In hospital and in the community

proud to make a difference

Sheffield Teaching Hospitals NHS

NHS Foundation Trust

Annual Quality Report 2013/14

Contents

We want to make a difference to the lives of those who rely on our care, compassion and skill at a time when they are at their most vulnerable.

Part 1

1.1 Statement on quality from the Chief Executive

At Sheffield Teaching Hospitals we remain committed to delivering the best clinical outcomes and a high standard of patient experience to patients both in our hospitals and in the community. Thanks to the dedication and professionalism of our 16,000 staff we have a strong track record in this area but we are never complacent and continually look to adopt best practice, drive innovation and most importantly learn and improve when we do not meet the high standards we have set for ourselves.

This drive for improvement is embodied within the Trust's Corporate Strategy 'Making a Difference'. The 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.

These aims have resulted in a range of organisational objectives that guide the development of directorate business plans as well as personal objectives. This Quality Report details the achievements and performance during the second year of this strategy (2013/14).

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

During 2013 more than £3m pounds was invested in expanding the Accident and Emergency Department at the Northern General Hospital to provide a better patient experience and to accommodate the growing numbers of people using our service. In this time attendance at our Accident and Emergency Department remained high, however our waiting times improved. In 2012/13, 93.2% of patients were seen within four hours or less, this improved in 2013/14 with 95.7% of patients being seen within four hours or less.

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

Ensuring waiting times are kept as low as possible is a priority as we know this is one of the things which patients tell us is important to them. We also want to make sure our waiting times processes and procedures are robust and enable our patients to receive swift and appropriate treatment. During 2013/14 we carried out a planned review of Cancer Waiting Times in response to the CQC inspection into Colchester Cancer Services and waiting times. The Trust is satisfied that similar issues are not present in our services and we continue to do all we can to ensure patients do not wait any longer than necessary for care.

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

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

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

Part 1

1.1 Statement on quality from the Chief Executive

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

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

In 2013/14, the Trust approved a £35m investment in technology which will provide the opportunity to transform the way we deliver care both within the hospital and also in people's own homes and communities. This 5 year programme will also enable the organisation to become paperlight and support the work underway to develop integrated care teams and new models of care.

The programme will oversee the implementation of three major systems; an electronic patient record, an electronic document management system, and a clinical portal. This will provide clinicians with the information they need, at all times and in all locations. It will improve patient safety and our communication with patients, increase operational effectiveness (releasing time to care) as well as supporting clinical practice and research.

The following pages detail more of the improvements we have made during 2013/14 and also some of our key priorities for the coming year. However, across the entire organisation, a culture of learning and continual improvement will continue to be encouraged and I am in no doubt that this will lead to further developments which result in the delivery of high quality patient care for 2014/15.

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

Sir Andrew Cash OBE
Chief Executive
22 May 2014

1.2 Introduction from the Medical Director

Quality Reports enable NHS Foundation Trusts to be held to account by the public, as well as providing useful information for current and future patients. This Quality Report is an attempt to convey an honest, open and accurate assessment of the quality of care patients received during 2013/14. Whilst it is impossible to include information about every service the Trust provides in this type of document, it is nevertheless our hope that the report goes some way to reassure our patients and the public of our commitment to deliver safe, effective and high quality care.

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

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

The proposed quality improvement priorities for 2014/15 were agreed by the Trust's Board of Directors, Healthcare Governance Committee, on 28 April 2014. The final draft of the quality report was sent to external partner organisations for comments in March 2014 in readiness for the publishing deadline of the 30 May 2014.

Dr David Throssell
Medical Director

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement 2012/13 and 2013/14

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

2012/13 Objectives	2012/13	2013/14
Optimise length of stay (see 2.1.1) Through a systematic process of review areas will be identified for improvement across the organisation. National benchmarks (Dr Foster benchmark comparators) will be used to assess areas where the length of stay could be appropriately reduced without impact on the quality of care or outcomes.	▼	▼
Discharge letters for GPs (see 2.1.2) Improve the quality of immediate discharge letters sent to General Practitioners (GPs) by auditing the content of letters within each Directorate against parameters agreed with NHS Sheffield. Deficiencies identified during this process will be addressed by actions at Directorate and Trust level.	=	▲
Giving patients a voice – Make it easier to communicate with the organisation (see 2.1.3) Making what we've got work well – to improve the response rate for frequent feedback forms by 20% and for comments cards by 50%. This has been achieved by more effective publicity to encourage patient feedback and communicating that improvements have been made as a consequence of patients views/suggestions,(e.g. 'you said – we did').	▲	See 2.1.3
Review mortality rates at the weekend (see 2.1.4) Review in detail the Trust's position with regard to mortality at the weekend and identify any significant differences, review causes and implement improvements if required.	▲	▲
Improve Dementia awareness (see 2.1.5) The Trust is dedicated to improving dementia awareness with our staff and meeting the needs of patients and carers with this condition. We will undertake environmental audits across all appropriate directorates so that improvement plans can be developed to address the needs of patients and carers experiencing dementia. (Link to the King's Fund Dementia work and ward essential maintenance programme).	▲	▲
2013/14 Objectives	**2012/13**	**2013/14**
Patient Experience: Cancelled Operations (see 2.1.6) Reduce the number of operations cancelled on the day of surgery.	New for 2013/14	▼
Patient Safety: Pressure Ulcers (see 2.1.7) Reduce the prevalence of Grade 2, 3 and 4 pressure ulcers reported within the Trust acute and community based services, including both ulcers acquired whilst receiving Trust care and community-acquired pressure ulcers.	New for 2013/14	▼
Clinical Effectiveness (outcomes): Improve discharge information for patients (see 2.1.8) Improve the provision of discharge information for patients by auditing the information provided and available for patients against Trust wide standards.	New for 2013/14	=

Key	= Almost achieved	▲ Achieved	▼ Behind schedule

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Update on objectives 2012/13

2.1.1 Optimise length of stay

Trustwide performance

2011/12	2.9 days
2012/13	2.8 days
2013/14	2.7 days

A number of initiatives have been introduced to facilitate patient flow, including meetings where patients with a length of stay over 15, 35 and 56 days are reviewed and action taken to resolve any unnecessary delays. Daily and weekly review of patients who are medically fit for discharge and regular monitoring of medical outliers (where the patient is in a speciality bed which is different from their current condition) also takes place.

Detailed admission/discharge and bed occupancy reports are also available to directorate management teams to allow them to focus resources in the most appropriate areas. A number of new matron posts have been introduced to support improved flow across the organisation.

In addition, the Trust works with partners as part of the Right First Time city wide health and social care partnership to improve patient flow across the health economy. Furthermore, the Trust has committed to integrating the Community Services and Geriatric and Stroke Medicine Directorates during 2014 to help streamline pathways for older people. This should in turn help improve the seamlessness of pathways, and support efforts to reduce hospital length of stay.

Pharmacy has an ongoing comprehensive action plan to reduce delays in the provision of discharge medication which acknowledges that there is no single cause of delay so there is no simple quick fix available.

The installation of an electronic prescribing system in the Trust will alleviate many of the existing issues, but at present pharmacy action focuses on continuing to improve current systems and processes, supplemented by two major change initiatives, namely the installation of automated robotic dispensing at the Northern General Hospital and the outsourcing of outpatient dispensing at the Royal Hallamshire Hospital to Boots. This has permitted the redeployment of STH pharmacy staff to improve inpatient services.

The Trust has also set up a multidisciplinary Task and Finish Group under the chairmanship of a Deputy Medical Director to address wider issues which are outside of the scope of pharmacy to address.

Optimising length of stay will continue to be a priority for the Trust during 2014/15.

2.1.2 Discharge letters for GPs

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

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

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

During 2013/14, 6,819 Frequent Feedback surveys and 684 comment cards were completed. This compared with 4,914 Frequent Feedback surveys and 2,857 comment cards completed during 2012/13. Whilst comment cards are still widely available across the Trust, we are no longer distributing these to patients through our volunteers, as the new Friends and Family Test (FFT) is now the priority. We decided that to give the comment cards out at the same time as the FFT cards would be confusing for patients. In the FFT, we are now seeing improvements in our response rates through new initiatives including surveying some patients by text.

2.1.4 Review mortality rates at the weekend

The Trust has continued to review weekend mortality during 2013/14, finding that our Hospital Standardised Mortality Ratio for weekday and weekend emergency admissions is both 'within expected range'. However, given the importance of mortality rates and continual monitoring to ensure that any variance can be spotted quickly and acted upon, it has been agreed that this will again be a priority for improvement for 2014/15.

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

2.1.5 Improving Dementia Awareness

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

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

A specific session on dementia awareness is currently included in the Trust induction for all members of staff, both clinical and non-clinical with 1,256 staff having attended during 2013/14. More comprehensive training is also available for those who regularly care for people with dementia to ensure they are equipped to care for this patient group. There are six e-learning courses associated with dementia and these were completed by staff a total of 1099 times throughout 2013/14. Also 205 staff have attended the University of Sheffield bespoke study day for dementia and delirium during 2013/14.

Objectives 2013/14

2.1.6 Patient Experience – Cancelled Operations

In 2012/13 7% of planned operations were regrettably cancelled on the day (clinical and non-clinical reasons) of surgery. We fell short of our target to reduce this figure to 4% by April 2014 however, the number of cancellations was less than in 2012/13.

