Sheffield Teaching Hospitals NHS
NHS Foundation Trust

QUALITY REPORT
2015-16

PROUD
TO MAKE A
DIFFERENCE
SHEFFIELD TEACHING HOSPITALS
NHS FOUNDATION TRUST

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

At Sheffield Teaching Hospitals NHS Foundation Trust we have a strong track record of delivering good clinical outcomes and a high standard of patient experience, both in our hospitals and in the community. However, we are never complacent and continually look to adopt best practice, drive innovation and most importantly learn and improve when we do not meet the high standards we have set for ourselves.

As a consequence, I am pleased to report that Sheffield Teaching Hospitals NHS Foundation Trust has continued to perform very well in 2015/16 and has made good progress against our quality priorities.

The Care Quality Commission inspected our community and acute services in December 2015, which saw more than 100 inspectors visiting our sites over a 10 day period. We are expecting their formal report by summer 2016.

Our drive for improvement is embodied within the Trust's Corporate Strategy 'Making a Difference' which is supported by a Quality Strategy and Governance Framework. The Corporate Strategy outlines five overarching aims:

- Deliver the best clinical outcomes.
- Provide patient centred services.
- Employ caring and cared for staff.
- Spend public money wisely.
- Deliver excellent research, education and innovation.

In summary our priority is to do all we can to continually implement quality improvement initiatives that further enhance the safety, experience and clinical outcomes for all our patients.

Nationally the NHS continues to operate within a very tough financial climate and our Trust is seeing an ongoing increase in demand for services. With the support of our staff and partners we are addressing these challenges by adopting new ways of working, forging partnerships with other health and social care providers and continuing to engage our staff by actively pursuing a culture of innovation and involvement.

Mortality rate is an important clinical quality indicator, and I am pleased to report that we have had a consistently 'lower than expected' or 'as expected' mortality rate for the past few years. This is testament to the skill and care of our teams. During 2015/16 we also continued to review weekend mortality rates.

Our Hospital Standardised Mortality Ratio for both weekday and weekend emergency admissions is also 'within expected range'.

We consider rigorous infection control and clean facilities to be fundamental to our care standards, and so I am pleased to report that this year, once again we met the national standards set for our organisation. We continue to work hard to minimise the chances of patients acquiring other hospital acquired infections, such as Norovirus and MRSA. During 2015/16 we had no cases of MRSA bacteraemia and the number of cases of *C.Difficile* fell to an all time low. We also invested more than £3 million in 17 new isolation rooms at the Hallamshire Hospital to help safely care for some of our most vulnerable patients, who have conditions such as myeloma and other cancers.

We have become one of the first NHS Trusts to join the Sign Up To Safety patient safety campaign. It is one of a set of national initiatives to help the NHS continually improve the safety of patient care. Collectively and cumulatively these initiatives aim to reduce avoidable harm by 50% and support the ambition to save 6,000 lives across the UK.

Safety, quality of services and sustainability is also a key aim of the Working Together Partnership, which brings together seven NHS trusts in our region to collectively make improvements. One of the Working Together projects now means that vital patient reports and tests are able to be shared quickly and securely across the seven trusts. This development will benefit millions of patients each year by enabling specialists to securely access test results that have been carried out in neighbouring hospitals, reducing the need for costly re-tests and ensuring quicker decision making about treatment.

Thanks to the fantastic efforts of Sheffield Hospitals Charity and our local communities a new helipad is being built at the Northern General Hospital, which will mean trauma patients get the emergency care they need even quicker.

Other priority areas include ensuring waiting times are kept as low as possible as this is one of the things our patients tell us is important to them. We want to make sure our waiting times processes and procedures are robust and enable our patients to receive swift and appropriate treatment. The average waiting time for care at the Trust is eight weeks or less and the majority of cancer treatment waiting time standards are consistently met.

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

It was exceptionally pleasing that national and local survey results during 2015/16 consistently showed that the majority of our patients and staff would recommend the Trust as a place to receive care and to work. Indeed we were named as one of the top 100 places to work in the NHS and our staff won a record number of quality and safety awards throughout the year. The Friends and Family Test for patients and staff is a valuable insight into where our future focus needs to be.

The integration of hospital, community and social care services continued at pace throughout 2015/16 to ensure our patients receive timely, seamless care and that wherever possible individuals are supported to live independently at home rather than be hospitalised. The Discharge to Assess process developed by our teams was highlighted as an exemplar by the Commission on Improving Urgent Care for Older People in their report – 'Growing old together: Sharing new ways to support older people.' Patients who no longer need hospital care are now assessed in their own home for their ongoing health and social care needs rather than in the less familiar hospital environment. During 2015/16 this resulted in over 9,000 older patients being discharged home in an average of 1.1 days from being medically fit compared with 5.5 days three years ago. Patient feedback has been very positive with more patients able to remain independent in their home, and 30,000 hospital bed days have been released for those patients who do require acute hospital care.

To further support this drive to work differently right across the Trust we introduced a new Patient Administration System and Electronic Document Management System as part of a five year Transformation Through Technology programme. This will provide the opportunity to change the way we deliver care both within the hospital and also in people's own homes and communities. This five year programme will also enable the organisation to become paper light and support the work underway to develop integrated care teams and new models of care.

Further information about this and other developments during 2015/16 can also be found in the Annual Report and on our website: www.sth.nhs.uk/news.

Of course none of these improvements are possible without the fantastic support of everyone who works for the Trust and our amazing volunteers and charities whose dedication and commitment is a source of great strength for the Trust. During the last 12 months we have continued to encourage more of our staff to be actively engaged and involved in decisions, setting the future direction of the organisation and innovations. We are committed to continuing this important work during 2015/16 because we believe our staff are key to the delivery of excellent patient care.

We feel it is very important that we value everyone who works in the organisation and the efforts they go to every day to make a difference to our patients. Thanks to the support of Sheffield Hospitals Charity we introduced the 'Little Thank You' e-card system during the year, enabling individuals and teams to be sent an electronic thank you card by their managers or fellow colleagues. This is just one way we can encourage and recognise the excellent work undertaken by every one of our 16,000 staff.

There is no doubt that in 2016/17, the environment in which we work will continue to be challenging, but I am confident that by fostering our culture of learning and continual improvement we will provide our patients with the safe, high quality care and experience they deserve.

The following pages give further detail about our progress against previous objectives and outline our key priorities for the coming year. To the best of my knowledge the information contained in this quality report is accurate.

Sir Andrew Cash OBE
Chief Executive

18 May 2016

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 2015/16. Whilst it is impossible to include information about every service the Trust provides in this type of document, it is nevertheless our hope that the report goes some way to reassure our patients and the public of our commitment to deliver safe, effective and high quality care.

The Quality Report Steering Group oversees the production of the Quality Report. The membership includes Trust managers, clinicians, Trust Governors, and a representative from Healthwatch Sheffield. The remit of the steering group is to decide on the content of the Quality Report and identify the Trust's quality improvement priorities whilst ensuring it meets the regulatory standards set out by the Department of Health and Monitor, the Independent Regulator for Foundation Trusts.

As a Trust we have consulted widely on which quality improvement priorities we should adopt for 2016/17. As with previous Quality Reports, the quality improvement priorities have been developed in collaboration with representatives from NHS Sheffield Clinical Commissioning Group (CCG), Healthwatch Sheffield and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

In developing this year's Quality Report we have taken into account the comments and opinions of internal and external parties on the 2014/15 Report. The proposed quality improvement priorities for 2016/17 were agreed by the Healthcare Governance Committee, on behalf of the Trust's Board of Directors, on 25 April 2016. The final draft of the Quality Report was sent to external partner organisations for comments in April 2016 in readiness for the publishing deadline of the 28 May 2016.

Dr David Throssell
Medical Director

2.1 PRIORITIES FOR IMPROVEMENT 2015/16

Our 2015/16 priorities are summarised below and explained further in this section.

To improve how complaints are managed and learned from within Sheffield Teaching Hospitals NHS Foundation Trust.	▲ Achieved
To improve staff engagement by using the tools and principles of Listening into Action (LiA).	〓 Almost achieved
To improve the safety and quality of care provided by the Trust in all settings with the aim of reducing preventable harm and improving quality.	〓 Almost achieved

2.1.1 To improve how complaints are managed and learned from within Sheffield Teaching Hospitals NHS Foundation Trust

Over the past three years a number of objectives have been highlighted to improve the complaints process within the Trust. Building on the work undertaken in 2014/15 the Trust has taken steps in 2015/16 to monitor and improve complainants' satisfaction.

Seeking the views of how complainants have found the complaints process through undertaking surveys and audits continues. From April 2014, the Trust, along with 22 other trusts, participated in the Patients Association Complainant Satisfaction Survey. All complainants whose complaint was considered to be closed were invited to participate in the survey. At the end of September 2015 the Patients Association had received 2,603 responses to the survey, 394 for the Trust.

The table below shows the comparison of the four key performance indicators (KPI) which were identified as baseline figures between the Trust and other participating trusts, and compares the data reported in the last Quality Report.

During 2014/15, 13 complainants took part in in-depth interviews regarding their experience of the complaints process. Their views and feedback were central to improving the process. These included actions to significantly improve response times, a comprehensive suite of complaints training modules for all staff and improvements to the complaints information we routinely collect and report (e.g. the introduction of 'reopened' complaint rates to the quarterly reports). We have committed to repeating the interviews annually and the 2015 interviews are nearing completion.

	APRIL 2014 - JAN 2015		FEB-SEPT 2015
Key performance indicators	**All participating trusts**	**STH**	**STH**
Number of responses	**1010**	**164**	**230**
1. Percentage of respondents who feel their complaint against the Trust has been resolved	50%	48%	54%
2. Percentage of respondents who feel their complaint was handled 'very well'	9%	8%	10%
3. Percentage of respondents who feel their complaint was dealt with 'quickly enough'	29%	36%	40%
4. Percentage of respondents who were 'very satisfied' with the final response	7%	8%	6%

Following national reports and recommendations for complaints handling, the Trust carried out the above-mentioned review of our complaints service. Alongside this, a detailed process- mapping exercise was carried out identifying areas of duplication and inefficiency. The complaints team were able to gain a good insight into how and where the current complaints process needed improvement. This information has been used to make improvements and create a more streamlined and user friendly process. This new process has been piloted within the General Surgery and Urology Directorates from May – October 2015. The main changes to the process are:

- More choice to the complainant on how they would like their complaint handled including offering meetings where appropriate.
- Improved communication with the complainant throughout the process, including an acknowledgement call within three days and keeping them up to date with any delays.
- Structured email sent to staff involved with the investigation to aid a more timely and accurate response.
- Escalation process for when responses from staff are not received on time.

The complaints team now undertake daily monitoring of monthly complaints caseloads with the aim of responding to 85% complaints within 25 working days.

A comprehensive programme of training has been developed to support the new approach to complaints. All training has been underpinned by an ethos of welcoming and acting on feedback. Training includes responding to issues 'on-the-spot', undertaking resolution focussed complaint investigations and producing high quality, evidence based responses.

The new complaints training programme has been running in the Trust since September 2015 and has had 232 attendances across the different courses available.

Attending the training has enabled staff to feel more confident in dealing with complaints and incidents on the spot. Overall 96 % of attendees would be likely or extremely likely to recommend the training. Further training is planned for 2016/17.

2.1.2 To improve staff engagement by using the tools and principles of Listening into Action

Listening into Action (LiA) was introduced in the Trust in the autumn of 2014 as a way of bringing about changes to make a positive impact for patients and for staff through high engagement strategies. The aim was to enable staff engagement in the collective effort of making improvements.

A steering group was established, chaired by the Chief Executive. This group meets monthly to evaluate the progress of LiA and its impact on the Trust.

There are eight key steps to the LiA process:

- Establish key stakeholders.
- Identify a mission.
- Establish a sponsor group.
- Make a powerful case for change.
- Get people on board.
- Hold a Big Conversation with staff, patients and stakeholders.
- Keep people involved and informed.

Since the launch of LiA there have been 40 schemes delivered by 26 teams. Each scheme has had the commitment and involvement of the Operations Directors, Nurse Directors and Clinical Directors. Schemes have been undertaken in 25 Directorates and across all Care Groups with a total of 2,500 staff being involved. The schemes include improving communication in Spinal Services and Patient Transport, improving signage in the Renal Unit and increasing discharges before lunch.

An event is held at the beginning of each phase of the LiA process to launch the schemes. There is a Compass Check Event halfway through the phase to ensure schemes are on track and a Pass it On Event at the end of the phase to share results and best practice.

Alongside the schemes there have also been 83 Big Conversations with staff across the organisation to engage all staff in the process.

The impact of LiA is currently being measured in a number of ways. Each scheme develops targets and desired outcomes at the start and these are revisited at the end of the scheme.

Examples of outcomes include:

- Reducing the number of patient-cancelled operations to 1.5 per week which has the potential to release £78,000 back into the Trust. The pilot informed the basis of a business case for the pilot which has now been agreed by the Trust Executive Group.
- Cardiology focussed on dispensing for discharge and the team have been trialling the use of pre-labelled discharge medication packs. This will reduce length of stay and increase patient flow.

2.1 PRIORITIES FOR IMPROVEMENT 2015/16

- A transport scheme has enabled the Trust to decrease the length of time it takes for GP assessed patients to be transferred and assessed in hospital. A significant number of patients are now managed within a two hour timeframe.

At every event we hold we ask staff for feedback on how motivated the session has made them feel in connection with LiA. Chart 1 shows accumulated data from teams who attended Launch, Compass Check and Pass it On events since LiA's introduction. A total of 384 respondents, equating to 1,152 responses, replied to the following three questions:

- How would you rate today's events?
- Do you feel that today has been a good use of your time?
- Do you feel that the LiA way will help us to improve patient care and how we work together?

The impact of LiA is also measured by a Pulse Check. This consists of 15 questions focussing on how staff feel they are supported to do their job, which link to the key areas of the staff survey. It is simple and quick to complete and administer. This was done at the start of the journey as a baseline across the Trust and then again in August 2015 with all the staff involved with LiA. To date 3,300 people have completed a Pulse Check.

Results in the Chart 2 show the scores benchmarked against the average score for all other trusts that have adopted LiA. This shows overwhelmingly that people who get involved in LiA feel better led, more involved, motivated and positive about their work and the Trust.

At the start of the LiA process in December 2014 a Journey Scorecard was undertaken. This is a list of 20 questions targeted at how leaders of the organisation feel they are able to create the right conditions for improvement and engagement. Overall the results showed a neutral response. A decision on when to revisit the Journey Scorecard is currently being discussed and agreed at the steering group.

