Public Document Pack

# Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee (Special)

## Thursday 10 April 2014 at 12.00 pm

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

**The Press and Public are Welcome to Attend**

**Membership**

Councillor Mick Rooney (Chair), Sue Alston, Janet Bragg, John Campbell, Katie Condliffe, Roger Davison (Deputy Chair), Tony Downing, Adam Hurst, Martin Lawton, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright

**Healthwatch Sheffield**
Helen Rowe and Alice Riddell (Observers)

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

Sheffield City Council

## PUBLIC ACCESS TO THE MEETING

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

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

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

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

If you require any further information about this Scrutiny Committee, please contact Matthew Borland, Policy and Improvement Officer on 0114 27 35065 or email matthew.borland@sheffield.gov.uk

## FACILITIES

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

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

# HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
# 10 APRIL 2014

## Order of Business

**1. Welcome and Housekeeping Arrangements**

**2. Apologies for Absence**

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

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

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

**6. Sheffield Teaching Hospitals NHS Foundation Trust - Quality Account 2013/14** (Pages 5 - 62)
Report of Dr David Throssell, Medical Director, Sheffield Teaching Hospital NHS Foundation Trust

**7. Sheffield Health and Social Care NHS Foundation Trust - Quality Account 2013/14** (Pages 63 - 106)
Report of Jason Rowlands, Director of Planning, Performance and Governance, Sheffield Health and Social Care NHS Foundation Trust

**8. Child and Adolescent Mental Health Service (CAMHS) Working Group Report** (Pages 107 - 118)
Report of Diane Owens, Policy and Improvement Officer

**9. Date of Next Meeting**
The next meeting of the Committee will be held on a date to be arranged

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## ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

New standards arrangements were introduced by the Localism Act 2011. The new regime made changes to the way that members' interests are registered and declared.

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

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

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

You **must**:

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

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

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

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

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

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -
  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

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

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

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

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

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

  (b) either -

  the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or

  if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in

land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

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

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously, and has been published on the Council's website as a downloadable document at -http://councillors.sheffield.gov.uk/councillors/register-of-councillors-interests

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

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

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

Further advice can be obtained from Lynne Bird, Director of Legal Services on 0114 2734018 or email **lynne.bird@sheffield.gov.uk**

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# Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
# 10th April 2014

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

**Subject:** Quality Report 2013/14

**Author of Report:** Sandi Carman
Head of Patient and Healthcare Governance
Sandi.carman@sth.nhs.uk
0114 22 66489

**Summary:**
Foundation Trusts are required to produce an Annual Quality Report, which sits alongside the Annual Report, and specific reporting requirements are detailed in Monitors NHS Foundation Trust Annual Reporting Manual 2013/2014.

The Quality Report has two key aims; to report on the quality of services delivered by Sheffield Teaching Hospitals in the year 2013/14 and to identify the Quality Report Objectives for 2014/15.

A draft of the Quality Report 2013/14 has been produced and is enclosed for the Committee to consider and provide views, comments and recommendations on the contents of the report. The most up to date data has been used, where available, throughout this report. Please note that in most cases this is quarter 3 data (the first 3 quarters of the financial year 2013/14) which will be updated when the data becomes available. Figures and sections that require updating are marked in red.

The Quality Report is made up of 4 parts:

**Part 1**
A statement on quality from the Chief Executive and the Medical Director.

**Part 2**
**Priorities for improvement** – the forward looking section of the report where the Trust documents the objectives for quality improvement within 2014/15 and why we have chosen these priorities. This section also includes an update on priorities set for 2012/13 and 2013/14.

**Statements relating to quality of NHS services provided** – content common to all providers which makes the accounts comparable between organisations and provides assurance that the Board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

**Part 3**
**Review of quality performance** report on the previous year's quality performance

**An explanation of who you have involved** and engaged with to determine the content and priorities contained in your Quality Account.

**Part 4**
Response to partner organisation comments following the Quality Report 2012/13 and provider organisation comments on the Draft Quality Report 2013/2014.

It is recognised that the objectives for 2014/15 in Part 2 cover only a small part of the improvement work in place across the organisation, and many other initiatives are reported within the Monitor Operational Plan and other external publications.

In order to identify the four priority objectives, a review has been completed of the key areas for action arising out of the Government final response to the Mid-Staffordshire Public Inquiry. Scoping work has also been undertaken looking at the national areas for improvement (such as mortality rates) and local initiatives such as responses from Trust surveys. Following this analysis and subsequent discussion with the Quality Report Steering Group and other parties the following Quality Report Objectives for 2014/15 are proposed:

1. To ensure that 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.
2. To improve complainant satisfaction with the complaints process.
3. To Review Mortality rates at the weekend.
4. To review the impact of waiting time on the patient experience (specifically patients waiting over 18 weeks for treatment).

These have been updated following suggestions made at the last Committee meeting.

The overall report production is supported by the Quality Report Steering Group which advises on content, format and design. The Quality Report Steering Group membership is supported by a number of Trust Governors who contribute widely to the process of production. The final Quality Report requires presenting to the Board of Directors in May 2014. In line with statutory requirements the draft Quality Report and various supporting documents will be submitted to KPMG for external assurance and audit.

A more accessible version of the quality report developed in collaboration with Trust Governors and Healthwatch representatives will be produced again this year and this will be shared with Scrutiny Committee members when available.

The Quality Report 2013/14 is presented to the Scrutiny Committee to request their views and comments.

**Type of item:**

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

**The Scrutiny Committee is being asked to:**

The Committee is asked to consider the Quality Report 2013/14 and provide views, comments and recommendations on the contents of the report.

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**Background Papers:**

Monitor NHS Foundation Trust Annual Reporting Manual 2013/14
Quality Account: Reporting Requirements for 2013/14- Gateway Reference No. 00931
Quality Account: Reporting Requirements for 2013/14- Gateway Reference No. 18690
Monitor detailed requirements for quality reports 2013/14
Quality Accounts a Guide for Overview and Scrutiny Committees
National Clinical Audits for Inclusion in Quality Accounts 2012/13

**Category of Report:** OPEN

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# Quality Report 2013/14

**Part 1**
A statement of quality from the Chief Executive and the Medical Director.

**Part 2**
Priorities for improvement.

Statements relating to quality of NHS services provided.

**Part 3**
Review of quality performance report on the previous year's quality performance

An explanation of who you have involved and engaged with to determine the content and priorities contained in your Quality Account.

**Part 4**
Response to partner organisation comments following the Quality Report 2012/13

The most up to date data has been used, where available, throughout this report. Please note that in most cases this is quarter 3 data (the first 3 quarters of the financial year 2013/14).

Version 4.0 26th March 2014

### 1.1 Statement on quality from the Chief Executive

At Sheffield Teaching Hospitals we remain committed to delivering good clinical outcomes and a high standard of patient experience to patients both in our hospitals and in the community. Thanks to the dedication and professionalism of our 15,000 staff we have a strong track record in this area but 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.

Throughout 2013/14 there have been further improvements in the quality of our care such as a reduction in healthcare associated infections, specifically a reduction in Clostridium Difficile rates which is now at an all-time low.

During 2013 more than £3 million pounds was invested in expanding the Accident and Emergency Department at the Northern General Hospital to provide a better patient experience and to accommodate the growing numbers of people using our service. In this time attendance at our Accident and Emergency Department remained high, however our waiting times improved. In 2012/13, 93.2% of patients were seen within four hours or less but in 2013/14 this rose to 95.5%.

In September 2013 the Care Quality Commission (CQC) conducted a routine unannounced inspection of the Trust. Inspectors visited Jessop Wing, Royal Hallamshire Hospital, Northern General Hospital and Weston Park Hospital to observe care on wards and in theatres.
The inspection reports were very positive and the Trust was found to be compliant with all the standards that had been inspected. Where the inspectors commented on areas where care or patient experience could be enhanced even further, we have developed our own internal action plan to achieve this wherever possible.

Ensuring waiting times are kept as low as possible is a priority 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. During 2013/14 we carried out a planned review of Cancer Waiting Times in response to the CQC inspection into Colchester Cancer Services and waiting times. The Trust is satisfied that similar issues are not present in our services and we continue to do all we can to ensure patients do not wait any longer than necessary for care.

We also take great care to accurately report waiting times for treatment to assist patients in making an informed choice about where to have their treatment. We have undertaken a review of our waiting lists to ensure that they correctly reflect the patients that still require treatment. We have also published a revised policy titled “Access Policy - Managing the 18 Weeks Referral to Treatment Waiting Times”. Implementation of the revised policy will ensure we continue to provide fair and equitable access for patients.

An area of improvement this year has been the reduction in the number of ‘Never Events’ within the Trust. In 2012/13 we regrettably had seven Never Events. Clearly our aim is to do everything possible to limit the chances of Never Events happening at all and during 2013/14 the Trust developed and implemented a Never Event action plan which brought together the lessons learned and actions from each of the seven individual incidents. This improvement work has resulted in a drop in Never Events, with four incidents reported during 2013/14. However we aim to reduce this even further during 2014/15.

Seeking and acting on patient feedback remains a high priority for the Trust. Our overall performance in national surveys consistently compares well against other trusts and, for key areas where performance is lower, actions are agreed to make improvements. Our Frequent Feedback surveys allow us to look in more detail at patient feedback at individual ward level. By focussing on a small number of important aspects of patient experience, we have seen improvements in these key areas. In the new Friends and Family Test, our scores consistently compare well nationally and we are now seeing improvements in our response rates through new initiatives including surveying some patients by text. We are planning work throughout the year to further improve the effectiveness of the complaints process. During 2014/15 we shall be working with the Patients' Association to survey all those who make a complaint to provide them with an opportunity to tell us about their experience.

The official Government response to the Mid-Staffordshire Public Inquiry 'Hard Truths' has now been published outlining how the whole health and care system will prioritise and build upon the previous work already undertaken following the Robert Francis QC report. As a Trust we have outlined our response to the Mid-Staffordshire Public Inquiry in Part 2 of this Quality Report. We have also selected one of our key quality objectives for 2014/15 directly from the Government's 'Hard Truths' paper. This is to ensure that every hospital patient should have the name above their bed of the consultant and nurse responsible for their care. More details can be found in Part 2 of this Quality Report.

Good staff engagement and involvement is key to the Trust's ongoing delivery of high quality care. In response to staff feedback a number of initiatives have been taken up throughout the year including the introduction of uniforms for Nurse Directors, and senior nursing staff to ensure patients and staff can easily recognise senior nursing staff. All Nurse Directors and the Chief Nurse, already carry out clinical shifts on wards every month to ensure they continue to experience first-hand the care being delivered and also to understand the challenges and opportunities nursing teams face. Throughout 2014 this initiative will be expanded to involve other senior managers who will also work alongside members of staff from a variety of clinical and non-clinical departments in order to further their understanding of the patient and staff experience.

In 2013/14, the Trust approved a £35 million pound investment in technology which will provide the opportunity to transform the way we deliver care both within the hospital and also in people's own homes and communities. This 5 year programme will also enable the organisation to become paperlight 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 improve patient safety and our communication with patients, increase operational effectiveness (releasing time to care) as well as supporting clinical practice and research.

The following pages detail more of the improvements we have made during 2013/14 and also some of our key priorities for the coming year. However, 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 2014/15.

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

### 1.2 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 2013/14. 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.

As a Trust we have consulted widely on which quality improvement priorities we should adopt for 2014/15. As with previous Quality Reports, the quality improvement priorities have been developed in collaboration with representatives from NHS Sheffield Clinical Commissioning Group, Healthwatch Sheffield and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee. We have held several meetings with Healthwatch enabling us to incorporate their comments and feedback in the production of this Quality Report, and have also taken into account the comments and opinions of internal and external parties on the 2012/13 Report.

The Quality Report Steering Group, whose membership includes Trust managers, clinicians and Governors, oversees this work. The remit of the steering group is to decide on the content of the Quality Report and to ensure that the Trust's quality improvement priorities are practical and achievable and address the key elements of quality including patient safety, the effectiveness of clinical treatment and patient experience. Meeting the regulatory standards set out by the Department of Health and Monitor, the Independent Regulator for Foundation Trust, also forms part of this group's remit.

The proposed quality improvement priorities for 2014/15 were agreed by the Trusts Board of Directors on 22 May 2014. The final draft of the quality report was sent to external partner organisations for comments in March 2014 in readiness for the publishing deadline of the 30 May 2014.

**Part 2**

**2.1 Priorities for Improvement 2013/14 and 2012/13**

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

| | | 2012/13 | 2013/14 |
|---|---|---|---|
| 2012/13 Objectives | **Optimise Length of Stay (see 2.1.1)**<br>Through a systematic process of review areas will be identified for improvement across the organisation. National benchmarks (Dr Foster benchmark comparators) will be used to assess areas where the length of stay could be appropriately reduced without impact on the quality of care or outcomes. | ▼ | ▼ |
| | **Discharge letters for GPs (see 2.1.2)**<br>Improve the quality of immediate discharge letters sent to General Practitioners (GPs) by auditing the content of letters within each Directorate against parameters agreed with NHS Sheffield. Deficiencies identified during this process will be addressed by actions at Directorate and Trust level. | = | ▲ |
| | **Giving patients a voice - Make it easier to communicate with the organisation (see 2.1.3)**<br>Making what we've got work well - to improve the response rate for frequent feedback forms by 20% and for comments cards by 50%. This has been achieved by more effective publicity to encourage patient feedback and communicating that improvements have been made as a consequence of patients views/suggestions,(e.g. 'you said - we did'). | ▲ | See 2.1.3 |
| | **Review Mortality rates at the weekend (see 2.1.4)**<br>Review in detail the Trusts position with regard to Mortality at the weekend and identify any significant differences, review causes and implement improvements if required. | ▲ | ▲ |
| | **Improve Dementia awareness (see 2.1.5)**<br>The Trust is dedicated to improving dementia awareness with our staff and meeting the needs of patients and carers with this condition. We will undertake environmental audits across all appropriate directorates so that improvement plans can be developed to address the needs of patients and carers experiencing dementia. (Link to the Kings Fund Dementia work and ward essential maintenance programme). | ▲ | ▲ |
| 2013/14 Objectives | **Patient Experience: Cancelled Operations (see 2.1.6)**<br>Reduce the number of operations cancelled on the day of surgery. | New for 2013/14 | ▼ |
| | **Patient Safety: Pressure Ulcers (see 2.1.7)**<br>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 | ▼ |
| | **Clinical Effectiveness (outcomes): Improve discharge information for patients (see 2.1.8)**<br>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 | ▲ |

**Key:**

| | | |
|---|---|---|
| = Almost achieved | = Achieved | = Behind Schedule |

**Update on objectives 2012/13**

**2.1.1 Optimise Length of Stay**

[DN: Performance data to be added]

A number of initiatives have been introduced to facilitate patient flow, including meetings where patients with a length of stay over 15, 35 and 56 days are reviewed and action taken to resolve any unnecessary delays. Daily and weekly review of patients who are medically fit for discharge and regular monitoring of medical outliers 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. A number of new Flow Matron posts have been introduced to support improved flow across the organisation.

In addition, 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. Furthermore, the Trust has committed to integrating the Community Services and Geriatric and Stroke Medicine Directorates from April 2014 to help streamline pathways for older people. This should in turn help improve the seamlessness of pathways, and support efforts to reduce hospital length of stay.

**2.1.2 Discharge letters for GPs**

The Trust has completed the rollout of e-discharge summaries which enable clinicians to fill in an electronic discharge template, helping to speed up the delivery and improve the discharge information available to GPs. This is automatically populated with key patient information, a significant area for improvement which was identified in the original review. Each week reports are sent to consultants where discharge summaries have not been completed, so this can be rectified as a priority.

Sheffield Clinical Commissioning Group have surveyed GPs to look at the impact of the new e-discharge summaries with some very positive feedback being received. Evaluation will continue and any areas for improvement will be address by the project team.

**2.1.3 Giving patients a voice - Make it easier to communicate with the organisation**

During 2013/14, 4722 Frequent Feedback surveys and 596 comment cards were completed. This compared with 4914 Frequent Feedback surveys and 2857 comment cards completed during 2012/13. Whilst comment cards are still widely available across the Trust, we are no longer distributing these to patients through our volunteers, as the new Friends and Family Test (FFT) is now the priority. We decided that to give the comment cards out at the same time as the FFT cards would be confusing for patients. In the FFT, we are now seeing improvements in our response rates through new initiatives including surveying some patients by text.

**2.1.4 Review Mortality rates at the weekend**

The Trust has continued to review weekend mortality during 2013/14, finding that our Hospital Standardised Mortality Ratio for weekday and weekend emergency admissions are 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 2014/15.

Working in collaboration with the Improvement Academy of the Yorkshire and Humber Academic Health Science Network the Trust is exploring the potential for external case note review of a sample of deceased patients. It is anticipated that this work will provide further insights and learning. This work also aligns with the stated intentions of NHS England in response to the Mid-Staffordshire Public Inquiry outcomes.

**2.1.5 Improving Dementia Awareness**

The Trust is dedicated to improving dementia awareness. A discreet symbol is being developed to enable staff to easily recognise patient suffering with dementia. This symbol will then prompt staff to refer to a booklet filled in by the patient, or anyone that may know them well such as their family or carers. This 'All About Me' booklet describes the patient's preferences, needs and routines and is kept by the bedside to allow staff easy reference during routine interactions.

At the Northern General Hospital, Vickers 4 is undergoing an improvement scheme which includes adding a bathroom to the building, as all other facilities are wetrooms with showers. Bedside televisions have been removed from certain areas to avoid causing some patients confusion and distress, though this is reviewed on an individual basis.

A specific session on dementia awareness is to be added to the Trust induction for all members of staff, both clinical and non-clinical from April 2014. More comprehensive training is available for those who regularly care for people with dementia to ensure they are equipped to care for this patient group.

**Objectives 2013/14**

**2.1.6 Patient Experience - Cancelled operations**

In 2012/13 6.5% of planned operations were regrettably cancelled on the day (clinical and non-clinical reasons) of surgery. The top five reasons for cancellations at the Trust account for 65% of all on-day cancellations at the Trust and these are:

- patient unfit
- patient did not attend
- operation not required
- patient cancelled or refused treatment
- lack of theatre time.

Although we fell short of our target to reduce this figure to 4% by April 2014, the number of cancellations was less than in 2012/13.

| Year | Cancelled Operations |
|---|---|
| 2011/12 | 1106 |
| 2012/13 | 1161 |
| 2013/14 | 955 (Q3) |

The target figure of 4% is a locally driven target and was agreed at the Trust's Surgical Board following an audit.

To achieve this target by 2015 a number of actions are underway, including trialling a system in Orthopaedics and General Surgery whereby nurses call patients at three days' notice to confirm their intended attendance. In high volume and cost areas such as Orthopaedic Surgery, Plastic Surgery, General Surgery and Ophthalmology, root cause analysis of cancellations will be a weekly exercise and key trends will be identified to inform improvement actions.

We have shortened the patient letters in Orthopaedics and the Day Surgery Unit and patients are asked to confirm by telephone that they will be keeping their appointment. Instructions regarding not eating before an operation are clearer than before and much of the information that was previously in the letter is now sent out in an inpatient handbook so the letter is focused on the admission details only. A similar review of letters is taking place in General Surgery.

Posters providing patient information on how to ensure their operation goes ahead as planned have been displayed in pre-operative assessment areas. Plans are underway for a patient information campaign on cancellation avoidance and the cost and impact of on-day cancellations.

The Surgical Pathway Group will discuss, develop and implement a patient information campaign regarding avoidable on-day cancellations and also a trial of text messaging for admissions. A cancellation policy will be discussed by the Surgical Board to detail the actions to be taken where no verbal confirmation can be made with patients in the days before their planned admission.

**2.1.7 Patient Safety - Pressure Ulcers**

[DN: Performance data to be added]

In order to try to reduce the prevalence of pressure ulcers from 5.95% in 2012/13 to 5% the Trust has established a project board, strengthened the Hospital Tissue Viability Team, effectively managed the supply of pressure relieving devices and improved data quality and information.

Further work within the hospitals is planned including the identification of patients at risk of developing a pressure ulcer, instigation of early intervention by the Pressure Ulcer Prevention Team, and targeted work with clinical areas with a high prevalence of pressure ulcers.

Initiatives have also been undertaken by the Hospital Tissue Viability Team in the community and include:

- an audit of practice against National Institute for Health and Care Excellence (NICE) recommendations for pressure ulcer prevention and pressure relieving equipment
- the implementation of an electronic wound template within the patient's electronic record (Systm1), where wound details and grade of pressure ulcer can be recorded
- the introduction of cameras to enable wound imaging, which can be attached to the electronic record and viewed remotely by the Tissue Viability Team
- work with the care home support team to develop, support and provide education to pressure ulcer link workers in care homes.

Further work is planned including a project for a Tissue Viability Nurse to work alongside a community team to understand the prevalence of pressure ulcers within their patient group.

The Tissue Viability Nurse will:

- consider the grade, chronicity and anatomical location of pressure ulcers
- evaluate the accuracy and completeness of risk assessments and review, and prevention care planning
- assess staff skills in pressure ulcer prevention, accuracy of reporting and grading and the use of the electronic template and wound images
- review progress with previous root cause analysis work and the implementation of the action plans developed as a result of previous pressure ulcers.

Work also continues to improve the quality of the data recorded and the information available to the clinical areas. Currently the information used to measure performance against the Commissioning for Quality and Innovation (CQUIN) target is taken from the Safety Thermometer (A national data collection instrument that collects incidence data once a month across all patients, hospital and community). This data collection tool has a number of limitations and work is underway in the Trust to enhance the information collected in order to better inform patient care.

**2.1.8 Clinical Effectiveness (Outcomes) - Improving discharge information**

Since May 2013, 458 patient information leaflets have been checked and revised. Of these 193 (42%) have had changes made to their discharge information. This work will be ongoing until all 1,500 leaflets within the Trust have been checked and updated. Due to the volume of leaflets it is anticipated that it will take a further 18 months before this work is completed.

