NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

Quality Strategy
2017-2020

PROUD TO MAKE
A DIFFERENCE

Introduction

Who we are

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's busiest and most successful providers of hospital and community-based healthcare. With a turnover over **£1 billion** and around **2 million patient contacts** each year, more than a million of those in the community, we provide a comprehensive range of local services to the residents of Sheffield, South Yorkshire, Mid Yorkshire and North Derbyshire and also some highly specialist services to all parts of England**.**

We employ over **16,000 talented and dedicated staff** who strive to provide an outstanding patient experience and high quality care for all of our patients. In addition, we have around **750 committed and enthusiastic volunteers**, who work tirelessly to enhance the experience of our patients and their families.

Above all, **patients** are at the heart of everything we do.

Our vision

Our Trust Corporate Strategy, Making a Difference (2017-2020), outlines our **vision** to be recognised as the best provider of health, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city. Our strategy identifies five key **strategic aims** for the next three years:

As one of the key supporting strategies, the **Quality Strategy** specifically underpins the following corporate aims and objectives:

Delivering the best clinical outcomes

- Treat and care for people in a high quality, safe environment and protect them from avoidable harm.
- Help people to recover from episodes of ill health or following injury.
- Maximise the health of those who use our services.
- Enhance the quality of life for people with long-term conditions.
- Ensure clinical practice is evidence-based.
- Ensure person centred and coordinated care for our patients near the end of life.

Providing patient-centred services

- Treat patients and their families with respect, dignity and care.
- Maximise the quality of the patient experience
- Communicate effectively and develop a vibrant system of engagement within the local community.
- Learn from complaints, compliments and other feedback.

Supporting strategies

The Quality Strategy cannot be viewed in isolation and instead should be viewed in the context of other Trust strategies and plans, many of which have a direct influence on our patients' experiences of the care they receive. For example, there is a well-established link between **staff experience** (People Strategy) and patient experience (1). In addition, patients frequently cite **access and waiting times** (Care Group Operational Strategies and Business Plans) as having significant influence over their overall experience (2). Furthermore, there is a body of research linking access and waiting times to patient safety and clinical effectiveness, which are widely acknowledged as key components of quality in healthcare (3). Figure 1below illustrates the Quality Strategy in the context of the Corporate Strategy (Making a Difference) and other supporting strategies and plans:

Figure 1: Trust strategies and plans

And underpinning all of these strategies are our Trust's **PROUD** values.

1. Dawson, J (2014). Staff experience and patient outcomes: what do we know? NHS Employers, London.
2. Coulter, A; Fitzpatrick, R; Cornwel, J (2009). Measures of patients' experience in hospital: purpose, methods and uses: The King's Fund, London.
3. Doyle C, Lennox L, Bell D (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open.

Context

Our plans to ensure we deliver the **highest quality care** are shaped by a range of national, regional, local and Trust-level factors. However, the overriding issues of the significant financial and operational pressures which are being felt right across the health and social care system affect our approach at every level. Our challenge is to deliver the highest quality care whilst ensuring future financial sustainability.

Factors which have shaped our approach within this strategy include:

National:

- **The Care Quality Commission's (CQC)** most recent inspection of STH was in December 2015, when the Trust was awarded a rating of 'Good' at a Trust-wide level. There were a number of areas that were highlighted as 'Outstanding' but also areas where some improvement was required and these areas have been our immediate focus. Recent changes to regulatory approaches will mean the introduction of new assessments of providers' use of resources (sustainability) and leadership (well-led) along with targeted inspections.
- The **Next Steps on the NHS Five Year Forward View** (March 2017) outlines the significant changes that will shape the NHS over the coming years. Of particular note for the Quality Strategy is the compelling case for improving how we involve people in their health care.
- **Lord Carter's review** of efficiency in hospitals highlights the need to minimise variation to optimise quality and efficiency and to deliver improved clinical outcomes and productivity.
- Changes to existing **national bodies** along with the introduction of new bodies which direct or support quality will influence our priorities and thinking. These include the **National Quality Board** which was re-established in April 2015, the **Parliamentary and Health Service Ombudsman** which continues to develop its thinking and focus and from April 2017, the newly-formed **NHS Resolution** and the new **Healthcare Safety Investigations Branch**.
- Working collaboratively as members of national groups or networks which support learning and improvement including the **Shelford Group** and **NHS Quest**.

Regional:

- The organisation of our local health and social care economy will change significantly during the lifetime of this strategy as our **Accountable Care System and Accountable Care Partnership** are developed and implemented.
- Working collaboratively as members of regional groups or networks which support learning and improvement including the **Academic Health Sciences Network.**

Local:

- Sheffield is an ethnically **diverse** city with around 19 per cent of the population from black or minority ethnic groups. 19 per cent of the population are people who have a disability and one in ten people are carers. These groups are those that are more likely to be seldom heard.

Trust:

- Quality is **embedded** in how we plan our services and how we review our performance, forming a strong foundation on which to continually improve.
- We have a well-established **quality improvement programme** including the Sheffield Microsystems Coaching Academy which supports building improvement capability into the workforce. In addition, a strong and innovative programme of **service improvement** continues to engage teams to innovate, improve and transform the quality and efficiency of our services.
- Since February 2017 complaints, patient engagement, safety, inquests and claims, and clinical effectiveness have been brought together within the same department. This new structure means closer **integration, shared learning and partnership working** across key disciplines which are central to our quality strategy.

Listening to our patients

At the heart of our Quality Strategy are our **patients**. Only by genuinely listening to patients can we truly understand the quality of our services and where we need to focus our efforts:

> 'People are not just experts in their own lives, conditions and care needs, they also hold vital knowledge about local services that we can harness to improve health and care. People who use services see the best and the worst that is on offer, and understand the emotional toll of ill health and caring. Through co-production, this knowledge can help drive improvements, making services more responsive to people's actual needs.'**(4)**.

