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

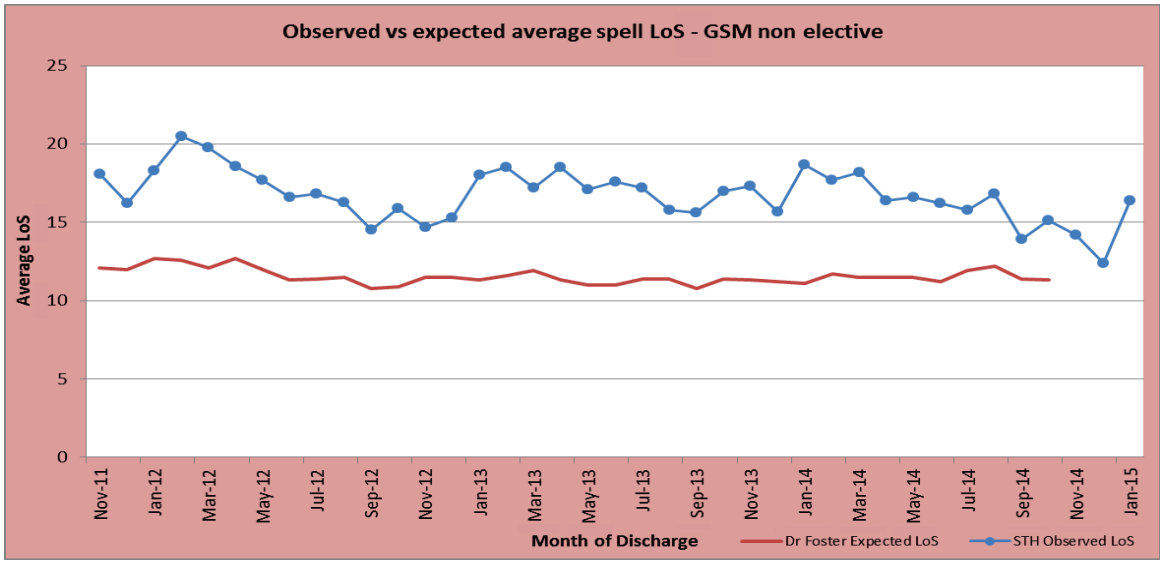
2.2.1 Optimise Length of Stay (LoS)

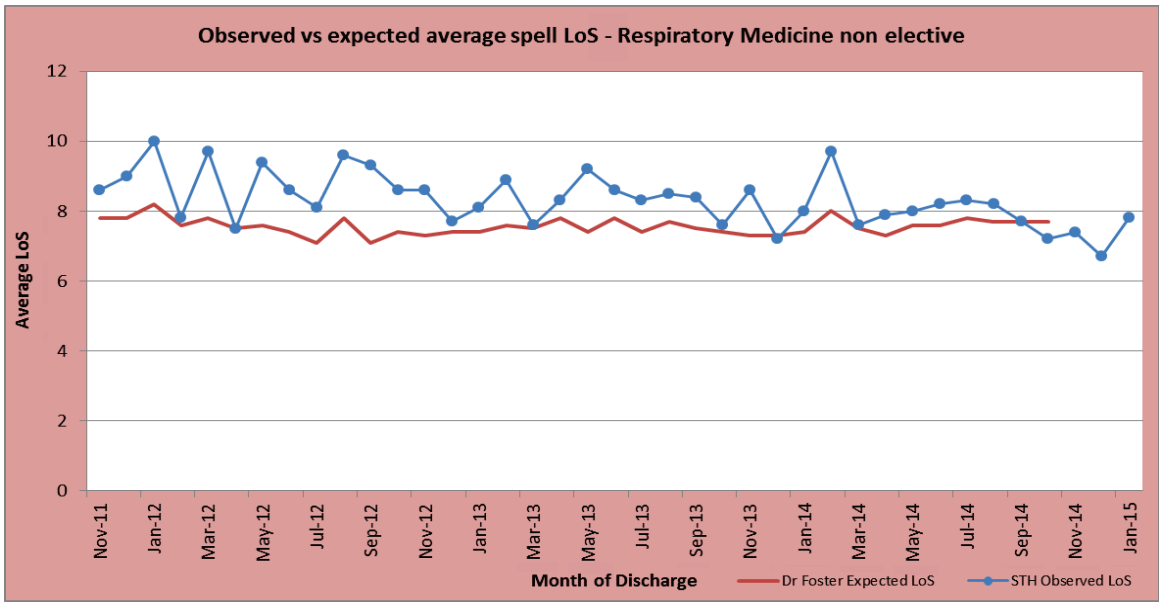
Reducing unnecessary hospitalisation for patients, through focusing on length of stay, represents an opportunity to improve quality and patient experience. Significant work has been done to understand the current situation and progress at specialty level. Analysis has been undertaken for each specialty 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.

