Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Annual Quality Report 2012-13




proud to make a difference

Contents

Foreword

This Quality Report details the quality improvement priorities taken forward during 2012/13 and describes the quality improvement priorities for the year ahead.

It also reviews the quality of services provided by the Trust and includes comments from the Trust Commissioners (NHS Sheffield Clinical Commissioning Group); Trust Governors and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee for Sheffield City Council. This version includes comments from Sheffield Healthwatch although the earlier consultations were undertaken in collaboration with Sheffield Local Involvement Network (LINk).

This report is written in the way required by Monitor, the Independent Regulator of Foundation Trusts and the Department of Health.

A second more accessible version will be produced for patients and public. Both versions will be available on the Trust's website (www.sth.nhs.uk) or from the Head of Patient and Healthcare Governance (details below).

We hope this Quality Report tells you what you want to know about the services provided by Sheffield Teaching Hospitals NHS Foundation Trust (STHFT). If you have any comments on the contents of the Quality Report, or how it is written, please contact:

Mrs Sandi Carman
Head of Patient and Healthcare Governance

Telephone: 0114 226 6489

Part 1

1.1 Statement on quality from the Chief Executive

At Sheffield Teaching Hospitals we are firmly committed to providing you with the highest quality of care. Thanks to the professionalism and dedication of our staff, we continue to provide high quality services to our patients in our hospitals and in the community. We have seen some very positive improvements in the quality of care provided over the last year such as the reduction in healthcare associated infections. We will continue to make improvements this year so our patients can be sure they are receiving the very best clinical care and outcomes.

Having welcomed our colleagues in Community Services to the Trust, we are already seeing closer working between hospitals and community services which is benefitting our patients. This has been formalised in the new corporate strategy 'Making a Difference' which is also supported by a new five-year Quality Strategy.

The Mid-Staffordshire Public Inquiry Report by Robert Francis QC denotes one of the most significant events in the recent history of the National Health Service. It is our duty to ensure that the Trust responds positively to the recommendations within the report. We are currently engaging with our staff and partners to review the report and to consider any actions in conjunction with the implementation of the 'Making a Difference' strategy. We will also report on our progress as part of our action plan in the 2013/14 Quality Report.

Our successes this year include an on-going reduction in *Clostridium Difficile* rates, improvement in our discharge information and a significant increase in the volume of feedback received from our patients.

However this year has been very challenging. The number of attendances at our Accident and Emergency Department remains high and the number of very sick patients requiring emergency admission to hospital has steadily risen. This has had a significant impact on the number of beds needed and the number of operations cancelled on the day of surgery. The cancelled operations issue is a consequence of the rise in emergency patients who had to take priority over non-urgent patients and therefore operating time and available beds had to be used for emergency patients. We will continue to work to address these challenges. A capital plan to expand the clinical area of the Accident and Emergency department is underway and we have in place a number of improvement initiatives focusing on patient flow into the wider hospital.

As a result of the Health and Social Care Act (2012) a number of changes have been made to the way our services are commissioned, regulated and delivered. We are therefore committed to working closely with our partners to ensure that the changes are effective and have a beneficial impact on the services we provide to patients. The city wide health and social care transformation programme - Right First Time, is an excellent example of this commitment to develop services which deliver the right care, in the right place, at the right time and in the most efficient way. In summary, patient care is, and will continue to be, our highest priority.

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

Sir Andrew Cash OBE
Chief Executive
23 May 2013

Part 1

1.2 Introduction from the Medical Director

Quality Reports enable NHS Foundation Trusts to be held to account by the public, as well as providing useful information for current and future patients. This Quality Report is an attempt to convey an honest, open and accurate assessment of the quality of care patients received during 2012/13. Whilst it is impossible to include information about every service the Trust provides in this type of document, it is nevertheless our hope that the report we present here will give you confidence in our ability to deliver safe, effective and high quality care.

We have consulted widely on which quality improvement priorities we should adopt for 2012/13. As with previous Quality Reports we have developed the quality improvement priorities in collaboration with representatives from NHS Sheffield Clinical Commissioning Group, the Local Involvement Network (LINk) and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee. Once again, this year the Trust has held several meetings with LINk. This partnership approach has enabled feedback from LINk to be considered in the production of this Quality Report.

The Quality Report Steering Group, whose membership includes Trust managers, clinicians and Trust Governors, oversees this work.

The remit of the steering group is to decide on the content of the Quality Report and to ensure that the Trust's quality improvement priorities are practical and achievable and address the key elements of quality including patient safety, the effectiveness of clinical treatment and patient experience. Meeting the regulatory standards set out by the Department of Health and Monitor, the independent regulator for Foundation Trusts, also forms part of this group's remit.

In the production of this report we have also taken into account the comments and opinions from internal and external parties on the 2011/12 Quality Report. The proposed quality improvement priorities for 2013/14 were agreed by the Trust's Board of Directors on the 17 April 2013. The final draft of the quality report was sent to external partner organisations for comments in April 2013 in readiness for the publishing deadline of the 31 May 2013.

Dr David Throssell
Medical Director

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement

2.1.1 Priorities for Improvement 2012/13

Last year we set five priorities for improvement. Our focus on these priorities has delivered many improvements; these are summarised below and are explained further in this section.

	Achieved	Almost achieved	Behind schedule
Clinical Effectiveness **1. Optimise length of stay** Through a systematic process of review identify areas for improvement across the organisation. Establish improvement plans to achieve necessary reductions in length of stay compared to national benchmarks (Dr Foster benchmark comparators).			✔
Patient Experience - communicate better **2. Discharge letters for GPs** Improve the quality of immediate discharge letters sent to General Practitioners (GPs) by auditing the content of letters within each Directorate against parameters agreed with NHS Sheffield. Deficiencies identified during this process will be addressed by actions at Directorate and Trust level.		✔	
Patient Experience **3. Giving patients a voice - Make it easier to communicate with the organisation** Making what we've got work well - to improve the response rate for frequent feedback forms by 20% and for comments cards by 50%. This has been achieved by promoting the processes and demonstrating effectiveness, for example through case studies and actively communicating feedback (e.g. 'you said - we did').	✔		
Safety - deliver harm free care **4. Review Mortality rates at the weekend** Review in detail the Trusts position with regard to Mortality at the weekend and identify any significant differences, review causes and implement improvements as required.	✔		
Quality: Holistic Care - to promote a good experience for patients who have Dementia **5. Improve Dementia awareness** Undertake environmental audits across all appropriate directorates and put in place improvement plans to address areas of concern (Link to the Kings Fund Dementia work and ward essential maintenance programme).	✔		

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.2 Clinical Effectiveness

Optimise length of stay

Target

Through a systematic process of review identify areas for improvement across the organisation. Establish improvement plans to achieve appropriate reductions in length of stay compared to national benchmarks (Dr Foster benchmark comparators).

Outcome

Work continues across the organisation to achieve a clinically appropriate length of stay when compared to national and local benchmarks. If achieved this would allow appropriate bed reductions across the Trust but specifically in Medical Specialties, Orthopaedics and General Surgery.

The main focus is on non-elective activity and particularly, the Medical Specialties of Geriatric & Stroke Medicine and Respiratory Medicine. These include improvements to patient discharge into community and social care services as agreed and supported through the Right First Time Programme.

Opportunities in elective services are fewer, but work continues to increase day case rates, improve processes and build on the enhanced recovery programme. The Surgical Pathways work stream is focusing on microsystems[1] work in Foot & Ankle, Gynaecology, Colo-rectal, Arthroplasty, Ophthalmology, Renal, Neurosurgery and Cardiology Catheter Laboratories.

Planning is currently underway to identify the priority activities for 2013/14 to support improved patient flow, including a Trust-wide review of emergency flow.

Case example: Geriatric & Stroke Medicine

Dr Foster Case Mix Adjusted Average: 12.5 days
Trust performance 2012/13: 15.5 days

Throughout the year the Average Length of Stay (AVLoS) was lower on a month by month basis when compared to 2011/12. The lowest AVLoS occurred in November at 13.1 days before peaking at 17.5 days in February 2013.

Trust wide performance

2011/12: 2.9 days
2012/13: 2.8 days

The Trust has improved its performance overall when compared to 2011/12 and further improvement work continues in this area. There are a number of factors which influence this performance including:

- The number of patients above 85 years of age requiring admission to hospital increased by 11% in December 2012 when compared to December 2011
- The increased admissions in the elderly population created an increased demand for supported discharges, which exceeded Community and Social Services capacity creating delayed transfers of care
- Adverse weather which was more prolonged than previous winters
- Earlier occurrence of and increased length of debilitation due to viral illnesses over the winter period

Length of stay is influenced by the integration between the hospital and the wider system (i.e. adult social care, primary and community health services); the Trust will work with its partners on the Right First Time initiative to ensure that any wider system issues are addressed. This objective will be carried over to 2013/14.

2.1.3 Patient Experience - communicate better

Discharge letters for GPs

Target

Improve the quality of immediate discharge letters sent to General Practitioners (GPs) by auditing the content of letters within each Directorate against parameters agreed with NHS Sheffield. Deficiencies identified during this process will be addressed at Directorate and Trust level.

Outcome

The Trust completed a project on the quality of immediate discharge letters during 2012/13 across all specialties with more than 1000 inpatient spells (episodes) per annum, a total of 28 specialties.

Three audits were completed to review the quality of immediate discharge letters:

Timeframe	Number of immediate discharge letters that were audited
April to June 2012 (Quarter 1)	439 (25%)
October to December 2012 (Quarter 3)	422 (21.6%)
January to March 2013 (Quarter 4)	495 (35%)

1 http://www.sheffieldmca.org.uk/sheffields_approach

Part 2

Priorities for Improvement and Statements of Assurance from the Board

The results for each audit in the key areas reviewed are detailed below:

Area reviewed	Q1	Q3	Q4
Documentation of patients' NHS numbers	60.1%	67.3%	64.6%
Documentation of full name of the consultant in charge of the patient's care	32%	53.4%	55.1%
Completion of the follow up arrangements	61.3%	65.2%	59.3%
Completion of the section about further advice to GPs	46.7%	58.5%	48.8%

Between July and September 2012 (Quarter 2) all 28 Directorates developed a local action plan to improve practice. The final two audits (Quarter 3 and 4) were undertaken to monitor any improvements made after the implementation of local action plans.

With the exception of the 'Documentation of full name of the consultant in charge of the patient's care' there is more work to be completed to improve the overall situation.

The Trust is currently in the process of adopting e-discharge summaries which will allow clinicians to fill in an electronic discharge template, helping to speed up the delivery and improve the discharge information sent to GPs. It is expected that the e-discharge system will be in place in all inpatient areas by the end of summer 2013. Incomplete discharge summaries will be rejected by the system which will improve overall compliance. This objective will be progressed through the e-discharge project in order to address the areas for improvement.

2.1.4 Patient Experience

Giving patients a voice: Making it easier to communicate with the organisation

Target

Making what we've got work well - to improve the response rate for frequent feedback forms by 20% and for comments cards by 50%. This has been achieved by promoting the processes and demonstrating effectiveness, for example through case studies and actively communicating feedback (e.g. 'you said - we did').

