Council of Governors

SUMMARY REPORT	Meeting Date:	22 June 2023
	Agenda Item:	14

Report Title:	**Quality Account 2022/23**	
Author(s):	Tani Baxter, Head of Clinical Governance and Risk	
Accountable Director:	Salli Midgley, Executive Director of Nursing and Professions	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	10th May 2023 & 14th June 2023
Key points/ recommendations from those meetings	May 23 - Initial draft of report covering only statutory elements. June 23 – Committee acknowledged report has been substantially revised since May's presentation. Comments made regarding the addition of a glossary into the report and the subsequent publication of an easy-read version.	

Summary of key points in report

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum.

Since March 2022, Quality Accounts are no longer a required part of an NHS foundation trust's annual report. Quality accounts do, however, continue to be prepared under separate arrangements.

Local auditor assurance on quality accounts is not mandated by NHS Improvement.

The draft Annual Quality Account for 2022/23 is attached to this summary. It was presented to the Quality Assurance Committee in May 2023, following which it was substantially updated and presented as a revised draft in June 2023.

This version of the quality account has been sent out to stakeholders requesting their contribution/ commentary. Only Sheffield ICB is obligated to provide comment, however, it is highly likely that Sheffield Healthwatch and the Local Authority Health and Wellbeing Scrutiny Board will as well. Any feedback received will be incorporated within the final draft which will be presented to the Board of Directors in June 2023 and subsequent publication on our website by 30 June 2023.

Recommendation for the Council of Governors to consider:

Consider for Action		Approval		Assurance	✓	Information	✓

The Council of Governors is asked to receive the Quality Account 2022/23 for information and feedback. Any feedback received will be incorporated within the final draft which will be presented to the Board of Directors in June 2023.

Please identify which strategic priorities will be impacted by this report:				
Recover services and improve efficiency	Yes	✓	No	
Continuous quality improvement	Yes	✓	No	
Transformation – Changing things that will make a difference	Yes	✓	No	
Partnerships – working together to make a bigger impact	Yes	✓	No	

Is this report relevant to compliance with any key standards?					State specific standard
Care Quality Commission Fundamental Standards	Yes	✓	No		*The quality account should demonstrate compliance with many of the Fundamental Standards, as well as contributing to the well-led domain.*
Data Security and Protection Toolkit	Yes	✓	No		
Any other specific standard?	Yes	✓		✓	*National Health Service (Quality Accounts) Regulations 2010 are specific to the production of the Quality Account.*

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety, Engagement and Experience	Yes	✓	No		*Patient and carer safety and experience should be positively impacted through the delivery of the Trust's Strategies and various enabling strategies.*
Financial (revenue &capital)	Yes	✓	No		*Considered but no current impact identified.*
Organisational Development /Workforce	Yes	✓	No		*Continuous quality improvement and staff training requirements are outlined within the individual objectives.*
Equality, Diversity & Inclusion	Yes	✓	No		*See section 4.3 in this report.*
Legal	Yes	✓	No		*It is a legal requirement for NHS Trusts to produce an annual Quality Account.*
Environmental sustainability	Yes	✓	No		*Considered but no current impact identified.*

Section 1: Analysis and supporting detail

Background

1.1 A Quality Account is a report that is published annually by providers, including the independent sector, and is available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

The Department of Health and Social Care requires providers to publish their final Quality Account on their external website by June 30 each year and providing the link to where this is published to the Secretary of State (via NHS England and Improvement).

The requirement is set out in the Health Act 2009.

1.2 Every Quality Account must include:

- A signed statement from the most senior manager of the organisation. Within this statement, senior managers should declare they have seen the Quality Account and they are happy with the accuracy of the data reported, are aware of the quality of the NHS services they provide, and highlight where the organisation needs to improve the services it delivers. The statement is also an acknowledgement of any issues in the quality of services currently provided.
- Answers to a series of questions all healthcare organisations are required to provide. This includes information on how the healthcare provider measures how well it is doing, continuously improves the services it provides, and how it responds to checks made by regulators like the Care Quality Commission (CQC). Guidance on how to answer each question is given to all providers to ensure the questions are answered in a uniform way.
- A statement from the organisation's main commissioner. The local Healthwatch and the Health and Wellbeing Board may also provide statements. These groups represent patients and the public on healthcare issues.

Publication Timetable

Once approved by the Quality Assurance Committee the final Quality Account will be presented to the Council of Governors for comment and then the Board of Directors for approval and will be published by 30th June 2023.

Stakeholder engagement is required from NHS Sheffield Integrated Care Board, the Local Authority Health and Scrutiny Committee and Sheffield Healthwatch. It is no longer mandated for Healthwatch and the Scrutiny Committee to provide comment on the report, however, if is still a requirement that the report is sent to them. Feedback received will be incorporated into the final version prior to presentation to the Board of Directors.

Section 2: Risks

2.1 It is considered to be extremely low risk that the Quality Account will not be published in accordance with the required publication timetable above.

2.2 Key stakeholders may not be able to provide their commentary in line with required timescales. However, this is deemed unlikely as this has never happened previously. If this did occur, publication would still go ahead in accordance with the set timescales.

2.3 Local auditor assurance on quality accounts is no longer mandated by NHS Improvement. This means that there is no external checking/testing of the information contained within the report, which may give rise to inaccurate information being published. There continues to be internal and external scrutiny on the Quality Account, therefore this is considered to be an extremely low risk.

Section 3: Assurance

Triangulation

3.1 The information that has been reported quarterly through the Quality Assurance Committee as part of our Quality Objectives updates triangulates with the information presented to the Board of Directors and its sub-committees throughout the year and is included within the Quality Account. A number of these indicators are also reported monthly within the Integrated Performance and Quality Reports presented to the Board of Directors and its sub-committees.

Engagement

3.2 Our Governors, Sheffield Integrated Care Board (ICB), Sheffield City Council and Sheffield Healthwatch were all consulted as part of the development of the Quality Objectives for 2022/23. Updates on progress throughout the year have also been provided, the most recent presentation to the Council of Governors took place on 7 February 2023.

As has been mentioned within the publication timetable above, stakeholder engagement is required from Sheffield ICB, the Local Authority Health and Scrutiny Committee and Sheffield Healthwatch. The attached version of the Quality Account has been sent to the relevant parties seeking their input/commentary by 22nd June 2023. This will then be incorporated within the final draft of the report.

Section 4: Implications

Strategic Priorities and Board Assurance Framework

1. Recover services and improve efficiency
2. Continuous quality improvement
3. Transformation - Changing things that will make a difference
4. Partnerships – Working together to have a bigger impact

4.1 The quality improvement projects, strategy implementation, objective delivery and performance management highlighted throughout the Quality Account 2022/23 cut across all four of SHSC's strategic priorities.

The quality objectives themselves are aligned to the most relevant strategic priority, these are outlined below.

Objective 1 – demonstrate a measurable and equitable reduction in the use of seclusion and restraint. This is aligned to strategic priority 2 and 4.

Objective 2 – Demonstrate improvements in the number of people from diverse communities accessing community-based mental health services. This is aligned to strategic priority 4.

Objective 3 – We will embed co-production with service users and carers in how we deliver and govern clinical services. This is aligned to strategic priority 2 and 4.

Equalities, diversity and inclusion

4.2 Within the quality objectives, there are specific priorities identified that relate to ensuring both equity in service users from all cultures, communities and backgrounds in accessing services, as well as ensuring restrictive practices within SHSC is equitable across all protected characteristics.

It is not deemed that a Quality and Equality Impact Assessment is required in relation to the Quality Account for 2022/23.

Culture and People

4.3 The Quality Account should amplify the culture of SHSC and celebrate the excellent work that our staff do in partnership with our service users, their carers and families. Without our dedicated, hard-working staff, we would not be able to fulfil our values and deliver our strategies, which help to develop our culture as an organisation.

Integration and system thinking

4.4 Sheffield Integrated Care Board (formerly Sheffield Clinical Commissioning Group) was involved in the development of the three-year quality objectives. Feedback is also sought from them each year in the development of the priority areas for these current objectives.

In developing the Quality Account 2022/23, we have looked towards other NHS Trust's Quality Accounts to consider improvements we would like to make on the format and contents of our report.

Financial

4.5 There are no identified financial implications relating to the publication of the Quality Account 2022/23.

Compliance - Legal/Regulatory

4.6 It is a legal requirement to produce and publish a Quality Account in accordance with the National Health Service (Quality Accounts) Regulations 2010.

Environmental sustainability

4.7 There are no identified environmental sustainability outcomes identified through the publication of the Quality Account 2022/23. It should be noted that paper copies are no longer required to be 'filed' with the Secretary of State, which could be considered an environmental sustainability benefit.

Section 5: List of Appendices

1. *Quality Account 2022/23*

Proud to care in Sheffield

Sheffield Health and Social Care NHS Foundation Trust

Quality Account

2022/23 Comms will provide final cover sheet

Contents

Introduction

Our Quality Account is an annual report to the people in our communities about the quality of services we provide. It is an opportunity for you to see what we are doing to improve the quality of care and treatment we deliver. Quality Accounts require us to measure and to describe quality in the following ways:

Patient Safety - This means delivering care in a way which minimises harm by using effective approaches that reduce unnecessary risks.

Clinical Effectiveness – This means delivering care that is based on evidence, people's needs, and results in improved health outcomes.

Patient Experience - This means delivering care which people can access easily that is tailored for their needs and preferences.

At Sheffield Health and Social Care NHS Foundation Trust we are continuously striving to improve the mental, physical and social wellbeing of the people in our communities. We aim to do this by:

- Working with and speaking up for local people
- Making sure our services concentrate on prevention and early intervention
- Always improving what we do
- Locating services as close to peoples' homes as we can
- Developing a confident workforce with colleagues who are good at what they do
- Ensuring excellent and sustainable services

What is Quality?

There has been a longstanding absence of a universally accepted definition of 'quality' within health care. However, the National Quality Board[2] has recently offered a nationally agreed definition. This definition refers to care that is effective, safe and provides as positive an experience as possible by being caring, responsive and person-centred. The definition also acknowledges that care should be well-led, sustainable and equitable, whilst recognising the environmental impact of service provision as part of efforts to improve care quality.

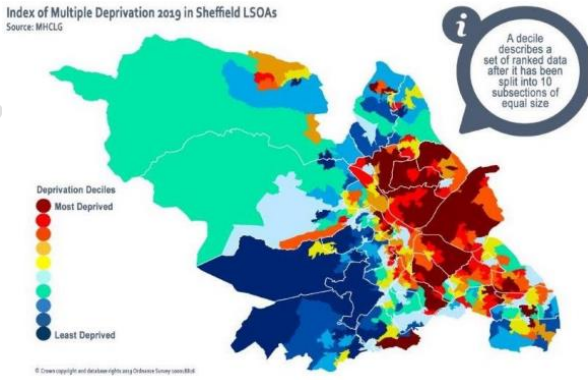
Our aim in reviewing and publishing information about quality enables us to demonstrate public accountability by listening to and involving the public, partner agencies and, most importantly, acting on feedback we receive. As well as producing this annual report, we produce quarterly updates on the progress of the achievement of our quality priorities, highlighted within this report. This Quality Account is published on our website in line with national requirements.

