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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 15 April 2015 at 10.00 am

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Mick Rooney (Chair), Sue Alston (Deputy Chair), Jenny Armstrong, Olivia Blake, John Campbell, Katie Condliffe, Jillian Creasy, Qurban Hussain, Anne Murphy, Denise Reaney, Jackie Satur, Philip Wood and Joyce Wright

Healthwatch Sheffield
Helen Rowe and Alice Riddell (Observers)

Substitute Members
In accordance with the Constitution, Substitute Members may be provided for the above Committee Members as and when required.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Healthier Communities and Adult Social Care Scrutiny Committee exercises an overview and scrutiny function in respect of the planning, policy development and monitoring of service performance and related issues together with other general issues relating to adult and community care services, within the Neighbourhoods area of Council activity and Adult Education services. It also scrutinises as appropriate the various local Health Services functions, with particular reference to those relating to the care of adults.

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Members of the public have the right to ask questions or submit petitions to Scrutiny Committee meetings and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

Scrutiny Committee meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information about this Scrutiny Committee, please contact Emily Standbrook-Shaw, Policy and Improvement Officer on 0114 27 35065 or email emily standbrook-shaw@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
15 APRIL 2015

Order of Business

1. Welcome and Housekeeping Arrangements

2. Apologies for Absence

3. Exclusion of Public and Press
To identify items where resolutions may be moved to exclude the press and public

4. Declarations of Interest (Pages 1 - 4)
Members to declare any interests they have in the business to be considered at the meeting

5. Minutes of Previous Meeting (Pages 5 - 18)
To approve the minutes of the meeting of the Committee held on 25th February, 2015.

6. Public Questions and Petitions
To receive any questions or petitions from members of the public

7. Quality Accounts - Yorkshire Ambulance Service
Presentation by Gareth Flanders, Head of Quality, Yorkshire Ambulance Service.

8. Quality Accounts - Sheffield Teaching Hospitals NHS Foundation Trust (Pages 19 - 74)
Report of Dr David Throssell, Medical Director.

9. Quality Accounts - Sheffield Children's Hospital NHS Foundation Trust (Pages 75 - 114)
Report of John Reid, Director of Nursing and Clinical Operations.

10. Sheffield Health and Social Care NHS Foundation Trust 2014-15 - Quality Report (Pages 115 - 156)
Report of Jason Rowlands, Director of Planning, Performance and Governance.

11. Work Programme (Pages 157 - 162)

Report of Emily Standbrook-Shaw, Policy and Improvement Officer.

12. Date of Next Meeting

The next meeting of the Committee will be held on a date to be arranged.

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 25 February 2015

PRESENT: Councillors Mick Rooney (Chair), Sue Alston (Deputy Chair), Jenny Armstrong, Olivia Blake, John Campbell, Katie Condliffe, Jillian Creasy, Qurban Hussain, Anne Murphy, Denise Reaney, Philip Wood and Joyce Wright

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Jackie Satur and Helen Rowe, Healthwatch representative.

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 In relation to Agenda Item 7 (Call-in of Leader's Decision Regarding the Tender for the Reprovision of Day Services and Residential Short-Term Care Beds for People with Dementia), the Chair, Councillor Mick Rooney, declared a Disclosable Pecuniary Interest as a Non-executive member of the Sheffield Health and Social Care NHS Foundation Trust and indicated that he would vacate the Chair and leave the room during consideration of that item. In addition, Councillor John Campbell declared a personal interest in Agenda Item 7, as he was the Deputy Convenor for Yorkshire and Humberside Unison.

3.2 In relation to Agenda Item 8 (Sheffield Teaching Hospitals Annual Quality Report 2014/15), Councillors Sue Alston and John Campbell each declared a Disclosable Pecuniary Interest as they were employees of the Sheffield Teaching Hospitals NHS Foundation Trust, but felt that their interest was not prejudicial in view of the nature of the report and presentation and chose to remain in the meeting during consideration of the item. In addition, Councillor Jillian Creasy declared a personal interest in Agenda Item 8, as she was an NHS employee, and Councillors Qurban Hussain and Denise Reaney also declared a personal interest in that item as they were both in receipt of a pension from the NHS.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 17th December 2014, were approved as a correct record and the contents of the attached Actions Update were noted.

4.2 Further to the consideration of the above minutes, the Committee asked the Policy and Improvement Officer to check on the accuracy of the statement 'Sheffield had escaped the increases in Accident and Emergency (A&E) admissions experienced in other areas', contained in the fourth bullet point at paragraph 6.2 (Better Care Fund – Update) and report back.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 The Chair, Councillor Mick Rooney, indicated that a written response would be provided to the questioner, who had asked a series of questions relating to the Council's implementation of the Living Wage for Care Workers and the Unison Ethical Care Charter, and that the response would be published with the agenda for the Committee's next meeting.

6. CALL-IN OF LEADER'S DECISION REGARDING THE TENDER FOR THE REPROVISION OF DAY SERVICES AND RESIDENTIAL SHORT-TERM CARE BEDS FOR PEOPLE WITH DEMENTIA

(NOTE: At this point, the Chair, Councillor Mick Rooney, left the room and the position of Chair was taken by the Deputy Chair, Councillor Sue Alston.)

6.1 The Committee considered the decision of the Leader of the Council, Councillor Julie Dore, made on 3rd February 2015, to give approval to tender for the reprovision of day services and residential short-term care beds for people with dementia.

6.2 *Signatories*

The Lead Signatory to the call-in was Councillor Jillian Creasy and the other signatories were Councillors Sue Alston, Robert Murphy, Sarah Jane Smalley and Brian Webster.

6.3 *Reasons for the Call-In*

The signatories had confirmed that they wished to scrutinise the decision relating to the tender, as it could have important and far reaching consequences for service users, their families, the carers and for colleagues providing hospital services.

6.4 *Attendees*

- Councillor Mary Lea (Cabinet Member for Health, Care and Independent Living)
- Joe Fowler (Director of Commissioning)
- Sharon Marriott (Commissioning Officer)
- Jason Swann (Project Officer, Commercial Services)

6.5 Councillor Jillian Creasy addressed the Committee as Lead Signatory and emphasised the importance of the decision to tender to a private provider. She

also expressed concerns about the decision to cut costs by £½ million and the lack of information on current provision and questioned the link which the present report had to the Dementia Strategy. Councillor Creasy also went on to refer to the implications for the integration of health and social care and whether any private provider would be able to provide the required service. In conclusion, she asked about the complexity of the care provided, what the view of the Clinical Commissioning Group (CCG) was, and the stage at which any further discussions with the Sheffield Health and Social Care Trust (the Trust) were at.

6.6 Public questions were asked about the savings to be made, discussions with the managers at Hurlfield View, consultation with staff, quality issues, the instability created by the introduction of a third party provider and ensuring the voice of carers was heard.

6.7 In response, Joe Fowler, Director of Commissioning, stated that there were no concerns as to the quality of services at Hurlfield View and pointed out that it was not a hospital but a residential care home which had about 20 beds and provided day care services. The aim was to change provision to meet people's needs in a community setting, rather than transporting them to one location for day care and, in doing this, the needs of hundreds of people would be met rather than just a handful. The proposed savings were set out in the report, with £700,000 being released to fund community based activities during Years 2 and 3. There were no plans to reduce bed based services at Hurlfield View and work had been undertaken with the Trust, so it would be disappointing if management had not been involved. The CCG were supportive of the overall Dementia Strategy and, if the Trust came up with a proposal to meet the Council's objectives, then this would be considered.

6.8 As a point of clarification, Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, indicated that the consultation which she had mentioned in a radio interview, referred to consultation which had taken place on Dementia work in Sheffield in 2012, which had revealed that people wanted more community based services.

6.9 Sharon Marriott, Commissioning Officer, indicated that work had been undertaken on the original Dementia Strategy, with Hurlfield View users being included in the consultation process. In relation to the tender process, carers and users had been advised of the proposals. It was estimated that there were approximately 6,000 dementia sufferers in Sheffield and the Council were in touch with 4,500 of these. A small part of the community was using Hurlfield View and the proposals aimed to shift investment to release funds to invest in community based services. Short-term care beds would facilitate unplanned admissions and these instances could be complex as crisis situations were often involved. Reasons for admission included deterioration in the user's condition, respite care and carers being taken ill. It should be noted that in December 2014, 60% of admissions were planned. In relation to the costs of running the service, the wider market had been examined and Core City comparisons had been made. It had been found that the cost of a nursing bed at Hurlfield View was £1,000 per week and that such a bed provided by EMI Care Homes was £600 per week. In conclusion, Sharon Marriott

emphasised that the proposal sought to release money to grow the day care service in a different setting, providing activities such as walking, hobbies and peer group settings.

6.10 Jason Swann, Commercial Services, explained that the present agreement for these services expired at the end of March 2015 and that the Council was legally obliged to carry out a formal test of services at Hurlfield View and, as such, meetings had been held with the Trust to allow this to take place. As the staff employed there were not Council staff, they couldn't be consulted with directly, with this being a Trust responsibility.

6.11 *Questions from Members of the Committee*

Members made various comments and asked a number of questions, to which responses were provided as follows:-

- Hurlfield View was not the only day care provider in the City, with the Alzheimer's Society and Age UK also providing such services. The intention was to build on what was there already in the community and have a mixture of paid and volunteer staff.

- Other organisations provided services for dementia sufferers with a spectrum from community support to services at Hurlfield View being available. It was hoped to keep an element of day provision at Hurlfield View.

- Any providers would need to comply with specific requirements on matters such as training.

- There were a range of nursing homes providing respite care.

- Carers and users had been notified of the proposals by letter and once a decision on the provider had been made a formal consultation would take place.

- Officers would advise the Leader and Cabinet Member if the Trust put in an appropriate proposal.

- The timescale for the start of the contract had been extended until the end of August 2015.

- The present model would not be sustainable if the present rate of increase in demand for dementia services continued.

- A range of options were available with regard to the tendering process, which could take the form of either asking for bids or going out for a price, with an evaluation being made on that basis. Regulations did allow for weight to be given to price.

- If a respite care bed was not available at Hurlfield View, there were other homes in the City which provided such care.

- The Council was not looking at a single organisation to work in the community and consideration had been given to operations in the form of clusters.

- One-third of the people using day care services at Hurlfield View paid for this. As far as community services were concerned, there was a mix, with some people paying for the service.

- The idea behind the tender was to move away from instructing organisations how to act and looking at higher level objectives. Evaluation would take place based on the ability to deliver outcomes.

- The Council was in the process of recruiting 20 support workers who would be able to assist people wishing to gain access to dementia services.

- The challenge for the Council was living within the financial constraints of a reducing budget, so value for money had to have some real impact. This proposal enabled a stepping up of the service and it was unfair to assume that paying a lower rate for the service implied a worse service.

- The Care Quality Commission (CQC) inspected the residential provision at Hurlfield View and would continue to do so, whilst the Contracts and Grants Monitoring Team monitored community based activities. In addition, regulatory frameworks were involved in the provision of clinical support. There was no extra cost in monitoring at the present time.

- The operation of the Stocksbridge satellite service would continue.

- It was proposed, after one year of operation, to look at real demand and service users and taper off the day care element. Consequently, there was a need to grow day care opportunities and initiatives.

- The Trust proposal did not meet the Council's requirements, and in any event, there was a legal requirement to go to tender. Whilst any further Trust proposals could be considered, there would be significant commercial risks.

- There were a range of providers who interfaced with the Trust already.

6.12 RESOLVED: That the Committee:-

(a) notes the contents of the report together with the comments made and responses provided;

(b) notes the decision of the Leader of the Council, made on 3rd February 2015, to tender for the reprovision of day services and residential short-

term care beds for people with dementia;

(c) recommends that no action be taken in relation to the call-in decision; and

(d) requests officers to take into account the discussion when drafting the next report to the Committee on Dementia Services.

(NOTE: Prior to the passing of the above resolution, an alternative motion was moved by Councillor Jillian Creasy and seconded by Councillor Denise Reaney, namely that:-

"The Committee refers the decision back to the Leader of the Council for reconsideration in the light of recommendations from the Committee."

This alternative motion was put to the vote and negatived).

7. SHEFFIELD TEACHING HOSPITALS ANNUAL QUALITY REPORT 2014/15

(NOTE: At this point the Chair, Councillor Mick Rooney, re-joined the meeting and took the Chair.)

7.1 The Committee received a report of the Medical Director, Sheffield Teaching Hospitals NHS Foundation Trust, on the Trust's Annual Quality Report. The report was supported by a presentation given by Sandi Carman, Head of Patient and Healthcare Governance, Sheffield Teaching Hospitals NHS Foundation Trust, which set out the Trust's 2014/15 Priorities and 2015/16 Proposed Priorities. Also in attendance for this item was Michael Harper, Chief Operating Officer, Sheffield Teaching Hospitals NHS Foundation Trust.

7.2 Members made various comments and asked a number of questions, to which responses were provided as follow:-

- Patient feedback was obtained by using leaflets for comments, volunteers speaking to patients and the use of the friends and family test which was used on discharge.

- Two-thirds of patients awaiting discharge now received their medication from the hospital pharmacy within one hour, with any delays being due to getting the prescriptions written. Reference would be made to this in the final Quality Report, as well as the use of volunteers in surveying patients' views.

- Initiatives were in place so that patients knew who was taking care of them. All staff were required to introduce themselves and wear name badges and the Patient First standard was being applied, but it was recognised that there was a need for improvement in this regard.

- Consideration would be given to ways in which the visual impaired could be supported to engage in the "named clinician" initiative and the outcome of this would be reported to the Committee when the final report was delivered.

- The Patient Association's Survey results contained a question relating to ethnic grouping and this would be given further consideration. The selection process for this survey was based on those who had complained and the complaint had been formally closed.

- In relation to verbal complaints made on the ward, managers were encouraged to be pro-active by seeking live feedback and managing situations locally. It was acknowledged that the level of conversation/dialogue may not be captured in complaints, but issues could be raised at ward or staff meetings. It was accepted that this was a challenge and needed to be handled carefully, so that there was not an increase in bureaucracy. The empowering of local managers to capture complaints made on the ward would be covered in the final report, but officers were mindful of the potential extra burden.

- Consideration would be given to the proactive inclusion of local patient complaints in incident report forms.

- Alternative means of complaint were available through the Patient Services team (previously called Patient Advice and Liaison Service), with posters being displayed on the wards. The importance of making it easier for patients to flag up issues was recognised.

- Complaints about food and access to a television in the Renal Unit at the Northern General Hospital would be investigated and reported back.

- In relation to the reporting of patient and non-patient incidents, 20,000 incidents were reported per year, which included near misses and where there was no harm to patients or staff. These were reported nationally. There was now a legal duty of candour and the reporting of near misses was encouraged.

7.3 RESOLVED: That the Committee:-

(a) thanks Sandi Carman and Michael Harper for their contribution to the meeting;

(b) notes the contents of the report and presentation and the responses to questions; and

(c) notes that the final Quality Report 2014/15 would be presented to the Committee at its meeting in April 2015.

8. COMMISSIONERS WORKING TOGETHER PROGRAMME UPDATE

8.1 The Committee received a paper which provided a briefing on the establishment of a collaborative partnership between NHS Commissioners to lead a transformational change programme across South Yorkshire and Bassetlaw,

North Derbyshire and Wakefield with a focus on hospital services. The paper was presented by Will Cleary-Gray, Working Together Director, Sheffield Clinical Commissioning Group (CCG).

8.2 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- The Ophthalmology Service was regarded as being unsustainable, with there being small patient numbers across multiple sites and a heavy reliance on locum cover.

- The programme brought the CCGs together to engender a different way of service provision. This may lead to people needing to travel to get the right service.

- There was a link with the National and Regional Commissions as the NHS was involved.

- It may be possible to include the Child and Adolescent Mental Health Service in the programme, but the priorities which had been identified were pressing. Further consideration could be given to this when the programme was reviewed.

- It could not be said that all the initiatives, such as the Better Care Fund, knitted together, as the programme focused on acute hospitals, although attempts would be made to draw these together.

- Training and workforce recruitment would be included as part of any programme review.

8.3 RESOLVED: That the Committee:-

(a) thanks Will Cleary-Gray for his contribution to the meeting;

(b) notes the contents of the paper and responses to questions; and

(c) requests the Policy and Improvement Officer to consider the inclusion of training and workforce recruitment in the Committee's Work Programme.

9. ADULT SOCIAL CARE PERFORMANCE UPDATE

9.1 Moira Wilson, Interim Director of Care and Support, Communities, gave a presentation which updated the Committee on Adult Social Care Performance and included supporting statistical information. Also present for this item was Jasper South, Head of Planning and Performance, Communities.

9.2 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- It was acknowledged that a quick response to complaints was required and that there was a need to improve on this. It was thought that the target response time for the Look Again complaints process was 10 working days, but this would be checked.

- Information on the delayed transfer of care came from the hospital's Patient Centre. This time delay was calculated from the point when the patient was deemed fit for discharge, but some delays were whilst patients were waiting further assessment. Organisations were working together to plan for discharge.

- There were some issues where recognised providers were in special measures, but the Council retained overall responsibility and the Contracts section worked closely with providers. It was possible to transfer some hours to secondary providers and the backlog was being addressed by bringing in new providers.

- Information on what service users should do in the event of their Home Support Worker not turning up was contained in each user's Care Plan. Staff complaints were monitored through the Council's Human Resources Service (HR) and the Council also had a Whistleblowing Policy. A check would be made on whether Members could access these complaints.

- The importance of improving information for potential users and Members was recognised, with Community Support Workers being used to facilitate this.

9.3 RESOLVED: That the Committee:-

(a) thanks Moira Wilson and Jasper South for their contribution to the meeting;

(b) notes the contents of the presentation and the responses to questions;

(c) recommends that a target of 10 working days be set for responses to complaints under the Look Again process; and

(d) requests that:-

(i) Council Members be provided with details of Adult Social Care providers across the City;

(ii) the length of time for users to access Adult Social Care services, following their initial assessment, be included in future reports; and

(iii) national targets be included in any future reports.

10. SHEFFIELD HEALTH INEQUALITIES PLAN

10.1 The Committee received a report of the Director of Public Health which provided an

update on progress on the implementation of the Sheffield Health Inequalities Plan. The report was presented by Dr Jeremy Wight, Director of Public Health.

10.2 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- Health Trainers worked in the community with practices to help people with adopting healthier lifestyles. This service was much valued by GPs and was funded by the Clinical Commissioning Group. The funding model had been reviewed by a Task and Finish Group which had recommended a change in emphasis to the development of social capital. A £30,000 reduction in the Community Wellbeing Programme was proposed for the financial year 2015/16.

- Dr Wight was not aware of any limit on the number of sessions which an individual could have with the Health Trainers, but would check on this. He understood that the Trainers would engage with users until it was felt there was nothing else to be gained.

- There were 160 Practice Champions working with 4 GP practices.

- The first stage of any new proposals for research should be to consider what studies had already been undertaken and, if these indicated that the question had already been answered, then further studies should not go ahead.

10.3 RESOLVED: That the Committee:-

(a) thanks Dr Jeremy Wight for his contribution to the meeting; and

(b) notes the contents of the report and the responses to questions.

11. CARE ACT 2014 - UPDATE

11.1 This item was deferred to a future Committee meeting due to time constraints.

12. WORK PROGRAMME 2014/15

12.1 The Committee received its Draft Work Programme 2014/15.

12.2 RESOLVED: That the Committee:-

(a) notes the Draft Work Programme; and

(b) requests:-

(i) the inclusion of an item on training and workforce planning;

(ii) the inclusion in the new Municipal Year of a review of the Air Quality

Action Plan; and

(iii) that the Policy and Improvement Officer circulates the minutes of the meeting of the Economic and Environmental Wellbeing Scrutiny and Policy Development Committee, held on 18th February 2015, which included the item 'Air Quality in Sheffield', to Committee Members.

13. UPDATE ON DEVELOPING A SOCIAL MODEL OF HEALTH

13.1 RESOLVED: That the Committee:-

(a) notes the contents of the update report on the Development of a Social Model of Health; and

(b) requests that Members with any queries on this should contact Dr Jeremy Wight by e-mail.

14. SHEFFIELD ADULT SAFEGUARDING PARTNERSHIP - BUSINESS PLAN UPDATE

14.1 RESOLVED: That the Committee:-

(a) notes the contents of the Sheffield Adult Safeguarding Partnership Business Plan Update report;

(b) notes that enquiries would be made to find out whether the Plan included situations where people were not receiving their proper care package; and

(c) requests that:-

(i) the Policy and Improvement Officer circulates the minutes of the meeting of the Safer and Stronger Communities Scrutiny and Policy Development Committee, held on 12th February 2015, which included the item "Responding to Domestic and Sexual Abuse in Sheffield", to Committee Members, with a view to seeing if there was anything that this Committee should look at; and

(ii) consideration be given to the inclusion of a recovery plan in the Safeguarding section of the presentation given in relation to Agenda Item 10 (Adult Social Care Performance Update).

15. DATE OF NEXT MEETING

15.1 It was noted that the next meeting of the Committee will be held on Wednesday, 15th April 2015, at 10.00 am in the Town Hall.

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Healthier Communities & Adult Social Care Scrutiny Committee
Actions update for meeting on 15th April 2015

Action	Minutes	Update	RAG
A&E Increases Minutes from the December meeting state that 'Sheffield has escaped the increases in A&E admissions experienced in other areas' – check accuracy of this statement.	17th December 2014	"The Trust did have an increase in emergency admissions within the first two weeks of January but overall in the month emergency admissions were below target. There were however a specific increase in the age and complexity of admissions through January and a specific increase in respiratory patients"	
Commissioners Working Together Programme Child & Adolescent Mental Health Services to be considered as a potential area for the Working Together Programme.	25th February 2015	Comments passed to CCG	
Adult Social Care Performance Update Consider creating a target for the 'Look Again' review process – suggested 10 working days. Provide action plan for getting safeguarding procedures back to acceptable levels Provide all Members with a list of providers by Ward	25th February 2015	Awaiting update Awaiting update Circulated 16th March 2015	
Air Quality Action Plan Circulate minutes of Economic & Environmental Scrutiny Committee's consideration of the AQAP	25th February 2015	Circulated 25th March 2015	
Domestic Abuse Circulate Minutes of Safer & Stronger Communities Scrutiny Committee's consideration of domestic abuse. Committee to identify any areas of interest.	25th February 2015	Circulated 16th March 2015.	
Child and Adolescent Mental Health Service (CAMHS) Working Group Report	10th April 2014	Scrutiny report to be used as part of evidence base to be presented to Health and Wellbeing Board, proposing changes to the way services are provided in Sheffield.	

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
15th April 2015

Report of: Dr David Throssell
Medical Director
Sheffield Teaching Hospitals NHS Foundation Trust

Subject: Quality Report 2014/15

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Summary:
Foundation Trusts are required to produce an Annual Quality Report, which sits alongside the Annual Report, and specific reporting requirements are detailed in Monitors NHS Foundation Trust Annual Reporting Manual 2014/15.

The Quality Report has two key aims; to report on the quality of services delivered by Sheffield Teaching Hospitals in the year 2014/15 and to identify the Quality Report Objectives for 2015/16.

A draft of the Quality Report 2014/15 has been produced and is enclosed for the Committee to consider and provide views, comments and recommendations on the contents for the report. The most up to date data has been used, where available, throughout this report. Please note that in most cases this is quarter 3 data (the first 3 quarters of the financial year 2014/15) which will be updated when the data becomes available. Due to the changes in the data the supporting narrative may also change slightly in the final version. Figures and sections that require updating are marked in **RED**.

The overall report production is supported by the Quality Report Steering Group which advises on content, format and design. The Quality Report Steering Group membership is supported by Healthwatch and a number of Trust Governors who contribute widely to the process of production. The final Quality Report requires presenting to the Board of Directors in May 2015. In line with statutory requirements the draft Quality Report and various supporting documents will be submitted to KPMG for external assurance and audit.