Outcome

Frequent Feedback Surveys

Target: 2976 Frequent Feedback surveys
Achieved: 4914
Increase of: 98% from 2011/12

Over the past 12 months, 33 additional Frequent Feedback volunteers have been recruited and trained in order to expand the Frequent Feedback survey programme. A detailed annual survey plan was also developed to support a new, more targeted approach which enables wards to receive their survey results within 48 hours of the survey being completed.

New areas included in the Frequent Feedback survey programme this year include Intermediate Care and the Jessop Wing (Maternity Services).

New questions included in the survey focus on staff attitudes in order to enable us to collect more detailed, ward-level feedback on this important aspect affecting patient experience.

Frequent Feedback ward-level scores and changes to services following feedback are reported on the ward information posters, which are located at the entrance to each ward. These posters are updated every 4 months.

Comments Cards

Target: 861 comments cards
Achieved: 2857
Increase of: 397% from 2011/12

Volunteers now routinely encourage patients to complete comments cards and this has had a significant impact as demonstrated by the number of responses received.

In addition to promoting comments cards through our volunteers, comments cards were also made available online in 2012.

All comments received are reported to directorates in the quarterly Patient Experience Reports and these comments are considered alongside all other patient feedback in agreeing local action plans.

Examples of actions identified within ward plans as a result of patient feedback include:

- A noise reduction strategy on Brearley 6 to ensure as quiet an environment as possible for patients
- Implementation of a new handover sheet on Chesterman 1 to ensure increased involvement of patients in discharge planning
- Awareness raising sessions for staff and creation of a quiet room on the Cardiac Catheter Suite to ensure conversations take place in an appropriate setting

For 2013 the new national Friends and Family Test will be introduced. From 1 April all inpatients and Accident and Emergency Department patients will have the opportunity to comment on our services when they are discharged. Consequently whilst the Trust comment cards will still be available for patients, the Friends and Family card will be given to patients on discharge.

2.1.5 Review Mortality rates at the weekend

Target

Review in detail the Trust's position with regard to Mortality at the weekend and identify any significant differences, review causes and implement improvements as required.

Outcome

The Trust has established a Mortality Steering Group, which meets monthly, includes a collaboration of managerial and clinical staff and aims to:

- Oversee activities related to the appropriate management of mortality and morbidity
- Promote best safety practice across the organisation and ensure that lessons learnt in one part of the organisation are appropriately shared across the wider organisation
- Develop and oversee the implementation of the Dr Foster and other tools for use when analysing mortality

To ensure consistent and accurate Mortality and Morbidity review the Trust is standardising systems in use across the organisation.

Overall the mortality ratio for the Trust remains low. Two key measures for mortality are used:

Hospital Standardised Mortality Ratio (HSMR)	
April 2012 to January 2013	**98%** This is rated as 'within expected range' (Dr Foster assessment)
April 2011 to March 2012	**98%**

Summary Hospital-level Mortality Indicator (SHMI)	
October 2011 to September 2012	**0.90** This is rated as 'Lower than expected' (Dr Foster) and 'As expected' (Information Centre)
October 2010 to September 2011	**0.90**

When looking specifically at weekend mortality there is variation in mortality rates depending on day of admission. This variation is anticipated and does not result in a mortality rate that can be described as 'higher than expected'. When reviewed against similar Trusts and comparing the range of variation possible the Trusts score is in the middle (i.e. average).

However the Trust will continue to review this area to ensure any variation between days of the week is minimal.

More widely the Trust is working with the Global Comparator groups of the Dr Foster GOAL project with one of the work streams looking at weekend mortality for Stroke patients. Analysis of the global mortality data for Stroke patients is being led by a team from North America and the Trust is working with the team as the UK link on this project.

Dr Marc Randall, Consultant Neurologist, is representing the Trust on the GOAL project and its ongoing work to compare and contrast organisational outcomes to learn from each other internationally.

At present the data comparing UK, Europe and North America is coded by country and the data is not identifiable by country or individual institution. The effect on Stroke mortality with weekend working is an area for review that appears global and not limited to individual countries. This ongoing work will eventually enable the Trust to analyse our performance in detail and understand how this compares with international partners.

This work will be continued into 2013/14.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.6 Promote a good experience for patients who have dementia

Target

Undertake environmental audits across all appropriate directorates and put in place improvement plans to address areas of concern (Link to the Kings Fund Dementia work and ward essential maintenance programme).

Outcome

In 2012, the Trust created a ward environment to meet the needs of patients who are cared for on our specialist Dementia Ward. This work was an extension of the work undertaken by the Trust on the Enhancing the Healing Environment Project supported by the Kings Fund.

Having undertaken an environmental audit and after talking to patients, visitors and staff, changes were planned to the ward in line with best practice guidance from both the Kings Fund and Stirling University. A significant refurbishment was then undertaken under the ward essential maintenance programme utilising additional Women's Royal Voluntary Service (WRVS) charitable monies.

Changes to the ward included the creation of a dining area and sitting room, clear demarcation of staff and patient areas, easily identifiable bed bays and the reduction of clutter.

Having successfully completed this work the Trust is currently in the planning stage for three further refurbishments involving the Assessment Units at the Northern General Campus.

As the objectives were not fully achieved, the Trust continued to monitor and address the following objectives which required further work in 2011/12:

2.1.7 Improving the care received by older people using our services - Nutritional assessment

Target

70% of patients aged 65 or over to be screened using the Malnutrition Universal Screening Tool (MUST) and 60% of those who are identified as being at risk to then receive a subsequent nutritional assessment (inpatient measure).

Outcome

46% of patients aged 65 or over received a MUST screen within 48 hours of admission (Audit data: November 2012).

Of those aged 65 or over and identified as being at risk i.e. a MUST score of 2 or more, 64% went on to receive an appropriate care plan.

This is an improvement on the historical achievements for screening (from 40% Audit data: February 2012). The Trust has undertaken detailed analysis work to address this issue. Nursing documentation has undergone a significant review resulting in the implementation of a new core screening booklet in September 2012 which contains the MUST score.

A continued focus on improvement around nutritional care will see the development and pilot of a nutrition and hydration accreditation programme for all clinical settings within Sheffield Teaching Hospitals. It is anticipated that the accreditation programme will include sections on food management, equipment, assessment and monitoring of care including documentation, artificial nutrition and hydration, education and training and patient information. Regular audits covering the range of sections will provide local and trust level data to ensure that nutritional and hydration care is continually monitored, providing more detail than the audits carried out in the past.

Progress on nutritional assessment and the nutrition and hydration accreditation programme will be reported in the 2013/14 Quality Report.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.8 Reduce hospital acquired infections

Target

To achieve a year on year reduction in a number of cases for Trust attributable *Clostridium Difficile*.

Outcome

The Trust is very pleased to have achieved its target to reduce the number of cases of *Clostridium Difficile* in 2012/13. The final number of cases at 104 was 29% below the threshold of 134. However, the Trust is determined to continue to improve and is considering what further improvements can be made to achieve a further substantial reduction in 2013/14.

2.1.9 Reduce the number of operations cancelled for non-clinical reasons

Target

768 cancellations or fewer in 2011/12 and 2012/13

Outcome

Year	Cancelled Operations
2008/09	879
2009/10	690
2010/11	768
2011/12	1106
2012/13	1161

In previous years bed availability had been thought to be the biggest single cause of cancelled operations for non-clinical reasons and significant progress had been made to address this issue.

Despite this progress the overall reduction in the early months of the year was not as great as anticipated as other problems needed to be addressed.

Maintaining progress through the winter period remains a concern as this illustrates the impact that high numbers of emergency admissions and winter viruses can have on elective activity. The improvement work required to address this area of concern links to the priority regarding 'length of stay'.

This priority will be carried over to 2013/14, as one of the key improvement priorities.

2.1.10 Priorities for Improvement 2013/14

This section describes the Quality Improvement Priorities that have been adopted for 2013/14. These have been agreed by the Quality Report Steering Group after discussion with patients, clinicians, Governors, LINk and Commissioners. These were approved by the Trust Board of Directors on 17 April 2013. The Trust has compared hospital and community service priorities for the coming year choosing three areas to focus on which span the domains of patient safety, clinical effectiveness and patient experience.

Priorities for 2013/14 are:

1. To reduce the number of operations cancelled on the day of surgery.
2. To reduce the prevalence of all Grade 2,3 & 4 pressure ulcers city wide.
3. To improve the provision of discharge information for patients.

In addition to these priorities for improvement there are many quality improvement proposals in the Sheffield Teaching Hospitals Quality Strategy and the Commissioning for Quality and Improvement (CQUIN) Programme (see part 2).

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.11 Detailed objectives linked to Improvement Priorities

Priority 1

Patient Experience

Our Aim	**Cancelled Operations** To reduce the number of operations cancelled on the day of surgery.
Past Performance	<table><tr><th>Year</th><th>Cancelled Operations</th></tr><tr><td>2008/09</td><td>879</td></tr><tr><td>2009/10</td><td>690</td></tr><tr><td>2010/11</td><td>768</td></tr><tr><td>2011/12</td><td>1106</td></tr><tr><td>2012/13</td><td>1161</td></tr></table>
Key Objectives	To reduce the number of operations cancelled on the day. We have commenced a review of the inpatient waiting list management process within Orthopaedics with the aim of standardising this process. This will then be rolled-out across our surgical specialities. In 2012/13 6.5% of planned operations were cancelled on the day (clinical and non-clinical reasons). The target is to reduce this figure to 4% (within month) by April 2014 and to realise a full year effect in 2014/15. A continual improvement approach will then be used to reduce this further in future years.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2013/14.
Board Sponsor	**Dr David Throssell** Medical Director
Implementation lead	**Rachel Cooper** Nurse Director

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Priority 2

Patient Safety

Our Aim	To reduce the prevalence of all Grade 2,3 and 4 pressure ulcers city wide.
Past Performance	Monthly survey data for the period from October 2012 to March 2013: Proportion with pressure ulcers acquired whilst in STHFT care = 1.77% Proportion with pressure ulcers prior to receiving care from STHFT = 4.18% Overall proportion = 5.95%
Key Objectives	Reduction in the prevalence of Grade 2, 3 and 4 pressure ulcers reported within STHFT acute and community based services, including both ulcers acquired whilst receiving STHFT care and community-acquired pressure ulcers. The aim is to reduce the 'all Pressure Ulcer Rate' from 5.95% to 5%. The target for this objective has been calculated on the basis of achieving the equivalent of a 50% reduction in the proportion of patients with ulcers acquired whilst receiving STHFT care, but expressed as a reduction in the overall proportion (that is, both those acquired in STHFT services and those acquired in the community). On this basis, the target proportion for 2013/14 is 5.0%. A Project Board will be established to oversee the service improvement work on reducing pressure ulcers. The Board will oversee specific streams of work on: • Ensuring that all patients at risk of developing pressure ulcers have an effective care plan which is implemented. • Ensuring the risk of a patient developing a pressure ulcer is effectively communicated when patients transfer between wards. • Reducing pressure ulcers which develop in patients receiving care in Critical Care Units which are often associated with medical equipment. • Effective use of aids to preventing pressure ulcers including cushions, mattresses and boots.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2013/14.
Board Sponsor	**Professor Hilary Chapman** Chief Nurse/Chief Operating Officer
Implementation lead	**Chris Morley** Deputy Chief Nurse

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Priority 3

Clinical Effectiveness (outcomes)

