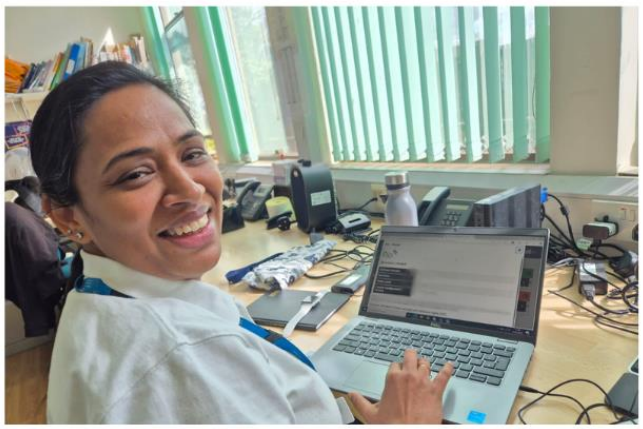
Proud to care in Sheffield

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Quality Account

2024/25



Contents

Part One

1.1 Welcome to the Quality Account and its purpose

What is a Quality Account?
A Quality Account is an annual report describing the quality of services provided by an NHS healthcare organisation. Quality accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our quality priorities and looks forward to the year ahead, defining our priorities for quality improvement and how we expect to achieve and monitor them.

The aims of the Quality Account

1. To help patients, families and carers make informed choices about healthcare providers.
2. To empower people to hold providers to account for the quality of services.
3. To engage leaders of an organisation in the quality improvement agenda.

Who reads the Quality Account?
The Quality Account is read by many different people, such as the people who we support through our services, their loved ones, colleagues, commissioners, partners and regulating bodies.

We produce our report for anyone who wants to know more about the quality of our services, and how we plan to maintain and improve them.

What information can be found in the Quality Account?
In this document, you will find information about how we measure and review the quality of the services we provide. You will also find our priorities for improvement for the year ahead. Like all NHS healthcare providers, we focus on three different aspects or domains of quality:

- Patient safety
- Clinical effectiveness
- Patient experience

Structure of the Quality Account
The structure of this Quality Account is in line with guidance published by the Department of Health and NHS England, and contains the following information:

- **Part 1**: Introduction and context
- **Part 2**: Information on how we have improved in the areas of quality we identified as important for 2024/25, our priorities for improvement in 2025/26 and the required statements of assurance from the Board of Directors
- **Part 3**: Further information on how we have performed in 2024/25 against our key quality metrics and national targets and the national quality agenda.

1.2 Statement on quality from the Chair and Chief Executive

Thank you for taking the time to read our 2024/25 Quality Account. This report reflects on a year marked by change, challenge and improvement both for the communities we serve and our organisation. Challenge through ongoing financial pressures, and improvement of our services, environments and partnerships within our city and across the South Yorkshire integrated care system.

During 2024/25 we have seen changes in our executive leadership. Dr Caroline Johnson replaced Salli Midgley as our Executive Director of Nursing, Professions and Quality, Dr Helen Crimlisk replaced Dr Mike Hunter as the Interim Medical Director and Helen Smart replaced Neil Robertson as our Interim Chief Operating Officer.

Sheffield Health and Social Care is always committed to safety first and driving quality for our service users, carers and wider communities. Our dedicated teams have demonstrated unwavering commitment in upholding exceptional standards over the last year. The second part of this report details the sheer number of quality initiatives that our services have undertaken over the last year to improve lives in Sheffield.

This Quality Account sets out what we have achieved during 2024/25, including the progress with our quality strategy. The document also shares our ambitions for 2025/26. We will continue to focus on safety and quality to improve lives lived and to address inequalities that people with mental health, learning disabilities and autism experience on a daily basis by ensuring our services are inclusive and we work in partnership in Sheffield and across the South Yorkshire Integrated Care System.

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 the Trust provides.

Thank you

Sharon Mays
Chair

Salma Yasmeen
Chief Executive

1.3 Statement from the Executive Director of Nursing, Professions and Quality, Medical Director and Chief Operating Officer

Over the course of 2024/25 we have continued our improvement journey. In March 2025 our Board approved our refreshed Reducing Restrictive Interventions Plan (2025/27). This plan aims to build on the significant achievements of the 2021-2024 strategy which saw seclusion episodes reduce from an average of 40-45 episodes of seclusion per month, to fewer than five episodes of seclusion per month in 2024/25 with February 2025 having no episodes across all wards. Additionally, the duration of prolonged seclusion episodes has significantly reduced.

In 2024/25 the Trust has been one of four national pilot sites for the Patient and Carer Race Equality Framework (PCREF). The pilot continues to build on already established partnerships, such as the Pakistan Muslim Centre (PMC), the Sheffield African Caribbean Mental Health Association (SACMHA), Aspiring Communities Together (ACT) and Sheffield Flourish, and is establishing new relationships with other community partners such as Maan Somali Mental Health Sheffield.

Over this period the Trust has continued to focus of reducing suicide, offering workforce training in suicide awareness and working in collaboration with city-wide partners on projects like, Real Time Surveillance, which allows us to track the number of suspected deaths by suicide in our area in real-time, giving us more up-to-date information about suicide in our area and helping us to identify and implement support to prevent suicide in a timelier manner, and the development of the electronic safety plan for people experiencing thoughts of suicide. From an estates perspective we have sought to reduce the risks posed by potential fixed ligature anchor points in all patient accessible areas.

We have reduced the number of falls in our patient groups by promoting awareness, offering direct support from the physical health team and by utilizing the Huddle up for Safer Healthcare (HUSH) methodology. Monthly falls prevention group meetings are attended by the multidisciplinary team (MDT), clinical effectiveness and moving and handling lead. The group reports directly to the physical health management group and committee.
Falls champions have been identified for both older adult's inpatient wards (G1 and Dovedale one) and the 2 care homes (Woodland View and Birch Avenue). The falls champions will work alongside the falls leads to promote best practice.

A significant amount of work has been undertaken to reduce waiting times for key services like Sheffield Adult Autism and Neurodevelopmental Service (SAANS) and the Gender Identity Service. Running parallel to this we have been implementing a ' Waiting Less and Waiting Well' programme of work to ensure that those people having to wait for services are contacted in a timely manner.

The Trust currently hosts a research portfolio of over £13.1m from the National Institute for Health and Care Research (NIHR) and UK Research and Innovation (UKRI) funded research programmes, developed through strong academic partnerships from across the region; including the University of York, the University of Sheffield, Sheffield Hallam University, the University of Leeds, the University

College London, Bangor University and Oxford Health Biomedical Research Centre. In March 2025, we held our Research and Effectiveness Showcase, which welcomed speakers and delegates from across the NHS and academia. It was a huge success, with a packed line up of speakers, an engaged audience and a poster competition giving the opportunity to showcase new research and improvement projects.

At the Trust, we have a commitment to provide quality care for everyone in our city. In line with our quality strategy, we have focused on four strategic aims:

- Deliver outstanding care
- Create a great place to work
- Effective use of resources
- Ensure our services are inclusive

Our staff and teams have shown incredible dedication to providing person-centred care this year and we are delighted to share some of the highlights in this Quality Account.

Dr Caroline Johnson Executive Director of Nursing, Professions and Quality	Prof Helen Crimlisk Interim Medical Director	Helen Smart Chief Operating Officer

1.4 About Our Trust

Sheffield Health and Social Care NHS Foundation Trust (SHSC) provides a wide range of inpatient, community and specialist services, including:

- Mental health
- Learning disabilities
- Dementia
- Long-term neurological conditions
- Forensic
- Autism and Neurodiversity

In partnership with Sheffield primary care, we also provide primary care mental health services and a range of specialist services including perinatal mental health; eating disorders; gender dysphoria; specialist psychotherapy and psychological care for people with physical health conditions.

We provide services to around 55,000 people a year, from an average of 30 sites across the city, as well as working remotely in the community, in people's homes, community centres, residential settings and on our streets.

During 2024/25 Sheffield Health and Social Care NHS Foundation Trust (SHSC) employed approximately 2,600 staff and had an annual income of £179.1m. We provide predominantly secondary mental health, learning disability and specialist services to the people of Sheffield.

You can find out more about the services we provide at www.shsc.nhs.uk

1.5 Pascale's Story

My name is Pascale Cartron and I am currently a service user under the care of the team at East Glade (CMHT South). My experience of SHSC stretches back to September 2019 when, after three long months of GP appointments, and many hours waiting in A&E, I, eventually, found my way into Secondary Mental Health Services by means of the team who assessed me and admitted me to hospital.

While that may seem like a straightforward description of what happened to me in 2019, the truth is that it is difficult to describe just how painful and traumatic it all was for me and for those close to me. This part of my experience immediately raises an urgent question: how can we make it easier for people to access Secondary Services, before they reach crisis point? This is just one of the many pressing questions to emerge from my story which is one of lived experience wrought through three breakdowns, two hospital admissions, a period under the care of the Crisis team, and a longer period under the care of the Community Mental Health team.

And so I have been wondering about how I can best share my story and reflections, along with some of the learning that has resulted from my experiences, both as a service user and as a staff member. (In 2022 I worked as a Peer Support Worker for the Crisis Resolution and Home Treatment team and, since November 2024, I have been working as an SHSC Expert by Experience). How can I do justice to all these experiences? How can I make them count for the purposes of this Quality Report and, hopefully, the benefit of those who read it?

The answer came to me a few days ago when somebody handed me a postcard of the Trust's newly-formulated values. Three seconds later and I realised that all of my experiences, both good and bad, all of my learning thus far, testifies to the absolute importance of those four same values! The values appear so simple and yet they are so meaningful to me. I honestly believe that they, very nearly, sum up what it is that makes for the best quality care. To put it another way, where my care has been successful, it is because clinicians and other staff have embodied those values, and where it has been poor, it has, in every example I can think of, been because this value, or that value, has been sadly lacking.

'We work together'

Yes! Please, please do! My story has all too often illustrated how 'silo working' has real-life, really harmful, consequences. It has, at times, been terrible to be confronted with those invisible, but almost tangible, barriers which mean that services don't work together. Rather than dwell too much on those negative experiences, however, I think the best evidence for the value of this Value is that I have been in remission for the past 16 months. During this time I have felt myself to be steadily gaining in strength and understanding, as well as the skills which

enable me to look after my mental health. It is no accident that the distinguishing feature of the last 16 months under my CMHT has been that my care has, for the first time, felt 'joined up'. The many parts of SHSC - my nurse key worker, the art therapists, doctor, occupational therapist, music therapist, and others - have felt to me to be working together as one team, helping me to stay well and enjoy life. Thank you so much, all of you, for helping to make such a difference to me and my family.

Important though that aspect is, however, colleagues working together is only one side of 'We work together'. I would therefore like to highlight my experiences of staff working with me as a service user, and with my family as my carers. The positive impact of engaging with carers is vividly illustrated by the story of my second admission to hospital. My catatonia was such that I was completely unable to speak. And yet in this most distressing of moments, the pain was made a little less by the wonderful way that the psychiatrist interacted with my husband. It gave me powerful reassurance, even in the midst of my distress and confusion, that here were people working together to help me, and this gave me hope that I could get better. Conversely, on those occasions where staff have been reluctant to engage with me or my family, I have been left feeling vulnerable and isolated. This shows me that the 'Triangle of Care', which at its heart is about clinicians, patients and carers all working together, is vital in a person's care.

Finally on this subject, I would like to say how encouraged I am that the Trust is moving over to the new 'Personalised Approach to Risk' whereby risk assessments are at last carried out in an on-going, collaborative way. This is such a significant example of working together with service users. I say this because, through this new approach, I myself now feel better able to understand and pro-actively manage my own risk. What a breakthrough!

'We keep improving'

Yes! Again! As a service user and as a staff member, I have seen many encouraging signs that we are not content just to keep doing things the way we've always done them, but that we really do want to keep improving. There is always room for further improvement but I am heartened by what I am seeing, particularly with regard to what seems to me to be an increasing appetite to listen and learn, and meaningfully involve those with lived experience in the co-production of Services. I am only too happy to play my part in this - why wouldn't I want to put all that hard-won knowledge and understanding to good use? I can but feel grateful for the way that lived experience illuminates so many issues to do with mental health and Mental Health Services. Increasingly, I am coming to understand just how strong an ally this insight is when it comes to the task of answering that most burning question of all, namely, how can we make Statutory Services as good as they possibly can be? How, actually, do we do that?

The answer to that question is doubtless extremely complex but there is one aspect about which I am convinced. I feel sure that great strides could be made in our quest for improvement if we could find a way to facilitate the careful introduction of more peer support workers. There is no doubt at all that when my family and I were in the eye of the storm of mental illness, the opportunity to meet with a peer; somebody who had been through it themselves and come out the other side, would

have made a massive difference. As my 11 year old said to me shortly after I came home from hospital, "If only we could have met someone who had already been through what you were going through, we wouldn't have been so terrified".

Six years on I am saddened that we are still not able to offer this particular comfort and hope to our inpatients and those close to them. It remains my dearest wish to see peer support workers working on all our wards because, in addition to the very special type of support that they can offer patients and their carers, peer support workers are in a unique position to lead and contribute towards the creation of the kind of working culture which is crucial to achieving the type of person-centred care that we all long for and strive for. The benefits would be such that the question going through my mind is "Why wouldn't we?".

'We are inclusive'

I'm not sure exactly where we are with this but, on a positive note, I have come across an open consensus that we are not currently where we need to be. There is undoubtedly still much work to do to make Services truly inclusive, but I personally am hopeful that, along with other streams of work, the 'Culture of Care' programme, (the aim of which is to make care on inpatient wards autism-informed, trauma-informed and culturally competent), will help to make wards more inclusive than they are at the moment. I really hope that the impact of all the work done will extend to other services and that, to name just one of the many ways in which we can be more inclusive, a means can be found to expand the work in order to also make Services more accessible for people who are neurodivergent in other ways.

One more thing about inclusivity: it seems to me that there is so much diversity and variety within the Voluntary Sector that if Statutory Services were to get much better at signposting to VCSE organisations, then this would have the overall effect of increasing inclusivity. In my own care, the Art Therapy team have been a shining example of good practice in this area. I am so grateful for the initiative they took in looking 'outwards' for the next therapeutic steps for me and others in my group. It was the best, most caring 'handover' and has turned out to be of enormous on-going benefit to me.

I would love to see more of this approach; for existing partnerships to be further strengthened and for new ones to be created. I really feel that the more we are able to form good relationships between Statutory and non-Statutory services, the easier it will be to be inclusive and the better we will find ourselves able to serve service users.

'We are respectful and kind'

Where to begin! I think everyone would agree that this is the very bedrock of good care. Whilst I am sadly not able to say that I have always been treated with respect and kindness, I'm so pleased to report that the overwhelming majority of my interactions with professionals have been therapeutic ones where kindness and respect have abounded. This has been especially true of the past 16 months since leaving hospital, but also of the time that I spent on Burbage ward, then known as Dovedale 2. I cannot speak highly enough of the care I received there, including from the Chaplaincy team. The role of chaplains can sometimes be overlooked but

it is no exaggeration to say that the time I was able to spend with them was key to my recovery. My overall experience has been that whenever such therapeutic relationships are built - including even those which are formed in a few seconds while walking down a long corridor - healing starts to happen.

'We are accountable'

I hope no-one will mind me squeezing in one more Value. I have done so because my family and I have unfortunately experienced first-hand what happens when the formal pathways of accountability, as well as the personal sense of accountability, break down. We have certainly paid a high price and yet, time and again, I have also witnessed, and greatly benefitted from, the fantastic work of people who so obviously do have a very strong sense of accountability. The positive impact on their work - and therefore ultimately on outcomes for service users and staff - is wonderful to see. Could it be that if our Trust were to focus on growing in this particular area, then this could bring very, very significant benefits to staff and service users alike?

I would like to finish by thanking all those who, in so many different ways and in so many different roles, have supported me to get well and stay well. You are all amazing and I could never thank you enough.

