Sheffield Teaching Hospitals NHS
NHS Foundation Trust

# Quality Report
## 2018-19

PROUD TO MAKE A DIFFERENCE
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

## Contents

# 1. Introduction

## 1.1 Statement on Quality from the Chief Executive

This Quality Report outlines some of those areas where we have already had good success thanks to the innovation, dedication and skills of our teams. It also sets out our priorities for 2019/20 along with areas where we need to continue to improve.

Ensuring our patients have good clinical outcomes and a positive experience are two of the five main aims of the Trust. To achieve this we strive to do all we can to provide high quality treatment and care for people and to ensure that we protect them from any avoidable harm.

During 2018/19 we were inspected by the Care Quality Commission and we were pleased that they rated the Trust as 'Good' overall with many 'Outstanding' features.

| | |
|---|---|
| Safe | GOOD |
| Effective | GOOD |
| Caring | GOOD |
| Responsive | OUTSTANDING |
| Well-led | GOOD |
| Overall rating | GOOD |

The process also provided information about where we can improve even further and these have been taken account of in our quality objectives and work programme for 2019/20.

Our drive for continual improvement is also embodied within the Trust's 'Making a Difference' Strategy which is supported by a Quality Strategy and governance framework. The Quality Strategy describes a new approach to the compilation, monitoring and performance management of our quality objectives, and places our Quality Board at the centre of these processes.

### *Our five 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

### *Our PROUD values underpinning these aims*

- Patient first - Ensure that the people we serve are at the heart of all we do
- Respectful - Be kind, respectful to everyone and value diversity
- Ownership - Celebrate our successes, learn continuously and ensure we improve
- Unity - Work in partnership and value the roles of others
- Deliver - Be efficient, effective and accountable for our actions

We have robust processes in place across the Trust from the Board of Directors to ward level to ensure we continually monitor clinical safety indicators and take action where issues are flagged. Our management structure is purposely heavily clinician led. This informs and drives decision making and retains our focus on delivering safe and high quality care.

We have more than two million patient care contacts every year across our five hospitals and community services and I am pleased to report that, once again, in 2018/19 our track record on the majority of clinical outcomes remained strong. For example, we have seen a 12 per cent reduction in the number of patient falls in inpatients settings and an increased awareness and monitoring of pressure ulcers as a result of Trust-wide initiatives such as 'React to Red' (RTR) and 'Safety Huddles' being routinely integrated into daily practice. We also rolled out the National Early Warning Score 2 (NEWS2) system to help staff identify, at an early stage, when a

patient may be deteriorating. This means we can take action earlier as well as ensuring consistency with early warning systems used in other Trusts. We know that ensuring patients receive the right care, at the right time, and in the right place, is critical if we are to deliver the best outcomes, help individuals remain in the best of health and live as independently as they can for as long as possible. This was the thinking behind the redesign of our hospital and community stroke services over the past year. As well as making changes which mean patients do not have to spend as much time in hospital, we have strengthened our community care with the opening of the new Stroke Pathway Assessment and Rehabilitation Centre (SPARC). The new centre ensures patients, who are not able to be discharged straight home from hospital, receive specialist rehabilitative support, 24 hours a day, at a critical point in their recovery.

Throughout the year we have also consolidated our work to ensure patients transition through the various stages of care as seamlessly as possible. A number of new ways of working have contributed to significant reductions in patients' lengths of stay and to ensure effective and timely discharges. Board rounds on our wards are now embedded as routine practice and mean that the whole ward team meets at a set time each day to review each patient and assess what is needed to ensure their care progresses without any unnecessary delays. The teams are using a system called 'Red to Green days' as part of this process. Integrated ward working, which involves including dedicated Therapists in a ward's core team, has also been piloted on a number of wards and the results have been very encouraging to date. This is now being implemented on more wards to further test the effectiveness of this approach.

When patients no longer need our care, we assist them to experience a smooth and timely discharge or transfer to the next stage of their care or to return home. Like many other Trusts across the country, this has been a more challenging area of improvement. However, it has also presented the opportunity to build strong multi-agency working, integrated models of care and a new discharge assessment process which puts the individual needs of the patient at the centre of the process.

By working together with our partners, including Sheffield City Council, NHS Sheffield CCG and Sheffield Health and Social Care NHS Foundation Trust, we have adopted the 'Why not home, why not today?' approach to expediting discharges. There has been additional investment in more intermediate care beds, social and nursing home care places and in our own community health services. Coupled with a redesign of processes and ways of working we have seen the number of delayed discharges reduce significantly in 2018/19.

Personalised, responsive and timely care is also important to those patients who are being referred for planned care. This is why we have strived for, and have continued to sustain, a strong performance against the 18 week Referral to Treatment (RTT) waiting time standard and our national performance remains in the top quartile. We have delivered this through a strong focus on systems, processes, governance and the implementation of national best practice. Across a number of elective care pathways, service improvement work has continued to identify and remove unnecessary delays and further improve efficiency of care.

As well as making changes to how we deliver care, we have also continued to ensure our facilities meet the personal and clinical needs of patients.

We opened the new £6.7 million Northern General Eye Centre which now provides a one-stop-shop for patients who need cataract surgery. We have refurbished the Radiology Unit at the Royal Hallamshire Hospital and completed the first phase of a £30 million theatre replacement project, providing four new state-of-the-art theatres on Q floor. During 2019/20 we will completely refurbish the remaining theatres on A floor.

Weston Park Hospital continued to be a focus of attention with further ward upgrades and new outpatient facilities built as part of a

longer term development project. Work also began on a £2.4 million aerial walkway which will connect Weston Park Hospital with the Jessop Wing and the Royal Hallamshire Hospital. This will mean patients can be transferred between departments more easily and without having to wait for transport to be arranged.

In total we have invested over £24.4 million in our facilities and equipment throughout the year including two new state-of-the-art birth pool rooms at the Jessop Wing and a replacement of the lifts at the Royal Hallamshire Hospital.

On a system-wide level we continue to be an active partner in the South Yorkshire and Bassetlaw Integrated Care System (ICS) and the Sheffield Accountable Care Partnership (ACP). These collaborative structures bring together health and social care organisations across the region and across Sheffield respectively to jointly plan and deliver services better tailored to the needs of the local population. During the year, both of these partnerships became more formalised and a number of clinical and non-clinical workstreams are in place aimed at improving patient experience and outcomes.

Further information about this and other developments during 2018/19 can also be found in the Annual Report and on our website: www.sth.nhs.uk/news.

Of course none of these improvements are possible without the support of all 17 thousand individuals who work for the Trust and our amazing volunteers and charities whose dedication and commitment is a source of great strength for our organisation.

It was exceptionally pleasing that national and local survey results during 2018/19 consistently showed that the majority of our patients and staff would recommend the Trust as a place to receive care and to work and indeed we were rated as above average in many of the key domains. Our staff also won a number of quality and safety awards throughout the year and the results from the Friends and Family Test for patients and staff give a valuable insight into where our future focus needs to be.

During the last 12 months we have continued to encourage more of our staff to be actively engaged and involved in decisions, setting the future direction of the organisation and innovations. We are committed to continuing this important work during 2019/20 because we believe our staff are key to the delivery of excellent patient care.

We feel it is very important that we value everyone who works in the organisation and the efforts they go to every day to make a difference to our patients. I am confident that by fostering our culture of learning and continuous improvement we will provide our patients with the safe, high quality care and experience they deserve.

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

**Kirsten Major**
**Chief Executive**

## 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 2018/19 at Sheffield Teaching Hospitals NHS Foundation Trust.

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

The Quality Board oversees the production of the Quality Report. The membership includes Trust managers, clinicians, Governors, and a representative from Healthwatch Sheffield. The remit of the Quality Board is to decide on the content of the Quality Report and identify the Trust's quality improvement priorities whilst ensuring it meets the regulatory standards set out by the Department of Health and Social Care and NHS Improvement.

As a Trust, we have considered carefully which quality improvement priorities we should adopt for 2019/20. As with previous Quality Reports, the quality improvement priorities have been developed in collaboration with Governors and with representatives from NHS Sheffield Clinical Commissioning Group, Healthwatch Sheffield and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee. This year, we have also undertaken consultation with members of the public, patients and staff.

In developing this year's Quality Report we have taken into account the comments and opinions of internal and external parties on the 2017/18 Report. The proposed quality improvement priorities for 2019/20 were agreed in March 2019 by the Trust Executive Group, on behalf of the Board of Directors. The final draft of the Quality Report was sent to external partner organisations for comments in April 2019 in readiness for the publishing deadline of 31 May 2019.

**Dr David Hughes**
**Medical Director**

# 2. Priorities for Improvement

*This section describes progress against the priorities for improvement during 2018/19 and provides an update on progress in relation to improvement priorities from previous years. In addition, priorities for 2019/20 are outlined, along with an explanation of the process for their selection.*

## 2.1 Priorities for Improvement 2018/19

### *Reduce inpatient falls during 2018/19 by 10 per cent*

The primary measurement outcome was a 10 per cent reduction in inpatient falls and inpatient hip fractures compared to the numbers for 2016/17.

The actual reduction in falls for 2018/19 is 11 per cent. There has also been a 25 per cent reduction in inpatient hip fracture; a decrease from 48 in 2016/17 to 36 in 2018/19.

Falls Safety Huddles have been introduced widely across the Trust and, in particular, on all wards in the Directorates with the highest falls rates.

Workstreams have been put in place to help achieve the 11 per cent reduction. These have included ensuring that the current version of the falls documentation was displayed on the Trust patient record system, Lorenzo.

In response to the results of the second National Audit of Inpatient Falls 2017, the Trust is currently reviewing the following topics:

- vision assessment
- documented review of medications that increase the potential for a patient to fall
- improved access to mobility aids
- increased awareness of keeping patient buzzers accessible and identifying patients who may be unable to use the buzzers due to cognitive problems

In January 2019, the Trust appointed a new Clinical Lead for Falls Prevention. The Strategic Falls Group will continue to monitor this work. An implementation sub-group has been developed to enable trial developments in falls prevention to be tested and to report effective measures to the Strategic Falls Group.

### *Develop a human factors plan which will have practical application and lead to tangible improvements in safety culture*

#### Background

There has been a significant drive nationally to better understand how the principles and practices of human factors, as used in many other safety critical industries, influence patient safety. Through an understanding of the effects of teamwork, culture, ergonomics and individual behaviours this is known to positively influence performance and ultimately increase patient safety.

The National Quality Board is committed to ensuring that human factors, principles and practices are embedded into the practices, systems, cultures and processes of all NHS organisations.

#### Achievements against objective

The Trust has worked with a human factors and patient safety specialist over the past eight months and this work has involved the following:

- a review of Trust strategies and documents
- a human factors gap analysis spanning all aspects of the Trust's operations from procurement to staff training
- interviews with key senior staff member in November 2018 with a stakeholder event held in January 2019

In addition, the Trust has undertaken work to scope safety culture assessment tools and to

assess which tool may be most appropriate for the Trust.

Measures of success for the project have been agreed and include:

- incorporating human factors messages within existing mandatory training programmes and developing specific human factors-based training programmes
- increased use of human factors-based tools within incident investigation processes
- incorporating human factors design principles within procurement processes

A final report with recommendations has been produced and next steps are to sign off the report, and agree an action plan to take forward the recommendations.

In addition, current options for undertaking safety culture assessments are in the process of being evaluated and costed.

### *Demonstrate a 30 per cent improvement in the early recognition and management of sepsis within the Trust*

#### Background

This objective was chosen in attempt to drive forward the work on the recognition and management of sepsis.

#### Achievement against the objective

During 2018 the Lead Sepsis Nurse undertook data collection within the Emergency Department and wards across the Trust. While early data collected demonstrated improvements in the early recognition of sepsis and timely antibiotic administration in the Emergency Department, this has been challenging to sustain over the 2018/19 winter period.

Between October 2017 and October 2018 the Emergency Department increased the timely recognition and screening for sepsis by 78 per cent, compared with the 30 per cent target; (41 per cent of patients screened in October 2017, which increased to 73 per cent in October 2018). On the wards there has been little difference during this time period with a slight reduction from a baseline of 80 per cent of patients being screened in October 2017 to 75 per cent in October 2018.

The timeliness of first observations within the Emergency Department has improved, with 79 per cent of patients receiving their observations within 15 minutes in the period December 2018 to March 2019, compared with 73 per cent in May to August 2018.

The number of patients in the Emergency Department to whom antibiotics have been administered within two hours has decreased from 87 per cent in October 2017 to 68 per cent in October 2018. There has been a similar decrease during this time period on the wards; from 71 per cent in October 2017 to 57 per cent in October 2018. Significant work has been undertaken, and is ongoing, in the Emergency Department and on the Acute Medical Unit (AMU) to improve upon this figure. This includes a sepsis quality improvement meeting (sepsis Big Room), a dedicated sepsis bleep holder and daily Safety Huddles.

As a result of this, the Trust has seen a four per cent reduction in mortality for those patients coded with sepsis (SOS-Insights). As further context, there has been no change in the mortality rate for coded sepsis nationally and Sheffield's average hospital length of stay and number of Intensive Care Unit bed days, related to coded sepsis, has remained the same.

The Lead Sepsis Nurse secondment ended at the end of March 2019, and the Trust is looking at other ways of data collection to continue this work.

The sepsis screening tool was evaluated, updated and re-launched during 2018/19. Quality improvement work is ongoing to ensure compliance with the new tool. The tool has been updated to reflect the move from using the Sheffield Hospitals Early Warning Score (SHEWS) system to the National Early Warning Score (NEWS2) system.

Work has also been taking during 2018/19 to consider the potential adoption of electronic

feedback mechanisms for compliance to screening and care delivery for patients. Electronic observations have been piloted on four acute wards via the e-whiteboard to develop the ability to better identify those patients at risk of sepsis. It is the intention that this will be rolled out in 2019/20 across all ward areas.

There has been a drive to improve sepsis awareness across the Trust during 2018/19 with a total of 80 per cent of clinical staff having received education on sepsis. Of these, 50 per cent have received an update to maintain resilience. Sepsis education has been provided face to face via the Sepsis Lead Nurse and Lead Educators and has also been also available via the Trust's e-learning system. All newly qualified nurses now receive a half-day session on the care of the deteriorating patient and sepsis as part of their induction. Going forward, all Foundation Year One Doctors will also receive a sepsis session as part of their induction.

To help demonstrate change, the Sepsis Lead Nurse has set up a sepsis 'Big Room'. This multi-disciplinary meeting meets regularly to measure change and analyse data. This will facilitate quality improvement work, developing systems and processes to improve the early recognition and management of sepsis.

The newly formed Deteriorating Patient Committee, chaired by the Medical Director, will lead on improving the early recognition and management of sepsis.

***Ensure a Trust-wide reduction by 10 per cent of all avoidable patient harm associated with pressure ulcer prevention and management***

Following NHSI recommendations in June 2018, the term 'avoidable patient harm' relating to pressure ulcers was withdrawn from use and the national reporting requirement ceased. As such, it has not been possible to identify whether the Trust has achieved the target set for a 10 per cent reduction.

Focus, instead, is now placed on identifying any lapses in care relating to pressure ulcer prevention and management. The Trust currently reports all pressure ulcers, regardless of whether or not there have been lapses in care. However, changes made to the reporting of pressure ulcers on the Trust's Datix system will ensure information on lapses in care is recorded in the future, enabling a distinction to be made in the next financial year.

Supported by the development of a pressure ulcer annual workplan, good progress has been made against the objective of reducing all pressure ulcers. Implementation of this workplan continues and is being monitored by the Pressure Ulcer Prevention and Management Steering Group and Care Group on Pressure Ulcers. This ensures that the Trust remains focused on reducing patient harm related to pressure ulcers and these arrangements also provide an opportunity for shared learning and improved communication about pressure ulcers Trust-wide.