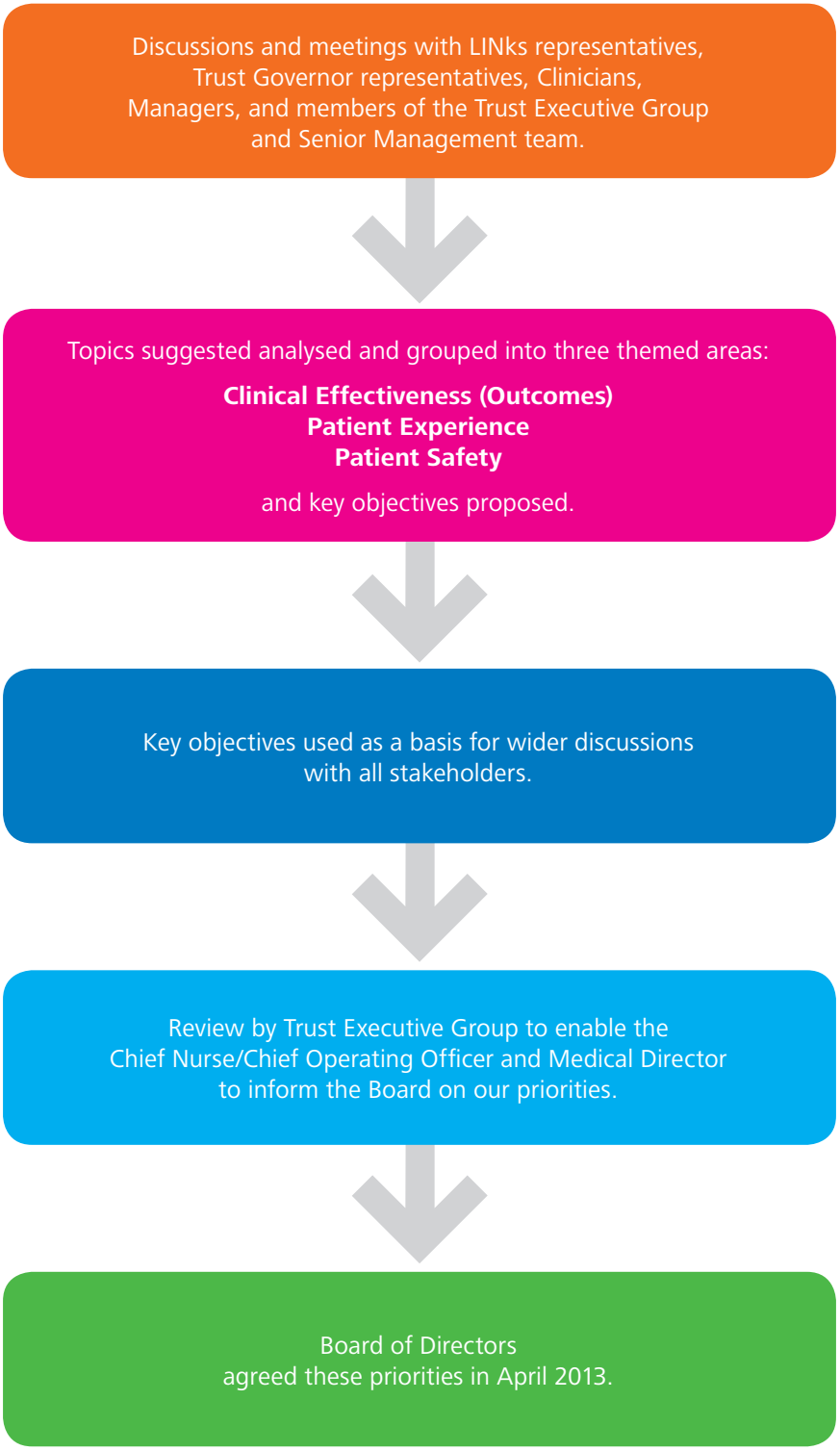
Our Aim	To improve the provision of discharge information for patients.
Past Performance	The quality of discharge information available for patients is variable, and has been a cause for complaint from some patients. Whilst local improvement work has taken place this audit work aims to ensure a Trust wide consistent standard for discharge information.
Key Objectives	To improve the provision of discharge information for patients by auditing the information provided and available for patients against Trust wide standards. Deficiencies identified during this process will be addressed by improvement activities at Directorate and Trust level. The software package Interlagos Advanced Publishing System[2] will enable Directorates to produce bespoke discharge information in a standardised format for use across the Trust. Improvements in discharge documentation will enable patients, relatives and carers to understand what to look for once they have been discharged including who to contact if concerned.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2013/14.
Board Sponsor	**Dr David Throssell** Medical Director
Implementation lead	**Janet Brain** Senior Manager, Clinical Effectiveness Unit **Sue Butler** Head of Patient Partnership **Sandi Carman** Head of Patient and Healthcare Governance

2 www.interlagos.co.uk

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.12 How did we choose these priorities?



Part 2

Priorities for Improvement and Statements of Assurance from the Board

Equality and Human Rights

The Trust considers that ensuring equality, diversity and human rights are an integral component of high quality services.

The Trust's progress on the Pubic Sector Equality Duty is published in the Trust annual Equality and Human Rights Report. Also included is data and information relating to people who use Trust services and people employed by the Trust. In April 2012 the Trust identified and published four Equality Objectives. These reports and information about the Trusts Equality Objectives are published on the Trust public website in the Equality and Diversity section.

The Trust adopts a number of approaches and practices to ensure that people have equal access to Trust services and a positive experience. Some of these approaches are well established whilst other areas are still in development. Services provided to people with Learning Disabilities are well embedded across the Trust, supported by the lead Nurse Director and each service area has a local lead. People are supported taking into account their individual needs and examples of action taken locally include communication books, longer appointments and a flexible approach to service delivery. There is a range of information available for staff and patients.

The Trust has also considered how it can best meet the needs of patients with Dementia and over the last few years a number of projects and partnerships with specialist services in the city have been taken forward.

Areas that are continuing to develop include improving access to large print or e-mail versions of correspondence which are available on request and ensuring that where people have specific needs these are identified at an early stage and communicated onwards when patients move to different areas of the Trust.

This work continues to be led and developed by the Equality and Humans Rights Manager.

2.2 Statements of Assurance from the Board

This section contains formal statements from the following services delivered by Sheffield Teaching Hospitals NHS Foundation Trust.

a) Services provided
b) Clinical Audit
c) Clinical Research
d) CQUINs framework
e) Care Quality Commission
f) Data Quality
g) Patient Safety Alerts
h) Annual Staff Surveys
i) Annual Patient Surveys
j) Complaints
k) Eliminating mixed sex accommodation
l) Coroners Rule 43 letter

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

a) Services Provided

During 2012/13, Sheffield Teaching Hospitals NHS Foundation Trust provided 40* core and sub-contracted general hospital services locally, tertiary services regionally and specialist services nationally. Sheffield Teaching Hospitals has reviewed all the data available to them on the quality of care in these NHS services. The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by Sheffield Teaching Hospitals for 2012/13.

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

* Taken from the Monitor schedule of services.

b) Clinical Audit

During 2012/13 38 national clinical audits and 3 national confidential enquiries covered NHS services that Sheffield Teaching Hospitals provides. During that period Sheffield Teaching Hospitals participated in 36 (95%) national clinical audits and 3 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The two national clinical audits and the Trusts reason for non-contribution this year are detailed later in this section.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals participated in during 2012/13 are shown in Table 1 as follows:

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Acute Care		
Adult community acquired pneumonia (British Thoracic Society)	Yes	100% (51/51)**
Adult critical care units (ICNARC CMP)	Yes	100% (1506/1506)
Emergency use of oxygen (British Thoracic Society)	Yes	100% (29/29)**
Patient Outcome and Death (NCEPOD)	Yes	87% (68/78)
National Joint Registry (NJR)	Yes	100% (1365/1365)
Non-invasive ventilation (British Thoracic Society)	Yes	100% (24/24)**
Renal colic (CEM)	Yes	100% (50/50)
Trauma (TARN)	Yes	96%(514/534)
Blood and Transplant		
Cardiothoracic transplants (Blood & Transplant)	Yes	100% (89/89)
Potential donor audit (Blood & Transplant)	Yes	100% (349/349)
Comparative audit of blood transfusion (Blood & Transplant)	Yes	100% (63/63)
Renal Transplantation (NHSBT UK Transplant Registry)	Yes	100% (55/55)
Cancer		
Bowel cancer (NBOCAP)	Yes	91% (313/343)
Head and neck oncology (DAHNO)	Yes	89% (123/138)*
Lung cancer (NLCA)	Yes	93% (445/480)*
Oesophago-gastric cancer (NAOGC)	Yes	32% (58/182)*
Heart		
Acute Myocardial Infarction: MINAP (NICOR)	Yes	100% (1389/1389)
Adult Cardiac Surgery (NICOR)	Yes	100% (792/792)
Cardiac Arrhythmia (NICOR)	Yes	100% (752/752)
Congenital Heart Disease: adults (NICOR)	Yes	100% (30/30)
Coronary Angioplasty (NICOR)	Yes	100% (1648/1648)
Heart Failure Audit (NICOR)	Yes	100% (503/503)
Cardiac Arrest (ICNARC)	No	See statement 1 below
Vascular Surgery (VSGBI)	Yes	61% (267/441)
Pulmonary Hypertension Audit (NHSIC)	Yes	100% (1291/1291)

Table continues overleaf:

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Long Term Conditions		
Adult asthma (British Thoracic Society)	Yes	100% (71/20)**
Bronchiectasis (British Thoracic Society)	Yes	100% (42/42)**
Diabetes - Adult (NHSIC)	Yes	100% (5322/5325)*
Diabetes Inpatient Audit (NHSIC)	Yes	100% (236/236)
Diabetes: Paediatric (RCPCH)	N/A	
Inflammatory Bowel Disease (RCP)	Yes	See statement 2 below
Asthma Deaths (RCP)	Yes	0/0 See statement 3 below
Pain Database (Dr Foster Research Ltd)	Yes	33.3% (4/12) See statement 4 below
Renal Registry (UK Renal Registry)	Yes	100% (648/648)
Mental Health		
Psychological therapies (RCPsych)	N/A	
Prescribing Observatory for Mental Health (POMH UK)	N/A	
Suicide and homicide in mental health (NCISH)	N/A	
Older People		
Carotid Interventions Audit (RCP)	Yes	95% (97/102)
Fractured Neck of Femur (CEM)	Yes	100% (50/50)
Hip Fracture Database (BOA & RCS)	Yes	100% (624/620)
National Audit of Dementia (RCPsych)	Yes	100% (80/80)
Parkinson's Disease (Parkinson's UK)	No	See statement 5 below
Stroke National Audit Programme - combined Sentinel and SINAP (RCP)	Yes	96% (932/970)*
Other		
Elective Surgery - National PROMS Programme (NHSIC)	Yes	76.5%
Women's and Children's Health		
Epilepsy 12 - childhood epilepsy (RCPCH)	N/A	
Maternal, infant and perinatal (MBRRACE)	Yes	100% (83/83)
Neonatal intensive and special care (RCPCH)	Yes	100% (841/841)
Paediatric asthma (British Thoracic Society)	N/A	
Fever in children (CEM)	N/A	
Paediatric intensive care (PICANet)	N/A	
Paediatric pneumonia (British Thoracic Society)	N/A	

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Please note the following:

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

** British Thoracic Society (BTS): Sample sizes are not predetermined for BTS audits but are based on a time-limited data period. This means that sometimes the number of cases submitted is higher than the required minimum standard.

