Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

QUALITY REPORT

2015/2016

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SECTION 4.0: QUALITY REPORT

Part 1: Quality Report 2015/16 Chief Executive's welcome

I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Report for 2015/16.

This Quality Report is our way of sharing with you our commitment to achieve better outcomes and deliver better experiences for our service users and their carers. We will report the progress we have made against the priorities we set last year, and look ahead to the areas we will continue to focus on for the coming year.

In June 2015 the Care Quality Commission (CQC) reported on their findings following their inspection of some of our services in October 2014. Overall, they assessed our Trust as Requires Improvement. The inspectors found many areas of good practice, but they also identified areas we needed to improve. This is discussed in more detail on pages 24-28.

It was important that we responded positively to the findings and feedback from the CQC. Our response was to fully acknowledge that while we strive to provide a quality service to the people of Sheffield and beyond, there are areas where we know we needed to improve and the CQC inspection offered us a further opportunity to reflect, learn and make improvements. That is what we have done, and our plans for moving forward are described on page 25.

We have made very significant improvements in recent years to services where there were big challenges. We have also made some significant service transformation. Information about these changes is summarised in this Quality Report, and our fuller Annual Report.

However, we also know that we can always improve and there are areas that we clearly need to focus on.

To support that improvement our Quality Improvement and Assurance Strategy refreshes our overall approach and framework.

The Strategy focusses on delivering continuous quality improvements. It recognises that each team will develop plans to improve quality, that we will have a number of Trustwide improvement priorities and a smaller number of Transformation Programmes.

The Trust Board will ensure that all staff understand what Quality Standards are expected and the part they play in delivering these standards.

This strategy aligns with the Trust's values: delivering care in partnership with staff and service users in a respectful and compassionate culture, and ensuring we are all accountable for delivering excellent care as a learning organisation.

Our ambition is to provide excellent services that deliver a really positive experience for the people who need them. We have much to do to ensure the quality of what we provide is of a consistently high standard for every person in respect of safety, effectiveness and experience. Our plans for quality improvement will ensure we make continued improvements.

In publishing this Quality Report the Board of Directors have reviewed its content and verified the accuracy of the details contained in it. Information about how they have done this is outlined in Annexe B to this report.

To the best of my knowledge the information provided in this report is accurate and represents a balanced view of the quality of services that the Trust provides. I hope you will find it both informative and interesting.

Kevan Taylor
Chief Executive
25 May 2016

Part 2A: A review of our priorities for quality improvement in 2015/16 and our goals for 2016/17

In setting our plans for 2015/16 we reviewed our priorities for quality improvement. The people who use our services and the membership of our Foundation Trust have been instrumental in deciding what our priorities are.

In undertaking this review the Board of Directors

- Reviewed our performance against a range of quality indicators;
- Considered our broader vision and plans for service improvement;
- Continued to explore with our Council of Governors their views about what they felt was important;
- Engaged with our staff to understand their views about what was important and what we should improve.

We then consulted on our proposed areas for quality improvement with a range of key stakeholders. These involved our local Clinical Commissioning Group, Sheffield City Council and Healthwatch.

Our Governors engaged with our members about our proposed priorities and we have received comments and feedback from over 300 of our members about our priorities we proposed for this year. From this review the Council of Governors have reviewed our plans and we have taken on board their feedback. In compiling this year's Quality Report we also met with Governors to review the draft Report. Governors provided their views and feedback on the content of the Report, ensuring the Report presented a balanced picture of the Trust's performance based on their knowledge and experience of working as Governors over the last year.

Our priorities for improvement during 2015/16 were:	
Responsiveness	*Quality Objective 1:* We will improve access to our services so that people are seen quickly
Safety	*Quality Objective 2:* We will improve the physical health care provided to our service users
Experience	*Quality Objective 3:* We will establish the Service User Experience Monitoring Unit to drive improvements in service user experience across the Trust

Quality Objective 1: We will improve access to our services so that people are seen quickly.

We chose this priority because

The evidence clearly demonstrates that prompt access to effective treatment has a significant impact on outcomes. When we met with our Governors this was a key area of concern for them. They wanted us to ensure that people got seen quickly when they needed to. Improving access is an area prioritised by our Commissioners and they are supportive of improvement and service reconfigurations to help us achieve this.

We had started to make some improvements in reducing waiting times but not as much as we wanted to. National Policy for mental health services is seeing the establishment of a range of *Achieving Better Access* standards for mental health services. Uniquely for the NHS these standards don't just focus on waiting times to see someone, but waiting times for service users to access and start receiving evidenced based treatments and therapies. This is a challenging agenda, but one that the Trust welcomes and fully supports.

We said we would

At the beginning of the year we agreed that we would continue to focus on waiting times to access services. During 2015/16 we planned to

- Review our capacity and resource plans for the Memory Service due to the increased levels of demand and agree a way forward with Commissioners;
- Ensure we deliver on the new national *Achieving Better Access* standards for waiting times for Improving Access to Psychological Therapies (IAPT) Service services and Early Intervention Psychosis services;
- Define waiting time standards for all our services and publish information about how we are performing for each service.

How did we do?

We have made real improvements in reducing waiting times and achieving national targets for Memory Services, IAPT Services and Early Intervention Services.

Memory Services

We continue to deliver excellent Memory Services for the people of Sheffield. Sheffield has the second highest diagnostic rates in England, which means people in Sheffield are far more likely to access support with memory problems than elsewhere in the country. More people are receiving support and treatments than before as we get more referrals and see more people.

Over the last several years, however, waiting times for the Memory Service have been unacceptably high. This has remained a shared concerned with our local Commissioners and a number of initiatives over the last three years have been introduced. While these previous attempts have resulted in more people being seen, they haven't had the desired impact of reducing waiting times.

We are pleased to report that further work this year has had a clear impact on reducing waiting times. The service has reviewed its pathway and referral management arrangements and additional short term investment was provided to tackle some waiting list backlogs. As a result of these changes waiting times have reduced significantly. Through the second half of 2015/16 people waited around 6.5 weeks to start their assessment, compared to 23 weeks in previous years. At the end of the year people contacting the service to make an appointment were being offered appointments within 4-5 weeks' time.

Measure	2014/15	2015/16
Number of people assessed for memory problems by Memory Management Services (new first appointments)	971	1,231
Average waiting time for people to be assessed by the Memory Management Service for a routine appointment	23 weeks	13 weeks (2015/16) 6.5 weeks (Oct15-Mar16)

IAPT Services

We had focussed on reducing waiting times for the IAPT Service over the previous two years through the CQUIN scheme. This had been successful in addressing certain GP Practice areas which were experiencing longer than average waiting times, and overall in reducing average waiting times across Sheffield.

This year saw the introduction of national access targets for mental health services for the first time. The national target was for 75% of people referred to IAPT Services to commence treatment within 6 weeks of their referral, and for 95% of people referred to commence treatment within 18 weeks.

Average waiting times	2014/15	2015/16
Average waiting time to start treatment	29 days 4.2 weeks	24 days 3.4 weeks

New national targets	2015/16 Q3	2015/16 Q4
Percentage accessing treatment within 6 weeks of referral (target is 75%)	76.7%	75.6%
Percentage accessing treatment within 18 weeks of referral (target is 95%)	97%	98.05%

The above table and information is based on reporting performance based on when people complete and finish their treatment. Someone who started their treatment in June 2015 and finished in November 2015 would be reported in the Q3 figures. This is in line with national reporting requirements, however, it doesn't fully represent how the service is performing for people who start their treatment in Q3.

The following table shows the waiting time performance for those who started their treatment in Q3 and Q4.

New national targets	2015/16 Q3	2015/16 Q4
Percentage accessing treatment within 6 weeks of referral (target is 75%)	84.5%	80.3%
Percentage accessing treatment within 18 weeks of referral (target is 95%)	99.1%	99.5%

Overall, our IAPT Services are performing very well. We are seeing more people than the national averages, which is good as it means our referral pathway and close working with GPs is ensuring that more people who could benefit from talking therapies are being referred. And people are accessing services quickly, which is important. Average waiting times continue to come down, and we are ensuring that the majority of people are starting treatment quickly.

Early Intervention for Psychosis Services

The Early Intervention for Psychosis access and waiting time standard has two elements:

- 50% of people with a first episode of psychosis are assessed and on the caseload of an Early Intervention Care Co-ordinator with 2 weeks of being referred;
- 100% of people with a first episode of psychosis are able to access NICE-recommended treatment in an Early Intervention Service, as defined by the relevant NICE Quality Standard.

The target introduced this year, from Quarter 4 onwards was that 50% of people with a first episode were on the caseload of an Early Intervention Care Co- ordinator within 2 weeks of being referred.

The Trust Board invested over £500,000 during the year to improve the numbers of Care Co-ordinators and therapists working into a newly organised Early Intervention Service. This has ensured we have been able to establish effective service pathways to respond to new referrals quickly.

In Quarter 4 we achieved the new standard for people with a first episode of psychosis being assessed and on the caseload of an Early Intervention Care Co-ordinator within 2 weeks. We achieved this for 50% of the people we saw.

How will we keep moving forward?

- We will continue to maintain our current performance levels across Memory Services, IAPT Services and Early Intervention Services;
- We will focus on our Liaison Services and Crisis Services to ensure we are well placed to deliver the next set of *Achieving Better Access* standards;
- We will finalise a standardised approach to reporting on waiting times for all other services and commence reporting during early 2016/17.

Quality Objective 2: We will improve the physical health care provided to our service users.

We chose this priority because

Physical health was a priority for our Governors and service users, as many of our service users are at higher risk of developing physical health problems. The evidence clearly shows that people with severe mental illness and people with learning disabilities have reduced life expectancy and greater morbidity, as do people who are homeless and people who misuse drugs and alcohol.

The need to deliver continued improvements in this area is key priority across health and social care in Sheffield, to help deliver improved outcomes and achieve a reduction in the gap in life expectancy for people with serious mental health illnesses and people with a learning disability. As we have developed our plans our clinicians have told us this was a key area they wished to focus on to deliver improvements. We know from reviewing progress against our Physical Health Strategy and national audits that we have further improvements still to make.

How did we do?

We have made good progress in some of our development priorities, however, it is clear that we still have further work to do to ensure that standards of practice are delivered consistently.

Smoking Cessation

Working with service users, staff and experts in smoking cessation strategies we have developed and introduced a proactive strategy that will see the Trust go totally Smoke Free from May 2016. The emphasis of our approach is firmly on health improvement and encouraging service users and staff to consider stop smoking, and ensuring they are able to access a range of support and help quickly in a way that suits them.

To support this strategy we commissioned the National Centre for Smoking Cessation Training to deliver a two-day, bespoke, face to face behavioural support training. They provide evidence based training, and are recognised as national and international experts in the field. Over the last year we trained over 50 staff within teams who are now able to offer smoking cessation interventions.

Integrating physical and mental healthcare within General Practice

We delivered a successful project that focussed on ensuring each GP Practice had in place a physical health screening tool and care plan process. This was developed in partnership with GPs and Public Health partners and supports GPs to monitor and undertake annual physical health checks for people with serious mental illnesses, and ensure that any necessary follow up interventions are then provided.

This innovative and successful approach was recognised nationally and the project won a national award from the Positive Practice in Mental Health Awards in the Integrating Physical and Mental Health category.

Improving communication with GPs about care of people on CPA
As part of the national CQUIN programme we aimed to deliver a range of practice standards for people who have serious mental health problems and whose care is managed under the Care Programme Approach. The standards aim to ensure we are communicating clearly and effectively with GPs about the physical and mental healthcare needs of people we support. This year's national audit shows that we have further improvements to deliver and our ongoing development plans during 2016/17 will address this. While we perform better in delivering practice standards relating to diagnosis, care planning and monitoring we need to improve our approaches to ensuring our plans are proactively promoting healthy lifestyle activities.

Standard	% achieved
Diagnoses (mental health and physical health related)	90%
Medication and monitoring arrangements	82.5%
Physical health plan if required	84%
Healthy Lifestyle plan	32%
Number of service users with all of the above met	22%

Improving physical health assessments for people with a serious mental illness receiving mental health in-patient care
As part of the national CQUIN programme we aimed to deliver a range of practice standards for people who have serious mental health problems who are in-patients on a mental health ward.

The standards aim to ensure that we are effectively screening and assessing the physical health care needs of our in-patients, and then taking appropriate actions if the results suggest a need to do so.

Overall, we achieve the standard thresholds for assessing and screening of 90%, however, we need to make improvements in ensuring we consistently act on the results, and can demonstrate we have done so as part of our care planning arrangements.

