2016/17
Quality Report

Sheffield City Council

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Contents

Part 1: Quality Report 2016/17 Chief Executive's welcome

I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Report for 2016/17.

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.

At the end of March 2017 the Care Quality Commission (CQC) reported on their findings following their comprehensive inspection of some of our services in November 2016. The Trust was assessed as 'Good'. This was upgraded from a 'Requires Improvement' rating following their inspection in October 2014 and report of June 2015.

We are all delighted that the Trust is now rated as 'Good' overall as it reflects the significant progress made since the last inspection two years ago. I am very proud of the way that everyone involved in the Trust – staff, service users, carers, volunteers and Governors - have worked together to bring about this improvement. It is a testament to all their hard work and dedication.

Eight of our ten core services are now rated as 'Good'. All our services were 'Good' or 'Outstanding' in the caring and responsive domains. The effective and responsive domains improved from 'Requires Improvement' to 'Good' since the last inspection. Three of the five social care locations also inspected this year improved from 'Requires Improvement' to 'Good'.

However, while there is much to be proud of in the inspection reports, we know we still have more work to do. We know that there are areas where we can do better and we are committed to making further improvements.

We take service user safety very seriously and we have already taken a number of actions in respect of the reports' recommendations. This is discussed in more detail on page 105.

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.

Our approach to quality is set out within our Quality Improvement and Assurance Strategy 2016-2022 and the accompanying implementation plan, which is in the process of being refreshed to accommodate the Trust's overall Quality Improvement Plan.

The purpose of the strategy is to develop a culture of continuous quality improvement. The 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 still have work to do to ensure the quality of what we

provide is of a consistently high standard for every person in respect of safety. 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

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

In setting our plans for 2016/17 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 included 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 more than 300 members about priorities we proposed for this year. From this review the Council of Governors has 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 represented 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 2016/17 were:

Responsiveness	**Quality Objective 1**: We will improve access to our services and treatment;
Safety	**Quality Objective 2**: We will improve physical health outcomes;
Experience	**Quality Objective 3**: We will improve experience through service user engagement and feedback.

Quality Objective 1: We will improve access to services and treatment

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 were seen quickly when they needed to be. 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 improvements in reducing waiting times over the past few years, but we knew that we still had more to do. 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 2016/17 we planned to:

- Exceed national standards for IAPT and Early Psychosis;
- Improve access to urgent and crisis services , ensuring effective access over the 7 day period;
- Provide access to a health based place of safety for people detained under section 136;
- Improve access to memory services;
- Improve access and support for people with substance misuse problems;
- Increase the number of people who have a care and treatment review;
- Reduce durations in in-patient care to a minimum.

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. Over the past, waiting times for the memory service had been unacceptably high. This had been a shared concern with our local Commissioners and a number of initiatives over the last three-four years have been introduced.

We are delighted to report that improvements throughout 2015/16 in reducing waiting times have continued and have been sustained at a steady rate during 2016/17. The care pathway and referral management arrangements have been reviewed and all waiting lists backlogs have been cleared. While we were beginning to see the impact of these improvements during 2015/16, with people beginning to wait around 6.5 weeks (from an average of 23 weeks during 2014/15), we have continued to improve this during 2016/17 and have consistently achieved an average of people waiting 3.9 weeks throughout the year.

Measure	2015/16	2016/17
Number of people assessed for memory problems by memory management services (new first appointments)	1,231	1,201
Average waiting time for people to be assessed by the memory management service for a routine appointment	13 weeks (2015/16) 6.5 weeks (Oct15-Mar16)	Q1 - 3.9 weeks Q2 – 4.1 weeks Q3 – 3.8 weeks Q4 – 3.8 weeks

Improving Access to Psychological Therapy (IAPT) Services

The focus on reducing waiting times for the IAPT Service over previous years had been successful in reducing the average waiting times across Sheffield, as well as reducing certain GP practices waiting times, where they were experiencing longer that average waiting times. In 2015/16 national access targets for mental health services were introduced for the first time. The national target was for 75% of people referred to IAPT Services to commence treatment within six weeks of their referral, and for 95% of people referred to commence treatment within 18 weeks.

National Target	2015/16			
Percentage accessing treatment within 6 weeks of referral (target is 75%)	Q1 n/a	Q2 n/a	Q3 76.7%	Q4 75.6%
	2016/17			
	Q1 77.4%	Q2 87.9%	Q3 89.2%	Q4 90.1%
Percentage accessing treatment within 18 weeks of referral (target is 95%)	**2015/16**			
	Q1 n/a	Q2 n/a	Q3 97%	Q4 98.1%
	2016/17			
	Q1 98%	Q2 99.5%	Q3 99.5%	Q4 98.8%

As is clearly shown in the tables above, our IAPT Services are performing very well and are exceeding both national targets. We are seeing more people than the national averages, which means our referral pathway and close working with GPs is ensuring that more people who could benefit from talking therapies are being referred. 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.

We re-launched our IAPT Services in May 2016 to enhance service user choice and further improve access. Service users can now access the IAPT Service at their GP practice as well as being able to self-refer. Online booking onto stress control and improving wellbeing sessions is also now available.

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 coordinator with two 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 was introduced from Q4 onwards in 2015/16 and last year the Trust Board invested more than £500,000 to improve the numbers of care coordinators and therapists working into a newly organised Early Intervention Service. This ensured we were able to establish effective service pathways to respond to new referrals quickly.

During the year we achieved the new standard for people with a first episode of psychosis being assessed and on the caseload of an Early Intervention care coordinator within two weeks. We achieved this for 57% of the people we saw.

Health Based Place of Safety

In November 2016 we increased our provision of our health based place of safety. The Place of Safety is a city wide service that has been provided since 2006 and provides a safe place for mental health assessments to take place for people found by the police in a public place who appear to need immediate care or control and have been detained under Section 136, Mental Health Act.

Our provision has increased from one to two beds and the suite has been renovated to provide a more comfortable and safer environment for people who are detained there.

Reduce Duration of In-patient Care

A key goal within our in-patient services this year was to reduce the length of time that people stayed within these facilities. Our analysis of this illustrates significant decreases in this during the year. Further information is contained in the 'Effectiveness' section within this report.

How will we keep moving forward?

- We will continue to maintain our current performance levels across Memory Services and IAPT Services and improve our performance within our 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 2017/18.

Quality Objective 2: We will improve physical health outcomes

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 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 to make.

We said we would
Continue our development plan, focussing in particular on the following areas:
- Assess the physical health needs of people receiving care

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.

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. While we perform better in delivering practice standards relating to diagnosis, care planning and medications, we need to improve our communication regarding physical health screening and observations.

Standard	% achieved
NHS Number	98%
Primary and secondary mental and physical health diagnoses	68%
Medications prescribed and recommendations	73%
Monitoring and/or treatment needs for cardio-metabolic risk factors identified	15%
Care Plan or discharge plan	78%

Improving physical health assessments for people with a serious mental illness receiving mental health in-patient care and community based 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 or receiving treatment in the community.

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 achieved an average of 98% for assessing and screening within our in-patient services and 64% for our community services. For the necessary interventions to be undertaken, following screening, we achieved 99% within our in-patient services and 68% for our community services. This continues to be an area for improvement as we move into 2017/18 as we strive to ensure our service users are receiving the necessary screening checks and that interventions are recorded accurately within our care planning arrangements.

In-patients **Standard – assessment and screening**	**% achieved or evidence of service user refusal**
Smoking circumstances	98%
Alcohol use	98%
Substance misuse use	98%
BMI measured	100%
BP measured	100%
Glucose levels measured	96%
Lipids recorded	96%

In-patients **Standard – evidence of physical health interventions when required/indicated**	**% achieved or evidence of service user refusal of treatment intervention**
Smoking circumstances	94%
Alcohol use	100%
Substance misuse use	100%
BMI measured	100%
BP measured	100%
Glucose levels measured	100%
Lipids recorded	100%

Community Services **Standard – assessment and screening**	**% achieved or evidence of service user refusal**
Smoking circumstances	78%
Alcohol use	63%
Substance misuse use	72%
BMI measured	47%
BP measured	58%
Glucose levels measured	69%
Lipids recorded	64%

Community Services Standard – evidence of physical health interventions when required/indicated	**% achieved or evidence of service user refusal of treatment intervention**
Smoking circumstances	56%
Alcohol use	56%
Substance misuse use	79%
BMI measured	50%
BP measured	75%
Glucose levels measured	63%
Lipids recorded	100%

Our performance overall in delivering each standard for each patient was 51% achievement of all the standards.

How will we keep moving forward?

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

- 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 initiatives in relation to smoking and alcohol as required within our CQUIN programme.

Quality Objective 3: We will improve experience through service user engagement and feedback

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 discussing priorities for the Trust, our Governors 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, which is led by a service user. This department supports the implementation of our Service User Engagement Strategy and improves our understanding of the experience of the people who use our services.

We said we would
Continue our development plan, focussing in particular on the following areas:
- Further development of approaches to regular monitoring of service user experience;
- Embed collaborative care planning;
- Reduce restrictive practices.

