Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Annual Clinical Effectiveness Report 2011-2012

Report Completed by CEU:

Catherine Bywaters	NICE / Information Coordinator
Hannah Constantine	Senior Facilitator
Louise Chopra	Senior Facilitator
Janet Brain	Senior Manager
Victoria Patel	Deputy Manager

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Contents

Overview

Introduction from the Senior Manager of Clinical Effectiveness

Sheffield Teaching Hospitals Foundation Trust (STHFT) is committed to excellence in all its clinical services and is delighted to present its Clinical Effectiveness Report for 2011/12 – an account of clinical audit and service evaluation activity and clinical effectiveness initiatives during that period.

Quality was defined in High Quality Care for All (DH 2008)[1] as

- **Safe;**
- **Effective;**
- With a positive **Patient Experience**.

However, changes in the economic climate since the NHS Next Stage Review require a wider focus on increased productivity and efficiency & the development and use of indicators on productivity, efficiency and value for money, alongside measures of quality such as patient experience and outcomes, are critical. Hence, we have adopted the definition of quality from the Institute of Medicine which identifies six characteristics of high quality care: safe, effective, patient centred, timely, equitable and efficient[2]. In response to this, during 2011/12 the Clinical Effectiveness Unit (CEU) has continued to build on previous progress made with evidencing the implementation of clinical effectiveness, working closely with other corporate departments to influence and support the delivery of both quality improvement and quality assurance.

The number of clinical audit and service evaluation projects registered centrally has increased this year by 24% (580 vs 468), only partially attributed to primary and community services joining STH NHSFT (65). This is impressive and demonstrates a culture of enthusiasm for continuous quality improvement and the adoption of "best practice" in the care provided to our patients.

Of high priority, once again, has been the co-ordination and support for participation across the Trust in the National Clinical Audit and Patient Outcomes Programme (NCAPOP). Similarly, assistance with the implementation and audit of national guidance, particularly National Institute for Health and Clinical Excellence (NICE) Guidance has been high priority work for CEU staff. The fast paced publication schedule of NICE Quality Standards has provided a focus for quality improvement and has laid the foundations for future systematic outcome measurement.

The strong commitment to education and to providing clinicians with the opportunity to access training for clinical effectiveness has been sustained. Our internal education programme has been aimed at providing staff responsible for, or participating in, clinical audit the knowledge and skills to facilitate the completion of effective & appropriate clinical audit projects.

The Trust Clinical Effectiveness Committee (CEC) has regularly reviewed the results and action plans of high priority local and national audits and remain committed to driving change where indicated to improve quality.

In November 2011, the Clinical Effectiveness Unit joined with Patient and Healthcare Governance – an alignment that will assist with the delivery of the Trust's *Quality Goals* (detailed in Quality Strategy 2012-2017). 2012 will see the launch of the Trust Quality Strategy which underpins the corporate strategic aims of delivering the best clinical outcomes, providing patient centred services and spending public money wisely. The use of effective measurement systems and tools will be essential in meeting this challenge. Measures will include

- patient and staff experience and satisfaction
- patient safety
- clinical outcomes

The data generated will demonstrate both quality improvement and quality assurance of our services and the CEU will orientate resources towards supporting these corporate strategic aims. Clinical audit outcomes will serve as proxy indicators of quality & the system for measurement will rely on having an agreed, prioritised Annual Trust Clinical Audit Programme in place that reflects national and local priorities including those of our main commissioner, NHS Sheffield. Transparency in local outcomes will also be supported through participation in NCAPOP as more clinical audit data is made available in the public domain (data.gov.uk website)**.**

This report should be read in conjunction with the Quality Report 2011/12 – a report to the public on the quality of the care patients received during 2011/12 and forthcoming improvement priorities for 2012/13.

Senior Manager, Clinical Effectiveness Unit

[1] High Quality Care for All, NHS Next Stage Review Final Report, Department of Health, June 2008

[2] Institute of Medicine, To Err is Human, 1999

Clinical Effectiveness Project Statistics for 2011/2012

This section provides an overview of the volume and range of clinical effectiveness activity registered in the Trust over the past 12 months.

The total number of projects registered with the CEU has increased by 24% from 2010/2011. However, this can partially be attributed to primary and community services joining STHFT. Table 1 shows the breakdown by project type.

Table 1

Type of Project	N	%
Clinical Audit	266	46
Service Evaluation	250	43
Clinical Audit and Service Evaluation	64	11
Total	**580***	**100**

The proportion of the clinical audit project portfolio commissioned by NHS Sheffield was 31% (see Table 2).

Table 2

Type of Clinical Audit	N	%
Commissioned Clinical Audit	77	31
Non-commissioned Clinical Audit	173	69
Total	**250**	**100**

**N.B. There will be a number of ongoing projects registered in 2010/2011 that will not be reflected in these figures. Additionally there are a number of pieces of NICE guidance on the commissioned programme which will not have undergone a formal audit.*

The figures generated in tables 1 and 2 are taken from clinical audit and service review work newly registered with the CEU for this period: they do not include projects that have been rolled over from previous years.

During 2011/12 STH NHSFT participated in 38 (93%) of national clinical audits and 2 (100%) national confidential enquiries of those which it was eligible to participate in (details will be available in the Quality Report 2011/12 on the Trust website or alternatively on *NHS Choices later in the year).*

The section of the report overleaf, highlights some of the clinical effectiveness activity registered with the CEU at Directorate level for 2011/12. It should be noted that, as Directorates vary in size and structure, so the number of projects registered by each will vary. Some Directorates may undertake one or two large scale, complex audits whilst others will execute a larger number of smaller projects over the year. This activity is over and above that associated with the high priority ongoing national audits or longer-term audits of NICE guidance. For purposes of reporting, the numbers of projects are mutually exclusive. However, it is worth noting that a number of these projects will involve collaborative work between a number of specialities, directorates and NHS partner organisations.

Clinical Effectiveness Activity

Directorate	Total Registered Projects	Service Evaluation	Audit	Audit and Service Evaluation	Abandoned	Complete	Current	On Hold
Anaesthetics	2	1		1			2	
Cardiology	1			1			1	
Cardiothoracic	27	11	12	4	2	8	16	1
Communicable diseases	15	6	8	1		1	11	3
Community	65	4	60	1	3	38	24	
Diabetes and endocrine	5	2		3			5	
Emergency medicine	15	3	10	2	2	2	11	
ENT	8	3	4	1			6	2
Gastroenterology	14	4	5	5		6	8	
General surgery	22	16	2	4	3	1	18	
Geriatric and stroke medicine	11	8	3				11	
Infectious diseases	1	1					1	
Laboratory medicine	29	16	10	3		7	18	4
Medical imaging and medical physics	18	12	1	5		1	16	1
Microbiology	1			1			1	
Neurosciences	24	12	11	1			22	2
Nursing	6	4	1	1		1	5	
Obstetrics, gynaecology, and neonatology	32	7	21	4		6	23	3
Occupational health	3	2		1			3	
Operating services, critical care and anaesthesia	39	15	21	3		8	27	4
Ophthalmology	4	2		2	1		3	
Oral and dental	36	18	12	6		4	25	7
Orthopaedics	26	16	6	4	1	3	18	4
Pharmacy	19	7	11	1	2		17	
Plastic surgery	6	3	2	1			6	
Professional services	29	22	7		1		22	5
Rehabilitation services	3	2	1			1	2	
Renal services	12	6	6			2	9	1
Respiratory medicine	23	5	14	4	1	5	17	
Specialised cancer services	14	9	5		1	2	11	
Specialised medicine	31	11	20		2	10	17	2
Specialised rehabilitation	7	2	3	2		3	3	1
Trustwide	15	10	5			6	8	1
Urology	8	4	3	1	1	1	6	
Vascular services	9	6	2	1		1	6	2
Grand Total	580	250	266	64	20	117	399	43

At a Glance

Clinical Effectiveness Committee (CEC)

The Trust CEC, chaired by the Associate Medical Director and reporting directly to the Healthcare Governance Committee (HCGC), has continued to meet bimonthly throughout 2011/12. The Terms of Reference for the Committee were updated in January 2012 to review the remit and ensure Trust care groups and relevant corporate functions continue to be represented by the membership. The Patient Governor and Public Governor Representatives have continued to attend following re-election during 2011.

