Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

2014/2015

Quality Account

Contents

The front cover and art design of this report is inspired by the Recovery Tree tapestry created by the Trust's Sukoon Group which was established on acute adult mental health in-patient wards at the Longley Centre with the aim of encouraging black and ethnic minority service users to engage with therapeutic interventions on the ward. The Recovery Tree project was developed to explore different aspects of recovery and what it means to each service user.

Quality Account

Part 1: Quality Account 2014/15 Chief Executive's welcome

I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Account for 2014/15.

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.

During this year we have continued to progress a number of important 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;
- Being clear about standards we want to deliver and working with people who use our services and our staff to deliver improvements;
- Ensuring staff within teams have access to better information about how they are performing in their aim to deliver high quality services.

In October and November of 2014 we had a planned inspection of our services by the Care Quality Commission. At the time of issuing this Quality Account and our Annual Report the findings from the Inspection have not been concluded or published. Therefore, we are unable to provide an account of the findings from the Inspection and our plans to respond at this stage. The findings of the Inspection will identify areas of concern about some services we provide, along with many examples of good practice. We are clear that the findings will help us focus on the issues that we need to improve and once they are available we will publish the reports and our development plan that shows how we will make the necessary improvements. More information about this is in section 2B of this report.

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 in many areas. However, we also know we can do better, and need to do better. Our ambition is to provide excellent services that deliver a really positive experience for the people who need them. We have much to do to ensure the quality of what we provide is of a consistently high standard for every person in respect of safety, effectiveness and experience. Our plans for quality improvement will ensure we make continued improvements.

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 2014/15 and our goals for 2015/16

In setting our plans for 2014/15 we reviewed our priorities for quality improvement. The people who use our services and the membership of our Foundation Trust have been instrumental in deciding what our priorities are.

In undertaking this review 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 Healthwatch.

Our Governors engaged with our members about our proposed priorities and we have received comments and feedback from over 400 of our members about our priorities we proposed for this year. From this review the Council of Governors have reviewed our plans and we have taken on board their feedback.

Through this year we 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 improvement during 2014/15 were:

Responsiveness

Quality Objective 1: We will improve access to our services so that people are seen quickly;

Safety

Quality Objective 2: We will improve the physical health care provided to our service users;

Experience

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

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

We chose this priority because

The evidence clearly demonstrates that prompt access to effective treatment has a significant impact on outcomes.

When we met with our Governors this was a key area of concern for them. They wanted us to ensure that people got seen quickly when they needed to. Improving access is an area prioritised by our Commissioners and they are supportive of improvement and service reconfigurations to help us achieve this. We had started to make some improvements in reducing waiting times but not as much as we wanted to.

We said we would

Reduce the time it took for people to get an assessment of their needs following a referral in our Improving Access to Psychological Therapies (IAPT) Service, adult Community Mental Health Teams (CMHTs)and our Memory Service.

How did we do?

We have made positive progress in some areas, but not within the Memory Service.

IAPT Service

The information below shows the positive progress made. This has been achieved through an on-going development programme focused on improving pathways and working relationships with each GP Practice. Through this we have reduced the numbers of inappropriate referrals which has meant we are able to see people more quickly than before. Over the last 2 years, we have introduced direct booking by GPs, which reduces the amount of time it takes to offer an appointment. This year we aimed to continue to reduce overall waiting times for the service. We also wanted to reduce waiting times in the 2nd half of the year for those GP Practices which had experienced the longest waits.

Measure	2013/14	2014/15
How many people started treatment	11,611	13,535
Average waiting time to start treatment	5.3 weeks	4.2 weeks
Average waiting time to start treatment for 8 GP Practices with longest waits.	9.6 weeks	2.3 weeks (Oct-March)

As well as monitoring performance based on average waiting times, we look to make sure as few people as

possible wait longer than the averages. The following information shows the proportion of people we saw within different time ranges.

Measure	2013/14	2014/15
Between 0-6 weeks	68%	79%
Between 6-12 weeks	22%	16%
Between 12-18 weeks	6%	3%
Longer than 18 weeks	3%	1%

The above information shows how long people have been waiting to access talking therapies within the IAPT Service. A small number of people once they have started treatment need to access counselling support, and they can wait around 14 weeks to start this. We plan to reduce waiting times for counselling over the next year.

CMHTs

The information below shows the position over the year. We have focussed on improving the way referrals are managed and triaged, appointments are made and assessment clinic slots are best utilised to meet demands. This work will continue and we expect to reduce the overall waiting time for the service.

Measure	2013/14	2014/15
Average waiting time for people to be assessed in our adult CMHTs for a routine appointment	36 days	40 days

As well as monitoring performance based on average waiting times, we look to make sure as few people as possible wait longer than the averages. The following information shows the proportion of people we saw within different time ranges.

Measure	2013/14	2014/15
Between 0-6 weeks	79%	82%
Between 6-12 weeks	16%	15%
Between 12-18 weeks	3%	2%
Longer than 18 weeks	2%	1%

Memory Service

We haven't made the progress we wanted to in reducing waiting times for this important service. During the year we agreed improvement plans with our Commissioners to provide more follow up support in community settings. This is more convenient for service users, and will free up resources in the specialist assessment clinic to see more new referrals. This should have a beneficial impact on reducing waiting times.

These changes were introduced during the autumn, and should have a more noticeable impact next year. However, during this year the number of referrals received by the service has increased by 41%.

Measure	2013/14	2014/15
No. of referrals	1,517	2,150
No. of initial assessments	1,396	1,700
Average waiting time for assessment	140 days	161 days

How will we keep moving forward?

We will continue to focus on waiting times to access services. During 2015/16 we plan to:

- Continue with the above improvement work for CMHTs;
- Review our capacity and resource plans for the Memory Service due to the increased levels of demand and agree a way forward with Commissioners and the Healthier Communities and Adult Social Care Scrutiny Committee;
- Define waiting time standards for all our services and publish information about how we are performing for each service;
- Ensure we deliver on the new national access targets for waiting times for IAPT Services and Early Intervention Psychosis services.

Quality Objective 2: We will improve the physical health care provided to our service users

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 have been 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.

The need to deliver continued improvements in this area is 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. As we have developed our plans our clinicians have told us this was a key area they wished to focus on to deliver improvements. We know from reviewing progress against our Physical Health strategy and national audits that we have further improvements still to make.

We said we would

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

- Smoking cessation - offering advice guidance and referrals to the Smoking Cessation Service to decrease smoking among service users, and develop our Trustwide plans to support smoking cessation;
- Alcohol – providing alcohol screening across services to ensure timely referral to appropriate services;
- Obesity - providing advice and support to address the issue of poor lifestyle choices, encouraging healthy diet and exercise;
- Diabetes - ensuring 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 - ensuring 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 – ensuring that all service users have appropriate physical health checks, whether completed by our services or within our partner organisations.

How did we do?

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

- Smoking cessation – we have improved the way we gather information about if people smoke and have encouraged staff to be more proactive about this. The Board has formally committed the whole of our organisation to going smoke-free. This programme will be formally launched early in 2015/16 and supported by a range of proactive initiatives to support service users and staff to stop smoking, while not allowing smoking anywhere within the Trust's premises;
- Alcohol - the Alcohol Screening Tool is incorporated into the city-wide 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 have begun to improve our standards of practice within our in-patient services for assessing alcohol use with service users, and have developed plans to extend this into community services. However, we need to continue to improve how we do this consistently, and ensure it informs on-going decisions about people's care and support;
- Obesity - an e-based version of the malnutrition universal screening (MUST) tool and associated training is in place across most of the in-patient areas and we have reviewed our weight management care pathway during the year. 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 and Diabetes Link Nurse roles. 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 implemented that contain diabetes related skills and knowledge, including Recognising and Assessing Medical Problems in Psychiatric Settings (RAMPPS), Foot Care, Physical Assessment, Apprentice Programmes. We have introduced an audit programme regarding standards to reduce harm for people with diabetes;
- 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 in oral health care;
- Physical Health checks - the recording of physical health assessment on has improved across our in-patient services, with a plan to address shortfalls in place. Revised protocols for the use MUST Tool, falls, patient safety thermometer, and the introduction of local audits in the previous year, 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 service.

National Physical Health Audit

The Trust participated in the national audit programme to support improvements in how we assessed and planned for the physical health needs of people with serious mental health problems. This audit formed part of the CQUIN scheme we have with NHS Sheffield CCG (see Part 2B). The audit had 2 important elements.

Physical health screening for in-patients

To ensure patients with a psychosis had received an assessment and appropriate plans were in place in respect of:

- Smoking;
- Lifestyle (including exercise, diet, alcohol and drugs);
- Body Mass index;
- Blood pressure;
- Glucose regulation;
- Blood lipids.

We re-audited the care provided as part of the national audit programme in December 2014, and achieved the above standards for 74% of in-patients with a psychosis.

