Sheffield Health and Social Care NHS
NHS Foundation Trust

Quality Account 2010/11

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Contents

Part 1

Statement on Quality from the Chief Executive

I am very pleased to introduce Sheffield Health and Social Care NHS Foundation Trust's third annual Quality Account. This account tells you about the quality of care and treatment provided by the Trust: it provides a balanced picture of our services and introduces the Trust's quality objectives for the year ahead.

We have developed this account in partnership with the Trust governors and members, as part of our processes for looking back on the year that has passed and looking forward to the year ahead. Our quality objectives have been decided through consultation with staff, governors, members and partners in the city of Sheffield.

In Sheffield Health and Social Care Trust (SHSC) we feel strongly that quality must lie at the heart of our business. Our vision of quality is 'health and social care that is service user centred, safe, effective and promotes equality and inclusion' (SHSC Quality Framework 2009). We see the interaction between service users, carers and staff as the key to making sure the services are of good quality.

I was delighted that this year we have adopted a new Service User Involvement Framework, which describes how we will work together with service users to improve quality. Two service users presented the Framework to the Trust Board and we were inspired by their stories of how they had worked with the Trust to make improvements in very different ways. You can hear Tim's story for yourself if you follow this link to the Patient Voices website: Patients voices - Tim's story.

We are not forgetting carers. One of our quality objectives for 2011/12 will be to improve the experiences of carers. Although carers may often represent or advocate on behalf of service users, they have their own needs too, and we intend to continue to respond to carers' needs in the year ahead.

The safety of service users is always our priority. My colleagues and I review all the serious incidents and complaints which are reported during the year, looking for any recurring themes or indications of problems in the overall high standard of care we provide. We have set up in-depth reviews of any areas of the Trust where we think there may be a problem. As a result of these efforts, we have introduced a new programme of staff training in clinical risk assessment and management for all staff with responsibilities for the care and treatment of service users.

We have strengthened our systems for staff appraisal and professional development, and we are making significant improvements to our staff training systems. Having skilled, well-motivated staff with a positive attitude is absolutely essential for maintaining and improving quality. On my visits to teams and services I have been able to see for myself how much effort staff throughout the organisation put into providing the best possible care. I was pleased to see my views supported by positive results from the Care Quality Commission (CQC) annual staff survey in 2010; the Trust was in the highest category (top 20% of mental health trusts in the country) for staff who would recommend the Trust as a place to work or to receive treatment.

The Trust reviews and considers the recommendations of national reports and inquiries, so that it can learn from elsewhere to improve its practice. For example, the Trust Board has reviewed the recommendations of the Francis Report, the inquiry into the Mid Staffordshire Hospital NHS Foundation Trust, and is making some changes to its governance structures as a result. From 1st April

2011, a new Board Sub-committee, the Quality Assurance Committee, will make sure that quality has the highest priority within the Trust and is high on the agenda of all Board meetings.

We received a Care Quality Commission (CQC) Planned Review of our healthcare regulated activities across 11 locations in 2010/11: this was one of the first planned reviews in the country under the CQC new procedures. The new CQC quality and safety outcomes are forming the basis for routine quality assessment in the Trust, informing team governance reports. We have set up a rolling Quality Check process to make sure we are compliant with the outcomes. During the Planned Review, the CQC found much to be positive about, for example in the ways in which we involve service users and carers in services. They also found some areas where we need to make improvements, for example in recording patient care. We will be pursuing the improvements we need to make vigorously over the next few months.

During 2010/11 there has been a focus on improving the quality of care and treatment for people with mental health problems through the developments of the Acute Care Pathway and the Scheduled Care Pathway. People in crisis are now seen more quickly than ever before. This work will progress further in 2011/12. We are promoting a Recovery approach to mental health care. It was great to see the Sheffield Pathways and Community Engagement Services (SPACES) launched this year – moving away from a traditional day service model to more flexible support with the aim of supporting people to be full members of their local communities. We support the development of self directed support and want to promote independence, choice and a positive and healthy life for everyone using our services. I have been delighted to see that the Improving Access to Psychological Therapies (IAPT) service, which provides talking therapies for people with common mental health problems in primary care, has been able to help so many people return to work and make a full recovery.

Learning disability services have also been working on improving the care pathways of people with learning disabilities in the city, so that people get the right help at the right time and quickly, whether their needs are for care from community learning disability teams or specialist support for people with challenging behaviour or additional mental health problems.

We will be putting a new emphasis on care for people with dementia and setting dementia care standards as a new quality objective for 2011/12. Research from the Alzheimer's Society this year has found that more people in Sheffield are being diagnosed with dementia than the national or regional average; 53% of people with dementia have received a diagnosis compared with 40% nationally. This means that we are in a strong position to get help to people with dementia and their families quickly.

Through the award of a new contract, Substance Misuse Services have secured the gateway for drug and alcohol services. This will make single entry points for drugs and for alcohol, so that people can find their way to the right service quickly. It will be easier to help people make choices about their care and treatment.

Finally, there will be big changes in the year ahead as colleagues from the former Primary Care Provider Services join us. We will become the provider of services in primary and community care. I am delighted to welcome our new colleagues. I am looking forward to us working together to make further improvements to quality, safety and service user experience across care pathways in the city.

My view of the quality of care and treatment provided by the Trust comes from my own experience of visiting teams and talking to staff and service users and carers on many different occasions - as well as reading reports and studying the data. I am confident that we provide good care with some excellent practice, but that there is always room for further improvement. I want to see a consistently excellent quality of care and treatment in every part of the Trust. My colleagues on the Trust Board and I are very motivated to make the services even better, and we believe that by working together as staff, service users and carers we will be able to make this happen.

I declare that to the best of my knowledge, the information contained in this document is accurate.

Signed

(signature to be inserted)

Kevan Taylor
Chief Executive

Part 2

2A Priorities for Improvement for 2011/12

The Trust takes action in a number of ways to improve the quality of the care and treatment it provides.

- It runs a number of quality improvement projects which are described in these accounts
- It reviews the information it holds about the quality, safety and effectiveness of care and about service user and carer experience. It looks at this information throughout the Trust, from Board to team level
- Every team in the Trust reviews its quality of care and service user experience in a team governance report at least once each year, and sets targets for improvement. This team governance process is the bedrock of quality in the Trust
- It shares good practice and learning from inside and outside the organisation
- It tries to learn when things have gone wrong, investigating carefully and taking action when needed after serious incidents or complaints
- It listens to feedback from its partners and stakeholders – its commissioners and regulators
- Above all, it tries to listen properly to what service users and carers are telling it about the quality of their care and treatment, and to use this feedback to make further improvements

During 2010/11, all these aspects of quality were considered in deciding on the priority objectives for the year ahead. There was an extensive and repeated consultation process with senior staff, governors, members and stakeholders. Governors were able to represent the views of service users, carers and staff as well as the wider public. From this process 4 new quality objectives have been developed for the year ahead. They are:

1. To improve nutritional support for service users, develop a Nutrition Strategy, reduce the risk of malnutrition and obesity and improve the quality and experience of meals provided by the Trust
2. To improve the quality of care for people with dementia and their families, by delivering the standards set out in the National Institute for Health and Clinical Excellence (NICE) Quality standard for dementia and reducing waiting times for assessment
3. To assess the needs of carers (in their own right) through surveys and interviews, and to develop and implement a carers' action plan to improve the quality of support they receive
4. To continue work on improving the experience of people from Black and minority ethnic groups who receive care and treatment from the Trust

1. To improve nutritional support for service users, develop a Nutrition Strategy, reduce the risk of malnutrition and obesity and improve the quality and experience of meals provided by the Trust

Why we have chosen this objective

The Trust Board and Governors believes that improving the physical health of people with mental health problems, learning disabilities and substance misuse must remain a key focus in 2011/12. It is a key patient safety issue to prevent malnutrition and the health risks from obesity. They also believe that having good and nutritious food and drinks is an important component of a good patient experience.

We want to keep up the work on nutrition in the year ahead, and continue rolling out the use of the standardised Malnutrition Universal Screening Tool (MUST) across the Trust.

We wish to improve the nutritional quality of meals in areas where it is required.

As a result of screening assessments, we have identified a problem with obesity on the adult mental health wards. A brief audit in January 2011 suggested that over 50% of service users on the adult wards were overweight or obese. This represents a significant risk to service users' health and wellbeing. We want to begin a new work stream to tackle the problem.

How we will measure progress

- Use of the MUST (Malnutrition Universal Screening Tool) on admission or soon after in all inpatient areas (100% target)
- Recording of weight, height, body mass index and waist circumference – each directorate to set appropriate targets for every team in the Trust and monitor completion, showing improvements made. We believe local targets are most appropriate because the risks of obesity and malnutrition are different for different groups of service users.
- Patient Environment Action Team (PEAT, an annual self-assessment of inpatient sites in England) assessments on food to stay 'good' and aim for 'excellent'
- Quality and Dignity Survey results on acute mental health wards to show more service users report the food is good and fewer say it is bad. Local surveys on other wards to maintain high satisfaction rates with meals. Target to be 80% satisfaction rate
- Compliance with nutritional standards in all areas where the Trust provides the meals (Audit results: to aim for 100%)

What we will do (including lead and timescales)

The leadership for this work will remain with the NICE Nutrition Group (Lead is Senior Nurse Jane McKeown). A permanent dietician appointment is to be made to support the work.

Actions will include:

1. The development of a Trust Nutrition Strategy

2. To continue the roll out of the MUST (malnutrition screening tool) including training staff in its use

3. Directorates to set appropriate team targets on nutrition at the start of 2011/12 as part of the team governance process, including:

    - MUST screening (which includes weight/height/body mass index (BMI))
    - Nutritional assessment of meals (where provided)
    - Service user feedback on meals (where provided)

    To monitor the delivery of these targets in reports to directorate senior management teams at least every 6 months.

4. To develop and implement a care pathway for obesity, including treatment options such as weight management groups in some areas

5. To continue PEAT assessments, Quality and Dignity Survey and local team surveys, to collect and collate service user feedback on the quality of food and drinks (where these are provided by the Trust)

7. Nutritional assessments of meals provided by the Trust to be completed for all inpatient areas. In any areas where the daily menu does not meet nutritional standards, actions plans to be developed and implemented to raise the quality of the meals

2. To improve the quality of care for people with dementia and their families, by delivering the standards set out in the National Institute for Health and Clinical Evidence (NICE) Quality Standard for dementia and reducing waiting times for assessment

Why we have chosen this objective

Consultation with governors, the Local Involvement Network (Sheffield LINk) and the Health and Wellbeing Scrutiny Board of Sheffield City Council all highlighted dementia care as an area to prioritise. The city has an increasing elderly population and awareness of the needs of people with dementia and their families has been growing. The National Institute for Health and Clinical Excellence (NICE) published a Quality Standard for dementia in 2010/11, which applies across the care pathway. The Trust wants to make sure it is able to meet the criteria in the NICE standard for dementia, in collaboration with other partners in the city in health and social care.

NICE Quality Standard for Dementia

There are 10 quality statements in the NICE Quality Standard for Dementia:

1. People with dementia receive care from staff appropriately trained in dementia care.
2. People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.
3. People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.
4. People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care co-ordinator and addresses their individual needs.
5. People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of advance statements, advance decisions to refuse treatment, Lasting Powers of Attorney, Preferred Priorities of Care.
6. Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions, identified by a care plan, to address those needs.
7. People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in the care plan.
8. People with known or suspected dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health.
9. People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.
10. Carers of people with dementia have access to a comprehensive range of respite/short break services that meet the needs of both the carer and the person with dementia.

How we will measure it

The NICE Dementia Quality Standard includes a number of ways of measuring outcome and we will adopt these (see www.nice.org.uk)

Key success indicators for the Trust will include:

- Current performance defined and analysed across the criteria in the Standard to provide baseline assessments. (Audit results: to aim for 100%)
- Improvements achieved in year for
    - Staff training – with 100% of defined staff receiving training relating to the care of someone with dementia
    - Access to memory assessment services – with a 25% increase in the number of people accessing an assessment compared to previous years
    - Advance statements – with 100% of clients having the opportunity to discuss future care and treatment
    - Waiting times for access to memory assessment reduced to 12 weeks by quarter 3 onwards

What we will do (including lead and timescales)

The Dementia Directorate senior management team will lead this work with support from the central services (leads Dr Peter Bowie, Clinical Director, Tony Bainbridge, Assistant Clinical Director; support from Paul Reeves, Planning and Performance Manager and Brian Hockley, Project Manager).

The Trust will work with its partners in health and social care across the city and play a full part in striving to provide health and social care for people with dementia and their carers that meets the Quality Standard.

An action plan for the implementation of the NICE standard for dementia is being developed. It will include an assessment of current provision and baseline audit as a first step, to see how the services match up against the standards and benchmarks. Following the audit, targeted plans will address any areas where improvements are needed. Progress will be monitored through the Quality Assurance Committee.

3. To assess the needs of carers (in their own right) through surveys and interviews, and to develop and implement a carers' action plan to improve the quality of support they receive

Why we have chosen this objective

During 2010/11 we focused on service user experience as a quality objective, and work in this area will continue throughout the Trust. In the year ahead we wish to make sure we focus on the needs of carers too. Carers can be seen as representatives of service users, and as an essential part of planning for their care, but they have needs in their own right too. In 2011/12 we will assess these needs and then develop a realistic and clear plan to meet them.

The whole city of Sheffield signed up to a Carers' Strategy in 2010 and we believe the time is right to turn the strategy into actions. The Trust's governors and Local Improvement Network (LINk) partners were keen to see actions on carers' needs included in this year's quality objectives.

Sheffield City-wide Carers Strategy

The City-wide Carers' Strategy sets objectives to improve the support for carers which include:

- To develop the Trust's infrastructure and improve joint working between partner organisations so that carers are better supported
- To identify hidden carers and raise awareness of carers and their caring responsibilities within organisations and in the wider community
- To provide information, advice and advocacy to enable carers to make informed choices
- To sustain carers in their caring role and prevent carer breakdown
- To involve carers individually and collectively in shaping, commissioning, monitoring and evaluating services and support for them and the people for whom they care
- To promote support for employees who have caring responsibilities
- To ensure that carers have a life of their own outside of their caring role
- To enable young carers to have the same life chances as other young people, and prevent young carers from taking on inappropriate caring roles

Monitoring of the use of carers' assessments in adult mental health services showed that 82.5% of carers were offered a carer's assessment in 2010/11, and 70.8% received a carer's assessment. (Figures are based on data for the end of Feb 2011).