1.6 National and Regional Awards

Health Service Journal (HSJ) Patient Safety Awards

This year, after being shortlisted for three awards, we attended the Health Service Journal (HSJ) Patient Safety Awards ceremony in September 2024, where we came away with the Community Care Initiative of the Year award for our holistic care in the community and the work we do to empower mental health staff to provide better care for physical health for people with mental health illness in the community.

In their award citation, the judges praised the team's "vital work on focussing on patients' needs and safety during medical intervention."

We also received three highly commended awards for our work in the Developing a Positive Safety Culture award, Patient Safety Team of the Year and Mental Health Safety Improvement award categories.

Part Two: Quality priorities for 2024/25 and required statements of assurance from the Board

2.1 Introduction – Purpose of this Section

In part two of our Quality Account, we report on the progress against our 2024/25 objectives and set out our priorities for 2025/26. We also provide a series of statements of assurance from the Board of Directors, in relation to mandated items as required by NHS England.

2.2 Our Organisational Improvement and Change Framework

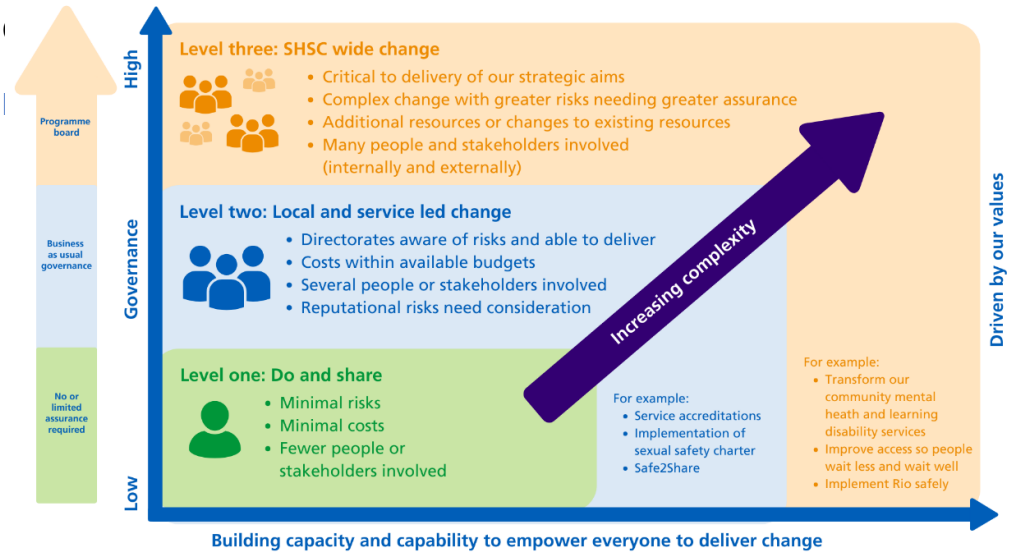
Here at the Trust our organisational approach to improvement and change strongly aligns with the NHS IMPACT approach to change. There are five components:

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership and behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

In 2024/25 we developed a framework which has helped us to understand the levels of cost, complexity and risk of improvement and change, to then provide the support and resources needed to promote its successful delivery.

The below model for improvement is at the heart of our continuous quality improvement approach. The Improvement and Change framework will support us to continue to build a culture of continuous improvement.

The Improvement and Change Framework



The adapted Model for Improvement, underpins our approach to improvement and helps staff understand how to structure their projects, set measurable goals, and apply data-driven approaches.

2.3 Examples of Change and Improvement Projects in 2024/25

Our approach to developing a culture of continuous improvements enables us to work across multiple projects with the right levels of autonomy and not prohibit our teams from making the small, but important changes, that make a significant difference.

There have been a large number of change improvement projects undertaken over the course of 2024/25, ranging from large scale Trust-wide change projects, such as the implementation of RiO (our new Electronic Patient Record) to small team-based improvements. We wish we could tell you about all the projects we are proud of, but there are too many to list. Instead, we are proud to give you a few highlights below:

2.3.1 Triangle of Care

The Triangle of Care is a partnership between professionals; the person being cared for and their carers. It is a good practice framework to aid better working with carers and recognises the essential role that carers play in our service users' lives. This partnership leads to better outcomes for our service users. The Triangle of Care is a three-stage process for organisations to work through, with stars awarded at each stage that highlights good practice in building a carer inclusive approach to care.

In June 2024, our inpatient wards, care homes and crisis teams were awarded our first star for completing stage one of the Triangle of Care accreditation from the Carers Trust.
We have continued to build upon this success and have commenced stage two of the process, which will focus on our community services. There have been 19 introductory workshops held between August and November 2024, with various teams in attendance. Teams are now in the process of completing their self-assessments about where they are against the six key standards and what they need to do to improve.

The six key standards are:

- Carers and the essential role they play are identified at first contact, or as soon as possible thereafter.
- Staff are 'carer aware' and trained in carer engagement strategies.
- Policy and practice protocols re: confidentiality and sharing information are in place.
- Defined post(s) responsible for carers are in place.
- A carer introduction to the service is available, with a relevant range of information across the care pathway.
- A range of carer support services are available.


CARERS TRUST

TRIANGLE OF CARE

This is to certify that

Sheffield Health and Social Care NHS Foundation Trust

has achieved Stage 1 of the Triangle of Care

Kirsty McHugh
Chief Executive, Carers Trust

Date: May 7th 2024

Teams should also be considering how to make these improvements in their service areas and continuing to build on the good progress we have made integrating the Triangle of Care standards. Ultimately, the Triangle of Care will bring about a culture where carers feel valued, included and feel like partners in care.

All completed self-assessments, testimonials from carers, staff and carer support organisations who have been involved in the Triangle of Care will be collated into a report and submitted to the Carers Trust in May 2025.
A review of the Trust's Triangle of Care Star 2 application will be presented to a peer panel at the Carers Trust, led by the Carer Lead, on 18th June 2025. This will be an opportunity to talk through the action plans following the self-assessments, to hear of successes and challenges and to hear about the Triangle of Care from the organisation at system level.

"Exceptionally kind and generous of nurse in charge to provide my partner with Christian literature - I am deeply touched by his kindness"

The self-assessments and action plan created will inform how we improve our engagement and involvement of carers across services. We will co-produce with carers and clinical teams the improvements required to ensure carers are at the heart of our service delivery. Carers will continue to be central in the development of this work, with their involvement assured through our established carers open door group, carers action group and focused task and finish groups.

2.3.2 Improving our Therapeutic Environments

In March 2024, our newly refurbished Stanage ward, at the Michael Carlisle Centre, opened its doors to staff and service users. The all new Stanage ward has 16 beds for male service users and offers a therapeutic environment with a more modern, safe and comfortable space for those using it. Although the design of the ward follows the same as Burbage ward, which reopened in late 2022, the flow of the specific rooms was coproduced with the ward team. The décor and furnishings

were consulted on by service users and staff, including the choice of artwork for the walls.

In January 2025, the refurbishment of Maple ward, at the Longley Centre, commenced, to create a space which is more therapeutic for our service users and better supports our staff to provide the best care we can. This work will remove fixed ligature anchor points, provide an accessible bedroom and de-escalation facilities and create a safe and therapeutic garden courtyard. All other existing facilities within the ward, such as the quiet space, lounge and dining room, clinic room etc, will be upgraded as part of this renovation.

We are undertaking this improvement work to our wards to ensure that we place the comfort and safety of our service users at the forefront by creating safe, high-quality environments. We are hoping that the renovation will be completed in the late Autumn 2025 and that Maple ward can then be reopened. This work completes the environmental issues highlighted during a previous Care Quality Commission (CQC) inspection in 2021. This is a significant achievement for us, and we are particularly proud that we worked together with our service users to design the new wards, with the aim of improving patient experience.

Our Woodland View Nursing Home has also recently commenced refurbishment in several key areas, to improve the quality of the facilities and improve the experience of our residents, their families and our staff.

2.3.3 Patient and Carer Race Equality Framework - developing inclusive care and services

November 2023 saw NHS England formally launching its first ever anti-racism framework: the Patient and carer race equality framework (PCREF). The Trust was an early adopter of this and working with communities has been integral to its development.

During the initial coproduction stage to develop the PCREF plan, we heard strongly from communities that they were unclear about and the different options of support that are available from mental health services. In response to this important feedback we asked Sheffield Flourish to codesign an information leaflet that would explain mental health support in an accessible format that could be translated into the common languages spoken in Sheffield. This has been done working with local communities, partnering NHS trusts, commissioners, Sheffield City Council (SCC) and teams within the Trust. Sheffield Flourish is now working with partners to translate the leaflet text into six languages, to be widely available in a printable format across Sheffield, and in our services, from April 2025.
As an early adopter site, the PCREF implementation pilot started in March 2023, completed in March 2025, however, the work continues far beyond the pilot phase. The pilot was funded by NHS England and delivered in collaboration with community partners and the University of Sheffield. This has followed 4 PCREF related activities:

- Enhanced monitoring of inpatient restrictive practice and post-incident review.
- Cultural advocacy on inpatient wards.

- Improving access and pathways into care to mental health services in racialised communities.
- Improvement of protected characteristics data collection methods.

The main output deliverable from the project will be demonstrated through the production of several logic models which will represent how the interventions listed above produce short- and long-term changes.

The logic model comprises of reviewing inputs, interventions and outcomes of the work strand. It helps with evaluation by setting out the relationships and assumptions, between what a programme will do and what changes it expects to deliver.

These activities and models will be continually evaluated and reviewed through the Trust's PCREF Delivery Plan and PCREF stakeholder delivery group. Over the next year, we will use the findings arising from the implementation activities to finalise the logic model, a visual representation to demonstrate change, and to produce implementation guidance to support future work in Sheffield.

Of particular success has been the development of two cultural advocacy workers, recruited by the Pakistan Muslim Centre (PMC), who have worked with over 300 service users across inpatient services this year. These roles support service users in navigating needs, creating a bridge between service users' cultural identities and the Trust's mental health services. In addition, we have previously invested funding into Sheffield African Caribbean Mental Health Association (SACMHA) bringing in a Race Equity Officer who has been focused on providing support to service users involved in an incident and Restrictive Practice, being a part of developing post incident support. This culturally sensitive support has significantly increased service users' engagement with their treatment. When service users feel that their cultural, dietary and spiritual needs are respected, they are more likely to participate in therapy sessions, attend ward activities and collaborate with healthcare staff. We have recently invested in developing Peer Workers in MAAN, Somali Mental Health.

The presence of cultural advocates has also built trust between service users and staff. Service users are more open to discussing their concerns and sharing their needs, knowing that their cultural context will be understood and respected. In June 2024, the Executive Board approved Sheffield's PCREF delivery plan for 2025-26.

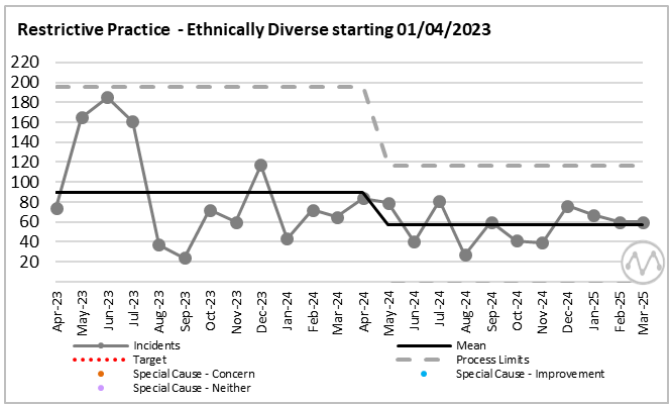
The Sheffield PCREF's top 5 areas of focus are:

- Advance Choice Statements
- Governance Structure
- Community Development Workers
- Develop a 'How to' toolkit (a practical guide to support staff in providing culturally competent care)
- Communications Plan

As a priority, there will be wider engagement and involvement of community leaders in the continued implementation and evaluation of PCREF, through the implementation group and invested into the VCSE (Voluntary, Community and

Social Enterprise) with Community Development Workers to support building on capacity to continue to develop culturally sensitive pathways in and out of care. This will be a priority focus in 2025/26.

In 2022/23 a quality objective priority was identified to reduce restrictive practice for people from ethnically diverse communities, this has carried on through as another area of focus under PCREF in improving health inequalities in relation to Restrictive interventions. The below chart demonstrates going from an average of 89 events each month in 2023/24 down to 57 in 2024/25. More detail around our ongoing work with Restrictive Practice can be read on page 20, in our Health Inequalities Statement and in our Use of Force Annual Summary.



2.3.4 Quality Improvement Collaborative: Waiting Less and Waiting Well

In July 2023, the Trust launched its first Quality Improvement Collaborative: Waiting Less and Waiting Well. The focus of the collaborative was based on feedback and complaints data highlighting issues with waiting lists. The Trust's Specialist Psychotherapy Service (SPS) (pictured below) has actively participated in the Collaborative, and by reviewing their entire service pathway, have succeeded in reducing waits at all points in the system.

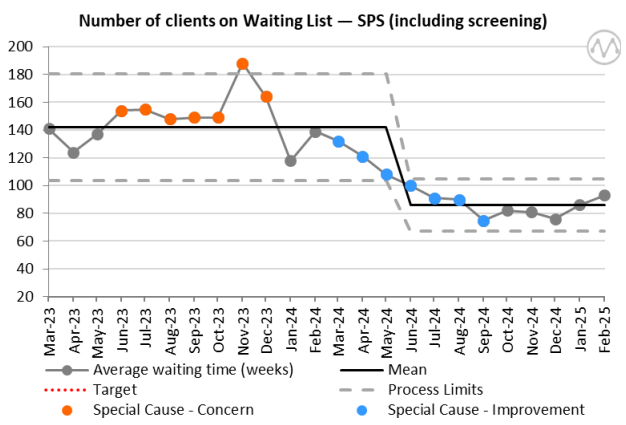
Recognising the prolonged waiting times from referral to triage, referral to assessment, and referral to treatment, the team focused on how to maximise their capacity and streamline these pathways. By reviewing the attendance and frequency of various meetings, SPS were able to release over 40 clinical hours per month.

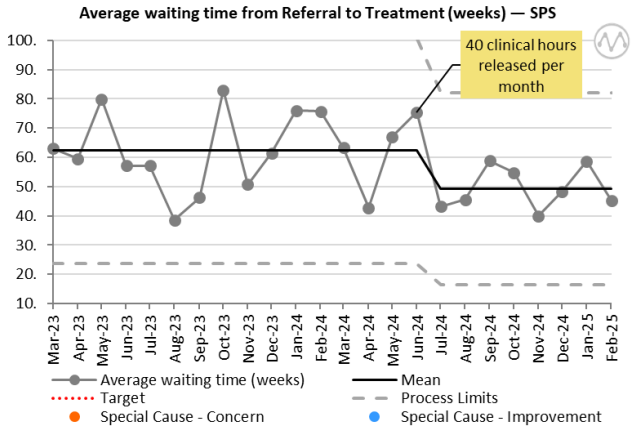
The team also developed therapy agreements to help standardise the number of therapy sessions service users received, and to provide more accurate clinician caseload management. SPS also worked with their Quality Improvement (QI) coach to improve the quality of their data, identifying the longest recorded waits and learning from the causes of this, and amending administrative processes accordingly.

