Board of Directors
Item number: 19
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Confidential/public paper:	Public
Report Title:	**Integrated Performance and Quality Report (IPQR)**
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Vision and values:	We use the IPQR to ensure that **we keep improving** the mental, physical and social wellbeing of the people in our communities as effectively as possible. We do this by monitoring the performance and quality of our services and providing assurance.
Purpose:	The IPQR is produced every month as part of the SHSC Performance Framework. It provides assurance on key performance and quality indicators. Where performance is worsening or below target, remedial actions will be taken and communicated in the narrative.
Executive summary:	This new version of the IPQR contains data to July 2025 and has been produced following engagement and feedback from stakeholders across the Trust including a task and finish group. It is intended to provide a more holistic, integrated, and strategically aligned understanding and assurance of the Trust's performance and the details of action that is being taken to improve. Because the new IPQR covers the relevant metrics, this will replace the old version of the IPQR from this month. There are three sections to the new IPQR: executive summary, overview of performance and annex: • The Executive summary (slides 4-6) includes our assessment in line with the Triple AAA approach. • The overview of performance section (slides 8-15) is organised into 4 sub-sections, one for each of SHSC's strategic objectives: deliver outstanding care, effective use of resources, reduce inequalities, and great place to work. The KPIs in each of these sections are included because they are reported nationally (for example, in the planning guidance and NHS oversight framework) or measure progress against our 2025-30 Strategy. This section also includes progress on the Trust's improvement and change programmes. • The Annex (slides 17-72) contains an overview of Trust wide performance against quality, people and finance metrics, followed by a section for each clinical service line's performance. Length of stay in bedded services is measured in days; wait times for community services are measured in weeks.

	Where appropriate, we continue to use statistical process control (SPC) charts to help distinguish between signals in data (which should be reacted to) and noise (which should not as it is occurring randomly). Using SPC charts can also provide assurance on whether a target will reliably be met or whether the process is incapable of meeting a target without a change. SPC charts are presented as full charts and as summary icons throughout the report. Some information is not available in the report this month. Benchmarking and targets for some metrics in the overview of performance section require further work before they can be populated. The mean average and SPC variation and assurance indicators for some metrics in the annex will be provided in next month's report (these are indicated with an asterisk). The following metrics are still in development and will be reported on as soon as possible: • Inpatients referred to stop smoking services • People accessing community mental health services with serious mental illness • Risk assessments meeting standard • Service users with care plans in place • Average RtT (referral to treatment) and RtA (referral to assessment) waits (all MH services ex. Talking Therapies) • Contextual metrics in the national oversight framework One green plan metric is included in this report: percentage of sites with a 'good' accredited travel plan. Further work will be done to add more metrics the next time the IPQR is presented to Board. Further work is needed to include the commissioned activity information in order to understand service line performance. **Appendix attached:** Integrated Performance & Quality Report July 2025

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*	X	*No*		
Deliver Outstanding Care	*Yes*	X	*No*		
Great Place to Work	*Yes*	X	*No*		
Reducing Inequalities	*Yes*	X	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.
The IPQR is shared on a regular basis with South Yorkshire ICB and reviewed in the Contracts Management Meeting between the ICB and SHSC for assurance.

Board assurance framework (BAF) and corporate risk(s):	All BAF risks apply
Any background papers/items previously considered:	This is the first time this version of the report has been received, however an IPQR is presented monthly to the executive management team and the quality assurance committee, as well as every other month to the finance and performance committee ahead of Board of Directors. Executive Management Team, 4 September 2025 Quality Assurance Committee, 10 September 2025 Finance and Performance Committee, 12 September 2025
Recommendation:	The Board of Directors is asked to: • Receive and consider the report for **assurance** • Use the report as a basis for discussion around Trust performance and quality of delivery • Request remedial action where required

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Integrated Performance & Quality Report

Information up to and including July 2025

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Introduction

This new version of the Integrated Performance and Quality Report (IPQR) has been produced following engagement and feedback from stakeholders across the Trust. It is intended to provide a more holistic, integrated, and strategically-aligned understanding and assurance of the Trust's performance and the details of action that is being taken to improve.

There are three sections: Executive Summary, Overview of Performance and Annex.

The Overview of Performance section is organised into 4 sub-sections, one for each of SHSC's strategic objectives: Deliver Outstanding Care, Effective Use of Resources, Reduce Inequalities, and Great Place to Work. The KPIs in each of these sections are included because they are reported nationally (for example, in the NHS Oversight Framework) or measure progress against our 2025-30 Strategy.

The Annex contains an overview of Trustwide performance against quality, people and finance metrics, followed by a section for each clinical service line's performance. Length of stay in bedded services is measured in days; wait times for community services are measured in weeks.

Where appropriate, we continue to use statistical process control (SPC) charts to help distinguish between signals in data (which should be reacted to) and noise (which should not as it is occurring randomly). Using SPC charts can also provide assurance on whether a target will reliably be met or whether the process is incapable of meeting a target without a change. SPC charts are presented as full charts and as summary icons throughout the report. Refer to appendices 1 and 2 for a full explanation.

Where abbreviated terms are used in the body of the report due to space constraints, the glossary in appendix 3 can be referred to for an explanation.

Some information is not available in the report this month. Benchmarking and targets for some metrics in the Overview of Performance section require further work before they can be populated. The mean average and SPC variation and assurance indicators for some metrics in the Annex will be provided in next month's report (these are indicated with an asterisk).

Board committee oversight: the footer of most pages contains 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	Finance & Performance
P	People
Q	Quality Assurance

Contents

Executive Summary (1)

Overarching Headline Indicators

Deliver Outstanding Care

- **ALERT** The trajectory to reduce out of area placements was not met in July which was driven by high demand, high LoS, and delayed discharges. Impact actions have been agreed through Home First to regain grip of our OAP reduction.
- **ALERT** Our performance against the new CYP access target has worsened to -9.7% from -4.9% in Apr-25. We are investigating the cause of this. Work to produce a historical view and forecast this metric is being prioritised as part of a recovery plan.
- **ADVISE** Further work is required on a new metric of crisis face to face contact within 24 hours. Data quality requires involvement - recovery actions are in place. Guidance has been shared and this is currently being tested by U&C leadership with a view to embedding it into standard processes within the next 2 months.
- **ASSURE** We are performing well across a number of metrics such as Community Perinatal, Talking Therapies, numbers of seclusions, waits over 52 weeks for community services and rate of restrictive interventions. Work continues to maintain and where possible to further improve.

Effective Use of Resources

- **ASSURE** We are reporting an overall break-even position YTD which is possible due to confidence in achieving VIP targets and the decision to rephase £1.6m of income. The underlying variance is mainly due to the pay award pressure £0.62m, value improvement plan (VIP) underachievement £0.56m and reduction in underspending areas against plan £0.47m.
- **ASSURE** As of July, Clinical Directorates are £560k behind value improvement programmes plan. However, they have plans to achieve the full £6.4m target. All corporate services are achieving target YTD.
- **ASSURE** We continue to meet the national target for 100% of tenders and procurement frameworks have a minimum 10% net zero weighting.

Reduce Inequalities

- **ASSURE** We have seen improvements in capturing protected characteristics data with 6 pilot teams. A dashboard has now been produced for all services, and a programme of work has been mobilised to capture protected characteristics across all services. Teams are working towards a target of 80% data completeness across all characteristics by Mar-26.

Great Place to Work

- **ALERT** Trustwide sickness absence rate persists above the 5.1% target. A sickness recovery plan has been developed and implementation began in August. Additional support is being provided to managers and monitoring is in place.
- **ALERT** PDR compliance at the end of the cycle was at the highest point in over 2 years (83.5%) but we did not achieve the target of 90%. A recovery plan will be required for 2026.
- **ADVISE** Supervision compliance has recently improved to 73.5% overall and 76.4% in clinical teams, however it is persistently below the 80% target. Clinical teams have a recovery target of 80% by the end of September.
- **ASSURE** National Education and Training Survey experience score - SHSC outperformed the national average by 2.6% and the regional average by 2.1% in the 2024 survey.

Transformation Programmes

- **ADVISE** 4 of the 7 key programmes are reporting amber indicating some slippage against in year milestones but with assurance provided that the overall timescale for delivery will be achieved and key risks have mitigations.
- **ASSURE** We are doing well on our ‘We Are Our Values' programme which is rated as green.

Executive Summary (2)

Corporate Metrics

Safety and Quality

- **ALERT** Complaint response rate has been below the target of 80% for three consecutive months. In July it improved to 68% with 6 complaints outstanding but is still below target. We continue to maintain contact with complainants, keeping them informed of the progress of their complaint through the process. A recovery plan has been commissioned.
- **ADVISE** There were a high number of unreviewed incidents on Burbage and Endcliffe wards in June. Intensive support has been implemented until end of Aug-25. All incidents are reviewed in the daily incident safety huddle and action taken to address safety risks immediately.
- **ADVISE** Friends and Family Test – 93 responses were received in July. Of these, 88 were positive however we need to improve engagement to increase the response rate.
- **ADVISE** Safer staffing – 6 services report high care hours per patient day (CHPPD) due to a combination of increased patient observations and high acuity. Endcliffe and Stanage nurse fill rates were impacted by short term sickness, pregnancy/maternity leave and vacancies.
- **ASSURE** All of the 31 service users discharged from wards in July were followed up within 72 hours, overachieving the 80% target.
- **ASSURE** A review of falls guidance against newly published NICE guidelines is currently in progress. Following this, an audit will be created for ongoing monitoring and assurance.

Our People

- **ADVISE** Turnover is on an improving trajectory though is still above the 10% target. The reduction is due to a drop in headcount and vacancies not being recruited to due to establishment reviews not completed.
- **ASSURE** Mandatory training compliance is generally strong and significantly above target.

Finance

- **ALERT** Due to an increase in out of area numbers in June and July there is an overspend of £0.2m against trajectory. Impact actions have been agreed through Home First to regain grip of our OAP reduction.
- **ASSURE** There is confidence that the £8m VIP requirement can still be met, therefore income has been rephased and report is on plan. A range of improvement actions are in place in relation to delivering our Value Improvement Programme.

Service Line Reporting

Crisis Services

- **ALERT** There has been a significant deterioration in NHS 111 abandonment rate to 27% against a target of 3%. NHS 111 call answer times continue to be significantly elevated and consistently failing targets. Nottingham Community Housing Association has committed to producing a recovery plan by the end of Aug-25.
- **ASSURE** Sickness absence was almost double the target at 9.3%. Funding for two band 6 nurses has been approved for Liaison Psychiatry on a temporary basis until mid-December.

Adult Acute Wards

- **ADVISE** The rolling 12 month discharged length of stay for Acute is not meeting the target of 40.7 days. This is partly due to the discharge of two very long stay clients in Jan-25 (982 days) and Feb-25 (630 days). If these clients were to be excluded then the average would be 47.4 days.
- **ASSURE** The longest length of stay currently is 840 days on Dovedale 2. On Endcliffe PICU there are 2 clients with a LoS over the benchmark figure of 71.6 days. Longer stay clients are reviewed regularly at MDT meetings. Escalations are raised where support is required to find appropriate placements. The overall number of individuals delayed has reduced and for Adult Acute & PICU has achieved the target of 10% for the last 6 months. However Trust wide delays including OOA remain high at nearly 20%. These issues are also a key area of focus as part of Home First and work with Sheffield City Council and the ICB.

Executive Summary (3)

Service Line Reporting (cont.)

Adult Community

- **ADVISE** Sickness remains high in North CMHT, there is a higher proportion of long term sickness which is being managed appropriately.
- **ASSURE** High volume of referrals in CMHTs from primary care. Work is underway to reset the referral process as part of Home First. Referral criteria has been reviewed and a new referral template for GPs has been developed which is expected to lead to appropriate referrals being sent to CMHTs.

Older Adults

- **ALERT** Supervision compliance is significantly below target across Older Adults services. Persistent sickness absence across Woodland View has affected supervision compliance which is well below the 80% target.
- **ADVISE** Vacancy rate is above the 10% trust target – at 13.2% in July 2025.
- **ADVISE** G1 and Dovedale 1 wards lengths of stay have recently fallen to 57 and 61 days respectively but are still above the target of 40 days.
- **ASSURE** The execution of a recovery plan in Memory Service has been highly effective in halving the waiting list for new assessments from a two year high of 1,150 in Aug-24 to 551 at the end of Jul-25. Wait for Assessment and Contact in Memory Service have fallen significantly in July.

Forensic and Rehabilitation

- **ALERT** The Forest Close live length of stay as at the end of July was significantly above the benchmarked target of 380 days. This is significantly skewed by 3 service users with a length of stay over 1000 days (longest stay 1842 days). MADE events are being established as part of Home First to work with system partners and resolve discharge delays.
- **ALERT** CERT caseload and AOT waiting lists are pressure points. Further investigation is required.
- **ADVISE** Forest Lodge admissions have been on hold since Mar-25 whilst a comprehensive programme of improvement has been undertaken to address workforce and quality concerns. This has included an increase in therapeutic activity, improving safeguarding processes and reducing restrictive interventions.

Learning Disabilities

- **ASSURE** Following the introduction of Rio, Specialist Community Learning Disability Service are still working to understand processes and system setup. The spike in referrals is artificial due to the team creating multiple referrals for each individual so they can be assigned by specialty. True referrals are not believed to have increased. Process changes have been made: referrals, waiting list and caseload should reduce over the next 6 months.

Highly Specialist Services

- **ASSURE** A plan is being developed to implement a nurse-led model in SAANS ADHD which will significantly increase capacity to deliver assessments and help reduce the waiting lists.
- **ASSURE** Increased staffing in the Gender Identity Clinic combined with work by the Organisational Development team has provided resilience and staff feeling better supported. Sickness absence has reduced over the last 12 months.
- **ASSURE** The waiting list for Gender Identity Clinic has stabilised due to increased capacity within the team to deliver assessments. As at the end of Jul-25, the service had delivered 124 assessments YTD and are on track to exceed their annual target of 170 assessments.
- **ASSURE** Referrals to Perinatal have been above the mean for 7 consecutive months. This is aligned to the national long-term expansion plan to increase the access rate to 7.5% of the population of pregnant and expectant mother through assertive promotion. The service has exceeded the national access rate target for 3 consecutive months.

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Overview of Performance

Information up to and including July 2025

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Overview of Performance | Deliver Outstanding Care (1)

			Jul-25						
Strategic Objective 1: Deliver Outstanding Care	**Target**	**Bench mark**	**Value**	***mean***	**Var.**	**Ass.**	**Early Warning Indicator**	**Mitigation**	**Comments**
Talking Therapies Reliable Improvement Rate	67%	-	**67.4%**	*67.0%*	• • •	?	N/A	N/A	Targets are currently being met by the service. Sheffield Talking Therapies is working to maintain this position. The expectation that recovery rates will fluctuate.
Talking Therapies Reliable Recovery Rate	48%	46.7%	**48.5%**	*48.8%*	• • •	?	N/A	N/A	
Average inappropriate out of area placements in month (Adult Acute & PICU)	24	-	**28**	-	-	-	Daily sitrep (developing a daily OOA slide)	Home First Programme	Stepped target to reduce to 5 placements by Mar-26. July's position is an improvement on June but the stepped target has still not been met.
Inappropriate out of area bed nights (Adult Acute & PICU)	744	-	**867**	-	-	-	Average admissions and discharges; LoS; CRFD	Home First Programme	Trajectory target not met this month.
Average discharged length of stay for adult and older adult MH acute and PICU beds (days)	76.6	-	**71**	-	-	-	Live LoS monitoring	Home First Programme (for adult acute)	Stepped target to reduce to 57.8 days by Mar-26. Target is currently being achieved.
Adults with a discharged length of stay over 60 days	TBC	-	**30.7%**	-	-	-	Live LoS monitoring	Home First Programme	Monthly figure, high in July due to some longer stay clients being discharged. We have historically benchmarked well.
Older Adults with a discharged length of stay over 90 days	TBC	-	**33.3%**	-	-	-	Live LoS monitoring	Home First Programme	Monthly figure, 4 of 12 discharges over 90 days.
People accessing Specialist Community Perinatal Mental Health service	703	-	**745**	-	-	-	N/A	N/A	The service has exceeded the national target for 3 consecutive months. We expect this success to continue. More information is in the Highly Specialist Services section of the Annex.

Overview of Performance | Deliver Outstanding Care (2)

			Jul-25						
Strategic Objective 1: Deliver Outstanding Care	**Target**	**Bench mark**	**Value**	***mean***	**Var.**	**Ass.**	**Early Warning Indicator**	**Mitigation**	**Comments**
Waits over 52 weeks for community services	0%	-	**0%**	*2.1%*	• • •	?	40+ week waiters	New process put in place Jul-25 to book appointments with all long waiters.	This metric applies to LTNC only. Performance has improved and it is expected that this will be sustained.
Annual change in CYP accessing MH services	-	-	**-9.7%**	-	-	-	To be defined	Recovery plan in place to ensure waiting well contacts made with CYP on waiting lists.	The position in July worsened from Apr-25 (-4.9%). This metric can fluctuate significantly as there are small numbers of CYP that access our services.
Crisis face to face contact within 24 hours	TBC	-	-	-	-	-	Data quality report (in development)	Guidance on how to record referral urgency to be shared with relevant teams for implementation. Improvement in recording will be monitored.	This is a new metric data quality is poor. Reporting will commence once improvements are achieved More information is in the Crisis section of the Annex.
Inpatients referred to stop smoking services	TBC	-	-	-	-	-	-	No mitigation required	Discussion taking place with service to agree an appropriate metric for inclusion.
People accessing community mental health services with serious mental illness	-	No national baseline	-	-	-	-	-	N/A	Diagnosis not consistently recorded. Improvement work ongoing.
Clinical staff trained in human rights	85%	-	**71.1%**	*65.4%*	• H •	F	Internal reporting	Human rights training is currently a module as part of Respect Level 1.	SHSC is a leading organisation in human rights training and performing better than similar organisations.
Number of seclusions	-	-	**6**	*6*	• • •	-	Internal reporting	Least Restrictive Practice Plan 2025-28	Seclusion episodes were to manage safety of staff and other service users due to those secluded presenting as risk to others. Long term reduction in use of seclusion from an average of c.45 per month in 2021 to 6 per month in 2025.
Rate of restrictive intervention use per 1,000 bed days	-	19.0	**17.0**	-	-	-	Daily incident huddle	Least Restrictive Practice Plan 2025-28; monthly and quarterly reviews for learning	Improvement from 23 in Apr-25. Work is ongoing to provide this metric historically.

Overview of Performance | Deliver Outstanding Care (3)

			Jul-25						
Strategic Objective 1: Deliver Outstanding Care	**Target**	**Benchmark**	**Value**	***mean***	**Var.**	**Ass.**	**Early Warning Indicator**	**Mitigation**	**Comments**
CQC safe inspection rating	Good	35% MH trusts rated 'good', 63% 'requires improvement' & 2% 'inadequate'	**Requires Improvement**	-	-	-	-	-	Our CQC rating is not considered as part of our National Oversight Framework score due to it being issued over 2 years ago.
NHS Staff Survey – Raising Concerns sub-score	-	SHSC is in the bottom quartile of national group	**6.3**	-	-	-	-	Comms and briefings to raise the profile of speaking up. Anonymous poll open until end of September.	Based on 2024 staff survey, we are 42nd out of 48 mental health and learning disability trusts. Actions are in place to ensure staff understand how to raise concerns and have confidence that they will be listened to.
Risk assessments meeting standard	95%	-	-	-	-	-	-	New training being launched on ESR for staff completing risk assessments alongside a new Risk Assessment being developed on Rio.	New metric based on clinical audits. We will report on this in the next report starting with August's data as a baseline. As training is introduced, we will be able to demonstrate improvement.
Service users with care plans in place	100% of those who require	-	-	-	-	-	Team level reporting will be developed	If required, a plan can be developed when baseline performance is understood.	New metric, this will be developed for August's data. The proposed metric needs refinement to number of days post-admission and referral. Initial findings show 96.7% of inpatient service users have a care plan in place in Jul-25.
CQC Community MH Survey satisfaction rate	-	6.7	**7.1**	-	-	-	Friends and Family Test	N/A	Our 2024 satisfaction score is broadly in line with other MH trusts; we are a little above the national average. We have seen a marginal improvement in score over the last 3 years.

Overview of Performance | Effective Use of Resources

		Jul-25			
Strategic Objective 2: Effective Use of Resources	**YTD Plan £'000**	**YTD Actual £'000**	**Full Year Target £'000**	**Mitigation**	**Comments**
Variance to financial plan year-to-date	0	**0**	0	£1.6m income rephasing	Block income rephased on basis that cost reductions will happen in future months to achieve plan.
Value of realised VIPs year to date	2,667	**2,107**	8,000		Clinical Directorates £560k behind plan at month 4. All corporate services are achieving target YTD.
Planned Surplus/Deficit	(1,857)	**(1,857)**	(4,871)	Value Improvement Programme	Forecast assumes full VIP target will be achieved, out of area will reduce in line with trajectory and further mitigations will be found for emerging pressures.

			Jul-25			
Strategic Objective 2: Effective Use of Resources	**Target**	**Bench mark**	**Value**	***mean***	**Mitigation**	**Comments**
Relative Difference in Costs	-	100%	**94%**	-	-	Our position for 2023/24 is 6% more efficient than the average provider however we have concerns around this value due to data quality. This requires further exploration and discussions with NHS England.
Live hospital length of stay (all MH inpatient services)	TBC	-	**73**	-	Home First Programme	Combined Live LoS for Adult Acute, Older Adult & PICU wards to align with Operational Planning metric.
Average RtT and RtA waits (all MH services ex. Talking Therapies)	TBC	-	-	-	-	Further work is required before we can report on this metric. Rio Optimisation work has found differences in understanding within services of clock stops.
Referrals In / Referrals discharged – all referrals all MH teams	Less than 100%	None available	**95%**	102%	-	This metric gives a view on whether a backlog is building. Average since Apr-25.
Digital Maturity Assessment	2.0	-	**2.0**	-	Digital investment (capital and revenue)	For 2024 our result improved to 2.0. The results are not comparable year on year due to a changing set of questions which are set nationally. This year we are more in the middle of the pack alongside a range of providers.
Data Security and Protection Toolkit	Approaching Standards	-	**Approaching Standards**	-	DSPT Improvement Plan	Improvement from last year's rating ('Standards Not Met').
Tenders and procurement frameworks with minimum 10% net zero weighting	100%		**100%**		Embedded in procurement processes	National target for all NHS procurements since Apr-22. We are currently achieving the target and work to ensure this continues.

Overview of Performance | Reduce Inequalities

			Jul-25						
Strategic Objective 3: Reduce Inequalities	**Target**	**Bench mark**	**Value**	*mean*	**Var.**	**Ass.**	**Early Warning Indicator**	**Mitigation**	**Comments**
Protected characteristics completion rates									
Sex	80% by Mar-26	-	**71.1%**	-	-	-	Protected characteristics dashboard	Focussed work with 6 teams using a behavioural change methodology has resulted in significant improvements in completion rates. Early learning is being implemented iteratively and the approach will be extended to other teams. Protected characteristics dashboard allows all teams to review and manage their performance. Performance is reviewed in monthly governance meetings with general managers. Comms plan has been developed to remind staff of the importance and offer support through crib sheets and visual guides for Rio.	Performance is highly variable across characteristics and clinical areas. Clinical service line reporting will be provided in the Annex in next month's report. Reporting currently relates to our secondary and tertiary community mental health services only and where service users have had at least one contact with a service in the last 12 months. We are progressing the technical work required to include inpatients and other services in reporting (Talking Therapies, ME/CFS, Health Inclusion Team and Long Term Neurological Conditions).
Sexual orientation	80% by Mar-26	-	**17.9%**	-	-	-			
Gender stated	80% by Mar-26	-	**20.5%**	-	-	-			
Religion / Belief	80% by Mar-26	-	**30.8%**	-	-	-			
Ethnicity	80% by Mar-26	-	**74.5%**	-	-	-			
Disability	80% by Mar-26	-	**0.8%**	-	-	-			
Marital status	80% by Mar-26	-	**61.2%**	-	-	-			
Note: Age is excluded as it is automatically generated through date of birth and is reported at 100% across all Trust services. For pregnancy and maternity, there is no national guidance on how to report on the completion rate. We are therefore working through the challenges of establishing a denominator.									
Staff that have completed cultural competence training	-	-	**0%**	-	-	-	-	-	Training has not yet commenced. In September, the PCREF Stakeholder Delivery Group will identify a plan for establishing and delivering this training.
Difference in percentage of non-white British staff to Sheffield population	-	-	**0.1%**	-	-	-	-	-	25.6% of SHSC staff are non-white British compared with 25.5% of Sheffield population (2021 Census). SHSC figure excludes 89 members of staff whose ethnicity is not recorded. This metric will be updated annually due to the slow rate of change.

Overview of Performance | Great Place to Work

			Jul-25						
Strategic Objective 4: Great Place to Work	**Target**	**Benchmark**	**Value**	***mean***	**Var.**	**Ass.**	**Early Warning Indicator**	**Mitigation**	**Comments**
Sickness absence rate	5.1%	6.1%	**6.8%**	*6.7%*	• • •	F	Supervision rates; Staff Survey & People Pulse morale indicators	Sickness Recovery Plan	Our sickness absence rate is persistently above our internal target of 5.1%. A recovery plan is in place. More information is in the Our People section.
Turnover rate (12 month WTE)	10%	15.1%	**11.9%**	*12.7%*	• L •	F	Sickness absence rates; Supervision rates		Above target due to a drop in headcount and vacancies not being recruited to due to establishment reviews not completed. More information is in the Our People section.
NHS Staff Survey Engagement Theme score	-	7.0	**6.7**	-	-	-	People Pulse survey	Staff Survey engagement plan	Based on 2024 staff survey. We are in the lowest quartile when compared with peers. Performance is marginally better than 2020.
National Education and Training Survey experience score	-	76.2% (national average) 76.7% (NE & Yorkshire)	**78.8%**	-	-	-	-		SHSC outperformed the national average by 2.6% and the North East and Yorkshire average by 2.1% in the 2024 survey. More information on the NETS may be found here (external link).
Flu vaccination rate (clinical staff)	-	-	-	-	-	-	-	-	This metric will be reported when vaccinations begin (typically October).

Overview of Performance | Improvement and Change Programmes (1)

Priority Programme	Status	Progress Update	Key Risk and Mitigation	Next Month's Deliverables
Home First		Areas of focus: Home Treatment Team and Flow SOP including gatekeeping, acute ward standards defined, GP referral criteria defined and continued grip on flow in and out of wards.	Risk to delivery of the reduction in the use of OOA beds – July position not achieved. Recovery actions in place, critical path identified and focus on ensuring workstreams are supported to make improvements (corporate risk 5001).Continue to monitor CFFD SUs to reflect work being done in this area with LA and internally. Daily monitoring of TCI SUs with aim to have capacity to enable those needing admission to get a bed.	• Continued grip on flow in and out of wards • Acute ward standards implementation starts • Gatekeeping SOP and plan agreed / implementation starts • Continued delivery of high impact actions CMHT / Beech / HTT & Flow
Gleadless and Heeley Neighbourhood Centre		Building costs confirmed within budget. Planning permission granted for works at Community Hall. Operational model developed. Building progress commencement and progression to plan.	Partners fail to agree on operational model. Further communication undertaken, and workshop planned for September. Slippage poses risk to contribution to national evaluation. Clarity of SHSC teams contributing to model, pending workshop.	• Further staff and community engagement. • Care model workshop • Commence procurement for crisis café and hospitality beds.
Therapeutic Environments		There will be a 2 week delay to the Maple Ward and Dovedale 2 projects. The Out of Area trajectory has been adjusted accordingly. An overspend of £130,000 has been reported on the Maple Ward works. This is to be considered within existing capital plan commitments. The staffing model for the fourth ward is in development. Further work is taking place on affordability.	Availability of operational team to take part in commissioning of fourth ward.	• Maple construction period continues • Options development for Older Adults Mental Health environments commences

Overview of Performance | Improvement and Change Programmes (2)

Priority Programme	Status	Progress Update	Key Risk and Mitigation	Next Month's Deliverables
Rio		Work ongoing to optimise the use of Rio with further enhancements planned.	Risk of delay to Rio optimisation or that developments do not deliver expected benefits. Investment required to upgrade system approved (corporate risk 5462).	• Review of optimisation requests • Integration go-lives
We Are Our Values		Star of the Month awards launched. New visuals around sites being prepared. 934 staff have engaged with the values via OD sessions. More sessions planned.	No key risks with score above 12. Previous key risk regarding budget allocation resolved.	• Visuals around sites to be rolled out across SHSC as part of re-brand in September.
University Partnership Trust		New name launched in Cascade. Domain name agreed. Plan in place to support successful launch. Legal aspects to name change approved at EMT. Plans for event with UoS and for AMM	• Time pressure to complete digital work aligned to launch date and AMM • Cost pressures in digital, estates and comms.	• Launch event 11th September • Joint strategy work commences • Changes critical for go-live: website, intranet, email addresses
Learning Disabilities		A six-month pilot confirmed service operating hours required. Service offer reviewed to ensure it is person centred. The offer has been made available in an easy read version. Review of productivity undertaken. VOT health will be working with the service to ensure staffing model is fit for purpose.	Risks of wait times for service users, mitigated by close attention to productivity and next phase of work with VOT.	• Co-location/ base move. • Interventions to be outcome based. • Finalising of activity collation • Completion and implementation of staffing model

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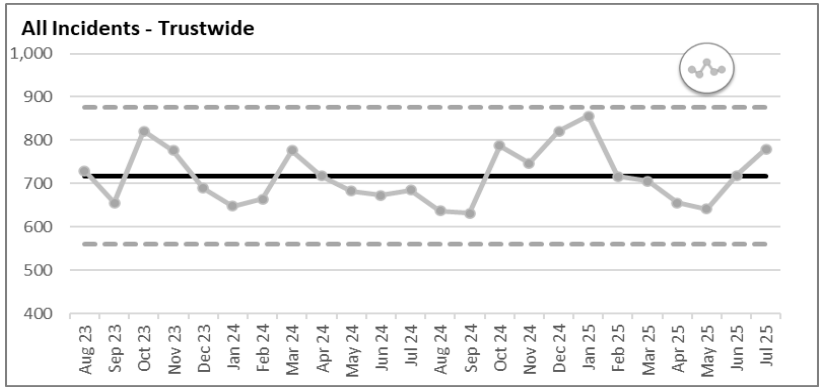
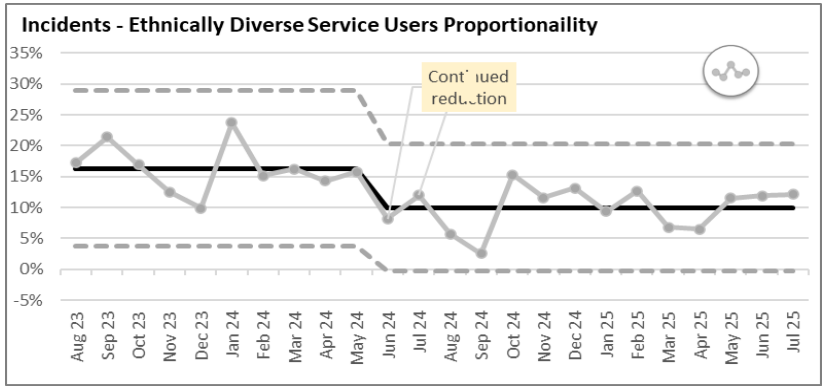
Annex: Safety & Quality

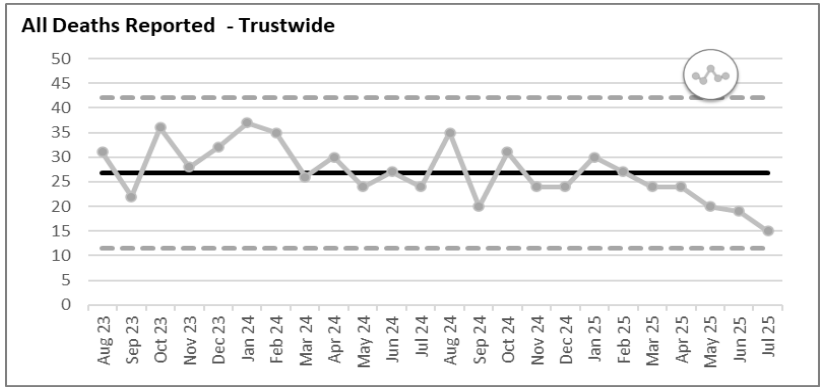
Information up to and including July 2025

Proud to care in Sheffield

Safety & Quality | Incidents







Incidents (Category)	Level	Value	Mean	Var.
Total Incidents	Trust	780	718	• • •
5 = Catastrophic	Trust	12	15	• • •
4 = Major	Trust	6	3	• • •
3 = Moderate	Trust	132	127	• • •
2 = Minor	Trust	273	278	• • •
1 = Negligible	Trust	344	35	• • •
0 = Near-Miss	Trust	8	14	• • •

Incidents by ethnicity	Level	Value	Mean	Var.
Ethnically Diverse Service Users	Trust	12.1%	10.1%	• • •
Asian / Asian British	Trust	16.7%	14.7%	• • •
Black / African / Caribbean / Black British	Trust	15.2%	11.0%	• • •
Mixed / Multiple Ethnic Groups	Trust	10.0%	14.7%	• • •
Other Ethnic Group	Trust	0.0%	29.8%	• L •
Unknown	Trust	8.3%	24.9%	• L •
White	Trust	12.0%	16.1%	• • •

Mortality	Level	Value	Mean	Var.
All Deaths	Trust	15	27	• • •
Unexpected Deaths	Trust	6	7	• • •
Suspected Suicides	Trust	1	2	• • •

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

Understanding the Performance

- 96.4% of incidents were reported by Clinical Directorates. Of those, the most frequently reported incident category was medication management (10.4%), followed by statutory/regulation breach (8.1%) and physical assault (8%).
- 6 major incidents reported: 2 for lack of secure facility, 2 regarding our electronic patient record system Rio, 1 for fire with doubtful origin and 1 for an attempted suicide.
- The average percentage of SUs from ethnically diverse communities who were admitted to SHSC beds and were either a victim or instigator of incidents is 14.4% in the past 2 years. However, this number could be higher as in July alone 10% of those admitted did not have their ethnicity recorded. For white people, on average 16.3% were involved in an incident for for the same period which suggests that white people are more likely to be involved in an incident in our bed-based services.