Standard – assessment and screening	% achieved or evidence of service user refusal
Smoking circumstances	94%
Alcohol use	96%
Substance misuse use	92%
BMI measured	90%
BP measured	97%
Glucose levels measured	91%
Lipids recorded.	82%

Standard – evidence of physical health interventions when required/ indicated	% achieved or evidence of service user refusal of treatment intervention
Smoking circumstances	67%
Alcohol use	87.5%
Substance misuse use	79%
BMI	62%
BP	54%
Glucose levels	91%

Our performance overall in delivering each standard for each service user was 44% achievement of all the standards. This is mainly due to the inconsistent approaches to ensuring appropriate follow up action is taken.

How will we keep moving forward?

We will continue with our development programme, ensuring over the next year that we:

- Successfully implement our Smoke Free strategy and evaluate the impact on the health of service users and our staff;
- Continue to implement a range of supporting programmes relating to staff awareness and training, team feedback on their own performance, to improve our compliance with care standards relating to physical health;
- Continue to progress a range of other important physical health initiative in relation to alcohol support and dental health that have been agreed locally within our CQUIN programme with our local Commissioners.

Quality Objective 3: We will establish the Service User Experience Monitoring Unit to drive improvements in service user experience across the Trust.

We chose this priority because

Understanding the experiences of the people who use our services is essential if we are to be successful in achieving quality improvement. When we met with our Governors to look at priorities for 2014/15 and beyond they told us that we should continue to support staff to have an appreciation and awareness of what it is like to receive care and to improve how we gather feedback about people's experiences.

The Board of Directors invested in the establishment of a service user monitoring unit within the Trust. This department was to be led by a service user and support the Trust's on-going strategies to improve our understanding of the experience of the people who use our services.

We said we would

Continue to deliver and develop the implementation plan to improve our approach to working with service users and understanding their experiences across the Trust.

How did we do?

2015/16 has seen a real increase in the level of service user and carer involvement across the Trust. Here is a snap shot of some of the key areas of activity:

- We have successfully rolled out the national Friends and Family Test and received over 2,000 individual responses with 9 out of 10 service users stating that they would recommend our services to friends and family (see Section 3.3);
- The Trusts' Service User Engagement Group (SUSEG) is now well established and has representation from all service Directorates and service users. It meets on a monthly basis and this year working groups have focused on five key areas of work:
  - Improving how we work with service users to recruit staff;
  - Improving how we work with service users to train staff;
  - Developing paid peer support;
  - Embedding a culture of recovery;
  - Establishment of the Service User Experience and Monitoring Unit.

- All areas of work have been co-produced with service users and staff. This group also planned and delivered a conference in February 2016 for over 100 delegates to help inform the future service user engagement strategy for 2016/2017. The event brought together service users, carers and staff and highlighted the value of service user and carer involvement in co-production of services and placing service users at the heart of decision making;
- In our Learning Disabilities Service regular 'Meet the Manager' sessions are held giving service users and carers an open forum to seek answers about the service from senior managers as well as proving an opportunity to update people on plans, policies and processes that impact them;
- Service users also worked with staff in our In-patient Directorate to co-design and implement collaborative care planning. This has seen positive improvement in service users feeling involved in their care and the work was shortlisted for a national award. Pilots are now taking place in our Community Mental Health Teams;
- There has been a significant increase in the number of people seeking volunteer experience within the Trust. Currently 168 people actively volunteer in a very wide variety of different areas which include: recruitment and selection, chaplain assistant, reading on a variety of different Trust sites, administrative support, befriending and co-delivering training to both staff and service users. These are just some examples of the different areas in which volunteers are involved.

How will we keep moving forward?

Following our highly successful engagement event in February 2016 we will review and relaunch our strategy for the next year.

We will continue to build on our approaches following the good progress made and will further develop and deliver improvements across the five key development areas.

Our Quality Objectives for 2016/17

In considering our goals for 2016/17 we have reviewed how we are performing.

The findings from the Care Quality Commission (CQC) inspection.

The CQC published the findings from its inspection of Trust services in June 2015. This is summarised in more detail in Section 2B of this report. The Trust's overall rating was Requires Improvement. Following the CQC inspection, the Board approved and targeted investment towards improving our care environment, monitoring systems and improved staffing capacity within our crisis care services. Progress in delivering the plan is reviewed by the Board on a monthly basis. Our improvement plans for 2016/17 will ensure that we continue to improve the crisis care pathway in respect of health based place of safety and capacity out of hours to support people presenting in a mental health crisis.

National Standards and Priorities

We have maintained a Green risk rating for quality governance since we became an NHS Foundation Trust.

We have exceeded the new national access standard for IAPT Services during 2015/16 and have plans in place that will assure achievement of the access standard for people experiencing a first episode of psychosis during 2016/17. Rates of diagnosis for people with dementia remain positive, with Sheffield consistently rated in the top 5 performing areas within England. We have agreed with our local Clinical Commissioning Group to take the lead role in Sheffield in delivering care and treatment reviews for people with a learning disability, ensuring that care is delivered in the community as the preferred and first choice.

Commissioning priorities for service developments

The main focus of the current and developing plans for service development across Sheffield, as it relates to the Trust, will be the development of sustainable community care systems that deliver quality care and experiences, positive outcomes and significant reduced demand on acute hospital based services. As part of this programme there will be a focus on mental health and ensuring urgent and crisis care pathways and provision are accessible and effective over the full 7 day period.

Commissioning priorities in respect of quality improvement for the services directly provided by the Trust are defined through the agreed CQUIN programme. The agreed areas of focus remain on improving physical health and developing improved outcome measures and experiences for service users.

Quality Improvement Goals

In determining our specific quality improvement goals the Board has been informed by the following considerations:

- We have a clear plan to continue to deliver improvements from the CQC Inspection;
- We currently perform well against the current national standards, and expect to deliver the new access standards for IAPT and Early Intervention Services;
- The revised Quality Improvement and Assurance strategy that is in place.

The Trust has a range of development priorities and actions in place that are focussed on maintaining and improving the quality of care provided. These priorities address our transformation priorities and a range of quality improvement programmes that focus on particular aspects of quality and safety, or build our capacity to deliver high standards of quality care.

We continue to focus on our quality improvement goals in respect of:

- Improving access;
- Improving physical health;
- Improving the experience of people who use our services.

Within this programme we have a specific focus on improving safety in respect of improved physical health outcomes and reducing restrictive interventions.

QUALITY GOAL 1: Improving access to services and treatment		
Directorate	**Directorate specific goal**	**Measured by**
Community	Achieving better access to mental health services standards achieved.	Exceed national standards: • IAPT standards of 75% accessing treatment in 6 weeks and 95% in 18 weeks; • Early psychosis standards of 50% accessing treatment in 2 weeks.
	Improved access to urgent and crisis services ensuring effective access over the 7 day period.	The number of people who receive a crisis assessment within 90 minutes of referral.
In-patient	Access to a health based place of safety for people detained under Section 136.	The number of people unable to access the health based place of safety.
Specialist	Improving access to Memory Services.	Waiting times for assessment at Memory Service. Waiting times to receive diagnosis following memory assessment.
	Improved access and support for people with substance misuse problems.	Number of people receiving and completing alcohol support and treatment.
Learning Disabilities	Care and Treatment reviews ensure community care is delivered where possible.	Number of people who have received a care and treatment review. Number and % of people who received a care and treatment review prior to admission. Number and % of people who received a care and treatment review within 2 weeks of admission.
	Reducing duration in in-patient care to a minimum.	Length of stay for in-patients at the Firshill Rise Assessment and Treatment Unit.

QUALITY GOAL 2: Improving experience through service user engagement and feedback		
Directorate	**Directorate specific goal**	**Measured by**
Community	Assessment of physical health needs of people receiving care	Number of community service users with a physical health assessment and plan shared with their GP. Number of community service users assessed as at risk of problematic alcohol use who are referred to specialist alcohol support services.
In-patient	Comprehensive physical health assessments of all in-patients	Number of in-patients with an assessment of their physical health needs. Number of in-patients with a treatment plan for their physical health needs where indicated.
Specialist	Assessment of physical health needs of people receiving care	Number of community service users with a physical health assessment and plan shared with their GP.
Learning Disabilities	People with a learning disability will receive an annual health check with their GP and have a health action plan and a hospital passport in place.	Number of people with a health action plan in place who are known to the Trust. Number of people with a hospital passport in place who are known to the Trust.

QUALITY GOAL 3: Improving experience through service user engagement and feedback		
Directorate	**Directorate specific goal**	**Measured by**
Community	Develop approaches to regular monitoring of service users experience.	Use of Friends and Family Test and outcome scores. Self-assessment against NICE Service User Experience Quality Standards.
	Embed collaborative care planning.	Rates of services users reporting as engaged with their collaborative care plan.
In-patient	Reduce restrictive practices.	Rates of restrictive practices.
	Embed collaborative care planning.	Rates of in-patients reporting as engaged with their collaborative care plan.
	Quality and dignity survey programme.	Use of quality and dignity service user survey.
Specialist	Develop approaches to regular monitoring of service users' experience.	Use of Friends and Family Test and outcome scores. Self-assessment against NICE Service User Experience Quality Standards.
Learning Disabilities	Reduce restrictive practices	Rates of restrictive practices as benchmarked against other local and national services. Audit of % and quality of Alternatives to Restraint Care Plans in relation to people on a DoLs.

Quality Assurance - How do we improve, monitor and assure ourselves about the quality of the services and care we provide

Our Approach to Quality Improvement

As part of our review and learning from the Care Quality Commission inspection we have reviewed and updated our Quality Improvement and Assurance Strategy. The purpose of the strategy is to develop a culture of continuous quality improvement by:

1. Delivering quality by creating the conditions for all our staff and every team to engage successfully in quality improvement underpinned by effective team governance;

2. Ensuring measurable quality objectives are agreed across the organisation;

3. Ensuring effective, supportive and responsive Trust governance and assurance systems;

4. Having clear arrangements to support delivery and accountability;

5. Ensuring we have accurate and appropriate information available about the quality of care provided at all levels.

Our revised Strategy, along with the implementation plan to deliver the Strategy is available on our website www.shsc.nhs.uk.

Quality Governance arrangements

In order to ensure quality, the Trust's governance arrangements are summarised as follows:

Board of Directors: Sets the Trust's strategic aims and ensures the necessary supporting strategies, operational plans, policy frameworks and financial and human resources are in place for the Trust to meet its objectives and review its performance.

Quality Assurance Committee: Brings together the governance and performance systems of the Trust in respect of quality. The Committee provides oversight of the Trust systems in respect of quality and risk management arrangements. The Committee is informed by the work of a range of Committees that oversee Trust systems and performance in respect of key matters relating to quality and safety, for example Control of Infection Committee, Safeguarding Adults and Children Committees, Mental Health Act Committee.

Audit and Assurance Committee: Reviews the existence and maintenance of an effective system of integrated governance, risk management and internal controls Trustwide.

Executive Management Team: Oversees the operational functioning and delivery of services and programme management oversight of key transformation and improvement projects.

Team and service level governance: Each team and service area has established governance systems and meetings that support the delivery of care. Teams regularly review the quality of care they are providing, identify and agree measures to make improvements and raise issues of concern with their senior management teams and the Trust if issues can't be resolved locally.

Systems of Internal Control: A range of policy frameworks and internal controls are in place to protect and assure the safety of care and treatment and the delivery of quality care in line with national policy and legislation. These range from Policy statements of the Trust (eg. Mental Health Act Policies), Risk Registers at service and Trustwide level and the Board Assurance Framework.

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service, Directorate and Trustwide level. Further developments are to be made within 2016/17 to enhance our performance management frameworks through effective business information systems. The Board's monthly and annual performance reporting processes ensure that the Executive Management Team are able to scrutinise and manage the operational performance of services and the Board to maintain overall oversight on the performance of the Trust. On an established quarterly cycle, the performance of all services are reviewed through Directorate-level Service Reviews. The Executive Team reviews with each operational Directorate their performance against planned objectives.

The above framework ensures that the Board of Directors is able to monitor and evaluate the performance of the Trust and its services and to initiate improvement actions were required.

The following information is publically available that provides more information about quality governance arrangements within the Trust.

Annual Governance Statement: Formal statement from the Board that defines the systems and processes in pace across the Trust. See our full Annual Report.

Board Assurance Framework: Defines the controls and actions in place to assure the Board that risks to the delivery of goals and objectives are in place and monitored. Available on the Trust's website.

Board Performance reports: A range of monthly and quarterly reports defining current performance. This will include the monthly progress report of the action plan following the CQC inspection. These are available in the Board Section of the Trust's website.

Strengthening our assurance processes

As part of the revised Quality Improvement and Assurance Strategy agreed by the Board we have identified and have put plans in place to further improve our governance arrangements in 2016/17. Key areas of focus include:

Building our Quality Improvement methods: We recognise that to deliver our quality improvement strategy, it is essential that staff have the ability to engage with improvement techniques. To support this strategy we have a programme to equip staff and teams with the time and the skills to deliver continuous quality improvement. While we will use a range of quality improvement techniques as appropriate, the core Trustwide approach that we will use will be Microsystems improvement methodology.