The purpose of CEC is to ensure that the Trust has a systematic approach to developing and reviewing the quality of clinical care by a process of clinical effectiveness review. This review process can provide the assurances that the Trust complies with both external and internal standards and requirements. This involves monitoring progress with the Trust Annual Clinical Audit Programme, which includes:

- National Clinical Audit and Patient Outcomes Programme (NCAPOP) projects,
- Quality Report audits, confidential enquiries & national data collections,
- PCT commissioned programme, including audits of NICE Guidance
- High priority Trust clinical audits
- Priority audits from directorate programmes
- Appropriate audits identified through Patient and Healthcare Governance

CEC also provides a forum for the formal monitoring and reporting of mortality alerts identified through Dr Foster Real Time Monitoring and feedback on Trust clinical effectiveness initiatives and Confidential Enquiry reports.

An additional remit of CEC is to oversee the actions generated from the established NICE Implementation Steering Group. This Group meets bimonthly, prior to the CEC meeting, to manage progress issues that have arisen with NICE guidance implementation. A full summary report of NICE current releases, NICE audits and NICE Implementation problems are then disseminated to CEC for review and discussion.

2011/12 has seen a national emphasis on the importance of involving NHS Boards on the Quality Improvement Agenda, particularly the practice of trust boards, or their sub-committees, reviewing reports and action plans resulting from both national and local clinical audits. During 2011/12 the Committee has reviewed the results and action plans of 18 national and 13 local audits over its six meetings and has also commenced monitoring the implementation of the plans to provide further assurances of quality improvements made as a direct result of clinical effectiveness projects.

A challenge for the Committee in 2012/13 will be to further promote the involvement of patients in clinical audit and service review and to update local guidance for clinicians on the various options for doing this. Recent national guidance from the Healthcare Quality Improvement Partnership (HQIP) will be utilised and close working with local colleagues in Patient Partnership is envisaged.

Contribution by Governor Representatives

In 2008/09 CEC invited STH Governors to nominate two of their number to join its membership. The places were willingly taken up by two of us who were keen to learn how the Trust kept oversight of standards. Governors were already represented on a panel overseeing complaints but that work was necessarily limited in its scope (determined by what came in) and if governors were to be satisfied that high clinical standards were being achieved and maintained they needed to be party to some other process. An assurance that a body like CEC existed would not have been sufficient; governors needed to be satisfied that the committee had the authority to act and was itself 'effective'.

We have seen (and joined in) a systematic approach to developing and reviewing the quality of clinical care. Neither of us have a clinical background so at times CEC has to pause while a medical term is explained. This never takes long but the trouble taken is illustrative of the spirit in which discussions take place. We hope to bring 'intelligent naivety' to CEC, inevitably drawing on our experience in other walks of life. The feedback we are given suggests that our contributions are valued.

The responsibilities we have been given by members of the Trust include holding the Board of Directors to account for the performance of the Trust. Measuring the quality of patient treatment and care is a key element of evaluating performance and we are conscious that Lord Darzi has named clinical effectiveness as one of the three components of quality. The Board needs to command the confidence of the public and our participation in the work of the CEC is but one of many ways in which that confidence can be, and is, maintained.

Quality Report 2011/2012

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 years Quality Report gives an honest and open assessment of the quality of the care patients received during 2011/2012 and should provide confidence in our ability to deliver safe, effective and high quality care.

This is the third year that the Trust will have published a report about the quality of its service.

Although the Quality Report is a Trust report intended for patients and the public, some parts have to be written in the way required by Monitor (the Independent Regulator of Foundation Trusts) and the Department of Health (DH). It is optional to refer to this as Quality Accounts or Quality Report. STHFT refer to it as Quality Report.

Clinical audit is one section of the Trust's Quality Report. During March and April 2012 the CEU collated the required information on prescribed statements provided by the DH in relation to the Trust's participation in clinical audit. For example:

- The number of national clinical audits and National Confidential Enquiries covering NHS Services that STHFT provides that we were eligible to participate in.
- The percentage which STHFT actually participated in.
- 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.

The Clinical Audit section also contains information about local and national audits and the actions taken locally to improve the quality of healthcare provided.

The final draft of the Quality Report was sent to external partner organisations for comments in early April 2012. The published Quality Report 2011/12 for STHFT will be found on the Trust website or alternatively on *NHS Choices* later in the year.

During 2011, STHFT participated in a consultation process led by HQIP identifying the value of each national audit to inform inclusion in the Quality Account list 2012/13 published by DH.

The Clinical Effectiveness Unit would like to extend thanks to everyone who contributed to the collation of the information required for the prescribed statements.

Dr Foster Real Time Monitoring (RTM)

RTM provides outcome information - specifically mortality, length of stay, readmissions and day case rate that allows the Trust to benchmark performance against other Trusts in England. During 2011/12 mortality data has continued to be formally monitored at the Clinical Effectiveness Committee on a routine basis. This has provided a mechanism whereby directorates can scrutinise any outcome significantly different from the national norm and then report findings to a central committee where any appropriate actions can be taken.

The system has also been used to provide the Trust Healthcare Governance Committee and Trust Executive Group with up to date information on the Trust Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI). More information is available on mortality in the Quality Report 2011/12 which will be found on the Trust website or alternatively on *NHS Choices* later in the year.

STHFT has been named the “Trust of the Year” (North) in the Dr Foster Good Hospital Guide – an award which recognises excellence in the NHS. This is the third time that the Trust has been awarded this national accolade in the last 5 years and to gain it a trust has to perform highly on two important measures of hospital quality – mortality and patient experience, STHFT was particularly commended for having one of the lowest mortality rates in the UK and for high levels of patient satisfaction.

National Institute of Health and Clinical Excellence (NICE)

The NHS is going through a transition; however, the term “quality” still persists. Quality continues to be described in terms of patient safety, patient experience and effectiveness of care as set out in High Quality for All: NHS Next Stage Review. During this NHS transition, NICE has also needed to evolve and expand. Since 2010, NICE has been producing quality standards, with the expectation that 150+ quality standards will be produced over the next 3-5 years. Quality standards are a series of approximately 15-20 pathway recommendations devised using existing NICE guidance and NHS evidence to provide the best quality, best value care pathways. The DH has stated that they will be used as a bridge between NHS outcomes, processes and structures, and will be used by the National Commissioning Board to design levers and incentives for improving outcomes through the Commissioning Outcomes Framework. These announcements highlight that NICE continues to play a prolific role within the NHS. This role has been further cemented by the DH’s Innovation: Health and Wealth Report (2012) with the announcement that there will be a central compliance regime for NICE Technology Appraisals, and that both commissioners and providers will be fined for non-compliance – the rhetoric being “comply or explain”. At STHFT, this potentially implies that processes will be amended to take into account the new announcements, with more work expected at the interface between directorate specialties and partner organisations.

National Audit

The emphasis on participation in national audit continues to grow with the annual publication of a NCAPOP commissioned by the Healthcare Quality Improvement Partnership (HQIP), the DH list of projects for inclusion in Quality Accounts reporting and other national audits which do not appear in either of these.

For 2011/12 the number of NCAPOP projects applicable to acute trusts and in which it is mandatory to participate was 24. The Trust participated and submitted data on all relevant projects which covered the following topics: Cancer (4), Cardiac (6), Children & Women's Health (2), Long Term Conditions (5), Mental Health (1), Older People (6).

The majority of national clinical audits which form the NCAPOP were also included in the Quality Account 2011/12 list alongside other national audits and national registries. The Trust participated in 19 of these additional audits under the following headings: Acute Care (7), Long Term Conditions (3), Elective Procedures (3), Renal Disease (2), Trauma (1), Blood Transfusion (2), End of Life (1).

It is not mandatory for trusts to participate in all audits in this list but they must describe in their Trust Quality Account which they have participated in and provide a rationale for non participation.

STHFT takes a local decision on participation in any other national audit not included in either the NCAPOP or Quality Account/Report (e.g. those developed by a Professional Body) based on two considerations, 1) how useful it is viewed in improving patient care provided by a Specialty/the Trust and 2) the practicality of undertaking the audit within available resources.