We are pleased that we have made the progress we have, however we will continue to focus on this important area. We need to improve the delivery of the standards and ensure the information from the assessments of people's physical health circumstances fully informs the on-going plans for people's care.

Communication with GPs

A key goal is to ensure that we have clear and shared information between our services and primary care about people's mental and physical health care needs. We audited how we were doing between July – August 2014, and we were not achieving the standards (see below). We developed clear guidance for services and repeated the audit in February – March 2015. We audited the records of 100 people on the Care Programme Approach to examine if we had shared information with their GPs about

- Their diagnosis in respect of the individual's mental and physical health conditions;
- Medications prescribed and arrangements for monitoring;
- The individual's physical health condition and on-going monitoring and treatment needs.

We achieved the standards for 94% of the records we audited.

How will we keep moving forward?

Overall, we continue to make progress, but we are clear that we have further work to do to ensure the best standards of care and support are being provided to people consistently. As part of our overall physical health strategy programme, we will be focussing on the following developments next year:

- Smoking cessation - ensuring nicotine replacement treatments/patches are available. Working with Pharmacy to ensure all in-patient areas have daily access to these options. Train staff to deliver smoking cessation advice and not be reliant on referral elsewhere;
- Evaluate a 'bespoke smoking cessation' service specifically tailored to individual service users with severe mental illness. A mental health nurse or allied health professional will be trained to deliver smoking cessation interventions, and to become the service user's mental health-smoking cessation practitioner;
- Continue working with GPs to ensure equity of access to primary care services for people with mental health problems, or a learning disability. Develop joint working initiatives/training plans with GPs to increase uptake by service users;
- Improve CMHT interventions in relation to physical health (assessing/screening) and continue to deliver the RAMPPS programme;
- Continue to audit compliance with physical health assessments for all our in-patient settings and oversee the quality and training standards required for Cardio Pulmonary Resuscitation (CPR) practice in settings that deliver mental healthcare.

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

We chose this priority because

Understanding the experiences of the people who use Trust services is essential if we are to be successful in achieving quality improvement. In November 2013 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 2014/15 and beyond 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.

The Board of Directors invested in the establishment of a service user monitoring unit within the Trust. This department was to be led by a service user and support the Trust's on-going strategies to improve our understanding of the experience of the people who use our services.

We said we would

- Establish a service user led unit to lead on work within the Trust to understand experience;
- Review our existing development plans to ensure they were focussed on the right issues.

How did we do?

We have started to review the approaches we use to understand service user experience across our different services. We will develop these next year, establishing best practice standards. We have implemented the Friends and Family Test to provide service users with simple ways to let us know about their experience.

Our plans for service user engagement

During the year we reviewed the progress being made on key development priorities. These were ensuring we provided recovery oriented services and care, and ensuring we engaged with service users in all aspects of how we provide care and deliver services.

Informed by this review we have established a Trustwide service user engagement group to lead on service user engagement and ensure a co-ordinated and effective approach is taken to delivering the improvements we need to make. This group is chaired

by a service user, supported by the Deputy Medical Director. The group has established the following objectives:

- To have in place effective and consistent approaches for the collection of Trustwide information about service user experience;
- To ensure service user involvement takes place at the most senior levels of decision making;
- To ensure that service users are partners in their own care and in supporting the recovery of others;
- To establish a performance framework for governing service user experience, ensuring regular feedback to Teams, the Board and Governors;
- To have in place a range of appropriate information technology based solutions to support the gathering and recording of service user feedback;
- To develop quality indicators for supporting recovery in appropriate service areas, based on and using the Implementation of Recovery Orientated Care (ImROC) 10 key challenges and the NICE Quality Standard for Service User Experience 2011.

How will we keep moving forward?

We will implement the above objectives, and report on progress next year.

How are we doing on our previous years Quality Objectives?

Introduction

In last year's Quality Account we reported on progress for the previous 2 year period 2012/13 to 2013/14. Because of the progress made we reported that we would no longer continue with some of our Quality Objectives. In doing this, we said that we would continue to report on progress in 2 important areas, even though they were no longer part of our formal Quality Objectives.

Reducing the incidence of violence and aggression and use of restraint and seclusion

Ensuring the safety of service users and our staff is of paramount importance to the Trust. As a result, one of our key areas of development continues to be the reduction of instances of violence and aggression and the subsequent use of restraint and seclusion.

The policy environment changed in 2014 following the publication of Positive and Proactive Care by the Department of Health and changes made to the Mental Health Act 1983 Code of Practice. Put together, the changes proposed in both documents are far reaching and extended beyond the remit of the Trust's original reduction programme. As a result, a project group was established, chaired by the Deputy Medical Director, to examine the changes proposed with a view to implementing them on a Trustwide basis.

These changes include:

- The creation of a Trustwide dashboard to capture all forms of restrictive intervention across all of our sites;
- The introduction of positive behavioural support or something similar in which to identify the root cause of behaviours that challenge;
- Increased access to meaningful activities across bed based services;
- Development of an environment and culture that supports service users' needs in a way that reduces to a minimum the need for restrictive interventions;
- Ending all face down physical restraint;
- Providing support to service users in a way that results in us no longer needing to use seclusion to keep people safe;
- Ensuring that staff have the resources and training to deliver care in an environment that feels safe and supportive.

Delivery of the programme is realising the following results:

- A single reported instance of face down restraint in 2014/15;
- Roll out of an e-reporting system in which to eradicate the current paperbased system and, by implication, increase instances of reporting;
- A much better and broader understanding of the way service users movements are being restrained and restricted as a result of better reporting. We have doubled our reported numbers of restraint related incidents.

Incident type	2012/13	2013/14	2014/15
Incident reported where **service users** had been:			
Secluded;	74	279	304
Restrained;	89	184	406
Assaulted;	387	384	420
Caused harm from assault.	72	75	217
Incidents reported where **staff** working in in-patient services:			
Had been assaulted;	606	595	489
Were harmed due to the assault.	99	108	157
Level of harm caused from the assault:			
Negligible harm;	68	87	117
Minor or moderate;	31	21	40
Major and above.	0	0	0

While our plan is ambitious and requires further development, the Trust has been encouraged by early successes. We believe that this plan achievable in the longer term and will promote our position as a caring and compassionate provider of choice.

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

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. For this reason, we continue to deliver a range of improvement programmes and monitor closely how we are doing.

In last year's Quality Account we reported that overall incidents of falls that resulted in harm had reduced by 25% over the three year period from 2011/12.

Over the last year the number of falls that resulted in harm increased, following a year on year decrease over the previous 3 years. A summary of the impact of the harm caused is provided in the table below:

How many incidents of	2012/13	2013/14	2014/15
Falls resulting in harm	403	387	404
Needed to attend hospital or A&E	52	50	51
Experienced minor harm	90	68	77

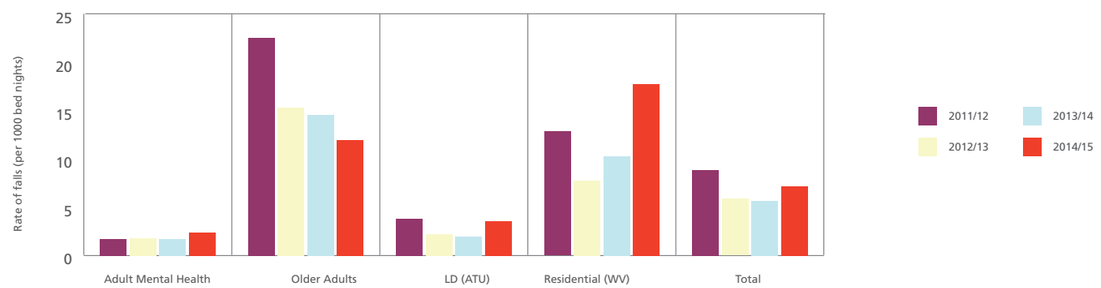
How many incidents of	2012/13	2013/14	2014/15
Experienced moderate harm	17	13	16
Experienced major harm	0	1	1

As the total number of falls that resulted in harm had reduced over the last 3-4 years, we had also closed a number of our bed based services as more community based services and support was introduced. The graph below shows the rates of falls compared against bed days across different types of services provided. It shows that for all services rates of falls reduced over the 3 year period 2011/12- 2013/14, with some increases over the last year. The main area where increased rates of falls are reported is within our services at Woodland View Nursing Home. Over the year there has been a change in client group with the service caring for people with more complex needs.

Our improvement plans continue to focus on the following areas:

- Practice improvement – improving assessment and falls screening processes over the first 3 days of a person's admission, followed by effective falls management plans for those considered to be of risk of falling;
- Awareness and training – delivering targeted staff training programmes for key services, such as Woodland View Nursing Home;
- Assistive technologies – continuing to explore how further use of assistive technologies can support falls reduction plans;
- Monitoring of progress – through ensuring all services have access to a range of information to understand how they are performing.