Peer Review and Self Inspection: Central to quality assurance will be the Peer Review process. This builds on our experience of being reviewed by the CQC and as CQC reviewers. The review process incorporates the CQC methodology and framework domains. Review outcomes are presented by the Chief Operating Officer to the Executive Team for scrutiny and management and to the Quality Assurance Committee for assurance.

Service User Led Monitoring of Services: The Trust uses a range of information to monitor service quality and performance. Our approach is to work with service users so they gather feedback from service users about their experiences of services on our behalf.

Team Level Information Needs: Alongside Trustwide information about quality, each team will have additional information needs that reflect the care they provide and deliver. Teams will be supported to establish their own information requirements so they have a balanced and informed understanding of the quality of care they are providing. As teams progress their quality improvement plans, being able to measure if improvements are being achieved will be key to the success of their quality improvement work.

Part 2B: Mandatory statements of assurance from the Board relating to the quality of services provided

2.1 Statements from the Care Quality Commission (CQC)

Sheffield Health and Social Care NHS Foundation Trust is required to register with the Care Quality Commission and our current registration status is registered without conditions and therefore licenced to provide services.

The CQC registers, and licenses the Trust as a provider of care services as long as we meet essential standards of quality and safety. The CQC monitors us to make sure we continue to meet these standards.

The Care Quality Commission has not taken enforcement action against the Trust during 2015/16. The Trust has not participated in any special reviews or investigation by the CQC during the reporting period in respect of the services we provide. The CQC undertook a citywide review of looked after children during the year, which we contributed to. No direct issues were highlighted regarding the way we deliver care, and the report is available here: http://shsc.nhs.uk/about-us/corporate-information/cqc/.

During 2014/15 we became the registered provider of the Brierley Medical Centre in Barnsley. We were asked to provide this service at short notice by the NHS Commissioner because the previous Practice was unable to continue delivery of appropriate services. Following suitable local alternatives being put in place within the Barnsley area we discontinued providing this service during 2015/16.

Planned Inspection reported in June 2015

In June 2015 the CQC published its findings from the planned inspection of services that took place in October 2014. They inspected the following mental health and learning disability services that we are registered to provide:

- Acute wards for adults of working age and psychiatric intensive care unit;
- Long stay/rehabilitation mental health wards for working age adults;
- Forensic in-patient/secure wards;
- Wards for older people with mental health problems;
- Wards for people with a learning disability or autism;
- Community-based mental health services for adults of working age;
- Mental health crisis services and health based places of safety;
- Community-based mental health services for older people;
- Community mental health services for people with a learning disability or autism.

They inspected the following social care services that we are registered to provide:

- Longley Meadows respite service for people with a learning disability;
- Hurlfield View community centre for older people with dementia;
- Woodland View Nursing Home;
- 136 Warminster Road respite service for people with a learning disability;
- Supported living services for people with a learning disability at Mansfield View;
- Supported living services for people with mental health problems at Wainwright Crescent respite service.

Overall, they assessed our Trust as 'requires improvement'. The inspectors found many areas of good practice and received many positive comments about care from service users and carers, in particular both staff and services were identified as being caring and responsive. One service (the forensic service at Forest Lodge) was rated as 'outstanding' and four services were rated as 'good' (wards for older people with mental health problems, community based mental health services for older people, mental health crisis services and health based places of safety and supported living at Mansfield View).

However, there were a number of areas where the inspectors found some issues about the way we provide services, particular areas of concern were identified in some services. Issues were raised in respect of safety and effectiveness across the Trust, including medicines management and staffing levels in certain areas.

It was important that we responded positively to the findings and feedback from the CQC. Our response was to fully acknowledge that while we strive to provide a quality service to the people of Sheffield and beyond, there are areas where we know we needed to improve and the CQC inspection offered us a further opportunity to reflect, learn and make improvements. That is what we have done.

Our action plan

We implemented an initial improvement plan at the end of the inspection in November 2014, and then a fuller plan in June 2015. The full action plan is available through our website at http://shsc.nhs.uk/about-us/corporate-information/cqc/ and each month we report publically on the progress we have made in delivering on the agreed actions (http://shsc.nhs.uk/about-us/corporate-information/board-of-directors/meeting-minutes-agendas/). A summary of some of the actions we have taken following the inspection is provided below:

- Continued with our programme to support more service users to leave long-stay in-patient care at Forest Close and Pinecroft into their own tenancies in the community. During 2015/16 36 people have been able to leave long-stay in-patient care and live in a more appropriate community setting;
- Increased the numbers of staff who work during the nights and at weekends in our community crisis services;
- Delivered a focussed service and quality improvement programme for our services at Woodland View Nursing Home, Firshill Rise and Forest Close;
- Strengthened the arrangements to ensure the Place of Safety service at Maple Ward is more accessible;
- Invested in more pharmacists to work in our community teams;
- Revised and strengthened our monitoring of systems and processes that support safety.

The Board has monitored progress against this plan each month and is assured that the actions we will continue to take will ensure that are well placed to deliver on our ambition to provide excellent services that deliver a really positive experience for the people who need them. We have much to do to ensure the quality of what we provide is of a consistently high standard for every person in respect of safety, effectiveness and experience. Our plans for quality improvement, outlined in Section 2A, will ensure we make continued improvements.

Overall Trust rating from the inspection

Inspection area of focus	Rating
Safety	Requires Improvement
Caring	Good
Responsiveness	Good
Effectiveness	Requires Improvement
Well Led	Good
Overall Trust Rating	Requires Improvement

Individual Service ratings

Health care services inspected	Rating
Acute wards for adults of working age and psychiatric intensive care unit (Rowan, Maple, Stanage, Burbage, ITS)	Requires Improvement
Long stay/rehabilitation mental health wards for working age adults (Forest Close & Pinecroft)	Requires Improvement
Forensic in-patient/secure wards (Forest Lodge)	Outstanding
Wards for older people with mental health problems (G1 & Dovedale)	Good
Wards for people with a learning disability or autism (Firshill Rise)	Requires Improvement
Community-based mental health services for adults of working age (Adult CMHTs)	Requires Improvement
Mental health crisis services and health based places of safety (Place of Safety on Maple Ward)	Good
Community-based mental health services for older people (Older Adult CMHTs)	Good
Community mental health services for people with a learning disability or autism (CLDTs)	Assessed but not rated by the CQC

Social Care services inspected	Rating
Longley Meadows respite service for people with a learning disability	Requires Improvement
Hurlfield View community centre for older people with dementia	Requires Improvement
Woodland View Nursing Home	Inadequate
136 Warminster Road respite service for people with a learning disability	Requires Improvement
Supported living services for people with a learning disability at Mansfield View	Good
Supported living services for people with mental health problems at Wainwright Crescent respite service	Requires Improvement

During 2015/16 annual compliance inspections have taken place this year at Woodland View Nursing Home and Longley Meadows, a respite service for people with a learning disability. Woodland View was assessed as no longer 'inadequate', but still 'requires improvement', with improvement actions required in relation to monitoring systems, medication practices and consistency of person centred care provided. Longley Meadows was rated as 'requires improvement', with improvement actions required in respect of monitoring systems, medication practices and practices relating to consent. Improvement plans are being finalised at the time of producing this report.

Mental Health Act reviews

During 2015/16 the CQC has undertaken six visits to services to inspect how we deliver care and treatment for in-patients detained under the Mental Health Act. They have visited the following services:

- Michael Carlisle Centre: Dovedale, Stanage;
- Longley Centre: Maple Ward, Intensive Treatment Service;
- Forest Close: Bungalows 1, 2, 3;
- Forest Lodge: Rehabilitation Ward.

2.2 Monitors' Assessment

Monitor reviews our performance and publishes a quarterly assessment on how we are doing. This information is available at http://www.monitor-nhsft.gov.uk.

The governance assessment (rated as either red or green) is based on the Trust's self-declaration by the Board of Directors alongside Monitor's own assessment of how we are performing. In considering this Monitor considers the following information:

- Performance against national standards;
- CQC views on the quality of our care;
- Information from third parties;
- Quality governance information;
- Continuity of services and aspects of financial governance.

The tables below feature our ratings for the last two years.

2014/15

The Trust's performance overall was assessed as Green for the year. This means that there were no evident concerns regarding our performance.

We did experience challenges in delivering one of the national indicators during the year. We failed to achieve the standard of providing follow up care within 7 days of discharge from in-patient care for people under the Care Programme Approach in Quarter 2. Improvements were made to support communication and monitoring around discharge plans. We achieved the standards for the rest of the year.

2015/16

The Trust's performance overall was assessed as Green for the year. This means that there were no evident concerns regarding our performance.

We did experience challenges in delivering one of the national indicators during the year. We failed to achieve the standard of ensuring the proportion of in-patients who experienced a delayed transfer of their care, when ready for discharge, did not

exceed 7.5% of the total in-patient numbers during Quarter 1 and 2 of the year. We introduced a number of improvements focussed on better joint working with social care services and the position improved for the rest of the year.

2015/16 Regulatory ratings	Annual Plan (expected rating)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of Services Rating	4	4	3	3	4
Governance Risk Rating	Green	Green	Green	Green	Green

2014/15 Regulatory ratings	Annual Plan (expected rating)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of Services Rating	4	4	4	4	4
Governance Risk Rating	Green	Green	Green	Green	Green

2.3 Goals agreed with our NHS Commissioners

A proportion of our income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2015/16 £1,671,000 of the Trust's contracted income was conditional on the achievement of these indicators. We achieved the majority of the targets and improvement goals that we agreed with our Commissioners. We received £1,531,225 (91.6%) of the income that was conditional on these indicators. For the previous year, 2014/15, the associated monetary payment received by the Trust was £1,483,000.

A summary of the indicators agreed with our main local health Commissioner Sheffield Clinical Commissioning Group for 2015/16 is shown on the next page.

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	
Improving physical healthcare to reduce premature mortality in people with severe mental illness. We wanted to improve our performance in three key areas: a) Implementing a range of measures, such as training, electronic recording of service user details and provision of information to teams about how they were performing, that would support improved practice. During the year we confirmed the arrangements for staff training and developed systems for recording and providing performance feedback to teams. We will continue to develop these next year.	ACHIEVED
b) Undertaking comprehensive assessments of people's physical health needs when admitted to in-patient services The aim was to achieve this standard for 90% of service users, with achievement above 50% required as a minimum. We achieved the standard for 46% of patients.	NOT ACHIEVED NOT ACHIEVED
c) Ensuring comprehensive information about service user care under the care programme approach was communicated with their GP. The aim was to achieve this standard for 90% of service users, with achievement above 50% required as a minimum. We failed to achieve this standard because we did not have arrangements in place to communicate to GPs about service users' healthy lifestyle plans. While we have made progress through the year, we are not delivering the standards that we want to on a consistent basis for the intended service user groups. Improving our approach to meeting people's physical health care needs, in partnership with primary care is a key objective that we continue to focus on. We will continue to deliver improvements in this area next year.	

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	
Improved use of electronic discharge communications between in-patient services and GPs. The goal was to ensure GPs received accurate information electronically following service user discharge from services. This was achieved through continuing the use of the e-discharge care plan, delivered to GPs electronically when the service user is discharged from the acute in-patient wards. Alongside this we agreed develop this and apply it to our community teams, developing and testing its use initially within the adult home treatment teams. This development was successfully completed, and we will continue to extend this across other community team services next year.	ACHIEVED
Reducing variation in waiting times for service users referred to the IAPT Services. We had focussed on reducing waiting times for the IAPT Service over the previous two years through the CQUIN scheme. This had been successful. This year saw the introduction of national access targets for mental health services for the first time. The national target was for 75% of people referred to IAPT Services to commence treatment within 6 weeks of their referral. Within Sheffield we were already achieving this target and through the CQUIN scheme we agreed to improve our performance from 77% in the first quarter to 80% by the end of the year. We were successful in achieving this and during Quarter 4 80.3% people accessed treatment within 6 weeks of their referral. In addition to this 99.5% accessed treatment within 18 weeks of referral.	ACHIEVED

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	
Improving physical health - Ensuring all in-patients have routine access to dental care. We undertook a baseline audit in Quarter 1 which showed that 34.7% of service users who had been an in-patient for over a year had an assessment their dental health needs completed with an appropriate plan in place for their dental health needs if required. We aimed to increase this to 84.7% by the end of Quarter 4, and achieved 97%.	ACHIEVED
Improving physical health - To improve the smoking cessation levels for staff and service users. With the support and engagement of the Clinical Commissioning Group we agreed a developmental indicator for the year that was informed by a workshop with staff and service users. The focus was to support the Trust's smoking cessation strategy with two goals under the CQUIN scheme: By December 2015, to have trained and accredited 30 Trust staff as NCSCT Level 2 Certified Stop Smoking Practitioners, and established a robust system across the Trust to enable electronic recoding of smoking status for all service users. We achieved these two aims, and by March 2016 this had increased to 50 staff having qualified. By March 2016 to have commenced a range of quit interventions for staff and service users, and produced a report for Commissioners outlining the progress made and outcomes achieved. This was provided. Through the development work undertaken the Trust has launched a new policy framework that proactively supports the introduction of a smoke free framework across the Trust for service users and staff.	ACHIEVED