The Quality Report 2014/15 is presented to the Scrutiny Committee to request their views and comments.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	**x**
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**x**
Other	**x**

The Scrutiny Committee is being asked to:
The Committee is asked to consider the Quality Report 2014/15 and provide views, comments and recommendations on the contents of the report.

Background Papers:

Monitor NHG Foundation Trust Annual Reporting Manual 2014/15
Quality Accounts: Guidance for NHS Trusts on arrangements for external assurance 2014/15
Quality Account: Reporting Requirements for 2014/15- Gateway Reference No. 03123
Monitor Detailed requirements for quality reports 2014/15
Quality Accounts: a guide for Local Involvement Networks
National Clinical Audits for Inclusion in Quality Accounts 2014/15
Quality Account's Data Dictionary 2014/15

Category of Report: OPEN

Annual Quality Report 2014/15

Part 1

Statement on Quality from the Chief Executive

At Sheffield Teaching Hospitals NHS Foundation Trust we remain committed to delivering good clinical outcomes and a high standard of patient experience both in our hospitals and in the community. Thanks to the dedication and professionalism of our staff, volunteers and partners we have a strong track record in this area. We are never complacent and continually look to adopt best practice, drive innovation and most importantly learn and improve when we do not meet the high standards we have set for ourselves.

This drive for improvement is embodied within the Trust's Corporate Strategy 'Making a Difference'. The strategy outlines five overarching aims:

- Deliver the best clinical outcomes
- Provide patient centred services
- Employ caring and cared for staff
- Spend public money wisely
- Deliver excellent research, education and innovation.

The corporate strategy is supported by a Quality Strategy and governance framework. In summary our priority is to do all we can to continually implement quality improvement initiatives that further enhance the safety, experience and clinical outcomes for all our patients.

However, the NHS nationally is currently operating within a very tough financial climate and our Trust is also seeing unprecedented increases in demand for both emergency and planned care. This was evident in the most extreme sense during last winter when we saw record numbers of patients who needed emergency care and admission to hospital. With the support of our staff and partners we are addressing these financial and demand challenges by adopting new ways of working, forging partnerships with other health and social care providers and continuing to engage our staff by actively pursuing a culture of innovation and involvement. As a consequence, I am pleased to report that Sheffield Teaching Hospitals NHS Foundation Trust has continued to perform very well in 2014/15 and has made good progress against our quality priorities for last year.

It was exceptionally pleasing that national and local survey results during 2014/15 consistently showed that the majority of our patients and staff would recommend our Trust as a place to receive care and to work. We are keen to learn where there are further opportunities to improve and the Friends and Family test for patients and our staff is a valuable insight into where our future focus needs to be. Our quality priorities for 2015/16 have reflected this feedback along with views from our partners and regulators.

A few of our successes this year include the further integration of hospital, community and social care services to ensure our patient's receive timely, seamless care and that wherever possible individuals are supported to live independently at home rather than be hospitalised. This work has been recognised as 'best practice' by both the Kings Fund and Health Foundation. During 2014/15 the integration developed further when the Directorate of Geriatric and Stroke Medicine (GSM) and Primary and Community Services Cares Group came together formally into one combined Directorate. This is enabling the excellent transformation work which has started to flourish further and embed as routine practice.

To further support this drive to work differently right across the organisation, during 2014/15, the Trust agreed to invest more than £35million in a five year technology transformation programme which will provide the opportunity to change the way we deliver care both within the hospital and also in people's own homes and communities.

This five year programme will also enable the organisation to become paper light and support the work underway to develop integrated care teams and new models of care. The programme will oversee the implementation of three major systems; an electronic patient record, an electronic document management system, and a clinical portal. This will provide clinicians with the information they need, at all times and in all locations. It will further improve patient safety and our communication with patients, increase operational effectiveness by releasing more time to care, as well as supporting clinical practice and research. The first phase of 'go live' will be in the autumn of 2015.

It is recognised that an important clinical quality indicator is the mortality rate after surgery and for many years I am pleased to report that we have had a consistently 'lower or as expected' mortality rate. This is testament to the skill and care of our teams.
During 2014/15 we also continued to review weekend mortality rates. Our Hospital Standardised Mortality Ratio for weekday and weekend emergency admissions is also both 'within expected range'. However, given the importance of mortality rates and continual monitoring to ensure that any variance can be spotted quickly and acted upon, it has been agreed that this will again be a priority for improvement for 2015/16.

We consider rigorous infection control and clean facilities to be fundamental to our care standards and so I am pleased to report that this year we saw a further reduction in cases of C.difficile and now have our lowest levels ever recorded. We continue to work hard to minimise the chances of patients acquiring other hospital acquired infections such as Norovirus and MRSA.

Other priority areas include ensuring waiting times are kept as low as possible as we know this is one of the things which patients tell us is important to them. We also want to make sure our waiting times processes and procedures are robust and enable our patients to receive swift and appropriate treatment. The average waiting time for care at the Trust is eight weeks or less and all the cancer treatment waiting time standards are consistently met. However, during recent years, growing numbers of patients and their doctors are choosing Sheffield Teaching Hospitals for their care and this has resulted in a significant increase in referrals for non-urgent care. This has, in turn, made meeting the 18-week waiting standard much more challenging. The Trust has recognised this and has developed a robust action plan which has already resulted in significant improvements. In 2014/15 all of the national 18 week waiting standards were met with the exception of one (admitted to hospital patients) which is continuing to improve and is just below the national standard.

During 2015/16 we are also reviewing the way we deliver urgent care not just within our own organisation but across the city's health and social care system. This will enable us to re-model how care is provided to meet the increasing demand we are now seeing routinely both in A&E and primary care. We are committed to ensuring we continue to provide safe, high quality emergency care within the national expected waiting time standards. During the winter of 2014 this was not consistently achieved due to exceptional levels of demand albeit on average we did treat 92.71% of patients within 4 hours. The national standard is 95%. Further information about other improvements and developments in the quality of care and patient experience during 2014/15 can also be found in the Annual Report and on our website: www.sth.nhs.uk/news.

Of course none of these improvements are possible without the fantastic support of everyone who works for the Trust. Our key asset is our staff and their dedication and

commitment is a source of great strength for the Trust. During the last 12 months have continued to encourage more of our staff to be actively engaged and involved in decisions, setting the future direction of the organisation and innovations. This has been well received and is reflected in a significant improvement to the Trust's staff engagement score in the national staff survey. We are now one of the top 20% of NHS Trusts with the highest staff engagement results. We are committed to continuing this important work during 2015/26 because we believe our staff are the key to the delivery of excellent patient care.

Indeed during 2014/15, improvements and innovations in patient safety and care developed by our staff saw the Trust win the highest number of independently judged awards including being shortlisted for seven HSJ Patient Safety and Care awards.

The following pages detail our progress so far and outline our key priorities for the coming year. Across the entire organisation, a culture of learning and continual improvement will continue to be encouraged and I am in no doubt that this will lead to further developments which result in the delivery of high quality patient care for 2015/16.

To the best of my knowledge the information contained in this quality report is accurate.

Sir Andrew Cash OBE
Chief Executive
[Date]

Introduction from the Medical Director

Quality Reports enable NHS Foundation Trusts to be held to account by the public, as well as providing useful information for current and future patients. This Quality Report is an attempt to convey an honest, open and accurate assessment of the quality of care patients received during 2014/15. Whilst it is impossible to include information about every service the Trust provides in this type of document, it is nevertheless our hope that the report goes some way to reassure our patients and the public of our commitment to deliver safe, effective and high quality care.

The Quality Report Steering Group oversees the production of the Quality Report. The membership includes Trust managers, clinicians, Trust Governors, and a representative from Healthwatch Sheffield. The remit of the steering group is to decide on the content of the Quality Report and identify the Trust's quality improvement priorities whilst ensuring it meets the regulatory standards set out by the Department of Health and Monitor, the Independent Regulator for Foundation Trusts.

As a Trust we have consulted widely on which quality improvement priorities we should adopt for 2015/16. As with previous Quality Reports, the quality improvement priorities have been developed in collaboration with representatives from NHS Sheffield Clinical Commissioning Group (CCG), Healthwatch Sheffield and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

In developing this year's Quality Report we have taken into account the comments and opinions of internal and external parties on the 2013/14 Report. The proposed quality improvement priorities for 2015/16 were agreed by the Healthcare Governance Committee, on behalf of the Trust's Board of Directors, on 23rd March 2015. The final draft of the Quality Report was sent to external partner organisations for comments in March 2015 in readiness for the publishing deadline of the 28th May 2015.

Dr David Throssell
Medical Director

Part 2

2.1 Priorities for Improvement 2012/13, 2013/14 and 2014/15

Our 2012/13, 2013/14 and 2014/15 priorities are summarised below and explained further in this section.

		2012/13	2013/14	2014/15
2012/13 Objectives	**Optimise length of stay** (see 2.2.1)	▼	▼	▼
	Discharge letters for GPs (see 2.2.2)	=	▲	▲
	Giving patients a voice – Make it easier to communicate with the organisation (see 2.2.3)	▲	▲	▲
	Review mortality rates at the weekend (see 2.2.4)	▲	▲	▲
	Improve dementia awareness (see 2.2.5)	▲	▲	▲
2013/14 Objectives	**Cancelled operations** (see 2.3.1) Reduce the number of operations cancelled on the day of surgery.	New for 2013/14	▼	▼
	Pressure ulcers (see 2.3.2) Reduce the prevalence of Grade 2, 3 and 4 pressure ulcers reported within the Trust acute and community based services, including both ulcers acquired whilst receiving Trust care and community-acquired pressure ulcers.	New for 2013/14	▼	▼
	Improve discharge information for patients (see 2.3.3) Improve the provision of discharge information for patients by auditing the information provided and available for patients against Trust wide standards.	New for 2013/14	▲	▲
2014/15 Objectives	**To ensure every hospital inpatient knows the name of the consultant responsible for their care during their inpatient stay and the name of the nurse responsible for their care at that time** (see 2.4.1)	New for 2014/15	New for 2014/15	▼
	To improve complainant satisfaction with the complaints process (see 2.4.2)	New for 2014/15	New for 2014/15	▲
	To review mortality rates at the weekend and to focus improvement activity where necessary (see 2.4.3)	New for 2014/15	New for 2014/15	=
	To review the impact of waiting times on the patient experience (specifically patients waiting over 18 weeks for treatment) (see 2.4.4)	New for 2014/15	New for 2014/15	▲

Key:

= **Almost Achieved**	▲ **= Achieved**	▼ **= Behind Schedule**

Priorities for Improvement and Statements of Assurance from the Board

2.2 Objectives 2012/13

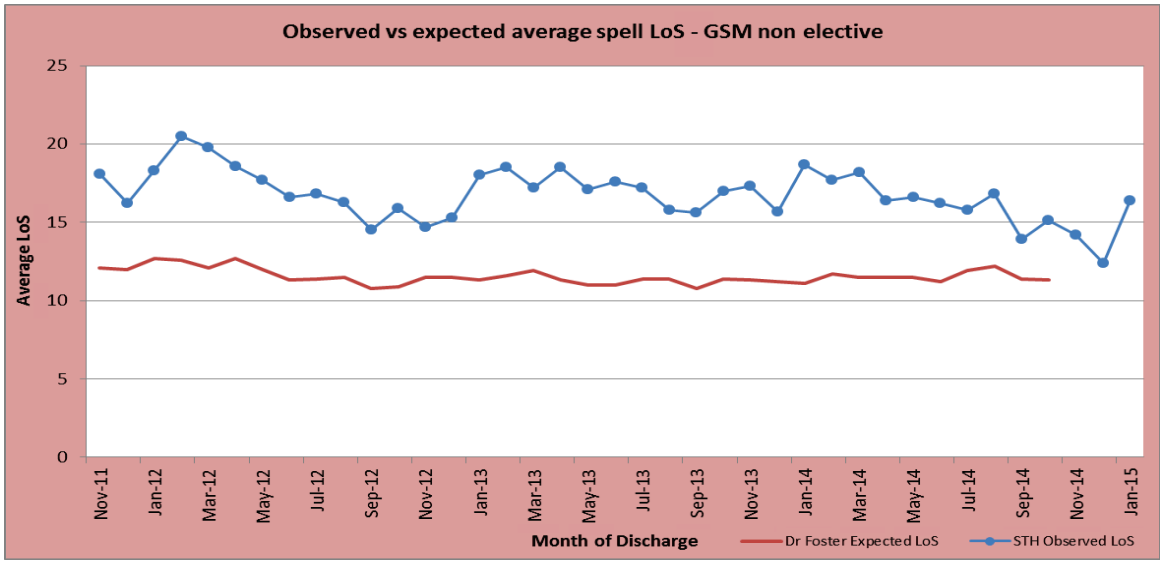
2.2.1 Optimise Length of Stay (LoS)

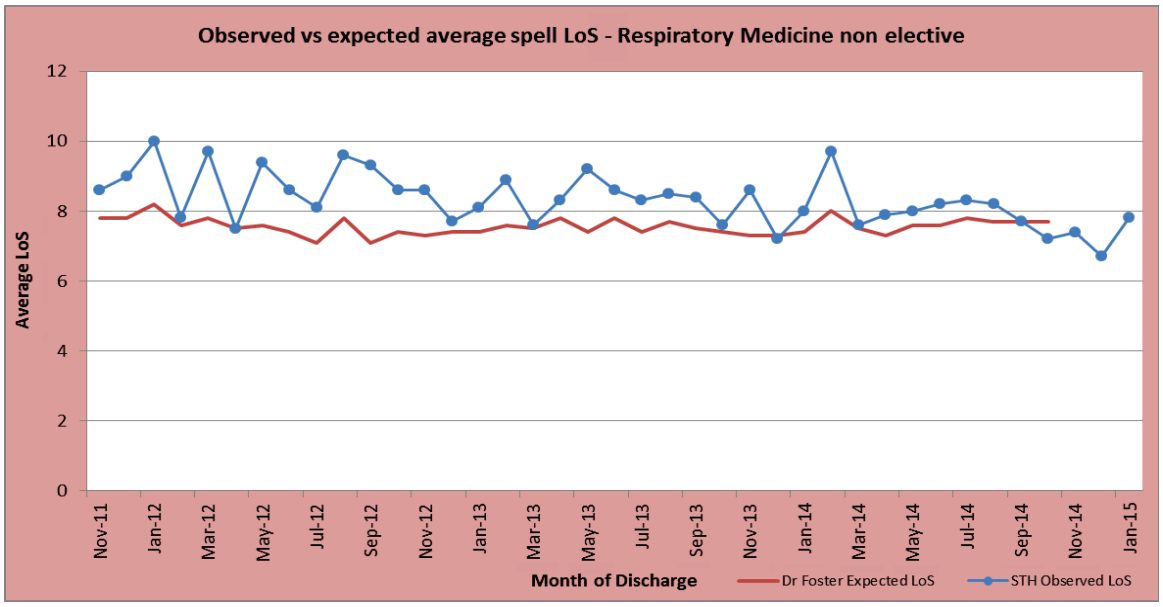
Reducing unnecessary hospitalisation for patients, through focusing on length of stay, represents an opportunity to improve quality and patient experience. Significant work has been done to understand the current situation and progress at specialty level. Analysis has been undertaken for each specialty to track performance against Dr Foster data for case-mix adjusted length of stay. The table below outlines the potential bed gains if key specialties non-elective lengths of stay were at national case-mix adjusted average. The data covers the period November 2013 to October 2014.

Specialty of Discharge (Non-Elective only)	Inpatient Spells	Expected LoS (Days)	Observed LoS (Days)	Difference	% of potential bed gain
Geriatric Medicine	6128	11.5	16.5	5.1	57.3
Respiratory Medicine	6248	7.6	8	0.5	5.7
Nephrology	1183	7.2	9	1.9	4.1
Gastroenterology	3102	6	6.7	0.7	4
Diabetic Medicine	2047	8.4	9.3	0.9	3.4
Trauma & Orthopaedics	3201	9.4	9.8	0.5	2.9
Colorectal Surgery	2971	4.5	5	0.5	2.7

N.B: Small volume specialties and volumes where Dr. Foster speciality classification has changed has been removed from the above chart (i.e. Cardiac)

The underlying performance has been analysed on a time series basis for each specialty to show overall trend against expected average length of stay. This is crucial to understanding the true position, as the two charts below demonstrate with both Geriatric and Stroke Medicine (GSM) and Respiratory charts showing improvement through a focus on redesigning their processes and systems.





Analysis has shown that concentration on a relatively small number of areas will deliver the majority of the improvements. It has been agreed to focus on the 'high opportunity' areas for 2015/16 with governance overseen through the Chief Executive Officer's Programme Management Office and the Improving Flow and Reducing LoS Steering Group, led by the Director of Strategy and Operations.

The Trust has been developing its arrangements to drive forward the overall length of stay work. Weekly admission, discharge and ward based length of stay information is now sent routinely to Nurse Directors and Operations Directors for distribution to their teams for action and improvement. A thorough assessment of specialty length of stay has also been developed.

Improvement projects such as Discharge to Assess, Improving Transport, Developing additional ambulatory pathways are underway, with the Steering Group overseeing this work. A number of directorates and teams are being supported by Service Improvement to improve flow and non-elective pathways, with added Service Improvement resource focused in this area. Improving ward processes will be a major focus for 2015, and a Ward Collaborative will be bringing together wards which aim to make and share improvements in this regard.

The Clinical Operations team are working with Matrons and Ward Managers to better utilise the expected date of discharge and focus on earlier discharges both in terms of length of stay and time of day. Patients with a length of stay over specific milestones are reviewed and action taken to resolve any unnecessary delays. Daily and weekly reviews of patients who are medically fit for discharge and regular monitoring of medical outliers (where the patient is in a speciality bed which is different from their current condition) also takes place. Detailed admission, discharge and bed occupancy reports are also available to directorate management teams to allow them to focus resources in the most appropriate areas. Through a review of the recent busy winter period, it is expected further learning will emerge to inform future operational plans to streamline existing pathways that will in turn support a reduced length of stay.

The Trust works with partners, as part of the Right First Time city wide health and social care partnership to improve patient flow across the health economy. The integration of Community Services, Professional Services, Palliative Care and Geriatric and Stroke Medicine Directorates has enabled the development of detailed actions plans to help

develop seamless pathways for older people thereby supporting efforts to reduce hospital length of stay.

2.2.2 Discharge Letters for GPs

The use of e-discharge summaries, which enable clinicians to complete an electronic discharge template, is now fully embedded within the Trust and GP practices. This has improved the discharge information available to GPs.

2.2.3 Giving Patients a Voice

During 2014/15, 9103 'Frequent Feedback' surveys were completed, this compared with 6,819 during 2013/14. 'Frequent Feedback' surveys were introduced into Community Services in January 2015 to allow more patients the opportunity to share with us their comments about the care the Trust provided.

We have continued to use the Friends and Family Test (FFT) in accident and emergency, inpatient and maternity services during 2014/15. In October 2014 we rolled out FFT to outpatient and day case services. The roll-out to Community Services was completed in January 2015, achieving early implementation to all services provided by the Trust.

2.2.4 Review Mortality Rates at the Weekend

The Trust has continued to review weekend mortality during 2014/15 as part of the 2014/15 objective for improvement. Please see 2.4.3 for further information.

2.2.5 Improve Dementia Awareness

The Trust is dedicated to improving dementia awareness with our staff and meeting the needs of patients and carers with this condition. The 'All About Me Booklet', which describes the patient's preferences, needs and routines, was launched during dementia awareness week in May 2014. The booklet is available to patients on all wards, with particular focus on those wards where dementia is most prevalent. Work is underway to maximise access to the booklets for carers and patients.

The Trust now has a Dementia Training Needs Analysis and Strategy which provides information on the many opportunities for training from e-learning to Masters Courses which are run by the University of Sheffield. Training is given to all new Trust staff on Central Induction and all volunteers. Training numbers for the Trust continue to increase.

A Dementia Champion Network has been developed across the Trust during 2014/15. In 2015/16 we plan on accrediting all clinical areas that have a dementia champion, supportive literature in the format of 'All About Me' leaflets and can demonstrate that staff are committed to being dementia friendly.

The first stage of the improvement scheme on Vickers 4, at the Northern General Hospital, has been completed and will continue throughout 2015/16.

2.3 Objectives 2013/14

2.3.1 Cancelled Operations

In 2014/15, 6.6% of planned operations were cancelled on the day of surgery due to clinical and non-clinical reasons. Although we are still short of our target to reduce this figure to 4%, the percentage of cancellations is decreasing year on year.

Year	Cancelled operations for clinical and non-clinical reasons	Total planned operations	% on day cancellation rate
2012/13	2394	34,364	7%
2013/14	2392	35,762	6.7%
2014/15 (April to Jan)	1975	29,769	6.6%

The five main reasons for cancellations at the Trust remained the same during 2014/15 as they were for 2012/13 and 2013/14. These were:

- patient unfit – hospital decision: patients arriving with an infection, or having results of standard tests outside of expected ranges (e.g. high blood pressure)
- patient did not attend – the patient did not arrive for the scheduled appointment
- operation not required – symptoms that have improved or disappeared
- patient cancelled or refused treatment – patients changing their mind, or unable to attend the scheduled date for surgery
- Lack of theatre time – previous cases on the list taking longer than expected; changes to the order of a list resulting in (or as a result of) delays

Throughout 2014/15, work continued to reduce the number of operations cancelled on the day. Orthopaedics and General Surgery now use a checklist, three days before the date admission, to confirm that a patient is fit, willing and able to attend for surgery as planned. Work is ongoing with all elective specialties to cascade the introduction of the checklist.

For 2015/16 a process where the Operating Theatre Patient Flow Co-ordinators work with Directorate teams, to understand and help resolve the root cause of the cancellations, will be developed.

A working group has been established to look at all aspects of the scheduling process, from when a patient is added to a waiting list through to when they attend for surgery. The purpose of this group is to gather information about existing processes across the Trust, share good practice between clinical Directorates and where possible to standardise practice. Work has begun on standardising patient letters and waiting list documentation. The working group is currently considering different ways of communicating with patients, for example through text or email reminders. A patient information campaign will be launched during 2015/16.

The challenge of reducing the on the day cancellation rate remains and will continue to be a priority for the Trust during 2015/16.

2.3.2 Pressure Ulcers

In order to try to reduce the prevalence of pressure ulcers to 5% further work within the acute service is progressing. This includes the identification of patients at risk of developing

a pressure ulcer, early intervention by the Pressure Ulcer Prevention Team, and targeted work with clinical areas.

Performance figures

Monthly survey data for the period	**2012/13**	**2013/14**	**2014/15**
Proportion with pressure ulcers acquired whilst receiving care from the Trust	**1.77%**	**1.41%**	**1.79%**
Proportion with pressure ulcers prior to receiving care from the Trust	**4.18%**	**4.31%**	**4.36%**
Overall proportion	**5.98%**	**5.72%**	**6.15%**

In November 2014 the 'Time to Turn' awareness campaign was launched. This coincided with the launch of a pressure care patient information leaflet, the changes of nursing care records to promote accurate documentation of skin condition and the development of staff educational resources. This has helped increase the profile and activities of the acute Tissue Viability Team.

There has been significant recruitment to the acute Tissue Viability Team since April 2014 and a permanent team has now been established incorporating the Pressure Ulcer Prevention Team. The team assess patients daily for their risk of developing pressure ulcers and target areas of high prevalence, instigating early pressure ulcer prevention. The acute team will be working on a number of key initiatives during 2015/16, aiming to develop, review or evaluate current services and practice in order to provide more effective, efficient care delivery and reduce pressure ulcer prevalence. This includes high pressure ulcer prevalence areas having 'on the spot' teaching programme for nurses and clinical support workers.

The acute team are also actively involved in the Total Bed Management project, which will see the Trust replace all its existing beds during 2016/17. The team have provided expert advice to inform the project, including outlining the specific requirements for beds and mattresses for patients to promote comfort and to reduce the incidence of pressure ulcers.