In November 2011, HQIP with support from the DH commenced a rolling programme for improvement of aspects of the national clinical audit programme. The key elements were:

- **Agreeing consensus in key principles in national audit**

Planned to create documents setting out essential criteria and principles for national clinical audits to inform commissioning decisions, help those designing audits and set out key aspects of any audit project including governance, purpose, methodology, transparency, action to drive change and measurement of outcomes. A guidance document 'Assessing & Improving Quality in National Clinical Audit' was produced in October 2011 with consultation on a draft 'Principles of Quality in National Clinical Audit' starting in February 2012.

- **New process for agreeing inclusion of national audits in the Quality Accounts list (link to QA section)**

A consultative process to agree a final list of audits to be included in the quality accounts reporting for 2012/13 took place in November/December 2011. Views were obtained from local and national stakeholders with both STHFT clinical staff and Clinical Effectiveness Unit staff involved in national audits participating in the survey.

- **Transparency and reporting**

In July 2011 the Government made an announcement on plans for data transparency. Clinical audit was one of the NHS areas included which stated 'Clinical audit data, detailing the performance of publicly funded clinical teams in treating key healthcare conditions will be published from April 2012. This service was piloted in December 2011 using data from the latest National Lung Cancer Audit.' As STHFT participates in this audit their data was available in the public domain. (data.gov.uk website)

- **Review of quality of existing funded audits**

From April 2012 HQIP will be commencing a more detailed, ongoing process of independent review of audits before they are renewed.

- **A feedback system for national audits**

  The national clinical audit feedback mechanism was launched in March 2012 allowing anybody participating in any aspect of national clinical audits to have their say and help with ongoing improvement. It has been designed for continuous use and will be analysed by HQIP on a monthly basis with feedback to appropriate organisations and a quarterly report of themes and actions published on the HQIP website.

The CEU continues to encourage and support feedback of national clinical audit results by the clinical staff to their clinical areas and multidisciplinary teams to develop local recommendations and action plans. Summary local reports are reviewed by the Trust Clinical Effectiveness Committee. The HQIP Transparency Strategy published in January 2012 includes reducing the time lag between data gathering and report publication and an increased focus on the implementation of audit results which should help to improve the timeliness of changes to practice locally.

Interface Audit

Interface audit can take place between organisations, e.g. primary and secondary care, or between directorates within STHFT. The introduction of the Community Services Directorate to the trust brings the opportunity for closer working across the organisation and the wider Sheffield health community.

The Sheffield Citywide Audit Group, hosted by NHS Sheffield, meets bi-monthly and this year discussions have focussed on identifying priority health topics which can be conducted as interface audits. Discussions are underway with potential stakeholders for two of the NICE Quality Standards and the audits should be agreed in May 2012.

Service Evaluation

With the introduction of the Trust's Quality Strategy, service evaluation will continue to play an important role in sustaining, monitoring and improving quality. Although it is important to continue to identify and measure areas that clinically are identified as a priority, the strategy has highlighted the Trusts key quality goals:

- Reducing mortality even further
- Reducing unnecessary hospital admissions
- Optimising length of stay
- Improve patient experience and staff satisfaction

The CEU will work alongside other corporate departments and clinical areas involved in quality improvement to align activity to the four key quality goals and prevent duplication of data collection. Whenever possible, we will efficiently use the same data to demonstrate both quality improvement and quality assurance of our services.

The CEU continues to support work with the National Cancer Peer Review Process, which measures patient/carers experience. This ongoing programme of work is a Trust priority and projects have been performed in a number of the Trust's Cancer Services. Patient and public responses included in these projects have resulted in changes to practice and improved services.

Although it is not currently mandatory to register service review projects, albeit best practice, it is recognised that directorates need a governance process to coordinate activity and to ensure that risk is assessed appropriately. This has led to the development of the 5-Step Governance Model to support service review, which was piloted in seven directorates within two care groups during 2010-11. The areas involved in the pilot are continuing to use the model to support service evaluation. During 2012 the

CEU will be working alongside Patient & Healthcare Governance and clinical directorates to promote the use of the model more widely within the Trust. This should provide local coordination and ownership of projects.

Education and Training

Members of the education team within the CEU have continued to support both internal and external courses. As well as our various workshops, we continue to deliver sessions on clinical audit and effectiveness for the Trust's Five Day Evidence Based Practice course and the Foundation Year 2 Training Programme. This year we started delivering a session on the University of Sheffield's postgraduate masters module in Clinical Management. In addition, work is underway to develop a programme of Continuing Professional Development for Audit Leads to support them within their roles.

The Education Advisor has continued to work with Sheffield Hallam University as the overall Course Leader and Module Leader for module 2 on the Postgraduate Certificate in Clinical Audit. The course is attended by both clinical audit and healthcare professionals from across the UK and the initial feedback on the first two modules has been very positive.

The CEU consulted with HQIP on the National Education & Training Strategy in Clinical Audit during 2010, the final document was released in March 2012 alongside the National Curriculum and Standards document. 2012 will see STHFT working in collaboration with all healthcare organisations in South Yorkshire and the Humber linked to Sheffield University Deanery. The purpose and outcome of this development is to agree and develop a consistent and standardised approach to education and training in clinical audit at all levels from medical student through to consultant. This development work is supported by HQIP and will be used as an exemplar nationally for other regions.

Junior Doctor Involvement in Clinical Audit

In July 2010, the Trust implemented the Policy on Involving Junior Doctors In Clinical Audit.
The purpose of this policy is to:

- Provide a recommended approach for involving junior doctors in clinical audit in all clinical specialties in the Trust consistent with current evidence of best practice in clinical audit and postgraduate training requirements
- Facilitate a shared understanding of the purpose of involving junior doctors in clinical audit and understanding of the clinical audit process among all junior doctors working in the Trust
- Encourage junior doctors to participate in clinical audits that are appropriate and effective and that support the Trust's commitment to continuously maintain and improve the quality and safety of patient care
- Provide for formal certification of participation in clinical audit for learning portfolios for junior doctors who meet the Trust's requirements for participation in clinical audit
- Clarify responsibilities for involving junior doctors in clinical audit amongst junior doctors, clinical supervisors, educational supervisors, clinical audit leads, the Postgraduate Medical Director and staff, the Trust's Clinical Effectiveness (or equivalent) Committee and the CEU staff.

The intended outcomes of this policy are:

- Junior doctors are supported to meet postgraduate training requirements and expectations relating to participation in clinical audit and have evidence of meeting the requirements.
- Clinical audits carried out by Foundation Programme doctors are consistent with the content of The Foundation Programme's syllabus and competences.
- Clinical audits carried out by Registrars are part of an appropriate planned programme of clinical audit in the specialties in which

they work.

- Clinical audits carried out by junior doctors are completed through all the stages of a clinical audit, that is, with evidence of improvements in practice when the findings of a clinical audit indicate the need for improvement.
- Clinicians and clinical audit leads support junior doctors in carrying out clinical audits consistent with defined roles and responsibilities.
- Junior doctors do not undertake inappropriate and ineffective clinical audit activities.

The policy can be accessed on the Trust website.

Information Governance

Information governance is a framework for handling personal information in a confidential and secure manner, to appropriate ethical and quality standards, in a modern health service. It sits alongside clinical governance, research and corporate governance and brings together all the requirements, standards and best practice which apply to the handling of personal information. Having robust information governance working practices gives patients/clients confidence that their information will not be disclosed or used inappropriately.

Clinical audit and service evaluation work involves the handling of personal information. Staff must ensure that they are aware of and adhere to information governance responsibilities when planning and undertaking clinical audit projects.

CEU staff will check that the project team are aware of their Information governance responsibilities for each stage of the clinical audit process to ensure that they know how to handle, store and dispose of information appropriately and advise on best practice guidelines.

Information Security

The objective of information security is to ensure confidentiality, integrity and availability of information assets, whilst minimising business damage through the implementation of standards, controls and procedures, which support the policy. Note: Information assets are stored physically and electronically, transmitted across networks or telephone lines, sent by fax, spoken in conversations and printed as hard copy.