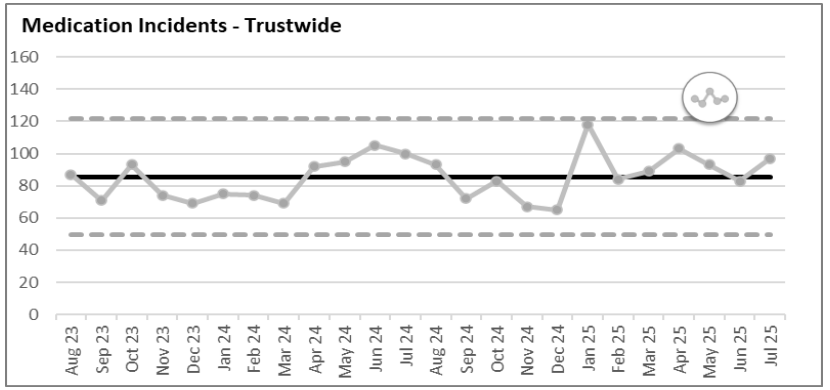
Actions

- Quality Objective 1: Implement Culture of Care and Inpatient Quality Improvement Programme
- Quality Objective 6: Ensure the Patient and Carer Race Equality Framework is embedded in practice by the end of 2025/26
- The Executive Director of Nursing, Professions and Quality has initiated a programme of intensive support for teams with the highest number of unreviewed incidents in June (Burbage and Endcliffe wards). Burbage ward has already been receiving support which has driven a reduction in unreviewed incidents. This work is ongoing until end of Aug-25. It is important to note that all incidents are reviewed in the daily incident safety huddle and action taken to address safety risks immediately.

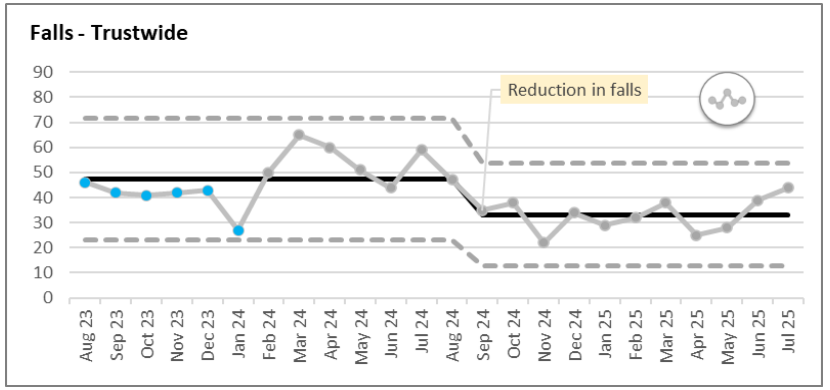
Risks

- BAF 0024 Risk of failing to meet fundamental standards of care caused by lack of appropriate systems and auditing of compliance with standards, resulting in avoidable harm and negative impact on service user outcomes and experience, staff wellbeing, development of closed cultures, reputation, future sustainability of particular services which could result in potential for regulatory action. While incidents remain unreviewed by services, learning from incidents is slow and we cannot be assured of the appropriate post incident support being provided. There is a recovery plan to reduce the number of unreviewed incidents by end of September.
- It is important for us to improve on the data quality of service user demographics for us to be able to accurately demonstrate the proportion for ethnically diverse people involved in incidents. There is an improvement group to address this issue.

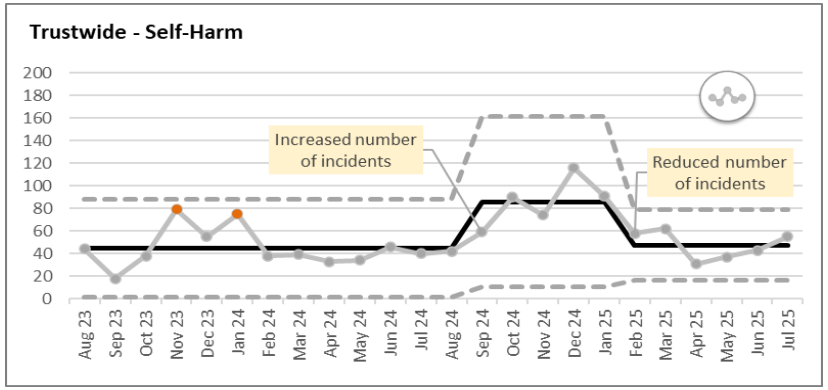
Safety & Quality | Incidents



Metric	Level	Value	Mean	Var.
All Medication Incidents	Trust	97	85	•••
All Medication Incidents	R&S	37	35	•••
All Medication Incidents	A&C	49	46	•••
Administration Incidents	Trust	10	14	•••
Meds Management Incidents	Trust	78	59	•••
Pharmacy Dispensing Incidents	Trust	4	6	•••
Prescribing Incidents	Trust	5	6	•••



Metric	Level	Value	Mean	Var.
Falls	Trust	44	33	•••
People	Trust	26	22	•••
Falls	Acute & Community	4	2	•••
People	Acute & Community	3	2	•••
Falls	Rehab & Specialist	40	31	•••
People	Rehab & Specialist	23	20	•••



Metric	Level	Value	Mean	Var.
Self-Harm	Trust	55	48	•••
Self-Harm	Rehab & Specialist	3	5	•••
Self-Harm	Acute & Community	52	49	•••
Headbanging	Trust	17	12	•••
Headbanging	Rehab & Specialist	1	0	•••
Headbanging	Acute & Community	16	12	•••

Understanding the Performance

- The most frequent **medication incident** types reported this month are 'fridge temperature out of range' (17%) and 'inappropriate / inadequate storage' (17%).
- The most frequent **falls incidents** were categorised as 'found on floor – no injury' (33%) and 'fall – whilst mobilising' (22%). 1 service user has increased in risk of falling following a deterioration in physical health; they went from average of 1 fall per month to 9 falls in July.
- Of the 33 incidents of **self-harm**, 30.1% identified injury of which the most frequently reported was 'abrasion/graze' (5) followed by 'superficial wound' (4).
- Medication incidents, falls and self-harm have been identified as priorities under the patient safety incident review plan.

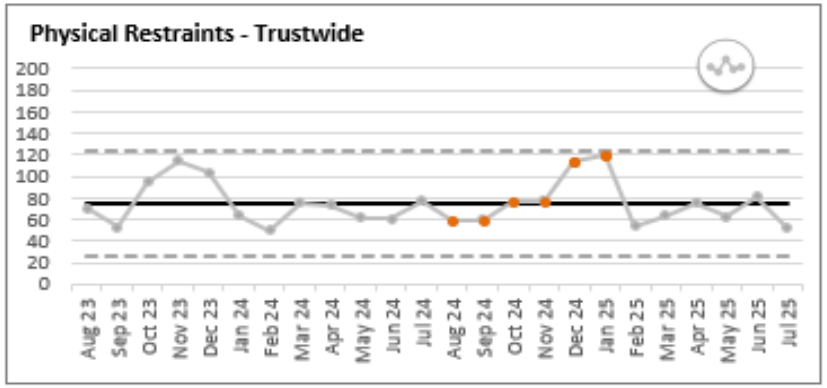
Actions

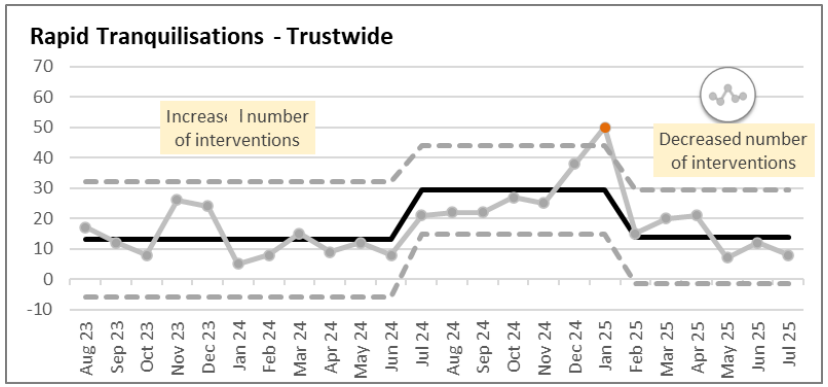
- The Medicines Optimisation Group review medication incidents and will be advising on actions aligned to their findings. Ahead of this, to improve medication related incidents, the El Dorado Medication Error Tool (EDMET) is being rolled out to inpatient and community services.
- HUSH (Huddling Up for Safer Healthcare) huddles take place 5 days a week to support discussion around service user care plans to prevent falls.
- A review of falls guidance against newly published NICE guidelines is currently in progress. Following this, an audit will be created for ongoing monitoring and assurance.
- Headbanging incidents are reviewed by the Physical Health Team to ensure neuro-observations have been completed in line with policy.

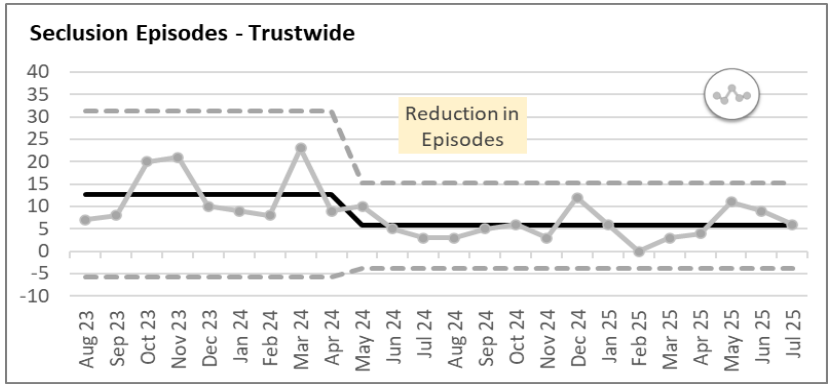
Risks

- Without providing the appropriate support, there is a risk of staff sickness increase and reduced standards of care. Therefore We are currently recruiting to expand our psychology support offer to staff so that they are supported and will be able to manage risks effectively in a trauma informed way.
- Risk of repeated types of incidents as medication errors are not improving. A nursing action plan is being used to strengthen knowledge and to reduce errors.

Safety & Quality | Incidents







Physical Restraint	Level	Value	Mean	Var.
Incidents	Trust	52	75	•••
Incidents	Rehab & Specialist	9	17	•••
Incidents	Acute & Community	43	58	•••
People	Trust	21	26	•••
People	Rehab & Specialist	6	7	•••
People	Acute & Community	15	19	•••

Rapid Tranquilisation	Level	Value	Mean	Var.
Incidents	Trust	8	14	•••
Incidents	Rehab & Specialist	4	7	•••
Incidents	Acute & Community	4	15	•••
People	Trust	7	8	•••
People	Rehab & Specialist	3	1	•••
People	Acute & Community	4	7	•••

Seclusion	Level	Value	Mean	Var.
Incidents	Trust	6	6	•••
Incidents	Rehab & Specialist	2	1	•••
Incidents	Acute & Community	4	6	•••
People	Trust	5	4	•••
People	Rehab & Specialist	1	1	•••
People	Acute & Community	4	4	•••

Understanding the Performance

- Endcliffe and Burbage wards are the highest reporters of restrictive practice, closely followed by Stanage ward due to clinical presentations and balancing safety and quality care with least restrictive approaches. They are being supported regularly by our Respect Team.
- In July 31% of restrictive interventions were for providing necessary medical treatment/interventions and personal care.
- 1 mechanical restraint was reported following the use of handcuffs by South Yorkshire Police while being transported to our PICU ward.

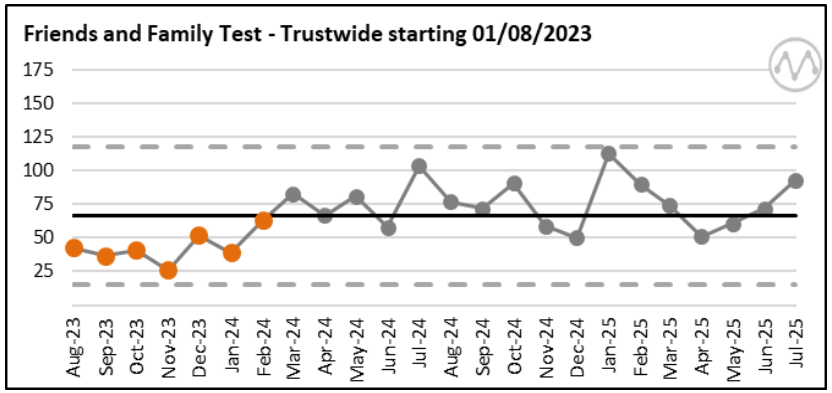
Actions

- Quality Objective 4: Embed a person-centred approach to care planning / restrictive practices – this is ongoing work through to Mar-26.
- Quality Objective 5: Continue to embed least restrictive practice and ensure patients from racialised communities are not overrepresented in the use of restrictive practices such as restraint and seclusion – this is ongoing work through to Mar-26.
- Following an increase in interventions needed on G1 ward attributing primarily to a service user with dementia, dementia awareness is now embedded into Respect Level 3 training.

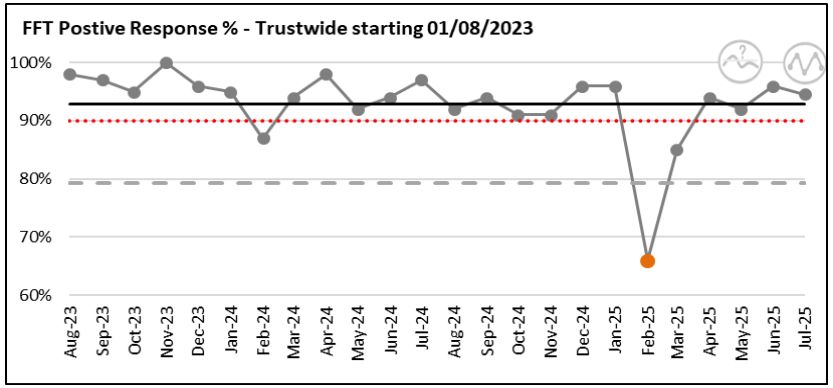
Risks

This month there were 17 instances of restrictive interventions used per 1,000 bed days. While we have significantly reduced the number of restrictive interventions, we continue to work to improve this further.

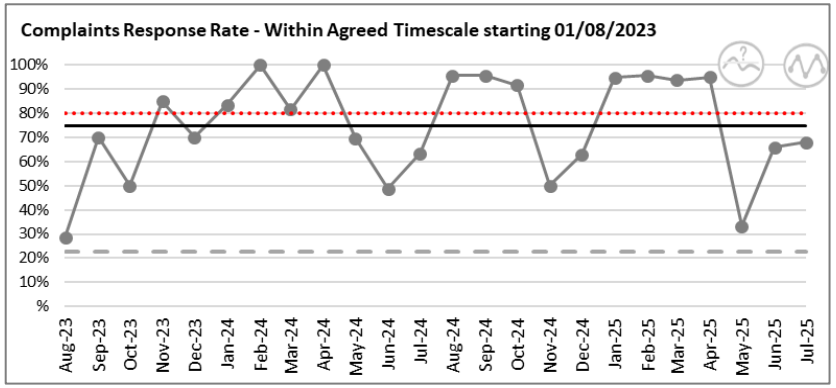
Safety & Quality | Experience



Metric	Level	Value	Mean	Var.
Friends & Family Test Number of Responses	Trust	93	67	• • •



Metric	Level	Value	Mean	Var.	Ass.	Target
Friends & Family Test Positive Responses	Trust	94.6%	92.9%	• • •	?	90%



Metric	Level	Value	Mean	Var.	Ass.	Target
Formal Complaints Received	Trust	16	12	• • •	-	-
Complaints Response Rate	Trust	68.4%	74.7%	• • •	?	80%

Understanding the Performance

Friends and Family Test – 88 positive responses, 1 negative and 4 neither positive nor negative.

Complaints – 16 formal complaints were received this month; 10 for Acute and Community and 6 for Rehabilitation and Specialist. Some complaints are regarding multiple categories. These are as follows:

- Communication (7)
- Values and Behaviours (4)
- Access to Treatment or Drugs (3)
- Clinical Treatment (3)
- Patient Care (3)
- Admissions And Discharges (2)
- Privacy & Dignity (2)
- Appointments (1)
- Other (1)
- Trust Policies (1)

Actions

We will improve the governance and feedback loop to our service users, carers and communities, and co-produce a survey. The refreshed survey will begin to be used in services in October.

In July, 68.4% of formal complaints were closed within agreed timescales. 6 remain outstanding due to still being under investigation (3), 1 with Executive Director for review, 1 response is drafted being reviewed for quality assurance and another is waiting for patient contact.

We continue to maintain contact with complainants so they are kept informed of the progress of their complaint through the process.

Risks

We are unable to provide the Friends and Family Test return rate this month as the active service users in the month has not yet been calculated. We have agreed a temporary pause on submissions to national reporting with NHS England.

Recent learning from complaints identified there is a clear potential pitfall for people accessing alternative diagnostic services. They may pay for a private diagnosis or even select a right-to-choose provider that cannot offer treatment. The person will then need to join NHS waiting lists. SAANS are currently verbally advising people who are considering alternative diagnostic providers to ensure that these can match their needs

Safety & Quality | Safer Staffing

Bedded Service	Bed Occupancy %	Total Complaints	Total Incidents	Patient Safety Incidents	Serious Incidents moderate and above	Staffing Incidents	Medication Incidents	Self-Harm Incidents
Burbage	100.0%	0	123	87	6	0	23	32
Dovedale 1	90.0%	0	33	15	3	0	4	1
Dovedale 2 Ward	101.1%	0	24	11	2	0	3	0
Endcliffe Ward	99.1%	2	87	53	21	0	3	14
Forest Close 1	95.8%	0	10	2	0	0	1	0
Forest Close 1a	98.4%	0	14	4	0	0	4	0
Forest Close 2	92.2%	0	25	9	1	0	7	0
Forest Lodge Assessment	77.8%	0	35	12	8	0	2	0
Forest Lodge Rehab	98.8%	1	18	6	5	0	2	0
G1 Ward	84.4%	0	28	20	0	0	6	1
Stanage	99.2%	3	50	23	6	0	4	0
HBPoS / Decisions Unit	n/a	0	29	7	6	0	3	5

Understanding the Performance

- **Burbage ward** – 1 service user accounted for 45 of the patient safety incidents reported, 31 of which were for self-harm.23 medication related incidents, 12 reported for inappropriate/inadequate storage relating to unlocked cupboards and waste due to poor labelling.
- **Endcliffe** – 1 service user accounted for 37 incidents, a combination of self-harm, assaults, damaged trust property.
- **Forest Lodge** – patient safety incidents in relation to illicit substance use and incidents related to gambling and coercion.

Actions

- The Personalised Assessment of Risk (PAR) project has developed training with 2 modules with pre-recorded training slides. The training department is supporting with the rollout on ESR for compliance monitoring of the new training.
- Respect Team are proactively supporting services where patient safety related incidents occur. They have reviewed care plans for service users who are frequently instigating escalated behaviours to ensure a robust plan is in place to support de-escalation and risk management.

Risks

- Increased concerns raised around risk of accessing gambling, coercion, contacting to arrange illicit substances. Therefore, a focused piece of work is being done around ensuring only appropriate access and use of mobile phones safely as part of wider improvement in Forest Lodge.

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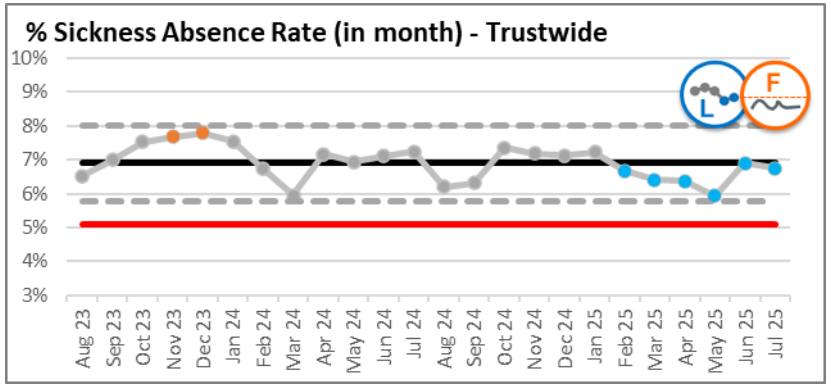
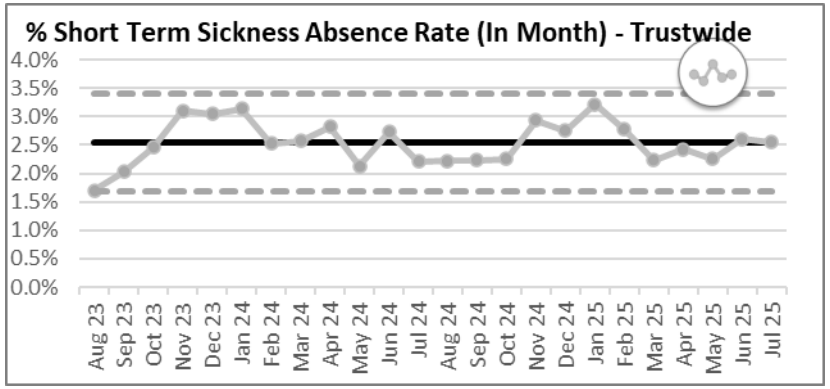
Annex: Our People

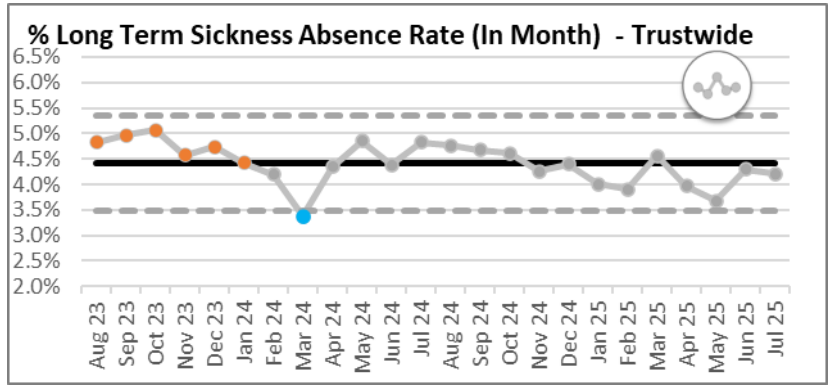
IPQR - Information up to and including June 2025

Proud to care in Sheffield

Our People | Sickness







Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness Absence in Month	Trust	6.8%	6.9%	· L ·	F	5.1%
Sickness Absence in Month	Clinical Ops	7.4%	7.7%	· · ·	F	5.1%
Sickness Absence in Month	Corporate	5.3%	4.5%	· · ·	?	5.1%
Sickness Absence in Month	Medical	4.4%	4.2%	· · ·	?	5.1%

Metric	Level	Value	Mean	Var.	Ass.	Target
Short Term Sickness Absence	Trust	2.6%	2.5%	· · ·	-	-
Short Term Sickness Absence	Clinical Ops	3.0%	2.9%	· · ·	-	-
Short Term Sickness Absence	Corporate	1.3%	1.4%	· · ·	-	-
Short Term Sickness Absence	Medical	1.9%	1.4%	· · ·	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Long Term Sickness Absence	Trust	4.2%	4.5%	· · ·	-	-
Long Term Sickness Absence	Clinical Ops	4.4%	4.8%	· · ·	-	-
Long Term Sickness Absence	Corporate	4.0%	3.1%	· · ·	-	-
Long Term Sickness Absence	Medical	2.5%	2.7%	· · ·	-	-

Understanding the Performance

We are consistently above our 5.1% target for sickness absence in clinical areas. Corporate sickness has also risen in recent months and is also above the 5.1% target.

Actions

A sickness action recovery plan has been developed and implementation began 05/08/2025. Additional support is being provided to services to manage sickness via weekly meetings. Target is reduction of Trustwide in month sickness by 1% by Dec-25 and 2% by Mar-26.

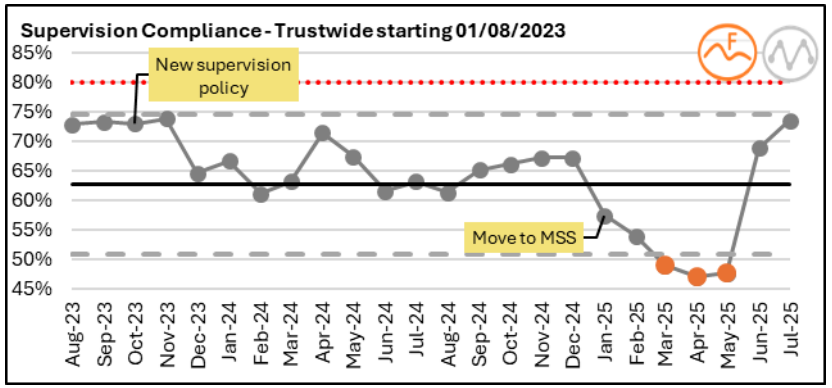
Actions to improve the management of sickness are being tracked for an interim period until assurance is given that sickness is being manged by managers effectively.

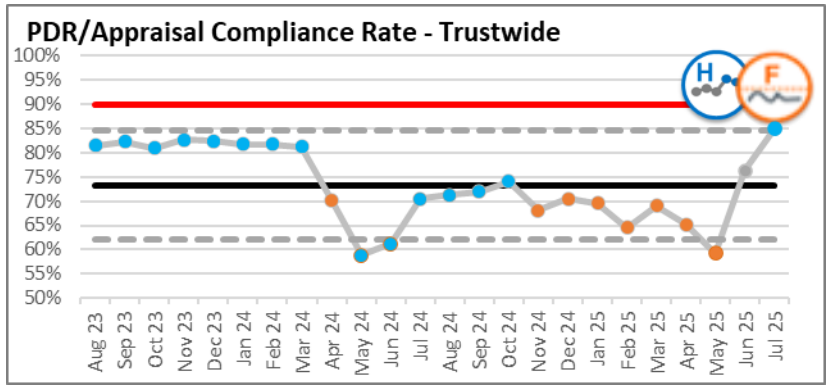
Additional support from HR includes one-to-one meetings, increased reporting, coaching, and training.

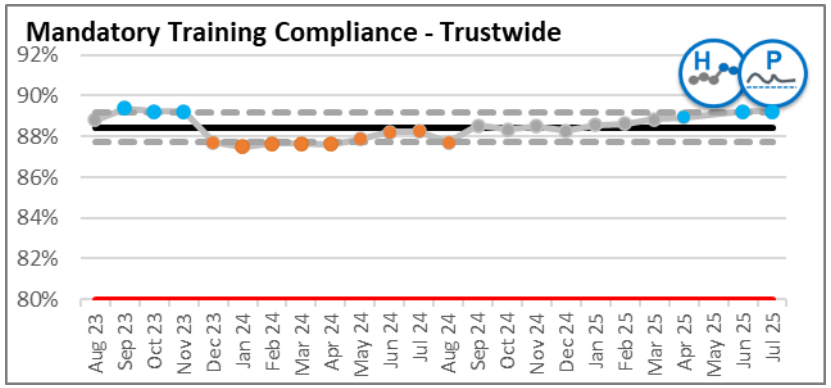
Risks

There is a risk that bank and agency usage cannot be reduced if sickness absence does not reduce. This in turn will risk achievement of our financial plan.

Our People | Supervision & Training







Metric	Level	Value	Mean	Var.	Ass.	Target
Supervision	Trust	73.5%	63.2%	· · ·	F	80%
Supervision	Clinical Ops	76.4%	63.3%	· · ·	F	80%
Supervision	Corporate	65.1%	65.5%	· L ·	F	80%
Supervision	Medical	58.4%	59.0%	· L ·	?	80%

Metric	Level	Value	Mean	Var.	Ass.	Target
Performance Appraisal	Trust	79.0%	73.2%	· H ·	F	90%
Performance Appraisal	Clinical Ops	79.0%	73.0%	· · ·	F	90%
Performance Appraisal	Corporate	83.6%	81.8%	· · ·	?	90%
Medical Appraisal	Medical	58.5%	51.7%	· · ·	F	90%

Metric	Level	Value	Mean	Var.	Ass.	Target
Mandatory Training	Trust	89.2%	88.4%	· H ·	P	80%
Mandatory Training	Clinical Ops	90.6%	89.8%	· H ·	P	80%
Mandatory Training	Corporate	87.3%	82.5%	· H ·	P	80%
Mandatory Training	Medical	91.4%	91.1%	· · ·	P	80%

Understanding the Performance

- Trustwide **supervision compliance** has recovered to the Nov-23 position following a significant worsening seen when recording was moved to ESR in Jan-25. However, this is still short of the target of 80%.
- **PDR compliance** improved significantly in June and again in July. The seasonal PDR window was extended to 31 July 2025. However, only 83.5% of staff had a PDR recorded, meaning that despite the extension, we still did not achieve the target of 90%.
- **Mandatory training** compliance is at 89.7% across the organisation and consistently above the 80% target for all directorates. However, Bank staff and Dovedale 1 ward are below 80% target at 79.9% and 79.3% respectively. We are also below target for 8 subjects.

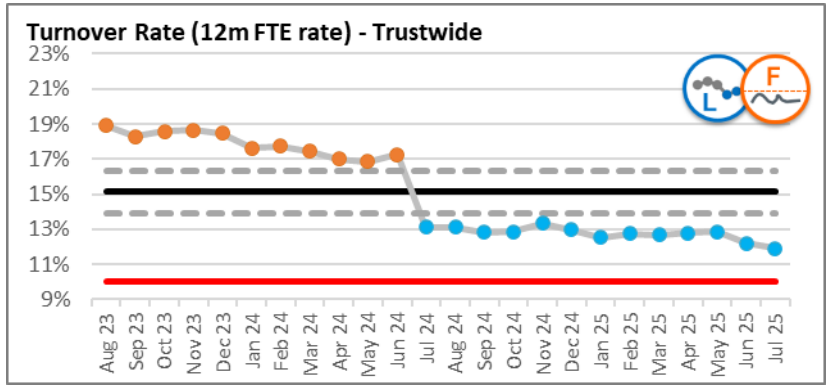
Actions

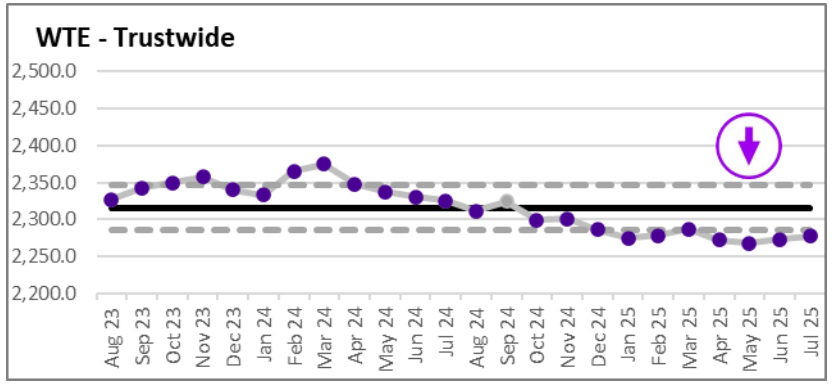
- The People directorate continues to support managers to increase **supervision**. Clinical teams target: 80% by Sep-25.
- Management focus on **mandatory training** courses has resulted in the following courses now being above target: Immediate Life Support, Rapid Tranquilisation, and MH Act.
- Recovery plans for clinical teams below 80% target for mandatory training are submitted to SLT and reviewed monthly.
- Moving and Handling Level 2 training restarted in Jul-25; plan to increase compliance to above 80% by Oct-25.
- The following subjects are below target as of Jul-25:
  - Information Governance (88%)
  - Safeguarding Adults Level 3 (75%)
  - Safeguarding Children Level 3 (65%)
  - Resus Level 2 (BLS) (74%)
  - Medicines Management (72%)
  - Respect Level 1 (76%)
  - Respect Level 3 (72%)
  - Moving & Handling Level 2 (47%)

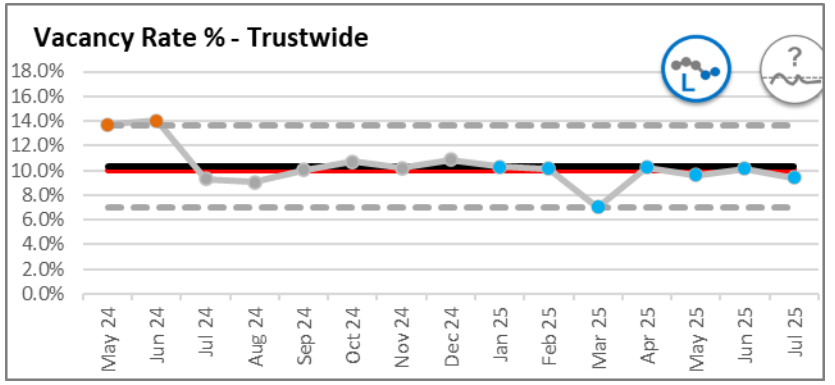
Risks

5321 - There is a risk that we are unable to meet mandatory training compliance levels caused by a variety of factors impacting on one or more training subjects including lack of suitable training space for delivery of training; trainer capacity, access to computers for e learning, and difficulties in staff release resulting in targets and CQC requirements not being met.

