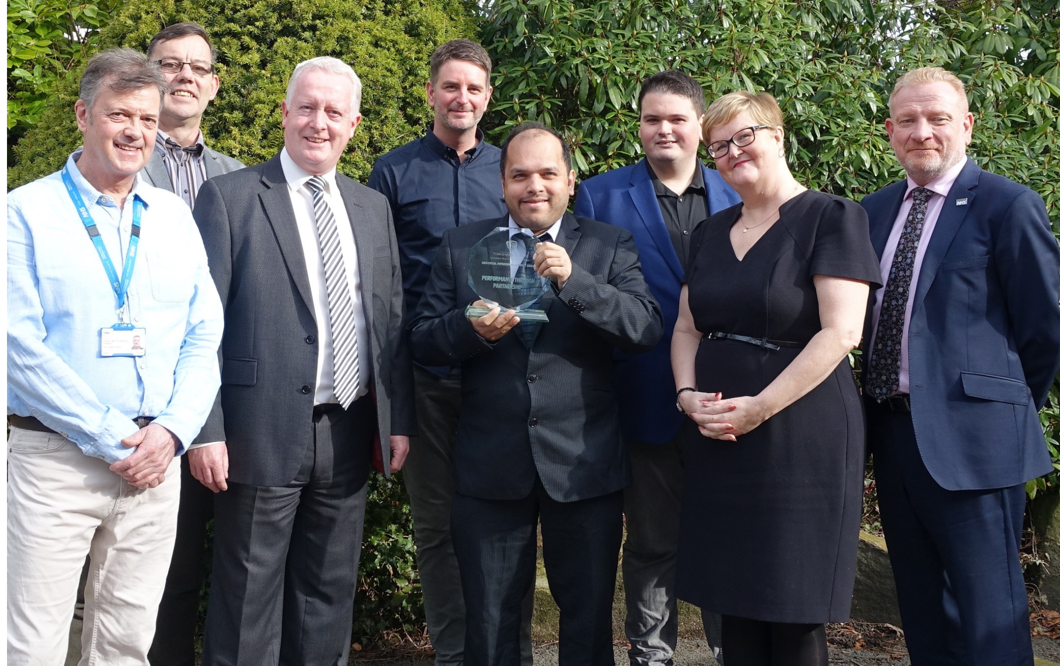
Sheffield City Council

NHS Sheffield Health and Social Care NHS Foundation Trust

Quality Report 2017-2018



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Part 1: Quality Report 2017/18 Chief Executive's welcome

I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Report for 2017/18.

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), following their comprehensive inspection in November 2016, assessed the Trust as 'Good' overall with eight out of our ten core services rated as 'Good'. While I was, and remain, very proud of this, we have continued working with staff, service users, carers, volunteers and Governors this year to make improvements where we know we could do better.

We are expecting a 'well-led inspection' by the CQC some time in the near future and are hopeful that the hard work and dedication shown by all staff and stakeholders will continue to shine through.

We take service user safety very seriously and we have made significant improvements in this area over the year. This is discussed in more detail on page 15.

We have significantly transformed our mental health community services this year, with a new operational and governance framework coming into place from April 2018. This has created some challenges, which our results from the staff survey and community mental health survey show, which we continue to work through. More information about this can be seen within this 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. As we head into the new financial year, we are refreshing this strategy to ensure it remains aligned with our business plans and quality improvement plans.

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. 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

Kevan Taylor
Chief Executive

Part 2A: A review of our priorities for quality improvement in 2017/18 and our objectives for 2018/19

In setting our plans for 2017/18 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 and service users to understand their views about what was important and what we should improve.

We then consulted on our proposed areas for quality improvement with a range of key stakeholders. These involved our local Clinical Commissioning Group, Sheffield City Council, Healthwatch and our Governors. Our Governors informed us of their priority areas going forwards into 2018/19, to ensure we incorporated these within our quality objectives.

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 2017/18 were:

Responsiveness	**Quality Objective 1**: We will improve access to our services and treatment
Experience	**Quality Objective 2**: We will improve service user experience, involvement and engagement
Safety	**Quality Objective 3**: We will improve physical, mental and social wellbeing outcomes for all service users.

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 got seen quickly when they needed to. Improving access is an area prioritised by our commissioners and they are supportive of improvement and service reconfigurations to help us achieve this.

We had started to make 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 2017/18 we planned to:

- Reconfigure community services
- Improve support and access for people with a learning disability into mainstream mental health services
- Return people being cared for in in-patient settings outside of Sheffield, back to Sheffield
- Improve access to urgent and crisis services , ensuring effective access over the seven day period
- To meet liaison, 24/7, urgent and emergency mental health targets
- Work towards an 18 week pathway ensuring urgent cases are offered an appointment within two to four weeks.

How did we do?

- All staff were allocated a role in the new adult community model and transferred into these roles by 31 January 2018
- The Single Point of Access (SPA) service went live on 18 December 2017
- There has been progress during 2017/18 with returning service users from out of city placements. At the end of Q4 2016/17 there were 14 people out of city. At the end of Q3 2017/18 there were 11 people out of city, the majority of these service users have a learning disability diagnosis. It is anticipated by the end of Q1 2018/19 there will be seven service users remaining out of city
- Liaison access targets (A&E) - High level of compliance with targets achieved. Although reliant on timely referral to liaison which is not always feasible as dependant of the physical health care issues being managed by A&E
- Greenlight toolkit audit has been completed. This is a self-audit tool for improving services for people with learning disabilities, including best practice and quality outcomes. Greenlight meetings are in situ and have an agenda which includes a review of positive and negative working practices and solutions to blocks. A resource of accessible information has been created with the aim of developing this into a website to support staff with the Accessible Information Standard.

How we have performed against working towards the 18 week pathway, ensuring urgent cases are offered an appointment within two to four weeks, is provided in the table overleaf.

Service	Urgent two to four weeks	18 week pathway achieved
Eating disorders	✓	✓
Gender identity service	✓ (young people transitioning services)	X
Relationship and sexual health	N/A	X
Sheffield adult autism and neurodevelopmental service (SAANS)	✓	X
Memory service	✓	✓
Long term neurological conditions – neuro enablement	✓	✓
Long term neurological conditions- brain injury	✓	✓

How will we keep moving forward?

- We have had some issues following the launch of our SPA service, relating to telephone response times. We are working hard to improve this and are closely monitoring progress in this area
- We have direct access to the substance misuse screening tool through the physical health assessment form on Insight. We will continue to roll the use of this out across our in-patient wards
- We will continue to ensure people who are being cared for outside of the city are returned to Sheffield
- We will undertake a re-audit of the greenlight toolkit.

Quality Objective 2: We will improve service user experience, involvement and engagement

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 Trust has a co-produced Service User Engagement Strategy, approved by the Board of Directors, which sets our approach to improving and understanding the experience of the people who use our services.

We said we would
We agreed to focus our efforts, in particular, this year on the following areas:
- To reduce the amount of restrictive practice and to improve service user experience when intervention is needed
- To have proactive engagement with service users throughout the redevelopment at the Longley Centre and other local service improvements, as well as within our governance meetings
- Increase service user involvement in developing collaborative care plans and evaluating outcomes within learning disability services
- To implement SafeWards within all in-patient settings. SafeWards is an evidence based intervention that is proven to reduce restrictive interventions.

How did we do?
- 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, overall, incidences of restrictive interventions are reducing within the Trust.

Incidences of restraint		
2015/16	**2016/17**	**2017/18**
716	764	736
Incidences of seclusion		
2015/16	**2016/17**	**2017/18**
418	304	302

  NHS Benchmarking data (2016/17) provides data per 10,000 bed days and show our rate for adults as 171, against a mean of 107. For older adults our rate is 91 against a mean of 77 (the lowest of the region).

  The Trust's plan for continuing to reduce restrictive practices has included the implementation of SafeWards, RESPECT training, post incident reviews and improving activity on wards
- There has been effective service user engagement in the Longley Centre design work at both team level and at wider stakeholder events. Our service user lead also went with a group of key representatives to visit another hospital to learn from best practice and hear about any lessons learned from their recent redesign. Service users have given positive feedback about the level of engagement and the way their ideas and perspectives are shaping the plans
- Within the Assessment and Treatment Service (ATS) Positive Proactive Support Plans (PPSP) and 'My Care Plans' are used across all service users with a weekly audit illustrating any gaps in content across professional groups

- A care plan quality review has been completed, resulting in a revamped Personal Behaviour Support (PBS) plan.

How will we keep moving forward?