The purpose of the Information Security policy is to safeguard both the organisation's and the patient's information within a secure environment.

Data Protection

Data Protection and the security of Personal Identifiable Data (PID) and sensitive and confidential information has never been more important. Protective measures for the security of electronic and manual data are mandated by the Trust to ensure we handle all data in a manner to ensure confidentiality, integrity and availability.

The Trust's Data Protection Policy complies with the legal requirements of the Data Protection Act 1998, the national responsibilities as defined in the Information Governance Toolkit, and the requirements of the Information Governance Assurance Framework 2009.

Confidentiality

All Trust staff (including medical and dental staff, whether directly employed by or holding honorary contracts with the Trust) are expected to be familiar with the Information Security, Confidentiality and Data Protection policies and procedures.

The Caldicott Guardian is Professor Mike Richmond, Medical Director; Deputy Caldicott Guardian is Peter Wilson, Information Governance, Caldicott & SIRO Support Manager. Sheffield Teaching Hospitals NHS Foundation Trust places great emphasis on the need for the strictest confidentiality in respect of personal health data.

Trust ratified Information Governance Controlled Documents can be found on the "Corporate Policies" page of the Intranet.

Trustwide Record Keeping

The Patient Record Keeping Policy has been updated this year to bring it in line with NHSLA standards. When the policy was updated, Primary and Community Services guidelines for record keeping were incorporated to ensure the policy is applicable for all records within STHFT.

Undertaking record keeping audits helps to ensure compliance with both professional and organisational record keeping standards and is a requirement for NHS Litigation Authority accreditation. It will also help to identify areas for further improvement and staff development.

The first Trustwide Interprofessional inpatient record keeping audit was completed last year and approved by the Patient Record Committee in May 2011. The project has successfully looked at the new single patient record which was brought about by the Interprofessional Patient Record project. Compliance as a Trust was 85.9% overall. The audit demonstrated areas for development, with the main issue revolving around staff not using the problem sheet and the signature sheet appropriately. The re-audit was completed January 2012 and it appears that the same areas highlighted in the first audit are still areas for development. Currently an action plan is being drawn up with the assistance of the Patient & Healthcare Governance department to tackle the recurring areas of development of documentation.

The first Trustwide outpatient records audit has now been completed. Between March 2011 and May 2011 all outpatient specialties were asked to audit the notes for patients in their care. A total of 36 specialties took part, with each specialty auditing between 10 to 50 sets of records, with a total of 567 records being audited Trustwide. The project has successfully looked at a range of outpatient records. Compliance as a Trust was 89.7% over all. The second audit of outpatient records was undertaken between February 2012 and April 2012.

During June 2011 Primary and Community Services Care Group undertook for the first time a service-wide audit of clinical records. Each service is required to audit a representative sample of their paper and/or electronic records. The results of the audit demonstrate compliance with 58% (n=33) of the 57 standards, with an overall compliance rate of 77%, which is below the minimum standard of 85%. An action plan has been drawn up to enable better recording of information in both paper and electronic records.

Clinical Effectiveness Successes

A number of projects are registered annually with the CEU. The majority of these projects lead to improvement in patient care and/or service provision. We also observe best practice being shared locally, regionally and nationally with colleagues, through conferences and education sessions. A few examples of these projects are included over the next few pages.

Pharmacy Pre-registration Awards

At the Yorkshire & Humber Pre-registration Trainee Pharmacists' Audit Awards in May 2012, a number of Sheffield Trainees were honoured for their audit work during 2011/12.

First prize for the oral presentation awarded to the audit on the **'Use of the IV Heparin Prescription and Monitoring Chart'**.

First prize for the poster was awarded to the audit of **'Insulin Self-administration by Hospital Inpatients'**.

The re-audit of **'Vaccine Cold Chain Management'** reached the semi-finals**.**

There are a total of 44 trainees from across the region, so this was a great achievement for Sheffield.

End of Life Care (EOLC) Strategy

The Government has published the End of Life Care (EOLC) Strategy, the first for the UK, promoting high quality care for adults at the end of life and recommending a care pathway approach for delivery of integrated care to individuals.

At our regional cancer care centre, all patients are risk assessed for thromboprophylaxis on admission, whilst patients who are entering the terminal phase of illness commence an EOLC pathway. We wanted to measure compliance with NICE guidance on reviewing and stopping thromboprophylaxis when patients are commenced on this pathway.

Retrospectively, data from case notes and drug charts of all patients who had died and entered the EOLC pathway on two main wards at Weston Park Hospital from January to November 2010 were collected. We looked at whether patients were receiving anticoagulation, the duration of the pathway and whether anticoagulation was reviewed.

We found the total number of deaths was 69. Of these, 7 notes were missing. 47% (29/62) were entered on an EOLC pathway. The duration of the EOLC pathway varied from some hours to 10 days. 48% (14/29 patients) were receiving anticoagulation (8 prophylactic enoxaparin, 5 therapeutic enoxaparin and 1 warfarin). 87.5% (7/8) patients receiving thromboprophylaxis had this reviewed and discontinued.

In conclusion, our audit confirmed most patients had thromboprophylaxis treatment reviewed when entered onto an EOLC pathway.

We would like to improve the compliance with NICE guidance through a combination of ward based teaching to doctors and nurses, formal presentations during hospital staff rounds and audit meetings, with results also being issued to oncology and haematology departments within this Trust. A poster displaying this audit was successfully entered for presentation at the Junior Doctor's Clinical Audit of the Year Event in Leicester on 17th November 2011, presented by Dr Redwood, with Paula Johnson present from Sheffield's Clinical Effectiveness Unit.

Development of Late Effects Nurse Competency document ratified by the RCN

Background
This project was developed as part of Sheffield National Cancer Survivorship initiative supported by National Cancer Action Team (NCAT) Developments in cancer treatments have led to an increased survival in children and young adults. Cancer treatments however are also associated with a high incidence of negative physical, psychological and social consequences. Providing services to manage these late effects is an emerging speciality in adults. The actual and potential role of nurses working within late effects services has not previously been explored.

Aims
To identify and compare the views of managers and nurses on the ideal and existing role of nurses in late effects services, and develop a competency framework for all qualified nurses working in this speciality

Methods
Structured questionnaires were developed to collect data in two phases. Phase 1 captured the views of 80 service managers on ideal roles; Phase 2 captured the perspectives of 36 nurses in existing roles. Questionnaires were distributed via cancer treatment centres across England, UK. Data were analysed using descriptive statistics and chi-squared tests.

Results
The ideal role from the manager's perspective was different from the role currently being carried out by nurses. Managers identified a range of potential activities including working with clinicians, service development. The nurses' current role focused more on the clinical component and contained fewer elements related to service development research or education.

Conclusion
A framework was designed from the results of the questionnaires and sent back to the respondents for further views and clarification. A focus event was also held in London with a group of late effects nurses to finalise the competency framework, and sent out to patient user groups for comments. The Late Effect nurse competency document was developed by and sent for ratification with the Royal College of Nursing & is now available on their web site to be used nationally. There have been various papers & posters presented nationally and in Europe, to promote the use of this framework.

Baby Friendly

Jessop Wing monitors breastfeeding rates to meet Department of Health requirements. We use the UNICEF UK Baby Friendly Initiative (BFI) 10 steps to successful breastfeeding audit tool and standards. The Jessop Wing passed stage 2 Baby Friendly Assessment in October 2011 & we have seen a marked improvement in the results of staff re-audit. The audit is undertaken to:

- Improve the support to breastfeeding mothers and infants by measurement of practice against BFI Standards
- Improve compliance to the Baby Friendly Standards within Maternity and Neonatal Services
- Increase the breastfeeding initiation rate in line with Government Directives (2% increase year on year)

Target population: All midwives; support workers, nursery nurses & neonatal nurses at the Jessop Wing. Data was collected from a randomly selected sample of 40 staff, by interview method.