How we will measure it

The success of the process will be measured by:

1. Completion of a Review of Carers' Needs and Views with a report produced for September 2011
2. Audit of staff carers to establish numbers and views on the information and support available by August 2011
3. These 2 pieces of work will inform decisions on targets for improvement and how these will be monitored.
4. Development and implementation of an action plan by December 2011
5. A baseline will established and indicators identified and in place for monitoring the delivery and impact of agreed action plan by January-March 2012
6. Monitoring of the implementation of the action plan will be through Quality Assurance Committee, with appropriate reports on carer employees to HR and Workforce Group
7. Continued review and monitoring of current carer assessment rates for people on Care Programme Approach (CPA):
    - To establish baseline figures for other service user groups
    - To show an improvement on the baseline figures of 82.5% of carers being offered a carers' assessment and 70.8% receiving an assessment.

What we will do (including lead and timescales)

This work will be led by Liz Johnson, Head of Patient Experience, Inclusion and Diversity and will involve carers in its development and delivery. Ian Hall will lead from HR on the delivery of a Carer Friendly Employee action plan

The Review of Carers' Needs and Views and the Staff Carer Audit will be completed by the end of quarter 2 (September 2011) and the linked action plans by the end of quarter 3 (December 2011) to ensure there will be a minimum of one quarter's monitoring of implementation before the end of 2011/12.

4. To continue work on improving the experience of people from Black and minority ethnic (BME) groups who receive care and treatment from the Trust

Why we have chosen this objective

This is an existing priority for the Trust where we plan to carry on developing the work in the year ahead. We believe it is still a priority for the Trust because there is continuing evidence that people from Black and minority ethnic groups are more likely to experience negative elements of care and less likely to experience more positive aspects. We have made improvements to the quality of the staff training we provide on equality and diversity, but we want to see a greater rate of progress in this area, and more staff receiving the training.

We have set up systems to review service user information by ethnicity, gender, age and other characteristics. From this work, we have found that people from Black and minority ethnic groups tend to have more repeat admissions (defined as more than 5 in 3 years.) In the next year, we want to understand why and take steps to improve the situation.

We also want to continue the important work that we have begun on improving how we respond to violence and aggression on the wards and implement a new approach to restraint, Respect. We began this work in response to critical feedback from the Maat Probe service user group. Although it cam out of work with people with acute mental health problems from Black African and African Caribbean backgrounds, we believe that changes will have benefits for service users across the Sheffield communities and in other areas of the Trust. Respect is a philosophy of care which is about empowering and enabling service users to prevent aggression in the first place, thereby reducing the amount of physical intervention required. We are trying to look at factors leading up to incidents of violence and aggression in a systematic way. This work has always previously been carried out with an individual service user perspective as part of a treatment, risk management or care plan. We have begun the analysis of incidents and assaults and verbal abuse on the wards by ethnicity, gender and age of victims and perpetrators, and we will be reporting on these issues in 2011/12.

The CQC Staff Survey 2010 and our own figures showed that we are still not training enough staff in equality and diversity. We will continue to roll out the improved training in equality and diversity and make sure it reaches more staff.

How we will measure it

- We will monitor and report on staff training in Equality and Diversity: our aim is that all targeted staff will have received the new training over the next 2 years. We hope to see an improvement in the CQC staff survey results with more staff reporting that they have received training in equality and diversity.

- We will audit the care pathways looking at length of stay and repeat admissions, and develop and implement an action plan from these findings. Delivery of the action plan will be monitored through the Quality Assurance Committee

- We will improve the routine monitoring of incidents of violence and aggression on wards with a more detailed breakdown of the information held, to make sure we have sound baseline measures. We will then set a target for reduction in the number of such incidents

- We will analyse length of stay, repeat admissions and incidents of violence and aggression by ethnicity, age and gender, to ensure that the planned actions and improvements result in an improved experience for men and women of all ages from all ethnic groups. We hope to see a significant improvement for people from BME groups.

- We will monitor and report on staff training in Respect. We intent to see an improvement on the baseline figure derived from the number of staff attending Managing Violence and Aggression courses during 2009/10. We also hope to report on the impact of the different approach provided by the Respect training.

What we will do (including lead and timescales)

The work on this objective will be led by the Black and Minority Ethnic Group/Community Engagement Group, chaired by the Executive Director of Operations, Clive Clarke. The project lead will be Kim Parker, Senior Nurse for Quality Improvement.

Work on the data analysis is already in place; monitoring the resulting reports will take place quarterly during the year, including reports on the number of staff trained in equality and diversity.

The care pathway audit will be completed by October 2011 and an implementation plan developed by December 2010 so that implementation can start next year.

Our goal is to implement the Respect approach throughout the organisation over the next 2-3 years. The plan for next year is to start training staff in pilot areas. A detailed implementation plan with timescales will be completed by July 2011.

Monitoring progress on the 4 quality objectives

Progress on all the objectives will be reported to the Quality Assurance Committee, a new Board committee, for assurance and exception reports.

Implementation reports and sharing good practice across the Trust will take place in the monthly Quality Improvement Group on a rolling programme during the year.

2B Feedback on Last Year's Quality Objectives

Last year the Trust set 4 quality objectives:

1. To achieve a target of 4 hours from referral to assessment for crisis referrals for service users in adult and older adult mental health care including dementia services
2. To improve the satisfaction of people from Black and minority ethnic groups with the cultural appropriateness and respect of the services they receive
3. To make sure we are collecting, listening to and acting on views and feedback from service users and carers
4. To improve the support, advice and care we provide to service users with regard to their nutritional needs

It has monitored progress on these objectives during the year and presented reports back to the Board, to senior staff and to Governors.

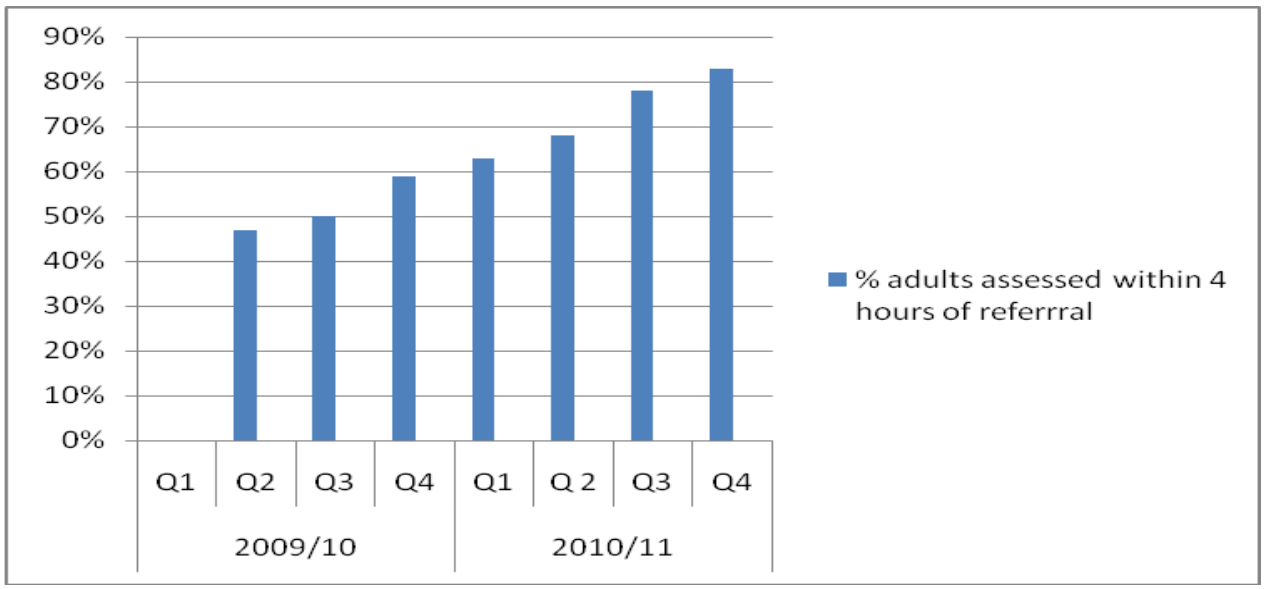
1. To achieve a target of 4 hours from referral to assessment for crisis referrals for service users in adult and older adult mental health care including dementia services.

We chose this target because service users, carers, governors and our commissioner, NHS Sheffield, all told us how important it was to them that service users did not have to wait for long when they most needed help, in a crisis.

What we found

The introduction of the new acute care pathway during the year has had the hoped for impact in reducing the length of time people in crisis have to wait for an assessment, with waiting time reducing quarter by quarter during 2010/11. A target of 80% of people of working age being seen within 4 hours was set for the year. Performance improved each quarter and the target was achieved by the end of the year. We will continue to work on timely access and monitor how long people wait in 2011/12.

Table 1 Waiting times for crisis assessment for working age adults: Percentage of adults assessed within 4 hours of referral over the last 2 years. Data from Yorkshire and the Humber CQUIN returns (Insight data)



The Trust has been working in partnership at a senior level with colleagues in South Yorkshire Police and Sheffield Teaching Hospitals NHS Foundation Trust to try to smooth the care pathways of people with mental health needs in extreme crisis and reduce time waiting for a bed. As a result of this, an extended weekend service has been introduced at Accident and Emergency to respond to people who are waiting for urgent mental health assessments.

The Trust also worked on baseline figures for waiting times in a crisis for other groups of service users during 2010/11.

People with dementia in urgent need of care and support receive a service from the Trust's Rapid Response Team. The current target is that contact will be made by the service for triage and initial assessment within 24 hours. At the end of the year this target had been met in 100% of cases. The challenge of a 4 hour response will be picked up in the work planned for 2011/12 to deliver the NICE quality standard for dementia.

Through the year, the Learning Disability Service have designed and developed a range of evidence based care pathways, drawing on NICE guidelines for a range of conditions, service user and carer feedback and the needs of people with learning disabilities. The pathways include access criteria and set standards for how long people might wait for a service, including urgent or crisis services. The service has developed implementation plans and begun implementing these care pathways as part of service redesign. Progress against the standards will be monitored in 2011/12 and reported to the Board.

2. To improve the satisfaction of people from Black and minority ethnic groups with the cultural appropriateness and respect of the services they receive

The work on this objective had a focus on 4 areas:

1. Making sure people from Black and minority ethnic groups were able to access help at an early stage
2. Reducing negative experiences such as being restrained or secluded
3. Increasing positive experiences such as access to talking therapies and positive activities
4. Improving staff training

What we found

Important work has developed positively over the last year to help us improve the experience and satisfaction of people from BME communities who use our services. We have completed a fundamental review into how we approach the management of violence and aggression within our inpatient services, and have developed new training programmes. We have considerable work still to do to improve experiences, and the positive progress we have made over the last 12 months puts us in a strong position to make real progress.

1. Access to services at an early stage and increasing access to talking therapies

There was good access to the Early Intervention Service by people from Black and minority ethnic groups. In 2010/11, 55% of EIS service users were White British, 6.5% Somali, 6.2% British Pakistani, and the remainder from other minority ethnic groups. This is a similar picture to the previous year (59% White British, 6.9% British Pakistani, 6.3% Somali). It means that young people

with psychosis from Black and ethnic minority groups are getting early diagnosis and treatment, and hence the best prospect of recovery.

However, we found out that people from Black and minority ethnic groups were less likely than White British people of the same age to be referred to IAPT (Increasing Access to Psychological Therapies) the primary mental health services that provide cognitive behaviour therapy and other evidence-based interventions for people with common mental health problems. In 2010/11, 88% of people accessing IAPT were White British (and including the old 'White' category), the same percentage as the previous year. The IAPT service is monitoring the effectiveness of its service for people from different ethnic groups, but the numbers are as yet too small for any firm conclusions to be drawn.

The IAPT service has set up a number of interventions to improve access for people from Black and minority ethnic groups:

- Extended the service into voluntary sector organisations with a strong BME focus (Roshni, Yemeni Community Association, Sharrow Community Forum)
- Recruited additional bilingual staff who are based in areas with high BME populations but can take referrals across the city
- Promoted the service in the local Polish language media

However, at the end of the year, although the number of people accessing IAPT had gone up overall, there was as yet no evidence for an increased uptake by people from Black and minority ethnic groups in particular.

Another service historically less likely to be accessed by people from Black and ethnic minority groups is the service for older people with mental health problems. The Older Adults Functionally Mentally Ill (FMI) Directorate have been working proactively through the Seldom Heard Working Group to engage more effectively with Black and minority ethnic communities. Following the FMI Governance Away Day in April 2010, all teams have been working to implement changes in service areas. Staff have been attending a range of visits and attending events to improve links. Every team is monitoring the percentage of service users from different ethnic backgrounds on its caseload.

Overall, 6% of FMI service users in 2009/10 were from Black and minority ethnic group backgrounds and 5% in 2010/11. The Directorate will be reviewing this result and what it needs to do to improve access for people from Black and minority ethnic groups in 2011/12.

2. Reducing negative experiences

The Trust is continuing to monitor the comparative rates of detention under the Mental Health Act, use of seclusion, restraint and length of stay for the 4 mental health acute wards as part of the CQUIN scheme.

Table 2: Detention, use of seclusion, length of stay on acute wards by ethnic group Data from Yorkshire and Humber CQUIN returns (Insight data)

	2010/11	**2009/10**
1. Number of people admitted to the wards		
White British	422	404
Black and minority ethnic group communities	142	168
Total	564	572
2. Number of people detained under the Mental Health Act		
White British	219	195

Black and minority ethnic group communities	110	102
Total	329	297
3. Number of people secluded		
White British	27	71
Black and minority ethnic group communities	14	40
Total	41	111
4. Number of people restrained		
White British	22	15
Black and minority ethnic group communities	8	12
Total	30	27
5. Average length of stay		
White British	52.8 days	53.5 days
Black and minority ethnic group communities	49.2 days	52.9 days

Table 2 shows that although slightly fewer people were admitted to the wards in 2010/11 in comparison with previous years, the number of people detained under the Mental Health Act went up. 58% of all those admitted during the year were detained under the Mental Health Act. (More people have been receiving treatment at home.)

People from Black and minority ethnic groups are still more likely than White British people to be detained under the Act. 55% of White British people admitted in 2010/11 were detained under the Act, in comparison with 77% of people admitted who were from Black and minority ethnic groups. In the previous year, 48% of White British people were detained in comparison with 61% of people from Black and minority ethnic groups.

People from Black and minority ethnic groups continued to have a slightly shorter length of stay on average.

There was a large overall drop in the number of people secluded from the previous year. People from Black and minority ethnic groups, however, were still more likely to be secluded. 10% of people from these groups were secluded on occasion during their time in hospital, in comparison with 6% of White British people. In the previous year, 24% of people from Black and minority ethnic groups were secluded at least once and 17% of White British people.