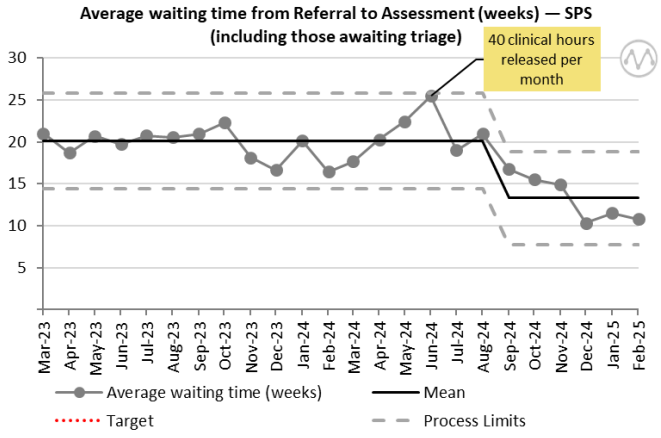
The combination of these initiatives has resulted in:

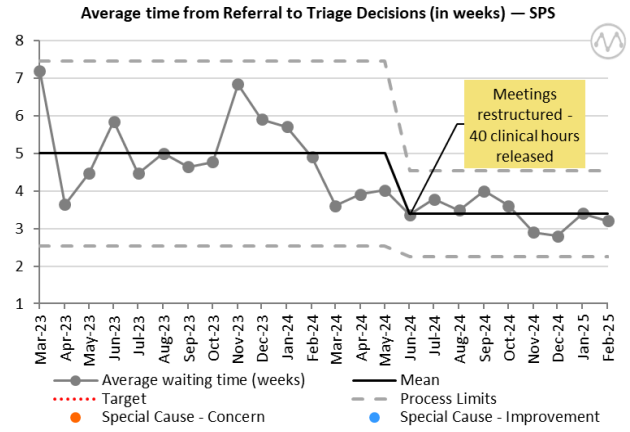
- 41% decrease in the number of people on the waiting list for assessment, from an average of 142 to an average of 84.

- 40% decrease in the time a referral is triaged, from an average of 5 weeks to an average of 3 weeks.
- 20% decrease in waiting time from referral to assessment, from an average of 20 weeks to an average of 16 weeks
- 19% decrease in waiting time from referral to treatment, from an average of 62 weeks to an average of 40 weeks.









The Neurological Enablement Service (NES) is a community team of multidisciplinary therapists who aspire to offer evidence-based, effective, efficient and patient-centered care, working with people managing the impact of their long-term neurological condition. As part of the waiting less waiting well collaborative with our Quality Improvement (QI) team, the service has been working to reduce the time from referral to contact with a clinician (establishing need, priority, identifying initial goals and signposting to either alternative services or support whilst they wait).

Over the last year, the service has reduced the average wait between referral and clinical contact from 50 days to 7 days. Following the 'plan do study act' (PDSA) QI methodology. The team trialled new ways of working and over three PDSA cycles managed to reduce the waiting time to an average of

7 days. This improvement has had a positive impact for both staff and service users.

2.3.5 Q Exchange 2024

Two QI project ideas from the Trust were successfully allocated funding from the Q Community's Q Exchange and commenced in November 2024. These are:

- **Improving the Psychiatric Decisions Unit (PDU)**
  The project aims to improve how our PDU is used to make sure people needing mental health care are seen by the right person, in the right place, at the right time. This will result in fewer A&E admissions and fewer mental health unit admissions. Initiatives include working with South Yorkshire Police to increase the awareness and usage of the PDU, where appropriate, and improving the PDU website to provide more accessible and accurate information to service users and carers. By increasing the number of people accessing the PDU, it is anticipated that a better patient experience will be provided as patients will experience a quieter and more appropriate environment, and be assessed by mental health professionals quicker. You can read more about this project here Improving the Psychiatric Decisions Unit (PDU) in Sheffield – Q Exchange

- **Qi4All**
  This project is all about improving access to QI by setting up a QI Academy for our partners to learn quality improvement skills and methodologies. We want to ensure QI skills are accessible for all, improving care across different levels in healthcare and VCSE (voluntary, community and social enterprise) organisations. The shared aim of the programme is to make QI skills accessible for more people, leading to more improvement where it is needed most. We aim to develop an improvement academy open to applications led by VCSE (voluntary, community and social enterprise) teams that specifically focus on improving mental health in the city of Sheffield. Teams are working with our charity partners, Aspiring Communities Together (ACT) and Sheffield African Caribbean Mental Health Association (SACMHA) and all participants are being funded to complete a Post Graduate Certificate. You can read more about this project here Quality Improvement for All (Qi4All) Academy – Q Exchange

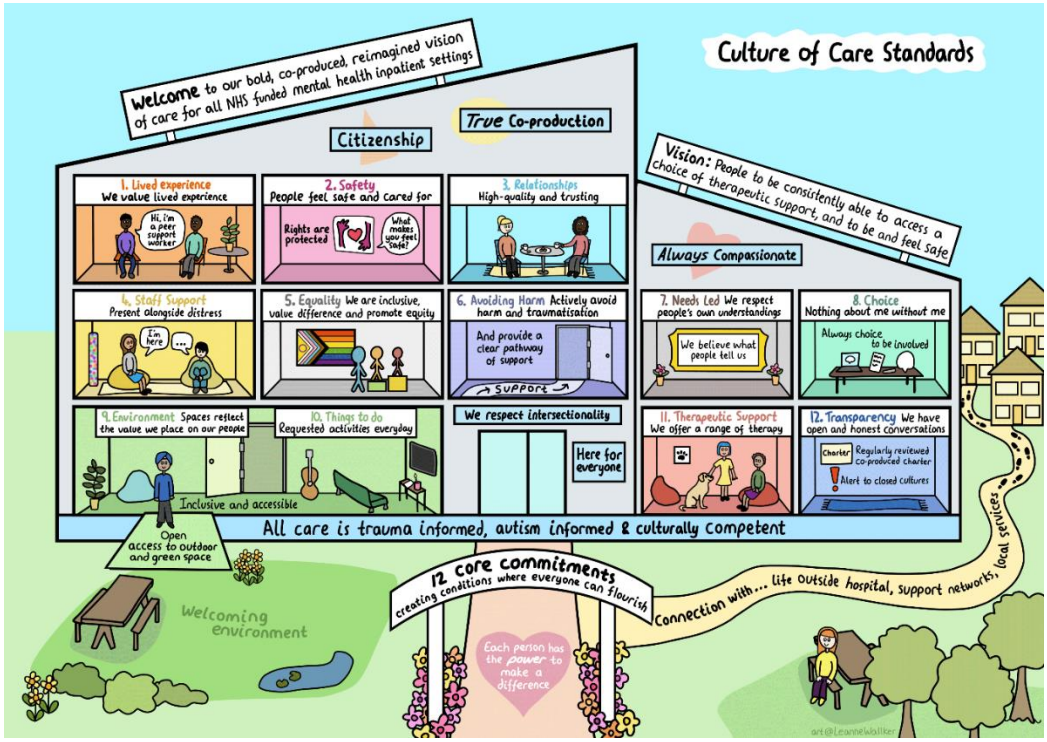
2.3.6 Culture of Care

The Trust is participating in NHS England's Quality Transformation Programme through Culture of Care, a two-year co-produced Quality Improvement Programme. The goal is to improve the culture of mental health, learning disability and autism in inpatient wards, ensuring they are safe, therapeutic, and equitable environments for both patients and staff. The culture of care programme offers quality improvement training and coaching to participating teams, and the offer of leadership coaching to senior executive sponsors of the work. By offering 'ward and board' coaching, we

hope to increase the impact and influence of the culture of care standards and underpinning equity principles. The thinking behind the programme was that this method would help to spread the message of culture of care beyond the walls of the participating wards to other parts of the organisation.

The programme is built on four key interventions designed to support wards in delivering safe, trauma-informed, therapeutic, and equity-focused care. It is the largest QI project in the mental health sector, involving all NHS and independent providers across England.

Underpinned by 12 core commitments (shown in the infographic below) and 74 individual standards, these standards were co-produced with people with lived experience, their families, inpatient staff, voluntary sector organisations, royal colleges and academic experts, reflecting a shared vision for inpatient services.



There are six strands of Culture of Care:

1. Ward-Based Quality Improvement
Participating wards: Endcliffe, Dovedale 1, Dovedale 2, and Burbage.
Ward teams engage in continuous improvement, focusing on care environments and staff well-being by:

- Identifying and implementing data-driven improvements.
- Co-producing change ideas with patients.
- Strengthening collaborative ward culture, promoting open communication across all levels.
- Embedding sustainable changes into everyday practice.
- Each team receives individual coaching from a national QI coach.

2. Staff Care & Support

A six-month module repeated three times, to create reflective spaces that drive practical improvements in staff well-being and workplace culture. First cohort: G1 and Stanage wards and the second Forest Close.

3. Ward Manager Development Programme
A six-month programme repeated three times, to strengthen leadership skills among ward managers. First participant: Dovedale 2 ward manager.

4. Personalised Risk Assessment & Formulation
The Trust is one of 10 Trusts selected for the Culture of Care pilot, run by the National Confidential Inquiry into Suicide and Self-Harm (NCISH). Over one year (Sept 2024 to Sept 2025), a new personalised risk assessment and formulation approach will be:

- Designed, tested, and evaluated.
- Supported by NCISH to enhance risk assessment frameworks.

5. Cross-Organisation Quality Improvement
Coaching is offered across the Trust based on ward-led QI outcomes.

6. Executive Leadership Support
Two executive sponsors receive coaching from people with lived experience to help them better support frontline teams, running alongside the ward improvement timeline.

Experts by Experience
A Lived Experience Programme Lead has been appointed to ensure Culture of Care remains co-produced. Experts by Experience have been recruited to:

- Support ward teams.
- Contribute to specific workstreams as needed.

As we move into 2025/26, a dashboard is being developed to enable us to monitor the improvements and the impact of this work programme, based on staff and patient experience.

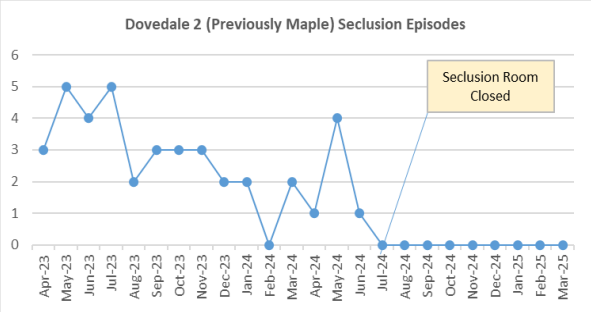
2.3.7 Least Restrictive Practice

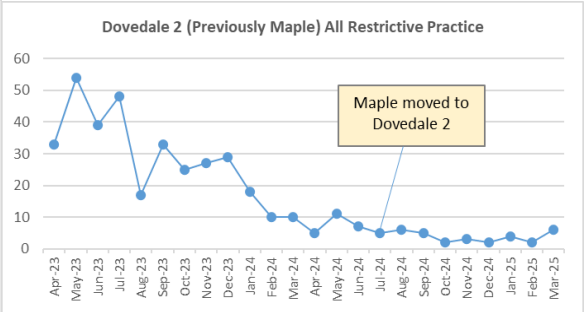
In April 2024, we hosted a Least Restrictive Practice Conference to celebrate and showcase the significant reductions we have made in the use of restrictive practice within our inpatient wards. We had a number of guest speakers presenting including Aji Lewis (mum of Seni Lewis), Kate Sanger and Alexis Quinn from the National Restraint Reduction Network Group.

This event coincided with the final year of our 3-year strategy, which has empowered staff to utilise and build on their trauma informed care skills by introducing approaches such as Safewards, Human Rights Act Training and Post Incident Reviews which create a culture of learning, reflection and ideas to improve quality. These interventions have

been significantly enhanced by new roles such as our Race Equity Officer to help improve the care and treatment of service users who are ethnically minoritised.

A fundamental culture change in how we respond to service users experiencing distress has been marked this year with the move of our final acute ward to an environment without a seclusion room. We have learnt that seclusion can be a de-humanising experience and cause further trauma to those being secluded. Often, the removal of one restrictive practice can be replaced by another. For example, an increase in the use of rapid tranquilisation can often be seen when physical restraint has reduced. Our continual commitment to use data to help us monitor and understand restrictive practices provides the assurance that this is not the case for the Trust. The charts below show that since Maple ward moved to Dovedale 2 which has no seclusion room, all other forms of restrictive practice (e.g. physical restraint, rapid tranquilisation) have also decreased, along with there being zero instances of seclusion since July 2024.





We have started to develop a new 3-year plan to build on our progress so far in our commitment to continually improving practice. We are working to streamline our approach in aligning this with other quality improvement initiatives to enhance positive change. Although the removal of seclusion marks a significant move, there is no room for complacency so we are broadening our scope and consideration of how people may experience restrictive practice in multiple ways. A workstream to look at restrictive practice in the community, the implementation of peer support workers on acute wards and plans to roll out the HOPE(S) clinical model in creating ways to look at barriers to change, when people may be experiencing the restrictions of long stays in hospital, is being developed. We will continue our commitment to embed trauma informed, human rights approach to care and least restrictive practice.

2.3.8 Mental Health Act Quality Improvement Programme

In 2021, the Government published a White Paper, Reforming the Mental Health Act, which accepted many of the recommendations from the 2018 Independent Review of the Mental Health Act and set out a series of ambitious reforms to care under the Act. To support these improvements, one of the recommendations taken forward in the White Paper was a commitment for NHS England to deliver a national Quality Improvement (QI) programme. The programme was set up to make sure that the principles of the Mental Health Act review are put into practice and inequities which are inherent in the system are addressed.

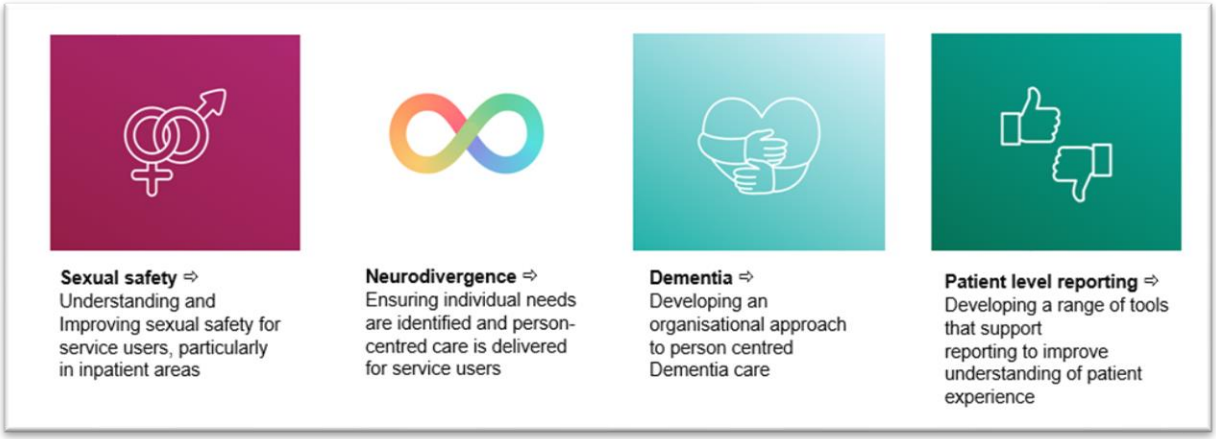
Forest Lodge was one of 15 pilot sites from 37 NHS trusts chosen for the programme. This was a coproduced piece of work, working alongside experts by experience and addressing inequalities which shifted the balance of power to enable patients to be able to take more of a lead in their own care and focussing our work on increasing equity of experience for individuals from ethnically diverse backgrounds.

Matron at Forest Close, attended the launch and said: "Inspiring presentations, challenging conversations and reflections on our practice at the NHSE QI event in Manchester. Thank you to colleagues who spoke and for their honest reflections about their journey. I am excited and enthused for the opportunities that this opens up for real coproduction."

The Quality Improvement Programme was launched to other organisations in July 2024. Colleagues from Forest Lodge shared their approach to working alongside experts by experience and addressing inequalities.

2.4 Our quality objectives 2024-2025

Our quality objectives were originally set to last for 3 years (2024-2027) however to align with our Trust Strategy we will identify yearly priorities. Our 2024-25 objectives have been developed in conjunction with a variety of stakeholders, including the Council of Governors, service user representative groups, NHS Sheffield Integrated Care Board (ICB) and Healthwatch Sheffield. The quality objectives for 2024-2025 are shown below:



When setting our three-year objectives, we reviewed the following in order to identify our quality priorities:

- the findings from our Care Quality Commission (CQC) inspections;
- our performance against a range of quality indicators, both internally and across mental health networks;
- considered our broader vision and plans for service improvement;
- explored with our Council of Governors their views about what was important to them;
- engaged with our staff and service users to understand their views about what was important and what they thought we needed to improve;
- engaged with our commissioners and other stakeholders to understand what their priorities for improvement were.

