Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

QUALITY ACCOUNTS
2013 – 2014

Contents

Part 1: Quality Account 2013/14 Chief Executive's welcome

I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Account for 2013/14.

This Quality Account is our way of sharing with you our commitment to achieve better outcomes and deliver better experiences for our service users and their carers. We will report the progress we have made against the priorities we set last year, and look ahead to the areas we will continue to focus on for the coming year.

Our vision is to be recognised nationally as a leading provider of high quality health and social care services and recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. We will be the first choice for service users, their families and Commissioners. 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 2013/14.

There is also significant potential to deliver improvements in quality by focussing on improvements within the day to day care and support we provide. Our on-going 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.

During this year we have prioritised 2 major development programmes that will help us to continue to improve quality in the future:

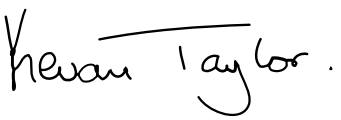
- Making resources available to support frontline clinical teams and our support services to effect quality improvement locally using evidence based methods;
- Improving how we involve people who use our services and better understand their experiences, so we can make better choices about what we want to improve.

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 Annexe 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

Part 2A: A review of our priorities for quality improvement in 2013/14 and our goals for 2014/15

We established our priorities for quality improvement in 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 2 year plan to deliver improvements.

In order to establish these areas as our priorities the 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 will show the progress we have made over the last 2 years. We will then confirm what new priorities have been identified for the future.

In reviewing our progress over the last 2 years 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 300 of our members about our priorities for the future. 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 and Healthwatch.

Our priorities for this year are:

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 peoples quality of life and well-being.

The National Falls and Bone Health Audit in 2011 showed that during 2010/11 falls were higher in the Trust's older people's in-patient areas than the national average rate of falls. 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 NHS Sheffield Clinical Commissioning Group who incentivised improvement in this area under the CQUIN scheme *(see page 20)*

We said we would

Introduce a 2 year plan that started in 2012/13 and continued 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 in-patient areas;
- Carry out environmental falls risk assessments in all in-patient 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 15%;
- 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 in-patient areas will be assessed to see if they are vulnerable to experiencing a fall.

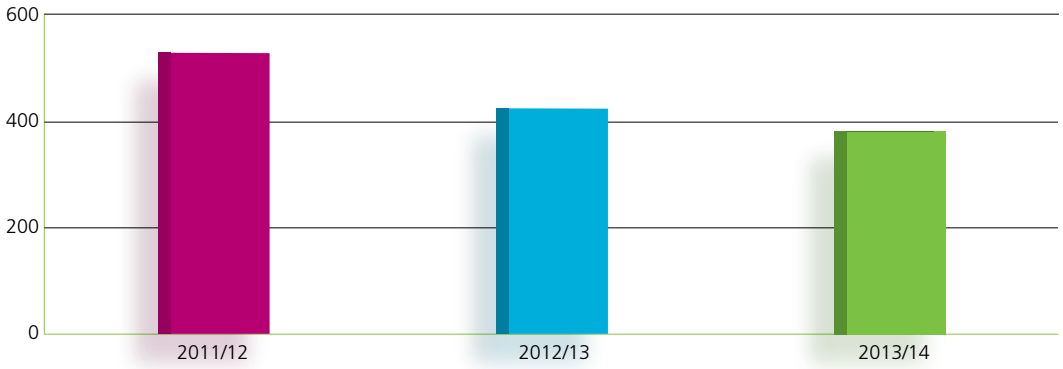
Clive Clarke (Deputy Chief Executive) at Sheffield Wellbeing Festival

How did we do?

We have made really good progress and the amount of harm is being reduced. We have introduced screening for falls within 72 hours of admission, Personal Falls Plans and improved assessment of our building environments for falls hazards. We have supported our staff through better training and have introduced Assistive Technology to reduce falls where needed (for example, using alarms and sensors in beds and chairs).

In 2011/12 there were 516 falls that resulted in harm. We wanted to reduce that by 15% to 439 during this year. The number of falls resulting in harm has reduced by 25% to 387 this year.

Service User falls that resulted in harm last 3 years



The severity of the harm experienced by people is also reducing:

How many people	2011/2012	2012/2013	2013/2014
Needed to attend hospital or A&E	62	52	52
Experienced minor harm	116	90	69
Experienced moderate harm	17	17	14
Experienced major harm	1	0	1

The numbers of falls that caused harm have reduced which is really positive. However, this has been influenced by the reduction in the amount of care we are providing in residential type services. As we have developed better community services we have had less need for in-patient or residential type support services. The amount of bed based care we have delivered has reduced by around 11% over the 2 years. Within our older people's services the reduction has been around 40%.

How will we keep moving forward?

We will ensure people admitted to our older adult wards are assessed for risk of falling and monitor this effectively.

We will continue to support practice improvement and awareness raising across our residential services.

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

We chose this priority because violence is not usual in our services. Most people's experience of care is safe and positive. However, sometimes people are agitated, distressed or scared and can behave aggressively. 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 in-patient 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. 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 that 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 service users, relatives or the public.

We said we would

Introduce 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 2013/14 our plans were 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 programme of practice reviews focussing on seclusion, de-escalation, physical health monitoring, post-incident reviews, use of green rooms;
- Undertake a review of staff experiences of delivering care and how we can better support them to deliver respectful and compassionate care.

The outcome we wanted to achieve was

- All in-patient nursing and support worker staff had been trained in RESPECT;
- Reduce the use of seclusion and restraint;
- Increase the percentage of service users in acute wards who report experiencing a safe environment in local surveys;
- 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 improvements for the longer term. Over the year the data is varied in what it shows across the different indicators.

The use of seclusion has increased significantly over the last year when we wanted it to decrease. The incidents are mainly within our Psychiatric Intensive Care Unit. We have reviewed this throughout the year and the Board's Quality Assurance Committee is assured that the high increase is a reflection of changes to service user needs and the way we are delivering care:

- We are seeing more people in Sheffield. In previous years we sent over 30 people a year to other hospitals when they were acutely distressed. Now we are seeing them in Sheffield, which is a positive improvement. As we care for more acutely ill and distressed people our use of seclusion has increased;
- We opened our new service for people with a learning disability in April-May (see page 41). During this time we cared for some people in our Psychiatric Intensive Care Service while waiting for the new service to open. The environment was not as well equipped as our new service for people with a learning disability and challenging behaviours. The individuals on the ward needed caring for in a low stimulus environment for periods of time;
- Overall, we are caring for more people who have more complex needs. The current ward environment is not best suited for the care of this vulnerable client group. The service has limited options for supporting service users in low stimulus environments.

In response to this we have agreed plans (see overleaf) that focus on practice development and a clear commitment to improve the ward facilities and environment.

Our development approach has been to work extensively with service users. We have worked with Maat Probe in support of their campaign for RESPECT, and they now commend our approach to other services. We have developed our training programmes in partnership with our service users who directly train our staff in RESPECT.

The RESPECT programme continues to be implemented as part of ongoing practice. We have successfully trained all our staff. This 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 that this is the main reason why reported incidents of violence towards staff has been increasing (see rows 4 and 6 below). 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 (see row 5 below).

Incident type	2011/12	2012/13	2013/14
Incidents reported where service users had been			
• Secluded	82	74	276
• Restrained	105	90	178
• Assaulted	387	388	381
• Caused harm from assault	89	72	73
Proportion of all reported service user incidents related to disruptive or aggressive behaviour			
• Within our Trust	15.5%	18.6%	19.3%
• National averages for mental health Trusts NPSA Benchmarking data	19%	17.4%	17%
Percentages of service users who report feeling unsafe in local surveys	25%	34% July 23% Dec	29% Aug 25% Mar
Incidents reported where staff working in inpatient services			
• Had been assaulted	364	606	592
• Caused harm from assault	110	99	108
Level of harm caused from the assault			
• Negligible harm	91	68	88
• Minor or moderate	19	31	20
• Major and above	0	0	0
Number of staff who reported to the national CQC staff survey that they had experience from service users, relatives or visitors			
• Physical violence	17%	22%	26%
• Harassment, bullying or abuse	19%	30%	34%

This is a complex issue to report on. Overall the reported incidents increased last year, but the majority of the incidents resulted in no harm or insignificant/negligible harm. Our conclusion is that this is a positive position for our services indicating that violent incidents are unusual. We will continue our development in this area by continuing with the RESPECT programme.

How will we keep moving forward?

We have developed a multi-disciplinary group that will take an overview of seclusion use in the Trust and will develop a strategic response that will aim for a reduction in use overall.

The Board has recognised the role and importance of the ward environment, and the need to improve our current service. The Board has approved an investment of £6.4 million to build a new Intensive Treatment Service ward.

We will continue with the successful RESPECT development programme.