- Post incident reviews are taking place, but there is not yet compliance with the agreed standard. Weekly reporting has commenced during 2017/18, which will continue into 2018/19 to ensure that our focus remains on reducing restrictive practices and post seclusion reviews
- Following our refreshed Service User Engagement and Experience 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 recruit additional staff within our Engagement and Experience Team to ensure we improve service user and carer experience and involvement
- We will continue to 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
- An audit of PBS planning within community teams will be undertaken.

Quality Objective 3: We will improve physical, mental and social wellbeing outcomes for all service users

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

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

We said we would
Continue our development plan, focussing in particular on the following areas:

- Reviewing our assessment processes to ensure a holistic assessment is offered to service users in our care
- Ensuring people with a learning disability receive an annual health check with their GP and have a health action plan and a hospital passport in place
- Implementing NICE guidelines when working with individuals with co-existing substance misuse dependency
- Improving the awareness of good diet in older people and people with dementia
- Increasing access to activity, including access to cardio walls and ensuring activity is everybody's business
- Minimising the risk of falls and reducing falls with harm.

How did we do?

- Our Physical Health Strategy has been reviewed, including a review of practices and procedures
- Physical health information is now being gathered at the point of referral and the new recovery services are developing systems to ensure all service users have a full physical health review, at least annually
- 52% of people with learning disabilities recorded on GP practice registers have had an annual health check. Not all of these individuals are under the Trust's care
- 278 people on the community learning disability team caseload have a hospital passport
- A baseline assessment against the NICE Quality Standard for coexisting severe mental illness and substance misuse: community health and social care services (NG58) was undertaken
- Across our dementia services over 97% of service users were screened using the MUST screening tool, with an average 78% screened within 48 hours
- Cardio walls are now in situ at both the Michael Carlisle Centre and Longley Centre.

How we have performed against minimising the risk of falls and reducing falls with harm is provided in the table below.

Year	***Number of service user falls***	***Number of service user falls with harm (ie an injury)***
2015/16	1164	368 (31.6%)
2016/17	989	277 (28%)
2017/18	974	231 (23.7%)

How will we keep moving forward?

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:

- Our physical health training will be reviewed to consider how we support policy into practice and learn from incidents
- Our Physical Health Group will be re-established and will review our physical health examination and assessment forms, ensuring they help practice and decision making
- We will monitor the progress made against our action plan following the baseline assessment of the NICE Quality Standard NG58
- We will continue to improve our responsiveness in undertaking falls risk assessment, ensuring these are carried out within three days of admission.

Our Quality Objectives for 2018/19

In considering our objectives for 2018/19 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 committed to strengthen its approach to service user safety across the Trust. A more focussed safety plan was developed that has been monitored throughout the year. This is being further developed as we set our safety priorities for 2018/19 and incorporate this into our refresh of our 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 2017/18. However, we did not achieve the access standard for people experiencing a first episode of psychosis during 2017/18. This is an area of priority for us as we move into 2018/19. 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 objective setting

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.

Our quality objectives for 2018/19 are:

Quality Objective 1: Improving access to services and treatment

Quality Objective 2: Improving service user and carer experience, involvement and engagement

Quality Objective 3: Improving physical, mental and social wellbeing outcomes for all service users.

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

During 2017/18 our clinical operational services have been reconfigured. The Trust has moved from having five clinical directorates, namely in-patient, community, learning disabilities, specialist services and primary care to having one clinical operations service, split into two care networks. Our GP practices fall outside of the care networks. Our two care networks (Crisis and Emergency Care Network, and Planned and Scheduled Care Network) have revised governance arrangements in place from 01 April 2018 and our focus this year is to embed these following the mobilisation of the reconfiguration.

The community mental health services in Sheffield have also been reconfigured in the last year. These changes have involved a wide process of discussion with service users, carers and staff and the new model of community mental health was introduced in January 2018.

Monitoring progress

Progress against the achievement of our quality objectives is monitored on a quarterly basis through our clinical operational services care networks. Progress is reported through our Executive Directors Group to our Quality Assurance Committee. We also share our progress, together with any concerns on achievement, with external partners.

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. They also receive 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 via the work of a range of committees that oversees Trust systems and performance in respect of key matters relating to quality and safety. They also receive 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 Directors Group: 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. They oversee 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 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 that 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 Trustwide 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 publically 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 2017/18, we are continuing to build on these into 2018/19 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 2018/19 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 and 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 continue to embed will be the Microsystem improvement methodology.

There are currently 24 teams across the organisation actively working with a dedicated Microsystem coach, with a further eight waiting to restart following a pause due to the recent reconfiguration and organisational changes. To date, 36 members of staff have completed, or are undertaking the Sheffield Microsystem Coaching Academy (MCA) training. Of these, 16 are actively coaching teams, with all four members of the Quality Improvement Team coaching multiple microsystems. Eight trained coaches have left the Trust, with one coach currently on maternity leave. Reasons attributed to the 11 trained coaches who remain in the organisation, but are not currently supporting a team primarily relate to personal capacity in terms of balancing demands from the 'day job' with continuing to commit to regular team coaching. Early cohorts included very senior staff members, who inevitably were not in a position to coach long term. However, this was deemed vital in order for the methodology to be fully understood and supported at a senior level within the Trust.

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. The Trust is registered to provide the following Regulated Activities:

- Accommodation for persons who require nursing or personal care
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury.

The Trust varied its registration by cancelling the Regulated Activity 'Personal Care' in January 2018, as a result of the Trust's supported living services at Mansfield View being transferred to another provider.

The CQC registers, and licenses the Trust as a provider of care services as long as we meet fundamental standards of quality and safety in compliance with the Health and Social Care Act 2008. The CQC monitors us to make sure we continue to meet these standards.

The CQC has not taken enforcement action against the Trust during 2017/18 and the Trust has not participated in any special reviews or investigations of the Trust by the CQC during the reporting period.

The Trust took part in the CQC Local Systems Review of Sheffield, which looked at how people move between health and social care, including delayed transfers of care. The review focussed on people aged over 65 years and included a review of commissioning across the interface and the governance of resources. The review did not specifically include mental health or specialist commissioning services, but looked at the experiences of people living with dementia moving through the system. As the Trust provides services for people over 65 years, including dementia services, it was a contributor to the review. The draft report is expected at the end of April 2018.

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.

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.

The primary medical services were inspected as part of the comprehensive inspection.

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.

Wainwright Crescent respite service was inspected in September 2017 as part of the CQC’s social care inspection regime and was rated as ‘Requires Improvement’ overall, with the domains ‘safe’ and ‘well-led’ rated as ‘Requires Improvement’; the domains ‘effective’, ‘caring’ and ‘responsive’ were rated as ‘Good’. The issues raised at Wainwright Crescent relate to monitoring systems, medication practices and practices relating to consent. An action plan was developed to address these issues.

Jordanthorpe Health Centre was inspected in September 2017 and rated ‘Good’ overall. Only two of the domains (‘safe’ and ‘responsive’) were assessed at this inspection, both being rated as ‘Good’. Clover City Practice was inspected in November 2017 and rated as ‘Good’ overall, with all five domains rated as ‘Good’.

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 has monitored progress against our improvement plan each month. We are confident that the actions we have taken 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 last 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	Good
Long stay/rehabilitation mental health wards for working age adults	Requires Improvement
Forensic in-patient / secure wards	Good
Wards for older people with mental health problems	Good
Wards for people with a learning disability or autism	Good
Community-based mental health services for adults of working age	Good
Mental health crisis services and health based places of safety	Requires Improvement
Community-based mental health services for older people	Good
Community mental health services for people with a learning disability or autism	Good
Substance misuse services	Good
Social care services	**Rating**
Woodland View Nursing Home	Good
Supported living services for people with mental health problems at Wainwright Crescent respite service	Requires Improvement
Primary care services	**Rating**
Clover City Practice	Good
Clover Group Practices	Good

Mental Health Act reviews

During 2017/18 the CQC has undertaken three visits to services to inspect how we deliver care and treatment for in-patients detained under the Mental Health Act. The services they visited this year were:

- Michael Carlisle Centre: Dovedale Ward
- Longley Centre: Endcliffe Ward
- Forest Close: Bungalows 1 and 2.

2.2 NHS Improvement's Assessment

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.

The Single Oversight Framework is NHS Improvement's risk assessment framework 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.

2017/18
The Trust has remained within segment 2 for the entire year. This is due to the non-achievement of one of the national indicators within our Early Intervention in Psychosis Services.

2016/17
The Trust was assessed as being in segment 2 since the new framework came into operation during the year. Under the former framework, the Trust was assessed as 'green' for the two quarters with no evident concerns regarding our performance.

