Front Sheet: Public Board of Directors
Item number: 10
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Private/ public paper:	Public
Report Title:	**Quality Assurance Report**
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Vision and values:	Working together for our service users ensures all our work is of the highest quality and that we maintain a strong commitment to quality in order to improve lives.
Purpose and key actions:	The report aims to provide an overview of the work completed relating to our quality assurance activity during Q2 2024/25 and Q3 2024/25. The Board are asked to receive the report and consider the assurance in its content.
Executive summary:	During 2024 the **Quality team had a change of leadership, and the Head of Quality Standards role was changed to Head of Clinical Quality**. The quality team have remained focused on implementing the Quality Strategy 2022-26. **Steady progress has been made in achieving the milestones set out in the strategy,** but a key component, the Quality Management System (QMS), has remained outstanding, due to the requirement for the new Electronic Patient Record system (Rio) to be fully implemented. Rio will be fully implemented in March 2024 which will enable the development of the QMS to commence in Q1 2025. The **Quality Strategy is now requiring a refresh** which will be completed by the end of Q3 2025/26. Standards of quality, culture and care visits have been affected by staffing challenges and changes in leadership, however, progress is now being made, with all visits scheduled and planned up to the end of 2025. The **launch of the physical health strategy has been delayed** due to reduced staffing numbers due to maternity leave and vacancies in the physical health team and competing priorities, however, recent cost neutral support has begun to have a positive impact on moving this work forward. **Service user and carer feedback has not been at the level expected** for an organisation of our size, however, there is now an improvement plan in place that will help increase the numbers and therefore improve quality. There have been **several positive quality improvement impacts** during this period including the development of RIO documentation, audits via Ulysess and the city-wide collaborative safety plan launch.

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	**Yes**				All of our work should support the principles of environmental sustainability and the effective use of resources.
Deliver Outstanding Care	**Yes**				In order to deliver outstanding care all of our services and all of our work with the people of Sheffield needs to be of the highest quality
Great Place to Work	**Yes**				Quality of care and quality of services ensures that those working for the Trust feel valued.
Ensuring our services are inclusive	**Yes**				Without inclusivity the highest possible level of quality is unachievable.

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
Quality Standards relate to Care Quality Commission (CQC) regulations under Health and Social Care Act, Equalities Act, Use of Force Act, Human Rights Act, the Health and Safety at Work Act and all other clinical standards such as NICE guidelines.	
BAF and corporate risk/s:	**BAF Ref: BAF.0029**: There is a risk to the quality and safety of patient care caused by 1) delays in accessing an acute hospital bed in Sheffield 2) poor care and experience from out of area hospital providers 3) delays in facilitating discharge from hospital beds. These issues affect the operational delivery of our acute, crisis and community services. *Revised time plan established. The full gate keeping brief to be met by June 2025, but an interim plan of gate keeping all AMHP assessments has been agreed subject to additional staffing to commence December 2024.* **BAF Ref: BAF.0029:** There is a risk that patient experience and quality of life maybe be negatively impacted due to longer than recommended waiting times to access highly specialist services, (ADHD and Gender Services), caused by demand exceeding commissioned capacity resulting in an impact on service user experience, staff wellbeing and reputational damage. *Deep dive from NHS E completed. Formal report expected latter part of Q4. Once received will review actions.* **BAF Ref: BAF.0013:** There is a risk that reporting systems do not support an effective response to sexual safety, racism and violence caused by the culture of reporting resulting in low staff morale, wellbeing and quality of care. *New resources have been made available through NHS England this branding needs to be incorporated in posters etc - (for staff facing not service users facing areas only) ESR portal behind schedule due to amendments to incorporate wider range of unacceptable incidents - priority to test with Staff Network groups in January.* **BAF Ref: BAF.0021A:** There is a risk that a safe electronic patient record (RIO) is not implemented and adopted by staff, caused by ineffective governance, insufficient training, poor staff engagement, and design or a lack of capacity and capability resulting in a protracted or failed governance that facilitates an unsafe or substandard implementation that puts service users at risk, an unacceptable burden on staff or significant time delays and additional costs. *Tranche two testing started Dec 9th.*
Any background papers/ items previously considered:	**Quality Assurance Report: 2023/24 Q4 & 2024/25 Q1**
Recommendation:	It is recommended that the Board of Directors: • Support the planned refresh of the Quality Strategy in line with the overall Trust Strategy • **Note** the delays to the development of the Quality Management System (QMS) due to the reliance on RIO implementation • **Note** the delay in launching the Physical Health Strategy due to resource constraints • **Note** that the various quality visits, previously delayed are now rescheduled and underway.