Our People | Turnover, Staffing & Vacancies







Metric	Level	Value	Mean	Var.	Ass.	Target
Turnover FTE (12m)	Trust	11.9%	15.1%	· L ·	F	10.0%
Turnover FTE (12m)	Clinical Ops	9.8%	12.9%	· L ·	?	10.0%
Turnover FTE (12m)	Corporate	13.3%	13.5%	· · ·	F	10.0%
Turnover FTE (12m)	Medical	29.2%	26.2%	H	F	10.0%

Metric	Level	Value	Mean	Var.
WTE	Trust	2277.5	2316.3	· L ·
WTE	Clinical Ops	1661.3	1773.9	· L ·
WTE	Corporate	440.5	348.3	· H ·
WTE	Medical	175.8	194.3	· L ·

Metric	Level	Value	Mean	Var.	Ass.	Target
Vacancy Rate	Trust	9.4%	*	· L ·	?	10.0%
Vacancy Rate	Clinical Ops	10.4%	*	· L ·	?	10.0%
Vacancy Rate	Corporate	8.6%	*	· · ·	P	10.0%
Vacancy Rate	Medical	2.1%	*	· · ·	P	10.0%

Understanding the Performance

Turnover is above the 10% target. This is due to a drop in headcount and vacancies not being recruited to due to establishment reviews not completed.

There is a freeze on recruitment in clinical areas whilst establishments are being finalised. This is leading to increased bank usage to cover vacancies.

Establishment data is accurate from August 2024 when collaborative working began with Finance colleagues to enter budget data into ESR. Work is ongoing to ensure cost centre hierarchies are consistent with Ledger data.

Actions

We are supporting recruitment and turnover through the workforce plans.

Workforce plans are being developed as part of the business and finance planning phase.

Finance and business plans will inform workforce plans and ensure we are focusing in the right areas where we need a recruitment plan to allow for changes In rigid establishments and a workforce plan if there are increased or decreases in establishment.

Risks

Vacancy rate is consistently on or around the target of 10% Corporate and Medical are consistently below with the expectation that this will increase vacancy rate with the recruitment freeze.

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Annex: Finance

IPQR - Information up to and including July 2025

Proud to care in Sheffield

Finance | Overview

Key Performance Indicator	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	25/26 Forecast £'000	Variance £'000
Surplus/(Deficit)	(1,857)	(1,857)	0	(4,871)	(4,871)	0
Adjusted Plan Surplus/(Deficit)	(234)	(234)	0	0	0	0
Cash	45,945	42,048	(3,897)	44,193	44,193	0
Efficiency Savings	2,667	2,107	(560)	8,000	8,000	0
Capital	(4,470)	(1,583)	2,887	(16,304)	(16,739)	(435)

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

Understanding the Performance

The year-to-date deficit has been reported as on plan with zero variance. The underlying variance was £1.6m behind plan at month 4. This is mainly due to the pay award pressure £0.62m, Value Improvement Plan (VIP) underachievement £0.56m and reduction in underspending areas against plan £0.47m.

Due to an increase in out of area numbers in June and July there is an overspend of £0.2m against trajectory.

There is confidence that the £8m VIP requirement can still be met, therefore income has been rephased and report is on plan.

The forecast is in line with plan on the basis that the £8m VIP requirement, unrealised mitigations to offset other pressures and Out of Area trajectory will be met.

Actions

Work is ongoing to ensure VIP proposals are signed off and the £8m target is achieved in year.
Home First programme actions to continue and move back towards trajectory.
Ensure VIP QEIAs and plans are signed off by 8th August.
Develop further recovery plans through Clinical Escalation Review of Overspends meeting.
Continue to progress actions under VIP Executive huddle – including actions relating to over-establishments (c£1m remaining)
Director of Finance to assess control framework and any proposed mitigations or additional controls to be reviewed at EMT.

Risks

If out of area activity does not reduce in line with trajectory then further mitigations will need to be found to mitigate this.
Pay award & NI funding shortfall £1.8m.
VIP delivery as current plans are made up in part by proposals that have yet to move to plans in progress.
Fulwood Demolition £250k.
SCC Income Clawback £0.2m.
Impact of any current or future strikes.
Cash is £3.9m below plan, this reflects a £6m shortfall due to the delay in the sale of Fulwood.

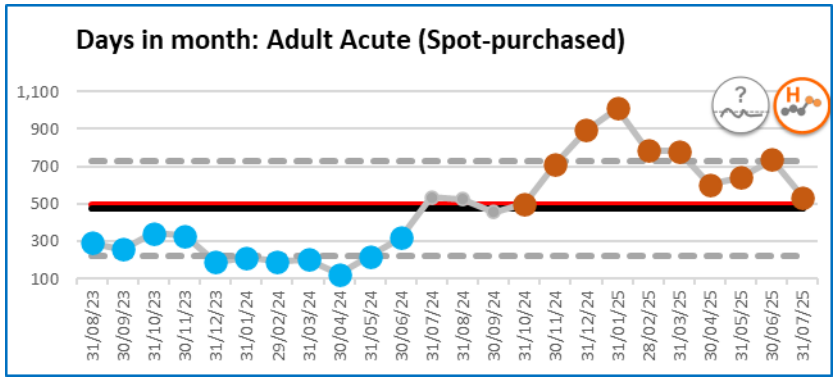
NHS
Sheffield Health and Social Care
NHS Foundation Trust

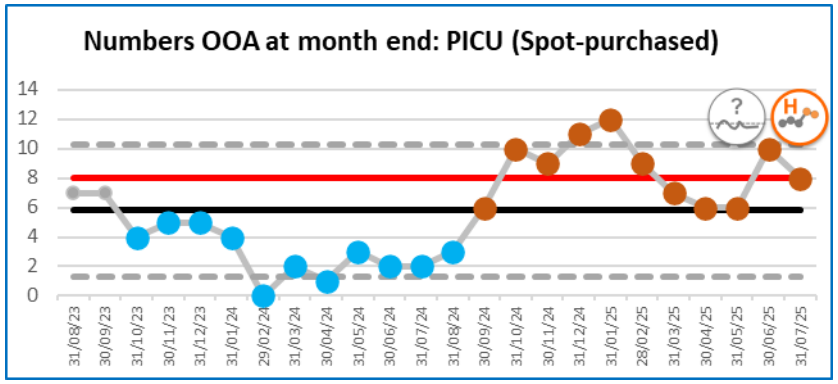
Annex: Clinical Services

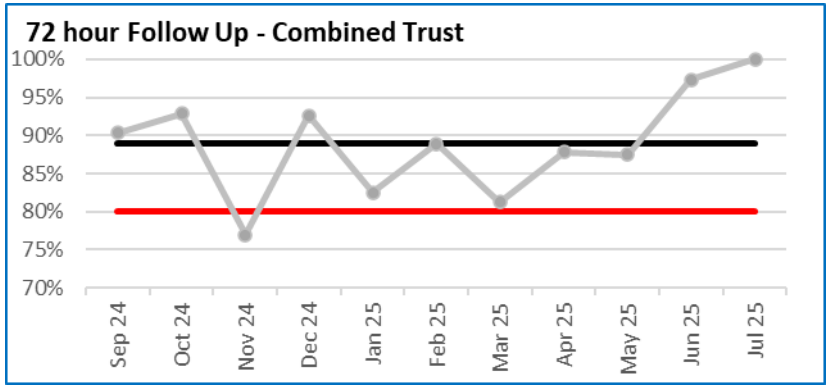
IPQR - Information up to and including July 2025

Proud to care in Sheffield

Trustwide | Out of Area & 72 Hour Follow-up







Metric	Level	Value	Mean	Var.	Ass.	Target
Discharged LoS	Acute & OOA	57	48.8	• • •	?	47
Discharged LoS	PICU & OOA	82	45.6	• • •	?	47
OOA days	Acute	533	474.5	• H •	?	496
OOA days	PICU	334	187.2	• • •	?	248
OOA days	Older Adult	0	9.6	• • •	?	0
OOA days	Rehab	107	119.9	• L •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
OOA at month end	Acute	14	15.6	• • •	?	16
OOA at month end	PICU	8	5.8	• H •	?	8
Admissions	Acute	13	10.1	• • •	-	-
Admissions	PICU	7	4.6	• • •	-	-
Admissions	Older Adult	0	0.3	• • •	-	-
Admissions	Rehab	2	0.2	• H •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
72-hour Follow up	Trust	100%	88.9%	-	-	80%
72-hour Follow up	Acute and Community	100%	88.6%	• • •	?	80%
72-hour Follow up	Rehab & Specialist	100%	84.7%	-	-	80%

Understanding the Performance

Overall there has been a downward trajectory since January 2025.

In July, there were 31 discharges eligible for follow up. All 31 were followed up within 72 hours which represents a significant overachievement against the target of 80%.

Note that the number of patients out of area is a snapshot reported as at month end. We will explore an additional metric that provides a balanced position across the month.

Actions

Additional actions have been mobilised to accelerate impact of the Home First Programme. We are analysing the reported length of stay of 57 days for SHSC & OOA beds as this remains consistently higher than target since the introduction of Rio.

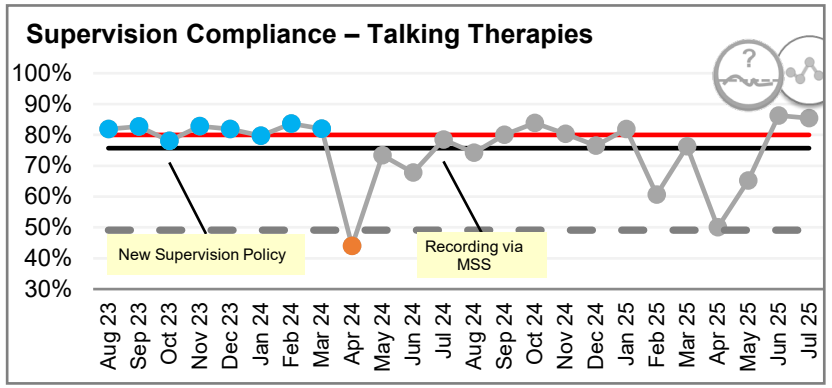
Targeted work has been taking place with Endcliffe ward (PICU) to improve flow and increase local capacity and throughput.

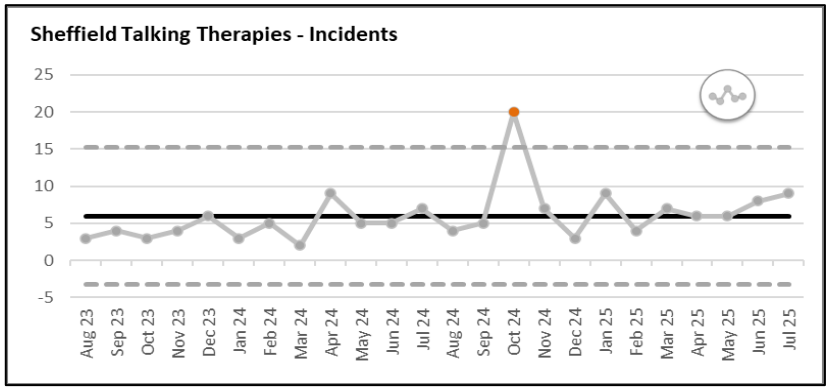
Risks

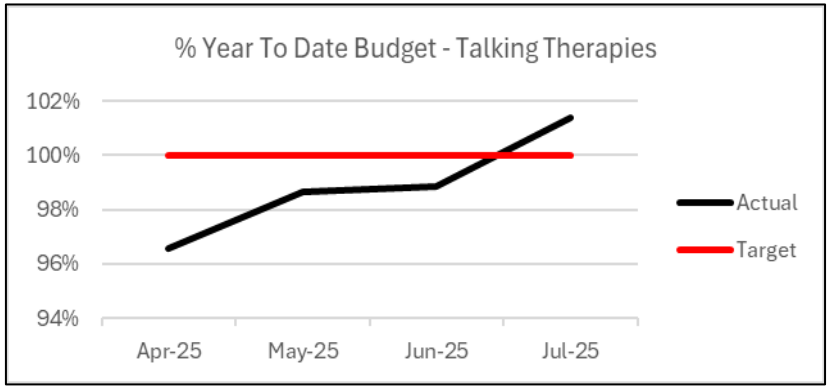
Not meeting out of area targets creates a risk of not meeting financial targets due to the extra costs involved with out of area placements.

Clients placed out of area may not be able to receive the input and support needed from SHSC staff and family due to the distances involved.

Talking Therapies | People, Safety, Quality, and Finance







Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	Talking Therapies	5.6%	5.3%	•••	?	5.1%
Supervision	Talking Therapies	85.4%	75.7%	•••	?	80%
Mandatory Training	Talking Therapies	91.9%	93.9%	• L •	P	80%

Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	Talking Therapies	9	6	•••	-	-
Unreviewed Incidents	Talking Therapies	1	*	*	-	-
FFT Responses	Talking Therapies	2	0	•••	-	-

Metric	Level	Value	Target
Vacancy Rate	Talking Therapies	4.6%	10%
Turnover Rate	Talking Therapies	7.1%	10%
YTD Variance to Budget	Talking Therapies	101%	100%

Understanding the Performance

- Sheffield Talking Therapies is exceeding most targets consistently or at least in the month of July. Performance against staff supervision, vacancies and turnover are good.
- Staff sickness is slightly above the Trustwide target of 5.1%.
- The service accounts for 1.2% of the total incidents reported across the Trust. The one unreviewed incident in July has now been reviewed.
- Value improvement programme targets have been achieved by the service.
- As of July, the service is over budget year-to-date by 1%.

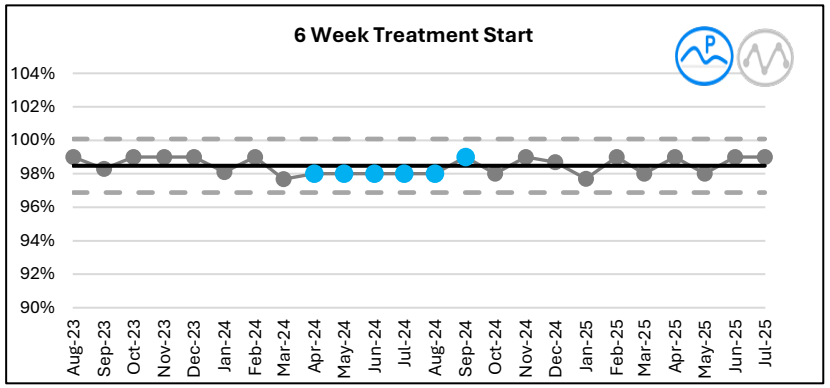
Actions

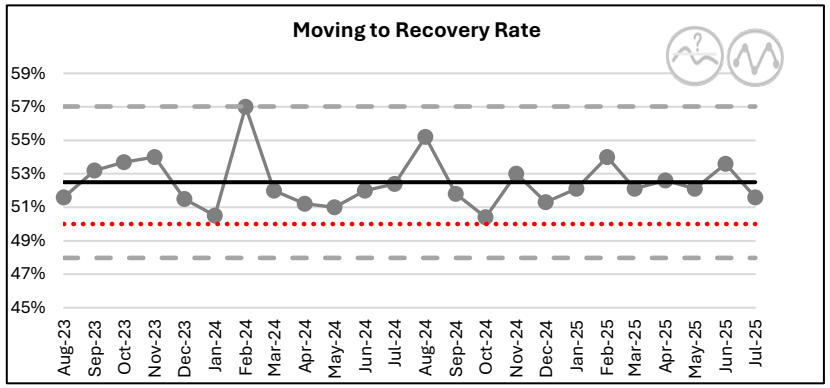
The mean and variance for unreviewed incidents will be provided in next month's reporting.

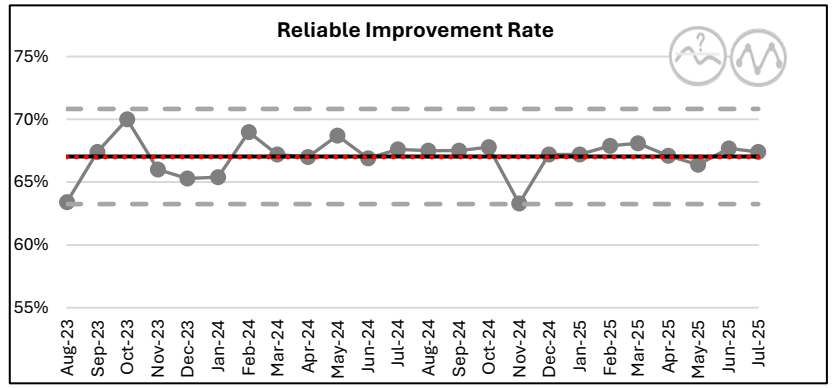
Risks

N/A

Talking Therapies | Performance







Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	Talking Therapies	1744	1518	•••	-	-
New to Treatment	Talking Therapies	1408	1125	•••	?	1352
6 Week Wait	Talking Therapies	99%	98.5%	•••	P	75%
18 Week Wait	Talking Therapies	100%	99.9%	•••	P	95%

Metric	Level	Value	Mean	Var.	Ass.	Target
Moving to Recovery Rate	Talking Therapies	51.6%	52.5%	•••	?	50%
Reliable Improvement Rate	Talking Therapies	67.4%	67%	•••	?	67%
Reliable Recovery Rate	Talking Therapies	48.5%	48.8%	•••	?	48%

Understanding the Performance

Sheffield Talking Therapies met all performance standards in July.

Actions

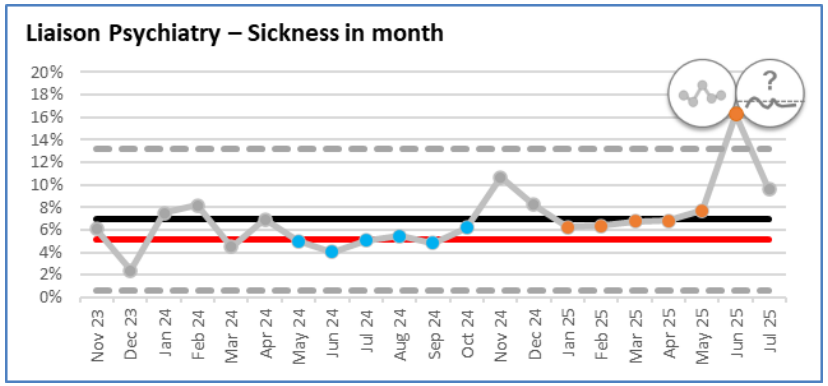
Continuous quality improvement work is ongoing in order to meet new standards (Reliable Improvement and Reliable Recovery standard) that have been set.

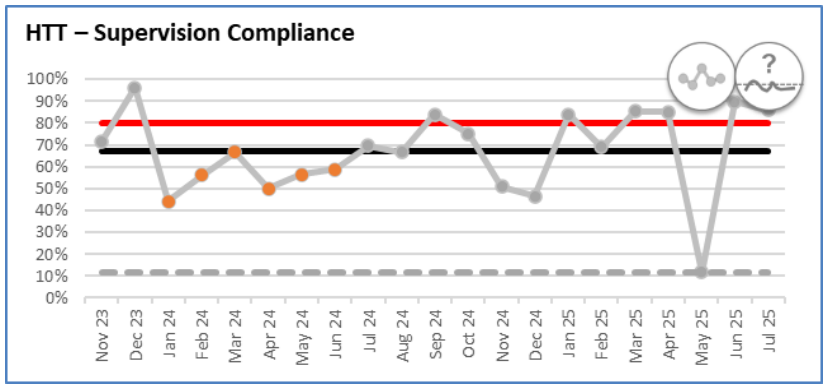
This work will build on a service-wide systems-thinking event that was held to amalgamate best practice. The event was held on Thursday 26th June.

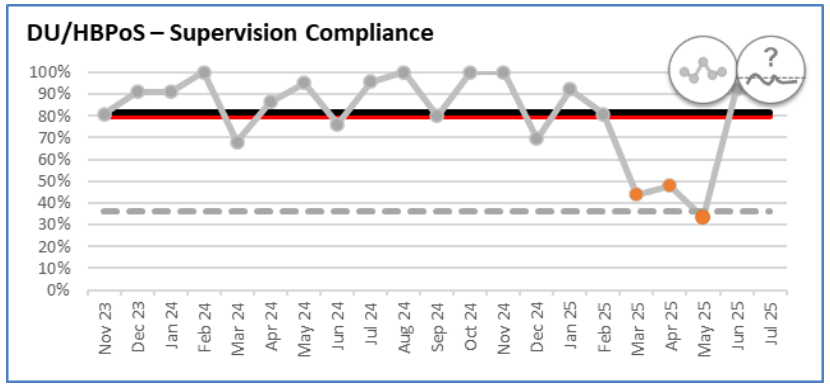
Risks

N/A

Crisis | People







Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	**Crisis**	**9.3%**	*	*	*	**5.1%**
Sickness	U&C	7.8%	6.1%	•••	?	5.1%
Sickness	HTT	8.6%	7.6%	•••	?	5.1%
Sickness	Liaison Psy.	9.6%	6.9%	•••	?	5.1%
Sickness	DU/HBPoS	14.9%	9.7%	•••	?	5.1%
Sickness	Flow	2.1%	6.4%	•••	?	5.1%

Metric	Level	Value	Mean	Var.	Ass.	Target
Supervision	**Crisis**	**80.6%**	**72.6%**	•••	?	**80.0%**
Supervision	U&C	71.9%	73.3%	•••	?	80.0%
Supervision	HTT	86.0%	66.8%	•••	?	80.0%
Supervision	Liaison Psy.	72.7%	74.7%	•••	?	80.0%
Supervision	DU/HBPoS	89.3%	81.6%	•••	?	80.0%
Supervision	Flow	90.9%	85.5%	•••	?	80.0%

Metric	Level	Value	Mean	Var.	Ass.	Target
Mand. Training	**Crisis**	**90.5%**	**90.4%**	•••	P	**80.0%**
Mand. Training	U&C	93.4%	92.5%	•••	P	80.0%
Mand. Training	HTT	86.2%	86.4%	•••	P	80.0%
Mand. Training	Liaison Psy.	92.5%	93.1%	•••	P	80.0%
Mand. Training	DU/HBPoS	91.0%	93.5%	•••	P	80.0%
Mand. Training	Flow	93.4%	91.3%	•••	P	80.0%

Understanding the Performance

Liaison Psychiatry sickness is high and above target but has returned to within normal variation after a spike in June. This has resulted in improved service user data recording and improved performance.

Supervision compliance has recovered for Crisis as a whole as a result of efforts to increase engagement and understanding of the ESR process in Home Treatment, Decisions Unit and Health Based Place of Safety.

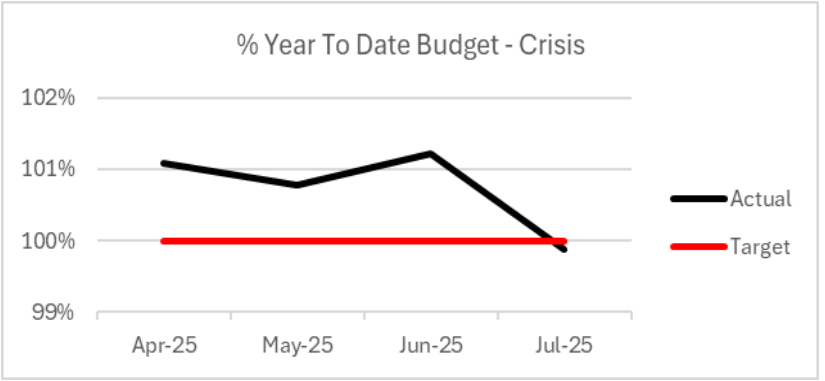
Actions

Temporary agency recruitment is planned for Liaison Psychiatry in response to the still elevated sickness position. Funding for two band 6 nurse roles to run until mid-December have been approved.

Risks

There is a concern that now supervision compliance has recovered in Crisis services, complacency could set in and compliance could subsequently decline.

Crisis | People and Finance



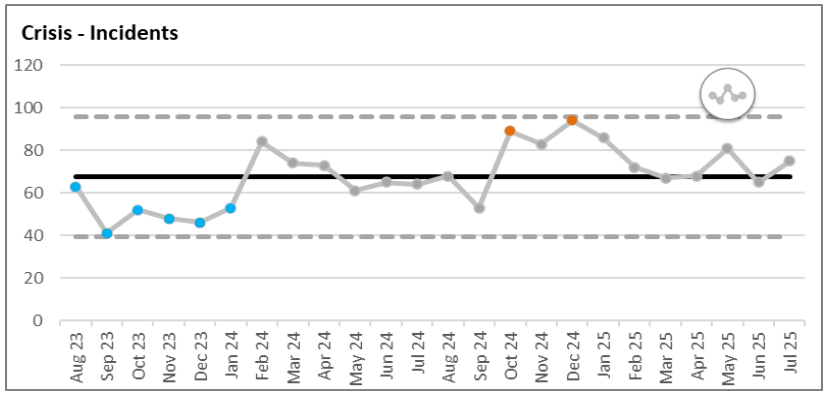
Metric	Level	Value	Mean	Var.	Ass.	Target
Vacancy Rate	**Crisis**	**9.1%**	*	*	*	**10%**

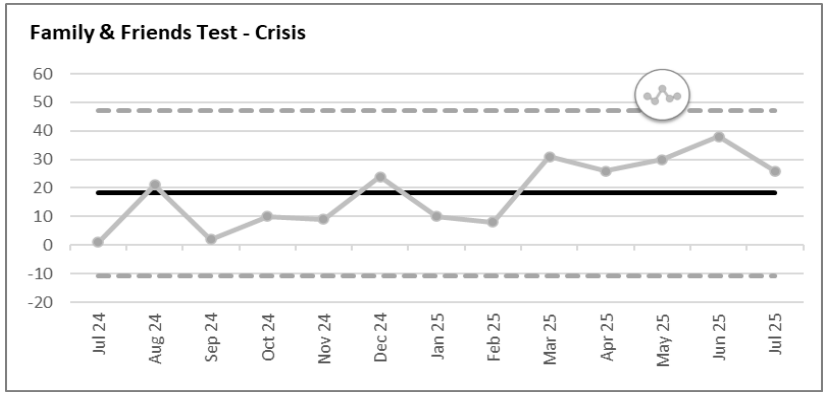
Metric	Level	Value	Mean	Var.	Ass.	Target
Turnover Rate	**Crisis**	**8.2%**	*	*	*	**10%**

Metric	Level	Value	Target
YTD Variance to Budget	**Crisis**	**100%**	**100%**

Understanding the Performance	Actions	Risks
Vacancy, turnover, and YTD budget are all within targets. Crisis spending exceeded YTD budget for the first 3 months of 2025/26 but has recovered in July.	Historic vacancy and turnover rate data has been requested to enable SPC chart production. This will allow assessment of variation in these measures as well as assurance against their respective targets.	N/A

Crisis | Safety and Quality





Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	**Crisis**	**75**	**68**	• • •	-	-
Incidents	U&C	12	7	• • •	-	-
Incidents	HTT	7	9	• • •	-	-
Incidents	Liaison Psy.	11	12	• • •	-	-
Incidents	DU/HBPoS	9	10	• • •	-	-
Incidents	Flow	16	9	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Unreviewed inc.	**Crisis**	**19**	*	*	-	-
Unreviewed inc.	U&C	0	*	*	-	-
Unreviewed inc.	HTT	2	*	*	-	-
Unreviewed inc.	Liaison Psy.	0	*	*	-	-
Unreviewed inc.	DU/HBPoS	11	*	*	-	-
Unreviewed inc.	Flow	2	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
FFT Responses	**Crisis**	**26**	**18**	• • •	-	-
FFT Responses	U&C	0	0	• • •	-	-
FFT Responses	HTT	0	0	• • •	-	-
FFT Responses	Liaison Psy.	0	2	• L •	-	-
FFT Responses	DU/HBPoS	26	16	• • •	-	-
FFT Responses	Flow	0	0	• • •	-	-

Understanding the Performance

- Crisis services accounted for 9.8% of the total incidents reported across the Trust in July, with their most frequent reported incidents being for ‘lack of beds/delayed availability’ and ‘number of staff’.
- The engagement team have reviewed how we gather our experience data and how the voice of service users, carers and citizens are incorporated into decision making. To ensure we close the feedback loop we are having a focus with teams on ‘you said, we did’. We are working with the QI team to manage the impact of this and will be having visible areas in services and ensuring regular communication around this.

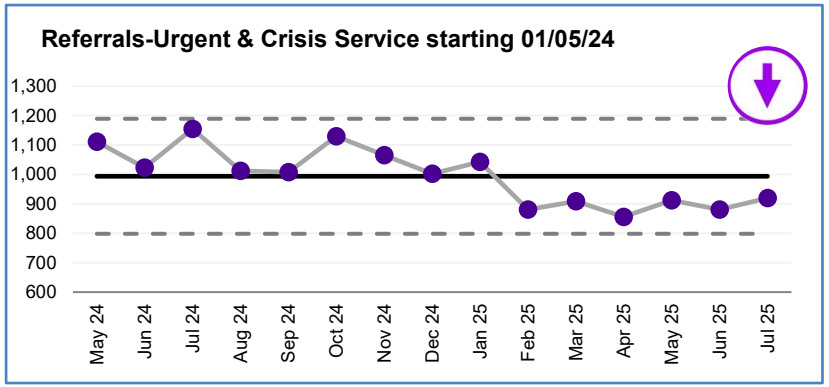
Actions

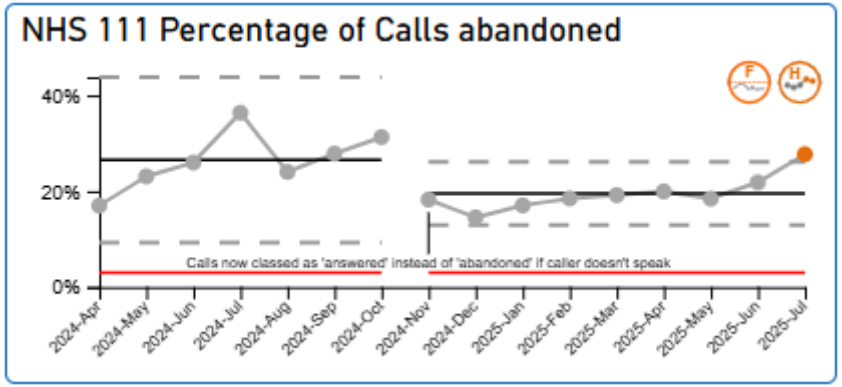
- We have collated Friends and Family Test (FFT) data for the last 12 months for each service, looking at key themes from feedback. This will be fed back and clinical teams will be supported by the Quality directorate with an action plan. Patient and carer experience advocates are being recruited across each service to support and additional engagement training will be provided.
- SPC mean and variation for unreviewed incidents will be calculated from next month’s report.

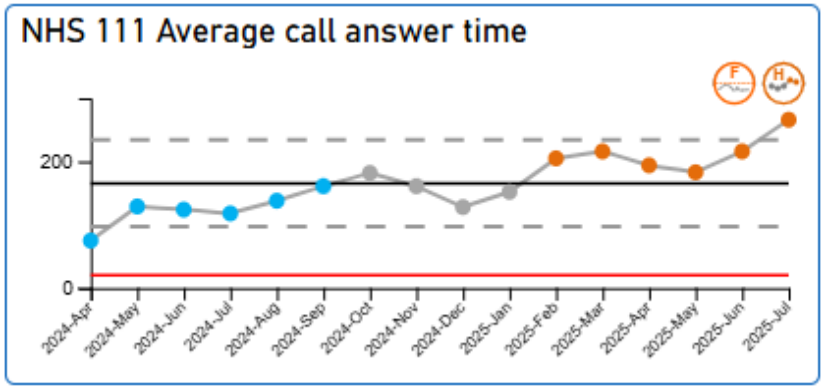
Risks

While incidents remain unreviewed at service level, we cannot be assured that effective learning is taking place or that the appropriate post incident support has been provided. Central review does occur on all incidents and support into teams is offered where appropriate.

Crisis | Urgent & Crisis, NHS 111 & Home Treatment Team







Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	U&C	920	993	• L •	-	-
% with F2F	U&C V. Urg.	*	16.8%	*	-	-
% F2F in 4h	U&C V. Urg.	*	45.0%	*	*	100%
% with F2F	U&C Urgent	0%	15.1%	• L •	-	-
% F2F in 24h	U&C Urgent	*	67.0%	*	*	100%

Metric	Level	Value	Mean	Var.	Ass.	Target
Mean call answer time	U&C	25s	27s	• • •	?	20s
Calls received	111	1584	1475	• • •	?	1600
% abandoned	111	27.7%	19.5%	• H •	F	3%
% escalated	111	6.7%	7.1%	• • •	-	-
95 centile answer time	111	953s	647s	• H •	F	120s

Metric	Level	Value	Mean	Var.	Ass.	Target
Mean answer time	111	266s	166s	• H •	F	20s
Referrals	HTT	88	97	• • •	-	-
% with F2F	HTT Urg.	13.3%	*	*	-	-
% F2F in 24h	HTT Urg.	50.0%	*	*	*	100%

Understanding the Performance

We have significant data quality issues with referral urgency: no Urgent & Crisis referrals were recorded as very urgent in July indicating that referral urgencies are not being corrected at triage. Only 5 referrals were recorded as urgent, none of which have F2F contacts recorded.

July is the 6th consecutive month that U&C have received below average referral volumes, indicating a significant shift in demand. Work is needed to ascertain whether this reduction is demand is limited to particular referral sources.

There has been a significant deterioration in NHS 111 abandonment rate. NHS 111 call answer times continue to be significantly elevated and consistently failing targets.

Actions

Nottingham Community Housing Association (NCHA) has committed to producing a recovery plan by the end of Aug-25. This will include actions to improve call answer times and abandonment rates.