The overall figures for restraint showed a small increase on the previous year, with the rise being in the number of White British people who were restrained and drop in the number of people from Black and minority ethnic groups.

Following feedback from the MAAT Probe group, the Trust has reviewed its approach to restraint and to managing violence and aggression on the wards. A new system, Respect, is being introduced, which service users report is more respectful and positive. Trainers have been retrained in this approach and will be training their colleagues in the new approach in the year ahead.

'Loved every minute of it, looking forward to doing the Instructor Course'
'This has been a revelation to me, a very different course-in a good way!'
'Thank you – very useful and thought provoking. Service User involvement is very powerful.'
'The entire course was excellent from the physical techniques to the philosophy behind it.'

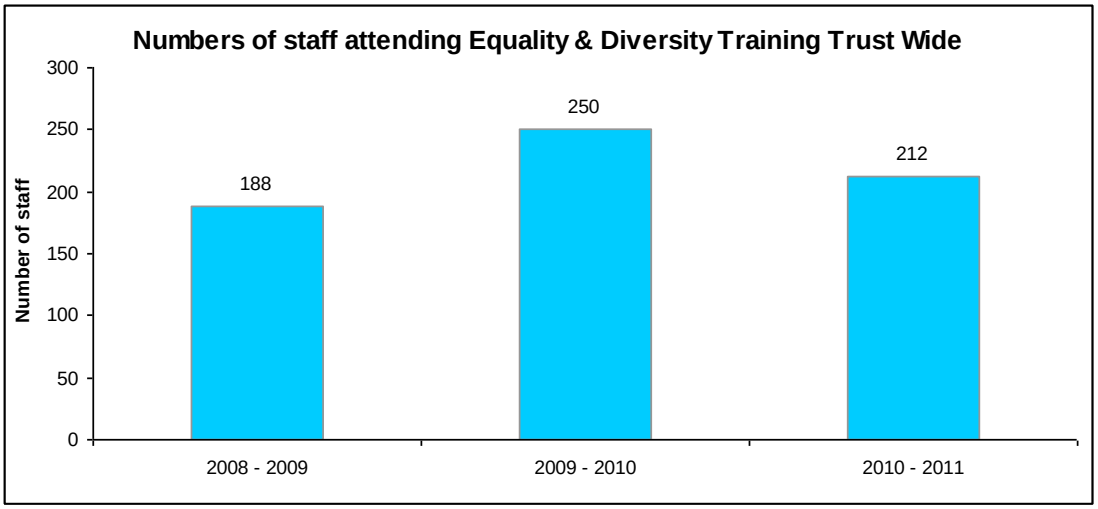
Comments from staff trainers attending the Respect 'train the trainers' course

3. Improving staff training

We have introduced new training programmes about diversity that have been well received by our staff. Induction training in diversity has been improved and a new Race Equality and Cultural Capability (RECC) training introduced. However, during this developmental period we have not been able to show an increase in the number of staff trained overall (see Table 3), and the CQC annual staff survey (2010) results showed that many staff were still reporting a lack of training in this important area. The Trust fell into the lowest 20% of mental health trusts on this item in the CQC 2010 staff survey and we are clear that we need to make more progress.

We therefore wish to continue to have a focus on improving the provision of staff training about diversity in the year ahead.

Table 3: Numbers attending Equality & Diversity Training (Data from ESR and training records)



3. To make sure we are collecting, listening to and acting on views and feedback from service users and carers

All teams in the Trust have a team governance process. This involves reviewing the quality of care and treatment provided by the team and setting targets for improvement. Each team meets regularly to look at the quality of care and produces a team governance report at least annually. Teams were asked in 2010/11 to make sure they were collecting service user feedback and using it as part of their team governance process.

An audit of service user feedback in teams took place in November 2010. This was the first full Trust-wide audit of the topic. All team managers were contacted by email and followed up with phone calls. 58 out of the 61 clinical teams responded (a response rate of 95%). Of the 58 teams that responded, 55 (95%) said that they had collected service user feedback in the last 12 months. 40 out of the 55 teams had used a service user survey and others had held meetings such as tenants' groups or community meetings, or collected face-to-face feedback. The overwhelming majority of teams had found collecting feedback useful, and 46 of the 58 teams who responded (82%) had used the service user feedback in their team governance reports. Teams were asked about any barriers they had experienced and problems such as communication difficulties of service users with dementia or

learning disabilities were mentioned. Staff also suggested new ways of collecting feedback and involving service users in team governance.

After this audit, the Trust held a Sharing Good Practice Day for staff and service users in February 2011. At this event, posters and talks showed many different ways of collecting feedback and involving service users. These included the Quality and Dignity Surveys carried out by service user volunteers on the acute mental health wards; simple surveys of people with dementia, carried out by staff from West Wing, Grenoside; and how work involving service users receiving crisis resolution and home treatment had benefitted the staff team as well as the service users. Staff leaving the event reported they had ideas and inspiration to take back to their teams with comments such as 'Really useful thought provoking day'.

The Trust will continue to place the experience of service users and carers at the heart of improving quality in the year ahead. Team governance reports will include service user feedback, and we hope to make it easier to compare across teams by using the same questionnaires or surveys in similar teams. Using service user volunteers to interview staff is another area we hope to continue and expand. In 2011/12, we will have a new focus on carers' experience, setting this as one of the Trust's quality objectives for the year ahead.

Service User Feed-back In Action - the Quality and Dignity Surveys

This project has service user volunteers talking to service users on the adult mental health wards, using semi-structured interviews to find out about their experiences of care and treatment on the wards. The service user volunteers are trained with the Trust induction process and supported by the Trust's PALS Officer. 200 service users on the wards have been interviewed since the start of the project in November 2009. Results are fed back to staff on the wards and used in team governance both to note good practice and to identify areas where action is needed to improve quality. Posters showing the findings have been displayed on the wards.

79% of the service users interviewed said they preferred to give feedback to a service user volunteer, rather than a member of staff.

Examples of improvements to services as a result of the Survey are:

- Advocacy services – the awareness of advice and advocacy from service users and staff has significantly gone up – 43% of service users were aware of advice or advocacy services (April-November 2010), up from 26% in 2009/10
- More service users are reporting that they know who their contact nurse is (up from 63% in 2009/10 to 80% in the period April-November 2010)
- An increase in people's awareness of the Recovery Folder (up from 34% in 2009/10 to 46% in the period April-November 2010). A Recovery Folder is a personalised resource full of information about mental health services and the service user's journey to recovery. The Recovery Folders are now being promoted as part of the Acute Care Pathway

The Quality and Dignity Surveys have been shared as an example of good practice regionally at an event on service user feedback organised by the Yorkshire and Humber Quality Observatory in March 2011.

4. To improve the support, advice and care we provide to service users with regard to their nutritional needs

This objective had 4 aims:

- To prevent the malnutrition of vulnerable people in our acute or residential services
- To prevent or reduce obesity of people who may be at greater risk because of medication, their health condition or disability
- To improve the health and wellbeing of service users both physically and mentally
- To offer a choice of good and healthy food (where we provide it) as an important part of a positive experience for people using our services

Work during the year

During the past 12 months the following work has been undertaken:

1. The introduction of best practice nutritional screening

Following a Trust-wide review of current screening processes, it was decided to implement the Malnutrition Universal Screening Tool (MUST) which is a validated tool recommended by the National Institute for Health and Clinical Excellence (NICE) Nutrition Guidance and a more systematic approach to screening than previous measures used. Initial staff training and implementation has taken place in older adult areas where service users are at the greatest risk of malnutrition, and the MUST was introduced in the second quarter on admission and in the third quarter on discharge.

Table 4: Malnutrition screening using the MUST each quarter
Data from Yorkshire and Humber CQUIN submission (Insight data)

Malnutrition screening using the MUST	2010/11			
	Q1	Q2	Q3	Q4
% older adult in-patients screened on admission	Data not collected	97%	100%	100%
% older adult inpatients screened on discharge	Data not collected	Data not collected	68%	97%

By the end of 2010, 100% of older adult service users were being screened on admission, using the MUST, and 97% on discharge. One person was not screened on discharge because they were on leave when they were discharged. 4 people were found to be at risk of malnutrition when they left the older adult wards, and they all had a care plan in place to address this concern.

This best practice screening tool is now being rolled out to other parts of the Trust, to supplement the existing practice of weighing and measuring people on admission to adult wards and learning disability inpatient and respite services.

2. Protected mealtimes

Protected mealtimes have been introduced to all areas through the NICE nutrition implementation group. This ensures that service users can enjoy their mealtimes without interruptions from visitors, whilst recognising that some family members may wish to assist their relatives at mealtimes. Recent Patient Environment Action Team (PEAT) visits reported that all areas were aware of protected mealtimes and most were displaying notices informing relatives of the initiative.

3. Staff training

Training requirements for staff around nutrition have been identified. All staff who work with service users are expected to have an awareness of healthy eating. A validated course for meal planners is to be run in May 2011, and if successful will be offered on an annual basis.

A business case was made and funding agreed to recruit a permanent dietician to the Trust, who will play a vital role in staff development as well as offering support for service users. The dietician will be asked to deliver focussed training to staff working with service users who are overweight or obese.

4. Meal planning and food standards

A review of mealtimes across the Trust by a dietician on secondment identified some areas where improvements were needed to the nutritional standards of meals. This will require a more planned and managed approach to menu planning in the future.

Older adult in-patient wards have undertaken a benchmarking exercise against the Essence of Care (2010) Food and Drink standards, using questionnaires. The results have gone back to the wards, and action plans are being developed for any weak areas found.

5. Mealtime experience

Service users are asked about meals in PEAT visits and in the Quality and Dignity surveys carried out by service user volunteers on adult acute mental health wards.

The surveys have shown that food preferences are personal and diverse. Respondents to the Quality and Dignity interviews, for example, showed a wide range of responses, some describing the food as excellent while others on the same ward said it was inedible. Overall 74% said the food was usually good, 13% said it was not usually good and the remainder did not express a firm opinion (Quality and Dignity Survey Report for April-December 2010).

The most recent annual PEAT surveys showed a ‘good’ score for food in all areas where food was provided. A new service user questionnaire has been piloted on one ward and the NICE Nutrition group plan will pilot it more widely in 2011.

2C How the Trust is developing its capacity to Assess, Improve and Assure Quality

The Trust's Quality Framework states that the heart of quality lies in the interaction between service users and all the staff of the Trust. Quality systems must run throughout the organisation, from the daily contacts between service users and staff in teams to the Board.

In SHSC, quality assessment, improvement and assurance is built on a team governance process. Every team in the Trust produces a team governance report at least annually, which is reviewed by their directorate senior management team. A review of team governance during 2010/11 showed that the process was embedded and working well, and the CQC assessor gave positive feedback as to how useful they were in providing evidence for the CQC planned review that took place in 2010/11. The team governance review found some variability in the content and quality of the team reports; during 2011/12 good practice and ideas for the further development of team governance will be shared between the directorates through the Quality Improvement Group.

The Trust has been implementing the Productive Ward and Productive Community Team on a rolling programme. The Productive series is an innovative approach with the goal of releasing more time for staff to spend in care and treatment with service users.

The Productive Programme

The Productive Series was developed by the NHS Institute for Innovation and Improvement and aims 'to release more time to care'. It is a team led improvement process. Using a 2 year modular approach with a range of tools and techniques, teams can focus on their systems and processes to enable them to become more efficient, resulting in safer and more reliable care. Staff can spend more time with patients. In Sheffield Health and Social Care Trust 6 wards, 3 community teams and the memory services are all taking part in the Productive Programme.

Key achievements to date are:

- One ward team timed how long some of the most frequently performed tasks took. By creating a tidier and simplified system they reduced one task from 51 seconds, to 5 seconds on average. Over a year this will release over 56 hours of nursing time.
- One ward reviewed and then introduced an individualised system for ordering patient care products. Patients now receive more individualised and comfortable care with less disruption and increased comfort. Almost £2,000 was saved in the first month and an estimated £100 per week from then on.
- One ward increased their direct care time from 23% to 35% by reviewing the amount of time spent on administrative tasks and reducing walking distance.
- The latest technology has been trialled on one ward to create a clinical dashboard that improves access to patient information and links to Insight and the Acute Care Pathway
- Dignity Walks are completed by each ward which involves walking through the ward with a service user or carer and viewing the ward through their eyes and then making improvements where issues are identified.

Four more teams will begin the Productive Programme in May 2011. The Productive series is a good example of how small changes, driven by staff on the ground, can make a real difference to patient care.

Major service improvement plans for the Trust, such as the Acute Care Pathway development, have built quality measurement in from the start. The Acute Care Pathway sets standards for the timeliness of access, the inclusion of service users, the use of care plans and risk assessments etc. and measures to see if these standards are met. The re-provision of learning disability services for people

with challenging behaviours and mental health problems has involved and included people with learning disabilities using the existing services, peer advocates and family members.

During 2010/11 the Trust reviewed its systems and structures for governance in the light of the recommendations of the Francis Inquiry Report, with a particular focus on the Board's role in understanding and assuring quality. From this work, a number of significant changes are being made which will come into operation from 1st April 2011. A new Board committee, the Quality Assurance Committee, is being instituted to make sure that quality issues receive the same attention from the Board as financial issues. The new Board committee structure will enable the Trust to provide the Board with the assurance and information it needs on quality, as well as demonstrate compliance with the regulations provided by Monitor (in its proposed new Compliance Framework) and the Care Quality Commission.

The Board has reviewed the learning from the Audit Commission Report *Taking It on Trust* and adopted a new model and format for the Board Assurance Framework, which links monitoring of the most serious and strategic risks to service delivery with an outcomes and impact monitoring approach. The robustness of these systems in keeping the focus on quality will be very important in the years ahead as health and social care services enter a period of funding constraint and transition.

At senior manager and clinician level, a new Quality Improvement Group is replacing the former Operational Management Group, with a clear remit to focus on quality improvement across the whole organisation. The new operational quality group will make sure there is better sharing and problem-solving across specialties, professional groups and service areas, breaking down silo approaches to quality. It will aim to share best practice to improve the quality of care in all the services we provide.

The Trust adopted a new Service User Involvement Framework in February 2011 which describes the Trust's vision and values for involvement and how the Trust will continue to support service user involvement in many different ways. The Board has a new re-engagement with the vision of service user and carer experience as lying at the heart of quality, and is making sure that it hears service user and carer views and listens to their experiences.

