Sheffield City Council

Sheffield Health and Social Care NHS

NHS Foundation Trust

QUALITY ACCOUNTS

2012/13

Contents

Part 1: Chief Executive's welcome

I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Account for 2012/13.

This Quality Account is our way of sharing with you our ongoing commitment to achieve better outcomes and deliver better experiences for our service users and their carers.

In this report we will outline our progress against the priorities we set last year, and look ahead to the areas we will continue to focus on for the coming year. Through the report we aim to be transparent and accountable for the quality of service that we provide.

Our vision is that people who use our services will achieve their full potential, living fulfilled lives in their community. We will deliver our vision by providing services that are world class in terms of quality, safety, efficiency and choice. Our services will deliver outcomes for individuals that are world class in terms of effectiveness of treatment, experience of care, recovery, independence and social inclusion.

The information in this Quality Account demonstrates how we are working to deliver this.

We achieve many improvements in quality by changing how we deliver services across the city. We may expand services, re-organise how we provide them, develop better partnerships with other services in Sheffield. Change and improvements are delivered in this way, and you will find information about these changes in our full Annual Report for 2012/13.

There is also significant potential to deliver improvements in quality, safety, effectiveness and experience through focussing on quality improvements within the day to day care and support we provide. Our ongoing challenge and commitment is to reflect on what we learn about the experiences of those who use our services and identify how it could be improved. Across the Trust we have many initiatives and development programmes which are designed to improve quality and you will find many examples detailed in this Quality Account.

When we look at how we are doing against most of the ways we evaluate our services, we are providing a good standard of care, support and treatment. This is something we are rightly proud about. However we also know we can do better, and need to do better. We have much to do to ensure the quality of what we provide is of a consistent high standard, every time, for every person in respect of safety, effectiveness and experience.

This Quality Account reflects our determination to develop our understanding and measurement of quality as experienced by the people who use our services, and our ambition to deliver continuous quality improvement in all our services.

In publishing this report the Board of Directors have reviewed its content and verified the accuracy of the details contained in it. Information about how they have done this is outlined in Annex B to this report.

To the best of my knowledge the information provided in this report is accurate and represents a balanced view of the quality of services that the Trust provides. I hope you will find it both informative and interesting.

Kevan Taylor

Chief Executive

Adelaide Mukasa, Rowan Ward Manager

Beighton Road, Learning Disability Service

Service User pottery at Moncrieffe Road

Part 2A: A review of our priorities for quality improvement in 2012/13 and our goals for 2013/14

We established our priorities for quality improvement in February-March of 2012. The people who use our services and the membership of our foundation trust have been instrumental in deciding what our priorities are. When we identified our priorities we agreed a two year plan to deliver improvements over the longer term.

In order to establish these areas as our priorities our Board of Directors:

- Reviewed our performance against a range of quality indicators
- Considered our broader vision and plans for service improvement
- Continued to explore with our Council of Governors their views about what they felt was important
- Engaged with our staff to understand their views about what was important and what we should improve.

We then consulted on our proposed areas for quality improvement with a range of key stakeholders. These involved our local Clinical Commissioning Group, Sheffield City Council and members of LINk (now Healthwatch).

This report confirms how we have progressed over the first year of our two year plan. It also confirms what actions we will continue to take and focus on next year to make further progress and improvement.

In reviewing our progress over the first year and finalising our plans for next year we have continued to engage with our members. Our Governors have undertaken this on our behalf and we have received comments and feedback from over 150 of our members about our proposals for next year. From this review the Council of Governors have reviewed our plans and we have taken on board their feedback.

Through next year we will report on progress against our quality improvement objectives through the following ways:

- The Board's Quality Assurance Committee
- The Board of Directors
- To our Council of Governors formally at their meetings during the year
- To our Commissioners.

We identified 5 quality improvement priorities for this year and the year ahead. They cover the following areas:

Improving safety	**Quality objective 1:** To reduce the number of falls that cause harm to service users
	Quality objective 2: To reduce the incidence of violence and aggression and the subsequent use of restraint and seclusion
Improving clinical effectiveness	**Quality objective 3:** To improve the identification and assessment of physical health problems in at-risk client groups
Improving the delivery of positive service user experiences	**Quality objective 4:** To improve the experience of first contact with the Trust's services
Improving access, equality and inclusion	**Quality objective 5:** To improve access to the right care for people with a dementia

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

We chose this priority because

Falls cause direct harm to service users because of injury, pain, restrictions on mobility and community participation. This harm impacts on people's quality of life and well-being. Three years ago, the National Falls and Bone Health Audit in 2011 showed that during 2010/11 falls were higher in the Trust's older people's inpatient areas than the national average rate of falls. There were 13.5 falls per 1000 bed nights compared with 8.4 falls nationally.

Our own data showed that during 2011/12 1,605 incidents of slips, trips and falls for service users were reported by the Trust. 32.1% (n=516) resulted in harm or injury to the service user concerned.

Guidance was available on how to reduce the severity, frequency and impact of falls from NICE. We believed there were clear opportunities to deliver real improvements in this important area. This was also a priority area for Sheffield Clinical Commissioning Group who incentivised improvement in this area under the Cquin scheme) (see page 20 within this Quality Report).

We said we would

Introduce a two year plan that started in 2012/13 and will continue into 2013/14. Within this plan we said we would:

- Implement MFRA (Multi-factorial Risk Assessment) screening tool for falls for all older people admitted to inpatient areas
- Carry out environmental falls risk assessments in all inpatient and residential areas
- Identify appropriate training packages for staff and deliver a programme of training.

The outcome we wanted to achieve was

- To reduce the number of falls that result in harm to service users by 5% by the end of this year and by 10% next 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
- That by the end of this year all older people admitted to inpatient areas will be assessed to see if they are vulnerable to experiencing a fall.

Beighton Road, Learning Disability Service

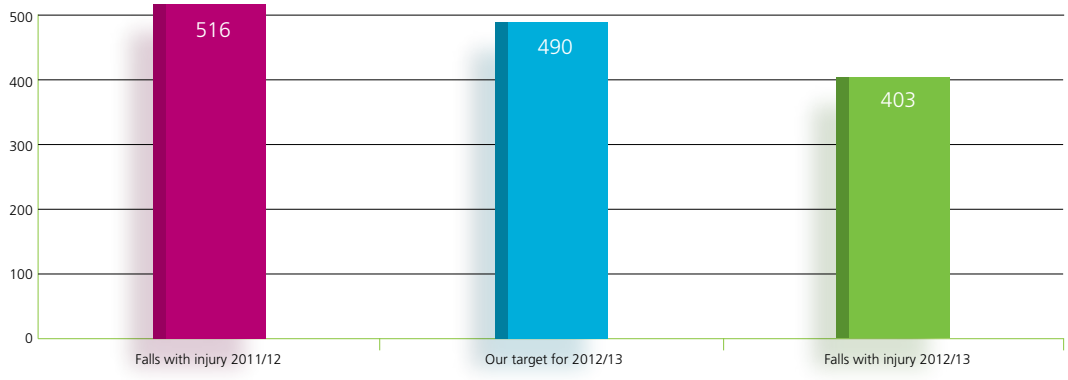
How did we do?

We have made really good progress. We have introduced screening for falls within 72 hours of admission, Personal Falls Plans, improved assessment of our building environments for falls hazards and hazard reduction opportunities. We have supported our staff through better training and are exploring ways to use Assistive Technology to reduce falls (for example, using alarms and sensors in beds and chairs so we know when someone is getting up).

The consistent approach to assessing people's needs, along with the staff support provided has made a clear difference this year. However we need to establish better ways of monitoring that this happens.

In 2011/12 there were 516 falls that resulted in harm. This year we wanted to reduce that by 5% to 490. The number of falls resulting in injury has reduced by 21% to 403 this year.

Service User falls that resulted in harm 2012/13



Of those who experienced harm from a fall, 52 people needed to attend hospital or A&E for treatment, compared to 61 in 2011/12.

Next year we intend to

Continue with our plans, as they have had a positive effect this year. We plan to

- Ensure falls that result in harm do not exceed 439 (our original two year target)
- Ensure people admitted to our older adult wards are assessed for risk of falling and monitor this effectively
- Evaluate the use of assistive technology, such as the bed and chair sensors
- Implement the risk assessment process (MFRA) to the residential care services that we provide support to.

Quality objective 2: To reduce the incidence of violence and aggression and the subsequent use of restraint and seclusion

We chose this priority because

When violence or the potential for violence happens, it causes harm, distress, anxiety and fear for both service users and our staff. This will clearly have an impact on how people feel in receiving care or providing care within our inpatient services. It is in everyone's interest to reduce violence and the fear and anxiety associated with violence.

In the past we have reported lower rates of violence and aggression when compared to other mental health trusts. Benchmarking information from the National Patient Safety Agency for the first 6 months of 2011/12 showed that 15.5% of patient safety incidents reported by the Trust were related to disruptive, aggressive behaviour, in comparison with 19% of incidents reported by mental health trusts nationally.

However, our own data showed that violent incidents made up a large proportion of our overall incidents. As well as this the CQC Staff Survey for 2011 showed 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 previous year. The proportion of staff who said they had experienced harassment, bullying or abuse from patients, relatives or the public in the previous 12 months was also above the national average.

We said we would

We have introduced a programme called RESPECT which is an ethical approach to managing aggression and violence.

Its aim is to support staff to empathise with the service user, to understand that the service user may well be frightened and that may be what is informing their aggressive presentation. The programme promotes early recognition of the signs of pending aggression which supports more appropriate de-escalation approaches but also acknowledges that, on occasion, violence will be instrumental and that intervening physically will be the only safe response.

We have trained our staff to respond to these circumstances safely and with sensitivity. The programme will touch everyone in the organisation as it also focuses on exploring the environment and the context that the aggression is displayed within and what we can do to make improvements to the way we provide our care generally.

Through this programme, during 2012/13 our plans were to:

- Continue to deliver the Respect training for all of our ward staff by the end of this year
- Continue to monitor the incidents of violence and aggression at team level, and analyse trends over time
- Establish reliable and consistent methods for the recording of restraint and seclusion on all inpatient areas, and establish clear baselines to inform ongoing evaluations
- Establish service level plans for the reduction of the use of restraint and seclusion in all inpatient areas
- Establish reliable and consistent reporting on the use of restraint in our community settings, establish baselines and set local reduction targets and agree actions.

The outcome we wanted to achieve was

By the end of this year we wanted to ensure all inpatient nursing and support worker staff within our inpatient services had been trained in the Respect Approach.

Through this year and by the end of next year we wanted to:

- To reduce the use of seclusion and the use of restraint
- To increase the percentage of service users in acute wards who report experiencing a safe environment in local surveys
- To reduce the number of staff reporting that they have experienced physical violence and harassment, bullying or abuse from service users, relatives or the public in the CQC Staff Survey.

How did we do?

We believe we are making good progress in delivering real improvements for the longer term. Over the year the data is varied in what it shows across the different indicators.