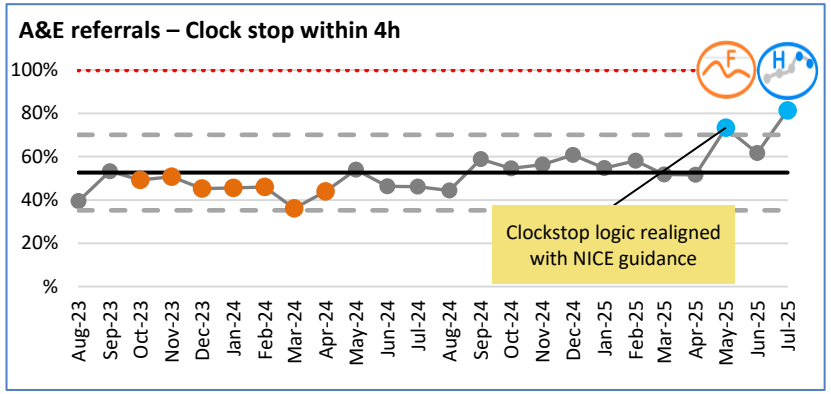
U&C data quality requires improvement around the recording of referral urgencies and appointment contacts. Referral urgencies are set to routine as default as urgency is unknown at the point a referral is received. Guidance has been shared with U&C regarding how to amend referral urgencies on Rio at the point of triage (within 1h after referral received). This is currently being tested by U&C leadership with a view to embedding it into standard processes within the next 2 months.

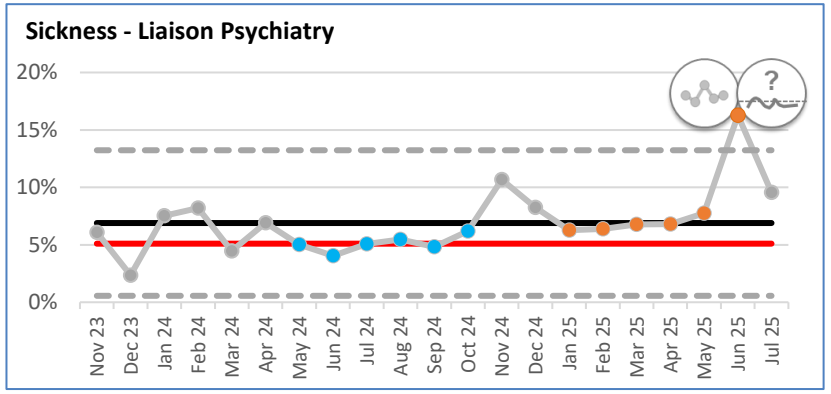
Risks

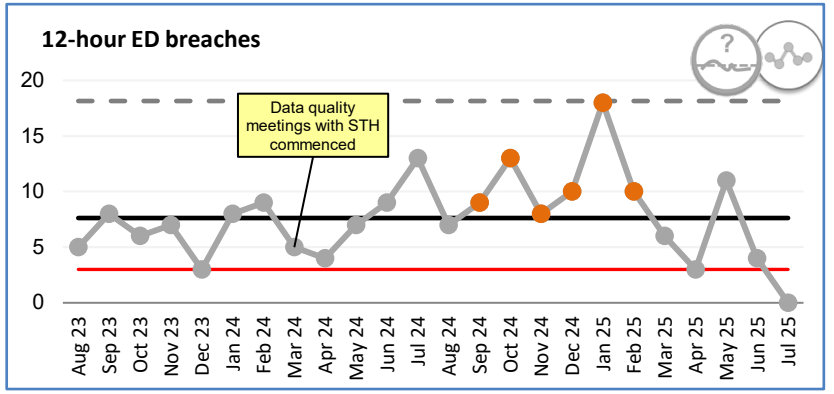
There is a risk that higher call answer times will further increase abandonment rates and put callers in mental health crisis at risk of further deterioration.

There is a risk to the safety and quality of patient care because NCHA is not regulated by the CQC.

Crisis | Liaison Psychiatry and Flow







Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	LP	571	529	• • •	-	-
% with F2F	LP A&E	88.0%	82.2%	• • •	-	-
% F2F in 1h	LP A&E	60.4%	62.4%	• • •	F	100%
% with clock stop	LP A&E	91.3%	*	*	-	-
% clock stop in 4h	LP A&E	81.4%	52.7%	• H •	F	100%

Metric	Level	Value	Mean	Var.	Ass.	Target
% with F2F	LP Urgent	85.3%	76.9%	• • •	-	-
% F2F in 24h	LP Urgent	75.3%	70.2%	• • •	F	100%
ED breaches	Trust	0	7.6	• • •	?	3
AROA month end	Trust	16	13	• • •	-	-

Understanding the Performance

All data completeness and service performance measures for Liaison Psychiatry (LP) have noticeably improved following a recovery in sickness rate. Clock stop performance (the percentage of patients referred from A&E that receive an assessment and have follow up care arranged or are discharged within 4h) has increased to a record high with special cause improvement.

There were 0 ED breaches (patients in emergency departments waiting for more than 12 hours to be transported to our inpatient care) in July. In the last two years, this is the only time 0 breaches has been achieved, and only the 3rd time that the target of 3 or less breaches has been met.

Actions

Work is underway to determine whether staff rosters are correctly aligned with daily fluctuations in demand or whether temporal capacity issues might be contributing to increased waiting times at certain times of the day.

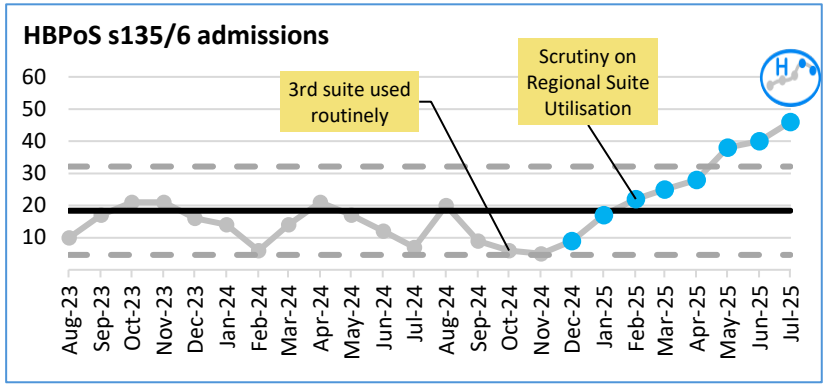
Crib sheets and guidance are being produced to support clinicians in using Rio correctly for the purpose of reporting accurate waiting times.

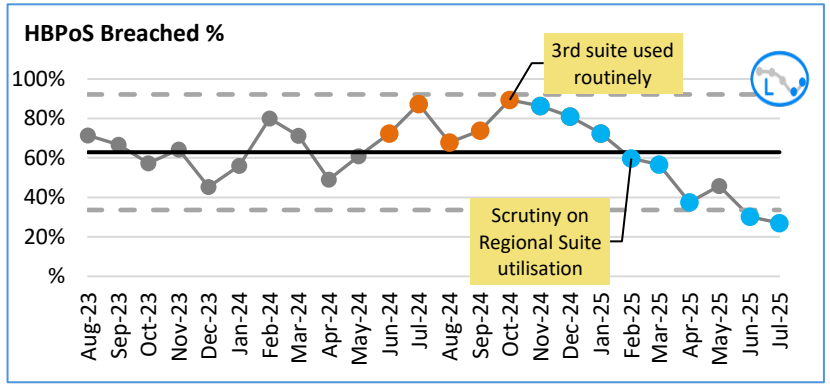
Risks

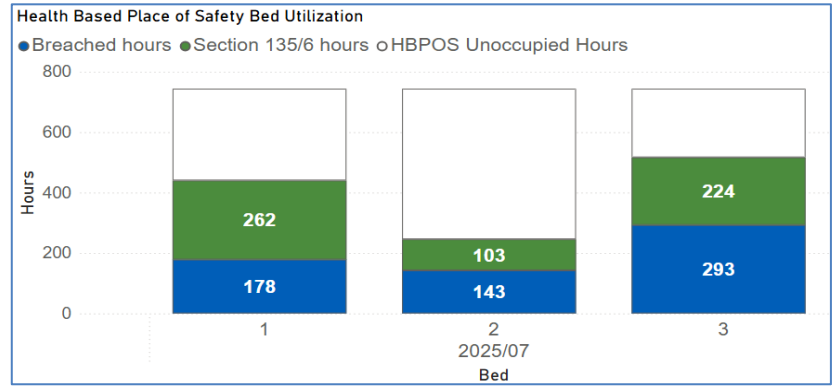
There is a risk that an increase in inappropriate referrals will reduce waiting time performance. This is because referrals that are deemed inappropriate for Liaison Psychiatry and 'triaged out' are not excluded from the denominator – there is no national guidance regarding reporting in relation to these referrals, nor do NHSE exclude them when analysing MHSDS data.

There is a risk to patient flow within the Trust when there is absence in the Flow team due to low staffing numbers.

Crisis | Health Based Place of Safety, Decisions Unit & Crisis House







Metric	Level	Value	Mean	Var.	Ass.	Target
Admissions	HBPoS	53	24	• H •	-	-
Section 135/6	HBPoS	46	32	• H •	-	-
% h s135/6	HBPoS	26.4%	*	*	-	-
Breaches	HBPoS	16	14	• • •	-	-
Breaches	Regional suite	0	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
% h breached	HBPoS	27.0%	62.9%	• L •	-	-
% h breached	Regional suite	00.0%	*	*	*	0%
% h closed	HBPoS	00.0%	*	*	-	-
% h unused	HBPoS	46.6%	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Admissions	DU	110	104	• • •	-	-
% occupancy	DU	56.1%	*	*	-	-
Admissions	Crisis House	13	16	• • •	-	-
% occupancy	Crisis House	79.0%	*	*	-	-

Understanding the Performance

There has been a further improvement in Health Based Place of Safety (HBPoS) percentage hours breached giving a new 2-year low. Number of breaches remains within normal variation: reduction in breach rate is attributed to shorter and more consistent lengths of stay (trending from May to July). Increased availability has again allowed for more section 135/136 admissions which is at a new 2-year high. Regional suite wasn't breached at all in July.

Actions

Data quality issues have been discovered relating to Crisis House admissions; the figures from Rio are lower than actuals reported by ReThink. The underlying cause of this is being investigated. The timeline for correction is to be agreed.

Decisions Unit are preparing for increases in referral demand and occupancy resulting from an upcoming patient initiated follow-up (PIFU) initiative and from further collaboration with Yorkshire Ambulance Service (PUSH). PUSH referrals from EOCs (Emergency Operations Centres) are expected to reduce ambulance calls out and attendance at ED.

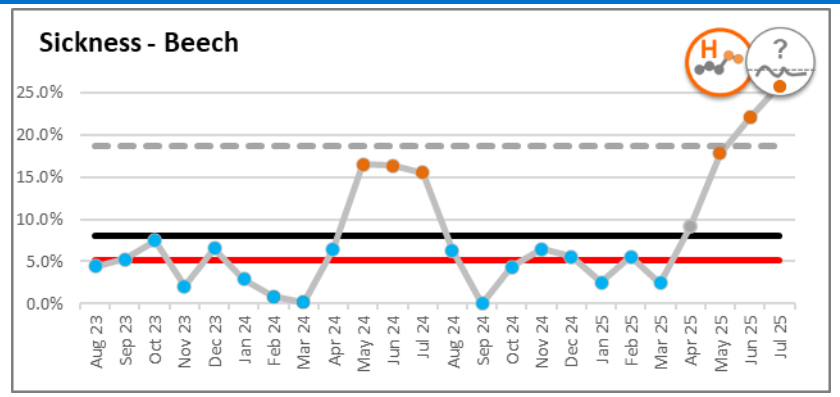
Risks

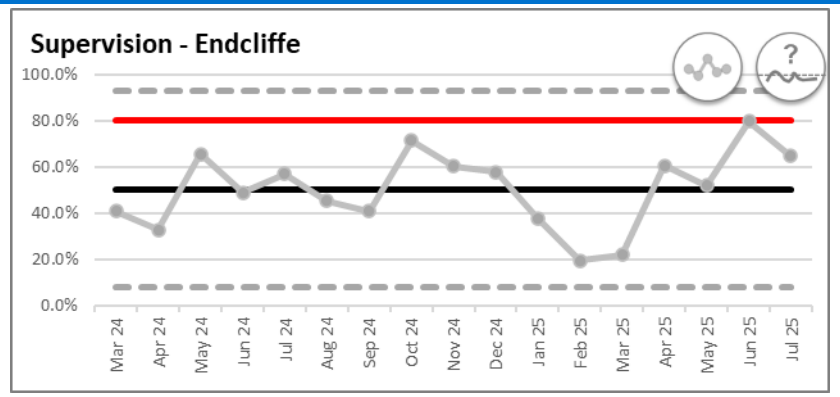
There is a risk that HBPoS bed availability may be used strategically to mitigate OOA bed usage which would result in higher breach rates.

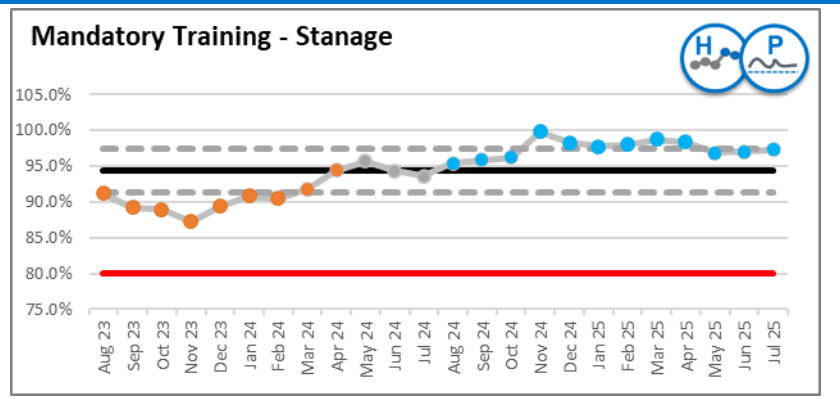
There is a risk of incomplete clinical records if not all referrals and admissions to Crisis House are recorded on Rio.

There is a risk that patients in the health-based place of safety (HBPoS) will not have adequate medical oversight caused by responsible clinician (RC) and medical cover being provided by doctors from other services resulting in a risk to clinical quality and safety.

Adult Acute | People







Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	**Acute**	**8.4%**	*	*	*	**5.1%**
Sickness	Burbage	8.9%	10.2%	• • •	?	5.1%
Sickness	Dovedale 2	5.7%	7.4%	• • •	?	5.1%
Sickness	Stanage	6.7%	5.1%	• • •	?	5.1%
Sickness	Endcliffe	7.6%	7.1%	• • •	?	5.1%
Sickness	Beech	25.8%	8.2%	• H •	?	5.1%

Metric	Level	Value	Mean	Var.	Ass.	Target
Supervision	**Acute**	**78.8%**	*	*	*	**80%**
Supervision	Burbage	75.5%	48.8%	• • •	?	80%
Supervision	Dovedale 2	64.7%	61.0%	• • •	?	80%
Supervision	Stanage	79.2%	56.8%	• • •	?	80%
Supervision	Endcliffe	64.7%	50.4%	• • •	?	80%
Supervision	Beech	84.6%	90.4%	• • •	?	80%

Metric	Level	Value	Mean	Var.	Ass.	Target
Man. Training	**Acute**	**92.0%**	*	*	*	**80%**
Man. Training	Burbage	88.0%	86.5%	• • •	P	80%
Man. Training	Dovedale 2	94.2%	91.4%	• • •	?	80%
Man. Training	Stanage	97.3%	94.3%	• H •	P	80%
Man. Training	Endcliffe	92.5%	86.6%	• • •	?	80%
Man. Training	Beech	97.3%	98.1%	• • •	P	80%

Understanding the Performance

Sickness has increased significantly at Beech; there are a relatively small number of staff and the increase is largely due to long term sickness which is ongoing and being managed appropriately.

Supervision compliance remains generally below target though improvements are being made in recording following a dip initially when recording moved to ESR.

Mandatory training compliance remains consistently high across Acute though there are specific courses that still need to be actively monitored.

Actions

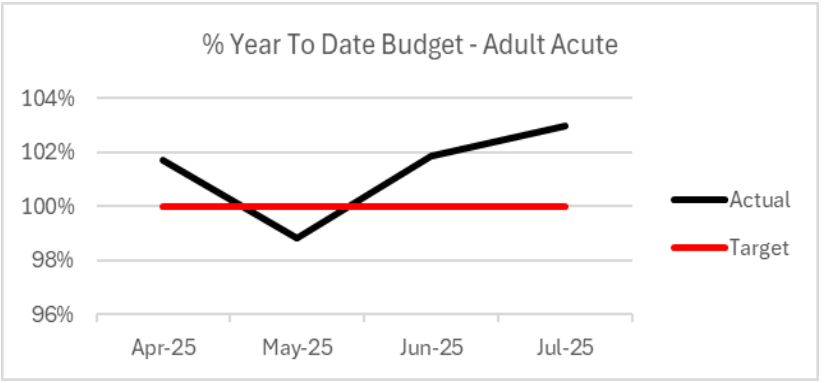
The People directorate continues to support managers to increase supervision compliance. Clinical teams target: 80% by Sep-25.

Recovery plans for clinical teams below 80% target for mandatory training are submitted to SLT and reviewed monthly.

Risks

Not meeting supervision compliance targets risks staff not receiving the support they require.

Adult Acute | People and Finance



Metric	Level	Value	Mean	Var.	Ass.	Target
Vacancy Rate	**Acute**	**12.0%**	*	*	*	**10%**

Metric	Level	Value	Mean	Var.	Ass.	Target
Turnover Rate	**Acute**	**9.6%**	*	*	*	**10%**

Metric	Level	Value	Target
YTD Variance to Budget	**Acute**	**103%**	**100%**

Understanding the Performance

Acute vacancy rate was slightly over the target in the month of July.

Turnover rate was 9.6%, very close to the target of 10%.

The budget target has been exceeded in 3 of the first 4 months of the financial year, July budget was 103% against target of 100%.

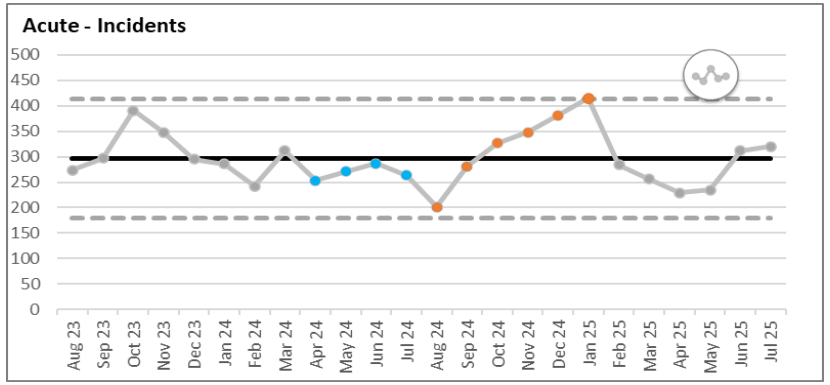
Actions

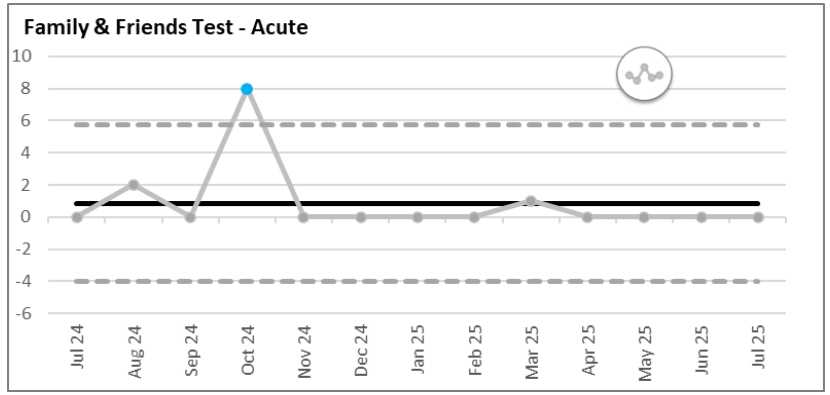
Vacancy and turnover rates will be monitored. Historic data has been requested in order to build a full picture and complete SPC charts.

Risks

N/A

Adult Acute | Safety and Quality





Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	**Acute**	**320**	**296**	•••	-	-
Incidents	Burbage	123	108	•••	-	-
Incidents	Dovedale 2	24	42	•••	-	-
Incidents	Stanage	50	61	•••	-	-
Incidents	Endcliffe	87	56	•••	-	-
Incidents	Beech	5	8	•••	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Unreviewed incidents	**Acute**	**60**	*	*	-	-
Unreviewed inc.	Burbage	5	*	*	-	-
Unreviewed inc.	Dovedale 2	1	*	*	-	-
Unreviewed inc.	Stanage	37	*	*	-	-
Unreviewed inc.	Endcliffe	4	*	*	-	-
Unreviewed inc.	Beech	0	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
FFT Responses	**Acute**	**0**	**1**	•••	-	-
FFT Responses	Burbage	0	0	•L•	-	-
FFT Responses	Dovedale 2	0	0	•••	-	-
FFT Responses	Stanage	0	0	•L•	-	-
FFT Responses	Endcliffe	0	0	•••	-	-
FFT Responses	Beech	0	0	•••	-	-

Understanding the Performance

- Acute services account for 42% of the total incidents reported across the organisation in July, with their most frequent reported incidents being for smoking breach, physical assault (patient to staff) and strangulation/ligation.
- The engagement team have reviewed how we gather our experience data and how the voice of service users, carers and citizens are incorporated into decision making. To ensure we close the feedback loop we are having a focus with teams on 'you said, we did'. We are working with the QI team to manage the impact of this and will be having visible areas in services and ensuring regular communication around this.

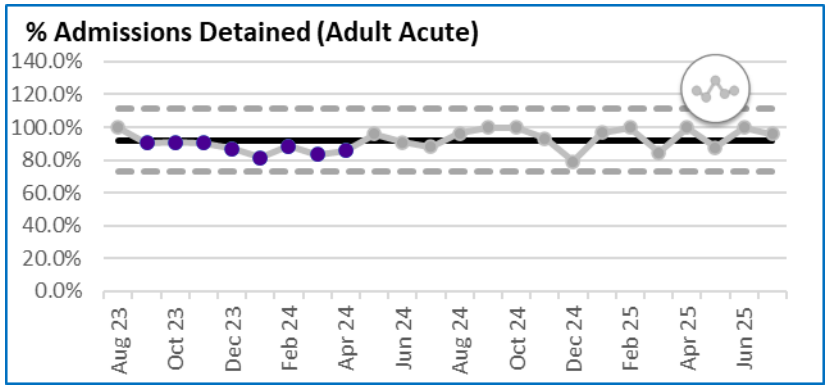
Actions

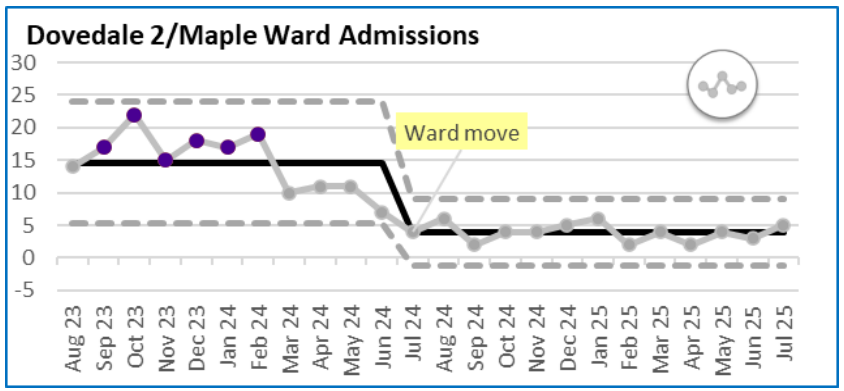
- We have collated Friends and Family Test (FFT) data for the last 12 months for each service, looking at key themes from feedback. This will be fed back and clinical teams will be supported by the Quality directorate with an action plan. Patient and carer experience advocates are being recruited across each service to support and additional engagement training will be provided.
- SPC mean and variation for unreviewed incidents will be calculated from next month's report.

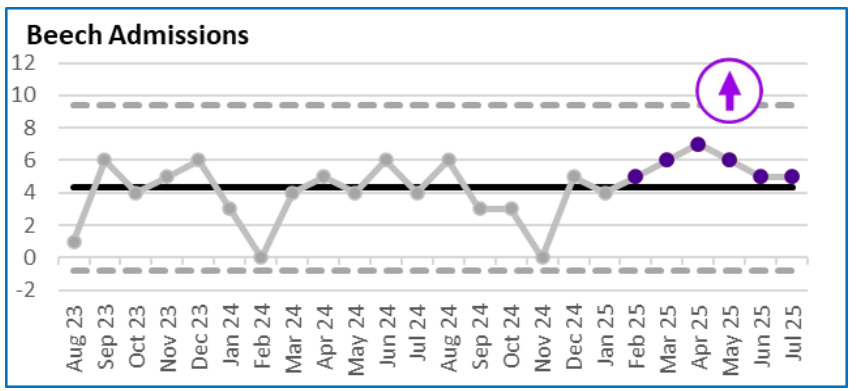
Risks

While incidents remain unreviewed at service level, we cannot be assured that effective learning is taking place or that the appropriate post incident support has been provided. Central review does occur on all incidents and support into teams is offered where deemed appropriate.

Adult Acute | Admissions and Discharges







Metric	Level	Value	Mean	Var.	Ass.	Target
Admissions	**Acute**	**25**	**25.0**	• • •	-	-
Admissions	Burbage	13	9.5	• • •	-	-
Admissions	Stanage	7	6.7	• • •	-	-
Admissions	Dovedale 2	5	8.8	• • •	-	-
Admissions	Endcliffe	8	4.0	• • •	-	-
Admissions	Beech	5	4.3	• H •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Discharges	**Acute**	**27**	**26.4**	• • •	-	-
Discharges	Burbage	12	10.2	• • •	-	-
Discharges	Stanage	11	7.8	• • •	-	-
Discharges	Dovedale 2	4	8.4	• L •	-	-
Discharges	Endcliffe	6	2.3	• H •	-	-
Discharges	Beech	6	4.4	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Detained Admissions	Acute	96.0%	91.9%	• • •	-	-
Transfers In	Acute	11	8.3	• • •	-	-
Transfers Out	Acute	9	6.9	• • •	-	-

Understanding the Performance

Admissions, discharges and transfers remain within expected levels.

Dovedale 2 admissions have been lower since Jun-24, this can be mainly attributed to the move from Maple ward to Dovedale 2 which saw a reduction in the number of beds available.

Detained admissions continue to account for nearly all admissions which leaves no capacity for elective admissions.

Admissions to Beech have been above the mean for 6 months though still within expected limits.

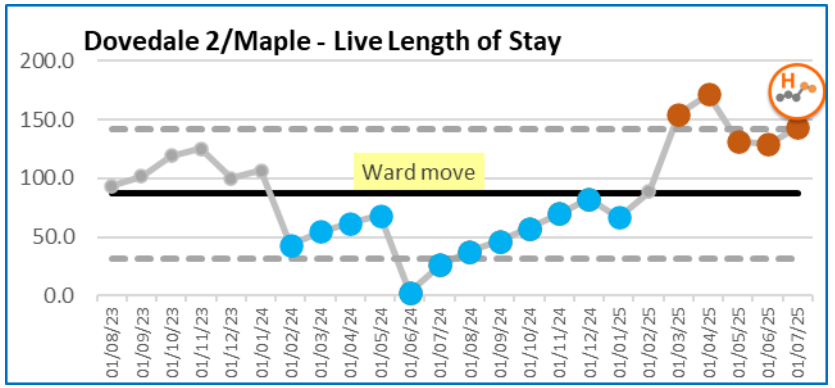
Actions

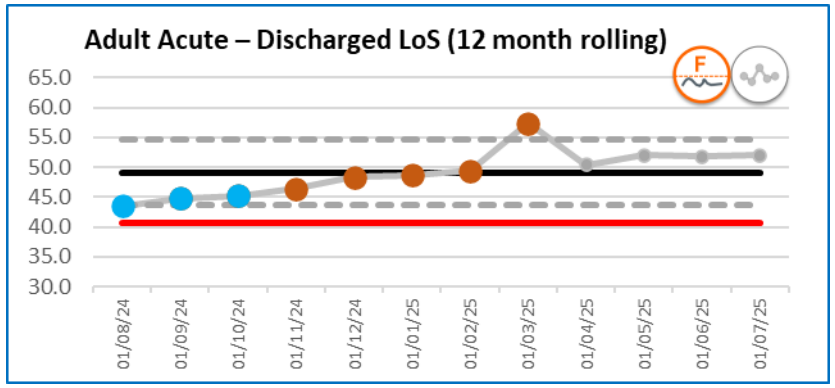
Our Home First Programme and insights from a consultancy have identified the key drivers are: capability and capacity of community and crisis services, the efficiency of hospital care (length of stay), and social care delayed discharge.

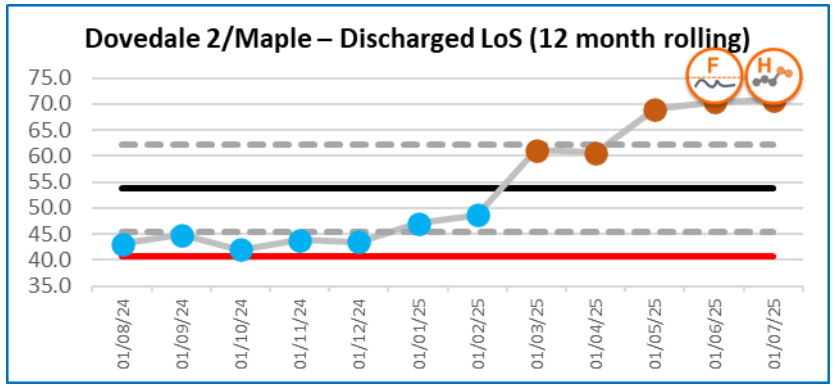
Risks

High levels of detained admissions restrict the availability of access for service users who do not need to be detained.

Adult Acute | Length of Stay and Bed Occupancy







Metric	Level	Value	Mean	Var.	Ass.	Target
Live LoS	**Acute**	**87.0**	**85.4**	• • •	-	-
Live LoS	Burbage	55.0	61.8	• • •	-	-
Live LoS	Stanage	77.0	56.4	• • •	-	-
Live LoS	Dovedale 2	144.0	87.0	• H •	-	-
Live LoS	Endcliffe	47.0	79.0	• • •	-	-
Live LoS	Beech	45.0	59.3	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Discharged LoS	**Acute**	**52.0**	**49.2**	• • •	F	**40.7**
Discharged LoS	Burbage	37.8	38.8	• • •	?	40.7
Discharged LoS	Stanage	64.4	47.7	• H •	?	40.7
Discharged LoS	Dovedale 2	70.8	53.8	• H •	F	40.7
Discharged LoS	Endcliffe	89.9	64.4	• H •	?	47.0
Discharged LoS	Beech	60.1	71.0	• L •	-	

Metric	Level	Value	Mean	Var.	Ass.	Target
Bed Occupancy	**Acute**	**97.1%**	**96.4%**	• • •	-	-
Bed Occupancy	Burbage	97.4%	91.5%	• H •	-	-
Bed Occupancy	Stanage	95.2%	96.3%	• • •	-	-
Bed Occupancy	Dovedale 2	99.5%	95.5%	• • •	-	-
Bed Occupancy	Endcliffe	96.5%	96.3%	• • •	-	-
Bed Occupancy	Beech	94.2%	83.0%	• • •	-	-

Understanding the Performance

The rolling 12 month discharged length of stay for Acute is not meeting the target of 40.7 days. This is partly due to the discharge of two very long stay clients in Jan-25 (982 days) and Feb-25 (630 days). If these clients were to be excluded, then the average would be 47.4 days.

The longest length of stay currently is 840 days on Dovedale 2 and on Endcliffe PICU there are 2 clients with a LoS over the benchmark figure of 71.6 days.

Bed occupancy on Burbage has been above the mean for 6 months but across all wards remains within expected limits.

Actions

Longer stay clients are reviewed regularly at MDT meetings and escalations are raised where support is required to find appropriate placements. This is also a key area of focus as part of Home First.

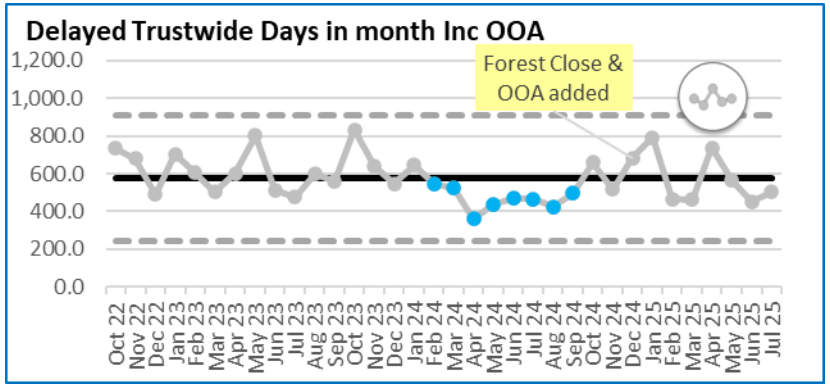
Plan for the re-opening of Maple Ward later in 2025 will increase local bed capacity.