Quality Assurance Report: July 2025- December 2025

1. Introduction

The report aims to provide an overview of the work completed relating to our quality assurance activity during Q2 2024/25 and Q3 2024/25 including:

- Developing and Embedding a Quality Management System
- Ensuring we have robust a Quality Assurance Framework in place.
- Fundamental Standards of Care (FSoC) visits to bedded services.
- Board Visits (Executive and Non- Executive Director visits to services)
- Culture and Quality visits (Community, Rehabilitation and Specialist services)
- Development of the physical Health Strategy
- Service user and carer feedback
- Quality assurance developments in relation to patient safety

2. Summary of progress against the Quality Strategy 2022-2026

2022	Robust QI skills training programme in place offering a suite of options to ensure accessibility and suitability for all	Benchmarking data for Inpatient areas against the fundamental standards of care will be available
2023	Continuous improvement embedded in all recruitment, induction, and PDR processes	Implementation of the SHSC Quality Management System (QMS) Approach
2024	All SHSC staff will have an enhanced understanding of Patient Safety having completed an agreed syllabus and implemented the Patient Safety Incident Response Framework (PSIRF)	Completion of Culture and Quality visiting programme across the organisation
2025	Evidence of established relationships across the city of Sheffield with voluntary and third sector communities that reflects the diversity and vibrancy of lived experience and support active involvement with SHSC	Collaborative working with local, regional and national partners to share best practice, knowledge and learning regarding our integrated approach to Quality Management

Overall, steady progress has been made against Quality Strategy objectives. However, implementation of the Quality Management System has been at a slower pace than we would have liked due to the interdependencies with the RIO EPR implementation. We have progressed other elements related to the QMS, though there is overall slippage on the timescales set for this 2023 priority. The QMS implementation group had paused due to significant leadership changes during 2024 (Head of Clinical Quality and Director of Nursing, Professions and Quality). Progression under the QMS is primarily with Quality Improvement. They have some significant projects that focus on Length of Stay, ward processes and out of area placements, with the support from Real World Health for their data analytics. Under Quality Control & Assurance, we have ended our contract with Tendable and recently signed a new contract obtaining the Ulysses audit platform which will enable us to expand our audits across to community teams with additional audits. All

existing audits, previously on Tendable, since July have been reviewed, amended and optimised to improve assurance and to enable us to identify actions for improvement. More information will be detailed in a specific report on the Quality Management System implementation in February 2025 Quality Assurance Committee.

Updates regarding the objectives linked to Coproduction and Lived Experience are provided within the strategy update presented to Quality Assurance Committee therefore not repeated within this report. Continuous Improvement and Sustainability are also reported through separate mechanisms.

Our 2024 objective for the completion of the agreed level 1 patient safety syllabus has been completed with our current data showing that 97.33% of staff have completed this training. The Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Incident Response Plan (PSIRP) was fully implemented in November 2023 with associated governance structures supporting the assurance of quality. The Patient Safety Incident Response Plan (PSIRP), which outlines our patient safety aims was reviewed, refreshed and approved for publication in November 2024.

2.1 The Quality Strategy 2022-26

The Quality Strategy 2022-26 is now nearing the end of its usefulness and is ready for a full review and re-write in order to reflect the organisations vision and values. During 2025 the whole strategy will be re-written, using service user expertise and co-production principles. It is aimed that the draft will be completed for review by Quality Committee by the end of quarter 3 2024/25.

3. Fundamental Standards of Care Visits

The 2024/25 programme of visits is taking place from December 2024 to early February 2025. The original start date of October was delayed due to team management changes. Fundamental Standards of Care visits have taken place at Beech step down service, Stanage Ward, Forest Close and Dovedale 2.