Examples of service user involvement and the use of service user feedback were on display at a Trust Sharing Good Practice Event in February 2011. Posters were on display including one from the Sun:Rise group:

Creative approaches to Service User Experience : Poster from Sun:Rise group

Sheffield City Council

Sheffield Health and Social Care NHS

NHS Foundation Trust

SUN:RISE

Service User Network:
Relevant Inclusive Supportive Exciting

What is SUN:rise?

- SUN:rise is a service user forum, we are also a subgroup of the Community Mental Health Team Forum.
- We aim to improve the ways in which service users can be involved in Trust business.
- We meet on the second Wednesday of every month in the city centre. Come and join us!

Lessons Learnt: Meetings that facilitate feedback

- Have a service user majority – it helps with the flow and depth of discussions
- Keep meetings regular and informal with a clear structure
- Have regular breaks
- Record comments and use these as feedback
- Use the Appreciation Scheme to compensate service users who regularly attend

Lessons Learnt: Service User Feedback

- The best feedback happens spontaneously through discussions and conversations
- Feedback needs to be logged there and then, as it happens
- Need to think about the best place to report the feedback
- It's a two way process. Need to feedback the feedback to the service users!
- Its not all about questionnaires and surveys

Lessons Learnt: Service User Recruitment

- Persist, persist, persist!
- Seek diversity in experience
- Reach out – look for feedback at service user events such as the Annual Members Meeting, Improving Quality Events, African Caribbean Event etc
- Encourage, nurture and support Service Users!

The Trust has set up a new web-based quality and performance data system, called Inform. This draws information from the 5 databases in the Trust which cover service user information (Insight), staff information (Electronic Staff Record or ESR), risk, safety, complaints and PALS information (Ulysses Safeguard) and financial information (Integra.) It uses the information to report on quality and performance indicators at Board, directorate and team level. Inform will form the basis of clinical governance and quality reports and will grow further in the year ahead. It is leading to improvements in data quality as each indicator in Inform has a clear definition which applies at all levels of the organisation, and the date and time at which a report is generated is recorded so that uncertainty is removed about time period to which the data applies.

The Trust is making further improvements to the use of clinical audit as a tool for service improvement and quality assurance. It already uses clinical audit extensively to monitor and show progress towards compliance with National Institute for Health and Clinical Excellence (NICE) guidance.

Effectiveness - the Implementation of NICE guidance

A full programme of NICE implementation continued during the year. The Trust is very committed to NICE implementation as a key part of improving quality. All relevant technology appraisals were implemented within the timescales in the year, and 13 active NICE guideline implementation groups are in place. The NICE depression guideline implementation group is working across the Trust, for example, to improve the effectiveness of treatment for depression of all types and at all ages. It carries out regular audits, alerts the teams to any gaps in NICE compliance, provides staff training and development on depression and information for service users about depression.

The Falls NICE guideline implementation group has made significant progress in reducing harmful falls by introducing a standard falls risk assessment and guidelines for managing suspected fractures. The older adults Functionally Mentally Ill wards in particular have done a lot of work to reduce falls – improving the environment, training staff and developing new treatments such as falls health promotion groups. The Trust is still a high reporter of falls, as staff are very conscious of the negative impact falls can have, but the number of falls resulting in a fracture has dropped from between 17 and 26 each year between 2006 and 2009 to 8 in 2010.

During 2010/11 the Trust laid out its plans to make significant changes to the investigation and management of serious untoward incidents. A number of improvements have already been made to support incident reporting and management. In the CQC Annual Staff Survey in 2010, staff responses put the Trust in the top 20% for the fairness and effectiveness of its incident reporting procedures, a significant increase since 2009.

We have worked on the timeliness of the Trust's reporting of serious incidents to NHS Sheffield and on to the national reporting system, and to improve the quality of investigation reports. The Trust has improved the documentation and guidance for the staff who produce the serious incident reports, using the National Patient Safety Agency incident reporting template. It has introduced an additional screening for all serious incident reports by the Executive Director for Nursing and Quality. Outstanding reports have been completed and 44% of reports met the 12 week completion target by the end of the year. Further improvements to timeliness and quality will take place in 2011/12, with close monitoring through the Quality Assurance Committee and with NHS Sheffield.

A new programme of training in clinical risk assessment and management started during the year. The Trust aims to ensure all its staff receive the training during the next year, and will then make sure similar training is provided routinely from then on.

Patient safety – staff training in clinical risk assessment and management

During 2010/11 the Trust set up a new clinical risk training programme for all health and social care staff who are responsible for the care and treatment of service users. 180 staff had completed the training by 31st March 2011. By the end of 2011/12, all of the targeted staff will have been trained in best practice in clinical risk assessment and management, including working with service users and their families to plan head ahead and keep people safe.

New Patient Safety and Health and Safety committees are being set up in 2011/12 to make sure progress on safety and risk management is sustained and developed further.

The Health and Safety Committee will include trade union representatives, and will address staff training in health and safety as a priority, following the disappointing results in the 2010 CQC staff survey on the numbers of staff reporting they had received training in health and safety.

2D Statements Relating to the Quality of Services Provided

(The content and wording of this section of the quality accounts is prescribed by the Department of Health and the regulator, Monitor).

1. Review of Services

During 2010/11 Sheffield Health and Social Care NHS Foundation Trust (SHSC) provided and/ or sub-contracted 109 NHS Services.

SHSC has reviewed all the data available to them on the quality of care in all of these NHS Services. The Trust reviews data on the quality of care with NHS Sheffield, PCTs, Sheffield City Council and the specialist commissioners in regular contract and performance meetings. Commissioners who have relatively small contracts with the Trust have agreed to accept the quality reviews provided through and accepted by NHS Sheffield, as our main commissioner.

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by SHSC for 2010/11.

These figures are derived from specific service headings in the contracts with the Trust's commissioners. Contracts for training and those with a value of less than £100,000 have been excluded – some of the latter may not be covered by a formal contract. Cost per case and non-contract 'permission to treat' requests have also been excluded.

The data reviewed includes patient safety, clinical effectiveness and patient experience and the amount of data available for review has not impeded this objective.

Table 5: Services commissioned where quality is reviewed

Commissioner	Services Commissioned	Number of services commissioned	Services formally reviewed with Commissioners	Services reviewed by the Board / Governance Structures
NHS Sheffield – mental health and learning disabilities	Directly Commissioned patient services	39	39	39
NHS Sheffield – substance misuse commissioned via Drug and Alcohol Action Team (DAAT)	Directly Commissioned patient services	3	3	3
Sheffield Local Authority	Directly Commissioned patient services	5	5	5
Other NHS Primary Care Trusts	Directly Commissioned patient services	52	52 reviewed (either via commissioner or via NHS Sheffield quality reviews)	52
Specialist Commissioners	Directly Commissioned	2	2	2

Commissioner	Services Commissioned	Number of services commissioned	Services formally reviewed with Commissioners	Services reviewed by the Board / Governance Structures
	patient services			
Housing Associations	Residential Care services	8	8	8

2. Participation in Clinical Audits

During 2010/11, there were 7 national clinical audits and 1 national confidential enquiry that were applicable to NHS services that Sheffield Health and Social Care NHS Foundation Trust (SHSC).

During that period SHSC participated in all 7 (100%) of the national clinical audits and the one (100%) national confidential enquiries, which it was eligible to participate in. The Trust participated in an additional 5 national audits which do not appear on the Department of Health list for inclusion in quality accounts (see www.dh.gov/qualityaccounts); these audits provide valuable opportunities for the Trust to benchmark its practice against other providers. It also participated in 49 local audits.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in and participated in during 2010/11 are as follows:

Table 6: Participation in national clinical audits and national confidential enquiry

Name of audit or enquiry	SHSC participation	Number of cases submitted	Number of cases as % asked for
National audit of psychological treatments (IAPT only)	Yes	1626	100%
Prescribing Observatory for Mental Health in the United Kingdom(POMH-UK) Topic 7 Lithium monitoring	Yes	24	100%
POMH-UK Topic 8 Medicines reconciliation	Yes	14	100%
POMH-UK Topic 6 Side effects of depot antipsychotics	Yes	102	100%
POMH-UK Topic 2 Metabolic side effects of antipsychotics	Yes	122	100%
POMH-UK Topic Antipsychotic use in learning disabilities	Yes	21	100%
National audit of schizophrenia	Will participate once audit	150 required	Not yet submitted

Name of audit or enquiry	SHSC participation	Number of cases submitted	Number of cases as % asked for
	starts August 11		
National confidential enquiry into suicide and homicide by people with mental illness	Yes	14	100%

The results of the national audits which are listed in the guidance for the Quality Accounts, and the action taken as a result, are shown in the table below:

Table 7: Results of listed national clinical audits and action taken

Name of Audit	Findings	Action taken or planned
National audit of psychological treatments (IAPT)	Data submitted to Royal College of Psychiatrists for analysis – results not yet available	To review results when available and agree actions.
POMH-UK Topic 7 Lithium monitoring	89% patients with documented evidence of renal function test conducted before lithium prescribed 89% patients with evidence of thyroid function test conducted before lithium prescribed 62% patients with evidence of weight, BMI (body mass index) or waist circumference measurements taken before lithium prescribed 75% patients with evidence of ECG (Echo cardiogram) conducted before lithium prescribed	<u>For all POMH-UK audits:</u> POMH UK audits are presented both locally and at the Trust-wide Audit meeting. Clinical teams put the findings of projects in their team reports. Individual pharmacists feed back to teams the results of audit through governance meetings. POMH UK also supply the Trust with a plethora of interventions including BNF (British National Formulary) prescribing cards for staff and information leaflets for service users and carers. These interventions are distributed to each clinical area. In addition to these interventions ICE (In case of emergency) lab reports have also been made available on the Insight system.
POMH-UK Topic 8 Medicines reconciliation	The Trust performed at a similar standard to other Trusts in the following areas: -documenting details about medication before admission -documenting details regarding adherence to medication - proportion of patients having 2 or more sources checked for reconciliation purposes within 24	In addition to the above interventions, there have also been changes to the acute care pathway on medicines reconciliation.

Name of Audit	Findings	Action taken or planned
	hours of admission (result down from previous year)	
POMH-UK Topic 6 Side effects of depot antipsychotics	Assessment of side effects of depot antipsychotics fell from 31% to 26% There was a reduction in documenting side effects rating scale, blood tests relating to side effects and physical examinations However, patients with no formal or informal assessment of side effects had improved from 31% to 24%	In addition to the above interventions, there have also been a series of training sessions to Community Mental Health Teams (CMHTs) on the monitoring of side effects.
POMH-UK Topic 2 Metabolic side effects of antipsychotics	The Trusts compliance to the standards was 40% for all 4 aspects of metabolic syndrome	In addition to the above interventions, there have also been a series of training sessions to CMHTs on the monitoring of side effects.
POMH-UK Topic: Antipsychotic use in learning disabilities	Results for this audit were generally positive: 100% documented indication for antipsychotic 100% reviewed need for antipsychotic reviewed (100%) 100% general assessment of side effects 100% lipid monitoring assessed 78% assessment of extra-pyramidal side effects 78% documented weight change 78% blood pressure monitored 78% blood glucose assessed	In addition to the above interventions, Pharmacy are also continually monitoring high dose and combination antipsychotics.
National audit of schizophrenia	To begin data collection June 2011	

The Trust chose to participate in 5 additional national audits:

Table 8: Results of additional national clinical audits and action taken

Name of Audit	Findings	Action taken or planned
NHS Litigation Authority Records Audit	The third annual records audit showed improvements in ten areas but weaknesses in the recording of risk assessments and management plans.	A programme of clinical risk training was developed. This was implemented from January 2011. In addition to this team results fed back to teams and local improvement actions taken.
National Patient Safety Agency (NPSA) Suicide Prevention toolkit	The audit was completed on two wards. It found that staff had not received clinical risk training for some time.	All of the staff on these wards have now been trained in clinical risk assessment and management.
Royal College of Psychiatrists Memory	The Trust's Memory Service met 131/147 standards and is now an	Recommendations for further improvement were:

Name of Audit	Findings	Action taken or planned
Services National Accreditation Programme (MSNAP)	accredited service under the Programme.	-to reduce the waiting time for appointments -to offer copy letters to referrers, service users and carers -to improve staff supervision and training -to conduct a survey of referrers' experience of the service
Falls – Royal College Physicians	Data has been submitted to the Royal College.	
Essence of care – food and nutrition	The audit identified that patients were not receiving a nutritional assessment on discharge.	New screening tool (MUST) has been implemented and a dietician has been appointed

On a quarterly basis the Board review the findings and progress of the 13 national audits. They also review the progress of 49 other local audits. In total 30 of local audits (61%) had reached the 'action' stage.

Some examples of improvements made following local clinical audits are given below:

Examples of improvements made following local audits:

1. Antipsychotic prescribing in the rapid response team

Following an audit done in the dementia rapid response and home treatment team there are now low levels of prescribing of antipsychotics in accordance with NICE guidelines.

2. Challenging behaviour audit

An audit of staff knowledge of challenging behaviour has led to a 75% reduction in the use of medication on one unit.

3. Audit of self-directed support

A baseline audit of self-directed support has led to all community mental health teams receiving three day training on how to deliver self-directed support. The audit will be repeated to see if the training results in increased uptake of self-directed support

Full details are available in the Trust's Annual Clinical Audit Report.

Following its review of governance systems this year, the Trust will be maximising the effective use of clinical audit to provide assurances to the Board and the new Quality Assurance Committee. New criteria for selecting clinical audit topics will ensure that national and strategic interests are addressed in the programme.

Changes will also be made to the Trust's Clinical Audit Group in the year ahead so that the audit capacity of doctors in training can be used to best effect for the benefit of the Trust as well as forming a key part of their training, and so that the Clinical Audit Group has more involvement from a wider range of professions.

3. Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust between 1 April 2010 and 31 March 2011 that were recruited during that period to participate in research approved by a research ethics committee was 163.

Sheffield Health and Social Care NHS Foundation Trust was involved in conducting 20 clinical research projects which aimed to recruit patients to studies in mental health, dementias and neuro-degeneration, stroke and general health services research, although not all studies recruited patients between 1 April 2010 and 31 March 2011.

Developing participation in research has been identified as a priority for the Trust, which recognises the potentially beneficial effects on quality of care and the recruitment and retention of skilled staff. The world-class stature of the University of Sheffield and Sheffield Hallam University in various areas of health-related research (e.g. psychological treatments and neuropsychiatry) provides the opportunity for Trust staff to partner with highly regarded researchers to develop the quantity and quality of research with which SHSC is involved.