Audit work identified two departments where discharge information could be more effective (Accident and Emergency Department and Urology Department). Both have received support to make improvements to their information.

All patient information leads/coordinators have been asked to review the practice of providing patients with information within their department/care group. In particular they have been asked to ensure that information is routinely given to patients upon discharge. A more robust mechanism for routinely providing discharge information is currently being investigated with the I.T department. This would involve adding details of patient information leaflets to the electronic discharge summary. This is likely to be a significant project and will need further planning during 2014/15.

Work is also currently underway to improve access to patient information via the Trust website. This will ensure patients and their families have access to leaflets after they have been discharged. Online access to patient information will be available by the end of April 2014.

**2.1.9 Priorities for Improvement 2014/15**

This section describes the Quality Improvement Priorities that have been adopted for 2014/15. These have been agreed by the Quality Report Steering Group after discussion with patients, clinicians, Governors, Healthwatch and Commissioners. These were approved by the Trust Board of Directors on 22 May 2014. The Trust has compared 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 2014/15 are:

1. To ensure that 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.
2. To improve complainant satisfaction with the complaints process.
3. To review mortality rates at the weekend.
4. To review the impact of waiting times on the patient experience (specifically patients waiting over 18 weeks for treatment).

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 Part 2).

**2.1.10 Detailed objectives linked to Improvement Priorities**

**Priority 1**

| | |
|---|---|
| **Our Aim** | To ensure that 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 |
| **Past Performance** | Whilst previously many ward areas used small notice boards above the bed to indicate the patient name and consultant, usage is now variable across the Trust. These were stopped in some areas due to concerns about confidentiality. However, where the boards are used they do not usually specify the nurse responsible for the patient's care on each shift. |
| **Key Objectives** | 1. To discuss this concept with senior sisters from across the Trust.<br>2. To form a small working party to agree the standards for displaying the information about the consultant and the nurse, and to lead on delivering objectives 3-6 below.<br>3. To consider options for practical ways of displaying this information, recognising that the physical environment of departments may differ.<br>4. To ensure that procedures for gaining appropriate consent to display the patient's name are put in place, and that the patient or their family are consulted about how the patients name should be displayed, e.g. first name and surname or title and surname.<br>5. To ensure that the initiative is implemented across hospital inpatient areas through 2014/15.<br>6. To consider how compliance with this standard can be monitored. |
| **Measurement and Reporting** | Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2014/15. |
| **Board Sponsor** | **Professor Hilary Chapman**<br>Chief Nurse |
| **Implementation Lead** | **Chris Morley**<br>Deputy Chief Nurse |

**Priority 2**

| | |
|---|---|
| **Our Aim** | To improve complainant satisfaction with the complaints process |
| **Past Performance** | Whilst satisfaction surveys of complainants are currently used, these are ad hoc and do not always provide enough detail to ascertain exactly where improvements are required. A new process was implemented in March 2014, whereby a sample of 30 complainants will be interviewed every 12 months, and from April, all complainants will receive the Patients' Association complainant satisfaction survey. This will provide baseline data and an ongoing measure of changes over the next 12 months. In addition, the survey will enable benchmarking against other trusts who also participate in the survey programme. |
| **Key Objectives** | 1. To establish a baseline measure of complainant satisfaction for the following key measures:<br>• % of respondents who feel their complaint against the Trust has been resolved<br>• % who feel their complaint was dealt with quickly enough<br>• % who were 'very satisfied' with the final response<br>• % who feel that overall their complaint was handled 'very well'<br>2. To benchmark performance in relation to key measures with other trusts<br>3. To set improvement targets for each measure and agree an action plan to work towards achieving these<br>4. To measure and report performance against improvement targets. |
| **Measurement and Reporting** | 1. Working with the Patients' Association, baseline satisfaction will be measured from April 2014 by means of a survey sent to all complainants. In addition, a sample of 30 complainants will be interviewed during March 2014 and January 2015.<br>2. An interim report will be provided in October 2014, when the first survey baseline and benchmark data is available.<br>3. A report on performance against targets will be produced when the next survey data is available in April 2015. |
| **Board Sponsor** | **Professor Hilary Chapman**<br>Chief Nurse |
| **Implementation Lead** | **Mrs Sue Butler**<br>Head of Patient Partnership |

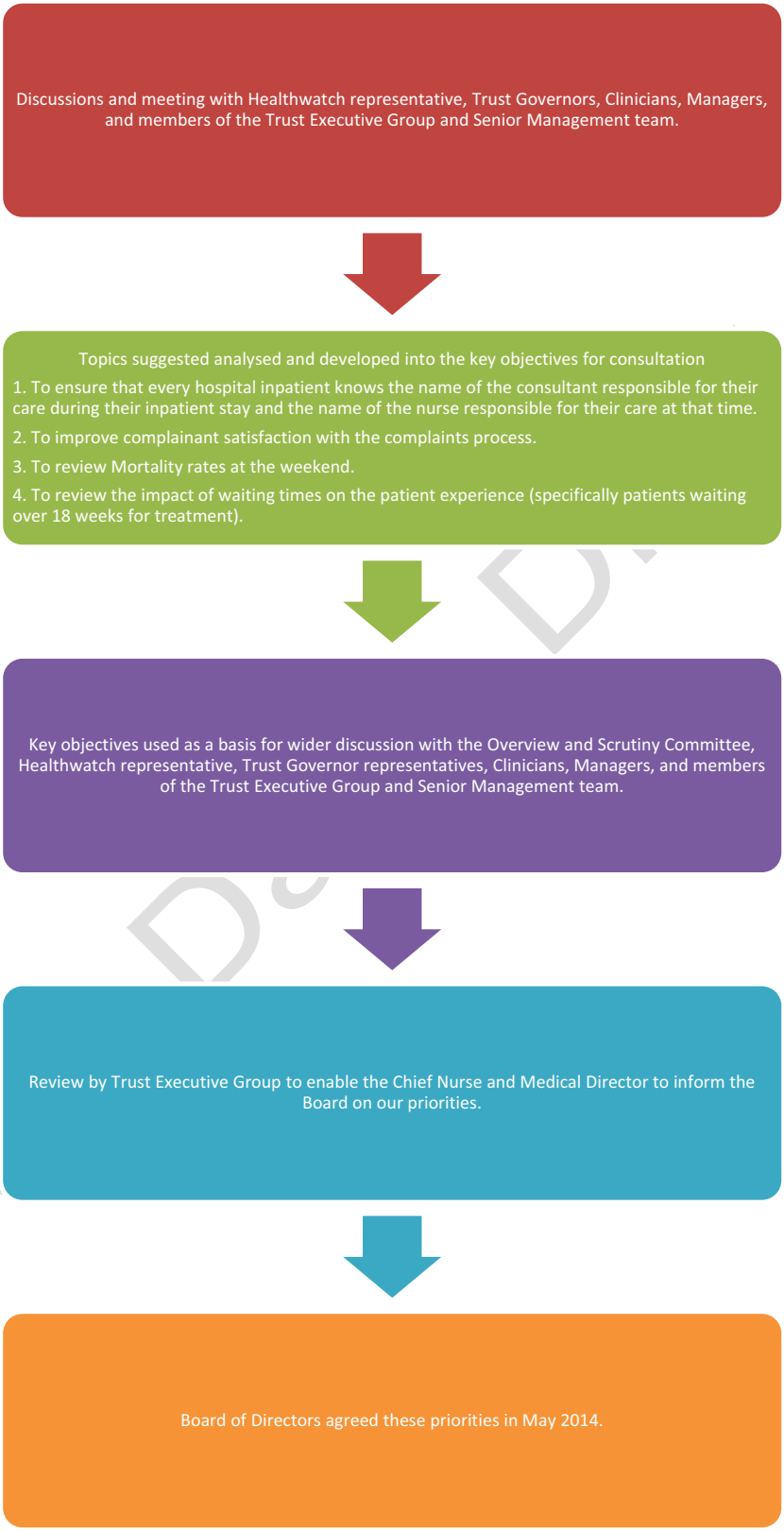
**Priority 3**

| | |
|---|---|
| **Our Aim** | To review Mortality rates at the weekend |
| **Past Performance** | This theme was a Quality Objective for the Trust in 2012/13 at which time the Trust reported:<br>*'When looking specifically at weekend mortality there is variation in mortality rates depending on day of admission. This variation is anticipated and does not result in a mortality rate that can be described as 'higher than expected'. When reviewed against similar Trusts and comparing the range of variation possible the Trusts score is in the middle (i.e. average)'*<br>Quality Report 2012/13 pg. 39.<br><br>Since this time the Trust has continued to develop its methods of analysis and there is a possibility that further understanding could be gained. In addition, it has become clear during discussions with Governors that some patients are reluctant to undergo surgical procedures on Fridays because of a perception that the risk of postoperative problems will be higher over the following weekend. Some patients decline surgery at the end of the week for this reason.<br><br>Working in collaboration with the Improvement Academy of the Yorkshire and Humber Academic Health Science Network the Trust is exploring the potential for an external review of a sample of case notes of deceased patients. It is anticipated that this work will provide further insights and learning. This work also aligns with the stated intentions of NHS England in response to the Mid-Staffordshire Public Inquiry outcomes. |
| **Key Objectives** | 1. In collaboration with the Mortality Steering Group, to put in place a process to which will allow the external review of a sample of patient notes to be carried out.<br>2. To analyse and interpret the findings to establish if any lessons can be learnt.<br>3. Depending on the findings, to establish improvement work streams to address the areas for improvement. |
| **Measurement and Reporting** | Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2014/15. |
| **Board Sponsor** | **Dr David Throssell**<br>Medical Director |
| **Implementation Lead** | **Dr Andrew Gibson**<br>Deputy Medical Director |

**Priority 4**

| | |
|---|---|
| **Our Aim** | To review the impact of waiting times on the patient experience (specifically patients waiting over 18 weeks for treatment). |
| **Past Performance** | Waiting for an appointment or treatment can be stressful for the patient and their carers and may significantly impact on the overall patient experience. There is a national target which specifies that the length of time between first referral and treatment should be no longer than 18 weeks. The Trust has a number of plans and strategies in place to reduce the length of time spent waiting for an appointment or treatment.<br><br>Our current 18 week performance is detailed on page XX<br><br>Patient experience information can be obtained from<br>• Inpatient and outpatient questionnaires<br>• Frequent Feedback surveys<br>• Friends and Family Test information<br>• Analysis of Complaints<br><br>However this information is not specific to patients waiting over 18 weeks for treatment and may not be representative of the overall situation. |
| **Key Objectives** | April – June<br>• Review all the feedback sources and identify a suitable method of obtaining patient feedback in relation to waiting for an appointment or treatment<br>• This may include designing and implementing a bespoke survey to further understand the impact on patient experience for patients.<br>• Baseline data to be collected using the most appropriate method.<br>July – Sept<br>• Analyse and interpret the findings to establish if any lessons can be learnt.<br>• Areas for improvement identified during this process will be addressed by improvement activities at Directorate and Trust level<br>Oct – Dec<br>Resurvey where indicated and consider the appropriateness of putting in place systems and processes to provide a consistent method of reviewing the experiences of patients who wait for treatment. |
| **Measurement and Reporting** | Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2014/15. |
| **Board Sponsor** | **Professor Hilary Chapman**<br>Chief Nurse |
| **Implementation Lead** | **Mrs Sue Butler**<br>Head of Patient Partnership |

### 2.1.11 How did we choose these priorities?



**Part 2**

**2.2 Statements of Assurance from the Board**

This section contains formal statements from 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 Report (previously Rule 43 report)
m) Response to The Mid Staffordshire NHS Foundation Trust Public Inquiry

**a) Services Provided**

During 2013/14 the Sheffield Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 40 relevant health services.

The Sheffield Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 40 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by the Sheffield Teaching Hospitals NHS Foundation Trust for 2013/14.

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

**b) Clinical Audit**

During 2013/14 37 national clinical audits and 4 national confidential enquiries covered relevant health services that Sheffield Teaching Hospitals NHS Foundation Trust provides

During that period that Sheffield Teaching Hospitals NHS Foundation Trust participated in 94.6% 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 Hospitals NHS Foundation Trust was eligible to participate in during 2013/14 are documented in table 1. The 2 national clinical audits and the Trusts reason for non-contribution this year are detailed later in this section.

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, 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

| **Audit and Confidential Enquiries** | **Participation N/A = Not applicable** | **% Cases Submitted** |
|---|---|---|
| **Acute Care** | | |
| Adult Critical Care (Case Mix Programme - ICNARC CMP) | Yes | |
| Emergency use of oxygen (British Thoracic Society) | Yes | 100% |
| Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death (NCEPOD) | Yes | |
| National Audit of Seizures in Hospitals (NASH) | Yes | 100% |
| National Joint Registry (NJR) | Yes | |
| Paracetamol overdose (care provided in emergency departments) (CEM) | Yes | 100% |
| Severe sepsis & septic shock (CEM) | Yes | 100% |
| Severe trauma (Trauma Audit & Research Network, TARN) | Yes | |
| **Blood and Transplant** | | |
| National Comparative Audit of Blood Transfusion programme (NHS Blood and Transplant)<br>Includes: | | |
| National Comparative Audit of the Use of Anti D | Yes | 100% |
| National Comparative Audit of the Management of patients in neuro critical care | No | See statement |
| **Cancer** | | |
| Bowel cancer (NBOCAP) | Yes | |
| Head and neck oncology (DAHNO) | Yes | |
| Lung cancer (NLCA) | Yes | |
| Oesophago-gastric cancer (NAOGC) | Yes | |
| **Heart** | | |
| Acute coronary syndrome or Acute myocardial infarction (MINAP) | Yes | |
| Cardiac Rhythm Management (CRM) | Yes | |
| Congenital heart disease (Paediatric cardiac surgery) (CHD) | Yes | |
| Coronary angioplasty | Yes | |
| National Adult Cardiac Surgery Audit | Yes | |
| National Cardiac Arrest Audit (NCAA) | No | See statement |
| National Heart Failure Audit | Yes | |
| National Vascular Registry<br>Elements include: | | |
| National Carotid Interventions Audit | Yes | |
| Abdominal Aortic Aneurysm (AAA) | Yes | |
| Peripheral Vascular Surgery -Lower limb angioplasty/stenting. | Yes | |
| Peripheral Vascular Surgery - Lower limb bypass | Yes | |
| Peripheral Vascular Surgery - Lower limb amputation | Yes | |

| | | |
|---|---|---|
| Pulmonary hypertension (Pulmonary Hypertension Audit) | Yes | |
| **Long Term Conditions** | | |
| Diabetes (Adult) ND(A) | Yes | 100% |
| National Diabetes Inpatient Audit (NaDIA) | Yes | 100% |
| Diabetes (Pregnancy) (NPID) | Yes | 100% |
| Diabetes (Paediatric) (NPDA) | N/A | N/A |
| UK Inflammatory bowel disease (IBD)<br>Includes: | | |
| Inflammatory bowel disease Inpatient Audit | Yes | 100% |
| Inflammatory bowel disease biological therapy audit | Yes | |
| Paediatric bronchiectasis (British Thoracic Society)<br>Previously part of the Bronchiectasis audit 2010-13 | N/A | N/A |
| Renal replacement therapy (Renal Registry) | Yes | |
| **Mental Health** | | |
| Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) | N/A | N/A |
| National audit of schizophrenia (NAS) | N/A | N/A |
| Prescribing Observatory for Mental Health (POMH) | N/A | N/A |
| **Older People** | | |
| Falls and Fragility Fractures Audit Programme (FFFAP) | Yes | |
| Sentinel Stroke National Audit Programme (SSNAP)<br>"Programme combines the following audits, which were previously listed separately in<br>QA: a) Sentinel stroke audit (2010/11, 2012/13), b) Stroke improvement national audit project (2011/12, 2012/13)" | Yes | |
| **Other** | | |
| Elective surgery (National PROMs Programme) | Yes | |
| **Women's and Children's Health** | | |
| Child health clinical outcome review programme (CHR-UK) | N/A | N/A |
| Epilepsy 12 audit (Childhood Epilepsy) | N/A | N/A |
| Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) | Yes | |
| Moderate or severe asthma in children (care provided in emergency departments) (CEM) | N/A | N/A |
| Neonatal intensive and special care (NNAP) | Yes | |
| Paediatric asthma (British Thoracic Society) | N/A | N/A |
| Paediatric intensive care (PICANet) | N/A | N/A |

Supporting Statements:

1. **National Comparative Audit of the Management of patients in neuro critical care**
   Due to the short time frame given the Trust was unable to put in place appropriate resources to participate.

2. **National Cardiac Arrest Audit (NCAA)**
   Work continues to improve compliance with completion of local Resuscitation Audit forms. The Trust Resuscitation Committee has deferred NCAA enrolment until 2015 when the changes in the audit process will enable benchmarking with other organisations.

The reports of [number] national clinical audits were reviewed by the Sheffield Teaching Hospitals NHS Foundation Trust in 2013/14 and Sheffield Teaching Hospitals 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:

- The Trust has introduced two major initiatives to help with assessments based around foot care following participation in the National Diabetes Inpatient Audit, the 'Think Glucose' educational programme and the 'Think Foot' initiative. This has included the introduction of a daily foot assessment tool to facilitate timely referrals of patients with foot problems to the multi-disciplinary team and the prevention of new foot problems developing in hospital inpatients.
- Following the National Audit of Dementia the Trust has developed a personal information booklet 'All About Me' which is specifically tailored for use by patients with confusion/dementia and their carers, based on the Alzheimer's Society 'This is Me' booklet. This will provide information for staff to facilitate individualised communication with and care for these patients. The booklet has been piloted on six wards and has been positively evaluated. It is to be introduced across the Trust and incorporated into the Trust's Dementia Training Strategy.
- The Trust has introduced a new Bronchiectasis specific clinic at the Northern General Hospital following completion of the British Thoracic Society National Bronchiectasis audit. The clinic team has also developed a Bronchiectasis Long Term Care Proforma (BLTCP) to ensure all appropriate information is collected at a patient's first consultation. This will improve patient overall care as well as compliance with the British Thoracic Society National Bronchiectasis audit.

**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. The standing agenda item at the Clinical Effectiveness Committee 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 Sheffield Teaching Hospitals NHS Foundation Trust in 2013/14 and Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Actions have been implemented following an audit to improve surgical procedure counts. Pre-printed white boards which identify all the accountable items have been displayed in all theatres, and revised local guidance has been introduced into the Trust. Three-monthly re-audits are to take place as well as feedback and training for staff.
- A three audit cycle on the length of time between referral and completion of dental treatment for children with suspected infectious endocarditis found the average time to have halved to 14 weeks in the third cycle. To reduce this even further the 'Fast-track' patient care pathway (previously introduced in February 2010 following the first audit) has now been updated and is available on all NHS Dental Hospital computers. A re-audit is planned for July 2014.
- After auditing practice against national and local venous thromboprophylaxis guidelines in spinal surgical patients in 2012 a spinal 'inpatient checklist' of tasks that spinal inpatients require has been introduced to improve compliance. A new trust drug prescription chart was also produced to act as a reminder and aid prescription of surgical stockings. Practice was re-audited in September 2013 with all areas seeing an improvement. The audit will be repeated again in June 2014 to ensure compliance is being maintained.

**c) Clinical Research**

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Teaching Hospitals NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was [number] (2012/13-12,142).

International Clinical Trials Day provides a key focus for clinical research. It is an annual global event celebrating the day that James Lind began his famous trial which led to the prevention of scurvy. This year the Trust will once again be raising awareness of the importance of clinical research, what it means, and how to get involved through a series of directorate events focused on the role of research nurses.

The Clinical Research Office and Sheffield's National Institute for Health Research (NIHR) Clinical Research Facility marked International Clinical Trials Day 2014 with a series of fun and interactive events at the 'Life: A festival celebrating medicine, dentistry, health & wellbeing'.

Researchers from across the Trust, including Sheffield's NIHR Clinical Research Facility, opened their doors on International Clinical Trials Day so that members of the public, staff and visits could find out about the vital role clinical research plays in helping us understand how medical conditions work, improve care for patients, and deliver better and more advanced treatments to the clinic quicker and faster.

**d) Commissioning for Quality and Improvement (CQUIN) Framework**

A proportion of Sheffield Teaching Hospitals NHS Foundation Trust income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between

Sheffield Teaching Hospitals 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 2013/14 and for the following 12 month period are available electronically at: www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=327

In 2013/14, 2.5% of our contractual income (£17.5 million) was conditional on achieving Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield.

For 2013/14 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 at the Accident and Emergency Department.

### 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 2013/14.

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

**Routine Inspections**
The Care Quality Commission carried out a routine two-week inspection at the Northern General Hospital, Royal Hallamshire Hospital, Jessop Wing and Weston Park Hospital in September 2013. The Care Quality Commission found the Trust to be meeting all of the standards that were inspected and found evidence of good care and robust governance. No action plan was required.

### f) Data Quality

Sheffield Teaching Hospitals NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:
— which included the patient's valid NHS number was:

99.7% for admitted patient care;
99.7% for out patient care; and
97.2% for accident and emergency care.

— which included the patient's valid General Medical Practice Code was:
99.8% for admitted patient care;
99.8% for out patient care; and
98.7% for accident and emergency care.

Sheffield Teaching Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was [percentage] and was graded [insert colour from IGT Grading scheme].

All relevant Data Quality Controls in the 500 series of the Information Governance Toolkit are graded at green and level 2 or above. Work is continuing by the Trust Data Quality Manager to satisfy the requirements for level 3 where this has not so far been reached.

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

1. Working in collaboration with Leeds Teaching Hospitals NHS Trust, establish a network of Data Quality professionals across Yorkshire and the Humber. Meet as a forum to share good practice and ideas.
2. Undertake a Trust-wide audit of all information systems, in order to establish how many are in existence, who manages them and what data quality controls are already in place.
3. Analyse the audit results and develop an action plan to introduce some standardisation of data quality control.
4. Undertake a project during 2014/15 to scope the potential for improved data recording in order to maximise Trust income.
5. The Trust is currently in the process of developing standard operating procedures for administrative functions that will standardise the processes around data capture and data entry. This will help in the drive to improve data quality.

