2023 19:00 | 48 |

Flow through PICU impacted by utilisation of the Emergency PICU referral pathway as well as increase in number of patients requiring PICU via recall/MoJ routes and a bed has to be found. This has led to the PICU & Acute system creating capacity to meet a clinical priority. Bed occupancy also impacted by requirement to ringfence beds to facilitate timely admissions. LoS for PICU disproportionally affected by 1 patient who has been on the ward for 848 days (at month end).



Endcliffe PICU - Live Length of Stay

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

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

| Older Adult Functional (Dovedale 1) | May-23 | | | |
|---|---|---|---|---|
| | n | *mean* | SPC variation | SPC target |
| Admissions | 3 | *5* | ●●● | / |
| Transfers in | 1 | | | |
| Discharges | 10 | *5* | ●●● | / |
| Transfers out | 1 | | | |
| Delayed Discharge/Transfer of Care (number of delayed discharges) | 5 | | | |
| Delayed Discharge/Transfer of Care (bed nights occupied by dd) | 116 | | | |
| Bed Occupancy excl. Leave (KH03) | 99.35% | *89.68%* | ●●● | / |
| Bed Occupancy incl. Leave | 100.86% | *95.69%* | ●●● | / |
| Average beds admitted to | 15.13 | | | |
| Average Discharged Length of Stay (12 month rolling) | 73.84 | *71.00* | ●●● | ? |
| Live Length of Stay (as at month end) | 69.60 | *68.04* | ●●● | / |

| Older Adult Dementia (G1) | May-23 | | | |
|---|---|---|---|---|
| | n | *mean* | SPC variation | SPC target |
| Admissions | 5 | *5* | ●●● | / |
| Transfers in | 0 | | | |
| Discharges | 5 | *6* | ●●● | / |
| Transfers out | 1 | | | |
| Delayed Discharge/Transfer of Care (number of delayed discharges) | 11 | | | |
| Delayed Discharge/Transfer of Care (bed nights occupied by dd) | 199 | | | |
| Bed Occupancy excl. Leave (KH03) | 71.77% | *75.61%* | ●●● | / |
| Bed Occupancy incl. Leave | 74.60% | *77.31%* | ●●● | / |
| Average beds admitted to | 11.94 | | | |
| Average Discharged Length of Stay (12 month rolling) | 78.58 | *68.87* | ● H ● | F |
| Live Length of Stay (as at month end) | 41.17 | *56.76* | ●●● | / |

**Length of Stay Detail May 23 – Dovedale 1**
Longest LoS (days) as at month end: **208**
Range = 1 to 208 days
Longest LoS (days) of discharges in month: **135**

**Length of Stay Detail May 23– G1**
Longest LoS (days) as at month end: **120**
Range = 2 to 120 days
Longest LoS (days) of discharges in month: **143**

**Narrative**
.

**Narrative**
The live length of stay has significantly reduced in May down to 41 days.
Due to excellent teamwork and working together with external partners our longest length of stay patient was successfully discharged, however as expected, this has also increased our average discharged LoS over 12 months.

**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.*

| Rehab (Forest Close) | May-23 | | | |
|---|---|---|---|---|
| | n | mean | SPC variation | SPC target |
| Admissions | 0 | 1 | ● ● ● | / |
| Transfers in | 1 | | | |
| Discharges | 1 | 2 | ● ● ● | / |
| Transfers out | 0 | | | |
| Bed Occupancy excl. Leave (KH03) | 90.32% | 83.00% | ● ● ● | / |
| Bed Occupancy incl. Leave | 99.89% | 92.63% | ● ● ● | / |
| Average Discharged Length of Stay (12 month rolling) | 268.21 | 274.47 | ● ● ● | P |
| Live Length of Stay (as at month end) | 363.60 | 315.19 | ● H ● | / |
| Number of People Out of Area at month end | 5 | | | |
| Number of Mental Health Out of Area Placements started in the period (admissions) | 0 | | | |
| Total number of Out of Area bed nights in period | 155 | | | |

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

**Length of Stay Detail May 23 - Forest Close (all)**
Longest LoS (days) as at month end: 1050
Range = 14 to 1050
Number of discharges in month: 1
Longest LoS (days) of discharges in month: 426

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

| Forensic Low Secure (Forest Lodge) | May-23 | | | |
|---|---|---|---|---|
| | n | mean | SPC variation | SPC target |
| Admissions | 1 | 1 | ● ● ● | / |
| Transfers in | 0 | | | |
| Discharges | 1 | 1 | ● ● ● | / |
| Transfers out | 0 | | | |
| Bed Occupancy excl. Leave (KH03) | 85.63% | 85.81% | ● H ● | / |
| Bed Occupancy incl. Leave | 99.12% | 92.31% | ● H ● | / |
| Average Discharged Length of Stay (12 month rolling) | 643.75 | 399.13 | ● L ● | P |
| Live Length of Stay (as at month end) | 406.08 | 330.68 | ● H ● | / |

**Forest Lodge**
Again, it should be noted that length of stay within Forest Lodge benchmarks very favourably against other low secure facilities across the country. Long stays are discussed within Horizon on a weekly basis, there are also risk assessments for appropriate placements.
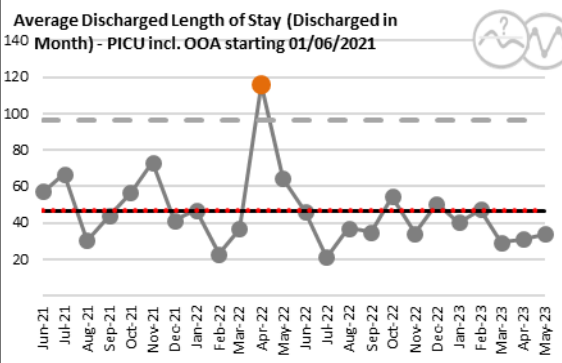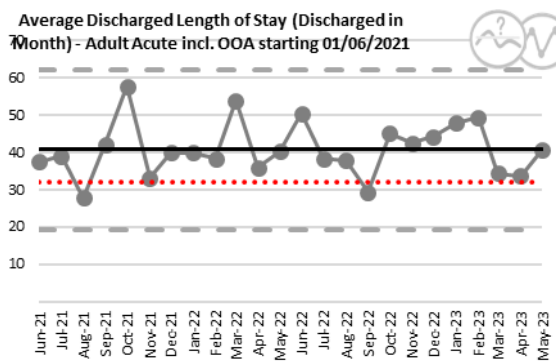
**The point at which someone is CRFD is reached when:**
- The multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in the current inpatient setting.
- To enable this decision:
  - There must be **a clear plan for the ongoing care and support that the person requires after discharge**, which covers their pharmacological, physical health, psychological, social, cultural, housing and finances, and any other individual needs or wishes.
  - The MDT must have **explicitly considered the person and their chosen carer/s' views and needs** about discharge and involved them in co-developing the discharge plan.
  - The MDT must also have **involved any services external to the trust in their decision making**, e.g. social care teams, where these services will play a key role in the person's ongoing care.

**Length of Stay Detail May 23 – Forest Lodge**
Longest LoS (days) as at month end: 1133
Range = 0 to 1133 days
Number of discharges in month: 1
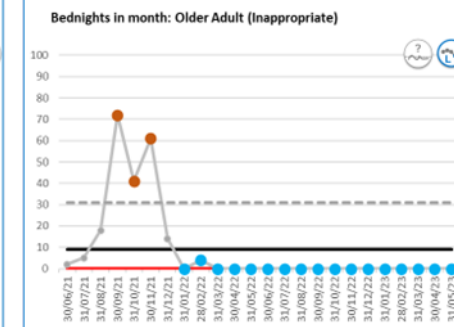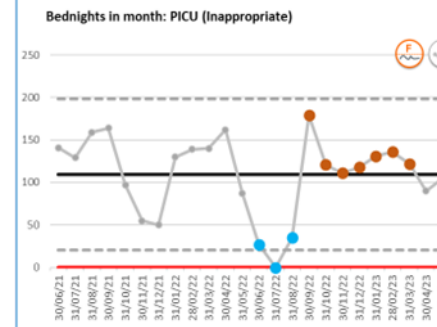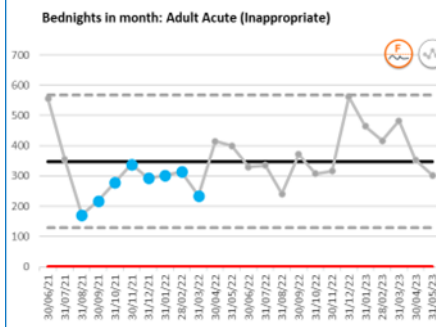Longest LoS (days) of discharges in month: 413

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

## Length of Stay


Average Discharged Length of Stay (Discharged in Month) - Adult Acute incl. OOA starting 01/06/2021


Average Discharged Length of Stay (Discharged in Month) - PICU incl. OOA starting 01/06/2021

| Adult Acute Discharged LoS (Rolling 12 month average) | | |
|---|---|---|
| Location | Total Discharges | Average Discharged LoS |
| Sheffield | 433 | 40 |
| OOA | 110 | 45 |
| Contracted | 115 | 42 |
| Combined | 658 | 41 |

| PICU Discharged LoS (Rolling 12 month average) | | |
|---|---|---|
| Location | Total Discharges | Average Discharged LoS |
| Sheffield | 88 | 36 |
| OOA | 35 | 42 |
| Combined | 123 | 37 |

## Out of Area


Bednights in month: Adult Acute (Inappropriate)


Bednights in month: PICU (Inappropriate)


Bednights in month: Older Adult (Inappropriate)

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

## HBPoS Repurposing


HBPoS Repurposed Beds
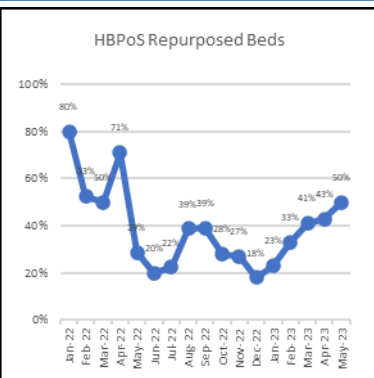
| May 2023 | | |
|---|---|---|
| Total Bed days | 31 | 31 |
| Days Repurposed | 10 | 21 |
| % Repurposed | 50% | |
| Days Occupied | 9 | 5 |
| % Occupied | 23% | |
| Days Available | 12 | 5 |
| % Available | 27% | |

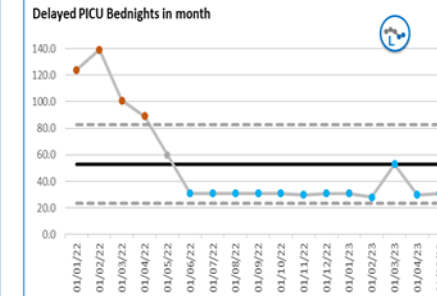| Health Based Place of Safety (HBPoS/136 Beds) | May-23 |
|---|---|
| Days repurposed | 31 |
| Days repurposed % | 50% |

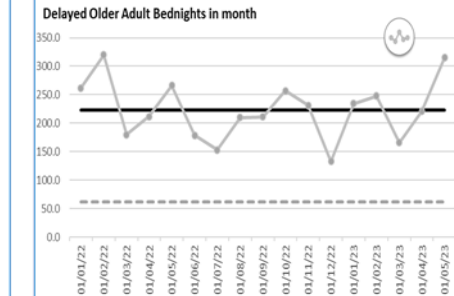## Delayed Care

### Delayed Care Narrative

% of bed nights occupied by delayed patients is 31.4% across adult acute wards. Weekly Clinically Ready for Discharge meeting membership has been extended to include social care colleagues to support earlier information sharing and discharges for those delayed.


Delayed Adult Acute Bednights in month


Delayed PICU Bednights in month


Delayed Older Adult Bednights in month
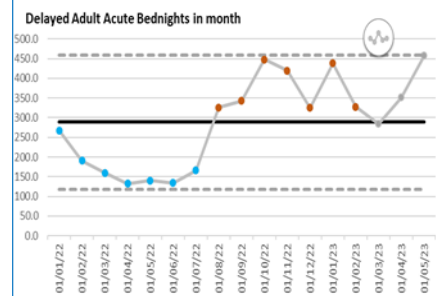
| Delayed Discharges Adult Acute | | |
|---|---|---|
| May 23 | Sum of Delayed Bednights | % Bednights occupied by DD |
| Adult Acute Total | 458 | 31.4% |

| Delayed Discharges PICU | | |
|---|---|---|
| May 23 | Sum of Delayed Bednights | % Bednights occupied by DD |
| Endcliffe | 31 | 10.0% |

| Delayed Discharges Older Adult | | |
|---|---|---|
| May 23 | Sum of Delayed Bednights | % Bednights occupied by DD |
| Older Adult Total | 315 | 32.8% |

## Narrative

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

Trustwide: 37/42 patients seen within 72 hours: 5 seen outside the target.

1 x followed up on day 3, 3 hours over the target from G1.