The results of the community wound survey in 2013 identified 206 pressure ulcers, 20% of the wound population at that time (n=1027), with over 36% of the pressure ulcers present for over 6 months. This prompted further in-depth data collection of pressure ulcers in one of the community teams. Information from this survey has informed training and communication programmes and a community wound survey was conducted in December 2014 to coincide with Safety Thermometer week. Full analysis of data is not complete but interim result suggests a reduction in overall numbers of pressure ulcers from 206 to 156.

Community Wound Survey

	2013	**2014***
Grade 1	50	25
Grade 2	104	84
Grade 3	31	39
Grade 4	13	13

*Interim results

The interim results show a reduction in both Grade 1 and Grade 2 pressure ulcers which would suggest that preventative strategies are working. The results also indicate that more work is required to consider prevention of pressure ulcer deterioration, which will be addressed as part of a 'react to red' campaign. Further analysis of the data will provide

detail of pressure ulcer deterioration while receiving care from the community nurses, including inherited pressure ulcers.

To support further data capture refinements have been made to the electronic wound template to allow recording of pressure ulcer grades and place of referral. Also most nurses now have cameras allowing images to be taken of wounds at first visit, which can be stored in the electronic record (with appropriate patient consent).

The Community Services Care Group holds a monthly Pressure Ulcer Care group meeting, which feeds into the Trust wide Steering Group and is also supported by a Regional Task Group for pressure ulcer prevention.

2015/16 will see the ongoing development of the Pressure Ulcer Champions with key roles and responsibilities. This will help to continue the work on training and documentation. Ongoing work with intermediate care teams will also continue to enable earlier identification of pressure ulcer risk and prevention.

2.3.3 Improve discharge information for patients

During 2014/15 890 patient information leaflets have been checked and revised bringing the total to 88% (1518/1722) since May 2013. Discharge information is now routinely checked in all leaflets before publication. As all leaflets are checked on a two year rolling basis, the work to check existing leaflets for discharge information is on track to be completed by the summer of 2015.

Audit work originally identified two departments where discharge information could be more effective (Emergency Department and Urology Department). Both departments have received support to make improvements to their discharge information and have now updated and re-published their leaflets. As with other Trust leaflets these are now routinely updated every two years.

In September 2014 a project group was set up to review the information provision for patients having surgery. This has already resulted in improvements in discharge information from the Theatre Admissions Unit. The group is now looking at establishing and rolling out a recommended information pathway encompassing the whole patient journey.

Online access to patient information was made available in May 2014. Patients can now download over 2800 leaflets from the Trusts website, 1480 of which are Trust leaflets. New or revised leaflets are automatically uploaded to the website each day ensuring patients can access the most up to date resources for their condition.

2.4 Objectives 2014/15

2.4.1 To ensure every hospital inpatient knows the name of the consultant responsible for their care during their inpatient stay and the name of the nurse responsible for their care at that time

A recommendation from the Mid Staffordshire NHS Foundation Trust Public Inquiry report and the Government's formal response Hard Truths was that every hospital patient should have the name of their consultant and the nurse responsible for their care above the bed. In order to explore the possibilities two focus groups were held comprising a representative group of nursing staff from Care Groups across the Trust.

The focus groups were mindful that the information must be accessible and visible for patients and therefore selected the use of tent boards. These are free standing and can be

placed on a patients table or bedside locker in where the patient can see the information displayed. The tent boards also have space on the back for staff to write "what matters to the patient today" with the aim of enabling communication and meeting the patient's specific needs.

[Picture of tent board to be inserted]

A trial of tent boards was undertaken on a GSM ward during October 2014 and evaluated well. A decision was taken to introduce their use across the hospital.

An education and awareness campaign started in October 2014 using a cascade training approach to introduce the use of tent boards in all areas. Leads and Educators from each Care Group coordinated the training, based on a common training plan, in their respective areas supported by staff from the Learning & Development Department.

The launch has been delayed until April 2015 due to a delay in obtaining the tent boards. Following the launch feedback will be gathered from both patients and staff to evaluating the effectiveness of the boards. To monitor the use of the tent boards Matrons will be doing spot-checks to check that they are in use and the information written on them is appropriate.

2.4.2 To improve complainant satisfaction with the complaints process

From April 2014, the Trust, along with twenty two other trusts, participated in the Patients Association Complainant Satisfaction Survey. All complainants who's complaint was considered to be closed were invited to participate in the survey. At the end of January 2015 the Patients Association had received 1010 responses to the survey, 164 for the Trust.

The most recent survey shows that the Trust scores similar to other trusts. In relation to the 4 key performance indicators, scores have been benchmarked and baseline measures have been established as follows:

Key performance indicators	All participating trusts	STH
% respondents who feel their complaint against the Trust has been resolved	50%	48%
% who feel their complaint was handled 'very well'	9%	8%
% who feel their complaint was dealt with 'quickly enough'	29%	36%
% who were 'very satisfied' with the final response	7%	8%

In addition to this the Trust undertook a detailed review of the quality of our responses to complaints. The review involved a paper-based audit of a sample of 56 complaint response letters along with face to face interviews with 13 complainants.

The Trust scored well in the paper-based audit, included offering complainants the opportunity to meet and discuss their concerns, and offering an apology where appropriate. Areas identified for improving the complaint response letters include explaining specialist or technical terminology and providing an explanation of the next steps following the complaint and any changes made.

In the interviews, the issues commented on positively include helpfulness of the member of staff dealing with the complaint and the comprehensiveness of the response. Issues causing most dissatisfaction include delayed responses and failing to keep complainants updated on progress.

A detailed action plan has now been agreed which involves significant changes to the complaints process. Changes include a new process to 'fast track' issues which we are able to resolve quickly. The new process sees the introduction of a tiered timescale for responding to complaints. This approach aims to ensure complaints are responded to in a timescale proportionate to the complexity and number of concerns raised. The changes will be supported by a comprehensive training programme for staff which will include skills based training such as investigation and letter writing skills.

The proposed changes are wide ranging and implementation of the action plan has required careful planning and consultation. It has therefore not been possible to implement the action plan during 2014/15; however the changes are to be piloted in the Urology and General Surgery directorates for six months from April 2015. As part of the pilot, targets to improve scores across a range of measures, including the four indicators above, will be agreed. An evaluation report will be provided in October 2015 which will include details of performance against improvement targets.

2.4.3 To review Mortality rates at the weekend and to focus improvement activity where necessary

To be added

2.4.4 To review the impact of waiting times on the patient experience (specifically patients waiting over 18 weeks for treatment)

The national 18 week wait target specifies that the length of time between the patient's first referral and their treatment should be no longer than 18 weeks. Whilst the Trust has initiatives and strategies in place to effectively manage waiting lists and waiting times, there has been a slight fall in overall performance from 2012/13 - 2013/14, as reported in the Annual Quality Report 2013/14.

Waiting for an appointment or treatment can be stressful for the patient and their carers and may significantly impact on the overall patient experience. A bespoke survey was therefore designed to better understand the personal experience of patients who had waited over 18 weeks for their admission or treatment.

The survey asked patients five questions about their health whilst waiting with the following aims:

- To review the impact of waiting times on the patient experience
- To explore ways of improving the experience during the wait.

119 randomly selected patients over the age of 16 years were contacted with a covering letter and a questionnaire. Patients were selected from a wide range of specialties as the patient experience of waiting for different procedures can be very different in terms of pain or anxiety levels.

Survey responses were anonymous, however patients who were happy to be telephoned for a more detailed interview were asked to provide their name and telephone number. 34 (28.6%) patients responded to the survey and the following summarises the results:

Whilst waiting:

- their mobility had deteriorated (29%)
- their ability to care for themselves had deteriorated (15%)
- their ability to perform usual activities deteriorated (38%)
- their pain or discomfort increased(56%)
- they became more anxious and/ or depressed (56%)

Patients were also given the opportunity to comment and many commented positively about their experience once they had been admitted. Others commented negatively about the impact of waiting and its effect on their health and their social, family or work life. Those surveyed who indicated that waiting had a negative effect on aspects of their health and wellbeing were from spinal, surgical, gynaecology and ophthalmic services. Financial difficulties were also indicated by those waiting for spinal services and ophthalmic services.

The Trust is now considering ways to improve how it communicates with patients who are waiting for a procedure or an admission. We are also exploring ways of giving patients a choice of how they would like to be kept updated, for example by phone, text or email.

Consideration is now being given to possible methods of regularly reviewing the experience of patients who wait for treatment.

2.5 Priorities for Improvement 2015/16

This section describes the Quality Improvement Priorities that have been adopted for 2015/16. These have been agreed by the Quality Report Steering Group in conjunction with patients, clinicians, Governors, Healthwatch and NHS Sheffield CCG. These were approved by the Healthcare Governance Committee, on behalf of the Trust's Board of Directors, on 23rd March 2015. The Trust has considered hospital and community service priorities for the coming year choosing three areas to focus on which span the domains of patient safety, clinical effectiveness and patient experience.

Priorities for 2015/16 are:

1. To improve how complaints are managed and learned from within Sheffield Teaching Hospitals.
2. To improve staff engagement by using the tools and principles of Listening into Action (LiA).
3. To improve the safety and quality of care provided by the Trust in ALL settings with the aim of reducing preventable harm and improving quality.

In addition to these priorities for improvement there are many quality improvement proposals in the Sheffield Teaching Hospitals Quality Strategy and the Commissioning for Quality and Improvement (CQUIN) Programme (see 2.7).

2.5 Detailed objectives linked to Improvement Priorities

Priority 1

Our Aim	To improve how complaints are managed and learned from within Sheffield Teaching Hospitals.
Past Performance	Nationally, there have been a number of recent and important reviews making recommendations relating to fundamental changes to the way in which complaints are managed. These include the Francis Report (2013), the Keogh Review (2013), the Berwick Review (2013) and the Clwyd/Hart Review (2013). In the light of these recent national reports and following the introduction of important initiatives such as the Friends and Family Test, the Trust is currently undertaking a refresh of our approach to patient experience. Aligned to the patient experience refresh is a programme of work to significantly improve our processes for managing complaints, given the current high profile of complaints both nationally and within the Trust.
Key Objectives	To provide formal training on complaints for around 2,400 Trust staff to develop their understanding and appreciation of the full benefits complaints can have on service improvement, and removing the stigma and negativity which often surrounds complaints. The training will help staff to view complaints more positively and open-mindedly, helping them to respond and use feedback more productively. The four core outcomes of the training include: • Achieving positive changes in staff attitudes about complaints • The organisation develops a more personal, resolution-based approach to complaints handling • Improved quality of responses that successfully resolve the complaint • The organisation actively learns lessons from complaints and improvements in services are evidenced. Following each training session each member of staff will be asked to complete an evaluation survey to ascertain their views on the effectiveness of the training. During 2015/16 patient feedback regarding care and experience through our ongoing programme of surveys, including the Friends and Family Test, will be reviewed to see if the training has had an impact. We will also monitor the proportion of positive and negative patient comments received through websites, social media and comment cards.
Measurement and Reporting	Quarterly updates will be reported to the Board with final outcomes being reported in the Quality Report 2015/16.
Board Sponsor	**Professor Hilary Chapman** Chief Nurse
Implementation Lead	**Sue Butler** Head of Patient Partnership

Priority 2

Our Aim	To improve staff engagement by using the tools and principles of Listening into Action (LiA).
Past Performance	Sheffield Teaching Hospitals staff survey results for 2013/14 were below average for motivation and involvement which are key components of staff engagement. Low staff engagement can impact on the patient experience. In order to improve overall staff engagement the Trust took a decision to invest in LiA which is a way of engaging staff in making changes and improvements. LiA has been adopted by over 50 NHS trusts and has been proven to make a difference. The Health Service Journal Staff Motivation Award has been won for the past three years by hospitals which have used LiA. LiA Trusts see the importance of engaging frontline clinical staff. As a first step 'Big Conversations' took place during November and December 2014 and January and February 2015. All staff were invited to attend these Trustwide events giving them the opportunity to identify what matters to them'. At the same time Trust Executive Group have identified 'the blueprint' which is the key performance areas that they feel LiA has an opportunity to influence. The impact of LiA is measured by a Journey Scorecard and a Pulse Check. The Journey Scorecard contains 20 questions, under four headings for senior leaders, to identify how well they feel they run the organisation. Baseline data for the Journey Scorecard was captured in December 2014. The scores shown below are aggregate scores with a range from 5 to 25. With 5 being strongly disagree on all indicators and 25 strongly agree with all indicators. Overall the results show that there are no strong indications positively or negatively. The Journey Scorecard scores were: • Navigation- 13.9 (Just below neutral) • Leadership- 15.5 (Neutral) • Ownership- People affected by change- 14 (Just below neutral) • Enablement- 13.2 (Just below neutral) The Pulse Check is 15 questions sent to all staff focusing on how they feel they are supported to be able to do their jobs. The Pulse Check revealed that only 17% of staff feel that day-to-day issues and frustrations are quickly identified and resolved. It also revealed that only 29% of staff believe that communication between senior management and staff is effective. However 68% of staff believe the Trust is proving high quality services to our patients/service users.
Key Objectives	• To create a culture of engagement where people feel able to make changes to their service which will positively impact on patient and staff experience. • To see an improvement in the LiA Pulse Check and the Journey Scorecard. • To ensure 25% of STHFT staff have engaged with LiA during

	2015/16 either in Team Conversations or in supporting teams and schemes. • To gain feedback on every LiA event, aspiring to achieve a score of 3 or above on average. (Score ranges from 1- Poor and 5- Excellent). • To use LiA tools and principals on key performance areas throughout the Trust demonstrating tangible improvements • To ensure each directorate has a LiA scheme based on one of the key performance areas during 2015/16 and that it is jointly led by a doctor, a nurse/AHP and a manager. • To improve the staff involvement scores in the staff survey with particular respect to the percentage of staff who perceive that managers act on staff feedback. We will also review the impact on the Trust's overall staff engagement index score. This was 3.81 for 2014/15.
Measurement and Reporting	The LiA steering group and sponsor group will monitor all the schemes and training throughout 2015/16. The Trust Executive Group will receive regular updates on progress with the final outcomes being reported in the Quality Report 2015/16.
Board Sponsor	**Mark Gwilliam,** Director of Human Resources **and** **Sir Andrew Cash** Chief Executive
Implementation Lead	**Jaki Lowe** LiA Lead

Priority 3

Our Aim	To improve the safety and quality of care provided by the Trust in ALL settings with the aim of reducing preventable harm and improving quality.
Past Performance	Sheffield Teaching Hospitals NHS Foundation Trust is committed to delivering safe patient care. In recent years we have delivered safety campaigns, such as 'Patient Safety First' and 'How safe is STH?' which have acted as a catalyst for a wide variety of workstreams and safety improvement initiatives across the Trust. In July 2014 the Trust committed to the three year 'Sign up to Safety Campaign'. The Trust's overall aim is to improve the reliability and responsiveness of care given to patients to achieve a 50% reduction in harm supported by the following five goals: 1. Cultural change that ensures that patient safety will be embedded within ALL aspects of clinical care. 2. Improved recognition and timely management of deteriorating patients leading to improved care. 3. Improved recognition and management of patients presenting with, or developing, Red Flag Sepsis and Acute Kidney Injury (AKI). 4. Absolute reduction in the cardiac arrest rate. 5. Improved communication through the introduction of structured processes to improve the transfer of time-critical patient information.
Key Objectives	As part of the three year plan for 'Sign up to Safety Campaign' the Trust aims to take the following actions for each of the 5 key areas during 2015/16: **1. Cultural change that ensures that patient safety will be embedded within ALL aspects of clinical care** • Undertake and analyse staff safety culture survey to better understand the issues faced by employees • Engage and empower patients regarding their inpatient safety via a Patient Safety Briefing, through the use of electronic and traditional media, external website development, patient questionnaires and hospital volunteers • Develop and deliver bespoke training packages in Human Factors awareness <u>Measurement:</u> • % of inpatients receiving Patient Safety Briefing information • Number of staff who undertook Microsystems coaching and the number of service improvement projects undertaken • Number of staff who undertook Human Factors training **2. Improved recognition and timely management of deteriorating patients leading to improved care** • Revise the current Sheffield Hospitals Early Warning Score (SHEWS) and subsequent escalation plan • Improve accuracy and completeness of observation recording the whole patient assessment and experience • Accelerate the adoption of the acutely deteriorating patient pathway in

	all inpatient areas Measurement: • % of deteriorating patients escalated appropriately as per trust policy (from audit data) • % of patient observations completed accurately and in full **3. Improved recognition and management of patients presenting with or developing Red Flag Sepsis and Acute Kidney Injury (AKI)** • Develop and trial care bundles for Red Flag Sepsis and AKI • Develop the current Laboratory Information Management System to facilitate and provide clinician and nursing prompts, to enable timely interventions for those 'at risk' patients • Make available an easily accessible 'at risk' patient dashboard for appropriate escalation of patients to be available throughout the Trust for use at handover Measurement: • Compliance with local AKI and Sepsis care bundles • Reduction in associated critical care utilisation **4. Absolute reduction in the cardiac arrest rate.** • Deliver a Patient Safety Collaborative focusing on improving management of deteriorating patients and to reduce Cardiac Arrests Measurement: • % of acute admissions where Do Not Attempt Cardiopulmonary Resuscitation status is recorded • Cardiac Arrest rate throughout the Trust **5. Improved communication through the introduction of structured processes to improve the transfer of time critical patient information.** • Utilise the Situation Background Assessment Recommendation (SBAR) tool to provide a structured approach to communication • Introduce 'Safety Huddles' to ensure that patient safety is at the forefront in every clinical handover • Improve clinical handover of 'at risk' patients from Day to Night teams (and vice versa) Measurement: • % of inpatient wards undertaking 'Safety Huddles' on a daily basis • % of referrals to Critical Care utilising SBAR • Hospital @ Night uptake of SBAR tool at handover – Audit of compliance
Measurement and Reporting	Regular updates will be submitted to the Safety and Risk Management Board with the final outcomes being reported in the Quality Report 2015/16.
Board Sponsor	**Dr David Throssell** Medical Director
Implementation Leads	**Sandi Carman** Head of Patient and Healthcare Governance **Andrew Scott** Patient Safety Manager **Dr Paul Whiting** Associate Medical Director for Patient Safety

2.6 How did we choose these priorities?

Discussions and meeting with Healthwatch representative, Trust Governors, Clinicians, Managers, and members of the Trust Executive Group and Senior Management team.

Topics suggested analysed and developed into the key objectives for consultation:

1) To improve how complaints are managed and learned from within Sheffield Teaching Hospitals

2)To improve staff engagement by using the tools and principles of Listening into Action (LiA)

3) To improve the safety and quality of care provided by the Trust in ALL settings with the aim of reducing preventable harm and improving quality

Key objectives used as a basis for wider discussion with the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee, Healthwatch representative, Trust Governor representatives, Clinicians, Managers, and members of the Trust Executive Group and Senior Management team.

Review by Trust Executive Group to enable the Chief Nurse and Medical Director to inform the Board on our priorities.

Board of Directors agreed these priorities in April 2015.

2.7 Statements of Assurance from the Board

This section contains formal statements for the following services delivered by Sheffield Teaching Hospitals NHS Foundation Trust.
a) Services Provided
b) Clinical Audit
c) Clinical Research
d) Commissioning for Quality and Improvement (CQUIN) Framework
e) Care Quality Commission
f) Data Quality
g) Patient Safety Alerts
h) Staff Engagement
i) Annual Patient Surveys
j) Complaints
k) Eliminating mixed sex accommodation
l) Coroners Regulation 28 Reports

For the first six sections the wording of these statements and the information required are set by Monitor and the Department of Health. This enables the reader to make a direct comparison between different Trusts for these particular services and standards.

a) Services Provided

During 2014/15 the Sheffield Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted **XX** relevant health services.

The Sheffield Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in **XX** of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represents **XX%** of the total income generated from the provision of relevant health services by the Sheffield Teaching Hospitals NHS Foundation Trust for 2014/15.

The data reviewed in Part 3 covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience.

b) Clinical Audit

During 2014/15 37 national clinical audits and 4 national confidential enquiries covered relevant health services that Sheffield Teaching Hospital NHS Foundation Trust provides.

During that period that Sheffield Teaching Hospital NHS Foundation Trust participated in 97.29% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that that Sheffield Teaching Hospital NHS Foundation Trust was eligible to participate in during 2014/15 are documented in table 1. The national clinical audit the Trust has not participated in is detailed later in the section.

The national clinical audits and national confidential enquires that that Sheffield Teaching Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Acute Care		
Case Mix Programme (CMP)	Yes	TBC
Emergency Use of Oxygen	Yes	01/02/15 (validation until May 2015)
British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	Yes	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	TBC
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)		
• Lower Limb Amputation	Yes	100%
• Tracheostomy Care	Yes	100%
• Gastrointestinal Haemorrhage	Yes	100%
• Sepsis	Yes	100%*
National Emergency Laparotomy Audit (NELA)	Yes	54%*
National Joint Registry (NJR)	Yes	TBC
• 1. Hip replacement		
• 2. Knee replacement		
• 3. Ankle replacement		
• 4. Elbow replacement		
• 5. Shoulder replacement		
• 6. Implant performance		
• 7. Hospital performance		
• 8. Surgeon performance (submitted for all)		
Vital signs in Children	N/A	N/A
Pleural Procedures	Yes	91%
VTE risk in lower limb immobilisation	TBC	TBC
Specialist rehab for patients with complex needs	TBC	TBC
Older people (care in emergency departments)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme		
1. Audit of the use of red cells	Yes	100%*
2. Audit of transfusion in children and adults with sickle cell disease	Yes	TBC
Cancer		
Bowel cancer (NBOCAP)	Yes	91%*
Lung cancer (NLCA)	Yes	93%*
National Prostate Cancer Audit	Yes	TBC
Oesophago-gastric cancer (NAOGC)	Yes	96%*
Head and neck oncology (DAHNO)	Yes	89%*
Heart		
Acute Coronary Syndrome or Acute Myocardial Infarction	Yes	TBC
Cardiac Rhythm Management (CRM)	Yes	TBC
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Yes	TBC

Coronary Angioplasty/National Audit of PCI	Yes	TBC
National Adult Cardiac Surgery Audit	Yes	TBC
National Cardiac Arrest Audit (NCAA)	Yes	See statement
National Heart Failure Audit	Yes	TBC
National Vascular Registry	Yes	TBC
Pulmonary Hypertension (Pulmonary Hypertension Audit)	Yes	TBC
Long Term Conditions		
Chronic Kidney Disease in primary care	N/A	N/A
National Diabetes Adults	Yes	100%
National Diabetes Foot care Audit	Yes	TBC
National Pregnancy in Diabetes Audit	Yes	100%
Diabetes (Paediatric) NPDA)	N/A	N/A
Inflammatory Bowel Disease (IBD) programme	Yes	74%*
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (organisational)	Yes	97%
Renal replacement therapy (Renal Registry)	Yes	TBC
Rheumatoid and Early Inflammatory Arthritis	Yes	TBC
Mental Health		
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	N/A	N/A
Prescribing Observatory for Mental Health (POMH) Prescribing for substance misuse: Alcohol detoxification	N/A	N/A
Prescribing Observatory for Mental Health (POMH) Prescribing for bipolar disorder (use of sodium valproate)	N/A	N/A
Prescribing Observatory for Mental Health (POMH) Prescribing for ADHD in children, adults and adolescents	N/A	N/A
Mental Health (care in emergency departments)	Yes	100%
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP) SSNAP Post-Acute Organisational Audit	Yes	91.3%*
Sentinel Stroke National Audit Programme (SSNAP)	Yes	TBC
Sentinel Stroke National Audit Programme (SSNAP) SSNAP Clinical Audit	TBC	TBC
UK Parkinson's Audit (previously known as National Parkinson's Audit)	TBC	TBC
• 1. Patient Management (Elderly Care & Neurology)	Yes	TBC
• 2. Physiotherapy	Yes	TBC
• 3. Occupational Therapy	Yes	TBC
• 4. Speech & Language Therapy (submitted for all)	Yes	TBC
Other		
Elective surgery (National PROMs Programme)		TBC
Groin hernia surgery	Yes	
Questionnaire 1 received		

Questionnaire 2 returned		
Varicose vein surgery	Yes	
Questionnaire 1 received		
Questionnaire 2 returned		
Hip replacement/revision surgery	Yes	
Questionnaire 1 received		
Questionnaire 2 returned		
Knee replacement/revision surgery	Yes	
Questionnaire 1 received		
Questionnaire 2 returned		
National Audit of Intermediate Care	Yes	TBC
National Ophthalmology Audit	TBC	TBC
UK Cystic Fibrosis Registry (need to confirm if this was included in the QuAcc)	TBC	TBC
Women's and Children's Health		
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	TBC
Neonatal Intensive and Special Care (NNAP)	Yes	TBC
Paediatric Asthma	N/A	N/A
Paediatric Intensive Care Audit Network (PICANet)	N/A	N/A
Epilepsy 12 Audit (Childhood Epilepsy)	N/A	N/A
Fitting Child (Care in emergency departments)	N/A	N/A

Please note the following
*Data for projects marked with ** require further validation. Where data has been provided these are best estimates at the time of compilation. Data for all continuous projects and confidential enquiries continues to be reviewed and validated during April, May or June and therefore final figures may change.

