NHS
Sheffield Health and Social Care
NHS Foundation Trust

Quality Report 2018/19

Contents

Part 1: Quality Report 2018/19 Chief Executive's welcome

I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Report for 2018/19.

This Quality Report aims to share with you our commitment to achieve improved outcomes and deliver better experiences for our service users, their carers and their families. We report within this document the progress we have made against the quality priorities we set last year, and look ahead to the areas where our focus will continue in the coming year.

During May – July this year (2018) we received a well-led inspection from the Care Quality Commission (CQC). The inspection report was published in October 2018 and rated the Trust as 'Good' in three domains, 'Requires Improvement' in the remaining two domains and 'Requires Improvement' overall. The inspectors found many areas of good practice, but they also identified areas we need to improve. We are confident that we will continue to improve services and will work with staff, service users, carers, volunteers and Governors to address the areas where standards were not as expected.

Our recent staff survey results show that we have some challenges to overcome. Further information on this is provided on page 30. Following significant transformation of our community mental health services, our survey results show that we are 'about the same' as other mental health trusts. The results show a slightly improved position from the previous year, but we know there is still work to do to ensure the quality of what we provide is of a consistently high standard for every person.

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

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

Kevan Taylor
Chief Executive

Part 2(a): Priorities for Improvement

Progress against our Quality Objectives in 2018/19

In setting our plans for 2018/19 the Board of Directors reviewed our priorities for quality improvement by:

- reviewing our performance against a range of quality indicators;
- considering our broader vision and plans for service improvement;
- exploring with our Council of Governors their views about what they felt was important;
- engaging 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 quality objectives for 2018/19 were:

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.

Quality Objective 1: Improving access to services and treatment

Why we chose this priority

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. This continues to be a challenging agenda, but is one that the Trust welcomes and fully supports.

We said we would

- Look into the problems we had with telephone response times following the launch of our SPA service (Single Point of Access).
- We have direct access to the substance misuse screening tool through the physical health assessment form on Insight, our clinical records system. We said we would continue to roll this out across our inpatient wards.
- Continue to ensure that people who are being cared for outside of the city are returned to Sheffield.
- Undertake a re-audit of the greenlight toolkit which focusses on improving access to mainstream services for people with a learning disability.

How have we done?

- We have selected a new telephone system and begun to implement it in our SPA service. The new system helps us to better understand the volume of calls we are receiving and ensures that calls are diverted quickly to people who can respond to them when the lines are busy.
- All of our inpatient areas now have direct access to the screening tool.
- We continue to have no individuals placed outside the city who need an admission to our acute wards and are making good progress in returning people back to Sheffield as quickly as possible if they need specialist treatment elsewhere.
- We have continued to work with partners across the city to ensure that people with a learning disability are enabled to access the services they need, making reasonable adjustments wherever possible to support them to do this. To embed this approach into everyday practice, a policy is being developed by the Trust for use across all our service areas.

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

Why we chose this priority

Understanding the experiences of the people who use our services and their carers/families is essential if we are to be successful in achieving quality improvement. 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 revised its Service User Engagement and Experience Strategy in April 2018. This strategy sets our approach to improving and understanding the experience of the people who use our services, their carers and families.

We said we would

- Improve compliance with the completion of post incident reviews by introducing weekly reporting and monitoring to ensure that our focus remains on reducing restrictive practices and post seclusion reviews.
- Continue to develop and deliver improvements as set out in our refreshed Service User Engagement and Experience Strategy and monitor our performance against this.
- Recruit additional staff within our Engagement and Experience Team to ensure we improve service user and carer experience and involvement.
- 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.
- Undertake an audit of Positive Behaviour Support planning within community teams.

How have we done?

- We have continued to work with our clinical teams to improve our completion of post incident reviews. There is still work to do, including adding it to our electronic clinical record system to standardise the way we record this information and making it easier for staff to record the information in a timely manner.
- Our Service User Service Engagement Group (SUSEG) has overseen the delivery of our Service User Engagement and Experience Strategy over the year, and has ensured that the implementation of our plan has continued with focus and pace.
- We welcomed two new members of staff into the Engagement and Experience Team this year, and are already seeing the positive impact they are making on this important agenda.
- An action plan was developed over the year to increase our service user feedback across the Trust, including active promotion of Care Opinion with service users and within our staff teams. We also had useful conversations with Nottinghamshire Healthcare NHS Trust who have been particularly successful in using Care Opinion, to understand how they have achieved this.

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

Why we chose this priority

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. 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 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.

We said we would

- Review our physical health training to consider how we support policy into practice and learn from incidents.
- Re-establish our Physical Health Group and review our physical health examination and assessment forms, ensuring they help practice and decision making.
- Monitor the progress made against our action plan following the baseline assessment of the NICE Guideline NG58 (Coexisting severe mental illness and substance misuse: community health and social care services).
- Continue to improve our responsiveness in undertaking falls risk assessments, ensuring these are carried out within three days of admission.

How have we done?

- We have reviewed our physical health training in line with national best practice, such as Recognising and Assessing Medical Problems in Psychiatric Settings, (RAMMPS) and Early Warning Score (EWS) training and from the lessons we have learned from incidents and audits within the Trust. Our Intermediate Life Support training also uses scenarios based on learning from within our Trust and from across the region.
- We have not re-established our Physical Health Group in this year as we had planned. However, this is now in progress, led by our new Deputy Chief Nurse. The review of our Physical Health Policy and supporting assessment forms are a priority in the Group's work programme.
- Progress against NICE Guideline NG58 has been monitored within Clinical Operational services to ensure that changes to practice have been made. The Clinical Effectiveness Group (CEG) has overseen progress as part of its remit to assure the Trust in relation to the implementation of NICE guidance.
- We have made positive progress with our falls risk assessments, with an overall 82.5% of assessments completed within 3 days of admission across our inpatient areas.

Our Quality Objectives for 2019/20

In considering our objectives for 2019/20 we have reviewed how we are performing.

The findings from the Care Quality Commission (CQC) well-led inspection
The CQC published the findings from its inspection of Trust services in October 2018. This is summarised in more detail in Section 2(b) of this report. The Trust's overall rating is 'Requires Improvement'. We have used feedback from the inspection to align our quality priorities with the areas where standards were not as expected

National Standards and Priorities
During 2018/19 our Single Oversight Framework segment rating remained at 2.

We have again exceeded the national access standards for IAPT Services during 2018/19, as well as exceeded the national access standard for people experiencing a first episode of psychosis.

Commissioning priorities for service developments
The main focus of the current and developing plans for service development across Sheffield, as they relate to the Trust, is the continued 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 is a focus on mental health and ensuring urgent and crisis care pathways and provision are accessible and effective over the full 7 day period.