The extensive staff development work we have done has had a positive impact in conveying expectations and the need to ensure all types of violence are accurately captured to ensure we fully understand day to day circumstances.

We believe at this stage that this is the main reason why reported incidents of violence towards staff has been increasing, especially over the last year. Detailed analysis highlights that the vast majority of these incidents are 'lower level' types of violence, such as pushing and shoving, that may well have not been reported previously.

The practice development work we have done, through the RESPECT programme and the introduction in some areas of designated spaces and facilities to support people to work through their agitation (such as 'Green Rooms') are showing positive results with reduced use of seclusion and restraint.

Incident type	2010/11	2011/12	2012/13
Incidents reported where service users had been			
• Secluded	91	80	71
• Restrained	168	105	85
• Assaulted	398	387	386
• Caused harm from assault	78	89	72
Proportion of all reported patient safety incidents related to disruptive			
• Within our Trust		15.5%	20.6%
• National averages for mental health trusts NPSA Benchmarking data		19%	18.2%
Percentages of service users who report feeling unsafe in local surveys	25%	25%	32% July 23% Dec
Incidents reported where staff working in inpatient services			
• Had been assaulted	324	364	608
• Caused harm from assault	97	110	101
Number of staff who reported to the national CQC staff survey that they had experienced from patients, relatives or visitors			
• Physical violence	17%	17%	22%
• Harassment, bullying or abuse	19%	19%	30%

This is a complex issue to report on. The threat of violence and actual violence clearly causes fear and psychological distress. The impact and consequences for people are individual to them. Reporting through data about incidents does not capture this fully, yet it is important to have an awareness of overall incident levels. That is what we report on here.

Overall at this stage in our development plan we believe we have made good and positive progress. This puts us in a positive position to continue to deliver improvements into next year and beyond.

Next year we intend to

- Reduce further the incidents of seclusion and restraint from the levels in 2012/13
- Continue with our investment in the Respect development programme
- Implement a range of new policy guidance that defines and supports expected practice, incorporating all our learning over the last 2 years
- Implement a programme of practice reviews focussing on seclusion, de-escalation, physical health monitoring, post-incident reviews, use of green rooms
- Continue with our staff training programme
- Undertake a review of staff experiences of delivering care and how we can better support them to deliver respectful and compassionate care
- Complete an initial assessment of the experiences of service users and staff in our non-residential and inpatient settings.

Quality objective 3: To improve the identification and assessment of physical health problems in at-risk client groups

We chose this priority because

Physical health was a priority for our governors and service users, as many of our service users are at higher risk of developing physical health problems. The evidence clearly shows that people with severe mental illness and people with learning disabilities have reduced life expectancy and greater morbidity, as do people who are homeless and people who misuse drugs and alcohol.

We were 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 introduction of physical reviews for people with long term mental health problems in primary care presented additional opportunities to make further improvements.

Audits of care records across our mental health and learning disability services in November 2011 showed overall in 78% of service users' records their physical health status was checked and documented. This was less across our community mental health service areas. Our GP services performed well across a range of areas in meeting the physical health care needs of people with mental health problems, although performance was poor for people newly diagnosed with dementia.

We said we would

- Implement the electronic Medical Examination on Admission and Lifestyle Assessment across all relevant services
- Train additional 30 staff to become 'healthy chat' key trainers with roll out training to a further 180 staff
- Develop and roll-out obesity care pathway supported by patient information resources, improved menu labelling and healthier set menus for inpatient services
- Ensure smoking status of all inpatients is recorded, with an increase in referrals to Stop Smoking Service and the introduction to inpatient services of smoking cessation experts
- Our GP services would improve the recording of BMI in people with psychosis and the completion of physical health checks for people newly diagnosed with dementia.

The outcome we wanted to achieve was

- '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
- Improved awareness of peoples smoking circumstances with appropriate support provided
- 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.

How did we do?

We continue to implement an Annual Physical Health Work Plan that looks to focus on the following areas:

- Smoking, Alcohol, Obesity, Diabetes, Physical Health Check recording, Annual Health Checks

During the year we have developed, piloted and introduced an innovative on-line screening tool that provides access to advice and assessment of peoples alcohol use. This has been a really positive and exciting development that allows people receiving support from across GP surgery's, Pharmacists, other health and social care services to get quick and tailored advice along with information about support services should they be needed. Over this year 914 people have benefitted from advice in this way.

We have also made progress in the following areas:

- 39 'health chat' key trainers have been trained
- 99% of sampled care plans in pilot services had evidence of health checks being done
- Our knowledge of peoples' smoking status increased from 55% in April 12 to 95% in December 12
- We have introduced diabetes link nurses within 10 of our Wards
- Our Clover Group of GP practices had completed 84% of physical health checks for people with dementia – against a target of 70%
- Completed 84% of BMI assessments of people with a psychosis – against a target of 90%.

OT exercise session at the Longley Centre

Next year we intend to

Continue our current plans to bring together achievable actions within the Trust and external to partner organisations. We will build on existing and planned developments to ensure that we and our partner organisations work collaboratively to ensure health of service users continues to improve.

The priorities for this year are continued work to improve the physical health of service users by focussing on:

- Smoking - Offering advice guidance and referrals to the smoking cessation service to decrease smoking amongst service users
- Alcohol - Provide alcohol screening across services to ensure timely referral to appropriate services
- Obesity - provide advice and support to address the issue of poor lifestyle choices, encouraging healthy diet and exercise
- Diabetes - To ensure those at risk, in particular those individuals who may experience weight gain due to their medication or lifestyle choices, are effectively screened for the risks of diabetes and are offered appropriate treatment, advice and guidance
- Dental - To ensure that Dental Care is included in both physical and lifestyle assessments and that access to dental care is made more readily available
- Physical Health Checks and annual health checks for vulnerable service users - Ensure that all service users have appropriate physical health checks, whether completed by our services or within our partner organisations.

Quality objective 4: To improve the experience of first contact with the Trust's services.

We chose this priority because

Our Governors and service users had identified this issue as a priority for positively influencing the service users' overall experience of the services we provide. 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.

Following low scores on the CQC Annual Community Mental Health for questions about a 24 hour phone line, the Trust had piloted an out-of-hours phone line to give advice and help to service users and carers, in partnership with Rethink. We were keen to learn from the pilot and provide ongoing support to service users

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, and we wanted to support this programme to deliver improvements to the day to day experiences of our service users.

We said we would

- Pilot an out of hours telephone helpline, evaluate how it worked and develop a plan for a sustainable service
- Deliver RESPECT training for all inpatient staff
- Review and revise standard communications relating to first contact including initial appointment letters and information leaflets sent out with initial appointments, and ward welcome packs
- Implement 15 Steps Challenge with our non -executive directors, staff and service users in inpatient areas and 1 community team.

The outcome we wanted to achieve was

- Improved awareness of services users about the support available through the crisis helpline
- More staff trained in customer care as part of the roll out of Respect training
- Better information provided to support service users entering our services
- To remain in top 20% of mental health trusts in CQC Annual Community Mental Health Survey for being treated with dignity and respect.

How did we do?

We have made positive progress with our helpline services, which have continued over this year. We will have opened a new Crisis House service, in partnership with Rethink, in April 2013. We expect it to provide support to over 300 people a year as an alternative to needing hospital care. As part of that service we have commissioned Rethink to provide the helpline service for our service users.

All inpatient staff have benefited from the RESPECT development and training programme by the summer of 2012, and it is having a positive effect across our services. We continue to provide the training to support new staff who have since joined the service, and to provide updates to existing staff who have been trained previously.

Areas of experience	2010/11	2011/12	2012/13
Awareness of crisis support available through telephone helpline (National Patient Survey)	51 out of 100	5.0 out of 10	n/a see note
Ensure all inpatient staff have benefited from Respect development programme	Nil	155 staff	Extra 209 364 in total
Service users reporting they are treated with respect (National Patient Survey)	95 out of 100	9.5 out of 10	n/a see note

*Note: We will use the national patient survey as a way of assessing feedback and progress over this year. Unfortunately the national survey had not been completed in time for us to include the results in this Report.

We did not make the progress we wanted to regarding reviewing the information we share with service users. We will address this better next year.

Next year we intend to

- Continue with the Respect development programme for new staff and the 15 Steps Challenge to support the delivery of improved experiences
- Continue to review service user experiences through local surveys
- Complete the review of the range of information we provide to service users and agree improvements
- Focus on supporting service users to access our services quickly. To support this we will confirm improvement targets in respect of our IAPT services (assessed within 4 weeks of referral) and our Community Mental Health teams (assessed within 2 weeks of referral) and establish targets for our Memory services (see Quality Objective 5).

Stanage Ward

Quality objective 5: To improve access to the right care for people with a dementia

We chose this priority because

Improving dementia care is a priority for the Trust, governors, the City Council, Sheffield Clinical Commissioning Group, and Healthwatch. The incidence of dementia is predicted to rise with Sheffield's aging population. We know that 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.

Overall 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 by their GP in primary care. In 2012 in Sheffield 63.6% of the expected number of people with a dementia have been registered, compared to the national average of 44.2%. Sheffield is the 2nd best performing area in England and Wales.

We wanted to build on the delivery of the NICE Quality Standard for Dementia and positive development work already underway over the last few years to improve access to our services and reduce waiting times. Within our learning disability services a specific dementia care pathway has been developed because of the increased risk of early dementia in people with Downs syndrome.

We have worked successfully in partnership with Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Clinical Commissioning Group to improve access to dementia support and care for people who require access to general hospital.

We said we would

- Continue the development of our Memory management services so we could provide more assessments and reduce waiting times
- Implement and evaluate the dementia pathway for adults with a learning disability
- Develop and implement a plan to improve access to services by people from Black and Minority Ethnic Groups
- Survey service users and carers of dementia services about their experience of care and respond to any issues raised.

The outcome we wanted to achieve was

- Support over 900 people with memory assessments, and reduce service waiting times from 14.7 weeks
- To 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 use of dementia services.

Art therapy session on Ward G1

How did we do?

We have made good progress in improving access, though we have further work to do to continue to reduce waiting times. While we have managed, through a range of service improvements to see more people, waiting times have got worse over the year.

Areas of experience	2010/11	2011/12	2012/13
Number of people who received an assessment and diagnosis	749	876	918
Average waiting times to access memory services	21.9 weeks	14.5 weeks	16.3 weeks
Number of people with a learning disability who were assessed for dementia	Not available	40 approx	29

We have completed an exciting project to gather the views and experiences of people with dementia. The 'Involving People with Dementia Project' aims to extend the good practice around service user involvement that already exists in SHSC by exploring how people with dementia could be better involved in service feedback, evaluation and planning. The project has resulted in a film being produced. The film aims to demonstrate that, given the opportunity, people with dementia have important things to contribute to services and society through their experience of dementia. The film powerfully shows how people with dementia have a voice and they want their voice to be heard. We are using this film to help raise awareness across Sheffield, both for our own staff and staff from other areas of health and social care.