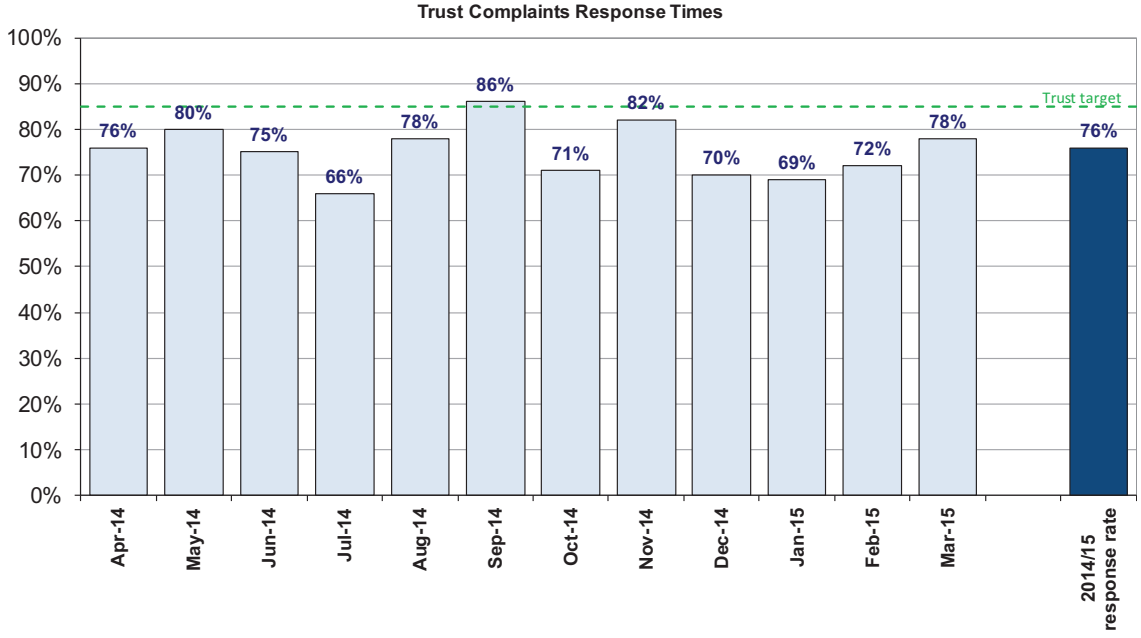
A new approach to auditing the quality of the complaints service against the standards we have set and patients' expectations was introduced in 2014. The Trust interviewed patients and families to understand their experience of the complaints process, and carried out a review of the complaint file in 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.

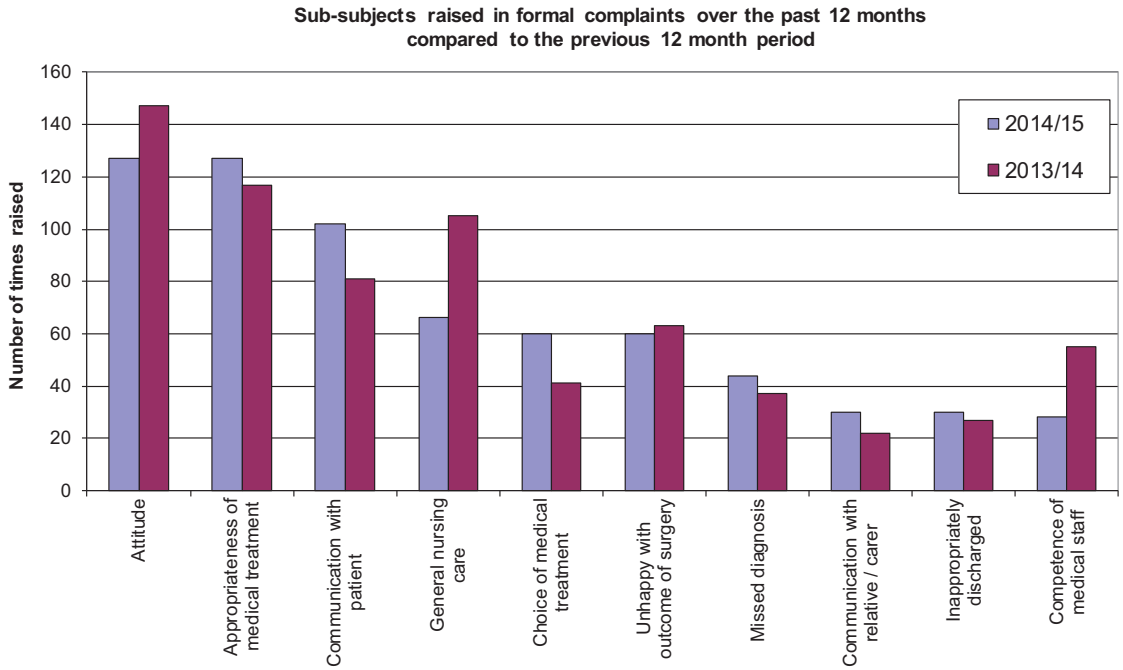
The Trust has taken part in the Patients Associations National Complainant Satisfaction Survey since 01 April 2014. The survey aims to provide an understanding of the experience of people making a complaint about the Trust. Results are benchmarked against other Trusts participating in the survey.

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