Part one: Statement on quality from the Executive Medical Director and Executive Director of Nursing, Professions and Operations

We are delighted to share our Quality Account for 2022/23 on behalf of the Board of Directors. This has been another challenging year for everyone, however the commitment and resilience of #TeamSHSC has enabled us to continue to deliver improvements in the quality of care that we provide.

Sheffield Health and Social Care NHS Foundation Trust (SHSC) employs over 3000 staff and has an annual income in 2021 of £131m. We provide predominantly secondary mental health, learning disability and specialist services to the people of Sheffield. Our strategic direction sets out where we aim to be as an organisation by 2026 and what we need to do to get there, in an increasingly changing world and NHS environment.

Sheffield is an unequal city with an 8-10 year life expectancy gap between areas that fall within the 10% most deprived in the country (Burngreave, Firth Park, Southey, Manor Castle, and Park and Arbourthorne) and areas amongst the 1% most affluent in the UK (Fulwood, Ranmoor and Dore). We have a high concentration of people seeking asylum and refugee status in some parts of the city, together with a high population of people over the age of 65 years living in other parts of the city. We know that people in poorer parts of Sheffield live shorter lives and have worse health than those in more affluent areas. We also see similar disparities affecting groups with specific shared characteristics, such as people from diverse communities, or people with learning disabilities. We recognise that our population requires different things of our services.



Highlights and lowlights of the year – use infographic from annual report if possible (ie quality focussed) remove above if too much. Need to talk about quality lead (BM) change over the year.

There are many features in our Quality Account which #TeamSHSC should be very proud of. Of note, we have xxxxxxxxxxxxxxx. Despite the impact that the pandemic has continued to have on the delivery of NHS services throughout the year, I am humbled by the number and breadth of quality initiatives that our services have been involved with. This commitment to quality improvement and working in partnership to deliver the best outcomes for our population is demonstrated throughout this report.

We are extremely proud that many of our teams applied for external awards, Quality improvement programmes or other national and regional initiatives which is a demonstration of our improvement and confidence over the past 12 months. This included our work around Restrictive Practice, Sexual Safety, falls management and working with the asylum seeker community.

In publishing this Quality Account 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 our knowledge the information provided in this report is accurate and represents a balanced view of the quality of services that SHSC provides.

Mike Hunter
Executive Medical Director

Salli Midgley
Executive Director of Nursing, Quality and Professions

Our Quality Strategy

This year we developed several strategies to support us to deliver high quality care within SHSC. Our Quality Strategy was approved in March 2022 and its purpose is to support the delivery of our aims and key priorities set out in our Clinical and Social Care Strategy, ultimately facilitating our journey to becoming an improvement focused organisation. SHSC is committed to ensuring that high standards of quality and patient care are delivered for our service users. The Quality Strategy sits alongside our other enabling strategies, as shown in the picture below.

All of the enabling strategies have clear objectives designed to drive quality and steer us towards becoming an improvement focused organisation. The approach we took in creating our Quality Strategy was to engage as widely as possible with service users, carers, staff and partners to listen to experiences, gather ideas about improvements and priorities and bring people on board.

Through the development of our Quality Strategy, we have agreed the priorities that will support us to make lasting improvements to the care we provide and to deliver our Clinical and Social Care Strategy. Delivery will be underpinned by the growth of an evidence-based Quality Management System (QMS) approach to co-ordinate and embed quality improvement, quality control, quality planning and quality assurance. The key priorities of our Quality Strategy are outlined below.

Key Priorities:

Develop a culture of continuous Improvement	Embed coproduction and lived experience methodology	Implement an evidence-based Quality Management System	Deliver a Quality Assurance Framework	Ensure sustainable high-quality outcomes
as an integral part of all that we do, ensuring a learning and just culture	in service developments and redesigns to provide responsive, accessible services	to coordinate and embed quality improvement, quality control, quality planning and quality assurance	to assure and control evidence-based care, benchmarking nationally as good quality	for the service users of today without compromising those of tomorrow

Part two (a)
Priorities for improvement

2.1 Quality Improvements

Quality improvement is undertaken by all our teams and wards across SHSC. Below is a selection of the some of our many quality achievements during the past year.

Zonal Engagement Work

Zonal Engagement aims to ensure appropriate observation of individual service users without the need to assign a particular staff member to be with the service user. The aim of making these changes is to make the environment safer for both service users and staff. It will increase engagement with service users but decrease surveillance which can be a source of frustration for patients. It can display better outcomes for patients by having appropriate staff presence. Care must be provided in an environment and manner that reflects the least level of restriction for the safe and supportive management of the patient.

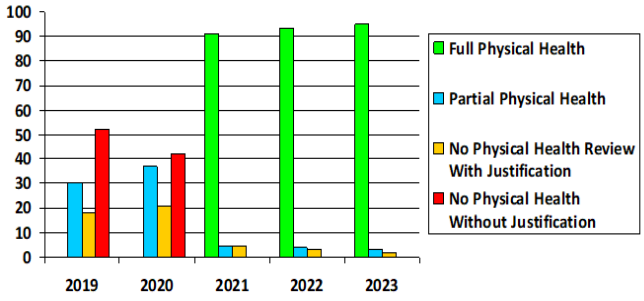
Zonal Engagement should therefore be seen as one method of reducing risk and enhancing the patients' experience. It is integral part of a wider risk assessment and contextual management process.

Care and support of patients will be addressed specifically within an individualised care plan. Patients will be assigned a level of engagement as laid out in the wider procedure and the assigned nurse should carry out documentation in accordance with that engagement.

Physical Health

Older Adult Home Treatment Service supports people who are over 65 who are experiencing a mental health crisis or difficulty which requires intense support. Traditionally, the service focussed on mental health recovery, however, this work has involved adopting a holistic assessment approach, and review support looking at social, psychological and pharmacological interventions which can optimise the patient's quality of life and prospect of psychiatric recovery and symptom management. This has helped to avoid lengthy waits for physical health problems, such as high blood pressure, which can impact mental health also.

Yearly Audit Presenting the percentage of patients who have a full and partial physical health review.



Falls HUSH huddles

Falls are extremely common in older adults, especially when admitted to hospital. Falls within our mental health organisation was identified as one of the top three organisational priorities. To address a high rate of falls that were occurring on our dementia unit, a Huddle Up for Safer Healthcare (HUSH) was introduced in collaboration with the Yorkshire and Humber Improvement Academy. This focused, multidisciplinary huddle supported shared understanding of patients most at risk and ensured that targeted interventions were in place. Data analysis showed that once huddles were embedded in May 2022 this led to over 50% reduction in the falls rate.

Quality Improvement in Tobacco Treatment (QuITT)

SHSC's Tobacco Treatment Team are taking part in the Quality Improvement in Tobacco Treatment Collaborative. This is a collaborative that aims to increase the number of patients in mental health inpatient units receiving smoking cessation treatment and is aligned to the NHS Long Term Plan.

One of our service users told us "I can walk my dog, Tommy, more and I'm not getting out of breath like on the hills, this time quitting seems real. I'm able to buy Tommy treats and use the money I would have been spending on cigarettes to put aside for my fuel bills."

Abdi (featured opposite) had smoked since the age of 15 and was concerned about his finances and the impact of smoking on his health. He switched to vapes and quit smoking with the help of the QUIT Team. Abdi struggled with initial lapses but, with support, achieved his 12 week quit. He was so passionate about quitting that he's even managed to get some of his friends to switch to vaping, so now the pressure of being around other smokers is no longer a problem. Adbi told staff "my health was deteriorating, and I was struggling to breathe. I enjoy meals now I have my taste buds back. I feel much healthier and not out of breath anymore. I've even joined the gym."

There are many other examples of the quality improvements that our teams have been involved in during 2022/23. Many of which are featured within this report.

2.2 Progress against our quality objectives in 2022/23

Our quality objectives were set in 2021 as a three year plan, this was our second year of working towards achieving those objectives which build on the progress we had made in 2021/22 to get 'Back to Good', improve the quality of services we deliver and improve safety for service users, staff and communities more broadly. We reviewed our actions for the second year of achieving the overall objectives by:

- considering the findings from our Care Quality Commission (CQC) inspections;
- reviewing our performance against a range of quality indicators, both internally and across mental health networks;
- considering our broader vision and plans for service improvement;
- exploring with our Council of Governors their views about was important to them;
- engaging with our staff and service users to understand their views about what was important and what they thought we needed to improve;
- engaging with our commissioners and other stakeholders to understand what their priorities for improvement were;
- considering the implications for us on the Use of Force Act and respecting people's human rights.

We consulted on our proposed areas for quality improvement with a range of key stakeholders, including Sheffield Place Integrated Care Board, Sheffield City Council, Sheffield Healthwatch, Sheffield Flourish and our Council of Governors.

Quality objectives

Our quality objectives for 2022/23 were:

- **Quality objective one:** Over a three-year period demonstrate a measurable and equitable reduction in the use of seclusion and restraint.

- **Quality objective two:** Over a three-year period demonstrate improvements in the number of people from diverse communities accessing community-based mental health services.

- **Quality objective three:** Over a three-year period we will embed co-production with service users and carers in how we deliver and govern clinical services.

Quality objective one: Over a three-year period demonstrate a measurable and equitable reduction in the use of seclusion and restraint

Why we chose this priority

We recognise that the Trust had been above the national average on the use of restraint and seclusion. We had multiple practices that are restrictive across the range of our services, from locked doors, restriction of personal items, use of enhanced observations, high detention rates and high levels of restraint and seclusion in some of our services.

Being restricted is a human rights issue and we recognise that for many of our service users restricting them, either through their movements or by their environment, can trigger increases in anxiety, flashbacks of past trauma and can cause a lack of trust. We are committed to reduce the amount of times we restrain and seclude service users, and we want to ensure that this reduction is the same across all service user groups, demographics and protected characteristics.

This objective is aligned to our Least Restrictive Practice Strategy, which is an enabling strategy of the Clinical and Social Care Strategy. It also aligns with our strategic priority 'continuous quality improvement'.

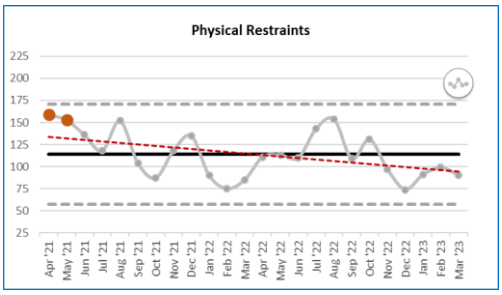
Year two - we said we would:

- Reduce the number of seclusions and physical restraints across inpatient services
- Reduce the length of seclusion episodes
- Roll-out of the revised Respect training programme to all inpatient eligible staff
- Develop our patient and carer race equity framework in collaboration with communities
- Co-produce and co-deliver human rights training to identified Human Rights Practitioners, in collaboration with British Institute of Human Rights
- Embed SafeWards (a model to improve safety of patients) across all our mental health inpatient wards

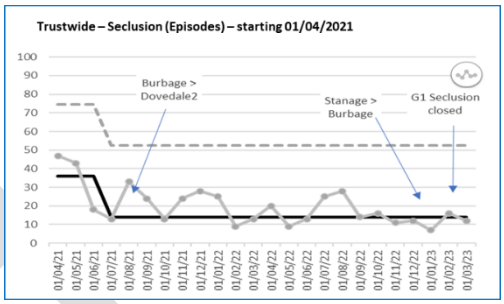
How have we done?