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

Year	Cancelled Operations for Clinical and Non-Clinical reasons	Total planned operations	% on day cancellation rate
2011/12	2,300	33,568	6.9%
2012/13	2,394	34,364	7%
2013/14	2,392	35,762	6.7%

*This data is for Main Theatres and the Day Surgery Units at the Northern General Hospital and the Royal Hallamshire Hospital.

The top five reasons for cancellations at the Trust account for 65% of all on-day cancellations at the Trust and these are:

- patient unfit - hospital decision: 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
- patient cancelled or refused treatment - patients changing their mind, or unable to attend the scheduled date for surgery
- 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

The top five reasons for cancellations at the Trust were the same for 2011/12 and 2012/13.

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

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

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

The Surgical Pathway Group will discuss, develop and implement a patient information campaign regarding avoidable on-day cancellations and also a trial of text messaging for admissions.

A management of cancellation policy will be discussed by the Surgical Board to detail the actions to be taken where no verbal confirmation can be made with patients in the days before their planned admission.

On-day cancellations will continue to be a priority during 2014/15 as the Trust views this as a significant area of concern.

2.1.7 Patient Safety – Pressure Ulcers

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

2012/13 performance figures:

Monthly survey data for the period from October 2012 to March 2013:	
Proportion with pressure ulcers acquired whilst receiving care from the Trust	1.77%
Proportion with pressure ulcers prior to receiving care from the Trust	4.18%
Overall proportion	5.95%

2013/14 performance figures:

Monthly survey data for the period from October 2013 to March 2014:	
Proportion with pressure ulcers acquired whilst receiving care from the Trust	1.41%
Proportion with pressure ulcers prior to receiving care from the Trust	4.31%
Overall proportion	5.72%

Whilst the proportion of patients acquiring pressure ulcers whilst receiving care from the Trust has fallen by 0.36%, a 20% reduction, the proportion of patients acquiring pressure ulcers prior to receiving care from the Trust has increased by 0.13% which has meant the total reduction is 0.23%.

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

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

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

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

The Tissue Viability Nurse will:

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

Work also continues to improve the quality of the data recorded and the information available to the clinical areas. Currently the information used to measure performance against the Commissioning for Quality and Innovation (CQUIN) target is taken from the Safety Thermometer (A national data collection instrument that collects incidence data once a month across all patients, hospital and community). This data collection tool has a number of limitations and work is underway in the Trust to enhance the information collected in order to better inform patient care. This will continue to be a priority for the Trust during 2014/15.

2.1.8 Clinical Effectiveness (Outcomes) - Improving Discharge Information

Since May 2013, 628 patient information leaflets have been checked and revised. Of these 243 (39%) have had changes made to their discharge information. This work will be ongoing until all 1,500 leaflets within the Trust have been checked and updated. Due to the volume of leaflets it is anticipated that it will take a further 18 months before this work is completed.

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

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

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

2.1.9 Priorities for Improvement 2014/15

This section describes the Quality Improvement Priorities that have been adopted for 2014/15. These have been agreed by the Quality Report Steering Group in conjunction with patients, clinicians, Governors, Healthwatch and NHS Sheffield CCG. These were approved by the Trust Board of Directors, Healthcare Governance Committee, on 28 April 2014. The Trust has compared hospital and community service priorities for the coming year choosing three areas to focus on which span the domains of patient safety, clinical effectiveness and patient experience.

Priorities for 2014/15 are:

1. To ensure that every hospital inpatient knows the name of the consultant responsible for their care during their inpatient stay and the name of the nurse responsible for their care at that time.
2. To improve complainant satisfaction with the complaints process.
3. To review mortality rates at the weekend and to focus improvement activity where necessary.
4. To review the impact of waiting times on the patient experience (specifically patients waiting over 18 weeks for treatment).

In addition to these priorities for improvement there are many quality improvement proposals in the Sheffield Teaching Hospitals Quality Strategy and the Commissioning for Quality and Improvement (CQUIN) Framework (see page 56).

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.10 Detailed objectives linked to Improvement Priorities

Priority 1

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

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Priority 2

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

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Priority 3

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

Part 2

Priorities for Improvement and Statements of Assurance from the Board

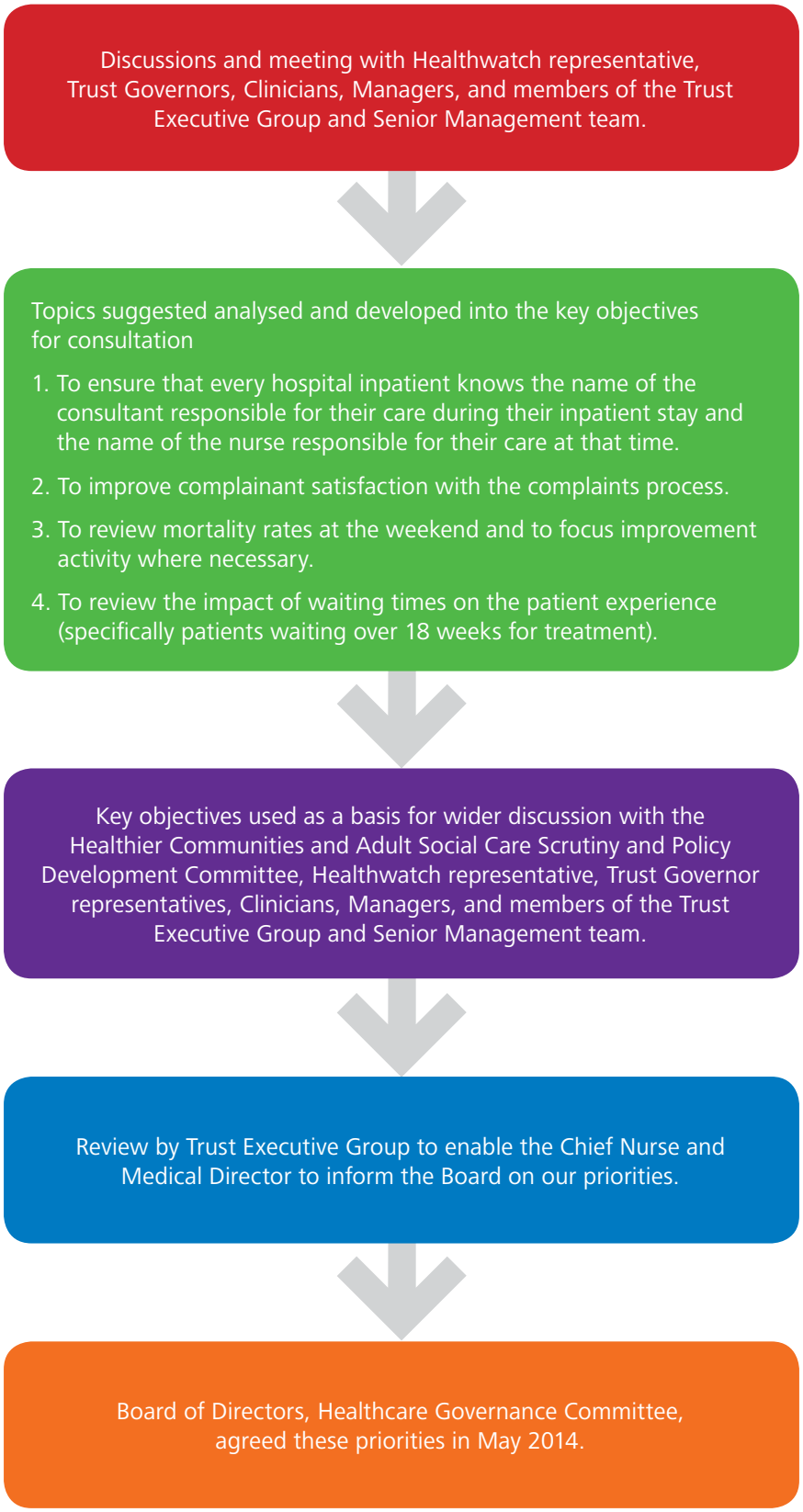
Priority 4

Our Aim	To review the impact of waiting times on the patient experience (specifically patients waiting over 18 weeks for treatment).
Past Performance	Waiting for an appointment or treatment can be stressful for the patient and their carers and may significantly impact on the overall patient experience. There is a national target which specifies that the length of time between first referral and treatment should be no longer than 18 weeks. The Trust has a number of plans and strategies in place to reduce the length of time spent waiting for an appointment or treatment. Our current 18 week performance is detailed on page 74. Patient experience information can be obtained from • Inpatient and outpatient questionnaires • Frequent Feedback surveys • Friends and Family Test information • Analysis of Complaints However this information is not specific to patients waiting over 18 weeks for treatment and may not be representative of the overall situation.
Key Objectives	**April – June** • Review all the feedback sources and identify a suitable method of obtaining patient feedback in relation to waiting for an appointment or treatment. • This may include designing and implementing a bespoke survey to further understand the impact on patient experience for patients. • Baseline data to be collected using the most appropriate method. **July – Sept** • Analyse and interpret the findings to establish if any lessons can be learnt. • Areas for improvement identified during this process will be addressed by improvement activities at Directorate and Trust level. **Oct – Dec** • Resurvey where indicated and consider the appropriateness of putting in place systems and processes to provide a consistent method of reviewing the experiences of patients who wait for treatment.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2014/15. Qualitative outcomes will be reported and where available performance measures will be used to demonstrate change.
Board Sponsor	**Professor Hilary Chapman** Chief Nurse
Implementation lead	**Mrs Sue Butler** Head of Patient Partnership

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.11 How did we choose these priorities?



Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.2 Statements of Assurance from the Board

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

a) Services Provided

b) Clinical Audit

c) Clinical Research

d) Commissioning for Quality and Improvement (CQUIN) Framework

e) Care Quality Commission

f) Data Quality

g) Patient Safety Alerts

h) Staff Engagement

i) Annual Patient Surveys

j) Complaints

k) Eliminating mixed sex accommodation

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

m) Response to The Mid Staffordshire NHS Foundation Trust Public Inquiry

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

a) Services Provided

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

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

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

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

b) Clinical Audit

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

During that period Sheffield Teaching Hospitals NHS Foundation Trust participated in 94.6% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2013/14 are documented in Table 1. The 2 national clinical audits and the Trusts reason for non-contribution this year are detailed later in this section.

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Table 1

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Acute Care		
Adult Critical Care (Case Mix Programme – ICNARC CMP)	Yes	100%
Emergency use of oxygen (British Thoracic Society)	Yes	100%
Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death (NCEPOD) studies:		
Lower Limb Amputation	Yes	100%
Tracheostomy Care	Yes	100%
Subarachnoid Haemorrhage	Yes	74%
Alcohol Related Liver Disease	Yes	79%
National Audit of Seizures in Hospitals (NASH)	Yes	100%
National Joint Registry (NJR)	Yes	99%
Paracetamol overdose (care provided in emergency departments) (CEM)	Yes	100%
Severe sepsis and septic shock (CEM)	Yes	100%
Severe trauma (Trauma Audit and Research Network, TARN)	Yes	76%
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme (NHS Blood and Transplant) Includes:		
National Comparative Audit of the Use of Anti D	Yes	100%
National Comparative Audit of the Management of patients in neuro critical care	No	See statement
Cancer		
Bowel cancer (NBOCAP)	Yes	91%*
Head and neck oncology (DAHNO)	Yes	89%*
Lung cancer (NLCA)	Yes	93%*
Oesophago-gastric cancer (NAOGC)	Yes	96%*
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	99%
Cardiac Rhythm Management (CRM)	Yes	100%
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	100%
Coronary angioplasty	Yes	100%
National Adult Cardiac Surgery Audit	Yes	99%
National Cardiac Arrest Audit (NCAA)	No	See statement
National Heart Failure Audit	Yes	89%
National Vascular Registry Elements include:		
National Carotid Interventions Audit	Yes	83%
Abdominal Aortic Aneurysm (AAA)	Yes	60%
Peripheral Vascular Surgery – Lower limb angioplasty/stenting.	Yes	78%
Peripheral Vascular Surgery – Lower limb bypass	Yes	70%
Peripheral Vascular Surgery – Lower limb amputation	Yes	54%
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	100%

Table continues overleaf:

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Long Term Conditions		
Diabetes (Adult) ND(A)	Yes	100%
National Diabetes Inpatient Audit (NaDIA)	Yes	100%
Diabetes (Pregnancy) (NPID)	Yes	100%
Diabetes (Paediatric) (NPDA)	N/A	N/A
UK Inflammatory bowel disease (IBD) Includes:		
Inflammatory bowel disease Inpatient Care Audit	Yes	100%
Inflammatory bowel disease Biologics Audit	Yes	77%
Paediatric bronchiectasis (British Thoracic Society) Previously part of the Bronchiectasis audit 2010-13	N/A	N/A
Renal replacement therapy (Renal Registry)	Yes	100%
Mental Health		
Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	N/A	N/A
National audit of schizophrenia (NAS)	N/A	N/A
Prescribing Observatory for Mental Health (POMH)	N/A	N/A
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	Yes	98%*
Sentinel Stroke National Audit Programme (SSNAP)	Yes	97%**
Other		
Elective surgery (National PROMs Programme). Procedures include:	Yes	
Groin hernia surgery		
Questionnaire 1 received		74.8%
Questionnaire 2 returned		57.9%
Varicose vein surgery		
Questionnaire 1 received		72.7%
Questionnaire 2 returned		41.5%
Hip replacement/revision surgery		
Questionnaire 1 received		87%
Questionnaire 2 returned		46.8%
Knee replacement/revision surgery		
Questionnaire 1 received		96.2%
Questionnaire 2 returned		37.6%

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Women's and Children's Health		
Child health clinical outcome review programme (CHR-UK)	N/A	N/A
Epilepsy 12 audit (Childhood Epilepsy)	N/A	N/A
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Moderate or severe asthma in children (care provided in emergency departments) (CEM)	N/A	N/A
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric asthma (British Thoracic Society)	N/A	N/A
Paediatric intensive care (PICANet)	N/A	N/A

Please note the following:

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

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

Supporting Statements:

1. **National Comparative Audit of the Management of patients in neuro critical care**

   Due to the short time frame given the Trust was unable to put in place appropriate resources to participate.

2. **National Cardiac Arrest Audit (NCAA)**

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

The reports of 24 national clinical audits were reviewed by the Sheffield Teaching Hospitals NHS Foundation Trust in 2013/14 and Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Some examples of which are included below:

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

Part 2

Priorities for Improvement and Statements of Assurance from the Board

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 through Audits and Confidential Enquiries across the United Kingdom – see table 1 for participation rate).

Local Clinical Audits

The reports of 140 local clinical audits were reviewed by the Sheffield Teaching Hospitals NHS Foundation Trust in 2013/14 and Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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

c) Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Teaching Hospitals NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 14,665 (2012/13 – 12,142).

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

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

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

d) Commissioning for Quality and Improvement (CQUIN) Framework

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

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at: *www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=327*

In 2013/14, 2.5% of our contractual income (£17.5m) was conditional on achieving Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals NHS Foundation Trust and NHS Sheffield CCG. During 2012/13 the Trust secured £14.8m on achieving Quality Improvement Innovation goals.

For 2013/14 the Commissioning for Quality and Innovation payment framework has included:

- improved identification and assessment of patients who may have Dementia, with over 90% of patients over 75 now screened for dementia
- improved responsiveness to the personal needs of patients, with over 90% of patients surveyed expressing complete satisfaction with the help they received with nutrition, pain control and going to the toilet

- reduction in the prevalence of pressure ulcers acquired whilst receiving hospital or community care
- improved communication with GPs following a patient's attendance at the Accident and Emergency Department.

e) Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against Sheffield Teaching Hospitals NHS Foundation Trust during 2013/14.

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

Routine Inspections

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

f) Data Quality

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

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

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

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

- 99.8% for admitted patient care;
- 99.8% for out patient care; and
- 98.7% for accident and emergency care.

Sheffield Teaching Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 68% and was graded green and satisfactory.

Sheffield Teaching Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- 8% primary diagnosis incorrect
- 10% secondary diagnosis incorrect
- 7% primary procedures incorrect
- 23% secondary procedure incorrect

To note: The figures above relate to the correct recording of patient diagnosis and procedures from case notes, not an error in clinical practice. The standard is 90% correct recording of the primary diagnosis and procedure, and 80% correct recording of the secondary diagnosis and procedure.

The results should not be extrapolated further than the actual sample audited. Areas audited were taken from a section of specialities specified nationally and by NHS Sheffield CCG, which were:

- 100 sets of case notes with a code of 'Digestive System Procedures and Disorders', with a specified level of complications and co-morbidities.
- 100 sets of case notes from an emergency admission with a code of 'Other Specified Admission and Counselling' with intermediate or major complications and co-morbidities.

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

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

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

Part 2

Priorities for Improvement and Statements of Assurance from the Board

g) Patient Safety Alerts

The National Patient Safety Agency analyses reports on patient safety incidents received from NHS staff and uses this to produce resources (alerts or rapid response requests) aimed at improving patient safety. Table 2 below details the Alerts and Rapid Response Reports which have been received during the year 2013/14.

Table 2: Alerts received during 2013/14

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

h) Staff Engagement

Staff Engagement

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

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

Staff Involvement

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

The Chief Executive undertook several staff open sessions to share and discuss the opportunities and challenges facing the organisation. He also spends time with a number of clinical and non-clinical departments each month to take the opportunity to chat with staff and listen to their feedback. The Chairman meets regularly with the Staff Governors and the whole Board visit a department every month to meet staff and recognise their efforts.

A number of 'Let's talk' engagement events have been held in directorates across the Trust in order to seek staff views and encourage ideas for service improvements.

In addition some directorates are now using the Microsystems Coaching Academy approach to improving services. Many areas have introduced staff suggestion boxes after these were successfully piloted in the Hotel Services Directorate during 2012/13.

The Clinical Assurance Toolkit in use in clinical areas includes a Staff Survey (based on the engagement questions in the NHS Staff Survey) and some other departments e.g. Pharmacy and Professional services undertake their own Staff Surveys. Furthermore, the Trust conducted a full census NHS Staff Survey in autumn 2013 to give all staff the opportunity to contribute their views and suggestions.