Single Oversight Framework

2017/18 Segmentation	**Annual Plan (expected rating)**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Segment	2	2	2	2	2
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

2.3 Goals agreed with our NHS commissioners

A proportion of our income in 2017/18 was conditional on achieving quality improvement and innovation goals. These were 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 2017/18 £1,186,527 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 £ 942,355 (79.4%) of the income that was conditional on these indicators. For the previous year, 2016/17 the associated monetary payment received by the Trust was £1,351,854 (71%).

A summary of the indicators agreed with our main local health commissioner NHS Sheffield Clinical Commissioning Group (SCCG) for 2017/18 is shown below.

Incentivising improvements in the areas of safety, access, effectiveness and user experiences	
Improving staff health and wellbeing a) Health and wellbeing indicators as measured within the staff survey relating to improving access to physiotherapy for people with MSK issues, reducing work related stress and taking positive action on health and wellbeing b) Achievement of a step-change in the health of the food offered on our premises in 2017/18; and ensuring contractual arrangements are in place with external suppliers to maintain progress c) Improving the uptake of flu vaccinations for frontline clinical staff.	NOT ACHIEVED ACHIEVED PARTIALLY 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 PARTIALLY ACHIEVED
Improving services for people with mental health problems that present to A&E To reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions.	PARTIALLY ACHIEVED
Transitions out of children and young people's mental health services a) To carry out a case note audit to assess the extent of joint transition planning b) To survey young people ahead of transition c) To survey young people post-transition.	ACHIEVED

Incentivising improvements in the areas of safety, access, effectiveness and user experiences	
Preventing ill health by risky behaviours – alcohol and tobacco To ensure all service users admitted to in-patient wards are screened for tobacco and alcohol usage, brief advice is given regarding the benefits of quitting and onward referral made as appropriate.	PARTIALLY ACHIEVED

The table on the previous page summarises the goals that we agreed with our commissioners, and the progress that we made. Full details of the agreed goals for 2017/18 and for the following 12 month period are available 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 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 2018/19.

2.4 Review of services

During 2017/18 the Trust provided and/or sub-contracted 48 relevant health services. The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2017/18. The Trust has reviewed all the data available on the quality of care in 48 of these relevant health services.

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 Sheffield City Council (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 ongoing service provision.

In 2016/17 SCCG 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 commissioners recognised the progress that the Trust had made in this area and the performance notice was subsequently lifted in May 2017. The Trust continues to perform well across mandatory training subjects and updates are regularly provided to our commissioners.

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.

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 2017/18.

South Yorkshire Fire and Rescue

In June 2017 the South Yorkshire Fire and Rescue Service removed the enforcement notice placed on us during 2016/17 following two fires on Burbage Ward, an in-patient ward within our adult mental health services. They were satisfied that remedial action had been taken to resume compliance with statutory duties. The service also carried out a number of familiarisation visits and inspections at Forest Lodge, Fulwood House, Michael Carlisle Centre, East Glade Centre and Woodland View during the year. None of these visits resulted in enforcement notices.

2.6 Compliance with NHS Resolution (formerly NHS Litigation Authority) Claim Management Procedures

The Trust is a member of NHS Resolution, who handle negligence claims made against the NHS. NHS Resolution give all member organisations a red, amber, green ('RAG') rating which determines the level of contribution each member makes to NHS Resolution for insurance cover. The Trust's current RAG rating is red, which reflects a level of concern based on the costs incurred from negligence claims arising from incidents over four to five 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 2017/18, who were recruited during that period to participate in research approved by a research ethics committee, was 1005.

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.

At the end of 2017/18 there were 39 active clinical research projects underway which aim to improve the quality of services, increase service user safety and deliver effective outcomes. Areas of research in which the Trust has been active over the last 12 months include:

- A ten centre randomised controlled trial of an intervention to reduce or prevent weight gain in severe mental illness
- A trial comparing the effectiveness of counselling for depression with cognitive behavioural therapy
- A multi-centre trial of a self-help intervention to improve quality of life in Alzheimer's disease
- Support for the families and carers of service users with dementia
- Interventions for service users with eating disorders
- The effectiveness of services for mothers with mental illness
- 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 2017/18 five national clinical audits and four 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 which 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 2017/18 are as follows:

National Audits and National Confidential Enquiries
Mental Health Clinical Outcome Review Programme 1. Suicide in children and young people
Mental Health Clinical Outcome Review Programme 2. Suicide, homicide and sudden unexplained death
Mental Health Clinical Outcome Review Programme 3. The management and risk of patients with personality disorder prior to suicide and homicide
Learning Disability Mortality Review Programme (LeDeR Programme)
National Core Diabetes Audit
POMH Topic 17: Use of depot/LA antipsychotics for relapse prevention
POMH Topic 15: Prescribing valproate for bipolar disorder
National Audit of Early Intervention Services
National Audit of Psychosis (NCAP)

The National Clinical Audits and National Confidential Enquiries that Sheffield Health and Social Care NHS Foundation Trust participated in during 2017/18 are as follows:

National Audits and National Confidential Enquiries
Mental Health Clinical Outcome Review Programme 1. Suicide in children and young people
Mental Health Clinical Outcome Review Programme 2. Suicide, homicide and sudden unexplained death
Mental Health Clinical Outcome Review Programme 3. The management and risk of patients with personality disorder prior to suicide and homicide
Learning Disability Mortality Review Programme (LeDeR Programme)
National Core Diabetes Audit
POMH Topic 17: Use of depot/LA antipsychotics for relapse prevention
POMH Topic 15: Prescribing valproate for bipolar disorder
National Audit of Early Intervention Services
National Audit of Psychosis (NCAP)

The Trust has also begun participation in the audit: POMH Topic 16: Rapid tranquillisation but as data collection for this audit spans 2017/18 and 2018/19 it will be reported in the 2018/19 quality report.

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 2017/18, 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.

National Audits and National Confidential Enquiries	Number of cases submitted as a percentage of those asked for
Mental Health Clinical Outcome Review Programme 1. Suicide in children and young people 2. Suicide, homicide and sudden unexplained death 3. The management and risk of patients with personality disorder prior to suicide and homicide	100% (Note 1 and 2)
Learning Disability Mortality Review Programme (LeDeR Programme)	72% (Note 3)
National Core Diabetes Audit	National data extraction
POMH Topic 17: Use of depot/LA antipsychotics for relapse prevention	100%
POMH Topic 15: Prescribing valporate for bipolar disorder	100%
National Audit of Early Intervention Services	100%
National Audit of Psychosis (NCAP)	100%

Note 1: The percentage figure represents the numbers of people who we reported as having prior involvement with.
Note 2: Submission of data for Quarters 3 and 4 of each year takes place within the reporting period of the following year. Therefore this figure includes Quarters 3 and 4 of 2016/17 and Quarters 1 and 2 of 2017/18.

Note 3: In some cases reporting had not occurred before the end of the 2017/18 reporting period due to the timeframe between the relevant death occurring and the end of the reporting period. All relevant cases will be reported in due course.

The reports of three National Clinical Audits were reviewed by the provider in 2017/18 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following action to improve the quality of healthcare provided:

- The National Clinical Audit reports reviewed during 2017/18 were from three POMH audits on medicine prescribing practice. The findings from these audit reports are being used to inform wider pieces of work looking at improving restrictive practices and physical health monitoring.

- Not all National Clinical Audits produced reports during 2017/18. In addition, two national clinical audits undertaken in 2016/17 reported their findings in 2017/18 and are therefore included here.

The reports of 20 local clinical audits were reviewed by the provider in 2017/18 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Local audits (reports reviewed in 2017/18)	**Key actions following the audit**
Record Keeping Audit 2016/17 and 2017/18	Local level actions taken to remind staff of good quality record keeping. Further clarity provided to staff on use of abbreviations - to be incorporated into the relevant policy.
QS86 Falls in older people	Regular Falls audits to be undertaken to ensure continued compliance with NICE guideline.
Collaboration with primary care clinicians 2016/17 audit	Guidance provided to staff on annual reviews of care. Changes made to the care plan form. Creation of a 'clinical review for GP' IT system solution.
Risk Assessments 2017 audit	Local action plans to address identified issues.
Care Plans 2017/18 audit	Changes made to the care plan form. Findings regarding evidence of collaboration shared with staff for improvements.
Cardio-Metabolic Assessment and Treatments 2016/17 audit	Agreed increased focus on physical health reviews in community settings.
Greenlight Toolkit Audit	Greenlight meeting used to develop and track action plan. Re-audit in 2018.
Audit of NICE Guidelines for Borderline Personality Disorder	Actions to be developed: to discuss with relevant quality and service management teams.
Assessment of NICE Guidance: NG43 Transition from children’s to adults’ services for young people using health or social care	Findings fed into CQUIN and other related joint work with CAMHS to improve transitions.