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:

8% primary diagnosis incorrect
10% secondary diagnosis incorrect
7% primary procedures incorrect
23% 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 with a code of 'Digestive System Procedures and Disorders', with a specified level of complications and co-morbidities.

- 100 sets of case notes from an emergency admission with a code of 'Other Specified Admission and Counselling' with intermediate or major complications and co-morbidities.

An action plan and training is being developed to address the mistakes in recording of secondary procedures, which mainly relates to the correct coding of CT scans.

### 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 Rapid Response Reports which have been received during the year 2013/14.

Table 2: Alerts received during 2013/14

| Ref | Title | Issued | Deadline | Closed |
|---|---|---|---|---|
| NHS/PSA/W /2013/001 | Placement devices for nasogastric tube insertion DO NOT replace initial position checks | 05/12/2013 | 08/01/2014 | 8/01/2014 |
| NHS/PSA/W /2014/001 | Risk of hypothermia in patients receiving continuous renal replacement therapy | 06/02/2014 | 06/03/2014 | 6/03/2014 |
| NHS/PSA/D/ 2014/002 | Non-luer spinal (intrathecal) devices for chemotherapy | 20/02/2014 | 20/08/2014 | Currently open |
| NHS/PSA/W /2014/003 | Risks of associating ECG records with wrong patients | 04/03/2014 | 04/04/2014 | Currently open |

### h) Staff Engagement

**Staff Engagement**

The Trust recognises the importance of positive staff engagement and good leadership to ensure good quality patient care. The strategic direction for staff engagement is set and monitored by the Staff Engagement Executive Group, chaired by the Executive Director of Human Resources and Organisational Development which reports to the Finance, Performance and Workforce committee, a subcommittee of the Board of Directors.

During 2013/14, the implementation of the Trust Staff Engagement Strategy has been ongoing with a particular focus on improving both staff involvement and the appraisal rates for all staff across the Trust.

**Staff Involvement**

The Trust has numerous mechanisms in place to encourage and learn from staff feedback.

The Chief Executive undertook several staff open sessions to share and discuss the opportunities and challenges facing the organisation. He also spends time with a number of 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 whole Board visit a department every month to meet staff and recognise their efforts.

A number of 'Let's talk' engagement events have been held in directorates across the Trust in order to seek staff views and encourage ideas for service improvements. In addition some directorates are now using the Microsystems Coaching Academy approach to improving services. Many areas have introduced staff suggestion boxes after these were successfully piloted in the Hotel Services Directorate during 2012/13.

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. Pharmacy and Professional services undertake their own Staff Surveys. Furthermore, the Trust conducted a full census NHS Staff Survey in autumn 2013 to give all staff the opportunity to contribute their views and suggestions.

The Trust has worked with NHS England on the introduction of staff 'friends and family' testing, which will be introduced into the Trust on a quarterly basis in 2014/15. This will give more staff the opportunity to give more frequent feedback on how patient services can be improved.

**Appraisal**

During 2013/14 a significant investment in appraisal training was made to support the performance, values and behaviours based appraisal process (based on the PROUD values) which was simplified and rolled out across the Trust to more staff.
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

There has been a significant rise in the number of staff receiving an appraisal during 2013/14 currently 92 %.

**Health and Wellbeing**

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. Staff views have been sought to identify what support they would like to see and in response to this a number of initiatives have been held on site, including exercise classes and weight management classes run by dieticians.

Following the successful pilot of a fast track musculoskeletal service for staff in the Jessop Wing by PhysioPlus we have expanded this service across the whole Trust effective 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.

The outcome of research undertaken in conjunction with Sheffield Hallam University regarding the provision of staff health checks proved promising and we are currently undertaking a larger scale research programme across the Trust to determine the efficacy of the service.

The purchasing annual leave scheme has again proved extremely popular with nearly 200 staff taking advantage of the scheme in the last year alone. Further developments in respect of this scheme are under consideration.

The Trust launched a Health & Wellbeing Lottery in 2013/14, with the intention of providing funds to improve the health and wellbeing of staff in the Trust via bids for funding.

**Leadership and Management Development**
The first leadership forum of the year held in May 2013, focused on the Trust's response to the recommendations in the Francis report, with over a hundred leaders from across the Trust attending. A second forum was held in November 2013 which had an emphasis on sharing knowledge across the Trust, particularly that gained by from colleagues whilst undertaking an MBA or an MSc in leadership.

The Trust's coaching capacity has been strengthened during 2013 with the first cohort of 14 people trained to be coaches and a further cohort commenced in the spring of 2014.

A Human Resources development programme was introduced during the year which was well supported and has already been repeated with plans for further cohorts in 2014.

A further two cohorts of staff have attended the Senior Leaders programme developed in conjunction with Sheffield Hallam University along with a further two cohorts of the level 3 ILM programme. Both these programmes now include sessions on the importance of good staff engagement and the leader's/manager's role in this.

The ‘Effective Manager’ rolling management programme and the Leadership Guest Lecture Series continue to be well received. A senior sisters’ development programme is being developed in response to recommendations in the Francis report for introduction in 2014.

**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 (3.71) as reported in the benchmarked NHS Staff Survey, improved during 2013, despite this being a challenging year. This improvement means that the Trust compares well to other acute trusts. It is very pleasing to note that 72 % of our staff would

recommend the Trust to family and friends for treatment which is well above the NHS average of 65%.

**Response rate**

| | 2012/13 | | 2013/14 | | Trust Improvement/Deterioration |
|---|---|---|---|---|---|
| | Trust | National Average | Trust | National Average | |
| Response Rate | 52% | 50% | 55% | 49% | 3% Improvement |

**Top five ranking scores:**

| Key Finding | 2012/13 | | 2013/14 | | Trust Improvement /Deterioration |
|---|---|---|---|---|---|
| | Trust | National Average | Trust | National Average | |
| Staff working unpaid extra hours (%) | 64 | 70 | 64 | 70 | No change |
| Staff experiencing harassment/bullying/ abuse from staff (%) | 23 | 24 | 21 | 24 | Improvement (2%) |
| Staff experiencing harassment/bullying/abuses from patients (%) | 32 | 30 | 26 | 29 | Improvement (6%) |
| Staff believing trust provides equal opportunities for career progression/promotion (%) | 86 | 88 | 91 | 88 | Improvement (5%) |
| Staff recommending Trust to work/for treatment | 3.65* | 3.57 | 3.79 | 3.68 | Improvement (0.14) |

**Bottom five ranking scores:**

| Key Finding | 2012/13 | | 2013/14 | | Trust Improvement /Deterioration |
|---|---|---|---|---|---|
| | Trust | National Average | Trust | National Average | |
| Staff having well structured appraisals in the last 12 months (%) ** | 26 | 36 | 28 | 38 | Improvement (2%) |
| Staff agreeing their roles make a difference to patients (%) | 87 | 89 | 87 | 91 | No change |
| Staff motivation at work | 3.68* | 3.84 | 3.72 | 3.86 | Improvement (0.04) |
| Received equality and diversity training in last 12 months (%) | 39 | 55 | 43 | 60 | Improvement (4%) |
| Staff feeling satisfied with the quality of work and patient care they are able to deliver (%) | 78 | 78 | 74 | 79 | Deterioration (4%) |

**Most improved**

| Key Finding | Trust 2012 | Trust 2013 |
|---|---|---|
| Staff recommendation of the Trust as a place to work or receive treatment | 3.65 | 3.79 |

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

**In common with a number of Trusts, the figure for staff indicating that they had received a well structured appraisal is lower than the percentage of staff appraised, and this issue is being addressed via the roll out of the simplified PROUD performance values and behaviours appraisal system and the increased investment in training for managers in appraisal skills.

The Trust has a staff engagement lead who works with staff in directorates to promote the sharing of good practice across the Trust. 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. The focus for 2014/15 will be to ensure more staff have a well structured appraisal and to continue to improve staff involvement. In addition directorates which have shown a deterioration in the key finding relating to the percentage of staff feeling satisfied with the quality of work/patient care they are able to deliver, are required to investigate this further in order to identify what improvements need to be made. Progress with the Trust and Directorate action plans is monitored via the Staff Engagement Executive Group.

A staff engagement score template has been developed based on the NHS Staff Engagement Toolkit which, using the full Staff Survey census data has enabled a staff engagement score to be calculated for every directorate for the first time. This is further broken down into staff involvement, advocacy and motivation which enables each directorate to focus on addressing their particular issues. Directorate staff engagement scores and staff friends and family test scores are also monitored via the Care Group performance review process.

**i) Annual Patient Surveys**

The Trust undertakes a wide range of activities to gain feedback from patients regarding the services they receive. Survey work during 2012/13 included participation in the national survey programme for inpatients, maternity and cancer services. In addition, our extensive programme of local surveys has continued, with around 400 patients each month participating in the 'frequent feedback' survey programme in which the views of patients about a wide range of services are gathered by trained volunteers. The new Friends and Family Test (FFT) has also been implemented across in-patients, accident and emergency and maternity services.

In the National In-Patient Survey 2013, our scores compare very well against other trusts. Areas where our scores were high include questions relating to cleanliness of rooms, wards and toilets and having trust and confidence in doctors and nurses. Areas identified where further improvements can be made include offering healthy food choices and ensuring patients have the opportunity to give us their views on the quality of care.

In the National Maternity Survey 2013 areas achieving high scores include women having a contact number for any worries post natally, and the partner being involved enough during

labour and birth. Questions where further improvements could be made include provision of information regarding emotional changes post natally and continuity of midwife support during post natal care.

The third National Cancer Survey was carried out in 2013. This Trust's scores were once again very good overall. High scoring questions include the patient's overall rating of care as 'excellent' or 'very good' and always providing privacy for patients when being examined or treated. Areas where scores were lower include the provision of written information about the type of cancer they had and the patient's family having the opportunity to talk to the doctor.

Following any patient feedback, action plans are agreed at local and Trust level to address areas where improvements can be made. There are ongoing 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) was introduced nationally from April 2013 for all adult acute in-patients and patients discharged from Accident and Emergency Departments, and from October 2013 for maternity services.

The test asks a simple, standardised question with response options on a 5-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.

Nationally, a variety of methods are being used by Trusts to collect FFT data, including paper/postcard, online, texting and electronic tablet methods. The method currently used to collect data within this Trust is a postcard at the point of discharge, which can be posted in a box on the ward/department or returned by freepost. The cards also contain a smartcode which allows patients to complete their response online. In addition, since mid-December 2013, SMS texting has been used to survey patients discharged from the Accident and Emergency Department.

Since July 2013, FFT scores and response rates have been published nationally each month, enabling trusts to compare feedback down to ward and service level. This Trust's scores and response rates are outlined in Part 3.

**j) Complaints Details for 2013, to be updated.**

**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.

In 2013 we received 1081 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

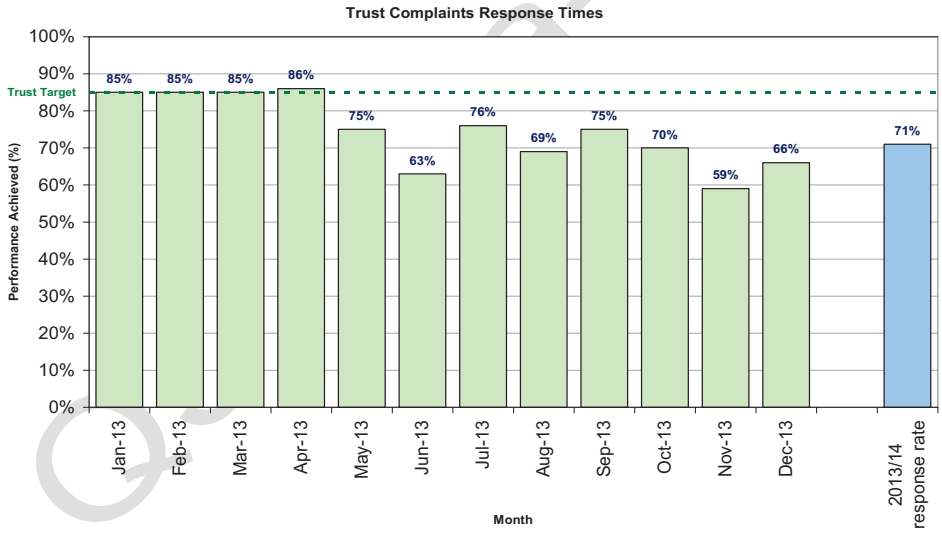
as a PST contact. If the concern or issue is not dealt with within two days, or if the enquirer remains concerned, the issue is re categorised as a complaint and processed accordingly. 1410 complaints requiring more detailed and in depth investigation were received. Table 3 provides a monthly breakdown of complaints and concerns received.

Table 3

| | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **New Complaints Received** | 128 | 122 | 164 | 121 | 118 | 83 | 114 | 112 | 111 | 105 | 137 | 95 | **1410** |
| **Patient Services Team (PST) Concerns** | 74 | 68 | 81 | 94 | 106 | 90 | 113 | 106 | 85 | 100 | 103 | 61 | **1081** |
| **Complaints and PST Enquiries combined** | **202** | **190** | **245** | **215** | **224** | **173** | **227** | **218** | **196** | **205** | **240** | **156** | **2491** |

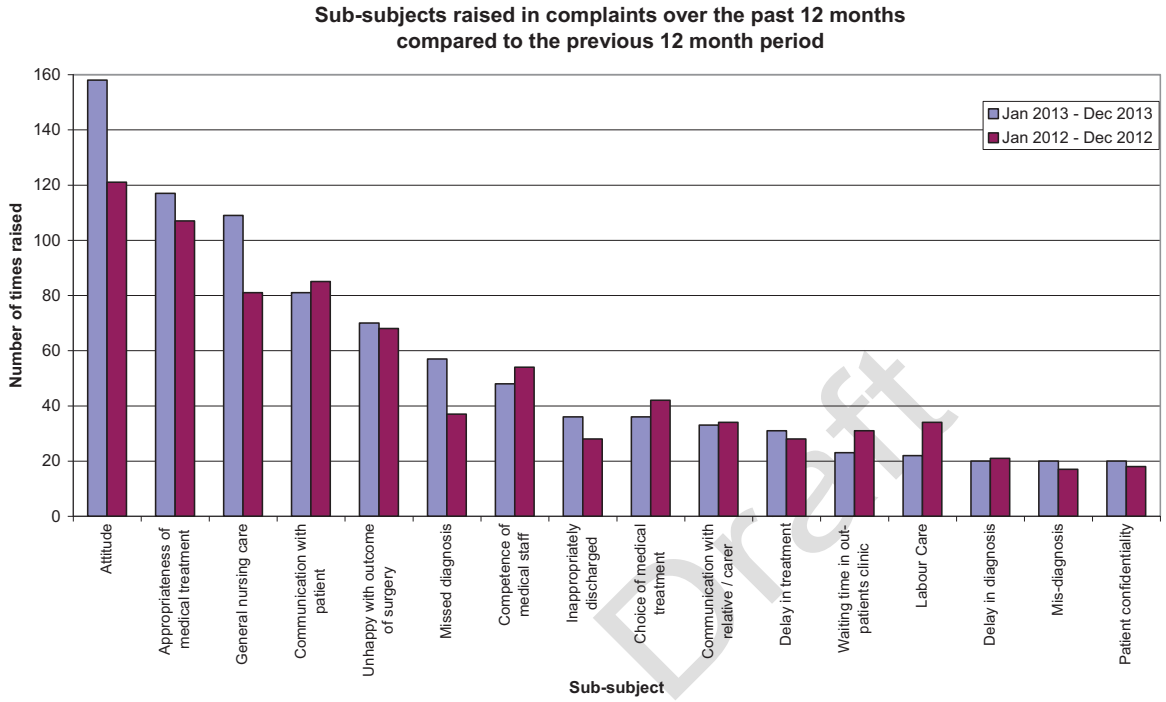
The Trust works to a target of responding to 85% complaints within 25 working days. The performance this year was 72% falling short of the target for the first time. Whilst good progress was made in the first four months of the year, the high number of complaints received in March saw a backlog develop which has meant that performance has remained below the target level for the rest of the year. Chart 1 shows a monthly breakdown of performance against the Trust target per month.

Chart 1




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. This 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. The chart below 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.

Chart 2






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

Staff attitude is of high importance to patients and continues to feature frequently in complaints. A number of actions are being taken to improve issues identified around staff attitude. These include:

- **The launch of the PROUD values**

The values were developed by staff and were launched two years ago to promote attitudes and behaviours which support an excellent patient experience. The values are now linked to staff appraisal, and staff are expected to demonstrate how they deliver the PROUD values.

- **Customer Care Training**

The Patient Partnership Department worked with a multi-disciplinary team in Orthopaedics to deliver a customer service programme which has providing staff training and facilitated discussions with staff to explore how their working environment could change to improve their ability to provide excellent customer care. The project is now being rolled out more widely in Surgical Services and across other care groups.

**Key Priorities for 2014/15**

Following a number of national reviews published last year including the Francis Inquiry[1], the Clwyd Hart Review[2], and Keogh[3] a comprehensive review of the complaints management process is planned for 2014. The review will identify a process which is responsive to the needs of patients and families using the complaints service. The review will ensure a responsive and timely process is implemented, which meets with recommendations made in the national reviews.

A programme of training for senior nursing and medical staff is to be introduced in 2014 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.

A new approach to auditing the quality of the complaints service against the standards we have set and patients' expectations will be developed and introduced in 2014. The Trust will interview patients and families to understand their experience of the complaints process, and will carry out a review of the complaint file in order to ensure it complies with the standards we have set. We will use the findings of this audit to continually improve and develop our complaints service.

**k) Eliminating 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. As a result we have not identified any breaches of the Eliminating Mixed Sex Accommodation during 2013/14.

**l) Coroners Regulation 28 Report (previously Rule 43 report)**

In July 2013 the Coroners and Justice Act 2009 came into force, together with accompanying Rules and Regulations, which represents an overhaul of the law in relation to inquests. There are changes to timescales, deadlines and associated fines, disclosure of evidence and also Rule 43 reports, which now come under Regulation 28 of the Coroner (Investigations) Regulations 2013.

The importance of these reports has been emphasised by changing the coroner's previous discretion to make a report, to a "duty" to make a report, where a matter giving rise to concern is identified.

These reports generally are written when the Coroner feels further improvement action needs to be implemented following a death. The Chief Coroner has also given additional guidance to coroners on these, and expressed his commitment to encourage changes which may prevent future deaths intended to improve public health and safety and have a practical effect.

The Trust has received no Regulation 28 Reports during 2013/14.

**m) Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry**

[1] Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
[2] Clwyd & Hart (2013) A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture
[3] Keogh (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report

*Hard Truths: The Journey to Putting Patients First* publication builds on the Government's initial response: *Patients First and Foremost,* which was published in March 2013. The publication explains the changes that have been put in place since the initial response, and sets out how the whole health and care system will prioritise and build on this.

The Trust has reviewed the *Hard Truths: The Journey to Putting Patients First* publication and drawn up an extensive action plan highlighting approximately 20 new actions which the Trust is currently taking forward. These matters will be incorporated into the Trust's Final Response Plan. Other partners will be involved in the development of this plan, such as, Healthwatch, Overview and Scrutiny Committee.

Our collective approach to quality improvement and governance, supported by a robust performance management framework, ensures that quality matters are monitored and, where deficits occur, that timely and proportionate action is taken to address these. Under the direct lead of an Executive Director, a thorough root cause analysis and risk assessment is undertaken and a mitigating action plan developed and implemented. The Trust Executive Group and the Board of Directors monitor the implementation of the action plan (and any responsive changes to the plan) via regular progress reports by the nominated leads.

