Sheffield City Council

Sheffield Health and Social Care NHS

NHS Foundation Trust

Quality Account 2014/15

Draft 2
April 2015

DRAFTING NOTES

1. Data is based on Apr-Dec or Apr-Feb out turn projected to year end to allow comparisons.
2. Most sections have been refreshed and updated, and are noted as such.
3. CQC Inspection findings are pending and therefore issues raised and the Trust's planned responses are not contained within this draft.

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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.

We achieve many improvements in quality by changing how we deliver services across the city. We may expand services, re-organise how we provide them, develop better partnerships with other services in Sheffield. Change and improvements are delivered in this way, and you will find information about these changes in our full Annual Report for 2014/15.

There is also significant potential to deliver improvements in quality by focussing on improvements within the day to day care and support we provide. Our on-going challenge and commitment is to reflect on what we learn about the experiences of those who use our services and identify how it could be improved.

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

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

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

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

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

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

Introduction to be re-drafted following CQC Report feedback to reflect key findings and Trust response.

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 300 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 IAPT service, adult Community Mental Health Teams and our Memory Service.

How did we do?

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

IAPT Services

The information below shows the positive progress made. This has been achieved through an on-going development programme focussed 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 quicker than before. Over the last two years we have introduced direct booking by GP's, which reduces the amount of time it used to take 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 second half of the year for those practices that had experienced the longest waits.

Measure	2012/13	2013/14	2014/15
Average waiting time to start treatment	5.6 weeks	5.3 weeks	3.5 weeks
Average waiting time to start treatment for 8 practices with longest waits.	n/a	9.6 weeks	1.9 weeks (Oct-March)

CMHT's

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	2012/13	2013/14	2014/15
Average waiting time for people to be assessed in our adult CMHT's for a routine appointment		36 days	40 days

Memory Service

We haven't made the progress we wanted to in reducing waiting times for this important service. During the year we agreed with our Commissioners improvement plans to provide more follow up support in community settings. The benefits of this are that it is more convenient for service users, and it 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	2012/13	2013/14	2014/15
No. of referrals		1,517	2,150
No. of initial assessments		1,396	1,700
Average waiting time for people to be assessed in our adult CMHT's for a routine appointment		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 CMHT's

- review our capacity and resource plans for the memory service due to the increased levels of demand and agree a way forward with commissioners
- define waiting time standards for all our services and publish information about how we are performing for each service.

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 learning disabilities 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 external to partner organisations. We planned to build on existing and planned developments to ensure that we and our partner organisations work collaboratively to ensure health of service users continues to improve.

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

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

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 improved our standards of practice within our inpatient services for assessing alcohol use with service users, and have developed plans to extend this into community services.

Obesity - An e-based version of the 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 and will be available during 2014/15.

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 in malnutrition universal screening tool (MUST), 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

DRAFTING NOTE: TO INSERT SUMMARY OF KEY FINDINGS (AUDIT RESULTS NOT PUBLISHED AT TIME OF DRAFT COMPLETION)

How will we keep moving forward?

Summary to be drafted that

- *Summarises key work programmes of Trust strategy*
- *Responds to findings of national audit*

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 lead 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?

The Service User Monitoring Unit was established during the year following the appointment of a service user to provide the necessary leadership to support the Trust to take this important agenda forward.

Towards the end of the year the Trust has completed a review of the areas that we will prioritise and focus on to support on-going improvements. We have established a development programme that will ensure the following goals and improvements are delivered:

- To have in place effective and consistent approaches for the collection of Trust-wide 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?

To draft summary of on-going plans

How are we doing on our previous years Quality Objectives?

Introduction

In last years Quality Account we reported on progress for the previous two 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 two 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 Trust-wide basis. These changes include:

- The creation of a trust wide 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 paper-based 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

Incident type	2012 /13	2013 /14	2014 /15
Incidents reported where **service users** had been			
• Secluded	74	279	324
• Restrained	89	186	433
• Assaulted	387	384	476
• Caused harm from assault	72	75	222
Incidents reported where **staff** working in inpatient services			
• Had been assaulted	606	595	409
• Were harmed due to the assault	99	108	137
Level of harm caused from the assault			
• Negligible harm	68	88	95
• Minor or moderate	31	20	43
• Major and above	0	0	0

Whilst this plan is ambitious and requires further development, the Trust has been encouraged by early successes. The Trust believes that this plan achievable in the longer term and will promote its 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.