- Firstly we committed to ensuring that we report all our use of restrictive practices via our incident reporting system. This is very important to ensure we can accurately measure changes in the use of restraint. It is also important so that we can benchmark (compare ourselves) to other organisations.

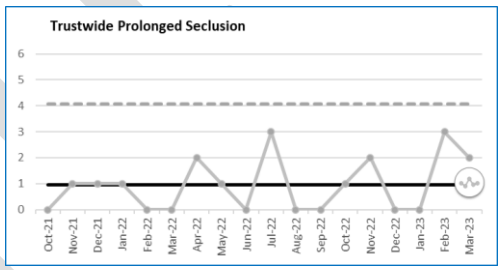
- The rate of Physical restraint incidents[SM1][SM2] is showing a steady decline in the number of occurrences of restraint over the last 24-month period despite the removal of Seclusion rooms. This is shown on the chart opposite.



- The number of seclusion episodes has reduced, (in line with the removal of the seclusion rooms on our inpatient wards (Dovedale 2 and Burbage and our dementia ward G1) and it is a significant achievement that the rates of physical restraint have not increased as a result (as shown in the chart opposite).



- Prolonged seclusions, which are defined as lasting over X?72 hours have an additional level of scrutiny from senior clinical leaders due to the very restrictive nature of the approach. It is hard to see an improvement in the reduction of prolonged seclusion in the reporting year in part due to the previous lack of reporting on timescales in previous years. We will continue to monitor the use of prolonged seclusion in 2023/24.



- We updated our Level 3 RESPECT training. This is the mandated training which all inpatient staff have to complete to meet the requirements of the Use of Force Act (2018). These changes mean that some staff have changed their levels of training required. Despite these changes we have achieved the following compliance in training at Level 3 across our inpatient wards.

Area	Respect Level 3 Compliance
Bank Primary Assignment	77.88%
Bank Nurses (Primary Assignment)	57.14%
Bank Support Workers (Primary Assignment)	81.11%
Acute Bed Services	74.45%
Burbage Ward	70.27%
Endcliffe Ward	81.08%
Maple Ward	71.43%
Dovedale 2	75.00%
Decisions Unit	72.73%
Forensic & Rehabilitation	85.83%
Forest Close 1	90.91%
Forest Close 1a	90.63%
Forest Close 2	80.95%

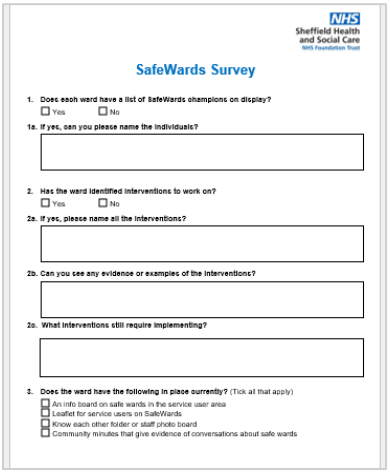
Forest Lodge	84.09%
Older Adults	63.54%
G1 Ward	86.05%
Dovedale 1	80.49%

- To support the development of our Patient and Carer Race Equity Framework (PCREF), we have recruited into a key role working into our diverse communities. Our Race Equity Community Lead commenced in post in December 2022 and is leading the work in conjunction with diverse community leaders, Sheffield Flourish and SHSC colleagues to develop our PCREF implementation plan.

  SHSC is an early adopter of the PCREF, a competency framework to help services provide culturally appropriate care by working with racialised communities and making practical improvements.

- We have delivered training to 18 Human Rights Practitioners in SHSC who will provide support, constructive challenge and scrutiny of practice across our clinical teams and into corporate clinical governance and assurance mechanisms. Practitioners receiving the training include ward managers, psychologists, matrons, heads of service and members of the engagement team.

- We have implemented SafeWards across our inpatient wards, we can demonstrate how this is embedded by the *Message of Hope* boards, *Know Each Other* boards and coproduced by staff and service users *Mutual Expectations* all being on display in our different inpatient services. In our SafeWards Forum leads for different services share details of initiatives implemented and how they are being used to improve experiences for staff and service users. Learning and good practice is regularly shared.


NHS
Sheffield Health and Social Care
NHS Foundation Trust

SafeWards Survey

1. Does each ward have a list of SafeWards champions on display?
☐ Yes ☐ No

1a. If yes, can you please name the individuals?

2. Has the ward identified interventions to work on?
☐ Yes ☐ No

2a. If yes, please name all the interventions?

2b. Can you see any evidence or examples of the interventions?

2c. What interventions still require implementing?

3. Does the ward have the following in place currently? (Tick all that apply)
☐ An info board on safe wards in the service user area
☐ Leaflet for service users on SafeWards
☐ Know each other folder or staff photo board
☐ Community minutes that give evidence of conversations about safe wards

Teams have submitted a brief summary report on their progress for implementing SafeWards to the Restrictive Practice lead nurse and a peer survey was piloted with Forest Close and Forest Lodge in 2022. The see and feel survey completed by peers is underway across all wards to learn from each other and share good practice.

Recent CQC Mental Health Act visits on Dovedale 1 and Forest Close have highlighted the least restrictive practice work.

Demonstrate improvements in the number of people from diverse communities accessing community-based mental health services

Quality objective two: Over a three-year period demonstrate improvements in the number of people from diverse communities accessing community-based mental health services

Why we chose this priority

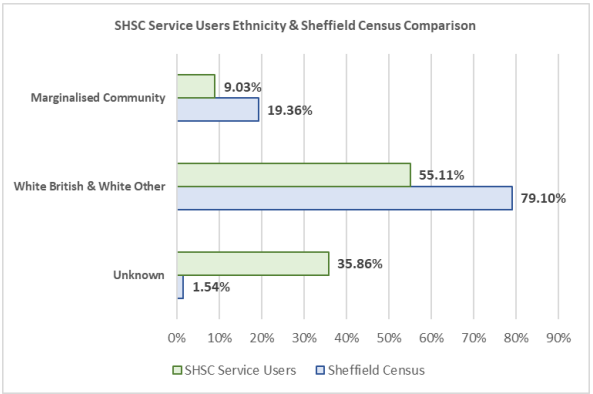
The National Institute for Mental Health in England report that people from diverse communities are more likely to have poorer health outcomes, a shorter life expectancy and have more difficulty in accessing healthcare than the majority of the population - and access to mental health services is a cause of concern. People from diverse communities are more likely to face challenges such as racism, stigma and inequalities, which can all affect mental health and wellbeing. The rates of mental health problems can be higher for some diverse groups than for white people, for example black people are more likely to be detained under the Mental Health Act, older South Asian women are an at-risk group regarding suicide, and refugees and asylum seekers are more likely to experience mental health problems that the general population. Getting people the help and support they need sooner, close to home (or ideally at home) means they are less likely to need more restrictive healthcare.
This objective is aligned to our Clinical and Social Care Strategy. It also aligns with our strategic priority 'Partnerships – working together to make a bigger impact'.

Year two - we said we would:

- Monitor and benchmark statistics relating to people accessing community services
- Develop cultural and race sensitive performance indicators
- Identify successes and share good practice from services
- Fully understand the range of community services, working together to reduce barriers and inequalities

How have we done?

We obtained 2021 census data and began to consider and understand what this highlights as areas for improvement. Census data shows 79.1% of the Sheffield population identify as white, 19.36% identify from diverse communities and 1.54% is unknown. Data from our electronic patient records system (Insight) shows that 55.11% of current service users are white, 9.03% are from diverse communities and 35.86% do not have ethnicity recorded.



Sheffield Census by Ethnic group	Observation	%
Asian, Asian British or Asian Welsh: Bangladeshi	4258	0.77%
Asian, Asian British or Asian Welsh: Chinese	7393	1.33%
Asian, Asian British or Asian Welsh: Indian	6798	1.22%
Asian, Asian British or Asian Welsh: Pakistani	27671	4.97%
Asian, Asian British or Asian Welsh: Other Asian	7440	1.34%
Black, Black British, Black Welsh, Caribbean or African: African	18237	3.28%
Black, Black British, Black Welsh, Caribbean or African: Caribbean	4647	0.84%
Black, Black British, Black Welsh, Caribbean or African: Other Black	2628	0.47%
Mixed or Multiple ethnic groups: White and Asian	5214	0.94%
Mixed or Multiple ethnic groups: White and Black African	2431	0.44%
Mixed or Multiple ethnic groups: White and Black Caribbean	7524	1.35%
Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups	4535	0.81%
White: English, Welsh, Scottish, Northern Irish or British	414698	74.52%
White: Irish	2750	0.49%
White: Gypsy or Irish Traveller	341	0.06%
White: Roma	2456	0.44%
White: Other White	19971	3.59%
Other ethnic group: Arab	8956	1.61%
Other ethnic group: Any other ethnic group	8575	1.54%
Total	556523	100%

We have been working with our Race Equity lead, Patient and Carer Race Equality Framework (PCREF) lead and community leaders to develop resources which will start to address the issues with asking and recording ethnicity. These resources will be shared on social media and will shared with staff to improve confidence of asking about protected characteristics, but also to communities so they understand why and how we use their personal information.

Quality objective three: Over a three-year period we will embed co-production with service users and carers in how we deliver and govern clinical services

Why we chose this priority

Person-centred and strength-based care are key components of our Clinical and Social Care Strategy. It is a key organisational priority of the Trust to continuously improve our approach to working with people who use our services and learn from their experience of care. The requirement to focus on experience, engagement and co-production to improve services is a linking thread across the Trust's strategies, working to enable the aims of the overarching Clinical and Social Care Strategy 2021-2026, which sets out the road map for Sheffield, based on an understanding of local need. The strategy works in line with the key deliverables of the NHS Long Term Plan, and aligns with our core values of 'working together for our service users' and 'everyone counts'. These local and national frameworks will work together to increase meaningful coproduction and help reduce health inequality.

This objective is aligned to the Experience and Engagement Strategy, which is an enabling strategy of the Clinical and Social Care Strategy. It also aligns with our strategic priority 'Partnerships – working together to make a bigger impact' and 'continuous quality improvement'.

Year two - we said we would:

- Develop and deliver co-produced complaints training
- Measure, collate and report on the outcomes of the co-production standards
- Agree the structure and opportunities for lived experience engagement
- Continue to develop and grow lived experience opportunities
- Review feedback mechanisms to increase feedback
- Co-develop robust peer support, lived experience, engagement and support networks

How have we done?

