# Board of Directors - Public

| SUMMARY REPORT | Meeting Date: | 22 November 2023 |
|---|---|---|
| | Agenda Item: | 14 |

| | | |
|---|---|---|
| **Report Title:** | Integrated Performance and Quality Report (IPQR) September 2023 | |
| **Author(s):** | Business and Performance Team | |
| **Accountable Director:** | Phillip Easthope, Executive Director of Finance, Digital & Performance | |
| **Other meetings this paper has been presented to or previously agreed at:** | **Committee/Tier 2 Group/Tier 3 Group** | People Committee<br>Quality Assurance Committee<br>Finance & Performance Committee |
| | **Date:** | 7th November 2023<br>8th November 2023<br>9th November 2023 |
| **Key points/ recommendations from those meetings** | **Comments from People Committee**<br><br>The committee received the following key alerts:<br><br>• Supervision within Rehab and Specialist services are consistently achieving 80% Trust target.<br><br>• Trust wide supervision compliance has sustained above the 24 month mean for the last 8 months.<br><br>• Mandatory Training consistently achieving 80% Trust wide.<br><br>• Areas for concern are staff sickness, staff turnover, PDR completion rate, and supervision. Recovery plans for supervision are in place. However, the committee requested that high level information on the trajectories for recovery plans for supervision, mandatory training and PDR completion rates are reported in the January IPQR.<br><br>**Comments from Quality Assurance Committee**<br><br>The committee received the report and noted the following highlights:<br><br>• Issues remain with the out of area use and repurposing of the Health-Based Place of Safety.<br><br>• There are still chronic issues with respect to waiting times across the highlighted services.<br><br>• Celebration of SPA and EWS following successful triaging and significant improvement in waiting lists.<br><br>• There was a period where restrictive practice wasn't used on Burbage for 2 weeks reflecting the improvement work ongoing on the ward.<br><br>• Currently issues with supervision are ongoing particularly around Acute and Community directorate. | |

| | |
|---|---|
| | • The Quality Improvement initiatives have reduced the triage wait from 4-6 weeks 12 months ago to 1 week for currently reviewing routine cases supporting readiness for transfer to Primary Community Mental Health Offer and Urgent and Crisis Offer.<br>• The positive impact the reducing restrictive practice plan was having and Dovedale 2's attempt to work in a trauma informed way.<br>**Comments from Finance & Performance Committee**<br>The committee noted receipt of the IPQR. The worsening financial position was discussed at length during the meeting as part of the regular financial reports. Related matters will be escalated to the Board as part of the FPC AAA report. |

**Summary of key points in report**

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

The report was presented and considered in detail to the People Committee, Quality Assurance Committee and Finance & Performance Committee in November 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.

Appendices attached: Integrated Performance & Quality Report – September 2023

**Recommendation for the Board/Committee to consider:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Consider for Action** | | **Approval** | | **Assurance** | ✓ | **Information** | ✓ |

The Trust Board is asked to accept the assurance provided by this report, whilst acknowledging the ongoing concerns to performance and quality in the identified areas.

| **Please identify which strategic priorities will be impacted by this report:** | | | | |
|---|---|---|---|---|
| Recover services and improve efficiency | *Yes* | ✓ | *No* | |
| Continuous quality improvement | *Yes* | ✓ | *No* | |
| Transformation – Changing things that will make a difference | *Yes* | ✓ | *No* | |
| Partnerships – working together to make a bigger impact | *Yes* | | *No* | ✓ |

| **Is this report relevant to compliance with any key standards ?** | | | | | **State specific standard** |
|---|---|---|---|---|---|
| **Care Quality Commission Fundamental Standards** | *Yes* | ✓ | *No* | | This report ensures compliance with NHS Regulation – CQC Regulation may be a by- product of this. |
| **Data Security and Protection Toolkit** | *Yes* | | *No* | ✓ | |
| **Any other specific standard?** | | | | | |

| **Have these areas been considered? YES/NO** | | | | | If Yes, what are the implications or the impact? If no, please explain why |
|---|---|---|---|---|---|
| Service User and Carer Safety, Engagement and Experience | *Yes* | ✓ | *No* | | Any impact is highlighted within relevant sections |

| | | | | | |
|---|---|---|---|---|---|
| Financial (revenue &capital) | *Yes* | ✓ | *No* | | CIP delivery is being offset by underspending on investments and COVID funding |
| Organisational Development /Workforce | *Yes* | ✓ | *No* | | Any impact is highlighted within relevant sections |
| Equality, Diversity & Inclusion | *Yes* | ✓ | *No* | | Work looking at EDI concerns is underway which may suggest the inclusion of certain indicators as future developments occur. |
| Legal | *Yes* | | *No* | ✓ | |
| Environmental sustainability | *Yes* | | *No* | ✓ | |

| Good Performance | | | | | | | |
|---|---|---|---|---|---|---|---|
| Committee | | | | KPI/Area | Refer to (slide) | Current Performance | Trend/Trajectory |
| F | Q | | | Waiting Lists | 6 |  | Reduced waiting list for SPA/EWS, Recovery North, Relationship & Sexual Service and Memory Service. |
| F | Q | | | Waiting Times | 6 |  | Sustained reductions in average wait time referral to assessment for Recovery South, Relationship & Sexual service and CLDT.<br>Also notable reductions referral to treatment wait times for SPA/EWS. |
| F | Q | | | Average Discharged Length of Stay - Endcliffe | 8 |  | Decrease in discharged length of stay (12 month rolling) on Endcliffe ward – comfortably within national benchmarks. |
| F | Q | | | Average discharged Length of Stay – Forest Close & Forest Lodge | 10 |  | Performance above national benchmarks. |
| F | Q | | | 72-hour follow up | 12 |  | 72-hour follow up compliance has seen sustained improvement above the 80% target. |
| F | Q | | | Talking Therapies – wait times | 13 |  | Talking Therapies consistently achieving the 6 and 18 week wait targets. |
| | Q | P | | Supervision | 27 |  | Rehabilitation & Specialist directorate are consistently achieving the 80% trust target.<br>Trustwide supervision compliance sustained above the 24-month mean for last 8 months. |
| | Q | P | | Mandatory Training | 28 |  | Consistently achieving the trustwide target of 80%. |

| Performance Concern | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Committee | | | | KPI/Area | Refer to (slide) | Performance | Trend/ Trajectory | Recovery Plan? |
| F | Q | | | Waiting Times | 6 |  | Increasing trend/sustained high waits in certain areas noted Recovery North (RtA), Recovery South (RtT), Memory Service (RtA and RtT), OA CMHT (RtT), Gender (RtA) | Recovery Plan x 3 (EWS, Recovery Teams, Memory Service) |
| F | Q | | | Waiting Lists | 6 |  | Increased waiting lists for OA CMHT, SPS PD, Gender, SAANS, HIT and LTNC. | Recovery Plan x 5 (Gender, SAANS, HIT, OACMHT & SMS) |
| F | Q | | | Caseloads/Open Episodes | 6 |  | Increasing trend/high caseloads in OA CMHT and Highly Specialist community services (Gender, STEP, SAANS, Perinatal) | Recovery Plan x 4 (OA CMHT, SMS, Gender & SAANS) |
| F | Q | | | Length of Stay and Delayed Discharge (inpatient areas) | 7 |  | Failing to meet target for average discharged length of stay (12 month rolling) | Linked to Out of Area Recovery Plan(s) x 3 |
| F | Q | | | Out of Area Placements | 7-8 |  | Prolonged failure to meet reduction/elimination of inappropriate OAPs in acute. | Out of Area Recovery Plan(s) x 3 |
| F | Q | | | Out of Area PICU Placements | 8 |  | High number of bednights for PICU OAPs in September | Out of Area Recovery Plan(s) x 3 |
| F | Q | | | Health Based Place of Safety repurposing | 11 |  | Repurposed for detained mental health admission 43/60 days (72%) of September. | Linked to Out of Area Recovery Plan(s) x 3 |
| | Q | P | | Staff sickness | 25 |  | Consistently failing to meet trust target of 5.1%. 7.1% for September 23 | Sickness Group |
| | Q | P | | Staff Turnover | 26 |  | High staff turnover rate (18.2%). This will have been impacted by the TUPE of staff from Substance Misuse in July 2023. To contact workforce to see if this can be excluded. | Sickness Group |
| | Q | P | | Supervision | 27 |  | Failing to meet 80% target trustwide. | CQC Back to Good Action Plan/Local Recovery Plans |
| | Q | P | | PDR | 27 |  | Consistently failing to meet trustwide target of 90% for PDR compliance. | CQC Back to Good Action Plan/Local Recovery Plans |
| F | | | | Agency and Out of Area Placement spend | 30 | | High agency and OOA spend. | Out of Area Recovery Plan(s) x 3<br><br>CIP Plans 22/23 |

NHS
Sheffield Health and Social Care
NHS Foundation Trust

# Integrated Performance & Quality Report

## Information up to and including September 2023

Proud to care in Sheffield

# Introduction

**Report Layout |** Information and metrics are grouped into the following themes in line with the KPIs for 23/24 and the Trust Performance Framework.

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

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

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

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

Unless otherwise stated the control limits (the range within which normal variation will occur) are set by 24 months of data points, for example in the case of Sep 2023 reporting, we are using monthly figures from Oct 2021 to Sep 2023. Where 24 months data is not available; we use as much as we have access to.

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

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

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

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

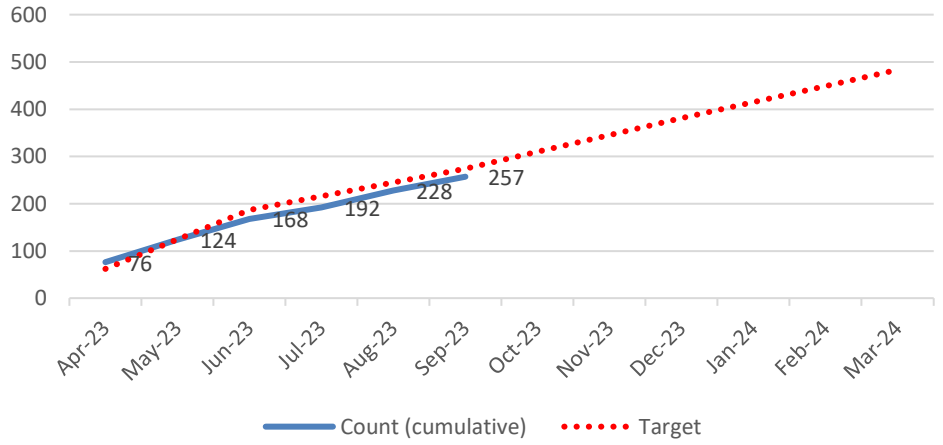
**Board Committee Oversight**
Please also note the addition of a colour-coded key to quickly identify which KPIs and metrics are of particular interest to a committee/which committee has oversight.

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

# NHS Long Term Plan – national metrics for 2023/24

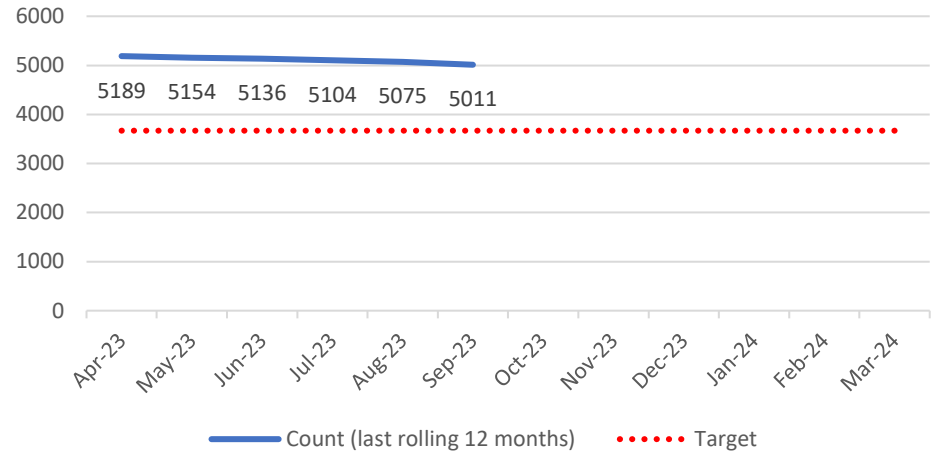
**Perinatal:** number of women accessing specialist community Perinatal MH services in the reporting period (cumulative)

Our target = 483 by March



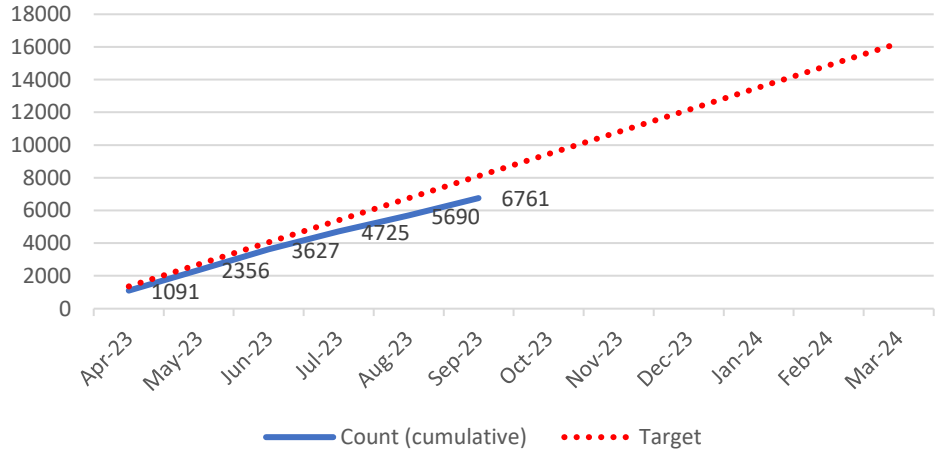

**Community:** Number of adults & older adults who receive two or more contacts from community mental health services

Our target = 3,666 each rolling 12-month period



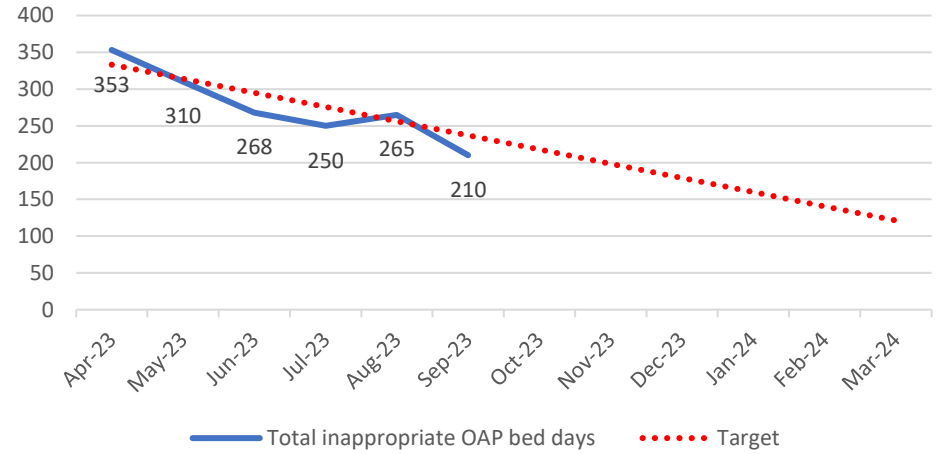

**Talking Therapies:** number of people first receiving Talking Therapies services (cumulative).

Our target = 16,220 by March




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

Our target = 2,500 bed nights




## Narrative

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

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

**Talking Therapies**
The service is expecting to be on track through Q3 onwards.

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

NHS
Sheffield Health and Social Care
NHS Foundation Trust

# Service Delivery

## IPQR - Information up to and including September 2023

Proud to care in Sheffield

# Responsive | Access & Demand | Referrals

| Referrals | Sep-23 | | | |
|---|---|---|---|---|
| **Acute & Community Directorate Service** | **n** | *mean* | **SPC variation** | **Note** |
| SPA/EWS | **677** | *670* | • H • | The increasing SPA referrals will continue to be reviewed however at this time there is nothing significant to note. |
| Crisis Resolution and Home Treatment | **775** | In February 2022, 5 teams merged to create the Crisis Resolution & Home Treatment Team (4 Adult Home Treatment Teams & Out of Hours). Due to the limitations of reporting from Insight, we will be able to accurately report on this when we have transferred to Rio. | | |
| Liaison Psychiatry | **518** | *492* | • H • | Shift of 7 consecutive months above the 24-month mean, this is predominantly due to an increase in A&E referrals. |
| Decisions Unit | **59** | *57* | • H • | Improved utilisation due to ongoing work to increase the number of referrals to DU from other services. Usage also increased due to HBPoS being unavailable. Above mean for last 7 months. However, a decrease seen compared to previous month (63). |
| S136 HBPoS | **18** | *29* | • • • | |
| Recovery Service North | **18** | *23* | • • • | |
| Recovery Service South | **41** | *23* | • H • | Unusually high number of referrals in September, the majority coming from other SHSC teams/services. To be monitored in coming months to identify if this is a one-off event or not. |
| Early Intervention in Psychosis | **38** | *38* | • • • | |
| Memory Service | **100** | *126* | • • • | |
| OA CMHT | **218** | *253* | • • • | |
| OA Home Treatment | **24** | *25* | • • • | |

| Referrals | Sep-23 | | | |
|---|---|---|---|---|
| **Rehab & Specialist Service** | **n** | *mean* | **SPC variation** | **Note** |
| CERT | **3** | *3* | • • • | |
| SCFT | **0** | *1* | • • • | |
| CLDT | **55** | *58* | • • • | CLDT figures represent distinct individuals so does not include multiple referrals per service user. |
| CISS | **1** | *3* | • • • | |
| Psychotherapy Screening (SPS) | **62** | *52* | • • • | |
| Gender ID | **12** | *41* | • L • | Delays adding referrals to the system. Business continuity plans utilised. |
| STEP | **139** | *110* | • • • | 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 | **45** | *35* | • • • | |
| SAANS | **326** | *421* | • L • | ASD: 120<br>ADHD: 206 |
| Relationship & Sexual Service | **15** | *19* | • • • | |
| Perinatal MH Service | **52** | *48* | • • • | |
| HAST | **15** | *15* | • • • | |
| HAST - Changing Futures | **0** | | | |
| Health Inclusion Team | **218** | *171* | • • • | |
| LTNC | **67** | *96* | • • • | |
| ME/CFS | **52** | *53* | • • • | |