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

Appraisal

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

Priorities for Improvement and Statements of Assurance from the Board

The PROUD values are:

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

There has been a significant rise in the number of staff receiving an appraisal during 2013/14. This stands at 97.3%.

Health and Wellbeing

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

Following the successful pilot of a fast track musculoskeletal service for staff in the Jessop Wing by PhysioPlus we have expanded this service across the whole Trust effective from April 2014. The Trust is looking to link this to the development of a fast track mental health pathway for staff absent due to stress, anxiety and depression. The intention is to develop a seamless service between Occupational Health, Physiotherapy and Mental Health practitioners to support staff who are absent and in time, be able to provide a preventative service. It is anticipated that this reduce sickness absence rates within the Trust and improve staff health and wellbeing overall.

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

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

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

Leadership and Management Development

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

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

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

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

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

NHS Staff Survey

Staff engagement is measured every year via the annual NHS Staff Survey which includes an overall score for staff engagement. It was pleasing to note that the overall Trust staff engagement score (3.71) as reported in the benchmarked NHS Staff Survey, improved during 2013, despite this being a challenging year. This improvement means that the Trust compares well to other acute trusts. It is very pleasing to note that 72 % of our staff would recommend the Trust to family and friends for treatment which is well above the NHS average of 65%.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Response rate

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

Top five ranking scores:

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

Bottom five ranking scores:

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

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Most improved

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

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

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

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

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

Although the Trust was benchmarked in the best 20% of acute Trusts for the key finding related to the percentage of staff working extra unpaid overtime the Trust acknowledges that at 64% this is still high and possible causes of this have been discussed at the Staff Engagement Executive Group and will continue to be monitored.

It was pleasing to note the improvement in the percentage of staff being bullied/abused by staff which resulted in the Trust being benchmarked in the best 20% of acute Trusts however work is continuing to addressing this further. A new 'Acceptable Behaviour at Work' policy was introduced in the summer of 2013 supported by literature and briefings.

This policy incorporates a process of tackling bullying and harassment as well as a range of informal measures to tackle concerns early. Bullying and harassment is also included in mandatory training. In addition 'Respect for others' is one of the core PROUD values being rolled out throughout the Trust which are included in both appraisal and recruitment.

i) Annual Patient Surveys

The Trust undertakes a wide range of activities to gain feedback from patients regarding the services they receive. Survey work during 2013/14 included participation in the national survey programme for inpatients, maternity and cancer services. In addition, our extensive programme of local surveys has continued, with around 400 patients each month participating in the 'frequent feedback' survey programme in which the views of patients about a wide range of services are gathered by trained volunteers. The new Friends and Family Test (FFT) has also been implemented across in-patients, accident and emergency and maternity services.

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

In the National Maternity Survey 2013 areas achieving high scores include women having a contact number for any worries post natally, and the partner being involved enough during labour and birth. Questions where further improvements could be made include provision of information regarding emotional changes post natally and continuity of midwife support during post natal care.

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

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

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Friends and Family Test

The Friends and Family Test (FFT) was introduced nationally from April 2013 for all adult acute in-patients and patients discharged from Accident and Emergency Departments, and from October 2013 for maternity services.

The test asks a simple, standardised question with response options on a 5-point scale, ranging from 'extremely likely' to 'extremely unlikely'. This Trust has also chosen to ask a follow-up question in order to understand why patients select a particular response.

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

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

j) Complaints

Improving the experience and learning from complaints

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

During 2013/14 we received 1205 concerns and enquiries which we were able to respond to within two working days. If telephone calls, emails or face to face enquiries are received by the Patient Services Team (PST) which staff feel can be dealt with quickly by taking direct action or by putting the enquirer in touch with an appropriate member of staff such as a matron or service manager, contacts are made and the enquiry is recorded on the complaints database as a PST contact. If the concern or issue is not dealt with within two days, or if the enquirer remains concerned, the issue is re categorised as a complaint and processed accordingly.

1378 complaints requiring more detailed and in depth investigation were received. Table 3 provides a monthly breakdown of complaints and concerns received.

Table 3

	Apr-13	May-13	June-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
New Complaints Received	121	118	83	114	112	111	105	137	95	130	139	113	1378
Patient Services Team (PST) Concerns	94	106	90	113	106	85	100	103	61	124	115	108	1205
Complaints and PST Enquiries combined	215	224	173	227	218	196	205	240	156	254	254	221	2583

The Trust works to a target of responding to 85% complaints within 25 working days. The performance this year was 72% falling short of the target for the first time. The high number of complaints received in January – March 2013 saw a backlog develop which has meant that performance dropped in May, and has remained below the target level for the rest of the year. Chart 1 shows a monthly breakdown of performance against the Trust target per month.

Priorities for Improvement and Statements of Assurance from the Board

Chart 1

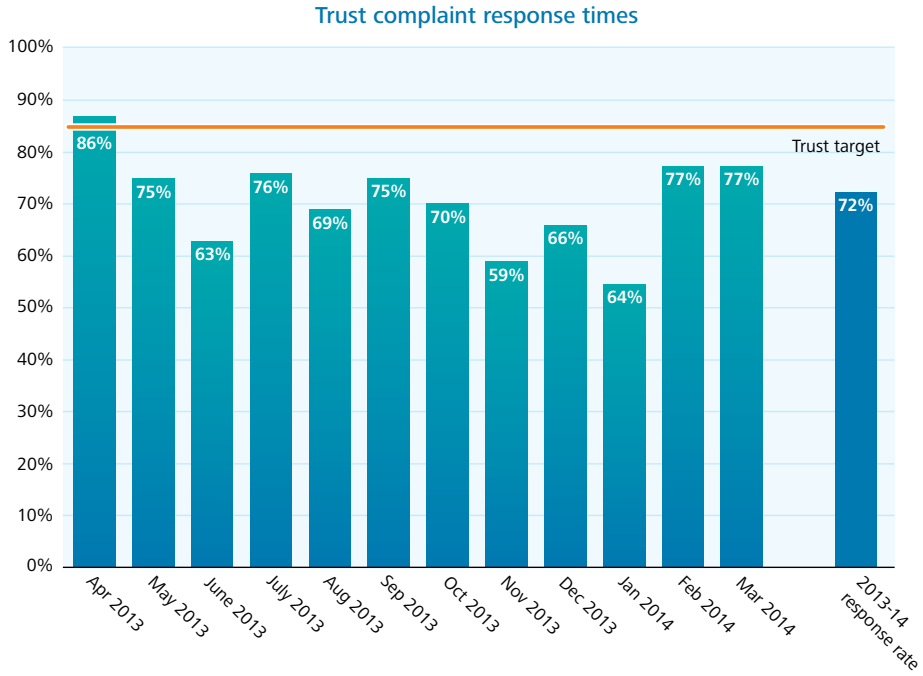
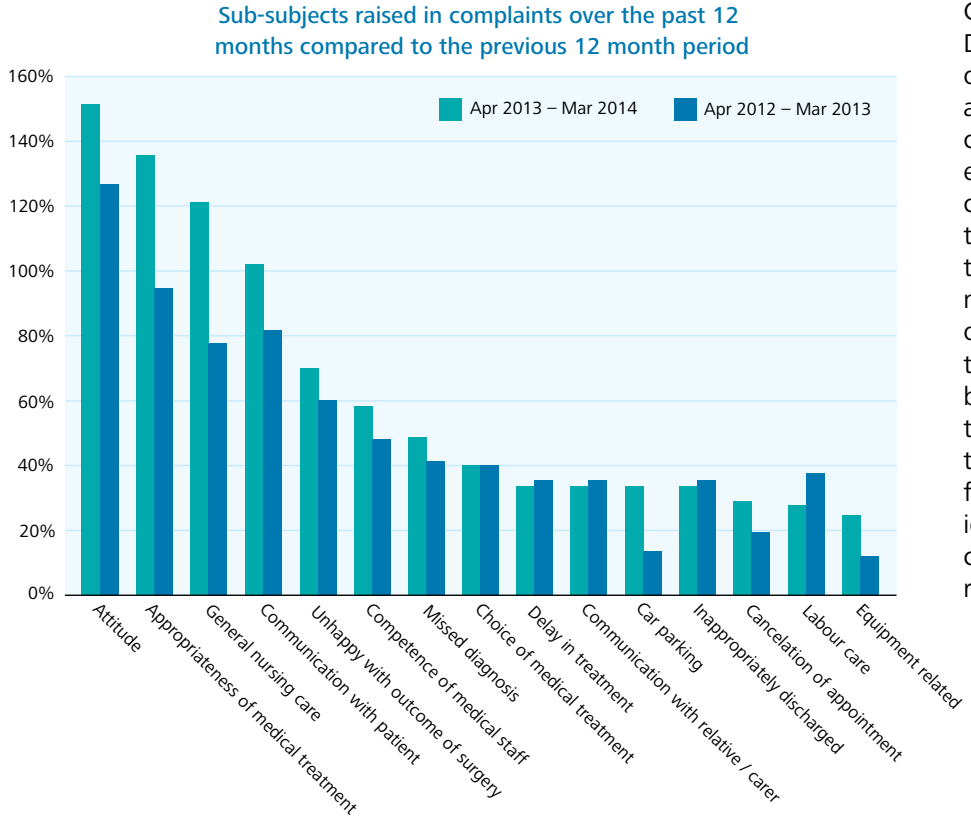


Chart 2



Regular complaints and feedback reports are produced for the Board of Directors, Patient Experience Committee, Care Groups and Directorates showing the number of complaints received in each area and illustrating the issues raised by complainants. This reporting process ensures that at all levels, the Trust is continually reviewing information so that any potentially serious issues, themes or areas where there is a notable increase in the numbers of complaints received can be thoroughly investigated and reviewed by senior staff. Chart 2 (left) shows the breakdown of complaints by theme. The findings show the top five themes are the same as those identified last year. Staff attitude continues to be the most commonly raised subject in complaints.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

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

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

- **The launch of the PROUD values**

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

- **Customer Care Training**

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

Key Priorities for 2014/15

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

A programme of training for senior nursing and medical staff is to be introduced in 2014 to support the new complaints process and ensure a consistent approach when investigating and responding to complaints. Staff leading complaints investigations will receive training to ensure complaint investigations are carried out thoroughly with findings communicated to patients and families in a clear, comprehensive way.