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	
Improving outcome measures - To develop a consistent way of recording information and commence reporting on the following areas: • The service user (or where appropriate their recognised carer and/or family) has contributed to the development of their care plan and has been given or offered a copy; • The service user's carers and/or family have been offered support and advice; • The service user has been given information on discharge to support their on-going recovery and to help them cope with a crisis. Developments to the Trust's patient information system were progressed through the year to improve approaches to the recording of information in the above areas. This was then supported by the introduction of feedback reports for teams. Further development work during 2016/17 is required to support the introduction of improved recording to capture support provided to carers.	PARTIALLY ACHIEVED
Improving outcome measures - Ensuring all cluster reviews are undertaken within the required time period. 'Clustering' is a method of determining and describing the different types of needs that people who use our mental health services have. A 'cluster review' is when we review the plan in place for each person to ensure it reflects their circumstances. We have different time periods in which we aim to complete people's reviews, some are more frequent than others. At the beginning of the year 81% of people were receiving their reviews within the required time periods. We aimed to increase this to 86% by the end of the year. We achieved this, and by Quarter 4 87.3% of people had who were in need of a cluster review had had one within the required time period.	ACHIEVED

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	
Improving outcomes - Ensuring that all service users are screened for alcohol misuse and that those in-patients screened as requiring specialist alcohol services are onward referred and seen. During Quarter 2 73.1% of people referred to our adult CMHTs had screening assessment for their alcohol use. We aimed to increase this to 90% by the end of Quarter 4, and achieved 92.5% During Quarter 2 75% of in-patients whose care plans were audited had an assessment of their alcohol use. We aimed to increase this to 90% by the end of Quarter 4, and achieved 92%.	ACHIEVED

The table above summarises the goals that we agreed with our Commissioners, and the progress that we made. Full details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at on our website at http://shsc.nhs.uk/about-us/corporate-information/publications/

The issues we have prioritised for next year are summarised as follows:

National indicators focussing on

- Improving physical healthcare to reduce premature mortality in people with severe mental illness – continuing the work from this year into next year, and extending it to people with serious mental health needs who receive community care;
- Improving staff health and wellbeing, focussing on a range of initiatives relating to improved health and sickness, healthier hospital food, improved flu vaccination uptake amongst staff.

Locally agreed indicators focussing on

- To improve standards of care for people receiving home treatment ensuring that service users have a copy of their care plan, that recovery and relapse prevention plans are in place and that advice and support is provided to carers;

- Improving access to dental care for service users with serious mental illnesses in the community under the care of designated teams;
- Cluster reviews – continuing to deliver further improvements next year;
- To improve the use of alcohol services for people under the care of our mental health or learning disabilities services;
- Improved support for carers of people on the Care Programme Approach through the offer and provision of carers assessments;
- The development of discharge information packs for people admitted to in-patient services.

The CQUIN programme for next year will support a continued focus on areas of joint priority between ourselves and our main Commissioner and we look forward to making progress in the above areas.

A key area we will be developing next year will be the support we provide and offer to carers. During 2015/16 we recognised that a range of improvements were required to improve the range of support provided to carers. For example, in Quarter 4 of 2015/16 we had only asked 77% of carers of people managed under the Care Programme Approach if they would like an assessment of their circumstances as a carer. These changes are necessary to ensure we have a good understanding of how we are performing in considering the needs of carers, and supporting carers to access the support they needed.

During 2015/16 we implemented the following changes

- Ensured all our care documentation was compliant with the requirements of the Care Act so that we are able to consistently review the needs of carers in line with the recommendations and principles of the Act;
- Developed our care pathways to ensure we explored carers issues with service users at the beginning of their care;
- Ensured we were able to identify the separate needs of young carers and to provide clear guidance of how their needs should be provided for;
- Raised the awareness across teams of the day to day support available for carers within the community;
- Initiated a training programme for staff, that will continue into 2016/17.

2.4 Review of services

During 2015/16 we provided and/or sub-contracted 52 services. These can be summarised as 43 NHS services and 9 social care services. The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of the relevant health services by the Trust for 2015/16.

The Trust has reviewed all the data available on the quality of care in these services. The Trust reviews data on the quality of care with NHS Sheffield Clinical Commissioning Group (CCG), other CCGs, Sheffield City Council and other NHS Commissioners.

The Trust has agreed quality and performance schedules with the main Commissioners of its services. With NHS Sheffield CCG and Sheffield City Council these schedules are reviewed on an annual basis and confirmed as part of the review and renewal of our service contracts. We have formal and established governance structures in place with our Commissioners to ensure we report to them on how we are performing against the agreed quality standards.

Following the CQC Inspection our Commissioners were understandably concerned regarding the findings for some of our services, particularly Woodland View Nursing Home and Firshill Rise. We worked closely with them to jointly review the issues raised and fully share our action plans. They undertook a review and a number of visits and inspections of these two services to assure themselves that the planned improvements were being made. The visits were sometimes planned, and sometimes unannounced and the Commissioners were sometimes accompanied by experts from neighbouring services. A contract notice was issued to clarify potential areas of concern regarding our training plans at Woodland View Nursing Home, and we were able to provide the necessary assurances that the agreed training plan was in place and was being progressed.

During the year Commissioners also undertook a service review of Longley Meadows, a respite service for people with a learning disability. This review identified some concerns regarding the standards of care and the service being provided. We worked closely with our Commissioners and put a development plan in place that has been closely reviewed and monitored by our Commissioners. The Commissioners have been assured that good progress has been made in delivering the actions necessary to respond to the concerns highlighted.

The Trust has established formal forums in place with our Commissioners. Through these forums NHS Sheffield CCG reviews our performance against quality standards and other performance targets and any issues of potential concern can be reviewed and necessary action plans agreed and monitored. During the year issues of concern

were raised and reviewed in respect of our performance in providing carers of people on the Care Programme Approach with a review and assessment of their needs. A range of development work was initiated to support improvements, however through the year the low level of performance remained. Further improvements have been incentivised during 2016/17 through the CQUIN framework (see above). As well as this the Trust's performance in relation to the numbers of people managed and supported under the Care Programme Approach was also reviewed. NHS Sheffield CCG was concerned that less people in Sheffield are managed under the Care Programme Approach than the national averages. Information was reviewed to developed a shared understanding, and the Trust introduced a plan that should result in an increase in the numbers of people managed under the Care Programme Approach.

2.5 Health & Safety Executive / South Yorkshire Fire & Rescue visits

Health and Safety Executive

There were no Health and Safety Executive visits to the Trust during 2015/16.

South Yorkshire Fire and Rescue

During 2015/16 the South Yorkshire Fire and Rescue service didn't undertake any visits or audits of the Trust's premises.

2.6 Compliance with NHS Litigation Authority (NHSLA) Risk Management Standards

The Trust is a member of the NHSLA, who handles negligence claims made against the NHS. The NHSLA gives all member organisations a red, amber, green ('RAG') rating which, determines the level of contribution each member makes to the NHSLA for insurance cover. The Trust's current RAG rating is red, which reflects a level of concern based on the costs incurred from negligence claims arising from incidents over 4-5 years ago.

2.7 Participation in Clinical Research

The number of service users receiving relevant health services provided or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust in 2015/16 who were recruited during that period to participate in research approved by a research ethics committee was 859.

Research is a priority for the Trust and is one of the key ways by which the Trust seeks to improve quality, efficiency and initiate innovation. Over the last year the Trust has worked closely with the Yorkshire and Humber Collaboration for Leadership in Applied Health Research and the Yorkshire and Humber Local Research Network to improve our services and increase opportunities for our service users to participate in research, when they choose do so. We have strong links with academic partners, including the Clinical Trials Research Unit and the School of Health and Related Research at the University of

Sheffield, the School of Health and Wellbeing at Sheffield Hallam University and the National Centre for Sports and Exercise Medicine, to initiate research projects in the Trust.

We adopt a range of approaches to recruit people to participate in research. Usually, we will identify individuals appropriate to the area being researched and staff involved in their care will make them aware of the opportunity to participate in the study. Service users and carers will be provided with a range of information to allow them to take informed decisions about whether they wish to participate and, if they agree, they will contacted by the research team. In 2015, we began to use the Join Dementia Research tool designed by the National Institute for Health Research in association with Alzheimer's Research UK and the Alzheimer's Society to match service users who have expressed an interest in research with appropriate studies.

We were involved in conducting 58 clinical research projects which aimed to improve the quality of services, increase service user safety and deliver effective outcomes. Areas of research in which the Trust has been active over the last 12 months include:

- A ten centre randomised controlled trial of an intervention to reduce or prevent weight gain in severe mental illness;
- A trial comparing the effectiveness of counselling for depression with cognitive behavioural therapy;
- A multi-centre trial of a self-help intervention to improve quality of life in Alzheimer's disease;
- Supporting for the families and carers of service users with dementia;
- Help to stop smoking for those with severe mental illness;
- Redesigning the early intervention in psychosis pathway;
- Co-morbidities between physical health and mental health;
- Pharmaceutical trials of new drugs for service users with dementia (including Alzheimer's disease).

2.8 Participation in Clinical Audits

National Clinical Audits and National Confidential Enquiries

During 2015/16 four national clinical audits and three national confidential inquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

During 2015/16 the Trust participated in 100% national clinical audits and 100% national confidential inquiries which it was eligible to participate in.

The table below lists the national clinical audits and national confidential inquiries the Trust participated in, along with the numbers of cases submitted by the Trust in total and as a percentage of those required by the audit or inquiry.

At the time of producing this report the results from the Guidelines audit and POMH UK audits had not been published. Therefore, we are unable to give an overview of the findings, and the action plan put in place to respond to the findings. We will publish information about this in next years Quality Account.

Name of national audit SHSC participated in	Number of cases submitted	Number of cases submitted as a percentage of those asked for
Guideline Audits		
Early intervention in Psychosis	26	26% (Note 1)
POMH UK		
Prescribing for Substance Misuse: Alcohol Detoxification	227	100%
Prescribing valproate for bipolar disorder	52	100%
Prescribing for ADHD in children, adolescents and adults	128	100%
National Confidential Inquiries		
Inquiry into Suicide & Homicide by people with mental illness	23	25% (Note 2)
Inquiry into Suicide & Homicide by people with mental illness Out of District Deaths	Nil	Nil – there were no cases this year
Inquiry into Suicide & Homicide by people with mental illness Homicide data	3	13% (Note 2)

Note 1: We provided all the requested information about the maximum number of service users who matched the audit requirements. We were asked to provide 100 cases, however we did not have that many service users who met the audit specification.

Note 2: The percentage figure represents the numbers of people who we reported as having prior involvement with as a percentage of all Inquiries made to us under the National Confidential Inquiry programme. ie in 75% and 87% of all inquiries, we had no record of having had prior involvement with the individual concerned.

2.9 Data Quality

Good quality information underpins the effective delivery of care and is essential if improvements in quality care are to be made. Adherence to good data quality principles (complete, accurate, relevant, accessible, timely) allows us to support teams and the Board of Directors in understanding how we are doing and identifying areas that require support and attention.

External Auditors have tested the accuracy of the data and our systems used to report our performance on the following indicators:

- 7 day follow up – people on CPA should receive support in the community within 7 days of being discharged from hospital;
- 'Gate keeping' - everyone admitted to hospital should be assessed and considered for home treatment;
- Service user feedback scores through the national Friends and Family Test survey as prioritised by our Governors.

As with previous years, the audit has confirmed the validity and accuracy of the data used within the Trust to monitor, assess and report our performance.

The Trust submitted records during 2015/16 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the published data for admitted care which included the patient's valid

- NHS number was 98.5%;
- Registered GP was 96.0%; and
- GP Practice was 98.88%

No other information was submitted.

The latest published data regarding data quality under the mental health minimum data set is for November 2015. The Trust's performance on data quality compares well to national averages and is summarised as follows:

Percentage of valid records	Data quality 2015/16	National Average
NHS Number	99.9%	99.6%
Date of birth	99.7%	99.6%
Gender	100%	100%
Ethnicity	93%	87.3%
Postcode	100%	99%
Commissioner code	100%	99.5%
GP Code	99.4%	98.4%
Primary diagnosis	100%	99.7%
HoNOS outcome	91.9%	91.5%
The Trust data is for the end of Q3 and comparative data is from the published MHMDS Reports for November 2015		

As a NHS Foundation Trust delivering mental health services we are required to deliver the following standards in respect of data completeness.