Chart 1

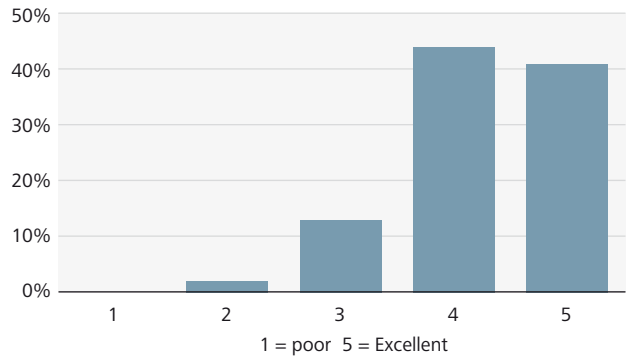
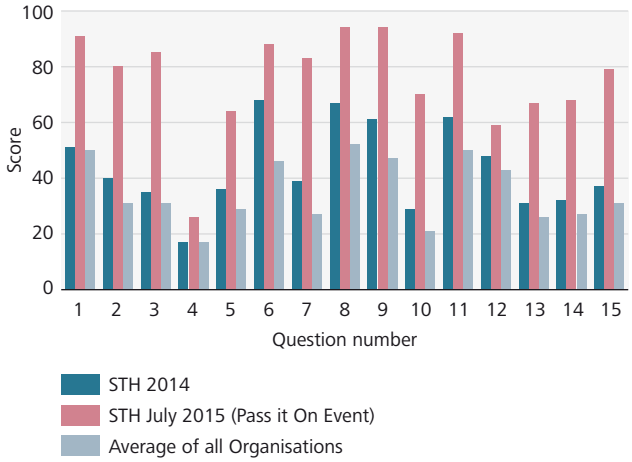


Chart 2



Questions	
Q1	I feel happy and supported working in my team/department/service
Q2	Our organisational culture encourages me to contribute to changes that affect my team/department/service
Q3	Managers and leaders seek my views about how we can improve our services
Q4	Day to day issues and frustrations that get in our way are quickly identified and resolved
Q5	I feel that our organisation communicates clearly with staff about its priorities and goals
Q6	I believe we are providing high quality services to our patients
Q7	I feel valued for the contribution I make and the work I do
Q8	I would recommend our Trust to my family and friends
Q9	I understand how my role contributes to the wider organisational vision
Q10	Communications between senior management and staff is effective
Q11	I feel that the quality and safety of patient care is our organisation's top priority
Q12	I feel able to prioritise patient care over other work
Q13	Our organisational structures and processes support and enable me to do my job well
Q14	Our work environment, facilities and systems enable me to do my job well
Q15	This organisation supports me to develop and grow in my role

2.1.3 To improve the safety and quality of care provided by the Trust in all settings with the aim of reducing preventable harm and improving quality

In July 2014 the Trust committed to the three year 'Sign up to Safety Campaign'. The Trust's overall aim is to further improve the reliability and responsiveness of care given to patients to achieve a 50% reduction in harm supported by the following five goals:

1. Cultural change that ensures that patient safety will be embedded within all aspects of clinical care.
2. Improved recognition and timely management of deteriorating patients leading to improved care.
3. Improved recognition and management of patients presenting with, or developing, Red Flag Sepsis and Acute Kidney Injury (AKI).
4. Absolute reduction in the cardiac arrest rate.
5. Improved communication through the introduction of structured processes to improve the transfer of time-critical patient information.

1. Cultural change that ensures that patient safety will be embedded within all aspects of clinical care

As part of working towards achieving this goal during 2015/16 the Trust introduced an Inpatient Patient Safety Briefing on all bedside televisions. This briefing aims to empower and engage patients regarding their own safety whilst in hospital giving them information on the risks of falls, DVTs and the importance of raising any allergies they may have.

In partnership with external providers the Trust has also introduced bespoke training packages in human factors awareness. These have included an introduction to Human Factors, providing staff with the skills to undertake simulation exercises and to improve the investigation and learning from serious incidents. During 2015/16 there have been 12 cohorts of training, resulting in 150 members of staff being training in Human Factors. These staff are now able to plan and implement simulation training within the Trust. Other, in-house, Human Factors training sessions have been delivered to date approximately 400 nurses and 800 junior doctors throughout 2015/16.

The Trust also delivered Microsystems Coaching to 27 staff during 2015/16. This training will continue in 2016/17.

In 2016/17 the Trust aims to undertake and analyse a safety culture survey to better understand the issues faced by employees.

2. Improved recognition and timely management of deteriorating patients leading to improved care

To improve the recognition of deteriorating patients the Sheffield Hospitals Early Warning Score (SHEWS) and subsequent escalation plan were revised in 2015/16. This has increased the sensitivity of the protocol, resulting in patients being escalated sooner which leads to improved care.

The acutely deteriorating patient pathway has been implemented across all inpatient areas during 2015/16, leading to consistency in documentation and escalation across all wards and directorates. The use of this pathway will be audited in 2016/17.

The Trust is currently considering an electronic solution to improve the accuracy and completeness of recording clinical observations. This work will continue in 2016.

3. Improved recognition and management of patients presenting with or developing Red Flag Sepsis and Acute Kidney Injury (AKI)

Care bundles for Red Flag Sepsis and AKI have been developed and implemented during 2015/16. The AKI bundle is currently supported by a team which provides in situ expert advice and training. They have been supported by developments to the current Laboratory Information Management System which has enabled prompts to be provided to clinicians and nursing staff highlighting 'at risk' patients. This has enabled timely interventions to be implemented. Compliance with the new care bundles will be audited in 2016/17. As part of this associated critical care utilisation will be reviewed.

The Emergency Department have introduced a care bundle based on the sepsis pathway. Four audits have taken place with each one demonstrating improvements in the speed of administering antibiotics. Throughout 2016/17 further work will be undertaken within the Emergency Department. This practice will be rolled out to other areas.

The key aim for 2016/17 is the development of an easily accessible 'at risk' patient dashboard to support the appropriate escalation of patients. This will be available throughout the Trust for use at handover.

4. Absolute reduction in the cardiac arrest rate.

The Trust continues to deliver a Patient Safety Collaborative focusing on improving the management of deteriorating patients and the reduction of cardiac arrests. The project to reduce the absolute numbers of preventable cardiac arrests has been multi-faceted and results have shown that there has been a reduction in the rate by 28%. Whilst these results are positive the Trust will ensure that further focussed work continues to maintain this reduction and reduce the cardiac arrest rate further. Audits continue to improve compliance across the Trust with DNACPR throughout 2016/17.

5. Improved communication through the introduction of structured processes to improve the transfer of time critical patient information.

The Trust has gained international recognition following the development of the 'Patient Safety Zone' concept. This ensures that the correct checks are made with patients prior to the delivery of care. It is difficult to identify the scale of the problem but it is known that incidents come from all areas of the Trust with the significant majority being classed as near misses or no harm events. The 'Patient Safety Zone' is a quality objective for 2016/17.

'Safety Huddles', small meetings focussed on patient safety, have been trialled on a small number of wards to ensure that any immediate safety concerns are shared amongst the ward staff. Some wards have focussed on specific issues, such as pressure ulcers and falls. This is currently being evaluated and the results from the individual wards will be analysed and the findings shared to encourage other areas to develop similar focussed brief meetings. This will ultimately ensure that patient safety is at the forefront in every clinical handover.

2.2 PRIORITIES FOR IMPROVEMENT 2014/15

2.2.1 To ensure every hospital inpatient knows the name of the consultant responsible for their care during their inpatient stay and the name of the nurse responsible for their care at that time.

A recommendation from the Mid Staffordshire NHS Foundation Trust Public Inquiry report and the Government's formal response Hard Truths was that every hospital inpatient should have the name of their consultant and the nurse responsible for their care displayed.

The Trust introduced Named Nurse/Named Consultant boards at the bedside across the hospital to meet this recommendation.

The launch of these boards took place in July 2015, with a mix of tent boards and wall mounted boards being distributed across the Trust. The type of board used is dependent on the different locations and patients' needs.

The tent boards have space on the back for staff to write "what matters most to me today". Staff are encouraged to ask the patient if there is anything in particular that they are worried about or anything that needs addressing. With the patient's consent, this is written down on the back of the board as a prompt to enable any relevant member of the multidisciplinary team to address the issue with the patient.

The use of the tent boards was evaluated in Emergency Services during February 2016. Hospital volunteers and a patient governor assisted in gaining feedback from both patients and staff to evaluate and monitor their effectiveness. Overall ward staff and patients felt positive about the boards, stating that they provide vital information. The evaluation found that on occasion the information documented is incomplete. To improve this, further education is planned for 2016/17, which will be followed by a Trust wide evaluation.

2.2.2 To review mortality rates at the weekend and to focus improvement activity where necessary

The Trust has continued to review mortality by day of the week during 2015/16. Findings show that our Hospital Standardised Mortality Ratio for all admissions for each day of the week, including Saturdays and Sundays, is 'as expected' when compared to the national average.

Whilst the true extent of the 'weekend effect' has not been clearly demonstrated we do know that staffing levels on the weekend are lower than those found on week days.

To see what effect this is having and to allow us to identify areas for improvement we have conducted a case note review on 80 patients using the structured process developed by Professor Allen Hutchinson.

We have undertaken this in conjunction with the Improvement Academy which is part of the Yorkshire and Humber Academic Health Science Network.

We are working with the Improvement Academy to develop an online training tool which will allow more members of staff to be trained in the structured case note review process.

Along with reviewing case notes we have also been given access to the Sheffield Coroner's records of narrative verdicts between 2014 and 2015. This data has now been collected and transcribed into a digital format and analysis is underway to see how this ties in with the findings from the case note review. Looking at the themes that develop from both of these approaches will allow the Trust to identify further areas for improvement.

2.2.3 To review the impact of waiting times on the patient experience (specifically patients waiting over 18 weeks for treatment)

The national 18-week wait target specifies that the length of time between the patient's first referral and their treatment should be no longer than 18 weeks.

During 2015/16 the possibility of creating local contact centres to facilitate communication improvements was reviewed, however at present there is no capacity with the Trust's current technology to add additional contact centres. Therefore the Trust is working on a business case to expand this which will be considered by our Capital Investment Team in April 2016. Rather than set up multiple local contact centres the business case proposes that two contact centres should be established, one at each campus.

Following reviewing the impact of waiting times on the patient experience in 2014, a survey has been developed which will be sent out to patients who have had to wait over 18 weeks for their treatment. This survey will be sent out annually and patients will be given the option to complete the survey online or by return of post. The first survey is due to be conducted in April 2016. The survey has the same five questions as asked in the initial review with the opportunity to provide more information for each question.

- Has your mobility deteriorated whilst you have been waiting for your appointment/operation/procedure?
- Has your ability to care for yourself deteriorated whilst you have been waiting for your appointment/operation/procedure?
- Has your ability to perform your usual activities deteriorated whilst you have been waiting for your appointment/operation/procedure?
- Has your pain or discomfort increased whilst you have been waiting for your appointment/operation/procedure?
- Have you become more anxious and or depressed whilst you have been waiting for your appointment/operation/procedure?

Once the results are available they will be reviewed against the baseline data and actions to improve practice will be drawn up as necessary.

2.3 PRIORITIES FOR IMPROVEMENT 2013/14

2.3.1 Cancelled Operations

In 2015/16 the on-day cancellation rate for elective surgery has dropped to around 6%. Although we are still short of our target to reduce this figure to 4%, the percentage of cancellations is decreasing year on year. Some on-day cancellations are unavoidable (e.g. patients presenting with unknown infection, or having transport issues on the day of surgery), but work has shown that even accepting these, a rate of 4% is achievable and would represent good practice.

Year	Cancelled operations for clinical and non-clinical reasons	Total planned operations	% on day cancellation rate
2012/13	2,394	34,364	7%
2013/14	2,392	35,762	6.7%
2014/15	2,420	36,274	6.6%
2015/16	2,235	35,723	6.2%

Data source: ORMIS Theatre System

The main reasons for cancelled operations during 2015/16 were:

- **Patient unfit** - patients arriving with an infection, or having results of standard tests outside of expected ranges (e.g. high blood pressure).
- **Patient did not attend** - the patient did not arrive for the scheduled appointment.
- **Operation not required** - symptoms that have improved or disappeared.
- **Lack of theatre time** - previous cases on the list taking longer than expected; changes to the order of a list resulting in (or as a result of) delays.

These reasons contribute to around 60% of all cancellations and further analysis has indicated that the highest rates of on-day cancellations occur in low complexity day case procedures. Throughout 2015/16 work has taken place to help improve the on-day cancellation rate focussing on the main reasons highlighted above and day case patients.

There has been a Listening into Action (LiA) scheme for cancelled operations, this has focussed on preventing Do Not Attends (DNA) and cancelled operations relating to patients being unfit on the day of surgery. The work has shown that a nurse calling patients four days before the planned admission to check they are fit, willing, ready and able to attend, has been effective in reducing the cancellations and DNAs in some day case patients. This process is supported by a text message reminder and the LiA team are working to implement the process to all elective specialties.

Weekly production control meetings take place between Theatre Lead Practitioners and Directorate teams. These meetings are an opportunity to review the forthcoming operating lists and discuss staffing, equipment requirements or other issues, and resolve these in advance of the list taking place. As part of the weekly production control meetings, cancellations are reviewed and teams are working on understanding the root cause of the problem and testing solutions to prevent future recurrence.

Work in these three areas will continue throughout 2016/17, with the support of the Surgical Flow Programme.

2.3.2 Pressure Ulcers

Further work within the Tissue Viability Service is progressing to reduce the prevalence of pressure ulcers to 5%. The target of 5% was agreed as part of the CQUIN negotiation for 2013/14. This work includes the identification of patients at risk of developing a pressure ulcer, early intervention by the Pressure Ulcer Prevention Team and targeted work with clinical areas.

As shown in the table below the overall proportion of pressure ulcers has increased to 6.8% during 2015/16 however the proportion of pressure ulcers acquired whilst receiving care from the Trust remains constant at 1.8%. The proportion with pressure ulcers prior to receiving care from the Trust (Inherited) has increased again this year to 5.0%. It is not clear why there has been an increase in inherited pressure ulcers, and whether this is a genuine increase in incidence or is related to greater staff awareness gained through education and improved accuracy of pressure ulcer incident reporting.

2.3 PRIORITIES FOR IMPROVEMENT 2013/14

Monthly survey data for the period	2012/13 Oct 12 – Mar 13	2013/14 Oct 13 - Mar 14	2014/15 Oct 14 – Mar 15	2015/16 Oct 14 – Mar 15
Proportion with pressure ulcers acquired whilst receiving care from the Trust	1.8%	1.4%	1.8%	1.8%
Proportion with pressure ulcers prior to receiving care from the Trust (Inherited)	4.2%	4.3%	4.4%	5.0%
Overall proportion	6.0%	5.7%	6.2%	6.8%

Data source: ORMIS Theatre System

Since the launch of the 'Time 2 Turn' pressure ulcer awareness campaign in November 2014 the community and acute Tissue Viability Teams have continued to deliver both bespoke local training and Trust wide education on pressure ulcer prevention and management.

Both teams have made progress with the development of a Trust wide Pressure Ulcer Prevention and Management Policy and initiated smaller projects in the light of pressure ulcer related trends throughout the year, for example, management of moisture lesions, heel pressure ulcers and device related pressure damage.

A clear process has been established in both the acute and community settings for the investigation of serious pressure ulcer development. Actions identified as part of an individual investigation or trend in pressure ulcers are then implemented at either Directorate or Trust wide level via the Pressure Ulcer Prevention and Management Steering Group.

The acute team remain actively involved in the Total Bed Management project, which will see the Trust replace all existing beds over the next five years. The team have provided expert advice to inform the project, including outlining the specific requirements for beds and mattresses for patients to promote comfort and to reduce the incidence of pressure ulcers.

Reducing pressure ulcers will remain a priority for the Trust during 2016/17. Further educational programmes are planned for 2016/17. This includes education on the recently introduced 'React to Red' campaign to raise awareness of Grade 1 (early stage) pressure damage to prevent deterioration to Grade 2. Link Champion roles for tissue viability are to be developed in both the acute and community services teams. This will be evaluated to review its impact.

As part of the new electronic patient record Lorenzo, tissue viability records and ward whiteboard referral systems will be developed to support early ward referrals.

Educational aids for the Trust tissue viability intranet page will be developed to support nurses with pressure ulcer grading, distinguishing between pressure and moisture, anatomical sites, process for reporting and investigating pressure ulcers and risk assessment.

2.3.3 Improve discharge information for patients

During 2015/16 work on improving discharge information for patients has been completed. All 1,722 leaflets have been checked to ensure that details about what danger signs to look out for and who to contact if necessary are included. The checking of leaflets is now an ongoing process as all leaflets are checked as part of a two year rolling programme.

New or revised leaflets continue to be automatically uploaded to the Trust website each day ensuring patients can access the most up to date resources for their condition.