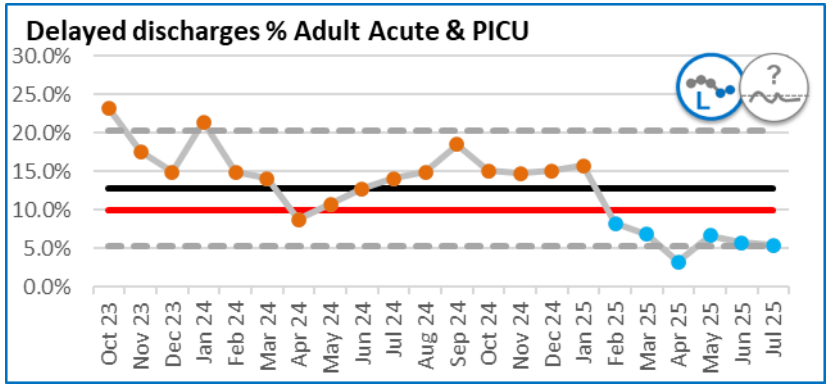
Risks

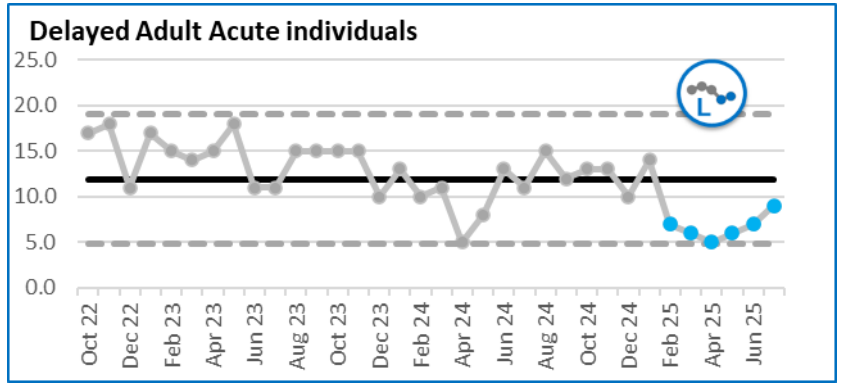
Longer lengths of stay restrict the access to beds for other service users.

If appropriate placements are unable to be found once service users are clinically ready for discharge, there is a risk that their recovery will be slower when in a ward environment.

Adult Acute | Delayed Care







Metric	Level	Value	Mean	Var.	Ass.	Target
Delayed individuals	**Acute**	**9**	**12**	• L •	-	-
Delayed % Adult Acute & PICU	Acute/ PICU	5.4%	12.8%	• L •	?	10.0%
Delayed Trustwide Days inc OOA	Trust	502	573.6	• • •	-	-
Delayed % Trustwide inc OOA	Trust	19.9%	18.7%	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Delayed Days	**Acute**	**90**	**267.4**	• L •	-	-
Delayed Days	Burbage	58	*	*	-	-
Delayed Days	Stanage	29	*	*	-	-
Delayed Days	DD2	3	*	*	-	-
Delayed Days	Endcliffe	0	19.1	• L •	-	-
Delayed Days	Beech	77	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Delayed Days %	**Acute**	**6.6%**	**18.9%**	• L •	-	-
Delayed Days %	Burbage	11.7%	*	*	-	-
Delayed Days %	Stanage	5.8%	*	*	-	-
Delayed Days %	DD2	0.8%	*	*	-	-
Delayed Days %	Endcliffe	0.0%	*	• L •	-	-
Delayed Days %	Beech	24.8%	*	*	-	-

Understanding the Performance

These charts show the occupied days each month and the percentage of days available occupied by delayed discharges for each of the areas. It is important to note that whilst the number of individuals delayed each month may reduce this does not always directly relate to the number of days occupied. E.g. 10 individuals could each be delayed by 2 days totalling 20 days, yet 1 individual delayed by 30 days still accounts for higher occupancy.

The overall number of individuals delayed has reduced and for Adult Acute & PICU has achieved the target of 10% for the last 6 months. However Trust wide delays including OOA remain high at nearly 20%.

Actions

Work with Local Authority colleagues at a senior level has seen improvements in the movement of delayed inpatients.

Senior executives now have greater oversight and quarterly review.

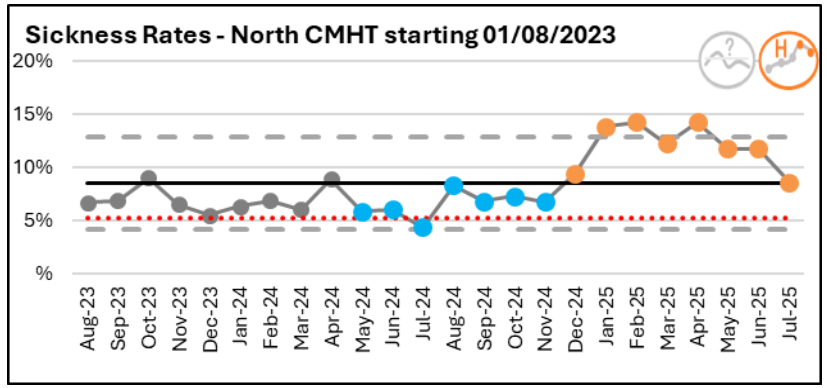
This is also a key area of focus as part of Home First and work with Sheffield City Council and the ICB.

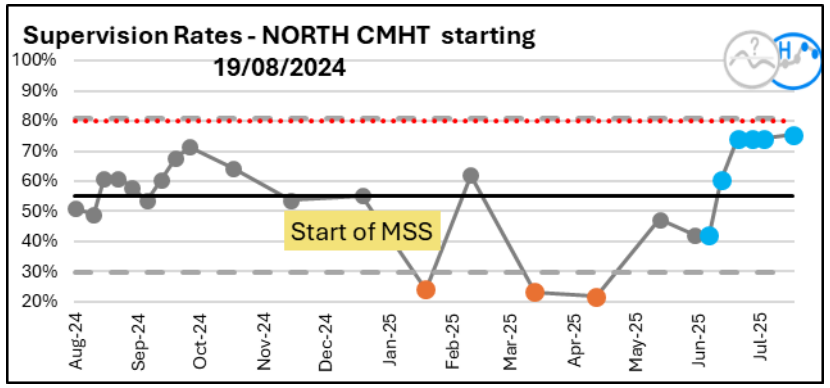
Risks

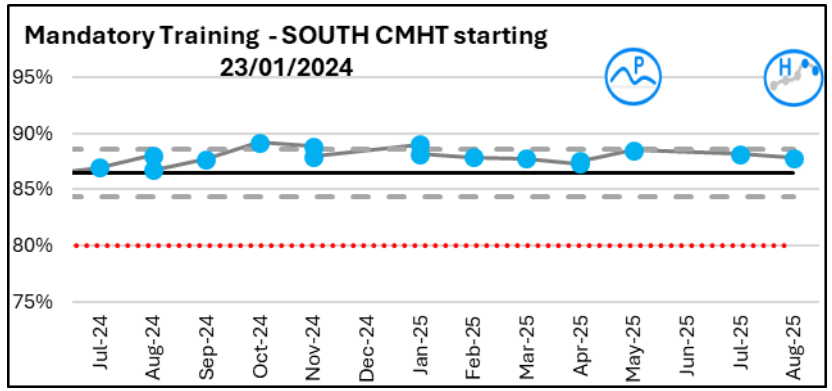
Delayed clients restrict the ability to admit new clients leading to reduced flow in the system and greater use of out of area beds.

Delayed clients will not receive the appropriate care for their recovery as the acute ward may not be the most appropriate environment for them.

Adult Community | People







Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	**Community**	**8.8%**	*	*	*	**5.1%**
Sickness	CMHT North	8.6%	8.5%	• H •	?	5.1%
Sickness	CMHT South	8.5%	5.8%	• • •	?	5.1%
Sickness	EIS	9.4%	7.7%	• • •	?	5.1%

Metric	Level	Value	Mean	Var.	Ass.	Target
Supervision	**Community**	**60.3%**	*	*	*	**80%**
Supervision	CMHT North	74.1%	55.3%	• H •	?	80%
Supervision	CMHT South	73.0%	68.9%	• • •	?	80%
Supervision	EIS	52.9%	48.4%	• • •	?	80%

Metric	Level	Value	Mean	Var.	Ass.	Target
Mandatory Training	**Community**	**93.0%**	*	*	*	**80%**
Man. Training	CMHT North	97.1%	97.6%	• • •	P	80%
Man. Training	CMHT South	88.1%	86.5%	• H •	P	80%
Man. Training	EIS	82.6%	83.7%	• • •	P	80%

Understanding the Performance

Sickness remains high in North CMHT, there is a higher proportion of long term sickness which is being managed appropriately.

Supervision recording is improving following changes in recording and the move to ESR. There is still a need to improve further, particularly in Early Intervention Service (EIS).

Mandatory training remains high with all services meeting the target.

Actions

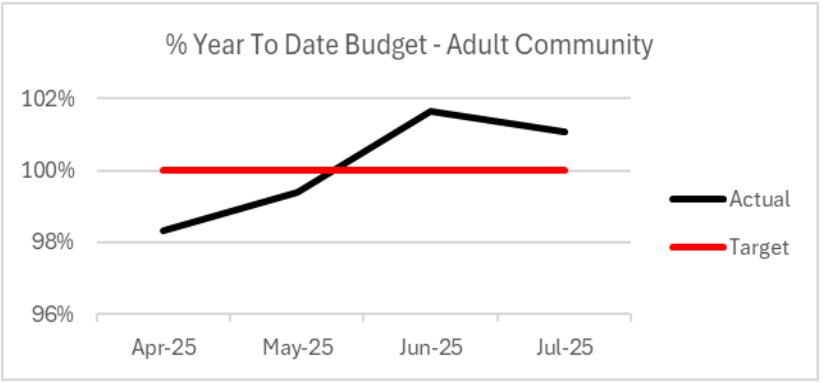
The People directorate continues to support managers to increase supervision compliance. Clinical teams target: 80% by Sep-25.

Recovery plans for clinical teams below 80% target for mandatory training are submitted to SLT and reviewed monthly.

Risks

Not meeting supervision compliance targets risks staff not receiving the support they require.

Adult Community | People and Finance



Metric	Level	Value	Mean	Var.	Ass.	Target
Vacancy Rate	**Community**	**12.3%**	*	*	*	**10%**

Metric	Level	Value	Mean	Var.	Ass.	Target
Turnover Rate	**Community**	**8.5%**	*	*	*	**10%**

Metric	Level	Value	Target
YTD Variance to Budget	**Community**	**101%**	**100%**

Understanding the Performance

Community vacancy rate was slightly over target in the month of July.

Turnover rate was 8.5%, just under the target of 10%.

The service line was over budget in the last 2 of the first 4 months of the financial year. July budget was 101% against target of 100%.

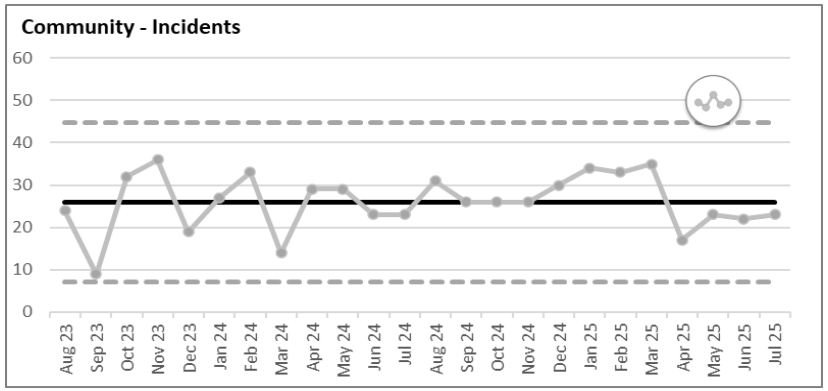
Actions

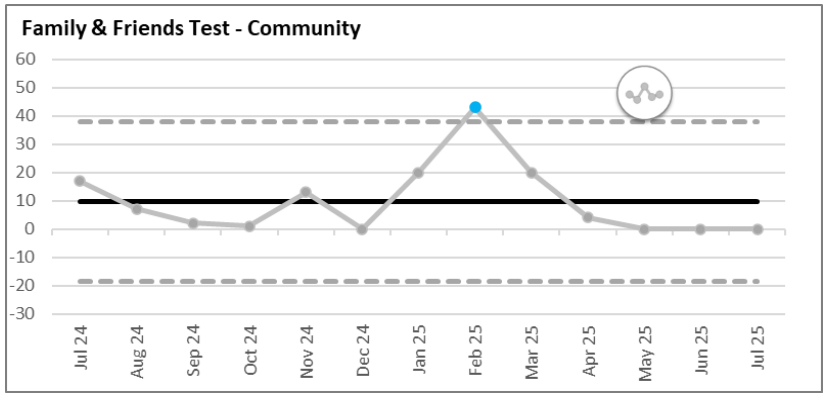
Vacancy and turnover rates will be monitored. Historic data has been requested in order to build a full picture and complete SPC charts.

Risks

N/A

Adult Community | Safety and Quality





Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	**Community**	**23**	**26**	• • •	-	-
Incidents	CMHT North	7	9	• • •	-	-
Incidents	CMHT South	11	10	• • •	-	-
Incidents	EIS	3	6	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Unreviewed incidents	**Community**	**59**	*	*	-	-
Unreviewed inc.	CMHT North	26	*	*	-	-
Unreviewed inc.	CMHT South	23	*	*	-	-
Unreviewed inc.	EIS	1	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
FFT Responses	**Community**	**0**	**10**	• • •	-	-
FFT Responses	CMHT North	0	6	• • •	-	-
FFT Responses	CMHT South	0	3	• • •	-	-
FFT Responses	EIS	0	0	• • •	-	-

Understanding the Performance

- Community services account for 3% of the total incidents reported across the organisation in July, with their most frequent reported incidents being for medication related incidents.
- The engagement team have reviewed how we gather our experience data and how the voice of service users, carers and citizens are incorporated into decision making. To ensure we close the feedback loop we are having a focus with teams on ‘you said, we did’. We are working with the QI team to manage the impact of this and will be having visible areas in services and ensuring regular communication around this.

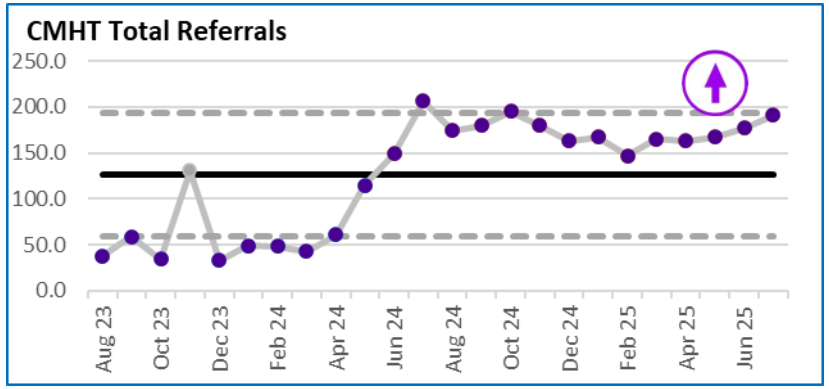
Actions

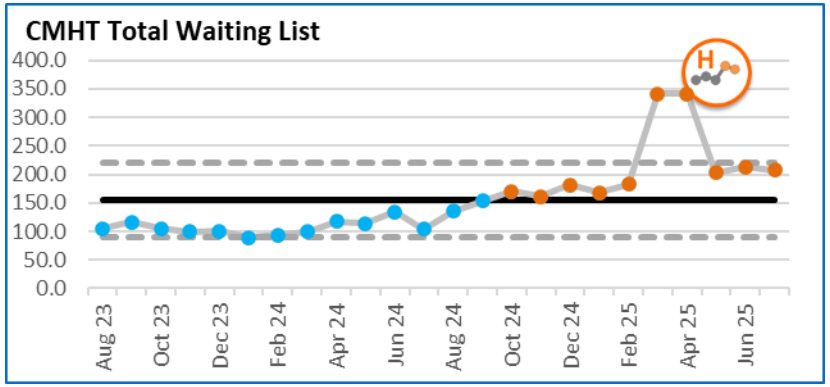
- We have collated Friends and Family Test (FFT) data for the last 12 months for each service, looking at key themes from feedback. This will be fed back and clinical teams will be supported by the Quality directorate with an action plan. Patient and carer experience advocates are being recruited across each service to support and additional engagement training will be provided.
- SPC mean and variation for unreviewed incidents will be calculated from next month’s report.

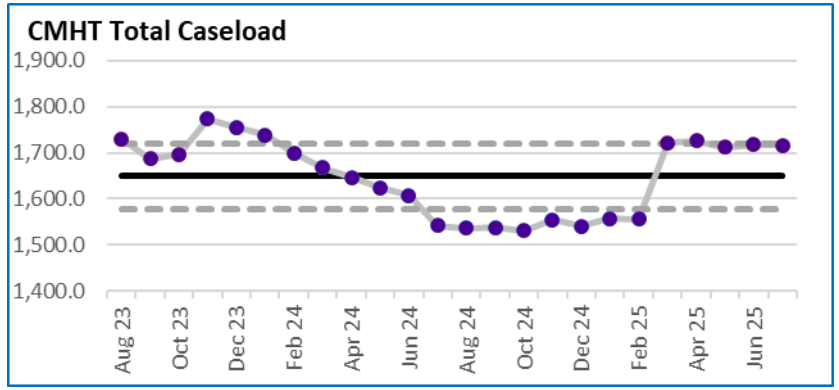
Risks

While incidents remain unreviewed at service level, we cannot be assured that effective learning is taking place or that the appropriate post incident support has been provided. Central review does occur on all incidents and support into teams is offered where deemed appropriate.

Adult Community | CMHT North, CMHT South & Early Intervention Service







Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	**Community**	**219**	*	*	-	-
Referrals	CMHT Total	191	126.5	• H •	-	-
Referrals	CMHT North	85	60.8	• • •	-	-
Referrals	CMHT South	106	65.9	• L •	-	-
Referrals	EIS	28	36.5	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Waiting List	**Community**	**236**	*	*	-	-
Waiting List	CMHT Total	207	155.7	• H •	-	-
Waiting List	CMHT North	107	92.9	• H •	-	-
Waiting List	CMHT South	100	60.0	• H •	-	-
Waiting List	EIS	29	22.5	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Caseload	**Community**	**2032**	*	*	-	-
Caseload	CMHT Total	1717	1649.1	• H •	-	-
Caseload	CMHT North	853	776.0	• H •	-	-
Caseload	CMHT South	864	872.5	• • •	-	-
Caseload	EIS	315	290.3	• H •	-	-

Understanding the Performance

High volume of referrals in CMHTs from primary care. Work is underway to reset the referral process and agree an SLA. Referral criteria has been reviewed and a new referral template for GPs has been developed which is expected to lead to appropriate referrals being sent to CMHTs.
CMHT waiting lists in the North have undertaken a stocktake and both teams are working through waiting lists and caseloads to ensure clients are correctly allocated on the system. South waiting list continues to increase. There is a separate waiting list for assessments and the team are also working to categorise service users needing care worker reallocations.

Actions

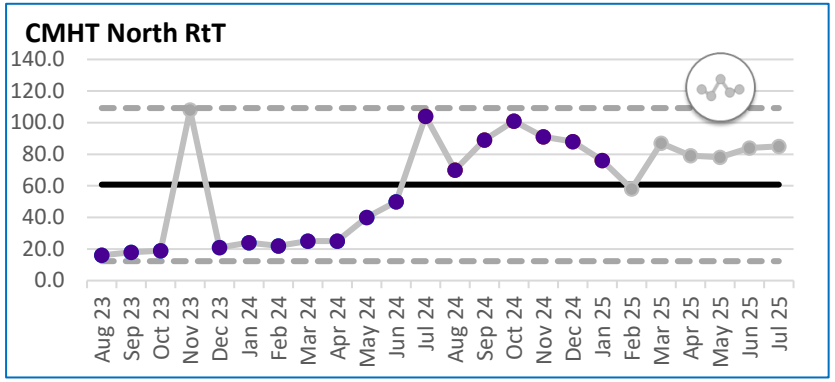
Work is ongoing on improving Trustwide waiting list definition and reporting in line with national guidance and reporting. A paper is being taken to SLT in August to propose a new approach.

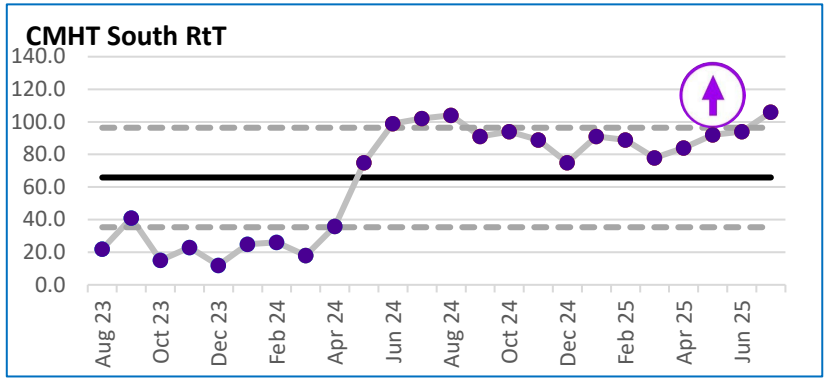
Risks

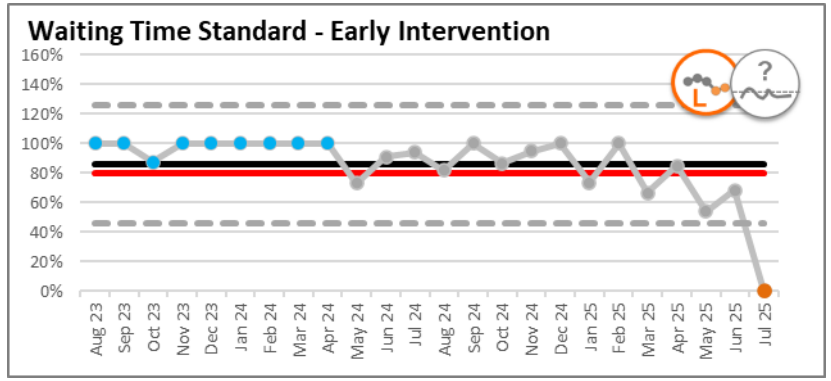
The current approach of counting all service users open to a service on wait lists risks limiting the view of service users waiting for a first contact/assessment.

Higher referral rates increase the team workload to triage and accept/reject referrals. Clients may wait longer as a result of the increased demand.

Adult Community | CMHT North, CMHT South & Early Intervention Service







Metric	Level	Value	Mean	Var.	Ass.	Target
RtA	**Community**	**219**	*	*	-	-
RtA	CMHT Total	191	*	• • •	-	-
RtA	CMHT North	85	60.8	• • •	-	-
RtA	CMHT South	106	65.9	• L •	-	-
RtA	EIS	28	36.5	• • •	-	-

Metric		Value	Mean	Var.	Ass.	Target
RtT	**Community**	*	*	*	-	-
RtT	CMHT North	35.6	14.0	• H •	-	-
RtT	CMHT South	30.8	13.0	• H •	-	-
Access Waiting Time	EIS	0%	85.7%	• L •	?	80%

Understanding the Performance

Community Mental Health Teams (CMHTs) and Early Intervention referral to treatment (RtT) wait time is now being reported using stricter national definitions following the move to Rio. These are being used to define treatment which has resulted in very low numbers of treatments compared to previous reporting which also impacts the waiting time calculations. CMHT processes are being reviewed.

Early Intervention access waiting time was achieved for 0 of 18 referrals (not discharged). This will be discussed in the team governance meeting to ensure the process is being followed correctly.

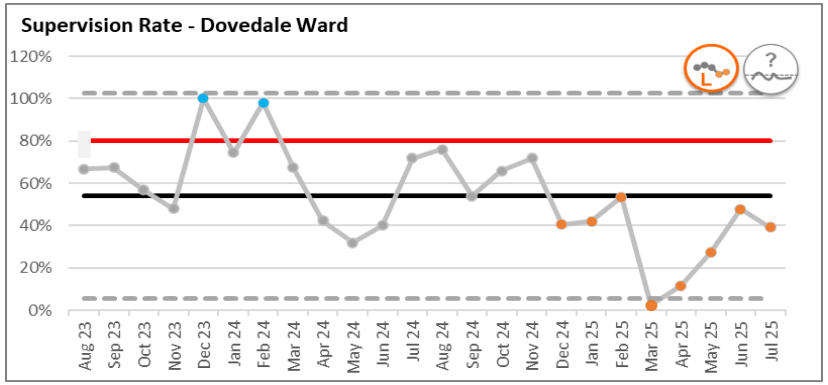
Actions

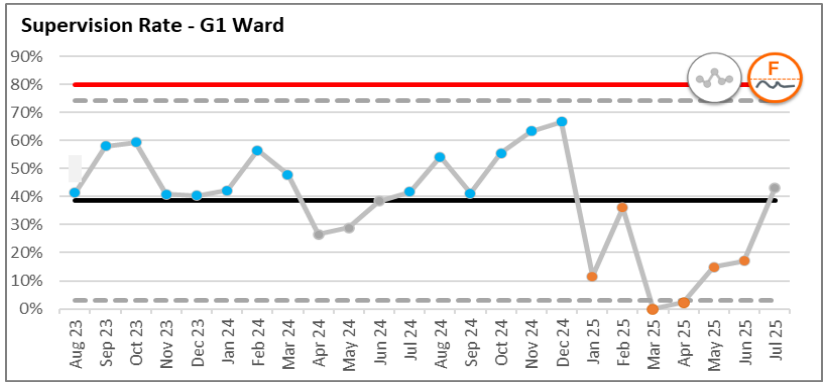
RtT reporting will be updated to the new community 4 week wait definition. A new data report is being developed that shows the status of activities and appointments needed to complete the 'clock stop'. Services will be provided with reports to support accurate recording and identifying cases where items are outstanding. A draft report developed in early Aug-25 will be shared with services and further developed through Aug and Sep-25.

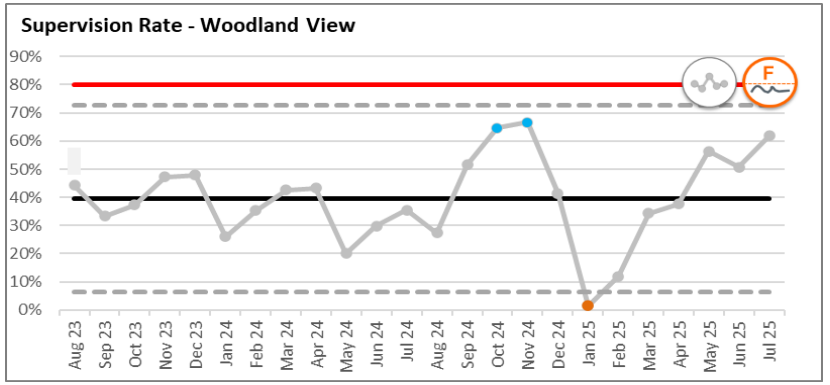
Risks

Current reporting does not accurately reflect service activity so services are not able to fully understand the referral to assessment and treatment times. Service users could be waiting longer than expected.

Older Adult | People







Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	**Older Adults**	**8.1%**	*	*	*	**5.1%**
Sickness	Dovedale 1	10.2%	17.6%	• L •	F	5.1%
Sickness	G1	10.7%	13.8%	• • •	F	5.1%
Sickness	Birch Avenue	6.0%	11.6%	• L •	F	5.1%
Sickness	Woodland View	13.0%	12.5%	• • •	F	5.1%

Metric	Level	Value	Mean	Var.	Ass.	Target
Supervision	**Older Adults**	**61.9%**	**55.5%**	• • •	F	**80%**
Supervision	Dovedale 1	39.1%	54.0%	• L •	?	80%
Supervision	G1	43.2%	38.7%	• • •	F	80%
Supervision	Birch Avenue	57.1%	57.3%	• • •	?	80%
Supervision	Woodland View	61.9%	39.5%	• • •	F	80%

Metric	Level	Value	Mean	Var.	Ass.	Target
Man. Training	**Older Adults**	**82.4%**	**82.9%**	• • •	?	**80%**
Man. Training	Dovedale 1	79.1%	83.1%	• L •	P	80%
Man. Training	G1	83.2%	87.0%	• L •	P	80%
Man. Training	Birch Avenue	80.2%	82.3%	• L •	P	80%
Man. Training	Woodland View	87.9%	82.0%	• H •	?	80%

Understanding the Performance

- **Sickness absence** is above target in all areas and particularly high at Dovedale 1, G1 and Woodland View.
- **Supervision compliance** is significantly below target across Older Adults services. Persistent sickness absence across Woodland View has affected supervision compliance which is well below the 80% target.
- Dovedale 1 **mandatory training** compliance is trending marginally below target and is at 79% for July. Though both are currently above target, G1 and Birch Avenue's compliance has declined recently.

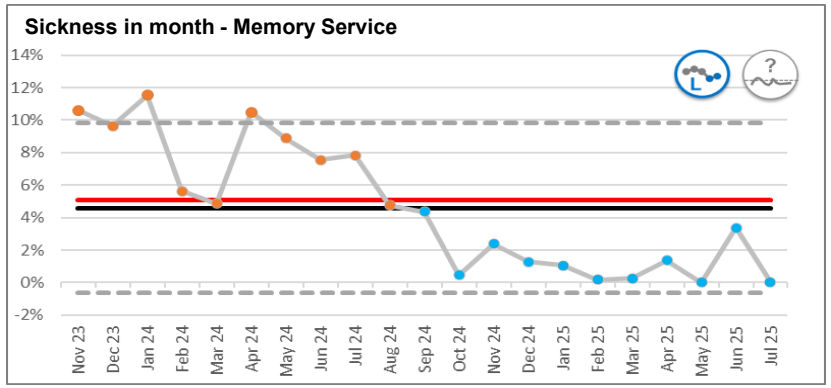
Actions

- Focus on supervision at **Birch Avenue** and **G1** has resulted in an improvement in August and in the last 4 months, respectively. This work continues.
- An action plan has been developed at **Dovedale 1** providing clarity on supervision responsibilities and admin staff are now booking staff in for mandatory training.
- G1 is exploring alternatives to Respect training for those staff who are not able to complete it due to their physical health.
- Moving & Handling Level 2 training restarted in July and future bookings are being made.

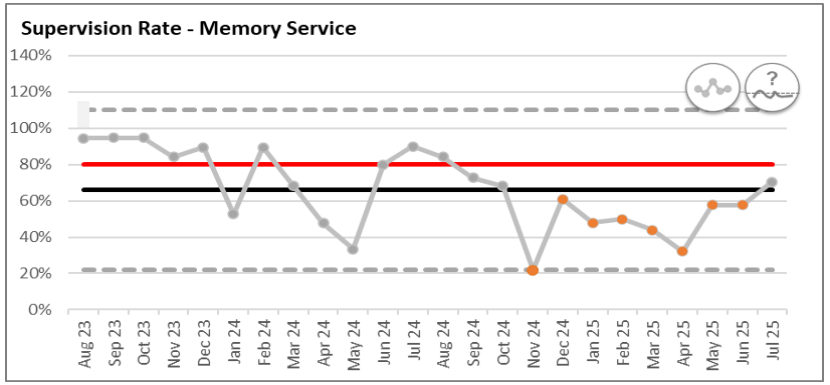
Risks

- Risk that continued high levels of sickness in **Woodland View** will impair progress on supervision compliance.
- Not meeting supervision compliance targets risks staff not receiving the support they require.
- Risk of falls in **Birch Avenue** where mandatory training courses Preventing Falls in Hospitals and Moving & Handling Level 2 have low compliance.
- **Woodland View** also has low compliance in Moving & Handling Level 2 but has high compliance in Preventing Falls in Hospitals.
- **G1** risks to staff and patients in short term due to lack of Respect training.

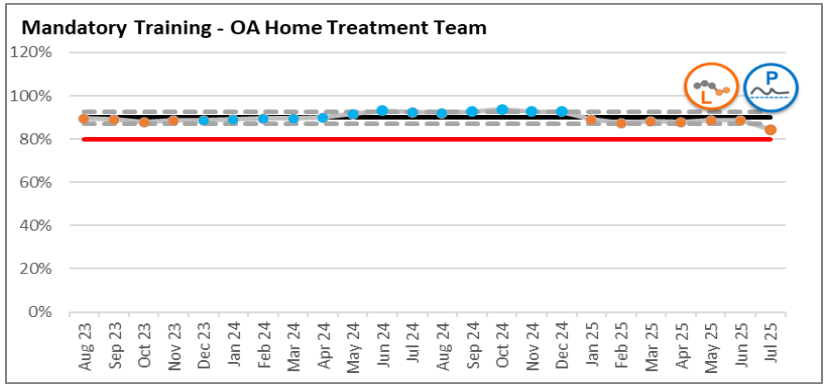
Older Adult | People



Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	CDSS	0.0%	11.6%	• L •	?	5.1%
Sickness	OA CMHT	6.0%	6.5%	• • •	?	5.1%
Sickness	OA HTT	5.8%	7.9%	• • •	?	5.1%
Sickness	Memory Service	0.0%	4.6%	• L •	?	5.1%



Metric	Level	Value	Mean	Var.	Ass.	Target
Supervision	CDSS	40.0%	79.3%	• • •	?	80%
Supervision	OA CMHT	74.4%	64.6%	• • •	?	80%
Supervision	OA HTT	89.2%	84.7%	• • •	?	80%
Supervision	Memory Service	70.4%	66.1%	• • •	?	80%



Metric	Level	Value	Mean	Var.	Ass.	Target
Man. Training	CDSS	99.2%	88.7%	• H •	P	80%
Man. Training	OA CMHT	86.0%	87.6%	• • •	P	80%
Man. Training	OA HTT	84.4%	89.8%	• L •	P	80%
Man. Training	Memory Service	86.7%	89.9%	• L •	P	80%

Understanding the Performance

- **Memory Service** sickness in special cause improvement - low and consistently below the Trust target since Sep-24.
- **Memory Service** supervision compliance was in decline since Jul-24. Though having improved in the last 3 months, further improvement is required to achieve the target.
- **Older Adult Home Treatment Team (OA HTT)** mandatory training compliance continues to achieve the target but has declined and is in special cause concern due to historically strong performance.