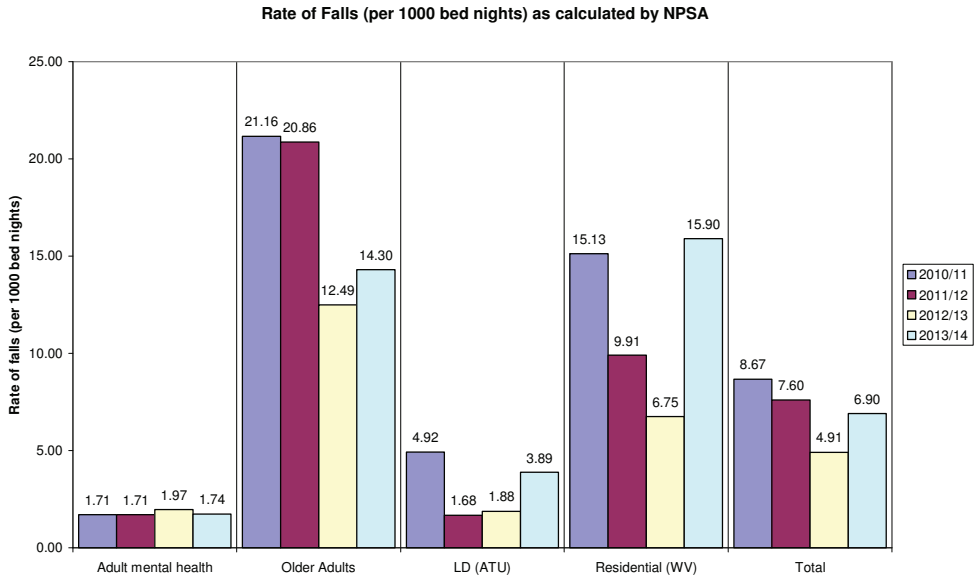
In last years Quality Account we reported that overall incidents of falls that resulted in harm had reduced by 25% over the three year period from 2011/12. Over the last year the number of falls that resulted in harm increased, following a year on year decrease over the previous 3 years. A summary of the impact of the harm caused is provided in the table below:

How many people	2012-2013	2013-2014	2014-2015
Falls resulting in harm	403	387	424
Needed to attend hospital or A&E	52	50	52
Experienced minor harm	90	68	81
Experienced moderate harm	17	13	17
Experienced major harm	0	1	0

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 three 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. 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 – by 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.
- 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



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. As we plan for the next year there are no significant areas of concern identified from our on-going engagement with our regulators, commissioners or our performance against the national standards required of us that indicate we need to prioritise improvement action.

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. However we also recognise that we can do better, and need to do better. We have much to do to ensure the quality of what we provide is of a consistent high standard, every time, for every person in respect of safety, effectiveness and experience.

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 agencies in Sheffield support people experiencing a crisis in the mental health. Our service development plans (summarised on our Annual Plan) will deliver changes that will improve people's experience of care. Our plans will improve primary care mental health provision, deliver more intensive community care and support and introduce more integrated approaches to how peoples care is organised and provided across both their health and social care needs and their psychological and physical health care needs.

Our quality objectives for the next year

We have reviewed progress over the last year and engaged with our Governors and members regarding priorities for quality improvement. As we look to this year we plan to focus our priorities for improvement in the areas described below. For each of the goals we will monitor our progress throughout the year against clear measures of success. We will report on progress to the Council of Governors, and publically in our Quality Account. The priorities are the specific areas we aim to improve during the year.

Alongside this we have a broader development plan that will ensure we make progress in developing our services in response to the findings of the CQC Inspection. (*Drafting note: will need to summarise issues once available*)

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

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

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

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

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

DELIVER BEST PRACTICE
Ensuring the care and support we provide is guided by what we know works

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

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

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

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

MONITOR & 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 & 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
- Audit Committee
- Mental Health Act Group

BOARD OF DIRECTORS

COUNCIL OF GOVERNORS

- Safeguarding Adults Steering Group
- Psychological therapies governance committee
- Medicines Management Committee
- Information Governance Gp
- Restrictive practices 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 four 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 delivery appropriate services.

Planned Inspection

During 2014/15 the CQC undertook a planned inspection of all the Trusts services, with the exception of our Substance Misuse Services and Primary Care/ GP Services which will be inspected during 2015/16.