# Responsive | Access & Demand | Community Services

| September 23 | *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 | **285** | *680* | • L • | **23.1** | *36.0* | • • • | **8.9** | *10.1* | • L • | **616** | *826* | • L • |
| MH Recovery North | **68** | *84* | • L • | **15.9** | *13.3* | • H • | **6.8** | *9.9* | • • • | **758** | *907* | • L • |
| MH Recovery South | **48** | *73* | • • • | **3.9** | *12.0* | • L • | **48.3** | *13.9* | • H • | **929** | *1049* | • L • |
| **Recovery Service TOTAL** | **116** | *156* | • L • | *N/A* | | | *N/A* | | | **1687** | *1957* | • L • |
| Early Intervention in Psychosis | **15** | *24* | • • • | | | | **100.0%** | | | **307** | *311* | • L • |
| Memory Service | **729** | *832* | • L • | **36.4** | *28.7* | • H • | **52.6** | *37.2* | • H • | **4257** | *4239* | • • • |
| OA CMHT | **307** | *213* | • H • | **9.7** | *8.4* | • • • | **12.3** | *10.4* | • H • | **1386** | *1270* | • H • |
| OA Home Treatment | *N/A* | | | *N/A* | | | *N/A* | | | **72** | *68* | • • • |
| **Rehab & Specialist Services** | **n** | *mean* | **SPC variation** | **n** | *mean* | **SPC variation** | **n** | *mean* | **SPC variation** | **n** | *mean* | **SPC variation** |
| IAPT | *N/A* | | | *N/A* | | | *N/A* | | | *N/A* | | |
| SPS (Screening) | | | | | | | | | | | | |
| SPS - MAPPS | **66** | *76* | • • • | **26.3** | *19.7* | • • • | **138.9** | *82.0* | • • • | **321** | *327* | • • • |
| SPS - PD | **49** | *43* | • H • | **18.1** | *15.0* | • • • | **12.7** | *56.5* | • • • | **200** | *192* | • • • |
| Gender ID | **2255** | *1841* | • H • | **271.0** | *162.1* | • H • | *N/A* | | | **3115** | *2727* | • H • |
| STEP | **115** | *162* | • • • | *N/A* | | | | | | **406** | *442* | • H • |
| Eating Disorders | **33** | *28* | • • • | **5.1** | *4.3* | • • • | | | | **208** | *214* | • L • |
| SAANS | **8381** | *6083* | • H • | **103.6** | *93.1* | • • • | | | | **6262** | *5934* | • H • |
| Relationship & Sexual Service | **46** | *123* | • L • | **18.9** | *63.3* | • L • | | | | **122** | *179* | • L • |
| Perinatal MH Service (Sheffield) | **28** | *24* | • • • | **2.9** | *3.0* | • • • | | | | **168** | *150* | • H • |
| HAST | **35** | *28* | • • • | **5.6** | *21.1* | • • • | | | | **82** | *81* | • • • |
| Health Inclusion Team | **731** | *377* | • H • | **9.7** | *9.4* | • • • | | | | **1635** | | |
| LTNC | **379** | *298* | • H • | *N/A* | | | | | | *N/A* | | |
| CFS/ME | *N/A* | | | | | | | | | | | |
| CLDT | **171** | *175* | • • • | **3.9** | *9.9* | • L • | **138.9** | | | **711** | *719* | • • • |
| CISS | *N/A* | | | *N/A* | | | *N/A* | | | **14** | *21* | • L • |
| CERT | | | | | | | | | | **47** | *45* | • H • |
| SCFT | | | | | | | | | | **24** | *24* | • L • |

## Narrative

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

**ME/CFS** – data quality work underway, including changes to coding on SystmOne – assessments and caseload figures pending quality check.

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

**SEDS** – Wait times increased in September. Work through QI collaborative on waiting well.

**STEP** – previous delays in processing referrals and discharges in a timely way has been resolved and wait list size is beginning to stabilise.

**HIT** – increase in referrals in August 2023 (backlog) have impacted on wait list size. Note that the reported figures count individuals who may be part of a family who have been referred.

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

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

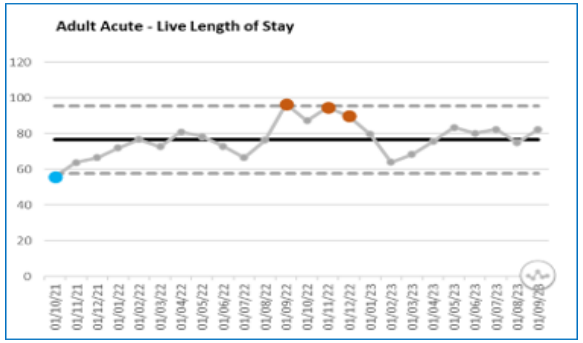
**ASD** – service provided to Sheffield and Derbyshire residents, and a number of mitigations are being looked at including waiting well project co-produced with VAS.

**OACMHT** – waitlist deep dive undertaken Sept-23 to understand what patients waiting for & to enable smooth transition to Rio. Reduced waitlist by a fifth (249).

# Safe | Inpatient Wards | Adult Acute & Step Down

| Adult Acute (Dovedale 2, Burbage, Maple) | Sep-23 n | Sep-23 mean | Sep-23 SPC variation | Sep-23 SPC target |
|---|---|---|---|---|
| Admissions | 31 | 30 | • • • | / |
| Detained Admissions | 28 | 27.38 | • • • | / |
| % Admissions Detained | 90.32% | 91.77% | • • • | / |
| Emergency Re-admission Rate (rolling 12 months) | 4.17% | | | |
| Transfers in | 9 | | | |
| Discharges | 30 | 30 | • • • | / |
| Transfers out | 7 | | | |
| Delayed Discharge/Transfer of Care (number of delayed discharges) | 15 | | | |
| Delayed Discharge/Transfer of Care (bed nights occupied by dd) | 393 | | | |
| Bed Occupancy excl. Leave (KH03) | 95.20% | 94.83% | • • • | / |
| Bed Occupancy incl. Leave | 101.95% | 98.94% | • • • | / |
| Average beds admitted to | 48.9 | | | |
| Average Discharged Length of Stay (12 month rolling) | 39.91 | 40.14 | • • • | F |
| Average Discharged Length of Stay (discharged in month) | 36.63 | 40.24 | • • • | ? |
| Live Length of Stay (as at month end) | 82.20 | 76.69 | • • • | / |
| Number of People Out of Area at month end | 8 | 12 | • • • | F |
| Number of Mental Health Out of Area Placements started in the period (admissions) | 6 | 9 | • • • | ? |
| Total number of Out of Area bed nights in period | 235 | 363 | • • • | F |

**Length of Stay Detail – Sep 23**
Longest LoS (days) as at month end:
369 on Dovedale 2 – Graded transition in progress with provider.
643 on Maple – Complex needs. Next step is professionals meeting.
176 on Burbage – Providers identified.
Longest LoS (days) of discharges in month:
Dovedale 2 = 56, Maple = 111, Burbage = 97




| Step Down (Beech) | Sep-23 n | Sep-23 mean | Sep-23 SPC variation | Sep-23 SPC target |
|---|---|---|---|---|
| Admissions | 6 | 5 | • • • | / |
| Transfers in | 1 | | | |
| Discharges | 5 | 5 | • • • | / |
| Transfers out | 0 | | | |
| Bed Occupancy excl. Leave (KH03) | 78.00% | 74.36% | • H • | / |
| Bed Occupancy incl. Leave | 80.00% | 83.03% | • • • | / |
| Average Discharged Length of Stay (12 month rolling) | 50.72 | 50.50 | • • • | / |
| Live Length of Stay (as at month end) | 67.63 | 47.30 | • H • | / |

**Length of Stay Detail – Sep 23**
Longest LoS (days) as at month end: 214 Accommodation allocated and awaiting confirmation of package of care.
Range = 18 to 214 days
Longest LoS (days) of discharges in month: 122 Issue relates to personal financial situation that is being managed.

**Narrative**
Metrics for Adult Acute within expected limits.
Out of area recovery plan in place.
Beech bed numbers have changed over the last month due to temporary move to Firshill Rise. They are now back at Beech but one bed remains closed.

**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*

# Inpatient Wards | PICU

| PICU (Endcliffe) | Sep-23 n | mean | SPC variation | SPC target |
|---|---|---|---|---|
| Admissions | 2 | 4 | • • • | / |
| Transfers in | 1 | | | |
| Discharges | 1 | 2 | • • • | / |
| Transfers out | 1 | | | |
| Delayed Discharge/Transfer of Care (number of delayed discharges) | 1 | | | |
| Delayed Discharge/Transfer of Care (bed nights occupied by dd) | 30 | | | |
| Bed Occupancy excl. Leave (KH03) | 99.00% | 95.02% | • • • | / |
| Bed Occupancy incl. Leave | 99.00% | 96.90% | • • • | / |
| Average beds admitted to | 9.90 | | | |
| Average Discharged Length of Stay (12 month rolling) | 33.47 | 40.91 | • L • | ? |
| Live Length of Stay (as at month end) | 158.00 | 111.57 | • H • | / |
| Number of People Out of Area at month end | 7 | 5 | • • • | F |
| Number of Mental Health Out of Area Placements started in the period (admissions) | 2 | 3 | • • • | ? |
| Total number of Out of Area bed nights in period | 205 | 150 | • H • | F |

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

| Start Date | LOS | |
|---|---|---|
| 02/02/2021 17:38 | 970 | Working with social care. |
| 13/04/2023 19:00 | 170 | Plans in place. |
| 08/06/2023 18:20 | 114 | Not clinically ready for discharge. |
| 25/06/2023 16:19 | 97 | Not clinically ready for discharge. |
| 21/07/2023 15:30 | 71 | Not clinically ready for discharge. |
| 01/08/2023 19:54 | 60 | Discharged. |

As at 30/09/23, there were 6 service users on Endcliffe Ward with a length of stay over the national average (benchmarked) of 47 days.
LoS for PICU disproportionally affected by 1 service user who has been on the ward for 970 days (at month end). With this service user excluded, the live LoS for PICU falls from 158 days to 67.8 days.

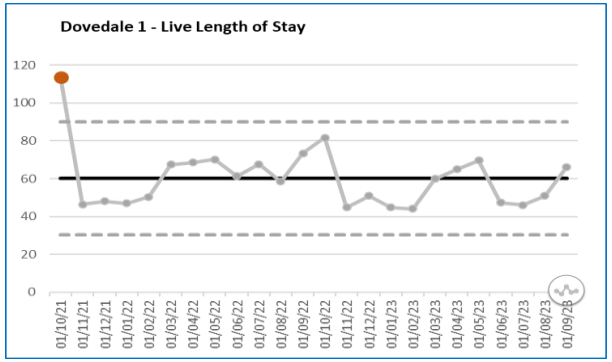
**Benchmarking PICU**
(2021 NHS Benchmarking Network Report – Weighted Population Data)

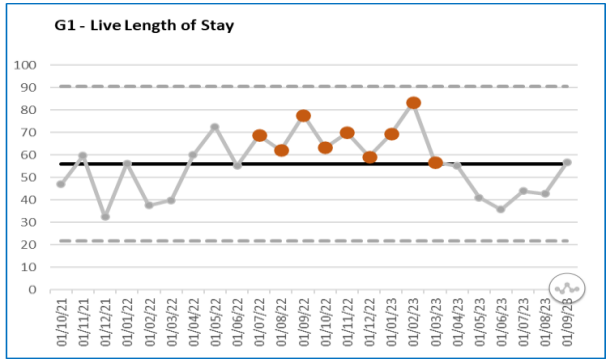
**Bed Occupancy** Mean: 84%
**Length of Stay (Discharged)** Mean: 47

# Safe | Inpatient Wards | Older Adults

| Older Adult Functional (Dovedale 1) | Sep-23 n | mean | SPC variation | SPC target |
|---|---|---|---|---|
| Admissions | 5 | 5 | • • • | / |
| Transfers in | 0 | | | |
| Discharges | 4 | 5 | • • • | / |
| Transfers out | 2 | | | |
| Delayed Discharge/Transfer of Care (number of delayed discharges) | 1 | | | |
| Delayed Discharge/Transfer of Care (bed nights occupied by dd) | 25 | | | |
| Bed Occupancy excl. Leave (KH03) | 95.33% | 90.17% | • H • | / |
| Bed Occupancy incl. Leave | 100.67% | 96.00% | • H • | / |
| Average beds admitted to | 15.10 | | | |
| Average Discharged Length of Stay (12 month rolling) | 39.91 | 40.14 | • H • | ? |
| Live Length of Stay (as at month end) | 66.27 | 60.15 | • • • | / |

**Length of Stay Detail Sep 23 – Dovedale 1**
Longest LoS (days) as at month end: 150
Range = 4 to 150 days
Longest LoS (days) of discharges in month: 54
Longest LoS now discharged.




| Older Adult Dementia (G1) | Sep-23 n | mean | SPC variation | SPC target |
|---|---|---|---|---|
| Admissions | 2 | 5 | • • • | / |
| Transfers in | 1 | | | |
| Discharges | 3 | 4 | • • • | / |
| Transfers out | 0 | | | |
| Delayed Discharge/Transfer of Care (number of delayed discharges) | 5 | | | |
| Delayed Discharge/Transfer of Care (bed nights occupied by dd) | 114 | | | |
| Bed Occupancy excl. Leave (KH03) | 97.92% | 77.35% | • • • | / |
| Bed Occupancy incl. Leave | 99.58% | 79.27% | • • • | / |
| Average beds admitted to | 15.93 | | | |
| Average Discharged Length of Stay (12 month rolling) | 83.79 | 74.48 | • H • | / |
| Live Length of Stay (as at month end) | 56.75 | 56.17 | • • • | / |

**Length of Stay Detail Sep 23– G1**
Longest LoS (days) as at month end: 112
Range = 8 to 112 days
Longest LoS (days) of discharges in month: 102

Longest LoS awaiting 24-hour care, actively liaising with provider.

Snapshot as of 17th October there are 5 outliers currently on G1.

**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) | Sep-23 n | mean | SPC variation | SPC target |
|---|---|---|---|---|
| Admissions | 0 | 0.88 | • • • | / |
| Transfers in | 1 | | | |
| Discharges | 0 | 2.00 | • • • | / |
| Transfers out | 0 | | | |
| Delayed Discharge/Transfer of Care (number of delayed discharges) | 0 | | | |
| Delayed Discharge/Transfer of Care (bed nights occupied by dd) | 0 | | | |
| Bed Occupancy excl. Leave (KH03) | 86.89% | 85.53% | • H • | / |
| Bed Occupancy incl. Leave | 100.67% | 94.73% | • H • | / |
| Average Discharged Length of Stay (12 month rolling) | 404.50 | 304.45 | • H • | P |
| Live Length of Stay (as at month end) | 381.42 | 357.04 | • • • | / |
| Number of Out of Area Placements started in the period (admissions) | 1 | | | |
| Total number of Out of Area bed nights in period | 154 | | | |
| Number of People Out of Area at month end | 6 | | | |

| Forensic Low Secure (Forest Lodge) | Sep-23 n | mean | SPC variation | SPC target |
|---|---|---|---|---|
| Admissions | 2 | 0.92 | • • • | / |
| Transfers in | 0 | | | |
| Discharges | 0 | 1.00 | • • • | / |
| Transfers out | 0 | | | |
| Bed Occupancy excl. Leave (KH03) | 0.95 | 0.9 | · H · | / |
| Bed Occupancy incl. Leave | 0.95 | 1.0 | • • • | / |
| Average Discharged Length of Stay (12 month rolling) | 657.2 | 456.1 | · H · | P |
| Live Length of Stay (as at month end) | 610.8 | 586.1 | · H · | / |

**The point at which someone is CRFD is reached when:**

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

**Forest Close**

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

**Long stays – Forest Close**

1172 – Longest LoS as at month end on Forest close 1A.