Supporting Statements:

1. ICNARC NCAA: Cardiac Arrest:

The Trust Resuscitation Committee acknowledges that whilst contributing to the National Cardiac Arrest Audit is desirable, it is not currently feasible due to the resource implications. The Trust is working towards improving compliance with completion of local Resuscitation Audit forms to enable participation in the audit in 2013/14.

2. Inflammatory Bowel Disease (RCP)

Data collection commenced for this audit but unfortunately the continuous follow up of patients proved unfeasible alongside clinical requirements and commitments. A plan is under discussion to enable participation in 2013/14.

3. Asthma Deaths (RCP)

The Trust has not yet had any eligible patients though are committed to participate fully in the Confidential Enquiry. Data collection period is 1 April 2012 - 31 January 2013 and submission deadline for data is 30 September 2013.

4. Pain Database (Dr Foster Research Ltd)

The follow up questionnaire is administered six months after the initial PROMS questionnaire, the patient response rate was 33% following distribution to 12 patients.

5. Parkinson's Disease (Parkinson's UK)

Implementation of the Action Plan was still in the active stage at the point of the re-audit commencing. The Trust position was to concentrate on completing the implementation of change and participate in the next round. This has been recognised nationally and future audits will be undertaken every second year rather than annually.

Clinical Audit (continued)

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals participated in, and for which data collection was completed during 2012/13, are listed above in Table 1 alongside the number of cases submitted to each audit or enquiry as a percentage of a number of registered cases required by the terms of that audit or enquiry.

The reports of 25 national clinical audits were reviewed by the Trust in 2012/13, 14 of these reports were reviewed by Committees of the Board and 11 reviewed by Senior Teams in clinical areas. Sheffield Teaching Hospitals intends to take a number of actions to improve the quality of healthcare provided, some the examples of which are included over the page.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

British Thoracic Society (BTS) National Non Invasive Ventilation (NIV) Audit 2012

Aim:

The aim is to identify that the expected standards of care required for patients (adults) receiving NIV are met; namely patient management, knowledge and skills, equipment and documentation. The audit includes questions on cause of respiratory failure, prior lung function and performance status.

Recommendations and Action Plan:

Recommendation	Action	Timescale
Continue to improve on the use of the Oxygen alert card.	100% of patients discharged from the Respiratory Support Unit following a known episode of hypercapnic respiratory failure should have an oxygen alert card issued.	Immediate September 12
Improve rehabilitation referral	Ensure all referral forms are available. Ensure all team know referral process. Ensure 'patient consent' or 'refusal to be referred' or 'referral inappropriate' is documented in casenotes.	Completed December 12
Review length of stay during the re-audit in February 13	Participate in BTS re-audit February 13.	February 13

Conclusion:

STH performs better than comparative units across UK based on BTS comparison data. Results locally demonstrate good compliance with audit standards and the action plan seeks to improve this position. The Trust is participating in the 2013 re-audit.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Audit of Insulin Self Administration

Aim:

To determine compliance with National Patient Safety Agency (NPSA) Patient Safety Alert (PSA) 003.

To determine if all hospital inpatients are given the choice of self-monitoring and managing their own insulin.

To determine if all hospital inpatients who self-administer insulin have the necessary equipment.

Main objectives:

Identify the proportion of diabetic patients self-administering insulin.

Check compliance with the PSA 003 checklist and the current audit standards.

Recommend methods of promoting self-administration of insulin where feasible and safe.

Recommendations and Action Plan:

Recommendation and Actions	Timescale
Roll-out Dispensing for Discharge on all wards which meet criteria	December 13
Consider implementing a rota of Medicine Management Technicians (MMT) who may be contacted to attend to assess the suitability of insulin management on wards without MMT	Completed (May 12)
Train pharmacists and MMTs in changes to self-administration policy in relation to patients on insulin	Completed (March 12)
Implement e-learning module for self medication to include changes for self administration of insulin described in revised policy	Completed (December 12)
Consider amendment of the medicines reconciliation chart to include: 'Patient normally self-medicates at home - yes/no'.	Completed (September 12)
Consider inclusion of 'Does the patient normally self-monitor their blood glucose at home?' on the assessment form for self-administration	Completed (September 12)
Recommend a suitable lockable device for insulin to wards without Dispensing for Discharge	Completed (September 12)
Improve patient awareness of the significance of safe medicine storage whilst in hospital - make the patient information leaflet for self administration available to all patients self administering insulin	Completed (September 12)

Conclusion:

Almost 100% compliance with the standard relating to the secure storage of medication and indicates self-administration at STHFT only occurs, quite rightly, when bedside lockers are available. STHFT also demonstrates exceptionally good practice in sharps disposal.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Confidential Enquiries

The Trust Patient Safety Manager has an overview of National Confidential Enquiry into Patient Outcome and Death Reports (NCEPOD) and puts action plans together as reports are issued. The standing agenda item at the Clinical Effectiveness Committee provides a forum for updates, and if any action plan requires an audit this is included on the Trust Clinical Audit Programme. One example of an audit related to 'Are we there yet?' is an Audit of Consent for Children's Surgery undertaken in April/May 2012. The Report (May 2012) has been reviewed at the Children's and Young People's Services Group.

Data is continually collected and submitted to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom - see table for participation rate).

Local Clinical Audits

The reports of 169 local clinical audits were reviewed by the Trust in 2012/13 and Sheffield Teaching Hospitals intends to take the following actions to improve the quality of healthcare provided:

Care Home Support Team: Core Skills Training Outcomes

Aim and Objectives

The aim of the audit was to measure improvement in practice by Care Home staff as a result of training provided by the Care Homes Support Team (CHST). This was to ensure that patients/residents in Care Homes would benefit from receiving care from well trained and skilled staff. The audit would identify future training needs for Care Home staff and priorities for the Care Home Support Team.

Recommendations:

As a result of the audit the following recommendations were made:

- Where concerns are raised about a care home's performance this training model be utilised and/or adapted to support an objective appraisal of specific areas of practice.
- Where care practices in individual care homes are identified as not improving, worsening or non-compliant, as measured against agreed standards and indicators at post training observation, appropriate actions to address the issues are to be taken by the CHST. This could include reporting concerns into the Key Performance Indicator (KPI) process and/or developing a further action plan with the care home manager.
- Where care practices in relation to specific standards, such as infection control and activity/occupation are not showing significant improvement at post observation this data is used to inform future training development proposals.
- This training approach be considered and further developed to support a model of self-assessment in care homes to benchmark practice and identify specific training needs.

Conclusion

This audit has shown that by developing a pre and post-observation tool and applying it within the workplace, it may be possible to measure both improvement in specific areas of practice as a result of CHST training and identify emerging and collective trends to inform future training development. Given this is a resource intensive approach to identifying practice and training needs in care homes, consideration should be given to further developing this tool to support a model of self assessment in care homes.

Dates for future re-audit

This audit relates to a time limited training programme that concluded in 2011. The recommendations and outcomes of this audit will be taken forward to inform future workforce development proposals through Sheffield City Council's Training and Commissioning Strategic Group, Quality in Care Homes Executive Board and Care Homes Support Team Task and Finish Group.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Thalidomide Celgene Pharmacy Audit

Thalidomide Celgene is prescribed and dispensed according to the Thalidomide Celgene Pregnancy Prevention Programme. Celgene Ltd. is obliged to report to the Medicines and Healthcare Products Regulatory Agency (MHRA) and the European Medicines Agency (EMEA) on the effectiveness of this programme. To achieve this, registered pharmacies are required to undertake a standard audit and submit their anonymised data to Celgene.

Aim:

Evaluate compliance with the Thalidomide Pharmion Prescription Authorisation and Treatment Initiation Forms.

Recommendations and Action Plan:

Recommendation	Action	Timescale
Improve filing of Prescription Authorisation Forms	File upgraded at the Northern General Hospital NGH	Completed
Raise awareness with pharmacists at NGH of risk and actions required	Notice alert placed in dispensing file	Completed
	Discuss at Monday morning meeting	Completed
Ensure a Prescription Authorisation Form is always sent to pharmacy with prescription	Ensure Prescription Authorisations Forms available to prescribers	Completed
Check on success of above actions.	Spot check of Prescription Authorisations Forms at NGH	Completed May 12 and July 12
Celgene re-audit	Re-audit in April 2013	April 13

Conclusion:

Although the compliance rate is very good and no patients were put at risk, it is vital that continuous full compliance is achieved for this audit as it is directly related to ensuring safety. Although we are only required to undertake the audit for Celgene annually, checks will be made more frequently to provide assurance of compliance.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Age Equality in Community Services

Aim:

The aim of the audit was to ensure compliance with Age Discrimination legislation. The objective was to provide an understanding of the Trust's current position. All services under the Primary and Community Services Care Group completed an on-line survey by 31 January 2013. A total of 24/28 services completed the survey. Therefore, the overall response rate was 85.7%.

Recommendations and Action Plan:

Recommendation	Action	Timescale
Service managers need to ensure they understand why Commissioners place age restrictions of service specifications and service level agreements.	Service Managers to seek clarity on the clinical reasons for any proposed age restrictions in contracts	Within 12 months or as contracts are reviewed (February 14)
The Care Group needs to review this audit periodically to ensure compliance	To re audit on a regular basis	Within 2 years (February 15)

Conclusion:

Community services have been shown in this audit to be open to all age groups except when age specific services are more appropriate, for example, under 16-18 years or where there is a restriction required through the contracting process.

Services had a lower age limit because there were other more appropriate services supporting children. There is guidance for transition of children into other services as they approach the age to move into our adult services at ages 16 or 18 years old. The exceptions to this are the Falls Service and Care Home Support Team whose lower limit is set by Commissioners. The Care Home Support Team focus is currently under review and they may be supporting age groups for individuals with Learning Difficulties within a Care Home setting. An upper age limit was only relevant to the specialist Weight Management service which is a commissioned service and the age parameters are set by NHS Sheffield.

The clinical reasons for age restriction require clarity within the service specification or service level agreement and this will be emphasised in the next contracting round.

c) Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Sheffield Teaching Hospitals in 2012/13 that were recruited during that period to participate in research approved by a Research Ethics Committee was 12,142 (2011/12 - 6646).

In line with the National Institute for Health Research publication 'We do clinical research: A guide for support material that help Trusts promote clinical research in the NHS' the Trust is taking steps to increase research awareness across the Trust. The Trust will be celebrating International Clinical Trials Day on the 20 May to commemorate the day that James Lind started his famous trial. James Lind is generally considered to be the originator of clinical trials because he was the first to introduce control groups into his experiments on patients with scurvy.

International Clinical Trials Day provides a focal point to raise awareness of the importance of research to health care and highlight how partnerships between patients and healthcare practitioners are vital to high-quality, relevant research. On the 20 May there will be promotional events across the Trust to raise research awareness.

d) CQUINs Framework

A proportion of Sheffield Teaching Hospitals income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Sheffield Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available on line at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275.

In 2012/13, 2.5% of our contractual income (£16.4 million) was conditional on achieving Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield.