**PART 3**

**REVIEW OF SERVICES IN 2013/14**

3.1 Quality Performance Information 2013/14

The indicators below align with the Trusts statutory obligations and local priorities and 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 | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| 1. Mortality-<br><br>(a) The value and banding of the summary hospital-level mortality indicator (SHMI) for the trust for the reporting period.<br><br>**National average: 1.0**<br>**Highest performing Trust score: 0.63**<br>**Lowest performing Trust score: 1.15** | .92<br><br>Banding: 'as expected' | .88<br><br>Banding: 'lower than expected' | (Jul 12-Jun 13)<br>**.88**<br><br>Banding: 'lower than expected' |
| (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.<br><br>**National average: 20.28**<br>**Highest Trust score: 44.09**<br>**Lowest Trust score: 0**<br><br>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.<br><br>The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this rate, and so the quality of its services, by:<br><br>• Ensuring consistent Mortality and Morbidity reviews are undertaken across the Trust.<br>• Monitoring the mortality data at a diagnosis level to ensure any areas for improvement are constantly reviewed and where appropriate actions are taken.<br><br>The SHMI reported in last year's Quality Report was qualified by the annotation that this was derived from the most recent rolling 12 month period i.e. Oct 2011 - Sept 2012. SHMI results are published six months and | 17.5% | 18.4% | **17.6%**<br>(Jul 12-Jun 13) |

| | | | |
|---|---|---|---|
| three weeks in arrears because of the need to validate the data nationally. The value for April 2012 – March 2013 was released at the end of October 2013 and reported as 0.88. This can be validated via the NHS Choices website. | | | |
| **Prescribed Information** | **2011/12** | **2012/13** | **2013/14** |
| 2. Patient Report Outcome Measures (PROMs)<br><br>The Trust's patient reported outcome measures scores for: | | | April – Sept 2013/14 |
| (i) Groin hernia surgery | | | |
| Sheffield Teaching Hospitals' score:<br>**National average:**<br>**Highest score:**<br>**Lowest score:** | 0.081<br>0.086<br>0.143<br>-0.002 | 0.108<br>0.084<br>0.157<br>0.015 | 0.068<br>0.085<br>0.131<br>0.019 |
| (ii) Varicose vein surgery | | | |
| Sheffield Teaching Hospitals' score:<br>**National average:**<br>**Highest score:**<br>**Lowest score:** | 0.065<br>0.094<br>0.167<br>0.049 | 0.076<br>0.093<br>0.138<br>0.023 | *<br>0.101<br>0.094<br>0.058 |
| (iii) hip replacement surgery primary | ** | | |
| Sheffield Teaching Hospitals' score:<br>**National average:**<br>**Highest score:**<br>**Lowest score:** | 0.386<br>0.415<br>0.463<br>0.306 | 0.406<br>0.437<br>0.543<br>0.319 | 0.39<br>0.447<br>0.545<br>0.373 |
| (iv) hip replacement surgery revision | ** | | |
| Sheffield Teaching Hospitals' score:<br>**National average:**<br>**Highest score:**<br>**Lowest score:** | 0.386<br>0.415<br>0.463<br>0.306 | 0.236<br>0.272<br>0.35<br>0.164 | *<br>0.260<br>*<br>* |
| (v) knee replacement surgery primary | ** | | |
| Sheffield Teaching Hospitals' score:<br>**National average:**<br>**Highest score:**<br>**Lowest score:** | 0.315<br>0.302<br>0.385<br>0.181 | 0.308<br>0.318<br>0.409<br>0.231 | 0.345<br>0.338<br>0.429<br>0.264 |
| (vi) knee replacement surgery revision | ** | | |
| Sheffield Teaching Hospitals' score:<br>**National average:**<br>**Highest score:**<br>**Lowest score:** | 0.315<br>0.302<br>0.385<br>0.181 | 0.211<br>0.251<br>0.369<br>0.194 | *<br>0.255<br>*<br>* |
| 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.<br><br>* Denotes that there are fewer than 30 responses as figures are only reported once 30 responses have been | | | |

| | | | |
|---|---|---|---|
| received.<br>** 2011/12 data presents primary and revision combined for both Hips and Knee procedures. 2012/13 and 2013/14 now present primary and revision separately therefore this data is not comparable.<br><br>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.<br><br>The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by:<br>• Continuing to review in detail a breakdown of EQ-5D and OHS data for hips and undertaking improvement work as necessary.<br>• Monitoring scores at directorate and Trust level to respond to feedback from patients and incorporating their views into quality improvements.<br>• Increasing the involvement and understanding of staff in how we use the information received through PROMs and working with staff to increase participation rates. | | | |

| Prescribed Information | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| 3. Readmissions<br><br>The percentage of patients aged:<br><br>1. 0 to 14; and<br>2. 15 or over,<br><br>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.<br><br>**Comparative data is not available**<br><br>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.<br><br>*These figures are different from subsequent years as the way the data is calculated has changed (Data definition).<br><br>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. | <br><br><br><br>0%<br>10.7%* | <br><br><br><br>0%<br>11.36% | <br><br><br><br>**0%**<br>**11.18%** |
| 4. Responsiveness to personal needs of patients<br><br>The Trust's responsiveness to the personal needs of its patients during the reporting period.<br><br>**National average: 72.8%**<br><br>The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by national CQC survey contractor.<br><br>*2013/14 scores represent the four questions from the National Inpatient Survey which have been selected nationally to form part of the CQUIN scheme, as a measure of responsiveness to patient needs. Prior to 2013/14, scores were based on five questions; the question regarding recommending friends and family to the Trust has been removed since the introduction of the national Friends and Family Test. | 72% | 68.6% | **79.3%*** |

| | | | |
|---|---|---|---|
| The Sheffield Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services. As in previous years the Trust and Sheffield CCG have agreed that, whilst important, the areas highlighted in the national survey were not as important as some fundamental areas. These include:<br>• help to go to the toilet<br>• controlling pain<br>• help with nutrition<br>• being treated with dignity.<br>These are the areas on which the Trust's Patient Experience is being measured through an ongoing programme of patient interviews (approximately 400 each month). | | | |
| **Prescribed Information** | **2011/12** | **2012/13** | **2013/14** |
| 5. Patients risk assess for Venous Thromboembolism (VTE)<br><br>The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.<br><br>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. We then report the data externally to the Department of Health.<br><br>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 completion of VTE risk assessment form for every patient admitted to Trust, feedback to Directorates on performance and carrying out root cause analysis of cases of VTE which are thought to be hospital associated. | 91.1% | 93.33% | **95.14%** |
| 6. Rate of Clostridium Difficile<br><br>The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged two or over during the reporting period.<br><br>**National average: xx**<br>**Highest performing Trust score: xx**<br>**Lowest performing Trust score: xx** | 30.0 | 17.7 | **14.1** |

| | | | |
|---|---|---|---|
| The Sheffield Teaching Hospitals NHS Foundation Trust considers that this The data is provided by the Health Protection Agency.<br><br>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. | | | |
| 7. Rate of patient safety incidents<br><br>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.<br><br>**Number of Incidents reported**<br><br>The incident reporting rate is calculated from the number of reported incidents per hundred admissions and the comparative data used is from the first 9 months of 2013/14. Full information for the financial year is not available from the National Reporting and Learning System until mid 2014.<br><br>**Cluster** average: xx**<br>**Highest performing Trust score: xx**<br>**Lowest performing Trust score: xx**<br><br>and the number and percentage of such patient safety incidents that resulted in severe harm or death.<br><br>**Cluster** reporting data: xx**<br>**Highest reporting Trust: xxx**<br>**Lowest reporting Trust: xxx**<br><br>* The figures for 2012/13 are different to those documented in last year's Quality Report as they have now been validated.<br><br>**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. | 10,192<br><br>5.2<br><br>46<br>(0.4%) | 9951*<br><br>5.1*<br><br>51*<br>(0.5%) | Indicative annual data based on Jan-Dec 2013<br><br>12988<br><br>6.3<br><br>92<br>(0.7%) |

| | | | |
|---|---|---|---|
| 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).<br><br>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.<br><br>**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. | | | |
| 8. Friends and Family Test- Staff who would recommend the Trust.<br><br>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.<br><br>**National average: 64%**<br>**Highest performing Trust score: xx**<br>**Lowest performing Trust score: xx**<br><br>The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by national CQC survey contractor.<br><br>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. | 75% | 70% | **72%** |
| 9. Friends and Family Test- Patients who would recommend the Trust<br><br>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. | New indicator | New indicator | **73%** |

| | | | |
|---|---|---|---|
| **National average: xx**<br>**Highest performing Trust score: xx**<br>**Lowest performing Trust score: xx**<br><br>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.<br><br>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 using FFT scores to trigger deeper action planning around problem wards. | | | |

ii) Mandated Indicators – Monitor Risk Assessment Framework (Table 2: Targets and indicators for 2013/14)

| Measures of Quality Performance | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| 10. Percentage of patients who wait less than 31 days from decision to treat to receiving their treatment for cancer- | | | Q1,Q2 &Q3 |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 98% | 98% | **98%** |
| 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 | | | Q1,Q2 &Q3 |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 91% | 89% | **88%** |
| 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 | | | Q1,Q2 &Q3 |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 95% | 95% | **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: | | | Q1,Q2 &Q3 |
| Surgery: | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 97% | 97% | **97%** |
| National Standard | 94% | 94% | 94% |
| Anti-cancer drug treatments: | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 99% | 100% | **99%** |
| National Standard | 98% | 98% | 98% |
| Radiotherapy: | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 98% | 99% | **99%** |
| 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 | | | (Data as of W/C 24/1/14) |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 95.6% | 93.2% | **95.5%** |
| National Standard | 95% | 95% | 95% |
| Data Source: Exeter National Cancer Waiting Times Database | | | |
| 15. MRSA blood stream infections- | | | (Data as of W/C 24/3/14) |
| Trust attributable cases in Sheffield Teaching Hospitals NHS Foundation Trust | 2 | 3 | **4** |
| Sheffield Teaching Hospitals NHS Foundation Trust threshold | 10 | 1 | 0 |
| 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% | 90.6% | **90.8%** |
| 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 | 97% | 96.6% | **94.9%** |
| National Standard | 95% | 90% | 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 | 90.4% | 93.2% | **93.7%** |
| National Standard | 92% | 92% | 92% |
| 19. Data Completeness for Community Services | | | |
| Referral to treatment information: | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | | 60% | **66%** |
| National Standard | New indicator | 50% | 50% |
| Referral information: | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | | 100% | **100%** |
| National Standard | | 50% | 50% |
| Treatment activity information: | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | | 100% | **100%** |
| National Standard | | 50% | 50% |

iii) Local Indicators

| Measures of Quality Performance | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| 20. Never Events | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust Performance | 3 | 7 | **4** |
| Data Source: National Patient Safety Agency | | | |
| The Trust has experienced 4 Never Events during the year; 3 retained objects and 1 misplaced nasogastric tube. | | | |
| Although this was an improvement from 2012/13 an external review of theatre Never Events was jointly commissioned with the commissioners. Findings will be used to plan future improvement activity. | | | |
| The Trust is actively promoting incident reporting to further enhance the safety culture of the Trust. This will ensure incidents are investigated, trends analysed and lessons are learnt across the Trust. | | | |

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| 21. Hospital Standardised Mortality Ratio (HSMR)<br><br>Sheffield Teaching Hospitals NHS Foundation Trust Performance<br><br>National Benchmark. A lower figure represents a better mortality rate.<br><br>*This figure is different from last year as it represents the whole year (April 2012- March 2013) rather than April 2012- January 2013 as reported in last year's Quality Report.<br><br>Data Source: Dr Foster | 98%<br><br>100% | 96%*<br><br>100% | **99%**<br><br>100% (April – Nov 13) |

**PART 4**

4.1 Response to partner organisation comments 2012/13

Sheffield Healthwatch, NHS Sheffield, Trust Governors and the Sheffield Health and Community Care Scrutiny Committee commented in the 2012/13 Quality Report. The following table summarises the Trust's response to those comments.

We would like to thank all individuals involved for taking the time to review our Quality Report and for the helpful feedback provided.

**NHS Sheffield Clinical Commissioning Group (2012/13)**

| Abridged Comments | Our Response |
|---|---|
| 1. The national surveys of patient experience results remain similar year on year, however the number of questions that were rated as significantly better, compared with other trusts has reduced from previous years. | The Trust's scores have remained similar year on year and consistently compare well against other Trusts nationally. The number of responses where our results were 'significantly better than average' was lower in the 2012 In-patient Survey than in previous years, although overall our scores remained high. We carefully reviewed the results of the survey and identified areas where actions were required to make improvements and, following this, we hope to see a higher number of responses achieving 'significantly better than average' scores in the 2013 In-patient Survey. |
| 2. The Trust has unfortunately experienced a number of never events during 2012/2013, and we are working closely with them to reduce the risk of recurrence. | In 2012/13 the Trust experienced seven Never Events<br><br>Following these Never Events the Trust developed a wider ranging Never Event action plan which brought together the lessons learned and actions from each of the individual incident action plans into a single overarching document. This has been shared within the Trust and also externally to the Commissioners, the Care Quality Commission and Monitor. A reduction in the number of Never Events has been evident in 2013/14 and further work continues to limit the chances of Never Events happening within the organisation. |
| Three of these priorities are worthy of specific comment:<br>3. Cancelling operations at short notice has a significant impact on patients. | Causes of cancellations are reviewed on a directorate by directorate basis with the actions designed to address the causes drawn up by each directorate. |

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| Understanding the causes of cancellations and more importantly, taking action to address these causes will improve individual patient's experience and will more broadly, contribute to the maintenance of 18 week waiting times. | These are then taken forward by the Surgical Board.<br><br>The Service Improvement team is working with Operating Services and Critical Care and the Surgical Specialties to address on the day cancellations. In several areas patients are routinely called three days prior to their admission to ensure they are fit, ready and willing to attend, to reduce the chances of any issues arising on the day that may prevent surgery taking place.<br><br>Please see section 2.1.6 in Part 2 of this report for more information. |
| 4. There has been a reduction this year in the overall number of patients with pressure sores in the community and an objective to reduce the numbers both in primary and secondary care next year will be welcome. It will be supported by the prevalence data submitted via the NHS Safety Thermometer and enable specific wards or services to be targeted. | The Trust has worked hard to reduce the number of pressure ulcers in both the hospital and community setting and is monitoring progress using both incident reporting and the NHS Safety Thermometer. This work has continued into 2013/14 and will also be an objective for 2014/15. |
| 5. The standardised provision of discharge information will be welcome to clinical commissioners and patients. It will support a more seamless transfer of care between primary and secondary care and it will provide patients and their carers with information on what to expect post discharge. | The project to improve discharge information has progressed this year.<br><br>Please see section 2.1.8 in Part 2 of this report for more information. |
| We do, however, note that the Trust has indicated that it will carry over and/or report on indicators from 2012/13 and 2011/12. These include:<br><br>6. Optimising length of stay – achievement of clinically appropriate length of stays in line with national and local benchmarks in key areas. | All directorates are working towards Dr Foster benchmarks and understand the specialty level variance. All specialties are working with detailed information showing actual length of stay by diagnosis and procedure (against Dr Foster benchmarked levels) to help them identify which particular patient pathways they should be focusing on. Please see section 2.1.1 in Part 2 of this report for more information. |
| 7. Improving the care of older people – nutritional assessment – achieve further improvements in the number of patients | The subject of nutrition and hydration is recognised as being a fundamental basic care need for patients within STH. The |

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| aged 65 or over screened using MUST and the percentage of patients at risk that receive an appropriate care plan. | Hydration and Nutrition Assurance Toolkit, (HANAT) has been developed using the expertise of the Trust Nutrition Steering Group. The HANAT had been tested, refined and evaluated (positively) on two wards. HANAT serves to bring together practices, staff and audits to benchmark clinical areas against good practice standards in nutrition and hydration. There is an intention to roll HANAT out to all acute ward areas in 2014/15. It is intended that the annual audit of nutritional screening practices, including MUST screening and the associated care planning will be included as part of HANAT. |

**Healthwatch Sheffield (2012/2013)**

| Abridged Comments | Our Response |
|---|---|
| 1. Page 33. Regarding the reference in the Foreword to the production of a second more accessible version of the Quality Report for patients and the public. Whilst this is welcome it is our understanding that agreement was reached at meetings during the year that this will be more than a summary version incorporated in the 'Making a Difference – a summary of quality improvements and priorities' document which has a limited circulation. We would like to see a clearer commitment in the Quality Report to the production and wide circulation of an easier to read summary version. | The Trust is committed to producing a summary version of the Quality Report for wider circulation. For the 2012/13 Quality Report this had been produced. This will be repeated for the 2013/14 Quality Report, working in collaboration with Trust Governors and Healthwatch. |
| <u>Optimise length of stay</u><br>2. We acknowledge the difficulty of optimising patients' length of stay in the Trust's hospitals, but we can find no overt commitment to continuing this priority into next year or any mention of how progress on this will be measured. We hope this will continue to be a priority for the Trust in succeeding years until the situation has improved. | Ensuring that length of stay is appropriate for the patients who receive care and treatment is a key priority for the Trust.<br>We are continuing to work with our clinical teams and also with partners to optimise length of stay.<br><br>Please see section 2.1.1 in Part 2 of this report for more information. |
| <u>Discharge letters for GPs</u><br>3. We note that the audits show mixed | The Trust has completed the rollout of e-discharge summaries which enable |

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| success and wonder whether the reasons for this were explored. We look forward to seeing the results following the introduction of the system of e-discharge summaries and that further local action plans will then be implemented. | clinicians to fill in an electronic discharge template, helping to speed up the delivery and improve the discharge information available to GPs.<br><br>Sheffield CCG have surveyed GPs to look at the impact of the new e-discharge summaries with some very positive feedback being received. Evaluation will continue and any areas for improvement will be address by the project team. |
| <u>Giving patients a voice</u><br>4. We welcome the increased feedback through forms and comment cards. This year's statistics are interesting but it would be helpful to see a comparison with the last two years and with the total number of patients being treated in the Trust's hospitals. | Whilst comment cards are still widely available across the Trust, we are no longer actively giving these to patients through our volunteers, as the new Friends and Family Test (FFT) is now the priority. We decided that to also give the comment cards out at the same time as the FFT cards would be confusing for patients. |
| <u>Holistic care to promote a good experience for patients who have dementia</u><br>5. All the reported work in relation to this priority has focused on the built environment and to a lesser degree on nutritional screening. Whilst this is important we would like to see some work on how the Trust can meet individual patients' needs and to know what measures and processes have been put in place to improve Dementia Awareness in the Trust's hospitals and how this will be kept ongoing, especially in the light of the Francis Report. We shall be interested to read about the progress of the three further up-grades – we consider Vickers 4 ought to also have priority as this ward is specifically focused on the after care of older people following orthopaedic operations. | A key area of focus in 2014 will be the Trust's commitment to improving patient centred care. Accordingly we are developing a discrete symbol to enable staff to recognise people suffering with dementia. This will then prompt staff to refer to the 'All About Me' booklet.<br><br>Improvement work on Vickers 4 is in progress. Please see section 2.1.5 in Part 2 of this report for more information. |
| <u>Reduce hospital acquired infections</u><br>6. We commend the Trust on a reduction in the number of cases of *C.difficile* in 2012/2013 and hope this will be continued. We would be interested to know what further improvements are under consideration. | In 2013/14 the Trust will continue to work to reduce the number of cases of C.difficile. In addition the Trust will aim to reduce the number of cases of MRSA Bacteraemia and increase the amount of Surgical Wound Surveillance to reduce the number of wound infections. |

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| 7. As a general statement we would find it most helpful to see priorities from the earlier years which have not been achieved or only partially achieved, included as on-going priorities in the following year as well as the measures used to indicate success. For example, it is acknowledged in the Quality Account that Nutritional Assessment will be reported in 2013/2014, but it is not in the summative list of priorities. | This comment is noted and the Trust will ensure that on-going priorities are reported in the 2013/14 report. |
| 8. We are surprised that Accident and Emergency waiting times are not a priority, as the Trust has failed to meet the 95% target in 2012/2013. | Waiting times in the Accident and Emergency department are a priority within the Trust. As a Trust we have concentrated a substantial amount of effort into bringing about changes which will help us to meet the four hour target and maintain that performance consistently. The Trust is pleased to note that we have met the four hour target during 2013/14. |
| 9. Last year we were clear in our comment that Community Services, part of the Trust's responsibilities, ought to be included in the Quality Account. We appreciate information may not be immediately available in a suitable statistical form, but the Report is not clear on this important and expanding part of its responsibilities. We will look for more evidenced descriptions in next year's Quality Account. | The Trust reports all appropriate Quality and Safety measures to ensure it provides a comprehensive overview of the services provided. These include community data. |
| <u>Clinical Audit</u><br>10. Page 51. Audit of Insulin Self Administration. We note that 100% compliance can be achieved if bedside lockers are available and we would be interested to know whether there are enough lockers for all patients who are capable of managing the self administration of their insulin? | The lockers we use to store medicines have to be secured to the wall or bedside locker to ensure the security of the medicines and the safety of other patients. Insulin is a high risk medicine which can cause death if given inappropriately. So the availability of the option to self administer insulin is governed by which ward the patient is admitted to and whether that ward has individual patient lockers.<br><br>Currently 83% of wards (excluding critical care areas where it is not anticipated that patients will be fit to self administer) have individual patient lockers for medicines. That means there |

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| | are 17% wards which currently do not have this facility. Pharmacy staff are working with a number of these wards to find funding to have lockers installed. We also continue to try to find a suitable portable, lockable container which can be locked into place at the patient's bedside but so far we have not been able to find an appropriate container which meets with the security and infection control requirements. |
| 11. Page 52. Care Home Support Team: Core Skills Training Outcomes. We welcome the training of care home staff through this initiative. It is not clear from the document if the Trust is going to continue to provide a comprehensive Care Home Support Team but we hope the Trust will continue to provide comprehensive Core Skills Training for care home staff, particularly in view of its increasing Community Services provision and responsibilities. | The Trust is pleased that its joint commissioners, the local authority and Sheffield CCG have agreed to continue funding this much needed service for a further two years. The team will have more of a focused approach in supporting those care homes with highest need from April 2014 as well as providing ongoing training pertinent to the needs of care homes. |
| 12. Page 55. (c) Northern General Hospital Mental Health Act Commission visit. By implication there was not full compliance and more detail on this visit report would be helpful. | After a routine visit from the Mental Health Act Inspector during March 2013, some areas for improvement were identified and the Trust has been working closely with Sheffield Health and Social Care Trust to address these. The Healthcare Governance Committee is overseeing the implementation of the improvement plan. Most actions were completed by September 2013.<br><br>The remaining actions include internal review and evaluation of the changes that have been made. The findings will inform a revision of the Trust's Detention under the Mental Health Act policy and procedures which is due to be completed by July 2014. |
| 13. Page 56. Data Quality. We are surprised that patients' unique NHS numbers are not used in every case/document; this presents a potential for serious confusion. | The Trust completion of NHS number in HES data is one of the highest in the country. The NHS Number benchmark is against all other hospital providers, amalgamated into a national figure. The benchmark figures for the period of April to December 2013 are: |