Supporting statements
National Diabetes Audit (Adults) (NDA(A))

NDA(A) numbers have decreased for this data submission due to exclusion of patients where their annual screening was completed by the GP rather than STHFT.

National Cardiac Arrest Audit (NCAA)
Local audits continue to be undertaken. Enrolment in the National Cardiac Arrest Audit (NCAA) will be considered during 2015 by the Trust Resuscitation Committee.

National Emergency Laparotomy Audit (NELA)
TBC

The reports of **[number]** national clinical audits were reviewed by the provider in 2014/15 and Sheffield Teaching Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Some of the examples of which are included below:

National Comparative Audit of Blood Transfusion: Audit of Anti-D Immunoglobulin Prophylaxis
The audit findings reflect that most anti-D immunoglobulin prophylaxis is delivered correctly and RhD negative women should be reassured that this is an important and effective programme that prevents a serious and life-threatening condition which used to affect large numbers of babies but no longer does.

Now that there is a single UK evidence-based guideline for anti-D immunoglobulin prophylaxis the results of this audit, and local policies, are being reviewed against the guideline and when local quality improvements have been introduced to address any deficiencies in the service, a local re-audit will be undertaken.

National Diabetes Inpatient Audit (NaDIA)
Following participation in the audit we have introduced new diabetes guidelines, treatment and monitoring charts, hypoboxes to treat low blood glucose levels and targeted ward based education to implement these changes. The in-patient diabetes programme is ongoing to support improvements in patient care.

NCAPOP - Head & Neck Cancer National Audit (DAHNO)

Since data was collected work has been undertaken to improve patients receiving pre-treatment dietetic assessments, improving the number of patients being seen by clinical nurse specialist (CNS) prior to commencement of first treatment and improving documentation when a CNS is present at the breaking of bad news.

Confidential Enquiries
The Trust has in place a process for the management of National Confidential Enquiry into Patient Outcome and Death Reports (NCEPOD) and puts action plans together as reports are issued. It is a standing agenda item at the Clinical Effectiveness Committee which provides a forum for updates, and if any action plan requires an audit this is included on the Trust Clinical Audit Programme.
Data is also continually collected and submitted to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom – see table 1 for participation rate).

Local Clinical Audits
The reports of **[number]** local clinical audits were reviewed by the provider in 2014/15 and Sheffield Teaching Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Trustwide Nursing Documentation Audit
Following a visit by the Care Quality Commission in September 2013, nursing documentation was identified as an urgent area for improvement, particularly focusing on nursing assessments and risk screening documents. It was therefore agreed at Trust level that a weekly audit be carried out across all wards for four weeks to improve compliance in these areas. After the four weeks, the results will be reviewed by the project team. Where wards are deemed compliant, spot checks will be undertaken to provide assurance. Where there is partial or non-compliance, wards are to continue to audit on a weekly basis until they reach compliance. The overall results suggest that nursing documentation has improved over the six month audit period, with many of the standards achieving above 90% compliance. Wards have used their local results to drive improvement by producing action plans to address specific issues. Using a rapid audit cycle has enabled changes to be implemented more quickly and the use of this will be proposed for a re-audit.

Audit of the Management of Patients with Sepsis at NGH
Conclusions from an audit of 50 septic patients selected based on clinically significant blood cultures or admission to Intensive Treatment Unit with primary reason of sepsis has led to the formation of a Trustwide Sepsis Action Plan helping to address such issues and identify potential solutions in order to produce Trustwide Sepsis management guidelines.

Audit of National Institute for Health and Clinical Excellence (NICE) Technology Appraisal 129 – Bortezomib monotherapy for relapsed multiple myeloma
The aim of this audit is to assess the extent to which the practice of the Department of Haematology at STHFT is in line with current recommendations from the national bodies, regarding the use of Bortezomib in the treatment of relapsed multiple myeloma.
The practices at the Haematology department in relation to the use of Bortezomib are consistent with current recommendations from the national bodies. It is recommended that this area is re-audited in 2-3 years or earlier if guidelines change.

c) Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Teaching Hospital NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 12,943 (2013/14-14,665).

International Clinical Trials Day provides a key focus for clinical research. It is a annual global event celebrating the day that James Lind began his famous trial which led to the prevention of scurvy. This year Sheffield Teaching Hospitals NHS Foundation Trust will be hosting some events at around raising awareness of the importance of clinical research, to staff and patients. We want to show what research means and how to get involved.
In addition, there will be a talk on 20 May 2015 in the Medical School Lecture Theatre from Julian Gunn and other speakers, accompanied by some interactive stalls about our research in the University of Sheffield Medical School Café 1828.

d) Commissioning for Quality and Improvement (CQUIN Framework)

A proportion of Sheffield Teaching Hospital NHS Foundation Trust income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between Sheffield Teaching Hospital NHS Foundation 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.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at: [insert web link]

In 2014/15 2.5% of our contractual income (£15.6 million) was conditional on achieving Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield Clinical Commissioning Group. During 2013/14 the Trust secured £16m on achieving Quality Improvement Innovation goals.

For 2014/15 the Commissioning for Quality and Innovation payment framework has included:-

- Improved identification and assessment of patients who may have Dementia with over 90% of patients over 75 now screened for dementia.
- Improved responsiveness to the personal needs of patients, with over 90% of patients surveyed expressing complete satisfaction with the help they received with nutrition, pain control and going to the toilet.
- Reduction in the prevalence of pressure ulcers acquired whilst receiving hospital or community care.
- Improved communication with GPs following a patient's attendance in outpatient clinic.

e) Care Quality Commission (CQC)

Sheffield Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully compliant. Sheffield Teaching Hospitals NHS Foundation Trust had no conditions on registration.

The Care Quality Commission has not taken enforcement action against Sheffield Teaching Hospitals NHS foundation Trust during 2014/15.

Sheffield Teaching Hospitals NHS Foundation Trust has not participated in any special review or investigations by the CQC during the reporting period.

f) Data Quality

Sheffield Teaching Hospitals NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:
— which included the patient's valid NHS number was:
98.8% for admitted patient care;
99.8% for out patient care; and
98.6% for accident and emergency care.

— which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care.

Sheffield Teaching Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2014/15 was **70%** and was graded as satisfactory and green.

Sheffield Teaching Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- 4% primary diagnosis incorrect
- 10.5% secondary diagnosis incorrect
- 5.6% primary procedures incorrect
- 1.9% secondary procedure incorrect

To note: The figures above relate to the correct recording of patient diagnosis and procedures from case notes. The standard is 90% correct recording of the primary diagnosis and procedure, and 80% correct recording of the secondary diagnosis and procedure.

The results should not be extrapolated further than the actual sample audited. Areas audited were taken from a section of specialities specified nationally and by our commissioners, which were:-

- 100 sets of case notes from the national area for audit – the HRG sub-chapter HD
- 100 sets of case notes from the local commissioner selected area for audit – the HRG sub-chapter NZ

Sheffield Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

1. Continue to work collaboratively with the network of Data Quality professionals across Yorkshire and the Humber. Meet quarterly as a forum to share good practice and ideas.
2. Analyse the audit results of the Trustwide audit of information systems and develop an action plan to introduce some standardisation of data quality control.
3. Work in close collaboration with the organisational change managers for the T3 project, to develop Standard Operating Procedures, and to build up a cross-trust network of local contacts for Data Quality issue resolution.
4. Develop a strategy to incorporate Data Quality into the Trust's Business Objectives.
5. Review and re-issue the Trust Data Quality policy, taking into account the recommendations of the 360 Assurance local audit into Data Quality.

g) Patient Safety Alerts

The National Patient Safety Agency analyses reports on patient safety incidents received from NHS staff and uses this to produce resources (alerts or rapid response requests) aimed at improving patient safety. Table 2 below details the Alerts and Raid Response Reports which have been received during the year 2014/15:-

Table 2: Alerts received during 2014/15

Ref	Title	Issued	Deadline	Closed
NHS/PSA/D/ 2014/002	Non-Luer Spinal (Intrathecal) Devices	20/2/2014	1/7/2014	Closed
NHS/PSA/W /2014/003	Risks of Associating Ecg Records With Wrong Patients	4/3/2014	4/4/2014	Closed
NHS/PSA/D/ 2014/005	Improving Medication Error Incident Reporting and Learning	20/3/2014	16/9/2014	Closed
NHS/PSA/D/ 2014/006	Improving Medical Device Incident Reporting and Learning	20/3/2014	16/9/2014	Closed
NHS/PSA/W/ 2014/007	Minimising Risks of Omitted and Delayed Medicines for Patients Receiving Homecare Services	10/4/2014	9/5/2014	Closed
NHS/PSA/W/ 2014/008	Residual Anaesthetic Drugs in Cannulae and Intravenous Lines	14/4/2014	13/5/2014	Closed
NHS/PSA/W/ 2014/009	Risk of Using Vacuum and Suction Drains When Not Clinically Indicated	6/6/2014	4/7/2014	Closed
NHS/PSA/D/ 2014/010	Standardising The Early Identification Of Acute Kidney Injury	9/6/2014	9/5/2015	Still Open
NHS/PSA/D/ 2014/011	Legionella and Heated Birthing Pools Filled In Advance of Labour in Home Settings	17/6/2014	30/6/2014	Closed
NHS/PSA/W/ 2014/012	Risk of Harm Relating to Interpretation and Action on Pcr Results in Pregnant Women	23/6/2014	31/7/2014	Closed
NHS/PSA/W/ 2014/013	Risk of Inadvertently Cutting in-Line (or Closed) Suction Catheters	17/7/2014	15/8/2014	Closed
NHS/PSA/W/ 2014/014	Risks Arising from Breakdown and Failure to Act on Communication During Handover at the Time of Discharge from Secondary Care	29/8/2014	13/10/2014	Closed
NHS/PSA/R/ 2014/015	Resources to Support the Prompt Recognition of Sepsis and the Rapid	2/9/2014	31/10/2014	Closed

	Initiation of Treatment			
NHS/PSA/W/ 2014/016	Risk of Distress and Death From Inappropriate Doses of Naloxone in Patients on Long-Term Opioid/Opiate Treatment	20/11/2014	22/12/2014	Closed
NHS/PSA/W/ 2014/017	Risk of Death and Serious Harm from Delays in Recognising and Treating Ingestion of Button Batteries	19/12/2014	19/1/2015	Closed
NHS/PSA/W/ 2014/18	Risk of Death and Serious Harm from Accidental Ingestion of Potassium Permanganate Preparations	22/12/2014	22/1/2015	Closed
NHS/PSA/W/ 2015/001	Harm from using Low Molecular Weight Heparins When Contraindicated	19/1/2015	2/3/2015	Closed
NHS/PSA/W/ 2015/002	Risk Of Death From Asphyxiation By Accidental Ingestion Of Fluid/Food Thickening Powder	06/02/2015	19/03/2015	Closed
NHS/PSA/W/ 2015/003	Risk Of Severe Harm And Death From Unintentional Interruption Of Non-Invasive Ventilation	13/02/2015	27/03/2015	Closed
NHS/PSA/W /2015/004	Managing Risks During The Transition Period To New Iso Connectors For Medical Devices	27/03/2015	Not due for closure until May 2015	Still Open

h) Staff Engagement

The Trust recognises the importance of positive staff engagement and good leadership to ensure good quality patient care. A formal 'back to the floor' programme to increase the visibility of senior managers was introduced in April 2014 and the Trust has hosted a number of staff engagement sessions as part of the Department of Health Connecting for Health scheme which have both evaluated well.

The strategic direction for staff engagement is set and monitored by the Staff Engagement Executive Group, chaired by the Director of Human Resources and Organisational Development, which reports to the Finance, Performance and Workforce committee, a committee of the Board of Directors.

During 2014/15, the implementation of the Trust Staff Engagement Strategy has been continued with a particular focus on improving both staff involvement and the quality of appraisal for all staff across the Trust.

Staff Involvement
This year Staff Friends and Family testing was introduced for all staff in the Trust in line with NHS England requirements. The decision was made to take a staggered approach to this with different directorates participating in quarters 1, 2 and 4 to ensure that all staff who work in the Trust could participate and the feedback could be utilised and acted upon. Separate staff FFT testing was not undertaken in quarter 3 as it is included in the NHS staff survey which STH participated in during October/November 2014.

Engagement events have been held across the Trust during 2014/15, particularly in clinical areas to discuss the findings of the staff FFT results which have resulted in staff making suggestions leading to improvements for both staff and patients. It is pleasing to note that

the Trust is now recognised as a centre of good practice for its approach and use of the staff FFT data to improve both staff and patient experience.

The Chief Executive has continued to spend time in clinical and non-clinical departments each month to take the opportunity to chat with staff and listen to their feedback. The Chairman meets regularly with the Staff Governors and the Board of Directors have a planned programme of visits across the trust to meet staff and recognise their efforts.

The Clinical Assurance Toolkit in use in clinical areas includes a Staff Survey (based on the engagement questions in the NHS Staff Survey) and some other departments e.g. Specialised Rehabilitation, Pharmacy and Human resources have undertaken their own Staff Surveys.

In addition an increasing number of directorates are now using the Microsystems Coaching Academy approach to involving staff in improving services.

Listening into Action (LIA)
In November the Trust launched 'Listening into Action' (LiA) which has been adopted by a number of Trusts. This will empower and involve staff in making improvements for patients. As a first step 'Big Conversations' took place with the Chief Executive during November and December 2014 and January and February 2015 and will help to identify 'what matters to staff'. At the same time TEG have identified 'the blueprint' which is the key performance areas that LiA has an opportunity to influence. The themes from the Big Conversations are:

- Being able to do our jobs to the best of our ability
- Feeling valued
- Being efficient
- Making it better for our patients
- Being better connected
- Be Proud
- Get the staffing right

A team has been appointed to lead this work and the first 15 schemes will be working on addressing the issues identified over the next few months with a 'Pass it on' sharing event planned for the summer.

Appraisal
We have continued to work on embedding the PROUD values into the Trust and these are incorporated into the recruitment process for all newly qualified staff nurses and Clinical support workers.

The PROUD values are:

- Patients First
  Ensure that the people we serve are at the heart of what we do
- Respectful
  Be kind respectful, fair and value diversity
- Ownership
  Celebrate our successes, learn continuously and ensure we improve
- Unity
  Work in partnership with others
- Deliver
  Be efficient, effective and accountable for our actions

The rollout of the PROUD performance and values based appraisal process has continued and this has evaluated positively in the staff survey with an increase in the number of staff who reported that they had a well-structured appraisal.

Leadership and Management Development

The Institute of Leadership and Management (ILM) Level 3 programme and the Effective Managers series continue to be provided. These are regularly reviewed and updated and continue to evaluate well. Due to the quality of assessment and internal verification offered by the Leadership Development team, we have now been awarded "ILM centre for Life" status. A new initiative was the post-Francis Senior Sister's development programme which launched in 2014.

The final senior leaders programme in its current format was run this year and work has commenced with Sheffield Hallam University in developing Senior Leaders Mark II.

A second cohort of coaches was trained during 2014 with the intention to train a third cohort in 2015. Two staff have been trained as coaching supervisors and supervision is now available to coaches within the Trust. The Leadership Development team will also be introducing "The Manager as coach" approach during 2015 which will further strengthen coaching capacity.

The team continues to make use of the INSIGHTS personality tool during programmes such as ILM, and increasingly with teams across the Trust, in order to enhance engagement and effectiveness. This is reflected in the improvements for both team working and staff engagement in the 2014 staff survey results.

The team will work with Human Resources and Occupational Health on "Mentally Healthy Workforce" sessions during 2015/16.

Health and Wellbeing

In September the Trust was delighted to welcome Dame Carole Black, an expert adviser to the Department of Health, who spoke to both Trust Executive Group (TEG) and senior managers on the importance of health and wellbeing and the strong links with the engagement agenda and productivity.

Following the successful pilot of a fast track musculoskeletal service for staff in the Jessop Wing by PhysioPlus this service was extended across the Trust from April 2014.

The Trust is looking to link this to the development of a fast track mental health pathway for staff absent due to stress, anxiety and depression. The intention is to develop a seamless service between Occupational Health, Physiotherapy and Mental Health practitioners to support staff who are absent and in time, be able to provide a preventative service. It is anticipated that this reduce sickness absence rates within the Trust and improve staff health and wellbeing overall.

Health and Wellbeing festivals, which provide staff with a range of information on how to improve their health and wellbeing, continue to be held across the Trust together with walking clubs and exercise classes. During 2015/16 proceeds from the Health and Wellbeing lottery will be used to fund further initiatives.

NHS Staff Survey

Staff engagement is measured every year via the annual NHS Staff Survey which includes an overall score for staff engagement. It was pleasing to note that the overall Trust staff engagement score 3.81 as reported in the benchmarked NHS Staff Survey, increased significantly which means that the Trust is above average for staff engagement in

comparison to other acute trusts. It is very pleasing to note that STH is in the top 20 % of acute trusts in the country for the number of staff who would recommend the trust to their friends or family either for treatment or as a place to work. There are improvements in a range of indicators in the 2014 staff survey with STH now in the top 20% for 13 of the 29 key findings.

Response rate

	2013/14		2014/15		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Response Rate	55%	49%	42%	42%	13% deterioration

The reduction in the response rate is thought to be partly due to 'survey fatigue' due to the introduction of Staff Friends and Family testing and many parts of the trust undertaking the survey on line for the first time.

Top four ranking scores:

Key Finding	2013/14		2014/15		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Staff working unpaid extra hours (%)	62	70	60	71	2% improvement
Staff witnessing potentially harmful errors, near misses or incidents in the last month (%)	33	33	26	34	7% improvement
Staff experiencing harassment/bullying/abuses from patients (%)	27	29	22	29	5% improvement
Staff experiencing physical violence from patients, relatives or the public in last 12 months (%)	18	14	9	14	9% improvement

Bottom five ranking scores:

Key Finding	2013/14		2014/15		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Staff able to contribute towards improvements at work (%)	65	68	63	68	2% deterioration
Staff agreeing their roles make a difference to patients (%)	87	91	88	91	1% improvement
Staff agreeing that they would feel secure raising concerns about unsafe clinical practice (%)	-	-	63	67	New question for 2014
Staff receiving health and safety training in the last 12 months (%)	70	76	70	77	No change

Most improved

Key Finding	STHFT 2013	STHFT 2014
Support from Immediate managers	3.59	3.81

* Possible scores range from 1 (poor) to 5 (good)

A Trust action plan has been drawn up to address the areas for improvement highlighted in the Staff Survey which is further supported by individual directorate staff engagement action plans which will be monitored by the Staff Engagement executive group.

The focus for 2015/16 will be to improve staff involvement through Staff Friends and Family Testing, Listening into Action and the Microsystems Academy. Action is already being taken to improve mandatory training compliance. The 'Raising Concerns' policy will be revised in light of the recent Francis 'Freedom to speak up' report, an independent review into creating an open and honest reporting culture in the NHS [ref in footnote]. A staff engagement score will once again be calculated for every directorate which will be monitored together with staff Friends and Family Test scores via the Care Group performance review process.

i) Annual Patient Surveys

The Trust continues to undertake a wide range of patient feedback initiatives regarding the services they receive. Survey work during 2014/15 included participation in the national survey programme for inpatients, accident and emergency departments and cancer services. Our extensive programme of local surveys has continued, with around 750 patients each month participating in the 'frequent feedback' survey programme in which the views of patients are gathered by trained volunteers. The Friends and Family Test has also been successfully rolled out across out-patient, day case and Community Services.

In the National In-Patient Survey 2014, our scores compare very well against other trusts nationally. Areas where our scores were high include questions relating to communications, information and explanations and having trust and confidence in doctors and nurses. Areas identified where improvements can be made include offering healthy food choices on the hospital menu and ensuring patients have the opportunity to give us their views on the quality of care they receive.

The fifth National Accident and Emergency Department Survey was carried out during 2014. Areas of high performance include patients feeling that they had enough time to discuss their problem with the doctor or nurse and patients' overall rating of their care and treatment in the department. Areas where improvements could be made include communications issues such as ensuring patients are informed of how long they may have to wait to be examined.

In the National Cancer Survey 2014, the Trust's scores were once again very good overall. High scoring questions include patients being offered a choice of different types of treatment and staff informing patients of who to contact if they were worried after their discharge. Areas where improvements can be made include ensuring that the patient's family are given all the information they need to help provide care at home, and ensuring staff ask patients what name they prefer to be called by.

Following any patient feedback, action plans are agreed at local and Trust level to address areas where improvements can be made. There are current programmes of work which aim to improve patient experience and Trust scores in both local and national surveys help us to monitor the impact of this work.

Friends and Family Test

The Friends and Family Test (FFT) is still being used in inpatients, A&E and maternity services. In October 2014 we rolled out FFT into outpatient and day cases and in January 2015 to Community Services, achieving the CQUIN target for early implementation ahead of the national deadline of April 2015.

The test asks a simple, standardised question with response options on a six point scale, ranging from 'extremely likely' to 'extremely unlikely'. This Trust has also chosen to ask a follow-up question in order to understand why patients select a particular response.

We use a variety of methods to collect the data within the Trust. In November 2014 the use of SMS text messaging was trialed on five wards. This had a positive effect on the response rate, most noticeably on Theatre Assessment Unit and Surgical Assessment Centre. In April 2015 we will be looking at the possibility of using this method on other wards.

The Trust's scores and response rates are outlined in Part 3.

j) Complaints

Improving the experience and learning from complaints
The Trust values complaints as an important source of patient feedback. We provide a range of ways in which patients and families can raise concerns or make complaints. All concerns whether they are presented in person, in writing, over the telephone or by email are assessed and acknowledged within two days and where possible, we aim to take a proactive approach to solving problems as they arise.

During 2014/15 we received 1338 concerns and enquiries which we were able to respond to within two working days. If telephone calls, emails or face to face enquiries are received by the Patient Services Team (PST) which staff feel can be dealt with quickly by taking direct action or by putting the enquirer in touch with an appropriate member of staff such as a Matron or Service Manager, contacts are made and the enquiry is recorded on the complaints database as a PST contact. If the concern or issue is not dealt with within two days, or if the enquirer remains concerned, the issue is re categorised as a complaint and processed accordingly.

1353 complaints requiring more detailed and in depth investigation were received. Table 3 provides a monthly breakdown of complaints and concerns received.