The acute and community Tissue Viability teams have been successfully integrated, with a key service priority being to standardise and improve wound care, particularly around pressure ulcers. A new Lead Tissue Viability Clinical Nurse Specialist (CNS) is in post to oversee and develop this new service. A city-wide educational strategy has been developed and implemented to support pressure ulcer prevention, including the 'React to Red' (RTR) training and link nurse programme.

Reporting of pressure ulcers is now established via Datix and the Nursing and Midwifery Dashboard, with goals for pressure ulcer reduction set and routinely reviewed.

New pressure ulcer definitions and measurements have been implemented following NHSI recommendations, and new processes are planned to ensure pressure ulcer investigations are of a high standard, provide assurance and ensure Trust-wide learning takes place.

Ongoing work continues to ensure photography plays a key role in pressure ulcer management, and also to ensure that patients and staff have access to pressure redistributing equipment in a timely manner.

***Improve recognition and timely management of deteriorating patients leading to improved care. Implement an electronic system for tracking patients' observations***

The Deteriorating Patient Committee was formed in 2019 to provide an oversight on all deteriorating patient workstreams and sub groups. With widespread and senior representation, its key workstreams are to implement and monitor the recognition, escalation and response to the deteriorating patient.

During 2018/19, a project working group was established to focus on the implementation of NEWS2. In preparation for this, NEWS2 training was undertaken by clinical staff and a Trust-wide communication plan was delivered to support its successful launch which took place on 25 March 2019.

Electronic observations on the e-whiteboard have been developed during 2018/19 to help improve the recognition of deteriorating patients. A solution to enable mobile devices to enter e-observations is currently being investigated. Following this, the roll out of observations on the e-whiteboard will be extended Trust-wide. During 2019/20 plans are also in place to look at new monitors that can connect to the Trust Wi-Fi to allow automated recording of patients' vital signs to the e-observations.

***Reduce preventable Acute Kidney Injury (AKIs) across the Trust***

Acute Kidney Injury (AKI) is a significant cause of morbidity and mortality in both acute hospitals and in the community. Compliance with a nursing care bundle and medical checklist has been shown to improve outcomes for patients who are admitted with, or develop AKI in the hospital setting.

From an audit of the notes of patients who had an alert of AKI from blood results, it was identified that practice could be improved and a strategy was identified to improve compliance by transferring the AKI alert onto the whiteboard displayed on the ward. This increase in visibility should improve the time taken to recognise the risk of AKI and prompt actions required in the care bundle and checklist.

A dataset has been developed to track patients with AKI and monitor performance in a real-time manner. This will allow early recognition and intervention by way of education for clinical areas, as well as showing any improvements in morbidity, mortality and length of stay.

At present the whiteboard IT solution has been developed alongside an initial dataset / dashboard. Further development of an appropriate software package is required to transfer the AKI alert signal from the laboratory IT system.

This three year objective has now been incorporated into an overarching workstream which will be overseen by the newly formed Deteriorating Patient Committee.

***Implement and evaluate at least one major co-production project and develop a plan for embedding this approach more widely***

During 2018/19, the Trust aimed to build on experience of co-production, working in partnership with our patients, their families and carers towards shared goals. Using NHS England's recognised 'Always Event®' methodology to support the co-production work, a two year pilot project commenced within one Trust specialty.

The Spinal Injuries Unit was identified as the pilot site and a Point of Care Team was established for the project. Qualitative patient feedback was sought through in-depth discussions with patients and their carers to identify improvements that could address what matters most to patients, their families and carers.

In partnership with patients, as well as taking into account previous feedback from complaints and the needs of the unit, a vision statement was identified which sets out that every patient should be offered an initial case conference multi-disciplinary meeting within three weeks of admission to the unit. Alongside this meeting, each patient should be

issued a 'Patient Passport' detailing their goals and allowing them to record progress made against those goals.

In 2018, case conference meetings were undertaken with a number of patients and an initial draft of a 'Patient Passport' was piloted with one patient.

In 2019/20, the unit aims to establish a service structure which will ensure a case conference is arranged for all newly admitted patients within three weeks of admission. Patient and staff feedback will be gathered and used to refine the 'Patient Passport' and the case conference meetings. Through the adoption of the 'Plan-Do-Study-Act' improvement methodology, the team will trial and iteratively improve the 'Patient Passport' booklet. This work will continue to be monitored through the Patient Experience Committee throughout 2019/20.

Upon completion of the project, the Trust's Patient Experience Unit will create a summary of the 'Always Event®' methodology and of co-production to aid the use of these methodologies in future quality improvement work.

***Ensure that End of Life Care is individualised and meets the needs of both patients and those who are important to them***

Five workstreams have been developed.

- Develop a Care Planning Toolkit
- Guidance Review
- Develop an Intranet Site
- Review of Education and Training
- Electronic Systems

Activity continued across the five workstreams in 2018/19 with significant improvements made. These were reflected when the CQC returned to the Trust in June 2018 and rated the Trust 'Good' for End of Life Care.

A central hub on the Trust's Intranet page has been developed to give staff access to all relevant End of Life Care information and resources. The Nursing Care Planning Toolkit in Lorenzo was rolled out and this records the preferred place of care and death for patients on an End of Life Care pathway. Education and training was reviewed during 2018/19 and an End of Life Care e-learning package developed for staff, using the key themes from the End of Life Care Survey undertaken in 2016/17.

Progress on the workstream will continue to be monitored via the End of Life Care Project Working Group.

***Ensure outpatient and inpatient letters are fit for purpose, are clear and understandable and meet the needs of both patients and national good practice guidelines***

Written correspondence is a key method used to communicate with patients. These letters contain a significant amount of information and it is important that they are clear and helpful to patients.

The different letters held on the Trust's electronic patient record system have been reviewed during 2018/19. There were 437 letter templates in total. These have now been reduced to 20 core templates.

The letter templates have been amended to ensure that they comply with dementia friendly and visual impairment guidelines which relate to patient correspondence.

Further work is planned in 2019/20 for patients to review and provide feedback on the templates. This work will be overseen by the Patient Experience Committee and, once agreed, the new letter templates will be implemented across the Trust.

***Significantly increase the scale of patient engagement with those who may be harder to reach or seldom heard***

In 2018/19, adopting a hub-and-spoke design, an engagement network database was established to provide access to large numbers of people and groups, including seldom heard groups, in order to increase the scope of feedback from patients, families and carers. The network will also utilise existing

databases and build on existing contacts with groups such as Healthwatch Sheffield.

Demographic analysis of our service users and the patient feedback routinely collected was undertaken to identify which patient groups are under-represented in terms of the feedback collected. This has been used to help identify an appropriate group for our initial pilot project, the topic having been agreed by the Patient Experience Committee.

This engagement objective will run until 2020 and the work that has been undertaken in 2018/19 is a key enabler.

In 2019/20, the process for using the engagement network will be piloted by running a survey which will provide us with the opportunity to both collect patient experience feedback and to evaluate the hub-and-spoke model. Knowledge gained will be used to refine the model for wider use to enable the Trust to collect patient feedback from specific groups in the way they prefer. This work will continue to be monitored by the Patient Experience Committee.

### *Increase the availability of high quality refreshment facilities in outpatients including hot drinks*

In 2018/19, a review was undertaken to identify what refreshment facilities were currently available within outpatient areas. The busiest outpatient departments were visited to gain an understanding of current provision, patients were surveyed and a consultation was undertaken with visitors and staff to understand needs in respect of refreshments in outpatient areas.

An options appraisal was then produced considering any contractual constraints with current suppliers. Locations were prioritised based on greatest need, i.e. limited access to refreshments and/or a lack of retail facilities in close proximity. Consideration was given to which areas see a higher number of patients who cannot drink prior to a clinical procedure.

Following this, two new high quality vending machines have been introduced into two outpatient departments; Outpatient Department One at the Northern General Hospital and Ophthalmology at the Royal Hallamshire Hospital. The Retail Development Project Team has agreed to review any further areas where the installation of vending machines would be an improvement.

### *Improve the process and quality of consenting with a focus on ensuring patients are provided with individualised information*

It is the duty of healthcare professionals to ensure that a patient is aware of the material risks involved in their proposed treatment and of any reasonable alternative or variant to that proposed treatment.

Patients require sufficient information (written or verbal) that is clearly communicated to them by the healthcare professional before they can decide whether to give their consent. This includes information relating to the benefits and risks of the proposed treatment, and alternative treatments, including the option to have no treatment.

The Clinical Effectiveness Unit (CEU) began to support Clinical Directorates to monitor compliance with the Trust's Consent to Examination or Treatment Policy from April 2017. In 2017/18, a two year priority for improvement was identified focusing on the process and quality of consenting, and the provision of individualised patient information. This stated that by the end of March 2020:

- 100 per cent of Clinical Directorates will have engaged with Clinical Effectiveness Unit to develop / implement processes to undertake the Trust-wide Consent Audit
- 100 per cent of pilot sites will have embedded the new combined patient information leaflet / procedure specific consent form
- The revised Trust consent forms will have been implemented.

At the end of March 2019, a total of 19 of 23 (83 per cent) Clinical Directorates are engaged with the Trust-wide Consent Audit of which 15 have completed the first cycle of measurement, and are either agreeing or have

agreed an action plan for improvement. One of the 15 areas has undertaken a second cycle of measurement and has identified a notable improvement.

Over the last 12 months, five pilot sites have identified a procedure to develop a combined procedure specific patient information leaflet and consent form. All sites are in the development phase aiming to implement the pilot during 2019/20. Following a regional and patient consultation, the lower gastrointestinal cancer team at Weston Park Hospital has finalised a combined procedure specific patient information leaflet and consent form for chemo-radiotherapy treatment for rectal cancer. The pilot of the use of the form will commence in April 2019.

Work is ongoing to revise the Trust's written consent forms. The Trust's solicitor has advised on producing the first draft of the revision of consent form. The Trust's specialist advisor for Mental Capacity Act and Deprivation of Liberty Safeguards has drafted the revision of consent form for patients who lack capacity to consent. Final versions of the revised consent forms will be agreed by the Consent Stakeholder Group and approved by the Medical Director before a wider consultation across the Trust.

The audit will be monitored through the Clinical Effectiveness Committee and progress against the objective will be reported through the Consent Stakeholder Group.

***Ensure that Sheffield Teaching Hospitals' Procedure Safety Checklist is embedded into practice, aiming to reduce errors and adverse events, and increase teamwork and communication***

The Trust aimed to embed into practice its Procedure Safety Checklist to reduce errors and adverse events, and increase teamwork and communication. The Safer Surgery Steering Group has been leading on many aspects of this workstream.

During 2018/19, the Safer Procedure Governance Group was developed. This group now monitors training, audits and policy revisions. This group oversaw the review and update of the Trust's Safer Procedure Policy including standardisation of the Procedure Safety Checklist. This is currently awaiting ratification.

An online learning programme for the World Health Organisation's (WHO) Safer Surgery Checklist for all relevant staff has been uploaded on to the Personal Achievement and Learning Management System (PALMS). This will enable staff to demonstrate an understanding of, and compliance with, the five steps to safer surgery / procedure according to the WHO guidelines, procedural checklists and supporting documentation. The training needs analysis for all staff groups is complete and due to be uploaded to PALMS, following which training reports will be monitored through the Safer Procedure Governance Group.

All 12 areas currently using the WHO Safer Surgery Checklist have participated in an audit of its use to date. Charles Clifford Dental Hospital (CCDH) has undertaken four cycles of measurement and action plans for improvement have reduced the risk of adverse incidents during procedures.

The overall compliance for the cardiac catheter suite procedure safety checklist has improved over the three data cycles, also reducing the risk of adverse incidents during procedures.

The programme of audit continues into 2019/20 for all areas using the safer procedure checklist.

## 2.2 Update on progress against previous priorities for improvement

### Listening into Action

Listening into Action (LiA) has been used to empower staff in identifying and driving through the changes and improvements they want to see. The programme commenced in 2014 and has had seven waves with a total of over 100 teams using the LiA 20 week process to make changes and improvements to enable effective and high quality services for patients and staff. Each scheme has the commitment and involvement of the Operations Director, Nurse Director and Clinical Director and is supported by a LiA facilitator with focused weekly LiA meetings. LiA has now become an established, sustained and well-recognised mechanism for driving change and improvement over a 20 week period, and the tools, techniques and facilitation for the process is supported through the Organisational Development Team.

### Mortality Rates

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Another mortality indicator is called the Hospital Standardised Mortality Ratio (HSMR). The SHMI includes all deaths, while the HSMR includes a basket of 56 diagnoses (around 85 per cent of deaths).

The Trust's SHMI mortality index remains in the 'as expected' range and the monthly HSMR figures since August 2018 have been within the 'as expected' range too. During 2018/19 the Trust's HSMR figures (105) for the rolling average period February 2018 to January 2019, was showing as 'higher than expected' which was unusual given the previous history of the Trust's mortality rates which have always been 'lower than expected' or 'as expected.' Discussions have been ongoing with Dr Foster Intelligence, who collect and publish the data, to understand the change. Some issues have been identified with the source data which is being reviewed. The monthly HSMR figures are showing 'as expected' since August 2018 but it will take some time for this to be reflected in the rolling average. We will continue to scrutinise both mortality indicators to identify any variations and to inform our ongoing quality and safety work.

### Optimise length of stay

The Trust has been continuing to develop its arrangements to optimise patient flow and reduce length of stay. Work to optimise length of stay has focused on the development of board rounds and Red2Green. Board rounds are daily, structured discussions of each patient's care and what is required that day for care to progress. Red2Green is a key tool used as part of the board round that supports teams to identify a key action for every patient to ensure daily progress of their care. It is a visual management tool that allows teams to identify whether that plan happens.

The programme has developed a successful intensive model for piloting gold standard board rounds incorporating Red2Green, across multiple wards, aimed at ensuring '*every patient has a plan and it happens*'.

Gold standard board rounds meet essential criteria that demonstrate effective structure and achievement of key outcomes. This also includes an afternoon check in using the Red2Green tool.

At December 2018, 17 wards across multiple specialties have implemented the tools. The new Trust Flow Working Group and Flow Overview Group have been established to support the delivery of key emergency pathway targets and ward performance improvement ensuring best practice systems and processes are implemented and sustained.

## 2.3 Priorities for Improvement 2019/20

*This section describes the Quality Improvement Priorities that have been adopted for 2019/20.*

This year, for the first time and in line with the Trust's Quality Strategy 2017 -2020, a new process for the selection of quality objectives has been implemented. This new approach incorporates much wider consultation and engagement involving our patients, visitors, Foundation Trust Members, and staff. A total of 1,478 responses were received.

The objectives for 2019/20 have been agreed by the Quality Board in conjunction with patients, clinicians, Governors and Healthwatch Sheffield. These were approved by the Trust Executive Group, on behalf of the Trust's Board of Directors, in March 2019.

The Quality Board will review quarterly progress reports on all Trust quality improvement priorities, providing advice and support where necessary to ensure the project achieves its goals within agreed timescales.

The objectives for 2019/20 are as follows:

### Safety

- Review the possibility of a real-time system or process which will support the early detection of, and appropriate response to, emerging/potential safety or risk issues.

### Patient Experience

- Evaluate new inpatient and outpatient letters, consulting widely with patients, including those from seldom heard or hard to reach groups. Use the Trust's new engagement hub as the vehicle for the consultation.

- Learn from an area that displays best practice in relation to 'customer service' and staff attitudes.

### Effectiveness

- Reduce the number of referrals logged on Lorenzo after 30 days of receipt from 57[1] (April 2019) to zero (0) to reduce delays inpatient journeys by 31 March 2020.

These four areas span the domains of patient safety, clinical effectiveness and patient experience.

[1] Data Source: Information Services report: 'APS Dash' (All care groups combined)

## How did we choose these priorities?

Discussions and meeting with Healthwatch representative, Trust governors, clinicians, managers, and members of the Trust Executive Group and senior management team.