Commissioning priorities in respect of quality improvement for the services directly provided by the Trust are defined through the agreed CQUIN programmes. The areas of focus as we move into 2019/20 are to follow-up patients, following hospital discharge, within 72 hours, to continue to screen for and provide advice regarding smoking and alcohol and data quality.

Our Governors also informed us of their priority areas going forwards into 2019/20, to ensure we incorporated these within our quality objectives.

Quality Objective Setting
In determining our specific quality objectives the Board of Directors has been informed by the following considerations:

- We have a clear plan to deliver improvements from the CQC inspection;
- We currently perform well against the current national standards;
- Quality improvement priority areas highlighted through our Governors.

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.

The quality objectives we have agreed for 2019/20 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.

What we want to achieve

Quality Objective 1:
Improving access to services and treatment;

- CQC Rating of Good during 2019/20*
- Early Intervention in Psychosis, Home Treatment (North) and Older Peoples CMHT services to gain RCPsych CCQI accreditation*
- Endcliffe Ward and Adult Mental Health Recovery service ready to apply for accreditation*
- Significant assurance from internal audit of system governance
- All national access standards in respect of waiting times
- 75% of people routinely referred to the Single Point of Access to access treatment within 8 weeks (from Q3 onwards).

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

- CQC Rating of Good during 2019/20*
- Every person secluded will have a post incident review completed (from Q3 onwards)
- Every person who has been secluded will have their physical health monitored in accordance with MHAct Code of Practice (from Q3 onwards)
- Every person who has received rapid tranquilisation will have their physical health monitored in accordance with NICE Guidance (from Q3 onwards)
- A reduction in the use of restrictive interventions on Maple and Endcliffe Wards
- A reduction of incidents of violence where harm has occurred in all inpatient wards
- All patients within Early Intervention in Psychosis and patients within Adult Mental Health Recovery Services on CPA will receive a cardio metabolic assessment (from Q3 onwards).

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

- CQC Rating of Good during 2019/20*
- All inpatient and community teams will increase the feedback received from the FFT and Care Opinion (from Q3 onwards) against their Q1 baseline
- An increase in the use of ReQoL, or an agreed equivalent outcome measure (from Q3), against their Q4 2018/19 baseline
- Early Intervention in Psychosis, Home Treatment (North) and Older Peoples CMHT services to gain RCPsych CCQI accreditation*
- Endcliffe Ward and Adult Mental Health Recovery service ready to apply for accreditation.*

* Signifies a measure that spans more than one quality objective.

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

Board of Directors: Sets the Trust's strategic aims and ensures the necessary supporting strategies, operational plans, policy frameworks and financial and human resources are in place for the Trust to meet its objectives and review its performance. Receives assurance reports on compliance with CQC standards as well as the improvements necessary to achieve quality services.

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

Audit Committee: Reviews the existence and maintenance of an effective system of integrated governance, risk management and internal control Trustwide.
Executive 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. Oversees the development and implementation of Trust wide compliance plans.

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

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

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

Systems of Internal Control: A range of policy and performance management frameworks (at individual and team level) as well as internal controls are in place to protect and assure the safety of care and treatment and the delivery of quality care in line with national policy and legislation.

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service, Care Network and Trust wide level. The Board's monthly and annual performance reporting processes ensure that the Executive Management Team is able to scrutinise and manage the operational performance of services and the Board to maintain overall oversight of the performance of the Trust. On an established bi-annual cycle, the performance of all services is reviewed through Care Network level Service Reviews. The Executive Team reviews with each operational care network 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 where required.

Our Assurance Processes

To deliver our strategy, it is essential that staff have the ability to engage with quality improvement techniques. Whilst we will use a range of quality improvement techniques as appropriate, the core Trust-wide approach that we will continue to embed will be the Microsystem improvement methodology.

Freedom to Speak Up

The Trust hopes that staff feel secure to raise concerns within their teams and speaking up about issues is considered " business as usual". However, this is not the case in all areas at all times and the Trust recognises more needs to be done to promote a speaking up culture. There are a variety of ways to raise concerns which include raising concerns with managers, in supervision, to the union, HR department and Freedom to speak Up Guardian. Some managers have an open door policy, including the Chief Executive, to encourage an open culture. Some teams also have comments boxes giving another avenue for staff to raise issues. Where concerns are raised to the Freedom to Speak Up Guardian, written feedback is provided when possible. The Guardian also ensures that no detriment occurs when staff speak up. For further information on this, please refer to the Freedom to Speak Up bi-annual reports to the Trust's Board of Director, available on our website.

Part 2(b): Statements of Assurance from the Board of Directors

Review of Health Services

During 2018/19 SHSC provided and/or sub-contracted 47 relevant health services. The Trust has reviewed all the data available to it on the quality of care in 47 of these relevant health services. The income generated by the relevant health services reviewed in 2018/98 represents 100% of the total income generated from the provision of relevant health services by SHSC for 2018/19.

National Clinical Audits and National Confidential Enquiries

During 2018/19 nine national clinical audits and four national confidential enquiries covered relevant health services that SHSC provides. During that period the 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 SHSC was eligible to participate in during 2018/19 are as follows:

National clinical audits and national confidential enquiries
Learning Disability Mortality Review Programme (LeDeR Programme)
Mental Health Clinical Outcome Review Programme 1. Suicide in children and young people
Mental Health Clinical Outcome Review Programme 2. Suicide, Homicide & Sudden Unexplained Death
Mental Health Clinical Outcome Review Programme 3. The Assessment of Risk and Safety in Mental Health Services
National Clinical Audit of Anxiety and Depression (NCAAD): Core Audit
National Clinical Audit of Anxiety and Depression (NCAAD): Psychological Therapies Spotlight Audit
National Audit of Care at the End of Life (NACEL)
National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis Spotlight Audit
National Core Diabetes Audit
Prescribing Observatory for Mental Health (POMH-UK): Topic 16: Rapid tranquillisation
Prescribing Observatory for Mental Health (POMH-UK): Topic 18: Prescribing clozapine
Prescribing Observatory for Mental Health (POMH-UK): Topic 6: Assessment of side effects of depot antipsychotics
Prescribing Observatory for Mental Health (POMH-UK): Topic 7: Monitoring of patients prescribed lithium

The national clinical audits and national confidential enquiries that SHSC participated in during 2018/19 are as follows:

National clinical audits and national confidential enquiries
Learning Disability Mortality Review Programme (LeDeR Programme)