Table 3

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Total
New formal complaints received	131	122	107	122	109	111	147	96	103	88	107	110	1353
New informal concerns received	81	98	123	112	110	106	122	110	94	111	116	155	1338
All concerns combined	212	220	230	234	219	217	269	206	197	199	223	265	2691

The Trust works to a target of responding to 85% complaints within 25 working days. The performance this year was 76% falling short of the target for the second consecutive year. The high number and complexity of complaints received in two specific Care Groups,

Emergency Care and Surgical Services has resulted in them underperforming against the target throughout the year. As complaints in these two Care Groups account for 43% of the total number of complaints received, this has a significant impact on the overall Trust performance. Chart 1 shows a monthly breakdown of performance against the Trust target per month.

Chart 1 – page XX – Trust Complaint response times

Chart 2 – page XX - Sub-subjects raised in complaints over the past 12 months compared to the previous 12 month period

Regular complaints and feedback reports are produced for the Board of Directors, Patient Experience Committee, Care Groups and Directorates showing the number of complaints received in each area and illustrating the issues raised by complainants. In 2014 the reporting structure for patient experience information was reviewed. A new monthly report has been introduced which focuses on key performance indicators for complaints handling and other feedback, with a more detailed quarterly report also being introduced. The reporting process ensures that at all levels, the Trust is continually reviewing information so that any potentially serious issues, themes or areas where there is a notable increase in the numbers of complaints received can be thoroughly investigated and reviewed by senior staff. Chart 2 shows the breakdown of complaints by theme. The findings show the top five themes are the same as those identified last year. Staff attitude continues to be the most commonly raised subject in complaints, however the number of complaints received about staff attitude has reduced when compared to 2013/14.

We remain committed to learning from, and taking action as a result of, complaint investigations. A formal process is in place which monitors and follows up actions agreed to ensure that any changes have been made and have been implemented as planned. This process is supported by Trust Governors who visit wards and departments to 'spot check' progress against action plans.

The Patient Partnership Department commenced a comprehensive review of the complaints management process in 2014 to identify a process which is responsive to the needs of patients and families using the complaints service. The review took into consideration recommendations from recent national reviews published over the last few years including the Francis Inquiry, the Clwyd Hart Review, and Keogh [references to added in footnote]. The new process is due to be piloted in Surgical Services during early 2015, with a view to this being rolled out across the Trust.

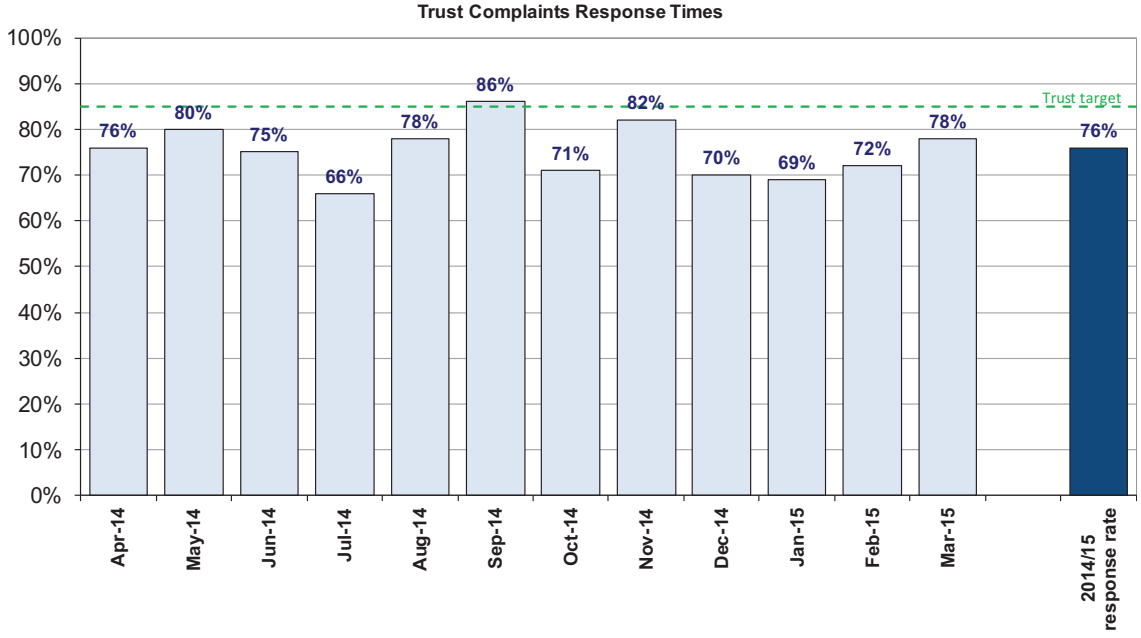
A new approach to auditing the quality of the complaints service against the standards we have set and patients' expectations was introduced in 2014. The Trust interviewed patients and families to understand their experience of the complaints process, and carried out a review of the complaint file in order to ensure it complies with the standards we have set. The findings from this audit have contributed to changes being made to the complaints process. This audit is due to be repeated in 2015.

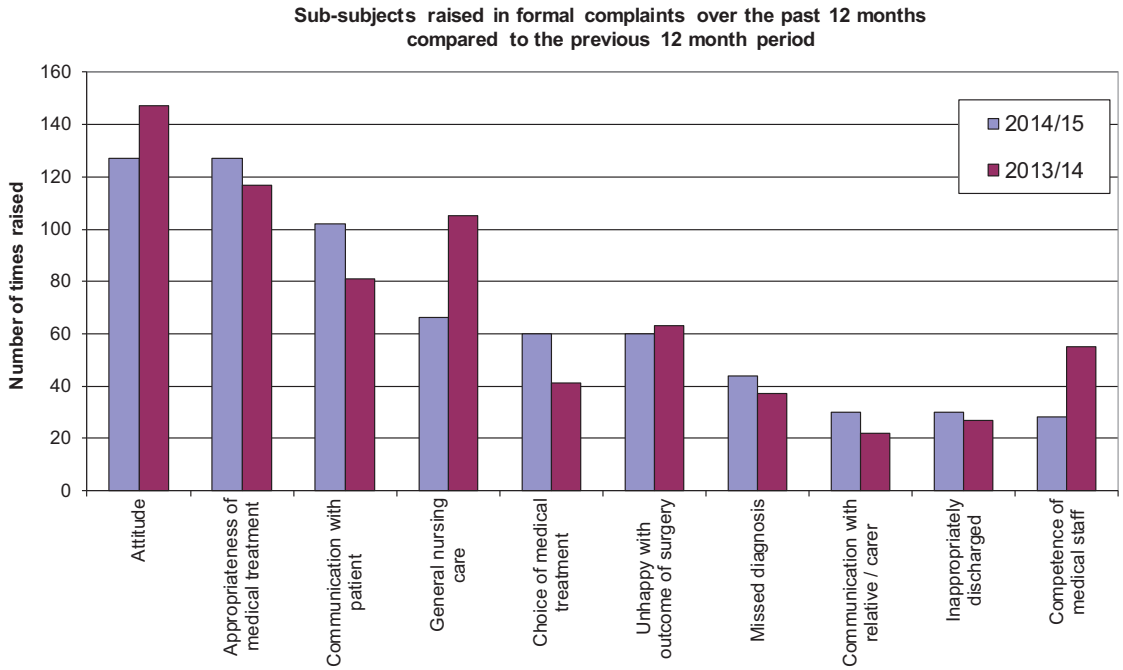
The Trust has taken part in the Patients Associations National Complainant Satisfaction Survey since 01 April 2014. The survey aims to provide an understanding of the experience of people making a complaint about the Trust. Results are benchmarked against other Trusts participating in the survey.

Key Priorities for 2015/16

A programme of training for senior nursing and medical staff is to be introduced in 2015 to support the new complaints process and ensure a consistent approach when investigating

and responding to complaints. Staff leading complaints investigations will receive training to ensure complaint investigations are carried out thoroughly with findings communicated to patients and families in a clear, comprehensive way.





k) Mixed Sex Accommodation

The Trust remains committed to ensuring that men and women do not share sleeping accommodation except when it is in the patient's overall clinical best interest or reflects their personal choice.

Unfortunately, on one occasion during this year, there were two patients who were placed in a mixed sex bay which cares for higher dependency patients and is normally exempt from the mixed sex arrangements. On this occasion, two patients who did not require high dependency care were placed in the bay. This was recognised and both patients were moved on the same day.

The reasons for these breaches have been explored and the arrangements within the Single Sex Accommodation Policy have been recirculated to the relevant staff.

l) Coroners Regulation 28 Reports

To be added

Part 3
REVIEW OF SERVICES IN 2014/2015

3.1 Quality Performance Information 2014/2015

These are the Trust priorities which are encompassed in the mandated indicators that the organisation is required to report and have been agreed by the Board of Directors.

The indicators include
- 6 that are linked to patient safety;
- 11 that are linked to clinical effectiveness; and
- 13 that are linked to patient experience.

(i) Mandated Indicators – Department of Health (Gateway reference 18690 and 00931)

Prescribed Information	2012/13	2013/14	2014/15
1. Mortality (a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period. **National average: 1.0** **Highest performing Trust score: 0.54** **Lowest performing Trust score: 1.20**	0.88 Banding: "lower than expected"	0.91 Banding: "as expected"	0.90 (July 13-June 14) Banding: "as expected"
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. **National average: 24.6%** **Highest Trust score: 49%** **Lowest Trust score: 7.4%** The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data are extracted from the Information Centre SHMI data set. The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this rate, and so the quality of its services, by: • Ensuring consistent Mortality and Morbidity reviews are undertaken across the Trust. • Monitoring the mortality data at a diagnosis level to ensure any areas for improvement are constantly reviewed and where appropriate ensure actions are taken to address. *The SHMI reported in last year's Quality Report	18.4%	20.3%	**21.5%**

was qualified by the annotation that this was derived from the most recent rolling 12 month period i.e. Oct 2012 - Sept 2013. SHMI results are published six months and three weeks in arrears because of the need to validate the data nationally. The value for April 2013 – March 2014 was released at the end of October 2014 and reported as 0.91. This can be validated via the NHS Choices website.			
Prescribed Information	**2012/13**	**2013/14***	**2014/15**
2. Patient Report Outcome Measures (PROMs) The Trust's patient reported outcome measures scores for:			April - June
(i) Groin hernia surgery			
Sheffield Teaching Hospitals' score: **National average:** **Highest score:** **Lowest score:**	0.108 0.084 0.157 0.015	0.075 0.085 0.142 0.008	0.022 0.082 TBC TBC
(ii) Varicose vein surgery			
Sheffield Teaching Hospitals' score: **National average:** **Highest score:** **Lowest score:**	0.076 0.093 0.138 0.023	0.102 0.093 0.149 0.023	0.117 0.102 TBC TBC
(iii) Hip replacement surgery primary			
Sheffield Teaching Hospitals' score: **National average:** **Highest score:** **Lowest score:**	0.406 0.437 0.543 0.319	0.401 0.436 0.570 0.332	TBC 0.498 TBC TBC
(iv) Hip replacement surgery revision			
Sheffield Teaching Hospitals' score: **National average:** **Highest score:** **Lowest score:**	0.236 0.272 0.35 0.164	0.153 0.254 0.362 0.153	TBC 0.747 TBC TBC
(v) Knee replacement surgery primary			
Sheffield Teaching Hospitals' score: **National average:** **Highest score:** **Lowest score:**	0.308 0.318 0.409 0.231	0.324 0.323 0.414 0.209	TBC 0.322 TBC TBC
(vi) Knee replacement surgery revision			
Sheffield Teaching Hospitals' score: **National average:** **Highest score:** **Lowest score:**	0.211 0.251 0.369 0.194	0.211 0.251 0.369 0.123	TBC 0.261 TBC TBC
PROMs scores represent the average adjusted health gain for each procedure. Scores are based on the responses patients give to specific questions on mobility, usual activities, self care, pain and anxiety after their operation as compared to the scores they gave pre-operatively. A higher score suggests that the procedure has improved the patient's quality of life more than a lower score. * This data may be different to the data reported in			

the 13/14 Quality Report, as the data is now complete for the financial year 2013/14. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from national Information Centre PROMs data set. The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by: • Continuing to analyse the EQ-5D and OHS data for hips. • Triangulating the EQ5D and OHS data with further data on patient experience, safety and outcomes and incorporating into quality improvements. • Process mapping the hip replacement pathway and undertaking improvement work as necessary.			

Prescribed Information	2012/13	2013/14	2014/15
3. Readmissions The percentage of patients aged: 1. 0 to 15; and 2. 16 or over, Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period. **Comparative data is not available** The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the Trust's Patient Administration System. The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by reviewing the reasons for readmissions and working with our partners in the wider Health and Social Care community to prevent avoidable readmissions. This will be delivered through the Right First Time city wide health and social care partnership. During 14/15 we undertook a specific project to examine the reasons for readmission in Urology. It is anticipated that this will be rolled out to a further specialty during 15/16..	0% 11.36%	0% 10.8%	0% 10.8&
4. Responsiveness to personal needs of patients The Trust's responsiveness to the personal needs of its patients during the reporting period. **National average: 71.9%** The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by national CQC survey contractor. *2014/15 National Survey scores represent three questions from the National Inpatient Survey selected as a measure of responsiveness to patient needs. This is compared to four questions for the 2013/14 score and five for the 2013/14 score.	68.6%	79.3%	75.1%*

The Sheffield Teaching Hospitals NHS Foundation Trust has agreed that help to go to the toilet, controlling pain, help with nutrition, and being treated with dignity are the areas on which the Trust's Patient Experience should be measured through an ongoing programme of patient interviews (approximately 800 each month).			
5. Friends and Family Test- Staff who would recommend the Trust The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. **National average: 64** **Highest performing Trust score: 89 (Acute Trusts)** **Lowest performing Trust score: 38** The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by national CQC survey contractor. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and so the quality of its services, by continually involving staff and seeking their views in how to make improvement in the quality of patient services for example through Listening into Action and Microsystems Academy.	70%	72%	78%
6. Friends and Family Test- Patients who would recommend the Trust The percentage of patients who attended the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. *The score for 2013/14 represents a scale of -100 to +100 is, using the Net Promoter Score calculation. From October 2014 NHS England stopped using the Net Promoter scoring system and moved to a percentage system.	New indicator	71*	XX

FFT scores are now recorded taking the percentage of respondents who 'would recommend' our service which is taken from ratings 1 (Extremely Likely) and 2 (Likely). The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is collected by the Picker Institute Europe, verified by UNIFY and reported by NHS England. For the electronic submissions data is collected by Healthcare Communications. The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by continuing to use FFT scores to trigger action planning around low scoring wards. This year thorough analysis of comments has led to planned work around noise at night and the temperature onwards. The Trust is planning to improve the way we use and promote patient comments, not only to inform action plans, but to report patient feedback more effectively to staff. There is further work planned to improve awareness of FFT both to increase staff and patient engagement with the survey, and to help staff use feedback as part of their routine reporting.			
Prescribed Information	**2012/13**	**2013/14**	**2014/15**
7. Patients risk assess for Venous Thromboembolism (VTE) The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. **Comparative data is not available** The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as we have processes in place to collect the data internally which is regularly monitored. We then report the data externally to the Department of Health. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and so the quality of its services, by ensuring	93.33%	95.16%	95.18%

completion of VTE risk assessment form for every patient admitted to the Trust, feedback to Directorates on performance and carrying out analysis of cases of VTE which are thought to be hospital associated. Since April 2014, the requirement to collect and submit VTE data has been an NHS Contract requirement, and is no longer a CQUIN indicator.			
Prescribed Information	**2012/13**	**2013/14**	**2014/15**
8. Rate of Clostridium Difficile The rate per 1000,000 bed days of cases of *C.difficile* infection reported within the Trust amongst patients aged two or over during the reporting period. **Comparative data is not available** *The rate shown is provisional until the Public Health England denominator rates are published. The denominator used is the 2013/14 figure as this is unlikely to change significantly. During 2014/15 there have been ** cases of *C.difficile* infection reported within the Trust. The national threshold for 2014/15 was 94. All Trust attributable cases now have a root cause analysis to identify if there has been any lapse in care. At publication ** cases have been highlighted as having a lapse in care. Quarter 3 and Quarter 4 cases are still being reviewed. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by the Public Health England. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this rate, and so the quality of its services, by having a dedicated plan as part of its Infection Prevention and Control Programme to continue to reduce the rate *of C.difficile* experienced by patients admitted to the Trust.	17.8	13.7	XX*

9. Rate of patient safety incidents The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	9951	9762*	10738***
Number of Incidents reported The incident reporting rate is calculated from the number of reported incidents per hundred admissions and the comparative data used is from the first XX months of 2014/15. Full information for the financial year is not available from the National Reporting and Learning System until mid 2015. **Cluster** average: XX** **Highest performing Trust score: XX** **Lowest performing Trust score: XX**	5.1	4.75*	XX
and the number and percentage of such patient safety incidents that resulted in severe harm or death. **Cluster** reporting data: XX** **Highest reporting Trust: XX** **Lowest reporting Trust: XX**	51 (0.5%)	59* (0.6)	70*** (0.6%) ***
* The figures for 2013/14 are different to those documented in last year's Quality Report as they have now been validated. **Comparative data is sourced from the National Reporting Learning System, data is split into cluster/peer groups with Sheffield Teaching Hospitals being part of the 'Acute Teaching Hospitals' cluster. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the National Reporting and Learning System (NRLS). The Sheffield Teaching Hospitals NHS Foundation Trust intends to increase the incident reporting rate by continuing to embed the web based reporting tool throughout the Trust. This will increase			

access to the reporting system, encourage increased incident reporting and speed up the Incident Management process. **To note:** As this indicator is expressed as a ratio, the denominator (all incidents reported) implies an assurance over the reporting of all incidents, whatever the level of severity. There is also clinical judgement required in grading incidents as 'severe harm' which is moderated at both a Trust and national level. This clinical judgement means that there is an inherent uncertainty in the presentation of the indicator which cannot at this stage be audited.			

ii) Mandated Indicators – Monitor Risk Assessment Framework (Table 2: Targets and indicators for 2014/15)

Measures of Quality Performance	2012/13	2013/14	2014/15
10. Percentage of patients who wait less than 31 days from decision to treat to receiving their treatment for cancer-			Q1, Q2 and Q3
Sheffield Teaching Hospitals NHS Foundation Trust achievement	98%	98%	97%
National Standard	96%	96%	96%
Data Source: Exeter National Cancer Waiting Times Database			
11. Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	89%	88%	85%
National Standard	85%	85%	85%
Data Source: Exeter National Cancer Waiting Times Database			
12. Percentage of patients who have waited less than 2 weeks from GP referral to their first outpatient appointment for urgent suspected cancer diagnosis			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	95%	94%	94%
National Standard	93%	93%	93%
Data Source: Exeter National Cancer Waiting Times Database			

13. All cancers: 31-day wait for second or subsequent treatment, comprising:			
Surgery:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	97%	97%	96%
National Standard	94%	94%	94%
Anti-cancer drug treatments:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	100%	99%	100%
National Standard	98%	98%	98%
Radiotherapy:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	99%	99%	98%
National Standard	94%	94%	94%
Data Source: Exeter National Cancer Waiting Times Database			
14. Accident and Emergency maximum waiting time of 4 hours from arrival to admission/transfer/discharge			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	93.2%	95.7%	92.7%
National Standard	95%	95%	95%
Data Source: Exeter National Cancer Waiting Times Database			
15. MRSA blood stream infections			
Trust attributable cases in Sheffield Teaching Hospitals NHS Foundation Trust	3	4	2
Trust assigned cases in Sheffield Teaching Hospital NHS Foundation Trust	New for 2014/15	New for 2014/15	4
Sheffield Teaching Hospitals NHS Foundation Trust threshold	1	0	0
The Trust assigned was introduced for the 2014/15 year and is the figure used to determine cases for which the Trust is held responsible and where fines may be attached.			
Data Source: Exeter National Cancer Waiting Times Database			
16. Patients who require admission who waited less than 18 weeks from referral to hospital treatment-			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	90.6%	90.4%	86.4% (to Feb)
National Standard	90%	90%	90%

17. Patients who do not need to be admitted to hospital who wait less than 18 weeks for GP referral to hospital treatment			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	96.6%	94.9%	94.6% (to Feb)
National Standard	90%	95%	95%
18. Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	93.2%	92.5%	92.7% (to Feb)
National Standard	92%	92%	92%
19. Data Completeness for Community Services			
Referral to treatment information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	60%	66%	66%
National Standard	50%	50%	50%
Referral information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	100%	100%	100%
National Standard	50%	50%	50%
Treatment activity information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	100%	100%	100%
National Standard	50%	50%	50%

iii) Additional Indicators

Measures of Quality Performance	2012/13	2013/14	2014/15
20. Never Events			
Sheffield Teaching Hospitals NHS Foundation Trust Performance	7	4	3
Data Source: National Patient Safety Agency			
At the time the previous Quality report was being produced a review of 'Never Events' within Operating Theatres was taking place. This report has since been received and published on the STH internet site.			
The Trust is actively promoting incident reporting to further enhance the safety culture of the Trust. This will ensure incidents can be investigated, trends analysed and lessons can be learnt across the Trust.			

21. Hospital Standardised Mortality Ratio (HSMR) Sheffield Teaching Hospitals NHS Foundation Trust Performance	96%	100%*	99% (Jan 14- Dec 14)
National Benchmark	100%	100%	100%
*This figure is different from last year as it represents the whole year (April 2013- March 2014) rather than April 2013- January 2014 as reported in last year's Quality Report.			
Data Source: Dr Foster			

Part 4
Response to partner organisation comments 2013/14

NHS Sheffield Clinical Commissioning Group 2013/14

The trust has unfortunately experienced challenges during 2013-14 with regard to delivery of the 'admitted' 18 weeks waiting time standards. The CCG welcomes the high priority being given to this key area of service delivery into 2014-15.	We have continued to experience problems throughout 2014/15 in achieving the 18 weeks waiting time standard, particularly for admitted patients. During 2014/15 86.4% of patients who required admission waited less than 18 weeks from referral to hospital treatment. This is compared to the national standard of 90%. The specialities where there are continuing challenges are Cardiology, Cardiac Surgery and Orthopaedics. We have been working with the Clinical Commissioning Group and NHS England throughout 2014/15 on this.

Healthwatch Sheffield (2013/14)

We have asked for an "**easier to read**" version of the long and detailed account a number of times and this year we are promised that one will be delivered simultaneous to the publication of this formal Quality Account / Quality Report. The "easier to read" document, as identified in the Department of Health guidance, is intended to be more suited to a general public audience, and be available on request. It should report at least, in an easily read format, what the Trust said it would do, what it did, and the results of those actions!	After working with Healthwatch and Patient Governors a summary 'easier to read' version of the Quality Report 2013/14 was drafted. This was then modified for publication within the Autumn issue of Good Health News. We all acknowledge that further work is required to improve the process of the production of an easier to read version. Taking this forward for 2015/16 a Healthwatch representative is now a member of the Quality Report Steering Group. This is enabling Healthwatch to be included throughout the process of the Quality Report.
We notice that customer satisfaction as indicated by Complaints is not showing appreciable improvement. The total number of complaints has increased, in particular the top five reasons for complaint, and this is a concern. We understand why the target (Trust determined?) of *85% of complaints being dealt with within 25 days* was missed, but look for improvement on this poor record next year. We see customer satisfaction as being important to the public of Sheffield.	During 2014/15 76% of complaints were dealt with within the Trust target of 25 days. It is believed that some of our complaints cannot be resolved in 25 days due to their complex nature. A new complaints process will be piloted in Surgical Services in 2015. The new process sees the introduction of a tiered timescale for responding to complaints. This approach aims to ensure complaints are responded to in a timescale proportionate to the complexity and number of concerns raised.