The UNICEF BFI Report on the stage 2 assessment 19-20 October 2011 stated;

'The Jessop Wing presents a positive approach to breastfeeding and has consistently displayed enthusiasm and commitment towards providing an effective training programme. The assessment revealed that staff are equipped with the knowledge and skills to implement BFI standards to promote and support breastfeeding. Both those involved with training and the staff are highly commended for the standards found at this assessment. The recommendation of the assessment team is that Stage 2 assessment be considered passed. The facility is now eligible to move on to Stage 3 assessment'.

An Audit of the Prescription Practices in three Paediatric Dental Departments in the North of England

Introduction
The prevalence of antibiotic resistance is increasing and studies have shown that there are no antibiotics to which bacteria have not developed resistance. It is recommended that in order to decrease the rate of development of resistance, colonisation resistance and reduce the development of hypersensitivity, healthcare workers must be prudent in the use of antibiotics.
The first cycle of this audit highlighted deficiencies in prescribing practices in the paediatric dental departments of Liverpool, Manchester and Sheffield. Only 28% of prescriptions were deemed clinically justified and 47% were completed satisfactorily.

Aims and Objectives
To evaluate if prescribing practices in the three departments had improved following education and training following cycle 1, with the following specific objectives:

- To examine if antibiotics are used appropriately
- To assess prescription accuracy
- To determine if sugar-free elixirs are prescribed

Standards
All prescriptions issued should be in accordance with recognised clinical guidelines.

Method
A retrospective case-note evaluation of 30 patients per centre who had been issued with a prescription.

Results
A total of 90 paediatric dental patients were included in each cycle of this audit. The issue of appropriate prescriptions increased from 28-52% in the second cycle as did prescription of sugar-free medicines which also improved from 53% to 67%. Prescription accuracy had increased slightly from 47% to 48%.

Discussion
This audit has highlighted deficiencies in prescribing in all three departments. Accuracy of prescribing and judicial use of antibiotics is important to minimise bacterial resistance and to ensure patient safety. The results of this audit compare well with previous studies carried out in general dental practice

Implementation of findings
Further education and training has been provided with the results presented locally and nationally. An aide-memoire demonstrating a correctly completed prescription has been placed in the prescription pad for future reference. Current guidelines are now included in departmental induction materials. A further audit cycle is planned.

Conclusion
This multicentre, multi-cycle audit has highlighted prescribing deficiencies in the three departments. There has been an overall improvement in the number of appropriate prescriptions and sugar free prescriptions however, prescription accuracy continues to be a problem.
This audit has won the British Society of Paediatric Dentistry Annual Scientific Meeting Audit Prize (Glasgow, 2011), the Sheffield Teaching Hospital NHS Trust (Charles Clifford Dental Hospital) Prize (June, 2011) and participated at the YEARN Conference (November, 2011) with a poster presentation.

Obstetrics and Gynaecology- an overview of the year

Our department has been very active in developing, delivering and managing a high quality multidisciplinary audit programme. All the aims of the programme have been achieved.

The aims of the programme are to:

1. Audit the quantity, quality and safety of our clinical care and the training provided to our trainees.
2. Improve the standard of care to our clients and ensure that these standards are compatible with the National standards derived from the NICE, The Royal College of Obstetricians and Gynaecologists (RCOG) and other National Bodies.
3. Participate in National Audits.
4. Ensure the results and the recommendations of all audits are shared with the multidisciplinary team and to increase the awareness of staff of any changes in our guidelines.
5. Ensure the recommendations are implemented and disseminated.
6. Involve the doctors and midwives in General Practice in developing care pathways for care of women as a result of audit findings and recommendations.
7. Share the results of some audits with National Audiences through International Conferences and publications.
8. Use the result of some basic audit in developing research aiming at finding better ways of improving future patients' care.
9. Work closely with the CEU, Audit Leads, Governance Group and CEC to promote, monitor the standards and the implementation of the national and local guidelines.
10. Develop active strategy to motivate junior doctors, midwives and nurses to engage in audits.

The annual audit programme is usually decided before the Junior Doctors start their work in our department. The audit group meet twice per year to plan the audit programme and the date of the presentations. Following the presentations and the discussion, the Audit Lead sends the result and the recommendation to all members of the directorate and places all the audit presentations on the directorate web page. An Audit intranet web page has been made available to all staff in the NHS in the UK to view the outcome of our audits via NHS hospital computers.

We have presented an audit on operative intervention in management of major postpartum haemorrhage at the 9th International Scientific Meeting of RCOG in Athens and it was published in the Journal of Obstetrics and Gynaecology.

From undertaking audit and service evaluation within our directorate many of our guidelines have been updated, and some have been developed. Following undertaking an audit on epilepsy in pregnancy a care pathway for pre-conception management of epileptic women has been discussed with the primary care group, to improve future pregnancy outcomes.

Audit Lead.

Safeguarding Vulnerable Adults

As part of the CQC regulations NHS services are required to ensure that people who use those services are safe from abuse. This involves identifying the possibility of abuse, preventing it, and responding appropriately to any allegation of abuse. A re-audit of adult safeguarding was undertaken in September 2011. Data was collected, in the form of questionnaires, from all Service Managers in Primary and Community Care Services; there was a response rate of 38%. Results showed an increase from the previous year's audit on all standards; although, compliance remained low against the standard for "the ability to recognise and identify abuse". Actions emanating from the audit included more role specific training to help staff recognise and identify all forms of abuse.

Senior Clinical Effectiveness Facilitator for Primary and Community Care Services Group

The Diagnosis and Management of DKA

Diabetic ketoacidosis (DKA) is a life-threatening but easily manageable condition if detected and treated quickly and appropriately.

STHFT have developed an evidence based guideline for the management of DKA. This requires a proforma to be filled in which details management such as fluid, insulin and electrolyte initiation and provides guidance criteria for referral to critical care.

The aim of the audit was to identify and appropriately treat patients who have diabetic ketoacidosis.

Recommendation	Action
Patient education about diabetes and DKA	Production or distribution of patient information leaflet to the patient's home
GP notification of DKA event	Automatic letter to GP advising appointment for diabetes education with recommendations about 'sick day rules' – when to contact healthcare professionals, BG goals and use of supplemental short-acting insulin during illness, means to suppress fever and treat infection, initiation of liquid diet containing carbohydrates and salt, never discontinue insulin
Early nurse review, urgent doctor review	Nurse review should incorporate BG and urinalysis, if positive, urgent review by doctor
Appropriate critical care referral	Ensure patients that meet HDU/ITU criteria are referred / reviewed
Record of biochemical markers with fluid prescription	Document last BG and potassium result next to each prescription of fluid on the sliding scale
Appropriate monitoring of biochemical markers after initiating treatment	Ensure U's & E's two hours post-initiation of treatment are handed over and documented
Modification of existing pro-forma	Incorporate a checklist of the above into the DKA pro forma
Ensure adherence to standards is improving	Re-audit in one year

Conclusion

DKA is a life-threatening condition which needs swift treatment to avoid mortality.

We recommend better patient education, early nursing review of key parameters followed by urgent review by doctors, appropriate referral to critical care, careful monitoring of biochemical parameters after initiation of treatment, and a re-audit in one year.

Respiratory Mental Health: Referrer Satisfaction

The Respiratory Mental Health Team (RMHT) offers assessment and treatment for people who are experiencing co-existing mental health problems (mainly anxiety and depression) and chronic respiratory illness.

The team consists of mental health nurses and occupational therapists, who work within primary care in order to reduce psychological distress, improve self-management, maximise quality of life and reduce the number of unplanned hospital admissions.

The audit was undertaken to identify whether the team is meeting quality of service standards. It was also an opportunity to collate qualitative information about the service.

Recommendations

The following recommendations are made as a result of the audit:

1. Communication improvements:
1.1. All referrers *without* access to SystmOne will receive a letter confirming that their referral has been received and processed.
1.2. All involved HCP's *without* access to SystmOne will receive a summary of the RMHT assessment and a brief summary of the plan of care.
1.3. All involved HCP's will receive a discharge summary.
1.4. A member of the RMHT will attend the respiratory team meetings held within primary and secondary care to improve communication and collaborative working across the respiratory services.
1.5. Members of the RMHT will attend Case Management meetings at regular intervals in order to improve communication.
1.6. The RMHT will "advertise" its services to GP practices.

