Sheffield Health and Social Care NHS

NHS Foundation Trust

Quality Accounts 2011/12

Ceramic art designed and made by Trust service users, Burbage and Stanage wards

Photograph by Forest Close Photography Group

Final Version

June 2012

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Part 1

A Statement on Quality from Kevan Taylor, the Chief Executive

This is our fourth Annual Quality Account and I hope you will enjoy reading it. It gives an overview of the quality of Sheffield Health and Social Care NHS Foundation Trust services and tells you what we have done to improve the quality and safety of care. It also sets 5 quality objectives for the year ahead; these are the five areas where we most want to make improvements in 2012 to 2013.

The Trust takes the dignity and respect of service users very seriously. Feedback from service users in the Care Quality Commission Annual Community Mental Health Patient Survey this year was positive about how people are treated by staff in the community mental health teams:

In the CQC Annual Community Mental Health Patient Survey for 2011, the Trust received the highest score nationally of people saying they were treated with dignity and respect by their health or social care worker.

Some service users have written to the Trust to express what it feels like to be treated with dignity and respect:

'Thank you for understanding my situation and the pain I was going through. You are a kind and considerate and very caring nurse. You have been there for me and giving me support. One day I am fine, another day I am rubbish, so rubbish, so bad, I don't even know who I am and you still gave me support and were nice, very nice to me at my worst times….. I find it difficult to talk about my problems with someone I do not know and you understand. Thank you for respecting my wishes and making me feel comfortable with you. I have taken your advice on board and I will continue working towards one day at a time toward recovery. '

Service user from the Transcultural Team

This has been a time of change and growth for the Trust, with new services joining us from the former NHS Sheffield PCT Provider Services. I have been delighted to welcome the Clover Group of General Practices, the Neuro-Enablement Services, the Homeless and Traveller team, the Chronic Fatigue Syndrome /Myalgic Encephalopathy (CFS/ME) service and a number of professionals such as Speech and Language Therapists and Physiotherapists in the Learning Disabilities Service. We have also been joined by the Sheffield Community Advocacy and Interpreting Service (SCAIS) and the Community Development Workers who bring extra expertise in working with minority communities into the Trust.

These services have brought fresh ideas and examples of good practice to Sheffield Health and Social Care NHS Foundation Trust. For example, the Brain Injury Research Rehabilitation Partnership:

The Brain Injury Research Rehabilitation Partnership – hosted by the Sheffield Community Brain Injury Rehabilitation Team

The Brain Injury Rehabilitation Research Partnership (BIRRP) started in 2006. It is a group consisting of survivors of brain injury, carers who have experience of caring for someone with a brain injury and clinicians from the Sheffield Community Brain Injury Rehabilitation Team (SCBIRT). BIRRP was established to develop a collaborative body that recognises the expertise that everyone has in managing life after brain injury and aims to bring this together to work on projects that will improve services for people.

Following significant consultation with many stakeholders, it was decided to develop a service evaluation project based around examination of the experiences that clients have had about discharge from SCBIRT. Some service users had described discharge from community services as being 'sent into the wilderness'. Service users and the clinical team were keen to gather information and learn from it so the Trust could look at how people experience moving from rehabilitation to life afterwards. This information can then be fed into operational practice and changes made accordingly.

The project is now well under way…

BIRRP has had a significant impact on service delivery and at the individual level for group members. Service user involvement is now embedded in the culture of the team and there is a genuine sense that service user voices are part of the conversation of operational delivery. This includes service user recruitment panels for all professional appointments, service user led training workshops in health and social care forums, participation on a plethora of health and social care advisory bodies, health champions, to name but a few of the pathways that members have taken.

BIRRP will continue to grow and develop and initiate other service evaluation plans. It is a model that continues to attract much attention from other services and we are about to embark on a collaboration with the Social Policy Research Unit at the University of York.

Mark Parker, Service Manager

The Trust has been able to share its areas of strength with the new services. In the field of quality, the Trust is sharing its passion and experience about local team governance approaches, where quality improvement comes from, and is led by the clinical team. All teams review the quality of care they provide in a team governance report, and set goals for improvements with their directors.

The Trust has invested in improving staff expertise in a number of areas:

- New risk assessment and management tools, the BRAM and DRAM, have been developed and introduced on a rolling programme throughout the Trust. All staff responsible for the care and treatment of service users are receiving training in clinical risk assessment and management: during the year 879 staff were trained. The number of staff being trained was increased and the time to complete the roll out to all staff was extended during the year.

- Training in equality and diversity has been reviewed and improved.
- The Respect Approach to preventing and managing violence and aggression is being introduced to all areas, with intensive staff training in the new, more person-centred approach. At the end of the year, 157 staff from the Trust's inpatient areas had received the training. Staff who have trained are very positive about the new approach.

> 'This is what I've been crying out for! A person centred approach which keeps people safe whilst maintaining their dignity.
> Respect is about challenging attitudes and behaviour and putting service users at the heart of what we do as mental health workers'
>
> Staff member
> Maple Ward

I would most like to highlight the areas where we have been working in partnership with service users and carers to improve services.

We held a brilliant event for the Recovery model in the Trust, addressed by Rachel Perkins, a service user, Clinical Psychologist and NHS manager from London, and by Trust champions for the model.

What is Recovery?

"Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems."

Shepherd, Boardman and Slade 2008

From Rethink website www.rethink.org.uk on 29.3.12

Staff were challenged and invigorated by the idea of working in 'co-production' with service users to bring about positive change. As a result, the Trust is setting up a Recovery College to provide education, training, consultation, support and advice to service users and staff and Recovery Enterprises, an umbrella organisation reflecting the principles of social enterprise, to develop creative work opportunities for service users.

Following the publication of the NICE (National Institute for Health and Clinical Excellence) Quality Standard for Service User involvement, the Trust is launching a Service User Experience Monitoring team. Service users from across the Trust, including people of all ages, from different races and

cultural backgrounds and including people with learning disabilities, will be working together on 2 big ideas:

- short, rapid surveys of service user feedback on care
- service user led interviews and longer surveys to find out about the experiences of service users in more detail.

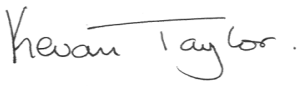
The Service User Experience Monitoring team is building on the expertise of service user volunteers who already visit the wards to interview inpatients about their experience of care in the Quality and Dignity surveys, or who visit alongside staff to give their perspective on care and whether it meets the requirements of the Care Quality Commission (CQC) or the Patient Environment Action Team (PEAT.)

I would like to take this opportunity to thank all those service users and carers who give up their time to work with the Trust to help improve the quality of care.

I would also like to pass on the thanks of myself and the Trust Board to all those staff who have worked hard during the year to maintain and improve the quality and safety of services. It was positive to see in the CQC Staff Survey results this year that the Trust again fell into the top 20% nationally for those staff who responded that they would recommend it as a place to work or receive treatment.

To the best of my knowledge the information in this document is accurate.

Signed



Kevan Taylor
Chief Executive

Part 2

Priorities for Improvement in 2012/13

The Trust has chosen 5 quality improvement priorities for the year ahead, to cover each of the following 4 areas:

1. Safety
2. Clinical effectiveness
3. Positive Service User Experience
4. Access, Equality and Inclusion

Trust Quality Objectives for 2012/13

There will be 2 safety objectives this year:

- **To reduce the number of falls that cause harm to service users**
- **To reduce the incidence of violence and aggression and the subsequent appropriate use of restraint and seclusion**

The clinical effectiveness objective is:

- **To improve the identification and assessment of physical health problems in at risk groups**

The positive service user experience objective is:

- **To improve the experience of first contact with the Trust**

The objective for access, equality and inclusion is:

- **To improve access to dementia care**

Objective 1:
To reduce the number of falls that cause harm to service users

We are intending to work on this issue as a priority for the next 2 years.

Exec / Director Lead: Liz Lightbown	**Operational Lead**: Elaine Hall

We chose this priority because:

- Falls cause direct harm to service users because of injury, pain, restrictions on mobility and community participation, impacting on quality of life and well-being
- The Trust reports high number of slips, trips and falls in comparison with other mental health trusts. Information from the National Patient Safety Agency showed that 49% of all the patient safety incidents reported in Sheffield Health and Social Care Trust were patient accidents in comparison with 25% as a national average for mental health trusts. (Information from the NPSA Organisation Patient Safety Incident Report for 1 April 2011 to 30 September 2011)
- The National Falls and Bone Health Audit in 2011 showed that during 2010/11 falls were higher in the Trust older people inpatient areas than the national average rates of falls. There were 13.5 falls per 1000 bed nights compared with 8.4 falls nationally
- There is guidance and support available on how to reduce the severity, frequency and impact of falls from NICE, Harm-free NHS and the Energise for Excellence national NHS campaign
- Recent audits for the Falls NICE guideline group have shown little reduction in falls so far.

The current situation is:

- During 2011/12 **1599** incidents of slips, trips and falls for service users were reported by the Trust
- **514** slips, trips or falls **(32.1%)** resulted in harm or injury to the service user concerned.
- This compares with **36.3%** resulting in injury in 2010/11, **33.8%** in 2009/10 and **35.6%** in 08/09.
- The diagram below shows the slips, trips and falls reported over the last 4 years
- It is evident that falls are a significant service user safety issue.

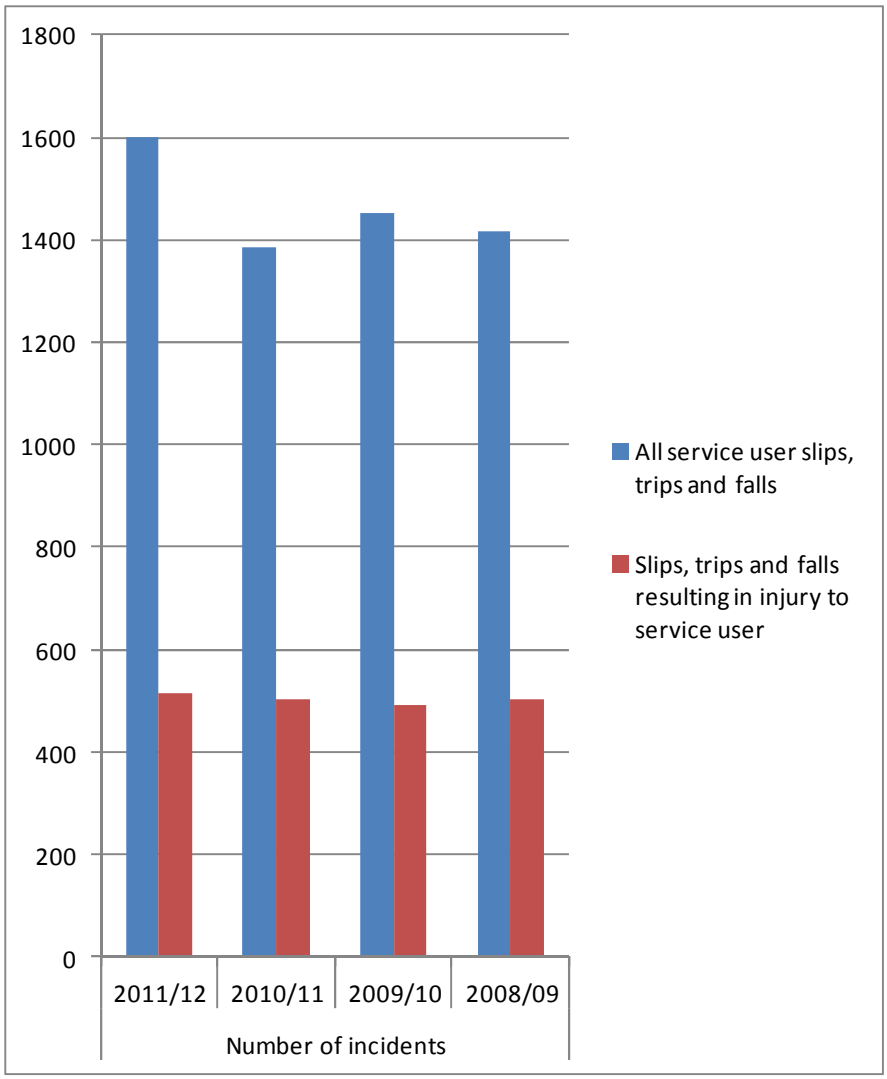


Diagram 1: Slips, trips and falls reported over the last 4 years (Data from Ulysses Safeguard)

N.B. Data has changed from previous Quality Accounts, because In previous years the Trust had included staff falls as well as service user falls. The above data represents recalculations of previous year's figures, excluding staff incidents. Changes also result from additional incidents being reported after the initial data capture date.

The intended outcomes are:

- To reduce the number of falls resulting in serious harm to service users by 5% by the end of the year and by 10% in the following year
- To reduce the level of harm experienced by service users from falls, as measured by reduction in number of falls resulting in A&E or hospital admission
- 100% of older people admitted to inpatient areas will be screened for falls using a standardised screening tool, the MFRA, by the end of the year

• Environmental falls risk assessments will be completed for all inpatient and residential areas		
This is what we will do:	**Lead**	Timescale
• Implement MFRA (Multi-factorial Risk Assessment) screening tool for falls for all older people admitted to inpatient areas	Elaine Hall	By September 2012
• Monitor the use of the MFRA	Elaine Hall, ward managers and Trust Falls Group	Minimum quarterly
• Carry out environmental falls risk assessments in all inpatient and residential areas	Elaine Hall, ward / team managers and Trust Falls Group	By December 2012
• Identify appropriate training packages for staff	Elaine Hall. Training dept	By September 2012
• Deliver falls training to staff	Training Dept	December 2012
Cost of implementation: • Amendment of Insight care record system to enable recording of MFRA • Release of staff time to train • Release of staff time to attend training		

Objective 2:
To reduce the incidence of violence and aggression and the subsequent appropriate use of restraint and seclusion

The introduction of the new approach to the management of violence and aggression, the Respect Approach, and the associated staff training, began in 2011/12 as part of a previous quality objective.

We intend to continue work on this objective into 2013/14.

Executive Director Lead: Clive Clarke	**Operational Leads:** Richard Bulmer and Kim Parker
We chose this priority because: • The Trust has started re-training all staff working on the inpatient wards in a new, more person-centred approach to the prevention and management of violence and aggression, the Respect Approach • The prevention and management of violence and aggression is as an area of concern for service users, with critical feedback about the negative impact on them	

'The Maat Probe Group, who are service users, came together and did a survey about how people had encountered control and restraint in hospital wards….

We the group put (a presentation) to Sheffield Care Trust, and we approached Grimsby Care Trust who lead on Respect de-escalation for distressed people. Respect is now being introduced to all nursing staff on all mental health wards.

We are all pleased that the Respect is taking place in Sheffield'

Members of Maat Probe African Caribbean service user group

- The Trust reports relatively low rates of violence and aggression overall towards service users from service users, according to the latest benchmarking information from the National Patient Safety Agency. This showed that 15.5% of patient safety incidents reported by the Trust in the first 6 months of 2011/12 were related to disruptive, aggressive behaviour, in comparison with 19% of incidents reported by mental health trusts nationally. The incidence is higher in some ward areas than others.
- The CQC Staff Survey for 2011 shows the Trust fell into the highest (worst) 20% of staff from all areas of the trust who reported that they had experienced physical violence from patients, relatives or the public in the last 12 months. The proportion of staff who said they had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months was also above the national average and had got worse since the previous year's survey.
- Sheffield City Council and NHS Sheffield have issued a new framework for Good Practice in the Prevention and Management of the Use of Restraint during 2011.
- There is good practice in the learning disabilities service on alternatives to restraint, that could be adapted and rolled out to other areas of the Trust

The current situation is:

- There were a total of **392** incidents reported in the year, where service users had been the victim of physical assault or attempted assault. The overwhelming majority of the assailants (386 or 98%) were other service users
- **15.4%** of patient safety incidents reported by the Trust were for aggressive behaviour in comparison with a national average for mental health trusts of 19%. (NPSA benchmarking data for first 6 months of the year.)
- **155** staff working in inpatient areas had completed the intensive 4 day level 3 Respect training by the end of 2011/12
- **17** staff had received the level 1 (introductory) Respect training: this programme was just beginning towards the end of the year.