	Following a recent audit it was found that the complainants value being kept updated with their complaint, this is something we are addressing with the 2015/16 priority around complaints training. A representative from Healthwatch Sheffield is a member of the Patient Experience Committee which has an oversight of the complaint work undertaken within the Trust. Please see Part 2 for more information on this.
It is noted that "Community Services" are now substantially within the remit of the Trust but the reporting does not always make this clear. There is a need to raise public awareness about the linkages and for there to be clearer reporting of those linkages made in future Quality Accounts.	All appropriate Quality and Safety measures are reported by the Trust within the Quality Report ensuring a comprehensive overview of the services we deliver is provided. Community services data is included within this.
We can find no mention of what has happened to the recently re-commissioned Care Home Support Team who support the care of those with Dementia and end-of-life care in the Home. We raised this in last year's comments.	The Care Home Support Team will not be re-commissioned from the 1st April 2015.
We would like to have seen greater emphasis on **Giving patients a voice.** Although this was one of last year's priorities, we feel it ought to be on-going and form an important element of feedback in the Quality Account.	Each year the results from the Trust patient surveys are reported within the Quality Report. Since the introduction of the Friends and Family Test we have reported the results within the Quality Report. Please see section 2.2.3 in Part 2 of this report for an update on the giving patients a voice objective.
Improving discharge is of national importance and we would like to see how the Trust has improved the experience and outcomes in next year's Account.	During 2014/15 890 patient information leaflets have been checked and revised, bringing the total to 88% (1518/1722) of patient information leaflets having been checked and revised since May 2013. Discharge information is now routinely checked in all leaflets before publication. Please see section … in Part 2 for more information on this.
The mandatory part of the document (the Quality Report) contains required comparative data; this is very helpful to readers and ought to be repeated throughout the document, as well as, in an appropriate form, in the *easier to read* document.	
Priority One: It is important that patients know who is treating and supporting them in	At the entrance of all wards there are boards clearly explaining the uniforms of the

hospital at all times, so we approve of this priority. Arranging for patients' names and those of the consultant / lead nursing staff, consistently throughout the hospital is a step towards improvement, but other measures such as suitable, clear and legible name badges, with title, might help.	different staff groups. All staff are required to wear Trust Identification Badges. The Trust has introduced the use of blue badges which clearly state the name and job title of the staff member; these are currently being rolled out.
Priority Two: Producing benchmark information is important to indicate improvement or otherwise over time, but the aim should be about dealing with the complaints faster and more appropriately, and making serious attempts to minimise complaints overall. We would be grateful to see the interim report when it is produced in October 2014.	Changes to the complaints process have been proposed following completing this objective. Changes include a new process to 'fast track' issues which we are able to resolve quickly. The new process sees the introduction of a tiered timescale for responding to complaints. This approach aims to ensure complaints are responded to in a timescale proportionate to the complexity and number of concerns raised.
Priority Four: We were not quite sure of the importance of this priority given that the Trust has achieved the national standard; nevertheless increased waiting times are important to patients and their carers; it could be argued that lengthy waiting times increase stress levels and may even exacerbate existing conditions, thus negatively affecting the Patient Experience. What is important is to reduce **all** waiting times to less than the agreed national standard which currently stands at 18 weeks.	We appreciate that minimising waiting times is important. Our aim with this priority was to look in detail at the experience of patients whilst waiting as this can be stressful for the patient and their carers and may significantly impact on the overall patient experience. Please see section 2.4.4in Part 2 for more information on this.

Healthier Communities and Adult Social Care Scrutiny and policy Development Committee comments:

The Committee also welcomes the planned publication of an "easier to read" version of the document and thanks Healthwatch Sheffield for their involvement in this.	
With regards to priority principle 3 "to review mortality rates at the weekend" there remains a level of concern amongst the general public regarding differences in mortality rates at weekends. The Committee is therefore pleased to see that the Trust is planning further analysis around this national target and welcomes any action that will be taken to restore public confidence or address any identified differences. In addition the Committee would like to request that this analysis also includes mortality rates at Bank Holidays.	After feedback from the Committee the review of Bank Holidays was included in the finale objective. Please see section …. in Part 2 for more information on this.

Governor Involvement in the Quality Report Steering Group

As before, we feel that it is essential to continue to work on those priorities from previous years that have not been achieved and we understand that this carries the risk that the amount of work may increase each year, since priorities may take longer than a year to achieve.	The report includes information on three years of objectives. The monitoring of previous objectives are built into ongoing regular monitoring within the Trust therefore are not included in the report.
We appreciate the enormous amount of work that goes into the writing of this report and also that the largely prescribed text makes the report more difficult for non-hospital related readers to understand. Last year's summary version was a worthwhile attempt, but there is room for improvement and we look forward to the contribution from Healthwatch members this time round.	

4.2 Statement from our partners on the Quality Report 2014/15

Statement from NHS Sheffield Clinical Commissioning Group

Healthwatch Sheffield 2014/15

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee comments:

Governor involvement in the Quality Report Steering Group

4.3 Statement of Directors' responsibility Statement of directors' responsibilities in respect of the Quality Report

4.4 Independent Auditors' Report to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust on

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee

15th April 2015

Report of: Sheffield Children's Hospital NHS Foundation Trust

Subject: Quality Account

Author of Report: John Reid, Director of Nursing and Clinical Operations

The Scrutiny Committee is being asked to:

Consider and comment of the annual quality report.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	**x**
Performance / budget monitoring report	**x**
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	

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Sheffield Children's NHS
NHS Foundation Trust

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DRAFT 1 REPORT TO THE TRUST BOARD OF DIRECTORS MEETING HELD ON 28 April 2015

Quality Report (Incorporating Quality Accounts) 2015

Trust objectives supported by this paper

- The paper supports the achievement of all Trust Objectives

Purpose of the paper

To summarise the performance of Trust in 2014-15 in relation to quality of care. To set the quality priorities for 2015-16 in consultation with our families, governors and agency partners.

The draft paper was consulted upon with all of our key stakeholders, as set out in the February Board schedule paper. The report will form the quality section of the Trust Annual Report to Monitor and a stand alone document on the NHS Choices Website.

Summary of key points

- The Trust has processes to provide assurance of safe quality standards
- There is a framework that supports identification of risk and poor patient experience and involves the Board and Governors in monitoring of action plans.
- Lapses in performance are known to the Board and investment of resources is appropriately targeted to resolve these.
- KPMG will provide an external audit opinion on the content and the assurance processes of the report.

Board Action required

Approval of the Quality Report

Author:	J Reid	**FOR APPROVAL**
Executive Sponsor:	J Reid	

SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST
QUALITY REPORT

1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST

1.1 Introducing the Trust

Sheffield Children's NHS Foundation Trust is one of only four dedicated children's NHS Trusts in the country. In many senses we are unique in having responsibility for most areas of local child health other than GP services and maternity. Our services encompass:

- **Primary Child Health Care** – e.g. Health Visitors and School Nurses
- **Secondary Health Care** – e.g. Sheffield Children's Hospital, community paediatrics, community children's nursing and therapists.
- **Tertiary Child Care** – e.g. Neurosurgery, Cancer Care, Critical Care
- **Child and Young Peoples Mental Health** – Community, day-patient and in-patient.

Our health visitors and school nurses work with the local authority and GPs to ensure that children are kept healthy. Our community paediatricians, nurses and therapists work with families to minimise hospital stays. In addition, we expect to see over 120, 000 outpatients; admit 20,000 planned cases and respond to 14,000 urgent admissions. Our Emergency Department reviews up to 200 children per day.

1.2 Chief Executive's Statement on Quality

Our Trust values of commitment to excellence, teamwork, accountability, compassion and integrity are at the core of all we do. By specialising in children's health we believe that we have a focus on each child and their family. Our goal is to keep children healthy, safe and able to achieve their potential.

The Trust has made real progress this year; we were judged GOOD by the Care Quality Commission and are in the midst of an extensive and exciting hospital redevelopment. We have completely replaced our patient administration software and despite initial problems are now seeing more children than ever.

There is no hiding the pressures that our services and the NHS are under. Our finances and performance have required some reordering of priorities but we remain focussed on achieving a reasonable balance that does not compromise patient safety.

The coming year will have new challenges but our staff are the biggest asset that we have. We will be working with them to develop services such as Child and Adolescent Mental Health, Neurosciences, Genetics and urgent care alternatives to A&E.

The Quality Report set out below is accurate, to the best of my knowledge, and is a balanced and accurate reflection of the quality assurance processes, structures and outcomes in use at Sheffield Children's NHS FT.

I hope you will find the report informative and that it will encourage you to work with us to improve children's health.

Mr Simon Morritt
Chief Executive

2 PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 Quality Improvement Priorities 2015-16

2.1.1 OUTPATIENT SERVICES

Our reasons:

For the vast majority of our families, clinic experience is the first and often the most frequent way that our services are experienced. If we get the appointments wrong, have delays in clinic or do not communicate properly then this can become a source of dissatisfaction and even complaint.

The administration, way-finding, environment and leaflets all combine to make or frustrate a successful clinical consultation.

The Trust will:

- Open a new outpatient department that is situated at the front of the hospital
- Open adjacent parking with lift access to clinics for disabled children.
- Improve our administration using self service check in, send telephone reminders, and reduce the number of occasions when children do not attend.
- Reduce the number of cancelled clinics
- Review the leaflets to allow parents to download onto mobile phones

2.1.2 SURGICAL PATHWAYS

Our reasons:

We are doing increasing numbers of surgical operations on children. Children often are able to benefit from day surgery which reduces the time in hospital, reduces the disruption to normal family life and frees up resources for children with longer term care needs.

Many of the reasons for surgical cancellations, such as infection, can be screened out in a pre admission clinic or telephone consultation with a nurse. Problems can be anticipated and information given that prepares the family for the visit.

The resulting pre admission pack can alleviate anxiety, reduce delays on the day, reduce the need for parents to give the same information to different staff and enhance safe surgery by early identification of risks such as allergies.

The Trust will:

- Set up a comprehensive pre admission service for children requiring planned surgery or investigations under anaesthetic
- Use telephone clinics wherever possible to improve convenience for families
- Investigate the potential for secure online submission of information as an option for families.
- Review our information leaflets associated with surgery and make these available online.

2.1.3 CHILD AND ADOLESCENT MENTAL HEALTH

Our reasons:

Mental health care for young people is a key priority for the NHS. The Trust has a unique opportunity to work with commissioners and the local authority in shaping care with integrated provision that extends from crisis management , including A&E and acute medical care to community mental health intervention and day or inpatient care.

The Trust will:

- We will develop services for 16-17 yr old young people in conjunction with Sheffield CCG
- We will prepare a tender for In Patient, Day Patient and Intensive home intervention support based at Becton in line with NHSE requirements
- We will use the Improved Access to Psychological Services (IAPT) training to widen the availability of our services and expand the means by which teachers, families and others can obtain advice on mental well being.

2.1.4 HOW PERFORMANCE WILL BE MONITORED

Progress on the above indicators will be monitored by reports to the Clinical Governance Committee and regular reports to the Trust Board. The Board will share its reports with the Council of Governors and its commissioners in NHS Sheffield and NHS England. All Board reports will be published on the Trust website.

2.1.5 PERFORMANCE ON QUALITY PRIORITIES 2014-15

The Trust set itself the following three areas of quality improvement for last year:

What we said.	**What we did.**
Implement ongoing recommendations from the NHS Response to the Mid Staffordshire Public Enquiry, 'Patients First and Foremost	Pilot a children's nursing dependency assessment. The trust has used the paediatric acute nursing dependency assessment tool since October. This estimates the dependency of the children twice daily and estimates the numbers of nurses required to safely nurse these children. The tool is the basis of setting and reviewing the nursing establishment six monthly. The recruitment to that establishment is then monitored monthly and published on our website.
	The required number of nurses and the actual number of nurses on duty has been on display at every nursing department entrance since may 2014.
	Extend our family surveys to our new-born high dependency ward and benchmark ourselves against other units. This extends our surveys to families we have not previously reached.. These surveys have been carried out, published and action plans are being developed or carried out.
	Ensure that changes to family demand for evening and weekend access are responded to. There will be a supernumerary overnight senior nurse to allow doctors to devote more time to treat each patient. The supernumerary hospital out of hours team has been operating since October 2014.
REORGANISE OUR CHILD	Demonstrate that the services are in accordance with the

What we said.	What we did.
AND ADOLESCENT PSYCHIATRY SERVICE TO ENSURE THAT IT HAS ADAPTED TO FIT WITH THE TYPE OF REFERRALS WE ARE RECEIVING.	standards of the royal college of psychiatrists, quality network for inpatient CAMHS (QNIC). All nursing establishments have been assessed against the standard. Establishments have been set and fully recruited to.
	Work with commissioners and the safeguarding board to ensure that local 16-18 yr old patients are accommodated, where needed, within the Becton young peoples unit or with our community teams. The commissioned pilot commenced in January 2015. First evaluation will be reported to Sheffield CCG in may 2015.
	Demonstrate that when young people are treated under the provisions of the mental health act, they and their families have full access to information, advice and representation. The audit carried out in January 2015 showed compliance with the improvements required by the CQC visit to Becton in 2014. Patient satisfaction surveys in CAMHS for 2014 reported
MINIMISE DISRUPTION TO OUR SERVICES FROM THE BUILDING OF THE NEW HOSPITAL WING	Improve access by aiming to have most of the parking improvements in place by the end of 2015. This includes the multi-storey parking opposite the main entrance and the underground parking with direct lift access for disabled families. Building program on schedule. Temporary main entrance in place.
	Transfer significant numbers of outpatient clinics to the northern general for the duration of the work. Clinic extension and redevelopment completed October 2014. Clinics transferred.
	Set up a remote supplies depot to ensure that all supplies, pharmacy and laboratory deliveries are consolidated into as few goods vehicles as possible and not competing with families for access. Deliveries consolidated and rescheduled for outside normal working hours.
	Public consultation of redesigned signage and artwork held in SCH main entrance during February and March 2015.

2.2 Statements of Assurance from the Board

2.2.1 GENERAL ASSURANCE

During 2014 -15 Sheffield Children's NHS FT provided and/or sub-contracted 102[1] relevant health services.

Sheffield Children's NHS FT has reviewed all the data available to them on the quality of care in 100% of these relevant health services.

[1] Based upon the services specified in the NHS Provider Contract for 2014-15.

The income generated by the relevant health services reviewed in 2014-15 represents 100% of the total income generated from the provision of relevant health services by Sheffield Children's NHS FT for 2014-15.

2.2.2 AUDIT AND NATIONAL CONFIDENTIAL ENQUIRY ASSURANCE

During 2014-15, 15 national clinical audits and 3 national confidential enquiries covered NHS services that Sheffield Children's NHS FT provides.

During that period Sheffield Children's NHS FT participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sheffield Children's NHS FT participated in, and for which the data collection was completed during 2014-15 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits and National Confidential Enquires for which the Trust was Eligible to Participate	**% of eligible cases submitted**
RCP (UK IBD Audit) Inflammatory Bowel Disease (Round 4)	20% (data collection issue)
National Paediatric Diabetes Audit (NPDA)	97.5%
Epilepsy 12 audit (Childhood epilepsy)	100%
Trauma Audit and Research Network (TARN): Major Trauma	98.8
National Cardiac Arrest Audit (NCAA)	100%
College of Emergency Medicine: Fitting Child (Care in Emergency Departments)	100%
National Comparative Audit of Blood Transfusion Programme : d) Use of Red Cells	100%
National Comparative Audit of Blood Transfusion Programme: Use of Blood in Sickle Cell Disease	100%
Paediatric Intensive Care Audit Network (PICANet)	Embrace: 100% PCCU: 100%
College of Emergency (CEM): Fitting Child	100%
European Prospective Multicentre Observational Study: Epidemiology of Severe Critical Events in Paediatric Anaesthesia (APRICOT)	100%
International Burns Injury Database (IBID)	100%

National Clinical Audits and National Confidential Enquires for which the Trust was Eligible to Participate	% of eligible cases submitted
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness (NCISH)	100% (No reportable deaths)
MBRRACE-UK Perinatal Confidential Enquiry (Links with the Child Death Outcome Review Programme)	100%
MBRRACE-UK Perinatal Confidential Enquiry – Congenital Diaphragmatic Hernia	100%
CE (CORP) RCoP National audit of Asthma Deaths	100% (No reportable deaths)

2.2.2.1 National Audit and Confidential Enquiry Reviews

The reports of 7 national clinical audits were reviewed by the provider in 2014-15 and Sheffield Children's NHS FT took the following actions to improve the quality of healthcare provided.

(1) MBRRACE-UK Perinatal Confidential Enquiry – Congenital Diaphragmatic Hernia

Local Actions Include	Now have a Lead Consultant
	Care pathway being written
	Information leaflet being written
	Discharge and follow-up guideline being written
	New guideline for Diaphragmatic Hernia being written for Neonatology
	Neurodevelopment follow-up under the neonatologist

(2) BTS Bronchiectasis 2013

Local Actions Include	Local audit undertaken which identified that 92.3% (national 63.8%) of SCH of patients seen by respiratory physiotherapist
	100% of patients had a CT chest performed which was better than the national cohort. 92.3%
	Comprehensive investigations significantly better than national.
	To discuss with named consultant form Clinical records committee regarding introducing an investigation sheet into all new respiratory patient clinical records

(3) BTS Paediatric Asthma

Local Actions Include	Audit results discussed at team meeting
	SCH had previously audited local guidelines and found good compliance
	Audit of clinical records planned to include review of discharge planning and follow up

(4) National Inflammatory Bowel Disease Audit

Local Actions Include	Daily scoring now taking place and has been incorporated into junior doctor induction
	All patients with diarrhoea should have their stools sampled – standard practice at SCH
	All patients should have nutritional assessment on admission – Dietetic team working to achieve this

(5) National Paediatric Diabetes Audit

Local Actions Include	Diabetes team review HbA1c at each patient consultation
	Regular patient reviews are undertaken with diabetes team and dieticians
	Patients made aware of the 24 hour availability of Diabetes team

(6) Prescribing Observatory for Mental Health (POMH-UK): Prescribing for ADHD in children, adolescents and adults

Local Actions Include	Correspondence with GP to include centile values of physical check ups
	To incorporate risk of substance diversion into ADHD assessment report to GP
	Identify growth and centile charts for use in CAMHS
	To disseminate recommendations and action plans to CWAMH

(7) Severe Trauma

Local Actions Include	Major Trauma Peer Review Group established
	Improved ED Consultant Cover in accordance with national recommendations
	Robust system implemented for provision of rehabilitation prescriptions
	Continual data quality checks

2.2.2.2 Local Audit and Service Evaluations

The reports of 194 local clinical audits service evaluations were reviewed by the provider in 2014-15 and Sheffield Children's NHS FT intends to take the following actions to improve the quality of healthcare provided, e.g.

(1) Haematology and Oncology: CA840 Re-audit of timely informing GP of carcinoma

Findings Include	Informing GPs by the end of the next working day has improved compared to the previous audit in 2012.
	It is often not documented when a GP is informed by telephone
Local Actions	Need to improve the filing of Inform GP faxes in the notes.

Include	Departmental guidelines have been amended to include documentation of telephoning GP

(2) Oral/Maxillofacial Surgery: CA764 Re-audit of accuracy of medication prescribing for children

Findings Include	The incidence in prescribing error has been reduced to 6% compared to 18% in the previous audit
	Percentage differences between the actual prescribed dose and the weight adjusted dose showed improvement compared previous audit
Local Actions Include	Education and training on correct drug prescribing at induction for new junior members.
	Reference cards with the correct weight adjusted dosages of the most commonly used medications to be given to new staff at their Induction.

(3) Ophthalmology: SE495-1 School eye screening service re-evaluation

Findings Include	Results show children are being tested at the correct age range and in a timely manner.
	No changes are required to the referral criteria pathway.
	All Key performance indicators have been met.
	The Sheffield School Vision Screening service continues to be of a high standard, with a low false negative rate, working well with the School Nursing services as well as Sheffield community optometrists.
Local Actions Include	School vision screening started later in year to reduce the number of false positives
	Opt-out consent implemented which improves the numbers of children tested within school

(4) Pharmacy: CA408 preparation of Emergency Drugs for intubation on PICU

Findings Include	Reduction of occasions where drugs in the EID box had expired compared to the 2012 audit; 6% compared with 34%.
	On 72% of occasions other drugs were present in the EID box. The majority were sodium chloride 0.9% flushes.
	On one occasion, a pre-filled ketamine syringe pack had been opened but not used and not discarded.
Local Actions Include	Update the EID guideline and include a pre
	Include information on the use of pre filled syringes

(5) Pharmacy: CA780 use of pre-printed stickers for IV Paracetamol prescriptions

Findings Include	80% of inpatient prescriptions for IV Paracetamol were prescribed using the pre-printed IV Paracetamol stickers.
	100% of IV Paracetamol stickers were completed with the dose in both milligrams and millilitres, be signed and dated by the prescriber, and if for neonates contain dosing interval

	100% of wards had pre-printed IV Paracetamol stickers in a blue wallet in the treatment room
Local Actions Include	The SC(NHS)FT policy concerning IV Paracetamol policy should be available on the intranet and added to the Guidelines for the Administration of Intravenous Paracetamol: CAEC Reg. ID no. 139
	Ward pharmacists should report all incidents of non-compliance with the IV Paracetamol policy should be reported
	For accessibility the ward wallet should be stored at the nurses' station, not the treatment room

(6) WAMH: CA885 Cardiometabolic Assessment for Patients with Schizophrenia & Communication with General Practitioners

Findings Include	Overall information from all lodges is provided to GP's that is of a high standard. Results demonstrate that 100% of all admission
	Lodges have a firm baseline from which to make improvements
	Results indicate that lodges assess 100% of all patients' and GPs receive details of medications
Local Actions Include	Ensure that all team members are actively using standard physical health checks and passing to admin teams to enter onto CareNotes
	In patient lodges to review share practice and consistency of recording blood lipids results (taken or not taken) within their documentation.
	Administrative pathways identified which require consistent approach around use of CareNotes templates and in the reviewing of CPA minute booklets
	Ensure that all team members are actively using standard physical health checks and passing to admin teams to enter onto CareNotes

(7) Dermatology: SE493 The Management of paediatric atopic eczema patients with food allergies. An assessment of the utilization of dietetic services and food challenge test in patients on elimination diet

Findings Include	Dermatology patients on restricted diet need a better access to the allergy and dietetic services
Local Actions Include	Develop pathway of referral for dermatology patients on restricted diet to the allergy and dietetic services
	Design joint protocol with allergy team for food challenges in children with eczema including agreed method for assessment of skin response
	Teaching session for the allergy nursing team to increase their experience with the possible skin reactions post oral food challenge tests and to implement an eczema severity scoring system

2.2.3 CLINICAL RESEARCH

The number of our patients receiving relevant health services provided or sub-contracted by Sheffield Children's NHS Foundation Trust in 2014-15 that were recruited during that period to participate in research approved by a research ethics committee is 1082. The Trust has 226 research studies currently active.

It has been an exciting year for grant awards, notably with the Trust receiving a grant of over £800,000 from the Wellcome Trust to carry out New Generation Genetic Sequencing on newborn blood screening samples. We continue to build on our collaborative work with Sheffield Hallam University and this year we secured our second NIHR Invention for Innovation (i4) grant with a third application being submitted in the next few weeks. The i4i funding scheme remit is to advance healthcare technologies and interventions for increased patient benefit in areas of existing or emerging clinical need. Other notable grants have been awarded to our researchers from the British Tinnitus Society, Newlife, the Skeletal Dysplasia Group and The Children's Hospital Charity.

Some examples of the research carried out in our Trust during the last year are:

2.2.3.1 Example to be inserted

2.2.3.2 Example to be inserted

2.2.4 USE OF THE CQUIN FRAMEWORK

A proportion of Sheffield Children's NHS FT income in 2014-15 was conditional upon achieving quality improvement and innovation goals agreed between Sheffield Children's NHS FT 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. Further details of the agreed goals for 2014-15 and for the following 12 month period are available online at http://www.sheffieldchildrens.nhs.uk/about-us/board-papers.htm, in our monthly Performance Report.

The amount of income in 2014/15 conditional upon achieving quality improvement and innovation goals was £2.91M; the amount conditional upon achieving quality improvement in 2013-14 was £3.03M.