One of the barriers to engaging with researchers was the length of time taken to give NHS approval to research projects. The Research Development Unit has prioritised this and approval times for national portfolio research projects have improved from an average of 70-80 days in October 2010 to approximately 20 days at the end of March 2011. A new Trust Director of the Research Development Unit was appointed In November 2011. He is establishing a new Research Committee to identify capacity and capability for research and promote participation in research working with established research partners.

Example of a research project carried out in the Trust - how it helps to improve the quality of care and treatment

Improving Quality and Effectiveness of Services, Therapies and Self-management of longer term depression (IQuESTS)

IQuESTS is a South Yorkshire project in conjunction with the University of Sheffield which aims to improve care for service users with long term depression.

It has 3 work programmes:

- System modelling of the care pathway and self management
- Understanding self-management by learning from service users
- Testing systems improvements

The programme will follow people who are receiving care for long-term depression over several years to better understand their experience of living with and managing depression. At the same time a clinical research service will test out aids for self-management for service users and clinicians.

Staff from the Trust are involved in the IQuESTS work. They will be able to bring the expertise they gain in treating depression and supporting people with long term depression in self management approaches to the work of mental health teams and services.

4. Goals Agreed with Commissioners: Use of CQUIN Payment Framework

A proportion of Sheffield Health and Social Care NHS Foundation Trust income in 2010/11 was conditional on achieving quality improvement and innovation (CQUIN) goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

In total £1,034,332 was conditional on meeting the CQUIN goals during 2010/11 and £719,394 (70%) had been retained at year end.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at http://www.shsc.nhs.uk/about-us/annual-plan-report/cquin.

5. What Others Say about the Trust: Statements from the Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered, without conditions, for all regulated activities in all locations for both health and social care.

The Care Quality Commission (CQC) has not taken enforcement action against the Trust in the year ending 31st March 2011.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. However, it has taken part in a planned review of its healthcare provision.

Following the planned review of all 11 healthcare locations during 2010/11, the CQC required the Trust to take 9 compliance actions (against 6 Essential Standards of Quality and Safety outcomes) and 1 improvement action, across 3 locations. The CQC found no problems in the remaining 8 locations, from the evidence it reviewed.

The Commission made a number of positive comments about the care and treatment provided by the Trust in its reports.

"On the site visit performed 11 January 2011 we found that both Maple and Rowan wards along with the Intensive Treatment Service (ITS), despite them being fully occupied, had a positive, calm and welcoming atmosphere. We found staff members to be competent, knowledgeable, friendly and helpful and had a positive commitment to the care of patients on the ward. We found systems and processes in place to ensure people who use services receive safe and coordinated care, treatment and support where more than one provider is involved, or where they are moved between services.

"We found people who use services and people who work in the location are in safe, accessible surroundings that promote their wellbeing. We found evidence to demonstrate that people who use services would have their health and welfare needs met by competent staff".

Some comments made by service users to the Care Quality Commission during their visits to wards in January 2011:

"Definitely had 100% good care on this ward since I've been here, staff been more than helpful…They come and tell us when they come on duty who has been assigned to me for the shift".

"Lots of activities to keep me busy. Enjoy going to OT pottery, baking."

"Feel safe and staff do a good job".

"I really believe they are really lovely staff. I couldn't do their job and be as calm and patient as them".

"My experience is that I have had a brilliant time here, in comparison to other services they are brilliant"

The Trust is implementing an action plan to make sure it addresses the compliance and improvement actions which resulted from the visit. The table below shows the concerns raised by the Care Quality Commission (red-amber-yellow-green rated for the seriousness of the concern identified), the actions planned and the progress made by the end of 2010/11.

Table 10: Progress on action plan following CQC Planned Review

Key: Seriousness of gap in compliance – level of risk

	Major concern
	Moderate concern
	Minor concern
	Compliant but action needed

Table 10: Progress on action plan following CQC Planned Review

Compliance actions Area for action			Action planned	Action taken by 31 March 2011
Outcome	**Location**	**Action needed**		
2: Consent to care and treatment	Michael Carlisle and Longley Centres	To improve recording of assessments of capacity to make decisions	Adult inpatient consultants and Mental Capacity Act lead have agreed best way to record medical conversations and capacity decisions. An action plan to implement the	Capacity to consent and SOAD decision forms have been developed and sent out. Action plan has been shared with consultants.
		To improve recording by medical staff of explanations of risks, benefits and alternative treatment options		

Compliance actions Area for action			Action planned	Action taken by 31 March 2011
Outcome	**Location**	**Action needed**		
			changes required is to be agreed and implemented by September 2011	
4: Care and welfare of people who use services	Michael Carlisle and Longley Centres	To improve systematic individualised risk assessment	Establish training programme on clinical risk assessment and management. Establish use of risk assessment tool Basic Risk Assessment, BRAM and Detailed Risk assessment, DRAM) Establish audit programme in use of risk assessment tools and quality of risk assessments.	Training programme in place. 180 staff trained (84 in acute services) as at 31st March.
		To improve the involvement of service users in the development of their care plans	Acute Care Forum (which has service user representation on it) to discuss the issue and formulate an improvement plan Monitor and review service user involvement in care planning	Discussion has taken place and actions agreed. Improvement plan in progress. Continuous monitoring through quality and dignity survey and feedback reports Ward managers / consultants contributed to independent review of service user involvement in ward rounds

Compliance actions Area for action			Action planned	Action taken by 31 March 2011
Outcome	**Location**	**Action needed**		
			Alter systems to enable patients the option to be included in MDT discussions	undertaken by Sheffield Advocacy Service
	Longley Centre	Review arrangements for single sex accommodation on Rowan ward	Relocate male patient occupying room in female area Review disabled facilities on the ward and develop business plan for the creation of additional disabled room in male area Options paper re: improving mixed sex accommodation to be developed for Executive Directors Group to evaluate and agree	Completed Reviewed facilities. Business plan not yet completed.
		Work with partners to improve section 136 detentions – find a more suitable location or manage the impact of detentions in a way that has less impact on the ward	Review arrangements for receiving patients under section 136.	
	Michael Carlisle Centre	Review arrangements for single sex accommodation	Ward walk rounds to be completed with PCT representative present. Implement action plan	Completed and action plan produced

Compliance actions Area for action			Action planned	Action taken by 31 March 2011
Outcome	Location	Action needed		
			Options paper re: improving mixed sex accommodation to be developed for Executive Directors Group to evaluate and agree	
		Respond to concerns raised by service users to CQC inspectors about attitude of a member of staff	Review complaints processes on ward. Review past complaints to identify any themes about member of staff	Completed Completed with no themes / issues identified.
		Continue to work on lessening impact of high bed occupancy	Introduce step down beds as part of pilot Evaluate impact of step down bed pilot Develop alternatives to admission in partnership with PCT. Review discharge process Review bed management processes	Completed – initial reduction in bed occupancy realised Completed – have reduced need for dual assessment pre discharge. Completed.
8: Cleanliness and infection control	Longley Centre	Improve cleanliness of seclusion room on ward	Amend cleaning schedules and review toilet and washing facilities	Completed

Compliance actions Area for action			Action planned	Action taken by 31 March 2011
Outcome	**Location**	**Action needed**		
			available.	
10: Safety and suitability of premises	Longley Centre	Replace clear glazing on link corridor and fire exit doors to improve privacy Review and improve heating	Obscure film to be fitted to glass Bleed all radiators Install pressurised gas fired boiler and low surface temperature radiators	Completed Completed
13: Staffing	Grenoside	Review permanent staffing arrangements to make sure there are sufficient staff to meet the needs of service users	Ward evaluation to include sections on staffing levels and skill mix. Review of flexible staffing arrangements Recruit additional staff	Evaluation commissioned – report expected May 2011 Review completed – implementation of revised system started Interviews fro 3x30 hours Band 5 nurses and 2 x 37.5 Band 5 nurses have taken place.
20: Records	Michael Carlisle and Longley Centres	Improve medical records systems (paper and electronic) to make sure key issues are recorded and subsequently accessible	Pilot and evaluate e-records in ITS Review content and accessibility of care records system via clinical summit. Review indexing of electronic care records and train staff in use of	Completed

Compliance actions Area for action			Action planned	Action taken by 31 March 2011
Outcome	**Location**	**Action needed**		
			electronic records. Remove/scan or archive as appropriate all paper patient records and move to total electronic care records	

Improvement actions				
Outcome	**Location**	**Action needed**	**Action planned**	**Action taken by 31 March 2011**
13: Staffing	MCC	To review locum cover and suitability of locum arrangements		Completed. Substantive postholder has returned to work

Recommendations				
Outcome	**Location**	**Action needed**	**Action planned**	**Action taken by 31 March 2011**
14: Supporting workers	Fulwood	Review discrepancy in PDR recording arrangements	Review individual team figures against those held centrally in the Electronic Staff Record	All teams reminded to include PDR rates in their team governance reports

6. Data Quality: Statement on the relevance of data quality and Trust actions to improve data quality

Data quality is important because it enables information to be shared that is accurate, timely and appropriate. The Trust is taking the following actions to improve data quality:

- We use both internal and external reports to monitor the quality of key indicators e.g.
    - NHS Sheffield monitor our data quality via nationally submitted datasets and discuss their findings with us
    - We have procedures in place to check the quality of data and correct inaccuracies and omissions before the submission of national datasets
- We make use of the external data quality reports generated by the Information Centre to assess data quality internally
- We wrote clear and consistent definitions for indicators in the Trust's new Inform system, a web-based data-store for quality and performance information
- Inform enables staff such as team managers or directors to assess the accuracy of the data held about their service quickly and address any anomalies identified as a result of this feedback loop
- We intend to place more key performance indicators relevant to data quality in the further development of Inform

- The Insight system has built-in routines to validate data as it is entered
- The Commercial Relations Department check details before submitting their returns to GP practices
- We make regular submissions to the Demographics Batch service to identify or verify NHS numbers, which helps to prevent the creation of duplicate client records and identify and remove existing duplicates
- Staff have access to the Summary Care Record/Personal Demographics Service so they can check NHS number, registered GP and address details. We are working to automate checking of registered GP for Insight clients
- We use the Enhanced Reporting Service to identify deaths of service users and keep the Insight system up-to-date

The data quality of the Annual Quality Account for 2009/10 was audited last year by the Audit Commission, who shared their findings with the Trust. A total of 14 recommendations for improvement were made by the auditors. Actions agreed following this audit have been implemented or are in progress, although some timescales have been delayed.

The Trust had access to sufficient sources of information to enable the production of these accounts and to cover the aspects of quality as required by the national guidance, including safety, clinical effectiveness and service user experience. It will continue to work on improvements to quality data reporting with the second phase of Inform and through comprehensive reports to the new Quality Assurance Committee.

Table 11: Aspects of Data Quality

1. NHS Number and General Medical Practice Code Validity
Sheffield Health & Social Care NHS Foundation Trust submitted the Admitted Patient Care (APC) Commissioning Data Set (CDS) and the Mental Health Minimum Dataset (MHMDS) to the required timetables to the Information Centre/Secondary Uses Service
The percentage of records in the CDS APC published data which included a valid NHS number was 99.8% (April-December 2010)
The percentage of records in the CDS APC published data which included a valid General Medical Practice Code was 100.0% (April-December 2010)
The percentage of records in the MHMDS published data which included a valid General Medical Practice Code was 99% (Quarter 1 2010-2011 figures)
Information Governance Toolkit
Sheffield Health & Social Care NHS Foundation Trust Information Governance Toolkit Assessment Report score overall score for 20010-2011 (version 8, March 2011 submission) was 59% and was graded red (not satisfactory).

Clinical Coding Audit
Sheffield Health & Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010-2011 by the Audit Commission

The Information Governance Toolkit Assessment changed significantly during 2010/11, setting a much higher standard than previously. The Trust made significant progress towards achievement of the new requirements during the year but was not able to reach the required standards on all items and reach a 'satisfactory' position by the end of the year. It has an action plan in place to deliver level 2 on all items and it has prioritised work on those items which have a direct bearing on the care and treatment of service users.

Part 3

3A Review of Quality Performance

This section provides evidence and an overview of the quality of care and treatment in the Trust. It considers all the components of good quality care:

1. Safety

The Trust prides itself on having a strong safety culture and it encourages staff to report incidents and 'near misses.' It does this to make sure that it can learn from looking at patterns and trends and make improvements to services to reduce the risk of harm to service users and others. In incident and serious incident reports, the Trust expects to see high number of incidents reported, but only a small proportion of these should be serious incidents, or ones that have resulted in harm to service users or others.

During the year there were 262 serious incidents reported by the Trust. The current Trust definition of a 'serious incident' means that this appears high in comparison with other NHS Trusts, including some other mental health trusts. The way in which the Trust assesses and defines a 'serious incident' has been reviewed in the year and will be changed in 2011/12 so that it more closely corresponds to the guidance from the National Patient Safety Agency (NPSA). We anticipate the number of incidents defined as 'serious' will decrease next year and we will be able to present more benchmarking data in future.

None of the serious incidents reported during the year were 'never events' i.e. incidents defined by the National Patient Safety Agency as ones which should have been prevented.

The NHS disseminates urgent patient safety alerts through the Central Alerting System. The Trust received 127 Central Alerting System (CAS) alerts during the year and 89% were concluded within the target timescale. This is an improvement from the previous year (71% within timescale) and we aim to have a 100% success rate on concluding the alerts in 2011/12.

Patient Safety Information

We have chosen to report on 4 specific types of incidents in particular in these accounts:

- The Trust reports a high number of slips, trips and falls. There was a reduction in the number of fractures resulting from falls during the year, down to 8 from a range of 17-26 per year over the previous 4 years (report from Falls NICE Guidelines Implementation group in February 2011). However there was no overall reduction in those falls resulting in injury of any kind. The Trust has an active programme of work in place to reduce the risk of falling and minimise the negative consequences which can result for service users following a fall.
- The risk of self harm or suicide is a concern for mental health and substance misuse services, and the Trust is implementing new clinical risk assessment and management training for staff.
- Violence, aggression and verbal abuse incidents are being scrutinised by the Trust as it plans to introduce the new Respect approach.
- Medication incidents are scrutinised regularly with lead Pharmacy involvement in the Incidents process. The overwhelming majority of these incidents do not result in harm to service users. Of the 18 that were rated as serious incidents, I person was admitted to hospital for observation and 1 was assessed by an Emergency Care Practitioner, but none resulted in actual harm (information from review of the 18 serious incident reports).