services	
Assessment of NICE Guidance: NG13 Workplace health: management practices	Practices are in line with guidance. Review practices against guidance as necessary in future.
Assessment of NICE Guidance: NG58 Coexisting severe mental illness and substance misuse: community health and social care services	Action plan under development.
Care Pathway for Early Onset Dementia	Acknowledged need to develop specific standards for this referral pathway.
Audit of Physical Investigations for Admitted Psychiatric Patients	The audit findings were presented at the Trust's weekly training event – Quality Improvement Group: Physical Health Screening. Increasing awareness of the Physical Health Investigations SOP.
Physical Health Monitoring in the Early Intervention Service	The results of this audit were presented to the members of the weekly EIS Microsystems team. The EIS team plan to address the issues raised in order to develop changes in team practice capable of driving the necessary improvements.
An audit on the accuracy of initial assessments completed on new patients referred to the Perinatal service	New proforma produced for initial assessments in the service to ensure NICE guideline followed.
Physical Health Monitoring in Patients on Antipsychotics	Findings shared with the South East Home Treatment Team for local improvements.
Audit of Gender Psychotherapy Service for Individual or Couple Therapy	Shared with service for local learning and improvements to pathway.
Clinical Audit to review case discussions of newly allocated service users within MDT meetings	Detailed information and discussion to be documented on the electronic care record instead of MDT minutes.
Local audit of completion of Physical Health Review forms and appropriate action taken	Shared with service for local learning and improvements to physical health reviewing.
Nalmefene Audit	Repeat training session on appropriate criteria for patients being considered for Nalmefene; as well as the pre-requisites before booking a patient in for consideration of Nalmefene prescription to the alcohol team.

* There were a number of local clinical audits where data collection took place during 2017/18 but the audit is not completed at the end of the year. The reports from these will be reviewed during 2018/19.

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:

- Early Intervention in Psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) - approved care package within two weeks of referral
- Improving Access to Psychological Therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within six weeks of referral
- Mortality 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 2017/18 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 2017. 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	Data quality 2017/18	National average
NHS Number	100%	100%	99.0%
Date of birth	100%	100%	99.9%
Gender	100%	100%	99.6%
Ethnicity	90.2%	88.7%	82.1%
Postcode	100%	100%	97.9%
GP Code	98.6%	98.0%	98.3%
The Trust data is for the end of Q3 and comparative data is from the published MHSDS Reports for December 2017			

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	2016/17	2017/18
Service user identifiers *(For example date of birth, gender)*	97%	100%	100%
Service user outcomes *(For example employment status, HoNOS scores)*	50%	96.1%	87.3%

Clinical coding error rates

Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 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 2017/18 was 68% for the 45 standards and was graded 'satisfactory'. A summary of our performance is provided below.

Information Governance Assessment framework - criteria	**2015/16**	**2016/17**	**2017/18 Current Grade**
Information Governance Management	66%	66%	66%
Confidentiality and Data Protection Assurance	66%	70%	74%
Information Security Assurance	66%	66%	66%
Clinical Information Assurance	66%	66%	66%
Secondary Use Assurance	70%	70%	70%
Corporate Information Assurance	66%	66%	66%
Overall	67%	68%	68%

Note:

(1) 'Satisfactory' means we are at least 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.

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 Improvement 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	National Incidents per 1,000 bed days
April 2014 - September 2014	2,129	55.3	32.8
October 2014 - March 2015	2,357	66.7	31.1
April 2015 – September 2015	1,982	60.8	38.6
October 2015 – March 2016	1,972	67.1	37.5
April 2016 – September 2016	2,267	86.0	42.5
October 2016 – March 2017	1,524	59.9	44.3
April 2017 – September 2017	2,132	83.0	51.5
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 continued to increase over the last three to four years. In the latest report published from the NRLS, the Trust is the fourth highest reporter of patient safety incidents out of 53 mental health trusts (using the reporting rate per 1,000 bed days). Nationally, the incident reporting rate has also increased over this period. Our reporting rate has increased due to an increase in the number of incidents reported within our community settings, together with a reduction in the amount of care we have provided within in-patient settings, reducing from 38,489 bed days in April 2014 – September 14 to 25,678 bed days in April 2017 – September 2017.

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 had no ‘never events’ within the reporting year 2017/18. In February 2018, the ‘never events’ list was updated by NHS England. The Trust assessed which events would apply to it and presented this information to the Quality Assurance Committee.

Patient safety alerts

The NHS disseminates safety alerts through a central alerting system. During 2017/18 the Trust received 105 non-emergency alert notices, (plus a further 23 which had a ‘response not required’ rating). 98% of these alerts were acknowledged within 48 hours. Nine were deemed to be applicable to the services provided by the Trust, (a further two are still being assessed for their relevance; the deadlines for which have not yet been reached). 95% of the applicable alerts were acted upon within the required timescale. A further two are still having their relevance assessed; the deadlines for which have not yet been reached. Our aim is to achieve 100% performance.

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 11% of all patient safety incidents reported by the Trust were related to self-harm, in comparison with 22% 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	National incidents as a % of all incidents
April 2014 - September 2014	260	12.2%	20.0%
October 2014 - March 2015	334	14.2%	21.2%
April 2015 – September 2015	280	14.1%	20.9%
October 2015 – March 2016	246	12.5%	22.2%
April 2016 – September 2016	313	13.8%	22.0%
October 2016 – March 2017	158	10.4%	23.4%
April 2017 – September 2017	243	11.4%	21.8%
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 to 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. It should be noted, however, that 95% of all our incidents have no or low harm. Our disruptive behaviour incidents are 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
April 2014 - September 2014	446	20.9%	16.1%
October 2014 - March 2015	471	20.0%	15.2%
April 2015 – September 2015	423	21.3%	15.3%
October 2015 – March 2016	401	20.3%	15.1%
April 2016 – September 2016	556	24.5%	14.4%
October 2016 – March 2017	353	23.2%	13.2%
April 2017 – September 2017	511	24.0%	13.0%
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 three 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
April 2014 - September 2014	136	6.4%	9.2%
October 2014 - March 2015	193	8.2%	8.9%
April 2015 – September 2015	161	8.1%	8.6%
October 2015 – March 2016	241	12.2%	8.4%
April 2016 – September 2016	228	10.1%	8.5%
October 2016 – March 2017	181	11.9%	8.5%
April 2017 – September 2017	198	9.3%	7.9%
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 corporate and mandatory training
- systems for the surveillance of infections
- an extensive audit programme
- the provision of expert guidance to manage infection risks identified.

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

Single sex accommodation
During 2017/18 we have had three reportable breaches on two separate occasions of the Department of Health Guidance on Eliminating Mixed Sex Accommodation on Dovedale older adult acute ward. There are a number of further non-reportable measures within the guidance which the Trust manages as well as possible in collaboration with SCCG, however we do not fully meet these due to the layout of the wards. The CQC 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. There is work underway on Dovedale Ward that will be completed by the end of April 2018.

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 continue to support staff awareness and provide improved comprehensive safeguarding training. This training is regularly reviewed to take account of safeguarding trends both nationally and locally, for example, Child Sexual Exploitation (CSE), PREVENT and Female Genital Mutilation (FGM). The Trust's training compliance has increased with much more positive feedback from our staff on the training received.

We have extended the child neglect and domestic abuse, human trafficking and modern day slavery elements of our training.

The Safeguarding Team offer one-to-one and group supervision sessions as well as advice on complex clinical case management.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)
The MCA and DoLS steering group has continued to maintain improvement in the implementation of the Mental Capacity Act and to preserve the rights of those subject to care delivered under the MCA and/or subject to DoLS. This year an audit tool to assess MCA assessments and Best Interest Decisions has been developed to ensure that there is a co-ordinated and consistent approach in place across the Trust. The audit tool has been made available for use in Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield City Council and NHS Sheffield CCG.

The steering group has also been developing further guidance for staff on 'Standards for Recording Consent and/or Mental Capacity Act Assessment in In-patient Wards', which is supported by a Legal Framework Decision Making Flowchart. The group's current work is developing guidance on 'Consent to Internal Referrals', which aims to provide clarity to staff on the appropriate process for seeking consent to internal referrals.

The Trust's training compliance as at 31 March 2018 for MCA and DoLS is given below.

DoLS Level 1	DoLS Level 2	MCA Level 1	MCA Level 2
78%	85%	92%	82%

Level 1 training for DoLS and MCA is now available as face-to-face training on staff induction, and is provided as face-to-face or e-learning for training updates.

A system for recording all DoLS applications made to the supervisory body has been developed with oversight and monitoring by the Mental Health Act Office.

A new consent and capacity form has been developed on Insight to enable the recording of all relevant clinical and non-clinical decisions regarding capacity, consent and best interests decisions in one central location. This will enable improved monitoring, audit and assurance of the application of both the MCA and the MHA in this regard. A comprehensive training plan has been delivered to all areas across the Trust, supported by a detailed help-sheet.