The intended outcomes are:

- To train all inpatient nursing and support worker staff in the Respect Approach by the end of the year
- To reduce the number of incidents of violence and aggression, after staff on ward areas have completed the Respect training, and sustain the reduction over the next 2 years
- To reduce the use of seclusion over the next 2 years
- To reduce the use of restraint over the next 2 years
- To increase the percentage of service users in acute wards who report experiencing a safe

environment in local Quality and Dignity surveys

- To increase the number of staff on acute wards who report a safe environment in local Productive Ward surveys
- To reduce the number of staff reporting that they have experienced physical violence from service users, relatives or the public in the CQC Staff Survey over the next 2 years
- To reduce the number of staff reporting that they have experienced harassment, bullying or abuse from patients, relatives or the public in the CQC staff survey over the next 2 years

This is what we will do:	**Lead**	**Timescale**
• Continue to deliver the Respect training to all inpatient staff	Kim Parker, Training team	All staff to be trained by the end of the year
• Continue to monitor the incidents of violence and aggression at ward and team level, and analyse trends over time and between teams	Kim Parker, ward and team managers, risk management team	Minimum quarterly reporting
• Establish reliable and consistent methods for the recording of restraint and seclusion on all inpatient areas	Kim Parker, ward and team managers, risk management team	
• Establish a baseline for the rates of restraint and seclusion in all inpatient areas	Kim Parker, ward and team managers, risk management team	
• Set local targets and agree actions for the reduction of the use of restraint and seclusion in all inpatient targets	Clinical and service directors, Kim Parker, ward and team managers	
• Establish reliable and consistent reporting on the use of restraint in SHSC community settings with vulnerable adults	Kim Parker, Zara Clarke, team managers, risk management team	
• Establish a baseline for the rates of restraint in SHSC community settings with vulnerable adults	Kim Parker, Zara Clarke, team managers, risk management team	
• Set local targets and agree actions for the reduction of the use of restraint in SHSC community settings with vulnerable adults	Kim Parker, Zara Clarke, team managers, risk management team	

Cost of implementation:

- Purchase of Respect Approach training materials (already purchased)
- Release of staff time to train
- Release of staff time to attend training

Objective 3:

To improve the identification and assessment of physical health problems in at risk groups

Exec / Director Lead: Liz Lightbown/ Tim Kendall	**Operational Lead:** Rose Hogan / Tony Flatley

We chose this priority because:

- Physical health is a priority for governors and service users, as many SHSC service users are at higher risk of developing physical health problems
- Evidence shows people with severe mental illness and people with learning disabilities have reduced life expectancy and greater morbidity: so do people who are homeless and people who misuse drugs and alcohol
- Physical health is a national priority in the Mental Health Strategy, NHS Outcomes Framework, Public Health Outcomes Framework
- We are already working on a number of programmes to make improvements e.g. physical health checks on wards, use of early warning signs toolkit, link nurses for illnesses such as diabetes, smoking cessation, health facilitators and health action plans, staff training in 'healthy chats'
- The expertise of the Clover Group, now part of the Trust, can be built on
- The introduction of physical reviews for people with long term mental health problems in primary care could be linked to CPA reviews – information such as body mass index, blood pressure etc could be added to communication between SHSC staff and GPs
- People with learning disabilities are supported by SHSC Health Facilitators to have their annual GP health check and develop a health action plan – this good practice could be spread to other areas
- The introduction of Energise for Excellence is planned
- The new Every Contact Counts e-learning tool, that supports staff to offer health promotion advice, is now available
- The regional 'health chats' approach is being adopted by the Trust. This gives frontline staff the confidence to talk to service users about potentially sensitive areas of their physical health such as obesity. It helps staff give clear and simple messages about improving physical health

The current situation is:

- Audits of Insight care records in November 2011 showed overall in 78% of service users' records their physical health status was checked and documented
- There was variability in performance between the 4 directorates.

Table 1: % service users whose physical health status had been checked, by directorate Data from Care Records Audit, November 2011. 579 Records were audited

Directorate	**% service users with physical health check/status recorded**
Acute Mental Health/Inpatients	81
Community Mental Health	65
Learning Disabilities	91
Specialist Services	90

- 25 staff have trained as 'health chat' key trainers
- 2 staff have trained as level 2 smoking cessation experts
- 60 staff attended Learning Beyond Registration (LBR) funded physical health courses during 2011/12: these included additional training in care for diabetes, kidney failure and heart failure.
- Clover Group practice recorded physical health checks for people newly diagnosed with dementia in 50% of cases (this was an underperformance on the QOF clinical indicator)
- Clover Group practice met the mental health QOF indicators including lithium checks, alcohol consumption, blood pressure, cholesterol levels, blood glucose and cervical screening of people with psychosis
- Clover Group recorded BMI in 85% people with psychosis: this was below the QOF target
- The Clover group could not meet the learning disability QOF indicator of thyroid checks for people with Downs' syndrome because the relevant patients were exempt.

The intended outcomes are:

- 'Health chat' key trainers to cascade training into clinical settings and become 'champions' for these settings
- 90% of people to have physical health checks recorded in all relevant service areas
- Diabetes link nurses in all inpatient areas
- Measure of better communication between SHSC and primary care on physical health key information e.g. blood pressure
- Clover group to improve performance and achieve the QOF targets on physical health checks for dementia and BMI for people with psychosis

This is what we will do:*	**Lead**	Timescale
• Implement the electronic Medical Examination on Admission and Lifestyle Assessment across all relevant services	Rose Hogan	Sept 2012
• Train additional 30 staff to become healthy chat key trainers	Rose Hogan	March 2013
• Key trainers to cascade training to 6 team members each	Rose Hogan	March 2013
• Develop and roll-out obesity care pathway	Rose Hogan	March 2013
• Produce patient information leaflet	Rose Hogan	Dec 2012
• Improve menu labelling and create healthy updates to menus	Rose Hogan	Sept 2012
• Ensure smoking status of all in-patients is recorded in patient record	Rose Hogan	March 2013
• Increase number of referrals to Sheffield Stop Smoking Service to 25 per quarter	Rose Hogan	March 2013
• Train 2 staff in each in-patient area to be level 2 smoking cessation experts	Rose Hogan	March 2013
• Clover Group to achieve QOF target in recording BMI in people with psychosis	Rachel Pickering	March 2013
• Clover Group to achieve QOF target in physical health checks for people newly diagnosed with	Rachel Pickering	March 2013

dementia		

Cost of implementation

- Release of staff time to train
- Release of staff time to attend training

Objective 4:

To improve the experience of first contact with the Trust

Exec / Director Lead:	**Operational Leads:**
Clive Clarke	John Burton, Kim Parker, Mia Bajin

We chose this priority because:

- It is a governor and service user priority, as part of a positive service user and carer experience
- Although the CQC Community Mental Health service user survey indicates that service users feel they are treated with dignity and respect in most instances, complaints about staff attitude are still received
- The Respect training which is being implemented for all staff (see objective 2) includes key elements about treating service users with dignity and respect. Initial feedback indicates a positive impact on staff attitude.
- First contact is relevant for Clover Group and Neuro-Enablement Services as well as 'old' SHSC services
- Following low scores on the CQC Annual Community Mental Health for questions about a 24 hours phone line, the Trust is piloting an out-of-hours phone line to give advice and help to service users and carers, in partnership with Rethink
- A new '15 Steps Challenge' is available as part of the Productive Series of service improvement tools and techniques. This assesses service user experience by literally walking through and obtaining the first impressions of a service

The current situation is:

- All new staff are trained at their induction in working respectfully with service users and carers
- **172** staff have received Respect training
- Top 20% (highest score) nationally in CQC Annual Community Mental Health Survey for service users responding they were treated with dignity and respect by their health or social care worker
- Middle 60% nationally in CQC Annual Community Mental Health Survey for service users responding that they had the phone number of someone from their local mental health services that they could ring out of hours
- 60% of service users, on the 4 acute mental health wards surveyed, reported that they had received a ward information pack or handbook in the last Quality and Dignity survey. The range was from 38% to 77% on the different wards.

The intended outcomes are:

- Greater staff awareness and focus on the importance of first contact for service users
- Delivery of an out of hours phone number for service users and carers

- More staff trained in customer care as part of the roll out of Respect training
- Review and revisions where needed, in partnership with service users, to standard communications e.g. initial appointment letters and information leaflets
- New standards to be agreed and implemented for the provision of information leaflets for new service users/ new referrals
- All service users on wards who want one will receive a ward 'welcome pack'
- To remain in top 20% of mental health trusts in CQC Annual Community Mental Health Survey for being treated with dignity and respect
- To improve score in CQC survey on 24 hour phone line

This is what we will do:	**Lead**	Timescale
• Pilot an out of hours telephone helpline	John Burton	March- April 2012
• Following the pilot, develop a plan for a sustainable out of hours phone line	John Burton	End April 2012
• Deliver Respect training	Kim Parker and Training team	See objective 2 above
• Implement 15 Steps Challenge with NEDS, staff and service users in inpatient areas and 1 community team	Kim Parker	Awaiting national release of 15 Steps
• Audit use of ward welcome packs and make any improvements needed following audit	Kim Parker	
• Review and revise standard communications relating to first contact including initial appointment letters and information leaflets sent out with initial appointments	Mia Bajin, Kim Parker	
• Set and monitor standards for the provision of information leaflets at first contact	Mia Bajin, Kim Parker	

Resources needed:

- Funding to support out of hours phone line (currently being piloted)
- Costs of production and printing of information leaflets and welcome packs
- Release of staff time to train
- Release of staff time to attend training
- Release of staff time and expenses for service users to implement 15 steps challenge

Objective 5:

To improve access to dementia care

Exec / Director Lead: Clive Clarke	**Operational Leads:** Michele Fearon/ Peter Bowie

We chose this priority because:

- Improving dementia care is a priority for the Trust, governors, the City Council and LINks
- The incidence of dementia is predicted to rise with Sheffield's aging population

- Early identification and rapid access to services can delay the impact of dementia and lead to a better quality of care and better support for carers
- We wish to build on the delivery of the NICE Quality Standard for Dementia
- It builds on work to reduce the waiting times for memory clinics
- Learning disability services are implementing a dementia care pathway because of the increased risk of early dementia in people with Downs syndrome
- There is partnership work with Sheffield Teaching Hospitals NHS Foundation Trust and NHS Sheffield and the voluntary sector to improve access to dementia care
- It links to Sheffield City Council Prevention work

The current situation is:

- Sheffield performs well in comparison with other areas in the identification of people with dementia, enabling them to access care and treatment. This is measured by people with a diagnosis on the Quality Outcomes Framework dementia register in primary care. The Alzheimers' Society prevalence and diagnosis map for 2011 showed 57% of those predicted to have dementia had been diagnosed, putting Sheffield in the top 3 areas nationally. See www.alzheimers.org.uk/dementiamap
- **862** people were diagnosed with dementia by the Memory Management Service in 2011/12
- The average waiting time for a first appointment with the Memory Management Service over the year was **14.7 weeks** , down from 21.3 weeks in 2010/11 and 28 weeks in 2009/10
- Approximately **40** people with learning disabilities were assessed for dementia
- People from Black and Minority Ethnic Groups are less likely than others to be diagnosed and treated with dementia
- The Clover Group practice recorded physical health checks for people newly diagnosed with dementia in 50% of cases (this was an underperformance on the QOF clinical indicator)

The intended outcomes are:

- To maintain the reduction in waiting time for memory service achieved over last 2-3 years and aim to reduce it further
- More than 900 people will be seen for assessment in Memory Management service. (The new target set by Commissioners is up from 800 to 900 new assessments and diagnoses)
- To evaluate the service user and carer experience and establish a reliable baseline for the number of people with learning disability receiving memory assessments
- To evaluate experience through service user and carer experience surveys for people receiving dementia services from the Memory Management Service
- To establish reliable baseline figures for people from different Black and minority ethnic groups accessing dementia services

This is what we will do:	**Lead**	Timescale
• Meet the new target for more memory assessments in the Memory Management Service	Peter Bowie, Tony Bainbridge	To report quarterly
• To maintain the reduction in the waiting times for first assessments and aim to reduce it further	Peter Bowie, Tony Bainbridge	To report quarterly
• Implement and evaluate the dementia pathway for adults with a learning disability	Debbie Albrow	From 1 April 2012
• Develop and implement a plan to improve access to memory services by people from Black and Minority Ethnic Groups	Elaine Hall	December 2012
• Survey service users and carers of dementia	Jane McKeown	October 2012

services about their experience of care and respond to any issues raised		

Resources needed:

- Staff time for quality improvement work
- Costs of surveys – production, administration, analysis – to be managed within Trust
- Evaluation of learning disability dementia care pathway to be completed by Psychologist in clinical training as part of course requirements

Spring flowers planted by the Gardening Group, Hawthorn ward, Longley Centre

Photograph by Forest Close Photography Group

How the Trust is developing quality improvement capacity and capability to deliver these improvements

When the Trust was developing its quality objectives for 2012/13, a number of possible objectives were put forward that concerned improving the Trust as an organisation, its systems and processes, to build capacity for quality improvement. Although these things are important, the Trust decided to focus on objectives that would have a direct, measurable impact for service users and carers. The Trust took the decision to remove them from the shortlist for quality objectives, but is still committed to developing a number of these projects. They include:

- Setting up the Service User Experience Monitoring Unit and making sure all teams in the Trust are using its service user survey, and all inpatient areas are visited by service user volunteers to interview people about their experience of care
- Creating a strong Recovery culture in the Trust, implementing the Recovery College and Recovery Enterprises
- Standardising team governance reports to enable benchmarking and compliance with CQC essential standards, while retaining team and directorate ownership and making sure there is joining up from team to Board with quality assessment, improvement and assurance
- Reviewing and improving quality measures and quality indicators in the light of the national outcomes framework, NHS Sheffield expectations, national development in the Quality Outcomes Framework (QOF) and mental health indicators
- Continuing to make improvements to how the Trust learns from serious incidents or complaints – when things have gone wrong – including being open with service users and families, and giving feedback to staff
- Continuing to develop support for carers, building on last year's quality objective and action plan
- Making sure all staff are trained in clinical risk assessment and management, and that effective, systematic risk tools including the Brief Risk Assessment and Management (BRAM) and the Detailed Risk Assessment and Management (DRAM) are in place throughout the Trust
- Implementing the NHS Equality Delivery Scheme
- Implementing the new Volunteer Policy and developing support for volunteers
- Continuing the work on food and improving nutrition that was a quality objective for 2011/12, through the Nutrition Group
- Supporting the Black and Minority Ethnic (BME) Strategy group to continue its work to improve the experience of care by service users from BME groups.
- Delivering Energise for Excellence, a new national quality framework:

Energise for Excellence (E4E)

Energise for Excellence in Care (E4E) is a quality framework for nursing and midwifery that aims to support the delivery of safe and effective care, creating positive patient and staff experiences that build-in momentum and sustainability; this is underpinned by 'Social movement thinking' principles.

Aims:

- Patients reporting a positive experience when accessing Healthcare
- Nurses driving the delivery of high quality and job satisfaction
- Commissioners using quality indicators to drive improvements in safe, efficient effective care
- Inform Boards in their decision making about nursing and patient care.

Overarching approach

From Department of Health website 4.1.12

Trust services were re-designed during the year to move from 6 to 4 directorates from October 2011 and reduce management costs where feasible. In addition to the Clover Group, the directorates are:

- Acute mental health (all adults)
- Community mental health (all adults)
- Specialist services
- Learning disabilities

The corporate services and systems that support frontline care have been redesigned to reflect these changes and give energy, leadership and resources into the new directorates. The senior nurses, for example, are now managed within the directorates rather than by the centre.

A number of directorates are committed to quality improvement projects within their service areas, for example:

- The Clover Group is taking steps to improve the quality of service user experience and is setting up new ways of involving service users in the practices

The Clover Group Practice – Patient Participation

A new Patient Group has been set up with 69 members from all the practice sites. Ages range from 16 to 86 years, and there is a good representation from all the communities the practices serve. The group began in November 2011 and has met twice so far: it also has its own website.

The Patient Group has set its own priorities which include:

- An appointments survey – carried out in several languages, on paper and online
- Improvements to Patient Information
- The development of Patient Group Advocates
- Patient involvement in protocols and procedures

- The Homeless and Traveller Service is working to improve health outcomes , especially of young people
- The Learning Disability Service is developing a new Integrated Support Service which will include a much improved in-patient environment for those service users with severely challenging behaviour or mental health problems, who currently use the Assessment and Treatment Unit.

During the year, the Trust implemented changes to its governance and performance management arrangements in the light of the Francis Report recommendations and its self review. A new Board sub committee, the Quality Assurance Committee, began in April 2011. The Committee has received regular updates on delivery of the Trust's quality objectives, and reports on different aspects of quality including safety, clinical effectiveness, service user experience, equality and inclusion. It

enables Board members to track progress on quality measures, audits and indicators, and also to have in depth discussion and review of quality issues. The governance committee structure overall has been reviewed and streamlined. The Trust's Quality Framework is being revised and a new Governance Handbook is being developed.