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 a learning disability 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

Continue our current plans to bring together achievable actions within the Trust and external to partner organisations. We planned to build on existing and planned developments to ensure that we and our partner organisations work collaboratively to ensure the 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 among 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.

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 people's smoking circumstances with appropriate support provided;
- Diabetes link nurses in all in-patient 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 Quality Outcome Framework (QOF) targets on physical health checks for dementia and BMI for people with psychosis.

How did we do?

We have made progress across all our development areas. A summary is provided below:

Smoking – We have improved the way we gather information about if people smoke and have encouraged staff to be more proactive about this. We have piloted a new project, to reduce smoking in people with serious mental illness, in one of our Community Mental Health Teams. This has involved working alongside Sheffield Right First Time and Sheffield Stop Smoking Services. A report on the outcomes from this pilot will be published.

Memory Service

Alcohol - The Alcohol Screening Tool that we have developed is now incorporated into the citywide Hidden Harm Protocol as the standard for identification, intervention and onward referral of those affected by alcohol misuse. The Hidden Harm Protocol is intended to protect vulnerable children whose parents are affected by substance and alcohol misuse. We are pleased with the success we have had in promoting increased access across Sheffield to advice and screening for alcohol use. We now plan to focus more on raising awareness within our own services.

Obesity - Following the appointment of a dietician, further resources were identified to support the appointment of an assistant dietician. Considerable improvement has taken place through the work of the nutritional strategy implementation group. An e-based version of the malnutrition universal screening tool (MUST) tool and associated training, has been implemented across most of the in-patient areas with plans to roll out to the rest of the services in 2014/2015. We have improved the quality of diet available and the experience of dining within residential services. Advice on diet is being made readily available including improved methods for measuring and recording hydration of vulnerable individuals.

Diabetes – We have continued to develop the role of our Physical Health Leads. This has led to an improvement in competency of staff in the use of related equipment and we are better able to respond to the needs of service users. A wide range of training programmes have been developed and are being implemented that contain diabetes related skills and knowledge, including Recognising and Assessing Medical Problems in Psychiatric Settings (RAMPPS), Foot Care, Physical Assessment, Apprentice Programmes.

Dental – We have developed links and joint working with the Dental Public Health Service. Initial work is being undertaken to identify a research proposal aimed at examining and improving the link between mental health and dental health services. Training programmes are being developed in partnership with Sheffield Teaching Hospitals NHS Foundation Trust in oral health care and will be available during 2014/15.

Physical health checks - The recording of physical health assessment has improved across our in-patient services, with a plan to address shortfalls in place. Revised protocols for the use in malnutrition universal screening tool (MUST), falls, patient safety thermometer, and the introduction of local audits in a number of areas, has improved the ability to provide accurate audits that feed into local governance. While this is positive, we recognise that we have much more to do to support people with their physical health needs across all of our services.

How will we keep moving forward?

We have a strategy in place that will continue to direct our work in improving people's physical health. We will confirm our annual development programme, which will outline the work we will be focussing on next year.

We have prioritised on-going improvements for physical health care and support as 1 of our Quality Objectives for next year.

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 service user survey for questions about a 24 hours 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 Mental Illness (MI). We were keen to learn from the pilot and provide on-going 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

- 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 Improving Access to Psychological Therapies (IAPT) Service (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).

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;
- Reduce the waiting times experienced by people to access services.

Daleside Ward

How did we do?

We have made positive progress with the provision of helpline support for service users. We opened a new Crisis House service, in partnership with Rethink MI, in April 2013. It has provided support to around 300 people a year as an alternative to needing hospital care. As part of Crisis House service Rethink MI also provide the crisis helpline service for our service users. During 2013/14 the crisis helpline received over 8,500 calls, which reflects how well it is being used.

All in-patient staff have benefited from the RESPECT development and training programme, 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	2011/12	2012/13	2013/14
Awareness of crisis support available through telephone helpline (National Patient Survey)	5.0 out of 10	5.3 out of 10	n/a see note
Ensure all in-patient staff have benefited from RESPECT development programme	155 staff	Extra 209 364 in total	Extra 332 (all trained)
Service users reporting they are treated with respect (National Patient Survey)	9.5 out of 10	9.4 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 have successfully recruited a team of service users to help us introduce the 15 Steps Challenge programme. This approach helps us to understand people's feelings and experiences of entering services for the first time. We have piloted this on 2 wards, and will be rolling it our across services next year.

During the year we wanted to reduce the waiting times for key services. We have made good progress within our IAPT Service and across our adult Community Mental Health Teams.

During the year we introduced a range of improvement approaches to 8 identified GP practices where patients were experiencing the longest waiting times for IAPT Services. Through better team working with primary care services and the introduction of simpler booking systems we have seen a really positive improvement. People are now able to access advice and support and start treatment much earlier than previously. As the year progressed waiting times have improved significantly (see row 2 below).

During 2012/13 we changed the way we organised our adult Community Mental Health Teams. One of the main reasons for this was to reduce waiting times by working more closely with primary care services. As the new services have been established during 2013/14 we are pleased to report that waiting times for assessments have significantly improved and we have made progress in reducing how long people have to wait overall. However, we want to make further improvements and to see more people within 2 weeks – which we did not manage to improve significantly over the last year.

To reduce waiting times	2012/13	2013/14
Average waiting time to access IAPT Services for treatment	5.6 weeks	5.3 weeks
Average waiting time to the 8 Practices with the longest waiting times	14.2 weeks	6.8 weeks annual average 3.7 weeks for the 2nd half of the year
Average waiting times for people to be assessed for a routine appointment within Community Mental Health Teams	10.9 weeks	6.1 weeks
Proportion of people referred to Community Mental Health Team services for a routine assessment who were assessed within 2 weeks of referral	23.8%	24.6%

How will we keep moving forward?

We will continue to roll out the 15 Steps Challenge programme.

We have prioritised further improvements in reducing waiting times as a Quality Objective for next year and will report on progress in future reports.

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, NHS 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 Sheffield 63.6% of the expected number of people with a dementia have been registered, compared to the national average of 44.2%. In 2013 this had increased to 68.1% and 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 Service a specific dementia care pathway has been developed because of the increased risk of early dementia in people with Down's Syndrome.

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

We said we would

- Recognise the clear disparity in waiting times for people needing to access our Memory Services compared to other routine services we provide. To address this we planned to review the options to deliver real improvements in waiting times for our Memory Services and confirm the targets we wish to deliver upon. We agreed to report on this in next year's Quality Account, along with the progress we have made;
- 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.

The outcome we wanted to achieve was

- Support over 900 people with memory assessments, and reduce service waiting times from 14 weeks;
- Establish a reliable baseline for the number of people with a learning disability receiving memory assessments;
- Evaluate experience through service user and carer experience surveys for people receiving dementia services from the Memory Service;
- Establish reliable baseline figures for people from different black and minority ethnic groups use of dementia services.

How did we do?

Over the last year we have not made the progress we wanted to in reducing waiting times for people to access our Memory Services.

Working with our Commissioner and primary care services in Sheffield we have delivered many improvements over the last 2 years.

Over the last 3 years we are seeing more people, and more people are being diagnosed and are receiving help and support than the national average. We have achieved this through a range of service improvements.

When compared to other Clinical Commissioning Groups in England and Wales Sheffield ranks 2nd for its diagnostic rate performance in 2013. So overall more people are accessing support and treatment in Sheffield than elsewhere – however people are having to wait to access support longer than we would want them to.

Access	2011/12	2012/13	2013/14
Number of people assessed and diagnosed by the service	876	846	884
Waiting time to access an assessment	14 weeks	15.4 weeks	15.8 weeks

We have been working hard with our Commissioners to agree the best way forward – so that we can continue to see more people and see them quickly.

Following development work during the year, and testing new approaches to provide follow up support in primary care rather than in our specialist clinics, we have agreed a new model with our Commissioners. Jointly we feel this is the best way forward for the people of Sheffield. We plan to:

- Continue to see more people for assessments and treatment in our specialist centres;
- Provide follow up support and reviews in partnership with primary care services, reducing the need for people to travel across Sheffield for their check ups.

We will finalise our agreements about how this is to be implemented.

We have established an aim to ensure people are able to access services for an assessment within 6-8 weeks during 2015/16 after all our changes have been introduced.

We have made good progress in developing innovative ways to better understand the experiences of people with dementia.

The Involving People with Dementia Project has been successful. We have developed a range of methods and approaches to gather feedback on people's experiences, such as gaining real time feedback, observational exercises, small group work using peer feedback. We are using these approaches to ensure we have an on-going awareness of people's experience, and use this knowledge to identify areas where we can make improvements.

The Voice of Dementia film has been a positive and exciting resource that we have developed. It is now used as an educational resource that promotes discussion and awareness raising about people with dementia and their ability to have a say about their lives. It is being used to support training of staff in Sheffield Teaching Hospitals NHS Foundation Trust and within the voluntary sector in Sheffield.