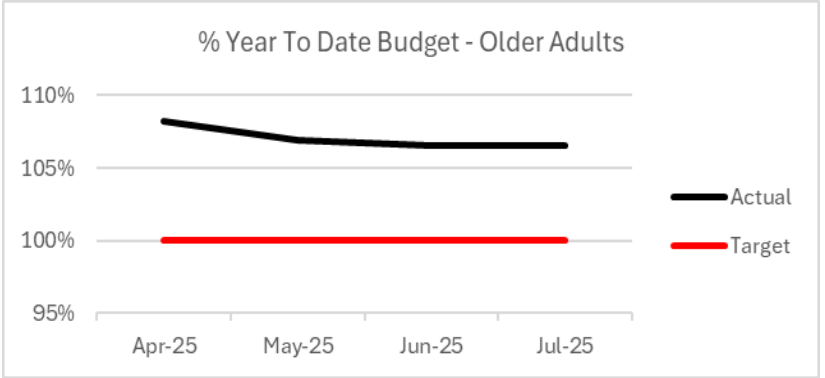
Actions

- **OA HTT** mandatory training compliance will be monitored within the service and in governance meetings to ensure the decline in performance does not persist.

Risks

- Not meeting supervision compliance targets risks staff not receiving the support they require.

Older Adult | People and Finance



Metric	Level	Value	Mean	Var.	Ass.	Target
Vacancy Rate	**Older Adults**	**13.2%**	*	*	*	**10%**

Metric	Level	Value	Mean	Var.	Ass.	Target
Turnover Rate	**Older Adults**	**9.7%**	*	*	*	**10%**

Metric	Level	Value	Target
YTD Variance to Budget	**Older Adults**	**107%**	**100%**

Understanding the Performance

Older Adult vacancy rate is above the 10% trust target – at 13.2% in July 2025.

Turnover rate is 9.7%, narrowly under target.

The service line has been over budget every month so far this year. In July, Older Adults was over budget by 7%.

Actions

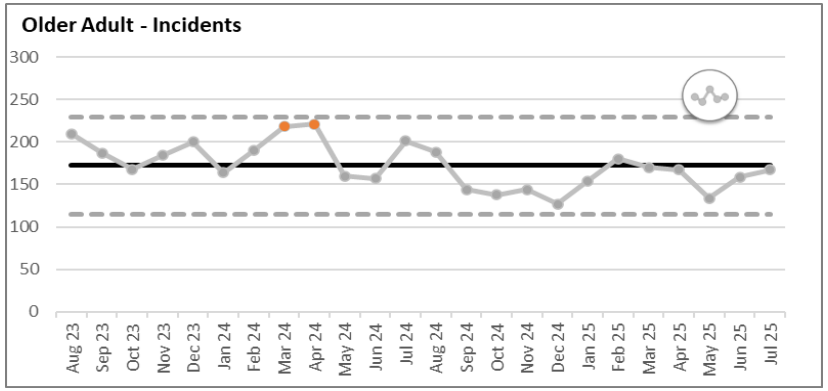
Vacancy and turnover rates will be monitored. Historic data has been requested in order to build a full picture and complete SPC charts.

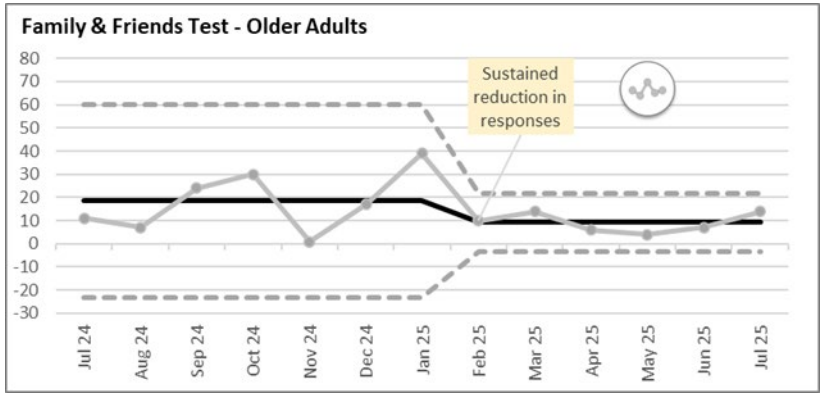
Finance Business Partners work with all teams across the Trust to support the effective management of budgets and realise the benefits of value improvement programmes.

Risks

There is a risk that the Trust's financial plan will not be met for the year if budgets are exceeded.

Older Adult | Safety and Quality





Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	**Older Adults**	**167**	**172**	• • •	-	-
Incidents	Dovedale	34	40	• • •	-	-
Incidents	G1	28	37	• • •	-	-
Incidents	Birch Ave.	44	42	• • •	-	-
Incidents	Woodland View	37	24	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Unreviewed inc.	**Older Adults**	**17**	*	*	-	-
Unreviewed inc	Dovedale	3	*	*	-	-
Unreviewed inc	G1	2	*	*	-	-
Unreviewed inc	Birch Ave.	1	*	*	-	-
Unreviewed inc	Woodland View	1	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
FFT Responses	**Older Adults**	**14**	**9**	• • •	-	-
FFT Responses	Dovedale	0	0	• • •	-	-
FFT Responses	G1	0	0	• • •	-	-
FFT Responses	Birch Ave.	0	0	• • •	-	-
FFT Responses	Woodland View	0	0	• • •	-	-

Understanding the Performance

Older Adult services account for 21.9% of the total incidents reported across the organisation in July, with the most frequent reported incidents for bed-based services being for ‘falls on level (below 1 metre)’ and physical assaults.

The engagement team have reviewed how we gather our experience data and how the voice of service users, carers and citizens are incorporated into decision making. To ensure we close the feedback loop we are having a focus with teams on ‘you said, we did’. We are working with the QI team to manage the impact of this and will be having visible areas in services and ensuring regular communication around this.

Actions

We have collated Friends and Family Test (FFT) data for the last 12 months for each service, looking at key themes from feedback. This will be fed back and clinical teams will be supported by the Quality directorate with an action plan. Patient and carer experience advocates are being recruited across each service to support and additional engagement training will be provided.

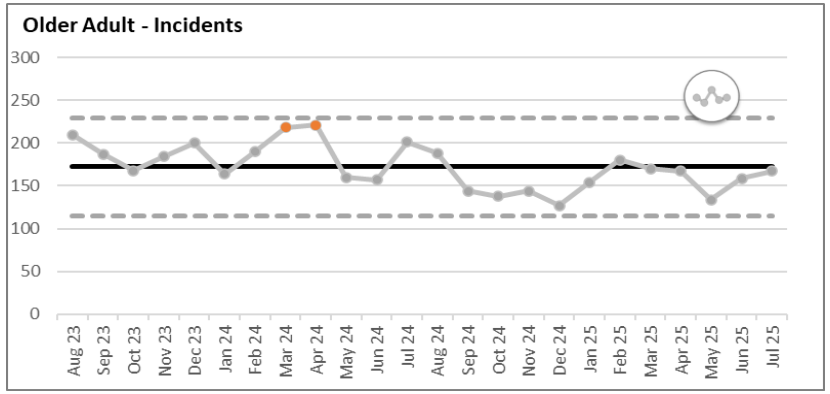
HUSH huddles take place 5 days a week to support discussion around service user care plans to prevent falls.

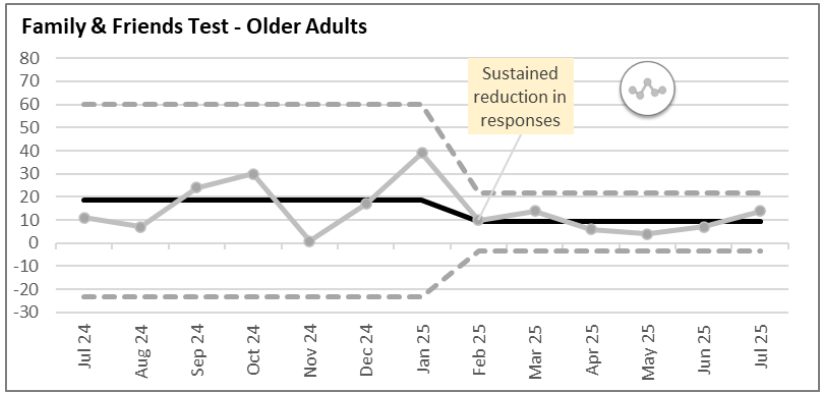
We will calculate mean and variance for unreviewed incidents from next month’s reporting.

Risks

While incidents remain unreviewed at service level, we cannot be assured that effective learning is taking place or that the appropriate post incident support has been provided. Central review does occur on all incidents and support into teams is offered where deemed appropriate.

Older Adult | Safety and Quality





Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	**Older Adults**	**167**	**172**	• • •	-	-
Incidents	CDSS	0	0	• • •	-	-
Incidents	OA CMHT	10	15	• • •	-	-
Incidents	OA HTT	10	7	• • •	-	-
Incidents	Mem. Ser.	4	2	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Unreviewed inc.	**Older Adults**	**17**	-	-	-	-
Unreviewed inc	CDSS	0	-	-	-	-
Unreviewed inc	OA CMHT	4	-	-	-	-
Unreviewed inc	OA HTT	0	-	-	-	-
Unreviewed inc	Mem. Ser.	3	-	-	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
FFT Responses	**Older Adults**	14	9	• • •	-	-
FFT Responses	CDSS	0	1	• L •	-	-
FFT Responses	OA CMHT	0	0	• • •	-	-
FFT Responses	OA HTT	0	0	• • •	-	-
FFT Responses	Mem. Ser.	14	13	• • •	-	-

Understanding the Performance

Older Adult services account for 21.9% of the total incidents reported across the organisation in July. The most frequently reported incidents for Older Adult community services were patient deaths and adult protection issues.

The engagement team have reviewed how we gather our experience data and how the voice of service users, carers and citizens are incorporated into decision making. To ensure we close the feedback loop we are having a focus with teams on You said we did. We are working with the QI team to manage the impact of this and will be having visible areas in services and ensuring regular communication around this.

Actions

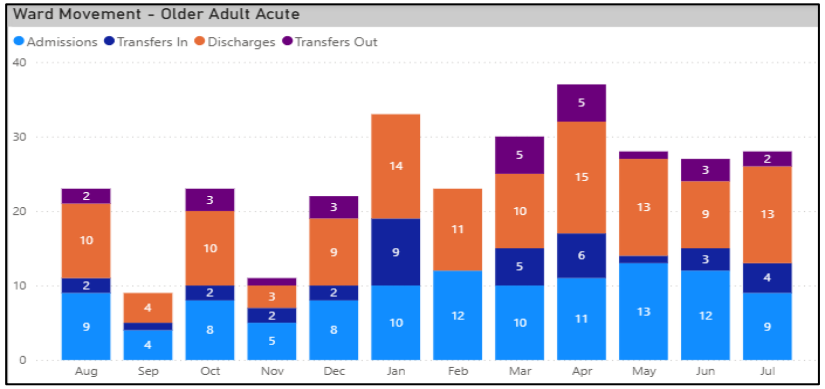
We have collated Friends and Family Test (FFT) data for the last 12 months for each service, looking at key themes from feedback. This will be fed back and clinical teams will be supported by the Quality directorate with an action plan. Patient and carer experience advocates are being recruited across each service to support and additional engagement training will be provided.

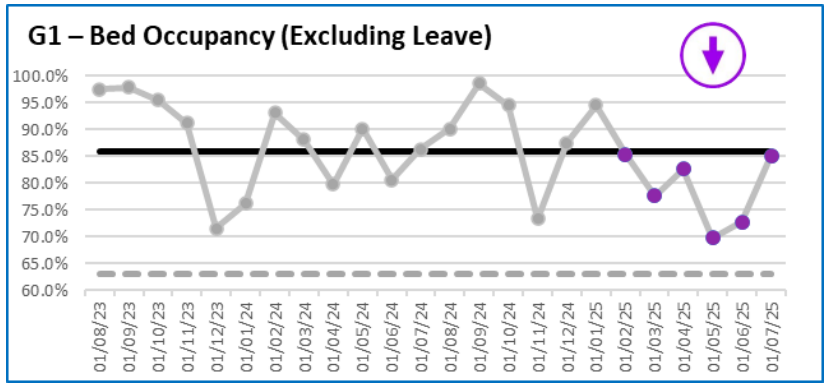
We will calculate mean and variance for unreviewed incidents from next month's reporting.

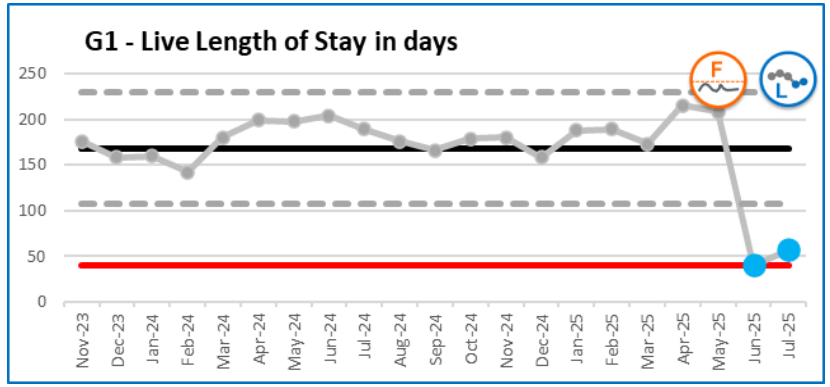
Risks

While incidents remain unreviewed at service level, we cannot be assured that effective learning is taking place or that the appropriate post incident support has been provided. Central review does occur on all incidents and support into teams is offered where deemed appropriate.

Older Adult | Inpatient Wards







Metric	Level	Value	Mean	Var.	Ass.	Target
Admissions	Dovedale 1	4	5	• • •	-	-
Transfers in	Dovedale 1	3	1.1	• • •	-	-
Discharges	Dovedale 1	5	5.3	• • •	-	-
Transfers out	Dovedale 1	2	0.8	• • •	-	-
Bed Occ.	Dovedale 1	88.2%	92.1%	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Admissions	G1	5	4.6	• H •	-	-
Transfers in	G1	1	0	• • •	-	-
Discharges	G1	8	4.6	• • •	-	-
Transfers out	G1	0	1	• • •	-	-
Bed Occ.	G1	85.1%	85.8%	• L •	-	-

Metric	Level	Value	Mean	Var.	Ass.	T.
Discharged LoS (12m)	Dovedale 1	88.8	*	*	*	40
Live LoS	Dovedale 1	60.5	72.2	• • •	?	40
Discharged LoS (12m)	G1	120.1	*	*	*	40
Live LoS	G1	56.7	168.3	• L •	F	40

Understanding the Performance

Occupancy of **G1** has increased from a low of 70% in May but has not been above the mean in 6 months. For this reason it is showing special cause variation.

Live length of stay is still fairly low on both wards – although is still above the target of 40 days. Significant drop on **G1** in June was due to successfully discharging a service user with a LoS of 1,998 days. This has also led to a significant increase in discharged LoS for G1. This metric is a rolling 12-month figure so the long stay will likely affect the figure for 12 months.

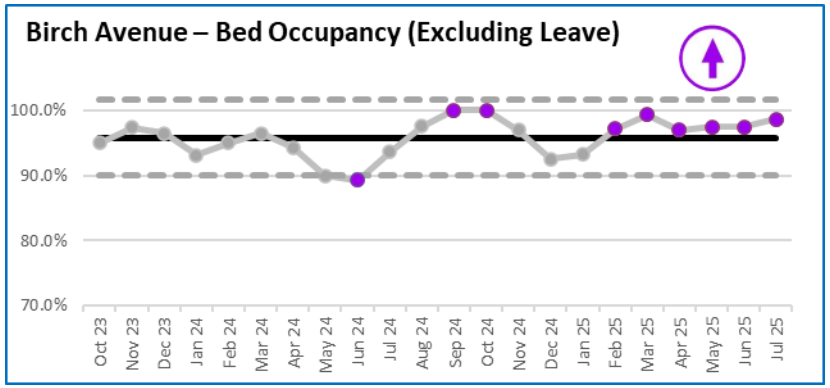
Actions

Longer stay clients are reviewed regularly at MDT meetings and escalations are raised where support is required to find appropriate placements.

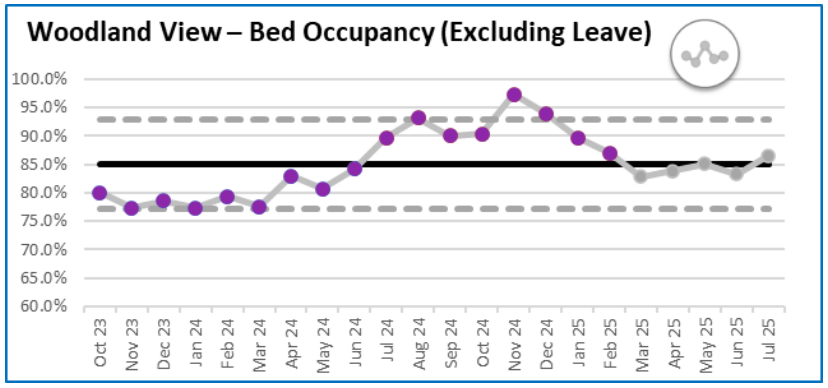
Risks

Longer lengths of stay restrict the access to beds for other service users.

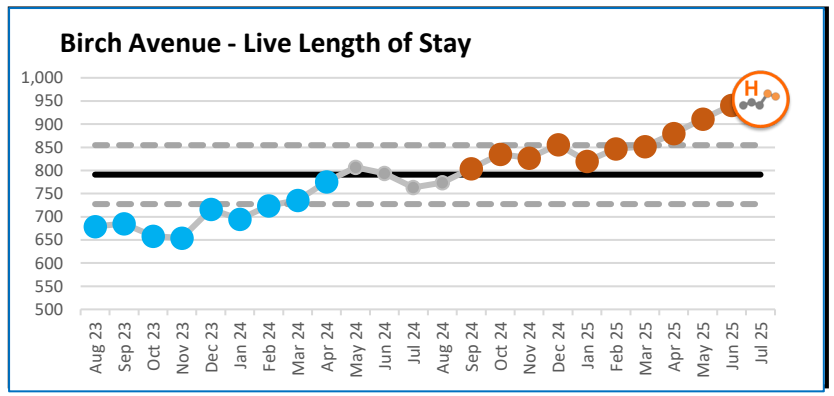
Older Adult | Specialist Nursing Homes



Metric	Level	Value	Mean	Var.	Ass.	Target
Admissions	Birch Ave.	1	1	• L •	-	-
Discharges	Birch Ave.	0	1	• L •	-	-
Bed Occ.	Birch Ave.	98.6%	95.8%	• H •	-	-



Metric	Level	Value	Mean	Var.	Ass.	Target
Admissions	Woodland V.	1	1	• • •	-	-
Discharges	Woodland V.	0	1	• • •	-	-
Bed Occ.	Woodland V.	86.5%	85.0%	• • •	-	-



Metric	Level	Value	Mean	Var.	Ass.	T.
Discharged LoS (12m)	Birch Ave.	550	721	• L •	-	-
Live LoS	Birch Ave.	949	791	• H •	-	-
Discharged LoS (12m)	Woodland V.	731.3	791	• • •	-	-
Live LoS	Woodland V.	915	968	• • •	-	-

Understanding the Performance

Birch Avenue bed occupancy was at capacity (40) at the end of July and has been above the mean in the last 6 months. Live length of stay is in special cause concern and has increased in each of the last 6 months and in July was 124 days over the mean.

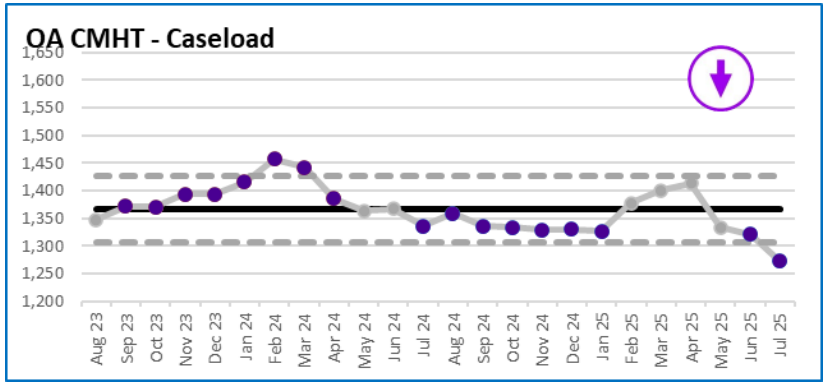
Actions

N/A

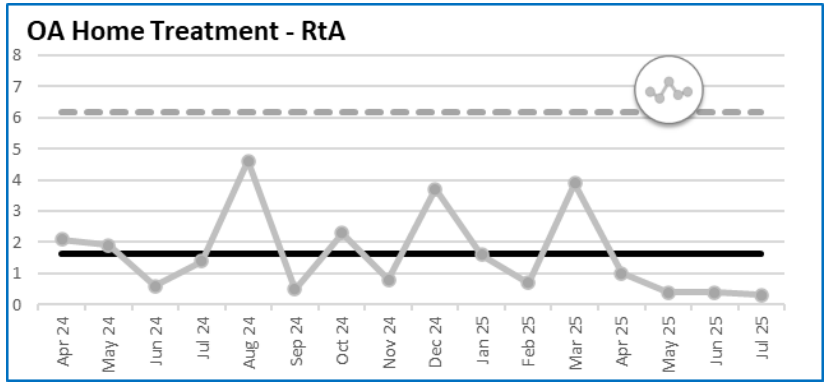
Risks

Birch Avenue has no capacity to take any further residents.

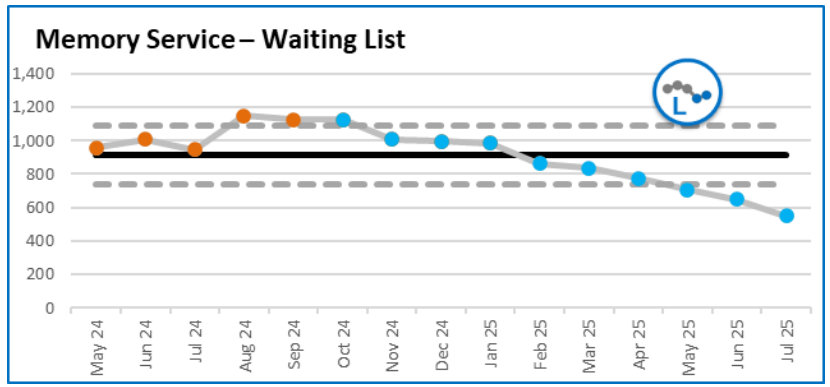
Older Adult | Community Services



Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	OA CMHT	136	129	• • •	-	-
Waiting List	OA CMHT	219	267	• L •	-	-
Wait to Assess	OA CMHT	15.4	12.8	• • •	-	-
Wait to Contact	OA CMHT	17.6	22.9	• H •	-	-
Caseload	OA CMHT	1273	1366	• L •	-	-



Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	OA HTT	31	26	• H •	-	-
Wait to Assess	OA HTT	0.3	1.6	• • •	-	-
Wait to Contact	OA HTT	*	*	*	-	-
Caseload	OA HTT	60	69	• • •	-	-



Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	Mem. Ser.	125	117	• • •	-	-
Waiting List	Mem. Ser.	551	912	• L •	-	-
Wait to Assess	Mem. Ser.	25.1	27.1	• • •	-	-
Wait to Contact	Mem. Ser.	48	-	• • •	-	-
Caseload	Mem. Ser.	4187	4143	• • •	-	-

Understanding the Performance

The execution of a recovery plan in **Memory Service** has been highly effective in halving the waiting list for new assessments from a two year high of 1,150 in Aug-24 to 551 at the end of Jul-25. Wait for Assessment and Contact in **Memory Service** have fallen significantly in July.

Improvements in consistency of activity recording in 2025 has led to lower reported waits for first assessment for **OA HTT**.

OA CMHT caseload fell for 4th successive month in July despite increase in referrals and was at the lowest level in the last two years. It has been below the mean for the last 3 months.

Actions

Initiatives in consistency in activity recording in **OA CMHT** and **OA HTT**.

Guidance and briefings on activity recording have been given to **OA HTT**. This has resulted in improvements in data quality and performance reporting.

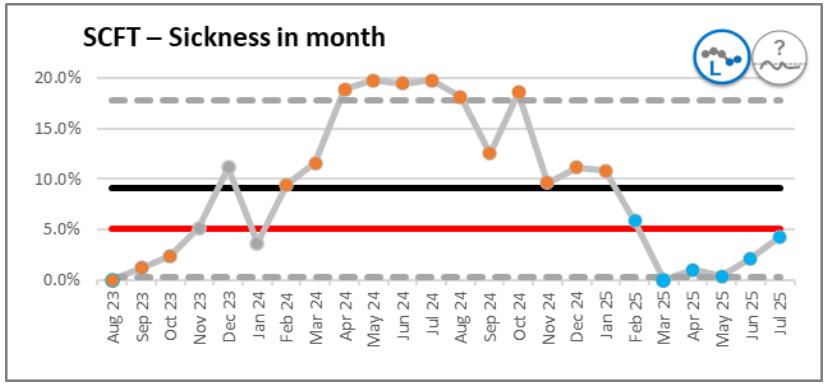
OA CMHT have set up a meeting to review and discuss activity recording.

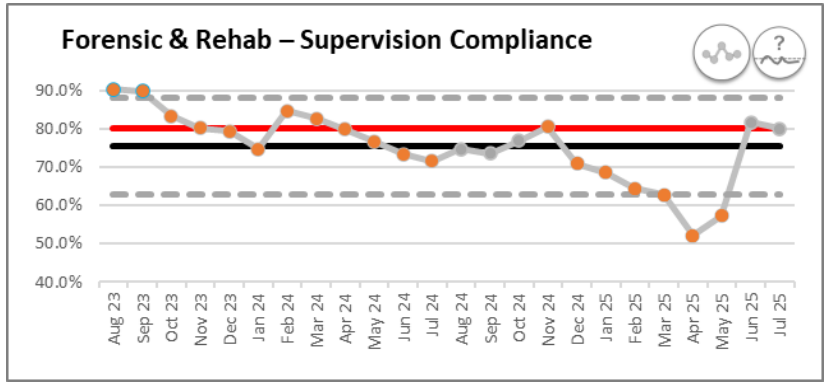
Risks

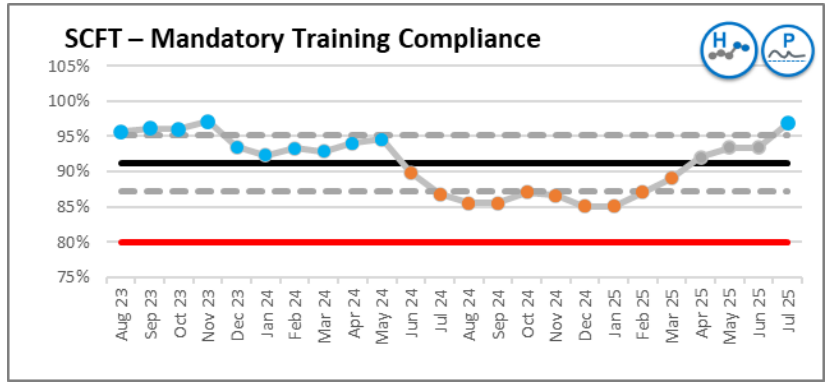
There is a risk that if activity recording does not improve, we will not be assured on wait times reporting.

Recording Diagnoses in Rio commenced in mid April 2025 so there are not enough data points to determine the mean.

Forensic & Rehabilitation | People







Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	**F&R**	**6.5%**	*	*	*	**5.1%**
Sickness	Forest Close	7.0%	8.5%	• • •	?	5.1%
Sickness	Forest Lodge	8.4%	9.5%	• • •	?	5.1%
Sickness	CERT	4.1%	9.1%	• • •	?	5.1%
Sickness	SCFT	4.3%	9.0%	• L •	?	5.1%
Sickness	AOT	4.2%	6.2%	• • •	?	5.1%

Metric	Level	Value	Mean	Var.	Ass.	Target
Supervision	**F&R**	**80.1%**	**75.4%**	• • •	?	**80%**
Supervision	Forest Close	81.6%	80.0%	• • •	?	80%
Supervision	Forest Lodge	77.2%	68.6%	• • •	?	80%
Supervision	CERT	92.9%	73.3%	• • •	?	80%
Supervision	SCFT	81.8%	87.3%	• • •	?	80%
Supervision	AOT	38.5%	69.5%	• • •	?	80%

Metric	Level	Value	Mean	Var.	Ass.	Target
Man. Training	**F&R**	**89.9%**	**91.2%**	• L •	P	**80%**
Man. Training	Forest Close	89.8%	91.5%	• L •	P	80%
Man. Training	Forest Lodge	89.4%	91.6%	• L •	P	80%
Man. Training	CERT	89.0%	90.3%	• • •	P	80%
Man. Training	SCFT	96.9%	91.2%	• H •	P	80%
Man. Training	AOT	90.2%	89.8%	• • •	P	80%

Understanding the Performance

- **Sickness absence rate** for Forensic & Rehab services overall was 6.5%, but this is driven by Forest Lodge and Forest Close which are above target. SCFT shows special cause improvements, while other teams remain in common cause variation.
- **Supervision compliance** is improving with training and support following the initial deterioration since Dec-24 due to recent change in recording system. At the end of Jul-25 overall compliance for F&R services is 80.1% and has returned to common cause variation.
- All F&R services are consistently achieving the 80% target for **mandatory training compliance**.

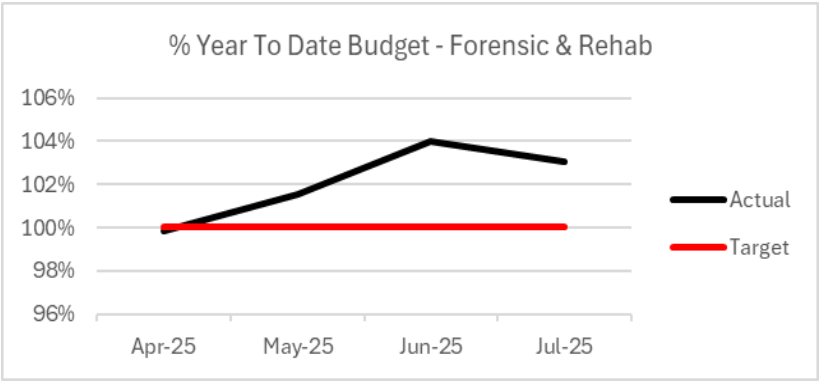
Actions

- All metrics are reported on in team governance meetings and regular reminders are sent for supervision and mandatory training. Support is provided to staff who have issues with recording supervisions.
- Close working and regular meetings with HR colleagues to ensure that people in the sickness process are supported to return to work, particularly in **Forest Close** and **Forest Lodge** where there are a few cases on long term sickness.
- Local action plans are in place and regular monitoring to ensure that teams are delivering and recording regular supervisions.

Risks

While supervision compliance reports improving, sometimes it can fluctuate significantly due to staff being unable to complete it on time due to workload or annual leaves, especially in smaller teams as the new reporting methodology allows wide variation.
High agency and bank usage in **Forest Lodge** required to cover long term sickness gaps causing financial pressures.

Forensic & Rehabilitation | People and Finance



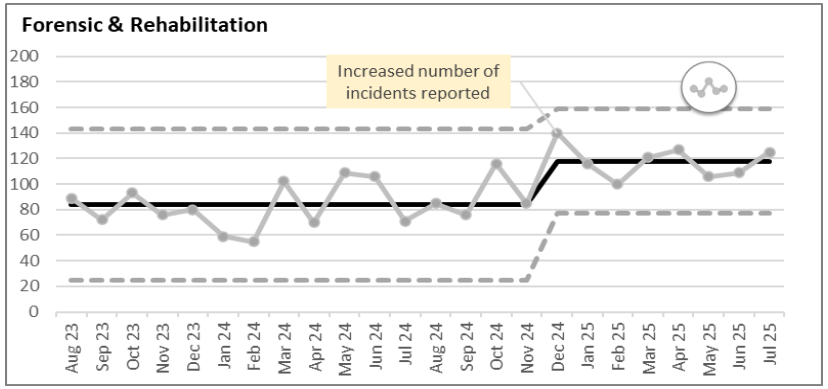
Metric	Level	Value	Mean	Var.	Ass.	Target
Vacancy Rate	**Forensic & Rehab**	**2.5%**	*	*	*	**10%**

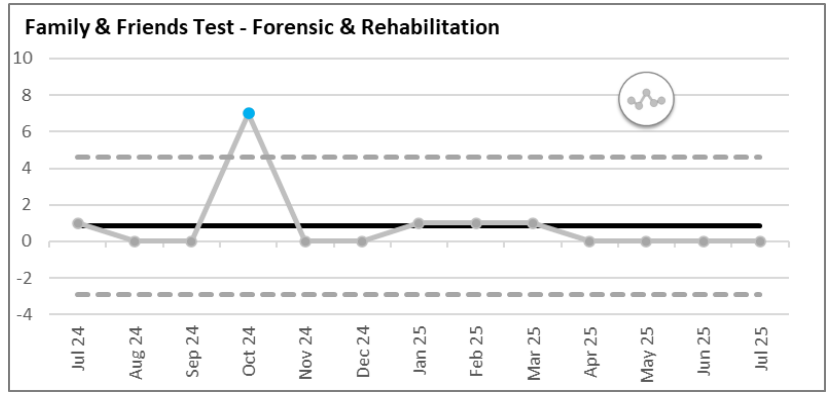
Metric	Level	Value	Mean	Var.	Ass.	Target
Turnover Rate	**Forensic & Rehab**	**10.6%**	*	*	*	**10%**

Metric	Level	Value	Target
YTD Variance to Budget	**F&R**	**103%**	**100%**

Understanding the Performance	Actions	Risks
Vacancies for the Forensic and Rehab service line are minimal – 2.5% under established FTE. Turnover rate is slightly above the trust target of 10%. The budget target has been exceeded in the last 3 of the first 4 months of the financial year, July budget was 103% against target of 100%		

Forensic & Rehabilitation | Safety and Quality





Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	**F&R**	**125**	**118**	•••	-	-
Incidents	Forest Close	49	35	•••	-	-
Incidents	Forest Lodge	70	51	•••	-	-
Incidents	CERT	4	6	•••	-	-
Incidents	SCFT	0	3	•••	-	-
Incidents	AOT	2	3	•••	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Unreviewed incidents	**F&R**	**12**	*	*	-	-
Unreviewed inc.	Forest Close	3	*	*	-	-
Unreviewed inc.	Forest Lodge	4	*	*	-	-
Unreviewed inc.	CERT	5	*	*	-	-
Unreviewed inc.	SCFT	0	*	*	-	-
Unreviewed inc.	AOT	0	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
FFT Responses	**F&R**	**0**	**1**	•••	-	-
FFT Responses	Forest Close	0	1	•••	-	-
FFT Responses	Forest Lodge	0	0	•••	-	-
FFT Responses	CERT	0	0	•••	-	-
FFT Responses	SCFT	0	0	•••	-	-
FFT Responses	AOT	0	0	•••	-	-

Understanding the Performance

Forensic & Rehabilitation services account for 16.4% of the total incidents reported in July, with their most frequent reported incidents being for 'regulation breach due to not completing physical security checks', followed by 'room searches'. There has been a push at Forest Lodge to improve recognition and reporting of security issues since Dec-24.
The engagement team have reviewed how we gather our experience data and how the voice of service users, carers and citizens are incorporated into decision making. To ensure we close the feedback loop we are having a focus with teams on 'you said, we did'. We are working with the QI team to manage the impact of this and will be having visible areas in services and ensuring regular communication around this.