How did we do?
The Board of Directors agreed an additional investment of £100,000 during the year to further develop the functioning of the service user monitoring unit within the Trust. An additional Engagement Manager has been recruited and a further post is currently being recruited to lead the implementation of our Service User Engagement Strategy.

We revised our implementation plan of the strategy, which was approved by the Board of Directors in March 2017.

We have contracted with Care Opinion to strengthen our service user and carer feedback mechanisms and to assist us to easily interpret our feedback. We have continued to increase the level of service user and carer involvement across the Trust.

Here are some of the key developments we have made this year:
- We held a conference in November 2016, following the redesign of our rehabilitation pathway to gain feedback from service users and staff about the changes. The revised pathway has resulted in shorter in-patient stays and joint working with community services;
- We are continuing to encourage more feedback through the Friends and Family Test, which nine out of 10 service users state that they would recommend our services to friends and family (see section 3.3);
- The number of local service user network groups we have running across the Trust has increased this year.

A comprehensive mapping exercise has begun this year to identify and collate levels of service user/carer engagement across all services within the Trust. From the information we have gained so far we can see teams are:
- Promoting the Friends and Family Test;
- Using Fastrack forms;
- Using "You said, we did" boards;
- Having service user membership in Microsystem improvement teams;

- Promoting carer groups;
- Holding drop in sessions for service users and their carers to talk to managers of the services;
- Obtaining regular service evaluations.

Service users are continuing to work with our staff in implementing and embedding collaborative care planning. This has seen positive improvement in service users feeling involved in their care.

The Trust has a Reducing Restrictive Practice Programme which looks at our usage of restrictive interventions across the Trust and considers progress against the Programme. Data for the number of service users who have been restrained and secluded are provided in the table below. The data shows that there has been no reduction in restrictive interventions within the Trust and there has been slow progress implementing actions to reduce restrictive interventions.

Incidences of Restraint		
2014/15	**2015/16**	**2016/17**
447	767	701
Incidences of Seclusion		
2014/15	**2015/16**	**2016/17**
322	335	296

The Trust's plan for reducing restrictive practice includes the implementation of Safewards, Respect training, post incident reviews and improving activity on wards. (Safewards is an evidence based intervention that is proven to reduce restrictive interventions).

How will we keep moving forward?
Following our refreshed strategy implementation plan, we will continue to develop and deliver improvements as set out in our strategy and monitor our performance against this.

We will develop our working with Care Opinion to increase the service user and carer feedback we are receiving and to make real improvements based on the feedback.

The in-patient Directorate will lead and manage the effective implementation of the plan to reduce restrictive interventions. This approach will include a monthly performance meeting where all in-patient wards will be held account to delivery of the agreed project plan within defined timeframes. Effective controls have been introduced to ensure delivery.

Our Quality Objectives for 2017/18

In considering our goals for 2017/18 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 March 2017. This is summarised in more detail in Section 2B of this report. The Trust's overall rating is 'Good'. Following the CQC inspection, the Board has committed to strengthening its approach to service user safety across the Trust. The Trust will develop a more focussed safety plan that will be incorporated into its Quality Improvement and Assurance Strategy.

National Standards and Priorities

Since the introduction of the Single Oversight Framework, we have maintained our segment rating of 2.

We have exceeded the national access standards for IAPT Services during 2016/17 and have achieved 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 five performing areas within England. We have worked in partnership with our local CCG in Sheffield to deliver 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 seven 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;
- The strengthened safety focus of our 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 service user experience, involvement and engagement;
- Improving physical, mental and social wellbeing outcomes for all service users.

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	Reconfiguration of community services including CMHTs, SORT and Specialist Psychotherapy	Attainment of Achieving Better Access standards • Referral conversation rate • No of people receiving treatment • No of people discharged / re-referred within 90 days.
In-patient	Increasing screening and referral to substance misuse Return people from out of city	Monitor in line with CQUIN reporting
Specialist	Liaison To meet 24/7 Urgent and Emergency Mental Health targets (issued Dec 16).	Liaison access target (achieving Better Access to 24/7 Urgent and Emergency Mental Health care; NHSE, NICE, Dec 2016) • Emergency – response within 1 hour • Assessment completed within 4 hours
	Older Adult Community To increase the number of service users responded to within one working day of referral.	Older Adult Community • Emergency/urgent – response within one working day (7 days a week)
	Specialist Services Work towards 18 week pathway ensuring urgent cases are offered an appointment within 2 to 4 weeks.	Specialist Services Waiting times achieved for urgent and routine cases
	To introduce pre-assessment sessions to inform choice and support consent (gender, aspergers)	
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.
	Improved support and access for people with a learning disability into mainstream mental health services.	Green light for mental health audit.

QUALITY GOAL 2: Improving service user experience, involvement and engagement		
Directorate	**Directorate specific goal**	**Measured by**
Community	Co-produce a local Service User Involvement and Engagement strategy to include major service change, local service improvement initiatives.	Strategy in place and monitored as part of Directorate's governance structures. Evidence of service user engagement in all change programmes.
	Undertake 6 monthly thematic review of Friends and Family Tests, complaints, compliments, incidents and serious untoward incidents	Evidence of embedding of action plans from complaints, incidents and serious untoward incidents, evidence of learning from thematic reviews and demonstrable change has been embedded.
In-patient	To reduce the amount of restrictive practice and to improve service user experience when intervention is needed	To reduce rates of restrictive practice by 20%
	To improve our engagement with service users at the In-patient foru	To improve attendance at Forums, establishing a benchmark and measuring against this
	To have proactive engagement with service users throughout the redevelopment at Longley	Evidence of engagement in a range of forums
	To ensure activity is everybody's business on acute and rehab wards	Service user feedback
	To implement Safewards fully in all teams	Evidence of implementation in each section
Specialist	Service user representatives will be: • Included in membership of service governance meetings or • Included within other alternative forums which include relevant information and discussions • Included in consultations regarding service developments/reconfigurations	Number of services evidencing regular service user representation
Learning Disabilities	Reduce restrictive practices. Develop PBS Academy framework.	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 Deprivation of Liberty Safeguards. Reduction in length of stay and delayed discharge within Firshill ATS. Reduction in length of stay and delayed discharge within out of area in-patient/locked rehab settings. Adoption and full implementation of Safewards within ATS.
	Service user engagement strategies.	On-going senior representation at SUEG and SUSG. Recording and learning from governance feedback mechanisms (FFT, compliments and complaints, surveys). Increased engagement with service user governor, families and people with lived experience in the coproduction of service level change.
	Service user involvement in developing collaborative care plans and evaluating outcomes. IT support to integrate accessible care plans and WHO-QoL8 into system.	Increased use of PPSP plan and My Care Plan across in-patient and community services. Increased use of WHO-Qol8 across in-patient and community services as an accessible quality of life measure. IT development/Clinical System Review Board.

QUALITY GOAL 3: Improving physical, mental and social wellbeing outcomes for all service users		
Directorate	**Directorate specific goal**	**Measured by**
Community	Review of assessment processes to ensure a holistic assessment is offered to service users in our care. Continue to interface with primary, acute and other secondary and maintain our delegated responsibility of adult social care to support service users in our care in accessing all elements of health and social care services. Use of PROM and PREM where validated. Implement NICE Guidelines when working with individuals with co-existing substance misuse dependency.	Compliance rates with physical health checks and communication to GPs Use of outcome tools Compliance with Dual Diagnosis.
In-patient	Requol quality of life outcome measure	Requol in place across all acute and rehabilitation services
	Physical health booklet and audits	Audits of physical health and of the use of the recovery booklet
	Increased access to activity including access to cardio walls and activity as everybody's business	Cardio wall to be in place at MCC and Longley site in current gyms
Specialist	Minimise risk of falls and reduce falls with harm • Screen for falls within 72 hours of admission and put a falls plan in place • All in-patient staff to be trained in Falls Management Level 1 and 2	Data distributed monthly to in-patient areas -Therapy Services Audit screening and falls plan Training report
	Improve the awareness of good diet in older people and people with dementia. Review the menus provided in the in-patient areas • Screen for malnutrition within 72 hours of admission • Training –all staff trained to use the MUST screening tool	MUST data Provide training at bases – DVD and cascade training

	• Staff training on eating healthy in dementia care in-patient areas	
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 SHSC. Number of people with a hospital passport in place who are known to SHSC.
	Use of PPSP and/or My Care Plan in the community to support a holistic understanding of need aligned to a PBS that maintains health and well-being.	Increased use of PPSP plan and My Care Plan. Increased use of WHO-Qol8 across in-patient and community services as an accessible quality of life measure.

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 are strengthening our safety focus within 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 Strategy is available on our website and our revised implementation plan will be available there, following approval by the Trust Board.

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. Receives assurance reports on compliance with CQC standards, as well as the improvements necessary to achieve quality services.

Quality Assurance Committee: Brings together the governance and performance systems of the Trust in respect of quality. The Committee provides oversight of Trust systems in work of a range of committees that oversees Trust systems and performance in respect of key matters relating to quality and safety. Receives assurance reports on compliance with CQC standards as well as the improvements necessary to achieve quality services.