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. Our target is 85% of

all investigations to be delivered within the 12 weeks. Since January 2017, we have successfully achieved this target.

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 one out of four quarters.

Overview of incidents by type

The table below reports on a number of incident types reported within the Trust. It breaks down the numbers reported, those that were patient safety incidents and reported to the NRLS, as well as those that resulted in harm for service users and staff.

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.

Reported incident numbers by type	2015/16	2016/17	2017/18
All incidents (service users, staff, members of public, buildings)	8552 (a)	8637 (a)	9191
All incidents resulting in harm	1699 (a)	1367 (a)	1309
Serious incidents (investigation carried out)	23	31 (g)	22
Incidents involving service users			
Patient safety incidents reported to NRLS (d)	5463 (a)	4438 (a)	3855
Patient safety incidents reported as 'severe' or 'death'	22 (a)	31 (a)	37
Expressed as a percentage of all patient safety incidents reported to NRLS (d)	0.40% (a)	0.70%	0.96%
Incident type	**2015/16**	**2016/17**	**2017/18**
Slips, trips and falls incidents	1208	1039 (a)	1079
Slips, trips and falls incidents resulting in harm	399	303 (a)	280
Self-harm incidents	676	530 (a)	460
Suicide incidents (in-patient or within 7 days of discharge)	1 (a)	1 (a)	0 (c)
Suicide incidents (community)	20 (b)	17 (c)	5 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	2429	2417 (a)	2783
Violence, aggression and verbal abuse incidents resulting in harm	406	401 (a)	439
Medication errors	674	810 (a)	858
Medication errors resulting in harm	2	2	3
Infection control			
MRSA Bacteraemia incidents	0	1	0
Clostridium difficile infection incidents (new cases)	5 (e)	4 (h)	2
Periods of increased infection/outbreak incidents Showing number of incidents, then people affected in brackets			
• Diarrhoea and vomiting (eg Norovirus)	4 (25)	4 (39)	5 (57)
• Coronavirus	1 (11)	0	0
• Influenza	0	0	2 (5)
MRSA screening (until 2015/16 based on randomised sampling to identify expected range to target)	21% (f)	43%	42%
Staff Influenza vaccinations	22%	25%	57.6%

(a) Incident numbers have increased/decreased from those reported in the 2016/17 Quality Report due to additional incidents being entered onto the information system, or incidents being amended, after the completion of the report.
(b) The figure has increased from that reported in last year's Quality Report due to the conclusion and judgements of HM Coroner's inquest.
(c) Figures likely to increase after the conclusion of future HM Coroner's inquests. Will be reported in next year's report.
(d) The NRLS is the National Reporting Learning System, a comprehensive database set up by the former National Patient Safety Agency that captures patient safety information.
(e) Four of the cases were assessed as being unavoidable.
(f) Department of Health screening guidance changed during 2016/17, it is therefore not possible to compare results prior to this.
(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) Three of the cases were assessed as being unavoidable.

Learning from deaths
During 2017/18, 713 of Sheffield Health and Social Care NHS Foundation Trust's patients died. All patients whose patient records are recorded on our Insight system and had contact with any of our services within six months of the date of death, have been included in the figures below.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
No. of deaths	190	135	185	203

The following table provides information on the number of case record reviews that have been undertaken as part of our Mortality Review Group, together with numbers of Structured Judgement Reviews and investigations that have been carried out within the reporting period.

Note: There have been no reviews completed within the reporting period for deaths occurring outside of the reporting period.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
No. of deaths reported above subject to review/ case record review	77	63	57	71
No. of deaths reported above subject to serious incident investigation processes	14	15	13	12

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Working with eight other mental health trusts in the north of England we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur. We have decided not to initially report on what are described in general hospital services as 'avoidable deaths' in in-patient services. This is because there is currently no research base on this for mental health services and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to in-patient services would give a misleading picture of a service that is predominately community focused. We will continue to review this decision and will continue to support work to develop our data and general understanding of the issues.

From the case record reviews we have undertaken, we have found two examples of poor care that we have subsequently reviewed more thoroughly. One case involved a service user being referred to mental health services a number of times, but the referrals were not accepted as the service user was not deemed to require secondary care services. When the referral was accepted, the service user died from natural causes, prior to mental health involvement. The second case involved a service user who had repeated patterns of engaging then disengaging with services, resulting in their episodes of care being closed. Their disengagement appears to be associated with periods of crisis.

Further reviews of both cases is being undertaken to ensure the learning associated from these is fed back into teams.

We have also identified 65 actions (from the first three quarters), as part of our serious incident investigations, that are likely to result in improvements in practice. These actions are reported within our quarterly incident management reports and published on our website.

During 2017/18 the Trust reported 25 deaths to the LeDeR programme, which was set up as a result of the confidential inquiry into premature deaths of people with learning disabilities. These deaths are still being reviewed by LeDeR, but the findings from these will be discussed through the Mortality Review Group and the learning shared with clinical teams.

3.2 Effectiveness

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

Primary Care Services – 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 31,500 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 populations. The Mulberry site provides a specialist healthcare service to Sheffield's asylum seeking population and victims of trafficking, along with the homeless asylum seekers. 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, screening and attending for chronic disease reviews and reviews of medication. The Clover Group works in partnership with local organisations to deliver educational messages and support to communities to understand the importance of regular health checks and screening. The practices have worked with a third sector partner to host practice champions, a group of patient volunteers whom which have been trained in key health topics including cancer screening, stopping smoking, health eating to deliver some activities and key messages across the community in Darnall, the Clover Group's biggest site. The Mulberry team also works very closely with significant partners around asylum health to support the health and social care needs of this particular vulnerable group.

Access to services, specifically in Darnall continues to be problematic due to the levels of need and high demand from the registered population. A significant amount of work has been carried out during 2017/18, which will continue during 2018/19, in response to delivery of improved access to services in all surgeries in the group, but Darnall 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	City	Heeley Green	Buchanan Road
2016/17	90%	90%	Not our service at that time	88.1%
2017/18	92.5%	92%	93.5%	Not our service at that time

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?			
		2015/16	2016/17	This year 2017/18	
Flu vaccinations					
Vaccinate registered population aged 65 and over	75%	71.3%	66.7%		
Vaccinate registered population aged 6 months to 64 years in an at risk population	70%	43.4%	88.6%		Needs to improve
Vaccinate registered population who are currently pregnant	70%	40.6%	36%		
Childhood immunisations					✓
Two year old immunisations	70-90%	90%	93%		
Five year old immunisations	70-90%	85%	93%		✓
Cervical Cytology	60-80%	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	2015/16	2016/17	2017/18
Drugs				
No client to wait longer than three weeks from referral to medical appointment	100%	100%	100%	100%
No drug intervention client to wait longer than five days from referral to medical appointment	100%	100%	100%	100%
No premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	100%
No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100%	100%
% problematic drug users retained in treatment for 12 weeks or more	90%	96% (opiates) 81% (non-opiates)	96%* (opiates) 82%* (non-opiates	94%* (opiates) 92%* (non-opiates
Alcohol Single Entry and Access				
No client to wait longer than one week from referral to assessment	100%	100%	100%	100%
No client to wait longer than three weeks from Single Entry and Access Point assessment to start of treatment	100%	100%	100%	100%
Outcomes, self care				
All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100%	100%

Information source: National Drug Treatment Monitoring System

* The latest reported position is October 2016-September 2017 as released on Q3 17/18 performance report.

Learning disability services
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 review of our stepped care pathways across the Community Learning Disabilities Team (CLDT), Community Intensive Support Service (CISS) and in-patient Assessment and Treatment Service.

The leadership team within learning disabilities services continues to work closely with key national agendas including:

- Transforming Care and Building the Right Support
- Learning Disabilities Mortality Review **(LeDeR)** Programme which was set up as a result of one of the key recommendations of the confidential inquiry into premature deaths of people with learning disabilities
- Stopping the Over Medication of People with Learning Disabilities (STOMP)
- Green Light for mental health support access to everyday mental health services and supports.

These priorities have included citywide and regional initiatives designed to build system wide capability in Positive Behaviour Support (PBS) via an ambitious training delivery plan focussing on workforce development not just across Sheffield but the wider Transforming Care Partnership (TCP).

The workforce development plan includes the implementation of a newly developed PBS Knowledge, Skills and Understanding Workbook (approved by the British Institute of Learning Disabilities (BiLD) and system of validation for city wide use in Learning Disabilities Services. PBS Workbook Training is being delivered to those individuals being discharged from hospital or those individuals who may be at risk of admission. This is supported by service user specific PBS workshops.