2.4 PRIORITIES FOR IMPROVEMENT 2012/13

2.4.1 Optimise Length of Stay

To improve the overall length of stay, weekly admission, discharge and ward based length of stay information continues to be routinely sent to Nurse Directors and Operations Directors. This information is cascaded to teams for action and improvement. Significant work has been completed to understand the current situation and progress at specialty level.

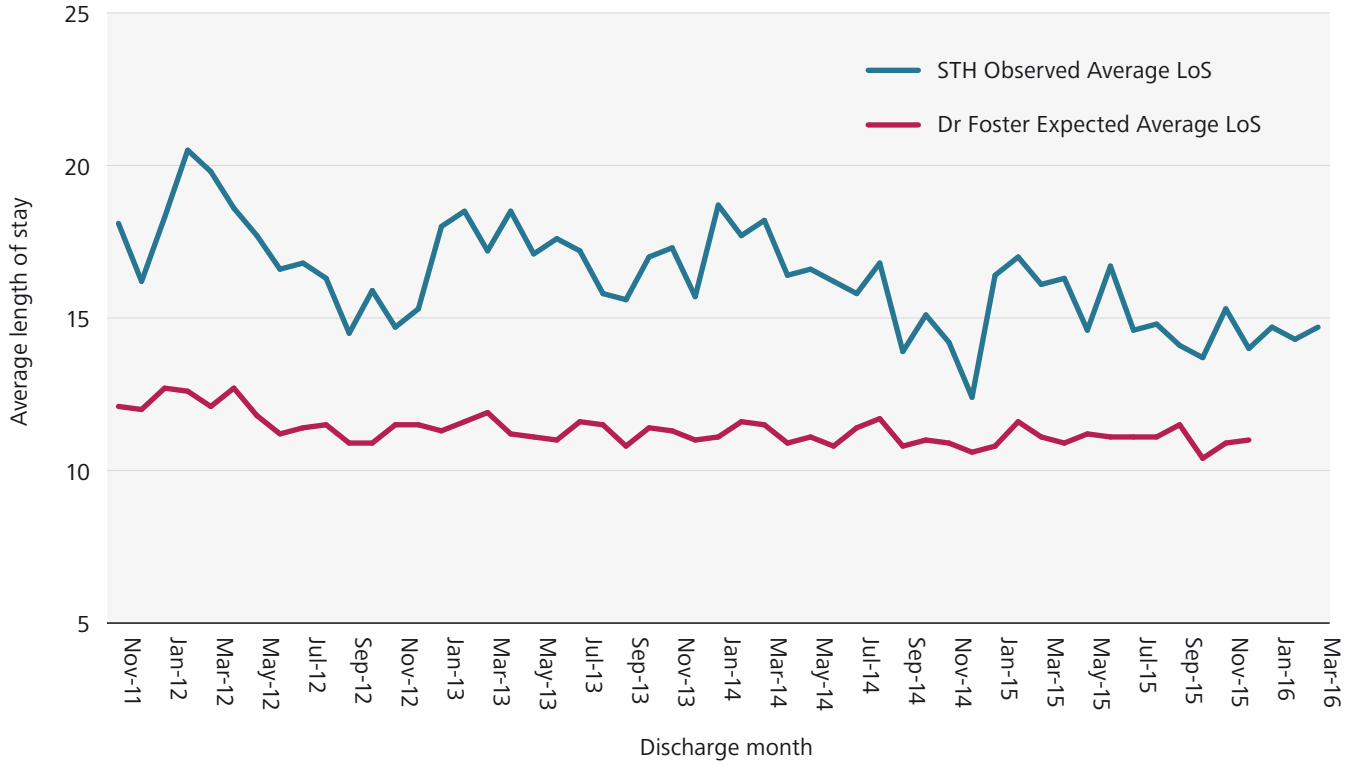
Analysis has been repeated for each specialty to track performance against Dr Foster data for case-mix adjusted length of stay. The underlying performance has been analysed on a time series basis for each specialty to show overall trend against expected average length of stay. Length of stay at diagnosis or procedure level is also shown, with opportunities for greater ambulatory pathway working. 50% of the potential bed gains are in Geriatric Medicine, Respiratory Medicine and Diabetic Medicine. Geriatric Medicine bed night potential gains have reduced by 18% since last year.

Other work the Trust has undertaken to continue to reduce the overall length of stay includes:

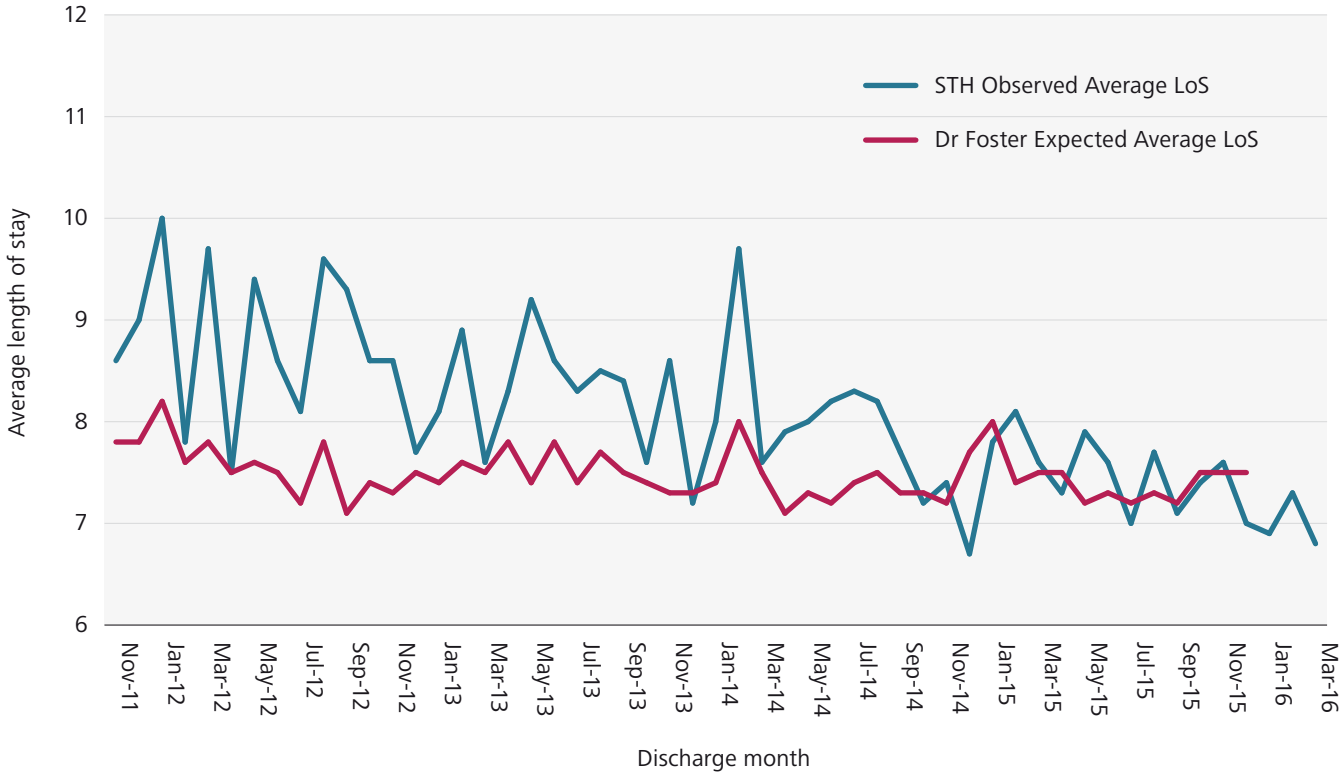
- Spreading good practice process improvement learning from the Respiratory Change Room microsystem and the Elderly Care Big Room. These are weekly multi-agency and multidisciplinary service improvement meetings.
- Tackling the issue of unnecessary hospital admissions by developing a comprehensive diagnostic tool to support directorates to identify opportunities for ambulatory care pathways.
- An Emergency Care Pathway Review has led to the implementation of 16 recommendations including development of a medical ambulatory assessment area and development of the Trust's SAFER Care Bundle.

At a strategic level, the Trust works with partners, as part of the Right First Time City Wide Health and Social Care Partnership, to improve patient flow across the health economy. The integration of Community Services, Professional Services, Palliative Care and Geriatric and Stroke Medicine Directorates into a single care group has enabled the development of a Care Group transformation plan to help develop seamless pathways for older people thereby supporting efforts to reduce hospital length of stay.

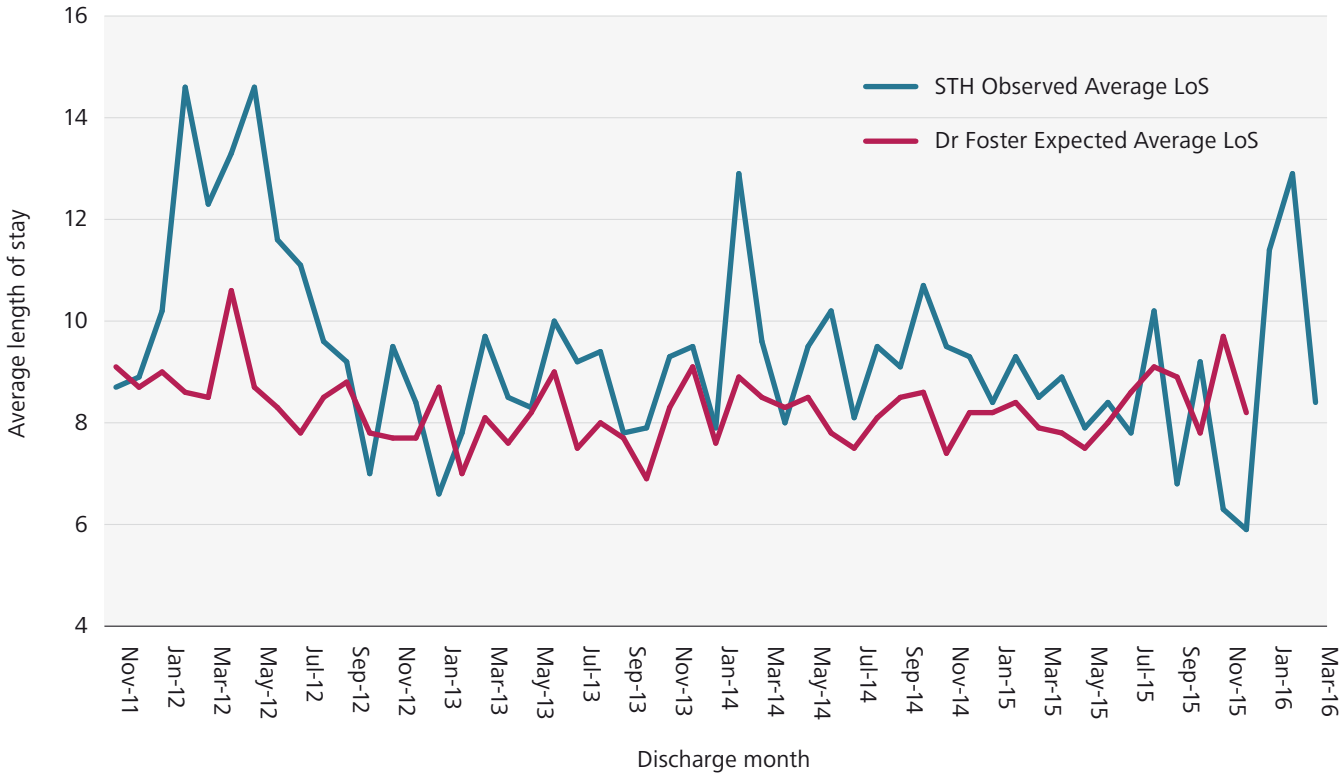
Non elective observed vs expected average Length of Stay
Geriatric and Stroke Medicine



Non elective observed vs expected average Length of Stay
Respiratory Medicine



Non elective observed vs expected average Length of Stay
Diabetic Medicine



2.5 PRIORITIES FOR IMPROVEMENT 2016/17

This section describes the Quality Improvement Priorities that have been adopted for 2015/16. These have been agreed by the Quality Report Steering Group in conjunction with patients, clinicians, Governors, Healthwatch and NHS Sheffield CCG. These were approved by the Healthcare Governance Committee, on behalf of the Trust's Board of Directors, on 21 April 2016.

The Trust has considered hospital and community service priorities for the coming year choosing three areas to focus on which span the domains of patient safety, clinical effectiveness and patient experience.

Priorities for 2016/17 are:

- To further improve the safety and quality of care provided to our patients by emphasising the importance of staff introducing themselves and checking the patient's identity against documentation.
- To further improve End of Life Care.
- To further improve the environment at Weston Park Hospital.

2.6 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2016/17

Priority 1

Our Aim	To further improve the safety and quality of care provided to our patients by emphasising the importance of staff introducing themselves and checking the patient's identity against documentation.
Past Performance	Nationally many trusts have adopted the campaign 'Hello my name is….' which addresses the issue of clear introductions but not the correct identification of patients. The Trust aims to combine consistent application of effective introductions to patients and correct identification of patients. It is difficult to quantify the exact number of incidents where this has been a factor but we are aware that it is in issue where we can improve.
Key Objectives	This project aims to reinforce with staff the importance of introductions and patient identification. We have piloted the project, 'Patient Safety Zone, in the Renal Unit at the Northern General Hospital site and have started work on Brearley 7. The project team do not intend to script how staff should interact with patients but aim to emphasise what the core minimum standards for introduction and patient identification are. The introduction should allow a patient to identify the member of staff later should they need to and should enable the patient to be clear on their role. Patient identification should be actively sought, requesting the patient to state their name and date of birth rather than offering a name and date of birth and asking if it is correct. Where a patient cannot reliably do this, the member of staff must check the patient's wrist band. The name and date of birth given or the details on the wrist band must be checked against documentation at the patient bed side to confirm they have the correct patient. Our current goal is to achieve compliance on the Renal Unit by early 2016 and to replicate this on Brearley 7 by mid-2016. Compliance is defined as staff introducing themselves 90% of the time, positive patient ID 100% of the time and 95% of staff patient interactions not being interrupted. The standard for patient ID is the one set out in the Trust patient identification policy. We are monitoring compliance via weekly audits done by the staff on the renal wards. After this we intend to roll the project out Trust wide, the LiA team are going to support us as we expand. This early testing period enables the development of effective implementation processes to ensure appropriate Trust wide application.
Measurement and Reporting	Results are reported to the central team weekly and this project is also monitored as part of the Trust'S LiA process. Final outcome data and improvements will be reported in the 2016/17 Quality Report.
Board Sponsor	**Dr David Throssell** Medical Director
Implementation Lead	Implementation Team: **Sandi Carman** – Head of Patient & Healthcare Governance (Lead) **Andy Ward** – Haematology Laboratory Manager **Julia Hanvere** – Matron **David Oskiera** – ST3 **Christine Cafferty** – Clinical Effectiveness Facilitator **Richard Clark** – Clinical Skills Teacher **Sharon Baker** – Blood Tracking Implementation Manager