2.4.1 Looking Back - Our Progress against the Quality Objectives 2024/25

Quality objective one:
Sexual safety – Understanding and Improving sexual safety for service users, particularly in inpatient areas

Why we chose this objective:
The CQC published its report in 2020 on sexual safety on mental health wards, which concluded that sexual incidents are commonplace on mental health wards, that they affect both service users and staff and that they may cause significant and lasting distress.

In response to the CQC Sexual Safety report and a request from the UK Secretary of State for Health and Social Care, sexual safety became a priority area for the mental health safety improvement programme and the national sexual safety collaborative was commissioned as part of this programme. The Trust is committed to undertaking improvement work relating to the priorities identified by the national sexual safety collaborative.

More recently, the Trust has joined NHS England's Sexual Safety in Health Care Organisational Charter which was launched in September 2023.

The following priorities were set for year one:

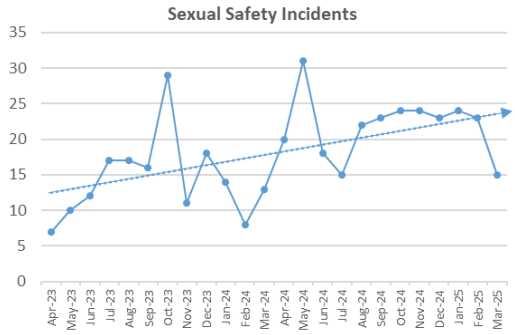
Year One - we said we would	How have we done?
Establish a working group, linked to PMO (Programme Management Office), to manage and oversee sexual safety workstream	✓
Develop a sexual safety dashboard to report against national sexual safety standards and to enable benchmarking to be undertaken	✓
Work with Senior Nursing Practitioners to embed the use of a ward charter for sexual safety, to improve psychological safety	✓
Build relationships with other stakeholders, including voluntary sector organisations	✓

Outcomes:

Sexual safety dashboard is distributed monthly to services, enabling services to include narrative around the findings. Engagement with the dashboard requires improvements in using the tool to collate and feedback narrative.

A draft version of the audit tool has been developed, one for teams and one for managers. This is being aligned with the dashboard and wider work, such as the sexual safety charter.

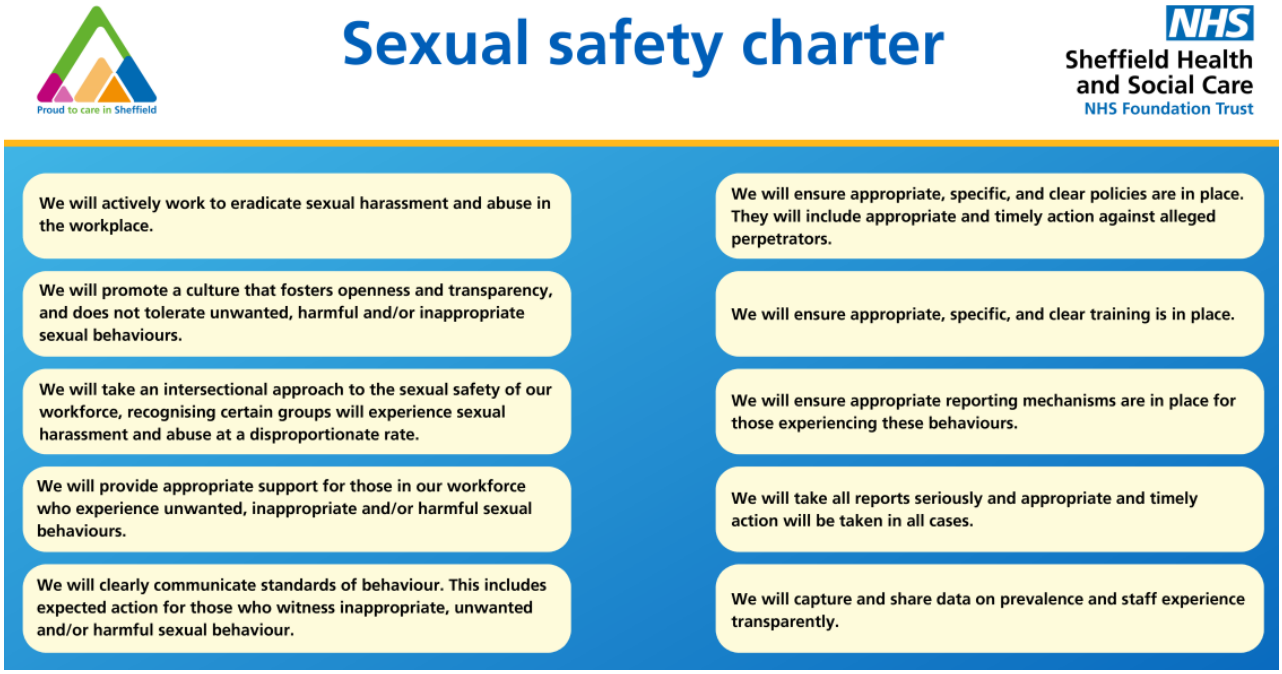
The chart to the right reflects the number of sexual safety incidents reported each month, the trend indicates an increase in the number of incidents being reported which is understood to reflect the work to raise the profile and improve response to sexual safety incidents rather than an increase in incidents occurring.



All sexual safety incidents are reviewed at the clinical service level through the incident huddles and then at a Trust level through the daily incident huddles and Patient Safety Incident Response Framework (PSIRF) process.

The Sexual Safety Charter (below) has been published within the organisation and key actions identified to ensure we meet the 10 pledges:

- Ensuring we have appropriate support in place for anyone reporting an incident
- Reviewing policies and updating them
- Improving reporting
- Developing training with NHS England
- Promoting the charter
- Linking with safeguarding colleagues



Each of our inpatient areas has a sexual safety plan in place which details sexual safety standards related to care processes. This includes an admission protocol and care plan format which embeds principles of the charter to ensure that these standards are reflected in a person's care from admission. The people directorate have also developed a questionnaire to understand people's experiences.

Quality objective two: Neurodivergence – Ensuring individual needs are identified and person-centred care is delivered for service users

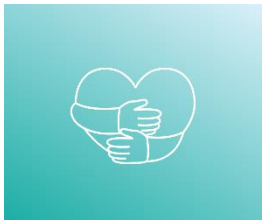
Why we chose this objective:
Autism influences how people experience and interact with the world. It is a lifelong neurodivergence and disability. Autistic people are different from each other, but for a diagnosis they must share differences from non-autistic people in how they think, feel and communicate. This objective drives the Trust to a more inclusive and person-centred approach to care ensuring staff have the right skills and confidence to care for service users with neurodivergence. Having a person-centred approach will improve patient experience and ensure services are more effective and efficient. The following priorities were set for year one:

Year One - we said we would	How have we done?
Establish baseline data on staff competence and confidence in their knowledge of autism and working with autistic people, with the aim of highlighting training gaps and needs	Year 2 (25/26)
Develop a community of practice for autism in conjunction with the Quality Improvement Team	✓

Undertake environmental assessments across Trust sites to highlight potential sensory difficulties for service users	
Roll-out co-produced and cofacilitated national autism trainer programme	
Recruit experts by experience to facilitate roll-out of training	

Outcomes:

- We have a new Autism Awareness E-Learning that collects feedback about staff knowledge, however, the number of returns received has been limited. Other avenues to be explored with training department feedback from Oliver McGowan Training.
- A quality improvement project is underway, where staff have begun to give feedback about their views regarding what they need from the Autism Community of Practice (COP). We are now moving to implementing the COP by setting up dates, themes and lead facilitators.
- Increased staff access to the National Autism Trainer Programme (including Anna Freud Training) designed to be a model that qualified trainers can take back to their own NHS Trust to facilitate training with their own colleagues together with a qualified Expert by Experience (EbE). We aim for the following:
  - Target: Train 10 staff based in community services and 10 staff based in inpatient services. The current figures are 9 community-based staff and 3 inpatient staff.
  - Training delivered alongside experts by experience (our ability to recruit experts by experience is dependent upon identifying local or regional funding).
- The wards across the Longley Centre, Michael Carlisle Centre and Forest have all participated in an environmental assessment and received a report with recommendations.
  - The Culture of Care work focusses on key adjustments for neurodivergent people.
  - Maple ward is working on an improved sensory design for autistic people.
- Sheffield NHS Talking Therapies and Eating Disorders Service are developing and running focused training on autistic inclusive adaptations with training input from Sheffield Adult Autism and Neurodevelopmental Service.
- SPELL (Structure, Positive approaches, Empathy, Low arousal and Links) awareness training has been delivered to Forest Close, Endcliffe & Community Enhanced Recovery Team.
- The Green Light Survey is starting to be rolled out with CERT identified as the first team to take part.



Quality objective three: Dementia – Developing an organisational approach to person-centred Dementia care

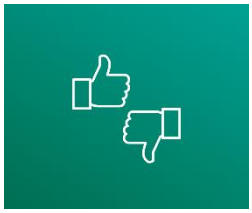
Why we chose this objective:
As part of the national community mental health framework, this quality objective supports improving the quality of community mental health services for older people with mental health problems and dementia. Ensuring that service users and their family and carers receive high quality, effective care, delivered by staff who are skilled and supported to deliver the care required and building a network of support through community relations and resources.

The following priorities were set for year one:

Year One - we said we would	How have we done?
Create a dementia taskforce in order to develop a workplan and prioritised list of required actions against this objective	Year 2 (25/26)
Enable the workstream lead to develop relationships with Dementia UK, Shindig, Alzheimer's Society and other voluntary organisations to understand the size of the Sheffield population need/demand in this area	✓
Identify a workstream lead	✓

Outcomes:

- Meetings have taken place with staff across Older Adult services to focus on dementia quality. Discussions were had around practices to keep or improve:
  - Connecting with wider charity/community organisations to support reaching people from various demographic groups – improving referral rates and assessment tools and processes for ethnically diverse communities.
  - Develop understanding of Talking therapies offer for people with Dementia
  - Community information resource to support pre-diagnostic counselling
- Feedback will be reviewed in year 2 to identify workplans/actions to be included in the multiple quality improvements/ transformations co-occurring in Older Adult services such as the Older Adult Improvement Programme; ICB focused work and quality improvement in the Sheffield Memory Service.
- Our 11 older adults' services came together in October 2024 on International Older People's Day, celebrating the work they do and shared learning from each other's teams' and expertise.
- Relationships developed with a network of community organisations and charities. Links were established with the Dementia Strategy Implementation Group, including a holding stall at the strategy launch event held in November 2024 about Trust services.



Quality objective four: Patient level reporting – Developing a range of tools that support reporting to improve understanding of patient experience

Why we chose this objective:
Ensuring we understand patient experience is a key element of quality, alongside providing clinical excellence and safer care. There are policy drivers to ensure this happens, such as the Patient and Public Involvement Strategy and Working in Partnership with People and Communities (NHS England, 2023).

Understanding patient experience and having various mechanisms to do this is integral in ensuring that we keep the experiential lens as a focus to our improvements we make to care. Having the patient voice and experiences central to our objectives ensures we maintain a focus on relational as well as functional aspects of care.

The following priorities were set for year one:

Year One - we said we would	How have we done?
Prepare communications to recruit lived experience expertise to join a coproduced patient level reporting review group	✓
Develop the patient level reporting review group with the recruited expertise, including a governance structure to ensure accountability and responsibilities are clear	Year 2 (25/26)
Work with the review group to develop the required mechanisms for measuring success, or otherwise, in collecting patient feedback	Year 2 (25/26)
Codesign a patient experience dashboard to bring all current feedback mechanisms together and close the feedback loop to ensure learning is undertaken	✓

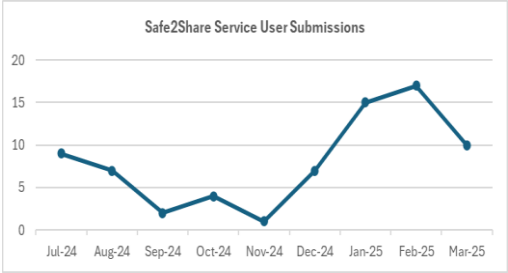
Outcomes:

- A service user experience dashboard is currently being developed with the aim of gathering information about all feedback methods used across the organisation. The dashboard will need to accommodate the different sources of feedback received.

- Initial scoping has taken place to understand what feedback is collected across services and directorates, next this feedback will be reviewed with service users and experts by experience.

- Refresh of groups and the governance process around service user feedback is currently being reviewed to ensure there is a structure from collection of experience to reporting to closing feedback (Organisation & Service Level). The Lived Experience and Co-production Assurance Group (LECAG) and SUN: RISE (service user engagement group) are part way through a refresh which is due to be completed in Spring 2025. LECAG will be key in reviewing feedback mechanisms.

- Safe2Share app commenced pilot during July 2024 and reporting commenced. Safe2Share is a digital platform where service users, carers and families can give feedback on their care and experiences. Safe2Share works in real-time, sharing the results with services and commissioners.
  Safe2Share was initially piloted with children and young people in inpatient areas across a range of Trusts, now it is being developed for adults and the Trust had been selected to receive funding from NHS England to develop and pilot Safe2Share for our acute wards and forensic services.

  A new project lead was recruited in November 2024, and the project started to look at themes and patterns in feedback whilst also identifying barriers in collecting service user feedback.

- It is recognised that the objectives set for year one have not been fully realised. A six-month feedback improvement plan is in place to ensure these objectives are met by July 2025.

2.5 Monitoring progress

Quality and performance are 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 our monthly 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 and the implementation of the quality strategy 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.

2.6 Quality Governance Arrangements

2.6.1 Strategy

During the latter half of this year, we began considering what our future strategy needs to look like. We held lots of forums and workshops to engage as many staff, service users, experts by experience, volunteers and members as we could. We will continue to review and refresh our Trust Strategy as we move into 2025/26.

Our quality strategy (2022-2026) is one of the enabling strategies that sits alongside our overarching Clinical and Social Care Strategy, enabling the implementation.

Currently, it defines the principle to be 'The Best We Can Be', leading person-centered health and social care across Sheffield and supporting delivery of the Integrated Care System mental health and learning disability priorities. We are committed to ensuring that high standards of quality and patient care are delivered for our service users, whether they be resident within local Trust inpatient areas or placed out of area with external providers.

In line with the overarching strategy refresh, work on our quality strategy will commence during 2025/26 to ensure it remains aligned to the overarching strategy. This strategy review will provide clarity for partners, staff and the public and to ensure we focus on the areas that will have the most impact and improve service user and staff experience.

Our governing committees retain oversight of strategy development and progress and have received regular progress reports on all strategies that underpin the delivery of our Clinical and Social Care Strategy.

2.6.2 Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) became operational in November 2023, and we have continued to embed it in 2024/25. The Trust's PSIRF plan sets out how we will develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRF enables us to choose which incidents we prioritise for a full investigation (there are some mandated examples), and which we will respond to differently – for example, by conducting a multidisciplinary review involving gathering teams around the table to discuss learning from an incident, or a facilitated debrief with individual teams. The purpose of these types of learning responses is to collaborate with key frontline teams to understand the barriers they experience in providing care and to empower teams to take local action to resolve these. PSIRF also encourages the voice of the patient, family and carers within these learning responses.

When we developed our PSIRF implementation plan, our Patient Safety Specialist, along with clinical staff and people with lived experience called "Patient Safety Partners", reviewed data from a number of years to identify which areas we needed to focus on to make the biggest impact in improving the quality of care. During 2024/25, we have reviewed and refreshed our implementation plan (PSIRP) to enable us to focus in on the top priority areas. This revised version of our implementation plan has been approved internally through our governance systems and has been shared with the Sheffield Integrated Care Board.