Accommodation services
This year has seen the conclusion of changes to our accommodation services with the vast majority of our staff successfully transferring with their Supported Living Service under TUPE transfer regulations to new Providers.

Community Learning Disabilities Team (CLDT)
The CLDT has 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.

The learning disability social work teams in Sheffield have now disbanded and the specialism in learning disabilities has been integrated into generic adult teams. The CLDT links into the generic teams to highlight the needs of people with a learning disability and what support they can provide for them and the wider learning disability community.

The CLDT has focused on the following priorities:

- Implementing a ‘Rapid Response Rota’ that ensures there is a named clinician to respond to urgent client issues where the client is new to service or if their allocated worker is not available

- Communicating with service providers and others about safe positioning for eating and drinking, and increasing the team's capacity for responding to high risk dysphagia clients
- Community nurses have been trained in phlebotomy and a needle phobia pathway has been researched and drafted
- A top tips booklet has been completed for Profound and Multiple Learning Difficulties (PMLD) clients and their carers
- A programme of bereavement training has been implemented for community nurses, assistant psychologists, and clinical assistants to inform our support of people with a learning disability who are grieving.

Community Intensive Support Service (CISS)
The CISS team has developed a revised discharge planning process and discharge pathway to support and expedite successful discharge transition, working with relevant key stakeholders. They continue to deliver a robust system of ensuring that people who are eligible for Care and Treatment Reviews receive them in a timely manner and that their rights are protected. This system is supported by independent experts by experience commissioned through Inclusion North.

Assessment and Treatment Service (ATS)
The Assessment and Treatment Service is a modern purpose built environment for the care of adults with learning disabilities and mental health needs that challenge services. Following a review of patient acuity, patient and staff safety and issues highlighted in our CQC inspection visits, a number of improvements and modifications to the building have been undertaken this year. These are:

- Seclusion suite and Green Room
- Activity room upgrade
- Bringing the clinic room and sensory room into the core ward area.

The ATS continues to engage in contract and specification discussions with NHS Sheffield CCG looking at achieving the right balance in terms of staffing capacity, bed numbers and a potential reduction in beds with the aim of reinvesting resource into supporting an enhanced Community Intensive Support (CISS) function. This work is being done in conjunction with supporting neighbouring CCGs to access our non-commissioned ATS bed as and when required. In 2018 our commissioned bed number will reduce from seven to six.

Buckwood View
The nursing home at Buckwood View that we provide with The Guinness Partnership continues to grow in its reputation for quality. It is 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. The service has implemented safety huddles as a method for reducing falls.

Mental health services
2017/18 has been a year of change throughout mental health services. This has impacted in services including mental health in primary care, community, in-patient and specialist mental health.
The community mental health services in Sheffield have been reconfigured in the last year. These changes have involved a wide process of discussion with service users, carers and staff. In January 2018 the new model of community mental health was introduced.

A new Single Point of Access (SPA) has been introduced to offer a one stop service for new referrals into secondary mental health. The SPA has been designed to be able to offer and triage up to 8,000 new referrals and a face-to-face assessment for 6,000 people a year. This service is supported by an emotional wellbeing service that offers short term interventions, where appropriate.

People who require longer term community support are treated and supported by a recovery service which offers care to 1,800 people. Each person has a care plan that is collaboratively designed with goals towards the person's recovery.

There is a citywide Early Intervention Service for people with a first episode of psychosis. In January 2018 new investment into the service has supported changes that mean that the team is able to offer a commencement of treatment within 14 days of the receipt of referral. In March 2018, the service achieved this goal for 86% of people. The Early Intervention Service works with service users to develop a care plan that guides treatment.

A citywide Home Treatment Service has been established this year. This is a community alternative to deliver acute care in people's homes, rather than resulting in a hospital admission. This service works closely with the Single Point of Access (SPA) to ensure an effective response for people in crisis. The team works with people on average for 18 days and facilitates their ongoing care and recovery.

Older adults who need care in the community are supported by a specialist team that provides treatment for 1,200 people.

The Improving Access to Psychological Therapies (IAPT) Service is a primary care based service providing treatment to people with depression and a range of anxiety disorders. Over 12,000 people benefit from this service. The aim is for a minimum of 75% of people to start treatment within six weeks and for a minimum of 95% to start treatment within 18 weeks. The service has exceeded both standards in 2017/8.

In April 2017 a health and wellbeing service was established for people with long term medical conditions. This has involved close working with the Sheffield Teaching Hospitals NHS Foundation Trust. This service offers psychological interventions for 3,500 people who have both mental and physical conditions. The physical health conditions include diabetes, respiratory, cardiac and muscular conditions.

The in-patient services in Sheffield include services for people with acute care needs (67 beds), psychiatric intensive care (10 beds), intensive rehabilitation (30 beds), a unit for people with mental health and learning difficulties (7 beds) and a forensic unit (22 beds). The service has continued to deliver effective care for people in Sheffield. Those patients with long term needs are also supported by the Community Enhanced Recovery Team (45 places). These services have delivered a number of quality initiatives including development of recovery care planning, safe wards, post incident reviews and a recovery college.

The acute in-patient service has worked with service users, carers and staff to develop a plan for a full refurbishment of the service at the Longley Centre. This proposal is currently being considered by the Trust's Board of Directors and the aim is for building work to commence in 2019.

MENTAL HEALTH SERVICES	This year's target	How did we do? 2015/16	2016/17	This year 2017/18	
Improving Access to Psychological Therapies Number of people accessing services	12,000	12,774	12,966	12,753	✓
New access targets introduced Q3 2015/16 • Start treatment within 6 weeks of referral • Start treatment within 18 weeks of referral	75% 95%	75.6% (Q4) 98.1% (Q4)	90.1% (Q4) 99.3% (Q4)	90.5% (Q4) 99.2% (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 new clients	75 new clients per year	228 new clients accessing services	270 new clients accessing services	238 new clients accessing services	✗ (5)
New access targets introduced Q4 2015/16 Start treatment within 2 weeks of referral	53%	50%	54.9%	48.3%	
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	1,418 episodes provided	1,499 episodes provided	1,530 episodes provided	✓
Delayed transfers of care Delays in moving on from hospital care should be kept to a minimum	No more than 7.5%	7.6%	5.81%	5.14%	✓
Cardio-metabolic assessment and treatment for people with psychosis a) in-patient wards b) early intervention in psychosis services c) community mental health services (people on care programme approach)	90% 90% 65%	N/A	86% 7% 16%	100% 11% 57%	Part ach-ieved
Annual care reviews Everyone on CPA should have an annual review.	95%	95.2%	92.9%	91%	Part year
'Gate keeping' Everyone admitted to hospital is assessed and considered for home treatment	95% of admissions to be gate-kept	99.5%	99.8%	99.2%	✓

Comparators (see note 1): National average		*97.4% (1)*	*98.5%*	*98.6%*	
Best performing		*100% (1)*	*100%*	*100%*	
Lowest performing		*61.9% (1)*	*92%*	*93.8%*	
Seven 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	98.3%	96.9%	94.5%	**Part Year**
Comparators (see note1): National average		*96.9% (1)*	*96.7%*	*96.1%*	
Best performing		*100% (1)*	*99.4%*	*99.4%*	
Lowest performing		*50% (1)*	*77.8%*	*79.9%*	
Service users discharged from hospital not on CPA should receive support at home within seven days of being discharged	People not on CPA (2)	83.5%	92.2%	88.38%	
All service users discharged from hospital should receive support at home within seven days of being discharged	All discharges (2)	89.7%	94.3%	90.3%	
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)*	4.8%	6.4%	3.9%	✓
Inappropriate out-of-area placements for adult mental health services	*N/A*	*N/A*	*N/A*	*N/A (4)*	✓

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 seven 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.
Note 4: SHSC is not it is not required to disclose performance as it has fewer than seven average bed days per month.
Note 5: Performance in the Early Intervention Service has been improving over the past few months as staff have been appointed into posts. March 2018 performance was 88.5%.

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.

Over the last three years waiting times for the Memory Service have significantly reduced. This has been as a result of a revised care pathway and referral management arrangements.

The current position is that appointments for initial assessment are consistently offered between two to four weeks from referral.