Table 12: Serious incidents, all incidents, specific incidents
Data from Ulysses Safeguard, supplemented by review of incident reports

Indicator	Number of Incidents		
	2010/11	2009/10	2008/09
All reported incidents	5914	6000	5921
All serious incidents	262	292	294
'Never events' Target =0	0	0	0
Suicide and self harm			
All reported self harm incidents	358	363	275
Suicide of inpatient or within 7 days of discharge	1*	1	0
Assault/verbal abuse			
All reported physical assaults where the instigator was a service user	758	1049	855
All reported physical assaults where the instigator was a service user and where the incident was graded as serious	12	12	12
All reported physical assaults where the instigator was a service user that resulted in injury	19	25	20
All physical assaults on staff by service users, carers, visitors, other staff and the public	526	708	612
Physical assaults on staff by service users, carers, visitors, other staff and the public where the incident was graded as serious	6	10	12
Physical assaults on staff resulting in injury	178	193	167
Slips, trips and falls			
All service user slips, trips or falls	1547	1524	1475
Slips, trips or falls resulting in service user injury	668	536	541
Medication			
All medication incidents	336	367	329

*Anticipated number: awaiting results of Coroners' Inquest for confirmation

Cleanliness and infection control information

The Trust has declared full compliance with the Hygiene Code and Infection Control regulations. It continues to report very low levels of healthcare acquired infections, methicillin-resistant Straphococcus aureus (MRSA) and clostridium difficile (c-diff.)

Table 13: Cleanliness and Infection Control indicators
Data from local Infection Control database – cases as defined by Health Protection Agency guidelines

Indicator	2010/11	2009/10	2008/09
MRSA cases	0	0	1
C-diff cases	1	1	Data not available
Outbreaks resulting in service closure	8	12	Data not available

This year the Trust is also reporting on outbreaks of infections (e.g. a cluster of people with the norovirus) which have resulted in services being closed. We have systems in place to deal with these emergencies, make sure people are safe and undertake rigorous cleaning, but hope to see further reductions in outbreaks in the year ahead.

We have also added information about the risks of infections faced by people using the Drugs and Alcohol Services this year:

Table 13: Infection Control and Substance Misuse Data from Insight

	2010/11	
BBV (Blood Born viruses) activity	**Target**	**As at end Q3**
New presentations offered BBV vaccination	90%	100%
New presentations who accept an offer commence a BBV vaccination	90%	91%
New presentations (previous or current injectors) have a recorded HEPATITIS C vaccination status	90%	96%
New presentations (current or ever injectors) offered a HEPATITIS C test	90%	100%
Number of HIV screening tests completed since 1st April 2010	Not applicable	524

Information on patients' physical health and wellbeing

As a Trust that provides services for people with learning disabilities, mental health problems or drug and alcohol misuse, we recognise that many of the people using our services face challenges to their physical health and wellbeing too. Our commissioners NHS Sheffield are also keen to see good quality physical healthcare in our services, and have set CQUIN targets in this area. We therefore monitor some key indicators of physical well-being.

We monitor all people who are admitted to inpatient services to make sure their physical health is maintained or improved if necessary. We do this by screening for pressure ulcers, nutritional status and overall physical health. The work on screening for nutritional status is described in more detail earlier in these accounts.

Table 14: Physical health indicators Data from CQUIN submissions – Insight data

Indicator	NHS Sheffield target	2010/11 Q4 figure	2009/10	2008/09
% of people screened for pressure ulcers (Grade II and above)	100%	100%	Data not collected	Data not collected
Physical health screening of older adults on admission	100%	100%	84%	81%
Nutrition (MUST) screening of older adults on admission	100%	100%	98.6%	Data not collected
Nutrition (MUST) screening of older adults on discharge	95%	97%	Data not collected	Data not collected

In previous Quality Accounts, data on physical health screening was presented from local records audits of a sample of cases: these new reports are derived from records of all older people admitted to inpatient areas and so are more comprehensive. For this reason, we have not presented the results from working age adults this year. Next year we intend to report more widely using the more comprehensive data.

The report on pressure ulcers is new this year. The pressure ulcer screening on the older adult inpatient areas showed that no service users were suffering from pressure ulcers of the Grade II or above level of severity.

A programme of work on pressure ulcers during the year saw a new protocol developed together with information for staff, service users and carers about pressure ulcers. Training for staff and Essence of Care benchmarking took place in older adults areas and the learning disabilities respite care service at Longley Meadows.

Single sex accommodation

The Trust declared compliance with the national standard for Eliminating Mixed Sex Accommodation during 2010/11. It has recently reviewed its Delivering Single Sex Accommodation Plan. In partnership with NHS Sheffield it holds regular visits across services to check continuing compliance and any issues identified as a result are included in the updated action plan. The action plan is monitored through the new Quality Assurance Committee (formerly through Quality and Risk Group.)

2. Effectiveness

The Trust assesses the effectiveness of the care and treatment it provides against both local and national standards. For example, it reviews if it is meeting the guidance from the National Institute for Health and Clinical Excellence (NICE) in the form of technology appraisals, standards and guidelines. Last year all NICE technology appraisals applying to the Trust were implemented within the 3 month target time and work was in progress to deliver all the NICE mental health guidelines.

Early intervention in psychosis

The Trust aims to diagnose and treat people with serious conditions quickly. Early identification and treatment of psychosis is known to improve the long term prognosis for people. The Trust therefore monitors the number of people seen by the Early Intervention Service (EIS). In 2010/11 129 new cases were seen by the EIS (data from Insight). This continues to outstrip the target set by NHS Sheffield of 90 new cases per year, building on the 285 new cases seen in 2009/10 and 147 in 2008/09.

In 2010/11, the Early Intervention Service received 1 complaint and 13 compliments. One compliment was:

> Thanks so much for being a brilliant social worker. You're fun to be around and seem to work really hard behind the scenes to make sure the people you're helping (to help themselves) get the best possible service
>
> West Early Intervention Service

Adult mental health care and treatment

The Trust monitors some other critical aspects of mental health service delivery and reports on them to the regulator, Monitor:

Table 15: Mental Health Indicators Data from Insight

Target indicator	Threshold	2010/11 Q4 figure	2009/10	2008/09
100% CPA patients receiving follow-up contact within 7 days of discharge from hospital	95%	96.4%	97.2%	97%
Minimising delayed transfers of care	No more than 7.5% delayed	6.9%	6.4%	6.9%
Admissions to inpatient services who had access to crisis resolution and home treatment ('gate keeping')	90% of all admissions	97.3%	94.6%	93.1%
New home treatment episodes	1202 people	1361	1365	1249
Everyone on CPA should have an annual review with their care co-ordinator	95% of people on CPA	99.3%	Not measured	Not measured
Everyone on CPA should have a formal review of their care plan	90% of people on CPA	91 – 93%	89%	85%
Access to an assessment within 4 hours of referral when in crisis	80% of people to be assessed within 4 hours by Q3	83.1%	59%	Not measured
Access to support/treatment within 8 weeks of referral (routine referrals)	50% of people to be assessed within 8 weeks by Q3	62.9% (at quarter 3) 67.8% (at quarter 4)	42.2%	Not measured

Improving Access to Psychological Treatment (IAPT)

Improving Access to Psychological Treatment services aim to treat people with mild or moderate mental health problems quickly, using effective talking therapies. These new services were set up in 2008/09.) The IAPT team measure the effectiveness and impact of what they do closely; for example, they collect systematic service user outcome measures to monitor the mental health and wellbeing of everyone they see for cognitive behaviour therapy or counselling

The table below shows the difference they are making to people, who are helped to recover and to return to work from benefits. Last year over 400 people were able to return to work:

Table 16: IAPT indicators
Data from Insight (quarterly returns to Department of Health)

Indicator	NHS Sheffield target	2010/11	2009/10	2008/09
Number of new cases seen by IAPT	5364	9036	6728	1937 (started from Oct 08)
Number (percentage) of people moving to recovery	50%	41%	44%	40%(part year)
Number of people returning to work from benefits	89 people	419	304	17 (part year)

Other services across the Trust are collecting evidence of the effectiveness of their interventions, using clinical outcome measures and measures of impact such as whether people are in work or in settled accommodation.

Access to Equipment

The Trust provides equipment for people with physical disabilities and frail health from the Community Equipment Store. It aims to deliver the necessary equipment within 7 days of assessment in 95% of cases. In 2010/11, it met this target.

Table 17: Access to equipment
Data from local reporting systems

Indicator	NHS Sheffield target	2010/11	2009/10	2008/09
Community equipment to be delivered within 7 days of assessment	95% to be delivered within 7 days	95.7%	97.2%	94.3%

Learning Disability Services

The Assessment and Treatment Unit achieved 100% against all its quality standards for service users in 2010/11.

These were:

- Having a discharge plan with clear advice for families and carers
- Having a care plan centred around individual needs
- Offered referral where appropriate to an independent advocacy service
- Having a plan to address health needs
- Having a communication profile/passport
- Individual risk management plan re restrictions (locked doors)
- Individual plans record what physical interventions are prescribed
- Maximum length of stay (12 months)

The community learning disability teams have introduced routine clinical outcome measures including HONOS-LD (HONOS for people with learning disabilities. The results from these measures will be reported next year. The learning disability teams are also collecting feedback from service users and carers.

> She listens to me. She took me on holiday and helped me get a ground floor flat. She is happy, kind and we have fun together.
>
> Compliment from service user with learning disabilities

Dementia Services

Early identification of dementia means treatment and support can start early and is more effective. Dementia services were redesigned in 2008/09 to provide more community based services and earlier diagnosis in Memory Clinics. The table below shows the increase in provision in community services.

Table 18: Dementia indicators
Data from Insight

Indicator	NHS Sheffield target	2010/11	2009/10	2008/09
Discharges from acute care (G1)	78	38	53	12 (new service during year)
Number of assessments for memory problems by Memory Management Service	600	728	636	614
Rapid response and access to home treatment	300	336	288	183 (new service)
Waiting times to access an assessment of memory problems	Not applicable	16	28	20

The dementia services are responding to urgent referrals within 24 hours as described above, but the wait for a memory assessment remains long. It reduced from 28 weeks in 2009/10 to 16 weeks in 2010/11. We will continue work on this issue, with our partners in the city, as part of the Trust quality objective to implement the NICE standard for dementia

The dementia services receive many more compliments than complaints:

Table 19: Dementia services
Complaints and compliments

Number of complaints / compliments received	2010/11	2009/10	2008/09
Total number of compliments	457	491	431
Number of informal complaints	1	11	6
Number of formal complaints	11	8	9
Total number of complaints	12	19	15

More information on complaints and compliments about all the services is available in the Annual Report on Complaints and Compliments, posted on the Trust website.

An example of a compliment about the dementia services:

> Many thanks for helping with Mum and all her needs. All staff have had a great attitude and I don't know what I would have done without your service. The care you have shown has been second to none.
>
> Dementia Rapid Response Team (North)

Drug and Alcohol Services

The Drug and Alcohol Services provided by the Trust measure the effectiveness and impact of their work against a number of quality indicators, which are set by the commissioners in contracts.

Table 20: Drug and Alcohol services – effectiveness and outcome measures Data from Insight and the National Drug Treatment Monitoring System (NDTMS)

Drugs and Alcohol quality indicator	Target	10/11	09/10	Data from
(DRUGS) No client should wait longer than 3 weeks from referral to medical appointment	100%	100%	100%	Insight
(DRUGS) No Drug Intervention Programme client should wait longer than 5 days from referral to medical appointment	100%	100%	100%	Insight
(DRUGS) No Premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	Insight
(DRUGS) No Prison release client should wait more than 24 hours from referral to medical appointment	100%	100%	100%	Insight
(ALCOHOL Single Entry and Access Point) No client will wait more than 1 week from referral to assessment	100%	100%	New target	Insight
(ALCOHOL TREATMENT SERVICE) No client should wait longer than 3 weeks from Single Entry and Access Point assessment to treatment start	100%	100%	New target	Insight
% Problematic Drug Users clients retained in treatment 12 weeks or more	Local DAAT target - 90%	89%	89%	NDTMS
Start/Initial Treatment Outcome Profile (TOP) completed	100%	96%	Not available	NDTMS
Review TOP completed	100%	59%	Not available	NDTMS
Discharge (Planned) TOP completed	100%	50%	Not available	NDTMS

Drugs and Alcohol quality indicator	Target	10/11	09/10	Data from
All clients new to treatment undergo physical health check as part of comprehensive assessment	100%	100%	New target	Insight
Number of service users & carers trained in overdose prevention and harm reduction	240	243	New target	Insight and audit
% of successful completions for the provision of treatment for injecting related wounds and infections	75%	92%	New target	Insight

Key (ratings as determined by Commissioners):

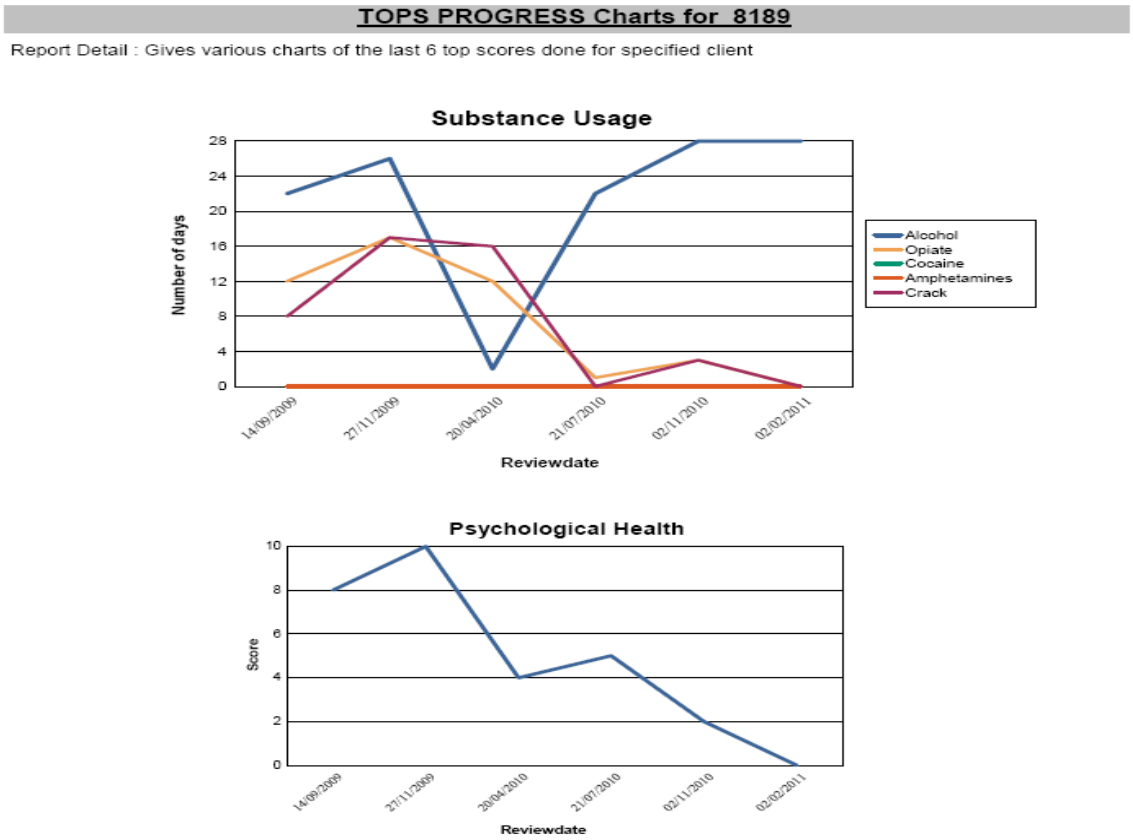
	Target not met
	Target partially/nearly met
	Target fully met

The sampling method used by the Commissioners for the Treatment Outcome Profile (TOP) outcome measure is that initial TOPs were measured for people starting in treatment during July, August and September 2010 (49 people), review TOPs were measured for these people if they remained in treatment for 6 months or more (39 people). Discharge TOPs were taken for people who were discharged drug free during July, August and September 2010 (6 people fell into this group). The target is met (green rating) if 80% are completed and not met if the percentage is 59% or less.