2. The RMHT will offer training to referrers. Including: identifying mental health problems, standardised assessments (PHQ9 and GAD7), and how to provide basic self-help material.

3. The team will continue to discuss service need with senior management and the business case for expanding the team to meet demand

4. A brief summary of this audit will be produced and made available to all HCP's referring to the service and to GP practices across Sheffield.

STHFT's NICE Processes Internally Audited

In December 2011, STHFT's processes underwent an examination by NHS Assure Internal Audit department (independent and objective assessors) and awarded a rating of B, which denotes significant assurance that there is good internal control with only minor risks/controls weaknesses, where it is considered desirable that action is taken. This provides the Trust with "significant assurance" that the procedure for implementing NICE Guidance is robust, which is a positive outcome for STHFT

National Service Framework (NSF) for Coronary Heart Disease (CHD): Audit of Cardiac Rehabilitation Services

Each year STHFT review practice to ensure we are meeting the Coronary Heart Disease NSF audit standards relating to cardiac rehabilitation services. Data is collected continuously by the cardiac rehabilitation nurses at STHFT and inputted, using Infoflex onto the MINAP database – all myocardial infarction patients between the ages of 35-74 years are included. The data collection period for this report is April 2011-March 2012 (figures taken from Infoflex). 100% of patients discharged from hospital with acute MI are offered cardiac rehabilitation and this is communicated to GPs for all patients. The Cardiac Team will try to ensure that these high standards are maintained.

Commissioned Audit Summary Table 2011/12

NICE Ref:	Title	Lead Directorate	Project Status
TA1	Wisdom teeth removal (re-audit)	Oral and dental	Awaiting production of final report.
TA80	Clopidogrel use	City-wide	Report received
TA85	Immunosuppressive therapy for renal transplantation in adults	Sheffield Kidney Institute	Project currently on-hold
TA133	Omalizumab for severe persistent allergic asthma	Respiratory	Report received
TA169	Sunitinib for the first line treatment of advanced and metastatic renal cell carcinoma	Oncology	Report received
TA170	Rivaroxaban for THR and TKR	Orthopaedics	Report received
TA177	Alitretinoin for chronic eczema	Dermatology	Report received
TA182	Prasugrel for the treatment of acute coronary syndrome	Pharmacy	Results to be reviewed.
TA187	Crohn's disease - infliximab and adalimumab	Gastroenterology	Report received, to be reviewed.
TA198	Tocilizumab for patients with RA	Rheumatology	Report received
CG10	One year outcome of diabetic foot ulcers and gangrene after revascularisation	Vascular	Audit period extended
CG36	Treatment of Atrial Fibrilation in Post-Op Cardiothoracic Patients	Cardiac Surgery	Data analysis underway
CG41	Familial breast cancer	Breast Surgery	Data collection ongoing
CG44	Heavy Menstrual Bleeding	Obstetrics & Gynaecology	Data collection ongoing
NICE Ref:	**Title**	**Lead Directorate**	**Project Status**
CG63	Diabetes in Pregnancy (re-audit)	Obstetrics & Gynaecology	Report received and to be reviewed.
CG65	Perioperative hypothermia	Anaesthetics –NGH	Awaiting completion of final report
CG67	Lipid Modification - Atorvastin 80mg use in patients with NSTEMI (Re-audit)	Cardiology	Project ongoing
CG68	Stroke (A retrospective review of imaging in acute admissions of Stoke and TIA presenting to STHFT)	MIMP	Report received
CG74	Surgical site infection	Plastic Surgery	Data collection ongoing

NICE Ref:	Title	Lead Directorate	Project Status
CG76	Medicines Adherence	Pharmacy	Report received
CG81	Breast Cancer (advanced) – capectibine	Cancer services	Report received and to be reviewed
CG93	Donor breast milk banks	Neonatology	Report received
CG94	Management of NSTEMI/Unstable Angina	MAU	Report received
CG94	Management of NSTEMI/Unstable Angina	Cardiology	Patient notes to be reviewed
CG95	Chest Pain of Recent Onset	Cardiology	Data being analysed
CG100	Alcohol use disorders - physical complications	MAU	Report received
CG106	Barrett's Oesophagus - ablative therapy	Gastroenterology	Results to be discussed with project team
CG108	Chronic Heart Failure	Cardiology	Project started
CG109	Transient Loss of Consciousness	MAU	Report received
CG110	Pregnancy and complex social factors	Obstetrics	Report received
CG112	Sedation in children and Young People	Paediatric Dentistry	Project started and data being collected.
CG121	Lung Cancer	Cancer Services	Project started
QS	Venous Thromboembolism	Trustwide	Report to be reviewed
	NCAPOP	**Lead Directorate (Speciality)**	**Comments**
	Cancer		
	Bowel Cancer (NBOCAP)	Colorectal	Continuous data collection
	Oesophago-gastric cancer (NOGCA)	General Surgery	Collecting data
	Head and Neck Cancer (DAHNO)	Oral & Dental/ENT	Continuous data collection.
	National Lung Cancer Audit (NLCA formerly LUCADA)	Respiratory Medicine	Collecting data
	Women and Children		
	National Neonatal Audit Programme (NNAP)	Neonatology	100% data submission. Local action plan developed.
	Heavy Menstrual Bleeding	Obstetrics & Gynaecology	Data collection finished and awaiting national report.
	Heart		
	Adult Cardiac Surgery	Cardiothoracic	Continuous data submission

	NCAPOP	Lead Directorate (Speciality)	Comments
	Heart		
	Congenital Heart Disease (including paediatric surgery)	Cardiothoracic	Continuous data submission.
	Coronary interventions (e.g., angioplasty, opening up heart artery)	Cardiothoracic	Continuous data submission. Data submitted and awaiting national report.
	Myocardial Infarction (MINAP)	Cardiothoracic	Report received
	Heart Rhythm Management (pacing/implantable defibrillators)	Cardiothoracic	Continuous data submission.
	Heart Failure	Cardiothoracic	Continuous data submission.
	Long term conditions		
	Diabetes	Diabetes & Endocrinology	Report received
	Renal Services - Patient Transport (National Kidney Care Audit)	Renal	Awaiting local action plan.
	Renal Services - vascular access (National Kidney Care Audit)	Renal	Awaiting local action plan.
	National Joint Registry (NJR)	Orthopaedics	Continuous data collection.
	Inflammatory Bowel Disease	Gastroenterology / General Surgery	Draft report being compiled.
	Pain Database	Critical Care	Data collection ongoing.
	NCAPOP	**Lead Directorate (Speciality)**	**Comments**
	Older People		
	National Carotid Interventions Audit (replaced Carotid Endarterectomy (UKCEA) *(preventing stroke)]*	Vascular	Continuous data collection
	National Falls & Bone Health Audit	Acute Medicine / Neurosciences / Specialised Med	Ongoing
	National Hip Fracture Database (NHFD)	Orthopaedics / Geriatrics	Report received

	OTHER NATIONAL AUDITS (PCT Commissioned)	Lead Directorate (Speciality)	Comments
	Consultant Sign Off in the Emergency Department	Emergency Dept	Local data collection, which will be compared against National for bench-marking.
	OTHER NATIONAL DATA COLLECTION FOR QUALITY ACCOUNTS (Commissioned)	**Lead Directorate (Speciality)**	**Comments**
	Peri-and Neonatal		
	CE (Corp)Perinatal Mortality - Maternal and Newborn Audit	Obstetrics	Data collection ongoing.
	Acute Care		
	Emergency Use of Oxygen	Respiratory Medicine	Report received
	Adult community acquired pneumonia	Respiratory Medicine	Report received
	Non invasive ventilation (NIV) adults	Respiratory Medicine	Report received
	Pleural Procedures	Respiratory Medicine	Report received
	National Cardiac Arrest Audit (NCAA)	Trustwide	STH currently undertaking an internal cardiac arrest audit, once adequate return and data is forthcoming from this, we will look to use it towards the National Audit.
	Vital signs in majors	Emergency Dept	Local action plan being produced
	Severe Sepsis and Septic Shock	ED	Data collection ongoing
	Adult Critical Care- Case Mix Programme	Critical Care	On track
	Long Term Conditions		
	National Parkinson's Audit	Geriatric Medicine & Neuromedicine	Data collection complete.
	COPD	Respiratory Medicine	Awaiting hospital specific report
	National Adult Asthma Audit	Respiratory Medicine	Report received
	Bronchiectasis	Respiratory Medicine	Report received
	Elective Procedures		
	VSSGBI Vascular Society Database	Vascular	On track
	National Elective Surgery PROMS: Four operations	General Surgery & Orthopaedics	Further information can be sought from the Patient and Partnership Initiative