Topics were suggested, analysed and developed into the key objectives for consultation.

Key objectives used as a basis for wider discussion with the public, patients, staff, Healthwatch representative, Trust governor representatives, clinicians, managers, and members of the Trust Executive Group and senior management.

Review by Trust Executive Group to enable the Chief Nurse and Medical Director to inform the Board on our priorities.

The Trust Executive Group, on behalf of the Trust's Board of Directors, agreed these priorities in March 2019.

## 2019/20 Objectives

### Safety

***Review the possibility of a real-time system or process which will support the early detection of, and appropriate response, to emerging/potential safety or risk issues***

**Objective breakdown:**

This is a one year objective.

Potential opportunities that will be explored include:

- Reviewing potential technological solutions to develop 'early warning' indicators which will identify a solution that will be implemented during 2020/21
- Reviewing spikes in complaints or incidents, which will trigger a more in-depth review in the area
- Using incident investigations to proactively identify and mitigate what might go wrong in the future
- Development of case studies on the use of technological solutions in the identification and mitigation of potential safety or risk issues.

**Objective output/metrics:**

The final output will be a report containing detailed case studies and identification of specific systems that can act as early warning systems for implementation during 2020/21.

### Patient Experience

***Evaluate new inpatient and outpatient patient letters, consulting widely with patients, including those from seldom heard or hard to reach groups. Use the Trust's new engagement hub as the vehicle for the consultation***

**Objective breakdown:**

This is a one year objective.

The purpose of this objective is to secure feedback from patients on the revised standard inpatient and outpatient appointment letters.

Work will involve:

- Using a sampling strategy to ensure representative sample of patients
- Designing an evaluation form
- An initial consultation via the hub followed by 'pop up' face to face event
- Analysis of feedback to identify if any further work is required on the letters and action plan.

**Objective output/metrics:**

The primary output will be the evaluation of the letters and the generation of a report on the consultation findings.

The secondary output will be to evaluate the use of the Trust's new engagement hub as a way of co-producing a product / service and this will be the subject of a separate report.

***Learn from an area that displays best practice in relation to 'customer service' and staff attitudes***

**Objective breakdown:**

This is a one year objective.

Work will involve:

- Reviewing all patient and staff experience data for inpatient areas and identify potential areas of excellent practice, from which one inpatient area will be selected to explore in detail
- Working with the selected area to look at working practices; points of excellent practice; staff and patient thoughts/views
- Collecting detailed information from the selected area which may include observational studies, environment audits, and patient/staff interviews
- Reviewing and analyse data to identify areas of excellent practice and key

measures/conditions which support good customer care.

- Developing a toolkit/guide to share identified excellent practice across all inpatient areas.

**Objective output/metrics:**

The final output will be a toolkit / guide for inpatient areas on best practice in the work environment which supports good customer care.

### Effectiveness

***Reduce the number of referrals logged on Lorenzo after 30 days of receipt from 57[2] (April 2019) to 0 in order to reduce delays in inpatient journeys by 31 March 2020***

**Objective breakdown**

This is a one year objective.

The Trust currently monitors the time taken between a referral being received into the organisation, registered and accepted on to the Patient Administration System Lorenzo. Where the time taken is greater than 30 days the referral delay is displayed on the Administration Professionalisation Programme performance dashboard as unacceptable performance.

The aim of this objective is to identify organisational best practice for referral registration and acceptance speed in high performing Directorates and the causes of referral registration and acceptance delays in low performing Directorates and develop a single STH approach that minimises delays.

Potential opportunities that will be explored include:

- A review of the available data for 2018/19 referral registration and acceptance speed to identify Directorates with high and low performance
- Face to face meetings with high and low performing Directorates to establish the enablers of, and barriers to, high performance
- The development and pilot of a single STH best practice approach
- The roll out of the best practice approach to the bottom five worst performing Directorates

**Objective Outcome/metrics**

This objective will be measured using the metric of number of patients over 30 days.

The baseline data shows that 57 referrals are logged after 30 days of receipt.

The aim is to improve so that 0 referrals are logged after 30 days of receipt by 31st March 2020.

The current threshold for unacceptable performance of 30 days will be lowered to 20 days to provide a new target against which to measure the success of the objective.

[2] Data Source: Information Services report: 'APS Dash' (All care groups combined)

## 2.4 Statements of assurance from the Board

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

*a. Services provided*
*b. Clinical audit*
*c. Clinical research*
*d. Commissioning for Quality Improvement (CQUIN) Framework*
*e. Care Quality Commission*
*f. Data quality*
*g. Patient safety alerts*
*h. Staff survey*
*i. Annual patient surveys*
*j. Complaints*
*k. Mixed sex accommodation*
*l. Coroners regulation 28 (Prevention of future death) reports*
*m. Never events*
*n. Duty of candour*
*o. Safeguarding Adults*
*p. Seven day service*
*q. Learning from deaths*
*r. Staff who speak up*
*s. Rota gaps*

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

### a. Services provided

During 2018/19, Sheffield Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 50 relevant health services. Sheffield Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 50 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant health services by Sheffield Teaching Hospitals NHS Foundation Trust for 2018/19.

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

### b. Clinical audit

During 2018/19, 55 national clinical audits and two 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 100 per cent of national clinical audits and 100 per cent of 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 2018/19 are documented in Table one. The national clinical audits the Trust has not participated in are detailed later in the 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 2018/19, 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.

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*Fig: Audit and confidential enquiries*

| Audits and confidential enquires | Participation N/A = Not applicable | % cases submitted |
|---|---|---|
| **Acute care** | | |
| Case Mix Programme (CMP) | Yes | 100% |
| Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)* | Yes | 100% |
| Seven Day Hospital Services | Yes | 100% |
| Surgical Site Infection Surveillance Service | Yes | 100% |
| Major Trauma Audit | Yes | 100% |
| **Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD):** | | |
| Perioperative diabetes | Yes | 81% |
| Pulmonary Embolism | Yes | 95% |
| National Emergency Laparotomy Audit (NELA) | Yes | 100% |
| National Joint Registry (NJR) | Yes | 100% |
| National Neurosurgery Audit Programme | Yes | 100% |
| National Ophthalmology Audit | Yes | 100% |
| National Bariatric Surgery (NBSR) | Yes | 83% |
| Vital Signs in Adults (care in Emergency Departments) | Yes | 100% |
| VTE risk in lower limb immobilisation (care in Emergency Departments) | Yes | 100% |
| **National Vascular Registry** | | |
| National Carotid Interventions | Yes | 100% |
| Abdominal Aortic Aneurysm | Yes | 69.4% |
| Peripheral Vascular Surgery - Lower limb angioplasty/stenting | Yes | 55%* |
| Peripheral Vascular Surgery - Lower limb bypass | Yes | 100% |
| Peripheral Vascular Surgery - Lower limb amputation | Yes | 39%* |
| Sentinel Stroke National Audit programme (SSNAP) | Yes | 90%** |
| **Blood and transplant** | | |
| National Comparative Audit of Blood Transfusion programme: | | |
| Audit of Massive Haemorrhage | Yes | 80% |
| Audit of O negative | Yes | 100% |
| Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children/FFP/Cryo Audit | Yes | 100% |
| Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection | Yes | 100% |
| Serious Hazards of Transfusion (SHOT): UK National Haemovigilance | Yes | 100% |
| **Cancer** | | |
| National Bowel Cancer Audit (NBOCA) | Yes | 100%* |
| National Lung Cancer Audit (NLCA) | Yes | 100%* |
| National Prostate Cancer Audit | Yes | 100%* |
| Oesophago-gastric Cancer (NAOGC) | Yes | 100%* # |

| Audits and confidential enquires | Participation N/A = Not applicable | % cases submitted |
|---|---|---|
| National Audit of Breast Cancer in Older Patients (NABCOP) | Yes | 100%* |
| **Heart** | | |
| Adult Cardiac Surgery | Yes | 100%* |
| Cardiac Rhythm Management (CRM) | Yes | 100%* |
| Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI) | Yes | 100%* |
| Myocardial Ischemia National Audit Project (MINAP) | Yes | 100%* |
| National Cardiac Arrest Audit (NCAA) | Yes | 90% |
| National Heart Failure Audit | Yes | >70%* |
| National Audit of Cardiac Rehabilitation | Yes | 100% |
| National Audit of Pulmonary Hypertension | Yes | 100%* |
| **Long term conditions** | | |
| Inflammatory Bowel Disease (IBD) programme | Yes | 15%* |
| **National Asthma and COPD Audit Programme:** | | |
| COPD | Yes | 98% |
| National Audit of Dementia | Yes | 100% |
| **National Diabetes Audits:** | | |
| National Diabetes Audit :Insulin Pump | Yes | 100% |
| National Diabetes Foot care Audit | Yes | Participating Denominator Unknown |
| National Pregnancy in Diabetes Audit | Yes | 100% |
| National Diabetes Audit – Adults | Yes | 100%* |
| UK Cystic Fibrosis Registry | Yes | 100% |
| **Mental health** | | |
| Learning Disability Mortality Review Programme (LeDeR Programme) | Yes | 100% |
| Mental Health Clinical Outcome Review | N/A | N/A |
| Prescribing Observatory for Mental Health (POMH-UK) | N/A | N/A |
| National Clinical Audit of Psychosis | N/A | N/A |
| **Older people** | | |
| **Falls and Fragility Fractures Audit programme (FFFAP):** | | |
| National Hip Fracture Database | Yes | 95.1% |
| National Audit of Intermediate Care (NAIC) | Yes | 77.9% |
| **Other** | | |
| Elective Surgery (National PROMs Programme): | | |
| Hips | Yes | 49% # |
| Knees | Yes | 47% # |
| BAUS Urology Audit - Cystectomy | Yes | 100%* |
| BAUS Urology Audit – Female Stress Urinary Incontinence (SUI) | Yes | 50% |
| BAUS Urology Audit – Nephrectomy | Yes | 63% |

| Audits and confidential enquires | Participation N/A = Not applicable | % cases submitted |
|---|---|---|
| BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL) | Yes | 92% |
| BAUS Urology Audit – Radical Prostatectomy | Yes | 100% |
| National Audit of Care at the End of Life (NACEL) | Yes | 100% |
| **Women's and children's health** | | |
| Child Health Clinical Outcome Review Programme | N/A | N/A |
| Feverish Children (care in Emergency Departments) | N/A | N/A |
| Maternal, New-born and Infant Clinical Outcome Review Programme | Yes | 100%* |
| National Maternity and Perinatal Audit (NMPA) | Yes | 100% |
| National Neonatal Audit Programme (NNAP) | Yes | 100% |
| National Paediatric Diabetes Audit (NPDA) | Yes | 100% |
| Paediatric Intensive Care (PICA Net) | N/A | N/A |
| National Audit of Seizures and Epilepsies in Children and Young People TBC | N/A | N/A |
| **Outcomes** | | |
| National Mortality Case Record Review Programme | Yes | 76%* |

*Please note the following*
**Data for projects marked with * require further validation. Where data has been provided these are best estimates at the time of compilation. Data for all continuous projects and confidential enquiries continues to be reviewed and validated during April, May or June and therefore final figures may change.*
*** This is normally reported in 'bands' in the SSNAP quarterly reports.*

### # Supporting statements

#### National Oesophago-gastric Cancer (NAOGC)

In the latest 2018 published report a case ascertainment of 60-70 per cent for the Trust is based upon a predicted number of cases, not actual number of cases. Some patients diagnosed in District General Hospitals (DGHs) and treated at the Trust, are included in the DGH submission figures to NAOGC, as opposed to the Trust. This is directed by the National Audit.

#### Elective Surgery (National PROMs Programme)

During 2016/17, the Trust became the provider for the Cobic (Capitation outcome-based incentivised contracts) commissioning contract within Musculoskeletal (MSK). The Trust hip and knee replacement activity that is assigned to off-site providers is included in the Trust's activity data. This is included within our 'eligible procedure' PROMs (Patient Reported Outcome Measures) data which are used to calculate participation rates. In terms of eligible hospital procedures, published by NHS England, the Trust has seen a large increase in the reported figures to previous years. The PROMs questionnaires, however, are completed off site and the outcomes are reported directly against these organisations. This has resulted in the Trust's participation rates for hips and knees currently being reported as much lower than they actually are.

The reports of 43 national clinical audits were reviewed by the provider in 2018/19 and Sheffield Teaching Hospitals NHS Foundation Trust intends to take actions to improve the quality of healthcare provided, examples of which are included below:

#### National Chronic Obstructive Pulmonary Disease Secondary Care Audit 2018

This continuous audit, which captures the process and clinical outcomes of treatment inpatients admitted to hospital in England and Wales with Chronic Obstructive Pulmonary Disease (COPD)

exacerbations, was launched on 1 February 2017. The report, which is the first report post launch of continuous data collection, presents the results of the cohort of patients discharged between the audit's launch date and 13 September 2017.

The results for the Trust are higher than the national average for Specialist Review within 24 hours, discharge care bundle, prescription of oxygen to stipulated target oxygen saturation and spirometry result available. The Trust has consistently been among the top performing hospitals since the audit started in February 2017. The national team noted;

*'In addition to entering a substantial number of patient records, your hospital (STH) has accomplished the following: achieved the best practice target each month; has a large percentage of patients prescribed oxygen to target saturation; and has very good numbers for availability of spirometry results.'*

The action plan seeks to further increase availability of spirometry results, increase the uptake (by current smokers) of prescribed smoking cessation pharmacotherapy, and increase the number of patients who required non-invasive ventilation, receiving non-invasive ventilation within three hours of arrival to hospital.

### National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) is a snapshot audit of the quality of diabetes care provided to people with diabetes during their hospital admission. The audit took place between 25 and 29 September 2017, at hospitals in England and Wales, and answers questions on diabetes management, patient harms and the patient experience.

This is the sixth annual report (published 14 March 2018), and includes data on the care of 16,010 inpatients, admitted at 208 hospital sites.

Data was collected prospectively from the prescription charts and case notes locally of 235 inpatients with diabetes [Northern General Hospital (NGH) 200, Royal Hallamshire Hospital (RHH) and Weston Park Hospital (WPH) 35)] on one day in September 2017 on the majority of wards across the Trust. Exclusions were Maternity Services, A&E and day case wards. A patient questionnaire was also given to each patient. Locally 167 (NGH 143, RHH and WPH 24) responded, 71 per cent response rate. Nationally there was a 54 per cent response rate.

The audit showed that STH (particularly NGH) had a higher prevalence of inpatients with diabetes than the national average. NGH also had a higher prevalence of type 1 diabetes inpatients at the time of the audit. Sheffield is a more deprived area with a higher incidence of diabetes in the population.

The comprehensive action plan involves piloting a new monitoring chart, rollout of electronic prescribing and the development of an electronic referral system across the Trust. There will also be enhanced weekend service, human factors training and updated e-learning modules. A successful bid to NHS England has expanded the inpatient diabetes service including Consultants, Diabetes Specialist Nurses, support workers and admin support.

### National Ophthalmology Audit/National Cataract Audit

The National Cataract Audit is a unique opportunity to update benchmark standards of care for cataract surgery in England and Wales. The project may help drive improvements in quality by identifying variations in access to, and outcomes of, cataract surgery. Cataract surgery is the most frequently undertaken NHS surgical procedure with approximately 400,000 cataract operations undertaken in England and 20,000 in Wales during 2016/17.

This summary is taken from the second prospective national annual report and includes data on 120,722 eligible cataract operations from 97,908 patients for the period 01 September 2016 to 31 August 2017.

The aim is to measure two primary indicators of surgical quality:

1. Posterior capsular rupture (PCR): a break in the posterior capsule of the lens can be a complication of cataract surgery. It allows vitreous (a transparent substance with the consistency of uncooked egg-white which occupies the space inside the eye behind the lens) to move forward into the anterior chamber of the eye. PCR is the most powerful, and only potentially modifiable, predictor of visual harm from surgery.
2. Visual Acuity (VA) Loss (visual harm from surgery): for cataract surgery, the most important outcome is vision; this is what matters most to patients. Vision which is worse after the operation than before is identified as an adverse outcome.