A more detailed commentary on our achievement against the Commissioning for Quality and Innovation (CQUIN) quality indicators is given below:

CQUINs for Specialist Services

Title	Description	Outcome
Safety thermometer	Achieve safety thermometer requirements set out by local commissioners	Achieved
Patient experience –	Development and roll out of Friends and Family	Achieved

Title	Description	Outcome
Continence	Test related question and follow up on suggested actions.	
Endocrine Outpatient coding	To generate proposals and pilot a process for outpatient diagnostic coding in specialised endocrinology.	Achieved
Telemedicine	Introduce telemedicine care for clinically appropriate patients within Neurology Epilepsy Nurse led clinics.	Achieved
Perinatal pathology	Impelment national reporting times for perinatal autopsies.	Achieved
Osteogenesis Imperfecta	Highly specialised services clinical outcome collaborative audit workshop and provider report.	Achieved
Ehlers Danlos Syndrome	Highly specialised services clinical outcome collaborative audit workshop and provider report.	Achieved
CAMHS Tier 4 – Cardio metabolic assessment for patients with Schizophrenia	Full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with schizophrenia.	Achieved
CAMHS Tier 4 – Assuring appropriateness of unplanned admissions	Completion of a multi-agency review of all unplanned admissions to general adolescent Tier 4 CAMHS within 5 working days of admission.	Achieved
CAMHS Tier 4 - Patient experience	Development and roll out of Friends and Family Test related question and follow up on suggested actions.	Achieved

CQUINs for Core Services

Title	Description	Outcome
Patient experience – AAU	Development and roll out of Friends and Family Test related question and follow up on suggested actions.	Achieved

Title	Description	Outcome
Trust Staff Feedback	Development and roll out of the Staff Friends and Family Test related question and follow up on suggested actions.	Achieved
Baby Friendly	To ensure that the Trust is prepared and able to deliver the requirements as per national scheme.	Achieved
Harm Free	The Continued use of the SCAN tool within the Trust, input data, share data among Children's Trust Network.	Achieved
Education Health Care Plan (SEN)	Implementation of the Health section of the Education Health Care Plan for patients with special educational needs.	Q1 – Achieved Q2 – 50% Achieved Q3 – 50% Achieved Q4 – Achieved (on track to)
15 Steps challenge for clinic and outpatient settings	To help staff, patients and service users work together to identify improvements to enhance the patient or service user experience. To provide a way of understanding patients and service users first impressions more clearly.	Achieved
School Nursing	Improved Provision of healthy eating information, referral and signposting to community based weight management services in targeted schools with high obesity prevalence.	Achieved
Hot Meals	Availability of cooked meals on wards for patients	Achieved
Breast feeding Health Visiting	Health visiting service to ensure that at least 81.2% of mothers breast feeding at new birth visit should still be breast feeding after 6-8 weeks.	Achieved

2.2.5 REGISTRATION WITH THE CARE QUALITY COMMISSION

Sheffield Children's NHS FT is required to register with the Care Quality Commission and its current registration status is unconditional. The Care Quality Commission has not taken enforcement action against Sheffield Children's FT during 2014-15.

Sheffield Children's NHS FT has not participated in special reviews or investigations by the Care Quality Commission during 2014-15.

Sheffield Children's Hospital was subject to a routine inspection of its services in May 2014. The hospital was judged "GOOD" overall.

The judgement details can be found at: http://www.sheffieldchildrens.nhs.uk/about-us/regulators/

Progress on actions taken can be found at:

http://www.sheffieldchildrens.nhs.uk/downloads/boardpapersjan2015/BoardPapers_Jan2015EncH.pdf

2.2.6 INFORMATION ON THE QUALITY OF DATA

Sheffield Children's NHS FT submitted records during 2014-15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 99.5% for admitted patient care; 99.8% for outpatient care; and 98.9% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was: 99.7% for admitted patient care; 99.7% for outpatient care; and 99.4 % for accident and emergency care.

Sheffield Childrens NHS Foundation Trust Information Governance Assessment Report overall score for 2014-15 was 66% this was graded green (satisfactory).

Sheffield Children's NHS FT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.
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2.2.7 IMPROVEMENTS TO THE QUALITY OF DATA

Sheffield Children's NHS FT will be taking the following actions to improve data quality:

- Implementing the recommendations of data quality related audit reports.
- Reconciling information from different systems to ensure data accuracy and completeness.
- Purchase of more comprehensive clinical coding software.
- Continuing to improve Clinical Coding through improved clinical engagement and through the strengthening of the Clinical Coding team structure.
- Investigation and rectification of data quality variances identified through national benchmarking tools.

2.2.8 INFORMATION ON THE QUALITY OF DATA

The following section sets out the data made available to Sheffield Children's NHS FT by the Health and Social Care Information Centre. The indicators below represent those relevant for the services provided by this trust. Most of the indicators specified are not relevant to a children's specialist trust and following agreement with commissioners, are not submitted as a data return. N.B. Where national data is historical, this reflects the latest data released by the HSCIC.

19. Patients readmitted to a hospital within 28 days of being discharged. (i) 0 to 15				
		National		
Financial Year	%	*Average (%)*	*Maximum (%)*	*Minimum (%)*
2014/15	*	*	*	*
2013/14	*	*	*	*
2012/13	*	*	*	*
2011/12	12.45	*10.61*	*12.45*	*9.69*
National data is based on the data for all acute specialist children's trusts (the category SCH comes under for this indicator). * denotes no national data available				

19. Patients readmitted to a hospital within 28 days of being discharged. (ii) 15 or over				
		National		
Financial Year	%	*Average (%)*	*Maximum (%)*	*Minimum (%)*
2014/15	*	*	*	*
2013/14	*	*	*	*
2012/13	*	*	*	*
2011/12	17.15	*12.3*	*17.15*	*8.53*
National data is based on the data for all acute specialist children's trusts (the category SCH comes under for this indicator). * denotes no national data available				

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

The Trust has a policy of allowing all parents to self refer to our Acute Assessment Unit within three days if they are concerned. We have submitted evidence to the CQC that much of the high readmission rate relates to attendances of children at our Acute Assessment Unit. The majority of these attendances are for less than 4 hrs.

The Sheffield Children's NHS FT intends to take the following actions to improve this percentage and so the quality of its services, by:

By agreement with our commissioners, we have introduced a medical short stay code which should remove the anomaly created by the current way of recording an Acute Assessment Unit attendance. This should allow a like for like comparison with all other units.

21. Staff who would recommend the trust to their family or friends.				
		National		
Year	%	*Average (%)*	*Maximum (%)*	*Minimum (%)*

2014	84	*67*	*93*	*38*
2013	83	*67*	*94*	*40*
2012	83	65	94	35
National data is based on the data for all acute & acute specialist trusts (the category SCH comes under for this indicator).				

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

This represents an indicator of the high standards that our staff aspire to.

The Sheffield Children's NHS FT intends to take the following actions to improve this percentage and so the quality of its services, by:

To continue to work with our staff to maintain and improve the standards within our trust.

24. Rate of C.difficile infection.				
		National		
Financial Year	Rate	*Average*	*Maximum*	*Minimum*
2013/14	12.3	*13.9*	*37.1*	*0*
2012/13	19.8	*16.2*	*31.2*	*0*
National data is based on the data for all trusts included in the indicator source data.				

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

The Trust has regularly reported low infection rates for C Difficile. This is due to the reduced susceptibility of children to this infection and to the high standards of infection control.

The Sheffield Children's NHS FT intends to take the following actions to improve this rate and so the quality of its services, by:

To continue to work with our staff to maintain and improve the standards within our trust.

25. Patient safety incidents and the percentage that resulted in severe harm or death.				
		National		
Period	Rate per 100 patient admissions	*Average*	*Maximum*	*Minimum*
Oct 13 - Mar 14	9.3	*9.7*	*32.9*	*4.7*
Apr 13 – Sep 13	8.8	*8.9*	*27.9*	*3.7*
Oct 12 - Mar 13	8.6	*9.1*	*30.95*	*3.77*
National data is based on the data for all acute specialist trusts (the category SCH comes under for this indicator). * denotes no national data available				

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

The Trust has a good reporting culture and we encourage Serious Incidents to be recorded wherever there was a variation from procedure. We initiate a root cause analysis and obtain learning. In a quarter of the cases reported, the outcome was unavoidable but we still obtain systems learning from the examination of the incident.

The Sheffield Children's NHS FT intends to take the following actions to improve this number and/or rate and so the quality of its services, by:

To continue to report as serious incidents anything that has a potential for harm and to improve systems as a result of the investigation.

2.3 Patient Experience

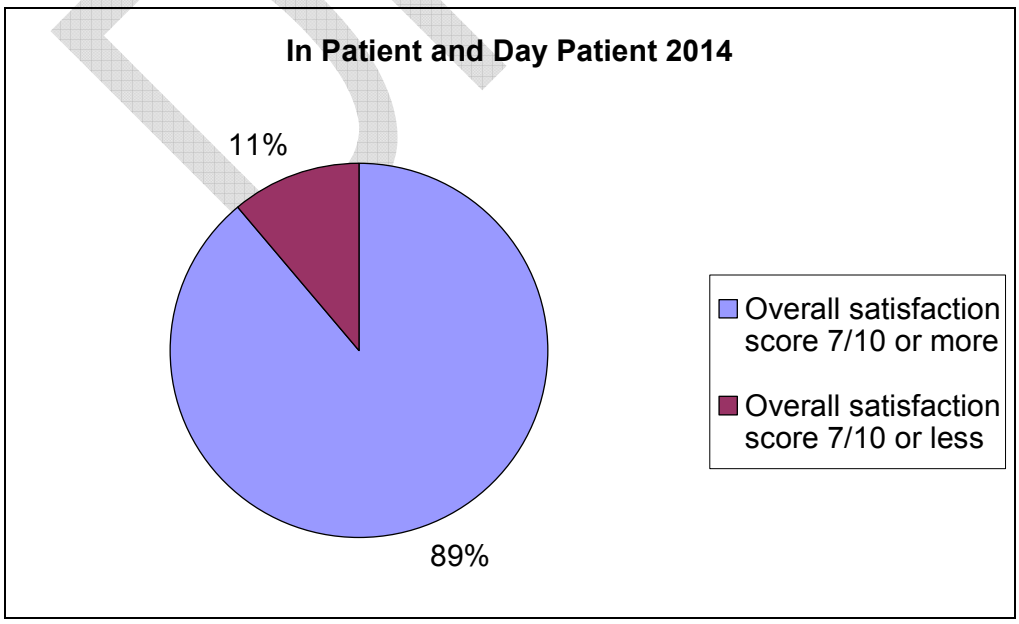
The Trust normally arranges for Picker to carry out a postal survey of its families attending A&E, Out Patients Department and all those admitted to an In-Patient department. This is carried out each year and then we compare our performance with the average of other children's units, who also participated. The full details of each survey are available on:

http://www.sheffieldchildrens.nhs.uk/patients-and-parents/patient-views.htm

In 2014-15, NHSE mandated that all In-Patient Children's Services must carry out the survey. All Neonatal Units were required to carry out a pilot survey and the Trust was one of the first in the country to carry out a survey of our Health Visiting Services. The results of these surveys are given below:

2.3.1 IN-PATIENT SURVEY 2014-15

The 2014-15 In-Patient Survey of 850 families (30.9% response) showed that the majority of our ward children and parents ranked their care well:



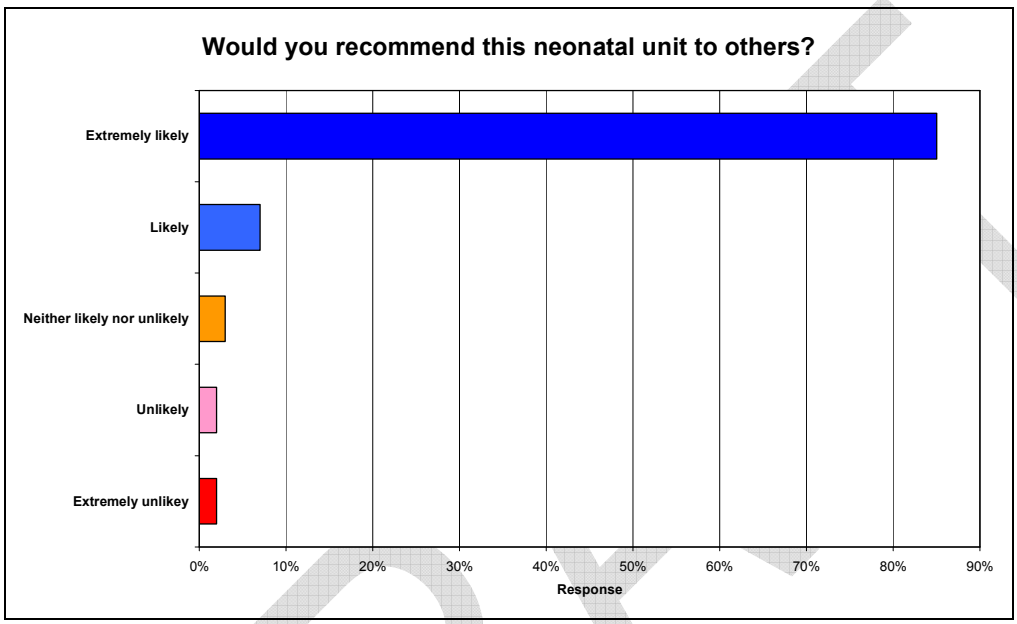
The Trust was significantly better than other children's units at providing parents with written information and in providing pain relief for children.

The Trust showed significant improvement over previous surveys in parents feeling their child was safe on the hospital ward, and in providing privacy and dignity on the ward.

There were no areas where the hospital was significantly poorer than other children's units.

2.3.2 NEONATAL UNIT SURVEY 2014-15

The 2014-15 Neonatal Unit Survey of 189 families (35% response) showed that the majority of our patients ranked their care well:



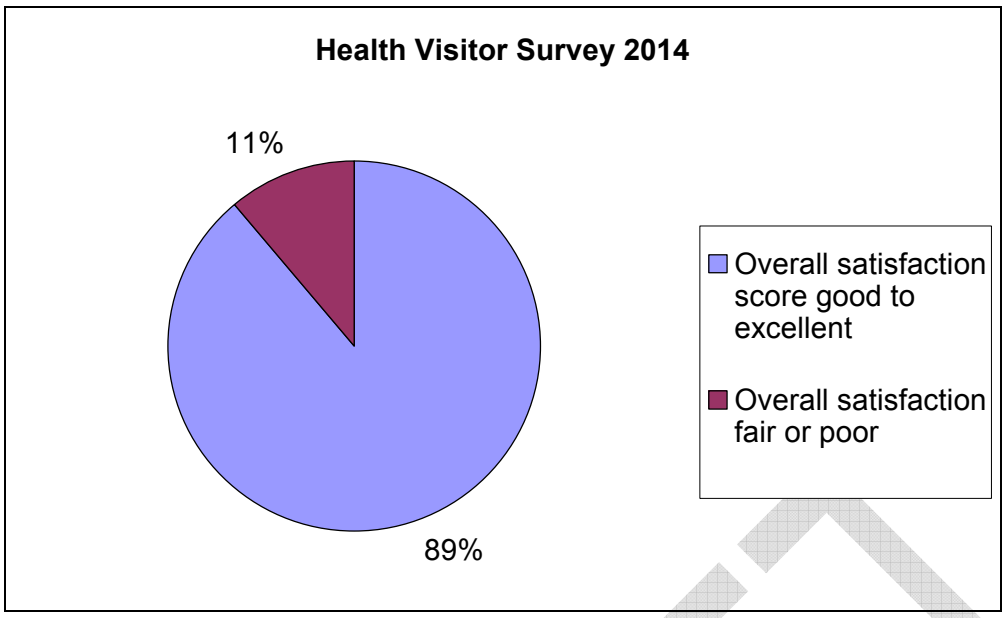
The Neonatal Surgical Unit was in the top 20% of the survey group in areas such as staff communication, support with feeding, nearby parent accommodation and emotional support.

The Trust was an outlier in not allowing parents to be present during ward rounds. The staff felt strongly that this was a patient confidentiality issue in a small unit. All parents are given the opportunity to have a confidential update with the surgeon or senior nurse and this perhaps accounts for the strong communication scores.

The staff could do more to promote local parent support groups such as BLISS. The rationale for not doing so is that these are predominantly about supporting families with premature babies rather than babies who have had surgery. Improved information will be made available in future.

2.3.3 HEALTH VISITOR SURVEY 2014-15

The 2014-15 Health Visitor Survey of 1000 families (35.1% response) showed that the majority of our families ranked their care well:



The survey showed that the Health Visitor Service is positively viewed by families. Health visitors are regarded as being available and/or flexible with appointments; the health visitors' manner was viewed as caring.

Action plans are being developed for improvement and include more visits around time of children weaning to solid food, more convenient appointments and better communication when appointments are delayed.

2.3.4 CAMHS SURVEYS 2014-15

To be included when year end results available

2.4 Complaints

During the financial year 2013 -14, a total of 122 formal complaints were received as at 31 March 2014. The rate of complaints is set out in the following table:

Year	Episodes of care	Complaints	No of complaints per 10,000 episodes
2014-2015	Data awaited	122	
2013 - 2014	197,112	116	5.88

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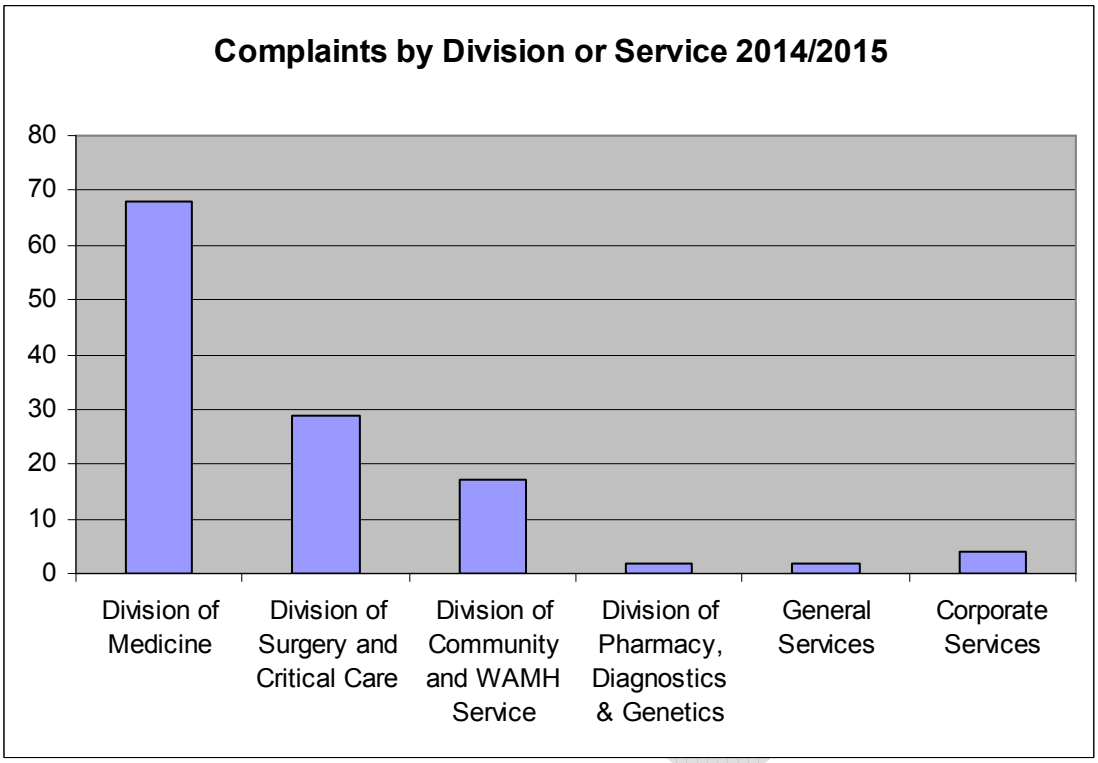
Further analysis shows the following are the main services receiving complaints:



2.4.1 REASON FOR THE COMPLAINT

Complaints are coded according to national coding descriptions:

Type of Complaint	No.
Care and treatment	51
Appointments/delay/cancellation	12
Attitude of staff	9
Transfer/admission arrangements	1
Lack of communication/information	26
Medical Records	1
Car parking	0
Breach of confidentiality	4
Privacy & dignity	0
Consent to treatment	1
Equipment	1
Other	16

The “care and treatment” category is a wide one set by the NHS complaints coding system. The main issues that we find in this relate to dissatisfaction with the diagnosis or treatment outcomes.

2.4.2 LEARNING FROM COMPLAINTS

Although there are some complaints which we cannot do anything about, we believe that the need to make a complaint demonstrates a failure in communication of our services. If a child experiences known complications of a treatment then it should not come as a surprise to the family; if a family is subject to delays then these should be reasonable and the family should have a right to be warned about them.

Some of the complaints which were made include:

Examples of complaints

- Safeguarding processes instigated quickly and not well communicated.
- Conflicting breast feeding advice given by different medical staff.
- pH probe displacement not recognised leading to the need for a repeat test.
- Correct introducer for tube replacement not available in accident and emergency.
- Open appointment rules not clearly explained.
- Delay in dietetic referral/review following attendance on AAU.

The following describes some changes in practice as a result of lessons learnt following complaints:

- A leaflet is being produced to explain the safeguarding process and investigations to families.
- Infant feeding nurse specialists are training medical staff in a proactive approach to breast feeding.
- Gastroenterology nurses are carrying out regular and updated training for ward nurses undertaking gastro care.
- Introducers for all feeding devices are now stocked in the Emergency Department.
- The Trust website has been updated to give clear information regarding open appointment timescales.
- Replacement of our patient booking software

2.4.3 REFERRALS TO THE OMBUDSMAN

During the last financial year, a total of two complainants referred their complaint to the Parliamentary and Health Services Ombudsman (PHSO). Two Previous referrals were also reported upon.

Division	File to PHSO	Summary of Complaint	PHSO decision
Medicine	March 2012	Safeguarding procedures initiated due to persistent use of alternative remedies against medical advice.	PHSO dermatology expert report critical of the Trust's position on the issue. Following challenge by the Trust the PHSO amended their findings. Family awarded £500 in recognition of distress and suboptimal complaint handling. Action plan in progress.
Medicine	July 2014	Photograph taken of child in respite care.	PHSO Report concluded that the Trust adequately explained its actions and there is no basis for the PHSO to uphold the complaint. Case closed.
Medicine	December 2014	Blood taken by trainee doctor without consent. Allegations about conflicting feeding advice and staff confusing the patient with another child.	Awaiting decision.

2.5 Potentially Serious Incidents

During the last financial year 2014-15, the Trust reported 7 Potential Serious Incidents. This is down from 12 the previous year. Each is investigated and any learning shared with the wider organisation. The Board is regularly updated wherever urgent learning requires to be implemented.

- Allegation of inappropriate behaviour by an agency staff at Becton. A full investigation was undertaken by South Yorkshire Police. No basis found for the allegations.
    - The Trust has introduced a revised robust induction for agency staff on safeguards when undertaking 1:1 supervision.
- Unexpected death of a patient at the end of spinal surgery due to right ventricular thrombus causing cardiac arrest and pelvic deep vein thrombosis unrelated to the surgery or anaesthesia.
    - The Coroner confirmed that an inquest would not be required in this case and no recommendations made.
- Inaccurate sweat test results used in the diagnosis of Cystic Fibrosis resulting in the potential for false negative results.
    - All affected patients notified and offered re-testing where applicable. A full review of laboratory training and procedures carried out.
- Grade 3 pressure sore noted on patient's hip under hip spica cast following re-attendance from home.
    - Development of a Pressure Sore Information Leaflet for patients at a high risk of developing pressure sores when discharged home.

The following investigation reports have yet to be approved by the SCH Risk Management Committee:

- Planned withdrawal of treatment on intensive care. Parents raised concerns in relation to treatment at the local hospital and at the Trust.
    - Investigation in progress
- Delay in diagnosis and treatment during the neonatal period.
    - Investigation in progress
- Inconsistent screening results for Cystic Fibrosis.
    - Investigation underway.