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

**Forest Lodge**

Again, it should be noted that length of stay within Forest Lodge benchmarks very favourably against other low secure facilities across the country. Long stays are discussed within Horizon on a weekly basis, there are also risk assessments for appropriate placements.

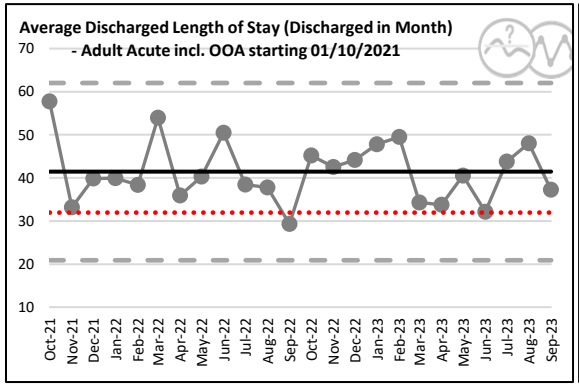
**Long stays – Forest Lodge**

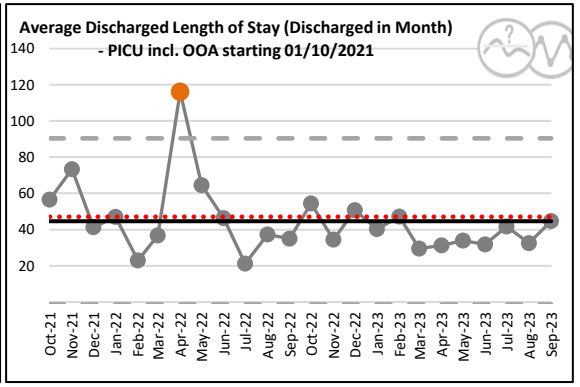
1255, 990 and 836 are the three top longest stays at Forest Lodge.
The rationale for LoS remains the same due to not being clinically ready. We are liaising with key agencies about next steps.

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

# UEC (Urgent & Emergency Care) Dashboard

## Length of Stay



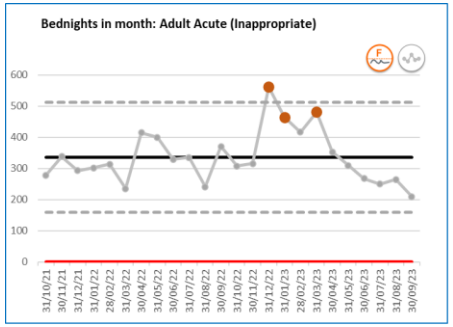

**Adult Acute Discharged LoS (Rolling 12-month average)**

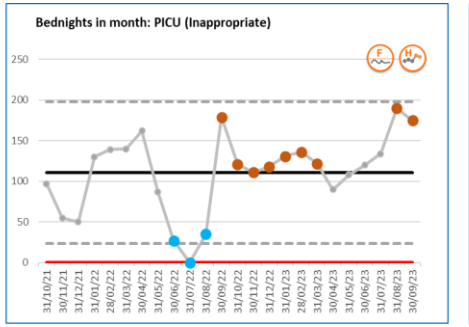
| Location | Total Discharges | Average Discharged LoS |
|---|---|---|
| **Sheffield** | 444 | 40 |
| **OOA** | 103 | 43 |
| **Contracted** | 105 | 47 |
| **Combined** | **652** | **41** |

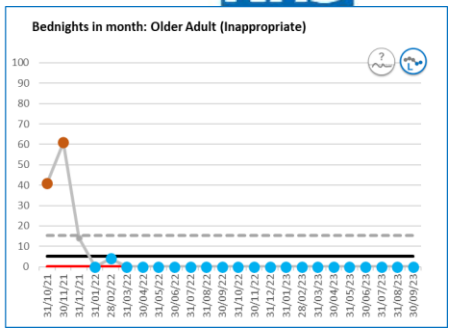
**PICU Discharged LoS (Rolling 12-month average)**

| Location | Total Discharges | Average Discharged LoS |
|---|---|---|
| **Sheffield** | 89 | 33 |
| **OOA** | 29 | 53 |
| **Combined** | **118** | **38** |

## Out of Area

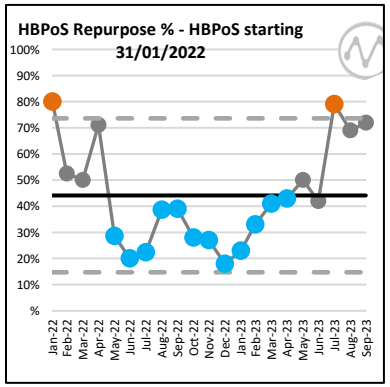



| Provider | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Sparklines (Oct-22 to Sep-23) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Sheffield Health and Social Care NHS Foundation Trust** | **14** | **20** | **20** | **20** | **20** | **20** | **15** | **7** | **9** | **10** | **7** | **8** | |
| Bradford District Care NHS Foundation Trust | 26 | 18 | 13 | 22 | 20 | 22 | 18 | 23 | 22 | 24 | 15 | 18 | |
| Tees, Esk and Wear Valleys NHS Foundation Trust | 11 | 4 | 4 | 8 | 11 | 25 | 19 | 22 | 9 | 6 | 4 | 7 | |
| South West Yorkshire Partnership NHS Foundation Trust | 19 | 21 | 18 | 17 | 22 | 14 | 11 | 13 | 14 | 23 | 11 | 5 | |
| Leeds and York Partnership NHS Foundation Trust | 17 | 10 | 14 | 15 | 16 | 15 | 24 | 17 | 24 | 13 | 23 | 37 | |
| Cumbria Northumberland, Tyne and Wear Partnership NHS FT | 11 | 22 | 12 | 4 | 10 | 18 | 14 | 10 | 10 | 6 | 8 | 8 | |
| Humber NHS Foundation Trust | 1 | 1 | 3 | 4 | 8 | 6 | 6 | 5 | 18 | 8 | 4 | 4 | |
| Rotherham Doncaster and South Humber NHS Foundation Trust | 6 | 6 | 5 | 12 | 18 | 9 | 23 | 10 | 14 | 16 | 16 | 18 | |
| Navigo (NE Lincs/Grimsby) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

## HBPoS Repurposing

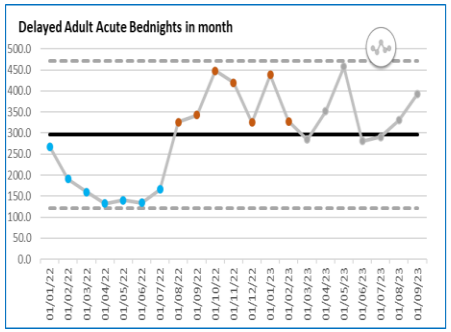


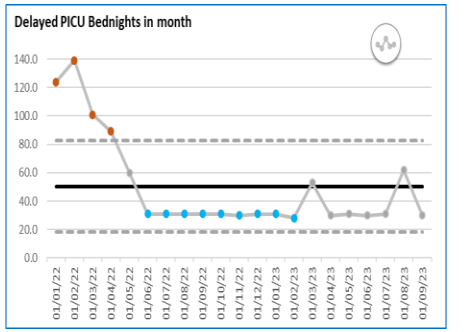

| Health Based Place of Safety (HBPoS/136 Beds) | Sep-23 |
|---|---|
| Occasions repurposed | 43 |
| Occasions repurposed % | 72% |

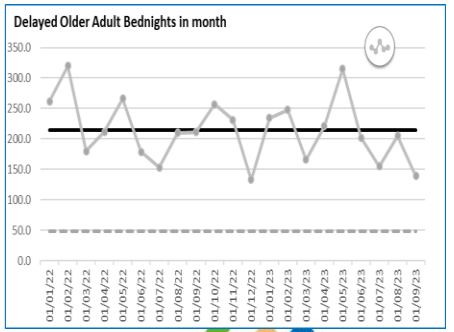
| September 2023 | | |
|---|---|---|
| Weekday Beds Available | 30 | 30 |
| Days Repurposed | 17 | 26 |
| % Repurposed | 71.67% | |
| Days Occupied | 9 | 4 |
| % Occupied | 21.67% | |
| Days Available | 4 | 0 |
| % Available | 6.67% | |

## Delayed Care

**Delayed Care narrative**
% of bednights occupied by delayed patients is 27.9% across adult acute wards. Weekly clinically ready for discharge meeting membership has been extended to include social care colleagues to support earlier information sharing and discharges for those delayed.



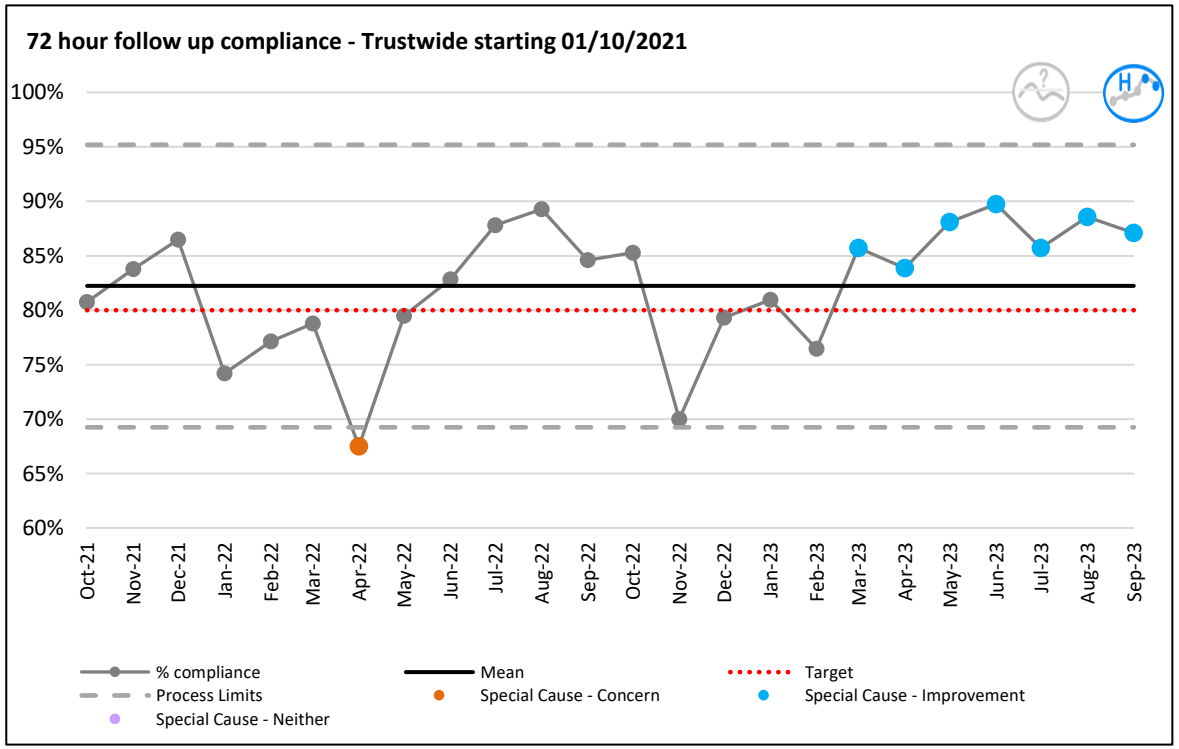




| Delayed Discharges Adult Acute | | |
|---|---|---|
| Sep 23 | Sum of Delayed Bednights | % Bednights occupied by DD |
| Adult Acute Total | 390 | 27.9% |

| Delayed Discharges PICU | | |
|---|---|---|
| Sep 23 | Sum of Delayed Bednights | % Bednights occupied by DD |
| Endcliffe | 30 | 10.0% |

| Delayed Discharges Older Adult | | |
|---|---|---|
| Sep 23 | Sum of Delayed Bednights | % Bednights occupied by DD |
| Older Adult Total | 139 | 14.9% |

# Effective | Treatment & Intervention – 72 hour follow up




| 72 hour Follow Up | | September 23 | | |
|---|---|---|---|---|
| | Target | % | No. | SPC Variation |
| Trustwide | 80% | 87.1% | 27/31 | • H • |

**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: 27/31 patients seen within 72 hours: 4 seen outside the target
Performance has consistently been above the average since March 23.

1 x contacted on day 3
Contacted on day 3, just outside of 72 hours.

2 x contact day 6 and 7
One contacted day 6 – potential recording issue.
One contacted day 7 – attempted contact on day 1 asked to contact once settled in by Care Manager.

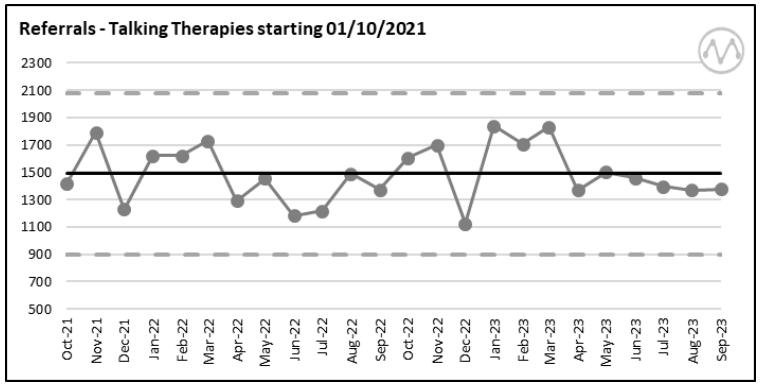
1 x no contact recorded
Team unable to contact due to patient needs.

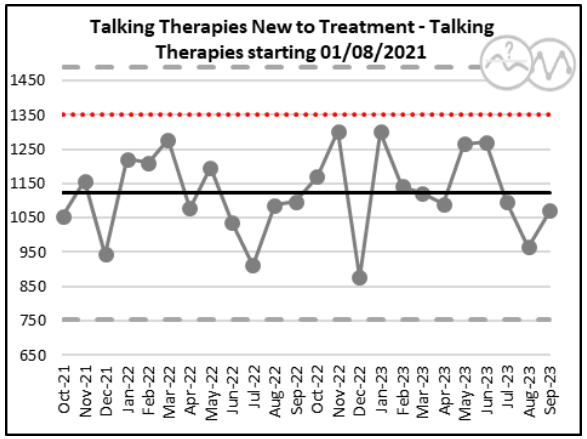
# Sheffield Talking Therapies | Performance Summary

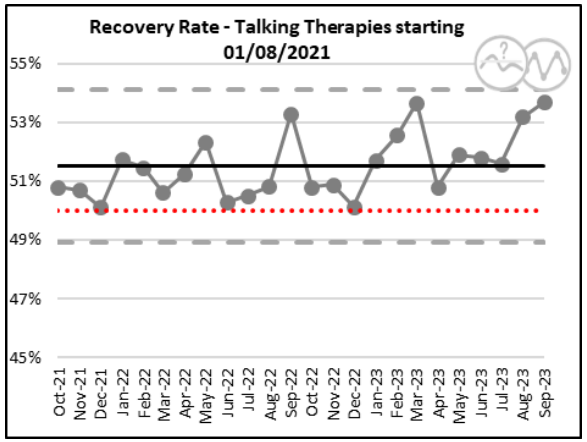
| Sheffield Talking Therapies | | Sept-23 | | | |
|---|---|---|---|---|---|
| Metric | Target 2022/23 | *n* | *mean* | *SPC variation* | *SPC target* |
| Referrals | / | **1378** | *1488* | • • • | / |
| New to Treatment | 1352 | **1071** | *1123* | • • • | ? |
| 6 week Wait | 75% | **99%** | *98.73%* | • • • | P |
| 18 week Wait | 95% | **100%** | *99.84%* | • • • | P |
| Moving to Recovery Rate | 50% | **53.70%** | *51.53%* | • • • | ? |

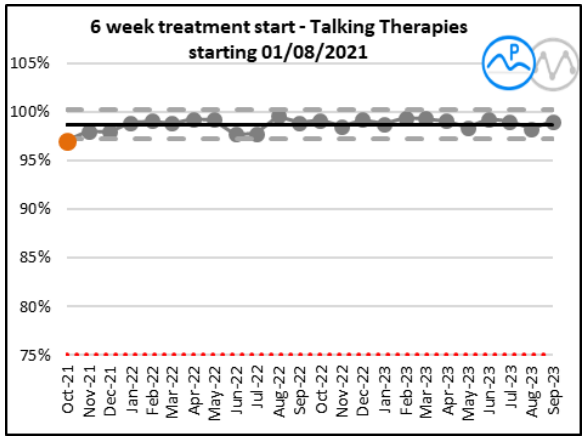
**Narrative**

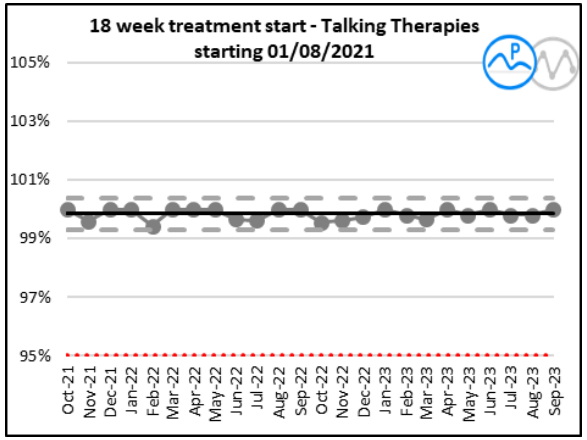
- Monthly Access Target from April 23 is now 1352
- Service has achieved the recovery rate standard for 23 consecutive months
- Continue to exceed the waiting time standard for people receiving their first treatment appointment