How will we keep moving forward?

We have agreed a development plan for service change with our Commissioners. The aim of this plan is to help us see more people and see them quickly. We will implement this plan during 2014/15 and report on progress in our future reports.

We have prioritised reducing waiting times over the next year as one of our Quality Objectives for the next year. We will continue to report on the experience of waiting times for Memory Services as part of this objective and our progress towards achieving our aim of waiting times of 6-8 weeks.

Our quality goals for next year

We consistently fare well compared to other Trusts in service user surveys, staff attitude surveys and reports from our regulators. The rest of this Quality Account report supports this view. Many of our services have been visited and evaluated by the Care Quality Commission. We consistently receive feedback highlighting that the care they observed was person centred and dignified. When they have identified areas we need to address we have taken action immediately.

Following concerns identified by Trust Executives and senior managers regarding 2 of our residential/ supported living homes for people with a learning disability we undertook a comprehensive review of culture and practice across all of our residential and supported living homes. The review looked at: management and leadership (including financial management), working practices, the service culture/ethos, the experience of service users and their families, and the overall quality of care. Areas of weakness in how care and support were being provided to people were identified and in a number of areas standards were below what we would expect to see. We have taken immediate action to address all such areas of concern. We fully acknowledge the need to ensure an individualised approach to each person's needs and we are continuing with a detailed programme of continuous quality and service improvement including enhancing the senior operational and clinical leadership of residential and supported living Learning Disability Services.

Overall we are a high performing organisation. We perform well in delivering the national standards asked of us across our services for primary care, learning disability, substance misuse and mental health. As we plan for the next 2 years there are no areas of concern identified from our on-going engagement with our regulators, Commissioners or our performance against the national standards required of us that indicate we need to prioritise improvement action.

Following the publication of the Francis report the Board of Directors undertook a review of our culture. The review was carried out with our staff, our clinical leaders and benefited from input from external experts in the field of compassionate care.

The Board concluded that our culture is very different from those organisations reviewed in the national reports. But we are not complacent. We operate in the same context and are subject to the same external pressures that contributed to the failings in those organisations and these are difficult times. Delivering high quality health and social care is becoming more complex and more challenging. Demand for services is increasing and we are currently operating in an environment of reduced public sector spending. Delivering high quality care in this environment is a challenge we are determined to meet.

We have a culture in which, should poor care take place, it is recognised and reported. We do know that we have instances when care is not at the standard we would wish for our friends or families. We are therefore keen to learn whatever lessons we can from such instances to improve the quality of what we do.

We have taken this opportunity to revitalize our commitment that the people who use our services are at the heart of everything we do.

We will ensure the successful delivery of our commitments to:

- Express more clearly and make real our commitment and expectations that service users are at the heart of all that we do;
- Strengthen service user feedback and engagement;
- Increase our openness and transparency;
- Strengthen staff engagement;
- Continue to develop engaging leadership at all levels;
- Enhance our governance processes;
- Develop the role of our Governors;
- Work in partnership with our Commissioners.

We have worked with our Governors to understand their views about what will make the most difference to improve the experience of people who use our services.

Our Governors surveyed the Trust's membership about our developing priorities and we received responses from over 300 members. Through a workshop and surveys our Governors have told us that we should focus on the following areas:

- To continue to support staff to have an appreciation and awareness of what it is like to receive care. This includes strengthening the culture of the organisation and our workforce, along with improving how we gather feedback about people's experiences. We have agreed objectives that will improve how we do this through monitoring service user experience, led by service users, alongside better workforce development that involve service users in the delivery of training to our staff;
- To continue to improve how quickly people can access support and care. This includes waiting times generally, access to preventative support and support during times of crisis. Feedback also highlighted that we should give attention to what happens when people receive care and support from different teams and reduce the amount of repeated assessments that people undergo. We have agreed a number of objectives that focus on reducing waiting times in key areas. We will review care pathways to simplify arrangements and reduce duplication for service users;

Opening of the new Intensive Support Service at Firshill Rise

- To prioritise our initiatives that are about freeing up staff time so they can spend more time providing direct care and support. There was a concern that we should ensure we have the right numbers of staff working within teams, particularly within our in-patient services. We will review our staffing levels across services and report on what we believe they should be and then monitor our delivery against those standards. We will work with teams to support them to review how they work and report on how we have reduced unnecessary bureaucracy as a result of this.

Our quality objectives for the next 2 years

We have reviewed the progress we have made over the last 2 years. We have made good progress in reducing falls that result in harm, and in improving the experience for service users and staff in relation to violent incidents and the use of seclusion. Practice and standards of care have improved. On-going development work will ensure the improvements are sustained and further gains are made. As we look to the next 2 years we plan to focus our priorities for improvement in the following 3 areas:

1. Responsiveness: We will improve access to our services so that people are seen quickly.

Why have we identified this?

- When we met with our Governors this was a key area of concern for them. They wanted us to ensure that people are seen quickly when required;
- Improving access is an area prioritised by our Commissioners and they are supportive of improvement and service reconfigurations to help us achieve this;
- We have already identified areas we wish to improve, and reduce the time people are having to wait. We have made some progress, but not as much as we would want to;
- We have identified the IAPT Service, our Community Mental Health Teams and our Memory Services as key areas in which to deliver improvements.

2. Safety: We will improve the physical health care provided to our service users.

Why have we identified this?

- As we have developed our plans our clinicians have told us this was a key area they wished to focus on to deliver improvements;
- It is a key priority across health and social care in Sheffield to help deliver improved outcomes and achieve a reduction in the gap in life expectancy for people with serious mental health illnesses and people with a learning disability;
- We know from reviewing progress against our Physical Health Strategy and national audits that we have further improvements still to make.

3. Experience: We will establish the Service User Experience Monitoring Unit to drive improvements in service user experience across the Trust.

Why have we identified this?

- Understanding the experiences of the people who use Trust services is essential if we are to be successful in achieving quality improvement:
- During this year we held a successful stakeholder event with service users and our public Governors to look at how we are involving service users – and make plans for how we want to do it better as we move forward;
- When we met with our Governors to look at priorities for next year they told us that we should continue to support staff to have an appreciation and awareness of what it is like to receive care and to improve how we gather feedback about people's experiences.

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

The Board, through its Audit and Assurance Committee, commissioned an Internal Audit review of our assurance processes. The aim of the review was to assess the effectiveness of the Board's arrangements to gain assurance on progress against the following 4 themes:

- Engagement on quality;
- Gaining insight and foresight into quality;
- Accountability for quality; and
- Managing risks to quality.

The review identified no high risk issues, and recommended that we finalise arrangements for the following:

- To finalise the review and re-launch of our overarching Quality Strategy;
- To satisfy itself that the Trust's arrangements for ensuring data quality provide appropriate assurance;
- To review the availability of national and local benchmarking information has been adequately assessed and is used where appropriate;
- To improve the effectiveness of its clinical audit function by implementing its improvement plan for audit.

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 2013/14. 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 2013/14 we de-registered Rutland Road (a respite care service for people with a learning disability) and Bolehill View (a respite care service for people with dementia) from our registration, as a result of the services moving to other locations.

We registered 136 Warminster Road as a respite care service for people with a learning disability.

Planned/Unplanned reviews

During 2013/14 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
  Cottam Road, Birch Avenue, East Bank Road, Beighton Road;
- Residential homes for people with dementia
  Woodland View;
- Respite Care services for people with a learning disability
  Longley Meadows, 136 Warminster Road;
- Respite Care services for adults
  Hurfield View, Wainwright Crescent;
- In-patient Services
  Forest Lodge;
- Supported Living services for people with a learning disability
  Mansfield View.

All services inspected were fully compliant with the exception of Beighton Road, Cottam Road and Mansfield View, where compliance actions were received for:

- Records *(Beighton Road, Cottam Road, Mansfield View)*;
- *Supporting Staff (Mansfield View, Cottam Road).*

Following the feedback received from the CQC we have taken immediate improvement actions and are awaiting repeat inspections by the Commission to confirm that we are fully compliant with these standards.

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

We also participated in a survey regarding places of safety. The results from this national survey will be published on the Commission's website.

Mental Health Act reviews

During 2013/14 the CQC has undertaken 10 visits to services to inspect how we deliver care and treatment for in-patients detained under the Mental Health Act. They review our processes for care, the environment in which we deliver our care and meet privately with in-patients. They have visited the following services:

- Michael Carlisle Centre
  Stanage Ward;
- Longley Centre
  Hawthorn, Intensive Treatment Service
  Maple, Rowan;
- Forest Close
  Bungalows 1, 1A, 2, 3;
- Grenoside Grange
  G1
- Assessment and Treatment Unit

We have also participated in a review of how we manage Community Treatment Orders.