DRAFTING NOTE: 1-2 PAGE OVERVIEW TO BE COMPILED HIGHLIGHTING THE ASSESSMENT SCORES FOR EACH SERVCIE TYPE AND HIGH LEVEL RESPONSE PLAN

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

Mental Health Act reviews (updated)

During 2014/15 the CQC has undertaken 7 visits to services to inspect how we deliver care and treatment for inpatients detained under the Mental Health Act. They review our processes for care, the environment in which we deliver our care and meet privately with inpatients. They have visited the following services: (*based on mid-March position*)

- Michael Carlisle Centre
  Dovedale 1 & 2, Burbage Ward
- Longley Centre
  Pinecroft Ward, Rowan Ward, ISS Service
- Forest Close
  Bungalows 1, 1A, 2, 3
- Forest Lodge
  Assessment Ward
- Grenoside
  Ward G1

2.2 Monitors' Assessment (updated)

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

The governance assessment (rated as either red or green) is based on the Trust's self-declaration by the Board of Directors alongside 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 below feature our ratings for the last two 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 second and third quarters we only achieved this for 89% of people. We introduced a range of changes that were focussed on

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

This enabled us to make improvements and we achieved the target by the end of the year, 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 inpatient care for people under the Care programme Approach in Quarter 2. 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 services rating	n/a	n/a	4	4
Governance risk rating	Green	Green	Green	Green
Note: During 2013/14 Monitors assessment framework changed to the Risk Assessment Framework in Quarter 3. The Financial risk rating was replaced by a Continuity of services rating A rating of 4 under the continuity of service rating is the equivalent of a 5 under the previous financial risk rating.				

2014/15 Governance assessment of our performance				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of services rating	4	4	4	4
Governance risk rating	Green	Green	Green	Green

2.3 Goals agreed with our NHS Commissioners (updated)

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 £tbd 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 tbc% 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 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 inpatient services, as measured by the NHS Safety Thermometer methodology. Incidents rates over a fixed 3 day period each month are reported. Between Oct 2013 - March 2014 there were 5 incidents of falls that resulted in harm to inpatients. Between Oct 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 peoples physical health needs when admitted to inpatient services b) Ensuring comprehensive information about service users care under the care programme approach was communicated with their GP. We aimed to achieve the above standards for 90% of service users. We made significant improvement during the year in our performance and met the standard fully for 70% of service users (*estimate at time of drafting*).	✓ PARTIALLY ACHIEVED
Reducing variation in waiting times for patients referred to the IAPT services We identified 8 GP practices where people were experiencing very long waiting times to access our IAPT services. We wanted to reduce the waiting times from an average of 9.6 weeks for the 8 practices to below 5 weeks for the period Oct 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 Oct 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 services had reduced from 5.4 weeks in 2013-2014 to 3.8 weeks in 2014-2015. (*Estimated based on end Feb data*)	✓ FULLY ACHIEVED

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	
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 inpatient services and GP's In the previous year we had piloted the introduction of electronic discharge communications to GP's for people discharged from inpatient care. This year we wanted to extend the e-discharge method of communicating discharge information to other services. 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 at (*insert web link*).

The issues we have prioritised in next years scheme are summarised as follows:

- Improving physical healthcare to reduce premature mortality in people with severe mental illness – continuing this years work into next year.
- IAPT 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 inpatient care for longer than a year.
- Smoking cessation support
- Cluster reviews – 80% of reviews are undertaken within the agreed timescales
- To improve our screening and assessment of peoples 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 (updated)

During 2014/15 SHSC provided and/or sub-contracted 52 services. These can be summarised as 43 NHS services and 9 social care services. The income generated by the relevant health services reviewed in 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 (updated)

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 didn't 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, based upon the previous claims history arising from incidents over 4-5 years ago.

2.7 Participation in Clinical Research (updated)

The number of patients 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 (updated)

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 which it was eligible to participate in.

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

Name of national audit SHSC participated in	Number of cases submitted	Number of cases submitted as a percentage of those asked for
Guideline Audits		
National Audit of Schizophrenia - To ensure that the cardio-metabolic parameters of inpatients 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 practices 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 (***Note 1***)	26	100%
National Confidential Inquiries		
Inquiry into Suicide & Homicide by people with mental illness	8	16% (***Note 2***)
Inquiry into Suicide & Homicide by people with mental illness Out of District Deaths	14	100%
Inquiry into Suicide & Homicide by people with mental illness Homicide data	3	10% (***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. ie 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 cardio-metabolic parameters of inpatients	**Results** – The audit findings have yet to be published. We know we have made good progress on our baseline audit results, but we still need to improve and get better at monitoring of physical health **The Actions we have taken are:** TBC
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 encelophalopathy. 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. Out of the service user prescribed medication for more than 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 aren't available for inclusion in this years report.