The main themes for quality improvement from the visits so far have been:

- Medicines management – administration and storage in clinical rooms
- Availability of service user and carer information/leaflets
- Mandatory training below compliance target for all areas
- Access to team development time

In the main these areas for improvement are resolvable locally without the need for a formal improvement action plan, however, Mandatory training compliance is a Trust-wide issue linked to increased activity and staffing priorities. Work is being led by the training department to review the mandatory training requirements and to try and focus on solutions to this risk, including exploration of bespoke alternatives to increase compliance.

3.1 Key individual findings

Team Culture and Staff and Service User Wellbeing

In the services visited so far there has been a strong sense of team cohesion and a positive caring culture, despite the many challenges these services face. Individual staff members spoke about the positive leadership approaches they experience within their teams that foster a supportive environment, and it was

noted on one of the visits that preceptees and students were feeling well supported on the ward. The interviews with individual service users were extremely positive about the care they were receiving and about the environments they were being cared for in. Family members interviewed also praised the staff for their hard work.

On Dovedale 2 the staff voiced that they felt they were not being given enough information about the refurbishment at the Longley Centre and wanted to know an estimated date of return to this site. Despite this, the staff also gave positive feedback on their current environment. 1 service user on Dovedale 2 said that they felt extremely safe on the ward and that staff were always on hand to support them. Another service user said they felt that there should be more 'off ward' Occupational Therapy (OT) and they said that the options were sometimes limited. The 15-step challenge at the start of the visit highlighted a calm and welcoming area that was clean and tidy. The random review of electronic patient records found that some of the care plans were in need of review, however, all had indications that they had been discussed with the service user. The Detailed Risk Assessment and Management plans were overly laden with historical incidents, but they did contain current and relevant details of active risks. During the visit the staff were engaged in training around improving documentation and the risk assessment process.

On Stanage Ward there was a noted positive increase in collaborative multidisciplinary team working and this was further evidenced by improvements to care planning documentation and shared, multidisciplinary responsibility for the section 17 leave risk assessment processes. The staff interviewed on Stanage Ward praised the local leadership and said they felt well supported. It was also noted that this ward had high rates of compliance with mandatory training requirements. 1 service user praised the Occupational Therapy resource which they felt had given them the opportunity to paint and spent 'valuable time' off the ward. Another service user praised the availability of snacks and drinks outside of the main mealtimes, although they also said that the ward can be stressful when other patients are unwell and in need of intensive support. A visiting family member said her son had benefited from his stay on the ward and she spoke of the support the team were giving him to be able to successfully return to his own property.

The Beech step down service was very welcoming and extremely clean and tidy. The visiting team noted that the housekeeper was meticulous in her approach to maintaining cleanliness. The staff praised the management of the team and said there had been a smooth transition from a retiring long-term manager to a new manager. The staff did say that they felt there needed to be more community team engagement into the service and 1 member of staff said that members of the community team often visit their service users and leave without first discussing their visit with the Beech staff team. The manager of the service said that he was actively working with community teams to improve collaboration. 1 service user spoke of their journey toward independent living and said they felt well prepared to continue their recovery once they were discharged. There was evidence of community meetings and collaborative activity and meal planning.

Forest Close were found to have fully collaborative care planning that also focused on health and well-being. All of the randomly selected collaborative care plans had been reviewed and were in date with clear evidence of service user input. The Detail Risk and Management plans were exemplary with pertinent risks prominent and clearly identified. The environment requires a refresh in some of the high traffic areas, but it was clean and welcoming with evidence of regular activities and planned groups that are aimed at enhancing recovery. All 4 of the service users that were interviewed praised the service

and the commitment of the staff. In one bedroom there was found to be an ineffectual blind spot mirror, and this was immediately reported to the manager who had already reported this to estates.

Person-Centered Care and Service User Experience

Whilst there is further work to do, both the staff and service user interviews highlighted evidence of strong person-centered approaches. All of the service users interviewed said they felt their needs were well catered for and that they were being well supported. There was evidence that care was individualized to meet the service users' needs and all of the areas visited were able to evidence involvement in co-production.