2 x followed up on day 4, from Maple and Burbage.

2 x no contact recorded from G1 and both discharged to Longley Park View Care Home. Both had different discharge destination postcodes and were not pulled through to the OA HTT 72 hour daily report.



72 hour follow up compliance - Trustwide starting 01/06/2021
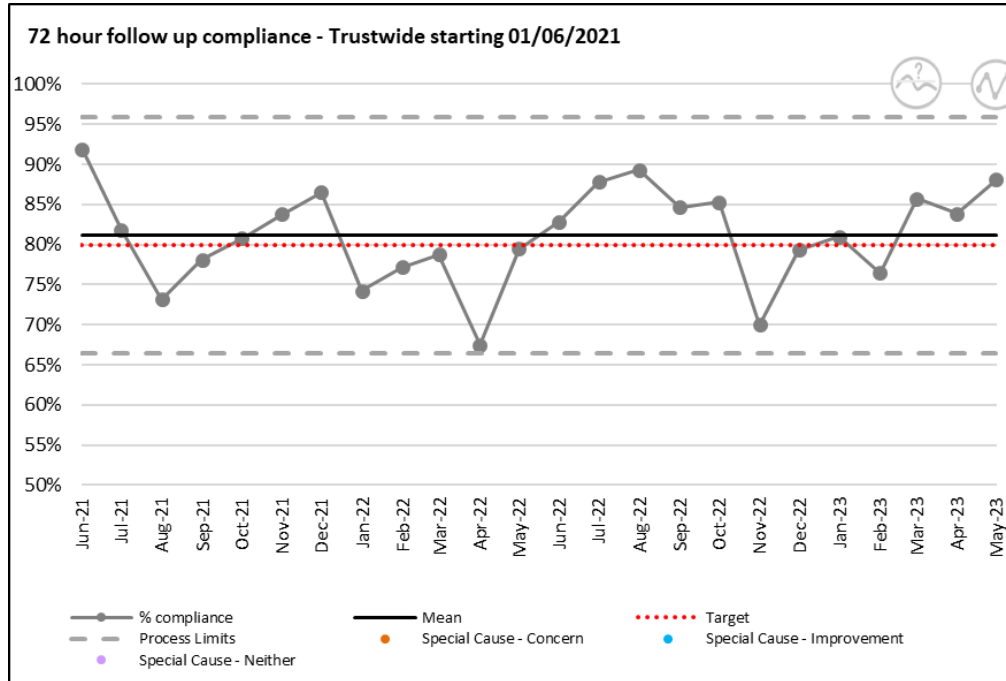
| CPA Review % Completed within 12 months | Target 2022/23 | | May-23 | | |
|---|---|---|---|---|---|
| | | n | *mean* | SPC variation | SPC target |
| Early Intervention | 95% | **99.1%** | *90.8%* | ● H ● | ? |
| MH Recovery North | 95% | **90.2%** | *90.0%* | ● ● ● | ? |
| MH Recovery South | 95% | **70.8%** | *73.2%* | ● ● ● | F |

| 72 hour Follow Up | May-23 | | | | |
|---|---|---|---|---|---|
| | Target | % | No. | SPC Variation | Target |
| Trustwide | 80% | **88.10%** | **37/42** | ● ● ● | ● ? ● |

# IAPT | Performance Summary

| IAPT | | May-23 | | | |
|------|------|------|------|------|------|
| Metric | Target 2022/23 | n | mean | SPC variation | SPC target |
| Referrals | / | 1503 | 1488 | ●●● | / |
| New to Treatment | 1431 | 1265 | 1136 | ●●● | ? |
| 6 week Wait | 75% | 98.40% | 98.39% | ● H ● | P |
| 18 week Wait | 95% | 99.80% | 99.81% | ●●● | P |
| Moving to Recovery Rate | 50% | 51.90% | 51.02% | ●●● | ? |

**Narrative**

- Service has achieved the recovery rate standard for 20 consecutive months.

- Continue to exceed the waiting time standard for people receiving their first treatment appointment.
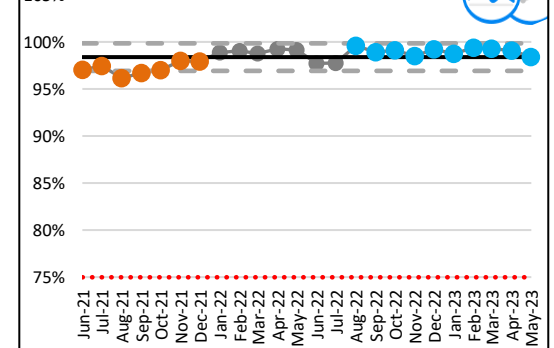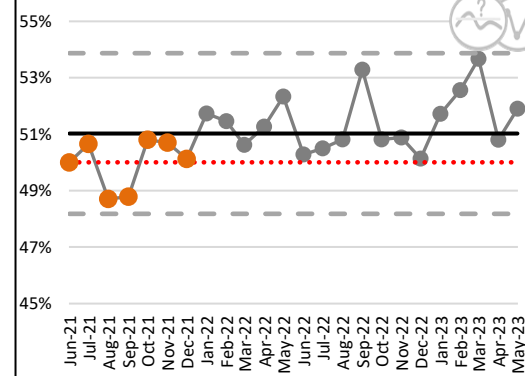


Referrals - IAPT starting 01/06/2021
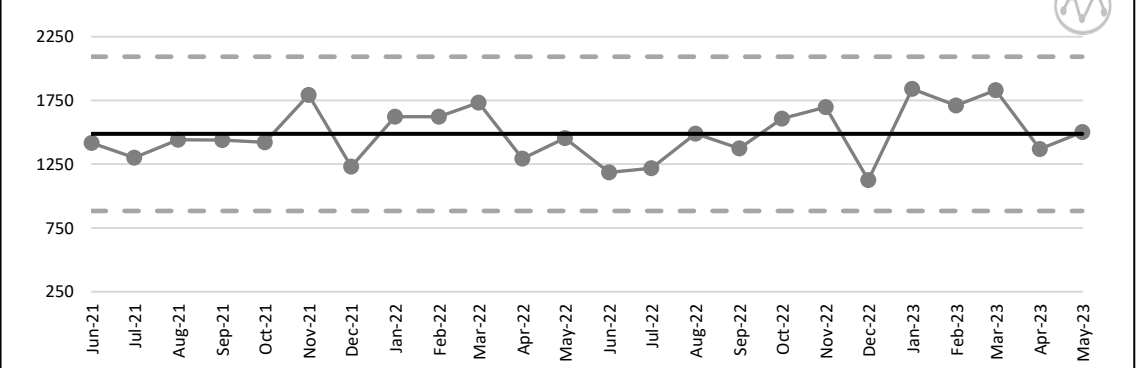


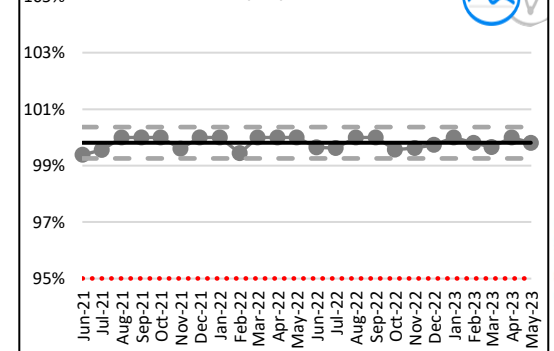IAPT New to Treatment - IAPT starting 01/06/2021
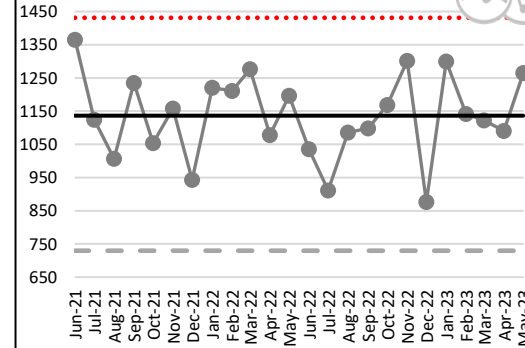


6 week treatment start - IAPT starting 01/06/2021



Recovery Rate - IAPT starting 01/06/2021



18 week treatment start - IAPT starting 01/06/2021

| START | | | | |
|---|---|---|---|---|
| **Opiates** | **Target 2022/23** | **n** | **SPC variation** | **SPC target** |
| Referrals | TBC | 78 | • • • | / |
| Waiting time Referral to Treatment ≤ 21 days | ≥ 95% | 100% | • • • | • • • |
| DNA Rate to Assessment | ≤ 15% | 19% | • • • | • • • |
| Recovery - Successful treatment exit | TBC | 5 | • • • | / |
| **Non-Opiates** | **Target 2022/23** | **n** | **SPC variation** | **SPC target** |
| Referrals | TBC | 62 | • • • | / |
| Waiting time Referral to Treatment | ≥ 95% | 85% | • • • | • • • |
| DNA Rate to Assessment | ≤ 15% | 42% | • • • | • • • |
| Recovery - Successful treatment exit | TBC | 14 | • • • | / |
| **Alcohol** | **Target 2022/23** | **n** | **SPC variation** | **SPC target** |
| Referrals | TBC | 160 | • • • | / |
| Waiting time Referral to Treatment | ≥ 95% | 100% | • H • | • P • |
| DNA Rate to Assessment | ≤ 15% | 27% | • • • | • • • |
| Recovery - Successful treatment exit | TBC | 42 | • • • | / |
| **Criminal Justice Caseload** | **Target 2022/23** | **April 2023** | | |
| Numbers on caseload (NDTMS) | 250 | 256 | | |

**Narrative**

**Engagement in treatment**

Referral numbers to the opiates, alcohol and non-opiates services are not currently working to a target but the treatment places are closely monitored by the commissioner. The service provides open access to treatment regardless of any previous presentations or drop-outs. For this reason, there is a group of service users who can cycle in and out of treatment. We work on addressing this through focussed engagement approaches with those who are repeat presentations, without denying treatment to anyone who needs it.

**Average waiting times for treatment assessment
April 2023**
Average wait time from referral to assessment in the opiates pathway was 4 days
Average wait time from referral to assessment in the non-opiates pathway was 12.5 days
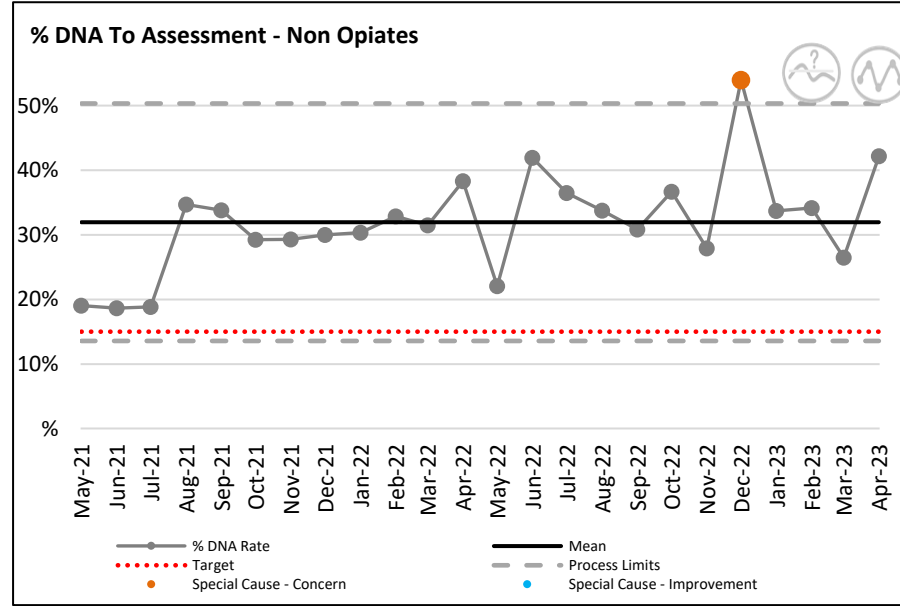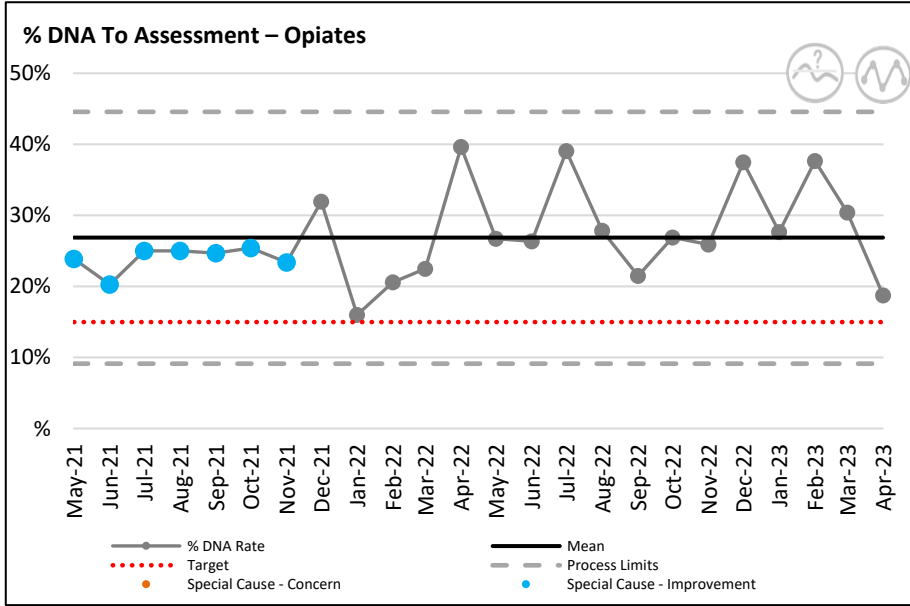Average wait time from referral to assessment in the alcohol pathway was 12.5 days