Percentage of valid records	Target	2014/15	2015/16
Service user identifiers For example date of birth, gender.	97%	99.8%	99.8%
Service user outcomes For example employment status, HoNOS scores	50%	90.3%	85.1%

Clinical coding error rates

Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

2.10 Information governance

We aim to deliver best practice standards in Information Governance by ensuring that information is dealt with legally, securely and effectively in order to deliver the best possible care to our service users.

During the year we completed a self-assessment through the Health & Social Care Information Centre Information Governance Toolkit framework. Based on our self-assessment Sheffield Health and Social Care NHS Foundation Trust's Information Governance Assessment Report overall score for 2015/16 was 67% for the 45 standards and was graded Satisfactory. A summary of our performance is provided below:

Information Governance Assessment framework - criteria	Achieved			
	2013/14	2014/15	2015/16	2015/16 Current Grade
Information Governance Management	73%	66%	66%	Satisfactory
Confidentiality and Data Protection Assurance	66%	66%	66%	Satisfactory
Information Security Assurance	66%	66%	66%	Satisfactory
Clinical Information Assurance	66%	66%	66%	Satisfactory
Secondary Use Assurance	76%	66%	70%	Satisfactory
Corporate Information Assurance	66%	66%	66%	Satisfactory
Overall	68%	66%	67%	Satisfactory

Note: 'Satisfactory' means we are at Level 2 on all the assessment criteria, based on our self-assessment. There are four levels, with Level 0 being the lowest rating and Level 3 the highest. Each year the standards are increased in different ways. So while our overall percentage scores remain the same the standards required to achieve 'satisfactory' are increased.

Part 3: Review of our Quality Performance

3.1 Safety

Overall number of patient related incidents reported

The Trust traditionally reports a high number of incidents compared to other organisations. This is a positive reflection of the safety culture within the Trust. It helps us to understand what the experience of care is like, spot trends and make better decisions about what we want to address and prioritise for improvement. NHS England assesses our performance using the data supplied through the National Reporting Learning System (NRLS). Our reporting rates are summarised in the table below:

Patient related incidents reported	Number of incidents reported	Our Incidents per 1,000 bed days (note 1)	National Incidents per 1,000 bed days
Apr 13-Sept 13	1,505	27.1	26.4
Oct 13 - Mar 14	1,625	42.4	32.5
Apr 14 - Sept 14	2,129	55.3	32.8
Oct 14 - Mar 15	2,357	66.7	31.1
Apr 15 – Sept 15	1,982	60.8	38.6
Source: National Reporting Learning System Incident rate = number of incidents compared to volume of in-patient care (occupied bed days)			

Our incident rate per 1,000 days has increased over the last 2-3 years. This is partly due to increased/ improved reporting rates, but more noticeably because over this period the amount of care we have provided within in-patient settings has reduced significantly from 55,599 bed days in Apr13 - Sept13 to 35,324 bed days in Oct14 -Mar15. If our numbers of bed days had remained at the same level of April 13 - Sept 13 then our incident rates for Oct 14 – Mar 15 would have been 44.4.

Nationally, based on learning from incidents and errors across the NHS, NHS England has identified a range of errors that should always be prevented. These are often referred to as 'never events', because with the right systems to support care and treatment in place they should never need to happen again. None of the incidents that occurred within the Trust over the last year were of this category.

Patient safety alerts

The NHS disseminates safety alerts through a Central Alerting System. The Trust responded effectively to all alerts communicated through this system. During 2015/16 the Trust received 82 non-emergency alert notices, of which 98% were acknowledged within 48 hours, 11 were applicable to the services provided by the Trust and 96% were acted upon within the required timescale. We aim to achieve 100%. In addition a further 19 emergency alerts were received and acted upon straight away.

Patient safety information on types of incidents

Self-harm and suicide incidents

The risk of self-harm or suicide is always a serious concern for mental health and substance misuse services. The latest NRLS figures show 14.2% of all patient safety incidents reported by the Trust were related to self-harm, in comparison with 21.2% for mental health Trusts nationally.

Proportion of incidents due to self-harm/suicide	Number of incidents reported	Our incidents as a % of all our incidents (note 1)	National incidents as a % of all incidents
Apr 13-Sept 13	176	11.7%	20.4%
Oct 13 - Mar 14	211	13.0%	21.0%
Apr 14 - Sept 14	260	12.2%	20.0%
Oct 14 - Mar 15	334	14.2%	21.2%
Apr 15 – Sept 15	280	14.1%	20.9%
Source: National Reporting Learning System			

Disruptive behaviour

In previous years the Trust has reported relatively low incidents of disruptive and aggressive behaviour within our services compared to other mental health organisations. This has increased over the last three years as we have prioritised and progressed significant improvement work under our RESPECT programme. Our reported incidents are now higher than the national averages. This is summarised in the table below:

Proportion of incidents due to disruptive behaviour	Number of incidents reported	Our incidents as a % of all our incidents	National incidents as a % of all incidents
Apr 13-Sept 13	290	19.3%	17.0%
Oct 13 - Mar 14	355	21.8%	16.1%
Apr 14 - Sept 14	446	20.9%	16.1%
Oct 14 - Mar 15	471	20%	15.2%
Apr 15 – Sept 15	423	21.3%	15.3%
Source: National Reporting Learning System			

Medication errors and near misses

Staff are encouraged to report near misses and errors to make sure that we are able to learn and make our systems as safe and effective as possible. The proportion of incidents reported that relate to medication errors has historically been below national averages. However, improved reporting has shown an increase of this type of incident over the last two years.

Proportion of incidents due to medication errors	Number of incidents reported	Our incidents as a % of all our incidents	National incidents as a % of all incidents
Apr 13-Sept 13	87	5.8%	8.8%
Oct 13 - Mar 14	98	6.0%	9.0%
Apr 14 - Sept 14	136	6.4%	9.2%
Oct 14 - Mar 15	193	8.2%	8.9%
Apr 15 – Sept 15	161	8.1%	8.6%
Source: National Reporting Learning System			

Cleanliness and infection control

The Trust is committed to providing clean safe care and ensuring that harm from infections is prevented. An annual programme of infection prevention and control details the methods and actions required to achieve these ends. This includes:

- processes to maintain and improve environments;
- the provision of extensive training;
- systems for the surveillance of infections;
- audit of both practice and environment;
- provision of expert guidance to manage infection risks identified.

This programme is monitored internally and externally by the provision of quarterly and annual reports detailing the Trust's progress against the programme. These reports are publically available on the Trust's website.

Single sex accommodation

The Trust is fully compliant with guidelines relating to providing for appropriate facilities for men and women in residential and in-patient settings. During 2015/16 we have reported no breaches of these guidelines. We reviewed arrangements to ensure mixed sex guidelines were adhered to within our services at Forest Close during the year. Following this we made some changes to accommodation arrangements to ensure we remained compliant with the guidelines.

Safeguarding

The Trust complies with its responsibilities and duties in respect of Safeguarding Adults and Safeguarding Children. We have a duty to safeguard those we come into contact with through the delivery of our services and to identify those who may have experienced or are experiencing abuse in all of its forms. We fulfil our obligations through ensuring we have:

- Systems and policies in place that are compliant with legislation and best practice;
- The right training and supervision in place to enable staff to recognise vulnerabilities and indicators which may suggest abuse and take action;
- Expert advice available to staff to enable them to reduce the risks to people, which is well utilised by staff.

We have worked hard over the last year to consolidate staff awareness and provide improved comprehensive safeguarding training which has increased training compliance over the year. We will continue with our training programme into next year, and will ensure improvements in training provision are delivered.

Reviews and investigations

We aim to ensure that we review all our serious incidents in a timely manner and share conclusions and learning with those affected, and our Commissioners. We monitor our performance in respect of completing investigations within 12 weeks and undertaking investigations that are assessed as being of an 'excellent/ good' standard. Following the conclusion of the investigation report with our Commissioners we have identified a need to ensure remaining requests for clarifications or further information are resolved within an appropriate timescale. Historically we have experienced challenges in this area and we continue to prioritise our efforts to improve this.

During the year we commissioned an external agency, Consequence UK, to undertake a review of our serious incident procedures to ensure they are effective and enable our investigation capacity to be focussed on the areas where the highest impact can be realised in terms of:

- Identifying best practice;
- Identifying lessons to be learnt;
- Ensuring lessons are effectively translated into action.

The recommendations following the review include adopting revised investigatory tools, including a care plan review template, report framework and action plan template and revising Trust policy to include these new tools. These tools enable the Trust to use its investigation resources more efficiently through concentrating on incidents where failings have occurred. This will heighten the learning that occurs following such incidents. These recommendations will be implemented during 2016/17.

Overview of incidents by type

The table overleaf reports on the full number of incidents reported within the Trust. It then reports on the numbers of those incidents that were reported to result in harm for service users and staff.

During 2014/15 we introduced an on-line incident reporting tool to make it easier for staff to report incidents that had occurred. We believe this is the main reason why the 'all incidents' reported has increased significantly during 2014/15, and has continued to increase as the tool has been rolled out across more services. Another change was the feedback we received from the CQC when they inspected our services in October 2014. They found that discrepancies across in-patient wards in medication stock, while noted at ward level, wasn't being reported through the Trust's incident procedures. As we have responded to this we are now capturing and reporting more medicines related incidents than before.

While we remain of the view that the main reason for the increased numbers is due to improved reporting practices we are committed to continually reviewing practice, reviewing the incident data and engaging with staff and service users to maintain a full awareness of safety across our services.

Overview of incidents by type

Incident numbers	2013/14	2014/15	2015/16
All incidents (service users, staff, members of public, buildings)	6477	7857 (a)	8486
All incidents resulting in harm	1419 (a)	1886 (a)	1668
Serious incidents (investigation carried out)	35 (a)	23 (a)	23
Incidents involving service users Patient safety incidents reported to NRLS (d)	3777	4946 (a)	5370
Patient safety incidents reported as 'severe' or 'death'	36 (a)	24	26
Expressed as a percentage of all patient safety incidents reported to NRLS (d)	0.98% (a)	0.49% (a)	0.48%
Incident Type	**2013/14**	**2014/15**	**2015/16**
Slips, Trips and Falls incidents	1175	1265 (a)	1207
Slips, Trips and Falls incidents resulting in harm	419	451 (a)	399
Self-harm incidents	444	668	674
Suicide incidents (in-patient or within 7 days of discharge)	0	0	0
Suicide incidents (community)	17 (b)	21 (b)	13 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	2162	2317 (a)	2392
Violence, aggression and verbal abuse incidents resulting in harm	266 (a)	393 (a)	405
Medication Errors	345 (a)	491 (a)	640
Medication Errors resulting in harm	1	0	2

Incident numbers	2013/14	2014/15	2015/16
Infection Control			
MRSA Bacteraemia incidents	0	0	0
Clostridium difficile Infection incidents (new cases) Showing number of incidents, then people affected in brackets	1	1	5(e)
Periods of Increased infection/Outbreak incidents			
• Diarrhoea and vomiting (eg Norovirus)	1	7	4 (25)
• Coronavirus	0	0	1 (11)
• Influenza	0	0	0
MRSA Screening – based on randomised sampling to identify expected range to target	47%	50%	21% (f)
Staff Influenza Vaccinations	50%	50.7%	22%

(a) Incident numbers have increased/decreased from those reported in the 2014/15 Quality Report due to additional incidents being entered onto the information system, or incidents being amended, after the completion of the report.

(b) The figure has increased from that reported in last year's Quality Report due to the conclusion and judgements of HM Coroner's inquest.

(c) Figures likely to increase after the conclusion of future HM Coroner's inquests. Will be reported in next year's report.

(d) The NRLS is the National Reporting Learning System, a comprehensive database set up by the former National Patient Safety Agency that captures patient safety information.

(e) Four of the cases were assessed as being unavoidable.

(f) Department of Health screening guidance changed during 2015/16, it is therefore not possible to compare results to previous years.

3.2 Effectiveness

The following information summarises our performance against a range of measures of service effectiveness.

Primary Care Services – Clover Group GP Practices

There are many performance targets allocated to GP Practices locally and nationally, namely immunisation and cancer screening, quality and access.

The Clover Group Practice have high numbers of patients who are registered who have complex needs. The large multi-site practice of 16,500 patients serves a majority multi-ethnic migrant population in areas of social deprivation within Sheffield. Over 60% of the registered population are from ethnic minority backgrounds, including one of the city's highest Slovak Roma population. The Mulberry site provides a specialist healthcare service to Sheffield's asylum seeking population and victims of trafficking. The needs of the practice populations bring a number of acknowledged challenges for the service to deliver the range of expected standards, as patients struggle to understand the importance of the range of health screening, and often a lack of long term stability in their lives mean that patients do not attend for planned care.

A significant amount of work goes into supporting the patients of the practice and more vulnerable groups to understand the benefits of uptake of vaccinations and screening and attending for chronic disease reviews and reviews of medication. The Clover Group works in partnership with local organisations to deliver educational messages and support to communities to understand the importance of regular health checks and screening. The practices have worked with a third sector partner to host practice champions, a group of patient volunteers whom which have been trained in key health topics including cancer screening, stopping smoking, health eating to deliver some activities and key messages across the community in Darnall, the Clover Group's biggest site. The Mulberry team also works very closely with significant partners around asylum health to support the health and social care needs of this particular vulnerable group.