- Commissioned the Patients Association to develop and deliver complaints training to over 50 staff. Following this we have further developed in-house training following listening exercises to what staff need from this.
- Services have carried out self-assessments which measure levels of service user and carer involvement. This helps teams to identify where the strengths and weaknesses lie with involving people with lived experience. The outcomes of this self assessment have been reported to the lived experience group. Work will now commence to identify where best practice is taking place and to share this with other services to increase coproduction across a range of services.
- We have agreed our policy to support lived experience roles in the organisation, people can now join us as volunteers, on a paid engagement basis or through paid roles which are developed at service level.
- The Quality of Experience Survey has been incorporated into Tendable (an electronic audit tool) to collect feedback from a wider perspective of the organisation.
- Local coproduced feedback form trials have taken place on Maple and Endcliffe Wards which was successful.
- New process for authentication of requests from us to contact out of area patients - making contact easier and more seamless.
- We have scoped new feedback mechanism opportunities tools - review of the year - 27 out of area placements contacted. 111 ward visits. reviewed the feedback mechanisms - scoping out new feedback tools to increase the feedback tools.
- we recognise that this work has been inpatient focussed and more work to collate feedback from community services is required

2.2 Our quality objectives for 2023/24

At the start of April 2021, we set three, three-year quality objectives. We recognised that making a meaningful impact can take time. As we have gone through years one and two of these objectives, we have considered them against a range of quality indicators to ensure they continue to be aligned to the priorities for the Trust. We have also considered them against the following areas:

Findings from the Care Quality Commission (CQC) inspections

The CQC published findings from inspections of Trust services throughout the year. These are summarised in more detail in Section 2(b) of this report. Feedback from these inspections has been used to ensure our quality priorities align and enable fundamental standards to be consistently met.

National standards and priorities

The Trust was placed in Quality Special Measures in May 2020 in response to concerns raised by the CQC. We then transitioned into the Recovery Support Programme. Following a more favourable CQC inspection and based on evidence of sustained improvements, the Trust's System Oversight Framework rating was downgraded from level four to level three, and we were able to exit the Recovery Support Programme, with an exit package of support in place.

Commissioning priorities for service developments

The Long-Term Plan focus on crisis care pathways and provision (ensuring they are accessible and effective seven days a week, 24 hours a day) perinatal community services, children and young people's mental health services, IAPT, eliminating out-of-area placements and suicide and bereavement support.

Commissioning priorities have historically been defined through the agreed Commissioning for Quality and Innovation (CQUIN) programmes. These were paused during the COVID-19 pandemic to enable the NHS to prioritise resources in managing the virus and maintaining safety. CQUINs recommenced in April 2022. More information on our achievements against these can be seen on page 22.

Our quality objectives were set for 3 years therefore as we move forward into 2023/24 we need to meet the full requirement of the objective.

Year three priorities – what we will do:

Quality objective one priorities 2023/24

- Deliver advanced Human Rights training within RESPECT Level 3 – compliance 80%
- Reduce the use of seclusion and prolonged seclusion for those people from a black and Afro Caribbean ethnicity (22/23 baseline)
- Introduce and evaluate cultural advocacy
- Ensure (100%) post-incident reviews for staff and service users following seclusion or prolonged restraint

Quality objective two priorities 2023/24:

Demonstrate improvements in the number of people from diverse communities accessing community-based mental health services

- Implement our Race Equity Engagement pathway
- Increase recording of ethnicity in the electronic patient record system (baselined 2022/23)
- Increase number of service users from diverse communities in community services (against 22/23 baselines)
- Publish the SHSC Patient and Carer Race Equity Framework

Quality objective three priorities 2023/24:

- Implement a coproduced plan for Carer and Young Carer involvement, aligned with the Triangle of Care
- Develop and upload to Jarvis, resources and tools to support staff with good coproduction skills and knowledge
- Undertake a team deep dive each quarter to highlight good practice in coproduction
- Deliver Coproduction Best Practice Forums once a quarter
- Increase the Lived Experience Bank (25%) and Volunteers (100%) to become actively involved in the work of SHSC
- Pilot a new feedback mechanism which is accessible, culturally appropriate and delivers timely feedback.

Monitoring progress

Quality and performance is defined and measured in accordance with the Trust's Quality Strategy for 2022-2026. The strategy is grounded in the approach from NHS England/Improvement to move towards a quality management system which will co-ordinate and embed quality improvement, quality control, quality planning and quality assurance across the Trust.

The Trust's performance management framework defines the metrics that are tracked within a monthly quality and performance report (the integrated performance and quality report (IPQR)). This is received monthly by each of the committees of the Board and the Board of Directors.

Progress against the quality objectives is reported through our Executive Directors to our Quality Assurance Committee. We also share our progress, together with any concerns on achievement, with external partners.

Quality governance arrangements

Over 2022/23 we have continued to improve the quality governance arrangements within SHSC to ensure that the essential quality and safety standards required are met by the services we deliver.

Strategy

In 2022 we developed several strategies that will support us to deliver high quality care within SHSC. During the first half of the year we focused on the development of delivery plans to enable our ambitions to become reality and have since focused on implementation. Our committees retain oversight of strategy progress and during 2022/23 they received regular progress reports relating to the range of strategies that underpin the delivery of our overarching Clinical and Social Care Strategy.

All of the SHSC enabling strategies have clear objectives designed to drive quality and steer us towards becoming an improvement focused organisation.

Capability and Culture

Our Back to Good Improvement plan has helped us to improve capability and competence in areas which CQC deemed us to be lacking including Application of the Mental capacity Act (2005) and Medicines Management. The learning gleaned from our incident review processes also informs our approach to strengthening the skills and confidence of our workforce. Learning is triangulated from a variety of sources and informs our Quarterly Learning Report and learning hub which is a fully accessible compendium of incident details and learning outcomes. A monthly learning bulletin is circulated to all staff and shared via the learning hub.

We have a range of regular visiting programmes within SHSC which enable us to review the quality and safety of services delivered, hear from the staff that work within them and understand the experiences of service users receiving care from them.

Fundamental Standards of Care (FSC) Visits

Initially introduced in October 2021 in response to the Section 29A warning notice issued by the CQC, outlining elements requiring improvements following the inspection to Acute Inpatient Areas, weekly visits were conducted to our 4 wards over a 6-week period. The visits were designed to measure the extent to which the standards of care set out within key SHSC Policies are delivered in care settings. In 2022, we extended the FSC visits to include all SHSC bed-based services. Individual areas are developing an improvement plan to address any areas where an assurance rating of amber or red has been awarded and oversight of progress is managed through the Clinical Quality and Safety Group. This programme of visits will be an annual activity that contributes to the triangulated assessment of quality delivered by these services.

Board Visits

Board visits were introduced in 2020 during the COVID19 pandemic in order to support Non-Executive and Executive Directors to visit services to listen to the views and experiences of staff and more recently service users. The principles for the visit are:

- Listen – to listen directly to staff in services/teams to hear their views and experiences.
- Ask – ask questions and see the visit as an opportunity to learn more about the service, for example, good practice for sharing and any key issues of concern.
- Assure – the information from the visit will support assurance at Board and service level.

In late 2022, we reviewed the visit approach and proposed a new methodology which whilst reduced the number of Board visits completed annually, sought to provide a more meaningful experience for board members, staff, and service users. This new approach will enable us to better triangulate some of the issues identified

through our performance and quality reporting. In 2022 we completed 31 Board visits to a range of services across SHSC consisting of bed based, community and rehabilitation provision.

Culture and Quality Visits

Any service that delivers patient care can have a closed culture. All services have been assessed for risk of closed culture based on the criteria identified within the work completed by CQC on closed cultures and then prioritised based on risk profile. The culture and quality framework consists of a desktop review of service information related to a range of performance and quality indictors which then informs the focus of the on site visit. During 2022, all but one area identified as 'high risk' received a Culture and Quality visit.

Our Board of Directors have been involved in numerous Board development sessions that have supported the Board to have the leadership, skills and knowledge to promote the delivery of the quality agenda.

Processes and Structures

Throughout 2022/23 we have continued to strengthen our approach to audit and assurance of some of the key standards of care of care we deliver through the implementation of the Tendable clinical audit platform across all of our bed-based services. The audits have been customised to measure our compliance with our policy standards across a range of areas including restrictive practice, physical health and infection prevention and control and service user experience. Since its introduction we have been able to better understand more about the quality of care we are delivering and where we need to make changes to improve the care offered. Services have instant access to audit results which empowers them to foster a culture of quality improvement within teams; regular reporting against standards also informs the conversations we have at committee meetings.

Our daily safety huddle reviews every incident reported through Ulysses Incident reporting system and supports thematic learning within the Trust when things go wrong. The weekly Serious Incident Panel provides oversight for our investigation processes and assurance regarding the quality of our learning.
Over 2022/23 we have developed an Out of Area Quality Assurance framework for both our block contract and spot purchase beds. We have completed several quality assurance visits to providers to review the quality of the care being provided to our service users and in some cases have suspended use of providers where concerns have arisen. We have regular quality review meetings for a range of services commissioned by SHSC.

We have continued to strengthen our working relationship with our CQC inspectors to ensure that communications are timely, transparent, and open when issues arise. This is facilitated through:

- Quarterly engagement meetings
- Timely response to CQC enquiries
- Routine sharing of Serious Incident Investigation reports

We have also worked collaboratively with CQC to provide a joined-up response for service users who frequently share their concerns with a range of organisations across the system and who have complex care needs. This approach has enabled organisations to offer a consistent and informed response that is service user led.

Measurement

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service level through a performance framework. Service level quality and performance reviews assist our services to understand the quality of care that is being delivered to some extent and where improvements are required. We are supporting each team to implement a team framework for governance which will enable them to better explore quality, performance and risks aligned to the framework. The existing framework is predominantly output focused; we have recognised the need to better equip our teams with outcomes led intelligence and as a result have begun to design a quality management system which will be tailored to the individuals needs of services, with the support of colleagues from NHS England and NHS Improvement.

Service Quality and Performance Reviews have taken place regularly, chaired by the Director of Finance and attended by the Executive leadership to positively challenge performance in clinical and corporate services across the organisation.

Freedom to Speak Up (FTSU)

The Trust encourages all staff to feel safe to raise concerns within their teams and for speaking up to be considered 'business as usual'. A FTSU Ambition and Strategy has been developed to help strengthen speaking up in the organisation and the themes for the next 3 years include:

- Developing the FTSU champion network to give staff more choice of who they can speak up to, should they feel unable to speak up in their workplace
- Raising awareness of FTSU and removing barriers so all staff feel safe to speak up and are actively encouraged to do so.
- To improve identification and promotion of learning from FTSU concerns.

When concerns are formally raised through the Freedom to Speak up Guardian, written feedback is provided, where possible, support for the individual raising the concern. All clinical concerns are signed off by a senior manager which helps with the identification and sharing of any learning in the appropriate areas.