DEMENTIA SERVICES	This year's target	How did we do?			
		2015/16	2016/17	This year 2017/18	
Discharges from acute care (G1)	N/A	48	55	55	✓
Number of people assessed for memory problems by memory management services (new first appointments)	N/A	1,231	1,201	1,222	✓
Rapid response and access to home treatment	350	295	269	258	⇩
Waiting times for memory assessment	N/A	13 weeks (2015/16) 6.5 weeks (Oct15-Mar16)	3.9 weeks	42% assessed within 3 weeks 94% assessed within 6 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	2015/16	2016/17	2017/18
Formal complaints	140	169	165
Informal complaints	263	223	73
Compliments	1142	925	572

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	4
Admissions and discharges	11
Appointments	23
Clinical treatment	25
Commissioning	2
Communications	26
Facilities	11
Integrated care	0
Other	8
Service user care	24
Prescribing	13
Privacy and dignity	7
Staff numbers	4
Trust admin/policies/procedures	10
Values and behaviours	58
Waiting times	12

This year the Parliamentary and Health Service Ombudsman notified us that four complaints had been referred to them. No further action was required in one case. Two cases are currently under investigation. One case was partially upheld by the Ombudsman – the Trust made an apology to the complainant.

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:

- Customer care training sessions to be provided to receptionists across the Clover Group
- The Perinatal Mental Health Service to produce written information about the risks and benefits of prescribed medication
- The Relationship and Sexual Health Service to produce a protocol to standardise the management of the cancellation of appointments.

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 compares about the same as to 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 2017.

The national Friends and Family Test results for mental health Trusts

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	89

Source: NHS England, Friends and Family Test data reports

April 2017-March 2018	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of feedback returns	84	147	240	93	178	136	192	190	127	153	144	124
% of Trust service users who would recommend the service they received	96	98	97	100	97	98	97	99	99	98	97	95
National average for mental health Trusts	89	89	88	89	88	89	88	88	88	89	89	89

Source: NHS England, Friends and Family Test data reports

The Trust continues to achieve above the national average of service users who would recommend our services to family or friends. Work continues on increasing the number of service users who undertake this survey.

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

MENTAL HEALTH SURVEY	2015 survey	2016 survey	2017 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	7.6 / 10	7.5 / 10	About the same
The way their care was organised	8.4 / 10	8.3 / 10	7.8 / 10	Worse
The planning of their care	6.9 / 10	6.9 / 10	6.7 / 10	About the same
Reviewing their care	7.2 / 10	6.9 / 10	6.7 / 10	Worse
Changes in who they saw	6.8 / 10	6.0 / 10	5.8 / 10	About the same
Crisis care	5.1 / 10	5.8 / 10	5.5 / 10	About the same
Treatments	7.3 / 10	7.3 / 10	7.3 / 10	About the same
Support and wellbeing	4.6 / 10	4.9 / 10	4.7 / 10	About the same
Overall views of care and services	4.6 / 10	7.2 / 10	6.9 / 10	About the same
Overall experiences	7.0 / 10	6.9 / 10	6.6 / 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.	2016 survey			2017 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?	4.9/10	7.0/10	6.1/10 About the same as other Trusts	4.4/10	7.1/10	5.5/10 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	8.9/10	8.3/10 About the same as other Trusts	7.4/10	8.2/10	8.2/10 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 the organisation and review of care, reported in the scores above. As reported on page 141 of this report, our community services have undergone major change this year, in order to improve the service offered in Sheffield and address concerns about service delivery. The period of the survey was at a time that the service changes were being consulted with staff,

service users and carers. The aim of the reconfiguration is to improve the experience of service users and carers.

In the last year the community services have begun the roll out of collaborative care planning. This approach to delivering and planning care, when successfully implemented, will address many of the areas contained within the survey.

The Trust will continue with the above actions to maintain and improve our position regarding the quality of our services. Our ongoing 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 (PLACE) across the Trust took place and was published in August 2017. The conclusion of the review is summarised in the table below. The latest results show that our hospital based facilities are above average in all but one category for one location. We have also achieved 100% for cleanliness at Grenoside Grange three years in a row with 100% being achieved another three times across the categories.

Site location	Date of review	Cleanliness	Food and hydration	Privacy and dignity	Condition and appearance
Longley Centre	August 2015	98.7%	93.7%	91.6%	90.6%
	August 2016	99.6%	89.7%	88.3%	95.8%
	August 2017	99.6%	90.9%	94.7%	96.8%
Michael Carlisle Centre	August 2015	99.4%	93.4%	95.5%	95.1%
	August 2016	98.7%	95.5%	85%	95.3%
	August 2017	98.0%	95.9%	94.3%	97.3%
Forest Close	August 2015	97.5%	94.2%	95.1%	97.9%
	August 2016	Not assessed due to refurbishment			
	August 2017	99.7%	94.3%	100%	99.8%

Site location	Date of review	Cleanliness	Food and hydration	Privacy and dignity	Condition and appearance
Forest Lodge	August 2015	99.8%	92.2%	95.1%	97.9%
	August 2016	100%	89%	92.7%	97.2%
	August 2017	99.5%	91.0%	100%	97.3%
Grenoside Grange	August 2015	100%	93.6%	89.5%	98.5%
	August 2016	100%	89.2%	87.8%	100%
	August 2017	100%	91.7%	100%	98.2%
Firshill Rise	August 2015	99%	90.8%	94.7%	92.7%
	August 2016	98.7%	92.1%	94.4%	98.2%
	August 2017	98.6%	92.5%	93.8%	98.3%
National average	August 2015	97.5%	88.5%	89.2%	90.1%
	August 2016	97.8%	89.7%	89.7%	94.5%
	August 2017	98.4%	89.7%	83.7%	94.0%

3.4 Staff experience

National NHS staff survey results

The experience of our staff indicates that they feel generally less positive than those in other Trusts when recommending us as a place to work or receive care. We are concerned by these results and have already commenced a number of workstreams to engage our staff in order for us to gain a greater understanding of this.

OVERALL ENGAGEMENT AND CARE	2015 score	2016 score	2017 our score	2017 national averages	2017 how we compare
Overall staff engagement	**3.76**	**3.74**	**3.64**	**3.79**	Worse than other Trusts
I would recommend my organisation as a place to work	62%	61%	53%	57%	Worse than other Trusts
I would recommend my organisation as a place to work or receive treatment	3.72	3.69	3.50	3.67	Worse than other Trusts
My organisation acts on concerns raised by service users	74%	73%	68%	75%	Worse than other Trusts
Care of service users is my organisation's top priority	76%	74%	68%	73%	Worse than other Trusts
% of staff experiencing harassment, bullying or	26%	20%	21%	21%	About the same as

abuse from staff in last 12 months					other Trusts
Top five rankings – The areas we compare most favourably in with other mental health and learning disability Trusts					
% of staff appraised in last 12 months	89%	95%	95%	89%	Better than other Trusts
% of staff able to contribute towards improvements at work	72%	73%	75%	73%	Better than other Trusts
% of staff experiencing physical violence from staff in last 12 months	6%	4%	2%	3%	Better than other Trusts
% of staff / colleagues reporting most recent experience of violence	82%	95%	94%	93%	Better than other Trusts
% of staff working extra hours (lower score is good)	63%	64%	70%	72%	Better than other Trusts
Lower five scores – The areas we compare least favourably in with other mental health and learning disability Trusts are as follows.					
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	24%	26%	38%	32%	Worse than other Trusts
% of staff agreeing that their role makes a difference to patients / service users	86%	87%	82%	88%	Worse than other Trusts
% of staff witnessing potentially harmful errors, near misses or incidents in last month	27%	29%	34%	27%	Worse than other Trusts
Effective use of patient / service user feedback	3.67	3.53	3.41	3.72	Worse than other Trusts
Staff feeling motivated at work	3.77	3.79	3.71	3.91	Worse than other Trusts

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	Q1	Q2	Q4*
	2016/17			2017/18		
Place to work						
% of staff who would recommend Trust as a place of work	68%	63%	60%	69%	54%	n/a
Average for England (Mental Health)	61%	62%	61%	62%	62%	n/a
Place to receive care						
% of staff who would recommend Trust as a place to receive care and treatment	75%	74%	77%	74%	65%	n/a
Average for England (Mental Health)	74%	75%	74%	74%	75%	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.

** Date for Q4 is not published until 24 May 2018, hence not included within this report.*

Our local survey results for the full year (when published) are expected to be, in the main, lower than the national average. This year our figures show that we are:

- Below national averages for staff recommending us as a place to work, in one out of two quarters
- Below national averages for staff recommending us as a place to receive care, in one out of two quarters.

Our service user Friends and Family Test results shown on page 141 show that nine out of 10 service users would recommend the Trust as a place to receive care.

The Trust employs around 2,405 people and as part of our responsibility to ensure we provide good quality care we participate in the annual NHS Staff Survey programme and local surveys as reported above. The NHS Staff Survey attempts to identify the major factors contributing to staff engagement and motivation. By focusing on these, we aim to enhance the quality of care provided to the people who use our services.

The NHS Staff Survey provides us with feedback on the Trust's performance across a range of relevant areas.