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

k) Eliminating Mixed Sex Accommodation

The Trust remains committed to ensuring that men and women do not share sleeping accommodation except when it is in the patient's overall clinical best interest or reflects their personal choice. As a result we have not identified any breaches of the Eliminating Mixed Sex Accommodation during 2013/14.

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

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

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

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

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

[1]Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

[2]Clwyd and Hart (2013) A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture

[3]Keogh (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report

Part 2

Priorities for Improvement and Statements of Assurance from the Board

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

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

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

The final Trust plan is not due to be considered by the Trust Board of Directors until May 2015 to enable a period of consultation to take place, however the actions required include implementation of the new Duty of Candour, publication of nurse staffing levels and improved information regarding how to make a complaint. Details of the plan and the actions undertaken will be included in the Quality Report 2015/16.

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

Part 3

Review of Services in 2013/14

3.1 Quality Performance Information 2013/2014

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.

For 2013/14 the Trust undertook a review of the priorities reported in the Annual Quality Report, mindful of the volume of activity reported it was agreed that the priority relating to 'Patients who receive Primary Percutaneous Coronary Intervention within 150 minutes of calling for help' would continue to be monitored at a local level within the speciality care group. It was therefore removed from the Quality Report template.

i) Mandated Indicators – Department of Health (Gateway reference 18690 and 00931)

Prescribed Information	2011/12	2012/13	2013/14
1. Mortality			
(a) The value and banding of the summary hospital-level mortality indicator (SHMI) for the trust for the reporting period. **National average: 1.0** **Highest performing Trust score: 0.63** **Lowest performing Trust score: 1.19**	.92 Banding: 'as expected'	.88 Banding: 'lower than expected'	**.89 (Oct 12 – Sept 13)** Banding: 'lower than expected'
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. **National average: 20.9** **Highest Trust score: 44.9** **Lowest Trust score: 0** 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 Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this rate, and so the quality of its services, by: • Ensuring consistent Mortality and Morbidity reviews are undertaken across the Trust. • Monitoring the mortality data at a diagnosis level to ensure any areas for improvement are constantly reviewed and where appropriate actions are taken. The SHMI reported in last year's Quality Report was qualified by the annotation that this was derived from the most recent rolling 12 month period i.e. Oct 2011 – Sept 2012. SHMI results are published six months and three weeks in arrears because of the need to validate the data nationally. The value for April 2012 – March 2013 was released at the end of October 2013 and reported as 0.88. This can be validated via the NHS Choices website.	17.5%	18.4%	**18.5% (Oct 12 – Sept 13)**

Prescribed Information	2011/12	2012/13	2013/14
2. Patient Report Outcome Measures (PROMs) The Trust's patient reported outcome measures scores for:			April-Sept 2013/14
(i) Groin hernia surgery			
Sheffield Teaching Hospitals' score:	0.081	0.108	0.068
National average:	0.086	0.084	0.085
Highest score:	0.143	0.157	0.131
Lowest score:	-0.002	0.015	0.019
(ii) Varicose vein surgery			
Sheffield Teaching Hospitals' score:	0.065	0.076	*
National average:	0.094	0.093	0.101
Highest score:	0.167	0.138	0.094
Lowest score:	0.049	0.023	0.058
(iii) Hip replacement surgery primary	**		
Sheffield Teaching Hospitals' score:	0.386	0.406	0.39
National average:	0.415	0.437	0.447
Highest score:	0.463	0.543	0.545
Lowest score:	0.306	0.319	0.373
(iv) Hip replacement surgery revision	**		
Sheffield Teaching Hospitals' score:	0.386	0.236	*
National average:	0.415	0.272	0.260
Highest score:	0.463	0.35	*
Lowest score:	0.306	0.164	*
(v) Knee replacement surgery primary	**		
Sheffield Teaching Hospitals' score:	0.315	0.308	0.345
National average:	0.302	0.318	0.338
Highest score:	0.385	0.409	0.429
Lowest score:	0.181	0.231	0.264
(vi) Knee replacement surgery revision	**		
Sheffield Teaching Hospitals' score:	0.315	0.211	*
National average:	0.302	0.251	0.255
Highest score:	0.385	0.369	*
Lowest score:	0.181	0.194	*

Table continues overleaf:

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

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

** 2011/12 data presents primary and revision combined for both Hips and Knee procedures. 2012/13 and 2013/14 now present primary and revision separately therefore this data is not comparable.

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

The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by:

- Continuing to review in detail a breakdown of EQ-5D and OHS data for hips and undertaking improvement work as necessary.
- Monitoring scores at directorate and Trust level to respond to feedback from patients and incorporating their views into quality improvements.
- Increasing the involvement and understanding of staff in how we use the information received through PROMs and working with staff to increase participation rates.

To further understand and improve PROMS scores, work has been initiated to map the process of questionnaire distribution to relevant patients and to work closely with clinicians to identify opportunities for improvements in the patient pathway.

Part 3

Review of Services in 2013/14

Prescribed Information	2011/12	2012/13	2013/14
3. Readmissions The percentage of patients aged: 1. 0 to 15; and 2. 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. *These figures are different from subsequent years as the way the data is calculated has changed (Data definition). The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by reviewing the reasons for 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.	 0% 10.7%*	 0% 11.36%	 **0%** **10.8%**
4. Responsiveness to personal needs of patients The trust's responsiveness to the personal needs of its patients during the reporting period. **National average: 72.8%** 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 scores represent the four questions from the National Inpatient Survey which have been selected nationally to form part of the CQUIN scheme, as a measure of responsiveness to patient needs. Prior to 2013/14, scores were based on five questions; the question regarding recommending friends and family to the Trust has been removed since the introduction of the national Friends and Family Test. The Sheffield Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services. As in previous years the Trust and NHS Sheffield CCG have agreed that, whilst important, the areas highlighted in the national survey were not as important as some fundamental areas. These include: • help to go to the toilet • controlling pain • help with nutrition • being treated with dignity. These are the areas on which the Trust's Patient Experience is being measured through an ongoing programme of patient interviews (approximately 400 each month).	72%	68.6%	**79.3%***

Part 3

Review of Services in 2013/14

Prescribed Information	2011/12	2012/13	2013/14
5. Patients risk assess for Venous Thromboembolism (VTE) The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. **Comparative data is not available.** The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as we have processes in place to collect the data internally as part of the CQUIN work, 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 Trust, feedback to Directorates on performance and carrying out analysis of cases of VTE which are thought to be hospital associated.	91.1%	93.33%	**95.16%**
6. 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 figures are published. The denominator used is the 2012/13 figure as this is unlikely to change significantly. During 2013/14 there have been 80 cases of *C.difficile* infection reported within the Trust. The national threshold for 2013/14 was 77. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as it is provided by the Health Protection Agency. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this rate, and so the quality of its services, by having a dedicated plan as part of its Infection Prevention and Control Programme to continue to reduce the rate of *C.difficile* experienced by patients admitted to the Trust.	30.0	17.8	**13.68***

Part 3

Review of Services in 2013/14

Prescribed Information	2011/12	2012/13	2013/14
7. 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.	10,192	9951*	11299
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 2013/14. Full information for the financial year is not available from the National Reporting and Learning System until mid 2014. **Cluster** average: 7.9** **Highest performing Trust score: 12.84** **Lowest performing Trust score: 4.87**	5.2	5.1*	4.87
and the number and percentage of such patient safety incidents that resulted in severe harm or death. **Cluster** reporting data: 552 (0.3%)** **Highest reporting Trust: 46 (0.9%)** **Lowest reporting Trust: 1 (<0.1%)** * The figures for 2012/13 are different to those documented in last year's Quality Report as they have now been validated. **Comparative data is sourced from the National Reporting Learning System, data is split into cluster/peer groups with Sheffield Teaching Hospitals being part of the 'Acute Teaching Hospitals' cluster. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the National Reporting and Learning System (NRLS). The Sheffield Teaching Hospitals NHS Foundation Trust intends to increase the incident reporting rate by continuing to embed the web based reporting tool throughout the Trust. This will increase access to the reporting system, encourage increased incident reporting and speed up the Incident Management process. **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.	46 (0.4%)	51* (0.5%)	21 (0.4)