The service is committed to using the TOP outcome measure with all its service users. Between 750 and 850 service users are in treatment at any one time, and TOPs are reviewed in a clinically appropriate way for over 80% of them.

The services monitor the effectiveness of the treatment they provide closely with individual service users, sharing this information with service users in a way that helps them see progress and understand their problems. The illustration below gives an anonymous example of the kind of data that is shared with service users in care and treatment; it shows how psychological health has deteriorated with increased consumption of alcohol, even though the use of illegal substances has reduced. This kind of information can provide invaluable insights for both service users and staff.

Example of Service User Outcome reports used to aid care and treatment by Drug and Alcohol Services



3. Service User and Carer Experience

The Trust collects service user and carer feedback about the quality of care and their experiences in many different ways. Among the most useful is the collection and analysis of the information from complaints and compliments:

Table 21: Complaints and compliments across the Trust
Data from Ulysses Safeguard

Indicator	2010/11	2009/10	2008/09
Number of formal complaints	86	79	68
Number of informal complaints	286	226	303
Number of compliments	1559	1440	1273

Compliments outnumbered complaints in 2010/11 by a proportion of 23 to one.

A full picture of the complaints and compliments received by the Trust is available on the Trust website in the Annual Complaints and Compliments Report. This includes feedback from the complainants (people making complaints) about the experience of complaining.

Issues raised in complaints are reviewed:

Table 22: Issues raised/categories of complaints across the Trust Data from Ulysses Safeguard

Category of Complaints	2010/11		2009/10		2008/09	
	Formal	Informal	Formal	Informal	Formal	Informal
Admission, transfer or discharge	11	7	9	12	4	14
All aspects of clinical care	34	52	35	44	32	62
Appointment delay or cancellation	3	10	6	10	0	8
Attitude of staff	16	57	19	39	19	61
Communication/ information to patients	2	12	3	4	0	16
Complaints Handling	1	0	0	0	0	0
Discrimination Age, Gender, Race	0	3	0	0	0	2
Failure to follow agreed policies	0	3	2	1	3	2
Hotel services including food	0	25	0	14	0	29
Other	2	12	1	25	1	16
PCT Commissioning	0	0	0	1	0	0
Policy & Commercial Decisions	4	15	0	12	1	13
Privacy and dignity	9	36	2	18	4	20
Patients' property and expenses	2	14	2	13	4	12
Personal records	0	6	0	0	0	0
Premises, aids and equipment	2	33	0	29	0	47
Transport	0	1	0	4	0	1

All complaints are investigated and, if they are upheld or partially upheld, actions plan will be put in place to address the problems.

During 2010/11, other sources of feedback included posts on the Patient Opinion website (a total of 5 posts were made about the Trust during the year) and on the Trust's own website (184 website enquiries were made and responded to during the year).

An idea of how the Trust is performing in comparison with other mental health trusts nationally can be obtained from the Care Quality Commission (CQC) Annual Patient Survey. In 2010 the Survey received responses from 303 service users (36% of all those surveyed.) The full results are available on the CQC website on www.cqc.org.uk

The Trust fell within the average range for the replies to the question 'Overall, how would you rate the care that you have received from Mental Health Services in the last 12 months?'

The table below shows results for CQC patient surveys over the last 3 years: it should be noted that the 2009 survey was of inpatients rather than community patients and so different questions were asked. This has made year on year comparisons more difficult. More detail on the 2009 results in available in last Year's Quality Accounts or on the CQC website.

Table 23: Care Quality Commission Patient Survey feedback Data from CQC

Topic	Summary of question asked	Results 2010 Survey (Community)	Results 2009 Survey (Inpatients)	Results 2008 Survey (Community)
Health and social care workers	Listen to you	Amber	Amber Psychiatrist	Red Psychiatrist
			Green Nurse	Amber Nurse
	Treat you with respect	Amber	Amber Psychiatrist	Amber Psychiatrist
			Green Nurse	Amber Nurse
Medications	Your views taken into account	Green	Amber Involvement in decisions about care and treatment	Green
	Given information	Green	Green Explain purpose Side effects	Amber Explain purpose Side effects
Talking therapies	Meet your needs	Amber	Amber	Green
	Find helpful	Green	Too few numbers replied	Amber
Care Coordinator	Do you know who it is	Amber	Not asked	Amber
Care Plan	Given a copy	Amber	Not asked	Amber
	Views taken into account	Green	Not asked	Green
Care Plan Review	Find helpful	Green Highest score nationally	Not asked	Amber
Day to Day Living	Help with work	Amber	Not asked	Amber
	Help with accommodation	Amber	Not asked	Not asked
Crisis Care	Number to call out of hours	Red	Red	Red

Key:

Green	Top 20% of Trusts
Amber	Middle range
Red	Bottom 20% of Trusts

Plans to improve the current arrangements to ensure service users can access support via a phone line out of hours have not progressed as intended. During 20010/11 the Trust had intended to strengthen access to telephone support for existing service users. Plans were outlined to provide improved out of hours support for adults with mental health problems in crisis through the Acute Care

re-configuration developments. Good progress has been made in responding to the needs of people in crisis (as reported elsewhere). However, the Trust has not been able to make the hoped for progress on improving access to telephone support 24 hours per day. It continues to be a priority for the Trust's governors to make sure this issue is resolved, and paper is going to Board on it in summer 2011. During 2011/12 the Trust will finalise its new service model for Acute Care services, and will ensure this need is effectively provided for.

Service user feedback at team level

Teams in the Trust are also collecting feedback from service users and using it to improve the quality of care, as described in the report on the quality objectives for 2010/11. There are 61 teams, wards or services in the Trust that provide health and social care for service users and carers.

Here are just a few examples of the kind of results that have come from this work:

Eating Disorders – Service User Questionnaire

Background

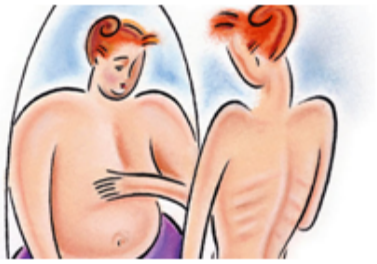
The aim of this survey was to ensure that patients were satisfied with their care from the Eating Disorders service in 2010 following discharge.

Results	% Yes
1. Were you satisfied with the waiting time?	100%
2. Were decisions about your care clearly communicated?	89%
3. Were you given useful information that helped you understand your difficulties?	78%
4. Was the service sensitive to the patients culture and background?	78%
5. Did the treatment you received help you deal with your difficulties?	78%
6. Did the treatment you received meet your need?	78%
7. Were you satisfied with the plans that were made following discharge?	67%
8. Overall, were you satisfied with the service?	78%

"Friendly and relaxed. Able to talk easily and openly, didn't feel judged or pressured"

"Learned to accept my difficulties and not be in denial"

"Referred me to in-patient care which was needed"



Conclusions / Next steps

Service users expressed overall satisfaction with their care from the Eating Disorders service. The only recommendation was to perhaps have more flexibility with appointments. The service is considering administering this regularly throughout treatment to obtain more feedback.

Hawthorn & Daleside Inpatient Exit Questionnaire

Aim

The aim of this project was to ask patients that stayed on Hawthorn and Daleside whether they were satisfied with their stay on the above wards in 2010.

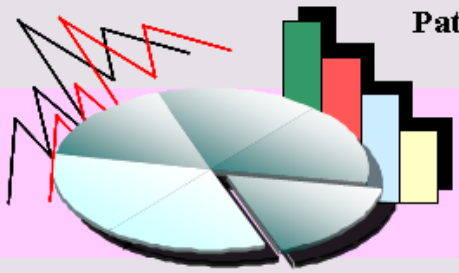
Results	Daleside % yes	Hawthorn % yes
Was your privacy and dignity respected?	100%	100%
How safe did you feel in your surroundings?	100%	100%
Did you receive enough information about the ward?	100%	100%
Did you meet with your named nurse to discuss your care?	83%	100%
Were you offered a copy of your care plan?	50%	66%
Did you see your doctor regularly?	66%	100%
Did you get the necessary information about your medication?	100%	83%
Were you able to participate in activities on the ward?	100%	100%
Were you offered occupational therapy regularly?	100%	100%
Did you know about arrangements for your follow up care?	100%	100%
Did you have confidence in the staff that worked with you?	100%	100%

Conclusions

Patients were "on the whole" satisfied with their care on Hawthorn and Daleside. It appeared that more patients need copies of their care plans.

"The staff were kind, they were always willing to help and put me at ease. They were very patient even when things got difficult"

LIMBRICK SATISFACTION SURVEY RESULTS 2010 – KEY FINDINGS



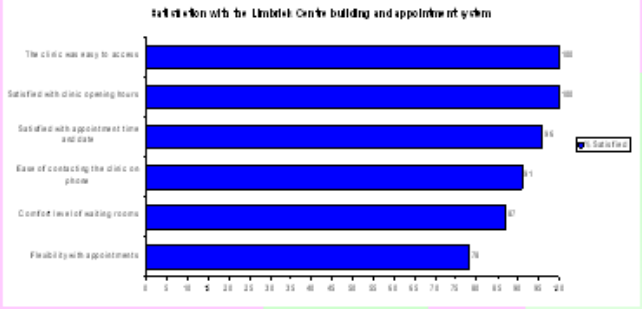
Patients Experience in Clinic, with Dr Mullins and with the Limbrick Staff

Background and Methodology

- Survey carried out to rate service users experience of outpatient appts at the Limbrick centre
- 23 service users gave feedback out of a possible 25 respondents.
- Responses scored on 1 to 5 scale (0 = worst, 5 = best) and service users comments
- Feedback carried out by volunteer service user at Limbrick Centre

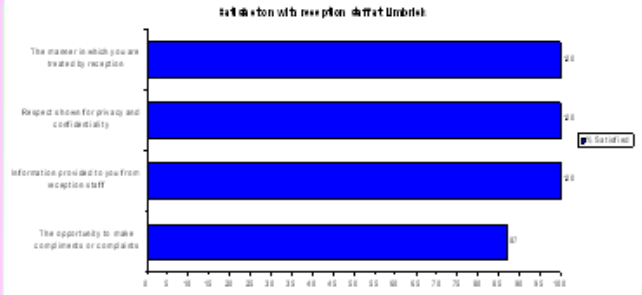
Demographics

Average Age	Female	Male	White British	Black/ Black British Caribbean	Black/ Black British African	Other
43	9	14	19	1	1	2



KEY AREA: THE LIMBRICK CENTRE EXPERIENCE

- 'Friendly and welcoming staff. Very understanding, talkative, competent and give opinions'
- 'Calm environment. Comforting and reassuring'
- 'Friendly/professional place'

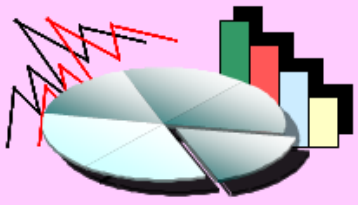


KEY AREA: THE LIMBRICK STAFF

- 'Very friendly, reassuring, efficient and trust them. Everyone is nice'
- 'Discreet, polite, professional, informative and accommodating'
- 'Cheery and welcoming'

KEY AREA: DR MULLINS

- 'Nicest Dr I have seen. Give him 10 out of 10'
- 'Compassionate, very good listener. Reassuring, sympathetic and forthright'
- 'Brings himself down to my level. Talks in normal terms not medical terminology'
- 'Helpful, understanding. Good at his job'
- 'Puts my families mind at ease'



OVERALL PERCEPTIONS:

- 'Limbrick Centre very warm and welcoming. Staff friendly and compassionate'
- 'Sympathetic, intelligent and compassionate psychiatrist. Easy to talk to and puts mind at rest'
- 'Staff cheery and welcoming'

4. Equality and inclusion

The Trust wants to make sure that it is treating its service users fairly and without discrimination and that it is responsive to the diverse needs of individuals and communities. It meets all its Equality duties and has a Single Equality Scheme and related action plan.

It has been carrying out a number of projects to improve the experience of people from Black and minority ethnic groups. This was a Trust quality objective for 2010/11 and the results are reported in detail above.

It has been working with other partners in the city to try to support people with mental health problems, drug or alcohol problems or learning disabilities into employment, training, volunteering. It has set a good example by becoming a Mindful Employer and supporting the employment of people with mental health problems within its services. In May 2010 it led a city-wide launch of the Mindful Employer Scheme and encouraged all local NHS providers, NHS Sheffield and the City Council to sign up to the scheme.

Table 24: Inclusion indicators for people with severe mental health problems Data from Insight and audit – Quarter 4 figures for the 2 years.

Indicator	Local Area Agreement target (where applicable)	2010/11	2009/10
People with severe mental health problems in employment (on Care Programme Approach) – number of people		102 people	98 people
People with severe mental health problems in employment (on Care Programme Approach) - % of people on CPA	8.02% of people on CPA in employment by Q4	6.3%	6.9%
% of Carers of people on CPA offered a carer's assessment		83.9%	85.6%
People accessing direct payments to purchase their own social care packages		115 people receiving direct payments by quarter 4	Not measured

The figures for people supported by IAPT who have returned to work off benefits have been described above.