**Criminal Justice**

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

**Feedback from service users**

We are currently developing a new survey to receive service user feedback. We are also looking at other ways we can work with our client base to get feedback and share ideas. We will then consider the different forums that it is important to share this and consider positive change.
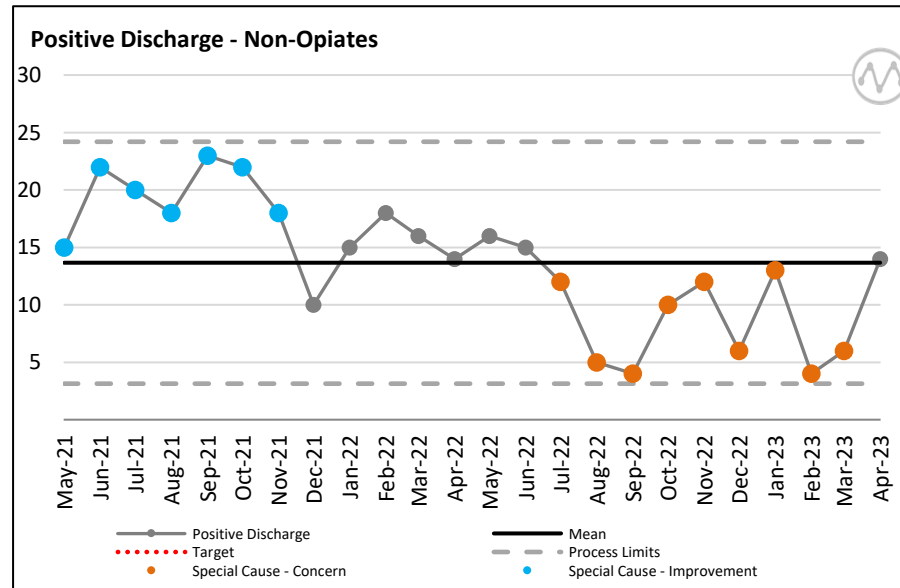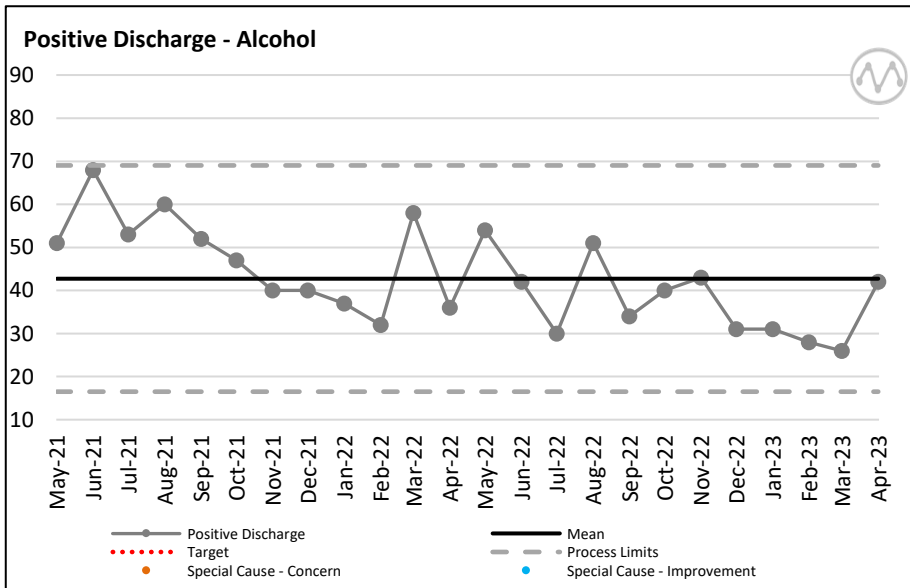
# START Performance | Highlights & Exceptions

## % DNA To Assessment – Opiates



Legend:
- % DNA Rate
- Target
- Special Cause - Concern
- Mean
- Process Limits
- Special Cause - Improvement

## % DNA To Assessment - Non Opiates



Legend:
- % DNA Rate
- Target
- Special Cause - Concern
- Mean
- Process Limits
- Special Cause - Improvement

### DNA to Assessment

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

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

## Positive Discharge - Alcohol



Legend:
- Positive Discharge
- Target
- Special Cause - Concern
- Mean
- Process Limits
- Special Cause - Improvement

## Positive Discharge - Non-Opiates



Legend:
- Positive Discharge
- Target
- Special Cause - Concern
- Mean
- Process Limits
- Special Cause - Improvement

### Recovery Successful treatment exits

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

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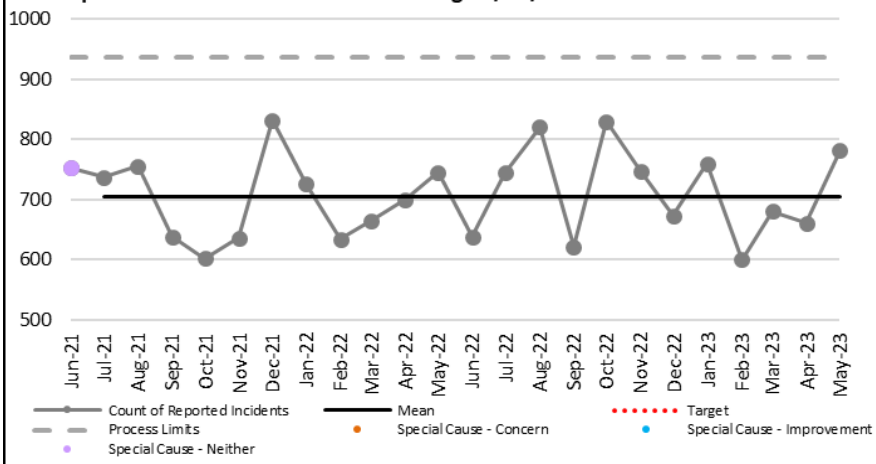
This can be seen in the chart, with more service users recorded as "dropped out" and fewer recorded as positive discharges.

# Safety & Quality

**IPQR - Information up to and including May 2023**

# Safe | All Incidents

## All Reported Incidents - Trustwide starting 01/06/2021



| Trustwide | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| **ALL** | **781** | *708* | ● ● ● |
| 5 = Catastrophic | **28** | *23* | ● ● ● |
| 4 = Major | **1** | *4* | ● ● ● |
| 3 = Moderate | **44** | *57* | ● ● ● |
| 2 = Minor | **317** | *258* | ● ● ● |
| 1 = Negligible | **371** | *353* | ● ● ● |
| 0 = Near-Miss | **20** | *19* | ● ● ● |

### Narrative
During May 2023, 1 incident was rated as Major. This was in relation to a COVID-19 positive case.

Of the 28 Catastrophic incidents, 21 were for Acute and Community services and 7 for Rehabilitation and Specialist services. All Catastrophic incidents were service user deaths, with the majority expected or suspected natural causes and will be reviewed in the mortality review group. No death related incidents have been identified as a S.I during this month.

### Narrative
Patient safety incidents are currently uploaded to the National Reporting Learning System (NRLS). The NHS is moving to a new platform, the Learning from Patient Safety Events (LFPSE) from 1 April 2023. All patient safety incidents will be uploaded to this from August 2023. The latest benchmarking information released from the NRLS covers the period April 2021 – March 2022 and was released on 13 October 2022. This shows SHSC's patient safety incident reporting rate at 83.0 incidents per 1000 bed days. Nationally, for mental health trusts, this rate varies from 7 to 222. Regionally (Yorkshire and the Humber), this rate varies from 42.7 to 132.6 patient safety incidents reported per 1,000 bed days.

The chart below shows SHSC patient safety incidents reported where harm was caused compared to no harm caused from May 2022 to April 2023

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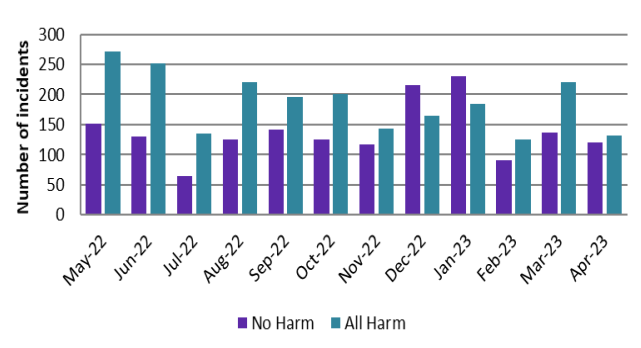


| Protecting from avoidable harm | Target | YTD |
|---|---|---|
| Never events declared | 0 | 0 |
| Methicillin-resistant Staphylococcus aureus (MRSA & MSSA) | 0 | 0 |

## Unreviewed Incidents (Overdue) - Clinical Directorates starting 01/06/2021



205 (R&S - 33, A&C - 172)
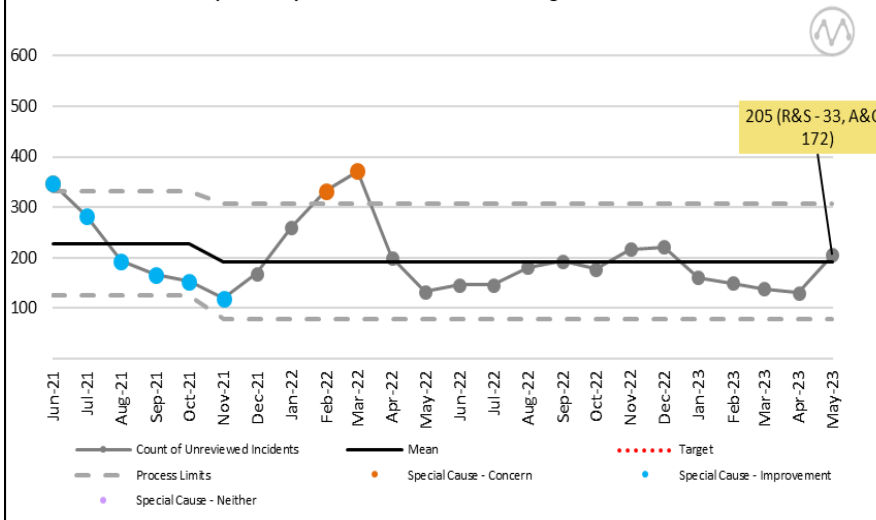
### Narrative
The unreviewed incidents are predominantly accounted for by the Acute and Community Directorate. 62 incidents remain unreviewed prior to May 2023.
Of the 205 unreviewed incidents, no incidents occurred prior to January 2023.
Directorate leads are working towards reducing the number of unreviewed incidents below 160.

### Medication incidents - Trust wide - starting 01/06/2021



| Trustwide | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| ALL | **73** | *83* | ● L ● |
| Administration Incidents | **11** | *15* | ● ● ● |
| Meds Management Incidents | **51** | *54* | ● ● ● |
| Pharmacy Dispensing Incidents | **3** | *8* | ● ● ● |
| Prescribing Incidents | **8** | *7* | ● ● ● |
| Meds Side Effect/Allergy Incidents | **0** | *0* | ● ● ● |

### Falls – Trustwide Incidents – Starting 01/06/2021



| Trustwide FALLS INCIDENTS | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| Trustwide Totals | **43** | *53* | ● ● ● |
| Acute & Community | **40** | *51* | ● ● ● |
| Nursing Homes | **28** | *30* | ● ● ● |
| Rehabilitation & Specialist Services | **3** | *2* | ● ● ● |

### Service users who fell – Trustwide – Starting 01/06/2021



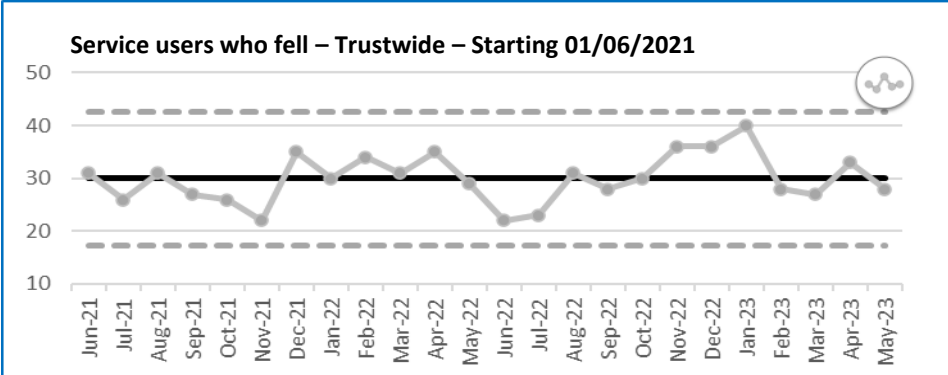| Trustwide FALLS - PEOPLE | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| Trustwide Totals | **43** | *30* | ● ● ● |
| Acute & Community | **25** | *28* | ● ● ● |
| Nursing Homes | **15** | *15* | ● ● ● |
| Rehabilitation & Specialist Services | **3** | *2* | ● ● ● |

## Narrative

**Medication Incidents**
During May 2023, there were 3 incidents rated as moderate. 2 were reported for Birch Avenue for Missed/Omitted Dose and Non-SHSC Pharmacy dispensing incident. The last incident was for Endcliffe ward CD Stock discrepancy.