For 2012/13 the Commissioning for Quality and Innovation payment framework has included:

- Improved identification and assessment of patients who may have Dementia with over 90% of patients over 75 now screened for dementia
- Improved responsiveness to the personal needs of patients, with over 90% of patients surveyed expressing complete satisfaction with the help they received with nutrition, pain control and going to the toilet
- The introduction of an enhanced recovery model of care for certain procedures in Urology and Gynaecology, so that patients appropriately spend less in time in hospital after their operation
- The introduction of a structured model of care for inpatients with Chronic Obstructive Pulmonary Disease (COPD), to improve their condition in hospital and reduce the chance that they are readmitted

e) Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Sheffield Teaching Hospitals during the period 1 April 2012 - 31 March 2013. Sheffield Teaching Hospitals has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13.

i. Northern General Hospital routine inspection

The CQC carried out a routine inspection of 4 wards at Northern General Hospital on 14 December 2012 and interviewed governance staff on 20 December 2012. The CQC found the Trust to be meeting all three standards that were inspected and were satisfied overall with their findings regarding respectful interactions, the management of clinical risk, safeguarding practice, training, care records, and governance structures and systems. No action plan was required by CQC.

ii. Royal Hallamshire Hospital routine inspection

The CQC conducted a routine inspection at Royal Hallamshire Hospital on 17 January 2013. The CQC found the Trust to be meeting both standards that were inspected and were satisfied overall with their findings regarding treating people with dignity and respect, induction, training, appraisal and supervision. No action plan was required by CQC.

iii. Northern General Hospital Mental Health Act Commission visit

The Mental Health Act Commission carried out a scheduled monitoring visit to Northern General Hospital on 21 March 2013 on behalf of the CQC. The Trust is currently implementing a plan to ensure full compliance with the Mental Health Act Code of Practice. Actions include finalising the Trust Mental Health Act policy, ensuring appropriate training is in place and formalising the arrangements required to ensure patients are detained safely.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

f) Data Quality

Sheffield Teaching Hospitals submitted records during 2012/13 to the Secondary User Service (SUS) for inclusion in the Hospital Episode Statistics (HES), which were included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

99.7% for admitted patient care

99.8% for outpatient care

98.7% for Accident and Emergency care

The percentage of records in the published data which included the patient's valid General Practitioner Registration Code was:

100% for admitted patient care

100% for outpatient care

100% Accident and Emergency care

These figures are at the same high level as previous years.

Sheffield Teaching Hospitals Information Governance Assessment Report overall score 2012/13 was 73% and was graded satisfactory and green.

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

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

1. Continue to feedback errors in incorrectly recorded GPs to Directorates
2. Review the Trust's Access Policy
3. Convene the new Waiting List Management Group to oversee the recording and reporting of waiting times including 18 weeks referral to treatment
4. Continue with the audit programme for clinical coding
5. Aim to improve the accuracy of clinical coding to achieve level 3 for this element of the Information Governance Toolkit.

Sheffield Teaching Hospitals was subject to a payment by results clinical coding audit by the Audit Commission during the reporting period and the error rate reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) was:

4.0% primary diagnosis incorrect

7.0% secondary diagnosis incorrect

7.0% primary procedures incorrect

8.0% secondary procedure incorrect

The figures above relate to the correct recording of patient diagnosis and procedures from case notes. The standard is 90% correct recording of the primary diagnosis and procedure, and 80% correct recording of the secondary diagnosis and procedure. This is an improvement from the last audit where up to 14% of the diagnosis was incorrectly recorded from the case notes.

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

60 sets of case notes with a code of pneumonia

60 sets of case notes with a code of inpatient fall

100 accident and emergency episodes of care.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

The following paragraphs and information are included as a response to feedback from LINks, the Trust's External Auditors and senior staff.

g) Patient Safety Alerts

The National Patient Safety Agency analyses reports on patient safety incidents received from NHS staff and uses this to produce resources (alerts or rapid response requests) aimed at improving patient safety. Table 1 below details the Alerts and Rapid Response Reports which have been received during the year 2012/13.

Table 1: Alerts completed and closed during 2012/13

NPSA Ref	National Patient Safety Authority - Alert Title
NPSA/2012/RRR001	Harm from flushing of nasogastric tubes before confirmation of placement
NPSA/2011/RRR003	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors
NPSA/2011/PSA003	The adult patient's passport to safer use of insulin
NPSA/2011/PSA001	Safer spinal (intrathecal), epidural and regional devices

There are no outstanding alerts for 2012/13.

h) Annual Staff Surveys

Staff Engagement

The Trust recognises the importance of positive staff engagement and good leadership to ensure good quality patient care.

Staff Involvement

During 2012 the implementation of the Trust Staff Engagement Strategy has been ongoing. A number of 'Let's talk' events and timeouts have been held in directorates across the Trust in order to seek staff views and encourage ideas for service improvements. The Chief Executive undertook a wide consultation exercise on the corporate strategy visiting a number of staff in their work areas. In addition regular meetings between the Chairman of the Trust and the Staff Governors have been introduced.

Appraisal

During 2012 a performance, values and behaviours based appraisal process was piloted with senior leaders in the Trust to confirm that our staff are not only competent but demonstrate the right values and behaviours. This is based on the PROUD values which were developed in conjunction with staff and patients i.e.

Patients first
Respectful
Ownership
Unity
Delivery

Evaluation of the pilot showed the importance of good quality appraisal training, so a significant investment in this area has been made to support the roll out of this appraisal process to all staff over the next few years.

Health and Wellbeing

Further Health and Wellbeing festivals have been held across the Trust in the last year which provide staff with a range of information on how to improve their health and wellbeing. Staff views have been sought to identify what support they would like to see and in response to this a number of initiatives have been held on site, including exercise classes and weight management classes run by dieticians.

Following the successful pilot of a fast track musculoskeletal service for staff in the Jessop Wing by PhysioPlus we are looking to expand this service across the whole Trust and link this to the development of a fast track mental health pathway for staff absent due to stress, anxiety and depression.

The intention is to develop a seamless service between Occupational Health, Physiotherapy and Mental Health practitioners to support staff who are absent and in time, be able to provide a preventative service which will reduce sickness absence rates within the Trust and improve staff engagement overall.

The outcome of research undertaken in conjunction with Sheffield Hallam University regarding the provision of staff health checks proved promising but consideration is being given to undertaking a larger scale pilot programme across the Trust to determine the efficacy of the service.

Leadership and Management Development

As part of the Trust's regular programme a leadership forum was held in November when Dr Joanna Watson, Clinical Director of the Point of Care programme at the Kings Fund spoke to delegates about the importance of the patient experience.

Our first Institute of Leadership and Management (ILM) level 5 programme is due to commence in September and steps have been taken to improve the mentoring and coaching capacity within the Trust with a number of managers currently being trained by an external organisation to act as performance coaches. In addition the Dartmouth Institute Microsystem coaching approach is being introduced to support service improvement.

A further 3 cohorts of staff have attended the Senior Leaders programme developed in conjunction with Sheffield Hallam University along with a further 2 cohorts of the level 3 ILM programme. The 'Effective Manager' rolling management programme and the leadership guest lecture series continue to be well supported with speakers from NHS Employers and the Dartmouth Institute[3] in America being welcomed to the Trust during the year.

3 www.sheffieldmca.org.uk/sheffields_approach

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Staff survey

Staff engagement is measured every year via the annual NHS staff survey which includes an overall score for staff engagement. It was pleasing to note that this progress was maintained during 2012 despite a period of change in the NHS.

Top five ranking scores:

Key Finding	STH 2012	NHS 2012	STH 2011	NHS 2011	Improvement/deterioration
Staff working unpaid extra hours (%)	**64**	70	**52**	65	Deterioration
Staff experiencing harassment/bullying/ abuse from staff (%)	**23%**	24%	**n/a**	n/a	
Staff recommending Trust to work/for treatment	**3.65***	3.57	**3.60**	3.50	Improvement
Handwashing materials available (%)	**61**	60	**69**	66	Deterioration
Work pressure felt by staff	**3.07***	3.08	**n/a**	n/a	

Bottom five ranking scores:

Key Finding	STH 2012	NHS 2012	STH 2011	NHS 2011	Improvement/deterioration
Staff motivation at work	**3.68***	3.84	**3.60**	3.82	Improvement
Staff having well structured appraisals in last 12 months (%)**	**26**	36	**27**	34	Deterioration
Effective team working	**3.61***	3.72	**3.62**	3.72	Deterioration
Received equality and diversity training in last 12 months (%)	**39**	55	**37**	48	Improvement
Support from immediate managers	**3.48***	3.61	**3.55**	3.62	Deterioration

Most improved

Key Finding	STH 2012	STH 2011
% of staff able to contribute to improvements at work	63	52
% staff appraised in last 12 months**	76	67

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

** In common with a number of Trusts, the figure for staff indicating that they had received a well structured appraisal is lower than the % of staff appraised, the appraisal improvement work detailed above seeks to address this concern.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

It is pleasing to note that 78% of the staff who work at Sheffield Teaching Hospitals are satisfied with the quality of work and patient care they are able to deliver and 70% of our staff would recommend the Trust to family and friends which is well above the NHS average of 60%.

An action plan has been drawn up to address the areas for improvement highlighted in the survey, which is currently being implemented.

i) Annual Patient Surveys

The Trust undertakes a wide range of activities to find out what patients feel about the services they receive. Survey work during 2012/13 has included participation in the national survey programme for inpatients, accident and emergency departments and cancer services. In addition, an extensive programme of local surveys is undertaken using a range of methods including paper based surveys and the real time frequent feedback system in which views of patients about a wide range of services are gathered by volunteers.

In the National Accident and Emergency Department Survey 2012, our scores were similar to those of other trusts. Questions where our scores were high include doctors and nurses working well together and courtesy of reception staff. Areas identified where improvements can be made include informing patients of the waiting time to be examined and the provision of written/printed information about the patient's condition and treatment.

The National Inpatient Survey 2012 also showed our scores overall to be in line with those of other trusts nationally. High scoring questions include cleanliness of the patient's room, ward and toilets and doctors being knowledgeable about the patient's condition and treatment. Lower scoring questions where improvements can be made include provision of enough information about ward routines and delays in discharge.

The second National Cancer Survey was carried out in 2012. This Trust's scores were once again very good overall. High scoring questions include the patient's overall rating of care as 'excellent' or 'very good' and staff providing complete explanations regarding operations. Areas where scores were lower include the provision of information regarding financial help and staff asking the patient what name they prefer to be called by.

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

j) Complaints

Improving the experience and learning from complaints.

The Trust continues to value complaints as an important source of patient feedback. We provide a range of ways in which patients and families can raise concerns or make complaints. All staff receive training at induction on how to respond to concerns and how to advise patients on making a complaint.

All concerns whether they are presented in person, in writing, over the telephone or by email are assessed and acknowledged within two days and where possible, we aim to take a proactive approach to solving problems as they arise. We have been able to respond to 85% of complaints requiring more detailed and in depth investigation within our target of 25 working days (1444 complaints received during 2012/13).