This strategy aims to build on our long history and excellent record of **patient engagement**, with a focus on strengthening three specific areas of engagement:

- We will reach out to those who are **harder to reach** or **seldom heard**. This includes older people, young people including young carers, people who are homeless and people from black and minority ethnic groups. These people are often those who need our services most but with whom we engage the least. During the lifetime of this strategy, we will undertake specific programmes of work to engage with harder to reach groups and, in doing so we will work with relevant voluntary sector organisations which have a wealth of experience and expertise to draw upon.

- We will **directly involve our patients** in decision making processes for agreeing quality improvement priorities each year. This means that, as well as reviewing our patient feedback, we will actively seek patients' views on what our priorities should be.

  We will also consult with our **staff**, who experience and understand first hand those problems which impact on patient experience. Staff have a unique understanding of where and how improvements can be made for the benefit of patients **(5)** and this strategy will ensure that their knowledge, experience and understanding inform our decisions. In addition, we will consult with our **governors** who bring valuable perspectives and who represent the interests of our members and the public.

  We will be transparent in how we select priorities and we will explicitly state which priorities have been selected based on feedback from our patients, staff and governors.

- We will build on our experience of **co-production,** working in partnership with our patients, their families and carers towards shared goals. Examples of successful co-production include re-designing the outpatient entrance area on A Floor at the Royal Hallamshire Hospital and current work with carers to identify, implement and evaluate service improvements which will make a real difference for them. We will implement and evaluate at least one major co-production project during the lifetime of this strategy and will develop a plan for embedding this approach more widely.

4. People and Communities Board (2016). Six principles for engaging people and communities, p.10. National Voices. Available at https://www.nationalvoices.org.uk/publications/our-publications/six-principles-engaging-people-and-communities
5. Ham, C; Berwick, D (2017). Organising care at the NHS front line: who is responsible? King's Fund, London.

Experience and research have shown that **early and continuous engagement** of patients has positive outcomes at all levels: **(6)**

- Involvement in **individual care and treatment** can improve care outcomes
- Involvement in **communities** can build resilience
- Involvement in **services** can lead to enhanced quality of care and services which are more aligned to patient needs
- Involvement in **planning** and in **defining outcomes** can have positive effects on decision-making processes and the quality of decisions

Meaningful and inclusive involvement starts with a **public commitment** to engagement and **agreed principles** which underpin all engagement activity. Our commitment to involve our patients and to listen to and act on their views is outlined in **Listening, Talking, Improving**: **Our principles for working in partnership with patients** (Appendix 1). These principles have been refreshed in consultation with our governors and with Healthwatch Sheffield and they will guide and underpin all our engagement work.

Our ambitions within the strategy represent a **step change** in the direct and large-scale involvement of not only our patients but also our staff, along with our governors, in the process of selecting quality improvement priorities. This will be achieved through tapping into methods already in place for surveying our patients , which enable us to contact large numbers of patients quickly and easily at minimal cost, along with more focussed work to talk directly with smaller numbers of patients to obtain more detailed feedback. Staff and governors will be consulted using generic internal communications methods, along with more individual approaches including direct email or attendance at key meetings such as the Governors Forum.

These methods have been used during the development of this strategy and have been successful in engaging patients, staff and governors.

6. National Involvement Partnership (2013). National Involvement Standards. National Survivor User Network. Available at http://www.nsun.org.uk/assets/downloadableFiles/4pi.-ni-standards-for-web.pdf

How the quality strategy was developed

The development of our strategy has been informed and guided by **conversations** with our staff, patients, governors and with Healthwatch Sheffield. These conversations have been held in a variety of ways and settings including individual discussions, presentations, meetings and surveys. All of these people have a wealth of experience, information and knowledge which, together with their **different perspectives** and **insights**, have made the strategy more relevant, informed and inclusive.

We took the following approach to the development of our strategy:

How we consulted	How this influenced our strategy
Asked our **patients, carers and families** what matters most to them when they receive care from us. More than 600 patients replied and their responses are summarised on page 8.	➢ The feedback from patients has informed the **definition of quality** which we have adopted and which will shape our approach. ➢ Key themes from this feedback will be fed into our **decision making** in selecting quality priorities.
Asked our **staff** what quality means to them in their job. Over 550 staff replied and their responses are summarised on page 9.	➢ The feedback from staff has informed the **definition of quality** which we have adopted and which will shape our approach. ➢ Key themes from this feedback will be fed into our **decision making** in selecting quality priorities.
Listened to and taken account of the views of **Healthwatch Sheffield,** whose insight and knowledge of patient experience are invaluable.	➢ Increased emphasis on **engaging with hard to reach groups.** ➢ Inclusion of an '**impact evaluation'** of the difference the strategy makes for patients.
Discussed our thinking with key **stakeholders** within our organisation including our **governors** and **senior managers.**	➢ Ensuring **clarity of responsibility** across different functions or committees to avoid duplication or overlap. ➢ Placing the Quality Strategy in the **context** of other Trust strategies and plans.
Shared our plans with **Sheffield Clinical Commissioning Group** and listened to their comments.	➢ Reaffirmed our plans to provide a short summary of the strategy.
Looked to our **current structures** to build on what works well.	➢ The **Quality Forum** will become the Quality Board, with new responsibilities for oversight and delivery and with membership including public representation.
Reviewed **best practice nationally** across the NHS and other organisations including acute NHS trusts identified as 'outstanding' by the CQC.	➢ Incorporated learning from **National Voices** into our principles for patient engagement. ➢ Gained insights and ideas from reading other trusts' Quality Strategies.
Reviewed **current literature and research** to ensure that the strategy incorporates the latest thinking.	➢ Adoption of the Darzi (2008) **definition of quality.** ➢ Adapted recent work from the **King's Fund** and the **Health Foundation** to shape our structure and process for selecting and overseeing quality priorities.

What is quality to our patients and our staff?

In developing our strategy, we sought the views of our patients and our staff about what quality means to them. A summary of their feedback is presented below and the detailed feedback will be fed into our quality improvement priorities.