2.6 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2016/17

Priority 2

Our Aim	To further improve End of Life Care
Past Performance	Over the past 18 months there has been a significant change in the way end of life care is delivered in hospitals. National this has included the removal of the Liverpool Care Pathway, and the Sheffield End of Life Care Pathway (EOLCP) locally, in line with Department of Health policy following the Neuberger Review (More Care, Less Pathway). Following this the Trust developed new local guidance (21st October 2015) focusing on looking after patients who may die in the next few hours or days. This is to ensure these patients receive the best and most appropriate care. This has been piloted on three wards and is being rolled out across the Trust.
Key Objectives	Our aim is to roll the new local guidance out across the Trust during 2016/17. As part of this an audit will be undertaken on the use of the guidance. This will measure the five priorities for the care of dying people: The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes and these are reviewed and revised regularly. Sensitive communication takes place between staff and the person who is dying and those important to them. The dying person, and those identified as important to them, are involved in decisions about treatment and care. The people important to the dying person are listened to and their needs are respected. Care is tailored to the individual and delivered with compassion – with an individual care plan in place. By March 2016 we expect to see at least 30% of audited deaths will demonstrate the five priorities for care of dying people demonstrated above. All complaints relating to end of life in 2013 were reviewed during 2014/15 and key themes were identified. The clinical team identified communication as a key theme in 64% (29/45) of the complaints. Following the implementation of new local guidance all end of life care complaints from the last quarter of 2016 will be reviewed to measure any improvements. During 2016/17 a bereavement survey will also be implemented. This will enable the Trust to look at themes relating to treatment at the end of life, highlighting any areas for improvement.
Measurement and Reporting	Results will be reported to the End of Life Strategy Group, this reports to the Trust Executive Group. Final outcome data and improvements will be reported in the 2016/17 Quality Report.
Board Sponsor	**Dr David Throssell** Medical Director
Implementation Lead	**Dr Kay Stewart** Palliative Care Consultant

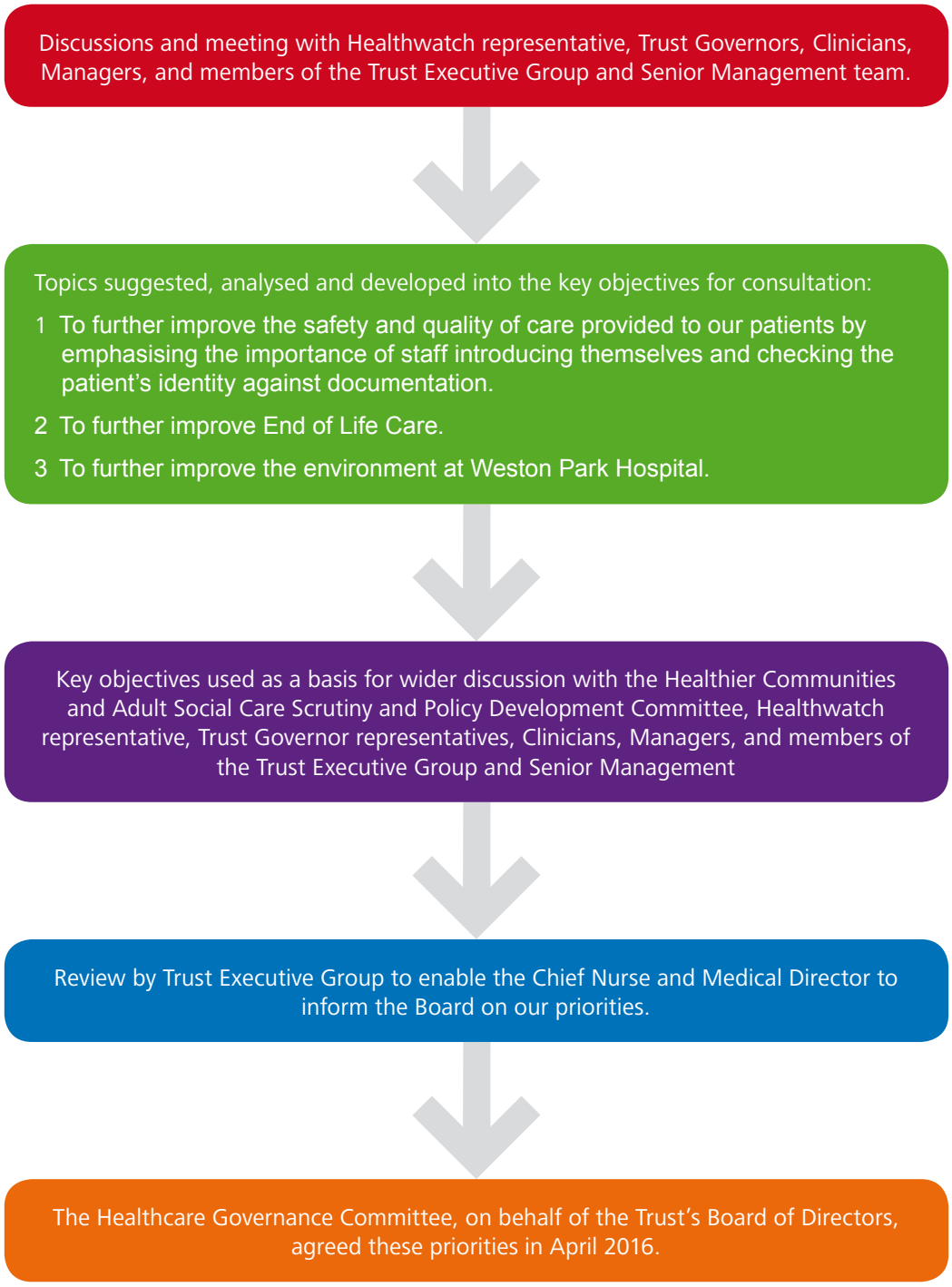
2.6 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2016/17

Priority 3

Our Aim	To further improve the environment at Weston Park Hospital
Past Performance	The hospital environment is an important element of a patient's experience. The Trust has a rolling programme of work to update and refurbish clinical areas to improve the environment and in turn improve the patient experience. Prior to the new Clinical Assessment Centre at Weston Park Hospital (WPH) opening in December 2015 clinical assessments were undertaken on Ward 2. The creation of the Clinical Assessment Centre has provided the opportunity for redevelopment and improvements to be made to the ward environment at WPH. The recent Care Quality Commission inspection highlighted the environment of WPH theatres as an area for improvement. Due to environmental difficulties within the theatres at WPH infection control accreditation is yet to be achieved. As a result the Trust will finalise plans aimed at improving the environment at WPH during 2016/17.
Key Objectives	To improve the environment at WPH all wards will undergo a total redesign and refurbishment. This will include increasing the number of en-suite rooms, the creation of a room for visitors, refurbishment of the patients' day room and a dedicated staff room. This will take place over 2-3 years. Year one will include establishing a clear specification for the developments. In addition, this year the Trust Patient Partnership team will work in collaboration with the Executive Team at WPH to identify any in year changes that are required following patient feedback. Following a comprehensive review of the theatres area an extensive action plan has been developed which focuses on five key areas , these are: • Security enhancement. • Signage - clear signage for patients and visitors. • Improved storage. • Refurbished recovery area. • Patient environment - improvements to the decor, an updated seating area and replacement of the flooring. This will be completed during 2016/17, although many immediate actions have already been implemented.
Measurement and Reporting	The improvement work will be monitored locally within the Directorate and reported in the 2016/17 Quality Report. Interim reports will also be provided to the Quality Report Steering Group and Patient Experience Committee.
Board Sponsor	**Professor Hilary Chapman**, Chief Nurse and David Throssell, Medical Director
Implementation Leads	**Dr Trish Fisher** – Clinical Director, Specialised Medicine **Martin Salt** - Nurse Director, Specialised Medicine **Dr Nick Barren** - Clinical Director, OSCCA **Karen Jessop** - Nurse Director, OSSCA **Phil Brennan** - Director of Estates

2.7 HOW DID WE CHOOSE THESE PRIORITIES?

How did we choose these priorities?



2.8 Statements of Assurance from the Board

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

a) Services Provided.
b) Clinical Audit.
c) Clinical Research.
d) Commissioning for Quality and Improvement (CQUIN) Framework.
e) Care Quality Commission.
f) Data Quality.
g) Patient Safety Alerts.
h) Staff Engagement.
i) Annual Patient Surveys.
j) Complaints.
k) Mixed Sex Accommodation.
l) Coroners Regulation 28 Reports.
m) Never Events.
n) Duty of Candour.
o) Safeguarding Adults.

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 those particular services and standards.

a. Services Provided

During 2015/16 the Sheffield Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 50 relevant health services.

The Sheffield Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 50 of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by the Sheffield Teaching Hospitals NHS Foundation Trust for 2015/16.

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

b. Clinical Audit

During 2015/16, 40 national clinical audits and three national confidential enquiries covered relevant health services that Sheffield Teaching Hospital NHS Foundation Trust provides.

During that period Sheffield Teaching Hospital NHS Foundation Trust participated in 95% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that Sheffield Teaching Hospital NHS Foundation Trust was eligible to participate in during 2015/16 are documented in Table 1. The national clinical audit the Trust has not participated in are detailed later in the section.

The national clinical audits and national confidential enquires that Sheffield Teaching Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

2.8 STATEMENTS OF ASSURANCE FROM THE BOARD

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Acute Care		
Case Mix Programme (CMP)	Yes	100%
Emergency Use of Oxygen	Yes	100%
Major Trauma Audit	Yes	100%
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD):		
Acute Pancreatitis	Yes	100%
Sepsis	Yes	95%
Gastrointestinal Haemorrhage	Yes	100%
National Audit of Intermediate Care	Yes	47%
National Emergency Laparotomy Audit (NELA)	Yes	40%
National Joint Registry (NJR)	Yes	97%
Procedural Sedation in Adults (Care in Emergency Departments)	Yes	100%
VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments)	No	See supporting statement on page 85
Blood and Transplant		
National Comparative Audit of Blood Transfusion Programme:		
Use of Blood in Haematology	Yes	100%
Audit of Patient Blood Management in Scheduled Surgery	Yes	100%
Cancer		
Bowel Cancer (NBOCAP)	Yes	87.7%*
National Lung Cancer Audit (NLCA)	Yes	100%*
National Prostate Cancer Audit (NPCA)	Yes	14.5%* See supporting statement on page 85
Oesophago-gastric Cancer (NAOGC)	Yes	77%*
Heart		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%*
Cardiac Rhythm Management (CRM)	Yes	100%*
Congenital Heart Disease (CHD)	Yes	100%*
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%*
Adult Cardiac Surgery	Yes	100%*

2.8 STATEMENTS OF ASSURANCE FROM THE BOARD

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
National Cardiac Arrest Audit (NCAA)	No	See supporting statement on page 85
National Heart Failure Audit	Yes	58%
National Vascular Registry:		
National Carotid Interventions Audit	Yes	78%
Abdominal Aortic Aneurysm (AAA)	Yes	73%
Peripheral Vascular Surgery – Lower limb angioplasty/stenting	Yes	86%
Peripheral Vascular Surgery – Lower limb bypass	Yes	55%
Peripheral Vascular Surgery – Lower limb amputation	Yes	34%
Pulmonary Hypertension Audit	Yes	100%
Long Term Conditions		
Chronic Kidney Disease in Primary Care	N/A	N/A
National Diabetes Audit – Adults:		
National Footcare Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
National Core	Yes	100%
Diabetes (Paediatric) (NPDA)	N/A	N/A
Inflammatory Bowel Disease (IBD) programme	Yes	99%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme:		
Pulmonary Rehabilitation	Yes	94%
Renal Replacement Therapy (Renal Registry)	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Yes	57%
UK Parkinson's Audit	Yes	100%
UK Cystic Fibrosis Registry	Yes	96.6%
National Complicated Diverticulitis Audit (CAD)	Yes	100%
Mental Health		
Mental Health Clinical Outcome Review Programme	N/A	N/A
Prescribing Observatory for Mental Health (POMH-UK)	N/A	N/A
Older People		
Sentinel Stroke National Audit programme (SSNAP)	Yes	90%+ **
Falls and Fragility Fractures Audit programme (FFFAP):	Yes	100%

2.8 STATEMENTS OF ASSURANCE FROM THE BOARD

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Fracture Liaison Service Database	N/A	N/A
Inpatient Falls	Yes	100%
National Hip Fracture Database	Yes	100%
Other		
Elective Surgery (National PROMs Programme) Pre-operative participation rate:		
Groin hernia	Yes	49%
Varicose vein Surgery	Yes	70.3%
Hip replacement/revision Surgery	Yes	79.2%
Knee replacement/revision Surgery	Yes	82.4%
Women's and Children's Health		
Child Health Clinical Outcome Review Programme	N/A	N/A
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
Neonatal Intensive and Special Care (NNAP)	Yes	100%*
Paediatric Asthma	N/A	N/A
Paediatric Intensive Care Audit Network (PICANet)	N/A	N/A
Paediatric Pneumonia	N/A	N/A
Vital signs in children (care in emergency departments)	N/A	N/A

2.8 STATEMENTS OF ASSURANCE FROM THE BOARD

Please note the following

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

** This is normally reported in 'bands' in the SNNAP quarterly reports.

Supporting statements

VTE risk in lower limb immobilisation (care in emergency departments)

The Trust did not participate as our current practice for screening patients is different to that being measured. Current practice is for the orthopaedic department, to whom the vast majority of patients are referred, screen the patient and not A&E. The Trust is currently considering whether practice needs to change.

National Prostate Cancer Audit (NPCA)

It is acknowledged that submission is lower than expected and work is underway to improve this for 2016/17.

National Cardiac Arrest Audit (NCAA)

The Resuscitation Committee have approved the process of enrolment to join the National Cardiac Arrest Audit in July 2016.

The reports of 23 national clinical audits were reviewed by the provider in 2015/16 and Sheffield Teaching Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Some examples are included below:

NCAPOP Falls and Fragility Fractures: National Hip Fracture Database (NHFD) 2014

The Trust participates annually in the NCAPOP Falls and Fragility Fractures: National Hip Fracture Database (NHFD). Performance is monitored on a quarterly basis by the NHFD Steering Group. Early 2015 figures show that pressure ulcers are now below 5%. The Trust is aiming to reduce patients developing a Grade 2 or above pressure ulcer to 3% by greater involvement of the Tissue Viability Team. The introduction of a Hip Fracture Liaison Nurse has resulted in a reduction in acute length of stay. A programme of quality improvement work is currently being undertaken looking at hip fractures sustained as an inpatient. Hip fracture leaflets are now given to all patients.

NCAPOP Sentinel Stroke National Audit Programme (SSNAP) 2014

The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work which aims to improve the quality of stroke care by auditing stroke services against evidence based standards. The results demonstrate that the Trust remain constant in many of the key indicator scores over the year. 72.1% of patients are directly admitted to a stroke unit within 4 hours of clock start , this is higher than the national average of 56.0%. The proportion of patients who were thrombolysed within 1 hour of clock start has improved from 44% to 46%.

The Trust monitor these results at the monthly thrombolysis meeting. Mood screening has improved from 22.6% to 44.6%. The proportion of patients treated by a stroke skilled Early Supported Discharge Team is much higher than the national average, with the re-introduction of the Community Stroke Service (CSS). In addition the Assessment and Rehabilitation Centre (ARC) has been commissioned to undertake six-monthly reviews from 1st April 2015 and the Trust look forward to reviewing the extended pathway results.

National Audit of Intermediate Care (NAIC) 2015

The National Audit of Intermediate Care (NAIC) is now in its fourth year of operation. The NAIC focuses on services which support usually frail, older people; at times of transition when stepping down from hospital or preventing admission to secondary or long term care. The audit measures intermediate care service provision and performance against standards derived from Department of Health guidance and from evidence based best practice.

When asked if services for home based and bed based have a mental health specialist included in the establishment of the service, the trust achieved 100% compliance compared with the national levels; home based services at 15.56% and bed based services at 13.51%. Does the service accept people who, in addition to a rehabilitation need, also have a cognitive impairment and or a challenging behavioural disturbance, the Trust achieved 100% compliance compared with the national levels; home based services 98.89% and bed based services 74.78%. For the remaining standards, the Trust results for both the home and bed based benchmarked above the national average, particularly in the quantitative elements such as price and volume of referrals.

Confidential Enquiries

The Trust has in place a process for the management of National Confidential Enquiry into Patient Outcome and Death Reports (NCEPOD) and puts action plans together as reports are issued. It is a standing agenda item at the Clinical Effectiveness Committee which provides a forum for updates, and if any action plan requires an audit this is included on the Trust Clinical Audit Programme.

Data is also continually collected and submitted to MBRRACE-UK (Mothers and Babies: Reducing Risk United Kingdom) The Trust has a 100% participation rate.