Our Memory Services benefited from a review with the Royal College of Psychiatrist's Memory Service National Accreditation Programme, which involved surveying independently the views of service users and their carers. The feedback from the accreditation is very positive and encouraging about the standard and quality of the care we provide, awarding our services an 'Excellent' rating.

We successfully implemented and evaluated a dementia pathway for adults with a learning disability.

We developed and introduced a programme of 'awareness raising' for BME Community groups about dementia and local services.

During the year we also worked in partnership with Sheffield Teaching Hospitals NHS Foundation Trust to support them to provide better care and treatment for people with dementia in their hospitals. The aim of this pilot was to increase access to specialist dementia trained staff to inform the decisions made about people's care and support needs. It has been successful so far, although the evaluation still continues into the next year.

We have continued to work closely during the year with Sheffield CCG and Sheffield City Council. Through these partnerships and commissioning relationships we have been able to make progress in improving access to community focused care and support.

Sheffield CCG has identified the need to support primary care services to better be able to monitor people at lower risk of developing dementia. They have developed proposals with us to provide specialist support to GP's to help with this. The expectation is that this will reduce some of the work of the existing memory services, freeing up time to see people who are newly referred quicker.

With the City Council we continue to implement city wide plans for the development and improvement of social care support for people with dementia. These plans are focussed on increasing our resources to provide more individually focussed support packages within local community areas, and reducing the level of resource allocated for residential based respite care and support. Over the last few years people have been using our 'resource centres' less and less for residential respite and so we are planning to use the resource to provide a different service in the future. This is expanded upon in our fuller Annual Report for 2012/13.

- Next year we intend to
- We recognise the clear disparity in waiting times for people needing to access our memory services compared to other routine services we provide. We want to address this. We will review the options to deliver real improvements in waiting times for our memory services and will confirm the targets we wish to deliver upon. We will then report on this in next year's Quality Account, along with the progress we have made
- We will work with GP practices in Sheffield, and the Clinical Commissioning Group to support more people who have been assessed for memory problems to receive their on-going monitoring with their GP, rather than needing to attend a specialist service
- Evaluate the effectiveness of the pilot liaison services into the local general hospital and agree future needs
- Build on the 'Involving People with Dementia Project' and introduce more ways to gain regular feedback from people with dementia
- Use the 'Voice of Dementia' film to support awareness raising and training for members of the public and staff across Sheffield working in relevant sectors.

How do our structures help ensure we are able to develop our quality improvement capacity and capability to deliver these improvements?

Our governance arrangements and structures support us to focus our efforts on improving the quality and effectiveness of what we do, and deliver on the objectives we have set

Engage and listen

Ensuring we understand the experience and views of those who use our services so we can make the right improvements.

Our Governors and membership share their experiences and views and inform our plans for the future.

We have a range of forums where service users come together to help us develop our services.

We use a range of approaches to seek the views of individuals who use our services such as surveys.

We have prioritised the development of service users to survey other service users about their experiences as this will give us much more reliable feedback.

Deliver best practice

Ensuring the care and support we provide is guided by what we know works.

We have a NICE Implementation programme to ensure we appraise our services against the available best practice and develop improvement plans.

We have developed a range of care pathways across services so we are clear about what we expect to be provided.

We have an established Audit programme that evaluates how we deliver care against agreed standards.

Regular Quality Improvement Group forum brings clinicians and managers together to share best practice.

Monitor and assess

Ensuring we evaluate how we are doing.

We have a team governance programme that supports each service to reflect on how they perform and agree plans for development.

We have prioritised the provision of information to teams so they can understand how they are doing, and we continue to improve our ability to provide them with the information they need.

We periodically self-assess our services against national care standards with service users, members, governors and our non-executive directors providing their views through visits and inspections.

Workforce development and leadership

Supporting and developing our staff to deliver the best care.

We have an established workforce training programme that aims to equip our staff with the skills, knowledge and values to deliver high quality care.

We have a well established culture and programme of developing our clinical and managerial leadership teams to support them to deliver improvements in care.

We use a range of service improvement and system improvement models to help us deliver the changes we wish to see, we continue to increase our ability to do this.

Quality and Assurance Committee

Evaluates and makes sense of the information from the above systems, and directs actions and decision making for future action

- Service user Safety Group
- Health and Safety Committee
- Infection Prevention and Control Committee
- Safeguarding Children Steering Group
- Audit committee
- Mental Health Act Group

Board of Directors

Council of Governors

- Safeguarding Adults Steering Group
- Psychological Therapies Governance Committee
- Medicines Management Committee
- NICE Steering Group
- Information Governance Gp

Part 2B: Mandatory statements of assurance from the board relating to the quality of services provided

2.1 Statements from the Care Quality Commission (CQC)

Sheffield Health and Social Care NHS Foundation Trust is required to register with the Care Quality Commission and our current registration status is registered without conditions and therefore licenced to provide services.

The Care Quality Commission has not taken enforcement action against the Trust during 2012/13. The Trust has not participated in any special reviews or investigation by the CQC during the reporting period.

The CQC registers, and therefore licenses the Trust as a provider of care services as long as we meet essential standards of quality and safety. The CQC monitors us to make sure we continue to meet these standards.

During 2012/13 we assumed the CQC registration of Woodland View Nursing Home, which was previously registered by Guinness Northern Counties Housing Association.

Planned/unplanned reviews

During 2012/13 the CQC visited the following locations as part of their review of our compliance with essential standards of quality and safety:

- Residential homes for people with a learning disability
  Buckwood View, Handsworth, Mansfield View, East Bank Road, Beighton Road
- Respite Care services for people with a learning disability
  Longley Meadows
  136a Warminster Road
- Respite Care services for adults
  Bolehill View, Hurlfield View
  Wainwright Crescent
- Inpatient Services
  Grenoside Grange.

All services inspected were fully compliant with the exception of Bolehill View, where compliance actions were received for:

- Consent to care and treatment and
- Care records.

Following the feedback received from the CQC we took immediate improvement action over the following month and the Commission confirmed following a repeat inspection that we were fully compliant with the required standards.

The reports from the planned reviews of compliance are all available via the Care Quality Commission website at www.cqc.org.uk.

At the publication date of the Trust Quality Account all improvement and compliance actions have been addressed and the Trust was fully compliant with the requirements of registration.

Mental Health Act reviews

During 2012/13 the CQC has undertaken 9 visits to services to inspect how we deliver care and treatment for inpatients detained under the Mental Health Act. They review our processes for care, the environment in which we deliver our care and meet privately with inpatients. They have visited the following services:

- Michael Carlisle Centre
  Stanage, Burbage, Daleside, Maple, Pinecroft
- Longley Centre
  Hawthorne, Intensive Treatment Service
- Forest Lodge
  Assessment & Rehabilitation wards

The feedback from these visits is helpful and allows us to ensure, and be assured, that we provide care in accordance with legislation and best practice guidelines. These reviews and inspections confirm that we continue to meet all essential standards.

2.2 Monitors' compliance framework

The Trust submits quarterly declarations to Monitor in relation to governance and finance. Monitor reviews the Trust's declaration and publishes a quarterly risk rating for each element. This information is available at www.monitor-nhsft.gov.uk.

The governance assessment (rated as either red, amber/red, amber/green or green) is based on the Trust's self-declaration by the Board of Directors against the following areas:

- Compliance with its constitution
- Growing a representative membership

- Maintaining appropriate structures
- Co-operating with other bodies
- Risk management
- Service performance and improvement in service quality.

The tables below feature our ratings for the four quarters of the last two years compared with the Trust's expectation at the beginning of the year as stated in our Annual Plans.

2011/12

The Trust was rated as Amber/ Red risk under governance following a review of its Inpatient Services by the Care Quality Commission in the previous year 2010/11. The CQC identified some moderate/ minor areas of concern that the Trust needed to address.

The Trust implemented a development plan that was agreed with the CQC, and the Amber/ Red assessment remained until the action plan was completed.

At the beginning of the year the Trust planned to have completed the required actions by September 2011, which it did so successfully.

The progress made by the Trust was reviewed and acknowledged by the CQC and the Trust continued with a Green risk rating for Governance for the rest of the year.

During the 2011/12 year the Trust achieved in each quarter all the quality standards required of a Mental Health NHS Foundation Trust.

2012/13

The Trust achieved all healthcare targets for each Quarter with the exception of Quarter 2.

During Quarter 2 the Trust failed to achieve the requirement to provide follow up care within 7 days of discharge from inpatient care for people under the Care Programme Approach. A range of improvement actions were implemented and the Trust continued to achieve the target for the rest of the year.

2011/12 Risk ratings compared to annual plan

	Annual plan 2011/12	Quarter 1 2011/12	Quarter 2 2011/12	Quarter 3 2011/12	Quarter 4 2011/12
Financial risk rating	4	4	4	4	4
Governance risk rating	Amber/ Red	Amber/ Red	Amber/ Red	Green	Green

2012/13 Risk ratings compared to annual plan

	Annual plan 2012/13	Quarter 1 2012/13	Quarter 2 2012/13	Quarter 3 2012/13	Quarter 4 2012/13
Financial risk rating	4	4	4	5	4
Governance risk rating	Green	Green	Amber/ Green	Green	Green

2.3 Goals agreed with our NHS Commissioners

A proportion of our income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2012/13 £1,639,911 of the Trust's contracted income was conditional on the achievement of these indicators. For the previous year, 2011/12, the associated monetary payment received by the Trust was £661,000. A summary of the indicators agreed with our main local health commissioner Sheffield Clinical Commissioning Group for 2012/13 and 2013/14 is shown below.