The Board has deepened its understanding of service user experience, with service user and carer presentations at every Board, and visits to services by Board members, including Non-Executive Directors. A Board development session was held in March 2012 to build on these approaches.

Discussions about service user involvement in improving services

Photo by Forest Close Photography group

Progress on last year's quality objectives

The Trust chose 4 quality objectives f0r 2011/12. They were:

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**.

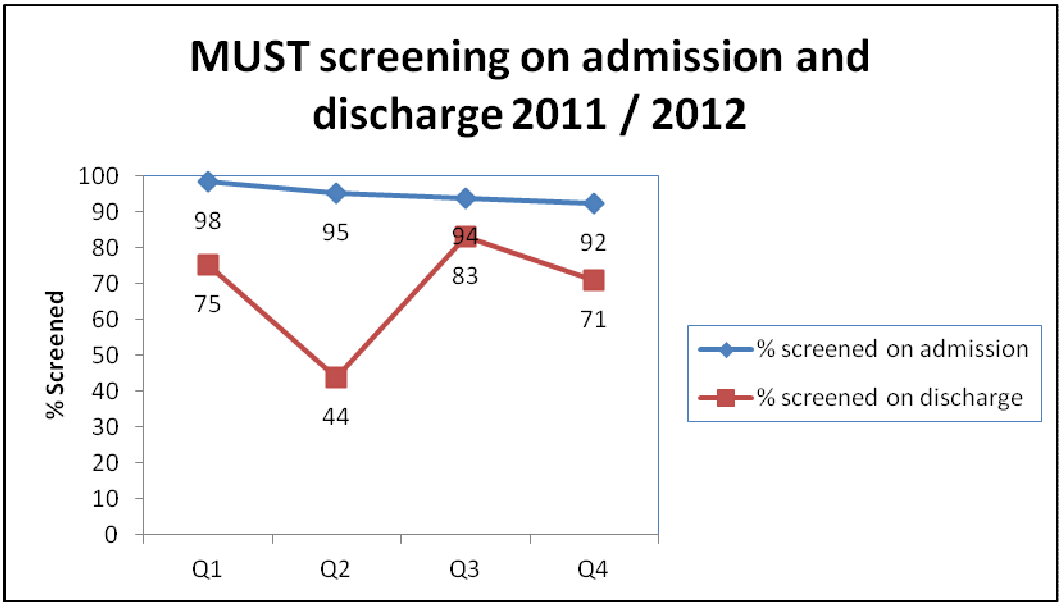
By the end of the year:

- The Nutrition Strategy was completed in draft form and being implemented during 2012.
- All directorates in the Trust had action plans for improving nutrition in their areas, and had set targets for improvement. This work will be continuing in the year ahead.
- A new Dietician post had been created and a part-time Dietician appointed to provide expert advice on food and nutrition
- All older people admitted to older adults' inpatient wards were being screened for malnutrition or obesity on admission and discharge using the Malnutrition Universal Screening Tool (MUST). If problems were found, action was being taken. The same programme was being extended to younger people admitted to inpatient wards.

  The percentage of service users screened on admission during 2011/12 was 95%. The percentage screened on discharge was 71%. The table below shows performance varied over the year.

  Diagram 2: Screening using the MUST (Malnutrition Universal Screening Tool) on admission and on discharge from wards, for each quarter of 2011/12.

  Data from Insight



- 14 Staff including nurses, OTs, catering and housekeeping staff working with people with mental health problems, received specialist weight management training

- An obesity care pathway is being developed by the dietician and there are plans to train more staff in weight management
- Patient Environment Action Team (PEAT) assessment visits in February 2012 found 4 out of 5 sites were 'good' against a target of food in all areas being 'good' or 'excellent.' The other site was assessed on the food PEAT standard for the first time this year: because of the timing of the inspection visit the food could not be tasted and so a score of 'acceptable' was deemed the maximum possible.
- New standards had been developed for nutritional assessment of meals and these were adopted in all areas of the Trust. Improvements were made in any areas where menus were found not to meet the standards
- A survey of 122 service users in February found:
    - 78% said the food looked nice when it arrived
    - 76% said the food tasted nice
    - 75% said they had a choice of what to eat
    - 72% said there was the right amount of food on the plate
    - 88% said they received enough to drink
    - 77% said they were usually able to eat the food provided
- Plans have been put in place in the different ward areas to improve the meals, based on the service user feedback

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.

By the end of the year:

- The Trust's dementia services were working with partners across the city to implement the NICE Quality Standard
- A review of the Trust services against the standards showed a gap in support for advanced directives. By December, everyone using the Memory Service was receiving advice or support in advanced directives at the post diagnostic review
- 134 more people received a memory assessment than in the previous year. (up from 728 to 862 people)
- Waiting times for memory assessments were down from 21.3 weeks last year to 14.7 weeks over the year

'I need to tell you that our appointments rescued us from a horrible and miserable situation in which we felt very frightened and helpless and lonely. I was drowning. You were the lifeboat. This came after months of terrible anxiety and waiting, intimidating tests and then the expected but overwhelming misery of the diagnosis. The change in our lives is massive, beyond description, and the losses are devastating. Really the only things that matter now are kindness, cheerful sympathy and practical help. These are what are helping us get used to things and hopefully mean we can find little joys and pleasures still.'

Letter to Memory Service North, Dementia Services

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

Progress on this objective was delayed by changes to staffing, but by the end of the year:

- Carers were involved in many ways in shaping and planning services

Examples of Carers' Involvement in Dementia Services

- 2 Carers who have been members of the 'Caring and Coping with Loss in Dementia' group (a 6-8 week course providing information and support for carers) have now been trained and are able to deliver the course alongside staff
- In the Memory Service, carers' feedback on follow-up appointments was addressed as part of the continuing Carers Experience Project
- Carer's feedback on the dementia cafes means that the cafes now offer education/training on topics service users and carers have chosen, rather than what the service thinks they might want

- Family carers of people using Trust services were asked in a survey about their needs and experiences. Only 25 were returned out of 240 sent out so the results must be treated with caution. The findings were generally positive 59% felt that their needs were being met, 9% felt that their needs were not being met and 39% said they did not know. 87% said their knowledge as a carer was respected by staff. 75% said they knew who to contact in a crisis but 25% either did not know or were unsure. 72% said they had received help or information: this was usually advice from staff or an information leaflet.
- Surveys were also completed by over 100 Trust staff with caring responsibilities:

Results of Survey of Staff Carers (2012)

An email was sent to all staff encouraging those with caring responsibilities to complete an online questionnaire. Out of approximately 2800 staff, 111 completed the survey.

- 80% of the staff who replied said that their line manager was aware of their caring responsibilities. 74% said their colleagues were also aware
- Staff had a good understanding of the Trust's Carers' Leave Policy. 80% were aware of it and 92% of those who had asked for carers' leave had received it.
- They had less knowledge of the Trust's Flexible Working Policy and how it could help carers. 11% had applied to work flexibly and 53% of these had been successful in their application.

Staff comments on the questionnaire have been analysed and a number of ideas will be taken forward. Key points include:

- More information is needed for staff who are carers about what kind of help and support they are entitled to from the Trust, and more general help and advice e.g. about local carers' groups. A staff carers webpage was suggested.
- Managers need to be knowledgeable and consistent in supporting staff carers. They may need some extra training in this area. A number of staff commented very positively on the support they received from their mangers, but others said their manager seemed unsure how to help and there seemed to be some inconsistencies in the application of the Carer Leave Policy.

- A Trust action plan, based on the surveys, is being completed and further work is planned for 2012/13
- **523** carers (**79.4%** of carers of people on the Care Programme Approach) were offered a carers' assessment and **67.4%** of those who wanted an assessment received one.

4. To continue work on improving the experience of people from Black and Minority Ethnic groups who receive care and treatment from the Trust

By the end of the year:

- Following critical feedback from Black service users, the Trust reviewed its ways of managing the risk of violence and aggression on the wards and has begun training all staff in a new approach, the Respect approach. By the end of January, 12 trainers had been identified and 48 staff had been trained, with overwhelmingly positive feedback; by the end of the year 172 staff had been trained. The delivery of the Respect training will be continuing as a key part of the objective to reduce the incidence of violence and aggression in 2012/13.
- Equality and diversity training for staff was also revised and by the end of the year 449 staff had received the new equality and diversity training. In the CQC Staff Survey for 2011 32% staff reported they had received training in this area. Although this was an improvement on the previous year, the Trust still performs poorly in comparison with other mental health trusts, falling in the lowest 20% nationally.
- Specialist Race Equality Cultural Capability training was delivered to 23 senior practitioners and other key clinical staff. This equips the staff to become an expert resource for their teams.

Statements related to the quality of services provided

Review of services

During 2011/12 SHSC contracted with / provided and / or sub-contracted 139 NHS Services.

SHSC has reviewed all the data available on the quality of care in all 139 of these NHS Services. The Trust reviews data on the quality of care with NHS Sheffield, other PCTs, Sheffield City Council and the specialist commissioners in regular contract and performance meetings. However; 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 2011/12 represents 100% of the total income generated from the provision of NHS services by SHSC for 2011/12.

The data reviewed included safety, clinical effectiveness and a positive service user experience and also access, equality and inclusion. The amount of data available for review has not impeded this objective.

These figures are derived from specific service headings in the contracts with the Trusts 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.

Participation in clinical audits

During 2011/12, 11 national clinical audits and 1 national confidential inquiry covered NHS services that Sheffield Health and Social Care NHS Foundation Trust provides.

During that time Sheffield Health and Social Care NHS Foundation Trust participated in all 11 (100%) of the national clinical audits and all 3 elements of the 1 (100%) national confidential inquiry of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that Sheffield Health and Social Care NHS Foundation Trust was eligible to participate in during 2011/12 are as follows:

Table 2: National Audits and Sheffield Health and Social Care Trust participation

Name of National Audit	SHSC participation	Number of cases submitted	Number of cases submitted as a percentage of those asked for
National Audit of Schizophrenia	Yes	150	100%
National Audit of Psychological Treatments	Yes (IAPT)	1607	100%
National Parkinson's Audit	Yes (Neuro-Enablement Services)	20	100%
POMH-UK Topic 2 – Metabolic side effects of antipsychotics	Yes	122	100%
POMH-UK Topic 8 – Medicines reconciliation	Yes	80	100%

POMH-UK Topic 9 – Antipsychotic use in learning disabilities	Yes	20	100%
POMH-UK Topic 11 – Dementia and antipsychotic prescribing	Yes	110	100%
National Diabetes Audit	Yes (Clover Group)	914	100%
NHS Litigation Authority – Records Audit	Yes	850+	Not applicable
National Suicide Audit	Yes	10	Not applicable
National Study of Suicide in England and Wales	Yes	5	45%
Name of national confidential inquiry			
National Confidential Inquiry into Suicides and Homicides by People with Mental Illness	Yes	20	*45%*
National Confidential Inquiry into Suicides and Homicides by People with Mental Illness – Out of District deaths	Yes	1	50%
National Confidential Inquiry into Suicides and Homicides by People with Mental Illness - homicides	Yes	1	7%

(POMH-UK is the Prescribing Observatory for Mental Health in the United Kingdom, a national organisation the monitors the use of medication in mental health, provides trusts with benchmarking data and guidance on best practice.)

The reports of 7 out of 11 of national clinical audits were reviewed by the Trust in 2011/12 (all those where the results were published during the year) and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

Table 3: Result and Actions from National Clinical Audits and Confidential Inquiries

National audit	**Results**		**Actions**	
	Positive findings – compliance with standards	**Underperformance or non-compliance with standards**	**Actions already taken**	**Actions to be completed**
National Audit of Schizophrenia	The audit identified that SHSC were performing in the top 10% of Trusts with regard to Polypharmacy.	When compared with other Trusts, our performance was below average on the following : • Service users report of experience of care • Monitoring of physical health • Prescribing of clozapine for treatment resistant patients The performance in	The consultants and psychologists that collected the data have initial ideas about how the Trust can improve. They include clearer guidance on what screening / monitoring should be done and an updated physical health form to be used	A session is planned for doctors in a few months time that covers a case study, discussion of various issues then leads on to new guidance on physical health screening, monitoring and intervention. The results will also

		relation to monitoring of weight was in the bottom 10%.	at CPA reviews.	be fed back at QIG and at the Trustwide Audit Meeting.
National Audit of Psychological Treatments	- The audit found that most service users were waiting not longer than 18 weeks - All therapists had completed formal training - Service routinely collects outcome data to determine effectiveness of therapy - Service users staying in therapy	When compared with other Trusts - Service users reported a less positive relationship with their therapist - Service users reported lower level of satisfaction with treatment - Clinical outcomes less favourable than other services benchmarked	- A series of away days and workshops looked at the whole system -More shared responsibility and integration with GPs was introduced - Bureaucracy was removed from the referral process -10% fewer DNA rates - 5% improvement in recovery rates -Significant improvement in PHQ (depression) scores	- To continue to improve the access, outcomes and efficiency of service - To look at interaction between IAPT and Community Mental Health Teams
National Parkinson's Audit	*Data was submitted in November 2011 for 20 service users. Report due June 2012*			
POMH-UK Topic 2 – Metabolic side effects of antipsychotics	- Compliance with the standards was below 50%	The audit showed - Low recording of obesity - Low recording of glucose levels - Low recording of lipids - Low recording of smoking cessation	- Action Group set up to improve the recording of metabolic side effects -Insight modified to record physical health data - New Physical Health Screening tool has been added to Insight (care record)	- To re-audit recording of the metabolic side effects using Insight

			- Staff advised to use the screening tool	
POMH-UK Topic 8 – Medicines reconciliation	The audit showed positive compliance: - the names and dosage of all the medications were recorded - the proportion of service users where 2 or more sources of information were checked, and the proportion where discrepancies were identified	The recording of details of adherence to medication was less good	- Audit results presented locally, by pharmacists to individual teams, and trust-wide at Audit and Quality Improvement Group meetings - Clinical teams include audit results and actions in team governance reports	-to improve recording of adherence to medication
POMH-UK Topic 9 – Antipsychotic use in learning disabilities	Positive results were found: - The need for anti-psychotic medication had been reviewed in last year - Evidence of general assessment in last year - Evidence of assessment of EPS	- Lower compliance found with recording of blood pressure	- Target set to increase documentation of blood pressure from 82% to 100%	-to re-audit against target
POMH-UK Topic 11 – Dementia and antipsychotic prescribing	The audit revealed good compliance with standards with - Proportion of service users with the indication for antipsychotic prescribing clearly documented - Potential underlying causes of BPSD considered	The audit showed lower compliance with: - Evidence that a risk benefit analysis had been carried out before starting antipsychotics - Evidence that service users and/or carers were consulted about risks and benefits	- Dementia services have plan to improve documentation of risk benefit analysis before prescribing	- Re-audit recording of risk benefit analysis

		of antipsychotics before starting treatment		
National Diabetes Audit	Data submitted in November 2011 for 914 patients. Report due mid 2012			
NHS Litigation Authority – Records Audit	A total of 579 patients had their records audited, compared to 318 last year. There have been significant improvements in the documentation of: • Employment / education status • Accommodation status • Diagnosis • HoNOS • Previous history in mental health • Mental state examination in last 6 months • Risk of sexual vulnerability • Suicide risk • Self harm risk • Child / adult protection risks • Up to date risk management plans • Risk plans containing non compliance advice • Service users being sent copies of their correspondence	Since last year, there has been significant reductions in the documentation of: • Potential for predatory behaviour • Individual names being assigned to action plans The following standards are still scoring below 50% in the audit: • Advance directives / statements • Evidence of relapse prevention plans • Risk plan advising GP	Following the previous audit the results were fed back to the senior management teams and down to the clinical teams. All teams were sent a web version of their results and a laminated card. The results were also presented at numerous forums. In addition to this, there have been some major developments to the Insight system including the introduction of DRAM risk assessment and the continued development of Form C. More teams are now using Insight instead of a paper record.	The latest results will be fed back to the senior management teams and clinical teams as before. Directorates will develop action plans to address the underperforming standards. Clinical teams will use their records audits as evidence for their team reports. A further audit will be scheduled.
National Suicide Audit	- Compliance good with 7 out of 8 standards	-The initial audit found that not all staff trained in risk assessment	- All staff now trained in risk assessment	- To extend audit to all wards at Michael Carlisle Centre

Local clinical audits are conducted by staff and teams evaluating aspects of the care they themselves have selected as being important to their teams. The commissioner, NHS Sheffield, also asks the Trust to complete a number of local clinical audits each year, to review local quality and safety priorities.