Although the figures for people on CPA in employment are below the target set by the Local Area Agreement, there has been a small rise in the numbers of people in work despite the economic challenges. The Trust has a focus on supporting people into work and volunteering, for example:

- Buster's café opened at the Grenoside site, staffed by services users and providing fair-trade teas and coffees;
- 'The Works', an interactive tool designed by service users with support from staff in the User Support and Employment team helps service users find ways into employment;
- the launch of a DVD 'It could work for you' this year, supporting service users into volunteering.

5. Staff views and experience of quality

The Trust believes that having sufficient, well trained and experienced staff is critical to providing the best quality care. Staff also have an important role in improving quality and in making sure that services are safe and the quality of care is good. Every year, the Care Quality Commission (CQC) commissions a review of staff in the NHS, including staff in SHSC.

During 2010/11, the CQC staff survey results showed that 68% of SHSC staff would recommend the Trust as a place to work, in comparison with 54% of NHS staff nationally. 63% of SHSC staff said that if a relative needed treatment they would be happy with the standard of care the Trust provides, compared with 59% of staff nationally. 81% of staff said they felt satisfied with the quality of work and patient care they were able to deliver, falling within the top 20% of mental health trusts nationally.

The Trust results fell within the top 20% nationally for the percentage of staff receiving job-relevant training, learning or development in the last 12 months. The numbers of staff reporting that they had received appraisals and personal development plans had risen significantly since the previous year from 48% to 66%, although the Trust remained in the lowest 20% nationally on this item. All teams have been asked to report on staff appraisals in their team governance reports.

6. Regulators' views

The Trust is regulated by the Care Quality Commission, which focuses on quality and service user experience, and Monitor, which focuses on finance and governance. It is also assessed by the NHS Litigation Authority (NHSLA) for risk management standards and the Patient Environment Assessment Team (PEAT.)

A summary of the Trust's compliance with these regulators is presented to the Board each month as part of a regulation dashboard

Table 24: Compliance with regulation
Data from Trust regulation dashboard, derived from regulator reports

Regulator		Status			Date last reviewed
Care Quality Commission	Healthcare locations	Fully registered – no conditions			Planned review winter 2010/11
	Social care locations	Fully registered – no conditions			
	Primary care locations from 1.4.11	Registration application in process – continued registration through NHS Sheffield until registration approved			
Monitor	Governance	Amber/green and Amber/red during year			March 2011
	Finance	4			March 2011
NHS Litigation Authority	Risk management standards	Level 1			March 2011
Patient Environment Access Team (PEAT) Good or above in		1.	2.	3.	
	Michael Carlisle	Good	Good	Excellent	March 2010
	Longley	Good	Good	Excellent	March 2010

Regulator		Status			Date last reviewed
1) Cleanliness & environment 2) Food 3) Privacy and dignity	Forest Lodge	Good	Good	Excellent	March 2010
	Forest Close	Good	Self Catering	Excellent	March 2010
	Grenoside	Good	Good	Excellent	March 2010

3B Development of the Quality Accounts

These are the third set of Quality Accounts produced by the Trust, and it has tried to make improvements to the development process each year. Last year's accounts were commended by both the Audit Commission and the Yorkshire and Humber Quality Observatory review for their balanced view and for their involvement and engagement with service users, carers and governors.

The Trust's governors asked to be involved at an earlier stage this year and for the quality accounts to be developed in tandem with the Annual Plan. This was done in a series of meetings during the year.

The Governors were particularly interested in shaping the choice of quality objectives for the year ahead. The Sheffield Local Involvement Network (LINk) and the City Council Health and Wellbeing Scrutiny Committee were also consulted during the winter of 2010/11.

A long list of potential quality objectives was developed from the following:

- the 2010/11 quality objectives were all included, as work was progressing on all of them, and the staff involved were keen to see further progress made;
- the information the Trust holds about the quality of its services and feedback from service users and carers was reviewed and areas where improvements were needed were found;
- senior leadership teams in the service directorates, and professional heads, were asked for their views about the priorities for improvement.

The long list was presented to the Board and the Board of Governors as part of the annual planning process. A new item – support for carers – was added at this point and the long list was cut down to 8 possible objectives. A further round of consultation with senior staff, the local LINk, the local Scrutiny Committee and Board resulted in the final 4 quality objectives for 2011/12.

The LINk suggested some areas they would wish to see reported in the accounts, including Central Alert System (CAS) alerts and feedback from the Care Quality Commission. Ideas for good indicators to use were sought from colleagues in the Trust in clinical as well as corporate roles and the author attended some directorate senior management teams to discuss ideas. All clinical directorates have been approached to contribute to the construction of the accounts.

National reviews and reports on Quality Accounts from Monitor, the Audit Commission and the King's Fund were reviewed as well as the Audit Commission assurance report on last year's Sheffield Health and Social Care NHS Foundation Trust quality accounts. Other trust's quality accounts have been considered. This has led to the addition of more data, especially on service user and carer experience. More service specific information has been included.

3C Statements from Partners and Stakeholders

A draft version of the Quality Account (or Quality Report) was circulated to key partners and stakeholders in the city for their comments. All have responded and their comments are presented below, together with a response from the Trust.

1. Shefffield LINk

These comments refer to the Draft Quality Account 2010/11 Version 5 dated 6.4.11.

The work you have undertaken to collect the views of your service users and carers is admirable; your use of volunteers rather than staff is an example of good practice that should be shared with the other Trusts in Sheffield and elsewhere. Extracts from the surveys would have been a helpful aid as part of the report especially as they were shared at an event in March. –

The productive programme is another area of good practice that deserves more local and national recognition as this fits better with patients being the focus rather than the administrative tasks.

Sheffield LINk agrees that the 4 priorities chosen are areas needing quality assurance. However the document could usefully refer to how this will be bench marked by this Trust compared to similar ones regionally and nationally. For example for access to the memory assessment services we are told there will be a 25% increase but not what the current figures are therefore how will we know that there has been the aimed for increase? Data reporting on the previous QA is not presented as performance over time and therefore it is difficult to be able to make comparison and evaluation of year on year performance.

Within the report page 11 there is mention of reporting to a new board Quality Assurance Committee, LINk suggests that these progress reports are made publically available on the Trust's web site as part of the "ongoing dialogue" that should take place throughout the year as part of the QA process.

In respect of last years priorities **1** the statement is To achieve a target of 4 hours from referrals for service users in adult and older adult mental health care including dementia services, the table of results does not cover those in the title of the priority only that for working age adults. The obvious areas missing in this QA are the need for both positive and negative aspects of performance to be identified. The first paragraph on page 13 is not a positive result against the 4 hour response but this is not made clear and we need to know what is going to be done about this.

Staff feedback, the views of staff are an important marker of an organisation's managerial competence, workforce well-being and hence its ability to deliver high-quality care. Staff views should be shown in the quality accounts. The annual national surveys of NHS staff provide a readily available source of data on the views of NHS staff. Your only mention of staff is in respect of one area of training.

The report is in the main a dialogue, this dialogue is clear and understandable to the public however LINk would recommend the use of visual aids to show readily where results are good, bad and indifferent. Emoticons could be used as a simple way of indicating this.

LINk commends the Trust in their inclusion of Patient Safety Alert data (page 33) which we requested were included in the report.

We are pleased to note that you will produce an easy read version of the QA report.

We are also pleased that one of the priorities for the year 2010/2011 is one we recommended last year "The quality of care for people with dementia".

Finally we state that Sheffield LINk accepts this QA as an honest account of the services provided by this Trust.

Mike Smith

Chair, Sheffield LINk

6th May 2011

Response from Sheffield Health and Social Care NHS Foundation Trust:

We would like to thank Sheffield LINk for their engagement in the development of the accounts and for their comments on the draft Quality Accounts. We are glad that they have noted our efforts to engage service users and carers in the development of the accounts, and that they recognise the accounts are an honest view of the services provided by the Trust.

We accept the comments about the need to improve the use of benchmarking data and to report more on trends over time, where this data is available. We take on board the comments about visual and graphic indicators to show where results are good, bad or indifferent. We will be working to make improvements in these areas over the year ahead and will hope to share this with the LINk in routine reporting.

In the final version of the accounts, we have added more in the commentary about the challenges of a 4 hour waiting time for a urgent dementia referrals. We have also added more on staff views on quality and made more use of the CQC staff survey in this respect.

2. Sheffield Health and Community Care Scrutiny Committee, Sheffield City Council

The draft Quality Accounts were presented to the Committee on 18 April 2010 and the following commentary was received as a result:

Response to the Sheffield Health and Social Care NHS Foundation Trust Quality Account

April 2011

This year we engaged with the Trust early on in the Quality Account process, enabling us to contribute to the consultation on which quality objectives should be included in the Quality Account.

We are pleased that our views were taken on board, and feel that the chosen objectives are appropriate and reflect what is important to Sheffield people. We are particularly pleased to see the inclusion of dementia care. The needs of people suffering from dementia and their carers have been a key focus of the Committee this year and we are pleased to see a commitment to improve care and reduce assessment waiting times.

We are pleased to see that the Quality Account presents a balanced picture of performance within the Trust, and includes staff and service user feedback, which we found particularly useful. We feel that the Quality Account contains some good examples of innovative working that has been effective in improving the quality of care provided to patients - particularly around service user feedback and the Productive Programme. We'd like to see the learning from these programmes shared with other Trusts in the City and beyond as an example of best practice.

We look forward to monitoring progress on the quality objectives over the course of the year.

Response from Sheffield Health and Social Care NHS Foundation Trust

We welcomed the involvement of the Committee in the development of the accounts this year and we would like to thank them for their positive comments. We will be very pleased to share the progress on the quality objectives over the year ahead.

3. NHS Sheffield

STATEMENT FROM NHS SHEFFIELD

Received from Tim Furness, Deputy Director of Strategy on 12 May 2011

We have reviewed the information provided by Sheffield Health and Social Care NHS Foundation Trust in this report. In so far as we have been able to check the factual details, our view is that the report is materially accurate and gives a fair picture of the Trust's performance.

Our view is that the Trust provides, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities. The Trust achieves good results against national standards and the quality accounts demonstrate improvements against its objectives for last year. In addition it has met most of the quality objectives set in our contract for 2010/11, reducing waiting times for access to care, reducing the length of stay on wards and reducing, through joint action with NHS Sheffield, the numbers of people who need to be placed in services outside Sheffield.

However, the Trust needs to improve the timeliness of its investigation and reporting of serious untoward incidents and we would have expected this account to describe current performance and the

plans in place to improve it. We would also have expected the account to set out plans to respond to those areas of the staff survey where the Trust does not perform as well as most mental health and learning disability providers.

Sheffield Health and Social Care NHS FT provides a wide range of services, and it is right that all of these services should aspire to make year-on-year improvements in the standards of care they can achieve. We support the specific priorities identified for the Trust in 2011/12, and welcome the ongoing priority given to the experience of users from BME groups, but would note that there is also a continued need for focus on a number of areas from the 2010/11 plan:

- Waiting times for a response to crises, including response to patients presenting in A&E
- Waiting times for non-urgent referrals
- Satisfaction of all service users
- Reducing and if possible eliminating inpatient placements outside Sheffield

In addition, and in support of the focus on nutritional support, we would like to see more consideration of the ways in which a mental health provider can support improvement in the physical health of all its patients, including support to stop smoking and promotion of healthy lifestyles.

Response from Sheffield Health and Social Care NHS Foundation Trust

We would like to thank NHS Sheffield for their comments and for their overview that 'the Trust provides, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities.'

We have made some changes and additions as a result of the NHS Sheffield feedback:

We have added more in the final version of the Quality Accounts on the timeliness and quality of our serious incidents reporting, in the context of the work we have described on improving our serious incidents systems and processes. We have also added more reference to the staff survey and in particular those areas where we performed less well in comparison with other trusts, and what we are doing to address these areas (e.g. the numbers of staff reporting that they have received training in equality and diversity in the last 12 months.)

We have made more reference in the final version of the accounts to the continuing work on the areas covered by the 2009/10 quality objectives and the physical health agenda.

We note that the other areas of quality proposed for inclusion by NHS Sheffield are already covered in the CQUIN and routine quality reporting to NHS Sheffield. Detailed information on the CQUIN indicators is available on the Trust website, as referenced in the accounts. NHS Sheffield priorities for quality improvement and those of our other commissioners were taken into consideration in the development of the quality accounts, alongside the views of other key stakeholders. However, we have chosen not to add all of them to the main text of the final version of the accounts at this point.

4. Trust Governors

The Quality Accounts and in particular the choice of quality objectives were presented to governors at a meeting in April 2011, together with the Trust's Annual Plan objectives for the year ahead. Governors were supportive of the choice of objectives and asked for more detail on the physical health

policy and staff training. The Governors asked about the Patient Survey results and the issue of the lack of a 24 hour phone line.

Subsequently Governors were invited to respond via email with more detail on their views of the Quality Accounts. Two emails were received, both wanting to see more progress on the delivery of a 24 hour phone line.

> 'My particular concern, and has been for some time, is the provision of an out of hours contact telephone number. We are 1 of very few trusts who don't have such a facility and service users want this to be a priority…….
>
> ….As a service user governor I continue to push for progress on this on behalf of our service users. Please listen to your service users and ensure that this is given the priority it deserves.
>
> I look forward to hearing regular updates on this subject.'

Extract from email from service user governor

Response from Sheffield Health and Social Care NHS Foundation Trust

We would like to thank the Governors and Members for their contribution over the year to the development of the Quality Accounts, as well as their feedback on the final version.

More detail has been added to the commentary in the Quality Accounts about the 24 hour phone line issue raised by the CQC Patient Survey results. Reports of progress on the issue during the year will be presented to Governors, alongside the regular feedback on progress on the quality objectives.

3D Annex: Statement of Directors' Responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health and Monitor have issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

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

- the Quality Accounts present a balance picture of the Trust's performance over the period covered:
- the performance information reported in the Quality Account 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 they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review: and the Quality Account has been prepared in accordance with Department of Health guidance and Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Accounts (available at www.monitor-nhs-ft.gov.uk/annualreportingmanual .)
- 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 2010 to June 2011
    - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
    - Feedback from the Commissioners dated 12 May 2011
    - Feedback from the Governors dated 7 April 2011
    - Feedback from the LINk dated 6 May 11
    - The Trust's quarterly complaints reports and previous Annual Complaints Reports, noting that the Annual Complaints Report for 2010/11 (to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009) was not available at the time of Quality Account preparation
    - The latest CQC national patient survey dated 14 September 2010
    - The latest CQC national staff survey dated 22 March 2011
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 3.6.11
    - Care Quality Commission quality and risk profiles dated September 2010, October 2010, November 2010, December 2010, February 2011, March 2011, April 2011

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

NB – sign and date in any colour ink except black

……..Date……..Chairman

……..Date……..Chief Executive