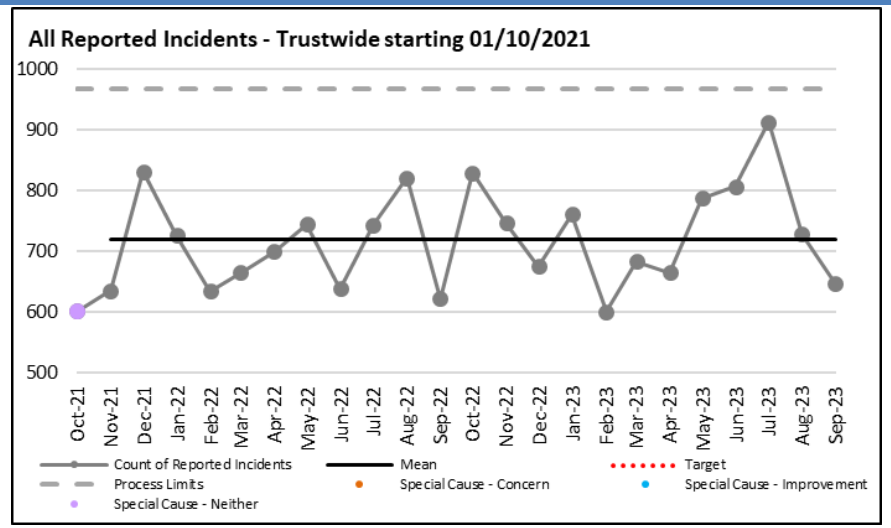
NHS
Sheffield Health and Social Care
NHS Foundation Trust

# Safety & Quality

## IPQR - Information up to and including September 2023

Proud to care in Sheffield

# Safe | All Incidents




| Trustwide | Sep-23 | | |
|---|---|---|---|
| | n | *mean* | SPC variation |
| **ALL** | **647** | *717* | • • • |
| 5 = Catastrophic | **12** | *24* | • • • |
| 4 = Major | **5** | *4* | • • • |
| 3 = Moderate | **53** | *50* | • • • |
| 2 = Minor | **244** | *273* | • • • |
| 1 = Negligible | **313** | *360* | • • • |
| 0 = Near-Miss | **20** | *20* | • H • |

**Narrative**

During September 2023, 5 incidents were rated as Major. These incidents were in relation to an infection, physical assaults, adult protection issues (exploitation abuse) and damaged trust property. High number of Near miss incidents reported from a combination of incidents, however no theme of type of incident.

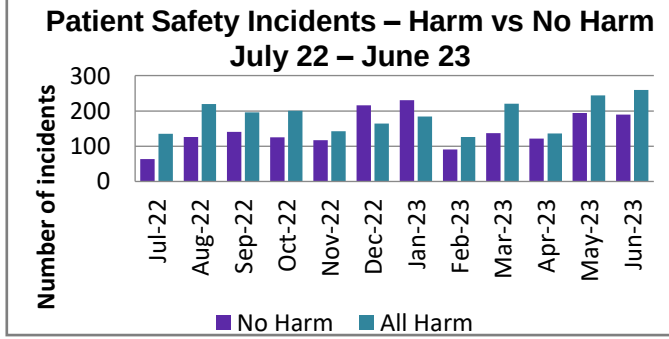
Of the 12 Catastrophic incidents recorded this month, 11 were for Acute and Community services and 1 for Rehabilitation and Specialist services. All Catastrophic incidents were service user deaths, with the majority expected or suspected natural causes and will be reviewed through the Mortality Review Group. No death related incidents have been identified as being an S.I.

**Narrative**

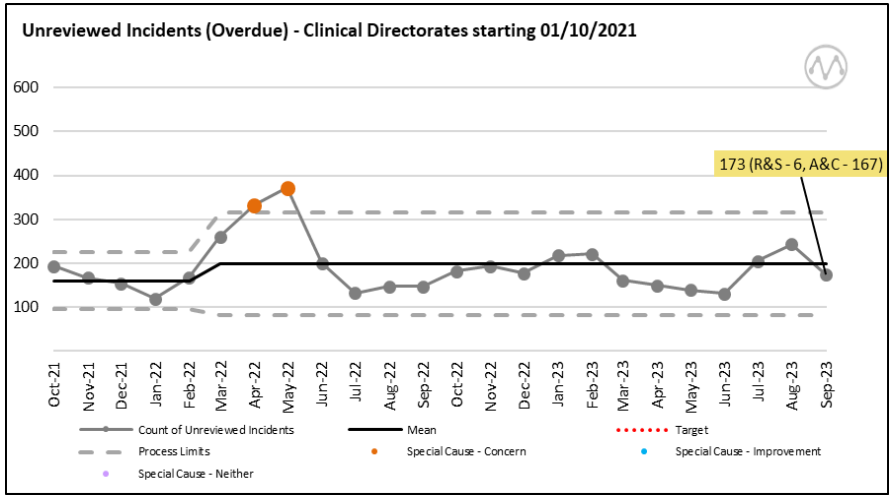
Up to 30th September 2023, NHS Trusts must report patient safety incidents to the National Reporting Learning System (NRLS). From 1st October 2023, all such incidents will be uploaded to a new platform, Learn from Patient Safety Events (LFPSE). It is not yet understood what benchmarking information will be available to Trusts via the new LFPSE platform.

The latest annual benchmarking information from the NRLS covers the period April 2021 – March 2022 and was released in 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 July 2022 to June 2023




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

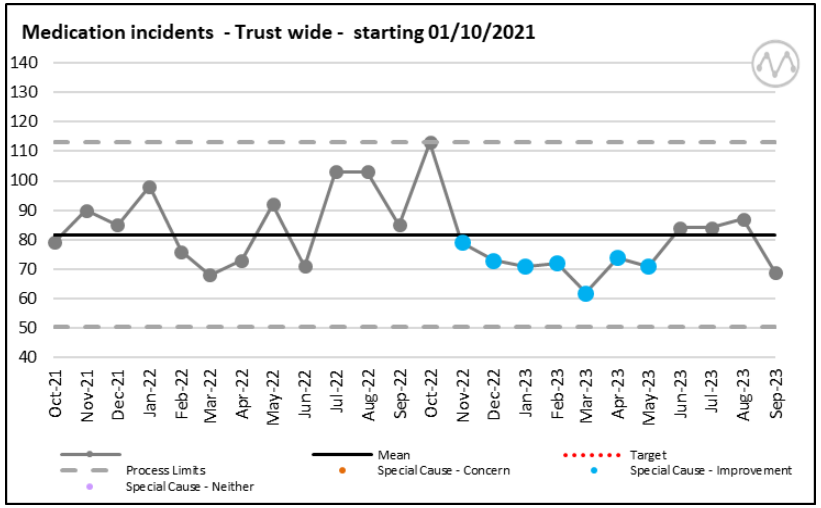



**Narrative**

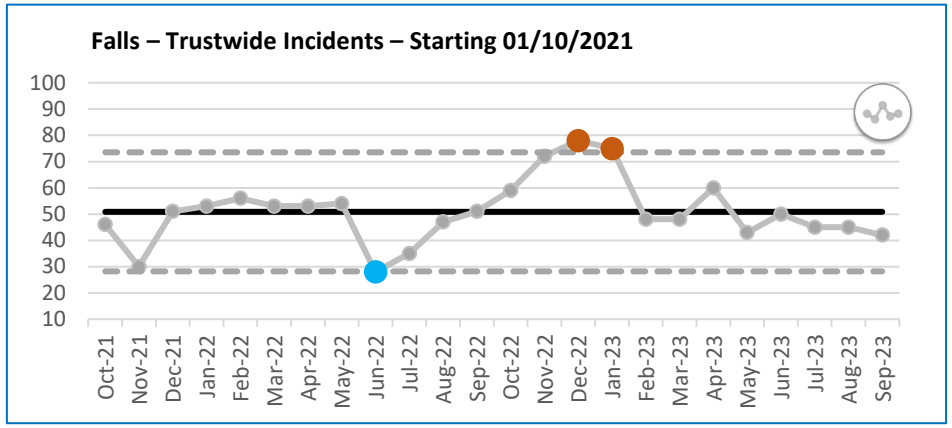
The unreviewed incidents are predominantly accounted for by the Acute and Community Directorate. 42 incidents remain unreviewed prior to September 2023.

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

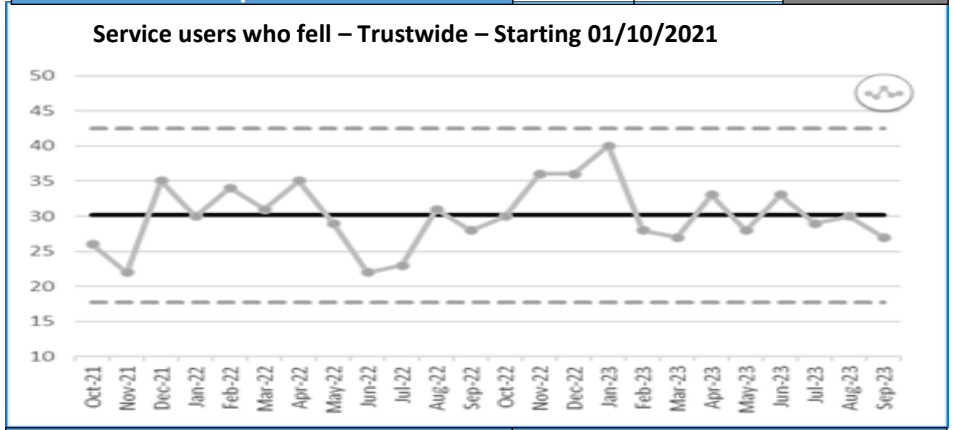
# Safe | Medication Incidents & Falls




| Trustwide | Sep-23 | | |
|---|---|---|---|
| | n | mean | SPC variation |
| ALL | 69 | 82 | • • • |
| Administration Incidents | 16 | 14 | • • • |
| Meds Management Incidents | 44 | 54 | • • • |
| Pharmacy Dispensing Incidents | 2 | 7 | • • • |
| Prescribing Incidents | 7 | 7 | • • • |
| Meds Side Effect/Allergy Incidents | 0 | 0 | • L • |




| Trustwide FALLS INCIDENTS | Sep-23 | | |
|---|---|---|---|
| | n | mean | SPC variation |
| Trustwide Totals | 42 | 51 | • • • |
| Acute & Community | 40 | 49 | • • • |
| Nursing Homes | 30 | 31 | • • • |
| Rehabilitation & Specialist Services | 2 | 2 | • • • |




| Trustwide FALLS - PEOPLE | Sep-23 | | |
|---|---|---|---|
| | n | mean | SPC variation |
| Trustwide Totals | 27 | 30 | • • • |
| Acute & Community | 25 | 28 | • • • |
| Nursing Homes | 17 | 16 | • • • |
| Rehabilitation & Specialist Services | 2 | 2 | • • • |

**Narrative**

**Medication Incidents**
During September 2023, there continues to be no incidents reported as Moderate or above. The meds management training for nursing staff is being reviewed.

**Falls Incidents**
Of the 43 incidents reported, 30 were in our Nursing homes. Birch Avenue continues to be the highest reporter of falls incidents, with 24 recorded for 12 people.

# Safe | Assaults, Sexual Safety & AWOL Patients

| Assaults on Service Users | Sep-23 | | |
|---|---|---|---|
| | n | *mean* | SPC variation |
| Trustwide | 29 | *26* | • • • |
| Acute & Community | 29 | *23* | • • • |
| Rehabilitation & Specialist | 0 | *2* | • L • |

| Assaults on Staff | Sep-23 | | |
|---|---|---|---|
| | n | *mean* | SPC variation |
| Trustwide | 73 | *62* | • • • |
| Acute & Community | 72 | *57* | • • • |
| Rehabilitation & Specialist | 1 | *5* | • L • |

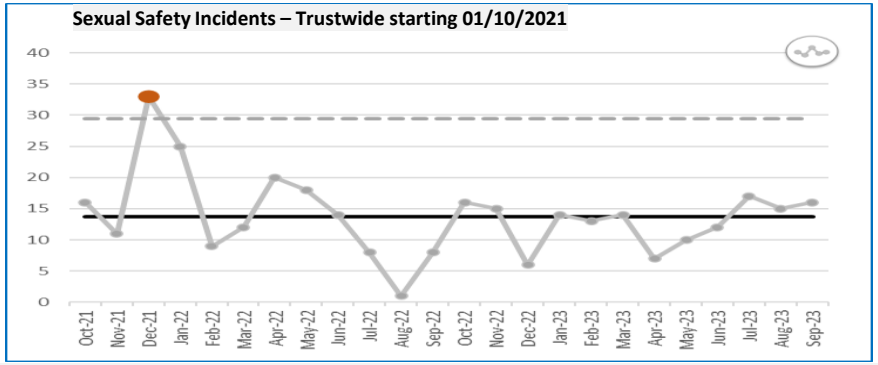
**Narrative**

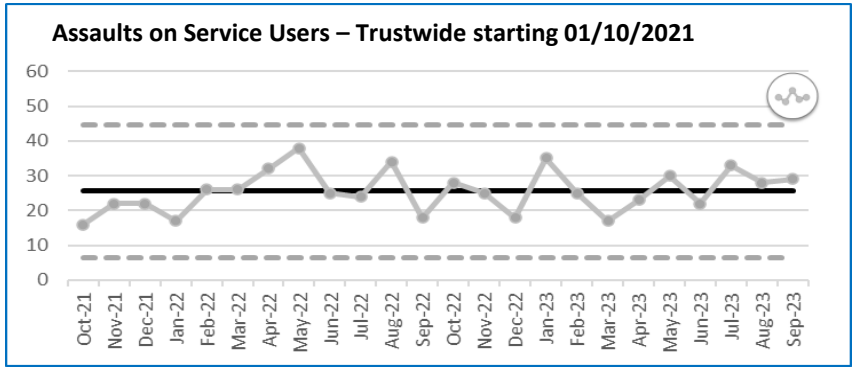
Of the 73 reported incidents of assaults on staff, 3 were rated as moderate. 2 on Endcliffe ward (service user to staff assault) and 1 on Dovedale 2 (sexual abuse, service user to staff).

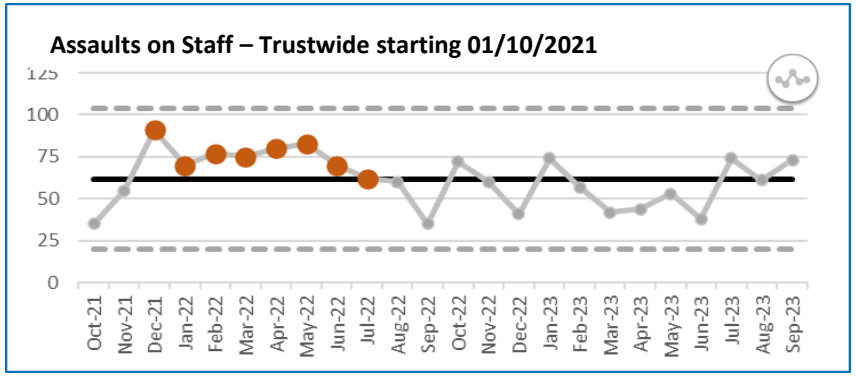
Out of the 29 assaults on staff incidents, 1 incident was reported as Major which occurred on Burbage Ward following assault service user to service user. There were 3 other incidents reported as moderate, 2 on Maple ward and 1 reported by Recovery Team north following other assaulting service user.

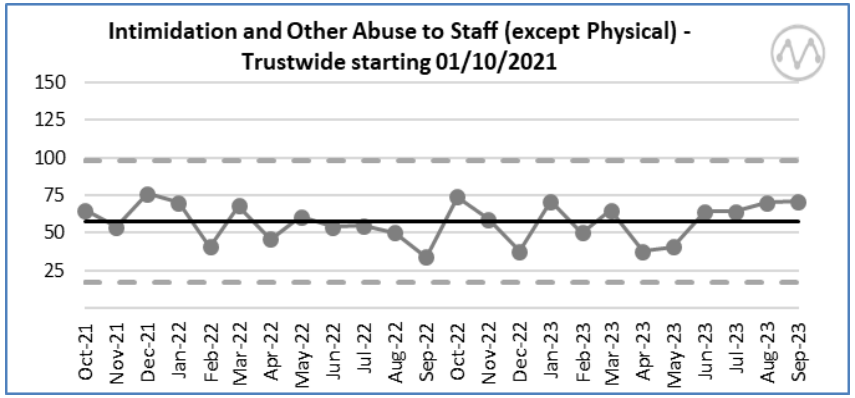
**Sexual Safety**

There were 16 sexual safety incidents reported in September 2023, of which, 1 moderate incident resulted in an SI following sexually explicit material being shared. All sexual safety incidents are reviewed in the sexual safety group. Any incidents involving staff are managed through the staff safeguarding policy. Whilst there has been no statistical change in the number of sexual safety incidents, we still consider this to be a priority area and a workplan has been developed.