During the visit to Stanage ward there was an engagement lead present on the ward signposting service users to community services and support including giving practical advice and support and supporting service users in accessing activities on and off the ward.

The review of documentation evidenced that there is a clear focus on physical health and wellbeing as well as mental health. There were some areas, related to record keeping that require further improvement, like the process for assessing risk, however, there is currently an ongoing quality improvement programme focused on this area.

Quality Hot Spots

In addition to the planned visits, ongoing intelligence is utilised to monitor services for "quality hot spots" through incident huddles, safeguarding concerns, complaints and freedom to speak up. Where potential hot spots are identified discussions take place with the Director of Nursing, Quality and Professions, Directorate Leadership Team and appropriate others; it is usual to ask the Head of Nursing to then lead the discussions to develop an improvement plan for the service. Over Quarter 1 and Quarter 2 the following services have been requested to develop Improvement Plans:

- Woodland View Nursing Home (ongoing – in monitoring and assurance)

Woodland View Nursing Home have an ongoing improvement plan set out by the Integrated Care Board (ICB) following their quality visit in 2024. Improvement work is well underway, led by the Head of Nursing and supported by the quality team. There have also been several 'whistle blowing' concerns raised to the Care Quality Commission (CQC) and each of these have been thoroughly investigated and responded to.

- Burbage Ward (ongoing – in monitoring and assurance)

Burbage is being provided with a range of improvement support, overseen by the Executive Director of Nursing, Quality and Professions, with weekly scheduled improvement meetings being held.

4. Board Visits

Over this period, we have continued to increase the opportunities that Board members have to engage and gather feedback from Service Users/Carers and from the staff in services being visited. We have also widened the program and started to include corporate/non-clinical based services. During 2024/25, thirty-three Board Visits have taken place and there are approximately seventeen visits currently being scheduled for the last part of the 2024/25 year.

Feedback following the visits has been extremely positive, with staff feeling that it was a good opportunity to show in detail the work they are doing. Staff also felt it was a good opportunity to talk to senior leadership about some of the challenges they face. One of the corporate teams visited fed back that they felt some of their challenges had been made easier as the visiting board member had followed up on their issues directly after the visit. One clinical team said they felt it was positive to discuss the support they are trying to provide to return out of city patients back to Sheffield.

5. Culture and Quality Visits

It is recognised that any service that delivers patient care can have a closed culture. All services have been assessed for risk of having a closed culture based on the criteria identified within the work completed by Care Quality Commission (CQC) on closed cultures and then prioritised based on risk profile. Sickness absence and a vacancy within the team has impacted on the number of visits this year, however eight services have been visited since April 2024. As with previous years, visits have been paused while the Fundamental Standards of Care visits take place. The remaining fifteen services yet to be assessed will be visited during 2025. These will be prioritised and scheduled from February 2025 on completion of the Fundamental Standards of Care visits. There had been a small number of visits where visit reports were not submitted and, due to changes in the team, these had not been followed up. This has now been resolved and reports and direct feedback has been provided.

6. Development of Physical Health Strategy

The Physical Health Team has been working on and developing 5 work streams in relation to the Physical Health Strategy for 2023-2026. The work streams and overarching strategy for the last 3 years were disseminated from an overall Physical Health objective set out by NHS England and shared at a local level from Sheffield ICB to Sheffield Health & Social Care.

On recently reviewing the previous strategy, it was determined that a number of key targets were not achieved fully or realised, and the progress of the previous strategy was not reviewed as part of the current 2023-2026 working plan. With that in mind the Physical Health Team have now incorporated elements of previous strategy work in the ongoing work plan.

The Physical Health team have completed a significant amount of work in relation to each work stream and overall strategy, especially over the last 6 months. This has been complex due to continued workload pressures, due to reduced team capacity; however, the team have used fortuitous, cost neutral, seconded expertise to bolster support and make progress. Ongoing updates are provided to both PHIG and SHSC via various working groups.

The key priority areas of focus are:

- **Deteriorating Patient**

Objective – For staff to have the skill and knowledge to safely identify the deteriorating patient and effectively manage their care. These clinical and holistic skills need to be integrated into everyday practice – not necessarily requiring formal patient assessment.