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|---|---|
| | 99.1% for admitted patient care<br>99.3% for outpatient care<br>95.8% for Accident and Emergency Care<br><br>The Trusts figures for 2013/14 are:<br>99.7% for admitted patient care<br>99.7% for outpatient care<br>97.2% for Accident and Emergency Care<br><br>Connecting for Health produced a leaflet that explains that it is not always reasonable or practical to expect 100% completion. The most common patient groups to not have an NHS Number are those from overseas, or from elsewhere within UK that do not use the English NHS Number.<br><br>The Trust undertakes rigorous processes to ensure we have the highest level of NHS number completion. These include nightly automated traces for all unvalidated NHS numbers held in our PAS system against the National Spine service. Any numbers that still remain untraced or unvalidated then have an attempted manual trace performed to try and resolve possible issues or conflicts. |
| 14. We would also like to see reported in Quality Accounts information of any Coroners Rule 43 Requests that were received by the Trust in 2012/2013 such as the number of Requests received during the year, their subjects, the actions taken and status of the Trust in respect of each. | In July 2013 the Coroners and Justice Act 2009 came into force, together with accompanying Rules and Regulations, which represents an overhaul of the law in relation to inquests. It had some quite significant practical implications in terms of timescales, deadlines and associated fines, disclosure of evidence and also Rule 43 reports, which now come under Regulation 28 of the Coroner (Investigations) Regulations 2013.<br><br>The Trust reports any Section 28 reports received within the Annual Quality Report. All Regulation 28 (Rule 43) requirements are reported in Part 2 of the Quality Report. |
| 15. Page 59. Staff Survey. It is of some concern to us that there are 5 areas of deterioration | The Trust has introduced a structured performance, values and behaviours |

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|---|---|
| in the survey results, and in particular that staff having well structured appraisals continues to be low scoring as it was last year. We would like to see reference to plans to address these findings. | appraisal process incorporating the PROUD values which although initially introduced for senior managers is in the process of being rolled out for all staff across the Trust.<br><br>The evaluation of the initial pilot highlighted the importance of appraisal training to ensure good quality so the Trust has invested significantly in appraisal training with all appraisers being trained in the new PROUD appraisal process before implementing it.<br><br>The Trust is committed to achieving a 95% staff appraisal rate by the year end. |
| 16. Page 60. Patient Surveys and complaints. We note that one of the identified areas of improvement in the national A & E Survey is the provision of written/printed information. This is an area that HWS would be keen to work with the Trust on to improve these communications. | The Emergency Department has been working closely with the Patient Partnership Department to review and standardise the existing written and electronic information for patients. This process has been clinically led from within the Emergency Department, and is in line with the Trust guidelines for patient information. All of the priority leaflets have now been reviewed and republished.<br><br>Leaflets can also be made available in other languages and formats on request. Work has now started on a generic discharge leaflet for patients and the Trust Patient Information Manager will involve Healthwatch in this process during 2014/15. |
| 17. Page 60. Complaints. We are surprised that number of complaints, their nature and actions taken as a result are not reported, which we feel are essential to the Quality Account. | The complaints section of the Quality Report 2013/14 has been expanded to ensure greater detail of actions following complaints can be reported. |
| 18. Page 62. Mandated Indicators. It would be helpful if the relevant years were repeated at the top of each page as aide memoire. | This was completed in the final published report. |

**Sheffield Health and Community Care Scrutiny Committee (2012/2013)**

| Abridged Comments | Our Response |
|---|---|
| 1. The committee recognizes that the Quality Account is not intended to reflect all of the improvement work which is taking place across the Trust, however suggests that a greater emphasis is placed on reporting progress on previous year's quality objectives. This would help us to build up a picture of how the Trust is progressing over time. | Within the 2013/14 Quality Report steps have been taken to ensure that the process of the Quality Objectives can be tracked over time. |

**Trust Governor Involvement (2012/2013)**

| Abridged Comments | Our Response |
|---|---|
| 1. We noted that not all the priorities for 2012/2013 were achieved and are very clear that processes should be in place to follow these up and to make sure that work continues on them to effect their achievement. | The Trust continues to focus on the priorities detailed within earlier Quality Reports. Progress is this reported in the 2013/14 Quality Report. |
| 2. 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. We look forward to a readable summary version. | Through the Quality Report Steering Group a selection of Trust Governors have assisted in producing the 2012/13 summary Quality Report. This will be repeated for the 2013/14 Quality Report, working in collaboration with Trust Governors and Healthwatch. |

4.2 Statement from our partners on the Quality Report 2013/14

**NHS Sheffield Clinical Commissioning Group (2013/14)**

[Comments to be added]

**Healthwatch Sheffield (2013/14)**

[Comments to be added]

**Healthier communities and Adult Social Care Scrutiny and Policy Development Committee (2013/14)**

[Comments to be added]

**Trust Governor Involvement (2013/14)**

[Comments to be added]

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# Report to Healthier Communities & Adult Social Care Scrutiny Committee
# 10th April 2014

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

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**Subject:** **SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST 2013-14 – QUALITY REPORT**

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

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**Summary:**

Sheffield Health & Social Care NHS Foundation Trust is in the early stages of producing its annual quality report. As part of the review of its quality over the 2013/14 period the Trust would like to

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

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

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

**The Scrutiny Committee is being asked to:**
The Committee is asked to review the Draft Quality Report and provide comment to the Trust on its assessment of the Quality of its services and the proposed priorities for 2014/15.

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

**Category of Report:** OPEN

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

**SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST 2013-14 – QUALITY REPORT**

### 1. Introduction/Context

1.1 Sheffield Health & Social Care NHS Foundation Trust is in the early stages of producing its annual quality report. As part of the review of its quality over the 2013/14 period the Trust would like to

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

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

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

2.1 Requirements to produce a Quality Account

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

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

2.2 Publication of the Trust's Quality Account

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

2.3 Status of the information in the attached Draft

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

- the full year has yet to be completed
- and information and analysis about performance over the Quarter 4 period has yet to be finalised
- some required/ essential information (patient surveys) have yet to report

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

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

2.4 Structure of the Report

Part 1: General introductions from the Chief Executive

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

- This outlines how we established the priorities we did, the goals we set ourselves this year, how we have progressed and what we propose to focus on next year.
- This is a key area we would value comment and feedback on

Part 2B: Mandatory statements

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

Part 3:Quality report

- Range of other information that the Trust monitors and reports on in respect of Quality
- At this stage we have not complied a summary assessment of service user experience and staff experience because the main national surveys have either not reported or have only reported very recently. It is intended to provide an updated presentation on these areas during the meeting.

2.5 Who we need to share our Quality Account with

Commissioners of NHS Services - the Trust has shared its draft Account with Sheffield CCG.

Scrutiny - Scrutiny Committee

An appropriate local Healthwatch from April 2013. We are meeting with Healthwatch w/c 7 April

## 3 What does this mean for the people of Sheffield?

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

## 4. Recommendation

4.1 The Committee is asked to review the Draft Quality Report and provide comment to the Trust on its assessment of the Quality of its services and the proposed priorities for 2014/15.

Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

# Quality Account 2013/14

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Draft 2
28 March 2014

This is a draft of the Quality Account report to support engagement with and feedback from stakeholders.

All performance information is based on April 13-December 13 extrapolated to full year to aid comparisons.

# Contents

## Part 1: Quality Account 2012/13 Chief Executive's welcome

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

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

Our vision is to be recognised nationally as a leading provider of high quality health and social care services and recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. We will be the first choice for service users, their families and commissioners. The information in this Quality Account demonstrates how we are working to deliver this.

We achieve many improvements in quality by changing how we deliver services across the city. We may expand services, re-organise how we provide them, develop better partnerships with other services in Sheffield. Change and improvements are delivered in this way, and you will find information about these changes in our full Annual Report for 2013/14.

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

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

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

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

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

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

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

Kevan Taylor
Chief Executive

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

We established our priorities for quality improvement in 2012. The people who use our services and the membership of our foundation trust have been instrumental in deciding what our priorities are. When we identified our priorities we agreed a two year plan to deliver improvements.

In order to establish these areas as our priorities the Board of Directors

- reviewed our performance against a range of quality indicators
- considered our broader vision and plans for service improvement
- continued to explore with our Council of Governors their views about what they felt was important
- engaged with our staff to understand their views about what was important and what we should improve

We then consulted on our proposed areas for quality improvement with a range of key stakeholders. These involved our local Clinical Commissioning Group, Sheffield City Council and members of LINk (now Healthwatch)

This report will show the progress we have made over the last two years. We will then confirm what new priorities have been identified for the future.

In reviewing our progress over the last two years and finalising our plans for next year we have continued to engage with our members. Our Governors have undertaken this on our behalf and we have received comments and feedback from over 300 of our members about our priorities for the future. From this review the Council of Governors have reviewed our plans and we have taken on board their feedback.

Through next year we will report on progress against our quality improvement objectives through the following ways:

- the Board's Quality Assurance Committee
- the Board of Directors
- to our Council of Governors formally at their meetings during the year
- to our Commissioners

***Our priorities for this year are:***

| | |
|---|---|
| ***Improving safety*** | ***Quality Objective 1***: To reduce the number of falls that cause harm to service users |
| | ***Quality Objective 2***: To reduce the incidence of violence and aggression and the subsequent use of restraint and seclusion |
| ***Improving clinical effectiveness*** | ***Quality Objective 3***: To improve the identification and assessment of physical health problems in at-risk client groups |
| ***Improving the delivery of positive service user experiences*** | ***Quality Objective 4***: To improve the experience of first contact with the Trust's services |
| ***Improving access, equality and inclusion*** | ***Quality Objective 5***: To improve access to the right care for people with a dementia |

## *Quality Objective 1: To reduce the number of falls that cause harm to service users*

### We chose this priority because

***Falls cause direct harm to service users because of injury, pain, restrictions on mobility and community participation. This harm impacts on peoples quality of life and well-being.*** The National Falls and Bone Health Audit in 2011 showed that during 2010/11 falls were higher in the Trust's older people's inpatient areas than the national average rate of falls. There were 13.5 falls per 1000 bed nights compared with 8.4 falls nationally.

Our own data showed that during 2011/12 1,605 incidents of slips, trips and falls for service users were reported by the Trust. 32.1% (n=516) resulted in harm or injury to the service user concerned.

Guidance was available on how to reduce the severity, frequency and impact of falls from NICE. We believed there were clear opportunities to deliver real improvements in this important area. This was also a priority area for Sheffield Clinical Commissioning Group who incentivised improvement in this area under the CQUIN scheme (see page 18)

### We said we would

Introduce a two year plan that started in 2012/13 and continued into 203/14. Within this plan we said we would

- Implement MFRA (Multi-factorial Risk Assessment) screening tool for falls for all older people admitted to inpatient areas
- Carry out environmental falls risk assessments in all inpatient and residential areas
- Identify appropriate training packages for staff and deliver a programme of training

### The outcome we wanted to achieve was

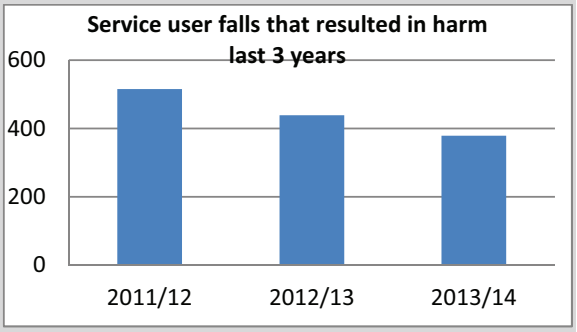
- To reduce the number of falls that result in harm to service users by 15% by the end of this year compared to two years ago.
- To reduce the level of harm experienced by service users from falls, as measured by reduction in number of falls resulting in A&E or hospital admission.
- That by the end of this year all older people admitted to inpatient areas will be assessed to see if they are vulnerable to experiencing a fall.

### How did we do?

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

Over the last 2 years 3 resource centres for older people have been closed as we have introduced new services. This has partly influenced the reduction in the numbers of falls as we have provided less care in residential type services. (*DN: final draft to quantify*)

In 2011/12 there were 516 falls that resulted in harm. We wanted to reduce that by 15% to 439 during this year. The number of falls resulting in harm has reduced by 26% to 379 this year.




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

| How many people | 2011-2012 | 2012-2013 | 2013-2014 |
|---|---|---|---|
| Needed to attend hospital or A&E | 62 | 52 | 50 |
| Experienced minor harm | 116 | 90 | 72 |
| Experienced moderate harm | 17 | 17 | 9 |
| Experienced major harm | 1 | 0 | 0 |

### How will we keep moving forward?

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

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

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

### We chose this priority because

***When violence or the potential for violence happens, it causes harm, distress, anxiety and fear for both service users and our staff. This will clearly have an impact on how people feel in receiving care or providing care within our inpatient services. It is in everyone's interest to reduce violence and the fear and anxiety associated with violence.***

In the past we have reported lower rates of violence and aggression when compared to other mental health trusts. Benchmarking information from the National Patient Safety Agency for the first 6 months of 2011/12 showed that 15.5% of patient safety incidents reported by the Trust were related to disruptive, aggressive behaviour, in comparison with 19% of incidents reported by mental health trusts nationally.

However, our own data showed that violent incidents made up a large proportion of our overall incidents. As well as this the CQC Staff Survey for 2011 showed the Trust fell into the highest (worst) 20% of staff from all areas of the trust who reported that they had experienced physical violence from patients, relatives or the public in the previous year.

### We said we would

We have introduced a programme called *RESPECT* which is an ethical approach to managing aggression and violence.

Its aim is to support staff to empathise with the service user, to understand that the service user may well be frightened and that may be what is informing their aggressive presentation. The programme promotes early recognition of the signs of pending aggression which supports more appropriate de-escalation approaches but also acknowledges that, on occasion, violence will be instrumental and that intervening physically will be the only safe response.

We have trained our staff to respond to these circumstances safely and with sensitivity. The programme will touch everyone in the organisation as it also focuses on exploring the environment and the context that the aggression is displayed within and what we can do to make improvements to the way we provide our care generally. Through this programme, during 2013/14 our plans were to

- Reduce further the incidents of seclusion and restraint from the levels in 2012/13
- Continue with our investment in the Respect development programme
- Implement a programme of practice reviews focussing on seclusion, de-escalation, physical health monitoring, post-incident reviews, use of green rooms
- Continue with our staff training programme
- Undertake a review of staff experiences of delivering care and how we can better support them to deliver respectful and compassionate care

### The outcome we wanted to achieve was

By the end of this year we wanted to ensure all inpatient nursing and support worker staff had been trained in the *RESPECT* Approach. We also wanted to

- Reduce the use of seclusion and the use of restraint
- Increase the percentage of service users in acute wards who report experiencing a safe environment in local surveys
- Reduce the number of staff reporting that they have experienced physical violence and harassment, bullying or abuse from service users, relatives or the public in the CQC Staff Survey

### How did we do?

We believe we are making good progress in delivering improvements for the longer term. Over the year the data is varied in what it shows across the different indicators.

The use of seclusion has increased significantly over the last year. We have reviewed this throughout the year and the Board's Quality Assurance Committee has been assured that the high increase is a reflection of changes to service user needs and the way we are delivering care:

- We are seeing more people in Sheffield. In previous years we sent over 30 people a year to other hospitals when they were acutely distressed. Now we are seeing them in Sheffield, which is a positive improvement. As we care for more

acutely ill and distressed people our use of seclusion has increased.

- We opened our new service for people with a learning disability in April-May (see page 35). During this time we cared for some people in our psychiatric intensive care service while waiting for the new service to open. The environment wasn't as well equipped as our new service for people with learning disabilities and challenging behaviours. The individuals on the ward needed caring for in a low stimulus environment for periods of time.
- Overall we are caring for more people who have more complex needs. The current ward environment is not best suited for the care of this vulnerable client group. The service has limited options for supporting service users in low stimulus environments.

The extensive staff development work we have done has had a positive impact in conveying expectations and the need to ensure all types of violence are accurately captured to ensure we fully understand day to day circumstances.

We believe that this is the main reason why reported incidents of violence towards staff has been increasing (*See Rows 4 & 6 below*). Analysis highlights that the vast majority of these incidents are 'lower level' types of violence, such as pushing and shoving, that may well have not been reported previously (*See Row 5 below*)

| Incident type | 2011/ 12 | 2012/ 13 | 2013/ 14 |
|---|---|---|---|
| 1) Incidents reported where **service users** had been | | | |
| • Secluded | 82 | 74 | 277 |
| • Restrained | 105 | 90 | 150 |
| • Assaulted | 387 | 387 | 378 |
| • Caused harm from assault | 89 | 72 | 65 |
| 2) Proportion of all reported **patient safety incidents** related to disruptive or aggressive behaviour | | | |
| • Within our Trust | 15.5% | 20.6% | n/a for draft |
| • National averages for mental health trusts | 19% | 18.2% | |
| *NPSA Benchmarking data* | | | |

| Incident type | 2011/ 12 | 2012/ 13 | 2014/ 14 |
|---|---|---|---|
| 3) Percentages of **service users** who report feeling unsafe in local surveys | 25% | 32% July<br>23% Dec | 29% Aug |
| 4) Incidents reported where **staff** working in inpatient services | | | |
| • Had been assaulted | 364 | 606 | 634 |
| • Caused harm from assault | 110 | 99 | 116 |
| 5) Level of harm caused from the assault | | | |
| • Negligible harm | 91 | 68 | 99 |
| • Minor or moderate | 19 | 31 | 17 |
| • Major and above | 0 | 0 | 0 |
| 6) Number of **staff** who reported to the national CQC staff survey that they had experienced from patients, relatives or visitors | | | |
| • physical violence | 17% | 22% | 26% |
| • harassment, bullying or abuse | 19% | 30% | 34% |

This is a complex issue to report on. The threat of violence and actual violence clearly causes fear and psychological distress. The impact and consequences for people are individual to them. Reporting through data about incidents does not capture this fully, yet it is important to have an awareness of overall incident levels. That is what we report on here.

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

### How will we keep moving forward?

- We have established a multi-disciplinary group to review each incident of seclusion to inform our understanding of how care is being provided to vulnerable people.
- The Board has recognised the role and importance of the ward environment, and the need to improve our current service. The Board has approved an investment of £6.4 million to build a new Intensive Treatment Service ward.
- We will continue with the *RESPECT* development programme

## *Quality Objective 3: To improve the identification and assessment of physical health problems in at-risk client groups*

### We chose this priority because

***Physical health was a priority for our governors and service users, as many of our service users are at higher risk of developing physical health problems.***
The evidence clearly shows that people with severe mental illness and people with learning disabilities have reduced life expectancy and greater morbidity, as do people who are homeless and people who misuse drugs and alcohol.

We were already working on a number of programmes to make improvements e.g. physical health checks on wards, use of early warning signs toolkit, link nurses for illnesses such as diabetes, smoking cessation, health facilitators and health action plans, staff training in 'healthy chats'. The introduction of physical reviews for people with long term mental health problems in primary care presented additional opportunities to make further improvements.

Audits of care records across our mental health and learning disability services in November 2011 showed overall in 78% of service users' records their physical health status was checked and documented. This was less across our community mental health service areas. Our GP services performed well across a range of areas in meeting the physical health care needs of people with mental health problems, although performance was poor for people newly diagnosed with dementia.

### We said we would

Continue our current plans to bring together achievable actions within the trust and external to partner organisations. We planned to build on existing and planned developments to ensure that we and our partner organisations work collaboratively to ensure health of service users continues to improve.

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

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

### The outcome we wanted to achieve was

- 'Health chat' key trainers to cascade training into clinical settings and become 'champions' for these settings
- 90% of people to have physical health checks recorded in all relevant service areas
- Improved awareness of peoples smoking circumstances with appropriate support provided
- Diabetes link nurses in all inpatient areas
- Measure of better communication between SHSC and primary care on physical health key information e.g. blood pressure
- Clover group to improve performance and achieve the QOF targets on physical health checks for dementia and BMI for people with psychosis

## How did we do?

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

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

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

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

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

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

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

## How will we keep moving forward?

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

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

## *Quality Objective 4: To improve the experience of first contact with the Trust's services*

### We chose this priority because

***Our Governors and service users had identified this issue as a priority for positively influencing the service users overall experience of the services we provide.*** Although the CQC Community Mental Health service user survey indicates that service users feel they are treated with dignity and respect in most instances, complaints about staff attitude are still received.

Following low scores on the CQC Annual Community Mental Health for questions about a 24 hours phone line, the Trust had piloted an out-of-hours phone line to give advice and help to service users and carers, in partnership with Rethink. We were keen to learn from the pilot and provide on-going support to service users.

The *RESPECT* training which is being implemented for all staff (*see objective 2*) includes key elements about treating service users with dignity and respect. Initial feedback indicates a positive impact on staff attitude, and we wanted to support this programme to deliver improvements to the day to day experiences of our service users.

### We said we would

- Continue with the *RESPECT* development programme for new staff and the 15 Steps Challenge to support the delivery of improved experiences.
- Continue to review service user experiences through local surveys.
- Complete the review of the range of information we provide to service users and agree improvements
- Focus on supporting service users to access our services quickly. To support this we will confirm improvement targets in respect of our Improving Access to Psychological Therapies (IAPT) services (assessed within 4 weeks of referral) and our Community Mental Health Team (CMHT) services (assessed within 2 weeks of referral) and establish targets for our Memory services (see Quality Objective 5)

### The outcome we wanted to achieve was

- Improved awareness of services users about the support available through the crisis helpline
- More staff trained in customer care as part of the roll out of Respect training
- Better information provided to support service users entering our services
- To remain in top 20% of mental health trusts in CQC Annual Community Mental Health Survey for being treated with dignity and respect
- Reduce the waiting times experienced by people to access services

### How did we do?

We have made positive progress with the provision of helpline support for service users. We opened a new Crisis House service, in partnership with Rethink, in April 2013. It has provided support to around 300 people a year as an alternative to needing hospital care. As part of Crisis House service Rethink also provide the crisis helpline service for our service users. During 2012/13 the crisis helpline was used to support xxx people, which reflects how well it is being used.

All inpatient staff have benefited from the *RESPECT* development and training programme, and it is having a positive effect across our services. We continue to provide the training to support new staff who have since joined the service, and to provide updates to existing staff who have been trained previously.

| Areas of experience | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Awareness of crisis support available through telephone helpline (*National Patient Survey*) | 5.0 out of 10 | 5.3 out of 10 | n/a see note |
| Ensure all inpatient staff have benefited from Respect development programme | 155 staff | Extra 209 364 in total | Extra 582 tbc in total |
| Service users reporting they are treated with respect (*National Patient Survey*) | 9.5 out of 10 | 9.4 out of 10 | n/a see note |

Note: We will use the national patient survey as a way of assessing feedback and progress over this year. Unfortunately the national survey had not been completed in time for us to include the results in this Report.