The reports of 53 local clinical audits were reviewed by the Trust in 2011/12 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of health care provided, based on a selection of these projects:

Table 4: Results and actions from local clinical audits

Local audit	**Results**		**Actions**	
	Positive findings – compliance with standards	**Underperformance or non-compliance with standards**	**Actions already taken**	**Actions to be completed**
Use of DRAM on wards (risk assessment and management tool)	- DRAM in place and being used on routinely wards	- Doctors not inputting to DRAM - DRAM not used as multi-disciplinary tool	- Additional training provided for doctors - Staff attendance at risk training monitored by directorate	- Re-audit of use of DRAM is underway to check progress
NICE Quality Standard for Depression	Good compliance with standards: - Diagnosis recorded - Risk assessment before prescribing	- Evidence that service user had received an appropriate information leaflet	- New checklist/template developed covering compliance with NICE Quality Standard for Depression	- To implement checklist - To re-audit
NICE Guidelines for Falls Prevention	- Rate of falls down on G1	Rate of falls increased on Daleside, Hawthorn and West Wing	-Findings presented to Quality Improvement Group	- To improve feedback of data on falls to wards - To review and improve actions to reduce falls
Referrals from GPs to Community Mental Health Teams (CMHTs)	- Referrals record: medical history, current medical status, ongoing problems and changes that have precipitated referral	- Referrals do not record as well: alcohol dependence, contact assessment form, adjustment/bereavement problems, ethnicity, carer and next of kin details, support systems/ agencies, urgency	- Results reported to GP group	- Considering future use of assessment criteria by CMHT referral screening staff when new referrals are received by CMHTs

Nutrition	Positive findings - Nutritional screening (using MUST) on admission for on older adults wards	Negative findings - Nutritional screening (using MUST) on discharge for on older adults wards - Nutritional screening for other wards not yet in place	- MUST results monitored by Nutrition Group and fed back to wards -Dietician visiting wards and training staff - Rates improving (up 39% on discharge)	- MUST to be rolled out to all acute wards with Dietician's support
Safeguarding adults	Majority of staff knew content of policy and who to contact when an adult had been abused. 85% staff had attended safeguarding adults training	9 staff found not to be CRB-checked. Doctors less well informed about safeguarding adults.	All staff now CRB checked. Doctors are being trained in safeguarding.	
Safeguarding children	Majority of staff have some understanding of child abuse and know who to contact	Only 1/3 staff knew who the Trust's Safeguarding lead doctor and nurse were	Audit results presented to safeguarding Steering Group and an action plan to improve training is being developed	To complete plan and implement improved training for staff in collaboration with other agencies
Accelerated Dementia Discharge Services (ADDS) – collaboration with Sheffield Teaching Hospitals Trust (STHFT)	STHFT staff aware of ADDS and the service they provided.	STHFT staff had less awareness of follow-up care provided by ADDS post-discharge	After consultation, it was agreed to introduce an information leaflet about ADDS , with contact details, and to offer brief information sessions about ADDS to STHFT staff	To implement the leaflet and information sessions and then re-audit
Caring and coping course, for carers of people with dementia	Audit found better results from 6 week than from 8 week course. 6 week course showed	8 weeks course benefitted carers on measures of insomnia and anxiety	Findings are being reviewed by service and will be used to improve support for carers	

	significant benefits on GHQ (general health) outcomes for carers			
Quality of A&E mental health referrals		Problems found in quality of mental health referrals made by medical staff in A&E.	Education and training provided for junior doctors in A&E	
Recording of capacity to consent on inpatient ward		Capacity to consent was not being recorded on Hawthorn ward	Capacity to consent forms introduced on Hawthorn ward and are being used by ward staff	
Prescription of exercise for people with long term neurological conditions		Audit found a need for regular exercise for people with long-term neurological conditions	Funding secured for targeted exercise group at Sheffield International Venues. Services signpost service users with long term conditions to this facility.	Training planned for Sheffield International Venues staff so they can support people with long term neurological conditions to exercise regularly

Research

Participation in clinical research

The number of patients receiving NHS services proved or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust in 2011/12 that were recruited during that period to participate in research on the National Portfolio of the National Institute for Health Research was 375 and the number recruited to studies approved by a research ethics committee was over 500.

Sheffield Health and Social Care NHS Foundation Trust was involved in conducting 17 clinical research projects which aimed to improve quality of services, increase service user safety and promote the ability of the Trust to meet the needs of NHS commissioners.

Research is a priority for Sheffield Health and Social Care NHS Foundation Trust and is one of the means by which the Trust seeks to improve quality, increase productivity and initiate innovation. The Trust recognises the key role of the NHS in promoting and conducting clinical research and the right of service users to be informed about opportunities to participate in ethically approved clinical research trials. The Trust works closely with the East Midland and South Yorkshire Mental Health Research Network and academic partners to maximise the research activity taking place in the Trust.

Together with Bradford Care Trust and the Universities of Sheffield and Oxford, the Trust is taking part in a national pilot study, funded by the Department of Health. The study is investigating how to use service user reported outcome measures to assess the effectiveness of treatment for depression by community mental health teams, including the teams working with older adults. It is hoped that this work will help develop a method for measuring the effectiveness of the care provided by mental health services in future.

Understanding and Preventing Adverse Effects of Psychological Therapies

An example of the research currently underway in the Trust is the study *Understanding and Preventing Adverse Effects of Psychological Therapies.* This work is funded by the National Institute for Health Research through their Research for Patient Benefit stream and conducted by collaboration between Trust clinicians and academics from the University of Sheffield. This is important research as the NHS has invested more than £170 million to improve access to psychological therapies. Although most service users benefit, some deteriorate after a course of psychological therapy and a significant proportion of service users do not complete the therapy. This project aims to improve quality of care and service user safety by establishing whether there are certain service users that have a greater risk of dropping out or experiencing deterioration after engaging in a course of psychological therapy.

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of Sheffield Health and Social Care NHS Foundation Trust income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between Sheffield Health and Social Care NHS Foundation 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.

Table 5: Contracts with CQUINs 2011/12

CQUIN Value and Payment achieved: data from Trust records

Contract Name	CQUIN Value 11/12	CQUIN Value Achieved 11/12
Sheffield Block Contract	£907,370	£606,804
Barnsley Block PCT Contract	£1,816	£1,217
Specialist Commissioning Grp (Hosted by Barnsley PCT)	£49,645	£49,645
Rotherham PCT Block Contract	£2,127	£1,425
Derbyshire County PCT Block Contract	£2,435	£1,631
Doncaster PCT Block Contract	£975	£653
TOTAL	£964,367	£661,375

Further details of the achieved goals for 2011/12 and for the following 12 month period are available electronically on the Trust website www.shsc.nhs.uk

What others say about Sheffield Health and Social Care NHS Foundation Trust

1. Statements from the Care Quality Commission (CQC)

Sheffield Health and Social Care 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. Full registration in all areas (and full compliance) has been maintained throughout the year. The Care Quality Commission (CQC) has not taken enforcement action against the Trust in the year ending 31st March 2012.

Sheffield Health and Social Care Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC visited the Michael Carlisle and Longley Centres to monitor the delivery of the action plan agreed following its planned review visit to the wards in January 2011, which had resulted in 8 compliance actions and 1 improvement action. On its return visit, the assessors commentated favourably on the progress that had been made. All compliance actions were lifted and 1 improvement action remained. This was related to care records during the transition from paper to electronic records.

The CQC also issued 1 compliance action for Grenoside Grange following the planned review in January 2011: this was related to staffing and the use of flexi staff, the permanent staff numbers and the skill mix. They visited Grenoside Grange in September 2011 and lifted the compliance action, as new staffing arrangements had been agreed and posts were under recruitment

The CQC visited Bole Hill View in December 2011 as a planned review of social care provision and found one improvement action, relating to records. An action plan is being implemented to address this issue.

Following the exposure by BBC Panorama of abuse at Winterbourne View, the CQC undertook a programme of visits to learning disability services nationwide. The Trust's Assessment and Treatment Unit was visited in November 2011 as part of this targeted inspection programme.

The CQC found the Assessment and Treatment Unit fully compliant and commended good practice in the care and welfare of service users in its feedback to the Trust, in particular the quality of the person centred plans and health action plans, and the relationships between staff and service users. An improvement action was made to improve the quality of the building, pending the move to new purpose designed premises in 2013. Remedial work to the building has begun.

The CQC has not produced an annual report on the implementation of the Mental Health Act by the Trust in 2011/12.

2. Monitor

At the end of 2011/12, the Trust had a 'green' rating for Governance from Monitor, the Foundation Trust regulator.

The Trust has assessed itself against the Monitor Quality Governance Framework and reviews this self assessment quarterly at the Quality Assurance committee.

Table 6: Monitor Quality Governance Framework –RAG rated summary (self assessment)

Strategy	Capabilities and Culture	Processes and structure	Measurement
1A. Does quality drive the Trust's strategy?	2A. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	3A. Are there clear roles and accountabilities with regard to quality governance?	4A. Is appropriate quality information being analysed and challenged?
1B. Is the Board sufficiently aware of potential risks to quality?	2B. Does the Board promote a quality-focused culture throughout the Trust?	3B. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	4B. Is the Board assured of the robustness of quality information?
		3C. Does the Board actively engage patients, staff and other key stakeholders on quality?	4C. Is quality information used effectively?

Key – item rated as amber if any actions still to complete – green if fully meets all Monitor guidance

- Item 3B is rated amber because of the continuing work on improving the management of serious incidents.
- Item 4B is rated amber because of the Trust's underperformance on the Information Governance toolkit. There is an action plan to improve this score.

3. NHS Litigation Authority Risk Management Standards

The Trust has currently attained Level 1 of the NHSLA risk management standards.

It plans to be re-assessed at Level 1 by the end of March 2013 and progress to Level 2 by November 2014.

4. Health and Safety Executive

There have been no visits by the Health and Safety Executive to Trust premises this year

5. Fire Authority

Following the recommendations arising from a serious fire in a care home in Scotland, the Fire Service set up a proactive series of visits to health and social care premises.

A Fire Authority inspection of Wainwright Crescent in September 2011 led to an Enforcement Notice, which was rapidly addressed. On a follow-up visit in November 2011, the Fire Service found all necessary actions had been taken and the Enforcement Notice was withdrawn.

6. Patient Environment Action Team

The Patient Environment Action Team (PEAT) assessment team this year included a service user and an external assessor from Bradford District Care Trust, who provided very valuable perspectives on the quality of the environment in in-patient areas.

Results for the 2010/11 Patient Environment Action Team (PEAT) assessment were published in August 2011.

Table 7: 2011 PEAT results

Site Name	Environment Score	Food Score	Privacy & Dignity Score
Longley Centre	Good	Good	Good
Michael Carlisle Centre	Good	Good	Good
Forest Close	Good	Acceptable*	Good
Forest Lodge	Good	Good	Excellent
Grenoside Grange	Excellent	Good	Excellent

* Following review, it was agreed that Forest Close could no longer be assessed as 'self-catering' and the quality of its food should be assessed. However, because the assessors were unable to visit at mealtime on the day of assessment and taste the food, the highest possible score was 'acceptable'.

Comparisons with the previous 2 years show;

Table 8: PEAT results for last 3 years – Environment

Site Name	Environment Score		
	2010/11	2009/10	2008/9
Longley Centre	Good	Good	Good
Michael Carlisle Centre	Good	Good	Good
Forest Close	Good	Good	Good
Forest Lodge	Good	Good	Good
Grenoside Grange	Excellent	Good	Good

Table 9: PEAT results for last 3 years - Food

Site Name	Food Score		
	2010/11	2009/10	2008/9
Longley Centre	Good	Good	Excellent
Michael Carlisle Centre	Good	Good	Good
Forest Close	Acceptable*	Self-catering	Self-catering
Forest Lodge	Good	Good	Excellent
Grenoside Grange	Good	Good	Excellent

*Following review, it was agreed that Forest Close should be assessed for the quality of food this year. However, because the assessors were not able to visit at mealtime on the day of the inspection and taste the food, the highest possible score was 'acceptable.'

Comparison with the PEAT environment scores over the last 3 years show a consistent picture, with the exception that the rating for Grenoside Grange, a dementia in-patient unit, increased form 'good' to 'excellent.'

'Generally a very pleasant environment that has benefitted from a lot of thought and work to create this working and caring environment. The practice of colour-coding toilets with red door frames was an imaginative and very practical piece of work: this has been followed through by coding toilet seats red as well. There have been significant improvements since the last inspection.'

Comment from PEAT submission on Grenoside Grange

A review of the PEAT scores for privacy and dignity over the last 3 years shows a lower score in 3 areas this year. This followed changes to how the team assessed single sex accommodation and their interpretation of the national and regional guidance.

There was no change to the lay-out or physical environment of the wards, but the Trust is assessing itself more rigorously against these standards in comparison to previous years.

Table 10: PEAT scores over last 3 years – Privacy and Dignity

Site Name	Privacy and Dignity Score		
	2010/11	2009/10	2008/9
Longley Centre	Good	Excellent	Excellent
Michael Carlisle Centre	Good	Excellent	Excellent
Forest Close	Good	Excellent	Excellent
Forest Lodge	Excellent	Excellent	Excellent
Grenoside Grange	Excellent	Excellent	Good

Data quality

Statement on relevance of data and actions taken to improve data quality

Data quality is important because it enables information to be shared that is accurate, timely and appropriate.

The Trust endeavours to triangulate information about quality and safety i.e. to check for a consistent picture across several different data sources. An example of this would be the work carried out to find out more about the risk of violence and aggression on the acute inpatient wards and how staff can best respond to it. Records of incidents of violence and aggression, staff survey results and the results of service user interviews have been brought together in the work that has led to the implementation of the new Respect training for staff.

Sheffield Health and Social Care NHS Foundation Trust will be taking the following actions to improve data quality:

- The 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
  - the Trust Information Management and Technology(IMT) team 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
- There are clear and consistent definitions for indicators in the Trust's new Inform system, a web-based datastore for quality and performance information
- Inform is designed to enable staff such as team managers or directors to assess the accuracy of data held about their service quickly and address any anomalies identified as a result of this feedback loop

- New key performance indicators relevant to data quality are being built into Inform as it develops
- The Insight (Patient Information) system has built-in routines to validate data as it is entered
- The Trust Commercial Relations department check details before submitting their returns to GP practices
- We make regular submissions to the Demographics Batch Service to identify and verify NHS numbers, which helps to prevent the creation of duplicate service user records and identify and remove existing duplicates
- Staff have access to the Summary Care Record/ Personal Demographics Service so that they can check NHS number, registered GP and address details. We are working to automate checking of registered GPs for Insight service users
- We use the Enhanced Reporting Service to identify deaths of service users and keep the Insight system up-to-date.

The Trust is rolling out electronic service user records to all parts of the Trust and the majority of teams are now running electronic records. Because Insight is a bespoke service user record and information system, it can be flexible and has been adapted to meet the specific needs of different service areas. New developments have included 'front pages' for staff in acute wards with key data visible at a glance. An Electronic Records Clinical Summit held in the summer attracted a large number of clinical staff who were able to contribute to further system improvements to meet the needs of staff and service users.

The data quality of the annual Quality Accounts for 2010/11 was audited last year by the Audit Commission on behalf of Monitor. They shared their findings with the Trust. A total of 5 recommendations for improvement were made by the auditors. (In the previous year there were 14 recommendations for improvement.) Actions were agreed and have been implemented.

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 data quality with the extension of Inform. It has implemented regular data quality reporting to the Information Governance Steering Group, covering submissions of the Mental Health Minimum Dataset

National Dataset Key Performance Indicators

Sheffield Health and Social Care NHS Foundation Trust submitted records during 2011/12 to the SUS (Secondary Uses Service) for inclusion in the HES (Hospital Episodes Statistics) which are included in the latest published data. The latest published data from the SUS data quality dashboard is for April 2011 - February 2012. The percentage of records in the published data that included the Patient's valid NHS number was 100%, and the percentage with a valid GP Registration Code was also 100%. (The data source is the SUS Data Quality Dashboard for Sheffield Health and Social Care Trust, published by the NHS Information Centre as of 16.5.12)

Data was submitted from the Admitted Patient Care (APC) Commissioning Dataset and the Mental Health Minimum Dataset (MHMDS) to the required timetables to the Information Centre/ Secondary Uses Service.

For the December 2012 APC submissions, 82% of inpatient records were reported to be comprehensively coded.