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, inspections and feedback confirm that we continue to meet all essential standards.

2.2 Monitors' Assessment

Monitor reviews our performance and publishes a quarterly assessment on how we are doing. This information is available at *http://www.monitor-nhsft.gov.uk*.

The governance assessment (rated as either red or green) is based on the Trust's self-declaration by the Board of Directors alongside Monitor's own assessment of how we are performing. In considering this Monitor considers the following information:

- Our performance against national standards;
- CQC views on the quality of our care;
- Information from third parties;
- Quality governance information;
- Continuity of services and aspects of financial governance.

The tables below feature our ratings for the last 2 years.

2012/13 Governance assessment of our performance

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial Risk Rating	4	4	5	4
Governance Risk Rating	Green	Amber/ Green	Green	Green

Note: During 2012/13 Monitor assessed performance under the Compliance Framework

2013/14 Governance assessment of our performance

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial Risk Rating	5	5	n/a	n/a
Continuity of Services Rating	n/a (4)	n/a (4)	4	4
Governance Risk Rating	Green	Green	Green	Green

Note: During 2013/14 Monitors' assessment framework changed to the Risk Assessment Framework in Quarter 3. The Financial Risk Rating was replaced by a Continuity of Services Rating. To help with comparisons we have shown what we would have been in Q1 and Q2 under the new framework.

2012/13

We 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 in-patient 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.

2013/14

The Trust's performance overall was assessed as Green for the year. This means that there were no evident concerns regarding our performance.

We did experience challenges in delivering 1 of the national indicators during the year. Our provision of annual care reviews for people whose care was delivered under the Care Programme Approach was not at the standard it should have been. We aimed to have ensured 95% or more of people under the CPA had received a review of their needs within the year. At the end of the 2nd and 3rd quarters we only achieved this for 89% of people. We introduced a range of changes that were focussed on:

- Reducing the need to have to re-organise planned care review meetings;
- Reviewing people more frequently than every 12 months.

This enabled us to make improvements and we achieved the target by the end of the year.

2.3 Goals agreed with our NHS Commissioners

A proportion of our income in 2013/14 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 (CQUIN) payment framework.

For 2013/14 £1,814,117 of the Trust's contracted income was conditional on the achievement of these indicators. We achieved all the targets and improvement goals that we agreed with our Commissioners. Therefore we received 100% of the income that was conditional on these indicators. For the previous year, 2012/13, the associated monetary payment received by the Trust was £1,639,911.

A summary of the indicators agreed with our main local health Commissioner, NHS Sheffield Clinical Commissioning Group for 2013/14 and for next year is shown below.

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	Goal during 2013/14	Continued into 2014/15
NHS Safety Thermometer Improve collection of data We wanted to monitor incidents of pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE. This was to ensure we were effectively monitoring safety. We agreed improvement targets to reduce incidents of falls and achieved them.	✓ Fully Achieved	✓
Reducing variation in waiting times for patients referred to the IAPT services We identified 8 GP Practices where people were experiencing very long waiting times to access our IAPT services. We wanted to reduce the waiting times from an average of 15 weeks to below 10 weeks for these 8 Practices. We were very successful with this. Waiting times reduced to 4.5 weeks for the period September 2013 to March 2014. Next year we will continue to work to reduce waiting times.	✓ Fully Achieved	✓
Reduced admissions to Acute Older Adult Wards through improved community care 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 gradually reduce the numbers of people who needed hospital care. We were successful with this goal. As a result of providing better community services the need for hospital care reduced by 36% this year compared to 2 years ago.	✓ Fully Achieved	**No** We have made the progress we wanted to. Routine monitoring will continue
Reduction in the number of falls causing harm This goal supported our Quality Objective 1. We successfully achieved our target of reducing harm caused from falls by 15% over the last 2 years. This has been achieved with incidents of harm reduced by 25% (See page 5 for details).	✓ Fully Achieved	**No** We have made the progress we wanted to. Routine monitoring will continue
Improving the management of Violence and Aggression within in-patient services This goal supported our Quality Objective 2. The focus was to improve the service user and staff experience in relation to violence and aggression. We implemented a successful development and service improvement programme (See page 7 for details).	✓ Fully Achieved	**No** We have made the progress we wanted to. Routine monitoring will continue

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	Goal during 2013/14	Continued into 2014/15
People using mental health services should have an agreed plan to help reduce and manage the person's risk We wanted to increase the numbers of service users who had risk reduction plans in place following their initial risk assessment. We achieved the target and by the end of this year 78.2% of people receiving on-going mental health care support had a risk reduction plan in place.	✓ Fully Achieved	**No** We have made the progress we wanted to. Routine monitoring will continue
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 for the number of people we would see for assessment within 2 weeks of the referral being made. We were successful with this.	✓ Fully 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. By the end of the year 77.7% of people had a care plan agreed within 6 weeks.	✓ Fully Achieved	✓
Improved use of electronic discharge communications between in-patient services and GPs During the year we introduced ways to send GPs information about a service user's care plan electronically rather than through the post. We piloted this and had a successful system in place by the end of the year on the pilot wards. This has improved the way we let GPs know about the arrangements for someone's care and treatment when they leave hospital. Next year we will complete its development and extend this to all wards.	✓ Fully Achieved	✓
Improved and standardised approaches to surveying service user experiences across all service areas We improved the way we asked people about their experience of the care and treatment we provided them. We introduced the Friends and Family Test as a pilot in some of our in-patient and community services	✓ Fully Achieved	✓
Introducing the Friends and Family test for service users and staff This new national CQUIN indicator will be introduced next year. It will help us get better feedback from the people who use our services, and our staff, about the quality of the care we are providing. This will help us make better choices about what we prioritise for improvement in the future.	No	✓
Improving physical healthcare to reduce premature mortality in people with severe mental illness This new national CQUIN indicator will be introduced next year. It will focus on improving the way we provide support for peoples physical health care needs in conjunction with primary care services.	No	✓

The table above summarises the goals that we agreed with our Commissioners, and the progress that we made. Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at www.shsc.nhs.uk.

2.4 Review of services

During 2013/14 SHSC provided and/or sub-contracted 52 services. These can be summarised as 43 NHS services and 9 social care services. The income generated by the relevant health services reviewed in 2013/14 represents 100% of the total income generated from the provision of the relevant health services by the Trust for 2013/14.

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 NHS Sheffield Clinical Commissioning Group, other Clinical Commissioning Groups, Sheffield City Council and other NHS Commissioners.

The Trust has agreed quality and performance schedules with the main Commissioners of its services. With NHS Sheffield Clinical Commissioning Group 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 2013/14.

South Yorkshire Fire and Rescue

During 2013/14 the South Yorkshire Fire and Rescue service visited and audited 2 of the Trust's premises. These were Forest Lodge, one of our in-patient services, and Woodland View, one of our residential homes. No notices regarding improvement actions were issued by the Fire service following these inspections.

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 former risk management standards cover organisational, clinical, non-clinical and health and safety risks.

The Trust was last assessed in March 2013 and was deemed to be compliant at Level 1 with the standards. Since then, the NHSLA has made changes to its processes and is now using individual claim history to assess Trusts. We are still awaiting further information as to the likely impact this will have for us.

2.7 Participation in clinical research

The number of service users receiving relevant health services provided or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust in 2013/14 who were recruited during that period to participate in research approved by a research ethics committee was 822.

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

The Trust was involved in conducting 60 clinical research projects which aimed to improve the 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:

- 10 centre randomised controlled trial of an intervention to reduce or prevent weight gain in schizophrenia (NIHR funded, SHSC is the sponsor and lead Trust);
- Stigma and discrimination aimed at mental health service users;
- DNA polymorphisms in alcohol misuse and schizophrenia;
- 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 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, efficiency and initiate innovation. Over the last year the Trust has worked closely with the East Midlands and South Yorkshire Mental Health Research Network and South Yorkshire Comprehensive Local 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.

2.8 Participation in Clinical Audits National Clinical Audits and National Confidential Enquiries

During 2013/14 4 national clinical audits and 3 national confidential inquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

During 2013/14 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 (re-audit) - To measure the Trust's performance against national NICE guidelines	200	100%
POMH UK		
Prescribing for ADHD (Topic 13) - To ensure service users with ADHD cared for in accordance with NICE guidelines	45	100%
Prescribing antipsychotics for people with dementia (Topic 11b) - To ensure national guidance are followed	33	100%
Prescribing anti-dementia drugs (Topic 4b) - To ensure national guidance are followed (Note 1)	Note 1	tbc
National confidential inquiries		
Inquiry into suicide and homicide by people with mental illness	16	30% (Note 2)
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 2)

Other local audit programmes		
Falls audit – To support the CQUIN scheme, see 2.3	31	n/a
Patient and staff safety - To support the CQUIN scheme, see 2.3	165	n/a
Patient safety thermometer - To support the CQUIN scheme, see 2.3	261	100%
NHS LA Care Records - To ensure risk assessment documentation is adhering to guidelines (Note 1)	Note 1	n/a
Suicide Audit - An audit in Community Teams of the NPSA suicide toolkit	7	100%
Food and nutrition – To ensure that in-patients are being screened for nutrition on admission and discharge	118	n/a
Safeguarding children and adults - A baseline audit of staff knowledge	480	n/a

Note 1: This audit commenced during 2013/14 but did not conclude until the following year. We will publish the findings in next year's Quality Account report.