Regular complaints and feedback reports are produced for the Board of Directors, Patient Experience Committee, Care Groups and Directorates showing the number of complaints received in each area and illustrating the issues raised by complainants. This reporting process ensures that at all levels, the Trust is continually reviewing information so that any potentially serious issues, themes or areas where there is a notable increase in the numbers of complaints received can be thoroughly investigated and reviewed by senior staff.

We remain committed to learning from, and taking action as a result of complaint investigations where it is found that mistakes have been made or where services could be improved. During the past year we have introduced a formal process for monitoring and following up actions agreed to ensure any changes have been made and implemented as planned.

Work on auditing both the quality of our complaints service against the standards we have set and the experience of complainants has continued during the year. We will continue to use the findings of this audit and review work alongside national initiatives and recommendations following the Mid Staffordshire NHS Foundation Trust Public Inquiry[4] to continually improve and develop our complaints service.

4 The Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013, HC 947, London: The Stationery Office.

k) Eliminating Mixed Sex Accommodation

The Trust remains committed to ensuring that men and women do not share sleeping accommodation except when it is in the patient's overall best interest or reflects their personal choice. As a result we have not identified any breaches of the Eliminating Mixed Sex Accommodation during 2012/13.

l) Coroners Rule 43 Letter

In September 2012 the Trust along with Doncaster and Bassetlaw Hospitals NHS Foundation Trust, received a Rule 43 letter from the Coroner following an inquest into the death of a patient who received care within Doncaster but was not transferred to Sheffield for emergency treatment. These letters are written when the Coroner feels further improvement action needs to be implemented following a death. In a joint response to the Coroner both hospitals detailed the changes made to the way we care for patients requiring urgent intervention in order to prevent a similar situation happening again.

Part 3

Review of Services in 2012/13

3.1 Quality Performance Information 2012/2013

Many of the indicators listed below are included to meet the requirements of the Department of Health and Monitor. For ease of reading we have added a Green, Amber and Red rating to identify good, adequate or poor performance.

As there are new indicators added this year all of the indicators have been grouped into three sections:

i) Mandated Indicators - Department of Health (Gateway reference 18690)

ii) Mandated Indicators - Monitor (Schedule 6 - Feb 13 v55)

iii) Local Indicators.

i) Mandated Indicators - Department of Health (Gateway reference 18690)

Prescribed Information	2010/11	2011/12	2012/13
1. Mortality			
(a) the value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period; **National average: 1** **Highest performing Trust score: 0.68** **Lowest performing Trust score: 1.21**	.86	.92*	**.90** **(Oct 11 - Sept 12)**
(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. (The palliative care indicator is a contextual indicator). **National average: 18.9%** **Highest performing Trust score: 43.3%** **Lowest performing Trust score: 0.2%** The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as *the data are extracted from the Information Centre SHMI data set*. The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this rate and so the quality of its services, by: • *Ensuring consistent Mortality and Morbidity reviews are undertaken across the Trust.* • *Monitoring the mortality data at a diagnosis level to ensure any areas for improvement are constantly reviewed and where appropriate ensure actions are taken to address.* * The 0.87 reported in last year's Quality Report was qualified by the annotation that this was derived from the most recent rolling 12 month period i.e. July 10 - June 11. SHMI results are published six months and three weeks in arrears because of the need to validate the data nationally. The value for April 2011 - March 2012 was released at the end of October 2012 and reported as 0.92. This can be validated via the NHS Choices website.	17.9%	17.5%	**18%** **(Oct 11 - Sept 12)**

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
2. Patient Report Outcome Measures (PROMs)			
The Trust's patient reported outcome measures scores for:			Apr - Jun 12
(i) Groin hernia surgery			
Sheffield Teaching Hospitals' score:	0.083	0.086	**0.104**
National average:	0.085	0.087	0.091
Highest score:	0.156	0.143	0.158
Lowest score:	-0.020	-0.002	0.017
(ii) Varicose vein surgery			
Sheffield Teaching Hospitals' score:	0.082	0.065	*
National average:	0.091	0.094	0.093
Highest score:	0.155	0.167	0.138
Lowest score:	-0.007	0.047	0.024
(iii) Hip replacement surgery			
Sheffield Teaching Hospitals' score:	0.359	0.365	*
National average:	0.405	0.416	0.437
Highest score:	0.503	0.532	0.502
Lowest score:	0.264	0.306	0.333
(iii) Hip replacement surgery			
Sheffield Teaching Hospitals' score:	0.327	0.313	**0.255**
National average:	0.299	0.302	0.312
Highest score:	0.407	0.385	0.387
Lowest score:	0.176	0.180	0.244

PROMs scores represent the average adjusted health gain for each procedure. Scores are based on the responses patients give to specific questions on mobility, usual activities, self care, pain and anxiety after their operation as compared to the scores they gave pre-operatively. A higher score suggests that the procedure has improved the patient's quality of life more than a lower score.

* Denotes that there are fewer than 30 responses as figures are only reported once 30 responses have been received.

The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as *the data are taken from national Information Centre PROMs data set*.

The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score and so the quality of its services, *by reviewing in detail a breakdown of EQ-5D and OHS data for hips and undertaking improvement work as necessary.*

Performance remains within acceptable ranges for other PROMs and scores will continue to be monitored. The focus is to understand the lower PROMs scores, which is a highly complex issue requiring expert input.

Part 3

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
3. Readmissions			
The percentage of patients aged:			
(i) 0 to 14; and	0%	0%	**0%**
(ii) 15 or over,	10.7%*	10.7%*	**11.36%**
readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust. **Comparative data is not available** The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as *the data are taken from the Trust's Patient Administration System*. * These figures are different from last year as the way the data is calculated has changed (Data definition). The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage *and so the quality of its services by reviewing the reasons for readmission and working with our partners in the wider Health and Social Care community to prevent avoidable readmissions. This will be delivered through the Right First Time initiative*.			
4. Responsiveness to personal needs of patients			
The trust's responsiveness to the personal needs of its patients during the reporting period. **National average: 68.1%** **Highest performing Trust score: 84.4%** **Lowest performing Trust score: 57.4%** The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as *the data are provided by national CQC survey contractor.* * The scores represent the five questions from the National Inpatient Survey which have been selected nationally to form part of the CQUIN scheme, as a measure of responsiveness to patient needs. The Sheffield Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, *as for the last two years the Trust and PCT have agreed that, whilst important, the areas highlighted in the national survey were not as important as some fundamental areas which include help to go to the toilet, controlling pain, help with nutrition, being treated with dignity and theses are the areas on which the Trust's Patient Experience is being measured through an ongoing programme of patient interviews (approximately 400 each month).*	71.9%	72%	**68.6%***

Part 3

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
5. Staff who would recommend the Trust The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. National average: 60% Highest performing Trust score: 94% Lowest performing Trust score: 35% The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described *as the data are provided by national CQC survey contractor.* The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage and so the quality of its services, by *continually involving staff and seeking their views in how to make improvements in the quality of patient services.*	73%	75%	**70%**
6. Patients risk assess for Venous Thromboembolism (VTE) The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. Comparative data is not available The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as they are taken from the Trusts Patient Administration System and audit data. * These figures are different from last year as the way the data is calculated has changed (Data definition). The Sheffield Teaching Hospitals NHS Foundation Trust *continues to take the following actions to improve this percentage and so the quality of its services, by ensuring completion of VTE risk assessment form for every patient admitted to STH. Undertaking surveillance of returns and feedback to Directorates on performance and carrying out root cause analysis of cases of VTE which are thought to be hospital associated.*	73.97%*	91.1%*	**93.33%**

Part 3

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
7. Rate of *Clostridium Difficile*			
The rate per 100,000 bed days of cases of *Clostridium Difficile* infection reported within the trust amongst patients aged two or over during the reporting period. National average: 18.5 Highest performing Trust score: 0 Lowest performing Trust score: 39.5 The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as the data is provided by the Health Protection Agency. The Sheffield Teaching Hospitals NHS Foundation Trust *continues to take* the following actions to improve this rate and so the quality of its services, by having a dedicated plan as part of it's Infection Prevention and Control Programme to continue to reduce the rate of *Clostridium Difficile* experienced by patients admitted to the Trust.	31.0	30.0	**17.7**

Part 3

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
8. Rate of patient safety incidents			
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period.			
Number of Incidents reported	10,495	10,192	**9,684***
The Incident reporting rate is calculated from the number of reported incidents per hundred admissions and the comparative data below is for the first 6 months of 2012/13. Full information for the financial year 2012/13 is not available from the National Reporting and Learning System until mid 2013 **Cluster** average: 6.8** **Highest performing Trust score: 12.12** **Lowest performing Trust score: 2.77**	5.3	5.2	**4.8** **As per NRLS data Apr-Sep 2012**
and the number and percentage of such patient safety incidents that resulted in severe harm or death. **Cluster** reporting data: 850 (0.6%)** **Highest reporting Trust: 81 (0.8%)** **Lowest reporting Trust: 1 (0.02%)**	55 (0.5%)	46 (0.4%)	**47* (0.5%)**
* Information taken from the Trust incident reporting system on 24/4/2013			
** Comparative data is sourced from the National Reporting Learning System, data is split into cluster/peer groups with Sheffield Teaching Hospitals NHS Trust being part of the 'Acute Teaching Hospitals' cluster.			
The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described *the data are taken from the National Reporting and Learning System (NRLS).*			
The Sheffield Teaching Hospitals NHS Foundation Trust intends to increase the incident reporting rate by introducing web based reporting throughout the Trust by autumn 2013. This will increase access to the reporting system, encourage increased incident reporting and speed up the Incident Management process.			
To note: As this indicator is expressed as a ratio, the denominator (all incidents reported) implies an assurance over the reporting of all incidents, whatever the level of severity. There is also clinical judgement required in grading incidents as 'severe harm' which is moderated at both a Trust and national level. This clinical judgement means that there is an inherent uncertainty in the presentation of the indicator which cannot at this stage be audited.			