Table 11: Data quality - APC and MHMDS submissions for last 3 years. Data from relevant published data for APC or MHMDS

Indicator	2011/12	2010/11	2009/10
% Records in CDS APC with valid NHS number		99.8%	
% Records in CDS APC with valid General Medical Practice Code		100%	
% Records in MHMDS with valid NHS number	99.9%		
% Records in MHMDS with valid General Medical Practice Code	99.5%	99%	
% Records in MHMDS with valid postcode	99.7%		
% Records in MHMDS with valid ethnic group	94.1%		
% Records with valid marital status recorded	92.7%		

By the end of 2011/12, the Clover Group had a total of 15,329 registered patients. 41 (0.3%) had no NHS number yet. (Data proved by Clover Group records as of 13.4.12.) It should be noted that the Clover Group includes the Mulberry Practice which works with asylum seekers and refugees. People new to the country may not yet have an NHS number allocated.

Clinical coding error rate

Sheffield Health and Social Care NHS Foundation Trust was not subject to Payment by Results clinical coding audit during 2011/12 by the Audit Commission.

A clinical coding audit was completed in line with the requirements of the Information Governance Toolkit in March 2011. The report received in July 2011 concluded that coding of primary diagnoses met the requirements of Level 3 of the Information Governance Toolkit, but that there was a shortfall in the recording of secondary diagnoses.

Information Governance Toolkit

In March 2011, Sheffield Health and Social Care Trust Information Governance Toolkit assessment report overall score was 60%, which was graded not satisfactory. This is because the Trust did not meet level 2 on all items. The Trust prioritised action on those areas of the Toolkit which would have the most impact or benefit for service users.

The Trust has a programme of work to improve performance on those items where Level 2 has not been achieved. Further information is available from the Information Manager.

Part 3: Review of Quality performance

This section provides an overview of the quality of care and treatment in the Trust. It considers all elements 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 it can learn from looking at patterns and trends and make improvements to services to reduce the harm to service users, carers, staff and others. In reports of incidents and serious incidents, the Trust expects to see a 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.

In the annual National NHS Staff Survey, Sheffield Health and Social Care Trust fell into the top 20% of Trusts for the percentage of staff reporting errors, near misses or incidents witnessed in the last month.

Like all NHS Trusts, Sheffield Health and Social Care Trust reports all patient safety incidents to the National Patient Safety Agency (NPSA). The NPSA is then able to produce benchmarking information, to show how this Trust compares with others. The latest information from the NPSA shows the Trust is in the highest 25% (ranked 5th) of mental health trusts nationally when it comes to reporting patient safety incidents, reporting 43.7 patient safety incidents per 1,000 bed days in comparison with a median figure nationally of 21.1

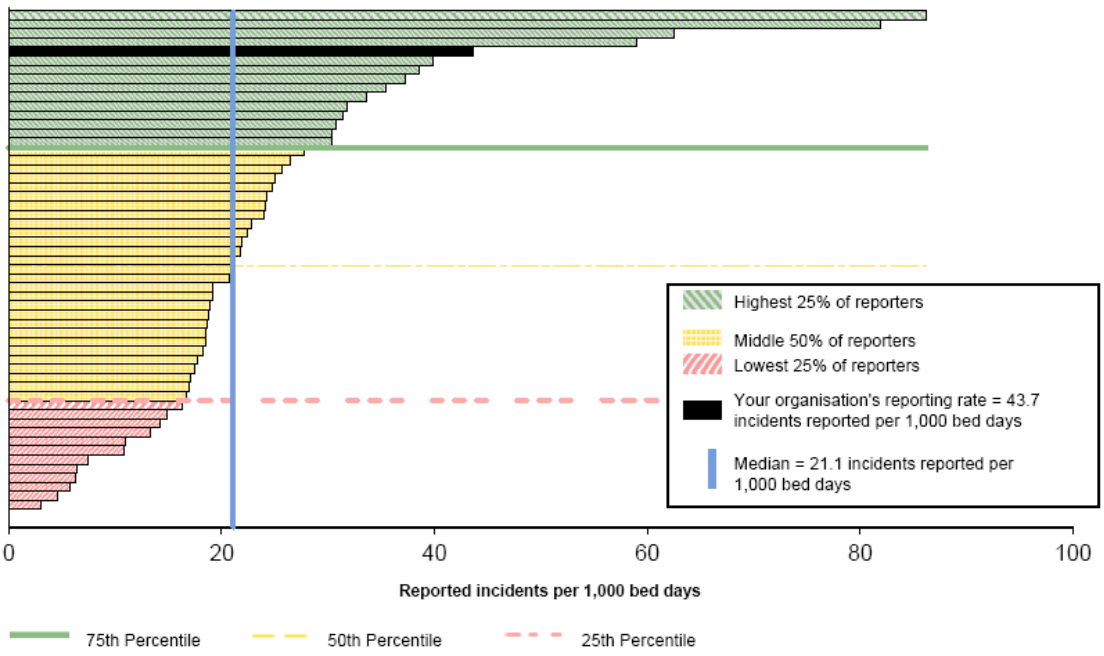
Table 12: Number of Incidents Reported: Benchmarking data for all mental health Trusts from NPSA for the period April - September 2011

This Table represents the most recent NPSA benchmarking data available and is extracted from the NPSA website

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLS) between 1 April 2011 and 30 September 2011. 1,882 incidents were reported during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 57 mental health organisations.



Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

During the year there were 101 serious incidents reported. 262 serious incidents were reported in the 2010/11 Quality Accounts. This reduction in numbers in part reflects a change in the Trust's definition of a serious incident to reflect the guidance from the National Patient Safety Agency.

6343 incidents were reported overall (including near misses and incidents where no harm occurred). The proportion of all incidents reported that were graded as serious during 2011/12 was therefore 1.6 %

Of all the patient safety incidents that were reported between April and September 2011, 0.4 % (8 incidents) resulted in severe harm or death, in comparison with 0.8% of all incidents reported by mental health trusts nationally (NPSA information for the first 6 months of 2011/12.) These figures indicate a positive patient safety culture in the Trust, because they indicate that staff are willing to report when things have gone wrong, and to learn from incidents.

Table 13: Findings on 'Errors and Incidents' from National NHS Staff Survey 2011 for SHSC

Information from Report on Picker Institute website

Question	Change since 2010 survey	Ranking, compared with other mental health trusts
% witnessing potentially harmful errors, near misses or incidents in the last month	No change	Above (worse than) average
% reporting errors, near misses or incidents in the last month	No change	Highest (best) 20%
Fairness and effectiveness of incident reporting procedures	No change	Average

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

The Trust is performance monitored by NHS Sheffield on its management of serious incidents. NHS Sheffield set targets for improving the timeliness of reporting and the quality of the incident reports. During 2011/12, the Trust reported 81.6% of its serious incidents within the 48 hour timescale, against a target of 60%; it submitted 60% of its investigation reports within a 12 week timescale, against a target of 70%. NHS Sheffield graded the quality of the investigation reports and found 65.8% were good or excellent, 34.2% were fair and none were poor. The target was that 70% were excellent and only 10.5% reached this standard.

The Trust has improved the quality and timeliness of its investigation reports over the last 12 months and aims to make further improvements in the year ahead.

Patient safety alerts

The NHS disseminates patient safety alerts through the Central Alerting System. The Trust received 112 Central Alerting System (CAS) alerts during the year and 97.3% were concluded within the target timescale. In the previous year there were 127 alerts and 89% were concluded within the timescale: in 2009/10 the percentage meeting the timescale was 71%.

All emergency alerts from other sources (including MHRA Drug alerts, MHRA Dear Doctor Letter and Chief Medical Officer messaging) are cascaded within the set timescales.

Patient Safety Information on types of incidents

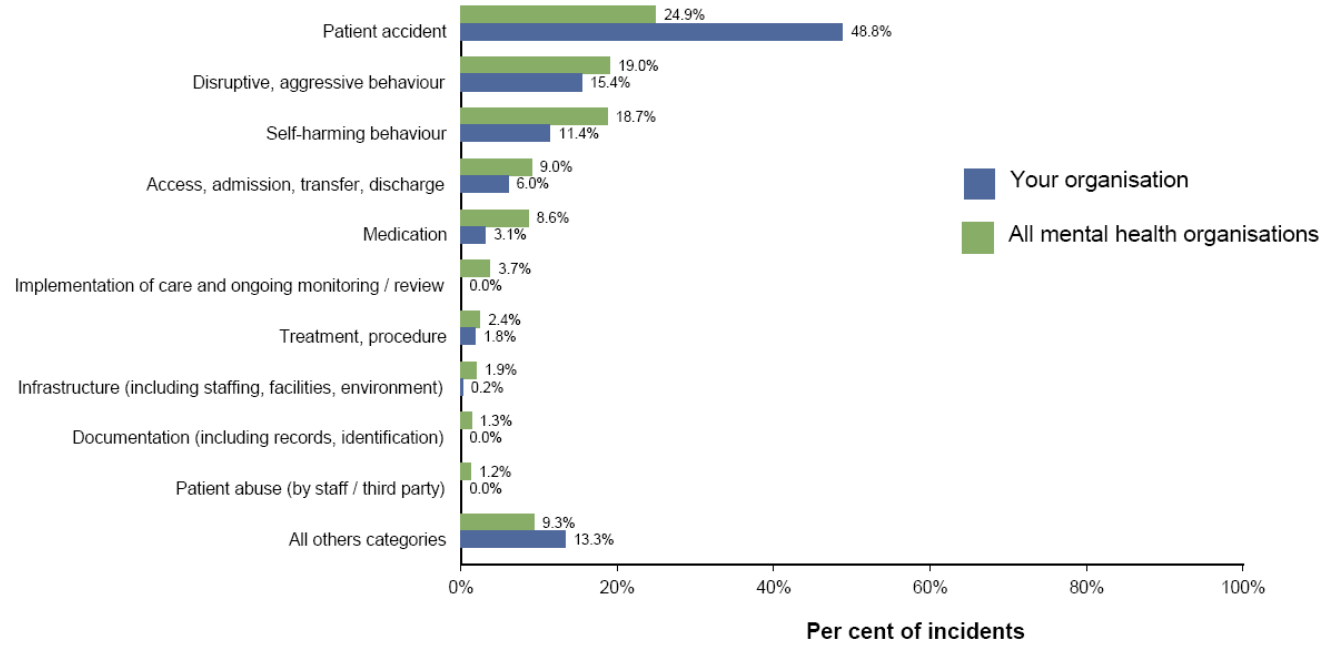
Like all NHS Trusts, Sheffield Health and Social Care Trust reports all patient safety incidents to the National Patient Safety Agency (NPSA). The incidents are grouped into different categories. The NPSA is then able to produce benchmarking information, to show how this Trust compares with others. The NPSA benchmarking information, although useful, has certain limitations:

- No two NHS Trusts are the same in terms of the services they provide or the populations they serve. Sheffield Health and Social Care Services, for example, provides service for substance misuse and the Clover Group general practices, but it does not provide child mental health services; other trusts in the 'mental health trust' group nationally will provide a different set of services
- At present, a relatively high proportion of the patient safety incidents reported by Sheffield Health and Social Care Trust fall into the 'other' category - 13.3% in comparison with 9.3% nationally. Work is underway to look at how the Trust categorises types of incidents in future.

Table 14: Types of incidents reported by the Trust in comparison with other mental health trusts nationally. Data extracted from NPSA website April 2012 and based on most recent available data (April-September2011)

What type of incidents are reported in your organisation?

Figure 2: Top 10 incident types



This year the Trust has chosen to report on the four specific areas of:

- Falls
- Self harm and suicide
- Violence and Aggression
- Medication

- **Falls**

The Trust reports high number of slips, trips and falls in comparison with other mental health trusts. Information from the National Patient Safety Agency showed that 49% of all the patient safety incidents reported in Sheffield Health and Social Care Trust were patient accidents in comparison with 25% as a national average for mental health trusts. (Information from the NPSA Organisation Patient Safety Incident Report for 1 April 2011 to 30 September 2011) This area has been chosen as a priority area for improvement in 2012/13 and is a Trust quality objective for the year ahead.

More information about the Trust and falls has therefore been provided in part 2 above, in the section on the quality objectives for 2012/13.

- **Self harm and suicide**

The risk of self harm or suicide is always a serious concern for mental health and substance misuse services. The NPSA figures show 11.4% of all patient safety incidents reported by the Trust were related to self harm, in comparison with 18.7% for mental health trusts nationally.

Table 15: Self harm incidents over last 4 years

Indicator	Number of incidents			
	2011/12	2010/11	2009/10	2008/09
All reported self harm incidents (Trust incident data from Ulysses Safeguard)	366	358	363	275
Suicide of inpatient or within 7 days of discharge (information from Coroner's Inquest findings)	3	1	1	0

During 2011/12 clinical risk training was provided for SHSC staff and new clinical risk assessment and management tools are being introduced throughout the Trust. 879 staff from all professional groups received the training, which covers the principles and practice of risk assessment and management. Within the new acute and scheduled care pathways for people with mental health problems, standards have been set for risk screening, risk assessment and risk management plans, as part of each person's care and treatment.

An audit of care records in November 2011 showed a significant improvement in the recording of clinical risk, with risk assessments and risk management plans in place.

- **Violence, aggression and verbal abuse**

The risk of violence or aggression for service users, family carers and staff remains a focus for the Trust, because of the impact it can have on people's lives and sense of safety and wellbeing. Some conditions such as dementia may sometimes increase the risk of violence or aggression for some of the people who experience them.

Overall the Trust reports relatively low incidents of violence and aggression from service users towards service users (NPSA benchmarking data for first 6 months of the year.) 15.4% of patient safety incidents reported by the Trust were for aggressive behaviour in comparison with a national average of 19%.

Table 16: Disruptive/Aggressive Behaviour Incidents Benchmarking Data from NPSA (data from April – Sept 2010 and 2011 respectively) Comparisons with other local Mental Health Trusts

Number and % of all patient safety incidents reported in this category

Trust	Disruptive/Aggressive Behaviour Incidents Reported	
	2011/12	2010/11
Trust A, Yorkshire and Humber	637 (24.6%)	528 (20.6%)
Trust B, Yorkshire and Humber	779 (23.5%)	390 (29.95%)
Trust C, Yorkshire and Humber	197 (18%)	128 (21.05%)
Sheffield Health and Social Care NHS Foundation Trust	290 (15.4%)	294 (17.2%)
Trust D, Yorkshire and Humber	455 (14.8%)	538 (22.3%)
Trust E, Yorkshire and Humber	296 (11.9%)	323 (18.1%)
Nationally (Mental Health Trusts)	**18,402 (19.1%)**	**19,699 (22.6%)**

The above data shows Sheffield Health and Social Care Trust remains well below the national average for mental health trusts.

The annual National NHS Staff Survey, carried out by the Picker Institute (previously done via the CQC), on behalf of the Department of Health, asks a random sample of Trust staff about their experience of violence and aggression at work. The survey for 2011 was published in March 2012 and the results showed:

Table 17: The Picker Institute Staff Survey results 2011 – findings on Violence and Aggression

Question on Violence and Aggression	Change since *2010*	Ranking, compared with all Mental health trusts in *2011*
% experiencing physical violence for patients, relatives or the public in last 12 months	No change	Above (worse than) average
% experiencing physical violence from staff in last 12 months	No change	Average
% experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Increase (deterioration)	Above (worse than) average
% experiencing harassment, bullying or abuse from staff in last 12 months	No change	Above (worse than) average
Perceptions of effective action from employer towards violence and aggression	No change	Above (better than) average

As described above, in the section on this year's quality objectives, a new programme of training for staff in how to prevent and manage the risk of violence, using the 'Respect' approach has begun during the year. Its aim is to improve how staff respond in situations where service users may become violent or aggressive, to minimise the risk of violence happening and reduce any potentially harmful consequences.

- **Medication**

Medication errors and near misses are another focus of Trust attention. Staff are encouraged to report near misses and errors that do not result in harm to make sure that they are able to learn to make the use and prescribing of medication as safe and effective as possible. 3.4% of patient safety incidents reported by the Trust related to medication, compared with 8.6% in mental health trusts nationally. There has been little change in the number of medication incidents reported by the Trust over the last 4 years.

Table 18: All medication incidents including 'near misses' for the last 4 years.

Data from Ulysses Safeguard.

Indicator	**Number of incidents**			
	2011/12	**2010/11**	**2009/10**	**2008/09**
All medication incidents	354	346*	367	329

* Slight discrepancy between 2010/11 figure in this table and those reported in last year's Quality Accounts is due to additional incidents being added to the database after the Quality Accounts were completed.