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

Executive Management Team: Oversees the operational functioning and delivery of services and programme management oversight of key transformation and improvement projects. The Medical Director is the Trust's Executive lead for quality improvement. Oversees the development and implementation of Trustwide compliance plans.

Service User Safety Group: Monitors the Trust's performance around incident management including serious incidents, learning from incidents, Trust mortality, the patient safety thermometer, infection prevention and control, falls, restrictive practices and all matters of patient safety.

Clinical Effectiveness Group: Establishes our annual clinical audit programme (which includes national and locally agreed clinical audits), oversees the implementation of NICE guidance and embeds the routine use of outcome measures in clinical services.

Service User Engagement Group: Improves the quality of service user quality and experience, ensures that service user experience drives quality improvement and enables the clinical directorates to enhance how they engage with service users.

Systems of Internal Control: A range of policy and performance management frameworks (at individual and team level) as well as 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.

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service, Directorate and Trust wide level. Further developments are to be made within 2017/18 to implement a business intelligence system that provides real-time quality information to front line teams

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 bi-annual 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 publicly available and 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
Following the plans put in place for 2016/17, we are continuing to build on these into 2017/18 and beyond.

We identified the areas below as key areas to enable us to improve our quality governance arrangements and these continue to be our focus from 2017/18 onwards:

- Peer Review and Self Inspection – Continue to build capacity and capability across the Trust by which to self-inspect our services and ensure compliance with quality standards (CQC, MHA,MCA,EMSA);

- Enabling service user engagement in our quality improvement projects – Ensuring that service users are enabled and supported to contribute to Microsystems projects within teams;
- Team Level Information Needs – Implementation of a business intelligence system to provide real-time quality information to front line teams.

To deliver our strategy, it is essential that staff have the ability to engage with improvement techniques. 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.

There are currently 29 teams across the organisation actively working with a dedicated Microsystem coach. A total of 31 coaches from the Trust will have completed their Microsystem coach training by July 2017, 18 of these remain active coaches.

In February 2017, the Trust's dedicated Quality Improvement (QI) Team delivered its first in-house Sheffield Microsystem Coaching Academy (MCA) 2 Day Improvement Course, which attracted 30 members of staff from a variety of clinical, managerial and front-line and Sheffield MCA websites.

Over the forthcoming months, the QI Team will continue to increase the number of coaches and teams engaged within the Trust, ensure consistency through coach peer support and supervision, expand service user and carer engagement and share outcomes, learning and best practice.

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 fundamental 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 2016/17 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC carried out a well-led review of the Trust in May 2016, following its previous comprehensive inspection in October 2014. Following this review, the Trust remained 'Good' in the well-led domain.

During 2016/17 we made changes to our registration in respect of Longley Meadows and Hurlfield View, due to the Local Authority changing its preferred provider. We also became the registered provider of Clover City Practice, a primary medical service (GP practice) we run in partnership with Primary Care Sheffield.

Planned Inspection reported in March 2017

In March 2017 the CQC published its findings from the second comprehensive inspection of services that took place in November 2016. They inspected the following mental health, learning disability, substance misuse and primary medical 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;
- Substance Misuse Services.

As part of this comprehensive inspection, they inspected the primary medical services that we are registered to provide under Jordanthorpe Health Centre.

Overall they assessed our Trust as 'Good', which is an improvement from our previous rating of 'Requires Improvement' in June 2015. The inspectors found many areas of good practice and received many positive comments about care from service users and carers, in particular our engagement with service users was described as outstanding and both staff and services were identified as being caring and responsive.

However, the Trust did receive 'Requires Improvement' in the 'safe' domain. Issues relating to our seclusion rooms and how we manage ligatures were areas identified as areas requiring improvements.

The following services were also inspected as part of the CQC's social care inspection regime during 2016/17:

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

Three out of the five social care services inspected this year improved from 'Requires Improvement' to 'Good' (Woodland View Nursing Home, 136 Warminster Road and Wainwright Crescent).

It is one of our key ambitions to continuously improve our approach to working with service users and learning from their experience of care. We remain, as always, committed to providing high quality health and social care services. We believe we are providing a good standard of care but we know we both can and need to make further improvements. We will use the inspection reports to further drive our quality improvement work forward.

Our action plan

Some of the actions we have taken following the inspection are provided below:

- Introduction of ligature risk reduction bedrooms;
- Introduced CCTV in seclusion rooms;
- Improved monitoring of physical observations;
- Looked at our staffing, management and leadership on our rehabilitation wards.

We still have a number of areas to work on as we strive for excellence across the organisation and we will continue to develop our work with other Trusts, to learn from others and share good practice in this area.

The Trust Board will monitor progress against our improvement plan each month. We are confident that the actions we are taking 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. 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	Good
Well Led	Good
Overall Trust Rating	**Good**

Individual Service ratings

Health care services	**Rating**
Acute wards for adults of working age and psychiatric intensive care unit (Rowan, Maple, Stanage, Burbage, Endcliffe)	Good
Long stay/rehabilitation mental health wards for working age adults (Forest Close and Pinecroft)	Requires Improvement
Forensic in-patient / secure wards (Forest Lodge)	Good
Wards for older people with mental health problems (G1 and Dovedale)	Good
Wards for people with a learning disability or autism	Good
Community-based mental health services for adults of working age (Adult CMHT's)	Good
Mental health crisis services and health based places of safety (Place of Safety on Maple Ward)	Requires Improvement
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)	Good
Substance misuse services	Good
Social Care services	**Rating**
Longley Meadows respite service for people with learning disabilities	Requires Improvement
Hurlfield View community centre for older people with dementia	Good
Woodland View Nursing Home	Good
136 Warminster Road respite service for people with learning disabilities	Good
Supported living services for people with mental health problems at Wainwright Crescent respite service	Requires Improvement

The issues raised at Longley Meadows and Wainwright Crescent relate to monitoring systems, medication practices and practices relating to consent. Action plans were developed to address these issues. (It should be noted that Longley Meadows has since closed, as has been reported earlier in this report).

Mental Health Act reviews

During 2016/17 the CQC has undertaken eight 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: *Stanage Ward, Burbage Ward;*
- Longley Centre: *Maple Ward;*
- Forest Close: *Bungalow 1a;*
- Forest Lodge: *Assessment Ward;*
- *Pinecroft Rehabilitation Service;*
- *G1 Dementia Ward;*
- *Firshill Rise: Learning Disability in-patient unit.*

2.2 NHS Improvement's Assessment

On 01 April 2016 Monitor became part of NHS Improvement. NHS Improvement is responsible for overseeing NHS Foundation Trusts, NHS Trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

During the year, Monitor's risk assessment framework has been superceded by the Single Oversight Framework (from 01 October 2016). The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework doesn't give a performance assessment in its own right.

The Framework helps NHS Improvement identify NHS providers' potential support needs across five themes:

- quality of care;
- finance and use of resources;
- operational performance;
- strategic change;
- leadership and improvement capability.

Trusts are segmented according to the level of support each trust needs. NHS Improvement can then signpost, offer or mandate tailored support as appropriate.

Each Trust is segmented into one of the following four categories:

Segment	Description
1	Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.
2	Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.
3	Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.
4	Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.

NHS Improvement produce a quarterly assessment of the segments Trusts are in. Our Trust is in segment 2.

Further information is available at https://improvement.nhs.uk/resources/single-oversight-framework-segmentation/

From 01 April to 30 September 2016, the former Risk Assessment Framework was in operation. This comprised of two risk assessments, a governance assessment (rated as either red or green) and a continuity of services rating (based on a 1 – 4 rating). Monitor previously used this Risk Assessment Framework to consider the Trust's performance in the following areas:

- 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 show our ratings for the previous year, together with this year's ratings.

2016/17

The Trust has been assessed as being in segment 2 since the new framework came into operation. Under the former framework, the Trust was assessed as Green for the two quarters with no evident concerns regarding our performance.

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.

Single Oversight Framework

2016/17 Segmentation	Annual Plan (expected rating)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Segment	2	N/A	N/A	2	2

Risk Assessment Framework

2016/17 Regulatory ratings	Annual Plan (expected rating)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of services rating	4	4	3	N/A	N/A
Governance risk rating	Green	Green	Green	N/A	N/A

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

2.3 Goals agreed with our NHS Commissioners

A proportion of our income in 2016/17 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 2016/17 £1,905,535 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 £1,351,854 (71%) of the income that was conditional on these indicators. For the previous year, 2015/16 the associated monetary payment received by the Trust was £1,531,225 (91.6%).

A summary of the indicators agreed with our main local health Commissioner Sheffield Clinical Commissioning Group for 2016/17 is shown below.