The Guardian also works with staff and managers to minimise the possibility of detriment arising from speaking up. Further information can be found in our Freedom to Speak Up reports to the Trust's Board of Directors, which are available in the Board papers section of our website at www.shsc.nhs.uk/about-us/board-directors/meeting-minutes-and-agendas

Part two (b): Statements of assurance from the Board of Directors

Review of health services

During 2022/23 the Trust provided 62 health services. The Trust continues to review all available data on the quality of care of these services through contractual monitoring. The income generated by the relevant health services received in 2022/23 represents 86% of the total income generated from the provision of services by the organisation. The remaining 14% relates to areas such as education and training. Additional System Development Funding (SDF) investment from baseline funding was received during the year as part of the NHS Mental Health Implementation Plan 2019/20 – 2023/24.

National clinical audits and national confidential enquiries

During 2022/23, 4 national clinical audits and xx national confidential enquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

During that period, SHSC participated in 100% of the national clinical audits and xx% of the 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 2022/23 are as follows:

- National Audit of Psychosis (NCAP)
- National Audit of Inpatient Falls (NAIF)
- POMH Topic 20b: Valproate prescribing in adult mental health services
- POMH Topic 7: Monitoring of patients prescribed lithium

The national clinical audits and national confidential enquiries that SHSC participated in during 2022/23 are as follows:

- National Audit of Psychosis (NCAP)
- National Audit of Inpatient Falls (NAIF)
- POMH Topic 20b: Valproate prescribing in adult mental health services
- POMH Topic 7: Monitoring of patients prescribed lithium

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 2022/23, 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
National Audit of Psychosis (NCAP)	100%
National Audit of Inpatient Falls (NAIF)	No cases requested (Organisational surveys only)
POMH Topic 20b: Valproate prescribing in adult mental health services	100%
POMH Topic 7: Monitoring of patients prescribed lithium	100%

Participation in clinical research

SHSC is funded through the National Institute of Health Research (NIHR) to support delivery of clinical trials and other high-quality research. This provides opportunities for SHSC to participate in new treatments and interventions not commissioned through usual care and can support staff development. In 2022/23 the number of staff or service users that participated in research on the NIHR portfolio was 303. During 2022/23 all previously paused (due to COVID-19), complex, interventional studies were re-opened and are being delivered using COVID-19 safe protocols and in line with SHSC policies.

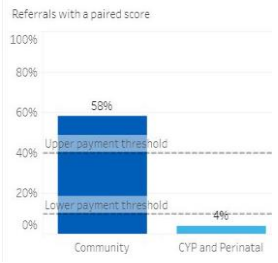
2.3 Goals under the Commissioning for Quality and Innovation (CQUIN) payment framework

The Commissioning for Quality and Innovation (CQUIN) payment framework allows commissioners to reward improvements in care by linking a commensurable of the Trust's income to the achievement of local, regional, and national quality improvement goals. The CQUIN goals are reviewed through contract monitoring processes. Following the COVID-19 pandemic, the CQUIN schemes were resumed from April 2022. Progress with the CQUIN schemes are reported quarterly in our Integrated Performance and Quality Reports (IPQR), presented to the Board of Directors. These reports are available through our website www.shsc.nhs.uk The six CQUIN indicators agreed with our main local health commissioner for 2022/23 are shown below, together with our performance.

CQuIN Ref	CQuIN	Description	Target	Performance
CCG1	Staff flu vaccinations	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	90%	**53% Not Achieved**
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral	35%	**0% Not Achieved**

		for a test to diagnose cirrhosis or advanced liver fibrosis.		
CCG10a	Routine outcome monitoring in CYP and perinatal mental health services	Achieving 40% of women in the perinatal period accessing mental health services, having their outcomes measured at least twice.	40%	**4%** **Not Achieved**
CCG10b	Routine outcome monitoring in community mental health services	Achieving 40% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice.	40%	**58%** **Achieved**
CCG11	Use of anxiety disorder specific measures in IAPT	Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).	65%	**Awaiting info**
CCG12	Biopsychosocial assessments by MH liaison services	Achieving 80% of self-harm referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	80%	**93%** **Achieved**

SHSC did not achieve all of our CQUINs for this year. Although for the last two years have seen large increases in the number of staff having their flu vaccine, we are still short of the nationally set target, despite trying numerous innovative ways to encourage staff take up. We are planning early in 2023 to improve our approach to vaccination in order to increase uptake in 23/24



We also did not achieve the target for referring alcohol dependent patients for cirrhosis tests, this CQUIN only applies to service users who had a primary diagnosis of alcohol dependence within our inpatient wards, therefore achieving this target on a very small number of patients was extremely challenging.

2.4 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 not admit any service user to the Assessment and Treatment Service (ATS), Firshill Rise, without the prior written agreement of the CQC.
- The registered provider must only accommodate a maximum of 30 service users at Woodland View.
- The registered provider must only accommodate a maximum of 10 service users at Beech.

We have completed the transfer of SHSC Headquarters from Fulwood House to Centre Court for the following regulated activities:

- Diagnostic and screening procedures,
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

Salli Midgley replaced Beverley Murphy as the Nominated Individual for SHSC in January 2023.

Wainwright Crescent has successfully relocated to Beech.

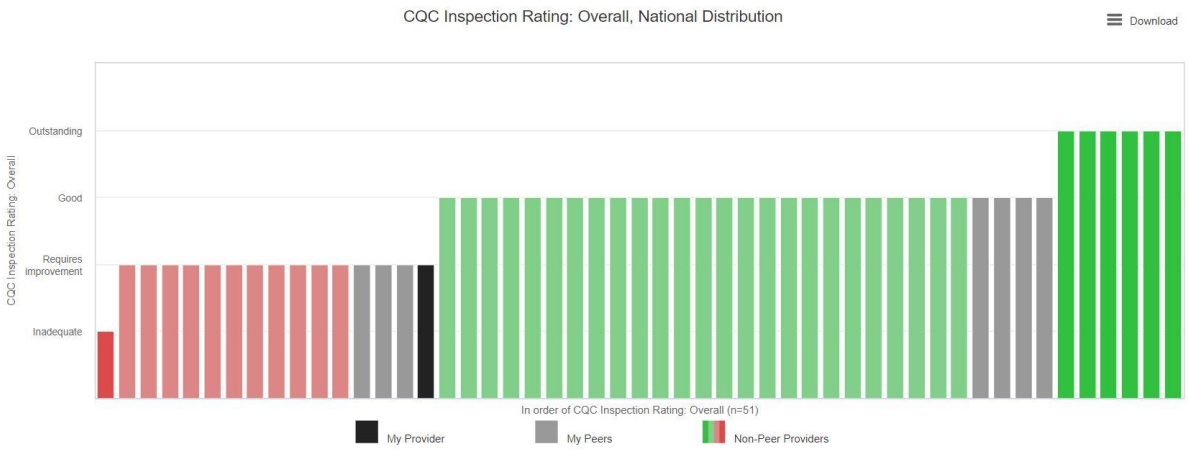
We have submitted a request to remove and vary the registration conditions relating to the Assessment and Treatment Service at Firshill Rise. Conversations are ongoing regarding the service model to be implemented however the decision to discontinue inpatient beds for this service has been agreed and as such the last service user left the service in September 2021.

Future changes to our registration during 2023/24 will be made relating to the relocation of the two remaining services in Fulwood House and subsequent removal of Fulwood House as a location for SHSC.

The overall CQC rating for Sheffield health and Social Care remains as:

Inspection area of focus	Rating
Safety	Requires improvement
Effectiveness	Requires improvement
Caring	Good
Responsiveness	Requires improvement
Well-led	Requires improvement
Overall Trust rating	**Requires improvement**

The graph below shows the national picture of CQC inspection ratings.



Source: Model Hospital

During 2022/23 Sheffield Health and Social care Trust received XX enquiries from the CQC in relation to the services we provide, all of which have been responded to.

2022/23 inspections

SHSC has not any CQC inspections during the year 2022/23 (check against standard wording from template how this needs recording)

Back to Good Improvement Programme

During 2022/23 we entered year 2 of our Back to Good programme, with all year 1 actions completed by XXXX. We completed a significant number of quality assurance checks of the evidence submitted to support the closure of actions which helped us to demonstrate robust decision making and provide assurance regarding embeddedness of the actions required to improve outcomes for our service users, carers and staff. 6-month embeddedness checks have been introduced for actions that do not routinely sit within one of the existing SHSC reporting arrangements. The progress of the Back to good programme has continued to be monitored monthly through the Back to Good Board and reported to Quality Assurance Committee and Board of Directors.

Staffing capacity posed an ongoing challenge to the achievement of several requirements; this was due to the ongoing impact of Covid during mid to late 2022 and the recruitment issues experienced nationally within nursing, Allied Health Professional and Medical roles. The requirements most notably affected were those that involved improvements in compliance with training and clinical supervision within our acute inpatient services. Our clinical teams have worked hard to improve compliance rates through innovative and multi-disciplinary team working.

Although we have experienced some challenges with the delivery of the Back to Good programme to initial timescales, the focus and drive to achieve the significant improvements following our CQC inspection by a range of teams and services demonstrates SHSC commitment to improvement.

It is anticipated that only 11[SM3] of the 75 requirements identified by CQC within the inspection will remain open past the end of the financial year 2022/23.

Monitoring of these improvements has been overseen through Quality Improvement Board with Regional NHSE, ICB and CQC colleagues alongside Sheffield Place and Sheffield Local Authority partners.

Mental Health Act reviews

During the 2022/23 reporting period, SHSC had two dedicated Mental Health Act Monitoring visits carried out by the Care Quality Commission (CQC). These visits were to ward G1 (our dementia inpatient ward) and to our rehabilitation wards 1a Forest Close and Forest Close Bungalows (Ward 1 and Ward 2).

In respect of the G1 visit, the CQC identified some actions which they wanted to be taken in respect of mental health legislation and plans to address these issues were formulated by the Trust accordingly. These plans were submitted to the CQC within the required timescales.

No actions were identified by the CQC in relation to the visit to Forest Close/Forest Close Bungalows. This is a tremendous achievement as it is very unusual for no actions to be identified during these monitoring visits.

The Mental Health Legislation Operational Group (MHLOG) reviews progress in respect of CQC Provider Action Statements on a monthly basis, as a standard agenda item. This also forms part of the mental health legislation compliance oversight to the Mental Health Legislation Committee (MHLC), which meets on a quarterly basis.

The majority of actions set out on the CQC Provider Actions Statements have been completed/closed, but some actions are long-standing, as they are part of much bigger pieces of work within SHSC. For example, there is a long-standing open action in respect of access to the gardens by service users on Maple Ward. This action forms part of the bigger buildings work programme on Maple Ward and can only be closed when the refurbishment at the Longley Centre has been completed.

2.5 Data Quality

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. Sheffield Health and Social Care NHS Foundation Trust did not submit records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

The Trust submits data to the Mental Health Services Data Set (MHSDS). The latest published data regarding data quality under the Data Quality Maturity Index (DQMI) is for November 2022.