Note 2: 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. ie in 70% of all inquiries, we had no record of having had prior involvement with the individual concerned.

The reports of 4 national and local clinical audits were reviewed by the Trust in 2013/14 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** – The audit findings have yet to be published. We know we need to improve and get better at monitoring of physical health. **The actions we have taken are:** To be confirmed when the audit findings are published.

Prescribing for people with ADHD	**Results** – We need to improve the range of information we gather to understand the needs of the service users we provide support for. **The actions we have taken are:** We will improve the information and educational support we provide to service users about medication and their needs. We will review how we provide support in conjunction with primary care services and improve the information we provide at the point of discharge.
Prescribing antipsychotics for people with dementia	**Results** – People with dementia who had been prescribed an antipsychotic medication had been prescribed it appropriately in line with guidelines. However we could improve how we involved carers in the decisions made regarding medication. **The actions we have taken are:** We will continue to monitor prescribing practices, paying attention to the above issues.
Prescribing anti-dementia drugs	**Results** – This audit was at the data collection stage during the drafting of this report. We will publicly report findings in next year's Quality Account. **The actions we have taken are:** To be established as the audit is concluded.
Local audit	**Results and actions**
Falls Audit	**Results** – Our achievement of the practice standards relating to falls assessment at admission, and establishing falls reduction plans for those at risk of falling improved during the year. **The actions we have taken are:** The detailed overview of the progress we have made is outlined on page 5 regarding our quality objective to reduce harm caused from falls.
Patient and staff safety	**Results** – Following the last survey done in December 2012 there have been improvements in all 6 questions on safety within the audit. **The actions we have taken are:** The detailed overview of the progress we have made is outlined on page 7 regarding our quality objective to reduce incidents of violence and aggression.

Patient safety thermometer	**Results** – The Trust continues to be at least 99% harm free, according to the 'snap shot' patient safety thermometer. **The actions we have taken are:** To continue to monitor progress and incidents of harm.
Suicide audit	**Results** – From the audit sample we were compliant with all the best practice standards in the NPSA Suicide Toolkit. We found isolated examples were we could improve communication with family members following such tragic events. **The actions we have taken are:** We will review the current arrangements in place to ensure information is shared with families and carers in an appropriate and supportive way.
Safeguarding Children and Adults	**Results** – The audit identified that the majority of staff reported they knew what to do if they had concerns regarding the safeguarding of children or adults. However the level of confidence staff felt they had in this area was variable. **The actions we have taken are:** We plan to ensure that more staff are able to receive training.
Food and nutrition	**Results** – We wanted to extend the nutritional assessments that were being done successfully on our Older Adult wards to our other in-patient services. The audit found that this was happening, but some wards still needed to make improvements. **The actions we have taken are:** We had previously appointed a dietician to support staff training and improve practice, and this is having a positive impact. We will continue to monitor the practice across all in-patient 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, NHS Sheffield Clinical Commissioning Group, 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;
- Waiting times – as prioritised by our Governors.

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.

The Trust submitted records during 2013/14 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 for admitted care which included the patient's valid:

- NHS number was 98.5%;
- Registered GP was 96.0%; and
- GP Practice was 98.88%.

No other information was submitted.

The latest published data from the SUS regarding data quality under the mental health minimum data set is for January 2014. The Trust's performance on data quality compares well to national averages and is summarised on the following page.

Pharmacy Department

Percentage of valid records	Data quality 2013/14	National average
NHS Number	100%	99.5%
Date of birth	100%	99.6%
Gender	100%	100%
Postcode	99.7%	99.3%
Commissioner code	100%	99.8%
GP code	97.3%	98.4%
Primary diagnosis	100%	99%
HoNOS outcome	100%	90.3%

The data and comparative data is from the published MHMDS Reports for January 2014

Clinical coding error rates

Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/14 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.

During the year we completed our assessments through the NHS Connecting for Health Information Governance Toolkit.

Sheffield Health and Social Care NHS Foundation Trust's Information Governance Assessment Report overall score for 2013/14 was 68% for the 45 standards and was graded satisfactory/green.

The summary of our performance is provided below.

	Achieved		
Criteria	**2012/13**	**2013/14**	**Current grade**
Information Governance Management	73%	73%	Satisfactory
Confidentiality and Data Protection Assurance	74%	66%	Satisfactory
Information Security Assurance	66%	66%	Satisfactory
Clinical Information Assurance	73%	66%	Satisfactory
Secondary Use Assurance	66%	76%	Satisfactory
Corporate Information Assurance	66%	66%	Satisfactory
Overall	69%	68%	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 Trusts for actively encouraging the reporting of incidents. For the 6 month period April- September 2013, we were average in terms of the numbers of incidents we reported, with an incident rate of 27.07% per 1,000 bed days. Sheffield Health and Social Care NHS FT considers that this data is as described due to other Trust's improving their reporting. Overall the numbers of incidents we reported was similar to previous years (see page 34). We believe this reflects that other Trusts are improving their rates of reporting in line with our historical higher levels.

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 2013/14 the Trust received 182 non-emergency alert notices, of which 100% were acknowledged within 48 hours, 6 were applicable to the services provided by the Trust and all were acted upon within the required timescale. In addition a further 49 emergency alerts were received and 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 11.7% of all patient safety incidents reported by the Trust were related to self harm, in comparison with 20.4% for mental health Trusts nationally (Apr-Sep13). This is similar to the previous year where the figures were 12.6% and 19% respectively.

During the last 3 years clinical risk training was provided for SHSC staff and new clinical risk assessment and management tools have been introduced throughout the Trust. Since 2011 881 staff from all professional groups received the training, which covers the principles and practice of risk assessment and management. We had planned to train 1,200 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 the last 2 years in line with the position reported in Part 2. 19.3% of patient safety incidents reported by the Trust were for aggressive behaviour in comparison with a national average of 17.4%, based on NPSA benchmarking data for first 6 months of the year. In the previous year, 2012/13 the figures were 18.6% and 17.4% 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. 5.8% of patient safety incidents reported by the Trust related to medication, compared with 8.8% in mental health Trusts nationally for the period April - September 2013. In the previous year, 2012/13 the figures were 5.6% and 8.4% respectively.

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;
- 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 Trust's progress against the programme. These reports are publicly available via Trust's website.

Single sex accommodation

The Trust is fully compliant with guidelines relating to providing for appropriate facilities for men and women in residential and in-patient settings. During 2013/14 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.

We have experienced difficulties in maintaining training for our staff. By the end of this year we had significantly increased training, and 72% of relevant staff have received adult safeguarding training and 82% of relevant staff have received level 3 Safeguarding Children training. We will continue to extend this next year.

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 affected, 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 review 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.

Overview of incidents by type

The table on the following 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	2011/12	2012/13	2013/14
All incidents	6407 (a)	6274 (a)	6408
All incidents resulting in harm	1678 (a)	1459 (a)	1416
Serious incidents (investigation carried out)	45	34	32
Patient safety incidents reported to NRLS (d)	3591 (a)	3371 (a)	3587
Patient safety incidents reported as 'severe' or 'death'	32 (a)	38 (a)	39
Expressed as a percentage of all patient safety incidents reported to NRLS	0.9%	1.1%	1.1%
Slips, Trips and Falls incidents	1651 (a)	1180	1171
Slips, Trips and Falls incidents resulting in harm	557 (a)	419 (a)	421
Self-harm incidents	369	425	443
Suicide incidents (in-patient or within 7 days of discharge)	3 (b)	1 (b)	0
Suicide incidents (community)	15 (b)	19 (b)	4 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	1644	1934 (a)	2129
Violence, aggression and verbal abuse incidents resulting in harm	276	237 (a)	266
Medication Errors	360	321	337
Medication Errors resulting in harm	0	1	1
Infection Control			
Infection incidents			
MRSA Bacteraemia	0	1	0
Clostridium difficile Infections	0	0	1
Periods of Increased infection/Outbreak			
• Norovirus	7 (60)	3 (28)	1 (12)
• Rotavirus	0	0	0
• Influenza	0	1 (3)	0
Showing number of incidents, then people affected in brackets			
Preventative measures			
MRSA Screening – based on randomised sampling to identify expected range to target	2%	39%	47%
Staff Influenza Vaccinations	37.6%	56%	50%

(a) The incident numbers have increased from those reported in the 2012/13 Quality Account report due to additional incidents being entered onto the information system, or incidents being amended after the completion of the report.