Access to services, specifically in two of the Clover Group teams in Darnall and Tinsley continue to be problematic due to the levels of need and high demand from the registered population. The Slovak Roma populations are registered here with high levels of need and complex issues. A significant amount of work will be carried out during 2016/17 in response to delivery of a new service specification working with patients, families, communities and carers to improve the access to these services.

The Quality Outcomes Framework (QOF) is one of the main quality indicators of primary care and provides a range of good practice quality standards for the delivery of GP services. The table below summarises the overall achievement of all the QOF standards.

The previous position was due to the introduction of many new QOF standards and an increase in % thresholds making QOF harder to achieve, rather than a reduction against the previous year's performance. Clover achieved exception performance in 2015/16 with a robust planned and structured approached to the management of key QOF indicators and chronic disease management. The contract target for QOF is 95%.

Year	Clover
2013/14	94%
2014/15	88%
2015/16	98%

The following table summarises performance against national standards for GP services.

With specific regard to the flu vaccinations below, the uptake was lower this year possibly due to a combination of mild winter weather and community pharmacy contracts where vaccines were delivered elsewhere. There are also additional requirements to immunise children with nasal flu.

PRIMARY CARE – CLOVER GPs	This year's target (%)	How did we do?			
		2013/14	2014/15	This year 2015/16	
Flu vaccinations Vaccinate registered population aged 65 and over	75%	75%	72%	71.3%	Needs to improve
Vaccinate registered population aged 6 months to 64 years in an at risk population	70%	58%	51.7%	43.4%	Needs to improve
Vaccinate registered population who are currently pregnant	70%	46%	33.6%	40.6%	Needs to improve
Childhood immunisations Two year old immunisations	70-90%	90%	90%	90%	✔
Five year old immunisations	70-90%	82%	82%	85%	✔
Cervical Cytology	60-80%	66.2%	66.5%	66.1%	✔

Source: System One and Immform

Substance Misuse Services

The four commissioned services continue to prioritise ensuring timely access to primary and secondary care treatment. The service aims to ensure all of Sheffield's population that would benefit from the range of services provided in drug and alcohol treatment are able to access support. The service adopts a range of approaches to engage with people from this vulnerable service user group. Priorities for next year include the further expansion of the universal screening tool to increase the number of people accessing support services for alcohol problems and maximising the numbers of people supported and ready to finish treatment drug and/or alcohol free.

DRUG & ALCOHOL SERVICES	This year's target (%)	How did we do?			
		2013/14	2014/15	This year 2015/16	
Drugs No client to wait longer than 3 weeks from referral to medical appointment	100%	100%	100%	100%	✔
No drug intervention client to wait longer than 5 days from referral to medical appointment	100%	100%	100%	100%	✔
No Premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	100%	✔
No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100%	100%	✔
% problematic drug users retained in treatment for 12 weeks or more	90%	96%	81%	96% (opiates) 81% (non-opiates)	✔
Alcohol Single Entry and Access No client to wait longer than 1 week from referral to assessment	100%	100%	100%	100%	✔
No client to wait longer than 3 weeks from Single Entry and Access Point assessment to start of treatment	100%	100%	100%	100%	✔
Outcomes, Self care All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100%	100%	✔

Information source: National Drug Treatment Monitoring System

Learning Disability Service

A fuller overview of developments within our Learning Disability Services is provided in our Annual Report. During the year there has been a commitment to improving care delivery in partnership with our service users, families, carers and local health and social partners. This has led to developments for our registered and supported living homes, improvements to our respite/short breaks service and a re-invigoration of our stepped care pathways across community and in-patient facilities.

The main service priorities over the last year have been to strengthen the leadership, capacity, culture and partnership working within the Intensive Support Service to improve the consistency of care and support the service to deliver the outstanding levels of service which it has demonstrated it can provide. Over the last year there are already signs of improvement, including significantly shorter periods of admissions and improved clinical outcomes at discharge, and the development plan agreed by the Board in January 2016 will support the service to sustain the improvements being made.

Transforming care is a national strategy developed as part of NHS England's commitment to improving the care of people with a learning disability. One main aim is to reduce admissions and unnecessarily lengthy stays in hospitals alongside reducing health inequalities. Care and Treatment Reviews (CTR) have been designed in response to these concerns. Each review brings together those responsible for commissioning services for individuals with independent clinical opinion and the lived experience of people from diverse communities with a learning disability and their families. The aim of the CTR is to bring a person-centred and individualised approach to ensuring that the needs of the person with a learning disability and their families are met and that barriers to progress are challenged and overcome.

As a service we started this process in October 2015 and since this time there have been over 30 reviews completed to date. Overall, the reviews so far have been well received and provide a great wealth of information about a person's history, with a focus on a person centred, community approach for any future care.

At Love Street, the Community Learning Disability Team has continued to maintain an incredible level of productivity following its 65% reduction in waiting times delivered towards the end of the previous year. This has been achieved through robust approaches to productivity management with staff on the front line contributing to lean and efficient methods of working. Access to care remains at less than 18 weeks for all aspects of multi-disciplinary input.

LEARNING DISABILITIES SERVICE	This year's target	How did we do?			
		2013/14	2014/15	This year 2015/16	
No-one should experience prolonged hospital care ('Campus beds')	Nil	Nil	Nil	Nil	✔
Completion of Care and Treatment Reviews (Nov 15 - March 16)					✔
Number of CRTs completed		n/a	n/a	36	
Percentage completed in timescale		n/a	n/a	88%	
All clients receiving hospital care should have					✔
full health assessments	100%	100%	100%	100%	
assessments and supporting plans for their communication needs	100%	100%	100%	100%	
Information source: Insight & Trust internal self-audit of care plans					

Mental Health Services

Our reconfiguration programme across mental health services has continued to deliver a range of improvements over the last year. The key aim of the new pathway that we have put in place is to rebalance the way in which we currently deliver care away from traditional in-patient settings and into the community. This means increasing access to and the quality of community services as well as incorporating new ones which will enable service users to receive a higher quality service closer to home.

This programme has resulted in substantially reduced lengths of hospital stays and, most importantly, no one has been sent out of city due to lack of bed availability for acute adult beds for the last 18 months. All service users are being offered effective and timely care and treatment near to their homes.

Through the reduction in use of in-patient services, we have been able to invest over £1.8m in improving our community mental health services. This includes:

- £556,000 in our early intervention services, which treat people who are experiencing a First Episode of Psychosis (this includes £249,000 investment by NHS England);

- £778,000 in increasing the capacity of our Community Mental Health Teams and Home Treatment Teams to work with people with complex needs in the community;
- £493,000 to set up an intensive psychological therapy programme for people with a personality disorder.

We have also been working on reconfiguration of our rehabilitation services to ensure that the people of Sheffield have the appropriate services locally and will no longer have to go out of city to receive hospital care. They can either be supported in the in-patient service at Forest Close or supported in the community by the Community Enhanced Recovery (CERT) Team with the aim of eventually transferring to their local Community Mental Health Team once their recovery is stabilised. In the past two years we have:

- Established the CERT Team in July 2014 which has successfully supported over 20 people to return to Sheffield;
- Implemented a recruitment plan to provide increased support to 24 service users, with a plan for the return of all out of city service users to Sheffield;
- Worked to create a single intensive rehabilitation unit at Forest Close to provide appropriate services for the people of Sheffield. Work on Bungalow 1 is complete and the rest of the work is due to be completed early in 2016/17.

As we have successfully implemented the above changes services continue to perform well across a range of measures used to monitor access and co-ordination of care, achieving all national targets expected of mental health services.

The table below highlights our comparative performance on CPA 7 Day follow up and Gatekeeping indicators. We have achieved the standards set for both measures. We compare above average for Gatekeeping and above average for CPA 7 Day follow up. Sheffield Health and Social Care Trust considers that this data is as described due to our development work to ensure effective and appropriate care pathways are in place and the improvements introduced in the previous year to strengthen communication and monitoring around discharge in respect of the CPA 7 Day Follow up standards.

During Quarters 1 and 2 we failed to achieved the delayed transfer of care target of 7.5%. In Quarter 1 our position was 8.6% and for Quarter 8.1%. The main reason for this increased rate was prolonged delays being experienced within our older adult in-patient wards for service users who needed after care packages arranging. During this period joint reviews and development with social services and our local Clinical Commissioning Group (NHS Sheffield) resulted in improvements and rates of delayed transfers of care reduced over Quarter 3 and 4.

During the year new access standards for mental health services were introduced for Improving Access to Psychological Therapies Services and Early Intervention Services for Psychosis. We welcome these new standards and the focus on ensuring that people are accessing and have started evidence based treatments within the specified periods of time. Our performance against the new targets is included in the table below.

MENTAL HEALTH SERVICES	This year's target	How did we do?			
		2013/14	2014/15	This year 2015/16	
Improving Access to Psychological Therapies Number of people accessing services	10,008	11,611	13,535	12,774	✔
New Access targets introduced Q3					
• Start treatment within 6 weeks of referral	75%	n/a	n/a	75.6% (Q4)	
• Start treatment within 18 weeks of referra	95%	n/a	n/a	98.1% (Q4)	
Early intervention People should have access to early intervention services when experiencing a first episode of psychosis. The national target is to ensure we see at least 95% of the intended 75 new clients.	75 new clients per year	106 new clients accessing services	174 new clients accessing services	228 new clients accessing services	✔
New Access targets introduced Q4					
Start treatment within 2 weeks of referral	50%	n/a	n/a	50%	
Access to home treatment People should have access to home treatment when in a crisis as an alternative to hospital care	1,202 episodes to be provided	1,415 episodes provided	1,310 episodes provided	1,418 episodes provided	✔

MENTAL HEALTH SERVICES	This year's target	How did we do?			
		2013/14	2014/15	This year 2015/16	
Delayed transfers of care Delays in moving on from hospital care should be kept to a minimum	No more than 7.5%	6.0%	4.4%	7.6%	Part Year
Annual care reviews Everyone on CPA should have an annual review.	95%	95.7%	95.6%	c.95.2%	✔
'Gate keeping' Everyone admitted to hospital is assessed and considered for home treatment	95% of admissions to be gate-kept	99.8%	99.8%	99.5%	✔
Comparators: National average		98.3%	98.1%	97.4% (1)	
Best performing		100%	100%	100% (1)	
Lowest performing		85.7%	64.6%	61.9% (1)	
7 day follow up Everyone discharged from hospital on CPA should receive support at home within 7 days of being discharged	95% of patients to be followed up in 7 days	96.1%	96.4%	98.3%	✔
Comparators (see note1): National average		97.3%	97.2%	96.9% (1)	
Best performing		100%	100%	100% (1)	
Lowest performing		88.8%	91.9%	50% (1)	
Emergency re-admissions: Percentage of service users discharged from acute in-patient wards who are admitted within 28 days.	5% National benchmark average is 9% (2)	3.6%	4.9%	4.8%	✔

Information source: Insight & Trust internal clinical information systems. Comparative information from Health and Social Care Information Centre.

Note 1: Source for comparative information: NHS England, Mental Health Community Teams Activity Report for Quarter 3.

Note 2: NHS Benchmarking report for mental health services 2014/15.

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Dementia Services

Our specialist in-patient service for people with dementia and complex needs continued focus on improving the care pathway to ensure discharge in a timely manner to the most appropriate package of community care. This results in much better outcomes for the individual concerned. This has enabled more throughput into the ward but recognises the increasing complexity of the service users admitted. As we deliver better and more intensive community services the need for in-patient care has been gradually reducing.

We continue to deliver excellent Memory Services for the people of Sheffield. Sheffield has the second highest diagnostic rates in England, which means people in Sheffield are far more likely to access support with memory problems than elsewhere in the country. More people are receiving support and treatments than before as we get more referrals and see more people.

Over the last several years, however, waiting times for the Memory Service have been unacceptably high. This has remained a shared concerned with our local Commissioners and a number of initiatives over the last three years have been introduced. While these previous attempts have resulted in more people being seen, they haven't had the desired impact of reducing waiting times.

We are pleased to report that further work this year has had a clear impact on reducing waiting times. The service has reviewed its pathway and referral management arrangements and additional short term investment was provided to tackle some waiting list backlogs. As a result of these changes waiting times have reduced significantly. Through the second half of 2015/16 people waited around 6.5 weeks to start their assessment, compared to 23 weeks in previous years. At the end of the year people contacting the service to make an appointment were being offered appointments within 4-5 weeks' time.