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

**Falls Incidents**
Of the 43 incidents reported, 28 were in our Nursing homes. Birch Avenue continue to be the highest reporting of incidents, 20 for 9 people. The clinical leadership team at Birch Avenue along with the Directorate Leadership Team (DLT) are aware of the increased falls risk. HUSH huddles with support of the improvement academy commenced from the start of February with a focus on falls reduction.

# Safe | Assaults, Sexual Safety & AWOL Patients

| Assaults on Service Users | May-23 | | |
|---|---|---|---|
| | n | mean | SPC variation |
| Trustwide | 30 | 24 | ● ● ● |
| Acute & Community | 29 | 22 | ● ● ● |
| Rehabilitation & Specialist | 1 | 2 | ● L ● |

| Assaults on Staff | May-23 | | |
|---|---|---|---|
| | n | mean | SPC variation |
| Trustwide | 52 | 63 | ● ● ● |
| Acute & Community | 50 | 56 | ● ● ● |
| Rehabilitation & Specialist | 2 | 6 | ● ● ● |

## Narrative

Of the 30 reported incidents of assaults on service users, 2 were rated as moderate involving the assault of a service user by another service user. 1 incident occurred on Maple Ward and the other on Endcliffe Ward. While the number of incidents remains within expected variance, there has been a steady incline in incidents reported.

Out of the 52 assaults on staff reported incidents, 14 incidents were reported as Moderate, 1 occurring in START Alcohol Service, 6 on Maple ward and 7 on Endcliffe ward.

## Sexual Safety

There were 10 sexual safety incidents reported in May 2023.
1 Incident was rated as moderate in START Alcohol Service. 2 incidents were rated as negligible and 7 were minor. No incident resulted in an SI.

Whilst there has been no statistical change in the number of sexual safety incidents, we still consider this to be a priority area and a workplan is being developed.
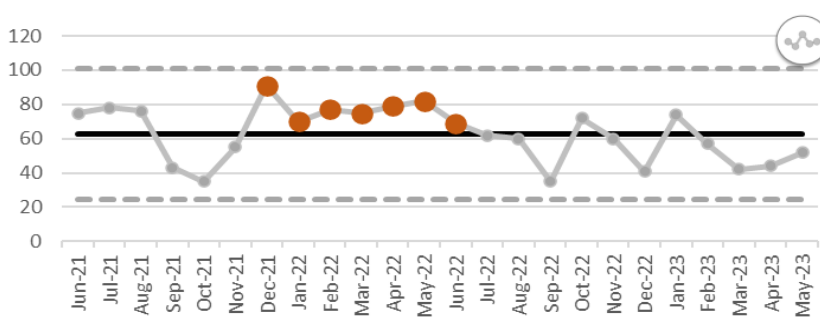

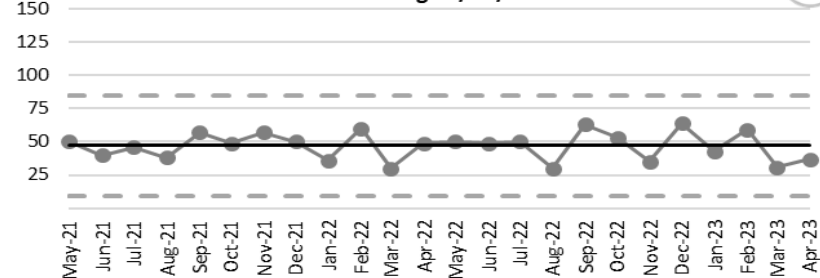Sexual Safety Incidents – Trust wide starting 01/06/2021
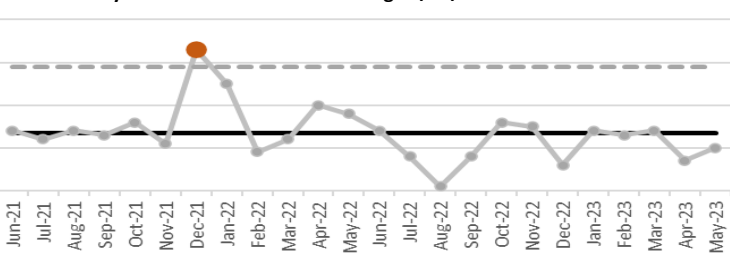

Assaults on Service Users – Trustwide starting 01/06/2021
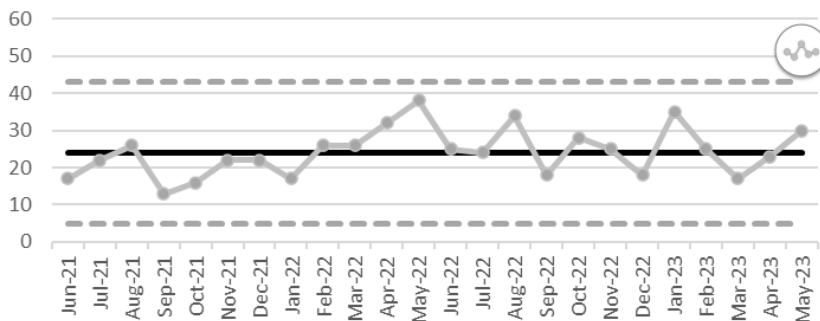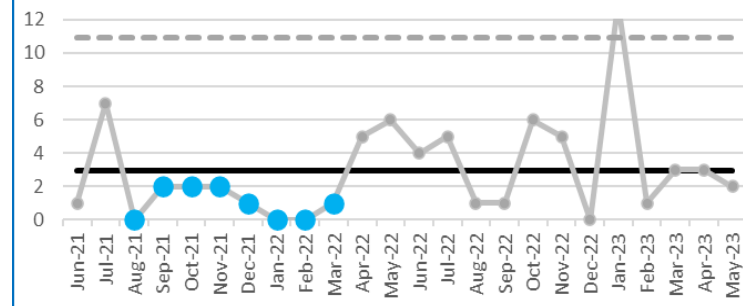

Assaults on Staff – Trustwide starting 01/06/2021


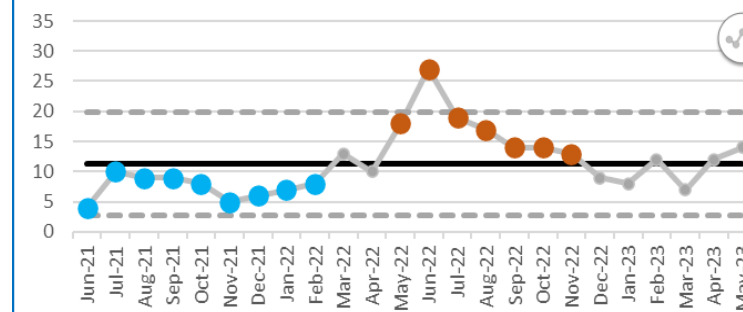Intimidation and Other Abuse to Staff (except Physical) - Trustwide starting 01/06/2021

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


Missing Patients Trustwide Informal


AWOL Patients Trustwide Detained

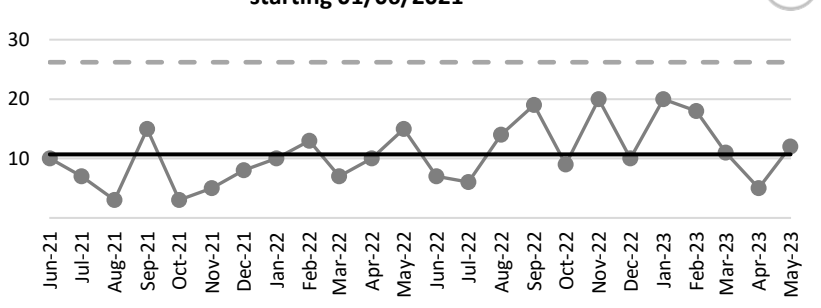| Trustwide | May-23 | | |
|---|---|---|---|
| | n | mean | SPC variation |
| Detained | 14 | 11 | ● ● ● |
| Informal | 2 | 3 | ● ● ● |

## Narrative

14 reported incidents in May 2023 of people under formal admission being AWOL. 2 incidents for Rehabilitation & Specialist Services for 2 people and 12 incidents for Acute & Community for 11 people.  At time of reporting:

- 1 people  were on a Section 2,
- 12 people were on a Section 3,
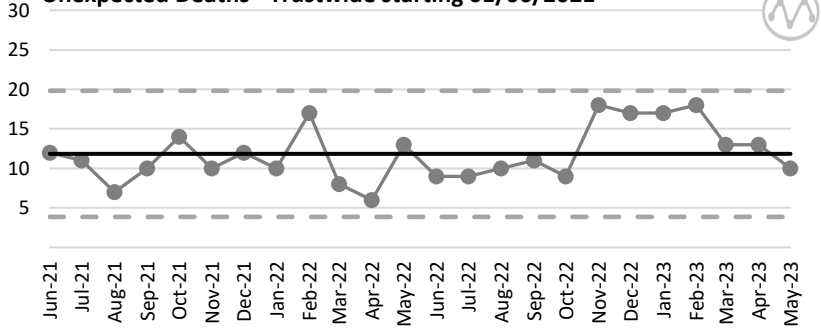- 1 person on MCA(DOLS)

# Deaths

### Expected Deaths - Trustwide starting 01/06/2021
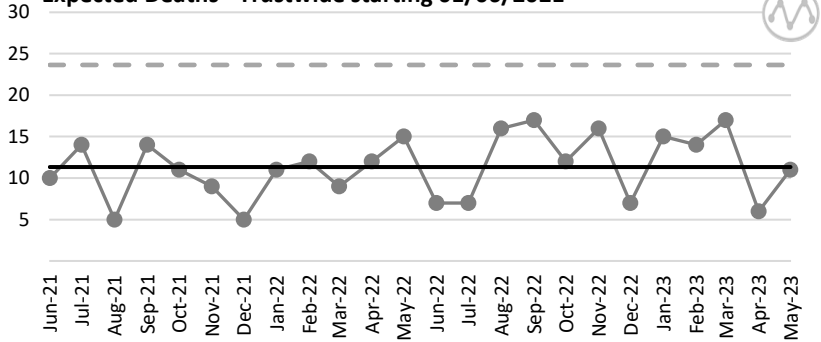


### Unexpected Deaths (Suspected Natural Causes) - Trustwide starting 01/06/2021



### Unexpected Deaths - Trustwide starting 01/06/2021



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

## Deaths Reported 1 June 2021 to 31 May 2023

| | |
|---|---|
| Awaiting Coroners Inquest/Investigation | 277 |
| Closed | 3 |
| Conclusion - Accidental | 1 |
| Conclusion - Alcohol/Drug Related | 10 |
| Conclusion - Misadventure | 1 |
| Conclusion - Other | 2 |
| Conclusion - Suicide | 10 |
| Natural Causes - No Inquest | 571 |
| Ongoing | 1 |
| **Grand Total** | **876** |