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	Goal during 2012/13	Is it a continued Goal for 2013/14
NHS Safety Thermometer Improve collection of data We wanted to improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE. This was to ensure we were effectively monitoring safety. We were successful in implementing this programme during the year.	✓ Achieved	✓
Reducing variation in waiting times for patients referred to the IAPT services Some GP practices in Sheffield were experiencing longer waiting times than others. We wanted to reduce the waiting times in these practices by 10%. We were successful with this. Waiting times reduced from 7 weeks to 5.4 weeks.	✓ Achieved	✓
Reduced admissions to Acute Older Adult Wards through improved community are for people in a crisis We had established new community services to provide alternatives to hospital admission. As a result of this we wanted to incrementally reduce the numbers of people who needed hospital care over the year. We were partially successful in achieving this goal, with less people needing hospital care in 3 of the 4 quarterly periods during the year.	✓ Partially achieved	✓
Improved recording of employment & vocational circumstances of people using mental health services To support our broader rehabilitation and recovery strategies we wanted to improve the information we had about individuals circumstances to help us better understand their needs and the progress made in supporting their recovery. We were successful in this, with 95.7% of service users in the target client group having the information updated in their care records.	✓ Achieved	No
Reduction in the number of falls causing harm This goal supported our Quality Objective No 1. We successfully achieved our target of reducing harm caused from falls by 5% this year (See Quality Objective 1 for details).	✓ Achieved	✓

Improving the management of Violence and Aggression within inpatient services This goal supported our Quality Objective No 2. The focus was to improve the service user and staff experience in relation to violence and aggression. We successfully reduced incidents in relation to seclusion and restraint. (See Quality Objective 2 for details)..	✓ Achieved	✓
People using mental health services should have an agreed plan to help reduce and manage the persons risk We wanted to increase the numbers of service users who had risk reduction plans in place following their initial risk assessment. We did not make the progress we expected to make this year, and will continue to deliver this objective next year.	✓ Did not achieved	✓
People who are referred for a routine assessment will be assessed within 2 weeks of the referral Following changes to our community mental health team services we wanted to deliver quicker access to our services following referral from GPs. We set a goal to see more people within 2 weeks of the referral being made. We were successful with this. We have made significant progress on this and in the second half of the year (Oct-March) 175% more people were being assessed within 2 weeks.	✓ Achieved	✓
People using mental health services should have a care plan agreed with them and in place within 6 weeks of the assessment In line with the above service changes, we wanted to ensure that following an assessment, those who needed on-going support and treatment then had a plan of care in place quickly. We did not make the progress we wanted to make. Over the year 57% of people had a care plan agreed within 6 weeks. We will continue to deliver on this objective next year.	✓ Did not achieved	✓
Patients receiving acute inpatient care should benefit from care and treatment from clinical psychologists We wanted to recruit and introduce clinical psychologist to work directly on our inpatient wards. During the year we undertook a range of development work with the ward teams to support the successful introduction of the new posts. We had wanted the new staff to start working on the wards during the year, however this did not happen as planned. The staff have been recruited and we will fully implement this goal from April 2013 onwards.	✓ Did not achieved	No
People with long term neurological conditions needs at level 2 or 3 should have agreed care plans in place We wanted to increase the proportion of people who had a care plan to co-ordinate their care with other services from 40% to 80% by the end of the year. We were partially successful and overall made good progress on this objective, achieving a 77% rate by the end of the year.	✓ Partially achieved	No
People with long term neurological conditions with a care plan (see above) should benefit from a holistic screening of need and client action plan We wanted to ensure service users benefited from a holistic plan of care. We agreed a target to achieve this for 90% of service users, and we achieved 100% through the year.	✓ Achieved	No
Improved use of electronic discharge communications between inpatient services and GP's This is a new goal for next year.	No	✓
Improved and standardised approaches to surveying service user experiences across all service areas This is a new goal for next year.	No	✓

2.4 Review of services

During 2012/13 SHSC provided and/or sub-contracted 54 services. These can be summarised as 36 NHS services, 7 integrated health and social care services and 11 social care services. The income generated by the relevant health services reviewed in 2012/13 represents 100% of the total income generated from the provision of the relevant health services by the Trust for 2012/13.

The Trust has reviewed all the data available on the quality of care in these services. The Trust reviews data on the quality of care with Sheffield CCG, other CCGs, Sheffield City Council and other NHS commissioners.

The Trust has agreed quality and performance schedules with the main commissioners of its services. With Sheffield CCG and Sheffield City Council these schedules are reviewed on an annual basis and confirmed as part of the review and renewal of our service contracts. We have formal and established governance structures in place with our commissioners to ensure we report to them on how we are performing against the agreed quality standards.

Our governance systems ensure we review quality across all our services.

2.5 Health and Safety Executive/ South Yorkshire Fire and Rescue visits

Health and Safety Executive

There were no Health and Safety Executive visits to the Trust during 2012/13.

South Yorkshire Fire and Rescue

During 2012/13 the South Yorkshire Fire and Rescue service visited and audited 9 of the Trust's premises. No notices regarding improvement actions were issued by the Fire service. The sites audited where as follows;

Hurlfield View, Grenoside Grange, Bolehill View, Longley Centre, Wardsend Road, Woodhouse Clinic, St Georges, Wainwright Crescent, Ivy Lodge.

2.6 Compliance with NHS Litigation Authority (NHSLA) risk management standards

The NHSLA handles negligence claims made against the NHS and works to improve risk management. Their risk management standards cover organisational, clinical, non-clinical and health and safety risks.

The Trust is compliant at Level 1 with the standards having last been assessed in March 2013. This means our processes for managing risks have been properly described and written down. We will be assessed again in March 2015.

2.7 Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 555.

We adopt a range of approaches to recruit people to participate in research. Usually we will focus on individuals appropriate to the area being researched, staff involved in their care will make them aware of the opportunity to participate and they will be provided with a range of information to allow then to take informed decisions about if they wish to participate.

The Trust was involved in conducting 36 clinical research projects which aimed to improve quality of services, increase service user safety and deliver effective outcomes.

Areas of research in which the Trust has been active over the last 12 months include:

- Improving the quality and effectiveness of therapies and self-management in depression
- Understanding and improving the safety of psychological therapies
- Developing interventions to improve the physical health of those with severe mental illness
- New treatments for service users with schizophrenia
- New treatments for service users with dementia (including Alzheimer's disease).

Research is a priority for the Trust and is one of the key ways by which the Trust seeks to improve quality and initiate innovation. Over the last year the Trust has worked closely with the East Midland and South Yorkshire Mental health Research Network to increase opportunities for our service users to participate in commercial clinical trials of new treatments and with academic partners, including the Clinical Trials Research Unit at the University of Sheffield, to initiate research projects sponsored by the Trust.

SHSC has been actively involved in the establishment of the Yorkshire and Humber Academic Health Sciences Network and will seek to maximise opportunities arising from this towards the goals of improving population health, transforming healthcare and wealth creation for the region.

2.8 Participation in clinical audits

National clinical audits and National confidential enquiries

During 2012/13 14 national clinical audits and 3 national confidential inquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

During 2012/13 the Trust participated in 100% national clinical audits and 100% national confidential inquiries which it was eligible to participate in.

The table below lists the national clinical audits and national confidential inquiries the Trust participated in, along with the numbers of cases submitted by the Trust in total and as a percentage of those required by the audit or inquiry.

Name of national audit SHSC participated in	Number of cases submitted	Number of cases submitted as a percentage of those asked for
Guideline audits		
National Audit of Schizophrenia (registered for re-audit) - To measure the Trusts performance against national NICE guidelines	150	100%
National Audit of Psychological Treatments - To measure the Trusts performance against national NAPT guidelines	4009	100%
National Parkinsons Audit - To measure the Trusts performance against National standards	53	100%
POMH UK		
Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards (Topic 1) – To ensure prescribing is appropriate within BNF limits	144	100%
Lithium Monitoring (Topic 7c) – To ensure Lithium is prescribed in accordance with NICE guidelines	108	100%
Prescribing antipsychotics for people with Dementia (Topic 11b)	279	100%
Metabolic side effects of antipsychotic (Topic 2f)	261	100%
Prescribing for people with a personality disorder (Topic 12a)	65	100%

Other audit programmes		
NHS LA – Records audit	579	N/A
Diabetes audit – Clover Group	1026	100%
Suicide audit	5	N/A
Food and nutrition	134	N/A
Safeguarding children – Baseline audit of knowledge	252	N/A
National confidential inquiries		
Inquiry into suicide and homicide by people with mental illness	16	30%*
Inquiry into suicide and homicide by people with mental illness Out of District Deaths	0	0%
Inquiry into suicide and homicide by people with mental illness Homicide data	4	33%*

*Note: the percentage figure represents the numbers of people who we reported as having prior involvement with as percentage of all Inquiries made to us under the National Confidential Inquiry programme. i.e. in 70% of all inquiries, we had not record of having had prior involvement with the individual concerned.

The reports of 14 national clinical audits were reviewed by the Trust in 2012/13 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

National audit	Results and actions
National audit of Schizophrenia	**Results** – We did well on polypharmacy (top 10%) but below average on user experience, monitoring of physical health and our prescribing of clozapine for treatment resistant patients. **The actions we have taken are:** Additional staff training has been provided on how to screen and intervene with patients physical health.

National audit of psychological treatments	**Results** – We did well on waiting times, skills and training of staff and our monitoring of outcomes of the treatment we provided, but below average on satisfaction and the outcomes of the treatment provided. **The actions we have taken are:** Reviewed the way we organise our services, improved our shared care with GP's and reduced the bureaucracy in our referral processes. Since then we have seen a 10% improvement in DNA rates, 5% improvement in recovery rates and significant improvement in client outcomes.
National Parkinsons audit	Data was submitted in December for 53 patients. A report will be available in June 2013.
Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards	**Results** – We have made improvements on the previous year's audit (2010) regarding the number of people who were prescribed higher dosages of drugs than the recommended limits, however this was not consistent across all of our services. **The actions we have taken are:** We have made it easier for staff to access to information regarding the effect of combining antipsychotics on the percentage maximum dose prescribed.
Lithium monitoring – To ensure Lithium is prescribed in accordance with NICE guidelines	**Results** – Our monitoring of lithium side effects is at 60%, which compared well in the audit, however we need to improve how we monitor lithium toxicity. **The actions we have taken are:** Services continue to monitor how we are doing. We will improve how we monitor risks relating to toxicity, and undertake a repeat audit to evaluate progress.
Prescribing antipsychotics for people with Dementia	**Results** – Most people were benefiting from a review and had evidence of having a plan in place regarding what works best if they experience a crisis. We need to improve how we communicate why we have prescribed the medication we have and when different treatment plans started. **The actions we have taken are:** We will improve the documentation of the clinical reason for proscribing the most recent antipsychotic and the duration of prescription of benzodiazepine.

Metabolic side effects of antipsychotic	**Results** – We did well on monitoring peoples blood pressure, but need to improve how we monitor peoples weight and encourage people to stop smoking. **The actions we have taken are:** We will improve practice and the documentation of smoking cessation, obesity and BMI. We have approved a Trust wide plan about improving peoples overall physical health.
NHS Litigation Authority – Records audit	**Results** – Compared to the previous years audit we have made significant improvement in the quality of the information we have about peoples circumstances, such as HoNOS assessments, sexual vulnerability, child/ adult protection issues. However we still need to improve key areas such as advance directives, risk prevention planning and communicating plans with GP's. **The actions we have taken are:** All services are developing plans to address the underperforming standards. We are already implementing a roll out of improved electronic patient records focussing on areas of risk and assessment, which will support improvements.
Diabetes audit	**Results** – We are doing well in how we monitor a range of risk issues for people who have diabetes (such as weight) and the treatment they are on (such as statins and ACE-inhibitors). We weren't doing as well in the supporting people to access well-structured education programmes. **The actions we have taken are:** To re-launch a patient education programme.
Suicide audit	**Results** – We were compliant with the majority of standards for the care plans that we audited. We need to improve how we communicate with families and carers after such tragic events, making sure they have information about what happened. **The actions we have taken are:** We have put plans in place to ensure information is shared with families and carers in an appropriate and supportive way.