Review of Services in 2012/13

ii) Mandated Indicators - Monitor (Schedule 6 - Feb 13 v55)

Measures of quality performance	2010/11	2011/12	2012/13
9. Percentage of patients who wait less than 31 days from diagnosis to receiving their treatment for cancer			
Sheffield Teaching Hospitals achievement	97%	98%	**98%**
National Standard	96%	96%	96%
Data Source: Exeter National Cancer Waiting Times Database			
10. Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer			
Sheffield Teaching Hospitals achievement	86%	91%	**89%**
National Standard	85%	85%	85%
Data Source: Exeter National Cancer Waiting Times Database			
11. Percentage of patients who have waited less than 2 weeks from GP referral to their first outpatient appointment for urgent suspected cancer diagnosis			
Sheffield Teaching Hospitals achievement	93%	95%	**95%**
National Standard	93%	93%	93%
Data Source: Exeter National Cancer Waiting Times Database			
12. All cancers: 31-day wait for second or subsequent treatment, comprising:			
Surgery:			
Sheffield Teaching Hospitals achievement	96%	97%	**97%**
National Standard	94%	94%	94%
Anti-cancer drug treatments:			
Sheffield Teaching Hospitals achievement	99%	99%	**100%**
National Standard	98%	98%	98%
Radiotherapy:			
Sheffield Teaching Hospitals achievement	97%	98%	**99%**
National Standard	94%	94%	94%
Data Source: Exeter National Cancer Waiting Times Database			

Review of Services in 2012/13

Measures of quality performance	2010/11	2011/12	2012/13
13. Accident and Emergency maximum waiting time of 4 hours from arrival to admission/transfer/discharge			
Sheffield Teaching Hospitals performance	97.6%	95.6%	**93.2%**
National Standard	95%	95%	95%
Data Source: Patient Administration System (PAS)			
14. MRSA blood stream infections			
Trust attributable cases in Sheffield Teaching Hospitals	9	2	**3**
Sheffield Teaching Hospitals threshold	13	10	1
Data Source: Health Protection Agency			
15. Patients who require admission who waited less than 18 weeks from referral to hospital treatment			
Sheffield Teaching Hospitals achievement	93%	90%	**90.6%**
National Standard	90%	90%	90%
Data Source: Patient Administration System (PAS)			
16. Patients who do not need to be admitted to hospital who wait less than 18 weeks for GP referral to hospital treatment			
Sheffield Teaching Hospitals achievement	98%	97%	**96.6%**
National Standard	95%	95%	95%
Data Source: Patient Administration System (PAS)			
17. Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway			
Sheffield Teaching Hospitals achievement	91%	90.4%	**93.2%**
National Standard	92%	92%	92%
Data Source: Patient Administration System (PAS)			
18. Patients who do not need to be admitted to hospital who wait less than 18 weeks for GP referral to hospital treatment			
Referral to treatment information:			
Sheffield Teaching Hospitals achievement			**60%**
National Standard			50%
Referral information:	New indicator	New indicator	
Sheffield Teaching Hospitals achievement			**100%**
National Standard			50%
Treatment activity information:			
Sheffield Teaching Hospitals achievement			**100%**
National Standard			50%

Part 3

Review of Services in 2012/13

iii) Local Indicators

Measure of quality performance	2010/11	2011/12	2012/13
19. Never Events			
Sheffield Teaching Hospitals Performance	2	3	**7**
Data Source: National Patient Safety Agency			
The Trust has experienced 7 Never Events during the year; 3 retained objects, 3 medication incidents following the incorrect prescribing and administration of Methotrexate and a misplaced nasogastric tube. A full review of Never Events has taken place and the Trust has been in close liaison with commissioners. A 'Never Event' summit took place in February 2013 to highlight issues across the Trust and ensure systems were in existence for the management of each separate category.			
The Trust is actively promoting incident reporting to further enhance the safety culture of the Trust. This will ensure incidents can be investigated, trends analysed and lessons can be learnt across the Trust.			
20. Hospital Standardised Mortality Ratio (HSMR)			
Sheffield Teaching Hospitals performance	91%	98%	**98%**
National Benchmark	100%	100%	100% (April 12 - Jan 13)
Data Source: Dr Foster			
21. Percentage of hip replacements we do in the Trust that are revisions			
Sheffield Teaching Hospitals performance	21.1%	20.3%	**25.7%**
National Benchmark not available	22.1%	21.3%	N/A
Data Source: Patient Administration System			
22. Patients who receive Primary Percutaneous Coronary Intervention within 150 minutes of calling for help			
Sheffield Teaching Hospitals achievement	N/A	74%*	**75.3%****
National Standard	N/A	75%	75%
Data Source: Myocardial Ischaemia National Audit Project (MINAP)			
* The value provided each year is an estimate of the data at the time of publication (75% as at April 2012). The process of validation of this data continues during April and May to meet the MINAP submission deadline of 31 May. This is because MINAP recognise that the data from patients treated up to the end of March requires inclusion and subsequently needs to be validated. MINAP published their annual report in November 2012 which, included the fully validated figure of 74% for 2011/12.			
** Interim return, further validation required.			

Part 4

4.1 Response to Partner organisation comments 2011/12

LINk, NHS Sheffield, Trust Governors and the Sheffield Health and Community Care Scrutiny Committee commented in the 2011/12 Quality Report. The following table summarises the Trust's response to those comments.

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

NHS Sheffield (2011/12)

Abridged comments	Our response
We do, however, note that the Trust made mixed progress during 2011/12 on delivering its agreed improvement priorities, and there are therefore some important outstanding issues for 2012/13. These include:	
• **Improving the care of older people:** achieving real progress on nutritional assessment and treatment and continuing to deliver reductions in the number of Grade 2 pressure sores	Nutrition is reported in section 2.1.7. Pressure Ulcers continue to be an area for improvement by the Trust. Overall, the proportion of patients who acquire pressure sores whilst in STHFT beds is 1.77%, we aim to reduce this by 50% during 2013/14.
• **Improving infection control:** achieving a significant reduction in the number of Clostridium Difficile infections, in line with the target set by the Department of Health of 134 cases for 2012/13	Reported in section 2.1.8
• **Reducing cancelled operations:** reversing the increase seen in 2011/12 in the number of planned operations which had to be cancelled for non-clinical reasons	Objective for this years Quality Report Section 2.1.11
• **Improving the patient experience of outpatient care:** ensuring that the Trust Outpatient Transformation Programme delivers real improvements for patients, in terms of environment, waiting times and customer service standards and works with clinical commissioners to ensure the right clinical balance of services between hospital clinics and community settings closer to patients' homes	The Trust has adopted 'Clinical Microsystems' as an approach to transform how services are delivered. This is a multi-disciplinary team approach that engages the people who are actually involved in delivering the service on a day-to-day basis. The approach also puts the patient at the heart of the redesign. Progress has been made in Renal, Cystic-fibrosis, Hearing services, Urology and Diabetic Foot Outpatient services where waiting times have come down by up to 20%. Work has commenced in Ante-natal, Oncology, Immunology and Anti-Coagulation Outpatient clinics. Work in the Anti-Coagulation services has also resulted in joint work with Sheffield Clinical Commissioning Group reviewing how phlebotomy will be delivered across the city in the future. The Trust recognise that it is critical to ensure that blood is taken at a time and place that is convenient for the patient.

Sheffield Local Involvement Network (2011/12)

Abridged comments	Our response
We have been assured that an 'easy read' version will be produced this year to sit alongside the more formal STHFT Quality Account. Sheffield LINk looks forward to receiving the 'easy read' version.	A summary version was incorporated in the 'Making a difference - a summary of quality improvements and priorities', a similar exercise will be repeated this year.
Sheffield LINk requests that STHFT consider how LINk can be provided with a full and complete version to enable comment within the required timescale.	The Trust will provide LINks and subsequently Healthwatch with a publication that includes the best available data at the time of distribution. Unfortunately due to the tight timescales this may not always include final year end figures for some indicators. The Trust recognises this is frustrating to partners when requested to review the Trusts achievements.
Sheffield LINk recommends that information regarding 'the place receiving discharged patients' and 're-admission data' both in the context of older people, be collected and a report made in the next QA.	During engagement meetings with LINks we discussed the challenge of providing discharge destination data, given there was no robust way of ensuring if this was the most appropriate destination for that patient. However the Trust is fully committed to the cross city initiative of Right First Time which aims to ensure that patients are treated in the most appropriate location and which aims to prevent inappropriate admission to hospital. Readmission data is included in Part 3 of the Quality Report.
Sheffield LINk would particularly wish to highlight the 'Productive Ward' and 'Proactive Rounding' as omitted priorities from the STHFT process and emphasise an expectation that work will continue in these areas.	Productive Ward is a series of tools and techniques produced by the NHS Institute for Innovation and Improvement. They are service improvement tools which can be used to try to improve the efficiency of wards and clinical departments. They are one of the tools that the Trust uses to improve efficiency on wards alongside other initiatives such as the Clinical Assurance Toolkit and E-rostering. We have been working with the Productive Ward initiative now for a number of years. The tools and techniques continue to be used by wards and departments across the Trust, alongside other service improvement activity such as the Clinical Microsystems work highlighted above. Care (Proactive) Rounding is being used across all parts of the organisation in a number of ways. Predominantly rounding is delivered on a two hourly basis and paperwork has been developed in areas to act as a prompt and provide further record of cares delivered to patients. Each area has its own guidance on completion depending upon their patient group, their needs and preferred ways of working. The paperwork is based on the NHS Quest Skin bundle. The Trust Record Keeping Group is currently reviewing the paperwork that exists in order to establish a preferred form. A minority of areas have opted for a paperless system but posters advertise to patients and visitors, as well as ward staff, that care rounding is being undertaken.

Abridged comments	Our response
Sheffield LINk requests that regular reports on priorities for improvement be placed on the STHFT website.	The Trust has made some progress towards achieving this objective as Board of Directors meetings are now held in public and monthly papers are published on the Trust website. These include a general update on improvement activity across the Trust. However the Trust recognises there is more work to be undertaken in this area.
Sheffield LINk will look forward to a proportionate but detailed report on Adult Community Services in next year's QA.	Community Services data is included within the performance data provided. This year the Pressure Ulcer improvement objective covers improvement work within the Community alongside Hospital services.
Sheffield LINk is pleased to note that staff received training especially in Dignity and Dementia, but it would give more reassurance if the proportion of staff compared to the total relevant workforce was always used rather than a single number.	This is noted for future reporting of training activity (when required). Training in dignity and dementia continues across the organisation.

Sheffield Health and Community Care Scrutiny Committee (2011/12)

Abridged comments	Our response
The Committee recognises that the Quality Priorities represent only a small part of the work that the Trust undertakes and looks forward to engaging with Trust over the coming year both in monitoring progress on the quality priorities, and on wider issues.	The Trust recognises the significant impact of the Mid-Staffordshire Inquiry Report and looks forward to working collaboratively with Committee members to ensure positive but robust arrangements are in place to enable appropriate scrutiny and oversight.
In particular, the Committee welcomes the work ongoing to understand the reasons for patients being readmitted to hospital. We look forward to seeing improvement on this performance indicator.	The Trust has undertaken work to look at the reasons for readmission, these are varied and a number do not relate to the previous reason for admission. Collaboration with partners across the City is essential to reduce the number of avoidable admissions and therefore the Right First Time initiative continues in collaboration with key partners across the City.
The Committee also recognises the increasingly important role the Trust has as a provider of Community Services and is keen to see greater emphasis on this area of work in future.	Community Services are an integral part of the Trust and bring a rich emphasis on both primary, community and intermediate care services, which has been increasingly valuable to provide a seamless service to our patients and their carers.

Trust Governor Involvement (2011/12)

Abridged comments	Our response
We noted that not all the priorities for 2011-2012 were achieved and confirmed that processes should be in place to follow these up and make sure that work continued on them to effect their achievement.	Priorities not achieved in the 2011/12 report are reported in this 2012/13 Quality Report. Where performance has required further improvement this work will continue.

4.2 Statement from our partners on the Quality Report 2012/13

Statement from NHS Sheffield Clinical Commissioning Group

We have reviewed the information provided by Sheffield Teaching Hospitals NHS Foundation Trust in this report. In so far as we have been able to check the factual details, our view is that the report is materially accurate and gives a fair picture of the Trust's performance.

Sheffield Teaching Hospitals provides a very wide range of general and specialised services, and it is right that all of these services should aspire to make year-on-year improvements in the standards of care they can achieve.

Our view is that Sheffield Teaching Hospitals NHS Foundation Trust provides, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities. The Trust continues to achieve good results in hospital standardised mortality ratios, remaining low relative to national averages, and it has achieved significant reduction in Clostridium Difficile cases this year. Other areas of achievement this year include dementia care and improving feedback from patients and carers via frequent feedback surveys and the introduction of the Friends and Family test in March 2013.