Patients

We asked our patients '*What matters most to you about the care you receive at our hospitals?'* Over **600 patients, their families and carers** responded. These are the **top themes** and the word cloud in Figure 2 summarises what our patients said:

- Kind, compassionate and caring staff
- Competent staff who inspire confidence and provide excellent clinical care
- Clear explanations and communications
- Not having to wait

Figure 2: Patient word cloud

And here is just a small selection of **comments** from our patients:

'That you have a fast service and friendly staff that know what they are doing and tell you the information necessary.'

'Seeing the same doctor every visit gives me confidence in my treatment as you build up a rapport with them and they get to know you and your condition.'

'That my husband was seen quickly when arriving there as with his medical problems it can be difficult for him to sit for long periods of time.'

'The personal touch. They know me. I know them. We chat. When you can talk to someone, trust them, it makes a big difference.'

Staff

We asked our staff *'Thinking about your job, what does quality mean to you?'* Over **550 staff** replied from across many staff groups. These are the **top themes** and the word cloud in Figure 3 summarises what our staff said:

- Showing kindness and respect
- Listening and communicating carefully and providing clear information
- Accuracy and competence: doing a 'good job'
- Having time to spend with patients
- Safety

Figure 3: Staff word cloud

For our **Chief Executive**, quality means:

'Ensuring that the patients we treat are safe, have a high quality patient experience, are well communicated with and are treated and cared for compassionately by a motivated and caring workforce. Quality also means to me a well-run organisation which is transparent and reflective of the community it serves and an environment which supports practice which is evidence-based through research, innovative and forward looking.'

And here is just a small selection of **comments** from our staff:

'Giving patients the most appropriate treatment and improving their quality of life.' (Consultant Clinical Oncologist)

'Quality to me means making people feel welcome and positive. This is just as important for staff as well as patients in my opinion.' (Clinical Support Worker)

'Typing clinic letters within 48 hours of the clinic and ensuring they are accurate and of a high standard.' (Audio Typist)

'Safe, clean, pleasant environment with well-maintained plant and equipment, no avoidable loss of service or availability to the patients and staff we serve.' (Head of Estates)

Purpose of the strategy

The overarching **purpose** of the strategy is to ensure that we continually review and improve the quality of our services and the care we provide, with the ultimate **aim** of delivering the highest quality healthcare possible.

The key **objectives** of the strategy are to:

- Significantly increase the **involvement of patients and staff** in the selection of annual quality improvement priorities to ensure that we focus on what matters most to those who use our services;
- Strengthen our **governance structure** to ensure oversight and delivery of our quality improvement goals;
- Demonstrate **tangible improvements** across priority areas, which improve the experience of our patients, their families and carers.

The strategy describes a **plan** for how we will continue on our journey of improvement over the next three years through providing:

- A **framework** for quality which will shape our approach;
- A **process** for agreeing quality priorities and a **structure** for overseeing the delivery of improvement goals;
- A set of underpinning **principles** to support patient engagement;
- An outline of associated workstreams for '**Building Capability'** and **'Performance Reporting'** which will support delivery of the strategy;
- A **timetable** for putting the strategy in place.

The strategy **recreates** rather than refreshes the Trust's Quality Strategy (2012-17), given the significant changes in the environment and context over this period of time, along with the emergence of new priorities and performance issues **(7)**. In doing this, it builds on existing structures and excellent programmes of work which are already in place across the Trust to support continual improvement.

Whilst the strategy has been informed by research and theory, it is intended to be a document that has **practical application** and impact. It is also intended to be a **'live'** document which will be continually reviewed and refreshed as opportunities or challenges arise, or as new thinking emerges. Quality is a constantly moving target **(8)** and whilst the '..broad direction of progress may be consistent..' changing context will require that '…adaptations be made to some elements of the strategy and to the approach for implementation.'**(9)**

A framework for quality

In providing a coherent **framework** which will shape our approach to quality improvement, we need to first be clear about our **definition** of quality.

Defining quality in healthcare is challenging. Quality means **different things to different people** and can encompass almost all aspects of healthcare. Quality is also **everyone's responsibility** but with no one person or department having sole responsibility **(10)**. Responsibility for quality in its broadest sense spans all of the Trust's strategies and plans, however the **scope** of this strategy is defined through the framework, structure and process it describes.

7. NHS Improvement (2016). In it together: developing your local system strategy: NHS Improvement, London.
8. National Quality Board (2011). Quality governance in the NHS: A guide for provider boards. Available at: http://webarchive.nationalarchives.gov.uk/20150407101419/http://www.midstaffspublicinquiry.com/sites/default/files/uploads/vol_3_chapter_24_footnotes_103_and_104_dh000600000084.pdf
9. World Health Organisation: A process for making strategic choices in health systems (2006), p.13. World Health Organisation, France.
10. The Health Foundation (2013). Quality made simple. The Health Foundation, London.

Whilst there is no universally accepted definition of quality within the NHS, there are three **domains of quality** which are common to most quality frameworks in healthcare (11). These three domains of Safety, Effectiveness and Experience defined quality in Lord Darzi's NHS Next Stage Review, 2008 (12). This definition of quality has been generally adopted across the NHS (13) and, importantly, it reflects the key themes in the feedback from the surveys we carried out with our patients and our staff. This definition will shape the Trust's approach to quality and our quality framework:

Figure 4: Lord Darzi (2008) definition of quality:

Patient safety	**Preventing avoidable harm (Is it safe?)**
Clinical effectiveness	**Achieving good outcomes and promoting a good quality of life, based on the best available evidence (Does it work?)**
Patient experience	**All aspects of care are characterised by compassion, dignity and respect (What is it like?)**

The **NHS Outcomes Framework**, 2017 (14) and the **Care Quality Commission**'s Key Lines of Enquiry (15)are also based around Lord Darzi's (2008) domains which cannot be viewed each in isolation but as interlinked, with equal importance being placed on each (16). In addition, each of the domains is influenced by **leadership** (Well-led) or **resources** (Sustainable use of resources) and Figure 5 below illustrates the relationship between the core domains and these two new areas of focus for the CQC:

Figure 5: Relationship between core domains, well-led and sustainable use of resources (17)