We declared our first Patient Safety Incident Investigation under the new framework at the end of the last financial year and have declared a further three this year. We are working on the learning that these processes have provided.

Our internal auditors are helping us to strengthen our arrangements in this area, which we will build into our PSIRF developments going forward. We have also worked alongside our commissioners to ensure our PSIRF and our PSIRP are focused on the priority areas for the trust. You can read more about these priorities on page 50.

We have continued to develop our quarterly learning reports, which are shared widely through our learning hub and pull together themes from incidents, complaints, safeguarding concerns, service user and family feedback and our regulators to ensure that we understand what our quality priorities are and take the necessary steps to enhance these.

2.6.3 Capability and Culture

We continue to strengthen the learning that we gather through a range of incident review and feedback mechanisms and where possible triangulate finding to provide us with better assurance and understanding about risks. Our Quarterly Learning Report and learning hub 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 will continue to develop and embed a culture of learning into action.

In 2025/26, we will be strengthening how we share and effectively disseminate learning from incidents through the development of a new learning into practice group. We will report more about this in our next annual report.

We have a range of regular visiting programmes within the Trust 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. More information about these can be found at section 2.6.5,

2.6.4 Processes and Structures

The Board ensures a robust approach to quality governance through the Quality Committee which is a subcommittee of the Board. The Quality Committee is chaired by a Non-Executive Director. It meets 11 times a year and its purpose is to oversee and ensure:

- ✓ the effective delivery of safe care at all times;
- ✓ timely access to effective care;
- ✓ positive experience and outcomes for service users and carers;
- ✓ effective quality assurance and improvement underpins all we do.

The Committee provides assurance to the Board on the probity of the Trust and supports the other Board Committees in the achievement of clinical effectiveness and safe outcomes for service users, maintaining positive service user and carer experience and equality and inclusion.

Both clinical directorates have established clinical governance structures which report through the corporate governance structures to Board.

Our daily safety huddle reviews every incident reported through Ulysses (our risk management system). This helps us to identify themes and to take appropriate action when things go wrong. The huddle is attended by clinical and corporate staff including representatives from safeguarding, physical health, infection prevention and control and health and safety, together with our patient safety partners. Any incidents of concern are escalated to the Executive Director of Nursing, Professions and Quality, together with our Head of Nursing. The level of learning response we require, following an incident, is determined by our Patient Safety Overview Panel, which meets weekly. This panel provides the oversight for our investigation and learning processes and assurance regarding the quality of our learning and how effectively this learning is shared across the organisation (and wider where appropriate).

This learning is included in a quarterly learning report that is presented to our Clinical Quality and Safety Group, which meets on a monthly basis. This group reports into the Quality Assurance Committee, which is a formal sub-committee of the Board of Directors.

During 2024/25 we commissioned the Good Governance Improvement organisation to carry out an in-depth review of our approach to quality governance. We continue to work with them and will incorporate their findings into our governance systems as we move forwards into 2025/26.

2.6.5 Measurement

Audit
Throughout 2024/25 we have continued to strengthen our approach to audit and assurance of some of the key standards of care we deliver. across all of our bed-based services, including our older adult 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 introducing these audits, 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 audits were completed through the use of Tendable (a quality inspection and reporting tool for healthcare), however the use of Tendable functionality had not been optimised in the way that was expected when the system was implemented. Following further consideration, we will be using the audit platform of our existing risk management system (Ulysses) to carry out our quality audits. We have embarked upon the implementation of this new audit platform and anticipate this being introduced in our community services in the summer of 2025.

Fundamental Standards of Care (FSC) Visits
Initially introduced in October 2021 in response to the Section 29A warning notice issued by the CQC, the methodology and approach has been reviewed and refined following the completion of each programme of visits based on learning and feedback from participants, staff and service users.

The visits, undertaken by a team of staff across all disciplines, are designed to measure the extent to which the standards of care set out within key Trust policies are delivered in our bed-based settings. An extensive assessment tool, which incorporates the previous '15 steps challenge' element, is used to record the findings of the visits. Individual areas develop their own improvement plans, on the back of the assessment tool and the learning and recommendations from the visits are shared with relevant oversight committees.

During 2024/25 additional monitoring visits have occurred to ensure embeddedness of good practice. Key highlights from our 2024/25 visits included:

- All areas visited scored above average (confident) on the 15-step challenge. These questions look at things like the environment, how welcoming the areas being visited were and whether important information about safety etc was provided.
- All areas held a formal Daily Safety Huddle that included multidisciplinary membership.
- Feedback received from patients/residents indicated that their concerns were listened to and that their needs were being met. The step-down unit at Beech, Stanage Ward and Forest Close were areas that were given particularly high praise by people using their services.
- The relatives and carers interviewed as part of the visits praised the staff and services for the care their loved ones were receiving. Our two nursing homes (Woodland View and Birch Avenue), Stanage Ward, G1 and Dovedale Ward received the highest praised from families during the visits.

There were a number of areas for improvement identified during the visits, including

- The overall standard of documentation within the Electronic Patient Record was found to be 'acceptable'. There were areas of extremely good practice in this area (Forest Close and Stanage Ward), however, in other areas improvements were needed to take this element to 'outstanding'. This work is already underway.
- The majority of services fell short of meeting their mandatory training compliance requirements, this was particularly around 'face to face' training attendance. This is monitored through our Integrated Performance and Quality report monthly, overseen by the People Committee.
- Environmental refurbishments were required in some areas (Dovedale ward, Woodland View Nursing Home and Forest Close in particular). Other areas had refurbishments underway, or planned, at the time of the visits.
- A small number of areas were identified as needing to provide more meaningful and regular activity for service users/residents (Dovedale 2 ward and Birch Avenue in particular).

In summary, the FSC visits highlighted lots of positive initiatives, showing high-quality patient/resident focused care and treatment with plenty of collaborative narrative from services users, relative and carers. The areas highlighted for improvement will continue as we move into 2025/26.

Board Visits
Board visits support Non-Executive and Executive Directors to visit services and to hear the views and experiences of staff and, more recently, service users. The principles in place for the visits are to:

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

During 2024/25, 35 board visits were undertaken. We have continued to review our approach to these visits and have, this year, introduced the opportunity for teams to share with Board members the areas they felt visitors to the service should be curious about, in order to provide additional insights. Teams now also actively look for ways Board members can speak directly with the people who use their services. Corporate teams were also added to the visits schedule for 2024/25.

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. Culture and Quality visits are based on a set of quality standard metrics related to the standards set out by the CQC which also give opportunities to highlight the positive work taking place within the organisation to improve staff wellbeing.

A smaller number of Culture and Quality visits than planned were completed in 2024, in part due to a temporary vacancy in the Care Standards Officer role but also because Culture and Quality visit are suspended to allow for the completion of the Fundamental Standards Visits. The Culture and Quality visit programme recommences in April 2025. In total 8 Culture and Quality visits took place in 2024. Key themes and areas for celebration, improvement and action are shared with the teams post visit through their local governance arrangements. There are 15 services yet to be visited since the programme recommenced.

The Culture and Quality visits did not find any evidence of closed cultures, however there was evidence of a need for improvements in communication to patients and their family in the Sheffield Eating Disorder Service and an improvement plan is underway in this area.

There was clear evidence of extremely good quality and cultures in the majority of the services visited and this was highlighted in the Gender Identity service where the visit was completed with people who had used or were actively using the service. They showed improved standards and improved communication with people waiting for their service. There was clear evidence of regular team meetings including team allocation, MDT and governance meetings.

The Assertive Outreach Team's morale and culture were good. We saw evidence of this in staff feedback, the general ethos of the team in terms of valuing and respecting the views from all staff disciplines and in the team's approach to supporting one another and service users. There is a low staff turnover and high regard for staff wellbeing, with good systems in place for supervision and ensuring staff safety. There was clear evidence of regular team meetings including huddles/team allocation, MDT and governance meetings with shared decision making around care and treatment of service users. In terms of improvements the team are considering how to further the physical health monitoring and care offered to service users and considering ways to increase co-production in service development.

The Community Enhanced Recovery Team (CERT) Staff on the whole stated that they "love the team" and find it "supportive", "compassionate" and "proactive". The Leadership Team were described as supportive and encouraging with reflective practice and time to decompress being encouraged and welcomed. In terms of improvements the team are working as a whole on developing a more holistic approach to delivering the service, linked to closer collaboration with service users. They are considering meeting attendance, governance and structure: Some staff were unsure if they were 'allowed' to attend certain meetings or which meetings they should attend. If staff miss meetings there is no process to ensure that information is shared. They are also planning to review their webpage on intranet/internet to ensure reflects the service as it currently is.

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.

All operational services have a consistent and established integrated performance and quality review framework that ensures day-to-day performance is reviewed.

2.7 Freedom to Speak Up

The Trust is committed to fostering a culture whereby speaking up is a normal part of everyday work. All staff should feel safe to raise concerns within their teams, knowing they will be listened to and supported.

From day one, a culture whereby speaking up is valued and encouraged is actively promoted. New starters are introduced to the importance of speaking up during their corporate induction, which is routinely delivered by the Chief Executive. This is followed by a dedicated session with the Freedom to Speak Up (FTSU) Guardian, reinforcing the Trust's commitment to openness, the various ways staff can raise concerns, and how they can contribute to strengthening the speaking-up culture. In line with the FTSU Ambition and Strategy, the FTSU Champion network is being expanded to provide staff with a wider choice of who they can speak to when seeking advice on raising concerns.

Ongoing efforts focus on understanding and reducing barriers to speaking up. The FTSU Guardian has delivered presentations addressing discrimination and providing practical approaches to identifying, addressing, and resolving concerns. Introductory sessions for new managers are offered as part of a rolling programme to help them understand their responsibilities in fostering strong speaking-up cultures within their teams. These sessions also focus on identifying and removing barriers that may prevent staff from speaking up.

The FTSU Guardian continues to work closely with senior leaders to raise concerns, enhance learning, and explore ways to further strengthen the speaking-up culture across the organisation. 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/boarddirectors/meeting-minutes-and-agendas

Our Chief Executive holds 'a conversation with the Chief Executive' sessions where staff are encouraged to speak up and share any concerns (and improvement suggestions/good practice). Executive Directors also visit sites/teams regularly to provide staff with further opportunities to raise concerns. Our chair and Chief Executive hold regular sessions with our staff network groups, to provide further opportunities for staff to speak up.

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

2.8 Review of health services

During 2024/25 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 2024/25 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.

2.9 National clinical audits and national confidential enquiries

During 2024/25, 8 national clinical audits and 3 national confidential enquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that Sheffield Health and Social Care NHS Foundation Trust was eligible to participate in during 2024/25 are as follows:

- National Clinical Audit of Psychosis (NCAP)
- National Audit of Dementia – spotlight on Memory Services
- National Audit of Inpatient Falls (NAIF)
- National Audit of Care at the End of Life (NACEL)
- National Audit of Eating Disorders (NAED)
- Prescribing Observatory for Mental Health (POMH-UK): Topic 21b: Use of melatonin
- Prescribing Observatory for Mental Health (POMH-UK): Topic 24a: Opioid medications in mental health services
- Prescribing Observatory for Mental Health (POMH-UK): Topic 18c: Use of clozapine
- The National Confidential Inquiry into Suicide and Safety in Mental Health

The national clinical audits and national confidential enquiries that Sheffield Health and Social Care NHS Foundation Trust participated in during 2024/25 are as follows:

- National Clinical Audit of Psychosis (NCAP)

- National Audit of Dementia – spotlight on Memory Services
- National Audit of Inpatient Falls (NAIF)
- National Audit of Care at the End of Life (NACEL)
- National Audit of Eating Disorders (NAED)
- Prescribing Observatory for Mental Health (POMH-UK): Topic 21b: Use of melatonin
- Prescribing Observatory for Mental Health (POMH-UK): Topic 24a: Opioid medications in mental health services
- Prescribing Observatory for Mental Health (POMH-UK): Topic 18c: Use of clozapine
- The National Confidential Inquiry into Suicide and Safety in Mental Health

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 2024/25, 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 Clinical Audit of Psychosis (NCAP)	No data submission requested in 2024/25
National Audit of Dementia – spotlight on Memory Services	No data submission requested in 2024/25
National Audit of Inpatient Falls (NAIF)	No cases requested (Organisational surveys only)
National Audit of Care at the End of Life (NACEL)	No eligible cases in 2024/25
National Audit of Eating Disorders (NAED)	No cases requested (Organisational surveys only)
Prescribing Observatory for Mental Health (POMH-UK): Topic 21b: Use of melatonin	100%
Prescribing Observatory for Mental Health (POMH-UK): Topic 24a: Opioid medications in mental health services	100%
Prescribing Observatory for Mental Health (POMH-UK): Topic 18c: Use of clozapine	100%
The National Confidential Inquiry into Suicide and Safety in Mental Health	100%

2.10 Participation in clinical research

The Trust is one of only four mental health Trusts with University Hospital Association membership, reflecting our commitment to research development, teaching and partnership working. We are funded through the National Institute of Health Research (NIHR) to support delivery of clinical trials and other high-quality research. To date (20/03/25) the number of staff or service users that participated in research on the NIHR portfolio in 2024/25 was 218.

The research we concentrate on emphasises working with partners, focussing on outcomes and addressing inequalities. Therefore, these figures reflect the nature of our research portfolio with studies being interventional and more complex in nature (rather than larger surveys/questionnaires). Interventional studies allow us to participate in new treatments that wouldn't ordinarily be provided through usual care and provide opportunities for staff development and training through delivery of new interventions.

Examples of this include - Supporting Physical Activity through Co-production in people with Severe Mental Illness (SPACES study) this is a NIHR Programme Grant for Applied Research to co-produce an intervention to address the inequalities in physical health affecting people with severe mental illness. Working with Greater Manchester Mental Health FT, the BART II trial has enabled the Trust staff to support an investigation into the efficacy of and deliver an intervention for young people who are at higher risk of developing bipolar disorder. While the Fresh Start study examined psychological interventions for people who self-harm. Our liaison psychiatry team has now incorporated learning from the Fresh Start study into clinical practice.

We also are delivering a growing portfolio of Life Sciences (commercial) research including: A Phase III, multicentre, randomised, double-blind, controlled study to investigate the efficacy, safety, and tolerability COMP360 psylocibin treatment for treatment-resistant depression. The Trust has been awarded funding to open a new Mood Disorders Research Clinic as part of the NIHR Mental Health Mission (to start in 2025/26).

The Trust are in the top 16% of all Trusts in England for NIHR Research Capability Funding (RCF) in 2024/25 and in the top six mental health Trusts. We have re-invested over £200k of RCF for the development of new research resulting in growth of over 300% in RCF income in the past three years. We have done this through partnership working across organisations and sectors, and by involving people with lived experienced at the heart of the research we develop. Service users who take part in research are asked for feedback on their experience of being involved. 87% of those asked would like to take part in research again and 91% found it a valuable experience.

We held our third 'Research and Evidence Showcase' in March 2025 which aligns with our Research, Innovation and Effectiveness strategy. The event showcased research and evaluation projects being led by or in collaboration with the Trust. There were 153 registered to attend including Trust staff, service users, governors and external partners.

2.11 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. however, NHS England confirmed its proposal to pause

the nationally mandated CQUIN quality incentive scheme. The current payment system governing payments to NHS providers was set for two years originally but extended for another year – covering 2023/24, 2024/25 and 2025/26.