Rate of falls (per 1000 bed nights) as calculated by the NPSA (April to March)



Our Quality Objectives for 2015/16

Overall, we perform well in delivering the national standards asked of us across our services for primary care, learning disabilities, substance misuse and mental health. We remain confident that we will continue to meet these standards.

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 in many areas. However, we also know that we can do better, and need to do better. Our ambition is to provide excellent services that deliver a really positive experience for the people who need them. 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. Our plans for quality improvement will ensure we make continued improvements.

In last year's report we outlined actions that we were taking following a review of culture and practice within our residential/supported living homes for people with a learning disability. We were committed to implementing a range of improvements to ensure personalised approaches were being taken to meet people's needs. Jointly with our Commissioners we have commissioned an external review of the progress made and the report confirms that we have made good progress in delivering the actions we set ourselves.

Significant development work will be progressed over the next year. The Sheffield-wide Crisis Concordat Action Plan will deliver much needed and important improvements in the way all services in Sheffield support people experiencing a mental health crisis. Our service development plans (see our Annual Plan) will improve primary care mental health provision, deliver more intensive community care and support integrated approaches to how peoples' care provided to meet their psychological and physical health care needs.

We will continue with our existing quality improvement programmes that focus on the following key areas:

- Recovery care planning;
- Service user engagement;
- Improving physical health care;
- Restrictive practices;
- Fall prevention and reduction;
- Support for carers;
- Improving access to evidence based treatments.

We will have clear plans in place to ensure we address the areas we need to improve from the findings of the CQC Inspection of our services. Key actions will focus on improvements in safety, effectiveness and staff training. These plans will be publicly available on our website.

Our quality objectives for 2015/16

We have reviewed progress over the last year and engaged with our Governors and members regarding about next year's priorities. Alongside the development plans noted above, during 2015/16 we have updated our quality objectives. For each of the objectives we will monitor progress through the year against clear measures of success and report on progress to the Council of Governors, and publicly in next year's Quality Account.

The quality objectives we have agreed are:

Our current 2 year improvement priorities:	During 2015/16 we will focus on:
1. Responsiveness: We will improve access to our services so that people have their needs assessed quickly.	We will ensure all our services have agreed waiting time targets and we will report on our achievements during the year.
2. Safety: We will improve the physical health care provided to our service users.	We will ensure service users receiving on-going care and treatment will have an assessment and plan to meet their assessed physical health needs.
3. Experience: We will establish the Service User Experience Monitoring Unit to drive improvements in service user experience across the Trust.	From April 2015 onwards, all services will seek service user feedback and show they have responded to the feedback provided.

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 (eg in-patient forum, SUNRISE, Physical Health Group, Service User Engagement Forum, user and carer forum across ISS, CLDTs and supported living).

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 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.

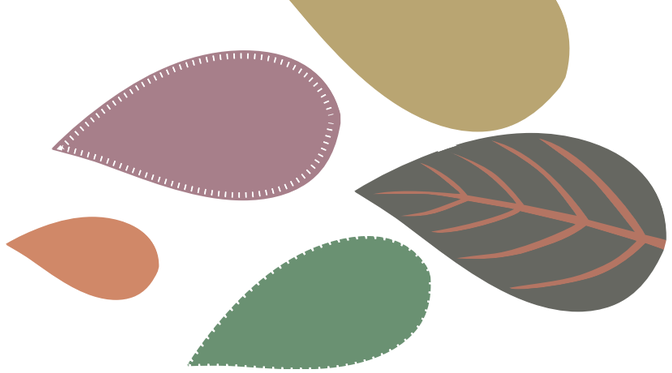
WORKFORCE DEVELOPMENT and LEADERSHIP

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 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 & Safety Committee
- Infection Prevention and Control Committee
- Safeguarding Children Steering Group
- Information Governance Group
- Mental Health Act Group

BOARD OF DIRECTORS

COUNCIL OF GOVERNORS

- Safeguarding Adults Steering Group
- Psychological Therapies Governance Committee
- Medicines Management Committee
- Restrictive Practives Group
- Service User Engagement Group

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 CQC registers, and 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.

The Care Quality Commission has not taken enforcement action against the Trust during 2014/15. The Trust has not participated in any special reviews or investigation by the CQC during the reporting period.

During 2014/15 we became the registered provider of the Brierley Medical Centre in Barnsley. We were asked to provide this service at short notice by the NHS Commissioner because the previous Practice was unable to continue to deliver appropriate services.

Planned Inspection

During 2014/15 the CQC undertook a planned inspection of some of the Trust's services. They inspected the following mental health and learning disability services that we are registered to provide:

- Acute wards for adults of working age and psychiatric intensive care unit;
- Long stay/rehabilitation mental health wards for working age adults;
- Forensic in-patient / secure wards;
- Wards for older people with mental health problems;
- Wards for people with a learning disability or autism;
- Community-based mental health services for adults of working age;
- Mental health crisis services and health based places of safety;
- Community-based mental health services for older people;
- Community mental health services for people with a learning disability or autism.

They inspected the following social care services that we are registered to provide:

- Longley Meadows respite service for people with learning disabilities;
- Hurlfield View community centre for older people with dementia;
- Woodland View Nursing Home;
- 136 Warminster Road respite service for people with learning disabilities;
- Supported living services for people with learning disabilities at Mansfield View;
- Supported living services for people with mental health problems at Wainwright Crescent respite service.

The Inspection took place during October - November 2014. At the time of producing this report the findings from the inspection have not been concluded or published. This is due to be finalised in June 2015.

There will be a range of issues that we will need to improve on in respect of safety and effectiveness. Along with the CQC we will publish the findings of the Inspection once they have been confirmed, along with our detailed action plan to respond to issues of concern identified. We will report publicly on the progress we have already made, and continue to make during 2015/16 to ensure we respond quickly and effectively to the feedback provided. The reports, our planned response and our progress reports will all be available on our website and formally reported in next year's Quality Account.

Mental Health Act reviews

During 2014/15 the CQC has undertaken 7 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
  Dovedale Wards 1 & 2, Burbage Ward
- Longley Centre
  Pinecroft Recovery Ward, Rowan Ward, Intensive Support Service
- Forest Close
  Bungalows 1, 1A, 2, 3
- Forest Lodge
  Assessment Ward
- Grenoside Grange Hospital
  Ward G1

2.2 Monitors' Assessment

Monitor reviews our performance and publishes a quarterly assessment on how we are doing. This information is available at **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 Monitors own assessment of how we are performing. In considering this, Monitor considers the following information:

- 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 overleaf feature our ratings for the last 2 years.

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 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 reorganise 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, and have continued to perform well during 2014/15.

2014/15

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 one of the national indicators during the year. We failed to achieve the standard of providing follow up care within 7 days of discharge from in-patient care for people under the Care programme Approach in the 2nd Quarter. Improvements were made to support communication and monitoring around discharge plans. We achieved the standards for the rest of the year.

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 Service Rating	n/a	n/a	4	4
Governance Risk Rating	Green	Green	Green	Green

Note: During 2013/14 Monitor's assessment framework changed to the Risk Assessment Framework in Quarter 3. The Financial Risk Rating was replaced by a Continuity of Service Rating. A rating of 4 under the Continuity of Service Rating is the equivalent of a 5 under the previous Financial Risk Rating.

A rating of 4 (which the Trust has) is a risk based rating used by monitor to assess the level of risk within the Trust based on its performance. A rating of 4 indicates that Monitor's assessment concludes there is no need to take any additional action in addition to routine monitoring of performance.

2014/15 Governance assessment of our performance

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of Service Rating	4	4	4	4
Governance Risk Rating	Green	Green	Green	Green

2.3 Goals agreed with our NHS Commissioners

A proportion of our income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2014/15 £1,780,537 of the Trust's contracted income was conditional on the achievement of these indicators. We achieved the majority of the targets and improvement goals that we agreed with our Commissioners. We received 83% of the income that was conditional on these indicators. For the previous year, 2013/14, the associated monetary payment received by the Trust was £1,814,117.

A summary of the indicators agreed with our main local health commissioner NHS Sheffield Clinical Commissioning Group for 2014/15 is shown below.