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	
Improving staff health and wellbeing a) The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues. b) Achievement of a step-change in the health of the food offered on our premises in 2016/17; and Submit national data collection returns by July based on existing contracts with food and drink suppliers c) Improving the uptake of flu vaccinations for frontline clinical staff	ACHIEVED ACHIEVED NOT ACHIEVED
Improving physical healthcare to reduce premature mortality in people with severe mental illness a) To demonstrate Cardio metabolic Assessment and Treatment for Patients with Psychoses in the following areas: I. In-patient Wards II. Early Intervention Psychosis Services III. Community Mental Health Services (Patients on CPA) b) Communication with GPs: To ensure that patients either have an updated CPA care plan or a comprehensive discharge summary; which is shared with their GP.	 PARTIALLY ACHIEVED NOT ACHIEVED
Improving access to dental care for service users with serious mental illnesses in the community under the care of designated teams	PARTIALLY ACHIEVED
Care planning standards Number of service users, treated by the CRHT Team who are assigned to a care cluster who, at the point of discharge, have three outcome measures recorded on their record.	ACHIEVED
Cluster reviews Ensuring all cluster reviews are undertaken within the required time period.	ACHIEVED
Access to Alcohol Services To improve the use of alcohol services for people under the care of our mental health or learning disabilities services.	PARTIALLY ACHIEVED

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	
Formal Carers Assessments Improved support for Carers of people on CPA through the offer and provision of carers assessments	PARTIALLY ACHIEVED
Patient Information The development of discharge information packs for people admitted to in-patient services	PARTIALLY 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 2016/17 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 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 within early intervention in psychosis services;
- Improving staff health and wellbeing – continuing the work from this year into next year, and focussing on improving the number of staff experiencing stress, MSK issues, providing lower sugar, lower salt content foods in our canteens and cafes and improving flu vaccination uptake amongst frontline staff;
- Ensuring the experience of service users who transition from children and adolescent mental health services into adult services is not affected due to the change in provider;
- To work with Sheffield Teaching Hospitals NHS Foundation Trust to provide alternative options for a cohort of people who would benefit from mental or psychosocial interventions to reduce their attendances at A&E;
- To improve the reporting, advice given and onward assistance and support for service users within in-patient settings in reducing their smoking and alcohol consumption.

The CQUIN programme for next year focuses purely on agreed national priorities. We look forward to working collaboratively with our neighbouring Trusts in order to progress these going forward.

We will continue to make improvements in the areas where we did not fully achieve our targets for this year and will monitor this internally as we go through 2017/18.

2.4 Review of services

During 2016/17 SHSC provided number of services via direct or sub-contracted arrangements. While a number of our services are commissioned via non-NHS bodies, predominantly our income is generated via commissioned services with NHS Sheffield Clinical Commissioning Group (SCCG) and the Sheffield City Council (SCC). These contracts cover a range of services i.e. Mental Health, Learning Disabilities, Substance Misuse, Dementia and integrated social care provision.

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 SCCG and other associate CCGs, SCC and

other NHS / non-NHS Commissioners; whether this is under the formal remit of the NHS National Standard Contract or via alternative contractual arrangements as appropriate.

The Trust has agreed quality and performance schedules with its main Commissioners of its services which are embedded within our formal contractual arrangements. With respect to SCCG and SCC; 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 on how we are performing against the agreed quality standards, during the course of the contract term and on-going service provision.

In 2016/17 Sheffield CCG issued a contract performance notice, in relation to the levels of staff who had undertaken the required mandatory training, against the compliance target we had set. Our target to achieve was 80% compliance for of all staff across all mandated subject areas. Our performance in this area was much lower than this and although improvement targets had been set, we struggled to maintain our performance. Additional resources, additional training sessions, together with a review of all our mandatory training finally began to have a positive impact, and our performance in this area has gradually improved throughout the year. Our Commissioners have indicated that our progress is positive and we are expecting the performance notice to be lifted imminently, as a result of this.

During 2016/17 year SCCG and SCC jointly undertook a service review of Longley Meadows, a respite service for people with learning disabilities. 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 was closely reviewed and monitored. The Commissioners were assured that good progress had been made in delivering the actions necessary to respond to the concerns highlighted. (This service closed during the year).

The Trust has established formal forums in place, in terms of monitoring our quality and contractual performance, in particular with our main Commissioners, SCCG and SCC. Through these forums SCCG and SCC have the opportunity to review our performance against quality standards and other performance targets, jointly with us, and query any issues of potential concern, with action plans implemented as necessary, and/ or monitoring arrangements put in place.

During the year issues of concern were raised in respect of our performance in investigating serious incidents in a timely manner. The national serious incident framework stipulates a timescale of 12 weeks from the date of the incident to an investigation being completed and reported into Commissioners. The Trust has struggled with achieving this target for a number of years and as such, our Commissioners requested a remedial action plan to enable the Trust to improve performance in this area. The aim of this was to ensure that all outstanding serious incident investigations were completed by the end of December 2016 and that performance was then maintained within the stipulated timescales. We succeeded in achieving this target and all our outstanding investigations were provided to the commissioners by 31 December 2016. Since this date, we have had no lapses of investigations taking longer than the 12 week timescale, unless previously authorised through the granting of an extension, which are only requested where extenuating circumstances prevail.

Performance in providing carers of people on the Care Programme Approach with a review and assessment of their needs has improved this year. We exceeded the target set through the CQUIN framework in the number of carers who have been asked whether they would wish to have an assessment undertaken. This in turn led to an increased demand of carers awaiting assessments. Additional resource was put in place to focus purely on undertaking these assessments to ensure carers were getting their needs assessed to ensure appropriate care packages were put into place.

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

Health and Safety Executive

There were no Health and Safety Executive visits to the Trust during 2016/17.

South Yorkshire Fire and Rescue

During 2016/17 the South Yorkshire Fire and Rescue Service issued an enforcement notice, following two fires on Burbage Ward, an in-patient ward within our adult mental health services. While the Trust has challenged part of this enforcement notice, remedial actions have been identified to ensure compliance with statutory duties. We are expecting the Fire and Rescue Service to undertake a further inspection in June 2017 where we anticipate this notice will be lifted.

2.6 Compliance with NHS Litigation Authority (NHSLA) Claim Management Procedures

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 more than four years ago.

2.7 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust in 2016/17 who were recruited during that period to participate in research approved by a research ethics committee was 933.

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 School of Health and Related Research in the University of Sheffield, the School of Health and Wellbeing at Sheffield Hallam University, the Sheffield Clinical Trials Research Unit 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 the necessary 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. SHSC also uses 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.

The Trust was involved in conducting 59 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 10 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 2016/17 six national clinical audits and one national confidential enquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

During that period Sheffield Health and Social Care NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sheffield Health and Social Care NHS Foundation Trust was eligible to participate in during 2016/17 are as follows:

- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
  - Inquiry into Suicide and Homicide by people with mental illness
  - Inquiry into Suicide and Homicide by people with mental illness Out of District Deaths
  - Inquiry into Suicide and Homicide by people with mental illness Homicide data
- Learning Disability Mortality Review Programme (LeDeR Programme)
- POMH Topics 1 and 3: Prescribing high-dose and combined antipsychotics
- POMH Topic 7: Monitoring of patients prescribed lithium
- POMH Topic 11: Prescribing antipsychotic medication for people with dementia
- POMH Topic 16: Rapid tranquillisation
- National Audit of Early Intervention Services

The national clinical audits and national confidential enquiries that Sheffield Health and Social Care NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name of national audit SHSC participated in	Number of cases submitted as a percentage of those asked for
National Clinical Audits	
Learning Disability Mortality Review Programme (LeDeR Programme)	68% ***(Note 1)***
National Audit of Early Intervention Services	100%
Prescribing Observatory for Mental Health	
POMH Topics 1 and 3: Prescribing high-dose and combined antipsychotics	100%
POMH Topic 7: Monitoring of patients prescribed lithium	100%
POMH Topic 11: Prescribing antipsychotic medication for people with dementia	100%
POMH Topic 16: Rapid tranquillisation	100%
National Confidential Inquiries ***(Note 3)***	
Inquiry into Suicide and Homicide by people with mental illness	20% (***Note 2***)
Inquiry into Suicide and Homicide by people with mental illness Out of District Deaths	Nil – there were no cases this year
Inquiry into Suicide and Homicide by people with mental illness Homicide data	10% (***Note 2***)
Note 1: In some cases reporting had not occurred before the end of the 2016/17 reporting period due to the timeframe between the relevant death occurring and the end of the reporting period. **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. i.e. in 80% and 90% of all inquiries, we had no record of having had prior involvement with the individual concerned. **Note 3**: Submission of data for Quarters 3 and 4 of each year takes place within the follow year reporting period. Therefore these figures include 2015/16 Quarters 3 and 4 and 2016/17 Quarter 1 and 2.	

The reports of four* national clinical audits were reviewed by the provider in 2016/17 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Review the EIP pathway including the structures and processes associated with the Early Intervention Service;
- Improve processes associated with physical health screening and reviews
- Make improvements to the ‘e-discharge’ system;
- Ensure relevant policies and procedures, along with associated training, are up to date and reflect the learning arising from the audits.

* These included three national clinical audits participated in during 2016/17 together with one participated in during 2015/16 and reported in 2016/17. POMH Topics 1 and 3, and Topic 16 are both due to be reported during 2017/18.

The reports of 17* local clinical audits were reviewed by the provider in 2016/17 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

* There were a number of local clinical audits undertaken but not finished during 2016/17. The reports from these will be reviewed during 2017/18.