Part 3

Review of Services in 2013/14

Prescribed Information	2011/12	2012/13	2013/14
8. Friends and Family Test – Staff who would recommend the Trust. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. National average: 64% Highest performing Trust score: 94% Lowest performing Trust score: 40% The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by national CQC survey contractor. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and so the quality of its services, by continually involving staff and seeking their views in how to make improvement in the quality of patient services.	75%	70%	**72%**
9. Friends and Family Test – Patients who would recommend the Trust The scale* 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. *A scale of -100 to +100 is, using the Net Promoter Score calculation. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is collected by the Picker Institute Europe, verified by UNIFY and reported by NHS England. The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by using FFT scores to trigger deeper action planning around low scoring wards.	New indicator	New indicator	**71**

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

Measures of quality performance	2011/12	2012/13	2013/14
10. Percentage of patients who wait less than 31 days from decision to treat to receiving their treatment for cancer			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	98%	98%	**98%**
National Standard	96%	96%	96%
Data Source: Exeter National Cancer Waiting Times Database			
11. Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	91%	89%	**88%**
National Standard	85%	85%	85%
Data Source: Exeter National Cancer Waiting Times Database			
12. Percentage of patients who have waited less than 2 weeks from GP referral to their first outpatient appointment for urgent suspected cancer diagnosis			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	95%	95%	**94%**
National Standard	93%	93%	93%
Data Source: Exeter National Cancer Waiting Times Database			
13. All cancers: 31-day wait for second or subsequent treatment, comprising:			
Surgery:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	97%	97%	**97%**
National Standard	94%	94%	94%
Anti-cancer drug treatments:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	99%	100%	**99%**
National Standard	98%	98%	98%
Radiotherapy:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	98%	99%	**99%**
National Standard	94%	94%	94%
Data Source: Exeter National Cancer Waiting Times Database			
14. Accident and Emergency maximum waiting time of 4 hours from arrival to admission/transfer/discharge			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	95.6%	93.2%	**95.7%**
National Standard	95%	95%	95%
15. MRSA blood stream infections			
Trust attributable cases in Sheffield Teaching Hospitals NHS Foundation Trust	2	3	**4**
Sheffield Teaching Hospitals NHS Foundation Trust threshold	10	1	0

Review of Services in 2013/14

Measures of quality performance	2011/12	2012/13	2013/14
16. Patients who require admission who waited less than 18 weeks from referral to hospital treatment			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	90%	90.6%	**90.4%**
National Standard	90%	90%	90%
17. Patients who do not need to be admitted to hospital who wait less than 18 weeks for GP referral to hospital treatment			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	97%	96.6%	**94.9%**
National Standard	95%	90%	95%
18. Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	90.4%	93.2%	**92.5%**
National Standard	92%	92%	92%
19. Data Completeness for Community Services			
Referral to treatment information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	New indicator	60%	**66%**
National Standard		50%	50%
Referral information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement		100%	**100%**
National Standard		50%	50%
Treatment activity information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement		100%	**100%**
National Standard		50%	50%

Part 3

Review of Services in 2013/14

iii) Additional Indicators

Measures of quality performance	2011/12	2012/13	2013/14
20. Never Events Sheffield Teaching Hospitals NHS Foundation Trust Performance Data Source: National Patient Safety Agency Unfortunately the Trust has experienced 4 Never Events during the year; 3 retained objects and 1 misplaced nasogastric tube. Although there were fewer Never Events than during 2012/13, one such event is too many and an external review of theatre Never Events was jointly commissioned with the NHS Sheffield CCG. Findings from this review will then be used to plan future improvement activity. The Trust is actively promoting incident reporting to further enhance the safety culture of the Trust. This will ensure incidents are investigated, trends analysed and lessons are learnt across the Trust.	3	7	**4**
21. Hospital Standardised Mortality Ratio (HSMR) Sheffield Teaching Hospitals NHS Foundation Trust Performance National Benchmark. A lower figure represents a better mortality rate. *This figure is different from last year as it represents the whole year (April 2012 – March 2013) rather than April 2012 – January 2013 as reported in last year's Quality Report. **This is within the expected range. Data Source: Dr Foster	98% 100%	96%* 100%	**103%**** **(April 13-Jan 14)** 100%

Part 4

4.1 Response to partner organisation comments 2012/13

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

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

NHS Sheffield Clinical Commissioning Group (2012/13)

Abridged comments	Our response
1. The national surveys of patient experience results remain similar year on year, however the number of questions that were rated as significantly better, compared with other trusts has reduced from previous years.	The Trust's scores have remained similar year on year and consistently compare well against other Trusts nationally. The number of responses where our results were 'significantly better than average' was lower in the 2012 In-patient Survey than in previous years, although overall our scores remained high. We carefully reviewed the results of the survey and identified areas where actions were required to make improvements and, following this, we hope to see a higher number of responses achieving 'significantly better than average' scores in the 2013 In-patient Survey.
2. The Trust has unfortunately experienced a number of never events during 2012/2013, and we are working closely with them to reduce the risk of recurrence.	In 2012/13 the Trust experienced seven Never Events Following these Never Events the Trust developed a wider ranging Never Event action plan which brought together the lessons learned and actions from each of the individual incident action plans into a single overarching document. This has been shared within the Trust and also externally to the NHS Sheffield CCG, the Care Quality Commission and Monitor. A reduction in the number of Never Events has been evident in 2013/14 and further work continues to limit the chances of Never Events happening within the organisation.
Three of these priorities are worthy of specific comment: 3. Cancelling operations at short notice has a significant impact on patients. Understanding the causes of cancellations and more importantly, taking action to address these causes will improve individual patient's experience and will more broadly, contribute to the maintenance of 18 week waiting times.	Causes of cancellations are reviewed on a directorate by directorate basis with the actions designed to address the causes drawn up by each directorate. These are then taken forward by the Surgical Board. The Service Improvement team is working with Operating Services and Critical Care and the Surgical Specialties to address on the day cancellations. In several areas patients are routinely called three days prior to their admission to ensure they are fit, ready and willing to attend, to reduce the chances of any issues arising on the day that may prevent surgery taking place. Please see section 2.1.6 in Part 2 of this report for more information.

Abridged comments	Our response
4. There has been a reduction this year in the overall number of patients with pressure sores in the community and an objective to reduce the numbers both in primary and secondary care next year will be welcome. It will be supported by the prevalence data submitted via the NHS Safety Thermometer and enable specific wards or services to be targeted.	The Trust has worked hard to reduce the number of pressure ulcers in both the hospital and community setting and is monitoring progress using both incident reporting and the NHS Safety Thermometer. This work has continued into 2013/14 and will also continue during 2014/15.
5. The standardised provision of discharge information will be welcome to clinical commissioners and patients. It will support a more seamless transfer of care between primary and secondary care and it will provide patients and their carers with information on what to expect post discharge.	The project to improve discharge information has progressed this year. Please see section 2.1.8 in Part 2 of this report for more information.
We do, however, note that the Trust has indicated that it will carry over and/or report on indicators from 2012/13 and 2011/12. These include: 6. Optimising length of stay – achievement of clinically appropriate length of stays in line with national and local benchmarks in key areas.	All directorates are working towards Dr Foster benchmarks and understand the specialty level variance. All specialties are working with detailed information showing actual length of stay by diagnosis and procedure (against Dr Foster benchmarked levels) to help them identify which particular patient pathways they should be focusing on. Please see section 2.1.1 in Part 2 of this report for more information.
7. Improving the care of older people – nutritional assessment – achieve further improvements in the number of patients aged 65 or over screened using MUST and the percentage of patients at risk that receive an appropriate care plan.	The subject of nutrition and hydration is recognised as being a fundamental basic care need for patients within STH. The Hydration and Nutrition Assurance Toolkit, (HANAT) has been developed using the expertise of the Trust Nutrition Steering Group. The HANAT had been tested, refined and evaluated (positively) on two wards. HANAT serves to bring together practices, staff and audits to benchmark clinical areas against good practice standards in nutrition and hydration. There is an intention to roll HANAT out to all acute ward areas in 2014/15. It is intended that the annual audit of nutritional screening practices, including MUST screening and the associated care planning will be included as part of HANAT.