Safeguarding children	**Results** – The audit identified that the majority of staff have 'some' understanding of the kinds of child abuse (particularly type of abuse). Most staff know who to contact if a child has been abused (this includes line manager, safeguard lead) **The actions we have taken are:** We will continue with our training programme to maintain and improve awareness.
Food and nutrition	**Results** – The audit has revealed that nutritional assessments are being done on admission for 96% of patients on the older adult wards. We need to extend this practice to our other wards. **The actions we have taken are:** We will extend the practice of undertaking nutritional assessments to our adult wards.

Local audit activity

Local clinical audits are conducted by staff and teams evaluating aspects of the care they themselves have selected as being important to their teams. Our main commissioner, Sheffield CCG, also asks the Trust to complete a number of local clinical audits each year, to review local quality and safety priorities. On a quarterly basis the Board review the progress of other local audits.

2.9 Data quality

Good quality information underpins the effective delivery of care and is essential if improvements in quality care are to be made. Adherence to good data quality principles (complete, accurate, relevant, accessible, timely) allows us to support teams and the Board of Directors in understanding how we are doing and identifying areas that require support and attention.

External Auditors have tested the accuracy of the data and our systems used to monitor the following indicators:

- 7 day follow up – everyone discharged from hospital should receive support in the community within 7 days of being discharged
- 'Gate keeping' – everyone admitted to hospital should be assessed and considered for home treatment

As with previous years, the audit has confirmed the validity and accuracy of the data used within the Trust to monitor, assess and report our performance.

Staff on Burbage Ward

The Trust submitted records during 2012/13 to the Secondary uses service (SUS) for inclusion in the Hospital episodes Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was 99.9% for admitted care. The percentage of records in the published data which included the patients valid General Practitioner Registration Code was 95.7% for admitted care. No other information was submitted.

The latest published data from the SUS regarding data quality under the mental health minimum data set is for April 2012- December 2013. The Trust's performance on data quality compares well to national averages and is summarised as follows:

Percentage of valid records	Data quality 2012/13	National average
NHS Number	99.9%	99.4%
Date of birth	100%	99.7%
Gender	100%	99.4%
Postcode	99.6%	99.0%
Commissioner code	100%	99.3%
GP Code	99.5%	98.3%
Primary diagnosis	100%	98.5%
HoNOS outcome	100%	88.9%

The data and comparative data is from the published MHMDS Reports for the Q1 – Q3 periods inclusive

Clinical coding error rates

Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission.

2.10 Information governance

We aim to deliver the best practice standards in Information Governance by ensuring that information is dealt with legally, securely and effectively in order to deliver the best possible care to our service users.

Concerns were highlighted in a number of areas during 2011/12. The Trust undertook development and improvement actions in response to the following issues:

- Information governance management - Improving the provision of training about information governance
- Clinical information assurance - Completion of staff training and audit for clinical coding
- Corporate information assurance - Completing a review and audit of corporate records.

During the year we completed our assessments through the NHS Connecting for Health Information Governance Toolkit. The Trust undertook and submitted a baseline assessment in October 2012 and a final assessment and submission in March 2013.

Following the improvement actions we had undertaken, Sheffield Health and Social Care NHS Foundation Trust's Information Governance Assessment Report overall score for 2012/13 was 69% for the 45 standards and was graded satisfactory/green.

Achieved

Criteria	2011/12	2012/13	Current grade
Information Governance Management	66%	73%	Satisfactory
Confidentiality and Data Protection Assurance	74%	74%	Satisfactory
Information Security Assurance	64%	66%	Satisfactory
Clinical Information Assurance	73%	73%	Satisfactory
Secondary Use Assurance	41%	66%	Satisfactory
Corporate Information Assurance	22%	66%	Satisfactory
Overall	60%	69%	Satisfactory

Part 3: Review of our quality performance

3.1 Safety

Overall number of incidents reported

The Trust traditionally reports a high number of incidents compared to other organisations. This is viewed as a positive reflection of the safety culture within the Trust. It helps us to be able to really understand what the experience of care is like, spot trends and make better decisions about what we want to address and prioritise for improvement. The National Patient Safety Agency consistently assesses our performance, using the data supplied through the National Reporting Learning System (NRLS) as in the highest (best performing) 25% of Trust's for actively encouraging the reporting of incidents. For the 6 month period April - September 2012, SHSC was the 10th highest performer of 56 mental health trusts.

Nationally, based on learning from incidents and errors across the NHS, the National patient Safety Agency has identified a range of errors that should always be prevented. These are often referred to as 'never events', because with the right systems to support care and treatment in place they should never need to happen again. None of the incidents that occurred within the Trust over the last year were of this category.

Patient safety alerts

The NHS disseminates safety alerts through a Central Alerting System. The Trust responded effectively to all alerts communicated through this system. During 2012/13 the Trust received 70 non-emergency alert notices, of which 100% were acknowledged within 48 hours, 4 were applicable to the services provided by the Trust and all were acted upon within the required timescale. In addition a further 37 emergency alerts were received an acted upon straight away.

Patient safety information on types of incidents

Self-harm and suicide incidents

The risk of self-harm or suicide is always a serious concern for mental health and substance misuse services. The NPSA figures show 11.3% of all patient safety incidents reported by the Trust were related to self harm, in comparison with 18.1% for mental health trusts nationally. This is similar to the previous year where the figures were 11.4% and 18.7% respectively.

During the last two years clinical risk training was provided for our staff and new clinical risk assessment and management tools have been introduced throughout the Trust. Last year 1,329 staff from all professional groups received the training, which covers the principles and practice of risk assessment and management. We had planned to train 2,000 members of staff. The main reason leading to our under achievement of our target has been capacity to support the release of staff from front line service delivery. We are reviewing our approaches to this for next year to ensure we can deliver improvements.

Violence, aggression and verbal abuse

In previous years the Trust has reported relatively low incidents of disruptive and aggressive behaviour within our services compared to other mental health organisations. This has increased during 2012/13 in line with the position reported in Section 2A. 20.6% of patient safety incidents reported by the Trust were for aggressive behaviour in comparison with a national average of 18.2%, based on NPSA benchmarking data for first 6 months of the year. In the previous year, 2011/12 the figures were 15.4% and 19% respectively.

Medication errors and near misses

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. 6.1% of patient safety incidents reported by the Trust related to medication, compared with 8.4% in mental health trusts nationally. There has been little change in the number of medication incidents reported by the Trust over the last 3 years.

Cleanliness and infection control

The Trust is committed to providing clean safe care for all our service users and ensuring that harm is prevented from irreducible infections.

To achieve this an annual programme is produced by the Infection Prevention and Control Team that details the methods and actions required to achieve these ends.

The programme includes:

- Processes to maintain and improve environments
- The provision of extensive training and education
- Systems for the surveillance of infections
- Audit of both practice and environment and
- The provision of expert guidance and information to manage infection risks identified.

The efficacy of this programme is monitored both internally and externally by the provision of quarterly and annual reports detailing the trusts progress against the programme. These reports are publicly available via the internet.

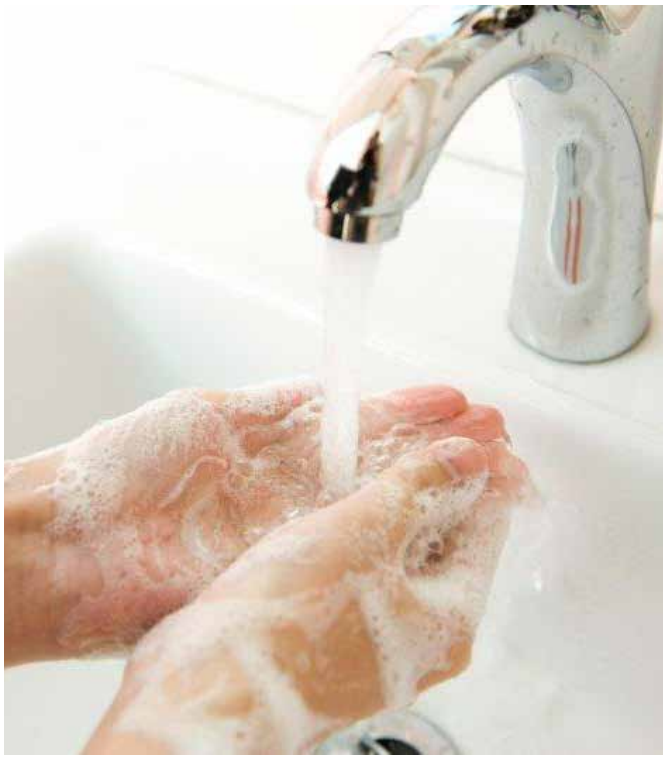
Single sex accommodation

The Trust is fully compliant with guidelines relating to providing for appropriate facilities for men and women in residential and inpatient settings. During 2012/13 we have reported no breaches of these guidelines.

Safeguarding

The Trust fully complies with its responsibilities and duties in respect of Safeguarding Vulnerable Adults, and Safeguarding Children. We have a duty to safeguard those we come into contact with through the delivery of our services. We fulfil our obligations through ensuring we have:

- Robust systems and policies in place that are followed
- The right training and supervision in place to enable staff to recognise vulnerability and take action
- Expert advice available to reduce the risks to vulnerable people.



Reviews and investigations

We aim to ensure that we review all our serious incidents in a timely manner and share conclusions and learning with those effected, and our commissioners.

We monitor our performance in respect of completing investigations within 12 weeks and undertaking investigations that are assessed as being of an 'excellent/ good' standard. Historically we have experienced challenges in this area and we continue to prioritise our efforts to improve our review processes.

Improvements and lessons learnt

All incidents are reviewed to ensure we are able to identify how we can make improvements and take corrective action to maintain and improve safety.

We formally review all serious incidents and the Trust's Quality Assurance Committee and Board of Directors reviews the findings and lessons learnt from the incidents. We review and share all findings with our Commissioners and review our improvement plans with them.

Examples of the types of improvement actions we have been able to take following reviews of serious incidents are

- Involving service user families/carers in their care/decision making
- Comprehensive and timely record keeping, ensuring the rationale for decisions made is recorded
- Making sure that urgent referrals into the Trust are easily identified
- Communication between NHS professionals to be strengthened to ensure information is shared appropriately.

Using incident data to prioritise improvement actions

From the incident data on the next page, and our review of the types of incidents that occur across our services, we prioritised falls and violent incidents for attention. 'Our plans, and progress against those plans are reported in detail on pages 6 and 8 of this report.

Overview of incidents by type

The table on the next page reports on the full number of incidents reported within the Trust. It then reports on the numbers of those incidents that were reported to result in harm for service users and staff.