Local Audit Recommendations

In total there were 46 recommendations from the various completed local audits. These have been grouped into seven themes, below shows the list of themes in order of popularity:

Themes	Frequency
System or process change	25
Training or meeting to inform people	19
Checklist to be introduced	12
Policy or guideline change	11
Prescribing changes	6
Care record changes	3
Re-audit recommended	3

Summary

From the seven themes that were derived from the recommendations there is an overarching theme of changes to systems or processes, these can be IT systems, admission procedures, prescribing methods, introduction of checklists and changes to policies/guidelines. The authors of the recommendations are rarely in a position to make the changes; this will usually be the responsibility of the Consultant or senior management team (SMT) from that respective directorate. Clinical Audit is a regular feature of SMT meetings so these recommendations are discussed and action plans are put in place as necessary.

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

- Seven day follow up – people on CPA should receive support in the community within seven days of being discharged from hospital;
- 'Gate keeping' - everyone admitted to hospital should be assessed and considered for home treatment;
- Restrictive Practices – Restraint data 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.

Sheffield Health and Social Care NHS Foundation Trust did not submit records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. The Trust did submit data to the Mental Health Services Data Set (MHSDS). The latest published data regarding data quality under the mental health minimum data set is for December 2016. The Trust's performance on data quality compares well to national averages and is summarised as follows:

Percentage of valid records	Data quality 2016/17	National average
NHS Number	100%	99.3%
Date of birth	100%	100%
Gender	100%	100%
Ethnicity	90.2%	83.1%
Postcode	100%	99%
Commissioner code	100%	96.1%
GP Code	98.6%	99.9%
Primary diagnosis	99.1%	N/A
HoNOS outcome	93%	N/A
The Trust data is for the end of Q3 and comparative data is from the published MHSDS Reports for December 2016		

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	2015/16	2016/17
Service user identifiers *For example date of birth, gender.*	97%	99.8%	100%
Service user outcomes *For example employment status, HoNOS scores*	50%	85.1%	96.1%

Clinical coding error rates
Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 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 and 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 2016/17 was 68% for the 45 standards and was graded Satisfactory. A summary of our performance is provided below.

	Achieved			
Information Governance Assessment framework - criteria	**2014/15**	**2015/16**	**2016/17**	**2016/17 Current Grade**
Information Governance Management	66%	66%	66%	Satisfactory
Confidentiality and Data Protection Assurance	66%	66%	70%	Satisfactory
Information Security Assurance	66%	66%	66%	Satisfactory
Clinical Information Assurance	66%	66%	66%	Satisfactory
Secondary Use Assurance	66%	70%	70%	Satisfactory
Corporate Information Assurance	66%	66%	66%	Satisfactory
Overall	66%	67%	68%	Satisfactory

Note:
(1) 'Satisfactory' means we are at Level 2 on all the assessment criteria, based on our self-assessment.
(2) There are four levels, with Level 0 being the lowest rating and Level 3 the highest.
(3) 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
Oct 15 – Mar 16	1,972	67.1	37.5
Apr 16 – Sept 16	2,267	86.0	42.5
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 three to four years. In the latest report published from the NRLS, the Trust is the second highest reporter of patient safety incidents out of 55 mental health trusts (using the reporting rate per 1000 bed days). Our incidents have increased partly due to increased/improved reporting, 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 26,363 bed days in Apr16 –Sept16. If our numbers of bed days had remained at the same level of April 13 - Sept 13 then our incident rates for Oct 15 – Mar 16 would have been 40.8.

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. The Trust reported one ‘never event’ within the reporting year 2016/17. This incident involved a collapsible shower rail on one of our in-patient wards, which failed to collapse when ligation was attempted. Although the incident itself caused no harm to the service user, the incident was reported and thoroughly investigated as a ‘never event’.

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 2016/17 the Trust received 116 non-emergency alert notices, of which 97% where acknowledged within 48 hours, 12 were applicable to the services provided by the Trust and 99% were

acted upon within the required timescale. We aim to achieve 100%. In addition a further 24 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 13.8% of all patient safety incidents reported by the Trust were related to self-harm, in comparison with 22.0% 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%
Oct 15 – Mar 16	246	12.5%	22.2%
Apr 16 – Sept 16	313	13.8%	22.0%
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-four years as we have prioritised and progressed significant improvement work under our *RESPECT* programme. This has resulted in improved reporting rates and 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%
Oct 15 – Mar 16	401	20.3%	15.1%
Apr 16 – Sept 16	556	24.5%	14.4%
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%
Oct 15 – Mar 16	241	12.2%	8.4%
Apr 16 – Sept 16	228	10.1%	8.5%
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 trusts progress against the programme. These reports are publically available via the internet.

Single sex accommodation

During 2016/17 we have had no reportable breaches of the Department of Health Guidance on Eliminating Mixed Sex Accommodation. There are a number of further non-reportable measures within the guidance which the Trust manages as well as possible in collaboration with Sheffield CCG, however does not fully meet these due to the layout of the wards. The CQC has also identified the limitations of the wards in the November 2016 inspection and the Trust CQC action plan addresses and monitors the improvements that we are making in this area.

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 continues to be 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, although we have further improvements to make. We will continue to develop our training programme into next year, as we have this year, which saw the introduction of key emerging themes within safeguarding including 'Prevent' and modern slavery and will ensure these developments and improvements in training provision continue.

Reviews and investigations

The National Framework for Serious Incidents stipulates that all serious incidents should be investigated in a timely manner and that conclusions and learning should be shared with those affected, and our Commissioners. Historically we have experienced challenges in achieving the 12 weeks target of completing investigations and our Commissioners requested remedial action was taken to address this during 2016/17. We developed an improvement plan to complete all outstanding serious incident investigations and to ensure that these improvements could be maintained throughout the rest of the year. Our Commissioners accepted our recovery plan and we delivered all outstanding incident investigations by 31 December 2016. Since January 2017, all our serious incident investigations have been delivered to our Commissioners within the agreed timescales.

As well as monitoring our investigation completion target, we also monitor the quality of our investigation reports and action plans. We have a target of 75% of all reports submitted being graded as 'good' or 'excellent' with our Commissioners. During the year, we achieved this in two out of four quarters.

Following the review last year of our serious incident procedures, we have further developed and strengthened our tools and templates used. We have also strengthened governance in respect of the sign off processes of investigations within the clinical directorates. Towards the end of the year, we commissioned our internal auditors to scrutinise our processes around serious incident investigations, to enhance our assurance in this area.

This review showed that while our processes have improved as we have been embedding our new review of care procedures, our policy needs to be updated to fully reflect the changes we have made. Work on this is underway.

Overview of incidents by type

The table, on the following page, 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.

Over the last several years the number of reported incidents has increased. Overall, we believe this is due to improvements in our staff reporting incidents, rather than a large increase in the numbers of incidents that are happening.

Two years ago 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. The CQC, at their previous inspection in 2014, identified discrepancies across in-patient wards in medication stock, while noted at ward level, wasn't being reported through the Trust's incident procedures. This has resulted in an increase in the number of medication incidents being reported, following

this concern being raised with staff. Over the summer months, we also saw an increase in the number of incidents relating to medication fridge temperatures not being within the necessary limits. This occurred due to improved monitoring of fridge temperatures and raising awareness that such findings warranted an incident to be reported.

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	2014/15	2015/16	2016/17
All incidents (Service users, staff, members of public, buildings)	7861 (a)	8549 (a)	8565
All incidents resulting in harm	1886	1669 (a)	1294
Serious incidents (investigation carried out)	23	23	28 (g)
Incidents involving service users			
Patient safety incidents reported to NRLS (d)	4948 (a)	5457 (a)	4302
Patient safety incidents reported as 'severe' or 'death'	24	21 (a)	37
Expressed as a percentage of all patient safety incidents reported to NRLS (d)	0.49%	0.38% (a)	0.86%
Incident Type	**2014/15**	**2015/16**	**2016/17**
Slips, Trips and Falls incidents	1265 (a)	1208 (a)	1034
Slips, Trips and Falls incidents resulting in harm	451	399	300
Self-harm incidents	668	676 (a)	521
Suicide incidents (in-patient or within 7 days of discharge)	0	0	0
Suicide incidents (community)	21	20 (b)	5 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	2323 (a)	2429 (a)	2402
Violence, aggression and verbal abuse incidents resulting in harm	394 (a)	406 (a)	397
Medication Errors	491	674 (a)	798
Medication Errors resulting in harm	0	2	2
Infection Control			
MRSA Bacteraemia incidents	0	0	1
Clostridium difficile Infection incidents (new cases)	1	5(e)	4 (h)
Periods of Increased infection/Outbreak incidents			
Showing number of incidents, then people effected in brackets	7	4 (25)	4 (39)
• Diarrhoea and vomiting (eg Norovirus)	0	1 (11)	0
• Coronavirus	0	0	0
• Influenza			
MRSA Screening (until 2015/16 based on randomised sampling to identify expected range to target)	50%	21% (f)	43%
Staff Influenza Vaccinations	50.7%	22%	25%

(a) Incident numbers have increased/decreased from those reported in the 2015/16 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) 4 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.

(g) This figure appears higher than in previous years as the Trust has implemented revised serious incident processes. This figure represents both level 1 and level 2 investigations.