	OTHER NATIONAL DATA COLLECTION FOR QUALITY ACCOUNTS (Commissioned)	Lead Directorate (Speciality)	Comments
	Cardiovascular Disease		
	Pulmonary Hypertension Audit	Respiratory Medicine	On track
	Acute Stroke: SINAP	Geriatrics and Stroke / Neurosciences	On track
	Renal Replacement Therapy	Renal	Data collection ongoing
	UK Transplant Registry: Renal Transplantation	Renal	Ongoing data collection.
	Renal Colic	Emergency Medicine	Local action plan to be developed
	Trauma		
	Severe Trauma	Emergency Medicine	On track
	Blood Transfusion		
	National Comparative Audit of Blood Transfusion: O negative blood use	Haematology	Report received
	National Comparative Audit of Blood Transfusion: platelets	Haematology	Report received
	Potential Donor Audit	Critical Care	On track
	National Comparative Re-Audit of Bedside Transfusion Practice	Haematology	Local action plan to be developed
	National Comparative Audit of the Medical Use of Blood	Haematology	On track
	Health Promotion		
	National Health Promotion in Hospitals Audit (risk factors)		Not participating due to scare resources.
	End of Life		
	National Care of the Dying Audit - Hospitals (NCDAH)	Trustwide/Palliative Medicine	Local action plan in development

	OTHER NATIONAL GUIDANCE (PCT Commissioned)	Lead Directorate (Speciality)	Comments
	NCEPOD- Patient Outcome and Death	Trustwide	On track
	NCEPOD- Are we there yet?	Trustwide	Audit registered and data collection planned for April 2012
	A Mixed Bag: Use of TPN	Trustwide	The majority of actions have been actionned and we are compliant; there are a few areas for development which the lead Consultant Gastroenterologist is following up on.
	An Age Old Problem	Trustwide	Associate Medical Director, Clinical Director for Professional Services and a consultant geriatrician are meeting monthly to address recommendations
	Record Keeping (as per standard 4)	Trustwide	Report received
	Lithium Therapy Monitoring		No audit required.
	REGIONAL/NHS SHEFFIELD PRIORITIES (Commissioned)	**Lead Directorate (Speciality)**	**Comments**
	Audit of standards for admission to obstetric triage/service evaluation looking at patterns of admission	Obstetrics & Gynaecology	Report received
	REGIONAL/NHS SHEFFIELD PRIORITIES (Commissioned)	**Lead Directorate (Speciality)**	**Comments**
	Yorks and Humber DNACPR		Participating in regional audit
	National CQUIN - Venous Thromboembolism	Trustwide	On track
	Regional/Local CQUIN - Enhanced recovery in colorectal surgery	Colorectal	Ongoing
	Regional/Local CQUIN - Asthma	Respiratory	Ongoing
	Audit of pathways and protocols		No requests to date
	Safeguarding - Documentation of routine enquiry during antenatal period	Obs & Gynae	Report received
	Audit of Mental Capacity Assessment following a safeguarding serious case review	Trustwide	Undergoing data analysis

	Community Commissioned Audits - NCAPOP	Lead Directorate (Speciality)	Comments
	National Falls and Bone Health – therapeutic exercise audit	Long-term conditions	Awaiting national audit
	National Falls and Bone Health – organisational and clinical audit	Long-term conditions	Report received
	Community Commissioned Audits – Other National Audits	**Lead Directorate (Speciality)**	**Comments**
	Clinical Record Keeping	Service-wide	Report received

Commissioned Clinical Effectiveness Summary Table (2011/2012)

Number	Issue Date	Title	Topic Status
TA219	Apr-2011	Everolimus for the second line treatment of renal cell carcinoma	Not recommended by NICE, therefore not routinely used at STHFT; however, it is available via the Cancer Drug Fund – the technology has never been applied for.
TA220	Apr-2011	Psoriatic arthritis – golimumab	At the time of release, the area planned to have full implementation within 3 months. There are currently 4 patients on this drug, all approved by the PCT panel.
TA221	Apr-2011	Thrombocytopenic purpura – romiplostim	Fully compliant, but audit will be required in the future.
TA222	Apr-2011	Ovarian cancer (relapsed) – trabectedin	This has been used in a clinical trial, but will not be used outside this, therefore we comply with NICE fully
TA223	May-2011	Peripheral arterial disease – cilostazol, naftidrofuryl oxalate, pentoxifylline and inositol nicotinate	Fully compliant in that (1) we have very little use of these drugs, and (2) colleagues understand the NICE guidelines & recognise that should they wish to prescribe a drug for claudication then this should be naftidrofuryl.
TA224	Jun-2011	Rheumatoid arthritis (methotrexate – naïve) – golimumab	NICE TERMINATED APPRAISAL
TA225	Jun-2011	Rheumatoid arthritis (after the failure of previous anti-rheumatic drugs) – golimumab	Increasing numbers of patients who are currently receiving anti-TNF inhibitors. It is imperative that those patients who do fail have access to approparite drugs. Compliance with NICE guidance is therefore essential
TA226	Jun-2011	Lymphoma (follicular non-Hodgkin's) – rituximab	Patient numbers are small, and the perception is that the guidance is being used in accordance with NICE guidance; however, an audit will be required when there are enough patients using the drug.
TA227	Jun-2011	Lung cancer (non-small-cell, advanced or metastatic maintenance treatment) –erlotinib (monotherapy)	NICE do not recommend this drug therefore it is not used in practice. The Trust comply with the guidance recommendations
TA228	Jul-2011	Multiple myeloma (first line) – bortezomib and thalidomide	Plans to implement to comply with NICE guidance.
TA229	Jul-2011	Macular oedema (retinal vein occlusion) – dexamethasone	At the time of issue, patients affected by this NICE guidance were receiving the technology on cost per case basis. Proposal to NHS Sheffield regarding service development in this area.
TA230	Jul-2011	Myocardial infarction (persistent ST-segment elevation) – bivalirudin	This guidance recommends bivalirudin with clopidogrel – this combination of drugs is not used for PPCI for STEMI. Clinicians at STHFT use prasugrel.
TA231	Jul-2011	Depression - agomelatine	NICE TERMINATED APPRAISAL

Number	Issue Date	Title	Topic Status
TA232	Jul-2011	Epilepsy (partial) – retigabine (adjuvant)	This has been placed on the hospital formulary.
TA233	Aug-2011	Ankylosing spondylitis – golimumab	Implementing to reach full compliance, as the guidance will allow for the use of the technology routinely.
TA234	Aug-2011	Rheumatoid arthritis – abatacept (2nd line)	Not recommended by NICE, and therefore not used.
TA235	Oct-2011	Osteosarcoma – mifamurtide	Application submitted to the Drugs and Therapeutic Committee for approval for implementation.
TA236	Oct-2011	Acute coronary syndromes – ticagrelor	Ticagrelor has been accepted onto the STH NHSFT formulary but will not be introduced until funding has been identified. NHS Sheffield released funding by the 3 month deadline.
TA237	Nov-2011	Macular oedema (diabetic) – ranibizumab	Not recommended by NICE, so cannot be used.
TA238	Nov-2011	Arthritis (juvenile idiopathic, systemic) – tocilizumab	Several young patients in adolescent clinic with SOJIA, and some are already on Tocilizumab on an individually approved basis. Will be fully compliant with the guidance.
TA239	Dec-2011	Breast cancer (metastatic) – fulvestrant	Not recommended, therefore not used.
TA240	Dec-2011	Colorectal cancer (metastatic) – panitumumab	NICE TERMINATED APPRAISAL
TA241	Jan-2011	Leukameia (chronic myeloid) – dasatinib, nilotinib, imatinib (intolerant, resistant)	Nilotinib is the only drug that has been recommended, and will be used in accordance to NICE guidance.
TA242	Jan-2011	Colorectal cancer (metastatic, 2nd line) – cetuximab, bevacizumab and panitumumab (review)	None of these drugs have been recommended by NICE. They are not used in practice.
TA243	Jan-2011	Follicular lymphoma – rituximab (review)	This is a review of previous guidance issued in Sept-2006. This guidance has been implemented.
TA244	Jan-2011	Chronic obstructive pulmonary disease – roflumilast	Not recommended for use outside of a clinical trial. Not used at STHFT.
TA245	Jan-2011	VTE – apixaban (hip and knee)	This particular technology is not used at STHFT as clinicians are using a different regimen – rivaroxaban.
TA246	Feb-2012	Venom anaphylaxis – immunotherapy pharmalgen	Implementing to comply.
TA247	Feb-2012	Rheumatoid arthritis – tocilizumab	Review of an earlier technology appraisal. STHFT compliant.
TA248	Feb-2012	Diabetes (type 2) – exenatide (prolonged release)	Compliant pre-NICE guidance.
TA249	Mar-2012	Atrial fibrillation – dabigatran etexilate	Awaiting position.
TA250	Apr-2012	Breast cancer (advanced) – eribulin	Not recommended, therefore not used.
TA251	Due Apr-2012	Hepatitis C (genotype 1) – boceprevir	Released 25th April 2012 – lead to be appointed