DEMENTIA SERVICES	This year's target	How did we do?			
		2013/14	2014/15	This year 2015/16	
Discharges from acute care (G1)	24	43	39	48	✔
Number of people assessed for memory problems by memory management services (new first appointments)	1,100	884	971	1,231	✔
Rapid response and access to home treatment	350	349	330	295	▼

DEMENTIA SERVICES	This year's target	How did we do?			
		2013/14	2014/15	This year 2015/16	
Waiting times for memory assessment	N/A	15.8 weeks	23 weeks	13 weeks (2015/16) 6.5 weeks (Oct15-Mar16)	✔

Information source: Insight & Trust internal clinical information system

3.3 Service user experience

Complaints and compliments

We are committed to ensuring that all concerns are dealt with positively and are used as an opportunity to make sure we are providing the right care and support. Service users, carers, or members of the public who raise concerns can be confident that their feedback will be taken seriously and that any changes made as a result of the findings of the investigation will be used as an opportunity to learn from the experience and make changes to practice and procedures.

The following summarises the numbers of complaints and positive feedback we have received.

Number of	2013/14	2014/15	2015/16
Formal complaints	147	173	140
Informal complaints	217	152	263
Compliments	1,196	1150	1,141

A summary breakdown on the issues highlighted through the complaints we received is provided overleaf.

Issue raised in complaint	Number of times
Access to Treatment or Drugs	8
Admissions and Discharges	10
Appointments	7
Clinical Treatment	13
Commissioning	1
Communications	12
End of Life Care	1
Other	11
Service User Care	17
Prescribing	4
Privacy and Dignity	3
Restraint	4
Trust Admin/Policies/Procedures	6
Values and Behaviours	43

This year the Parliamentary and Health Service Ombudsman notified us that two complaints had been referred to them. No further action was required in one case. The other case is currently under investigation. Of the outstanding cases referred to the Ombudsman prior to 01 April 2015, one required no further action, two cases required remedial action (for example, a letter of apology) and at the time of finalising this report, the outcome of one case is still awaited.

A full picture of the complaints and compliments received by the Trust over the year is available on our website in the Annual Complaints and Compliments Report. We also publish information about the complaints and compliments we have received on a quarterly basis. The reports can be accessed via the following link: www.shsc.nhs.uk/about-us/complaints

We use complaints as an opportunity to improve how we deliver and provide our services. A number of service improvements were made as a result of complaints this year. For example:

- A review of the diagnostic and appointment processes within the Sheffield Adult Autism and Neurodevelopmental Service as well as a review of all information available and provided to service users before their appointment and following their diagnosis;
- The Relationship & Sexual Service reviewed information required in order to complete triage process and considered whether there are ways that this requirement could be met in a timelier manner to shorten the triage phase;
- Staff on the Psychiatric Intensive Care Unit completed the Trust's Race Equality and Cultural Capability Training and implemented the Safe Wards interventions in full;
- The Community Directorate developed an information guide for service users who are in receipt of a care budget that relates to social care needs only;
- The Eating Disorder Service reviewed its current treatment model in relation to difficult to engage service users and is giving consideration to adopting more of an outreach approach rather than relying purely on an opt-in system;
- A review of the Trust's Cashiers Policy as it relates to the reimbursement of service users travel costs for hospital appointments;
- A review of procedures regarding the routine checking of correspondence and a review of how teams communicate with service users, including the use of text and e-mail messages.

What do people tell us about their experiences?

We have two national survey tools to help us understand the experience of our service users. Firstly, the national Friends and Family Test, which shows that people who have used our services are more likely to recommend the services they received to their friends and family. Secondly, the national patient survey for mental health Trusts, which highlights that the experience of our service users compares about the same as to other mental health Trusts.

The tables below summarise the overall results from the last national survey undertaken in 2015.

The national Friends and Family test results for mental health Trusts

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Number of feedback returns	115	166	82	223	120	151	163	157	141	287	269	72
% of Trust service users who would recommend the service they received	91%	92%	93%	95%	98%	95%	96%	96%	95%	95%	98%	99%
National average for mental health trusts	87%	88%	87%	87%	88%	86%	87%	87%	88%	87%	87%	87%

Source: NHS England, Friends and FamilyTest data reports

The Care Quality Commission's annual mental health survey of service users

MENTAL HEALTH SURVEY Issue – what did service users feel and experience regarding	2014 Survey		2015 Survey	
	Patient response	How did we compare with other Trusts	Patient response	How did we compare with other Trusts
Their health and social care workers	7.5 / 10	About the same	7.4 / 10	About the same
The way their care was organised	8.4 / 10	About the same	8.4 / 10	About the same
The planning of their care	6.5 / 10	Worse	6.9 / 10	About the same
Reviewing their care	7.2 / 10	About the same	7.2 / 10	About the same
Changes in who they saw	5.9 / 10	About the same	6.8 / 10	About the same
Crisis care	5.9 / 10	About the same	5.1 / 10	Worse
Treatments	7.2 / 10	About the same	7.3 / 10	About the same
Other areas of life	4.8 / 10	About the same	4.6 / 10	About the same
Overall views and experiences	7.0 / 10	About the same	7.0 / 10	About the same

The following table relates specifically to the nature of the relationship service users experienced with the staff involved with their care and treatment.

Patient Survey – overall experience	2014 Survey			2015 Survey		
	Lowest national score	Highest national score	Our score	Lowest national score	Highest national score	Our score
In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	5.3 / 10	7.4 / 10	6.0 / 10 About the same as other Trusts	5.0 / 10	7.4 / 10	5.9 / 10 About the same as other Trusts
Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	7.8 / 10	9.0 / 10	8.2 / 10 About the same as other Trusts	7.7 / 10	8.8 / 10	8.0 / 10 About the same as other Trusts

The above table highlights our comparative performance on service user experience in respect of contact with our staff and the support and care we have provided. In most of the areas covered in the survey the experience of our service users is about the same as it is in other Trusts in the country. While this offers some assurance about the quality of the services we provide we want to do better than this. We want the experience of our service users to be really positive and among the best in the country. We are concerned that the feedback highlights services users have a poorer experience of care when in a crisis than in other Trusts in the country, and will ensure our current plans continue to deliver the necessary improvements.

Sheffield Health and Social Care NHS Foundation Trust considers that this data (the survey scores in the above table) and the poorer experience in respect of support in a crisis is as described because service users reported variable knowledge and awareness of who to contact within the service during a time of crisis. We are not clearly and consistently communicating information about how to access support during times of crisis.

In response to this we need to continue with our development programme to improve our care pathways for people experiencing a crisis and ensure they are effective.

Our adult services are undergoing a transformation programme to improve the provision of care across community services. This work has a wide scope, and concentrates on developing evidence-based pathways of care, including ensuring high quality crisis care is available, and that service users are provided with better information about their care in general, and are fully involved in their care planning.

Our older adult services have responded to the issues raised around out of hours care by ensuring that staff are routinely telling service user how to contact the out of hours team, who have received training in working with older adults. In addition, the working hours for some teams have been extended to ensure that there is more specialist provision for older adults out of hours.

Our adult and older adult services have worked closely together over the last 12 months to improve services out of hours with significantly increased capacity in the out of hours and liaison services, as well as the development of the Single Point of Access.

We will continue to take the above actions to maintain and improve our position regarding the quality of our services. Our on-going development programmes, our Quality Objectives, and our focus on supporting individual teams to understand their own performance and take decisions to improve the quality of care they provide locally are some of the key actions that will support this.

Improving the experience through better environments – investing in our facilities

The environment of the buildings in which we deliver care has an important part to play and has a direct impact on the experience of our service users.

The design, availability of space, access to natural light, facilities and access to outside areas are all fundamental issues. Getting them right has a direct impact on how people feel about the care and treatment they are receiving. We have made significant progress this year in addressing key areas where our buildings haven't been as good as we have wanted them to be.

Intensive Treatment Service – secure care for people who are acutely mentally ill and in need of intensive care and support

We opened the new Endcliffe Ward in January 2016. This new purpose built facility provides the highest standards of in-patient design and will significantly support the clinical team to deliver excellent and personalised care and treatment to a very vulnerable group of service users.

Our previous ward facility was too small and it did not provide access for the service users to outside space. Recognising this, the Board of Directors invested £4.5million to build a new ward. The Board was proud to open the new facility in January, which not only provides a better environment but also increases the number of beds available to reduce the need for out of town care.

We are pleased to report that the new Endcliffe Ward won the national Design in Mental Health Award for best refurbishment project of 2015/16.

Dovedale Ward – improving in-patient care for older people

Our wards for older people were not as well designed as they needed to be. There was limited communal space and many of the bedroom areas were small and did not provide en-suite facilities for service users. In response to this we opened a new ward in April at the Michael Carlisle Centre. Supported by an investment of over £320,000 Dovedale Ward now provides better access to en-suite facilities and an improved ward environment.

General environment – external review and feedback

The last Patient Led Assessment of the Care Environment across the Trust took place and was published in August 2015. The conclusion of the review is summarised in the table below. The latest results show that our hospital based facilities are above average in all categories for all of our facilities. Between 2014 and 2015 we improved our assessed scores in 21 of the 24 categories.


Sheffield Health and Social Care NHS
Our

Site Location	Date of Review	Cleanliness	Food and Hydration	Privacy and Dignity	Condition and appearance
Longley Centre	March 2013	89.4%	92.5%	89.7%	79.3%
	March 2014	96.4%	90.2%	89.6%	92.1%
	August 2015	98.7%	93.7%	91.6%	90.6%
Longley Meadows	March 2013	83.7%	87.4%	53.9%	65.6%
	March 2014	99.0%	90.1%	83.6%	95.7%
	August 2015	99.2%	91.9%	86.7%	93.7%
Michael Carlisle Centre	March 2013	95.5%	94.7%	94.2%	80.1%
	March 2014	99.2%	95.5%	89.0%	98.9%
	August 2015	99.4%	93.4%	95.5%	95.1%
Forest Close	March 2013	93.4%	88.6%	85.9%	77.1%
	March 2014	96.8%	92.6%	85.1%	94.5%
	August 2015	97.5%	94.2%	95.1%	97.9%
Forest Lodge	March 2013	83.4%	89.0%	96.2%	73.7%
	March 2014	98.0%	85.4%	82.9%	95.8%
	August 2015	99.8%	92.2%	95.1%	97.9%
Grenoside Grange	March 2013	84.9%	92.5%	87.7%	80.1%
	March 2014	99.7%	94.7%	83.3%	100.0%
	August 2015	100%	93.6%	89.5%	98.5%
Firshill Rise	March 2013	n/a	n/a	n/a	n/a
	March 2014	98.5%	87.7%	91.4%	98.4%
	August 2015	99%	90.8%	94.7%	92.7%
National average	March 2013	95%	84%	88%	88%
	March 2014	97.8%	88.8%	87.7%	92.0%
	August 2015	97.5%	88.5%	89.2%	90.1%

3.4 Staff experience

National NHS Staff survey results

The experience of our staff indicates that they feel generally positive about working for the Trust and about the quality of care they are able to deliver. This is a positive position for us to be in, and it helps us to move forward in partnership with our staff and deliver further improvements.

OVERALL ENGAGEMENT & CARE	2013 score	2014 score	compare	2015 Our score	2015 National averages	2015 How we compare
Overall Staff Engagement	3.81	3.78	Best 20%	3.75	3.75	Average
I would recommend my organisation as a place to work	69%	65%	n/a	62%	56%	n/a
I would recommend my organisation as a place of work, or to receive treatment	3.80	3.78	n/a	3.72	2.66	n/a
My organisation acts on concerns raised by service users	73%	76%	n/a	74%	72%	n/a
Care of service users is my organisation's top priority	73%	76%	n/a	76%	70%	n/a
TOP 5 RANKINGS – The areas we compare most favourably in with other mental health and learning disability Trusts						
Percentage of staff appraised in last 12 months	76%	89%	Above average	93%	89%	Above average
% of staff reporting most recent experience of harassment, bullying or abuse (new)	n/a	54%	n/a	61%	49%	Above average
Staff satisfaction with resourcing and support (new)	n/a	n/a	n/a	3.42	3.31	Above average
Percentage of staff suffering work related stress in last 12 months (lower score is good)	41%	47%	Worse 20%	36%	39%	Above average
% of staff working extra hours (lower score is good)	62%	63%	Best 20%	63%	74%	Above average

OVERALL ENGAGEMENT & CARE	2013 score	2014 score compare		2015 Our score	2015 National averages	2015 How we compare
LOWER 5 SCORES – The areas we compare least favourably in with other mental health and learning disability Trusts are as follows.						
% of staff feeling pressure in the last 3 months to attend work when feeling unwell	tbc	66%	tbc	64%	55%	Below average
% of staff agreeing that their role makes a difference to patients / service users	90%	89%	Below average	86%	89%	Below average
% of staff experiencing physical violence from staff in last 12 mths	3%	6%	Worse 20%	6%	3%	Below average
Effective use of patient / service user feedback	n/a	3.67	Above average	3.53	3.68	Below average
% of staff feeling motivated at work	3.78	3.77	Worse 20%	3.79	3.88	Below average
Source: NHS Staff Survey						

Local staff surveys – Friends and Family Test

Within the Trust we complete local survey of staff experience each quarter using the Friends and Family Staff (FFT) survey.