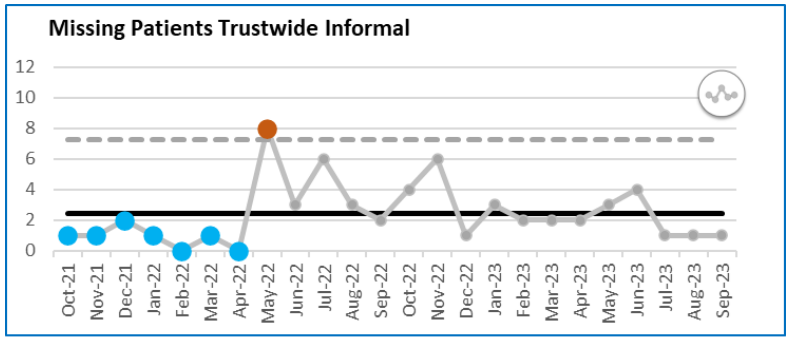


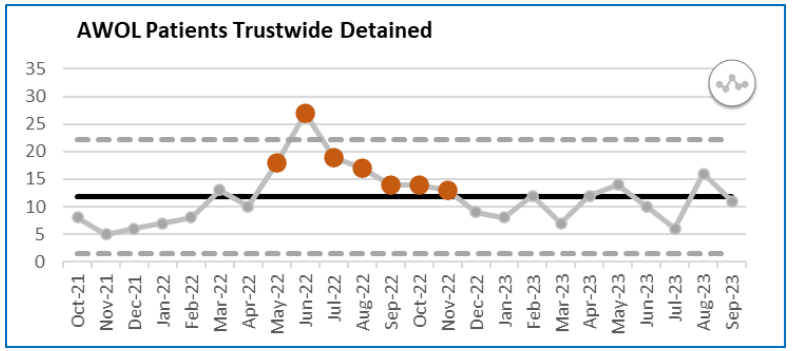




| Protecting from avoidable harm | Target | YTD |
|---|---|---|
| Reportable Mixed Sex Accommodation (MSA) breaches | 0 | 0 |



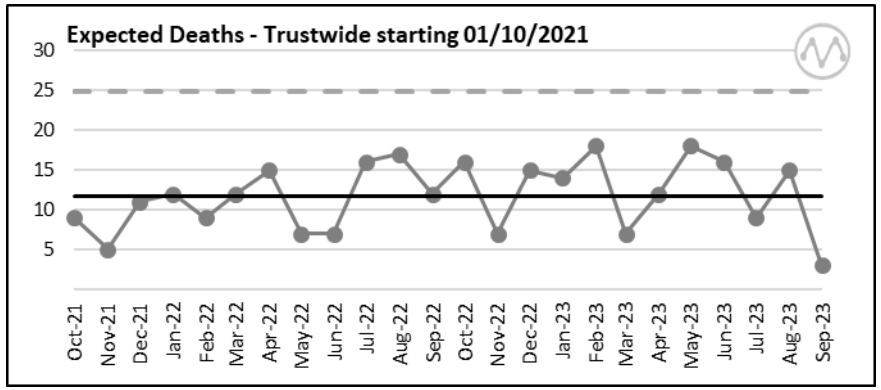

| Trustwide | Sep-23 | | |
|---|---|---|---|
| | n | *mean* | SPC variation |
| Detained | 11 | *12* | • • • |
| Informal | 1 | *2* | • • • |

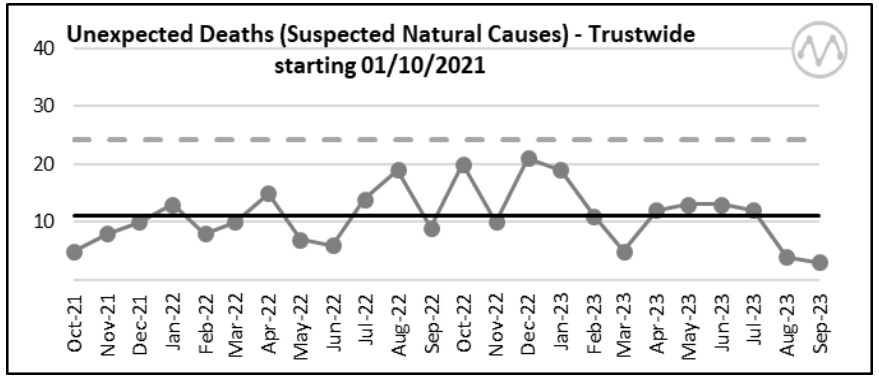
**Narrative**

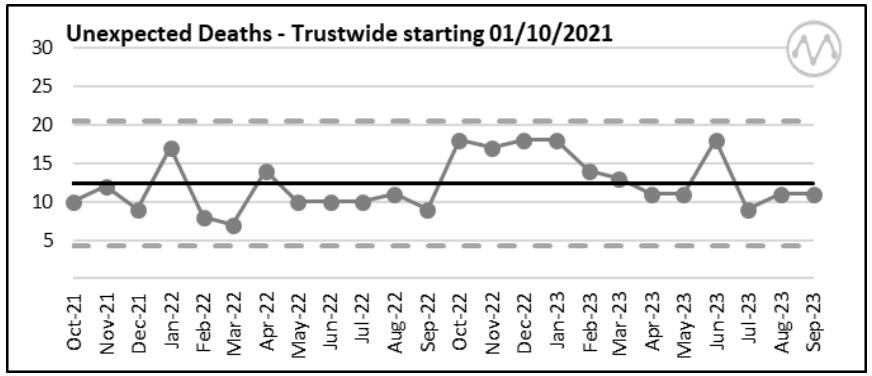
11 reported incidents in September 2023 of people under formal admission being AWOL. 3 incidents for Rehabilitation & Specialist Services for 2 people and 8 incidents for Acute & Community for 7 people. At time of reporting:

- 1 person was on a Section 2,
- 6 people were on a Section 3
- 1 person was on Section 37/41
- 1 person was on Section 37

# Deaths

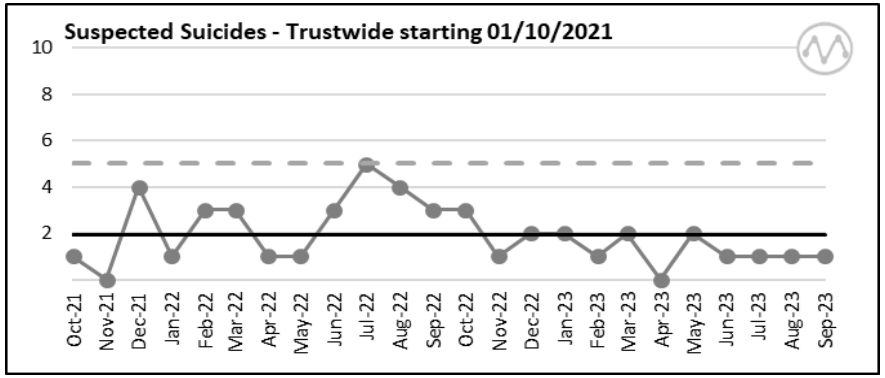


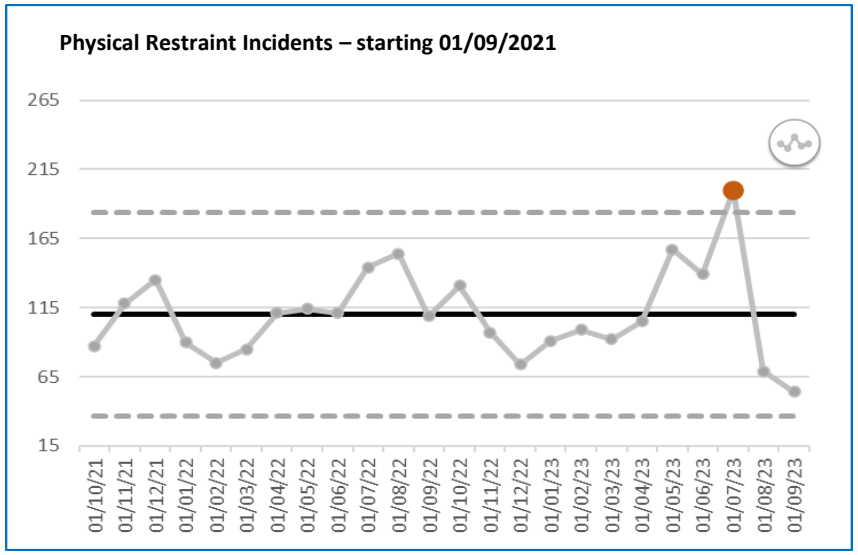

**Quarterly mortality reports are presented to the Quality Assurance Committee and Board of Directors.**

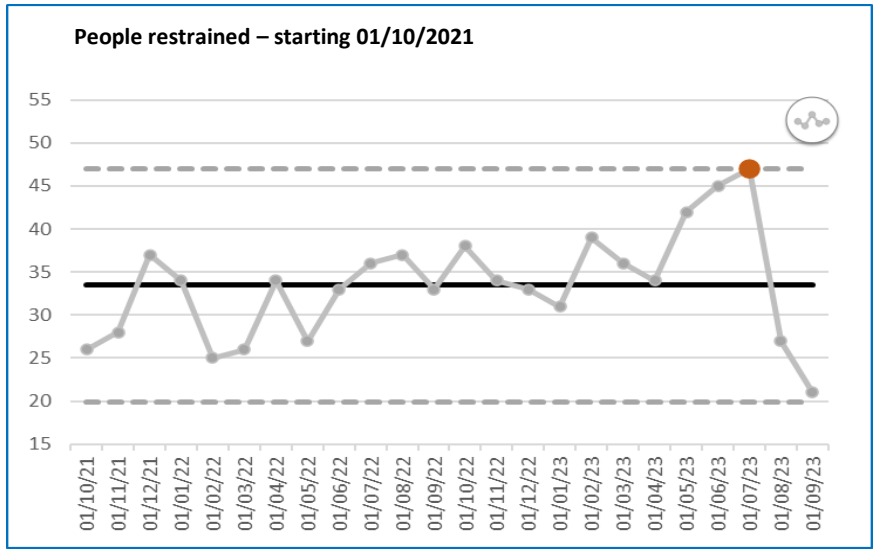
| Deaths Reported 1 October2021 to 30 September 2023 | |
|---|---|
| Awaiting Coroner's Inquest/Investigation | 205 |
| Closed | 3 |
| Conclusion - Accidental | 3 |
| Conclusion - Alcohol/Drug Related | 19 |
| Conclusion - Misadventure | 2 |
| Conclusion - Other | 2 |
| Conclusion - Open | 1 |
| Conclusion - Suicide | 21 |
| Natural Causes - No Inquest | 633 |
| Ongoing | 2 |
| **Grand Total** | **891** |

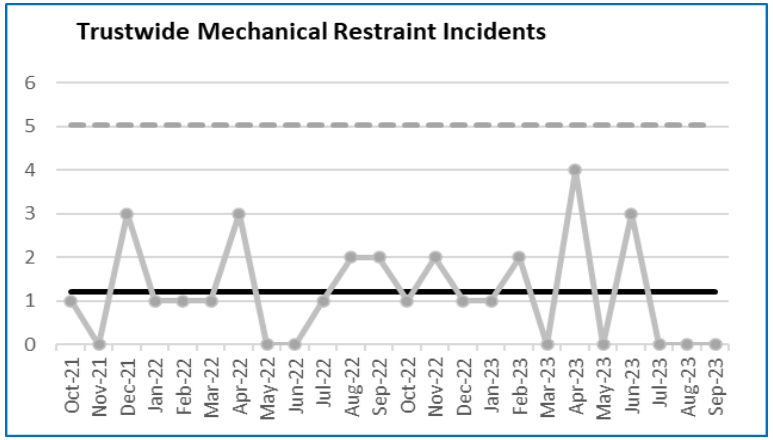



| COVID-19 Deaths 1 April 2020 – 30 September 2023 | |
|---|---|
| ATS (Firshill Rise) | 1 |
| Birch Ave | 5 |
| CISS (LDS) | 1 |
| CLDT | 6 |
| G1 Ward | 6 |
| Liaison Psychiatry | 10 |
| LTNC | 3 |
| Memory Service | 7 |
| Mental Health Recovery Team (South) | 2 |
| Neuro Case Management Team | 1 |
| Neuro Enablement Service | 4 |
| OA CMHT North | 22 |
| OA CMHT South East | 15 |
| OA CMHT South West | 9 |
| OA CMHT West | 5 |
| OA Home Treatment | 3 |
| SPA / EWS (Netherthorpe) | 1 |
| START Alcohol Service | 1 |
| START Opiates Service | 2 |
| Woodland View \| Oak Cottage | 2 |
| **Grand Total** | **107** |

# Safe | Restrictive Practice | Physical Restraint




| Physical Restraint INCIDENTS | Sep-23 | | |
|---|---|---|---|
| | n | *mean* | SPC variation |
| TRUSTWIDE | **54** | *110* | • • • |
| **Acute & Community** | **53** | *107* | • • • |
| Dovedale 2 Ward | **14** | *25* | • • • |
| Burbage Ward | **1** | *9* | • • • |
| Maple Ward | **25** | *28* | • • • |
| HBPoS (136 Suite) | **0** | *1* | • • • |
| Endcliffe Ward | **9** | *19* | • • • |
| Dovedale 1 | **0** | *15* | • • • |
| G1 Ward | **2** | *6* | • • • |
| Birch Ave | **2** | *4* | • • • |
| Woodland View | **0** | *1* | • • • |
| **Rehabilitation & Specialist** | **1** | *3* | • • • |
| Forest Close | **0** | *2* | • • • |
| Forest Lodge | **1** | *1* | • • • |

| Physical Restraint PEOPLE | Sep-23 | | |
|---|---|---|---|
| | n | *mean* | SPC variation |
| TRUSTWIDE | **21** | 35 | • • • |
| **Acute & Community** | **20** | 33 | • • • |
| Dovedale 2 Ward | **4** | 6 | • • • |
| Burbage Ward | **1** | 5 | • • • |
| Maple Ward | **9** | 7 | • • • |
| HBPoS (136 Suite) | **0** | 1 | • • • |
| Endcliffe Ward | **3** | 6 | • • • |
| Dovedale | **0** | 3 | • • • |
| G1 Ward | **2** | 3 | • • • |
| Birch Ave | **1** | 2 | • • • |
| Woodland View | **0** | 1 | • • • |
| **Rehabilitation & Specialist** | **0** | 2 | • • • |
| Forest Close | **0** | 1 | • • • |
| Forest Lodge | 0 | 1 | • • • |

## Narrative

### Physical Restraint

There were 54 incidents of restraint recorded for 21 people, a continual decrease to previous months.

There has been a significant reduction in restrictive practice for a few individuals who have previously been in receipt of multiple interventions on Maple ward, G1, Burbage and Endcliffe Ward.

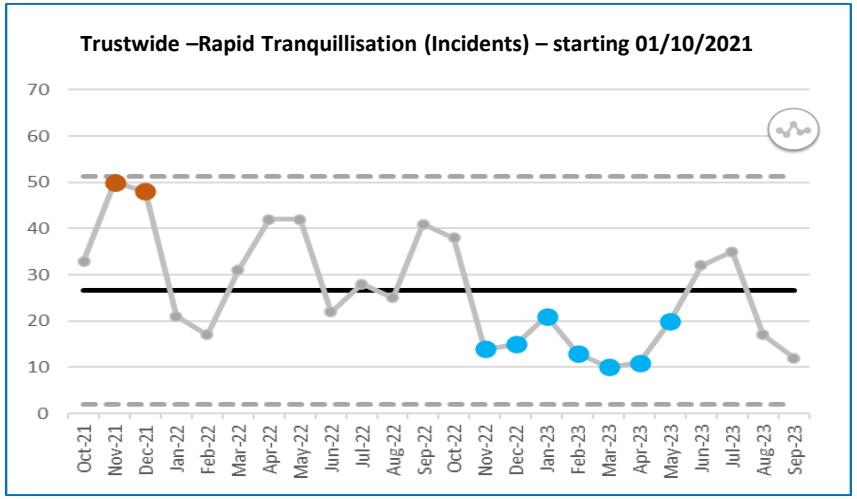
Burbage ward has had a period of over weeks without any restrictive practices which links directly to their Reducing Restrictive Practice plan.