### Suspected Suicides - Trustwide starting 01/06/2021
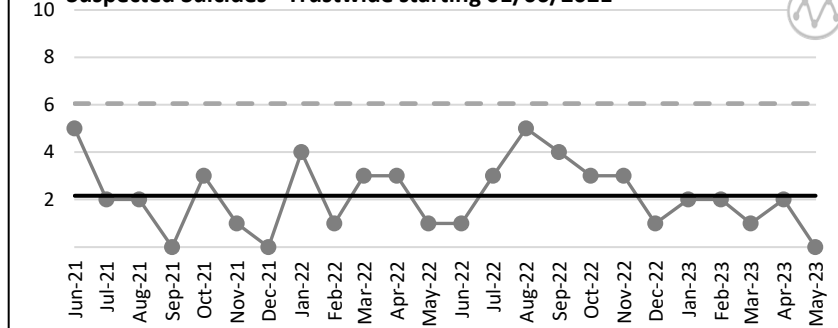


## COVID-19 Deaths 1 April 2020 – 31 May 2023

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

**Physical Restraint Incidents – starting 01/06/2021**
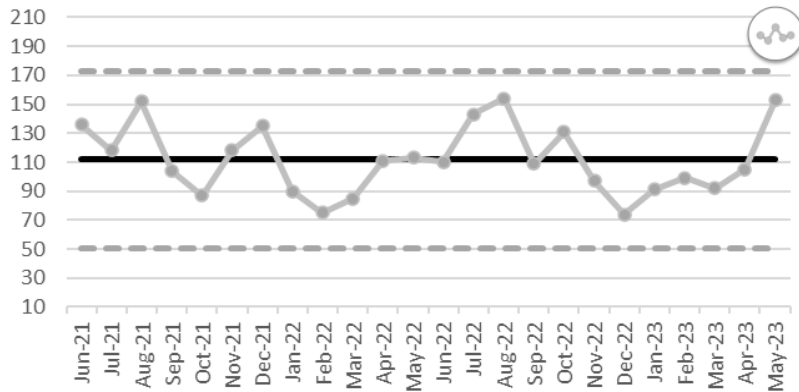


**People restrained – starting 01/06/2021**
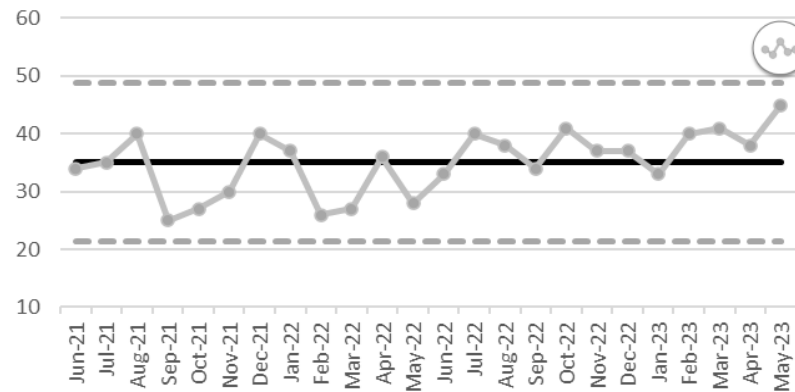


**Trustwide Mechanical Restraint Incidents**



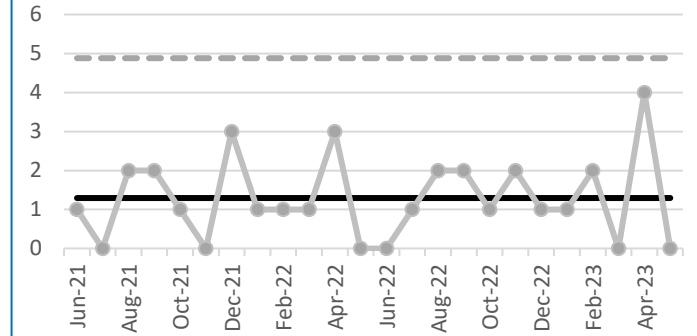| Physical Restraint INCIDENTS | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| TRUSTWIDE | **153** | *112* | ● ● ● |
| **Acute & Community** | **152** | *108* | ● ● ● |
| Dovedale 2 Ward | **49** | *22* | ● H ● |
| Burbage Ward | **7** | *9* | ● ● ● |
| Maple Ward | **48** | *26* | ● ● ● |
| HBPoS (136 Suite) | **0** | *1* | ● ● ● |
| Endcliffe Ward | **24** | *18* | ● ● ● |
| Dovedale 1 | **10** | *23* | ● ● ● |
| G1 Ward | **7** | *6* | ● ● ● |
| Birch Ave | **5** | *3* | ● ● ● |
| Woodland View | **2** | *1* | ● ● ● |
| **Rehabilitation & Specialist** | **0** | *2* | ● ● ● |
| Forest Close | **0** | *1* | ● ● ● |
| Forest Lodge | **0** | *1* | ● ● ● |

| Physical Restraint PEOPLE | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| TRUSTWIDE | **45** | *35* | ● ● ● |
| **Acute & Community** | **44** | *33* | ● ● ● |
| Dovedale 2 Ward | **7** | *6* | ● ● ● |
| Burbage Ward | **5** | *5* | ● ● ● |
| Maple Ward | **10** | *7* | ● ● ● |
| HBPoS (136 Suite) | **0** | *1* | ● ● ● |
| Endcliffe Ward | **9** | *6* | ● ● ● |
| Dovedale 1 | **3** | *3* | ● ● ● |
| G1 Ward | **4** | *4* | ● ● ● |
| Birch Ave | **4** | *2* | ● ● ● |
| Woodland View | **2** | *1* | ● ● ● |
| **Rehabilitation & Specialist** | **0** | *2* | ● ● ● |
| Forest Close | **0** | *1* | ● ● ● |
| Forest Lodge | **0** | *1* | ● ● ● |

**Narrative**

**Physical Restraint**
May has seen an increase in the number of physical restraints. There were 153 incidents recorded for 45 people.

Dovedale 2 has shown a high number of incidents reported with 7 service users in relation to physical assaults. 24 of the 49 incidents on Dovedale 2 was for 1 service user.
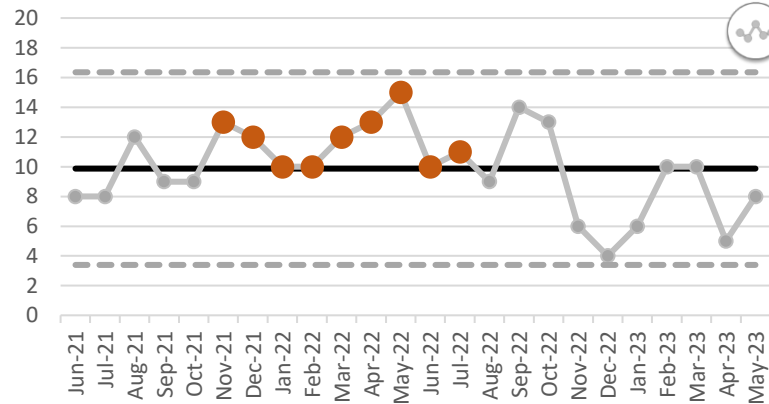
**Mechanical Restraint**
There have been no reported incidents for the use of Mechanical restraints during May 2023.

# Safe | Restrictive Practice | Rapid Tranquillisation

**Trustwide –Rapid Tranquillisation (Incidents) – starting 01/06/2021**
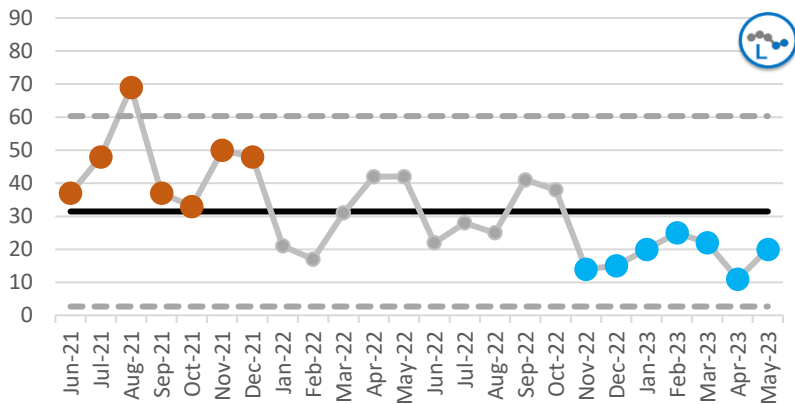


**Trustwide – Rapid Tranquillisation (People)– starting 01/06/2021**



| Rapid Tranquillisation INCIDENTS | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| TRUSTWIDE | **20** | *32* | ● L ● |
| **Acute & Community** | **20** | *31* | ● L ● |
| Dovedale 2 | **13** | *9* | ● ● ● |
| Burbage Ward | **0** | *2* | ● ● ● |
| Maple Ward | **2** | *7* | ● ● ● |
| HBPoS (136 Suite) | **0** | *0* | ● ● ● |
| Endcliffe Ward | **5** | *4* | ● ● ● |
| Dovedale 1 | **0** | *9* | ● L ● |
| G1 Ward | **0** | *0* | ● L ● |
| **Rehabilitation & Specialist** | **0** | *0* | ● L ● |
| Forest Close | **0** | *0* | ● L ● |
| Forest Lodge | **0** | *0* | ● L ● |

| Rapid Tranquillisation PEOPLE | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| TRUSTWIDE | **8** | *10* | ● ● ● |
| **Acute & Community** | **8** | *10* | ● ● ● |
| Dovedale 2 | **3** | *3* | ● ● ● |
| Burbage Ward | **0** | *1* | ● ● ● |
| Maple Ward | **1** | *2* | ● ● ● |
| HBPoS (136 Suite) | **0** | *0* | ● ● ● |
| Endcliffe Ward | **4** | *2* | ● ● ● |
| Dovedale | **0** | *1* | ● ● ● |
| G1 Ward | **0** | *0* | ● L ● |
| **Rehabilitation & Specialist** | **0** | *0* | ● L ● |
| Forest Close | **0** | *0* | ● L ● |
| Forest Lodge | **0** | *0* | ● L ● |

**Narrative**

**Rapid Tranquillisation**
20 incidents of rapid tranquillisations used were recorded during May for 8 people.
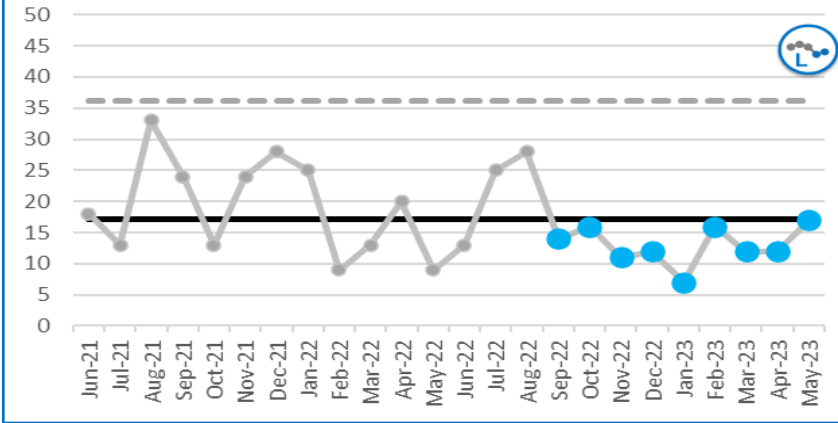
There continues to have been no reported incidents of rapid tranquillisation in the Rehabilitation & Specialist Directorate.

Low use of rapid tranquillisation is to be discussed at medicines optimisation committee
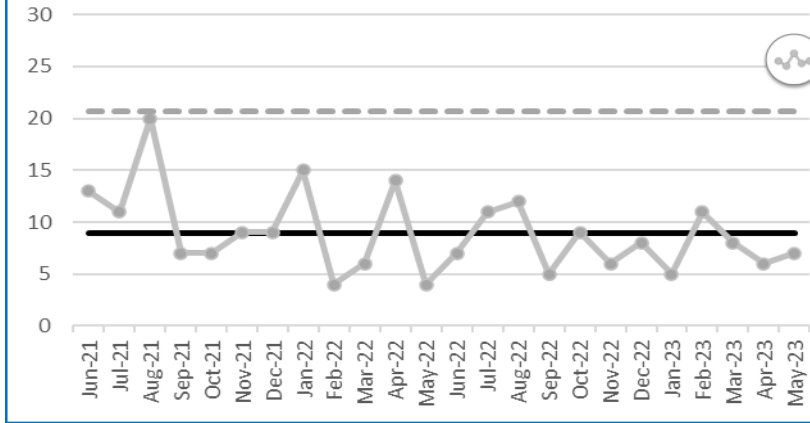
# Safe | Restrictive Practice | Seclusion

**Seclusion (Episodes) – starting 01/06/2021**



**Seclusion (People) – starting 01/06/2021**



| Seclusion INCIDENTS | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| **Trustwide** | **17** | *17* | ● L ● |
| **Acute & Community** | **17** | *13* | ● ● ● |
| Maple Ward | **6** | *4* | ● ● ● |
| HBPoS (136 Suite) | **0** | *2* | ● ● ● |
| Endcliffe PICU | **11** | *8* | ● ● ● |
| **Rehabilitation & Specialist** | **0** | *1* | ● ● ● |
| Forest Lodge | **0** | *1* | ● ● ● |

| Seclusion PEOPLE | May-23 | | |
|---|---|---|---|
| | **n** | *mean* | **SPC variation** |
| Trustwide | **7** | *9* | ● ● ● |
| **Acute & Community** | **7** | *8* | ● ● ● |
| Maple Ward | **4** | *3* | ● ● ● |
| HBPoS (136 Suite) | **0** | *1* | ● ● ● |
| Endcliffe PICU | **3** | *3* | ● ● ● |
| **Rehabilitation & Specialist** | **0** | *1* | ● ● ● |
| Forest Lodge | **0** | *0* | ● ● ● |

**Narrative**

**Seclusion**
17 Seclusion episodes recorded for 7 people in May 2023.

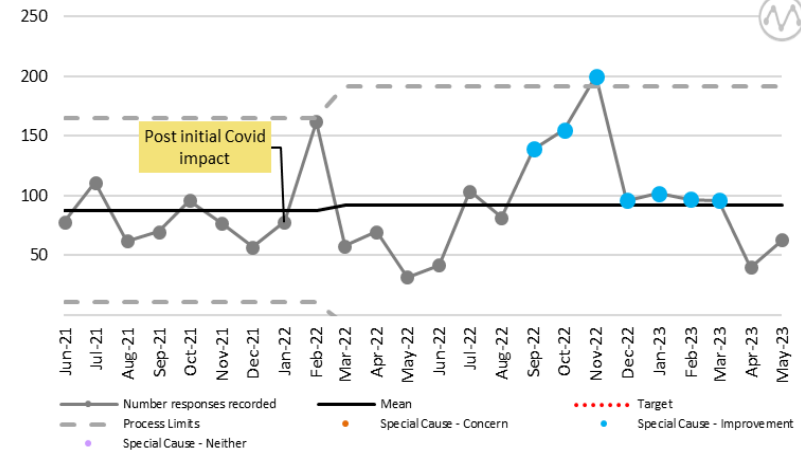G1 Ward, Dovedale 2 and Burbage continue to operate without a seclusion facility.