Incentivising improvements in the areas of safety, access, effectiveness and user experiences	
Implement the Friends and Family Test Survey We introduced the Friends and Family Test survey for service users and staff. By getting regular and consistent feedback from service users and our staff about the experience of receiving care, and providing care, we will be able to make better decisions about what we need to improve. We now need to continue to promote its use so everyone has the opportunity to provide feedback.	✔ FULLY ACHIEVED
NHS Safety Thermometer – reduce rates of falls that result in harm The target was to reduce the numbers of falls that resulted in harm within in-patient services, as measured by the NHS Safety Thermometer methodology. Incidents rates over a fixed 3 day period each month are reported. Between October 2013 - March 2014 there were 5 incidents of falls that resulted in harm to in-patients. Between October 2014 - March 2015 there were 2 incidents of falls that resulted in harm to inpatients. The median rate of falls has reduced within this timeframe from 0.5 to 0 (zero).	✔ FULLY ACHIEVED
Improving physical healthcare to reduce premature mortality in people with severe mental illness We wanted to improve our performance in 2 key areas: a) Undertaking comprehensive assessments of people's physical health needs when admitted to inpatient services	◗ PARTIALLY ACHIEVED
The aim was to achieve this standard for 90% of service users with achievements above 50% required as a minimum. We achieved the standard for 74% of service users. b) Ensuring comprehensive information about service users care under the care programme approach was communicated with their GP. The aim was to achieve this standard for 90% of service users, with achievement above 50% required as a minimum. We achieved the standard for 94% of service users.	✔ FULLY ACHIEVED

Incentivising improvements in the areas of safety, access, effectiveness and user experiences

Reducing variation in waiting times for patients referred to the IAPT Service We identified 8 GP Practices where people were experiencing very long waiting times to access our IAPT Service. We wanted to reduce the waiting times from an average of 9.6 weeks for the 8 Practices to below 5 weeks for the period October 2014 - March 2015 for each of the 8 Practices. We were very successful with this. Waiting times reduced overall for the 8 Practices to 1.9 weeks for the period October 2014 -March 2015. Each of the 8 Practices had an average waiting time of below 3 weeks. The city-wide average waiting times for the whole of the IAPT Service reduced from 5.4 weeks in 2013/14 to 3.8 weeks in 2014/15.	✔ FULLY ACHIEVED
People who are referred for a routine assessment will be assessed within 2 weeks of the referral We set a goal a goal for the number of people we would see for assessment within 2 weeks of the referral being made. We were successful in achieving the improvement targets over 3 of the 4 quarterly periods in the last year.	◗ PARTIALLY ACHIEVED
People using mental health services should have a care plan agreed with them and in place within 4 weeks of the assessment. We wanted to ensure that following an assessment, those who needed on-going support and treatment then had a plan of care in place quickly. We achieved the target set for this.	✔ FULLY ACHIEVED
Improved use of electronic discharge communications between in-patient services and GP's In the previous year we had piloted the introduction of electronic discharge communications to GPs for people discharged from in-patient care. This year we wanted to extend the e-discharge method of communicating discharge information to a community team as part of a continued roll-out programme. The aim behind this is to ensure GP's have immediate access to information about on-going care arrangements when someone is discharged. We continued to make progress on this, however, it did take longer than expected. We have made further changes to how this works and it will continue to be used next year.	◗ PARTIALLY ACHIEVED

The table above summarises the goals that we agreed with our Commissioners, and the progress that we made. Full details of the agreed goals for 2014/15 and for the following 12 month period are available electronically **www.shsc.nhs.uk/about-us/corporate-information/publications**.

The issues we have prioritised in next year's scheme are summarised as follows:

- Improving physical healthcare to reduce premature mortality in people with severe mental illness – continuing this year's work into next year;
- IAPT Service - continued focus on waiting times – for 80% of people to start treatment within 6 weeks of being referred;
- To improve access to dental care for people who need in-patient care for longer than a year;
- Smoking cessation support;
- Cluster reviews – 80% of reviews to be undertaken within the agreed timescales;
- To improve our screening and assessment of people's alcohol use;
- To improve the information we collect about if people have a copy of their care plan, the advice and support provided to carers and the use of recovery and relapse prevention plans;
- To continue to use of the e-discharge care plans, extending its use to other services in the Trust.

2.4 Review of services

During 2014/15 SHSC provided and/or subcontracted 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 2014/15 represents 100% of the total income generated from the provision of the relevant health services by the Trust for 2014/15.

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 CCG, other CCGs, Sheffield City Council and other NHS Commissioners.

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

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

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

Health and Safety Executive

There were no Health and Safety Executive visits to the Trust during 2014/15.

South Yorkshire Fire and Rescue

During 2014/15 the South Yorkshire Fire and Rescue Service did not undertake any visits or audits of the Trust's premises. In the previous year, 2013/14, 2 such visits were undertaken and 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 covered organisational, clinical, non-clinical and health and safety risks.

These factors create a 'RAG' rating which, in turn, determines the level of contribution the Trust makes to the NHSLA for insurance cover. The Trust's current RAG rating is red, which reflects a level of concern based on the cost incurred from negligence claims. This concern is based upon the previous claims history of the Trust, arising from incidents over 4-5 years ago.

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 2014/15 who were recruited during that period to participate in research approved by a research ethics committee was 843.

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 Yorkshire and Humber Collaboration for Leadership in Applied Health Research and the Yorkshire and Humber Local Research Network to improve our services and increase opportunities for our service users to participate in research, when they choose do so.

We have strong links with academic partners, including the Clinical Trials Research Unit and the School of Health and Related Research at the University of Sheffield, and the School of Health and Wellbeing at Sheffield Hallam University, to initiate research projects in the Trust.

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.

In 2015, SHSC will begin to use the Join Dementia Research tool designed by the National Institute for Health Research in association with Alzheimer's Research UK and the Alzheimer's Society to match service users who have expressed an interest in research with appropriate studies.

The Trust was involved in conducting 63 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;
- Stigma and discrimination experienced by mental health service users;
- Supporting for the families and carers of service users with dementia;
- Help to stop smoking for those with severe mental illness;
- Improving transition from children's to adult mental health services;
- Co-morbidities between physical health and mental health;
- New treatments for service users with dementia (including Alzheimer's disease).

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

During 2014/15 4 national clinical audits and 3 national confidential inquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

During 2014/15 the Trust participated in 100% national clinical audits and 100% national confidential inquiries in which it was eligible to participate.

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 percentage of those asked for
Guideline Audits		
National Audit of Schizophrenia – to ensure that the cardio-metabolic parameters of in-patients with schizophrenia were recorded	100	100%
POMH UK		
Prescribing for Substance Misuse (Topic 14a) – to ensure that prescribing practices are in line with NICE guidance	49	100%
Prescribing for people with Personality Disorder (Topic 12b) – to ensure that prescribing practice are in line with NICE guidance	52	100%
Antipsychotic prescribing for people with Learning Disabilities (Topic 9c) – to ensure that prescribing practices are in line with NICE guidance (see note 1)	26	100%
National Confidential Inquiries		
Inquiry into Suicide and Homicide by people with mental illness	8	16% (see note 2)
Inquiry into Suicide and Homicide by people with mental illness Out of District Deaths	14	100%
Inquiry into Suicide and Homicide by people with mental illness Homicide data	3	10% (see note 2)

Note 1: This audit was undertaken and submitted in March 2015 and the results are not available at the time of completing this report.

Note 2: The percentage figure represents the numbers of people who we reported as having prior involvement with as a percentage of all Inquiries made to us under the National Confidential Inquiry programme, i.e. in 84% and 90% 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 2014/15 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 and recording of cardiometabolic parameters of in-patients	**Results** – the aim of the audit was to assess if service users with a psychosis had received an assessment and appropriate plans were in place in respect of: • Smoking; • Lifestyle (including exercise, diet, alcohol and drugs) • Body Mass index; • Blood pressure; • Glucose regulation; • Blood lipids. We achieved the above standards for 74% of the service users audited. This was an improvement on previous audits and assessments. We are pleased that we have made good progress in this important area, but are clear that we have more to do to deliver the necessary standards of care consistently. **The Actions we have taken are**: We will continue with our existing development plans to improve awareness and training and monitor practice across in-patient teams to support further improvements. We will continue to audit standards of practice and care.
Prescribing for Substance Misuse	**Results** – 84% of service users had their drinking history documented on admission. 86% of service users had been prescribed the recommended medication for managing acute withdrawal. 69% of service users had a physical health assessment on admission and 71% had a liver function test done on admission. In total only 53% of service users were assessed for Wernicke's encephalopathy. Thiamine was only being prescribed parentally for 57% of service users. **The Actions we have taken are**: Training and development will be provided to support an improvement in assessment and prescribing practices.
Prescribing for people with Personality Disorder	**Results** – 64% of service users had a reason documented for prescribing antipsychotics. Of the service users prescribed medication for more 4 four weeks, 68% had a review. **The Actions we have taken are**: We will continue to monitor prescribing practices, paying attention to the above issues. Significant development work is being progressed to review and improve care pathways and the treatment and support provided to people with a personality disorder.
Antipsychotic prescribing for people with Learning Disabilities	**Results** – the data for this audit was submitted in March 2015 and results from the national audit are not available for inclusion in this year's report.

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 CCG, also asks the Trust to complete a number of local clinical audits each year, to review local quality and safety priorities. On a quarterly basis the Board review the progress of other local audits.