Sheffield Health and Social Care Trust service users surveyed by the Care Quality Commission in the 2011 Community Mental Health Survey reported a generally positive experience with medication.

Table 19: CQC Patient Survey results 2010 and 2011 – questions on medication

Data from CQC website

Question	2011 results	2010 results
Do you think your views were taken into account in deciding which medicines to take?	Average (Middle 60% of trusts)	Above average (Top 20% of trusts)
Were the purposes of the medication explained to you?	Above average (Top 20% of trusts)	Average (Middle 60% of trusts)
Were you told about possible side effects of medications?	Above average (Top 20% of trusts)	Above average (Top 20% of trusts)
Were you given information about the medication in a way that was easy to understand?	Above average (Top 20% of trusts)	Above average (Top 20% of trusts)
Has a mental health or social care worker checked with you how you are getting on with your medication?	Above average (Top 20% of trusts)	Average (Middle 60% of trusts)

- **Cleanliness and infection control**

The Trust has declared full compliance with the Code of Practice and Infection Control regulations again in 2011/12. It continues to have very low levels of the healthcare associated infections methicillin-resistant straphococcus aureus (MRSA) and clostridium difficile (c-diff).

The Trust has also chosen to report on outbreaks of infections (e.g. a cluster of people with the norovirus) which have resulted in services being closed. There are systems in place to deal with these emergencies, making sure people are safe and premises are rigorously clean. The Trust also carries out routine infection control audits in all areas.

Staff receive training in cleanliness and infection control throughout the Trust. Trust teams and services, including the Clover Group, will contribute to in-depth investigations of C-diff cases (using Root Cause Analysis) when required.

Table 20: Infection Control indicators:

Data from local Infection Control database – cases as defined by Health Protection Agency guidelines

Indicator	Number		
	2011/12	2010/11	2009/10
MRSA cases	1	0	0
C-diff cases	1	1	1
Outbreaks resulting in service closure	6	8	12

People using the Substance Misuse services face particular risks of infection from blood born viruses. The teams provide tests and vaccinations to help reduce these risks and prevent infections.

Table 21: Infection Control in Substance Misuse Services: measures to reduce the risk of blood born viruses (BBV)

Data from Insight

Indicator	Target	2011/12 figures	2010/11 figures
New presentations offered BBV vaccination	90%	100%	100%
New presentations who accept an offer to commence a BBV vaccination	90%	98%	91%
New presentations (previous or current injectors) who have a recorded Hepatitis C vaccination status	90%	95%	96%
New presentations (current or ever injectors) offered a Hepatitis C test	90%	100%	100%
Number of HIV screening tests completed	Not applicable	311	422

Single sex accommodation

The Trust has declared compliance with single sex accommodation in 2011/12. There has been 1 breach of the Eliminating Mixed Sex Accommodation (EMSA) regulations during the year. This was investigated and remedied.

A programme of building work is in place to improve compliance. Guidance on the EMSA standards is available for managers and there is an information leaflet for service users. Service users' views on sharing ward spaces are elicited regularly, at admission in the acute wards and every month in the recovery wards.

Safeguarding

Sheffield Health and Social Care Foundation Trust continue to work in partnership with statutory and voluntary services to ensure a consistent and structured approach is taken in Safeguarding Adults and Children. There is regular training for staff on safeguarding adults and children and the Trust has completed training audits to check all staff receive the necessary training. Any gaps in coverage found were addressed.

A number of complex reviews began during the year within the Trust Safeguarding Adults and Children's processes, linked to national reviews and changes. The policies and procedures for safeguarding adults, children and domestic abuse are being fully reviewed and updated with a date for completion set for May 2012. The Trust's Insight recording and data collection systems were reviewed and the safeguarding team is working in collaboration with the IT department to implement changes to the electronic system following the review.

The Safeguarding Adults team are working in partnership with the Local Authority to implement the Vulnerable Adults Risk Management Model (VARMM) for the care of those at high risk of self neglect.

The Executive lead for Safeguarding Adults and Children is Liz Lightbown. The Non-executive lead for Safeguarding Adults and Children is Councillor Mick Rooney. The Professional lead for Safeguarding Adults and Children is Dr Nusrat Mir.

2. Clinical Effectiveness

The Trust assesses the effectiveness of the care and treatment it provides against local and national standards and targets. For example, it reviews its care against the standards and guidance laid down by the National Institute for Health and Clinical Excellence (NICE)

Because the Trust covers a wide range of diverse services, this section of the Quality Accounts is divided up into different service areas.

Mental Health Services

The year has seen some important changes in the delivery of adult mental health services with the embedding of the Acute Care Pathway and the delivery of new Scheduled Care Pathway. Quality standards are fundamental to both these pathways, which have been designed to make sure service users get the right care at the right time. The electronic care record, Insight, enables team and directorate managers to get rapid feedback on whether the quality standards are being met, such as how long people have to wait for an assessment or whether they have received a care plan or a risk assessment. At the same time, mental health clustering has been introduced, a new way of grouping service users by need, which has been developed nationally to help facilitate the introduction of Payment by Results (PbR) in Mental Health. Staff who are introducing the clusters in their everyday work are gaining new insights into how to provide the right care in the right team.

Table 22: Mental Health indicators. Data from Insight

Indicator or standard	Target/threshold (set by NHS Sheffield)	2011/12	2010/11	2009/10
Service users on CPA receiving follow-up within 7 days of discharge from hospital	95%	96.8%	96.4%	97.2%
Minimising delayed transfers of care	No more than 7.5% delayed	4.2%	6.9%	6.4%
Admissions to inpatient services who had access to crisis resolution and home treatment (gatekeeping)	90& of all admissions	99.4%	97.3%	94.6%
New home treatment episodes	1202	1443	1361	1365
Everyone on CPA should have an annual review with their care co-ordinator	95% of people on CPA	98.7%	99.3%	Not measured
Everyone on CPA should have a formal review of their care plan	90% of people on CPA	89.5%	91.8%	89%
Access to assessment within 4 hours of referral when in crisis	80% of people to be assessed within 4 hours	92%	83.1%	59%
Access to support/treatment within 8 weeks of referral (routine referrals)	50% of people to be treated within 8 weeks	77%	67.8%	42.2%

Early Intervention in Psychosis

Early identification and treatment of psychosis is known to improve the long term likelihood of recovery. The Trust therefore monitors the number of people seen by the Early Intervention Service.

Table 23: Early intervention in Psychosis – new cases seen each year

Data from Insight

Indicator	Target (set by NHS Sheffield)	New cases 2011/12	New cases 2010/11	New cases 2009/10
Number of people seen by Early Intervention Service	90 new cases per year	136	129	285

Improving Access to Psychological Therapies

Improving Access to Psychological Therapies (IAPT) Services aim to treat people with mild or moderate mental health problems, using effective talking therapies. They aim to help people stay in work or get back to work quickly. The IAPT team monitor the effectiveness and impact of what they do closely: for example, they collect systematic outcome measures from the people who use their service for cognitive behaviour therapy or counselling.

Table 24: Effectiveness of IAPT services

Data from Insight

Indicator	Target (set by NHS Sheffield)	2011/12	2010/11	2009/10
Number of new cases seen	5364	10,661	9036	6728
Percentage of people moving to recovery	50%	49.5%	41%	44%
Number of people returning to work from benefits	89 people	396	419	304

Although Sheffield IAPT just fell below the local target for percentage of people moving to recovery, its performance remains strong in comparison with other parts of the country.

Dementia services

During the year, the dementia services audited themselves against the standards in the NICE Quality Standard for dementia and have made improvements, such as making sure people newly diagnosed with dementia have access to advice about advanced directives. They have also seen more people and reduced waiting times for a memory assessment.

Table 25: Effectiveness of Dementia Service

Data from Insight

Indicator	Target (set by NHS Sheffield)	2011/12	2010/11	2009/10
Discharges from acute care (G1)	78	34	38	53
Number of assessments for memory problems by memory management services	600	862	728	636
Rapid response and access to home treatment	300	267	336	288
Waiting times for memory assessment	N/A	14.7 weeks	21.3 weeks	28 weeks

Substance Misuse

The Drug and Alcohol Services provided by the Trust measure the effectiveness and impact of what they do against a number of indicators, set by their commissioners.

Alcohol awareness event run by Trust staff

Table 26: Drug and Alcohol Services quality indicators – performance over last 3 years

Data from Insight and NDTMS

Indicator	Target (set by commissioner)	2011/12	2010/11	2009/10
(Drugs) No client to wait longer than 3 weeks from referral to medical appointment	100%	100%	100%	100%
(Drugs) No drug intervention client to wait longer than 5 days from referral to medical appointment	100%	100%	100%	100%
(Drugs) No Premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	100%
(Drugs) No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100%	100%
(Alcohol Single Entry and Access Point) No client to wait longer than 1 week from referral to assessment	100%	100%	100%	Not applicable
(Alcohol Treatment Service) No client to wait longer than 3 weeks from Single Entry and Access Point assessment to start of treatment	100%	100%	100%	Not applicable
% problematic drug users retained in treatment for 12 weeks or more	90%	94%	89%	89%
Start/Initial Treatment Outcome Profile (TOP) completed	100%	96%	96%	Not applicable
Review TOP completed	100%	80%	59%	Not applicable
Discharge (planned) TOP completed	100%	100%	50%	Not applicable
All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100%	Not applicable
Number of service users and carers trained in overdose prevention and harm reduction	240	292	243	Not applicable
% successful completions for the provision of treatment for injecting-related wounds and infections	75%	85%	92%	Not applicable

Learning Disabilities

There were no people in campus provision in Sheffield Health and Social Care NHS Foundation Trust last year. We always aim to provide person-centred care that meets individual's needs.

In Learning Disability Services, the annual Sheffield WILD (working in Learning Disabilities) awards ceremony for staff saw a number of teams and individuals win recognition for their excellence, creativity and innovation. For example the Assessment and Treatment Unit staff team won an award for their work to improve the health of service users. The same team were commended by the Care Quality Commission on an inspection visit for the quality of their person-centred care plans and health action plans.

Clinicians in the learning disability services have been involved in developing quality standards which can be used by commissioners and contractors to assess the quality of specialist care for people with challenging behaviour and autism in care homes and other services. This work developed as part of the city's response to the Winterbourne report, following the BBC Panorama report on maltreatment of vulnerable people with learning disabilities in care.

Learning disability staff have also been working in partnership with Sheffield Teaching Hospitals NHS Foundation Trust colleagues to improve access to healthcare by people with learning disabilities:

Hospital Passport for People with a Learning Disability

The Hospital Passport has been updated by Mencap and the Joint Learning Disability Services. It is designed to be taken to hospital when the person attends outpatients or is admitted to a ward.

The Passport gives hospital staff important information about the person. It uses a traffic light system of colours:

- Red = Things you MUST know about me
- Amber = Things that are important to me
- Green = My likes and dislikes

The Hospital Passport is available to download from www.signpostsheffield.org.uk

Anne Hutchinson, Health Facilitation Coordinator

Clover Group

QOF Overview

General practices are assessed against the national Quality and Outcomes Framework.

The Quality and Outcomes Framework consists of 143 indicators totalling 1000 points across 4 domains, these being clinical, organisational, additional services and patient experience. 88 indicators are clinical and they carry 661 points: the 1 patient experience indicator carries 33 points.

Attached to the Clover Group Practices (APMS) contract is a series of key performance indicators and the practice is required through one of these KPI's to achieve 95% of the available QOF points. QOF performance is assessed annually and achievement based on our position on 31 March forms a

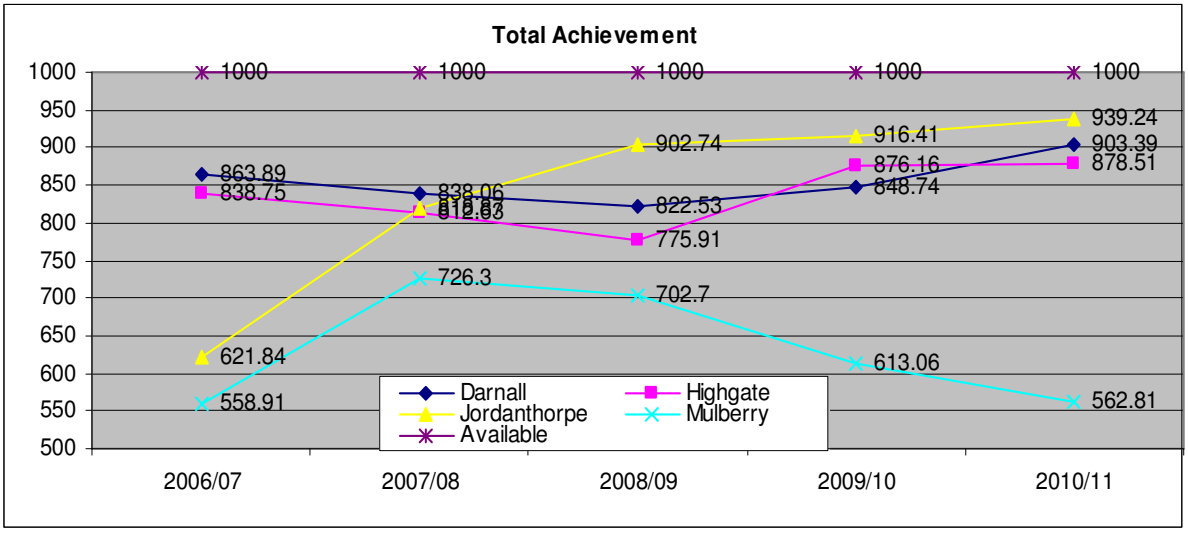
significant funding stream for the service. The Clover Group Practices target for 2012/13 is to achieve 100%.

Historical Position

As individual practices 3 of our 4 sites made significant progress over the preceding 5 years. The Mulberry Practice, which provides health services for asylum seekers and refugees, was unable to meet many QOF targets as the demographic of the site means that it is atypical with very low levels of chronic disease and extremely high levels of depression and mental health.

Table 27: QOF Performance over last 5 years, broken down by site

Data from Clover Group records



Achievement 2011/12

The Clover Group Practices achievement in 2011/12, our 1st year as one practice, has seen significant improvement in our QOF performance. This increase is attributable to:

- The specific issues at Mulberry being nullified by the merge
- Sharing of best practice across the sites
- Improved performance management in year

Table 28: Clover Group QOF performance for 2011/12. Data from Clover Group records

Achievement 2011/12	Maximum Indicators	Achieved Indicators	Maximum Points	Achieved Points 31st March 2012*	Achieved Points Final position May 2012 (expected)*
Clinical	88	77	661	653.04	653.04

Organisational	45	44	262	244.24	259.24
Additional Services	9	9	44	44	44
Patient Experience	1	1	33	33	33
Total	**143**	**131**	**1000**	**974.29**	**989.28**

The indicators that the practice did not meet in 2011/12 were:

- Patient review within 6 months of confirmed diagnosis for cancer patients
- Physical health checks for people with a new diagnosis of dementia
- Assessment of depression in people with diabetes and coronary heart disease
- Follow-up assessment of people with a new diagnosis of depression
- Body-mass index checks of people with psychosis
- Recording of smoking status in people aged 15 years and above.

A protected learning event will be held early in 2012/13 for clinical staff across the sites to discuss how to address these areas. It is important to note that the practice was not significantly away from target in any area.

3. Positive Service User Experience

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

Table 29: Complaints and compliments across the Trust over the last 3 years

Data from Ulysses Safeguard

Indicator	2011/12	2010/11	2009/10
Number of formal complaints	97	86	79
Number of informal complaints	215	286	226
Number of compliments	1401	1559	1440

Compliments again outnumbered complaints by a high margin in 2011/12, although there was a reduction in the overall number of compliments recorded.

89% of the formal complaints were responded to within 25 working days, down from 97% in the previous year. 100% of the informal complaints were responded to within 5 working days, the same as last year.

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

All complaints are investigated and, if they are upheld or partially upheld, an action plan will be put in place to address the problems found. The types of complaints made are reviewed to see if there are any consistent themes or trends.

Analysis of complaints themes show that the categories 'all aspects of clinical' care and 'staff attitude' are consistently the most common causes of complaints overall, both formal and informal. They are broad categories which cover many different areas.

During 2011/12, other sources of information and feedback about the service user experience included:

- **Patient Advice and Liaison Service (PALS) queries**. There were 79 PALS queries in the year about the Trust services. Examples included a request from a service user about how to access help for anxiety, and requests from potential volunteers seeking opportunities in the Trust.
- **Posts on the Patient Opinion website**. There was one post made about the Trust on this website during the year: it was positive
- **Posts on the Trust's own website**. There were 230 of these during the year. The most frequent type of query was related to work experience or jobs, but there were also requests for information about services and how to get help. 7 posts were dealt with as Complaints and are included in the information on Complaints above.