2 instances of prolonged seclusion recorded for 2 people. 1 instance on Endcliffe ward lasting 509 hours and the other instance on Maple lasting 95 hours.

Policy was followed during all instances of prolonged seclusion, with directorate leadership reviews and clinical executive reviews.

**Long-Term Segregation**
No long-term segregation in May 2023.

Friends and Family Test - Trustwide starting 01/06/2021

Post initial Covid impact

Legend: Number responses recorded — Mean ······ Target — Process Limits ● Special Cause - Concern ● Special Cause - Improvement ● Special Cause - Neither



Trustwide Total Compliments - starting 01/06/2021



Trustwide Total Complaints - starting 01/06/2021

**Narrative**

In May 2023, the Trust received a total of 63 responses to the FFT questions; 61 of the responses were positive regarding the FFT Question, 1 stated that their care was Neither Good nor Poor, 1 stated their care Poor, thus equating to 97% positive responses.

**A few positive responses are listed below:**
"Every department I visited to try and solve my problem have been nothing short of fantastic. All this has taken a lot of time and effort by everyone concerned. So, a big thank you to everyone; not to forget speech and language therapists." – LTNC Neuro-Enablement Service "Very relaxed, warm and clear answers given on how the course will run." – Early Intervention Service (EIS)
"Comfortable room and assessor was friendly and reassuring. Made me feel comfortable and open." – SAANS
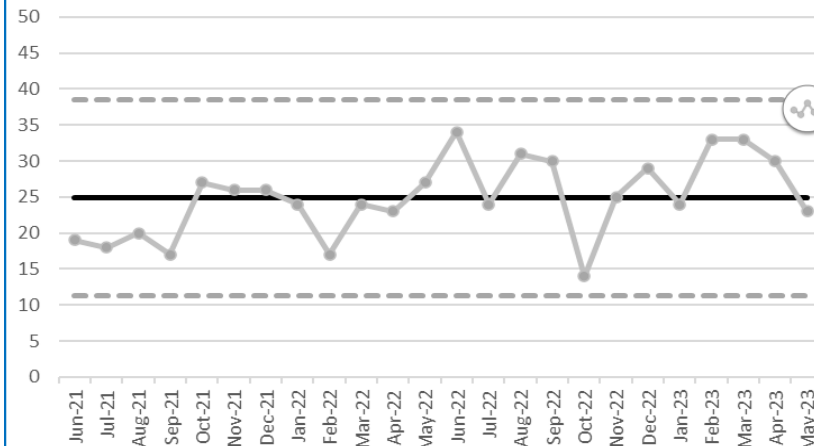
**A neutral response listed below:**
"Due to COVID, long time starting and another long time with strikes." – Memory Services

**A few negative responses are listed below:**
"The waiting process was extremely long, and I am very disappointed with the outcome that it feels as though I am stuck in the exact same position as I was beforehand and haven't made any developments or progress." – STEP
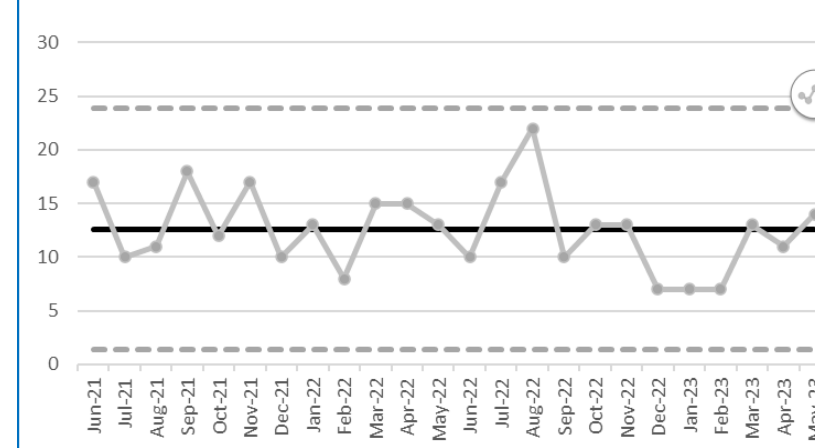
**Compliments**

There have been 23 compliments recorded as received in May. 12 received for Acute and Community and 11 for Rehabilitation and Specialist services.
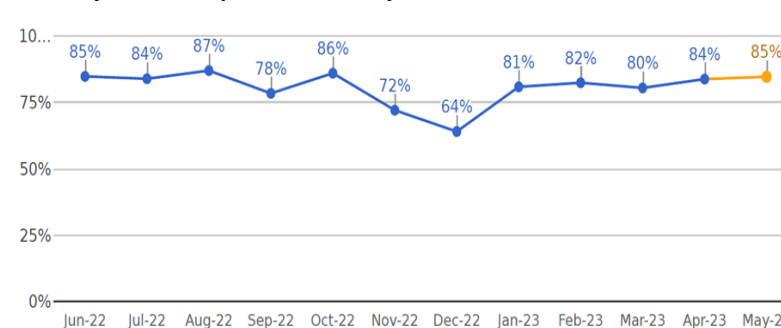
**Quality of Care Experience Survey**



**Complaints**

There were 13 new formal complaints received in May 2023. Access to Treatment remains as the most frequent complaint type.

6 formal complaints closed - 4 within agreed time and 1 after agreed time and 1 was closed due to no consent.

**Quality of Care Experience**

In May 2023, a total of 19 inspections were carried out across 8 areas – Forest Lodge, Forest Close – Ward 1a, Forest Close – Ward 1, Forest Close – Ward 2, Burbage, Beech, Maple Ward
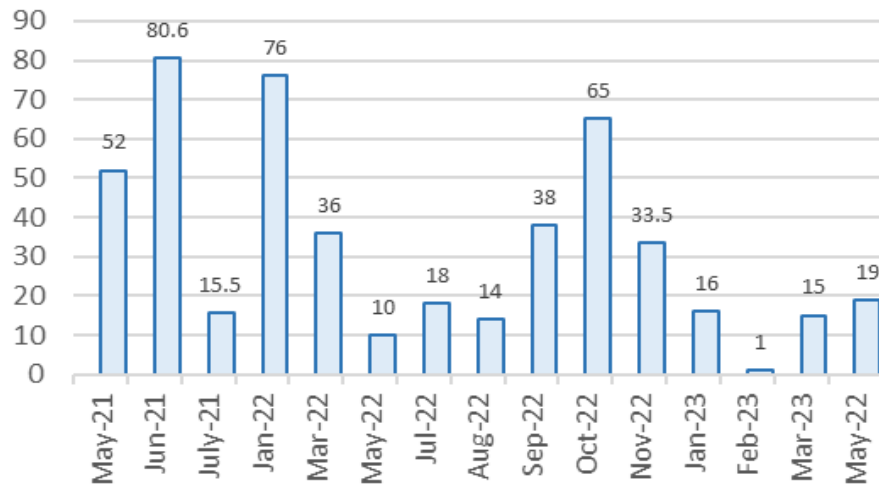
The average score across the organisation this month is 85%.

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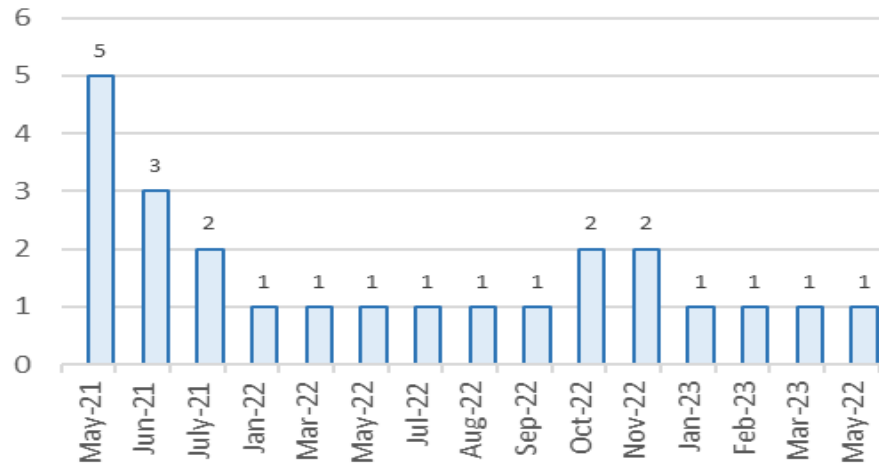
# Our People

**IPQR - Information up to and including May 2023**

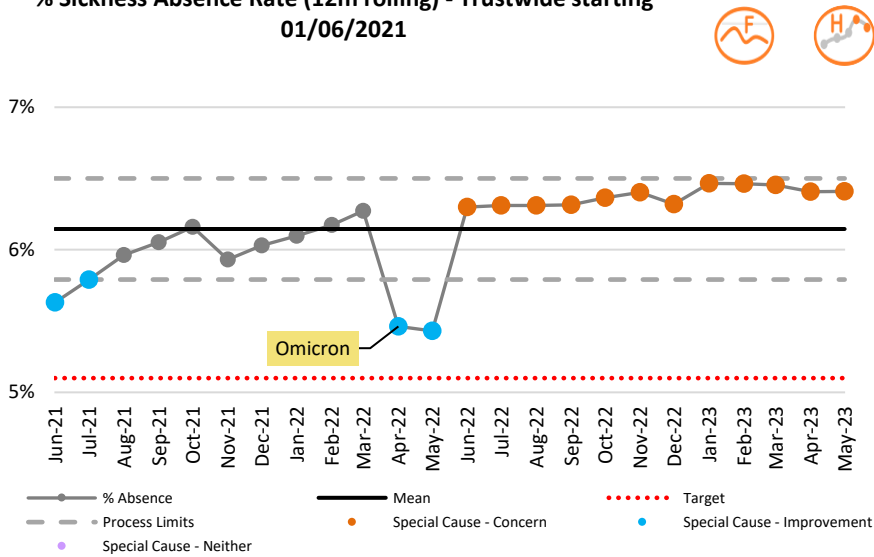Average Number of Days Between Incident & RIDDOR Reported
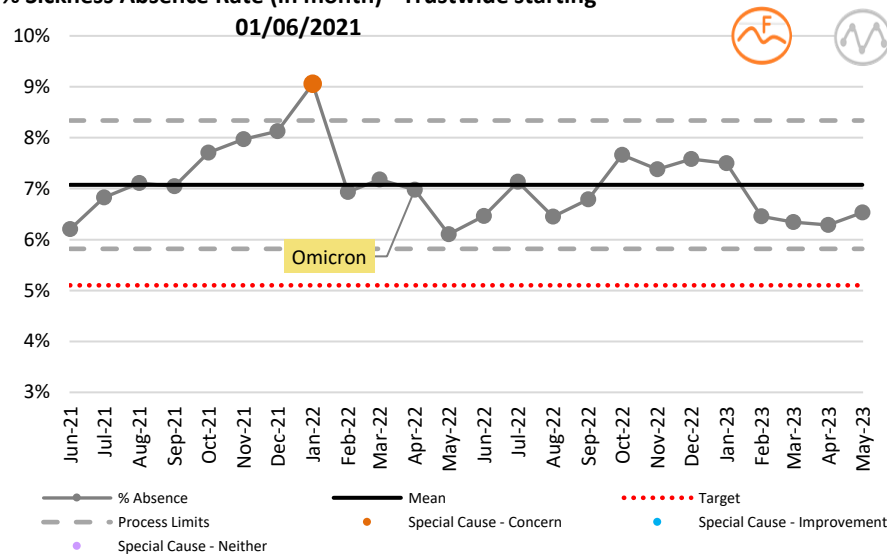