Incident type	2010/11	2011/12	2012/13
All incidents	5981	6408 (a)	6260
All incidents resulting in harm	1627	1689	1508
Serious incidents (investigation carried out)	38	45	34
Patient safety incidents reported to NRLS (d)	3359	3598	3340
Patient safety incidents reported as 'severe' or 'death'	28	41	42
Expressed as a percentage of all patient safety incidents reported to NRLS	0.8%	1.1%	1.3%
Slips, Trips and Falls incidents	1449	1652	1180
Slips, Trips and Falls incidents resulting in harm	554	558	420
Self-harm incidents	365 (a)	369 (a)	425
Suicide incidents (in-patient or within 7 days of discharge)	1	2 (b)	0 (c)
Suicide incidents (community)	24	13	5 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	1485	1644	1930
Violence, aggression and verbal abuse incidents resulting in harm	267	276	240
Medication Errors	354 (a)	360 (a)	321
Medication Errors resulting in harm	0	0	1
Infection Control			
Infection incidents			
MRSA Bacteraemia	0	0	1
Clostridium difficile Infections	0	0	0
Periods of Increased infection/Outbreak			
• Norovirus	7 (52)	7 (60)	3 (28)
• Rotavirus	1 (5)	0	0
• Influenza	0	0	1 (3)
Showing number of incidents, then people affected in brackets			
Preventative measures			
MRSA Screening – based on randomised sampling to identify expected range to target	n/a	2%	39%
Staff Influenza Vaccinations	20%	37.6%	56%

(a) The incident numbers have increased from those reported in the 2011/12 Quality Account report due to additional incidents being entered onto the information system after the completion of the report.

(b) The figure has decreased from that reported in last year's Quality Account report due to an HM Coroner's inquest which has not yet been held. It is likely that this figure will increase in next year's report

(c) Figures are likely to increase pending the conclusion of future HM Coroner's inquests. This will be reported in next year's report.

(d) The NRLS is the National Reporting Learning System, a comprehensive database set up by the former National Patient Safety Agency that captures patient safety information.

3.2 Effectiveness

The following information summarises our performance against a range of measures of service effectiveness.

Primary Care Services – Clover Group GP Practices

The Quality Outcomes Framework (QoF) provides a range of good practice standards for the delivery of GP services. Traditionally the 4 practices that have formed the Clover Group have been below the Sheffield averages in their performance against these standards have previously been in the lowest quartile in the city. The practice serves a majority multi-ethnic migrant population in areas of social deprivation within Sheffield. This brings a number of acknowledged challenges for the service to deliver the range of standards.

Over the last 2 years, significant progress and achievements have been made. In 2011/12 the Clover Group of practices improved to be in the highest quartile in Sheffield and their challenge this year was to sustain this improvement. They have achieved this, which is an excellent achievement and demonstrates that real improvements are being implemented for the longer term benefit of the communities the practices serve.

In 2011/12 the service achieved a total of 98.7% of all the QoF standards, with a Sheffield-wide average of 97%. This year in 2012/13 the service achieved 98.2% of the standards.

The following table summarises performance against national standards for GP services. Health screening for the practice population is challenging and influenced by the high proportion of the patient group being from BME communities. The service has been working closely with its community groups to increase awareness and access arrangements for health screening programmes to support improvements. Uptake in the programmes gradually increases over the years.

Primary Care – Clover GP's	This years target	How did we do in year 2011 – 12	How did we do this year
Flu vaccinations			
Vaccinate registered population aged 65 and over	75%	75%	78% ✓
Vaccinate registered population aged 6 months to 64 years in an at risk population	70%	50%*	56% ↑
Vaccinate registered population who are currently pregnant	70%	45%*	51% ↑
Childhood immunisations			
Two year old immunisations	70-90%	90%	90% ✓
Five year old immunisations	70-90%	81%	85%
Cervical cytology	60-80%	66.7%	66.4%

*Note: The target for 2011/12 was 50% & 45% respectively
Information source: System One and Immform

Drug and alcohol services

The service continues to prioritise ensuring timely access to primary and secondary care treatment. The service aims to ensure all of Sheffield's population that would benefit from the range of services provided in drug and alcohol treatment are able to access support. The service adopts a range of approaches to engage with people from this vulnerable service user group.

Priorities for next year including further expansion of the universal screening tool to increase the number of people accessing primary care services for alcohol problems and maximising the numbers of people supported and ready to finish treatment drug and/or alcohol free.

Drug and alcohol services	This years target	How did we do in year 2011 – 12	How did we do this year
Drugs			
No client to wait longer than 3 weeks from referral to medical appointment	100%	100%	100% ✓
No drug intervention client to wait longer than 5 days from referral to medical appointment	100%	100%	100% ✓
No Premium client should wait longer than 48 ours from referral to medical appointment	100%	100%	100% ✓
No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100% ✓
% Problematic drug users retained in treatment for 12 weeks or more	90%	94%	95% ✓
Alcohol single entry and access			
No client to wait longer than 1 week from referral to assessment	100%	100%	100% ✓
No client to wait longer than 3 weeks from Single Entry and Access Point assessment to start of treatment	100%	100%	100% ✓
Outcomes, self care			
Initial Treatment Outcome Profile (TOP) completed	100%	96%	98% ✓
Review TOP completed	100%	80%	71% ✓
Discharge TOP completed	100%	100%	100% ✓
All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100% ✓
Number of service users and carers trained in overdose prevention and harm reduction	240	292	272 ✓
% Successful completions for the provision of treatment for injecting-related wounds and infections	75%	85%	94%

Information source: National Drug Treatment System

Learning disability services

A key area of focus has been ensuring that people with complex and challenging behaviours are supported through community focused support packages within Sheffield and the individual's local community as far as possible.

During the last year the service has made good progress in supporting people to return to Sheffield from out of town placements. Within our local inpatient services we have ensured that individual clients do not experienced prolonged periods in hospital beyond what the client needs. We have delivered care that is well co-ordinated and focus on the needs of individuals, and delivered in a personalised and dignified way (as evidenced by visit reports from the CQC).

Learning disability services	This years target	How did we do in year 2011 – 12	How did we do this year
No-one should experience prolonged hospital care ('Campus beds')	Nil	Nil	Nil to date ✓
All clients receiving hospital care should have full health assessments	100%	100%	100% ✓
Assessments and supporting plans for their communication needs	100%	100%	100%

Information source: Insight & Trust internal clinical information system

Dementia services

Our specialist inpatient service for people with dementia and complex needs has prioritised its focus on improving the care pathway to ensure discharge in a timely manner either home or as close to a person's home as possible. This results in much better outcomes for the individual concerned. This has enabled more throughput into the ward but recognises the increasing complexity of the service users admitted.

We continue to explore ways to build on the excellent success of the memory service in improved access and improved diagnosis rates within Sheffield. Making further improvements in this area is a priority for us next year.

Dementia services	This years target	How did we do in year 2011 – 12	How did we do this year
Discharges from acute care (G1)	30	34	53 ✓
Number of assessments for memory problems by memory management services	900	876	918 ✓
Rapid response and access to home treatment	350	338	339 ✓
Waiting times for memory assessment	N/A	14.5 weeks	16.3 weeks projected ↓

Information source: Insight & Trust internal clinical information system

Independent living and choice

Independent living and choice	This years target	How did we do in year 2011 – 12	How did we do this year
Access to equipment • Community equipment to be delivered within 7 days of assessment	95% of items to be delivered within 7 days	95.3%	95.2% project ✓
Choice and control • People accessing direct payments to purchase their own social care packages	N/A	263 people with budgets agreed Further 203 actively exploring	454 people with budgets agreed ✓ Further 312 actively exploring

Information source: Insight & Trust internal monitoring systems

Mental health services

Services continue to perform well across a range of measures used to monitor access and co-ordination of care, achieving all national targets expected of mental health services. A range of key service changes have been introduced during the last year (for information about them see our Annual Report), and the Trust has ensured that performance levels have been maintained during times of extensive change.

The table below highlights our comparative performance on 7 Day follow up and Gatekeeping indicators. Sheffield Health and Social Care NHS Foundation Trust believes that its above average performance on gatekeeping is due to its robust care pathway arrangements across community mental health team, home treatment and inpatient services. The Trust is below average in respect of 7 day follow up standards. This is influenced mainly by failures to achieve the standard in the second quarter of the year. Following review at the time our discharge arrangements were strengthened further. Sheffield Health and Social Care NHS Trust has taken the following actions to improve this.

- Improved information sharing and monitoring of client circumstances to ensure the follow up happened as planned
- Combined with all service users who are discharged receiving additional telephone based support immediately after their discharge, in addition to the planned follow up visit.

These measures will support improvements in the quality of our services over the next year.

Mental health services	This years target	How did we do in year 2011 – 12	How did we do this year
Improving access to psychological therapies			
• Number of people accessing services	5,364	10,661	10,735 ✓
• Numbers of people returning to work	89 people	396 (18.6%)	344 (31%) (a)
• Number of people achieving recovery	50%	49.5%	46%
Early intervention			
• People should have access to early intervention services when experiencing a first episode of psychosis	90 new cases per year	136 new clients accessed services	107 new clients accessed services ✓
Access to home treatment			
• People should have access to home treatment when in a crisis as an alternative to hospital care	1,202 episodes to be provided	1,443 episodes provided	1,418 episodes provided ✓
'Gate keeping'			
• Everyone admitted to hospital is assessed and considered for home treatment	90% of admissions to be gate-kept	99.4% National average 97.4% (b)	99.5% National average 98.2% (b) ✓
Delayed transfers of care			
• Delays in moving on from hospital care should be kept to a minimum	No more than 7.5%	4.2%	4.7% ✓
7 day follow up			
• Everyone discharged from hospital on CPA should receive support at home within 7 days of being discharged	95% of patients to be followed up in 7 days	96.8% National average 97.3% (b)	95% National average 98.2% (b) ✓
Annual care reviews			
• Everyone on CPA should have an annual review with their care coordinator	95%	98.7%	98% ✓
• Everyone on CPA should have a formal review of their care plan	90%	89.5%	86.3%

Information source: Insight & Trust internal clinical information system

Note

(a) 31% represents the % of those who were not in work at the beginning of treatment, who had returned to work at the end of treatment. During 2012/13 1,099 of the 10,735 people seen where not in work at the beginning of treatment. 344 of them (31%) returned to work by the time treatment had been completed.

(b) Comparative information from Health and Social Care Information Centre. 2012/13 national average figure based on data published for the Apr 12-Dec12 period.

3.3 Service user experience

Complaints and compliments

A full picture of the complaints and compliments received by the Trust over the year is available on our website in the Annual Complaints and Compliments Report. This includes feedback from the complainants (the people who have made the complaint) about their experience of the complaints process and if they felt their concerns were appropriately addressed and taken seriously.

All complaints are investigated and if we agree with the concern being raised we will put in place an action plan to address the problem. The following summarises the numbers of complaints and positive feedback we have received:

We do use complaints as an opportunity to improve how we deliver and provide our services. Examples of some of the changes we have made from reviewing concerns that people have raised with us are:

- Sheffield Aspergers Service to produce a written information pack for service users with ADHD
- Improved the information we provide to service users about how to reduce side effects from medication
- Development of peer support networks for service users with personality disorders
- Introduced improvements within inpatient wards to provide a reasonable variety and quantity of diet to meet service user needs, e.g. halal and vegan meals.