Mental Health Clinical Outcome Review Programme 1. Suicide in children and young people
Mental Health Clinical Outcome Review Programme 2. Suicide, Homicide & Sudden Unexplained Death
Mental Health Clinical Outcome Review Programme 3. The Assessment of Risk and Safety in Mental Health Services
National Clinical Audit of Anxiety and Depression (NCAAD): Core Audit
National Clinical Audit of Anxiety and Depression (NCAAD): Psychological Therapies Spotlight Audit
National Clinical Audit Care at the End of Life (NACEL)
National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis Spotlight Audit
National Core Diabetes Audit
Prescribing Observatory for Mental Health (POMH-UK): Topic 16: Rapid tranquillisation
Prescribing Observatory for Mental Health (POMH-UK): Topic 18: Prescribing clozapine
Prescribing Observatory for Mental Health (POMH-UK): Topic 6: Assessment of side effects of depot antipsychotics
Prescribing Observatory for Mental Health (POMH-UK): Topic 7: Monitoring of patients prescribed lithium

The national clinical audits and national confidential enquiries that SHSC participated in, and for which data collection was completed during 2018/19, 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 clinical audits and national confidential enquiries	Number of cases submitted as a percentage of those asked for
Learning Disability Mortality Review Programme (LeDeR Programme)	100% (Note 1 and 2)
Mental Health Clinical Outcome Review Programme 1. Suicide in children and young people 2. Suicide, Homicide & Sudden Unexplained Death 3. The Assessment of Risk and Safety in Mental Health Services	100% (Note 3)
National Clinical Audit of Anxiety and Depression (NCAAD): Core Audit	100%
National Clinical Audit of Anxiety and Depression (NCAAD): Psychological Therapies Spotlight Audit	100%
National Clinical Audit Care at the End of Life (NACEL)	No case-note audit
National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis Spotlight Audit	100%
National Core Diabetes Audit	National data extraction

Prescribing Observatory for Mental Health (POMH-UK): Topic 16: Rapid tranquillisation	100%
Prescribing Observatory for Mental Health (POMH-UK): Topic 18: Prescribing clozapine	100%
Prescribing Observatory for Mental Health (POMH-UK): Topic 6: Assessment of side effects of depot antipsychotics	100%
Prescribing Observatory for Mental Health (POMH-UK): Topic 7: Monitoring of patients prescribed lithium	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 2017/18 and Quarters 1 and 2 of 2018/19.

Note 3: In some cases reporting had not occurred before the end of the 2018/19 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 6* national clinical audits were reviewed by the provider in 2018/19 and SHSC intends to take the following actions to improve the quality of healthcare provided:
We have updated the prescribing guidelines for valproate as well as looking to improve prescribing practice and physical health monitoring for people with psychosis. We will be making a number of improvements in relation to the care of patients following rapid tranquillisation. We are the process of making a number of improvements to our Early Intervention Service to enable them to meet all the expected standards for early intervention services.

* A number of the national clinical audits participated in during 2018/19 will be publishing their reports during 2019/20. In addition, three national clinical audits undertaken in 2017/18 reported their findings in 2018/19 and are therefore included here.

The reports of 19* local clinical audits were reviewed by the provider in 2018/19 and SHSC intends to take the following actions to improve the quality of healthcare provided:
Community mental health services are identifying and taking action on any gaps in the recording of physical health reviews. Learning disability services are increasing the use of clinical outcome measures. We have strengthened our work on the development of a personality disorder pathway. We aim to improve the extent of collaboration with service users in care planning. We are targeting better identification of carers and recording of their views when planning care.

The findings of many local clinical audits are reviewed at team-level and therefore individual teams will identify their own areas for improvement and actions to take.

* There were a number of local clinical audits where data collection took place during 2018/19 but the audit is not completed at the end of the year. The reports from these will be reviewed during 2019/20.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by SHSC in 2018/19 that were recruited during that period to participate in research on the National Institute for Health Research (NIHR) portfolio was 1070. These are research studies considered by the NIHR to be of high quality and demonstrating clear benefit to the NHS, Social Care or Public Health.

Goals under the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of SHSC's income in 2018/98 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2018/19 £1,150,451 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 £821,998 (71.5%) of the income that was conditional on these indicators. For the previous year, 2017/18 the associated monetary payment received by the Trust was £942,355 (79.4%).

The five indicators agreed with our main local health Commissioner Sheffield NHS Clinical Commissioning Group for 2018/19 are shown below.

CQUIN	Performance
1. Improving staff well-being: a) Introduction of Health and Wellbeing Initiatives b) Healthy food for NHS staff, visitors and patients c) Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff	Achieved[1] Achieved Partially Achieved
2. Improving Physical Healthcare to Reduce Premature Mortality in people with Severe Mental Illness (PSMI) a) Cardio metabolic assessment and treatment for patients with psychoses b) Collaboration with primary care clinicians	Partially Achieved Partially Achieved
3. Improving services for people with mental health needs who present to A&E.	Achieved

4. Transitions out of Children and Young People's Mental Health Services	Partially Achieved
5. Preventing ill health by risky behaviours – alcohol and tobacco a) Tobacco screening b) Tobacco brief advice c) Tobacco referral and medication offer d) Alcohol screening e) Alcohol brief advice or referral	Partially Achieved Achieved Partially Achieved Achieved Achieved

[1] *NHS Sheffield CCG has verified this part of the CQUIN as being achieved*

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at http://shsc.nhs.uk/about-us/corporate-information/publications/

Registration with the Care Quality Commission (CQC)

Sheffield Health and Social Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with conditions. The Trust has the following conditions on registration:

- The Registered Provider must only accommodate a maximum of 12 service users at Wainwright Crescent.
- The Registered Provider must only accommodate a maximum of 60 service users at Woodland View.

The Care Quality Commission has not taken enforcement action against SHSC during 2018/19. The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

During 2018/19 the CQC published its 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.

Well-led inspection

In October 2018 the CQC published its findings from the well-led inspection of the Trust that took place between May and July 2018. The Trust was assessed against the five key questions, 'Is it safe, effective, caring, response and well-led?'

They inspected the following mental health and learning disability services that we are registered to provide:

- Acute wards for adults of working age and psychiatric intensive care unit;
- Long stay/rehabilitation mental health wards for working age adults;
- Forensic inpatient / 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.

Overall the CQC assessed our Trust as 'Requires Improvement', with 'Good' achieved in three of the key questions for effectiveness, caring and responsive. Our previous inspection (November 2016) rating was 'Good' overall, with 'Requires Improvement' in one key question for safety.

Overall Trust rating from the last inspection

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

The inspectors found many areas of good practice, but they also identified areas we need to improve. We are confident that we will continue to improve services and will work with staff, service users, carers, volunteers and Governors to address the areas where standards were not as expected.