Number of Incidents - RIDDOR Reported

| Metric | Target | | May-23 | | | |
|--------|--------|---|--------|---|---|---|
| | | n | *mean* | SPC variation | SPC target | |
| Sickness 12 Month (%) | 5.10% | **6.41%** | *6.15%* | ● H ● | F | |
| Sickness In Month (%) | 5.10% | **6.53%** | *7.08%* | ● ● ● | F | |
| Long Term Sickness (%) | ~ | **3.98%** | *4.67%* | ● ● ● | / | |
| Short Term Sickness (%) | ~ | **2.56%** | *2.41%* | ● ● ● | / | |
| Headcount Staff in Post | ~ | **2739** | *2618* | ● H ● | / | |
| WTE Staff in Post | ~ | **2410** | *2296* | ● H ● | / | |
| Turnover 12 months FTE (%) | 10% | **15.22%** | *15.63%* | ● ● ● | F | |
| Training Compliance (%) | 80% | **87.82%** | *88.89%* | ● L ● | P | |
| Supervision Compliance (%) | 80% | **73.72%** | *71.77%* | ● ● ● | F | |

# Well-Led | Sickness

## % Sickness Absence Rate (12m rolling) - Trustwide starting 01/06/2021

Omicron

Legend:
- % Absence
- Mean
- Target
- Process Limits
- Special Cause - Concern
- Special Cause - Improvement
- Special Cause - Neither

## % Sickness Absence Rate (in month) - Trustwide starting 01/06/2021

Omicron

Legend:
- % Absence
- Mean
- Target
- Process Limits
- Special Cause - Concern
- Special Cause - Improvement
- Special Cause - Neither

## % Long Term Sickness Absence Rate (In Month) - Trustwide starting 01/06/2021

Omicron

Legend:
- % Long Term Absence
- Mean
- Target
- Process Limits
- Special Cause - Concern
- Special Cause - Improvement
- Special Cause - Neither

## % Short Term Sickness Absence Rate (In Month) - Trustwide starting 01/06/2021

Omicron

Legend:
- % Short Term Absence
- Mean
- Target
- Process Limits
- Special Cause - Concern
- Special Cause - Improvement
- Special Cause - Neither
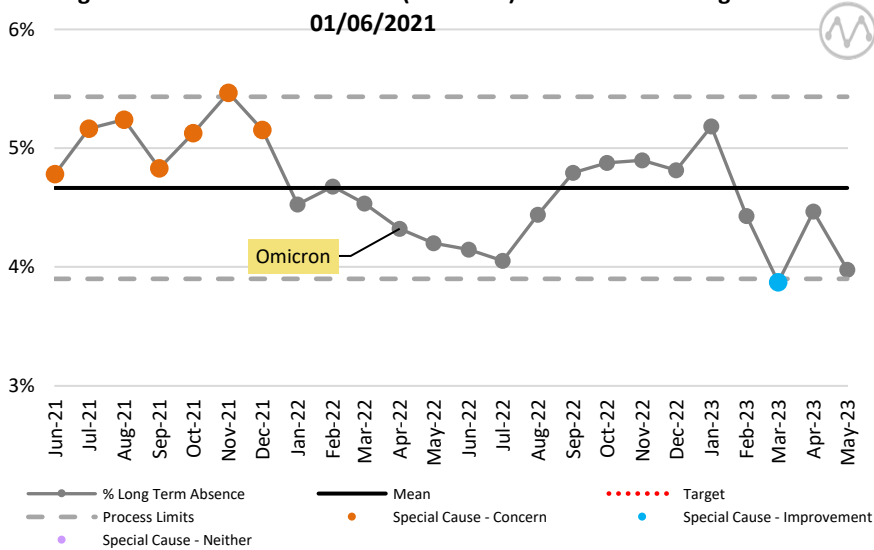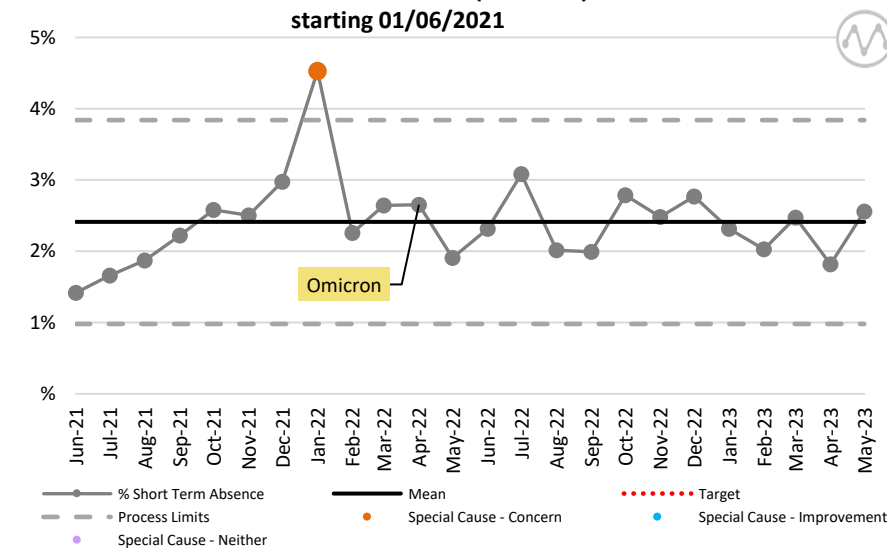
### Narrative

Slight rise in Sickness for May 2023 to 6.53%. Still operating within parameters but above the 5.1% Target set by the Organisation.
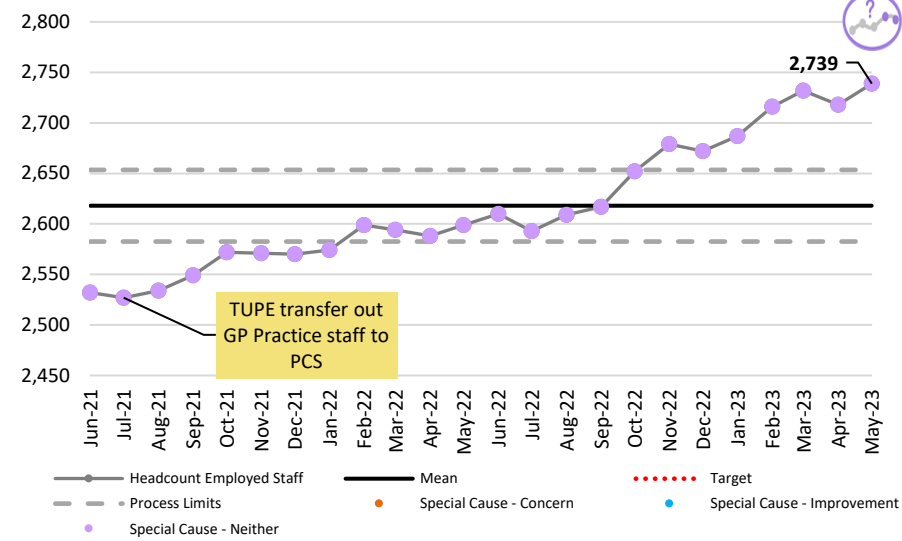
Short Term Sickness is still operating below the previous 2-year mean average and just above the lower performance threshold.

Long Term sickness however has risen slightly from 1.82% to 2.56% from April to March.

Continued efforts to reduce sickness are ongoing as part of the Absence reduction project which is governed through the Agency reduction CIP Programme.
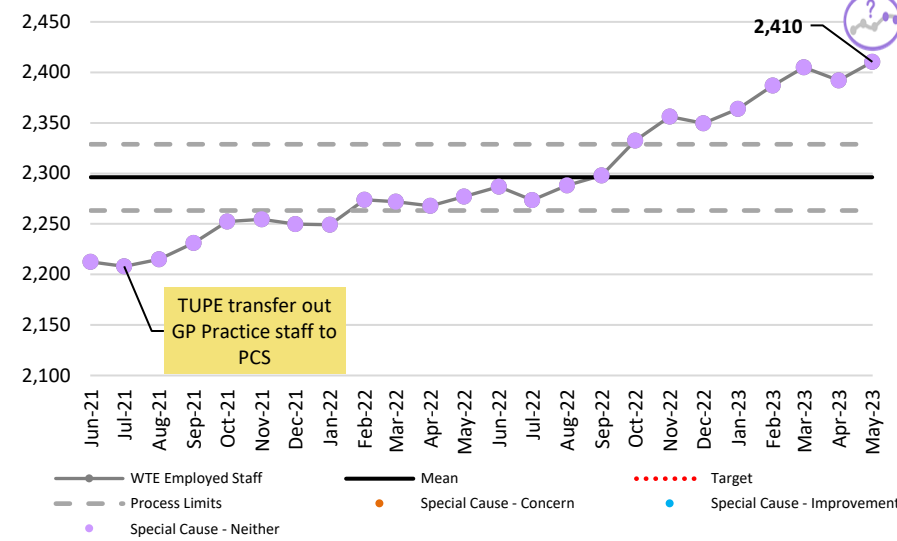
New Workbooks are being piloted to capture and manage long-Term sickness. Long-term Sickness will be monitored on a case-by-case basis and support offered on a monthly basis to managers to support colleagues back to work with reasonable adjustments.

S10 – Stress/Anxiety/depression continues to be the highest reason for sickness accounting for 38% of all absence reasons.

## Headcount - Trustwide starting 01/06/2021



2,739

TUPE transfer out GP Practice staff to PCS

Legend:
- Headcount Employed Staff
- Mean
- Target
- Process Limits
- Special Cause - Concern
- Special Cause - Improvement
- Special Cause - Neither

## WTE - Trustwide starting 01/06/2021



2,410

TUPE transfer out GP Practice staff to PCS

Legend:
- WTE Employed Staff
- Mean
- Target
- Process Limits
- Special Cause - Concern
- Special Cause - Improvement
- Special Cause - Neither