(b) The figure has decreased from that reported in last year's Quality Account report due to the conclusion of an HM Coroner's inquest.

(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

There are many performance targets allocated to GP Practices locally and nationally. The 4 Practices who form the Clover Group have been below the Sheffield averages in some of their performance standards mainly due to the high levels of complex patients registered. The Practices serve a majority multi-ethnic migrant population in areas of social deprivation within Sheffield, with 65% of the registered population from ethnic minority backgrounds and Slovak Roma and asylum seeking populations (16,500 total population). This brings a number of acknowledged challenges for the service to deliver the range of performance standards as patients struggle to understand the importance of the range of health screening, and chaotic lifestyles mean that patients do not attend for their planned care.

The Quality Outcomes Framework (QoF) provides a range of good practice quality standards for the delivery of GP services. Significant progress and achievements have been made and in 2011/12 the Clover Group of Practices improved to be in the highest quartile in Sheffield and their challenge since then has been 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 2012/13 the service achieved a total of 98.3% of all the QoF standards, with a Sheffield wide average of 96.3%. This year in 2013/14 the service achieved 94% of the standards, however this reduction is in relation to the introduction of many new standards and an increase in % thresholds making QoF harder to achieve.

The following table summarises performance against national standards for GP services.

Primary Care – Clover GPs	This years target	How did we do? 2011/12	2012/13	This year 2013/14
Flu vaccinations				
Vaccinate registered population aged 65 and over	75%	75%	78%	75% ✓
Vaccinate registered population aged 6 months to 64 years in at risk population to 64 years in an at risk population	70%	50% (1)	56%	58% Working to improve
Vaccinate registered population who are currently pregnant	70%	45% (1)	51%	46% Working to improve
Childhood immunisations				
2 year old immunisations	70-90%	90%	90%	90% ✓
5 year old immunisations	70-90%	81%	85%	82% ✓
Cervical cytology	60-80%	66.7%	66.4%	66.2% ✓

Note 1: The target for 2011/12 was 50% & 45% respectively
Information source: System One and Immform

Substance Misuse Services

The 4 commissioned services continue 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 include the further expansion of the universal screening tool to increase the number of people accessing support 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? 2011/12	2012/13	This year 2013/14
Drugs				
No client to wait longer than 3 weeks from referral to medical appointment	100%	100%	100%	100% ✓
No drug intervention client to wait longer than 5 days from referral to medical appointment	100%	100%	100%	100% ✓
No Premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	100% ✓
No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100%	100% ✓
% problematic drug users retained in treatment for 12 weeks or more	90%	94%	95%	96% ✓
Alcohol Single Entry and Access				
No client to wait longer than 1 week from referral to assessment	100%	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%	100% ✓
Outcomes, Self Care				
Initial Treatment Outcome Profile (TOP) completed	80%	96%	98%	83% ✓
Review TOP completed	80%	80%	71%	89%
Discharge TOP completed	80%	100%	100%	67% ✓ (2 out of 3 clients)
All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100%	100% ✓
Number of service users and carers trained in overdose prevention and harm reduction	240	292	272	258 ✓
% successful completions for the provision of treatment for injecting-related wounds and infections	75%	85%	94%	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 in-patient services we have ensured that individual service users do not experienced prolonged periods in hospital beyond what the service user needs. We have delivered care that is well co-ordinated and focussed on the needs of individuals, and delivered in a personalised and dignified way.

Learning Disability Services	This years target	How did we do? 2011/12	2012/13	This year 2013/2014	
No-one should experience prolonged hospital care ('Campus beds')	Nil	Nil	Nil	Nil to date	✓
All clients receiving hospital care should have:					
• Full health assessments	100%	100%	100%	100%	✓
• Assessments and supporting plans for their communication needs communication needs	100%	100%	100%	100%	

Information source: Insight and Trust internal clinical information system

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.

The table overleaf highlights our comparative performance on 7 Day follow up and Gatekeeping indicators. Sheffield Health and Social Care Trust considers that this data is as described for the following reasons:

- Priority we have placed on ensuring effective and appropriate care pathways are in place;
- Effective leadership within our clinical services;
- Performance monitoring that is focussed on ensuring services have information they need to deliver care.

Sheffield Health and Social Care Trust intends to ensure the above approaches continue to support our on-going positive performance on these indicators.

We did experience challenges in delivering one of the national indicators during the year. Our provision of annual care reviews for people whose care was delivered under the Care Programme Approach was not at the standard it should have been. We aimed to have ensured 95% or more of people under the CPA had received a review of their needs within the year. At the end of the 2nd and 3rd quarters we only achieved this for 89% of people. We introduced a range of changes that were focussed on:

- Reducing the need to have to re-organise planned care review meetings;
- Reviewing people more frequently than every 12 months.

This enabled us to make improvements and we achieved the target by the end of the year. For the 4th quarter we achieved 95.7%

Mental Health Services	This years target	How did we do? 2011/12	2012/13	This year 2013/14	
Improving Access to Psychological Therapies					
• Number of people accessing services	8,904	10,661	10,735	11,611	✓
• Numbers of people returning to work (a)	89 people	396 (19%)	344 (31%)	300 (12%)	
• Number of people achieving recovery	50%	49.5%	46%	47%	
Early intervention • People should have access to early intervention services when experiencing a first episode of psychosis	90 new clients per year	136 new clients accessing services	107 new clients accessing services	106 new clients accessing 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	1,415 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)	99.8% National average 98.3% (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%	6.0%	✓
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)	96.1% National average 98.1% (b)	✓
Annual care reviews • Everyone on CPA should have an annual review	95%	98.7%	98%	95.7% (c)	✓

Information source: Insight & Trust internal clinical information system

Note

(a) 12% 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 2013/14 2,459 of the 11,611 people seen were not in work at the beginning of treatment. 300 of them (12%) returned to work by the time treatment had been completed.

(b) Comparative information from Health and Social Care Information Centre. 2013/14 national average figure based on data published for the Apr 13-Dec13 period.

(c) The 95.7% figure represents the Trust's performance at the end of the year. During the year the Trust failed to meet this target in Q2 and Q3 with performance levels at 89% for both quarters.

Dementia Services

Our specialist in-patient 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. We have not reduced waiting times over the last year, and without changes to the way we provide services waiting times will start to get longer as we see even more people. Making further improvements in this area is a priority for us next year, and we have outlined how we plan to do this in previous sections of this report (see Quality Objective 5 on page 14).

Dementia Services	This years target	How did we do? 2011/12	2012/13	This year 2013/14
Discharges from acute care (G1)	27	34	53	43 ✓
Number of assessments for memory problems by memory management services	930	876	846	884 ↑ Getting better
Rapid response and access to home treatment	350	338	339	349 ✓
Waiting times for memory assessment	N/A	14 weeks	15.4 weeks	15.8 weeks ↓ Getting worse

Information source: Insight and Trust internal clinical information system

Independent Living and Choice

Independent Living and Choice	This years target	How did we do? 2011/12	2012/13	This year 2013/14
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%	96.7% ✓
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	635 people with budgets agreed ✓ Further 219 actively exploring

Information source: Insight and Trust internal monitoring systems

3.3 Service User Experience

Complaints and compliments

We are committed to ensuring that all concerns are dealt with positively and are used as an opportunity to make sure we are providing the right care and support. If our service users remain unhappy following this and feel the need to formally complain we are committed to ensuring complaints are dealt with promptly and investigated thoroughly and fairly.

Service users, carers or members of the public who raise concerns can be confident that their feedback will be taken seriously and that any changes made as a result of the findings of the investigation will be used as an opportunity to learn from the experience and make changes to practice and procedures.

We 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:

- An 'alert' system implemented within the IAPT Service to identify people who have been on the waiting list for more than 2 months so their circumstances can be reviewed;
- Administration systems reviewed and improved so we can monitor what stage individuals' application for Self-Directed Support packages are at;
- The Trust's Managing Substance Misuse and Harmful Substances on In-patient Wards Policy reviewed to include all substances that may impact on the health and wellbeing of individuals.

The following summarises the numbers of complaints and positive feedback we have received.

Number of	2011/12	2012/13	2013/14
Formal complaints	110	142	147
Informal complaints	235	260	217
Compliments	1, 401	1,396	1193

During the last year 9 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. In 1 case the Ombudsman asked the Trust to provide an update on the action plan arising from the complaint investigation and to issue a small ex-gratia payment. The Trust did so. In all other cases the Ombudsman has taken no action.

A full picture of the complaints and compliments received by the Trust over the year is available on our website in the Annual Complaints Report. This includes feedback from the complainants about their experience of the complaints process and if they felt their concerns were taken seriously and appropriately addressed. The report can be accessed via the following link: *http://www.shsc.nhs.uk/about-us/complaints* .