The objective is to identify good practice and areas for improvement. The national report recommends where opportunities for improvements are found, these should be acted upon to enhance the quality of the patient care being provided.

The Trust's data shows that 42.7 per cent of our cataract patients had ocular co-pathology. A risk adjustment had been performed by the statisticians in the National Ophthalmology Database team to account for the more complex workload. The Trust is understandably delighted that our PCR rate of 0.8 per cent is less than the national average of 1.1 per cent.

Since the publication of the second prospective audit annual report, the Royal College of Ophthalmologists National Ophthalmology Database have now received further information from NHS Digital that accurately reports the case ascertainment rate for the Trust. The centre's case ascertainment rate should be 100 per cent. This will be evident in the 2017/18 report which is due to be published in 2019.

In May 2018, the Trust opened the Northern General Eye Centre, a state-of-the-art cataract facility. This heralds the next chapter in the provision of cataract care to the population of Sheffield. All Ophthalmic Surgeons participate in the audit. The National Ophthalmology Database audit shows that the Trust has excellent results.

### Confidential Enquiries

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

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

### Local Clinical Audits

The reports of 304 local clinical audits were reviewed by the provider in 2018/19 and Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- **Re-audit of Gefitinib usage and outcomes for Lung Cancer (NICE TA192)**

The drug Gefitinib is recommended as an option for the first-line treatment of people with locally advanced or metastatic Non-Small Cell Lung Cancer if:

- they test positive for the epidermal growth factor receptor tyrosine kinase (EGFR-TK) mutation and
- the manufacturer provides Gefitinib at the fixed price agreed under the patient access scheme.

The aim of the audit was to assess usage and outcomes of treatment with first line Gefitinb in EGFR mutation positive Non-Small Cell Lung Cancer.

*Standard 1:4 – 100 per cent of patients will be chemotherapy naïve (our audit showed 90 per cent, 27 out of 30). It is a NICE guideline that it should be first line treatment.*

Some patients commence chemotherapy due to a delay in results for EGFR testing. The pathway at the time of the audit was that tissue testing for EGFR mutation is managed locally. Notification of results communicated to referring consultants. It was a pharmacy standard on chemo care that it should be first line treatment but this could be changed by the prescribing consultant.

Further analysis of the three patients demonstrated that one patient had previously adjuvant treatment prior to metastatic disease. Two further patients were treated with one cycle of chemotherapy as EGFR results could not initially be obtained, and they were later changed to EGFR TKI therapy once results were available.

An action plan for improvement against the standard was agreed and implemented and included the following actions:

- Pharmacy protocol changed so consultants are unable to allocate EGFR treatments unless it is a first line treatment
- Improved communication of results to both consultant and multi-disciplinary team members and multi-disciplinary team coordinator to ensure the results are available faster
- All EGFR mutation testing managed locally as far as possible to achieve faster results to improve speed of results

Overall the standards were met with good compliance. With regard to standard 1:4, further analysis demonstrated that the patients were treated appropriately but the action plan for improvement should enable more timely appropriate treatment as results will be available faster. A re-audit is planned for October 2019.

- **Assessment of the use of Intravenous/Subcutaneous fluids inpatients in the last days of life**

Maintaining hydration at the end of life can be both emotive and controversial. Practice varies widely across the UK regarding the use of clinically assisted hydration at the end of life and decisions are often dependent on the setting, and also individual clinician or healthcare professional preference and experience of its use.

Communication between the patient and / or those important to them surrounding subcutaneous or intravenous hydration is of utmost importance, as is discussion surrounding any symptoms of dry mouth and need for mouth care. In addition, it is important to assess that if fluid is prescribed, that it is administered correctly, and, if not used at all, that this decision is clearly documented in the patient's notes.

The patient's condition should be kept under review, especially if they live longer than expected. If this is the case it is recommended to reassess the appropriateness of providing clinically assisted nutrition or hydration, as the patient's condition changes.

The objectives of the audit were:

- To assess if a discussion has taken place between healthcare professionals and the patient and/or those important to them about hydration
- To assess if there was a discussion about dry mouth and mouth care with the patient and/or those important to them
- To assess if fluids were offered; what symptoms were they prescribed for and if not prescribed, to assess why not
- If fluids were prescribed, which fluids were prescribed; what route was used; and how much was prescribed over 24 hours

- To assess if there were any problems with administering fluids; if so, what were these problems and were they documented
- To assess if fluids were prescribed and administered, how much did the patient actually receive and if the patient did not receive the prescribed amount, was the reason documented
- To assess if fluids were prescribed and administered, if they continued until the patient died; if stopped prior to death, why were they stopped.

Measurement in 2017 was undertaken. Areas of non-compliance were risk assessed and an action plan for improvement was agreed and implemented to improve assessment of the use of intravenous/subcutaneous fluids inpatients in the last days of life. The following actions were taken:

1. Introduction of a ward round sticker at Palliative Care Unit with a prompt to consider hydration in advance of the patient entering the final phase of life
2. To routinely discuss with a patient (and those important to them) about dry mouth and mouth care and for this to be considered as part of daily review of patients who are dying – this is described in the guidance for the care of the person who may be in the last hours to days of life
3. If fluids are provided, this should be reassessed, balancing potential benefits and harms and to be considered as part of daily review of patients who are dying
4. If fluids are not provided, this should be reassessed, balancing potential benefits and harms to be considered as part of daily review of patients who are dying

A re-audit was undertaken in 2018 and results compared to the first cycle of measurement. There was an improvement in compliance for all standards. The results were risk assessed and the target score was achieved. The risk score has identified the need for the next cycle of measurement to take place within 12 months. Further actions for improvement have been agreed and a new target risk score identified to further reduce the level of risk.

- **Use of Trastuzumab (Herceptin) in breast cancer**

Trastuzamab is used in both the adjuvant and palliative setting for patients with HER2+ve breast cancer. This monoclonal antibody therapy can have serious side effects, hence ensuring it is prescribed in the correct settings, and it is important that appropriate monitoring is carried out. NHS England requires a mandatory audit of Trastuzumab use and asked the Trust to do a short audit on its usage.

The aim of the audit was to ensure that Trastuzumab is being used in the correct setting, with appropriate tests having been performed before initiation of treatment.

The objectives of the audit were to collect information regarding the indication, prescription and monitoring of Trastuzumab using the proforma provided by NHS England.

The primary outcome measures were whether patients had a documented HER2 status and cardiac functional assessment before initiation of treatment. The audit found that 100 per cent of patients had both of these assessments performed:

The Trust are safely prescribing and monitoring as per NICE Guidance and NHS England requirements for the use of Trastuzumab (Herceptin) in breast cancer.

### c. Clinical research

The number of patients receiving NHS Services provided or subcontracted by Sheffield Teaching Hospitals in 2018/19 that were recruited to studies during that period to participate in the National Institute of Health Research (NIHR) portfolio research trials was 11,641. This was 127 per cent of our end of year target. We have made excellent progress in continuing to improve our performance.

#### Patient and public involvement and engagement

During 2018/19, the Trust has been building on its existing infrastructure for patient and public involvement and engagement, and the

successful events and activities that took place last year.

In 2018, a set of national standards for public involvement in research was launched to improve the quality and consistency of public involvement in research. As part of this launch, organisations were invited to apply to be part of a 12 month testing process from April 2018/19, to evaluate how the six standards work in practice. From over 50 applications, the Clinical Research and Innovation Office (CRIO) submitted a successful application to test the communications standard, and was chosen as one of just ten Test Bed projects across the UK.

Locally, this means we have been working closely with our existing public involvement panels to ensure that opportunities to be involved in research are more visible to more people, there is diversity of representation in public involvement groups, and to provide/receive meaningful feedback that can be acted upon to improve the quality of public involvement. Nationally, this is giving the Trust the opportunity to share learning and experiences with a broad spectrum of research groups and institutions, and to make recommendations for the final version of the Standards. Being a Test Bed site has meant that many of our activities throughout the year have been carried out using the standards as a guide.

### Events

In 2018, the annual NIHR 'I Am Research' campaign for International Clinical Trials Day was run in conjunction with celebrations for NHS70. The Trust held NHS70 celebrations on 5 July 2019 outside Sheffield Cathedral. The public involvement groups were invited to have stalls to showcase some of the outstanding research taking place at the Trust, and the opportunities for getting involved in research. There were many interactive activities and with a theme that focused on the past, present and future of the NHS. Staff and volunteers could highlight the crucial role research played in developments through the years in diagnosing, treating and preventing diseases.

To tie in with the NHS70 celebrations, the Trust held a Tea Party for Public Involvement Volunteers to thank them for their vital contribution to health research at the Trust. Nearly 40 people came together to catch up with fellow volunteers, share best practice and discuss public involvement plans at the Trust for the coming months. Attendees were also encouraged to bring along a friend or family member to find out more about being involved in research; as a result new members have been welcomed to the public involvement groups.

### New panels

Opportunities for involvement in research at the Trust have broadened over the last 12 months with the initiation of several new public involvement panels in different disease areas. As a result of the Trust being successful in the application for an NIHR Biomedical Research Centre in 2017, new patient and public involvement and engagement panels for Multiple Sclerosis, and for Stroke, have been established and are already providing value to research in these areas. The Musculoskeletal Care Group was successful in securing funding from the Research Design Service Yorkshire and Humber Public Involvement Fund to establish a Musculoskeletal Public Involvement Group. They have the funding to pay for their communications to be translated into five different languages which will make involvement opportunities more accessible for more people. In the coming years the Trust wants to expand on this to try to ensure individuals can be involved on any panels regardless of language or communication requirements.

### Training

The CRIO continues to offer public involvement volunteers the opportunity to attend training in research and public involvement. Going forward from 2018, the training has been adapted and improved based upon feedback from previous attendees, working with (and will continue to do so in the future) existing volunteers to ensure this training is suitable for people with differing communication needs, and to develop

new materials so that separate training sessions can be offered to people new to public involvement and those with more experience.

### Communications

During 2018 new communications methods have been introduced, including social media, and a newsletter, to ensure the public are aware of activities that are taking place, opportunities for involvement, and news about how involvement in research at the Trust is benefitting patients. With Trust staff and public involvement, the pages of the CRIO website are being reviewed and updated. This will ensure the information is up-to-date and relevant, the pages are easy to navigate and people can easily direct themselves to the information that they want to find.

### Staff Engagement

The first Research and Innovation Conference to increase engagement with Trust research staff and those who are interested in research took place in September 2018 and was at capacity with nearly 200 delegates attending. During the afternoon four parallel breakout sessions were run of which one was dedicated to public involvement in research. This was designed and presented by our Patient Research Ambassadors and the feedback from delegates was overwhelmingly positive. After the event, delegates commented on feeling proud and inspired by the research and innovation taking place across the Trust, and many felt more knowledgeable about where they can go to access support, and the numerous other groups that they can collaborate with to carry out research that will ultimately benefit patients.

## d. Commissioning for Quality and Innovation (CQUIN Framework)

A proportion of Sheffield Teaching Hospitals NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the 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 (CQUIN) payment framework.

Further details of the agreed goals for 2018/9 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/publication/commissioning-for-quality-and-innovation-cquin-guidance-for-2017-2019/

In 2018/19, £18,174,872 of our contractual income was conditional on achieving the Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield Clinical Commissioning Group (CCG) / NHS England. Of the 2.5 per cent of contract income associated with the National (CCG commissioned) CQUIN schemes, one per cent was linked to engagement with sustainability and transformation plans. The remaining one and a half per cent was linked to achievement of CQUIN goals.

In total across all Commissioners there were 20 different CQUIN schemes which included a focus on improving the health and wellbeing of staff, preventing ill health by risky behaviours, i.e., use of alcohol and tobacco, and the management of the prescribing of drugs for the treatment of Hepatitis C.

During 2017/18 the Trust secured £15,754k on achieving the Quality Improvement and Innovation Goals.

## 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 (CQC) has not taken enforcement action against Sheffield Teaching Hospitals NHS Foundation Trust during 2018/19.

Sheffield Teaching Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2018/19.

The Trust participated in the CQC's Local System Review (LSR) of the Sheffield Health and Social Care System during 2017/18. The CQC LSR report was published on 8 June 2018. Below is a brief summary of the report:

Key strengths:

- Most people felt they were treated with kindness and that frontline staff provided person-centred care, going the extra mile for people they cared for
- There are strengthening relationships and a strong commitment to achieve the best outcomes for the people in Sheffield
- The system works well together in a crisis and to address challenges and system pressures
- There are opportunities for increasing the scale of positive innovations being tested
- The Joint Health and Wellbeing Strategy and the Accountable Care Partnership are providing a stronger framework for joint working and delivering Shaping Sheffield and the Better Care Fund
- The development of shared agreements and approaches, such as the Community Intermediate Care Services, are making a positive impact.

Areas where the system needs to further develop/improve as a system:

- Discharges from hospital
- Fully embedding a collaborative approach with all staff and supporting staff to work in this way
- Developing joint plans for delivering services
- Better integrating the voluntary, community and social enterprise with statutory service delivery
- Involving social care providers in market shaping and service development
- Evaluating pilots and test projects
- Concerns from service users and carers relating to: Continuing Healthcare reviews and social work assessments; help and support for carers; information on services and activities; and communication around delays in treatment.

A city-wide action plan has been developed and focuses on improving and accelerating progress on the following themes:

- A way of working that is built around acknowledging and improving older people's views and experiences and which drives a citywide vision
- A shared city-wide workforce strategy to support front-line staff in delivering this vision and in particular further develops multi-agency working
- Developing clearer governance arrangements to ensure stronger joint-working between organisations and greater involvement for the Voluntary, Community and Faith sector
- A meaningful shift to prevention at scale, supported by clear commissioning arrangements and digital interoperability
- A strong system focus on enabling the right support from the right person in the right place at the right time, to give the best possible experience.

In 2018 the Trust also welcomed inspectors from the CQC to carry out an inspection of services and care. On 4 June 2018, as part of the CQC inspection cycle, NHSI undertook an assessment of the Trust's use of resources. From 12 to 14 June 2018, the CQC carried out an unannounced inspection of the urgent and emergency, medical, surgical and end of life services provided by this Trust. An announced 'well-led' inspection took place between 11 and 13 July 2018, during which the CQC looked at the quality of leadership at the Trust and how well the Trust manages the governance of its services. During the announced inspection there were further unannounced visits to the Emergency Department and wards, with a mental health team from the CQC reviewing various records.

The Trust's Inspection Report was published on 14 November 2018 with the Trust achieving an overall rating of 'Good' with an overall rating of 'Outstanding' for responsive. The Trust-wide ratings are detailed below:

***Fig: 2018 CQC Rating***

| | |
|---|---|
| Safe | GOOD |
| Effective | GOOD |
| Caring | GOOD |
| Responsive | OUTSTANDING |
| Well-led | GOOD |
| Overall rating | GOOD |

In response to the Trust's Inspection Report, a high-level action plan was agreed to address the 41 'Must Do' and 'Should Do' recommendations identified within the report. This is a significant reduction with the Trust having received 83 recommendations following the 2015 inspection.

The high-level action plan was submitted to CQC on 12 December 2018. The implementation of the actions is being overseen by the Trust's Healthcare Governance Committee.