(h) 3 of the cases were assessed as being unavoidable. The last case is dated 30/3/17, as such the avoidable figure may change next year.

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, including immunisation uptake, cancer screening, Quality Outcome and Frameworks.

The Clover Group Practice has high numbers of patients who are registered who have complex needs. The large multi-site practice of 26,500 patients serves a majority multi-ethnic migrant population in areas of social deprivation within Sheffield with a majority of the population being of 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 along with the homeless. 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 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 2017/18 in response to delivery of improved access to services in these surgeries in particular.

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 perceived drop in achievement is due to a systematic increase in disease prevalence through in-depth audits; the result being to skew the percentage achievements from the resulting new patients.

Year	Clover
2014/15	88%
2015/16	98%
2016/17	90%

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?			
		2014/15	2015/16	This year 2016/17	
Flu vaccinations					
Vaccinate registered population aged 65 and over	75%	72%	71.3%	66.7%	
Vaccinate registered population aged 6 months to 64 years in an at risk population	70%	51.7%	43.4%	88.6%	Needs to improve
Vaccinate registered population who are currently pregnant	70%	33.6%	40.6%	36%	
Childhood immunisations					✓
Two year old immunisations	70-90%	90%	90%	93%	
Five year old immunisations	70-90%	82%	85%	93%	✓
Cervical Cytology	60-80%	66.5%	66.1%	61.8%	✓

Information source: SystmOne 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 and ALCOHOL SERVICES	This year's target	2013/14	2014/15	2015/16	2016/17
Drugs					
No client to wait longer than 3 weeks from referral to medical appointment	100%	100%	100%	100%	100%
No drug intervention client to wait longer than 5 days from referral to medical appointment	100%	100%	100%	100%	100%
No Premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	100%	100%
No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100%	100%	100%
% problematic drug users retained in treatment for 12 weeks or more	90%	96%	81%	96% (opiates) 81% (non-opiates)	96%* (opiates) 82%* (non-opiates
Alcohol Single Entry and Access					
No client to wait longer than 1 week from referral to assessment	100%	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%	100%
Outcomes, Self care					
All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100%	100%	100%

Information source: National Drug Treatment Monitoring System

* The latest reported position is September 2016 as released on Q3 16/17 performance

Learning Disability Services

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 a re-invigoration of our stepped care pathways across community and in-patient facilities.

The main service priorities over the last year for the Assessment and Treatment Service (ATS) in-patient area have been to strengthen and consolidate clinical leadership capacity, to focus on service development and quality improvements to increase the

patient experience and clinical outcomes and to support and maintain a consistent and high quality service.

The ATS service has been rated ‘Good’ across all five domains in the recent Trust wide CQC inspection. This was a fantastic achievement, and the only in-patient ward to achieve this status across all domains.

The ATS service has successfully developed Business Plans for improvements in environmental and clinical safety agreed via Business Planning Group. This work will enhance the environment and provide an environment fit for purpose and support clinical safety and minimise care pathway disruption for service users. Work has also progressed regarding a new service staffing model to meet the clinical needs of the in- patient area to ensure quality is maintained. Early indications highlight a reduction in incidents across quarter 4 with an enhanced staffing model in place.

The LD leadership team continues to work within the national Transforming Care agenda both locally and regionally. The team has developed a revised discharge planning process and discharge pathway to support and expedite successful discharge transition, working with relevant key stakeholders.

Quality improvements have been developed and maintained in the use of DRAMs (Detailed Risk Assessment Measures), recording and implementation of the Mental Health Act Standards, Compliance with the Mental Capacity Act and improvement in service user collaboration/ engagement through MDT planning/ attendance and the Rainbow Group for service users.

At Love Street, the Community Learning Disability Team/Community Intensive Support Service was rated GOOD across all five domains in the recent Trust wide CQC inspection. The community teams have continued to maintain waiting times at 18 weeks for all aspects of multi-disciplinary input. This has been achieved by robust approaches to productivity management with staff on the front line contributing to lean and efficient methods of working and streamlining their processes. 2016 has seen the Community Learning Disability Teams focus on ensuring that all clients have an up to date Detailed Risk Assessment Measure (DRAM) completed on Insight, with current rate of 91% completed, with further work being carried out to address any outstanding.

The Community Learning Disability Team/Community Intensive Support Service have set up new care pathways into the service including an Assessment Clinic, Eligibility Clinic, Falls Clinic and Dementia Clinic, with further work being carried out around Autism pathways, Challenging Behaviour pathway. Links have been developed with external services regarding the Dysphagia pathway, leading to the team winning a National Community Care Award. A Rapid Response pathway is also up and running, to enable a co-ordinated and timely response to urgent client need.

Work has also been undertaken to improve the referral pathway into the teams and to provide clearer guidance for clinicians around expectations including an operational pathway document.

This year has seen much change in our accommodation services with the transfer to a new provider of the last of the five registered care homes we were delivering in partnership with housing associations. These homes have simultaneously been re-provided as supported living services rather than care homes, and have been

commissioned to deliver significantly more hours of support to the people who use these services.
We have also seen the end of our respite/short breaks services this year with the closure of Longley Meadows and the transfer of Warminster Road over to Sheffield City Council. We worked with 7Hills, exploring the potential for us to remain a provider in this market, but were not successful in developing a model that could be cost competitive.

We have also agreed withdrawal from our supported living services with local authority Commissioners. The process of transferring services to new providers is being undertaken in the first half of 2017/18. We expect the majority of our staff in these services will transfer with them under TUPE regulations.

The nursing home at Buckwood View that we provide with The Guinness Partnership is also to be reviewed in early 2017/18. This service continues to grow in its reputation for quality, was again rated as good in all areas by the CQC, and has recently won an award for its implementation of the national 'React to Red' tissue viability campaign.

Transforming care is a national strategy developed as part of NHS England's commitment to improving the care of people with learning disabilities. 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 learning disabilities and their families. The aim of the Care and Treatment Review is to bring a person-centred and individualised approach to ensuring that the person with learning disabilities and their families are met and that barriers to progress are challenged and overcome.

For the period 16 October 2015 to 11 April 2017 a total of 91 adult Care and Treatment Reviews have been completed.

In September 2015, SCCG delegated responsibility for the set-up, implementation and on-going development of the Care and Treatment Review Process for adults to the Learning Disabilities Directorate, Sheffield Health and Social Care NHS Foundation Trust (SHSC). This process is now well established. However a gap existed in the provision of Children's CTRs which leaves SCCG (as the responsible Commissioner) exposed to multiple risks.

SECG commissioned SHSC to deliver 10 children's community CTRs as part of a six month pilot project. In addition to trialing the Children's CTR process, the project has delivered Children's CTR pathway and protocols, risk register and training for Paediatric staff.

LEARNING DISABILITIES SERVICE	This year's target	How did we do?				
		2013/14	2014/15	2015/16	This year 2016/17	
No-one should experience prolonged hospital care ('Campus beds')	Nil	Nil	Nil	Nil	1	✓
Completion of Care and Treatment Reviews (01 April 2016-31 March 2017)						✓
Number of CTRs completed		n/a	n/a	36	47	
Percentage completed in timescale		n/a	n/a	88%	98%	
All clients receiving hospital care should have						✓
full health assessments	100%	100%	100%	100%	100%	
assessments and supporting plans for their communication needs	100%	100%	100%	100%	100%	✓

Information source: Insight and 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 more than two years. All service users are being offered effective and timely care and treatment near to their homes. The number of people accessing alternative to hospital treatment has increased meaning more people are supported in their own community rather than being admitted to hospital.

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 more than 30 people to return to Sheffield;
- Implemented a recruitment plan to provide increased support to 35 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. The unit at Forest Close has been completely refurbished;
- A recovery college at the Forest Close site has been established to support a range of activities to enhance the service user experience and their road to recovery.

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 key developments supported through the investment from the in-patient reduction are with our intensive Home Treatment Service and Early Intervention Psychosis (EIP) Service.

During 16/17 our South West Home Treatment team has been successful in gaining Royal College of Psychiatrists Accreditation. This provides a benchmark for the standards to be adopted across the city as we move towards a city wide model of provision.

Gatekeeping data reflects the focus of our developments over the year with supporting service users at home and providing alternatives to admission. Bar on one occasion, this has remained at 100%

Our EIP Service has through the course of the year successfully achieved the access wait time standard as set out in the national requirements. The resources have now been brought together into one city wide team in preparation to meet the national treatment standards set out as best practice.

Improvements have been made to our care planning processes which enable us to measure and demonstrate a greater collaboration in jointly producing care plans with service users.

Our data shows that the number supported under the Care Programme Approach (CPA) have increased and although the data shows some fluctuation, annual CPA reviews have remained within a 92-95% achievement rate.

We have maintained a focus on the benefits of supporting the role of carers as described in the Care Act 2014. Over the course of the year the numbers of offered an assessment and offered and received an assessment has increased.