2.12 Registration with the Care Quality Commission (CQC)

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

The Trust has the following conditions on registration:

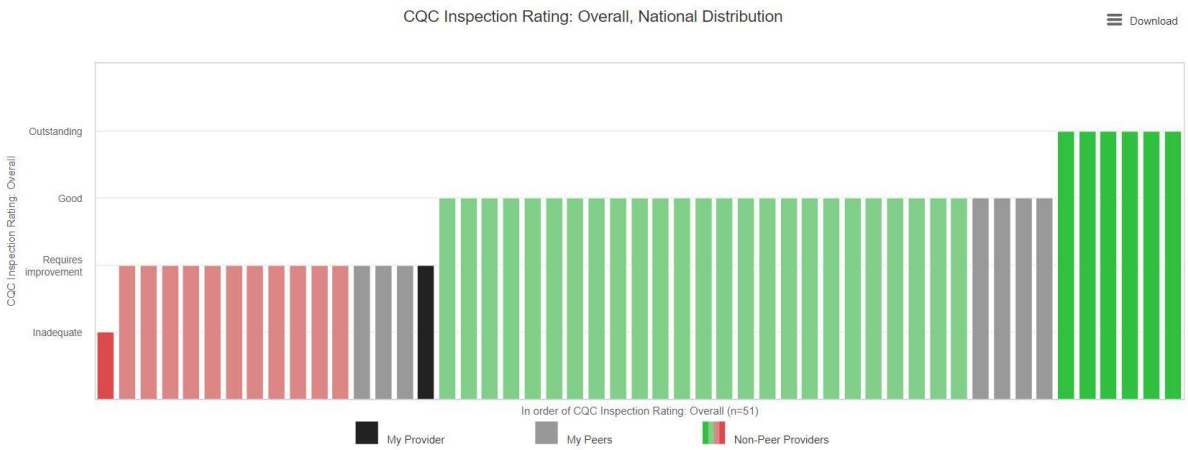
- The registered provider must only accommodate a maximum of 30 service users at Woodland View.
- The registered provider must only accommodate a maximum of 10 service users at Beech.

We have made some changes to our registration during 2024/25 including removal of the Assessment and Treatment Service (ATS) at Firshill Rise. CQC are currently working to remove reference to this from our ratings profile. Other changes made were due to the relocation of some of our community-based services and a change to the Nominated Individual.

As we have not had a recent CQC inspection the overall CQC rating for Sheffield Health and Social Care NHS Foundation Trust 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 2024/25, Sheffield Health and Social Care NHS Foundation Trust received 54 enquiries from the CQC (compared to 42 in 2023/24), in relation to the services we provide, all of which have been responded to.

2.13 CQC Mental Health Act Monitoring Visits

During the 2024/25 reporting period, the Care Quality Commission (CQC) conducted 5 routine, unannounced visits to Trust in-patient areas. The purpose of these visits is to specifically review compliance with mental health legislation. Services visited were Dovedale 1 ward, Forest Lodge, Maple ward, Endcliffe ward and Burbage ward.

A range of positive feedback was provided to the Trust following these visits, including patients reported feeling they were being looked after well, carers said staff kept them up-to-date and engaged them in their relative's care. Other patients described staff as being friendly and supportive and that they felt safe on their ward. Carers reported that the care provided to their relative was good, staff were supportive and that they felt listened to by staff. Some carers fed back that staff were flexible, where possible, in respect of visits.

The visits also identified some gaps in practice, which we are working to address. Namely, patients not being fully involved in the creation and review of their care plans, insufficient recording, high use of bank/agency staff and occasions when medication had been given when it had not been certified to be given.

During one visit, the CQC raised a concern regarding the possibility that mental capacity legislation was not being followed in one case. Additional assurance was sought and provided, which the CQC was satisfied with.

Where gaps have been identified through these visits, action plans have been developed and submitted to the CQC in accordance with their stipulated timescales.

The Mental Health Legislation Operational Group oversees this area of work, reporting into the Mental Health Legislation Committee.

Findings from the Care Quality Commission (CQC) inspections and reviews

The CQC published findings from inspections of mental health services and reviews they carried out nationally throughout the year. Whilst the Trust has not participated in any special reviews or investigations by the CQC during the reporting period 2024/25, we have considered the CQC's feedback and focus in other organisations to ensure our quality priorities align and to enable fundamental standards to be consistently met.

Commissioning priorities for service developments

The Long-Term Plan aims to create a more comprehensive service system – particularly for those seeking help in crisis – with a single point of access for adults

and children and 24/7 support with appropriate responses across NHS 111, ambulance and A&E services. It also highlights the need for capital investment, to ensure suitable therapeutic environments for inpatients.

Commissioning priorities have historically been defined through the agreed Commissioning for Quality and Innovation (CQUIN) programmes. These were recommenced in April 2022, following the COVID-19 pandemic. More information on these and our achievements against these can be seen on page 39.

2.14 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 2023/24 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 December 2024.

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 2022/23	Data quality 2023/24	Data quality 2024/25	National average
NHS Number	100%	100%	100%	81.3%
Date of birth	100%	100%	100%	92.3%
Gender	100%	100%	99.9%	66.6%
Ethnicity	100%	100%	60.3%	78.1%
Postcode	100%	100%	99.5%	90.9%
GP code	100%	100%	100%	86.1%
Overall Score	94.2%	92.2%	89.1%	75.1%

The DQMI includes other indicators in addition to those listed above.
Source: NHS Digital, Digital Quality Maturity Index.

Performance and quality reporting

The Integrated Performance and Quality Report (IPQR) is received by our board and three of our board committees when they meet to provide assurance. It is also published on our website. The IPQR is produced every month as part of the Trust Performance Framework. It provides assurance on key performance and quality indicators and to ensure we are always improving the mental, physical and social wellbeing of the people in our communities as effectively as possible.

2.15 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 by the Audit Commission during 2024/25.

Trust commissioned a clinical coding audit in April 2024 which found that coding for primary and secondary diagnoses both achieved “Standards Met”, and that the clinical coder also met the required training standard.

2.16 Doctors in training

As part of the Doctors and Dentists in Training Terms and Conditions of Service (England) 2016, the Trust 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.

The Trust calls upon internal and external (agency) locums to cover gaps in our rota. Gaps are caused by various issues such as long-term and short-term sickness, pregnancy and parental leave, Occupational Health recommendations and LTFT arrangements. 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 2024	68	36
July, August, Sept 2024	93	60
Oct, Nov, Dec 2024	88	39
Jan, Feb, March 2025	86	44

On occasion, we have required Staff, Associate Specialist and Specialty Doctors (SAS doctors) and consultants to act down to ensure the city-wide out of hours service is properly staffed.

The Trust 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 Zoe Kwan, will continually work with trainees to ensure they are working safely and within limits.

Part two (c): Reporting against core indicators

The Trust considers that the data provided earlier within this report and below is as described for the following reasons. External auditors have, 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		
		2022/23	2023/24	2024/25
 **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	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.		
 **72 Hour follow up** (New standard from 2020/21)	80% (Target set for 2020/21)	80%	86% ↑	81% ↓
Everyone admitted to hospital is assessed and considered for home treatment.	95% of admissions to be gate-kept	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.		
 **Emergency Re-admissions** Percentage of service users discharged from acute inpatient wards who are admitted within 28 days.	5% National benchmark (2019/20) 7% Average	4.79%	4.3% ↓	3.1% ↓

Community Mental Health Services Experience:		2022 Survey	2023 Survey	2024 Survey
Q. Service users' overall experience of using NHS mental health services	Our score	6.8/10	**6.9/10** ↑	**6.9/10** ↑
National Average		6.7/10	6.7/10	6.5/10
Best performing		7.8/10	7.7/10	7.7/10
Lowest performing		6.1/10	5.9/10	5.5/10
Q. Were you given enough time to discuss your needs and treatment?	Our score	6.9/10	**6.9/10**→	**7.5/10** ↑
National Average		6.8/10	6.8/10	6.7/10
Best performing		7.9/10	7.6/10	7.6/10
Lowest performing		6.3/10	6.3/10	6.0/10
Q. Did the person or people you saw understand how your mental health needs affect other areas of your life?	Our score	6.8/10	**6.7/10** ↓	**6.9/10** ↑
National Average		6.8/10	6.4/10	6.4/10
Best performing		7.6/10	7.3/10	7.4/10
Lowest performing		5.9/10	5.7/10	5.6/10
Q. Did the person or people you saw appear to be aware of your treatment history? (From the 2023 survey this question was replaced with: Did you have to repeat your mental health history with your mental health team?)	Our score	6.8/10	**4.7/10** ↓	**5.0/10** ↑
National Average		6.9/10	4.6/10	4.4/10
Best performing		7.8/10	5.4/10	5.5/10
Lowest performing		5.8/10	3.9/10	3.4/10

Patient safety incidents		**2022/23**	**2023/24**	
Number of patient safety incidents reported to NRLS (note one)	N/A (Note 2)	xx (Note 2)	xx (Note 2)	National percentage of patient safety incidents resulting in severe harm or death is 0.75%
Rate of patient safety incidents per 1,000 bed days	N/A (Note 2)	xx (Note 2)	xx (Note 2)	
Number of patient safety incidents resulting in severe harm or death	N/A (Note 2)	xx (Note 2)	xx (Note 2)	
Percentage of patient safety incidents resulting in severe harm or death	N/A (Note 2)	xx (Note 2)	xx (Note 2)	

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

Note 2: The NRLS is the former National Reporting Learning System, a comprehensive database set up by the former National Patient Safety Agency that captures patient safety information. The NRLS has been replaced by the Learn from patient safety events (LFPSE), however, annual data is not yet available through this system.

Part three: Other quality information

3.1 Safety indicators – Learning from Incidents

During 2024/25, the top four patient safety incident categories reported were disruptive/distressed behaviour, self-harm, moving and handling (restraint) and slips/trips and falls. As restrictive practices is one of our quality objectives, restraint has already been covered in this report, below highlights our other three top reporting incident categories.

Abuse Incidents
The Trust takes disruptive, distressed behaviour extremely seriously and encourages our staff to report all occurrences. Within the Trust there is an ongoing theme of 'low' or 'no harm' incidents related to abuse 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 94% of all abuse reported incidents within the Trust during 2024/25 resulted in 'no' or 'low' harm.

Our abuse incidents for 2024/25 and the previous two years are summarised in the table below. It should be noted that national data is not currently available due to the ceasing of the National Learning Response System and the introduction of the Learning from Patient Safety Events portal (LFPSE). We have therefore provided only internal data where national data is not available.

Proportion of incidents due to abuse	Number of incidents reported	Our incidents as a percentage of all our incidents	National incidents as a percentage of all incidents
Apr 22 to Mar 23	604	9.4%	Not available
Apr 23 to Mar 24	771	10.8%	Not available
Apr 24 to Mar 25	745	8.6%	Not available

Source: National Reporting Learning System (NRLS) and internal data recorded on Ulysses Risk Management System

We continue to work on improving our therapeutic environments and understand the triggers that cause these types of incidents. In addition, the violence and aggression and the sexual safety workstreams have been reviewed and a comprehensive action plan has been developed, including policy reviews, strengthening of risk assessments to safeguard staff and revised risk assessments. The zero tolerance policy is also being embedded in every level of service.

Below is one example of this work.…

Spotlight on Stanage Ward
An external review was undertaken on Stanage Ward (previously Burbage Ward) by Dr Brodie Paterson, following a small number of serious incidents taking place.

The ward team has been following up the recommendations from the review and have adopted the Broset Tool which enables staff to identify imminent violent behaviour by responses to a few questions. The result of implementing this tool has been significant. Stanage has shared their great work on the national patient safety NHSE website and this year won a Trust SHINE award for compassionate care.

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. A thematic review of all self-harm incidents in a 12-month period has taken place in 2024/25 and, from this, a Trustwide improvement plan has been created to meet the key recommendations, including focused work for the female service users who 81% of incidents this year are attributed to. Part of this includes work to improve collaborative planning and use of de-escalation techniques and de-escalation spaces, and support and upskill staff to respond to self-harm.

The Trust has historically been below national averages for this type of incident reporting. National data is not currently available due to the ceasing of the National Learning Response System and the introduction of the Learning from Patient Safety Events portal (LFPSE). We have therefore provided only internal data where national data is not available.

Our self-harm incidents for 2024/25 and the previous two years are summarised in the table below, we are seeing an increase in self-harm incidents each year, with an increase of 3.8% in 2024/25 compared to 2023/2024

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 22 to Mar 23	709	5.1%	Not available
Apr 23 to Mar 24	716	4.9%	Not available
Apr 24 to Mar 25	743	8.6%	Not available

Source: National Reporting Learning System (NRLS) and internal data recorded on Ulysses Risk Management System

Our IPQR reports show that self-harm, in the form of headbanging incidents have increased during 2024/25. Every headbanging incident is reviewed by the physical health team to ensure that a headbanging care plan is in place for the service user and that staff are mitigating the possibility of injuries occurring.

We have continued to develop a framework for embedding trauma-informed clinical practice in local clinical teams through trauma-informed training and outcomes/ evaluation through a staff and service user questionnaire.

Slips, Trips and Falls

Preventing service users from falling within our care and reducing the impact of falls when they do occur, is a key priority for the Trust. Service users' mobility is

assessed when on admission to our inpatient and residential settings, we consider footwear options, assistive technology and meaningful engagement levels in order to reduce the potential of falling. However, even with this, some service users do fall, with the highest number of reported falls being by our two older people's nursing homes.

Our slips, trips and falls incidents for 2024/25 and 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 22 to Mar 23	723	5.2%	N/A
Apr 23 to Mar 24	595	4.1%	N/A
Apr 24 to Mar 25	508	5.8%	N/A

Source: National Reporting Learning System (NRLS) and internal data recorded on Ulysses Risk Management System

Lessons Learned

Learning from patient safety incidents highlights that there is a continued need for focus on improving communication with patients and their families, between the Trust teams and with external partner agencies.

Investigations showed that work to improve our Detailed Risk Assessment and Management plan (DRAM) is necessary to ensure it is fit for purpose. This work has already begun and forms part of our transition to a new electronic patient record system. Extensive work is also underway to improve the experience of patients waiting for services and for patients being cared for out of the city.

It is essential that the Trust has robust management plans in place and immediate risk reduction and improvement plans to address the issues in the medium term. We have clear evidence of learning that indicates where these situations continue (increased levels of self-harm, falls and sexual safety issues) that the morale of staff is impacted, and cultural norms, values and behaviour can also be impacted leading to an increased risk to the safety of patients. It is pleasing to see evidence that Quality Improvement continues to have a positive impact on learning across teams. We need to continue to work on improving plans and developing quality improvement projects to fully demonstrate robust improvement for patient safety and experience.

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.

During 2024/5, 395 Sheffield Health and Social Care NHS Foundation Trust patients died. Of the total number of deaths, 69% were deemed to be from natural causes. This comprised the following number of deaths occurred in each quarter of that reporting period:

99 in the first quarter
94 in the second quarter
105 in the third quarter
79 (needs updating for year end) in the fourth quarter

Four patient safety incident investigations (PSIIs) have been declared since the commencement of PSIRF (one in quarter four of 2023/24, three during 2024/25). Only two out of the four PSIIs relate to deaths that have occurred. The additional two relate to serious harm or potential harm that could have occurred, warranting sufficient concern for a full and thorough investigation.

The table below shows the number of learning responses carried out during 2024/25 for deaths occurring.

Learning Response	Quarter 1	Quarter 2	Quarter 3	Quarter 4
48hr Reports	22	10	21	15
Local Learning Reviews (LLRs)	6	4	7	6
Coordinated Learning Review (CLRs)	4	0	2	1
After Action Review (AARs)	9	2	1	2
Structured Judgement Reviews (SJRs)	3	2	2	2
Patient Safety Incident Investigations (PSIIs)	0	1	1 (not death)	1

Source: Internal data from Ulysses Risk Management System

The number of deaths in each quarter, for which a case record review or an investigation was carried out, was:
3 in the first quarter
3 in the second quarter
2 in the third quarter
3 in the fourth quarter

The majority of deaths reported by Trust staff are in relation to older people living in community settings with a diagnosis of dementia and conditions related to older age. The most common cause of death is natural causes. There continues to be learning opportunities in relation to suspected suicides in the community, linked to ongoing improvement actions for communication and documentation. Learning from Structured Judgement Reviews (case records reviews) highlights that there is good monitoring of older adults with dementia who are prescribed anti-psychotic medication. There is also a continued theme of complex comorbid physical health issues and mental health issues that require expert support across a range of professionals.