Number of	2010/11	2011/12	2012/13 (*)
Formal complaints	86	97	143
Informal complaints	286	215	260
Compliments	1,559	1,401	1,368

Data is for Apr – Dec: 3 Quarters

During the last year 12 people referred their concerns to the Health Services Ombudsman because they were dissatisfied either with the Trust's response or the way we investigated their concerns. The Ombudsman did not feel there was a need to undertake any further investigations into the issues within these complaints.

Over the last year we have implemented a range of changes to how our services are delivered. We have re-organised our community mental health teams and closed some day centres and bed based services as we have provided more care in more appropriate community based settings. All service changes can bring a feeling of uncertainty and disruption to continuity of care. We have placed great emphasis on reducing the impact on the people who use our services while we introduce these changes. We are pleased that our service changes have not been a notable cause or reason for why people have raised concerns about their care through complaints or other means of feedback.

Improving the experience through better environments – investing in our facilities

The environment of the buildings in which we deliver care has an important part to play and has a direct impact on the experience of our service users.

The design, availability of space, access to natural light, facilities and access to outside areas are all fundamental issues. Getting them right has a direct impact on how people feel about the care and treatment they are receiving. We have made significant progress this year in addressing key areas where our buildings haven't been as good as we have wanted them to be.

Firshill Rise – services for people with a learning disability and challenging behaviour

Our current facilities, the Assessment and Treatment Unit, were inappropriate and very limiting. Despite this the CQC recognised that we were providing excellent care despite the poor facilities.

Intensive Treatment Service – secure care for people who are acutely mentally ill and in need of intensive care and support

Our current ward facility is too small and it does not provide access for the service users to outside space. This significantly impacts on the experience of care for the individuals on the ward, as well as the staff delivering care.

Recognising this, we have approved an investment of £2.8 million to design and build a new Ward on our Longley Centre site. This will result in real improvements to the design and feel of the Ward, much better facilities and access to dedicated gardens and outdoor space. The work on the commissioning of the new ward has started during this year, and we look forward to it opening towards the end of 2013/14.

We have invested £3.2 million over two years in a new purpose built community facility to provide residential based care and treatment for people with challenging behaviour as part of the Intensive Support Service. The new facility has been built this year and will open in May 2013. We see this as a tremendous move forward for us, and are excited about the significant improvements in care and support that we will be able to provide, and the real improvements in the experience for the individuals we support with the opening of this new facility.

General environment

During 2012/13 no external reviews of our facilities took place. The previous PEAT assessment took place in 2010/11. The conclusion of the review is summarised as follows:

Site Location	Environment Score	Food Score	Privacy and Dignity Score
Longley Centre	4 Good	5 Excellent	4 Good
Michael Carlisle Centre	4 Good	5 Excellent	4 Good
Forest Close	4 Good	5 Excellent	4 Good
Forest Lodge	4 Good	5 Excellent	4 Good
Grenoside Grange	5 Excellent	5 Excellent	5 Excellent

The reviews are helpful in providing the Trust with external feedback about the environment in which we are providing our services. The review team involves people external to the Trust, including service users and carers to gain their perspective and view about our facilities.

What do people tell us about their experiences?

That national patient survey for mental health trusts suggests that the experience of our service users compares well to other mental health trusts.

Mental health survey

Issue – what did service users feel and experience regarding	2010 Survey that reported in 2011		2011 Survey that reported in 2012	
	Score	Top 10 of 65 Trusts?	Score out of 10	Top 10 of 60 Trusts?
Their Health & Social Care workers	8.9	Yes	9	Yes
Medication	7.6	Yes	7.5	Yes
Access to Talking Therapies	7.4		8.0	Yes – highest
Support from Care Co-ordinator	8.5	Yes	8.6	
Their Care Plan	7.0		7.3	Yes
Care Reviews	8.0	Yes	7.7	
Awareness about support options for Crisis Care	6.5		5.9	
Day to day living	6.0		6.0	Yes
Overall view of care	7.2	Yes	7.2	Yes
Overall score	**7.5**	**Yes Joint 2nd**	**7.5**	**Yes joint 3rd**

	2010 Survey that reported in 2011			2011 Survey that reported in 2012		
	Lowest 20% score	Top 20% score	Our score	Lowest national score	Top national score	Our score
Patient Survey						
How well did people who use our services comment on their experience of contact with a health or social care worker?				8.2 overall	9.1 overall	9.0 overall
Did staff listen carefully to you?	8.6	8.9	9.3	8.2	9.3	9.1
Did staff take your views into account?	8.3	8.7	8.9	7.9	9.0	8.9
Did you have trust and confidence in them?	8.1	8.5	8.5	7.6	9.0	8.7
Did they treat you with dignity and respect?	9.1	9.4	9.5	8.8	9.7	9.5
Were you given enough time to discuss your condition?	8.0	8.5	8.6	7.7	8.7	8.6

The table on the previous page highlights our comparative performance on service user experience in respect of contact with our staff. Sheffield Health and Social Care NHS Foundation Trust is proud of this positive position. We believe that this position is due to our focus on ensuring the individual client is the focus of our care planning and review processes, supported by clear information about their care, delivered by staff with strong focus on service user engagement

Sheffield Health and Social Care NHS FT will continue to take actions to maintain this current positive position regarding the quality of our services. Our ongoing development programmes, such as the RESPECT programme, our Quality Objectives, and our focus on supporting individual teams to understand their own performance are some of the key actions that will support this.

The below table highlights highlights our comparative performance regarding the quality of our services from the perspective of our staff. Sheffield Health and Social Care NHS Foundation Trust considers this positive position is a result of our efforts to engage with our staff and involve them in the plans and decisions regarding how we move forward and focus on improving the quality of our services.

We place increasing emphasis on ensuring staff in teams are aware how we are performing, making best use of the information we have to support this.

Sheffield Health and Social Care NHS FT intends to continue with its programme of improving team governance to improve further the involvement of staff in reviewing how we are doing and taking decision locally about how to make further improvements.

Working with the people who use our services to make the changes they want to see

We engage with service users in a range of ways to understand their experiences and then use that information to make improvements. The following is provided to give an illustration of examples of this.

Learning disabilities services

Connections forum – Service users feedback they feel they belong more and are helping to improve their service. This involvement has given them greater confidence in themselves.

Autism – Through asking the client base what they felt was required in the brochure, the service was able to create a brochure that clients feel would be more useful to them.

Eating disorders

Satisfaction has improved in four out the eight standards since 2011. Survey feedback has led to services looking at flexible appointments and how we provide post discharge support.

Mental health assertive outreach services

Survey feedback has highlighted we are getting better at planning activities jointly with service users. Service users are feeling more involved.

Community mental health teams

Feedback has led to improved access to information regarding employment and vocational services around Sheffield.

	2010 Survey that reported in 2011			2011 Survey that reported in 2012		
	Lowest 20% score	Top 20% score	Our score	Lowest national score	Top national score	Our score
Staff Survey						
What percentage of staff would recommend the trust as a provider of care to their family or friends	3.30	3.56	3.6	3.36	3.68	3.63
	Average score 3.42			Average score 3.54		

Memory services

Surveys have led to steps to ensure that the cafes (support networks for carers and service users) offer what the service user and their carer/supporter want each week rather than what the service think they might want.

GP services – Clover Group

Improving access to health services has been a major work-stream for the Clover Group year on year.

Despite major service developments to improve access and patient satisfaction, the Clover Group has not seen the desired impact of the service re-designs in increasing patient satisfaction with the system. Surveys continue to highlight a high level of dissatisfaction and frustration from the people who use the practices. Nationally the satisfaction rates in the GP National Survey for all GP services suggest that respondents from black and ethnic communities are on average up to 20% less satisfied in some indicators, than their white British counterparts, specifically from Asian or Asian British communities. This experience is replicated locally in the Clover practices.

The Clover Group have a constant programme of service developments to improve services to patients and engage the community. All of the practices have implemented a system offering an open access/ drop-in clinic which has resulted in a significant increase in access to available appointments.

3.4 Staff experience

National NHS staff survey results

Engagement	Previous year	This year		
	2011/12	2012/13	National averages	Comparisons
Overall staff engagement	3.69 out of 5	3.73		Better than average
Able to contribute to improvements	70%	73%	71%	
Recommend Trust as place to work or receive treatment	3.59 out of 5	3.63	3.54	
Top 5				
% Of staff working extra hours	53%	64%	70%	Top 20% getting worse
% Receiving job related training and learning	n/a	85%	82%	Top 20%
Work pressures felt by staff		2.93 out of 5	3.02	Top 20%
Job satisfaction	3.6 out of 5	3.72	3.66	Top 20% Got better
Good communications with senior management		35%	30%	Top 20%

Engagement	Previous year		This year	
	2011/12	2012/13	National averages	Comparisons
Worse 5				
% Of staff receiving H&S Training	70%	50%	73%	Worse 20% Got worse
% Of staff receiving equality and diversity training	32%	38%	59%	Worse 20%
Staff appraisals	78%	79%	87%	Worse 20%
% Staff suffering work related stress	34%	46%	41%	Worse 20% Got worse
Effective team working	3.73 out of 5	3.77	3.83	

Overall the Trust is encouraged with the above results. The positive feedback around engagement continues to support our ongoing work and focus in improving quality and delivering our plans for service improvement.

The full survey will be available via the CQC site. The survey provides a vast amount of detail around complex issues. The Trust looks to take a balanced view on the overall picture, recognising that some of the lines of enquiry may appear contradictory. For example, the survey indicates we are in the best 20% of Trusts for staff not feeling pressures from work, and the worse 20% for staff suffering work related stress.

The areas we have prioritised for ongoing and further development work are as follows:

Stress within our workforce

It remains important for us to focus on this issue, especially in light of the range of change programmes we are pursuing. We have developed improved access arrangements to occupational health services. We have our own dedicated staff counselling services and we are making better use of this service to support staff whose services are undergoing change.

Staff appraisals

We will continue to focus our efforts to improve both the frequency and the quality of the appraisals and development plans for our staff. To support this we are introducing more simpler arrangements and procedures to ensure this can happen.

Training

We have an extensive training programme in place. During 2012/13 we reviewed all our training provision alongside a needs analysis of what was required to support our staff with the skills they needed to deliver high quality care. We introduced a new training prospectus that defines the training that should be provided to staff working in our different service areas. Through the next year we will continue to monitor how this is being delivered.

Annexe A

Statements from local networks, overview and scrutiny committees and Primary Care Trusts

Healthwatch

Healthwatch Sheffield is grateful for sight of the Sheffield Health and Social Care NHS Foundation Trust's Draft Quality Account for 2012-13 and welcomes the opportunity to provide comments.