Overall we are encouraged with the above results, although there are areas that we still need to improve on. The positive feedback around engagement over the last several years continues to support our ongoing focus on improving quality and delivering our plans for service improvement. The full survey will be available via the 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 2017 survey feedback the areas we have prioritised for ongoing and further development work are as follows:

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 strategy, will ensure staff experience quality improvement positively. We will create and develop the conditions across all our services to make this a reality all of the time.

The ability for the Trust to deliver on this strategy depends on staff having the ability to engage with improvement techniques. To support this strategy we have a programme to equip staff and teams with the information, time and the skills to deliver continuous quality improvement. While we will use a range of quality improvement techniques as appropriate, the core Trustwide approach that we will use will be the Microsystems improvement methodology. All teams will be trained in this methodology and have access to ongoing 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 patients, relatives or the public
Our results in this area of the staff survey have shown a decline this year, and our performance is lower than the national average. We know from our incident reporting data that the number of staff reporting incidents of this nature has only increased by a marginal amount from the previous year. Our data also tells us that the harm caused to staff from these incidents has reduced by almost 9% from 2016/17 to 2017/18. Any level of violence against staff is a concern. Out of 1,040 incidents of physical violence reported, only 20 of these resulted in harm of a moderate or major nature.

Staff motivation at work
There is a correlation of this indicator with the percentage of staff feeling their role makes a difference (mentioned above) and the quality of appraisals indicator. Both of these may also have influenced staff engagement and motivation. The reconfiguration of services and staff resourcing are key themes given by staff within the comments of the staff survey, with staff reporting significant impact on not only staff but services and service users, subsequently affecting morale, health and wellbeing and sense of doing a job well.

When considering how the Trust should respond to the staff survey, we need to take account of the apparent impact of service reconfiguration, which is a key theme within the survey comments. Further work is in progress to map actions and initiatives already in place related to the findings with poor scores, and will be used to enable focus on priority areas. This will also be informed by reports on hotspots by department based on the bottom five key findings. The staff survey results and subsequent action will further support delivery of the Trust's Workforce and Organisation Development Strategy, enabling Directorates to consider how to promote the psychological relationship between staff and the Trust to enable transparency, and clarity of mutual obligations to support overall staff engagement.

ANNEXE A

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

Healthwatch

Thank you for inviting us to comment on this year's Quality Report. We are pleased to have built on our constructive relationship with the Trust this year.

We broadly welcome your quality objectives for 2018/19, although we note that they are lacking in detail. To ensure that your priorities have a better chance to drive improvement, each objective would benefit from greater clarity about what you plan to achieve by when, so that progress can be meaningfully measured.

When you list achievements against CQUIN goals, we noted that only one indicator was achieved and we would like to be able to read a narrative regarding the 'not achieved' and 'partially achieved' goals.

Access to services continues to be raised with us as problematic, and latterly the reconfiguration of community mental health teams and the introduction of your Single Point of Access. We liaise with the Trust about these issues on an ongoing basis and find you to be open and accessible, but we would have welcomed clearer indications within the Quality Report as to whether these two changes have resulted in the improvements in access they were designed to achieve.

The number of patient related incidents is much higher than the national average and you are assured that this is representative of a reporting and safety culture. Given that the CQC has rated the Trust as requiring improvement in the safe domain, it may have been helpful to provide a more comprehensive narrative to explain the significant differences.

We are pleased to see the achievements of your drug and alcohol services and the progress you have described in improving care in partnership with learning disabilities service users, and the high percentage of people with dementia receiving appropriate and timely screening.

In considering whether your account reflects the experiences shared with us by service users and their families, we recognise the themes resulting from the community mental health survey and the NHS staff survey. We recommend that the Trust commits to measuring the impact of the updated Quality and Assurance Strategy, listens to the concerns of staff and service users and works with them as equal partners to improve both the experience of service users and the working life of staff.

Chief Officer
Healthwatch Sheffield
20 May 2018

Our response

We welcome the feedback from Healthwatch and will ensure we provide the required level of detailed information through our regular engagement meetings. We look forward to working with them next year and to strengthen assurance around our reconfigured services.

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee
I would like to thank the Trust for this opportunity to comment on the 2017/18 Quality Report on behalf of the Healthier Communities and Adult Social Care Scrutiny Committee.

Mental health has been a key area of interest for the committee this year. We have been made aware of some service user concerns over the reconfiguration of Community Mental Health Teams, and will be including this on our work programme for 2018/19. Beyond this, we have not been alerted to any performance or service delivery issues relating to the Trust.

In terms of the Quality Objectives identified, I am supportive of the broad aims, and will be keen to see how the detailed plans for achieving the objectives develop, and how success will be measured.

I am pleased to see the Trust's results for the Friends and Family Test are above the national average, and that in general, performance across the Trust is on target. We have noted the performance issues around the early intervention service for first episodes of psychosis, and will be looking to see that the additional investment in the service results in improved performance over the longer term.

These are challenging times for the NHS and people working in it, however the staff survey results highlight some concerns and we hope to see a reversal in the downward trend over 2018/19. I'd like to take this opportunity to thank of the staff at the Trust, particularly those on the front line who work tirelessly to deliver much needed services across the City.

Chair
Healthier Communities and Adult Social Care Scrutiny Committee
15 May 2018

Our response
We welcome the feedback from the committee and thank them for their praise of our staff and recognition of the challenges we face. We look forward to working with them next year and to strengthen assurance around our reconfigured services.

NHS Sheffield Clinical Commissioning Group
NHS Sheffield Clinical Commissioning Group (CCG) commissions Sheffield Health and Social Care NHS Foundation Trust to provide a range of mental health, specialist mental health and learning disability services, in which we seek to continually innovate and improve the quality of services provided by the Trust and the experience of those individuals who access them. We do this by reviewing and assessing the Trust's performance against a series of key performance and quality indicators as well as evaluating contractual performance via the appropriate governance forums i.e. contract management groups / Board meetings. We work closely with the Care Quality Commission and NHS Improvement, who are regulators of health (and social care) 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.

The CCG has had the opportunity to review and comment on the information contained within this Quality Report prior to its publication. While a number of the initiatives will

carry forward into 2018/19 i.e. the impact of the community reconfiguration, the performance of SPA and the delivery against the NICE standards of care for EIP, the CCG is confident that to the best of our knowledge the information supplied within this report is an accurate and a true record, reflecting the Trust's performance over the period April 2017 – March 2018.

This Quality Report evidences that the Trust has achieved positive results against most of its key objectives for 2017/18. Where issues relating to clinical quality have been identified, action plans or next steps have been put in place, jointly between our respective organisations to ensure that improvements are made. We will continue to take this approach into 2018/19 and beyond, and monitor these in conjunction with the NHS Standard Contractual terms and conditions. We will continue to build on existing effective and transparent clinical and managerial relationships to proactively address issues relating to clinical quality so that standards of care are maintained while services continue to transform and reconfigure to ensure they meet the changing needs of our local population and individuals' needs.

Director of Commissioning and Performance, and Head of Contracts
NHS Sheffield Clinical Commissioning Group
15 May 2018

Our response
We welcome the response from NHS Sheffield Clinical Commissioning Group. We look forward to working with the CCG during 2018-19 to ensure that standards of care are maintained while services continue to transform and reconfigure to ensure they meet the needs of our local population.

ANNEXE B

2017/18 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 to prepare Quality Accounts 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 NHS 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 2017/18 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 2017 to May 2018
  - papers relating to quality reported to the board over the period April 2017 to May 2018
  - feedback from commissioners dated 15/05/2018
  - feedback from Governors dated 14/12/2017 and 15/02/2018
  - feedback from local Healthwatch organisations dated 20/05/2018
  - feedback from Overview and Scrutiny Committee dated 15/05/2018
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2017
  - the latest national patient survey issued in November 2017
  - the latest national staff survey issued in March 2018
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 24/05/2018
  - CQC inspection report dated March 2017
- 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
- 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 24 May 2018

Chief Executive 24 May 2018

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 & Social Care NHS Foundation Trust to perform an independent assurance engagement in respect of Sheffield Health & Social Care NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) - approved care package within two weeks of referral; and
- improving access to psychological therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within six weeks of referral.

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 2017/18* ('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 2017/18.*

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 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;

- feedback from commissioners, dated 15 May 2018;
- feedback from governors, dated 14 December 2017 and 15 February 2018;
- feedback from local Healthwatch organisations, dated 20 May 2018;
- feedback from Overview and Scrutiny Committee, dated 15 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2017;
- the latest national patient survey, dated November 2017;
- the latest national staff survey, dated March 2018;
- Care Quality Commission Inspection, dated 30 March 2017;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 24 May 2018; 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 & 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 2018, 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 & 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 2018:

- 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
Leeds

24 May 2018