<u>Local audit activity</u>

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 would be:

- 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 inpatients are being screened for nutrition on admission and discharge

2.9 Data Quality (updated)

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 (tbc)

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. (*this is the expected position – audit underway*)

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 Trusts 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		

Clinical coding error rates (updated)

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 (updated)

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. 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

Part 3: Review of our Quality Performance

3.1 Safety (updated)

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
Apr 12 - Sept 12	36.15%	23.8%
Oct 12 - Mar 13	29.1%	25.25%
Apr 13 - Sept 13	27.07%	26.4%
Oct 13 - Mar 14	29.23%	26.71%
Apr 14 - Sept 14	tbc	tbc
Source: National Reporting Learning System		

Drafting note: No data has been released yet for 2014/15. Mandated management commentary on Trust position compared to averages, and changes to previous years to be completed once latest data is available.

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 20.4% 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
Apr 12 - Sept 12	11.3%	18.1%
Oct 12 - Mar 13	13.9%	19.8%
Apr 13 - Sept 13	11.7%	13%
Oct 13 - Mar 14	20.4%	21%
Apr 14 - Sept 14	tbc	tbc
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. This is summarised earlier in Section 2. 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
Apr 12 - Sept 12	20.6%	18.2%
Oct 12 - Mar 13	16.5%	16.6%
Apr 13 - Sept 13	19.3%	21.8%
Oct 13 - Mar 14	17%	16.7%
Apr 14 - Sept 14	tbc	tbc
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. This is summarised in the table below:

Proportion of incidents due to medication errors	Our rates	National average
Apr 12 - Sept 12	6.1%	8.4%
Oct 12 - Mar 13	5.1%	8.3%
Apr 13 - Sept 13	5.8%	8.8%
Oct 13 - Mar 14	6%	9%
Apr 14 - Sept 14	tbc	tbc
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 is prevented from irreducible infections. To achieve this an annual programme is produced by the Infection Prevention and Control Team that details the methods and actions required to achieve these ends. The programme includes:

- processes to maintain and improve environments;
- the provision of extensive training;
- systems for the surveillance of infections;
- audit of both practice and environment;
- provision of expert guidance to manage infection risks identified.

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

Single sex accommodation

The Trust is fully compliant with guidelines relating to providing for appropriate facilities for men and women in residential and inpatient settings. During 2014/15 we have reported no breaches of these 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 that are followed
- the right training and supervision in place to enable staff to recognise vulnerability and take action
- expert advice available to reduce the risks to vulnerable people

We have 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. By the end of this year *TBC*% of relevant staff have received adult safeguarding training and *TBC*% of relevant staff have received level 3 Safeguarding Children training. We will continue with our training programme into the next year.

Reviews and investigations

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

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

Improvements and lessons learnt

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

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

Examples of the types of improvement actions we have been able to take following reviews of serious incidents are	• *[Summary of examples from the last year to be compiled]*

Overview of incidents by type – (updated: incident data for Apr-Dec14, 9 mths, has been used and prorated up to a 12 mth equivalent to allow basic comparisons in the draft)

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.

Incident Type	2012/13	2013/14	2014/15
All incidents	6275 (a)	6477 (a)	7907
All incidents resulting in harm	1461 (a)	1424 (a)	1963
Serious incidents (investigation carried out)	33 (a)	34 (a)	27
Patient safety incidents reported to NRLS (d)	3372 (a)	3615 (a)	3448
Patient safety incidents reported as 'severe' or 'death'	38	35 (a)	23
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)	1271
Slips, Trips and Falls incidents resulting in harm	420 (a)	419 (a)	465
Self-harm incidents	425	444 (a)	717
Suicide incidents (in-patient or within 7 days of discharge)	1	0	0
Suicide incidents (community)	19	15 (b)	15 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	1934	2162 (a)	2355
Violence, aggression and verbal abuse incidents resulting in harm	237	269 (a)	404
Medication Errors	322 (a)	345 (a)	453
Medication Errors resulting in harm	1	1	0
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)	4 (15)
• Influenza	1 (3)	0	0
Showing number of incidents, then people effected in brackets			
Preventative measures			
MRSA Screening – based on randomised sampling to identify expected range to target	39%	47%	tbd
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 (not updated)

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 practice serves a majority multi-ethnic migrant population in areas of social deprivation within Sheffield, with 65% of the registered population from ethnic minority backgrounds and Slovak Roma and asylum seeking populations (16,500 total population). This brings a number of acknowledged challenges for the service to deliver the range of performance standards as patients struggle to understand the importance of the range of health screening, and chaotic lifestyles mean that patients do not attend for their planned care.