Examples of the types of local audits we have undertaken over the last year are:

- Falls Audit – to ensure that service users are screened for risk of falls within 72 hours of admission and that there is a falls plan in place;
- NHS LA Care Records - to ensure risk assessment documentation is adhering to guidelines;
- Food and nutrition – to ensure that in-patients are being screened for nutrition on admission and discharge.

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 report our performance on the following indicators:

- 7 day follow up – people on CPA should receive support in the community within 7 days of being discharged from hospital;
- 'Gate keeping' - everyone admitted to hospital should be assessed and considered for home treatment;
- Waiting times for IAPT services – 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 2014/15 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 regarding data quality under the mental health minimum data set is for January 2015. The Trust's performance on data quality compares well to national averages and is summarised as follows:

Percentage of valid records	Data quality 2014/15	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 2015.		

As a NHS Foundation Trust delivering mental health services we are required to deliver the following standards in respect of data completeness.

Percentage of valid records	Target	2013/14	2014/15
Service user identifiers For example date of birth, gender.	97%	99.8%	99.8%
Service user outcomes For example employment status, HoNOS scores	50%	95.3%	90.3%

Clinical coding error rates

Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission.

2.10 Information governance

We aim to deliver 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 framework. Based on our self-assessment Sheffield Health and Social Care NHS Foundation Trust's Information Governance Assessment Report overall score for 2014/15 was 68% for the 45 standards and was graded satisfactory/ green. A summary of our performance is provided below:

	Achieved			
Criteria	2012/13	2013/14	2014/15	Current Grade
Information Governance Management	73%	73%	66%	Satisfactory
Confidentiality and Data Protection Assurance	74%	66%	66%	Satisfactory
Information Security Assurance	66%	66%	66%	Satisfactory
Clinical Information Assurance	73%	66%	66%	Satisfactory
Secondary Use Assurance	66%	76%	66%	Satisfactory
Corporate Information Assurance	66%	66%	66%	Satisfactory
Overall	69%	68%	66%	Satisfactory

Note: 'Satisfactory' means we are at Level 2 on all the assessment criteria, based on our self-assessment. There are 4 levels, with Level 0 being the lowest rating and Level 3 the highest.

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 a positive reflection of the safety culture within the Trust. It helps us to understand what the experience of care is like, spot trends and make better decisions about what we want to address and prioritise for improvement. NHS England assesses our performance using the data supplied through the National Reporting Learning System (NRLS). Our reporting rates are summarised in the table below:

Incident rates per 1,000 bed days	Our rates	National average
April 12 - September 12	36.1%	23.8%
October 12 - March 13	29.1%	25.2%
April 13 - September 13	27.1%	26.4%
October 13 - March 14	42.4%	26.7%
April 14 - September 14	55.3%	32.8%

Source: National Reporting Learning System

The above changes in reporting rates are due to errors in the reports published by the NRLS and reduced bed days within our services as we have developed better community services. During April 12-September 12 our reported incidents under the NRLS was 1,858. During April 14-September 14 it was 2,129. This represents an increase in reported incidents of 14.5%. The national rates of reported incidents for the same period increased by 21.6% from 110,360 to 134,187. Our reported rates of bed days over the same period reduced from 51,400 in April 12-September 12 to 38,489. This is the main reason our reported rates have increased.

Nationally, based on learning from incidents and errors across the NHS, NHS England 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 2014/15 the Trust received 99 non-emergency alert notices, of which 94% where acknowledged within 48 hours, 18 were applicable to the services provided by the Trust and all were acted upon within the required timescale. In addition a further 26 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 latest NRLS figures show 12.2% of all patient safety incidents reported by the Trust were related to self-harm, in comparison with 21% for mental health trusts nationally.

Proportion of incidents due to self-harm/suicide	Our rates	National average
April 12 - September 12	11.3%	18.1%
October 12 - March 13	13.9%	19.8%
April 13 - September 13	11.7%	20.4%
October 13 - March 14	13.0%	21.0%
April 14 - September 14	12.2%	20.0%

Source: National Reporting Learning System

Violence, aggression and verbal abuse experienced by service users

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 over the last 3 years as we have prioritised and progressed significant improvement work under our RESPECT programme. Our reported incidents are now comparable with the national averages. This is summarised in the table below:

Proportion of incidents due to disruptive behaviour	Our rates	National average
April 12 - September 12	20.6%	18.2%
October 12 - March 13	16.5%	16.6%
April 13 - September 13	19.3%	17.0%
October 13 - March 14	21.8%	16.1%
April 14 - September 14	20.9%	16.1%

Source: National Reporting Learning System

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. Overall, the proportion of patient incidents that relate to medication errors in the Trust is below the national averages. Reported incidents have increased during 2014/15 due to improved reporting of discrepancies in stock balances, missed administrations and unclear prescribing.

Proportion of incidents due to medication errors	Our rates	National average
April 12 - September 12	6.1%	8.4%
October 12 - March 13	5.1%	8.3%
April 13 - September 13	5.8%	8.8%
October 13 - March 14	6.0%	9.0%
April 14 - September 14	6.4%	9.2%

Source: National Reporting Learning System

Cleanliness and infection control

The Trust is committed to providing clean safe care for all our service users and ensuring that harm from infections is prevented. An annual programme of infection prevention and control details the methods and actions required to achieve these ends. This includes:

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

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 at **www.shsc.nhs.uk**

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 2014/15 we have reported no breaches of these guidelines. We reviewed arrangements to ensure mixed sex guidelines were adhered to within our services at Forest Close during the year. Following this, we made some changes to accommodation arrangements to ensure we remained compliant with the guidelines.

Safeguarding

The Trust 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:

- Systems and policies in place;
- 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 worked hard over the last 2 years to improve staff awareness and provide appropriate training so that staff are aware of the issues and know what to do if they have any concerns. While most staff are familiar with the appropriate safeguarding procedures we have experienced challenges in delivering on-going training for staff. We will continue with our training programme into the next year and will ensure improvements in training provision are delivered.

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 this.

Overview of incidents by type

The table below 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. During 2014/15 we introduced an on-line incident reporting tool to make it easier for staff to report incidents that have occurred. We believe this is the main reason why the number of 'all incidents' reported has increased significantly during 2014/15, noting that the number of patient safety incidents reported to NRLS has remained stable. We will closely monitor this during 2015/16.

Incident Type	2012/13	2013/14	2014/15
All incidents	6275 (a)	6477 (a)	7808
All incidents resulting in harm	1461 (a)	1423 (a)	1878
Serious incidents (investigation carried out)	33 (a)	34 (a)	20
Patient safety incidents reported to NRLS (d)	3372 (a)	3616 (a)	3251
Patient safety incidents reported as 'severe' or 'death'	38	35 (a)	19
Expressed as a percentage of all patient safety incidents reported to NRLS	1.1%	0.97% (a)	0.66%
Slips, Trips and Falls incidents	1181 (a)	1175 (a)	1260
Slips, Trips and Falls incidents resulting in harm	420 (a)	419 (a)	448
Self-harm incidents	425	444 (a)	668
Suicide incidents (in-patient or within 7 days of discharge)	1	0	0
Suicide incidents (community)	19	16 (b)	16 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	1934	2162 (a)	2302
Violence, aggression and verbal abuse incidents resulting in harm	237	269 (a)	395
Medication Errors	322 (a)	345 (a)	485
Medication Errors resulting in harm	1	1	0

Incident Type	2012/13	2013/14	2014/15
Infection Control			
Infection incidents			
MRSA Bacteraemia	1	0	0
Clostridium Difficile infections (new cases)	0	1	1
Periods of increased infection/outbreak			
• Norovirus & Rotavirus	3 (28)	1 (12)	7 (64)
• Influenza	1 (3)	0	0
Showing number of incidents, then people affected in brackets			
Preventative measures			
MRSA Screening – based on randomised sampling to identify expected range to target	39%	47%	50%
Staff Influenza Vaccinations	56%	50%	50.7%

(a) Incident numbers have increased/decreased from those reported in the 2013/14 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 increased from that reported in last year's Quality Account report due to the conclusion and judgements of 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 are within 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 large Practice (16,700+ patients) serves a majority multi-ethnic migrant population in areas of social deprivation within Sheffield, with over 60% of the registered population from ethnic minority backgrounds, including one of the city's highest Slovak Roma population . The Mulberry site provides specialist and GP healthcare services to Sheffield's asylum seeking population. These populations bring 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 often 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. The table below summarises the overall achievement of all the QoF standards. The reduction on 2013/14 was due to the introduction of many new standards and an increase in % thresholds making QOF harder to achieve, rather than a reduction against the previous year's performance.

Year	Clover
2012/13	98.3%
2013/14	94%
2014/15	88%

The following table summarises performance against national standards for GP services. With specific regard to the flu vaccinations below, the uptake was lower this year possibly due to a combination of mild winter weather and adverse media publicity regarding the efficacy of the vaccine.