Actions

We have collated Friends and Family Test (FFT) data for the last 12 months for each service, looking at key themes from feedback. This will be fed back and clinical teams will be supported by the Quality directorate with an action plan. Patient and carer experience advocates are being recruited across each service to support and additional engagement training will be provided.

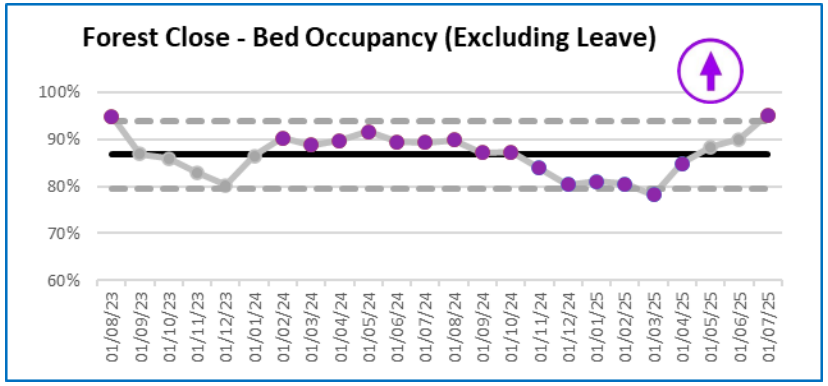
We will calculate mean and variance for unreviewed incidents from next months reporting.

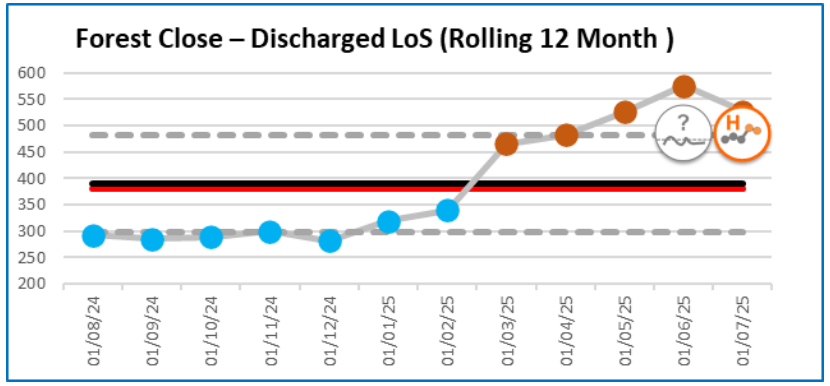
Engaging with Experience & Engagement team to improve utilisation of Family & Friends Test uptake.

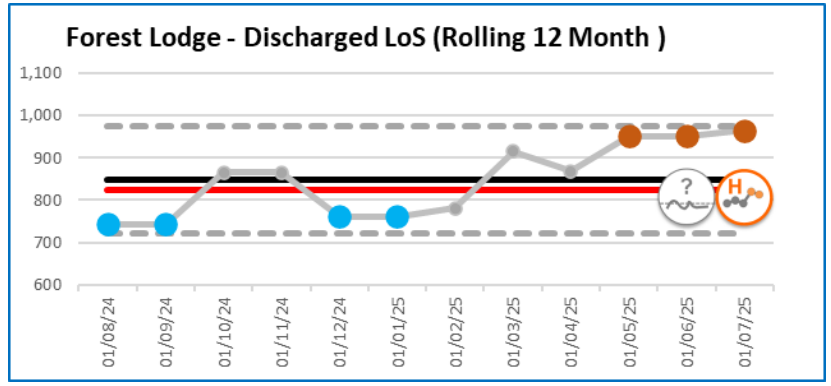
Risks

While incidents remain unreviewed at service level, we cannot be assured that effective learning is taking place or that the appropriate post incident support has been provided. Central review does occur on all incidents and support into teams is offered where deemed appropriate.

Forensic & Rehabilitation | Inpatient Wards







Metric	Level	Value	Mean	Var.	Ass.	Target
Admissions	Forest Close	1	1	• • •	-	-
Transfers in	Forest Close	1	1.5	• • •	-	-
Discharges	Forest Close	0	2	• • •	-	-
Transfers out	Forest Close	0	0.6	• • •	-	-
Bed Occ.	Forest Close	95%	87%	• H •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Admissions	Forest Lodge	0	1	• • •	-	-
Transfers in	Forest Lodge	1	0.6	• • •	-	-
Discharges	Forest Lodge	1	1	• • •	-	-
Transfers out	Forest Lodge	1	0.6	• • •	-	-
Bed Occ.	Forest Lodge	85%	93%	• L •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Discharged LoS (12m)	Forest Close	527	390	• H •	?	380
Live LoS	Forest Close	450	453.5	• • •	F	380
Discharged LoS (12m)	Forest Lodge	965	848	• H •	?	823
Live LoS	Forest Lodge	1075	809.2	• H •	?	823

Understanding the Performance

Forest Lodge admissions are on hold since Mar-25 whilst a comprehensive programme of improvement has been undertaken to address workforce and quality concerns. This is why the bed occupancy for Forest Lodge has reduced significantly in recent months. The one transfer in July was an internal transfer between the two Forest Lodge wards.

The **Forest Close** live length of stay as at the end of July was significantly above the benchmarked target of 380 days. This is significantly skewed by 3 service users with a length of stay over 1000 days (longest stay 1842 days).

Actions

The programme of improvement on **Forest Lodge** has included an increase in therapeutic activity, improving safeguarding processes and reducing restrictive interventions.

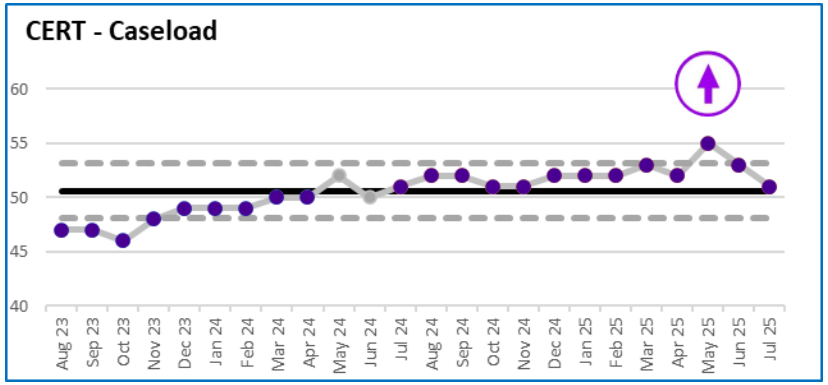
Ongoing meetings with commissioners and internal partners to monitor and improve quality and standards of care at Forest Lodge.

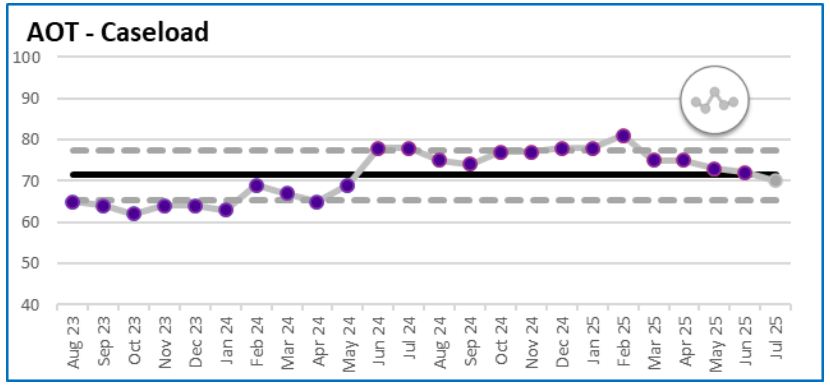
MADE events are being established as part of Home First to work with system partners and resolve discharge delays.

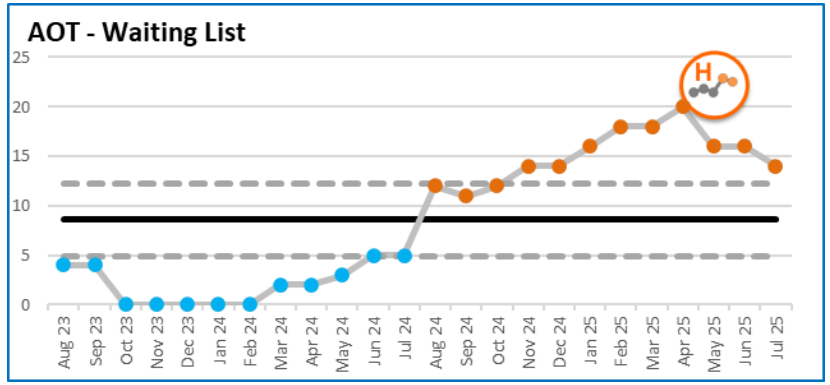
Risks

There is an increased likelihood of incurring financial penalties from South Yorkshire & Bassetlaw Provider Collaborative as a result of underoccupancy at **Forest Lodge** whilst admissions are on hold. There is a requirement to be 93% occupied to avoid financial penalties.

Forensic & Rehabilitation | Community Services







Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	CERT	4	3	• • •	-	-
Wait to Assess	CERT	1	*	*	-	-
Caseload	CERT	51	51	• H •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	SCFT	0	1	• • •	-	-
Wait to Assess	SCFT	0	*	*	-	-
Caseload	SCFT	25	24	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	AOT	1	2	• • •	-	-
Waiting List	AOT	14	9	• H •	-	-
Wait to Assess	AOT	1	*	*	-	-
Caseload	AOT	70	71	• • •	-	-

Understanding the Performance

CERT continues to operate under high caseload - 51 in July. Referrals remain inconsistent in volume and suitability, while transfer delays to CMHT are often impacted by MoJ restrictions, which then impacts the ability to take on new service users.

AOT's waiting list shows marginal reduction in Jul-25, but remains high, driven by staffing constraints and limited transfer to CMHT. There was additional recruitment in May-25 which explains the slight reduction, although demand continues to outweigh the capacity of the service. Referred clients remain on the referrer's caseload until taken on by AOT, however AOT consultation is available for them.

Actions

CERT has worked to support the wider system to accept referrals outside of the usual referral criteria.

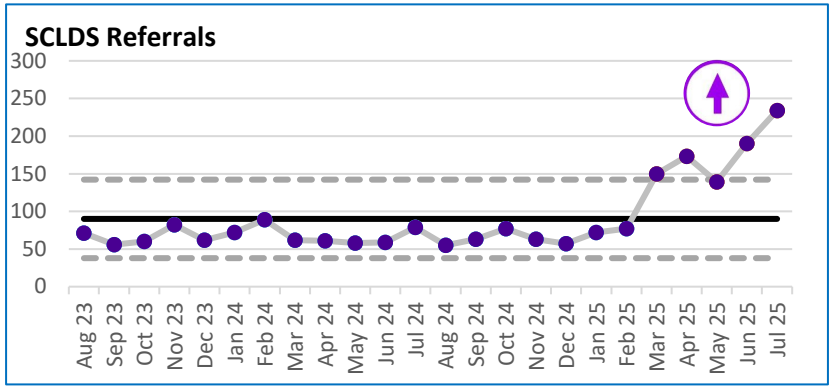
AOT's waiting list is under regular review, with the allocation of keyworkers when capacity allows to reduce waiting times.

Risks

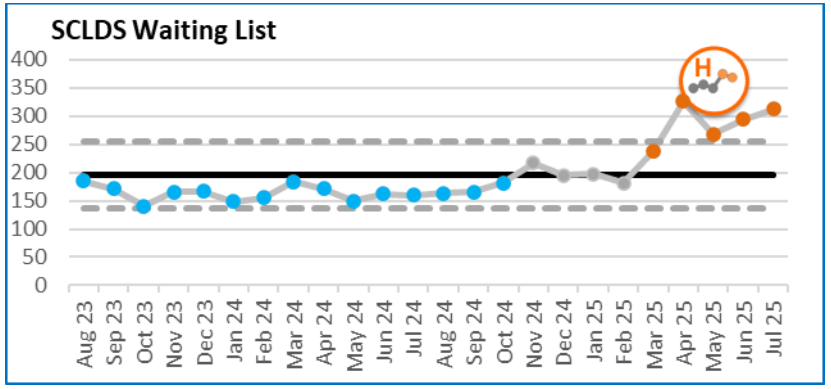
Primary risk across three teams lies in referrals out to CMHT being subject to extended waiting time. This contributes to delayed discharges, high caseload and limit the ability to take new referrals.

Patients on **AOT** waiting list require more intensive, assertive service but are not receiving this whilst on the waiting list.

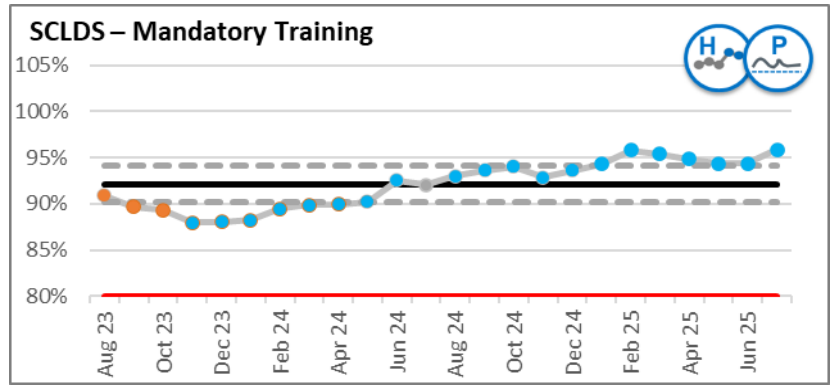
Learning Disabilities | Overview



Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	SCLDS	234	90.0	• H •	-	-
Waiting List	SCLDS	312	195.7	• H •	-	-
Wait to Assess	SCLDS	13.4	8.8	• • •	-	-
Caseload	SCLDS	829	730.7	• H •	-	-



Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	SCLDS	1.1%	4.0%	• • •	?	5.1%
Supervision	SCLDS	90.5%	*	*	*	80%
Mandatory Training	SCLDS	95.8%	92.1%	• H •	?	80%



Metric	Level	Value	Mean	Var.	Ass.	Target
Vacancy Rate %	SCLDS	4.6%	*	*	*	10%
Turnover Rate %	SCLDS	7.1%	*	*	*	10%
YTD Variance to Budget	SCLDS	79.4%	-	-	-	100%

Understanding the Performance

Following the introduction of Rio the team are still working to understand processes and system setup. The spike in referrals is artificial due to the team creating multiple referrals for each individual so they can be assigned by specialty. True referrals are not believed to have increased. This practice should change following optimisation work. Increased referrals due to the understanding of Rio processes since February have resulted in an increase to the waiting list and overall Caseload.

Actions

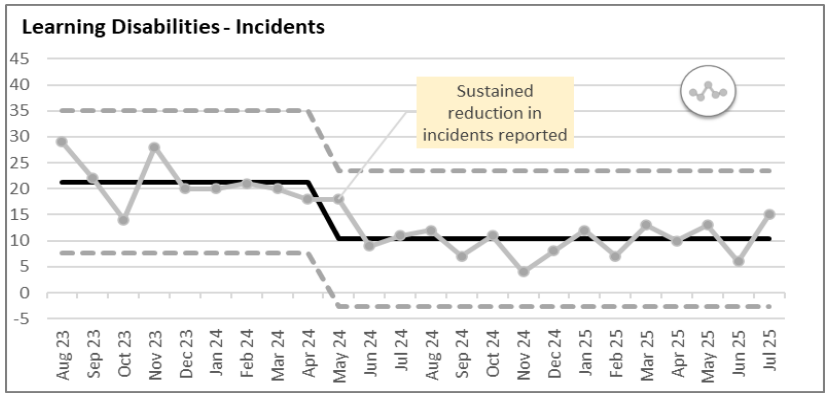
Following Rio optimisation sessions a number of actions have been added to the Rio configuration team worklist. The team are dependent on digital capacity to make these changes.

SCLDS are also changing working practices to use only one referral for each client and add to multiple waiting lists and assign to multiple health care practitioners. This should see referrals, waiting list and caseload reduce over the next 6 months.

Monitor vacancy & turnover rates. Historic data has been requested in order to build a full picture and complete SPC charts.

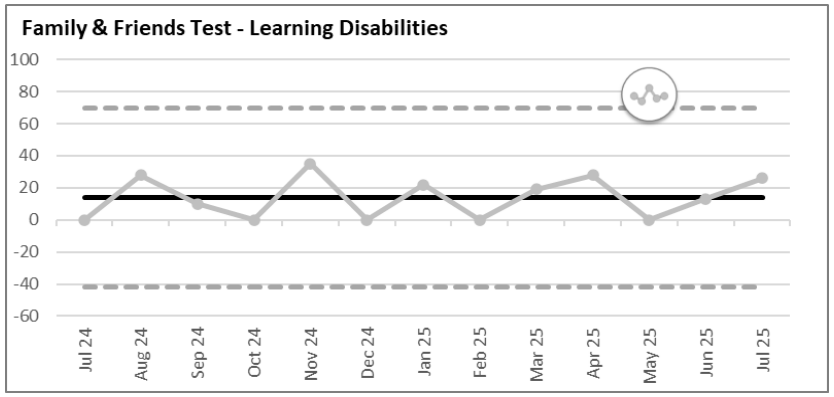
Risks

Learning Disabilities | Safety and Quality



Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	SCLDS	15	10	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Unreviewed incidents	SCLDS	12	*	*	-	-



Metric	Level	Value	Mean	Var.	Ass.	Target
Friends and Family Test Responses	SCLDS	26	14	• • •	-	-

Understanding the Performance

- Learning Disabilities service account for 2% of the total incidents reported across the organisation in July, with their most frequent reported incidents being for Clinical records/documentation, patient death, prescribing.
- The engagement team have reviewed how we gather our experience data and how the voice of service users, carers and citizens are incorporated into decision making. To ensure we close the feedback loop we are having a focus with teams on **You said we did.** We are working with the QI team to manage the impact of this and will be having visible areas in services and ensuring regular communication around this.

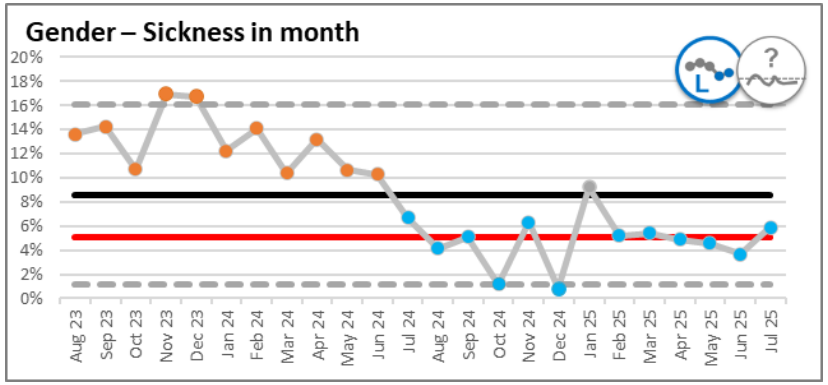
Actions

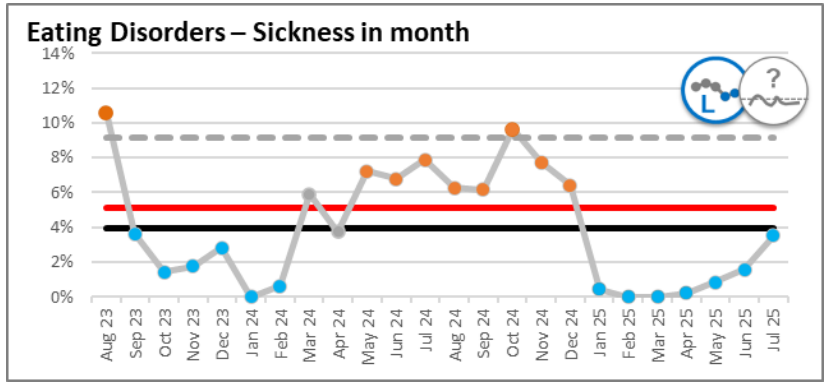
- We have collated Friends and Family Test (FFT) data for the last 12 months for each service, looking at key themes from feedback. This will be fed back and clinical teams will be supported by the Quality directorate with an action plan. Patient and carer experience advocates are being recruited across each service to support and additional engagement training will be provided.
- We will calculate mean and variance for unreviewed incidents from next month's reporting.

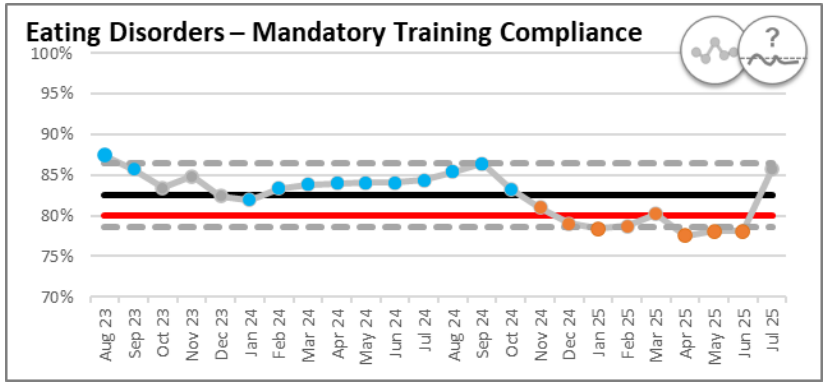
Risks

While incidents remain unreviewed at service level, we cannot be assured that effective learning is taking place or that the appropriate post incident support has been provided. Central review does occur on all incidents and support into teams is offered where deemed appropriate.

Highly Specialist Services | People







Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	**HSS**	**6.4%**	*	*	*	**5.1%**
Sickness	Gender	5.9%	8.6%	• L •	?	5.1%
Sickness	Eating Dis.	3.5%	4.0%	• L •	?	5.1%
Sickness	SAANS	1.3%	4.9%	• • •	?	5.1%
Sickness	Perinatal	6.3%	8.1%	• • •	?	5.1%
Sickness	HAST	0.0%	8.5%	• L •	?	5.1%

Metric	Level	Value	Mean	Var.	Ass.	Target
Supervision	**HSS**	**86.3%**	*	*	*	**80%**
Supervision	Gender	76.5%	62.3%	• • •	?	80%
Supervision	Eating Dis.	94.1%	44.5%	• • •	?	80%
Supervision	SAANS	100%	87.7%	• • •	?	80%
Supervision	Perinatal	84.6%	67.7%	• • •	?	80%
Supervision	HAST	100%	39.1%	• • •	?	80%

Metric	Level	Value	Mean	Var.	Ass.	Target
Man. Training	**HSS**	**91.0%**	**90.0%**	• H •	P	**80%**
Man. Training	Gender	88.0%	87.3%	• H •	P	80%
Man. Training	Eating Dis.	85.8%	82.6%	• • •	?	80%
Man. Training	SAANS	94.3%	93.9%	• • •	P	80%
Man. Training	Perinatal	87.5%	89.7%	• • •	P	80%
Man. Training	HAST	75.9%	*	*	*	80%

Understanding the Performance

- Following the implementation of a recovery plan, **Eating Disorders** has improved mandatory training compliance to 85.8%, the first time they have achieved the target in 9 months.
- The SMT have worked with team managers and clinical leads to ensure that there is an improvement in supervision recording to ensure standards and targets are met.
- Increased staffing in the **Gender Identity Clinic** combined with work by the Organisational Development team has provided resilience and staff feeling better supported. Sickness absence has reduced over the last 12 months.

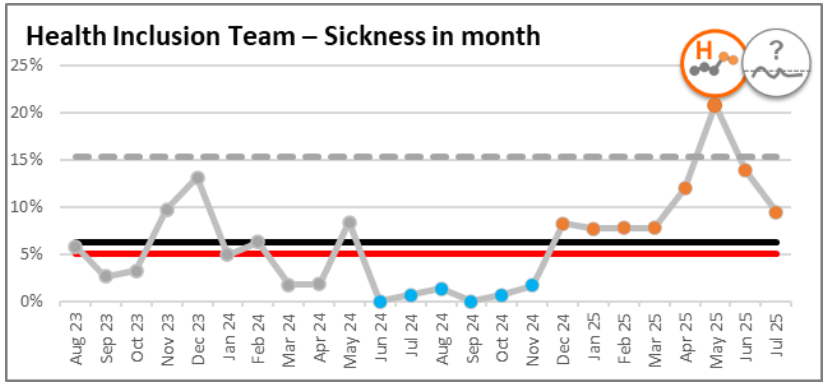
Actions

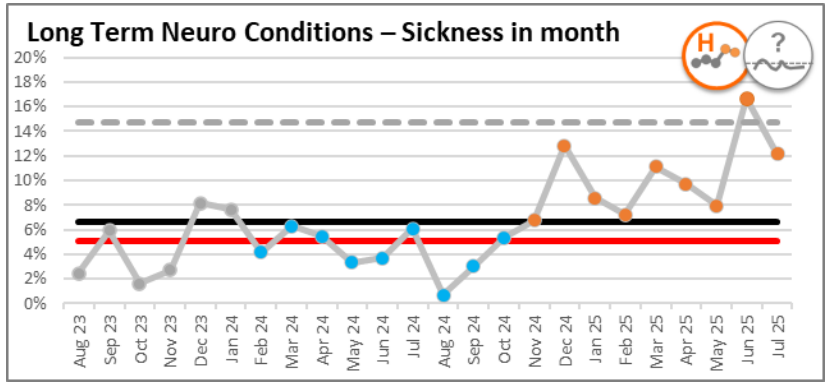
- Continued proactive approach for mandatory training as per the **Eating Disorders** recovery plan – ensuring that this time is built into job planning and becomes regular practice in embedding the new way of working.
- Close working with HR colleagues to ensure that people in the sickness process are supported to return to work.

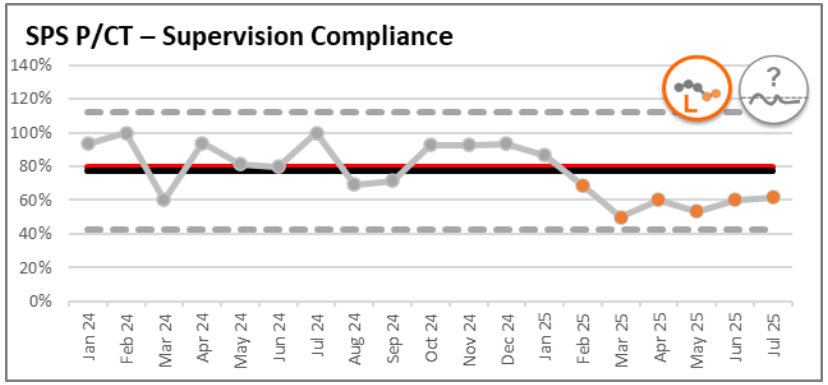
Risks

- There is a risk that the supervision reporting can fluctuate significantly, especially in smaller teams as the new reporting methodology allows wide variation due to the smaller window of opportunity (6 weeks).

Highly Specialist Services | People







Metric	Level	Value	Mean	Var.	Ass.	Target
Sickness	SPS MAPPS	6.1%	7.0%	• • •	?	5.1%
Sickness	SPS P/CT	11.3%	6.5%	• • •	?	5.1%
Sickness	Psy. Sexual	0.0%	3.3%	• • •	?	5.1%
Sickness	HIT	9.5%	6.2%	• H •	?	5.1%
Sickness	LTNC	12.1%	6.6%	• H •	?	5.1%
Sickness	ME/CFS	0.0%	1.8%	• L •	?	5.1%

Metric	Level	Value	Mean	Var.	Ass.	Target
Supervision	SPS MAPPS	92.3%	84.7%	• • •	?	80.0%
Supervision	SPS P/CT	61.5%	77.3%	• L •	?	80.0%
Supervision	Psy. Sexual	80.0%	92.7%	• • •	?	80.0%
Supervision	HIT	92.3%	83.9%	• • •	?	80.0%
Supervision	LTNC	89.3%	69.9%	• • •	?	80.0%
Supervision	ME/CFS	81.8%	79.6%	• • •	?	80.0%

Metric	Level	Value	Mean	Var.	Ass.	Target
Man. Training	SPS MAPPS	96.9%	94.1%	• H •	P	80.0%
Man. Training	SPS P/CT	94.7%	90.5%	• H •	P	80.0%
Man. Training	Psy. Sexual	99.3%	*	*	*	80.0%
Man. Training	HIT	93.5%	95.8%	• • •	P	80.0%
Man. Training	LTNC	90.1%	89.8%	• • •	P	80.0%
Man. Training	ME/CFS	95.0%	92.1%	• H •	P	80.0%

Understanding the Performance

Specialist Psychotherapy Service Personality/Complex Trauma team were consistently under performing for 6 months against supervision compliance targets due to various reasons, including recording issues. There is an action plan to address this and we anticipate an improvement in August's report.

Note excellent mandatory training compliance above 90% across all teams on this page.

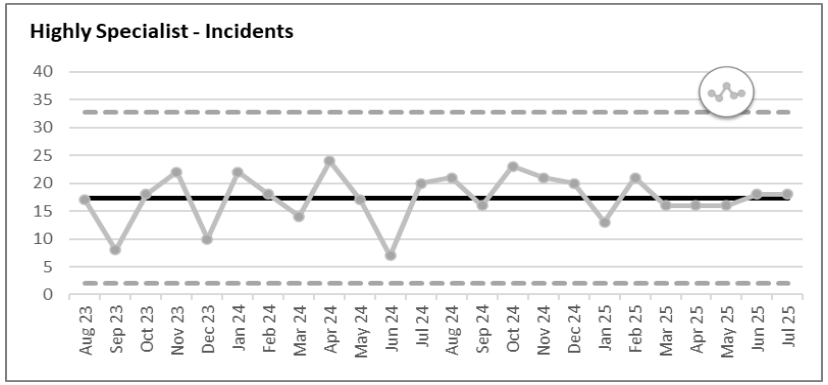
Actions

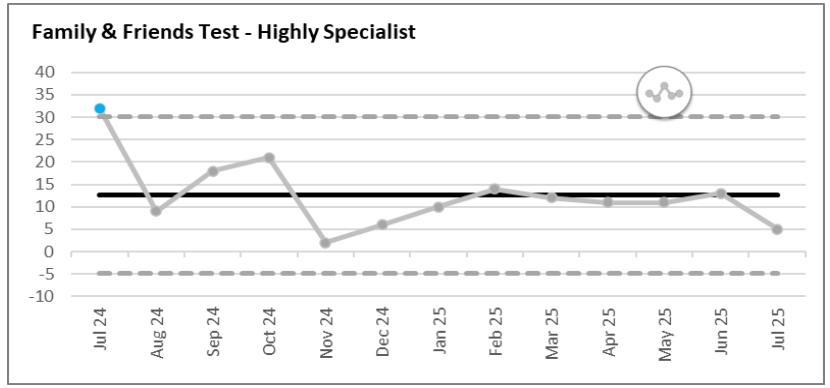
There have been higher than average sickness absence levels in both **Long Term Neurological Conditions** and **Health Inclusion Team** that are unrelated to work. The managers in both areas are working closely with individuals and HR to support safe transition back into work.

Risks

N/A

Highly Specialist Services | Safety and Quality





Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	**HSS**	**18**	**17**	•••	-	-
Incidents	Gender	2	2	•••	-	-
Incidents	Eating Dis.	2	1	•••	-	-
Incidents	SAANS	0	1	•••	-	-
Incidents	Perinatal	0	3	•••	-	-
Incidents	HAST	2	1	•••	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Unreviewed inc.	**HSS**	**4**	*	*	-	-
Unreviewed inc.	Gender	0	*	*	-	-
Unreviewed inc.	Eating Dis.	2	*	*	-	-
Unreviewed inc.	SAANS	0	*	*	-	-
Unreviewed inc.	Perinatal	0	*	*	-	-
Unreviewed inc.	HAST	0	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
FFT Responses	**HSS**	**5**	**13**	•••	-	-
FFT Responses	Gender	0	0	•••	-	-
FFT Responses	Eating Dis.	0	0	•••	-	-
FFT Responses	SAANS	2	6	•••	-	-
FFT Responses	Perinatal	0	0	•••	-	-
FFT Responses	HAST	0	0	•••	-	-

Understanding the Performance

- Highly Specialist Services account for 2.4% of the total incidents reported across the organisation in July, with their most frequent reported incidents being for IT & Information Governance.
- The Engagement Team have reviewed how we gather our experience data and how the voice of service users, carers and citizens are incorporated into decision making. To ensure we close the feedback loop we are having a focus with teams on ‘you said, we did’. We are working with the QI team to manage the impact of this and will be having visible areas in services and ensuring regular communication around this.