During this year, following our review of the Francis report we have started publicly publishing information about complaints and compliments on our website on a quarterly basis.

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.

During 2011/12 we invested £3.2 million 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. We were proud and excited when the new centre was formally opened in May 2013 by one of our service users, Mr Rex Coldwell. This has provided a great opportunity for us to improve on the personalised care we were already providing. The standard of the new community centre and its positive impact on the environment in which we can now deliver high quality care has been commended by the CQC when they visited to inspect the new service.

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, the Board of Directors approved an investment of £6.4 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 started during this year, and we look forward to it opening over the next 18 months.

Dovedale Ward – improving in-patient care for older people

Our 2 wards for older people on the Longley and Michael Carlisle Centre sites are not as well designed as they need to be. There is limited communal space and many of the bedroom areas are small and don't provide en-suite facilities for service users. We are developing plans to deliver significant improvements in the design and environment within our in-patient wards.

As part of this work we invested £328,000 to improve facilities and moved Hawthorn Ward to Dovedale Ward. The newly refurbished ward was opened in April 2014. This means that service users now have better access to en-suite facilities and an improved ward environment.

Longley Meadows – respite services for people with a learning disability

Following feedback from service users and carers we have invested £250,000 to improve the environment at Longley Meadows. This involved a refurbishment programme to improve the environment and décor within the centre.

General environment

During 2013/14 no external reviews of our facilities took place. The Patient Led Assessment of the Care Environment (PLACE) took place at the end of 2012/13. The conclusion of the review is summarised as follows:

Site Location	Cleanliness	Food and Hydration	Privacy and Dignity	Condition and Appearance
Longley Centre	89%	92%	89%	79%
Longley Meadows	83%	87%	53%	65%
Michael Carlisle Centre	95%	94%	94%	80%
Forest Close	93%	88%	85%	77%
Forest Lodge	83%	89%	96%	73%
Grenoside Grange	84%	92%	87%	80%
Trust average	88%	90%	84%	75%
National average	95%	84%	88%	88%

Following the review the Board approved a development plan to address a range of improvements and overall décor across the estate, with the more sustainable improvements planned for Longley Meadows facilities.

What do people tell us about their experiences?

The National Patient Survey for mental health Trusts highlights 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	2011 Survey		2012 Survey		2013 Survey	
	Score	Top 10	Score	Top 10	Score	Top 10
Their Health & Social Care workers	8.9	✓	9	✓	8.7	✓
Medication	7.6	✓	7.5	✓	7.0	
Access to Talking Therapies	7.4		8.0	✓	7.6	✓
Support from Care Co-ordinator	8.5	✓	8.6		7.7	
Their Care Plan	7.0		7.3	✓	6.6	
Care Reviews	8.0	✓	7.7		7.3	
Awareness about support options for Crisis Care	6.5		5.9		6.1	
Day to day living	6.0		6.0	✓	5.1	
Overall view of care	7.2	✓	7.2	✓	7.0	
Overall score	**7.5**	**Joint 2nd**	**7.5**	**Joint 3rd**	**7.0**	**Joint 5th**

The following table relates specifically to the nature of the relationship service users experienced with the staff involved in their care and treatment.

	2011 Survey that reported in 2012			2012 Survey that reported in 2013		
	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	8.0 overall	9.0 overall	8.7 overall
Did staff listen carefully to you?	8.2	9.3	9.1	8.2	9.2	8.9
Did staff take your views into account?	7.9	9.0	8.9	7.9	8.9	8.6
Did you have trust and confidence in them?	7.6	9.0	8.7	7.5	8.7	8.6
Did they treat you with dignity and respect?	8.8	9.7	9.5	8.6	9.5	9.4
Were you given enough time to discuss your condition?	7.7	8.7	8.6	7.4	8.8	7.9

The table overleaf highlights our comparative performance on service user experience in respect of contact with our staff. We are pleased about this positive position. While the scores are slightly reduced compared to the previous year the CQC survey analysis highlights that this reduction is not significant.

We consider that this data (the survey scores in the above table) is as described for the following reasons:

- During 2012/13, when the survey was being undertaken, we were undertaking extensive service re-organisation across our Community Mental Health Teams;.
- In the context of so much change, we are pleased that the feedback results are in line with previous scores;
- 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.

We will continue to take actions to maintain this current positive position regarding the quality of our services. Our ongoing development programmes, 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 our comparative performance regarding the quality of our services from the perspective of our staff. We consider 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.

We intend to continue with our 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.

3.4 Staff experience

National NHS staff survey results

The experience of our staff indicates that they feel positive about the quality of care they are able to deliver. This is a positive position for us to be in, and it helps us to move forward in partnership with our staff and deliver further improvements.

Staff Survey

What percentage of staff would recommend the Trust as a provider of care to their family or friends	Lowest 20% score	Top 20% score	Average score	Our score
2011 Staff Survey	3.30	3.56	3.42	**3.60**
2012 Staff Survey	3.36	3.68	3.54	**3.63**
2013 Staff Survey	3.40	3.68	3.55	**3.80**

Overall Engagement and Care	Previous year		This year 2013/14		
	2011/12	2012/13	Our score	National averages	Comparisons
Overall staff engagement	3.69 out of 5	3.73	3.81	3.71	Top 20%
Recommend Trust as place to work or receive treatment	3.59 out of 5	3.63	3.80	3.55	Top 20%
Care of service users is my organisation's top priority	n/a	71%	73%	63%	
Staff feel able to contribute to improvements	70%	73%	74%	71%	Above average
Top 5 Rankings– the areas we compare most favourably in with other mental health and learning disability Trusts					
% of staff who feel satisfied with the quality of work and service user care they are able to deliver	77%	78%	83%	77%	Top 20%
% receiving job related training and learning	n/a	85%	88%	82%	Top 20%
% of staff working extra hours (low is good)	53%	64%	62%	71%	Top 20%
% of staff feeling harassment, bullying or abuse from other members of staff (low is good)	21%	19%	16%	20%	Top 20%
% of staff believing the Trust provides equal opportunities for career progression and promotion	88%	90%	93%	89%	Top 20%
Other best scores - We were also in the best 20% of mental health and learning disability Trusts in the following areas					
Job satisfaction	3.6 out of 5	3.72	3.76	3.66	Top 20%
Fairness and effectiveness of our incident procedures	3.49 out of 5	3.54	3.60	3.52	Top 20%
Feeling pressure in last 3 months to attend work when unwell	19%	20%	19%	22%	Top 20%
WORSE 5 – the areas we compare least favourably in with other mental health and learning disability Trusts					
% of staff receiving health and safety training	70%	50%	48%	75%	Worse 20%
% of staff receiving equality and diversity training	32%	38%	35%	67%	Worse 20%
% of staff having an appraisal	78%	79%	76%	87%	Worse 20%
% of staff experiencing physical violence from service users, relatives or members of the public	20%	21%	26%	19%	Worse 20%
% of staff feeling motivated at work	3.73 out of 5	3.77	3.73	3.85	Worse 20%

The Trust employs around 3,000 people and as part of our responsibility towards enhancing staff loyalty and motivation, we carry out an annual NHS Staff Survey programme.

We then develop action plans that are based on the outcomes of this survey and share details with all staff through our regular communication channels. The NHS Staff Survey provides us with feedback on the Trust's performance across a range of relevant areas.

The results are focused on the pledges to staff contained in the NHS Constitution, which are:

Pledge 1: to provide all staff with clear roles; responsibilities and rewarding jobs;

Pledge 2: to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed;

Pledge 3: to provide support and opportunities for staff to maintain their health, wellbeing and safety;

Pledge 4: to engage staff in decisions that affect them and the services they provide, as well as empowering them to put forward ways to deliver better and safer services.

The NHS Staff Survey attempts to identify the major factors contributing to staff engagement and motivation. By focusing on these, the Trust aims to enhance the high quality care it offers to the people who use its services.

Overall, we are encouraged with the results overleaf. The positive feedback around engagement continues to support our on-going 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 with job satisfaction from work, and the worse 20% for staff feeling motivated at work.

The areas we have prioritised for on-going and further development work are as follows:

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 simpler arrangements and procedures to ensure this can happen. Next year we will adopt an approach to appraisals that ensures everyone will receive their appraisal between April and July. This will help us to ensure all staff benefit from an appraisal on an annual basis.

Training

We have an extensive training programme in place. We have put a lot of emphasis on developing local priorities about the development needs of our staff, that will support the improvements in quality we want to make and ensuring these are delivered effectively. Overall this is reflected in the positive feedback from staff in respect of engagement, satisfaction with the care they deliver and staff believing they can make improvements locally. We compare very well for staff who believe they have received job related learning and development opportunities (top 20%).