Quality and Dignity Survey

A third Quality and Dignity survey was completed during the year. In this work, a service user volunteer interviews service users on the wards and asks them about the quality of care they have received. There is a focus on feeling safe and being treated with dignity and respect. Service users on the wards have welcomed this opportunity to express their views to a fellow service user. The Quality and Dignity Survey has now been completed 3 times, in 3 phases:

- Phase 1: November 2009- March 2010
- Phase 2: April 2010 – November 2010
- Phase 3: January 2011 to July 2011

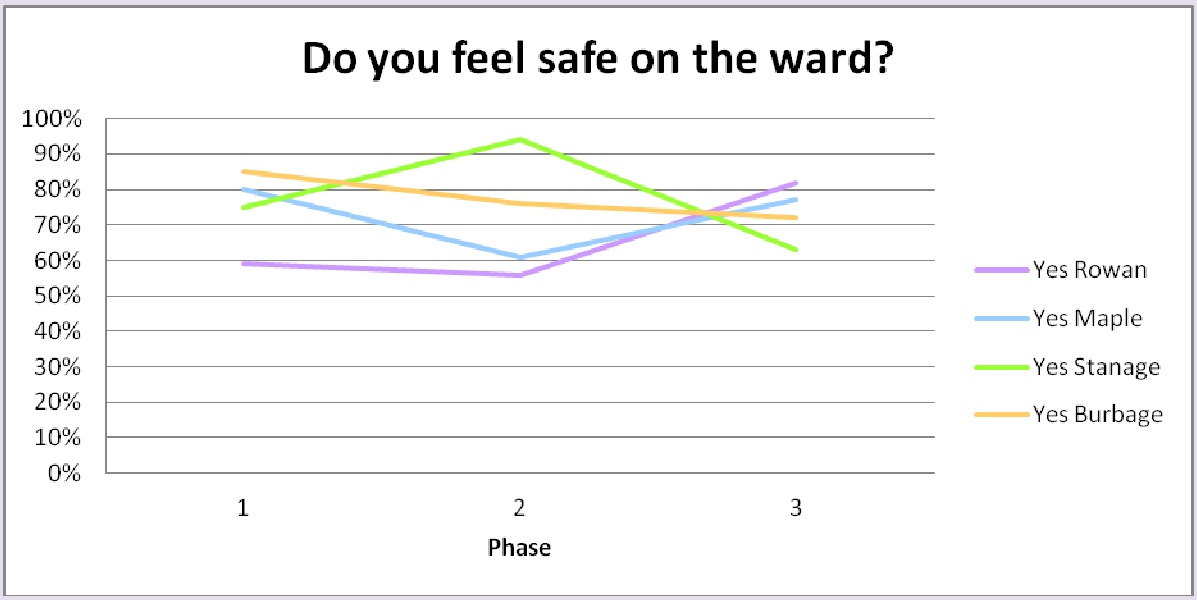
The results are fed back to ward staff and discussed at the Acute Care Forum. They are used to inform team governance and make improvements to the quality of care.

Examples of Quality and Dignity Survey responses on safety, dignity and privacy

All the diagrams below are extracted from the Quality and Dignity Survey themes and trends report

1. Safety

Results over the 3 time periods and over the 4 wards are fairly consistent for the question '*Do you feel safe on the ward?*' with around 75% of service users saying they did feel safe

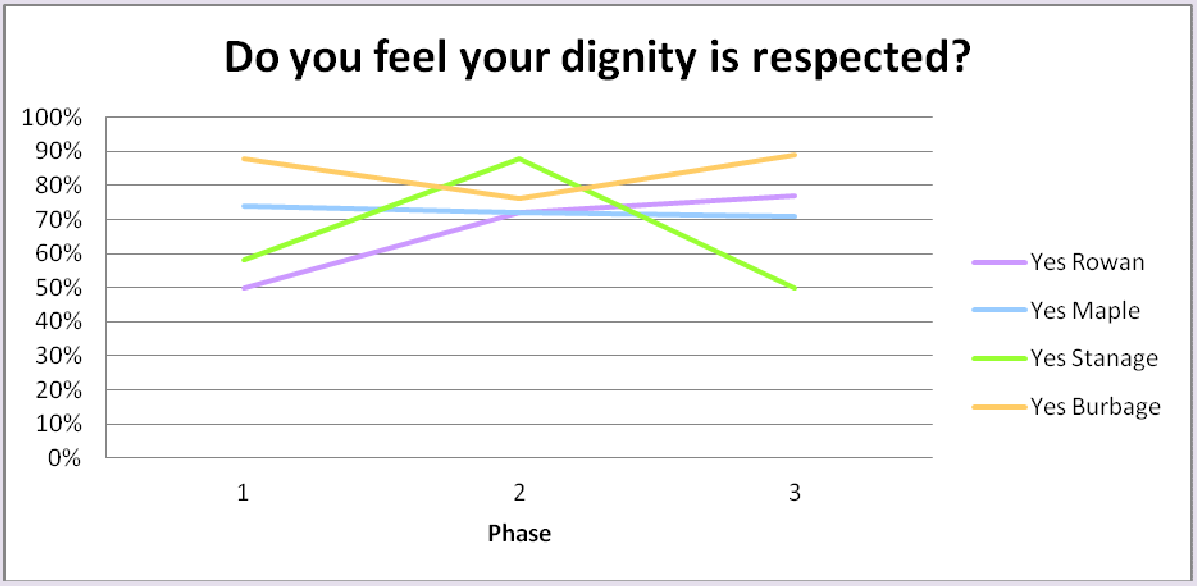


The narrative responses show why. The reasons were mostly a perceived threat from other service users, for example:

- 'Not when a particular patient kicks off, I always lock my door at night'
- 'Sometimes a bit nervous, because of other patients, especially at staff handover times'
- 'Some of the louder unpredictable patients can be worrying'

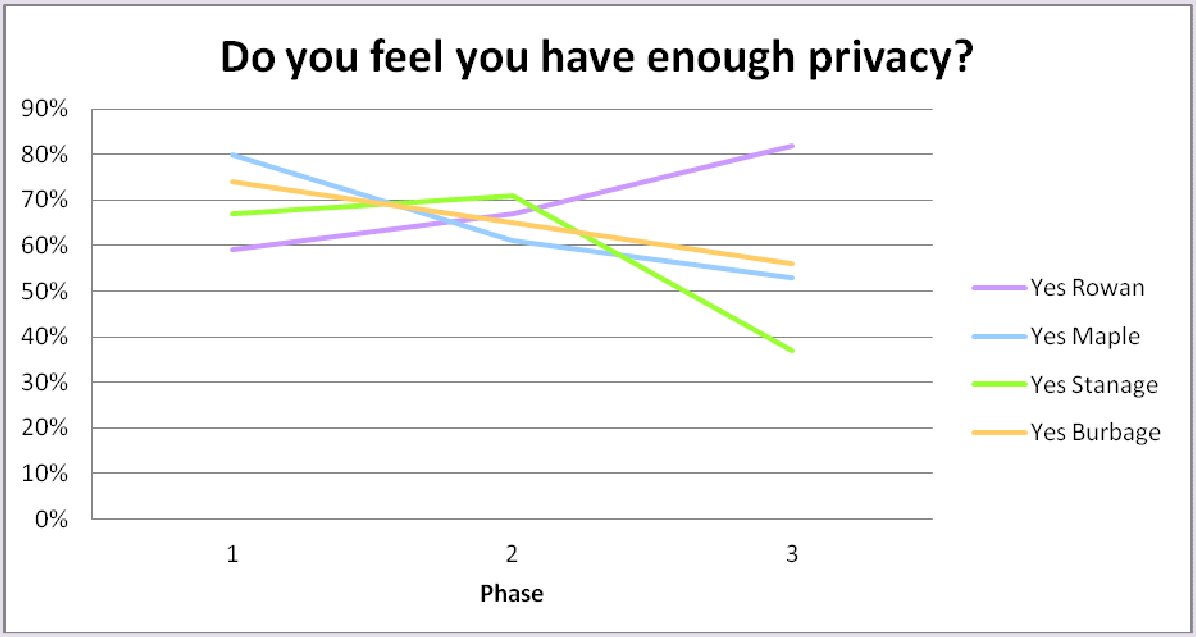
2. Dignity

For the question '*Do you feel your dignity is respected?*', there is an upward trend in 3 out of the 4 wards. At Phase 1, 69% said yes; at Phase 2 it was 77% and at Phase 3 it was 72%



3. Privacy

There is a downward trend in responses to the question '*Do you feel you have enough privacy?*' in 3 out of 4 wards and the results on this area were disappointing



The wards receive detailed feedback from the survey including the service users' comments. This enables them to address any areas identified as problematic, such as people feeling they do not have enough privacy, or some service users feeling less safe when staff are in handover meetings.

Staff can see which wards are getting more positive feedback and learn from each other's best practice. Managers address the variation between wards with a range of proactive measures including leadership and team development work.

Service user satisfaction surveys

The majority of teams in the Trust are carrying out service user satisfaction surveys as part of their team governance procedures.

There are many examples where service user feedback has led to changes and improvements in services:

Service users from Sheffield Outreach Team (SORT) gave qualitative feedback about Occupational Therapy Services. This led to activities being more focused on service user needs, specifically social groups, exercise classes and allotment sessions.

The Chronic Fatigue Service has involved service users from the start in giving regular feedback. This has led to an 'Introduction to Pacing' information session, for example. Feedback that people struggle to attend the clinic, which can make their symptoms worse, led to a range of access methods being offered. The service saw a rise from 38% saying that appointments were 'very convenient' in 2010 to 51% in 2011.

GP Patient Survey

Clover Group service users are asked to complete GP Patient Surveys. The results have shown both positive and negative feedback during the year.

The GP services have introduced their own surveys and started new ways of involving and engaging service users.

CQC Community Mental Health service user survey

Each year, the CQC surveys a random sample of community mental health survey users, enabling the Trust to compare its results with other mental health trusts. In 2011 replies were received from 294 people: this was 35% of those surveyed in comparison with a national response rate of 33%.

The full results are published on the Care Quality Commission website www.cqc.org.uk

The key result from this year's survey was that the Trust was in the top 20% of trusts nationally when service users were asked to rate their care overall in the last 12 months. It was also in the top 20% for the responses to the question 'Have mental health services involved a member of your family or someone close to you, as much as you would like?' For all questions it was either in the top 20% or the middle range: none fell into the bottom 20%.

The results on medication have been reported in the safety section above.

Results can be compared with previous years, but this present some difficulty with the 2009 survey, where inpatients were surveyed rather than community mental health patients and different questions were asked. There were also fewer people surveyed and fewer responses, making some of the responses insufficient for data analysis.

Table 30: Results from CQC Service User Survey over last 3 years. Data from CQC website

Theme	Question	2011	2010	2009
Health and social care workers	Did this person listen carefully to you?	Top 20%	Middle 60%	Middle 60% (Psychiatrist) Top 20% (Nurse)
	Did they take your views into account?	Top 20%	Middle 60%	Not asked
	Did they treat you with respect and dignity?	Top 20%	Middle 60%	Middle 60% (Psychiatrist) Top 20% (Nurse)
Talking therapies	Did you find talking therapy you received in the last 12 months helpful?	Top 20%	Top 20%	Insufficient replies
Care co-ordinator	Do you know who our care co-ordinator is?	Top 20%	Middle 60%	Not asked
	Can you contact your care co-ordinator if you have a problem?	Middle 60%	Top 20%	Not asked
	How well does your care coordinator organise the care and services you need?	Top 20%	Middle 60%	Not asked
Care plan	Do you understand what is in your care plan?	Middle 60%	Top 20%	Not asked
	Do you think your views were taken into account?	Top 20%	Top 20%	Not asked
	Does your care plan set out your goals?	Middle 60%	Middle 60%	Not asked
	Have mental health services helped you start achieving your goals?	Middle 60%	Top 20%	Not asked
	Does your care plan cover what you should do if you have a crisis?	Top 20%	Middle 60%	Not asked
	Have you been given (or offered) a copy of your care plan?	Middle 60%	Middle 60%	Not asked
Care plan review	In the last 12 months, have you had a care plan review meeting?	Middle 60%	Middle 60%	Not asked
	Were you told you could bring a friend, relative or advocate?	Top 20%	Middle 60%	Not asked
	Were you given a chance to express your views?	Top 20%	Top 20%	Not asked
	Did you find the care review helpful?	Top 20%	Top 20%	Not asked
Crisis care	Do you have the number of someone from local mental health services you can ring out of hours?	Middle 60%	Bottom 20%	Bottom 20%

Theme	Question	2011	2010	2009
Day to day living	Over the last 12 months, have you received support in getting help for your physical health needs?	Top 20%	Middle 60%	Not asked
	..help with care responsibilities	Middle 60%	Middle 60%	Not asked
	..help with finding or keeping work?	Top 20%	Bottom 20%	Not asked
	..support with finding or keeping accommodation?	Middle 60%	Middle 60%	Not asked
	..help with financial advice or benefits?	Middle 60%	Middle 60%	Not asked

Actions planned which it is hoped may impact on the CQC service user survey results in future include:

- The new Scheduled Care Pathway has been designed to set standards for activities like care plan reviews and assessments related to work and accommodation
- The pilot of an out of hours phone line to provide a contact number for service users and carers has begun and will be evaluated, to see if it brings the anticipated benefits.

Staff experience

2011 National NHS Staff Survey Results

The quality of services delivered by the Trust depends on the quality of staff. It is essential that we have the staff with the right skills, knowledge, experience and attitude. One important way of knowing how staff feel about their work is through the annual NHS staff survey.

The results from the 2011/12 survey, which was completed by staff in autumn 2011, were positive overall for staff engagement in their work. They show that Sheffield Health and Social Care Trust staff would recommend it as a place to work or receive treatment, as they did last year.

The following tables show the overview picture of staff engagement, and then give the 4 best and 4 worst results for the Trust.

Table 31: Overall staff engagement

Extract from National NHS Staff Survey 2011, published by the Picker Institute

Key factor	Change since 2010 survey	Ranking, compared with other mental health trusts
Overall staff engagement	No change	Highest (best) 20%
Staff ability to contribute towards improvements at work (the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work)	No change	Highest (best) 20%
Staff recommendation of the trust as a place to work or receive treatment (the extent to which staff think care of service users is the trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment)	No change	Highest (best) 20%
Staff motivation at work (the extent to which they look forward to going to work and they are enthusiastic about and absorbed in their jobs)	No change	Average

The following tables show the areas where the Trust performed best and worst in 2011 staff survey, which was published in March 2012.

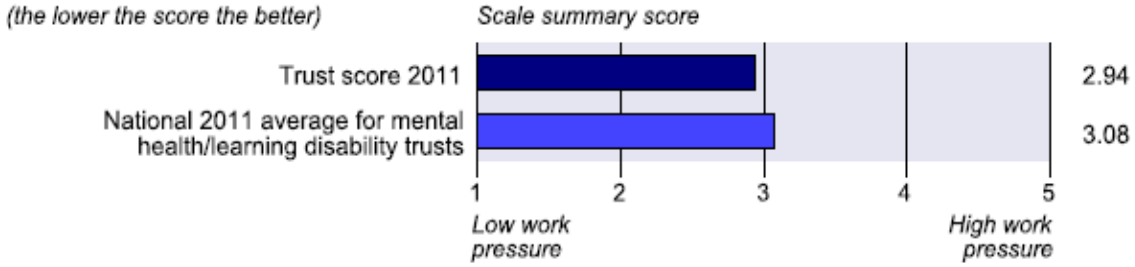
The top ranking scores show areas where the Trust staff are reporting a very positive experience of work. There are actions in place to improve the areas where Trust staff are indicating a less positive experience than colleagues elsewhere.

Table 32: Top and Bottom 4 ranking scores in 2011 Staff survey

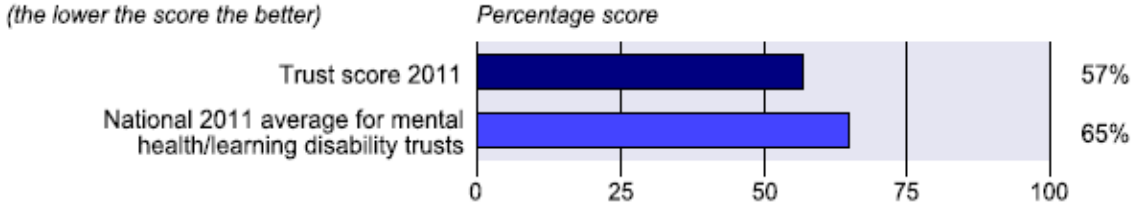
Extract from National NHS Staff Survey 2011, published by Picker Institute.