Our action plan
We have taken the following actions to address the areas for improvement highlighted by the CQC:

- We have developed action plans with each sub-action with a target date for completion
- We have taken action in the meantime to mitigate any risk whilst actions that take time to complete, for example where adjustments to premises are required
- Any areas that were identified for immediate action have been addressed
- Introduced a robust monitoring and governance process to ensure there is clear oversight whilst actions progress

Wainwright Crescent respite service was inspected in November 2018 as part of the CQC's social care inspection regime and was rated as 'Good' overall and 'Good' for all five key questions. This is an improvement from the previous inspection (carried out in

September 2017) when the service was rated as 'Requires Improvement' overall, with 'Requires Improvement' for the key questions for safety and well-led.

Mental Health Act Reviews
During 2018/19 the CQC has undertaken 8 visits to services to inspect how we deliver care and treatment for inpatients detained under the Mental Health Act. The services they visited this year were:

- Michael Carlisle Centre: Stanage Ward, Burbage Ward
- Longley Centre: Maple Ward
- Forest Close: Bungalow 1a
- Forest Lodge: Rehabilitation Ward, Assessment Ward
- Assessment and Treatment Unit (Firshill Rise)
- Grenoside Grange: G1 Ward

Data Quality
Sheffield Health and Social Care NHS Foundation Trust did not submit records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

The Trust submitted 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 2018.

The Trust's performance on data quality compares well to national averages and is summarised as follows:

Percentage of valid records	Data quality 2017/18	Data quality 2018/19	National average
NHS Number	100%	100%	99%
Date of birth	100%	100%	100%
Gender	100%	100%	100%
Ethnicity	88.7%	86%	91%
Postcode	100%	100%	98%
GP Code	98.0%	99%	100%
Overall Score	N/A	97.4%	98%
The Trust data is for the end of Q2 and comparative data is from the published MHSDS Reports for September 2018			

Source: NHS Digital, Digital Quality Maturity Index

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. This year has seen the introduction of the Data Security and Protection Toolkit, which has replaced the former Information Governance Toolkit.

The Trust's overall rating for is "Standards not fully met (Plan Agreed)".

Below are the Trust's previous years' scores against the Information Governance Toolkit, together with the Data Security and Protection Toolkit scores for 2018/19.

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

Source: NHS Digital, Information Governance Toolkit Results Report

Data Security and protection Toolkit – National Data Guardian Standards	2018/19
Personal Confidential Data	88% Complete
Staff Responsibilities	100% Complete
Training	100% Complete
Managing Data Access	100% Complete
Process Reviews	100% Complete
Responding to Incidents	100% Complete
Continuity Planning	50% Complete
Unsupported Systems	100% Complete
IT Protection	67% Complete
Accountable Suppliers	100% Complete
Overall	94% Complete

Source: NHS Digital, Data Security and Protection Toolkit Assessment Results

Clinical Coding

Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

Learning from Deaths

During 2018/19 670 of Sheffield Health and Social Care NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of the reporting period.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
No. of Deaths 2017/18	190	135	185	203
No. of Deaths 2018/19	177	144	172	177

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 above.

By 31 March 2019, 295 case record reviews and 49 investigations had been carried out in relation to 344 of the deaths included in the table above. In 2 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out is provided in the table below.

2017/18	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
2018/19	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
No. of Deaths reported above subject to review/ case record review	75	53	77	90
No. of Deaths reported above subject to serious incident investigation processes	8	14	15	10

The table above 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.

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. The table below provides the breakdown of these cases per quarter.

2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4
No. of Deaths	0	1	0	0
As % of all deaths	0%	0%*	0%	0%
2018/19	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
No. of Deaths	0	0	0	0
As % of all deaths	0%	0%	0%	0%

*1 death in 713 deaths (equivalent to 0.001403%)

From the case record reviews we have undertaken this year, we have found one example of very poor care that we have subsequently reviewed more thoroughly. This case involved a service user's records lacking narrative detail around clinical decision making, involving their referral to our services, our triage processes and discharge back to the individual's GP. Whilst the individual had a range of complex physical health problems, which ultimately led to their death, we believe that there was a missed

opportunity for our services to fully engage with them, prior to their death. The learning from this case has been shared with the teams involved and through the Trust's Service User Safety Group.

We have also identified 50 actions, 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.

Part 2(c): Reporting against Core Indicators

The Trust considers that the data provided earlier within this report and below is as described for the following reasons:

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 with previous years, the audit has confirmed the validity and accuracy of the data used within the Trust to monitor, assess and report our performance. The Trust will continue to monitor and take corrective action where targets are not met to improve the quality of its services.

MENTAL HEALTH SERVICES	**This year's target**	**How did we do?**			
		2016/17	**2017/18**	**This year 2018/19**	
7 day follow up Everyone discharged from hospital on CPA should receive support at home within 7 days of being discharged	People on CPA (1) 95% of patients on CPA to be followed up in 7 days	96.9%	94.5%	92.6%	✓ **Part year**
Comparators (note 1): National average		*96.7%*	*96.1%*		
Best performing		*99.4%*	*99.4%*		
Lowest performing		*77.8%*	*79.9%*		
Service users discharged from hospital not on CPA should receive support at home within 7 days of being discharged	People not on CPA (1)	92.2%	88.8%	86%	
All service users discharged from hospital should receive support at home within 7 days of being discharged	All discharges	94.3%	90.3%	89%	
'Gate keeping' Everyone admitted to hospital is assessed and considered for home treatment	95% of admissions to be gate-kept	99.8%	99.2%	98.5%	✓
Comparators: National average		*98.5%*	*98.6%*		
Best performing		*100%*	*100%*		
Lowest performing		*92%*	*93.8%*		

Emergency re-admissions: Percentage of service users discharged from acute inpatient wards who are admitted within 28 days.	*5%* *National benchmark* *Average is 9%*	*6.4%*	*3.9%*	*4.1%*	✓
Community Mental Health Services Experience: Percentage of service users' experience of contact with a health or social care worker. Q. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	N/A	**2016 Survey** 6.1/10	**2017 Survey** 5.5/10	**2018 Survey** 5.7/10	About the same as other Trusts
Best performing		7.0/10	7.1/10	*6.8/10*	
Lowest performing		4.9/10	4.4/10	*4.1/10*	
Q. Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	N/A	8.3/10	8.2/10	8.0/10	About the same as other Trusts
Best performing		8.9/10	8.2/10	*8.9/10*	
Lowest performing		7.7/10	7.4/10	*7.6/10*	
Patient Safety Incidents: Number of patient safety incidents reported to NRLS (note 2) Rate of patient safety incidents per 1000 bed days Number of patient safety incidents resulting in severe harm or death Percentage of patient safety incidents resulting in severe harm or death	N/A	**2016/17** 3791 (note 4) 68.4 35 (note 4) 0.92%	**2017/18** 3989 (note 4) 76.4 37 0.93%	***2018/19*** *1828* (note (3) 69.7 (note *3)* 16 (note 3, 4) 0.88% (note 3)	National % of patient safety incidents resulting in severe harm or death is 1.1%

Information source: Insight, NRLS, Ulysses, CQC Community Mental Health Survey results. Comparative information from Health and Social Care Information Centre, NHS Digital, NRLS and NHS England.