We have successfully recruited a team of service users to help us introduce the 15 Steps Challenge programme. This approach helps us to understand people's feelings and experiences of entering services for the first time. We have piloted this on two wards, and will be rolling it our across services next year.

During the year we wanted to reduce the waiting times for key services. We have made good progress within our IAPT services and across our adult community mental health teams.

During the year we introduced a range of improvement approaches to identified GP practices where patients were experiencing the longest waiting times for IAPT services. Through better team working with primary care services and the introduction of simpler booking systems we have seen a really positive improvement. People are now able to access advice and support and start treatment much quicker than before.

During 2012/13 we changed the way we organised our adult community mental health teams. One of the main reasons for this was to reduce waiting times by working more closely with primary care services. As the new services have been established during 2013/14 we are pleased to report that waiting times for assessments have significantly improved.

| To reduce waiting times | | 2012/ 13 | 2013/ 14 |
|---|---|---|---|
| Average waiting time to access IAPT services for treatment | | 5.6 weeks | 5.3 weeks |
| Average waiting time for the 8 practices with the longest waiting times | | 14.2 weeks | 6.8 weeks |
| Average waiting times for people to be assessed within community mental health teams | | 5.7 weeks | 2.2 weeks |
| Proportion of people referred to CMHT services assessed within 2 weeks of referral | | 23.7% | 25% |

**Next year we intend to**

- We will continue to rollout the 15 Steps Challenge programme across services
- We have prioritised further improvements in reducing waiting times as a Quality Objective for next year and will report on progress in future reports.

## *Quality Objective 5: To improve access to the right care for people with a dementia*

### We chose this priority because

***Improving dementia care is a priority for the Trust, governors, the City Council, Sheffield Clinical Commissioning Group, and Healthwatch. The incidence of dementia is predicted to rise with Sheffield's aging population. We know that early identification and rapid access to services can delay the impact of dementia and lead to a better quality of care and better support for carers.***

Overall Sheffield performs well in comparison with other areas in the identification of people with dementia, enabling them to access care and treatment. This is measured by people with a diagnosis on the Quality Outcomes Framework by their GP in primary care. In 2012 Sheffield 63.6% of the expected number of people with a dementia have been registered, compared to the national average of 44.2%. Sheffield is the 2nd best performing area in England and Wales.

We wanted to build on the delivery of the NICE Quality Standard for Dementia and positive development work already underway over the last few years to improve access to our services and reduce waiting times. Within our learning disability services a specific dementia care pathway has been developed because of the increased risk of early dementia in people with Downs syndrome.

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

### We said we would

- Recognise the clear disparity in waiting times for people needing to access our memory services compared to other routine services we provide. To address this we planned to review the options to deliver real improvements in waiting times for our memory services and confirm the targets we wish to deliver upon. We agreed to report on this in next years Quality Account, along with the progress we have made.
- Work with GP practices in Sheffield, and the Clinical Commissioning Group to support more people who have been assessed for memory problems to receive their on-going monitoring with their GP, rather than needing to attend a specialist service.
- Evaluate the effectiveness of the pilot liaison services into the local general hospital and agree future needs
- Build on the 'Involving People with Dementia Project' and introduce more ways to gain regular feedback from people with dementia.
- Use the 'Voice of Dementia' film to support awareness raising and training for members of the public and staff across Sheffield working in relevant sectors.

### The outcome we wanted to achieve was

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

### How did we do?

Over the last year we haven't made the progress we wanted to in reducing waiting times for people to access our memory services.

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

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

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

| Access | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Number of people assessed and diagnosed by the service | 876 | 846 | 892 |
| Waiting time to access an assessment | 14 weeks | 15.4 weeks | 15.8 weeks projected |

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

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

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

We will introduce the new model in stages through 2014/15 and will monitor the impact this has.

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

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

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

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

### How will we keep moving forward?

- We have agreed a development plan for service change with our commissioners. The aim of this plan is to help us see more people and see them quickly. We will implement this plan during 2014/15 and report on progress in our future reports.
- We have prioritised reducing waiting times over the next year as one of our Quality Objectives for the next year. We will continue to report on the experience of waiting times for memory services as part of this objective and our progress towards achieving our aim of waiting times of 6-8 weeks.

## Our quality goals for next year

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

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

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

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

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

We have taken this opportunity to revitalise our commitment that the people who use our services are at the heart of everything we do. We will ensure the successful delivery of our commitments to

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

We have worked with our Governors to understand their views about what will make the most difference to improve the experience of people who use our services. Our Governors surveyed the Trust's Membership about our developing priorities and we received responses from over 300 Members. Our Governors, through a workshop and surveys they have told us that we should focus on the following areas:

- To continue to support staff to have an appreciation and awareness of what it is like to receive care. This includes strengthening the culture of the organisation and our workforce, along with improving how we gather feedback about people's experiences. We have agreed objectives that will improve how we do this through monitoring service users experience, led by service users, alongside better workforce development that involve service users in the delivery of training to our staff.

- To continue to improve how quickly people can access support and care. This included waiting times generally, access to preventative support and support during times of crisis. Feedback also highlighted that we should give attention to what happens when people get care and support from different teams and reduce the amount of repeated assessments that people receive. We have agreed a number of objectives that focus on reducing waiting times in key areas. We will review care pathways to simplify arrangements and reduce duplication for service users.

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

## Our quality objectives for the next two years

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

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

*Why have we identified this?*

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

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

*Why have we identified this?*

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

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

*Why have we identified this?*

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

## How do our structures help ensure we are able to develop our quality improvement capacity and capability to deliver these improvements?

Our governance arrangements and structures support us to focus our efforts on improving the quality and effectiveness of what we do, and deliver on the objectives we have set

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

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

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

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

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

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

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

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

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

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

**MONITOR & ASSESS**
**Ensuring we evaluate how we are doing**

We have a team governance programme that supports each service to reflect on how they perform and agree plans for development

We have prioritised the provision of information to teams so they can understand how they are doing, and we continue to improve our ability to provide them with the information they need

We periodically self-assess our services against national care standards with service users, members, governors and our non-executive directors providing their views through visits and inspections

**WORKFORCE DEVELOPMENT & LEADERSHIP**
**Supporting and developing our staff to deliver the best care**

We have an established workforce training programme that aims to equip our staff with the skills, knowledge and values to deliver high quality care

We have a well established culture and programme of developing our clinical and managerial leadership teams to support them to deliver improvements in care

We use a range of service improvement and system improvement models to help us deliver the changes we wish to see, we continue to increase our ability to do this

**QUALITY ASSURANCE COMMITTEE**
**Evaluates and makes sense of the information from the above systems, and directs actions and decision making for future action**

- Service user safety group
- Health & Safety Committee
- Infection Prevention and Control Committee
- Safeguarding Children Steering Group
- Audit Committee
- Mental Health Act Group

**BOARD OF DIRECTORS**

**COUNCIL OF GOVERNORS**

- Safeguarding Adults Steering Group
- Psychological therapies governance committee
- Medicines Management Committee
- NICE Steering Group
- Information Governance Gp

## Part 2B: Mandatory statements of assurance from the Board relating to the quality of services provided

### 2.1 Statements from the Care Quality Commission (CQC)

Sheffield Health and Social Care NHS Foundation Trust is required to register with the Care Quality Commission and our current registration status is registered without conditions and therefore licenced to provide services.

The Care Quality Commission has not taken enforcement action against the Trust during 2013/14. The Trust has not participated in any special reviews or investigation by the CQC during the reporting period

The CQC registers, and licenses the Trust as a provider of care services as long as we meet essential standards of quality and safety. The CQC monitors us to make sure we continue to meet these standards.

During 2013/14 we de-registered Rutland Road (a respite care service for people with a learning disability) and Bolehill View (a respite care service for people with dementia) from our registration, as a result of the services moving to other locations. We registered 136 Warminster Road as a respite care service for people with a learning disability.

**Planned / Unplanned reviews**

During 2013/14 the CQC visited the following locations as part of their review of our compliance with essential standards of quality and safety:

- Residential homes for people with a learning disability
  *Cottam Road, Birch Avenue, East Bank Road, Beighton Road*
- Residential homes for people with dementia
  *Woodland View*
- Respite Care services for people with a learning disability
  *Longley Meadows, 136 Warminster Road*
- Supported Living services for people with a learning disability
  *Mansfield View*
- Respite Care services for adults
  *Hurfield View, Wainwright Crescent*
- Inpatient Services
  *Forest Lodge*

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

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

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

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

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

**Mental Health Act reviews**

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

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

We have also participated in a review of how we manage Community Treatment Orders. The feedback from all these visits is helpful and allows us to ensure, and be assured, that we provide care in accordance with legislation and best practice guidelines. These reviews and inspections confirm that we continue to meet all essential standards.

## 2.2 Monitors' Assessment

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

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

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

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

2012/13

We achieved all healthcare targets for each Quarter with the exception of Quarter 2.

During Quarter 2 the Trust failed to achieve the requirement to provide follow up care within 7 days of discharge from inpatient care for people under the Care Programme Approach. A range of improvement actions were implemented and the Trust continued to achieve the target for the rest of the year.

2013/14

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

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

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

This enabled us to make improvements and we achieved the target by the end of the year. (DN: Expected position)

| 2012/13 Governance assessment of our performance | | | | |
|---|---|---|---|---|
| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
| Financial risk rating | 4 | 4 | 5 | 4 |
| Governance risk rating | Green | Amber/Green | Green | Green |
| *Note: During 2012/13 Monitor assessed performance under the Compliance Framework* | | | | |

| 2013/14 Governance assessment of our performance | | | | |
|---|---|---|---|---|
| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
| Financial risk rating | 5 | 5 | n/a | n/a |
| Continuity of services rating | n/a *(4)* | n/a *(4)* | 4 | 4 |
| Governance risk rating | Green | Green | Green | Green |
| *Note: During 2013/14 Monitors assessment framework changed to the Risk Assessment Framework in Quarter 3. The Financial risk rating was replaced by a Continuity of services rating. To help with comparisons we have shown what we would have been in Q1 & Q2 under the new framework.* | | | | |

## 2.3 Goals agreed with our NHS Commissioners

A proportion of our income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

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

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

| ***Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences*** | Goal during 2013/14 | Continued into 2014/15 |
|---|---|---|
| NHS Safety Thermometer Improve collection of data<br>We wanted to monitor incidents of pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE. This was to ensure we were effectively monitoring safety. We agreed improvement targets to reduce incidents of falls and achieved them. | ✓ FULLY ACHIEVED | ✓ |
| Reducing variation in waiting times for patients referred to the IAPT services<br>We identified 8 GP practices where people were experiencing very long waiting times to access our IAPT services. We wanted to reduce the waiting times from an average of 15 weeks to below 10 weeks for these 8 practices. We were very successful with this. Waiting times reduced to 4.5 weeks for the period September 2013 to March 2014. Next year we will continue to work to reduce waiting times. | ✓ FULLY ACHIEVED | ✓ |
| Reduced admissions to Acute Older Adult Wards through improved community care for people in a crisis<br>We had established new community services to provide alternatives to hospital admission. As a result of this we wanted to gradually reduce the numbers of people who needed hospital care. We were successful with this goal. As a result of providing better community services the need for hospital care reduced by 36% this year compared to 2 years ago. | ✓ FULLY ACHIEVED | No<br>We have made the progress we wanted to |
| Reduction in the number of falls causing harm<br>This goal supported our Quality Objective No 1. We successfully achieved our target of reducing harm caused from falls by 26% over the last 2 years. (See page 4 for details) | ✓ FULLY ACHIEVED | No<br>We have made the progress we wanted to |
| Improving the management of Violence and Aggression within inpatient services<br>This goal supported our Quality Objective No 2. The focus was to improve the service user and staff experience in relation to violence and aggression. We implemented a successful development and service improvement programme. (See page 5 for details) | ✓ FULLY ACHIEVED | No<br>We have made the progress we wanted to |

| ***Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences*** | Goal during 2013/14 | Continued into 2014/15 |
|---|---|---|
| People using mental health services should have an agreed plan to help reduce and manage the persons risk<br>We wanted to increase the numbers of service users who had risk reduction plans in place following their initial risk assessment. We achieved the target and by the end of this year 76% of people receiving on-going mental health care support had a risk reduction plan in place. | ✓ FULLY ACHIEVED | No<br>We have made the progress we wanted to |
| People who are referred for a routine assessment will be assessed within 2 weeks of the referral<br>Following changes to our community mental health team services we wanted to deliver quicker access to our services following referral from GPs. We set a goal a goal for the number of people we would see for assessment within 2 weeks of the referral being made. We were successful with this. | ✓ FULLY ACHIEVED | ✓ |
| People using mental health services should have a care plan agreed with them and in place within 6 weeks of the assessment<br>In line with the above service changes, we wanted to ensure that following an assessment, those who needed on-going support and treatment then had a plan of care in place quickly. By the end of the year 75% of people had a care plan agreed within 6 weeks. | ✓ FULLY ACHIEVED | ✓ |
| Improved use of electronic discharge communications between inpatient services and GP's<br>During the year we introduced ways to send GP's information about a clients care plan electronically rather than through the post. We piloted this and had a successful system in place by the end of the year. This has improved the way we let GP's know about the arrangements for someone's care and treatment when they leave hospital. | ✓ FULLY ACHIEVED | ✓ |
| Improved and standardised approaches to surveying service user experiences across all service areas<br>We improved the way we asked people about their experience of the care and treatment we provided them. We introduced the Friends and Family Test as a pilot in some of our inpatient and community services | ✓ FULLY ACHIEVED | ✓ |
| Introducing the Friends and Family test for service users and staff<br>This new national CQUIN indicator will be introduced next year. It will help us get better feedback from the people who use our services, and our staff, about the quality of the care we are providing. This will help us make better choices about what we prioritise for improvement in the future. | No | ✓ |
| Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness<br>This new national CQUIN indicator will be introduced next year. It will focus on improving the way we provide support for peoples physical health care needs in conjunction with primary care services. | No | ✓ |

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

## 2.4 Review of services

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

The Trust has reviewed all the data available on the quality of care in these services. The Trust reviews data on the quality of care with Sheffield CCG, other CCGs, Sheffield City Council and other NHS commissioners.

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

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

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

### Health and Safety Executive

There were no Health and Safety Executive visits to the Trust during 2013/14.

### South Yorkshire Fire and Rescue

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

## 2.6 Compliance with NHS Litigation Authority (NHSLA) Risk management Standards

The NHSLA handles negligence claims made against the NHS and works to improve risk management. Their former risk management standards covered organisational, clinical, non-clinical and health and safety risks.

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

## 2.7 Participation in Clinical Research

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

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

The Trust was involved in conducting 60 clinical research projects which aimed to improve the quality of services, increase service user safety and deliver effective outcomes. Areas of research in which the Trust has been active over the last 12 months include:

- 10 centre randomised controlled trial of an intervention to reduce or prevent weight gain in schizophrenia (NIHR funded, SHSC is the sponsor and lead Trust)
- Stigma and discrimination aimed at mental health service users
- DNA polymorphisms in alcohol misuse and schizophrenia
- Understanding and improving the safety of psychological therapies
- Developing interventions to improve the physical health of those with severe mental illness

- New treatments for service users with dementia (including Alzheimer's disease).

Research is a priority for the Trust and is one of the key ways by which the Trust seeks to improve quality, efficiency and initiate innovation. Over the last year the Trust has worked closely with the East Midland and South Yorkshire Mental health Research Network and South Yorkshire Comprehensive Local Research Network to increase opportunities for our service users to participate in commercial clinical trials of new treatments and with academic partners, including the Clinical Trials Research Unit at the University of Sheffield, to initiate research projects sponsored by the Trust.

## 2.8 Participation in Clinical Audits

### National Clinical Audits and National Confidential Enquiries

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

During 2013/14 the Trust participated in 100% national clinical audits and 100% national confidential inquiries which it was eligible to participate in.

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

| Name of national audit SHSC participated in | Number of cases submitted | Number of cases submitted as a percentage of those asked for |
|---|---|---|
| Guideline Audits | | |
| National Audit of Schizophrenia (re-audit) - To measure the Trusts performance against national NICE guidelines | 200 | 100% |
| POMH UK | | |
| Prescribing for ADHD (Topic 13) - To ensure service users with ADHD cared for in accordance with NICE guidelines | 45 | 100% |
| Prescribing antipsychotics for people with dementia (Topic 11b) - To ensure national guidance are followed | 33 | 100% |
| Prescribing anti-dementia drugs (Topic 4b) - To ensure national guidance are followed (***Note 1***) | ***Note 1*** | tbc |
| National Confidential Inquiries | | |
| Inquiry into Suicide & Homicide by people with mental illness | 16 | 30% (***Note 2***) |
| Inquiry into Suicide & Homicide by people with mental illness Out of District Deaths | 0 | 0% |
| Inquiry into Suicide & Homicide by people with mental illness Homicide data | 4 | 33% (***Note 2***) |
| Other local audit programmes | | |
| Falls Audit – To support the CQUIN scheme, see 2.3 | 31 | N/A |
| Patient and staff safety - To support the CQUIN scheme, see 2.3 | 165 | N/A |
| Patient safety thermometer - To support the CQUIN scheme, see 2.3 | 261 | 100% |
| NHS LA Care Records - To ensure risk assessment documentation is adhering to guidelines (***Note 1***) | ***Note 1*** | N/A |
| Suicide Audit - An audit in Community Teams of the NPSA suicide toolkit | 7 | 100% |
| Food and nutrition – To ensure that inpatients are being screened for nutrition on admission and discharge | 118 | N/A |
| Safeguarding children and adults - A baseline audit of staff knowledge | 480 | N/A |

***Note 1***: This audit commenced during 2013/14 but did not conclude until the following year. We will publish the findings in next years Quality Account report.
***Note 2***: The percentage figure represents the numbers of people who we reported as having prior involvement with as percentage of all Inquiries made to us under the National Confidential Inquiry programme. ie in 70% of all inquiries, we had no record of having had prior involvement with the individual concerned.

The reports of 4 national and local clinical audits were reviewed by the Trust in 2013/14 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

| National audit | Results and actions |
|---|---|
| National Audit of Schizophrenia | **Results** – The audit findings have yet to be published. We know we need to improve and get better at monitoring of physical health<br><br>**The Actions we have taken are:**<br>TBC |
| Prescribing for people with ADHD | **Results** – We need to improve the range of information we gather to understand the needs of the service users we provide support for.<br><br>**The Actions we have taken are:**<br>We will improve the information and educational support we provide to service users about medication and their needs. We will review and how we provide support in conjunction with primary care services and improve the information we provide at the point of discharge. |
| Prescribing antipsychotics for people with dementia | **Results –** People with dementia who had been prescribed an antipsychotic medication had been prescribed it appropriately in line with guidelines. However we could improve how we involved carers in the decisions made regarding medication.<br><br>**The Actions we have taken are:**<br>We will continue to monitor prescribing practices, paying attention to the above issues. |
| Prescribing anti-dementia drugs | **Results** – This audit was at the data collection stage during the drafting of this report. We will publically report findings in next year's Quality Account.<br><br>**The Actions we have taken are:**<br>To be established as the audit is concluded. |
| **Local audit** | **Results and actions** |
| Falls Audit | **Results** – The our achievement of the practice standards relating to falls assessment at admission, and establishing falls reduction plans for those at risk of falling improved during the year.<br><br>**The Actions we have taken are:**<br>The detailed overview of the progress we have made is outlined on page 4 regarding our quality objective to reduce harm caused from falls. |
| Patient and staff safety | **Results** – Following the last survey done in December 2012 there has been improvements in all six questions on safety within the audit.<br><br>**The Actions we have taken are:**<br>The detailed overview of the progress we have made is outlined on page 5 regarding our quality objective to reduce incidents of violence and aggression. |
| Patient safety thermometer | **Results** – The Trust contines to be at least 99% harm free, according to the 'snap shot' patient safety thermometer.<br><br>**The Actions we have taken are:**<br>To continue to monitor progress and incidents of harm |

| | |
|---|---|
| Suicide Audit | **Results** – From the audit sample we were compliant with all the best practice standards in the NPSA Suicide Toolkit. We found isolated examples were we could improve communication with family members following such tragic events.<br><br>**The Actions we have taken are:**<br>We will review the current arrangements in place to ensure information is shared with families and carers in an appropriate and supportive way. |
| Safeguarding Children and Adults. | **Results** - The audit identified that the majority of staff reported they new what to do if they had concerns regarding the safeguarding of children or adults. However the level of confidence staff felt they had in this area was variable.<br><br>**The Actions we have taken are:**<br>We plan to ensure that more staff are able to receive training. |
| Food and nutrition | **Results –** We wanted to extend the Nutritional assessments that were being done successfully on our Older Adult wards to our other inpatient services. The audit found that this was happening, but some wards still needed to make improvements.<br><br>**The Actions we have taken are:**<br>We had previously appointed a Dietician to support staff training and improved practice, and this is having a positive impact. We will continue to monitor the practice across all inpatient wards. |

Local audit activity

Local clinical audits are conducted by staff and teams evaluating aspects of the care they themselves have selected as being important to their teams. Our main commissioner, Sheffield CCG, also asks the Trust to complete a number of local clinical audits each year, to review local quality and safety priorities. On a quarterly basis the board review the progress of other local audits.

## 2.9 Data Quality

Good quality information underpins the effective delivery of care and is essential if improvements in quality care are to be made. Adherence to good data quality principles (complete, accurate, relevant, accessible, timely) allows us to support teams and the Board of Directors in understanding how we are doing and identifying areas that require support and attention.