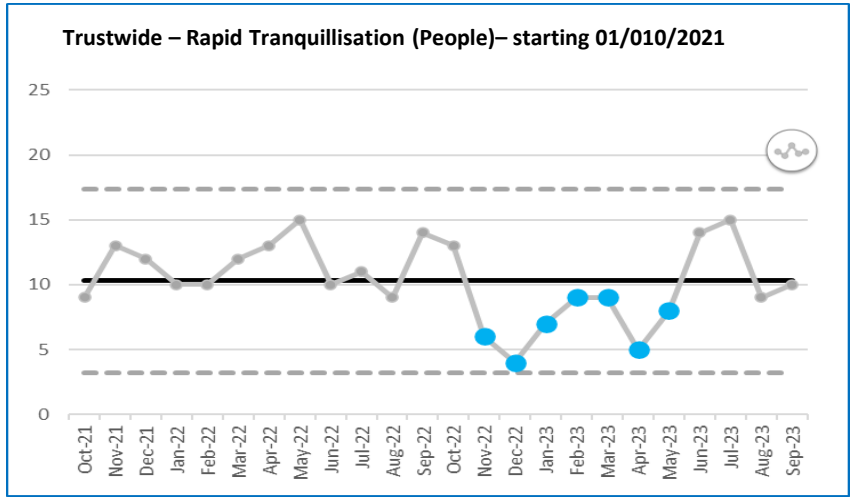
Dovedale 2 previously reported a high volume of restraint for the response to self-harm. As the self-harm incidents have reduced and they work in a more trauma informed way, the Restrictive Practice response has reduced.

### Mechanical Restraint

There continues to have been no incidents reported for the use of mechanical restraints in September 2023.

# Safe | Restrictive Practice | Rapid Tranquillisation




| Rapid Tranquillisation INCIDENTS | Sep-23 | | |
|---|---|---|---|
| | n | *mean* | SPC variation |
| TRUSTWIDE | **12** | *27* | • • • |
| **Acute & Community** | **12** | *26* | • • • |
| Dovedale 2 | **3** | *10* | • • • |
| Burbage Ward | **0** | *2* | • • • |
| Maple Ward | **5** | *6* | • L • |
| HBPoS (136 Suite) | **0** | *0* | • L • |
| Endcliffe Ward | **4** | *4* | • • • |
| Dovedale 1 | **0** | *5* | • • • |
| G1 Ward | **0** | *0* | • • • |
| **Rehabilitation & Specialist** | **0** | *0* | • L • |
| Forest Close | **0** | *0* | • • • |
| Forest Lodge | **0** | *0* | • L • |

| Rapid Tranquillisation PEOPLE | Sep-23 | | |
|---|---|---|---|
| | n | *mean* | SPC variation |
| TRUSTWIDE | **10** | *10* | • • • |
| **Acute & Community** | **10** | *10* | • • • |
| Dovedale 2 | **3** | *3* | • • • |
| Burbage Ward | **0** | *1* | • • • |
| Maple Ward | **5** | *2* | • • • |
| HBPoS (136 Suite) | **0** | *0* | • L • |
| Endcliffe Ward | **2** | *2* | • • • |
| Dovedale | **0** | *1* | • • • |
| G1 Ward | **0** | *0* | • • • |
| **Rehabilitation & Specialist** | **0** | *0* | • L • |
| Forest Close | **0** | *0* | • • • |
| Forest Lodge | **0** | *0* | • L • |

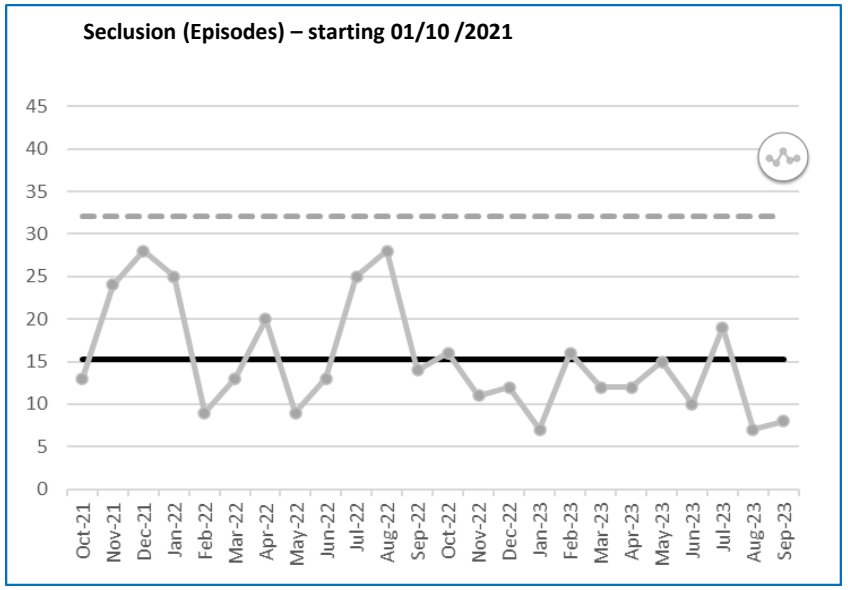
**Narrative**

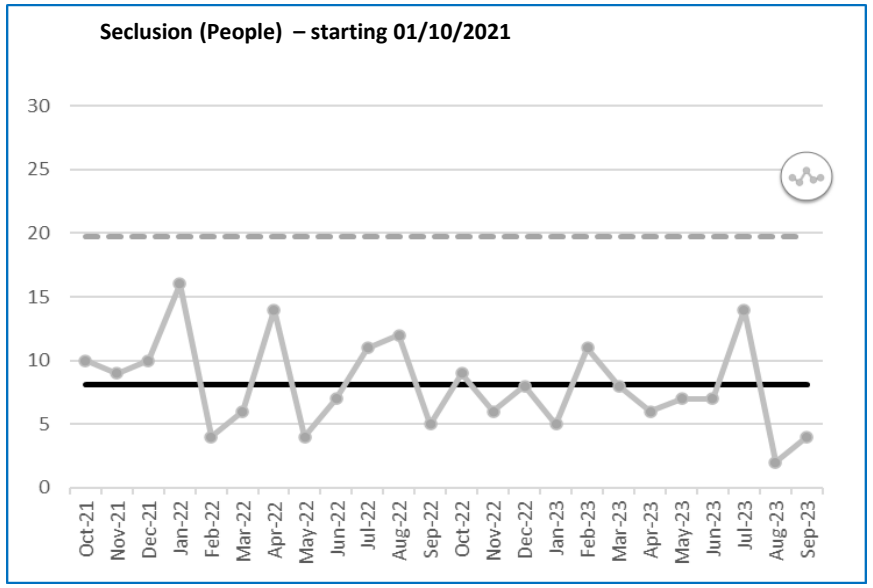
**Rapid Tranquillisation**
12 incidents of rapid tranquillisations used were recorded during September for 10 people.

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

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

# Safe | Restrictive Practice | Seclusion




| Seclusion INCIDENTS | Sep-23 | | |
|---|---|---|---|
| | n | *mean* | SPC variation |
| **Trustwide** | **8** | *15* | • • • |
| **Acute & Community** | **8** | *12* | • • • |
| HBPoS (136 Suite) | **0** | *0* | • L • |
| Maple Ward | **3** | *4* | • • • |
| Endcliffe Ward | **5** | *7* | • • • |
| **Rehabilitation & Specialist** | **0** | *0* | • L • |
| Forest Lodge | **0** | *0* | • L • |

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

**Narrative**

**Seclusion**
8 Seclusion episodes recorded for 4 people in September 2023.

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

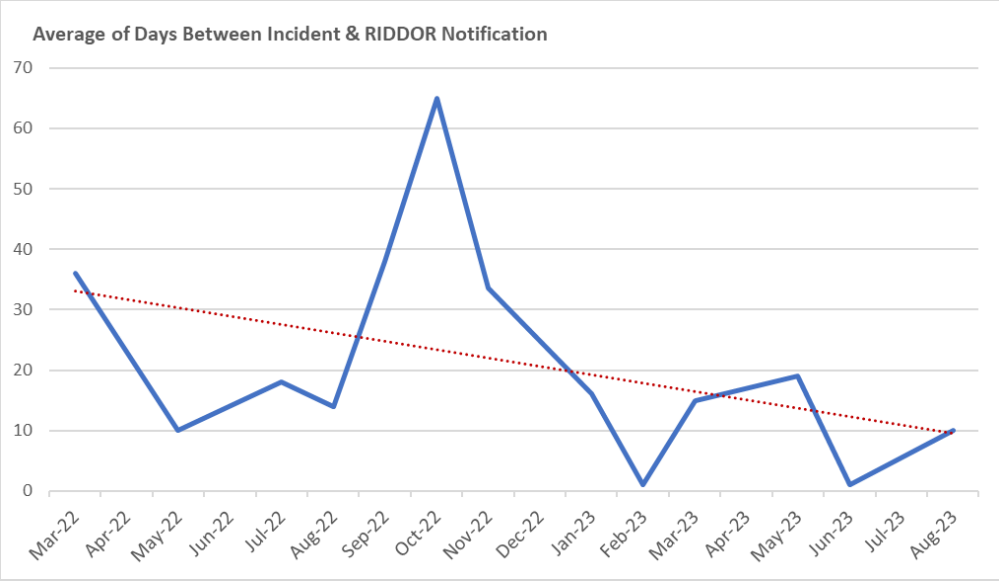
There continues to be no seclusion episodes reported in Rehabilitation & Specialist services.

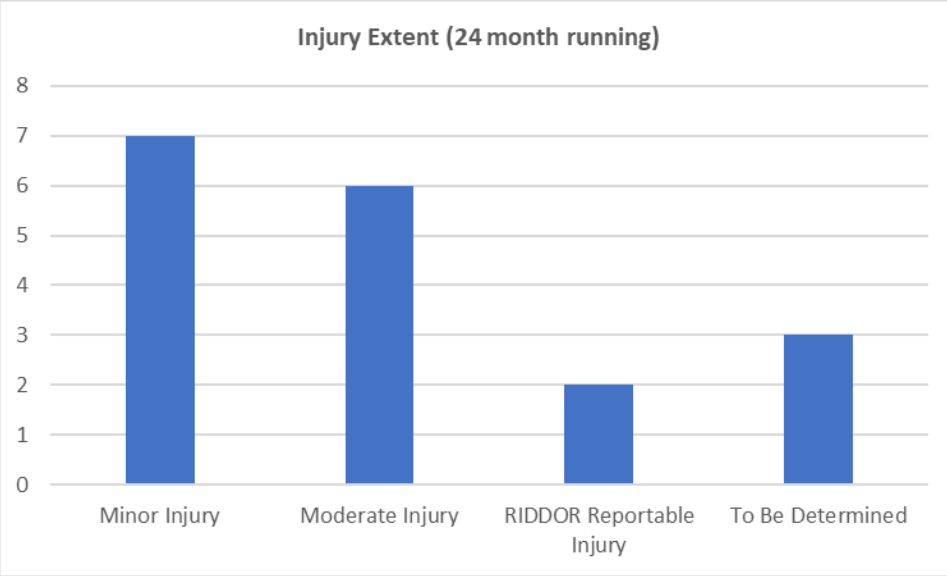
1 Seclusion episode was recorded as a prolonged episode in September for Maple ward, lasting 94 hours and 10 minutes (3.9 days). Policy was followed re this episode of prolonged seclusion, with directorate leadership reviews and clinical executive reviews taking place.

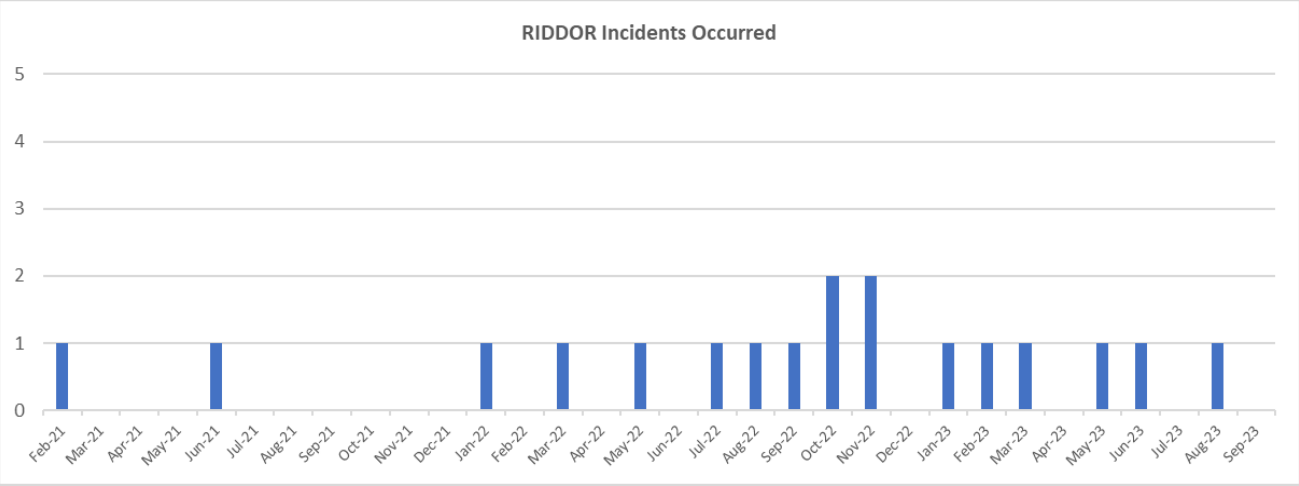
Linking our Least Restrictive Practice strategy and CQuIn, there is an ongoing quality improvement project for accurately recording timings of restrictive interventions, including seclusion episodes.

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

# RIDDOR



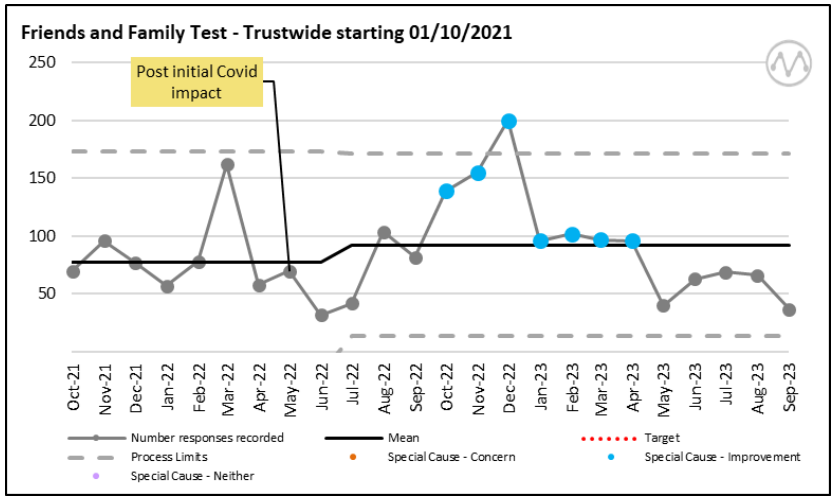



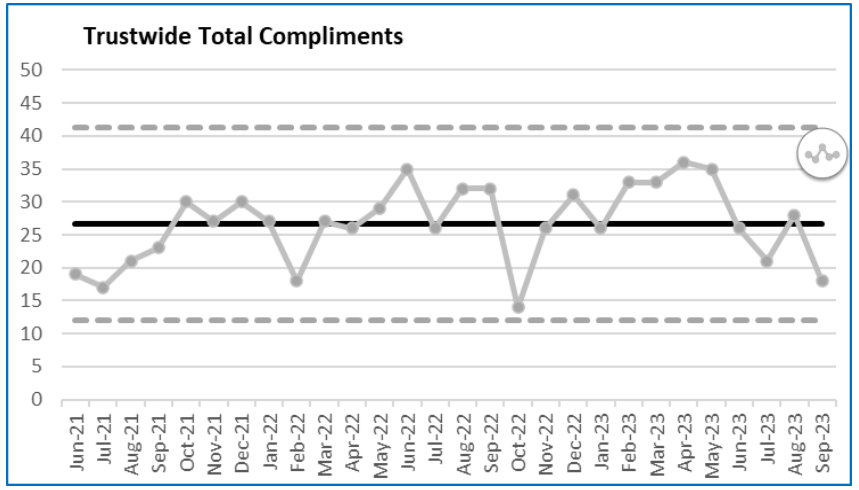



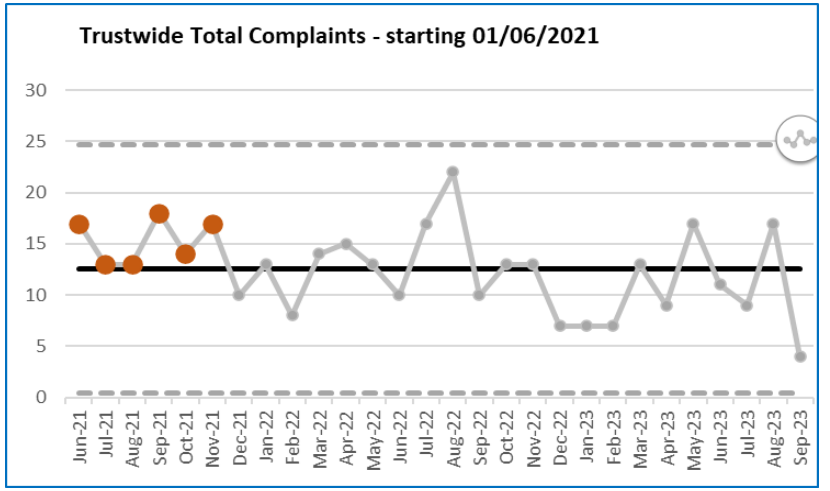

**Narrative**

In September 2023, no incidents have been identified as RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations). The Average of days between incident occurring and being reported RIDDOR continues to show improvement with a steady decline in the number of days between.