Note 1: Quality Account guidance states that all discharges from inpatient areas should be classified as being on CPA. Therefore all discharges have been included for calculating 7 day follow-up. This has previously only been reported *for those people on CPA.*
Note 2: 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.
Note 3: Information reported only covers the first 6 months of 2018/19.
Note 4: Data previously reported using Ulysses information, now reported using NRLS data so different from previous Quality Reports.

Part 3: Other Quality Information

3.1 Safety Indicators

Patient Safety 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 Trust has historically been below national averages for this type of incident reporting. The latest NRLS figures show 10% of all patient safety incidents reported by the Trust were related to self-harm, in comparison with 23% for mental health trusts nationally. Our self-harm incidents for the last three years are summarised in the table below:

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
Apr 15 – Sept 15	280	14.1%	20.9%
Oct 15 – Mar 16	246	12.5%	22.2%
Apr 16 – Sept 16	313	13.8%	22.0%
Oct 16 – Mar 17	158	10.4%	23.4%
Apr 17 – Sept 17	243	11.4%	21.8%
Oct 17 – Mar 18	239	12.9%	23.8%
Apr 18 – Sept 18	189	10.3%	23.2%
Source: National Reporting Learning System			

Disruptive, aggressive behaviour incidents

As a Trust we take disruptive, aggressive behaviour extremely seriously and encourage our staff to report any such occurrences of this. Our RESPECT programme has also affirmed the need to report this kind of unwanted behaviour. We remain a high reporter of this type of incident, compared to other mental health trusts nationally. From the disruptive, aggressive behaviour incidents reported since 1 April 2018, 18.2% of the 26.7% reported in this category were due to physical aggression. It should be noted that over 95% of all incidents reported by the Trust resulted in 'no' or 'low' harm. A number of measures have been taken by the Trust to improve safety and to reduce incidences of assault, including the introduction of body worn cameras and the presence of security staff. Our disruptive, aggressive behaviour incidents for the last three years 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
Apr 15 – Sept 15	423	21.3%	15.3%
Oct 15 – Mar 16	401	20.3%	15.1%
Apr 16 – Sept 16	556	24.5%	14.4%
Oct 16 – Mar 17	353	23.2%	13.2%
Apr 17 – Sept 17	511	24.0%	13.0%
Oct 17 – Mar 18	505	27.2%	13.0%
Apr 18 – Sept 18	488	26.7%	12.4%
Source: National Reporting Learning System			

Medication errors and near miss incidents

Medicines safety is everyone's business and it is essential that people obtain the best possible outcomes from their medicines. The safety of medicines can be a continual challenge. It is crucial that the Trust understands why these medicines incidents occur; why they occur when they do and what actions can be taken in order to reduce the impact and reoccurrence of such incidents. 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. Our medication incidents for last three years are summarised in the table below:

Proportion of incidents due to medication errors	Number of incidents reported	Our incidents as a % of all our incidents	National Incidents as a % of all incidents
Apr 15 – Sept 15	161	8.1%	8.6%
Oct 15 – Mar 16	241	12.2%	8.4%
Apr 16 – Sept 16	228	10.1%	8.5%
Oct 16 – Mar 17	181	11.9%	8.5%
Apr 17 – Sept 17	198	9.3%	7.9%
Oct 17 – Mar 18	180	9.7%	7.8%
Apr 18 – Sept 18	208	11.4%	7.7%
Source: National Reporting Learning System			

3.2 Clinical Effectiveness Indicators

As the Trust provides both primary care, in the form of GP practices and IAPT services, as well as secondary care services, ie community, residential and inpatient services, we have selected the three clinical effectiveness indicators below to ensure our Quality Report reflects the breadth of the care we provide to our service users.

Primary Care Quality Outcomes Framework – GP Practices

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 shows the achievement against the QOF for this year, in comparison with the previous two years. It should be noted that the Clover Group QOF covers Darnall Primary Care Centre, Highgate Surgery, Jordanthorpe Health Centre and Mulberry Practice.

Year	Clover Group	City	Heeley Green	Buchanan Road
2016/17	92.1%	86.7%	Not our service at this time	88.1% but not our service at this time
2017/18	92.4%	91.4%	93.6%	90.6% but not our service at this point
2018/19	90.6%	92%	95.2%	92.6%

Source: NHS Digital

Accessing Substance Misuse Services
The four commissioned services continue to prioritise ensuring timely access to primary and secondary care treatment.

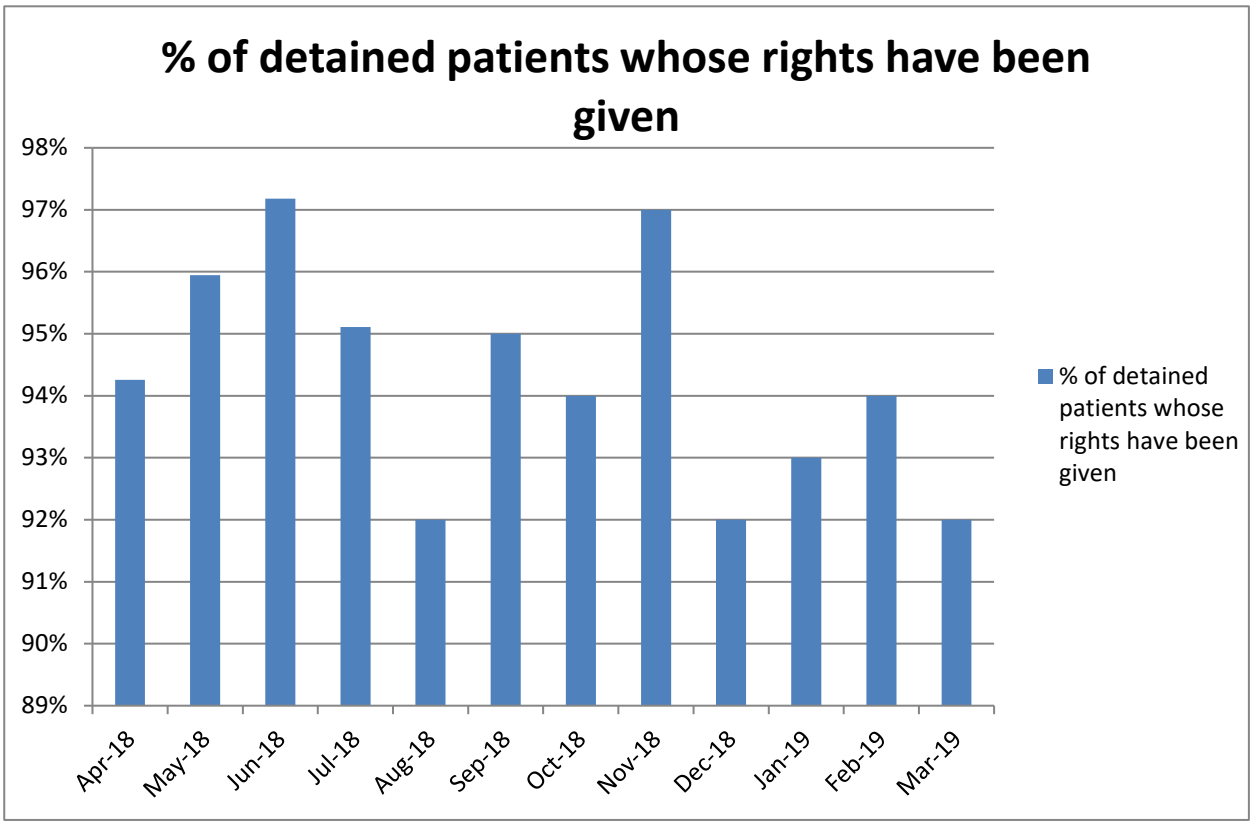
The service aims to ensure all of Sheffield's population that would benefit from the range of services provided in drug and alcohol treatment are able to access support. The service adopts a range of approaches to engage with people from this vulnerable service user group.