Local Clinical Audits

The reports of 302 local clinical audits were reviewed by the provider in 2015/16 and Sheffield Teaching Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit of diagnosis and management of urinary tract infections in elderly inpatients

Urinary tract infections (UTI) are often over-diagnosed in elderly patients aged > 70 years. Diagnosis can be very challenging in this age group due to atypical presentation such as falls, immobility or confusion, and due to patients being unable to provide a history. Anecdotally, a large number of urine samples were sent to the Trust's microbiology laboratory without a clear clinical indication, these are often labelled as 'routine specimen' or 'positive urine dipstick'. This practice could lead to inappropriate antibiotic prescribing. The audit emphasised areas for improvement, most notably concerning the appropriate duration and type of antibiotics given and the poor accuracy of dipsticks. New evidence-based guidelines on the diagnosis of UTI have been developed including a new UTI algorithm for elderly inpatients under Geriatric Medicine, this removes the use of dipsticks in patients aged > 70 years with a suspected UTI. With support from a Trust Nurse Educator, educational sessions have been delivered on the new evidence-based guidelines to both nursing staff and doctors. In addition, and with the aid of the Trust Continence Advisor, awareness is being raised of the risks associated with delaying urinary catheter removal. A re-audit is planned for 2016/17.

An Audit of the incorporation of the Insulin Passport into healthcare practice

Insulin is frequently associated with increased morbidity and mortality when prescribed or administered incorrectly. A total of 16,600 incidents were identified nationally by the National Reporting and Learning Service (NRLS) over a six year period (November 2003 – November 2009), which involved the prescribing of insulin. Approximately a fifth (26%) of these incidents were due to the wrong dose, strength or frequency, while 14% were attributable to the wrong insulin product being prescribed or dispensed. 'The Adults Patients Passport to Safer Insulin', a directive produced by the National Patient Safety Agency in 2011, focussed its efforts on reducing errors involving insulin. This issue was to be tackled using a patient record known as the Insulin Passport.

During 2014 a project was undertaken to assess compliance with the requirement to issue patients on insulin with a passport, and determine whether the Insulin Passport has been adopted into common practice. Compliance with the Insulin Passport was poor, patients were not issued with an Insulin Passport. The findings were presented to the CCG Medicines Safety Group, Diabetes Team and to the Pharmacy Clinical Governance Network. A risk assessment has also assessed the benefits and risks associated with using the Insulin Passport. This was found to be low risk. During 2015, discussions with The Area Prescribing Group led to a proposal being accepted that Sheffield (primary and secondary care) will not routinely issue the Insulin Passport. Instead, Healthcare Professionals will clarify the patient's insulin by asking to see their insulin and when admitted to secondary care, checking the summary care record. The Medicines Code has been updated to reflect the change in practice. An audit of the new practice is planned for 2016/17.

Audit to assess the incidence and determine the frequency of minor oral surgery related post-operative complications at Charles Clifford Dental Hospital

Postoperative complications are unforeseen events that can increase the morbidity, over and above what would be expected from a particular operative procedure under normal circumstances. Though they are rare, their occurrence leads to a prolonged phase of treatment. It is important, therefore, to be familiar with all the postoperative Minor Oral Surgery (MOS) complications, as this will improve patient education and lead to early recognition and management. An audit was undertaken to assess the incidence and determine the frequency of postoperative complications in patients who had undergone MOS procedures at Charles Clifford Dental Hospital. The results revealed compliance in four of the five standards set with significantly less complication rates than that reported in the literature. The standard not met was the management of post-operative pain. This action has since been acted upon by disseminating the results to all dental nurses working in MOS clinics responsible for giving post-operative advice in a talk session. At that

meeting discussions took place on the post-operative analgesia advice and alternative strategies to aid with post-operative pain. To reflect this, an improvement in the information given to patients on post-op analgesia advice in the patients information leaflet has been amended. A further re-audit is planned for 2016.

c. Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Teaching Hospital NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 12,023 (2014/15 -12,943).

International Clinical Trials Day provides a key focus for clinical research. It is an annual global event celebrating the day that James Lind began his famous trial which led to the prevention of scurvy. This year Sheffield Teaching Hospitals NHS Foundation Trust hosted a day of events, linked with the University of Sheffield Faculty of Arts and Humanities celebrations. This included hosting our annual Consumers in Research event at lunchtime, with around 100 delegates attending and celebrates our Patient & Public Involvement work at the Trust. Then in the evening, STH hosted an event called "It's all in the mind" with University of Sheffield which included an exhibition and 90 minutes of talks on how art can stimulate recovery (e.g. Dementia Choir).

d. Commissioning for Quality and Improvement (CQUIN Framework)

Sheffield Teaching Hospitals NHS Foundation Trust income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework as this was not available to the Trust. However the Trust had the opportunity to participate in a Local Incentive Scheme with NHS Sheffield CCG.

For 2015/16 the Local Incentive Scheme included five goals, these were:

- Dementia and delirium - to support the identification of patients with dementia and delirium, also and in combination alongside other medical conditions. It aims to prompt appropriate referral, follow up, and effective communication between providers and general practice.
- Care planning – to improve care planning in community services for patients with long-term conditions.
- Timeliness of clinic letters- to improve the timeliness and detail contained with follow up letters to GPs.
- Reducing Emergency Readmissions- post discharge follow up intervention within a pilot area of Urology and Care of the Elderly.
- Breastfeeding – reduction in breastfeeding drop off rates at discharge.

e. Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against Sheffield Teaching Hospitals NHS foundation Trust during 2015/16.

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

In December 2015, we welcomed inspectors from the CQC to carry out a comprehensive inspection of our services and care across the Trust. This saw more than 100 inspectors visiting our hospital and community sites during the week of 7 December 2015. The CQC returned to do an unannounced visit on 23 December 2015 to complete their inspection. The outcome of the December inspection has yet to be formally reported to the Trust. We are expecting their formal report by spring 2016. The results of which will be reported in the 2016/17 Quality Report.

The CQC also undertook a review of the provision within health services for looked after children and safeguarding children across Sheffield from 26 to 30 October 2015. Areas that were visited by the inspectors in the Trust included Maternity services, Sexual Health Services (SHS) and the ED. In accordance with the request from the CQC, clinical staff from each area were interviewed and the Named Professional for Safeguarding Children and Lead Nurse for Children and Young People attended the Sexual Health Services and the Emergency Department meetings respectively. The Named Midwife was interviewed for the inspection of Maternity services.

Within the report, published 18 January 2016, are ten recommendations that apply to the Trust across the areas inspected. An action plan, with timescales for completion, has been agreed with colleagues from the practice areas and the Deputy Chief Nurse. Actions include updating the electronic record system to ensure that the questions about any safeguarding concerns are all completed at the initial assessment for a young person attending the ED.

Within SHS there has been a change in practice since January 2016 so that the two IT systems that are used for patient records are both checked at each appointment as the patient may have been seen in different departments within the service.

Maternity Services are to develop a template to assist midwives to produce Specific, Measurable, Attainable, Realistic and Timely (SMART) pre-birth plans. All pre-birth plans will be shared with the parents and documented in the records.

A new pathway for pregnant women has been implemented to ensure that women are seen alone and a question about domestic violence asked to provide a comprehensive assessment of risk to safeguard both the pregnant women and the unborn baby. The Midwifery policy for Routine Enquiry will be amended to state that all women must be seen alone at least once in the ante-natal period so that routine enquiry into domestic abuse can be completed. An audit of routine enquiry will then be completed.

The action plan has been submitted to the Designated Nurse at Sheffield CCG who will monitor progress on a quarterly basis until full compliance is achieved. Additionally there will be monitoring of progress through the Trust's Safeguarding Leads meeting that is chaired by the Deputy Chief Nurse.

f. Data Quality

Sheffield Teaching Hospitals NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:

99.8% for admitted patient care;

99.8% for outpatient care; and

98.9% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:

99.8% for admitted patient care;

99.8% for outpatient care; and

99.9% for accident and emergency care.

Sheffield Teaching Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 74% and was graded as satisfactory and green.

Sheffield Teaching Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

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

- Continue to work on the Data Quality Baseline Assessment to report on all systems across the Trust and develop an action plan to introduce some standardisation of data quality control.
- Continue to lead and work collaboratively with the members of the Data Quality Operational Group to feed issues into training and bring Data Quality in line with the Trust ethos of 'Right First Time'.
- Work in close collaboration with the Organisational Change Managers for the Transformation Through Technology (T3) project, to continue to review Standard Operating Procedures and training; and to maintain cross-trust network of local contacts for Data Quality issue resolution.
- Develop a strategy to incorporate Data Quality into the Trust's Business Objectives, work on the Trusts Data Quality Improvement Plan and review and re-issue the Data Quality Policy.

g. Patient Safety Alerts

The National Patient Safety Agency analyses reports on patient safety incidents received from NHS staff and uses this to produce resources (alerts or rapid response requests) aimed at improving patient safety.

Table 2 opposite details the Alerts and Raid Response Reports which have been responded to during the year 2015/16.

h. Staff Engagement

The Trust is committed to developing good leaders and ensuring good staff engagement and wellbeing, as it recognises the importance of these for quality patient care.

During 2015/16, the implementation of the Trust Staff Engagement Strategy has been continued with a particular focus on improving staff involvement and wellbeing for all staff. A staff engagement SharePoint site has been developed and launched on the Trust Intranet site. This promotes the sharing of good practice in staff engagement, whilst providing easier access for staff to information.

2.8 STATEMENTS OF ASSURANCE FROM THE BOARD

Table 2 - Alerts and Raid Response Reports

Ref	Title	Issued	Deadline	Closed
NHS/PSA/D/2014/010	Standardising the Early Identification of Acute Kidney Injury	9/6/2014	9/5/2015	Closed
NHS/PSA/W/2015/004	Managing Risks During the Transition Period to New ISO Connectors for Medical Devices	27/3/2015	8/5/2015	Closed
NHS/PSA/W/2015/005	Risk Of Death Or Severe Harm Due To Inadvertent Injection Of Skin Preparation Solution	26/05/2015	07/07/2015	Closed
NHS/PSA/W/2015/006	Harm From Delayed Updates To Ambulance Dispatch And Satellite Navigation Systems	09/07/2015	16/07/2015	Closed
NHS/PSA/Re/2015/007	Addressing Antimicrobial Resistance Through Implementation Of An Antimicrobial Stewardship Programme	18/08/2015	31/03/2016	Closed
NHS/PSA/RE/2015/008	Supporting The Introduction Of The National Safety Standards For Invasive Procedures	14/09/2015	14/09/2016	Open
NHS/PSA/Re/2015/009	Support To Minimise The Risk Of Distress And Death From Inappropriate Doses Of Naloxone	26/10/2015	26/04/2016	Open
NHS/PSA/W/2015/011	The Importance Of Vital Signs During And After Restrictive Interventions/Manual Restraint	03/12/2015	21/01/2016	Closed
NHS/PSA/W/2015/012	Risk Of Using Different Airway Humidification Devices Simultaneously	15/12/2015	02/02/2016	Closed
NHS/PSA/W/2016/001	Risk Of Severe Harm Or Death When Desmopressin Is Omitted Or Delayed In Patients With Cranial Diabetes Insipidus	08/02/2016	21/03/2016	Closed

Staff Involvement

The Trust participated in the staff Friends and Family Test in quarter 1, 2 and 4, as well as undertaking a full census staff survey in quarter 3. Engagement events have been held across the Trust during 2015/16, particularly in clinical areas to discuss the findings of the staff Friends and Family Test results. These events have resulted in staff making suggestions, leading to improvements for both staff and patients. It is pleasing to note that the Trust is now recognised as a centre of good practice in its approach, and use of the staff Friends and Family Test data, leading to improve both staff and patient experience. The Trust Staff Engagement Lead has been invited to share good practice at several NHS England events.

The Chief Executive and other Executive Directors have continued to spend time in clinical and non-clinical departments each month to take the opportunity to chat with staff and listen to their feedback.

The Chairman meets regularly with the Staff Governors and the Board of Directors have a planned programme of visits across the Trust to meet staff and recognise their efforts.

The Clinical Assurance Toolkit used in some clinical areas includes a Staff Survey (based on the engagement questions in the NHS Staff Survey), whilst some other departments e.g. Pharmacy, have undertaken their own Staff Survey.

The Trust was pleased to welcome Professor Michael West of Aston University in July 2015, who talked about the importance of team effectiveness/ staff experience on positive patient outcomes, over 150 senior leaders attended. We were also pleaseD to hold our first Clinical Leadership Forum for Clinical Directors and Clinical Leads in June 2015. This was well attended with a further forum held in January 2016.

2.8 STATEMENTS OF ASSURANCE FROM THE BOARD

NHS Staff Survey

Staff engagement is measured every year via the annual NHS Staff Survey, which includes an overall score for staff engagement. The Trust staff engagement score for 2015 was 3.74 as reported in the benchmarked NHS Staff Survey. It is encouraging to note that 76% of our staff would recommend the Trust to family and friends for treatment, this is well above the NHS average for combined acute and community trusts of 68%. Additionally 64% of our staff would recommend the Trust as a place to work, this again is above the NHS average for combined acute and community trusts of 58%.

Response rate

2014/15		2015/16		Trust Improvement/ Deterioration
Trust	National Average	Trust	National Average	
42%	42%	51%	41%	9% Improvement

Top four ranking scores

Key Finding		2014/15		2015/16		Trust Improvement/ Deterioration
		Trust	National Acute Average	Trust	National Combined Acute & Community Average	
KF27	Percentage of staff/ colleagues reporting most recent experience of harassment, bullying or abuse	41%	39%	45%	38%	4% Improvement
KF16	Percentage of staff working extra hours	61%	71%	65%	72%	4% deterioration (above average)
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	20%	23%	21%	24%	1% deterioration (above average)
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	90%	87%	89%	87%	1% deterioration (above average)

N.B Please note in 2015 Sheffield Teaching Hospital NHS Foundation Trust was benchmarked in the newly created combined acute & community group not against acute trusts as in previous years.

2.8 STATEMENTS OF ASSURANCE FROM THE BOARD

Bottom four ranking scores

Key Finding		2014/15		2015/16		Trust Improvement/ Deterioration
		Trust	National Acute Average	Trust	National Combined Acute & Community Average	
KF13	Quality of non-mandatory training, learning or development	-	-	3.88	4.04	Not a key finding in 2014
KF3	Staff agreeing their roles make a difference to patients	-	-	86%	90%	Not comparable to 2014
KF7	Staff able to contribute towards improvements at work	63%	68%	63%	71%	No change
KF32	Effective use of patient/ service user feedback	3.61	3.65	3.52	3.66	0.09 deterioration

This year there have been a number of significant changes in the key findings and a change in weighting therefore the NHS Staff Survey Coordination Centre have advised that some key findings are not comparable to previous year's data.

Biggest Deteriorations since 2014

Key Finding		2014/15		2015/16	
		Trust	National Acute Average	Trust	National Combined Acute & Community Average
KF10	Support from immediate managers	3.80	3.63	3.59	3.71
KF17	Percentage of staff suffering work related stress in the last 12 months	30%	37%	37%	36%
KF6	Percentage of staff reporting good communication between senior management and staff	35%	30%	29%	30%

The Trust has a Staff Engagement Lead and a Staff Surveys Coordinator who work with staff in Directorates to promote the sharing of good practice across the Trust. A Trust action plan has been drawn up to address the areas for improvement that is further supported by individual Directorate staff engagement action plans. This also builds on the Staff Friends and Family Test findings.

A full census survey was undertaken at the same time as the benchmarked survey, this enables a staff engagement score to be calculated for every Directorate. Directorate staff engagement scores and staff Friends and Family Test scores are monitored via the Care Group performance review process and the Staff Engagement Executive.