Independent Investigations into Homicides

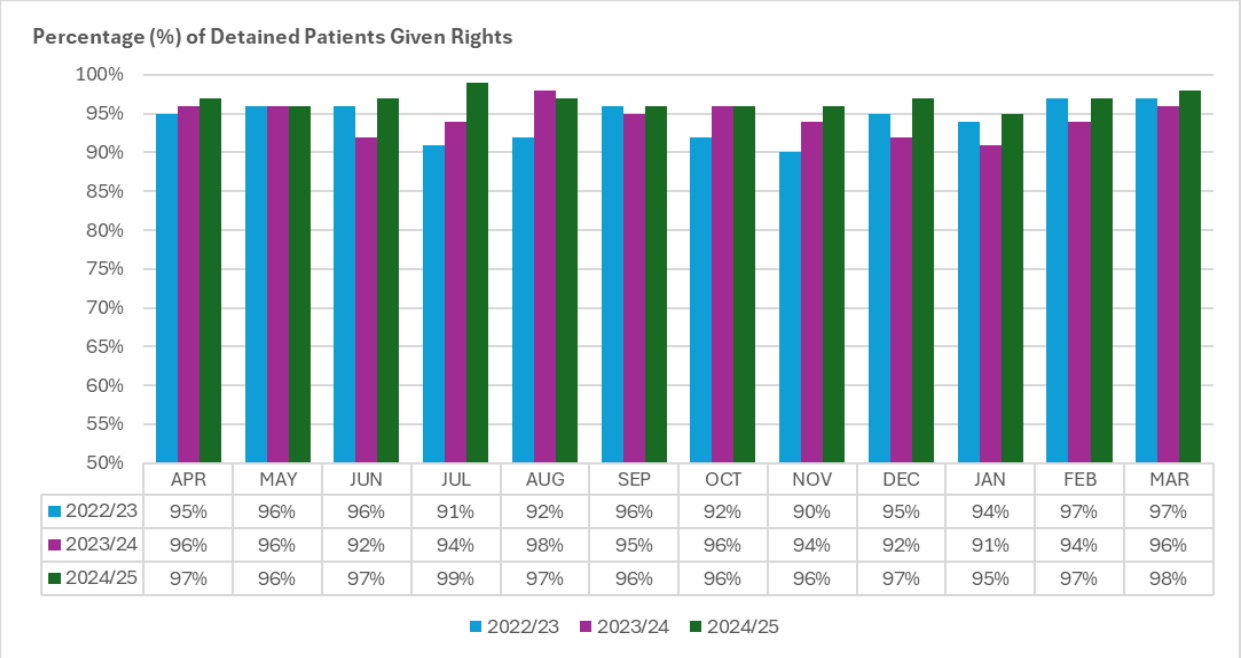
During 2023/24, NHS England commissioned two independent investigations into homicides committed by people in receipt of mental health services from the trust.

These cases are historical, dating back to 2022. This was done in accordance with relevant legislation. One investigation was concluded during the year and NHS England have published the findings on their website. The second investigation will be published during 2025/26. The Trust developed and submitted to NHS England a joint action plan to address the recommendations identified within both these investigations. Progress against the action plan is monitored through internal governance mechanisms.

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 three years. It should be noted that there is variation in performance within teams.



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2022/23	95%	96%	96%	91%	92%	96%	92%	90%	95%	94%	97%	97%
2023/24	96%	96%	92%	94%	98%	95%	96%	94%	92%	91%	94%	96%
2024/25	97%	96%	97%	99%	97%	96%	96%	96%	97%	95%	97%	98%

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

The above graph shows the Trustwide results of people's rights being read. However, it does not show the variation across teams, or across the different parts of the Mental Health Act. 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. The above data shows that we are improving in this area, with the average percentage of rights given in 2024/25 being 97% compared to 95% in 2023/204 and 94% in 2022/23.

Human Rights

In 2021, the Trust broke new ground in the NHS by becoming the first mental health trust in the UK to embed a full-time human rights professional within an NHS mental health organisation. Our Human Rights Officer (HRO) works across the Trust's directorates and professions, including (but not limited to) mental health nurses, psychologists, psychiatrists, social workers, corporate teams, and physician associates.

The role of the HRO ensures both the technical application of the Human Rights Act and the promotion of human rights as a catalyst for cultural change in service delivery. To pursue this goal, the HRO has established an extensive in-person training program for frontline staff. The centrepiece of this initiative is a practice leaders program—a three-day course designed to develop practice leaders who can champion human rights within their teams and services. As of December 2024, 58 practice leads have been trained.

From September 2022 to August 2024, approximately 500 staff members participated in 3+ hours of face-to-face training on the operation of the Human Rights Act, initially through an elective course and later via the mandatory RESPECT Level 3 update course. Between August 2024 and August 2025, approximately 1,200 staff members will receive 90+ minutes of training through the RESPECT Level 1 course.

The HRO has embedded human rights into policy documentation and review processes, including the Trust's CCTV in inpatient services policy and the Blanket Restrictions Policy. The HRO was integral to the development and delivery of the Least Restrictive Practice Strategy, 2021-2024. The HRO works with the Trusts Patient and Carer Race Equality Framework (PCREF) and is integral to the Home First strategy.

The Trust is being noted by other organisations for our work in this field. The international NGO Human Rights Watch visited the Trust in the winter of 2024 to learn from the Trust’s experience in human rights-based service delivery. A new human rights strategy will be developed in Spring 2025.

3.3 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
Sheffield Talking Therapies: waiting time to begin treatment (from IAPT minimum dataset): within six weeks of referral

Mental health services	This year's target	2022/23	2023/24	2024/25	
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%	75.5%	94.02%	91.3%	**Achieved**
Sheffield Talking Therapies (STT) a) Proportion of people completing treatment who move to recovery	50%	52%	52.41%	52.2%	**Achieved**
b) Waiting time to begin treatment					
i. Within six weeks of referral	75%	99.4%	98.75%	98.5%	**Achieved**
ii. Within 18 weeks of referral	95%	99.8%	99.84%	99.9%	**Achieved**

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 Sheffield Talking Therapy 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.

Out of Area Placements

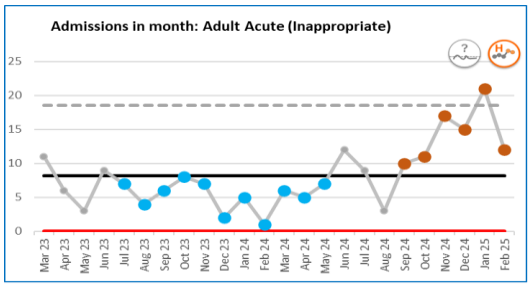
Inappropriate out-of-area placements for adult mental health services:

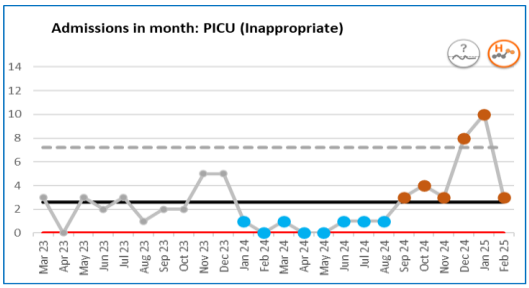
We understand the importance and need for our patients to be cared for as close to home as possible. We do our utmost to make this happen, however, sometimes we have to place people outside of Sheffield in an 'out of area placement'.

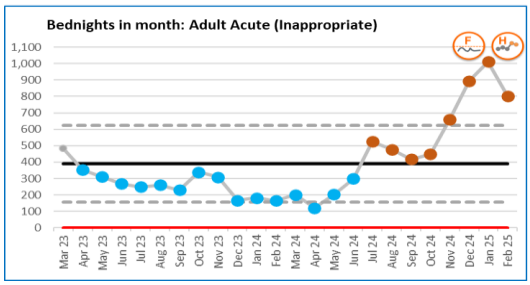
2022/23 was the first year the Trust had been required to disclose performance against this indicator, as we had previously had fewer than seven average bed nights per month. The total bed nights used in 2024/2025 are:

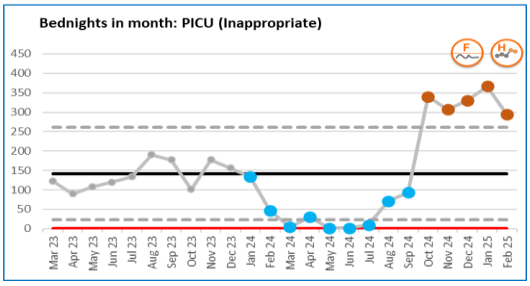
- Adult Acute: 6626
- PICU: 1216
- Older Adult: 0

The charts below reflect the admissions and bed nights occupied by Sheffield service users placed in out of area beds (i.e. outside of Sheffield). This shows a high rate of out of area placements, compared to the previous year.

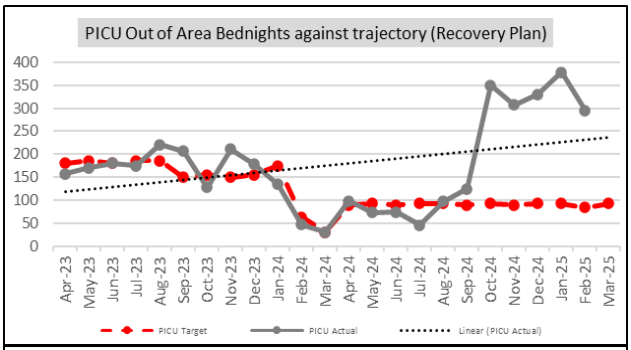


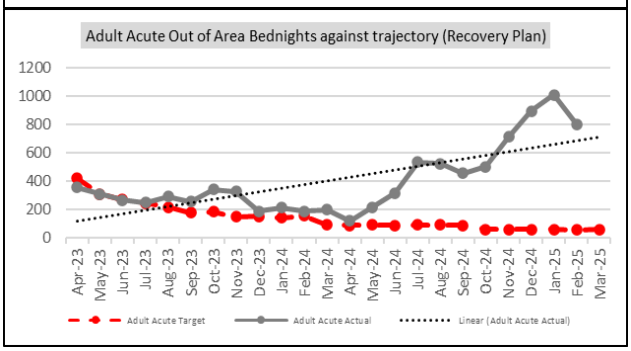






We have significantly underperformed against our previous trajectories to reduce Out of Area Hospital Placements. This is reflected in the charts to the right on bed nights against recovery plan trajectory. Our rates of admission and discharge fluctuate considerably creating pulses in demand. Our Home First Programme and insights from VOT Health have identified the capability and capacity of community and crisis services, the efficiency of hospital care (length of stay), and social care delayed discharge as key drivers.





The Home First Programme launched under a revised structure and terms of reference in February 2025 and has established a revised trajectory, which was received at Trust Board in March 2025. The Home First Programme will be central to delivering a number of interventions to support the achieving our ambition for zero out of area placements so that Sheffield patients will be treated in Sheffield. Operationally we expect performance against plan to fluctuate – this will require further modelling in line with the expected impact of the Home First programme plan and wider Trust work.

The Programme Board, workstream leads, VOT Health, and our QI team are working together on this. They are creating plans to achieve these goals and identifying wider quality, experience and productivity metrics to track progress against them. This will allow for early identification of whether a different approach or further work is required.

3.4 Experience indicators

Learning from Complaints and Compliments

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

The Trust 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. There will be 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.

We developed a new complaints training package during 2023/24 which we have continued to deliver this year. This has been positively received by staff and further improvements have been made to the training following the feedback received and to embed key priorities. The focus of the training has been on ensuring that robust complaint investigations are undertaken, that service users receive compassionate and thorough responses, and that appropriate learning is taken forward.

The complaints team has also placed considerable emphasis working with services to encourage the early resolution of any issues that arise quickly and prevent formal complaints. The table below shows the number of complaints received into the organisation over the past three years. This shows there has been a very slight decrease in year-on-year formal complaints at a time when services have been under considerable pressure.

	Year		
No. of Complaints	**2022/23**	**2023/24**	**2024/25**
	142	129	133

Source: Internal Ulysses data

The largest theme for formal complaints was access to care (22%), then communication (18%), values and behaviours (16%), and clinical care (15%).

During 2024/25, we have begun working on developing the intelligence gathered from non-formal contacts from our service users (informal concerns) to identify areas requiring improvement. We logged 172 informal concerns during 2024/25 – 45% of these related to communication issues, which highlights the importance of early resolution of those problems. 20% of the concerns logged related to service user access to care, again a key theme for the Trust.

We are currently working with the operational and directorate leadership teams to review and further strengthen complaint learning processes and action assurance mechanisms. We have also strengthened measures to evaluate our complaints processes. Both diversity monitoring forms and complaint evaluation questionnaires have been introduced, and this data will be available during 2025/26.

During 2024/25, we have begun working on developing the intelligence gathered from non-formal contacts from our service users (informal concerns) to identify areas requiring improvement. Although this work has commenced, we will continue to gather this as we move into 2025/26.

Compliments can come in many different forms, from ‘thank you’ cards, to letters and boxes of chocolates or biscuits and can be made from service users to individual staff members, to teams or from one staff member/team to another. Compliments generally involve individual staff members, or entire teams, going ‘above and beyond’ or ‘the extra mile’ in helping services users in their recovery compliments received thank the staff for ‘caring’ and ‘being fantastic’.

The table below shows the number of compliments received into the Trust over the last three years. Figures show a 16% increase in the number of compliments received from 2022/23 to 2023/24 and a 7% reduction from 2023/24 to 2024/25.

	Year		
No. of Compliments received	**2022/23**	**2023/24**	**2024/25**
	343	407	382

Source: Internal Ulysses data

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.

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%	87%
April 2023 to March 2024	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Percentage of Positive returns	95%	97%	99%	93%	98%	97%	95%	100%	96%	95%	87%	94%
National average for mental health trusts (1)	87%	87%	88%	87%	87%	87%	87%	88%	87%	86%	87%	86%
April 2024 to March 2025	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Percentage of Positive returns	98%	92%	94%	97%	92%	94%	91%	91%	96%	96%	66%	85%
National average for mental health trusts (1)	85%	88%	88%	88%	88%	88%	89%	89%	89%	89%		

Source: NHS England, Friends and family test data reports

(1) NHS England FFT results should not be used to directly compare providers, the national averages are provided for information purposes only.

The Trust continues to achieve above the national average for the percentage of service users who would recommend our services to family or friends; however, our overall response rate is low. We are working with a renewed communications campaign with a weekly internal newsletter, a slide monthly information cascade and working with our communications team to improve visibility of the FFT on the external website and working with our community partners to promote.

Community Mental Health Survey

The community mental health survey has been completed by the CQC. The 2024 Community Mental Health Survey involved 53 providers of NHS mental health services in England. People aged 16 and over were eligible for the survey if they (1) had received specialist care or treatment for a mental health condition, (2) had at least one contact between 1 April and 31 May 2024, as well as at least one other contact either before, during or after the sampling period, and (3) were not a current inpatient.

The Trust had a response rate of 21.43% which is slightly higher than the national average of 20%.

Overall, there had been improvement in 3 areas which scored ‘somewhat better’ than last year and one which scored ‘better’. In no sections were the results worse than last year.

These areas of improvement were:

- Were you given enough time to discuss your needs and treatment?
- Did you feel your NHS mental health team listened to what you had to say?
- Thinking about the last time you received therapy; did you have enough privacy to talk comfortably?

- Aside from this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?

There were several scores which remain below average, including around repetition of mental health history and signposting to other services. This feedback will be incorporated into service level plans for the next year.

3.5 Looking Forward - Our Priorities for 2025/26

This report has set out our quality objectives for 2024-2027. During the year, we have continued to refine these to ensure they remain aligned to the overall strategic direction of the organisation. We believe that making some refinements to the objectives enables us to broaden the impact of the quality objectives, thereby improving patient experience, clinical effectiveness of our services and the quality of the care we provide.