External Auditors have tested the accuracy of the data and our systems used to monitor the following indicators

- 7 day follow up - everyone discharged from hospital should receive support in the community within 7 days of being discharged
- 'Gate keeping' - everyone admitted to hospital should be assessed and considered for home treatment
- Waiting times – as prioritised by our Governors

As with previous years, the audit has confirmed the validity and accuracy of the data used within the Trust to monitor, assess and report our performance. (DN: expected)

The Trust submitted records during 2013/14 to the Secondary uses service (SUS) for inclusion in the Hospital episodes Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was 98.9% for admitted care. The percentage of records in the published data which included the patients valid General Practitioner Registration Code was 95.9% for admitted care. No other information was submitted.

The latest published data from the SUS regarding data quality under the mental health minimum data set is for April 2013- December 2014. The Trusts performance on data quality compares well to national averages and is summarised as follows:

| Percentage of valid records | Data quality 2013/14 | National average |
|---|---|---|
| NHS Number | 100% | 99.4% |
| Date of birth | 100% | 99.7% |
| Gender | 100% | 99.4% |
| Postcode | 100% | 99.0% |
| Commissioner code | 100% | 99.3% |
| GP Code | 100% | 98.3% |
| Primary diagnosis | tbc | 98.5% |
| HoNOS outcome | tbc | 88.9% |
| The data and comparative data is from the published MHMDS Reports for the Q1-Q3 periods inclusive | | |

DN: the above data is based on Q3 Trust data. The national average isn't available currently to aid comparison. Last years averages are provided for information

**Clinical coding error rates**

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

## 2.10 Information governance

We aim to deliver the best practice standards in Information Governance by ensuring that information is dealt with legally, securely and effectively in order to deliver the best possible care to our service users.

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

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

DN: The Trusts annual performance is currently being assessed and is not available at the time of issuing this draft report.

| | Achieved | | |
|---|---|---|---|
| Criteria | 2012/13 | 2013/14 | Current Grade |
| Information Governance Management | 73% | Tbc | Satisfactory |
| Confidentiality and Data Protection Assurance | 74% | Tbc | Satisfactory |
| Information Security Assurance | 66% | Tbc | Satisfactory |
| Clinical Information Assurance | 73% | Tbc | Satisfactory |
| Secondary Use Assurance | 66% | Tbc | Satisfactory |
| Corporate Information Assurance | 66% | Tbc | Satisfactory |
| Overall | 69% | tbc | Satisfactory |

# Part 3: Review of our Quality Performance

## 3.1 Safety

### Overall number of incidents reported

The Trust traditionally reports a high number of incidents compared to other organisations. This is viewed as a positive reflection of the safety culture within the Trust. It helps us to be able to really understand what the experience of care is like, spot trends and make better decisions about what we want to address and prioritise for improvement. The National Patient Safety Agency consistently assesses our performance, using the data supplied through the National Reporting Learning System (NRLS) as in the highest (best performing) 25% of Trust's for actively encouraging the reporting of incidents. For the 6 month period April- September 2013, SHSC was the 10th highest performer of 56 mental health trusts.

Nationally, based on learning from incidents and errors across the NHS, the National patient Safety Agency has identified a range of errors that should always be prevented. These are often referred to as 'never events', because with the right systems to support care and treatment in place they should never need to happen again. None of the incidents that occurred within the Trust over the last year were of this category.

### Patient safety alerts

The NHS disseminates safety alerts through a Central Alerting System. The Trust responded effectively to all alerts communicated through this system. During 2013/14 the Trust received 70 non-emergency alert notices, of which 100% where acknowledged within 48 hours, 4 were applicable to the services provided by the Trust and all were acted upon within the required timescale. In addition a further 37 emergency alerts were received an acted upon straight away.

### Patient safety information on types of incidents

Self-harm and suicide incidents

The risk of self-harm or suicide is always a serious concern for mental health and substance misuse services. The NPSA figures show 11.3% of all patient safety incidents reported by the Trust were related to self harm, in comparison with 18.1% for mental health trusts nationally. This is similar to the previous year where the figures were 11.4% and 18.7% respectively.

During the last three years clinical risk training was provided for SHSC staff and new clinical risk assessment and management tools have been introduced throughout the Trust. Last year 1,329 staff staff from all professional groups received the training, which covers the principles and practice of risk assessment and management. We had planned to train 2,000 members of staff. The main reason leading to our under achievement of our target has been capacity to support the release of staff from front line service delivery. We are reviewing our approaches to this for next year to ensure we can deliver improvements.

Violence, aggression and verbal abuse

In previous years the Trust has reported relatively low incidents of disruptive and aggressive behaviour within our services compared to other mental health organisations. This has increased during 2012/13 in line with the position reported in Section 2. 20.6% of patient safety incidents reported by the Trust were for aggressive behaviour in comparison with a national average of 18.2%, based on NPSA benchmarking data for first 6 months of the year. In the previous year, 2012/13 the figures were 20.6% and 18.2% respectively.

Medication errors and near misses

Staff are encouraged to report near misses and errors that do not result in harm to make sure that they are able to learn to make the use and prescribing of medication as safe and effective as possible. 6.1% of patient safety incidents reported by the Trust related to medication, compared with 8.4% in mental health trusts nationally. There has been little change in the number of medication incidents reported by the Trust over the last 3 years.

**Cleanliness and infection control**

The Trust is committed to providing clean safe care for all our service users and ensuring that harm is prevented from irreducible infections.
To achieve this an annual programme is produced by the Infection Prevention and Control Team that details the methods and actions required to achieve these ends.

The programme includes:

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

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

**Single sex accommodation**

The Trust is fully compliant with guidelines relating to providing for appropriate facilities for men and women in residential and inpatient settings. During 2012/13 we have reported no breaches of these guidelines.

**Safeguarding**

The Trust fully complies with its responsibilities and duties in respect of Safeguarding Vulnerable Adults, and Safeguarding Children. We have a duty to safeguard those we come into contact with through the delivery of our services. We fulfil our obligations through ensuring we have

- robust systems and policies in place that are followed
- the right training and supervision in place to enable staff to recognise vulnerability and take action
- expert advice available to reduce the risks to vulnerable people

**Reviews and investigations**

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

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

**Improvements and lessons learnt**

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

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

Examples of the types of improvement actions we have been able to take following reviews of serious incidents are

- Involving service user families/carers in their care/decision making
- Comprehensive and timely record keeping, ensuring the rationale for decisions made is recorded
- Making sure that urgent referrals into the Trust are easily identified
- Communication between NHS professionals to be strengthened to ensure information is shared appropriately

**Using incident data to prioritise improvement actions**

From the incident data below, and our review of the types of incidents that occur across our services, we prioritised falls and violent incidents for attention. Our plans, and progress against those plans is reported in detail on pages 4 and 5 of this Report

**Overview of incidents by type**

The table below reports on the full number of incidents reported within the Trust. It then reports on the numbers of those incidents that were reported to result in harm for service users and staff.

| Incident Type | 2011/12 | 2012/13 | 2013/14* |
|---|---|---|---|
| All incidents | 6408 (a) | 6260 | 5693 |
| All incidents resulting in harm | 1689 | 1508 | 1385 |
| Serious incidents (investigation carried out) | 45 | 34 | 30 |
| Patient safety incidents reported to NRLS (d) | 3598 | 3340 | 3489 |
| Patient safety incidents reported as 'severe' or 'death' | 41 | 42 | 30 |
| Expressed as a percentage of all patient safety incidents reported to NRLS | 1.1% | 1.3% | 1.2% |
| Slips, Trips and Falls incidents | 1652 | 1180 | 1136 |
| Slips, Trips and Falls incidents resulting in harm | 558 | 420 | 405 |
| Self-harm incidents | 369 (a) | 425 | 422 |
| Suicide incidents (in-patient or within 7 days of discharge) | 2 (b) | 0 (c) | 0 (c) |
| Suicide incidents (community) | 13 | 5 (c) | 11 |
| Violence, aggression, threatening behaviour and verbal abuse incidents | 1644 | 1930 | 2088 |
| Violence, aggression and verbal abuse incidents resulting in harm | 276 | 240 | 253 |
| Medication Errors | 360 (a) | 321 | 342 |
| Medication Errors resulting in harm | 0 | 1 | 2 |
| Infection Control | | | |
| *Infection incidents* | | | |
| MRSA Bacteraemia | 0 | 1 | 1 |
| Clostridium difficile Infections | 0 | 0 | 0 |
| Periods of Increased infection/Outbreak | | | |
| • Norovirus | 7 (60) | 3 (28) | 3 (28) |
| • Rotavirus | 0 | 0 | 0 |
| • Influenza | 0 | 1 (3) | 1 (3) |
| Showing number of incidents, then people effected in brackets | | | |
| *Preventative measures* | | | |
| MRSA Screening – based on randomised sampling to identify expected range to target | 2% | 39% | 39% |
| Staff Influenza Vaccinations | 37.6% | 56% | 56% |

(a) The incident numbers have increased from those reported in the 2011/12 Quality Account report due to additional incidents being entered onto the information system after the completion of the report.
(b) The figure has decreased from that reported in last year's Quality Account report due to an HM Coroner's inquest which has not yet been held. It is likely that this figure will increase in next year's report
(c) Figures are likely to increase pending the conclusion of future HM Coroner's inquests. This will be reported in next year's report.
(d) The NRLS is the National Reporting Learning System, a comprehensive database set up by the former National Patient Safety Agency that captures patient safety information.

## 3.2 Effectiveness

The following information summarises our performance against a range of measures of service effectiveness.

**Primary Care Services – Clover Group GP Practices**

The Quality Outcomes Framework (QoF) provides a range of good practice standards for the delivery of GP services. Traditionally the 4 practices that have formed the Clover Group have been below the Sheffield averages in their performance against these standards have previously been in the lowest quartile in the city. The practice serves a majority multi-ethnic migrant population in areas of social deprivation within Sheffield. This brings a number of acknowledged challenges for the service to deliver the range of standards.

Over the last 3 years, significant progress and achievements have been made. In 2011/12 the Clover Group of practices improved to be in the highest quartile in Sheffield and their challenge since then has been to sustain this improvement. They have achieved this, which is an excellent achievement and demonstrates that real improvements are being implemented for the longer term benefit of the communities the practices serve.

In 2012/13 the service achieved a total of 98.3% of all the QoF standards, with a Sheffield wide average of 96.3%. This year in 2013/14 the service achieved 95% of the standards.

The following table summarises performance against national standards for GP services. Health screening for the practice population is challenging and influenced by the high proportion of the patient group being from BME communities. The service has been working closely with its community groups to increase awareness and access arrangements for health screening programmes to support improvements.

| PRIMARY CARE – CLOVER GP's | This years target | How did we do? 2011-12 | 2012-13 | This year 2013-14 | |
|---|---|---|---|---|---|
| **Flu vaccinations** | | | | | |
| Vaccinate registered population aged 65 and over | 75% | 75% | 78% | 75% | ✓ |
| Vaccinate registered population aged 6 months to 64 years in an at risk population | 70% | 50% (1) | 56% | 58% | **Needs to improve** |
| Vaccinate registered population who are currently pregnant | 70% | 45%(1) | 51% | 46% | |
| **Childhood immunisations** | | | | | |
| Two year old immunisations | 70-90% | 90% | 90% | 90% | ✓ |
| Five year old immunisations | 70-90% | 81% | 85% | 82% | |
| **Cervical Cytology** | 60-80% | 66.7% | 66.4% | 66.2% | ✓ |

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

**Substance Misuse Services**

The four commissioned services continue to prioritise ensuring timely access to primary and secondary care treatment. The service aims to ensure all of Sheffield's population that would benefit from the range of services provided in drug and alcohol treatment are able to access support. The service adopts a range of approaches to engage with people from this vulnerable service user group. Priorities for next year include the further expansion of the universal screening tool to increase the number of people accessing support services for alcohol problems and maximising the numbers of people supported and ready to finish treatment drug and/or alcohol free.

| DRUG & ALCOHOL SERVICES | This years target | How did we do? 2011-12 | 2012-13 | This year 2013-14 | |
|---|---|---|---|---|---|
| **Drugs** | | | | | |
| No client to wait longer than 3 weeks from referral to medical appointment | 100% | 100% | 100% | 100% | ✓ |
| No drug intervention client to wait longer than 5 days from referral to medical appointment | 100% | 100% | 100% | 100% | ✓ |
| No Premium client should wait longer than 48 hours from referral to medical appointment | 100% | 100% | 100% | 100% | ✓ |
| No prison release client should wait longer than 24 hours from referral to medical treatment | 100% | 100% | 100% | 100% | ✓ |
| % problematic drug users retained in treatment for 12 weeks or more | 90% | 94% | 95% | 96% | ✓ |
| **Alcohol Single Entry and Access** | | | | | |
| No client to wait longer than 1 week from referral to assessment | 100% | 100% | 100% | 100% | ✓ |
| No client to wait longer than 3 weeks from Single Entry and Access Point assessment to start of treatment | 100% | 100% | 100% | 100% | ✓ |
| **Outcomes, Self care** | | | | | |
| Initial Treatment Outcome Profile (TOP) completed | 100% | 96% | 98% | 81% | ✓ |
| Review TOP completed | 100% | 80% | 71% | 88% | |
| Discharge TOP completed | 100% | 100% | 100% | 44% | ✓ |
| All clients new to treatment receive physical health check as part of comprehensive assessment | 100% | 100% | 100% | 100% | ✓ |
| Number of service users and carers trained in overdose prevention and harm reduction | 240 | 292 | 272 | 202 | ✓ |
| % successful completions for the provision of treatment for injecting-related wounds and infections | 75% | 85% | 94% | 96% | ✓ |

*Information source: National Drug Treatment System*

**Learning Disability Services**

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

During the last year the service has made good progress in supporting people to return to Sheffield from out of town placements.

Within our local inpatient services we have ensured that individual clients do not experienced prolonged periods in hospital beyond what the client needs. We have delivered care that is well co-ordinated and focus on the needs of individuals, and delivered in a personalised and dignified way.

| LEARNING DISABILITIES SERVICE | This years target | How did we do? 2011-12 | 2012-13 | This year 2013-14 | |
|---|---|---|---|---|---|
| No-one should experience prolonged hospital care ('Campus beds') | Nil | Nil | Nil | Nil to date | ✓ |
| All clients receiving hospital care should have | | | | | |
| full health assessments | 100% | 100% | 100% | 100% | ✓ |
| assessments and supporting plans for their communication needs | 100% | 100% | 100% | 100% | |

*Information source: Insight & Trust internal clinical information system*

**Mental Health Services**

Services continue to perform well across a range of measures used to monitor access and co-ordination of care, achieving all national targets expected of mental health services. A range of key service changes have been introduced during the last year (for information about them see our Annual Report), and the Trust has ensured that performance levels have been maintained during times of extensive change.

The table below highlights our comparative performance on 7 Day follow up and Gatekeeping indicators. Sheffield Health and Social Care Trust believes (DN: to identify comparative performance at year end and provide comment regarding over or under comparisons).

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

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

This enabled us to make improvements and we achieved the target by the end of the year. (DN: Expected position)

| MENTAL HEALTH SERVICES | This years target | How did we do? 2011-12 | 2012-13 | This year 2013-14 | |
|---|---|---|---|---|---|
| **Improving Access to Psychological Therapies**<br>• Number of people accessing services<br>• Numbers of people returning to work (a)<br>• Number of people achieving recovery | 8,904<br>89 people<br>50% | 10,661<br>396 (19%)<br>49.5% | 10,735<br>344 (31%)<br>46% | 11,365<br>tbc (tbc%)<br>tbc% | ✓ |
| **Early intervention**<br>• People should have access to early intervention services when experiencing a first episode of psychosis | 90 new clients per year | 136 new clients accessing services | 107 new clients accessing services | 112 new clients accessing services | ✓ |
| **Access to home treatment**<br>• People should have access to home treatment when in a crisis as an alternative to hospital care | 1,202 episodes to be provided | 1,443 episodes provided | 1,418 episodes provided | 1,414 episodes provided | ✓ |
| **'Gate keeping'**<br>• Everyone admitted to hospital is assessed and considered for home treatment | 90% of admissions to be gate-kept | 99.4%<br>National average 97.4% (b) | 99.5%<br>National average 98.2% (b) | 100%<br>National average tbc (b) | ✓ |
| **Delayed transfers of care**<br>• Delays in moving on from hospital care should be kept to a minimum | No more than 7.5% | 4.2% | 4.7% | 6.3% | ✓ |
| **7 day follow up**<br>• Everyone discharged from hospital on CPA should receive support at home within 7 days of being discharged | 95% of patients to be followed up in 7 days | 96.8%<br>National average 97.3% (b) | 95%<br>National average 98.2% (b) | 98.4%<br>National average tbc (b) | ✓ |
| **Annual care reviews**<br>• Everyone on CPA should have an annual review. | 95% | 98.7% | 98% | 95% (c) | ✓ |

*Information source: Insight & Trust internal clinical information system*

Note

(a) 31% represents the % of those who were not in work at the beginning of treatment, who had returned to work at the end of treatment. During 2012/14 tbc of the tbc people seen where not in work at the beginning of treatment. tbc of them (31%) returned to work by the time treatment had been completed.

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

(c) The 95% figure represents the Trust's performance at the end of the year. During the year the Trust failed to meet this target in Q2 and Q3 with performance levels at 89% for both quarters.

**Dementia Services**

Our specialist inpatient service for people with dementia and complex needs has prioritised its focus on improving the care pathway to ensure discharge in a timely manner either home or as close to a person's home as possible. This results in much better outcomes for the individual concerned. This has enabled more throughput into the ward but recognises the increasing complexity of the service users admitted.

We continue to explore ways to build on the excellent success of the memory service in improved access and improved diagnosis rates within Sheffield. We have not reduced waiting times over the last year, and without changes to the way we provide services waiting times will start to get longer as we see even more people. (See Quality Objective 5 on page 11). Making further improvements in this area is a priority for us next year.

| DEMENTIA SERVICES | This years target | How did we do? 2011-12 | 2012-13 | This year 2013-14 | |
|---|---|---|---|---|---|
| Discharges from acute care (G1) | 27 | 34 | 53 | 45 | ✓ |
| Number of people assessed for memory problems by memory management services | 930 | 876 | 846 | 892 | ⇧ Getting better |
| Rapid response and access to home treatment | 350 | 338 | 339 | 369 | ✓ |
| Waiting times for memory assessment | N/A | 14 weeks | 15.4 weeks | 15.8 weeks projected | ⇩ Getting worse |

*Information source: Insight & Trust internal clinical information system*

| INDEPENDENT LIVING & CHOICE | This years target | How did we do? 2011-12 | 2012-13 | This year 2013-14 | |
|---|---|---|---|---|---|
| **Access to equipment**<br>• Community equipment to be delivered within 7 days of assessment | 95% of items to be delivered within 7 days | 95.3% | 95.2% | 96.7% | ✓ |
| **Choice and control**<br>• People accessing direct payments to purchase their own social care packages | n/a | 263 people with budgets agreed<br><br>Further 203 actively exploring | 454 people with budgets agreed<br><br>Further 312 actively exploring | 603 people with budgets agreed<br><br>Further 204 actively exploring | ✓ |

*Information source: Insight & Trust internal monitoring systems*

## 3.3 Service user experience

### Complaints and compliments

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

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

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

| Number of | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Formal complaints | 97 | 143 | 126 |
| Informal complaints | 215 | 260 | 218 |
| Compliments | 1,401 | 1,368 | 1,144 |

During the last year 9 people referred their concerns to the Health Services Ombudsman because they were dissatisfied either with the Trusts response or the way we investigated their concerns. The Ombudsman did not feel there was a need to undertake any further investigations into the issues within these complaints.

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

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

We do use complaints as an opportunity to improve how we deliver and provide our services. Examples of some of the changes we have made from reviewing concerns that people have raised with us are:

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

### Improving the experience through better environments – investing in our facilities

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

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

***Firshill Rise – services for people with a learning disability and challenging behaviour***

Our current facilities, the Assessment and Treatment Unit, were inappropriate and very limiting. Despite this the CQC recognised that we were providing excellent care despite the poor facilities.

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

***Intensive Treatment Service – secure care for people who are acutely mentally ill and in need of intensive care and support***

Our current ward facility is too small and it does not provide access for the service users to outside space. This significantly impacts on the experience of care for the individuals on the ward, as well as the staff delivering care.

Recognising this, the Board of Directors approved an investment of £6.4 million to design and built a new Ward on our Longley Centre site. This will result in real improvements to the design and feel of the Ward, much better facilities and access to dedicate gardens and outdoor space. The work on the commissioning of the new ward has started during this year, and we look forward to it opening over the next 18 months.

***Dovedale Ward – improving inpatient care for older people***

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

As part of this work we invested £328,000 to improve facilities and moved Hawthorne Ward to Dovedale Ward. The newly furbished ward opened will open in April 2014. This means that patients now have better access to en-suite facilities and an improved ward environment.

**Longley Meadows – respite services for people with a learning disability**

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

**General environment**

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

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

Following the review the Board approved a development plan to address a range of improvements. Particular attention has been given to improving cleanliness and overall décor across the estate, with more substantial improvements planned for the Longley Meadows facility.