2.8 STATEMENTS OF ASSURANCE FROM THE BOARD

			STH 2014	STH 2015	Average (median) for combined acute and community trusts
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	White	23%	22%	28%
		BME	17%	28%	26%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19%	20%	24%
		BME	24%	24%	26%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	93%	93%	89%
		BME	68%	61%	74%
Q17b	In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues?	White	7%	5%	5%
		BME	15%	19%	13%

An action plan is being developed to address the above findings and will be the focus for the Diversity and Inclusion Workforce Group. The Trust has recently approved funding to establish a diversity post which will focus on workforce matters. The Trust continues to have a LiA scheme focusing on diversity and inclusion.

We have continued to work on embedding the PROUD values into the Trust ethos. These values are increasingly being incorporated into the recruitment process for all staff and are used for all newly qualified staff nurses, clinical support workers and apprentices. The Trust uses a Performance, Values and Behaviour based appraisal process to further embed the PROUD values and to provide staff with quality well-structured appraisals.

The PROUD values are:

- **Patients First**
  Ensure that the people we serve are at the heart of what we do
- **Respectful**
  Be kind respectful, fair and value diversity
- **Ownership**
  Celebrate our successes, learn continuously and ensure we improve
- **Unity**
  Work in partnership with others
- **Deliver**
  Be efficient, effective and accountable for our actions

The new Senior Leaders programme was developed in partnership with Sheffield Hallam University and launched in January 2016. There are 23 participants on the course, which will run for six months of the year. The programme consists an Insights Discovery Day and each participant will complete an NHS Healthcare Leadership 360 degree feedback.

The Frontline Leadership programme has been created in partnership with Sheffield Hallam University and is primarily for our Clinical Leads. This programme was launched in November 2015 and two cohorts are now in progress totalling17 participants. This programme will run for six months, and will include set training days and 1:1 tutorials to give support to Clinical Leads in developing their service improvement project.

The Institute of Leadership and Management programme continued to be provided during 2015/16, numbers for each cohort have been increased from 25 to 30 to meet the increasing demand. This is continually reviewed and updated with feedback from candidates and continues to be well evaluated.

A new format for the Effective Management Series has been developed to offer a management development pathway for aspiring and new managers into the organisation. This offers a selection of sessions that begin with introductory, intermediate and on to advanced that can be selected as pure development, as part of an induction, or as ongoing development for existing

managers. This is still organised as a step-in step-off programme to encourage all managers across the organisation to attend sessions that are relevant or of interest to them.

A third cohort of the Performance Coach ran in 2015, and we now have a total of 36 coaches trained and active across the organisation. We are currently working across the region to develop a Coaching Database which will act as a central resource for coaches to connect and build upon coaching relationships.

The fast track physiotherapy service introduced last year has proved popular with staff, and this year a psychological service for complex staff cases has been developed in Occupational Health. We have also introduced more personal resilience sessions for staff.

The Mentally Healthy Workforce approach is embedded within current Leadership and Management Development programmes. Additional training is being offered to develop this package to include Supportive Leadership as well as the original training package. This will delivered in spring 2016 and will be rolled out later in the year.

The Trust was pleased to be one of 12 trusts in the country selected for Simon Stevens' Healthy NHS workforce programme, and as a result of this, free health checks will be introduced for the over 40s in the coming months. Staff will also be asked to identify the top three things they would like the Trust to address to support their wellbeing.

The Raising Concerns at Work Policy has been revised, this Policy supports staff who wish to raise concerns.

i. Annual Patient Surveys

Seeking and acting on patient feedback remains a high priority. The Trust continues to undertake a wide range of patient feedback initiatives regarding the services they receive. Survey work during 2015/16 included participation in the National Survey Programme for inpatient and maternity services.

The Friends and Family Test is now carried out in inpatient, outpatient, A&E, maternity, and community services. This allows us to look in more detail at patient feedback at individual ward and service level where our scores consistently compare well nationally, with good response rates being achieved.

During early 2016, a new local inpatient satisfaction survey and outpatient satisfaction survey began, once the results are available they will provide further feedback on the experience of patients who visit our Trust. In addition, the Trust will be undertaking a series of topic specific surveys throughout 2016/17, the first one being End of Life Care which commences at the end of April 2016.

The National Inpatient Survey scores were high for questions relating to communications, information and explanations, and having trust and confidence in doctors and nurses. Areas identified where improvements can be made include offering healthy food choices on the hospital menu and ensuring patients have the opportunity to give us their views on the quality of care they receive. We are awaiting the CQC analysis of national results, these compare the Trust against all other trusts.

In the National Maternity Survey 2015, the Trust's scores were once again very good overall. High scoring questions include mothers being spoken to in a way they could understand, partners or someone close being able to be involved as much as they wanted, having a contact telephone number for a midwife or midwifery team, and being asked how they were feeling emotionally. Areas where improvements can be made include, being given a choice about where antenatal check-ups would take place, partners or someone close being able to stay as much as the mother wanted, being given enough information about their own physical recovery after birth and details of who to contact if they needed advice about any emotional changes they might experience after birth.

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

Friends and Family Test

The Friends and Family Test is still being used in Inpatients, Day Case, Accident and Emergency, Maternity Services, Outpatients and Community. It was rolled out to the Minor Injuries Unit in 2015/16 feedback is reported in the A&E report. The Friends and Family Test asks a simple, standardised question with a six point scale, ranging from 'extremely likely' to 'extremely unlikely'. The Trust has also chosen to ask a follow-up question in order to understand why patients select a particular response.

We use a variety of methods to collect the data within the Trust. A new survey contractor was appointed in 2015/16 to improve the way we collect and report feedback. This has enabled feedback to be more responsive and consistent. As part of the way we collect feedback, new Friends and Family Test postcards have been designed and distributed to all areas that carry out the Friends and Family Test using postcards. The new cards include the option of completing the survey via SMS or online, giving

more choice to patients. Dementia friendly cards have been introduced in areas that see a large proportion of patients with dementia.

Although there are no national targets for response rates, the Trust is committed to maintaining good response rates for the Friends and Family Test to ensure feedback data is robust. The Trust has therefore set response rate targets for inpatients at 30%, and A&E and maternity services at 20%. Over the past 12 months inpatients (31.4%) and A&E (20.9%) both achieved their locally set target. Maternity services, (18.8%), fell slightly below their target. Targets for outpatients and community services are currently being determined.

Due to low response rates in maternity services, an action plan was introduced to raise awareness and re-emphasise the importance for staff to promote the Friends and Family Test. This has resulted in an improvement in their response rates and the 20% target is now regularly achieved.

To monitor our results we have updated our monthly reports to include response rates, positive and negative scores and the links to patient comments. When the Trust's targets are not being met, the relevant areas are highlighted in the monthly reports.

Patients receiving the Friends and Family Test are now able to leave further feedback via a two minute voice message. This voice message is themed and included in Friends and Family Test feedback. Improvements are to be made to the 'You Said We Did' posters which display the results and action planning reports. These are automatically generated each month, and a link to these is included in the monthly report.

Work is planned in 2016/17 to start generating weekly automatic reports for staff to receive feedback and response rates on a regular basis, and respond to any issues more efficiently.

j. Complaints

The Trust values complaints as an important source of patient feedback. We provide a range of ways in which patients and families can raise concerns or make complaints. All concerns whether they are presented in person, in writing, over the telephone or by email are assessed and acknowledged within two days and where possible, we aim to take a proactive approach to solving problems as they arise.

Table 3

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
New informal concerns received	139	133	141	131	108	137	169	151	176	151	139	114	1689
New formal complaints received	88	116	111	114	96	81	127	135	104	135	133	138	1378
All concerns combined	227	249	252	245	204	218	296	286	280	286	272	252	3067

During 2015/16 we received 1,689 informal concerns which we were able to respond to within two working days. If telephone calls, emails or face to face enquiries are received by the Patient Services Team (PST) and if staff feel they can be dealt with quickly by taking direct action, or by putting the enquirer in touch with an appropriate member of staff, such as a Matron or Service Manager, contacts are made and the enquiry is recorded on the complaints database as an informal concern. If the concern or issue is not dealt with within two days, or if the enquirer remains concerned, the issue is re-categorised as a complaint and processed accordingly.

1,378 complaints requiring more detail and in-depth investigation were received. Table 3 provides a monthly breakdown of formal complaints and informal concerns received. Of the complaints closed during 2015/16, 48% (640/1329) were upheld by the Trust. The Parliamentary and Health Service Ombudsman (PHSO), investigate complaints made regarding Government departments and other public sector organisations and the NHS in England. They are the final step of the complaints system, giving complainants an independent and last resort to have their complaint reviewed. During 2015/16 the PHSO closed 26 cases regarding the Trust, 19% (5/26) of which were upheld.

2.8 STATEMENTS OF ASSURANCE FROM THE BOARD

The Trust works to a target of responding to 85% complaints within 25 working days. The performance this year was 85%, achieving the target for the first time in three years. Significant work has been undertaken this year to reduce the number of open and overdue complaints which formed a large backlog awaiting a response. This involved daily monitoring of all complaints due to be closed each month being undertaken with regular updates being sent to the Deputy Chief Nurse, Nurse Directors, Deputy Nurse Directors and Complaint Co-ordinators with any complaints that are identified as likely to become overdue being escalated. This ensures the necessary information is available to respond to the complaint, within the appropriate timescales. This has removed any backlog of complaints and improved the management of complaints overall. Chart 3, below, shows a monthly breakdown of performance against the Trust target per month.

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. A monthly dashboard report focuses on key performance indicators for complaints handling and other feedback, supported by a more detailed quarterly report. The reporting process ensures that at all levels the Trust is continually reviewing information, so that any potentially serious issues, themes or areas where there is a notable increase in the numbers of complaints received can be thoroughly investigated and reviewed by senior staff.

Chart 4, overleaf, shows the breakdown of complaints by theme. The findings show that four of the top five themes are the same as those identified last year. Complaints received relating to staff attitude have reduced significantly since last year, and now sits at the fourth most raised theme this year. This reduction in complaints relating to staff attitude is as a result of a number of initiatives undertaken by the Trust, such as customer care training, the implementation of the PROUD values and deeper analysis of complaint themes undertaken by the Patient Experience Committee, where locally agreed actions were implemented to improve the experience of patients.

We remain committed to learning from and taking action as a result of complaint investigations. A selection of actions taken as a result of complaints is featured in quarterly reporting.

During 2015/16, the Trust developed a new complainant satisfaction survey to survey all those who make a complaint to provide them with an opportunity to tell us about their experience. This will commence in April 2016 and be carried out alongside routine audits of complaint responses and complainant interviews to ensure we have a full understanding of the experience complainants have when making a complaint.

Chart 3 - monthly breakdown of performance against the Trust target per month

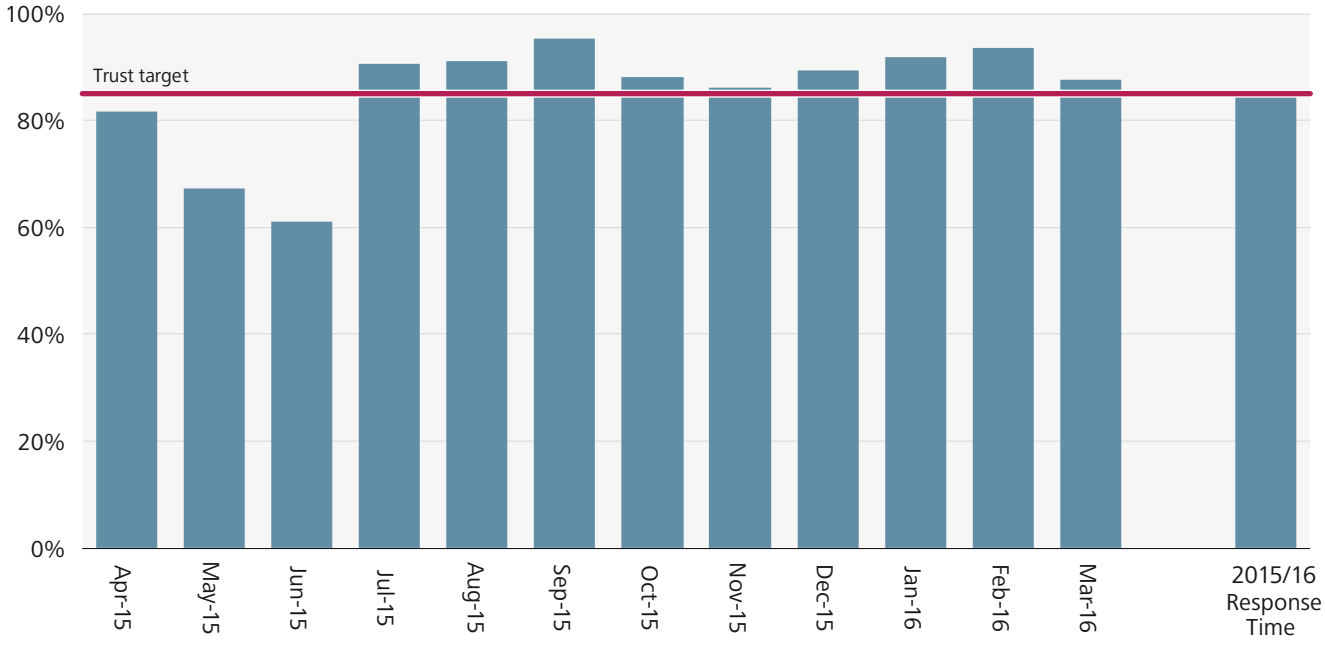
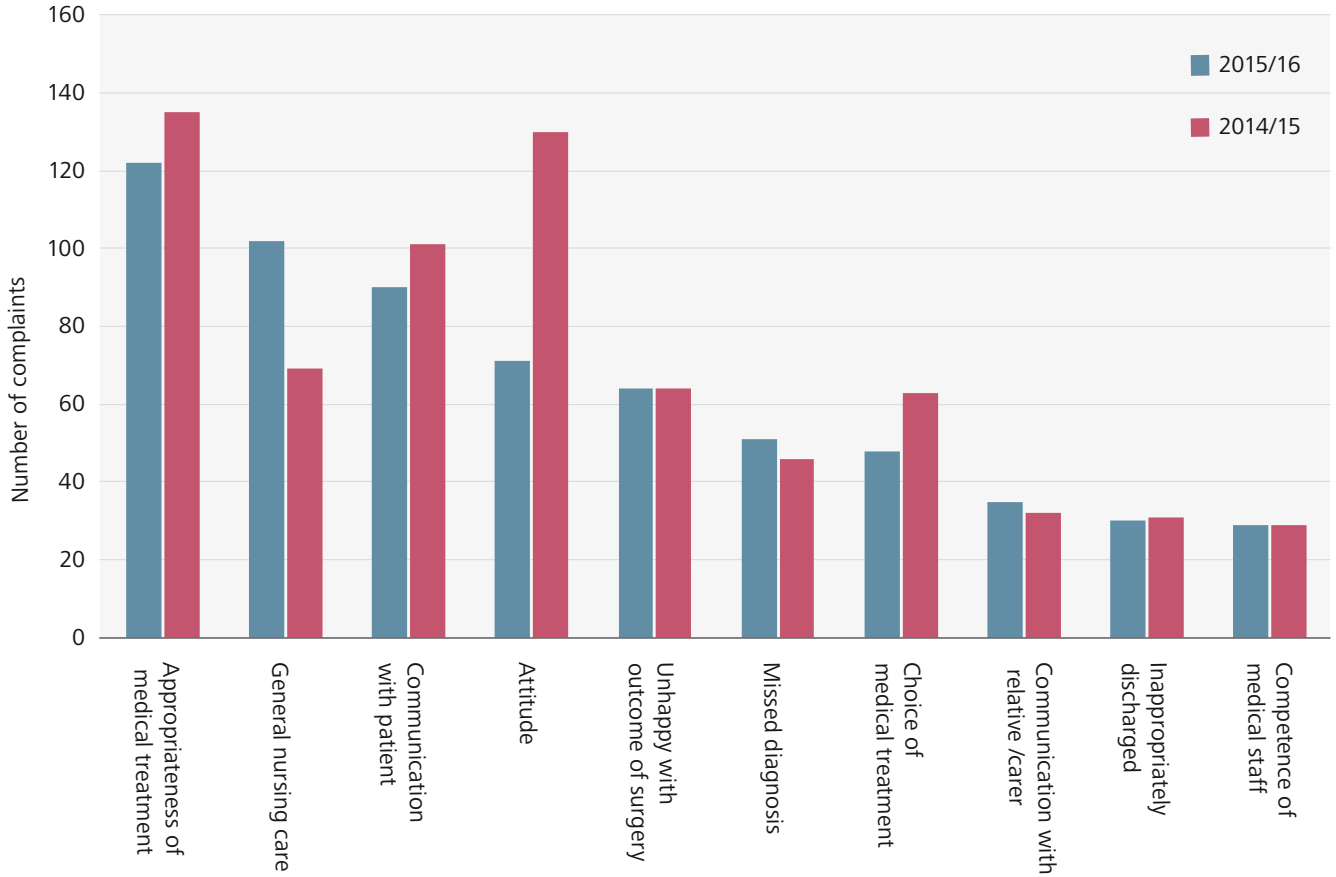


Chart 4 - breakdown of complaints by theme



k. Mixed Sex Accommodation

The Trust remains committed to ensuring that men and women do not share sleeping accommodation except when it is in the patient's overall clinical best interest, or reflects their personal choice. As a result we have not identified any breaches in the Eliminating Mixed Sex Accommodation during 2015/16.

l. Coroners Regulation 28 Prevention of Future Death Reports

When reviewing a death the Coroner has a duty to consider whether a person or an organisation should be taking steps to prevent similar deaths under Regulation 28 of the Coroner's (Investigations) Regulations 2013. A Coroner will issue a Prevention of Future Death (PFD) Report when there is a concern that the circumstances creating a risk of further deaths could recur or continue to exist. The person or organisation must then respond in detail the action taken or to be taken, or must explain why no action is proposed.