The work we started in 2024/25 regarding our dementia quality objective (Developing an organisational approach to person-centred Dementia care) will be incorporated into our Older Adults Improvement Programme as we move to align our quality objectives with our strategy refresh.

In line with our strategy refresh, our quality objectives for 2025/26 will be:

Quality Objective 1: Implement Culture of Care and Inpatient Quality Improvement Programme

Why this is important:

Implementing the NHS England Culture of Care programme within the Trust is vital for creating a compassionate, inclusive, and supportive working environment across all services. The Trust is committed to delivering high-quality, person-centred care, and the Culture of Care programme reinforces this by focusing on staff wellbeing, compassionate leadership, and a shared sense of purpose to enhancing the quality and safety of care for service users.

Priorities for this year will include:

- Evidence based pathways of care across acute mental health wards (all age functional model)
- Broadening the neurodivergence elements of this objectives into fully personalised care
- Understanding staff competence and confidence in their knowledge of working with neurodivergence, with the aim of highlighting training gaps and needs
- Further developing inclusive trauma informed care
- Ensuring we provide inclusive strength-based care
- Creation of a new risk assessment tool that has a positive impact on patient experience and improves the quality of services we provide
- Ensuring our care planning is effective and improves patient and staff experience

- Ensuring lived experience roles are implemented at all levels throughout the organisation.

Quality Objective 2: **Improve Community Risk Management through Intensive and Assertive Review**

Why this is Important:

Improving community risk management through intensive and assertive review is crucial to ensuring the safety of both service users and the wider public, particularly in light of the tragic Nottingham homicides. These events highlighted significant gaps in identifying, monitoring, and responding to escalating risks within community mental health settings. By adopting a proactive, structured, and multi-agency approach to risk assessment and intervention, services can better identify individuals at high risk of harm to self or others. Intensive and assertive reviews allow for timely escalation, improved care planning, and more effective coordination between mental health teams, social care, and the criminal justice system.

Priorities for this year will include:

- Development and implementation of a centralised learning into action plan in response to the findings from the independent reviews of homicides in Nottingham
- Implementation of the new risk assessment tool developed through the Culture of Care Programme
- Review and strengthen assertive approaches to care delivery and risk management (e.g. Assertive Outreach)

Quality Objective 3: **Continue to embed human rights into day-to-day practice and introduce an ethics panel**

Why this is Important:

A human rights approach and the establishment of an ethics panel are important priorities for the Trust as they reinforce the Trust's commitment to dignity, equality, and person-centred care. The Trust supports some of the most vulnerable people in Sheffield many of whom may be at risk of having their rights restricted due to the nature of their mental health needs or the services they access. Embedding a human rights framework ensures that care decisions are made transparently, proportionately, and with respect for individuals' autonomy and freedoms. An ethics panel provides a structured, multidisciplinary space to explore complex or morally challenging situations, supporting staff in making decisions that are not only legally compliant but also ethically sound. Together, these initiatives help build a culture of accountability, compassion, and fairness—key to maintaining the trust of our patient's and families and delivering safe, equitable services across the organisation.

Priorities for this year will include:

- Continued delivery of Human Rights Training to all patient facing staff
- Develop and implement an ethics panel.

Quality Objective 4: **Embed a person-centred approach to care planning / restrictive practices**

Why this is Important:

A person-centred approach to care planning and the use of restrictive practices is essential to ensure that care is respectful, dignified, and tailored to the unique needs and preferences of each individual. This approach places service users at the heart of decision-making, fostering collaboration and empowerment rather than control. In contexts where restrictive practices are considered—such as seclusion, physical restraint, or medication—ensuring that these interventions are used only as a last resort, and are clearly documented, reviewed, and agreed upon wherever possible with the individual, is critical. Prioritising person-centred care planning helps reduce the need for restrictions over time and supports a more compassionate, responsive, and accountable culture of care across the Trust

Priorities for this year will include:

- Develop a co-produced improvement programme aimed at improving the quality of care plans
- Continue to work with volunteers and Experts by Experience to understand the experience of patients, families and carers in care planning.
- Explore options to introduce a patient portal to increase involvement in care planning.

Quality Objective 5: **Continue to embed least restrictive practice and ensure patients from racialised communities are not overrepresented in the use of restrictive practices such as restraint and seclusion**

Why this is Important:

Continuing to embed least restrictive practice is vital to delivering equitable, compassionate, and rights-based care, particularly in addressing the disproportionate use of restrictive interventions such as restraint and seclusion on patients from racialised communities. National data consistently shows that people from racialised communities more likely to be subjected to coercive practices in mental health settings, often as a result of systemic inequalities, unconscious bias, and a lack of culturally informed care. The Trust has worked to confront and actively address these disparities by embedding the principles of least restriction into everyday practice. The Trust has worked to embed cultural advocacy workers from SACMHA and Pakistan Muslim Centre (PMC) into wards and also employs a Human Rights Officer.

Priorities for this year will include:

- Further reducing the use of seclusion towards our aspiration of zero by 2028
- Continue to focus on the management of violence and aggression with an emphasis on prevention
- Deliver cultural competence training to staff
- Continue to deliver trauma informed care training
- Develop and deliver an initiative to understand and address restrictive interventions in the community

Quality Objective 6: ***Ensure the Patient and Carer Race Equality Framework is embedded in practice by the end of 2025/26***

Embedding the Patient and Carer Race Equality Framework (PCREF) is essential in ensuring that the Trust provides inclusive, and culturally responsive care Through embedding PCREF the Trust will work in genuine partnership with patients, carers, and communities to reshape policies, workforce practices, and service delivery through an anti-racist lens. This is essential to building trust, reducing the disproportionate use of restrictive practices, and ensuring that care is safe, person-centred, and respectful of cultural identity. It also reflects the Trust's commitment to equity, transparency, and continuous improvement in the way it serves all people across Sheffield

Priorities for this year will include:

- Establishment of 3 Community Development workers
- Ensuring data is routinely collected in relation to ethnicity within clinical records.
- Membership of a task and finish group to develop a Triangle of Care (TOC) self-assessment audit tool in relation to the PCREF in collaboration with the Carers Trust and Avon and Wiltshire Mental Health Partnership NHS Trust
- Achieve 2 star Triangle of Care rating by the end of 2025/26
- Establishment of a PCREF stakeholder delivery group comprised of community leaders from racialised communities.

Measuring Success

The following will be our measures of success:

- *Culture of Care Patient experience Dashboard embedded in practice*
- *Audit of the quality of personalised risk assessments demonstrating compliance*
- *85% of clinical staff trained in human rights*
- *Every patient will have an up to date, personalised and strengths based care plan that they have had the opportunity to coproduce*
- *Continued reduction in seclusion compared with 2024/25*
- *Restrictive interventions data demonstrating that patients from racialised communities are not overrepresented in the use of restrictive practices such as restraint and seclusion.*
- *The Patient and Carer Race Equality Framework is embedded*
- *Clearly defined, evidence based pathways of care across all age functional acute wards*
- *All patients have their ethnicity recorded in the electronic patient record*
- *Evidence of reduced inequalities in PCREF data*
- *Achieve 2 star Triangle of care accreditation by the end of 2025/26*

Annexe A

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

Healthwatch Sheffield Statement

Thank you for sharing this year's quality account with us. Our response draws on patient and public views via our volunteers, and the feedback we've received about the Trust's services over the last year.

Since its last CQC inspection in May 2021, the Trust remains in 'requires improvement' but has evidenced in this Quality Account that it is working proactively to address concerns raised in the regulator's findings. We were pleased that discussion about the improvements that need to take place are now being had more publicly.

We noted a real improvement in the accessibility and tone of this report compared with previous years – along with a strong focus on the human element of care that goes beyond clinical aspects. The report displays a clear intention to listen to service users, families, and carers, and learn from both positive and negative experiences. We are pleased to see this and read several examples of the Trust incorporating involvement or co-production into its care models, with examples including involving carers in care plans (Triangle of Care), and establishing new community partnerships as part of the Patient and Carer Race Equality Framework (eg cultural advocacy workers, work on reducing restraint and seclusion). With a great deal of focus on race equity, we were slightly concerned to read the information on data quality which suggests that ethnicity recording has dropped by 40% in the last year; we would be interested to know what has happened here.

Co-production as a model for improving care, and/or adopting a person-centred approach to care, is also included as a key consideration within current quality objectives. This suggests an increased focus on patient voice, which we would welcome. It would have been good to see more examples of patient experiences when talking about listening to service users and how the Trust uses those experiences to learn - particularly when looking at neurodivergence, race and culture, and dementia – in order to understand whether (and how) these changes are felt by patients in practice. It would also be helpful to understand how co-production and involvement is threaded through transformation projects and different workstreams - and how Trust governance structures will support that.

The quality account shows overall good progress on priority objectives over the last year, with many actions completed and plans to complete outstanding actions. This is presented in a way that is easy to understand. The objectives for the year ahead do, in our opinion, reflect the priorities of patients and the public, with an emphasis on human rights, inclusion, personalised care, learning from national incidents, community feedback, and embedding lived experience to drive meaningful change. The list of key measurables at the end is particularly helpful to understand how the Trust plans to achieve this.

In the section on learning from complaints and compliments, we were pleased to read about work on the complaints procedure. This work builds on the CQC finding that there wasn't an accessible complaints policy available to the public, people didn't know how to complain, and when complaints were made the Trust did not use them to improve services. In previous years, service users have told us a lot about their experience trying to raise a complaint with the Trust - and feeling as though they were dismissed, waited too long for a response, the process wasn't accessible, or were otherwise unhappy with the experience. We are currently hearing about this less often, so will be keen to monitor whether people's experience of making a complaint does improve.

One issue we do hear about regularly, and which is important to patients, is about struggling to get a referral into the Trust's services. People face issues with eligibility criteria or experience administrative problems between their GP and the Trust. It would be worth considering this cohort when continuing your work around waiting lists, as they may not be counted in the data but experience significant delays accessing care. Collaborative work with the Integrated Care Board/primary care partners would be key to understanding this issue.

With involvement in mind, we would ask that in future years the Trust gives us a longer timescale to review this (quite lengthy) report. This would allow us to more thoroughly reflect on the feedback that service users share with us and the way it related to work that the Trust is doing.

Healthwatch Sheffield
23 May 2025

Our Response:

We welcome the feedback received from Healthwatch Sheffield and look forward to continuing to work with you in 2025/26.

Sheffield City Council Health Scrutiny Sub-committee Statement

The first draft report was provided to Sheffield City Council Health Scrutiny Sub-Committee on 5th June 2025. The following response was agreed at that meeting:

The Sub-Committee welcomed the opportunity to discuss the Trust's Quality Account and they found the discussions informative and helpful. In particular the discussion focussed on a number of issues which the Sub-Committee members sought clarification and reassurance on:

- Progress with regard to the estate and single sex provision. It was noted that there is still work to do on the estate for older people. The Trust requires the capital to carry out this work.
- Progress regarding the culture shift, person centred care and co-production
- Training provided to staff on seclusion. The Sub-Committee welcomed the significant reduction in seclusions and the system put in place to support staff in this direction of travel.
- Work with Trans communities will be influenced by recent ruling.
- Out of Area placements and the effectiveness of the "Home First" initiative. It was noted that there had been a concerning upward trend in the number of Out of Area placements during 2024/5, with the reasons for this increase not made entirely clear in the report. The Home Treatment team and their gate-keeping role had made a significant impact on this. It was also noted that the national core indicator for gate-keeping hospital admissions ("everyone admitted to hospital is assessed and considered for home treatment") was retired in 2021; the Sub-Committee was reassured to learn that the Trust continues to implement the same principles.
- Dip in Friends and Family positive responses in Feb 2025; the Sub-Committee was pleased to hear about the Trust's focus on "In the moment" feed-back after every intervention but felt that information around this was not presented entirely clearly in the report.
- It was noted that the document was very big and not particularly user friendly. It was therefore suggested that a readers panel might be asked to assess it for improvements and a reduction in its size.

The Sub-Committee members were reassured by measures being put in place by the Trust to address these issues and received verbal updates very positively.

They wished to congratulate the Trust on their progress made since last year and particularly welcomed the focus on culture shift.

The Sub-Committee looks forward to receiving further updates in the future.

Sheffield City Council Health Scrutiny Sub-Committee
6th June 2025

Our Response:

We welcome the feedback received from the Health Scrutiny sub-committee and look forward to continuing to work with you in 2025/26.

SHSC Quality Report 2024/25

Statement from NHS South Yorkshire Integrated Care Board

NHS South Yorkshire Integrated Care Board (ICB) commissions Sheffield Health and Social Care NHS Foundation Trust (Trust) to provide a range of mental health, specialist mental health and learning disability services, within which we seek to continually innovate and improve the quality of and the experience of those individuals who access them. We do this by reviewing and assessing the Trust's performance against a series of key performance and quality indicators and evaluating contractual performance via the appropriate governance forums i.e. Contract Management Group, Quality Review Group and Contract Management Board meetings. We work closely with the Care Quality Commission and NHSE, who are regulators of health (and social care) services in England.

The ICB has had the opportunity to review and comment on the information contained within this Quality Account prior to its publication and is confident that to the best of its knowledge the information supplied within this report is an accurate and a true record, reflecting the Trust's performance over the period April 2024 – March 2025.

The ICB and Trust continue to work together to address issues related to clinical quality so that standards of care are upheld.

To support long term improvements for service users, their carers and families the trust committed to six quality objectives over a three-year period from 2024 to 2027, and work to achieve these continues to be progressed. The ICB will continue to support these programmes of work and looks forward to the objectives being met in full. The new objectives are outlined below:

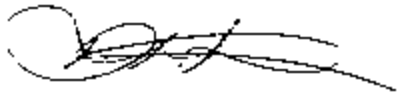
- **Quality objective one:** Implement Culture of Care and Inpatient Quality Improvement Programme
- **Quality objective two:** Improve Community Risk Management through Intensive and Assertive Review
- **Quality objective three:** Continue to embed human rights into day-to-day practice and introduce an ethics panel
- **Quality objective four:** Embed a person-centred approach to care planning / restrictive practices

- **Quality Objective five:** Continue to embed least restrictive practice and ensure patients from racialised communities are not overrepresented in the use of restrictive practices such as restraint and seclusion.

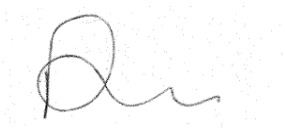
- **Quality Objective six:** Ensure the Patient and Carer Race Equality Framework is embedded in practice by the end of 2025/26.

The ICB will continue to work together with the Trust to address issues related to clinical quality so that standards of care are upheld and also to evolve services and ensure the changing needs of our local population are met and inequalities reduced.

Submitted by Dani Hydes on behalf of:



Dani Hydes
Deputy Director of Quality



Alun Windle
Deputy Chief Nurse

9 June 2025

Our Response:

We welcome the feedback received from Sheffield Integrated Care Board (ICB) and look forward to continuing to work with you in 2025/26.

Annexe B

2024/25 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.

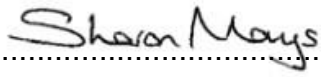
In preparing the quality account, directors are required to take steps to satisfy themselves that:

- the content of the quality account meets the requirements set out in the NHS foundation trust annual reporting manual 2024/25
- 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 2024 to March 2025
  - papers relating to quality reported to the Board over the period April 2024 to March 2025
  - feedback from commissioners dated 9 June 2025
  - feedback from governors 20 June 2024 and 25 Feb 2025
  - feedback from local Healthwatch organisation dated 23 May 2025
  - feedback from overview and scrutiny committee dated 6 June 2025
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2024
  - the national patient survey 2024
  - the national staff survey 2024
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 16 June 2025
  - CQC inspection reports
- 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:

……25 June 2025…… Date  Chair

……25 June 2025..... Date  Chief Executive