Primary Care – Clover GPs	This year's target	How did we do?			
		2012/13	2013/14	This year 2014/15	
Flu vaccinations					
Vaccinate registered population aged 65 and over	75%	78%	75%	72%	✔
Vaccinate registered population aged 6 months to 64 year in an at risk population	70%	56%	58%	51.7%	✔
Vaccinate registered population who are currently pregnant	70%	51%	46%	33.6%	✖
Childhood immunisations					
2 year old immunisations	70-90%	90%	90%	90%	✔
5 year old immunisations	70-90%	85%	82%	82%	✔
Cervical Cytology	60-80%	66.4%	66.2%	66.5%	✔

Source: National Reporting Learning System

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 year's target	How did we do?			
		2012/13	2013/14	This year 2014/15	
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%	95%	96%	81%	✔
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%	98%	83%		
Review TOP completed	80%	71%	89%	Unable to report at this time due to NDTMS reporting system issue	
Discharge TOP completed	80%	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	272	258	Discontinued as a measure due to service specification changes. New performance metrics in place for 2015-16	
% successful completions for the provision of treatment for injecting-related wounds and infections	75%	94%	94%		

Information source: National Drug Treatment Monitoring System

Learning Disability Services

The Intensive Support Service provides intensive support to people with complex learning disabilities, mental health problems and challenging behaviours. The focus over the last year has been to develop the service to ensure co-ordinated support is available to support people's needs within a community and in-patient setting.

The Community Learning Disability Teams (CLDT) aim to provide assessments of people's needs and co-ordinated support for people with complex needs. The CLDT service has prioritised improving access and reducing waiting times over the last year due to concerns that people were waiting for very long periods to access support. In the Autumn of 2014 there were 388 people on the waiting list for an assessment. By the end of March 2015 this had been reduced to 82 people. Waiting times over the same period had reduced from 40-46 weeks to 1-10 weeks, depending on which professional the person needed to see.

LEARNING DISABILITIES SERVICE	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
No-one should experience prolonged hospital care ('Campus beds')	Nil	Nil	Nil	Nil	✔
All clients receiving hospital care should have:					
• full health assessments	100%	100%	100%	100%	✔
• assessments and supporting plans for their 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 CPA 7 Day follow up and Gatekeeping indicators. While we have achieved the standards set for both measures, we compare above average for Gatekeeping and below average for CPA 7 Day follow up. We consider that this data is as described for the following reasons:

- Our development work to ensure effective and appropriate care pathways are in place;
- Failure to achieve the standards for CPA 7 day follow up in the 2nd Quarter of 2014/15.

The national average performance for CPA 7 Day follow up is 97.2% for the Q1-Q3 period. Our performance each quarter was 96.5% (Q1), 92.9% (Q2), 98.7% (Q3) and 98.6% (Q4). We have reviewed the circumstances behind the care provided for those who were not supported within the 7 day period after discharge. In the majority of cases the arrangements in place to deliver follow up care were appropriate and proactively implemented. NHS Sheffield CCG, our main Commissioner, has reviewed our performance under our contract with them, particularly in respect of the failure to achieve the standards over the 2nd Quarter. Informed by the reviews we have undertaken we have introduced measures to further improve communication between teams around discharge planning. We will review all future breaches with our Commissioner. We intend to ensure the above approaches continue to support effective delivery of standards in respect of Gatekeeping and CPA 7 day follow-up.

MENTAL HEALTH SERVICES	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
Improving Access to Psychological Therapies					
Number of people accessing services	10,008	10,735	11,611	13,535	
Number of people achieving recovery	50%	46%	47%	45%	✔
Early intervention					
People should have access to early intervention services when experiencing a first episode of psychosis	90 new clients per year	107 new clients accessing services	106 new clients accessing services	174 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	1,418 episodes provided	1,415 episodes provided	1,310 episodes provided	✔
Delayed transfers of care					
Delays in moving on from hospital care should be kept to a minimum	No more than 7.5%	4.7%	6.0%	4.4%	✔
Annual care reviews					
Everyone on CPA should have an annual review.	95%	98%	95.7%(a)	95.6%	✔
'Gate keeping'					
Everyone admitted to hospital is assessed and considered for home treatment	95% of admissions to be gate-kept	99.5%	99.8%	99.8%	
Comparators (b) National average		98.2%	98.3%	98.1%	✔
Best performing		100%	100%	100%	
Lowest performing		81.2%	85.7%	64.6%	

MENTAL HEALTH SERVICES	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
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	95%	96.1%	96.4% (c)	✔
Comparators (b) National average		97.5%	97.3%	97.2%	
Best performing		100%	100%	100%	
Lowest performing		92.7%	88.8%	91.9%	

Information source: Insight and Trust internal clinical information system

Note:

(a) The 95.7% figure represents the Trust's annual performance. The Trust failed to achieve the standard over the Quarter 2 period.

(b) Comparative information from Health and Social Care Information Centre.

(c) The 96.4% figure represents the Trust's performance at the end of the year. During the year the Trust failed to meet this target in Q2.

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. As we deliver better and more intensive community services the need for in-patient care has been gradually reducing.

We continue to explore ways to build on the excellent success of the Memory Service in improved access and improved diagnosis rates within Sheffield. Sheffield has the 2nd highest diagnostic rates in England, which means people in Sheffield are far more likely to access support with memory problems than elsewhere in the country. More people are receiving support and treatments than before as we get more referrals and see more people. As we see more people we have not reduced waiting times over the last year (see Part 2). We have introduced changes to the way we provide services, delivering more follow up support in local communities and we expect to deliver reductions in waiting times next year.

DEMENTIA SERVICES	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
Discharges from acute care (G1)	27	53	43	38	✔
Number of assessments for memory problems by memory management services	930	846	884	963	✔
Rapid response and access to home treatment	350	339	349	330	OK
Waiting times for memory assessment	N/A	15.4 weeks	15.8 weeks	23 weeks	▼ Getting Worse

Information source: Insight and Trust internal clinical information system

INDEPENDENT LIVING and CHOICE	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
Access to equipment Community equipment to be delivered within 7 days of assessment	95% of items to be delivered within 7 days	95.2%	96.7%	95.8%	✔
Choice and control People accessing direct payments to purchase their own social care packages	n/a	454 people with budgets agreed	635 people with budgets agreed	666 people with budgets agreed	✔

Information source: Insight and Trust internal clinical information system

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. 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.

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

Number of	2012/13	2013/14	2014/15
Formal Complaints	142	147	173
Informal Complaints	260	217	152
Compliments	1,396	1,196	1,150

This year the Parliamentary and Health Service Ombudsman notified us that 10 complaints had been referred to them by people who were dissatisfied with the Trust's response to their complaint. They were also still reviewing 1 case referred to them in 2013/14. No further action was required in 3 of the cases, 5 cases required remedial action (for example, apologies, reassessment and/or financial compensation) and, at the time writing this report, the outcome of 3 cases is still awaited.

A full picture of the complaints and compliments received by the Trust over the year is available on our website in the Annual Complaints and Compliments Report. This includes feedback from the complainants (the people who have made the complaint) about their experience of the complaints process and if they felt their concerns were appropriately addressed and taken seriously. We also publish information about the complaints and compliments we have received on a quarterly basis. The reports can be accessed via the following link:

www.shsc.nhs.uk/about-us/complaints

We use complaints as an opportunity to improve how we deliver and provide our services. A number of service improvements were made as a result of complaints this year. For example:

- Supported by investment from our Commissioners we have increased the numbers of staff working in A&E, Out of Hours and at weekends to provide quicker access to support people experiencing a mental health crisis;
- The Specialist Psychotherapy Service has improved the information available about the services they offer and how to access them;
- We improved the administrative arrangements to ensure quick responses were made to crisis referrals, ensuring professional staff were aware of the referral as it was received;
- We increased the nursing staffing levels at Woodland View Nursing Home to support improvements in service user experience and safety;
- We improved the drainage system at one of our premises to better protect neighbours should overspills occur;
- We improved the floor coverings at Hurlfield View Resource Centre.

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 have not been as good as we have wanted them to be.

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 has invested £6.4 million to 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 dedicate gardens and outdoor space. The building work started during 2014/15 and we look forward to the new ward opening towards the end of 2015.

Dovedale Ward – improving in-patient care for older people

Our wards for older people on the Longley and Michael Carlisle Centres were not as well designed as they needed to be. There was limited communal space and many of the bedroom areas were small and do not provide en-suite facilities for service users.

In response to this we opened a new ward in April on the Michael Carlisle Centre. Supported by an investment of over £320,000 Dovedale Ward now provides better access to en-suite facilities and an improved ward environment.

Woodland View Nursing Home – improving community care for older people

We have invested over £400,000 in a range of design and structural improvements to improve the environment and services provided at Woodland View Nursing Home.