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

Percentage of valid records	Data quality 2020/21	Data quality 2021/22	Data quality 2022/23 (November 2022)	National average (November 2022)
NHS Number	100%	100%	100%	71.5%
Date of birth	100%	100%	100%	99.6%
Gender	100%	100%	100%	98.6%
Ethnicity	100%	100%	100%	85.2%
Postcode	100%	100%	100%	94.6%
GP code	100%	100%	100%	79.8%
Overall Score	94.1%	94.3%	94.2%	71.5%

The DQMI includes other indicators in addition to those listed above.
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.

We continue to make submissions to the national Data Security and Protection Toolkit, which replaced the former Information Governance Toolkit.

The Trust's Data Security and Protection Toolkit overall rating for 2021/22 is 'Approaching Standards'. We have developed an improvement plan to meet the required standards and this was accepted by NHS Digital.

The Trust's scores for the National Data Guardian Standards as measured by the Data Security and Protection Toolkit for the latest submission are provided in the table below. Submissions for 2022/23 are not due until the end of June 2023.

Data Security and Protection Toolkit – National Data Guardian Standards	2019/20	2020/21	2021/22
Personal confidential data	100% complete	88% complete	95% complete
Staff responsibilities	100% complete	100% complete	100% complete
Training	75% complete	100% complete	86% complete
Managing data access	100% complete	100% complete	85% complete
Process reviews	100% complete	100% complete	100% complete
Responding to incidents	100% complete	100% complete	93% complete
Continuity planning	100% complete	50% complete	100% complete
Unsupported systems	100% complete	100% complete	92% complete

IT protection	100% complete	67% complete	96% complete
Accountable suppliers	100% complete	100% complete	100% complete
Overall	97.5% complete	94% complete	94% complete

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

The Trust is considering ways to improve our training score performance within the toolkit.

Clinical coding

Clinical coding is the process of translating medical information from patient records in hospitals, into alphanumeric codes. Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.
SHSC has previously commissioned clinical coding audits, most recently in 2022 – the results found that we achieved the 'Exceeded' level for Data Security Standards specified within the DSPT and that our clinical coding was of a good standard of accuracy. The audit confirmed that our clinical coder was up to date with their required training and demonstrated a sound grasp of national clinical coding rules and standards.

Doctors in training

As part of the Doctors and Dentists in Training Terms and Conditions of Service (England) 2016, SHSC is required to produce an annual report on rota gaps and the plan for improvement to reduce these. This report is produced by our Guardian of Safe Working and is presented to our Board of Directors. The following is a summary of the findings within this report, which is published on our website if you would like to see the details.

SHSC calls upon internal and external (agency) locums to cover gaps in our rota. Gaps are caused by various issues such as sickness, parental leave, pregnancy and COVID-19 related absences and recommendations from Occupational Health to come off the rota. The table below shows the gaps that were filled either by internal or agency locums throughout the year.

Reporting period	Internal locum cover	Agency locum cover
April, May, June 2022	25 rota gaps	53 rota gaps
July, August, Sept 2022	50 rota gaps	27 rota gaps
Oct, Nov, Dec 2022	60 rota gaps	24 rota gaps
Jan, Feb, March 2023	79 rota gaps	23 rota gaps

SHSC conducts recruitment initiatives with the Royal College of Psychiatrists such as 'Choose Psychiatry' to increase the numbers of trainees to increase the fill rate of training posts and meet the needs of on-call shifts.

Our Guardian of Safe Working, Dr Raihan Talukdar, is constantly working with trainees to ensure they are working safely and within limits.

Professional Leadership

We have received Endorsement from Faculty of Leadership and Management highlighting that doctors at all levels have enhanced leadership skills which supports the SHSC team with the delivery of high quality care.

During 2022 we also commenced work on our Nursing Strategy; a document that outlines our ambitions and the key things we need to do to ensure we have a workforce that is fit for the future. Our strategy reaffirms the role of our nursing workforce in the delivery of high quality and safe care.

During 2022 we also introduced the Professional Nurse Advocate (PNA) Training Programme which saw several of our Nursing team complete a level seven module in restorative supervision. PNAs are trained to listen and understand the challenges fellow colleagues and teams are facing in order to not only promote professional development and optimise patient care, but focus upon staff wellbeing.

Psychological professions senior leadership continue to lead on the implementation of the Clinical and Social Care Strategy: this year has a focus on quality informed clinical outcomes. We have also been working as part of a national trailblazer group developing a new occupational role, Clinical Associate Psychologist and won the HSJ award for Workforce Initiative of the year in November 2022.
This year, our Allied Health Professionals (AHP) and Peer Support Workers (PSW) have been:

- Strengthening AHP Leadership across the clinical directorates (two new clinical lead AHP posts)
- Introduction and development of occupational therapy (OT) 6-day week provision to adult acute wards (evenings/weekend)
- Masters Northern Art Psycho-Therapy course transition to Sheffield Hallam University
- PSW Lead post made permanent
- PSW: commenced work on PSW strategy/plan – now in final draft
- PSW: development of and recruitment to PSW posts in operational teams/services
- Commencement of AHP Strategy/plan (in line with the national and SY ICS AHP strategy)
- Pilot of art therapy and music therapy posts on the adult acute wards: with transition to permanent posts
- Annual Arts in Mental Health Exhibition delivered in partnership with FLOURISH
- OT Apprenticeship posts x2 in year 2

- Health and Wellbeing Resource: review and further development of this useful trustwide toolkit
- Delivered SHSC's Nutrition and Hydration Operational Policy and undertaken first year review

Pharmacy senior leadership continue to develop the pharmacy plan looking at skill-mix and further development of roles to support a more agile workforce with patient safety and high-quality pharmaceutical care at the heart of it. Further development of new roles – Medicines Management Technicians to support and improve medicines optimisation across trust. During 2022/23, pharmacy working in conjunction with nursing; introduced an annual and 3 yearly medicines competency framework for nurses inclusive of a mandatory calculations component. Revised and revamped Medicines Optimisation and Rapid Tranquillisation training for nursing staff co-delivered with nursing to enhance medicines and patient safety.

Part two (c): Reporting against core indicators

SHSC considers that the data provided earlier within this report and below is as described for the following reasons. External auditors have, in previous years, tested the accuracy of the data and our systems used to report our performance on a variety of performance indicators.

These audits 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	Target	Our performance			
		2020/21	2021/22	This year 2022/23	
Seven day follow up Everyone discharged from hospital on CPA should receive support at home within seven days of being discharged.	95% of patients on CPA to be followed up in seven days	95.6% (Q3)	This indicator was suspended in Q3 2019/20. A consultation followed and the outcome was published in April 2021 which stated this indicator has been retired.		**N/A**
National average		95.5% (Q3)			
Best performing		100% (Q3)			
Lowest performing		86.3% (Q3)			
72 hour follow up (New standard from 2020/21)	80% (Target set for 2020/21)	70%	91.3%	80%	**Achieved**
'Gate keeping' Everyone admitted to hospital is assessed and considered for home treatment.	95% of admissions to be gate-kept	97.3%	99.3% (Q4[SM4] [TB5])		**Achieved**
National average		xx	97.7% (Q4)	% (Q4)	

Best performing		xx	100% (Q4)	% (Q4)	
Lowest performing		xx	89.6 (Q4)	(Q4)	
Emergency re-admissions Percentage of service users discharged from acute inpatient wards who are admitted within 28 days.	5% National benchmark (2019/20) Average is 7%	5.88%	4.79%	4.3%	**Achieved**
Community Mental Health Services Experience: Service users' overall experience of contact with a health or social care worker during 2021/22.	Our score	**2020 Survey** 7.4/10	**2021 Survey** 6.6/10	**2022 Survey** **6.8/10**	**Average performance compared to other Trusts**
National Average		N/A	6.8/10	**6.7/10**	
Best performing		7.8/10	7.5/10	7.8/10	
Lowest performing		6.1/10	5.9/10	6.1/10	
Q. Were you given enough time to discuss your needs and treatment?	Our score	7.8/10	6.9/10	**7.2/10**	**Average performance compared to other Trusts**
National Average		N/A	6.8/10	**7.1/10**	
Best performing		8.3/10	7.9/10	8.4/10	
Lowest performing		6.5/10	6.3/10	6.2/10	
Q. Did the person or people you saw understand how your mental health needs affect other areas of your life?	Our score	7.6/10	6.8/10	**7.2/10**	**Above Average performance compared to other Trusts**
National Average		N/A	6.8/10	**6.8/10**	
Best performing		7.8/10	7.6/10	7.9/10	
Lowest performing		6.0/10	5.9/10	5.9/10	
Q. Did the person or people you saw appear to be aware of your treatment history?	Our score	7.6/10	6.8/10	**7.0/10**	**Average performance compared to other Trusts**
National Average		N/A	6.9/10	**6.9/10**	
Best performing		7.8/10	7.8/10	8.0/10	
Lowest performing		6.2/10	5.8/10	5.8/10	

Patient safety incidents		**2020/21**	**2021/22**	**2022/23**	
Number of patient safety incidents reported to NRLS (note one)	N/A (Note 2)	3,756	3,763	xx (Note 3)	
Rate of patient safety incidents per 1,000 bed days	N/A (Note 2)	76.6	83	xx (Note 3)	National percentage of patient safety incidents resulting in severe harm or death is 0.75%
Number of patient safety incidents resulting in severe harm or death	N/A (Note 2)	50	55	xx (Note 3)	
Percentage of patient safety incidents resulting in severe harm or death	N/A (Note 2)	0.95%	1/1%	xx (Note 3)	

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

Note 1: 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 2: Due to the COVID-19 pandemic, NRLS reports were not been produced for the period April 2020 to March 2021.

Note 3: Due to the NRLS data being reported annually, data for the period April 2022 to March 2023 has not yet been published.

Part three: Other quality information

3.1 Safety indicators – Learning from Incidents

Disruptive/distressed Behaviour
SHSC takes disruptive, distressed behaviour extremely seriously and encourages our staff to report all occurrences. Within SHSC there is an ongoing theme of 'low' or 'no harm' incidents related to violence and aggression by service users towards staff and/or other service users. Our RESPECT programme has also affirmed the need to report this type of distressed behaviour. We remain a high reporter of this type of incident, compared to other mental health trusts nationally. It should be noted that 90% of all patient safety incidents reported by SHSC during 2022/23 resulted in 'no' or 'low' harm.

Our disruptive, distressed behaviour incidents for the previous three years are summarised in the table below. It should be noted that data for 2022/23 has not been published at the time of printing.

Proportion of incidents due to disruptive behaviour	Number of incidents reported	Our incidents as a percentage of all our incidents	National incidents as a percentage of all incidents
Apr 19 to Sept 19	458	28.7%	11.5%
Oct 19 to Mar 20	489	32.5%	11.0%
Apr 20 to Mar 21*	1,217	32.4%	10.9%
Apr 21 to Mar 22*	959	25.5%	9.5%

Source: National Reporting Learning System (NRLS)

Note: *From April 2020 annual data has been produced by the NRLS, as opposed to the previous six monthly reports.