The Quality Outcomes Framework (QoF) provides a range of good practice quality standards for the delivery of GP services. 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 years performance.

Year	Clover	Sheffield average
2012/13	98.3%	96.3%
2013/14	94%	Tbc
2014/15	tbc	tbc

The following table summarises performance against national standards for GP services.
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PRIMARY CARE – CLOVER GP's	This years 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%	
Vaccinate registered population aged 6 months to 64 years in an at risk population	70%	56%	58%	To be confirmed after year end
Vaccinate registered population who are currently pregnant	70%	51%	46%	
Childhood immunisations				
Two year old immunisations	70-90%	90%	90%	
Five year old immunisations	70-90%	85%	82%	
Cervical Cytology	60-80%	66.4%	66.2%	

Information source: System One and Immform

Substance Misuse Services (not updated)

The four 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 & ALCOHOL SERVICES	This years 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%	tbd%	✓
No drug intervention client to wait longer than 5 days from referral to medical appointment	100%	100%	100%	tbd%	✓
No Premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	tbd%	✓
No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100%	tbd%	✓
% problematic drug users retained in treatment for 12 weeks or more	90%	95%	96%	tbd%	✓
Alcohol Single Entry and Access					
No client to wait longer than 1 week from referral to assessment	100%	100%	100%	tbd%	✓
No client to wait longer than 3 weeks from Single Entry and Access Point assessment to start of treatment	100%	100%	100%	tbd%	✓
Outcomes, Self care					
Initial Treatment Outcome Profile (TOP) completed	80%	98%	83%	tbd%	✓
Review TOP completed	80%	71%	89%	tbd%	
Discharge TOP completed	80%	100%	67% (2 out of 3 clients)	tbd%	✓
All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100%	tbd%	✓
Number of service users and carers trained in overdose prevention and harm reduction	240	272	258	tbd	✓
% successful completions for the provision of treatment for injecting-related wounds and infections	75%	94%	94%	tbd%	✓

Information source: National Drug Treatment Monitoring System

Learning Disability Services (updated)

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

Within our local inpatient services we have ensured that individual clients do not experienced prolonged periods in hospital beyond what the client needs.

LEARNING DISABILITIES SERVICE	This years 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 to date	✓
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 & Trust internal clinical information system

Mental Health Services – Updated

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 below 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. Sheffield Health and Social Care Trust considers that this data is as described for the following reasons

- The priority we have placed on ensuring effective and appropriate care pathways are in place
- effective leadership within our clinical services and performance monitoring that is focussed on ensuring services have information they need to deliver care
- Failure to maintain the required standards for CPA 7 day follow up consistently during the year.

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) and 98.7% (Q3). We have reviewed the circumstances behind the care provided for those who weren't 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. Informed by the reviews we have undertaken we have introduced measures to further improve communication between teams around discharge planning.

Sheffield Health and Social Care Trust intends to ensure the above approaches continue to support effective delivery of standards in respect of Gatekeeping and CPA 7 Day follow up.

Updated: All data projected position based on Apr-Feb out turn

MENTAL HEALTH SERVICES	This years target	How did we do? 2012/13	2013/14	This year 2014/15	
Improving Access to Psychological Therapies • Number of people accessing services • Numbers of people returning to work (a) • Number of people achieving recovery	10,008 n/a 50%	10,735 344 (31%) 46%	11,611 300 (12%) 47%	13,254 tbd tbd	✓
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	172 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	1,311 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%	4.2%	✓
Annual care reviews • Everyone on CPA should have an annual review.	95%	98%	95.7% (c)	95.7%	✓
'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		*Tbc*	*Tbc*	*100%*	
Lowest performing		*tbc*	*tbc*	*66%*	
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%	95.6% (d)	✓
Comparators (b): National average		*98.2%*	*98.1%*	*97.2%*	
Best performing		*Tbc*	*Tbc*	*100%*	
Lowest performing		*tbc*	*tbc*	*91.5%*	

Information source: Insight & Trust internal clinical information systems

Note

(a) 12% represents the % of those who were not in work at the beginning of treatment, who had returned to work at the end of treatment. During 2013/14 2,459 of the 11,611 people seen where not in work at the beginning of treatment. 300 of them (12%) returned to work by the time treatment had been completed. (*data to be updated for 2014/15 year*)

(b) Comparative information from Health and Social Care Information Centre. 2014/15 national comparator figures based on data published for the Apr 14-Dec14 period.