General environment – external review and feedback

The last Patient Led Assessment of the Care Environment (PLACE) took place at the end of 2013/14. The conclusion of the review is summarised in the table below. Between 2013 and 2014 we improved our assessed scores in 19 of the 24 categories, and in 2014 the standards provided across the Trust's services were above the national average in 19 of the 28 categories (we had an extra site location in 2014, Firshill Rise).

Following a review of the last assessment the Board approved a development plan to address a range of improvements. Particular attention has been given to improving cleanliness and overall décor across the estate.

Site location	Year	Cleanliness	Food & Hydration	Privacy & Dignity	Condition & Appearance
Longley Centre	March 2013	89.4%	82.5%	89.7%	79.3%
	March 2014	96.4%	90.2%	89.6%	92.1%
Longley Meadows	March 2013	83.7%	87.4%	53.9%	65.6%
	March 2014	99.0%	90.1%	83.6%	95.7%
Michael Carlisle Centre	March 2013	95.5%	94.7%	94.2%	80.1%
	March 2014	99.2%	95.5%	89.0%	98.9%
Forest Close	March 2013	93.4%	88.6%	85.9%	77.1%
	March 2014	96.8%	92.6%	85.1%	94.5%
Forest Lodge	March 2013	83.4%	89.0%	96.2%	73.7%
	March 2014	98.0%	85.4%	82.9%	95.8%
Grenoside Grange	March 2013	84.9%	92.5%	87.7%	80.1%
	March 2014	99.7%	94.7%	83.3%	100.0%
Firshill Rise	March 2013	n/a	n/a	n/a	n/a
	March 2014	98.5%	87.7%	91.4%	98.4%
National average	March 2013	95%	84%	88%	88%
	March 2014	97.8%	88.8%	87.7%	92.0%

What do people tell us about their experiences?

The national patient survey for mental health Trusts highlights that the experience of our service users is comparable with other mental health Trusts.

The table overleaf summarises the overall results from the last national survey undertaken in 2014. The national patient survey was changed in 2014, and its new structure means that comparisons to previous years surveys cannot be readily undertaken. Therefore, we haven't reported in this report on the survey scores from previous years. However, this information is available in our Quality Account for the previous year 2013/14.

Mental Health Survey 2014 **Issue** – what did service users feel and experience regarding;	**Patient response**	**How did we compare with other Trusts?**
Their health and social care workers	7.5/10	About the same
The way their care was organised	8.4/10	About the same
The planning of their care	6.5/10	Worse
Reviewing their care	7.2/10	About the same
Changes in who they saw	5.9/10	About the same
Crisis care	5.9/10	About the same
Treatments	7.2/10	About the same
Other areas of life	4.8/10	About the same
Overall views and experiences	7.0/10	About the same

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

Patient Survey	**2014 Survey**		
	Lowest national score	**Highest national score**	**Our score**
How well did people who use our services comment on their overall experience of contact with a health or social care worker	7.3	8.4	7.5/10
Did they feel staff listened carefully to them?	7.7	8.9	8.2/10
Did they feel they were given enough time to discuss their needs and treatment?	7.2	8.4	7.4/10
Did they feel the member of staff had an understanding of how their mental health needs affect other areas of their life?	6.5	8.1	7.0/10

The table above highlights our comparative performance on service user experience in respect of contact with our staff and the support and care we have provided. In most of the areas covered in the survey, the experience of our service users is about the same as it is in other Trusts in the country. While this offers some assurance about the quality of the services we provide, we want to do better than this. We want the experience of our service users to be really positive and among the best in the country. We are concerned that the feedback highlights that service users have a poorer experience of the arrangements for planning their care than in other Trusts across the country, and we will ensure our current plans continue to deliver the necessary improvements..

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

- We need to continue with our development programme to improve our approaches to care planning, ensuring recovery orientated care is based around the goals that individuals set for themselves. This programme has been successfully established within our in-patient services, and was introduced within our community services during the year. We plan to extend this approach to care planning to the rest of our community teams;
- We need to reduce the time staff in teams have to spend on administrative tasks that take them away from time with service users. We have introduced a range of productivity improvement and mobile working initiatives. The focus of this work is to ensure staff can spend the maximum amount of time directly with service users.

We will continue to take the above actions to maintain and improve our position regarding the quality of our services. Our on-going development programmes, our Quality Objectives, and our focus on supporting individual teams to understand their own performance and take decisions to improve the quality of care they provide locally are some of the key actions that will support this.

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**
2012 Staff Survey (score out of 5)	3.36	3.68	3.54	3.63
2013 Staff Survey (score out of 5)	3.40	3.68	3.55	3.80
2014 Staff Survey (percentage score)	n/a	n/a	60%	67%

The above table highlights how our staff view the quality of services provided by the Trust compared to staff in other mental health organisations.

We consider this data is as described due to our continued efforts to engage with our staff and involve them in the plans and decisions regarding ho 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 decisions 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.

OVERALL ENGAGEMENT& CARE	Previous years			2014		
	2012 Score	2013/14 Score	Compare	Our score	National averages	Comparisons
Overall Staff Engagement	3.73	3.81	Best 20%	3.81	3.71	Best 20%
Care of service users is my organisation's top priority	71%	73% n	n/a	76%	65%	n/a
TOP 5 RANKINGS – The areas we compare most favourably in with other mental health and learning disability Trusts						
Recommend Trust as place to work or receive care and treatment	3.63	3.80	Best 20%	3.78	3.57	Best 20%
% of staff who feel able to contribute to improvements	73%	74%	Above average	75%	72%	Best 20%
% of staff agreeing that they would feel secure raising concerns about unsafe clinical practice	n/a	69% n/a	n/a	72%	69%	Best 20%
Fairness and effectiveness of our incident procedures (score out of 5)	3.54	3.60	Best 20%	3.61	3.52	Best 20%
% of staff working extra hours (lower score is good)	64%	62%	Best 20%	64%	71%	Best 20%
OTHER BEST SCORES – We were also in the best 20% of mental health and learning disability Trusts in the following areas						
Job satisfaction (score out of 5)	3.72	3.76	Best 20%	3.73	3.67	Best 20%
% of staff reporting good communication between senior management and staff	35%	36%	Above average	37%	30%	Best 20%
WORSE 5 – The areas we compare least favourably in with other mental health and learning disability Trusts (in this year's survey the Trust was assessed to be in the worse 20% for only 4 categories)						
% of staff receiving H&S Training	50%	48%	Worse 20%	62%	73%	Worse 20%
% of staff witnessing potentially harmful errors, near misses or incidents in the last month	26%	24%	Below average	32%	26%	Worse 20%
% of staff experiencing physical violence from staff in last 12 months	4%	3%	Below average	6%	3%	Worse 20%
% of staff feeling motivated at work	3.77	3.78%	Below average	3.77	3.84	Worse 20%

The Trust employs around 3,000 people and as part of our responsibility to ensure we provide good quality care we participate in the annual NHS Staff Survey programme. The NHS Staff Survey attempts to identify the major factors contributing to staff engagement and motivation. By focusing on these, we aim to enhance the quality of care provided to the people who use our services. The NHS Staff Survey provides us with feedback on the Trust's performance across a range of relevant areas.

Overall, we are encouraged with the above results. The positive feedback around engagement continues to support our on-going focus on improving quality and delivering our plans for service improvement. The full survey will be available via the CQC website. The survey provides a large amount of detail around complex issues. We look 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 job satisfaction, and the worse 20% for staff feeling motivated at work.

Last year's survey (2013) highlighted that we were in the worse 20% for staff appraisals, providing diversity training and providing health and safety training. Over the last year we have focussed on these areas and are pleased to report good progress.

Our performance, as assessed through the staff survey, shows that we are now above average in providing staff with appraisals, increasing from 78% in 2013 to 90% in 2014. While we still compare as below average for providing diversity training and health and safety training, we have made good progress in improving this. Staff reporting that they have received diversity training has increased by 19% and for health and safety training by 14%.

Informed by the 2014 survey feedback the areas we have prioritised for on-going and further development work are as follows:

Training

We have an established training programme in place. We have placed significant 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 well for staff who believe they have received job related learning and development opportunities (above average).

However, we continue to experience challenges in ensuring all staff remain up to date with some routine and important training needs. Areas we need to improve, for example, are safeguarding, mental capacity act, refresher training in RESPECT and basic life support. NHS Sheffield CCG has reviewed this area of concern with the Trust and have closely monitored progress against our development plan. The Trust is committed to delivering sustained improvements next year, building on the progress made during 2014/15. Last year we made a range of changes to make key training areas more accessible to staff, for example, introducing more on-line training resources for staff. These changes have had a positive impact as the results in the 2014 survey show. We will continue with them next year, ensuring we have a clear improvement programme in place to make sure staff remained equipped to deliver safe and effective care.