During 2014/2015 the Trust received and responded to two PFD Reports. The first report was received in May 2015 and was addressed to Sheffield City Council as well as the Trust. The patient died due to sepsis from infected pressure sores. Numerous agencies had been involved in the patient's care prior to death. The PFD report arose from the Coroner's concern that care could have been improved by better communication between agencies. The Coroner did not find that in this case, this would have changed the outcome, but was concerned that similar failures in other cases may have more directly attributable consequences. The Coroner suggested that Sheffield City Council and the Trust consider meeting and seek to establish a robust method of communication between all involved, with particular reference to pressure care needs.

Several multi-disciplinary meetings took place following this, resulting in detailed action plans. In relation to the Trust, the action plan included:

- Training, documentation and audit in relation to pressures sores.
- Training, review of processes and development of quality assurance process in relation to referrals from the ward to district nurses.
- Better lines of communication between the Trust and social workers/care providers through SPA multi-disciplinary team.
- Provision of "Time to Turn" booklets to carers and relatives.

A second report was sent to the Trust in July 2015, by the Doncaster Coroner in relation to a case where the Trust had not been requested to provide reports or attend the inquest. The patient died from lung damage caused by Amiodarone toxicity. The Coroner raised concern that there was no evidence of any protocols for advising primary care providers of the need to closely monitor patients who have been prescribed Amiodarone or that adequate steps were taken to ensure adequate monitoring for this patient.

The response reassured the Coroner that there is, and was at the time, an appropriate Shared Care Protocol for Amiodarone in place, which details the monitoring requirements and that the Trust had also appropriately undertaken the baseline monitoring prescribed by the protocol, and alerted the GP to the protocol in the discharge correspondence. No further action was required.

m. Never Events 2015/16

Never Events are defined as "serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers".

During 2015/16 four Never Events occurred at the Trust, these are detailed below.

Wrong Intraocular lens insertion (two incidents)

These two incidents occurred within two weeks of each other with different staff involved. On both occasions patients had an incorrect strength lens inserted into their eye during routine cataract surgery. The error was identified before the patients left the theatre and the correct lenses were implanted.

The actions taken following this Never Event included extra training for theatre staff regarding the choice of intraocular lens insertion. This includes the development of a flowchart to assist staff in understanding the choice of lens to be used. This now enables staff to provide a second check of the choice of intraocular lens insertion that the surgeon has made. A Cataract Safer Surgery Checklist has also been developed and implemented. More staff have been recruited to the area and managers are now ensuring that staff get experience in every area of ophthalmology surgery.

Operation to remove Peri-anal Cyst

A patient was admitted for removal of a small cyst. The operation report states the operation carried out was 'removal of small cyst anal area'. However, the histology findings of the excision showed the removal of a skin tag. The surgeon who carried out the procedure did not perform the required pre-operative checks, and did not mark the site which would have been required as part of the Surgical Safety Checklist (WHO, 2008).

The Safer Procedure Policy has been published and shared with medical staff within Surgical Services following this Never Event. The policy details the requirements that must be undertaken for all surgery, and includes guidance on marking and the checks to be undertaken.

Wrong Site Anaesthetic Block

A patient was in theatre for repair of a right sided fractured neck of femur. Following insertion of the anaesthetic block the patient was turned and it was realised that the block had been given on the wrong side. The anaesthetist then continued with a spinal anaesthetic and the procedure was performed. No further block was given to the correct side as the patient received alternative methods of pain relief. The operation proceeded without incident and the patient made a good recovery

The Safer Procedure Policy relating to "stop before you block" has been reviewed and updated. This has been shared with medical staff within Surgical Services following this Never Event. Identification of patients requiring a block now takes place at team brief and a staff member is identified to lead the "stop before block" for that theatre list.

n. Duty of Candour

Duty of Candour came into force on 27 November 2014 requiring all Care Quality Commission registered healthcare organisations to disclose all events that have led to significant harm. Candour is defined in Robert Francis' report as *'the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made'*.

The Duty of Candour applies to all cases of 'significant harm'. This new classification covers the National Reporting and Learning System categories of 'moderate', 'severe' and 'death', and also 'prolonged psychological harm'.

The introduction of a statutory Duty of Candour is a major step towards implementing a key recommendation from the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry). Candour is recognised as a practice that can benefit patients and carers who have experienced harm during health care.

The Being Open appendix of the Trust's Incident Management Policy has been updated to outline the process for reporting cases to which Duty of Candour applies. The Duty of Candour appendix includes the Ten Principles of Being Open as identified in the National Patient Safety Agency's document Being Open and the process to follow within the Trust.

The electronic Incident Management System (Datix) has been adapted to automatically request that reviewers consider whether Duty of Candour applies for any incidents resulting in a 'moderate' or greater outcome. If the member of staff undertaking the review decides that Duty of Candour applies they are requested to input the name of the individual who will be leading the incident and coordinating communication with the patient/ relatives/carers.

As well as updating the policy, an education plan has been developed. This consists of three levels of education.

For level 1 education, a staff leaflet 'Introducing Duty of Candour' was developed and distributed to all staff being paid by the Trust with their payslip in January/February 2015. The leaflet covers the following:

- What is Duty of Candour?
- How does it affect me?
- How did it come about?
- What do I need to do if I witness or am involved in an incident?
- How is it decided whether an incident led to moderate, major or catastrophic harm?
- Is this something I will continue to hear about?
- Where can I go for further information?

Level 2 training consists of a 30 minute awareness presentation titled 'Duty of Candour at STH'. It explains what Duty of Candour is and what individuals need to do if an incident arises. As part of our ongoing learning within the organisation, Directorates are encouraged to discuss and share learning from Duty of Candour incidents at local governance meetings throughout the year, with wider shared learning across the Directorate as appropriate.

Level 3 training consists of a three hour workshop which has been developed for staff dealing with Duty of Candour incidents or those responsible for further cascading Duty of Candour at STH awareness training within the Directorates. This workshop covers:

- Duty of Candour – What is it?
- How do we manage Duty of Candour incidents at STH?
- Duty of Candour – How to communicate about an incident with patients and carers?

To date 821 staff have received Level 2 training and 111 staff have attended a Level 3 workshop. Further training is planned for 2016/17.

To ensure that we learn from Duty of Candour incidents across the organisation, it has been agreed that every three to six months a sharing of learning from the management of Duty of Candour incidents will form part of the Safety and Risk Management Board meeting.

As part of the Patient and Healthcare Governance intranet site a Duty of Candour section has been developed, which includes the Duty of Candour leaflet, the updated policy and videos of the presentations.

o. Safeguarding Adults

The Trust is part of a wider network of agencies including the Local Authority, Sheffield Health and Social Care NHS Foundation Trust, the Police, South Yorkshire Fire and Rescue, the Domestic Abuse Co-ordination Team (DACT) and Sheffield CCG, who make up the Sheffield Adult Safeguarding Partnership. The Partnership reports to the Safeguarding Adults Executive and Operational Boards, Chaired by an independent Chair.

The Trust has policies, guidance and processes in place to identify and report all types of abuse of patients, carers, family members or staff. This includes the reporting of domestic violence and abuse. The Trust's Safeguarding Adults team works in close collaboration with the Trusts Safeguarding Children's team, the maternity services Vulnerabilities team, Emergency Department (ED) and Human Resources to identify and support vulnerable individuals who are subject to domestic violence and abuse.

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

These are the Trust priorities which are encompassed in the mandated indicators that the organisation is required to report and have been agreed by the Board of Directors.

The indicators include

- 6 that are linked to patient safety;
- 11 that are linked to clinical effectiveness; and
- 13 that are linked to patient experience.

Mandated Indicators - NHS England (Gateway reference 04730)

Prescribed Information	2013/14	2014/15	2015/16
Mortality The value and banding of the summary hospital-level mortality indicator (SHMI) for the trust for the reporting period National Average: 1.0 Highest performing trust score: 0.65 Lowest performing trust score: 1.18 (Figures for Oct14 - Sept15)	0.91 Banding: as expected	0.91* Banding: as expected	(Oct14-Sept15) 0.93 Banding: as expected
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. National average: 26.0% Highest trust score: 53.5% Lowest trust score: 0% (Figures for Oct14 - Sept15) The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data are extracted from the Information Centre SHMI data set. The SHMI makes no adjustment for palliative care because there is considerable variation between trusts in the way that palliative care codes are used. Adjustments based on palliative medicine treatment specialty would mean that those Organisations coding significantly for palliative medicine treatment specialty would benefit the most in terms of reducing the SHMI value (the ratio of Observed/Expected deaths would decrease because the expected mortality would increase). Hence, SHMI routinely reports % patient deaths with palliative care coding as a contextual indicator to assist with interpretation of data. The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this rate, and so the quality of its services, by: • Working in partnership with NHS England and the Yorkshire and Humber Improvement Academy to implement the Self-assessment on Avoidable Mortality and identify and action areas for improvement • Ensuring consistent Mortality and Morbidity reviews are undertaken across the Trust. • Monitoring the mortality data at a diagnosis level to ensure any areas for improvement are constantly reviewed and where appropriate ensure actions are taken to address. *The SHMI reported in last year's Quality Report was qualified by the annotation that this was derived from the most recent rolling 12 month period i.e. Oct 2013 - Sept 2014. SHMI results are published six months and three weeks in arrears because of the need to validate the data nationally. The value for April 2014 – March 2015 was released at the end of October 2015 and reported as 0.91. This can be validated via the NHS Choices website.	20.3%	23.8%*	(Oct14-Sept15) 25.2%

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

Prescribed Information	2013/14	2014/15*	2015/16
Patient Report Outcome Measures (PROMs) The Trust's EQ5D patient reported outcome measures scores for:			April– Sept 2015
Groin hernia surgery			
Sheffield Teaching Hospitals' score:	0.075	0.050	0.077
National average:	0.085	0.084	0.088
Highest score:	0.142	0.138	0.135
Lowest score:	0.008	0.000	0.008
Varicose vein surgery			
Sheffield Teaching Hospitals' score:	0.102	0.089	0.115
National average:	0.093	0.095	0.104
Highest score:	0.149	0.154	0.130
Lowest score:	0.023	-0.002	0.037
Hip replacement surgery primary			
Sheffield Teaching Hospitals' score:	0.401	0.402	0.455
National average:	0.436	0.437	0.454
Highest score:	0.570	0.524	0.520
Lowest score:	0.332	0.331	0.359
Hip replacement surgery revision			
Sheffield Teaching Hospitals' score:	0.153	0.302	**
National average:	0.254	0.278	0.279
Highest score:	0.362	0.376	**
Lowest score:	0.153	0.186	**
Knee replacement surgery primary			
Sheffield Teaching Hospitals' score:	0.324	0.329	0.395
National average:	0.323	0.315	0.334
Highest score:	0.414	0.418	0.412
Lowest score:	0.209	0.204	0.207
Knee replacement surgery revision			
Sheffield Teaching Hospitals' score:	0.253	0.249	**
National average:	0.244	0.258	**
Highest score:	0.279	0.331	**
Lowest score:	0.123	0.179	**

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

PROMs scores represent the average adjusted health gain for each procedure. Scores are based on the responses patients give to specific questions on mobility, usual activities, self-care, pain and anxiety after their operation as compared to the scores they gave pre-operatively. A higher score suggests that the procedure has improved the patient's quality of life more than a lower score. *This data is different to the data reported in the 2014/15 Quality Report, as the data is now complete for the financial year 2014/15. ** 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 this data is as described as the data is taken from the Health and Social Care 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: • Analysis of Trust level data to further inform local improvements. • All hip and knee replacements admitted to dedicated ward with ERP. • Case Note Reviews for poorly reported outcomes. • Ongoing local programme of improvement projects. The following changes have been made as a result: • Patient information card to raise awareness to symptoms of potential post op joint infection and contact details for urgent review introduced • Blood Transfusion Guidelines updated • Use of Cryocuff in recovery and on ward to help reduce post op knee swelling • An improved analgesia regime for TKR to improve post op pain and reduce length of stay.			