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

(d) The 95.6% figure represents the Trust's annual performance. The Trust failed to achieve the standard over the Quarter 2 period.

Dementia Services (updated)

Our specialist inpatient service for people with dementia and complex needs has prioritised its focus on improving the care pathway to ensure discharge in a timely manner either home or as close to a person's home as possible. This results in much better outcomes for the individual concerned. This has enabled more throughput into the ward but recognises the increasing complexity of the service users admitted. As we deliver better and more intensive community services the need for inpatient 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. 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 years target	How did we do? 2012/13	2013/14	This year 2014/15
Discharges from acute care (G1)	27	53	43	38 ✓
Number of people assessed for memory problems by memory management services	930	846	884	941 ✓
Rapid response and access to home treatment	350	339	349	328 ✓
Waiting times for memory assessment	N/A	15.4 weeks	15.8 weeks	tbd ⇩ Getting worse

Information source: Insight & Trust internal clinical information system

INDEPENDENT LIVING & CHOICE	This years 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 & Trust internal monitoring systems

3.3 Service user experience

Complaints and compliments (updated)

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	170
Informal complaints	260	217	152
Compliments	1,396	1,196	1107

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 [insert figure] of the cases, [insert figure] cases required remedial action (for example, apologies, reassessment and/or financial compensation) and, at the time writing this report, the outcome of [insert figure] 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 report 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 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 neighbors should overspills occur;
- We improved the floor coverings at Hurlfield View Resource Centre.

Improving the experience through better environments – investing in our facilities (updated)

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

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

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 inpatient 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 don't provide en-suite facilities for patients.

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 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 Trusts 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%	92.5%	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? (updated)

That national patient survey for mental health trusts highlights that the experience of our service users compares about the same as to other mental health trusts.

The table below 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 can't be readily undertaken.

MENTAL HEALTH SURVEY 2014 Issue – what did service users feel and experience regarding	Patient response	How did we compare with other Trusts
Their Health & 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.

	2014 Survey		
	Lowest national score	Highest national score	Our score
Patient Survey 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 treatments?	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 above table highlights our comparative performance on service user experience in respect of contact with our staff. Sheffield Health and Social Care Trust is pleased about this positive position.

While the scores are slightly reduced compared to the previous year the CQC survey analysis highlights that this reduction is not significant.

Sheffield Health and Social Care NHS FT considers that this data (the survey scores in the above table) is as described for the following reasons;

- In the previous year extensive service re-organisation across our community mental health team services was undertaken
- In the context of so much change, the experience of service users is similar to the national averages, with the exception of people experience of the planning for their care

During the year a range of quality improvement programmes were introduced across our community mental health teams. The focus of the improvement programmes have been 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 inpatient services, and is being introduced within our community services.
- 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.

Sheffield Health and Social Care NHS FT 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)	tbd	tbd	60%	67%

The above table highlights our comparative performance regarding the quality of our services from the perspective of our staff.

Sheffield Health and Social Care Trust considers this data is as described due to our continued efforts to engage with our staff and involve them in the plans and decisions regarding how we move forward and focus on improving the quality of our services. We place increasing emphasis on ensuring staff in teams are aware how we are performing, making best use of the information we have to support this.

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

3.4 Staff experience (updated)

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	2012	2013		2014 Our score	2014 National averages	2014 How we compare
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/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	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 years 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%

Source: NHS Staff Survey

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 site. The survey provides a large amount of detail around complex issues. The Trust looks to take a balanced view on the overall picture, recognising that some of the lines of enquiry may appear contradictory. For example, the survey indicates we are in the best 20% of trusts for staff job satisfaction, and the worse 20% for staff feeling motivated at work.

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

Last year we made a range of changes to make key training areas more accessible to staff. An example of this would be 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, focussing on improved access to health and safety training and diversity training.

Staff witnessing harmful incidents and errors

[*Drafting note: at this stage this is considered to be a reflection of the Trust's high (positive) reporting culture in respect of safety incidents. Further analysis is being undertaken in respect of a incident data*]

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 (ie 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

The relatively low score for staff motivation at work contrasts with the Trust being in the top 20% for staff satisfaction, and for recommending the Trust as a place to work as well as being above average for feeling satisfied with the quality of work that they do. However, we will continue with our staff development and engagement plans to deliver a range of improvements in staff experience of working within the Trust.

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