Healthwatch Sheffield (2012/13)

Abridged comments	Our response
1. Regarding the reference in the Foreword to the production of a second more accessible version of the Quality Report for patients and the public. Whilst this is welcome it is our understanding that agreement was reached at meetings during the year that this will be more than a summary version incorporated in the 'Making a Difference – a summary of quality improvements and priorities' document which has a limited circulation. We would like to see a clearer commitment in the Quality Report to the production and wide circulation of an easier to read summary version.	The Trust is committed to producing a summary version of the Quality Report for wider circulation. For the 2012/13 Quality Report this had been produced. This will be repeated for the 2013/14 Quality Report, working in collaboration with Trust Governors and Healthwatch.
Optimise length of stay 2. We acknowledge the difficulty of optimising patients' length of stay in the Trust's hospitals, but we can find no overt commitment to continuing this priority into next year or any mention of how progress on this will be measured. We hope this will continue to be a priority for the Trust in succeeding years until the situation has improved.	Ensuring that length of stay is appropriate for the patients who receive care and treatment is a key priority for the Trust. We are continuing to work with our clinical teams and also with partners to optimise length of stay. Please see section 2.1.1 in Part 2 of this report for more information.
Discharge letters for GPs 3. We note that the audits show mixed success and wonder whether the reasons for this were explored. We look forward to seeing the results following the introduction of the system of e-discharge summaries and that further local action plans will then be implemented.	The Trust has completed the rollout of e-discharge summaries which enable clinicians to fill in an electronic discharge template, helping to speed up the delivery and improve the discharge information available to GPs. NHS Sheffield CCG have surveyed GPs to look at the impact of the new e-discharge summaries with some very positive feedback being received. Evaluation will continue and any areas for improvement will be address by the project team.
Giving patients a voice 4. We welcome the increased feedback through forms and comment cards. This year's statistics are interesting but it would be helpful to see a comparison with the last two years and with the total number of patients being treated in the Trust's hospitals.	Whilst comment cards are still widely available across the Trust, we are no longer actively giving these to patients through our volunteers, as the new Friends and Family Test (FFT) is now the priority. We decided that to also give the comment cards out at the same time as the FFT cards would be confusing for patients.

Abridged comments	Our response
Holistic care to promote a good experience for patients who have dementia 5. All the reported work in relation to this priority has focused on the built environment and to a lesser degree on nutritional screening. Whilst this is important we would like to see some work on how the Trust can meet individual patients' needs and to know what measures and processes have been put in place to improve Dementia Awareness in the Trust's hospitals and how this will be kept ongoing, especially in the light of the Francis Report. We shall be interested to read about the progress of the three further up-grades – we consider Vickers 4 ought to also have priority as this ward is specifically focused on the after care of older people following orthopaedic operations.	A key area of focus in 2014 will be the Trust's commitment to improving patient centred care. Accordingly we are developing a discrete symbol to enable staff to recognise people suffering with dementia. This will then prompt staff to refer to the 'All About Me' booklet. Improvement work on Vickers 4 is in progress. Please see section 2.1.5 in Part 2 of this report for more information.
Reduce hospital acquired infections 6. We commend the Trust on a reduction in the number of cases of *C.difficile* in 2012/2013 and hope this will be continued. We would be interested to know what further improvements are under consideration.	In 2013/14 the Trust will continue to work to reduce the number of cases of *C.difficile*. In addition the Trust will aim to reduce the number of cases of MRSA Bacteraemia and increase the amount of Surgical Wound Surveillance to reduce the number of wound infections.
7. As a general statement we would find it most helpful to see priorities from the earlier years which have not been achieved or only partially achieved, included as on-going priorities in the following year as well as the measures used to indicate success. For example, it is acknowledged in the Quality Account that Nutritional Assessment will be reported in 2013/2014, but it is not in the summative list of priorities.	This comment is noted and the Trust will ensure that on-going priorities are reported in the 2013/14 report.
8. We are surprised that Accident and Emergency waiting times are not a priority, as the Trust has failed to meet the 95% target in 2012/2013.	Waiting times in the Accident and Emergency department are a priority within the Trust. As a Trust we have concentrated a substantial amount of effort into bringing about changes which will help us to meet the four hour target and maintain that performance consistently. The Trust is pleased to note that we have met the four hour target during 2013/14.
9. Last year we were clear in our comment that Community Services, part of the Trust's responsibilities, ought to be included in the Quality Account. We appreciate information may not be immediately available in a suitable statistical form, but the Report is not clear on this important and expanding part of its responsibilities. We will look for more evidenced descriptions in next year's Quality Account.	The Trust reports all appropriate Quality and Safety measures to ensure it provides a comprehensive overview of the services provided. These include community data.

Abridged comments	Our response
Clinical Audit 10. Audit of Insulin Self Administration. We note that 100% compliance can be achieved if bedside lockers are available and we would be interested to know whether there are enough lockers for all patients who are capable of managing the self administration of their insulin?	The lockers we use to store medicines have to be secured to the wall or bedside locker to ensure the security of the medicines and the safety of other patients. Insulin is a high risk medicine which can cause death if given inappropriately. So the availability of the option to self administer insulin is governed by which ward the patient is admitted to and whether that ward has individual patient lockers. Currently 83% of wards (excluding critical care areas where it is not anticipated that patients will be fit to self administer) have individual patient lockers for medicines. That means there are 17% wards which currently do not have this facility. Pharmacy staff are working with a number of these wards to find funding to have lockers installed. We also continue to try to find a suitable portable, lockable container which can be locked into place at the patient's bedside but so far we have not been able to find an appropriate container which meets with the security and infection control requirements.
11. Care Home Support Team: Core Skills Training Outcomes. We welcome the training of care home staff through this initiative. It is not clear from the document if the Trust is going to continue to provide a comprehensive Care Home Support Team but we hope the Trust will continue to provide comprehensive Core Skills Training for care home staff, particularly in view of its increasing Community Services provision and responsibilities.	The Trust is pleased that its joint commissioners, the local authority and NHS Sheffield CCG have agreed to continue funding this much needed service for a further two years. The team will have more of a focused approach in supporting those care homes with highest need from April 2014 as well as providing ongoing training pertinent to the needs of care homes.
12. Northern General Hospital Mental Health Act Commission visit. By implication there was not full compliance and more detail on this visit report would be helpful.	After a routine visit from the Mental Health Act Inspector during March 2013, some areas for improvement were identified and the Trust has been working closely with Sheffield Health and Social Care Trust to address these. The Healthcare Governance Committee is overseeing the implementation of the improvement plan. Most actions were completed by September 2013. The remaining actions include internal review and evaluation of the changes that have been made. The findings will inform a revision of the Trust's Detention under the Mental Health Act policy and procedures which is due to be completed by July 2014.

Abridged comments	Our response
13. Data Quality. We are surprised that patients' unique NHS numbers are not used in every case/document; this presents a potential for serious confusion.	The Trust completion of NHS number in HES data is one of the highest in the country. The NHS Number benchmark is against all other hospital providers, amalgamated into a national figure. The benchmark figures for the period of April to December 2013 are: 99.1% for admitted patient care 99.3% for outpatient care 95.8% for Accident and Emergency Care The Trusts figures for 2013/14 are: 99.7% for admitted patient care 99.7% for outpatient care 97.2% for Accident and Emergency Care Connecting for Health produced a leaflet that explains that it is not always reasonable or practical to expect 100% completion. The most common patient groups to not have an NHS Number are those from overseas, or from elsewhere within UK that do not use the English NHS Number. The Trust undertakes rigorous processes to ensure we have the highest level of NHS number completion. These include nightly automated traces for all unvalidated NHS numbers held in our PAS system against the National Spine service. Any numbers that still remain untraced or unvalidated then have an attempted manual trace performed to try and resolve possible issues or conflicts.
14. We would also like to see reported in Quality Accounts information of any Coroners Rule 43 Requests that were received by the Trust in 2012/2013 such as the number of Requests received during the year, their subjects, the actions taken and status of the Trust in respect of each.	In July 2013 the Coroners and Justice Act 2009 came into force, together with accompanying Rules and Regulations, which represents an overhaul of the law in relation to inquests. It had some quite significant practical implications in terms of timescales, deadlines and associated fines, disclosure of evidence and also Rule 43 reports, which now come under Regulation 28 of the Coroner (Investigations) Regulations 2013. The Trust reports any Section 28 reports received within the Annual Quality Report. All Regulation 28 (Rule 43) requirements are reported in Part 2 of the Quality Report.

Abridged comments	Our response
15. Staff Survey. It is of some concern to us that there are 5 areas of deterioration in the survey results, and in particular that staff having well structured appraisals continues to be low scoring as it was last year. We would like to see reference to plans to address these findings.	The Trust has introduced a structured performance, values and behaviours appraisal process incorporating the PROUD values which although initially introduced for senior managers is in the process of being rolled out for all staff across the Trust. The evaluation of the initial pilot highlighted the importance of appraisal training to ensure good quality so the Trust has invested significantly in appraisal training with all appraisers being trained in the new PROUD appraisal process before implementing it. The Trust is committed to achieving a 95% staff appraisal rate by the year end.
16. Patient Surveys and complaints. We note that one of the identified areas of improvement in the national A&E Survey is the provision of written/ printed information. This is an area that HWS would be keen to work with the Trust on to improve these communications.	The Emergency Department has been working closely with the Patient Partnership Department to review and standardise the existing written and electronic information for patients. This process has been clinically led from within the Emergency Department, and is in line with the Trust guidelines for patient information. All of the priority leaflets have now been reviewed and republished. Leaflets can also be made available in other languages and formats on request. Work has now started on a generic discharge leaflet for patients and the Trust Patient Information Manager will involve Healthwatch in this process during 2014/15.
17. Complaints. We are surprised that number of complaints, their nature and actions taken as a result are not reported, which we feel are essential to the Quality Account.	The complaints section of the Quality Report 2013/14 has been expanded to ensure greater detail of actions following complaints can be reported.
18. Mandated Indicators. It would be helpful if the relevant years were repeated at the top of each page as aide memoire.	This was completed in the final published report.