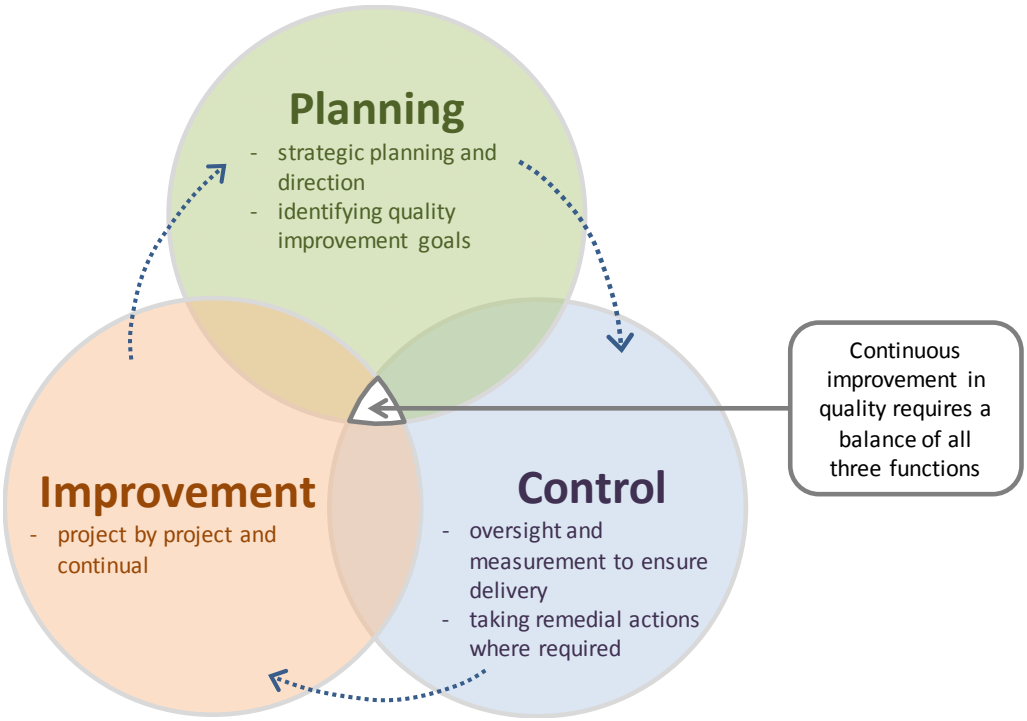
11. Molloy, A et al (2016). A clear road ahead: Creating a coherent quality strategy for the English NHS. The Health Foundation, London.
12. Department of Health (2008). High quality care for all: NHS Next Stage Review final report. Department of Health; London.
13. NHS England (2015). Improving Experience of Care through people who use services. Available at: https://www.england.nhs.uk/wp-content/uploads/2013/08/imp-exp-care.pdf
14. Department of Health (2017). NHS Outcomes Framework. Available at: http://www.content.digital.nhs.uk/catalogue/PUB23992/nhs-out-fram-indi-may-17-dash.pdf
15. Care Quality Commission (2017). Key lines of enquiry, prompts and ratings characteristics for healthcare services. Available at: https://www.cqc.org.uk/sites/default/files/20170609_Healthcare-services-KLOEs-prompts-and-characteristics-FINAL.pdf
16. Doyle C, Lennox L, Bell D (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open.
17. National Quality Board (2016): A shared commitment to quality. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf

A structure for quality

Whilst capability and culture underpin the successful implementation of a quality strategy, it is **structures** and **processes** which make sure it happens **(18)**. Having robust mechanisms in place to provide support for and oversight of the delivery of the strategy is essential and the structure and process described aim to ensure that the strategy is put into practice.

The structure outlined within the strategy reflects a widely acknowledged approach to the delivery of continual quality improvement, the **'Juran Trilogy' (19)**. This approach is based on the individual and collective importance of three core functions in achieving high quality in any industry, with emphasis on the inter-relationship between **Planning** (strategy and goals), **Control** (oversight and monitoring) and **Improvement** (delivery of quality improvement goals, project by project). This is illustrated in Figure 6 below:

Figure 6: The Juran Trilogy (19)



The structure which will **oversee and monitor** delivery of the strategy builds on existing architecture and is described below and illustrated in Figure 7:

- A new, overarching **Quality Board** will provide direction and oversight of the implementation of the Trust's Quality Strategy. The Quality Board will replace and build on the work of the Trust's Quality Forum, which served to bring together key senior leaders from across the organisation with a remit for quality. In addition, as the Quality Board will have overall responsibility for the process of agreeing, delivering and reporting quality objectives each year, it will also take over the work of the Quality Report Steering Group.

18. Monitor (2010). Quality governance framework. Monitor; London.
19. Molloy, A et al (2016). A clear road ahead: Creating a coherent quality strategy for the English NHS. The Health Foundation, London