Drug and Alcohol Services Waiting Times	**This year's target**	**2016/17**	**2017/18**	**2018/19**
Opiates Service Referral to booked assessment within 7 days (local monitoring)	N/A	New service targets established	99.7%	99.2%
Referral to start of Tier 3 treatment within 21 days (local and National target)	95%		100%	99.9%
Non-Opiates Service Referral to booked assessment within 7 days (local monitoring)	N/A	New service targets established	96.9%	98%
Referral to start of Tier 3 treatment within 21 days (local and National target)	95%		99%	96.7%
Alcohol Service Referral to booked assessment within 7 days (local monitoring)	N/A	New service targets established	100%	100%
Referral to start of Tier 3 treatment within 21 days (local and National target)	95%		100%	100%

Source: National Drug Treatment Monitoring System and local performance data

Mental Health Act Compliance

Many service users within Trust services are subject to the Mental Health Act. It is imperative, therefore, for the Trust to ensure service user rights are protected are aware of their rights under the Act. The trust undertakes weekly audits within all inpatient areas to ensure service user rights are protected and our practice is in line with legislation. The graph below shoes the percentages of detained patients whose rights have been given.



Mental Health Service Indicators

MENTAL HEALTH SERVICES	This year's target	2016/17	2017/18	This year 2018/19	
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	270 new clients accessing services	238 new clients accessing services	179 new clients accessing services	✓
Start treatment within 2 weeks of referral	53%	54.9%	48.3%	74.6%	

Cardio-metabolic assessment and treatment for people with psychosis					
a) inpatient wards	90%	86%	100%	60%	**Part Ach-ieved**
b) early intervention in psychosis services	90%	7%	11%	30%	
c) community mental health services (people on care programme approach)	65%	16%	57%	16%	
Improving Access to Psychological Therapies					
a) Proportion of people completing treatment who move to recovery	12,000	12,966	12,753	13,585	✓
b) Waiting time to begin treatment					
i. Within 6 weeks of referral	75%	90.1% (Q4)	90.5% (Q4)	90.3% (Q4)	
ii. Within 18 weeks of referral	95%	99.3% (Q4)	99.2% (Q4)	98.5% (Q4)	

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

3.3 Experience Indicators

a) Service User Friends and Family Test

The tables below shows the results from the service user Friends and Family Test this year, compared to the previous two years.

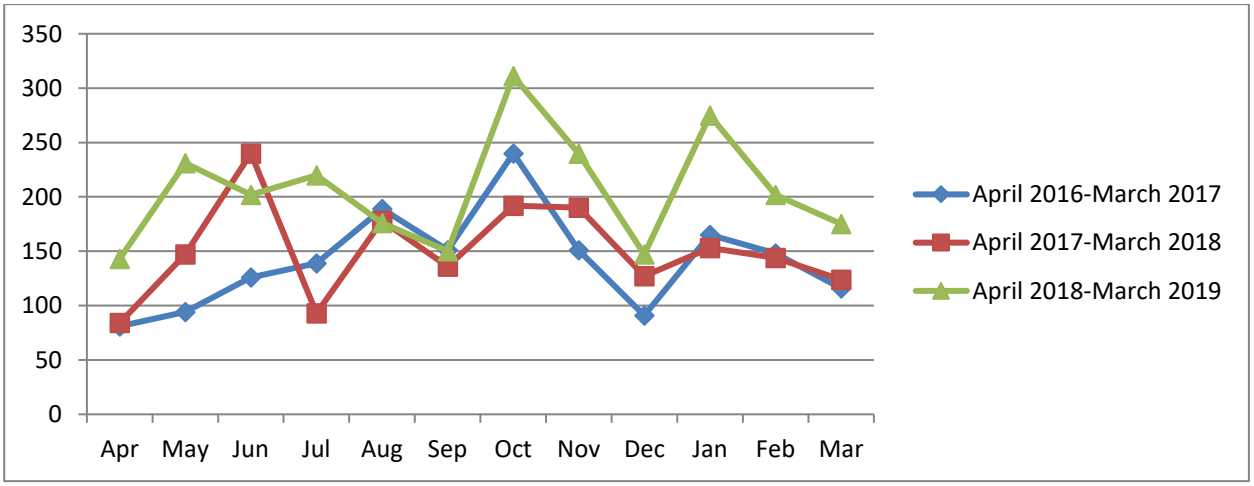
Service User Friends and Family Test Results 1 April 2016 – 31 March 2019												
April 2016-March 2017	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
% of Trust service users who would recommend the service they received	93	93	95	96	99	95	95	98	96	99	91	97
National average for mental health trusts (1)	87	87	87	87	88	87	88	88	86	88	88	89

April 2017-March 2018	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% of Trust service users who would recommend the service they received	96	98	97	100	97	98	96	94	94	95	97	95
National average for mental health trusts (1)	89	89	88	89	88	89	88	88	88	89	89	89
April 2018-March 2019	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
% of Trust service users who would recommend the service they received	96	97	95	93	95	94	99	95	95	93	90	92
National average for mental health trusts (1)	89	89	89	89	90	90	90	89	89	90	89	Not yet avail-able

Source: NHS England, Friends and family test data reports
(1) *NHS England FFT results should not be used to directly compare providers, the national averages are provided for information purposes only*

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 services that actively use the Friends and Family Test and the number of individuals who undertake the survey. The graph below shows a positive upward trend in the number of responses since April 2016.