TOP FOUR RANKING SCORES

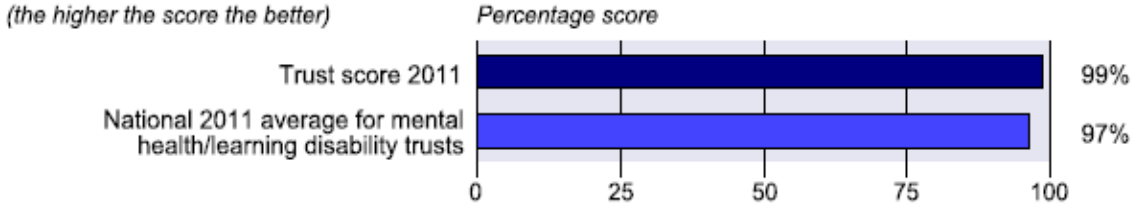
✓ KF5. Work pressure felt by staff



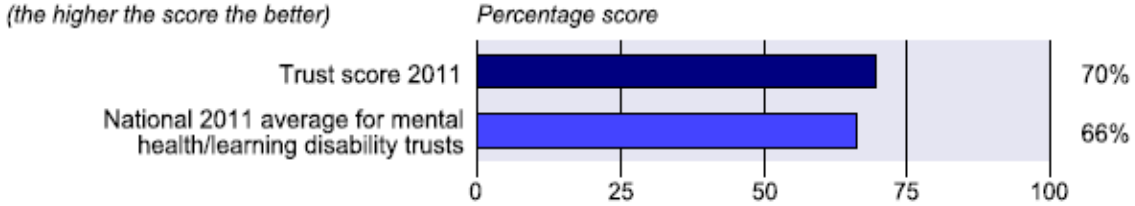
✓ KF8. Percentage of staff working extra hours



✓ KF21. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

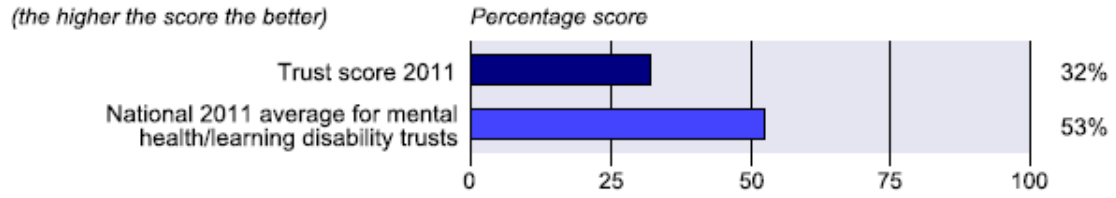


✓ KF31. Percentage of staff able to contribute towards improvements at work

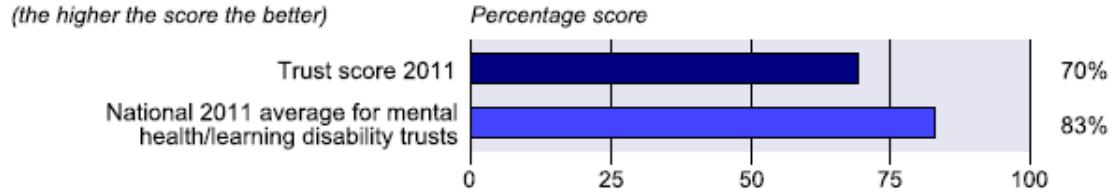


BOTTOM FOUR RANKING SCORES

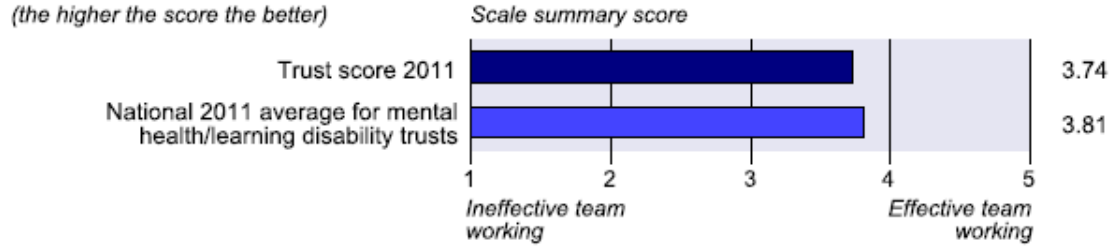
! KF36. Percentage of staff having equality and diversity training in last 12 months



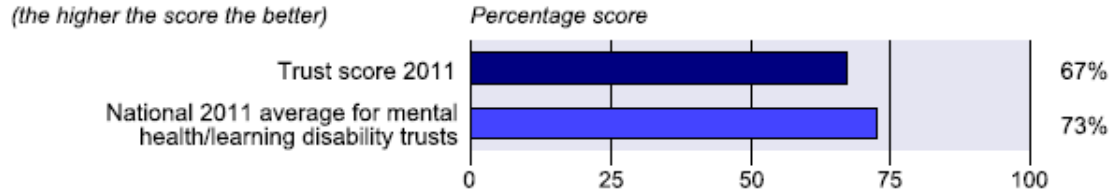
! KF16. Percentage of staff receiving health and safety training in last 12 months



! KF6. Effective team working



! KF14. Percentage of staff appraised with personal development plans in last 12 months



The improvements to equality training have been reported above in the section on last year's quality objectives. There has also been a trust wide focus on improving the provision and uptake of personal development plans, with teams and managers monitoring this issue, but the staff responses on this question in the survey have indicated that this work must continue and strengthen in 2012/13.

A newly re-established Health and Safety Committee is highlighting health and safety training issues.

Support is offered to teams where there are issues or concerns about effective team working by the Organisational Psychology staff. This may take the form of support for a one-off team development event or a more intensive period of support.

Equality, Diversity and Human Rights

Sheffield Health and Social Care NHS Foundation Trust provides services to a wide range of communities in Sheffield and is committed to eliminating unlawful discrimination and promoting equality of opportunity. We believe that the public, service users and staff should have equal access to services and job opportunities offered by the Trust.

Equality and Human Rights are for everyone. This means people who use services or members of staff. Everyone has a right to be treated with dignity and respect, this means to have their Human Rights respected. Equality is relevant to everyone; people should not face discrimination and should have equal opportunities irrespective of characteristics that they may have.

More information on the Trust's performance on equality, diversity and human rights is available on the Trust website www.shsc.nhs.uk

Development and monitoring of the Quality Accounts

This is the fourth year of Sheffield Health and Social Care NHS Foundation Trust Quality Accounts, so many of the quality indicators chosen to give an overview of quality in the Trust have been retained so that readers can see changes and developments over the years. However, new services have joined the Trust and are included in this year's accounts for the first time. The format is similar to previous years and follows the Department of Health and Monitor guidance

The process of developing this year's quality accounts began in the Autumn of 2011:

- The quality data, reports and survey results which are presented regularly to the Quality Assurance Committee were reviewed
- Benchmarking data was sought from the NPSA results and CQC surveys
- Yorkshire and Humber Quality Observatory were consulted for their ideas on the development of regional and national mental health quality indicators
- Clinical and service directors, lead professionals and senior managers were asked for their ideas for quality improvement
- At a meeting of the Board of Directors and Council of Governors, feedback was given on the delivery of the 2011/12 quality objectives and ideas for next year's objectives were elicited

From this process, a long list of potential quality objectives was created, which went for further consultation with governors, LINKs, senor clinicians and managers. From the long list, a final shortlist of 7 resulted from the consultation and the Trust Board selected a final 5 quality objectives for 2012/13.

The first draft of the Quality Accounts were presented to February Board and then, with minor amendments to create version2, sent out for consultation with Sheffield City Council Health and Wellbeing Scrutiny Committee, LINKs, NHS Sheffield and colleagues in the Trust.

Progress on the quality objectives is monitored quarterly by the Quality Assurance Committee. Quality data is reviewed at the Quality Assurance Committee and at Board (through dashboard and exception reports.) The Committee and Board also review regular reports on the key aspects of quality – service user safety, clinical effectiveness and a positive service user experience.

Statements from Local Involvement Networks, Overview and Scrutiny Committees and Primary Care Trusts

Because of the prescribed consultation timetable, commissioners and partner organisations had to comment on an early draft of the quality accounts. Many of the issues raised below have been addressed in the later versions, as year end figures became available and the text could be expanded and clarified, in the light of feedback and further information.

1. Sheffield Local Involvement Network

Sheffield LINk have been able to meet with the author of this report on one occasion, this has enabled a better understanding of the expectations of a report that is understandable to the public and yet meets the format and content requirements placed upon the Trust from Monitor.

We hope that the Trust will produce an easy read version of the QA report.

Sheffield LINk provide the commentary for this years Quality Account without seeing the final document and therefore this has to be borne in mind as further information contained in the final document could have made a difference to our commentary.

Last year Sheffield LINk commented:

"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."

Unfortunately you have not included in this years Quality Account details of the extensive work the Trust has been undertaking to develop the Service User Monitoring Unit, we believe this should have been included as an excellent example of user engagement.

Page 7 refers to staff training in the "Respect Approach" - for this to be meaningful there needs to be an explanation of what the "Respect Approach" is.

Page 9/10 the Objectives have lost their numbering. We find it difficult to give constructive commentary in respect of "This is what we will do" as apart from the objective on page 9 there is nothing listed for what you will do, therefore we don't know if it will be effective or not at this stage.

There is a lot of use of acronyms e.g. page 15 DAAT, page 19 DRAM, either an explanation of them within the text or a glossary to them within the document is needed to meet the needs of the wider audience for this document.

Part 3 of the document (Safety) we find it extremely difficult to judge if these results are good, bad or indifferent - the use of traffic lights or emoticons would help the lay reader with this information.

Page 35 if you are not going to provide the information of who the other Trusts are then just give us Sheffield against the national average, also is "second lowest regional reporter" the best way of saying this as it could mean you don't report them all!

In respect of Patient Safety Alerts we request that greater detail is provided, the actions taken and did they meet the required timescale.

Page 39 Dementia services, Sheffield LINk receive a great deal of service user input about these services and from this information we believe that although your Trust exceeds the performance of other regional Trusts the people of Sheffield should not have to wait 8.5 weeks to be seen at a memory clinic. Early diagnosis enables better management of the condition which is more cost effective all round. Therefore we urge this to remain very much a priority to reduce this wait to no more than 4 weeks.

Throughout the document there is frequent use of % figures where no indication of what the % represents which makes it difficult to understand the rationale of including them.

Sheffield LINk agrees that the 5 priorities chosen are areas needing a quality assurance focus. We suggest that the reporting on them will include being bench marked against similar Trusts both regionally and nationally.

We are also pleased that one of the priorities focuses on dementia as this is an area we receive very frequent contact about, we also expect to see Woodland View reported upon in next year's Quality Account.

We are pleased that your Trust has included all the service areas that were new to you from April 2011 under the PCT's Transforming Community Services policy.

Mike Smith

Chair, on behalf of Sheffield LINk

Sheffield Health and Social Care Trust response

Thank you very much for your feedback. We regret that the timing of the consultation period means that you had to comment on an earlier version of the accounts, and we hope you will be able to see that many of the points you raised have been addressed in this later version. For example, we have included more explanation and definition of acronyms and we have been able to add the final percentage figures to tables. There is a description of the Service Use Experience Monitoring Unit, which we agree is one of the highlights of last year in the Trust.

We have tried to add more commentary to explain the significance of the safety data, and to put it in context with benchmarked data. We are always trying to find more data to enable benchmarking, but this remains a challenge for mental health trusts nationally.

We will be producing a service user friendly version of the quality accounts as part of our review of the year, to be published later in 2012. We will make sure you get a copy.

We note your comments on the waiting times for dementia assessments and share your concerns, which is why access to dementia care has been set as one of our quality objectives for the year ahead. However, we are not able to commit to a 4 week wait at present, when we are simultaneously investing energy to increase the number of people who access these services.

2. Sheffield City Council Healthier Communities and Adult Social Care Scrutiny Committee

Response to the Sheffield Health and Social Care Foundation Trust's Quality Account 2012

As in previous years, the Committee welcomes the opportunity to comment on the Health and Social Care Foundation Trust's draft Quality Accounts, and commends the Trust for presenting an honest and balanced picture of performance. We feel it is very important that the Quality Account is easy to understand for members of the public, and that content is relevant, succinct and clear.

The Committee considers that the quality priorities selected by the Trust reflect the needs of the City, and are particularly pleased to see improving access to dementia care as an objective this year. This has long been a priority for us, and we look forward to seeing significant improvement in this area over the coming year.

The Committee recognises that the quality priorities represent only a small part of the work that the Trust carries out, and welcomes the Trust setting up a Service User Experience Monitoring Unit. The Committee believes strongly that involving service users is a key factor in successful service development and quality improvement.

The Committee is pleased to see that the Trust's quality of care, and involvement of members of service users' families is rated highly by service users, as demonstrated by the 2011 Care Quality Commission Mental Health service user survey, which put the Trust in the top 20% of trusts nationally. The Committee congratulates the Trust on this achievement.

Emily Standbrook

Policy Officer (Scrutiny)

31st March 2012

Sheffield Health and Social Care Trust response

We would like to thank the Committee for their response and for the discussions held at their meeting.

We are glad that you have chosen to comment on the development of the Service User Experience Monitoring Unit and we intend to report more on this initiative in next year's quality accounts.

3. NHS Sheffield

STATEMENT FROM NHS SHEFFIELD

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 2011/12, reducing waiting times for access to care, taking actions to improve the physical health of their patients and to support people into employment.

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. We support the Trust's drive to improve the quality of care and recognise the particular challenge to do so whilst making significant changes in services to improve efficiency and have constructed the quality indicators and the CQUIN scheme in our contract for 20112/13 to this end.

Sheffield Health and Social Care Trust response

Thank you for your comments, and for your earlier informal feedback which we were able to use to make improvements to the first drafts of the quality accounts.

We welcome the regular opportunity to meet with the Primary Care Trust to review the quality of care we provide, during the course of the year. We welcome too your support for our choice of quality objectives for the year ahead.

Governors' views

The Trust's governors received an in-year progress report on the quality accounts, with an emphasis on the delivery of the quality objectives, and they were involved in the development of this year's accounts.

Following discussions at a Council of Governors meeting, the governors suggested new topics for quality objectives this year which were included in a 20 item 'long list'. They were asked to vote on the long list in an electronic survey. 19 Governors responded: their rank order of priority was:

1. Improve access to services for homeless people
2. Deliver training for all staff in customer care with a 'recovery' focus (valuing service users and their contribution)
3. Improve access in crisis services

4. Improve the experience of first contact with the Trust

5. Improve the quality of support proved by the Trust for carers

6. Make sure the Trust recognises and assesses unmet need in people already receiving services (e.g. physical health problems)

7. Implement service user surveys and questionnaires consistently throughout the Trust

8. Improve nutritional support for service users

9. Deliver the new 'Respect' training for staff to help them prevent and manage violence and aggression

10. Expand and develop the 'recovery' work in the Trust

The Trust will be working on all of these in the year ahead, even though not all of them were included in the final choice of quality objectives by the Board of Directors.

The Board of Directors took the view that it wanted to select objectives that would have a real and evident impact for service users and were not primarily about improving internal Trust systems and processes. It also chose some new areas this year rather than areas where work was already underway and well established such as the work on nutrition.

We note that the quality objective on 'improving first contact' was first proposed by governors and adopted by the Board as one of the 5 quality objectives for 2012/13. We very much welcome the extra perspective on quality which our governors bring to these accounts.

Annex: Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation Trust Boards on the form and content of the annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The quality report presents a balance picture of the foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review:
- And the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board

30.5.12 Date  Chairman

30.5.12 Date  Chief Executive

Independent assurance on the Quality Accounts

These Quality Accounts have been independently audited by the Audit Commission against the standards set out in the Detailed Guidance for External Assurance on the Quality Accounts available on the Monitor website www.monitor-nhsft.gov.uk

The Audit Commission have found that the Quality Accounts for 2011/12 meet the standards set by Monitor.

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How to give feedback on these accounts

Your comments and feedback are welcome and will help us improve the Quality Accounts next year.

Please send your feedback to

Tina Ball, Director of Quality

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Tel: 0114 271 6393

Or

Tony Flatley, Lead Nurse

Email: tony.flatley@shsc.nhs.uk

Tel: 0114 271 6713