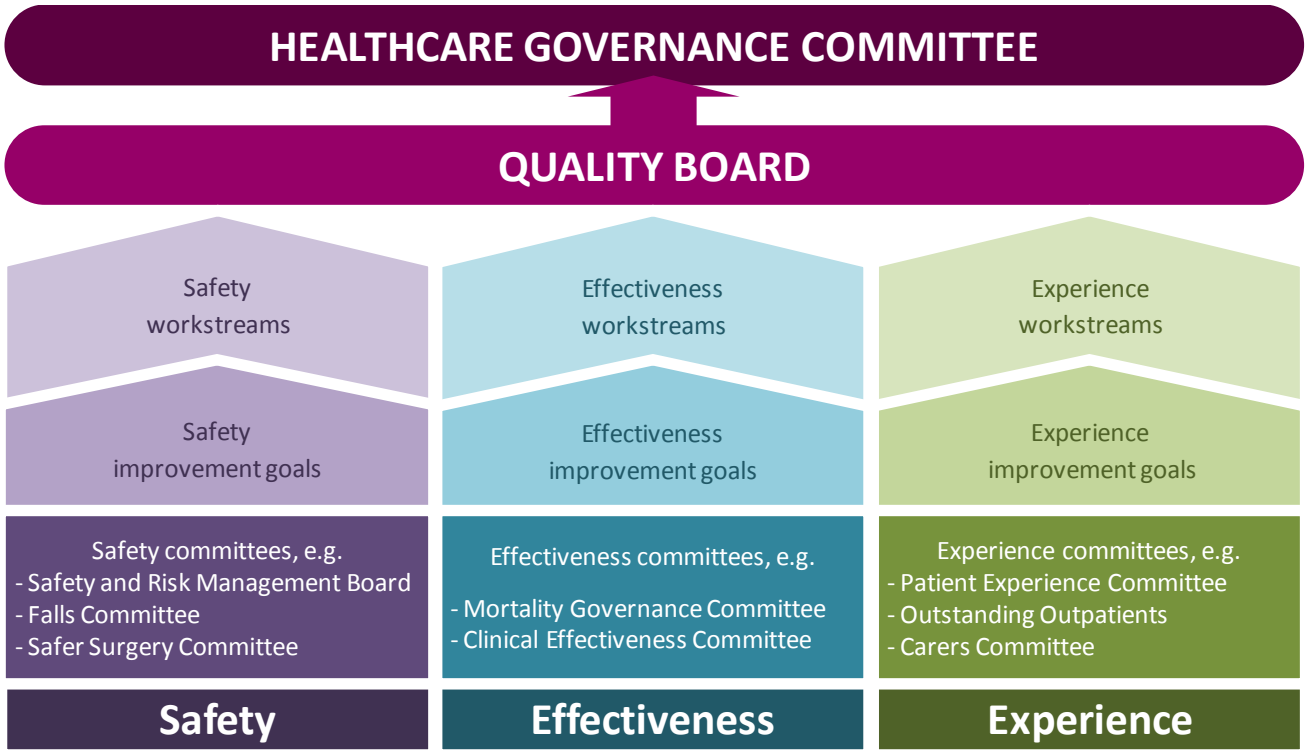
- The new Quality Board will have a remit and accountability for the delivery of the Quality Strategy and quality improvement priorities. It will also ensure that the voice of the patient is heard and its **membership** will include governor, Healthwatch Sheffield and voluntary sector representation.

- The **Executive Directors** with responsibility for the Quality Strategy are the Chief Nurse (Patient Experience) and the Medical Director (Patient Safety and Effectiveness). They, or a nominated Deputy, will chair the Quality Board.

- The Quality Board will report to the **Healthcare Governance Committee.**

- A number of **existing committees** across the Trust currently lead or oversee programmes of work which relate directly to one or more of the three dimensions of quality. These include the Patient Experience Committee (experience); the Safety and Risk Management Board (safety); and the Clinical Effectiveness Committee (effectiveness). In addition, the **Making it Better Board** oversees implementation of the Making It Better Programme, which aims to support the Trust to deliver its overall strategy with a focus on improved quality and sustainable finances. Whilst the Quality Board will complement the work of these committees, there will inevitably be areas of overlap which will need local agreement in terms of the most appropriate vehicle for ensuring delivery.

Figure 7: Structure for quality



A process for quality

Improvements in the quality of care do not happen by chance; they are planned **(20)**. Agreeing **quality improvement goals** (the 'planning' stage of the Juran Trilogy) is a key part of the process of continual improvement. The selection of quality improvement priorities, for which goals are then agreed, needs to be based on a consistent and transparent approach with clear reasons and rationale for the selection of each priority **(21)**.

20. Ham, C; Berwick, D; Dixon, J (2016). Improving quality in the English NHS: A strategy for action. The King's Fund, London.
21. Raleigh, V; Foot, C (2010). Getting the measure of quality: Opportunities and challenges. The King's Fund, London.

The process described will ensure that the views of **relevant stakeholders**, including our patients and staff, are actively sought and considered when agreeing quality priorities each year.

In addition**, guidelines** for the selection of priorities (Figure 8) will bring an element of consistency to the process. Those criteria in red are 'essential'. These guidelines will be refined and improved over time:

Figure 8: Guidelines for selecting quality improvement priorities

Guidelines for selecting quality improvement priorities	✓ or X
Patient- focussed: an aspect of care that is high priority for our patients or staff	
Well-informed: performance data highlights scope for improvement or variation in performance	
High-impact: affects a large number of patients; achieves a significant improvement	
Innovative: original; introduces new ideas; takes advantage of an emerging opportunity	
Challenging: stretching; ambitious; tackles a long-standing or difficult problem	
Achievable: realistic; has a defined end point	
Aligned: supports Trust priorities and values; does not duplicate other work	
Measurable: impact or outcomes can be measured and demonstrated.	

In addition to the guidelines which will support the selection of priorities, there also needs to be a balance of priorities with the following **additional considerations** being taken into account:

- **Internally and externally driven**: there should be a balance of national and local priorities to ensure that improvement is 'top-down' and 'bottom-up' at the same time.' **(22).** This approach aligns with the Trust's approach to selecting priorities for the Trust Clinical Audit Programme each year.
- **Manageable:** there should be between 9-12 current priorities each year. The priorities should be spread across the three domains.
- **Short, medium and longer term:** priorities should include in-year (short term), two-year (medium term), and three- to five- year projects (longer term) in recognition of the fact that more substantial projects will take longer to complete. This approach aligns with and builds on the current approach to Quality Report objectives which incorporates short and medium term objectives, meaning that each year there is a combination of one-year priorities, two-year priorities in their first year, and two-year priorities in their second (final) year. However, the new approach will also allow for longer- term quality objectives. Ideally, there will be an even spread of short ,medium and longer-term priorities, so that after year one of the cycle, between five to seven new priorities will be selected each year.
- **Large and small scale:** priorities need not be large scale or involve complex problems. Small changes can make a big difference. If a project is considered appropriate in line with the guidelines for selection, then more straightforward or smaller-scale projects should feature alongside more complex or large-scale projects.
- **Pathway and service/issue specific:** priorities which are holistic in their approach and which relate to pathways of care should feature as well as priorities which may be service or issue specific.