## f. Data quality

Sheffield Teaching Hospitals NHS Foundation Trust submitted records during 2018/19 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:

99.9 per cent for admitted patient care

99.9 per cent for outpatient care

99.2 per cent for Accident and Emergency Care

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

100 per cent for admitted patient care

100 per cent for outpatient care

100 per cent for Accident and Emergency Care

Sheffield Teaching Hospitals NHS Foundation Trust was not subject to a Payment by Results audit process during 2018/19. Sheffield Teaching Hospitals NHS Foundation Trust continues with the following programmes to improve its data quality:

- The Electronic Patient Record and Data Quality Team are well established and continue to support and drive forward a coordinated Data Quality agenda across the organisation
- The reporting dashboards to support improvement to Data Quality, including the Administrative Patient Safety Dashboard, is well established within the organisation
- The Data Quality Steering Group, chaired by the Assistant Chief Executive, is well established, and continues to support data quality improvement across the organisation
- The Trust systems trainers are now fully integrated within the Performance and Information function, to support users in learning from errors, and further improve training to focus on data quality
- The Administrative Profession Programme has been launched with a view to ensuring all those undertaking administrative functions are suitably trained and supported. This includes standardisation of procedures, and availability of standard operating procedures for all tasks.

The Data Security & Protection Toolkit assessment, the replacement of the Information Governance Toolkit, was submitted on March 29, 2019 and graded at 'Standards met' on 5 April 2019.

## g. Patient safety alerts

Patient safety alerts are issued via the Central Alerting System on behalf of NHSI to ensure safety critical information and guidance is appropriately cascaded to the NHS and independent providers of health and social care.

The patient safety alert 'Resources To Support Safer Care For Patients At Risk Of Autonomic Dysreflexia' was issued in July 2018, with an expectation of compliance by 25 January 2019. Providers were asked to review local clinical policy and guidance relating to bowel assessment and management, including review of local training and education provision, particularly around the care of patients with spinal cord injury or neurological conditions that have led to neurogenic bowel dysfunction.

Although our review identified local policy and compliance with education and training provision, variances in practice were identified across the Trust and it was considered that to ensure full compliance that a Trust-wide bowel management policy was required. In response, a new policy was developed, however due to requiring input from various stakeholders across the Trust, this took longer than expected to finalise. The document is now complete and requires final ratification and approval at the Nursing Executive Group, in line with Trust processes. Following ratification this policy will be appropriately disseminated at which stage the Trust will be able to demonstrate full compliance and be confident in the closure of this alert. It is anticipated this will be complete by the end of April 2019.

***Fig: Patient Safety Alert***

| Reference | Title | Issued | Deadline (action complete) | Closed |
|---|---|---|---|---|
| NHS/PSA/D/2017/006 | Confirming removal or flushing of lines and cannulae after procedures | 09/11/2017 | 09/08/2018 | Closed |
| NHS/PSA/D/2016/009 | Reducing the risk of oxygen tubing being connected to air flow meters | 04/10/2016 | 04/07/2017 | Closed |
| NHS/PSA/W/2018/002 | Risk Of Death Or Severe Harm From Inadvertent Intravenous Administration Of Solid Organ Perfusion Fluids | 17/04/2018 | 31/05/2018 | Closed |
| NHS/PSA/RE/2018/003 | Resources To Support The Safe Adoption Of The Revised National Early Warning Score (News2) | 25/04/2018 | 21/06/2018 | Closed |
| NHS/PSA/RE/2018/004 | Resources To Support Safer Modification Of Food And Drink | 27/06/2018 | 01/04/2019 | Closed |
| NHS/PSA/RE/2018/005 | Resources To Support Safer Care For Patients At Risk Of Autonomic Dysreflexia | 25/07/2018 | 25/01/2019 | Overdue |
| NHS/PSA/RE/2018/006 | Resources To Support The Safe And Timely Management Of Hyperkalaemia (High Level Of Potassium In The Blood) | 08/08/2018 | 08/05/2019 | Open |
| NHS/PSA/RE/2018/007 | Management Of Life Threatening Bleeds From Arteriovenous Fistulae And Grafts | 12/11/2018 | 13/05/2019 | Open |
| NHS/PSA/RE/2018/008 | Safer Temporary Identification Criteria For Unknown Or Unidentified Patients | 05/12/2018 | 05/06/2019 | Open |
| NHS/PSA/W/2018/009 | Risk Of Harm From Inappropriate Placement Of Pulse Oximeter Probes | 18/12/2018 | 18/06/2019 | Open |

## h. NHS Staff Survey

The response rate to the 2018 survey from STH staff was 46 per cent which was above the national average for our benchmarking group and an improvement on the 2017 Trust response rate (44 per cent).

The benchmarked findings of the 2018 survey are now presented as ten theme scores (scored out of ten) which can be seen in the table below. The Trust is benchmarked in the Combined Acute and Community Trusts group.

***Fig: Response rate to the NHS Staff Survey: Staff involvement***

| 2017/18 | | 2018/19 | |
|---|---|---|---|
| Trust | National Average | Trust | National Average |
| 44% | 43% | 46% | 41% |

***Fig: Staff survey results***

| | 2018/19 | | 2017/18 | | 2016/17 | |
|---|---|---|---|---|---|---|
| | Trust | Benchmarking group | Trust | Benchmarking group | Trust | Benchmarking group |
| Equality, diversity and inclusion | 9.3 | 9.2 | 9.3 | 9.2 | 9.3 | 9.3 |
| Health and wellbeing | 5.9 | 5.9 | 6.1 | 6.0 | 6.1 | 6.1 |
| Immediate managers | 6.8 | 6.8 | 6.8 | 6.8 | 6.8 | 6.8 |
| Morale | 6.3 | 6.2 | Not available | Not available | Not available | Not available |
| Quality of appraisals | 5.6 | 5.4 | 5.5 | 5.3 | 5.5 | 5.4 |
| Quality of care | 7.4 | 7.4 | 7.5 | 7.5 | 7.5 | 7.5 |
| Safe environment – bullying and harassment | 8.4 | 8.1 | 8.4 | 8.1 | 8.4 | 8.2 |
| Safe environment – violence | 9.5 | 9.5 | 9.5 | 9.5 | 9.5 | 9.5 |
| Safety culture | 6.8 | 6.7 | 6.8 | 6.7 | 6.8 | 6.7 |
| Staff engagement | 7.0 | 7.0 | 7.1 | 7.0 | 7.0 | 7.0 |

Of the ten themes in the 2018 benchmarked report the Trust scored above average for five:

- Equality, Diversity and Inclusion
- Morale
- Quality of Appraisals
- Safe environment, bullying and harassment
- Safety culture

The other key themes scored as average. No theme scored below average.

The highest score was achieved in ‘Equality, Diversity and Inclusion’ and the lowest was ‘Quality of appraisals’. There has been little significant change in theme scores since last year with only ‘Quality of care’ and ‘Health and wellbeing’ showing a statistically significant deterioration.

With regard to the health and wellbeing indicator, the Trust continues to build on work already underway to support staff and in early 2019 we introduced a new 24 hours counselling service. A financial wellbeing support service for staff was also introduced in November 2018.

The individual question data shows that the percentage of staff recommending the Trust as a place for treatment remains well above average at 81 per cent (compared to the Combined Acute and Community average of 69.9 per cent). Equally, the percentage of staff recommending the Trust as a place to work to work is above average at 67.8 per cent (compared to the benchmarking group average of 61.1 per cent).

The Trust launched a People Strategy in 2018 with ten workstreams which will address the various areas raised in the staff survey. A Trust level staff engagement action plan will be also produced, which will be underpinned by Directorate action plans. These will be monitored by the HR Strategy Group and the Human Resources and Organisational Development Committee, which is a sub group of the Board of Directors.

The Trust has also established a new Equality, Diversity, and Inclusion (EDI) Board. The Board will provide oversight to the development and implementation of the Trust's strategic approach to meeting the relevant duties set out in the Equality Act, 2010, and the policy approach of the NHS relating to meeting the duties embedded in the NHS Equality Delivery System 2.

With a diverse and broad membership including senior leaders and the Board reports to the Trust Executive Group, the EDI Board will oversee any EDI work carried out in respect of workforce, patients and service delivery.

As part of the Trust's commitment to support, celebrate and integrate all aspects of equality, inclusion and diversity, members of the Board of Directors were reverse mentored by 12 Black, Minority and Asian (BAME) staff giving them insight into what it is like being a BAME member of staff working for the Trust. This experience provided the Board of Directors with a valuable one to one opportunity to explore issues of inclusivity and identify priority areas of focus for the organisation.

The Promoting and Valuing Difference Workstream of the Trust's People Strategy oversees the development and delivery of the Workforce Race Equality Standard (WRES).

The WRES Strategy and Action Plan and Sheffield Implementation Guide and data have been uploaded to the Trust's website. Our WRES data has highlighted the work that needs to be carried out to further improve the experiences of our staff. The EDI Workforce Lead is overseeing the implementation of Trust-wide staff networks which will provide peer support for staff, act as a voice for the organisation on issues that impact on BAME, disabled and Lesbian, Gay, Bisexual and Transgender (LGBT) staff and provide advice and support on issues which are felt to be important to address.

***Fig: Work Race Equality Standard (WRES)***

| WRES Metric | Metric Description | Ethnic Group | 2017 | 2018 | Direction | Representative Target | North 2017 | National 2017 |
|---|---|---|---|---|---|---|---|---|
| Metric 1 | Percentage of BME staff in Bands 8-9, VSM (including Executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce | BME Staff in Post | 13.01 | 13.16 | ▲ | 19 | 7.50 | 16.30 |
| | | BME 8a + & VSM | 4.20 | 4.30 | ▲ | 13 | 4.00 | 10.40 |
| Metric 2 | Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts | White | 1.22 | 1.21 | ▼ | 1.00 | 1.54 | 1.6 |
| Metric 3 | Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process | BME | 1.57 | 1.40 | ▼ | 1.00 | 1.27 | 1.37 |
| Metric 4 | Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff | White | 1.01 | 1.06 | ▲ | 1.00 | 0.99 | 1.22 |
| Metric 5 | KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | White | 20.47 | 21.03 | ▲ | 0 | 26.0 | 27.9 |
| | | BME | 21.45 | 21.48 | ▲ | 0 | 27.4 | 28.7 |
| Metric 6 | KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | White | 19.12 | 18.67 | ▼ | 0 | 21.6 | 24.4 |
| | | BME | 22.7 | 24.28 | ▲ | 0 | 25.1 | 26.5 |
| Metric 7 | KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion | White | 90.18 | 89.94 | ▼ | 100 | 88.1 | 87.6 |
| | | BME | 71.42 | 74.79 | ▲ | 100 | 77.1 | 75.5 |
| Metric 8 | Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? B) Manager/team | White | 4.51 | 4.53 | ▲ | 0 | 5.6 | 6.2 |
| | | BME | 14.78 | 12.67 | ▼ | 0 | 13.4 | 13.8 |
| Metric 9 | Percentage of BME Board membership | White | 100 | 88 | ► | 81 | 90 | 88 |
| | | BME | 0 | 0 | ► | 19 | 6 | 7 |

## i. Annual patient surveys

Seeking and acting on patient feedback remains a high priority. The Trust continues to undertake a wide range of patient feedback initiatives regarding the services they receive. Survey work during 2018/19 included participation in the National Survey Programme for inpatient, cancer and maternity services. National results, including comparative scores, will be available during 2019.

Throughout 2018, a series of local satisfaction surveys have been undertaken covering inpatient, outpatient and community patients, as well as a specific carers' survey.

During 2018/19, the CCQ published results from the 2017 National Inpatient Survey, 2017 National A&E Survey, 2017 National Cancer Survey, and the 2018 National Maternity Survey.

- **National Inpatient Survey 2017**

The National Inpatient Survey 2017 was carried out across 148 acute and specialised NHS Trusts. All adult patients (aged 16 and over) who had spent at least one night in hospital, and were not admitted to maternity or psychiatric units during July 2017, were eligible to be surveyed. 1,199 eligible patients from this Trust were sent a survey, and 529 were returned, giving a response rate of 44.1 per cent. This is compared to the national response rate of 41 per cent.

Compared to other Trusts participating in the National Inpatient Survey, the Trust scored 'about the same' as most other Trusts on the majority of questions and scored 'better' than other Trusts on six questions. This is an improvement on 2016 where the Trust scored 'about the same' as other Trusts on all questions.

In terms of the question relating to overall experience, the Trust score of 8.5 was ranked 'about the same' as the national average. This was a 'significant improvement' from the Trust 2016 score of 8.1. Overall, in the 56 questions that were used in both the 2016 and 2017 surveys, the Trust scored significantly better in 20 questions and did not score significantly worse in any questions. Results and comments from the National Inpatient Survey have been considered alongside other patient experience data, and workstreams are either planned or in place to address priority areas where improvements can be made.

- **National Cancer Patient Experience Survey 2017**

The National Cancer Survey 2017 was carried out across 146 acute hospital NHS Trusts on all adult patients (aged 16 and over) with a primary diagnosis of cancer, discharged following an inpatient episode, or day case attendance for cancer related treatment in the months of April, May and June 2017. A total of 2,175 eligible patients from the Trust were sent a survey, and 1,367 were returned, giving a response rate of 63 per cent. This is compared to the national response rate of 63 per cent.

The Trust scored within the expected range on 55 out of 59 questions, above the expected range on three questions and below the expected range on one question. Areas where the Trust scored above the expected range were: staff giving information about support groups, groups of doctors or nurses not talking in front of the patient as if they were not there, and staff giving information about who to contact post discharge. The area where the Trust scored below the expected range was: being given easy to understand written information about the type of cancer they had at 69 per cent compared to a National average of 73 per cent. The Trust also scored below the expected range for this question in the 2016 survey at 69 per cent.

Directorates and teams providing care for patients with cancer have used the patient comments from the National Cancer Survey, which provide substance and context to scores, to produce an action plan to improve services for patients. Actions include:

Lead Cancer Nurse to review the quality of all tumour site patient information. The majority of information is from national organisations such as Macmillan and Cancer Research UK.

The Trust Lead Nurse will discuss performance at a national level and compare how other organisations are addressing this.

- **National Maternity Survey 2018**

The 2018 survey of women's experiences of maternity services involved 130 NHS acute Trusts in England. Women were eligible for the survey if they had a live birth during February 2018, were aged 16 years or older, and gave birth in a hospital, birth centre, maternity unit, or at home. A total of 375 eligible patients from this Trust were invited to take part in the survey and 133 completed the survey giving a response rate of 35 per cent. This is a decrease from the response rate for the 2017 survey of 39 per cent and slightly below the response rate for similar trusts of 36 per cent.

*Antenatal Care*

- The Trust scored 'about the same' as other Trusts in all questions for antenatal care
- The Trust did not score significantly worse or better in any question from the 2017 scores

*Labour and Birth*

- The Trust scored 'about the same' as other Trusts in all questions for labour and birth and were not significantly higher or lower than 2017 in any question

*Postnatal Care*

- The Trust scored 'about the same' as other Trusts in most questions, except two where the Trust scored worse than most other Trusts. The two questions were:

***Fig: National maternity survey results – postnatal care (bottom scores)***

| | Trust | | National Average |
|---|---|---|---|
| Question | 2017 | 2018 | 2018 |
| Found partner was able to stay with them as long as they wanted | 59% | 61% | 70% |
| Told who to contact if they needed advice about any emotional changes | 74% | 65% | 78% |

The Trust scored significantly lower than 2017 in the following three questions:

***Fig: National maternity survey results – postnatal care (previous year comparison)***

| | Trust | | National Average |
|---|---|---|---|
| Question | 2017 | 2018 | 2018 |
| Feeding your baby: Felt midwives gave consistent advice | 87% | 76% | 80% |
| Care at home after the birth: Felt midwives aware of medical history | 86% | 74% | 75% |
| Care at home after the birth: Given information or advice about contraception | 92% | 84% | 89% |

The Maternity Patient Experience Committee agreed an action plan to improve services for patients focusing on areas raised by the survey.