Place to work	Q1	Q2	Q4
% of staff who would recommend Trust as a place of work	70%	67%	n/a
Average for England	63%	62%	n/a

Place to receive care	Q1	Q2	Q4
% of staff who would recommend Trust as a place to receive care and treatment	80%	76%	n/a
Average for England	79%	79%	n/a

Source: NHS England
Note: the FFT for staff is not undertaken in Q3 due to the national staff survey being completed at that time. Q4 data not available at time of publishing Report.

Our local survey results generally are higher than the feedback from the national staff survey and are:

- Higher than the national averages for staff recommending us as a place to work;
- In line with national averages for staff recommending us as a place to receive care.

The Trust employs around 3,000 people and as part of our responsibility to ensure we provide good quality care we participate in the annual NHS Staff Survey programme and local surveys as reported above. The NHS Staff Survey attempts to identify the major factors contributing to staff engagement and motivation. By focusing on these, we aim to enhance the quality of care provided to the people who use our services. The NHS Staff Survey provides us with feedback on the Trust's performance across a range of relevant areas.

Overall, we are encouraged with the above results, although there are areas that we still need to improve on. The positive feedback around engagement over the last several years continues to support our ongoing focus on improving quality and delivering our plans for service improvement. The full survey will be available via the Care Quality Commission website. The survey provides a large amount of detail around complex issues. The Trust looks to take a balanced view on the overall picture.

Informed by the 2015 survey feedback the areas we have prioritised for on-going and further development work are as follows:

Attendance at work when feeling unwell

The level of sickness absence continues to be a focus for action for the Trust as it remains higher than our organisational target of 5.1%. We have a continuous plan for raising awareness of the importance of the issue including our Promoting Attendance Conferences. From the last conference we developed a revised Action Plan which included the appointment of an Attendance and Sickness Absence Case Manager to review in detail those individuals whose level of sickness absence across the whole Trust has given cause for concern, and to provide managers with dedicated support and guidance in managing situations where triggers within the Policy have been hit. We have also undertaken a process of reviewing and renaming the existing absence management policy with a view to simplifying the language and the various stages contained within it. We are working closely with Staff Side colleagues in a partnership approach.

In managing sickness cases we recognise the importance of good quality medical advice and information to support employees both during their absence and to facilitate a supported return to work at the earliest opportunity. We have, therefore, started a process of reviewing the specification for our Occupational Health provision with a view to establishing what improvements can be made to the service. We already provide a confidential staff counselling service and we are looking to build on this by looking at what 'fast track' support might be put in place to support employees with physical and mental health issues from within services provided by the Trust.

Making a difference to service users

As reported in Section 2A, we have reviewed and updated our Quality Improvement and Assurance Strategy. In this strategy we recognise that if we want to make sustainable quality improvements it has to be owned and led by staff within the team concerned. Every member of staff is responsible for maintaining and delivering high standards of care and is expected to strive to improve the quality of care we provide. Our approach, through the new strategy, will ensure staff experience quality improvement positively. We will create and develop the conditions across all our services to make this a reality all of the time.

The ability for the Trust to deliver on this strategy depends on staff having the ability to engage with improvement techniques. To support this strategy we have a programme to equip staff and teams with the information, time and the skills to deliver continuous quality improvement. While we will use a range of quality improvement techniques as appropriate, the core Trustwide approach that we will use will be Microsystems improvement methodology. All teams will be trained in this methodology and have access to on-going coaching and supervision.

Through our development plans we will ensure that our clinical teams:

- Are service user focussed and working collaboratively with service users to deliver personalised care;
- Collect and use appropriate outcome measures to understand effectiveness, safety, experience, and efficiency;
- Have fully trained staff who are supported through supervision and appraisal, understand the quality standards to be delivered and their responsibilities in this;
- Have access to and use high quality information and information technologies;
- Have training and coaching in process improvement skills;
- Have committed and shared leadership;
- Have support from the wider organisation when needed.

Effective use of service user feedback

Understanding the experiences of the people who use our services is essential if we are to be successful in achieving quality improvement. The Trust uses a range of information to monitor service quality and performance. Our approach is to work with service users so they gather feedback from service users about their experiences of services on our behalf. This provides a richer and more informed view about the experience people have of receiving care from us.

Staff experiencing assaults from other staff

Last year, the percentage of staff reporting physical violence from other staff moved from Better than Average to the bottom 20%. A similar result has occurred this year, consequently we will commission an 'in depth' review of this issue. This result, from the staff survey, does not accord with any other reports under our various procedures we have in place across the Trust and the survey indicates no statistically significant change from last year. We have received no complaints of this nature, no reports of serious incidents of this nature, a reduction in claims of bullying and harassment, and staff-side representatives are as perplexed by this outcome as the Trust at this stage.

Any level of violence against staff is a concern. This finding from the survey does not correlate with any reported incidents which would be regarded as gross misconduct and subject to a disciplinary process and potential dismissal. The report has been shared with Staff Side representatives and we will work together to understand the potential for such issues to be unreported. We will also continue to review incident reports to establish if they involve any indications of this issue.

Staff motivation at work

While there are some conflicting outcomes from the Staff Survey regarding staff motivation, it is pleasing that our overall score on this issue has risen slightly, especially when compared with the opposite being recorded nationally. Staff still perceive the Trust generally as a place where they or a family member would receive good treatment, and the number of staff experiencing stress is reported as having reduced significantly this year. Having said that, we will continue to monitor this issue closely, particularly given the earlier issue of staff attending work when possibly feeling unwell.

ANNEXE A

Statements from local networks, overview and scrutiny committees and Clinical Commissioning Groups

Healthwatch

Healthwatch Sheffield is pleased to be offered the opportunity to comment on the Trust's Quality Account. This year the Trust has put considerable effort into meeting with Healthwatch on a more frequent basis, and we feel this has benefited our understanding of their decision making and processes.

As in previous years, the Trust has formatted the document so that it is as accessible and easy to read as it can be given existing constraints. We ask, as we did last year, that the Trust gives some thought to the production of an easier to read version or summary to enable as many people as possible to read the contents.

We note that the priorities for 2016/17 seem broadly similar to last year, and are pleased to see that the Trust acknowledges that there is on-going work to do in these areas. There has been considerable progress on some of last year's priorities, most notably in reducing the waiting times for memory services.

We have once again seen an increase in the number of violent incidents reported in this document, and continue to have conversations with the Trust around the action that is being undertaken to monitor and address this.

At the time of reviewing the draft Report, information was not fully finalised regarding Quality Objective 2 (improving physical health) and we await further feedback to be assured that progress has been made.

Also, within the draft Report data on the performance of the Clover Group was not available to us. As we had raised performance issues last year with the Trust, we have no option but to remain concerned.

There has been an overall improvement in the PLACE scores for most sites this year, and we have worked with the Trust to provide volunteers to support this process.

In conclusion, we feel that this report is clear, well written, and acknowledges where there is more work still to do. We thank the Trust for their work this year and look forward to working with them in 2016/17.

Healthwatch
12 May 2016

Our response

We welcome the helpful feedback from Healthwatch following a review of a draft of our Quality Report.

The final Report contains relevant information regarding progress on our Quality Objective for improving physical health, along with performance data on the Clover Group. We have shared this information with Healthwatch and will review it further in our regular scheduled review meetings.

We will be producing an easy ready summary version of our account. We look forward to on-going dialogue and meetings with Healthwatch during 2016/17 during which we will be able to review progress in more detail on the above issues and other areas of interest.

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee welcome the opportunity to consider your draft Quality Account in line with NHS (Quality Accounts) Regulations 2010. We view this as a valuable aspect of health service provision scrutiny that looks at the things that are important to the public of Sheffield and make the following comments:

The Committee would like to see three year performance trend throughout with the inclusion of comparator year data and that objectives/priorities do not fall off or out of the report if not achieved. Pleased to see Quality Objectives for 2016/17 reflect CQC improvement requirement, it is appropriate continuing to focus on these.

We welcome the improvement in waiting times reported 2015/16 and that the Trust has achieved most of their targets. The reference to working to improve services out of hours over the last 12 months is positive; look forward to the Trust sharing the evidence of impact on the service users.

The Committee note patient related incidents have increased and the CQC assessment required this as an area for improvement. We observe a variable performance with an increase in number of incidents but reduction in most serious incidents and look forward to seeing the outcome of conclusions being implemented from the serious incident procedures review, with a degree of reassurance for the public.

We are pleased to see 93% of staff appraised in last 12 months. The Committee welcome presentation of three year staff experience trend data and would like to see a breakdown by ethnicity.

Scrutiny and Policy Development Committee
09 May 2016

Our response

We welcome the feedback from the Committee in respect of the acknowledgments of progress made over the last year, along with areas for further consideration.

We continue to develop our performance reporting methods and throughout the report have presented performance data over the previous three years were the data is readily available and the target has been established over three years or longer.

In some areas we are reporting on new targets, such as the new access and waiting time targets that were introduced during 2015/16. Before this we did not have the capacity to report on the specific target, for example, access target for Early Intervention in Psychosis services, because this was not previously a quality target and we did not collect information on our performance in that area.

We will continue to monitor our performance trends over the longer term and will incorporate this feedback in our on-going performance reporting framework.

We are finalising our plans to respond to the feedback from the national staff survey and will ensure these plans respond to any differences of experience by ethnicity and will report on this next year.

Sheffield Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group (CCG) has had the opportunity to review and comment on the information contained within this Quality Report prior to its publication. Sheffield Health and Social Care NHS Foundation Trust have considered our comments and have made amendments where necessary. The CCG is therefore confident that to the best of our knowledge the information supplied within this report is factually accurate and a true record, reflecting the Trust's performance over the period April 2015 – March 2016.

The CCG commissions Sheffield Health and Social Care NHS Foundation Trust to provide a range of general and specialised mental health and learning disability services. We aspire to continually improve the quality of services provided by the Trust and the experience of those people who use them. We do this by reviewing and assessing the Trust's performance against a series of key performance indicators as well as evaluating contractual performance. We also work closely with the Care Quality Commission, who are the independent regulator of all health and social care services in England, as well as Monitor who are the sector regulator for health services in England (and who

are now part of NHS Improvement), to ensure that care provided by the Trust meets the regulators requisite standards and that the Trust is well led and is run efficiently.

This Quality Report evidences that the Trust has achieved positive results against most of its key objectives for 2015/16. Where issues relating to clinical quality have been identified, we have worked closely with the Trust to ensure that improvements are made. We will continue to take this approach into 2016/17 and beyond, through what will be a very challenging period for the NHS. We will continue to build on existing good clinical and managerial relationships to proactively address issues relating to clinical quality so that standards of care and governance are upheld whilst services continue to evolve to ensure they meet the changing needs of our local population. We will continue to set the Trust challenging targets whilst at the same time incentivise them to deliver high quality, innovative services.

Sheffield CCG
17 May 2016

Our response

We welcome the comments and response from NHS Sheffield Clinical Commissioning Group.

We look forward to working with the CCG during 2016/17 to ensure the plans in place to deliver the necessary improvements will result in real benefits and improved outcomes for the people of Sheffield.

ANNEXE B

2015/16 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Reports for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

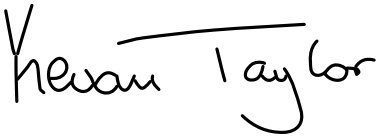
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2015 to May 2016;
    - Papers relating to Quality reported to the Board over the period April 2015 to May 2016;
    - Feedback from the Commissioners dated 17 May 2016;
    - Feedback from Governors on 10 May 2016;
    - Feedback from Healthwatch on 12 May 2016;
    - Feedback from the Scrutiny Committee on 09 May 2016;
    - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
    - The latest national patient survey issued in 2015;
    - The national staff survey issued February 2016;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated [tbc] May 2016; and
    - Care Quality Commission report following its inspection of Trust services published in June 2015 and intelligent monitoring reports issued during 2015/16;
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice; and
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Chairman
25 May 2015



Chief Executive
25 May 2015

ANNEXE C

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust to perform an independent assurance engagement in respect of Sheffield Health and Social Care NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- Admissions to inpatient services had access to crisis resolution home treatment teams; and
- 100% enhanced Care Programme Approach patients receive follow up contact within seven days of discharge from hospital.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes and papers for the period April 2015 to April 2016;
- papers relating to quality reported to the Board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from Healthwatch Sheffield;
- feedback from Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- the 2015/16 Head of Internal Audit's annual opinion over the Trust's control environment; and
- the latest CQC Intelligent Monitoring Report.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent

permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sheffield Health and Social Care NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Sheffield Health and Social Care NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
Leeds
26 May 2016