**What do people tell us about their experiences?**

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

| MENTAL HEALTH SURVEY Issue – what did service users feel and experience regarding | 2011 Survey | | 2012 Survey | | 2013 Survey | |
|---|---|---|---|---|---|---|
| | Score | Top 10 | Score | Top 10 | Score | Top 10 |
| Their Health & Social Care workers | 8.9 | ✓ | 9.0 | ✓ | 8.7 | ✓ |
| Medication | 7.6 | ✓ | 7.5 | ✓ | 7.0 | |
| Access to Talking Therapies | 7.4 | | 8.0 | ✓ | 7.6 | ✓ |
| Support from Care Co-ordinator | 8.5 | ✓ | 8.6 | | 7.7 | |
| Their Care Plan | 7.0 | | 7.3 | ✓ | 6.6 | |
| Care Reviews | 8.0 | ✓ | 7.7 | | 7.3 | |
| Awareness about support options for Crisis Care | 6.5 | | 5.9 | | 6.1 | |
| Day to day living | 6.0 | | 6.0 | ✓ | 5.1 | |
| Overall view of care | 7.2 | ✓ | 7.2 | ✓ | 7.0 | |
| Overall score | 7.5 | Joint 2nd | 7.5 | Joint 3rd | 7.0 | Joint 5th |

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

| | 2011 Survey that reported in 2012 | | | 2011 Survey that reported in 2012 | | |
|---|---|---|---|---|---|---|
| | Lowest 20% score | Top 20% score | Our score | Lowest national score | Top national score | Our score |
| ***Patient Survey*** How well did people who use our services comment on their experience of contact with a health or social care worker | 8.2 overall | 9.1 overall | 9.0 overall | 8.0 overall | 9.0 overall | 8.7 overall |
| Did staff listen carefully to you? | 8.2 | 9.3 | 9.1 | 8.2 | 9.2 | 8.9 |
| Did staff take your views into account? | 7.9 | 9.0 | 8.9 | 7.9 | 8.9 | 8.6 |
| Did you have trust and confidence in them? | 7.6 | 9.0 | 8.7 | 7.5 | 8.7 | 8.6 |
| Did they treat you with dignity and respect? | 8.8 | 9.7 | 9.5 | 8.6 | 9.5 | 9.4 |
| Were you given enough time to discuss your condition? | 7.7 | 8.7 | 8.6 | 7.4 | 8.8 | 7.9 |

The above table highlights our comparative performance on service user experience in respect of contact with our staff. Sheffield Health and Social Care Trust is pleased about this positive position.

While the scores are slightly reduced compared to the previous year the CQC survey analysis highlights that this reduction is not significant. During 2012/13, when the survey was being undertaken, we were undertaking extensive service re-organisation across our community mental health team services. In the context of so much change, we are pleased that the feedback scores are as positive as they are.

We believe that this position is due to our focus on ensuring the individual client is the focus of our care planning and review processes.

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

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

The above table highlights our comparative performance regarding the quality of our services from the perspective of our staff. Sheffield Health and Social Care Trust considers this positive position is a result of our efforts to engage with our staff and involve them in the plans and decisions regarding how we move forward and focus on improving the quality of our services. We place increasing emphasis on ensuring staff in teams are aware how we are performing, making best use of the information we have to support this.

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

## 3.4 Staff experience

### National NHS Staff survey results

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

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

Overall we are encouraged with the above results. The positive feedback around engagement continues to support our on-going work and focus in improving quality

and delivering our plans for service improvement.

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

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

**Staff appraisals**

We will continue to focus our efforts to improve both the frequency and the quality of the appraisals and development plans for our staff. To support this we are introducing more simpler arrangements and procedures to ensure this can happen. Next year we will adopt an approach to appraisals that ensures everyone will receive their appraisal between April and July. This will help us ensure all staff benefit from an appraisal on an annual basis.

**Training**

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

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

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

**Violence against staff from patients, relatives or the public**

This important area has been key improvement priority for the Trust for the last two years. The Quality Objectives section of this report provides a detailed account of the work we have done (see page 5).

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

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

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

# Report to the Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee Thursday 10th April 2014

**Report of:** Child & Adolescent Mental Health Service (CAMHS) Working Group, Cllr Mick Rooney, Working Group Chair

**Subject:** Child & Adolescent Mental Health Service CAMHS Working Group Report

**Author of Report:** Diane Owens, Policy & Improvement Officer
0114 27 35065, diane.owens@sheffield.gov.uk

**Summary:** The Child & Adolescent Mental Health Service (CAMHS) Working Group was set up by the Healthier Communities & Adult Social Care Scrutiny Committee in September 2012. The Group used a range of techniques to undertake a review of CAMHS in Sheffield, this included desk top research, meetings and interviews. The Working Group would now like to present their report to the Scrutiny Committee for sign off.

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

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

**The Scrutiny Committee is being asked to:**

- Comment on and approve the Working Groups Report (Appendix 1)
- Note and comment on the combined response to the report which has been compiled by Sheffield City Council (Children, Young People & Families), Sheffield Clinical Commissioning Group (CGG) and Sheffield Children's NHS Foundation Trust (Appendix 2).
- Include the subject of transitions within the CAMHS service as a topic on the Committees 2014-15 Work Programme.

**Background Papers:** n/a
**Category of Report:** OPEN

# CAMHS Working Group Report

## 1. Introduction/Context

1.1 The CAMHS Working Group was set up by the Healthier Communities & Adult Social Care Scrutiny Committee in September 2012.

1.2 There are six members of the group, Cllr Mick Rooney (Scrutiny & Working Group Chair), Cllr Sue Alston, Cllr Janet Bragg and Anne Ashby, Alice Riddell and Helen Rowe (LiNK / HealthWatch representatives).

1.3 The Working Group used a variety of methods to gather data for this review, including desk top research and speaking with a wide range of individuals and organisations involved with the CAMHS service, including young people who receive a CAMHS service and their parents / guardians.

1.4 The Group have also spoken with representatives from the NHS and Clinical Commissioning Group, Sheffield Children's Hospital, GP's and Sheffield Councils Children Young People & Families services.

1.5 The review identified a number of possible areas for improvement as well as possible solutions; from this the Working Group has outlined 10 principles which they feel the service needs to be built on and should deliver against.

1.6 A draft of the report was shared with Sheffield City Councils (Children, Young People & Families), Sheffield Clinical Commissioning Group (CGG) and Sheffield Children's NHS Foundation Trust. The three organisations have subsequently produced a combined response to the "10 principles for the service" as outlined in the report. Their response also provides additional information with regards to questions raised by the Working Group. This document is attached as Appendix 2.

1.7 It should be noted that the Working Group recognise that since this review began a number of changes have been made to the CAMHS service to bring about improvements

## 2. Matters for consideration

2.1 The CAMHS Working Group is presenting its report for sign off by the Scrutiny Committee and is also sharing a combined response from Sheffield City Council (Children, Young People & Families), Sheffield Clinical Commissioning Group (CGG) and Sheffield Children's NHS Foundation Trust

## 3. What does this mean for the people of Sheffield?

3.1 It is important that the CAMHS service is delivering the expected outcomes for young people and their families.

## 4. Recommendations

The Scrutiny Committee is asked to:

- Comment on and approve the Working Groups Report (Appendix 1)
- Note and comment on the combined response to the report which has been compiled by Sheffield City Council (Children, Young People & Families), Sheffield Clinical Commissioning Group (CGG) and Sheffield Children's NHS Foundation Trust (Appendix 2).
- Include the subject of transitions within the CAMHS service as a topic on the Committees 2014-15 Work Programme.

**Appendix 1 –** CAMHS Working Group Report
**Appendix 2 –** Combined response to the report from Sheffield City Council (Children, Young People & Families), Sheffield Clinical Commissioning Group (CGG) and Sheffield Children's NHS Foundation Trust.

# Child & Adolescent Mental Health Service (CAMHS) Working Group Report

Appendix 1

*The CAMHS Working Group is a Sub Group of the Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee*



March 2014

V00.03

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## 1.0 Overview

The CAMHS (Child & Adolescent Mental Health Service) Working Group was set up by the Healthier Communities & Adult Social Care Scrutiny Committee in September 2012 to undertake a review into CAHMS services in Sheffield. The review covered the full range of CAMHS services from tiers 1-4.

Membership of the Group was as follows: Cllr Mick Rooney (Scrutiny & Working Group Chair), Cllr Sue Alston, Cllr Janet Bragg and Anne Ashby, Alice Riddell and Helen Rowe (LiNK / HealthWatch representatives).



The Working Group used a variety of methods to gather data for the review, including desk top research and speaking with a wide range of individuals and organisations involved with the CAMHS service, including young people who receive a CAMHS service and their parents / guardians. The Group have also spoken with agencies involved in both the commissioning and provision of CAMHS services; the Clinical Commissioning Group (CCG), Sheffield Children's Hospital, GP's and Sheffield Councils Children Young People & Families services.

The Working Group would like to thank the people who have taken part in this review.

The review identified a number of possible areas for improvement as well as possible solutions; from this the Working Group have outlined 10 principles which they feel the service needs to be built on and should deliver against.

It should be noted that the Group recognise that since this review began a number of changes have been made to the CAMHS service to bring about improvements; the impact of these changes will be discussed with both commissioners and providers of the services following publication of this report.

## 2.0 Possible areas for improvement

This section outlines the main themes that emerged as part of the review.

### 2.1 Communication

Concerns were raised regarding incidents of poor communication, including information on waiting times, outcomes of referrals and reasons for unsuccessful referrals or cases being closed. Some GP's also acknowledged that their referral letters do not always contain sufficient detail, as it can be difficult for them to elicit the required information in a 10 minute appointment.

There were also concerns raised regarding a lack of clarity about referral options, which can result in both inappropriate referrals and a reluctance to make referrals, which could cause unnecessary work and further delays. Concerns were also raised about GP referral notes not always being referred to in assessments (which means young people have to re-tell their story and are not always comfortable doing so, which could result in information being missed). The lack of a clear route for parents to pass information to CAHMS privately (as they are not always comfortable sharing this in front of their child) was also raised.



### 2.2 Pathways

A number of concerns were raised regarding the pathway, specifically in terms of complexity and timescales. There was also a feeling from some that the service could be inflexible at times (leading to some commissioning their own service) and that there is a lack of advocacy / support for both patients and carers. There were concerns raised regarding a lack of understanding and co-ordination between the full range of services available, including mainstream, voluntary and community sector and those commissioned separately e.g. by Community Youth Teams. The lack of a "family assessment / whole system approach" was also felt by some to be a missed opportunity in terms of offering a more holistic approach which would make families aware of the other support that may be available e.g. social care support / benefits.



Early intervention and prevention including the role of Schools was also raised, it was felt there is a lack of awareness amongst young people regarding early intervention services and an apparent inconsistent approach within Schools in terms of counselling and mental health support. The absence of an IAPT (Improving Access to Psychological Therapies) service for children and low referrals for those under 30's was also raised.

### 2.3 Waiting Times

Long waiting times which could result in both deterioration in a person's condition and a reluctance from GP's to make referrals were raised as an issue, along with a lack of awareness of the interim support available to people whilst they are on the waiting list e.g. the telephone helpline. Concerns were also raised about the ability of the service to respond in emergency situations due to waiting times.

### 2.4 Services for 16-18's

Concerns were raised that many disorders treated by CAMHs are not treated post 16, two key questions were being asked:

What preparation is done for discharge at 16? And, what services is available post 16 (other than tier 4)? Issues were also raised regarding the suitability of the current 16-17's services, specifically the need for a graduated transition (not a cut off at 18) and the fact that adult services are not always suitable for young people.

**2.5 The system**

The current delivery model was felt by some to be quite "old fashioned" and clinically based, with venues that are not always accessible for young people, these factors can result in people refusing a service / dropping out. The focus of spend across the different tiers (2-4) was also queried, in terms of whether it is based on analysis of need and whether there is an over weighting towards tier 4 (which is very costly). The current delivery model was also questioned by some i.e. is having one sole provider the best model for the City? The current performance monitoring framework was also cited as focusing on process and not outcomes

**2.6 Identifying principles for the service**

**Based on the concerns raised, the Working Group believes there are two key areas to focus on:**

- The Pathway, and
- Raising awareness amongst young people, effective signposting and involvement

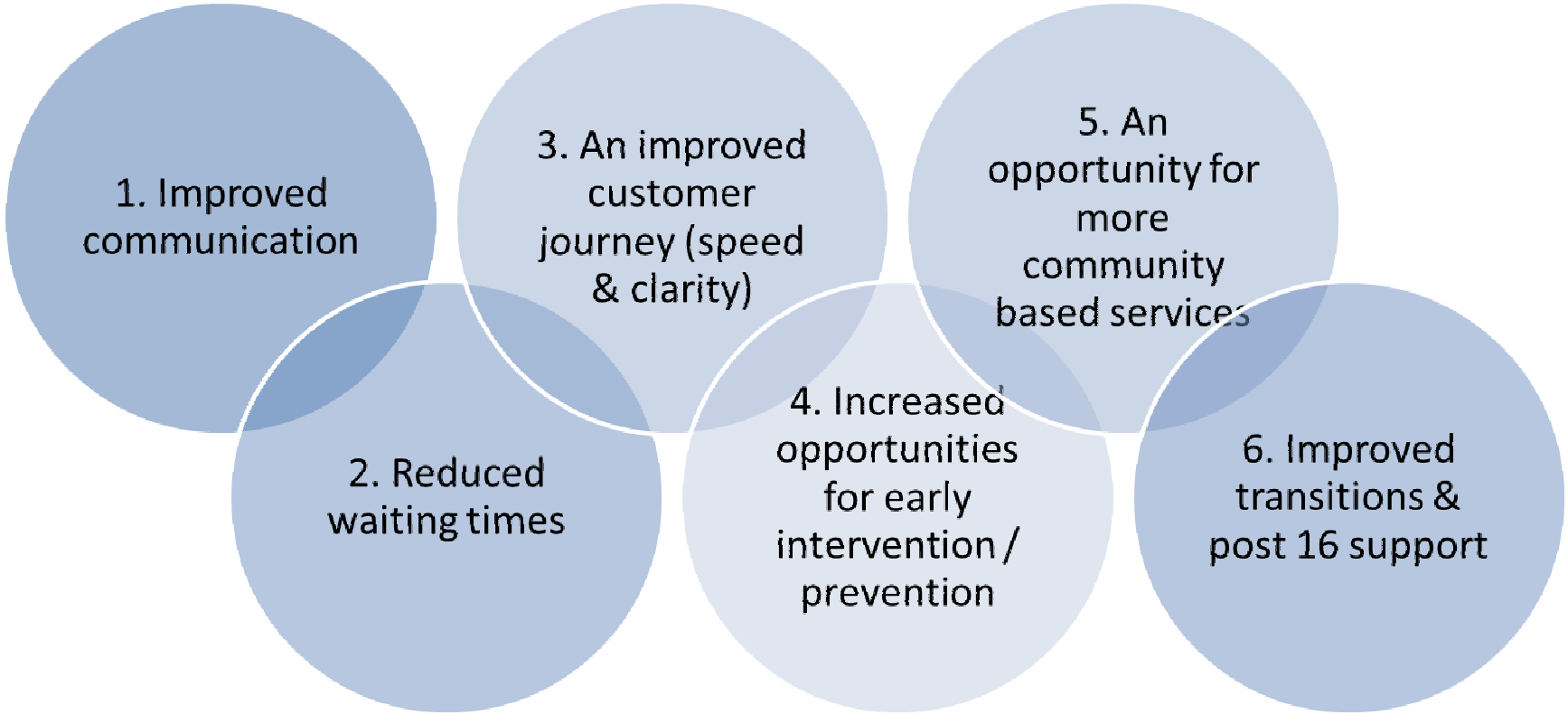
Under these headings the Group identified 10 "principles" or values which they believe the service should be built on and should deliver against

**3.0 10 Principles for the Service**

| | |
|---|---|
| ➢ **The Pathway** | |
| **1** | **Communication** - is key at all stages of the process, this includes information on waiting times / interim support / outcomes and reasons for case closure. |
| **2** | **Clear information** – should be produced to outline the services available and the referral routes. This needs to be accessible to both those making referrals and those who access services (see point 10 co-production). |
| **3** | **Family assessment and confidentiality-** where possible, a family assessment should be offered to ensure a more holistic approach (accepting that this is not always possible as some young people will request confidentiality). There also needs to be a clear route for parents to pass on information confidentially throughout the process. |
| **4** | **Role of the GP**– GP referral notes should be transferred onto the Assessor and should be fully used as part of the assessment process. Communication channels between the GP and the Assessor should remain open. |
| **5** | **Transitions** - there needs to be early preparation for those transitioning out of a service and clarity in terms of next steps. |
| **6** | **Services for those aged 16-25** - there should be a specially commissioned young adult's service for those aged 16-25; consideration should be given to having this as a community based service. |
| **7** | **Single point of referral** - there should be a single point of referral and standardised referral documentation, this process should assess the person and determine which pathway they go on to. |
| **8** | **Improving Access to Psychological Therapies (IAPT)** - consideration should be given to developing an IAPT service for young people. |
| ➢ **Raising awareness amongst young people, effective signposting and involvement** | |
| **9** | **Role of Schools** - The role of Schools needs to be increased to improve communication with young people and aid an early intervention / prevention approach. Schools need to consistently promote the services that are available i.e. through the School email services / intranet, and should have staff with the knowledge / skills to make referrals. |
| **10** | **Co-production** - young people who access the service and their carers need to be involved in designing the service, including producing communication materials and performance monitoring criteria. |

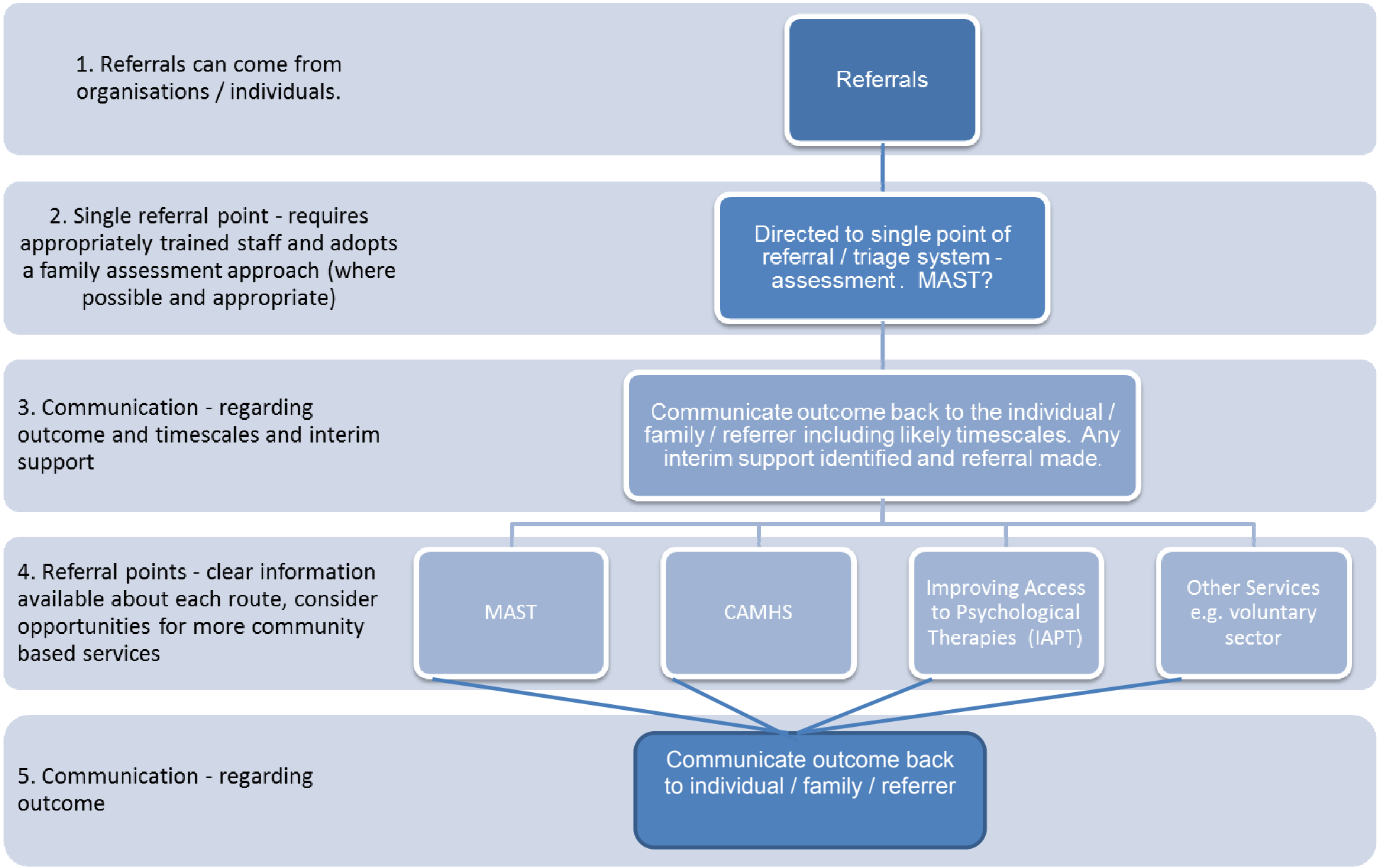
### 3.1 Key outcomes

The Working Group believes that adopting these 10 principles could help ensure the following key outcomes for the service.



**3.2 Possible Customer Journey (based on a single referral point)**

The diagram below outlines at a very high level the possible stages in the process and how they relate to some of the 10 principles.



## 4.0 Conclusions

The Group have outlined 10 key principles which they believe the service needs to be based on, which would in turn enable it to deliver the key outcomes they have identified: The Group also feel the customer journey should be simplified, to try and ensure there is clarity in terms of referral options and to reduce down waiting times.

## 5.0 Recommendations & Sharing the Report

The Working Group would like to make the following recommendations:

**5.1** That the Clinical Commissioning Group (CCG), Sheffield Councils Children's Commissioning Services and Sheffield Children's Hospital Foundation Trust are asked to provide a final joint response to the "10 key principles for the service" (as identified on page 4 of this report) which could be made available to parents / guardians and young people who took part in the review.

**5.2** That the Scrutiny Committee adds the subject of "transitions within the CAMHS service" as a topic for its 2014-15 Work Programme.

## Sharing the report

Once finalised this report will be shared with Cllr Mary Lea, Cabinet Member for Health, Care and Independent Living, Cllr Jackie Drayton, Cabinet Member for Children, Young People and Families, the Clinical Commissioning Group (CCG), Sheffield Councils Children's Commissioning Services and Sheffield Children's Hospital Foundation Trust. The report will also be made available to the parents / guardians and young people who took part in the review.

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