The national surveys of patient experience results remain similar year on year, however the number of questions that were rated as significantly better, compared with other trusts has reduced from previous years.

The trust has unfortunately experienced a number of never events during 12/13, and we are working closely with them to reduce the risk of recurrence.

Nonetheless, we are satisfied that the specific priorities for 2013/14 which the Trust has highlighted in this report - understanding why operations are cancelled, reducing the prevalence of all Grade 2, 3 and 4 pressure ulcers city wide and improving the provision of discharge information for patients - are all appropriate areas to target for continued improvement.

Three of these priorities are worthy of specific comment.

- Cancelling operations at short notice has a significant impact on patients. Understanding the causes of cancellations and more importantly, taking action to address these causes will improve individual patient's experience and will more broadly, contribute to the maintenance of Eighteen Week Waiting times.
- There has been a reduction this year in the overall numbers of patients with pressure sores in the community and an objective to reduce the numbers both in primary and secondary care next year will be welcome. It will be supported by the prevalence data submitted via the NHS Safety Thermometer and enable specific wards or services to be targeted.
- The standardised provision of discharge information will be welcome to clinical commissioners and patients. It will support a more seamless transfer of care between primary and secondary care and it will provide patients and their carers with information on what to expect post discharge.

We do, however, note that the Trust has indicated that it will carry over and/or report on indicators from 2012/13 and 2011/12 in 2013/14. These include:

- Optimising length of stay - achievement of clinically appropriate length of stays in line with national and local benchmarks in key areas
- Improving the care of older people - nutritional assessment - achieve further improvements in the number of patients aged 65 or over screened using MUST and the percentage of patients at risk that receive an appropriate care plan

Submitted by Jane Harriman on behalf of:

Kevin Clifford, Chief Nurse

and

Kate Gleave, Contract Lead STHFT

Sheffield Clinical Commissioning Group

April 29th 2013

Part 4

Commentary from Healthwatch Sheffield on the Sheffield Teaching Hospitals NHS Foundation Trust Quality Accounts 2012-13

These comments are based on the Trust's draft Quality Report 2012/13 version 1.0 dated 29th April 2013 and on meetings with the Trust to discuss the Report throughout the year.

We appreciated the opportunity to work with STHFT throughout the year preparing and debating the Quality Account, but also in the process, to feed our concerns and compliments into the Trust's working practices. From our perspective the process has been invaluable, particularly in understanding the constraints and difficulties in delivering the planned-for outcomes.

Part 1

Page 33. Regarding the reference in the Foreword to the production of a second more accessible version of the Quality Report for patients and the public. Whilst this is welcome it is our understanding that agreement was reached at meetings during the year that this will be more than a summary version incorporated in the 'Making a difference - a summary of quality improvements and priorities' document which has a limited circulation. We would like to see a clearer commitment in the Quality Report to the production and wide circulation of an easier to read summary version.

Page 34. We are pleased to see the statement from the Chief Executive on the importance of the Mid-Staffordshire Public Inquiry Report and the commitment to respond positively to its recommendations.

Part 2

2.1.1 Priorities for Improvement 2012/13

1. Optimise length of stay - Behind Schedule

We acknowledge the difficulty of optimising patients' length of stay in the Trust's hospitals, but we can find no overt commitment to continuing this priority into next year or any mention of how progress on this will be measured. We hope this will continue to be a priority for the Trust in succeeding years until the situation has improved.

2. Discharge letters for GPs - Almost Achieved

We note that the audits show mixed success and wonder whether the reasons for this were explored. We look forward to seeing the results following the introduction of the system of e-discharge summaries and that further local action plans will then be implemented.

3. Giving Patients a Voice - Achieved

We welcome the increased feedback through forms and comments cards. This year's statistics are interesting but it would be helpful to see a comparison with the last two years and with the total number of patients being treated in the Trust's hospitals.

5. Holistic Care to promote a good experience for patients who have dementia, Improve Dementia Awareness - Achieved.

All the reported work in relation to this priority has focused on the built environment, and to a lesser degree on nutritional screening. Whilst this is important we would like to see some work on how the Trust can meet individual patients' needs and to know what measures and processes have been put in place to improve Dementia Awareness in the Trust's hospitals and how this will be kept ongoing, especially in the light of the Francis Report. We shall be interested to read about the progress of the three further up-grades - we consider Vickers 4 ought to also have priority as this ward is specifically focused on the after care of older people following orthopaedic operations.

Page 41, 2.1.8 Reduce hospital acquired infections.

We commend the Trust on a reduction in the number of cases of *C. Difficile* in 2012-13 and hope this will be continued. We would be interested to know what further improvements are under consideration.

2.1.10 Priorities for Improvement in 2013/14

As a general statement we would find it most helpful to see priorities from the earlier years which have not been achieved or only partially achieved, included as on-going priorities in the following year, as well as the measures used to indicate success. For example, it is acknowledged in the Quality Account that Nutritional Assessment will be reported in 2013/14, but it is not in the summative list of priorities.

We are surprised that Accident and Emergency waiting times are not a priority as the Trust has failed to meet the 95% target in 2012-13.

Last year we were clear in our comment that Community Services, part of the Trust's responsibilities, ought to be included in the Quality Account. We appreciate information may not be immediately available in a suitable statistical form, but the Report is not clear on this important and expanding part of its responsibilities. We will look for more evidenced descriptions in next year's QA.

Part 4

Clinical Audit

Page 51. Audit of Insulin Self Administration. We note that 100% compliance can be achieved if bedside lockers are available and we would be interested to know whether there are enough lockers for all patients who are capable of managing the self administration of their insulin?

Page 52. Care Home Support Team: Core Skills training Outcomes. We welcome the training of care home staff through this initiative. It is not clear from the document if the Trust is going to continue to provide a comprehensive Care Home Support Team but we hope the Trust will continue to provide comprehensive Core Skills Training for care home staff, particularly in view of its increasing Community Services provision and responsibilities.

Page 55. (c) Northern General Hospital Mental Health Act Commission visit. By implication there was not full compliance and more detail on this visit report would be helpful.

Page 56. Data Quality. We are surprised that patients' unique NHS numbers are not used in every case / document; this presents a potential for serious confusion.

Page 57. Patient Safety Alerts. Sheffield LINk always asked Trusts to include information on Patient Safety Alerts (PSAs) in Quality Accounts. Therefore we are pleased to see that that all PSAs were completed during 2011-12 and that there are no outstanding alerts for 2012-13.

We would also like to see reported in Quality Accounts information on any Coroners Rule 43 Requests that were received by the Trust in 2012-13 such as the number of Requests received during the year, their subjects, the actions taken and status of the Trust in respect of each.

Page 59. Staff Survey. It is of some concern to us that there are 5 areas of deterioration in the survey results, and in particular that staff having well structured appraisals continues to be low scoring as it was last year. We would like to see reference to plans to address these findings.

Page 60. Patient Surveys and Complaints. We note that one of the identified areas for improvement in the national A&E Survey is the provision of written/printed information. This is an area that HWS would be keen to work with the Trust on to improve these communications.

Page 60. Complaints. We are surprised that numbers of complaints, their nature and actions taken as a result are not reported, which we feel are essential to the Quality Account.

Part 3

Page 62. Mandated Indicators. It would be helpful if the relevant years were repeated at the top of each page as an aide memoire.

Part 4

We commend the Trust for giving detailed responses to comments received from external partner organisations on the 2011-12 Quality Report, which is most helpful.

Notwithstanding all of the above, we felt the on-going relationship during the year to be most positive, productive and helpful, and we wish to commend the Trust and its officers for willingly joining with us in this debate and dialogue.

Mike Smith
Chair, Sheffield LINk (to March 2013)

Pam Enderby
Chair, Healthwatch Sheffield

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

The Healthier Communities and Adult Social Care Scrutiny Committee welcomes the opportunity to comment on the Sheffield Teaching Hospitals NHS Foundation Trust's Quality Account.

We'd like to thank the Trust for taking account of the views, comments and issues raised by the Committee during the Quality Accounts process, and is pleased to see that the Trust has engaged widely with stakeholders, such as the Local Involvement Network, in the development of the final report.

The Committee commends the Trust for the format and presentation of the report - which makes a complicated subject matter clear and easy to understand.

The Committee recognises that the Quality Account is not intended to reflect all of the improvement work which is taking place across the Trust, however suggests that a greater emphasis is placed on reporting progress on previous year's quality objectives. This would help us to build up a picture of how the Trust is progressing over time.

The Committee looks forward to working with the Trust over the coming year, and seeing progress on this year's quality priorities.

Cllr Mick Rooney
Chair

Governor involvement in the Quality Report Steering Group

Five Governors attended the Quality Report Steering Group during the year. We enjoyed our participation in the group and felt heard.

We contributed to deciding the content and the wording of the Quality Report.

Choosing the priorities for the Quality Report was challenging as many were proposed both from within the Trust and by LINk. Those chosen had to be both relevant and meaningful, and also measurable. Outcomes of softer more feeling-centred priorities are more difficult to measure and this may have also limited the choice even though such priorities have as much value.

We felt that the final choices for 2013/14 were a good and representative sample that could give meaningful results and result in real improvements in quality.

We noted that not all the priorities for 2012/13 were achieved and are very clear that processes should be in place to follow these up and to make sure that work continues on them to effect their achievement.

We appreciate the enormous amount of work that goes into the writing of this report and also that the largely prescribed text makes the report more difficult for non-hospital related readers to understand. We look forward to a readable summary version.

Andrew Manasse

17 April 2013

4.3 Statement of Directors' responsibility

Statement of directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to May 2013
  - Papers relating to Quality reported to the Board over the period April 2012 to May 2013
  - Feedback from the commissioners dated 29 April 2013
  - Feedback from Governors dated 17 April 2013
  - Feedback from Local Healthwatch dated 14 May 2013
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22 May 2013
  - The latest national inpatient survey March 2012 and the Accident and Emergency Survey December 2012
  - The latest national staff survey March 2013
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 23 May 2013
  - CQC quality and risk profiles dated March 2012 - March 2013
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
  - the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275).

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

By order of the Board

Chairman

23 May 2013

Chief Executive

23 May 2013

4.4 Independent Auditor's Report to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Sheffield Teaching Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.
- Emergency readmissions within 28 days of discharge from hospital

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to April 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to April 2013;
- Feedback from the Commissioners dated 29 April 2013;
- Feedback from local Healthwatch organisations dated 14 May 2013;
- The Trust's 2012/13 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2012/13;
- The 2012 national inpatient survey dated Feb 2013
- The 2012 accident and emergency department patient survey;
- The 2011/12 cancer patient experience survey dated Aug 2012;
- The 2012/13 national staff survey;
- Care Quality Commission quality and risk profiles dated April 21012 to April 2013;
- The draft Head of Internal Audit's annual opinion over the Trust's control environment dated 25 April 2013 and
- Quality Report Steering Group minutes for the period April 2012 to April 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Sheffield Teaching Hospitals NHS Foundation Trust's quality agenda,

performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sheffield Teaching Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sheffield Teaching Hospitals NHS Foundation Trust

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

KPMG LLP,
Statutory Auditor
1 Neville Street,
Leeds,
LS1 4DW

23 May 2013