Actions

We have collated Friends and Family Test (FFT) data for the last 12 months for each service, looking at key themes from feedback. This will be fed back and clinical teams will be supported by the Quality directorate with an action plan. Patient and carer experience advocates are being recruited across each service to support and additional engagement training will be provided.

We will calculate mean and variance for unreviewed incidents from next month’s reporting.

Risks

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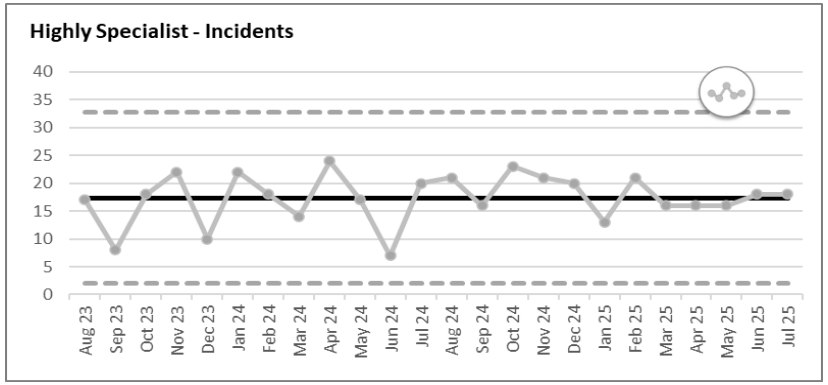
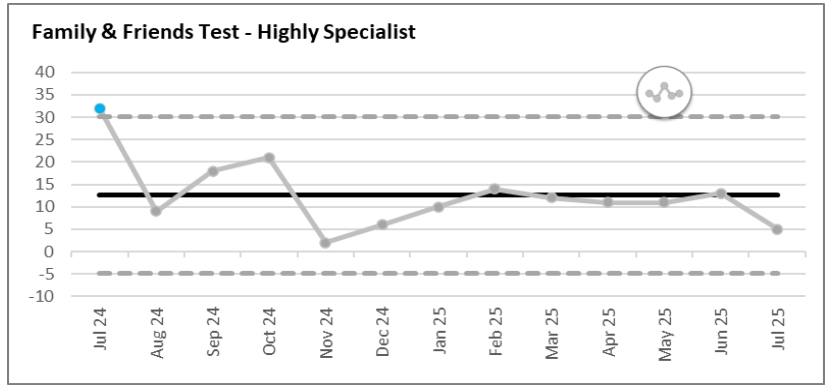
Highly Specialist Services | Safety and Quality





Metric	Level	Value	Mean	Var.	Ass.	Target
Incidents	SPS MAPPS	0	1	•••	-	-
Incidents	SPS P/CT	1	1	•••	-	-
Incidents	Psy. Sexual	0	0	•••	-	-
Incidents	HIT	0	0	•••	-	-
Incidents	LTNC	2	3	•••	-	-
Incidents	ME/CFS	0	0	•••	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Unreviewed inc.	SPS MAPPS	0	*	*	-	-
Unreviewed inc.	SPS P/CT	0	*	*	-	-
Unreviewed inc.	Psy. Sexual	0	*	*	-	-
Unreviewed inc.	HIT	0	*	*	-	-
Unreviewed inc.	LTNC	0	*	*	-	-
Unreviewed inc.	ME/CFS	0	*	*	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
FFT Responses	SPS MAPPS	0	0	•••		-
FFT Responses	SPS P/CT	0	0	•••		-
FFT Responses	Psy. Sexual	0	0	•••		-
FFT Responses	HIT	0	0	•••		-
FFT Responses	LTNC	2	1	•••		-
FFT Responses	ME/CFS	1	3	•••		-

Understanding the Performance

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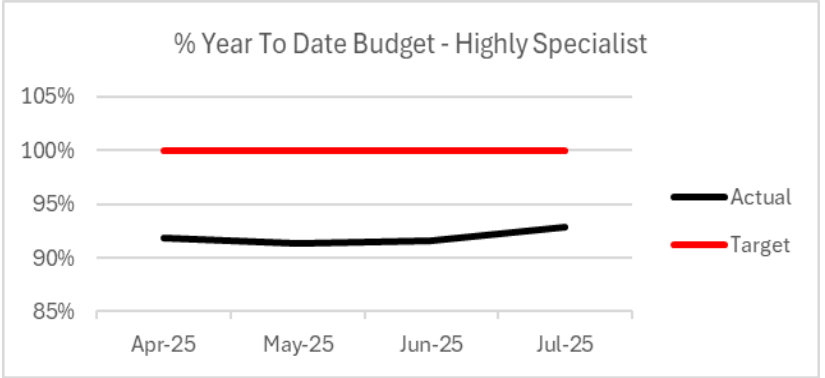
Highly Specialist Services | People and Finance



Metric	Level	Value	Mean	Var.	Ass.	Target
Vacancy Rate	**HSS**	**11.3%**	*	*	*	**10%**

Metric	Level	Value	Mean	Var.	Ass.	Target
Turnover Rate	**HSS**	**10.6%**	*	*	*	**10%**

Metric	Level	Value	Target
YTD Variance to Budget	**HSS**	**92.9%**	**100%**

Understanding the Performance

Highly Specialist vacancy rate was slightly over the target in the month of July.

Turnover rate was also slightly above the 10% target.

The service line have been underspent for every month of this financial year. The year-to-date position as of July has the service at 7.1% below budget. This is due to a high vacancy rate and lower bank and agency usage than other service lines. Specialist roles in HSS are often more difficult to recruit to both substantively and on a temporary basis.

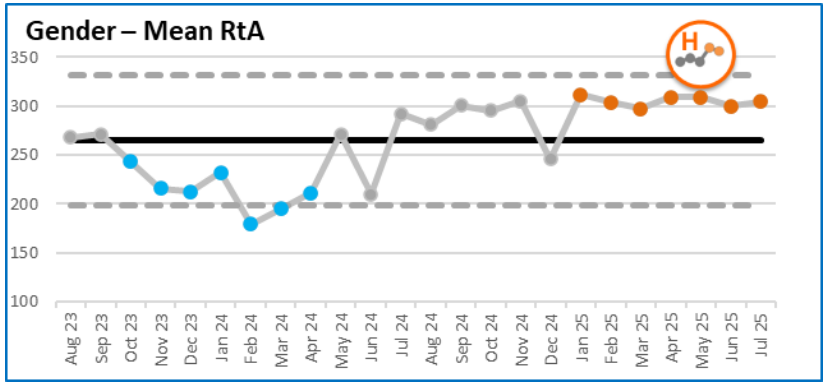
Actions

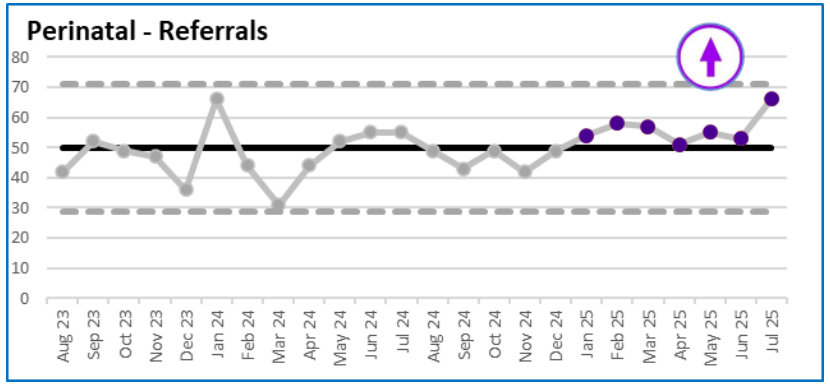
A decision has been made to pause recruitment in Long Term Neurological Conditions while the service review is ongoing.

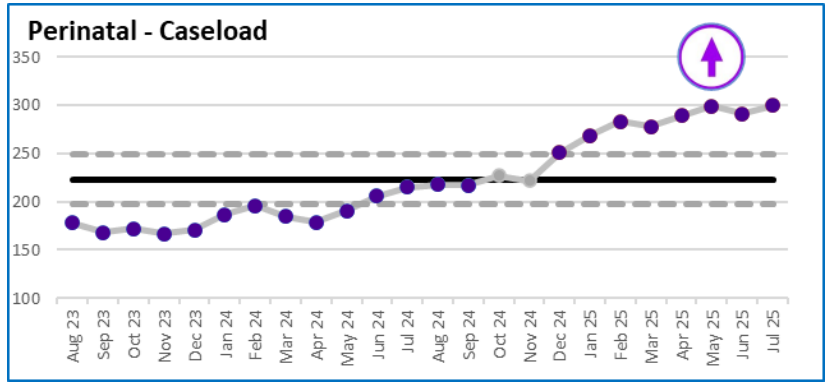
Risks

There is a risk that waiting times will continue to worsen and wait lists increase if services are not fully staffed.

Highly Specialist | Gender, Eating Disorders, Perinatal







Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	Gender	41	36	• • •	-	-
Waiting List	Gender	2391	2381	• • •	-	-
Wait to Assess	Gender	304.6	265.1	• H •	-	-
Wait to Treat	Gender	*	*	*	-	-
Caseload	Gender	3341	3348	• • •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	Eating Dis.	41	42	• • •	-	-
Waiting List	Eating Dis.	41	34	• • •	-	-
Wait to Assess	Eating Dis.	5.2	5.6	• • •	-	-
Wait to Contact	Eating Dis.	*	*	*	-	-
Caseload	Eating Dis.	229	202	• H •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	Perinatal	66	50	• H •	-	-
Waiting List	Perinatal	40	32	• H •	-	-
Wait to Assess	Perinatal	4.1	3.5	• • •	-	-
Wait to Contact	Perinatal	*	*	*	-	-
Caseload	Perinatal	300	223	• H •	-	-

Understanding the Performance

The waiting list for **Gender** remains in common cause variation and has stabilised around the mean due to increased capacity within the team to deliver assessments. As at the end of July 2025, the service had delivered 124 assessments in 2025/26 and are on track to exceed their annual target of 170 assessments. The aim is to ensure that the number of assessments delivered per month meets demand from the number of referrals per month to prevent waiting list and waiting times from increasing.

Referrals to **Perinatal** have been above the mean for 7 consecutive months. This is aligned to the national long-term expansion plan to increase the access rate to 7.5% of the population of pregnant and expectant mother through assertive promotion. The access rate counts the number of individuals that received at least one contact with the service in a rolling 12-month period. The service has exceeded the national target for 3 consecutive months. We expect this success to continue.

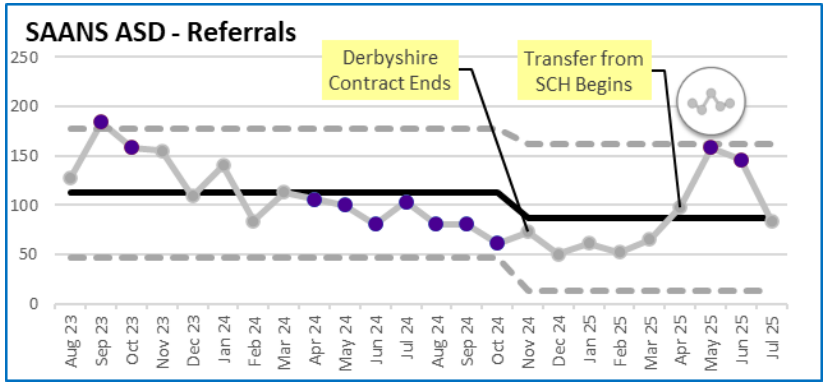
Actions

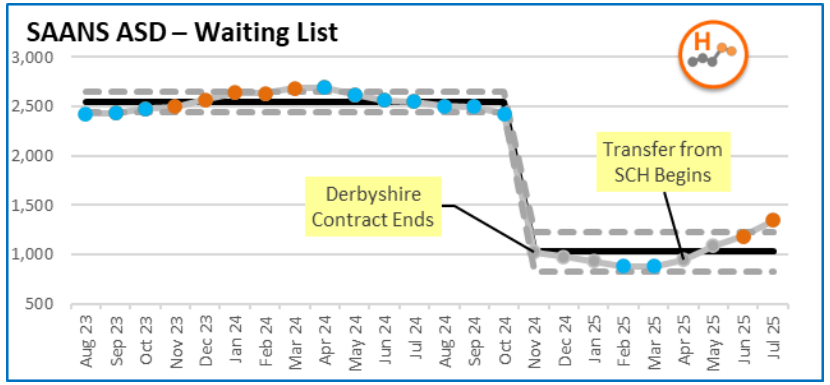
- **Eating Disorders** will receive additional investment to increase its workforce to expand its community provision into Barnsley Doncaster and Rotherham. This is presently in the mobilisation phase with posts out to advert and new SY bases being identified. The aim of the expanded service is to provide better connected care to people in their locality and will enable more patients to be assessed and treated annually.
- An action was identified in Rio optimisation workshops for the configuration team to ensure that all treatment activities are linked to a relevant SNOMED code. Once this has been completed, we will be able to report accurate data for referral to treatment wait times.

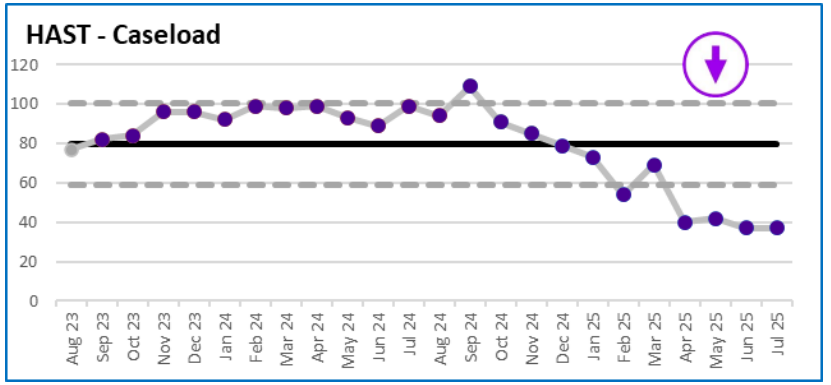
Risks

- Increased waits for psychological therapies in **Perinatal** due to an increased demand and short-term capacity gaps due to maternity leave arrangements. This has led to longer lengths of stay for some individuals therefore increasing caseload numbers.
- There is a risk that increased number of assessments in **Gender** creates internal waits for diagnosis and in other parts of the pathway.

Highly Specialist | SAANS ASD, ADHD, HAST







Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	SAANS ASD	84	87	• • •	-	-
Waiting List	SAANS ASD	1346	1029	• H •	-	-
Wait to Assess	SAANS ASD	75.4	79.0	• • •	-	-
Wait to Contact	SAANS ASD	*	*	*	-	-
Caseload	SAANS ASD	2168	2632	• L •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	SAANS ADHD	95	70	• • •	-	-
Waiting List	SAANS ADHD	4601	4268	• • •	-	-
Wait to Assess	SAANS ADHD	251.5	*	*	-	-
Wait to Contact	SAANS ADHD	*	*	*	-	-
Caseload	SAANS ADHD	4603	5106	• L •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	HAST	9	13	• L •	-	-
Waiting List	HAST	13	28	• L •	-	-
Wait to Assess	HAST	7.9	7.9	• • •	-	-
Wait to Contact	HAST	*	*	*	-	-
Caseload	HAST	37	80	• L •	-	-

Understanding the Performance

SAANS ASD referral levels have returned to the mean following a spike over the last two months. This spike relates to the block transfer of service users from Sheffield Children's Hospital (SCH) and has resulted in an increased waiting list. The transfer of patients is now complete so we would expect referral and waiting list levels to stabilise in the coming months.

HAST referral levels have decreased significantly since the Changing Futures funding ended in March 2025. We understand that agencies within the city have interpreted this as the closure of HAST. Waiting list and caseload figures remain low due to more stringent referral management to ensure that the reduced team are able to manage the workload safely and effectively.

Actions

A plan is being developed to implement a nurse led model in **SAANS ADHD** which will significantly increase capacity to deliver assessments and help reduce the waiting lists. SPC charts will be developed for ADHD waiting times in Dec-25 when there are enough data points available from when assessments recommenced in September 2024 after being paused in June 2023.

Further communications to agencies within the city to address the low referral levels in **HAST.**

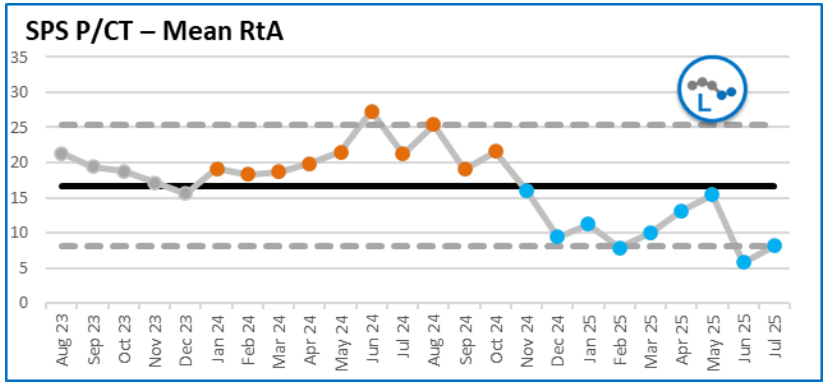
HAST will receive increased investment to expand its workforce to be able to deliver against the new service specification. Work is underway to review and identify the most appropriate workforce to deliver against the specification requirements.

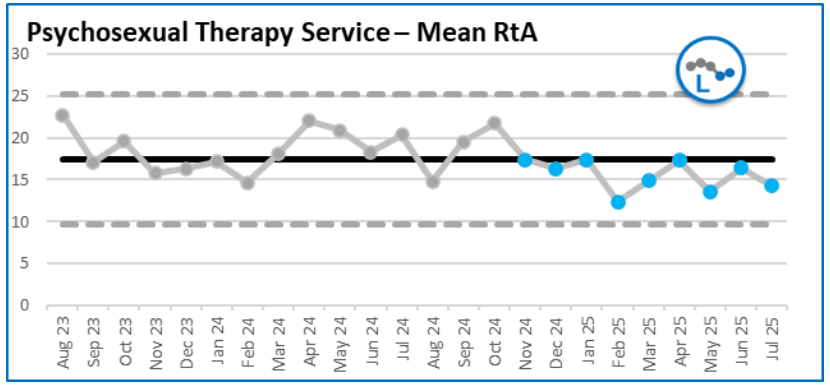
An action was identified in Rio optimisation workshops for the configuration team to ensure that all treatment activities are linked to a relevant SNOMED code. Once this has been completed, we will be able to report accurate data for referral to treatment wait times.

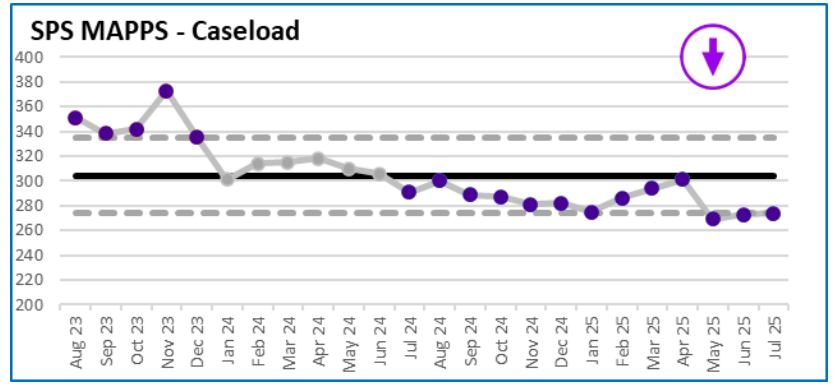
Risks

There is a risk that the demand for **ADHD** assessment continues to outweigh the capacity of the team to deliver assessments.

Highly Specialist | SPS MAPPS, P/CT, Psychosexual Therapy







Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	SPS MAPPS	28	35	•••	-	-
Waiting List	SPS MAPPS	*	*	*	-	-
Wait to Assess	SPS MAPPS	18.8	17.0	•••	-	-
Wait to Treat.	SPS MAPPS	*	*	*	-	-
Caseload	SPS MAPPS	274	304	• L •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	SPS P/CT	16	15	•••	-	-
Waiting List	SPS P/CT	*	*	*	-	-
Wait to Assess	SPS P/CT	8.2	16.7	• L •	-	-
Wait to Treat.	SPS P/CT	*	*	*	-	-
Caseload	SPS P/CT	184	203	• L •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	Psy. Sexual	22	19	•••	-	-
Waiting List	Psy. Sexual	44	50	•••	-	-
Wait to Assess	Psy. Sexual	14.2	17.4	• L •	-	-
Wait to Treat.	Psy. Sexual	*	*	*	-	-
Caseload	Psy. Sexual	126	125	•••	-	-

Understanding the Performance

The mean referral to assessment wait times for **SPS P/CT** have sustained below the mean for 9 consecutive months due to increased staff capacity to deliver assessments in a timely manner. The service strives to assess service users within 18 weeks of referral and are exceeding this target.

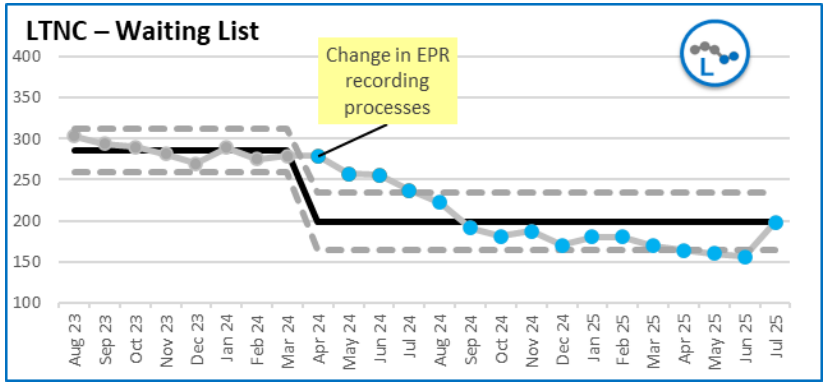
Actions

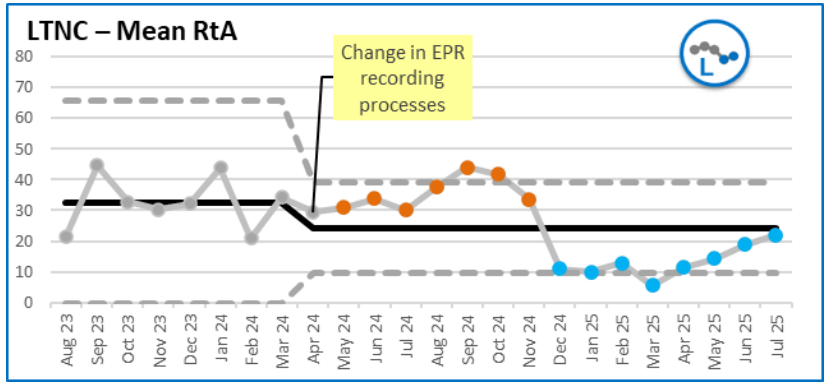
SPS teams continue to work with Digital configuration colleagues to develop suitable waiting lists in the EPR. Once this is resolved, we will be able to report accurate data for waiting lists.
Work is ongoing in **SPS** with Highly Specialist leadership to work towards the VIP programme and developing a QEIA.
An action was identified in Rio optimisation workshops for the configuration team to ensure that all treatment activities are linked to a relevant SNOMED code. Once this has been completed, we will be able to report accurate data for referral to treatment wait times.

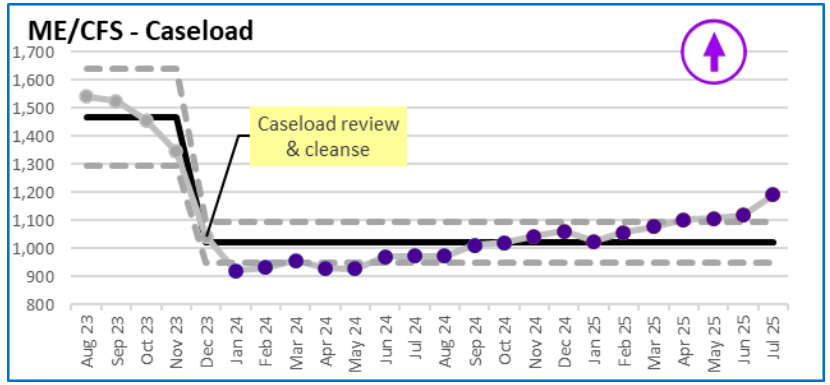
Risks

The ongoing work with Digital configuration teams means that there is currently a risk that we are unable to accurately report on our wait lists and RtT wait times from Rio data in **SPS**. This risk may lead to difficulty in managing wait times.

Highly Specialist | HIT, LTNC, ME/CFS







Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	HIT	208	185	• • •	-	-
Waiting List	HIT	132	128	• • •	-	-
Wait to Assess	HIT	3.6	3.3	• • •	-	-
Caseload	HIT	1777	1676	• H •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	LTNC	71	75	• • •	-	-
Waiting List	LTNC	198	199	• L •	-	-
Wait to Assess	LTNC	22.1	24.2	• L •	-	-
Wait to Contact	LTNC	*	*	*	-	-
Caseload	LTNC	540	492	• H •	-	-

Metric	Level	Value	Mean	Var.	Ass.	Target
Referrals	ME/CFS	83	65	• • •	-	-
Waiting List	ME/CFS	162	145	• • •	-	-
Wait to Assess	ME/CFS	22.2	24.3	• L •	-	-
Wait to Contact	ME/CFS	*	*	*	-	-
Caseload	ME/CFS	1191	1022	• H •	-	-

Understanding the Performance

The waiting list for **LTNC** has significantly decreased since April 2024 when a change was made in the way that referrals were logged on to the EPR system. There has also been improvement with the referral to assessment wait times – with a shift of 8 months below the mean. This is following some work with the waiting less, waiting well QI collaborative.
The figure for referrals to **ME/CFS** covers only new referrals to the team and not referrals that have been re-referred following a request for further information from GPs. The team have trialled a new way of working in July 2025, with referrals requiring additional information being put on to a holding waiting list instead of being declined and needing re-referral as previously. This should help to report the referrals and wait times more accurately.

Actions

A whole **LTNC** service review began with capacity and demand work for speech and language therapy which concluded in Jul-25. Further review of all clinical pathways will begin in August to effectively model the capacity and workforce required to deliver safe and effective care to the people who require the service. An update on timescales and expected benefits will be shared in the next report.

Risks

People awaiting a swallowing (dysphagia) assessment in **LTNC** are experiencing long waits due to clinical capacity issues related to long-term sickness and recent recruitment difficulties. As a result, people may experience increased swallowing difficulties and exacerbation of serious associated symptoms that could lead to hospital admission.

SystmOne data quality issues continue to be an escalated unaddressed risk that is being discussed with Digital colleagues presently. There is a risk that the performance data quality will continue to be below expected standards creating barriers for teams and ops leads to address any issues of under performance.

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Appendices

Proud to care in Sheffield

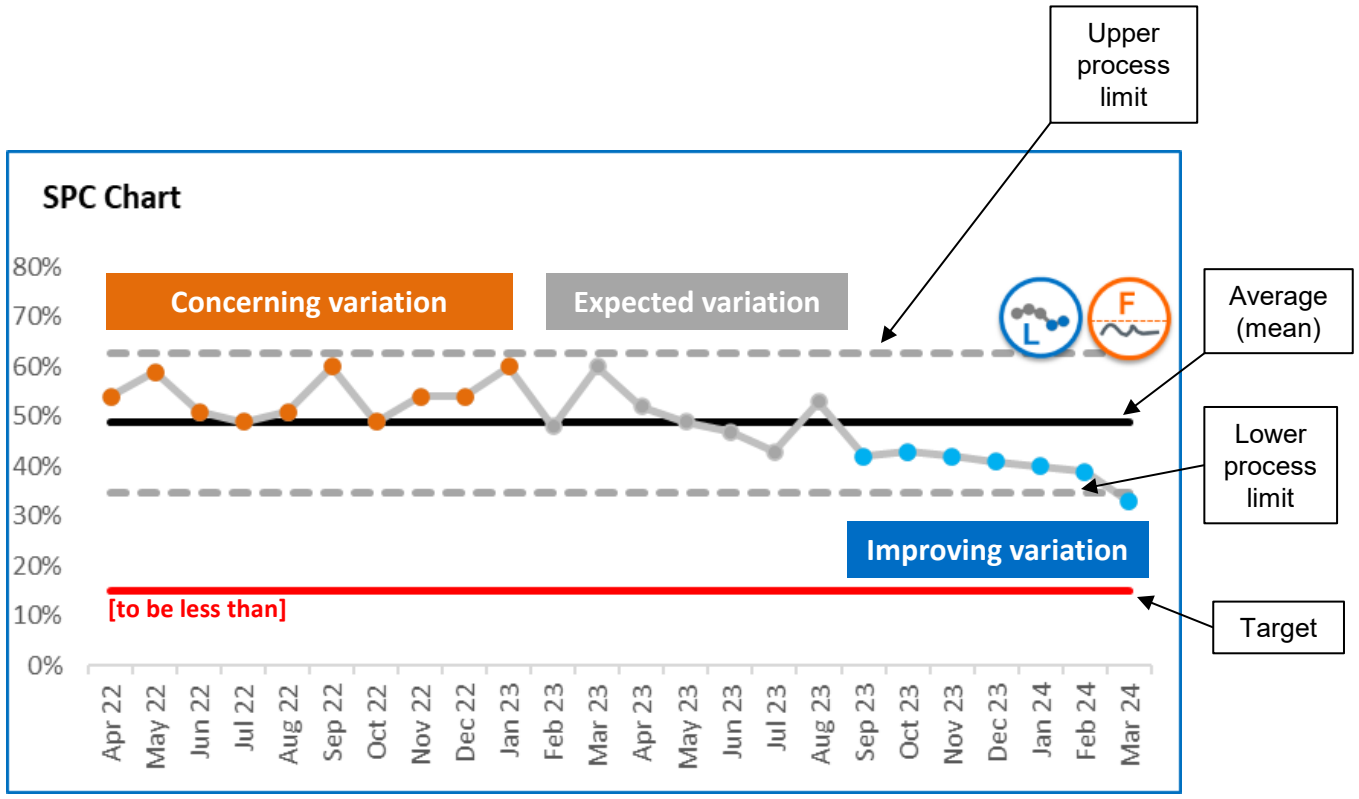
Appendix 1 | Interpreting SPC Charts

A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly). The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented.

Blue – there is a pattern of improvement which should be learnt from.

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Concerning and improving variation are 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

Appendix 2 | Interpreting SPC Icons

These icons provide a summary view of the important messages from SPC charts.

Variation / performance Icons

Icon	Technical description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction.	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation where neither high nor low is good.	**Something's going on!**	Investigate to find out what is happening / happened, what you can learn, and whether you need to change something.

Assurance icons

Icon	Technical description	What does this mean?	What should we do?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. 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 3 | Glossary

A&C	Acute and Community Services
AOT	Assertive Outreach Team
ASD	Autism Spectrum Disorder
AWOL	Absent without Leave
CER	Clinical Establishment Review
CERT	Community Enhancing Recovery Team
CFS	Chronic Fatigue Syndrome
CISS	Community Intensive Support Service
CLDT	Community Learning Disability Team
CMHT	Community Mental Health Team
CMS	Case Management Service
CPA	Care Plan Approach
CRFD	Clinically Ready for Discharge
CRHTT	Crisis Resolution Home Treatment Team
CTO	Community Treatment Order
DD	Delayed Discharge
DD1	Dovedale 1
DD2	Dovedale 2
DIPQR	Directorate Integrated Performance & Quality Report
DNA	Did not attend
DU	Decisions Unit
DWM	Deputy Ward Manager
ED	Emergency Department
EI	Early Intervention
EPQR	Executive Performance and Quality Review
EPR	Electronic Patient Record
EWS	Emotional Wellbeing Service
F2F	Face to Face
FFT	Family and Friends Test
FTE	Full-Time Equivalent
HAST	Homeless Assessment and Support Team
HBPoS	Health Based Place of Safety
HCA	Healthcare Assistant
HCSW	Healthcare Support Workers
HTT	Home Treatment Team
ICB	Integrated Care Board
ILS	Immediate Life Support
IPQR	Integrated Performance and Quality Review
KPI	Key Performance Indicator
LCL	Lower Control Limit
LD	Learning Disabilities
LoS	Length of Stay
LTNC	Long Term Neurological Conditions
MAPPS	Mood, Anxiety and Post-Traumatic Stress Disorder Psychotherapy Service
ME	Myalgic Encephalomyelitis
MH	Mental Health
MoJ	Ministry of Justice
MSS	Manager Self Service
NCHA	Nottingham Community Housing Association
NES	Neurological Enablement Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OA	Older Adult
OAPs	Out of Area Placements
OOA	Out of Area
P/CT	Personality/Complex Trauma
PDR	Performance Development Review
PICU	Psychiatric Intensive Care Unit
PSIRF	Patient Safety Incident Response Framework
QI	Quality Improvement
QoCE	Quality of Care Experience
R&S	Rehabilitation and Specialist Services
RMN	Registered Mental Health Nurse
RPU	Referral Point Unit
RtA	Referral to Assessment
RtT	Referral to Treatment
SAANS	Sheffield Adult Autism and Neurodevelopment Service
SCBIRT	Sheffield Community Brain Injury Rehabilitation Team
SCFT	Specialist Community Forensic Team
SNP	Senior Nurse Practitioner
SPA	Single Point of Access
SPC	Statistical Process Control
SPS	Specialist Psychotherapy Service
SPTS	Sheffield Psychosexual Therapy Service
TUPE	Transfer of Undertakings (Protection of Employment)
U&C	Urgent and Crisis
UCL	Upper Control Limit
VIP	Value Improvement Plan
WTE	Whole-Time Equivalent
YAS	Yorkshire Ambulance Service
YTD	Year to Date