These comments are based on the Draft 5 version of the Quality Accounts for 2012-13 dated 5 April 2013 and following a meeting with the Trust on 26th April. Paragraph and page numbers cited below refer to this version.

We felt that a regular dialogue throughout the Quality Account's production would be beneficial to all parties, and it was unfortunate this had not happened this year. We look forward to a productive relationship between SHSCFT and Healthwatch Sheffield in the forthcoming year.

We were surprised not to see a mention of the impact of the Francis Report (Mid Staffs) on the work and approach of the Trust. It was explained to us that the Trust felt this was not part of this Quality Report. However the Trust will include it in all their work and keep the service users up to date with changes made due to the Francis Report.

We were pleased to learn that two other versions of the full report would be made: an "Easy Read" version for certain groups of service users, and a more accessible version for the general public.

We felt that the review of priorities in 2012-13 and goals for 2013-14 (pages 5 to 17) was very clearly set out under a set of consistent sub-headings which helped understanding and commend the Trust on this.

Objective 1 (page 6): We look forward to learning how "assistive technologies" have helped to reduce falls in next year's report. Similarly we are pleased that the learning from the inpatient service improvement programme is to be applied to residential care services.

Objective 2 (page 8): Violence to staff. Where the term "lower level" is used we think an example would be useful. It would also be helpful to have some comparable data from other Trusts and with the national average.

Objective 3 (page 10): It is pleasing to see the progress made in respect of physical health. We would like to see a work stream on physical health and medication and suggest that the online screening tool could perhaps be extended to include medication.

Objective 4 (page 12): First contact with the Trust's services, It would be helpful to see the last 2 years data for comparison, rather than just the last year.

We welcome the new Crisis House service (page 13) and look forward to learning about it in next year's Quality Account. We hope the use of this facility will be on an emergency basis only as its capacity is small; long term needs of patients being catered for elsewhere.

Objective 5: We agree that it is regrettable that waiting times to access memory services have increased, We appreciate that those identified as emergencies must take priority for this service. Again it would be helpful to see 3 years data and also comparative data with other Trusts which would put the data into perspective.

We note the information on working in partnership with Sheffield Teaching Hospitals which is very positive for those patients with dementia. We would have liked to see mention of the Trust's work in partnership with Sheffield City Council as the Council has closed a dementia resource centre during 2012-13 and is planning to close a second leaving just one centre operational.

We are happy to see references to web links for further information but would also like to see how this information could be accessed in other ways.

Page 22 section 2.7: Participation in Clinical Research. It is good to see that research is playing an important role in the Trust. We assume that the Trust follows the NICE guidance in recruiting patients and staff to participate in research and feel this would be worth mentioning.

3.1 Safety (pages 29-32): We appreciate the space constraints and would like to suggest more detail could be offered via the website plus other means for those not connected to the web.

Sheffield LINk always asked Trusts to include information on **Patient Safety Alerts (PSAs)** in Quality Accounts. Therefore we are pleased to see (page 29) the action taken on the PSAs received during 2012-13.

We would also like to see reported in the Quality Account information on any **Coroners Rule 43 Requests** that were received by the Trust in 2012-13 such as the number of Requests received during the year, their subjects, the actions taken and status of the Trust in respect of each.

3.2 Effectiveness (pages 33-37): The tables are very clear and we found the use of symbols to indicate performance helpful. Again the last 2 years data would have been helpful. We are pleased to see some primary care indicators from the Clover Group of practices.

Complaints and compliments (page 38). It would be helpful to have information on the nature of complaints and the learning from them and action taken.

Service User Experience (page 40). We commend the Trust on its showing in the national patient survey for mental health trusts.

We are pleased about the new buildings and garden proposed for Longley Centre and how these will provide considerable benefit to patients as this has been an area of focus for the LINk/ Healthwatch Sheffield.

We would have liked to have seen included a report on the services at Woodland View Care Home as these are now run by the Trust.

Finally we are pleased to say that the Trust and Healthwatch have agreed to work jointly to improve awareness of each other's roles and that the suggestion of an article in the Trust's staff magazine on Healthwatch has been welcomed.

Mike Smith (Chair Sheffield LINk to March 2013)

Pam Enderby (Chair Healthwatch Sheffield)

9 May 2013

Our response

We welcome the helpful feedback from Healthwatch. As a result of the feedback we have been able to make some changes to the report to make it clearer. We have provided information about previous years performance when relevant and we have explained better some of the statements we have made. We have reduced the reference to web based sources of information by expanding further on some of the information provided in the main Report.

With regard to specific areas of feedback. It was always within our plans for physical health (Quality Objective 3) to recognise the important role of medication and the impact this can have on people's physical health. We have made clearer reference to the focus on this area in our on-going plans. Comparative information is provided within the report, for example where we report on rates of aggressive behaviour. Unfortunately we do not have comparable data for specific service waiting times, such as memory services. We have expanded on the areas of partnership work with the CCG and the City Council in respect of the development of services for people with dementia.

We have provided examples of the types of research we are mainly involved in, and examples of the learning and changes we have made following the conclusions from complaints or incident investigations. We have not had any Coroners Rule 43 Requests during 2012/13.

We welcome the opportunity to raise awareness of the role of Healthwatch during the next year. We will also be exploring with Healthwatch how we can maintain an on-going dialogue through the year to report on the progress we make over the next 12 months.

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

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee welcomes the opportunity to comment on the Trust's Quality Account.

The Committee is pleased to see the progress made against the quality priorities, although notes that at the time of consideration full year information was not yet available. From the information presented, progress against reducing harm from falls, and improving the identification and assessment of physical health problems in at risk client groups was notable.

We were reassured to hear that the significant increase in staff reporting incidents of violence and assault is due to improved staff awareness as a result of the staff development work that has been undertaken.

It was harder for the Committee to comment on the performance information relating to Quality Objective 4 – improving the experience of first contact with the Trust's services – due to figures being unavailable at that time. We look forward to seeing progress in this area over the coming year.

On Quality Objective 5 – improving access to the right care for people with dementia, the Committee has concerns around the length of time people are waiting to access the Memory Clinic. We share the Trust's ambition of reducing waiting times, and will be monitoring progress on this over the next year. We welcome the progress made on the 'Involving People with Dementia' Project, and suggest that the film produced as a result of the project is shared widely across the city. We offer our assistance in doing this.

The Committee is pleased to note the involvement of the Trust Governors and Service Users in the development of the Quality Account – and feels that this should be emphasised. We also feel that further emphasis could be given to the Trust's built environment, and work going on around Capital developments and improvements in the Quality Account.

In terms of presentation, the Committee welcomes plans to develop an easy read version of the final document. We would like to see where possible, trend information provided over a 3 year period. Including benchmarking and comparisons with other areas within the report would help to give a clearer picture of Trust performance. Consideration could also be given to including information about internal Trust structures and their contribution to quality development.

We look forward to working with the Trust over the coming year, and progressing the quality priorities further.

26 April 2013

Our response

We welcome the feedback from the Healthier Communities and Adult Social Care Scrutiny Committee. We have made a range of amendments to our Quality Report to incorporate the feedback provided to give a broader view on our progress in improving quality.

We share the Committee's concern regarding the length of time people have to wait to access our memory services. We have made good progress in previous years, supported by our Commissioner for the service Sheffield CCG. We will continue to progress options to make further improvements over the next year and will report on our progress during the year.

Sheffield Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group (CCG) has had the opportunity to review and comment on the information in this quality account prior to publication. Sheffield Health and Social Care NHS Foundation Trust has considered our comments and made amendments where appropriate. We are confident that to the best of our knowledge the information supplied within this report is factually accurate and a true record, reflecting the trust's performance over the period April 2012 – March 2013.

Sheffield Health and Social Care NHS Foundation Trust provides a range of general and specialised mental health, learning disability, substance misuse, community rehabilitation and primary care services to the people of Sheffield, 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.

Our overarching view is that Sheffield Health and Social Care NHS Foundation Trust continues to provide high quality services, which are underpinned by strong contractual performance. This quality account evidences that the trust has achieved positive results against its objectives for 2012-13 and highlights where further improvement has been identified for 2013-14. The CCG is in agreement with the trusts identified objectives for quality improvement (identified below) in 2013-14 and has used the 2013-14 CQUIN scheme to support the trust to deliver these priorities.

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

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

Quality Objective 3: To improve the identification and assessment of physical health problems in at-risk client groups.

Quality Objective 4: To improve the experience of first contact with the Trust's services.

Quality Objective 5: To improve access to the right care for people with a dementia.

Moving forward into 2013-14 the CCG will build on existing good clinical and managerial working relationships to progress the development of initiatives that will drive for quality and deliver the required levels of efficiency.

9 May 2013

Our response

We welcome the feedback from Sheffield Clinical Commissioning Group. We have made a range of amendments to our Quality Report to incorporate the feedback provided to give a broader view on our progress in improving quality.

We are pleased that we have a broad agreement on the areas and priorities that need improving. The use of the CQUIN scheme to incentivise progress in the same areas is a positive reflection of this.

We look forward to delivering further benefits and improved outcomes with the support of our main health commissioner, alongside agreed efficiency improvement programmes.

Annexe B

2012/13 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 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:

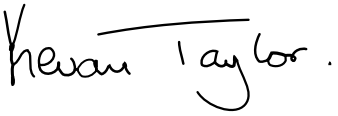
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from Sheffield City Councils Healthier Communities and Adult Social Care Scrutiny Committe dated 26 April 2013;
- Feedback from the commissioners dated 3 May 2013;
- Feedback from governors dated 25 April 2013;
- Feedback from LINks/ Healthwatch dated 9 May 2013;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2012;
- The [latest] national patient survey issued in 2012;
- The national staff survey issued February 2013;
- The Head of Internal Audit's annual opinion over the trust's control environment dated 28 May 2013; and
- Care Quality Commission quality and risk profiles issued monthly during 2012/13;
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice; and
- 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 www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at 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

Chairman

28th May 2013



Chief Executive

28th May 2013

Annexe C

Independent Auditor's Report to the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust to perform an independent assurance engagement in respect of Sheffield Health and Social Care NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital;
- Admissions to inpatient services had access to crisis resolution home treatment teams; and

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- The Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's 2012/13 Detailed Guidance for External Assurance on Quality Reports; and
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from Sheffield City Councils Healthier Communities and Adult Social Care Scrutiny Committee dated 26 April 2013;
- Feedback from the Commissioners dated 3 May 2013;
- Feedback from local Healthwatch organisations dated 9 May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2012;
- The national patient survey issued in 2012;
- The national staff survey dated February 2013
- Care Quality Commission quality and risk profiles issued monthly during 2012/13; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 28 May 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting Sheffield Health and Social Care NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sheffield Health and Social Care NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- Making enquiries of management
- Testing key management controls
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sheffield Health and Social Care NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- The Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's 2012/13 Detailed Guidance for External Assurance on Quality Reports; and
- The indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

KPMG LLP, Statutory Auditor

Leeds

29th May 2013