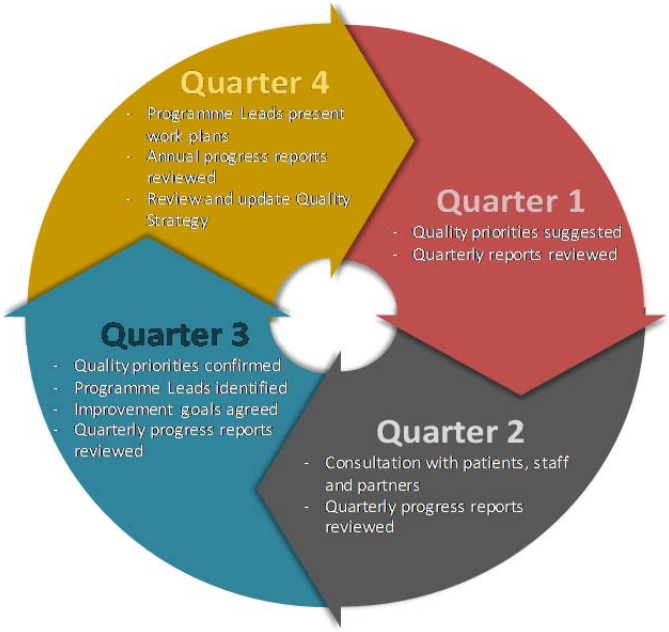
22. National Advisory Group on the Safety of Patients in England (2013). A promise to learn, a commitment to act. Improving the safety of patients in England. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

The **process** for selecting annual quality priorities will be as follows:

- **Quarter one:** The Quality Board will suggest topics for quality improvement for the next year, based on the guidelines and additional considerations for selection.
- **Quarter two**: There will be consultation with patients, Trust staff, governors, Healthwatch Sheffield and any other relevant partner organisations, including the Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee, regarding the proposed priorities and suggestions of others.
- **Quarter three**: Improvement priorities will be finalised; programme leads will be confirmed for each of the priorities and improvement goals will be agreed.
- **Quarter four**: Programme leads will present to the Quality Board a work plan for each improvement priority, outlining a programme of work to ensure delivery of the project within the timeframe.
- **Quarterly** progress reports will be presented to the Quality Board with an annual summary report presented during **Quarter four.**

The process is summarised in Figure 9 below:

Figure 9: Process for agreeing annual quality priorities and goals



This process aligns with the timeline for selecting and reporting **Quality Report** objectives and this new process will replace the Quality Report process, with the annual Trust quality priorities and goals being adopted as the Quality Report objectives and being reported through the annual Quality Report. In turn, these objectives will also feed into the Trust's annual **corporate objectives.**

In **year one** (2017-18), current priorities and goals already in place will continue, with the new process commencing in **year two** and becoming fully embedded in **year three.** Year one priorities are summarised in Appendix 2. These were agreed through the relevant Trust groups including the Quality Report Steering Group, Patient Experience Committee, Mortality Governance Committee and the Safety Improvement Group. A number of these groups include Trust governors and Healthwatch Sheffield in their membership.

The quality framework, structure and process will be **reviewed and adapted** as it is put into practice, to allow us to reflect our experience by changing and refining this new approach.

Supporting workstreams

Building capability

Underpinning this strategy is an on-going programme of work aiming to **build capability** across our workforce to support the three quality domains. To ensure continuous improvement across all aspects of our work, we will continue to **support staff** to lead improvements by providing education and training in sciences, skills and practices within quality, safety and effectiveness.

Continuing and enhancing the excellent programmes of **training and education** which we already have in place is essential to the success of this strategy. These include:

Experience:

- A programme of **customer services training** has been in place since 2013, with over 1000 staff participating to date. Evaluations are excellent, with staff reporting changes in their practice as a result of the training.
- A suite of skills- and awareness-based **complaints training** has been delivered since 2015. Training focuses on key skills including writing letters of response, along with education to support cultural change. This includes training to support a shift from 'responding' to 'resolving' and seeing complaints as opportunities to learn and improve.

Safety:

- Comprehensive two-day training is provided to support staff involved in the **management and investigation of serious incidents**. This includes investigation and report-writing skills along with action planning for learning and improvement. In addition, **in-situ simulation training** has proved to be an engaging tool for reviewing and learning from serious incidents.
- Develop online packages for **Duty of Candour training** to be made available on PALMS during 2017/18

Effectiveness:

- The Trust now has 40 individuals trained to undertake a **Structured Judgement Review** (SJR) following a death in the Trust. During 2017/18 further training is to be provided to these individuals to enable them to train others in the SJR process.
- Annual training for **Trust Audit Leads** was developed in 2015 and continues to be delivered to help ensure consistency across the Trust in the delivery of the Audit Lead role.
- A number of clinically-based training programmes support our work to promote a safety culture, including education and awareness programmes in relation to **Acute Kidney Injury** and **Sepsis**. This important training will continue to be developed over the lifetime of this strategy.

Quality Improvement:

- The **Microsystems Coaching Academy** (MCA): The core objective of the Academy is to develop coaches and work with teams to help them to get started on their own improvement journey.
- The **Flow Coaching Academy**: The aim of the Flow Coaching Academy is to teach how to apply team coaching skills and improvement science at care pathway level in order to improve patient flow. The FCA programme develops coaches with the skills to work across care pathways and includes experiential learning along with face-to-face training sessions.
- **'Introduction to Quality Improvement'** Two Day Courses**:** The two days are designed to introduce the basics of quality improvement through a mixture of presentation, video and practical exercises. The course is aimed at anyone who is interested in quality improvement, as a leader, a potential MCA coach or as part of an improvement team.

We will continue to support and promote these programmes of training, along with developing new programmes over the next three years.

Performance reporting

The way in which we report our **quality performance** is periodically reviewed as a matter of course. Good performance reporting is based on quality not quantity and '..is a means to an end, never an end in itself. The purpose of information is to promote action.' **(23)**.

In 2014 a new architecture for the reporting of patient experience data was agreed and has been in place since 2015. The architecture defines **key performance indicators** for reporting patient experience and supports the provision of monthly summary data, more detailed quarterly data, and annual performance review data which also looks forward to the coming year. In addition, there is flexibility to provide ad hoc reports which are required from time to time, for example to provide 'deeper dive' information into issues of concern or areas of outstanding performance.