Sheffield Health and Community Care Scrutiny Committee (2012/13)

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

Trust Governor Involvement (2012/13)

Abridged comments	Our response
1. We noted that not all the priorities for 2012/2013 were achieved and are very clear that processes should be in place to follow these up and to make sure that work continues on them to effect their achievement.	The Trust continues to focus on the priorities detailed within earlier Quality Reports. Progress is this reported in the 2013/14 Quality Report.
2. We appreciate the enormous amount of work that goes into the writing of this report and also that the largely prescribed text makes the report more difficult for non-hospital related readers to understand. We look forward to a readable summary version.	Through the Quality Report Steering Group a selection of Trust Governors have assisted in producing the 2012/13 summary Quality Report. This will be repeated for the 2013/14 Quality Report, working in collaboration with Trust Governors and Healthwatch.

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

Statement from NHS Sheffield Clinical Commissioning Group

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

Our view is that Sheffield Teaching Hospitals NHS Foundation Trust provides, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities.

During 2013-14 key quality performance requirements have been delivered in challenging areas such as A&E and Cancer waiting times. Within the Acute setting reductions in the incidence of *Clostridium Difficile* have continued to be achieved and the trust should be commended for this performance.

The trust has unfortunately experienced challenges during 2013-14 with regard to delivery of the 'admitted' 18 weeks waiting time standards. The CCG welcomes the high priority being given to this key area of service delivery into 2014-15.

Our overarching view is that Sheffield Teaching Hospitals NHS Foundation Trust continues to provide services to a high standard. This quality account evidences that the Trust has achieved positive results against the majority of its key objectives for 2013/14. Where issues relating to clinical quality have been identified in year, the trust has been open and transparent and the CCG have worked closely to provide support where appropriate to allow improvements to be made.

The CCG is in agreement with the identified priority areas for improvement in 2014-15. Our aim is to proactively address issues relating to clinical quality so that standards of care and clinical governance 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:

Kevin Clifford
Chief Nurse

and

Ian J Atkinson
Contract Lead STHFT

May 9th 2014

Part 4

Healthwatch Sheffield 2013/14

Healthwatch Sheffield (HWS) were pleased to have been involved in the later parts of the process in drawing up the Quality Account; we acknowledge the challenges faced by the Trust in providing a suitable product required by Monitor and other Regulatory bodies, as well as making it fit for purpose for the general public.

We have asked for an "easier to read" version of the long and detailed account a number of times and this year we are promised that one will be delivered simultaneous to the publication of this formal Quality Account / Quality Report. The "easier to read" document, as identified in the Department of Health guidance, is intended to be more suited to a general public audience, and be available on request. It should report at least, in an easily read format, what the Trust said it would do, what it did, and the results of those actions.

We notice that customer satisfaction as indicated by Complaints is not showing appreciable improvement. The total number of complaints has increased, in particular the top five reasons for complaint, and this is a concern. We understand why the target (Trust determined?) of 85% of complaints being dealt with within 25 days was missed, but look for improvement on this poor record next year. We see customer satisfaction as being important to the public of Sheffield.

It is noted that 'Community Services' are now substantially within the remit of the Trust but the reporting does not always make this clear. There is a need to raise public awareness about the linkages and for there to be clearer reporting of those linkages made in future Quality Accounts.

We can find no mention of what has happened to the recently re-commissioned Care Home Support Team who support the care of those with dementia and end-of-life care in the home. We raised this in last year's comments.

We would like to have seen greater emphasis on Giving patients a voice. Although this was one of last year's priorities, we feel it ought to be on-going and form an important element of feedback in the Quality Account.

Improving discharge is of national importance and we would like to see how the Trust has improved the experience and outcomes in next year's account.

The mandatory part of the document (the Quality Report) contains required comparative data; this is very helpful to readers and ought to be repeated throughout the document, as well as, in an appropriate form, in the easier to read document.

We understand the Trust's priorities must reflect a wide range of interests and demands, nevertheless, HWS and the public of Sheffield would like to influence and to help in the determination of those priorities much earlier in the process.

Priority One: It is important that patients know who is treating and supporting them in hospital at all times, so we approve of this priority. Arranging for patients' names and those of the consultant / lead nursing staff, consistently throughout the hospital is a step towards improvement, but other measures such as suitable, clear and legible name badges, with title, might help.

Priority Two: Producing benchmark information is important to indicate improvement or otherwise over time, but the aim should be about dealing with the complaints faster and more appropriately, and making serious attempts to minimise complaints overall. We would be grateful to see the interim report when it is produced in October 2014.

Priority Three: We are pleased that attention continues to be placed on this national target as it is of concern to the Public. The Public's perception of the level of care at weekends or over bank holidays is that it is different to that received during the 'normal' working week - work to alleviate that concern or to rectify identified differences will be well received.

Priority Four: We were not quite sure of the importance of this priority given that the Trust has achieved the national standard; nevertheless increased waiting times are important to patients and their carers; it could be argued that lengthy waiting times increase stress levels and may even exacerbate existing conditions, thus negatively affecting the Patient Experience. What is important is to reduce all waiting times to less than the agreed national standard which currently stands at 18 weeks.

We would like to thank the Trust for caring for the public and patients of Sheffield and for the work involved in producing this report. Significant improvements to the Quality Account have been made over time and this must be acknowledged.

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

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee welcomes the opportunity to comment on the Trust's Quality Account for this year.

The Committee feel that the Quality Account priorities for 2013/14 capture the main concerns of Sheffield people. The Committee is pleased to see that both formal and informal feedback channels are reflected in the priorities and welcomes the Trusts planned improvements to their feedback systems as outlined in Priority 2, which aims to improve complainant satisfaction with the Trusts complaints process. The Committee also welcomes the planned publication of an "easier to read" version of the document and thanks Healthwatch Sheffield for their involvement in this.

The Committee welcomes the focus on reducing the number of operations cancelled on the day of surgery (Objective 2.1.6 Patient Experience - Cancelled operations) and commends the level of analysis the Trust is undertaking in this area. In addition, the Committee support the Trusts commitment to ensure clear and effective communication with patients and their family and friends throughout the admissions process.

In particular, the Committee recognises the work that the Trust has already undertaken to try and reduce the amount of time patients being discharged wait for their medication. The Committee appreciates the complexity of this issue and welcomes the multidisciplinary approach that the Trust has adopted to ensure further progress is made. The Committee also welcomes the planned information technology developments such as moving towards electronic communication approaches, which should ensure quicker and safer information exchanges.

With regards to priority principle 3 "To review mortality rates at the weekend" there remains a level of concern amongst the general public regarding differences in mortality rates at weekends. The Committee is therefore pleased to see that the Trust is planning further analysis around this national target and welcomes any action that will be taken to restore public confidence or address any identified differences. In addition the Committee would like to request that this analysis also includes mortality rates at Bank Holidays.

The Committee recognises that the Quality Priorities represent only a small part of the work that the Trust undertakes and looks forward to engaging with the Trust over the coming year both in terms of the Quality Account and across a wider range of issues.

Governor involvement in the Quality Report Steering Group

A number of governors attended the Quality Report Steering Group during the year. We enjoyed our participation in the group and we felt heard.

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

Choosing the priorities for the Quality Report was challenging as there were proposals both from within the Trust and from outside. Those chosen had to be both relevant and meaningful, preferably patient centered and also, very important, measurable.

We were happy with the final choices for 2014/15. They are a good and representative sample from a number of choices and the intention is that, one way or another, they should all significantly improve patient experience.

As before, we feel that it is essential to continue to work on those priorities from previous years that have not been achieved and we understand that this carries the risk that the amount of work may increase each year, since priorities may take longer than a year to achieve.

We appreciate the enormous amount of work that goes into the writing of this report and also that the largely prescribed text makes the report more difficult for non-hospital related readers to understand. Last year's summary version was a worthwhile attempt, but there is room for improvement and we look forward to the contribution from Healthwatch members this time round.

Andrew Manasse
28 April 2014

4.3 Statement of Directors' responsibility

Statement of directors' responsibilities in respect of the Quality Report

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

Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support 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 2013/14;
- 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 2013 to June 2014
  - papers relating to Quality reported to the Board over the period April 2013 to June 2014
  - feedback from commissioners dated 9th May 2014
  - feedback from governors dated 28th April 2014
  - feedback from local Healthwatch organisations dated 30th April 2014
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22nd May 2014
  - the latest national inpatient survey February 2014, the latest National Cancer Patient Experience survey October 2013 and the National Maternity Survey December 2013
  - The latest national staff survey dated February 2014
  - the head of internal audit's annual opinion over the trust's control environment dated 22nd May 2014
  - CQC quality and risk profiles dated April 2013-March 2014.
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information 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 in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) 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
22nd May 2014

Sir Andrew Cash OBE
Chief Executive
22nd May 2014

4.4 Independent Auditors' 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 2014 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

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

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

Respective responsibilities of the Directors and auditors

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

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

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

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

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

- Board minutes for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey;
- The 2013/14 national staff survey;
- Care Quality Commission quality and risk profiles/ intelligent monitoring reports 2013/14; and
- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Sheffield Teaching Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sheffield Teaching Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

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

KPMG LLP

Chartered Accountants
1 The Embankment
Leeds
LS1 4DW

22 May 2014