- **Friends and Family Test**

The Trust continues to participate in the Friends and Family Test (FFT), which is carried out in inpatient, outpatient, A&E, maternity, and community services. The FFT asks a simple, standardised question (*Would you recommend this service to friends and family?*) with a six point scale, ranging from 'extremely likely' to 'extremely unlikely'. During 2018/19, the total percentage of patients who scored 'extremely likely' and 'likely' across all five elements of the FFT was 93 per cent.

The Trust has also chosen to ask a follow-up question in order to understand why patients select a particular response. The FFT allows us to look in more detail at patient feedback at individual ward and service level where our scores consistently compare well nationally, with good response rates being achieved. FFT also provides us with a high volume of free-text comments as well as voice messages.

The Trust uses a number of different methods to carry out FFT depending on the patient group and care setting. Postcards remain a

reliable method of collecting the views of patients therefore this method continues to be used in most inpatient areas and within maternity services. Interactive Voice Messages and Text Messages are the main methods of carrying out FFT in A&E, outpatients and community.

To aim to increase response rates from the Emergency Department, there was a move from using SMS messaging for collecting FFT feedback to using paper cards in November 2018. The impact of this change of methodology will be evaluated after a six month period. Response rates are continually reviewed to ensure areas receive a good response rate whilst ensuring they use the most appropriate method for their area and patients.

From November 2017, the reporting of the GP Collaborative Service was moved from being reported within the Community FFT to the A&E element of the FFT, as it was suggested that the GP Collaborative might closely align with emergency / urgent services in terms of patient feedback. This would allow the Trust to more accurately benchmark against other trusts. The impact of this change on FFT scores for Community Services was monitored through 2018; however, no difference was found. GP Collaborative FFT reporting was therefore moved back to being reported within the Community Services element of the FFT in November 2018, as this is where the GP Collaborative sits managerially.

Although there are no national targets for response rates, the Trust is committed to maintaining good response rates for FFT to ensure feedback data is robust. Therefore, the Trust works to a response rate target for inpatients of 30 per cent, A&E and maternity services 20 per cent, outpatient 9 per cent and Community Services 12.5 per cent. These response rate targets are based on previous performances to ensure existing standards are maintained.

Over the last 12 months, 145,392 FFT responses were received by STH across all areas. Inpatients (29 per cent), A&E (20 per cent), maternity (23 per cent), community (13 per cent) and outpatients (9 per cent) all achieved their locally set response rate target during this time with the exception of inpatients where the target was 30 per cent.

FFT results are monitored through monthly reports of response rates, numbers of responses, positive scores and negative scores. The report also provides the facility for all wards and departments to review anonymous patient comments relevant to their area.

The scores and response rates across all areas of FFT comparing 2017/18 with 2018/19 are detailed below.

When the Trust's response rate targets are not being met, the relevant areas are highlighted in the monthly reports. Response rates are monitored and reported on a quarterly basis in the Integrated Quality Report and monthly in FFT reports that are reviewed by the Patient Experience Committee.

***Fig: Scores and response rates for FFT***

| | 2017/2018 | | | | 2018/2019 | | | |
|---|---|---|---|---|---|---|---|---|
| FFT Area | Positive Score | Negative Score | Response Rate | No. of Responses | Positive Score | Negative Score | Response Rate | No. of Response |
| Inpatient | 96% | 2% | 30% | 37,204 | 96% | 2% | 29% | 36,918 |
| Outpatient | 94% | 2% | 9% | 80,138 | 95% | 2% | 9% | 72,631 |
| Maternity | 95% | 1% | 28% | 5,065 | 97% | 1% | 23% | 4,033 |
| Community | 89% | 3% | 12% | 9,422 | 90% | 3% | 13% | 9,852 |
| A&E | 87% | 7% | 21% | 18,230 | 87% | 8% | 20% | 21,958 |
| Trust Total | 94% | 3% | 12% | 150,059 | 93% | 3% | 13% | 145,392 |

## j. Complaints

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

During 2018/19, we received 1,997 informal concerns which we were able to respond to within two working days. If telephone calls, emails or face to face enquiries are received by the Patient Services Team (PST) and if staff feel they can be dealt with quickly by taking direct action, or by putting the enquirer in touch with an appropriate member of staff, such as a Matron or Service Manager, contacts are made and the enquiry is recorded on the complaints database as an informal concern.

If the concern or issue is not dealt with within two working days, or if the enquirer remains concerned, the issue is re-categorised as a complaint and processed accordingly.

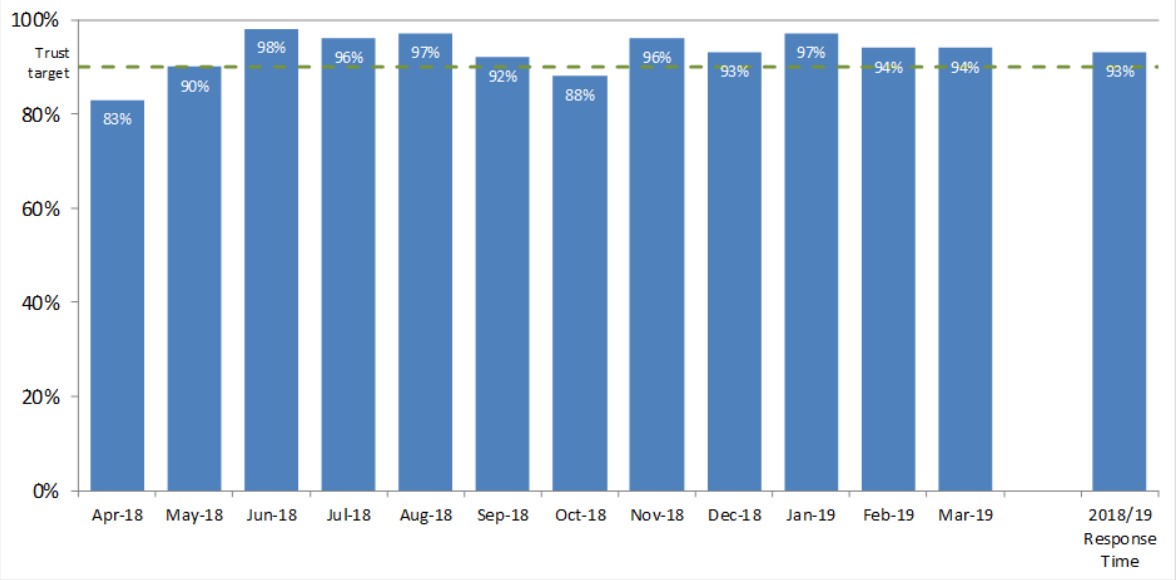
During 2018 /19, 1562 complaints requiring a more detailed and in-depth investigation were received. A monthly breakdown of formal complaints and informal concerns received during 2018/19 is provided below.

***Fig: Complaints received during 2018/19 by month***

| | April | May | June | July | August | Sept | Oct | Nov | Dec | Jan | Feb | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| New informal concerns received | 125 | 132 | 140 | 140 | 156 | 159 | 191 | 193 | 160 | 229 | 190 | 182 | 1997 |
| New formal complaints received | 131 | 135 | 143 | 142 | 130 | 106 | 131 | 124 | 96 | 150 | 133 | 141 | 1562 |
| All concerns combined | 256 | 267 | 283 | 282 | 286 | 265 | 322 | 317 | 256 | 379 | 323 | 323 | 3559 |

Of the complaints closed during 2018/19, 624 (40 per cent) were upheld by the Trust. The Parliamentary and Health Service Ombudsman investigate complaints made regarding Government departments and other public sector organisations and the NHS in England. They are the final step of the complaints process, giving complainants an independent and objective body to review their complaint. During 2018/19 the Parliamentary and Health Service Ombudsman closed seven cases regarding the Trust, 13 per cent (one) of which was partially upheld and no complaints were fully upheld.

***Fig: Breakdown of complaints response times by month***

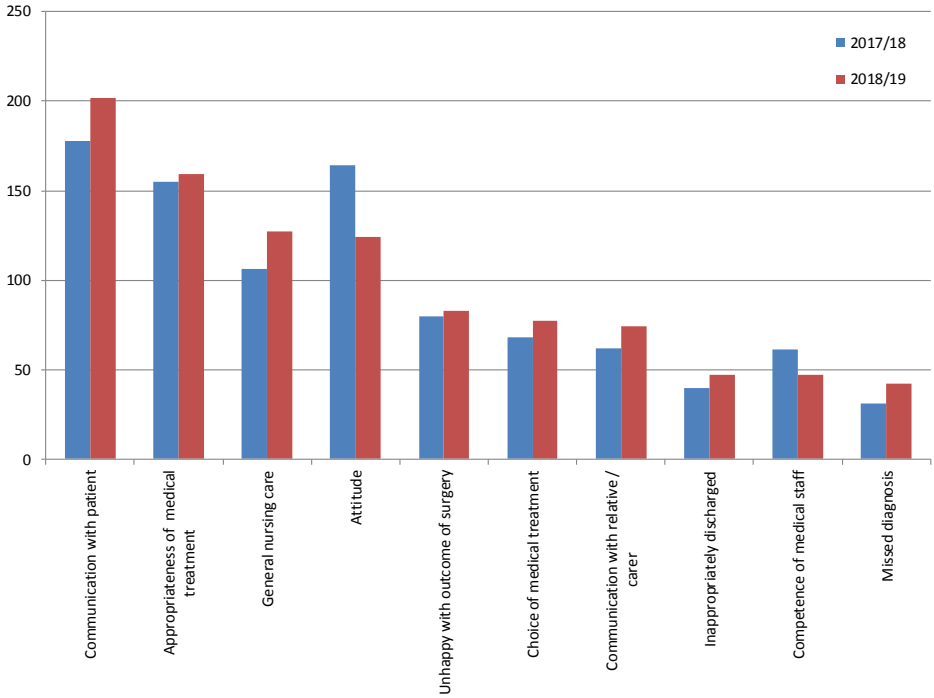



From April 2018, the target response rate for complaints to be closed within the agreed timescale was raised from 85 per cent to 90 per cent. Despite significant staffing issues within the complaints team between April and November 2018, this target was achieved in all but two months.

Monthly complaints reports are produced for Care Groups and Directorates showing the number of complaints received and target response times so that activity is monitored at Directorate level.

This reporting process ensures that at all levels the Trust is continually reviewing information, so that any potentially serious issues, emerging themes or areas where there is a notable increase in the numbers of complaints received, can be thoroughly investigated and reviewed by senior staff .

***Fig: Breakdown of complaints by theme***



Findings from analysis of complaints show that the top five themes of complaints are the same as those identified last year. During 2018/19, 'Attitude' has dropped out of the top three, and has been replaced by 'General nursing care'.

When presented as a percentage, complaints relating to 'Attitude' are two per cent lower this year, complaints relating to 'Communication with patient' have increased by slightly more than one per cent (1.2%) and those relating to 'General nursing care' have increased by a similar amount (1.1%). The remainder of the themes identified are comparable to last year, with a variation of less than one per cent.

We remain committed to learning from, and taking action as a result of, complaint investigations. A selection of actions taken as a result of complaints is featured in the Trust's Integrated Quality Report.

### k. Mixed sex accommodation

The Trust remains committed to ensuring that men and women do not share sleeping accommodation, except when it is in the patient's overall clinical best interest, or reflects their personal choice.

During January 2019, there were two breaches of this standard. Due to a period of exceptional demand, a decision was taken after very careful consideration to temporarily place two male patients in the Respiratory Support Unit which was empty at that particular time. Overnight two female patients who required Respiratory Support Unit care were appropriately admitted to the unit, however, at that point the male patients should have been moved. The transfer did not occur before the women were placed on the ward and so a breach occurred. Explanations and apologies were offered to the patients affected. The Chief Operating Officer has undertaken a review with the Clinical Operations Team, which has highlighted the need for clear contingency plans to be in place at the time the decision is taken to use the Respiratory Support Unit in this way. This is the first time a mixed sex breach has occurred since March 2017.

### l. Coroners' Regulation 28 (Prevention of future death) reports

There was one Regulation 28 sent to Yorkshire Ambulance Service and the Trust during 2018/19.

This related to a misunderstanding between the family and the GP Collaborative Service as to who would call an ambulance. A response was submitted reiterating the actions that had already been taken to reduce the risk of such a situation arising again.

### m. Never Events

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

During 2018/19 four Never Events occurred at the Trust. Two of these were in relation to retained foreign object post procedure and two related to wrong site surgery.

Learning from Serious Incidents and Never Events is shared through multiple forums within the Trust. Two of the Never Events involve the surgical count process and actions taken as a result include the following:

- The Trust Surgical Count Policy has been reissued to all staff within theatres
- The Trust Surgical Count Policy has now been fully implemented in the Cardiac Catheter Suite so that surgical counts are undertaken in line with current policy and clear guidance regarding the responsibility within the Cardiac Catheter Suite
- A review of how all new and updated policies and procedures are shared and implemented in the future, specifically within the Cardiac Catheter Suite, has taken place
- All surgical packs will be reviewed to ensure that all items not in line with the Surgical Count Policy are removed

- A rapid cycle audit programme of the Surgical Count Policy will be undertaken
- The implantable cardiac devices care pathway documentation has been reviewed ensuring reference to the safer surgical checklist.

The two incidents related to wrong site surgery were both in relation to the administration of injections into the incorrect site and were outside of the surgical environment. Both incidents occurred in the last quarter of 2018/19 and so the full investigation informing required actions to prevent future recurrence are not yet complete. All Serious Incidents are shared at the Trust's Safety and Risk Committees to ensure that wider learning and actions are developed and implemented.

## n. Duty of Candour

To ensure the Trust continues to comply with Duty of Candour requirements during 2018/19 a number of refresher training sessions were held for staff, in conjunction with the Trust's solicitors. These sessions were well attended with over 150 staff attending. The Duty of Candour Policy is currently in the process of being updated and reviewed and will be appropriately shared and disseminated when complete.

The current process for recording incidents that trigger Duty of Candour is integrated into the Datix system to provide ongoing assurance that the requirements are being met. In order for Duty of Candour to be considered an incident has to be both classed as a patient incident and moderate, major or catastrophic severity. When this happens a trigger is instigated within Datix to consider whether Duty of Candour applies. During 2018/19 317 incidents met this criterion and of these, 190 incidents were highlighted as requiring the statutory duty to be implemented.

Further analysis has been undertaken of the remaining 127 incidents where Duty of Candour was not deemed applicable, despite being a patient incident of moderate or above severity. This identified that 23 incidents were linked to pressure ulcers which were present on the patient's admission and a further 11 were easily identifiable as being no harm incidents, confirming duty of candour did not apply.

A review of the remaining 93 incidents demonstrated no clear trends or themes. Summary compliance 'spot check' audits take place each quarter to review these incidents, ensuring Duty of Candour is applied where applicable. This provides assurance that Directorates are complying with the statutory duty. The outcomes of these audits are discussed quarterly at the Trust's Patient Safety and Risk Committee.

## o. Safeguarding adults

The Trust is a partner in a network of agencies including Sheffield City Council, Sheffield Health and Social Care NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, South Yorkshire Police, South Yorkshire Fire and Rescue, and NHS Sheffield CCG, who make up the Sheffield Safeguarding Partnership for Children, Young People and Adults. The Partnership Executive Board leads and holds these individual agencies to account ensuring that agencies support and empower children and adults at risk, to protect them from abuse or neglect.

The Trust provides safeguarding training and has a number of safeguarding policies, guidance and processes in place to support staff to identify and report all types of abuse of patients, carers, family members, visitors or staff. This includes the reporting of Female Genital Mutilation and radicalisation.

The Trust's Safeguarding Team supports staff to identify and assist adults at risk who are subject to domestic violence and abuse, working in particularly close collaboration with the maternity services vulnerabilities team, the Emergency Department and Human Resources.