Work will now focus on developing a new **reporting architecture**, integrating patient experience, patient safety and clinical effectiveness data to reflect themes, trends and learning from across these areas. In addition, this new reporting framework will become the main vehicle for on-going reporting of progress against quality improvement priority goals, with the Quality Report providing the vehicle for the annual report. This new approach to reporting will align with other relevant reporting mechanisms including the Integrated Performance Report and the Nursing and Midwifery Dashboard.

At the heart of our reporting will be:

- a new set of **patient-driven quality measures**, ensuring that we are measuring what matters most to our patients.**(24)**;
- **benchmarking** of our performance nationally and, wherever possible, internationally so that we know where we stand relative to the best;
- reporting at **local (ward and department) level** so that we know whether and where there is variation in performance and to support action planning at local level;
- a focus on **improving** services and sharing **learning**, promoting '..challenge and inquiry – not to seek reassurance and move on..' **(25)**.

In addition, the following considerations will be built into our review of reporting:

- developing **pathway-based reporting** and 'whole pathway metrics' **(26)** through determining, measuring and reporting the most important measures of quality relevant to each patient pathway over the whole pathway of care;
- more routinely **triangulating** patient data with staff and other relevant data, for example feedback from students/learners who view the organisation with a fresh pair of eyes;
- a review of **data quality**, to ensure accuracy, validity, timeliness and comprehensiveness;
- identifying any **asymmetries** in reporting to ensure comprehensive and equitable reporting without duplication.

23. Chartered Institute for Management Accountants (2003). Performance Reporting to Boards: A Guide to Good Practice. Available at: http://www.cimaglobal.com/documents/importeddocuments/perfrpttoboards_techguides_2003.pdf
24. Doyle C, Lennox L, Bell D (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open.
25. Foot, C (2013). The Keogh Review: a welcome return to 2008. The King's Fund, London. Available at: https://www.kingsfund.org.uk/blog/2013/07/keogh-review-welcome-return-2008
26. Jonas, S et al (2012). Measuring quality along care pathways. The King's Fund, London. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_document/Outcomes-measuring-quality-the-king's-fund-aug-2012.pdf

Measuring the success of this strategy

The success of the strategy will be measured against its three objectives:

- Significantly increase the **involvement of patients and staff** in the selection of annual quality improvement priorities to ensure that we focus on what matters most to those who use our services;
- Strengthen our **governance structure** to ensure oversight and delivery of our quality improvement goals;
- Demonstrate **tangible improvements** across priority areas, which improve the experience of our patients, their families and carers.

Each of our quality improvement goals will have agreed measures to demonstrate **impact and improvement** and these measures will form the basis of our evaluation of the success of the strategy.

In addition, **performance indicators** for measuring the success of the strategy will be developed and refined through the Quality Board. These will include specific measures to evaluate the impact of the strategy on the **experience of our patients**.

Performance indicators may include:

- % quality improvement goals achieved within agreed timescales
- Numbers of patients and staff who are involved in the process
- Numbers of patients from hard to reach groups who are involved in the process
- Views of the Quality Board on its effectiveness

Patient experience impact measures may include:

- National and local patient survey scores
- Decrease in complaints relating to issues addressed through quality improvement goals
- % quality priorities selected which are high priority for patients or staff

When will we make this happen?

Our plan for taking forward quality improvement over the next three years means building on current good practice, whilst also putting in place a new framework, structure and processes. Timescales for putting in place the new arrangements are shown in Figure 10 below:

Figure 10: timescales for implementation

Objective	By when
Establish the Quality Board	First meeting January 2018
Agree quality improvement priorities	Year 1: agreed and in place March 2017. Year 2: February 2018 (to align with timescales for agreeing 2018/19 Quality Report objectives). Year 3: December 2018 (From this time onwards the new process and timescales will be fully embedded).
Agree an engagement plan for hard to reach/seldom heard groups	Plan agreed by February 2018.
Identify one large-scale co-production project, to pilot and evaluate a co-production approach.	Project identified by December 2017 Project completed by March 2019 Project evaluated by June 2019 Plan for embedding co-production more widely by December 2019
Review and evaluate current training programmes.	Recommendations by December 2017.
Review reporting across experience, effectiveness and safety.	New reporting in place by January 2018; fully embedded by April 2018.
Agree measures for the success of the strategy including specific impact measures in relation to patient experience	Measures agreed by March 2018

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Listening, Talking, Improving

Principles for working in partnership with patients, families and carers

Introduction

We believe listening, talking and responding to our patients, their families and carers should be part of our everyday work. We want to be sure that their views are at the heart of planning and improving our services.

We are committed to:

- Achieving further improvements in patient and customer service by learning from and building on best practice across the NHS and other customer-focused organisations
- Continually seeking and responding to patient feedback and giving a commitment to change in response to the views of patients
- Listening to our patients with respect and openness

This document describes how we will seek and act on feedback from patients, by setting out our vision and the principles by which we will seek to involve patients. It is part of an ongoing process of building a patient - focused approach and a culture of working in partnership with patients, recognising that patients can find it difficult to give feedback for a variety of reasons.

The principles aim to ensure that we take steps to overcome any difficulties or barriers to feedback which our patients may face. A core value of our work is our commitment to diversity and inclusiveness. We see this as a social and moral responsibility and it informs everything we do.

This document builds on existing foundations and good practice, as well as introducing new ideas and ways of involving people. These include:

- embracing new and transformational methods of working with patients as partners, such as co-production
- working in collaboration with local and national voluntary organisations to reach groups whose views may not often be heard. These include groups who support and campaign for people who are homeless, young people including young carers and people from black and minority ethnic groups.

Our Principles are an integral part of our Quality Strategy (2017-2020), which explicitly states the Trust's ambitions to significantly increase the scale of patient engagement, with a focus on those who may be harder to reach or seldom heard and with a focus on co-design and co-production.