Spotlight on Stanage Ward
Following a number of incidents of assaultive behaviours on Stanage Ward (one of our male inpatient wards) during Quarter One and Two, the Director of Nursing invited an independent review of the care, environment and staffing. Amongst a number of recommendations to improve the experience of staff and service users; the use of a specific tool called the Brøset Violence Checklist, was recommended. Whilst this tool is still in the pilot phase, early indications are that there has been a significant reduction in the number of violent incidents reported by this ward in the later quarters of the year.

This period of work also coincided with the removal of the seclusion room on Stanage ward. The significant achievement of the team in reducing incidents of distress and violence is a clear cause for celebration given the previous context of the environment in which they worked. The environmental improvements in moving from Stanage to Burbage, independent review and skill mix review have positively impacted on patient and staff experience.

Stanage Ward – Incidents of Exploitation/Abuse - 1 April 2022 to 31 March 2023

Period	Severity of Incident			
	Near Miss	Negligible	Minor	Moderate
Q1	9	104	81	19
Q2	0	116	84	11
Q3	1	129	60	5
Q4	9	103	52	8

Self-harm and Suicide

The risk of self-harm or suicide is always a serious concern for mental health, learning disabilities and substance misuse services. There continues to be an ongoing rise in the number of self-harm incidents on our inpatient wards which often leads to an increased use in restrictive practices such as restraint and rapid tranquilisation. These types of interventions can have a negative impact on the psychological well-being of service users and increase their experience of trauma. Work is in progress to improve collaborative planning and use of de-escalation techniques and de-escalation spaces, rather than restraint to support service users who are self-harming (noted to be mainly female patients).

SHSC has historically been below national averages for this type of incident reporting. The latest National Reporting Learning System (NRLS) figures show 15% of all patient safety incidents reported by the Trust were related to self-harm, in comparison with 26.1% for mental health trusts nationally.

Our self-harm incidents for the previous three years are summarised in the table below:

Proportion of incidents due to self-harm/suicide	Number of incidents reported	Our incidents as a percentage of all our incidents	National incidents as a percentage of all incidents
Apr 19 to Sept 19	168	10.5%	24.2%
Oct 19 to Mar 20	175	11.6%	23.6%
Apr 20 to Mar 21*	563	15%	26.1%
Apr 20 to Mar 21*	548	14.6%	26.4%

Source: National Reporting Learning System (NRLS)

Note: *From April 2020 annual data has been produced by the NRLS, as opposed to the previous six monthly reports.

SHSC remains below the national average for the number of self-harming behaviour patient safety incidents reported to the NRLS.

We will be developing a Trustwide Self Harm improvement plan for 2023/24 as part of our focus of the introduction of the patient safety incident response framework.

Sexual Safety – Spotlight on Forest Close

"An issue was raised at the community meeting by a service user which led to some really helpful conversations amongst the group".

We wanted to increase the percentage of service users who felt safe from sexual harm within our intensive rehabilitation in-patient service. We were part of the national safety collaborative supported by the Royal College of Psychiatrists, which gave us access to benchmarking and quality initiatives nationally. The team wanted to equip service users with the skills needed to have safe, supportive and honest conversations around intimacy and to support staff to feel confident in having these conversations. We were also very keen to ensure that our approach was trauma-informed and involved good co-production with staff and service users.

"There have been occasions where service users have felt able to raise incidents of past trauma with staff and then psychology support brought in".

In the work done so far, one of the outcomes we are particularly proud of is the relationships we built on trust with our service users to understand their perspectives better. For example, staff have fed back specific examples where they feel that conversations have led to good outcomes.

Staff training was undertaken and after 6 weeks an average of 80% of participants strongly agreed or agreed that it raised awareness, increased confidence, would help initiating conversations and would be applicable in practice.

"We have seen examples where people have reflected on past relationships and then talked about hopes and aspirations for the future".

It has been challenging at times to co-produce/co-facilitate the groups as some service users felt that they would rather have staff leading the sessions. We wanted to introduce a buddying system to support this, but service users were clear that they wanted staff to continue to run the sessions as they are. This may due to their mental wellbeing and complex life experiences.

Medication Errors and Near Misses

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 SHSC understands why such medicines incidents occur, why they occur when they do and what actions can be taken to reduce the impact and frequency of such incidents. Staff are encouraged to report near misses and errors to make sure that we can share lessons learnt, and make our systems as safe and effective as possible. Themes continue to emerge in relation to procedural task errors, rather than administration errors. The most common theme was failure to provide a second signature when administering controlled medication. This has improved from the previous year since the introduction of the nursing medicine competency framework.

Our medication incidents for the previous two years are summarised in the table below:

Proportion of incidents due to medication errors	Number of incidents reported	Our incidents as a percentage of all our incidents	National incidents as a percentage of all incidents
Apr 19 to Sept 19	115	7.2%	7.2%
Oct 19 to Mar 20	83	5.5%	7.0%
Apr 20 to Mar 21*	216	5.8%	6.6%
Apr 21 to Mar 22*	258	6.9%	6.6%

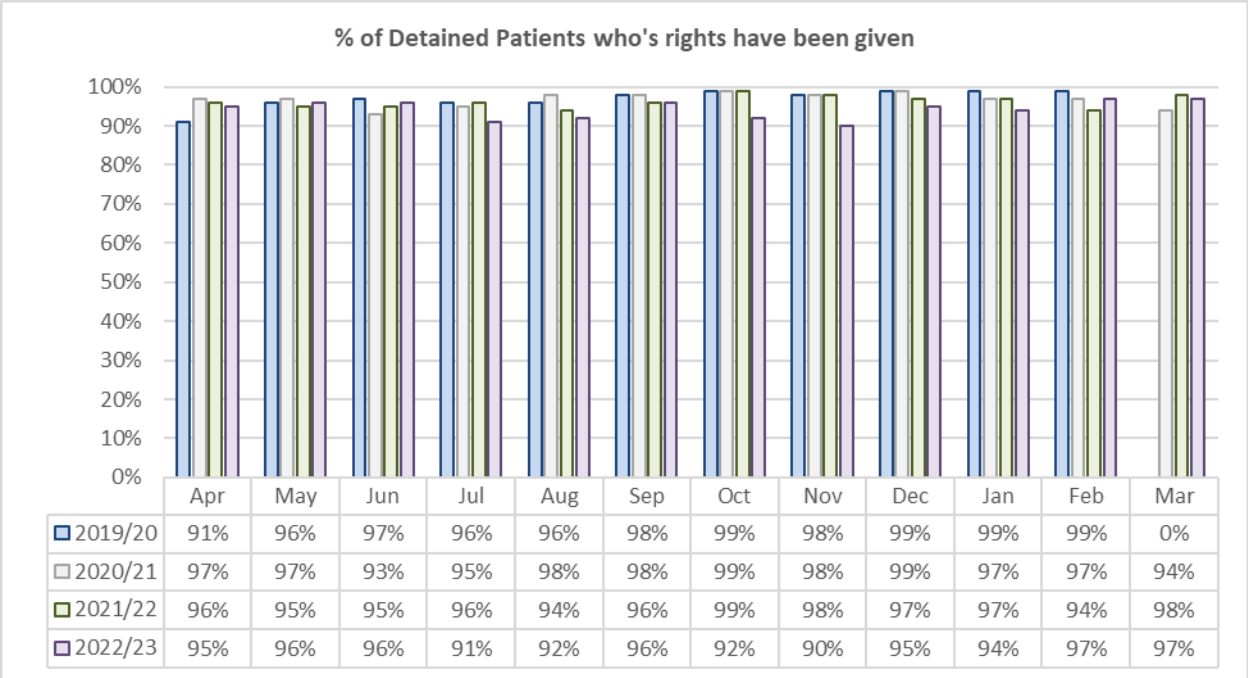
Source: National Reporting Learning System (NRLS)

Note: *From April 2020 annual data has been produced by the NRLS, as opposed to the previous six monthly reports.

3.2 Clinical effectiveness indicators

Mental Health Act compliance
People who are subject to detention under the Mental Health Act, are deprived of their liberties. It is imperative, therefore, for the Trust to ensure service user rights are protected and that are individuals 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 shows the percentages of detained patients whose rights have been given for the last four years.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	91%	96%	97%	96%	96%	98%	99%	98%	99%	99%	99%	0%
2020/21	97%	97%	93%	95%	98%	98%	99%	98%	99%	97%	97%	94%
2021/22	96%	95%	95%	96%	94%	96%	99%	98%	97%	97%	94%	98%
2022/23	95%	96%	96%	91%	92%	96%	92%	90%	95%	94%	97%	97%

Source: Weekly Trust audit results of Insight records and MHA papers

There are no results from March 2020, as this weekly audit was suspended as part of the Trust's COVID-19 management plans.

The Trust does not have any major concerns regarding its performance in this area. However, plans are in place to ensure that inpatient wards can see in 'real time' what actions are required to be compliant with the Mental Health Act at all times.

Human Rights
Embedding human rights into SHSC's day-to-day practice is a component of its strategic priorities (under the wider banner of continuous quality improvement). In 2021, SHSC appointed a full time Human Rights Officer (HRO) – (the first such appointment in any mental health trust in the UK), to ensure that human rights compliance is sustainably integrated into SHSC's service delivery.
The Trust's human rights work has two broad strands:

1. Legal - This is to ensure that our services are delivered in compliance with our obligations under the Human Rights Act 1998.

2. Cultural - This concerns utilising human rights law as a catalyst for organisational cultural change. To this end embedding human rights-based practice is to enhance understanding amongst the leadership, staff and service users of the rights holder/duty barer relationship contained in the Human Rights Act and promoting human rights as an ethical framework in which decision making and service delivery is provided.

Throughout 2021/22 our partners at the British Institute of Human Rights (BIHR), ran staff training for 90+ staff across the service. Including for 15 'practice leads' who are now human rights leaders in their respective services. The HRO will carry on both these components as an internal programme to ensure that it's a regular fixture of SHSC's training offering to staff and that these 'practice leads' are maintained as in-house expertise nodes and the network expanded upon. The HRO will also act as the coordinating facilitator of the expanding group of human rights leads.

The HRO will provide targeted trainings tailored to the needs of staff working in their specialisms to promote human rights frameworks geared towards the specificities of their practice areas. Human rights can sometimes be a complex area of law to navigate, thus, the HRO will remain the internal resource for staff across the service providing guidance on the operation of the Human Rights Act as it relates to day-to-day patient care planning, Trust governance, policy development and review and staff training.

Mental health service indicators

Below shows a number of nationally set indicators, together with their definitions and our performance against the targets set.