## p. Seven day services

A national Seven Day Services Forum was established by Professor Sir Bruce Keogh, NHS England (NHSE) Medical Director, in 2013 and asked to concentrate its first stage review on urgent and emergency care services

and their supporting diagnostic services. The Seven Day Services Forum's Summary of Initial Findings was presented to the Board of NHS England in December 2013. One of its recommendations was that the NHS should adopt ten evidence-based clinical standards for urgent and emergency care and supporting diagnostics to end current variations in outcomes for patients admitted to hospital at the weekend. NHSE's Board agreed to all of the Forum's recommendations, including full implementation of the clinical standards.

To support quality improvement and measure progress in the achievement of seven day hospital services the Trust has taken part in the NHS England case note review since April 2016. This covers the management of patients admitted as an emergency, measuring practice against the four priority clinical standards. The four priority clinical standards are:

| | |
|---|---|
| Clinical Standard (2): | Time to First Consultant Review |
| Clinical Standard (5): | Consultant Directed Diagnostics |
| Clinical Standard (6): | Consultant Directed Interventions |
| Clinical standard (8): | Ongoing Review |

Key findings from the Spring 2018 survey demonstrate that the Trust has made significant progress to meet these standards.

Clinical Standard (2) – Time to First Consultant Review:

- 81 per cent of patients were seen and assessed within 14 hours of admission
- Variations exist across the specialities with respect to time to first Consultant review
- Variations exist throughout the week for the majority of the specialities.

Clinical Standard (5): - Consultant Directed Diagnostics:

- On the whole, the data supports the view that critical and urgent patients requiring the necessary diagnostics are receiving them in a timely manner

Clinical Standard (6) – Consultant Directed Interventions:

- The Trust has reported that hospital inpatients have timely 24 hour access, seven days a week, to Consultant-directed interventions

Clinical Standard (8) – Ongoing Review (Once Daily Review):

- Across the Trust, results demonstrate that a good proportion of patients (86 per cent) needing a once daily review generally received one
- Patients requiring a once daily review were less likely to receive one at the weekend compared to the weekday (71 per cent vs. 91 per cent).

Clinical Standard (8) – Ongoing Review (Twice Daily Review):

- The majority of patients requiring a twice daily review received one (95 per cent)
- Patients requiring a twice daily review were less likely to receive one at the weekend compared to the weekday (91 per cent versus. 97 per cent)

In November 2018, the Trust was notified by NHSI and NHSE of changes to the Seven Day Service measurement. The survey tool will be replaced by a Board Assurance Framework for measuring seven day service delivery.

This new measurement system replaces the existing self-assessment survey and consists of a standard measurement and reporting template, which all Trusts will complete with self-assessments of their delivery of the seven day service clinical standards. This self-assessment will then be formally assured by the Trust Board and the completed template submitted to regional and national seven day service leads to enable measurement against the national ambitions for seven day services.

This process and template has been designed in partnership with Trust Medical Directors to ensure that they not only produce an

assessment of seven day service delivery that is more accurate, rounded and complete but also reduce the administrative burden on Trusts by aligning with existing data collections.

The Trust is required to implement the Board assurance process from March 2019, with the assurance template completed, along with supporting evidence from local audits to allow Trust Boards to give formal assurance of the self-assessment.

The long association between the Trust and the seven day services agenda means that significant progress has been made. There is however recognition that further progress is needed and this is reflected in the Trust's financial plans. The list of projects that are directly or indirectly related to the implementation of the four clinical standards is lengthy but includes the following significant elements:

- Allocation of funding to enhance Consultant presence at the weekends
- Progress towards a 24/7 safety net of coordinated care across the Trust
- Establishing a 7/7 Consultant directed echocardiography service
- Embedding the agenda within the Workforce Strategy
- Increased Consultant presence within specific Directorates
- Increased capacity within the assessment areas
- Introduction of board rounds

The Trust is also mindful of the desired implementation of the remaining six standards and has made significant progress in several areas especially in regard to implementation of standard nine (Transfer to Community, Primary and Social Care).

## q. Learning from deaths

During 2018/19, 2,806[3] of Sheffield Teaching Hospitals NHS Foundation Trust's patients died, including 25 stillbirths. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 651 in the first quarter;
- 672 in the second quarter;
- 692 in the third quarter;
- 791 in the fourth quarter.

By 31 March 2019, 2,158[4] Medical Examiner (ME) case record reviews (NGH deaths) and eight investigations have been carried out in relation to the deaths included in data contained within the above paragraph.

In eight cases a death was subjected to both a ME case record review and an investigation. The number of deaths in each quarter for which a ME case record review or an investigation was carried out was:

- 524 in the first quarter (81 per cent of all deaths);
- 556 in the second quarter (83 per cent of all deaths);
- 540 in the third quarter (78 per cent of all deaths);
- 538 in the fourth quarter (68 per cent of all deaths).

The number of deaths in each quarter for which a ME case record review and a Structured Judgement Review (SJR) was carried out was:

- 15 in the first quarter (3 per cent of ME case record reviews);
- 40 (of 41 SJRs requested) in the second quarter (7 per cent of ME case record reviews);
- 108 (of 115 SJRs requested) in the third quarter (20 per cent of ME case record reviews);

[3] Source: Information Services 'Deaths in Hospital' report run on 2 April 2019
[4] Assuming that all NGH deaths are reviewed by the Medical Examiner

- 56 (of 87 SJRs requested) in the fourth quarter (10 per cent of ME case record reviews).

Zero (0) representing Zero per cent (0%) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using the ME case record review and SJR. However, 14 cases have been identified for further investigation and have yet to be reviewed by the Serious Incident Group to make this decision.

As a first step SJR summaries are sent to relevant Directorates for discussion at speciality mortality and morbidity meetings where local actions can be agreed and progressed (where these are within the scope of Directorates to do so).

Already the analysis of the deaths by the Faculty of clinicians using the SJR method has identified areas of potential intervention. Some of these areas of work reflect national issues, such as the quality of notes documentation, and are correspondingly difficult to action locally although the move to an electronic patient record will help to mitigate this. Other emerging themes, such as sepsis management and Acute Kidney Injury (AKI) management, are already being addressed by different workstreams within the Trust and reinforce the need for robust work in these areas.

In addition, it is important that other themes which emerge are assigned a priority by the Trust to enable a sustainable work plan to be created with embedded metrics that allow measurement of healthcare improvement.

Discussions within the Trust both at Executive level and Directorate level will be required to create models for intervention.

There are ongoing discussions with Directorate Governance Leads, Clinicians and the SJR Faculty to evaluate the process and feedback mechanisms.

A total of 55 deaths prior to 1 April 2018 had a SJR undertaken after 1 April 2018 and one is still awaiting a SJR. Three of the 55 scored 2 (poor care). Two of these were reviewed by the Deputy Medical Director and Deputy Chief Nurse. One was amended to a 3 (good) following added context from the Directorate and further investigation has been requested for the second. The third is currently in progress.

Zero (0) representing Zero per cent (0%) of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the ME case record review and SJR. However, one case has been identified for further investigation and is yet to be reviewed by the Serious Incident Group to make this decision.

Zero (0) representing Zero per cent (0%) of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

### r. Staff who speak up

Employees of the Trust have a number of ways they can raise concerns about patient safety or about any perceived bullying and harassment.

The two main policies which support staff in doing this are: the Raising Concerns at Work Policy and the Acceptable Behaviour at Work Policy.

We encourage all staff to raise concerns with their line manager or someone within their line management structure in the first instance but if they feel unable to do this we do have two Freedom to Speak Up Guardians in the Trust who are supported by a number of trained Freedom to Speak Up Advocates who are located across the organisation. Their contact details can be found on the Human Resources intranet page and are publicised on posters across the organisation.

There are regular communications to Trust employees about the Freedom to Speak Up process and all staff raising concerns through

this route receive feedback via the Guardian / Advocate who they raised their concern with and/or the investigating manager.

All staff raising genuine concerns are protected in line with whistleblowing legislation.

### s. Rota gaps

Due to vacancies or unanticipated sickness some specialties have elements of their staff rota that need to be filled.

The Trust has a very successful internal locum bank, with which more than 90 per cent of Trust doctors in training are registered, and this provides a cohort of doctors who are familiar with the Trust, its processes, procedures and IT systems who can be deployed at short notice as required.

- Deploying alternative non-medical staff to carry out clinical and non-clinical tasks where appropriate

A well-established Hospital Out of Hours service is in place at both campuses, and makes efficient use of the out of hours workforce, allocating tasks to the most appropriate staff member, some of whom are non-medical. In addition to its core non-medical and dedicated co-ordinating staff, the service relies on fixed contributions from junior medical staff from each participating specialty.

- Novel recruitment strategies

The Trust has devised innovative ways of attracting and maintaining medical staff who wish to take time out of clinical practice by creating posts catering for the needs of both the service and individuals, and this approach has met with some success. The creation of Trust Clinical Fellows, who are offered a combination of clinical work and training opportunities outside a traditional numbered training post, has also been successful, particularly in the Emergency Department.

A number of approaches have been explored relating to the training of non-medical staff to undertake tasks traditionally carried out by doctors. These include the training of Advanced Clinical Practitioners who train for between one and three years before they are fully-qualified, and the appointment of a cohort of Physicians' Assistants. At present, Physicians Assistants are not permitted to prescribe medication or order radiological investigations, and whilst plans are emerging nationally to address this, the relevant legislation is unlikely to become law for one to two years.

# 3. Quality performance information 2018/19

*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:*

- Six that are linked to patient safety;
- Eleven that are linked to clinical effectiveness; and
- Thirteen that are linked to patient experience

***Fig: Quality Performance Information***

| Prescribed Information | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|
| **The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust for the reporting period.** | | | Oct 17 – Sept 18 |
| National Average: 1 .00<br>Highest performing Trust score: 0 .69<br>Lowest performing Trust score: 1 .27<br>*(Figures for October 17 - September 18)* | 0.98 Banding: as expected | 0.96* Banding: as expected | 0.96 Banding: as expected |
| The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. | 29 .0% | 27.4%* | 26.6% |
| National average:33.6%<br>Highest trust score: 59 .5%<br>Lowest trust score: 14.3%<br>*(Figures for October 17 - September 18)* | | | |

Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as the data are extracted from the NHS Digital SHMI data set.

The SHMI makes no adjustment for palliative care because there is considerable variation between trusts in the way that palliative care codes are used. Adjustments based on palliative medicine treatment specialty would mean that those organisations coding significantly for palliative medicine treatment specialty would benefit the most in terms of reducing the SHMI value (the ratio of Observed/Expected deaths would decrease because the expected mortality would increase).

Hence, SHMI routinely reports percentage patient deaths with palliative care coding as a contextual indicator to assist with interpretation of data.

Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this coding rate, and so the quality of its services, by implementing an additional step whereby the Coding Department receive a monthly report from the Palliative Care Service which details every patient seen.

The Trust is also now producing a coding report which informs the position that the code for specialist palliative care has been entered to optimise the expected deaths model calculation for HSMR.

Both reports have taken effect from October 2018.

*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. October 2016 - September 2017. SHMI results are published five months and three weeks in arrears because of the need to validate the data nationally. The value for April 2017 - March 2018 was released on 20 September 2018 and reported as 0.96. This can be validated via the NHS Choices website.

** O/E ratio is the ratio of observed deaths divided by expected deaths

| Prescribed Information | 2016/17 Finalised | 2017/18 Provisional | 2018/19 Provisional |
|---|---|---|---|
| **Patient Report Outcome Measures (PROMs)** The Trust's EQ5D patient reported outcome measures scores for: | | | |
| (i) Groin hernia surgery | | | |
| Trust score: | 0.077 | 0.077 | No longer part of the National PROMs programme |
| National average: | 0.089 | 0.089 | |
| Highest score: | 0.140 | 0.122 | |
| Lowest score: | 0.000 | 0.000 | |
| (ii) Varicose vein surgery | | | |
| Trust score: | * | * | No longer part of the National PROMs programme |
| National average: | 0.096 | 0.096 | |
| Highest score: | 0.134 | 0.134 | |
| Lowest score: | 0.000 | 0.000 | |
| (iii) Hip replacement surgery primary | | | |
| Trust score: | 0.417 | 0.449 | 0.527 |
| National average: | 0.445 | 0.468 | ** |
| Highest score: | 0.537 | 0.566 | ** |
| Lowest score: | 0.310 | 0.376 | ** |
| (iv) Hip replacement surgery revision | | | |
| Trust score: | 0.291 | * | 0.343 |
| National average: | 0.292 | 0.289 | ** |
| Highest score: | 0.362 | 0.322 | ** |
| Lowest score: | 0.239 | 0.227 | ** |
| (v) Knee replacement surgery primary | | | |
| Trust score: | 0.317 | 0.376 | 0.382 |
| National average: | 0.324 | 0.338 | ** |
| Highest score: | 0.404 | 0.417 | ** |
| Lowest score: | 0.242 | 0.234 | ** |
| (vi) Knee replacement surgery revision | | | |
| Trust score: | 0.249 | * | 0.169 |
| National average: | 0.273 | 0.292 | ** |
| Highest score: | 0.297 | 0.328 | ** |
| Lowest score: | 0.000 | 0.196 | ** |

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

** Denotes data not yet released

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.

Please note that groin hernia and varicose vein have been removed from the programme from October 2017.

Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the NHS Digital PROMs data set. Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score, and through this the quality of its services, by:

- Implementing decolonisation pre operatively with an aim to reduce post-operative infections rates.
- Facilitated ward move to be nearer theatres for all arthroplasty patients - Theatres started piloting a spot type probe attached to the patient from the Theatre Admissions Unit through to recovery, to monitor the patient's temperature throughout this journey. This supports NICE guidance that recommends maintaining the patient's temperature greater than 36 degrees to assist in wound healing and a reduction in Surgical Site Infections.