## Narrative

Headcount and WTE continue to rise and are above the upper threshold once again.
Turnover rate remains around 15% - This includes TUPE transfers of AHP staff and Doctors rotation. With these staff groups removed our turnover rate is around 12.99%
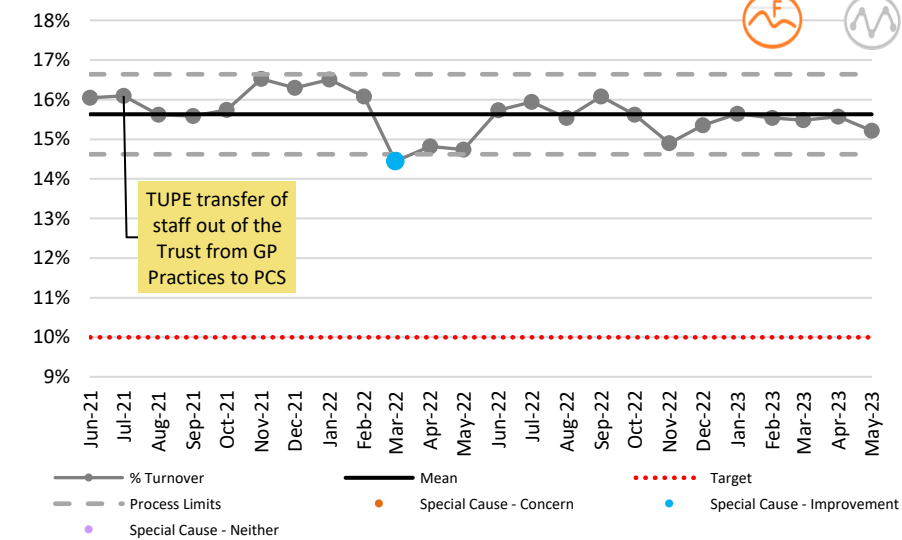Vacancies split by directorate. Working on a split by org L5 department for next people committee:
Medical – 17.1% of all vacancies
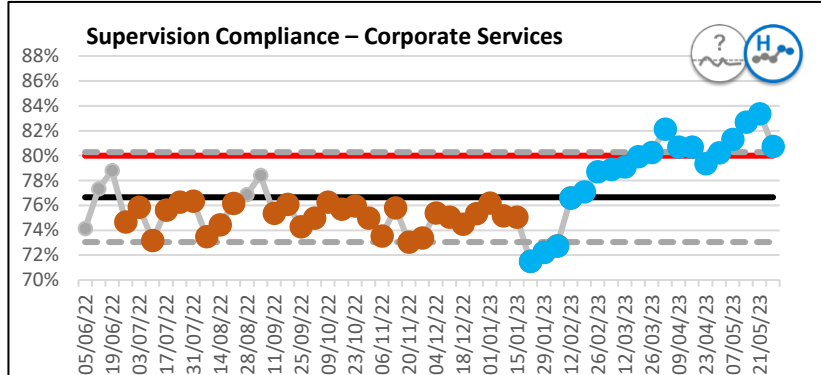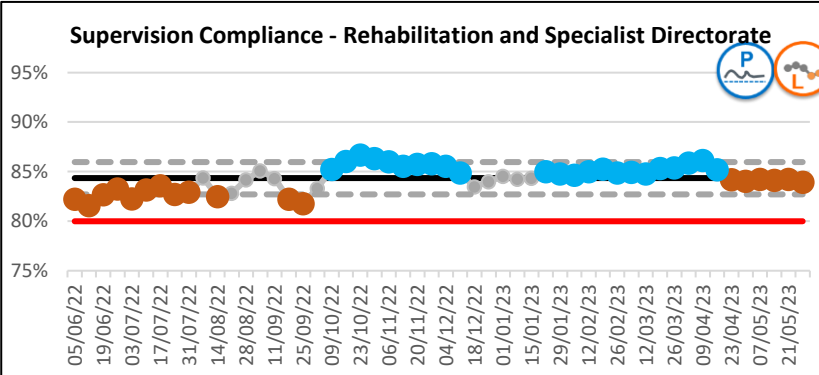Clinical Ops – 56.4% of all vacancies
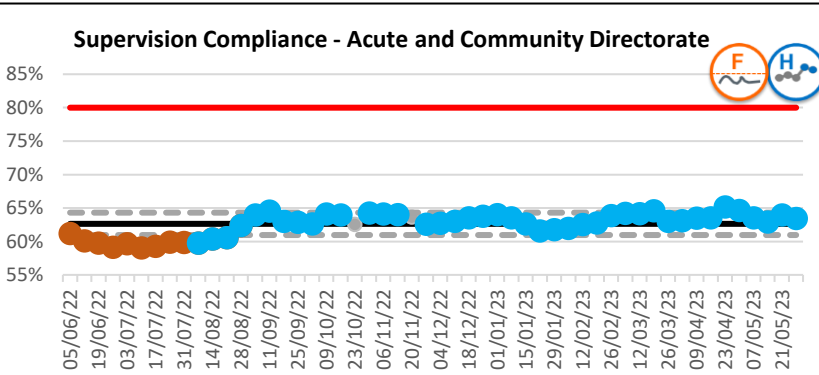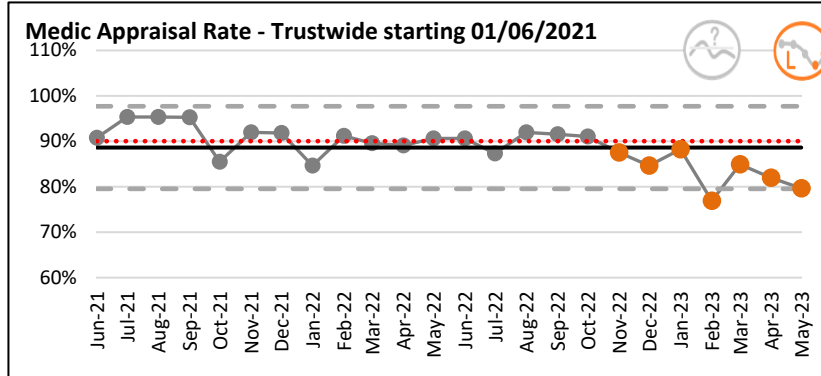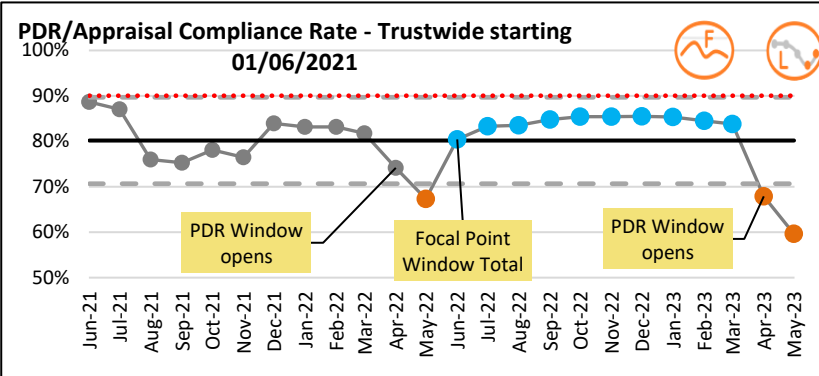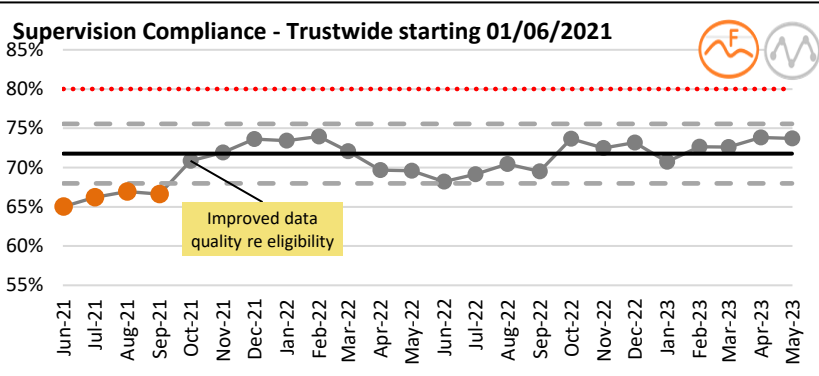Corporate – 31.3% of all vacancies
The breakdown of the vacancy rate per Org L3
Medical – 8.5%
Clinical Ops 3.2%
Corporate – 8.1%

## Turnover Rate (12m FTE rate) - Trustwide starting 01/06/2021



TUPE transfer of staff out of the Trust from GP Practices to PCS

Legend:
- % Turnover
- Mean
- Target
- Process Limits
- Special Cause - Concern
- Special Cause - Improvement
- Special Cause - Neither

### Supervision Compliance - Trustwide starting 01/06/2021



Improved data quality re eligibility

### PDR/Appraisal Compliance Rate - Trustwide starting 01/06/2021



PDR Window opens

Focal Point Window Total

PDR Window opens

### Medic Appraisal Rate - Trustwide starting 01/06/2021



### Supervision Compliance - Acute and Community Directorate



### Supervision Compliance - Rehabilitation and Specialist Directorate



### Supervision Compliance – Corporate Services



**AIM**

We will ensure that 80% staff have received at least the required minimum of 8 supervisions in a 12-month period (6 for part time staff), and that it is recorded in and reported on from a single source – the Supervision webform.

**Narrative**

As at 31 May 2023, average compliance with the 8/12 target is:

Trustwide **73.72%**
Clinical Services **72.12%**

Weekly updated information is monitored and reviewed weekly by Directors and Service Leads. Clinical Directorate Service Lines and teams performance is monitored each month at Directorate IPQR reviews; Corporate Services at triannual performance reviews.

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

**Mandatory Training Compliance - Trustwide starting 01/06/2021**
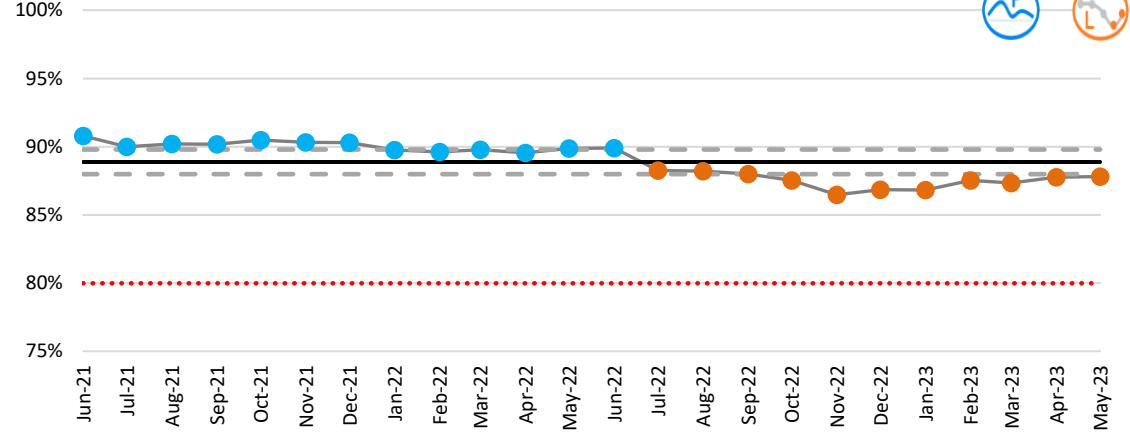


**Narrative**

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

**AIM**

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

| COMPLIANCE – As at date | 02/05/2023 | 23/05/2023 |
|---|---|---|
| **Trustwide** | **87.77%** | **87.82%** |
| Directorate/Service Line | | |
| Corporate Services | 82.34% | 82.47% |
| Medical Directorate | 86.00% | 85.04% |
| Acute & Community – Crisis | 89.48% | 89.38% |
| Acute & Community – Acute | 89.36% | 89.13% |
| Acute & Community – Community | 91.63% | 91.86% |
| Acute & Community – Older Adults | 84.72% | 85.52% |
| Rehab & Specialist – Forensic & Rehab | 92.20% | 91.98% |
| Rehab & Specialist – Highly Specialist | 91.38% | 91.60% |
| Rehab & Specialist – Learning Disabilities | 90.78% | 89.97% |
| Rehab & Specialist – IAPT | 93.75% | 94.93% |
| Rehab & Specialist – START | 84.26% | 82.79% |

# NO FINANCIAL REPORTING FOR MONTH 1&2 OF 2023/24

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<br>The icon which represents the last data point on an SPC chart is displayed. | | | | | | Assurance Icons<br>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 | | **Start Date** | 01/01/2019 |
| **Team/Service** | Team/Directorate/Trust | | **Duration** | 24 | Months |
| **Your Measure** | Your metric | | **Baseline** | |
| **Improvement Indicator** | High is Good | | **Min Value** | 0 |
| **Target** | 85 | | **Max Value** | 100 |

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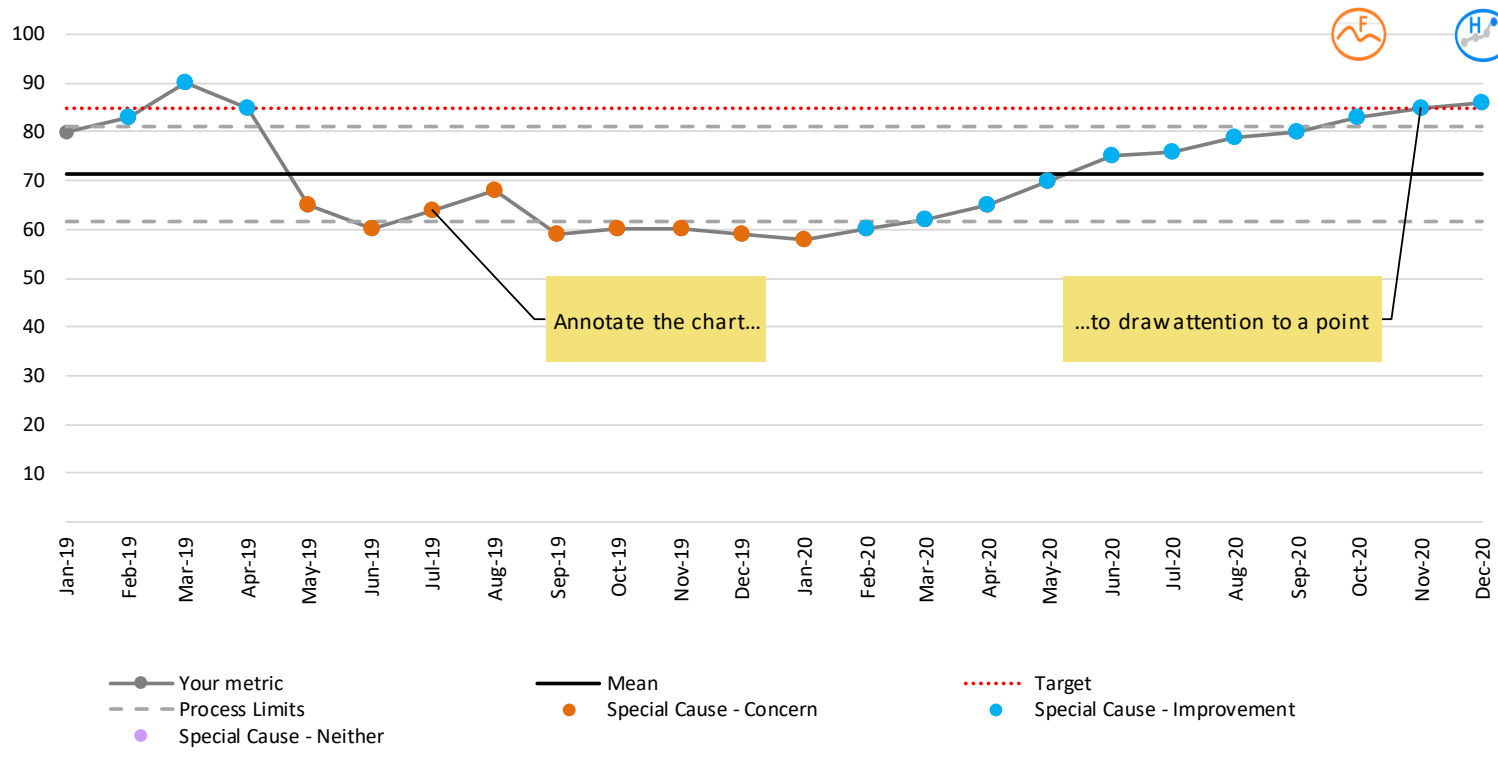


## Observations

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. |