- **Living Well**

Objective - Living Well encompasses a range of areas which support people to improve their health. This includes services for people living with mental health disorders, brain injury, dementia, learning disability, autism, neurodevelopmental conditions, eating disorders, long term neurological conditions, gender dysphoria and more. It is about being able to live well with

ongoing physical health conditions or new conditions or how we can improve upon our general health.

- **Planned Care**

Objective -To safely manage any known physical health condition and respond effectively in a non-urgent care approach. These clinical and holistic skills need to be integrated into everyday practice – not necessarily requiring formal patient assessment.

- Unplanned Care/Events

Objective - To safely manage any known physical health condition and respond effectively to any urgent care need.

- **Digital Health**

Objective – To ensure improvements are being made in relation to digital connectivity which spans all workstreams.

The team recently piloted a Physical Health audit in 4 services across the Trust, specifically to look into how we are documenting and using information about service users' physical healthcare needs whilst in our care.

What we found:

What are we doing well?

- 82% of service users had had a physical health review by the 4 teams in the last 12 months.
- 69% had recent considerations and discussions around physical healthcare needs during an interaction. Also, 67% had a Personal Emergency Evacuation Plan (PEEP) in place. This was only applicable for inpatient and rehab services.
- 59% of the submissions received had a clearly documented management plan in place to support their physical health needs.
- 59% had evidence of the service users' involvement in the management of their physical health condition.

What can we improve on?

- Only 24% reported that the service user had a clearly documented clinical emergency rescue plan in place.
- 53% of the submissions received had a physical health care need identified within 24 hours of admissions or initial community contact.
- Whilst 71% reported that the physical health element of care plans were easy to follow, only 57% reported they were easy to find on Insight and Rio, with many comments indicating there was no centralised place and they had to go to three or four different places to gather information they needed.

Following the full implementation of the Rio EPR the physical health team will widen the audit to include a range of other services with a view to supporting services to make continued improvements.

7. Service User and Carer Feedback

We need to have the service user and carer voice and experience at the centre of all we do at SHSC if we are to continue to strive to improve the quality of the services we provide.

There is a risk currently that our Friends and Family Test feedback response data is low, therefore as a result we are not capturing experience to improve quality. There is now a plan in place to address this in a number of ways;

improved communication and visibility with community services and increased promotion of the QR code as a method for giving feedback. The improvement plan will be presented as a part of the Lived Experience Report which is also being presented to the Board of Directors in January 2025.

8. Quality Assurance Developments in Relation to Patient Safety

The Physical Health team have been heavily engaged in developing the appropriate forms and documentation for EPR in quarter 2 and 3. The physical health lead has taken lead responsibility for ensuring that key deadlines for submission were met and for bringing together a range of professionals to ensure that the forms and documentation meet the standards required by clinicians and none-clinicians who will use the forms going forward.

8.1 Moving from Tendable to Ulysses

During quarter 2 and 3 the move from the costly Tendable electronic system to the more cost-effective Ulysses system has been underway. Feedback from staff in relation to the Tendable system was that it was complicated to use and difficult to interpret the subsequent data. The quality team are developing Ulysses to provide front line staff with the ability to gather quality audit data from across our organisation, which will give us the ability to analyse this data with the view to improving quality and service user experience. The timeline for completion of this work is April 2026 and there will be direct reporting to the Quality Assurance Committee.

8.2 City-wide Safety Plans to reduce service user suicide

During quarter 2 SHSC collaborated in the launch of the city-wide electronic safety plan. The electronic plan was developed by SHSC, Flourish, the Local Authority and lived experience expertise. The safety plan can be a personal tool or shared with trusted friends, family, or professionals to ensure the people of Sheffield have support when needed.

9 Conclusion and Next steps

During Q2 and Q3 2024/25 there has been a continued focus on quality monitoring and improvement. In addition, there have been some changes to leadership which has brought a renewed focus on the quality governance infrastructure. As a result, the Quality Strategy will be refreshed during Q1-Q3 2025/26, to build upon the progress made through the previous strategy.

The Quality Management System will be finally developed and implemented once the new Electronic Patient record RIO is implemented in March 2025. This will enable QAC to have a more robust oversight of quality across the Trust.