Overall, over 80% of staff have received training in diversity and health and safety issues. However, our existing training programme does not ensure that this is repeated for all staff every year.

During 2014/15 we will further review our training provision alongside the needs analysis we have undertaken of the skills our staff need to deliver high quality care. We will aim to develop more targeted approaches in respect of key training areas where these will be beneficial. Through the next year we will continue to monitor how this is being delivered.

Violence against staff from service users, relatives or the public

This important area has been a key improvement priority for the Trust for the last 2 years. The Quality Objective section of this report provides a detailed account of the work we have done (see page 7).

The evidence indicates that there has been a significant improvement in awareness and reporting among staff. Through the extensive training we have provided we have been actively encouraging staff to report all incidents, no matter how insignificant, to ensure we have as full and informed a picture as possible.

What our incident data shows us is that there has been a significant increase in reported incidents, but no associated increase in harm to staff. In fact the severity of harm experienced by staff as a consequence of assaults in the workplace has decreased.

We will continue with our existing development plans which we believe are resulting in clear improvements in service user and staff experience in relation to violent, aggressive and threatening behaviour.

Annexe A

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

Healthwatch

Healthwatch Sheffield acknowledges the work done by Sheffield Health and Social Care Trust in 2013/14 and welcomes the opportunity to provide feedback on their Quality Account.

The document is clearly laid out and there appears to have been a genuine attempt to make it as understandable as possible, which is to be commended. We have asked that the Trust consider a summary or easy read version to accompany the report so that more people can read and understand the contents.

The progress made against the 5 priorities for improvement is important, and we note that there have been tangible outcomes for service users in most areas. We have spoken to the Trust about the large increase in seclusion of patients (Objective 2) and understand the reasons behind this and the processes that are being followed to address this. We look forward to seeing significant change in this area in 2014/15. We are pleased that the Trust has chosen to take forward improving people's physical health as a priority for 2014/15 and hope to see some quantifiable data showing improvement next year. Healthwatch recognises and praises the prioritisation of reduction in waiting times both in this year and the forthcoming year. We understand that good progress has been made in some areas, most notably those with the longest waiting times, but are concerned that the waiting times for memory clinic services are growing and would like to see evidence of targets and action planning to address this.

We are pleased to note that the Quality Objectives for the next 2 years include a recognition of the importance of quality improvement through service user experience, and commend the Trust for this.

Healthwatch notes that where reports and audits have led to results and actions (p.26) these do appear to have been used as a basis for formulating the Quality Objectives.

We recognise that there are some issues with some areas of performance with the Clover Group of GPs, and expect that the Trust will wish to keep this under review.

We note the low PLACE score for some of the Trust's settings, and have raised the particular issue of Longley Meadows directly with the Trust, to which we received a sufficient response. We will continue to monitor this and other settings and hope to work with the Trust to provide PLACE volunteers next year.

In conclusion, we welcome this report which is clear, and written in an open and honest style. We commend the Trust for their acknowledgement of where things could be done better and look forward to working with them to achieve this in 2014/15.

Professor Pam Enderby,

Chair, Healthwatch Sheffield

Our response

We welcome the helpful feedback from Healthwatch.

We look forward to reporting in the future on the progress we continue to make with this year's quality priorities. Our planned investment in new facilities for our Intensive Treatment Service will support real improvements in the way we deliver care, and we look forward to that service opening in 2015/16. With NHS Sheffield Clinical Commissioning Group we share the concerns regarding long waits to access Memory Services. We have outlined the plans we have agreed with the Clinical Commissioning Group, to make progress on this during 2014/15, and deliver improvements (See Quality Objective 5). We will report on this in next year's Report.

We will continue to monitor progress in performance across all our services. We expect to see further improvements within the Clover Group, which overall is performing very well across most indicators.

We look forward to ongoing joint work in respect of PLACE assessments and value the contribution and perspective that Healthwatch can provide.

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

As in previous years, the Committee welcomes the opportunity to comment on the Health and Social Care Foundation Trust's draft Quality Accounts

The Committee feel that the quality priorities selected by the Trust reflect the needs of the people of Sheffield. In particular, the Committee welcomes the continued prioritisation of dementia services through Quality Objective 5: "To improve access to the right care for people with a dementia". The Committee support the focus on reducing waiting times in terms of diagnosing people with dementia and the Trust's efforts to look at interim solutions to addressing this issue. Dementia and memory management services are areas that the Committee have given particular consideration over the past 2 years and we look forward to seeing improvements in due course.

The Committee have spoken with the Trust regarding the significant increase in the use of seclusion of patients (Objective 2) over the last 12 months. The Committee understand the reasons for this and were satisfied with the response given by the Trust which confirmed that this was being monitored regularly by the Trust Board's Quality Sub Committee.

The Committee also supports the Trust's plans to construct a new Psychiatric Intensive Care Unit (PICU) on the former Oakwood site at the Northern General Hospital which will result in a larger unit with improved facilities for patients.

In terms of physical wellbeing the Committee is pleased to see that the Trust continues to demonstrate a commitment to the physical wellbeing of patients. Both through its Physical Health Strategy and the prioritisation of Quality Objective 3: "To improve the identification and assessment of physical health problems in at-risk client groups". The Committee welcome the progress that has been made to date and looks forward to seeing continued improvements in the future.

The Committee believes strongly that involving service users is a key factor in successful service development and quality improvement and so commends the fact that a number of the Trust's Governors are also people who access the Trust's Services. In addition in the interests of accessible information, the Committee supports Healthwatch Sheffield's request that the Trust consider producing a summary or easy read version to accompany the Quality Report.

The Committee commends the Trust for presenting an honest and balanced picture of performance and looks forward to engaging with the Trust on both the Quality Accounts and a broader range of issues over the coming year.

Our response

We welcome the feedback from the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

We all acknowledge the 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 NHS Sheffield Clinical Commissioning Group. We have outlined the plans we have agreed with the Clinical Commissioning Group, to make progress on this during 2014/15, and deliver improvements (See Quality Objective 5). We will report on this in next years Report.

NHS Sheffield Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group (CCG) has had the opportunity to review and comment on the information contained within this quality account prior to its publication. Sheffield Health and Social Care NHS Foundation Trust have considered our comments and have made amendments where necessary. The CCG is therefore 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 2013 – March 2014.

The CCG commissions Sheffield Health and Social Care NHS Foundation Trust to provide a range of general and specialised mental health and learning disability services. We aspire to continually improve the quality of services provided by the Trust and the experience of those people who use them. We do this by reviewing and assessing the Trust's performance against a series of key performance indicators as well as evaluating contractual performance. We also work closely with the Care Quality Commission, who are the independent regulator of all health and social care services in England, as well as Monitor who are the sector regulator for health services in England, to ensure that care provided by the Trust meets the regulators requisite standards and that the Trust is well led and is run efficiently.

Our overarching view is that Sheffield Health and Social Care NHS Foundation Trust continues to provide services to a good standard, which is underpinned by strong contractual performance. This quality account evidences that the Trust has achieved positive results against the majority of its key objectives for 2013/14. Where issues relating to clinical quality have been identified, we have worked closely with the Trust to ensure that improvements are made.

During 2014/15 we will continue to work closely with the Trust and will build on existing good clinical and managerial working relationships. Our aim is to proactively address issues relating to clinical quality so that standards of care and clinical governance are upheld whilst services continue to evolve to ensure they meet the changing needs of our local population. We will continue to set the Trust challenging targets whilst at the same time incentivise them to deliver high quality, innovative services.

Kevin Clifford

Chief Nurse

Our response

We welcome the comments and response from NHS Sheffield Clinical Commissioning Group.

We look forward to delivering further benefits and improved outcomes for the people of Sheffield with the support of our main health Commissioner.

Annexe B

2013/14 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:

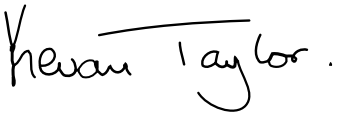
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 to May 2014;
  - Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
  - Feedback from the Commissioners dated 2 May 2014;
  - Feedback from Governors dated 8 May 2014;
  - Feedback from Healthwatch dated 29 April 2014;
  - Feedback from the Scrutiny Committee dated 9 May 2014;
  - The Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
  - The [latest] national patient survey issued in 2013;
  - The national staff survey issued February 2014;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 28 May 2014; and
  - Care Quality Commission quality and risk profiles issued monthly during 2013/14;
- 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

28 May 2014



Chief Executive

28 May 2014

Annexe C

Independent Auditors' 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 2014 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach patients received follow-up contact within seven days of discharge from hospital; and
- Admissions to in-patient services had access to crisis resolution home treatment teams.

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 the 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 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey;
- The 2013/14 national staff survey;
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

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 2014, 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 2014:

- 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 above; 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

Chartered Accountants

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28 May 2014