Staff witnessing harmful incidents and errors

This figure has increased from 24% to 32% since last year. It is the only score which the results have highlighted as an area where staff experience has deteriorated; the mental health Trust average is 26%. The 2013 survey reported the mental health Trust average as 26% so at that time the Trust rated better than average in this score. The reason for this increase is not clear and the data is not straightforward as the Trust has maintained its position on the reporting of near misses (91%) and is in the best 20% of comparable Trusts for the fairness and effectiveness of its reporting procedures. It is likely that the most credible explanation is that the score relates to the fact that while several people may have witnessed an incident, only 1 person would have reported it. It is also recognised that the Trust moved to electronic reporting last year and it is not known whether this could have had some form of impact on the apparent discrepancy. We will further review incident trends and consider if there is any correlation and develop an action plan accordingly.

Staff experiencing assaults from other staff

The percentage of staff reporting physical violence from other staff has moved from better than average to the bottom 20%. This result does not accord with any reports under our various procedures and the survey indicates no statistically significant change from last year. At the same time the report indicates that the percentage of staff experiencing harassment from staff is better (lower) than average.

Any level of violence against staff is a concern. This finding from the survey does not correlate with any reported incidents which would be regarded as gross misconduct and subject to a disciplinary process and potential dismissal. The report is being shared with Staff Side representatives and we will work together to understand the potential for such issues to be unreported. We will also review incident reports to establish if they involve any indications of this issue.

Staff motivation at work

This is part of the staff engagement category where the Trust scores highly. At this stage, we have not identified any specific action in response to this because of the imprecise nature of the category and its inconsistency with the other indicators such as staff satisfaction and recommending the Trust as a place to work or receive treatment. However, the Trust will explore whether further information can be obtained to inform further understanding, for example, a question in the Staff Friends and Family Test.

ANNEXE A

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

Healthwatch

Healthwatch Sheffield are pleased to be able to comment on this Quality Account produced by Sheffield Health and Social Care NHS Foundation Trust.

We note that they have maintained a similar style and layout to last year's document and we are encouraged to see that the language used is on the whole understandable. We would still like to see the production of an easier to read or summary version of the report, as has been done in other Trusts in Sheffield. We would be willing to work with the Trust to achieve this.

We would challenge the Trust's assertion in Quality Objective 1 that they have made positive progress in some areas, as in fact it appears they have only made progress in 1 of the 3 highlighted areas. We did note the growing waiting times for the memory clinic in our response last year and are disappointed that this has continued, though we note the increased demand for the service and that the Trust is going to define waiting time standards in the forthcoming year.

We are pleased that the planned Service User Experience Monitoring Unit has been established, but would have liked to see a little more information about what it has achieved in this year.

Healthwatch notes the continued rise in serious incidents for both patients and staff. We commented on a similar situation last year and were assured that this was in part due to better reporting, however, we would still hope to see the total number of incidents fall or level off.

We also note that the NHS staff survey shows a worse than average result for staff undergoing Health and Safety training. The accompanying narrative states that the Trust has implemented a range of changes to make training more accessible for staff, and we would therefore ask that the Trust looks again at these changes in light of the information contained in the staff survey. We also see that double the average percentage of staff to staff violence is being reported and are pleased to see in the narrative that the Trust are taking this issue very seriously and is looking into how this figure may have arisen.

We are also concerned that in last year's comments we mentioned performance issues with the Clover Group, and that the figures for this year were not available in the draft we received, so at the time of writing our concerns still stand. We will of course revisit this once this year's figures are available to us.

We would like to thank the Trust for providing us with this draft Quality Account, and are pleased to have been invited to participate in their Service User Experience Safety Group in 2015/16.

Our response

We welcome the helpful feedback from Healthwatch following a review of a draft of our Quality Account.

It is clear that we have not made the progress we wanted to in reducing waiting times for access to Memory Services. While the service has done well to increase the number of people it has been able to assess by 21%, we remain concerned that waiting times have increased. This concern is equally shared by the Scrutiny Committee and NHS Sheffield Clinical Commissioning Group. We will continue to develop plans with the support of our Commissioners and report on progress during 2015/16.

The final version of our Quality Account summarises the work progressed with in the Trust in respect of service user monitoring and engagement.

We continue to monitor and evaluate our incident data. The final report contains the annual position for the 2014/15 year with commentary on the changes and trends. Overall, patient safety incidents or serious incidents have not increased this year compared to the previous year, although it is the case that overall rates of reported incidents have increased. The Board's Quality Committee will continue to monitor trends during the year.

The CQC staff survey confirms that we made a significant level of improvement during 2014/15 in ensuring staff have received Health and Safety training, increasing by 14%, while remaining worse than the national average. We believe the changes we have introduced have had an impact during 2014/15, but it is clear we have more to do and our plans will ensure further progress is made. At this stage we cannot account for the feedback from the staff survey regarding staff reporting incidents of violence from other staff. It does not accord with any other information available to the Trust and we will continue to explore this through the next year.

The annual performance figures for Clover are reported in the final Account. Performance levels have decreased due to increased thresholds for the targets, and there has been a deterioration within rates of screening. We will continue to respond to the needs of the Practice population with a range of approaches and improvement actions.

We will be producing an easy read summary version of our Quality Account.

We look forward to on-going dialogue and meetings with Healthwatch during 2015/16 during which we will be able to review progress in more detail on the above issues and other areas of interest.

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

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

The Committee feels that the quality priorities are appropriate, and through its work this year has not been made aware of any concerns about the Trust's performance by members of the public. The Committee remains concerned at the waiting times for the Memory Clinic, and will continue to monitor this over the coming year. The Committee is pleased to see the continued focus on the physical health of patients, and looks forward to seeing improvements.

We are disappointed to see that the Trust is below average on service user satisfaction with their care planning according to the 2014 Mental Health Service. We hope to see evidence that the Trust's continued focus on service user experience through the quality priorities will drive improvement in this.

The Committee found the Quality Report well presented, and easy to follow, and would like to suggest that in future, the Trust engages earlier with Healthwatch Sheffield in the Quality Accounts process.

The Committee recognises that the mandatory timescales for production of the Quality Report can be problematic, and often requires Trusts to consult on the document before they have full year performance information. The Committee will raise this with the Department of Health and Monitor.

The Committee thanks the Trust for their co-

operation this year, and looks forward to discussions on the outcome of the recent Care Quality Commission inspection in the summer.

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 welcome the opportunity to review our plans and progress further with the Committee during 2015/16. We are concerned that the feedback from the national patient survey highlights services users have a poorer experience of the arrangements for planning their care than in other Trusts in the country. We will ensure our current plans continue to deliver the necessary improvements. We have established a number of review meetings with Healthwatch during 2015/16 to support on-going dialogue about the Trust's performance and progress against its quality priorities.

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 Report 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 2014 – March 2015.

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.

This Quality Report evidences that the Trust has achieved positive results against most of its key objectives for 2014/15. Where issues relating to clinical quality have been identified, we have worked closely with the Trust to ensure that improvements are made. During 2015/16 we will continue this work in what will potentially be a very challenging year, and will do this through building 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.

Our response

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

We look forward to working with the CCG during 2015/16 to ensure the plans in place to deliver the necessary improvements will result in real benefits and improved outcomes for the people of Sheffield.

ANNEXE B

2014/15 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:

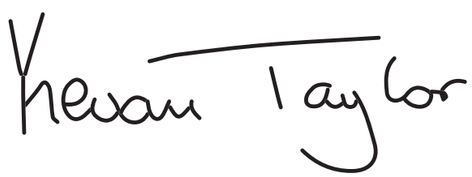
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2014 to May 2015;
    - Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
    - Feedback from the Commissioners dated 19 May 2015;
    - Feedback from Governors in May 2015;
    - Feedback from Healthwatch dated 21 May 2015;
    - Feedback from the Scrutiny Committee dated 27 April 2015;
    - 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 2014;
    - The national staff survey issued February 2015;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2015; and
    - Care Quality Commission intelligent monitoring reports issued during 2014/15;
- 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
22 May 2015



Chief Executive
22 May 2015

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 2015 (the Quality Report) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- 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 two 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 2014/15 (the Guidance); 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 Guidance.

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 2014 to May 2015;
- Papers relating to quality reported to the Board over the period April 2014 to May 2015;
- Feedback from Commissioners, dated May 2015;
- Feedback from Governors, dated May 2015;
- Feedback from Healthwatch Sheffield, dated April 2015;

- Feedback from Overview and Scrutiny Committee dated April 2015;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2014;
- The 2014/15 national patient survey;
- The national staff survey, dated February 2015;
- The 2014/15 Care Quality Commission Intelligent Monitoring Report; and
- The Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2015.

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 the 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 2015, 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, except 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;
- Analytical procedures;
- 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; and
- 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.

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 affect 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 of these criteria, 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 2015:

- 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 Guidance; 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 and the six dimensions of data quality set out in the Guidance.

KPMG LLP,
Chartered Accountants
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Leeds
LS1 4DW

26 May 2015


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LIKE
FREE
FREE
CURE
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SUPPORT
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JOY
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