# Caring | User Experience




**Narrative**

In September 2023, the Trust received a total of 37 responses to the FFT questions; 36 of the responses were positive, 1 FFT card did not answer the question "Thinking About the Service We Provide How Was Your Experience of Our Service". This equates to 97.3% positive responses received in September 2023. With 37 responses and 4938 active clients, the observed response rate for September 2023 is 0.75%, below the Trust Aspiration Response Rate at 5%.

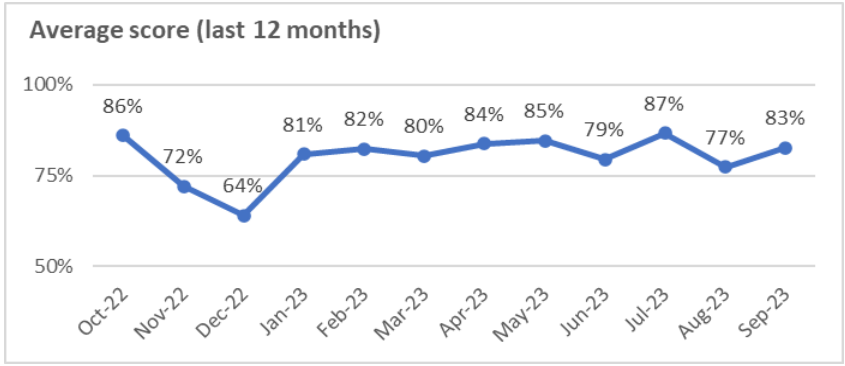
**A few positive responses are listed below:**

- "Answered all our questions regarding medication / treatment without us actually having to ask the questions. Did so in a calm, concise, way that enabled the patient and the family to access all the information without causing any stress and anxiety to the patient or family. Both an asset and credit to the service treating the patient and family with dignity and respect." – Memory Service
- "Efficient and good communication." – LTNC Neuro-Enablement Service (NES)
- "Make you feel valued and understands your difficulties." – LTNC Neuro Case Management Service
- "Well organised, clear, un-pressurising. Good to have someone who has been a service user as part of the teaching group. Friendly and non-judgemental." – Short Term Educational Programme (STEP)

**Compliments**

There have been 18 compliments recorded as received in September. 16 received for Acute and Community and 2 for Rehabilitation and Specialist services.

**Quality of Care Experience Survey**




**Complaints**

There were 5 new formal complaints received in September 2023. Access to Treatment remains as the most frequent complaint type. The ethnicity of the service users whose care was the subject of the complaint is 2 White British, 1 White Other and 2 unstated.

11 formal complaints closed in the month: -

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

**Quality of Care Experience**

In September 2023, a total of 20 inspections were carried out across 9 areas – Forest Lodge, Forest Close – Ward 1a, Forest Close – Ward 1, Forest Close – Ward 2, Burbage, Maple Ward, Dovedale 1, G1, Birch Avenue - at an average of 2.22 inspections per area.

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

NHS
Sheffield Health and Social Care
NHS Foundation Trust

# Our People

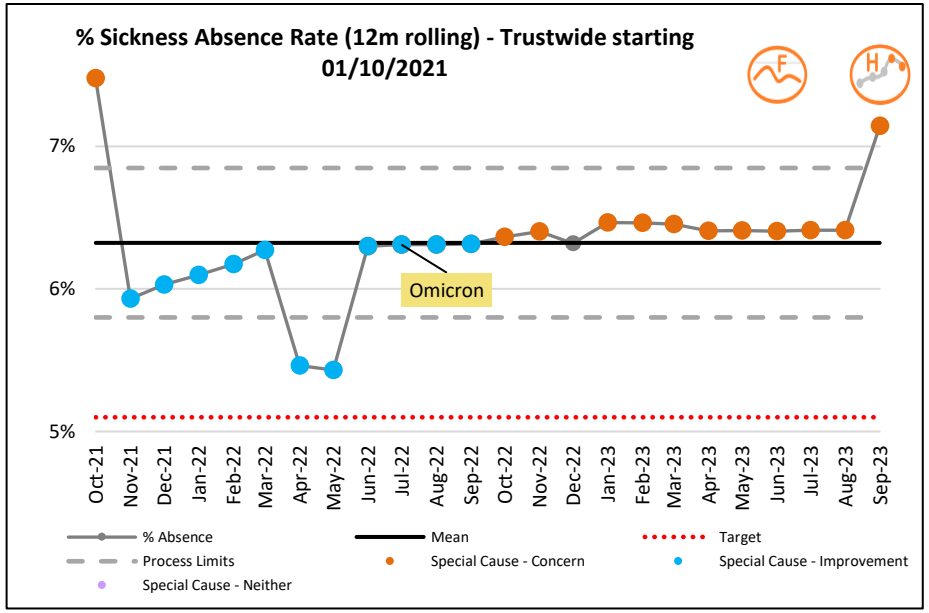
## IPQR - Information up to and including September 2023

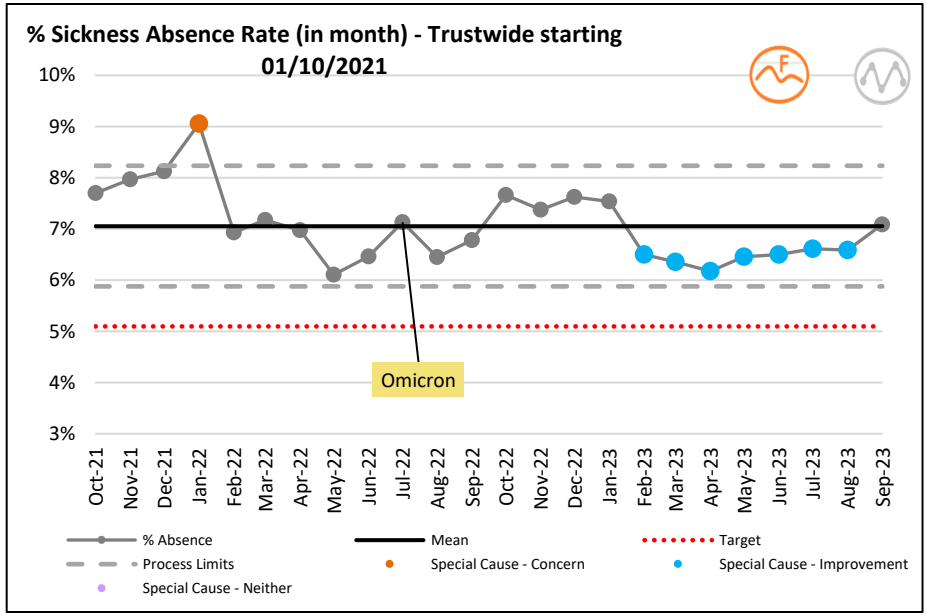
Proud to care in Sheffield

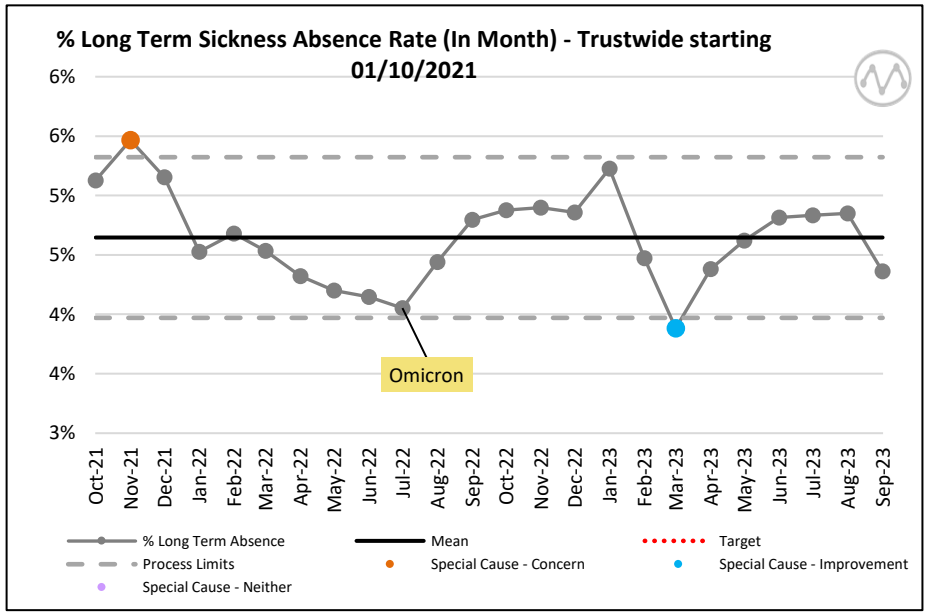
# Well-Led | Workforce Summary

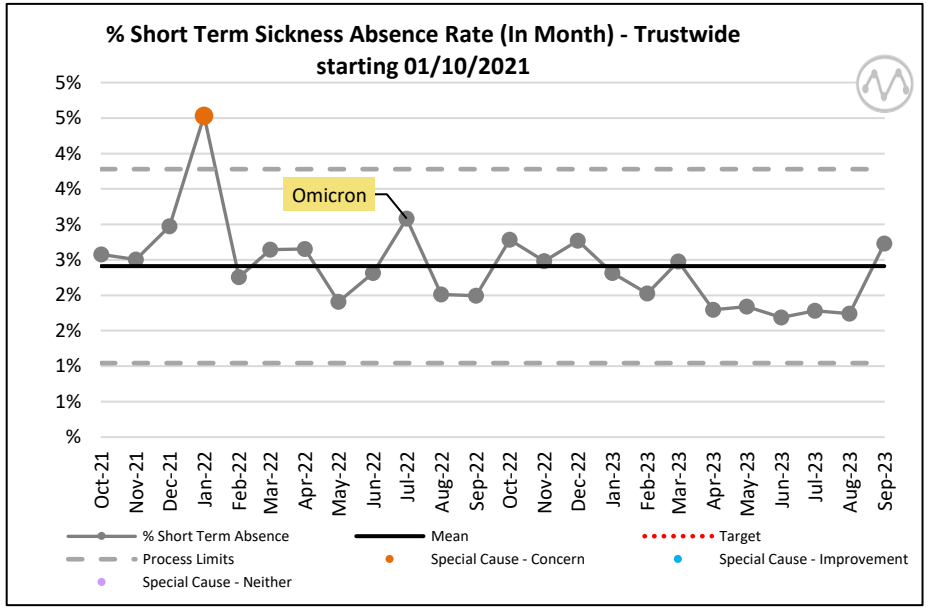
| | | Sep-23 | | | |
|---|---|---|---|---|---|
| **Metric** | **Target** | **n** | ***mean*** | **SPC variation** | **SPC target** |
| Sickness 12 Month (%) | 5.10% | **7.14%** | ***6.32%*** | • H • | F |
| Sickness In Month (%) | 5.10% | **7.09%** | ***7.06%*** | • • • | F |
| Long Term Sickness (%) | ~ | **4.36%** | ***4.65%*** | • • • | / |
| Short Term Sickness (%) | ~ | **2.73%** | ***2.41%*** | • • • | / |
| Headcount Staff in Post | ~ | **2665** | ***2645*** | • H • | / |
| WTE Staff in Post | ~ | **2346** | ***2322*** | • H • | / |
| Turnover 12 months FTE (%) | 10% | **18.18%** | ***15.8%*** | • H • | F |
| Training Compliance (%) | 80% | **88.9%** | ***88.67%*** | • • • | P |
| Supervision Compliance (%) | 80% | **73.78%** | ***71.99%*** | • H • | F |

# Well-Led | Sickness



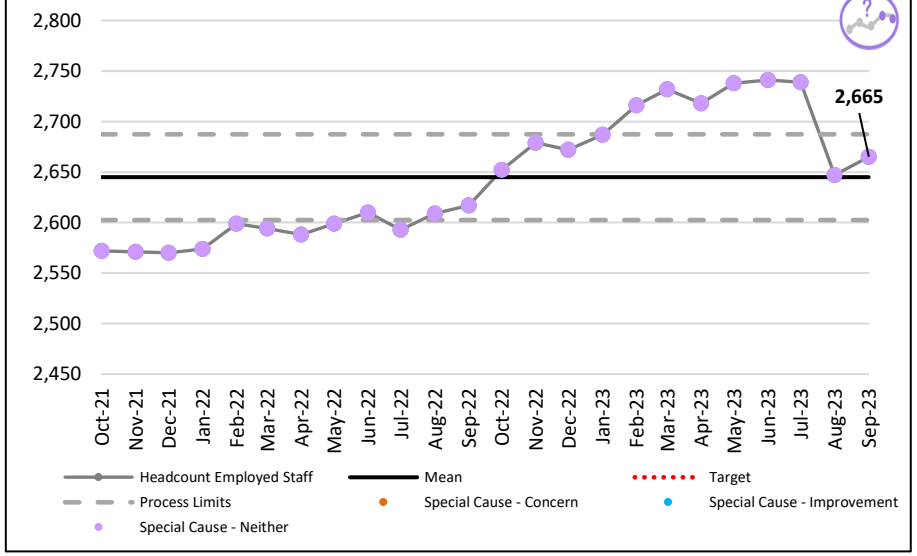



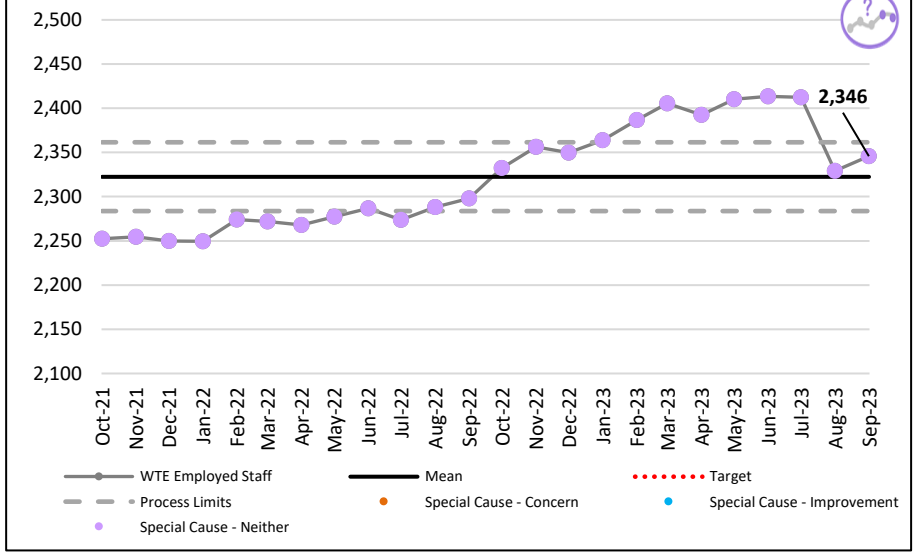

## Narrative

# Well-Led | Staffing

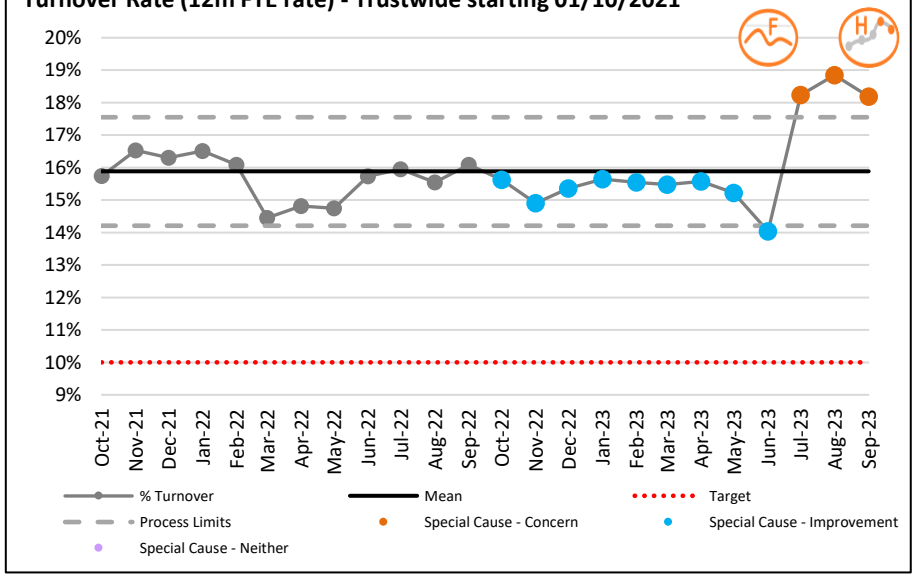
**Headcount - Trustwide starting 01/10/2021**