***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.

Mental health services	This year's target	2020/21	2021/22	This year 2022/23	
Early intervention People should have access to early intervention services when experiencing a first episode of psychosis and receive a NICE-approved care package within two weeks of approval.	60%	70%	57.4%	75.5%	**Achieved**
Improving Access to Psychological Therapies (IAPT) a) Proportion of people completing treatment who move to recovery	50%	51%	52%	52%	**Achieved**
b) Waiting time to begin treatment					
i. Within six weeks of referral	75%	98.8%	99.4%	99.4%	**Achieved**
ii. Within 18 weeks of referral	95%	100%	99.8%	99.8%	**Achieved**
Inappropriate out-of-area placements for adult mental health services	Last year was the first time the Trust had been required to disclose performance against this indicator, as we had previously had fewer than seven average bed days per month. The numbers for 2022/23 are: • Adult Acute – 4160 • PICU – 1263 • Older Adult – 0				

Information source: NHS England Mental Health Dashboard and internal clinical systems data.

The Trust has performed well against the nationally set standards and targets. We have met, and in most cases over-performed, in them. Our IAPT service has over-achieved its six and 18 week waiting targets.

Our Early Intervention Service access within two weeks, the seven day follow up following admission and ensuring all admissions are considered for home treatment (gatekeeping) targets have all been achieved for the majority of the year.

Performance is reported to the Board of Directors using the IPQR report as part of the Performance Framework.

Learning from Deaths

We publish mortality data on a monthly basis within our Integrated Performance and Quality Report (IPQR). This goes through our governance committee to our Board of Directors and can be found on our website here.

3.3 Experience indicators

Learning from Complaints and Compliments

SHSC is committed to ensuring that concerns raised by people using its services, carers and relatives of those using its services, and members of the public are acknowledged, investigated and responded to, and that the organisation learns from any failings identified.

SHSC aims to promote a culture in which all forms of feedback are listened to and acted upon. Complainants can be confident there will be no barriers to them receiving fair treatment and clear information during the complaint process, irrespective of social and cultural background. Complaints, compliments, general comments and suggestions are welcomed.

Complaints and compliments are monitored and recorded through our monthly IPQR reports that are presented to our governance committees and the Board of Directors. In addition to this a quarterly learning lessons report is produced that highlights what we have learned from the complaints we receive, together with what actions we will take to address any issues. We also produce an annual complaints report which is presented through our Quality Assurance Committee to our Board of Directors. This report can be accessed through our website at www.shsc.nhs.uk/contact-us/complaints together with our monthly IPQR reports.

Service User Friends and Family Test

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give your views after receiving NHS care or treatment.

The table below shows the results from the service user Friends and Family Test (FFT) this year, compared to the previous two years. The FFT was suspended nationally from February 2020 to February 2021 due to the COVID-19 pandemic. SHSC incorporated the FFT question into other surveys during this time, however, external reporting and benchmarking was suspended.

April 2020 to March 2021	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Percentage of Trust service users who would recommend the service they received	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	98%	98%	97%	98%
National average for mental health trusts (1)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	87%	88%	87%	87%

April 2021 to March 2022	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Percentage of Trust service users who would recommend the service they received	89%	94%	92%	90%	92%	96%	85%	94%	88%	90%	91%	93%
National average for mental health trusts (1)	86%	85%	85%	86%	85%	85%	87%	86%	88%	86%	86%	86%
April 2022 to March 2023	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Percentage of Positive returns	93%	97%	98%	97%	93%	94%	94%	100%	99%	97%	96%	97%
National average for mental health trusts (1)	86%	86%	86%	86%	86%	87%	86%	86%	84%	87%	87%	

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.

SHSC continues to achieve above the national average for the percentage of service users who would recommend our services to family or friends; however our overall response rate is low.

Care Opinion

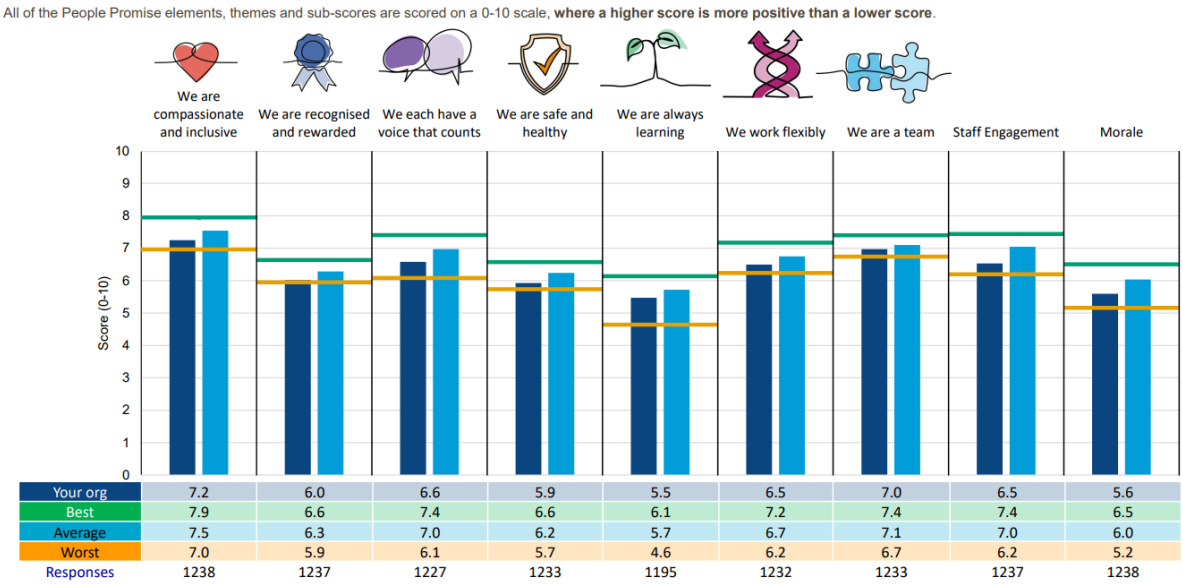
SHSC has previously subscribed to Care Opinion, an online feedback platform where service users and their carers can post feedback for health and social care providers. The average number of stories posted per quarter was approximately eight; we know this is not representative of the number of people who use our services.

During 2022, relaunch sessions were held with attendees from across SHSC in an attempt to increase the amount of feedback/story postings. This saw a slight increase in November but was not sustained.

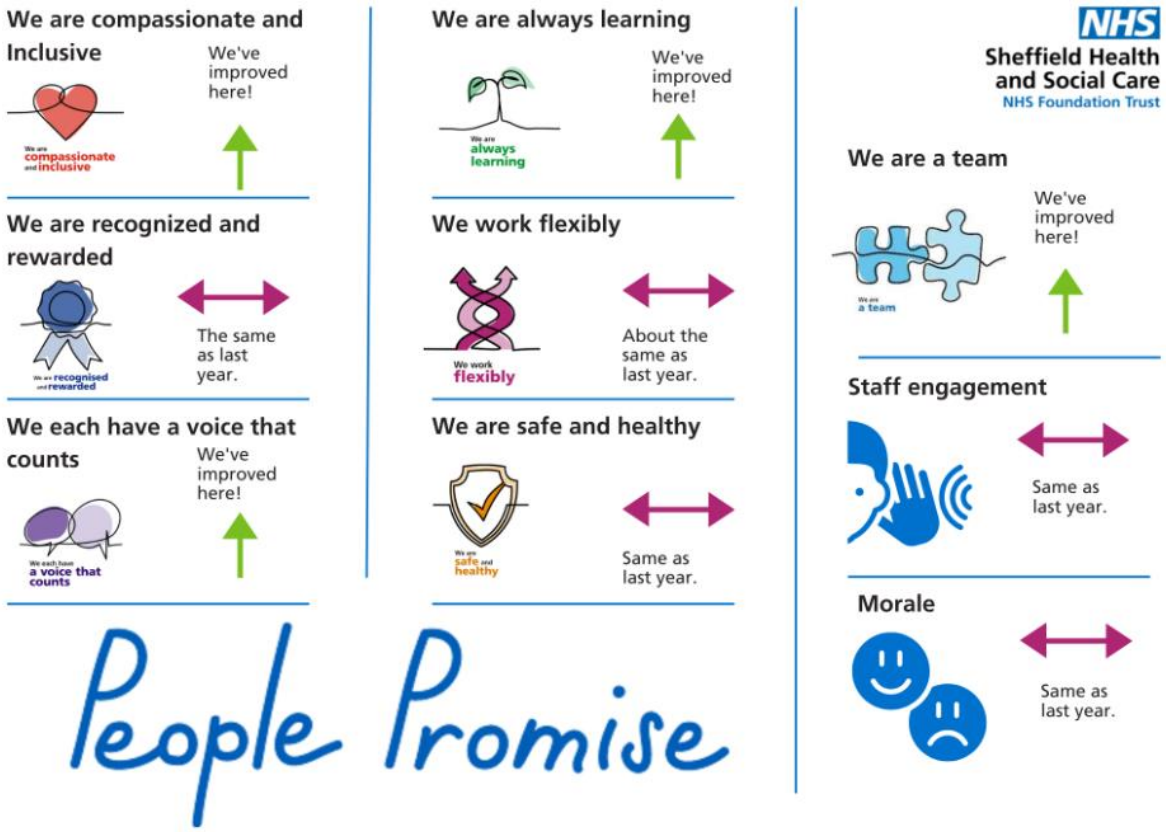
As there has been no significant or sustained increase in story/feedback posting observed since this relaunch period, SHSC is pursuing alternative patient feedback tools which may be better utilised by our service users. Service users and their carers are still able to post feedback on the Care Opinion platform but we will not subscribe to the additional functions.

National NHS Staff Survey

The national NHS staff survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. The survey is aligned to the NHS People Promise and is commissioned by NHS England. The National NHS Staff Survey 2022 was published in March 2023 and is grouped to give scores against theme areas. Scores for each indicator, together with that of the survey benchmarking group (mental health and learning disability) are presented below.



Source: National NHS Staff Survey Results Benchmarking Report 2022



The Trust continues to develop a systematic approach to action in response to the results from the National NHS Staff Survey and a Staff Survey Steering Group has been operational throughout the year with membership from across the organisation.

Further information on our response can be found in our 2022/2023 Annual Report on the SHSC website.

Annexe A – To be completed following consultation and commentary being received

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

Healthwatch Sheffield Statement

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

NHS Sheffield Clinical Commissioning Group Statement

Annexe B – to be completed in final draft

2022/23 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 account.

In preparing the quality account, directors are required to take steps to satisfy themselves that:

- the content of the quality account meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23
- the content of the quality account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2022 to March 2022
  - papers relating to quality reported to the Board over the period April 2022 to March 2023
  - feedback from commissioners dated xx June 2023
  - feedback from governors dated xxx February 2023
  - feedback from local Healthwatch organisation dated xx June 2023
  - feedback from overview and scrutiny committee dated xx June 2023
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2022
  - the national patient survey 2022
  - the national staff survey 2022
  - the Head of Internal Audit's annual opinion of the trust's control environment dated xx June 2023
  - CQC inspection reports dated 16 February 2022, 19 August 2021 and 15 July 2021
- 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 account, 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 account 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 account.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account.

By order of the Board:

.....xx June 2023……. Date.....…..... Chair

.....2xx June 2023..... Date..... Chief Executive