MENTAL HEALTH SERVICES	This year's target	How did we do?			
		2014/15	2015/16	This year 2016/17	
Improving Access to Psychological Therapies Number of people accessing services	12,000	13,535	12,774	12,966	✓
New Access targets introduced Q3 2015/16 • Start treatment within 6 weeks of referral • Start treatment within 18 weeks of referral	75% 95%	n/a n/a	75.6% (Q4) 98.1% (Q4)	90.1% (Q4) 99.3% (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	174 new clients accessing services	228 new clients accessing services	270 new clients accessing services	✓
New Access targets introduced Q4 2015/16 Start treatment within 2 weeks of referral	50%	n/a	50%	54.9%	
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	1,310 episodes provided	1,418 episodes provided	1,499 episodes provided	✓
Delayed transfers of care Delays in moving on from hospital care should be kept to a minimum	No more than 7.5%	4.4%	7.6%	5.81%	**Part year**
Annual care reviews Everyone on CPA should have an annual review.	95%	95.6%	95.2%	92-95.6% (Q3-Q$)	✓
'Gate keeping' Everyone admitted to hospital is assessed and considered for home treatment	95% of admissions to be gate-kept	99.8%	99.5%	99.8%	✓
Comparators (see note 1): National average		*98.1%*	*97.4% (1)*		
Best performing		*100%*	*100% (1)*		
Lowest performing		*64.6%*	*61.9% (1)*		

7 day follow up (2) Everyone discharged from hospital on CPA should receive support at home within 7 days of being discharged	People on CPA (2) 95% of patients on CPA to be followed up in 7 days	96.4%	98.3%	96.9%	✓
Comparators (see note1): National average		*97.2%*	*96.9% (1)*	*n/a*	
Best performing		*100%*	*100% (1)*	*n/a*	
Lowest performing		*91.9%*	*50% (1)*	*n/a*	
Service users discharged from hospital not on CPA should receive support at home within 7 days of being discharged	People not on CPA (2)	*n/a*	*n/a*	*92.2%*	
All service users discharged from hospital should receive support at home within 7 days of being discharged	All discharges (2)	*n/a*	*n/a*	*94.3%*	
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% (3)*	*4.9%*	*4.8%*	*TBA*	✓

Information source: Insight and 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: Quality Account guidance states that all discharges from in-patient areas should be classified as being on CPA. Therefore, all discharges have been included for calculating 7 day follow-up. This has previously only been reported for those people on CPA.

Note 3: NHS Benchmarking report for mental health services 2014/15.

Dementia Services

Our specialist in-patient service for people with dementia and complex needs has continued to 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 increased 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 ongoing support and treatment that is appropriate to their specific needs as we are now able to provide a bespoke service of support and education for the user and their carer that is tailored to the needs of the individual.

For several years waiting times for the Memory Service were unacceptably high. This has remained a shared concern with our local Commissioners. 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 pilot weekend working in the service. 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 26 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.

The current position is that appointments for initial assessment are consistently offered between 2-3 weeks from referral.

DEMENTIA SERVICES	This year's target	How did we do?			
		2014/15	2015/16	This year 2016/17	
Discharges from acute care (G1)	N/A	39	48	55	✓
Number of people assessed for memory problems by memory management services (new first appointments)	N/A	971	1,231	1,201	✓
Rapid response and access to home treatment	350	330	295	269	↓
Waiting times for memory assessment	N/A	23 weeks	13 weeks (2015/16) 6.5 weeks (Oct15-Mar16)	3.9 weeks	✓

Information source: Insight and Trust internal clinical information system

3.3 Service user experience

Complaints and compliments

The Trust is committed to ensuring that all concerns and complaints are managed promptly and investigated thoroughly and fairly. We value the feedback we receive from service users, relatives and carers and recognise the importance of using this feedback to develop and improve services.

The table below summarises the numbers of complaints and positive feedback we have received over the past three years.

Number of	2014/15	2015/16	2016/17
Formal complaints	173	140	169
Informal complaints	153	263	223
Compliments	1147	1142	925

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

Issue raised in complaint	Number of times
Access to Treatment or Drugs	9
Admissions and Discharges	12
Appointments	6
Clinical Treatment	16
Commissioning	1
Communications	23
Facilities	2
Integrated Care	2
Other	5
Service User Care	28
Prescribing	6
Privacy and Dignity	8
Staff Numbers	3
Trust Admin/Policies/Procedures	3
Values and Behaviours	43
Waiting Times	2

This year the Parliamentary and Health Service Ombudsman notified us that five complaints had been referred to them. No further action was required in one case. Three cases are currently under investigation. One case was partially upheld by the Ombudsman – we apologised for the failings identified and made a small ex-gratia payment. Of the outstanding case referred to the Ombudsman prior to 01 April 2016, no action was required of the Trust.

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. These include:

- The Improving Access to Psychological Therapies (IAPT) Service has developed clear communication protocols which outline decisions made and the approximate waiting times (if known);

- Changes were made to the Memory Service operational processes to include the use of case management principles to ensure that service users and carers are supported in appropriate ways;
- A review has been undertaken of the management of referrals in the Sheffield Adult Autism and Neurodevelopmental Service (SAANS) from receipt to the issuing of the first appointment, with guidance and training on the process to be provided to all administrative staff;
- Clover City Practice has retrained all its nurses in relation to the appropriate storage of vaccines and has installed data-logger devices in all fridges in order to alert staff earlier to low and high temperatures;
- The telephone system at Woodland View has been reviewed and changes made to ensure that callers are able to contact to individual cottages in an effective and timely manner;
- The Alcohol Service has reviewed its prescribing module and changes have been made.

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: https://shsc.nhs.uk/about-us/corporate-information/complaints

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 highly 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 is comparable with other mental health trusts.

The tables below summarises the results from the Friends and Family Test over the last two years, together with the last national Community Mental Health Survey undertaken in 2016.

The national Friends and Family test results for mental health trusts

April 2015-March 2016	Apr	May	Jun	Jul	Aug	Sep	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 family test data reports

April 2016-March 2017	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of feedback returns	81	94	126	139	189	151	240	151	91	165	148	116
% of Trust service users who would recommend the service they received	93	93	95	96	99	95	95	98	96	99	91	97
National average for mental health trusts	87	87	87	87	88	87	88	88	86	88	88	n/a

Source: NHS England, Friends and family test data reports

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

MENTAL HEALTH SURVEY	2015 Survey		2016 Survey	
Issue – what did service users feel and experience regarding	Patient response	Patient response	Patient response	How did we compare with other Trusts
Their Health and Social Care workers	7.4 / 10	7.4 / 10	7.6 / 10	About the same
The way their care was organised	8.4 / 10	8.4 / 10	8.3 / 10	About the same
The planning of their care	6.9 / 10	6.9 / 10	6.9 / 10	About the same
Reviewing their care	7.2 / 10	7.2 / 10	6.9 / 10	About the same
Changes in who they saw	6.8 / 10	6.8 / 10	6.0 / 10	About the same
Crisis care	5.1 / 10	5.1 / 10	5.8 / 10	About the same
Treatments	7.3 / 10	7.3 / 10	7.3 / 10	About the same
Support and wellbeing	4.6 / 10	4.6 / 10	4.9 / 10	About the same
Overall views of care and services	4.6 / 10	4.6 / 10	7.2/10	About the same
Overall experiences	7.0 / 10	7.0 / 10	6.9 / 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.

Service user's experience of contact with a health or social care worker during the reporting period.	2015 Survey			2016 Survey		
Patient Survey – overall experience	**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?	5.0/10	7.0/10	5.9/10 About the same as other Trusts	4.9/10	7.0/10	6.1/10 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?	7.7/10	8.8/10	8.0/10 About the same as other Trusts	7.7/10	8.9/10	8.3/10 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 amongst the best in the country.

We are concerned about the lower levels of satisfaction with crisis care, reported in the scores above. A likely explanation for the poorer reported experience of support in a crisis is the variable knowledge and awareness of who service users should contact in a time of crisis. Information about how to access support during times of crisis needs to be clearly and consistently communicated.

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, ensuring availability of high quality crisis care, and that service users are fully involved in their care planning and better informed about their care provision.

Older adult services have responded to the issues raised around out of hours care by extending the working hours for some teams to increase specialist provision for older adults. Also by ensuring that service users are now told routinely how to contact the out of hours team and by training this team in working with older adults. 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.

Sheffield Health and Social Care NHS FT will continue with the above actions to maintain and improve our position regarding the quality of our services. Our on-going development programmes and Quality Objectives focus on supporting individual teams to understand their own performance and take decisions to improve the quality of care they provide.

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.

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 2016. The conclusion of the review is summarised in the table below. The latest results show that our hospital based facilities are above average in most of the categories for all of our facilities. Between 2014 and 2016 we improved our assessed scores in 16 of the 24 categories.