| Measures of Quality Performance | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|
| **Readmissions**<br><br>The percentage of patients aged: 0 to 15; and<br><br>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.<br><br>*Comparative data is not available*<br><br>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, Lorenzo.<br><br>Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and through this the quality of its services, continuing to enhance assessment areas such as the Frailty Unit on the NGH site and the Urology Assessment Unit on the RHH site that both serve to reduce readmissions and improve pathways for patients. Expanding our ambulatory care offering is also a priority in the coming months. An Action Plan has been developed to address any areas within the Trust where readmissions may be higher than comparative Trusts. This work will be overseen by the Central Readmissions Group. | 0%<br><br>14.7% | 0%<br><br>14.88% | 0%<br><br>16.49% |
| **Responsiveness to personal needs of patients**<br><br>The Trust's responsiveness to the personal needs of its patients during the reporting period.<br><br>National average: 92% (this is based on the average scores across all NHS trusts who are contracted with Picker Europe, the CQC's national surveys contractor)<br><br>The Trust score is made up of the following:<br>Did you get enough help from staff to eat your meals? – 86%<br>Do you think the hospital staff did everything they could to help control your pain? – 94%<br>Treated with respect and dignity – 99%<br><br>Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by National CQC Survey Contractor.<br><br>Sheffield Teaching Hospital NHS Foundation Trust continues to take action to improve this rate, and so the quality of its services, by implementing local surveys during 2019/20 to enhance our understanding of patient needs. The final programme for the additional local surveys is currently being agreed. | 74.7% | 80.4% | 93% |

| Measures of Quality Performance | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|
| **Patients risk assessed for venous thromboembolism (VTE)s**<br><br>The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.<br>*Comparative data is not available*<br><br>Sheffield Teaching Hospital NHS Foundation Trust considers that this data is as described as the data is taken directly from the Trust's Electronic Patient Record.<br><br>Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and through this the quality of its services, by having established processes in place that check if a patient has had a VTE risk assessment. Where this has not been completed this is followed up and completed. | 95.2% | 95.29% | 95.04% |
| **Rate of Clostridium Difficile**<br><br>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.<br>*Comparative data is not available*<br><br>*This is the final figure for 2017/18 following the review of quarter 4 cases post publication of the 2017/18 Quality Report<br><br>**The rate shown is provisional until the Public Health England denominator rates are published. The denominator used is the 2017/18 figure as this is unlikely to change significantly.<br><br>During 2018/19 there have been 84 *C.difficile* Hospital Onset/Healthcare associated episodes detected within the Trust. The national threshold for such episodes for 2018/19 was 86<br><br>All Hospital Onset/Healthcare Associated cases have a root cause analysis to identify if there has been any possible lapse in care. At publication (as of the end of Quarter 3) 10 cases have been highlighted as possibly having a lapse in care. Quarter 4 cases are still being reviewed.<br><br>Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by Public Health England.<br><br>Sheffield Teaching Hospitals NHS Foundation Trust continues to take a range of actions to improve this rate, and through this 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. | 20 3 | 15.2* | 15.4** |

| Measures of Quality Performance | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|
| **Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer** | | | Q1, Q2 & Q3 data used |
| **Urgent GP referral for suspected cancer** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 83% | 78.94%* | 74.53 |
| National Standard | 85% | 85% | 85% |
| **NHS Cancer Screening Service referral** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 96.31% | 91.84%* | 87.80% |
| National Standard | 90% | 90% | 90% |
| *This figure is different from last year as it represents the whole year (April 2017 – March 2018) | | | |
| *Data Source: Open Exeter National Cancer Waiting Times Database* | | | |
| **Rate of patient safety incidents** | | | April to Sept 2018 |
| 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. | 20,089 | 21,313* | 11,358** |
| **Number of incidents reported** | | | |
| The incident reporting rate is calculated from the number of reported incidents per thousand bed days and the comparative data used is from the first 6 months of 2018/19. | 37.15 | 39.2* | 44.2** |
| **Cluster average: 44.5 / Highest performing Trust score: 107.4 / Lowest performing Trust score: 13.1 | | | |
| **The number and percentage of patient safety incidents that resulted in severe harm or death** | 18 (0.1%) | 50* (0.2%) | 32** (0.3%)** |
| **Cluster reporting data: 19 (0 .3%) / Highest reporting Trust: 87 (0.4%) / Lowest reporting Trust: 0 (0%) | | | |
| * The figures for 2017/18 are different to those documented in last year's Quality Report as they have now been validated. | | | |
| **Full information for the financial year 2018/19 is not available from the National Reporting and Learning System (NRLS) until September 2019. Data reported covers April to September 2018. | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust encourages reporting of all incidents and as a result has seen the numbers of reported incidents increase, reflecting a continually improving safety culture. The numbers of incidents reported are monitored by the Patient and Occupational Safety and Risk Committee's and at local Directorate governance meetings. | | | |
| *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* | | | |

| Measures of Quality Performance | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|
| **Maximum six week wait for diagnostic procedures** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement. . | 98 .93% | 92 .95% | 98.75% |
| National Standard | 99% | 99% | 99% |
| **Accident and Emergency maximum waiting time of 4 hours from arrival to admission/ transfer/ discharge** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 86.77% | 88.64% | 87.30% |
| National Standard | 95% | 95% | 95% |
| **MRSA blood stream infections** | | | |
| Hospital Onset bacteraemia cases in Sheffield Teaching Hospitals NHS Foundation Trust | 2 | 3 | 2 |
| Trust assigned cases in Sheffield Teaching Hospital NHS Foundation Trust (No longer applicable) | 2 | 3 | n/a |
| Sheffield Teaching Hospitals NHS Foundation Trust threshold for Hospital Onset episodes. | 0 | 0 | 0 |
| The Trust assigned category was introduced for the 2013/14 and ceased as 2017/18 | | | |
| **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 | 93.16% | 94.4% | 91.6% |
| National Standard | 95% | 95% | 95% |
| **Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 93.5% | 95.7% | 93.4% |
| National Standard | 92% | 92% | 92% |
| **Patients who require admission who waited less than 18 weeks from referral to hospital treatment** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 85.4% | 88.21% | 85.2% |
| National Standard | 90% | 90% | 90% |
| **Never Events (Count)** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 6 | 3 | 4 |
| **Hospital Standardised Mortality Ratio (HSMR)** | | | Jan 18-Jan 19 |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 105% | 107%* | 108% |
| National Standard | 100% | 100% | 100% |
| *Data source: Dr Foster* | | | |
| *This figure is different from last year as it represents the whole year (April 2017 – March 2018) and an annual benchmark rather than February 2017 – January 2018 as reported in last year's Quality Report. | | | |

| Measures of Quality Performance | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|
| **Certification against compliance with requirements regarding access to healthcare for people with a learning disability** | | | |
| Does the NHS Foundation Trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? | Yes | Yes | Yes |
| Does the NHS Foundation Trust provide readily available and comprehensible information to patients with learning disabilities about treatment options, complaints procedures and appointments? | Yes | Yes | Yes |
| Does the NHS Foundation Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? | Yes | Yes | Yes |
| Does the NHS Foundation Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? | Yes | Yes | Yes |
| Does the NHS Foundation Trust have protocols in place to encourage representation of people with learning disabilities and their family carers? | Yes | Yes | Yes |
| Does the NHS Foundation Trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? | Yes | Yes | Yes |
| **Data Completeness for Community Services** | | | |
| **Referral to treatment information:** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 65% | 62% | 59.94% |
| National Standard | 50% | 50% | 50% |
| **Referral information:** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 100% | 100% | 100% |
| National Standard | 50% | 50% | 50% |
| **Treatment activity information:** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 100% | 100% | 100% |
| National Standard | 50% | 50% | 50% |

| Measures of Quality Performance | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|
| **Friends and Family Test - Staff who would recommend the Trust (from Staff Survey)**<br>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.<br>National average: Combined Acute and Community Trusts – 69.9%. All Trusts – 70.9%<br>Highest performing Trust score:(Combined Acute and Community Trusts): 90.3%<br>Lowest performing trust score: (Combined Acute and Community Trusts): 49.2%<br>Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is provided by the national CQC survey contractor.<br>Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and through this the quality of its services, by seeking staff views and involving them in improving the quality of patient services via Listening into Action, Microsystems Academy, Staff Friends and Family Test and our ongoing staff engagement work. | 81% | 81% | 81% |
| **Friends and Family Test - Patients who would recommend the Trust**<br>The percentage of patients who attended the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.<br>The Friends and Family Test (FFT) scores are now recorded taking the percentage of respondents who 'would recommend' our service which is taken from ratings One (Extremely Likely) and Two (Likely).<br>Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is collected by the Healthcare Communications, verified by UNIFY and reported by NHS England.<br>Sheffield Teaching Hospital NHS Foundation Trust continues to take the following actions to improve this rate, and through this the quality of its services:<br>• A monthly report is circulated across the Trust informing staff of scores and response rates, as well enabling them to review the comments that patients have left about their experience<br>• Monthly FFT scores are compared with the 12 month Trust score as well as the 12 month national score to monitor performance<br>• The Patient Experience Committee monitors FFT | All areas 93%<br>Inpatient 96%<br>A&E 86%<br>Maternity 96%<br>Outpatient 94%<br>Community 88% | All areas 94%<br>Inpatient 96%<br>A&E 88%<br>Maternity 95%<br>Outpatient 94%<br>Community 89% | All areas 94%<br>Inpatient 96%<br>A&E 87%<br>Maternity 97%<br>Outpatient 95%<br>Community 90% |

| | | | |
|---|---|---|---|
| scores for all elements of the FFT to identify any trends or concerns and takes the necessary action should the positive score fall in any particular area of the Trust. This moved from a monthly to a quarterly basis in December 2018 to allow for sufficient numbers of responses to be received for any change to be statistically significant | | | |

# 4. Statements from our Partners on the Quality Report

### Governor involvement in the Quality Board

Three governors are currently members of the Quality Board. Our role is to assist the Quality Board in choosing the appropriate priorities regarding improving quality of care for patients.

This year, all members of the Trust, governors, visitors and staff have had an opportunity to help the Trust decide it's priorities to improve the patient experience. Nearly 1,500 people responded to this request and the members of the Quality Board are prioritising and responding to these objectives.

The Quality Board continues to observe and respond to best practice and uses this as a benchmark for other objectives.

We are welcomed and encouraged at all stages of report writing, including contributing to the content and wording and will ensure that work continues to influence good patient care.

Kath Parker, Patient Governor
12th April 2019

### Statement from NHS Sheffield Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group (CCG) has reviewed the information provided by Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) 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 representation of the Trust's performance.

STHFT 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. The report fairly articulates where this has been achieved and also where this has been more challenging.

During 2018/19 the Trust has achieved a number of key Constitutional standards and key quality performance measures which includes achievement in the incomplete 18ww target and diagnostics. However, the Trust has continued to experience challenges in the delivery of the 95% A&E target and a number of the cancer wait targets.

The CCG's overarching view is that STHFT continues to provide, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities. This quality report evidences that the Trust has achieved positive results in a number of its key objectives for 2018/19. Where issues relating to clinical quality have been identified in-year, the Trust has been open and transparent and the CCG has worked closely with the Trust to provide support where appropriate to allow improvements to be made.

The CCG jointly agreed the identified priority areas for improvement in 2019/20 which are reflected in the locally agreed Service and Development Improvement Plan. Our aim is to pro-actively address issues relating to clinical quality so that standards of care are upheld whilst services continue to evolve to ensure they meet the changing needs of our local population. The CCG will continue to set the Trust challenging targets whilst at the same time incentivise them to deliver high quality, innovative services.

Submitted by Beverly Ryton on behalf of:

Mandy Philbin, Chief Nurse, and Cath Tilney, Deputy Director of Contracting

3rd May 2019

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

We'd like to thank the Teaching Hospitals Trust for sharing their Quality Account with us. We're pleased to note that the Trust has engaged more widely in identifying priority objectives for this year, and look forward to seeing improvements in areas that really matter to people using health services in Sheffield.

We're pleased to see the detailed narrative on progress of last year's quality priorities, however we would welcome a 'measure of success' to let us know if progress has been good enough, and whether the objectives have been met.

We noted last year that urgent suspected cancer GP referral to treatment times for cancer were below the National Standard, and note again with disappointment that performance in this area has dropped further during 2018/19. We want to understand where the hold ups in the pathway are, and will be looking for evidence of improvement over the coming year.

We're pleased to note that the number of staff who would recommend the Trust as a place for treatment, and as a place to work is higher than average. We'd like to take this opportunity to thank all the staff at the Trust for their hard work in delivering such important services for the City.

We look forward to increasing our engagement with the Trust during 2019/20, as we consider developments through the Accountable Care Partnership in Sheffield, and as we look at the Hospital Services Programme through our work on the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee.

16th April 2019

### Statement from Healthwatch Sheffield

Thank you for inviting us to comment on this year's Quality Account. We value our relationship with the Trust and your enthusiasm to involve Healthwatch Sheffield in the development and oversight of your quality priorities. We are pleased to participate in the Quality Board, which supports the management of quality objectives.

We are broadly satisfied with the progress reported against 2018/19's quality objectives. We welcome the progress made on the priority to 'implement and evaluate at least one major co-production project and develop a plan for embedding this approach more widely'. We encourage the Trust to embed principles of co-production and shared decision making, such as in-depth discussions with patients and their carers wherever possible.

Following on from last year, we welcome the continued roll out of Falls Safety Huddles across the Trust, and the resulting reduction in falls.

Last year we highlighted the importance of implementation of the Accessible Information Standard (AIS) with regard to two specific quality objectives. We encourage you to work closely with patients and carers with sensory impairments to measure whether the changes being made are having a positive impact on them.

Specifically, in light of the problems experienced by Deaf patients in receiving equal access to your services, and the action plan you have in place, we would have expected progress against this to have been mentioned in your Quality Account.

We welcome the progress made in standardising letter templates, and we are pleased that engaging with patients widely to evaluate these remains priority for 2019/20. We look forward to working with you on this through the Patient Experience Committee (PEC).

We are pleased to note that in all but two months, you met the target of 90% response times for complaints, which had been raised from the previous target of 85%. However, this year a small number of people told us they were not satisfied with the substance of responses to their complaints; timeliness is not the only indicator of a well-functioning complaints system.

We broadly welcome your quality objectives for 2019/20 and we strongly support the Trust's inclusion of patients and visitors in deciding which areas to focus on in the 2019/20 quality objectives. We are particular pleased to see the Trust's explicit commitment to patient involvement, especially with patients whose experiences are less well understood.

Healthwatch Sheffield works with Sheffield's diverse communities to bring their views and

experiences to commissioners and providers. This year, we have shared experiences of trans patients, patients with disabilities, young people, asylum seekers and refugees and BAMER communities. We hope the Trust will make full use of our findings and our networks in order to hear a wider range of views.

The Quality Account generally reflects what people have shared with us this year about their experiences. Throughout the year patients and carers have been keen to recognise the impact of staff members who kept them well informed and had a positive attitude, and reported feeling looked after because of this.

Waiting times and communication with patients following appointments were the areas that patients and carers we heard from felt were most in need of improvement. In four of the six measures for waiting times which are reported on in the 'Measures of Quality Performance' section, the Trust reports falling slightly below national standards. It would have been useful to see some discussion of this in the Quality Account, and how improvements will be made.

We note the Trust has acknowledged specific areas for improvement based on the results of the National Maternity Survey 2018. This is consistent with feedback we have received from patients who told us their partner was not able to stay with them for as long as they wanted them to.

We look forward to working the Trust this year as part of the Quality Board and Patient Experience Committee.

1st May 2019

## Statement of Directors' Responsibilities for the Quality Report

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

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

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

The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance Detailed Requirements for Quality Reports 2018/19.

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 2018 to April 2019
- papers relating to quality reported to the Board over the period April 2018 to April 2019
- feedback from Commissioners dated 3 May 2019
- feedback from Governors dated 12 April 2019
- feedback from local Healthwatch organisations dated 1 May 2019
- feedback from Overview and Scrutiny Committee dated 16 April 2019
- the Trust's draft complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13 May 2019

- the latest national patient surveys, dated June 2018 (Inpatients), January 2019 (Maternity) and September 2018 (Cancer)
- the latest national staff survey published February 2019
- the Head of Internal Audit's annual opinion of the Trust's control environment discussed at the Audit committee of 20 May 2019
- CQC inspection report dated 14 November 2018

The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.

The performance information reported in the Quality Report is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board of Directors

**Tony Pedder OBE**
Chairman
21 May 2019

**Kirsten Major**
Chief Executive
21 May 2019

# 5. Independent Auditor's Limited Assurance 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 2019 (the 'Quality Report') and certain performance indicators contained therein.

## Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers; and
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

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 NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2018/19; 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 supporting guidance and the six dimensions of data quality set out in the Detailed Requirements 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 supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2018 to April 2019;
- Papers relating to quality reported to the Board over the period April 2018 to April 2019;
- Feedback from NHS Sheffield Clinical Commissioning Group, dated 3 May 2019;
- Feedback from Governors, dated 16 April 2019;
- Feedback from the Healthwatch Sheffield, dated 1 May 2019;
- Feedback from Sheffield City Council Healthier Communities and Adult Social Care Scrutiny Policy Development Committee, dated 16 April 2019;
- The Trust's 'Annual Complaints Report 2018/19' published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;

- The latest national patient surveys;
- The latest national NHS staff survey, dated February 2019;
- Care Quality Commission inspection report, dated 14 November 2018;
- The Head of Internal Audit's annual opinion over the Trust's control environment for the period April 2018 to March 2019; and
- Any other information included in our review.

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, 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 2019, 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, except where terms are expressly agreed and with our prior consent in writing.

## Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- 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; and
- reading the documents.

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

## 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.

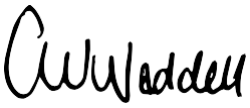
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore,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

The scope of our assurance work has not included governance over quality or 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 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2018/19; 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 and supporting guidance.



Cameron Waddell
Partner, for and on behalf of Mazars LLP

Chartered Accountants and Statutory Auditor

Salvus House
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23 May 2019

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