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

Prescribed Information	2013/14	2014/15	2015/16
Readmissions The percentage of patients aged: 0 to 15; and 16 or over, readmitted to a hospital, which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period. **Comparative data is not available** The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the Trust's Patient Administration System up to October 2015 and then from Lorenzo. The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by reviewing the reasons for readmissions and working with our partners in the wider Health and Social Care community to prevent avoidable readmissions. This will be delivered through the Right First Time City Wide Health and Social Care Partnership. During 2015/16 the project was further expanded to examine reasons for readmissions in Care of the Elderly.	 0% 10.8%	 0% 10.8%	 0.3% 11%
Responsiveness to personal needs of patients The Trust's responsiveness to the personal needs of its patients during the reporting period. National average: 73.5% (this is currently based on picker average, not national) The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by National CQC Survey Contractor. *2013/14 National Survey scores represent four questions from the National Inpatient Survey selected as a measure of responsiveness to patient needs. This is compared to three questions for the 2014/16 and 2015/16 score. The Sheffield Teaching Hospital NHS Foundation Trust continues to take the following actions to improve this rate, and so the quality of its services, by implementing a new local inpatient survey which will survey a sample of 2000 patients from one month each quarter. Each quarter, patients from the sample will be asked six core questions, including one on privacy and dignity and follow-up questions which will be themed and change each quarter, as follows: • February 2016 - Noise & Food. • April 2016 – Staff. • July 2016 – Discharge. • October 2016 – Communication. • January 2017 – Environment.	79.3%*	75.1%	76.9%

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

Prescribed Information	2013/14	2014/15	2015/16
Friends and Family Test - Staff who would recommend the Trust (from Staff Survey) 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**: Combined acute & community trusts - 67% All trusts - 69% **Highest performing trust score**: (Combined acute & community trusts): 89% **Lowest performing trust score**: (Combined acute & community trusts): 46% The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is provided by the 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 seeking staff views and involving them in improving the quality of patient services via Listening into Action, Microsystems Academy, initiatives such as "Give it a Go Week" and "Right Good Week", Staff Friends and Family Test and our ongoing staff engagement work.	72%	78%	76%
Friends and Family Test - Patients who would recommend the Trust The percentage of patients who attended the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. *The score for 2013/14 represents a scale of -100 to +100 is, using the Net Promoter Score calculation. From October 2014 NHS England stopped using the Net Promoter scoring system and moved to a percentage system. The Friends and Family Test scores are now recorded taking the percentage of respondents who 'would recommend' our service which is taken from ratings 1 (Extremely Likely) and 2 (Likely). The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is collected by the Healthcare Communications, verified by UNIFY and reported by NHS England. The Sheffield Teaching Hospital NHS Foundation Trust continues to take the following actions to improve this rate, and so the quality of its services, by reviewing the methods of data collection used within Community Services. The Trust is to start generating weekly automatic reports for staff to keep on top of scores and response rates.	71*	92%	All areas 92% Inpatient and A&E only 91%

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

Prescribed Information	2013/14	2014/15	2015/16
Patients risk assessed for venous thromboembolism (VTE) The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. **Comparative data is not available** The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as we have processes in place to collect the data internally which is regularly monitored. We then report the data externally to the Department of Health. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and so the quality of its services, by • ensuring completion of VTE risk assessment form for every patient admitted to the Trust • feedback to Directorates on performance against target • analysis of cases of VTE which are thought to be hospital associated	95.16%	95.18%	95.18%
Rate of *Clostridium Difficile* The rate per 100,000 bed days of cases of *C.Difficile* infection reported within the Trust amongst patients aged two or over during the reporting period. **Comparative data is not available** *The rate shown is provisional until the Public Health England denominator rates are published. The denominator used is the 2014/15 figure as this is unlikely to change significantly. During 2015/16 there have been 78 cases of *C.Difficile* infection attributable to the Trust. The national threshold for 2015/16 was 87. All Trust attributable cases now have a root cause analysis to identify if there has been any lapse in care. At publication eight cases have been highlighted as possibly having a lapse in care. Quarter 3 and Quarter 4 cases are still being reviewed. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by the Public Health England. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this rate, and so the quality of its services, by having a dedicated plan as part of its Infection Prevention and Control Programme to continue to reduce the rate of *C.Difficile* experienced by patients admitted to the Trust.	13.7	16.2	13.6*

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

Prescribed Information	2013/14	2014/15*	2015/16**
Rate of patient safety incidents The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	9762	14605	13509
Number of Incidents reported The incident reporting rate is calculated from the number of reported incidents per hundred admissions and the comparative data used is from the first 6 months of 2015/16. Cluster average: 39.29 Highest performing trust score: 74.6 Lowest performing trust score: 18.07	4.75	25.57	29.93
The number and percentage of such patient safety incidents that resulted in severe harm or death. Cluster reporting data: 39 (0.4%) Highest reporting trust: 178 (0.2%) Lowest reporting trust: 6 (0.1%)	59 (0.6%)	44 (0.3%)	24 (0.1%)
* The figures for 2014/15 are different to those documented in last year's Quality Report as they have now been validated. **Full information for the financial year 2015/16 is not available from the National Reporting and Learning System (NRLS) until November 2016. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the NRLS. The Sheffield Teaching Hospitals NHS Foundation Trust intends to increase the incident reporting rate by 5%. **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.			

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

Mandated Indicators – Monitor Risk Assessment Framework

Measures of Quality Performance	2013/14	2014/15	2015/16
Percentage of patients who wait less than 31 days from decision to treat to receiving their treatment for cancer			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	98%	97%	97%
National Standard	96%	96%	96%
Data Source: Exeter National Cancer Waiting Times Database			
Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer			Q1, Q2 and Q3 data used
Sheffield Teaching Hospitals NHS Foundation Trust achievement	88%	85%*	83%**
National Standard	85%	85%	85%
Data Source: Exeter National Cancer Waiting Times Database *Includes reallocation of some breaches from the Trust to referring trusts in Q4 in 2014/15 ** Includes reallocation of some breaches from the Trust to referring trusts in Q1, Q2 and Q3 in 2015/16			
Percentage of patients who have waited less than 2 weeks from GP referral to their first outpatient appointment for urgent suspected cancer diagnosis			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	94%	94%	93%
National Standard	93%	93%	93%
Data Source: Exeter National Cancer Waiting Times Database			

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

Measures of Quality Performance	2013/14	2014/15	2015/16
All cancers: 31-day wait for second or subsequent treatment, comprising:			
Surgery:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	97%	95%	95%
National Standard	94%	94%	96%
Anti-cancer drug treatments:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	99%	100%	99%
National Standard	98%	98%	98%
Radiotherapy:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	99%	98%	98%
National Standard	94%	94%	94%
Data Source: Exeter National Cancer Waiting Times Database			
Accident and Emergency maximum waiting time of 4 hours from arrival to admission/ transfer/ discharge			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	95.7%	92.7%	*
National Standard	95%	95%	95%
At the end of September 2015, the Trust introduced a new Accident and Emergency tracking system, as part of the move to a new Electronic Patient Record. This has presented various technical difficulties and challenges to accurately capture data on patients wait in A&E. Due to this we have not been reporting our A&E waiting time data nationally. This has been the subject of ongoing discussion between the Trust and Monitor, NHS England and Sheffield CCG.			
MRSA blood stream infections			
Trust attributable cases in Sheffield Teaching Hospitals NHS Foundation Trust	4	2	0
Trust assigned cases in Sheffield Teaching Hospital NHS Foundation Trust	4	4	0
Sheffield Teaching Hospitals NHS Foundation Trust threshold	0	0	0
The Trust assigned was introduced for the 2013/14 and is the figure used to determine cases for which the Trust is held responsible and where fines may be attached.			
Patients who require admission who waited less than 18 weeks from referral to hospital treatment			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	90.4%	86.3%	87.3%
National Standard	90%	90%	90%

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

Measures of Quality Performance	2013/14	2014/15	2015/16
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 NHS Foundation Trust achievement	94.9%	94.8%	95.9%
National Standard	95%	95%	95%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	92.5%	92.8%	93.5%
National Standard	92%	92%	92%
Certification against compliance with requirements regarding access to healthcare for people with a learning disability			
Does the NHS Foundation Trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	New for 2014/15	Yes	Yes
Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about treatment options, complaints procedures and appointments?	New for 2014/15	No	Yes
Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	New for 2014/15	Yes	Yes
Does the NHS foundation trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	New for 2014/15	Yes	Yes
Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	New for 2014/15	Yes	Yes
Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	New for 2014/15	No	Yes

3.1 QUALITY PERFORMANCE INFORMATION 2015/16

Measures of Quality Performance	2013/14	2014/15	2015/16
Never Events (Count)			
Sheffield Teaching Hospital NHS Foundation Trust Performance	4	2*	4
Data Source: National Patient Safety Agency			
** The figures for 2014/15 are different to those documented in last year's Quality Report as one never event was downgraded.*			
Hospital Standardised Mortality Ratio (HSMR)			
Sheffield Teaching Hospital NHS Foundation Trust Performance	100%	99%*	96% (Jan 15-Dec 15)
National Benchmark	100%	100%	100%
Data source: Dr Foster			
*This figure is different from last year as it represents the whole year (April 2014 – March 2015) rather than Jan 2014-Dec 2014 as reported in last year's Quality Report.			
Data Completeness for Community Services			
Referral to treatment information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	66%	66%	62%
National Standard	50%	50%	50%
Referral information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	100%	100%	100%
National Standard	50%	50%	50%
Treatment activity information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	100%	100%	100%
National Standard	50%	50%	50%
Referral to treatment information – following an audit of the 2014/15 data the methodology for calculating the figure for this measure was revised for 2015/16. For info, the 2014/15 figure using the revised methodology would have been 56%.			
Referral and activity information – all required information is captured using mandatory fields on SystmOne so it is not possible to staff to save a referral or activity without all required information recorded.			

Governor Involvement in the Quality Report Steering Group

We continue to work on the ongoing priorities highlighted in previous year's report and have added three additional Quality Objectives for the coming year. These objectives have been agreed in collaboration with Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee.

The governors are involved at all stages of the report, contributing to the content and the wording. Our intention is to make it easy to understand for all readers.

This year the steering group are considering Patient Safety, End of Life Care and the Environment. We felt that these choices would result in measurable improvements in the patient's experience.

One of these initiatives had originated from one of the staff engagement events, emphasising the need to engage with all staff and consideration is given to suggestions from all areas.

This is once again an immense piece of work and the governors have been happy to contribute to this.

Kath Parker
Patient Governor

25th April 2016

Statement from NHS Sheffield Clinical Commissioning Group

NHS Sheffield CCG (CCG) has 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, the CCG view is that the report is materially accurate and gives a fair picture of the Trust's performance.

Sheffield Teaching Hospitals NHS Foundation Trust 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.

During 2015/16 the Trust has achieved a number of key Constitutional standards and key quality performance measures such as incomplete 18ww targets.

However, the Trust has continued to experience challenges in the delivery of 18 weeks waiting time standards in several individual specialties, and diagnostic waiting times, in particular, in gastroenterology and endoscopy.

The Trust has also struggled to achieve the 95% A&E target during the year.

The implementation of Lorenzo, a new Patient Administration System (PAS), in September 2015 meant that the trust experienced difficulties in validating reported data for a number of key indicators, and significant work was required to validate collected data to confirm accuracy including submissions for 18 week and diagnostics reporting. A&E reporting in particular was significantly affected and the Trust suspended reporting in September and remained unable to report for the rest of the year.

The CCG worked closely with the Trust during this period, and continues to do so, to find alternative methods to gain assurance on the Trust's performance. The CCG is assured that the Trust continues to fully prioritise these areas of provision for improvement during 2016/17 and that the Trust has taken appropriate steps to safeguard patient safety and service quality.

Following the regulatory visit made to STHFT by the Care Quality Commission (CQC) in December 2015, the Trust and CCG are awaiting the final publication of the CQC's report on the healthcare services. The CCG will work closely with the Trust to put in place any identified actions to improve the quality of services.

The CCG's overarching view is that Sheffield Teaching Hospitals NHS Foundation Trust continues to provide, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities. This quality report evidences that the Trust has achieved positive results in a number of its key objectives for 2015/16. Where issues relating to clinical quality have been identified in year, the Trust has been open and transparent and the CCG has worked closely with the Trust to provide support where appropriate to allow improvements to be made.

The CCG is in agreement with the identified priority areas for improvement in 2016/17. Our aim is to pro-actively address issues relating to clinical quality so that standards of care are upheld whilst services continue to evolve to ensure they meet the changing needs of our local population. The CCG will continue to set the Trust challenging targets whilst at the same time incentivise them to deliver high quality, innovative services.

Submitted by Beverly Ryton on behalf of:

Tim Furness
Director of Delivery

Abigail Tebbs
Deputy Director of Contracting

11th May 2016

Statement from Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee welcome the opportunity to consider your draft Quality Report in line with NHS (Quality Accounts) Regulations 2010. We view this as a valuable aspect of health service provision scrutiny that looks at the things that are important to the public of Sheffield.

The Committee note the Quality Report as a document is dual purpose and encourage the publication of two versions for different audiences. The sharing of priorities in October was welcomed and working further together on the process timetable will facilitate full comment on all aspects of the Quality Account for next year.

The Committee welcome progress made on the handling of complaints and improving complainant satisfaction. For next year's priorities we are pleased to see the inclusion of further work to improve safety and quality of care, as well as arrangements to improve End of Life Care and look forward to getting feedback on these in due course. The Committee also welcome improvements in the patient experience at Weston Park; we hope that this will include the roof terrace, as this is important to patients and families. We would like to see progress continuing to be made in key areas not selected yet as a priority – Frailty Unit and SAFER bundle. In particular, progress in speeding up discharge including tackling delays in the prescription/ pharmacy process.

The Committee are pleased to see some improvement in number of on day cancellations but welcome further progress. We especially want to see progress to 'Optimise Length of Stay, commitment of all to change, to enable discharge quicker and encourage further improvement through local co-production such as Right First Time.

In reviewing Quality Performance Information 2015/16 we are disappointed with the readmission rate; and look forward to seeing next year the outcome of the work on understanding why this is happening, including a look at a more detail age breakdown or indication of whether it is age related.

The Committee note that the percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer is below national standard and there has been deterioration in performance over last 3 years. We hope there are plans in place to improve this.

The Committee are pleased to note in response to our previous comments that, for transparency 'Never Events' are included in the Quality Report. It is good to see the improvements in results from staff survey, we are concerned with areas that have deteriorated and express concern at the disparity between white and BME experiences in the Work Race Equality Standard (WRES) particularly standards KF21 and Q17b, we look forward to seeing anticipated improvements.

May 2016

Statement from Healthwatch Sheffield

Healthwatch Sheffield would like to thank the trust for their continuous efforts to include them throughout the Quality Reports process this year. The trust has been open and transparent throughout the year and as a consequence, Healthwatch Sheffield has had good knowledge of the whole process and the evidence behind the decisions that have been made.

We note that the trust appears to have made good progress on its objectives from previous years, although we remain concerned that pressure ulcers continue to rise despite this having been an objective since 2013/14. We will continue to work with the trust to monitor this.

We were asked to contribute to a short list of priorities for 2016/17 and broadly support those chosen for the coming year, and feel that in particular improving the environment at Weston Park will have long term wellbeing benefits for patients.

We are also pleased to note that the trust has met its target of 85% response times for complaints, and we know from our conversations at the Patient Experience Committee that there is further work going on in this area to refine how complaints are categorised and responded to.

Healthwatch Sheffield, as in previous years, would be happy to work with the trust on the production of an easy read version of this report. Last year's version was again, a step forward from previous years and we hope this progress will be maintained.

In conclusion, we feel that this report is a good representation of the trust's current position and reflects the fact that it is aware of its strengths and those areas where it needs to improve.

We thank the trust for the opportunity to comment on this document and look forward to working with them in future.

May 2016

4.2 STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

Statement of Directors' Responsibilities for 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 NHS 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 2015/16 and supporting guidance
- 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 2015 to May 2016
  - papers relating to Quality reported to the board over the period April 2015 to May 2016
  - feedback from commissioners dated 11 May 2016
  - feedback from governors dated 27 April 2016
  - feedback from local Healthwatch organisations dated May 2016
  - feedback from Overview and Scrutiny Committee dated May 2016
  - the trust's draft complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2016
  - the latest national patient survey
  - the latest national staff survey published February 2016
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 17 May 2016
  - the CQC Intelligent Monitoring Report published May 2015.
- 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 manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

Tony Pedder OBE
Chairman

18 May 2016

Sir Andrew Cash OBE
Chief Executive

18 May 2016

4.3 INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST ON THE 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 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Monitor intended that we should review the 'percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge' indicator. However, the Trust has agreed with Monitor that this indicator need not be presented in the Trust's Quality Report. Monitor has advised that, in this instance, the selection for assurance should be the cancer waits indicator.

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 and supporting guidance 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicator 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 supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance 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 and papers for the period April 2015 to April 2016;
- papers relating to quality reported to the Board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from Healthwatch Sheffield;
- feedback from Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- the 2015/16 Head of Internal Audit's annual opinion over the Trust's control environment; and
- the latest CQC Intelligent Monitoring Report.

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 the 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 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator.

4.3 INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

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, except 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 indicator;
- 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 and supporting guidance to the categories reported in the Quality Report; and
- 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.

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 affect 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 of these criteria, 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 and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was 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 2016:

- 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
Manchester

25 May 2016