Site Location	Date of Review	Cleanliness	Food and Hydration	Privacy and Dignity	Condition and appearance
Longley Centre	March 2014	96.4%	90.2%	89.6%	92.1%
	August 2015	98.7%	93.7%	91.6%	90.6%
	August 2016	99.6%	89.7%	88.3%	95.8%
Longley Meadows	March 2014	99.0%	90.1%	83.6%	95.7%
	August 2015	99.2%	91.9%	86.7%	93.7%
	August 2016	100%	89.1%	86.7%	97.1%
Michael Carlisle Centre	March 2014	99.2%	95.5%	89.0%	98.9%
	August 2015	99.4%	93.4%	95.5%	95.1%
	August 2016	98.7%	95.5%	85%	95.3%
Forest Close	March 2014	96.8%	92.6%	85.1%	94.5%
	August 2015	97.5%	94.2%	95.1%	97.9%
	Not assessed due to refurbishment				
Forest Lodge	March 2014	98.0%	85.4%	82.9%	95.8%
	August 2015	99.8%	92.2%	95.1%	97.9%
	August 2016	100%	89%	92.7%	97.2%
Grenoside Grange	March 2014	99.7%	94.7%	83.3%	100.0%
	August 2015	100%	93.6%	89.5%	98.5%
	August 2016	100%	89.2%	87.8%	100%
Firshill Rise	March 2014	98.5%	87.7%	91.4%	98.4%
	August 2015	99%	90.8%	94.7%	92.7%
	August 2016	98.7%	92.1%	94.4%	98.2%
National average	March 2014	97.8%	88.8%	87.7%	92.0%
	August 2015	97.5%	88.5%	89.2%	90.1%
	August 2016	97.8%	89.7%	89.7%	94.5%

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 and CARE	2014 score	2015 score	2016 Our score	2016 National averages	2016 How we compare
Overall Staff Engagement	**3.78**	**3.76**	**3.74**	**3.77**	**Average**
I would recommend my organisation as a place to work	65%	62%	61%	56%	n/a
I would recommend my organisation as a place to work or receive treatment	3.78	3.72	3.69	3.63	n/a
My organisation acts on concerns raised by service users	76%	74%	73%	74%	n/a
Care of service users is my organisation's top priority	76%	76%	74%	72%	n/a
% of staff experiencing harassment, bullying or abuse from staff in last 12 months	n/a	26%	20%	22%	Above average
TOP 5 RANKINGS – The areas we compare most favourably in with other mental health and learning disability trusts					
% of staff appraised in last 12 months	76%	89%	95%	89%	Above average
% of staff believing that the organisation provides equal opportunities for career progression or promotion	n/a	87%	90%	87%	Above average
% of staff / colleagues reporting most recent experience of harassment, bullying or abuse	n/a	61%	65%	60%	Above average
% of staff / colleagues reporting most recent experience of violence	n/a	82%	95%	93%	Above average
% of staff working extra hours (lower score is good)	62%	63%	64%	72%	Above average
Lower 5 Scores – The areas we compare least favourably in with other mental health and learning disability trusts are as follows.					
% of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or	n/a	66%	67%	55%	Below average

themselves					
Quality of non-mandatory training, learning or development	n/a	3.97	3.98	4.06	Below average
% of staff experiencing physical violence from staff in last 12 months	3%	6%	4%	3%	Below average
Effective use of patient / service user feedback	n/a	3.67	3.53	3.68	Below average
% of staff feeling motivated at work	3.78	3.77	3.79	3.91	Below average

Source: NHS Staff Survey

Local staff surveys – the friends and family test

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

	Q1	Q2	Q4
Place to work			
% of staff who would recommend Trust as a place of work	68%	63%	n/a
Average for England	64%	64%	n/a
Place to receive care			
% of staff who would recommend Trust as a place to receive care and treatment	75%	74%	n/a
Average for England	80%	80%	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 not available at time of publishing Report.

Our local survey results have in previous years been generally higher than the national average. This year figures show that we are:

- In line with national averages for staff recommending us as a place to work;
- Slightly below national averages for staff recommending us as a place to receive care. The national staff survey, however, shows our performance slightly above the national average regarding recommending our Trust as a place to work.

Our service user friends and family test results shown on page 46 show that nine out of 10 service users would recommend the Trust as a place to receive care.

The Trust employs around 2,700 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 on-going focus on improving quality and delivering our plans for service improvement. The full survey will be available via the CQC 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 2016 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 to ensure it achieves and remains lower 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 Trust wide 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 physical violence from other staff
While our results in this area of the staff survey have improved this year, we continue to be concerned about any staff who are experiencing violence of any nature from other staff members. This result, from the staff survey, does not accord with any other reports under 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 a slight increase this year. This is one of the areas we will be working on as we our develop action plan to address our lower scores.

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 Sheffield Health and Social Care NHS Foundation Trust's Quality Report 2016/17. We have met and maintained contact with the Trust through this year, and this has provided us with a wider knowledge of the Trust's decision making, challenges, and processes.

We note that the recent CQC inspection report has rated the Trust as 'good' overall and achieved two 'outstanding' in the caring and responsive domain. We congratulate the Trust on the hard work and improvements that have been made in many areas, including improved waiting times in IAPT and Early Intervention services, and increased place of safety provision. The PLACE assessments show that the Trust has again maintained a high level of cleanliness across all sites and average or above in nearly all remaining categories and sites.

We welcome the Trust's continuing focus on closer collaboration with GPs to improve physical healthcare for post discharge patients, and the development of discharge information packs for service users to assist their continuing recovery. We are also pleased to see the work undertaken to understand issues around transition from CYP to adult mental health services, and hope the surveys will help to understand the issues and inform policy and practice. We wait to see how this progresses. Also welcome is the commitment to a significant amount of work into improved access to the Clover Group Practice services in high demand areas. We regularly receive feedback in all three of these service areas, and will continue to monitor.

The rate of patient related incidents reported seems to have increased significantly and is of concern to Healthwatch Sheffield. We appreciate that some increase may be due in part to improved reporting systems which should be welcomed. However, we feel it isn't helpful to compare figures from two different years (bed days from 2013, reported incidents from 2016, as noted in the draft Quality Report provided to us). The rate is measured per 1000 bed days to provide a proportionate view of incidents over time (and enable national comparison). If the number of bed days has been reduced significantly, we should expect to see a proportionately significant reduction in reported incidents. This does not seem to have happened and therefore remains a concern.

We are pleased to see the priority of improving patient experience through service user engagement this year has developed well, with an increase in service user groups, mapping exercise, friends and family tests; and that this feedback is helping to inform individual teams as well as Trust wide services. We hope these initiatives continue to help shape processes.

We thank the Trust for their work this year and look forward to working with them in 2017/18.

Healthwatch
09 May 2017

Our response
We welcome the feedback from Healthwatch and their acknowledgments of progress made over the last year. We have discussed the concerns regarding our incident reporting rate with our Commissioners, who hold a different perspective to Healthwatch, indeed they see this shows our positive safety culture. We welcome the opportunity to discuss this further at our next scheduled session.

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
We welcome the opportunity to comment on the Trust's Quality Account for 2016/17.

During the course of our scrutiny work this year, no concerns have been raised with us about service delivery or performance of the Trust. We are pleased to note that the Care Quality Commission has rated the Trust as 'Good', and welcome the progress that has been made towards achieving last year's quality goals, particularly around waiting times for the Memory Clinic and IAPT. We are pleased to see that the report sets out what further improvement action will be taken where further progress is required.

We are pleased to see that this year's quality goals are clearly set out, alongside how they will be measured. We look forward to seeing the progress made against these goals next year.

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
09 May 2017

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.

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 2016 – March 2017.

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 Trusts 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 NHS Improvement who are the sector regulator for health services in England, 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 2016/17. 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 2017/18 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.

Sheffield Clinical Commissioning Group
19 May 2017

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

We look forward to working with the CCG during 2017/18 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

2016/17 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.

NHS Improvement 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.

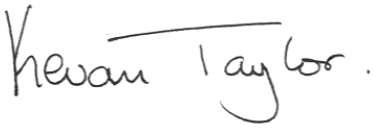
In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance;
- 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 2016 to May 2017;
  - Papers relating to Quality reported to the Board over the period April 2016 to May 2017;
  - Feedback from the Commissioners dated 19 May 2017;
  - Feedback from Governors dated 27 April 2017;
  - Feedback from local Healthwatch organisations dated 09 May 2017;
  - Feedback from the Overview and Scrutiny Committee dated 09 May 2017;
  - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2016;
  - The latest national patient survey issued in November 2016;
  - The latest national staff survey issued March 2017;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 26 May 2017; and
  - Care Quality Commission report following its inspection of Trust services published in March 2017 and intelligent monitoring reports issued during 2016/17;
- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

Chair 26 May 2017



Chief Executive 26 May 2017

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 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

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

We refer to these national priority indicators collectively as the 'indicators'.

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 issued by NHS Improvement.

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 requirements for quality reports for foundation trusts 2016/17 ('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 the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 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 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 19 May 2017;
- feedback from governors, dated 27 April 2017;
- feedback from local Healthwatch organisations, dated 9 May 2017;

- feedback from Overview and Scrutiny Committee, dated 9 May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2016 national patient survey;
- the 2016 national staff survey;
- Care Quality Commission Inspection, dated 30 March 2017;
- the 2016/17 Head of Internal Audit's annual opinion over the Trust's control environment, dated 26 May 2017; and
- any other information included in our review.

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 2017, 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 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.

Limitations
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 2017:

- 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 indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
1 Sovereign Square, Sovereign Street, Leeds, LS1 4DA

26 May 2017