Service User Friends and Family Test – No. of Responses 1 April 2016 – 31 March 2019



Source: NHS England, Friends and family test data reports

b) National Community Mental Health Survey

The table below shows the Trust's scores for the national Community Mental Health survey for this year, compared with the previous two years.

MENTAL HEALTH SURVEY	2016 Survey	2017 Survey	2018 Survey	
What did service users feel and experience regarding:	**Service User responses**			**How did we compare with other Trusts**
Their Health and Social Care workers	7.6 / 10	7.5 / 10	7.2/10	About the same
The way their care was organised	8.3 / 10	7.8 / 10	8.1/10	About the same
The planning of their care	6.9 / 10	6.7 / 10	6.9/10	About the same
Reviewing their care	6.9 / 10	6.7 / 10	6.8/10	About the same
Changes in who they saw	6.0 / 10	5.8 / 10	6.4/10	About the same
Crisis care	5.8 / 10	5.5 / 10	6.5/10	About the same
Medicines	New section for 2018		7.1/10	About the same
Treatments	7.3 / 10	7.3 / 10	7.3/10	About the same
Support and wellbeing	4.9 / 10	4.7 / 10	4.3/10	About the same
Overall views of care and services	7.2/10	6.9 / 10	6.9/10	About the same
Overall experiences	6.9 / 10	6.6 / 10	6.6/10	About the same

Source: CQC Community Mental Health Survey Reports

The 2018 survey results above show a slight improvement across some of the sections of the survey, with others staying the same and two sections declining. The two areas where the Trust's results declined from the 2017 survey are 'health and social care workers' and 'support and wellbeing'. National results in these sections showed the highest scoring trust achieving 7.7 out of 10 (health and social care workers) and the lowest scoring 5.9. For the support and wellbeing section, the highest trust scored 5.5 out of 10 and the lowest scored 3.3. SHSC scored 'about the same' as all other mental health trusts in all questions across each section. 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. The Trust will continue to maintain and improve our position regarding the quality of our services.

c) National NHS Staff Survey

The national NHS staff survey results this year have been reported based on themes, whereas previously results were reported against 'key findings'. Results below are therefore only shown in comparison to the previous year's results (2017). The Trust's results have not changed significantly since the 2017 staff survey, except in one area (immediate managers) where the score has improved. 'Morale' is a new section introduced in the 2018 survey, so there are no previous results for comparison in this area.

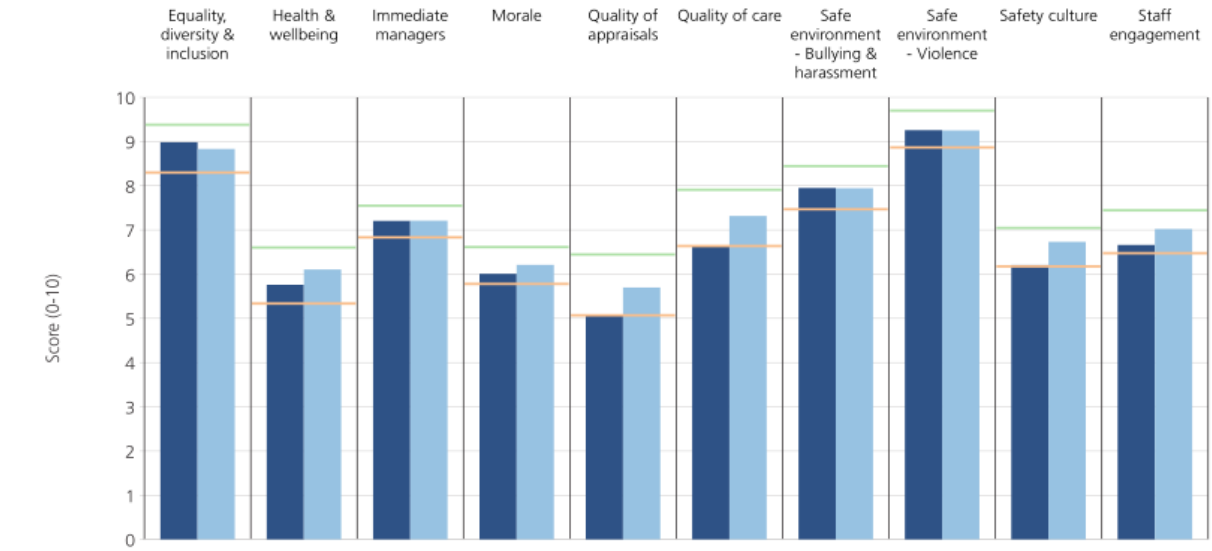
The Trust scores 'above or average' in four survey sections and below average in six sections. Whilst these scores are comparable with the previous year's survey, we remain concerned by these results and have commenced a number of workstreams to engage our staff in order for us to gain a greater understanding of this. Listening into Action is a new way of working that the Trust is adopting which is clinically led from the frontline. It is an evidence-based, simple way to empower staff and teams to take immediate, local actions which make a real difference for staff, service users and carers, with the backing of senior leaders. The Trust believes this will help us make the changes we need to make SHSC a better place to work and receive care.

2018 National Staff Survey Theme Results – Significance Test

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.8**	817	**9.0**	821	Not significant
Health & wellbeing	**5.7**	820	**5.8**	828	Not significant
Immediate managers	**7.0**	823	**7.2**	830	↑
Morale		0	**6.0**	808	N/A
Quality of appraisals	**4.9**	755	**5.1**	758	Not significant
Quality of care	**6.8**	667	**6.6**	658	Not significant
Safe environment - Bullying & harassment	**7.9**	814	**7.9**	823	Not significant
Safe environment - Violence	**9.1**	816	**9.3**	819	Not significant
Safety culture	**6.3**	821	**6.2**	816	Not significant
Staff engagement	**6.6**	830	**6.7**	834	Not significant

Source: NHS England National Staff Survey Benchmark Report 2018

2018 National Staff Survey Theme Results Overview



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.5	6.6	6.4	7.9	8.4	9.7	7.0	7.4
Your org	9.0	5.8	7.2	6.0	5.1	6.6	7.9	9.3	6.2	6.7
Average	8.8	6.1	7.2	6.2	5.7	7.3	7.9	9.3	6.7	7.0
Worst	8.3	5.3	6.8	5.8	5.1	6.6	7.5	8.9	6.2	6.5
No. responses	821	828	830	808	758	658	823	819	816	834

Source: NHS England National Staff Survey Benchmark Report 2018

ANNEXE A

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

Healthwatch Sheffield Statement

“Thank you for inviting us to comment on this year's Quality Account. We are pleased to have built on our constructive relationship with the Trust this year. The version of the Account we received lacked some figures, which made it difficult to provide a thorough response.