**WTE - Trustwide starting 01/10/2021**



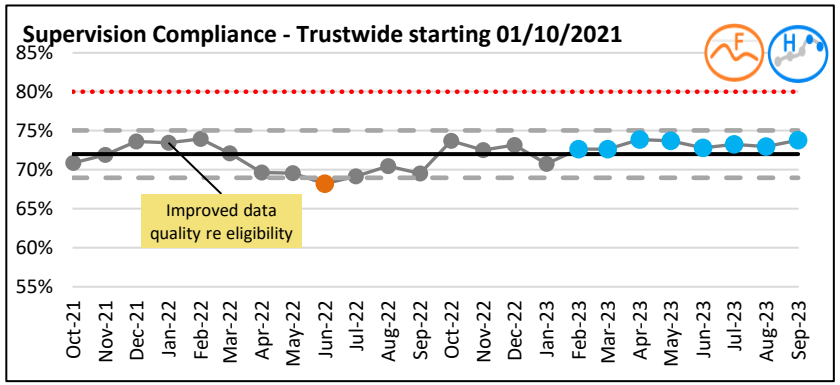

**Turnover Rate (12m FTE rate) - Trustwide starting 01/10/2021**

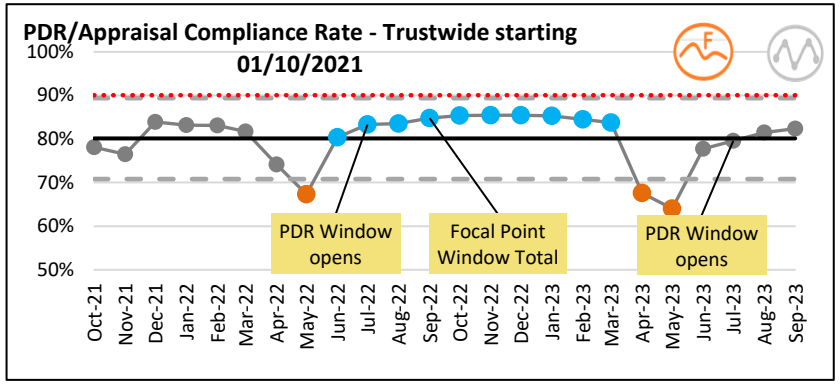


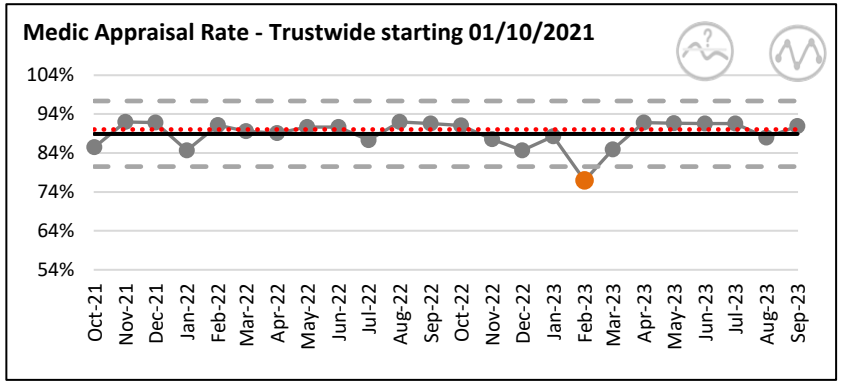

**Narrative**

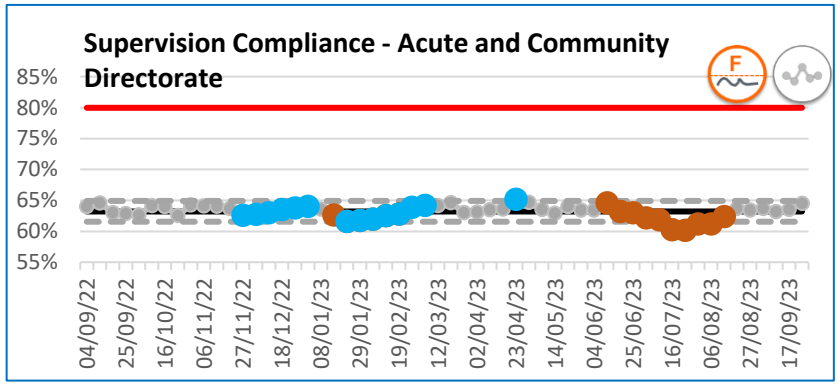
Substance misuse TUPE 31 July 2023

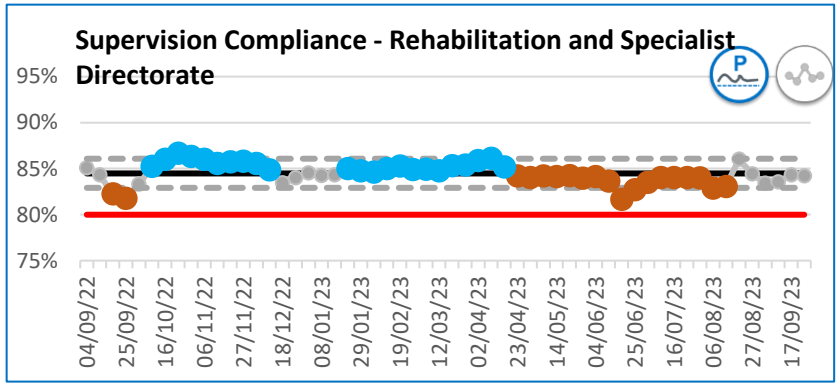
# Well-Led | Supervision & PDR/Appraisal

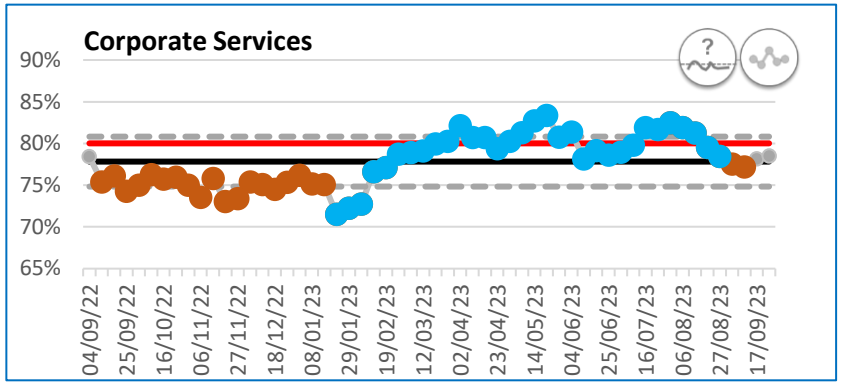



**AIM**

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

**Narrative**

As at 30 September 2023, average compliance with the 8/12 target is:

Trustwide **73.78%**

Clinical Services **72.68%**

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

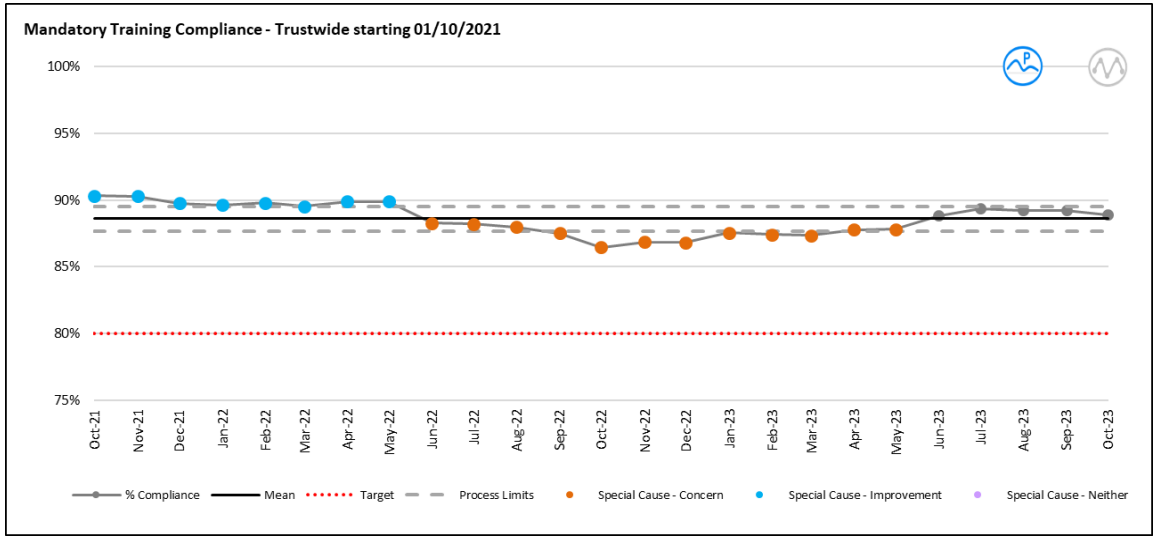
A recovery plan is in action for our acute and PICU wards, monitored through the Back to Good Programme Board.

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

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

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

# Mandatory Training




**AIM**

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

| COMPLIANCE – As at date | 05/09/23 | 26/09/23 |
|---|---|---|
| **Trustwide** | **89.23%** | **88.90%** |
| Directorate/Service Line | | |
| Corporate Services | 84.34% | 83.33% |
| Medical Directorate | 90.17% | 90.09% |
| Acute & Community – Crisis | 88.34% | 88.72% |
| Acute & Community – Acute | 90.34% | 90.10% |
| Acute & Community – Community | 94.23% | 93.76% |
| Acute & Community – Older Adults | 87.56% | 87.56% |
| Rehab & Specialist – Forensic & Rehab | 92.2% | 92.2% |
| Rehab & Specialist – Highly Specialist | 89.76% | 88.84% |
| Rehab & Specialist – Learning Disabilities | 90.64% | 89.67% |
| Rehab & Specialist – Talkin Therapies | 94.93% | 94.95% |
| | | |

**Narrative**

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

As at 26/09/2023 the nearest training report to end of September position
There are currently 10 subjects below 80%:

Safeguarding Children Level 3 66.82% down 0.09%
Mental Health Act 69.19% up 0.71%
Medicines Management 67.87% up 0.5&
Deprivation of Liberty Standards Level 1 79.74% down 0.91%
Deprivation of Liberty Standards Level 2 76.92% up 2.85%
Rapid Tranquilisation 79.27% up 3.45%
Moving and Handling Level 2 74.94% up 0.83%
Resus Level 2 (BLS) 68.47% down 0.32%
Respect Level 3 70.48% up 0.72%
Clinical Risk 79.15% down 0.75%

Immediate Life Support is above 80% for the first time since June 2022 at 81.13% up 5.45%
We are hoping that in October Dols Level 1 will return above and that Rapid Tranq will reach 80% as well

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

Resus Level 2, Resus Level 3 and Moving and Handling continue to be run in portercabins with reduced numbers at Woodland View due to ongoing roof replacement work which was paused recently for a month due to recent onsite issues relating to water samples.

Clinical risks related to Mandatory Training compliance issues are now a standing item at the monthly to the Clinical Quality and Safety, second report is being received by the meeting on Monday 16th October.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

# Financial Performance

## IPQR - Information up to and including September 2023

Proud to care in Sheffield

# Executive Summary

| Key Performance Indicator | YTD Plan £'000 | YTD Actual £'000 | Variance £'000 | Annual Plan £'000 | 23/24 Forecast £'000 | Variance £'000 |
|---|---|---|---|---|---|---|
| Surplus/(Deficit) | (1,816) | (2,692) | (876) | (3,262) | (3,262) | 0 |
| Out of Area spend * | (4,590) | (4,866) | (276) | (8,496) | (9,995) | (1,499) |
| Agency spend | (3,380) | (3,379) | 1 | (6,479) | (6,470) | 9 |
| Cash | 45,280 | 44,254 | (1,026) | 47,405 | 45,951 | (1,454) |
| Efficiency Savings | 1,972 | 1,972 | 0 | 5,734 | 5,734 | 0 |
| Capital ~ | (6,548) | (4,728) | 1,820 | (12,791) | (12,791) | 0 |

| KPI | | Target | Number | Value |
|---|---|---|---|---|
| Invoices paid within 30 days (Better Payments Practice Code) | NHS | 95% | 100% | 100% |
| | Non-NHS | 95% | 99.4% | 99.0% |

YTD: Year To Date
* Includes Purchase of Healthcare only, excludes travel costs.
~ The capital plan was rephased in M3 to reflect the updated expenditure profile. Total for the year is unchanged.

**At month 6, we are reporting off plan** with a YTD deficit of £2.692m.

**There is a risk that the deficit will be significantly higher** than the reported forecast deficit of £3.262m. NHS England & ICB rules require us to report breakeven.

**Out of Area (OOA) cost will exceed plan** based on current spend levels.

**Delivery of recurrent efficiency savings is off plan by £0.7m**. Non-recurrent interest receipts enable us to report breakeven. The OOA workstream is forecast to under-deliver by £1.5m. Mitigations must be found to prevent the deficit exceeding £3.262m.

**Cash balances remain healthy but lower than planned** due to increased capital spend and the deficit. There are no concerns regarding cash flow or material bad debt risks to highlight at present.

**The revised capital plan is underspent by £1.82m YTD due to timing of works. The total plan of £12.791m is forecast to be spent in full.** This assumes a £4m receipt from the sale of Fulwood. This funding uncertainty is a planned and managed risk, but it has significant operational implications hence the amber rating. The situation is monitored very closely and will be reported promptly if the risk increases or materialises.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Report ends
Page intentionally blank

Proud to care in Sheffield

# Appendix 1 | SPC Explained

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

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

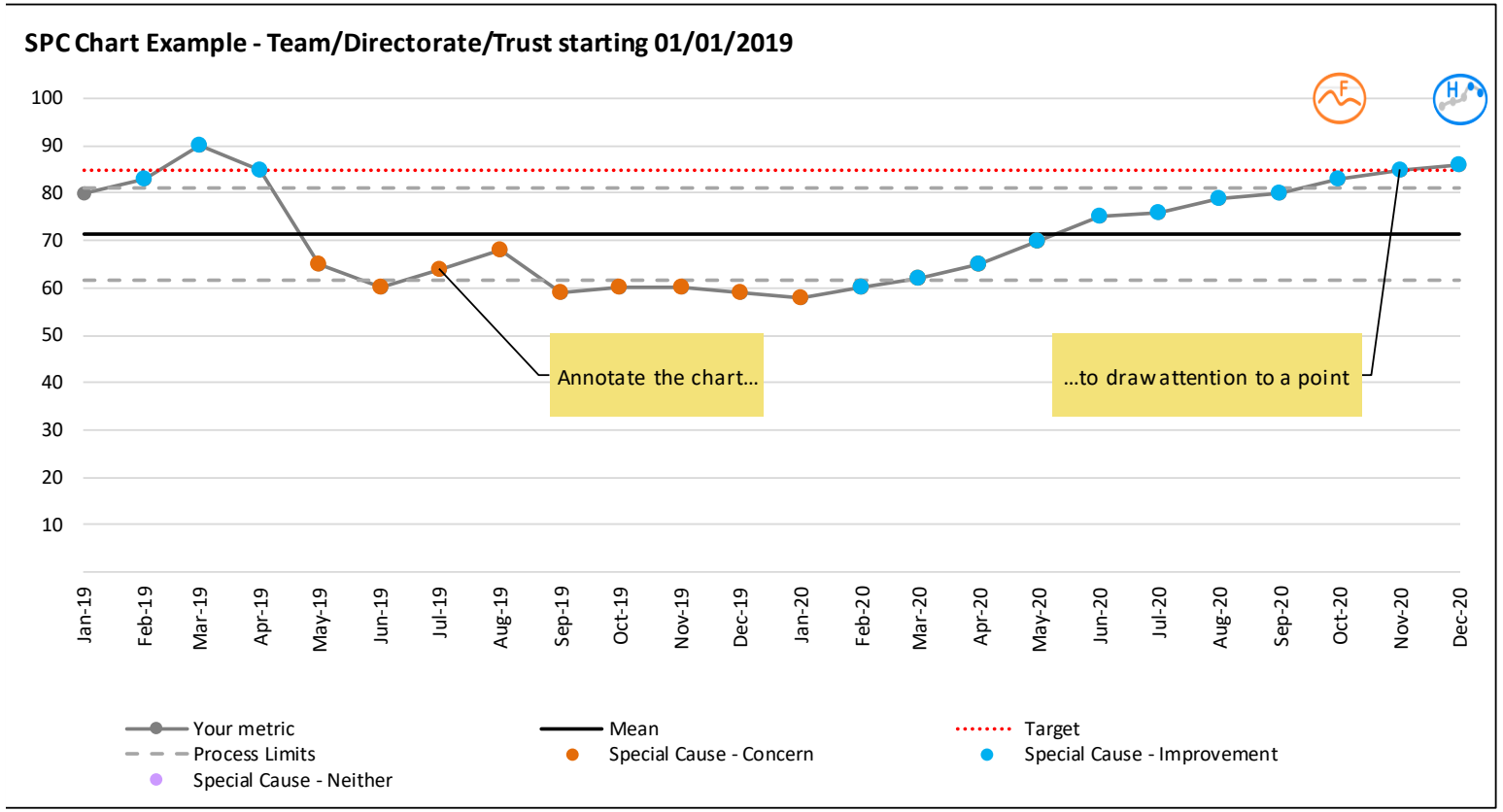
- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

| **Variation Icons**<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 |
| **Team/Service** | Team/Directorate/Trust |
| **Your Measure** | Your metric |
| **Improvement Indicator** | High is Good |
| **Target** | 85 |

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




**Observations**

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

| | |
|---|---|
| Single Point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There are 6 points above the UCL and 7 points below the LCL. |
| Trend | When there is a run of 6 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control. |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. |