Reports relating to the Serious Untoward Incidents are shared with the relevant Manager and Clinical Director or equivalent in addition to being presented at the Risk Management Committee. Following the Risk Management Committee and in order to facilitate organisational learning, the reports are discussed at each Directorate Board meeting with any recommendations being monitored through the Risk Management Committee.

All Potential Serious Untoward Incidents are subject to a root cause analysis and the result shared with the Risk and Audit Committee.

3 OTHER INFORMATION

The trust set a number of quality indicators to be monitored during 2014-15. Our performance is set out below. Where changes are proposed, the old indicators will continue to be monitored and any deterioration will be highlighted in future reports.

3.1 Patient Safety

Patient Safety AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	ACHIEVEMENT 2014/15
Ensure mandatory training is achieved annually. Target - at least 80% of staff attain annual mandatory training update.	Data being compiled	
Reduce medication incidents that cause harm. Target – medications with an outcome of harm reduced to 1% of all recorded medication incidents.	Data being compiled	
All CAMHS patients with continuing needs to have a transition plan agreed with adult health services that the young person is aware of. Target – Only CAMHS patients of 18 years or over will transfer to adult mental health teams. 100% of transfer will only occur following a written referral and acceptance. Non acceptance will be referred to commissioners.	Data being compiled	

3.1.1.1 Proposed New Indicators 2015-16

- In Patient Dashboard
- Safeguarding in CAMHS
- Health Care Assistant Training

The first indicator

This is the publication of a dashboard of quality indicators by department including nurse staffing recruitment, infection control measures, medication error rate, friends and family score, training, staff appraisal and other elements. These will be refreshed monthly to monitor standards and areas for improvement.

The second indicator

Safeguarding training in CAMHS should be enhanced to encompass changes to deprivation of liberty law, learning from child sexual exploitation cases, issues associated with older young people. The Trust will recruit an additional named nurse for child protection to facilitate this.

The third indicator

Health care assistant training will be standardised to ensure that key clinical competencies are identified, trained for and assessed to deal with local interventions and service needs.

3.2 Clinical Effectiveness

Clinical Effectiveness AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	ACHIEVEMENT 2014/15
Review and reduce the reason for our higher than average rate of re-admission of patients within 28 days of an elective admission. Target – rate of attendance to be at or below national average.	Data being compiled	
Review and reduce the reason for our higher than average rate of re-admission of patients within 48 hrs of an emergency admission. Target – rate of attendance to be at or below national average	Data being compiled	
Ensure that patients have a discharge letter	Data being compiled	

Clinical Effectiveness AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	ACHIEVEMENT 2014/15
sent to their GP within 2 working days of discharge. Target – 85% of letters to be sent within 2 working days.		

3.2.1.1 Proposed New Indicators 2014-15

- Emergency Department Consultant Cover
- Multi lingual communcation
- Long term ventilation

The first indicator

Our Accident and Emergency Department has seen unprecedented pressures this year and expects this to increase in the future. To ensure that all children are seen quickly and are safely assessed, the trust is appointing additional consultants in emergency medicine to ensure that we are able to have a consultant in the department from 8am until midnight every day. We believe that this measure and joint work with Sheffield CCG will ensure that the trust is able to maintain its current position on waiting times in A&E.

The second indicator

The Trust is aware of an increase in the needs of our population where English is not the first language. We will work with GPs and HVs to produce a series of voice files in Roma that can be accessed via the internet. This should allow staff to play standard messages to families about public health issues, important signs that need further medical attention or just how to access services. These will also be available on the internet to the public as a resource.

Our Out Patient self check-in will have a facility to allow families to select the language for written and verbal instruction.

Our web site has a facility to convert its contents to any language.

The third indicator

We have over 50 children on long term respiratory ventilation at home. We aim to support these children to get home sooner from critical care and to remain well at home. We will be employing a WellChild community nurse to provide intensive support on discharge and institute regular / on demand telephone access to the respiratory team.

3.3 Patient Experience

Patient Experience AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	ACHIEVEMENT 2014/15
A&E Survey to be replaced with 2014 Neonatal Survey. Target – no Picker Problem Scores greater than average for other children's units.	Data being compiled	Survey carried out. Due to be released from NHS embargo in May. http://www.sheffieldchildrens.nhs.uk/patients-and-parents/patient-views.htm Action plan underway.
Home from Home target to be replaced with Health Visitor survey action plan based upon 2014 result. Target – achievement of action plan prior to resurvey in 2016.		Survey carried out. http://www.sheffieldchildrens.nhs.uk/downloads/patientsurveys/SCNHSFTHealthVisitingSurvey2014.pdf Action plan underway.
Roll out of the Friends and Family Test in a child friendly format as an electronic page to all bed end patient entertainment consoles. Target – test results to be better than national average.	Data being compiled	

3.3.1.1 Proposed New Indicators 2014-15

- Parking and Patient Access
- Friends and Family Test
- HV support during weaning period

The first indicator

We intend to open a 100 space multi storey car park this year opposite the main entrance for visiting families. We will also open an underground car park with lift access for children with mobility problems. We expect that this will address one of the biggest sources of discontent with our services.

The second indicator

The Trust will text all families following attendance or admission to increase the frequency and span of feedback. We will allow all the facility to access our website to send free text suggestions and comments.

The third indicator

Our HV survey showed that families felt that there was insufficient support during the period when children wean to solid food. This has resulted from the timing of visits according to the national Healthy Child Program. The service intends to work with Local Authority commissioners to address ways of providing on demand support from the local health visitors.

3.4 National staff attitude survey

Each year the Trust takes part in the national staff attitude survey. This survey provides invaluable information to ensure that the views of staff at work are heard and appropriate responses to the feedback are made. The Trust is part of the specialist trust group which has the highest overall scores of any group. The trust has the complication of having mental health services which is uncommon in this group. When our mental health services are compared to others then again we compare favourably. We are disappointed that we have not been able to improve in the last year from the previous year and will be working on how this can be addressed.

3.4.1 SUMMARY OF PERFORMANCE

Response rate

2013		2014		Improvement/deterioration
Our Trust	National average	Our Trust	National average	
54%	53%	37%	42%	Deterioration

Top four ranking scores[2]

Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)

2013		2014		Improvement/deterioration
Our Trust	National average	Our Trust	National average	
97%	90%	96%	92%	No change

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (the lower the score the better)

2013		2014		Improvement/deterioration
Our Trust	National average	Our Trust	National average	
19%	22%	19%	23%	No change

Percentage of staff experiencing discrimination at work in last 12 months (the lower the score the better)

2013		2014		Improvement/deterioration
Our Trust	National average	Our Trust	National average	
6%	9%	6%	9%	No change

Percentage of staff believing the trust provides equal opportunities for career progression or promotion (the higher the score the better)

[2] *These scores are the four key findings from the staff attitude survey where Sheffield Children's NHS Foundation Trust compares most favourably with other acute specialist Trusts*

2013		2014		Improvement/deterioration
Our Trust	National average	Our Trust	National average	
95%	90%	94%	90%	No change

Bottom four ranking scores[3]

Percentage of staff agreeing that their role makes a difference to patients (the higher the score the better)

2013		2014		Improvement/deterioration
Our Trust	National average	Our Trust	National average	
86%	91%	86%	92%	No change

Staff motivation at work (the higher the score the better)

2013		2014		Improvement/deterioration
Our Trust	National average	Our Trust	National average	
3.79	3.91	3.73	3.90	No change

Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (the higher the score the better)

2013		2014		Improvement/deterioration
Our Trust	National average	Our Trust	National average	
76%	82%	76%	84%	No change

Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (the lower the score the better)

2013		2014		Improvement/deterioration
Our Trust	National average	Our Trust	National average	
7%	7%	10%	6%	Deterioration

Key areas of improvement

To be updated

Future priorities and targets

To be updated

3.4.2 MONITOR INDICATORS AND THRESHOLDS PERFORMANCE

	Performance indicator	Target or threshold	14/15 trust performance	Achieved
CE	Maximum time of 18-weeks from point of referral to treatment for admitted patients	90%	Data being collated	

[3] *These scores are the four key findings from the staff attitude survey where Sheffield Children's NHS Foundation Trust compares least favourably with other acute specialist trusts in England*

	Maximum time of 18-weeks from point of referral to treatment for non-admitted patients	95%	Data being collated	
	Maximum time of 18-weeks from point of referral to treatment for patients on an incomplete pathway	92%	Data being collated	
	A&E: maximum waiting time of four-hours from arrival to admission, transfer or discharge.	≤ 95%	Data being collated	
	All cancers: 62 day wait for first treatment from: Urgent GP referral for suspected cancer NHS Cancer screening service referral	 85% 90%	 N/A	 N/A
	All cancers: 31-day wait for second or subsequent treatment, comprising: Surgery Anti-cancer drug treatments radiotherapy	 94% 98% 94%	 100% 100% N/R	 ✓
	All cancers: 31-day wait from diagnosis to first treatment	96%	100%	✓
	Cancer: two-week maximum wait from referral to first seen, comprising: All urgent referrals (cancer suspected) For symptomatic breast patients (cancer not initially suspected)	 93% 93%	 100% N/R	 ✓
OUTCOMES	C.Difficile infection	4*	6	X
	Data completeness: community services, comprising: Referral to treatment information Referral information Treatment activity information	 50% 50% 50%	Data being collated	

* de minimis of 12 applied by Monitor

The table above summarises the Trust's performance in 2014/15 against the targets used by Monitor to calculate governance risk rating against their Risk Assessment Framework.

Additional Information

Referral to Treatment Time Performance at Speciality Level - Dental breaches

- Paediatric Dentistry Admitted – for 4 months between August and November the targets were not achieved

- Paediatric Dentistry Non- admitted – for 9 months in the last year targets were not achieved

The Trust continues to have difficulties as a result of delays at the Charles Clifford Dental Hospital, with a high number of patients transferred beyond their breach dates. There is a local agreement in place with Sheffield Teaching Hospitals to share breaches in dentistry where patients have been transferred to the trust and some improvements have been made with the length of waits patients have experienced prior to transfer to the Trust having reduced.

Radiology Diagnostic Waits

The Trust has had a marked increase in the requirements for X ray and scanning diagnostic tests. The diagnostic results are a critical part of the outpatient clinic process and the inpatient admission process. The results determine whether further tests or treatment are required. The trust has to achieve 99% of diagnostic tests in 6 weeks or under.

- **MRI Tests:** between April 2014 and February 2015 there were 20 patients in total who waited more than 6 weeks for an MRI Scan. Delays are often associated with the need for children to be anaesthetised during the scan.

- **CT Scan:** there were no patients waiting more than 6 weeks throughout 2014/15.

- **Non-obstetric Ultrasound:** there were no 2 patients waiting more than 6 weeks in 2014/15.

- **DEXA Scan (Bone Scan):** between April and February there were no patients waiting more than 6 weeks for a DEXA Scan .

The decision taken last year to commission another MRI scanner attached to our operating theatres means that additional capacity will come on line at the point of opening of the new theatres and will also enable our surgeons to do MRIs on patients during surgery.

4 ANNEX A. STATEMENT OF DIRECTORS RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014-15 and supporting guidance.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2014 to June 2015
    - Papers relating to quality reported to the board over the period April 2014 to June 2015
    - Feedback from the commissioners dated XX May 2015
    - Feedback from governors dated XX May 2015
    - Feedback from Local Healthwatch organisations received XX May 2015
    - Feedback from Local Scrutiny Committee dated XX May 2015
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, entitled Integrated Governance Annual Report, XX May 2015
    - The latest children's in-patient survey 2014-15
    - The latest national staff survey 2014-15
    - The Head of Internal Audit's annual opinion over the trust's control environment dated XX May 2015
    - CQC hospital Intelligent monitoring dated XX May 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)

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

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

5 ANNEX B. CONSULTATION IN THE PREPARATION OF THE QUALITY REPORT

A number of staff, families and organisations were involved in the consultation process to produce this report and the Trust is grateful for the time and effort of all who have contributed. The final version has tried to accommodate the comments received or the minutes of the meetings at which it was discussed but it is accepted the production of the report is ultimately the responsibility of the Board of Directors.

5.1 Consulted Agencies or Groups:

5.1.1 SHEFFIELD CLINICAL COMMISSIONING GROUP

The first draft report was provided to NHS Sheffield on XX May 2015

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5.1.2 SHEFFIELD HEALTH WATCH

The first draft report was provided to Health Watch on XX May 2015and a meeting was held with key members of Health Watch and the Director of Nursing and Clinical Operations on XX May 2015The following response was received:

5.1.3 YORKSHIRE OVERVIEW AND SCRUTINY COMMITTEE

The first draft report was provided to the South Yorkshire Oversight and Scrutiny Committee on XX May 2015. The Director of Nursing and Clinical Operations attended the Committee on XX May 2015. The following response was received:

5.1.4 COUNCIL OF GOVERNORS SHEFFIELD CHILDREN'S NHS FT

The first draft report was provided to the Governors on XX May 2015 The draft was the subject of a discussion on XX May 2015 between the Director of Clinical Operations and the Council. The attached is an extract from the minutes of the meeting.

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Report to Healthier Communities & Adult Social Care Scrutiny Committee
15th April 2015

Report of: Jason Rowlands, Director of Planning, Performance & Governance
Sheffield Health & Social Care NHS FT

Subject: **SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST 2014-15 – QUALITY REPORT**

Author of Report: Jason Rowlands, Director of Planning, Performance & Governance

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Summary:

Sheffield Health & Social Care NHS Foundation Trust is in the early stages of producing its annual quality report. As part of the review of its quality over the 2014/15 period the Trust would like to

- Share with the Scrutiny Committee its assessment of the quality of the services provided
- Seek and receive comments from the Scrutiny Committee regarding their assessment of the quality of the Trust's services based on the work and actions of the Committee over the year
- Seek advice and feedback from the Scrutiny Committee on the proposed priority areas for quality improvement that we intend to focus on next year.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	**X**
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**X**
Other	

The Scrutiny Committee is being asked to:
The Committee is asked to review the Draft Quality Report and provide comment to the Trust on its assessment of the Quality of its services and the proposed priorities for 2015/16.

Background Papers:
List any background documents (e.g. research studies, reports) used to write the report. Remember that by listing documents people could request a copy.

Category of Report: OPEN

Report of the Director of Planning, Performance & Governance
Sheffield Health & Social Care NHS FT

SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST 2014-15 – QUALITY REPORT

1. Introduction/Context

1.1 Sheffield Health & Social Care NHS Foundation Trust is in the early stages of producing its annual quality report. As part of the review of its quality over the 2014/15 period the Trust would like to

- Share with the Scrutiny Committee its assessment of the quality of the services provided
- Seek and receive comments from the Scrutiny Committee regarding their assessment of the quality of the Trust's services based on the work and actions of the Committee over the year
- Seek advice and feedback from the Scrutiny Committee on the proposed priority areas for quality improvement that we intend to focus on next year.

2. Main body of report, matters for consideration, etc

The following is provided as a guide to the content of the Quality Report at this stage of Drafting

2.1 Requirements to produce a Quality Account

The National Health Service (Quality Accounts) Regulations 2010, as amended, require NHS Trusts and NHS Foundation Trust's to produce an annual account/ report regarding the quality of its services. This requirement and subsequent guidance relates to the quality of the NHS services provided by the NHS Trust's.

The overall structure is prescribed by guidance. There are set issues that the Quality Account must comment upon, and for some issues the way the Trust should comment is prescribed by both the legislation and guidance. (this mainly relates to Part 2A & Part 3 of the attached draft)

2.2 Publication of the Trust's Quality Account

We have a legal duty to send a copy of our final agreed Quality Account to the Secretary of State. Additionally, we are required to make our Quality Account publicly available on the NHS Choices website by 30 June. The Trust would also make the report publicly available through its own website.

2.3 Status of the information in the attached Draft

Unfortunately at this stage in the year we are unable to provide a Draft that captures a full assessment of our performance. Mainly this is because

- the full year has just been completed and all data is not yet available
- and information and analysis about performance over the Quarter 4 period has yet to be finalised
- some required/ essential information is not available at the time of compiling this draft. Mainly this relates to feedback from all the visits undertaken by the CQC during their inspection of the Trust's services during October-November 2014.

It is acknowledged that this has an impact on the Scrutiny Committee's ability to provide fully informed comment. However, it is hoped that the information contained in the attached provides an appropriate overview and feel for the expected position once all the analysis has been completed.

The attached Draft is based on performance information for the 9 month period April-December, extrapolated to give a full year equivalent position – this is to aid comparisons with previous years information. To date the Trust is not aware of anything over the January-March period that would materially effect this picture, although the exact positions are not yet available.

2.4 Structure of the Report

Part 1: General introductions from the Chief Executive

Part 2A:Overview and report on our main areas for quality improvement

- This outlines how we established the priorities we did, the goals we set ourselves this year, how we have progressed and what we propose to focus on next year.

Part 2B: Mandatory statements

- These mainly are the prescribed and required areas that we are mandated to comment

Part 3:Quality report

- Range of other information that the Trust monitors and reports on in respect of Quality

2.5 Who we are sharing our Quality Account with

Commissioners of NHS Services - the Trust will share its draft Account with Sheffield CCG.

Scrutiny - Scrutiny Committee

Sheffield Healthwatch

3 What does this mean for the people of Sheffield?

3.1 This Quality Report provides information and assurance regarding the quality of care provided by Sheffield health and Social Care NHS Ft to the people of Sheffield

4. Recommendation

4.1 The Committee is asked to review the Draft Quality Report and provide comment to the Trust on its assessment of the Quality of its services and the proposed priorities for 2015/16.

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.

Contents

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.

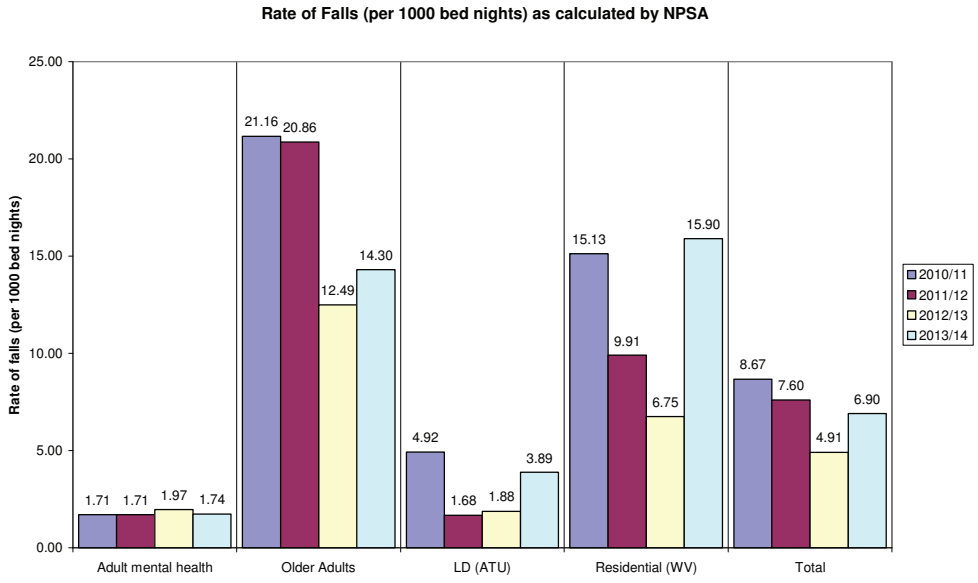
In last years Quality Account we reported that overall incidents of falls that resulted in harm had reduced by 25% over the three year period from 2011/12. Over the last year the number of falls that resulted in harm increased, following a year on year decrease over the previous 3 years. A summary of 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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Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
Draft Work Programme 2014-15

Chair: Cllr Mick Rooney **Vice Chair**: Cllr Sue Alston
Meeting day/ time: Wednesday, 10am-1pm
Please note: the Work Programme is a live document and so is subject to change.

Topic	Reasons for selecting topic	Contact	Date	Expected Outcomes
15th April 2015				
Sheffield Health and Social Care Trust – Annual Quality Account.	The Committee is required to comment on the Quality Accounts of providers of health services in the City	Jason Rowlands, Director of Planning and Performance, Sheffield Health and Social Care NHS Trust	April 2015	Committee comments will be published as part of final Quality Account.
Sheffield Children's Hospital, Annual Quality Account	The Committee is required to comment on the Quality Accounts of providers of health services in the City	John Reid, Director of Nursing and Clinical Operations, Sheffield Children's Hospital.	April 2015	Committee comments will be published as part of final Quality Account.
Sheffield Teaching Hospitals NHS Foundation Trust – Annual Quality Account	The Committee is required to comment on the Quality Accounts of providers of health services in the City	Sandi Carman, Head of Patient and Healthcare Governance.	April 2015	Committee comments will be published as part of final Quality Account

Yorkshire Ambulance Service Annual Quality Account	The Committee is required to comment on the Quality Accounts of providers of health services in the City	Gareth Flanders, Head of Quality	April 2015	Committee comments will be published as part of final Quality Account
Date TBC				
Right First Time Programme.	Minutes from 17th September 2014: the committee requests a progress report on the Right First Time Programme. including details of patient feedback, and the communication and informatics workstreams.	Kevan Taylor Sheffield Health & Social Care Foundation Trust	Tbc	
Dementia Strategy Update	Minutes from the meeting on 15th October request an update on the dementia strategy in 6 months, to include information on prevention.	Sarah Burt, Senior Commissioning Manager, NHS Sheffield CCG.	Tbc	
NHS 5 Year Forward View – NHS Sheffield CCG response	Update on Sheffield's response to the NHS 5 Year Forward view.	Tim Furness, NHS Sheffield CCG	tbc	

Update on the transition from residential to supported living in the learning disability service (minutes 17/12/14)	To receive an update on how the transition has gone, to include comments from service users, families and the independent advocacy service	Joe Fowler, Director of Commissioning	June 2015	
Update on the development of a voluntary code of conduct for supported living (minutes 17/12/14)	To receive a progress report on developing the code.	Joe Fowler, Director of Commissioning	June 2015	
Alternatives to A&E Services in Sheffield	Understand what the alternatives to A&E in Sheffield are and how they are being promoted.		tbc	
End of Life Care – access to services.	Update on the work and action plan undertaken by Public Health to identify whether certain groups and communities have difficulty in accessing services.	Marianna Hargreaves, NHS Sheffield CCG	June 2015	

A Guide to Health Scrutiny in Sheffield	Presenting the final draft health protocol for approval by the Scrutiny Committee.	Cllr Mick Rooney, Chair	tbc	
Transitions within the CAMHS service	There was a recommendation in the CAMHS Working Group Report to include this topic on the work programme for 2014-15.	Anthony Hughes (CYPF), Tim Furness (CCG), Steve Jones (SCH)	tbc	
Commissioning Primary Care	Minutes from 17th July 2013 the Scrutiny Committee identifies the need for discussions with the National Commissioning Board's Local Area Board regarding GP practices in the City, including the numbers, location and skill mix." Public Question – 17th Dec 2014 re NHS England's approach to commissioning GP Services.	tbc	tbc	
Sheffield Adult Safeguarding Partnership	15th January 2014 6.4 (c.) (iiii) Susan Fiennes shares details of any steps taken to improve safeguarding procedures, in the light of the Winterbourne Care Home	Sue Fiennes, Simon Richards	June 2015	

	case, with Members of this Committee when available			
Briefing Papers				
Sheffield Adult Safeguarding Partnership - Annual Report 2012/13	Minutes from15th January 2014, the Committee requests that the Sheffield Adult Safeguarding Partnership (iii) provide a progress report to the Committee on a quarterly basis.	Simon Richards, Head of Quality & Safeguarding & Sue Fiennes, Independent Chair	(April 2014) July, Oct 2014, Feb 2015	
Task & Finish Work				
CAMHS Working Group	Report finalised and response received. Awaiting Submission to Health and Wellbeing Board	Emily Standbrook-Shaw, Policy and Improvement Officer		

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