We were pleased to read about the activities you have carried out relating to the quality objectives set for 2018/19, however we really want to understand the impact of the activity – the difference you have made to outcomes for patients and carers.

Regarding the objectives for 2019/20, we note that these are the same as the previous two years. It would be helpful to understand how your plans fit into what is clearly a multi-year approach, with clarity about what you plan to achieve by when, so that progress can be meaningfully measured over this longer time frame.

We recommend that in preparing your objectives for 2020/21, you review whether this multi-year approach is effective or whether setting more specific objectives that are achievable within an annual cycle might help to focus your efforts and provide greater insight into what has been achieved.

It’s positive that the percentage of service users who would recommend the Trust to family and friends continues to be above the national average. It’s also positive that waiting time targets for drug and alcohol services continue to be met, and that IAPT provision continues to be a strength, with the Trust exceeding national access standards.

However, the quality account raises some concerns that may require a fuller explanation. The percentage of detained patients who were given their rights under the Mental Health Act is 92-97% for each month. Lay readers may struggle to understand why every patient would not be given their rights. Additionally, the number of incidents of medication errors has not improved since last year, and this seems to be an area where you could explain more fully how you are applying the learning from incidents to prevent similar errors being made in the future.

As with last year, we encourage you to include a narrative explaining progress against the CQUIN programme, especially those that were not achieved or partially achieved. This would help to develop a shared understanding between the Trust and lay people reading this report.

We support the Trust’s open response to the CQC well-led inspection and how the findings have been used to inform the quality plan for 2019/20. We are particularly concerned that the ‘safety’ domain received a rating of ‘requires improvement’ and this correlates with results from the staff survey, where ‘safety culture’ falls below the national average.

We hope that the Listening into Action scheme will support greater staff engagement and hope this will be reflected in next year's staff survey.

In considering whether your account reflects the experiences shared with us by service users and their families, we support the Trust's focus on improving experience of the Single Point of Access (SPA). Initial teething problems have been addressed which is positive, but we continued to hear from people who felt there was a lack of appropriate care and communication when they contacted the SPA, particularly in a crisis.

Access to the right services at the right time for all services is consistently raised with us as a priority for local people and this year we have made formal recommendations to the Trust on this issue. We have also made formal recommendations about simplifying referral processes and the information made available to people about when and how they can access services, and what support is available while they are waiting.

We fully support the Trust's focus on 'developing sustainable community care systems that deliver quality care and experiences'. And, in particular, improvements in urgent and crisis care provision, as we know that people do not always find crisis responses to be timely or adequate.

We will continue to contribute the experiences shared with us with the Trust directly and with the multi-agency Crisis Care Concordat Implementation Group.

We are really pleased to see the Trust's use of Care Opinion develop and we hope to see this embedded as business as usual, as well as being used creatively in areas that you are focusing on for improvement.

We thank the Trust for your work this year and look forward to continue to work with you in the year ahead."

Chief Officer
Healthwatch Sheffield
21 May 2019

Our response

We welcome the response from Healthwatch and look forward to continuing our work with them next year. We aim to build on the feedback received to ensure that future Quality Reports offer greater accessibility to the public.

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

"We'd like to thank the Sheffield Health and Social Care NHS Foundation Trust for inviting us to comment on this year's Quality Account. Thanks also for engaging with us on our work on mental health that we are carrying out with the Children, Young People and Family Support Scrutiny Committee. This work continues, and will report in the coming months.

We are supportive of the priorities that the Trust has chosen, and are pleased to see that clear objectives have been set for each priority – we look forward to hearing of progress against them in next year's Quality Account.

We are commenting on the Quality Account at a time when final data and analysis is not available – so we are unable to take a comprehensive overview of performance – however we are pleased to see the broadly positive results of the 'Friends and Family Test'. We are concerned that the staff survey results indicate that the Trust is underperforming in terms of safety culture, and likewise that patients scored their experience of care low around support and wellbeing in the National Community Mental Health Survey. We'll be looking for improvement next year.

We'd like to finish by thanking the staff at the Trust for their continued hard work in providing such vital services to people in Sheffield."

Chair
Healthier Communities and Adult Social Care Scrutiny Committee
13 May 2019

Our response

We welcome the feedback from the Committee and their praise of the hard working efforts of our staff. We look forward to continuing to work with them next year and to share progress of our achievements against our chosen priorities.

NHS Sheffield Clinical Commissioning Group Statement

"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 and 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 2018 – March 2019.

This Quality Report evidences that the Trust has achieved positive results against most of its key objectives for 2018/19. 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 2019/20 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 whilst services continue to transform and reconfigure to ensure they meet the changing needs of our local population and individuals' needs."

Deputy Chief Nurse
NHS Sheffield Clinical Commissioning Group

Senior Quality Manager
NHS Sheffield Clinical Commissioning Group

20 May 2019

Our response

We welcome the response from NHS Sheffield Clinical Commissioning Group and look forward to working with them next year to continue to improve the quality of our services. We will work with the CCG to ensure that standards of care are maintained and meet the changing needs of our local population.

ANNEXE B

2018/19 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.

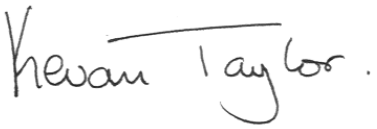
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in *the NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- 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 2018 to May 2019
  - papers relating to quality reported to the board over the period April
  - 2018 to May 2019
  - feedback from commissioners dated 20 May 2019
  - feedback from governors dated 21 November 2018 and 31 January 2019
  - feedback from local Healthwatch organisations dated 21 May 2019
  - feedback from Overview and Scrutiny Committee dated 13 May 2019
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2018
  - the latest national patient survey issued in November 2018
  - the latest national staff survey issued in February 2019
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 23 May 2019
  - CQC inspection report dated October 2018
- 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
- 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 2019



Chief Executive 28 May 2019

ANNEXE C

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

We have been engaged by the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust to perform an independent assurance engagement in respect of Sheffield Health and Social Care NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority 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

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 2018/19* ('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 Guidance.

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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 20 May 2019;
- feedback from governors, dated 21 November 2019 and 31 January 2019;
- feedback from local Healthwatch organisations, dated 21 May 2019;
- feedback from Overview and Scrutiny Committee, dated 13 May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated November 2018;

- the latest national staff survey, dated February 2019;
- Care Quality Commission Inspection, dated October 2018;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 23 May 2019; and
- any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sheffield Health and Social Care NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change

over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

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

KPMG LLP

KPMG LLP
Chartered Accountants
Leeds

29 May 2019