Our vision

Our vision is to see engagement with patients, their families and carers embedded at all levels and in all aspects of our work. This means that we will:

- Ensure patients and their relatives always have the opportunity to tell us about their experience of our services.
- Ensure our staff seek and follow up feedback from patients as an integral part of their role.
- Ensure our staff integrate partnership working with patients into service planning, decision making and service evaluation in relation to the services and facilities we provide.
- Involve staff, user groups, partner and other organisations, including the voluntary sector, in the planning of changes to our services.
- Demonstrate improvements to services as a result of continuing feedback from and partnership working with patients.

How we will make it happen

• Structure

We will ensure that there is a structure in place to support engagement. This will:

- Ensure listening and responding to patients is integrated into all aspects of our work.
- Ensure follow up action is taken.
- Ensure that patients and the public know the actions we take as a result of their comments.
- Identify a Board Executive Director who will champion and lead patient engagement.
- Identify a senior lead within each Care Group who will champion patient engagement.
- Enable staff within the Trust who have specialist roles in patient engagement to work effectively together.
- Link patient engagement with associated Trust work, including safety, audit and planning.

• Resources

The Trust will support patient engagement activity by:

- Providing appropriate resources, in particular funding staff, facilities and external expertise.

- Working with other organisations in order to share good practice, avoid duplication and make best use of resources.
- Choosing engagement activity according to priorities identified through feedback from patients or by the outcomes of local and national research in relation to patient experience.

• Partnership Working

As well as working with health, social care and voluntary and charitable sector partners, we will also work with non-NHS organisations, including the private sector, in order to learn from each other.

We will in particular continue to work closely with Healthwatch Sheffield to tap into their extensive networks and wealth of knowledge and experience in engaging with the local population.

• Feedback and Communications

Wherever possible we will provide full and timely feedback to patients whose views we seek as part of our engagement activities.

We will use a variety of methods of communication to ensure we reach as wide an audience as possible. These will include:

- Directly communicating with patients where they have given their permission for us to do this
- Reporting on the outcomes of engagement activity through our Trust website, 'Good Health' members newsletter, social media and the local media.

• Methods of Engaging Patients and the Public

We will use different approaches in order to engage as widely as possible.

At an individual level, this means listening to and talking with patients and the public whilst carrying out day to day work.

More generally, we will draw upon a range of methods appropriate to both the issue in question and the specific population. Such methods will include small discussion groups, one-to-one interviews, remote methods such as email, text or web-based discussions, formal consultations or meetings in the community.

We will identify any barriers to engagement for specific groups or communities and ensure the right methods are chosen and support is offered. Barriers may include practical barriers such as childcare or full-time work; communication barriers such as not being able to read confidently or not speaking English; or emotional barriers such as a lack of confidence.

- **Improving Services**

The Trust will act on the findings and feedback from engaging with patients. The ultimate aim is to improve services results and recommendations of to make changes or improvements wherever possible. There will also be a system for monitoring the implementation and effectiveness of changes.

Case studies of the positive impact of involvement will be used to share good practice and celebrate achievement.

- **Monitoring and Reporting**

The Trust reports monthly, quarterly and annually on patient feedback to the Healthcare Governance Committee. The quarterly and the annual reports are published on the Trust's web site.

The reports also outline improvements made as a direct result of patient feedback. In addition, they reflect positive comments and feedback received from patients.

Where national data is available, we benchmark information and performance with our peers.

- **Training and Support**

The Trust will train and support all staff and help patients who want to give feedback.

Directorates will identify leads to offer support and guidance to staff when undertaking their engagement activities.

There will be a variety of resources available to support staff and patient in partnership working.

Staff and service users will be involved in designing and delivering staff training courses and materials.

Review of our principles

The Principles will be reviewed two years from the date of approval.

Contacts

If you would like further information or need any advice or help regarding patient engagement please contact the Patient Partnership Department on 0114 271 3085.

Comment Cards

The Trust has 'Tell us What You Think' comment cards. Please ensure these are available on your ward/department and encourage patients and families to fill these in. Please contact the Patient Partnership Department for further information about the comment cards and how to order them.

This document has been produced in consultation with Trust governors, who have been elected by patients and the public.

Appendix 2

Current quality objectives (2017-18)

The objectives below were agreed through the Trust's current processes for agreeing quality priorities and have involved:

- Review of data relating to quality to identify areas for improvement
- Incorporating relevant findings and recommendations from the inspection undertaken by the CQC in December 2015
- Incorporating relevant national priorities and objectives
- Discussion with relevant Trust groups including the Quality Report Steering Group, Patient Experience Committee, Mortality Governance Committee and the Safety Improvement Group. A number of these groups include Trust governors and Sheffield Healthwatch in their membership

The new Quality Board will begin to oversee and receive progress reports relating to each of these objectives from January 2018.

Safety

- Cultural change that ensures that patient safety will be embedded within all aspects of clinical care.
- Improved communication through the introduction of structured processes to improve the transfer of time critical patient information transfers.
- Further improve the safety and quality of care provided to our patients through initiatives such as the Patient Safety Zone and Safety Huddles.

Experience

- Improved complaints management through increased responsiveness and a more personal approach with a focus on 'resolving' rather than 'responding'. Deliver targeted staff training to support improvements to the complaints process.
- Develop our programme of surveys through: improving response rates to the Friends and Family Test in key areas and undertaking more detailed analysis of results to inform action planning and service improvements; identifying key themes from the Friends and Family Test and the programme of local surveys and implementing improvements to services; introducing a new carers survey and implementing improvements to services as a result of feedback.
- Introduce Electronic Care Planning across the Trust to improve the quality of care planning.
- Further improve End of Life Care.

Effectiveness

- Establish a process for reviewing all in-hospital deaths in compliance with NHS England Learning from Deaths Guidance (ref)
- Embed risk assessment of clinical audit outcomes to assure implementation of changes in practice
- Review the process for local policy audit and develop a work programme for implementation of the new process
- Absolute reduction in the cardiac arrest rate.
- Improved recognition and timely management of deteriorating patients leading to improved care.
- Improved recognition and management of patients presenting with or developing Red Flag Sepsis and Acute Kidney Injury.