Number	Issue Date	Title	Topic Status
TA252	Due Apr-2012	Hepatitis C (genotype 1) – telaprevir	Released 25th April 2012 – lead to be appointed
TA253	Due Apr-2012	Leukaemia (chronic myeloid, first line) – dasatinib, nilotinib and standard dose imatinib	Released 25th April 2012 – lead to be appointed
CG121	Apr-2011	Lung cancer	Discussed at the North Trent Cancer Network and it has been decided that we will not be fully compliant due to a number of minor issues. These issues have been discussed at the Trust NICE Implementation Group who agreed that the deviations are acceptable and low risk.
CG122	Apr-2011	Ovarian cancer	Practice in secondary care equivalent to NICE recommendations
CG123	May-2011	Common mental health disorders	Applicable to Primary Care only
CG124	Jun-2011	Hip fracture	The current position demonstrates that STHFT are compliant against the majority of the NICE guidance. However, there are some indications that may need further work – development work is currently being carried out in A&E
CG125	Jul-2011	Peritoneal dialysis	3 recommendations currently not being fully met by the area. The first recommendation, renal is working with service improvement to help set up a service for late presenters. The remaining 2 recommendations are unlikely to be met. One instructs that stage 5 CKD patients who meet certain criteria should have peritoneal dialysis as first choice rather than haemodialysis – renal consultants offer free choice. The other recommendation not met is switching treatment modalities. NICE recommend not switching in anticipation of potential future complications such as encapsulating peritoneal sclerosis. STHFT do occasionally switch if the risk of EPS is significant. This has been discussed at the NICE group and signed off as acceptable deviations presenting low risk.
CG126	Jul-2011	Stable angina	Practice very much in line with guidance, with the exception of referrals to community rehabilitation programmes. Work undertaken to increase the amount of referrals.
CG127	Aug-2011	Hypertension	This guidance does not have a bearing on acute services, but the acute lead will be working with the community lead to aid implementation.
CG128	Sept-2011	Autism in children and young people	Not applicable
CG129	Sept-2011	Multiple pregnancy	Recommendations from NICE guidance incorporated into local guidance.
CG130	Oct-2011	Hyperglycaemia in acute coronary syndromes	Currently reviewing and implementing the guidance.
CG131	Nov-11	Colorectal cancer	STHFT fulfil the NICE Guidance pre-publication. The only difference is we offer surveillance colonoscopy at 5 years rather 1 years. However, changes made and colonoscopy is now offerred after 1 year
CG132	Nov-11	Caesarean section	Local guidelines have been updated to take into account new recommendations

Number	Issue Date	Title	Topic Status
			from NICE guidance. There is a pathway for women requesting CS with no indications to discuss pros and cons of CS against vaginal birth.
CG133	Nov-11	Self-harm (long term management)	Not applicable
CG134	Dec-11	Anaphylaxis	Lead working to implement guidance
CG135	Dec-11	Organ donation	The guidance has provided recommendations for increased referral to the organ donation service. The lead is currently working with the relevant clinical areas to address the guidance in order to reach compliance.
CG136	Dec-11	Service user experience in adult mental health	Not applicable
CG137	Jan-12	Epilepsy (update)	The position in Sheffield is that they are satisfied that they are compliant with the NICE guidance, with the exception of patients being seen within 2 weeks of seizure onset by a specialist- currently does not happen, but work is ongoing to improve this issue.
CG138	Feb-12	Patient experience in adult NHS services	There are a number of elements to this guidance and Quality Standard. The standards are aspirational and the service aims to incorporate into service provision within the next few years. The Patient Partnership Initiative team wishes to discuss with their group, with the view to setting out a plan for the financial year 2012-2013 to incorporate some of the standards into their annual work plan.
CG139	Mar-12	Infection control (update)	Awaiting identification of clinical lead in Community Care
QS	Aug-11	Alcohol dependence and harmful alcohol use	SHSCFT initiated a potential interface project; however, this is currently on hold from the Mental Health Trust. Action: to develop a working group for the Trust.
QS	Sept-11	Breast cancer	A business case is being developed to increase the provision of specialist nursing support. Also, there has been a change to the recommendations regarding follow-up imaging – the new guidance has recommended that follow-up imaging to be every year rather than 5 yearly - this will have a cost implication, which is currently being addressed.
QS	Jun-11	Chronic Heart Failure	Up to three statements will form 2012/2013 CQUIN
QS	Mar-11	Chronic Kidney Disease	There are a number of current data collection systems that measures some of the statements – compliance has been achieved.
QS	Jul-11	COPD	Meeting the NICE recommendations, however, there are issues with oxygen prescribing, but this is outside of STHFT's control, a National issue.
QS	Jun-10	Dementia	New pathway set up against the QS, which needs to be measured against - project currently underway. Hospital diagnosis and referral to memory clinic a

Number	Issue Date	Title	Topic Status
			national CQUIN.
QS	Mar-11	Depression in adults	Work ongoing to assess current infrastructure and service provision, with the clinical psychology service addressing areas of need.
QS	Mar-11	Diabetes in adults	Actions identified with the intention to implement
QS	Nov-11	End of life care	NICE has defined 12 months as the time frame for patients with certain conditions to begin end of life planning. The end of care pathway usually begins in the last few days of life. Being addressed as a City-wide project.
QS	Mar-11	Glaucoma	There are two statements in the QS resulting from the clinical guideline that we have previously agreed departures from. STHFT clinical lead working with the joint Clinical Director of the CCG to develop community working in this area.
QS	Mar-12	Hip Fracture	STHFT are mostly compliant with NICE guidance. However, there are some indications that may need further work – work currently underway in A&E.
QS	Mar-12	Lung cancer	This has been discussed at the North Trent Cancer Network and it has been decided that we will not be fully compliant; this is due to a number of minor issues. These issues have been discussed at the NICE Implementation Group and agreed that the deviations are acceptable and low risk.
QS	Feb-12	Patient experience in NHS services	There are a number of elements to this guidance and Quality Standard. The standards are aspirational and the service aims to incorporate into service provision within the next few years. The Patient Partnership Initiative team wishes to discuss with their group, with the view to setting out a plan for the financial year 2012-2013 to incorporate some of the standards into their annual work plan.
QS	Dec-11	Service user experience of mental health services	Not applicable
QS	Oct-10	Specialist neonatal care	Monitoring systems set up. Data for the majority of the standards can be accessed electronically.
QS	Jun-10	Stroke	Some statements measured via the stroke national audits. Currently reviewing the stroke rehabilitation statement.
QS	Jun-10	VTE Prevention	Risk assessment and appropriate prophylaxis prescribing measured by CQUIN. We measure risk assessment within 24hrs rather than ‘at admission’.